PUBLIC BOARD MEETING

Thursday 5 October 2023, 10am
Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
64/23	10.00	(i) Apologies for Absence – Paula Woods, Elaine Inglesby (ii) Quoracy Statement (iii) Declarations of Interest in items on the agenda		Information Assurance
65/23 Page 4	10.00	Minutes of the last meeting: Board meeting held 3 August 2023		Assurance/ Approval
66/23 Page 13	10.05	Matters Arising from the Action Log		Assurance
67/23	10.10	Any urgent items to be taken at the discretion of the Chair		
68/23	10.10	Patient Story – Warrington Community Paediatric Services (for presentation at the meeting)		Information
69/23 Page 23	10.30	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Approval
70/23 Page 40	10.45	Key Corporate Messages – presented by the Chief Executive	1	Information
QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered				
71/23 (i) Page 46 (ii) Page 74 (iii) Page 90	10.55	(i) IQPR – presented by Executive Leads (ii) Listening to Staff Voices and Freedom to Speak Up – presented by the Chief Nurse (iii) Emergency Preparedness, Resilience and Response (EPRR) Annual Report – presented by the Chief Operating Officer	ALL 2,3,5, 2,3	Assurance Approval Approval

(iv) Page 116 (v) Page 166 (vi) Page 173		(iv) Winter Plan – presented by the Chief Operating Officer (v) Learning from Deaths Report – presented by the Medical Director (vi) Report from the Quality and Safety Committee held on 24 August 2023 – presented by the Deputy Committee Chair	2,3 2,3 2,3,6	Assurance Assurance Assurance
BREAK – 10 MINUTES				
RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
72/23 (i) Page 184 (ii) Page 195 (iii) Page 200 (iv) Page 204	12:10	(i) Finance Report – presented by the Director of Finance (ii) Green Plan – presented by the Deputy Director of Estates (iii) Reinforced Aerated Autoclave Concrete (RAAC) concrete issues – presented by the Deputy Director of Estates (iv) Report from the Finance and Performance Committee held on 21 September 2023 – presented by the Committee Chair	4 7 2,7 4,7,8	Assurance Assurance Assurance Assurance
PARTNERSHIPS: We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local ommunities				
73/23 Page 210	1.00	Integration and Collaboration Update – presented by the Programme Director of Integration and Collaboration	3-8	Assurance
STAFF: We will ensure that the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive				
74/23 (i) Page 215 (ii) Page 245	1.15	(i) Report from the People Committee held on 13 September 2023 – presented by the Committee Chair (ii) 2022-23 Annual Appraisal and Revalidation and Medical Governance Report – presented by the Medical Director	5, 6 5, 6	Assurance Approval
OVERARCHING CORPORATE GOVERNANCE ITEMS				
75/23 (i) Page 262 (ii) Page 274	1.40	(i) Senior Information Risk Owner (SIRO) Report – presented by the Director of Finance (ii) Application of the Trust Seal – presented by the Trust Secretary	1 1	Assurance Assurance
76/23	2.00	Review of meeting and Items to be added to the Board Assurance Framework		Information

77/23	2.05	Opportunity for questions to the Board from staff, media or members of the public at the discretion of the Chair		Information

DATE & TIME OF NEXT MEETING

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

MOTION TO EXCLUDE

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

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

Unapproved Minutes from a Public Board Meeting
Held on Thursday 3 August 2023, 10am
Ground Floor Meeting Room, Spencer House, Dewhurst Road, Birchwood, Warrington

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

In Attendance
Tania Strong, Head of Human Resources (for item 57/23iii)
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

For Patient Story (item 54/23 only)
John, Patient
Alyson Roberts, Occupational Therapist, Neuro Rehabilitation Service

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

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

50/23 **(i) APOLOGIES FOR ABSENCE**
Rob Foster, Programme Director of Integration and Collaboration

(ii) QUORACY STATEMENT

The Chair confirmed that the meeting was quorate.

(iii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No declarations of interest were made.

51/23 MINUTES OF THE LAST MEETING

BOARD MEETING HELD 1 JUNE 2023

The minutes were approved as an accurate record.

EXTRAORDINARY BOARD MEETING HELD ON 28 JUNE 2023

The minutes were approved as an accurate record.

52/23 MATTERS ARISING FROM THE ACTION LOG

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

88/23 Update on Provider Collaboratives

The Chair reported that a meeting was being scheduled to take place in October 2023 including Non-Executive Directors and Chairs from the member organisations of the collaborative.

23/23i IQPR

The Board noted that the new format of the IQPR report was included on the agenda today including the requested information.

