Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING

Thursday 6 June 2024, 1.15pm
Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
30/24	1.15	(i) Apologies for Absence		Information
31/24	1.15	(i) Quoracy Statement (ii) Declarations of Interest in items on the agenda		Assurance
32/24 Page 4	1.15	Minutes of the last meeting: Board meeting held 4 April 2024	1	Assurance/ Approval
33/24 Page 16	1.20	Matters Arising from the Action Log	1	Assurance
34/24	1.30	Any urgent items to be taken at the discretion of the Chair		
35/24	1.30	Patient Story – Community District Nursing, Halton	2,3,7	Information
36/24 Page 23	1.55	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Approval
37/24 Page 39	2.10	Key Corporate Messages – presented by the Chief Executive	1	Information
QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered				
38/24 (i) Page 49 (ii) Page 84 (iii) Page 97 (iv) Page 182 (v) Page 190	2.25	(i) IQPR Month 12 – presented by Executive Leads (ii) Report from the Quality and Safety Committee held on 18 April 2024 – presented by the Committee Chair (iii) Paediatric Audiology – presented by the Medical Director (iv) Learning from Deaths Report – presented by the Medical Director (v) Quality Account – presented by the Chief Nurse	1 2,3 2 2 2	Assurance Assurance Assurance Assurance Approval

3.40 - **10 MINUTES BREAK**				
RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
39/24 (i) Page 261 (ii) Page 269 (iii) Page 276 (iv) Page 287	3.50	(i) Finance Report – presented by the Director of Finance (ii) CIP Governance Report – presented by the Director of Finance (iii) Report from the Finance and Performance Committee – Extraordinary Committee held on 24 April and meeting held on 23 May 2024 – presented by the Committee Chair (iv) Report from the Audit Committee held on 25 April and Extraordinary meeting held on 23 May 2024 – presented by the Committee Chair	5 2, 5 5 1, 5	Assurance Assurance Assurance Assurance
PARTNERSHIPS: We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities				
40/24 Page 299	4.35	(i) 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				
41/24 Page 314	4.45	(i) Report from the People Committee held on 8 May 2024 – presented by the Committee Chair	4,6	Assurance
OVERARCHING CORPORATE GOVERNANCE ITEMS				
42/24 (i) Page 330 (ii) Page 343	4.55	(i) Board Terms of Reference – presented by the Director of Corporate Governance (ii) Fit and Proper Persons Annual Review – presented by the Director of Corporate Governance	1	Approval Assurance
43/24	5.10	Review of meeting and Items to be added to the Board Assurance Framework	1	Information
44/24	5.15	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 8 August 2024 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

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Unapproved Minutes from a Public Board Meeting
Held on Thursday 4 April 2024, 10am
Ground Floor Meeting Room, Spencer House, Dewhurst Road, Birchwood, Warrington

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

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

For Patient Story 20/24
Jo Gibbins, Warrington 0-19 Service Team Leader

Observers/members of the Public
Kevin Goucher, Public Governor, Warrington
Andrew Mortimer, Public Governor, Warrington

15/24 (i) APOLOGIES FOR ABSENCE

Amena Patel, NExT Director

16/24 (i) QUORACY STATEMENT

The Chair confirmed that the meeting was quorate.

(ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No declarations of interest were made.

17/24 MINUTES OF THE LAST MEETING

BOARD MEETING HELD 8 FEBRUARY 2024

Page 6 Leadership strategy item first paragraph, second sentence to read: 'The paper, which was taken as read, provided a *breadth* of detail to reflect on the work being done around the strategy and its components.'

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

18/24 MATTERS ARISING FROM THE ACTION LOG

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

72/23i Finance Report (Place financial position)

It was noted that the information required for Warrington and Halton was still not available. It was agreed that this item would remain on the action log until it could be resolved.

85/23i IQPR

The Board agreed that this action was completed and could be rated as blue on the action log.

85/23iii EPRR

The Board agreed that this action was completed and could be rated as blue on the action log.

86/23i Finance Report – month seven (Planning Guidance)

Following discussion it was agreed that the planned seminar session on 2 May would discuss CIP/Boosting Efficiencies and plans during quarter four of the current financial year once the planning guidance was available. This would include performance and finance elements as well as the controls in place.

80/24 Key Corporate Messages

The Chief Nurse confirmed that a return visit was being scheduled. An update would be provided on this in due course.

10/24i Finance Report

It was agreed that the Director of Finance would take this action forwards outside of the meeting – it would be important to consider the benefits and value that the Trust brought to the system and describe this in a holistic way.

The Board agreed that the following blue rated items would be removed.
88/23iii We each have a voice that counts
89/23 New Board Assurance Framework
08/24 Key Corporate Messages

19/24 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.

20/24 PATIENT STORY – WARRINGTON 0-19 SERVICE

The Board welcomed Jo Gibbins, Warrington 0-19 Service Team Leader, who delivered a presentation concerning Michael, a patient of the service with complex health needs which were both life changing and lifelong. Michael had cerebral palsy, with a significant brain injury to the right side, hydrocephaly, was severely visually impaired and had global developmental delay; he was unable to speak or cry, or to sit and had poor head control and was unable to move his limbs freely. He also had a limited diet of soft foods and would regularly choke. Jo Gibbins explained that Michael and his parents moved from Nigeria to Warrington in March 2023 when Michael was aged two years. Michael had received no care in Nigeria and therefore there had been no records for him or conversations previously about his care and needs. On his arrival in the UK there was no care plan in place for Michael.

Jo Gibbins described the support that had been put in place by the 0-19 Service. This had included regular visits, referrals for assessment by a Health Visitor for Michaels needs and wider support for his family. This had included support for the emotional health and well-being of Michael's parents, as well as for Michael with a clear family approach. This included some sensitive and difficult conversations with the family. There had been a range of services involved in Michael's care from Bridgewater and other partner agencies including the Local Authority. This had included Physiotherapy, Occupational Therapy, Speech and Language Therapy, the Child Development Centre, Dietician, Liaison with GP, Orthopaedics, Opthalmology and the Sensory Impairment Team, Audiology and Assisted Living Team providing specialist equipment. There had been support provided to the family to help them to navigate service. Jo Gibbins described the difference that the care received had made to Michael and his quality of life. This had included glasses and support from visual impairment teacher at home, increased movement of limbs following physiotherapy, support from a Dietitian and following receipt of prescribed milk, Michael was now gaining weight well and eating a wider variety of foods. He had also been referred to Nursery and would begin to attend later in the year. The family also now had SEND support.

The Board agreed that the story demonstrated both the delivery of expert care and good practice; the family had been seen at an early stage and relevant referrals were then made, Michael's needs were prioritised by services and he was seen quickly and there had been a whole family approach with support for Michael and his family, building good and trusting relationships with them and collaborating on his care plan which was discussed and agreed at all times. Effective multi-agency working and collaboration was recognised between all practitioners involved in his care and establishing a care plan and joint visits with good communication.

21/24 BOARD ASSURANCE FRAMEWORK

The Trust Secretary presented a report setting out the changes to the Board Assurance Framework over the previous Committee cycle. She highlighted that BAF4 had been reviewed and that there had been a reduction in the likelihood scoring as a result of the improved staff survey scores for the Trust as well as Key Performance Indicators (KPIs) in place as additional assurance. The Board approved the reduction of the score to eight, and noted and approved the remainder of the recommended changes.

22/24 KEY CORPORATE MESSAGES

The Chief Executive presented the report updating the Board concerning key matters within the Trust and the wider NHS. He acknowledged the level of engagement of Non-Executive and Executive Directors over the period. The Chief Executive highlighted the Bridgewater Research Festival that took place on 1 February 2024 with Keynote Speaker, Professor Dame Caroline Watkins, Professor of Stroke and Older People's Care, Director of Research and Enterprise; Director of Lancashire Clinical Trials Unit and Director of Lancashire Research Institute for Global Health and Wellbeing (LIFE), Faculty of Health and Care, University of Central Lancashire (UCLAN). The event highlighted the opportunities available to engage more fully in research across clinical professions, building on the good foundations with the Trust's platform with UCLAN. The Medical Director advised that the Trust had been awarded NIHR funding to develop initial support for a research project, however this was at an early stage.

The Chief Executive also highlighted the Reciprocal Mentoring for Inclusion Event held on 29 February which was facilitated by Liverpool John Moores University. Participants were able to share their experiences and ideas of the programme over the last six months, which saw staff partnered with senior leaders. This had proved to be a valuable programme with feedback that would be taken back into the Trust across all levels of the organisation. Positive feedback was also expected from the Vice Chancellor on 5 April. The Director of People highlighted that the event had been inspiring and was based on the lived experience of individuals. She confirmed that the feedback would be taken forwards via the Trusts Equality, Diversity and Inclusion (EDI) group.

The Chief Executive highlighted a correction at 2.6 of the report: he explained that the planned session with the Neurodevelopment Pathway Team in Warrington was rescheduled and a follow up session took place with the Chief Operating Officer on 3 April. He highlighted that more detailed information had been included within the report concerning the Time to Talk sessions, this also included less positive feedback. The Chief Executive referred to a key theme that had been identified across Dental teams where they had felt disconnected from the wider organisation. This had also been reflected within some staff survey results for those teams. He explained that there would be some actions to be taken concerning communications and engaging more directly with those services/teams and being present which the Trust and the Executive Management Team (EMT) would respond to as well as this being as part of the staff survey action plan that would be discussed later on the agenda.

The Chief Executive also noted that some services had fed back that teams had been finding it difficult to fit in all statutory and mandatory training due to service pressures. He referred to a recent session he had attended with the OCATS service along with the Chair where there had been a suggestion made to design an approach to statutory and mandatory training being around specific clinical teams with a task and finish group that could explore this. The Chief Executive commented that the Trust must be aware of the consequences to the approach taken for mandatory training; that this must add value and not be burdensome. The Director of People advised that a corporate and clinical induction programme was being considered where all of the required training would be undertaken in the first few days in post. Newly appointed staff would be provided with a 'passport' that would contain their training record which would help to prevent having to duplicate training and support work with services on subject matter experts. This could also include competencies and role requirements such as administering of insulin.

The Chief Executive referred to the external publications and reports within the final section of the report. He encouraged colleagues to read the Independent Review of Greater Manchester Mental Health NHS Foundation Trust by Professor Oliver Shanley OBE. This

evidenced the consequences of poor engagement and leadership in an organisation with issues in one particular unit. He advised that Bridgewater could take some learning from those experiences as they did not solely relate exclusively to a mental health setting. The Chief Executive also referred to Reducing Health Inequalities: A Guide from NHS Trust Board Members and encouraged colleagues to read this document. He advised that Health Inequalities would need to be included in the Board seminar programme. The Medical Director confirmed that this had been scheduled with the Trust Secretary for July 2024. The Chief Executive advised that he would also circulate two further documents following today's meeting: NHS Confederation 'Putting Money Where Our Mouth Is' and the Kings Fund: 'Illustrating the Relationship between Poverty and NHS Services' which related to the impact of poverty on the NHS and assessing the impact on funding to address inequalities more generally.

The Chief Executive referred to the Planning Guidance that was released on 28 March and noted the importance on reducing waits in community services, including the need to reduce children's waits to below 52 weeks. He highlighted that the Trust had worked to raise the profile of this and yet this doesn't feature on national reporting. There would be a need to align all services to Primary Care Networks (PCNs) and integrated neighbourhood teams and this would continue to progress. This would be discussed as part of finance discussions later in the agenda and at the next Board seminar.

The Medical Director referred to a comment within the report where dental staff had asked if they could provide treatment to one another. He raised his concerns regarding this and sought further information so that this could be investigated as it may not be appropriate and could present General Dental Council (GDC) implications. The Director of People clarified that this had been asked at a recent Time to Talk session that she had attended with Non-Executive Director, Gail Briers with St Helens Dental Team. It had been suggested that staff could treat one another to prevent them needing to take time away from work for dental treatment. The Medical Director would take this forwards with the Director of People outside of the meeting. The Director of People confirmed that this was not taking place currently but had only been a suggestion.

The Chair and the Board noted that today would be the final Board meeting for Non-Executive Director, Linda Chivers. The Chair thanked her for her considerable contribution to the Trust over her six-year tenure as the Trust's Vice Chair and Audit Committee Chair.

The Board received the report for note.

23/24 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 as at month 10. The Chief Operating Officer reported that there were several red rated indicators in relation to operational delivery with increasing pressures in the Children's Services Directorate which impacted both quality and finance. Two red rated indicators were reported in relation to the cancer performance but there was a clear rationale for the breaches which were largely unavoidable. From a quality perspective, there had been a deterioration in risks managed in line with the policy and also in relation to the percentage of risks over 12. She reported that there had been a noted increase in the percentage of medication incidents causing harm. The majority of the red rated areas with the exception Urgent Treatment Centre (UTC) had been discussed by the Quality and Safety Committee with related reports being taken through the last meeting.

Non-Executive Director, Tina Wilkins referred to page seven of the report/page 53 of the pack, which noted that interviews had taken place for a Band seven Audiologist/Team Leader role and recruitment would progress to backfill a Band six vacancy that had been created to ensure that the team would be fully recruited to and that it would have available capacity to deliver. She asked how this would be done, recognising that there were challenges within the current recruitment market. The Chief Operating Officer advised that the Band seven role was a new post with internal candidates. Interviews were held with teams in Halton and St Helens working together to review candidates. The Chief Nurse advised that this was part of work that the Trust was exploring around development roles for staff.

Non-Executive Director, Gail Briers observed that the IQPR report provided a high level of assurance and noted the alignment of the red rated areas to the reports being received by the Quality and Safety Committee. She commented that the Board could have confidence from this that the Committee was discussing the key issues in an open and transparent way. Non-Executive Director colleagues supported this, with comments endorsing the excellent report, and acknowledging its progress. It was agreed that the report in its current form should remain unchanged if possible for the next 12 months. The Chief Nurse added that another element contributing to the positive progress with the alignment of triangulation of information was that reports were being taken through the Councils supporting each Committee. The Board agreed that the report clearly demonstrated a 'golden thread' and provided a strong level of assurance.

The Chief Operating Officer informed the Board that it would be necessary to consider the new planning guidance and any additional indicators, as well as an indicator refresh on activity and performance that will be taken through the appropriate channels.

(ii) REPORT FROM THE QUALITY AND SAFETY COMMITTEE HELD ON 28 FEBRUARY 2024

The Board received a report from the Quality and Safety Committee meeting held in February 2024 from Non-Executive Director and Committee Chair, Gail Briers for assurance.

The Chief Operating Officer reported that there had been positive news concerning funding for Oldham General Anaesthesia (GA) sessions. This would support the pathway and there would be an update on this to the next meeting of the Committee.

(iii) LEARNING FROM DEATHS REPORT – QUARTER TWO

The Medical Director presented a retrospective Learning from Deaths report for the second quarter of 2023/24. He reported that within this period there had been 569 deaths of which 16 had been reviewed. There had been no concerns raised in relation to care provided by Bridgewater. Two themes had been highlighted in terms of learning: firstly, following a Warrington Joint Agency Review (JAR) of a neonatal/newborn death, a task and finish group was established to explore how agencies can share safe sleep messages with parents and carers. This would be supported by the Warrington Children's Safeguarding Specialist Sudden and Unexpected Death in Childhood (SUDIC0) Nurse and the Bridgewater Warrington 0-19 service. Learning was recommended to be shared from this across all Directorates and secondly; where patients attending the Widnes Urgent Treatment Centre were advised to attend A&E to look at how that patient intends to travel and ensure this was recorded in the electronic patient record. Some challenge was made concerning the information within the report, in particular as to why only 16 reviews had been undertaken from 569 deaths. It was also questioned as to how the Trust was continuing to align to a process focussed around acute organisations. This resulted in challenges in being able to

communicate the context of community deaths within a report. **It was agreed that the process behind the selection of the 16 deaths would be reviewed by the Quality and Safety Committee to ensure that the right cases were being selected for review.**

The Board received the report but agreed that it would not be able to accept full assurance in view of the above.

It was noted that the Trust's Learning from Deaths Policy was being reviewed to ensure alignment with other community organisations and avoidance of duplication across Place. Ongoing challenges were noted recognising that the national Learning from Deaths Policy remained predominantly acute trust focussed, and this presented difficulties to align this to community trusts. **It was also agreed that the Quality and Safety Committee would review the revised Trust Learning from Deaths policy. The Board would continue to receive the quarterly report which would be focussed on learning and themes.** The Medical Director confirmed that the Learning from Deaths Annual Report would be presented to the Board in October 2024.

(IV) CLINICAL LEADERSHIP STRATEGY

The Board endorsed the Trust's Clinical Leadership Strategy, which had been developed in consultation with the Trust's clinicians. The Board recognised the document as being a first step, as this would be a living document that would further evolve around a changing system and agreed that it would be important to link this to the Communities Matter strategy and demonstrate the difference between Trust ambitions and the wider elements of what is needed for its patients.

(V) EPRR UPDATE

The Chief Operating Officer presented a report describing the actions and progress following the February 2024 Board meeting. The Trust had made significant progress against 30 of the 58 standards, acknowledging that the ICB was co-ordinating work streams, to which the Trust was contributing. The Trust's EPPR Group would continue to meet fortnightly. Supporting task and finish groups would continue to manage the delivery of the work programme. An internal data repository would be maintained utilising the core standard template and outputs from the various task and finish groups and the Trust would 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. The ICB strategic group had agreed to provide assistance across all organisations and example documents will be shared in respect of new and emerging pandemics, counter measures, self-awareness and training, incident communications plan, mutual aid arrangements and Hazmat.

Concerning the risks, the Chief Operating Officer highlighted that whilst additional resource had been allocated to support the EPRR group and associated task and finish groups, it had been acknowledged that the lack of dedicated capacity to the overall EPRR function remained as a risk to the organisation and risks had been recorded on the Trust's Risk Register to reflect the current organisational non-compliance status, the identified potential capacity shortfall risk and the current training and competency deficit against the required training standards for all participating on-call staff. She confirmed that the position would continue to be monitored and reviewed against the overall action plan deliverables and reported via the regular updates into the Executive Management Team (EMT) and Risk Management Council. She confirmed that a further report would be presented in September 2024.

The Board acknowledged that progress was being made noting that the position had changed significantly at the end of the calendar year following NHS England review of the compliance against the indicators. It welcomed the progress made to date, thanking those staff involved in this work, and acknowledged the risks outlined, noting that those would continue to be monitored.

24/24 RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(I) FINANCE REPORT – MONTH 11

The Director of Finance took the month 11 report as read. The key highlights were noted: That the Trust was reporting a small surplus of £0.02m, which was slightly ahead of plan. There was a savings requirement of £5.15m (5.2%) in line with Integrated Care Board (ICB) instruction. The Trust was reporting a year-to-date achievement of £4.82m against a plan of £4.72m. The Director of Finance reported that Agency spend was £4.62m against a plan of £3.99m: he explained that there were significant plans in place to reduce agency spending into next year. Those plans were already in train and were beginning to deliver in months 11 and 12.

The Director of Finance highlighted CIP/Boosting Efficiencies delivery and informed the Board that work was in progress to finalise numbers for month 12 to determine recurrent and non-recurrent areas and to agree what would be taken forwards in the next financial year. This would be discussed further by the Board during May at a planned Board session, where the Board would be taken through governance arrangements and reporting concerning finance.

Regarding Capital expenditure, the Director of Finance reported that significant work had taken place at Europa Point which was significantly contributing to the achievement of expenditure and Capital. The Capital plan also included replacements for IT equipment. He confirmed that the Finance Team were confident currently that the Trust would achieve its Capital spend.

The Director of Finance commented on the system position and noted that this had not been included within the circulated report as this was a changeable and evolving position. He confirmed that there was currently an over spend against the plan. There had been recognised challenges within the system with overspend for the new Hospital within the region which was expected to be recovered from the Integrated Care Board (ICB). The Director of Finance advised that discussions were taking place on minimising the over spend into the end of the financial year and there were no current indications as to how this would appear across the ICB.

Non-Executive Director, Bob Chadwick asked whether the CIP/Boosting Efficiencies position for 2024/25 would be available for the next Board meeting and asked what would be in the pipeline. The Director of Finance advised that the May Board seminar session would receive an update on the schemes: some of those were already in place and information would be presented on those and delivery and expected timescales. There would also be an update on the governance processes around this.

Non-Executive Director, Linda Chivers referred to the last Board seminar session on 11 March concerning CIP/Boosting Efficiencies; this had included a discussion on how comfortable the Board would be if it only achieved 50% of schemes being recurrent. She highlighted that the Trust was now at a minimum of 33%. The Director of Finance advised that as part of the budget setting process, recurrent CIP would be taken out. This was

currently at £1.8m which was the current minimum, however at the month 12 review this figure was likely to change.

Non-Executive Director, Linda Chivers replied that the Trust must be clear on its position for the next focussed discussion and it must be confident as to what can be realistically achieved. She challenged that if the Trust strived for the full target as recurrent, this would then put pressure on staff and managers who must now achieve that position. She commented that if the Board agreed that it would not be able to achieve this and had a realistic position, this would place less pressure on teams and managers. Non-Executive Director, Tina Wilkins agreed that plans must be clearly set out, including the areas where the Trust was confident it would achieve its target as well as where it was less sure where recurrent savings would be achieved. She commented that she would be keen to have sight of this information during May at the Board session and the Finance and Performance Committee where this would be monitored.

The Chief Nurse agreed with the points made by Non-Executive Director, Linda Chivers and advised that teams and managers were being asked to ensure that all CIP/Boosting Efficiencies Schemes were recurrent. She advised that as many schemes and efficiency savings would be recurrent as possible to work towards to the target. The Director of Finance agreed that the target must be realistic but also challenging. It would be important to understand the current position and the challenges for full sightedness.

The Board reviewed and approved the process described for the National Costing Collection, which provided assurance to the Board concerning the plan to complete the mandated costing submissions for 2022/23.

(II) REPORT FROM THE FINANCE AND PERFORMANCE COMMITTEE HELD 23 MARCH 2024

The Board received a report from the Finance and Performance Committee meeting held in March 2024 from Non-Executive Director and Committee Chair, Tina Wilkins for assurance.

Non-Executive Director, Linda Chivers highlighted that Bridgewater had become the first NHS organisation to achieve 100% utilising multi-factor authorisation. The Board welcomed this and thanked all staff involved in this work. The Chair commented that she had observed this Committee meeting and commented that she had found the meeting to be very effective and that she considered the balance between finance and performance to be optimal.

25/24 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) STRATEGY IN ACTION

The Programme Director of Integration and Collaboration presented a report to provide sightedness to the Board concerning progress with integration and collaboration developments and delivery of the Communities Matters Strategy. This included updates regarding the Population Health dashboard, strategic objective deliverables, delivery plan progress, Strategy into Action examples and case studies and place-based updates.

Non-Executive Director, Tina Wilkins welcomed the explanation of the ratings against progress of the schemes and projects, and the milestones and key actions on page 130 of the document. **She referred to the Strategy in Action collaboration with Primary Care Networks (PCNs) and asked if the Clinical Directors could be invited to attend a future Board session. This suggestion was agreed by the Board and an invite would be**

extended to attend a Board session during Summer 2024. The Board welcomed the format of the report which clearly demonstrated the progress that was being made against the strategy. The Chief Executive commented that the Board must be assured that conversations were taking place within the Directorate Leadership Teams (DLTs) on their contributions and this must be understood by the Executive Management Team (EMT). The Programme Director of Integration and Collaboration advised that he would discuss this with the Senior Leadership Team concerning reporting and shared learning across directorates, and this would be taken forwards as part of further work.

The Board received the report for information.

(ii) HEALTH EQUITY UPDATE

The Medical Director presented a report updating the Board regarding health equity progress and activity. To support its communities and partners as part of the ICB Population Pledge Programme, the Board agreed upon three areas of focus: smoking prevention (including vaping), alcohol and physical activity; those areas would be included as metrics to be monitored within the Trust's newly developed performance report. Performance would be subject to review by the newly formed Health Equity Group and drilled down into individual services, with the performance threshold to be considered annually. The Board agreed that the Trust would apply for Anchor Institution status. It was noted that there would be some consequences as a result of this for example, considerations around purchase decisions. In addition, it was agreed that there would be a need to revisit the Community Health Workers project and its impact. The project was currently being funded via vacancies until September 2024. There would be a need for an alternative source funding for the project.

26/24 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 8 MARCH 2024

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

The Board finally endorsed the Equality, Diversity and Inclusion (EDI) Strategy as recommended by the People Committee. The Board took the opportunity to thank Equality and Inclusion Manager, Ruth Besford, for her work on the strategy. The Director of People would feed this back.

(ii) STAFF SURVEY RESULTS AND ACTION PLAN

The Board received a report from the Director of People. She highlighted that 62% of Bridgewater staff completed the survey this year, making it the best ever response rate for the Trust. The areas showing a decrease for 2023 compared to the Community Trust average were: 'We are recognised and rewarded' (-0.1); 'We are always learning' (-0.1) and 'We work flexibly' (-0.1) Staff Survey Action Plans will once again be created Trust-wide and at directorate level. The Staff Engagement Framework for 2024/25 would include engagement activities that aligned to the feedback received from the survey to further support the fulfilment of the seven elements of the NHS Our People Promise. The Board received the report for assurance and noted the comprehensive staff survey action plans. It was acknowledged that there had been considerable positive progress but there was still more work to be done. The action plans would now develop and grow from a Trust-wide, corporate and directorate perspective and would be monitored via the People Operational Delivery (POD) Council, the Performance Council and the Directorate Leadership Team (DLT).

The Board received the report for assurance.

(iii) PEOPLE PLAN

The Director of People presented a high-level summary on the Trust's progress against delivery of the NHS People Plan, People Promise and the Trust's People Strategy. This highlighted the progress that was being made with key People Indicators and the plans to continue to enhance the Trust's People agendas with a view to continued improvement in staff experience.

Non-Executive Director, Elaine Inglesby welcomed the use of the Trust's own data to drive decisions and improvements. The Chief Executive supported this and noted that whilst there had been significant work undertaken, there would still be more to do. The Director of People confirmed to the Chief Executive that there had been funding made available for legacy mentors and a role profile had been devised. The mentors would be experienced members of staff and would support and mentor others, including offering restorative mentoring. The Chief Nurse added that the aim would be to have a Professional Nurse Advocate with a Legacy Mentor in each service and work was being undertaken to consider how this could be progressed. This would include a registry of supervision across services. The Chief Executive commented that there would also be ideas for newly appointed/qualified staff that could also have value. This should also be included as part of informing work. The Chief Nurse confirmed that all staff were encouraged to put ideas forwards.

The Board acknowledged the significant work that had taken place, with support from key personnel from across the Trust and took the opportunity to thank the Director of People and her team for their work on the plan.

27/24 OVERARCHING CORPORATE GOVERNANCE ITEMS

(I) ANNUAL BOARD EFFECTIVENESS REVIEW

The Board received the annual effectiveness review report which provided assurance that the Board was operating effectively, with positive feedback received.

(II) BOARD BUSINESS CYCLE REVIEW

The Board reviewed and approved the business cycle, subject to **one minor change to be made concerning the timing of the presentation of the Learning from Deaths Annual Report: this would need to change from June 2024 to October 2024.**

(III) APPLICATION OF THE TRUST SEAL

The Board received a report for its information which detailed the seven applications of the Trust seal over the period.

28/24 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

Board members reviewed the meeting and agreed that there had been a good level of discussions during the meeting today, and an excellent standard of reports.

29/24 OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

A number of questions concerning items on the agenda were received from Governor Observers:
Following a question concerning children's waiting lists, the Chief Operating Officer confirmed to Kevin Goucher that each patient would be reviewed as part of day-to-day work on waiting lists, according to clinical need, with waiting times assessed alongside clinical harms reviews. She noted that there would be regular movements on those lists. There would also be Health Visitors, as well as other professionals, parents and families who would highlight any children who may need to be escalated. She confirmed that patients would not be split off into a different 'high-risk' category as this would not be practical for numerous reasons. The Chief Nurse added that the performance against the waiting lists was monitored at the Trust's Performance Council.

The Medical Director clarified the position concerning the Neonatal deaths referred to in the Learning from Deaths report to Kevin Goucher: the Trust did not have any Neonatal hospital based deaths and any investigation into any such cases would be undertaken by the relevant acute trust. He confirmed that Learning from Deaths was focussed on learning and was not an actual investigation into the reasons behind a death as this was a separate process.

The Chief Nurse confirmed to Kevin Goucher that opportunities for staff as part of the Clinical Leadership Strategy would be taken forwards as part of ongoing communications and workforce plans within each team.

The Medical Director advised Andrew Mortimer that there had been criteria around the 16 cases that were referred to within the Learning from Deaths report. He confirmed that there was a policy in place that had been followed to select those cases, however there would be further explanation around this criteria and policy as well as scrutiny of the sample of cases at the Quality and Safety Committee.

DATE AND TIME OF NEXT MEETING

Thursday 6 June 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
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	**BLUE**	**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. April 2024: Item to remain on the action log until the information is available/action is resolved. May – this action is now closed as it will be superseded by integration work.

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	**BLUE**	April 2024: it was agreed that the action was completed
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	**BLUE**	April 2024: it was agreed that the action was completed
07.12.23	**86/23i**	**Finance Report – month seven**	It was agreed that the Board would hold a seminar session to discuss CIP/Boosting Efficiencies and plans during quarter four of the current financial year once the planning guidance was available.	Jan McCartney /Nick Gallagher	**BLUE**	April 2024: discussion to take place at the 2 May Board Seminar session.

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
08.02.24	08/24	Key Corporate Messages	Visits will also be scheduled to Rochdale and Oldham dental services to check how the staff in those services feel. Intense support should be offered to Bury Dental team and that a return visit should be scheduled in a few weeks' time.	Lynne Carter	**GREEN August 2024**	May 2024: Visit to Oldham Dental Services to take place on 20 June. Visit to Rochdale to be scheduled – date to be confirmed. Visit to Bury Dental Team to take place on 19 June.
08.02.24	**09/24i**	**IQPR**	Addition of narrative requested around anticipated trajectory for recovery in future reiterations of the IQPR, as well as a note of any delegation of matters to any of the Committees	Sarah Brennan	**BLUE**	April 2024: Information included within the report.
08.02.24	**09/24iii**	**EPRR**	The Board would receive an update in April 2024 as this will be the mid-year review and will add a 6-monthly update to the Board business cycle in relation to EPRR moving forwards.	Sarah Brennan/Jan McCartney	**BLUE**	April 2024: Item included on the agenda.
08.02.24	**09/24iv**	**Draft Clinical Leadership Strategy**	The timing of the finalised strategy to be presented to the Board, will be arranged as appropriate.	Lynne Carter	**BLUE**	April 2024 Strategy received and approved.

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
08.02.24	**10/24i**	**Finance Report**	The Board acknowledged the complexity of the contribution quantification task, given the multifactorial nature of the support, as well as unavailability of the data from the system partners. The Board, however, agreed that such measuring exercise should be undertaken, based on our assumptions, to be able to identify our contribution as a blend of activity, finance, acuity, complexity and qualitative narrative.	Nick Gallagher	**BLUE**	March 2024: Local Place leadership is looking to introduce a monthly financial report to include all system partners. This will be shared with the Board as soon as it is available. The Trust does not have access to the detailed financial positions of all Place partners to produce this system position. April 2024: It was agreed that the Director of Finance would take this action forwards outside of the meeting – it would be important to consider the benefits and value that the Trust brought to the system and describe this in a holistic way. May: Action superseded via integration work.

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
04.04.24	**23/24iii**	**Learning from Deaths**	It was agreed that the process behind the selection of the 16 reviews from the overall 569 deaths would be reviewed by the Quality and Safety Committee to ensure that the right cases were being selected for review.	Ted Adams	**GREEN June 2024**	April: Following discussion at the Quality and Safety Committee, it was agreed that a paper would be taken back to the June Board to describe from the policy how the 16 reviews were selected from the 569 deaths. The Board will then confirm if it requires any further action/scrutiny on this at the Quality and Safety Committee. This information will be provided to the Board as an appendix to the usual LFD report. The Board report will be shared with Committee members in advance of this going into the Board so that they are sighted on the content.

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
04.04.24	**23/24iii**	**Learning from Deaths**	It was agreed that the Quality and Safety Committee would review the revised Trust Learning from Deaths policy. The Board would continue to receive the quarterly report which would be focussed on learning and themes.	Ted Adams	**GREEN June 2024**	April 2024: Committee will receive a paper regarding the policy to review in June. This would describe how the Bridgewater policy was derived from the national policy. A report would also be received on learning from deaths (LFD): It was agreed that a report would be required concerning the broader elements of LFD: thematic learning/evidence of learning from deaths including safeguarding/child deaths. This must be clearly drawn out within reports to this Committee – Committee will require the appropriate assurance around this so that it could then feed that assurance back into the Board.
04.04.24	**25/24i**	**Strategy in Action**	PCN Clinical Directors to be invited to attend a future Board session - an invite would be extended to attend a Board seminar during Summer 2024.	Rob Foster	**GREEN**	May 2024: invite letter to be sent to seven PCNs.

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
04.04.24	**27/24ii**	**Board Business Cycle**	One minor change to be made concerning the timing of the presentation of the Learning from Deaths Annual Report: this would need to change from June 2024 to October 2024.	Jan McCartney	**BLUE**	Amendment has been made.

Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**36/24**		
Report Title	**BOARD ASSURANCE FRAMEWORK**		
Executive Lead	Colin Scales, Chief Executive Officer		
Report Author	Jan McCartney, Director of Corporate Governance		
Presented by	Jan McCartney, Director 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 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**	**6 June 2024**
Agenda Item	**36/24**		
Report Title	**BOARD ASSURANCE FRAMEWORK**		
Report Author	Jan McCartney, Director 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.

1.5 This paper also describes the highest risks for the Trust and recommends a new BAF8, Integration with Warrington and Halton Hospital.

2. CHANGES TO THE BOARD ASSURANCE FRAMEWORK

2.1 BAF 1: Governance

The Audit Committee met on 25 April as asked for the following additions;

- Addition of assurance levels from MIAA audits.
- Update of the rationale for current score in BAF 1 to reflect that the Well-led plan had been developed and completed and further actions would be aligned with the updated CQC guidance on Well Led.
- Approved Internal Audit Plan 2024-25 and Anti-Fraud Plan 2024-25

The Audit Committee also held an extraordinary Committee on 23 May 2024 and asked for the following internal audit to be added to the BAF

- Board Performance Reporting – high assurance

The Committee confirmed that the risk rating should remain at 8, which is at target.

The Chief Executive Officer, who is the lead executive for this BAF, reviewed this BAF during May.

2.2 BAF 2: Quality

The Quality & Safety Committee met on 18 April 2024 where it was agreed that Padgate House should be added to the emerging risks section.

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

The Risk Management Council met on 29 May 2024 and agreed risks 1138, 1139, 3262, 3266 and 3271 should be added to BAF 2. These will be further considered at the Q&S Committee meeting on 27 June 2024.

2.3 BAF 3: Health Equity

The Quality & Safety Committee met on the 18 April 2024.

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

2.4 BAF 4: Staff

The People Committee met on 8 May 2024.

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

2.5 BAF 5: Resources

The Finance & Performance Committee met on 23 May 2024 where the following changes were made:

- Gaps in Controls, 2024/25 plan reflects challenging CIP
- Emerging risks, final plan not yet approved by NHS England
- Rationale for current score – the potential additional savings ask from place and the CIP Challenges
- Emerging risks, lack of planning guidance as currently the risks are unknown

The Committee recommended that due to the financial uncertainty the likelihood should be increased to 3, resulting in an overall score of 12 high.

The People Committee met on 8 May 2024 where no changes were recommended.

The Risk Management Council met on 29 May 2024 and agreed risks 1138, 1139, 3262, 3266 and 3271 should be added to BAF 5. These will be further considered at the F&P Committee meeting on 25 July 2024.

2.6 BAF 6: Equality, Diversity & Inclusion

The People Committee met on 8 May 2024.

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

2.7 BAF 7: Partnerships

Executive Management Team met on 19 May 2024.

No change was recommended to the risk rating remains medium at 9.

2.8 BAF 8: Integration with Warrington and Halton Hospital

This is a newly drafted BAF risk, compiled by the Executive Management Team.

This is to ensure that risks identified during the integration work is captured and managed with close Board oversight of the process. The Executive Management Team will manage this risk and provide updates to the Board.

The inherent and current risk rating were identified as significant at 16.

3. HIGHEST RISKS

3.1 The Trust's six highest risks are as follows:

a. Risk 1138 (score 16)
Community Paediatric doctor capacity, Warrington

b. Risk 1139 (score 16)
Community Paediatric / neurodevelopment pathways waiting times, Halton

c. Risk 3241 (score 16)
Community Paediatric demand and capacity, Warrington and Halton

d. Risk 3262 (score 16)
Padgate House demand and capacity, Warrington

e. Risk 3266 (score 16)
Community Paediatric clinical harm reviews, Warrington and Halton

f. Risk 3271(score 16)
Community Paediatric ADHD diagnostic reviews, Warrington and Halton

All remaining risks on the risk register are scored 12 or below

4. RECOMMENDATION

4.1 The Board is asked to approve the changes recommended by the Committees and the Executive Management Team.

Appendix 1: Board Assurance Framework

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 30 May 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**	**BAF 8** **Integration with WHH** **Failure to effectively integrate services with WHH**
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 2 (L) = 8 **medium** 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 3 (L) = 12 high 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 Rating** Inherent risk rating 4 (C) x 4 (L) = 16 **significant** Current risk rating 4 (C) x 4 (L) = 16 **significant** Target risk rating 4 (C) x 2 (L) = 8 **medium**
Risk Appetite: Cautious	**Risk Appetite:** Open	**Risk Appetite:** Open	**Risk Appetite:** Open & Seek	**Risk Appetite:** Open	**Risk Appetite:** Seek	**Risk Appetite:** Seek	**Risk Appetite:** Open & Seek

Board Assurance Framework (BAF) May 2024 – Board V2

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
- Partnerships

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: May 2024 **Audit Committee** last review: April 2024 Risk Ratings review: April 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	**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 2024/25 • Anti-fraud plan agreed for 2024/25 • 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 **Audits** • Board Performance Reporting – High Assurance (2024/24) • Board Assurance Framework Review - (2023/24) • Risk Management Core Controls – high assurance (2023/24) • DSPT Audit – substantial assurance (2022/23)
Risks on register 12 2428: Data Security Protection 2880 Policies 3161 EPRR Training Compliance 3173 EPRR On Call Arrangements 3211 Halton IHA Referrals 3236 EPRR Capacity	**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 completed and signed off by the Audit Committee April 2024.			

Gaps in controls and assurance:	**Mitigating actions:**	**Emerging risks:**
• 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. • The immaturity of the work on measuring the delivery and impact of the Trust's strategy	• Board oversight	Financial system risks impacting on the Trust. Operational Planning Guidance impact

Board Assurance Framework (BAF) May 2024 – Board V2

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: April 2024 **Q&S Committee** last review: April 2024 Risk Ratings **review**: April 2024 ***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 – Community Paediatric doctor capacity, Warrington 1139 – Community Paediatric / NDP waiting times, Halton 3241- Community Paediatrics demand, Warrington & Halton 3262 - Padgate House demand and capacity, Warrington 3266 – Community Paediatric clinical harm reviews, Warrington & Halton 3271 - Community Paediatric ADHD diagnostic reviews, Warrington & Halton **Cross-referenced with BAF 5, Resources**	**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)

Risks on register 12
1771: Dental Estates
2428: Data Security Protection
2473 Estates H&S Compliance
2880 Policies
3064 Warrington MASH Capacity
3140 Safeguarding IHA Pathway
3145 DN Capacity - Wellbeing
3146 DN Capacity
3188 Interpretation Services
3210 Community Paediatrics
3211 Halton IHA Referrals
3213 Fleet House - Estates
3241Community Paediatrics
3245 MMR Staff Vaccination Status
	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			

Gaps in controls and assurance:	Mitigating actions:	Emerging risks:
• Staff compliance with mandatory and service and role specific training • Paediatric Audiology • Clinical leadership strategy – in development • Recruitment & Retention • CIP 2023/24		Community Paediatrics – 1. ADHD/ASD national medication shortage, and 2. ADHD increasing levels of demand Padgate House

Board Assurance Framework (BAF) May 2024 – Board V2

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: April 2024 **Q&S Committee** last review: April 2024 Risk Ratings review: April 2024 ***In collaboration with F&P and People***	If we fail to understand health inequity with our communities, we may fail to deliver services in an equitable way, which could contribute to health inequity and our patient's ability to improve their health. **Risks on register 15 plus** No risks at this level	**Prevent Controls** • Board development • Chair working within wider system • Contributing to work across the system in relation to developing Children's Services • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • Health Inequalities and Prevention Pledge Trust Board Oversight – engagement and delivery of Health & Care Act & strategic milestones • Performance framework – enabling strategies - operation delivery plans • Embedding an expectation of improving health equity in board, committees and Trust groups.	**Detect Controls** • Execs carrying out SRO roles within system, e.g. starting well, living well and aging well. • Joint working on a number of projects with commissioners and local authority • Patient Satisfaction Surveys • Regular Exec meetings with commissioners and other key stakeholders • Senior staff involvement with borough based integrated care partnerships visions including: 'Warrington Together', 'One Halton' and Dental Networks • Understanding activity and referral data in relation to access to services • Health & Wellbeing Boards • CIPHA • Childrens and Adults safeguarding Boards	**Assurances** • Emerging integrated governance structures with partners • Engagement internally / externally • Executive Directors hold regular meetings with all key partners and stakeholders • Implementing Dental Strategy with partners • Mental Health, Community and Learning Disability Provider Collaborative member – Trust is host, including employing staff – C&M Health and Care provider collaborate including employing and hosting staff • MOU in place where services are delivered in conjunction with other partners • Programme Director – Collaboration and Integration • Achieving Anchor status • Developing health equity indicators in IQPR **Audits** • Waiting List Management – substantial assurance (2022/23)

Risks on register 12
2473 Estates H&S Compliance
3064 Warrington MASH Capacity
3140 Safeguarding IHA Pathway
3145 DN Capacity - Wellbeing
3146 DN Capacity
3188 Interpretation Services
3210 Community Paediatrics
3211 Halton IHA Referrals
3241 Community Paediatrics
	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.			

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

Board Assurance Framework (BAF) May 2024 – Board V2

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 2 (L) = 8 **medium**
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: May 2024
 	
People Committee
last review: May 2024
 	
Risk Ratings review: May 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
		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
				• Improved staff survey scores (2023)
				• Improved KPI 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)

Risks on register 12
1771: Dental Estates
3064 Warrington MASH Capacity
3145 DN Capacity – Wellbeing
3146 DN Capacity
3245 MMR Staff Vaccination Status
	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			

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 • 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

Board Assurance Framework (BAF) May 2024 – Board V2

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 3 (L) = 12 high
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: May 2024
 	
F&P Committee
last review: May 2024
 	
Risk Ratings review: May 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
	1138 – Community Paediatric doctor capacity, Warrington
	1139 – Community Paediatric / NDP waiting times, Halton
	3241- Community Paediatrics demand, Warrington & Halton
	3262 - Padgate House demand and capacity, Warrington
	3266 – Community Paediatric clinical harm reviews, Warrington & Halton
	3271 - Community Paediatric ADHD diagnostic reviews, Warrington & Halton
	
	Cross-referenced with BAF 2, Quality
		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
				• Key Financial Controls – substantial assurance 2023/4)
				• 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

Risks on register 12
1771: Dental Estates
2428: Data Security Protection
2473 Estates H&S Compliance
3145 DN Capacity – Wellbeing
3146 DN Capacity
3161 EPRR Training Compliance
3173 EPRR On Call Arrangements
3213 Fleet House – Estates
3236 EPRR Capacity
3241 Community Paediatrics
3251 Cleaning Contract - Estates
	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
	
	Additional place integration savings ask alongside the CIP challenges			

Gaps in controls and assurance:	Mitigating actions:	Emerging risks:
• The 2024/25 Trust plan reflects challenging CIP and non-recurrent issues • 2024/25 BEC programme challenge • 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	• 2023-24 Trust CIP forecast will be achieved	• ICB management of system deficit • Review of Trust estate • Final plan not yet approved by NHS England

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: May 2024 **People Committee** last review: May 2024 Risk Ratings review: May 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	**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)

Risks on register 12
3188 Interpretation Services
3241 Community Paediatrics
	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			

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

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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 • Partnerships	**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: May 2024 **EMT** last review: May 2024 Risk Ratings review: May 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	**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 • Medical Director is SRO for Starting Well	**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 • EDI Strategy in place • Public & Community Engagement Group – ToR signed off
Risks on register 12	**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			

Gaps in controls and assurance:	**Mitigating actions:**	**Emerging risks:**
• Maturity of place-based relationships • Impact of pressures (inc. finance) • Halton SEND inspection November 2023	• 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	• Enabling • Speech & Language Therapy - Halton • Warrington Place Review

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BAF 8: **Integration with Warrington & Halton Hospital (WHH) NHS FT** **Failure to effectively integrate services with WHH**	**RELATED OBJECTIVES:** • Quality • Health Equity • Staff • Resources • Equality, Diversity and Inclusion • Partnerships	**RISK RATING:** Inherent risk rating: 4 (C) x 4 (L) = 16 **significant** Current risk rating: 4 (C) x 4 (L) = 16 **significant** Target risk rating: 4 (C) x 2 (L) = 8 **medium**	**RISK APPETITE:** **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**		
Chief Executive last review: May 2024 **EMT** last review: May 2024 Risk Ratings review: May 2024	If the Trust fails to successfully integrate services with WHH in a timely manner, there is a risk that: - The system remains clinically and financially unsustainable - Community services not having due prominence within the new structure - We will not make the sustained improvements needed to the local urgent and emergency care system and pathways - Patients will not benefit from integrated pathways and there may be detriment to service pathways and outcomes - Staff anxiety will be high, and could result in an increase in absence levels and turnover rates - Positive partnership working arrangements could be adversely affected, impacting on a positive employee relations climate - The governance will become cumbersome **Risks on register 15 plus** No risks at this level	**Prevent Controls** • Oversight from the ICB • Chief Executives' Memorandum of Understanding • Establishment of joint governance arrangements to oversee the integration programme • Joint legal advice • Monitoring of the Trust's People Indicators • HR Business Partner and OD Practitioner alignment to DLTs • Staff Health and Wellbeing Offers / Prospectus, and established Wellbeing Conversations • JNCC and LNC, supported by positive partnership working arrangements with regular HR and Staff-side meetings scheduled in between formal meetings, including an informal catch up with the CEO and DoP&OD • Our Just Culture approach/programme – 4 Step Process • Risk Management Council • QIA/EQIA process • Regular communication with all staff groups • Performance Council	**Detect Controls** • Co-designed place-based clinical integration of services • Co-designed clinical strategy • Co-designed Organisational Change Plan • Delivery on the urgent and emergency care recommendations • Joint Executive meetings identified • Support from the ICB • Annual Staff Survey and National Quarterly Pulse Surveys (NQPS) • Employee relations monitoring and case reviews and monitoring, as reported to the People Committee • Freedom To Speak Up (FTSU) monitoring and reporting to the People Committee • Incident management process • FTSU • Patient complaints/concerns	**Assurances** **Audits** **Internal Audit –** Not applicable
Risks on register 12	**Rationale for current score** Current risk rating reflects that the Board acknowledges that, despite the controls and assurances in place, this will be an ongoing piece of work potentially result the risks caused by such plans in terms of staff anxiety and paralysis of decision making.			

Gaps in controls and assurance:	**Mitigating actions:**	**Emerging risks:**
• Governance and legal advice required	• Joint legal advice commissioned	• The achievement of additional financial savings / efficiencies targets above existing organisational CIP plans

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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	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	5	3	15	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	3	4	12	3	4	12				→	✔	✔	✔	✔	✔	✔
BAF 4	**Staff** Failure to create an environment for staff to grow and thrive	4	4	16	4	1	4	4	3	12	4	2	8	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	4	2	8	4	3	12				↑	✔	✔	✔	✔	✔	✔
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	4	3	12	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	3	3	9	3	3	9				→	✔	✔	✔	✔	✔	✔
BAF 8	**Integration with WHH** Failure to effectively integrate services with WHH	4	4	16	4	2	8	-	-	-	-	-	-	-	-	-					✔	✔	✔	✔	✔	✔

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Appendix 2: Risk grading criteria

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

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

	Consequence score & descriptor with examples				
Risk type	**Very low 1**	**Low 2**	**Moderate 3**	**High 4**	**Very high 5**
a. Patient harm or **b. Staff harm** or **c. Public harm**	Minimal physical or psychological harm, not requiring any clinical intervention. e.g.: • Discomfort.	Minor, short term injury or illness, requiring non- urgent clinical intervention (e.g., extra observations, minor treatment or first aid). e.g.: • Bruise, graze, small laceration, sprain. Grade 1 pressure ulcer. Temporary stress / anxiety. • Intolerance to medication.	Significant but not permanent injury or illness, requiring urgent or on-going clinical intervention. e.g.: • Substantial laceration / severe sprain / fracture / dislocation / concussion. Sustained stress / anxiety / depression / emotional exhaustion. • Grade 2 or3 pressure ulcer. Healthcare associated infection (HCAI). • Noticeable adverse reaction to medication. • RIDDOR reportable incident.	Significant long-term or permanent harm, requiring urgent and on-going clinical intervention, or the death of an individual, e.g.: • Loss of a limb Permanent disability. • Severe, long-term mental illness. • Grade 4 pressure ulcer. Long-term HCAI. • Retained instruments after surgery. • Severe allergic reaction to medication.	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 Statistical probability below 0.1% Very good control	Between 1 chance in 1,000 and 1 in 100 Statistical probability between 0.1% - 1% Good control	Between 1 chance in 100 and 1 in 10 Statistical probability between 1% and 10% Limited effective control	Between 1 chance in 10 and 1 in 2 Statistical probability between 10% and 50% Weak control	Greater than 1 chance in 2 Statistical probability above 50% Ineffective control

Risk scoring matrix

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

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

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**37/24**		
Report Title	**KEY CORPORATE MESSAGES**		
Executive Lead	Colin Scales, Chief Executive		
Report Author	Jan McCartney, Director of Corporate Governance		
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 equality, 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**	**6 June 2024**
Agenda Item	**37/24**		
Report Title	**KEY CORPORATE MESSAGES**		
Report Author	Jan McCartney, Director of Corporate Governance		
Purpose	To update the Board concerning key matters within the Trust and the NHS as a whole.		

1. INTEGRATION – BOARD UPDATE FROM CHIEF EXECUTIVES

1.1 The following statement has been provided by Colin Scales, Chief Executive, Bridgewater Community Healthcare NHS FT and Simon Constable, Chief Executive, Warrington and Halton Teaching Hospitals NHS FT:

"Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare have a shared overriding aim of delivering a sustainable healthcare system for patients and staff.

The challenges facing the NHS are well-documented and are reflected locally here in Warrington and Halton, as they are elsewhere regionally and nationally. Our urgent care system is not working optimally, we are currently unsustainable financially and we have identified significant opportunities to improve care for our patients.

It is clear there are opportunities for further integration between our two organisations.

With that in mind, and working with system colleagues across Warrington and Halton, we are developing plans to bring our two organisations together, along with local system partners, to integrate our teams and maximise the benefit of our collective expertise. This will help us to jointly make best use of resources, but more importantly to improve care for our patients.

We are currently in the earliest stages of discussions, with the full backing and support of NHS Cheshire and Merseyside."

2. NON-EXECUTIVE DIRECTOR UPDATES

2.1 The Chair accompanied the Chief Executive on a Time to Talk session with the Warrington IV Therapy Team on 10 April. On 11 April the Chair shadowed a District Nursing Team in Grappenall, Warrington.

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

- People Committee Task Group on 15 April
- Time to Shine meeting on 19 April

- Audit Committee private meeting with external auditors on 25 April
- Cheshire and Merseyside ICS NEDs finance discussion on 10 April

2.3 Non-Executive Director, Martyn Taylor attended the Safeguarding Trust Assurance Group meeting on 15 April and the Time to Shine meeting on 19 April, where presentations were given on wheelchair, dental and podiatry services.

2.4 Non-Executive Director, Bob Chadwick attended the Cheshire and Merseyside Audit Chairs meeting on 30 April. During April Bob met with a number of Board members, as part of the induction process, as follows:

8 April – Chief Nurse, Chief Operating Officer and Non-Executive Director, Tina Wilkins
22 April – Non-Executive Directors, Martyn Taylor and Elaine Inglesby
24 April – Medical Director

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

Council of Governors meeting on 17 April
Private Audit Committee meeting with external auditors on 25 April
Halton and Warrington Council of Governors meeting on 7 May

Gail also had two 1-1 meetings with the Freedom to Speak Up Guardian, an introductory meeting with the newly appointed Non-Executive Director and a mentoring meeting Amena Patel.

2.6 Non-Executive Director, Elaine Inglesby attended numerous meetings, as follows:

- The EDI working group on 27 March
- Salford due Diligence meeting on 11 April
- People Committee Task & Finish Group on 15 April
- Halton & Warrington Governors meeting on 7 May
- MHLDC Board meeting on 13 May

Elaine also accompanied a member of the Executive Management Team on their Time to Talk visits:

- Phlebotomy service on 23 April
- Dene Drive Dental Team on 8 May
- Warrington Urgent Care Response and Virtual Ward teams on 16 May
- Widnes District Nursing Team on 20 May

On 10 April, Elaine was involved in the Governors/Non-Executive Director's service visit at Warrington Wolves and the focus was estates in the morning and Podiatry service in the afternoon.

A 1-1 meeting took place with Elaine and the Chief Operating Officer on 12 April and as part of the buddying arrangement, Elaine met with the Medical Director and Equality Diversity and Inclusion (EDI) Working Group. On 22 April, Elaine had an induction meeting

with Non-Executive Director, Bob Chadwick, and on 17 May, Elaine met with the Deputy Director of Estates, John Morris and the Lead Governor, Christine Stankus.

3. EXECUTIVE UPDATES

3.1 The Chief Executive participated in the stakeholder panel for the Warrington Borough Council Director of Public Health appointment.

3.2 The Chief Executive attended the MHLDC Board meeting on 13 May.

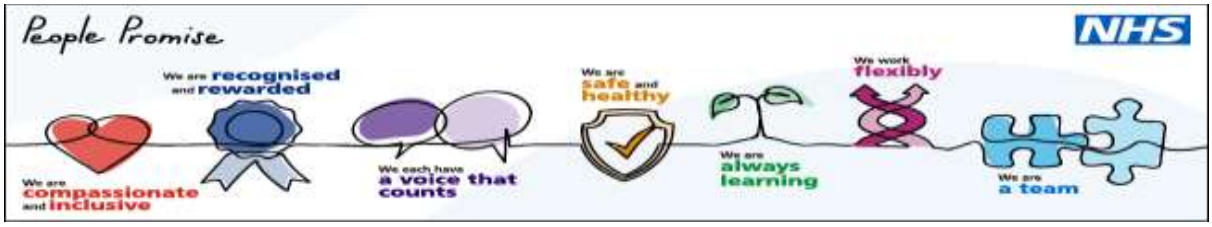
3.3 On 30 April, the Chief Executive had a follow up meeting with the Chief Executive of Halton Borough Council to discuss more ways of collaborative working in the borough.

3.4 On 9 May, the Chief Executive met with the Chief Executive of PC24 to discuss collaborative working opportunities.

3.5 An NHS Leading for Improvement Event took place on 30 April at the Floral Pavilion, New Brighton. The Director of People & Organisational Development, the Chief Operating Officer and the Medical Director attended. Keynote speakers provided presentations and several organisations from across the system were in attendance to exhibit and talk to attendees.

3.6 Executive and Senior Team Engagement

The Trust's Time to Talk process now aligns to the NHS Our People Promises and its seven 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:

a. On 10 April, the Chief Executive, accompanied by the Chair, met with the Warrington IV Therapy Team based at Bath Street. The Chief Executive, accompanied by Non-Executive Director, Elaine Inglesby met with the Dene Drive, Dental Team in Winsford on 8 May. On 16 May, the Chief Executive met with the Warrington Adults Urgent Community Response Team based at St Werburgh's Community Hub in Warrington.

b. On 13 May, the Chief Nurse met with the Halton Children's Team based at Kingsway Children's Centre, Widnes, accompanied by Non-Executive Director, Abdul Siddique.

c. On 10 April, the Chief Operating Officer met with the Halton 0-19 Team and on 20 May, met with the Widnes South District Nursing Team based at Chapelfields Health Centre. Non-Executive Director, Elaine Inglesby accompanied the Chief Operating Officer for this session.

d. The Director of Finance met with the Warrington Phlebotomy team on 23 April. Non-Executive Director, Elaine Inglesby also attended this session. On 8 May, the Director of Finance met with the Dental Team based at The Fountains Health Centre in Chester.

e. The Director of People & Organisational Development met with the Halton Children's Physio/OT service on 18 April.

f. The Director of Corporate Governance met with the Leadership and Organisational Development Team on 1 May.

3.7 Board Sessions/Events

a. A Board Seminar took place on Thursday 2 May. The focus of the session was financial planning, boosting efficiency 2024-25 and the Warrington integration and collaboration work.

4. DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

4.1 Following the Time to Talk sessions, monthly feedback from the Executive Team is collated, examples of feedback from recent sessions include:

"The team felt that they were caring and supportive towards each other and they looked out for each other personally and professionally."

"The team were open and honest. They were keen to share all their successes and showcase their upcoming work."

"The team were very welcoming and extremely open. They are an experienced team who are very clear about their role and are quite rightly proud of the work they do."

"The team reported some concerns in respect of car parking and telephone connections but felt positive about the development of their team and services".

People Promises

We are compassionate and Inclusive

Halton 0-19 Widnes team said they enjoy their jobs; however, they sometimes do not feel part of Bridgewater due to Spencer House being a distance from them. They felt that they cannot attend activities such as health and wellbeing offers as they are mostly based at Spencer House. This makes them feel excluded.

Halton's Family Nurse Partnership service stated that they feel that their work makes a positive difference to Bridgewater and its patients. They are proud of the difference they make to the community.

Warrington Adult's Phlebotomy team recommended Bridgewater as a great place to work.

We are recognised and rewarded

From feedback received, there was a general consensus that staff are not rewarded for the work they do. Some teams felt that they receive good recognition from their immediate line manager and senior leaders but less so from operational managers.

One team raised concerns around particular roles being banded lower at Bridgewater compared to other NHS trusts.

One team felt the profile of the service should be raised with partners.

We each have a voice that counts

When asked if teams were able to suggest improvements in their department, Halton's 0-19 Widnes team said yes, but sometimes the suggestions are not implemented, and they are not told why. Teams want to feel more involved in shaping the way they deliver their services.

One team raised concerns about the relationship between the Trust and a partner, specifically around clinical decisions being challenged.

Visited teams felt confident in raising concerns and were able to identify Helen Young as the Freedom to Speak up Guardian. Multiple teams mentioned how they were confident that concerns would be listened to and actioned appropriately.

We are safe and healthy

A reoccurring theme from feedback received was that teams feel that the Trust are taking positive action in relation to health and wellbeing, however, the location of events can be challenging. Multiple teams stated how they feel that events only take place in Spencer House, and they have to travel too far to attend so they often feel left out. Staff within the Dental Directorate have requested whether other NHS organisations can offer wellbeing events to reduce the need for travel.

Fountains Dental service expressed concerns at the number of visits they are receiving, for example, CQC mock visits, Time to Talk visits etc. They felt that the number of visits they are receiving is impacting them and effecting service delivery. The team also mentioned how they recognise the importance of the visits but would appreciate if the process of planning visits could be reviewed.

