NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING

Thursday 8 February 2024, 10am
Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
01/24	10.00	(i) Apologies for Absence		Information
02/24	10.00	(i) Quoracy Statement (ii) Declarations of Interest in items on the agenda		Assurance
03/24 Page 3	10.00	Minutes of the last meeting: Board meeting held 7 December 2023	1	Assurance/ Approval
04/24 Page 11	10.05	Matters Arising from the Action Log	1	Assurance
05/24	10.15	Any urgent items to be taken at the discretion of the Chair		
06/24	10.15	Patient Story: Halton 0-19 Service - Drugs & Alcohol	2,3,7	Information
07/24 Page 16	10.40	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Approval
08/24 Page 31	10.55	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				
09/24 Page 41 Page 78 Page 89	11.10	(i) IQPR (new style report) – presented by Executive Leads	1	Assurance
		(ii) Report from the Quality and Safety Committee held on 21 December 2023 – presented by the Committee Chair	2,3	Assurance
		(iii) EPRR Update – presented by the Chief Operating Officer	1,2,4, 5,7	Assurance
			1,3	Information

Page 96 Page 108 Page 117		(iv) Draft Clinical Leadership Strategy – presented by the Deputy Chief Nurse		Assurance
		(v) Freedom to Speak Up – presented by the Deputy Chief Nurse	2	Assurance
		(vi) Halton SEND Report – presented by the Chief Operating Officer	1,2,3, 6,7	

12.20 - **10 MINUTES BREAK**	

RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
10/24 Page 129		(i) Finance Report – presented by the Director of Finance	5	Assurance
Page 138	12.30	(ii) Report from the Finance and Performance Committee held on 25 January 2024 – presented by the Committee Chair	5	Assurance
Page 145		(iii) Report from the Audit Committee held on 11 January 2024 – presented by the Committee Chair	1	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 communities				
11/24 Page 154	1.05	Strategy in Action – presented by the Programme Director of Integration and Collaboration	3,7	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				
12/24 Page 168 & Appendix Pack A	1.20	(i) Report from the People Committee held on 17 January 2024 – presented by the Committee Chair (ii) Equality Delivery System Plan EDS Action plan Public Sector Equality Duty Annual Report	4,6	Assurance/ Approval
		(iii) Apprenticeship Week – Presentation/stories from Bridgewater Apprentices	4	Information

OVERARCHING CORPORATE GOVERNANCE ITEMS				
13/24	2.05	Review of meeting and Items to be added to the Board Assurance Framework	1	Information
14/24	2.10	Opportunity for questions to the Board from staff, media or members of the public at the discretion of the Chair	1	Information

DATE & TIME OF NEXT MEETING Thursday 4 April 2024, 10am at Spencer House, Dewhurst Road, Birchwood, Warrington
MOTION TO EXCLUDE **(Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960)**

Unapproved Minutes from a Public Board Meeting
Held on Thursday 7 December 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
Elaine Inglesby, Non-Executive Director
Abdul Siddique, Non-Executive Director
Martyn Taylor, Non-Executive Director
Paula Woods, Director of People and Organisational Development

In Attendance
Rob Foster, Programme Director of Integration and Collaboration
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

For Patient Story (item /23 only)
Jilly Wallis, Associate Director of Halton Adult Community Services

Observers/members of the Public
Peter Hollett, Public Governor, Halton

78/23 **(i) APOLOGIES FOR ABSENCE**
Tina Wilkins, 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.

79/23   **MINUTES OF THE LAST MEETING**

BOARD MEETING HELD 5 OCTOBER 2023

One correction was agreed to be made to the last minutes: Surname for HR graduate observer to be sourced and included.

One point of clarification was noted concerning the discussion in relation to the staff survey on page six of the minutes: Non-Executive Director, Linda Chivers asked whether the figure quoted within the minutes of 500 staff who had indicated that they would not feel confident to raise a clinical concern was accurate. The Chief Executive advised that this was a pro-rata figure from the percentage of the survey responses to the question asked. He advised that this was one of the many reasons for the work being undertaken related to Freedom to Speak Up and ensuring a culture where staff felt comfortable to raise concerns and issues. It was agreed that an amendment would be made to the last minutes to clarify this figure.

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

80/23   **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 had taken place of Provider Collaborative Chairs and Non-Executive Director representatives in October. Going forwards, Elaine Inglesby would act as the Non-Executive Director representative for Bridgewater. The Collaborative would need to consider how the work would be reported through to each of the Constituent Boards. **It was agreed that this action would be rated as blue/completed,** and that the forward steps would now be around how the Collaborative would keep Constituent Boards up to date.

70/23 Key Corporate Messages

An update regarding the time to talk process was included within the People reports included on the agenda today.

71/23iii EPRR

An update report was included on the agenda today.

72/23i Finance Report

The Director of Finance confirmed that financial information for Place (Warrington and Halton) would be included within the finance report once it was available. **It was agreed that this action would remain on the action log until this was provided.**

The Board agreed that the following blue rated items would be removed.
57/23iii Freedom to Speak Up (FTSU) Report
58/23i Finance Report
58/23ii Adaptive Reserve Report
60/23ii Update on the North West Anti-Racist Framework

81/23   **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.

82/23   PATIENT STORY – HALTON HEART FAILURE SERVICE

The Board received a presentation from Jilly Wallis on the project which was a Cheshire and Mersey pathway for those living with heart failure. Local health and care leaders published an integrated pathway through the Cheshire and Merseyside Cardiac Board. To deliver this pathway, Widnes PCN defined the need to enhance services for patients with heart failure (HF) providing improved access and health outcomes. A collaborative project was identified with opportunities to improve integration, outcomes and patient and professional experience along the heart failure journey and reduce the structural challenges and inequalities across the healthcare system related to this disease. There had been a wide range of engagement from partner organisations across the system, including external companies ORCHA, Care Labs and Boehringer Ingleheim and nine patients, all with differing severities, socio economic situations, postcodes ages and genders. Work was undertaken via two rounds of participation to identify quick wins and challenges with patients and care teams separated by organisation and to co-create integrated solutions with patients and multidisciplinary groups. A number of recommendations were identified: a multilayer approach to raising heart failure awareness and drive detection across Cheshire and Merseyside: collaborative and educational practices to drive earlier detection, proximity to services facilitating equitable access to testing and specialist care confirming a diagnosis and initiating evidence-base management at an earlier point, a series of collaborative tools (including digital apps via ORCHA), services and community initiatives to provide tailored support for patients and carers to manage their chronic heart failure; integrated and co-ordinated approach to accompany patients in their transition from acute to rehab and chronic care (including broadening the reach of virtual wards and/or remote technology to monitor patients) and specialist training and collaborative pathways to have earlier and more compassionate end of life conversations with patients and families. An update was provided on the work to date across those areas.

The Chief Nurse asked whether the presentation would be shared at future Time to Shine meetings. Jilly Wallis confirmed that this would happen once there had been further work undertaken and additional traction. She also confirmed to the Chief Nurse that prevention advice was linked into the pathways. The Chief Nurse also asked whether work could be rolled out with community nurses across Warrington. Jilly Wallis advised that this was likely to take place during the later half of 2024. Jilly Wallis advised Non-Executive Director, Elaine Inglesby that there was public health involvement in the work to support places such as local gyms with their health assessments around early identification. She advised that it would be known when the scheme had made a difference to patients when they were able to observe a difference in the care they received which would provide better outcomes, however this was currently challenging to quantify. She considered that having the appropriate pathways in place and measures was important and to keep a focus on measuring success. There would be further work in the future to measure whether staff were picking up more patients after they had been trained to identify issues/early intervention with a focus on the outcomes. The Chief Operating Officer advised that there would be links into the neighbourhood teams, with an opportunity to identify people at an earlier stage of the caseload, opposed to at the end of life stage. She noted that patients could sometimes deteriorate quickly with heart failure and this work should significantly help to improve their care.

Non-Executive Director, Gail Briers highlighted the wider opportunities that could be realised as a result of embracing the technology via ORCHA with the use of different applications for different conditions that were available. She considered that this could be worth investment as it could provide support for patients, efficiencies and transformation that would be of high value, releasing staff and improving outcomes. She referred to past positive experiences that she had from use of this technology. She suggested that a time to talk session with ORCHA would be beneficial to explore this. The Medical Director advised that there would also be elements around ensuring following of NICE guidance and ensuring auditing of this work. He explained that he had invited ORCHA to present to a future DIGIT meeting. He noted that there would be a substantial investment to become a member of ORCHA however he recognised the points made by Non-Executive Director, Gail Briers but commented that digital literacy of those to use the applications including staff would need to be factored into any considerations. The Chief Nurse added that there were clinical aspects that would need

to be considered around use of the applications and considering the return on investment on efficiencies and clinical benefits. Jilly Wallis highlighted that the ORCHA applications were one of many tools and it could be decided at a later point that a different route may be more beneficial. Jilly Wallis confirmed to the Chief Executive that there were links into Cardiology at both local Acute Trusts with ongoing discussions taking place.

The Board thanked Jilly Wallis for the presentation and welcomed the approach and work undertaken to date which it considered to be a blueprint for how the Trust would like to work in the future with patients at the centre.

83/23   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. The Trust Secretary asked the Board if it would agree to retire this version of the Board Assurance Framework, with the new version to be agreed later in the agenda and then taken forwards from today's meeting. The Director of People highlighted that there had been a discussion at the People Committee in November concerning the lack of a software system around talent management and succession planning, which was a national issue. **It was agreed that this should be captured within the new BAF as a gap in control. The Board agreed to retire the current version of the BAF.**

84/23   KEY CORPORATE MESSAGES

The Chief Executive presented the report and highlighted the activity and engagement over the period by the Executive and Non-Executive Directors, work of the Trust with the Princes Trust to support care leavers to move into apprenticeships: he reported that the Trust now had over 100 apprentices in the organisation and it was hoped that the organisation would continue to build on this; he reflected upon the HSJ awards from 16 November and whilst the Trust had not been successful he noted that it was keen to celebrate its work and submit applications for awards for both clinical and non-clinical areas. Feedback was also noted from recent time to talk visits and a particular reference made to the NHS Providers Review of the Year document which was considered to be a good reflection of the challenges within the community sector.

85/23   QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered

(i) IQPR

The Board received an update on performance across operations, quality, finance and people indicators. It was noted that there would be some challenges going forwards in terms of balancing demand with finances and risks and delivering the quality of services required. This had also been discussed at the recent Finance and Performance Committee in November.

A discussion took place concerning the report that was presented to the Board: Non-Executive Director, Gail Briers commented that from an assurance perspective, the report had been through the Committees and therefore viewed previously. She suggested that this should be a paper for the Board and not a presentation/performance report with the key outcomes from each of the Committees and where the triangulation has taken place, a paper that described the process for the report with the IQPR in its current format as an appendix. She considered that repeating the same information across all meetings was not of value. The Chief Nurse agreed with the points raised and noted that the data was triangulated in the council meetings (risk management, quality and performance) and this could help to give the narrative with detail appended. The Chief Executive also agreed with the points raised and proposed that a report style should be brought to the Board from the next meeting. He acknowledged that teams were challenged but highlighted that aspects such as referrals and activity being down in numbers needed to be explained. There would also be a question of

65 weeks waiting times on discussions around NHS Finance and constitutional waiting times which the Trust must work to deliver: he suggested that it would be useful to provide further assurances that the Trust would achieve and maintain the waiting times and demonstrate a positive trajectory for this. Non-Executive Director, Elaine Inglesby suggested that the report should also explain actions being taken in relation to red rated indicators, noting that some of the areas had been red for a considerable time, as well as addressing areas that were mismatched such as around activity in Warrington, which was reported as reduced but also above the upper limit. The Trust Chair also noted that consideration would need to be given to productivity and how this was measured going forwards. The narrative within the report could provide some understanding around this. The Chief Executive also proposed that a staff story could be provided to the Board which would explain the material changes in the nature of caseloads from prior to the pandemic to the current point in time and the demand which was being placed on to services in a different way, particularly with reference to community nursing.

It was agreed that a revised style of report would be provided going forwards, incorporating the comments/suggestions made by the Board, which would be in a report format opposed to a presentational style, with narrative included and demonstrating where information had been considered (such as within the Risk, Performance or Quality Councils). This would include the indicator diagrams and relevant information being appended.

(ii) REPORT FROM THE QUALITY AND SAFETY COMMITTEE HELD ON 26 OCTOBER 2023

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

(iii) EPRR RE-ASSESSMENT

The Board received an update report from the Chief Operating Officer on the Trust's compliance progress against the NHS Core Standards for EPRR. She referred to the initial report that the Board had received at its October meeting which detailed that the self-assessment had been undertaken in line with previous years and concluded that the Trust was fully compliant with 47 standards, partially compliant with nine and non-compliant with two standards. This gave an overall assessment of "partially compliant." The Chief Operating Officer reported that the self-assessment along with the supporting evidence was subsequently submitted to the NHS England EPRR team for their review. This review process was new for 2023/24 and involved a robust and detailed analysis of compliance evidence. She explained that as a result of this review, the Trust had subsequently been regraded to a "non-compliant" position overall, with one standard agreed as compliant, 55 partially compliant and two deemed to be non-compliant. The Chief Operating Officer confirmed that the Trust was not an outlier in this, with the ICS and all organisations within it now reporting as non compliant. A number of actions and work streams were being taken forward to achieve compliance and this included a local resilience group which had met to look at how compliance would be achieved with the Chief Operating Officer attending as a member. The Trust also had an internal group established to meet on a fortnightly basis to consider each individual domain, including wider elements such as communications and infection, prevention and control. The work would be monitored via the EPRR Group and the Executive Management Team.

Non-Executive Director, Elaine Inglesby asked whether there would be an appetite for a place based approach to EPRR recognising that other organisations within the system were non compliant. The Chief Operating Officer advised that there had not been a place appetite, however the Provider Collaborative would have a group that would look at community standards and domains collaboratively. This would be taken forward across the ICB and encourage discussions on working together across organisations in a different way. Non-Executive Director, Linda Chivers commented that the Trust must consider how this matter would be reflected within the Board Assurance Framework and consider wording on the rationale as well as within risk registers. The Chief Executive commented that a risk based approach must be taken, particularly around the areas where the Trust had been assessed

as non-compliant. He commented that a joined up approach on capacity was needed across the system with specialist attention from the NHS England team on what could be done.

The Board recognised that the current position was disappointing and going forwards the working group must be in place to consider requirements in place and across the system. It was agreed that the Board must be sighted on the action plan as it progresses against the areas of non-compliance. It was noted that the Trust must demonstrate improvements within the next three months when there would be an ICB review. **It was agreed that a report would be presented to the February Board to indicate progress, how much more work was required and what resources may be needed.**

86/23   RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(I) FINANCE REPORT – MONTH SEVEN

The Board received the report setting out the month seven position: The current financial position was on track and a focus continued on agency spending. CIP remained an area of challenge with the Trust still behind the recurrent expectation of 5.1% with opportunities still being explored to work towards this. Opportunities that transpired later in the year would be rolled into 2024/25. The Board unanimously agreed that a financial position must not be delivered if it compromised the quality and safety of care for patients. The Trust was continuing its Quality Impact Assessment (QIA) panels in this regard, with a significantly robust process to ensure that CIP schemes would not have an impact on quality and safety. The QIA panel would assess the risk/s and if they could be mitigated. The Chief Nurse/Deputy Chief Executive had been appointed as the Senior Responsible Officer (SRO) for CIPs and there would be no CIP schemes going forwards without a QIA. A detailed discussion took place concerning CIP, the option to triangulate information via the IQPR to set out where the Trust would spend money which would impact on quality with narrative to provide assurance to the Board, and whether there would be any appetite in Place or the System for shared CIPs going forwards. It was also considered that efficiencies should be considered over three to five years and that there was some importance around discussions with commissioners around elements such as service creep and being able to save and invest back into services. **It was agreed that the Board would hold a seminar session to discuss CIP and plans during quarter four of the current financial year once the planning guidance was available.**

(II) REPORT FROM THE FINANCE AND PERFORMANCE COMMITTEE HELD 23 NOVEMBER 2023

The Board received a report from the Finance and Performance Committee meeting held in November 2023 from Non-Executive Director and Deputy Committee Chair, Martyn Taylor for assurance.

(III) REPORT FROM THE AUDIT COMMITTEE HELD ON 12 OCTOBER 2023

The Board received a report from Non-Executive Director and Audit Chair, Linda Chivers following the meeting held on 12 October.

87/23   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 to give oversight to the Board concerning progress with integration and collaboration developments including: the NHS prevention pledge and Widnes Urgent Treatment Centre (UTC), Dentally: the New Patient Access System for the Dental Network, and progress with delivery of the Trust's Communities Matter strategy as well as public and community engagement on work

of the Public and Community (PACE) Group, partnerships including the Provider Collaborative and measuring and monitoring the Trust's strategy. A verbal update was also provided by the Medical Director concerning the GP health connect partnership. This confirmed that work was underway to scope and develop a project to focus on the Integrated Neighbourhood model, with clearly defined population cohorts, in collaboration and partnership with local general practice.

88/23   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 15 NOVEMBER 2023

The Board received a report from the People Committee held on 15 November by Non-Executive Director and Committee Chair, Abdul Siddique.

(ii) UPDATE ON ANTI-RACIST FRAMEWORK

The Director of People presented a report to update the Board on the delivery and implementation of the Framework. This was being progressed via the new Equality, Diversity, and Inclusion (EDI) Working Group, with governance through the People Operational Delivery (POD) Council and into to the People Committee. The membership included People Directorate colleagues and two Non-Executive Directors, and was committed 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 Trust staff and our patients and communities. The Framework would 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 a bronze level award. Staff engagement would be at the heart of this as well as providing evidence to demonstrate that the Trust was reducing inequalities within the boroughs that it serves. The Board endorsed the approach and it was emphasised that the work must be threaded through the whole organisation and making a real difference for patients and staff. The Medical Director noted that as well as the focus on anti-racism, there were wider agendas in addition for the Trust to consider that would have an impact in terms of inequity.

(iii) WE EACH HAVE A VOICE THAT COUNTS

The Board received a report from the Director of People, following on from a Freedom to Speak Up update to the October Board, which gave an overview of the many mechanisms within Bridgewater to enable the Trust to listen to staff, ensuring the commitment to the People Promise of 'we each have a voice that counts'.

Following a comment from Non-Executive Director, Gail Briers, the Board recognised that the report collated all of the opportunities for staff to raise concerns and whilst there was assurance of the processes in place to listen to staff, the Board agreed that it required further information and evidence that staff were raising concerns: this would include work to ensure that all feedback from time to talk sessions was reflected, to ensure that all information whether positive or negative was captured and actions taken; that the Trust was creating the right conditions to enable staff to speak up and ensuring a culture of psychological safety and; that there was evidence that staff were raising issues that were then acted upon. This would include assurances being reported through to the People Operational Delivery (POD) Council into the People Committee. **Consideration would need to be given to how information and assurance was reported into the Board.** It was suggested that a discussion could take place at a future Board session on the time to talk feedback and the format as well as consider the approach to the time to talk sessions for the Non-Executive Directors.

89/23   OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) NEW BOARD ASSURANCE FRAMEWORK

The Board approved the new format of the BAF. **The Board agreed that whilst BAF1 may reflect risks to the Trust's reputation, protection of the Trust's reputation was only inappropriate if this was put before necessary actions being taken (such as in the Letby case). BAF1 would be reflective of this position and the Audit Committee would receive a recommendation on this from the Executive Team**.

(ii) 2024/25 CORPORATE CALENDAR

The Board reviewed and approved the corporate calendar for 2024/25.

90/23   REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

Wording concerning reputation to be amended on the new version of the BAF.

91/23   OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

The Programme Director of Integration and Collaboration confirmed to Peter Hollett that there had been work from a partnership perspective concerning patients in hospital and prevention of future admissions. Work had taken place in Warrington and there would be a review of an analysis of this to explore the data and any specific examples. He explained that within the Trust's places, partnership working was underway to directly target and look at how out of hospital care in the community could be optimised and to support keeping people in their places of residence and supporting care homes. There was also local and national reporting on the figures by provider and ICB and analytics also on the reasons behind this as well. The Chief Operating Officer volunteered to discuss this and any other relevant matters with Peter Hollett outside of the meeting. Further discussions could also be taken through the local governors meeting.

The Trust Chair confirmed to Peter Hollett that there were routes within the Trust for staff to raise any issues anonymously.

DATE AND 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.

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	**BLUE**	**December 2023:** update provided to the Board – agreed that this item can be rated blue/completed.

ACTION LOG

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

Key

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

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	**BLUE**	**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	**BLUE**	**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:** The Director of Finance confirmed that financial information for Place would be included within the finance report once it was available. It was agreed that this action would remain on the action log until this was provided. **February 2024**: Information still in development across both local places.
07.12.23	83/23	**Board Assurance Framework**	Lack of a software system around talent management and succession planning to be reflected, which was a national issue. It was agreed that this should be captured within the new BAF as a gap in control. The Board agreed to retire the current version of the BAF.	Jan McCartney	**BLUE**	Updates have been made to the new Board Assurance Framework. New BAF is now in place replacing the former version.

3

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date Due Date/BRAG Status	Comments/Further Action
07.12.23	85/23i	**IQPR**	It was agreed that a revised style of IQPR report would be provided going forwards, incorporating the comments/suggestions made by the Board, which would be in a report format opposed to a presentational style, with narrative included and demonstrating where information had been considered (such as within the Risk, Performance or Quality Councils). This would include the indicator diagrams and relevant information being appended.	Sarah Brennan	**GREEN February 2024**	**February 2024:** Item included on the agenda
07.12.23	85/23iii	**EPRR**	It was agreed that a report would be presented to the February Board to indicate progress with achieving compliance/how much more work was required and what resources may be needed.	Sarah Brennan	**GREEN February 2024**	**February 2024:** Item included on the agenda
07.12.23	86/23i	**Finance Report – month seven**	It was agreed that the Board would hold a seminar session to discuss CIP and plans during quarter four of the current financial year once the planning guidance was available.	Jan McCartney /Nick Gallagher	**GREEN**	Advice to be provided regarding scheduling / when information is available.

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	**Comments/Further Action**
07.12.23	88/23iii	**We each have a voice that counts**	Consideration would need to be given to how information and assurance was reported into the Board.	Lynne Carter	**GREEN**	**February 2024:** FTSU report is included on the agenda. The January 2024 Board Time Out Session received a presentation from the Trust's Freedom to Speak Up Guardian. This informed the format of a twice-yearly report to Trust Board.
07.12.23	89/23	**New Board Assurance Framework**	The Board agreed that whilst BAF1 may reflect risks to the Trust's reputation, protection of the Trust's reputation was only inappropriate if this was put before necessary actions being taken (such as in the Letby case). BAF1 would be reflective of this position and the Audit Committee would receive a recommendation on this from the Executive Team.	Jan McCartney	**GREEN February 2024**	**February 2024:** Review by EMT and update incorporated in February BAF report.

5

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	08 February 2024
Agenda Item	07/24		
Report Title	BOARD ASSURANCE FRAMEWORK		
Executive Lead	Colin Scales, Chief Executive Officer		
Report Author	Samantha Scholes, Head of Corporate Governance		
Presented by	Samantha Scholes, Head of Corporate Governance		
Action Required	☒ To Approve	☐ To Assure	☐ To Note

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**	☒ **EMT**

Strategic Objectives

☒ **Equality, 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**

Governance	Quality	Health Equity	Staff	Resources	Equality, Diversity & Inclusion	Partnerships
Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Failure to deliver quality services and continually improve	Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Failure to create an environment for staff to grow and thrive	Failure to use our resources in a sustainable and effective way	Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**8 February 2024**
Agenda Item	**07/24**		
Report Title	**BOARD ASSURANCE FRAMEWORK**		
Report Author	Samantha Scholes, Head of Corporate Governance		
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 <u>BAF 1: Governance</u>

The Audit Committee met on 11 January 2024 and recommended the following updates:

- Emerging risks updated and moved as these were now being realised

- Addition of recent internal audits

- Separation of mitigating actions from gaps in controls and assurance

- Update on the principal risk wording to accurately reflect the impact

No change was recommended to the risk rating which remains medium at 8.

2.2   BAF 2: Quality

The Quality & Safety Committee met on 21 December 2023 where the following changes were made:

- Emerging Risks: addition of capacity to Community Paediatrics to reflect the challenges

No change was recommended to the risk rating which remains significant at 15.

The Risk Management Council met on 31 January 2024 and agreed risks 1138, 1139, 3138, 3178 and 3198 should be added to BAF 2 and 3. These will be further considered at the Q&S Committee meeting on 28 February 2024.

2.3   BAF 3: Health Equity

The Quality & Safety Committee met on the 21 December 2023 where no changes were made.

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

The Risk Management Council met on 31 January 2024 and agreed risks 1138, 1139, 3138, 3178 and 3198 should be added to BAF 2 and 3. These will be further considered at the Q&S Committee meeting on 28 February 2024.

2.4   BAF 4: Staff

The People Committee met on 17 January 2024 where the following changes were made:

- Addition of three recent internal audits

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

2.5   BAF 5: Resources

The Finance & Performance Committee met on 25 January 2024 where the following changes were made:

- Removal of Risk 3155, which was agreed by Risk Management Council 31 January

- Acceptance of the People Committee recommendation for the Apprenticeship Levy be added to Assurances

No change was recommended to the risk rating which remains medium at 8.

2.6   BAF 6: Equality, Diversity & Inclusion

The People Committee met on 17 January 2024 where no changes were made.

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

2.7   BAF 7 – Partnerships

Executive Management Team met in January 2024 where the following changes were made:

- Updates and additions to Prevent Controls & Assurance

- Addition of Halton SEND to gaps in control and assurance

- Addition of mitigating actions

It was recommended to the risk rating was reduced from 12 high, to 9, medium

3. RECOMMENDATION

3.1   The Board is asked to approve the changes recommended by the Committees and note that two of the BAF risks (BAF 1, BAF 5) remain at target and the risk rating of BAF 7 has reduced.

Appendix 1: Board Assurance Framework

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK
LAST UPDATED February 2024

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) = 9 **medium** 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

| 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: January 2024 **Audit Committee** last review: January 2024 Risk Ratings review: January 2024	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 failure to deliver 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 – high assurance (2022/23) • Stress Risk Assessment – limited assurance (2023/24) • Dental Network – moderate assurance (2023/24) • Consultant Job Planning – moderate assurance (2023/24)

| **Gaps in controls and assurance:**
• 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 | **Mitigating actions:**
• Board oversight | **Emerging risks:**
Financial system risks impacting on the Trust.
Operational Planning Guidance impact |

Board Assurance Framework (BAF) February 2024 – v2

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

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: December 2023
 	
Q&S Committee
last review: December 2023
 	
Risk Ratings review: December 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
	
	1138: Inability to meet increased demand
	1139: Insufficient clinical capacity
	3138: Neurodevelopmental (NDP) pathway delays
	3178: Waiting lists
	3198: ADHD medication prescribing, long-term
	
	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: • Staff compliance with mandatory and service and role specific training • Paediatric Audiology • Clinical leadership strategy – in development • Recruitment & Retention • CIP 2023/24	Mitigating actions:	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: December 2023 **Q&S Committee** last review: December 2023 Risk Ratings review: December 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** 1138: Inability to meet increased demand 1139: Insufficient clinical capacity 3138: Neurodevelopmental (NDP) pathway delays 3178: Waiting lists 3198: ADHD medication prescribing, long-term	**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
	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.
				Audits
				• Waiting List Management – substantial assurance (2022/23)

Gaps in controls and assurance: • 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	**Mitigating actions:**	**Emerging risks:**

Board Assurance Framework (BAF) February 2024 – v2

NHS Bridgewater Community Healthcare NHS Foundation Trust

BAF 4: Staff — Failure to sustain an environment for staff to develop, grow and thrive.	RELATED OBJECTIVES:	RISK RATING:	RISK APPETITE:
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: January 2024
 	
People Committee
last review: January 2024
 	
Risk Ratings review: January 2024
	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)
				• Consultant Job Planning – moderate assurance (2023/24)
				• Stress Risk Assessment – limited assurance (2023/24)

Gaps in controls and assurance:	Mitigating actions:	Emerging risks:
• 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 • Lack of national system for talent management – Trust has local processes in place		System wide commitment to level playing field on incentives National shortage of key staff groups

| 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: January 2024
 	
F&P Committee
last review: January 2024
 	
Risk Ratings review: January 2024
 	
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.
	
	(Resources 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
				• Apprenticeship Levy
				
				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:	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 • EPRR current position – task and finish group meeting fortnightly to address gaps		ICB management of system deficit Review of Trust estate

NHS Bridgewater Community Healthcare NHS Foundation Trust

| 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: January 2024 **People Committee** last review: January 2024 Risk Ratings review: January 2024 *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: • Engagement with staff groups including BAME and LGBT+ staff (remain until all established Networks are considered to be embedded)	Mitigating actions:	Emerging risks:

| 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 3 (L) = 9 **medium**
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: January 2024 **EMT** last review: January 2024 Risk Ratings review: January 2024	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 and Community Link Workers providing targeted support to contribute to the overall enhancement of well-being • SLA in place with GP Health Connect	**Detect Controls** • Ongoing Board development • Chair has developed a strong network 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 • 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 engagement • Clinical engagement with Dental managed clinical networks • Place-based maturity assessments (Warrington Together and One Halton) • Joint commitment to strengthening our commitment to Warrington Council • Warrington Together Quality & Performance Group participation • One Halton Quality & Performance Group participation • CEO is SRO for C&M Virtual Wards Programme • CEO is chair of C&M People Board	**Assurances** • Implementation of dental strategy with partners • SLAs and MOUs 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 • Progress on Family Hubs with Halton Council and partners • Voluntary Sector partnership and investment • MOU with University of Central Lancashire • Research partnerships with NIHR ARC • Delivery of Newton Europe actions in partnership with Place

| **Gaps in controls and assurance:**
• Maturity of place-based relationships
• Impact of pressures (inc. finance)
• Halton SEND inspection November 2023 | **Mitigating actions:**
• Attendance at Warrington and One Halton workshops
• Halton SEND: contributing to priority action plan and attending Improvement Board meetings to ensure action is taken to resolve areas of concern | **Emerging risks:**
• Enabling
• Speech & Language Therapy - Halton |

No.	Risk Title	Inherent Score			Target Score			Q3 Dec 23			Q4 Jan Mar			Q1 Apr Jun			Q2 Jul Sep			Change	Impact on Objectives					
		C	L	S	C	L	S	C	L	S	C	L	S	C	L	S	C	L	S		Quality	Health Equity	Staff	Resources	Equality, Diversity & Inclusion	Partnerships
BAF 1	**Governance** Failure to implement and maintain sound systems of corporate governance	4	4	16	4	2	8	4	2	8											✔	✔	✔	✔	✔	✔
BAF 2	**Quality** Failure to deliver quality services and continually improve	5	5	25	5	2	10	5	3	15											✔	✔	✔	✔	✔	✔
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	2	5	10	2	2	4	2	4	8											✔	✔	✔	✔	✔	✔
BAF 4	**Staff** Failure to create an environment for staff to grow and thrive	4	4	16	4	1	4	4	2	8											✔	✔	✔	✔	✔	✔
BAF 5	**Resources** Failure to use our resources in a sustainable and effective way	4	4	16	4	1	4	4	2	8											✔	✔	✔	✔	✔	✔
BAF 6	**Equality, Diversity & Inclusion** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	4	4	16	4	1	4	4	3	12											✔	✔	✔	✔	✔	✔
BAF 7	**Partnerships** Failure to work in close collaboration with partners and staff in place and across the system	3	4	12	3	2	6	3	4	12											✔	✔	✔	✔	✔	✔

Board Assurance Framework (BAF) February 2024 – v2

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.

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

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	Between 1 chance in 1,000 and 1 in 100	Between 1 chance in 100 and 1 in 10	Between 1 chance in 10 and 1 in 2	Greater than 1 chance in 2
Statistical probability below 0.1%	Statistical probability between 0.1% - 1%	Statistical probability between 1% and 10%	Statistical probability between 10% and 50%	Statistical probability above 50%
Very good control	Good control	Limited effective control	Weak control	Ineffective control

Risk scoring matrix

Consequence			Likelihood		
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	2	3	4	5

Likelihood

Rating	**Very low** **(1-3)**	**Low** **(4-6)**	**Medium** **(8-9)**	**High** **(10-12)**	**Significant** **(15-25)**
Oversight	Specialty / Service level annual review		Directorate quarterly review		Board monthly review
Reporting	None		Relevant Board Committee		

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**8 February 2024**
Agenda Item	**08/24**		
Report Title	**KEY CORPORATE MESSAGES**		
Executive Lead	Colin Scales, Chief Executive		
Report Author	Colin Scales, Chief Executive		
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 -** 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**
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	**Quality** Failure to deliver quality services and continually improve	**Health Equity** Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	**Staff** Failure to create an environment for staff to grow and thrive	**Resources** Failure to use our resources in a sustainable and effective way	**Equality, Diversity & Inclusion** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	**Partnerships** Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	8 February 2024
Agenda Item	08/24		
Report Title	KEY CORPORATE MESSAGES		
Report Author	Colin Scales, Chief Executive		
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 first meeting of the MHLDC Provider Collaborative Board meeting on 27 November and joined the North West System Leaders call on 12 December.

The Trust Chair accompanied the Chief Executive on the following Time to Talk sessions:

29 November – Trafford Dental Team based at Seymour Grove.
11 December – Dental Team based at Bath Street Health & Wellbeing Centre
10 January – Warrington Dermatology Team based at Halliwell Jones Stadium

The Trust Chair observed the Audit Committee meeting held on 11 January.

1.2   Non-Executive Director, Linda Chivers participated in an Audit Committee private meeting with MIAA Internal Audit and Counter Fraud members and attended the monthly catch up meeting with MIAA for Internal Audit. In addition, Linda attended the Rest of England Governors meeting.

1.3   Non-Executive Director, Martyn Taylor attended the Time to Shine meeting held on 8 December where presentations were given in respect of the 0-19 services and Warrington Neuro Rehab. Martyn attended several Time to Talk sessions, as follows:

29 November – Hallwood Dental services with the Trust Secretary
11 December – Community Nurses based at Grappenhall with the Chief Operating Officer
4 January – the Infection Control Team at Spencer House with the Chief Nurse
10 January – Bury Dental services with the Chief Nurse
17 January – Warrington Falls Team with the Director of Finance

1.4   Non-Executive Director, Tina Wilkins attended a private meeting of Audit Committee members and MIAA Internal Audit and Anti-Fraud on 11 January 2024.

Tina accompanied the Director of People & OD on the Time to Talk sessions with the Halton Stroke Team on 21 December 2023.

1.5   Non-Executive Director, Gail Briers attended a number of meetings, as follows:

5 December – Northwest Regional Non-Executive Director meeting
15 December – Leader in Me event
20 December and 24 January – Council of Governors meetings
11 January – private meeting of Audit Committee members

Gail also had 1-1 meetings with the Freedom to Speak Up Guardian on 5 December and on 15 January met with the Chief Operating Officer.

1.6   Non-Executive Director, Elaine Inglesby attended numerous meetings, namely the Warrington and Halton Governors meeting; Non-Executive Network North West; Council of Governors; People Committee; Board Committee; Board Away Day; Audit Committee; MHLDC Board meeting and two MHLDC Non-Executive Directors meetings.

As part of the buddying arrangement, Elaine had a 1-1 meeting with the Medical Director.

1.7   Non Executive Director Abdul Siddique attended the face to face time to talk session with the Community Nurses based in Grappenhall with the Chief Operating Officer and Non-Executive Director Martyn Taylor.

2. EXECUTIVE UPDATES

2.1   On 21 December 2023, the Chief Executive attended a virtual ward round for Halton Frailty with the Operational, Clinical Nurse Lead at Widnes Urgent Care Centre.

2.2   The Chief Executive attended the One Halton Partnership Board Time-Out session on 24 January 2024.

2.3   Executive and Senior Team Engagement

The Trust's Time to Talk process has been revisited by the Executive Team and its structure now aligns to the NHS Our People Promises and its 7 elements.

These are measured by the Staff Survey and Quarterly Pulse Survey which enables us to further internally assess how we are delivering on these Promises.

The sessions are set up to allow the Executive Team to update staff on Trust news, ask questions about the teams and service and to take an interest in staff health and wellbeing. It also provides an opportunity for staff to share good news stories and to ask any questions of the executive team.

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

2.3.1 On 29 November 2023, the Chief Executive met with the Trafford Dental Team based at Seymour Grove. He also met with the Dental Team based at Bath Street Health &

Wellbeing Centre on 11 December 2023. On 10 January 2024, a session took place with the Warrington Dermatology Team based at Halliwell Jones Stadium. The Chair accompanied the Chief Executive on all visits.

2.3.2 The Chief Nurse met with the Immunisation Team on 4 January and on 10 January visited the Bury Community Dental Team based at Moorgate Primary Care Centre. Non-Executive Director, Martyn Taylor joined the Chief Nurse on both visits.

2.3.3 The Director of Finance held a face to face meeting with Drive Ability North West on 10 January. On 18 January he also met with the Warrington Fall Reablement Team based at Irwell Road and was accompanied by Non-Executive Director, Martyn Taylor.

2.3.4 The Director of People & OD met with the St Helens Stroke Team on 21 December. Non-Executive Director, Tina Wilkins also attended this session.

2.3.5 The Chief Operating Officer attended the Education Secretary's Gillian Keegan's visit to the Kingsway Family Hub in Widnes in recognition of the work that has been done in place by partners including Halton Borough Council in relation to family hubs. Halton was selected as one of 75 local authorities announced in 2022 as eligible to receive a share of £301.75 million investment from the government to establish a Family Hubs and Start for Life programme.

2.3.6 The Chief Operating Officer met with the Warrington South Community Nursing Team on 11 December and was accompanied by Non-Executive Directors, Martyn Taylor and Abdul Siddique. She also met with the Warrington Paediatric Continence Team on 19 December.

2.3.7 The Trust Secretary held two sessions. A face to face session with the Hallwood Dental Team on 29 November and a virtual session with the Education & Professional Development Team on 18 December.

2.4   Board Sessions/Events

2.4.1 A successful Leader in Me event took place on Friday, 15 December. The theme of the event was taken from the People Promise – "We each have a voice that counts". Nazir Afzal OBE was the keynote speaker, who spoke openly about his previous career as Chief Crown Prosecutor for North West England.

The second session of the day was with the Lead Freedom to Speak Up Guardian, Helen Young, who explained why it was important for staff to speak up if they see anything they do not feel comfortable with to protect patient safety and the lives of our staff.

The Chief Nurse delivered a speech about having 'a voice that counts' for the final session of the event and those in attendance were asked four questions about speaking up, which was taken from the NHS Staff Survey. Colleagues were then asked the same four questions after the session and the following results were presented.

Staff Survey question	Start %	End %
Q19a – **I would feel secure raising concerns about unsafe clinical practice.**	91%	93%
Q19b – **I am confident that my organisation would address my concern.**	74%	82%
Q23e – **I feel safe to speak up about anything that concerns me in this organisation.**	80%	83%
Q23f – **If I spoke up about something that concerned me, I am confident my organisation would address my concern.**	63%	71%

2.4.2 A Board Time-Out session took place on 15 January 2024. The morning session focused on Quality Review Visits and an update was provided on Patient Safety Incident Response Framework (PSIRF). The afternoon session focused on Freedom to Speak Up and the Strategy Dashboard.

2.5   Celebrating Success

2.5.1 Helen Crowder and Suzanne Taylor from the Clinical Audit Team have completed and passed the May Seacole Leadership Course.

2.5.2 Jimmy Cheung from the Medicines Management Team has been accepted on to the Elizabeth Garrett Anderson Leadership Programme.

2.5.3 The Bridgewater Research Festival is scheduled to take place on Thursday, 1 February with Professor Dame Caroline Watkins from UCLan presenting in the afternoon and awards given to groups of staff at the Trust to pump prime an initial research project.

3. DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

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

"This is a small, but perfectly formed Team. They work really well together and are cohesive. They love working for the Trust and they shared good practice freely. "

"One member of the Team had recommended the Trust to their daughter who now works for the Trust. A member of the Team also reported career progression from a band 3 to a band 4."

People Promises

We are compassionate and Inclusive

During visits, staff described the Trust as supportive and open.

Halton Stoke team described the Board and senior leaders as very visible as well as a Trust that promotes wellbeing and flexible working.

Staff suggested that it would be beneficial to display board structures and pictures in their service area. The Director of People committed to exploring this as structures for each service has recently been produced for display.

Warrington Children's Immunisation team said they feel valued by the Trust.

The Corporate Safeguarding Team had members within it that felt working for the Trust was akin to having won the lottery. They were actively recommending the Trust as a place to work to their friends and family with one member flagging vacancies featured in the Bridgewater Bulletin.

The Bury Dental Team felt part of the Greater Manchester dental network but there is still work to do in terms of them feeling part of the overall Dental Network.

We are recognised and rewarded

When asked if staff feel recognised for their good work, staff said they feel valued and supported. One team particularly looked forward to the new 'My Contribution' in Team Brief.

The Bury Dental Team stated that they felt recognised and rewarded for their work.

We each have a voice that counts

Teams were aware of who the Freedom to Speak Up Guardian (Helen Young) is, although some could not recall her name but were able to describe her and knew that she was located at Spencer House. One team confirmed that Helen Young had been out to see them and spoke at one of their Team Meetings.

We are safe and healthy

During visits, staff suggested that the Trust have a 'great' wellbeing offer. Staff had some suggestions around this, which included more flexibility needed with regards to part time workforce unable to free themselves up during 9-5.

Staff also made it aware that occupational health referrals were put in place swiftly, but the approach from OH sometimes felt 'transactional' and they would be welcoming of something much more personal from OH in terms of the approach to assessments, such as the option to have this via Teams, face-to-face or even a phone call.

Staff who had been absent from work confirmed they had been supported by their manager whilst off work and during their phased return to work.

We are always learning

Staff stated they felt supported to undertake statutory and mandatory training. Some staff questioned whether some of the training they were undertaking is perhaps not needed for their role. The visiting Executive has stated they will take this forward with the EPD Team as training is role specific.

The Bury Dental Team asked for consideration for a wider training offer.

We work flexibly

Submitted paperwork states that staff confirmed they were aware of the Trust's Flexible Working Policy and that it is in use within their teams.

One particular member of staff within the Halton Stroke Team was delighted that a 'retired and returned' flexible working arrangement was available to them.

We are a team

Teams confirmed that regular team meetings take place.

One team confirmed that they read the Bulletin and engaged in Team Brief.

The Corporate Safeguarding Team make every effort to have their lunch together when they can, but advised they made time for lunch and rest breaks.

3.2 Confirmed actions stated on completed Time to Talk paperwork

Halton Stroke Team

Scope to have an Admin apprentice, having seen how the Trust is investing in this area:
The Director of People & OD is exploring the possibility of an apprentice with the Talent for Care Team.

Occupational Health – Flexible Service Provision:
The Director of People & OD is to explore whether referrals can be given as an option to staff by way of telephone, face to face and/or Teams to make this more personal and fitting to the individual's circumstances.

The OH Service Provision will be discussed as per established contract management meetings that regularly take place with HR and the Provider.

Scope to have Board structures displayed in Trust premises/service areas:

Exploration of Board Structures and pictures being displayed in Trust premises/services is being picked up by the Director of People & OD.

Children's Immunisation Group

Work space issues in Spencer House:

The Trust's Chief Nurse committed to look at work space with the Head of Service and propose solutions.

Audiology (Woodview)

The Director of People & OD asked Operational Leads if they had any audio machines and equipment that they could loan to the service. The responses received were channelled to the Audiology Lead.

Bury Dental Team

Discussion took place around better utilisation of surgeries and some concerns were raised about waiting lists, referral criteria and theatre access. The Service Manager and Clinical Lead were part of the discussion and will take this forward.

4.	EXTERNAL PUBLICATIONS AND REPORTS

4.1 NHS Providers' report: Boosting referrals into urgent community response services
Integrated care boards, community providers and primary care networks have been asked to increase the volume and consistency of referrals into urgent community response (UCR) services to improve patient care, ease pressure on ambulance services and avoid admissions.

Community providers are already working hard to scale up their UCR services and have been very successful in helping people access care at home, making swift progress since NHS England introduced a national direction to ensure a greater degree of consistency across these services.

However, according to this NHS Providers' report, Community Network members say there is scope to go further to drive up the number of patients who benefit from UCR services, including through boosting referrals into the service from key system partners.

The report can be found here:https://nhsproviders.org/community-network-urgent-community-response-briefing-2023/key-points

4.2 Independent Report of Greater Manchester Mental Health Foundation Trust

The independent review of the Trust, commissioned by NHS England is found here: https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2024/01/Final-Report-Independent-Review-of-GMMH-January-2024.pdf

4.3 NHS Confederation report
Integrated care partnerships: driving the future vision for health and care
The report can be found here: https://www.nhsconfed.org/publications/integrated-care-partnerships-driving-vision-health-care

4.4 HFMA briefing: Considering health inequalities in business cases

This briefing looks at practical ways in which business cases can consider health inequalities. It steps through the five-case model recommended by HM Treasury, looking at how the impact of health inequalities can be quantified and brought into the narrative of the business case. It also suggests questions that people can ask themselves to ensure they have considered health inequalities in all the relevant sections of their business case.

It can be found here: https://www.hfma.org.uk/publications/considering-health-inequalities-business-cases

4.5 NHS Providers create regular podcasts for members. Their latest podcast 'winter performance data and new innovations can be found here.
The Provider Podcast: winter performance data and new innovations - NHS Providers

4.6 NHS Providers create regular podcasts for members. Their latest podcast 'winter performance data and new innovations can be found here.
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5.	RECOMMENDATIONS

5.1   The Board is asked to note the report.

NHS
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Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS		Date	08 February 2024
Agenda Item	09/24i			
Report Title	INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR) - MONTH 8 DECEMBER 2023			
Executive Lead	Executive Directors			
Report Author	Executive Directors			
Presented by	Executive Directors			
Action Required	☐ To Approve	☒ To Assure		☒ To Note

Executive Summary
The IQPR performance is in relation to Month 8 – December 2023.

Overall, there are several red indicators in relation to operational delivery with increasing pressures in the Children's Services Directorate which impact both quality and finance. There are some seasonal pressures which have impacted the performance of the Widnes Urgent Treatment Centre. The cancer indicators are all green in month which is an improved position following some previous months where red indicators were noted.

From a quality perspective, there are some indicators in month which have been impacted by the introduction of the patient safety incident response framework (PSIRF). The people indicators are green, or they are close to the target i.e. sickness actual and rolling. From a finance perspective, tight controls are in place to attempt to reduce against costs and to manage spend on pay and non-pay.

The Board are asked to note the contents of the report and be assured by the actions that are being taken to address the red indicators. |

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**
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	**Quality** Failure to deliver quality services and continually improve	**Health Equity** Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	**Staff** Failure to create an environment for staff to grow and thrive	**Resources** Failure to use our resources in a sustainable and effective way	**Equality, Diversity & Inclusion** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	**Partnerships** Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	08 February 202
Agenda Item	09/24i		
Report Title	INTEGRATED QUALITY AND PERFORMANCE REPORT – MONTH 8 DECEMBER 2023		
Report Author	Executive Directors		
Purpose	To describe the performance in relation to service performance, quality, people, and finance in Month 8 – December 2023.		

1. INTRODUCTION

1.1 The IQPR relates to the performance across the Trust in Month 8 – December 2023.

1.2 This is a new report format to summarise the position in relation to service performance, quality, people, and finance to the Trust Board. The report had previously been provided via a verbal update which accompanied the scorecards that are presented.

1.3 Providing a written report enables additional assurance to be provided in relation to the actions that are being taken to address the red indicators and gives an overview of the performance across the IQPR.

1.4 There are several new indicators contained within the report which were previously agreed via the relevant Committee and by Board which provide additional information to the Board across each of the IQPR domains.

2. SERVICE PERFORMANCE

CANCER PERFORMANCE

2.1 All of the five cancer indicators (relating to dermatology) in month are reporting as green which is an improvement on Month 7 where four of the indicators were green.

<u>Actions being taken</u>

All of the cancer indicators are monitored closely internally and via the Cancer Alliance Network where the Trusts performance is considered good. Dermatologist time is clinically prioritised around the delivery of the cancer standards and urgent patients, ensuring that the 28-day faster diagnosis target is met.

A&E PERFORMANCE

2.2 Three of the eight (National) A&E indicators relating to the performance of the Widnes Urgent Treatment Centre (UTC) are reporting as red. Two of these indicators relate to performance outside of the 4-hour waiting time target and one relates to the percentage of patients referred to A&E.

2.3 The UTC has experienced an 11% increase in patient acuity which has been responsible for the increase in the number of patients referred to A&E. The acuity and increased levels of staff sickness in month have contributed to an increase in the waiting times which have exceeded the 4-hour target. There has also been several closures of surrounding UTCs which have impacted the Widnes UTC.

Actions being taken

Staff sickness is being closely monitored in conjunction with the Directorate HR Business Partner and the use of masks is being considered with support from the Infection, Prevention and Control Team. There are daily system pressures calls with partners where any service impacts such as site closures are discussed and if there is the potential to roster additional staff to support the system pressures this is enacted.

DATA QUALITY

2.4 Both data quality maturity index indicators are reporting red in month as they have done for the last 4 months, this is due to a lack of compliance in recording several fields. 'Coded finding' is only recorded in 6% of records. This is an issue that needs to be resolves with each service based on the applicable diagnostic codes.

Actions being taken

The Data Quality Steering Group is working with the clinical teams to increase compliance across the required fields. The Directorates are also looking to implement a new Clinical Digital Leads which will work with the business intelligence team, IT, and configuration to implement changes such as this.

DID NOT ATTEND / WAS NOT BROUGHT

2.5 Percentage did not attend (DNA) / was not brought for Warrington Adult's and Children's services exceeded the required targets.

Actions being taken

Consideration is being given to implementing a patient appointment booking system to ensure that DNAs are reduced, by enabling patient/families/carers to select appointment times which they can attend as opposed to appointments being allocated so that clinical time is fully utilised. Initial discussions have taken place with the Assistant Director for Digital Services and the Chief Clinical Nursing Officer and discussions will progress internally via DIGIT to consider this with implementation being initially proposed during the 2024-25 financial year.

AUDIOLOGY

2.6   The number of audiology breaches in month has reduced to 91 from 98 and the service is aiming to clear all breaches by the end of March 2024. The target is to have no 6-week breaches.

2.7   Following the Paediatric Audiology Incident there were several patients who needed to be seen in clinic for further testing following inaccuracies in their auditory brainstem response testing at Warrington and Halton Teaching Hospitals. This combined with the catch-up school hearing testing which was deferred during COVID 19 impacted the service considerably and created a significant number of breaches.

Actions being taken

The service has maximised the clinical time available, they have also implemented recommendations from an external service review which was completed in 2023 which made recommendations to change clinical protocols freeing up the capacity of the Associate Specialist. There is a Band 7 role out to recruitment which will give the service additional capacity.

LOCAL INTEGRATED CARE BOARD REFERRALS TO PLAN AND ACTIVITY TARGETS

2.8   Referrals to plan and activity targets are red across all the Directorates, this is because the referral and activity levels have not been refreshed since 2018-2019 and they do not reflect the impact of the pandemic or changes in referral patterns for children's services or the change in patient acuity in adult services.

Actions being taken

The targets are being refreshed in fortnightly meetings with the Integrated Care Board (ICB) Team and formally through the Finance and Activity Review Group so that these reflect the post COVID referral and activity levels. This will help decision to be made about what can be delivered within the existing service funding if there are no additional monies available to support the services who are significantly exceeding their referral and activity targets.

NATIONAL WAITING TIMES

2.9   The percentage of patients who are seen within the 18-week RTT has fallen to 58.88% due to and increasing pressures in the Warrington and Halton Community Paediatrics Services.

2.10 Consultant led waiters over 52 weeks sit with the Halton Community Paediatric Service. All waiters over 52 weeks are subject to clinical harm reviews.

2.11 There is no consultant led waiters over 78 weeks and all services are focused on clearing the over 65-week waiters by 1st April which is the National Target.

2.12 There are a few services with waiters over 52 weeks, these are mainly with the Childrens Directorate due to increasing demand for services. These are:

- Halton Community Paediatrics
- Warrington Community Paediatrics
- Warrington Paediatric Speech and Language Therapy
- Halton Podiatry

Actions being taken

Warrington and Halton Community Paediatrics

In relation to the Community Paediatrics services, there are several actions being taken in to review how the services are delivered internally and in conjunction with partners. Internally the services are reviewing the workforce to see where Community Paediatrician capacity can be released and how the service can be delivered by an alternative skill mix. Additional specialist speech and language therapists have been employed in Warrington and in Halton a business case is being prepared for an Advanced Clinical Nurse Practitioner. There are also discussions in both places around how the universal and graduated offer can be more effectively utilised, prior to referring into the specialist Community Paediatric service. There is a workshop currently being planned for March with ICB Commissioners which will have several place-based partners in attendance including education, social care and 0-19s.