23/23ii Performance Framework

The Trust Secretary confirmed that the action was ongoing and that all Chairs of Committees and Councils could link in at any time. The Board agreed that this action could be rated as blue and removed.

23/23iii Committee Chair's Report from the Quality and Safety Committee (change to risk management system)

Non-Executive Director, Gail Briers confirmed that the Quality and Safety Committee was monitoring the transition to PSIRF and that any move to a different risk management system from Ulysses following the transition would be taken through DIGIT. The Board agreed that this matter was being progressed and could now be rated as blue on the action log. Any further updates would be provided once further information became available.

23/23iv Learning from Deaths

The Medical Director confirmed that the report was a Board level report and would be taken directly through to the Board going forwards. The Board agreed that the action could be rated as blue.

24/23i Finance Report – month nine (incentives offered to potential new staff by other organisations in the system)

The Board considered that the ICB was managing this risk directly and the action could now be removed. The Chief Executive advised that any further issues would be taken forward at Chief Executive level with any organisations concerned.

42/23ii Fit and Proper Annual Review

The Trust Secretary confirmed that this action was now completed and no issues were identified from checks undertaken with professional regulatory bodies.

49/23 Items to be added to the Board Assurance Framework (addition to reflect clean audit opinion)

The Trust Secretary confirmed that this action had been completed. The Board agreed that this action could be rated as blue.

It was agreed that the following completed blue rated items could be removed from the action log:

21/23 Board Assurance Framework
27/23iii Staff Survey
27/23v Statutory and Mandatory Training

53/23 ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE TRUST CHAIR

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

54/23 PATIENT STORY – NEURO REHABILITATION SERVICE

A patient story was presented by John, with Alyson Roberts from the Neuro-Rehabilitation Team. After John was referred to the service in January 2022, he was then introduced to Acceptance and Commitment Therapy (ACT). He explained how over time this approach had helped him significantly to improve his mindset and management of his RRMS which had positively impacted his life and relationships. The Chief Executive asked Alyson Roberts for the perspective of herself and the team on John's story and how this might help to influence future service delivery. Alyson Roberts advised that the service treated patients as individuals, with Psychologist Dr Lydia Dr Lydia Rizopoulos focussing on John and his values and motivations. The Board acknowledged the importance and impact of the service being patient centred, focussing on people as individuals, their values and motivations to help them to achieve the best outcomes from treatment. John also shared his view that patients could support their treatment and medications by working on their mindset, diet and physiotherapy.

55/23 BOARD ASSURANCE FRAMEWORK

The Trust Secretary presented the Board Assurance Framework and highlighted a number of changes recommended by Board Committees during the last cycle for the Board's approval which were set out at section two of the report. She reported that the main updates reflected the end of year external audit and Head of Internal Audit Opinion.

The Board accepted all of the recommended changes to be made to the Board Assurance Framework.

56/23 KEY CORPORATE MESSAGES

The Chief Executive took the report as read and highlighted the extent of engagement externally and internally of Executive and Non-Executive Directors. The report included detail of Executive and Non-Executive activity over the period. The Board noted that a number of Bridgewater staff had been selected to travel to London to attend a service at Westminster Abbey on Wednesday 5 July to celebrate 75 years of the NHS. The Chief Executive drew attention to one external publication in relation to the Covid-19 enquiry. He informed the Board that the Trust had not been asked to provide any information in relation to this to date.

A discussion took place concerning the feedback from the Executive and Non-Executive Time to Talk sessions with services following a point raised by Non-Executive Director, Gail Briers. The Trust Secretary suggested that Non-Executive Directors be invited to provide feedback following the visits. The Director of People suggested that the questions asked as part of the sessions could be refined to include key elements around important areas such as Freedom to Speak Up, the Long-Term Workforce Plan and psychological safety. **The Director of People and Trust Secretary would liaise to discuss this further and consider the use of a feedback questions summary sheet.**