Some teams confirmed that they are able to take rest breaks during their day, however they do not have a breakout area.

Warrington Adult's Phlebotomy service raised concerns around verbal abuse from patients. The team expressed how patient complaints had increased due to service changes.

One team raised concerns about a lack of clinical leadership, due to time commitments.

We are always learning

From feedback received, there was a general theme that colleagues are supported when undertaking statutory and mandatory training. However, colleagues would appreciate if face-to-face sessions could be delivered in various areas as it is difficult for staff to travel to Spencer House.

Some teams also discussed the benefits of Leader in Me events but understood when they cannot attend. They suggested that the events could be filmed to be shared with staff at a later date.

We work flexibly

Teams confirmed that they are aware of the new flexible working policy. Teams raised concerns around how they had been told that flexible working does not apply to them or how flexible working requests had been refused leading to colleagues leaving the trust. Visiting Executive Representatives agreed to raise this with the relevant ADs.

We are a team

Most teams confirmed that they have regular team meetings. Teams also mentioned that relevant information from Team Brief is cascaded by team leaders.

Multiple teams expressed their concerns around the integration with WHHFT and want clarity on what this means for them. Teams also mentioned that they were disappointed to hear of the plans through employees of WHHFT before an announcement was made at Bridgewater. As discussions progressed, teams were satisfied that Bridgewater had been open and honest with them.

4.2 Confirmed actions stated on completed Time to Talk paperwork

Halton Family Nurse Partnership
Concerns raised around integration with WHH as this had just been announced.
Chief Nurse to discuss with EMT to ensure appropriate consistent messaging for all teams.

Halton 0-19 – Widnes
Uniform – Team want to wear uniform.
Chief Operating Officer has escalated request to Chief Nurse and Associate Chief Nurse.

Update: A consultation will take place – HR Business Partner for Childrens will be involved with Associate Chief Nurse who will consult with staff side.

Estates at Chapelfield – multiple issues – cleanliness, parking, treatment room bed, size, no lunch area, kitchen old and tired, windows not cleaned.
Chief Operating Officer has escalated issue to the Deputy Director of Estates

Update: Some issues are being picked up – others will be addressed. £400k of capital has been allocated to estates – some of which will be used to address some issues raised.

Halton 0-19 – Occupational Therapy and Physiotherapy team

Escalation of session feedback – Team needs capacity and demand planning, wellbeing support, OD initiatives etc.
Director of People & Organisational Development has agreed to escalate feedback to various managers and up to Executive level.

Leadership & Organisational Development team

Concerns around local integration communication.
Director of Corporate Governance to feedback the team's concerns around how integration is communicated.

Fountains Dental service

Trust Communications
Director of Finance to feedback to Communications team around some colleagues missing bulletin emails.

Signage issue
Director of Finance to feedback to Estates team around lack of signage at Fountains Dental service.

Health and wellbeing location issues
Director of Finance to feedback to OD around the possibility of Health and Wellbeing events being offered in various locations.

Warrington Adults Phlebotomy service

Issues related to verbal abuse from patients
Director of Finance to feedback to Warrington AD around staff receiving abuse from patients due to service changes.

Urgent Community Response Warrington Team

All concerns were referred to the Associate Director who met with the Chief Nurse and Chief Operating Officer regarding these issues.

5. EXTERNAL PUBLICATIONS AND REPORTS

5.1 The Infected Blood Inquiry

The Infected Blood Inquiry was an independent public statutory inquiry into the use of infected blood chaired Sir Brian Langstaff. The report was published on 20 May 2024. The Inquiry Report | Infected Blood Inquiry

5.2 Urgent and emergency care recovery plan year 2: Building on learning from 2023/24

The Delivery plan for recovering urgent and emergency care was published in January 2023. This letter and guidance highlight the progress made over 2023/24 in delivering the actions set out in the delivery plan.
PRN01288_i_Urgent-and-emergency-care-recovery-plan-year-2-building-on-learning-from-2023-24-May-2024.pdf (england.nhs.uk)

5.3 NHS Oversight Framework.

This framework replaces the previous NHS system oversight framework and describes NHS England's approach to oversight of both integrated care boards (ICBs) and trusts. This is currently open for consultation before roll out during July 2024.
NHS England » NHS Oversight Framework

5.4 NHS Audit Committee Handbook

A fully revised edition of the NHS audit committee handbook was published by the Healthcare Financial Management Association (HFMA) in March 2024.

The revision reflects recent learning from governance failings in the corporate and public sectors, and the changed context following the Health and Care Act 2022. It considers the impact of system working and collaboration on the work of the audit committee.

5.5 HFMA briefing: Head of Internal Audit Annual Opinion

The accountable officer of each NHS organisation has the responsibility for maintaining a sound system of internal control and governance that supports the achievement of the organisation's policies, aims and objectives, while safeguarding quality standards and public funds. Internal audit has a key role in providing assurance over these arrangements, which is reported in the annual head of internal audit (HoIA) opinion.

This paper looks at what the HoIA opinion is; why it is important; the requirements for the HoIA opinion; and key considerations. This paper will be of particular interest to internal auditors, finance directors and their teams, non-executive directors and directors of governance.

The briefing can be found here: https://www.hfma.org.uk/publications/head-internal-audit-annual-opinion

6. RECOMMENDATIONS

5.1 The Board is asked to note the report.

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**38/24i**		
Report Title	**INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR) - MONTH 12 - MARCH 2024**		
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 12 – March 2024.

There continues to be several red indicators in relation to operational delivery with increasing pressures in the Children's Services Directorate which impact both quality and finance (Community paediatrics and audiology). The cancer and A&E indicators are however displaying an improved position

From a quality perspective, there is an improvement in risks managed in line with the policy and also in relation to the percentage of risks over 12. There is a decrease the compliance with infection, prevention, control (IPC) audits. The people indicators demonstrate an improved position, with actual and rolling sickness being marginally outside of the target. From a finance perspective, the Trust reached the breakeven position with a full year achievement of the cost improvement programme.

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** (People indicators only)	☐ **EMT**

Strategic Objectives

☐ **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.

☐ **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**	**6 June 2024**
Agenda Item	**38/24i**		
Report Title	**INTEGRATED QUALITY AND PERFORMANCE REPORT – MONTH 12 – MARCH 2024**		
Report Author	Executive Directors		
Purpose	To describe the performance in relation to service performance, quality, people, and finance in Month 12 – March 2024.		

1. OVERVIEW

1.1 The IQPR relates to the performance across the Trust in Month 12 – March 2024.

1.2 The IQPR for Month 12 has been reviewed in its entirety by the Finance and Performance Committee in May 2024.

1.3 The Quality and Safety Committee reviewed the Month 11 Quality Indicators in April 2024.

1.4 The People Committee reviewed the People Indicators from Month 12 in May 2024.

1.5 The IQPR was not reviewed by the Performance Council due to the Directorate Quarterly Performance Reviews in May 2024. All areas were however discussed specific to the Directorate in each of the reviews.

2. SERVICE PERFORMANCE

CANCER PERFORMANCE

2.1 All of the cancer indicators (relating to dermatology) in month are reporting as green, which is an improved position to the February position where the 31 day wait from diagnosis to first treatment was reporting as red. The March position which relates to the January performance shows a positive increase in the 28-day faster diagnosis standards which has reached 93.22%. Over the last 12 month the performance against the 28-day faster diagnosis standard has been consistent and the Trust is ranked 3rd in Cheshire and Merseyside.

Rank	Provider	Percentage diagnosed or ruled out in 28 days	Meeting target	Not meeting target	Total number of patients
1	The Walton Centre	100.0%	100.0%		196
2	Alder Hey Childrens	97.7%	97.7%		215
3	Bridgewater Community Healthcare	86.2%	86.2%		3,363
4	The Clatterbridge Cancer Centre	81.9%	81.9%		182
5	Warrington and Halton Teaching Hospitals	75.8%	75.8%		11,199
6	Wirral University Teaching Hospital	73.7%		73.7%	23,044
7	East Cheshire	72.7%		72.7%	8,149
8	Liverpool University Hospitals	71.3%		71.3%	42,595
9	Mersey and West Lancashire Teaching Hospitals	70.2%		70.2%	38,392
10	Mid Cheshire Hospitals	68.1%		68.1%	19,016
11	Countess Of Chester Hospital	64.8%		64.8%	16,038
12	Liverpool Heart And Chest	57.0%		57.0%	142
13	Liverpool Womens	39.6%		39.6%	4,559

Actions being taken

All of the cancer indicators are monitored closely internally and via the Cancer Alliance Network via the data received and quarterly performance meetings.

Target date for compliance

The indicators are now compliant. The service will continue to focus on achieving the targets on a weekly and monthly basis; however, some elements are outside the control of the service i.e. due to patient choice or clinically indicated reasons.

Committee Oversight

A paper was presented to the Quality and Safety Committee in April 24 and the Committee decided that any quality and safety issues could be managed by the Quality Council and that escalations would be received via the Quality Council Chairs report into the Quality and Safety Committee in the same way escalations in relation to deterioration in performance are monitored via the Performance Council Chairs report to the Finance and Performance Committee.

A&E PERFORMANCE

2.2 Only one of the eight (National) A&E indicators relating to the performance of the Widnes Urgent Treatment Centre (UTC) is reporting as red in month. The one remaining red indicator relates to the percentage of patients referred to A&E.

2.3 Two indicators in month have demonstrated an improved performance, these relate to total time in A&E (% of patients who have waited <= 4 hours) and Total time in A&E – 95th Percentile (Mins). Both have demonstrated significant improvements in performance.

2.4 The Integrated Care Board tasked all urgent treatment centres to achieve 100% against the total time in A&E (% of patients who have waited <= 4 hours). The service achieved this from 1st to 30th March and on the 31st March there were a small number of breaches which meant that overall, for the month of March 99.78% against the 100% target was achieved. This was still a very positive performance and contributed to the overall Cheshire and Merseyside performance.

Actions being taken

The service is working hard to maintain performance against the new green indicators in month and ensuring that the learning from March is embedded in service delivery. The subcontract for the provision of medical services into the urgent treatment centre is being developed and it is hoped that this will support a move to compliance with the percentage of patients referred onto A&E.

Target date for compliance

The service expects to remain compliant with the new green indicators, but more work needs to be undertaken in relation to the development of clinical pathways to support the reduction in referrals to A&E. It is anticipated that this will be achieved over the next six months.

DATA QUALITY

2.5 Both Data Quality indicators continue to report as red in month. The Data Quality Maturity Index score is made up of four datasets, these being the Emergency Care Data Set (ECDS), Community Services Data Set (CSDS), Mental Health Services Data Set (MHSDS) and Commissioning Data Set Outpatients (CDS).

2.6 Focus continues around the ECDS data and the CSDS indicators which have the most impact on the Trust scores.

2.7 The Data Quality Maturity Index (DQMI) published 3 months in arears will increase next month as NHS England are now not expecting an outpatient data submission and therefore the weighting for this will be removed.

Actions being taken

The Data Quality Steering Group continues to work with clinical teams to increase compliance across the required fields. Subsets of the Data quality steering group have been established and this work is ongoing.

Target date for compliance

Due to the work that is required in relation to these indicators it will be a longer period of time before compliance with this indicator is achieved.

DID NOT ATTEND / WAS NOT BROUGHT

2.8 Percentage did not attend (DNA) / was not brought for Warrington Adult's and Children's services continue to exceed the required targets. There are however positive improvements in both areas and a reduction of DNA's/ was not brought.

Actions being taken

Services continue to focus on ensuring patients are supported to attend their appointments to maximise clinical time. Teams are monitoring DNAs and was not brought, and these are reported at monitored at Performance Council.

Target date for compliance

Warrington adults hope to achieve this target early into the new financial year. Work is ongoing for children's services, particularly around speech and language therapy which has a high number of DNAs.

AUDIOLOGY

2.9 The number of audiology breaches in month have increased from 35 to 100 in month.

2.10 We had anticipated to be able to clear the breaches in March however there has been an increased number of referrals from school hearing screening and a Band 6 vacant post which we have been unable to recruit to which is causing pressure on appointments where two audiologists are required.

2.11 The high demand on the neurodevelopment pathway has also impacted as many of the referrals on this pathway also need hearing tests to rule out deafness being the cause of social communication difficulties.

2.12 The service capacity is also being used by patients who require follow up appointments.

Actions being taken

Recruitment to the Band 6 post continues and the team are being supported to maximise their capacity to reduce the number of breaches.

Target date for compliance

The service was aiming to be compliant in April, but this is now unlikely until the end of Q3.

Committee Oversight

The Quality and Safety Committee provided oversight following the paediatric audiology incident. There are no papers due to the committee, but an escalation will be received via the Quality Council should this be required.

LOCAL INTEGRATED CARE BOARD REFERRALS TO PLAN AND ACTIVITY TARGETS

2.13 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. This work continues and fortnightly meetings are in place.

Target date for compliance

The 13 services being reviewed will be expected to potentially be completed during Quarter 1 2024 and then there will be another cohort of services identified to be reviewed so it will take a number of months to reset the aggregated targets, but an improvement should be seen by the end of Quarter 1.

NATIONAL WAITING TIMES

2.14 The percentage of patients who are seen within the 18-week RTT improved in month from 53.76% to 55.66%.

2.15 The RTT is no longer reported nationally in the current format as reported in the IQPR, therefore some of the waiting times indicators will need to be reviewed and refreshed in line with the Community Health Services Data submission. A proposal will be brought to the Finance and Performance Committee and then onto Board for approval.

2.16 Consultant led waiters over 52 weeks sit with the Halton Community Paediatric Service. All waiters over 52 weeks are subject to clinical harm reviews. There are currently only a small number of consultant led waiters over 52 weeks, however, there has now been harms identified.

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

2.18 There are a small number of 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
- Halton Podiatry

There are now no over 52 week waits in the Warrington Paediatric Speech and Language therapy service.

Actions being taken

Warrington and Halton Community Paediatrics

There is a considerable focus of attention on the Community Paediatrics services due to the current waiting list pressures. A business case was shared with the Halton ICB to request the additional nursing staffing capacity, and this was rejected, we are now looking at a business case for additional speech and language therapists to support some of the waiting list pressures. The locum Community Paediatricians have been extended till the end of June and it likely that this will be extended further to October as the service capacity is still significantly impacted due to the additional prescribing activity which is required to support monthly prescribing of medication and to manage the increasing waiting list demands and also to see the patients that have been expedited when harm or concerns have been identified via clinical harm reviews.

Halton Podiatry

The Halton Podiatry service has been working to reduce all of the long waiters and the longest waiter is now at 76 weeks and there are 48 patients who are over 52 weeks. The service is on track to reduce the longest wait for 65 weeks by 1st October. The waiting list has reduced considerably from 1525 in August to 991 in March.

Target date for compliance

- Over 65-week waiters to be cleared by October 2024 where possible – this will be a significant risk for Halton and Warrington Community Paediatrics.
- All service to focus on achieving the 18-week RTT with 2025-26.

Committee Oversight

The risks in relation to Community Paediatrics are being monitored by the Quality and Safety Committee who are receiving regular bi-monthly reports.

MANDATED HEALTH VISITOR CONTACTS

Not reported this quarter

DENTAL

2.19 The waiting list data has not been updated for Cheshire and Merseyside and Greater Manchester North and West due to the impact of the transfer of clinical system from SOEL to Dentally and the challenges in relation to accessing back-end reporting data. It is hoped that this will be resolved by Quarter 1. We have some early indications of a positive improvement in performance, but the data quality is being checked to confirm the improved position.

2.20 The numbers of patients waiting to be seen in Oldham, Rochdale and Bury has shown a 12.7% decrease which is demonstrating the positive impact of the work of the task and finish groups.

2.21 There are a number of waiters currently over the 65-week target which are currently being reviewed by the Clinical Directors.

2.22 The most significant pressures are in paediatric general anaesthesia, inhalation sedation and minor oral surgery. Paediatric GA capacity is under some significant pressures as the available theatre capacity is being requested to manager over 65-week elective capacity pressures.

Actions being taken

Discussions are ongoing with Commissioners, and it is anticipated that the monies to maintain the GA sessions in Oldham will be identified. The work of the task and finish groups is continuing ensuring that the referral and discharge is consistently implemented. The transfer to dentally for Oldham, Rochdale and Bury is being completed.

Target date for compliance

- All over 65-week waiters to be cleared by October 2024 as per the Operational Planning Guidance 24/25

Committee Oversight

An update paper was taken to the Quality and Safety Committee who accepted the level of assurance provided in relation to the actions that were being taken and who will escalate any concerns in the Quality Council Chairs report.

3. SERVICE QUALITY

INCIDENTS

3.1 In month, there has been an increase in the % of incidents causing harm from 29.03% to 40.5% which is more in line with the previous 3 months.

Actions being taken

This Patient Safety Incident Response Framework (PSIRF) is now being embedded and the associated processes and reporting groups are monitoring the incidents that cause harm to ascertain the reasons for the harm.

3.2 Duty of candour is reporting as red in month at 75% due to one incident awaiting a decision whether duty of candour was applicable.

3.3 The percentage of incidents that are medicines incidents is green however the medication incidents which cause harm is reporting at 15.38%. This is due to two incidents causing minor harm. Overall, there were 13 medicines incidents in month.

Actions being taken

The Medication Safety Officer is reviewing all medication incidents which cause harm and ensuring that there are actions in place to ensure that there are lessons learnt.

RISKS

3.4 The percentage of risks above 12 has decreased in month due to a review of all of the risks on the risk register.

3.5 The number of risks managed in line with the policy has increased from 75.52% to 84.04% in March after a period of focus on ensuring that risks are in date.

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. Work is continuing to ensure that all risks are managed in line with the policy.

FALLS PER 1,000 BED DAYS – BED BASED

3.6 The falls per 1,000 bed days has increased from 14.02 to 18.37 in March as this has not been consistently outside of the limits this indicator will be monitored over the next few months.

TOTAL NUMBER OF PRESSURE ULCERS

3.7 The total number of pressure ulcers in March has increased from 16 to 29. This is the first red data point and so this indicator will continue to be monitored.

POLICIES

3.8 The percentage of policies which are within their review date is red, with 84.56% of policies being 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

3.9 Compliance with the Infection, Prevention and Control audit has decreased to 79% 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 and IPC is monitoring compliance.

CQUIN

Not reported in month

4. PEOPLE

ACTUAL AND ROLLING SICKNESS

4.1 The rolling sickness rate is just above the Trust target of 5.5% and sits at 5.57% which is a consistent with the January and February position. The actual sickness absence rate has decreased from 5.91% to 5.54% in month.

4.2 This change is not unexpected and is largely attributable to seasonal variation and this is reflected in the increase in short term absence from 2.26% to 3.5%.

Actions being taken

- Sickness data is sent to Directorate and Corporate leads on a monthly basis.
- HR Team are aligned to advise and guide in terms of absence management.

- 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 DLT's and uptake has increased. Next steps are to look at the opportunity of introducing an electronic version of the form and 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.
- New holistic Wellbeing Policy is near to launch which will support a significant culture change around absence management with a move away from triggers and a focus on a person-centred approach to wellbeing and supporting attendance.

5. FINANCE

5.1 The Trust is reporting a final adjusted breakeven position, in line with the plan.

5.2 The Trust has a savings requirement of £5.15m (5.2%) in line with ICB instruction.

5.3 The Trust is reporting a full year savings achievement of £5.24m against a plan of £5.15m.

5.4 Income is £101.92m for the year against a plan of £97.94m.

5.5 Expenditure is £103.03m for the year against a plan of £97.94m.

5.6 Pay is £67.81m for the year against a plan of £64.15m.

Actions being taken

There is a considerable focus in services reviewing how day to day costs can be controlled and agency usage controlled as far as possible. Budget managers are exploring cost improvement schemes and opportunities which will contribute to the delivery of next year's Boosting Efficiency Programme.

6. SUMMARY

6.1 There are several service performance indicators which continue to report as red, however there are some positive improvements in relation to the cancer targets, A&E targets and the short- and long-term absence.

6.2 There is good oversight of the red indicators by the Committees of the board and discussions are taking place in relation to all of the red indicators and where required further assurance in relation to actions being taken are being requested.

7. RECOMMENDATION

7.1 The Board are asked to note the contents of the IQPR Month 12 report and to accept assurance that there are a significant number of actions being undertaken to address the areas where performance is red.

Communities Matter

Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Integrated Quality and Performance Report

Information Team

Reporting Period: March 2024 (Month 12)

Contents

Introduction

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

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

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

This month's report describes activity in March 2024.

Within this Report

1. KPI Amendments

No in month amendments, however there are four indicators which were previously reported nationally which fed into the ‘Referral To Treatment’ data sets which are now no longer reported externally for all of the services that previously sat in this data set.

A review of these indicators will be undertaken and consideration of the indicators in the Community Health Services data set will be undertaken and a proposal will be brought back to the Finance and Performance Committee in July for discussion and onward approval at Board.

2. Recommendations:

The Board are asked to:

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

Trust Overview

Executive Summary

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

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

The March figure for the indicator Data Quality Maturity index (DQMI) Monthly published score (3 months in arears), is based on December 2023 data.

Responsive (Operations)

There are 17 green indicators in month 12.

There is considerable pressure on the Warrington Audiology service due to a number of factors and the number of breaches have risen in month. There is support from the Operational Manager to address this but it is key that a Band 6 vacancy is successfully recruited to.

A number of the indicators in relation to referrals and activity need to have a refresh of target levels and these are being picked up by the service level reviews of the specification.

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 21 green indicators in month 12. All of the training indicators remain green.

There is a particular focus around risk management and getting all policies up to date.

People

2 out of the seven people indicators are red in month 12. These relate to sickness absence actual and rolling and the target has only been missed slightly but the trend is positive.

Making Good Use of Resources (Finance)

There is a positive position reported in relation to finance with most indicators reporting as green or amber and the breakeven year end position has been achieved.

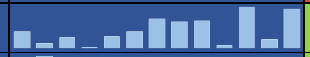
Operations

Trust Scorecard

Operations														
KPI Name	Target	Trend Line	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Warrington Dermatology Cancer 2 week referrals (urgent GP)	93%		98.16% (▼)	96.82% (▼)	97.78% (▲)	98.59% (▲)	98.67% (▲)	98.42% (▼)	96.56% (▼)	96.63% (▲)	95.3% (▼)	96.67% (▲)	97.83% (▲)	98.44% (▲)	97.36% (▼)
Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94%		100% (▲)	100% (►)	71.43% (▼)	100% (▲)	100% (►)	80% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%		100% (▲)	100% (►)	100% (►)	92.86% (▼)	100% (▲)	100% (►)	87.5% (▼)	90.91% (▲)	100% (▲)	90.91% (▼)	94.12% (▲)	93.75% (▼)	100% (▲)
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%		75% (▼)	77.27% (▲)	86.67% (▲)	95.83% (▲)	90% (▼)	87.5% (▼)	88.46% (▲)	93.75% (▲)	87.5% (▼)	80% (▼)	83.33% (▲)	89.29% (▲)	92.59% (▲)
28 day faster diagnosis	75%		91.01% (▲)	86.96% (▼)	82.91% (▼)	84.47% (▲)	87.57% (▲)	86.71% (▼)	89.74% (▲)	81.54% (▼)	87.61% (▲)	81.07% (▼)	80.72% (▼)	87.21% (▲)	93.22% (▲)
A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		98.1% (▲)	96.8% (▼)	97.53% (▲)	98.42% (▲)	97.2% (▼)	98.53% (▲)	96.84% (▼)	94.62% (▼)	94.74% (▲)	86.59% (▼)	88.25% (▲)	93.71% (▲)	99.78% (▲)
Total time in A&E - 95th Percentile (Mins)	4 Hrs		03:31 (▲)	03:51 (▼)	03:52 (▼)	03:40 (▲)	03:51 (▼)	03:34 (▲)	03:48 (▼)	04:04 (▼)	04:04 (▼)	05:04 (▼)	04:55 (▲)	04:29 (▲)	03:39 (▲)
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 (▲)	01:38 (▼)	01:55 (▼)	01:50 (▲)	01:36 (▲)
A&E Time to treatment decision (median) <=60 mins (Mins)	60 Mins		00:08 (▼)	00:09 (▼)	00:09 (▲)	00:08 (▲)	00:09 (▼)	00:07 (▲)	00:09 (▼)	00:09 (▼)	00:08 (▲)	00:10 (▼)	00:09 (▲)	00:08 (▲)	00:07 (▲)
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 (▲)	00:34 (▼)	00:26 (▲)	00:23 (▲)	00:21 (▲)
A&E Unplanned re-attendance rate <=5%	5%		0% (►)	0% (►)	0.03% (▼)	0% (▲)	0.03% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0.08% (▼)	0.34% (▼)	0.25% (▲)	0.17% (▲)
A&E left without being seen <=5% (left before trx completed)	5%		0.09% (▼)	0.09% (▼)	0.18% (▼)	0.19% (▼)	0.06% (▲)	0.18% (▼)	0.08% (▲)	0.08% (▲)	0.26% (▼)	0.19% (▲)	0.18% (▲)	0.42% (▼)	0.3% (▲)
Percentage referred onto A+E (UTC)	5%			12.37% (►)	13.02% (▼)	10.66% (▲)	12.17% (▼)	12.13% (▲)	12.33% (▼)	10.95% (▲)	9.86% (▲)	9.8% (▲)	9.89% (▼)	11.2% (▼)	9.94% (▲)
Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%		99.73% (▲)	99.73% (►)	99.7% (▼)	99.7% (►)	99.72% (▲)	84.52% (▼)	84.15% (▼)	84.67% (▲)	84.75% (▲)	83.99% (▼)	84.11% (▲)	84.28% (▲)	80.03% (▼)
Data Quality Maturity index (DQMI) Monthly published score (3 months in arears)	95%		88.6% (▼)	89.4% (▲)	88.7% (▼)	88.8% (▲)	90.3% (▲)	90.8% (▲)	89.8% (▼)	91.1% (▲)	89.1% (▼)	89.2% (▲)	90.2% (▲)	57.5% (▼)	57.3% (▼)

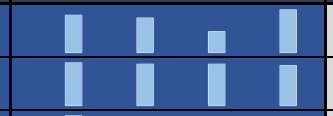
Operations

Trust Scorecard

Operations														
KPI Name	Target	Trend Line	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Percentage of DNAs/Was not brought - Childrens	3%		4.92% (▲)	5.33% (▼)	5.19% (▲)	5.24% (▼)	4.64% (▲)	6.32% (▼)	4.58% (▲)	4.45% (▲)	4.59% (▼)	5.7% (▼)	5.27% (▲)	4.64% (▲)	4.31% (▲)
Percentage of DNAs/Was not brought - Warrington Adults	3%		3.31% (▼)	3.55% (▼)	3.35% (▲)	3.45% (▼)	3.39% (▲)	3.39% (▲)	3.15% (▲)	3.53% (▼)	3.28% (▲)	3.2% (▲)	3.29% (▼)	3.58% (▼)	3.33% (▲)
Percentage of DNAs/Was not brought - Halton Adults	3%		0.98% (▲)	0.74% (▲)	0.86% (▼)	0.66% (▲)	0.89% (▼)	0.97% (▼)	1.23% (▼)	1.16% (▲)	1.18% (▼)	0.72% (▲)	1.45% (▼)	0.82% (▲)	1.41% (▼)
Proportion of Urgent Community Response referrals reached within two hours	70%		88.81% (▼)	97.52% (▲)	91.07% (▼)	91.18% (▲)	97.3% (▲)	87.2% (▼)	91.6% (▲)	88.7% (▼)	81.8% (▼)	92.5% (▲)	87.67% (▼)	89.8% (▲)	81.8% (▼)
Audiology - Number of 6 weeks diagnostic breaches	0		9 (▼)	67 (▼)	85 (▼)	77 (▲)	73 (▲)	87 (▼)	62 (▲)	98 (▼)	91 (▲)	55 (▲)	35 (▲)	33 (▲)	100 (▼)
Referrals to plan - Childrens	95%		122.93% (▼)	92.83% (▲)	103.62% (▲)	110.95% (▼)	110.92% (▲)	107.48% (▲)	107.63% (▼)	108.23% (▼)	107.78% (▲)	106.62% (▲)	107.9% (▼)	108.63% (▼)	107.99% (▲)
Referrals to plan - Warrington Adults	95%		80.45% (▼)	75.88% (▼)	78.75% (▲)	81.64% (▲)	81.27% (▼)	81.08% (▼)	80.48% (▼)	81.24% (▲)	81.09% (▼)	80.46% (▼)	80.98% (▲)	81.21% (▲)	80.17% (▼)
Referrals to plan - Halton Adults	95%		99.42% (▼)	96% (▼)	94.95% (▼)	94.61% (▼)	92.73% (▼)	93.26% (▲)	92.37% (▼)	92.68% (▲)	92.47% (▼)	91.99% (▼)	93.26% (▲)	94.12% (▲)	94.09% (▼)
% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92%		57.99% (▲)	58.67% (▲)	67.55% (▲)	69.21% (▲)	65.29% (▼)	67.59% (▲)	65.39% (▼)	64.39% (▼)	58.88% (▼)	60.14% (▲)	57.28% (▼)	53.76% (▼)	55.66% (▲)
% of waiters over 52 weeks - consultant Led	0%		0% (►)	0% (►)	0% (►)	0% (►)	0.17% (▼)	0.03% (▲)	0.12% (▼)	0% (▲)	0.03% (▼)	0.03% (▲)	0.26% (▼)	0.03% (▲)	0.91% (▼)
% of waiters over 78 weeks -consultant Led	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
% of waiters over 104 weeks-consultant Led	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
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% (▼)	1.06% (▼)	0.83% (▲)	0.81% (▲)	0.88% (▼)
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% (▼)	67.04% (▼)	68.4% (▲)	67.66% (▼)	67.83% (▲)
Warrington Adults Activity Variance	3%		-19.55% (▼)	-24.12% (▼)	-21.25% (▲)	-18.36% (▲)	-18.73% (▼)	-18.92% (▼)	-19.52% (▼)	-18.76% (▲)	-18.91% (▼)	-19.54% (▼)	-19.02% (▲)	-18.79% (▲)	-19.83% (▼)
Warrington Childrens Activity Variance	3%		9.44% (▼)	4.95% (▲)	18.93% (▼)	28.77% (▼)	27.42% (▲)	21.31% (▲)	21.76% (▼)	24.42% (▼)	25.5% (▼)	22.83% (▲)	24.54% (▼)	25.5% (▼)	24.98% (▲)
Halton Adults Activity Variance	3%		-0.58% (▼)	-4% (▼)	-5.05% (▼)	-5.39% (▼)	-7.27% (▼)	-6.74% (▲)	-7.63% (▼)	-7.32% (▲)	-7.53% (▼)	-8.01% (▼)	-6.74% (▲)	-5.88% (▲)	-5.91% (▼)
Halton Childrens Activity Variance	3%		58.95% (▲)	-26.72% (▲)	-22.5% (▲)	-19.91% (▲)	-18.87% (▲)	-18.74% (▲)	-19.5% (▼)	-21.97% (▼)	-24.47% (▼)	-23.64% (▲)	-23.28% (▲)	-23.21% (▲)	-24.12% (▼)

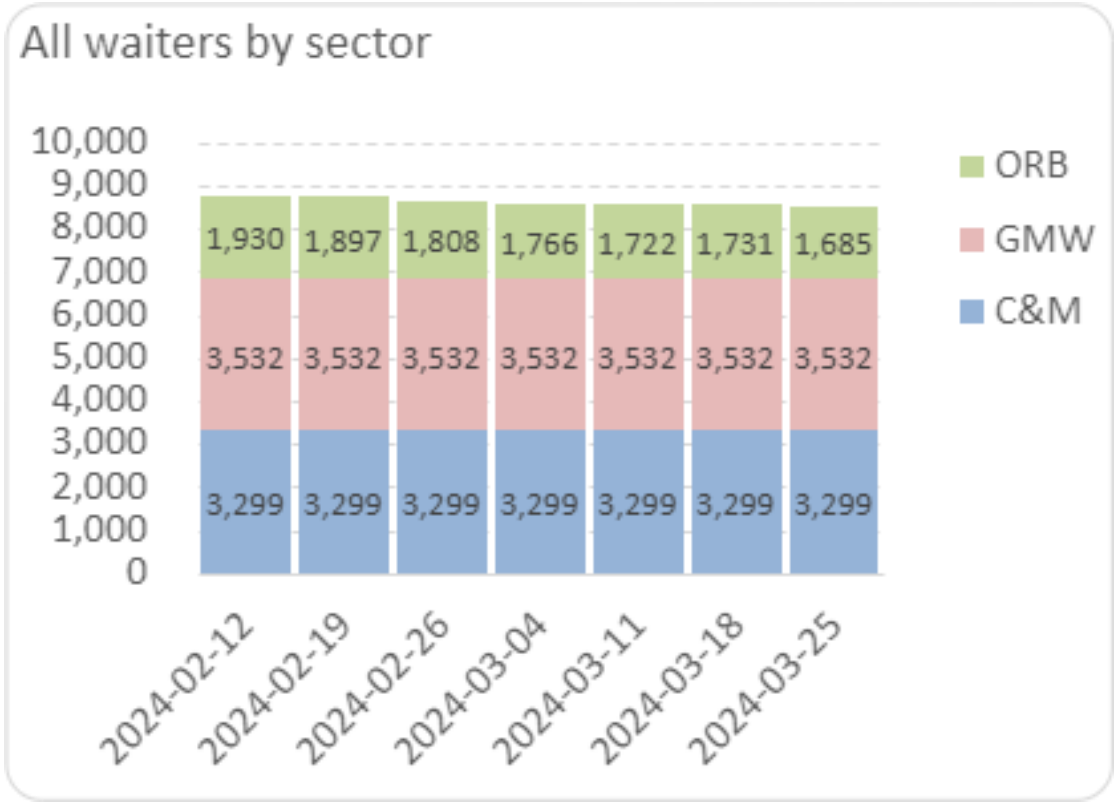
Operations

Trust Scorecard

Operations															
KPI Name	Target	Trend Line	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Halton					66 (▲)			60 (▼)			37 (▼)			75 (▲)	
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Halton	95%				87.55% (▼)			84.72% (▼)			84.15% (▼)			81.53% (▼)	
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Halton	90%				91.21% (▲)			89.04% (▼)			80% (▼)			84% (▲)	
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Halton	85%				89.14% (▲)			82.93% (▼)			60.45% (▼)			67.21% (▲)	
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Halton	85%				92.81% (▲)			92.68% (▼)			90.39% (▼)			83.77% (▼)	
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton	90%				70.59% (▲)			71.26% (▲)			78.06% (▲)			81.25% (▲)	
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton	90%				90.55% (▼)			86.53% (▼)			93.46% (▲)			92.28% (▼)	
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Warrington					267 (▲)			265 (▼)			279 (▲)			318 (▲)	
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington	95%				90.05% (▼)			94.27% (▲)			91.65% (▼)			92.71% (▲)	
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Warrington	90%				95.75% (▼)			95.67% (▼)			96.91% (▲)			97.61% (▲)	
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Warrington	85%				94.63% (▲)			95.03% (▲)			96.35% (▲)			97.46% (▲)	
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Warrington	85%				98.38% (▲)			98.11% (▼)			98.66% (▲)			99.21% (▲)	
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Warrington	90%				94.46% (▲)			93.9% (▼)			94.93% (▲)			96.38% (▲)	
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Warrington	90%				98.62% (▼)			98.21% (▼)			97.64% (▼)			98.95% (▲)	
Available Virtual Ward Capacity per 100,000 head of population							6.76 (►)	6.52 (▼)	5.48 (▼)	8.42 (▲)	8.66 (▲)	9.53 (▲)	6.41 (▼)	10.16 (▲)	8.57 (▼)

Operations: Exception Reporting

Charts



Issue

Dental - Patients waiting by Sector

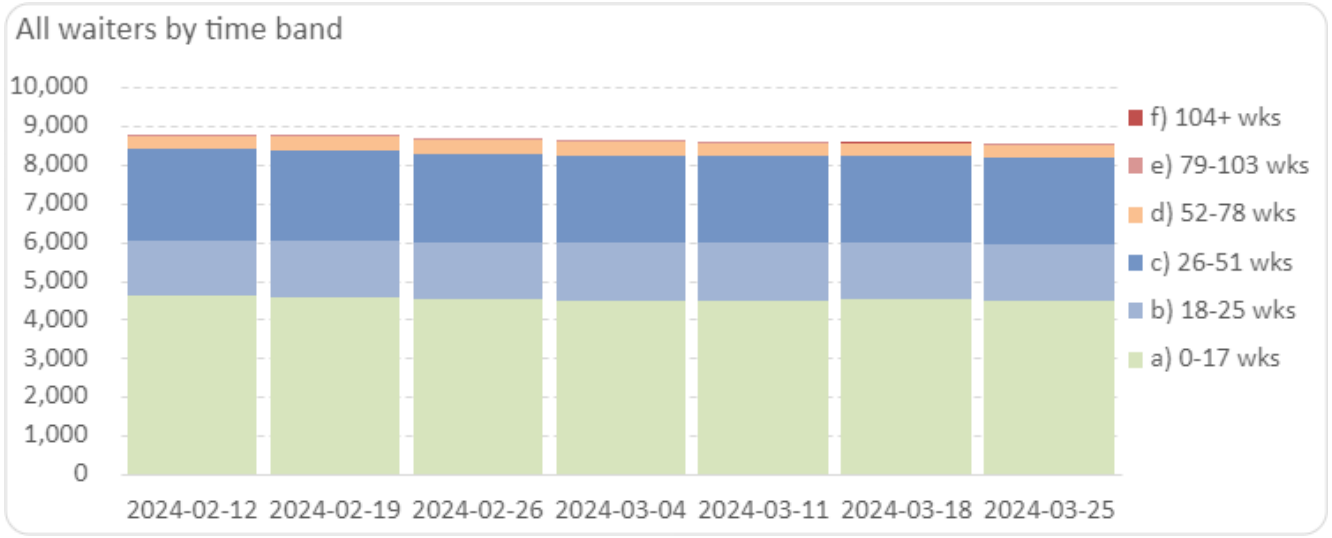
The biggest volumes of waiters waiting for dental treatment remain within Cheshire and Merseyside, centred on the Minor Oral Surgery Pathway, and within Greater Manchester, specifically Paediatric Exodontia.

The volume within GM NE reduced within March. GMW and C+M sectors have transferred onto new Patient Administration System – Dentally. At the same time as this transfer, we have implemented new acceptance and discharge criteria and had a focus on patients waiting for treatment on the Inhalation Sedation pathway

The dental position includes:
All dentally data are as close of play Thursday 11th April

Operations: Exception Reporting

Charts



Issue

Dental – Waiters by time band

The number of waiters over 78 wks has consistently fallen over the previous months.

The focus of the service is now on eliminating the number of waiters waiting >65 weeks by end of September 2024.

This is a challenging target as the majority are associated with the Paediatric GA Pathway.

The dental position includes:
All dentally data are as close of play Thursday 11th April

Operations: Exception Reporting

Dental – Waiters by time band

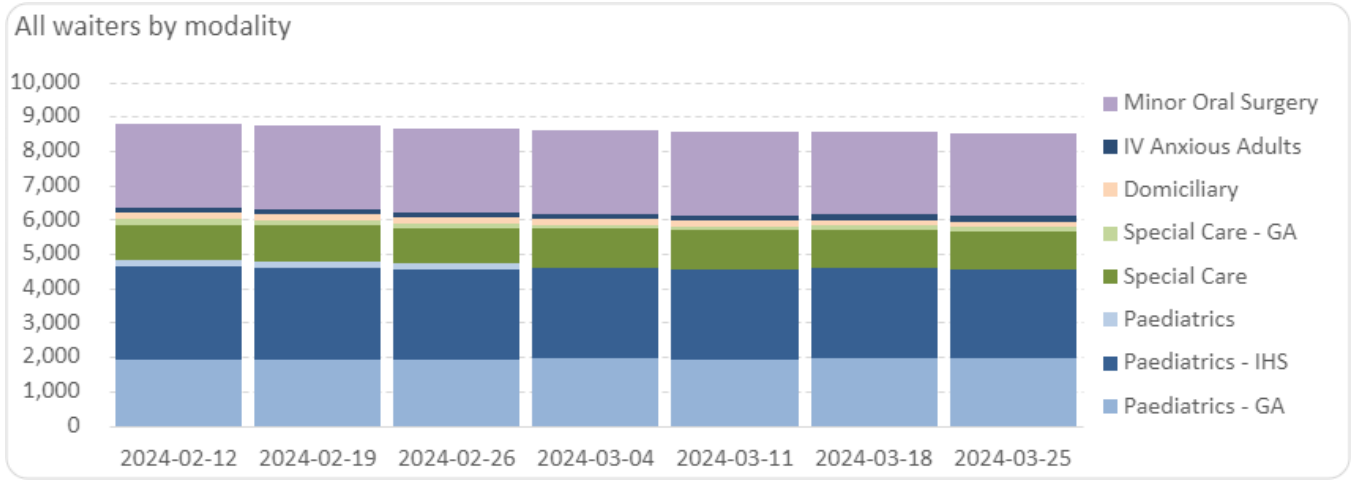
Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
12/02/2024	4,606	1,431	2,362	346	16	0
19/02/2024	4,584	1,440	2,338	350	16	0
26/02/2024	4,539	1,451	2,289	345	15	0
04/03/2024	4,497	1,479	2,258	350	13	0
11/03/2024	4,485	1,484	2,238	335	11	0
18/03/2024	4,509	1,469	2,243	329	11	1
25/03/2024	4,493	1,455	2,231	324	13	0

The service is focused on eliminating those patients waiting >65 weeks, within the 52-78wks wait band. Subject to validation we have 100 waiters, predominantly within the Paediatric GA pathway.

The dental position includes:
All dentally data are as close of play Thursday 11th April

Operations: Exception Reporting

Charts



Issue

Dental - Patients waiting by treatment

The volume of waiters remains largely static, in total, and largely static across the main pathways.

The largest volume of waiters remain within Minor Oral Surgery, and Paediatrics, centred within Greater Manchester.

The introduction of the new acceptance and discharge criteria should start to impact total volumes in coming months.

The dental position includes:
All dentally data are as close of play Thursday 11th April

Quality: Exception Reporting

Trust Scorecard

Quality														
KPI Name	Target	Trend Line	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of Never Events	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
% of incidents causing harm (levels 2-5)	2%		29.89% (▼)	18.53% (▲)	24.48% (▼)	22.86% (▲)	27.27% (▼)	18.53% (▲)	24.32% (▼)	35.25% (▼)	40.15% (▼)	43.04% (▼)	41.03% (▲)	29.03% (▲)	40.5% (▼)
% - Compliance with reporting time frames for StEIS within 48 hours	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	0% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)
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% (►)
DOC (Duty of Candour) - 10 day compliance (part 1)	100%		100% (►)	100% (►)	50% (▼)	100% (▲)	85.71% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)	50% (▼)	100% (▲)	0% (▼)	75% (▲)
% of incidents that are medication incidents	10%		11.21% (▼)	8.33% (▲)	9.45% (▼)	7.89% (▲)	14.57% (▼)	11.76% (▲)	7.28% (▲)	13.82% (▼)	14.48% (▼)	8.28% (▲)	4.74% (▲)	8.75% (▼)	7.26% (▲)
% of medication incidents that caused harm	2%		2.56% (▲)	11.11% (▼)	16.67% (▼)	0% (▲)	13.64% (▼)	0% (▲)	9.09% (▼)	9.52% (▼)	9.52% (►)	8.33% (▲)	20% (▼)	14.29% (▲)	15.38% (▼)
Information Governance Training	95%		89.31% (▲)	88.86% (▼)	90.23% (▲)	91.83% (▲)	97.22% (▲)	97.26% (▲)	96.89% (▼)	98.15% (▲)	97.98% (▼)	97.55% (▼)	97.33% (▼)	96.84% (▼)	97.34% (▲)
Safeguarding Childrens Level 1	90%		93.99% (▲)	92.69% (▼)	93.89% (▲)	96.13% (▲)	98.46% (▲)	98.65% (▲)	98.49% (▼)	98.77% (▲)	99.23% (▲)	98.79% (▼)	98.62% (▼)	99% (▲)	99.41% (▲)
Safeguarding Childrens Level 2	90%		91.23% (▲)	89.97% (▼)	91.8% (▲)	94.24% (▲)	97.4% (▲)	98.58% (▲)	98.47% (▼)	99.33% (▲)	99.58% (▲)	99.17% (▼)	98.73% (▼)	99.14% (▲)	99.66% (▲)
Safeguarding Childrens Level 3	90%		93.13% (▲)	93.84% (▲)	94.6% (▲)	97.17% (▲)	98.18% (▲)	96.54% (▼)	96.21% (▼)	95.19% (▼)	95.5% (▲)	96.89% (▲)	95.5% (▼)	97.11% (▲)	99.29% (▲)
Safeguarding Adults Level 1	90%		94.79% (▲)	93.57% (▼)	94.82% (▲)	96.32% (▲)	98.39% (▲)	98.97% (▲)	98.56% (▼)	98.97% (▲)	99.29% (▲)	98.48% (▼)	98.76% (▲)	98.94% (▲)	99.61% (▲)
Safeguarding Adults Level 2	90%		88.86% (▲)	88.79% (▼)	90.83% (▲)	92.41% (▲)	97.07% (▲)	97.95% (▲)	98.17% (▲)	99.23% (▲)	99.32% (▲)	98.98% (▼)	98.96% (▼)	98.86% (▼)	99.48% (▲)
Safeguarding Adults Level 3	90%		76.09% (▼)	79.72% (▲)	83.6% (▲)	84.43% (▲)	92.01% (▲)	93.03% (▲)	92.94% (▼)	93.06% (▲)	94.55% (▲)	96.99% (▲)	97.4% (▲)	97.41% (▲)	98.58% (▲)
% of risks managed in line with policy	100%		84.21% (▼)	89.02% (▲)	73.48% (▼)	94.38% (▲)	88.21% (▼)	85.48% (▼)	88.2% (▲)	89.33% (▲)	91.94% (▲)	81.67% (▼)	77.08% (▼)	75.52% (▼)	84.04% (▲)
Percentage of risks identified as 12 or above	10%		12.87% (▼)	16.18% (▼)	14.36% (▲)	13.48% (▲)	15.38% (▼)	10.75% (▲)	10.67% (▲)	12.36% (▼)	11.29% (▲)	12.22% (▼)	15.63% (▼)	13.02% (▲)	12.77% (▲)
% of falls identified as serious	5%		4.76% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	6.25% (▼)	0% (▲)	0% (►)	0% (►)	8.7% (▼)	0% (▲)	0% (►)
Falls per 1,000 bed days - bed based	14		6.7 (▲)	12.66 (▼)	5.71 (▲)	5.85 (▼)	9.71 (▼)	10.51 (▼)	15.15 (▼)	7.62 (▲)	10.18 (▼)	10.56 (▼)	12.54 (▼)	14.02 (▼)	18.37 (▼)

Quality: Exception Reporting

Trust Scorecard

Quality														
KPI Name	**Target**	**Trend Line**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Total number of pressure ulcers	27		36 (▼)	15 (▲)	27 (▼)	15 (▲)	19 (▼)	11 (▲)	24 (▼)	18 (▲)	21 (▼)	18 (▲)	22 (▼)	16 (▲)	29 (▼)
% of Category 4 Pressure Ulcers acquired in Bridgewater	20%		0% (▲)	6.67% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	5.56% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)
% of Cat 3 & Unstageable Pressure Ulcers acquired in Bridgewater	20%		25% (▼)	6.67% (▲)	0% (▲)	13.33% (▼)	26.32% (▼)	9.09% (▲)	12.5% (▼)	11.11% (▲)	9.52% (▲)	16.67% (▼)	4.55% (▲)	37.5% (▼)	3.45% (▲)
MRSA - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
C.Diff - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
E Coli- Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Bacteraemia - Total Number of outbreaks	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Complaints that are managed within the policy timelines	100%			100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
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% (►)
% of all policies within review date	90%										87.64% (►)	84.94% (▼)	85.33% (▲)	84.94% (▼)	84.56% (▼)
IPC assurance audit compliance	90%		78% (▼)	91% (▲)	81% (▼)	89% (▲)	89% (►)	87% (▼)	89% (▲)	79% (▼)	81% (▲)	81% (►)	85.8% (▲)	81% (▼)	79% (▼)
Record keeping Audit completion compliance	90%		119.93% (▲)			96.89% (▼)			104.76% (▲)			104.28% (▼)			119.93% (▲)
Overall CQC rating (Yearly)	Good											Requires Improvement (►)			
Flu vaccinations for frontline healthcare workers (CQUIN01)	80%				61.3% (▲)									54.41% (▼)	
Malnutrition screening for Community Hospital Inpatients (CQUIN14)	90%				100% (►)			100% (►)			88.16% (▼)			92.5% (▲)	
Assessment, diagnosis and treatment of lower leg wounds (CQUIN13)	50%				66.67% (▲)			64.71% (▼)			85.51% (▲)			85.51% (►)	
Assessment and documentation of pressure ulcer risk (Community Hospital Inpatients) (CQUIN12)	85%				100% (▲)			100% (►)			46.05% (▼)			28.75% (▼)	

People

Trust Scorecard

People														
KPI Name	Target	Trend Line	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
% Headcount of new starters attending induction programme	95.00%		99.61% (▼)	99.36% (▼)	99.29% (▼)	99.36% (▲)	98.94% (▼)	99.68% (▲)	99.29% (▼)	99.62% (▲)	99.31% (▼)	99.75% (▲)	99.17% (▼)	99.81% (▲)	99.94% (▲)
Staff turnover (rolling)	12.00%		13.25% (▲)	13.65% (▼)	15.72% (▼)	12.99% (▲)	13.13% (▼)	13.31% (▼)	12.98% (▲)	11.95% (▲)	12.15% (▼)	11.71% (▲)	11.35% (▲)	11.33% (▲)	11.32% (▲)
% Overall Organisation Sickness rate (rolling)	5.50%		6.3% (▲)	6.07% (▲)	5.9% (▲)	5.89% (▲)	5.65% (▲)	5.66% (▼)	5.56% (▲)	5.63% (▼)	5.59% (▲)	5.47% (▲)	5.52% (▼)	5.56% (▼)	5.57% (▼)
Sickness absence rate (Actual)	5.50%		5.5% (▼)	5.16% (▲)	5.06% (▲)	5.24% (▼)	5.38% (▼)	5.45% (▼)	5.57% (▼)	5.94% (▼)	5.78% (▲)	5.58% (▲)	6.9% (▼)	5.91% (▲)	5.54% (▲)
% of staff with a current PDR	85.00%		70.56% (▼)	71.62% (▲)	72.85% (▲)	77.23% (▲)	91% (▲)	89.99% (▼)	87.59% (▼)	83.43% (▼)	88.06% (▲)	86.04% (▼)	88.55% (▲)	90.02% (▲)	90.68% (▲)
% Long Term Absence	Improvement in Month		3.82% (▲)	3.72% (▲)	3.85% (▼)	3.74% (▲)	3.85% (▼)	3.86% (▼)	4.04% (▼)	4.11% (▼)	3.52% (▲)	3.25% (▲)	3.4% (▼)	3.34% (▲)	3.01% (▲)
% Short Term Absence	Improvement in Month		1.6% (▼)	1.47% (▲)	1.25% (▲)	1.36% (▼)	1.3% (▲)	1.38% (▼)	1.5% (▼)	1.76% (▼)	2.26% (▼)	2.26% (▲)	3.5% (▼)	2.57% (▲)	2.53% (▲)

Finance

Month Twelve 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. All references in this report will be to the updated plan.

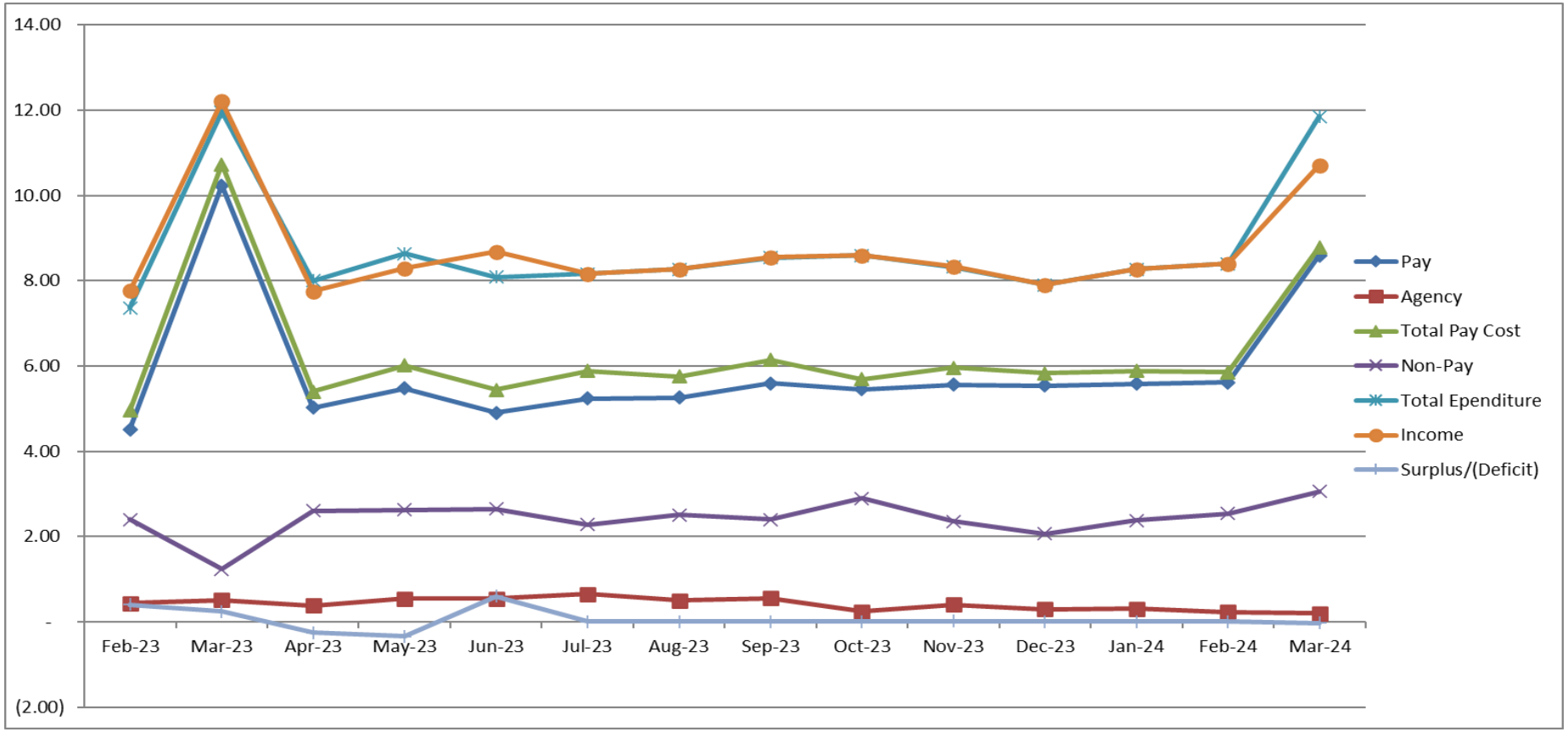
Summary Performance Month 12 2023-24	Month 12 Plan (£M)	Month 12 Actual (£M)	Month 12 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.10)	(10.71)	2.60	(97.94)	(101.92)	3.98	(97.94)	(101.92)
Expenditure - Pay	5.46	8.59	(3.13)	64.15	67.81	(3.67)	64.15	67.81
Expenditure - Agency	0.24	0.20	0.04	4.22	4.82	(0.60)	4.22	4.82
Expenditure - Non Pay	2.39	3.10	(0.71)	29.26	30.90	(1.64)	29.26	30.90
EBITDA	(0.01)	1.19	(1.20)	(0.31)	1.62	(1.93)	(0.31)	1.62
Financing	0.03	(0.04)	0.06	0.31	(0.51)	0.82	0.31	(0.51)
Normalised (Surplus)/Deficit	0.01	1.15	(1.14)	0.00	1.10	(1.10)	0.00	1.10
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.01	1.15	(1.14)	0.00	1.10	(1.10)	0.00	1.10
Other Adjustments	0.00	(1.11)	1.11	0.00	(1.11)	1.11	0.00	(1.11)
Adjusted Net (Surplus)/Deficit	0.01	0.04	(0.03)	0.00	(0.00)	0.00	0.00	(0.00)
CIP	0.43	0.42	(0.01)	5.15	5.24	0.09	5.15	5.24
Capital	0.00	1.46	(1.46)	2.38	2.42	(0.04)	2.38	2.42
Cash	24.66	17.33	(7.32)	24.66	17.33	(7.32)	24.66	17.92
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 twelve are as follows:

- The Trust is reporting a final adjusted breakeven position, in line with the plan.
- The Trust has a savings requirement of £5.15m (5.2%) in line with ICB instruction.
- The Trust is reporting a full year savings achievement of £5.24m against a plan of £5.15m.
- Income is £101.92m for the year against a plan of £97.94m.
- Expenditure is £103.03m for the year against a plan of £97.94m.
- Pay is £67.81m for the year against a plan of £64.15m.

Finance

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

- Agency spend £4.82m for the year against a plan of £4.22m.
- Non pay expenditure is £30.90m for the year against a plan of £29.26m.
- Capital charges are £0.82m below plan.
- Adjusted items (impairments and stock) are £1.11m.
- Capital expenditure is £2.42m for the year, £0.04m above the revised plan of £2.38m.
- Cash is £17.33m.

Appendix

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

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NHS Oversight Framework

File created on: 17/04/2024

NHS Oversight Framework - Organisation Detail

Org Type	Org Name Full	Aggregation Source	Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
MHPRV	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S000a: NHSOF Segmentation	Month	2024 02	2:Flexible support					
		MH Provider	S035a: Overall CQC rating	Month	2024 02	2 -Requires improvement					52/69
		MH Provider	S059a: CQC well -led rating	Month	2024 02	2 -Requires improvement					54/69
		MH Provider	S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual; calendar year	2022	7.28%	11.1%		↑		23/71
		MH Provider	S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual; calendar year	2022	13.4%	20%		↓		28/71
		MH Provider	S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service	Annual; calendar year	2022	22.8%	27.6%		↑		18/71
		MH Provider	S067a: Leaver rate	Month	2023 12	5.78%	7.39%		↓		3/71
		MH Provider	S068a: Sickness absence rate	Month	2023 10	5.89%	5.39%		↑	↑	40/71
		MH Provider	S069a: Staff survey engagement theme score	Annual; calendar year	2022	7.18/10	6.79/10		↑		24/71
		MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual; calendar year	2022	10.7%		12%	↑	↑	28/69
		MH Provider	S071c: Proportion of staff in senior leadership roles who are disabled	Annual; calendar year	2023	7.14%		3.2%	↑		14/69
		MH Provider	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual	Annual; calendar year	2022	61.3%	56%		↑		25/71
		MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2022	7.41/10	6.99/10		↑		22/71
		MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2022	6.96/10	6.43/10		↓		23/71
		MH Provider	S133a: Staff survey - compassionate and inclusive theme score.	Annual; calendar year	2022	7.65/10	7.23/10		↑		22/71
		MH Provider	S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Annual; calendar year	2023	1.4		1	↑		29/69
		MH Provider	S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual; calendar year	2023	1		1	↑		39/69

Rank Banding

- Highest performing quartile
- Interquartile range
- Lowest performing quartile

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Committee Chair's Report

Name of Committee/Group:	Quality and Safety Committee		**Report to:**	Board of Directors
Date of Meeting:	Thursday 18 April 2024		Date of next meeting:	Thursday 27 June 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 Elaine Inglesby, Non-Executive Director Martyn Taylor, Non-Executive Director Lynne Carter, Deputy Chief Executive and Chief Nurse Sarah Brennan, Chief Operating Officer Dr Ted Adams, Medical Director	**In attendance:** Jeanette Hogan, Deputy Chief Nurse Susan Burton, Associate Chief Nurse Tania Strong, Interim Head of Human Resources Jan McCartney, Director of Corporate Governance **Observers**: Karen Bliss, Trust Chair Rita Chapman, Public Governor, Rest of England	**Key Members not present**:	**Apologies received from:** Abdul Siddique, Non-Executive Director Christine Stankus, Lead Governor (observer)

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Dental Update	2,3		The Committee received a report providing significant detail of the work that had been undertaken concerning dental services. This explained that the work of the task and finish groups was progressing well, with some positive outcomes being achieved. Clinical involvement in those groups had been of key importance and had ensured a strong correlation between what was happening within the services and the work of the task and finish groups. The work had also achieved clarity around the actual provision of community dental services and what they are responsible for, which had supported the harmonisation of the approach. The Cheshire and Merseyside network had a more established referral criteria, treatment pathways and discharge and this had now been embedded into the Greater Manchester services. This would create some capacity to address some of the long waiting times within the service and to ensure a focus on the patients that needed to be seen, including the special care patients who could not access a General Dental Practitioner and children requiring more complex extractions.	The Committee noted the content of the report and accepted this as assurance that patients continued to receive safe and effective care and that waiting times were reducing and would reduce further over the coming months. The Committee commended the work undertaken and the progress that had been made.