Warrington Paediatric Speech and Language Therapy

The speech and language therapy team have been supporting the delivery of the neurodevelopment pathway delivering complex social communication assessments which has impacted the delivery of the core service. The neurodevelopment pathway now has its own specialist speech and language therapists to deliver these assessments and so this will create capacity for the service to reduce the waiting times to within the required 65-week time period.

Halton Podiatry

The Halton Podiatry service has been working to reduce all of the long waiters within the 65-week waiting time by maximising clinical capacity and prioritising the delivery of clinically important activity. The team have looked at the referral form and process and have been working with ICB Commissioners to refresh the service specification in line with the model delivered in Warrington. The team have also been working with the Warrington Podiatry team whose waiting time is within the 18-week RTT.

MANDATED HEALTH VISITOR CONTACTS

2.13 The IQPR now details the indicators for the Mandated Health Visitor contacts delivered as part of the 0-19 services in Halton and in Warrington. In Warrington four of the five indicators are green with the face-to-face visit within 14 days of birth being red.

2.14 In Halton, three of the five indicators for the mandated contacts are red.

A considerable amount of work in being undertaken to look to change these to green. There are however significant challenges in supporting families to engage with mandated visits in Halton and supporting them to understand the importance of the contacts as well as delivering them in accessible locations and at times where families can engage. This is where the work around the families' hubs is expected to impact. The teams are also monitoring compliance with these visits on a weekly basis and on the majority of occasions these visits take place albeit they breach the mandated timescales for the visit particularly around the contact within 14 days.

DENTAL

2.15　The numbers of patients waiting to be seen in each of the sectors for dental has remained static and the service are focused on clearing all of the 65-week waiters.

2.16　There are a number of waiters currently over the 65-week target which will need to be seen prior to the 1st April 2024.

2.17　The most significant pressures are in paediatric general anaesthesia and inhalation sedation. Paediatric GA capacity has been impacted by the recent Junior Doctor strikes which has resulted in GA sessions being cancelled.

Actions being taken

The service is developing a service recovery plan to ensure that all the over 65-week waiters will be cleared by 1st April, and this will be presented to the Executive Management Team for review and scrutiny. The service is working with the Managed Clinical Networks and the Clinical Recovery Groups to establish whether any long waiters can be transferred to Trafford or treated in the hub at Whiston to reduce the paediatric general anaesthesia waiting times. Funding requests have been submitted to continue the general anaesthesia provision at Oldham and to increase the staffing capacity to deliver the oral surgery contract in Cheshire and Merseyside.

Internally there are task and finish groups which are reviewing the referral criteria and to ensure that this is consistent and the discharge criteria for special care patients.

3.　SERVICE QUALITY

INCIDENTS

3.1　In month, there has been a 16% increase in incidents causing harm (level of harm graded as 3-5).

Actions being taken

This will be monitored closely over the next few months as this is the first month of the implication of the Patient Safety Incident Response Framework (PSIRF). It is not anticipated that these levels of harms will continue. The PSIRF implementation has a

supported roll out and there is the appropriate governance framework in place to support the review of incidents.

3.2   The percentage of incidents that are medicines incidents and medication incident which cause harm has fallen in month

Actions being taken

Most of these incidents are from Padgate House where there is dedicated support from the Medication Safety Officer. There has been an electronic patient record implemented at Padgate and this has increased the number of incidents. There have also been several incidents related to errors with discharge medications which are being reviewed with the acute providers.

RISKS

3.3   The percentage of risks above 12 has fallen and risks are monitored and reviewed at Risk Council. This is likely to increased moving forwards as there are several risks emerging in relation to Halton Community Paediatrics.

Actions being taken

Risks are recorded at service level and reviewed at the Directorate Level and risks of 12 and above are reviewed by the Risk Council and challenged to ensure that the risk is appropriately scored and that the mitigation in place gives confidence that the Trust is managing the risk and the actions required are being undertaken.

POLICIES

3.4   The percentage of policies which are within there review date is red, with 87% of policies up to date.

Actions being taken

Compliance with policies within the review date are being monitored by Quality Council and the Quality and Safety Committee and this has been discussed. Services are being supported to ensure that policies are up to date and to consider whether the policy is needed and a reference to clinical guidelines could be considered instead of a bespoke Trust policy.

INFECTION, PREVENTION AND CONTROL

3.5   Compliance with the Infection, Prevention and Control audit sits at 81% which is below the 90% target.

Actions being taken

Services are being supported to ensure that this audit is completed and the target of 90% is achieved.

CQUIN

3.6   Compliance with the CQUINN target around pressure ulcer prevention and treatment has fallen to 46% in month and this is being addressed at the Quality Council.

Actions being taken

Discussions have taken place at the Quality Council to review how compliance with this target can be increased. Actions are also in place via the new PSIRF framework to support actions around pressure ulcers and to look to increase compliance.

4.   PEOPLE

ACTUAL AND ROLLING SICKNESS

4.1   Both actual and rolling sickness rates are just above the Trust target of 5.5% respectively. Both have seen an improvement from October to November. The rolling sickness absence rate improved slightly from 5.63% in October to 5.59% in November. The actual sickness absence rate has improved slightly from 5.94% in October to 5.78% in November. In February 2021, the rate was at its lowest rate of 4.88% against the Trust's target of 4.80%, at that time.

Actions being taken

- Sickness data is sent to Directorate and Corporate leads on a monthly basis
- The HR Team are aligned to DLTs to provide advice and guidance in terms of absence management and wellbeing support
- The uptake of Stress Risk Assessments has been a key focus over recent months with a view to addressing our highest reason for absence. Uptake is monitored by the DLTs, and uptake has increased. The next steps are to look at the opportunity of introducing an electronic version of the Stress Risk Assessment Form, supported by Manager training to support better user experience, and importantly reporting on Trust wide and Borough themes.
- Health and Wellbeing offers are targeted at our highest reason for absence and the Health and Wellbeing Team are doing targeted work in services where sickness is particularly high.

SHORT TERM ABSENCE

4.2   Short-term absence levels have increased in month, but this is expected given the time of year. Rates have increased from 1.76% in October in 2.26% in November. Short- term absence is impacted by the usual winter illnesses predominantly, which is not unusually high for this time of year.

Actions being taken

Communications have been cascaded in relation to good practice in relation to infection and prevention control. Absence hot spots have been identified and more targeted work has been undertaken by the IPC Team in those areas.

5. FINANCE

5.1 There is increased expenditure in relation to pay, non-pay and agency costs.

5.2 The increased pay costs are due to the 2023-2024 pay award.

5.3 The increased non-pay costs are due to the subcontract which is in place with DMC to deliver activity in dermatology which is priced on a discounted tariff price which is paid via non-pay.

5.4 Agency costs above plan are due to dermatology and community paediatrics. There are also additional agency costs in the Widnes UTC, Halton District Nursing and Padgate House.

5.5 The cash balance has shown a reduction of £6.91 million.

Actions being taken

The DMC contract is now only in place for 2 week wait surgical activity so the non-pay costs are anticipated to reduce significantly from April when this contract ends, and the activity is delivered via the service level agreement which has been established with Intersource for the provision of a dermatology medical service.

There is considerable focus on the agency spend in all areas and the service level agreement with Intersource which commenced in January 2024 will reduce this for dermatology. There are plans in place to reduce the spend for the Halton District Nursing Service through additional recruitment to replace the band 5's which have secured band 6 roles. There are several posts at Padgate House which are in the process of being recruited which will ensure that the service is not reliant on agency use. Sickness/absence is being closely monitored at the Widnes UTC to reduce the reliance on agency, there are also some posts which are currently being recruited to.

6. SUMMARY

6.1 There are several service performance indicators reporting as red and there is growing pressure in the children's directorate due to an increased number of referrals and services pressures. This is impacting waiting times (both RTT and over 52 weeks) and increasing the need for additional locum capacity which impacts the agency spend.

6.2 There are several actions in place to address the areas which are challenged and the majority of these can be managed internally but there are a number of service performance actions which need support from ICB Commissioner and partners in place/system.

7. RECOMMENDATION

7.1 The Board are asked to note the contents of the IQPR Month 8 report and to accept assurance that there are a significant number of actions being undertaken to address the areas where performance is red.

Integrated Quality and Performance Report

Information Team
Reporting Period: November 2023 (Month 8)

NHS
**Bridgewater
Community Healthcare**
NHS Foundation Trust

Contents

- **Section 1: Trust Overview**

- **Section 2: Operations – Responsive**

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

- **Section 4: People**

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

Introduction

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

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

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 November 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 Octobers validated position.

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

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

Responsive (Operations)

There are 22 green indicators in month 8. There is one new red indicator this month pertaining to the '% of waiters over 52 weeks - consultant Led' indicator.

There are several new indicators in this report particularly in relation to the mandated offer delivered by Health Visitors in the 0-19s services in Halton and Warrington. Performance against these indicators varies in the places which they are delivered due to challenges in engaging in parents.

There is a significant review of the delivery of the Community Paediatrics services and how we can look to transform these both internally and in conjunction with partners to manage the increasing number of referrals to the service.

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 24 green indicators in month 8. Some of the month 8 indicators have been impacted by the introduction of the Patient Safety Incident Response Framework (PSIRF). Compliance against these indicators will be monitored and the indicators will be reviewed to ensure that they enable performance against PSIRF to be reported accurately against the framework.

People

Three out of the seven people indicators are red in month 8. The indicators now include the short term and long-term sickness percentages. There is a positive position in relation to turnover which remains green in month and PDR compliance is also green in month.

Making Good Use of Resources (Finance)

There is a positive position reported in relation to finance with most indicators reporting as green. There is a focus on reducing the agency costs and there are plans in place to improve this from a dermatology perspective with a January implication. CIP plans are being developed for 2024-25.

Operations

Trust Scorecard

Code	KPI Name	Target	Trend Line	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr-23	May-23	Jun-23	Jul 23	Aug-23	Sep 23	Oct 23	Nov-23
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93%		92.34% (▲)	94.39% (▲)	98.84% (▲)	99.55% (▲)	98.16% (▼)	96.82% (▼)	97.78% (▲)	98.59% (▲)	98.67% (▲)	98.42% (▼)	96.56% (▼)	96.63% (▲)	95.3% (▼)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94%		100% (►)	83.33% (▼)	100% (▲)	75% (▼)	100% (▲)	100% (►)	71.43% (▼)	100% (▲)	100% (►)	80% (▼)	100% (▲)	100% (►)	100% (►)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%		100% (▲)	100% (►)	100% (►)	83.33% (▼)	100% (▲)	100% (►)	100% (►)	92.86% (▼)	100% (▲)	100% (►)	87.5% (▼)	90.91% (▲)	100% (▲)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%		100% (►)	100% (►)	93.33% (▼)	87.5% (▼)	75% (▼)	77.27% (▲)	86.67% (▲)	95.83% (▲)	90% (▼)	87.5% (▼)	88.46% (▲)	93.75% (▲)	87.5% (▼)
OP06	28 day faster diagnosis	75%		73.02% (▼)	75.29% (▲)	75.95% (▲)	81.14% (▲)	91.01% (▲)	86.96% (▼)	82.91% (▼)	84.47% (▲)	87.57% (▲)	86.71% (▼)	89.74% (▲)	81.54% (▼)	87.61% (▲)
OP07	A&E: Total time in A&E (% of pts who have waited < 4hrs)	95%		87.43% (▼)	82.48% (▼)	93.72% (▲)	96.01% (▲)	98.1% (▲)	96.8% (▼)	97.53% (▲)	98.42% (▲)	97.2% (▼)	98.53% (▲)	96.84% (▼)	94.62% (▼)	94.74% (▼)
OP08	Total time in A&E 95th Percentile (Mins)	4 Hrs		05:11 (▼)	06:06 (▼)	04:27 (▲)	03:57 (▲)	03:31 (▲)	03:51 (▼)	03:52 (▼)	03:40 (▲)	03:51 (▼)	03:34 (▲)	03:48 (▼)	04:04 (▼)	04:04 (▼)
OP09	Total time in A&E Median (Mins)	4 Hrs							01:30 (►)	01:30 (▲)	01:20 (▲)	01:32 (▼)	01:26 (▲)	01:27 (▼)	01:45 (▼)	01:32 (▲)
OP10	A&E Time to treatment decision (median) < 60 mins (Mins)	60 Mins		00:12 (▼)	00:14 (▼)	00:10 (▲)	00:08 (▲)	00:08 (▼)	00:09 (▲)	00:09 (▲)	00:08 (▲)	00:09 (▼)	00:07 (▲)	00:09 (▼)	00:09 (▲)	00:08 (▲)
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 (▼)	00:26 (▼)	00:25 (▲)
OP12	A&E Unplanned re attendance rate < 5%	5%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.03% (▲)	0% (▼)	0.03% (▲)	0% (▼)	0% (►)	0% (►)	0% (►)
OP13	A&E left without being seen <=5% (left before trx completed)	5%		0.27% (▼)	0.89% (▼)	0.13% (▲)	0.03% (▲)	0.09% (▼)	0.09% (▼)	0.18% (▼)	0.19% (▼)	0.06% (▲)	0.18% (▼)	0.08% (▲)	0.08% (▲)	0.26% (▼)
OP14	Percentage referred onto A+E (UTC)	5%							12.37% (►)	13.02% (▼)	10.66% (▲)	12.17% (▼)	12.13% (▲)	12.33% (▼)	10.95% (▲)	9.86% (▲)
OP15	Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%		99.83% (►)	99.82% (▼)	99.71% (▼)	99.71% (►)	99.73% (▲)	99.73% (►)	99.7% (▼)	99.7% (►)	99.72% (▼)	84.52% (▼)	84.15% (▼)	84.67% (▲)	84.75% (▲)
OP16	Data Quality Maturity index (DQMI) Quarterly published score (2 months in arears)	95%		86.7% (▲)	56.4% (▼)	88.8% (▲)	88.7% (▼)	88.6% (▼)	89.4% (▲)	88.7% (▼)	88.8% (▼)	90.3% (▲)	90.8% (▲)	89.8% (▼)	91.1% (▲)	89.1% (▼)

Operations

Trust Scorecard

Operations

Code	KPI Name	Target	Trend Line	Nov 22	Dec 22	Jan-23	Feb 23	Mar-23	Apr 23	May-23	Jun 23	Jul 23	Aug-23	Sep 23	Oct 23	Nov 23
OP32	Percentage of DNAs/Was not brought Childrens	3%		4.78% (▼)	5.46% (▼)	3.66% (▲)	4.99% (▼)	4.92% (▲)	5.33% (▼)	5.19% (▲)	5.24% (▼)	4.64% (▲)	6.32% (▼)	4.58% (▲)	4.45% (▲)	4.59% (▼)
OP33	Percentage of DNAs/Was not brought Warrington Adults	3%		3.47% (▲)	3.71% (▼)	3.62% (▼)	3.02% (▲)	3.31% (▼)	3.55% (▼)	3.35% (▼)	3.45% (▼)	3.39% (▲)	3.39% (▲)	3.15% (▲)	3.53% (▼)	3.28% (▼)
OP34	Percentage of DNAs/Was not brought Halton Adults	3%		0.93% (▲)	1.89% (▼)	1.9% (▼)	1.04% (▲)	0.98% (▲)	0.74% (▲)	0.86% (▼)	0.66% (▲)	0.89% (▼)	0.97% (▼)	1.23% (▼)	1.16% (▲)	1.18% (▼)
OP35	Proportion of Urgent Community Response referrals reached within two hours	70%		97.14% (▼)	95.88% (▼)	94.92% (▼)	96.62% (▲)	88.81% (▼)	97.52% (▲)	91.07% (▼)	91.18% (▲)	97.3% (▲)	87.2% (▼)	91.6% (▲)	88.7% (▼)	81.5% (▼)
OP36	Audiology Number of 6 weeks diagnostic breaches	0		4 (▼)	4 (►)	1 (▲)	5 (▼)	9 (▼)	67 (▼)	85 (▼)	77 (▲)	73 (▼)	87 (▼)	62 (▲)	98 (▼)	91 (▲)
OP38	Referrals to plan - Childrens	95%		123.75% (▲)	121.82% (▲)	122.9% (▼)	122.8% (▲)	122.93% (▼)	92.83% (▲)	103.62% (▼)	110.95% (▼)	110.92% (▲)	107.48% (▲)	107.63% (▼)	108.23% (▼)	107.78% (▼)
OP39	Referrals to plan - Warrington Adults	95%		81.58% (▼)	81.04% (▼)	81% (▼)	80.77% (▼)	80.45% (▼)	75.88% (▼)	78.75% (▲)	81.64% (▲)	81.27% (▼)	81.08% (▼)	80.48% (▼)	81.24% (▲)	81.09% (▼)
OP40	Referrals to plan - Halton Adults	95%		102.13% (▲)	101.09% (▲)	100.83% (▲)	100.37% (▲)	99.42% (▼)	96% (▼)	94.95% (▼)	94.61% (▼)	92.73% (▼)	93.26% (▲)	92.37% (▼)	92.68% (▼)	92.47% (▼)
OP41	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92%		35.29% (▼)	34.75% (▼)	39.76% (▲)	41.49% (▲)	57.99% (▲)	58.67% (▲)	67.55% (▲)	69.21% (▲)	65.29% (▼)	67.59% (▲)	65.39% (▼)	64.39% (▼)	58.88% (▼)
OP42	% of wa ters over 52 weeks consu tant Led	0%		0.29% (▲)	0.28% (▲)	0.11% (▲)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	0.17% (▼)	0.03% (▲)	0.12% (▼)	0% (▲)	0.03% (▼)
OP43	% of wa ters over 78 weeks consultant Led	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
OP44	% of wa ters over 104 weeks consu tant 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% (▲)	0.92% (▼)	1.01% (▼)
OP46	All waiters % waiting under 18 weeks(also include Dental)	92%							69.49% (►)	71.53% (▲)	70.92% (▼)	70.79% (▼)	69.47% (▼)	69.23% (▼)	72.01% (▲)	67.56% (▼)
OP48	Warrington Adults Activity Variance	3%		18.42% (▲)	18.96% (▼)	19% (▼)	19.23% (▼)	19.55% (▼)	24.12% (▼)	21.25% (▼)	18.36% (▼)	18.73% (▼)	18.92% (▼)	19.52% (▼)	18.76% (▼)	18.91% (▼)
OP49	Warrington Childrens Activity Variance	3%		7.73% (▼)	5.81% (▲)	7.19% (▼)	7.98% (▼)	9.44% (▼)	4.95% (▲)	18.93% (▼)	28.77% (▼)	27.42% (▲)	21.31% (▲)	21.76% (▼)	24.42% (▼)	25.5% (▼)
OP50	Halton Adults Activity Variance	3%		2.13% (▲)	1.09% (▲)	0.83% (▲)	0.37% (▲)	-0.58% (▲)	4% (▼)	5.05% (▼)	5.39% (▼)	7.27% (▼)	6.74% (▲)	7.63% (▼)	7.32% (▼)	7.53% (▼)
OP51	Halton Childrens Activity Variance	3%		64.61% (▲)	63.76% (▲)	64.36% (▼)	62.26% (▼)	58.95% (▲)	26.72% (▲)	22.5% (▼)	19.91% (▲)	18.87% (▼)	18.74% (▲)	19.5% (▼)	21.97% (▼)	24.47% (▼)

Operations

Trust Scorecard

Operations

Code	KPI Name	Target	Trend Line	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-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 (▼)			37 (▼)
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% (▼)			84.15% (▼)
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% (▼)			80% (▼)
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% (▼)			60.45% (▼)
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% (▼)			90.39% (▼)
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% (▲)			78.06% (▲)
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% (▼)			93.46% (▲)
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 (▼)			279 (▲)
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% (▲)			91.65% (▼)
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% (▼)			96.91% (▲)
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% (▲)			96.35% (▲)
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% (▼)			98.66% (▲)
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% (▼)			94.93% (▲)
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% (▼)			97.64% (▼)
OP66	Available Virtual Ward Capacity per 100,000 head of population											6.76 (▲)	6.52 (▼)	5.48 (▼)	8.42 (▲)	8.66 (▲)

Operations: Exception Reporting

Chart

All waiters by sector

	ORB	GMW	C&M
2023-10-16	1,943	3,428	3,529
2023-10-23	1,982	3,459	3,448
2023-10-30	1,997	3,483	3,434
2023-11-06	2,001	3,497	3,483
2023-11-13	2,019	3,511	3,525
2023-11-20	2,033	3,495	3,531
2023-11-27	2,007	3,504	3,514
2023-12-04	1,980	3,538	3,374
2023-12-11	1,982	3,532	3,299
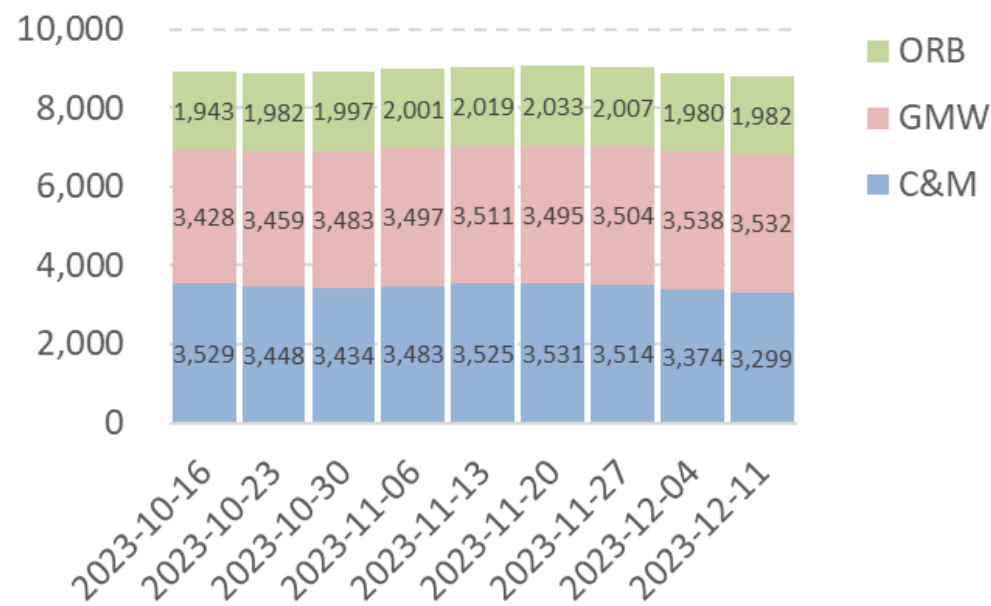
Issue

Dental - Patients waiting by Sector

The number of patients waiting for dental treatment has fallen slightly or remained consistent for all sectors.

Task and finish groups are in place to address some of the waiting list pressures.

Operations: Exception Reporting

Chart

All waiters by time band

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

X-axis dates: 2023-10-16, 2023-10-23, 2023-10-30, 2023-11-06, 2023-11-13, 2023-11-20, 2023-11-27, 2023-12-04, 2023-12-11

Y-axis: 0 to 10,000
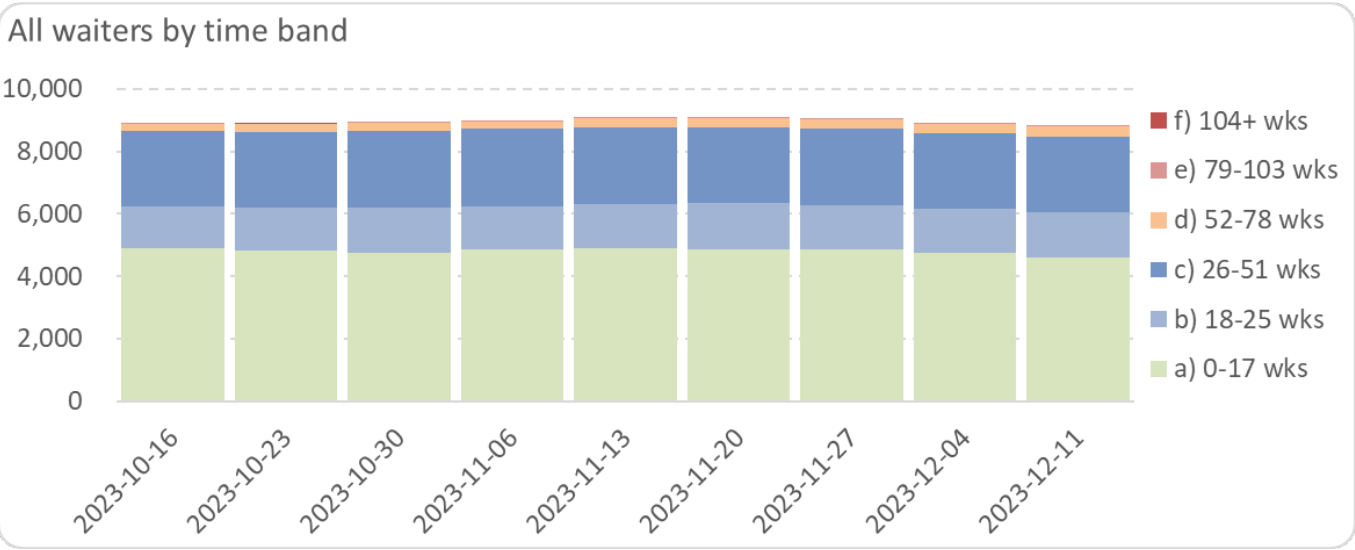
Issue

Dental – Waiters by time band

There is a key focus within the service to manage any waiters over 65 weeks and those that will be waiting over 65 weeks by April 1st to ensure that we are within the national guidance of having no waiters over 65 weeks by 1st April.

Operations: Exception Reporting

Dental – Waiters by time band

Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
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
2023-11-20	4,869	1,471	2,422	293	4	0
2023-11-27	4,876	1,416	2,429	299	5	0
2023-12-04	4,750	1,410	2,423	302	7	0
2023-12-11	4,618	1,448	2,425	313	9	0

Operations: Exception Reporting

Chart

All waiters by modality

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

X-axis: 2023-10-16, 2023-10-23, 2023-10-30, 2023-11-06, 2023-11-13, 2023-11-20, 2023-11-27, 2023-12-04, 2023-12-11
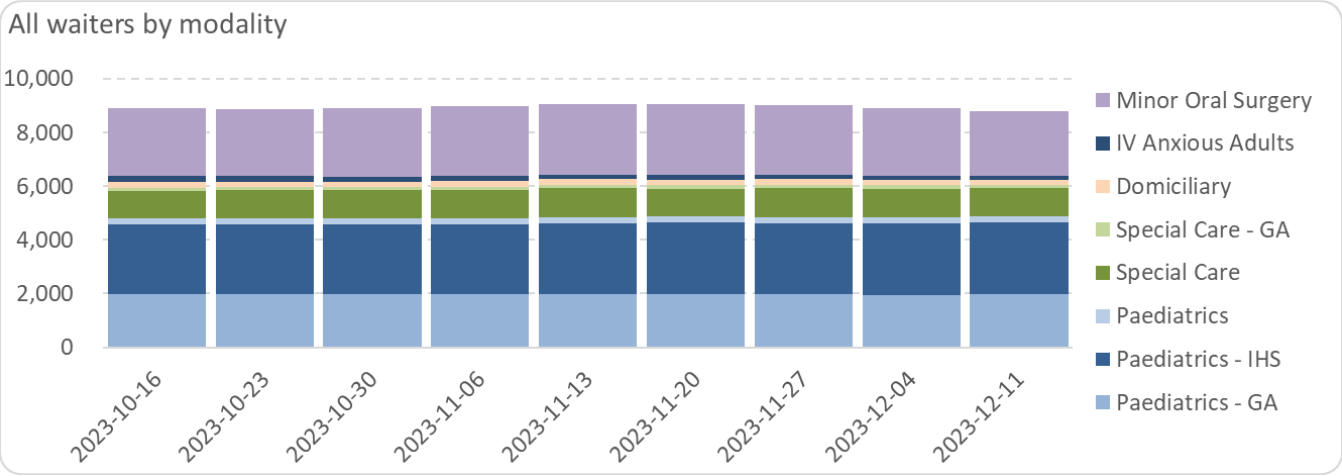
Issue

Dental - Patients waiting by treatment

The number of patients on all treatment bands has remained consistent or has fallen slightly.

All treatment bands are monitored at the dental network finance, workforce and performance meetings.

Quality
Executive Summary

There are 8 Quality indicators reporting as red, 1 indicator reporting as amber and 24 green indicators in November 2023.

The 8 indicators which were red in November are as follows:

- % of incidents causing harm (levels 3-5) – Increase in Month
- % - Compliance with reporting time frames for StEIS within 48 hours – New in Month
- % of incidents that are medication incidents – Improvement in Month
- % of medication incidents that caused harm – No change in Month
- Percentage of risks identified as 12 or above – Improvement in Month
- % of all policies within review date – New in Month
- IPC assurance audit compliance – Improvement in Month
- Assessment and documentation of pressure ulcer risk (Community Hospital Inpatients) (CQUIN12) – Decrease in Quarter

The 1 indicator which was amber in November is as follows:

- Malnutrition screening for Community Hospital Inpatients (CQUIN14) – Decrease in Quarter

Quality: Exception Reporting
Trust Scorecard

Quality

Code	KPI Name	Target	Trend Line	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-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%		24.33% (▼)	22.53% (▲)	20.57% (▲)	26.05% (▼)	29.89% (▼)	18.58% (▲)	24.54% (▼)	23.04% (▲)	27.2% (▼)	19.89% (▲)	23.6% (▼)	23.82% (▼)	39.37% (▼)
QU09	% - Compliance with reporting time frames for StEIS within 48 hours	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	0% (▼)
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%		75% (▼)	75% (►)	100% (▲)	100% (►)	100% (►)	100% (►)	50% (▼)	100% (▲)	85.71% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)
QU14	% of incidents that are medication incidents	10%		9.25% (▲)	12.09% (▼)	8.61% (▲)	8.68% (▲)	11.21% (▼)	12.68% (▼)	8.62% (▲)	7.09% (▲)	13.5% (▼)	9.6% (▲)	7.64% (▲)	12.43% (▼)	10.1% (▲)
QU16	% of medication incidents that caused harm	2%		2.63% (▲)	0% (▼)	2.78% (▼)	3.45% (▼)	2.56% (▲)	2.33% (▲)	6.06% (▼)	0% (▲)	6.12% (▼)	0% (▲)	9.09% (▼)	9.52% (▼)	9.52% (►)
QU18	Information Governance Training	95%		91.21% (▼)	91.47% (▲)	90.79% (▼)	88.59% (▼)	89.31% (▲)	88.86% (▼)	90.23% (▲)	91.83% (▲)	97.22% (▲)	97.26% (▲)	96.89% (▼)	98.15% (▲)	97.98% (▼)
QU19	Safeguarding Childrens Level 1	90%		92.55% (▲)	92.32% (▼)	92.68% (▲)	93.76% (▲)	93.99% (▲)	92.69% (▼)	93.89% (▲)	96.13% (▲)	98.46% (▲)	98.65% (▲)	98.49% (▼)	98.77% (▲)	99.23% (▲)
QU20	Safeguarding Childrens Level 2	90%		84.87% (▼)	85.94% (▲)	87.15% (▲)	89.61% (▲)	91.23% (▲)	89.97% (▼)	91.8% (▲)	94.24% (▲)	97.4% (▲)	98.58% (▲)	98.47% (▼)	99.33% (▲)	99.58% (▲)
QU21	Safeguarding Childrens Level 3	90%		83.77% (▲)	89.37% (▲)	86.44% (▼)	89.19% (▲)	93.13% (▲)	93.84% (▲)	94.6% (▲)	97.17% (▲)	98.18% (▲)	96.54% (▼)	96.21% (▲)	95.19% (▼)	95.5% (▲)
QU22	Safeguarding Adults Level 1	90%		92.9% (▲)	92.87% (▼)	93.49% (▲)	94.43% (▲)	94.79% (▲)	93.57% (▼)	94.82% (▲)	96.32% (▲)	98.39% (▲)	98.97% (▲)	98.56% (▼)	98.97% (▲)	99.29% (▲)
QU23	Safeguarding Adults Level 2	90%		77.18% (▲)	80.67% (▲)	83.45% (▲)	86.47% (▲)	88.86% (▲)	88.79% (▼)	90.83% (▲)	92.41% (▲)	97.07% (▲)	97.95% (▲)	98.17% (▲)	99.23% (▲)	99.32% (▲)
QU24	Safeguarding Adults Level 3	90%		69.21% (▼)	77.16% (▲)	76.26% (▼)	78.45% (▲)	76.09% (▼)	79.72% (▲)	83.6% (▲)	84.43% (▲)	92.01% (▲)	93.03% (▲)	92.94% (▼)	93.06% (▲)	94.55% (▲)
QU32	% of risks managed in line with policy	100%		87.07% (▼)	92.05% (▲)	98.73% (▲)	93.94% (▼)	84.21% (▼)	89.02% (▲)	73.48% (▼)	94.38% (▲)	88.21% (▼)	85.48% (▼)	88.2% (▲)	89.33% (▲)	91.94% (▲)
QU33	Percentage of risks identified as 12 or above	10%		17.01% (▼)	16.56% (▲)	12.1% (▲)	11.52% (▲)	12.87% (▼)	16.18% (▼)	14.36% (▲)	13.48% (▲)	15.38% (▼)	10.75% (▲)	10.67% (▲)	12.36% (▼)	11.29% (▼)
QU36	% of falls identified as serious	5%		0% (►)	0% (►)	0% (►)	4% (▼)	4.76% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	6.25% (▼)	0% (▲)	0% (►)
QU37	Falls per 1,000 bed days - bed based	14		11.72 (▲)	11.39 (▲)	8.65 (▲)	11.63 (▼)	6.7 (▲)	12.66 (▼)	5.71 (▲)	5.85 (▼)	9.71 (▼)	10.51 (▲)	15.15 (▼)	7.62 (▲)	10.18 (▼)

Quality: Exception Reporting

Trust Scorecard

Quality

Code	KPI Name	Target	Trend Line	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
QU41	Total number of pressure ulcers	27		29 (▼)	25 (▲)	33 (▼)	31 (▲)	36 (▼)	15 (▲)	27 (▼)	15 (▲)	19 (▼)	11 (▲)	24 (▼)	18 (▲)	22 (▼)
QU46	% of Category 4 Pressure Ulcers acquired in Bridgewater	20%		0% (►)	0% (►)	3.03% (▼)	6.45% (▼)	0% (▲)	6.67% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	5.56% (▼)	0% (▲)
QU47	% of Cat 3 & Unstageable Pressure Ulcers acquired in Bridgewater	20%		17.24% (▼)	20% (▼)	21.21% (▼)	16.13% (▲)	25% (▼)	6.67% (▲)	0% (▲)	13.33% (▼)	26.32% (▼)	9.09% (▲)	0% (▲)	11.11% (▼)	4.55% (▲)
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% (►)	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% (►)
QU62	% of all policies within review date	90%														87.64% (►)
QU63	IPC assurance audit compliance	90%		72% (►)	67.1% (▼)	90% (▲)	96% (▲)	78% (▼)	91% (▲)	81% (▼)	89% (▲)	89% (►)	87% (▼)	89% (▲)	79% (▼)	81% (▲)
QU64	Record keeping Audit completion compliance	90%				94.82% (▲)		119.93% (▲)			96.89% (▼)			104.76% (▲)		
QU70	Overall CQC rating (Yearly)	Good			Requires Improvement (►)											
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% (►)			88.16% (▼)
QU74	Assessment, diagnosis and treatment of lower leg wounds (CQUIN13)	50%		39.6% (▲)			41.18% (▲)			66.67% (▲)			64.71% (▼)			85.51% (▲)
QU75	Assessment and documentation of pressure ulcer risk (Community Hospital Inpatients) (CQUIN12)	85%		100% (►)			98.59% (▼)			100% (▲)			100% (►)			46.05% (▼)

People

Executive Summary

Three out of seven People indicators are shown as red in November 2023.

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

- Percentage Overall organisation sickness rate (rolling) – Increase in Month
- Sickness absence rate (Actual) – Increase in Month
- % Short Term Absence – Increase in Month

People

Trust Scorecard

People

Code	KPI Name	Target	Trend Line	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
PO01	% Headcount of new starters attending induction programme	95.00%		99.34% (▼)	99.74% (▲)	99.6% (▼)	99.8% (▲)	99.61% (▼)	99.36% (▼)	99.29% (▼)	99.36% (▲)	98.94% (▼)	99.68% (▲)	99.29% (▼)	99.62% (▲)	99.31% (▼)
PO02	Staff turnover (rolling)	12.00%		28.47% (▲)	28.54% (▼)	27.91% (▲)	27.61% (▲)	13.25% (▲)	12.69% (▲)	14.69% (▼)	12.04% (▲)	12.22% (▼)	12.3% (▼)	12.04% (▲)	10.89% (▲)	11.04% (▼)
PO03	% Overall Organisation Sickness rate (rolling)	5.50%		6.81% (▲)	6.75% (▲)	6.52% (▲)	6.41% (▲)	6.3% (▲)	6.07% (▲)	5.9% (▲)	5.89% (▲)	5.65% (▲)	5.66% (▼)	5.56% (▲)	5.63% (▼)	5.59% (▲)
PO04	Sickness absence rate (Actual)	5.50%		6.1% (▼)	7.11% (▼)	6.19% (▲)	5.26% (▲)	5.5% (▼)	5.16% (▲)	5.06% (▲)	5.24% (▼)	5.38% (▼)	5.45% (▼)	5.57% (▼)	5.94% (▼)	5.78% (▼)
PO05	% of staff with a current PDR	85.00%		67.44% (▲)	66.09% (▼)	70.13% (▲)	72.57% (▲)	70.56% (▼)	71.62% (▲)	72.85% (▲)	77.23% (▲)	91% (▲)	89.99% (▼)	87.59% (▼)	83.43% (▼)	88.06% (▲)
PO06	% Long Term Absence	Improvement in Month		3.98% (▲)	4.39% (▼)	4.36% (▲)	3.98% (▲)	3.82% (▲)	3.72% (▲)	3.85% (▼)	3.74% (▲)	3.85% (▼)	3.86% (▼)	4.04% (▼)	4.11% (▼)	3.52% (▲)
PO07	% Short Term Absence	Improvement in Month		2.17% (▼)	2.63% (▼)	1.9% (▲)	1.39% (▲)	1.6% (▼)	1.47% (▲)	1.25% (▲)	1.36% (▼)	1.3% (▲)	1.38% (▼)	1.5% (▼)	1.76% (▼)	2.26% (▼)

Finance

Month Eight Finance Report

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.

Summary Performance Month 08 2023-24	Month 8 Plan (£M)	Month 8 Actual (£M)	Month 8 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.11)	(8.33)	🟢 0.22	(65.50)	(66.65)	🟢 1.14	(97.94)	(99.58)
Expenditure - Pay	5.46	5.56	⚠ (0.10)	42.30	42.49	⚠ (0.19)	64.15	64.15
Expenditure - Agency	0.24	0.40	⚠ (0.16)	3.27	3.80	⚠ (0.52)	4.22	4.72
Expenditure - Non Pay	2.39	2.79	⚠ (0.40)	19.72	20.71	⚠ (1.00)	29.26	31.19
EBITDA	(0.03)	0.41	⚠ (0.44)	(0.22)	0.35	⚠ (0.57)	(0.31)	0.48
Financing	0.03	(0.43)	🟢 0.45	0.21	(0.37)	🟢 0.58	0.31	(0.48)
Normalised (Surplus)/Deficit	(0.00)	(0.01)	🟢 0.01	(0.01)	(0.02)	🟢 0.01	0.00	(0.00)
Exceptional Costs	0.00	0.00	🟢 0.00	0.00	0.00	🟢 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	(0.00)	(0.01)	🟢 0.01	(0.01)	(0.02)	🟢 0.01	0.00	(0.00)
Other Adjustments	0.00	0.00	🟢 0.00	0.00	0.00	🟢 0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	(0.00)	(0.01)	🟢 0.01	(0.01)	(0.02)	🟢 0.01	0.00	(0.00)
CIP	0.43	0.53	🟢 0.10	3.43	3.43	⚠ (0.00)	5.15	5.15
Capital	0.36	0.28	🟢 0.08	1.34	0.70	🟢 0.64	2.10	2.10
Cash	24.75	17.85	⚠ (6.91)	24.75	17.85	⚠ (6.91)	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
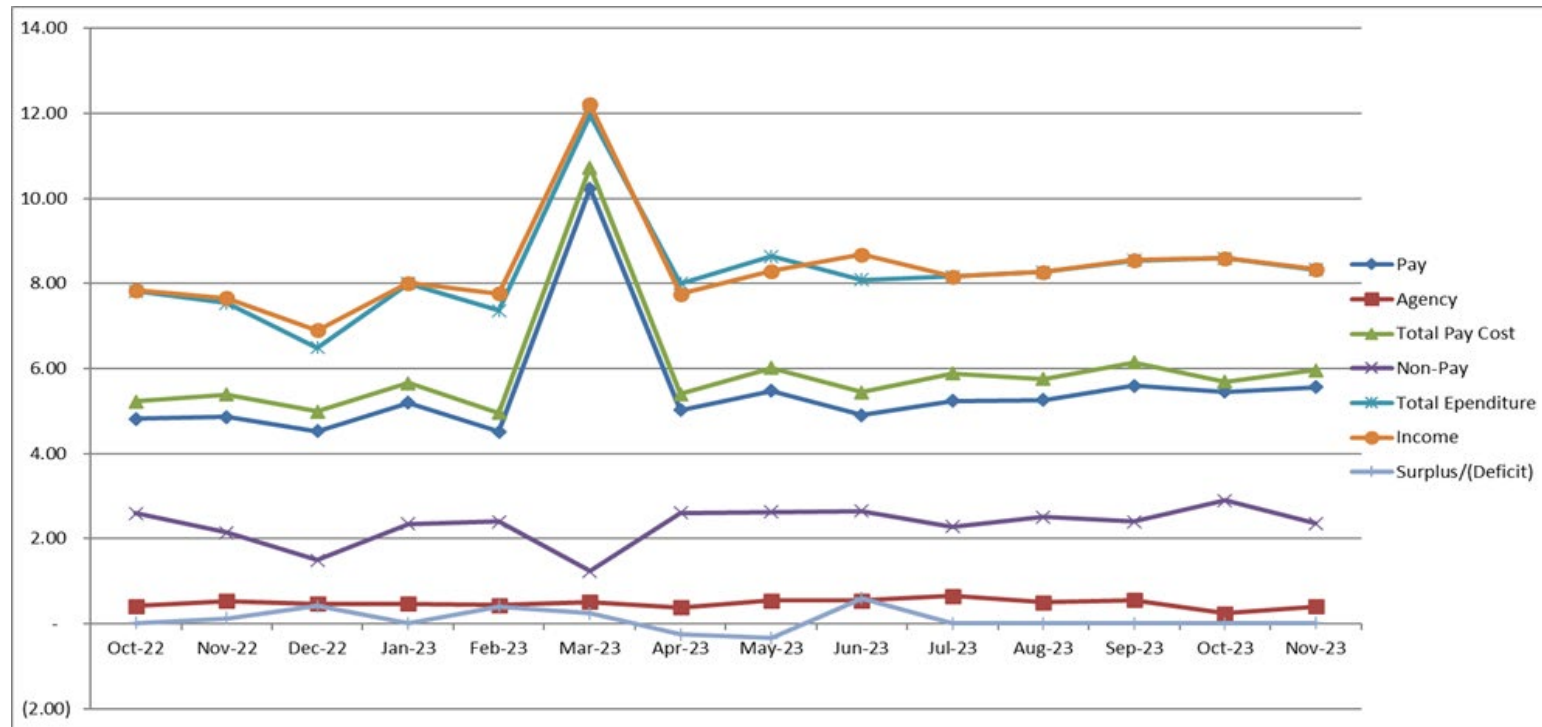
Finance

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

2.1 The key headlines for month eight are as follows:

- The Trust is reporting a small surplus of £0.02m, slightly ahead of 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 savings achievement of £3.43m against a plan of £3.43m.

- Income is £66.65m for the year-to-date against a plan of £65.50m.

- Expenditure is £66.63m against a plan of £65.50m.

- Pay is £42.49m against a plan of £42.30m.

Finance

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

- Agency spend £3.80m against a plan of £3.27m.

- Non pay expenditure is £20.71m against a plan of £19.72m.

- Capital charges are £0.58m below plan.

- Capital expenditure is £0.70m at month eight, planned spend is £1.34m.

- Cash is £17.85m.

Appendix

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

NHS Oversight Framework

File created on: 20/12/2023

Committee Chair's Report

T Name of Committee/Group:	Quality and Safety Committee		Report to:	Board of Directors
Date of Meeting:	Thursday 21 December 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 Elaine Inglesby, Non-Executive Director Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer Ted Adams, Medical Director	**In attendance:** Jeanette Hogan, Deputy Chief Nurse Susan Burton, Associate Chief Nurse Mark Charman, Assistant Director of Transformation Tania Strong, Interim Head of Human Resources Barry Hutton, Associate Director, Dental Network (to item 114/23) Jane Morris, Acting Lead Clinical Director- Dental Network (to item 114/23) Jan McCartney, Trust Secretary **Observers**: Christine Stankus, Public Governor, Rest of England Claire Barton, Staff Governor	**Key Members not present**:	**Apologies received from:** Abdul Siddique, Non-Executive Director

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Assurance Report – Dental Services		🟩	The Committee received a detailed presentation from the Dental Network's Acting Lead Clinical Director which provided assurance regarding how the new dental team were ensuring that patients received safe and effective care despite long waiting lists. This included an overview of the new management structure, the Community Dental Service, its waiting times, steps in place to manage this and measures to keep patients safe, as well as the key challenges and issues for the service. It was confirmed that there were no current harms identified from the harm reviews undertaken.	The Committee acknowledged the challenges across the system and appreciated the work being done to address those areas and to ensure that patients were being kept as safe as possible in a high pressured situation. The Committee also welcomed the business case

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

Committee Chair's Report

		🟩	The Committee noted that Commissioners had been pleased with the service that the Trust had provided and had asked Bridgewater to submit a business case. This would be around oral surgery capacity and a bid had been placed for £356,000. Should the funding be secured it would enable recruitment of additional staff and the capacity was planned to be put into one clinic: Hallwood, a surgery clinic. It was hoped that this would become almost a hub and have a specialist in situ supervising less experienced colleagues. The services hoped that the funding would be secured so that the work could begin and this would then enable a reduction in waiting lists.	to seek necessary funding to support capacity and reduce the waiting lists.

A verbal update would be provided to the Committee on the progress/outcome of the business case by the Chief Operating Officer in February 2024. |
| Serious Incidents Compliance Report | | 🟩 | The Committee noted that there had been five incidents which were subsequently managed as serious incidents. The Trust reported four of these incidents inside the 48-hour threshold, however one incident was identified outside of this period, during a retrospective review of reported incidents under the previous system/framework, following publication of the Trust's Patient Safety Incident Response Plan and the transition from the previous system to PSIRF. The transition to PSIRF was continuing as planned. Pressure ulcers remained as the most commonly reported type of serious incident, with a reduction in incidents reported during October and November 2023. There was ongoing work to ensure that actions identified in serious incident investigations were being completed within the agreed time scales, and that assurance was provided to the Trust and the Integrated Commissioning Board (ICB) that actions had been taken to prevent further incidents. It was also noted that the Trust's Patient Safety Incident Response Plan and Patient Safety Incident Response Policy were published on the Trust's external web site on 21 November 2023. | The Committee received the report for assurance that there were systems and processes in place to effectively manage serious incidents reported in the Trust and acknowledged the progress in relation to the implementation of PSIRF. The Committee endorsed the proposed future reporting template which was provided for review. |

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			As part of the transition arrangements with changes to the internal reporting system, there were also directorate specific incident reporting groups. This would include Childrens, Halton Adults, Warrington Adults and Dental services. The meetings would have a more local feel in terms of the culture and processes around PSIRF across the directorates, discussing local learning and local reporting. The Serious Incident Review Panel (SIRP) will be replaced by a fortnightly Patient Safety Incident Response Framework and Learning Panel (PSIRFaLP). There would be a phased transition to this during December 2023 and January 2024, to allow for the completion of legacy serious incidents which are being managed under the Serious incidents Framework (SIF).	
Summary Report for Risks Relating to Quality and Safety			The Committee received a report which detailed the approach being taken around the level of scrutiny of risks, ensuring appropriate management. It was confirmed that the Chief Nurse had recently undertaken a deep dive of all risks on the register. Both the Chief Nurse and Chief Operating Officer were present at the last meeting of the Risk Management Council and a rigorous debate had taken place concerning risks, ensuring a good level of scrutiny and per challenges on areas such as scoring and assurance. Future Risk Council meetings would have specific topics to consider each month with deep dives on different areas, this would be wider than only risks scoring 12 or above to ensure the same level of rigour around assurance on all risks on the register. A brief discussion took place concerning the categorisation of quality and safety risks: it was noted that the lack of availability of ADHD medications was not currently shown as a quality and safety risk. It was confirmed that the categorisation of risks would be taken forwards via the Risk Council.	The Committee requested that detail of risks that had been opened or closed within the period should be provided in future reports. The Committee would also receive an assurance report on the progress being made with out of date policies to its next meeting. The Committee received the report for assurance that the risks scoring 12 plus in relation to Quality and Safety in the Trust were being managed effectively not withstanding the additional actions above

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Committee Chair's Report

		■		required for the February meeting.
IQPR – month seven		■	The Committee noted a small increase in the number of instances causing harm in month, with a more significant increase in the percentage of incidents related to medication. However the associated harm levels had remained mainly unchanged. There had been challenges concerning medicines incidents from a Padgate House perspective which was the reason for the increase, the root cause of this was in relation to discharge medication errors and an issue around training needs which was now being addressed. An increasing number of risks scoring 12 or above was highlighted, which was being seen from an operational delivery perspective. There were increasing challenges, particularly around some of the children's services and in relation to services with longer waiting lists. Those services were being actively monitored. A review of Directorate specific risks would be undertaken in the round, with a review of each different metric.	The Committee received the IQPR for assurance that quality indicators and standards were being managed effectively.
Patient Experience Report – Quarter two		■	A total of 8,779 people had provided feedback during the quarter compared to 8,574 in the previous quarter. 96% responders had rated their experience as either good or very good. A total of nine formal complaints were received during this period compared to 12 during quarter one and 15 during the same period last year. Of these six related to Adult Services: Halton (2), Warrington (4), two related to Children's Services: Halton (1), Warrington (1) and one related to Dental Services. A total of 298 PALS contacts were reported for Bridgewater for this period compared to 285 received during quarter one and 242 during the same period last year. There were four joint complaints received during this period: Urgent Treatment Centre, Halton (2), Intermediate Care, Warrington (1) and one relating to the Health Visiting Service, Paediatric Speech and Language Therapy Service, Paediatric Community Medical Service, Warrington (1). There were two MP letters received during this period in relation to District Nursing/Community Matrons, Halton (1) and	The Committee received the report for assurance and endorsed the actions taken.

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			District Nursing, Warrington (1). There was a total of 4,997 compliments received about Bridgewater services.	
			The report included information regarding lessons learned from any patient feedback, as well as the toolkits that are completed with any complaints. Recommendations and actions from those complaint investigations were recorded and progress against completion was documented. It was highlighted that there was some positive information concerning how the teams were working with clinical services to enable further gathering of feedback and involving patients, children and families in the development of services.	
			Some red rated areas were highlighted related to lessons learned which were awaiting evidence from a service and this was significantly overdue. The service had the evidence and this was a timing issue in terms of bringing the information through to the quality meetings to give assurance that the evidence met and addressed the actions. This was expected to be addressed during January 2024.	
Report from the Quality Council			The Committee received a report detailing the key considerations of the Quality Council held on 27 October 2023. This included:	The Committee received the report for assurance.
			Risk 3154 in relation to referrals to wheelchair services for the provision of strollers to be used to support activities of daily living with for children with reduced impulse control and executive functioning: there had been a task and finish group established. This has now concluded after developing assessment guidance, which enabled a multidisciplinary assessment and decision to ensure child safety and ongoing oversight of the provision of any of those strollers. An update was received also on the progress against the national patient safety alert around bed grab handles and turning devices.	
			Work in relation to outstanding action plans in Warrington and Halton was underway, with additional support by Quality Matrons with additional review meetings and prioritisation within the quality meetings to ensure that all the plans that are reviewed and would be able to be signed off as	

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soon as possible. This included the ADHD medication shortage and a discussion took place around two risks that had been added to reflect the impact upon children that were unable to receive the medication, but also related to the Community paediatricians capacity and demand that's being put on the service with the increased workload to liaise and ensure that families were supported with any change in medications that are required. A working group would be meeting weekly and supported by medicines management and the appropriate representation across the two boroughs.