Non-Executive Director, Tina Wilkins highlighted that four Non-Executive Directors attended a recent meeting of the North West Non-Executive Directors Network. She explained that this event focussed on the role of the Non-Executives around EDI and the differences they could make in their roles. Shared experiences were discussed at the event and this included potential areas of improvement. The discussions had included disability as a protected characteristic and how this could be supported via Non-Executive roles. Non-Executive Director, Elaine Inglesby reflected upon how the Trust could make anti-racism business as usual, which was also raised at the Non-Executive Director Network meeting. She commented that EDI patients were proven to be some of the longest waiters. She asked whether the Trust may have any elements within its structural processes that may be contributing to this and whether this could be discussed as part of the anti-racism framework item later on the agenda. She considered that anti-racism should run through the organisation and structural processes and should not be confined only to the People Committee's remit. The Director of People advised that a report had been written on system and infrastructures via the Trust's Equality and Diversity Lead, Ruth Besford. An initial self-assessment had been undertaken which needed to be socialised and considered around how wider feedback could be obtained. The Director of People added that the Trust had linked in with the Region to explore work that could be undertaken collaboratively. She commented that questions from the anti-racism toolkit needed to be asked, as well as a wider discussion on objectives and links beyond services and delivery. The Board acknowledged the importance of a 'golden thread' throughout the organisation. The Director of People would link in with Non-Executive Director, Elaine Inglesby outside of the Board to discuss this further, however she advised that there was a piece of work to be undertaken to identify work already undertaken and to bridge any identified gaps. The Trust was also liaising with a neighbouring organisation who had offered to share some of their exemplar work with Bridgewater, recognising that all organisations would have similar issues to address, such as equality of access.

The Board received the report.

57/23 QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered

(i) IQPR new format report

The Chief Operating Officer presented detail of the proposed new indicators for the IQPR report which were recommended to the Board following review and scrutiny by the Finance and Performance Committee. She noted that some elements would require further review by the People and Quality and Safety Committees, for example in relation to some different elements of tracking through PSIRF. There would also be a new SOF framework that may interrupt some indicators but this was not anticipated to become an issue.

Non-Executive Director, Elaine Inglesby asked whether the new indicators would be smarter and how those would be monitored. The Chief Operating Officer advised that the Trust was not able to currently monitor when the targets would be achieved and the previous indicators were not smart, however there would be defined periods with the new targets of when they would be able to be achieved. A brief discussion took place concerning the level of information that would be appropriate to be presented to the Board. The Chair noted that the Board required the appropriate level of assurance opposed to operational detail. The Director of Finance referred to SPC charts which could be created for areas that had the appropriate

level of detail, however he acknowledged that others were still to develop a reliable trend but the mechanisms were in place to do this. Non-Executive Director, Martyn Taylor commented that the Board should receive exception reports for the Board to discuss actions and challenges on areas of issue.

The Board approved the proposed changes to the indicators, recognising that this was a baseline document, and would receive the first new format report to its October meeting.

(ii) IQPR Report – Month Two

The Board received the month two IQPR report. The Chief Operating Officer highlighted improvements in the Trust's RTT performance. This was due mainly to improvements within dermatology and waiting times. She reported that red rated indicators were demonstrating improvements and that those were largely related to training. The Trust held a small percentage of risks scoring as high and the Board were assured that those risks were being reviewed.

The Director of People confirmed to Non-Executive Director, Martyn Taylor that there was an improved position on safeguarding adults and childrens training and information governance training compliance. She was confident that with the exception of PPDR appraisal compliance rates, all compliance targets had been achieved and this included 90% on information governance training.

The Chief Operating Officer advised the Chair that a detailed report had been taken to the Finance and Performance Committee concerning the outputs from the recent dental quality summit. She explained that there were some internal issues regarding acceptance and discharge criteria and following a deep dive concerning waits, there was a trajectory for improvement being devised but she acknowledged that there was a significant cohort of patients to be managed. There would need to be commissioner support to continue to fully progress this work. The Chief Executive noted that there was ownership and a commitment at the quality summit to address the prevalent issues within the service. He referred to the earlier point raised by Non-Executive Director, Elaine Inglesby and questioned whether the dental waiting lists may be an entry point in relation to EDI access and this could be a good route to analysing whether there were any issues in this regard as there was a diverse population within the areas that dental services operated within.

The Board received the report for assurance.

(iii) Freedom to Speak Up Report

The Freedom to Speak Up Guardian presented a report which gave an overview of the current Freedom to Speak Up (FTSU) provision, activity and learning. This included information on the FTSU self-reflection and planning tool, which would evaluate the current baseline and identify actions to inform an improvement and development plan spanning the next 6-24 months. The report had provided three case studies of staff experiences of FTSU; follow ups would be undertaken for two of those cases as it had been identified that the experiences of the staff concerned had not been optimum. The Board noted that speaking up processes appeared to be working well functionally within the Trust, however case studies had demonstrated some issues on psychological safety which was reflected nationally.