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			Waiting time data had demonstrated some progress and some positive movement. It was hoped that the impact of the task and finish groups would further support the work and reduce the waiting times for children across the network.	
Serious Incidents Compliance Report	2, 3		The Trust had now established its Directorate Incident Review and Learning Groups (DIRLG's), the local priority groups (which oversee pressure ulcers, medication incidents and falls). The Patient Safety Incident Response Framework (PSIRF) and Learning Panel had been established as the forum that will have oversight of management of patient safety incidents in the Trust. Reported incidents had indicated that pressure ulcers continued to be the most frequently reported type of patient safety incident in the Trust. Harms had been reviewed via a harms analysis. This had included an assessment of the impact of harms on the safety of patients. There had been six incidents during March which had been reported as causing moderate harm, this included a medication error in Halton Community Nursing, pressure ulcers in Warrington District Nursing, safeguarding incidents and the fall at Padgate House. There had been positive compliance with PSIRF training for level one (94.2%) and level two (89.18%). The next steps for this would be that enhanced training would take place for staff who required this.	The Committee noted the content of the report and was assured that the Trust was progressing its transition regarding the PSIRF and LFPSE schemes. Whilst it agreed that there was a gap in assurance concerning medicines management issues, this was expected to be resolved via the action above. Following discussion it was agreed that future Quality Council reports must provide detail of reports and information in relation to medicines management reporting and the levels of assurance received.
Summary Report for Risks Relating to Quality and Safety	2, 3		The report detailed the risks identified in relation to quality and safety, extracted from Ulysses on 3 February and 3 March 2024. Those risks had been discussed at the subsequent meetings of the Risk Management Council. There had been 16 risks regarding quality and	The Committee received the report for assurance.

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			safety identified in February 2024, while in March 2024 there were 13 risks. Those risks continued to be identified and managed. There were two new risks relating to quality and safety reported to the Risk Management Council in February 2024 and one new risk reported March 2024: those related to demand and capacity challenges in Warrington and Halton Community Paediatric Services and medicines management at Padgate House. The Committee received the report and was assured that the risks scoring 12 plus in relation to quality and safety were being identified and managed effectively. It was noted that in reading across to the IQPR report, the Trust was reporting 75% compliance against a target of 100% against risks being reviewed in a timely manner. It was noted that the Trust was still moving forward on an improvement journey and it was expected that this would be resolved.	
Patient Experience Report – Quarter three			The Committee received a report which included the results of the Friends and Family Test (FFT), patient survey results and the numbers and types of complaints and Patient Advice and Liaison Services (PALS) queries received, and the lessons learned. It was confirmed that the Trust had received a total of 14 formal complaints during the quarter compared to nine in the previous quarter and 14 in the same period in the last year. Some concerns were raised and discussed concerning a number of MP letters received by the Trust dating back to March 2023. The issues had not been resolved as the letters had been sent to the Trust via an old email address that has been obsolete for a number of years with no access. This matter was being taken forwards via DIGIT where a process to review email addresses that had remained unused such as this one, was being implemented to ensure that they were properly shut down going forwards.	The Committee accepted the assurance provided via the report that activities were being undertaken within the Trust to promote patient engagement and feedback and to ensure learning from their experiences.

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Committee Chair's Report

IQPR – month 11	2, 3		The Trust had 11 red indicators in month. Two of those were in relation to CQUIN targets with the majority of the newly red rated areas being in relation to Duty of Candour and 10-day compliance. There had been four incidents, as set out within the report, which no longer required Duty of Candour, with one incident where a delayed decision had been accepted and one where an outcome was still awaited. Falls per thousand bed days had increased in month, and this was being monitored by the Falls Priority Working Group with plans in place, as well as reviewing learning. This correlated to the work being undertaken around Padgate House in terms of management of quality and safety issues. There had been instances of risks not being managed in line with the policy which had been discussed. The percentage of risks had fallen slightly in month, despite the red rating. Risks had been accumulated around Community Paediatrics, with a report included on the agenda later. In terms of the incidents causing harm, there had been an improvement of the assessment of the harms. Pressure ulcers had been reported in month which were being monitored as part of the Trust's quality priorities with the PSIRF framework. Work was ongoing in relation to Infection, Prevention and Control Assurance Audits. Discussions were taking place with teams to ensure that they prioritised this. In terms of the CQUIN indicators, the flu vaccination remained below the 80% target at 54.4%; The Trust was not an outlier, and this was a national issue. However, the Trust had the third highest uptake across the Cheshire and Merseyside system. The Trust's category three and unstageable pressure ulcer target was at 20% and this indicator was currently reporting at 28.75%. Quality improvement work related to pressure ulcer management was a Trust quality priority as part of PSIRF implementation and this was being taken forward as part of the work at Padgate House around quality and safety.	It was agreed that the confidence levels regarding SPC Charts would be reviewed by the Chief Operating Officer with the information team and a proposal would be presented back to the Committee in June. This meeting would also receive a verbal update on proposed changes on indicators in the IQPR. The Committee asked to be kept informed with policy compliance: the February meeting had been advised that there was a trajectory being set to achieve full compliance and currently there was a decreasing position and the Committee must monitor this. The Committee received the report for assurance.

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			From a CQUIN point of view, this was only reported on a quarterly basis. There had been a decline within quarter two but this correlated to the period of time where the patient records where transferred to an electronic system in Padgate House, therefore the issues that had been highlighted related to how the data was being collected for that audit, opposed to an issue with the quality of care. A significant improvement was expected to be observed for quarter four and work was continuing with the audit team.	
Report from the Quality Council	2, 3		The Committee received a report from the March 2024 meeting of the Quality Council. It was noted that there were items included on the Committee's April agenda that were also covered at the Quality Council meeting The key considerations included: Halton and Warrington Adult Services: Highlights had focussed around outstanding action plans through the Council. Some of those were in relation to complaint action plans and others concerned historic serious incident action plans. There had been significant progress reported towards completion. The meeting also considered monitoring of policies and ensuring that any extensions had been robustly considered with mitigations in place. Those were being monitored via the Directorate quality meetings. Children's Directorate: The Council received a report across Warrington and Halton around the outstanding complaint action plans that have now been reviewed and approved, as well as reporting on historic serious instant action plans which had since been approved and submitted to the ICB. The meeting also received accounts of the challenges and the risks faced within the Community Paediatric Service and the Neurodevelopment Pathway. The Council noted that the clinical harm reviews were still being completed for any children waiting over 52	The Committee received the report for assurance and agreed that the content of the report was indicative that the governance and reporting processes in place were effective, with key elements being reported to and discussed by the Quality Council and being reflected in the reports being brought into the Committee.

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			weeks, with triage of those cases with work underway to ensure the consistency of those reviews across the two boroughs. Dental: Challenges were reported concerning interpreting services and the availability for face to face contact. The Trust had requested further updates concerning the outcomes of meetings in relation to this to be presented to the next meeting. There had also been challenges reported concerning the transition to Dentally, and those areas were being addressed. The service had given a report on the quality work undertaken in Greater Manchester where the Clinical Directors had reviewed all patients waiting longer than 40 weeks for general anaesthetic due to the complexity of their requirements. It had been established that no patients had come to any clinical harm and no cases were considered to be urgent. This work would continue with regular reports being presented to the Council. Safeguarding: Positive feedback was provided from the ICB on their quarter three quality schedule submission. However, they had highlighted that they were unable to receive full assurances around the completion of the initial health assessments (IHAs). A full description was able to be provided of the actions in place. Information was provided on capacity issues within Community Paediatrics and work undertaken to ensure that all staff had received the appropriate Children in Care level three training. There was a verbal report provided to the Council confirm that there had been significant progress in staff completing the training since the report was written. An update was noted in relation to Trust improvement plans: there were nine plans within the programme with positive progress being made: there was significant progress noted against dermatology plans and a reduction in the number of red ratings. Medicines Management Report: The main area raised from this report related to incidents within Padgate House. Further information around the	

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			actions in place and progress against those actions was requested by the Council and would be presented at the next meeting in May 2024.	
Community Paediatrics Risks Update Report and Update on Halton SEND	2, 3		The Committee received a detailed report from the Chief Operating Officer and acknowledged that there had been no traction or impact from work due to the challenges being faced by the service. The risks to the service were described as significant due to the increasing number of children being referred to the service and the length of time that they are waiting to be seen, as well as additional factors such as the shortage of ADHD medications, the impact of the commissioning of the Halton paediatric speech and language therapy contract and the additional capacity needed for medical staff to undertake their additional responsibilities such as Initial Health Assessments (IHA's), safeguarding and child protection medical responsibilities. Despite the best efforts of the teams and the Children's Directorate Leadership Team, supported by the Executive Management Team, the risks had not reduced. A new accumulative risk was reported in relation to demand and capacity for both Warrington and Halton Neurodevelopment Pathways scoring 15. Waiting times continued to increase and were likely to be in excess of the 65-week waiting target which would need to be achieved by September 2024 as per Operational Planning Guidance. It was reported that the financial budget of the service and the directorate would not enable the Trust to achieve this, with a position then where clinical harm reviews would need to be carried out for multiple children to ensure that they were safe whilst waiting. Complaints were also reported to be increasing from families and Members of Parliament (MPs) in relation to waiting times and this was expected to continue. Halton SEND: Following the receipt of the Halton Local Area SEND inspection report, meetings had continued to take place with the health providers across Halton. A priority action plan was developed and	The Committee agreed that this matter must be escalated to the Board for a rigorous discussion to take place on the potential options. A further update would be provided to the Committee in June 2024. It was proposed that the approach taken with dental services including the establishment of task and finish groups may be beneficial in this case to take forward issues, proposed actions and improvements. This may also need to be escalated outside of the Trust to the ICB concerning the difficulties for the Trust to resolving this ongoing and challenging position.

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			submitted and approved by OFSTED and the Care Quality Commission (CQC). The Trust would make a contribution to two particular priority action areas and would be represented at key meetings including priority action groups ensuring contribution to the delivery of required actions.	
Dermatology Services Update Report			The Committee received a report which it accepted as assurance that the service was being managed effectively to ensure that safe and high-quality care was being delivered. It noted the reduction in the risks within the service and the improvements that had been made.	It was agreed that the Committee did not require a further update unless any exceptions were raised going forwards by the Quality Council.
Listening to Staff Voices	2, 3		The Chief Nurse presented a report which provided an update following the commencement of Listening to Staff Voices sessions in January 2024. The sessions provided an opportunity for staff to raise and discuss any clinical and professional issues, share ideas and to contribute to the future vision and quality of care provided by the Trust. The Chief Nurse explained that the sessions were also introduced to ensure that staff were fully informed and clear regarding the routes to be taken should they need to raise any concerns, particularly following the recent Letby case. The Chief Nurse added that the sessions complemented the Time to Talk programme and the recent consultation sessions held on the Clinical Leadership Strategy. The report set out the feedback that had been received from the staff who had attended the sessions so far.	It was agreed that future follow up reports included information on tangible actions in response to the areas raised by staff. The next report would be focussed on the areas that had changed and the impact as a result of staff feedback. It was agreed that this Committee would have oversight of this, however if it was considered that any areas were not relevant to the Committee this could be reviewed following receipt of the next reports.
CQC Update Report	2, 3		The Chief Nurse confirmed that there had been no meetings held with the CQC since the last meeting of the Committee. She reported there had been a number of visits with MIAA to undertake mock inspections of some Trust services. The report from those visits had only been received	The Committee noted the update and would receive a further report at its June

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			very recently and therefore the feedback would be reported on in due course. In addition, the Trust had now received the CQC booklet in relation to preparation for a CQC inspection. A discussion had also taken place on 16 April at the Executive Management Team meeting concerning the new Well Led Framework and how the Trust could provide evidence around this across the organisation. The Chief Nurse would be leading on this work.	meeting on the CQC's expectations and what work had been undertaken to date by the Trust to prepare for an inspection.
Quality Impact Assessment (QIA) Report	2,3		An update report was provided on the activity undertaken by QIA Panels between January and February 2024. There had been seven QIA's undertaken during this time: four QIAs were closed as it was agreed that risks had been sufficiently mitigated: two QIAs were agreed and would continue to be monitored by the Panel to monitor risks and: one QIA was due for review but was longer required and had been closed to the panel. It was confirmed that two proposals related to Cost Improvement Plans/Boosting Efficiencies.	The Committee received the report and was assured that the Trust had appropriate steps in place to safeguard the quality and safety of patient care when working within business continuity, delivering significant changes to its services by any policy, project or savings.
Review of MIAA and Clinical Audits: Padgate House Controlled Drugs and Medicines Management Audit			The Medical Director informed the Committee of a review conducted on 25 January 2024 by MIAA into the Trust's Controlled Drug practices at Padgate House Intermediate Care bed-based facility. There had been one critical finding in relation to administration and storage of out-of-date medications. This was due to patients being given out of date medications on seven separate occasions, with the medicines only just expired. The critical rating had been due to potential compromised efficacy and safety, however it was reported as unlikely that patients had suffered harm due to this. There were also six medium recommendations outlined. Work would be undertaken with the Trust's partner organisation, Warrington Council, to look at some of the issues outlined. In terms of next steps, this would be to review and agree the recommendations which was currently taking place.	A report would be presented back to the Committee in June to review the incidents, the risks and progress being made against an action plan that would be put into place. The Committee agreed that this matter would be highlighted to the Board with any changes/updates on the risk scoring following the Risk Management Council and any actions taken between today's

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Committee Chair's Report

			The Committee acknowledged that there were broader issues present at Padgate House in addition to those medicines management concerns that had been raised. It was noted that the MIAA audit would be taken through the Audit Committee following a review of the recommendations. In terms of quality and safety, the Committee requested an update/response to the issues that had been raised and would continue to have an oversight of this over the coming months, separately from the MIAA audit. The Chief Operating Officer advised that a quality summit approach would be taken to focus on improvements at Padgate House, this would include the quality and safety weekly meetings which would monitor the actions that were in place.	meeting and the next Board meeting taking place. An update could take place verbally if required.
Quality Account – Interim Report			The interim report was presented which provided an outline of the process undertaken in the production of the Quality Account and the progress that had been made to date. This also included information on development of the 2024/25 Quality Account and the approach for next year.	The Committee acknowledged the progress made to date with the Quality Account and agreed that an e-governance route would be taken to approve the process that the Quality Account had been taken through, to be assured that this met the necessary requirements, was fit for purpose and that this had been checked in the proper way. The final version of the Quality Account is included on the Board agenda for the Board's sign off – with the Committee having been assured on the

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Committee Chair's Report

				process undertaken around the production of the report.
Quality and Safety Committee – consideration of strategies			The Director of Corporate Governance presented a report to the Committee following its request for clarification to be provided as to which strategies it should receive and the purpose for them. Following discussion by the Executive Management Team, it was confirmed that the Committee should only be considering the enabling strategies that linked to the delivery of the Communities Matter Strategy, and for the Quality and Safety Committee, those would be in relation to Medicines Management, Dental and Safeguarding.	The Committee acknowledged that its business cycle would require updating to reflect the timings for receipt of the strategies over the year. It was agreed that the Medical Director would provide an update to the next meeting of the Committee concerning the Medicines Management Strategy, to confirm if the Trust had a single strategy in place, whether this was in date, if this was not in place when this would be, and advise when this would be available to be presented to Committee.
Committee Annual Report	1		The Committee received the annual report. It was agreed that the business cycle would require an update to reflect the timing of the presentation of the strategies as agreed earlier in the meeting, including the new Medicines Management Strategy.	The Committee agreed that the report would be presented to the Audit Committee to provide assurance that this Committee was functioning effectively in accordance with its terms of reference.
Committee Effectiveness Review	1		The Committee received the feedback from its annual self-effectiveness review, where input was received from all Committee members, regular	The Committee received the report for assurance.

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			attendees and observers. It was noted that the feedback was wholly positive and demonstrated that the Committee was operating effectively with a high standard of reports being presented on key items of business and areas of risk, with rigorous discussion and debate taking place. Challenges were noted concerning the length of the agendas due to the considerable number of items of business, however the meeting was considered to be excellently chaired with the business being managed well within the allotted meeting times.	
Board Assurance Framework (BAF)	2, 3		It was agreed that Padgate House should be reflected within BAF2 as an emerging risk and a gap in control, recognising the earlier discussions around this and the recognised issues and challenges. It was agreed that should the risk scoring be changed at the next Risk Management Council, the Committee Chair would be advised by the Chief Nurse/Deputy Chief Nurse and this could then be reflected within the Committee report to the Board (an update is provided on this under the items for escalation section below). A risk in relation to British Medical Association (BMA) Industrial Action could be removed as this was no longer a prevalent issue.	The Committee considered the risks scorings for BAF2 and 3 and agreed that currently there would be no changes required.
Assurance Reports Required	2, 3		No items were identified.	
Items to be shared/escalated with the Board or other Committees	1, 2 3		The Committee agreed that risks and issues within Community Paediatrics would be escalated to the Board. The Board's attention is also drawn to the current issues within Padgate House as outlined above. Since the Quality and Safety Committee meeting took place in April, the risk score for the Padgate House risk was confirmed as remaining at 12 by the Risk Management Council, and there have been no patient safety	

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Committee Chair's Report

			incidents resulting in moderate or above harm levels. A quality summit was held on 21 May and an action plan is now being developed.	
Review of meeting	1		All participants and observers were invited to comment on the meeting.	
Risks Escalated: As above.				

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**38/24iii**		
Report Title	Warrington Paediatric Audiology Service		
Executive Lead	Ted Adams Medical Director		
Report Author	David Mills, Deputy Medical Director		
Presented by	Ted Adams, Medical Director		
Action Required	☒ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

An incident in NHS Lothian relating to the standard of Paediatric Audiology testing led to a national review of Paediatric Audiology Services. Four organisations (across five sites) were identified as reporting a lower-than-expected yield of permanent childhood hearing impairment in babies. Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHTH) were identified within this cohort and subsequently a serious incident review was commenced.

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	**Quality** Failure to deliver quality services and continually improve	**Health Equity** Failure to collaborate with partners and communities to	**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	**Partnerships** Failure to work in close collaboration with partners and staff

Corporate Governance and failure to deliver on the Trust's Strategy		improve health equity and build a culture that champions ED&I for patients			champions equality, diversity and inclusion for patients 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	6 June 2024
Agenda Item	38/24iii		
Report Title	Warrington Paediatric Audiology Service		
Report Author	David Mills, Deputy Medical Director		
Purpose	To provide assurance on the quality and safety of the service offered by Bridgewater's Warrington Paediatric Audiology Service an external peer review and internal root cause analysis was arranged.		

1. Introduction

An incident in NHS Lothian relating to the standard of Paediatric Audiology testing led to a national review of Paediatric Audiology Services. Four organisations (across five sites) were identified as reporting a lower-than-expected yield of permanent childhood hearing impairment in babies. Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHTH) were identified within this cohort and subsequently a serious incident review was commenced.

The initial focus of the investigation was on the Auditory Brainstem Response (ABR) testing undertaken at WHTH, but the scope of the investigation was extended to include Bridgewater's Warrington Paediatric Audiology Service, which operates a joint clinical pathway with the WHTH service.

In response to the incident, a multi-disciplinary team (MDT) was assembled, comprising reviewers from the national audiology team, Bridgewater, and WHTH, to review a cohort of 48 children that were on the joint Bridgewater/WHTH patient pathway within the timeframe of the investigation.

The overall findings of the MDT review of the 48 cases were:

- 27 cases of no harm – this is where sufficient audiological information is available to demonstrate that the patient has received, or is receiving appropriate treatment, and no harm has occurred.
- 10 cases where harm level could not be established due to parental choice, where children were not brought to their appointment.
- 8 cases where harm level could not be established due to ongoing care, where further audiological assessment is required before an outcome can be determined.
- 2 cases where harm could not be determined, where the child has moved out of area and contact cannot be established.
- 1 case of low harm – this harm is due to a possible delay in fitting of hearing aids to a child. The delay was not attributable to the Bridgewater element of the patient pathway.

2. Initial actions

2.1 External Peer Review

The external peer review was undertaken in June 2023 by Kathryn Lewis, CSS Divisional Audiology Lead, Manchester University NHS Foundation Trust and Rachel Ward, Head of Paediatric Audiology, Manchester University NHS Foundation Trust.

The findings of the external review are based on clinical observations, case note reviews, and staff interviews. The full report can be found in Appendix 1.

As part of the Executive Summary of the report, the reviewers state that: "While the observation did promote discussion and consideration of alternative approaches, there were no clinical safety concerns from the clinical observation carried out."

The findings of the review identified many areas of good practice, most notably:

- A lovely atmosphere create by clinicians and a nice rapport with families and children was seen, and good clear explanations of results and management plans observed.
- Good testing facilities with plans to further improve the test equipment.
- A range of appointments were observed with different skill mix and combinations of staff across the different clinics with all staff working well together.
- The standard appointment times are appropriate, but the team can request a longer time with the patient to be booked.
- There is a joint ENT clinic with the Associate Specialist in Community Paediatrics for more complex children.
- Excellent links with other community services.
- Good quality administrative support.

The findings of the review also identified several areas of concern – these comments are taken directly from the report and illustrate some of the issues that exist in the Bridgewater service:

- There are concerns that, despite the pathway being described as a joint pathway and some joint working taking place, the handover of care and the sharing of information between Bridgewater and WHH creates risks and unknowns about patient care.
- From experience and observation throughout the service review and meetings there is very little evidence of a joint pathway. While there is a transfer of information from one service to another this does not mean it is joint.
- The lack of shared decision making, shared information and transparent working between Bridgewater and WHH creates risks for Warrington babies and children.
- There is a need for external peer review because of the small size of the service (population, number of cases of hearing loss and size of the team).
- There is significant lack of information about the hearing aid provision provided to the Bridgewater team and Teachers of the Deaf.
- There is a need for a service lead with a high level of both audiological and scientific knowledge to build on the existing good quality service and for future development and monitoring of the service.
- The main risks for Warrington babies and children with hearing loss is that the initial assessment and hearing aid provision are carried out by a completely different trust to the one that is providing the ongoing management plan and care plan for the children. The Bridgewater service for Warrington babies at Sandy Lane and the

service at Halton are well placed to do that. They have the skills and existing good relationships with Halton. The provision of the whole care pathway would create a service that was cohesive across the whole pathway without any handover points to another trust.

The report detailed several recommendations for improvements to elements of the service, and a 31-point action plan has been drawn up to address the recommendations and is currently being implemented.

2.2 Internal Root Cause Analysis (RCA)

An internal RCA was undertaken in September 2023, led by the Trust's Assistant Director of Transformation, to establish the root cause of any issues within the Bridgewater element of the Warrington Paediatric Audiology patient pathway.

The RCA examined the findings of the multi-disciplinary team review of the individual cases in scope, the outcomes of the external review of the service, and fact-finding by the investigating officer. A copy of the RCA can be found in Appendix 2.

The key findings of the RCA were:

- Sub-optimal handover processes within the joint element of the patient pathway between WHTH and Bridgewater, and vice-versa that introduce unnecessary risk to the quality and safety of the service provision, particularly:
    - Lack of shared decision making.
    - Lack of shared information and transparent working.

- Lack of high-level audiological and scientific knowledge within the Bridgewater element of the service that is required to interpret complex audiological information such as ABR results, leading to:
    - Accepting inaccurate, incomplete, and/or inconclusive ABR test results from WHH.
    - Acting on inaccurate, incomplete, and/or inconclusive ABR test results from WHH.

- Issues within the WHH element of the patient pathway (out of Bridgwater's scope):
    - Discharging children at a level of 40dBnHL at Auditory Brainstem Response (ABR) testing, when the recommended discharge level is 35dBnHL.
    - Issues with ABR testing, including lack of bone conduction testing and use of masking.
    - Misinterpretation of ABR results, where ABR traces were not entirely clear.

The root cause of the issues was determined to be that the patient pathway is provided by two different Trusts, which introduces unnecessary risks to the quality and safety of patient care.

It was of concern that the initial assessment and hearing aid provision is carried out by a completely different Trust to the one that is providing the ongoing management plan and care. The handover and sharing of information between Bridgewater and WHTH introduced risks to the quality and safety of the patient pathway.

The RCA presented five recommendations to address the root cause(s) of the incident. A six-point action plan has been developed to implement the recommendations.

2.3 Improving Quality in Physiological Services – IQIPS

The United Kingdom Accreditation Service (UKAS) IQIPS (Improving Quality in Physiological Services) is the only recognised accreditation standard for physiological science services, including audiology services.

The Trust received communication from the Care Quality Commission (CQC), via a letter to WHTH on 19th April 2024, requesting the Trust Board to consider the assurance that they have about the safety, quality, and accessibility of its Paediatric Audiology Services. The thrust of the letter is the CQC's view on IQIPS and the importance of Paediatric Audiology Services achieving accreditation, stating that "participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. ICBs should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems."

The CQC states that, where services are not IQIPS accredited, this should be formally registered as a quality risk on the quality reporting system.

Following Board review of current assurance, the CQC require a report detailing:

- Whether the Paediatric Audiology Service has achieved IQIPS accreditation, including whether there were any improvement recommendations made.
- Whether the Paediatric Audiology Service is working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis.

The CQC states that it is not their intent to undertake stand-alone site visits based on the information that we provided to them in response to their letter.

2.4 Proposed Response to CQC Questions

CQC question: Whether the Paediatric Audiology Service has achieved IQIPS accreditation, including whether there were any improvement recommendations made.

Response: Bridgewater's Paediatric Audiology Services have not yet achieved IQIPS accreditation.

CQC question: Whether the Paediatric Audiology Service is working towards IQIPS accreditation.

Response: Paediatric Audiology Services are in the early stages of working towards IQIPS accreditation, although no formal application has been made to UKAS.

CQC question: What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.

Response: Paediatric Audiology Services are in the process of undertaking an internal benchmarking exercise against the criteria for the IQIPS standards. The aim of this exercise is to provide an understanding of where elements of the service potentially meet the IQIPS standards and where there are shortfalls. This will give a sense of the current position of the service, the work required to meet the IQIPS standards, and an opportunity to gather existing evidence of compliance with the standards prior to formally engaging with UKAS.

The current progress with the internal benchmarking exercise can be found in Appendix 3.

CQC question: The expected timeline for gaining accreditation.

Response: The detailed timeline for gaining accreditation has not yet been established. To achieve accreditation, Bridgewater's Warrington and Halton services will work together, and in partnership with the WHTH service. The mechanism for this partnership working has not yet been agreed and will require discussion between all parties before the timeline for gaining accreditation can be finalised.

CQC question: The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis.

Response: The audiology incident review period was 2018 to 2022 and the cases in scope of the investigation were:

- All babies and children referred to Bridgewater's Warrington Paediatric Audiology Service following diagnostic ABR testing by WHTH.
- All babies and children referred to Bridgewater's Warrington Paediatric Audiology Service by a health professional, following discharge from diagnostic ABR testing by WHTH.

48 cases were identified as in-scope of the investigation for Bridgewater – these were joint Bridgewater/WHTH cases. These cases were reviewed by a multi-disciplinary team comprising external peer reviewers from the national audiology team and internal reviewers from Bridgewater and WHTH.

The overall findings of the 48 cases reviewed were:

- 27 cases of no harm – this is where sufficient audiological information is available to demonstrate that the patient has received, or is receiving appropriate treatment, and no harm has occurred.
- 10 cases where harm level could not be established due to parental choice, where children were not brought to their appointment.
- 8 cases where harm level could not be established due to ongoing care, where further audiological assessment is required before an outcome can be determined.
- 2 cases where harm could not be determined, where the child has moved out of area and contact cannot be established.
- 1 case of low harm – this harm is due to a possible delay in fitting of hearing aids to a child. The delay was not attributable to the Bridgewater element of the patient pathway.

For the 8 cases where care is ongoing under Bridgewater services, once the outcome is established, a flagging system has been introduced to ensure that any harms identified will be reported as a clinical incident and investigated appropriately.

For those children where care is not determined due to parental choice, safety netting advice has been enhanced, with the 0 – 19 service and GPs being made aware of these cases.

3. CONCLUSION

3.1 The Trust implemented a robust and thorough response to the Audiology incident, comprising three main components:

- A multi-disciplinary team review of the cases in scope of the investigation (including internal and external reviewers).
- An external review of the Paediatric Audiology Service.
- An internal Root Cause Analysis of the incident.

The outputs of these pieces of work provided significant assurance of the quality and safety of the Warrington Paediatric Audiology Service. Action plans are in place as a result of the findings of the above to further improve the service offer; however, the overarching message is that no harms were caused to any of the children in-scope resulting from the care received by the Bridgewater service.

4. RECOMMENDATION

4.1 The Board is requested to accept the contents of this report as assurance of the actions taken to investigate and remediate the issues associated with the audiology incident, and to consider its response to the CQC questions, based on the information within this report.

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Professor Simon Constable
CEO Warrington and Halton Teaching Hospitals NHS Foundation Trust

By email

19.4.2024

Your account number: RWW

Dear Board Members,

Re: Paediatric audiology services,

As you may be aware, an expert review undertaken by NHS Lothian in Scotland, found failings in the standard of Paediatric Audiology service that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

These findings led to a review of the service provided by four NHS trusts in England which found similar failing. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and ICBs to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

Childhood deafness is a significant health and developmental risk. A National Deaf Children's Society survey in 2023 showed that;

- 527, 898 children are known to the hearing services.
- In 2022 there were an estimated 8,405 children not supported by a hearing service.

- Ninety-four percent of children referred to ear nose and throat (ENT) services were missing the six-week initial appointment target, with an average waiting time of 141 days.
- More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.
- Most paediatric audiology services (79%) did not offer wax removal, and most of them referred children to ear nose and throat (ENT) services for this, leading to lengthy delays.
- Thirty-nine percent of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.
- Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).

The main themes identified by providers in the same survey were long waiting lists, staffing issues, increasing demands on services, barriers to gaining Improving Quality in Physiological Services (IQIPs) accreditation and other resource or funding issues.

The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019. The incidence of permanent deafness generally remains stable, so this may suggest that some children have not yet been identified.

CQC are working closely with NHSE to help understand the current situation across the country regarding the level of assurance boards have about the quality of hearing services for children that they commission or provide.

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC we strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. ICB's should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems.

Services that are not IQIPs accredited should formally register this as a quality risk in their quality reporting system.

Please can I ask that at the next full board meeting, the board considers the assurance that they have about the safety, quality, and accessibility of your children's hearing services. Following that consideration, the board should submit a report to CQC that makes clear;

- Whether you have achieved IQUIPS accreditation, including whether there were any improvement recommendations made.
- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

NHSE have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.

Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it.

To enable CQC to understand the progress made towards accreditation and to understand how the service across the county is improving over time, We are keen to understand the progress made towards accreditation and how the service across the county is improving over time. We would therefore ask that further to your initial report to CQC (as outlined above), an additional review of assurance is conducted at a subsequent board meeting and a further follow up report on progress is provided to us.

The intent of this letter is information gathering and to gain a picture of service provision and the speed with which improvements are being made across the country. We are wanting to collaborate with other stakeholders to do our part in bringing about improvements in the care and treatment of this cohort of children.

Information returns from providers will be shared with operational colleagues to add to the wider information held about providers. It may be used to assist in the determination of risk levels within services for children and young

people, but at this point it is not the intent to undertake stand-alone site visits based on what we are told about the service in your trust. That does not mean we will not conduct a thematic review or bespoke assessment process in the future, but rather to reiterate that we want to focus on getting a clear picture about what is happening at provider level now.

For clarity, we require consideration by the full board at the next meeting, with an initial response to CQC no later than 30 June 2024, with a subsequent response following the next full board meeting. If there is any reason this cannot be achieved, please do come back to us with the reasons and when you consider you might be able to tell us about your service.

If you have any questions about this letter, you can contact the lead senior specialist for this work, Terri Salt by email using the details below.

Email: terri.salt@cqc.org.uk

Yours sincerely,

Prem Premachandran MBE
Medical Director
Care Quality Commission

Bridgewater Community Healthcare NHS Foundation Trust

Audiology Service Review - Warrington

2023

Confidential

Carried out June 2023 by

Kathryn Lewis, CSS Divisional Audiology Lead, Manchester University NHS Foundation Trust

Rachel Ward, Head of Paediatric Audiology, Manchester University NHS Foundation Trust

Contents

Executive Summary

This report is based on clinical observations, case note reviews and staff interviews during visits to the Warrington Paediatric Audiology Service within the Bridgewater Community Healthcare NHS Foundation Trust (BCHFT) in June 2023. The Halton, St Helens and Knowsley Paediatric Audiology service is not in the scope of this review.

Warrington Paediatric Audiology service pathway is jointly provided by BCHFT and Warrington and Halton Teaching Hospitals Foundation Trust (WHHFT).

The review only reports on findings and recommendations on the elements of the Warrington pathway provided by Bridgewater Community Healthcare NHS Foundation Trust. The service is based at Sandy Lane Children's Centre and Westbrook Medical Centre. Clinics and facilities were only observed at Sandy Lane Children's Centre.

During the service review BCHFT were advised by WHHFT that the reviewers were not allowed to speak to or observe the Warrington Audiologists. This leaves key elements of the pathway (ABR hearing assessment and hearing aid provision) without a formal independent review. This is a concern for confidence across the whole pathway for Warrington children.

Most of the Bridgewater Audiology Community team, the Operational Manager and a Teacher of the Deaf were interviewed as part of the review process. A range of questions were asked that covered pathways, policies, protocols and processes, training, support and communication.

The overall review and observation of the team is that they are a happy, supportive, and enthusiastic caring team who want to deliver the best for the children and their families.

They have a good supportive professional network, especially with the Newborn Hearing Screening Programme (NHSP) team, Halton Audiology, and a good working relationship with the Adult Audiology team at WHH, and have easy access to teachers of the Deaf, Speech and language therapy, physiotherapy, Occupational therapy, Psychology when needed.

The service has had a vacancy for a Band 6 (WTE) Audiologist for 2 years which has added pressure to the staff and service. The staff have worked hard together to fill this gap as much as possible. However, this has resulted in the Associate Specialist in Community Paediatrics adopting more of an Audiologist role to ensure that clinics could run.

While the observation did promote discussion and consideration of alternative approaches, there were no clinical safety concerns from the clinical observation carried out.

The service does need a lead Band 7 audiologist to provide scientific leadership, ensuring up to date practice and with time to appraise and develop the service further. Employing a lead with the relevant skill set and experience at this level would also provide an opportunity to explore the service providing a full Paediatric assessment and hearing aid service from ABR assessment to provision of hearing aids. This would require a review of the current staffing levels and skill mix to identify the requirements to provide these additional services.

As a result of the findings, a total of 20 recommendations have been made (1 urgent, 11 high priorities, 8 medium priority). The ultimate aim of the service review is to ensure that the hearing needs of babies born in Warrington are met through the care pathway that is in place. The highest priority identified in this review is that there has been no independent service review of the aspects of the pathway provided by WHH.

For BCHFT the most urgent recommendations include development of a Band 7 scientific lead and review of the department structure. This could involve closer working if not a merger with the Halton, St Helens and Knowsley Audiology department under BCHFT. This would result in the development of a more resilient service with the opportunity for the service to be led by a Chief Audiologist and clear opportunities for clinical supervision and career development/progression. It would result in clinical standardisation in terms of service provision which would facilitate the IQIPS accreditation process.

Glossary

ABR	Auditory Brainstem Response - an objective test to determine hearing thresholds
AC	Air conduction
IQIPS	Improving Quality in Physiological Sciences - UKAS provided quality assurance for Audiology
NHSP	Newborn Hearing Screening Programme
OAE	Oto-acoustic emission - an objective test to determine cochlear function
Play audiometry	Stimulus response technique to establish hearing levels, whether the sounds are played in the soundfield or through headphones and the bone conductor
RECD/REM	Real ear to coupler difference (RECD) and Real ear measurement (REM) are methods to take in to account the individual characteristics of the child's ear to programme the hearing aid.
SII	Speech Intelligibility Index - a measure of how audible speech is with the amplification provided by a hearing aid
SystmOne	Electronic patient record
ToD	Teacher of the Deaf
VRA	Visual Reinforcement Audiometry - a behavioural test of hearing for infants between 8 months and 24 months of age
BC	Bone conduction
WTE	Whole time equivalent

Background

The Newborn Hearing Screening Programme (NHSP) national team within NHS England audited the data held within the NHSP national IT system, Smart4Hearing (S4H) at the request of NHS England following the NHS Lothian report. A reporting period of 2018-2021 was chosen, allowing for variations in birth rate and incidence of hearing loss to be averaged over a 3-year period. A positive predicted value for the NHSP was therefore able to be calculated, allowing a national average yield to be plotted and outlying sites to be identified.

Warrington site was found to be one of five outliers having significantly low yield from the newborn screen. The full audit of electrophysiological testing at WHHFT was carried out by the national oversight group. Details of findings and recommendations from this are not contained within this report.

BCHFT asked for an independent review of its Audiology service for Warrington babies following the outcome of the audit. The review was to include all audiological services which take place at or commissioned by the Trust for babies born in Warrington. This included paediatric assessment and paediatric habilitation (but not hearing aid provision) and aetiology. Whilst the review reported on the overall quality and safety of the service, it was agreed it would not verify individual staff's competence. BCHFT does provide a separate paediatric audiology service based in Halton, providing services for Halton, St Helens and Knowsley but this report applies only to the service for Warrington babies.

BCHFT in Warrington offer clinics at two sites, one at Sandy Lane Child Development Centre Children's and one at Westbrook Medical Centre The administration team who supports the service are based at Sandy Lane Child Development Centre.

Methods

The methodology of the review followed that of the BAA review in NHS Lothian (BAA-Governance-Report_NHS-Lothian-Paediatric-Audiology.pdf (baaudiology.org)) and subsequent service reviews. Two registered Clinical Scientists with combined significant clinical experience in paediatric audiology but also with experience in staff training, service leadership, quality assurance and management carried out the review. Four methods were used for the review; a document review, clinical observations, review of patient notes and 1:1 interviews with staff.

The review used a variety of standards as a basis of the observation of clinical work and review of patient notes, including key elements of the BAA Paediatric Audiology Quality standards (https://www.baaudiology.org/app/uploads/2022/07/BAA-Paed-QS-final-version.pdf) and parts of the UKAS IQIPS standards 2023 for audiology (https://www.ukas.com/wp-content/uploads/2023/02/IQIPS-standard-2023.pdf).

Document review

The Trust shared current protocols, departmental structure, and information documents prior to the on-site visit. The documents were used to identify areas for further investigation during the visit, highlight gaps and inform the recommendations of the review.

Clinical Observations

The BAA quality standards and IQIPS standards do not specify what knowledge and skills are required for clinical appointments. The audit team used the information from the relevant modules of the BAA Higher Training Scheme (HTS). These are agreed levels of competence and knowledge to carry out paediatric appointments within audiology. Further information can be found here: https://www.baaudiology.org/careers/hts/ .

Details of the requirements can be found in appendix B and were provided to the Trust prior to the visit.

It was possible to observe four sessions of hearing assessment clinics and one session for hearing aid patients. All clinical staff were observed. Most of the clinic sessions were observed by both reviewers together. The clinic sessions provided the opportunity to talk with the clinical team and ask questions about clinical thinking and department practice and protocols. The reviewers made independent notes which were used to identify themes for areas of good practice and areas of concern.

Patient note audit

Patient notes written by each of the clinical staff were reviewed for the observed clinics as well as a selection of patient notes from recent patients. Information on the patient management system; test results, hearing aid information (where applicable) and patient letters were looked at. Contents were reviewed against the UKAS IQIPS standards 2023 (CL3 & 4).

Semi-structured interviews

Interviews with staff were carried out using the topic guides developed for the NHS Lothian review (appendix A). They were used to explore the current departmental culture and awareness of governance structure and delivery. All audiology staff were able to see the topic guides prior to their interviews.

Three clinical staff, one screener and the operational manager covering Audiology and a Teacher of the Deaf who works with the teams at both BCHFT and WHHFT took part in the interviews. All but one interview took place face to face with one of the reviewers, with one via Teams. The reviewer took notes which were used to identify themes for areas of good practice and areas of concern.

Topics included:

- Education, training, and continual professional development, to include individual skills and confidence in own clinical practice
- Evidence-based care and effectiveness to include protocol development / review, access to and use of the evidence base

- Organisational and clinical leadership, to include annual appraisal and objective setting, team meetings, support, and culture
- Risk management, to include what to do if there are concerns
- Clinical audit, including current awareness and involvement
- Managing and learning from complaints and compliments

Findings

All staff were open and candid during the review and all information requests were accommodated promptly. It was acknowledged that both the NHSP audit review and the service review had caused the teams stress, but all staff were professional throughout the visit.

The findings from the different elements of the review are summarised into the following themes:

- Department culture
- Recruitment and staff structure
- Clinical strategy and testing
- Staffing, training and maintenance of clinical skills
- Pathway

Department culture

The teams involved in the Paediatric Assessment and Hearing aid pathway are based at different sites and managed under Acute and Community services.

A positive lovely atmosphere was evident in the clinics despite the staff being observed as part of the service review. This appeared to be reflective of the team enjoying their role and wanting to do the best for children and their families. The appeared to be good relationships between the team members. Families appeared happy with their encounters with the team, and this is evident in the feedback that is given to the service as part of the satisfaction survey used within the department.

The team at Bridgewater demonstrated a supportive and caring culture and all staff interviewed reported being happy in their roles and with all the team and with the support they are given. They have good contacts within the Sandy Lane building and often will seek advice from the Safeguarding team, physiotherapy, Speech and Language Therapy, Neurodevelopment team, who are all on site. Externally they have good relationships with the WHH team, ToD and the Halton Paediatric audiology team (led by Alison Rimmer and Dr Hilali).

All staff felt that they had strong professional networks and attend Regional Paediatric network and CHSWG meetings.

The general observation during the interviews is that the initial incident and subsequent service review has taken a high emotional wellbeing toll on the clinical team, who feel a great deal of responsibility for the clinical outcomes and ongoing care of the children and families.

Appraisals/PDR for the Audiologists are carried out by the Operational Manager; however, the senior Audiologist has now had training to appraise her team members.

The team have bi-monthly meetings and team communication is excellent. There have not been any complaints regarding clinical provision and the only risks are regarding the recent challenges for the team because of the service review and the emotional impact of this on the team.

Audit was discussed and there is a continuous audit of the school screening service outcomes and an audit of the meningitis/sepsis referrals (reported to Paediatric medical group). The Audiologist who carries out the school screening audits mentioned the high number of unilateral losses picked up at school age screen. These have not been reported to date and a recommendation is that this is audit is formalised to understand what is happening in this group of patients.

There have been annual service reviews with the Head of Childrens Services, however, there has not been any feedback from these. This was discussed with the Operational manager (who is new to post), and she will see if any information can be found as this would help with any current review.

Recruitment and staff structure:

There has been a vacant Band 6 post for 1.0 WTE for 2 years which has added pressure on to the service. Staff have worked hard together to fill the gaps. The post has been advertised twice without any suitable candidates applying. There are reported challenges for the department in attracting staff and because the role does not cover paediatric hearing aid work. None of the staff within the team work full time.

The department has made positive steps to maintain clinical skills and have supported one staff member to carry out hearing aid work at Halton.

All staff have a PDR (undertaken by the Operational Manager), and access to CPD funding is available. There has been access to the British Academy of Audiology Higher Training Scheme (HTS) for one of the senior Audiologists and they are looking to complete all the paediatric modules.

The vacancy has increased wait times which the service has managed as much as possible and the team have introduced systems and ways of working to ensure key patients are not lost within waiting lists.

Due to the vacant post the Associate Specialist in Community Paediatrics has been taking on a role that could be carried out by an Audiologist. This has reduced the time available for the specialist work that is part of the associate specialist role and has resulted in staff working beyond their contracted hours to meet the requirements of their job plan and the needs of the service. This is not sustainable.

Clinical strategy:

The impact on testing from the stress of being observed and in the context of the service review is recognised when writing findings about the observed testing.

There were constructive discussions during the clinic observations covering different approaches and techniques that can be adopted and could be of benefit. All children appeared to receive an accurate measure of their hearing during the clinic observation. Stage A equipment checks were carried out and recorded appropriately.

There is good experience within the team but as with any site there is risk from training in-house, working in a small team and in a small service.

A summary of the discussions and findings from the clinic observation can be found in Appendix C.

The service and team benefit from the skills within the team of an Associate Specialist in Community Paediatrics with Audiology training. Children with additional needs or suspected or confirmed social communication disorders are usually triaged or brought back for review into a clinic with the associate specialist. While this can be of benefit in some cases there are many of these children who whose audiology needs could be well met within an audiologist led clinic. This approach does add even more pressure on the consultant led clinics and the associate specialist's time. The potential for a Band 7 role with an audiologist with more experience in paediatric audiology would also reduce the demand on associate specialist lead clinics.

Staffing training and maintenance of clinical skills:

There is no issue of access to funding for appropriate training and CPD. One of the senior staff has undertaken one of the M-level Paediatric modules at Manchester University. They have attended external courses and conferences

All qualified staff have received appropriate theoretical and practical training through the professional bodies and/or Degree.

Staff generally have been trained on their practical skills in house. Clinical observation identified some good practice and the staff were away of and followed the department guidance (Paediatric Audiology Local Guidelines/Care Pathways based on National Guidelines, February 2023).

The team has forged links with Halton Paediatric Audiology Service for advice and maintaining skills. There is potential to create more formal arrangements and pathways with the Halton service. The service at Halton provides a full service across the whole pathway.

As mentioned, there were constructive discussions during the clinic observations which included discussion and debate about different approaches and techniques that can be adopted and advantages and disadvantages of these. The team would benefit from reflecting on the clinical guidance document and discussions on justified safe deviations. This would enable a more flexible approach to obtain information about nature, degree and extent of the hearing loss.

Peer review is currently an informal process within the team. This needs to be a more formal process with cross site peer review with Halton.

Appraisal/PDR is carried out by the Operational manager. The appraisal for the Associate Specialist is coordinated through the Medical Directorate. The Medical Director is the Responsible Officer for the Trust and oversees the medical appraisal process.

Pathway:

The pathway is described as a joint pathway with 2 providers involved at different points.

Initial assessment:

The initial ABR hearing assessment following referrals form the newborn hearing screen is carried out at WHH. If there is a permanent hearing loss diagnosis, the Associate Specialist in Community Paediatrics is asked to attend the follow up appointment so that she can break the news. The ToD is also in attendance (as confirmed by the ToD interviewed).

ABR results are sent to BCHFT for the attention of the Associate Specialist in Community Paediatrics for those children with any hearing loss which needs further follow up. It has been presumed that the testing has been carried out accurately and to the national guidelines and that the results have been reported correctly. Examples of the information passed from WHH to BCHFT was seen during the observation days. It would be helpful for there to be increased understanding and knowledge in BCHFT of ABR assessment and ability to critically review the information being passed over from Warrington to BCHFT.

There is evidence of limited audiological information obtained during the ABR testing at WHH with frequently missing bone conduction testing and testing of additional frequencies and no masking. It can be easier to obtain this information using ABR and these missed opportunities created significant pressure on the behavioural testing to be carried out at BCHFT to fully understand a child's hearing loss.

Hearing aids:

A budget for hearing aids sits in BCHFT but is then passed over to WHH. No breakdown of how this money is spent is given back to BCHFT. There is no ability for the team at BCHFT to influence the range of aids offered which can lead to difficulties.

There is a BCHFT staff member who is maintaining hearing aid knowledge and skills by attending hearing aid review clinics at the BCHFT service at Halton.

The first hearing aid fitting is carried out at WHH by WHHFT Audiologists, with the Audiologists attending Sandy Lane Child Development Centre for subsequent work on the hearing aid review appointments. The hearing aid repair service is carried out at WHH.

Children attend Sandy Lane Child Development Centre for a hearing aid review. There is an initial 45 minute appointment with the BCHFT team to review the progress, address concerns, assess the hearing and agree any management plan. The information about the hearing is then passed over to the WHH audiologists who also have a scheduled 45 minute appointment with the child to look at the hearing aid provision.

The structure of the hearing aid review visit is therefore very formulaic. This structure prevents any flexibility to meet the needs of the child and family. An example was given of the challenges if a child arrives for their appointment with the BCHFT with a broken hearing aid which relies on the WHH team fixing or replacing. Separating the two aspects is disjointed for families and clinicians and creates challenges for management of the hearing loss.

If there are concerns about the progress of a child it is hard to know how that is addressed. The ToD contacts the Bridgewater team if an assessment is required and WHH if there are any concerns regarding the hearing aid. There is no clarity on who takes overall charge of the child pathway and child's progress.

BCHFT do not have access to the HA fitting or REM traces through Auditbase or Otosuite. The WHH Audiologists provide written information about the hearing aid appointment to BCHFT on a standard form formatted with both tick boxes and free text. From cases seen during the review the free text appears to be used to indicate the prescription formula used and whether RECD or REMs were carried out. It did not contain information about the match to target (options would be from a simple description, to a copy of the prescription and gain curves or use of the SII) or how the prescription has

been generated[1]. As with the audiology team, the only information received by the Teacher of the Deaf about the hearing aids is the aid type and no information on settings or verification. The ToDs run the aids through the test box themselves for any information on output etc.

The hearing aids on offer under the control of WHH and there have been cases where the provision wanted by the team at BCHFT has or could not be provided by WHHFT[2].

Communication regarding hearing aids is a concern. There is limited information about the aids that are fitted by WHH both to the BCHFT Audiology team and ToD.

The ToD reported that they are working with the teams to improve some communication and introduce signed consent forms to enable sharing of information with both services. Hearing aid information only states the type of device fitted and only rarely is any REM information indicated. The ToD has set up a meeting with WHH to try an improve this. They often do not get information in a timely manner if a child has had their hearing device changed or removed. Bone conduction aids for Warrington children are fitted at Alder Hey and they do not get information back from them quickly.

Summary

Areas of good practice

A lovely atmosphere was observed in clinic. The clinicians clearly enjoy their job, working with children, get on together and work together as a team.

Families appeared to feel comfortable within the appointment. A nice rapport with families and children was seen and good clear explanations of results and management plans observed. Family satisfaction is reflected in the feedback the service receives.

There is a good size test room and observation room at Sandy Lane Child Development Centre and good office facilities. There are plans to improve the visual reinforcement system with a new visual reward system. The environment is child friendly.

At Westbrook Medical Centre there is a sound treated room and the clinics that operate there reflect the limitations of that test environment. A new soundproof room is being set up at another centre and the BCHFT team are involved in its design and set up.

Clear written record of Stage A checks on is scanned in and monitored.

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[1] For example it did not indicate whether BC levels had been used to generate the target and or the hearing levels used to generate the target when there was missing frequency information from the testing (which is not uncommon).

[2] There was a case of a child during the observation with a mild loss due to fluctuating glue ear. The plan agreed with the parent during the BCHFT part of the appointment was to continue with a lower powered aid but the WHHFT did not have an aid to meet this need. A case was described where the BCHFT have been unsuccessful in their request to WHH for an alternative hearing aid model for a child when the standard offer from WHH does not meet the needs of the child.

Calibration is overseen by an audiologist within the team and is up to date. Calibration certificates were seen. The soundfield was calibrated appropriately and the set up was correct. The team are aware of the requirements for the soundfield for the planning and construction of their new test booth.

There is an excellent link between the BCHFT Audiology service and other community services. They are based in the same building and there was frequent mention of making phone calls or going to talk to other professionals within services such as community paediatrics, speech and language therapy and the safeguarding team.

All staff can easily triage referrals within SystmOne. If there is a query about a referral staff will confer with colleagues or the lead for advice.

There is a well monitored opt in system when children are due for their appointment. A letter is sent inviting families to book an appointment and they have 10 days to respond. Those who do not respond are flagged within SystmOne for the clinician to review the case. At this point there are options including discharge, offer another opt in or involve other professionals such as the health visitor or ToD for those where there are concerns or those with hearing aids to encourage attendance.

The use of SystmOne gives the audiology team access to all the community records for the child. This was seen being used well in the planning for appointments and to follow up on any concerns or queries for a child.

The team have been able to design the proforma on SystmOne to record the history, testing and outcomes of Audiology appointments. Parental responsibility, consent, who attended the appointment with the child are clearly documented in the system and there is an alert for those with programmable ventricular (PVP) shunts. There has been good dialogue with developers to make modifications as the team have been using the system.

Tick sheet is used to mark the responses and no responses in VRA and this is scanned into the patient record along with copies of the tympanometry traces and OAE traces when performed.

The clinic letter following the appointment is addressed to the family (with the team aiming to email this) and sent electronically to the GP through SystmOne. Other community professionals see the report on the system but can be flagged for attention as required.

There is good quality administrative support and the clinical team have confidence in that support. Clinicians can safely advise families that they can contact the team by phone if there are any problems.

Staff are mindful of the waiting list and any current delays between expected and actual review dates, particularly when arranging to see priority children again. There is good flexibility in the system so that staff can write instructions to the booking team with confidence that these instructions are followed.

The standard appointment times are appropriate, but the team can request a longer time with the patient as required.

Speech testing is regularly carried out alongside formal hearing assessment. This typically is done prior to the hearing test which in some cases reduces how much hearing threshold testing can be carried out on children who easily become restless.

A range of appointments were observed with different skill mix and combinations of staff across the different clinics with all staff working well together.

Complex children and those with suspected social communication difficulties are booked in to clinics with the Associate Specialist in Community Paediatrics.

Good infection control observed.

The team are actively exploring how to share information more effectively and electronically with the ToD and the ToD raised this in relation to consent forms needing to be updated. The ToD is also aware of where they need to improve their communication about children being issued with assistive devices by their service.

There is a joint ENT clinic with the Associate Specialist in Community Paediatrics for more complex children at WHH. The Audiology cover is provided by WHH on clinic for those who can be tested using audiometry and a 'push button'. Younger children are referred back to BCHFT for behavioural testing as required.

Good access to a nurse led dewax service with the nurse experienced in young children. There were however gaps and longer waits in this service when the nurse was on maternity leave during which time the service was provided by the ENT doctors.

Summary of main areas of concern

There are concerns that despite the pathway being described as a joint pathway and some joint working, the hand offs and the sharing of information in to the BCHFT service from WHH creates risks and unknowns about patient care.

The decision made by WHH to not participate in the service review which is ultimately about the care of Warrington babies is a point of serious concern. The lack of shared decision making, shared information and transparent working from WHH creates the risks for Warrington babies and children.

From the findings of the service review there is very little evidence of a joint pathway of care. Although there are two providers contributing to the pathway and there is some transfer of information from one service to another, the care itself is disconnected and disjointed. There should be one service responsible for whole pathway including identification of hearing loss, management and investigations into that hearing loss and provision of hearing aids.

There is a need for external peer review because of the small size of the service (population, number of cases of hearing loss and size of the team).

There is significant lack of information about the hearing aid provision provided to the BCHFT team and Teachers of the Deaf.

There is a need for a service lead with high level of both audiological and scientific knowledge to build on the existing good quality service and for future development and monitoring of the service. This would open opportunities to expand what services BCHFT provide for children in Warrington.

The service does currently rely on staff stepping up and filling the gaps created by the vacancy, different skill mix within the clinics.

The main risks for Warrington babies and children with hearing loss is that the initial assessment and hearing aid provision are carried out by a completely different trust to the one that is providing the ongoing management plan and care plan for the children. The BCHFT with its service for Warrington babies at Sandy Lane and the service at Halton is well placed to do that. They have the skills and existing good relationships with Halton. The provision of the whole care pathway would create a service that was cohesive across the whole pathway without any handover points to another trust.

Recommendations

The following recommendations are made and have been classed according to priority. Urgent and high priority recommendations are to address immediate clinical risks. Medium priority recommendations are those which are proposed to ensure robust quality assurance.

Urgent – to address immediately

1. Only the aspects of the pathway provided by BCHFT have been reviewed. There must be an external service review of the WHH aspects of the pathway. This is in addition to the current support they are receiving for ABR assessment and the national audit of the traces.

High – for action within 6 months

2. Develop an audiological and scientific leadership role within the service of at least a Band 7 level. This role should include non-clinical time to develop, review practice, policies, audit, create a programme of quality assurance. There should be support to work towards IQIPS accreditation.
3. Review the structure, pathway and skill mix for the clinics that are currently commissioned and for any potential future models of provision. This will depend on and include successful recruitment into the current vacant post and restructuring to create a Band 7 Audiologist post.
4. A programme of external peer review by an experienced audiologist for all members of the team carrying out hearing assessment at BCHFT. The peer review should cover all the behavioural test techniques to assess hearing in the different age groups up to 7-year-olds. The review should look at following of BSA protocols, justifications of modifications made and ability to be flexible in test technique dependent on the questions about the hearing and the child.
5. Reflect as a team on the discussions and findings about clinical strategy including NST, holding back the reward, varying frequency and stimulus to NBN when children are not conditioning and increased gaps between presentations. The team should also review the step sizes being used during testing to ensure the default when a child stops responding is that the sound needs to be increased by standard steps to the point where the child starts to respond again.
6. Review the department policy as a team considering in particular the number of frequencies to be tested but with the introduction of exceptions e.g., child with complex needs, child who

responded to three frequencies and has OAEs recordable in both ears, when there is a need to address gaps in the knowledge about the hearing loss.

7. Increase the amount of threshold testing (rather than screening at 20dBHL) for BC in cases where it is important to establish the true size of the air-bone gap and to obtain accurate BC levels for use in the prescription formula for those who have hearing aids.
8. Introduce a system using a hearing aid and remote microphone set up so that the tester in the observation room and the tester in the room can communicate with effectively with each other.
9. Alter the set up for performance testing so that the person presenting sounds who is behind the child can see the child, their hands and facial expressions. Options include rearranging the desk so that the audiometer is closer to the child.
10. Repeat tympanometry in all cases where an abnormal trace is obtained to ensure reliability of the result.
11. Examine and report internally at the Quality Council and externally at the Place Based Audiology Meeting on the outcomes and data from the school hearing screen. This should include looking at the outcome of the newborn hearing screen and any subsequent testing that was carried out.
12. Obtain a breakdown of how the hearing aid budget given over to WHH is used.