Discussion also took place concerning Infection, Prevention and Control work at Warrington Wolves. Work was in place to reduce the risk and ensure all the requirements were met and with oversight by a weekly meeting with operational, IPC and Estates representation to progress this plan. Initial work that was required had reportedly been completed on 21 December. Therefore the risk would be reviewed with a view to reducing the scoring.

Escalations from the Safeguarding Trust Assurance Group (STAG) meeting: This had included a benchmark marking exercise that had been undertaken against the Royal College of Community paediatricians and child health standards for child protection medicals. An action plan had been developed and a decision taken that this would be monitored and taken forward through the clinical audit program.

Vaccination uptake: flu vaccine uptake at 43% for all staff and COVID 27.8%.

Medicines management: Discussions were taking place as referenced earlier during the meeting concerning incidences at Padgate House. A review would be taking place to ensure all of the issues were covered and the risks were being reduced.

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Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

| Community Paediatrics Update Report | | | The Committee received a report concerning risks within the Community Paediatric Medical Services in Halton and Warrington. The delivery of the services was challenging due to the increase in the number of referrals for neurodevelopmental diagnostic assessment received following the pandemic and the national shortage of attention deficit hyperactivity disorder (ADHD) medication. The services held several risks on the risk register which were regularly being reviewed to ensure that they were up to date. Both services were regularly monitoring their waiting list position and considering the impact that this had had on both the individual child and their family's health and wellbeing, and the quality of service delivered and there were several actions being taken to manage the identified risks. It was noted that the challenges could not be solved by Bridgewater alone, particularly related to the ADHD medication, and that there was a wider system issue with the increasing referrals being received and the challenges from a waiting list perspective (59 weeks and Halton and 51 weeks in Warrington).

The Committee noted that there were 12 open risks on the risk register for the service, one scoring extremely high and three moderate, largely linked to capacity challenges and the impact of ADHD medication shortages and challenges with shared care. In addition there was also the input of different practitioners into the development pathway assessments. Discussions were taking place with partners including positive discussions with Halton ICB Commissioners, who were looking at how they could support the Trust with additional funding into this service to provide more activity.

The Chief Operating Officer, Chief Nurse and the Medical Director had met separately with the Director for Children's Social Care in Halton on 20 December. Research had also been undertaken on work in Portsmouth and in Cambridgeshire as well which was being taken forward with teams.

The Chief Operating Officer informed the Committee that a discussion would take place at EMT concerning whether an executive oversight group be established to oversee the management of the risks in the | It was agreed that a further detailed update report would be provided in February 2024 to ensure that the Committee was sighted on the key risks and areas, recognising the level of concern around the issues described.

A discussion took place concerning Board oversight of these issues, given that they related to wider aspects than quality and safety such as finance and workforce, it was suggested that community paediatrics be escalated to the Board and this was agreed at the end of the meeting. |
|---|---|---|---|---|

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			services. It was confirmed that the CQC were well sighted on the situation and challenges via regular communications, with briefings at the quarterly meetings. A discussion took place concerning the information within the reports, with some Non-Executive Directors seeking further information concerning potential harms and any safeguarding issues. The Committee noted that a monthly harm review now took place between the two boroughs to review the clinical harms including the reviews that had been completed. Conversations would then take place with clinicians and medical leads and operational managers to explore if anything key had been missed with any children. Concerning safeguarding, there were two risks, one in Halton and one in Warrington which highlighted a lack of capacity in teams to provide that support. Conversations were taking place between the community paediatrics team, children in care and safeguarding team who worked closely together.	
Verbal update concerning Halton SEND			The Chief Operating Officer provided a brief verbal report: The update was currently limited in available detail: a letter had been received on 15 December and the ICB and Council had been reviewing the feedback provided. The Chief Operating Officer advised that the rating was not yet known however she acknowledge there was still work to be done concerning the service, the system and the leadership arrangements across different areas.	The Committee noted the update report. A further update will be presented to the Board in February by the Chief Operating Officer.
QIA CIP Report – quarter one			Following the request made by the Committee in October 2023, the Deputy Chief Nurse presented a report to provide assurance that the Trust had appropriate steps in place to safeguard the quality and safety of patient care when delivering significant changes to its services by any policy, project or savings scheme, or working within business continuity arrangements that may have an impact on the quality of care provided.	The Committee accepted the recommendations.

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			The Committee welcomed the level of detail provided within the report and the transparency concerning the accounting decisions that had been made to achieve savings. The Committee acknowledged the detail of the schemes and was assured that there was a robust process in place for CIP QIA and that this was being followed appropriately. This included a process to return a scheme back for a further QIA assessment post delivery which helped to ascertain that mitigations had addressed any areas of risk. However a caveat to this was that as an organisation, there should be a commitment to ensure transformational plans as well as making savings going forwards, recognising that this could be a challenge as it was difficult to innovate and transform when monies were being utilised to deliver the bottom right hand corner which it would like to avoid going forwards.	
CQC Update Report			The Deputy Chief Nurse provided a brief verbal report: Following the last meeting of this Committee in October, there had been no meetings with the Trust's Relationship Manager and there had been no requirements to escalate any areas of concern to the CQC.	The Committee received the update for information.
Trust Improvement Plan Update			It was reported that there were 10 transformation plans: Five of those had shown an increase in the overall blue and/or green actions. Those plans related to: Community Nursing in Halton, Warrington Community Equipment Stores, the NDP pathway community Paediatrics in Halton and Warrington, the Children's Services Boost Plan. Two plans had shown an increase in red ratings: Dermatology action plan and the current strategy. One plan was completed in relation to the Insulin review and the Quality Council agreed its removal on 27 November. The dental plan was considered to be no longer viable, with further information required around this to determine whether this would be progressed or not. This would need to be worked through by the service prior to any decisions as to whether the plan would progress or be closed down. A discussion took place on the low number of dental improvement plans: it	The Committee was assured that the Trust Improvement Plan was reviewed and reported on a two-monthly basis, that progress with individual action plans was routinely monitored, and exceptions were reported into the Quality Council.

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

			was noted that whilst there were plans in train, those would need to be co-ordinated and then included on the Trust Improvement Plan. Work was also ongoing around three green indicators that had moved to red within the community equipment store plan. This was due to a delay in the demand and capacity modelling. Support had been allocated to move this forward and return the ratings to green.	
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 Deputy Chief Nurse provided an update concerning the progress of the recommendations from the MIAA audit undertaken in June 2023 related to the processes for recording patient experience feedback and focusing specifically on the monitoring of the actions. The key areas of the audit findings were around the monitoring processes which had received a moderate level of assurance. This had found that actions from patient feedback were not SMART or measurable alongside queries as to whether it was possible to evidence sharing of actions with/dissemination to the operational teams. An action plan was now in place which was shared with the Committee: all of the recommendations of the audit had been completed, however there was one area concerning the Trust's own internal assurance that would be carried forwards into the New Year: an audit would be undertaken with patient experience colleagues to ensure that there was robust assurance that the actions from any feedback or complaints were embedded within local teams.	The Committee welcomed the progress made and received the update for assurance
Board Assurance Framework (BAF) and New Board Assurance Framework			A discussion took place concerning the reflection of community paediatric services on the BAF. It was agreed that this should be reflected. It was identified that the Risk Management Council had met on 20 December and discussed the related risk which was listed as high (15) on the risk register, but due to the timings of the meeting this was yet to be reflected on the BAF.	It was agreed that there were no further updates required to be made to BAF2, 3 or 6 or any of the scorings.
Assurance Reports Required			No items were identified.	

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

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

Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Items to be shared with the Board or other Committees			Following consideration of the Community Paediatric Risks Update, the Committee discussed an escalation for insight and oversight from the executive team regarding the Community Paediatric risks.	It was proposed that a discussion should take place at EMT concerning a brief presentation to be provided to the closed section of the Board in relation to fragile services to ensure board sightedness on key issues such as this.
Review of meeting			All participants and observers were invited to comment on the meeting.	
Risks Escalated: Community Paediatrics Service as above.				

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**8 February 2024**
Agenda Item	**09/24iii**		
Report Title	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) UPDATE**		
Executive Lead	Sarah Brennan, Chief Operating Officer & AEO		
Report Author	John Morris, Deputy Director Estates / EPRR		
Presented by	Sarah Brennan, Chief Operating Officer & AEO		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

To update the Board in respect of the 23/24 EPRR work programme and progress against the delivery of the National Core Standard Framework.

In late 2023, feedback was received from the NHS England Emergency Preparedness, Resilience and Response (EPRR) that the Trust was considered to be non-compliant overall with the 58 standards as described in the National Core Standard Framework. This was following a detailed assessment of evidence submitted by the Trust in relation to the standards where previously this was based on a self-assessment. It transpired that all Trusts in the Integrated Care Board (ICB) Cheshire and Merseyside were also non-compliant.

The Board received this feedback at the December 2023 Board and asked for assurance that there was a plan in place to support the journey towards compliance with the required standards. This report as been prepared to update the Board of the actions that have been taken to date and any risks in relation to delivery of the required actions.

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

Strategic Objectives

☐ **Equality, 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**
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	**Quality** Failure to deliver quality services and continually improve	**Health Equity** Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	**Staff** Failure to create an environment for staff to grow and thrive	**Resources** Failure to use our resources in a sustainable and effective way	**Equality, Diversity & Inclusion** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	**Partnerships** Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	8 February 2024
Agenda Item	09/24iii		
Report Title	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) UPDATE		
Report Author	John Morris, Deputy Director Estates / EPRR		
Purpose	To update the Board in respect of the 23/24 EPRR work programme and progress against the delivery of the National Standards Framework.		

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 The Board received a paper in December reporting that, following NHSE review, the Trust along with all other ICB organisations including the ICB, had been considered overall non-compliant against the 58 standards contained with the EPRR framework.

1.3 The revised assessed data was submitted to NHSE on the 07/12/23.

2. PURPOSE

2.1 The purpose of the paper is to update the Board as to the work undertaken since the December submission and to present the 23/24 EPRR work programme (appendix 1) to provide assurance that there is a plan in place to support the Trust to achieve compliance with the required standards.

3. PROGRESS TO DATE

3.1 An EPRR Group held its first meeting on 5 December 2023 and currently meets fortnightly to ensure there is sufficient oversight, direction, and accountability.

3.2 All Directorate Leadership Teams (DLT's) are represented with additional support from IT and Corporate Governance.

3.3 The main duties and responsibilities of the EPRR Group are:

- To maintain EPRR arrangements in line with the Trust's organisational EPPR policy which is referenced and aligned to national guidance.
- To produce an annual work programme and action plan to deliver compliance with the national core standards framework.
- To oversee and provide support to peers to achieve compliance with the framework.
- To present EPRR assurance reports to the Board twice a year aligned to national guidance reporting expectations.

- To oversee and provide management support across the functional subject areas of EPRR, on call and business continuity.
- To work with Education & Professional Development colleagues to develop a training needs analysis for on call members, ensuring all evidence is held centrally.
- To ensure appropriate emergency planning arrangements are cascaded to all staff utilising a variety of communication channels.
- To maintain integrated PLACE working arrangements.
- To ensure attendance at ICB/Local Health Resilience Partnership (LHRP)/PLACE EPRR meetings, sharing appropriate feedback to the group.
- To oversee, update and/or implement internal policies, procedures and processes ensuring compliance with EPRR national core standards.

3.4 Each of the 58 standards have been cohorted into primary domains and separate task and finish groups, focusing on the individual domains have been established to achieve compliance. Tasks defined to effect completion of these actions are captured utilising Microsoft Planner and are assigned to one or more individuals with deadlines and a mechanism to submit evidence of completion.

3.5 The EPRR group will provide the oversight and assurance to EMT on a bi-monthly basis.

3.6 The work programme and associated action plan has been submitted to the ICB/Strategic LHRP for review and feedback is currently awaited. A number of identified work-streams have been completed to date. These include;

- EPRR policy approved by CCPG, potentially this will need further revision based on the work that we are doing with other providers.

- Terms of reference, standing agenda, reporting cycle defined.

- Teams and Microsoft Planner structure established.

- Hazmat meetings held with UTC and CHP colleagues.

- Comms/warning and informing document, including VIP plan (also supporting safeguarding in implementing the Lampard enquiry recommendations). Incident communications plan drafted.

- Business Continuity group established, and action plan agreed. Operational plans completed and currently being reviewed to ensure consistency in line with the revised business continuity procedure. Sit rep reporting visible via Qlik.

- Meetings held with EPD in terms of training need analysis and competency framework.

- Local Resilience forum risk registers have been presented to Risk Management Council

- Review of on-call arrangements commenced including staffing cohort, escalation processes, handover arrangements and supporting documentation.

3.7 Strategic and tactical LHRP meetings now include ICB wide papers (to provide additional evidence and assurance) for example mass fatality arrangements and appropriate updates.

3.8 The ICB/Strategic LHRP have established a number of working groups to review, from a whole ICB perspective, the following areas:

    a. Evacuation and Shelter

    b. Energy Resilience and Telecoms

    c. Training and Exercises

    d. Cyber

3.9 In addition, the Strategic LHRP has agreed to create task and finish groups to review process etc in respect of

    a. Risk Registers

    b. Core Standard process.

3.10 Community/Mental Health organisations have also established a EPRR subgroup in order that best practice/shared learning specific to the sector can be developed against the domain standards. This group has identified Training Needs and Hazmat as the focus for the initial work-stream.

4. RISKS

4.1 The delivery and achievement of the 58 standards is a complex and detailed requirement. Whilst additional resource has been allocated to support the EPRR group and associated task and finish groups, it is acknowledged that the lack of dedicated capacity to the overall EPRR function remains a risk to the organisation.

4.2 There are three risks which have been recorded on the risk register in relation to EPRR:

    1. Risk 3173 (12) is recorded on the risk register to reflect the current organisational non-compliance status.

    2. Risk 3236 (12) reflects the identified potential capacity shortfall risk.

    3. Risk 3161 (12) reflects the risk in respect of the current training and competency deficit against the required training standards for all participating on-call staff.

4.3 The risks will continue to be reviewed against the overall action plan deliverables and reported via the regular updates into EMT and risk council and any potential gaps will be escalated.

5. NEXT STEPS

5.1 The Trust's EPPR Group will continue to meet on a fortnightly basis. The work plan is as detailed in Appendix 1.

5.2 Utilising the task and finish group, work to embed policies, plans, processes, and guidance utilising the Trust's internal governance frameworks as appropriate e.g.

- Operational team Business Continuity status recorded on Qlik and referenced at weekly update meetings.

- Business Continuity Management System and supporting procedure to be included on all DLT agendas.

- Documentation review and evidence storage.

5.3 The Trust will ensure attendance at Strategic and Tactical LHRP meetings, as well as attending the newly formed working groups, and will seek clarification of the ICB review action plan process.

5.4 The suggested evidence checklist shared at the January Strategic LHRP Core Standards group will meeting a be distributed to the internal EPRR group, to all task and finish representatives and a review will be undertaken to see where gaps in our evidence are identified.

5.5 To work with the LHRP Strategic Core Standards Group on joint areas of challenge which have been identified which are:

- New and emerging pandemics
- Countermeasures
- Self-awareness and training
- Incident Communications Plan
- Mutual aid arrangements
- Hazmat

5.6 To update the Executive Management Team if there are any risks to the delivery of the standards and how can they be mitigated.

6. RECOMMENDATION

6.1 The Board is asked to accept the content of this report as assurance that actions are being taken to address the deficiencies identified.

6.2 To receive an update in April 2024 as this will be the mid-year review and to add a 6-monthly update to the business cycle in relation to EPRR moving forwards.

Appendix 1 - PLEASE NOTE THESE RAG RATINGS HAVE BEEN DEVELOPED VIA SELF ASSESSMENT – THEY HAVE NOT BEEN EXTERNALLY VALIDATED.

EPRR : STRATEGIC AND OPERATIONAL 2023/24 WORKPLAN

| Completed |
| In progress |
| Behind schedule |
| Not yet commenced |

DOMAIN REFERENCE	STANDARD REFERENCE	STRATEGIC OBJECTIVE	SRO	OPERATIONAL WORK-STREAM	DEADLINE
ALL		ACTION PLAN/TASK LIST	SS	DOCUMENT ACTION PLAN/TASKS WITHIN MICROSOFT PLANNER	
			SS	Assign tasks utilising Planner to leads, assign template to enable oversight reporting to EPRR group	31/01/2024
			SS	Work with Community EPRR group to standardise templates/best practice for organisational adoption.	31/01/2024
			JM	Work with local PLACE organisations to standardise templates/best practice for organisational adoption.	29/02/2024
GOVERNANCE	1	EPRR GROUP	JM	Establish meeting schedule and required attendees	31/12/2023
			JM	Agree TOR and governance arrangements (EMT)	31/12/2023
			JM	Agree standing agenda items	31/12/2023
			JM	Agree EPRR work programme	31/12/2023
			SS	Review Board business cycle for report inclusion	31/01/2024
			JM	Establish Task and Finish group to manage standard work programme	31/12/2023
GOVERNANCE	1-6	LEADERSHIP	SB	Amend job descriptions AEO/EPRR lead	31/01/2024
				Review Strategic/Tactical job descriptions	29/02/2024
				Cost Centre creation	03/01/2024
				Review EPRR policy through CCPG	31/01/2024
				Establish Task and Finish group to manage standard work programme	05/12/2023
DUTY TO ASSESS RISK	7-8	RISK MANAGEMENT	JM	Align Risk Council agenda to incorporate community and national risk registers	31/01/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
DUTY TO MAINTAIN PLANS	9-19	PLANNING ARRANGEMENTS	JM/MBr/KS	Review and update plans and arrangements as defined in the EPRR framework	31/08/2024
				Review and update planning documentation in line with current guidance	29/02/2024
				Prepare library of documents as per core standards 11-19	29/02/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
COMMAND AND CONTROL	20-21	COMMAND AND CONTROL	JM	Prepare individual training programme as per TNA analysis	Continuous
				Update EPRR/oncall escalation processes	29/02/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
TRAINING AND EXERCISING	22-25	TRAINING AND EXERCISING	JM	Develop Qlik/OLM process to hold education records as per TNA analysis	29/02/2024
				Develop EPRR testing and exercising schedule for all on call members	29/02/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
RESPONSE	26-30	RESPONSE	JM/SS	Review current ICC arrangements to align with current guidance	29/02/2024
				Review decision logging process and situation reporting processes	31/01/2024
				Update EPRR/oncall operational processes	31/01/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
WARNING AND INFORMING	33-36	COMMUNICATIONS	JM/MB	Develop separate communications (EPRR) strategy	29/02/2024
				Develop and align separate communication on call policy and process to support EPRR	29/02/2024
				Align internal communications policy to PLACE/ICB partners	29/02/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
COOPERATION	37-43	ENGAGEMENT	SB/JM	Ensure attendance (AEO) and input into LHRP agenda and work programme	Continuous
				Work with PLACE partners to agree information sharing arrangements	Continuous
				Establish community organisation sub group	31/01/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
BUSINESS CONTINUITY	44-53	POLICY	EL	Refresh BCP policy, aligned to ISO 22301	29/02/2024
				Establish scope and objectives to underpin Business Continuity Management System (BC	31/01/2024
				Establish BCMS continuous improvement cycle and relevant audit cycle	30/09/2024
				Update and review all BCP's across operational and corporate departments	29/02/2024
				Sit rep reporting inclusive of BCP position	31/01/2024
				Establish process with procurement/departments to ensure 3rd party BCP	30/06/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024
HAZMAT/CBRN	55-66	ASSURANCE	JM/MM	Develop policy and operational processes in accordance with current guidance	31/03/2024
				Develop building policy to support operational arrangements	31/03/2024
				Work with PLACE partners to agree operational arrangements	31/03/2024
				Develop Qlik/OLM process to hold education records as per TNA analysis	29/02/2024
				Establish Task and Finish group to manage standard work programme	31/01/2024

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	8th February 2024
Agenda Item	09/24iv		
Report Title	DRAFT CLINICAL LEADERSHIP FRAMEWORK		
Executive Lead	Lynne Carter – Chief Nurse/Deputy CEO Ted Adams – Medical Director		
Report Author	Lynne Carter – Chief Nurse/Deputy CEO Ted Adams – Medical Director		
Presented by	Jeanette Hogan Deputy Chief Nurse		
Action Required	☐ To Approve	☐ To Assure	☒ To Note
Executive Summary			

Ensuring that the Trust has excellent leaders is the purview of the Chief Nurse and Medical Director. In turn they will engage the Executive team's expertise in supporting and developing how clinical leaders are selected, nurtured and encouraged to develop.

Covid 19 significantly changed the way that NHS services were run and during that time recruiting and retaining staff was at the forefront to ensure that we were able to manage the pandemic.

Discussions have been held with clinical staff groups and formal workforce planning was undertaken to specifically ensure right sizing our clinical workforce. These meetings enabled clinical staff to discuss and describe their views on the changing workforce and specifically on clinical challenges. Through the lens of patient safety and the increasing demand for clinical staff there was a need for a focus on clinical leadership. This will build on our strengths and make transparent the routes for clinicians to progress within the organisation and continue to deliver improvements in quality and safety for our patients.

In nursing and in the professions allied to medicine, a clinical leadership group is being set up under the leadership of the Chief Nurse which includes representatives of each clinical discipline outside medicine and dentistry together with human resources, education and transformation to manage the implementation of the framework. This group will also include doctors and dentists, particularly in exploring the need for clinical support to groups taking on para-medical and para-dental roles.

The Clinical Leadership framework consists of the following components:

- Workforce planning
- Career
- Capability
- Culture
- Preceptorship and peer support
- Talent management
- Leadership

- Organisational culture

The clinical leadership structure in our medical services is currently stable with no recent changes. The dental clinical leadership structure was changed in 2023 following a review. Both medical and dental clinical leaders have recently been part of a Trust development day, with plans to pick up on the learning through the regular Medical and Dental Leadership Team meetings, which have occurred bi-monthly since January 2020.

It is intended that the full framework will be launched in April 2024. Staff meetings have been held in January describing the proposals and gaining staff support, these will continue in quarter 4 to gain feedback and further ideas.

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

Strategic Objectives
☒ **Equality, 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**
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	**Quality** Failure to deliver quality services and continually improve	**Health Equity** Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	**Staff** Failure to create an environment for staff to grow and thrive	**Resources** Failure to use our resources in a sustainable and effective way	**Equality, Diversity & Inclusion** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	**Partnerships** Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS – PUBLIC BOARD	Date	8th February 2024
Agenda Item	09/24iv		
Report Title	DRAFT CLINICAL LEADERSHIP FRAMEWORK		
Report Author	Lynne Carter – Chief Nurse / Deputy CEO, Ted Adams – Medical Director		
Purpose	To inform the Trust Board of the developments of the clinical leadership framework within the Trust.		

1. INTRODUCTION

1.1 The Trust's clinical teams consist of a wide range of professional groups. Whilst the majority of professionally registered staff are nurses, other groups include therapists (e.g. speech and language, physiotherapists, occupational therapists), dentists, doctors, midwives and many other professional staff groups. *Clinical Leadership - a framework for action* (NHSE 2019), highlighted the priority and benefits for organisations to develop clinical leadership at all levels to enable and assure the delivery of high-quality care, both within organisations and in the new integrated delivery systems. This provides Bridgewater with the opportunity to develop staff potential from our diverse range of clinical groups. This framework helps to put a structure both around the support we must give our staff and how the clinical voice in our internal leadership forums supports our patients.

1.2 The Medical Director and Chief Nurse provide clinical oversight to the Board and are responsible for ensuring that services provide clinically led and clinically appropriate services to our patients. They are responsible for ensuring that the clinical voice is heard in all clinical and non-clinical services and for identifying and helping to develop clinical leaders at the Trust.

1.3 The benefits of having an engaged, motivated and trained cohort of clinical leaders cannot be understated. Evidence suggests that effective clinical leaders in health services emphasise continually that safe, high quality, compassionate care is the top priority. They ensure that the voice of patients is consistently heard at every level; patient experience, concerns, needs and feedback (positive and negative) are consistently attended to.

1.4 Covid 19 significantly changed the way that NHS services were run and during that time recruiting and retaining staff was at the forefront to ensure that we were able to manage the pandemic. Health and wellbeing of staff was also increasingly important and the need to build confidence quickly within our teams was prioritised. During that time clinical educators

and practice development facilitators worked to ensure competence and safety of our staff and patients.

1.5 Bridgewater has always had talent management programmes and succession planning. However, the need to provide staff quickly during Covid meant the further expansion of apprenticeship programs and new to care initiatives which we could then support through to professional registration and beyond. We seconded a number of staff into formal nurse training and intend to continue this development.

1.6 The Trust introduced a Professional Lead for Allied Health Professionals (AHP) and a strategy for AHPs was produced and disseminated across the Trust. A further role of professional Lead for Dental Nurses and Therapists is being introduced. These roles are part of the senior clinical team led by the Chief Nurse.

1.7 During late 2022 and throughout 2023, meetings were held with clinical staff groups and formal workforce planning was undertaken to specifically ensure right sizing our clinical workforce. These meetings enabled clinical staff to discuss and describe their views on the changing workforce and specifically on clinical challenges. Together with the changing patient safety focus and the increasing demand for clinical staff there was a need for a detailed clinical leadership review. This needed to build on our strengths and make transparent the routes for clinicians to progress within the organisation and continue to deliver improvements in quality and safety for our patients.

1.8 Our staff want the development opportunities of this framework and are encouraged that the Trust is investing in its clinical staff. Many of the staff sessions included positive discussion about potential roles and how they could support our patients in different ways. Clinical staff are aware of the increased referrals and waiting lists and are keen to change their skill set to modernise and improve care delivery.

1.9 The lack of a recognised staffing model for community services was a significant difficulty in securing appropriate clinicians and we seconded the Deputy Chief Nurse into NHSE for a year to work with them on the development of a clinical staffing model for community nursing services. At the same time, we invested in an electronic roster system which not only enabled staff numbers to be planned but also has the ability to flex to the acuity and dependency of patients. This has the further advantage of being able to determine the skills and competencies of staff required in our services.

1.10 The increased demand for our services both during and after Covid added another challenge and the need to provide innovative solutions to patient care escalated. The ability to adequately describe the staff needed to meet the potential activity gives our clinicians the opportunity to work with partner organisations and the system to ensure that staffing is a priority.

1.11 New developments such as virtual wards are significantly improved by the input of our senior clinicians who understand the needs of the patients but also the potential skill sets of clinicians to deliver in the most cost effective and optimum way.

2. THE IMPORTANCE OF OUTSTANDING CLINICAL LEADERSHIP?

2.1 There has been significant research around` leadership models and developing leaders in all sectors including healthcare over many years, however clinical leadership has a different focus and requires additional skills. The need to manage and lead teams is critical but so is the ability to assess competence, provide clinical excellence, seek new opportunities for care and truly change the care delivered for our patients. This not only benefits patients at the time of care delivery but has a huge contribution to offer in managing health equity and population health for the future. A systematic review of nursing leadership found a relationship between positive relational leadership styles and higher patient satisfaction, lower patient mortality, fewer medication errors and fewer hospital-acquired infection. The evidence suggests that clinical leadership is associated with higher productivity and better organisational performance.

2.2 In Bridgewater our services encompass children, adults, special needs and challenging behaviours with specialist services in dentistry and other pathways. We have the opportunity to influence health but also to add value to the communities we serve as they are also areas where we recruit staff from. Our clinicians are our biggest workforce group, and our Trust is clinically led and operationally supported by our corporate services.

2.3 *Clinical leadership - a framework for action*, describes what clinical leaders need in order to best serve healthcare. These include:

- Effective team-based working within and across organisational boundaries.
- Innovation and experimentation to build new ways of delivering care.
- A collaborative and compassionate basis to enable staff to do their best work.

The *NHS Long Term Workforce plan 2023* and the introduction of integrated care systems further determined the need for greater clinical focus.

2.4 Clinical leaders participate in senior leadership teams and have a collective responsibility, and in Bridgewater this is the basis for our triumvirate directorate approach. Our senior leadership team and directorate structure ensure the clinical voice is heard at all levels.

Underpinning clinical leadership are five main elements:

- Building confidence
- Widening perspectives
- Talent management
- Practical levers
- Organisational culture

2.5 Within these elements there are specifics around role modelling, new role development, high quality line management, transferability of clinical skills, professional reporting lines and staff recognition and reward. Bridgewater already has a developing *Just Learning Culture* which encourages learning from incidents, compassionate leadership, valuing professional diversity and promoting listening to clinical staff and providing psychological safety.

2.6   There has always been a thriving educational support function for our staff and links to many higher educational establishments. Our continued efforts to provide health and wellbeing for our staff also include recognition and reward incentives and supports new roles in care.

2.7   The NHS Leadership Academy developed a *Clinical Leadership Competency Framework* in 2011 which is still in use across the NHS and describes the competencies required by all clinical leaders. These areas are depicted below:

These competencies enable clinicians to demonstrate strengths in each area which together improve the delivery of clinical services.

Each area has sections of learning which take the clinician through skill building, an example is below, and these levels have specific behaviours:

These sections enable competencies to be built and demonstrated, ensuring that staff are ready to move forward with their career pathway and providing evidence.

2.9   In Bridgewater we have a comprehensive training programme and a workforce planning function which works with services to determine roles and responsibilities together with the competence required for each of their needs. The workforce planning element works with teams recognising changes in service need, acuity and dependency and supports creating new staff roles.

2.10   Our apprenticeship work and links to local colleges has already enabled us to introduce new into care staff and support nursing associates and secondments to professional registrations. This has the added benefit of contributing to our communities in terms of employment and having a "grow your own" approach.

2.11   It is well documented that organisations require leaders who understand and demonstrate their accountability, role and responsibility to care. The Kirkup Report 2022, Francis Report 2013 and Ockenden Report 2023 all identified that clinical voices need to be heard and supported to improve quality and safety.

2.13   Clinical leaders play a crucial role in influencing, facilitating, supporting and monitoring the openness and transparency required to provide effective high-quality care. These leadership roles are often not predefined but emerge from clinical settings where staff have expertise, knowledge and the respect of their peers, the trusts role is to recognise, support and enable these within a leadership framework. We want to define these roles within our services ensuring that we are always able to provide the best staff and services.

2.14   The best clinical leaders have self-belief, self-awareness and personal integrity which drives improvement. Our current support structures for developing optimum clinical leadership include the senior nursing and AHP team, the workforce and apprenticeship teams, education professional development team, the internal dental clinical networks, the medical and dental leadership forum, the transformation team and the services themselves, what is now needed is a framework to encompass that.

2.15   Feedback from our non-medical and non-dental clinical staff is that they often cannot see a leadership role unless it is within the operational management structure, we know that staff leave the Trust for promotion in other organisations. There is often a lack of clarity of Agenda for Change banding criteria, specifically where the management of staff and resources involves higher banding than clinical knowledge and skill. The need to adequately describe clinical roles through standardised job descriptions and clear competency frameworks is crucial.

2.16   Concerns raised by our staff include a fear of loss of identity as a clinician, loss of clinical skills and of clinical credibility therefore there is a need to promote leadership roles as part of (rather than alternatives to) clinical careers which can help to overcome some of these negative assumptions. Most clinicians choose their career because of the contact with patients and the satisfaction this can give and this in turn increases the benefit to our patients .

2.17   We also need to support the staff working in integrated service delivery models with other organisational structures, increasing their confidence and ability to lead and innovate whilst retaining their clinical identity and sense of belonging to our organisation.

2.18   Additionally, within the Trust we have some small, poorly resilient teams with specialist practitioners who require more support and an infrastructure to enable them to maintain and

develop their clinical capabilities. This may include rotation into specialist centres or job sharing roles where increased knowledge and supervision can be gained.

2.19   We also have the same issue as most healthcare organisations with high numbers of vacancies and an ageing workforce. Our preliminary work has shown us that we can attract staff and support their development however a more overt clinical leadership model is needed. The roles of professional lead for allied health professionals and professional lead for dental nurses and therapists are intended to support competence development and deliver greater supervision which is restorative and developmental as well as role modelling and providing aspirational opportunities for staff.

2.20   We are also introducing senior clinical roles in services which provide specialist care. These new roles will offer the opportunity for staff to be appointed as a development role with the support to achieve the requisite skill requirements prior to permanent appointment. There are several of our staff who are also acquiring advanced clinical practice skills through external learning which will enable greater flexibility and capacity in our services.

2.21   The NHS Long Term Plan highlights the importance of clinical leadership in the new developing care systems. Evidence suggests clinical leadership promotes innovation and experimentation to find new ways of delivering high quality safe care increasing the likelihood of meeting any challenges.

2.22   New roles have already been developed in community nursing and dental nursing and these are being advertised currently.

2.23   The allied health professional workforce is historically fragmented, given it is composed of a number of different professions, reducing visibility and engagement. The introduction of the professional lead for AHP within the trust has supported talent management, succession and development planning, promoting AHP visibility and a focused voice to enhance a diverse clinical leadership within the trust. A number of senior allied health professional roles have also been developed enhancing the scope of practice of these professionals and these will continue to be developed as part of workforce planning. We have also recruited to degree apprenticeships within Physiotherapy, Occupational Therapy, and Podiatry to further support AHP roles and career pathways.

2.22   Professional Nurse Advocates have been introduced across the Trust and it is our ambition to have at least one of these in every service supporting supervision. Legacy mentors have been introduced and will continue to develop their approach. Clinical practice educators have been introduced and there are plans for more to be introduced this year.

2.23   A clinical leadership forum is being set up in May 2024 under the leadership of the Chief Nurse which includes representatives of each clinical discipline together with human resources, education and transformation to manage the implementation of the framework.

3.   THE CLINICAL LEADERSHIP FRAMEWORK

The framework consists of several areas:

3.1 Workforce planning

3.1.1 The workforce plan for each service identifies clinical leadership roles from band 2 to band 8, these may be existing roles with additional clinical components or new roles for development. The workforce plans inform our strategic plan for future training and education, and thereby enhance practice, increase confidence, improve patient outcomes and result in staff feeling valued. An example of this is the development of a clinical nurse specialist role in dermatology. These roles will be included in structure charts for visibility and congruence with the operational structure. The current workforce plans are being finalised.

3.2 Career pathway

3.2.1 The current apprenticeship strategy will make explicit all routes for developments from basic care levels through to advanced knowledge and practice. These roles will be clearly identified within each service and will be monitored as they develop.

3.2.2 We will continue to support staff to undertake professional registration courses for example nursing associates, registered nurses, and registered allied health professionals and will make explicit how many of these roles are available with a clear application and implementation process.

3.2.3 In dental services we are developing dental nurse roles with a special interest for example in safeguarding and also dental therapist roles which can expand the clinical care offered to our patients to improve health. A number of these roles are already available and are being appointed to.

3.2.4 The recent change in how dentists are engaged as clinical leaders continues to bed-in after some initial challenges with implementation. With clinical directors in Greater Manchester, Cheshire and Merseyside, an overall clinical director and senior clinical expertise in Oral Surgery and Special Care Dentistry with formal appointments in place provides a new sense of clinical ownership of the dental network. Work is ongoing to identify a way to provide senior clinical expertise in paediatric dentistry.

3.2.5 All new clinical roles will be identified in services up to consultant nurse or consultant therapist level together with the academic and clinical skill requirement for each. This also enables greater skill mixing with medical and dental roles and the introduction of advanced practitioners.

3.2.6 In community nursing senior community nurse roles have been developed and are being advertised and recruited.

3.2.7 Our training and continuous development programme will reflect the roles described and will be delivered and monitored closely. The development of these will be identified in individual staff professional and performance development documents.

3.3   Capability

3.3.1   The educational and knowledge requirements for each role will be identified and made available for all staff to see. The approval, monitoring, and competence development will be managed by Associate Directors, clinical leads and human resources with leadership from the Chief Nurse, Director of People and Organisational Development and Chief Operating Officer. All role descriptions will be standardised and will have clear competency requirements. The skills and competencies required will also be inputted to the staff roster system to demonstrate appropriate staffing models for each service.

3.3.2   Medical and dental clinical leadership role descriptions already exist. The Trust is currently considering how medical leadership can support our highly-trained senior nursing and AHPs to deliver care that allows patients to stay at home e.g. in supporting the virtual ward.

3.4   Culture

3.4.1   Developing a culture within the trust whereby clinical leadership is recognised and valued has been a feature of the trust for some time, this framework will make this more transparent. Shadowing and rotational posts will be advertised across the trust and staff will be supported and encouraged to apply for these roles with a streamlined transfer process. The time and supervision required will be agreed as part of these processes to enable staff to maintain clinical skills and professional registration whilst in leadership roles. The visibility of these roles will be increased in order for staff to be aware of them and to increase aspirations of existing staff.

3.4.2   Supervision both clinical and managerial will be defined and monitored to ensure support and adequate reflection and restoration for all staff.

3.5   Preceptorship and Peer Support

3.5.1   Our multi professional preceptorship policy defines the consistent approach and standards to supporting newly registered practitioners. Cohorts of staff undergoing specific development will be kept together for feedback and support for example new to care staff, these will be supported by the senior nurse and Allied Health Professional team.

3.5.2   Every clinical role will have explicit competence requirements which will be monitored by the clinical leads within each service. There will be specific clinical leadership skills included.

3.5.3   Peer groups and forums will be developed to promote greater engagement of clinical staff in quality improvement and to nurture emerging talent and all staff who develop into new roles will be expected to provide feedback and to promote these roles within the organisation.

3.6   Talent Management

3.6.1   Our talent management and succession planning framework will be visible across the trust encompassing all details of opportunities and the processes for staff together with a talent register which is reflected in workforce planning across all services.

We will continue developing a range of opportunities for staff to build their confidence, leadership capabilities and experience, such as:

- Mentoring opportunities.

- Shadowing at committees and board.

- Attending external meetings at Place.

- Coaching opportunities.

- Clinical placements in other organisations.

- Exposure and funding to attend Royal College of Physicians' Clinical Director courses.

- We are also working with higher education institutions around joint appointments and research opportunities.

3.7   Leadership opportunities

3.7.1   We will provide greater flexibility and opportunities for staff to undertake leadership roles whilst maintaining their clinical skills highlighting to staff the visible value of the clinical voice at all levels of decision-making. This will also promote improved performance as an effective and productive use of resources delivering system transformation whilst assuring high-quality care for all.

3.7.2   There is currently the opportunity for staff in managerial roles who have clinical backgrounds to maintain their clinical practice and competency which will give them greater flexibility in career choices. This also means that we have clinical innovation coupled with managerial accountability and autonomy, an example of this is the management role in Halton Intermediate Care and Frailty services.

3.8   Organisational culture

3.8.1   As a trust we embarked upon a Just Culture journey encouraging staff to learn from incidents and concerns, this culture further promotes clinicians at all levels to change practice, improving our services and our patient care.

3.8.2   The Time to Shine forum will remain as a vehicle for staff to showcase clinical improvements however we will also develop support for our staff to publish and take part in more research opportunities.

4.   NEXT STEPS

4.1   It is intended that the full framework including all of the actions below will be launched in April 2024. Staff meetings have been commenced in January describing the proposals and gaining staff support, these will continue throughout quarter 4 to gain feedback and further ideas.

4.2 Job descriptions are being standardised and will have competency frameworks for each level and band. This work has begun and the specific timescale for completion of all job descriptions is June 2024.

4.3 Leadership training and development opportunities will be advertised each quarter in our bulletins and specific development will be identified for new roles for example advanced care practitioners. Each service will ensure that this development is completed as part of the new role development.

4.4 Routes to identifying a dental paediatric specialist are ongoing.

4.5 A transfer process for learning and experience is being developed including rotational posts which will then be promoted across the trust. This will be completed by June 2024. Each service workforce plan including all new roles will be publicised across the trust from April 2024.

4.6 A formal supervision register is being developed to ensure restorative and reflective supervision is in place for all staff, this will ensure supervision is part of each new role and will be in place by April 2024

4.7 The talent management and succession planning process is being formalised and will be published across the Trust.

5. RECOMMENDATION

5.1 The Board is asked to note the clinical leadership development to date and to approve the continued roll out of this framework, the sessions that will take place to further co-produce the strategy prior to receiving the final strategy at the April Board meeting.

References

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West, M., Armit, K., Loewenthal, L., Eckert, R., West, T. and Lee, A. (2015) Leadership and Leadership Development in Healthcare: The Evidence Base. London, Faculty of Medical Leadership and Management

Wong C, Cummings G, Ducharme L. (2013) The relationship between nursing leadership and patient outcomes: a systematic review update. J Nurs Manag; 21: 709-724.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 February 2024**
Agenda Item	**09/24v**		
Report Title	**FREEDOM TO SPEAK UP**		
Executive Lead	Lynne Carter - Chief Nurse/Deputy CEO		
Report Author	Helen Young – Freedom to Speak Up Guardian		
Presented by	Jeanette Hogan - Deputy Chief Nurse		
Action Required	☐ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary
This report:
➢ Provides an overview of the current Freedom to Speak Up (FTSU) provision.
➢ Presents plans for a review of the Trust's Speaking Up processes as per the requirements of the National Guardian's Office.
➢ Seeks engagement from the Board as part of this process to ensure the organisation's ongoing commitment to Speaking Up.

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

Strategic Objectives
☒ **Equality, 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**

Governance	Quality	Health Equity	Staff	Resources	Equality, Diversity & Inclusion	Partnerships
Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Failure to deliver quality services and continually improve	Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Failure to create an environment for staff to grow and thrive	Failure to use our resources in a sustainable and effective way	Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	08 February 2024
Agenda Item	09/24v		
Report Title	FREEDOM TO SPEAK UP REPORT		
Report Author	Helen Young - Freedom to Speak Up Guardian		
Purpose	To make the Board aware of current Freedom to Speak Up provision, and to appraise of plans to support a Freedom to Speak Up improvement and development plan.		

1. SCOPE

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

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

1.3 To provide Board with an update from the National Guardians Office (NGO).

1.4 To inform Board that staff will be asked to complete another anonymised survey about Freedom to Speak Up to ascertain if any improvements are needed.

2. INTRODUCTION

2.1 Freedom to Speak Up is about feeling able to speak up about anything that gets in the way of doing a great job. That could be a concern about patient safety, a worry about behaviours or attitudes at work, or an idea which could improve processes or make things even better.

2.2 Details for both the Guardian(s) and Champions are on the MyBridgewater page and the link to the FTSU page is now displayed on the main intranet home page. If staff feel the need to seek support from the FTSU Guardians or Champions, they can do so either face to face or via a phone call or email, or via Microsoft Teams. Regular updates are included in the Trust's Bulletin and information cascade system the 'Team Brief' which all staff can attend monthly.

3. SUMMARY OF ACTIVITY

3.1 For the Quarter 3 reporting period 2023, there were 8 Freedom to Speak Up (FTSU) concerns raised in total. Concerns were raised on an individual and collective basis and for NGO reporting purposes this involved 17 members of staff. Cases have increased

during this reporting period, which is positive in terms of awareness of the reporting mechanisms available to staff.

3.2   Of the 8 cases 7 remain open and active due to the complexities and the Guardian is liaising with senior management and has been able to provide some feedback to the staff who raised the concerns. One case is now closed, and the staff member was able to provide some valuable feedback and see 3.11.

3.3   For this reporting period Q3 the most concerns raised were by the Greater Manchester Dental network (figure 1). This could be due to the media plan that was implemented and the increased visibility of the FTSU Guardian during Freedom to Speak Up month in October 2023.
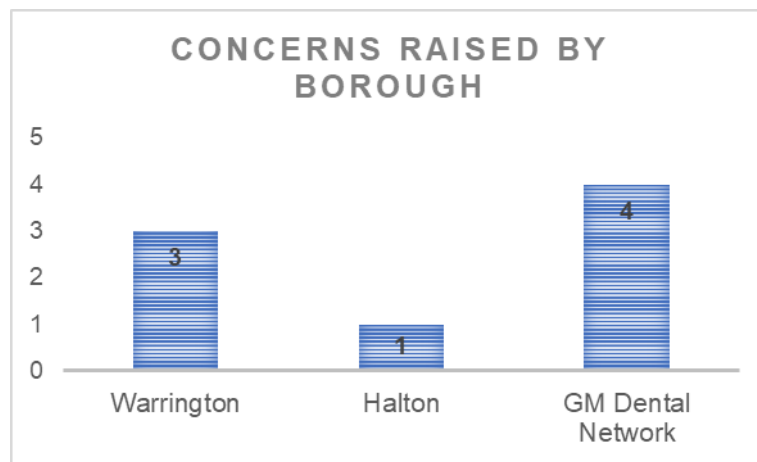
Figure 1: Concerns raised by Borough.

3.4   Staff continue to want their concerns raised in confidence (figure 2).
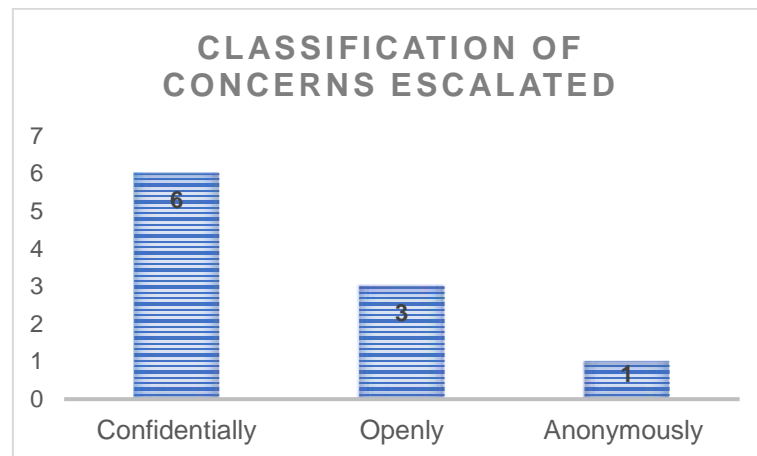
Figure 2: Classification of Concerns Escalated.

3.5   As in previous reports concerns continue to be multi factorial in nature (figure 3) and from a staff / worker category perspective, the main professional group reporting concerns continues to be registered nurses and a slight increase in the number of clerical and administrative workers.

THEMES OF CONCERNS RAISED

Theme	Value
Staff Safety	1
Behavioural/ Relationship (Inc Bullying & Harassment)	3
System/Process	4

Figure 3: Themes of Concerns raised.

3.6 **Main themes in 2023:** Concerns raised continue to be interlinked such as relationships, staffing and processes.

3.7 At this point in time, we do not appear to have indicators of concern e.g., a high proportion of the cases being raised anonymously or overarching themes. Issues raised appear to be service specific e.g., banding issues, procurement issues, recruitment and staffing.

3.8 Since 2022 and taken over a 12-month period the number of concerns raised has doubled. This could be due to the increased visibility of the Guardian and media campaign. There was a slight increase in October 2023 which could be due to October being FTSU month and the increased visibility of the Guardian.
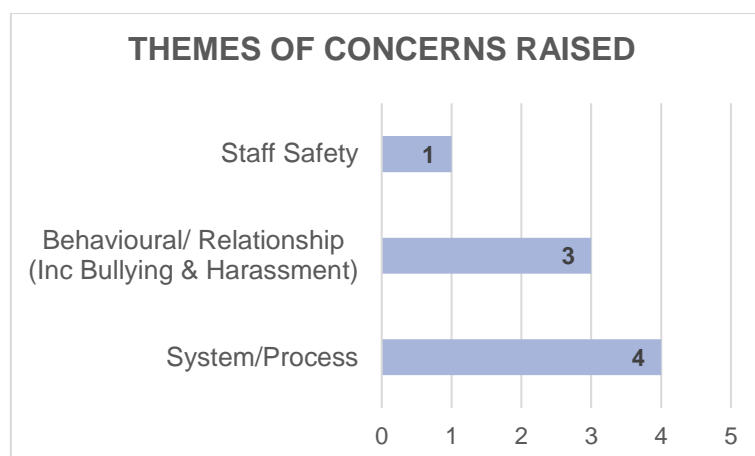
	2022												
Freedom to Speak Up Contacts	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
	0	0	0	0	2	1	0	0	0	2	3	0	8

	2023												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
Freedom to Speak Up Contacts	1	0	0	0	2	1	3	1	0	5	2	1	16

3.9 As an organisation we are aware of our staff turnover and retention rates and the data supporting this is well known. There are plans in place to continue to develop offers such

as an 'employer of choice' e.g. flexible working etc. There is also the new Multidisciplinary Preceptorship Policy, Legacy Mentors, Professional Nurse Advocates (PNA's) and workforce planning which are all tools to try and increase retention and all reported via POD Council.

3.10 As previously reported when the Guardian has met with staff and several staff have reported feeling 'not valued' which had been fed back to managers. Staff feeling undervalued had already been identified and discussions held as to how this could be addressed. The Communications and Engagement team are looking to further improve staff engagement, reward and recognition, and 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.

3.11 **Lessons learnt:** To protect the anonymity of a staff member a concern raised was to do with a particular NHS / Bridgewater process. The staff member was asked to give feedback on their experience and to point out what could have been better managed. Feedback is important so that we know if a process is working or if change is needed. In this situation the staff member had a negative experience and therefore their feedback is important to evaluate the process. The staff members issue is now resolved, and their feedback will be used to adapt the process and improve the experience for other staff.

3.12 To improve the speaking up process the Guardian asks for feedback once a case is closed and on this occasion the feedback received was positive "My experience was very positive and made me feel listened to whilst also using appropriate channels to address my concern" and please also see 4.5.

3.13 As numbers of concerns raised remain low and we also know that staff 'speak up' in other ways, further work is needed re triangulation of data from other sources for trend analysis to understand what the data is telling us and if there is cause for concern. The Guardian will continue to link with HR, Risk Managers etc, to identify if trends are occurring and what actions need to be taken.

4. SELF ASSESSMENT ACTION PLAN UPDATE

4.1 The self-assessment action plan is progressing well, and updates of progress will continue to be presented at People Committee and reported to Board.

4.2 In total there are 26 Key Actions, of which 4 have been completed, (see appendix one).

4.3 Actions 4,5 and 6 all relate to FTSU eLearning and training. At a Board meeting the decision was made to make FTSU training mandatory for all staff.

4.4 The FTSU Guardian has competed the 'Process for requesting inclusion of new topics to the training offer' form and will present the proposal at the next Education Governance Group Meeting. Once this is agreed staff will be informed and the training rolled out.

4.5 Actions 9 and 21 focus on detriment and to 'identify a mechanism for evaluation of speaking up experiences, including detriment'. The new evaluation form once embedded

(6.6), is one tool that can be used to identify if staff have experienced detriment and steps can then be taken as to how we can tackle this and prevent it occurring.

5. UPDATE FROM THE NATIONAL GUARDIANS' OFFICE (NGO)

5.1 On the 16th November 2023 the National Guardians Office Annual Report was laid before Parliament, highlighting the work of Freedom to Speak Up guardians and the National Guardian's Office. The report also shares learning which indicates that more work is needed for speaking up to be described as 'business as usual'.

5.2 Information taken from the NGO Annual Report April 2022 – March 2023 - 'Making Speaking Up business as usual', highlighted that in this year's NHS Staff Survey, The Freedom to Speak Up sub-score had declined from 6.5 in 2021 to 6.4. This fall equates to a 1.5% change. Given the size of the survey (over 600,000 workers) this equates to a declining perception of over 9,000 workers in how safe and supported they feel to speak up about anything which gets in the way of them doing their job.

5.3 The NGO sense that high profile cases this year have contributed to this silencing effect. These cases where people have experienced detriment for speaking up have the potential to undo much of the progress being made.

5.4 **NGO work programme for 2024**: Alongside supporting Freedom to Speak Up Guardians, the NGO have identified four core themes which are directing their work programme for 2024 as follows:
   ➤ Improving their systems to better support their offer to Freedom to Speak Up guardians.

   ➤ Ensuring all workers have a voice wherever they work, including in primary medical services.

   ➤ Exploring how they can support the knowledge and skills of Non-Executive Directors and those with organisational oversight.

   ➤ Building on insights from their first Speak Up review, initiating the next review and establishing the framework for future assessments.

6. RECOMMENDATIONS AND FUTURE DEVELOPMENTS

6.1 FTSU Champions: The number of champions is growing and in total we now have 8 champions and plan to recruit more this year. Staff will be able to find out more about the role on the FTSU MyBridgewater page.

6.2 The Guardian met with the FTSU Guardian from the Wirral where they have 124 Champions. This meeting was to see how they developed the number of champions they have and if we could replicate this. They took a targeted approach to recruiting some of their champions e.g. staff from their network groups and then asked for expressions of interest. This is something that we will scope further, and further guidance is provided by the NGO to assist us in doing this.