The Board re-iterated its commitment to ensuring that staff must feel safe to raise issues and any impediments must be made known to the Board. The Chief Nurse advised that the Trust had recently appointed a FTSU Guardian, whom she had asked to be based with different teams/staff when office based, as well as FTSU Champions across services. It was recognised that when staff had a positive experience in speaking up, this would encourage others. The Board recognised that there was an opportunity for the Trust to become an exemplar for FTSU and ensuring a culture where all staff felt safe to speak up. The Board noted that October would be FTSU month which would provide further opportunities to highlight FTSU across the Trust. The Director of People advised that there would be a

number of campaigns rolled out around Just Culture to encourage staff to raise concerns and this was a part of the seven people promises as part of the Culture and People POD. There would be communications disseminated throughout the Trust by the Communications Team, but the importance of an impact from floor to Board was recognised. The Board acknowledged that there was more work to be undertaken.

The Head of HR confirmed to Non-Executive Director, Linda Chivers that the reference to Non-Executive Director involvement in allegations of detriment referred to any cases that were of sufficient complexity or severity to require an independent person's involvement and this would only be in exceptional circumstances.

A discussion took place concerning the potential to roll out a mandatory one-off FTSU training module and the benefits of this. Following comments from the Chief Executive, it was agreed **that a set of approaches for taking FTSU forwards throughout the Trust would be taken through the Executive Management Team and the People Committee and would be presented back to the Board. This would be multi-factorial and would include the mandatory training module if this was felt to be appropriate.**

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

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

58/23 RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(i) Finance Report

The Board received a report setting out the financial position of the Trust at month three. It approved the Capital Programme for 2023/24 on the recommendation of the Finance and Performance Committee. A discussion took place concerning the system financial position and it was noted that there would be a financial strategy in place to ensure a break-even position, with a recognition that organisations such as Bridgewater, which was performing well, should not have to address other organisation's deficits. The Chair had suggested Non-Executive involvement in this work and commented that all organisations must have a role in solving system issues collectively. The Board agreed that the Trust would continue to play its role in supporting the system, whilst protecting its own resources and challenging where elements were being moved towards the community to support the acute sector without appropriate resources.

The Board agreed that it would welcome some information on the work around the Trust's Green Plan. **The Director of Finance would progress this with the Deputy Director for Estates. Some previous reports would be shared with the Board with a decision to be made on the information that the Board would like to see.**

(ii) Adaptive Reserve Report

A briefing was received from the Director of Finance concerning the adaptive reserve including the background around fund purpose and how the 2022/23 Adaptive Reserve funding was utilised across the system. The Board considered the option to invest £250k into the year two Adaptive Reserve Fund, however **it agreed that an outcome analysis must be undertaken before the Trust committed to investing any further monies. There were important factors to be considered from year one such as assurances on value for money and benefit for patients and it would be important to understand the maturity of the arrangements in place for year two. A report would be presented to the Board in October 2023.**

(iii) Report from the Audit Committee held on 28 June, 6 July and 26 July 2023

The Board received reports from Extraordinary meetings of the Audit Committee held on 28 June and 26 July and the full meeting held on 6 July 2023 presented by the Committee Chair, Linda Chivers.

(iv) Report from the Finance and Performance Committee held on 20 July 2023

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

59/23 PARTNERSHIPS: We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities

(i) Integration and Collaboration Update

An update was provided to the Board concerning Place and the Provider Collaborative. This included plans to bring together chair and non-executive representatives from the member organisations of the Mental Health, Learning Disabilities and Community Provider Collaborative (MHLDC PC) for a discussion concerning future NED input over the next six weeks. A description of governance around the collaborative would be circulated through the constituent boards during October. It was noted that the Trust Strategy would be shared imminently with the Place Based committees, including Health and Wellbeing Boards and the Warrington Together Partnership Boards. The Board received the report and noted the leading role of the Trust in and ongoing commitment to system working.

60/23 STAFF: We will ensure that the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive

(i) Report from the People Committee held on 12 July 2023

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

The Board noted an escalation from the Committee concerning the proposed review of sickness and turnover targets which were recommended as 5.5% (from 4.8%) and 12% (from 8%) respectively. The Director of People confirmed that the position would be reviewed in three months time and subjected to a 12 month review. The Director of People confirmed to Non-Executive Director, Elaine Inglesby that two years of data was taken for rolling and actual figures with a median taken to identify the proposed targets, as well as comparisons with other organisations.