Medium – for action within 6 months to 12 months maximum.

13. For an improved patient pathway, bring provision of hearing aids under the team working in the BCHFT service. This would require additional staffing and supports the creation of a Band 7 role. There is existing skill set within the team and this is kept up to date by the senior staff attending and supporting paediatric hearing aid clinics at Halton.
14. Review the department practice where children with no risk factors are being brought back for review at 4 years of age.
15. Reconsider the standard carrying out of speech testing in clinics prior to threshold obtained hearing tests to maximise the amount of threshold testing that is achieved.
16. Ensure that the placement of the sound level meter for speech testing gives an accurate measure of the talker's voice level.
17. Establish a programme of audit and actions that are reported to the teams.
18. Set up newer VRA reward system with increased number of puppet options.
19. Introduce a system where all assessment results and hearing aid programming information (from the manufacturer and hearing aid verification system) can be shared between BCHFT and WHHT. This may involve shared access to the audiology patient management in addition to the use of SystmOne in BCHFT.
20. To apply for UKAS accreditation for the service that is currently provided. This could be aligned with Halton (who are going ahead with this) to save on monies and have shared protocols and pathways. The application would need to be supported with project management resource to support the process.

References

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NHS Lothian Paediatric Audiology Governance Review (2021). BAA-Governance-Report_NHS-Lothian-Paediatric-Audiology.pdf (baaudiology.org)

2023 Standard for Improving Quality in Physiological Sciences, UKAS. IQIPS-standard-2023.pdf (ukas.com)

Appendix A

Topic Guides for Interviews

Introduction for all interviews

Reminder of the purpose of the interview: to ensure everyone has opportunity to input into the review, to find out more about their experiences and thoughts of working in the department and of governance aspects, opportunity for them to highlight areas of good practice and if there are any areas of concern. The ultimate aim to ensure the patients and their families receive the expected level of service.

What is said during the interview is confidential and will be used together with the other information from the visit to write a report for the Trust. Anything we write about in the report from these interviews will be kept anonymous. There are only two occasions when this would be broken;

- If something was raised which is a clinical risk, which we would have a duty to report.
- We might find that training needs are identified, and if so, would need to highlight which members of staff may benefit from which training.

Are you happy to proceed on that basis?

We are not trying to catch individuals out, we want to get an accurate picture of the service, and therefore would like everyone to be as open and honest as possible. We will be making notes as we are meeting with lots of people and don't want to lose track.

Topic guide for Audiologists

1. Can you give us a summary of your career to date, from how you decided to work in Audiology and how you trained, to your current post?

Prompts: Why audiology, where trained, what qualifications, where worked / roles, when joined the Trust, role at the Trust - range of clinics / frequency

2. What do you enjoy and what do you not enjoy about your current role?

Prompts: enjoy all clinics equally, some more challenging, would like to do more or different clinics?

3. What does it feel like to work at the Trust?

Prompts: close / happy team, busy?

4. How do you keep up to date with clinical practice? Are you supported with this by the Trust (time / resources)? Do you enjoy development opportunities?

Prompts: examples of CPD, courses, conferences, access and use of the evidence base, membership of professional bodies, team approach?

5. What level of confidence do you have in your current clinical skills and knowledge?

Prompts: better in some areas that others? Is line manager aware of any areas of weakness / areas needing updating?

6. Once you have completed testing a child / adult, how to you know how to manage them, e.g. discharge, review, diagnose hearing loss?

Prompts: what review period, how is it ensured there is a consistency of decision making across all clinics, how confident are they at diagnosing a hearing loss

7. Are you confident to diagnose a permanent hearing loss if you found one?

Prompts: Have you diagnosed PCHI, who gives the diagnosis, training in sharing the news?

8. Do you use clinical guidelines or protocols?

Prompts: which ones / when used / where are they kept / who develops them / when did you last refer to them.

9. What would you do if you have concerns about a child, from a safeguarding angle? Have you had any safeguarding concerns?

Prompt: procedure for reporting, what constitutes a concern, e.g. with loss and DNAs

10. How would you rate the services offered by Audiology and why?

Prompts: would they recommend the service / areas of good practice / areas needing improvement

11. How is the service reviewed and developed?

Prompts: protocol review and updating, willing to acknowledge problems, who does work / leads, work together to improve performance, team meetings, audit work and surveys, is quality important?

12. What do you do if you have concerns about the service? Do you know what to do if you feel concerns are not being addressed?

Prompts: confident to raise concerns, confidence they will be listened to, whistle-blowing procedure

13. How are complaints handled, for example if someone started complaining in a clinic or a complaint letter was received?

Prompts: Who do they got to, Trust procedures, does dept regularly review complaints and lessons learnt?

14. Who is your line manager? Do you meet with them individually?

Prompts: regular 1:1s, appraisal / objectives / PDP, feel supported and valued?

15. How does the department celebrate success?

Prompts: how is success communicated / recognised, shared sense of achievement?

16. Any other questions which have arisen from discussion or observation.

17. Is there anything else you would like to say that we have not covered?

Topic guide for additional questions for Head of Service

1. How are the various management responsibilities organised, e.g. dedicated regular time for this, are some aspects delegated?

Prompts: Who does what / timetabling / staff management / who is responsible in HoD absence?

2. Are there any specific clinical responsibilities for the HoD, e.g. does anything need to be checked, signed off etc.?

Prompts: what happens during absence, if signing off why is this (? lack of confidence in others / oversight)

3. How is it decided which staff do which clinics?

Prompts: does a particular band of staff do particular clinics or those with particular training

4. How does communication work within the department?

Prompts: team meetings, huddles, emails, informal discussion, challenges with part time staff

5. How does training and CPD work, does the department have a budget for this, and how are needs identified?

Prompts: Included in appraisal process, training updates for whole department or individuals, do staff go to conferences, regional meeting etc.

Appendix B

BAA Higher Training Scheme competencies

Higher Training Scheme Competencies in Paediatrics

N. B. criteria 12 applied to newborn hearing screening follow-ups only, references to hearing aids relevant only in appropriate clinics / with children with aids.

Competency		0 - Does not meet required standard	1 - Meets required standard	2 - Exceeds required standard
1	Prepare test facilities & equipment, to include daily calibration checks and room set up	Omits or incorrectly performs calibration checks and equipment setup, OR is unable to identify the consequences of proceeding with incorrectly calibrated or faulty equipment, or room set up inappropriate for the session	Performs calibration checks and equipment setup correctly, and is able to identify the main consequences of proceeding with incorrectly calibrated or faulty equipment, and the room is set up appropriately for the session	Performs calibration checks and equipment setup skilfully, and is able to identify detailed consequences of proceeding with incorrectly calibrated or faulty equipment, and room is set up with a high attention to detail and patient needs
2,3	Formulate assessment plans, liaising with the relevant professionals to co-ordinate assessments & care, as appropriate. Plan clinical approaches, using clinical reasoning strategies, evidence-based practice	Does not select appropriate or person-specific assessment or management plans, OR is unable to explain the reasoning behind the approach taken, OR does not show sufficient knowledge of the current research evidence and clinical guidance, OR does not liaise with relevant professionals as appropriate	Identifies appropriate assessment and management plans and modified to meet individual needs. Is able to broadly explain the reasoning underpinning the approach taken using current research evidence and clinical guidance. Liaises with relevant professionals as appropriate	Creates an assessment or management plan which is highly tailored to the patient's specific needs and consistent with current clinical guidance and evidence-based practice and liaises with the relevant professionals as appropriate
4	Take a full and relevant history	Obtains insufficient information about the child's history to date, family history or parent's / carer's understanding	Uses effective questioning and listening to elicit sufficient information about child's history to date, family history AND parent's / carer's understanding	Uses skilful questioning, and active listening to elicit a comprehensive picture of the patient's history to date, family history and parent's / carer's understanding
5	Carry out testing / verification in a safe and effective manner adapting as required to ensure testing / verification is appropriate for the developmental age of the child, and information gained is maximised within the time available	Assessment is unsafe, OR does not follow local or national guidance (or without evidence-based justifications as to why not), OR is not completed within an appropriate time, OR does not adapt the testing process to maximise data collection	Performs assessment safely, according to local and national guidance and within the appropriate appointment time allocation. Adapts the testing process where appropriate to ensure the most valuable data is prioritised	Performs assessment skilfully, according to local and national guidance and within the appropriate appointment time allocation. Adapts the testing process where appropriate to ensure the most valuable data is prioritised

6	Show creativity, initiative, and originality of thinking in tackling and solving practical problems	Does not show creativity, initiative, and originality of thinking in tackling and solving practical problems if they arise during the session	Shows creativity, initiative, and originality of thinking in tackling and solving practical problems if they arise during the session	Shows a high level of creativity, initiative, and originality of thinking in tackling and solving practical problems if they arise during the session
7, 8	Collate relevant information, interpret, and make an informed decision concerning the diagnosis and management of individual cases , to include hearing aid programming adjustments and onward referral to ENT or other appropriate professions if any red flags or significant hearing changes .Ensure that parents / carers are part of the decision making with use of patient centred care	Does not identify an appropriate range of diagnostic and management options for the patient or does not ensure parents / carers are part of the decision-making process	Integrates the details from the history, test results, research evidence, current clinical guidance, and patient preferences to identify a range of appropriate diagnostic and management options for the patient, including onward referral AND ensures the parents / carers are part of the decision-making process	Integrates the details from the history, test results, research evidence, current clinical guidance to identify the full range of appropriate diagnostic and management options for the patient, (including onward referral) and their likely benefits and limitations, and fully involves the parents / carers in decision making
9	Ensure any concerns regarding safeguarding are recorded appropriately and are acted on, adhering to local protocol	Does not pick up on safeguarding concerns OR does not record them appropriately, OR does not act according to local protocol	Picks up on safeguarding concerns and records them appropriately according to local protocol	Picks up on safeguarding concerns and shows a high level of knowledge about how to act on these, using appropriate documentation and referring to local protocols
10, 11	Keep parent/carers and patients fully informed during all aspects of the appointment, obtaining consent for procedures as appropriate Communicate effectively with parents and children giving clear information on the plan for the session, hearing aid orientation, results, recommendations and management plan to children and families using appropriate language and communication strategies. Give clear information on results of hearing tests, advice, and recommendation for follow-up actions/interventions to parents/carers and/or patients using appropriate language and communication strategies. This includes the ability to 'share difficult news' to parents/carers about hearing loss in infants and children	Communicates information to parents / carers in a way that is generally unclear or contains irrelevant information OR does not obtain consent	Communicates relevant information about testing and management options to parents / carers clearly and in a way that broadly meets their needs. Obtains consent	Effectively and clearly communicates relevant information about testing and management options to parents / carers in a way that is highly tailored to their needs. Obtains consent.

12	Through peer review, critically appraise the interpretation of results and management outcomes made by other clinicians; identify indicators for improvement, and feedback as appropriate.	Is not familiar with criteria OR does not interpret traces correctly OR does not select appropriate improvement indicators OR does not feedback appropriately	Shows familiarity with criteria, appraises results and management options appropriately, identifies improvement indicators and feeds back	Shows a high level of familiarity with criteria, skilfully appraises results and management options, identifies improvement indicators and feeds back
13	Keep appropriate clinical records	Clinical record omits key information or is omitted from the clinical record system	Provides a clear summary of the clinical episode, which is stored in an appropriate clinical record system	Provides clear and detailed information about the clinical episode, which is stored in an appropriate clinical record system
14	Write reports on test results and recommendations suitable for the intended audience, to include a range of professionals and parents/carers	Report omits key information, is disorganised or written using unprofessional terminology	Report provides a clear summary of the clinical episode which is logically structured and written using professional terminology	Report provides clear and detailed information about the clinical episode, which is highly organised, concise, and well written using professional but accessible terminology

15	Demonstrate the ability to, and articulate clearly through presentation and constructive discussion with colleagues: • Relate their own practice to a supporting knowledge base – including reference to evidence based and/or recognised good practice • Clearly justify <u>any</u> of their own clinical decisions made in the assessment or management of patients • Critically appraise the context of individual assessments within national and local structures/processes for assessment and diagnosis of hearing impairment • Critically evaluate and reflect on their own actions • Show independent thought through evaluation and presentation of alternative (and justified) approaches to existing local practice	Limited ability to reflect on and critically evaluate own clinical practice or explain clinical reasoning. Demonstrates limited knowledge of subjects discussed OR Does not demonstrate a good working knowledge of relevant national guidelines or policies, or evidence base, or calibration aspects OR Unable to interpret or make informed decisions concerning the diagnosis, needs or management of individuals cases OR Does not demonstrate a good working knowledge of local structures, or offer critical comment OR Does not demonstrate critical evaluation or reflection skills of own practice and others, or not aware of the limits of own skills or knowledge, or when to seek advice OR Does not show independent thought during constructive discussion	Able to reflect on and critically evaluate own clinical practice and explain clinical reasoning. Demonstrates comprehensive knowledge of subjects discussed AND Demonstrates a good working knowledge of relevant national guidelines and policies, relevant evidence base, has a good working knowledge of the relevant calibration aspects of any equipment used AND Demonstrates the ability to interpret and make informed decisions concerning the diagnosis, needs and management of individual cases AND Demonstrates a good working knowledge of the local structures (i.e. care pathways) for processing patients and offer critical comment AND Demonstrates critical evaluation and reflection skills of own practice and others, and awareness of the limits of own skills and knowledge and when to seek advice AND Shows independent thought during constructive discussion	Able to provide insightful reflection and critical evaluation of own clinical practice, and explain clinical reasoning with reference to research evidence and clinical practice AND Demonstrates wider knowledge of subjects discussed AND Demonstrates a high level of working knowledge of relevant national guidelines and policies, relevant evidence base, Has a high level of working knowledge of the relevant calibration aspects of any equipment used AND Demonstrates the ability to skilfully interpret and make informed decisions concerning the diagnosis, needs and management of individual cases AND Demonstrates a high level of working knowledge of the local structures (i.e. care pathways) for processing patients and offer critical comment AND Demonstrates a high level of critical evaluation and reflection skills of own practice and others, and high awareness of the limits of own skills and knowledge and when to seek advice AND Shows a high level of independent thought during constructive discussion

Learning outcome	Learning outcome number	0 Does not meet examination standard	1 Meets examination standard	2 Exceeds examination standard
Prepare test facilities & equipment, to include daily calibration checks and room set up	1	Omits or incorrectly performs calibration checks and equipment setup, OR is unable to identify the consequences of proceeding with incorrectly calibrated or faulty equipment, or room set up inappropriate for the session.	Performs calibration checks and equipment setup correctly, and is able to identify the main consequences of proceeding with incorrectly calibrated or faulty equipment, and the room is set up appropriately for the session.	Performs calibration checks and equipment setup skilfully, and is able to identify detailed consequences of proceeding with incorrectly calibrated or faulty equipment, and room is set up with a high attention to detail and patient needs.
Formulate review and management plans, liaising with the relevant professionals to co-ordinate assessments & care, as appropriate Plan clinical approaches, using clinical reasoning strategies, evidence-based practice and person-centred care	2,3	Does not select appropriate or person-specific assessment or management plans, OR is unable to explain the reasoning behind the approach taken, OR does not show sufficient knowledge of the current research evidence and clinical guidance, OR does not liaise with relevant professionals as appropriate.	Identifies appropriate assessment and management plans, and modifies these to meet individual needs. Is able to broadly explain the reasoning underpinning the approach taken using current research evidence and clinical guidance. Liaises with relevant professionals as appropriate.	Creates an assessment or management plan which is highly tailored to the person's specific needs and consistent with current clinical guidance, highly person-centred approaches and evidence-based practice and liaises with the relevant professionals as appropriate.
Take a full and relevant history	4	Obtains insufficient information about the child's progress, difficulties and needs, health, and listening environments.	Uses effective questioning and listening to elicit sufficient information about the child's progress, difficulties and needs, health, and listening environments.	Uses skilful questioning, and active listening to elicit a comprehensive picture of the child's progress, difficulties and needs, health, and listening environments.
Keep parent/carers and patients fully informed during all aspects of the appointment, obtaining consent for procedures as appropriate. Communicate effectively with parents and children giving clear information on the plan for the session, hearing aid orientation, results, recommendations and management plan to children and families using appropriate language and communication strategies.	5,11	Communicates information to parents / carers and children in a way that is generally unclear or contains irrelevant information OR does not obtain consent.	Communicates relevant information about testing and management options to parents / carers and children clearly and in a way that broadly meets their needs. Obtains consent.	Effectively and clearly communicates relevant information about testing and management options to parents / carers and children in a way that is highly tailored to their needs. Obtains consent.

Carry out assessment / verification in a safe and effective manner adapting as required to ensure assessment / verification is appropriate for the developmental age of the child, and information gained is maximised within the time available	6	Assessment / verification is unsafe, OR does not follow local or national guidance (or without evidence-based justifications as to why not), OR is not completed within an appropriate time, OR does not adapt the testing process to maximise data collection.	Performs assessment / verification safely, according to local and national guidance and within the appropriate appointment time allocation. Adapts the testing process where appropriate to ensure the most valuable data is prioritised.	Performs assessment / verification skilfully, according to local and national guidance and within the appropriate appointment time allocation. Adapts the testing process where appropriate to ensure the most valuable data is prioritised.
Show creativity, initiative and originality of thinking in tackling and solving practical problems	7	Does not show creativity, initiative and originality of thinking in tackling and solving practical problems if they arise during the session.	Shows creativity, initiative and originality of thinking in tackling and solving practical problems if they arise during the session.	Shows a high level of creativity, initiative and originality of thinking in tackling and solving practical problems if they arise during the session.
Collate relevant information, interpret and make an informed decision concerning the management of individual cases, to include hearing aid programming adjustments and onward referral to ENT or other appropriate professions if any red flags or significant hearing changes Develop individual management plans, ensuring that children and parents / carers are part of the decision making with use of person-centred care, to include transition plans at the appropriate stage to ensure a managed transition into adult services. Uses shared decision making to explore the range of treatment options available in a collaborative way.	8,9	Does not identify an appropriate range of management options for the child or does not ensure parents / carers/child are part of the decision-making process OR does not make the appropriate hearing aid adjustments OR does not identify the need for or make appropriate referrals if required OR does not develop an individual's management plan OR does not use shared decision making and collaboration.	Integrates the details from the history, test results, research evidence, current clinical guidance and patient preferences to identify a range of appropriate management options for the patient, including onward referral AND ensures the parents / carers and children are part of the decision making process AND makes the appropriate hearing aid adjustments AND does identify the need for and make appropriate referrals if required AND develops an individual management plan AND does this collaboratively.	Integrates the details from the history, test results, research evidence, current clinical guidance to identify the full range of appropriate management options for the patient, (including onward referral) and their likely benefits and limitations, and fully involves the parents / carers and children in decision making AND skilfully makes the appropriate hearing aid adjustments AND develops a highly personalised individual management plan with clear collaboration.
Give advice on assistive listening devices, FM systems and apps, as appropriate, and ways these may be obtained, making referrals as needed	10	Does not recognise need to give advice OR does not give advice as required OR does not give accurate advice does not explain how these may be obtained OR does not make appropriate referrals if appropriate.	Recognises the need to give advice and gives accurate advice to include how these may be obtained and refers as appropriate.	Proactively gives advice regarding a range of devices / systems / apps to ensure access to speech and environmental sounds, tailored to the individual child and family, to include how these may be obtained and refers as appropriate.

Demonstrate the ability to, and articulate clearly through presentation and constructive discussion with colleagues: • Relate their own practice to a supporting knowledge base – including reference to evidence based and/or recognised good practice • Clearly justify any of their own clinical decisions made in the assessment or management of patients • Critically appraise the context of individual assessments within national and local structures/processes for paediatric habilitation • Critically evaluate and reflect on their own actions • Show independent thought through evaluation and presentation of alternative (and justified) approaches to existing local practice	14	Limited ability to reflect on and critically evaluate own clinical practice, or explain clinical reasoning. Demonstrates limited knowledge of subjects discussed. OR Does not demonstrate a good working knowledge or relevant national guidelines or policies, or evidence base, or calibration aspects OR Unable to interpret or make informed decisions concerning the needs or management of individuals cases OR Does not demonstrate a good working knowledge or local structures, or offer critical comment OR Does not demonstrate critical evaluation or reflection skills of own practice and others, or not aware of the limits of own skills or knowledge, or when to seek advice. OR Does not show independent thought during constructive discussion	Able to reflect on and critically evaluate own clinical practice, and explain clinical reasoning. Demonstrates comprehensive knowledge of subjects discussed. AND Demonstrates a good working knowledge of relevant national guidelines and policies, relevant evidence base, has a good working knowledge of the relevant calibration aspects of any equipment used AND Demonstrates the ability to interpret and make informed decisions concerning the needs and management of individual cases AND Demonstrates a good working knowledge of the local structures (i.e. care pathways) for processing patients and offer critical comment AND Demonstrates critical evaluation and reflection skills of own practice and others, and awareness of the limits of own skills and knowledge and when to seek advice Shows independent thought during constructive discussion	Able to provide insightful reflection and critical evaluation of own clinical practice, and explain clinical reasoning with reference to research evidence and clinical practice. AND Demonstrates wider knowledge of subjects discussed. AND Demonstrates a high level of working knowledge of relevant national guidelines and policies, relevant evidence base, has a high level of working knowledge of the relevant calibration aspects of any equipment used AND Demonstrates the ability to skilfully interpret and make informed decisions concerning the needs and management of individual cases AND Demonstrates a high level of working knowledge of the local structures (i.e. care pathways) for processing patients and offer critical comment AND Demonstrates a high level of critical evaluation and reflection skills of own practice and others, and high awareness of the limits of own skills and knowledge and when to seek advice AND Shows a high level of independent thought during constructive discussion

Keep appropriate clinical records	12	Clinical record omits key information OR is omitted from the clinical record system.	Provides a clear summary of the clinical episode, which is stored in an appropriate clinical record system.	Provides clear and detailed information about the clinical episode, which is stored in an appropriate clinical record system.
Write reports on test results and recommendations suitable for the intended audience, to include a range of professionals and parents/carers	13	Report omits key information, is disorganised or written using unprofessional terminology.	Report provides a clear summary of the clinical episode which is logically structured, and written using professional terminology.	Report provides clear and detailed information about the clinical episode which is highly organised, concise, and well written using professional but accessible terminology.

Learning outcomes	0 Does not meet examination standard	1 Meets examination standard	2 Exceeds examination standard
Give advice on assistive listening devices, FM systems and apps, as appropriate, and ways these may be obtained, making referrals as needed	Does not recognise need to give advice OR does not give advice as required OR does not give accurate advice does not explain how these may be obtained OR does not make appropriate referrals if appropriate.	Recognises the need to give advice and gives accurate advice to include how these may be obtained and refers as appropriate.	Proactively gives advice regarding a range of devices / systems / apps to ensure access to speech and environmental sounds, tailored to the individual child and family, to include how these may be obtained and refers as appropriate.
Keep patient fully informed during all aspects of the appointment, obtaining consent for procedures as appropriate Communicate effectively with patients giving clear information on the plan for the session assessment results, recommendations and management using appropriate language and communication strategies	Communicates information in a way that is generally unclear or contains irrelevant information.	Communicates relevant information about testing and management options clearly and in a way that broadly meets their needs.	Effectively and clearly communicates relevant information about testing and management options in a way that is highly tailored to their needs.
Keep appropriate clinical records	Clinical record omits key information or is omitted from the clinical record system.	Provides a clear summary of the clinical episode, which is stored in an appropriate clinical record system.	Provides clear and detailed information about the clinical episode, which is stored in an appropriate clinical record system.
Write reports on test results and recommendations suitable for the intended audience, to include a range of professionals	Report omits key information, is disorganised or written using unprofessional terminology.	Report provides a clear summary of the clinical episode which is logically structured, and written using professional terminology.	Report provides clear and detailed information about the clinical episode which is highly organised, concise, and well written using professional but accessible terminology.

Learning outcomes	0 Does not meet examination standard	1 Meets examination standard	2 Exceeds examination standard
Demonstrate the ability to, and articulate clearly through presentation and constructive discussion with colleagues: • Relate their own practice to a supporting knowledge base – including reference to evidence based and/or recognised good practice • Clearly justify <u>any</u> of their own clinical decisions made in the assessment or management of patients • Critically appraise the context of individual assessments within national and local structures/processes for paediatric habilitation • Critically evaluate and reflect on their own actions • Show independent thought through evaluation and presentation of alternative (and justified) approaches to existing local practice	Limited ability to reflect on and critically evaluate own clinical practice, or explain clinical reasoning. Demonstrates limited knowledge of subjects discussed. OR Does not demonstrate a good working knowledge or relevant national guidelines or policies, or evidence base, or calibration aspects OR Unable to interpret or make informed decisions concerning the needs or management of individuals cases OR Does not demonstrate a good working knowledg or local structures, or offer critical comment OR Does not demonstrate critical evaluation or reflection skills of own practice and others, or not aware of the limits of own skills or knowledge, or when to seek advice. OR Does not show independent thought during constructive discussion.	Able to reflect on and critically evaluate own clinical practice, and explain clinical reasoning. Demonstrates comprehensive knowledge of subjects discussed. AND Demonstrates a good working knowledge of relevant national guidelines and policies, relevant evidence base, Has a good working knowledge of the relevant calibration aspects of any equipment used AND Demonstrates the ability to interpret and make informed decisions concerning the needs and management of individual cases AND Demonstrates a good working knowledge of the local structures (i.e. care pathways) for processing patients and offer critical comment AND Demonstrates critical evaluation and reflection skills of own practice and others, and awareness of the limits of own skills and knowledge and when to seek advice Shows independent thought during constructive discussion.	Able to provide insightful reflection and critical evaluation of own clinical practice, and explain clinical reasoning with reference to research evidence and clinical practice. AND Demonstrates wider knowledge of subjects discussed. AND Demonstrates a high level of working knowledge of relevant national guidelines and policies, relevant evidence base, Has a high level of working knowledge of the relevant calibration aspects of any equipment used AND Demonstrates the ability to skilfully interpret and make informed decisions concerning the needs and management of individual cases AND Demonstrates a high level of working knowledge of the local structures (i.e. care pathways) for processing patients and offer critical comment AND Demonstrates a high level of critical evaluation and reflection skills of own practice and others, and high awareness of the limits of own skills and knowledge and when to seek advice AND Shows a high level of independent thought during constructive discussion.

Appendix C

Commentary on clinical observations

Staff did show good awareness of the behaviour and listening of the children and the risk of false positives. At times it felt that some of the testing was quick. Slowing down the testing and presentations would increase robustness of the testing. There were discussions about the BSA protocol for Visual Reinforcement Audiometry which the team were aware of and discussions about valuable additional techniques such as holding back the reward in VRA to help differentiate between checking behaviours and true responses. These were good reflective discussions.

There was use of no sound trials, but this could have been used more in the VRA observed. There could have been longer gaps between presentations for play audiometry. The team reported that they introduce techniques such as these when they are concerned but there is benefit of using this as standard for all children.

It was felt that the team needed a bit more confidence in establishing conditioning for play audiometry which may have allowed them to increase how much information they obtained however they were still successful when using VRA for these children.

There did appear to be different approaches in step size used particularly when increasing the volume of the test sound after a child had not responded. This was not uniform across all clinicians and in all cases. While some variation can be needed in some children there was concern that too frequently the assumption appeared to be that the child had stopped responding rather than was not hearing the sound.

There was a tendency to screen the bone conduction at 20dBHL rather than to obtain thresholds in children who were having their hearing loss managed. This could result in under-estimation of the size of the air bone gap and the amount of amplification required or miss a very mild high frequency sensorineural hearing loss.

The department policy requires 4 thresholds to be obtained as a minimum for soundfield testing and if required ear-specific testing and bone conduction testing. From observation and case reviews it was felt that the strive to meet this requirement lead to missed opportunities to fully understand the true hearing levels and carrying out masking.

For example case notes were seen for a child with a suspected severe-profound hearing loss in one ear identified on the ABR. Masking had not been performed on the ABR. Behavioural testing had been carried out including ear-specific testing at all 4 frequencies in the normal hearing ear and in the suspect ear but this had not been masked. There are good arguments in this case once normal hearing has been assured in the 'good' ear to concentrate on testing just one or two frequencies in the suspect ear and to mask these to fully understand the true hearing levels. This would provide much more valuable information for ongoing management and counselling and information for the parent.

During the observation and MDT case review discussions following the initial incident at Warrington cases were seen where children were to be recalled at 4 years despite satisfactory hearing being established and meeting discharge criteria. There were no clear obvious reasons for this and it is not included in the department guidelines. One case was for a child who had had meningitis. The recall decision was based on advice from a fellow professional although the national guidance is that no

further follow-up is required once the hearing levels have been established. While the offer of an appointment at 4 years was not often taken up by families there are still administrative tasks that do take time and it can have an impact on understanding true waiting lists and numbers.

The current talk through system to allow the tester in the observation room to talk to the tester in the room doesn't work well. The testers were observed to be very quiet. They did not generally share thoughts with each other about the reliability of the responses or the child's behaviour. This was reported as typical and wasn't because of being observed. There is huge advantage from ongoing voiced dialogue of thoughts and interaction between the two testers.

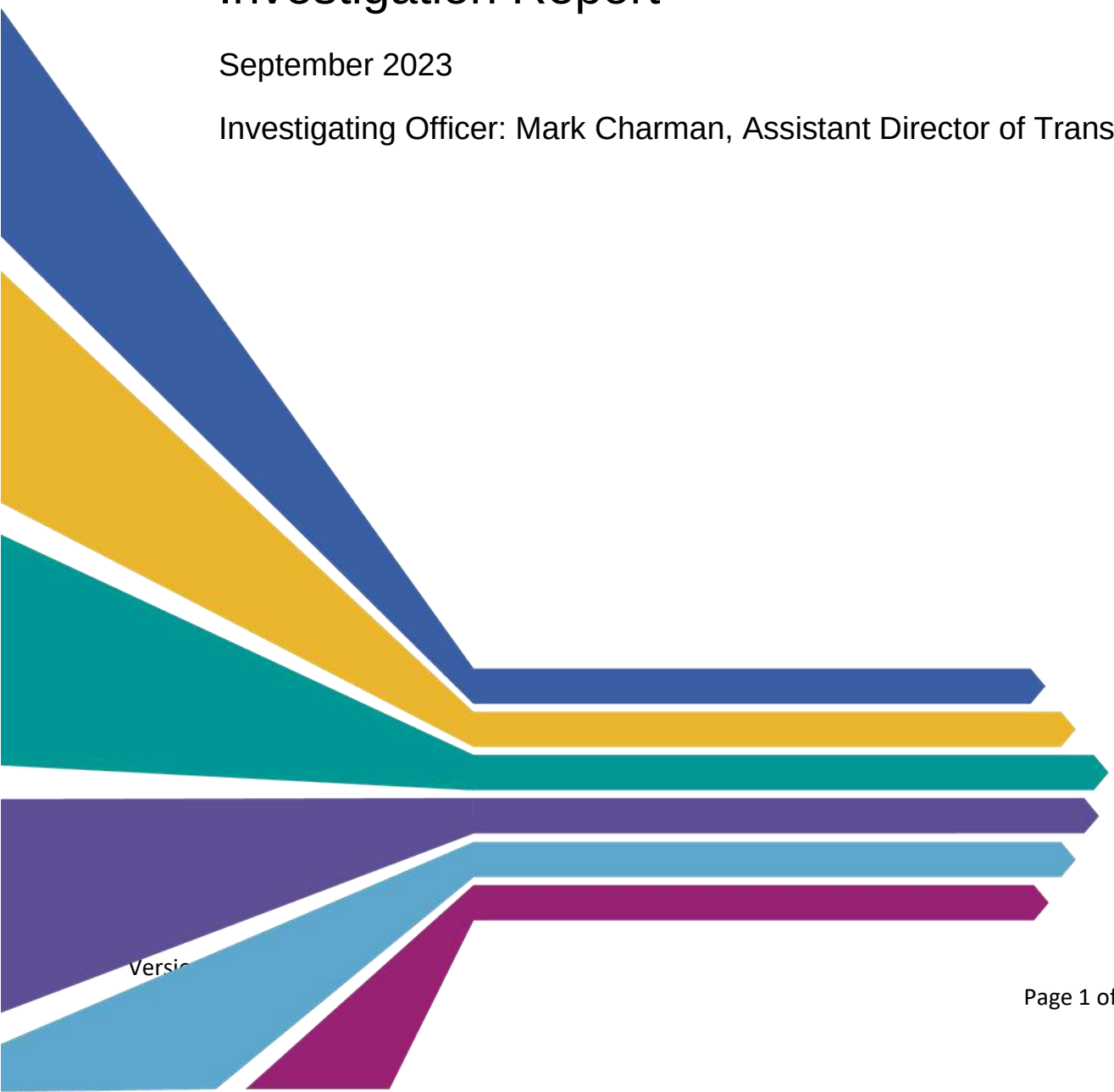
The set up for the VRA meets the requirements and is appropriate although the new planned VRA reinforcement towers will improve this further. It was felt that arrangement for 2 tester play audiometry was not helpful as the tester responsible for presenting the sounds was looking at the back of the child's head. The set up also makes it difficult in a one-tester clinic if the child is struggling to attend to play audiometry. Simple changes in the lay out of the desk and angle of the child's chair and table will help. These were discussed with the team.

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Warrington Paediatric Audiology Incident Investigation Report

September 2023

Investigating Officer: Mark Charman, Assistant Director of Transformation



Versi

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Abbreviations

ABR:	Auditory Brainstem Response
BAA:	British Academy of Audiology
BC:	Bone Conduction
BSA:	British Society of Audiology
CSS:	Commissioning Support Service
dBnHL:	Decibels Normal Hearing Level
EMT:	Executive Management Team
ENT:	Ear, Nose and Throat
ICBL	Integrated Care Board
IQIPS:	Improving Quality in Physiological Services
MDT:	Multi-Disciplinary Team
NBN:	Narrow Band Noise
NDCS:	National Deaf Children's Society
NST:	No Sound Trial
OAE:	Oto-acoustic Emission
PCHI:	Permanent Childhood Hearing Impairment
UKAS:	United Kingdom Accreditation Services
VRA:	Visal Reinforcement Audiometry
WWH:	Warrington and Halton Hospitals

Executive summary

Summary of incident

Following an incident in Lothian and a subsequent national review of Auditory Brainstem Response (ABR) testing, four organisations (across five sites) were identified as reporting a lower-than-expected yield of permanent childhood hearing impairment in babies. Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) were identified within this cohort and, subsequently, a serious incident review was commenced.

The initial focus of the investigation was on the Auditory Brainstem Response (ABR) testing undertaken at WHH, but the scope of the investigation was extended to include Bridgewater Community NHS Healthcare NHS Foundation Trust who support the delivery of the integrated paediatric audiology pathway. Bridgewater do not carry out any ABR testing.

Purpose of report

This report was commissioned by Bridgewater's Executive Management Team (EMT), and is based on the findings of a multi-disciplinary team (MDT) review of the individual cases in scope, the outcomes of the external review of Bridgewater's Warrington Paediatric Audiology Service, and fact-finding by the Investigating Officer

The purpose of this report is to detail the findings and outcomes of the above reviews and to establish the root cause of any issues and anomalies within the Bridgewater element of the Warrington paediatric audiology patient pathway, and to present recommendations based on these findings.

Scope of the investigation

The review period is 2018 to 2022, and the cases in scope of the investigation are:

- All babies and children referred to Bridgewater's Warrington Paediatric Audiology Service following diagnostic ABR testing by WHH.
- All babies and children referred to Bridgewater's Warrington Paediatric Audiology Service by a health professional, following discharge from diagnostic ABR testing by WHH.

Main findings

1. Findings from MDT Review of Individual Cases

48 cases were identified as in-scope for MDT review. These cases were joint cases, having received care from both WHH and Bridgewater audiology services. The MDT consisted of representatives from WHH and Bridgewater, and external peer reviewers from the national team.

Each case was reviewed individually to identify any issues with the management of the patient, and to determine whether any harms had, or could potentially have occurred.

The overall findings of the 48 cases reviewed were:

- 27 cases of no harm – this is where sufficient audiological information is available to demonstrate that the patient has received, or is receiving appropriate treatment, and no harm has occurred.
- 20 cases where harm level could not be established – this is where insufficient audiological information is available to determine whether any harm has occurred, and further audiological assessment is required before it can be established whether any harm has occurred*.
- 1 case of low harm – this harm is due to a possible delay in fitting of hearing aids to a child. The delay was not attributable to the Bridgewater element of the patient pathway.

*Audiological assessment of children can take several months to complete, as it is dependent on the developmental stage of the child, and their willingness and ability to cooperate with the testing.

The Investigating Officer reviewed each report for the 48 cases to establish trends in the individual findings of the MDT. An overview of these is as follows:

i) Issues within the Bridgewater element of the patient pathway:

- Accepting inaccurate, incomplete, and/or inconclusive ABR test results received from WHH.
- Acting on inaccurate, incomplete, and/or inconclusive ABR test results received from WHH.

ii) Issues with the joint element of the patient pathway, where patient handover occurs between WHH and Bridgewater, and vice-versa. This is with particular regards to a lack of shared decision making, shared information and transparent working.

iii) Issues within the WHH element of the patient pathway that were identified during MDT review – these are out of scope for Bridgewater's internal investigation, but are included here to provide context for this report:

- Discharging children at a level of 40dBnHL at Auditory Brainstem Response (ABR) testing, when the recommended discharge level is 35dBnHL.
- Issues with ABR testing, including lack of bone conduction testing and use of masking.
- Misinterpretation of ABR results, where traces were not entirely clear.

2. Findings from External Review of Bridgewater Audiology Service

The findings of the external review are based on clinical observations, case note reviews and staff interviews by the CSS Divisional Audiology Lead and the Head of Paediatric Audiology from Manchester University NHS Foundation Trust.

As part of the Executive Summary of the report, the reviewers stated that: "While the observation did promote discussion and consideration of alternative approaches, there were no clinical safety concerns from the clinical observation carried out".

The findings of the review identified many areas of good practice, most notably:

- A lovely atmosphere create by clinicians and a nice rapport with families and children was seen, and good clear explanations of results and management plans observed.
- Good testing facilities with plans to further improve the test equipment.
- A range of appointments were observed with different skill mix and combinations of staff across the different clinics with all staff working well together.
- The standard appointment times are appropriate, but the team can request a longer time with the patient to be booked.
- There is a joint ENT clinic with the Associate Specialist in Community Paediatrics for more complex children.
- Excellent links with other community services.
- Good quality administrative support.

The findings of the review also identified several areas of concern – these comments are taken directly from the report and illustrate some of the difficulties which exist in the Bridgewater service.

The external review only examined the Bridgewater service at the request of WHH:

- There are concerns that, despite the pathway being described as a joint pathway and some joint working taking place, the handover of care and the sharing of information between Bridgewater and WHH creates risks and unknowns about patient care.
- From experience and observation throughout the service review and meetings there is very little evidence of a joint pathway. While there is a transfer of information from one service to another this does not mean it is joint.
- The lack of shared decision making, shared information and transparent working between Bridgewater and WHH creates risks for Warrington babies and children.
- There is a need for external peer review because of the small size of the service (population, number of cases of hearing loss and size of the team).
- There is significant lack of information about the hearing aid provision provided to the Bridgewater team and Teachers of the Deaf.

- There is a need for a service lead with a high level of both audiological and scientific knowledge to build on the existing good quality service and for future development and monitoring of the service.
- The main risks for Warrington babies and children with hearing loss is that the initial assessment and hearing aid provision are carried out by a completely different trust to the one that is providing the ongoing management plan and care plan for the children. The Bridgewater service for Warrington babies at Sandy Lane and the service at Halton are well placed to do that. They have the skills and existing good relationships with Halton. The provision of the whole care pathway would create a service that was cohesive across the whole pathway without any handover points to another trust.

The report detailed several recommendations for improvements to various elements of the service, but there were no concerns raised regarding the overall quality and safety of the service. An overview of the recommendations can be found in Appendix 1.

Incident description and Consequences

Overview of Incident

In 2021, following identification of issues with identification of Permanent Childhood Hearing Impairment (PCHI) in the NHS Lothian Audiology Service, NHS England commissioned a peer review of NHS new-born hearing screening programme data from sites across the UK.

Four Trusts, including Warrington and Halton Teaching Hospitals NHS Foundation Trust, across five sites nationally, were initially identified with a lower-than-expected yield of PCHI. Subsequently, these Trusts were peer reviewed in relation to their ABR testing process. The number of organisations involved in this issue has now increased to six.

To manage the incident, a Serious Incident Response Group was established, with membership comprising WHH, NHSE Newborn Screening Programme Team representatives, the British Academy of Audiology (BAA), and the National Deaf Children's Society (NDCS). The group is chaired by the Deputy Chief Nurse from the Cheshire and Mersey Integrated Care Board (ICB).

The primary focus of the incident is on the diagnostic Auditory Brainstem Response (ABR) testing undertaken by WHH, where the national peer review team identified several areas of concern, most notably:

- Discharging patients at a level of 40dBnHL at ABR testing, when the recommended discharge level is 35dBnHL.
- Misinterpretations of result, where ABR traces were not entirely clear, but deemed valid rather than inconclusive.
- Time available to undertake ABR testing was not always used optimally, sometimes leading to missing or incomplete data.

The WHH element of the pathway is outside of the scope of this report, which is centred on Bridgewater's internal audiology patient pathways. However, it is referenced here, as any issues with the WHH element of the pathway can have a knock-on effect for onward management of the cohort of children subsequently referred to Bridgewater Audiology Services.

Of the children identified in the overarching cohort, 48 of these were jointly managed by WHH and Bridgewater, and are in-scope of this investigation.

Each case was categorised in terms of priority, and reviewed by a multi-disciplinary team (MDT) comprising representatives from Bridgewater, WHH, and representation from the Newborn Hearing Screening national team:

- Priority 1 (P1)
  - Definition: Risk of unconfirmed bilateral hearing loss
  - Number in cohort: 20
  - MDT review date: 3rd & 15th May 2023

- Priority 2 (P2)
  - Definition: Risk of unconfirmed unilateral hearing loss
  - Number in cohort: 9
  - MDT review date: 23rd May 2023

- Priority 3 (P3)
  - Definition: Discharged, but not tested to discharge criteria
  - Number in cohort: 19
  - MDT review date: 3rd & 15th May 2023

The Trust's internal investigation and external peer review revealed shortcomings in the management of babies and children referred to Bridgewater's Warrington Paediatric Audiology Service from WHH; specifically:

- Sub-optimal processes for handover of patient care between WHH and Bridgewater, and vice-versa.
- Accepting inaccurate, incomplete, and inconclusive ABR test results from WHH.
- Acting on inaccurate, incomplete, and inconclusive ABR test results from WHH.

<u>Overview of Consequences</u>

The primary consequences of this incident are:

- Potential harm to patients due to sub-optimal handover processes within the joint element of the patient pathway between WHH and Bridgewater.
- Potential harm to patients due to accepting and acting upon inconclusive test results received from WHH.

It should be noted that, at the time of writing this report, only one case of harm has been identified by MDT review of the 48 Bridgewater cases, which was categorised as Low Harm.

The secondary consequence is:

- Potential reputational damage to the Trust, due to high profile press coverage of the incident that could affect external (patient and professional) confidence in the quality and safety of the service offered by Bridgewater.

Terms of reference for the investigation

In accordance with Bridgewater Community Healthcare NHS Foundation Trust Incident Reporting Policy, and the Trust's contractual obligations with the Clinical Commissioning Groups, the Trust is required to undertake an internal investigation for every SI that occurs in the service.

The standard Terms of Reference of the investigation and report are to:

1. Determine an exact chronology of the patient's accessing the service from the referral until the date that the service learned of the incident.
2. Assess whether actions taken were appropriate and seek external review where appropriate
3. Consider whether actions of the staff comply with Trust Policy/Guidelines and external policy/guidance in place at the time of the incident
4. Determine the root cause(s) of the incident where applicable
5. Identify any changes to Policy or Practice that need to be made
6. Ensure confidentiality and compliance with of Data Protection and Human Rights Acts
7. Identify whether the care or service delivery offered by the Trust was sub-optimal in any way or contributed to the incident.
8. Determine whether the Trust's Being Open and Duty of Candour Policy has been complied with and ensure that there is meaningful engagement with affected patients and relatives during the investigation and at the conclusion of the investigation.
9. Identify any good practice.
10. Determine if there were any actions the service could have taken to prevent the incident or reduce the likelihood of it happening
11. Identify any other service issues, not material to the incident, but nevertheless requiring action.
12. Identify lessons learned from the incident to share across the Trust.
13. Present relevant and appropriate recommendations and an action plan for implementation.
14. Feedback to staff involved in the investigation

Contact with others involved

WHH sent an initial letter to the families of all children in scope on 17th March 2023, to inform them that a national review of children's specialist hearing testing had identified concerns about how tests were performed at several hospitals across the country, including Warrington and Halton Teaching Hospitals, and that a review of children seen by the service between 2018 and 2022 was planned, which included their child.

A helpline was set up to respond to and assist families with any concerns or questions resulting from receipt of the letter. The helpline number was included in the initial letter to families.

With regards to the 48 children in scope of this investigation, subsequent contact was made by Bridgewater, week commencing 21st August 2023, to inform families of the outcome of the review and, where appropriate, invite the families to attend for further hearing assessments, or in the case of children already under review with the Audiology Service, to highlight the importance of attending their review appointments.

Chronology

№	DATE&TIME	EVENT	SUPPLEMENTARY INFORMATION	GOOD PRACTICE
1.	9th October 2021	NHS Lothian Audiology Report Published.	Audit findings identified a series of serious issues particularly within the early years (under 5) age groups of the Paediatric Audiology service. These have led to significant failings, adversely impacting the early years spoken language acquisition of numerous children, affecting a number of these children for life.	
2.	October 2021 – March 2023	NHSE National review of referral from Newborn Hearing Screening Programme.		
3.	23rd February 2023	Bridgewater informed of being identified as in-scope of the investigation.	This is due to being part of the integrated pathway delivered by WHH and Bridgewater.	
4.	17th March 2023	WHH Letter to families advising of review of cases following national incident.		
5.	24th March 2023	Deputy Chief Nurse and Chief Operating Officer join WHH review of cases to observe the process.	This was to consider how Bridgewater could contribute to the review moving forward.	
6.	3rd & 15th May 2023	MDT review of priority 1 and 3 cases.	20 cases in priority 1 cohort. 19 cases in priority 3 cohort.	
7.	23rd May 2023	MDT review of priority 2 cases.	9 cases in priority 2 cohort.	
8.	27th & 29th June 2023	Bridgewater external peer review of Warrington Audiology Service.		

9.	8th August 2023	Draft external peer review report received.		
10.	21st – 26th August 2023	Follow-up letters sent to families.	Letter detailed outcome of initial individual case review and next steps.	
11.	28th August – 1st September 2023	Commence contacting families to arrange appointments for further hearing assessment.		Children should be reviewed until ear specific results have been obtained.

Findings of the Investigation

1. Care and Service Delivery

The overall findings of the 48 cases reviewed are:

- 27 cases of no harm – this is where sufficient audiological information is available to demonstrate that the patient has received, or is receiving appropriate treatment.
- 20 cases where harm level could not be established – this is where insufficient audiological information is available to determine whether any harm has occurred, and further audiological assessment is required before it can be established whether any harm has occurred.
- 1 case of low harm – this harm is due to a possible delay in fitting of hearing aids to a child due to poor testing strategy by WHH and delays introduced by the child's parents' whist they considered hearing aids as a treatment option.

2. Contributing Factors

- Sub-optimal handover processes within the joint element of the patient pathway between WHH and Bridgewater, and vice-versa that introduce unnecessary risk to the quality and safety of the service provision, particularly:
    - Lack of shared decision making,
    - Lack of shared information and transparent working.
- Lack of high-level audiological and scientific knowledge within the Bridgewater element of the service that is required to interpret complex audiological information such as ABR results, leading to:
    - Accepting inaccurate, incomplete, and/or inconclusive ABR test results from WHH.
    - Acting on inaccurate, incomplete, and/or inconclusive ABR test results from WHH.
- Issues within the WHH element of the patient pathway:
    - Discharging children at a level of 40dBnHL at Auditory Brainstem Response (ABR) testing, when the recommended discharge level is 35dBnHL.
    - Issues with ABR testing, including lack of bone conduction testing and use of masking.
    - Misinterpretation of ABR results, where ABR traces were not entirely clear.

3. Conclusions

It is clear that the main risk to the quality and safety of the service provision lies with issues with the ABR testing delivered by WHH, and within the joint element of the patient pathway where handover of care takes place between WHH and Bridgewater, and vice-versa,.

Once transferred to the Bridgewater service, the external peer review has confirmed that the remainder of the patient pathway within Bridgewater is safe, although several recommendations were made for further improvements.

There is an urgent requirement to review the joint element of the patient pathway, in conjunction with WHH colleagues, to identify areas of risk and concern, and develop and implement a remedial action plan to effect immediate improvements to the quality and safety of patient handover.

Whilst the above will deliver short term improvements to the joint pathway, a longer-term solution is required to ensure a sustainable quality service, via a single provider solution that is in-line with most paediatric audiology services nationally.

A proposal should be drawn up that details Bridgewater as the single provider of the entire paediatric audiology pathway, leading to a business case to this effect for discussion with commissioners, with a view to re-commissioning a single pathway solution via the Bridgewater service.

4. Root Cause(s)

The root cause of the issues described in this report is that the patient pathway is provided by two different Trust's, which introduces unnecessary risks to the quality and safety of patient care.

It is of particular concern that the initial assessment and hearing aid provision is carried out by a completely different trust to the one that is providing the ongoing management plan and care plan and, despite the pathway being described as a joint pathway, and some joint working taking place, the handover and sharing of information between Bridgewater and WHH creates risks and unknowns about patient care.

There is very little evidence of a truly joint pathway – the lack of shared decision making, shared information and transparent working between WHH and Bridgewater creates risks for Warrington babies and children, and there is a significant lack of information about the hearing aid provision provided to the Bridgewater service and Teachers of the Deaf.

Additionally, as second root cause affecting the Bridgewater element of the service is a lack of high-level audiological and scientific knowledge within the service that is required to interpret complex audiological information, such as ABR results.

5. Recommendations

In relation to the primary root cause, related to the risks within the joint element of the pathway, where patients care is handed over between Bridgewater and WHH, and vice-versa, it is recommended that:

1. The joint element of the pathway is reviewed as a matter of urgency, to identify the specific areas of risk and to determine how these can be mitigated, and the overall pathway improved.

2. A business case should be created that describes the benefits of the entire pathway being delivered by a single provider, and what this provision would look like if delivered by Bridgewater. The business case should be presented to commissioners with a view to re-commissioning the service as a single pathway that is delivered solely by the Bridgewater service. The business case must detail the entire patient pathway, identify the required skills mix and expertise, and ensure that the appropriate level of funding is secured to maintain delivery of a high quality, safe, effective, and efficient service.

In relation to the secondary root case, regarding the lack of high-level audiological and scientific knowledge, it is recommended that:

3. The service should identify/appoint a suitably qualified clinical lead with a high level of both audiological and scientific knowledge to build on the existing good quality service and for future development and monitoring of the service.

In addition to the above, it is recommended that:

4. The service develops and implements an action plan to fully address the recommendations resultant from the external peer review of the service. A list of these recommendations can be found in Appendix 1.

5. The service continues to review the cases where the harm level is not yet known, until the point where ear specific audiological test results are confirmed, or as close to this as the patient ability/cooperation will allow, so that the harm level of each patient within the 48 joint cases can be established. Following closure of the overarching investigation, any future harms identified should be managed via the Trust's incident management pathway.

Action Plan

Agency/Organisation: Bridgewater Community Healthcare NHS Foundation Trust

Author: Mark Charman, Assistant Director of Transformation

RED	Major delay, behind schedule, or not started,
AMBER	Minor delay, nearing completion
GREEN	Progress on track or complete with evidence
BLUE	Complete and includes evidence and is signed off by appropriate Director/Committee/Group

No	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date	Progress	Date Completed
1.	The joint element of the pathway is reviewed as a matter of urgency, to identify the specific areas of risk and to determine how these can be mitigated, and the overall pathway improved.	1. Review joint pathway and handover points, in conjunction with WHH. 2. Identify areas of risk/improvement. 3. Develop improvement plan. 4. Implement plan. 5. Three months' post implementation review.	Findings and recommendations of external peer review of the service.	Improved safety and quality of current handover pathway.	Associate Specialist in Community Paediatrics	October 2023	25% complete	
2.	A business case should be created that describes the benefits of the entire pathway being delivered by a single provider, and what this provision would	1. Create initial proposal and options appraisal for EMT 2. Develop a business case for the preferred option.	Findings and recommendations of external peer review of the service.	Provision of a single pathway solution by Bridgewater that delivers sustainable	Head of Children's Services	December 2023	0% complete	

	look like if delivered by Bridgewater. The business case should be presented to commissioners with a view to re-commissioning the service as a single pathway that is delivered solely by the Bridgewater service. The business case must detail the entire patient pathway, identify the required skills mix and expertise, and ensure that the appropriate level of funding is secured to maintain delivery of a high quality, safe, effective, and efficient service.	3. Present proposal to commissioners for discussion/agreement. 4. If successful, develop implementation plan. 5. Implement new single pathway. 6. Three months' post implementation review		high quality patient care.				
3	The service should identify/appoint a suitably qualified clinical lead with a high level of both audiological and scientific knowledge to build on the existing good quality service and for future development	1. Scope current services in both Halton and Warrington to identify a suitable staff member to fulfil this role. 2. Create redesign proposal to introduce the clinical lead into the service.	Findings and recommendations of external peer review of the service.	Ensure appropriate leadership is in place to provide high-level audiological and scientific knowledge to support effective delivery of all	Head of Children's Services	November 2023	30% complete	

	and monitoring of the service.	3. Obtain EMT approval. 4. Discharge redesign proposal.		aspects of the service.				
4.	The service develops and implements an action plan to fully address the recommendations resultant from the external peer review of the service	1. Develop action plan from review recommendations 2. Assign appropriate leads and resource to deliver the plan. 3. Implement the action plan and compile evidence for completed actions. 4. Three months' post implementation review.	Recommendations from external peer review of the service.	Completion of the action plan with appropriate supporting evidence.	Associate Specialist in Community Paediatrics	January 2023	10% complete	
5.	The service continues to review the cases where the harm level is not yet known, until the point where ear specific audiological test results are confirmed, or as close to this as the patient ability and cooperation will allow, so that the harm level of each patient within the 48	1. Ensure that all patients within the cohort remain on routine audiological review until the appropriate discharge criteria has been met, or any permanent hearing impairment is confirmed. 2. Upon achievement of discharge criteria of confirmation of	MDT Review	Ensure that the hearing status of all children in the cohort is known. Ensure that all cases have an assigned level of harm. Ensure that, in cases where harm	Associate Specialist in Community Paediatrics	October 2023	85%	

	joint cases can be established. Following closure of the overarching investigation, any future harms identified should be managed via the Trust's incident management pathway	permanent hearing, assess harm level. 3. For cases where harm has occurred, the Trust's incident management process must be implemented.		has occurred, that this appropriately managed via Trust policy.				

Appendix 1 – Overview of Recommendations from External Peer Review

Urgent – to address immediately:

1. Only the aspects of the pathway provided by BCHFT have been reviewed. There must be an external service review of the WHH aspects of the pathway. This is in addition to the current support they are receiving for ABR assessment and the national audit of the traces.

High – for action within 6 months:

2. Develop an audiological and scientific leadership role within the service of at least a Band 7 level. This role should include non-clinical time to develop, review practice, policies, audit, create a programme of quality assurance. There should be support to work towards IQIPS accreditation.

3. Review the structure, pathway and skill mix for the clinics that are currently commissioned and for any potential future models of provision. This will depend on and include successful recruitment into the current vacant post and restructuring to create a Band 7 Audiologist post.

4. A programme of external peer review by an experienced audiologist for all members of the team carrying out hearing assessment at BCHFT. The peer review should cover all the behavioural test techniques to assess hearing in the different age groups up to 7-year-olds. The review should look at following of BSA protocols, justifications of modifications made and ability to be flexible in test technique dependent on the questions about the hearing and the child.

5. Reflect as a team on the discussions and findings about clinical strategy including NST, holding back the reward, varying frequency and stimulus to NBN when children are not conditioning and increased gaps between presentations. The team should also review the step sizes being used during testing to ensure the default when a child stops responding is that the sound needs to be increased by standard steps to the point where the child starts to respond again.

6. Review the department policy as a team considering in particular the number of frequencies to be tested but with the introduction of exceptions e.g., child with complex needs, child who responded to three frequencies and has OAEs recordable in both ears, when there is a need to address gaps in the knowledge about the hearing loss.

7. Increase the amount of threshold testing (rather than screening at 20dBHL) for BC in cases where it is important to establish the true size of the air-bone gap and to obtain accurate BC levels for use in the prescription formula for those who have hearing aids.

8. Introduce a system using a hearing aid and remote microphone set up so that the tester in the observation room and the tester in the room can communicate with effectively with each other.

9. Alter the set up for performance testing so that the person presenting sounds who is behind the child can see the child, their hands, and facial expressions. Options include rearranging the desk so that the audiometer is closer to the child.

10. Repeat tympanometry in all cases where an abnormal trace is obtained to ensure reliability of the result.

11. Examine and report internally at the Quality Council and externally at the Place Based Audiology Meeting on the outcomes and data from the school hearing screen. This should include looking at the outcome of the newborn hearing screen and any subsequent testing that was carried out.

12. Obtain a breakdown of how the hearing aid budget given over to WHH is used.

Medium – for action within 6 months to 12 months maximum:

13. For an improved patient pathway, bring provision of hearing aids under the team working in the BCHFT service. This would require additional staffing and supports the creation of a Band 7 role. There is existing skill set within the team and this is kept up to date by the senior staff attending and supporting paediatric hearing aid clinics at Halton.

14. Review the department practice where children with no risk factors are being brought back for review at 4 years of age.

15. Reconsider the standard carrying out of speech testing in clinics prior to threshold obtained hearing tests to maximise the amount of threshold testing that is achieved.

16. Ensure that the placement of the sound level meter for speech testing gives an accurate measure of the talker's voice level.

17. Establish a programme of audit and actions that are reported to the teams.

18. Set up newer VRA reward system with increased number of puppet options.

19. Introduce a system where all assessment results and hearing aid programming information (from the manufacturer and hearing aid verification system) can be shared between BCHFT and WHHT. This may involve shared access to the audiology patient management in addition to the use of SystmOne in BCHFT.

20. To apply for UKAS accreditation for the service that is currently provided. This could be aligned with Halton (who are going ahead with this) to save on monies and have shared protocols and pathways. The application would need to be supported with project management resource to support the process.

Sharing Learning across the Organisation

Service/Team	Warrington Paediatric Audiology Service
Borough	Warrington
Date Identified	March 2023
Contact Name and Number/Email ***(if people want to contact you to learn more)***	Mark Charman mark.charman@nhs.net
How was the issue raised ***(i.e. incident, complaint, other-please state)***	NHS England
What did we learn-key points: ***In a couple of sentences***	The joint audiology patient pathway between Warrington Hospital and Bridgewater introduced unnecessary risk to the patient, due to lack of joint working, shared information, and transparency.
What did we change in practice: ***In a couple of sentences***	Review of the joint pathway to identify the areas of risk and introduce new ways of working and mitigation to minimise the risk when delivering the joint patient pathway.
What difference has this change made:	The revised pathway has only just been introduced. An audit of the outcomes of the revised pathway is required to establish the improvements made by the revisions.