6.3   **Visibility:** The FTSU Guardian aims to be more visible across Bridgewater and will continue to attend team meetings and events and will also go to bases and meet staff on an ad hoc basis and the Guardian will continue to present at the corporate induction for new staff.

6.4   As part of the self-assessment action plan, staff will be asked to complete another FTSU staff survey, and this will take place at the end of January 2024. Repeating the survey will capture the views of any new staff into the organisation and identify if more improvements need to be made and if 'barriers' to speaking up still exist.

6.5   **MyBridgewater page:** The page continues to be developed and evolve into a platform that provides information on 'speaking up' that is informative and provides a quick and easy way of communicating information to staff about how to 'speak up'. Guardian contact details are provided and there will be a section about the FTSU Champions and their role in speaking up and who they are and how they can be contacted.

6.6   Currently in development is a section on lessons learnt and anonymised staff case studies so that we can evidence that improvements have been made and that staff are listened to.

Appendix 1

FTSU Key Actions

FTSU self assessment
Key Action 2023 2024

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 February 2024**
Agenda Item	**09/24vi**		
Report Title	**AREA SPECIAL EDUCATIONAL NEEDS / DISABILITIES (SEND) INSPECTION – HALTON LOCAL AREA PARTNERSHIP**		
Executive Lead	Sarah Brennan, Chief Operating Officer		
Report Author	Sarah Brennan, Chief Operating Officer		
Presented by	Sarah Brennan, Chief Operating Officer		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Executive Summary

In November 2023, an Area SEND inspection of the Halton Local Area Partnership was undertaken jointly by Ofsted and the Care Quality Commission (CQC). The feedback is provided in the attached report.

The framework and handbook for inspecting local area arrangements for children and young people with special educational needs and/or disabilities (SEND) was devised jointly by Ofsted and the Care Quality Commission (CQC) for use from 2023 and will be periodically reviewed and amended.

The Trust is working with Halton Borough Council and the place based Integrated Care Board (ICB) Team to develop the priority action plan as a result of the feedback given as well as focusing on an internal action plan which is currently in development to address some of the concerns raised in relation to the services provided by the Trust.

Previously considered by:

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

Strategic Objectives

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

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

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

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

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

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

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	08 February 2024
Agenda Item	09/24vi		
Report Title	AREA SPECIAL EDUCATIONAL NEEDS / DISABILITIES (SEND) INSPECTION – HALTON LOCAL AREA PARTNERSHIP		
Report Author	Sarah Brennan, Chief Operating Officer		
Purpose	To inform the Board of the outcome of the Halton Local Area Partnership SEND Inspection		

1. INTRODUCTION

1.1 The Halton Local Area Partnership was inspected jointly by Ofsted and the Care Quality Commission (CQC) from 20th to 24th November 2023.

1.2 The framework and handbook for inspecting local area arrangements for children and young people with special educational needs and/or disabilities (SEND) was devised jointly by Ofsted and the Care Quality Commission (CQC) for use from 2023 and is periodically reviewed and amended as required.

1.3 The last inspection took place in March 2017 and was critical in a number of areas in relation to the Trust (2697147 (ofsted.gov.uk)).

1.4 Halton Borough Council and NHS Cheshire and Merseyside Integrated Care Board (ICB) are jointly responsible for the planning and commissioning of services for children and young people with SEND in Halton.

1.5 The Trust provides several services which support children with SEND in Halton including:

- 0-19 service including health visitors and school nurses

- Community Paediatric Medical Service

- Neurodevelopment Nursing Team

- Multidisciplinary Assessment Team

- Occupational Therapy

- Physiotherapy

- Safeguarding and Children in Care Team

1.6   A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support, we shorten this to SEND.

1.7   The SEND Code of Practice 2014 and the Children and Families Act 2014 gives guidance to health and social care, education and local authorities to make sure that children and young people with SEND are properly supported.

2. INSPECTION OUTCOME

2.1   The inspection outcome was that there are:

'*widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently.*'

2.2   The Partnership has achieved the lowest of the three possible outcomes and that a monitoring inspection will be carried out in approximately 18 months and a full reinspection will be carried out in with approximately 3 years.

2.3   A priority action plan must be prepared and submitted by the Partnership to Her Majesty's Chief Inspector within 35 working days following the publication of the inspection report (26th January 2024).

3. ACTIONS

3.1   Internally, there are a number of actions being undertaken and a comprehensive action plan is being developed in relation to the community paediatrics and the neurodevelopmental pathway. Potential transformation opportunities are being considered and fully embedding a skill mixed workforce.

3.2   A meetings is being scheduled with Commissioners to look at how the universal and graduated offer connects to the service to ensure that the service is using its capacity to manage the specialist referrals and we anticipate that this will take place in March.

3.3   The Trust will be working with the place-based team to contribute to the Council Led Priority Action Plan and will attend the Improvement Board Meetings to ensure that action is taken to resolve the areas of concern identified.

4. RECOMMENDATION

4.1 The Board are asked to note the contents of the Area SEND inspection of the Halton Local Area Partnership inspection.

Area SEND inspection of Halton Local Area Partnership

Inspection dates: 20 to 24 November 2023

Date of previous inspection: 27 to 31 March 2017

Inspection outcome

There are widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently.

A monitoring inspection will be carried out within approximately 18 months. The next full reinspection will be within approximately three years.

As a result of this inspection, His Majesty's Chief Inspector requires the local area partnership to prepare and submit a priority action plan (area SEND) to address the identified areas for priority action.

Information about the local area partnership

Halton Borough Council and NHS Cheshire and Merseyside Integrated Care Board (ICB) are jointly responsible for the planning and commissioning of services for children and young people with SEND in Halton.

There have been significant changes to the senior leadership of Halton's SEND services since the previous inspection. These include the appointment of a new chief executive officer (CEO), several interim directors of children's services, a newly appointed operational director for education, inclusion, and provision, and a new head of service for SEND. A permanent director of children's services started in October 2023.

The commissioning of health services changed across England in 2022. On 1 July 2022, NHS Cheshire and Merseyside ICB became responsible for the commissioning of health services in Halton.

The local authority has a core provider of alternative provision (AP) for children or young people who have been, or are at risk of being, permanently excluded. The local authority does not commission any other AP.

What is it like to be a child or young person with SEND in this area?

Too many children and young people with SEND in Halton wait an unacceptable time to have their needs accurately identified and assessed. For example, children and young people wait too long to access a neurodevelopmental assessment. Most children and young people wait more than 18 months. This means that for some children and young people, their needs escalate to crisis point. While there are some support services available while they wait, too few children, young people and families benefit from these. Families experience ineffective communication while waiting. This causes significant frustration and results in a lack of trust in the system.

Some children and young people of all ages, including those moving from the early years to primary school, and from secondary education to further education, transition without having their needs identified effectively. One in five children do not receive their two-year developmental check. As a result, there is a missed opportunity to identify children's emerging SEND.

Too many children and young people do not receive the right help at the right time. While some services, such as the early help team, integrated physiotherapy and occupational therapy and the specialist teaching teams, provide effective and valued support, there is a lack of capacity across the partnership. Many practitioners work in isolation. This leads to an ineffective and inefficient coordination of support for children and young people with SEND from birth to 25.

Parents, carers, and professionals describe how the 'tell it once approach' is not established in Halton. This leads to duplication of work and delays for children and young people across health, social care, and education teams. Furthermore, it significantly impacts on parents' and carers' trust in the system, as they must retell their stories repeatedly.

Children and young people wait too long to be assessed for an education, health and care (EHC) plan. There are too many barriers in place, further hampered by significant confusion about how to request an EHC plan. Some parents, carers and professionals reported that the partnership requires them to provide two cycles of 'assess, plan, do, review', and educational psychology involvement, before an EHC plan needs assessment can be requested. This approach means that it takes too long to start the process.

The planning to meet some children and young people's needs relies too heavily on one or two supportive professionals, or their parents and carers driving the process. There are limited useful systems around the child or young person to promote successful planning to meet their education, social care and health needs effectively.

Information gathering and sharing between partners is poor. Children's and young people's needs are not understood and met swiftly and effectively through well-coordinated approaches. Consequently, many children and young people with SEND receive an experience that is not as joined up across health, education, and social care

as it should be. There are significant delays in children's plans being issued, often due to capacity within service. Too much is left to chance.

Children and young people with SEND educated in supportive settings with experienced staff and sufficient capacity benefit from the settings' determination. This is despite the local partnership's weak systems.

What is the area partnership doing that is effective?

- Leaders are committed to listening to children and young people, parents and carers. The parent carer forum is a respected and valued strategic partner. A new coproduction strategy has been co-created. However, there is more work to do to embed coproduction with children, young people, parents and carers across the SEND system at all levels.

- Leaders gather and use the views of children and young people to shape services. For example, the parent carer forum heard the voices of disabled children in mainstream schools. Consequently, the partnership established a twice-monthly youth club, which is well attended.

- The school nursing service in Halton is highly valued by many stakeholders. School nurses build positive relationships with, and are easily accessible to, children and young people with SEND aged five to 19. They provide targeted early intervention and advice to both individuals and groups of children and young people. Education leaders appreciate the effective staff training provided by the service.

- Preparation for adulthood processes are positive for some children and young people with SEND, including care leavers. Disabled children and young people benefit from the support of the transition team. Children and young people with attention deficit hyperactivity disorder (ADHD) have a well-supported transition to the adult ADHD service. These teams work collaboratively with other services, such as the educational psychology service and youth justice service to prepare children and young people for the future.

- Older children and young people with SEND access targeted support from the 14 to 19 Team. This team provides impartial advice and guidance to help young people make choices around future learning and careers that are available in the local area. The service is appreciated by parents, carers and education professionals and supports positive preparation for adulthood outcomes across Halton.

- Practitioners in Halton are person-centred and promote a flexible approach to working with children, young people, and their families. Practitioners use innovative and creative ways to capture the voices of children and young people accurately. For example, in care plans and case recording.

- Children and young people with SEND are typically visible and valued in Halton. Clubs and activities support children and young people with SEND to develop their interests and, in some cases, gain further qualifications. Children feel welcomed and supported to access a range of community-based activities.

- The play library helps parents to try different sensory toys to see if these will support their children's needs. The recruitment and training of personal assistants within early help further support children and young people's integration into society.

- Children and young people placed in local authority-commissioned AP receive suitable oversight. This helps to ensure that they are safe and have their needs met effectively in these placements.

What does the area partnership need to do better?

- While partnership leaders are ambitious for children and young people with SEND, there is significant work to do for positive impact to be felt. Leadership instability has impacted negatively on the pace and traction of SEND improvement in Halton. While the newly established leadership team has identified key areas of development, strategic planning in many areas is underdeveloped.

- Leaders have been too slow to respond to the rising numbers and increasing complexity of children and young people's needs across Halton. There is no clear recovery plan in place. Many children and young people are not having their needs met in a timely and appropriate way. For example, a lack of effective commissioning means that some children do not have the correct specialist seating. This impacts on every area of their life.

- Partnership leaders do not work together effectively to jointly commission services. There is no joint commissioning strategy. Despite there being multiple sources of information, leaders are not using these effectively to make commissioning decisions. As a result, services and settings are developing isolated practices to meet needs. Additionally, for some children and young people accessing the Child and Adolescent Mental Health Service, there is no equivalent adult service. This results in gaps in treatment.

- The recently commissioned speech and language therapy service has not been mobilised effectively. This has led to further delay and uncertainty for children and young people and their families. Leaders have an unclear understanding of the number of children and young people currently waiting. Moreover, there has been insufficient consideration of the impact of recent changes to the workforce on children and young people with SEND.

- The local area partnership's strategy for AP is in its infancy. Despite leaders' attempts to communicate the strategy's aims and objectives, there is confusion

about the desired impact and next steps. The partnership has a limited understanding of AP in the area. This is partly due to the vast majority of AP being commissioned by schools. However, the local area partnership has not made sufficient inroads to understanding the scale and nature of AP in Halton. This means that the partnership is unable to accurately evaluate and respond to gaps and opportunities in AP for children and young people with SEND. School leaders are keen to broaden the AP offer, but insecure commissioning arrangements continue to delay the strategy.

- The scrutiny and challenge of the SEND system in Halton is ineffective at many levels of governance. While there is a new SEND governance board, the influence of this is currently limited and is not impacting positively on children and young people with SEND and their families in Halton.

- While newly written EHC plans are showing early signs of improvement, and leaders know what a good EHC plan looks like, a considerable number of EHC plans remain variable in quality and effectiveness. Quality assurance is hampered as many health professionals do not receive a copy of the draft or final plan. While some professional advice is effective and useful, too much advice is not as useful, nor as specific, as it should be. This includes advice from social care professionals and advice created as part of group consultation with educational psychologists and specialist teaching teams.

- There is inconsistency in the expertise and understanding of education, health and social care practitioners who provide advice for the EHC process, due to variability in training. Generic outcomes and strategies in some professional advice hinders the SEND team's ability to create an EHC plan that identifies and meets the needs of the child or young person effectively.

Areas for priority action

Responsible body	Areas for priority action
Halton Borough Council and NHS Cheshire and Merseyside Integrated Care Board (ICB)	Leaders at Halton local authority and the NHS Cheshire and Merseyside ICB should cooperate at pace to improve the shared strategic oversight, governance, support and challenge to drive improvements to meet the needs of children and young people with SEND in Halton.
Halton Borough Council and NHS Cheshire and Merseyside Integrated Care Board (ICB)	Leaders in the local authority, ICB and education, health and social care providers should improve the efficiency and quality of their information gathering and sharing processes to ensure that children's and young people's needs are understood accurately and met more swiftly and effectively through coordinated approaches.
Halton Borough Council and NHS Cheshire and	Leaders across education, health and social care should improve the joint commissioning of services to ensure

Merseyside Integrated Care Board (ICB)	that children, young people and their families receive sufficient support to have their needs met effectively.
Halton Borough Council and NHS Cheshire and Merseyside Integrated Care Board (ICB)	Leaders across education, health and social care should urgently improve the early identification of needs and access to specialist health pathways, including the neurodevelopmental assessment pathway and speech and language therapy and the support available, while children and young people wait.
Halton Borough Council and NHS Cheshire and Merseyside Integrated Care Board (ICB)	Leaders across education, health and social care should improve the timeliness of new EHC plans and updates to EHC plans following the annual review process, so that, if appropriate, children and young people receive an effective EHC plan within statutory timescales.

Areas for improvement

Areas for improvement
Leaders should improve the quality of assessment, advice and planning across education, health and social care so that children and young people's needs are better understood and met swiftly and effectively through coordinated approaches.
Leaders across the partnership should strengthen processes for the quality assurance of EHC plans and use these to improve the quality of new and existing EHC plans.
Leaders should ensure that communication with stakeholders, including parents, carers, children and young people, is enhanced. This includes the communication about how leaders plan to develop systems and processes. This should focus on improving parents' and carers' trust in the system. Communication between teams and services should be improved to better identify and meet children and young people's needs.
Leaders should improve the pace and traction of the AP strategy to ensure that it impacts positively on children and young people with SEND.

Local area partnership details

Local Authority	Integrated Care Board
Halton Borough Council	NHS Cheshire and Merseyside Integrated Care Board (ICB)
Zoe Fearon, Director of Children's Services	Graham Urwin, CEO
www3.halton.gov.uk	www.cheshireandmerseyside.nhs.uk
Municipal Building, Kingsway, Widnes WA8 7QF	NHS Cheshire and Merseyside, No 1 Lakeside, 920 Centre Park, Warrington WA1 1QY

Information about this inspection

This inspection was carried out at the request of the Secretary of State for Education under section 20(1)(a) of the Children Act 2004.

The inspection was led by one of His Majesty's Inspectors (HMI) from Ofsted, with a team of inspectors, including an HMI from social care and Ofsted Inspector from Education, a lead Children's Services Inspector and a team Children's Services Inspector from the Care Quality Commission (CQC).

Inspection team

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Geraldine Bates, CQC Lead Inspector

Louise Holland, CQC Inspector

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 February 2024**
Agenda Item	**10/24i**		
Report Title	**FINANCE REPORT – MONTH NINE (DECEMBER 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 nine:

- The Trust is reporting a small surplus of £0.02m, slightly ahead of 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 £3.86m against a plan of £3.86m.
- Income is £74.55m for the year-to-date against a plan of £73.60m.
- Expenditure is £74.53m against a plan of £73.60m.
- Pay is £48.03m against a plan of £47.76m.
- Agency spend is £4.09m against a plan of £3.51m.
- Non pay expenditure is £22.79m against a plan of £22.10m.
- Capital charges are £0.61m below plan.
- Capital expenditure is £0.85m at month nine, planned spend is £1.84m.
- Cash is £16.80m

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**
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	**Quality** Failure to deliver quality services and continually improve	**Health Equity** Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	**Staff** Failure to create an environment for staff to grow and thrive	**Resources** Failure to use our resources in a sustainable and effective way	**Equality, Diversity & Inclusion** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	**Partnerships** Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 February 2024**
Agenda Item	**10/24i**		
Report Title	**FINANCE REPORT MONTH NINE (DECEMBER 2023)**		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the financial position as at Month Nine		

1. SCOPE

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

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

2. FINANCIAL POSITION AS AT MONTH NINE

6.1 The key headlines for month Nine are shown in the table below.

6.2 The purpose of this paper is to update the Board on the financial position of the Trust at the end of December 2023 (Month 09).

6.3 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.

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

Table 1 – Summary of Financial Performance

Summary Performance Month 09 2023-24	Month 9 Plan (£M)	Month 9 Actual (£M)	Month 9 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.11)	(7.90)	⚠ (0.21)	(73.62)	(74.55)	🟢 0.93	(97.94)	(99.18)
Expenditure - Pay	5.46	5.54	⚠ (0.08)	47.76	48.03	⚠ (0.26)	64.15	64.15
Expenditure - Agency	0.24	0.30	⚠ (0.06)	3.51	4.09	⚠ (0.58)	4.22	4.62
Expenditure - Non Pay	2.39	2.08	🟢 0.32	22.10	22.79	⚠ (0.68)	29.26	30.94
EBITDA	(0.03)	0.00	⚠ (0.03)	(0.24)	0.36	⚠ (0.60)	(0.31)	0.54
Financing	0.03	(0.01)	🟢 0.03	0.23	(0.38)	🟢 0.61	0.31	(0.54)
Normalised (Surplus)/Deficit	0.00	(0.00)	🟢 0.00	(0.01)	(0.02)	🟢 0.01	0.00	0.00
Exceptional Costs	0.00	0.00	🟢 0.00	0.00	0.00	🟢 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.00	(0.00)	🟢 0.00	(0.01)	(0.02)	🟢 0.01	0.00	0.00
Other Adjustments	0.00	0.00	🟢 0.00	0.00	0.00	🟢 0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.00	(0.00)	🟢 0.00	(0.01)	(0.02)	🟢 0.01	0.00	0.00
CIP	0.43	0.43	🟢 0.00	3.86	3.86	🟢 0.00	5.15	5.15
Capital	0.50	0.14	🟢 0.36	1.84	0.85	🟢 0.99	2.10	2.10
Cash	24.42	16.80	⚠ (7.62)	24.42	16.80	⚠ (7.62)	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
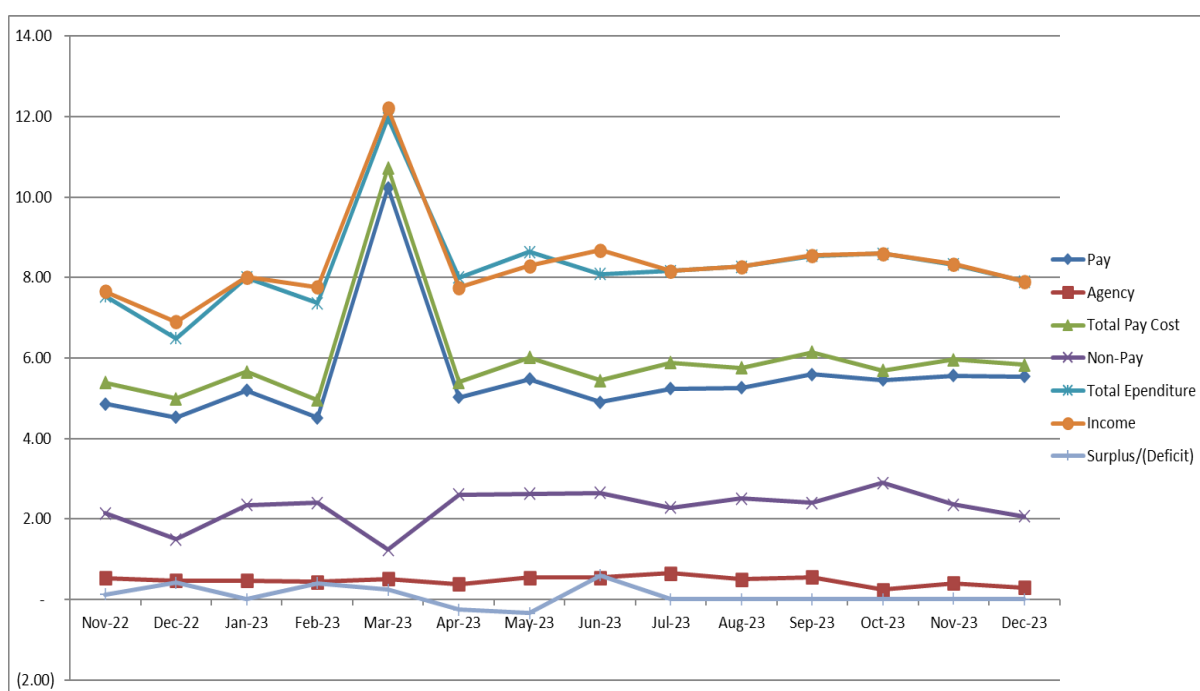
6.5   The Trust is reporting a surplus of £0.02m, slightly ahead of the plan of break even.

➢ **Income**

- Income was below plan by £0.21m in month, primarily due to a reduced payment for Dental services in GM as a result of an overpayment in month eight.

➢ **Pay**

- Pay costs are below plan by £0.08m in month nine due to the medical and dental pay award not reflected in the revised plan.

➢ **Agency**

During month nine, the Trust has incurred costs of £0.30m against the plan of £0.24m.

The month-on-month expenditure has decreased by £0.10m. (See Appendix 1 for details).

The full year plan remains at £4.22m though the forecast has increased to £4.62m. Each directorate has a recovery plan to achieve the plan position by year-end.

The forecast has increased due to the delay in implementing the new outsourcing SLA for Dermatology and the continued requirement for locum Paediatricians.

The four services with the highest agency spend 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 now requires Executive approval for exceptional circumstances and has significantly reduced, spend is mainly via GRI covering 8 WTE vacancies.
- Warrington and Halton 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 in Warrington and the Trust is in discussions with the ICB to secure additional funding for Halton.
- Intermediate Care Bed Based (Padgate House) – high cost off framework agency use now requires Executive approval for exceptional circumstances and has significantly reduced.

Agency costs incurred in month nine equated to 44.37 whole time equivalent staff.

Area	Sum of YTD Actual £k	Sum of Forecast £k	Revised Agency Cap Forecast £k
Childrens	436.34	537.34	485.14
Corporate	190.55	237.05	203.60
Dental	101.45	101.45	78.79
Halton	956.48	1,106.98	937.96
Warrington	2,404.75	2,645.75	2,517.11
Grand Total	**4,089.56**	**4,628.56**	**4,222.61**

> **Non Pay**

During month nine the Trust has spent £2.08m on non-pay, £0.32m below plan.

The underlying (adjusted for the cumulative reprofiling impact) overspend on non pay is consistent with previous months and largely due to:

- Increasing spend on drugs, particularly 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 income.

> **Financing Costs**

- Additional interest received and an improved statement of financial position have contributed to reduced financing costs and a £0.61m variance favourable to plan.

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

6.7 **Forecast Outturn 2023/24**

- The Trust is on track to achieve the planned break-even position. Any additional service pressures are expected to be met within the current funding envelope. The Trust is anticipating it will spend its capital allocation.

3. COST IMPROVEMENT PLAN (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 The additional requirements include the 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 nine is £3.86m, against which achievement of £3.86m is reported.

3.5 The current forecast outturn is that the Trust will achieve the £5.1m total CIP plan, of which a minimum of £2.4m is expected to be recurrent.

3.6 Further detail is provided in the table below:

Category	M9 £k	Recurrent £k	Non Recurrent £k
Income	1,401	642	759
Pay	1,982	345	1,637
Non Pay	457	357	100
Total	**3,840**	**1,344**	**2,496**

4. CAPITAL, CASH AND BETTER PAYMENT PRACTICE CODE

4.1 Total capital expenditure as at 31st December was £0.85m against a plan of £1.84m.

4.2 The capital programme includes a contingency of £0.20m which has reduced by £0.05m due to new schemes, which have been identified as business critical during Month Nine and approved and included in the capital plan for 2023/24. Should these schemes not progress then schemes on the reserve list will be deployed.

The prioritisation order for schemes is as follows:
- Schemes brought forward from 2022/23.
- Locally mandated schemes, i.e., those schemes which must be funded from capital.
- Business critical schemes, i.e., schemes which are critical to service delivery.
- Risk score order.

4.3 Procurement is now progressing orders in conjunction with services.

4.4 The Trust is anticipating it will spend its capital allocation.

4.5 In December 2023 there was a net cash outflow of £1.05m with a closing cash balance of £16.80m.

4.6 The cash outflow has arisen due to a reduction in income receipts in month (all other cash outflows, including payments to NHS suppliers and Payroll costs have remained consistent with the previous month). The decrease in income received ties in with the increase in total aged debt outlined in section 4.6 below.

4.7 Total debt as at 31st December is £10.74m after allowing for the bad debt provision, of which £7.20m relates to invoiced debt. Overall debt has increased by £0.91m from November and this is due to the net reduction in the bad debt provision of £0.87m following the review at Month 9 which identified those invoices which had been provided for but subsequently recovered from the debtor during the year to date.

4.8 Invoiced debt has increased by £0.32m and of that, overdue debt has increased by £0.79m due primarily to the debtor balances with Warrington Borough Council and Halton Borough Council for which payment was delayed hence resulting in the related invoices falling into the 1-30 days overdue at Month 9 close. These invoices have been paid since month end.

4.9 Total trade and other payables as at 31st December are £9.92m, of which £4.26m relates to creditors.

4.10 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
Nov-23	95.0	91.1	92.8
Dec-23	95.0	97.5	96.7
Year to date performance	95.0	96.5	96.9

4.11 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.

5. CHESHIRE AND MERSEYSIDE ICS FINANCIAL POSITION

7.1 As at month nine, the system forecast outturn is to achieve the rebased system plan of breakeven. Additional funding has been distributed and all organisations are expected to achieve their rebased plans.

7.2 Bridgewater Community Healthcare NHS Foundation Trust (BCH) did not receive any additional funding and has not revised its forecast outturn planned position of breakeven.

7.3 Despite the additional funding, several provider Trusts are reporting year to date pressures placing risk on their achievement of their revised plans. The current expectation is that these pressures will be managed by the relevant provider organisations.

7.4 BCH are part of the Warrington Place, as Warrington is the Trust's largest Place commissioner. As at month nine, Warrington Place is showing a significant variance from plan, and discussions with the ICS are ongoing to achieve a breakeven outturn position.

6. 2023/24 PLANNING

6.1   Final National guidance has not yet been published. In the absence of this guidance and recognising the shortened period to produce plans and follow appropriate governance within organisations, the Trust is developing a draft plan based on outline assumptions referenced in draft planning documents, adjusted for any expected local variations. This should allow for a draft plan to be produced in mid February that can be amended if required following the issue of final guidance.

6.2   Cheshire and Merseyside ICS have issued some key planning guidelines for organisations to follow pending the receipt of the final National guidance.

6.3   A separate briefing paper outlining these assumptions will be circulated to Board members.

6.4   The ICS are also currently considering the introduction of organisational and Place control totals. It is unclear at this time as to the criteria that will be adopted to set these limits. The ICS is also considering realigning Place allocations to match the allocation methodology prior to the pandemic. Further details are expected in the coming weeks.

7. RECOMMENDATIONS

7.1   The Board is asked to:

- Note the contents of this report.

- Note the financial position.

Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	Finance and Performance Committee		Report to:	Board of Directors
Date of Meeting:	25 January 2024		Date of next meeting:	21 March 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 Martyn Taylor, Non-Executive Director Nick Gallagher, Director of Finance Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer	**In Attendance & Observers:** Rachel Hurst, Deputy Director of Finance Eugene Lavan, Deputy Chief Operating Officer Mark Charman, Assistant Director of Transformation Dave Smith, Assistant Director of IT John Morris, Deputy Director of Estates Gareth Pugh, Assistant Director of Finance Debbie Weir, Financial Controller Sam Scholes, Head of Corporate Governance Paul Foster, Associate Director of Procurement Anita Buckley, Information Team, joined the meeting at 11.15 am Rita Chapman, Governor Observer Paula Wright, Chief Nursing Information Officer	**Key Members not present:**	**Apologies received from:** Linda Chivers, Non-Executive Director Jan McCartney, Trust Secretary

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
CIP Chair's Report	5		The Committee received the chair's report.	The Committee noted that taking both recurrent and non recurrent schemes into account the Trust will achieve its CIP requirement. However, there

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		🟧		is a shortfall in recurrent schemes which potentially will be needed to be taken forward into 2024/25. The Committee also noted the update from Quality Committee that a report had been received which provided assurance regarding the requirement and process for QIAs. The Committee noted that the process to determine whether a QIA should be conducted is done in conjunction with clinical colleagues. The Committee was informed that plans were in train to take forward a transformational approach to the delivery of efficiencies from 2024/25 onwards which would be over a longer term approach. The governance is currently being developed and BOOST (Building On Our Strengths Together) methodology will be utilised and this will be led by the Chief Nurse who is now the SIRO for CIP.
Finance Report	5	🟩	Month 9 finance report received and provided assurance. The Committee noted that: • Month 9 23/24 is breakeven and on plan • CIP is on plan • BPPC has improved • Healthy cash position • Capital programme	The Committee noted the financial position is on plan. The Committee noted that CIP is on plan. The Committee noted that a cross reference will be undertaken between CIP report (anticipated savings) and Finance report (delivered savings). The Committee noted agency spend and noted that agency usage including off framework was reducing. The Committee noted the shift from agency to bank to recruitment.

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Committee Chair's Report

				The Committee noted the capital position and the assurance provided in terms of outstanding schemes.

The Committee noted the positive update on aged debt since the month end.

The Committee recommended the financial report to the Board. |
| Financial Planning | 5 | | The Committee received a verbal update. | The Committee noted that planning guidance had not yet been issued however the Trust is working on the assumption that there will be a flat cash settlement and using 5% CIP as a prudent estimate in preparing plans. |
| Accounting Policy and Procedures | 5 | | The Committee received a verbal update. | The Committee no material changes so far and an updated GAM (General Accounting Manual) is expected in the next few weeks.

The Committee will be kept updated if there are any significant changes. |
| Procurement | 5 | | The Committee received the report. | The Committee noted the improvement in scoring for the accreditation process.

The Committee noted the pleasing reduction in retrospective waivers. |
| Performance | 5 | | The Chair's report from Performance Council for month 08 was received. | The Committee received the report. The Committee noted that for dental that there were red RAG ratings for performance, finance, and people.

Currently, there are four task and finish groups which are looking at acceptance criteria for |

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				treatment and discharge criteria for special care patients to ensure that delivery is in line with the contracted specifications and that additional uncontracted activity is not being delivered which detracts capacity to deliver contracted activity.
Performance	5		IQPR for month 8 was received by the Committee.	The Committee noted the report with the addition of several new key performance indicators.

All the cancer indicators are reporting as green in month.

There are three indicators relating to the performance of the Widnes UTC which are red, these relate to the total time in A&E – 95th centile and median and the percent of patients referred to A&E. There has been an 11% increase in acuity of patients attending the facility and an increasing level of staff sickness. Actions are in place to look to ensure that these targets return promptly to green, and the metrics are monitored daily.

There is a small improvement in relation to the number of breaches in audiology and the team are working to clear the breaches by the end of March.

The RTT position has deteriorated due to an increase in the waiting times for both the community paediatrics in Halton and Warrington.

DNA/Was not brought are being reviewed, particularly in relation to children's services to ensure that all available capacity is fully utilised. |

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Committee Chair's Report

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Referrals to plan and activity targets are being refreshed with commissioners.

Mandated contact visits for health visitors are now monitored in the IQPR and the performance in Halton is below that of Warrington and work is in place to address this.

From a dental perspective the waiting list size remains static, and the team are focussing on clearing the over 65-week waiters. There are challenges around the available GA capacity which has been impacted by the Junior Doctor strikes.

From a quality perspective, incidents that cause harm have increased in month and this is the first month where the patient safety incident response framework has been introduced.

Medicines incidents, medicines incidents which cause harm and risks above 12 have all seen an improvement in month. The percentage of policies in date and the IPC Assurance Audit are reporting as red.

From a people perspective, there are 3 red indicators. Sickness absence rolling and actual are just slightly above the 5.5% target and short-term absence has increased in month.

From a finance perspective, pay, non -pay and agency are all above plan. Agency costs are being tightly controlled and a further reduction in
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Key/legend:

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Committee Chair's Report

				costs is expected as we move into the January performance.
Estates			No update due this month	
Digital	5		Chair's report from DIGIT	The Committee received the report. The Committee noted the excellent progress in implementing MFA (Multi Factor Authentication)– the Trust is in the top 10 of organisations in terms of progress with implementation and aims to have all accounts transferred by the end of January. The Committee noted the issues with the Data Warehouse failures and the potential knock on impacts in terms of reporting, ability to retrieve data and staff time.
Audit	5		MIAA and KPMG Audit recommendations	The Committee noted the report.
Risks	5		Risk paper	The Committee noted the report. The Committee noted that there was a potential duplication of risks and scoring variance (Estates/IPC) and that will be reviewed at the next Risk Council.
BAF	5		BAF 5	The Committee reviewed the new BAF 5 – Resources. The Committee noted a potential lack in consistency regarding the risk assessment and scoring of CIP by individual directorates.

				The Committee proposed that gap in control mitigations were reviewed especially with regard to CIP – The Trust is meeting CIP however there are shortfalls at directorate level and also the split between recurrent and non recurrent delivery.
Governance	5		Committee Annual Review of Effectiveness	The Committee received the results of the survey.
				The Committee noted that the vast majority of responders either agreed or strongly agreed to the statements, demonstrating a high level of satisfaction with the effectiveness of the Committee's function.
			Review of meeting	The Governor observer noted the depth of discussion relating to CIP and the key issues faced by dental services.

Risks Escalated: None from the meeting

Actions delegated/escalated to other Committees:

Nothing delegated/escalated

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Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	Audit Committee		Report to:	Board of Directors
Date of Meeting:	11 January 2024		Date of next meeting:	23 April 2024
Chair:	Linda Chivers, Non-Executive Director		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Linda Chivers, Non-Executive Director, Committee Chair Tina Wilkins, Non-Executive Director, Committee Vice-Chair Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director – joined at 11 am Abdul Siddique, Non-Executive Director	**In Attendance & Observers:** Nick Gallagher, Director of Finance Rachel Hurst, Deputy Director of Finance Debbie Weir, Financial Controller Sarah Brennan, Chief Operating Officer Sam Scholes, Head of Corporate Governance Gary Baines, Regional Assurance Manager, MIAA Adrian Poll, Senior Audit Manager, MIAA Phillip Leong, Anti-Fraud Specialist, MIAA James Boyle, Director, KPMG Adam Lyon, Manager, KPMG Paula Woods, Director of People and OD for item 12/24 (iii) Dr Ted Adams, Medical Director, from 11.30 am to 12.00 pm <u>Observers</u> Karen Bliss, Trust Chair Bob Chadwick, NED from February 2024 Andrew Mortimer, Governor Observer Paula Wright, Chief Nurse Information Officer Belinda Corris, Anti-Fraud Specialist	**Key Members not present:**	**Apologies received from:** Lynne Carter, Chief Nurse Jan McCartney, Trust Secretary Kevin Goucher, Governor

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Committee Chair's Report

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Self-Assessment of Committee Effectiveness	1		The Committee received detailed results of the annual assessment of the Committees' effectiveness. This year, the content of the Committee Effectiveness Survey had been reviewed by the Audit Committee Chair and the Trust Secretary and as a result three new questions were added and some existing questions have also been slightly rephrased to improve clarity. A good number of responses was received with a very positive overall score of 4.83 out of 5. It was highlighted that specifically two questions received the highest marks of 5 out of 5, these were regarding the quality and effectiveness of chairing and the accuracy of minutes.	Assurance received This will be added to BAF 1
Audit Committee Business Cycle 2024 – 25	1		The Committee received and approved the renewed Business Cycle for 2024-25. The Business Cycle had been comprehensively reviewed with several updates in July 2023 and approved by the Board in August 2023. There were no further updates proposed at this point to the 2024-25 Business Cycle. The next review was scheduled for July 2024, alongside the Terms of Reference. Both documents will be then received by the Board in August 2024.	Business Cycle for 2024-25 approved
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. The Action Plan provided 'success criteria' for each recommendation. The plan also clearly identified overseeing Committees for each action.	Assurance received.

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			The Committees will recommend to the Audit Committee that the recommendations can be closed down, once the recommendation has been fully embedded and part of business as usual.	
			It was noted that there was an additional action ongoing to link the supporting strategies to delivery of the Trust Strategy. The Committee also requested that the use of language in the action plan should be more affirmative to reflect the current position and completion of action.	
			Notwithstanding the comments, the Committee were satisfied that there was a clear line of sight between recommendations and overseeing committees, as well as progress taking place towards the completion of the recommendations.	
Clinical Audit Review	1		The Committee received a report outlining the governance arrangements around the Clinical Audit Review.	Assurance received
			The Committee noted that that the Clinical Audit Review sits within the remit of the Quality and Safety Committee, and the Audit Committee takes assurance solely on the processes and governance being in place.	
			The Committee acknowledged that there was a lot of information within the report, however, it was still early days, and the details of clinical audits would be going to the Q&S Committee.	
			From the point of view of the Audit Committee, it was noted that processes were in place, which can be followed through by the Q&S Committee, as well as appropriate trigger mechanism for issues to be raised at the appropriate Committees.	
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, which was robustly discussed, it was agreed to add the following:

- Gaps section: succinct references to mitigating actions within the gaps section.
- Emerging risks section: lack of Operational Planning Guidance and seeing the financial system risk in broader perspective (as stopping the Trust developing and implementing our own strategy)
- Re-wording of reputational risks (to be undertaken by EMT)
- Addition of assurance level findings for the three completed audit reviews (Stress Risk Assessments, Dental Network and Consultant Job Planning)
- Assurances from annual effectiveness reviews for Audit Committee and Internal Audit Service

There was no proposed change to the current risk score of BAF 1.

In considering the assurance paper covering the Corporate Risk Register processes, the Committee noted that the Risk Management Council was recently attended by the Chief Operating Officer and the Chief Nurse, who had also reviewed the entire risk register and provided feedback to risk owners, where required.

An in-depth discussion took place relating to the level of detail and the view of the full Risk Register by the Non-Executive Directors. It was noted that the NEDs were welcome to observe the Risk Management Council at any time. The Committee agreed that further discussion would take place outside of the meeting on how the NEDs could get oversight and triangulation regarding risks and see if any slight amendments could be made a way forward.

The Committee took assurance regarding the operation of the systems and processes that facilitate and support the management of risk in the Trust.

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Committee Chair's Report

Registers of Interests	1, 5		The Committee received updates on the declarations of interest from Decision-making staff and Governors and agreed the registers could be published. It was noted that the annual collation of Mandatory Declarations from Decision Making Staff will commence in in the next reporting period, via SLT cascades and Team Brief announcements. The Declarations from the Board Members will be requested in February 2024 alongside the Fit and Proper Persons declarations.	Assurance received.
Review of Losses, Special Payments and Waivers	1,5		Proposed bad debt write offs totalling £4,271.06 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 6 waivers, which were documented.	Assurance received.
Update on new procurement regime	1,5		The Committee received a verbal update from the Director of Finance regarding upcoming changes to the procurement regime. It was noted that the NHS guidance associated with this was still awaited, however, the latest information suggested that the implementation date was anticipated to be October 2024. The Committee were reassured that the finance team keep abreast with all new developments, to ensure the Trust is on track with all preparatory work. Further update would be presented to the Committee, when available.	Information received
Review of annual accounts progress	1,5		The Committee received a verbal update from the Deputy Director of Finance regarding the progress of annual accounts. The Committee noted that the process was ongoing as usual at this time of the year and no concerns were raised at this point by the Finance Team.	Assurance received

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Mersey Internal Audit Agency Progress Report	1, 2		The Committee received assurance that the Internal Audit Programme was progressing to plan.	Assurance received
			The Committee noted the completion of the three reviews: • Stress Risk Assessments – Limited Assurance • Dental Network – Moderate Assurance • Consultant Job Planning – Moderate Assurance	The Assurance level for reviews: Stress Risk Assessments Dental Network Consultant Job Planning
			Stress Risk Assessments The Director of People and Organisational Development attended the meeting to discuss the results of the Stress Risk Assessments review and the action plan to meet the recommendations. The Committee noted that there were many areas of good practice outlined in the review. Out of four objectives of this MIAA review, the Trust scored GREEN in two, AMBER in one and RED in one (objective: Stress risk assessments are being recorded). The Director of People and Organisational Development detailed multiple actions in progress to address this objective.	will be added to the appropriate BAFs .
			The Committee Chair noted that this review will be overseen by the People Committee making sure that the recommendations are actioned appropriately.	
			Dental Network The Committee noted that this was a periodic review of the service, which concluded in moderate assurance overall, noting that there are good clinical policies in place, good evidence of action planning to be taken forward to improve the service. However, the findings were that the governance arrangements and the reporting arrangements could be enhanced.	
			The Chief Operational Officer and the Medical Director reassured the Committee that that the findings were linked to the implementation of new structures and since the review the actions have progressed significantly and should not pose any challenges.	

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			The Committee Chair noted that this review will be overseen by the Quality and Safety Committee making sure that the recommendations are actioned appropriately. Consultant Job Planning The Committee noted an overall conclusion of moderate assurance, noting that the job plans were in place but there were differences in consistency formats of those particular job plans reviewed. The Medical Director reassured the Committee that corrective actions to address this were well underway and already started the process of job planning for 24/25 with very good engagement from the operational teams. The Committee Chair noted that this review will be overseen by the People Committee making sure that the recommendations are actioned appropriately. The Committee further noted that six other reviews were in progress and on track to be finalised in time for the Head of Internal Audit Opinion. The Committee would like to note the attendance at the meeting of those Executive Leads for completed Audits and the detail they provided which enhanced the members ability to scrutinise the review findings.	
Annual Review of Effectiveness of Internal Audit	1		The Committee received the results of the Annual Review of Effectiveness of Internal Audit. A high level of returns was achieved, ensuring a wide scope of responses, including Audit Committee members, attendees, External Audit and those colleagues, who had a working relationship with MIAA in 2023 but do not attend the Committee. Overall satisfaction for scored questions was 4.29 out of 5. For questions requiring other response options, the majority of responders either agreed or strongly agreed to the statements, demonstrating a high level of satisfaction with the effectiveness of the internal audit function.	Assurance received This will be added to BAF 1

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			Multiple positive comments were made regarding the function.	
Anti-Fraud Annual Plan 2024-25	1,4		The Committee received the draft Anti-Fraud Annual Plan 2024-25. The draft plan was based on the core mandatory requirements. A full work plan will be submitted to the Audit Committee in April, once a refreshed risk assessment is completed, which incorporates events over the last 12 months.	Information received
MIAA Anti-Fraud Progress report	1,4		The Committee received the regular progress report. It was noted that as always this was a comprehensive report on the work undertaken. The Committee noted the increasing fraud risks to public sector bodies. It was apparent from the level of detail in the report that mitigations are in place and the Trust is kept abreast of all new information. The Committee noted that that three fraud referrals were received within the reporting period, one of which was closed off and two were being looked at. Four investigations carried forward from the previous reporting period, two of which have been closed off and two remained under investigation.	Assurance received
External Audit progress report	1,5		The Committee received a verbal update from the External Auditor, who advised that that the detailed planning, risk assessment work and VFM considerations were underway with the intention to bring the fully finalised plan and VFM assessment to the next Audit Committee. There were no issues to raise at this time.	Assurance received
Health Sector Update	1,5		The Committee received the technical update from the External Audit. The Committee were aware of many of these updates from across the Board and Committees discussions. However, it was good to get the external view of new developments as well for triangulation.	Information received

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Committee Chair's Report

External Audit Plan	1, 5		The Committee received an indicative audit plan and strategy for the year ending 31 March 2024. It reflected that the planning and risk assessment work is ongoing with the aim to present the final plan in Audit. The Committee noted the Confirmation of Independence statement of the External Auditors. The External Auditors reported the reduction of work in some areas (materiality level, IFRS 16, removal of certain audit risks) which reflect assurance gained in the prior year. The Committee were pleased to note that the work done across the last three years was now feeding through in terms of reduction in some areas of work and reflecting the KPMG confidence in the Trust's systems.	Assurance received
Agreement of External Audit fees (recommendation to COG)	1,5		The Committee noted that this item had been completed via e-governance in September for Audit Committee, and in October for the Council of Governors, to ensure that the fees were approved and signed off in order to continue the work with KPMG for this financial year.	Information received
Review of the meeting	1		There was general agreement the meeting had been effective with good level of debate.	
Risks Escalated: None from the meeting				

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	Date	**8TH FEBRUARY 24**
Agenda Item	**11/24**		
Report Title	**STRATEGY INTO ACTION**		
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 -** 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**
Governance	**Quality**	**Health Equity**	**Staff**	**Resources**	**Equality, Diversity & Inclusion**	**Partnerships**
Failure to implement and maintain sound systems of Corporate	Failure to deliver quality services and continually improve	Failure to collaborate with partners and communities to improve health	Failure to create an environment for staff to grow and thrive	Failure to use our resources in a sustainable and effective way	Failure to build a culture that champions	Failure to work in close collaboration with partners and staff in

Governance and failure to deliver on the Trust's Strategy		equity and build a culture that champions ED&I for patients			equality, diversity and inclusion for patients and staff	place and across the system
				2		

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	Date	**8TH FEBRUARY 24**
Agenda Item	**11/24**		
Report Title	**STRATEGY INTO ACTION**		
Report Author	Rob Foster – Programme Director Collaboration and Integration		
Purpose	The purpose of this report is to present an update on progress with, and delivery of the Trust's Community Matters 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 Recognising the importance of Board ownership and ensuring the Board is fully sighted on the delivery of all aspects of the Communities Matter strategy, the report is split into five sections:
- Population Health dashboard
- Strategic objective deliverables
- Delivery Plan progress
- Strategy into action examples and case studies
- Place-based updates

1.3 To support this further, it is proposed that, through a Board seminar, we establish a mid-year review of the delivery of the strategy and invite teams, services and partners to present and demonstrate the work being undertaken both internally and externally. It also presents the opportunity to focus on ad discuss future ambitions and plans to further develop and drive initiatives and projects to help support the achievement of our strategy.

2. POPULATION HEALTH DASHBOARD

2.1 The population health dashboard presents key indicators for the Warrington and Halton places. The indicators are benchmarked against national and North-West levels, and also show, where applicable, changes from the previous year.

2.2 The metrics are designed to provide a summary on life expectancy, health life expectancy, inequalities, deprivation, school readiness, child health and oral health. The concept being to present a summary at an overall population level that enables us to consider our progress and focus on our mission statement of improving health, health equity, prosperity and wellbeing. Other population health metrics are available and can be included, with more dental metrics being considered for inclusion already.

2.3   Given the refresh of these metrics is annualised, this dashboard won't change regularly, however, its purpose is to help frame the population needs and the areas within which we deliver local services.

2.4   We will also develop and evolve this dashboard as place-based dashboards are developed and finalised to ensure alignment of key/critical metrics.

2.5   This population health data is important in informing our engagement and discussions with local government and place-based partners, as we continue to build on existing, and developing new approaches to addressing health inequalities.

ID	Indicator	Age	Sex	Period	Warrington		Halton		Value (NW)	Value (England)	Unit
					Value	Change prev. yr	Value	Change prev. yr			
A01a	Healthy life expectancy at birth	All ages	Male	2018-20	64.6	No sig change	61.4	No sig change	61.5	63.1	Years
A01a	Healthy life expectancy at birth	All ages	Female	2018-20	64.8	No sig change	58.0	No sig change	62.5	63.9	Years
A01b	Life expectancy at birth	All ages	Male	2021	78.3	n/a	77.1	n/a	77.2	78.7	Years
A01b	Life expectancy at birth	All ages	Female	2021	82.5	n/a	80.5	n/a	81.3	82.8	Years
A02a	Inequalities in life expectancy at birth	All ages	Male	2018-20	10.3	No sig change	11.7	No sig change	11.6	9.7	Years
A02a	Inequalities in life expectancy at birth	All ages	Female	2018-20	8.2	No sig change	9.6	No sig change	10	7.9	Years
B01b	Children in absolute low income families (u16)	<16 yrs	Persons	2021/22	10.3	n/a	13.8	No sig change	16.6	15.3	%
B01b	Children in relative low income families (u16)	<16 yrs	Persons	2021/22	15.3	n/a	21.2	No sig change	23.7	19.9	%
B02a	School readiness: percentage of children achieving a good level of development at the end of Reception	5 yrs	Persons	2021/22	69.5	n/a	60.1	n/a	61.7	65.2	%
c08a	Child development: percentage of children achieving a good level of development at 2 to 2 and a half years	2-2.5 yrs	Persons	2022/23	74.7	Decrease	63.5	Decrease	79.3	79.3	%
C09a	Reception prevalence of overweight (including obesity)	4-5 yrs	Persons	2022/23	23.2	No sig change	25.8	No sig change	23.1	21.3	%
C09b	Year 6 prevalence of overweight (including obesity)	10-11 yrs	Persons	2022/23	35.5	No sig change	42.0	No sig change	38.3	36.6	%
E02	Percentage of 5 year olds with experience of visually obvious dental decay	5 yrs	Persons	2021/22	30.5	No sig change	33.9	No sig change	30.6	23.7	%

Source: Office for Health Improvement & Disparity – Fingertip reports

3. STRATEGIC OBJECTIVE DELIVERABLES

3.1   This section focuses on the progress against the 31 "We will…" statements that underpin and drive delivery of our six strategic objectives.

3.2   A RAG assessment is included against each, alongside a brief narrative to provide headline updates on progress.

- Blue - completed
- Green – underway and on track
- Amber – underway and behind schedule
- Red – delayed commencement and/or significant delays to progress
- Grey – not yet commenced (and not planned to commence)

3.3   The Board have discussed and agreed on the development of metrics to support this section, focusing on staff insights, patient insights, IQPR metrics and resource information. Further work is underway to ensure complete alignment between the 'Strategy into action' metrics and IQPR, and the reporting of progress at both a Corporate level and Directorate level, which will be included in this report moving forward.

3.4   As the table below demonstrates, work is progressing across all of the objective deliverables, with none yet completed. Alignment to Delivery Plans and other trust-based activities are referenced in the update column to provide practical examples and evidence of progress.