The Board endorsed the recommended reports for final sign off:
- Gender Pay Gap Report 31st March 2023
- WDES 2023
- WDES Action Plan 2023
- WRES (including Bank and Medical Workforce)
- WRES Action Plan

(ii) Update on the North West Anti-Racist Framework

The Director of People presented the report detailing the new Framework, information on progress to date, and actions and alignment to national mandated equality drivers. An initial draft action plan was shared with the Board which would be taken through the People Operational Delivery (POD) Council and the Race Inclusion Network. The Board would receive a further update on progress of the plan in due course. It was recognised that there

had been work undertaken, but it was noted that it was not yet possible for the Trust to rate itself against the gold, silver and bronze framework accreditations.

The Board re-iterated its commitment to supporting anti-racism and agreed that it would draw upon the expertise in the organisation to take this work forward in an inclusive way. Non-Executive Directors were invited to take part in a scoping exercise, to be driven by the Executive Management Team, to agree 'what good would look like'. It was agreed that an update on the work and progress would be presented back to the Board. The Director of People would link in with the Trust Secretary and the Chair to agree timescales for this.

(iii) NHS Long-Term Workforce Plan

The Director of People presented a report to the Board following the publication of the plan on 30 June 2023. This detailed the key themes and the Trust's positive position against the elements of the plan, along with next steps. The Board acknowledged the significant work that was already in train concerning a modern and accessible workforce which had contributed to this position, with workforce plans in place across every team and service, as well as development plans for staff.

Non-Executive Director, Gail Briers commented that devolved autonomy would be important to consider as part of this work and how this could be enhanced as part of Cost Improvement Plans (CIPs) and recruitment plans for example.

The Chief Nurse confirmed to Non-Executive Director, Elaine Inglesby that workforce plans had been in train for a period of time and Executive Team members had met with groups of staff to develop ideas, such as training nurse associates, She confirmed that a workforce plan was in place for each team and service. She advised that staff had been significantly engaged in this work and presenting their ideas. Those ideas were taken forwards in teams and Directorate Leadership Teams (DLTs) having plans in place to develop their staff.

61/23 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) Strategy and Board Assurance Framework Update

The Board received an update on progress with the delivery of the new Communities Matter Trust Strategy, as well as the progress on the new Board Assurance Framework which it received for assurance. The Board recognised that a rigorous process had been in place around the new strategy. The Trust Secretary advised that the Board Assurance Framework was being updated following the agreement of the new Trust Strategic Objectives and would be presented to the Board in October 2023.

(ii) Board Commitee Terms of Reference and Business Cycles

The Board endorsed the Terms of Reference and Business Cycles for all of its Committees. The Chief Nurse highlighted that the Terms of Reference for the Councils which underpinned the Board Committees were also being reviewed to ensure alignment between the two.

(iii) Board Business Cycle

The Board agreed its business cycle for 2023/24 subject to some minor amendments:
Correct timing to be checked for the Gender Pay Gap Report;
Finance plan would not be presented to every meeting.

The Board noted that the business cycle was a fluid document which would be kept updated to support future agenda planning.

62/23 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

The Board agreed that there had been good robust discussions at debate at today's meeting. The Chair thanked all present for their contributions.

There were no items identified to be added to the Board Assurance Framework.

63/23 OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

There were no questions raised.

DATE AND TIME OF NEXT MEETING

Thursday 5 October 2023, 10am, at Spencer House, Dewhurst Road, Birchwood, Warrington.

MOTION TO EXCLUDE

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

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

ACTION LOG

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

Key

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

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

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date: Due Date/BRAG Status	Completion Date: Comments/Further Action
08.12.22	88/22ii	Update on Provider Collaboratives	**The Board agreed that regular meetings would be required at least quarterly with Executive and Non-Executive Directors from each of the organisations within the Collaborative to discuss key matters and strategies. The Chair agreed to raise this at the meeting of CEOs and Chairs of the Collaborative in January 2023.** **The Board would also welcome presentation of the report which was provided to all of the Boards within the Collaborative on a regular basis.**	Karen Bliss	**GREEN**	August 2023: The Chair confirmed that a meeting of NEDs and Chairs from the member organisations of the collaborative was being scheduled for October 2023. October 2023: meeting of Chairs & NEDs taking place 18 October 2023 Collaborative Board meeting early November 2023
06.04.23	23/23i	IQPR	**The Executive Management Team to discuss disaggregated data and elements that may be useful to include in the IQPR going forwards to provide further assurances to the Board on key matters.**	Colin Scales	**BLUE**	August 2023: Report included on the agenda.