Completed "Shared Learning" templates will be sent to the Trust's Communications Department by the Risk Team, to ensure that lessons are posted on the Trust's Hub.

Bridgewater Community Healthcare NHS Foundation Trust

IQIPS

Improving Quality in Physiological Services - Warrington

21/09/2023

Status Key	
Blue	Complete
Green	On Track
Amber	Minor Delay < 2 Weeks
Red	Major Delay > 2 Weeks

Blue	Green	Amber	Red
/	/	/	/

Version: Current Version **Last Update: Date of Last Update**

DOMAIN 1 – Patient Experience

1. The service implements and monitors systems to ensure patients are able to access patient friendly information about what happens before, during and after specific examinations/procedures.	**Overall Status**	

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
1.1	There are defined roles and responsibilities for each area of development and maintenance of patient information *Leaflets provided by Mary Corkery dept – Mary to provide evidence – log of all leaflets, process for review and any changes.*		16/01/2024				
1.2	There are systems in place to ensure that patients are provided with information within specified timescales about the details and purpose of their examination/ procedure to allow preparation for each appointment *Leaflet on appointment – admin. Sent out with appointment letter by admin. When booked over the phone with parents, confirmation letter has leaflet incorporated with it, or can email to parents if preferred. SMS message sent with date and time of apt on booking.*		16/01/2024		50%		0009 Information about your child's a
1.3	There are systems in place to ensure patients are able to access information in relevant formats *Might be displayed on website? Use Synertec software for different language? All templates are on systemone. Gaps – different size prints, braille, languages, QR code to add to letter?* *Adam Britton to link in with Pat – copy of leaflet for website.* *Current formats – paper, website*		16/01/2024		30%		Children's Audiology – Warrington – Bridgewater Community Healthcare NHS Foundation Trust Warrington Children's Audiology - Glue Ear Leaflet (bridgewater.nhs.uk)
1.4	There are systems in place to ensure patients are aware who is present at and who is performing their examination/procedure *Clinicians introduce themselves at the start of the clinic*	Same SOP – introduction	16/01/2024		30%		
1.5	There are systems in place to ensure patients know how, when and by whom results/reports will be communicated	Same SOP - During apt – end. Clinician will either provide results there and then and next					

	Results given at the time of the appointment and in a letter to parent, GP, teacher of the deaf afterwards.	steps or will advise pt when the results will be available and who will inform/contact pt.					
1.6	There are systems in place to ensure that patients have access to information about peer/self-help and support groups *Cheshire deafness support network, teachers of the deaf events. To send information of what there is to access. Caroline to send.*	Same SOP – during apt, leaflets/information presented to pt with contacts for further info. Leaflets/ info as evidence.	16/01/2024		40%		Ask Ollie - support 1.6.docx
1.7	There are systems in place to ensure patient information materials are developed, available and reviewed with lay/patient representatives and updated within specified timescales *CCPG – lay readers/people? Check if this is a part of the process – link in with Mary regarding this. Leaflet to be ratified – lack of knowledge but have understanding.*	Will need advice for services.					

2. The service implements and monitors systems to ensure the privacy, dignity, comfort and security of patients are respected throughout contact with the service.	**Overall Status**	

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
2.1	There are defined roles and responsibilities for professional leadership and management with regards to privacy, respect, comfort and security of the patient population *Voice of child? Kathryn Royden – meeting minutes as evidence. Policies.*	Advice from Patient Experience.					?
2.2	There are systems in place to encourage and support staff to be welcoming and to act with discretion and respect towards patients and carers *Employee code of conduct.*		16/01/2024		100%		2.2 - employee code of conduct.docx
2.3	There are systems in place to ensure that patients' privacy, dignity and security are maintained *Policy ?*	Advice from HR – policy to be embedded.	16/01/2024		100%		2.2 - employee code of conduct.docx Photos of medical records room and reception.
2.4	There are systems in place to help maintain patients' comfort *Selection of chairs and air-con. Waiting rooms, - links in with pt requirements on opt in letter. Wheelchair access, water dispenser, disable toilets and parking bays. – photo's to capture evidence.*	Advice from HR – policy.	07/02/2024		80%		Photos of waiting room/disabled toilets etc.

3. The service implements and monitors systems to ensure informed patient consent is obtained for each examination/procedure.						**Overall Status**	
Task Number	**Key Tasks**	**Lead**	**Planned Start Date**	**Planned End Date**	**% Complete**	**Status**	**Comments/Evidence**
3.1	There are defined roles and responsibilities for obtaining informed consent *Prior to apt – implied consent, patient turns up. Need informed consent – robust process in place that patient has received information but need mechanism to capture consent. Implied opting in, patient needs to opt out – electronically. Leaflet to be attached to opt in letter prior to apt to capture consent, when opt in make sure patient understood information. – send leaflet out again with apt letter.* *Hearing aid route, note consent? Verbal consent at the time. Book back in for impressions due to time capacity. This can be done during original apt.*	Part of SOP – needs to address how informed consent is received. (altered based on patients needs e.g. disabilities) Evidence of consent. Should be a process in place already.	16/01/2024		20%		
3.2	There are systems in place to ensure that patients are able to discuss their examination/procedure options with an appropriate staff member *Screenshot of proforma used.*	Consultation. SOP – at start of apt, discussion with patient re: examination procedure.	16/01/2024		60%		Proforma used for Audiology.docx
3.3	There are systems in place to enable patients to give or withhold informed consent for all examinations/procedures *Tick box on proforma. Included in screenshot. Decision about next process is flagged with parent.*	Linked to 3.1	16/01/2024		60%		Proforma - tick box.docx
3.4	There are systems in place to arrange taking of consent from children and patients with particular needs for all examinations/procedures *Included in tick box. Caroline to add voice of child consent box.*	Liked to 3.1 – based on patient requirements. Ability to read. Service should have this in place.	16/01/2024		30%		
3.5	There are systems in place to enable patients to give or withhold informed consent for access to and distribution of test results and reports *Informed at clinic, add tick box to proforma – GP and teacher of the deaf – happy to share reports.*	As above. Should all be captured in one form. Patient discussion.	16/01/2024		30%		
3.6	There are systems in place to enable patients to give or withhold informed consent for their data to be used for teaching and/or research purposes *Add to opt in letter, information provided prior to apt. implied consent. Concerns can then be flagged at initial apt.*	As above. Should be a box for information for teaching and research purpose. Consent form that pt ticks. Applied to notes.	16/01/2024		30%		Waiting for opt-in letter to embed

4. The service implements and monitors systems to ensure that service delivery is patient focused.						**Overall Status**	
Task Number	**Key Tasks**	**Lead**	**Planned Start Date**	**Planned End Date**	**% Complete**	**Status**	**Comments/Evidence**
4.1	There are defined roles and responsibilities for professional leadership and management to ensure patient-focused care *PDRs, clinical supervision – in house. Northwest quality audiology group – external peer review group. Aid to try and set up and formulise. In process of linking with Halton.*		16/01/2024		20%		PDR templates?
4.2	There are systems in place to ensure that the service is accessible to all patients and carers *Evidence. Text relay.*	Lifts, baby changing facilities, wheelchair access, big enough doors for wheelchairs – sufficient parking, disabled bay parking – photos to capture evidence. Non-physical evidence – braille, accessibility criteria correct? Phone for query? – require evidence from service – how ensure access is available to everyone.	07/02/2024		80%		Photos as evidence.
4.3	There are systems in place to ensure appointments are available to meet patient needs and circumstances and co-ordinated with other appointments where possible *Opt in system, negotiate appointment times. Rely on patients to inform information – SLT apts to tie in. parents will provide information usually with admin to coordinate apts for accommodation.*	Service need to provide appointment SOP. Write one? When referral is received – process map. Steps to apt stage. Opt in system – Halton? If not got we need to arrange. One for each service – then create streamline/hybrid.	16/01/2024		20%		SOP and Process map
4.4	There are systems in place to ensure positive identification of patients *Done in clinic – check name, date of birth, address, telephone and capture email address. When pt arrives, ask name of child and go on apt ledger and mark as arrived. Clinical team come from clinical rooms to collect child and take to clinical room.*	Process map? Patient contact – confirm pt identifiers (IDV) when patient arrives, check IDV.	16/01/2024		20%		SOP
4.5	There are systems in place to ensure specific requirements of patients and careers are identified and responded to *System one has access to various pt info, other clinical letters etc, patient information received prior through system one and also during triage. Parents will also provide information during opt in process. Note added to system one to alert clinicians, also significant event also noted in system one. Possibility to amend opt in letter to*	Process map – point of first contact (Telephone) ask any specific needs – e.g. guide dogs, other children - respond appropriately. – Ask service.	16/01/2024		20%		SOP

	inform service of specific requirements beforehand for accommodation. Autistic pts has an NDCs leaflet – send copy over.						
4.6	There are systems in place to ensure that relevant information is communicated to individual patients during their contact with the service, including arrangements for transfer/continuity of care *Transition document, Jane Gober children 15 years – due to leave school – in charge of distributing to family including education info. Hearing aids seen up to 18 years. Warrington provide info leaflet on what is available, first initial apt is sent by service.*	Part of process map and SOP – identifying patient requirements. Links in to information leaflets etc.	16/01/2024		30%		0302 Audiology Transition Leaflet.pc SOP and Process map

5. The service implements and manages systems to ensure that patients are able to feedback on their experience of the service and that the feedback is acted upon	**Overall Status**	

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
5.1	There are defined roles and responsibilities for obtaining and managing feedback from patients, carers and relatives *QR codes on confirmation letters and SMS messages are sent. There are also forms within clinics to be completed.*	Patient Experience – Hitesh, what mechanisms are in place to capture patient feedback – talk to us forms. Friends and family tests. QR codes?	16/01/2024		40%		Introduction (ratemynhs.co.uk) Link taken from Warrington Childrens Audiology information page on the Bridgewater intranet Need evidence of forms?
5.2	There are systems in place to develop, agree and maintain materials to support patient feedback, involving input from patients/lay people *Patient experience group.*	Patient Experience – Hitesh.	16/01/2024		70%		Patient Experience Report September 2 Dates of meetings?
5.3	There are systems in place to ensure patients and carers are able to give feedback in a variety of formats and in confidence *Patient feedback forms provide contact information. Double check website for contact information*	Patient Experience – Hitesh. Explanation of what it is but also actual evidence – talk to us form/ pathway, creation.	16/01/2024		30%		Introduction (ratemynhs.co.uk) Link taken from Warrington Childrens Audiology information page on the Bridgewater intranet Same as 5.1?
5.4	There are systems in place to ensure results of patient feedback are collated, analysed and findings are disseminated to relevant parties and acted upon *Yes – included in reports. Monthly reports.*	Patient Experience – Hitesh.	16/01/2024		20%		Monthly reports?

DOMAIN 2 – Facilities, Resources and Workforce

6. The service implements and monitors systems to ensure the facilities and environment support delivery of the service	**Overall Status**	

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
6.1	There are defined roles and responsibilities for each area of facilities and environment management for supporting service delivery *Estates function.*	John Morris – management of area and building. Documents.					
6.2	There are systems in place to ensure that all areas used by the service meet the specific needs of the patient population (including children and those with particular needs) and staff *Photos to capture evidence for patients in facilities.*	Photos – waiting area for enough seats. Drinking fountains. Sign posts. Ask reception for directions, sit in waiting room – review patient care and information.	07/02/2024		80%		Photos
6.3	There are systems in place to ensure the management of space to facilitate efficient working *Office space, two clinical rooms, main CDC and westbrook moving to Europa – purpose build soundproof room, should be ready end of March. Main test room and observation room attached. Etology explanations can be done in separate rooms. Quiet room also for sensitive issues. Soundproof rooms at CDC.*	Service to tell how clinical time is allocated to test rooms, sufficient use of the equipment.	07/02/2024		80%		Photos
6.4	There are systems in place to ensure that all areas used by the service are well maintained *Estates. Mechanism in place to flag issues.*	John Morris – Estates – process					
6.5	There are systems in place to ensure that access to particular areas is restricted where appropriate *Photos for evidence.*	Photos, key codes, key fobs – clinical area buzzers	07/02/2024		80%		Photos
6.6	There are systems in place to ensure the management and control of environmental conditions *Test rooms are airconditioned, silent for testing.*	Identifying who is responsible for heating, what happens to patient requests. Automatic settings?	07/02/2024		80%		Photos

7. The service implements and monitors systems to procure and manage equipment to deliver the service.						**Overall Status**	
Task Number	**Key Tasks**	**Lead**	**Planned Start Date**	**Planned End Date**	**% Complete**	**Status**	**Comments/Evidence**
7.1	There are defined roles and responsibilities for the procurement and management of all equipment and consumables *Procurement.*	Sarah Davies – Procurement. Describe process – ordering and best deals					
7.2	There are systems in place for the procurement of all equipment and consumables *Key health supply – contract.*		20/01/2024		70%		KHS contract.docx
7.3	There are systems in place to assure installation, calibration, operation and performance of equipment *Audits - Caroline completes – to chase.* *Fault – evidence in place – Caroline to provide document. Short history provided to Warrington and recommendations are provided but this falls on Warrington's facility. Patient reviewed in service for behavioural and audiograms then pass back to Warrington for their part. Warrington write a report but this does not include fitting information etc.*	SOP – Stage A check – applied to all equipment, clinician checks each piece of equipment daily. Should also be calibration certificates. Embed evidence.					
7.4	There are systems in place to ensure equipment is appropriate for patients, staff, children and those with particular needs *Selection of tests that are child friendly, meet patient needs.*	Service demonstrating range of different testing facilities. Range of testing to cover particular needs. Photos as evidence and part of SOP. Adapt to patient needs.	07/02/2024		40%		Photos
7.5	There are systems in place to ensure maintenance and quality assurance of all equipment with corresponding records *Calibration and PAT testing certificates.*	As above. Calibration and PAT testing.	07/02/2024		30%		Photos as well as certificates.
7.6	There are systems in place to ensure equipment failures and faults are monitored and managed *Asset register – correct format.*	Request information from Service. Stage A test. Who deals with this.					
7.7	There are systems in place to ensure that equipment replacement is planned and implemented *5 year rolling plan – expensive equipment. Build in maintenance cycle, accrue money for replacement. Asset register – monitor how old equipment is. BAA recommendations.*	Service rolling equipment replacement programme – lifespan for equipment. Service accrue money for this. Plan in place?					

8. The service implements and monitors systems to recruit, manage and support staff to deliver the service.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
8.1	There are defined roles and responsibilities for management and professional leadership *Covered in above with clinical supervision etc.*	Service lead to describe what clinical supervision is, as part of development. – Service to provide information and evidence – clinical supervision sheets – anonymise.					
8.2	There are systems in place to ensure clear definition and management of tasks for staff to deliver the service *SOP*	SOP – whole SOP will cover this. Process map from start to finish.					
8.3	There are systems in place to ensure there are sufficient staff within the service with an appropriate mix of skills to enable delivery of the service *Aware of staff skills within service. Workforce planning with Kathryn S required. Massively understaffed within the service. Plan has been changed to fit existing budget for workforce.*	Demand and Capacity for service. Organisational structure as evidence.	16/01/2024		80%		45 Audiology Childrens 300322.dc
8.4	There are systems in place to ensure agreed contracts of employment, job descriptions/job plans, and that staff appraisals or personal development plan reviews are conducted for all staff *Policies.*	PDR policy, Contracts/JDs – HR. Appraisals – PDR. Evidence as confirmation email. HR Business partner to provide email as evidence for every staff member in the service to provide everyone has JD and contract in place. JD is agreed prior to advert. Contract is arranged once they start. HR BP to confirm process.	16/01/2024		40%		8.4 - agenda for change policy.docx
8.5	There are systems in place to ensure that employment policies and any changes are communicated and consistently applied *Process in place.*	Sam Scholes – evidence of process for changes to policies and how they are communicated. Team brief – circulate to relevant services for comment. Preferably a process map.	10/03/2024		70%		8.5 Screenshot taken from the mon
8.6	There are systems in place to manage all out of hours service provision including staff rotas *N/A*				100%		
8.7	There are systems in place to ensure that in collaboration between the employer and employee support is available to manage stress and achieve a work/life balance *PDRs/1:1s*	PDRs/1:1s and open-door policy.					

8.8	There are systems in place for managing conflicts of interest *Freedom to Speak Up etc.*	Freedom to Speak Up, Guardians and Champions. PDRs and 1:1s					
8.9	There are systems in place to ensure staff are able to feedback in confidence on the service and contribute to service management *Covered in requirements.*	Team meetings and 1:1s, comfortable voicing opinions. – Notes, minutes from team meetings – adapt to confidentiality.					

9. The service implements and monitors systems to ensure staff are fully trained and competent to deliver the service.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
9.1	There are defined roles and responsibilities for the management of staff competence *Clinical supervision.*	Clinical supervision.					
9.2	There are systems in place to support and manage the recruitment of staff *Systems in place.*	HR advice – recruitment and retention policy. Embed					
9.3	There are systems in place to ensure staff are competent to undertake the role to which they have been appointed, including a process for remedial action if concerns around staff competency are raised *>>*	PDRs and 1:1s/clinical supervision. HR policy – PDR policy – what to do with staff concerns. Steps of actions.					
9.4	There are systems in place to check qualifications and registration of relevant staff are upto-date *Notified of professional registration.*	Recruitment policy check qualifications. AHP lead Philip Mumberson, Nursing AHP lead – check with Susan Burton.					
9.5	There are systems in place to ensure all staff are properly inducted into new roles, including any additional education *Recruitment and local inductions – proforma.*	Part of recruitment policy, new staff corporate and local induction.					
9.6	There are systems in place to ensure staff are adequately supervised while training *Training is offsite. New equipment – training will be provided by reps. New starter supervision.*	Information from the Service.					
9.7	There are systems in place to ensure the service maintains competencies to address the requirements of providing the service (including where appropriate provision for children, and those with particular needs) *CPD.*	Competency framework – clinical supervision.					

9.8	There are systems in place to ensure that all staff are supported in the maintenance of necessary skills, knowledge and levels of competence via CPD, and to develop new competencies to the level as defined by the relevant statutory or professional body *CPD – clinical supervision and appraisals. TNA and mandatory training.*	Evidence – staff have time to do CPD. Clinical supervision.					

10. The service implements and monitors systems to engage in integrated service and workforce review, planning and development.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
10.1	There are defined roles and responsibilities for each area of service review, planning and improvement, and workforce planning and development *Workforce planning and heads of service will maintain responsibility.*	Service for advice.	20/10/2023		50%		Warrington Audiology - TNA Cli
10.2	There are systems in place to support service review, improvement and planned developments with the involvement of patients, staff, users and others *Childrens hearing support working group (CHSWG) – local authorities, minutes go to parents also. Patient engagement.*	Service for advice.					
10.3	There are systems in place to ensure strategic service planning and workforce planning are integrated *Directorate annual plan. Extended DLTs*	Kathryn Sharkey for advice. Service development to meet strategy.					
10.4	There are systems in place to assess, agree and implement workforce development initiatives, which include the involvement of senior managers *Workforce planning.*	Kathryn Sharkey – advice.	20/10/2023		50%		Warrington Audiology - TNA Cli
10.5	There are systems in place to support engagement with content and delivery of relevant education and training *EPD team – service specific to source training. Manufacturers*	EPD team – Carol Leverette?					
10.6	There are systems in place to support and monitor staff retention and ensure succession planning arrangements *Monitor staff retention – reported at Performance Council. Success plan could be put in place with appropriate staff – workforce planning sessions cover this. – KS to provide session. Recruitment drive.*	Kathryn Sharkey – advice. Retention and Recruitment policy. Staff development?					

11. The service implements and monitors systems to manage its budget and service contracts.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
11.1	There are defined roles and responsibilities for budget and contract management *Yes, finance dept.*	Gareth Pugh - advice					
11.2	There are systems in place to ensure regular monitoring and reporting of budgets *Monthly at PC*	Gareth Pugh – advice – finance committee and F&P.					
11.3	There are systems in place to ensure all staff are aware of budget management processes and the implications for their area of responsibility *Kathryn Royden covers this – budget holder. Cannot view budget. There are systems in place to control this. Should be sighted on budget to manage service.*	Gareth Pugh – each directorate should have a lead Finance Business Partner.					
11.4	There are systems in place to ensure engagement with wider financial planning processes *GP reviews this.*	Gareth Pugh - advice					
11.5	There are systems in place to procure, manage and monitor delivery of contracted services *Contracts manger – GP*	Gareth Pugh - advice					
11.6	There are systems in place to ensure arrangements for dealing with income generated by service activity and/or charitable donations *If service had required staff – could income generate.*	Gareth Pugh – processes – although audiology doesn't income generate, there are other services in place that do accrue income generation. Process in place to manage appropriately.					

12. The service implements and monitors systems to manage complaints

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
12.1	There are defined roles and responsibilities for managing complaints *Policy*		20/02/2024		80%		12.1 - complaints section policy.docx
12.2	There are systems in place to manage verbal and written complaints >>		20/02/2024		80%		12.2 - complaints section policy.docx
12.3	There are systems in place to investigate and respond to complaints within specified timeframes >>		20/02/2024		80%		12.3 complaints training.docx
12.4	There are systems in place to train staff in dealing with those wanting to make complaints >>	Mandatory training – E-learning. All staff compliant	21/03/2024		80%		12.4 complaints training.docx
12.5	There are systems in place to ensure complaints are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon >>	Policy	20/02/2024		80%		12.5 Complaints process.docx

DOMAIN 3 - Safety

13.The service implements and monitors systems to manage the risk of infection.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
13.1	There are defined roles, responsibilities and accountabilities regarding infection control >>		25/01/2024		80%		13.1 IPC roles and responsibility policy
13.2	There are systems in place to define, assess and manage the risk of infection >>		25/01/2024		80%		13.2 IPC policy.docx
13.3	There are systems in place to manage patients with contagious and communicable disease and/or suppressed immune systems *Document circulated re: covid-19, highlighting what staff need to do. Highlights different processes. – embed document.*	??					
13.4	There are systems in place to ensure the care of any individual exposed to contagious and communicable diseases	Policy?					

	??						
13.5	There are systems in place to ensure decontamination of equipment and the environment following an incident >>		25/01/2024		80%		13.5 IPC policy.docx
13.6	There are systems in place to ensure incidents and errors are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon >>		25/01/2024		80%		13.6 - Incident reporting policy.doc

14. The service implements and monitors systems to manage the risks associated with hazardous substances and materials.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
14.1	There are defined roles, responsibilities and accountabilities for the control of hazardous substances and materials *COSHH? – John Morris*	??					
14.2	There are systems in place to define, assess and manage risks associated with hazardous substances and materials >>	Mi Kar					
14.3	There are systems in place to ensure the safe storage, handling and disposal of hazardous substances and materials >>	COSHH policy???					
14.4	There are systems in place to ensure appropriate protective equipment is available, maintained and used appropriately >>	^^					
14.5	There are systems in place to ensure decontamination and care of people following an incident *EPRR*	^^					
14.6	There are systems in place to ensure decontamination of equipment and environment following an incident >>	^^					
14.7	There are systems in place to ensure incidents and errors are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon >>	^^					

15. The service implements and monitors systems to manage safe moving & handling.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
15.1	There are defined roles and responsibilities for moving and handling >>		10/03/2024		80%		15.1 - moving and handling policy.doc
15.2	There are systems in place to define, assess and manage risks associated with moving and handling >>		10/03/2024		90%		15.2 - moving and handling policy.doc Image taken from Moving and Handlir
15.3	There are systems in place to ensure that moving and handling aids are available. Maintained and used appropriately >>	Policy					
15.4	There are systems in place to assure the safe transport of patients >>	Reasonable adjustments policy					
15.5	There are systems in place to ensure incidents and errors are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon >>	Restraint policy					
15.6	There are systems in place to define, assess and manage the holding and restraint of patients including specific policies for children and vulnerable adults >>	Restraint policy	25/01/2024		80%		15.6 restraint policy.docx

16. The service implements and monitors systems to manage violence & aggression

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
16.1	There are defined roles and responsibilities regarding the management of violence and aggression >>	Security policy	25/01/2024		80%		16.1 - Security policy.docx
16.2	There are systems in place to define, assess and manage violence and aggression *Conflict resolution mandatory training*	Security policy					
16.3	There are systems in place to ensure support for patients, staff and others who have been involved in an incident *PAM, wellbeing policy counselling and therapy*	??					

16.4	There are systems in place to ensure incidents and errors are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon >>	Incident reporting policy	25/01/2024		80%		16.4 incident reporting.docx

17. The service implements and monitors systems to ensure general health & safety of patients, staff & others.

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
17.1	There are defined roles and responsibilities for each area of general health & safety >>	Health and safety roles	25/01/2024		80%		17.1 Roles and Responsibilities hea
17.2	There are systems in place to define, assess and manage general health and safety risks >>	Health and safety					
17.3	There are systems in place to manage adverse healthcare events *Incident reporting, followed up risk score to dictate process. PSIRF*	??					
17.4	There are systems in place to maintain staff awareness and training on health and safety including fire >>	E-learning models - policies	20/02/2024		100%		17.4 Screenshot taken from employe 17.4 training - policy.docx
17.5	There are systems in place to ensure health and safety equipment is available , maintained and used appropriately *John M – estates, building appliances and maintenance, mandatory training.*	??					
17.6	There are systems in place to ensure appropriate signage and hazard warnings >>	COSHH – Estates – Mi Kah					
17.7	There are systems in place to ensure incidents and errors are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon >>	Incident policy	25/01/2024		80%		16.4 incident reporting.docx

DOMAIN 4 - Clinical

18. The service implements and monitors systems to assure the delivery of the service from referral to discharge from the service, including follow-ups

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
18.1	There are defined roles and responsibilities for leadership and integrated governance for diagnostic/treatment pathways *Process map shared by PT.*	Patient pathways – process map					
18.2	There are systems in place to manage diagnostic/treatment pathways from referral to discharge from the service within specified timescales, including the management of DNAs and cancellations *SOP process will cover.*	services					
18.3	There are systems in place to ensure a collaborative approach to define and deliver diagnostic/treatment pathways and to maintain communication within and outside the service *SOP will cover communications, referrals to joint ENT clinics etc.*	services					
18.4	There are systems in place to ensure clinically relevant information is received from referrers and patients *Yes, triage etc – offer training to capture adequate training*	Services					
18.5	There are systems in place to ensure vetting, justification and prioritisation of referrals *Yes, triage and training*	services					
18.6	There are systems in place to ensure the specific needs of children are met *Yes, pictures for children.*	services	16.01.2024		80%		ali-gets-hearing-aids (2).pdf
18.7	There are systems in place to manage unexpected diagnoses, red flags and indications of potential medical emergencies *Yes, triage, Caroline attended national training, print outs can be embedded, also included in mandatory training. De-fib in CDC – long term service.*	Services					

19. The service implements and monitors systems to assure the quality of the diagnostic test

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
19.1	There are defined roles and responsibilities for managing the quality of each group of diagnostic tests *Clinical supervision, diagnostic tests – ABR testing. Service review recently undergone.*	Services -					
19.2	There are systems in place to develop, agree, maintain and apply protocols for each diagnostic test *Protocols – BSA guidelines. Local policies based on national guidance – reviewed by Rachel Ward. PT to send for embedding.*	Services					
19.3	There are systems in place to ensure that all test protocols are accessible and communicated to all appropriate staff *Protocol folders, CDC hold all in document. Discussed at team meetings and documented. Minutes can be embedded.*	Services					
19.4	There are systems in place to assure the diagnostic quality of the test *External review for behavioural testing will cover this. Cases to be reviewed in meetings and captured in minutes, periodic case reviews.*	Services					

20. The service implements and monitors systems to assure the clinical and technical quality of the interpretation of diagnostic results, and their reporting and communication in a timely manner

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
20.1	There are defined roles and responsibilities for interpreting and reporting test results *SOP when and who does test.*	Services					
20.2	There are systems in place to develop and agree the structure and content of diagnostic reports to meet local needs *Individual reports, template can be used. Audiogram and test results are also included with history and clinical notes. Individual care plans.*	Services					
20.3	There are systems in place to ensure that all appropriate staff are aware of the agreed formats for reporting/communication of results *Team meetings, discuss changes etc.*	Services					

20.4	There are systems in place to assure the quality and accuracy of the interpretation and reporting of test results *Peer review.*	Services					
20.5	There are systems in place to ensure communication of diagnostic reports to referrers and multidisciplinary team meetings within specified timescales *Communicate results – process map.*	Services					
20.6	There are systems in place to manage alterations and amendments to diagnostic reports *Addendum added to letters with date, added to the bottom of report. Alterations documented.* *Permanent changes to report – discussed in team meeting and flagged in emails.*	Services					

21. The service implements and monitors systems to assure the clinical and technical quality of treatments, interventions and invasive procedures

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
21.1	There are defined roles and responsibilities for staff who carry out treatments or interventional procedures *SOPs in place.*	Services					
21.2	There are systems in place to define, assess and manage risks related to treatments or interventional procedures *Risks will be written down during procedures. Included in policies. BSA guidelines.*	Services					
21.3	There are systems in place to develop, agree, maintain and implement protocols for all treatments and interventional procedures which should be evidence based, validated and objective *BSA guidance.*	Services					
21.4	There are systems in place to ensure that protocols for treatments and interventional procedures are accessible and communicated to all appropriate staff *Look up on K-drive*	Services					
21.5	There are systems in place to assure and measure the quality and outcomes of treatments or interventional procedures *Peer review and patient feedback. Diagnostic waits and KPIs for waiting times. Meningitis audit, record keeping*	Services					

	audit. Teacher of the deaf, academic achievements and speech testing.						

22. The service implements and monitors systems to manage drugs, contrast media, gases and medical devices

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
22.1	There are defined roles and responsibilities for drugs and contrast media management *N/A*					100%	
22.2	There are systems in place to manage the prescription and administration of drugs and contrast media *N/A*					100%	
22.3	There are systems in place to ensure the identification and management of patients at risk of adverse reactions to specific drugs and contrast media *N/A*					100%	
22.4	There are systems in place to manage the preparation, administration and withdrawal of drugs and contrast media *N/A*					100%	
22.5	There are systems in place to ensure the management and care of patients receiving drugs and contrast media, including response to adverse reaction *N/A*					100%	
22.6	There are systems in place to ensure that drugs and contrast media are securely and safely stored *Medicines audit, annually even though not applicable*	Policies/services					

23. The service implements and monitors systems to minimise clinical risk and manage incidents and errors arising from clinical activity

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
23.1	There are defined roles and responsibilities for risk management *Risk policy*	Risk policies					
23.2	There are systems in place to define, assess and manage clinical risk						

	Clinical audit, Ulysees						
23.3	There are systems in place to ensure appropriate response to clinical incidents *Ulysees*						
23.4	There are systems in place to manage medico-legal and research examinations or procedures, and this includes ensuring that requests are justified *Clinical audit and research. Rachel Hall/ Jan Mc or Ted A Medico-legal*						
23.5	There are systems in place to ensure incidents and errors are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon *Ulysees*						

24. The service implements and monitors systems to manage clinical records

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
24.1	There are defined roles, responsibilities and accountabilities for each area of clinical records management *Clinical records policy and audits*	Clinical records policies Clinical audit – records audit annual. Service should have results of previous audits					
24.2	There are systems in place to maintain patient confidentiality *Data protection, locking screen, patient confidentially at reception.*	Data protection and confidentiality policy					
24.3	There are systems in place to ensure the secure and confidential storage, retrieval, transmission and transportation of patient records *>>*	Records management policies					
24.4	There are systems in place to manage sharing of patient data between organisations *Systems can be put in place. Need advice.*	Sharon ormesher					
24.5	There are systems in place to ensure control and audit of access to patient data	Dave – policy?					

	Access to clinical system – passwords and certain platforms. Flags specific activity.						

25. The service implements and monitors systems to review current and emerging clinical practice, implementing new and innovative practice as appropriate

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
25.1	There are defined roles and responsibilities for clinical governance, including reviewing current practice and the development of new clinical practices *Heads of service, CCPG – changing practice and processes need to be reviewed by group.*	Services					
25.2	There are systems in place to ensure regular audit of current clinical practice, review and dissemination of findings and appropriate action *Clinical audit.*	Services					
25.3	There are systems in place for reviewing emerging clinical practices and implementing new practice as appropriate *NICE guidance or notified via professional bodies, teams meetings and minutes.*	Services					
25.4	There are systems in place to ensure governance arrangements to support introduction and audit of new clinical practices *Clinical audit.*	Services					
25.5	There are systems in place to support engagement in research and development activities *Research and development team – Rachel Hall*	Services					

26. The service implements and monitors systems to manage the physiological science specialism specific risks

Task Number	Key Tasks	Lead	Planned Start Date	Planned End Date	% Complete	Status	Comments/Evidence
26.1	There are defined roles and responsibilities regarding clinical audiology risks *Head of service – reported on Ulysees, discussions with safeguarding (within building)*	Service specific risks are					

26.2	There are systems in place to ensure the maintenance and checking of the safety of electrical equipment *PAT tested and Key Health, Asset registration and certificates*	Services					
26.3	There are systems in place to ensure that there is appropriate management of patients who have any adverse reaction or distress resulting from audiological examinations/procedures *SOP? Guided by parents during testing processes.*	Services					
26.4	There are systems in place to ensure adequate supervision of patients undergoing procedures with the potential to cause an adverse reaction, including vestibular tests *N/A*					100%	
26.5	There are systems in place to ensure that patients with a clinical history that contraindicates any audiology procedures are identified, risk assessed and procedures modified appropriately *BSA Guidance and SOP*	Services					
26.6	There are systems in place to ensure that adequate guidance is given to patients regarding the safe usage of devices and consumables issued *N/A*					100%	

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**38/24iv**		
Report Title	**LEARNING FROM DEATHS QUARTER THREE AND FOUR 23/24**		
Executive Lead	Ted Adams Executive Medical Director		
Report Author	Andi Sizer Principal Lead for Public Health		
Presented by	David Mills Deputy Medical Director		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

Bridgewater Community Healthcare NHS Foundation Trust Board recognises that effective implementation of the Learning from Deaths Framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high-quality sustainable services to patients and service users.

This report meets the requirements of the National Quality Board (NQB) guidance (2017) for NHS providers on how they should learn from the deaths of people in their care. The information and learning were, overseen by our Serious Incident Review panel (SIRP).

Of the deaths reported to the Trust that met the Learning from Deaths (LFD) policy criteria for Q3 (**16)** and Q4 (**16)** were reviewed and closed. None of the **32** deaths were related to a deficit in care provided by Bridgewater.

There were no concerns raised from the deceased family/carers and no concerns raised by staff about the care that Bridgewater delivered to patients who died.

It is noted that the number of deaths reviewed equalling 16 in each quarter is coincidental and not representative of a sample number but equating to all deaths that met the LFD policy criteria and guidance.

The Board should note that this report is considered at Quality Council and then noted at EMT before being presented at Board. The Board is reminded of the national directive that Boards consider Trusts' Learning from Deaths reports.

Recommendation:

The Board is, asked to note the contents of the report and agree the level of assurance that can be taken from the detailed analysis of activity and learning in 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**	**6 June 2024**
Agenda Item	**38/24iv**		
Report Title	**LEARNING FROM DEATHS QUARTER THREE AND QUARTER FOUR 23/24**		
Report Author	Andi Sizer Principal Lead for Public Health		
Purpose	The purpose of this paper is to provide assurance to the members of the Board of Directors in relation to the implementation of the Learning from Deaths framework.		

1. SCOPE

1.1 Each death reported directly to the Trust prompts an incident report, and if appropriate, a Learning from Death's report, the analysis of which contributes to this report. This process allows the Trust to be confident that it proactively seeks to improve care provided at the end of life and is learning from cases when things go wrong, and when appropriate, when something did not go wrong.

1.2 Bridgewater becomes aware of deaths from several sources including:

1. A Bridgewater staff member attends a home visit and is met by a relative/carer and told that the patient has passed.
2. A staff member attends the patient home, and the patient is found unresponsive.
3. A telephone message from a relative/carer or residential setting such as care home or nursing home.
4. A communication from the Acute Trust when they are aware the patient had been receiving services from Bridgewater prior to admission for example 0-19 and District Nursing service.
5. When accessing the Electronic Patient Record (EPR) and a death notification has been added.
6. A communication from the local safeguarding team.

1.3 This 2023/24 Q3 and Q4 report on Learning from Deaths across the Trust has been written in line with the Trust's Learning from Deaths Policy, which follows the NHS National Quality Board guidance (2017).

1.4 The Trust Serious Incident Review Panel (SIRP) met weekly, and service leads provided individual reports on the deaths that the Trust had been notified of and that met the criteria for investigation as detailed in the policy.

1.5 The 16* deaths reviewed in Q3 were all adults where the individuals had been seen within 30 days by a Bridgewater member of staff prior to death, and had died unexpectedly.

1.6 The 16* deaths reviewed in Q4 were 13 unexpected adult deaths seen within 30 days and three child deaths, one expected and two unexpected.

1.7 There were three deaths in Q3 where a Learning Disability diagnosis was known, and these were reported to the Cheshire and Merseyside LeDeR steering group.

1.8 There were no Learning Disability deaths in Q4.

(* It is noted that the deaths in both quarters reviewed in line with the policy amounting to 16 per quarter is coincidental and not reflective of a sampling application.)

2. INTRODUCTION

2.1 The total Q3 and Q4 deaths (32) were investigated and closed by the Trust SIRP

2.2 None of the 32 deaths were related to a deficit in care provided by Bridgewater.

2.3 In Q3 and Q4 there were no concerns raised from deceased family/carers and no concerns raised by staff about the care that Bridgewater delivered to patients who died.

2.4 None of the deaths investigated under the Learning from Deaths policy were associated with any care delivery concern or harm caused by services provided by the Trust. Duty of Candour was not applicable in any of these cases. However, some themes have been identified as learning areas for the Trust – see 3.2 below.

2.5 It is to be noted that this report covers those deaths investigated and closed at the time of writing and as such there may be an increase in closed deaths for this quarter and this will be reflected in the yearend report.

3. INFORMATION

Summary of Thematic Learning

3.1 Each unexpected death reported during Q3 and Q4 has been analysed and investigated appropriately to identify if care provided by the Trust resulted in harm or contributed to the death and if any relevant learning exists for the Trust and the wider health and social care system.

3.2 SIRP did feel that there was learning for the Trust after reviewing the deaths.

Learning	Example	Dissemination
Detailing patient's wishes and goals in the EPR.	An example being the patient's expresses wishes to	As part of the Psychotherapy services developments the initial

	return home from a stay in residential care.	patient assessment now reflects this.
Low mood.	When a patient expresses low mood, it can be detrimental to their wellbeing and recovery.	When a patient expresses low mood a low mood assessment is now completed as good practice.
To ensure patient centered care is delivered, and always include the patient in decision making	The patient was deemed to have the capacity to make decisions, however, they were not consulted on the decision to have a therapy review of stairs and toilet equipment.	This was discussed as part of a group supervision session.
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	Paremedictics not being aware of the DNACPR being in place.	Opportunity to work with North West Ambulance Service (NWAS) colleagues to consider the 'message in a bottle' scheme for development.

4. RECOMMENDATION

5.1 The Trust Board is asked to receive this paper for assurance of the process undertaken in quarters three and four, and to note the subsequent learning for the Trust.

Appendix: Q3and Q4 LFD Board paper.

The Trust Board have requested this appendix to be included. The purpose of this is to detail the process of the LFD reviews in quarter two and provide greater clarity on the methodology used to determine which deaths should be subject to an LFD review in Bridgewater Community Healthcare NHS Foundation Trust

In Q2 16 deaths were reported and reviewed at SIRP in line with the Trust Learning from Deaths Policy. (It is noted that these deaths were reviewed against the September 2020 policy.)

However, during Q2 2023/24, 569 deaths were reported on the 'Qlik Sense' dashboard pertaining to Bridgewater patients who had an open record and/or an active referral at date of death in Halton and Warrington. This information is derived directly from SystemOne and EMIS data. All deaths are reported onto the spine and this enables healthcare organisations to manage any outstanding appointments etc, but these did not meet the criteria for learning form deaths.

This information has historically been included in the LFD report but it does not relate to the deaths that the Trust is notified about that should be subject to an LFD review in line with the policy.

The purpose of the Qlik data is to make sure open records are closed and is used for administrative purposes only.

The disparity between the two figures is because the Qlik Sense data includes all deaths about which we are notified and will include deaths in Acute Trusts and elsewhere. Those deaths reviewed for a LFD are patients who have died and meet the criteria ; It is not the case that all 569 deaths were reviewed and whittled down to 16.

Current process for reporting a death.

The Operational Manager ensures a death is reported as an incident in the Trust's incident reporting system within 48 hours of the service being made aware of the death, if it meets the criteria below:

1. The bereaved family have expressed a concern about the care their relative received from the Trust or other partner services.

2. Staff employed by the Trust have expressed a concern about the quality of care received by the deceased e.g., did not die in their preferred place of care.

3. The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g., through audit or CQC inspection).

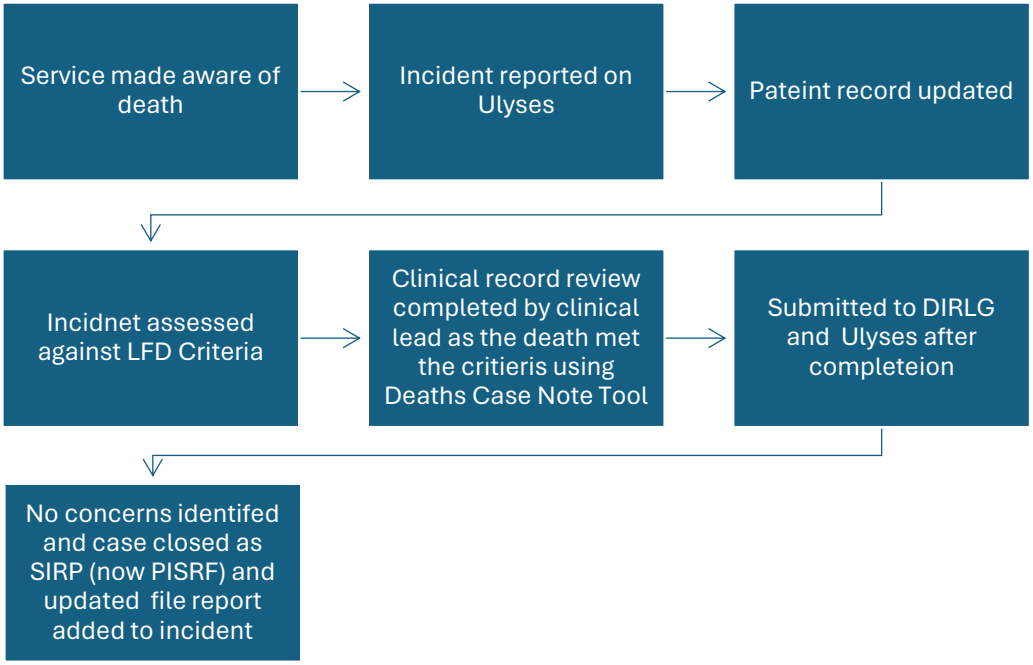
4. The deceased patient had a learning disability.

5. The deceased patient was a child aged <18 years.

6. The death was unexpected, and the last service intervention was less than 30 days ago.

The 16 deaths in quarter two where the deaths that services were notified about and were reviewed against the Trust Policy LFD criteria as detailed above (September 2020 policy). The policy has since been updated and was ratified in April 2024.

All the 16 deaths reviewed in 2023/24 were reviewed against the 2020 policy and followed the cycle below as no concerns were raised.



The table below shows the updated 2024 policy LFD criteria

Circumstances (unexpected deaths)	Timescale for completion
All patients' who at the time of death were in an **intermediate care bed** where Trust services are providing care.	Within **72 hours / 3 working days** of the incident being reported*
All patient deaths were the patient had a **learning disability/autism**	Within **72 hours / 3 working days** of the incident being reported*
All child deaths aged **< 18 years (expected or unexpected)** except in the case of a baby who died in hospital and who's care has been in hospital from the beginning to the end of their life, or who was not born alive.	Within **72 hours / 3 working days** of the incident being reported*
All deaths were **Initial concerns** noted in relation to the circumstances surrounding the patient's death or the care provided by the Trust.	Within **72 hours / 3 working days** of the incident being reported*
All deaths were there are **no** initial concerns identified relating to the circumstances surrounding the patient's death or the care provided by the Trust, where the Trust is the **main provider** and the patient has been seen by a service within 30 days.	Within ten working days of the incident being reported*
Expected death e.g., patient was on an end-of-life pathway where there were no concerns identified or if the person had Learning Disability or Autism.	**No** LFD review required.

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Creating stronger, healthier, happier communities.

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Board Report

Title of Meeting	**Trust Board**	**Date**	**6 June 2024**
Agenda Item	**38/24v**		
Report Title	**QUALITY ACCOUNT 2023/24 (FINAL DRAFT)**		
Executive Lead	Lynne Carter: Chief Nurse/Deputy CEO		
Report Author	Sharan Herbert: Head of Clinical Governance & Quality		
Presented by	Jeanette Hogan: Deputy Chief Nurse		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary

- The Quality Accounts sets out the strategic ambition to deliver high quality safe and effective care for our patients. Each year all NHS provider organisations are required to produce a Quality Account to highlight the progress that they have made against key priorities. This includes a review of services, evidence in relation to involvement in national, local, and clinical audits, an overview of any research activity as well as the current CQC ratings. The Quality Accounts also identifies the quality priorities for the organisation for the following year
- The report is to provide an update to the Trust Board in relation to the progress of the Quality Account for 2023/24

Previously considered by:

Quality & Safety Committee

Strategic Objectives

☐ **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.

☐ **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 REPORT

Title of Meeting	**Trust Board**	**Date**	**6 June 2024**
Agenda Item	**38/24v**		
Report Title	**QUALITY ACCOUNT 2023/24 (FINAL DRAFT)**		
Report Author	Sharan Herbert: Head of Clinical Governance & Quality		
Purpose	The report is to provide an update to the Trust Board in relation to the progress of the Quality Account for 2023/24		

1. SCOPE

1.1 NHS organisations are required to publish an annual Quality Account

1.2 The Quality Account must be published on the Trust's website by June 30th each year, following the end of the reporting period

1.3 Quality Accounts no longer have to be externally audited

2. INTRODUCTION

2.1 Each year all NHS provider organisations are required to produce a Quality Account to highlight the progress that they have made against key priorities. This includes a review of services, evidence in relation to involvement in national, local, and clinical audits, an overview of any research activity as well as the current CQC ratings. The Quality Accounts also identifies the quality priorities for the organisation for the following year

2.1 The report will provide an update on the progress to date and a new approach for Part 3 of the Quality Account

3. INFORMATION

3.1 The Quality Account is separated into three parts:

- Part one: Our Quality Account:
- Part Two: Priorities for improvement and statements of assurance from the Board
- Part Three: Quality of care

3.2 **Part One: Our Quality Account**: Requires a statement on Quality from the Chief Executive. This is written towards the end of the Quality Account process when the Chief Executive has read the report and then gives a synopsis of the progress to date

3.3 **Part Two: Priorities for improvement and statements of assurance from the Board** this section requires two statements of assurance that has to be completed. The number of national clinical audits that were reviewed and the number of local clinical audits.

3.4 For 2023/24 these were as follows:

During the reporting period the Trust participated in 100% of the national clinical audits which it was eligible to participate in.

The national clinical audit that the Trust was eligible to participate in during 2023-24 are as follows:

- National Diabetes Foot care Audit (NDFA) - (including Annual National Diabetes Audit (NDA) Integrated Specialist Survey)

The national clinical audit that the Trust participated in, and for which data collection was completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title of National Audit	**Number of cases submitted to national audit as a percentage of the number of registered cases required by the terms of that audit**
National Diabetes Audit - Adults (foot care)	100%

No national clinical audit reports were received by the provider in 2023-24 and due to the delayed timescales from the National Bodies to publish reports, the following audits we participated in during 2023-24 will be published as follows:

Title of National Audit	**Findings and Actions**
National Diabetes Audit - Adults (foot care)	7-year data collection restarted in April 2022 – due 2029

The Trust participated in eight Local Clinical Audits during 2023-24. The provider reviewed three completed audit reports and intends to take actions to improve the quality of healthcare provided

3.5 Part Two also requires mandated data sets. As these are Q4 data sets, these are populated into the report in the month of May as the data has to be closed on March 31st and then validated during the month of April

3.6 For Part Two of the report all data sets are verified through the Performance Team and the IQPR. Throughout the year teams will write reports for the Quality Council and the Performance Council in order to demonstrate progress throughout the year. This provides the Councils with assurance that programmes are on track or delayed and require further support. The Quality Account then provides the overall summary for the year

3.7 The Trust also has to set out its Quality Priorities for the **year 2024/25.** These are:

1. Community Accreditation Scheme
2. Consolidation of the Patient Safety Incident response Framework (PSIRF)
3. Development of Core Role Competencies

3.8 **Community Accreditation Scheme:** A Trust wide Quality Review Visit (QRV) process was developed and implemented in 2023/24. The QRV's utilise the Bridgewater accreditation tool to enable identification of good practice and areas that require improvement. Now the process and tool has been tried and tested the steering group are planning the next progression to an accreditation scheme, which will rate each team based on the assessment standards and direct the schedule of future accreditation assessments.

The work will begin with engagement with clinical teams to support the further development of the process, scoring system and reward criteria post assessment. Learning from the Quality Review Visits will inform the development of the accreditation scheme.

3.9 **Consolidation of the Patient Safety Incident response Framework (PSIRF):** The Trust had their PSIRF Plan and Policy signed off in November 2023 with implementation beginning in 2024. In the new framework, Directorates have a weekly incident review meetings (Directorate Incident Response Learning Groups -DIRLG) which ensures that incidents and are managed locally and effectively with the correct proportionate response allocated to the incident.

From the Trust incident data, three Local Incident Priority Groups were established to identify themes and trends.

The groups are:

1. Medicine Management
2. Falls Group
3. Pressure Ulcer Group

The groups will develop systems learning and generate quality improvements.

The overarching Trust Panel that will give assurance to the Board is called Patient Safety Incident Response Framework and Learning panel (PSIRFaLP)

The implementation of PSIRF within the organisation is being monitored by the PSIRF Implementation Group who have oversight of the project.

3.10 **Development of Core Role Competencies:** A Project Group, known as the Capability Task Force Group, has been established with Terms of Reference in place. The Group has representation from the work force, human resources, operational staff, clinical staff, education, and development department and led by a Project Manager.

The aim of the group is to develop a range of work force competences, supported with a capability framework for both clinical and non-clinical roles. Comprehensive research has been undertaken of a range of national and local documentation, including existing

competences within Bridgewater Community Health Care Foundation Trust has been sourced and reviewed. A State of Readiness Toolkit has been developed which acts as a project plan, including the domains of:

- Strategy.
- Workforce Planning.
- Roles and Responsibilities.
- Training and Education.

In the first instance, competences will be developed for the District Nursing service, and cross referenced to service specification expectations and Agenda for Change job profiles. It is anticipated that, over time, a suite of competences will be in place for all roles and that job descriptions will be reviewed and or revised in line with competency expectations. The use of core role competences are based on knowledge, skill and behavioural expectations of staff aimed at strengthening professional expectations of staff whilst facilitating development and career opportunities, adopting a consistent approach.

All competences will be cross referenced to the Trust Strategy, Trust policies, NHS People Promise, and Health Professional Codes as applicable. The core competences are themed within the following 7 domains:

- Promoting Heath and Preventing Ill Health
- Core Assessment and Case Management
- Promoting and Evaluating Evidenced Based Practice
- Team Involvement, Co-Ordination, and Management.
- Improvements in Safety and Quality of Care
- Care Co-ordination and System Leadership
- Being Accountable

3.11 The review of the Quality Indicators for 2022/23 and the new priorities for 2023/24 are reviewed by the Executive Team responsible for Quality. This is to ensure that they are inline with the Trust strategy and that we are delivering on our quality promise

3.12 **Part Three: Quality of Care:** For the 2023/24 Quality Account, this section has taken a different approach to what has been published in previous years. Having reviewed other Community Trusts Quality Accounts, their Part Three has a more celebratory feel to this section, whilst Bridgewater has previously described in detail the quality work of their services. As this is a public document, ours in comparison was a very large report with facts and figures and is very descriptive

3.13 We have worked closely with our Communication Team and have used our ‘Thank You Awards’ nominations and winners to describe in pictures and words the celebration of our quality of work within our services. This approach has given the report a more public focused approach to our quality improvement work

3.14 The Quality Account has been presented to the ICB on the 17th May 2024 and we await the ICB letter on the 12th June 2024, which has to be attached to the appendices of the Quality Account as stakeholder feedback

3.15 The Quality Account remains in Final DRAFT until the stakeholder feedback is received. Once the letter is inserted into the report, the front and back covers and insert pages can be attached and the final dates added to the Chief Executives and the Chairs signatures. The report will then be ready for submission to Parliament alongside the Trust Annual Report

3.16 The Quality Account will be published on the Trust Website at the same time as the Trust Annual Report

4. RECOMMENDATION

4.1 That the Trust Board approve the FINAL DRAFT as a reflection of the progress to date with the Quality Account

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Font Cover to be added ready for Publication.

Quality Account 2023-2024

Contents of the Quality Account Check at the end

QUALITY ACCOUNT
PART 1

Part 1

Statement on Quality by Chief Executive

Bridgewater is committed to the provision of high-quality services. The systems, processes and procedures that sit within our clinical and corporate teams are robust and reflect the need to support staff who work within our local communities.

Working across a diverse, geographic footprint presents challenges. Having an approach to quality that allows teams to assess and scrutinise their practice is essential, so we have worked hard to make sure teams understand the importance of monitoring and measuring compliance and reporting in a timely and meaningful way.

Our teams are supported by colleagues whose focus is to drive through a programme of learning and best practice. Quality meetings are a central feature of this approach, as are Quality Review Visits introduced this year to support the ability of teams and individuals to explain the systems and processes that underpin their practice to their peers. Sharing the learning from these visits via the Trust's Time to Shine sessions has provided us with a highly effective platform of communication.

The provision of high quality, patient focused care is dependent on many diverse factors as our Quality Account demonstrates. As there is no single measure, this depends upon robust systems of measurement and reporting.

The introduction this year of the Patient Safety Incident Response Reporting Framework added additional rigour to our approach. Ensuring staff were aware of the additional requirements was essential in implementing the system. That is why we and all other NHS Trusts across the country made it a mandatory requirement for all staff to understand the requirements and added it to our annual programme of mandatory staff training.

Whilst systems and processes are fundamental to our approach, it is our staff who make it happen. Providing them with the training, skills and equipment required to do their job is a fundamental requirement of any NHS organisation.

We are extremely proud and privileged to have received national recognition for several of our services in year.

Our urgent Community Response Service in Halton is an excellent example of where we were able to demonstrate how strong partnership working, shared understanding of the challenges and a joint approach to prevent unnecessary hospital admissions is making a very real difference on the ground.

We were also delighted to receive the national Preceptorship for Nursing Interim Quality Mark: supporting our newly qualified staff as they embark on their journey into community nursing is essential if we are to retain our workforce.

We are rightly proud of clinical and corporate teams and their shared commitment to supporting each other.

These are extremely challenging times for the NHS and in common with other trusts, have and continue to struggle to recruit to several vacancies. That is why we are committed to further developing our apprenticeship offer. We now have more than 100 clinical and corporate apprentices working across the organisation, many of whom are drawn from the communities where we deliver care, bringing with them the knowledge and understanding of the communities they serve and commitment to Place.

In 2023-24 we launched our new five-year strategy, Communities Matter. This sits at the heart of our ambitions to further develop the relationships to support better patient care – to prevent unnecessary hospital admissions and support the safe discharge of patients into our communities.

Our clinical teams are dealing with ever more complex cases but are supporting individuals to live within their own homes and receive care that is constantly monitored and measured to ensure it meets the standards required but more importantly the expectations of our patients, their families, and carers.

It is essential that we retain our focus on quality and continue to drive through the learning of colleagues and share best practice when and where possible.

It is a testament to this approach that more than 90 per cent of our patients routinely describe the quality of our services as good or very good.

I am extremely proud of this achievement and our staff. I hope you enjoy reading our Quality Account for the year 2023-24 and trust it will give some insight into the many systems, processes and procedures that support the delivery of high-quality services.

Chief Executive

Colin Scales

About the Quality Account

Quality Accounts are annual reports to the public prepared by providers of NHS healthcare organisations about the quality of services they deliver. The purpose of Quality Accounts is to encourage healthcare organisations to assess quality across all the healthcare services they offer, allowing organisations to demonstrate their commitment to continuous, evidence-based quality improvement, and to explain their progress to the public.

Our Quality Account is divided into three sections:

Part 1	• Statements about our Quality from the Chief Executive
Part 2	• Priorities for the Trust to improve the quality of our care during 2023-24. • Statements about the quality of services provided by the Trust.
Part 3	• Looking back over the last year 2023-24.

QUALITY ACCOUNT
PART 2

Part 2 - Priorities for Improvement and Statements of Assurance from the Board

Priorities for Improvement in 2024-25

The Trust continues to develop a continuous improvement culture which is driven by our staff and quality teams. The Trust invests in Leaders in Me Events, Time to Shine and Staff 'Thank You' Awards to develop staff, capture and share great practice and ideas, innovation and improve the quality of care delivered to our patients.

As part of our new strategy, ***'Communities Matters. Creating stronger, healthier, happier communities. 2023-2026'***, we have reviewed our mission statement:

"We will improve health, health equality, wellbeing and prosperity across local communities, by providing person-centred care in collaboration with our partners".

In considering our priorities for 2024-25, the Trust has identified the following priority areas to improve and develop further over the next 12 months:

1. Community Accreditation Scheme
2. Consolidation of the Patient Safety Incident Response Framework (PSIRF)
3. Development of Core Role Competencies

Quality priorities for the year 2024-25 include:

No	Name Quality Priority	Synopsis
1	Community Accreditation Scheme	A Trust wide Quality Review Visit (QRV) process was developed and implemented in 2023/24. The QRV's utilise the Bridgewater accreditation tool to enable identification of good practice and areas that require improvement. Now the process and tool has been tried and tested the steering group are planning the next progression to an accreditation scheme, which will rate each team based on the assessment standards and direct the schedule of future accreditation assessments. The work will begin with engagement with clinical teams to support the further development of the process, scoring system and reward criteria post assessment. Learning from the Quality

		Review Visits will inform the development of the accreditation scheme.
2	Consolidation of the Patient Safety Incident Response Framework (PSIRF)	The Trust had their PSIRF Plan and Policy signed off in November 2023 with implementation beginning in 2024. In the new framework, Directorates have a weekly incident review meetings (Directorate Incident Response Learning Groups -DIRLG) which ensures that incidents are managed locally and effectively with the correct proportionate response allocated to the incident. From the Trust incident data, three Local Incident Priority Groups were established to identify themes and trends. The groups are: 1. Medicine Management 2. Falls Group 3. Pressure Ulcer Group The groups will develop systems learning and generate quality improvements. The overarching Trust Panel that will give assurance to the Board is the Patient Safety Incident Response Framework and Learning Panel (PSIRFaLP) The implementation of PSIRF within the organisation is monitored by the PSIRF Implementation Group who have oversight of the project.
3	Development of Core Role Competencies	A Project Group, known as the Capability Task Force Group, has been established with Terms of Reference in place. The group has representation from work force, human resources, operational staff, clinical staff, education, and the

		learning & development department and led by a Project Manager. The aim of the group is to develop a range of work force competences, supported with a capability framework for both clinical and non-clinical roles. Comprehensive research has been undertaken of a range of national and local documentation, including existing competences within Bridgewater Community Health Care Foundation Trust, has been sourced and reviewed. A State of Readiness Toolkit has been developed which acts as a project plan, including the domains of: • Strategy. • Workforce Planning. • Roles and Responsibilities. • Training and Education. In the first instance, competences will be developed for the District Nursing service, and cross referenced to service specification expectations and Agenda for Change job profiles. It is anticipated that, over time, a suite of competences will be in place for all roles and that job descriptions will be reviewed and or revised in line with competency expectations. The use of core role competences is based on knowledge, skill and behavioural expectations of staff aimed at strengthening professional expectations of staff whilst facilitating development and career opportunities, adopting a consistent approach. All competences will be cross referenced to the Trust Strategy, Trust policies, NHS People Promise, and Health Professional Codes as

		applicable. The core competences are themed within the following seven domains: • Promoting Heath and Preventing Ill Health • Core Assessment and Case Management • Promoting and Evaluating Evidenced Based Practice • Team Involvement, Co-Ordination, and Management • Improvements in Safety and Quality of Care • Care Co-ordination and System Leadership • Being Accountable

The table below highlights the implications on workforce and finance.