NHS Bridgewater Community Healthcare NHS Foundation Trust

Strategic Objective deliverables summary

	ID	Deliverable	Update
QUALITY	Q1	We will apply a systematic approach to the measurement of safety, patient experience, continuous learning, leadership and governance, ensuring accountability for improvement in line with the CQC quality statements.	Re-introduced quality support visits, developing the metrics to evolve towards accreditation across all services.
	Q2	We will use Our Building On Our Strengths Together (BOOST) methodology to drive forward continuous quality improvements in the services we provide, led by our staff. This will be supported by access to learning, mentoring and training to improve the care delivered.	Evidenced through various Directorate Delivery Plans. Boost plans developed in Childrens, Dermatology, District Nursing
	Q3	We will ensure patients and their families, including children and young people, are more involved in shaping our services, and the voice of the child, and their feedback will shape service transformation plans, alongside the views, insight and experience of our staff.	Establishing an approach to engage with patients and families to embed lived experience into our service developments and improvements, across Children's and relevant Dental services. We are in the process of recruiting to a Patient Partner role (voluntary role), who will provide independant insights into our trust processes.
	Q4	We will learn through an open approach when things go well and when things go wrong, and we will continually strive to improve the care we provide to patients. Implementing the new NHS Patient Safety Strategy including the Patient Safety Incident Response Framework and Patient Safety Partners.	Clear focus on implementation, engagement and roll out of PSIRF across all the organisation
	Q5	We will support staff and services to recover from the impact of the pandemic and ensure that patients receive care in a timely way.	Supporting all clinical staff through embedding an enhanced preceptaship programme across the organisation, including legacy mentors and further roll out of the professional nurse advocates.
HEALTH EQUITY	HE1	We will implement the evidence-based, priority areas of focus from the NHS Prevention Pledge.	Awarded Prevention Pledge in September 23. Internal focus on MECC elements - smoking cessation, alcohol, physical activity (supporting people to access services). Work also underway with BI team, focusing on completeness of patient records in capturing equality markers.
	HE2	We will work with partners in place to change the way our services are designed and delivered to ensure more equitable access, which will support improved outcomes and experience.	Embedded into the respective place-based groups focusing on addressing inequalities. Working with Children's team, Halton Public Health, local GPs, WHH, housing, environmental colleagues to focus on damp and mould, with a view to supporting children and families with respiratory conditions
	HE3	We will influence, shape and support the delivery of Health and Wellbeing strategies in the places that we work.	We have engaged with places to support the development of H&WB strategies and we are working in collaboration with partners to translate strategies into priorities and actions through the existing governance arrangements.
	HE4	We will further develop working relationships with all our health and care partners to identify high intensity users of services and support these patients to access the right services at the right time.	Projects are underway/commencing with partners to optimise Virtual Ward, UCR services (learning from Newton review), CORE20PLUS5 initiatives in both places and with primary care partners
	HE5	We will enhance our relationships with the voluntary sector and we will work in partnership with them to support the needs of our most vulnerable and at risk patients.	We have invested in voluntary sector link workers and Patient Partners to create a closer partnership between our services and the diversity of voluntary sector organisations to provide support to our patients.
STAFF	S1	We will maximise our workforce intelligence to fully understand our workforce profile to inform workforce planning utilising Population Centric Workforce Planning approaches.	People operational delivery council established comprising membership from quality, nursing, operations, people, reporting into the People Committee. Workforce planning approach and timetable for the completion of plans in every services.
	S2	We will promote 'Grow your Own' initiatives with the local community to understand the potential future workforce and create job pipelines with colleges, local businesses and our strategic partners within each borough.	Careers and Apprenticeship Team actively engaged and promoting the opportunities of local employment with local education institutes and other local providers.
	S3	We will maximise utilisation of the apprenticeship levy to support the development of our workforce.	106 apprentices already in post, fully utilising the apprenticeship levy. We are using the forthcoming National Apprenticeship Week to host a session on Friday 9th February for our governors, Board members, senior leaders and partners to meet our BW Apprentices.
	S4	We will realise the added value to our workforce of our volunteers, third sector organisations and the armed forces.	Innovative approaches to bring in volunteers (Patient Partners), our voluntary sector link workers (employed by local VCSE organisations in our places), and continued implementation of the Armed Forces covenant.
	S5	We will create opportunities for working together with our community and other health and social care providers.	Leading the Warrington Together workforce group and will be actively involved in the One Halton equivolent, to develop place-based workforce plans. Further workforce at-scale opportunities being developed via the Provider Collaboratives and ICB HR Directors network. Work programmes are further supported by national workforce/people programmes.
	S6	We will create a culture where we are supportive of innovative roles – new ideas and innovative ways of working, upskilling and transforming services.	Examples of roles include apprenticeships, AHP rotational roles, Vol sector link workers. Community Health Workers. Advanced Clinical Practitioners strategy is emerging for Cheshire & Merseyside, which BW is involved in, and we have 15.8 WTE ACPs in BW (as at Nov 23).

	ID	Deliverable	Update
RESOURCES	R1	We will work in collaboration with staff, partners and communities to transform the way we provide services to generate efficiencies, which can be reinvested to improve the quality of care and improve outcomes in health equity.	Embedded and collaborating in place-based and dental infrastructure, as well as the Provider Collaborative, developing and delivering a range of projects to improve outcomes, equity and qaulity of care
	R2	We will enable excellent digital and data services to drive and deliver efficiency and optimisation.	Through DIGIT, we are delivering a range of digital and data projects supporting services (eg Dentally EPR, development of service scorecards with our BI team)
	R3	We will look to reduce carbon emissions and deliver the Trusts Green Plan.	On-going focus and delivery of the Trust's Green Plan, including initiatives to install LED lighting across all freehold sites, and developing schemes looking at EV infrastructure aligned to NHS net zero travel and transport strategy and decarbonisation i.e. replacing gas boilers with electric, hot desk provision to support flexible working (reduced commuter mileage)
	R4	We will embed Anchor principles and look to procure locally where we can.	Through our procurement partner (WHH), all procurements consider social value and place-based investment
	R5	We will work with partners to maximise and right size our estates.	Baseline mapping completed and feeding into Directorate/service plans and place-based discussions to consider options
	R6	We will work with partners to operate within our financial allocations and maintain financial balance.	BW is meeting financial targets and forecasting financial balance at year end
EDI	EDI1	We will build a culture that champions diversity, equity and inclusion. Supporting and developing our people to provide compassionate and culturally competent care to our patients and each other.	New equality working group established with NED input. Focus on various elements including Just Culture, Civility and respect, Expanding equality training offer, Anti racism framework etc
	EDI2	We will be proactive in anticipating the diversity of our patient needs and will respond to them to ensure we achieve the best outcomes.	Work underway with BI team, focusing on completeness of patient records in capturing equality markers. Work underway to develop interpretor services and support to services and families.
	EDI3	We will become an Anchor Institute in the community: We will take our social and environmental responsibility seriously, addressing the socioeconomic determinants of health.	Continued implementation of our Green Plan. Continued focus on local recruitment and focus on apprenticeships. As an example, the CHW project recruited and trained local people.
	EDI4	We will improve the reach of our organisation and grow our standing in the community through local partnerships	Community engagement work underway via PACE, involving governors. Mapping underway to ensure representation of all voices.
PARTNERSHIPS	Ptnr1	We will continue work in close partnership with local General Practice, the Primary Care Networks and GP Federations to further enhance the quality and provision of services across our local communities.	Various schemes underway or at planning stage with Primary Care, involving Integrated Teams, Urgent Treatment Centres and LTC pathways. Work also underway with GPs in Warrington for mass adoption of Dermatology A&G service
	Ptnr2	We will work closely with all our partners to drive forward continuous quality improvements in the services we collectively provide.	Embedded into place-based arrangements and Dental networks, developing and delivering work programmes to improve services/outcomes
	Ptnr3	We will work across our organisational boundaries with partners in place as we create future integrated care and service models.	Work underway with place-based partners to consider and explore closer partnership working arangements and models
	Ptnr4	We will work with partners to improve equity in health outcomes.	Embedded into the respective place-based groups focusing on addressing inequalities
	Ptnr5	We will work with our system partners to collaborate at scale to enable better care at place.	Active involvement in the MHLDC Provider Collaborative at Board and project levels. Investment in the Collaborative PMO (hosted by BW) has brough focus and acceleration of project work.

4. DELIVERY PLAN PROGRESS

4.1 The Delivery Plan progress section provides a summary of current Delivery Plan projects.

4.2 All plans follow the same governance process and format and are embedded into the existing organisations governance arrangements, reporting into councils, the transformation group and/or Directorate Leadership Teams (DLTs), where monitoring and scrutiny takes place.

4.3 The table provides a summary of progress against the schemes and projects, showing an overall RAG, and then progress against milestones and key actions accordingly.

	Childrens Action Plans	Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
Transformation/TIP	Childrens Boost Plan	2	30	1	3	36	Red
Transformation/TIP	Halton ND Pathway & Community Paediatrics Plan	1	47	0	0	48	Green
Transformation/TIP	Warrington ND Pathway & Community Paediatrics Plan	17	38	1	0	56	Green
Transformation	Health Visiting Action Plan	1	12	0	0	13	Green
Transformation	School Nursing	0	3	0	0	13	Red
Transformation	Warrington Audiology	0	0	0	0	0	Green
Transformation	Warrington 0-19	35	20	4	0	59	Amber
Transformation	Warrington Physiotherapy	21	4	0	0	25	Green
Transformation	SEND	11	1	0	0	12	Green
Transformation	SEND Operational	3	10	1	0	14	Amber

	Halton Adults Action Plans	Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
Transformation	Halton and Warrington Tissue Visabilty	6	5	0	0	11	Red
Transformation	Halton Heart Failure Pathway Development	11	9	0	0	20	Green
Transformation	Halton Virtual Ward	19	2	11	0	32	Red
Transformation	Service User Access to Widnes Urgent Treatment Centre	10	3	0	0	13	Green
Transformation	Community Nurses	32	6	2	0	40	Amber
TIP	Drive Ability North West	16	0	4	1	21	Red

	Warrington Action Plans	Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
Transformation	Community Falls and Rehab	6	7	0	0	13	Green
Transformation/TIP	Dermatology	13	7	13	10	43	Red
Transformation	Neuro-ABI Waiting List	0	0	0	0	0	Green
TIP	Community Equipment Stores	39	0	0	3	42	Amber

	Dental Action Plans	Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
Transformation	Dental Nurse Career Development	19	2	11	0	32	Red

	Cross Directorate Action Plans	Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
TIP	Carers Strategy	9	0	2	0	11	Red
TIP	Insulin Aggregated Review	16	0	0	0	16	Blue
TIP	Community Nursing Halton & Warrington	32	17	2	0	51	Green

4.4 Detailed delivery plans can be made available to Board members on request.

4.5 The 'overall status' RAG ratings are calculated for Green (95% of actions complete/on track), Amber (90%-95% of actions complete/on track) and Red (less than 90% of actions complete/on track).

AHP Rotation - Halton adults Directorate

Summary

The project aims to pilot AHP Rotation within Bridgewater, initially with Band 5 Occupational Therapists (Ots). There has been difficulty in recruiting OTs and Physios into some Bridgewater services. Anecdotally, it has been said by OTs and physios that they prefer to work in rotation posts, which may account for the difficulty with recruitment within Community Trust who don't currently offer this. Warrington (along with many Acute) Hospital already offer rotational posts for OTs and Physios' and initially discussions took place with them to gather information on how this works within the hospital.

A working group has been set up to take this project forward. It has been agreed that:

- Rotation would include services who currently have Band 5 OT vacancies across the Trust.
- The rotation would be 6-9 months continuous. i.e., move after 6 months but process will be a continuous one. It was agreed that the rotation would be continuous as having staff go back to the substantive post where the vacancy is, may bring some risk of a greater leave rate, as they may not have enjoyed that part of the rotation.

Expected benefits

- Enhancing recruitment and retention of staff, by offering a new and innovative role
- Developing a new skill mix through the introduction of new roles and ways of working
- Partnership working across our services
- Making Bridgewater a good place to work
- Growing our own Band 6's but supporting Band 5 staff gain experience and developing skills
- Development of clinical reasoning of higher bands
- Organisational reputation, forward thinking, few Community Trusts off rotational posts
- Responsive to staff feedback regarding rotational posts.
- Fostering a learning environment
- Time effective recruitment process and financial benefits e.g., potential reduction in recruitment costs

Progress to date and next steps
- The project team identified all relevant vacant posts and engaged with managers/team leads accordingly.
- Identified opportunities for rotational posts with Driving Assessment team, Warrington Neuro Rehab team and Halton wheelchair team.
- The group worked with services and the People team to co-produce a new Job Description (JD) for the rotational posts, and that JD has successfully been through the Agenda for Change panel accordingly.
- Adverts for the vacant posts were placed before Christmas with no applicants.
- The team engaged with the Royal College of OT's to raise awareness and secured their support in sharing adverts. Adverts have been placed again, which are currently open.
- If successful, the team have ideas for further expansion of the scheme but the focus currently remains on recruiting to the vacant posts.

Dentally - Dental Directorate and Digital Team

Summary
This project focuses on the replacement of two Dental Electronic Patient Record (EPR) systems (SOEL Health used in Cheshire & Merseyside, and Carestream R4 used in Greater Manchester) with a single EPR (Dentally) to move to single system across the Dental service, providing a single record for any patient, in any location.

The single solution also helps achieve national directives to ensure *internet first* and *cloud first* compliance.

A Project Board and Implementation Group was established with full implementation of the system being monitored by the Dental Directorate Leadership Team.

Expected benefits
- A single EPR system helps with a consistent approach and agile working for dental workforce
- Following a second phase implementation of patient facing functionality, improvements in patient flow and booking and efficiency as a result of:
  - Reduction in DNA's or late cancellations – Where appropriate, patients should be able to book appointments/cancel and rebook well in advance;
  - Patients receiving text reminders
- On-line uploading of medical history in advance of attending clinic – reducing administrative tasks and improving efficiency
- Patient satisfaction – better access to information, more control of appointments, potential reduction in average waiting times
- Staff Satisfaction – through easier login, access to diagnostics (eg xrays available via a bridge in dentally), and the move to integrated solutions enables a reduction in admin time to manage messages/reduction in need for repeat assessments/treatment due to launch of SMS service.
- Reporting – access to live 'front-end' data for reporting and importable extract data for wider business intelligence.
- BSA transmission of treatment (automatically transmitted in Dentally).
- Archiving of 'aged' data - the solution allows measurable data migration of thousands of patient records, as well as an annual process that provides compliance benefits.
- Financial – Time saved/reduced DNA's (Cost of unutilised/wasted slots).
- Robust Future Support Model – Use of Ivanti Service Desk system and network of 'super users'
- Wider User Group/support across other organisations. (Standardised Custom Screens/Reporting etc).
- Standardisation of Dental reporting in line with other Bridgewater Clinical Systems.

Progress to date and next steps
- The SOEL system was replaced and went live on 14th December
- The Carestream system is scheduled to be replaced and go live on 14th March
- Thereafter, patient facing functionality will be enabled in a phased approach
- Staff training is provided by the supplier over Teams, where the sessions are recorded and available for staff to access (and re-access) to support their learning and uptake.

Apprenticeships - People Team

Summary
Apprenticeships are being used strategically by the Trust, to address skills gaps and staffing shortages. They offer the Trust the opportunity to attract new talent and widen access to our vacancies. Additionally, apprenticeships can be used as a means of career development and progression for existing staff which has the potential to contribute to improved staff retention.

Apprenticeship training is paid for by utilising the Trust's Apprenticeship Levy funds. The Levy will fund 100% of the cost of training an apprentice, however, this does not include salary and employment costs.

The Trust are committed to making our apprenticeship vacancies attractive, offering permanent contracts of employment with a conditional promise of the role and pay progression subject to successful completion of apprenticeship training

Expected benefits
- Widening access and innovative solutions to addressing workforce challenges
- Engaging with local communities, colleges and local businesses to 'grow our own'
- Increasing local employment
- Improved staff recruitment and retention
- New skills development
- Introducing diversity into teams
- Boosting productivity
- Government support through funding

Progress to date and next steps
- We have recently recruited a further 5 apprentices to bring the number of staff currently employed and registered as apprentices across the organisation to 106.
- Apprentices are based across all Directorates in the organisation. The highest level of engagement is in Warrington and our centralised talent pool continues to grow and support us to fill vacancies more efficiently.
- 72% of apprentices are undertaking programmes that are clinical in nature. The majority of these apprentices will be eligible for new professional registration with either the NMC or the HCPC upon completion of their respective programmes.
- Continued use of the growing Salisbury Managed Procurement Services (SMPS) Framework for the provision of apprenticeship training and end-point assessment is providing assurance that the Trust are accessing quality provision that provides the best value for money.
- Planning is underway to mark National Apprenticeship Week 2024 which is in early February. This week is well recognised nationally and a great opportunity for us to market upcoming apprenticeship opportunities at targeted events in our communities.
- The Careers and Apprenticeship Team Lead is currently supporting service level workforce planning meetings across the Trust to advise on potential opportunities to utilise apprenticeships to support skills gaps, staffing shortages and succession planning

Family Hubs – Children's Directorate

Summary

Our Children's Directorate are working in partnership to actively drive forward the establishment of family hubs in Halton. Halton was one of 75 local authorities announced on 2 April 2022 as eligible to receive a share of Government investment to establish a Family Hubs and Start for Life programme. There are now four family hubs in Halton – Kingsway, Brookvale, Halton Lodge and Windmill Hill, with others to follow by March 2025.

Family hubs are not just a physical space. They bring services together to improve access, improve the connections between families, professionals, services, and providers, and put relationships at the heart of family support, offering support to families from conception to those with children of all ages (which is 0-19 or up to 25 for those with special educational needs and disabilities (SEND)).

The views and wishes of the family are put front and centre to the support they receive. It is a partnership with parents and family plans are co-constructed. By finding out what is working well for families and what areas they may be worried about, the family hub can help to build on families' strengths and identify areas where further support might be needed. Organisations work together to provide this early help offer: the local authority children's services; health visiting; school health; CAMHS; housing; maternity services and crucially the voluntary and community sector. All are equal partners in this family hub relationship.

Benefits
- Providing families with a single, simple access point to integrated family support services
- Each family hub is bespoke to its local community, meeting local needs
- Services working together for families with a universal 'front door', shared outcomes and effective governance
- Partnership working through co-location, data sharing and common approaches
- Families only have to tell their story once
- More efficient use of resources through improved and enhanced coordination
- The family hub prioritises strengthening relationships, and builds on family strengths
- Research demonstrates that those growing up in poverty will go on to experience adversity later in life. Family hubs can play a part in addressing this.

Progress to date and next steps
- Launched first set of Family Hubs in Halton
- Established Family Hub governance structure and joint leadership roles
- Undertaken staff recruitment and training
- Agreeing data sharing agreements to share and receive information on a timely basis
- Established links with partner services and agencies including schools, primary care and the third sector
- Commissioned Fatherhood Institute to develop Father Inclusive Practice across Halton
- Launched a new Baby Shower event on a monthly basis to promote the antenatal and post natal offer for families
- Research and insights will be undertaken into any barriers accessing Family Hub services
- We will be mapping the assets and buildings in line with the hub and spoke model
- We will further develop the governance structures for long term sustainability

- We will launch an Early Help Strategy in line with the Family Hub Model and developments.

Virtual Ward - Provider Collaborative

Summary

Virtual Wards (VW) were introduced as a concept to allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery whilst reducing demand on hospital beds. People on a VW are cared for by a multidisciplinary team in the community who can provide a range of tests and treatments.

VWs aren't a replacement for hospital care, they are an alternative, offering the health and care system the chance to be more efficient; providing the best care possible whilst being able to properly prioritise urgent care and ongoing care.

VWs are operational in all nine places across C&M. To date, the C&M ICB has overseen the VW programme, but the management, oversight, budget and delivery has now been transferred to the Mental Health, Learning Disability and Community (MHLDC) Provider Collaborative.

Expected benefits
- Earlier discharge from hospital for appropriate patients
- Reducing Length of Stay and pressure on hospital beds
- Supports 'left shift' principle
- Increased utilisation of technology and digital devices to support patients reside and remain in their usual place of residence
- Reduced re-admission rates
- More effective resource utilisation and efficiency both 'in hospital' and 'out of hospital'
- Increased data sharing and multi-disciplinary working in the community

Progress to date
- The C&M target for the number of open VW beds is 590 by April 24, with 419 currently operating (Jan 24).
- Furthermore, the target utilisation of those open beds is 80% (by April 24), with the current utilisation at 69.7%.
- All places have fixed specialty bed targets, but demand is variable across different providers.
- The MHLDC is scheduling site-by-site review meetings will providers to ensure plans are in place to achieve the stated targets.
- Recruitment to funded posts has been challenging due to national staffing shortages, as well as local budgetary conversations. Discussions are underway with ICB colleagues regarding on-going funding allocations to address some of the challenges.
- A clinical engagement strategy is being taken forward by a VW clinical advisory group, working across and engagement with acute and community providers.
- Work is underway with the regional team focusing on data quality and a provider collaborative data quality group is being established to ensure robust, timely and accurate planning, monitoring and reporting.
- Finally, a joint provider pharmacy team is due to commence in February to support the further rollout and growth in VW activity and pathway developments.

Focus in April

In April, as well as other updates, this section will include a specific focus on:

- Health equity
- Partnership working with Primary Care/General Practice

6. PLACE-BASED UPDATES

Halton place

6.1 On 24th January, the One Halton Partnership Board held a workshop, facilitated by AQuA, which the Chief Executive, Medical Director and Programme Director attended. The purpose of the workshop was to:
- Review and recommit to the vision, purpose and priorities;
- Discuss and agree our role as system leaders in delivering our priority themes;
- Review and confirm the priority themes and key work programmes.

6.2 The session was well attended with representation from across the partnership. Various discussions took place during the workshop, with agreed areas of focus and actions to progress further through the Partnership Board.

Warrington Place

6.3 A follow up meeting took place to further develop the approach to partnership working and the critical role the VCSE sector play in delivering place-based, holistic care and support.

6.4 This work involves the local voluntary sector, Warrington Borough Council, Bridgewater and other local providers.

7. RECOMMENDATIONS

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

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	People Committee	**Report to:**	Board of Directors
Date of Meeting:	17 January 2024	Date of next meeting:	13 March 2023
Chair:	Abdul Siddique, Non-Executive Director	Parent Committee:	Board of Directors
Members present/attendees:	<u>Members</u> Abdul Hafeez Siddique, Non-Executive Director (Committee Chair) Dame Elaine Inglesby, Non-Executive Director (Committee Vice-Chair) Paula Woods, Director of People & Organisational Development (Committee Lead Exec) Tina Wilkins, Non-Executive Director Linda Chivers, Non-Executive Director Lynne Carter, Deputy Chief Executive and Chief Nurse Sarah Brennan, Chief Operating Officer Dr Ted Adams, Medical Director Attendees 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 Helen Young, Freedom to Speak Up Guardian Nicola Handford, Adult Immunisation and IPC nurse (joining part way through the meeting) Samantha Scholes, Head of Corporate Governance, Observers Sarah Power, Governor Observer	Quorate (Yes/No):	Yes
		Key Members not present:	Jan McCartney, Trust Secretary Rachel Game, Governor Observer

🟥	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

	Paula Wright, Chief Nursing Information Officer		

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 and approval purposes. This report relates to the mandated contractual equality requirement as set out in section of the NHS Standard Contract (Service Conditions – Full Length). The Equality Delivery System (EDS) relates to both employment and service delivery. Committee members suggested that next year, the actions be smarter in content to allow better demonstration of the significant work that has been undertaken, taking into account that many of the actions are an on-going process of embedding improvement and change. That said, People Committee approved the report for onward submission to Board for overall approval, before submission to NHSE by 28th February 2024.	The Committee approved the report for onward submission to Board for overall approval, before submission to NHSE by 28th February 2024.
PUBLIC SECTOR DUTY EQUALITY DUTY (PSED) FOR WORKFORCE AND SERVICES ANNUAL REPORT			The paper was presented by Ruth Besford, Equality and Diversity Lead for assurance and approval purposes. The General Equality Duty of the Equality Act 2010 places a requirement of due regard to three equality aims on all public sector bodies. The Duty also has three reporting requirements, the Specific Duties:	The Committee approved the report for onward submission to Board for overall approval, before publication by 30th March 2024.

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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
			• Publishing relevant equality objectives at least every four years. • Publishing annual a report detailing how due regard to the three aims has been met. • Publishing annually by 30th March a gender pay gap report. The report presented to this Council fulfils the second of these reporting duties. The extensive amount of work that goes into this report was recognised and it was approved for onward submission to Board in February for publishing by 30th March 2024.	
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 3059 – Junior Doctor strikes - remains at a score of 6 Risk ID 3191 – Staff Health and Wellbeing – remains at a score of 9 **Educational and Professional Development (EPD) and Organisational Development (OD) Risk Report**	The Committee noted the content of the reports and were assured on the management of risks.

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Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

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			During the reporting period there are a total of 2 Risks on the EPD and OD Risk Register in the reporting period, both scored below 12 as at 3rd of July 2023. Risk ID 3078: Mandatory Training - remains at a score of 9. Risk ID 3176: Oliver McGowan Training – Remains at a score of 6. **Communications Risk Report** There are no reported Communication risks. There were no emerging risks presented.	
IQPR – PEOPLE INDICATORS	BAF 5 and 6 WLR 9 PP 1-7		The 7 IQPR people indicators were presented to the Committee for month 8 by Jo Waldron, Deputy Director of People and Organisational Development (OD). Four of the seven indicators were reporting green, which is the most positive position the indicators have been in for some considerable time. Induction – 99.31% against a target of 85%. Staff Turnover – 11.04% against a target of 12%. PPDR Compliance – 88.06% against a target of 85% Long Term Absence – 3.52% - Improvement in month Detailed reports in relation to Sickness and Statutory and Mandatory Training and PPDR rates were presented later in the meeting as per the agenda. The report narrative focusses	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings.

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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
			on the efforts across the Trust to improve our staff Retention rates. The Committee asked at the last meeting, for detail around the introduction of the new Band 6 Senior Community Nurse post. It was reported that we have internally recruited 7 staff into this new role, which is still live on NHS jobs.	
DIRECTOR'S UPDATE REPORT	BAF 5 and 6 WLR as highlighted in the report PP as highlighted in the report		The Director's Update Report was presented by Paula Woods, Director of People and OD, for information and assurance purposes. The report aims to update the Committee on the Regional, National and local level 'People' agendas. 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, included areas where there are challenges and potential risks in delivery. The Director's update report tabled the following: • The appointment of a new Secretary of State for Health and Social Care – Victoria Atkins • Industrial Action Update – Junior Doctors, Consultants and SAS Doctors • NHS Workforce Solution Transformation Programme Update • National Support for People Agendas • NHS Executive Leaders Wellbeing Programme	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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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
			• Very Senior Manager (VSM) Framework and Pay Award Update • HSJ Awards 2023 – Community Care Provider of the Year – Award Ceremony Outcome • The National Preceptorship for Nursing Quality Mark • The Annual Staff Survey 2023 – Initial Result Tables • North West Support for People Agendas • North West Anti-racist Framework Update – Report presented to Trust Board in December • Warrington Together Workforce & OD Enabling Group Update (WEG) and Phase II Workforce Delivery Plan: Project Update (including RAG ratings and risks) • Scaling up People Services in Cheshire & Merseyside Cheshire & Merseyside's People Directors Network – Terms of Reference (change of title from HR to People) • Cheshire & Merseyside Workforce Metrics December 2023 (September data) and NHS Oversight Framework (NOF) People Metrics • Health & Wellbeing Fortnight – 9th to 20th of October – Evaluation/Feedback • Rugby League Cares – Evaluation/Feedback • Targeted Health and Wellbeing • Health & Wellbeing Action Plan • Executive Team Development Programme Update	

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
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 last 12-month period, rolling sickness absence rates overall has been in downward trend with slight fluctuations in some months. In January 23 we reported a rolling absence of 6.19% and in December 2023, 5.47% which is within the Trust target. Actual sickness absence % rate has fluctuated more frequently over the 12-month period, in January 23 reporting 6.52% and in December 23, 5.58% which is slightly above the Trust target. Support and programmes of work to support improvements were presented to the Committee.	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied.
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 25 employee relations cases opened, and at present there are 9 cases currently open. It was noted by the Committee that positively there are no cases in excess of 6 months in this reporting period. The Committee asked that next time, the report includes an overview of those staff who are in work and those who may be off sick.	The report was noted by the Committee and were assured on the progress. The Committee asked that next time, the report includes an overview of those staff who are in work and those who may be off sick.

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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
FREEDOM TO SPEAK UP REPORT			The Freedom to Speak Up Report was presented by Helen Young for information and assurance purposes. The report provided the following to the Committee: • Details Freedom to Speak Up Activity. • An update re the FTSU self-assessment action plan. • Update from the National Guardians Office. • Recommendations and future developments. • Seeks to provide assurance to the People Committee that these areas of work are being appropriately managed. The Board report included in the Director of People's update paper outlined all of our avenues in relation to 'We each have a voice that counts.'	The Committee noted the reports and were assured on the progress and plans.
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. • First test audit for District Nursing and Community Matrons undertaken in September 2023. • Second audit is planned for February 2024. • Implementation plan to extend use of the tool to other community nursing teams is in development. • Data collection is currently undertaken via Microsoft teams forms, work is currently underway to develop electronic data collection tools	The Committee noted the reports and were assured on the progress and plans.

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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 following policy has been approved by JNCC during the reporting period: • Gender Diversity in the Workplace Support Policy & Toolkit (New) The policy provided an update on the progress of other policies which had previously been presented to Committee. The Committee noted that there had been some delays around the approval of policies in recent months and suggested that there may be a requirement for a longer consultation period.	The Committee noted the content of the report. Consider longer consultation periods for policy review.
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, 839 staff (54.7%) have received a flu vaccination. This is a 9% increase from the same reporting period in 2022/23. This campaign to date, 465 (30.3%) members of staff received their COVID-19 booster vaccination.	The Committee noted the reports and were assured on the progress and plans.

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			The report provided details on how the IPC Team have encouraged uptake and made vaccinations available across the Trust, including doing some targeted work in teams with low uptake.	
STAFF NETWORKS GOVERNANCE ASSURANCE			The report was presented by Ruth Besford, EDI Lead for information and assurance purposes. The report detailed the activity in relation to the five active staff networks, along with plans to further embed them across the organisation by better utilising their experiences to drive forward actions.	The Committee noted the content of report.
COMMUNICAITONS UPDATE			The report was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes. The report detailed general, internal and external communications activity, along with examples of Partnership Working and Horizon planning for the coming months.	The Committee noted the content of report.
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, Application of Non-Compliance Principles and Apprenticeships update.	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 report.

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	PP 1, 4 and 5		All mandatory training modules are above the Trust target, with the majority in excess of 95% compliance. This is testament to the time and effort put into this agenda across the Trust as a whole, including the support services ensuring that the appropriate training is accessible and reporting is robust. That said, there are still staff who remain non-compliant with some key modules which pose an associated risk, particularly in clinical areas, namely, Safeguarding, Resuscitation and Moving and Handling. Clear messages were disseminated in early September asking for full compliance with Resuscitation Level 2 and 3, Safeguarding Level 2 and 3 and Moving and Handling Level 2, by 30th September 2023. A paper follows to update on the application of the principles post 30th September 2023. There was a discussion as to whether we may need to review the target; however it was agreed that we should consider this again in 12 months' time, since we have only recently been able to report such positive figures.	
APPLICATION OF NON-COMPLIANCE PRINCIPLES FOR STATUTORY AND MANDATROY TRAINING	BAF 5 and 6 PP 1, 4 and 5		The report was presented by Sarah Brennan, Chief of Operations for information and assurance purposes. The report provided the Committee with details of the numbers of staff who have been restricted to non-clinical duties as a result of non-compliance with key mandatory training modules i.e Safeguarding, Resuscitation and Moving	The Committee noted the report.

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			and Handling, along with actions to mitigate the risk of this in the future.	
APPRENTICESHIP SCHEME AND LEVY			The report was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes. The report outlined the number of registered Apprentices across the Trust, including those in the planning. The report outlined the significant work that has been undertaken to increase our uptake in Apprenticeships which has resulted in the Trust maintaining zero expiry from the Apprenticeship Levy account for 13 successive months.	The Committee noted the report.
MIAA INTERNAL AUDIT UPDATE - **JOB PLANNING AUDIT AND ACTION PLAN**	BAF 5 and 6		The report was presented by Ted Adams, Medical Director for information and assurance. Mersey Internal Audit Agency undertook an audit of the Trust's Consultant job planning process in late 2023. The audit received moderate assurance, with 1 high risk rating, 4 medium ratings and 1 low rating. The accompanying action was presented to the Committee and updates on progress will be presented at future meetings.	The Committee noted the report and were assured on the progress.
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	BAF 4 and 6		As per the introduction of the new BAF, this Committee will oversee BAF 4 and 6. It was suggested by the Director of People that the Job Planning Audit be added to BAF 4 and for the Stress Risk Assessment Audit to be added to BAF 6.	The Committee were assured on the progress and governance around the monitoring of the BAF.

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			It was also suggested that our work in relation to Apprenticeships be added to BAF 5 – Resources.	
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 5 and 6		It was noted that both the EDS2023 and Public Sector Equality Duty (PSED) Report were approved for escalation for Board for overall approval.	EDS2023 and PSED Report to be escalated to February 2024 Board for overall approval.
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.	
Risks Escalated			None.	

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PEOPLE COMMITTEE

Title of Meeting	**PEOPLE COMMITTEE**	**Date**	**17 January 2024**
Agenda Item	**05/24**		
Report Title	**EQUALITY DELIVERY SYSTEM 2023 (EDS)**		
Executive Lead	Paula Woods, Director of People and Organisational Development		
Report Author	Ruth Besford, Equality & Inclusion Manager		
Presented by	Ruth Besford, Equality & Inclusion Manager		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary

This report provides information on the Equality Delivery System (EDS) 2023 final report. A mandated requirement of the NHS Standard Contract, the toolkit is designed to support alignment and evidencing against a number of national and NHS mandates including the General Equality Duty of the Equality Act 2010 and delivery of Core20Plus5.

Through the gathering of evidence against deliverables for 11 outcomes covering service delivery, staff experience, and inclusive leadership, stakeholders can discuss and agree scores for each outcome that, collated, gives an overall Trust grade for equality performance in the year. Grades range from undeveloped to excelling, with only those organisations meeting every deliverable for every protected characteristic or vulnerable group achieving excelling.

The Trust agreed with Halton and Warrington commissioners the three services for 2023 review – the Urgent Treatment Centre Widnes, the Podiatry Service in Warrington, and Bath Street Dental Service.

Domain 1 peer review has been undertaken by colleagues in Health Watch in Halton and in Warrington. Domain 2 stakeholder review was completed internally by Staff-side colleagues and Staff Network members. Domain 3 peer review was completed by colleagues at Wirral Community Health and Care NHS Foundation Trust.

In 2023 the EDS rating for the Trust is developing; this reflects developing in three of four Domain 1 outcomes, achieving for each of the four Domain 2 outcomes, and achieving for each of the three Domain 3 outcomes. Scores were five for Domain 1, eight for Domain 2, and six for Domain 3, giving a total score of 19.

The final report and action plan can be viewed at Appendix 1, and this Committee is asked to approve the report and escalate to February Board for final approval to allow publication and submission to NHS England before the deadline date of 28th February 2024.

Previously considered by:

☐ **Flu Group**

☐ **Medical & Dental Professional Governance**

☐ **Freedom to Speak Up Guardian Group**

☒ **POD COUNCIL**

NHS

**Bridgewater
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NHS Foundation Trust

Equality Delivery System 2023

Date:

Contents

The Equality Delivery System (EDS) for the NHS

The Equality Delivery System, or EDS, is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach to addressing health inequalities through three domains:

- Domain 1 – Services
- Domain 2 - Workforce experience
- Domain 3 - Leadership.

EDS is driven by data, evidence, engagement, and insight.

Implementation of the Equality Delivery System (EDS) is a mandated requirement on both NHS commissioners and NHS providers, and organisations are encouraged to collaborate with commissioners and partner organisations, and to follow the implementation of EDS in accordance EDS guidance documents.

The EDS scores and ratings

In partnership with stakeholders the evidence gathered for each of the 11 outcomes is reviewed and given a score based on evidence of equality for protected characteristic groups. Added together these scores given a domain score and rating, and then a total score and rating. The table below details the EDS scores and ratings.

Table 1: Showing the EDS scores and ratings table

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

This EDS Report is adopted from the national template, and is designed to give an overview of the Trust's most recent EDS implementation and grade. Once completed, the report is submitted via england.eandhi@nhs.net and published on the Trust's website at https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/. This EDS report relates to 2023.

If you require this report in another language or accessible format please contact ruth.besford@nhs.net

Trust overview

Name of Organisation	Bridgewater Community Healthcare NHS Foundation Trust
Organisation Board Sponsor/Lead	Paula Woods (Director of People and Organisational Development)
Name of Integrated Care System	NHS Cheshire and Merseyside
EDS Lead	Ruth Besford (Equality & Inclusion Manager)
EDS engagement date(s)	October 2023 – staff networks (Domain 2) October 2023 – staff side (Domain 2) December 2023 – Wirral Community Health and Care NHS FT (Domain 3) January 2024 – Healthwatch Halton, and Warrington (Domain 1)
At what level has this been completed? • **Individual organisation** • **Partnership* (two or more organisations)** • **Integrated Care System-wide***	Individual - Bridgewater Community Healthcare NHS Foundation Trust
Date completed	TBC
Date authorised	TBC
Month and year published	TBC

Completed actions from previous year

Action/activity	Related equality objective
Public engagement: Contact Healthwatch Halton, and Warrington for support on public engagement. Develop Trust engagement strategy and action plan for equality/protected characteristic groups in the communities. Further embedding of partnerships and collaboration. Review service links to partners in delivery of care and wellbeing support. **Update:** Partial completion. Bridgewater's Engagement Group re-formed and refreshed, engagement strategy in review. Healthwatch representation on group. Communities Matter Strategy launched in 2023 which has engagement embedded as part of health inequalities Strategic Objective. Public and Community Engagement Group formed 2023. This has membership in development, target engagement groups regarding equality and health inclusion identified and engagement started in 2023. Findings logged and shared through the Trust's Transformation Team, and regular updates planned with groups to share progress on agreed actions. Action deadline date amended to reflect further work to do to embed and complete this action set.	Draft and agree community engagement and oversight plan.

Patient records: Review and update patient record systems to ensure equality information is captured for: • Race/ethnicity • Disability **Update:** Partial completion. Group formed to review patient records. Work has started on a review of ethnicity coding, and two main patient record systems are being prepared for updates to NHS Spine to record Accessible Information Standard/Reasonable Adjustments. There is More to do so this action remains with a revised date.	Deliver inclusion and equity for disabled service users action plan.
Making Every Contact Count (MECC): Review use of MECC in services. Review and ensure alignment to signposting, and social prescribing where appropriate. **Update:** Executive Management Team sign off of mandatory training recommendation has been completed. Service specific training is to be discussed with the Trust's EPD lead in January 2024 for launch from April.	
Just Culture, Civility and Respect: We will embed equality voice in Just Culture and Civility and Respect governance through further establishment of Staff Networks, and equality engagement in the community.	Develop governance for Saff Networks.

Update January 2024: EDI Working Group established. Membership is in development, with expressions of interest received from Staff Network members and HR. The Working Group is to deliver an EDI Improvement Plan and is supporting the Board's commitment to the North West Anti-Racist Framework. Further embedding of our Just Culture, Civility and Respect programmes is a priority. Action date amended to reflect the continuation of this work.	
Health and wellbeing: Objective - Establishment of accessible and user-friendly single process, and one stop shop, for health and wellbeing support and advice. **Update:** An extranet was launched in late 2023 which makes health and wellbeing information more accessible and easily found for staff, including ability to access via App or personal laptop with authentication code. The Trust is an early adopter of an agreed regional Wellbeing Policy developed in partnership with Trade Union bodies. The Policy is more supportive of staff health and wellbeing from an holistic and person centred perspective, and with the developed toolkit and processes we have, this should embed a more holistic and preventative approach to illness and staff wellbeing. There is further work to do to embed the very particular requirements of outcome 2A, so the deadline date has been amended to allow for continuation of this work.	
Abuse, harassment, discrimination, or physical violence reporting monitoring:	Embed NHS EDI Improvement Plan in Working Groups and governance. Review Equality Act compliance.

We will embed the use of a new employee relations tracker to monitor and review cases related to protected characteristic groups and incidents involving staff members behaviours. We will develop a quarterly review process for Ulysses incident monitoring and review for incidents involving patients and/or family members. **Update:** Partial completion. A new employee relations tracker is embedded. Bi-monthly reporting of employee relations cases is progressed via the Trust's People Committee where questions are asked regarding particularly ethnicity of staff. Civility and respect training has been rolled out to a small number of teams. This is under review as at January 2024 to make it more relevant to our Trust services. Policy review has been completed and updated policies relaunched with a new toolkit support it, including the embedding of a Behavioural Framework for staff. The Working group will align to Civility and Respect, Just Culture, and Violence Prevention and Reduction Standards. It should be noted that there are some delays on sign off for new publicity materials. Action deadlines have been amended to reflect ongoing work with our Civility and Respect campaign, and further action is required on monitoring of patient related incidents through Ulysses.	Further develop our action plan and governance for North West Anti-Racist Framework.
Violence and Aggression Policy: Work with relevant Trust Leads is in train to review and update our Violence and Aggression policy to address the identified current issues in timeliness in addressing patient behaviours through devolved autonomy, and establishment of authority interventions to support engagement with patients/families involved. **Update:** Staff comments have been fed back to the Policy Author, and the policy review included comments received from our Staff Network members in	Embed NHS EDI Improvement Plan in Working Groups and governance. Review Equality Act compliance. Further develop the action plan and governance for North West Anti-Racist Framework.

consultation with them. Further work is needed in relation to reporting and monitoring, as referenced above. This action is to be closed as it aligns to above continuing action.	
Occupational Health: There will be links with our HR Team to explore our occupational health contract provision, and flag some comments raised by Staff Network members regarding this outcome. **Update:** Comments have been shared with HR Colleagues. There is further work to do to embed culturally appropriate independent support options for staff, particularly in relation to incidents of bullying, harassment, abuse and violence. This aligns to the health and wellbeing action set above. This will be closed and merged with above. A point to note is that our employee relations cases are fewer than they have been and we are seeing a positive trend in the number of formal cases.	
Recommendation of the Trust as a place to work: There has been a request for the addition of two Friends & Family Test (FFT) questions to the Trust's exit interview questionnaire, via the Trust's Recruitment and Retention People Operational Delivery Group (POD). **Update:** Partially completed. Ongoing work is taking place via the People Operational Delivery Council (POD) to understand staff reasons for leaving, including the deletion of the 'other' option on ESR to prevent this being chosen with no explanation of the reason for leaving. Further work is to be undertaken, particularly on leavers within the first one to two years of starting, and reasons for returning, which the Trust is seeing increasing numbers of staff doing. Corporate Induction has a number of retire and return staff and also staff who have left the Trust and opted to come back at the earliest opportunity.	Relates to all equality objectives related to staff in some way.

Inclusive leadership visibility: Develop an events and communications plan for equality, involving the Executive Team to build visibility on our existing commitment to equality. **Update:** Staff Networks have active Executive sponsorship, and for some there are meeting Chairs. Executives supported events such as a Disability Awareness Day, and Menopause Cafes in 2023. Executive members (and Staff Network sponsors) participated in a Reciprocal Mentoring for Inclusion Programme. 2023, and 2024 equality calendars included details of communications plans for observances and events. Staff Networks were highlighted in Team Brief through Executive sponsors in 2023.	
EDI Council: We will develop governance, structures, and objective for the new EDI Council of Staff Networks and Executives. **Update:** EDI Working Group under establishment, reports to People Operational Delivery Council (POD), People Committee to Board. Alignment with health inequalities/anchor institute group in progress. Membership in development, includes representation from Staff Networks.	Embed NHS EDI Improvement Plan in Working Groups and governance.
EDI dashboard: We will finalise the draft EDI dashboard and embed this within business cycles of relevant governance structures for regular monitoring and review. **Update:** Since agreeing this action, the Model Employer dashboard has been released. This action is closed.	

Equality Act compliance: We will develop a communications and training plan to further embed awareness and knowledge of the General Equality Duty in all leaders for policy, service delivery, and strategy development. **Update:** Operational Managers and first line Managers training was held in 2023 covering equality duties and requirements. Equality impact and risk are embedded in Quality Impact Assessment Panels for service redesign and cost improvement plans. Further work is to be done and a meeting is planned with the Navajo Lead in January 2024 to discuss possible Trust training options and Equality Act compliance. The deadline date has been amended to reflect ongoing work.	Review Equality Act compliance.

Domain 1: Commissioned or provided services

Outcome 1A: Patients (service users) have required levels of access to the service.

Evidence:

- Communities Matter strategy details borough specific data and priorities. https://bridgewater.nhs.uk/communities-matter/

- Information regarding patient record challenges shared with stakeholders.

- Commitment to collaborative work across Cheshire and Merseyside detailed, including language interpretation quality standard, reasonable adjustments, and gender reassignment support – actions to improve identified barriers and inequalities to mitigate data limitations.

- Patient experience and feedback provided to stakeholders for three reviewed services, including any incidents, complaints, and lessons learned. Services reviewed were:

    - Urgent Treatment Centre Halton.

    - Podiatry Warrington.

    - Bath Street Specialist Dental Warrington.

- Building accessibility was detailed, including where appropriate accessibility guides available through the AccessAble website.

- PLACE assessment took place at the Urgent Treatment Centre in September 2022. Action plans are being monitored through Borough Quality Meetings. Finding and recommendations were:

    - Adult hoist for service users with physical disabilities accessing treatment beds.

    - Other small accessibility actions such as moving pull cord in accessible toilet.

    - Improved signage to UTC in main building.

- Improved calling system to avoid missed and repeated calls.

- Some basic housekeeping such as empty hand gel dispensers, some soft furnishings showing signs of wear and repair, and lack of water for service users.

- Language interpretation support detail was provided, including procurement based on a quality standard developed in Cheshire and Merseyside following engagement and desktop evidence review of barriers to access related to language support provision.

- ReachDeck software on the public facing website allows translation or interpretation of service information into suitable format for viewer's needs.

- Recording of reasonable adjustments in patient records discussed, including working group to update and embed recording through national updates to National Care Record System.

- The Trust is a Disability Confident Leader, and while this relates mostly to employment there are indicators relevant to service delivery, and the action plan notes these – including AIS/reasonable adjustment records, and patient engagement.

- All staff can access information and advice about different needs in healthcare including those related to religion (this includes annual Ramadhan advice through the relevant month of fasting).

- Staff are supported by policy and training relevant to protected characteristics, including child and adult safeguarding.

- Trust records in relation to gender diversity was detailed, including regional and Trust level work to improve recording, awareness, and the support provided to gender diverse patients and their families.

- Work has been undertaken in services to improve the recording of marriage and civil partnership, updating legacies within record systems that were not inclusive of the diversity of family units that exist.

- The Trust has in development new resources regarding civility and respect. At present zero tolerance posters are available for display in services, but this isn't aligned to workforce messages and the new civility and respect toolkit and violence prevention and reduction standard. A working group that includes Human Resources (HR), Equality, Diversity, and Inclusion (EDI), Health and Safety, and Risk teams have worked together to update and align policy, develop new communication resources, and develop and start to deliver training.

- The Trust Board has committed to the NHS NW Anti-Racist framework and is working towards an application for bronze accreditation in the coming months. This is being led by the EDI working group. While predominantly about employment the framework does have a limited number of service facing deliverables, and of course good employment is one of the Marmot social determinants of health. Through engagement with the Staff Network, with local voluntary groups, and alignment with Anchor Institute/Health Equity leads in the Trust, the intent is to deliver actions that will support both workforce and the communities in which they live.

- Regular communications are issued to all staff regarding anti-bullying and harassment, racism, LGBT+phobia etc to raise awareness and provide signposting to support. Freedom To Speak Up (FTSU) is also aligned to EDI to provide additional reporting routes.

- The Trust launched its new carers strategy in 2023 and implemented service changes to ensure that carers attending services with loved ones or as patients themselves are identified, recorded, and signposted as appropriate to support services. Staff training has been rolled out to support this development. https://bridgewater.nhs.uk/aboutus/information-for-carers/

- The Trust was awarded Defence Employers Recognition Scheme bronze, and Veteran Aware accreditation in late 2022. Action plans are in place to ensure progression/re-accreditation as the Trust works to remove barriers to access for the armed forces community, and to improve equity and inclusion for the community in services and employment. This supports the new legal duty of due regard to the Armed Forces Covenant.

- Trust services work actively with asylum seekers housed throughout the boroughs, and signpost and support registration with services as needed to ensure barriers to accessing NHS services are removed or minimised.

- Commissioning and service practice was detailed to demonstrate inclusion culture in services for all patient and community groups.

- Engagement with local voluntary groups representing protected characteristic and vulnerable groups has commenced in 2023 and includes Irish Community Care, Trinity Safe Space, and Warrington Deaf Club (whose members include Halton residents). The information provided in this engagement is noted within public engagement trackers that are held by the transformation team who support services in delivery of borough operation plans, themselves aligned to the Trust's strategic

objectives. There is a commitment in the public engagement work to continue to engage with the same groups, and feedback actions undertaken as a result of conversations held.

- All Trust policies undergo equality impact assessment (EqIA) before submission for the first stage of approval, and the EDI lead is a core member of policy consultation. This works to ensure that negative impacts are eliminated or minimised, and positive impact highlighted, these EqIA are considered by policy review groups as part of discharge of due regard responsibilities.

- Research is important in the Trust with clinical and corporate staff supported to undertake individual and collaborative research, with the updates made in National Institute for Health and Care Research impact on inequalities is embedded in review of research proposals regionally. The Warrington Neurosciences service have in 2023 successfully bid for funding for two projects looking at inequality in Warrington.

- Trust strategy and commitments can be viewed on the webpages and documents linked through https://bridgewater.nhs.uk/aboutus/

- Borough operational plans for 2023/24 as related to three services was detailed for stakeholder review.

- The Patient Partners Programme, a well-established programme that involves patients at service level in improvements in service delivery, was detailed, including service alignment and involvement in this programme.

Outcome 1A score: 1

Outcome 1A rating: Developing

Outcome owner: Chief Nurse/Chief Operating Officer/Clinical Leads

Outcome 1B: Individual patient's (service users) health needs are met.

Evidence:

- Location for appointment meets needs as much as possible within restraints of treatment and equipment.

- Reasonable adjustments for patients with disabilities.

- Language interpretation support available in all services.

- All staff can access information and advice about different needs in health care including those related to religion (this includes annual Ramadhan advice through the relevant month of fasting).

- Staff are supported by policy and training relevant to protected characteristics, including child and adult safeguarding.

- Multi-disciplinary teams embedded in many services to support those with higher and more complex needs, particularly in relation to disability in either children or adults.

- Many services designed to support higher need related to protected characteristic, for example Bath Street Dental is commissioned to deliver services to people who are unable to access high street services as a result of additional needs related to disability, severe anxiety etc. See more in the embedded evidence document which provides health inequalities information by protected characteristic for three EDS2023 services.

- Civility and respect, and zero acceptance of harassment, bullying, violence, and abuse. Recognising still the impact of conditions and treatments on behaviours in some patients.

- Inequalities documents available for boroughs. Census 2021 and public health information available through Principal Lead for Public Health and Informatics team.

- The Trust is in the process of refreshing its patient and public engagement strategy and approach following the Covid 19 pandemic, as such this isn't fully embedded yet.

- Engagement is undertaken and includes:

- - Public engagement with voluntary sector groups in 2023, and calendar in development for 2024.

  - Patient Partners programme – long standing programme of patient voice in service redesign.

  - Trust Governors input and challenge, public and staff.

  - Engagement through equality forums across region.

- Regular patient feedback from all services is through the standard Talk to Us forms, and data from this in relation to the three services under this review is detailed throughout the stakeholder pack.

- The Patient Experience Team works with individual services on bespoke patient engagement exercises.

- The Team also leads on the Trust's Patient Partners programme, an established programme for involvement of patients at service level in service improvements. Evidence detailed service involvement in the stakeholder pack.

- Individual services undertake engagement with local groups and with patients.

- The Trust's Quality Impact Assessment panel includes standardised paperwork that includes engagement around service changes, and assessment of equality risk. The Trust's EDI lead is a core member of the panel and using the EqIA risk guidance developed by Midlands & Lancs Commissioning Support Unit supports assessment of equality risk and due regard to the Trusts duties under the General Equality Duty.

- The Trust's Director of Collaboration and Integration is leading on engagement with seldom heard and voluntary sector groups, supported by the EDI lead and transformation team.

- The public engagement that has taken place in 2023 is being used to inform the borough operational delivery plans, all of which include engagement as part of their plans for 2023/24. Equality impact was reviewed for all plans at the planning stage, and EqIA are being undertaken before plans go before the QIA panel for sign off, see example below:

- As a Trust committed to becoming an anchor institute the public health lead for the Trust is leading, with executive support, on action plans in relation to this. This is being aligned to workforce EDI work and to the public engagement taking place.

- The Community Health and Wellbeing Worker pilot in Warrington is providing family level interventions for self-referrals and referrals from other organisations/services. This is very much a holistic public health service with strong links to voluntary

sector organisations who can support particular areas of health and wellbeing need.
https://bridgewater.nhs.uk/warrington/community-health-and-wellbeing-workers-oakwood-warrington/

- In autumn 2023 the Trust appointed the first voluntary sector link workers following engagement with voluntary sector groups during 2023. Employed by the voluntary sector and working within Bridgewater the role is designed to link Trust services to voluntary sector organisations, providing a link for signposting and linking to opportunities such as social prescribing opportunities in our boroughs.

- Trust services regularly signpost to VSCE relevant to their area of service delivery, and when need arises look outside of their area of delivery to support patients, for example District Nurses looking for support when a need is identified in a holistic review of a patient.

- Person centred care that meets individual need is one of the Trust's overarching values, and this is supported by policy and practice across all clinical and corporate services.