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date: Due Date/BRAG Status	Completion Date: Comments/Further Action
06.04.23	23/23ii	Performance Framework	**It was agreed that Committee Chairs would engage with Chairs of the Risk Management, Quality and Performance Councils and meet at regular intervals to discuss expectations around reporting and information through to Committees, building relationships and supporting/mentoring as needed.**	Jan McCartney	**BLUE**	August 2023: The Trust Secretary advised that this was ongoing and it was possible for the Chairs to link with the Chairs of Councils at any time. The Board agreed that this action was completed.
06.04.23	23/23iii	Committee Chair's report from the Quality and Safety Committee	**Discussion to take place concerning the potential change from Ulysses to Datix systems for the Trust and providing assurance on this issue to the Quality and Safety and Finance and Performance Committees including advice related to the practicalities of any transition.**	Colin Scales, Jan McCartney, Jeanette Hogan	**BLUE**	August 2023: The transition to PSIRF will be monitored by the Quality and Safety Committee. The decision to move to any new risk management system would be taken through to DIGIT.
06.04.23	23/23iv	Learning from Deaths	**It was agreed that further detail was required for future reports around unexpected deaths, a review of terminology used within the report and a stronger emphasis on the learning from deaths. The Deputy Chief Nurse would liaise with the Medical Director.**	Ted Adams	**BLUE**	August 2023: The Medical Director confirmed that the report was a Board level report and would be taken directly through to the Board going forwards.

ACTION LOG

Key

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

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

Date	**Minute Ref**	**Issue**	**Action**	**Director**	**Completion Date**	
					Due Date/BRAG Status	**Comments/Further Action**
06.04.23	24/23i	Finance Report – month nine	**It was noted that there were higher incentives and rewards being offered to potential staff by other organisations which went against the system's agreed principles. This would be raised with the organisations responsible at Chief Executive level.**	Colin Scales	**BLUE**	August 2023: The Board considered that the ICB was managing this risk directly and the action could now be removed. Any further issues would be picked up at CEO level.

ACTION LOG

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

Key

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

Date	Minute Ref	Issue	Action	Director	Completion Date: Due Date/BRAG Status	Completion Date: Comments/Further Action
06.04.23	27/23iii	Staff Survey	**Director of People to provide further information to clarify table four within the report.** **Director of People to contact the organisation supporting the staff survey to explore comparators on a regional or sub-regional basis as this would add more value opposed to community organisation to community organisation comparisons.**	Paula Woods	BLUE	May 2023: A Staff Survey Update Report is included on the agenda for the June Board. The Staff Survey table will illustrate Trust specific 'v' comparator data going forwards with regards to the 5% differentials in improved performance and areas of deterioration. July 2023: As per June Board, the Trust's Deputy Director of Communication & Engagement explored comparators for the 2023 Staff Survey with Quality Health to see if the Trust can benchmark against Acute Trusts for the 2023 Survey. This is not possible as per there being a Community Trust specific benchmarking group.

ACTION LOG

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

Key

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Green	**Progressing to timescale**
Blue	**Completed**

Date	**Minute Ref**	**Issue**	**Action**	**Director**	**Completion Date** Due Date/BRAG Status	**Comments/Further Action**
01.06.23	41/23v	Freedom to Speak Up Annual Report (FTSU)	**The Board agreed that it was of key importance to ensure that the Trust was demonstrating that it was listening to the experiences of staff who had been through the FTSU process. It was agreed that the right way for this to be taken through to the Board would be considered and this would be decided following the conclusion of the self-assessment process.**		**BLUE**	The self-assessment report was presented to the August Board meeting.
01.06.23	42/23ii	Fit and Proper Annual Review	**It was clarified that those Board members who were also members of professional regulatory bodies would need to be checked against their registers i.e., Nursing and Midwifery Council/British Medical Association and others. This would be undertaken.**	Jan McCartney	**BLUE**	August 2023: The Trust Secretary confirmed that this action was now completed and no issues had been identified. A paper will be taken to the Audit Committee in October with a project plan on the updated FPPT and update on progress to date.
28.06.23	49/23	Items to be added to the Board Assurance Framework	**It was agreed that the Board Assurance Framework would be updated to reflect the clean audit opinion as described above.**	Jan McCartney	**BLUE**	August 2023: The Trust Secretary confirmed that this action had been completed.