	Quality	Workforce	Finance
1	Implementation of the Community Accreditation scheme	Engagement with clinical and corporate staff	Cost of ongoing implementation and management of accreditation scheme
2	Consolidation of the Patient Safety Incident Response Framework (PSIRF)	Engagement with clinical, corporate staff and ICB	Cost of Project Support staff
3	Development of Core Role Competencies	Engagement with clinical, and corporate staff	Cost of Project Support staff

The priorities will be monitored through the Trust's Quality Team. Information will be gathered by triangulating data and quality reports which will be discussed, challenged, and monitored at monthly Borough Quality and Operational meetings. Reports will be shared with the Quality Council to provide assurance to the Quality & Safety Committee which reports to the Board.

To provide assurance to the Trust Board, the Committee monitors performance on a bi-monthly basis by receiving regular reports on all quality and operational issues. This enables the Trust to demonstrate its commitment of encouraging a culture of continuous improvement and accountability to patients, the community, and our key stakeholders.

Review of progress against the 2023-2024 Priorities for Improvement

Priority for Improvement	Update
Universal in reach – personalised in response - a modernised health visiting and school nursing service delivery model	Universal in reach; personalised in response - A modernised health visiting, and school nursing service delivery model priority commenced in 2022-23. The new model aims to provide a greater emphasis on the proactive assessment of children, young people, and family's needs, with an agile skill mix that can seamlessly respond to unique requirements. The model will help to improve accessibility, enabling young people to receive proactive, early, and bespoke interventions to help build their resilience and embed lifelong, healthy habits, to give them the best start in life. Throughout 2022 planning work was undertaken and two staff engagement workshops took place in January 2023, focusing on the revised model for school nursing and health visiting across both Halton & Warrington Boroughs. The teams worked together to identify how they could strengthen multi-professional care pathways and better integrate services to support a healthy pregnancy, children 0 – 19 years, and up to 25 years for children with SEND. The school nursing and health visiting teams looked at creative ideas to meet the population's needs and demands at place, whilst ensuring the service provides a workforce that is focused on improving outcomes, reducing inequalities, and sustaining high quality outcomes for children, young people, families, carers, and local communities alike. Action plans have been developed for both the health visiting & school nursing services across the Boroughs, focusing on additional universal contacts to address key universal health priorities, increased emphasis on personalised care, updating new language recognised within the guidance, and increased scope on emotional health & wellbeing assessments. The new service model is fully embedded and is being monitored quarterly through the Local authority contract meetings.

To continue and progress work to address health inequalities and deliver on the Core20PLUS5 approach.	As a Trust we have acknowledged that population health and health equity are key aspects of quality and patient care. We will only provide truly high-quality care if we reach everyone who needs us and ensure we deliver good outcomes across a wide range of interventions for all who make up our communities. Our commitment to improving Health Equity was to include it as a strategic aim in the Trust's strategy: Communities Matter. The strategy prioritised our commitment to the people and communities we serve and our collaboration with local partners. We have committed to providing person centred care that improves health in its broader sense and reduces health inequalities. The Trust has adopted the Cheshire and Merseyside Prevention Pledge. pledging 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 Pledge has enabled Bridgewater to embed the Marmot Principles of prevention of ill-health into Trust strategies and the trust is now moving towards becoming an 'Anchor Institution' in 204/05. The Prevention Pledge has given us a better understanding of the contribution we make and can make as an 'anchor' organisation in our community. We have explored how we maximise our impact on local health and wellbeing in how we deploy our significant assets and 'purchasing power', such as providing more employment opportunities for local people or buying from local suppliers. There are also synergies with the Trust's Green Plan. To support our communities and place partners, three metrics have been included within the Trust's newly developed performance report. These are smoking (including vaping), physical activity and alcohol. A ten percent Trust compliance activity has been set and performance will be subject to review by the newly formed Health Equity Group and drilled down to individual services. The performance threshold will be considered annually, and a percentage increase applied. The triumvirate of smoking, alcohol, and physical activity are what Guenther et al (2020) describe as the heterogeneity of risk preferences. People make behavioural decisions based on their perceptions of risk, their personal characteristics, and circumstances, and of the behaviours of those around them, family, friends, and communities. To understand our population and to design services, we need to record these risk factors within our Electronic Patient Record (EPR). These health parameters have been agreed with the

<table>
<tr><td></td><td>Directors of Public Health in Warrington and Halton as relevant and with improvement, as suitably broad to effect a change in our patients' health in line with Core20PLUS5. Making Every Contact Count training is being rolled out across the Trust in May 2024

We are engaged with several place-based collaboratives for the Core20PLUS5. These include the cancer and the cardio-vascular disease workstreams in Halton, a healthy weight strategy development in Warrington and our engagement across both boroughs with the Wellbeing workstreams.

In the Dental Directorate a review of the patients on our waiting lists and health inequalities has been procured. This health equity audit approach aims to generate robust population health data to examine the relationship between health determinants, access to health services and care outcomes across our dental population.

<table><tr><td>To continue and progress work to address health inequalities and deliver on the Core20PLUS5 approach.</td><td>MECC - Making Every Contact Count and smoking cessation training for staff.

Addition reporting requirements in EPR</td><td>Digital and analytical</td></tr></table></td></tr>
<tr><td>Begin to scope the development of a community accreditation scheme.</td><td>Within the first quarter of 2023/24 the Quality Review Steering group was established, the group initially met weekly and identified and monitored actions required to enable the first Quality Review Visit (QRV) to take place within quarter two. During the first quarter the QRV process was developed, which utilises the Bridgewater accreditation tool and supports the identification of good practice and areas requiring additional support and actions. The QRV standard operating procedure was developed and remains under review as the steering group learns from visits undertaken. Based on the visits and feedback received from clinical staff the process was adapted to strengthen the support teams received prior to the visit and led to the inclusion of a pre visit leaflet which answered frequently asked questions.

There has been 15 QRV's undertaken since their launch in quarter two, including:

• Three in Childrens Directorate
• Five in Halton Adults Directorate
• Six in Warrington Adults Directorate
• One in the Dental Directorate</td></tr>
</table>

Birchwood, Warrington 0-19 Quality Review Visit

Each team receive a detailed QRV report within ten working days of the visit, the report identifies good practice alongside recommending areas which could be strengthened. Operational Managers are asked to translate recommendations into action within the service/team self-assessment framework.

Post receiving the QRV report teams are encouraged to complete a brief questionnaire to support further developments of the process. The team will also be invited to Time to Shine to share their learning and their self-assessment framework.

Comments from staff:

The development, progress, and initial findings from the QRV's was presented to a Trust Board time out in January 2024.

Further reporting of QRV's will be via a bi-annual report to Quality Council.

Halton Palliative Care Team Quality Review Visit

Statements of Assurance from the Board – Review of Services

During 2023-24 the Trust provided and/or sub-contracted a wide range of community-based services (82 health services) to people in their own homes or from clinics predominantly in Warrington and Halton, and several surrounding areas identified on the Map of Services at the end of the report.

The Trust has reviewed all the data available to them on the quality of care in 100% of the NHS health services we deliver. The income generated by the health services provided and/or sub-contracted in 2023-24 represents 97% of the total income generated by the Trust for 2023-24.

Participation in Clinical Audit

During 2023-24 one national clinical audit covered relevant health services that Bridgewater Community Healthcare NHS Foundation Trust provides.

During that period the Trust participated in 100% of the national clinical audits which it was eligible to participate in.

The national clinical audit that the Trust was eligible to participate in during 2023-24 are as follows:

- National Diabetes Foot care Audit (NDFA) - (including Annual National Diabetes Audit (NDA) Integrated Specialist Survey)

The national clinical audit that the Trust participated in, and for which data collection was completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title of National Audit	Number of cases submitted to national audit as a percentage of the number of registered cases required by the terms of that audit
National Diabetes Audit - Adults (foot care)	100%

No national clinical audit reports were received by the provider in 2023-24 and due to the delayed timescales from the National Bodies to publish reports, the following audits we participated in during 2023-24 will be published as follows:

Title of National Audit	Findings and Actions
National Diabetes Audit - Adults (foot care)	7-year data collection restarted in April 2022 – due 2029

The Trust participated in eight local clinical audits during 2023-24. The provider reviewed three completed audit reports and intends to take actions to improve the quality of healthcare provided.

Participation in Clinical Research

The number of Trust staff and patients receiving relevant health services provided or subcontracted by Bridgewater Community Healthcare NHS Foundation Trust in 2023-24, who were recruited during that period to participate in research approved by a research ethics committee was 352.

Goals agreed with Commissioners - Use of the CQUIN Payment Framework

In 2022/23 the Commissioning for Quality and Innovation (CQUIN) payment framework was reintroduced following the Covid-19 pandemic. In 2023/24 there were four CQUINs applicable to the Trust as detailed below:

CQUIN number	Detail	Compliance	
CCG 01	**Influenza**	Q1	N/A
		Q2	N/A

	Achieving between 75-80% uptake of flu vaccinations by frontline staff with patient contact. **Comments:** Although this figure is lower than the CQUIN minimum target of 75%, and lower than what the Trust aspires to achieve, across the Cheshire and Mersey, and Greater Manchester regions, flu uptake has been significantly lower this year than previous years. However, of the sixteen providers across both regions, Bridgewater is the joint 3rd highest vaccinator. In total, 846 flu vaccinations were given by the Trust. At the end of the flu season 2023/24, the Infection Prevention & Control (IPC) team plan to undertake a survey as completed in 2022/23 to try and understand low uptake of the flu vaccination to see if there is anything that can be done differently next year to improve compliance. Vaccinations for 2024/2025 flu programme were ordered in September 2023: 1100 QIVC vaccine and 40 AQIV (over 65's) vaccine. A lower order amount was placed this year to reflect the previous year's uptake and to help minimise waste / costings.	Q3 Q4	54.2% 56%
CCG 14	**Malnutrition screening in the community** Achieving 70-90% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24, with evidence of actions taken against identified risks. Bridgewater has a stretch target of 90%.	Q1 Q2 Q3 Q4	100% 88.16% 93% 79%
CCG 13	**Assessment, diagnosis, and treatment of lower leg wounds** Achieving 25-50% of patients with lower leg wounds receiving appropriate assessment, diagnosis, and treatment in line with NICE Guidelines. Bridgewater has a stretch target of 75% to be achieved by the end of Q4 2023-2024 **Comments:**	Q1 Q2 Q3 Q4	64.7% 85.51% 85.51% 78.69%

	Whilst the minimum target has been achieved in quarters 2, 3 and 4, work is continuing to further improve compliance.		
CCG12	**Assessment and documentation of pressure ulcer risk** Achieving 70-85% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. Bridgewater have a stretch target of 90% to be achieved by the end of Q4 2023-2024. Data for Q2 is low, as during this time there was a transition from paper records to Electronic Patient Records (EPR). Data for Q3 was reviewed and an anomaly was identified in the comorbidity question therefore, the data was resubmitted, and the correct data is now presented.	Q1	100%
		Q2	46.5%
		Q3	93%
		Q4	93%

Good progress has been made in all areas, and the majority of targets being met for Q4. Lower Flu vaccinations, represent a national trend. In 2024-25, work will continue to ensure the good practice continues and is embedded. Ultimately improving the quality of care for our patients.

Care Quality Commission (CQC)

Bridgewater Community Healthcare NHS Foundation Trust is required to maintain registration with the Care Quality Commission (CQC) and its current registration status is full and unconditional.

The Trust last underwent a comprehensive Well-Led Inspection in September 2018. The report was published on 17th December 2018 and demonstrated a significant improvement since the 2016 inspection with several service lines and domains in the year achieving an improved rating of 'good'. Due to the weighting given to the inspection at Trust level, the overall rating for the Trust remains as **Requires Improvement.**

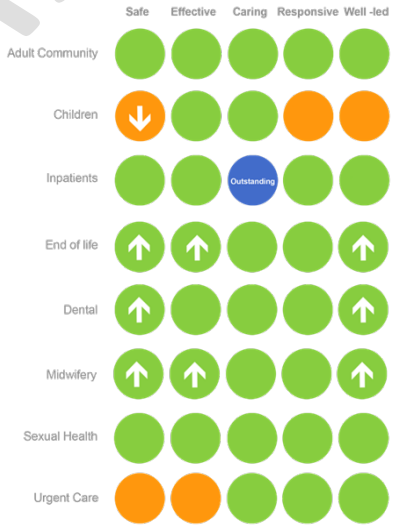
In 2023 the Trust commissioned an independent 'Well-Led' Review by Facere Melius, a healthcare improvement consultancy who focused on corporate, quality, and safety governance. This was because the last CQC inspection was in 2018 and due to the COVID pandemic, all CQC inspections were suspended, and the 2018 inspection was now 5 years out of date.

The team from Facere Melius examined many Trust documents ranging from Board papers (both public and closed) and Committee Team and Trust Council meeting reports and papers. Several meetings were observed including board strategy sessions. Over thirty face to face and video interviews were completed with Board, staff, and external partners.
The 2023 report was presented to the Trust Board in June 2023 with only nine recommendations of which the Board received with positivity.

As part of their conclusions, they wrote:

'Accountabilities and responsibilities are understood, and senior leaders are appropriately held to account. The trust is developing its assurance performance framework to support the wider understanding of accountability. This will undoubtedly help support good governance within the trust, and support for the sub-directorate tier will need to be put in place as this is implemented'.

No specific concerns have been raised by the CQC in 2023/24 and the Trust continues to meet all the requirements of our registration. The CQC has not issued any regulatory enforcement notices to the Trust.



SEND Inspection

In November 2023, a Special Educational Needs and/or Disability (SEND) inspection took place in the Halton.

A **SEND (Special Educational Needs and Disabilities)** inspection evaluates arrangements for all children and young people aged **0 to 25** who fall under the **SEND code of practice**. This includes those with an **education, health, and care (EHC) plan** as well as those receiving **special educational needs (SEN) support**[1]. The inspection focuses on assessing how these arrangements are identified, assessed, and met within the local area. Inspectors work jointly from **Ofsted** and the **Care Quality Commission (CQC)**.

Following any inspection, a priority action plan has been developed to address the identified areas for priority action, led by the Halton Borough Council and NHS Cheshire and Merseyside Integrated Care Board (ICB), including:

Priority 1 - Strategic Oversight and Governance

Priority 2 - Cohesive communication / joined up systems.

Priority 3 – Joint Commissioning

Priority 4 – Early identification of need and access

Priority 5 – Education Health and Care Plans

For Bridgewater, the report highlighted good practice within the school nursing service:

'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'.

Learning from Deaths

The Trust Board recognises that effective implementation of the Learning from Deaths Framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high-quality sustainable services to patients and service users.

Each unexpected death reported and reviewed in 2023/24 has been analysed and investigated appropriately in line with the Trusts Learning from Deaths Policy, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

Of the deaths 56 deaths reviewed and closed under the Learning from Deaths policy in 2023/24 none were associated with any care delivery concern or harm caused by services provided by the Trust. Duty of Candour was not applicable in any of these cases. There were no concerns raised from the deceased family/carers and no concerns raised by staff about the care that Bridgewater delivered to patients who died.

Some themes were identified as learning for the Trust, including communication with partner agencies and documentation/record keeping.

An example being that tasks/requests sent to GP practice should be followed up by a phone call to ensure that the information is reviewed and acted upon in a timely manner.

Another being that all staff should ensure that they complete Mental Capacity assessments with patients who lack capacity and complete a Best Interest decision with appropriate others.

NHS Number and General Medical Practice Code Validity

Bridgewater Community Healthcare NHS Foundation Trust submitted records during 2023-24 for inclusion in relevant national datasets.

The percentage of records in the latest published data (December 2023) which included the patient's valid NHS number was:

Data set	Bridgewater Compliance	National Average
Community Services Data Set	100.00%	81.03%
Emergency Care Data Set	100.00%	81.03%
Mental Health Services Data Set	100.00%	81.03%

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

Data set	Bridgewater Compliance	National Average
Community Services Data Set	100.00%	100.00%
Emergency Care Data Set	99.00%	86.01%
Mental Health Services Data Set	100.00%	86.01%

Information Governance

Information Governance provides the framework to enable staff to deal consistently with the various rules, laws, and guidance in relation to how information is handled. Ensuring the security of Trust information requires engagement from individuals, teams, service, and departments. For example, information asset owners, service / department managers, Estates, Facilities and Procurement. Information Governance covers the whole range of processing of information. From personal information, such as information relating to patients, and employees and corporate information such as financial and accounting records, policies, and contracts.

To ensure our staff, patients and service users know how we handle their information we have up to date Privacy Notices including a bespoke Privacy Notice for the children who attend our services.

The Digital Information Governance and Information Technology (DIGIT) group has set out the Trust's Digital Strategy and has plans in place for this to be achieved.

The Trust, like all organisations who process health information must be registered with NHS England's Data Security Protection Toolkit (DSPT). The Trust achieved 'standards met' in for the last couple of years.

The DSPT is also a place where health organisations report a serious data security breach. Any breach that affects the rights and freedoms of individuals is investigated by the Information Commissioners Office (ICO).

The Trust has not reported any serious incidents within the last 12 months.

Clinical Coding Error Rate Validity

Bridgewater Community Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2023-24 by NHS Improvement.

Statement on Relevance of Data Quality and Actions to Improve Data Quality Validity

Bridgewater Community Healthcare NHS Foundation Trust will be taking the following action to improve data quality.

The Trust recognises the need to ensure that all Trust and clinical decisions are based on sound data and has several controls in place to support the process of ensuring high quality data.

The Trust uses Mersey Internal Audit Agency (MIAA) to audit performance and performance management processes. The overall objective of the audits is to provide assurance that the Trust has an effective process-controlled system for performance reporting and ensure that mitigating plans are in place to achieve maximum performance and support patient quality.

The Trust has continued to be proactive in improving data quality by providing:

- Implemented successful updates to national submissions to reflect latest version standards.
- Set up Data Improvement sessions across all services - initially targeting waiting lists validation and best practice in data inputting.

- Worked with our 0-19 services to implement improvements to universal pathway recording which facilitates the split of Health Visiting and School Nursing activity flowing through national data sets.
- Development of Self-serve Qlik Sense reports to drive maximum achievement of timely record completion.
- Written and implemented a new Data Quality Policy whilst establishing new data quality steering group that feeds into Trust committees, complimenting existing governance processes.

Reporting against Core Indicators

In accordance with NHS England requirements, Bridgewater Community Healthcare NHS Foundation Trust is able to provide data related to the following core indicators using data made available by NHS Digital.

Friends & Family Test (FFT)

Core Indicator Staff Friends & Family Test	Bridgewater 2020	Bridgewater 2021	Bridgewater 2022	Bridgewater 2023	National Average for Community Trusts 2023	Highest Community Trust 2023	Lowest Community Trust 2023
If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation **(Question 25d NHS Staff Survey)**	78.1%	77.6%	79.2%	80.5%	77.1%	84.1%	50.9%
% Of staff that would recommend the Trust as a place to work. **(Question 25c NHS Staff Survey)**	60.2%	57.5%	57.6%	64.9%	68.3%	46.0%	55.9%

The Trust intends to take the following actions to improve these scores further, and so the quality of its services by:

- Reimaging the Staff Engagement Champions so they become People Promise Champions and People Promise Ambassadors. This will help deliver the importance of the NHS People Promise and the link this has to the NHS Staff Survey each year and the regular National Quarterly Pulse Survey
- Trust-wide Corporate and Directorate specific NHS Staff Survey Action Plan templates have been created. These plans are not about quantity of information written down, they are more about the quality of that information and the assurance given in fulfilling any said actions.
- All action plans, whether Trust-wide or Directorate, will be used to demonstrate improvements over the next 12 months. These plans will be carefully monitored through various Trust governance channels.
- The National Quarterly Pulse Survey (NQPS) runs during the months of January (Q4), April (Q1) and July (Q2). It also asks colleagues if they would recommend Bridgewater to their family and friends as a place of work and receive treatment. The survey is anonymous and enables colleagues to add their feedback / comments when responding. The results of these survey are fed back into the regular People Operational Delivery (POD) Council and are displayed on the MyBridgewater extranet.
- In addition to the NHS Staff Survey, the NQPS provides Bridgewater with four temperature checks per year to monitor progress and consider staff feedback.

Patient Safety Incidents

Core Indicator		2019-20	2020-21	2021-22	2022-23	2023-24
The number and, where available, rate of patient safety incidents reported within the Trust during 2023/24, and the number and percentage of such patient safety incidents	The number and, where available, rate of patient safety incidents reported within the Trust during 2023-24.	5,402 incidents were reported. 2,661 incidents (49%) were reported to NRLS*	4,887 incidents were reported. 2,062 incidents (45%) were reported to NRLS*	4,676 incidents were reported. 1,884 incidents (40%) were submitted to NRLS*	4,407 incidents were reported. 1,600 incidents (36%) were submitted to NRLS*	4,157 incidents were reported. 1,672 incidents were reported to NRLS* 1,007 incidents were reported to LFPSE**
	The number and percentage of such	There were 7 incidents reported that resulted	There were 2 patient safety incidents	There were 0 patient safety incidents	There were 0 patient safety incidents	There were 0 patient safety incidents

that resulted in severe harm or death	patient safety incidents that resulted in severe harm or death	in severe harm / death, 3 of which met the criteria for a patient safety incident.	reported that resulted in severe harm to patients	that resulted in severe / harm death to patients	that resulted in severe / harm death to patients	that resulted in severe / harm death to patients

** NRLS -National Reporting and Learning System.*
*** LFPSE – Learning from Patient Safety Event service, the Trust transferred from the NRLS to LFPSE on 04th October 2023.*

During 2023-2024 the Trust implemented the following which have impacted on the reporting and management of patient safety incidents: -

a) Learning From Patient Safety Event (LFPSE) service – which was implemented on 04th October 2023. This is a new national service which is replacing the National Reporting and Learning System (NRLS)
b) Patient Safety Incident Response Framework (PSIRF) – which was implemented from 22nd November 2023. PSIRF replaces the Serious Incidents Framework (2015)

Both developments have impacted on the Trust's arrangements for the reporting and management of incidents.

The Trust considers that the data for 2023-24 is as described for the following reasons, compared to 2022-23:

- During 2023-24, 4,157 incidents were reported. These were submitted to national portals as follows: -

Between 01st April 2023 to 03rd October 2023, 818 of these were submitted to the National Reporting and Learning Service (NRLS) as patient safety incidents.

- Following transition to Learning from Patient Safety Event (LFPSE) service on 04th October 2023, the Trust reported 1,007 patient safety incidents that related to Bridgewater services to the LFPSE portal.
- There were zero patient safety incidents reported as resulting in severe harm or death. The gradings for the severity of outcomes, are challenged as part of the Trust's incident management processes, to ensure that the recorded severity reflects the harm for which the patient sustained, opposed to the clinical outcome for the patient.

- Compared to 2022-23 the volume of reported patient safety incidents has decreased by 250 (5.6%)
- The Trust continues to encourage staff to report incidents, to prevent recurrence of incidents where possible and to promote opportunities to support staff learning and support service improvement.
- The Trust has maintained provision of a virtual training package for reporting and management of incidents, which is designed to ensure that staff are aware of the Trust's processes.
- Until 01st November 2023, despite considerable service pressures, the Trust continued to hold weekly Patient Safety Groups and Serious Incident Review Panels, which were also used as an opportunity for interested staff to observe the process of managing incidents.
- The Trust implemented the Patient Safety Incident Response Framework (PSIRF), on 22nd November 2023, this resulted in new governance structures being introduced for the oversight of incidents. These include weekly Directorate Incident Review and Learning Groups (DIRLG's), three Local Incident Priority Groups and an overarching Trust panel called PSIRFaLP
- The DIRLG's meet weekly to ensure that incidents are being managed correctly, including the proportionate use of learning resources.

The Trust considers that this data is as described for the following reasons, compared to 2022-23:

- During quarter 1 (Q1) there was a decrease in the number of patient safety incidents reported, when 342 incidents were reported compared to Q4 of 2022-2023, when 404 patient safety incidents were reported in the Trust. The decrease during Q1, was not statistically significant as the monthly numbers of reported incidents throughout the year were within the expected upper and lower control limits, for the numbers of reported patient safety incidents.
- The overall number of patient safety incidents in 2023-24 decreased. The ratio of No Harm incidents (Near Miss, Insignificant outcomes) was 46% of the total number of patient safety incidents reported. This compares with 2022-2023 when 45% of the reported patient safety incidents did not result in any harm to the patients. This highlights the need for ongoing work to encourage the free and open reporting of all incidents by the staff in the Trust.
- The number of Serious Incidents reported in 2023-24 (prior to implementation of PSIRF) was 23. The most frequently reported type of incidents were pressure ulcers that developed during care provided by the Trust, which accounted for 20 cases. As this related to the period prior to PSIRF implementation, it only relates to a portion of the year and cannot be used as a comparator with the previous year.
- The Trust is providing virtual training regarding the reporting and management of incidents. This process will continue to enhance the Trust's incident reporting

culture, by ensuring that there is increased knowledge of the processes for reporting and management of incidents.

- The Trust has implemented levels 1 & 2 of the national patient safety training programmes, the Trust elected to make these mandatory for its staff. These provide a good vehicle to increase awareness of the value of reporting incidents.

The Trust has taken the following actions to improve this data and indicators, and so the quality of its services, by:

- Weekly Directorate Incident Review and Learning Groups, which have replaced the Borough / service specific Patient Safety Group meetings. These meetings are held to ensure that there is an effective overview of all reported incidents in the Directorates. These review meetings ensured that all incidents were reported and managed correctly depending on the nature and severity of the incident and were chaired by the Director of Nursing (or equivalent) for the relevant Borough/service.
- From November 2023, these meetings were replaced by the weekly Directorate Incident Review and Learning Groups, which provide a directorate specific focus on the reporting and management of incidents. These meetings are chaired by the relevant Director of Nursing / equivalent post.
- At each DIRLG, there is an opportunity to focus and challenge the reporting and management of incidents in the directorate.
- A 'virtual' training program remains in place regarding the 'Reporting and Management of Incidents.' This is designed to give staff knowledge of the Trust's arrangements for the reporting and management of all incidents. This is supplemented by one-to-one support sessions involving incident managers, and the Risk Team to address specific concerns regarding use of the Trust's Risk Management system.
- Maintaining support for incident investigators and managers, through regular peer review. Review of investigations at the Directorate Incident Review and Learning Groups (Patient Safety Group prior to 01 November 2023) and Serious Incident Review Panel(s)
- Ensuring that risk management processes are embedded, in the operational Boroughs/ services. This is achieved by ensuring that there is regular challenge of risks to allow the Trust to be assured that risks are identified and are being managed to a satisfactory standard. Management of risk is challenged at the monthly Risk Management Council
- Ensuring the continued routine scrutiny of incidents on a daily, weekly, and monthly basis by the Risk Team and Directorate Incident Review and Learning Groups and ensuring the active involvement of senior clinicians to increase data quality and accuracy. The Trust has previously gained assurance regarding the

quality of reported incident data from the data quality reports prepared by the NRLS, these will be replaced by reports generated by the LFPSE

- Maintaining the production of daily, weekly, and monthly automated aggregate reports regarding incidents to assist the Trust's managers and staff to manage the incidents that have occurred in their respective areas of the Trust
- Before the implementation, the Patient Safety Incident Response Framework (PSIRF), the Trust regularly met representatives of our commissioners to oversee ongoing investigations.
- The Trust has remained in contact with commissioner representatives, regarding completion of actions arising from historic incidents. Commissioners now gain assurance about the safety of the Trust from oversight and participation in the Trust's governance structure for patient safety incidents.

QUALITY ACCOUNT
PART 3

Part 3 – Looking Back Over the Year 2023-24

At Bridgewater Community Healthcare NHS Trust, we are proud of our dedicated staff and teams who work hard to maintain a safe, effective, and caring services to our patients and service users. Throughout 2023/24 there were a lot of achievements both at local, regional, and national level. Below are some examples of those achievements.

Bridgewater awarded National Preceptorship for Nursing Interim Quality Mark

Bridgewater is committed to providing newly qualified colleagues with a structured preceptorship programme which supports their move into community care and provides a solid foundation for lifelong learning.

The National Preceptorship Team has awarded us this quality mark for our nursing preceptorship as it reflects the high quality of preceptorship offered at Bridgewater.

Valid for two years, the Trust will be able to promote this achievement and quality mark to further shout loud about our preceptorship programme.

Our thanks go to the following colleagues: Philip Mumberson, Karen Lea, Yvonne Ball, Susan Burton, Jo Waldron, Jeanette Hogan and members of the multi-professional preceptorships task and finish group, and our nursing teams including preceptors and preceptees.

Speaking about the achievement, Karen Lea and Yvonne Ball, Clinical Practice Educators, said:

"We are delighted to have been recognised for the hard work in developing and implementing a successful preceptorship programme that supports newly qualified community nurses within Bridgewater."

The awarding panel said it was very clear that Bridgewater provides an exceptional Preceptorship experience for our early career professionals.

Urgent Community Response service wins national award.

Bridgewater Community Healthcare NHS Foundation Trust has received a prestigious national award after being honoured for their work in preventing older people and adults with complex health needs from being admitted to hospital.

Paul Sinha from TV Quiz The Chase, Lydia Vallance-Prentice, Clinical Lead, HICAF, Liz Gibbons, Advanced Clinical Practitioner, HICAF, Jillian Wallis, Associate Director of Halton Adult Community Services and Jane Hadfield, National Lead, Talent for Care and NHS Apprenticeships, NHS England.

As an integrated partnership between Halton Borough Council and St Helens and Knowsley NHS Trust; the Halton Urgent Community Response (UCR) service provides tailored care for patients who would have traditionally only been offered treatment within a hospital setting.

The service not only creates seamless care for patients inside and outside of hospital, but helps with timely discharges and prevents admissions, enabling patients to remain in their own homes.

An expert panel of judges praised Halton UCR highly for helping to improve standards of care across the region.

Feedback from patients has been excellent with a 98% level of satisfaction reported across the provision.

Excellent patient feedback is mirrored by staff. 95.2% of the staff in the new team said that they felt their role made a difference to patients/service user care. A further 97.1% said that they feel valued in their role.

Speaking at the award ceremony Lydia Vallance-Prentice, Clinical Lead for Halton Integrated Care and Frailty Service at Bridgewater Community Healthcare, said:

"It's a great achievement to win this award. The whole team are fantastic in the way that they work closely together to ensure that seamless care is provided to individuals to prevent hospital admissions."

Community Health & Wellbeing Workers

Bridgewater's Community Health and Wellbeing Workers have made it their aim to help improve the mental and physical health of people living in the Oakwood area of Warrington.

That can mean reaching out to people before they even realise, they need them, preventing ill health before it happens. You might have seen a member of the team knocking on a door near you.

Discover how they could help you, by watching this short film about the difference they're already making to other people in your area.

Our Community Health and Wellbeing Workers provide a listening ear, signpost people to the help and support available, and give them the time and space to share any concerns or anxieties they may have.

One Oakwood resident said of a Community Health and Wellbeing Worker:

"I was in a really, really bad way at the time, diagnosed with fibromyalgia, long covid, mental health issues and then she came out to see me – and she completely changed my life."

Meanwhile another resident said:

"She came in and we got chatting and I didn't think, not that I didn't need help, but that I wasn't there for it, that it wasn't for me… I was just like, in a bubble, just in my own bubble. It's made a huge, huge difference."

Sam Ollerenshaw, Community Health, and Wellbeing Worker Manager, added:

"It's fabulous to see and hear about the work being done and the difference being made by our staff."

If you live in the Oakwood area and feel that you or a family member might benefit from meeting up with a Community Health and Wellbeing Worker, simply give them a call!

Drive Ability Northwest celebrates 30 years supporting people to stay mobile and independent.

Photograph (L-R): Deborah Murgatroyd (Clinical Lead Occupational Therapist), Jabeen Bowes (Approved Driving Instructor), Ken Bullas and wife Gail Bullas.

Over this time, this free NHS service, which is commissioned by charity Driving Mobility and the Department of Transport, has benefitted countless people across the Northwest.

Being able to use a car is invaluable, and for many it is essential to their wellbeing – especially people with restricted mobility or a disability.

Drive Ability Northwest's Occupational Therapists and Approved Driving Instructors support people with medical conditions, disabilities, and those affected by old age, to drive safely and maintain or regain their independence as drivers or passengers.

The anniversary showcase, at Haydock Park Racecourse was attended by staff and service users past and present, as well as healthcare and voluntary sector personnel, eager to discover how the service can help the people they care for.

Truly interactive, the day featured driving demonstrations, presentations, and a talk by Merseyside Police, who are working in partnership with the service on a new joint initiative supporting vulnerable road users to drive more safely.

Speaking at the occasion, Colin Scales, Chief Executive of Bridgewater Community Healthcare NHS Foundation Trust said:

"Drive Ability Northwest is a prime example of how we as a NHS Community Trust work successfully in partnership with organisations like Driving Mobility and Merseyside Police, to deliver specialist services into the heart of our local communities.

"For the past 30 years this service has helped to improve the safety, independence and quality of life of so many people."

It turned out to be a double celebration on the day, as Clinical Lead Occupational Therapist Deborah Murgatroyd celebrated her own 30 years of working for Drive Ability Northwest.

Praising the work of Deborah and her NHS colleagues, Ken Bullas, who was supported by the service to return to driving following a stroke, said:

"My wife contacted Drive Ability Northwest because we knew how important it was that I was still safe to drive.

"The staff really listened to our worries and after I'd been assessed, I was so happy when I was told I could still drive. I can't walk very well, but having the car, it's like a new chapter of life, it's given me my independence."

Jabeen Bowes, an Approved Driving Instructor at Drive Ability Northwest, added:

"It means a lot to have Ken here with us celebrating 30 years of the service. We go on a very important journey with our patients, and I really did with Ken. It's so worthwhile when you can see the results of what you do and how you make a difference."

For further information, please visit the Drive Ability Northwest website at bridgewater.nhs.uk/drive.

Safeguarding Team

Commissioners Service Excellence Award for MASH Team

During Q1 Warrington Multi Agency Safeguarding HUB (MASH) team were nominated for and awarded the Commissioners Service Excellence Award by Cheshire Police. In nominating the MASH Sgt Cal Cuerden recognised the strong partnership working within the MASH and the impact this had on him as he developed within his role.

The award is a fitting tribute for all the hard work achieved by all multi-agency partners within the MASH as well as the support provided to 'health' screening processes in MASH by Bridgwater wider Children's Safeguarding Team.

Westminster Abbey Celebrations

On Wednesday 5th July 2023, the Lead CIC Nurse attended a ceremony at Westminster Abbey to celebrate the 75th anniversary of the NHS. Her attendance followed a nomination made by the Trusts Head of Safeguarding which recognised how Halton's CIC team had used feedback received from a Halton care leaver to shape the development of their service offer. She was accompanied by the care leaver in question as well two other staff members from the wider Trust.

The event, held on the actual day the NHS was created three quarters of a century ago, was a big thank you to health service staff and volunteers, past and present.

Prior to travelling down to London for the ceremony, staff attending the ceremony on behalf of the Trust met with Trust Chief Executive Colin Scales as he congratulated them on this national recognition, saying:

"*We're incredibly proud of all our colleagues, but this honour is about you as individuals.*"

"*I'm thrilled that you've been recognised for all the amazing work you do and the absolute dedication you've shown to serving the health needs of our community, here at Bridgewater.*"

The group travelled to London via train the day prior to the ceremony so that an early start the next morning was possible. This allowed for some time to explore the city, which the young person particularly enjoyed as he had never visited London before! The group were lucky enough to explore the surrounding areas of Westminster following the ceremony and even managed a brief visit to Buckingham Palace and Covent Garden for a spot of lunch! During the ceremony, following the prime minister's speech and whilst taking in the breathtaking views of the abbey, the young person commented to the Lead Nurse "*How lucky are we to be singing the National Anthem in Westminster Abbey, not many people can say that's something they have experienced!*"

"A critical function, the Safeguarding Adults team have made safeguarding a core business across the Trust. Giving professional, high-quality supervision and advice, the team always remain kind and considerate in their work as they deliver safeguarding support and supervision to frontline teams".

Safeguarding Conference

In November 2023 Bridgewater hosted its first annual safeguarding conference and what a magnificent event it was. The theme of this one-day event was 'All Age Exploitation'. In the morning Practitioners from across both adults and children's services within Bridgewater participated in sessions on 'Trauma informed practice', 'Pan Cheshire All Age Exploitation Strategy' and 'Creating Safer Organisations' whilst in the afternoon Manchester based Lad's Like Us' held the room as they shared their own experiences of exploitation, healing journeys and key messages #ASKWHY.

Comments included:

"I definitely feel more capable of considering the impact trauma can have on people when I am having conversations with them".

"Invaluable knowledge gained".

Overall, a great start on which to focus our thoughts for the next conference in 2024.

Trust Annual 'Thank You' Awards

During 2023/24 the Trusts annual 'Thank You' Awards had a special twist, as the Trust helped celebrate 75 years of the NHS.

Our annual celebrations acknowledge the huge contribution that our staff make to local people. Every year it gets harder to choose a winner but for 2023/24 our winners were:

NHS 75 Award

Awarded to the entire workforce of Bridgewater Community Healthcare

In this special anniversary year, the NHS is admired globally, and everyone at BCHFT plays a part in that. The Trust Chair, Karen Bliss and CEO, Colin Scales wished to recognise and thank colleagues for the work they do day in, day out. Acting as one big team, this award was accepted on behalf of the BCHFT workforce by one of the newest members of the organisation, Degree Nurse Apprentice, Stephanie Carruthers and Deborah Murgatroyd, Clinical Lead Occupational Therapist for Drive Ability Northwest, who has served in the NHS for over thirty years.

Chair's Award

Warrington Wheelchair Service

Warrington Wheelchair Service work to provide a safe environment in which people with mobility issues can be assessed and provided with the equipment they need to live a more independent life. The team consistently go the extra mile for patients, with just one example being the rescue of a stranded patient whose only working wheelchair was in a car boot within a locked garage. Showing heart, tenacity and compassion, the team worked well over their schedule to also ensure the patient's wheelchair was fixed within just two hours.

Clinical Employee of the Year

Kathryn Philips - Medication Safety Officer

An important role at the Trust, as Medication Officer Kathryn is involved in many work-streams. Described as an advocate for staff and patients alike, as well as an amazing role model, Kathryn is known for her warm, open communication with secondary care teams to greatly improve patient outcomes. Her colleagues describe her as a superhero in disguise, with Bridgewater a better place for having her in it.

Non-Clinical Employee of the Year

Joan Ward - Multi-Disciplinary Team Case Co-ordinator, Halton Children's Specialist Services

Joan brings a wealth of experience to her role at the Trust, with her level of specialist knowledge having helped to secure additional funding. Her team describe her as having excellent forecasting skills, which help them to plan and embrace any challenges that may come their way. Most of all, Joan is known for her special ability to create calm on a day-to-day basis, a quality her colleagues all recognise and welcome.

Clinical Team of the Year

Joint winners - Paediatric Audiology, Halton and Paediatric Bladder and Bowel, Warrington

- Showing true commitment to their patients, the Paediatric Audiology team in Halton have excelled in decision making around how they can deliver a quality service. As part of this, they have even started a Saturday clinic for their patients.
- Over in Warrington, the Paediatric Bladder and Bowel team have worked tirelessly to deliver waiting list targets, whilst at the same time providing excellent care to children and their families.

Non-Clinical Team of the Year -

Joint winners - The Community Equipment Service and Safeguarding Adults Team

- Compassionate and dependable, the Community Equipment Service ensure that patients have the equipment necessary to support their day-to-day living. As such, they are pivotal in supporting patient care across Halton, Warrington and St Helens in Social and Healthcare, Children's, and Adults.
- A critical function, the Safeguarding Adults team have made safeguarding a core business across the Trust. Giving professional, high-quality supervision and advice, the team always remain kind and considerate in their work as they deliver safeguarding support and supervision to frontline teams.

Research and Innovation Award -

Joint winners - Wendy Gardener, 0-19 Practice Development Lead and Warrington Neuroscience Service

- As the 0-19 Practice Development Lead, Wendy is behind the new, innovative, and unique Digital Healthy Weight Care package for children and families in Warrington, which has already been nominated for a national award.
- Dedicated to fair access to healthcare for all, the Warrington Neuroscience Service recently successfully applied for funding for two projects which address inequality in Warrington and help develop the services they offer their patients. Both are patient centred, innovative, and forward thinking.

Partnership and Collaboration Award -

Drive Ability Northwest

Drive Ability Northwest support people to who have a medical condition, a disability, or feel older age is affecting their ability to drive, helping them to drive safely and maintain or regain their independence as a driver or a passenger. They have partnered with three police forces, two fire and rescue services and two government agencies to support vulnerable road users, creating outreach centres and increasing patient access to other support networks. This year, they have already won a national award for their work with Merseyside Police.

Kindness and Compassion Award -
Oldham Community Dental team

The Oldham Community Dental team demonstrated their commitment to care not just for their patients, but their families, after a moment of crisis which began when a patient's mother became ill during his treatment. This led the team to support the family through a journey involving numerous support services, all of which, happily, led to a positive outcome.

The annual Bridgewater 'Thank You' Awards were held at Haydock Park Racecourse. The event is only possible thanks to the kind support of its sponsors, who included: Eric Wright Facilities Management, NHS Professionals, CRP Group, NewZapp, Catalyst BI and Dentally.

NHS England Compliance

It is a requirement of NHS England that Trusts establish and effectively implement systems and processes to ensure that they can meet national standards for access to health care services. In 2023-24, several performance standards were measured in their assessment of the overall governance. These are summarised in the table below and demonstrates achievement against the threshold/target during each month of the year.

KPI Name	Target	Apr 23	May 23	Jun-23	Jul-23	Aug 23	Sep-23	Oct-23	Nov 23	Dec-23	Jan-24	Feb-24	Mar 24
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%	77.27% (▲)	86.67% (▲)	95.83% (▲)	90% (▼)	87.5% (▼)	88.46% (▲)	93.75% (▲)	87.5% (▼)	80% (▼)	83.33% (▲)	89.29% (▲)	92.59% (▲)
Warrington Dermatology Cancer 28 day faster diagnosis	75%	86.96% (▼)	82.91% (▼)	84.47% (▲)	87.57% (▲)	86.71% (▼)	89.74% (▲)	81.54% (▼)	87.61% (▲)	81.07% (▼)	80.72% (▼)	87.21% (▲)	93.22% (▲)
Elective % of patients waiting under 18 weeks RTT Non Admitted (Incomplete pathway)	92%	58.67% (▲)	67.55% (▲)	69.21% (▲)	65.29% (▼)	67.59% (▲)	65.39% (▼)	64.39% (▼)	58.88% (▼)	60.14% (▲)	57.28% (▼)	53.76% (▼)	55.66% (▲)
UTC: Total time in A&E (% of pts who have waited < 4hrs)	95%	96.8% (▼)	97.53% (▲)	98.42% (▲)	97.2% (▼)	98.53% (▲)	96.84% (▼)	94.62% (▼)	94.74% (▲)	86.59% (▼)	88.25% (▲)	93.71% (▲)	99.78% (▲)
Diagnostics Audiology Number of 6 weeks diagnostic breaches	0	67 (▼)	85 (▼)	77 (▲)	73 (▲)	87 (▼)	62 (▲)	98 (▼)	91 (▲)	55 (▲)	35 (▲)	33 (▲)	100 (▼)
Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%	99.73% (▶)	99.7% (▼)	99.7% (▶)	99.72% (▲)	84.52% (▼)	84.15% (▼)	84.67% (▲)	84.75% (▲)	83.99% (▼)	84.11% (▲)	84.28% (▲)	

The Trust is required to report on the length of time between referral to a consultant-led service and the start of treatment being received. Referral to Treatment time is the length of time between a patient's referral to one of our services to the start of their treatment.
The indicator is defined as the percentage of incomplete pathways within 18 weeks for patients at the end of the reporting period. The Trust has focused workstreams for services that are currently not meeting the 18-week RTT, these include Dermatology, Community Paediatrics Warrington & Community Paediatric Halton.
During 2024/2025 these pathways will be reported via the Community Health Services monthly Sitrep report. This is at the request of NHS England.

Cancer service

The Trust delivers Dermatology community-based cancer services to patients living in the Warrington area which is commissioned by Warrington place Integrated Commissioning Board (ICB).

The service continues to strive to achieve compliance in all areas of the cancer key quality indicators and continues to work with the Cheshire & Merseyside Cancer Alliance.

The service continues to strive to achieve compliance in all areas of the cancer key quality indicators and continues to work with the Cheshire & Merseyside Cancer Alliance. The service achieved the 62-day cancer standard, 87.67% threshold (85%) for March 2023 to February 2024 as the Cancer data is reported a month in arrears,

from referral to treatment (When cancer is first suspected, everyone should have a confirmed diagnosis and start treatment within 62 days).

The service has made significant progress towards the 28 Faster Diagnosis Standard (FDS). The target is that a patient should not wait more than 28 days from referral to finding whether they have cancer. The 28-day FDS target is set at 75%, the service has achieved this target 85.77% for March 2023 to February 2024 as the Cancer data is reported a month in arrears.
Where the cancer standard targets have not been achieved the Trust has implemented several strategies to improve performance this is captured within the Dermatology Trust improvement plan.

Freedom to Speak Up (FTSU)

Speaking Up is integral to enabling the Trust to continuously improve through demonstrating positive behaviours and living our values. When staff have the freedom to 'Speak Up,' they have psychological safety in their place of work and will feel able and safe to contribute diverse ideas and opinions about what is going well, or wrong and what should improve, be resolved, or done better.

Since January 2023 when a Lead Freedom to Speak Up Guardian was appointed, work has continued to further establish that the Speaking Up agenda should become 'business as usual' within the Trust. To continue to support staff, leaders, and managers, the Lead Guardian is supported by a second Guardian and a small network of Champions. Compared to other NHS Trusts, Bridgewater is relatively small but encompasses a large footprint as services are spread out across the Northwest. The number of Champions has recently doubled to nine and the aim for 2024 is to aspire to recruiting a total of 50 Champions from a range of services and job roles.

The FTSU cycle of Speak Up, Listen Up, Follow Up is integral to the Trust's core PEOPLE values of being:

- Person centred.
- Empowered
- Open and honest
- Professional
- Local
- Efficient

For staff to understand the vital role they play in ‘speaking up’ eLearning training is available which explains in a clear and consistent way, what speaking up is and its importance in creating an environment in which people are supported to deliver their best. The culture and processes that make Speaking up possible must be underpinned by the knowledge of how to Speak Up, to ensure Freedom to Speak Up is embedded in every service and every team. Making the training mandatory is a way of enabling this to happen and when it has been authorised the intention is to make the training mandatory before the end of 2024, for all staff.
The training is divided into three parts:

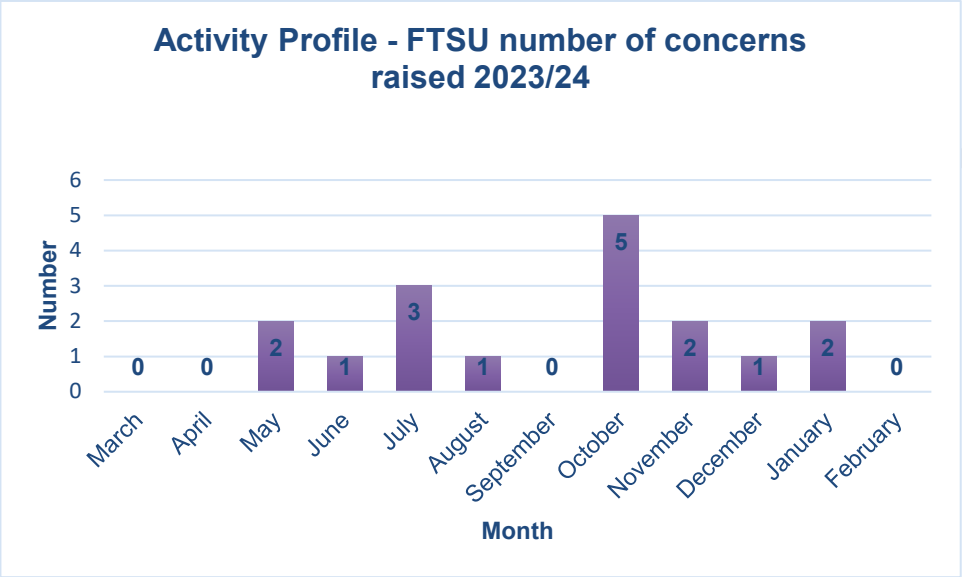
- **Speak Up:** Core training is for all workers including volunteers, students, and those in training.
- **Listen Up:** This training for all line and middle managers and is focussed more on listening up and the barriers that can get in the way of speaking up.
- **Follow Up:** This training is aimed at all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.

To embed the ethos of making speaking up ‘business as usual’ staff are also encouraged to speak up in other ways, linking to the NHS People Promise of ‘We each have a voice that counts.
Regular FTSU updates are included in the Trust’s Bulletin and information cascaded via ‘Team Brief’ which all staff can attend monthly. A quarterly Newsletter is also produced as another form of communication to staff and a way of feeding back learning and lessons learned.

Speaking Up activity, themes and trends of concerns raised to the FTSU Guardians are reported to the Trust Board, bi-monthly to the People Committee and quarterly to the National Guardian’s Office. To identify patterns, trends and potential areas of concern, the themes from speaking up cases will be compared with other data and information. This intelligence will be used to identify ‘hotspots’ were speaking up may.

be happening more or less often than expected, and to identify what aspects of patient safety and quality, worker well-being and culture need attention.

During 2023/24 (March 2023 to February 2024) a total of seventeen concerns have been raised with the FTSU Guardian, compared to 9 in 2021-22 – comparatively an increase of 88%. This has been attributed to the greater level of awareness raising activities undertaken during 2023, which also corresponded with Speaking Up month in October 2023.

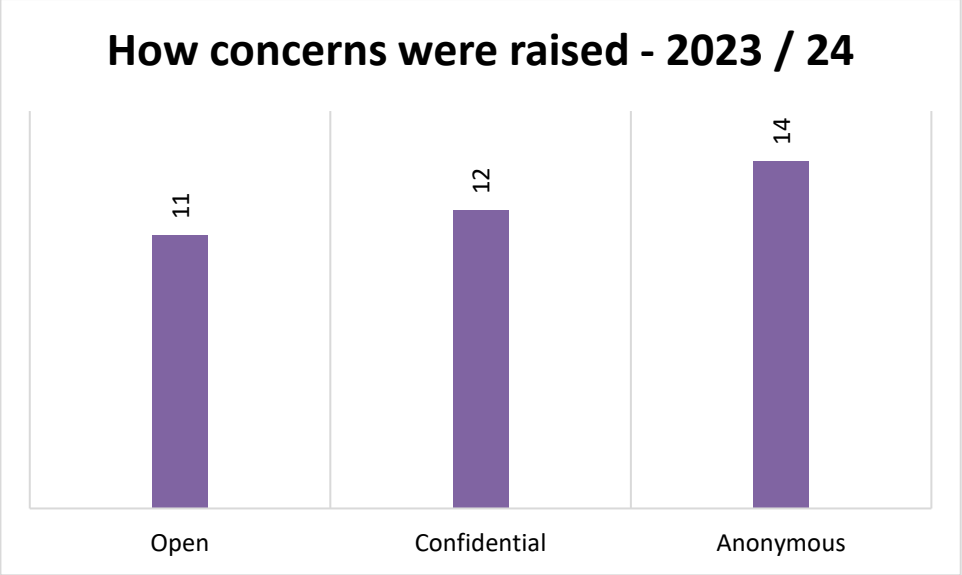


Unlike previous years of those concerns raised, the majority focused this time on behavioural / relationship issues and systems and process, instead of patient safety and quality- see table below. Whilst the main themes are detailed below, concerns raised continue to be multi-factorial and at times complex in nature.

From a worker category perspective, the main professional group reporting concerns are Registered Nurses – see table below. This reflects our overall workforce demographic as nurses make up the largest proportion of our workforce.

Following the raising of a concern through FTSU, recommendations might include self-management of next steps, FTSU intervention to facilitate resolution, or review or investigation.

However, due to the sensitive nature of some of the concerns raised some staff raising a concern as a collective concern wanted to remain anonymous whilst others in the same group wanted to remain confidential, hence why the numbers below appear higher than the number of concerns raised – table below.



It would appear that a high proportion of staff want to remain anonymous but on further scrutiny of the data, one concern raised anonymously was raised by a number of staff, hence why the number appears high.

Slightly more staff wanted to remain confidential than open. Evidence would suggest that staff raising concerns openly feel psychologically safe to do so and more work may need to be done to identify if there are barriers preventing staff from speaking up openly and how we can overcome them.

As part of quality improvement and to assess the effectiveness of the 'speaking up' process in achieving its intended aims, a new online FTSU staff evaluation form has been developed. The results will be used to make any improvements that are needed or to highlight good practice and have their say.

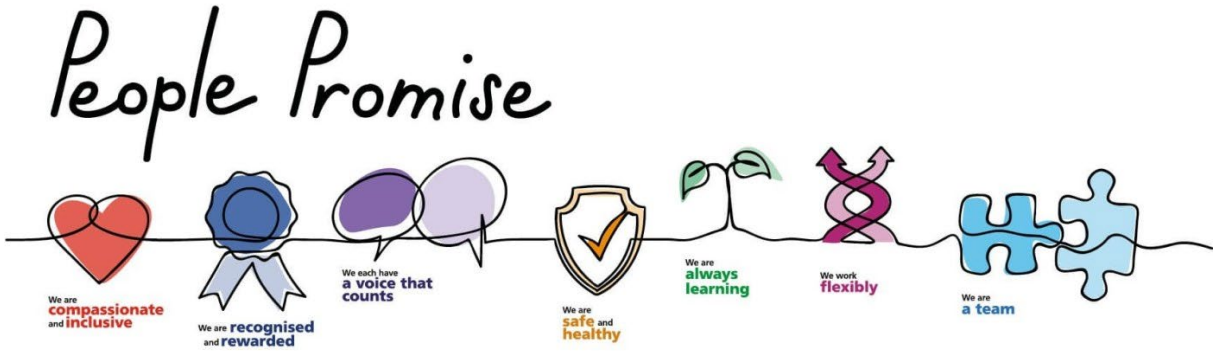
Staff Survey Results:

Despite it being 12-months of various ups and downs when it comes to our NHS challenges and pressures, the results showcase a good improvement for the organisation.

Do we have parts of the survey that fall short, and we need to improve? Yes absolutely. We are never complacent when it comes to the annual NHS Staff Survey. We will continue to work hard to improve on the areas that need greater support.

Before we get into the results themselves, this is now the third year in which the findings have been aligned to the seven elements of the NHS People Promise. This updated way of reporting is really starting to bring a consistent and robust way of

measuring employee experience across the NHS. If we also include the additional elements of 'staff engagement' and 'morale', it takes the overall reporting of the NHS Staff Survey to nine elements.



Trust Breakdown

In 2023 we conducted an all-staff electronic survey.

This meant all eligible colleagues were invited to take part by email. When the survey closed in late November, 62% of #TeamBridgewater colleagues had their say. This made it our best ever response rate to date. In 2022 the response rate was 56%.

The table below gives a very quick snapshot of our 2023 results, compared to the national average of NHS Community Trusts in England.

People Promise Element/ Theme	BCHFT 2023 score	Community Trust Average	Trust results v's Community Trust Average
We are compassionate and inclusive	7.8	7.8	0.0
We are recognised and rewarded	6.4	6.5	-0.1
We each have a voice that counts	7.2	7.2	0.0
We are safe and healthy	6.5	6.4	0.1
We are always learning	5.9	6.0	-0.1
We work flexibly	6.8	6.9	-0.1
We are a team	7.2	7.2	0.0
Staff engagement	7.3	7.3	0.0
Morale	6.3	6.2	0.1

As you can see from the graphic above, two of the nine elements show a positive increase, four remain static and three show a slight decrease.

The three elements that have shown a slight decrease will be the areas the organisation will focus on as part of its 2024/25 action planning. These are:

1. **We are recognised and rewarded.**
2. **We are always learning.**
3. **We work flexibly.**

Interestingly, the next graphic shows a comparison between the Trust's 2023 results and its 2022 results.

The sea of green highlights that all elements show an improvement. This really does reflect our positive journey of improvement.

People Promise Element/ Theme	BCHFT 2022 score	BCHFT 2023 score	Trust 2023 vs Trust 2022
We are compassionate and inclusive	7.7	7.8	0.1
We are recognised and rewarded	6.1	6.4	0.3
We each have a voice that counts	7.1	7.2	0.1
We are safe and healthy	6.3	6.5	0.2
We are always learning	5.3	5.9	0.6
We work flexibly	6.4	6.8	0.4
We are a team	7.0	7.2	0.2
Staff engagement	7.2	7.3	0.1
Morale	6.1	6.3	0.2

Regional Breakdown

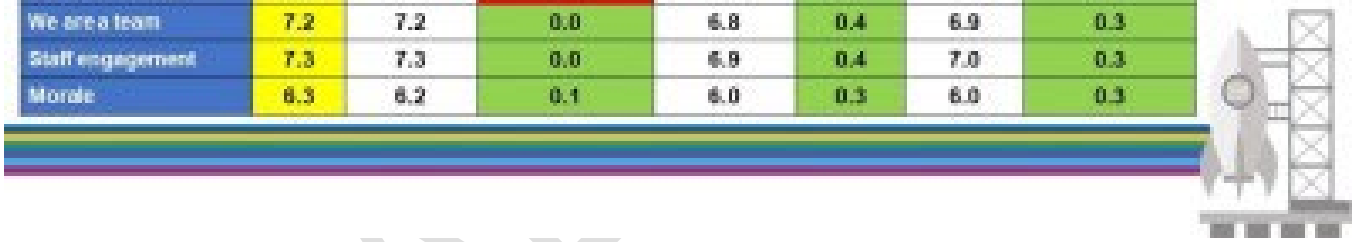
As we have reported previously, the data for Bridgewater Community Healthcare is compared to other Community Trusts up and down the country.