- **Outcome 1B score: 1**
- **Outcome 1B rating: Developing**
- **Outcome owner: Chief Nurse/Chief Operating Officer/Clinical Leads**

Outcome 1C: When patients (service users) use the service, they are free from harm.

Evidence:

- Patient experience data, including incidents shared with stakeholders.
- The Trust has policy and procedure in place to support patient safety, this includes but is not limited to:
  - Advanced care planning.
  - Chaperone.
  - Children In Care (Looked After Children).
  - CPR – Do Not Attempt (DNACPR).
  - Incident reporting.
  - Infection prevention and control.
  - Patient access.
  - Pressure ulcer.
  - Safeguarding – adults and children.
- Services also have specific guidelines (using either regionally/locally agreed procedures, or the Royal Marsden clinical procedures) such as:
  - UTC specific fracture guideline.
  - UTC overarching clinical pathway guideline.
- Elements of many policies focus on safety and inclusion for applicable protected characteristic groups. For example:
  - Age – safeguarding adults, and children, infant feeding policy, and many specific policies for children's services, and

some more relevant for elderly or frail patients such as wound care and pressure ulcer policies.

- Disability – reasonable adjustments policy, and working with people with learning disability guideline.

- Gender reassignment – policy in development in partnership with Cheshire and Merseyside equality colleagues and local trans groups, many complexities mean it is taking time. All Trust policies have EqIA and updates made to reflect trans needs and legislation as required.

- Marriage and civil partnership – all policies have an EqIA and updates made as required as to narrative and recording of opposite/same sex marriage and civil partnership.

- Pregnancy and maternity – supporting bereaved parents, surrogacy, and others.

- Race or ethnicity – language interpretation, domestic abuse, FGM, honour-based violence, forced marriage etc. policy. Trafficking and modern slavery guidelines.

- Religion or belief – violence and aggression policy, and dignity and respect policy for staff, end of life care.

- Sex – most policies relate to all genders, with no gender specific services the Trust does not generally have gender specific policies and work is ongoing through EqIA to ensure all policies reflect gender diversity. Some clinical procedures are relevant to a gender.

- Sexual orientation - all policies have an EqIA and updates made as required as to narrative and recording of opposite/same sex marriage and civil partnership and next of kin etc.

- The Trust is actively working to embed policy and practice to implement the new NHS Patient Safety Incident Reporting Framework (PSIRF), which will replace existing serious incident reporting processes in 2023/24. This work is led by the Board with representatives from across the Trust, including engagement with the Equality Lead.

- All Trust staff must undertake regular mandated training, compliance is actively monitored and managed by Board. Some training is role specific, such as level three safeguarding, some is for all staff including the new Oliver McGowan training.

- Additional training is identified in annual service training needs analysis, or if appropriate as a result of HR processes such as disciplinary or capability.

- Training recommendations are governed through the Education Governance Group, part of the quality and people governance structures, to ensure all training is appropriate and of high quality.

- Additional training may be identified through reviews and incidents, for example a safeguarding review in Halton has identified a training need in relation to Gypsy, Roma, and Traveller communities, training that is being developed for the 0 – 19s services in Halton and Warrington with Irish Community Care.

- Voice of the child is an important programme in the Trust, ensuring the capturing of a child's voice, whatever, age, so that their needs are included in care planning. A dedicated intranet page provides guidance and resources for staff, and programme lead regularly presents on the programme to relevant forum in the Trust, for example to the engagement group, and to Time to Shine (the monthly forum for showcasing learning and best practice in Trust services).

- Professional curiosity is a further programme, this time led by safeguarding, that teaches clinicians to look further and explore holistically the factors influencing the health and wellbeing of an individual or family.

- All Trust staff are enabled to report incidents and near misses. The incident reporting policy is available to all staff, including via a quick link on the intranet. From November 2023 this is also available via other devices as the Trust has moved to an extranet accessible to all our staff via their nhs.net email address. The Ulysses reporting system was updated in 2022 to more effectively record incidents related to protected characteristic groups, particularly those related to violence, aggression, harassment, and abuse related to a protected characteristic.

- The NHS Staff Survey asks questions about reporting of incidents and staff feeling safe to do so. The Trust recognises the difference in responses for some protected characteristic groups, and through the Staff Networks, FTSU engagement etc is working to improve staff confidence and awareness of reporting of any incidents of concern. Differential responses for disabled and ethnically diverse staff for every staff indicator in 2023 was presented to Board in August.

I feel safe to speak up about anything that concerns me in this Trust (agree/agree strongly):

- **2020** - disabled staff 59.2% not disabled staff 69.4%. Ethnically diverse staff 72.7% white staff 67.4%

- **2021** – disabled staff 62.4 not disabled staff 72.0% Ethnically diverse staff 64.4% white staff 70.2%

- **2022** – disabled staff 65.0% non disabled staff 70.8%. Ethnically diverse staff 60.4% white staff 70.1%

If I spoke up about something that concerned me, I am confident that this Trust would address my concerns (agree/agree strongly):

- **2021** – disabled staff 48.6% not disabled staff 60.2%. Ethnically diverse staff 55.6% white staff 57.8%

- **2022** – disabled staff 55.2% not disabled staff 59.1%. Ethnically diverse staff 52.1% white staff 58.8%

- Incidents are monitored through the quality governance structure of the Trust to Board, with root cause analysis undertaken, and lessons learned shared with all staff in Bridgewater Bulletins.

- Patients can report via services and through Patient Experience, with all contacts monitored, recorded, and reviewed. Patient experience in the Trust is largely positive, with the majority of complaints or poor feedback relating to waiting times, understandable as many services have significant waiting lists following the Covid 19 pandemic measures that impacted on delivery in many Trust areas. More work could be done to increase access to patient reporting, while mechanisms are in place to report using talk to us forms, and a child friendly version, and through SMS messaging, telephone etc. there are still potential barriers for people with language needs and/or sensory impairments, and work is starting to engage with local groups to look at effective ways of eliminating or mitigating against these barriers. https://bridgewater.nhs.uk/patient-information/

- The Trust has a Freedom to Speak Up Guardian who is actively engaging with staff to support understanding of reporting mechanisms, including FTSU. They are supported in their role through a second guardian and a small group of champions – a project is underway to recruit a champion in every service in 2023/24. FTSU is embedded in the governance of the Trust through both the People structures and the quality structures, all leading to Board.

- The Trust is committed to the Just and Learning Culture programme led by Mersey Care, and following training of approx. 60 ambassadors in 2022 has seen updates to policy and practice to improve reporting and learning from incidents and near misses.

- The Trust's Equality Lead is actively involved in both Just Culture, and Violence Prevention and Reduction workstreams to ensure equality voice is heard, they are also embedded within Trust governance, including at the Trust's Health & Safety Working group.

- Engagement with the Trust Equality Lead also takes place when protected characteristic groups are identified in patient safety incidents or formal complaints. For example, in 2023 there has been a complaint received about provision of care to an autistic patient at the UTC; information was provided on possible training options for staff in this instance as part of the patient safety review.

Outcome 1C score: 1

Outcome 1C rating: Developing

Outcome owner: Chief Nurse/Chief Operating Officer/Clinical Leads

Outcome 1D: Patients (service users) report positive experiences of the services.

Evidence:

- **See also previous outcomes.**

- The primary mechanism for receiving patient feedback is via the national talk to us (TTU) processes, these look at experiences including communication and respect, but in Bridgewater don't identify by protected characteristic group – the forms are processed manually and to complete this extra data analysis would take a lot of resource. Patient experience reports are reviewed by the Bridgewater Engagement Group and reported through the governance structure for quality and safety to Board.

- The Trust has a child friendly TTU form in use across services and also uses text messaging to receive feedback after an appointment. Work is ongoing in partnership with local groups to develop a TTU form for patients with learning disabilities.

- Where more formal feedback is gathered, for example complaints, the patient experience team work to understand any potential equality factors and work closely with the equality lead on any lessons learned or further understanding that is needed to better address the complaint and make necessary changes as a result.

- The UTC is supported by the Trust's Communications Team in social media and poster campaigns to support the service, and this of course is supported by national campaigns regarding effective and timely access to NHS services – right time, right service messages to minimise demand on accident and emergency services.

- The Patient Experience Team leads on the Trust's Patient Partners programme, an established programme for involvement of patients at service level in service improvements. See previous outcome.

- The Trust, in partnership with other providers and commissioners in the EDS Collaborative commenced work on actions to identify and address inequality in access and outcome. With the changes to the NHS commissioning landscape this group became part of the overall Patient Equality Focused Forum, with work on one piece of work continuing – transgender support in services. Actions completed and embedded in Bridgewater include the quality standard for language interpretation in procurement; and work is continuing in some areas, such as armed forces community support, using best practice

developed by the collaborative. The local standard contracts also include requirements related to accessible information, and action plan that is being delivered across the Trust.

- The public engagement referenced in the previous box includes actions to embed improved support, access, and engagement with the groups linked with, and these action plans, through the Trust's Transformation Team, are used to inform operational delivery plans.

- An example of action taken following engagement is the appointment of voluntary sector Link Workers in autumn 2023, employed by the voluntary sector and working within Bridgewater the role has been designed to provide a link between Trust services and the range of voluntary sector organisations in our borough, allowing signposting to appropriate services and opportunities.

- The Trust's Just and Learning Culture programme makes the clear link between staff and patient experience. Just Culture is an approach that looks to informally fact find following any instance where things didn't go to planned or where something occurred that is outside of expected standards, this may include medication errors, bullying, and other instances involving staff. The informal fact find looks to determine what factors led to an incident, and what can be put in place to prevent a re-occurrence, this might include better IT, training, reasonable adjustments, or health interventions. Through this process only those incidents that merit formal processes are escalated to disciplinary or grievance sparing staff the experience of protracted HR procedures that can detriment individuals and teams. Throughout the health and wellbeing of all involved is now prioritised.

- Just Culture is a core element of corporate induction, which all new starters are expected to attend (average attendance in person at this monthly event above 99%. There is an option to complete this virtually or one to one for those unable to attend).

- The Just Culture programme is aligned to the civility and respect, violence and aggression, and equality workstreams, recognising that staff experiences of bullying, harassment, violence, aggression, or abuse impacts on patient experience. The programmes are aligned at corporate induction, as referenced above.

- A working group is leading implementation of refreshed programmes for civility and respect, and violence prevention and reduction standard, this includes EDI input to ensure the Staff Network voice is included.

- The Trust's staff Networks provide a safe space for staff from particular identity groups to regular meet and discuss issues and ideas with executive sponsors. Topics for action have included centralisation of reasonable adjustment budgets and input into occupational health contract decision making, and currently support for international staff and diversity representation in recruitment.

- Freedom To Speak (FTSU) Up is aligned to EDI in the Trust, and the Guardians attend the Staff Networks periodically to talk about FTSU to members. Speaking up regarding incidents of bullying, harassment, and discrimination is encouraged as it recognises that these experiences and behaviours impact on patient experience as well as staff.

- Health and wellbeing of staff is a priority in the Trust and staff are encouraged and enabled to access both formal and informal support for their health and wellbeing. Regular events are held, such as a Health and Wellbeing Fortnight, and communications are issued every week in the Bridgewater Bulletin. This might include topics such as smoking cessation, suicide prevention, mental health awareness, physical exercise, or financial wellbeing. Health and wellbeing is embedded within staff governance structures. Proactive interventions include an employee adjustment passport for disabled staff and carers in the workforce, health and wellbeing conversations and action plans, training, and organisational development intervention in teams that require support/interventions.

- Limited data is available through the national NHS Staff Survey. While it is possible to review data at directorate level it is not possible to look at this at service level. This is due in part to data protection as many Trust services have small numbers of staff who would be potentially identifiable at that granular level. The Trust engages with staff through six support networks to understand experience and develop and implement action plans for staff experience aligned to data such as the WRES and WDES, and to national mandate such as the NHS EDI Improvement Plan.

- The Trust is committed to the NW Anti-Racist Framework, seeing Board level engagement and oversight of this key programme to improve the workplace and service experience of ethnically diverse people.

- The Trust recognises too that our staff, and their families, are also likely our patients. Data reviewed by workforce in 2022 showed that 77% of staff live in our core areas of Cheshire and Merseyside, and the majority of the rest are living locally to our dental service delivery footprint or close by in areas of Lancashire. A data review undertaken for the launch of the Trust's new Communities Matter Strategy identifies that in any one year about 1/3 of the population in our community services footprint access our services, whether on a single occasion or multiple services and dates.

- The Communities Matter Strategy itself makes the clear link of staff and patients through its six strategic objectives – including health inequalities and equity. Reports for the WRES, WDES, Gender Pay Gap, and annual equality report can all be found at https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/ .

Outcome 1D score: 2

Outcome 1D rating: Achieving

Outcome owner: Chief Nurse/Chief Operating Officer/Clinical Leads

Domain 1 score and rating – 5: developing.

Domain 2: Workforce health and wellbeing.

Outcome 2A: When at work staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions.

Evidence:

- Sickness absence data monitoring at Divisional Leadership Team (DLT), People Operational Delivery (POD) Council, and People Committee – reporting through to Board.

- Stress risk assessments, display screen equipment assessment, pregnancy risk assessment, health and safety assessments, eye test support, etc are all available and actively used with applicable staff.

- A staff risk assessment audit was undertaken in 2023, including communications and support to all teams to complete team and individual assessments.

- There is signposting to support including mental health and occupational health, external support organisations, reasonable adjustments, carers support, flexible working and special leave options.

- Occupational Health, Able Futures, Access to Work, and other support is offered to relevant staff – some options area accessible through self-referral.

- Rugby League Cares sessions are offered to all teams and some individuals are focusing on mental health and the wider healthy lifestyle choices that support mental health and resilience.

- Human Resources (HR) and Health and Wellbeing (HWB) Teams are monitoring both of the above offers.

- Support to attend medical and treatment appointments is within the HR policy.

- There is HR support to staff and line Managers to access support during or following sickness absence.

- Support is provided to staff in any informal or formal HR process, and following any incident such as violence, bullying, harassment, clinical error etc.

- There is a Policy for special leave which includes support for home life emergencies and planned leave. in 2023 this was being updated to include annual camp for reservists and cadet force adult volunteers, and carers.

- We have options for career breaks, and purchasing additional annual leave.

- There are various flexible working options available including term time working, part time, compressed hours, job share, agile and home working. Most staff are digitally enabled to support flexible working.

- We have had a push on flexible working following our staff survey results – audit, communications, Electronic Staff Record (ESR) recording.

- Flexible working is open in all recruitment, with exceptions to be agreed by HR only after thorough investigation of the rationale.

- Carers support is provided to approximately 40% of staff who are unpaid carers.

- HWB is included within the POD Council business cycle, including for example discussions on dental support for staff.

- HWB conversation training is ongoing – HWB conversations are part of annual appraisal and line manager conversation cycle. Aligns to passport/wellbeing plans for all staff.

- There is a HWB intranet (Hub) pages and links.

- We hold an Annual HWB fortnight with virtual and face to face events for all staff, and signposting through 'market place' area.

- We have HWB Organisational Development (OD) interventions.

- We have HWB champions.

- Ther are regular activities, such as stop smoking day, and cycle to work day promoted.

- We have a Menopause café, Hub page, and support group for all staff with lived experience and allies.

- Ther are strong links between HWB, HR, and Equality, Diversity, and Inclusion (EDI) to embed equality and inclusion, and reduction of health inequalities in HR and HWB work.

- We have signposting to harassment and hate crime support.

- There is the promotion of national offers for ethnically diverse, disabled, and LGBTQIA+ staff.

- There is Armed Forces community signposting to support for staff and patients.

- Weekly communications to all staff feature in the Bridgewater Bulletin, for example:
    - Rugby League Cares sessions: Offload wellbeing sessions for all staff.
    - April is Stress Awareness Month.
    - Managing Emergency Alerts on your phone to stay safe if you're experiencing domestic abuse.
    - Staff wellbeing – support and self-help.
    - Hormone Replacement Therapy (HRT) pre-payment certificate.
    - Health & Wellbeing Training – Looking after yourself and each other.
    - Mental Health Awareness week: 15–19 May.
    - Launch of the new Warrington Happy? Ok? Sad? Website.
    - Continued free access to wellbeing apps.
    - Menopause Café – Save the date!
    - Access to occupational physiotherapy.

Outcome 2A score: 2

Outcome 2A rating: Achieving

Outcome owner: People Directorate

Outcome 2B: When at work staff are free from abuse, harassment, bullying, or physical violence from any source.

Evidence:

- Policy:

  - Violence and Aggression Policy – including flags/alerts and red card system. does not state that staff can refuse to see patients who have abused them, but duty of care will support staff to make that choice where possible, and where not possible (due to staffing numbers for example) other steps will be put in place through formal policy and informal practice to ensure staff feel safe and supported.

  - Civility and Respect at Work Policy and Toolkit.

  - Equal Opportunities Policy.

  - Grievance Policy and Disciplinary Policy and toolkits.

- Reporting options for staff to report incidents. Including updated Ulysses system to more effectively report and monitor incidents of racism etc.

- Support provided to staff after incidents. Occupational Health services including 24/7 self-referral to confidential counselling and trauma support. Able Futures mental health support is available for all staff.

- Signposting to external support for protected characteristic groups is available for staff on the intranet.

- Violence Prevention and Reduction Standard Working Group gap analysis/action plan includes EDI input.

- Race Inclusion Network have been consulted on our Violence and Aggression Policy review.

- Anti-racism statement - https://bridgewater.nhs.uk/aboutus/

- Trust Just Culture and informal fact finding and formal grievance and disciplinary processes.

- Corporate induction covers civility and respect, anti-racism and equality, Freedom to Speak Up (FTSU), and Just Culture.

- Just Culture and Civility and Respect induction highlights links with patient experience and outcome.

- The Trust's OD Team support services through in-reach training and support where closed or bullying cultures are reported.

- Franklin Covey and other learning and development programmes re leadership and team behaviours available for staff.

- Civility and respect training, aligned to national toolkit in rollout to Trust teams.

- Executive sponsorship of staff support networks ensures voice to Board.

- Staff-side colleagues support is available to all members. Close working relationship between Staff-side, Executives and HR.

- FTSU Guardian and Champion aligned to Staff Networks.

- Equality Delivery System engagement and action plan focusing on bullying and harassment.

- Communications via Team Brief and Bulletin for relevant events and awareness weeks including anti-bullying week.

- Data in the NHS Staff Survey has shown some progress in relation to race and disability since 2015 and 2019 when the Standards were launched – other protected characteristic groups are too low to analyse.

- Employee relations data – monitored through governance detailed in outcome 2a evidence.

- Employee relations data shows very few cases being managed through dignity and respect policy and process.

- NHS Staff Survey 2022 data shows that:

  - 22.8% of Trust staff have experienced bullying, harassment, or abuse from patients in last 12 months. Average for Community Trusts.

  - 7.3% of staff have experienced bullying, harassment, or abuse from managers. Average for Community Trusts.

  - 13.4% of Trust staff have experienced bullying, harassment, or abuse from colleagues in the last 12 months. Average for Community Trusts.

  - Indicators showing a pattern of slow improvement, included for staff from PC groups – where there is still a gap between their experience and that of comparator groups.

- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data show improvements from the start of reporting, though this shows annual fluctuations.

- Staff Network engagement in WRES and WDES action planning re bullying and harassment.

Outcome 2B score: 2

Outcome 2B rating: Achieving

Outcome owner: People Directorate and Health and Safety Team

Outcome 2C: Staff have access to independent support and advice when suffering from stress, abuse, harassment, bullying, or physical violence from any source.

Evidence:

- Support for staff including occupational health service, (including trauma support), and Able Futures.

- Signposting to external support agencies, including for hate crime and suicide prevention available to all staff on intranet.

- Regular Bridgewater Bulletin communications including hate crime awareness, anti-bullying week, LGBT History Month.

- Anti-racism Framework commitment - https://bridgewater.nhs.uk/aboutus/

- Staff-side Representatives active in Trust.

- Facilities time for Staff-side Representatives in Trust.

- Joint Negotiating and Consultation Committee and Local Negotiating Committee provide regular formal engagement with leadership and staff side.

- Regular meetings between staff side and CEO/other Executives.

- Good working relationship with Staff-side, though impartiality and challenge remain active.

- Two FTSU Guardians in place – one based in HR, and one recruited from clinical services.

- Active FTSU promotion work over last 12 months.

- Strong alignment to EDI with collaborative work on for example FTSU month.

- FTSU champions recruited from across the Trust, including from Staff Networks.

- Executive and Non-Executive Director (NED) leadership and support for FTSU, including support from a NED looking to engage Race Inclusion Network membership in FTSU awareness raising.

- FTSU at least an annual conversation at staff support networks.

- Plans in implementation following the Lucy Letby trial, including attendance at a HBW fortnight supported by Executives/NEDs.

- Trust FTSU intranet page - new extranet supports access via telephone and external device to improve staff access.

- Five active staff support networks for carers, disability, menopause, LGBTQIA+, and race/ethnicity. All have executive sponsorship and engagement.

- Networks meet monthly via Microsoft Teams, EDI Lead and chairs are available at other times to support staff.

- FTSU further embedding within Staff Networks following Letby trial.

- Staff Networks engaged on NHS Staff Survey results for WRES, WDES, and Navajo.

- Staff Network maturity action plan part of EDI action plan 2023 – 2024.

- Team Brief Staff Network focus slides throughout spring 2023.

- Regular Bridgewater Bulletin communications highlight Staff Networks.

- New starter email action in progress to highlight Staff Networks, HWB, civility and respect, and FTSU reporting.

- Staff Networks promoted at staff events.

- Face to face menopause cafes started 2023 – two topics this year included symptoms and managing mental health.

- Equality impact assessments (EqIA) completed for all HR, corporate and clinical policies. EqIA is embedded within policy governance.

- Staff side representation part of governance in Clinical and Corporate Policy Group and HR Policy Group.

- Lone Workers, and violence and aggression policies and procedures. Policy provides detail of 'after' incidents.

- Staff Race Inclusion Network engaged in violence and aggression policy consultation.

- Violence Prevention and Reduction Standard working group and gap analysis/action plan, includes EDI lead and staff side.

- Civility and respect policy refresh as part of local alignment with training and new toolkits, all aligned to national Civility and Respect, and Violence Prevention and Reduction workstreams.

- Civility and respect working group developing communications package for staff, services, and public.

- Just Culture programme – including refresh of grievance and disciplinary policy.

Outcome 2C score: 2

Outcome 2C rating: Achieving

Outcome owner: People Directorate and Health and Safety Team

Outcome 2D: Staff recommend the Trust as a place to work and receive treatment.

Evidence:

- Workforce project 2022 looked at staff base/home locations. In Warrington and Halton 50% staff on average were local.
- NHS Staff Survey 2022 results for questions 23c and 23d:
  - Age average = 67.7%
  - Disability = 65.8%
  - Ethnically diverse = 68.8%
  - Female = 69.8%
  - Male = 69.0%
  - Self-described gender identity = 63.6%
  - No religion = 68.1%
  - Christian = 70.6
  - Muslim = 80.8%
  - Other religion = 68.6%
  - LGB+ = 77.3%
  - Carer = 68.1%
- Average is in 60 - 70% range and therefore between developing and achieving for this outcome.
- Staff survey, and monthly sickness absence data taken to People Committee, Board, and underlying governance for review and action planning.
- Recruitment and retention groups looking at actions including retention/stay and exit interviews.

- 'Other' removed as an option for staff leaving question to support better understanding of reasons for leaving.

- Primary reasons for leaving in 2022-23:
    - Health
    - Retirement
    - Work-life balance
    - Flexi-retirement
    - Promotion
    - Relocation

- Exit interview and termination forms monitored by the Trust's People POD

- Involvement and leadership of local place based 'people' work groups focusing on recruitment and retention in health care at a borough level, allows engagement and understanding of other Trust's offers, challenges, and successes.

- EDI involvement at place and regional level to share good practice – including development of trans support policy, Armed Forces support, and disability support.

- Engagement work with local charity sector groups to improve experiences for protected characteristic groups in workforce and services.

- Close alignment with local education providers to improve offer to local communities in apprenticeships and other opportunities.

- Health and wellbeing support for all staff including Occupational Health, Able Futures, Access to Work, resilience hubs, Rugby League Cares.

- Resources and signposting for self-care.

- Regular HWB communications.

- HWB fortnight held annually.

- HWB conversations training and mandated within annual appraisal and line Manager conversation cycle.

- Employee Adjustment Passport – policy and guidance published in 2019/20. Updated to wellbeing plans in 2023.

- Signposting to external support for specific conditions.

- Staff support networks available for staff.

- WRES, WDES, Disability Confident Leader, and Navajo LGBT+ Charter Mark all require regular review of data for staff from these groups.

- Staff Networks engaged on results and development of action plans.

- Accreditations and standards signed off and monitored through governance, including full staff survey breakdown for WRES and WDES.

- Carers support – 38% of staff in 2022 NHS Staff Survey stated they provided unpaid care. Support includes special leave, Staff Network, flexible working options, and employee adjustment passport.

- Menopause support – circa 48% of staff are female and aged over 45. The figure doesn't include early and premature menopause, differential by ethnicity and some disabilities, or those who identify with diverse gender identities. Support includes Staff Network, signposting, Teams Channel, cafes, policy, HWB conversations, employee adjustment passport.

- Staff risk assessments undertaken for stress, pregnancy/maternity/breastfeeding, and occupational risks.

- Flexible working is available and promoted to all staff, including in all recruitment. This includes working hours/days/period, part time and job sharing, agile working, and working from home when travelling to visit patients. Audit being undertaken of all staff flexible working as part of NHS Staff Survey action plan.

Outcome 2D score: 2

Outcome 2D rating: Achieving

Outcome owner: People Directorate

Domain 2 score and rating – 8: achieving.

Domain 3: Inclusive leadership.

Outcome 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.

Evidence:

Internal_Governance_Structure.pdf

- Internal governance structure:

- EDI embedded in:

  - Health and Safety Sub-Committee.

  - People Committee.

  - People Operational Delivery Groups - PODs (as at August 2023 these have been reviewed and a new POD Council established with EDI as standing agenda item, working/task and finish groups remain under this new POD Council, and EDI Working Group in stage of establishment).

  - Corporate and Clinical Policy Group – EqIA for every policy as part of consultation.

  - Education Governance.

  - Time to Shine.

  - Attendance at Safeguarding and other meetings is as required/invited.

- Board and People Committee have EDI within business cycles, reviewed on annual basis to reflect national reporting changes.

- Exception reporting from the Trust's People Committee and Quality & Safety Committee escalates anything outside of the business cycle.

- Quality Impact Panel reviews EDI impacts as part of panel business for every document presented. The Trust's EDI Lead is a core member of the panel. All Cost Improvement Plan (CIP) schemes also go through panel for sign off before progression.

- The POD Council and People Committee provide governance for EDI and Staff Networks, JNCC and LNC provides a forum for engagement with Staff-side.

- EDI strategic objective for Trust embedded as part of Board and Committee papers oversight alongside Board Assurance Framework which has individual section for EDI. Update: strategic objectives updated since initial evidence gathering for EDS – now two strategic equality objectives – health inequalities, and compassion and inclusion, Board Assurance Framework revised and updated in line with these changes.

- The Trust has leads for EDI and for public health and health inequalities. Both have Executive Leads/sponsors as per the Director of People & OD and Medical Director.

- There is Warrington and Halton commissioner oversight for EDI.

- Staff support networks all have executive sponsorship and regular attendance:

  - Carers Support Network – Chief Nurse/Deputy Chief Executive.

  - Enabled Network – Director of Finance - active participant in reciprocal mentoring for inclusion programme with network member. Supported by Director of People and OD.

  - LGBTQIA+ Staff Network – Chief Operating Officer and Trust Secretary.

  - Menopause Support Network – Medical Director. Network chairs - Trust Secretary and Head of Corporate Governance.

  - Race Inclusion Network – Director of People and OD, with Chair role also, supported by CEO and Trust Chair. Deputy Chair recruited from Staff Network membership.

- All networks meet monthly on average (August excluded) and execs attend on average 50 – 75% of monthly meetings.

- The Trust is running a pilot Reciprocal Mentoring for Inclusion Programme facilitated by Liverpool John Moores University. Six partnerships of Executive and senior leaders with staff members who identify with ethnically diverse, disabled, or neurodivergent identities.

- Reciprocal mentoring programme being aligned to EDI Working Group planning.

- The Trust has a strategic equality objective, and a strategic health inequality objective, both set out in the Communities Matter and People Strategies https://bridgewater.nhs.uk/communities-matter/

People_Strategy_Refreshed_2022-2025.pdf

- EDI objective for every Board member annually, including 360 Board appraisal.

- The Trust's EDI Strategy was due for review in 2023 in line with the Communities Matter and People Strategies. This was postponed while the Trust awaited the publication of the NHS EDI Improvement Plan and the updated North-West Anti-Racist Framework. A strategy refresh is scheduled from winter 2023.

- All borough directorates have annual operational plans aligned to Communities Matter and People strategies embedding EDI and health inequalities objectives in annual service plans.

- Oversight of plans is via Senior Leadership Team. Delivery is supported through the Transformation Team, including through the BOOST (Building On Our Strengths Together) co-production programme.

- The Trust's EDI Lead has been engaged in reviewing all draft plans and providing an informal EqIA review of each workstream.

- All workstreams will go through the Quality Impact Assessment panel before progressing.

- Lived experience panels in development with AqUA.

- The Bridgewater Engagement Group is being re-launched following pandemic pause, with a strong focus on engagement with public/communities/patients/staff under one group as opposed to spread across teams and meetings.

- Through the Transformation Team learning and actions from public engagement is being embedded within operational delivery plan implementation. This includes engagement with local disability, Deaf, carers, race/ethnicity, and asylum seeker representative groups.

- NHS Staff Survey directorate level results and action plans are mandated, including EDI theme – progress is monitored through people governance structure to Board.

- Patient stories are shared with the Trust Board regularly, often arising from patient services contacts, similarly lessons learned are shared across the Trust and at Board and actions, including where needed allocation of additional resources, agreed.

- Time to Talk events are held with all Trust Teams on a monthly basis. This is a space for staff members to raise issues and ideas direct to Board members so that actions can be taken. This might include facilitating resources to support simple actions that improve workplace experience.

- Time to Shine events are held monthly showcasing lessons learned and best practice examples from services across the Trust.

- The Trust Board re-confirmed its commitment to the NW Anti-Racist Framework in 2023 and has previously facilitated events such as Board Development, and Leader in Me days for staff to learn more and discuss experiences and ideas around racism and discrimination in the workplace and in service delivery.

- We have Board commitment to Trust accreditations including Disability Confident Leader, Veteran Aware, Navajo LGBT+ Charter Mark, and Employers for carers accreditation.

- Board led Just Culture and Civility and Respect programmes have been running since 2020. These are now embedded.

- Engagement and feedback from Staff Networks informs Board commitment and action on areas such as diversity in recruitment panels, support for international staff, reasonable adjustment pathways – all are in development.

- Board led centralisation of staff reasonable adjustments budget following engagement with the Staff Enabled Network in 2021.

- Trust Executive support for events including:

  - Warrington Disability Awareness Day.

  - Liverpool Pride and Bridgewater Pride Month.

  - Board Development Day – anti-racism, facilitated by Real and Authentic Representations of African People (RARA).

  - Leader in Me – anti-discrimination, facilitated by RARA.

  - NED support for Ramadan including staff lunch and learn opportunity.

  - Black History Month support and involvement.

- Blogs and other comms regularly produced that include EDI.

- Executive speaker (medical director) at menopause café, further external speakers for World Menopause Day 2023.

- EDI working group in development - open to all staff with lived experience, allyship, or commitment to EDI.

- Trust Governors aligned through corporate governance for oversight and feedback on Trust governance and meetings. Regular governor meetings held, supported by executives. Governors also support with Time to Talk and attend Time to Shine events.

- FTSU Guardian regular attends Staff Network meetings and is engaged with Staff Network members as applicable.

- Staff side have strong working relationship with Board and senior leads and meet regularly through JNCC, LNC, and other meetings to discuss staff concerns and ideas – Staff-side Chair meets regularly with Chief Executive Officer and Director of People & OD.

- There is regional and national HR Directors Network membership – including health and wellbeing, anti-racist framework, and other EDI topics.

- Place based partnerships, including leadership of these in the region.

Outcome 3A score: 2

Outcome 3A rating: Achieving

Outcome owner: Board

Outcome 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.

Evidence:

- **See also 3A, above.**

- There is an EqIA review as part of policy consultation for HR, corporate, and clinical policy. Standard operation procedures also screened for impact. Embedded within policy process and governance.

- Review of 'publishing' requirement part of EDI action plan for 2023 – 24: advised by NHS England EDS lead that publishing is best practice and can support avoidance of early legal challenge, is not however mandated as long as contemporaneous EqIA evidence available if required.

- EDI and health inequalities embedded within People, Communities Matter, and Carers Strategies, and EDI lead consulted in development of same.

- EDI Strategy for Trust – for review in December 2023 following publication of NHS Workforce Long Term Plan, NHS EDI Improvement Plan, and refreshed People and Communities Matter Strategies.

- EDI integral to Quality Impact assessment of service redesign, CIP, borough operational plan workstreams, and any services flagged as part of business continuity. EDI Lead is part of the QIA panel, and provides additional support to service leads in development of EqIA and EDI risk for QIA.

- Work is ongoing to build public engagement on service redesign following Covid19 pandemic. This is led by the Programme Director for Collaboration and Integration.

- 100% of ethnically diverse were staff risk assessed as part of Covid 19 risk assessments.

- Panel reviewed all high risk assessment forms – using form developed in Cheshire and Merseyside these were all assessments for ethnically diverse staff, staff with disabilities and long term conditions that led to clinical vulnerabilities, older staff, and pregnant/infant feeding staff.

- Risk mitigations put in place, including working from home, Personal Protective Equipment, reassignment of duties, and if needed medical suspension was an option.

- Covid 19 risk assessments were completed for all staff with disabilities or long-term conditions, ethnically diverse staff, older staff, and staff who were pregnant, on maternity leave, or infant feeding.

- Stress risk assessment for team and individuals are available – an audit being undertaken by HR on usage and quality in autumn 2023.

- Risk assessment for pregnancy and maternity, and breastfeeding embedded within pregnancy, maternity, and adoption policy, and HR training for managers.

- Draft menopause risk assessment completed – awaiting publishing of national menopause support policy to ensure alignment.

- Occupational health support to identify risk and mitigation including reasonable adjustments for staff.

- Workplace risk assessment, including display screen equipment, embedded and led by the Trust's Health and Safety Lead.

- Risk assessment embedded within relevant policy, including in relation to lone workers, and occupational risks. Includes alignments to violence and aggression, and civility and respect, and includes racism and other hate incidents.

- Risk assessment monitoring is via the Health and Safety Sub Committee and through the People governance structure including JNCC to capture Staff-side views.

- Staff Network engagement used to develop action plans for WDES and WRES, signed off by Board via the People Committee.

- Staff Network engagement to be used in delivery of North-West Anti-racist Framework action plan through membership of the EDI Working Group.

- Menopause and carers support groups support development of actions relevant to gender pay gap.

- LGBTQIA+ Staff Network leads on Navajo LGBT+ Charter Mark action plans and re-accreditation.

- Community and patient data used to develop Communities Matter Strategy.

- Workforce data used to inform all workforce plans for recruitment and retention, including where appropriate EDI drivers and unequal impacts.

- EDI embedded with governance, including in EDI Board Assurance Framework.

- Actions embedded within overarching EDI action plan for 2023 – 2024 which is aligned to national NHS EDI Improvement plan

Outcome 3B score: 2

Outcome 3B rating: Achieving

Outcome owner: Board

Outcome 3C: B Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

Evidence:

- Mandated reports for Gender Pay Gap, WRES, WDES, and EDS on POD Council, People Committee and Board business cycles, including signing off action plans.

- All above action plans included in overarching annual EDI action plan; monitoring, and exception reporting through People Committee to Board.

- Trust EDI work monitored by commissioners through quarterly quality meetings.

EDI Action Plan
2023-2024.docx

- Board commitment to NW Anti-racism Framework, commitment to apply to refreshed framework in 2023/24.

Appendix 3
Anti-racist Framework

- All of the below have action plans embedded within governance:
    - Trust is Disability Confident Leader, accredited through external validation.
    - Trust is a Defence Employer Recognition scheme bronze level holder.

- Trust holds Veteran Aware accreditation.

- Trust holds Navajo LGBT+ Charter Mark.

- Trust commitment to application to Employers for Carers accreditation scheme.

- Trust is a signatory to the sexual safety charter.

- Trust is a signatory to the care leavers charter and is engaging with local care leavers.

- Accessible Information Standard action plan part of Halton and Warrington commissioner business cycle for oversight.

- Patient Safety Incident Response Framework being implemented in the Trust.

- Patient and Carer Race Equality Framework not applicable and not a mental health Trust.

- Trust well led review held in 2023, led by independent evaluation.

- WRES data shows that Board and senior leaders are representative of the boroughs served, and ethnically diverse Board members were over-represented compared to the overall workforce.

- WDES data shows that Board is not representative of either workforce or community.

- Data at Agenda for Change band 8c and above is difficult to assess due to very small numbers – data suggests that in clinical roles there is better representation of ethnically diverse staff at these higher bands, reflective of the population and workforce, and for disabled staff representation in non-clinical roles is representative.

- Under-representation in the workforce is identified in the WRES and WDES action plans and aligns to those priorities outlined in the Trust level reports from the national teams.

- The Trust Board is 50/50 female to male. At Non-Executive level there are more female than male NEDS. The Trust is 90% female overall.

- Data for LGB+ is low, and for gender identity national ESR is quite restrictive so the Trust will support gender changes for staff but are restricted in options by the national record.

- In relation to religion the low numbers don't allow statistical significance to be assigned to the diversity of religions in our areas – many Trust staff identify with no religion.

- The data below is taken from ESR as at 31st March 2023. It includes all staff in Agenda for Change pay bands, including a small number in medical and dental roles paid through this pay scheme. It does not include very senior managers, for this information is available in the WRES and WDES but is otherwise not referenced due to data protection.

  - Between the ages of 31 and 60 staff overall representation gradually increases. Younger staff and those over 60 have smaller representation in the Trust. Older staff are more likely to be in higher pay bands than younger, reflective of years of experience and ongoing career development.

  - Disability overall = 3.2%. Over-represented at bands 7, 8a, and 8c, under at bands 8b and 8d. No staff with disability in band 9.

  - 6.23% of staff identify with global majority ethnic heritages. Global majority staff are over-represented at band 7 but under-represented at higher bands – the WRES disparity ratio shows the differences between non-clinical and clinical groups. In medical and dental there is much greater representation, this reflects patterns across the NHS.

  - Women account for 89.8% of the workforce. Women are over-represented in the workforce up to and including band 7, but then representation drops to 50/50% at band 8d.

  - ESR data for religion, sexual orientation and gender diversity are too low for statistical review.

- Pattern of small improvements since reporting began for frameworks and standards, but consistent improvement not achieved – in part due to often very small numbers of staff influencing statistical significance.

- Governance to Board via POD Council and People Committee. Monitoring of action plans developed in partnership with Staff Networks through same governance.

- Staff Network and EDI Working Group – Board and senior leadership sponsorship and Chair.

- Menopause Support Policy.

- Health and wellbeing conversations and adjustment passport includes menopause.

- Menopause included in new Wellbeing Policy – Trust an early adopter/pilot site for this new regional policy.

- Menopause Teams Channel for Staff Network members.

- Intranet page includes factsheets and signposting.

- Menopause Champions in place in Trust.

- Trust engagement at Warrington and St Helens borough level on menopause friendly.

- World Menopause Day/Bridgewater Menopause Fortnight comms.

- Menopause cafes including Executive Director speaker with menopause clinical expertise, and external speakers.

- Fresh Packs through charitable funds for staff emergency access to sanitary supplies.

- Action plan to ensure sanitary vending machines in new buildings.

- Staff lived experience stories shared to raise awareness of menopause impacts.

- Social media including for other female by birth conditions.

- Occupational health – counselling, physiotherapy, and Cognitive Behavioural Therapy available and used by staff affected by menopause.

- Uniforms support in hot weather, including update to policy in 2023.

- Draft menopause risk assessment – awaiting release of national policy to ensure alignment.

- Menopause recording in ESR engagement undertaken with network members.

- Borough operational delivery plans aligned to Communities Matter Strategy.

- Place based partnership working as collaboratives for providers and workforce. Leadership of some regional/borough groups by Trust Executives.

- Links to groups across place, including EDI, supportive of collaboration on work such as reasonable adjustments, language interpretation quality standards, and trans support.

- Integration of services such as One Front Door in Warrington. Service changes routed through QIA panel, which includes review and risk rating of equality impact.

Outcome 3C score: 2

Outcome 3C rating: Achieving

Outcome owner: Board

Domain3 score and rating – 6: achieving.

EDS 2023 Final score and rating

Organisation name: Bridgewater Community Healthcare NHS Foundation Trust (RY2)

EDS overall organisational rating: 19 (Developing)

Note:

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped.**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing.**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving.**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling.**

EDS 2023 action plan.

EDS Lead: Ruth Besford (Equality & Inclusion Manager)
EDS action plan activity: 2023 - 2025
EDS Executive sponsor(s): Dr Ted Adams (Medical Director) and Paula Woods (Director of People and OD)
Authorisation date:

Domain	Outcome	Objective	Action	Completion date
1	1A	Build on existing data available within patient record systems.	Review and update patient record systems to ensure equality information is captured for: • Race/ethnicity • Disability • Sexual orientation • Religion or belief Embed Accessible Information Standard recording and flagging requirements in EMIS and SystmOne as a standardised process.	31.12.2024
1	1A	Improved staff confidence for supporting transgender and gender diverse patients.	Development of policy, process, and training offer for transgender support in services.	31.03.2025

1	1B	Public engagement - further embedding of partnerships and collaboration.	Review service links to partners in delivery of care and wellbeing support. Roll out 2024 community engagement plan. PACE membership to include operational leads from four directorates for links to operational delivery plans and service delivery.	31.03.2025
1	1C	Alignment of Just Culture and Civility and Respect work programmes, with inequality work programmes.	Embed equality voice in Just Culture and Civility and Respect governance through further establishment of staff networks, and equality engagement in the community. Launch Civility and Respect within services.	30.06.2024
1	1C	Better access for D/deaf patients.	Review phone in option via Signalise Co-op for D/deaf patients.	30.06.2024
1	1D	Embedding EqIA in service redesign.	Work with Transformation Team to ensure EqIA embedded within directorate operational delivery planning.	31.03.2024

2	2A	Establishment of accessible and user-friendly single process, and one stop shop, for health and wellbeing support and advice.	Establish task and finish group to look at all options available to staff and managers and develop action plan to meet objective. Consider access to independent culturally appropriate support and advice for protected characteristic groups.	30.09.2024
2	2A	Improved health and wellbeing offer across geographical spread.	Review options for provision of health and wellbeing activities, events, and support in person across geographical spread of services.	31.03.2025
2	2B	Improved quarterly monitoring: 1.	Develop quarterly review process for Ulysses incident monitoring and review for incidents involving patients and/or family members. Delivery of Civility and Respect communications materials and plan.	30.06.2024 30.06.2024
2	2B	Improved quarterly monitoring: 2.	Review recording of stress risk assessments – issue, completion, and follow up.	31.12.2024
2	2B	Expanded equality awareness offer.	Develop cultural awareness plan, and plan for implementation.	31.03.2025
2	2C	Staff Networks further embedded and engaged, including in decision making and equality analysis and assessment of strategy, policy, and programmes of work.	Continued implementation of staff networks action plans to mature and embed existing six networks across the Trust.	31.03.2024 – amended to align with equality objective deadline.

2	2C	Improved staff experience of absence management processes.	Launch Wellbeing Policy and Toolkit, and monitor and review uptake, outcome, and feedback.	31.03.2025
2	2C	Improved NHS Staff Survey results for flexible working questions.	Review 2023 – 2025 responses following flexible working project undertaken in 2023/24.	31.03.2025
2	2D	FFT questions within exit interviews.	Further review of reasons for leaving after one to three years. Review of reasons for return.	31.07.2024
3	3B	EqIA training and further awareness embedded across leadership.	Develop communications and training plan to further embed awareness and knowledge of General Equality Duty in all leaders for policy, service delivery, and strategy development.	31.12.2024
3	3C	Embedded equality and inequality information in Board and Committee papers.	Speak to Executives and Trust Chair re adoption of Leadership Framework for Health Inequalities Improvement https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement	31.12.2023

Acronyms used within document:	• BAF – Board Assurance Framework
	• CQC – Care Quality Commission
	• EDS – Equality Delivery System
	• EMIS – Egton Medical Information Systems (company)
	• EqIA – Equality impact assessment
	• FFT – Friends and Family Test
	• FNP – Family Nurse Partnership service
	• FTSU – Freedom To Speak Up
	• GPG – Gender Pay Gap
	• H&S – Health and Safety
	• HR – Human Resources
	• HV – Health Visiting service
	• JNCC – Joint Negotiating and Consulting Committee
	• LGBT+/LGBTQIA+ – Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual/Agender. The + specifies other diverse gender and sexual identities
	• MECC – Making Every Contact Count
	• MIAA – Mersey Internal Audit Agency
	• NHS – National Health Service
	• OH – Occupational Health
	• Place – refers to collaboration across region of Cheshire and Merseyside
	• POD – People Operational Delivery groups
	• PSED – Public Sector Equality Duty
	• WDES – Workforce Disability Equality Standard
	• WRES – Workforce Race Equality Standard

PEOPLE COMMITTEE

Title of Meeting	**PEOPLE COMMITTEE**	**Date**	**17 January 2024**
Agenda Item	**06/24**		
Report Title	**PUBLIC SECTOR EQUALITY DUTY ANNUAL REPORT 2024**		
Executive Lead	Paula Woods, Director of People and Organisational Development		
Report Author	Ruth Besford, Equality & Inclusion Manager		
Presented by	Ruth Besford, Equality & Inclusion Manager		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**
Executive Summary			

The General Equality Duty of the Equality Act 2010 places a requirement of due regard to three equality aims on all public sector bodies:

- Eliminate discrimination, harassment, victimisation, and other prohibited conduct.
- Advance equality of opportunity for protected characteristic groups.
- Foster good relations between those in protected characteristic groups and those not in those groups.

The Duty also has three reporting requirements, the Specific Duties:

- Publishing relevant equality objectives at least every four years.
- Publishing annually a report detailing how due regard to the three aims has been met.
- Publishing annually by 30th March a gender pay gap report.

The report presented to this Council fulfils the second of these reporting duties.

The report provides detail on how the Trust has shown due regard in employment and service delivery activities and covers for example:

- Overview of legal equality and human rights duties.
- Equality governance framework.
- Trust strategy and action plans.
- Engagement with staff and patients/communities.
- The policies, processes, and practices for due regard in employment.
- Data.

The appendices cover the legal reporting required in the NHS Standard Contract, much of which is reported individually, with full reports signposted from the document.

This Committee is asked to approve the Annual Report 2024 to allow progression to February Board sign off, this will allow publication before the mandated deadline of 30th March 2024.

Previously considered by:	
☐ **Flu Group**	☐ **Freedom to Speak Up Guardian Group**
☐ **Medical & Dental Professional Governance**	☒ **POD COUNCIL**

Strategic Objectives
☒ **Equality, 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**
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	**Quality** Failure to deliver quality services and continually improve	**Health Equity** Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	**Staff** Failure to create an environment for staff to grow and thrive	**Resources** Failure to use our resources in a sustainable and effective way	**Equality, Diversity & Inclusion** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	**Partnerships** Failure to work in close collaboration with partners and staff in place and across the system

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

PEOPLE COMMITTEE REPORT

Title of Meeting	**PEOPLE COMMITEE**	**Date**	**17 January 2024**
Agenda Item	**06/24**		
Report Title	**PUBLIC SECTOR EQUALITY DUTY ANNUAL REPORT 2024**		
Report Author	Ruth Besford, Equality & Inclusion Manager		
Purpose	To present for People Committee approval the mandatory Public Sector Equality Duty Annual Report 2024.		

1. SCOPE

1.1   The Public Sector Equality Duty Annual Report is mandated within the:

      a. Equality Act 2010 – General Equality Duty, and Specific Duties.

      b. NHS Standard Contract.

1.2   There is also relevance within the report to legal duties in relation to the Human Rights Act 1998.

1.3   Workforce, services, patients, and communities are all within scope for the reporting of due regard to the General Equality Duty.

2. INTRODUCTION

2.1   Section 149 of the Equality Act 2010 sets out the legal equality duties of all public sector organisations in England. Detailed within section 149, the General Equality Duty, is a duty of due regard on all relevant bodies, which includes all NHS bodies, to three aims:

      a. To eliminate discrimination, harassment, victimisation, and other conduct prohibited by the Act.

      b. To advance equality of opportunity between people who share a protected characteristic and people who do not, the Act states that this includes:

            i. Removing or minimising disadvantages suffered by people due to their protected characteristics.

           ii. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

         iii. Encouraging people from protected groups to participate in public life or in other activities where the participation is disproportionately low.

c. To foster good relations between people who share a protected characteristic and people who do not, which includes promoting understanding of and between different groups and tackling prejudice, racism, homophobia, transphobia, religious hatred and disability harassment and hatred.

2.2 Due regard means thinking about these three aims in all Trust business. This consideration should be robust, timely, conscious, and carried out with an open mind as to the outcomes.

2.3 The Public Sector Equality Duty also has three reporting requirements set out in the Specific Duties:

a. To publish relevant equality objectives at least every four years.

b. To publish annually a report detailing how the duty of due regard has been met in employment and service delivery in the previous year.

c. To publish annually a gender pay gap report.

2.4 This paper to the People Committee presents the annual due regard report, fulfilling the second of these Specific Duties on publishing.

3. PUBLIC SECTOR EQUALITY DUTY ANNUAL REPORT 2024

3.1 The report presented to this Committee, as stated previously, supports fulfilment of the second of the General Equality Duty Specific Duties through the provision of information on how equality and inclusion is considered in all Trust business – whether this is throughout the employment journey, in delivery of equitable services, or through engagement with diverse communities.

3.2 General detail is provided about the Trust, along with more specific information on the policies, processes, strategies, and action plans that support due regard to equality for staff, patients, and communities.

3.3 Data is an important part of demonstrating due regard and this can be seen in the workforce information; and there are specific data requirements set out in the NHS Standard Contract, these are detailed within the appendix with links provided to the full relevant reports where applicable.

4. RECOMMENDATION

4.1 People Committee members are asked to approve this report, and to escalate to February Board for final sign off to allow for publication on the Trust's website before the deadline date of 30th March 2024.

Public Sector Equality Duty

Annual Report

Date: January 2024

Contents

Glossary of acronyms

BOOST	Building On Our Strengths Together (Programme)
BSL	British Sign Language
EDI	Equality, Diversity, and Inclusion
EDS	Equality Delivery System
GP	General Practice
HR	Human Resources
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Agender/Asexual. + denotes other gender and sexual identities
NICE	National Institute of Clinical Excellence
NHS	National Health Service
PDSA	Plan, Do, Study, Act
POD	People Operational Delivery
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Introduction

Welcome to our Public Sector Equality Duty Annual Report for 2024.

The past year has been a busy one for equality, diversity, and inclusion in the NHS and in Bridgewater with the publication of the NHS Long Term Workforce Plan; Equality, Diversity, and Inclusion (EDI) Improvement Plan; a refreshed North West Anti-Racist Framework; NHS Sexual Safety Charter; Patient Safety Incident Reporting Framework; and Anchor Institute commitments and actions.

Equality, diversity, and inclusion remains a priority area of focus for Bridgewater, running throughout updated People, and Communities Matter Strategies, strategic equality objectives, borough action plans, and becoming ever more embedded across all areas of business, and a core part of every employee's role.

Dedicated resource and support for improving equality, diversity, and inclusion is a strong commitment of the Trust, as is ensuring that the actions we take are rooted in co-design and the voice of minoritised groups. It is not enough to tick a box, the Trust wants to take meaningful steps, in partnership with our workforce, patients, and the communities we serve, so that true and lasting positive outcomes are achieved/ Anything less is not acceptable.

This report provides further information on the equality, diversity, and inclusion commitments and work of Bridgewater.

If you have any questions or queries regarding the information in this report, or if you require the information in another language or format, please do not hesitate to contact us using the contact details below.

Thank you.

Paula Woods (Director of People and Organisational Development).

Ruth Besford (Equality & Inclusion Manager).

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Executive Summary

This report provides information that supports the Trust's legal duties to demonstrate due regard to equality, diversity, and inclusion (EDI) in all areas of business; duties that are set out in the Equality Act 2010, and Human Rights Act 1998 and are briefly detailed in the following section.