ACTION LOG

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

Key

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

Date	Minute Ref	Issue	Action	Director	Completion Date: Due Date/BRAG Status	Completion Date: Comments/Further Action
03.08.23	57/23iii	Freedom to Speak Up (FTSU) Report	**The Board agreed that a set of approaches for taking FTSU forwards throughout the Trust would be taken through the Executive Management Team and the People Committee and would be presented back to the Board. This would be multi-factorial and would include the mandatory training module if this was felt to be appropriate.**	Lynne Carter	**GREEN October 2023**	October 2023: a report is included on the agenda
03.08.23	58/23i	Finance Report	**It was proposed that the Board would receive information on the Green Plan. The Director of Finance would progress this with the Deputy Director for Estates. Some previous reports would be shared with the Board with a decision to be made on the information that the Board would like to see.**	Nick Gallagher	**GREEN**	October 2023: was part of Board Time Out session,7 September and a report is included on the agenda

ACTION LOG

Key

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

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

Date	**Minute Ref**	**Issue**	**Action**	**Director**	**Completion Date**	
					Due Date/BRAG Status	**Comments/Further Action**
03.08.23	58/23ii	Adaptive Reserve Report	**The Board agreed that an outcome analysis must be undertaken before the Trust committed to investing any further monies. There were important factors to be considered from year one such as assurances around value for money and benefit for patients and it would be important to understand the maturity of the arrangements in place for year two. This would be presented in October.**	Nick Gallagher	**GREEN October 2023**	October 2023: report will be circulated prior to the Board meeting taking place in October

ACTION LOG

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

Key

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

Date	**Minute Ref**	**Issue**	**Action**	**Director**	**Completion Date**	
					Due Date/BRAG Status	**Comments/Further Action**
03.08.23	60/23ii	Update on the North West Anti-Racist Framework	**The Board agreed that it would draw upon the expertise in the organisation to take this work forward in an inclusive way. Non-Executive Directors were invited to take part in a scoping exercise, to be driven by the Executive Management Team, to agree 'what good would look like'. It was agreed that an update on the work and progress would be presented back to the Board. The Director of People would link in with the Trust Secretary and the Chair to agree timescales for this.**	Paula Woods	**GREEN**	The People Committee met on the 13th of September. Later that day, the North West BAME Assembly held the first of a series of hour long implementation webinars which was attended by the Director of People & OD, Head of HR and Equality & Inclusion Manager. At the Committee, the Trust's Head of HR, Tania Strong proposed the establishment of a Task & Finish Group. She confirmed that since the last Board meeting, key personnel had been reviewing the Framework in more detail and we have evidence at Bronze level, tipping into Silver. Bronze will be worked on in the first instance. The Task & Finish Group is to be established in October and arrangements are underway which will engage those NEDs who volunteered to support the exploring of what good would look like. The Group will report their progress via the POD Council and People Committee. The Director of People & OD will report progress to the EMT.

ACTION LOG

Key

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

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

Date	**Minute Ref**	**Issue**	**Action**	**Director**	**Completion Date**	
					Due Date/BRAG Status	**Comments/Further Action**
03.08.23	61/23iii	Board Business Cycle	**The Board agreed its business cycle for 2023/24 subject to some minor amendments:** **Correct timing to be checked for the Gender Pay Gap Report;** **Finance plan would not be presented to every meeting.**	Jan McCartney	**BLUE**	

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**05 October 2023**
Agenda Item	**69/23**		
Report Title	**BOARD ASSURANCE FRAMEWORK**		
Executive Lead	Colin Scales, Chief Executive Officer		
Report Author	Jan McCartney, Trust Secretary		
Presented by	Jan McCartney, Trust Secretary		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Purpose

To approve the recommendations received from the Committees of the Board.

Executive Summary

The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.

The BAF is the key mechanism which the Board uses to hold itself to account. It provides a structure to focus on risks that might compromise the Trust in achieving its strategic objectives and confirms to the Board of Directors that there is sufficient assurance on the effectiveness of controls

Previously considered by:

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

Strategic Objectives

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

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

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

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

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

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

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05/10/2023
Agenda Item	69/23		
Report Title	BOARD ASSURANCE FRAMEWORK		
Report Author	Jan McCartney, Trust Secretary		
Purpose	The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.		

1. EXECUTIVE SUMMARY

1.1 The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.

1.2 The BAF is the key mechanism which the Board uses to hold itself to account. It provides a structure to focus on risks that might compromise the Trust in achieving its strategic objectives and confirms to the Board of Directors that there is sufficient assurance on the effectiveness of controls.

1.3 The Board Assurance Framework is received at the Board, all the Committees of the Board and other key decision-making / operational meetings. It is a working document that is used in Committees and meetings to ensure the meeting agendas remain focused and proactive on strategic objectives. The recommended changes can be found in section 2.

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

2. CHANGES TO THE BOARD ASSURANCE FRAMEWORK

2.1 **BAF1 – Failure to implement and maintain sound systems of Corporate Governance**

The Audit Committee has not met since the last Board meeting, it is next due to meet on 15 October.