From a regional NHS Northwest geography and a regional Cheshire and Merseyside Integrated Care Board (ICS) geography (the ICS system we report into as an organisation), we are really pleased to say that once again Bridgewater is excelling

across the People Promise themes and the two elements of 'staff engagement' and 'morale'.

Knowing we are flagging green when compared to the averages of both NHS North-West and the Cheshire and Merseyside ICS is something we can be proud about today.

People Promise Element / Theme	BCHFT 2023 score	Community Trust Average	Trust results v's Community Trust Average	North West Average	Trust results v's North West Average	C&M ICS Average	Trust results v's CM ICS Average
We are compassionate and inclusive	7.8	7.8	0.0	7.3	0.5	7.4	0.4
We are recognised and rewarded	6.4	6.5	-0.1	6.0	0.4	6.1	0.3
We each have a voice that counts	7.2	7.2	0.0	6.8	0.4	6.8	0.4
We are safe and healthy	6.5	6.4	0.1				
We are always learning	5.9	6.0	-0.1	5.6	0.3	5.6	0.3
We work flexibly	6.8	6.9	-0.1	6.3	0.5	6.2	0.6
We are a team	7.2	7.2	0.0	6.8	0.4	6.9	0.3
Staff engagement	7.3	7.3	0.0	6.9	0.4	7.0	0.3
Morale	6.3	6.2	0.1	6.0	0.3	6.0	0.3



The full findings of the 2023 NHS Staff Survey, which includes two reports, can be found on the official NHS Staff Surveys website at www.nhsstaffsurveys.com/.

QUALITY ACCOUNT APPENDIX

Appendix A – Stakeholder Feedback

Quality Account Statement 2023-24

Bridgewater Community Healthcare NHS Foundation Trust

Appendix B – Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2023/24* and supporting Q*uality Account Requirements 2023/24*
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes for the financial year, April 2023 and up to the date of this report ("the period")
    - Papers relating to quality reported to the Board over the period.
    - Feedback from Commissioners
    - Feedback from Governors (not applicable for this iteration)
    - Feedback from local Healthwatch organisations (not applicable for this iteration)
    - The Trust's complaints report awaiting publication under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The 2023 staff survey published February 2024
    - The Head of Internal Audit's annual opinion over the Trust's control environment (not applicable for this iteration); and
    - Care Quality Commission inspection report, dated 17th December 2018
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- the performance information reported in the Quality Report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

regulations) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

NB: sign and date in any colour ink except black

(Chair)

Date: To be dated before publication

(Chief Executive)

Date: To be dated before publication

Appendix C – Glossary

BCHFT	Bridgewater Community Healthcare NHS Trust
CIC	Children in Care
CQC	Care Quality Commission – An independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality & Innovation - The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients
CSDS	The Community Services Data Set – pseudonymised patient based data and information for community services.
DSPT	Data Security and Protection Toolkit
DIGIT	Digital Information Governance & Information Technology
DIRLG	Directorate Incident Review & Learning Group
ECDS	Emergency Care Data Set – pseudonymised patient based data and information for emergency services (our UTC data).
EOL	End of Life Services - service provided by Bridgewater Community Healthcare Foundation Trust
EPR	Electronic Patient Record
FDS	Faster Diagnosis Standard
FFT	Friends and Family Test – introduced to help service providers and commissioners understand whether their patients are happy with the service provided.
FTSU **FTSUG**	Freedom to Speak Up Freedom to Speak Up Guardian
GP	General Practitioner
HV	Health Visitor
ICB	Integrated Commissioning Board

ICO	Information Commissioners Office - The UK's independent authority set up to uphold information rights in the public interest
LeDeR	Learning Disability Mortality Review - aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death and works to ensure that these are not repeated elsewhere.
LFPSE	Learning from Patient Safety Events Service
MARAC	Multi Agency Risk Assessment Conference - associated with the Safeguarding team
MASH	Multi-Agency Safeguarding Hub - multi-agency team consisting of health, local authority, and the police within Safeguarding Services
MECC	Making Every Contact Count
MIAA	Mersey Internal Audit Agency
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NHS England	NHS England authorises the new clinical commissioning groups, which are the drivers of the new, clinically led commissioning system introduced by the Health and Social Care Act
NHSI	NHS Improvement - Helps the NHS to meet short-term challenges
NICE	National Institute for Health and Care Excellence (NICE) – provides national guidance and advice to improve health and social care
NRLS	National Reporting and Learning Services - A central database of patient safety incident reports
NQPS	National Quarterly Pulse Survey

OCDS	Outpatient Commissioning Data Set - pseudonymised outpatient-based data and information for monitoring and contracting purposes.
Ofsted	Office for Standards in Education, Children's Services, and skills - inspects and regulates services that care for young children
PHE	Public Health England - executive agency of the Department of Health
POD	People Operational Delivery
PSIRF	Patient Safety Incident Response Framework
PSIRFaLP	Patient Safety Incident Response Framework & Learning Panel
QA	Quality Assurance
QIA	Quality Impact Assessment – a tool used to identify a potential impact of our policies, services and functions on our patients and staff
QRV	Quality Review Visit
RAG	Red, Amber Green rating – a simple colour coding of the status of an action or step in a process.
RTT	Referral to Treatment Time
SEND	Special Educational Needs & Disabilities
SOP	Standard Operating Procedure – is a documented process in place to ensure services are delivered consistently every time
UCR	Urgent Community Response
Ulysses	Bridgewater Community Healthcare Foundation Trust's IT risk management and patient safety system

Appendix D – Our Services

Warrington Adults

Our Warrington Services consist of a large team of community nurses supported by

beds, care in care homes, equipment services, wheelchair services, acquired brain injury and neuropsychology as well as podiatry, musculoskeletal and orthopaedic clinical assessment, and dermatology.

Halton & St Helens Adults

As in Warrington, our Halton services have a large team of community nurses supported by specialised nurses and matrons. With a Neuro Rehabilitation service, we also provide integrated urgent care and integrated frailty services with local providers, as we support the community and intermediate care needs of the population.

Our Urgent Treatment Centre in Widnes is the focal point for a lot of community-based services, with clear connections to our own services and those of our local partners. We also deliver wheelchair services, equipment services, podiatry and speech and language services.

The St Helens based Drive Ability North-West service, delivered in partnership with Driving Mobility and the Department of Transport, provides services across the North-West of England.

Dental Services

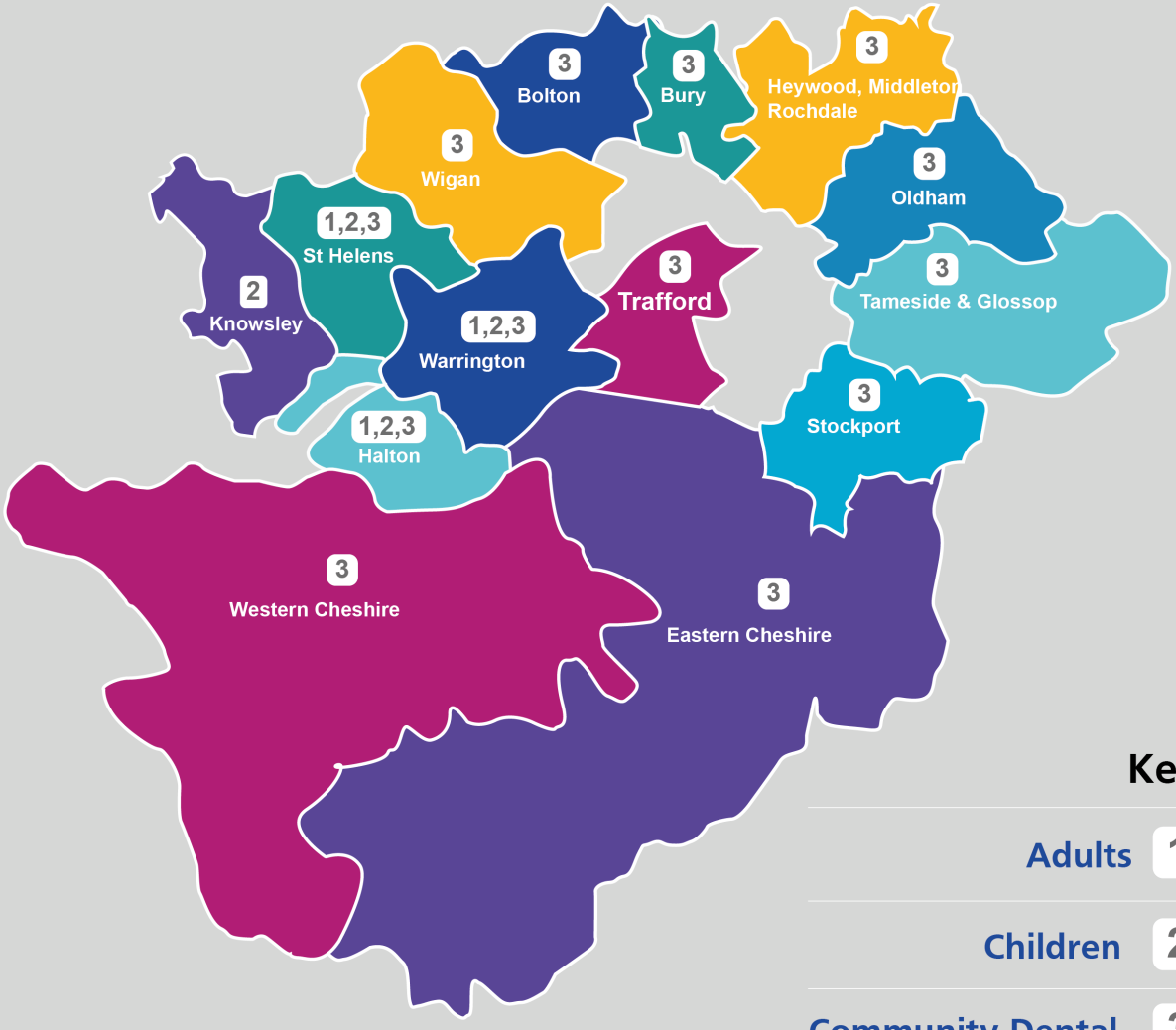
The Bridgewater Dental Network currently provides services to a combined

and special needs which make it impossible for them to access treatment from an NHS family dentist (General Dental Practice).

We deliver 0-19s (25 for those with special educational needs) services in Warrington and Halton as well as several specialised children's services in locations such as St Helens and Knowsley.

These include audiology, occupational therapy, physiotherapy and speech and language. We also have community paediatric services and deliver the neurodevelopmental pathway in both Halton and Warrington.

Bridgewater Community Healthcare NHS Foundation Trust
Map of Services



We provide services across three Integrated Care Systems, and 25 local places, with a total catchment population of 7.7 million people. Our reach is vast. In over 90% of the sites we deliver from, we are not the sole provider. We co-locate with other providers to deliver services in the heart of communities across the North-West.

Back Cover To Be added Before Publication

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**39/24(i)**		
Report Title	**FINANCE REPORT – MONTH ONE (APRIL 2024)**		
Executive Lead	Nick Gallagher – Executive Director of Finance		
Report Author	Rachel Hurst – Deputy Director of Finance		
Presented by	Nick Gallagher – Executive Director of Finance		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

To brief the Board on financial performance for month one:

- The Trust is reporting a deficit of £0.15m, behind plan.
- The Trust has a savings requirement of £4.94m (5.2%) in line with ICB instruction.
- The Trust is reporting a year-to-date savings achievement of £0.10m against a plan of £0.20m.
- Income is £8.05m against a plan of £7.99m.
- Expenditure is £8.21m against a plan of £7.96m.
- Pay is £5.62m against a plan of £5.27m.
- Agency spend is £0.21m against a plan of £0.22m.
- Non-pay expenditure is £2.43m against a plan of £2.49m.
- Capital charges are £0.04m below plan.
- Capital expenditure is £0.04m at month one, planned spend is £0.05m.
- Cash is £15.09m.

Previously considered by:

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

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.

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**	**6 June 2024**
Agenda Item	**39/24(i)**		
Report Title	**FINANCE REPORT MONTH ONE (APRIL 2024)**		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the financial position as at Month One		

1. SCOPE

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

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

2. FINANCIAL POSITION AS AT MONTH ONE

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

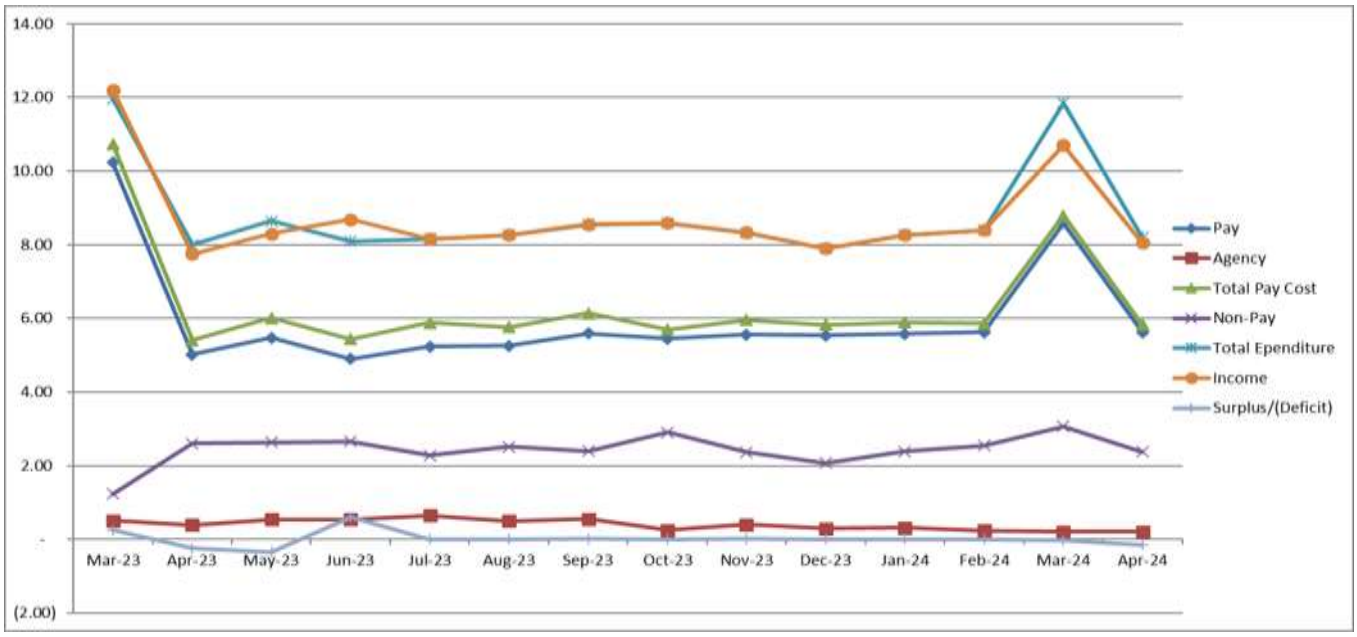
2.2 The purpose of this paper is to update the Board on the financial position of the Trust at the end of April 2024 (Month 1).

Table 1 – Summary of Financial Performance

Summary Performance Month 01 2024-25	Month 1 Plan (£M)	Month 1 Actual (£M)	Month 1 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(7.99)	(8.05)	0.06	(7.99)	(8.05)	0.06	(95.86)	(95.86)
Expenditure - Pay	5.27	5.62	(0.35)	5.27	5.62	(0.35)	64.50	64.50
Expenditure - Agency	0.22	0.21	0.01	0.22	0.21	0.01	1.59	1.59
Expenditure - Non Pay	2.49	2.43	0.06	2.49	2.43	0.06	29.90	29.90
EBITDA	(0.02)	0.21	(0.23)	(0.02)	0.21	(0.23)	0.13	0.13
Financing	(0.01)	(0.05)	0.04	(0.01)	(0.05)	0.04	(0.13)	(0.13)
Normalised (Surplus)/Deficit	(0.03)	0.15	(0.18)	(0.03)	0.15	(0.18)	0.00	0.00
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	(0.03)	0.15	(0.18)	(0.03)	0.15	(0.18)	0.00	0.00
Other Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	(0.03)	0.15	(0.18)	(0.03)	0.15	(0.18)	0.00	0.00
CIP	0.20	0.10	(0.10)	0.20	0.10	(0.10)	4.94	4.94
Capital	0.05	0.04	0.01	0.05	0.04	0.01	2.10	2.10
Cash	18.03	15.09	(2.95)	18.03	15.09	(2.95)	17.48	17.48
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 2023/24 to 2024/25



2.3 The Trust is reporting a deficit of £0.15m, which is behind plan.

Income

- Income was above plan by £0.06m in month.

Pay

- Pay costs are above plan by £0.35m in month one. The overspend is primarily driven by phasing of the plan and non delivery of CIP in month one.

Agency

During month one, the Trust has incurred costs of £0.21m against the plan of £0.22m.

The month-on-month expenditure has increased by £0.01m.

The four services with the highest agency spend cumulatively are:

- UTC Widnes – nursing and GP shifts.
- Halton District Nursing – covering vacancies and absences.
- Intermediate Care Bed Based (Padgate House) – nursing and HCA shifts covering vacancies and absences.
- ABI Warrington – locum psychologist covering a vacant post (also covering Halton)

Agency costs incurred in month one equated to 34.22 whole time equivalent staff.

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

Area	Sum of YTD Actual £k	Sum of Forecast £k	Revised Agency Cap Forecast £k
Childrens	34.15	229.65	229.65
Corporate	17.11	59.61	59.61
Dental	-	-	-
Halton	79.37	631.18	631.18
Warrington	78.50	664.19	664.19
Grand Total	**209.14**	**1,584.63**	**1,584.63**

Non Pay

During month one the Trust has spent £2.43m on non pay, £0.06m below plan.

Financing Costs

- Additional interest received and an improved statement of financial position have contributed to reduced financing costs and a £0.04m variance favourable to plan.

2.4 Adjusting for any one off working capital adjustments, all month one rates are consistent with expectations and previous year comparators (see table 2 above).

3. COST IMPROVEMENT PLAN (CIP)

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

3.2 The additional requirements include an element for the convergence reduction in funding in 2024/25 along with the need a requirement to deliver 2023/24 non recurrent CIP recurrently in 2024/25.

3.3 This results in total savings for 2024/25 of £4.94m (5.2%) in line with ICB instruction.

3.4 The Trust plan to month one is £0.20m, against which achievement of £0.10m is reported.

3.5 Further detail will be provided in future months.

4. CAPITAL, CASH AND BETTER PAYMENT PRACTICE CODE (BPPC)

4.1 Total capital expenditure as at 30th April was £0.04m against a plan of £0.05m.

4.2 The list of prioritised capital schemes for 2024/25 is shown at Appendix 1 and Procurement colleagues are now progressing those schemes in conjunction with services.

The prioritisation order for schemes is as follows:

1. Schemes brought forward from 2023/24.
2. Locally mandated schemes, i.e., those schemes which must be funded from capital.
3. Business critical schemes, i.e., schemes which are critical to service delivery.
4. Risk score order.

Progression will be discussed at the monthly Capital Council meetings and those schemes not progressing will be removed from the capital programme and replaced by schemes from the reserve list.

4.3 In April 2024 there was a net cash outflow of £2.25m with a closing cash balance of £15.09m.

4.4 The cash outflow has arisen due to higher than normal BACS payments runs to non NHS suppliers in the month (all other cash outflows, including payments to NHS suppliers and Payroll costs have remained reasonably consistent with the previous month). The increase in payments also explains the general reduction in Trade and Other Payables from £9.85m in March 2024 to £8.38m in April 2024.

4.5 Total debt as at 30th April is £10.08m after allowing for the bad debt provision, of which £3.64m relates to invoiced debt.

4.6 Invoiced debt has decreased by £0.59m although overdue debt has increased by £2.00m.

4.7 Total trade and other payables as at 30th April are £8.38m, of which £5.17m relates to creditors.

4.8 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-24	95.0	95.6	97.9
Year to date performance	95.0	95.6	97.9

4.9 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 maintained improved approval and payment times.

5. 2024-25 PLANNING

5.1 The Trust submitted its final draft 2024-25 plan on 2nd May 2024. The plan submitted is a break even position, as agreed by the Trust Board following discussions at the Board Seminar on 2nd May 2024.

5.2 The Cheshire and Merseyside ICS has submitted an overall system deficit plan, which will require significant improvement. All organisations have been asked to review their draft plans to contribute to this improvement.

5.3 The Board will be kept updated on further change requests for consideration going forward.

6. RECOMMENDATIONS

6.1 The Board is asked to note the contents of this report.

- Note the contents of this report.
- Note the financial position.
- Note the break even plan submitted

Appendix 1 – Approved 2024/25 Capital Programme

Appendix 1 - Approved 2024/25 Capital Programme

Project Description	Scheme Lead	Prioritisation Risk	A2 code	Plan - (24/25) £	YTD Actual - M1 (24/25) £	Forecast outturn £
23/24 Schemes			*Various*	*0.00*	*16,696.72*	*16,696.72*
Driveability NW relocation improvements	John Morris	Locally mandated		120,000.00		120,000.00
Green plan phase 3	John Morris	Locally mandated		120,000.00		120,000.00
Spencer Dermatology fit out	John Morris	Locally mandated		500,000.00		500,000.00
Backlog maintenance contingency	John Morris	Locally mandated		280,000.00		280,000.00
Ashton PCC - aircon	John Morris	360		60,934.56		60,934.56
Total Premises Schemes				**1,080,934.56**	**16,696.72**	**1,097,631.28**
23/24 Schemes			*Various*	*0.00*		*0.00*
X13 Gen 1 laptop upgrade	Alan Tweddell	350		169,344.00		169,344.00
X390 laptop upgrade	Alan Tweddell	350		85,502.02		85,502.02
Total IT Schemes				**254,846.02**	**0.00**	**254,846.02**
23/24 Schemes			*Various*	*0.00*		*0.00*
Dene Drive - replacement intra oral x-ray machine		B/f from 23/24		9,900.00		9,900.00
Point of care testing machine for Widnes UTC		B/f from 23/24		22,800.00		22,800.00
Medical Gas manifold		B/f from 23/24		46,000.00		46,000.00
Hallwood dental chair	Karen Eden	370		34,746.00		34,746.00
Bury 3x IHS machines	Jackie McGee	360		13,002.00		13,002.00
Oldham ICC - IHS machines x 4	Jackie McGee	360		21,040.00		21,040.00
Oldham ICC - washer disinfectors x2	Jackie McGee	360		38,080.80		38,080.80
Wheelchair tippers at Phoenix & Moorgate	Sam Morrison	360		56,000.00		56,000.00
Bury Surgical motor and handpiece	Jackie McGee	360		6,023.81		6,023.81
HCRC dental chair	Karen Eden	360		33,240.00		33,240.00
HCRC washer disinfector	Karen Eden	360		25,389.38		25,389.38
Bath Street dental chair	Karen Eden	360		25,146.00		25,146.00
Moorgate dental chairs x 4	Justine English	360		138,240.00		138,240.00
College Street washer disinfector	Karen Eden	360		18,680.54		18,680.54
Total Equipment Schemes				**488,288.53**	**0.00**	**488,288.53**
23/24 Schemes			*Various*	*0.00*	*1,008.86*	*1,008.86*
Dentally implementation		B/f from 23/24		40,000.00	21,172.31	40,000.00
Safemove VPN upgrade	Alan Tweddell	Business Critical		15,000.00		15,000.00
Digital dictation and voice recognition	Sandra Alderson	380		46,313.65		46,313.65
Total Intangibles Schemes				**101,313.65**	**22,181.17**	**102,322.51**
Contingency				174,617.24	0.00	156,911.66
Total Contingency				**174,617.24**	**0.00**	**156,911.66**
TOTAL CAPITAL SPEND				**2,100,000.00**	**38,877.89**	**2,100,000.00**
CAPITAL SPEND PLAN - PER ORIGINAL PLAN				2,100,000.00	38,877.89	2,100,000.00
PDC FUNDING RECEIVED				0.00	0.00	
FORECAST OVERSPEND/(UNDERSPEND)				**2,100,000.00**	**38,877.89**	**2,100,000.00**

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**39/24ii**		
Report Title	**COST IMPROVEMENT PROGRAMME GOVERNANCE**		
Executive Lead	Lynne Carter, Chief Nurse/Deputy CEO		
Report Author	Lynne Carter, Chief Nurse/Deputy CEO		
Presented by	Nick Gallagher, Director of Finance		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

Cost improvement plans are required by every NHS organisation and the percentage required of the overall budget is set each year. For 24/25 Bridgewaters overall CIP requirement is c.£5m

The trust is required to ensure that each scheme is identified, planned, implemented and evaluated without reducing patient quality or safety, and is not detrimental to staff wellbeing.

Several documents have been reviewed to ensure that our schemes and processes follow best practice.

These are:

Monitor/Audit Commission Delivering sustainable CIPs 2012
Sustainable cost improvement programmes for the NHS - GOV.UK (www.gov.uk)

NHSI Carter Efficiency Guidance 2018
Operational Productivity Sub Programme CIP Guidance (model.nhs.uk)

NHS Efficiency Map 2019 NHSEI/HFMA
NHS value and efficiency map - April 2024 update.pdf (hfma.org.uk)

NHS Delivery and continuous improvement review: recommendations 2023
NHS England » NHS delivery and continuous improvement review: recommendations

24/25 MIAA Insight Cost Improvement Programmes How do processes compare? May 2024
cost-improvement-programmes-survey.pdf (miaa.nhs.uk)

Our governance process is described in the attached paper and evidences the alignment with best practice.

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 equality, 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**	**6 June 2024**
Agenda Item	**39/24ii**		
Report Title	**COST IMPROVEMENT PROGRAMME GOVERNANCE**		
Report Author	Lynne Carter, Chief Nurse/Deputy CEO		
Purpose	To provide assurance of a comprehensive governance process aligned with recognised best practice.		

1. SCOPE

1.1 The governance processes for Cost Improvement Programmes (CIP) have been reviewed for the year 24/25.

1.2 The process has then been assessed against current best practice, specifically *24/25 MIAA Insight Cost Improvement Programmes How do processes compare? May 2024*

1.3 The paper documents the processes which enable the trust to deliver cost improvements without detriment to patient safety and/ or quality using the Trusts governance framework of Councils and Committees through to Board.

2. INTRODUCTION

2.1 Bridgewater Community Healthcare NHS FT (the Trust) has always planned and delivered its Cost improvement Programme (CIP) requirement and there have been some excellent schemes which enabled the delivery of recurrent and non-recurrent savings. There has always been a push to deliver recurrently as this ensures the next year CIP schemes are easier to deliver, however there is always an element of non-recurrent savings.

2.1 During the pandemic all NHS organisations had more complex financial arrangements which included funding for additional staff and bed base including community services, indeed we were actively encouraged to recruit more staff including the use of agency and this was funded although non-recurrently. There was also non-recurrent funding available for non-pay including equipment and premises which enabled different delivery of care at a time of high pressure.

2.2 The Monitor and Audit Commission document 2012 identified key principles which are still relevant today regarding the delivery of cost improvement programmes and these key factors are:

2.3 Since the end of the pandemic there have been more stringent rules to manage the budgets and services back to pre-pandemic levels, despite increased waiting lists and more complex care requirements and, particularly since the inception of Integrated Care Boards (ICB), the system wide requirements are a more significant priority.

2.4 Headcount of staff is expected to return to pre pandemic levels in line with budgets and therefore there should be a corresponding decrease in costs. It is vital that there are in place specific enablers for any programmes and that these include good management capability, the right tools and data, robust internal controls and optimal use of workforce.

2.5 Optimal use of workforce includes skill mix, absence management, new roles, retention and workforce planning, including good job planning and rostering, and these are reported via the People Committee to ensure a positive rather than negative impact on any service implementing an efficiency programme.

2.6 We have a robust workforce planning process and a schedule for every service to have a workforce plan that has a review mechanism built in and this is supported by key personnel and subject matter experts who go out to Teams and proactively engage with them.

2.7 In addition, the Carter report 2018 has also been considered for any efficiencies in corporate services and particularly the Model Hospital data. Procurement is already a shared service with the Warrington and Halton Hospital Foundation Trust (WHHFT) and continues to deliver savings and efficiencies.

2.8 The proposed integration with WHHFT gives even greater opportunities in procurement but also in estates, technology and patient care. This will impact positively on urgent and

emergency care and system efficiency which will benefit both Warrington and Halton places as well as the Cheshire and Merseyside system. This requires a greater degree of clarity as to where the saving occurs in the patient pathways however is not a barrier to improvement savings and will lead to greater financial resilience.

2.9 The management of cost improvements in the trust has usually followed the same process with services identifying reductions and these being managed with a quality impact process and mitigation of risks. These have been successful, however there was usually a significant element of non- recurrent savings, and these have proved more difficult to identify.

3. CHANGING PROCESS

3.1 For the year 24/25 it was decided to review the processes and to ensure that the workforce system requirements could be met. As the cost of staff is the most significant budget item, it naturally follows that reduction in staff posts will be required. In the year 23/24 the Trust had already reduced its agency costs, so this was not an area of focus for 24/25.

3.2 We had also implemented an e roster process for all staff which would enable greater scrutiny and management of staffing to meet the activity demands of the services. This system enables rosters to be developed which include skill mix and competency matched to activity and complexity requirements In addition, most services had a formal capacity and demand process completed and workforce planning sessions were completed.

3.3 The Trusts CIP Council was reviewed, and changes were made to the process of identifying schemes moving away from the percentage saving target being apportioned to each service/budget. This was in part because the senior staff in the trust felt that they had fewer areas to look at in individual services and wanted more crosscutting schemes. The CIP Council was also renamed the Boosting Efficiency Council (BEC) to reflect the change to looking at efficiency and effectiveness.

3.4 In addition, a brainstorming session was held with all budget holders to engage all teams in the process and to collect new ideas which could be worked up.

3.5 The CIP Council was reviewed in terms of membership and new Terms of Reference (TOR) were produced. The existing CIP tracker was maintained as this proved very useful to the team. The Quality Impact Assessment (QIA) and Equality Impact Assessment (EQIA) processes were also reviewed to ensure they still met best practice.

3.6 Each scheme is cross referenced to the risk register and monitored via Risk Management Council and the Board Assurance Framework if necessary. Performance, Risk, People and Quality councils will all be impacted by Boosting Efficiency schemes and give a regular opportunity to monitor changes and provide the opportunity to quickly act on any schemes which require changes.

3.7 The QIA and EQIA process also ensures that the risks are mitigated, reflected in the risk register and are re- evaluated post implementation.

3.8 The Deputy Chief Executive is the Senior Responsible Officer (SRO) for the whole programme and each task and finish group in the Council has an exec SRO.

The task and finish groups are:

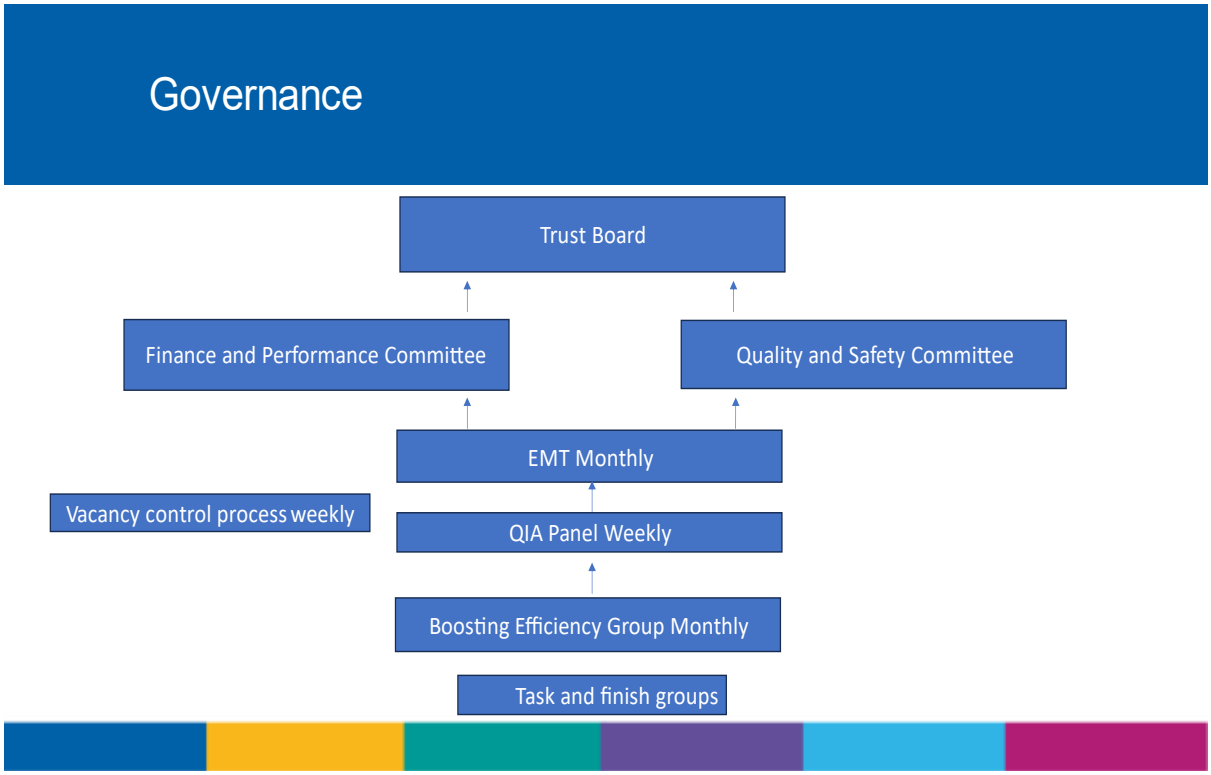
- Estates including utilisation.
- Capacity and demand including rotas.
- Digital solutions including review of all software licences/functionality.
- Procurement including product reviews.
- Medicines management including the use of generic drugs and formularies.
- Equipment including servicing and decontamination.
- Service specification reviews.
- Income streams
- Bank and agency including overtime.
- Waiting list management

3.9 Any directorate only schemes will be discussed at the Directorate Leadership Team meetings and then feedback into the BEC accordingly.

3.10 All QIAs will be identified at the BEC and then scheduled for the panel, which meets weekly as needed. Once the panel has agreed the mitigation and action this will be fed back to the scheme owner and will be added to the tracker. There will also be additions to the risk register and dates reset for post implementation review. Although best practice suggests 6/9/12 month intervals there are schemes which will be brought back sooner dependent upon the risk mitigation.

4. GOVERNANCE

4.1 The Trust Governance Process map.



4.2 The chart above shows the governance arrangement which has been assessed against the MIAA process described in 24/25 MIAA Insight Cost Improvement Programmes How do processes compare? May 2024.

4.3 There is a Programme Management Office to oversee the governance arrangements which is the Boosting Efficiency Council

4.4 Specific committees are charged with the oversight of CIPs, and these are Finance and Performance Committee regarding the CIP finance tracking and impact on performance and the Quality and Safety Committee which reviews the QIA/EQIA and any impact on patient safety and quality.

4.5 Executive Management Team oversee integrated performance via Directorate Management Reviews and council chairs reports.

4.6 QIA panel meetings are in place with TORs and clarity of membership and the Chief Nurse and Medical Director sign off all QIAs.

4.7 Directorates have completed bottom up and top-down identification of schemes. All cross-cutting themes have been identified and added to the task and finish groups.

4.8 Financial review of budgets is being completed to identify underspends which influence Directorate reviews and the already identified schemes from 23/24 which are carried forward.

4.9 The CIP brainstorming workshops led by the Deputy Chief Executive is now being followed up regarding specific ideas from budget managers.

4.10 Milestone tracking is being added to the tracker for all schemes and 3 yr. forward plans are being identified.

4.11 Milestone post implementation reviews are planned as a minimum at 6/9/12 months.

4.12 All schemes are identified as:

- Cost reduction e.g. removing posts no longer needed.
- Cost avoidance e.g. removing agency or bank costs.
- Income generation e.g. payment for services outside of existing contracts e.g. Driveability
- Service productivity e.g. improved performance without additional costs.

4.13 The Trust Board receives Chairs reports from Committees which highlight performance in cost improvement programmes and there is always a line of sight through the tracker.

5. RECOMMENDATION

5.1 The Board is asked to recognise the governance process for Cost Improvement Programmes and to be assured that this meets current best practice.

Committee Chair's Report

Name of Committee/Group:	Extraordinary Finance and Performance Committee		**Report to:**	Board of Directors
Date of Meeting:	24 April 2024		Date of next meeting:	23 May 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 Bob Chadwick, Non-Executive Director Linda Chivers, Non-Executive Director Martyn Taylor, Non-Executive Director Nick Gallagher, Director of Finance Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer	**In Attendance** Rachel Hurst, Deputy Director of Finance Gareth Pugh, Assistant Director of Finance Jan McCartney, Director of Corporate Governance	**Key Members not present**:	**Apologies received from:** Linda Chivers, Non-Executive Director

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Annual Accounts	5		The Committee received the annual accounts. The Trust reported a £4k surplus for 2023/24 (after technical adjustments). This is the position that the Trust would be measured on against the break-even plan and included in system performance. SOCI showed £730k deficit, prior to technical adjustments (such as impairments) that would be made to reconcile to £4k surplus.	The Committee noted that the draft accounts presented today would be submitted at 12pm, with a meeting with Auditors later today at 1pm. Any amendments that were then made to the accounts would be presented back to this Committee, the Extraordinary Audit Committee and the Extraordinary Board meetings in June 2024.

	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

			Statement of Financial Position (Balance Sheet) largely consistent with previous years apart from reduction in trade and other payables and a reduction in provisions as discussed during the year. The Trust was slightly underspent on its capital resource limit.	The Committee noted that the date for the final submission for the Annual Accounts, including the Trust's Annual Report, was 28 June The Committee wished to thank Finance colleagues for their work in producing the Annual Accounts in view of a challenging period, producing the accounts alongside planning work which was ongoing.
Review of meeting	5			Any further comments or questions on the Annual Accounts could be raised with the Finance Team outside of today's meeting if required. There were no items identified from today's meeting for inclusion on the Board Assurance Framework.
Risks Escalated: None from the meeting. **Actions delegated/escalated to other Committees:** **Nothing delegated/escalated**				

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Committee Chair's Report

	Finance and Performance Committee			Board of Directors
	23 May 2024			25 July 2024
	Tina Wilkins			Yes
	Committee Members Present: Tina Wilkins, Committee Chair Linda Chivers, Non-Executive Director Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Bob Chadwick, Non-Executive Director Nick Gallagher, Director of Finance Sarah Brennan, Chief Operating Officer Lynne Carter, Chief Nurse	**In Attendance:** Rachel Hurst, Deputy Director of Finance Gareth Pugh, Assistant Director of Finance Mark Charman, Assistant Director of Transformation Debbie Weir, Financial Controller Louise Thornton, Financial Accountant Anita Buckley, Information Team Jan McCartney, Director of Corporate Governance **Observers:** Rita Chapman, Public Governor for Rest of England		**Apologies received from:** Dave Smith, Assistant Director of IT

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
CIP/Boosting Efficiencies Chair's Report	5		The Committee received the chair's report.	The report described the boosting efficiencies process and progress developing the governance, however it lacked the detail around schemes and delivery. The committee recognised the work in progress but were concerned at the level of detail at this stage of the year.

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				The committee requested a breakdown and RAG rating showing the maturity and deliverability of schemes. The committee requested clarity on reporting of recurrent and non recurrent savings. The committee stressed the importance of delivering the 5% recurrent savings in the approved plan, recognising that an additional savings ask for Place was being proposed.
Finance Report	5		Month 01 finance report received and provided assurance. The Committee noted that: • Month 01 is reporting a deficit position of £0.15m behind the plan. • Deficit primarily driven by CIP shortfall. • Until final plan is approved, detailed budgets are based on 23/24. • Healthy cash position • Capital programme on plan. • Agency spend is on plan	The Committee noted the financial position and the reason for the adverse variance to plan. The Committee noted that detailed CIP plans are still being developed. The committee requested the finance report references the deliverability of schemes using a RAG rating aligned to the Boosting Efficiencies Chair report. The Committee noted the overspend on pay costs but recognised that the levels of review and scrutiny were limited in month 1 as teams focussed on year end accounts and 2024/25 planning. The committee were reminded that monthly finance reports would continue to be circulated even if the committee only meets bimonthly. The committee noted that the agency spend was in line with plan, which had been significantly reduced in 2024/25.

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				The committee were assured that additional scrutiny would be exercised with regards to capital spend to ensure schemes were completed as early as possible in the financial year. The committee were informed of the decision to no longer proceed with the Salford 0-19 service tender. The Committee recommended the financial report for approval to the Board.
2023/24 Impairment Review of Property, Plant and Equipment	5		The committee received a report on the detail and impact of the impairment review for 2023/24	The committee noted the report and raised concerns that assets appeared to have been lost. The committee were assured that all responsible managers have been issued with asset lists and reminded of their responsibility to maintain and monitor assets.
Grip and Control Checklist	5		The committee received a verbal update.	The updated checklist including the additional ICB control requests will be presented to the committee in July.
2023/24 External Audit update	5		The committee received a verbal update.	The committee were informed that the Trust was in line with the plan, and slightly ahead in some areas. No significant concerns had been identified to date. The committee were also informed that KPMG had indicated that there may be an additional

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				charge this year. The committee requested that the progress against plan continues to be monitored closely and any additional charges are robustly challenged.
2024/25 Financial Planning	5		The Committee received a verbal update.	The Committee were informed of the latest ICB financial position and the ask for additional savings from Place as a result of integrated working. This is £5m. Concerns were raised around the deliverability of any additional ask and the impact this could have on the Trusts existing CIP plans. The committee will be kept updated, but this is likely to be a future Board discussion.
Performance	5		Report from Quarterly Performance Reviews held in place of Performance Council was received.	The Committee received the report providing a comprehensive update on the Directorate Quarterly Performance Reviews as at month 12. Dental • Service overspend primarily driven by unachieved CIP and unfunded general anaesthetic sessions in Oldham. • Significant reduction in waiting lists driven by impact of task and finish group looking at acceptance and discharge criteria, treatment planning and HIS delivery. • No workforce / quality issues raised. Children's

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				• Service overspend driven by high agency usage of locums in community paediatrics. • All over 52-week waits have been validated and harm reviews undertaken. No harms identified in this reporting period. • Performance reporting as red across children's services. • Demand continues to exceed capacity for Community Paeds (Warrington and Halton) and Audiology. Prioritisation based on clinical need. • Quality reporting as red due to level 15 risk across Warrington and Halton Paeds (demand, capacity, and resource related) Warrington Adults • Directorate overspend due to dermatology and Padgate House largely. • No off framework agency in month. • Dermatology agency spend to significantly reduce following outsourcing arrangement. • Working hard to manage district nursing vacancies and turnover. • Focus continues on completion of all dermatology action plans. Halton Adults

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				• Overspend due to agency staffing in district nursing. • Promotion of NHSP bank and consideration of new roles to mitigate going forward. • Podiatry noted as red for performance due to number of high waits, however on a downward trajectory. • Focus on reducing waiters to under 65 weeks and review of current specification.
Performance	5		IQPR for month 12 was received by the Committee.	The Committee noted the report. Operations – 17 red and 16 green indicators. • A number of the indicators in relation to referrals and activity need to have a refresh of target levels and these are being picked up by the service level reviews of the specification. • Due to validation and review timescales for Cancer, the RAG rating on the dashboard for these indicators is based on Februarys validated position. • The indicator Proportion of Urgent Community Response referrals reached within two hours, the March figure is subject to change following the refresh submission in May. • Improvement in month in cancer targets – all indicators green.

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				• A&E targets – all indicators green. National target of 100% set for UTC – Actual 99.78%. • Referral to treatment – percentage within 18 weeks has remained below target primarily due to the increased number of children waiting for community paediatrics. • There is considerable pressure on the Warrington Audiology service due to a number of factors and the number of breaches have risen in month. A band 6 vacancy is key to this performance issue. • The RTT position has deteriorated due to increase in waiting times for both community paediatrics in Halton and dermatology. Nationally, there has been an ask to stand down submission of Community data from RTT submissions. • DNA/Was not brought are being monitored particularly in relation to children's services and has improved but still below target. • From a dental perspective waiting list size continues to decrease as a result of the focussed task and finish group. • From a quality perspective, the % of incidents causing harm (levels 2-5) indicator has increased in March to 40.50%.

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Committee Chair's Report

				Quality – There are 9 Quality indicators reporting as red and 21 green indicators in March 2024. • The DOC (Duty of Candour) - 10-day compliance indicator has improved to 75% in March. • The % of medication incidents that caused harm indicator has increased from 14.29% in February to 15.38% in March People - Two out of seven People indicators are shown as red in March 2024. • % Overall Organisation Sickness rate (rolling) – Reported red since December 2023, best position January 2024 5.52% versus the target of 5.5% now at 5.57% • Sickness absence rate (Actual) – Reported as red since September 2023, best position is in month reporting at 5.54% versus the target of 5.5%. Finance - From a finance perspective, pay, non pay and agency are all above plan. Agency costs are being tightly monitored and controlled, with plans in place to significantly reduce in 2024/25.
Digital	5		Chair's report from DIGIT	The Committee received an update from DIGIT. The Committee noted that the formal process for the restructure of IT remains underway but is of concern in light of recent ICB workforce restrictions and controls.

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Committee Chair's Report

Audit	5		MIAA and KPMG Audit recommendations	The Committee noted the report.
Risks	5		Risk paper	The Committee noted the report.
Finance and Performance strategies.	5		The Committee received a report detailing the strategies referenced in the Communities Matter Organisational strategy that the Committee were responsible for monitoring and delivering.	The committee noted the paper but recognised that the list was limited to those strategies referenced in the Communities Matter Strategy and additional strategies may also require committee responsibility. It was agreed that additional strategies could be added to the list contained within the report as appropriate.
BAF	5		BAF 5	The Committee reviewed BAF 5 – Taking into account the CIP challenge and the current scheme development and delivery, combined with the additional in year savings target for integration, the Committee recommended that the BAF risk score be increased 12. The Committee requested that the gap in control and mitigation narrative be updated to reflect the new financial year.
Risks Escalated: None from the meeting. **Actions delegated/escalated to other Committees:** **Nothing delegated/escalated**				

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	**Audit Committee**		**Report to:**	**Board of Directors**
Date of Meeting:	25 April 2024		Date of next meeting:	23 May 2024 – Extra ordinary meeting 26 June 2024 – Extra-ordinary meeting 4 July 2024 – full meeting
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 Bob Chadwick, Non-Executive Director Gail Briers, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director Abdul Siddique, Non-Executive Director	**In Attendance & Observers:** Nick Gallagher, Director of Finance Rachel Hurst, Deputy Director of Finance Debbie Weir, Financial Controller Louise Thornton, Senior Financial Accountant Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer Jan McCartney, Director of Corporate Governance Adrian Poll, Senior Audit Manager, MIAA Phillip Leong, Anti-Fraud Specialist, MIAA James Boyle, Director, KPMG Adam Lyon, Manager, KPMG <u>Observers</u> Andrew Mortimer, Governor Observer Kevin Goucher, Governor Jenny Fay, Finance team Linda Daisley, Anti-Fraud Specialist	**Key Members not present**:	**Apologies received from:** Martyn Taylor, Non-Executive Director Gary Baines, Regional Assurance Manager, MIAA

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Annual Audit Committee Report 2023/2024	1		The Committee received the report outlining the Committee's activity for 2023/2024 and took assurance on its own governance and processes in adhering to and delivering against the Committee's Terms of Reference	Assurance received
Annual Reports for each of the Committees of the Board 2023/2024	1		The Committee received and accepted the Annual Reports from the Finance and Performance, People and Quality and Safety Committees and took assurance that their governance and processes ensured they had adhered to and delivered against their Terms of Reference. The Committee also considered the Annual report from the Nominations and Remuneration Committee. Subject to approval from the Trust Chair of the report the Committee took assurance that the governance and processes ensured the committee had adhered to and delivered against its Terms of Reference	Assurance received Trust Chair to review the Annual Report from the Nominations and Remuneration Committee
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 Committee accepted that the Action Plan was complete and that ongoing actions were regularly monitored by relevant Board Committee and with two caveats agreed to close the action. The caveats were that the Board consider the inclusion of an annual session to consider succession planning and talent management and that the Executive summary to the BAF report includes the top three themes/risks.	Assurance received. The Board to consider the inclusion of an annual session on succession planning and talent management

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Committee Chair's Report

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. In relation to BAF1, which was robustly discussed, it was agreed: • To request that the Chief Executive Officer review BAF 1 in advance of each Audit Committee to provide assurance. • To update the rationale for the current risk score for BAF1 to reflect that the Well-led plan had been developed and completed and that further actions would be aligned to the updated CQC guidance on Well-Led 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 in March 2024 a review regarding the quality of risks on the risk register was undertaken by the Deputy Chief Nurse and a number of recommendations on improvements made to individual risk owners. Mention was also made of the recent MIAA review of Risk Management core controls and processes. The report gave a High level of assurance.	Assurance received. Chief Executive Officer to review BAF 1 prior to each Audit Committee Rationale for BAF1 current risk score to be updated to reflect closure of the Well-Led action plan and that further actions would be aligned to the updated CQC guidance
Registers of Interests	1, 5		The Committee received updates on the declarations of interest including those declarations received in the annual mandatory collation for Decision Making staff and agreed the registers could be published. It was noted that compliance was good with: Directors of the Board 100% Governors 100% Band 8+ 91.12%	Assurance received.

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			Medical 92.3% Dental 91.3% Outstanding declarations are being actively chased. The Committee referred a query to the People Committee on the Trust's policy and process where there were personal relationships within a team.	People Committee to provide assurance that the trust's policy and processes relating to personal relationships within teams is robust
Review of Losses, Special Payments and Waivers	1,5		Proposed bad debt write offs totalling £1,480.90 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 13 waivers, which were documented.	Assurance received.
Review of Accounting Policies	1,5		The Committee received a report detailing the proposed accounting policies to be adopted for the 2023/2024 year. There was little change beyond: - An update to Revenue from NHS contracts to reflect the financial framework in 2023/2024 - An update to the provision rates to be used in 2023/2024 - An update to financial year references It was noted that there was a new accounting standard IFRS 17: Insurance Contracts adopted for use by public bodies from 1 April 2025 but retrospectively applied to 1 April 2024. The Committee were assured this standard is not expected to have a significant impact on NHS bodies.	Information received

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Committee Chair's Report

Review of Standing Financial Instructions	1,5		The Committee received a report outlining proposed changes to the Standing Financial Instructions. There were no significant changes.	Information received
Review of the Scheme of Reservation and Delegation	1,5		The Committee received the document which outlined the proposed changes to bring the document in line with current Terms of Reference for the Board and all the Committees of the Board.	Information received and proposed changes accepted
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. It was noted that the Finance team had completed and submitted the draft accounts in line with the submission deadline and provided early to KPMG, the Trust's external auditors. In the context that we remain in a planning period for the 2024/2025 financial plan this was noted as an excellent performance.	Assurance received
Review of Anti-Fraud, Bribery and Corruption Policy	1,5		The Committee received an updated on the revisions to the policy, many of which related to language and formatting. There was one notable change to the policy to ensure it aligns to the NHS Counter Fraud Authority Fraud Strategy 2023 to 2026 in compliance of component 2 of the government functions standards for counter fraud. The update also included inclusion of details of the rile and responsibilities of the Director of People and OD and updated contact details for the Anti-Fraud Specialist linked to the Trust. It was also proposed that the referral form template be amended to ensure individuals are not discouraged from raising genuinely held concerns if they do not believe they have evidence to support that concern	The Anti-Fraud, Bribery and Corruption policy was approved

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Committee Chair's Report

Mersey Internal Audit Agency – Internal Audit Plan for 2024/25	1,2,3 ,4,5, 6,7		The Committee received the final draft internal Audit Plan for 2024/2025 following significant input from both Executive Directors and Non-Executive Directors. A request was made that other than mandated audits set for Quarter 4 all other audits should be completed earlier in the year to reduce pressure on both Trust and MIAA staff at year end.	Internal Audit Plan for 2024/2025 approved Add to BAF 1
Mersey Internal Audit Agency Progress Report	1, 2, 5		The Committee received assurance that the Internal Audit Programme was progressing to plan. The Committee noted the completion of the three reviews: • Quality Spot Checks – Limited Assurance • Key Financial Systems Controls – Substantial/High Assurance • Risk Management Key Controls – High Assurance It was noted as part of the report on follow up of prior recommendations that there were no critical or high priority recommendations outstanding that were past their review date. <u>Quality Spot Checks Risk Assessments – Prescribing and Management of Controlled Drugs</u> The Chief Nurse and Chief Operating Officer responded to questions on the review's findings, particularly in relation to the storage and administration of out of date medications and gave assurance that remedial work had been immediately undertaken. A full quality review is being undertaken by a senior team member at Padgate House and monthly controlled drug audit checks were being put in place. This review and recommendations will be being followed up by the Quality and Safety Committee who had already had sight of the full report.	Assurance received The Assurance level for reviews: Quality Spot Checks, Key Financial Systems Controls and Risk Management Key Controls will be added to the appropriate BAFs

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Committee Chair's Report

Draft Annual Internal Audit Report and Head of Internal Audit Opinion	1		The Committee received the draft Head of Internal Audit Opinion for 2023/2024 which was shared as being Substantial Assurance. The opinion is formed on the basis of: - An assessment of the design and operation of the underpinning Assurance Framework, Risk Management systems and supporting processes - An assessment of the range of individual assurances arising from MIAA's risk based internal audit assignments - An assessment of the organisation's response to Internal Audit recommendations and the extent to which they have been implemented. The Committee also noted the robust approach within MIAA to their own quality assurance.	Assurance received This will be added to BAF 1 once it is a final opinion
Internal Aduit Charter	1		The Committee noted the Internal Audit Charter which is mandated through the Public Sector Internal Audit Standards (2-187). This is a formal document which defines the internal audit activity's purpose, authority and responsibility.	Information received
Anti-Fraud Annual Plan 2024-25	1,5		The Committee received the final Anti-Fraud Annual Plan 2024-25. The plan considers national and regional fraud risk areas, risks identified from the most recent fraud risk assessments, national counter fraud priorities and local management requests..	The Anti-Fraud Plan for 2024/2025 was approved Add to BAF 1
MIAA Anti-Fraud Annual Report including the Progress report	1,5		The Committee received the annual report which also covered the regular progress report. It was noted that as always this was a comprehensive report on the work undertaken.	Assurance received

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Committee Chair's Report

			The Committee noted the that the Anti-Fraud Specialist was recommending that the various components which make up the Counter Fraud functional standards be self-assessed as green . 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 Chair thanked the Anti-Fraud Specialist Phillip Leong for his hard work and support to the teams and the Trust. Phillip is moving on within MIAA and will be replaced by Linda Daisley, who was observing the meeting	
External Audit progress report	1,5		The Committee received a verbal update from the External Auditor, who advised that KPMG will commence work in the background on the draft accounts prior to coming on site.	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.	Information received
External Audit Plan and Value for Money Assessment	1, 5		The Committee received the final audit plan and strategy for the year ending 31 March 2024. KPMG confirmed that the Value for Money (VFM) assessment was complete with no significant risks identified.	Assurance received
Review of the meeting	1		There was general agreement the meeting had been effective with good level of debate and sufficient opportunity to contribute.	
Risks Escalated: None from the meeting				

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	**Audit Committee**		**Report to:**	**Board of Directors**
Date of Meeting:	23 May 2024		Date of next meeting:	26 June 2024 – Extra-ordinary meeting 4 July 2024 – full meeting
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 Bob Chadwick, Non-Executive Director Gail Briers, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director Martyn Taylor, Non-Executive Director	**In Attendance & Observers:** Nick Gallagher, Director of Finance Debbie Weir, Financial Controller Louise Thornton, Senior Financial Accountant Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer Jan McCartney, Director of Corporate Governance Colin Scales, Chief Execuitve Officer and Accountable Officer Gary Baines, Regional Assurance Manager, MIAA Adrian Poll, Senior Audit Manager, MIAA Adam Lyon, Manager, KPMG <u>Observers</u> Andrew Mortimer, Governor Observer	**Key Members not present**:	**Apologies received from:** Abdul Siddique, Non-Executive Director Rachel Hurst, Deputy Director of Finance James Boyle, Director, KPMG Linda Daisley, Anti-Fraud Specialist (not required to attend the meeting) Kevin Goucher, Governor

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

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

Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Mersey Internal Audit Agency Progress Report	1, 2, 3,4,5 ,6, 7		The Committee received assurance on the final completion of the Internal Audit Programme for 2023/24. The Committee noted the completion of two reviews: • IT Supplier Management – Limited Assurance • Board Performance Reporting – High Assurance It was noted as part of the report on follow up of prior recommendations that there were no critical or high priority recommendations outstanding that were past their review date. <u>IT Supplier Management - Limited Assurance</u> The Director of Finance responded to questions on the review's findings, particularly in relation to the 3 High risks recommendations identified. This review and recommendations will be being followed up by the Finance and Performance. <u>Board Performance Reporting High Assurance</u> The Committee noted the excellent work that had been undertaken to review and improve Board Performance reporting and congratulated all those involved in achieving the High Assurance level. The recommendations for this review will be followed up by the Finance and Performance Committee.	Assurance received The Assurance level for reviews: IT Supplier Management and Board Performance Reporting will be added to the appropriate BAFs.

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Committee Chair's Report

Draft Annual Internal Audit Report and Head of Internal Audit Opinion	1		The Committee noted that the draft Head of Internal Audit Opinion for 2023/2024 which was shared as being Substantial Assurance had not changed since the April meeting. The opinion is formed on the basis of: - An assessment of the design and operation of the underpinning Assurance Framework, Risk Management systems and supporting processes - An assessment of the range of individual assurances arising from MIAA's risk based internal audit assignments - An assessment of the organisation's response to Internal Audit recommendations and the extent to which they have been implemented.	Assurance received. This will be added to BAF 1 once it is a final opinion
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
2023/2024 Impairment Review of Property, Plant and Equipment	1,5		The Committee noted the report provided which had also been considered at the Finance and Performance Committee.	Assurance received
Going Concern Assessment	1,5		The Committee received the report outlining the basis for asking Board to approve that it considered the Trust to remain a Going Concern.	The Audit Committee recommend that the Board accept the recommended view and statement

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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

Draft Annual Accounts	1,5		The Committee considered the draft Annual Accounts which are still subject to external audit. The Committee noted the two areas of critical judgement in relation to the non-consolidation of the Trust's Charitable Funds as they are held and manged by Mersey Care Foundation Trust under a Service Level Agreement and the valuation of the Trust's land and building in year.	Assurance received
Draft Annual Report and Annual Governance Statement	1		The Committee considered the most recent update to the draft Annual Report and Annual Governance Statement, noting there may be further amends prior to final approval in June. It noted the log of queries and changes to date, helpfully compiled by Agnes Cunliffe. The Chief Executive Officer attended the meeting in his capacity of Accountable Officer to give his assurance that the governance processes in place across the Trust were appropriate and well applied.	Assurance received
External Audit progress report	1,5		The Committee received a verbal update from the External Auditor, who advised that good progress was being made with the majority of samples submitted, noting there were less samples this year.	Assurance received
Review of the meeting	1		There was general agreement the meeting had been effective with all participants having the opportunity to comment or raise questions.	
As this was the last meeting of the outgoing Audit Chair she thanked all members and participants in the Audit Committee for their support and diligence in fulfilling their obligations. She wished the Trust well for the future and handed the role of Audit Chair over to Bob Chadwick.				
Risks Escalated: None from the meeting				

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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

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**40/24i**		
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 Failure to implement and maintain sound systems of Corporate Governance and failure to deliver	**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	**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	**Partnerships** Failure to work in close collaboration with partners and staff in place and

on the Trust's Strategy		champions ED&I for patients			patients and staff	across the system

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**40/24i**		
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 provides updates on:

- Population Health dashboard
- Strategic objective deliverables
- Delivery Plan progress
- Strategy into action examples and case studies

2. Population Health dashboard

2.1 The population health dashboard presents key indicators for the Warrington and Halton places, and this report introduces indicators covering the places where we deliver dental services. The indicators are benchmarked against national and North-West levels (where data is available), and also show, where applicable, changes from the previous reporting period.