Specific information is provided on prioritisation of EDI in the Trust through governance, strategy, and action planning, along with the alignment to national programmes and plans including the NHS People Plan, Our NHS People Promise, and the EDI Improvement Plan.

Anti-discrimination, and zero acceptance of discrimination, harassment, and bullying of minoritised groups is at the core of the Trust's work, and detail is provided on Trust implementation plans for meeting the commitments of the refreshed North West Anti-Racist Framework.

Information is provided on how the Trust is engaging with its workforce, patients, and communities to develop action plans with regards to the delivery of co-created actions that effect sustained positive improvements on equality in employment, in services, in community access to health care services, and on community health inequalities.

More detail on day-to-day processes, policies, and actions that support equality, diversity, and inclusion in the workforce and in service delivery are provided through bullet point lists.

Data is provided where available and where this is personal identifiable information it will not be disclosed. The Trust recognises that patient data has limitations currently, and a small group is working to address the gaps in equality data that exists in patient records.

Accreditations including Disability Confident, Navajo, and Veteran Aware are detailed. These accreditations are important to the Trust as they drive us forward to continually make improvements for the equality of those groups. Progress is reviewed externally and impartially.

Finally, the appendices to the report refer to language interpretation usage, and results for Workforce Disability and Race Equality Standards 2023, Equality Delivery System 2023, and Gender Pay Gap 2023.

It is intended that the information provided is comprehensive and provides assurance that due regard to equality and inclusion is embedded throughout Trust business.

Equality and human rights

The Equality Act came into force in England in 2010. The Act brought together 116 separate pieces of equality legislation into one simplified and streamlined act that brought protection from discrimination for nine protected characteristic groups:

- Age.

- Disability. This includes:

    o Physical, mental, sensory, learning, and hidden disabilities.

    o Neurodivergent differences such as for example autism, dyslexia, and dyspraxia.

    o Some people with long term conditions, where their impact is significant on day to day living.

- Gender Reassignment (Transgender).

- Marriage & Civil Partnership (including same sex marriage).

- Pregnancy and Maternity.

- Race (Ethnicity).

- Religion or Belief (including no belief).

- Sex (we recognise and value the diversity of gender identity and expression beyond the male/female binary).

- Sexual Orientation (we recognise and value all sexual orientations and identities, recognising that this is a wide and not static spectrum of individuality).

Bridgewater also recognises other often disadvantaged and vulnerable groups. These include:

- Carers.

- Military veterans and the armed forces community.

- Asylum seekers and refugees.

- Other complex needs that include drug or alcohol addition/dependency, sex workers, and homelessness and vulnerably housed.

- People living in areas of high social deprivation.

For organisations providing public services the Equality Act introduced a Public Sector Equality Duty (Section 149 of the Act). The Public Sector Equality Duty has two duties:

- The General Equality Duty.

- The Specific Duties. There are three parts to the Specific Duties:

    o To publish at least annually evidence of compliance with the General Equality Duty

    o To publish at least every four years measurable and achievable equality objectives

    o To publish annually by 30th March data and action plan for gender pay gap.

This report is our 2024 compliance with the first of these Specific Duties.

Our annual equality objectives, the second of the two Specific Duties, are on our website at https://bridgewater.nhs.uk/aboutus/equalitydiversity/ .

The Trust's gender pay gap reports can be found at https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/ and a summary on page 64.

The General Equality Duty

The General Equality Duty requires public sector organisations to have due regard to three aims in all they do:

- To eliminate discrimination, harassment, victimisation, and other conduct prohibited by the Act.

- To advance equality of opportunity between people who share a protected characteristic and people who do not, the Act states that this includes:

    - Removing or minimising disadvantages suffered by people due to their protected characteristics.

    - Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

    - Encouraging people from protected groups to participate in public life or in other activities where the participation is disproportionately low.

- To foster good relations between people who share a protected characteristic and people who do not, which includes promoting understanding of and

between different groups and tackling prejudice, racism, homophobia, transphobia, religious hatred and disability harassment and hatred.

Due regard means thinking about these three aims in all Trust business. This consideration should be robust, timely, conscious, and carried out with an open mind as to the outcomes.

Human rights

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to.

The Act sets out a series of articles, the basic rights based on the values of FREDA:

- Fairness
- Respect
- Equality
- Dignity
- Autonomy

There are three fundamental types of rights:

- Absolute rights can never be limited or restricted in any way. The right to freedom from torture and inhuman or degrading treatment is an example.
- Limited rights can be breached in certain circumstances, but breaches must be measured and proportionate. A good example in health care is the right to liberty and security, where a person may be detained under the Mental Health Act to protect their safety and that of others if there is a cause for concern.
- Qualified rights form the majority of human rights and provide the freedoms for example of thought and expression, and religion and belief. A public authority can breach these rights to protect the rights of others, but any steps taken must be proportionate and no more than necessary.

As a public authority the Trust has a legal obligation to ensure the human rights of its workforce, patients and communities are protected within the discharge of its business.

The Trust has policy, procedure, and governance in place to monitor equality and human rights impacts to ensure legal duties are met.

Equality governance

Day to day responsibility sits with the Equality & Inclusion Manager, with executive responsibility in the portfolio of the Director of People & Organisational Development.

Governance is in place that provides challenge around the equality work of the Trust and provides assurance to Board. This is as follows:

- Working Groups, including a newly established EDI Working Group, and Recruitment and Retention Working Group, all report into the People Operational Delivery Council. EDI representation is included on all groups and/or consultation takes place in delivery of new projects such as current staff competencies development.

- The People Operational Delivery (POD) Council; reporting to the People Committee the Council provides the operational management for delivery of all work related to staffing and the delivery of the Trust's People Strategy. EDI representation is a core Council member and a standing agenda item.

- People Committee. Provides assurance to Board and has delegated authority for approval from Board for decisions related to staffing. There is EDI representation on the Committee, and mandated equality reports are escalated to Board via a Chair's report from the People Committee.

- Joint Negotiating and Consultation Committee (JNCC); provides a partnership forum for workforce matters with both Management and Staff-side colleagues. An EDI update is a regular agenda item and there is EDI representation on the Committee.

- HR Policy Group; the Trust's EDI Lead is a core member of the group. All policies must undergo an equality impact assessment and are reviewed by the EDI Lead as part of policy consultation before submitting to the Group.

- Corporate and Clinical Policy Group; EqIA is a mandated element of policy development and review, and the Trust's EDI Lead is part of the standard consultation for all policies going through this Group.

- Quality Impact Assessment Panels; include equality impact risk assessments of all service changes, cost improvement plans (developed by CIP Council), and borough operational delivery plans where service pathways etc are to be redesigned.

- The Trust Board has EDI on its business reporting cycle, and through sponsorship of Staff Networks the Board are kept informed of diverse staff voice.

- Bridgewater Engagement Group. Recently re-established, the Group includes EDI representation and is providing Trust leadership on patient and community engagement, but also includes a review of staff engagement.

The Trust also reports to Halton and Warrington commissioners through quarterly assurance meetings – equality has a distinct section within the NHS Standard Contract on which compliance and progress must be reported on quarterly.

The Trust is accountable to Government Equalities Office and NHS England for progress on equality specifically in relation to:

- Workforce Race Equality Standard (WRES)

- Workforce Disability Equality Standard (WDES)

- Gender Pay Gap

- Equality Delivery System

NHS EDI Improvement Plan

The NHS EDI Improvement Plan was published in June 2023 and mandates deliverables under six high impact action areas:

1. Chief Executives, Chairs, and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

2. To embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

3. To develop and implement an improvement plan to eliminate pay gaps.

4. To develop and implement an improvement plan to address health inequalities within the workforce,

5. To implement a comprehensive induction, onboarding, and development plan for internationally recruited staff.

6. To create an environment that eliminates the conditions in which bullying, discrimination, harassment, and physical violence at work occur.

In addition to the high impact areas there are a series of deliverables against each protected characteristic group.

Mapping has been undertaken against existing Trust action plans and objectives, including those for Disability Confident, the North West Anti-Racist Framework, WRES, and WDES. The EDI Improvement Plan is now informing refresh of the Trust's EDI Strategy.

Work is being undertaken and overseen by the new EDI Working Group, with assurance and oversight through Trust governance to Board.

More information on the NHS EDI Improvement Plan can be found at
https://www.england.nhs.uk/publication/nhs-edi-improvement-plan/

Equality Strategy and Action Plans

Our current Equality, Diversity, & Inclusion Strategy 2020 - 2023, is built on the conversations we held with our Staff Networks and is aligned to national actions such as the NHS People Plan.

The Strategy, signed off with the full commitment and active support of our Executive and Non-Executive Directors, recognises that every member of staff is a key stakeholder in the delivery of the Strategic Equality Objective and action plans for Bridgewater. The aim is to ensure that equality is fully embedded across the Trust, and integral to the everyday narrative of all our staff.

The Strategy's vision, aims and principles promote a workplace and services that are compassionate, inclusive, representative, respectful, value diversity, and embed respect and support for individual contributions, needs and aspirations.

Our Strategy will be reviewed in 2024 in consultation with our staff and Staff Networks, whereby we ensure equality is an integral part of every strategy across the Trust, with its own clear narrative and commitments within each.

The current strategy can be found on our website at https://bridgewater.nhs.uk/aboutus/equalitydiversity/ .

The Trust sets annual equality objectives underpinned by action plans for delivery of these objectives. These equality objectives are the practical steps that support the Trust in achieving its overarching strategic equality objective and health equity objective. In 2023 – 2024 the equality objectives are to:

- Embed the NHS EDI Improvement Plan in Working Groups and Trust governance. Completed.

- Develop an action plan and governance for the North West Anti-Racist Framework. 31st January 2024.

- Review Equality Act 2010 compliance. 31st March 2024.

- Continue the delivery of the Accessible Information Standard action plan for patient records through national records updates. 31st March 2024.

- Provision of new language interpretation contracts for spoken/written language and signed languages. Completed.

- Draft and agree a community engagement calendar and oversight plan. Completed.

- Prepare a mid-point assessment and action plan for Veteran Aware accreditation. 31st January 2024.

- Prepare an application and action plan for silver Defence Employers Recognition Scheme. 31st March 2024.

- Draft and launch an ESR how to self-report equality guide. 31st December 2023.

- Develop and publish a Gender Diversity in the Workplace Policy and Toolkit. 31st March 2024.

- Develop and publish a Reservist Policy and Toolkit. 31st March 2024.

- Develop and publish a Reasonable Adjustments for Staff Policy and Toolkit. 31st March 2024.

- Establish a calendar for menopause café events. Completed.

- Develop governance for the Trust's Staff Networks. 31st March 2024.

Anti-Racism

Bridgewater is committed to improving race equality for our staff and our communities, and to being actively anti-racist.

We are committed to improving awareness and understanding, from an individual to a Trust level, of the ways in which many of us have benefitted from privilege and systemic racial discrimination throughout our lives.

We will as a Trust demonstrate honestly and transparency; we will admit where we have gaps in knowledge, understanding, data, representation; we will be open and honest about where we believe we can do better; and we will actively facilitate and listen to the voices of our diverse workforce and communities, recognising that Black, Asian and minority ethnic groups are not a collective whole any more than 'White British' is a group with identical views, needs, aspirations and inequalities.

We will work in true partnership with our Staff Networks and with our wider communities to develop and deliver real and sustainable plans that address racism, discrimination, and inequality.

The above statement was published by the Trust Board in 2020 and remains a positive statement of intent regarding the creation and embedding of an anti-racist culture in Bridgewater. This intent is reiterated in the Board's commitment to the regional NHS North West Black, Asian, and Minority Ethnic Assembly Anti-Racist Framework, which outlines a set of priorities and deliverables to support the development of an anti-racist culture and practice in employment and service delivery.

The Framework has been revised in 2023 to include bronze to gold attainment levels. Alongside colleagues across the North West, and with the support of the Assembly members, the Trust's Equality, Diversity, and Inclusion (EDI) Working Group is developing an action plan for submission of an application to bronze level with longer term actions to support progression through the scheme to gold level eventually.

The Trust is committed to a real collaborative journey with staff and communities with lived experience of racial inequality and racism. There are deliverables within the bronze level of the Framework that could be evidenced now, however data tells us that inequality still exists in our workforce for ethnically diverse staff, and conversations with community groups raises the barriers to access faced by diverse groups in the areas we serve. We want to dig deeper into the inequalities, undertake supportive conversations with staff and communities, so that we can gain greater understanding and through that co-design actions that have real and lasting positive impact for those affected.

About Bridgewater

As part of the Cheshire & Merseyside Integrated Care System (ICS), PLACE-based Partnerships, and Provider Collaboratives, the Trust is a key partner in the delivery of joined up approaches to improve health and care outcomes in the region.

Bridgewater provides community services in Halton (Runcorn and Widnes), and Warrington. These services include 0 – 19 services; district nursing and community matrons; therapy services including physiotherapy and speech and language therapy; and specialist services such as palliative care and mental wellbeing.

The Trust also has a number of services who deliver in St Helens and Knowsley, and our Drive Ability North West Service delivers across the North West of England.

The Trust's specialist dental services are provided across a larger area within Cheshire, Merseyside, and Greater Manchester for patients who because of differing needs and vulnerabilities are unable to access high street dental services.

Figure 1: Bridgewater Map of Services
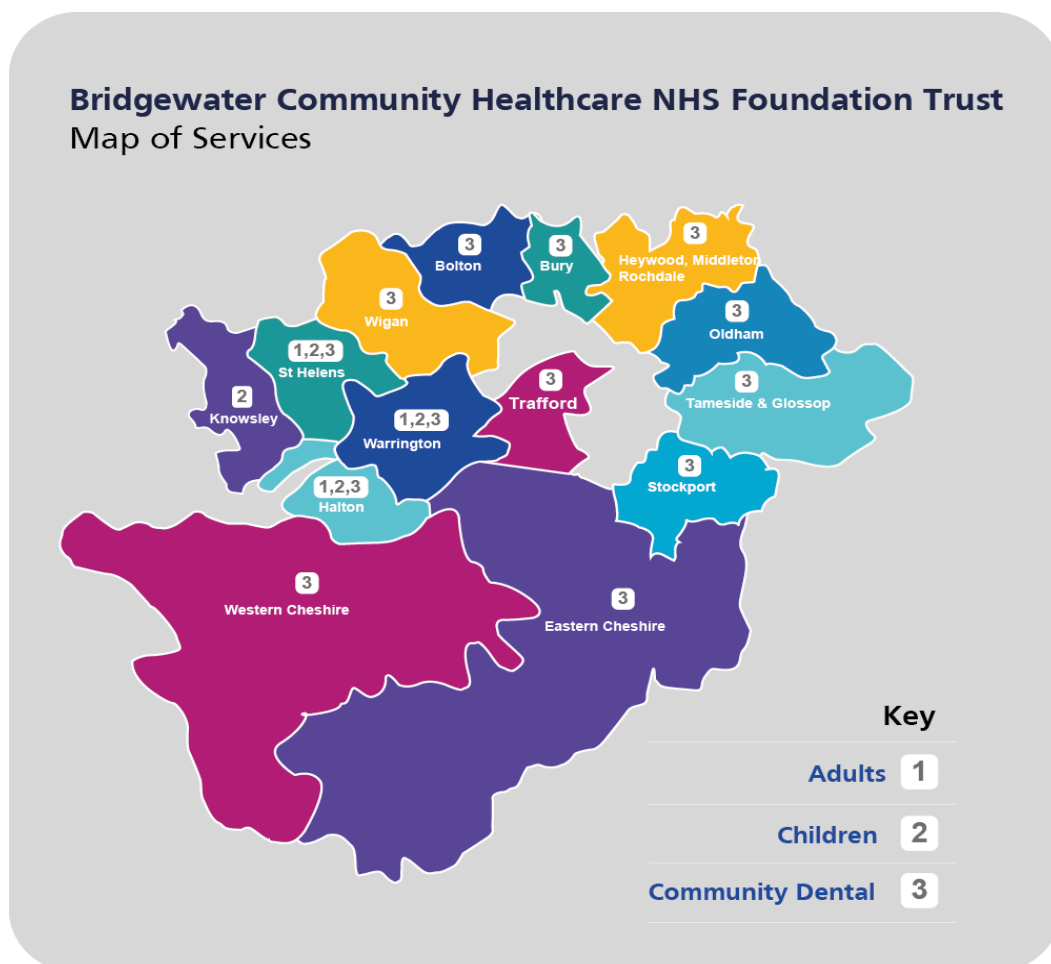
The Trust's mission is to 'improve health, health equity, wellbeing, and prosperity across local communities by providing person centred care in collaboration with our partners'.

This mission is delivered within the framework of PEOPLE values:

- Person centred.

- Empowered.

- Open and honest.

- Professional.

- Local.

- Efficient.

Figure 2: Bridgewater People Values image

Trust Strategy

In 2023 the Trust published a refreshed People Strategy and new Communities Matter Strategy.

The People Strategy is aligned to the national NHS People Plan and Our NHS People Promise and sets out a vision of a modern employment culture where staff want to work, and where they are equipped with the skills and flexibility to deliver innovative models of care.

Strategic priority 3 in the People Strategy is equality and diversity. They are to:

Pledge: We will attract and recruit a diverse workforce who aspire to work within an innovative community healthcare integrated organisation and our recruitment will select those who align to our inclusive culture and our future plans for community services (collaboration and integration)

The People Strategy commits to actions for equality and inclusion:

- Review recruitment and promotion practices to ensure staffing reflects the diversity of the communities that we serve.

- Reduce any ethnicity gaps in formal disciplinary and grievances processes.

- Become an 'Employer of Choice' across all staff groups by offering a modern employment culture, harnessing a bespoke approach to local, regional, national, and international labour markets.

- Develop a unique and flexible employment package to attract the best talent.

- Identify our 'difficult to recruit' posts and create bespoke recruitment campaigns to address these.

- Review best practice and ensure our 'offer' is reflective and responsive to the organisation's needs.

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

- Tackle health inequalities within our communities and strive to improve the quality of their lives and access to employment and services.

- Develop our on-boarding approach so that we appeal to staff with protected characteristics because we have adopted an inclusive approach to our recruitment, and we enhance the induction and preceptorship and support to all new staff.

- Complete Quality Impact Assessments (QIA) for any fundamental changes made to our workforce and service delivery, ensuring the quality of care we deliver is not adversely affected.

- Embed equality, inclusion and diversity as fundamental principles in all activities affecting current and future workforce.

The new Communities Matter 2023 – 2026 strategy builds on the previous Quality and Place Strategy developed in partnership with communities in 2018.

At its heart, the new Strategy has collaboration and partnerships, including with other NHS and care providers, voluntary sector partners, staff, patients, and the diverse communities in our regions. Aligned to the place-based priorities identified by the ICS, the Strategy commits to collectively addressing the demands and acuity of need, as well as taking positive steps to address where possible the inequity in the social determinants of health evidenced between the least and most deprived areas we serve.

The Communities Matter Strategy details the six strategic objectives of the Trust:

- **Quality** - We will deliver high quality services in a safe, inclusive environment where our patients, 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.

Further information on the Communities Matter Strategy 2023 – 2026, including context and deliverables for the six strategic objectives can be found at https://bridgewater.nhs.uk/communities-matter/ .

The Trust's Equality, Diversity, and Inclusion Strategy 2020 – 2023 is due for review and refresh in 2023, a project that is taking place in partnership with Staff Networks

and community partners at the time of writing. The refresh was held while the Trust awaited the publication of the NHS Equality, Diversity, and Inclusion Improvement Plan to ensure effective alignment with this national mandate. More information on the national plan can be found by following the link below:

https://www.england.nhs.uk/publication/nhs-edi-improvement-plan/

Staff voice

The annual NHS Staff Survey has a number of equality and inclusion related questions and provides all staff with an opportunity to anonymously feed back to us their views based on their own experiences of the workplace.

The Trust has seen a steady increase in the number of respondents every year, with more than half of all staff now completing the survey. We have observed an increasing number of responses from staff within diverse groups, notably those from ethnically diverse heritages, and staff with disabilities and long-term conditions. This is encouraging as it is critical to our aims of really understanding the lived experience of our minority groups.

Since 2020 we have been building our Staff Networks to provide a safe space for the voice of diverse groups of staff. The Staff Networks, and their Executive sponsors are as follows:

- Carers Support Network – Chief Nurse/Deputy Chief Executive

- Enabled Network – Director of Finance

- LGBTQIA+ Staff Network – Chief Operating Officer, and Trust Secretary

- Menopause Support Network – Trust Secretary

- Paths to Parenthood – new network in development

- Race Inclusion Network – Director of People and Organisational Development (Chair), Chief Executive, and Trust Chair

The Networks are also supported by the Trust's Freedom To Speak Up Guardian, ensuring that staff who raise issues can be supported to further highlight those concerns where appropriate.

The Networks will also be key partners in the new EDI Working Group, providing voice and challenge for co-design and delivery of actions plans for equity in the workplace and in services.

Other opportunities for staff to speak direct to Board include the regular Time to Shine meetings (a chance to highlight learning and good practice, and open to all staff); Time to Talk (a planned series of service/staff visits with Executive and Non-executive Directors); and Leader In Me (quarterly events open to all staff focusing on specific topics each time).
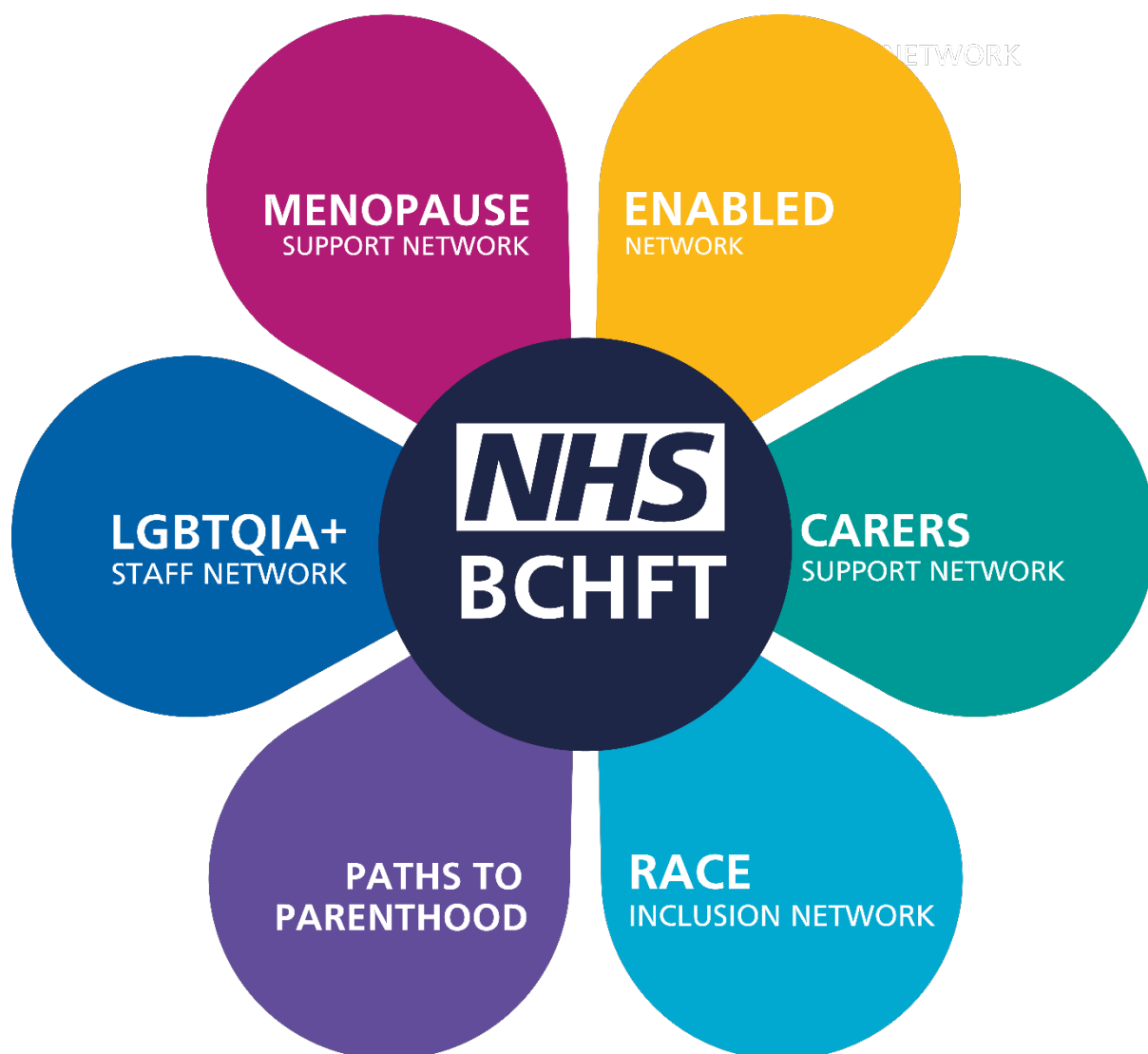
Community engagement

The Trust has a well-established Patient Experience Team who provide a key source of information and support for all patients accessing Trust services.

As the subject matter experts for patient experience the Team manage the Talk To Us survey of patients; support Trust services undertaking additional patient experience engagement; run the nationally recognised Patient Partners Programme; and are the managers of informal and formal concerns and complaints raised with the Trust.

They also collate the patient stories that are presented to Board. These are important stories that tell both of best practice and where things have gone wrong. These stories delivered direct to Trust leaders allow best practice to be shared, lessons to be learned, and resources or actions identified as needed. Patient stories can be viewed on the Patient Experience Team website at https://bridgewater.nhs.uk/patient-information/patient-stories/ .

In 2023 the Bridgewater Engagement Group has been re-established with an increased focus on engagement with communities, building on existing engagement with patients, and including staff engagement within its membership for the first time.

Engagement has started with representative groups in Trust communities, including Warrington Disability Partnership, Irish Community Care, Trinity Safe Space, and Warrington Deaf Club. The actions from each meeting are logged and then managed through the Transformation Team, in this way they are included within delivery of borough operational delivery plans.

A priority is continued engagement; not just talking once to a group but going back to provide updates on actions and to continue the conversations so that changing needs can be understood, effectiveness of actions monitored, and actions updated as necessary to ensure they achieve the outcome planned.

A calendar of engagement events for 2024 is in development, including the commitment to continue talking to the groups already met, and the calendar is seeking to ensure representation of the diversity of communities in the region.

Tackling health inequalities

As an NHS community provider, the Trust is committed to reducing health inequalities through the adoption of the Prevention Pledge and developing the role of an anchor institution.

The Prevention Pledge consists of a set of commitments whereby the Trust pledges support to achieve action on improving population health with a specific focus on prevention measures, for the benefit of staff, patients, and the wider community.

The strategic core commitments have been considered in line with commitments in the NHS Long-Term Plan, sub-regional prevention priorities, and in particular the Cheshire and Merseyside Population Health Framework. These are key to influencing multi-agency action to address social determinants of health; to ensure that as an employer, a purchaser and a local 'anchor institution' the Trust can help moderate inequalities and ensure that we tackle the relative disparities in access to services, patient experience and healthcare outcomes.

Working alongside the National Healthcare Inequalities Improvement Team and guided by Marmot principles, the Trust has developed approaches to prevention, working with partners 'at place', to address inequalities and deliver local priorities and prevention ambitions set out within the NHS Long Term Plan and in COVID-19 recovery plans.

More information on the Cheshire and Merseyside Prevention Pledge can be found at https://www.cheshireandmerseyside.nhs.uk/about/sustainability/nhs-prevention-pledge/

Due regard in employment

Due regard in employment requires us to consider the three aims of the Equality Duty in all workforce related issues, including for those potentially joining our Trust, and those who support our work through their invaluable volunteering contributions.

Data regarding our staff can be seen on pages 29 to 35, but here are the fundamental functions we carry out which support due regard in our employment actions and decisions.

- The Trust's People Strategy aligns with the national NHS People Plan and the Our NHS People Promise, both of which have equality and inclusion throughout. Priority three of the People Strategy is specific to equality, but equality and inclusion are woven throughout the priorities set out in the document. Equality and the creation of compassionate and inclusive environments for staff and patients is one of the strategic objectives within the Communities Matter Strategy.

- All Trust workforce policies undergo scrutiny for equality impact at design or review. Sign off is not given until such time as any identified potential negative impact is addressed through minimisation or elimination.

- Policy governance is overseen through the Joint Negotiating and Consultation Committee (JNCC) and People Committee, the latter providing assurance to Board. Day to day policy design and review is managed through the HR Policy Group, where the Trust's EDI Lead is a management member.

- Staff-side colleagues work closely with corporate and clinical/medical leads through the Joint Negotiating and Consultation Committee and Local Negotiating Committee (LNC). Their insight and challenge on staff issues ensures the Trust considers impact, including equality impact, of workforce policy, strategy, and plans.

- As a Disability Confident Leader, and Defence Employer Recognition Scheme Trust, we offer a guaranteed interview to any candidates who identify as disabled, or an armed forces community member on their application, and who meet the essential criteria of the role.

- All Agenda for Change job descriptions (bands 2 to 9), undergo thorough scrutiny and are evaluated through the Agenda for Change Job Evaluation Scheme. This is a process which has membership support from HR and Staff-side colleagues.

- All staff, except those in very senior leadership roles, are recruited on nationally agreed terms and conditions, either Agenda for Change or Medical and Dental.

- The Trust is increasingly utilising apprenticeship programmes as a way of offering on-the-job training and development opportunities to individuals who are new to the sector or looking to progress within their current role. The apprenticeships are proving to be powerful for promoting equality, diversity, and inclusion within the workforce and community. Increased apprenticeship opportunities are being provided for those who may have no prior experience in the sector but who have the potential to succeed and make valuable contributions to our workforce. This approach helps to break down barriers to entry and create more inclusive workplaces that reflect the diversity of our wider community.

- In addition to providing external apprenticeship opportunities, our programmes also provide existing staff with opportunities to develop and progress. This helps to ensure that all members of our staff can achieve their full potential, regardless of their background or previous experience.

- The Trust regularly engages with local partners including schools, colleges, youth organisations, and local Job Centres, to support members of our community to access our vacancies. By offering job application and interview advice and guidance, we are helping to break down barriers to entry and ensure everyone has an equal opportunity to succeed. This approach also helps to build stronger connections between our organisation and the wider community, promoting a more inclusive and collaborative working environment.

- We recognise that everyone learns differently and that some individuals may require additional support to complete their apprenticeship successfully. That is why we are committed to supporting all apprentice learners who have dyslexia or other learning needs to access and complete our programmes. By providing additional support, including access to diagnosis and workplace assessment, we are ensuring that everyone has an equal opportunity to succeed and contribute to our workforce.

- We offer our staff the opportunity to gain Maths and English qualifications, enabling them to apply for higher level apprenticeship opportunities. This approach is particularly important for promoting diversity and inclusion as it helps to ensure that everyone has an equal opportunity to progress and achieve their full potential, regardless of their previous education or qualifications.

- All staff can access occupational health services, who provide support and advice on health and wellbeing, including advice and support for staff with disabilities requiring reasonable adjustments.

- Occupational health services include counselling services available 24/7, along with trauma support services. Cognitive behavioural therapy is also available and has been utilised by staff members to manage peri-menopause symptoms.

- There are a range of other health and wellbeing support offers available, managed by the Trust's Health & Wellbeing Lead. This includes Able Futures, (the Department for Work and Pensions Mental Health Service), and Rugby League Cares sessions for individuals and teams.

- The Health and Wellbeing Organisational Development Lead and Health & Wellbeing Co-ordinator proactively work with managers and teams, engaging with colleagues around the Bridgewater Health & Wellbeing offer for support, advice, guidance and tools.

- The Trust's annual Health and Wellbeing Fortnight in 2023 featured face to face and virtual sessions that included a market stall for health and wellbeing offers, a menopause café, exercise opportunities, a Rugby League Cares session, and flu and Covid 19 vaccine clinics.

- The Trust is in the process of embedding a new annual staff review cycle which will formalise health and wellbeing conversations as part of annual staff conversations with their managers. This is in addition to informal and ad hoc conversations as need arises, and is aligned to the soon to be launched Wellbeing Policy. The new policy has been developed regionally in partnership with Trade Union Bodies. As an early adopter the Trust has supported the development of a robust policy that will provide a more holistic and person centred approach to wellbeing and sickness absence, including wellbeing passports (in addition or instead of the existing staff passport), disability leave, and the removal of absence triggers except where absence gives a cause for concern.

- In 2023 the Trust's approach to conducting stress risk assessments has undergone an audit, with actions to be taken to improve completion of individual and team assessments. Pregnancy and maternity risk assessments are well established in the Trust to support any staff member who is pregnant, or infant feeding as they return to work.

- Sickness absence is monitored through Trust governance, and includes monitoring of any trends in relation to protected characteristic groups.

- Bespoke health and wellbeing offers, for example for Black, Asian, and minority ethnic staff, are flagged to staff through Staff Network mailing lists and through the Bridgewater Bulletin. Signposting is provided to individual staff as need arises, for example Galop UK for LGBT+ phobic related incidents, and a signposting document to internal and external support is

provided on the MyBridgewater extranet and communicated regularly in the Bridgewater Bulletin.

- Flexible working is open to all staff, taking into consideration the needs of the service, and more than half of our staff work flexibly. Retire and return is also an option that many staff eligible to retire, have taken up in recent years. Other options for staff include special leave options to support family emergencies, career break options, and maternity, paternity, and shared parental leave.

- The Special Leave policy, at the time of writing, is about to be signed off. This refreshed policy includes additional paid leave for unpaid carers in the workforce, and additional leave for annual camp for reservists and cadet force adult volunteers.

- All HR policies, as part of design or planned review, are moving to a new more user friendly and person-centred format that includes toolkits to support managers and raise staff awareness to accessible advise and support as relevant to each policy.

- New policies in 2023 have included a Reservists Policy and Toolkit, and Gender Diversity in the Workplace Policy and Toolkit.

- We make reasonable adjustments for staff with disabilities, or unpaid caring responsibilities, and these can be recorded and held by the staff member in the Trust's Employee Adjustment Passport.

- A number of staff in the past year have been supported to undertake diagnosis assessments for neurodivergence. A diagnosis is not a prerequisite for support being provided in the workplace, but feedback from those staff tells us that a diagnosis can be a 'weight lifted' 'finally understanding myself'.

- In April 2021, the costs for making reasonable adjustments for staff with disabilities was centralised in line with best practice set out by the NHS Workforce Disability Equality Standard Team.

- The principles of our Just and Learning Culture programme are being continually assimilated and embedded into routine practice. In essence a Just and Learning Culture is fundamental and integral to the culture of the Trust, underpinned by an emphasis on the values and behaviours of civility and respect, kindness, and compassion. The Trust has made significant progress in reviewing and revising its human resources, employee relations policies and procedures to ensure that justice and inclusion are cornerstones of practice.

- Promotion of our Just and Learning Culture has expanded with routine delivery of training to new employees and learners in addition to the established workforce.

- Equality and inclusion, anti-racism, Freedom To Speak Up, Just Culture, health and wellbeing, and civility and respect are all elements of the mandated corporate induction attended or accessed by all new starters. In addition, training has been provided to first line managers, students, and operational managers in 2023, combining equality, Just Culture, and civility and respect into one training package.

- The Staff Networks provide an opportunity for staff to meet in a safe space to share experiences and ideas, and to provide challenge to the Trust on equality activities planned or underway. Conversations with the Race Inclusion Network for example in 2023 have supported the development of project proposals for diversity and equity representatives in recruitment, and international staff support. Both are important projects to support compliance with the NHS EDI Improvement Plan and for improvements in the Workforce Race Equality Standard.

- A lot of work has been undertaken to embed support for unpaid carers within Bridgewater. This has included the establishment of the Carers Support Network, and the drafting of a Carers Support Policy. Work has been led by the Trust's Health & Wellbeing Co-ordinator and is aligned to similar work being undertaken in relation to carers accessing Trust services or support patients who are.

- Work has continued on the development of a menopause friendly culture in the Trust with a Working Group and staff support network meeting regularly. Two face to face cafes have been held in late 2023, a new addition to the existing virtual support options; these featured speakers on understanding menopause, and menopause and mental health. The Menopause Support Policy has been in effect since 2022 and is awaiting the release of the anticipated national NHS policy for review and action as needed.

- Employment, and health and safety laws also underpin our employment practice, including providing protection and reporting processes for staff from discrimination, violence, bullying and harassment.

- Staff can report incidents through a number of channels including Ulysses (for incidents related to patients/families), through online and anonymous reporting for staff incidents, directly to HR and Staff-side colleagues, and to the Trust's Freedom To Speak Up Guardian and Champions.

- In 2023 a second Freedom To Speak Up Guardian was appointed. They sit independently from HR, but work closely with the existing Guardian in that

team. The Guardians attend the Staff Networks regularly and are supporting the new EDI Working Group. It is the aspiration of the Executive Team to have a Champion in every Trust team and communications, awareness raising, and recruitment has intensified in late 2023 to meet this aim.

- The Trust launched a new Civility and Respect training programme in 2023 based on the national NHS toolkit. This is underpinned by a refreshed Civility and Respect Policy. A Working Group (comprising HR, Staff-side, equality and inclusion, and health and safety) have developed a new communications campaign aimed at staff and those accessing services. This Working Group has aligned work on civility and respect, equality, and Violence Prevention and Aggression Standards.

- Annual data is provided by the NHS Staff Survey and through the Gender Pay Gap, and Workforce Disability and Race Equality Standards. These provide the Trust with a profile of progression across the years, and through engagement with our Staff Networks we are able to identify barriers, gaps, issues, and then agree actions to take to continue the work of eliminating any discriminatory practices, or behaviours witnessed or experienced by our staff.

- We have Quality Impact Assessment Panels that look at service changes and the potential impact on protected groups, including within the workforce, and equality impact and risk is included within this.

- We ensure due regard through robust processes that are reported through our governance structures to Board. These structures ensure that all areas of Trust business are appropriately under scrutiny, and are, most importantly, interlinked with issues arising in our People Committee - for example being brought to the attention of our Audit, Finance and Performance Committees.

Workforce data

Please see in the table below information on the workforce by protected characteristic group as at the snapshot date of 1st November 2023.

Table 1: Showing the equality demographics of all staff as at 1st November 2023

Staff in post equality demographics at 1st November 2023		
Age %	Under 21	<3.00
	21 – 30	11.02
	31 – 40	24.36
	41 – 50	25.70
	51 – 60	28.20
	61 – 70	9.38
	Over 70	<3.00
Disability %	No	81.67
	Yes	3.90
	Not Stated	14.43
Maternity %	Maternity leave as at reporting date	<3.00
Race/Ethnicity	Asian, Asian British (inc Indian, Pakistani, Bangladeshi, Sri Lankan, and other)	3.65
	Black British, Black African and Caribbean	<3.00
	Chinese	<3.00
	Mixed ethnicity	<3.00
	Other Ethnicity	<3.00
	White, (inc. White British, Irish, European, and Other)	92.20
	Not Stated	<3.00
Religion/Belief %	Christianity	44.15
	Islam, Buddhism, Hinduism, Sikhism	<3.00
	No Religion	13.82
	Other	4.69
	Not Stated/ Do Not Wish To Disclose	34.35
Note: The electronic staff record is limited to male/female/other at this time.		
Gender Identity %	Male	10.14
	Female	89.16
Sexual identity %	Heterosexual	73.93
	LGB+	<3.00
	Not Stated/Do Not Wish To Disclose	24.36
Marital status %	Married	57.23
	Civil partnership	<3.00
	Single	29.61
	Other (inc. divorced, separated, and widowed)	11.71

To provide some further details:

- Staff group:

    o Additional professional scientific and technical 6.82%.

    o Additional clinical services 16.44%.

    o Administrative and clerical 25.82%.

    o Allied health professionals 11.02%.

    o Estates and ancillary <3.00%.

    o Healthcare scientists <3.00%.

    o Medical and dental 4.87%.

    o Nursing and midwifery 33.98%.

    o Students <3.00%.

- Full time staff 52.68% and part time staff 47.32%.

- 35 countries of birth are represented in addition to the nationals from the UK, the workforce is truly global.

- Pay band:

    o 36.11% in Agenda For Change bands 2 to 4.

    o 39.34% in Agenda For Change bands 5 or 6.

    o 19.00% in Agenda For Change bands 7 to 9.

    o 5.48% in Medical and Dental pay scale.

Recruitment data

Data taken from the electronic staff record for the period 1ˢᵗ April to 1ˢᵗ November 2023 shows that:

- There were 188 new starters in total.

- 66 started part time work, 122 full time work.

- By pay band:

  o 28 were Agenda for Change band 2.

  o 36 were Agenda for Change band 3.

  o 16 were Agenda for Change band 4.

  o 56 were Agenda for Change band 5.

  o 29 were Agenda for Change band 6.

  o 15 were Agenda for Change band 7.

  o Less than 10 were recruited to higher Agenda for Change pay bands or medical and dental roles.

- By staff group:

  o 65 were in nursing and midwifery.

  o 52 were in administrative and clerical.

  o 36 were in additional clinical services.

  o 22 were in allied health professionals.

  o 13 were in other groups including medical and dental, students, estates, and healthcare scientists.

While the Trust does not actively undertake international recruitment programmes as a community organisation, we have applied for an organisational Certificate of Sponsorship to support the recruitment of people on sponsorship visas. We do currently recruit staff who have been born and trained overseas. During this period we recruited more than 10 members of staff from European, African, and South East Asian nations.

The table below shows the equality demographic breakdown of new starters in the period. Pregnancy and maternity is not detailed as during this period there were no new starters on maternity leave.

Table 2: Showing new starter equality demographic data from 1st April to 1st November 2023

New starter demographics 1st April to 1st November 2023 *Percentages less than 3% are not disclosed for data protection*		
Age %	Under 21	3.72
	21 – 30	22.87
	31 – 40	31.38
	41 – 50	19.15
	51 – 60	20.21
	61 – 70	<3.0
	Over 70	0.00
Disability %	No	62.2
	Yes	4.79
	Not Stated	32.98
Race/Ethnicity %	Asian, Asian British (inc Indian, Pakistani, Bangladeshi, Sri Lankan, and other)	3.19
	Black British, Black African and Caribbean	<3.0
	Chinese	<3.0
	Mixed ethnicity	<3.0
	Other Ethnicity	0.00
	White, (inc White British, Irish, European, and Other)	90.96
	Not Stated	<3.0
Religion or belief %	Christianity	20.21
	Islam, Buddhism, Hinduism, Sikhism	3.19
	No Religion	28.19
	Other	<3.0
	Not Stated/ Do Not Wish To Disclose	46.81
Note: The electronic staff record does not record transgender, instead is limited to male/female/other at this time.		
Gender Identity %	Male	14.89
	Female	85.11
Sexual orientation %	Heterosexual	72.87
	LGB+	<3.0
	Not Stated/Do Not Wish To Disclose	25.53
Marital status %	Married	48.86
	Civil partnership	<3.0
	Single	41.48
	Other (inc. widowed, separated, and divorced)	7.39

Leaver data

Data from the electronic staff record for the period 1st April to 1st November shows:

- 104 leavers were permanent members of staff; 11 were on fixed term contracts.

- By pay band:

    o 42 were in Agenda for Change bands 2 to 4.

    o 52 were in Agenda for Change bands 5 or 6

    o Less than 10 were Agenda for Change band 7.

    o 14 higher Agenda for Change pay bands 8 and 9, very senior managers, or medical and dental staff.

- By staff group:

    o 38 were in nursing and midwifery.

    o 30 were in administrative and clerical.

    o 20 were in additional clinical services.

    o 11 were medical and dental.

    o 16 were in other groups including allied health professionals, estates, and additional professional and scientific staff.

- 71 members of staff had less than 5 years' service with the Trust; a further 20 had between 5 and 9 years' service; 7 had 10 to 14 years' service; 6 up to 19 years' service; and 11 had more than 20 years of service.

- Reasons for leaving varied with the largest number leaving for a better reward package, and a significant number leaving to take retirement or flexi retirement. A challenge for the Trust has been not just the numbers leaving for a better reward package (which might include promotion opportunities) but also the number of 'other' reasons where nothing has been recorded on the Electronic Staff Record.

- The People Operational Delivery Group are actively addressing these issues, including removal of the 'other' option on the system; more robust exit interview processes and reporting with the opportunity to complete exit interviews with members of staff outside of the individual's line management; scoping exercises with other local providers for benefits and pay offers; enhancing our reward and recognition agenda, and work to support healthy life balances and flexible working choices.

Table 3: Showing the equality demographic data for staff leaving the Trust between 1st April and 1st November 2023

Leaver's demographics 1st April to 1st November 2023 *Percentages less than 3% are not disclosed for data protection*		
Age %	Under 21	<3.00
	21 – 30	16.52
	31 – 40	28.70
	41 – 50	17.39
	51 – 60	21.74
	61 – 70	15.65
	Over 70	
Disability %	No	84.35
	Yes	5.22
	Not Stated	10.43
Race/Ethnicity %	Asian, Asian British (inc. Indian, Pakistani, Bangladeshi, Sri Lankan, and other)	5.22
	Black British, Black African and Caribbean	<3.00
	Chinese	<3.00
	Mixed ethnicity	<3.00
	Other Ethnicity	<3.00
	White, (inc. White British, Irish, European, and Other)	87.83
	Not Stated	<3.00
Religion or belief %	Christianity	42.61
	Islam, Buddhism, Hinduism, Sikhism	5.22
	No Religion	12.17
	Other	5.22
	Not Stated/ Do Not Wish To Disclose	34.78
Note: The electronic staff record does not record transgender, instead is limited to male/female/other at this time.		
Gender Identity %	Male	89.47
	Female	10.43
Sexual orientation %	Heterosexual	73.91
	LGB+	<3.00
	Not Stated/Do Not Wish To Disclose	24.35
Marital status %	Married	48.18
	Civil partnership	<3.00
	Single	37.27
	Other (inc. widowed, separated, and divorced)	14.55

Employee relations

From 1st April 2023 to 20th November 2023 there were 16 new employee relations cases logged by the Human Resources Team. Due to the very low numbers involved in each type of case it is not possible to report here due to information being potentially personally identifiable. The low numbers also preclude the identification of statistical significance in relation to protected characteristic group representation of those involved.

Oversight of employee relations cases sits with the People Committee; this group has delegated responsibility from Board in relation to workforce issues. Regular challenge is offered around protected characteristic representation in employment relations cases, and Committee members exhibit rigour in examination of data and the steps taken to both expedite cases so that all staff are treated with compassion and fairness, and that the health and wellbeing of all staff involved is central to each case.

The Trust committed to a Just and Learning Culture in 2021, as such employee relations cases are now approached through a Just Culture process. This includes informal fact finding, lessons learned, health and wellbeing support, timeliness of actions, and it all means that only cases that truly require formal process being escalated into disciplinary, grievance, civility and respect, or other formal policy process.

NHS Staff survey

The annual NHS Staff Survey provides an important snapshot of staff experience every autumn. With results published in February/March each year the Trust is able to review the experiences of staff against a number of questions and a smaller number of themes, and this includes data available by some protected characteristic groups. This data can be viewed in the 2023 Workforce Disability and Race Equality Standard reports published on the Trust website at https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/

The Trust's Communication and Engagement Team manages the production and delivery of directorate level action plans based on directorate results for the annual survey, with themes aligning to the Our NHS People Promise. This means that directorates have action plans that include targeted actions related to the Compassion and Inclusive theme.

The Communication and Engagement Team also lead on staff engagement with a large network of Staff Engagement Champions across the Trust. While work is underway to refresh the role of the champions following the challenges of the Covid 19 pandemic, the Champions themselves continue to support engagement with their teams including fun activities to build team morale, and awareness raising events such as men's health week.

Equality accreditations

Disability Confident

The Trust was delighted to be awarded Disability Confident Leader level in March 2022. This was in collaboration with the Shaw Trust who provided leadership, advice, and final verification of evidence of progress in relation to disability equality.

An action plan is being delivered through the EDI Working Group to fill gaps, embed best practice, and further develop our employment and service delivery practices in anticipation of re-assessment in February 2025.

Figure 4: Disability Confident Leader Logo

Navajo Charter Mark

In summer 2022 we were proud to be re-accredited with the Navajo Charter Mark for LGBT+ inclusion in employment and service delivery.

Assessed externally by Navajo staff and volunteers the re-accreditation looked at current policy and practice, and progress on the action plan agreed in 2018 when first awarded the Charter Mark.

Work to deliver the action plan is through the EDI Working Group before re-accreditation in 2024.

Figure 5: Navajo Charter Mark logo

Merseyside & Cheshire LGBTIQA Chartermark

Armed Forces Friendly

The Armed Forces Act 2021 placed a new due regard duty on organisations in relation to the armed forces community, due regard to the commitments of the Armed Forces Covenant.

Bridgewater has for several years been a signatory of local covenants across our boroughs, Royal Assent of the new Act felt the time was right for the Trust to review and make its own commitments to this community. The Armed Forces Covenant was signed by Board in 2022 and set out the following additional commitments:

- **Promoting the Armed Forces:** promoting the fact that we are an armed forces-friendly organisation, to our staff, customers, suppliers, contractors and wider public.

- **Accessible health and dental services:** ensuring our services are accessible and inclusive for the armed forces community, and that there is no disadvantage suffered in accessing our services for members of the community.

- **Veterans:** supporting the employment of veterans, recognising military skills and qualifications in our recruitment and selection process; and working with the Career Transition Partnership to support the employment of service leavers.

- **Service families:** supporting the employment of service family members and providing flexibility in granting leave for service family members before, during and after deployment.

- **Reserves:** supporting our employees who are members of the Reserve Forces; granting additional leave for annual Reserve Forces training; supporting any mobilisations and deployment; and actively encouraging members of staff to become Reservists.

- **Cadet Organisations:** supporting our employees who are volunteer leaders in military cadet organisations, granting additional leave to attend annual training camps and courses; actively encouraging members of staff to become volunteer leaders in cadet organisations; and recognising the benefits of employing cadets/ex-cadets within the workforce.

- **National Events:** supporting Armed Forces Day, Reserves Day, the Poppy Appeal Day, and Remembrance activities.

The Trust was awarded Defence Employers Recognition Scheme bronze level in November 2022.

With the support of the Trust's Veteran Health Care Alliance representative, Bridgewater was delighted to be awarded Veteran Aware accredited status in February 2023. This is a significant recognition of the work undertaken so far to develop and embed armed forces friendly cultures in employment and in service delivery.

Figure 6: Defence Employers Recognition Scheme bronze award

Figure 7: Veteran Aware logo

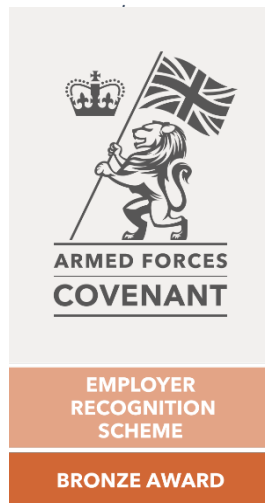Our next steps are the delivery of an action plan through the EDI Working Group to fill those identified gaps and implement a number of actions, including refresh of communications and literature produced a number of years ago.

The Trust is part of local and regional armed forces networks and is looking to develop further engagement with the armed forces community in the workforce and in the community.

Due regard in service delivery

Due regard to our patients, their families, and carers, and our diverse communities requires us to consider the three aims of the Equality Duty in all service delivery and healthcare related issues. This includes a focus on accessibility, experience, outcomes, and inequalities.

Outlined below are the fundamental functions which support and promote due regard in our employment actions and decisions:

- The Trust's Communities Matter Strategy, Trust Mission, and PEOPLE Values, all have equality and inclusion embedded. The Communities Matter Strategy details the Trust's strategic objectives, two of which relate directly to health equity, equality, and inclusion. Valuing diversity and meeting individual needs are at the heart of the Trust's delivery of community and specialist dental services.

- Equality is a regular feature on Committee agendas reporting up to Board to ensure oversight, challenge, and assurance. See Equality Governance section.

- Trust services are often commissioned quite specifically and may therefore exclude, with justifications, some members of protected characteristic groups, a good example being the differentiation of 0 – 19 Children and Adult Services. Other services require specific criteria set by commissioners, for example GP registration or particular levels/types of need. Others may be clinic based or in people's homes. In all services staff will work as flexibly as they are able to support patient access. This may include domiciliary visits from a primarily clinic-based service (where equipment etc practicalities allow), or signposting and support to other services to support access. Many services also work closely with partner organisations that may include other NHS Trusts, the local authority, and voluntary sector organisations.

- The Trust's Quality Impact Assessment Panels include standardised paperwork that includes engagement around service changes, and assessment of equality risk. The Trust's EDI Lead is a core member of the panel, and using the equality impact assessment risk guidance developed by Midlands & Lancs Commissioning Support Unit supports assessment of equality risk and due regard to the Trusts duties under the General Equality Duty.

- All Trust policies, procedures and guidelines related to patients and services have an equality impact assessment completed by the Trust's equality lead as part of consultation. Final sign off is given through the governance pathway

from the Trust's Corporate and Clinical Policy Group on to our Quality & Safety Committee and ultimately, to Board.

- All policies are drafted and reviewed by subject matter experts and are reviewed by a large consultation group that includes clinical and corporate staff. Clinical policies are taken from national best practice including NICE guidelines and the Royal Marsden Manual of Clinical and Cancer Nursing Procedures.

- Many policies relate at least in part to equality, but of particular note are the Equal Opportunities Policy, Language Interpretation Policy, Reasonable Adjustments for Patients Policy, and Violence and Aggression Policy. Policies also cover for example consent, Mental Capacity Act, and Safeguarding, which includes child sexual exploitation, female genital mutilation, honour-based violence, and other topics. All undergo equality impact assessment.

- Equality information in patient records is a challenge for the Trust with many fields related to protected characteristic data not mandated at this time. Notes regarding particular needs or concerns are regularly made in patient records, for example language, reasonable adjustments, safeguarding etc, but these aren't in a format that allows data to be pulled from records for review, and indeed data protection would mean that some of this would never be available for general review.

- As a result, the Trust committed to membership of the Cheshire and Merseyside equality collaborative some years ago. A group led by commissioning colleagues that looked at research and engagement, nationally, regionally, and locally, on barriers to access that impacted on equality for protected characteristic and vulnerable groups and took actions collaboratively to address these. Work has included the development of the quality standard for language interpretation, work on accreditation for support for the armed forces community, and ongoing work to develop a transgender patient support policy. The Trust, and the region, remain committed to collaboration on equality across the region for the benefit of staff, patients, and communities.

- At present the recording of reasonable adjustments is within the notes of patient records. With the updates to the NHS Spine/National Care Record System about to launch the Trust's ability to record and access existing information about reasonable adjustments should improve, in line with the NHS Accessible Information Standard. A Working Group is looking at developing training, a standard operating procedure, communications, and updates to existing policies in relation to this development.

- Trust records in relation to gender diversity have limitations, so Trust policy and guidance to staff details noting and using affirmed pronouns and names.

The Trust is part of the Cheshire and Merseyside equality collaborative that with engagement with local groups is developing a transgender support policy for patients – a complex piece of work due to the many medical factors that are relevant to gender across the organisations. As a Navajo LGBT+ Charter Mark holder the Trust has an action plan to improve LGBT+ equity and inclusion in services, this includes this policy along with engagement, training, and other actions. The Trust committed to NHS Rainbow Badges in 2019 and has a training module for staff to access before making their commitment to the Badges; consideration is being made to the new phase 2 accreditation scheme. Information for staff support considered the Brianna Ghey trial in late 2023 and included signposting to staff and patient support for those impacted by the trial and the publicity surrounding its outcome in December 2023.

- Work has been undertaken in services to improve the recording of marriage and civil partnership, updating legacies within record systems that were not inclusive of the diversity of family units that exist.

- Regular patient feedback from all services is through the standard Talk to Us forms.

- The Trust has a child friendly Talk To Us form in use across services and also uses SMS messaging to receive feedback after an appointment. Work is ongoing in partnership with local groups to develop a Talk To Us form for patients with learning disabilities.

- Where more formal feedback is gathered, for example complaints, the Patient Experience Team work to understand any potential equality factors and work closely with the equality lead on any lessons learned or further understanding that is needed to better address the complaint and make necessary changes as a result.

- The Patient Experience Team works with individual services on bespoke patient engagement exercises. The team also leads on the Trust's Patient Partners programme, an established programme for involvement of patients at service level in service improvements.

- We understand that patients and carers are often best placed to gauge how services are performing. Patient Partners is an approach that aims to actively encourage patients, their families and carers to work in collaboration with services to identify areas for improvement in quality of care and service delivery. A network of clinical staff meets regularly to discuss and share good practice in involving patients and carers in service improvement activities. The network aims to ensure all services continually listen to the unique insight of patients and carers in order to inform service development and to improve patient care and service quality.

- Individual services undertake engagement with local groups and with patients. For example for the redesign of the neurodevelopment diagnosis pathway in Warrington the children's service is engaging with WARPAC and with the local authority and schools to gain views and feedback and share information on the proposal.

- Patient experience reports are collated monthly and shared within governance structures, through to Board. Patient stories are a regular Board agenda item, both good news stories, and stories where things may not have gone to plan, and lessons have been learned through governance reviews.

- The Trust also engages at place level with partners in the Integrated Care Board/Integrated Care System, provider collaborative, and equality groups such as local armed forces networks. The Trust also has links with local Healthwatch organisations and is working to better engage with them in a supportive partnership.

- The North West and Cheshire and Merseyside regions are fortunate to have strong and support equality networks for leads, bringing together information, best practice, and issues from across the region, including from engagement with voluntary sector and patient groups.

- Engagement with local voluntary groups representing protected characteristic and vulnerable groups has commenced in 2023 and includes Irish Community Care, Trinity Safe Space, and Warrington Deaf Club (whose members include Halton residents). The information provided in this engagement is noted within public engagement trackers that are held by the transformation team who support services in delivery of borough operation plans, themselves aligned to the Trust's strategic objectives. There is a commitment in the public engagement work to continue to engage with the same groups, and feedback actions undertaken as a result of conversations held.

- The Trust has a strong focus on the 'voice of the child' and has published information and training to support staff in this important area. The webpage introduction states:

  - *The voice of the child is a phrase used to describe the real involvement of children and young people. It means more than seeking their views, which could just mean the child saying what they want, rather than being really involved in what happens. Lord Laming said of Victoria Climbié that no-one could describe a day in her life.*

  - *Children and young people should have the opportunity to describe things from their point of view. They should be continually involved, and have information fed back to them in a way that they can understand.*

- o *There should always be evidence that their voice has influenced the decisions that professionals have made. Voice of the child can help others gain a sense of a child's life experience.*

- o *Understanding the life experience can help professionals make the right decisions for children.*

- Professional curiosity is a further programme of work, this time led by our Safeguarding Team, that teaches clinicians to look further and explore holistically the factors influencing the health and wellbeing of an individual or family.

- Incident reporting is embedded across the Trust. The NHS Staff Survey asks questions about the reporting of incidents and staff feeling safe to do so. The Trust recognises the difference in responses for some protected characteristic groups, and through the Staff Networks and recent Freedom To Speak Up engagement activities the Trust is working to improve staff confidence and awareness of reporting of any incidents of concern. Differential responses for disabled and ethnically diverse staff for every staff indicator in 2023 was presented to Board in August.

- The Trust's Leader in me event that took place in December 2023 focused on us each having a voice that counts, and the various ways and means by which staff can raise concerns.

- Incidents are monitored through the quality governance structure of the Trust to Board, with RCAs undertaken, and lessons learned shared with all staff in Bridgewater Bulletins.

- The Trust's Just Culture programme is a key part of improving patient safety and experience, with its focus on improving staff reporting of incidents and near misses, and the informal initial approach and ongoing wellbeing focus to embed psychological safety for staff. 60 ambassadors were trained as the programme started to be implemented. This includes the EDI Lead, HR Team, service and operational leads, and the Head of Risk. These ambassadors had a role supporting the delivery of action plans to embed a Just Culture across the Trust. Work continues and is now aligned to the Patient Safety Incident Response Framework work plans.

- The Trust is actively working to embed policy and practice to implement the new NHS Patient Safety Incident Reporting Framework which will replace existing serious incident reporting processes in 2023/24. This work is led by the Board with representatives from across the Trust, including engagement with the equality lead.

- The Trust's approach to transformation and quality improvement is known as the BOOST (Building On Our Strengths Together) programme. The approach features a strong ethos of staff inclusion and engagement, with programmes of work being agreed and developed from the "bottom up" – usually starting with a series of staff workshops that are open to staff at all levels within the organisation, where ideas are gathered to form the basis of directorate and service work streams.

- BOOST's methodology is based on NHS England's Change Model, using simple PDSA (Plan, Do, Study, Act) cycles to drive change, and is supported by the Trust's Transformation Team. Upon creation of a transformation or quality improvement plan, follow up staff workshops are arranged, to ensure that staff engagement remains central to the steering and delivery of the plans.

- Progress with transformation and quality improvement plans are monitored by the Trust's Transformation Council to ensure appropriate governance is in place, and that plans have high visibility within the organisation.

- All Trust staff must undertake mandatory training, of which some is standard for all and some role specific. This includes equality eLearning every three years that covers legislation and also scenario-based learning.

- Training recommendations are governed through the Education Governance Group, part of the quality and people governance structures, to ensure all training is appropriate and of high quality.

- Additional training may be identified through reviews and incidents, for example a safeguarding review in Halton has identified a training need in relation to Gypsy, Roma, and Traveller communities, training that is being developed for the 0 – 19s services in Halton and Warrington with Irish Community Care.

- Civility and respect and violence prevention are key priorities in the Trust, with work already referenced being undertaken on a refresh of messages, policies, and training. This includes these behaviours towards patients from staff and from other patients/members of the public. While reports of these behaviours towards patients are very low in the Trust we are working hard to ensure through engagement and other work that this is an accurate reflection rather than an unwillingness or barrier to reporting for protected characteristic groups in services.

- https://www.bridgewater.nhs.uk/wp-content/uploads/2018/07/Bridgewater-Patient-charter.pdf

- The Trust has in development new resources regarding civility and respect. At present zero tolerance posters are available for display in services, but these need to align the new civility and respect toolkit and violence prevention and reduction standard. A Working Group that includes HR, EDI, health and safety, and risk have worked together to update and align the policy, develop new communication resources, and develop and start to deliver training.

- The Trust Board has committed to the NHS North West Anti-Racist Framework and is working towards an application for bronze accreditation in the coming months, this is being led by the EDI Working Group. The Trust could potentially apply for accreditation more quickly than this, but we want to fully engage with our staff with regards to lived experience and embed their experiences, ideas, and concerns in actions that will fundamentally address race (in)equity within the structure of the Trust. While predominantly about employment the Framework does have a limited number of service facing deliverables, and of course good employment is one of the Marmot social determinants of health. Through engagement with the Trust's Race Inclusion Staff Network, with local voluntary groups, and alignment with Anchor Institute/Health Equity leads in the Trust the intent is to deliver actions that will support both workforce and the communities in which they live.

- Regular communications are issued to all staff regarding anti-bullying and harassment, racism, LGBT+phobia etc to raise awareness and provide signposting to support. Freedom To Speak Up is also aligned to EDI to provide additional reporting routes.

- All Trust services can access language interpretation for spoken and signed languages. At present other formats such as Makaton, Easy Read and Braille are sourced ad hoc as the Liverpool Framework for these lots is finalised. In house the Trust has specialist learning disability support in Halton through the Community Matron Team who advise and supports services in relation to access and support for learning disabilities patients in the borough. Work is underway to look at how patients can access Trust services via the interpreter services themselves, becoming more of a two-way source of access support. Please see Appendix 5 for our language interpretation usage in 2023.

- AccessAble have produced access guides to some Trust clinics through Community Health Partnerships, our landlord in some services. These are available on their website, and the Trust is looking to engage with AccessAble about guides for our Trust owned buildings in 2023-2024.

- A Patient Led Assessment of the Care Environment (PLACE) took place at Widnes Urgent Treatment Centre in September 2022. PLACE involves local people (known as patient assessors) going into healthcare settings to assess how the environment supports the provision of clinical care. An action plan

based on patient assessors' recommendations is currently being worked through by the Operational Manager of the Urgent Treatment Centre and the Estates team. The action plan is monitored at the Borough Quality meetings.

- The Trust is a Disability Confident Leader, and while this relates mostly to employment there are indicators relevant to service delivery, and the action plan notes these, including accessible information/reasonable adjustment records, and patient engagement.

- The Trust's internet has been refreshed in 2022, based on national accessibility guidelines. The website hosts ReachDeck accessibility software that allows patients to tailor their view to best suit their needs, whether this is translation, screen masks, text to speech, or creation of MP4 files.

- The house writing guide for leaflets and patient information was refreshed in 2022 based on national accessibility guidelines. The new templates are created to allow easy access using digital technology, but paper copies, translations and other formats will always still be produced based on patient need.

- All staff can access information and advice about different needs in health care including those related to religion (this includes annual Ramadhan advice through the relevant month of fasting).

- Trust teams undertake regular communications and awareness raising to ensure all staff are aware of diverse need and experience. This includes annual religious and cultural events such as Ramadan, Diwali, and Spring Festival, and also awareness raising such as hate crime awareness, violence against women, and safeguarding children.

- The Trust launched its new Carers Strategy in 2023 and implemented service changes to ensure that carers attending services with loved ones or as patients themselves are identified, recorded, and signposted as appropriate to support services. Staff training has been rolled out to support this development. https://bridgewater.nhs.uk/aboutus/information-for-carers/

- The Trust was awarded Defence Employers Recognition Scheme bronze, and Veteran Aware accreditation in late 2022, action plans are in place to ensure progression/re-accreditation as the Trust works to remove barriers to access for the armed forces community, and to improve equity and inclusion for the community in services and employment. This supports the new legal duty of due regard to the Armed Forces Covenant.

- Trust services work actively with asylum seekers housed throughout the boroughs, and signpost and support registration with services as needed to ensure barriers to accessing NHS services are removed or minimised.

- The Community Health and Wellbeing Worker Programme is a new model of care that provides universal and integrated geography-based outreach in peoples own homes, based on the Brazilian Family Health Strategy model. It is currently running within the Oakwood area of Birchwood, which according to the Index of Multiple Deprivation is ranked in the top 20% of the most deprived areas in the UK. This is a proactive approach, whereby the Community Health and Wellbeing Workers actively seek out engagement in the service at a household level, thereby allowing for the discovery of unmet health needs, with the ultimate aim of reducing inequality. Employment requirements are kept to a minimum to allow for increased diversity in the team of Community Health and Wellbeing Workers, with the aim of employing as locally as possible.

- In autumn 2023 the Trust appointed the first voluntary sector Link Workers following engagement with voluntary sector groups during 2023. Employed by the voluntary sector and working within Bridgewater the role is designed to link Trust services to voluntary sector organisations, providing a link for signposting and linking to opportunities such as social prescribing opportunities in our boroughs.

- Research is important in the Trust with clinical and corporate staff supported to undertake individual and collaborative research, with the updates made in National Institute for Health and Care Research impact on inequalities is embedded in review of research proposals regionally. The Warrington Neurosciences service have in 2023 successfully bid for funding for two projects looking at inequality in Warrington.

- Staff are supported by the internal Library Service who advise on updated NICE guidance, changes to legislation, current news, and who provide an invaluable source of support in developing the patient policies, procedures, and guidelines.

- The Trust's services are effectively supported by our Safeguarding Teams, with staff and named nurses working collaboratively with outside agencies to ensure the most vulnerable in our communities are identified and supported.

- There is robust health and safety, and risk management in place with policy, training, and governance to ensure the safety and wellbeing of staff and patients accessing services, this includes processes around violence and aggression prevention, reduction, management, and support.

- As a Trust committed to becoming an anchor institute the public health lead for the Trust is leading, with executive support, on action plans in relation to this. This is being aligned to workforce EDI work and to the public engagement taking place.

- In 2023 it was agreed with Cheshire and Merseyside commissioner colleagues that three Trust services would undergo equality review and grading through the Equality Delivery System (EDS). These were Urgent Treatment Centre Widnes (Halton), Podiatry Warrington, and Bath Street Dental Warrington. The domain scores can be seen in appendix 1, and the full evidence report can be viewed at https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/ .

- As referenced previously the Trust has refreshed and re-launched its Bridgewater Engagement Group, and work has begun on engaging with representative groups in the community. However, in 2023 this was not aligned to EDS stakeholder review and grading, and as a result we want to thank Healthwatch colleagues in Halton and Warrington for providing the necessary peer review for domain 1.

- As stated earlier in the report the Trust was awarded a number of accreditations in 2022 that recognise equality in service delivery, and action plans are being implemented to continue to improve in these areas.

Governors

As an NHS Foundation Trust we have some devolved decision making authority, with our members and governors supporting and challenging the Trust in our strategy and how we operate and run services.

Our members can be service users, carers, staff, and other local people interested in Bridgewater. They represent the areas in which the Trust delivers services, i.e. Halton, Warrington and those parts of the North West region where we provide community dental services including Bolton, Oldham, Rochdale, Bury, Ellesmere Port, St Helens, Widnes, Warrington and Leigh.

We strive to ensure our members are representative of the communities in which they live. When recruiting members we pay due regard to the diversity of an area and endeavour to encourage people from a diverse range of groups through targeted engagement with local groups.

Our public governors are elected by our members to undertake specific roles, including the appointment of the Trust Chair and non-executive directors, and holding the Board to account on decision making and progress; we make every effort to encourage diversity in applications to public governor roles as they are advertised.

Our staff governors are elected by our staff members. Again, we are seeking to harness the knowledge of our colleagues who are members of our Race Inclusion Network, Enabled Network, and other Staff Networks, by encouraging them to consider standing for election in 2023.

It is important our Council of Governors is reflective of the communities they serve and the staff they represent, and we make every effort to consider the diversity of the towns where we deliver services. We remain cognisant of the need to encourage greater representation of culturally diverse and challenged sectors and shall be working closely with those groups in the months to come.

Local demographics

Based on 2019 ONS income deprivation mapping.

In Halton 18.5% of the population was defined as income deprived in 2019, and the authority is the 31st most income deprived local authority in England:

- 35 of the 70 neighbourhoods in Halton are in the 20% most deprived in England.

- 12 of the 79 neighbourhoods in Halton are in the 20% least deprived in England

Figure 8: Showing a map of socio-economic deprivation in Halton
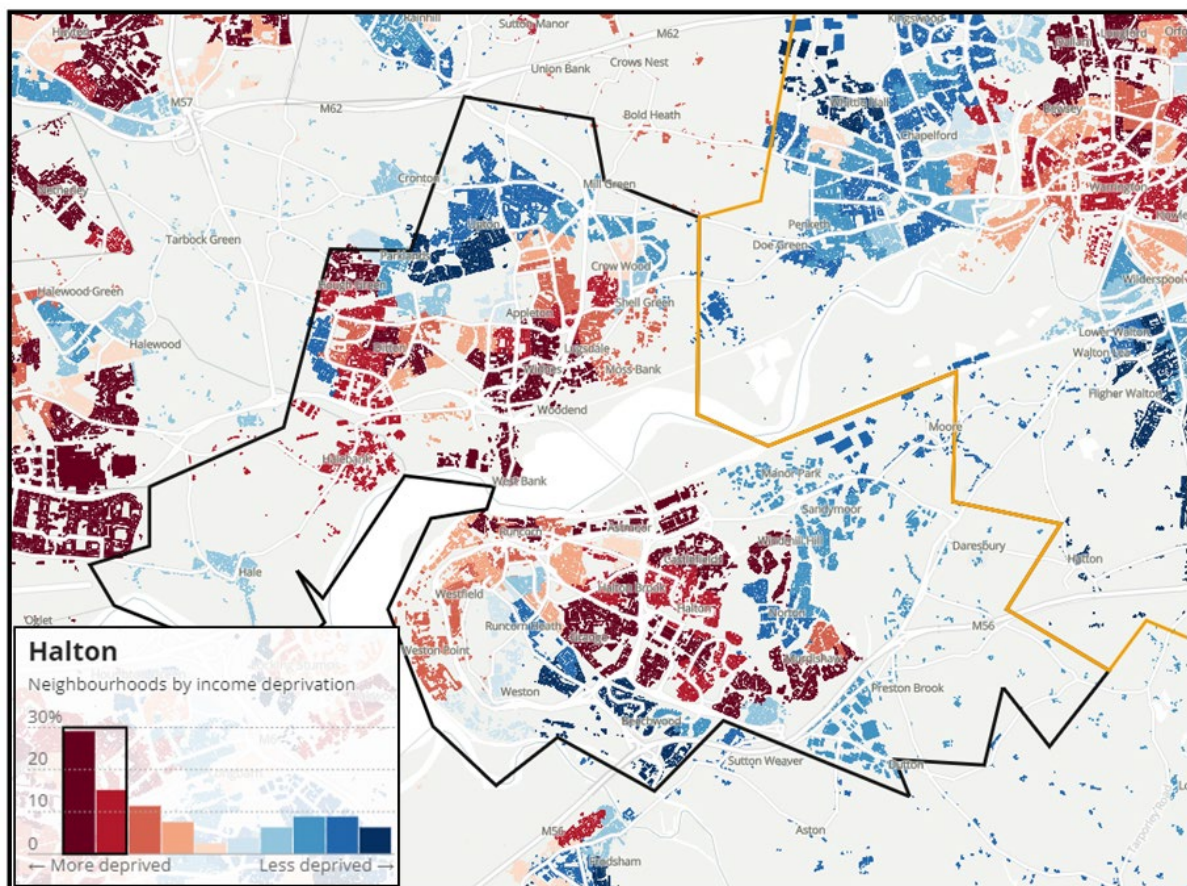
In Warrington 10.9% of the population was defined as income deprived in 2019, and the local authority was ranked 153rd most deprived in England (out of 316 local authorities:

- 22 of the 127 neighbourhoods in Warrington were ranked in the 20% most deprived in England.

- 40 of the 127 neighbourhoods were ranked in the 20% least deprived in England.

Figure 9: Showing a map of socio-economic deprivation in Warrington
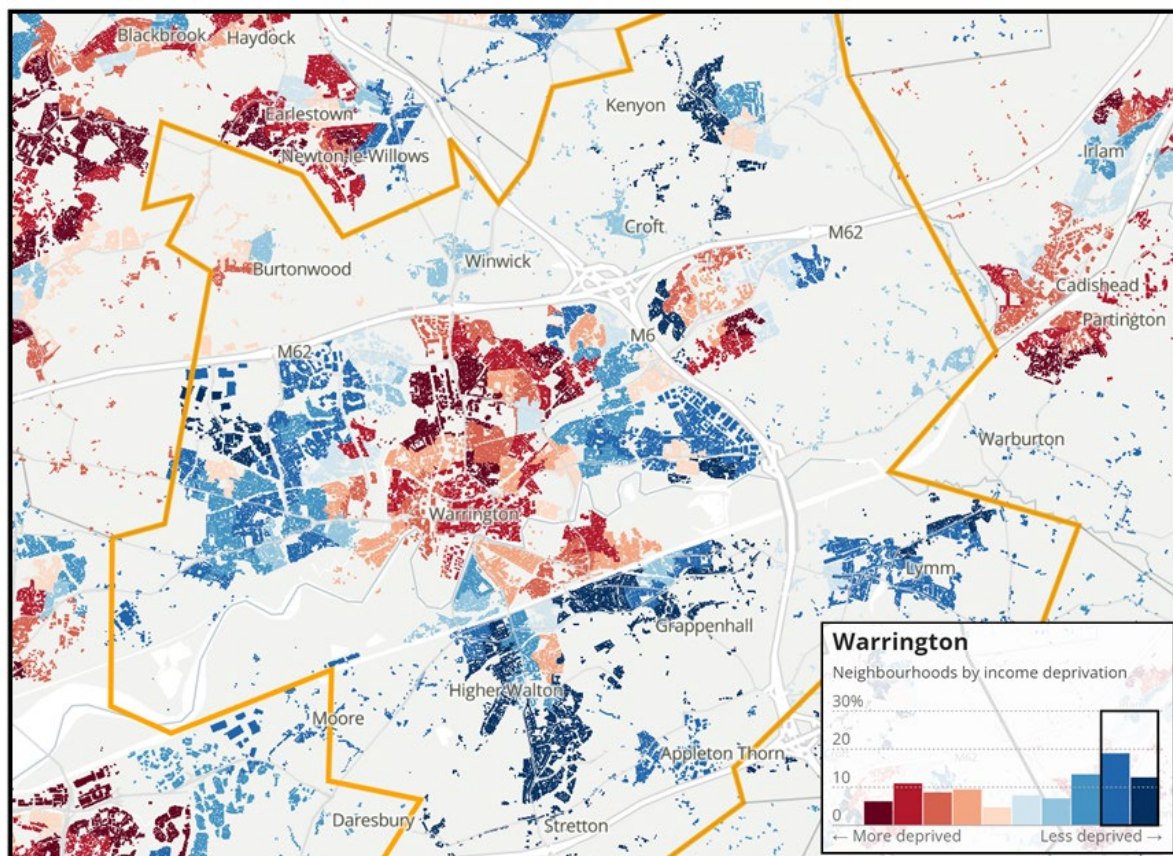
Population Data Halton:

Census 2021 data tells us that:

- The Halton population is 128,478.

- 51% are female, and 49% male.

- 19% of the population were under 16, a further 4.3% under 20, and 19.7% were aged 65 or over.

- 42% were married or in a civil partnership.

- 96.5% were white, and 3.5% from ethnically diverse heritages.

- 3.0% identified with a non-UK national identity solely.

- 58.6% identified as Christian, with 1.6% identifying with other religions.

- 95.2% were UK born, with 1.8% identifying as born outside Europe, the majority in the Middle East or Asia.

- 0.4% of households had no adult residents with English as a first language, and a further 1.7% of households with no residents with English as a first language.

- 55.1% were employed, with 2.7% unemployed, 22.1% retired, 3.8% students, and 14.5% economically inactive due to disability/ill health, caring responsibilities, or other reasons.

- 2.6% identified with diverse sexual identities.

- 208 residents identified as trans, non-binary or another gender identity.

- 10.7% identified as disabled under the legal definition of such, a total of 13,770 residents.

- 6.6% of residents provided 20 or more hours of unpaid care for a loved one.

- 5,000 residents identified as an armed forces veteran or service leaver having served in the regulars and/or reservist forces.

2021 Census Profile
for areas in England a

The public health profile for Halton shows inequality in:

- Life expectancy at birth.

- Under 75s mortality rate for cardiovascular disease.

- Emergency emissions for self-harm.

- Hip fractures in the over 65s.

- Alcohol concerns.

- Obesity.

- Teenage conception.

- Smoking during pregnancy.

- Breastfeeding rates.

https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132701/pat/6/par/E12000002/ati/302/are/E06000006/yrr/1/cid/4/tbm/1

The child health profile for Halton shows inequality in:

- School readiness.

- Children in care.

- Obesity.

- Dental decay.

- Teenage conception.

- Alcohol under 18s.

- Substance misuse in 15 to 24 year olds.

- Smoking during pregnancy.

- Breastfeeding.

- Emergency admissions in under 4s (worst in country).

- Other hospital admissions in children and young people.

https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133228/pat/6/ati/402/are/E06000006/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

Population Data Warrington:

Census 2021 data tells us that:

- The Warrington population is 210,974.

- 50.5% are female, and 49.5% male.

- 18.1% of the population were under 16, a further 4.1% under 20, and 19.0% were aged 65 or over.

- 46.9% were married or in a civil partnership.

- 93.5% were white, and 6.5% from ethnically diverse heritages.

- 5.8% identified with a non-UK national identity solely.

- 56.7% identified as Christian, with 3.4% identifying with other religions, the predominant being Muslim.

- 90.6% were UK born, with 3.8% identifying as born outside Europe, the majority in the Middle East or Asia.

- 0.8% of households had no adult residents with English as a first language, and a further 3.7% of households with no residents with English as a first language.

- 58.3% were employed, with 2.3% unemployed, 23.1% retired, 3.6% students, and 10.7% economically inactive due to disability/ill health, caring responsibilities, or other reasons.

- 2.5% identified with diverse sexual identities.

- 402 residents identified as trans, non-binary or another gender identity.

- 7.6% identified as disabled under the legal definition of such, a total of 16,091 residents.

- 3.6% of residents provided 20 or more hours of unpaid care for a loved one.

- 6,875 residents identified as an armed forces veteran or service leaver having served in the regulars and/or reservist forces.

2021 Census Profile
for areas in England a

Public health profile for Warrington shows inequality in:

- Life expectancy at birth for some groups.

- Under 75s mortality from cardiovascular disease.

- Emergency admissions for self-harm.

- Hip fractures in the under 65s.

- Alcohol admissions in under 18s.

- Obesity.

- Breastfeeding.

- Violence crime.

https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132701/pat/6/ati/302/are/E06000007/iid/90366/age/1/sex/1/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

Child health profile for Warrington shows inequality in:

- Homelessness.

- Dental decay.

- Alcohol under 18s.

- Substance misuse in 15 to 24 year olds.

- Breastfeeding.

- Various hospital admissions in children and young people.

https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/ati/402/are/E06000007

Patient feedback

The Trust's Patient Experience Team provide leadership and day to day management of patient feedback; this includes the Talk to Us Form returns, questions, compliments, and formal and informal complaints.

All services are required to seek patient feedback through the Talk to Us forms, which are available as in a paper format, as a text message, and in a child friendly version, and in development is an Easy Read form in co-production with local learning disabilities groups.

The data is collated monthly and shared within governance structures up to Board, where patient stories are also regularly shared – see page https://bridgewater.nhs.uk/patient-information/ .

The team works closely with the EDI Lead to ensure any potential equality factors are identified in questions submitted or complaints raised. There have been no identified equality related complaints in 2023.

Table 4: Showing patient feedback data from 1st January to 30th September 2023

January - March 2023	
Percentage of patients who rated their experience good or very good	95.8%
Compliments received	4,938
Contacts received – informal concerns, signposting, liaison, and advice/information	270
Informal concerns Treatment Rooms (5) Health Visiting (3)	17
Formal complaints Paediatric Community Medical Service (4)	9
Joint complaints	1
MP letters Paediatric Community Medical Service, Warrington (2), Dental, Warrington (1)	3
Complaints referred to the Parliamentary and Health Service Ombudsmen	0
April – June 2023	
Percentage of patients who rated their experience good or very good	95.7%
Compliments received	3,532
Contacts received – informal concerns, signposting, liaison, and advice/information	285
Informal concerns Halton (17) Warrington (28) Dental (7)	52
Formal complaints Halton (6) Warrington (6)	12

Joint complaints	1
MP letters Paediatric speech and language service, Warrington	1
Complaints referred to the Parliamentary and Health Service Ombudsmen	0
July - September 2023	
Percentage of patients who rated their experience good or very good	96.0%
Compliments received	4,997
Contacts received – informal concerns, signposting, liaison, and advice/information	298
Informal concerns Adult Services: Halton (5), Warrington (5) Children's Services: Halton (3), Warrington (6) of which seven relate to Children's Specialist Services: Paediatric Community Medical Services (5): Halton (3), Warrington (2), Children's Neuro-developmental Service (2) and four relate to Dental Services: ORB (3), Stockport (1).	23
Formal complaints Halton (3), Warrington (5), Dental (1)	9
Joint complaints Urgent Treatment Centre Halton (2), Intermediate Care Warrington (1), Health Visiting/Paediatric Speech and Language Therapy/Paediatric Community Medical Service Warrington (1)	4
MP letters District Nursing/Community Matrons Halton (1), District Nursing Warrington (1)	2
Complaints referred to the Parliamentary and Health Service Ombudsmen	

Borough plans

The borough operational delivery plans have been developed for 2023/24 aligned to the Trust's six strategic objectives with actions identified based on data, local and national priorities, and staff and patient engagement.

Each Trust directorate has an operational delivery plan:

- Childrens

- Halton Adults

- Warrington Adults

- Dental

The plans include an introduction, current context, achievements in the previous year, and identified priorities. The plans were reviewed by the Trust's EDI Lead prior to finalising to provide an equality impact assessment of the planned actions.

As the Trust has a strategic objective for health equity, and one for EDI, each plan has deliverables targeted at these areas.

Childrens:

- Warrington Health and Wellbeing Hub

- Halton Health and Education Hub

- Development of a children, young people, parent, and carers participation plan

Halton Adults:

- To explore service-user access to the Widnes Urgent Treatment Centre (UTC). Enabling us to ensure services are targeted at those most in need, to enhance outcomes and improve the health and wellbeing of local population.

- To continue to work with system partners to develop an enhanced Heart Failure Pathway within Halton- improving care and health outcomes for those patients with Heart failure and their carers and families.

- To develop and implement a high quality, safe and effective Enhanced Care Home Support Service Model in Halton which will enhance care home delivery, improve outcomes, and support a reduction in unnecessary hospital admissions.

- We will prioritise all services users including the most vulnerable people that access our services.

- To strive to secure a healthy and diverse workforce.

- We will continue to improve the reach of our organisation and grow our standing in the community through local partnerships.

Warrington Adults:

- Intermediate Care Services – Community. This workstream has several strands and includes the ongoing service improvement between Warrington Borough Council IMC at Home service and the IMC therapy service, further development of the integrated management and governance structures and redesign of the community rehabilitation and falls service within the IMC landscape.

- Neurosciences Service. Functional Electrical Stimulation (FES) Project. The use of electrical stimulation has been recommended in the RCP guidelines for the upper and lower limb (RCP, 2018). There is currently only one clinician trained in this modality and there are long waiting lists.

- Neurosciences Services. Provision of splinting – external funding has supported the development of the service for specialist thermoplastic splinting for upper and lower limb dysfunction.

- Warrington One Front Door (OFD). This is a project led by Warrington Borough Council, we are a key partner and fully signed up to this approach through our collaborative Warrington Together.

- Patient Involvement and Engagement

Dental:

- Implement the place - based Safeguarding/Advocates roles

- Collaborate with HEE, to host a second year of Foundation Dental Therapists: and expand our offer to hosting Foundation Dentists

- Implement a paediatric GA pathway at Oldham General Hospital for Oldham, Rochdale and Bury.

- Ensure a high quality, responsive interpreter service is procured.

Appendix 1 – EDS2023

The Equality Delivery System, or EDS, was refreshed by NHS England in 2022 to provide a simplified, easy to use toolkit for co-delivery with stakeholders from patients, communities, the workforce and Staff-side, and for domain 3 peer support organisations.

In domain 1 the outcomes have remained largely the same, with clearer deliverables now provided to be evidenced against. These look at access, outcome, safety, and experience of diverse patients and communities accessing services.

Domain 2 has been updated to take account of the inequality clearly evidenced in the disproportionate impact of Covid 19 on ethnically diverse communities, and those with underlying health conditions. EDS now supports the outcomes of the WRES and WDES by supporting organisations to make the connections between race and disability inequality and discrimination and health and wellbeing. The other seven protected characteristic groups and other vulnerable groups are of course also included in evidence gathering and review.

Domain 3 remains focused on the inclusive behaviours and messages of Trust leaders and how equality governance and oversight is managed within the Trust.

The 11 outcomes of EDS2023 cover three domains:

- Commissioned and provided services.

- Workforce health and wellbeing.

- Inclusive leadership.

Three services were agreed with Halton and Warrington commissioners for 2023 review in domain 1:

- Urgent Treatment Centre Halton.

- Podiatry Warrington.

- Bath Street Dental Warrington.

Engagement for evidence review and grading was undertaken with stakeholders from Staff-side and Staff Networks for domain 2, and peer review was given by local Healthwatch representatives for domain 1, and Wirral Community Health and Care NHS Foundation Trust equality colleagues for domain 3, with heartfelt thanks to all.

The full EDS20232 report can be viewed on our website at https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/ but results are detailed below.

EDS2023 Domain and Outcome	Rating
Domain 1: Commissioned or provided services	
1A: Patients (service users) have required levels of access to the service	Developing
1B: Individual patients (service users) health needs are met	Developing
1C: When patients (service users) use the service, they are free from harm	Developing
1D: Patients (service users) report positive experiences of the service	Achieving
Domain 2: Workforce health and wellbeing	
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions	Achieving
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Achieving
2C: Staff have access to independent support and advice when suffering stress, abuse, bullying, harassment, and physical violence from any source	Achieving
2D: Staff recommend the organisation as a place to work and receive treatment	Achieving
Domain 3: Inclusive leadership	
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Achieving
3A: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Achieving
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Achieving
Overall rating	**Developing** **(total score of 19)**

Appendix 2 - Gender Pay Gap 2023

The full report for Gender Pay Gap at 31st March 2023 can be found on our website, but please see below in brief our 2023 results.

Table 6: Showing Gender Pay Gap results for 31st March 2023

	March 2019		March 2020		March 2021		March 2022		March 2023	
Number of male and female staff in quartiles 1 to 4										
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
1	660	57	397	44	370	50	371	50	328	44
2	621	61	416	24	397	23	391	30	347	24
3	626	42	415	25	392	28	395	26	343	29
4	707	97	373	67	364	56	367	54	316	55
Mean Gender Pay Gap										
Percentage %	22.38		25.35		16.14		14.45		15.97	
Cost £	4.53		5.56		3.26		2.95		3.48	
Median Gender Pay Gap										
Percentage %	1.54		9.19		2.37		0.34		3.16	
Cost £	0.23		1.56		0.38		0.06		0.55	
Bonus pay										
Percentage %	No bonus pay gap, all clinical excellence awards to female staff in relevant period								0.00	

Appendix 3 – Workforce Disability Equality Standard 2023 (WDES)

The full report for WDES 2023 can be found on our [website](#), but please see below in brief our 2023 results.

Table 7: Showing the WDES results for 2023

Metric						
1. Percentage of staff in each AfC Band 1-9 or Medical and Dental pay grades, compared with the percentage of staff in the workforce overall. Disaggregated by non-clinical staff, clinical staff, and medical and dental staff. *Note rounding up of numbers may mean a slightly higher figure than 100% is seen in the below.*						
	Non-clinical			**Clinical**		
	Disabled	**Not Disabled**	**N/S**	**Disabled**	**Not Disabled**	**N/S**
AfC1 - 4	5.5	82.2	12.3	1.7	78.8	19.5
AfC5 - 7	2.3	79.1	18.6	3.1	82.3	14.1
AfC8a – 8b	0.0	83.9	16.1	5.1	64.4	30.5
AfC8c - VSM	10.0	70.0	20.0	2.8	80.6	16.6
	Medical and Dental Grades:					
Consultants	0.0	80.0	20.0			
Non-Consultant Career Grade	1.4	78.8	19.7			
Trainee Grades	0.0	0.0	0.0			
2. Relative likelihood of being appointed from shortlisting across all posts	1.0 times – equity between disabled and not disabled applicants					
3. Relative likelihood of entering capability processes	No formal capability procedures related to performance No formal capability procedures related to ill health for staff with a disability					

Metric - continued

4.	**A) Percentage of staff experiencing bullying, harassment, and abuse from patients/relatives/public in last 12 months**	25.4% Disabled 20.8% Not Disabled
	Percentage of staff experiencing bullying, harassment, and abuse from managers in last 12 months	10.4% Disabled 6.6% Not Disabled
	Percentage of staff experiencing bullying, harassment, and abuse from staff in last 12 months	22.1% Disabled 10.7% Not Disabled
B)	**Percentage staff reporting bullying, harassment, and abuse in last 12 months**	48.6% Disabled 51.4% Not Disabled
5.	**Percentage believing the Trust provides equal opportunities for career progression and promotion**	56.2% Disabled 62.0% Not Disabled
6.	**Percentage feeling pressure by manager to attend work even when feeling unwell**	19.0% Disabled 15.8% Not Disabled
7.	**Feeling valued by the Trust**	40.8% Disabled 48.3% Not Disabled
8.	**Satisfaction that reasonable adjustments made to support them in their work**	85.6% Disabled
9.	**A) Staff engagement score (Disabled staff only)**	6.9 Disabled 7.3 Not Disabled
	B) Have you taken action to facilitate the voices of Disabled staff	Yes
10.	**Percentage difference between Board membership and overall workforce** **Disaggregated by voting and non-voting members**	-3.0% Disabled -23.0% Not Disabled

Trust Overall Workforce:

Disabled: 3.2%

Non-Disabled: 80.5%

Unknown: 16.4%

Appendix 4 – Workforce Race Equality Standard 2023 (WRES)

The full report for WRES 2023 can be found on our [website](#), but please see below in brief our 2023 results.

Indicator

1. Percentage of staff in each AfC Band 1-9 or Medical and Dental pay grades, compared with the percentage of staff in the workforce overall. Disaggregated by non-clinical staff, clinical staff, and medical and dental staff

	Non-clinical			Clinical		
	White	Black, Asian, or minority ethnic	Not stated, or unknown	White	Black, Asian, or minority ethnic	Not stated, or unknown
Under AfC Band 1	0.39	0.06	0.00	0.00	0.00	0.00
AfC1	n/a	n/a	n/a	n/a	n/a	n/a
AfC2	4.54	0.06	0.00	2.01	0.10	0.06
AfC3	8.89	0.52	0.19	7.92	0.13	0.13
AfC4	2.21	0.00	0.00	7.92	0.58	0.06
AfC5	2.27	0.26	0.19	15.12	0.84	0.19
AfC6	1.56	0.00	0.00	18.04	0.71	0.26
AfC7	1.04	0.26	0.00	9.99	0.19	0.13
AfC8a	1.30	0.06	0.00	3.24	0.19	0.06
AfC8b	0.58	0.06	0.00	0.26	0.00	0.00
AfC8c	0.71	0.00	0.00	0.16	0.13	0.00
AfC8d	0.13	0.00	0.00	0.06	0.00	0.06
AfC9	0.06	0.00	0.00	0.00	0.00	0.00
VSM	0.19	0.06	0.13	0.06	0.00	0.00
	Medical and Dental Grades:					
Consultants	0.19	0.32	0.13			

Non-Consultant Grade	2.92	1.56	0.13	

2.	Relative likelihood of being appointed from shortlisting across all posts	1.44 times more likely to be appointed if you are White
3.	Relative likelihood of entering formal disciplinary processes	2.46 times more likely to enter formal disciplinary processes if you are Black, Asian, or minority ethnic
4.	Relative likelihood of accessing non-mandatory training/CPD	1.79 times more likely to access this training if you are Black, Asian, or minority ethnic
5.	Percentage of staff experiencing bullying, harassment, and abuse from patients/relatives/public in last 12 months	Black, Asian, or minority ethnic 29.2% White 21.6%
6.	Percentage of staff experiencing bullying, harassment, and abuse from staff in last 12 months	Black, Asian, or minority ethnic 25.0% White 16.9%
7.	Percentage believing the Trust provides equal opportunities for career progression and promotion	Black, Asian, or minority ethnic 45.8% White 62.0%
8.	In the last 12 months personally experiencing discrimination from manager/team leader/other colleagues	Black, Asian, or minority ethnic 10.4% White 3.8%
9.	Percentage difference between Board membership and overall workforce Disaggregated by voting and non-voting members	Black, Asian, or minority ethnic 8.1% White -20.7%

Trust Overall Workforce:

Black, Asian, and minority ethnic: 99 (5.75%)

White: 1,562 (90.7%)

Not stated: 61 (3.5%)

Appendix 5 – Language Interpretation 2023

The provision of language and communication support for people whose first language isn't English, or for people with disabilities or impairments with communication support needs, is very important for effective and safe provision of care, and equity of outcome.

As a Trust through the EDS Collaborative we have implemented the use of a language interpretation quality standard for procurement of interpretation services across Cheshire and Merseyside providers.

Up to 20th August 2023 all language interpretation services were provided by a single external provider, from 21st August two new contracts began, one for spoken languages (including translation of spoken languages in written formats), and signed languages.

A small number of contracts are still to be agreed through the procurement exercise referenced above and led by commissioners in Merseyside, this includes Easy Read, and interpretation/translation services for visually impaired and blind patients.

The following tables provide information on:

- Volume and spend on language interpretation from 1st January to 20th August 2023 – table 8.
- Total service requests for spoken language interpretation from 21st August to 30th November 2023 – table 9.
- Volume for British Sign Language (BSL) interpretation requests from 21st August to 30th November 2023 – table 10.
- Volume by language for spoken interpretation requests from 21st August to 30th November 2023 – table 11.
- Service usage for spoken language interpretation from 21st August to 30th November 2023 – table 12.

Table 8: Showing the volume and spend on language interpretation between 1st January and 20th August 2023

	Bookings	Spend
Face to Face	1,335	42,229.10
Telephone	564	5,385.60
Video	47	4,907.83
Translation	148	4,768.00
Total	**2094**	**57,290.53**

Table 9: Showing total service requests for spoken language interpretation since 21st August 2023

Spoken Language	Bookings
Face to Face	287
Telephone	217
Video	148
Translation	27
Total	**679**

Table 10: Showing the volume for BSL interpretation since 21st August 2023

BSL	Bookings
Face to Face	32

Table 11: Showing the volume by language of spoken language interpretation bookings from 21st August to 30th November 2023

Top 10 Spoken Languages Requested	Volume
Face to face:	
Urdu	114
Bengali	48
Arabic	17
Romanian	13
Kurdish Sorani	12

Polish	8
Mandarin Chinese	8
Cantonese	7
Portuguese	7
Russian	6
Telephone:	
Cantonese	34
Polish	28
Arabic	25
Romanian	22
Kurdish Sorani	18
Urdu	13
Turkish	6
Portuguese	6
Russian	5
Slovak	5
Video:	
Polish	39
Cantonese	29
Romanian	12
Arabic	12
Kurdish Sorani	12
Turkish	8
Urdu	8
Russian	5
Kurdish Badini	5
Tamil	5
Translation:	
Kurdish Sorani	4

Polish	4
Slovak	3
Cantonese	3
Romanian	2
Tamil	2
Urdu	2
Arabic	2
Turkish	1
Mandarin Chinese	1

Table 12: Showing service usage for spoken language interpretation from 21st August to 30th November 2023.

Top 10 Service Usage	Volume
Pennine Dental	111
Warrington OCATS	98
Oldham Dental	48
Warrington Speech and Language	42
Bury Dental	35
Halton Urgent Treatment Centre	35
Ashton Dental	31
Warrington Dental	30
Bolton Dental	27
Warrington Health Visiting South Team	22

We have been working closely with our spoken language interpretation providers throughout 2023 as we have worked through some particular difficulties sourcing face to face interpretation in some languages.

There are different factors that are influencing this issue including a shortage of trained interpreters in the region, and a culture change to home working. Our language interpretation providers have worked to actively recruit throughout 2023.

Strategic Objectives
☒ **Equality, 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**
Governance	Quality	Health Equity	Staff	Resources	Equality, Diversity & Inclusion	Partnerships
Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Failure to deliver quality services and continually improve	Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Failure to create an environment for staff to grow and thrive	Failure to use our resources in a sustainable and effective way	Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Failure to work in close collaboration with partners and staff in place and across the system

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

PEOPLE COMMITTEE REPORT

Title of Meeting	PEOPLE COMMITEE	Date	17 January 2024
Agenda Item	05/24		
Report Title	EQUALITY DELIVERY SYSTEM 2023 (EDS)		
Report Author	Ruth Besford, Equality & Inclusion Manager		
Purpose	To present to this Committee for approval and escalation to February Board the final report for the mandatory Equality Delivery System 2023.		

1. SCOPE

1.1 This report relates to the mandated contractual equality requirement as set out in section 13.5 of the NHS Standard Contract (Service Conditions – Full Length).

1.2 The Equality Delivery System (EDS) relates to both employment and service delivery.

2. INTRODUCTION

2.1 The EDS toolkit was originally mandated in the NHS Standard Contract in April 2015 (Service Conditions 13.5: Equity of Access, Equality and Non-discrimination). There have been subsequent reviews and updates, the most recent being completed with a re-launched toolkit in late summer 2022.

2.2 The eleven outcomes of the current toolkit require evidence, review and stakeholder grading for patient access and experience (outcomes 1 to 4 in Domain 1), staff health and wellbeing (outcomes 5 to 8 in Domain 2), and leadership in inclusion (outcomes 9 to 11 in Domain 3).

2.3 Used effectively EDS supports:

    a. Evidence of due regard to the General Equality Duty (Equality Act 2010).

    b. Delivery of Core20Plus5, either at Trust or regional level.

    c. Alignment with the Leadership and Capability, and People themes of the NHS Oversight Framework 2022/23.

    d. Alignment with the Workforce Disability and Race Equality Standards, and through improvements in these evidence for Disability Confident Leader re-accreditation and the North West Anti-Racist Framework.

    e. Delivery of the five priority areas for health inequalities set out in the 2021/22 Priorities and Operational Planning Guidance: Implementation Guidance.

2.4   From the first iteration the EDS for the NHS has been a toolkit designed to support equality improvement through engagement and c-design with protected characteristic groups, either in design and delivery of services or in employment.

2.5   Scores and grades for EDS are as follows:

Undeveloped activity – organisations score 0 for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated Undeveloped
Developing activity – organisations score 1 for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated Developing
Achieving activity – organisations score 2 for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated Achieving
Excelling activity – organisations score 3 for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated Excelling

2.6   Each of the 11 outcomes has a series of deliverables that, along with quantitative data from varied data sources and qualitative data based on lived experience of people from protected characteristic or vulnerable groups, determines the end results. For example, if a deliverable in the excelling area of an outcome is not met then excelling cannot be achieved.

2.7   NHS England, the CQC, Equality and Human Rights Commission, and commissioners have all stated that they would not expect any Trust to be excelling, and indeed increased scrutiny of evidence and process would be undertaken if a Trust published an excelling result. Commissioners have been clear that EDS is to be open and honest, and a developing grade is perfectly acceptable with accompanying action plan developed with stakeholders to address gaps in evidence or areas of identified inequality.

3. EDS 2023 PROCESS

3.1   Following the NHS England technical guidance, in 2023 three services for Domain 1 review were agreed with Warrington and Halton Commissioners in June:

        a. Urgent Treatment Centre, Widnes.

        b. Podiatry Service, Warrington.

        c. Bath Street Dental Service.

3.2   With the support of leads from the three services and from other Trust teams, evidence was gathered for each deliverable in the four outcomes of Domain 1:

        a. Patients have required levels of access to the service.

        b. Individual patient's health needs are met.

c. When patients use the service they are free from harm.

d. Patients report positive experiences of the service.

3.3 What is important to remember is that EDS isn't about overall experience of patients (or staff for the later outcomes), it is about the experiences of those from protected characteristic and vulnerable groups.

3.4 For Domains 2 and 3 evidence was similarly gathered for the deliverables for each outcome:

a. Domain 2:

i. When at work staff are provided with support to manage asthma, COPD, diabetes, mental health, and obesity.

ii. When at work staff are free from abuse, bullying, harassment, or physical violence from any source.

iii. Staff have access to individual advice and support when suffering from stress, abuse, bullying, harassment, or physical violence from any source.

iv. Staff recommend the Trust as a place to work and receive treatment.

b. Domain 3:

i. Board and senior leaders (Very Senior Managers and Band 9) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.

ii. Board/Committee papers (including minutes) identify equality and health inequality related impacts and risks and how they will be mitigated and managed.

iii. Board members, system, and senior leaders (Very Senior Managers and Band 9) ensure levers are in place to manage performance and monitor progress with staff and patients.

3.5 EDS is not a tool for self-assessment but a tool for transparency and co-design for improvement. Engagement is a fundamental part of EDS, with stakeholder/peer review and grading providing the final Trust results for the year.

3.6 Health Watch colleagues in Halton and Warrington were asked to support peer review of Domain 1 in lieu of a formal patient stakeholder engagement forum in Bridgewater. A review pack of evidence was issued for the four outcomes in Domain 1.

3.7 Engagement sessions with Staff Network members and Staff-side colleagues were undertaken in September/October with discussions taking place regarding evidence provided in a Domain 2 stakeholder pack. As a result of hosting a number of engagement sessions averages for each outcome in Domain 2 provided the final score and grading in these outcomes.

3.8 Following the technical guidance peer review for Domain 3 outcomes with colleagues from Wirral Community Health and Care NHS Foundation Trust was completed in December, with peer review support also provided by the Trust's EDI Lead at Mersey Care in December. This has allowed an exchange of best practice and ideas that can support future Trust developments.

3.9 The final element of engagement is development of an action plan to address the identified gaps or areas of improvement co-designed and delivered in partnership with stakeholders. This can be seen in the accompanying document, at Appendix 1.

3.10 The final Trust rating was developing; this reflected a score of 5 (developing) in Domain 1, a score of 8 (achieving) in Domain 2, and a score of 6 (achieving) in Domain 3. The total score being 19. This places the Trust in the high end of the ratings matrix, two points away from an achieving rating.

3.11 The final EDS report is attached as Appendix 1 for the People Committee's approval.

4. EDS NEXT STEPS

4.1 Following approval by this Committee the final stages for EDS 2023 are as follows:

    a. Escalation to Board for sign off in February.

    b. Publication on the Trust website and submission to NHS England before the deadline date of 28th February 2024.

    c. Submission of quarter 4 report to Halton and Warrington commissioners.

    d. Finalisation and implementation of action plans in partnership with Trust teams and Staff Networks.

    e. Embedding monitoring and review of action plans in EDI Working Group.

5. RECOMMENDATION

5.1 That this Committee approve the EDS2023 report and agree escalation to February Board for final approval.