2.2 This section has been further updated to include population health metrics that align with our Health Inequalities and supporting Make Every Contact Count (MECC) approach within the organisation. This includes metrics on:

- Alcohol
- Smoking
- Physical activity and weight

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Population health summary – community services

					Warrington		Halton				
ID	Indicator	Age	Sex	Period	Value	Change prev. yr	Value	Change prev. yr	Value (NW)	Value (England)	Unit
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	%
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	%
Alcohol											
	Admission episode for alcohol related cardiovascular disease	All ages	Persons	2021/22	746	n/a	914	n/a	806	759	Rate/ 100,000
	Incidence rate of alcohol-related cancer	16yrs +	Persons	2017-19	39.52	n/a	43.06	n/a	41.32	38	Rate/ 100,000
Smoking											
	Smoking prevalence in adults - current smokers	18yrs +	Persons	2022	9.9	n/a	13.3	n/a	13.4	12.7	%
Physical activity											
	Percentage of physically active adults	19yrs +	Persons	2021/22	69.2	n/a	63.1	n/a	65.2	67.3	%
	Percentage of physically inactive adults	19yrs +	Persons	2021/22	21.1	n/a	23.7	n/a	24.2	22.3	%
	Percentage of 15 year olds with a mean daily sedentary time +7 per day in the last week *	15 yrs	Persons	2014/15	66.7	n/a	76.9	n/a	n/a	70.1	%
	% physically active for at least one hour per day seven days a week *	15 yrs	Persons	2014/15	12.2	n/a	12.0	n/a	n/a	13.9	%
Weight											
	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	%
	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	%
	Adults classified as overweight or obese	18yrs +	Persons	2021/22	70.6	n/a	71.2	n/a	66.7	63.8	%

Source: Office for Health Improvement & Disparities, Fingertips reports
* Public Health Institute, Faculty of Health, Liverpool John Moores University

Dental metrics

Local Authority name	5-year-old population (mid 2020)	Average number of dentinally decayed, missing due to dental decay and filled teeth (Mean d3mft)			Percentage of children with any decay experience (% d3mft>0)		
		2022	*2019*	Change	2022	2019	Change
England	689,190	0.8	*0.8*	0.0	23.7	*23.4*	0.3
North West	89,619	1.2	*1.2*	0.0	30.6	*31.7*	-1.1
Bolton	3,990	1.8	*1.1*	0.7	42.8	*32.7*	10.1
Bury	2,378	1.5	*1.4*	0.1	34.6	*35.2*	-0.6
Cheshire West and Chester	3,862	0.9	*0.6*	0.3	25.4	*22.7*	2.7
Halton	1,640	1.1	*1.0*	0.1	33.9	*27.0*	6.9
Oldham	3,431	1.6	*1.9*	-0.3	39.5	*43.2*	-3.7
Rochdale	3,157	1.7	*1.7*	0.0	39.8	*40.7*	-0.9
St. Helens	2,045	1.0	-	n/a	31.2	-	n/a
Stockport	3,598	0.6	*0.5*	0.1	17.5	*22.0*	-4.5
Tameside	2,918	1.2	*1.0*	0.2	33.0	*33.1*	-0.1
Trafford	3,023	0.8	*1.0*	-0.2	24.5	*26.0*	-1.5
Warrington	2,538	1.0	*0.8*	0.2	30.5	*24.3*	6.2
Wigan	3,860	1.2	*1.0*	0.2	32.6	*31.9*	0.7

Key 1
2022 vs England and NW

Red	Above England and NW
Amber	Below NW but above England
Green	Below England and NW

Key 2
Change between 2019 and 2022

Red	Increase from 2019
Green	Reduction from 2019

Source:
National Dental Epidemiology Programme for England - Oral health survey of 5 year olds - 2019 and 2022 surveys
Office for Health Improvement and Disparities

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)

3.3.1 As previously discussed, given the Communities Matters strategy is a 3 year plan, bi-annual strategic milestones for the forthcoming year, set at September 24 and March 25, have been developed by EMT and are included in the table below.

3.4 These milestones will continue to be reviewed and, where appropriate, updated to ensure they remain relevant and timely.

3.5 As the table demonstrates, work is progressing across all of the objective deliverables, with none yet completed.

Bridgewater Community Healthcare NHS Foundation Trust

Strategic Objective deliverables summary

Quality

	ID	Deliverable	*June 24 update*	Sept 24 milestone	Mar 25 milestone
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.	There have been 19 QRVs completed across the four Directorates. All service Self Assessments have been requested to review compliance against completion. Training package developed to support new members of the QRV team. QRV inspectors to be widened to include senior clinical leads, a list of potential roles is being scoped.	Evaluation of accreditation tool completed. Reporting system agreed and metrics finalised. Engagement with staff re scoring system that will inform teams reports	Transition to accreditation scheme achieved from Quality Review Visits and implementation of the reporting matrix that will inform risk stratification and schedule.
	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.	Additional BOOST plans identified to support quality initiatives such as, implementation of accreditation and the work of the voice of the child group. Meeting between the Associate Chief Nurse and Assistant Director of Transformation with AQUA arranged to explore further opportunities to support quality improvement.	Ensure plans are in place and underway for all Boosting Efficiencies Council Task and Finish Groups workstreams. Undertake AQuA training to increase QI capability within the Transformation Team	Ensure completion of all Boosting Efficiencies Council Task and Finish Group workstreams.
	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.	Patient partner completing induction and observing range of quality & safaty meetings in the trust	The patient partner role is embedded within the patient safety meetings within the Trust, providing insights as to the patient perspective and having a positive contribution to meetings. Recruitment to a second patient partner commenced. Directorate specific plans to advance patient / family experience are evident at the Bridgewater Engagement Group	The impact of activity at the Bridgewater Engagement Group and having a patient partner is now evident within the Trust with demonstrable influence achieved to support staff and the development of a culture that is inclusive of a patient / child / family / public centred approach within the Trust.
	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.	PSIRF oversight group (PSIRFALPS) commenced. Advanced training for investigators procured and booking dates circulated	% of staff who have completed level one and two PSIRF training. Number of staff trained in advanced PSIRF skills. Staff have a positive understanding of the PSIF approach to patient safety	A systems approach to understanding and learning from patient safety incidents is embedded within the Trust with engagement and involvement of patients and families central.
	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.	Multidisciplinary preceptorship group continue to meet, led by the AHP Lead.	There will be an implementation plan for AHP preceptoship, identifying key areas for development for AHPs. This will be informed by the new national standards for AHP Precpeptorship. It will be co-produced by representatives of each of the Trust's AHP professions aliong with wider subject-matter experts.	Preceptorship policy, processes and support will be in place to enable services across the Trust to deliver a truly multiprofessional preceptorship relevant to their specific context.

Health equity

	ID	Deliverable	*June 24 update*	Sept 24 milestone	Mar 25 milestone
HEALTH EQUITY	HE1	We will implement the evidence-based, priority areas of focus from the NHS Prevention Pledge.	*Work continues to progress towards the full awarding of the Prevention Pledge. Our Make Every Contact Count (MECC) initiative has been developed and will be rolled out to all front line services in June 24. This will involve online training, supplimented with place-based specific training where*	Anchor instituation pledge signed.	Prevention pledge full award
	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.	*We are continuing our partnership approach to this in both Warrington and Halton through the respective place-based partnerships and "wells" groups. The groups are at different stages of maturity but we are embedded in all.*	Engagement with relevant "wells" within Halton and Warrington with clear objectives from each well	Damp and mould policy / SOP in final stages of agreement
	HE3	We will influence, shape and support the delivery of Health and Wellbeing strategies in the places that we work.	*The JSNA group in Warrington has completed its review of the JSNA, which has now been signed off and approved. There are a number of CORE20Plus5 projects commencing via the the place-based partnerships, which are heavily influenced by the JSNA.*	Gain understanding from our places what their priorities for improving health equity are and embed these into our own work	Work programmes and projects underway with evidence of impact starting to be demonstrated.
	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.	*We are continuing to focus internally on data quality and data capture to ensure we are able to identify patients/cohorts who are/aren't accessing services/appointments and any inequalities associated with this. Through our place-based projects, including CORE20Plus5, we are actively working in*	Improved data about our users collected within our electronic systems	Identify and define a high intensity user for our services
	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.	*Our Voluntary Sector Link Worker project continues to deliver support to our services and local people. A case study is provided, detailing the scheme, progress and next steps*	Post advertised to support projects relevant to supporting vulnerable patients	Project lead in place and activities defined

Staff

	ID	Deliverable	June 24 update	Sept 24 milestone	Mar 25 milestone
STAFF	S1	We will maximise our workforce intelligence to fully understand our workforce profile to inform workforce planning utilising Population Centric Workforce Planning approaches.	*Service Workforce Planning Sessions are ongoing comprising of membership the from Quality, Operational and People teams. 30 Services have been completed with further sessions booked in during June and July.*	All workforce plans in place	All workforce plans implemented as per agreed staffing
	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 in our local communities, promoting the Trust as a local employer of choice and sharing education, information, advice and guidance relating to NHS Careers. 4 such events have been attended in April and May, and 3 planned events in June. The events are also supported with Bridgewater's NHS Career Ambassadors. These include events at local high schools, colleges, job centres and community events. A Community Careers Engagement Annual Report has been produced for 23/24, outlining all of the work of the Talent for Care Team as supported. This was presented to the Trust's People Committee in May.*	We will have continued to engage in the usual way as per our current engagement methods	We will have continued to engage in the usual way as per our current engagement methods
	S3	We will maximise utilisation of the apprenticeship levy to support the development of our workforce.	*There are currently 95 employees registered as apprentices across the Organisation and a further 17 confirmed planned starts in the coming months. 17 Apprentices completed their respective apprenticeship programme in 2023/24 and 16 of those remain substantively employed by the Trust, many progressing into higher banded roles as a direct result of their apprenticeship. The Trust has maintained zero fund expiry position from the apprenticeship levy account, with the last expiration of funds occurring in October 2022.*	Monitor and report our apprenticeship numbers and levy utilisation to POD Council and People Committee, taking forward any actions to address areas of concern	Monitor and report our apprenticeship numbers and levy utilisation to POD Council and People Committee, taking forward any actions to address areas of concern
	S4	We will realise the added value to our workforce of our volunteers, third sector organisations and the armed forces.	*New Starters data including veteran recruitment was presented to June's POD Council. All roles are adervertised via the Career Transition Partnership for veterans to access.*	Periodically report numbers to POD Council, taking forward any actions improve intake where appropriate	Periodically report numbers to POD Council, taking forward any actions improve intake where appropriate
	S5	We will create opportunities for working together with our community and other health and social care providers.	*We continue to provide leadership (and Chairing) to the Warrington Together Workforce Enabling Group (WEG) and will be actively involved in the One Halton equivalent, to develop place-based workforce plans. Further workforce at-scale opportunities are being developed via the Provider Collaboratives and ICB HR Director's network. Work programmes are further supported by national workforce/people programmes. ICB scale work has commenced for some of the workstreams. Bridgewater are engaged in all programmes. Integration and collaboration with WHH is being explored from a Workforce/People perspective.*	Continue to engage in partner meetings and take forward agreed actions	Continue to engage in partner meetings and take forward agreed actions
	S6	We will create a culture where we are supportive of innovative roles – new ideas and innovative ways of working, upskilling and transforming services.	*14 AHP and Nursing pre registration degree apprenticeship positions. Increase in Trainee Nursing Associate positions in adults and children's nursing teams - 17 in training. Voluntary sector link workers. 3 Community Health Workers. 18 Advanced Clinical Practitioners on programme. New Therapy Assistant Apprenticeships are providing a pipeline of talent for the AHP support workforce and supporting the establishment of a full AHP Career Pathway.*	Periodically report numbers to POD Council, taking forward any actions improve intake where appropriate	Periodically report numbers to POD Council, taking forward any actions improve intake where appropriate

Resources

	ID	Deliverable	June 24 update	Sept 24 milestone	Mar 25 milestone
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.	*The Trust continues to work closely with partners to ensure effective utilisation of resources.* *Newton review workstreams up and running. Trust membership of all workstreams and SRO for UCR.* *Place based integrated working - governance frameworks, workstreams and efficiency opportunities relating to closer integrated working with Warrington and Halton Foundation Trust (WHH) drafted and initial meetings held.*	Initial Newton review benefits to be realised. Place based integration - detailed efficiency opportunities and delivery plans to be developed with timelines for delivery	Newton review workstreams to have service improvements / changes embedded to deliver efficiencies. Place based integration - delivery of efficiencies in line with plans - continued review of opportunities.
	R2	We will enable excellent digital and data services to drive and deliver efficiency and optimisation.	*Continued monitoring of digital plans through DIGIT, reporting into F&P.* *Digital is a key workstream within the BOOSTing efficiency programme, with multiple schemes identified for development and roll out in 2024/25.* *Dentally, the dental EPR system is now fully live across the Trust.* *Place based integration - Digital workstream identified and being developed.*	Approved BOOSTing efficiency programmes in train with delivery profiles, expectation of efficiencies delivered throughout 2024/25. Place based integration - review of organisational Digital strategies to develop a single strategy, areas of integration and collaborative working identified with an approved plan for implementation.	All approved BOOSTing efficiency programmes delivered in line with plans. Place based integration - draft Bridgewater / WHH Digital strategy developed. Progress on areas of integration and collaborative working.
	R3	We will look to reduce carbon emissions and deliver the Trusts Green Plan.	*Progress on the Green Plan reported through F&P.* *All capital schemes identified for 24/25 have been assessed against the green plan.* *LED lighting and EV charging installations have been completed for Europa Point.* *Place based integration - Estates (including Green Plan) workstream identified and being developed.*	Approved BOOSTing efficiency programmes in train with delivery profiles, expectation of efficiencies delivered throughout 2024/25. Place based integration - review of organisational Estate (including Green Plan) strategies to develop a single strategy, areas of integration and collaborative working identified with an approved plan for implementation.	All approved BOOSTing efficiency programmes delivered in line with plan. Place based integration - Single Green Plan developed for Bridgewater and WHH. Progress on areas of integration and collaborative working.
	R4	We will embed Anchor principles and look to procure locally where we can.	*We continue to work with our procurement partner, developing and enhancing monitoring arrangements to enable us to identify further opportunities, and to optimise the social value impact, of all local contracts. Funding for the link worker programme is ringfenced in 2024/25, along with funding to support and develop integrated pathways between community and voluntary sector services, as part of our approach to realising health equity.*		
	R5	We will work with partners to maximise and right size our estates.	*Warrington place-based estates review group continue to meet. C&M estates group in early stages of development. The Trust is represented and contributes to both.* *Internal estate group has been established and is meeting regularly to map existing estate occupancy and identify opportunities to maximise utilisation and opportunities for collaborative working with local partners.* *Estate Efficiency is also a dedicated workstream within the BOOSTing efficiency programme.* *Place based integration - Estates (including Green Plan) workstream identified and being developed.*	Approved BOOSTing efficiency programmes in train with delivery profiles, expectation of efficiencies delivered throughout 2024/25. Recommendations from internal estate review group to be considered against the Place based integration findings and action plan developed. Place based integration - review of organisational Estate (including Green Plan) strategies to develop a single strategy, areas of integration and collaborative working identified with an approved plan for implementation.	All approved BOOSTing efficiency programmes delivered in line with plan. Internal estate efficiency schemes scheduled and in progressed in line with agreed plans. Place based integration - Single Estate strategies developed for Bridgewater and WHH. Progress on areas of integration and collaborative working.
	R6	We will work with partners to operate within our financial allocations and maintain financial balance.	*The Trust met all of its financial targets in 2023/24. Accounts are currently being audited.* *Place based high level financial position monitoring developed for NHS partners in 2024/25.*	Monitor Trust financial performance against plan, along with Place performance to include delivery of efficiency savings and any associated impact across partners.	Monitor Trust financial performance against plan, along with Place performance to include delivery of efficiency savings and any associated impact across partners. Delivery of all Trust targets.

EDI

	ID	Deliverable	June 24 update	Sept 24 milestone	Mar 25 milestone
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.	*A further faciliated session has taken place with the EDI group, to develop the vision and approach for our EDI working group that aligns to the six Strategic Objectives set out in Communities Matter. We have commenced direct engagement with staff through awareness raising sessions. These have focused on menopause and LGBT+. We have also submitted our application for silver-level with the Defence Employers Recognition scheme.*	We will have meaningful Trust wide and Directorate Action Plans in place in relation to staff survey results. Action plans will be informed by staff voice. Improvement in NQPS results for July 24	Demonstrable evidence of Staff Survey action plan delivery via 'You said, We did.....We are doing'
	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.	*An internal task and finish group is being established to deliver the NHS digital reasonable adjustments flag. As this will involve our EPR systems, we will be linking with local PCNs to ensure we have common approach. We continue to pro-actively manage the language interpreter contract, identifying sustainable solutions moving forward. The focus being on spoken language. We have also signed a contract with AccessAble for provision of disability access information for our patients.* *HEAT (Health Equity Assessment Tool) will be embedded in all service reviews and transformation programmes to ensure Health Equity is considered in all transformation work.*	Engagement with relevant "wells" within Halton and Warrington with clear objectives from each well, with clear projects and deliverables developed. Outputs from AccessAble will be publically available.	Specific projects designed and in progress to improve equity. Impact starting to be demonstrated. Demonstrable improvements in the capture and data quality for reasonable adjustment flags
	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.	*We have been a key partner in the launch of the Warrington Living Well Hub. The installation of EV chargers at Spencer House and Europa Point is underway. Installation of LED lighting at Wolves has been completed.*	Anchor instituation pledge signed.	Prevention pledge full award
	EDI4	We will improve the reach of our organisation and grow our standing in the community through local partnerships	*The PACE group Terms of Reference have been approved and a business case for PACE resource has been approved by EMT. Work with our services continues to identify PACE opportunities and a workshop is planned for the end of June to develop a PACE work plan for the forthcoming year*	We will have identified and engaged with all identified groups. We will have embedded the governance loop across all Directorates	Demonstrable changes will have taken place based on feedback from our PACE work.

Partnerships

	ID	Deliverable	June 24 update	Sept 24 milestone	Mar 25 milestone
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.	*We are continuing to work with the PCNs in Halton and Warrington on a range of intitiatives, all of which focus on the opportunities of closer integrated working. This includes a focus on urgent care pathways, long term conditions management, joint working and the realisation of quick-wins.*	Have established projects and governance in situ across a number of projects in both Warrington and Halton with PCNs/Federations. Initial impact/benefits being realised	We will have integrated working and integrated models in place across a number of services, delivered in partnership with local PCNs and Federation.
	Ptnr2	We will work closely with all our partners to drive forward continuous quality improvements in the services we collectively provide.	*We continue to work as part of place-based arrangements to both progress initial workstreams, whilst in parallel finalising the overarching work programmes, priorities and identifying the key metrics to monitor progress and impact*	Clear programme and project priorities and governance established in both WT and OH, with projects underway	Place-based working will be deeply embedded, driving and delivering impact for local people across a range of integrated services.
	Ptnr3	We will work across our organisational boundaries with partners in place as we create future integrated care and service models.	*Work is progressing in both 'places' to develop and implement forms of integrated teams/integrated working. This involves both PCNs, local councils and other partners. We have been a key partner in the development and delivery of the multi-agency Living Well hub in Warrington.*	As well as the progress being made with PCNs, we will have established projects underway and associated governance in place with both WBC and HBC to realise collaborative benefits.	We have established formal joint entities in place with both local councils, delivering integrated services for local people
	Ptnr4	We will work with partners to improve equity in health outcomes.	*The JSNA group in Warrington has completed its review of the JSNA, which has now been signed off and approved. There are a number of CORE20Plus5 projects commencing via the the place-based partnerships, which are heavily influenced by the JSNA.*	Engagement with relevant "wells" within Halton and Warrington with clear objectives from each well, with clear projects and deliverables developed	Specific projects designed and in progress to improve equity. Impact starting to be demonstrated.
	Ptnr5	We will work with our system partners to collaborate at scale to enable better care at place.	*We continue to work as part of the provider collaborative and are in the process of reviewing and finalising the portfolio of programmes and projects for 24/25 to ensure alignment to the key priorities of the system, places and partner organisations.*	The Provider Collaborative work programme, projects and assocated governance in place, communicated with the system and work actively underway	The Provider Collaborative will have delivered impact 'at scale' across a number of its workstreams

4. Delivery Plan progress

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

4.2 Based on feedback from the Board, the RAG methodology has been adjusted accordingly:

- Red – where 5% of tasks are Red
- Amber – where 10% of tasks are Amber and/or Red
- Green – where more than 90% of tasks are green

4.3 Identification of the governance group (council, DLT) who are monitoring and scrutinising the plans has also been added, with *Target project completion date* and a *Forecast RAG* to be added in the next report.

4.4 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 Directorate Action Plans	Oversight Group/Council	Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
New Children#s BOOST Action Plan	Quality Council	0	90	0	0	90	Green
Paediatric Audiology Review Action Plan	Quality Council	22	4	2	3	31	Red
Paediatric Audiology RCA Action Plan	Quality Council	0	6	0	0	6	Green
Voice of the Child Action Plan	Quality Council	17	16	0	3	36	Red
Health Visiting Action Plan	Transformation Group	1	17	0	0	18	Green
School Nursing	Transformation Group	0	17	0	0	17	Green
Warrington 0-19	Children's DLT	35	32	4	0	71	Green
Warrington Physiotherapy	Children's DLT	21	4	0	0	25	Green
SEND	Children's DLT	11	1	0	0	12	Green
SEND Operational	Children's DLT	3	10	1	0	14	Green

Halton Adults Directorate Action Plans		Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
Halton and Warrington Tissue Viability	Halton Adults DLT	10	3	8	0	21	Amber
Halton Heart Failure Pathway Development	Transformation Group	16	2	4	0	22	Amber
Halton Virtual Ward	Transformation Group	25	0	0	0	25	Green
Service User Access to Widnes Urgent Treatment Centre	Transformation Group	15	0	2	0	17	Amber
Community Nurses (Halton & Warrington)	Quality Council	43	3	5	0	51	Green
Community Equipment Stores	Quality Council	39	0	0	3	42	Red
Drive Ability Northwest	Quality Council	19	0	0	2	21	Red

Warrington Adults Directorate Action Plans		Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
Community Falls and Rehab	Warrington Adults DLT	15	3	0	0	18	Green
Dermatology	Quality Council	53	0	0	7	60	Red
Warrington Wolves Improvement Plan	Quality Council	19	6	1	0	26	Green

Dental Directorate Action Plans		Complete	On Track	Minor Delay <2 Weeks	Major Delay >2 Weeks	Total	Overall Status
Dental Nurse Career Development	Transformation Group	20	9	11	0	40	Amber

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

5. Strategy into action example

Bridgewater Community Link Workers Project

Summary

The Bridgewater Community Link Workers project serves as a link to the local VCSE for Warrington and Halton Bridgewater patients and services, offering essential support and guidance to individuals facing a myriad of challenges.

Working in partnership with Warrington Voluntary Action and Halton & St Helens Voluntary and Community Action, Bridgewater commissioned two Link Workers to provide direct support to the respective community-based services, and their patients.

Expected benefits:

- Improved Patient Outcomes: Enhanced collaboration with community services leads to better patient support, addressing social determinants of health and improving overall health outcomes.
- Increased Efficiency: Clearer referral criteria and guidelines streamline the service delivery process, reducing inappropriate referrals and ensuring that patients receive the right support at the right time.
- Resource Optimisation: By addressing gaps and partnering with local authorities, the project optimises resource allocation, reducing strain on clinical services.
- Enhanced Mental Health Support: Expanding mental health support options, especially for underrepresented groups, ensures more comprehensive care for individuals in need.
- Empowered Communities: Clearer referral pathways and guidelines empower community members to navigate support services effectively, leading to better utilisation of available resources.
- Social Inclusion: By addressing social isolation through community engagement and tailored support, the project helps individuals build meaningful connections and improve their quality of life.
- Personalised Care: Person-centred approaches ensure that support is tailored to individual needs, promoting a sense of autonomy and empowerment among service users.

Progress to date and next steps

- Since its inception in September 2023, the Link Workers have engaged with our clinical services to foster collaboration and develop effective referral pathways. Up to March 24, 164 referrals have been made into the service.
- Through these referrals, a number of challenges have been identified, including transportation barriers. This includes indirect bus routes and cost implications which pose challenges for individuals seeking access to essential activities and support services. Moving forward, the project aims to collaborate with local transportation authorities to address barriers, improve access to essential services and complement the gap in transport by exploring future community transport type investment.
- The project also plans to expand mental health support options, particularly for underrepresented groups, through partnerships with relevant stakeholders and incorporate equality from an equitable lens for accessibility.

- The project will be implementing clearer referral criteria and guidelines to ensure appropriate referrals and streamline service delivery processes. To support this, the Link Workers will be able to access SystmOne from May.
- In the upcoming quarter, the project will extend its reach to individuals aged 0-19, aiming to provide holistic, person-centred support through family engagement, equitable access, and youth empowerment.
- The project has been capturing individual case studies and these can be made available to Board members upon request.

6. RECOMMENDATIONS

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

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	People Committee	**Report to:**	Board of Directors
Date of Meeting:	08 May 2024	Date of next meeting:	10 July 2024
Chair:	Abdul Siddique, Non-Executive Director	Parent Committee:	Board of Directors
Members present/attendees:	Members Abdul Hafeez Siddique, Non-Executive Director (Committee Chair) Dame Elaine Inglesby, Non-Executive Director (Committee Vice-Chair) Paula Woods, Director of People & Organisational Development Tina Wilkins, Non-Executive Director Linda Chivers, Non-Executive Director Lynne Carter, Deputy Chief Executive and Chief Nurse Sarah Brennan, Chief Operating Officer, attending until 11 am Bob Chadwick, Non-Executive Director Attendees Jan McCartney, Director of Corporate Governance Jo Waldron, Deputy Director of People and Organisational Development Mike Baker, Deputy Director of Communications and Engagement David Mills, Deputy Medical Director - attending on behalf of the Medical Director Tania Strong, Interim Head of Human Resources Kathryn Sharkey, Head of Workforce Carl Dixon, Head of Leadership and Organisational Development Adie Richards, Education and Professional Development Lead Razia Nazir, Knowledge & Library Services Manager Ruth Besford, Equality and Inclusion Manager Helen Young, Freedom to Speak Up Guardian Denise Bradley, Unison Bridgewater Branch Secretary and Staff Side Chair Lynda Richardson, Board and Committee Administrator	Quorate (Yes/No):	Yes
		Key Members not present:	Ted Adams, Medical Director Rachel Game, Governor Observer Bob Chadwick, Non-Executive Director

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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

	Observers Christine Stankus, Lead Governor, Observer Arshad Ashraf, Public Governor, Observer Sarah Power, Staff Governor, Observer		

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
			Helen Young presented the Freedom to Speak up report, which was noted as a Quality Report as opposed to an annual report as per the agenda item. The report was presented for assurance purposes. The report provided the following: • The report showed the number of staff raising concerns and identified themes and trends. • An update on the NGO a self-reflection tool and action plan. • An overview of the FTSU eLearning training package to assist staff in understanding the vital role they play in 'speaking up'. Some discussion around staff wanting anonymity when they raise concerns and what the nature of those concerns are. Themes will be included in the next report.	The Committee noted the report was noted. Next report to include themes around the nature of concerns which are anonymous.
RISK REPORT UPDATES • **HR** • **OD/EPD** **COMMUNICATION**	BAF 4 and 6		Jo Waldron presented the People Directorate Risk Reports 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).	The Committee noted the content of the reports and were assured on the management of risks.

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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
			There are a total of 5 Risks on the HR Risk Register. Five were reported to Risk Council (as at 3rd March 2024) **Risk ID 3059**: remains at a score of 6 – Junior Doctor strikes took place over the 24th – 29th February. The Trust focus is on supporting the system as part of the wider Winter pressures response. **Risk ID 3191**: has a score of 9 - This risk and plans for the Trusts new Wellbeing Policy in coming months will continue to be monitored in terms of impact. **Risk ID 3245:** has a score of 12 – this was entered onto the register on the 16th February as a new risk – relates to the delay in provision of information available from PAM our Occupational Health provider relating to employee immunisation status for Measles (MMR Vaccination). This may also be an emerging risk in relation to the robustness of vaccination information held by PAM, subject to further scrutiny. **Risk ID 3078:** Mandatory Training - remains at a score of 9. Despite the significant progress, staff still remain non-compliant with a number of core mandatory training modules. **Risk ID 3176:** Oliver McGowan Training – Remains at a score of 6. Currently encouraging uptake of E-Learning which is currently at 95.85% at the time of writing. The risk is specifically in relation to the national requirements of the training requiring a face-to-face delivery to all staff by trainers with lived experience of Autism.	

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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
IQPR – PEOPLE INDICATORS	BAF 4 and 6 WLR 9 PP 1-7		The seven IQPR people indicators were presented to the Committee for month 10 by Jo Waldron, Deputy Director of People and Organisational Development (OD). As per our intention to provide the Committee with the latest information available, the month 12 position was a focus for the report. Whilst 3 of the indicators were reporting green in month 10, this position had improved in month 12 with 5 indicators reporting green, with the exception of Sickness Absence Rolling and Actual. Month 12 IQPR Indicators were reporting as follows: • Turnover rate is reporting green and within Trust target at 11.32%, slightly improved from month 11 which was at 11.33%. • Rolling sickness absence for the period 01 April 2023 – 31 March 2024 was 5.57% against a target of 5.5%, compared to 01 April 2022 – 31 March 2023 (6.29%). • Actual sickness absence has decreased month on month since January 24 and is at 5.54% in March, which is slightly above Trust target. • At month 12 each Mandatory Training module, including PPDR has increased compliance with the exception of Infection Control Level 2. This has slightly decreased however remains above target. The target for MT compliance is 85% with the exception of Corporate Induction and Data Security Awareness which remain at a target of 95%.	The Committee noted and were assured of the progress with the indicators. The next POD report to include details of the number of Flexible Working applications received since the campaign, along with a summary of the decisions.

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			The report also provided an overview by exception on the Trust governance in relation to HR Policy update and ratification with an exception report for each expired policy. There are currently 53 HR policies and out of these policies, 83% are in date and 17% have expired. The Polices that have expired all have agreed extensions. There was a detailed discussion around flexible working and the impact of the recent campaign. Assurance was provided by members in relation to the monitoring and awareness raising for this initiative.	
DIRECTOR'S UPDATE REPORT	BAF 4 and 6 WLR as highlighted in the report PP as highlighted in the report		The 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 report, included areas where there are challenges and potential risks in delivery. My May report featured the following: • Industrial Action Update: Junior Doctors, Consultants and SAS Doctors, along with the new Pay Circular for Consultants in England • Department of Health & Social Care – Call for evidence: Separate pay spine for Nurses • NHS Job Evaluation Group (JEG) – National Nursing and Midwifery Job Profiles Review • Optimising, Rationalising and Reform of Statutory and Mandatory Training • National Induction Programme	The Committee noted the report and its comprehensive contents.

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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
			• Operational Planning and Contracting Guidance (Workforce aspects) • CPOCT – Chief People Officer for Community Trusts Group • NHS Leadership Competency Framework for Board Members (LCF) and Supporting New Standards for Board Members • National People Policies Update, including our local policy determination • North West Wellbeing Policy – Early Adopter Update: Approval and Launch • Workforce Plans and ICB Workforce Assurance Meetings • Workforce Monitoring and Pay Controls (including Vacancy Management) • Draft" North West EDI Board Assurance Panel and Operational Assurance Panel: Terms of Reference, Governance and Operational Procedures • North West Chief People Officer Network Update • Cheshire & Merseyside's People Directors Network (PDN) Update: Scaling People Services and the MHLDC Provider Collaborative Workforce Programmes • North West Creating Careers: A Step Ahead • Warrington Together Workforce & OD Enabling Group Update (WEG) and Delivery Oversight Committee Update (DOC) • Flexible Working Campaign – Making Flexible Work	

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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
			• Senior Leaders Development Programme: "Today's Talent… Tomorrow's Future" - Invites for Expressions of Interest • Career & Apprenticeship Team Updates • Annual Careers Engagement Report 2023/24 • Staff Health & Wellbeing Updates • Rugby League Cares – Sessions for the Executive Team and Edge Hill Programme Study • Acknowledgement to Linda Chivers, Non-Executive Director and Member of the People Committee The appendices referenced in the report, were included separately with the Committee agenda, in the usual way. Links to information were embedded.	
NATIONAL STAFF OPINION SURVEY – RESULTS REPORT AND ACTION PLAN	BAF 4 and 6		The report was presented by Mike Baker, Deputy Director of Communications and Engagement for assurance purposes. In 2023, six of the nine elements / themes show a matched or increased value on the Community Trust average. Three elements now show a decrease. This is a contrast with 2022, where there were four. These three elements will be the areas that the Trust will work closely on as part of its organisation-wide action planning. The areas showing a decrease compared to the Community Trust average are as follows: We are recognised and rewarded (-0.1) We are always learning (-0.1)	The reports were noted and the Committee noted the valuable picture this new analysis presents.

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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
			We work flexibly (-0.1) The directorate information contained greater breakdown of content across the previous 3 years and therefore a more detailed picture. Some improvement showing across all the Directorates which is positive; however still some concerns around Dental C&M and Corporate Estates. Any areas highlighted in red displayed where a directorate had scored lower than the Trust score and will result in the directorate focussing on these areas for further improvement and development at directorate level. Staff Survey Action Plans are currently in the process of being created and implemented with a key focus on quality, not quantity and the plans being informed by staff voice.	
COMMUNICATIONS AND ENGAGEMENT UPDATE			The report was presented by Mike Baker for information and assurance purposes and provided an overview of the Communications and Engagement activity as follows: • Staff Survey Action Plans • The National Quarterly Pulse Survey (NQPS) • CQC Preparation • Making Flexible Work • Recruitment Pack • Brand Guidelines – update • Communities Matter – Start of Year event • Introducing our new People Promise Champions • Feel Good Friday	The Committee noted the report and were assured on the programmes of work.

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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
			• #TeamBridgewater 'Thank You' Awards • Greater integration within Warrington and Halton Discussion took place around the Communications impact on the integration plans and it was recognised that the plans are likely to be wide spread across the whole People Directorate, as we focus on continuing to provide our staff with the right support whilst going through a period of significant change.	
EMPLOYEE RELATIONS REPORT	BAF 4 and 6 PP 3		The 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 38 employee relations cases opened, and at present there are 11 cases currently open – overall activity remains low. Breakdown of cases by ethnicity of employee is provided in order to monitor for any potential bias within our processes – at present a rolling figure of 8% of cases involve those employees from a minority ethnic background compared to a Trust population of circa 6%. Since the last report a further two members of staff have been suspended, with an existing suspension being lifted – details of costs associated with suspension are detailed at section 3.11. The direct cost of suspensions since December 2023 has totalled £6501.78.	The report was noted by the Committee and were assured on the progress.

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			There are no formal cases pertaining to the medical and dental workforce.	
FREEDOM TO SPEAK UP REPORT	BAF 4 and 6		The 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. • The results of the FTSU Staff Survey. • Update from the National Guardians Office. • Recommendations and future developments.	The Committee noted the reports and were assured on the progress and plans.
SYSTEM STAFFING IMPLEMENTATION UPDATE	BAF 4 and 6		The System Staffing Implementation Update report was presented by Jeanette Hogan, Deputy Chief Nurse for information and assurance purposes which outlined the implementation progress for both CNSST and the SNCT across the Trust. **Implementation of CNSST:** Currently two audits cycles have been completed in District Nursing and Community Matron services in September 2023 and February 2024 to test the implementation processes. Specialist Nursing services – test audit completed week of 8th April 2024. Analysis and interpretation of the data had commenced, however, on 25th April the Trust was contacted by the Head of Workforce North West NHSE, to advise all Trusts are to undertake a three month pause of any activity related to use	The Committee noted the reports and were assured on the progress and plans. Agreed that the report will be presented on a quarterly basis from this point on.

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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
			of the CNSST tool. This is to enable NHSE and the Safe Staffing Faculty to look at improving the effectiveness, reliability and usability of the CNSST tool. Therefore, future reports will not contain any further updates for the present until we receive further communication from NHSE. **Implementation progress of SNCT:** A community nursing safer staffing group has been introduced to coordinate the development of those systems in adult community nursing services that will support a better understanding of staffing capacity and demand within clinical services that will inform workforce planning. This includes not only the CNSST and SNCT, but the SafeCare and E Community modules as well as a review of existing activity data reporting potential. The Committee reiterated the Jeanette Hogan's disappointment at the delay in the release of the CNSST given the amount of effort that has been put into data gathering. Jeanette Hogan committed to continue to keep the Committee updated on.	
KNOWLEDGE AND LIBRARY SERVICES ANNUAL REPORT			The report was presented by Razia Nazir, Knowledge and Library Services Manager for information and assurance purposes. The Library & Knowledge Service (LKS) has continued to support initiatives and partnerships developed over previous years such as working closely with the Corporate Clinical	

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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
			Policy Group (CCPG), Research & Clinical Audit, and teams such as Safeguarding and Wellbeing. The service has also continued to support staff and learners across the organisation helping them to develop their study skills and find good quality information for personal and professional development and provided services to support staff in their workplace to save their time. LKS data for the previous financial year was presented in the report along with the national picture on the Quality and Improvement Outcomes Framework (QIOF) for the assessed period (2020-21). Plans for the coming year were presented which focussed on the promotion of the service, developing digital ways of delivery along with quality impact monitoring.	
ANNUAL OCCUPATIONAL HEALTH SERVICES REPORT			The report was presented by Tania Strong, Head of HR for information and assurance purposes. Overall, a total of 2371 referrals have been made over the 12 month period, covering, management referrals, health surveillance, immunisations, the physiotherapy information line (PhiL), wellbeing, musculoskeletal and neurodiversity. 665 appointments were prompted by management referral and of these mental health and musculoskeletal were the highest presenting reasons for referral. 193 referrals came via PHiL with the majority of cases being split equally across the 40-49, 50-59 and 60+ age brackets.	

	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

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 EAP service supported 87 individuals via 125 calls, of these, 48 were referred for structured therapy with a total of 225 therapy sessions being delivered within the reporting period. The main reason for contact was mental health, followed by bereavement. Overall following formal therapy there was a 50.9% improvement in GAD-7 scores (measuring the severity of anxiety). The PAM Assist App was launched in March 2024 and data will be available to monitor take up of this wellbeing offer going forward. 12.64% of appointments were wasted over the year from an occupational health perspective – as part of our plans for efficiencies the detail behind these DNAs and wasted appointments, data has been requested from PAM for review, to understand the reasons for non-attendance, cancellation or not being able to proceed.	
ORGANISATIONAL DEVELOPMENT UPDATES: **(i) Apprenticeship Scheme and Levy**	BAF 4 and 6 PP 4 and 5		The report was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes. There are currently 95 employees registered as apprentices across the Organisation and a further 17 confirmed planned starts in the coming months. 17 Apprentices completed their respective apprenticeship programme in 2023/24 and 16 of those remain substantively	The report was noted by the Committee along with the positive progress that has been made with the agenda. Update on Workforce Planning progress to be included in the POD Council Chair's Report at the next Committee.

	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

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
			employed by the Trust, many progressing into higher banded roles as a direct result of their apprenticeship. The Trust has maintained zero fund expiry position from the apprenticeship levy account, with the last expiration of funds occurring in October 2022. There was a 48% increased spend in 2023/24 compared to 2022/23, resulting in an 'overspend' of £63,259.39 based on the annual levy budget. The change from dramatic underspend to overspend illustrated in 4.6, is a positive indicator, as it provides assurance that the Trust is utilising the budget that we have accrued in previous years before it becomes vulnerable to expiry. Workforce planning, modelling and proposals are ongoing intended to inform the Trust's decision making and commitment to the potential apprenticeship offers for 2024/25.	
MIAA INTERNAL AUDIT UPDATE - **STRESS RISK ASSESSMENT REVIEW 23/24.** - **JOB PLANNING AUDIT AND ACTION PLAN**	BAF 4 and 6		**STRESS RISK ASSESSMENT REVIEW 23/24** Presented for information to confirm that suggestions made at the last Committee in relation to making amendments to the actions to ensure that they are measured, and RAG rated appropriately. Changes made and approved via E-Governance following the March 24 Committee. Linda Chivers noted that it's a concern when we get Limited assurance, but the important thing is that we act on it, and this is what we have done on this occasion. It was also noted	The Committee noted the report and were assured on the progress. It was suggested that a review of the timeframes on the Job Planning Audit and Action Plan take place, to consider whether the high impact actions need to be addressed sooner.

	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

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
			that the draft Head of Internal Audit Opinion for this year is still substantial assurance this year, which has been driven by the response and the implementation of the recommendations which is testament to how the Trust approaches dealing with these things head on. **JOB PLANNING AUDIT AND ACTION PLAN** Paper and action plan presented with an updated action plan. All actions are on track. Since the last People Committee the main update is that exploration on the use of an electronic Job Planning tool to improve record management and facilitate the process. Further clarification and details on the system will be discussed with the potential suppliers. A completed job plan audit was presented (action 1.2) at the Medical and Dental Governance meeting. Compliance with the existing job planning policy was good. At the same meeting an equivalence exercise (action 5.1) was undertaken with no unexplained differences on the core supporting professional activities (SPA) and additional responsibilities between doctors. The next update to the action plan will come to the next People Committee.	
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. **There were no suggested changes to the BAF's at this time and there were no changes to the risk scores.**	The Committee were assured on the progress and governance around the monitoring of the BAF.

	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
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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
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 4 and 6		Nothing for escalation this time	
REVIEW OF MEETNG ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			The Chair thanked Linda Chivers for her contributions to this meeting. Sarah Power, Staff Governor noted that the meeting was very informative and the comfort break was a welcome addition. The Committee noted the change in papers and welcomed the work that had taken place in relation to this and thanked those who contributed to this. Christine Stankus noted some of the amazing work that is taking place, particularly the work on Apprenticeships and Flexible Working. Christine thanked the Committee for their invaluable contribution and the quality of the reports.	
Risks Escalated			None.	

	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

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Creating stronger, healthier, happier communities.

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**42/24i**		
Report Title	**BOARD OF DIRECTORS - TERMS OF REFERENCE**		
Executive Lead	Karen Bliss, Chair		
Report Author	Samantha Scholes, Head of Corporate Governance		
Presented by	Jan McCartney, Director of Corporate Governance		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary

The Board is asked to approve the Terms of Reference

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 equality, 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**	**6 June 2024**
Agenda Item	**42/24i**		
Report Title	**BOARD OF DIRECTORS - TERMS OF REFERENCE**		
Report Author	Samantha Scholes, Head of Corporate Governance		
Purpose	Review and update of the Board of Directors Terms of Reference		

1. SCOPE

1.1 The terms of reference (ToR) for the Board of Directors and its committees should be reviewed annually to ensure they remain fit for purpose.

1.2 The last review took place in August 2023 however as these were inadvertently not presented to Board for formal approval, a further review has taken place.

2. PROPOSED CHANGES

2.1 The proposed changes from both August 2023 and June 2024 are minor and whilst detailed in the version control sheet of the attached Terms of Reference are also provided below:

2.1	Aug 2023	Board of Directors	**Membership** Removal of reference to two part-time Medical Directors **Frequency of Meetings and Location** Addition of the Council of Governors (along with the Board of Directors) holding an Annual General Meeting. Removal of 'This will be in combination with the Council of Governors' Annual Members Meeting. **Duties and Responsibilities** Amendment of vision to mission Addition of strategic to objectives Removal of 'Fair and' in relation to Just Culture Removal of Success from Financial and Quality **Outputs**

			Clarification that there will be a Board summary report to Council of Governors and publication on Trust website Amendment of issue and review dates
2.2	Jun 2024	Board of Directors	**Frequency of Meetings and Location** Amendment of Annual General Meeting to Annual Members Meeting **Throughout** Amendment of Trust Secretary to Director of Corporate Governance Amendment of issue and review dates

3. RECOMMENDATION

3.1 The Board is asked to approve the proposed changes

Appendix A: Board Terms of Reference v2.2 DRAFT

NHS
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Board of Directors
Terms of Reference

Name	Board of Directors
Purpose	The Trust exists to "provide goods and services for any purposes related to services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health" The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee or to an Executive Director. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Chair. The Board leads the Trust by undertaking three key roles: • Formulating strategy • Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable • Shaping a positive culture for the Board and the organisation The general duty of the Board and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the public it serves and for its staff.
Basis of Authority	These terms of reference describe the role and working of the Board and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis for the terms of reference for the Board's own Committees. The Trust is required to establish a Board of Directors in accordance with the requirements of the Health and Social Care (Community Health and Standards) Act 2003 (as amended by the Health and Social Care Act 2012) and the Trust's constitution. All members of the Board shall act collectively as a unitary Board with each member having equal liability.
Membership	All Executive and Non-Executive Directors of the Trust are members of the Board of Directors. Directors entitled to vote are Executive and Non-Executive Directors only. All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands. A paper ballot may be used if a majority of the Board of Directors present and entitled to vote so request. In the event of a tied vote, the Chair can exercise a casting vote. In the event of a vote Non-Executive votes must always outnumber Executive votes. Board membership shall be as follows:

	• An independent Non-Executive Chair • Six other independent Non-Executive Directors (including the Vice Chair and Senior Independent Director) Up to six Executive Directors, currently comprising: • Chief Executive Officer (also the Accountable Officer) • Deputy Chief Executive Officer / Chief Nurse • Director of Finance • Chief Operating Officer • Medical Director • Director of People & Organisational Development **Role of the Chair** The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole. The Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board. **Role of the Chief Executive** The Chief Executive (CEO) reports to the Chair and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO. The CEO is the Trust's Accountable Officer and is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board. The CEO is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board. **Attendance** The Director of Corporate Governance will be a regular attender at the Board but does not have voting rights. The Board shall be supported administratively by the Director of Corporate Governance whose duties in this respect will include: • Agreement of agenda for Board and Board Committee meetings with the Chair and CEO. • Collation of reports and papers for Board meetings • Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward • Advising the Board on governance matters. Corporate governance support will take minutes and provide appropriate support to the Chair and Board members.
Connectivity	Committees reporting to the Board: • Audit Committee • Finance and Performance Committee • Nominations and Remuneration Committee • People Committee

	• Quality and Safety Committee • Any other ad-hoc Committee established by the Board
Frequency of Meetings and Location	Ordinary meetings of the Board of Directors shall be held at regular intervals, at such times and in such places as the Board may determine from time to time. Meetings will normally be bi-monthly however the Board may agree to vary the frequency. Each member is to attend at least 75% of the diarised meetings within a calendar year. These meetings will be structured in two parts with Part I being open to members of staff, the public and the media to attend and with Part II being held in private. In addition, the Board of Directors and Council of Governors will hold an Annual Members Meeting to which members of staff, the public and the media will be invited to attend. If required, the Board may meet via digital technology. In this event, participation shall be deemed to constitute presence in person at the meeting.
Quoracy	The Board of Directors will be quorate when seven Directors, including not less than three Executive Directors (one of whom must be the Chief Executive or the Deputy Chief Executive), and not less than four Non-Executive Directors (one of whom must be the Chair or Vice-Chair of the Board). If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	**General Responsibilities** The general responsibilities of the Board are: • To work in partnership with service users, carers, local health organisations, local government authorities and others as part of the Integrated Care System to provide safe, accessible, effective and well governed services for the population it serves • To ensure that the Trust meets its obligations to its patients, stakeholders and its staff in a way that is wholly consistent with values and probity and with established Codes of Conduct. • To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner. **Leadership** The Board provides active leadership to the organisation by: • Ensuring there is a clear mission and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed. • Ensuring the Trust is an excellent employer by the development of a people strategy and its appropriate implementation and operation. **Strategy** The Board:

- Sets and maintains the Trust's strategic mission, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives.
- Monitors and reviews management performance to ensure the Trust's strategic objectives are met.
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

- The Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.
- The Board is responsible for ensuring a Just Culture and taking a positive stance on Anti-Racism.

Governance

The Board:

- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to NHS Foundation Trusts.
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of Trust business.
- Ensures that the statutory duties of the Trust are effectively discharged.

Risk Management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans and pathways, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for senior positions.

Communication

	The Board: • Ensures an effective communication channel exists between the Trust, the Council of Governors, members, staff and the local community. • Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback. • Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly, primarily via the Trust's website. • Publishes an annual report and annual accounts. **Financial and Quality** The Board: • Ensures that the Trust delivers high quality safe and effective care. • Ensures that the Trust operates effectively, efficiently, economically. • Ensures that the Trust strives to achieve the targets and requirements of stakeholders within the available resources. • Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.
Inputs	An agenda and any supporting papers shall be sent to each Director in electronic form so as to arrive with each Director normally no later than five working days in advance of each meeting. Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item. • Reports and plans as per agreed Board of Directors work plan, • Chair's Reports from Committees • Reports / formal correspondence from Regulators & key stakeholders • Escalation from Board level Committees • Request for further information or assurance from Council of Governors
Outputs	• Board summary report to Council of Governors and publication on Trust website.
Closed Session	On specific occasions it may be necessary for the Board to meet in closed sessions. Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.
Other Matters	**Attendees** • Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the Board. Deputies have no voting rights. • Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation.) **e-Governance Process** In order to facilitate the Board undertaking the business required of it, there will on occasion be a need for this to be conducted outside of its scheduled meetings in

	circumstances where it would not be practical to hold a meeting on a face to face basis. In such circumstances the Board is authorised by its Terms of Reference to conduct business via a process of 'e-Governance'. The rules to be observed when conducting business in this manner are as follows: • The business to be conducted must be set out in formal papers accompanied by the usual cover sheets which clearly set out the nature of the business to be conducted and the proposal which Members are being asked to consider. • The papers will be forwarded by the Director of Corporate Governance via e-mail to all Members of the Board who, subject to their availability, are expected to respond by e-mail to the same distribution list with their views within three working days of receipt of the papers. • For the conclusion of the Board to be valid, responses must be received from a quorate Board membership and in instances where the approval of the Board is sought, all such responses should support the proposal. • In the event that there is not a unanimous agreement of all responding Members, the proposal shall be considered not to be approved. • The Director of Corporate Governance will summarise the conclusions reached for the agreement of the Chair and this summary will be presented to the next scheduled meeting of the Board following which it will be appended to the minutes of that meeting and included in the Board Action Log as necessary.
Process for monitoring compliance with Terms of Reference	The Board shall self-assess its performance following each meeting and shall conduct an annual review of its effectiveness. (See Appendix A) These Terms of Reference will be reviewed by the Board at least annually.
Issue Date	June 2024
Review Date	June 2025

Appendix A

Monitoring Compliance with the Terms of Reference for Board of Directors

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / Committee which will receive the findings / monitoring report	Group / Committee / individual responsible for ensuring that the actions are completed
Duties of the Board	Review of agenda items	Director of Corporate Governance	Annually	Board of Directors	Board of Directors
Reporting arrangements to the Trust Board	Review of Board agenda	Director of Corporate Governance	Annually	Board of Directors	Board of Directors
Membership, including nominated Deputy	Annual report	Director of Corporate Governance	Annually	Board of Directors	Board of Directors
Frequency of attendance by Members	Annual report	Director of Corporate Governance	Annually	Board of Directors	Board of Directors
Reporting arrangements	Review of minutes	Director of Corporate Governance	Annually	Board of Directors	Board of Directors
Requirements for a quorum	Review of minutes	Director of Corporate Governance	Annually	Board of Directors	Board of Directors
Frequency of meetings	Review of minutes	Director of Corporate Governance	Annually	Board of Directors	Board of Directors

The monitoring of compliance for the Board will be undertaken on behalf of the Trust by the Director of Corporate Governance.

ISSUE DATE	June 2024
REVIEW DATE	June 2025

Version Control Sheet

Version	Date	Reviewed By	Comment
1.1	October 2020	Board of Directors	Reviewed
1.2	March 2022	Board of Directors	Addition of establishment requirements Definition of membership Frequency of meetings defined Chairman amended to Chair
2.0	June 2022	Board of Directors	Full review of format Clarification of single vote shared by two part time Medical Directors Members required to attend 75% of diarised meetings per year Addition of working in partnership as part of the Integrated Care System **Inputs** Provision of agenda and supporting papers Chairs' Assurance Reports received Escalation from Board level Committees Requests from Council of Governors **Outputs** Board Assurance Report to Council of Governors Board summary on Trust website **Other Matters** Executive members authorised to appoint deputies to act on their behalf, without voting rights Other invitees at the discretion of the Chair **Appendix A** Monitoring Compliance added
2.1	Aug 2023	Board of Directors	**Membership** Removal of reference to two part-time Medical Directors **Frequency of Meetings and Location** Addition of the Council of Governors (along with the Board of Directors) holding an Annual General Meeting. Removal of 'This will be in combination with the Council of Governors' Annual Members Meeting. **Duties and Responsibilities** Amendment of vision to mission Addition of strategic to objectives Removal of 'Fair and' in relation to Just Culture Removal of Success from Financial and Quality

			Outputs Clarification that there will be a Board summary report to Council of Governors and publication on Trust website Amendment of issue and review dates
2.2	Jun 2024	Board of Directors	**Frequency of Meetings and Location** Amendment of Annual General Meeting to Annual Members Meeting **Throughout** Amendment of Trust Secretary to Director of Corporate Governance Amendment of issue and review dates

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**6 June 2024**
Agenda Item	**42/24ii**		
Report Title	**FIT AND PROPER PERSONS ANNUAL REVIEW**		
Executive Lead	Karen Bliss, Chair		
Report Author	Samantha Scholes, Head of Corporate Governance		
Presented by	Jan McCartney, Director of Corporate Governance		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

NHS England (NHSE) published a new Fit and Proper Person Test (FPPT) Framework on 2 August 2023, complemented by guidance on elements of implementation from 30 September 2023 and with full implementation by 31 March 2024.

The legislation remains unchanged as annual FPPTs have taken place since 2014, however the new framework supports NHS organisations' compliance with the regulations and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements.

There has been a comprehensive programme of updating the Trust's documentation and processes to comply with the requirements, along with undertaking and documenting extensive Fit and Proper Person Tests for each member of the Board, comprised of directors, plus those who advise it.

The outcome of the tests is that each member of the Board is considered to be a Fit and Proper Person which will be reported to the NHSE Regional Director by 30 June 2024.

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**	**6 June 2024**
Agenda Item	**42/24ii**		
Report Title	**FIT AND PROPER PERSONS ANNUAL REVIEW**		
Report Author	Samantha Scholes, Head of Corporate Governance		
Purpose	To provide assurance that the new FPPT Framework has been implemented and that the annual test has been undertaken for all Board members and those who advise the Board.		

1. SCOPE

1.1 A review of Fit and Proper Person Test (FPPT) compliance for all Board members and those who regularly attend and advise the Board is undertaken annually.

1.2 There are 14 Board members and two people who regularly attend and advise the Board.

2. INFORMATION

2.1 Following receipt of FPPT self-attestations and in conjunction with received Declarations of Interest from all 16 people identified, the following tests were undertaken, and outcomes recorded:

a. Last appraisal date

b. Training & Development – mandatory training

c. Disciplinary findings

d. Grievance against the Board member

e. Whistleblowing claims against the Board member

f. Behaviour not in accordance with organisational values an behaviours or related local policies

g. DBS disclosure information

h. Companies House Register check

i. Bankruptcy & Insolvency Registers

j. Disqualified Directors Registers

k. Disqualification from being a Charity Trustee

l. Employment Tribunal Judgement

m. Web and social media checks for news reports plus all social media platforms including;

    i. X

ii. Facebook
iii. Threads
iv. LinkedIn
v. Tik Tok
vi. YouTube

n. Professional Register check – where applicable

3. OUTCOME

3.1 Of the 16 people whose self-attestations and declarations were tested, the Head of Corporate Governance is satisfied that they all meet the criteria for a Fit and Proper Person.

4. INFORMATION

4.1 The Board is asked to accept the assurance that the Trust's Fit and Proper Persons Test has been undertaken for all available members and advisors and that all continue to meet the criteria.

Appendix 1: 2024 Board FPPT

Name	FPPT Annual self-attestation received	DOI received	Training & Development - all mandatory completed	Last Appraisal Date	Disciplinary Findings - search	Grievance against Board member - search	Whistleblowing claims against Board member - search	Behaviour - search	Type of DBS disclosed	DBS Date	DBS No	Companies House Register check	Bankruptcy & Insolvency Register check	Disqualified Director Register check	Disqualification from being a Charity Trustee check	Employment Tribunal Judgement check	Web & Social Media searches	Professional registration check	Professional registration number	Professional registration expiry
Abdul Siddique	12/03/24	07/02/24	06/03/24	29/06/23	12/03/24	12/03/24	12/03/24	12/03/24	Standard	26/08/20	1537975202	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Bob Chadwick	14/12/23	28/11/23	06/03/24	N/A retiree	N/A retiree	N/A retiree	N/A retiree	N/A retiree	Standard	15/12/23	1860421570	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Colin Scales	13/03/24	04/03/24	06/03/24	13/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	27/10/11	25096701	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Edward (Ted) Adams	28/02/24	28/02/24	06/03/24	28/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	05/01/21	1538927071	✔	✔	✔	✔	✔	✔	14/03/24	GMC: 6071221	04/08/24
Elaine Inglesby	06/02/24	06/02/24	06/03/24	09/08/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	04/02/23	1817211140	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Gail Briers	14/03/24	07/02/24	06/03/24	20/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	24/08/20	1707486920	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Jan McCartney	12/03/24	05/02/24	06/03/24	17/07/23	26/02/24	26/02/24	26/02/24	26/02/24	None	Not required	Not required	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Karen Bliss	29/02/24	09/02/24	06/03/24	30/05/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	12/12/19	1683898246	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Linda Chivers	22/02/24	06/02/24	22/02/24	22/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Not found	Not found	Not found	✔	✔	✔	✔	✔	✔	04/01/24	CIMA: 990873977	31/12/24
Lynne Carter	15/03/24	15/02/24	22/02/24	26/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Enhanced	26/03/18	1609985464	✔	✔	✔	✔	✔	✔	14/03/24	NMC: 78A0613E	31/03/25
Martyn Taylor	07/02/24	07/02/24	06/03/24	27/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	31/01/22	1764711143	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Nick Gallagher	13/03/24	19/03/24	06/03/24	20/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	09/01/19	1643218092	✔	✔	✔	✔	✔	✔	04/01/24	CIMA:1-LPV7	31/12/24
Paula Woods	05/02/24	02/02/24	06/03/24	14/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	07/07/20	1702877689	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Rob Foster	13/03/24	28/02/24	06/03/24	15/06/23	26/02/24	26/02/24	26/02/24	26/02/24	None	Not required	Not required	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Sarah Brennan	01/02/24	01/02/24	06/03/24	12/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	02/04/19	1653396354	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A
Tina Wilkins	13/03/24	07/02/24	06/03/24	29/06/23	26/02/24	26/02/24	26/02/24	26/02/24	Standard	24/08/20	1677261079	✔	✔	✔	✔	✔	✔	N/A	N/A	N/A