There are not changes to recommend and the BAF risk rating remains at target.

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

The Quality & Safety Committee met on 24 August 2023 where the following recommendation was made.

- Paediatric audiology incident removed as this now not a serious incident

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

2.3 **BAF3 – Managing demand and capacity**

The Quality & Safety Committee met on 24 August 2023 where the following recommendation was made.

- Paediatric audiology incident removed as this now not a serious incident

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

2.4 **BAF4 – Financial sustainability**

The Finance & Performance Committee met on 21 September 2023 and asked the Director of Finance to update the Gaps in Control section to reflect the challenges with CIP and agency spend targets. This change has been made.

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

2.5 **BAF5 – Staff engagement and morale**

The People Committee met on 13 September 2023 where the Committee recommended:

a) Pay deal updated to reflect this is complete for AfC staff, no further negotiations offered.

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

2.6 **BAF6 – Staffing levels**

The Quality & Safety Committee met on 24 August 2023 where the following recommendation was made.

- District nursing challenges be included on gaps in control, and
- Reference to the safer staffing system which is yet to be operational across the Trust.

The People Committee met on 13 September 2023, no changes were recommended.

Neither Committee recommended a change in the current risk rating.

2.7 **BAF7 – Strategy and organisational sustainability**

The Finance & Performance Committee met on 21 September 2023, no changes were recommended to this BAF and the risk rating remains on target.

2.8 **BAF8 – Digital Services**

The Finance & Performance Committee met on 21 September 2023. The Committee recommended the following updates:

- In Gaps in Control, reference to the fact the CNIO role remains vacant,
- The ongoing issues with EMIS patient record system and its license

The risk rating and rationale was updated to reflect the increased risk identified at the Committee. The likelihood was increased resulting in a 4(c)x3(L)=12, high risk.

3. RECOMMENDATION

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

Appendix A – Board assurance framework

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 28 September 2023

STRATEGIC OBJECTIVES

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

BAF 1	BAF 2	BAF 3	BAF 4	BAF 5	BAF 6	BAF 7	BAF 8
Failure to implement and maintain sound systems of Corporate Governance	**Failure to deliver safe & effective patient care**	**Managing demand & capacity**	**Financial sustainability**	**Staff engagement & morale**	**Staffing levels**	**Strategy & organisational sustainability**	**Digital services**
BAF 1	**BAF 2**	**BAF 3**	**BAF 4**	**BAF 5**	**BAF 6**	**BAF 7**	**BAF 8**
Inherent risk rating 4(C) x 4 (L) = 16**,** **significant** Current risk rating 4(C) x 2 (L) = 8, **medium** Target risk rating 4(C) x 2(L) = 8, **medium**	Inherent risk rating 5(C) x 5 (L) = 25, **significant** Current risk rating 5 (C) x 3 (L) = 15, **significant** Target risk rating 5(C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 4 (L) = 16, **significant** Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 2 (L) = 8, **medium** Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 1 (L) = 4, **low**	Inherent risk rating 5(C) x 4 (L) = 20, **significant** Current risk rating 5 (C) x 3 (L) = 15, **significant** Target risk rating 5 (C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 3 (L) = 12, **high** Current risk rating 4 (C) x 2 (L) = 8, **medium** Target risk rating 4 (C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 2 (L) = 8, **medium**

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

BAF 1: **Failure to implement and maintain sound systems of Corporate Governance**	**TRUST OBJECTIVES:** • People • Sustainability		**RISK RATING:** Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4(C) x 2 (L) = 8**, medium** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**RISK APPETITE:** **CAUTIOUS**
Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**	
Chief Executive Officer Deputy CEO / Chief Nurse Last reviewed: July 2023 Audit Committee Last reviewed: July 2023 Risk Ratings reviewed: July 2023	**Failure to implement and maintain sound systems of Corporate Governance.** If the Trust is unable to put in place and maintain effective corporate governance structures and processes. Caused by insufficient or inadequate resources and / or fundamental structural or process issues including those caused by the pandemic. **Risks on register 15 plus** No risks at this level	Governance structure approved by Board and audited by internal auditors. Substantial Assurance - Heads of Audit opinion 202/23 2023 Well Led report and recommendations accepted	**Prevent Controls** • Trust Board • Governance structure approved by the Board, SFIs &Scheme of Reservation and Delegation • Operational management structure and policies and procedures are in place • Board Assurance Framework & Risk Register **Detect Controls** • The committees receive by exception reports from Ops leads, these are reported to the Board • Staff engagement • Performance Council established • Senior Leadership Team meeting monthly • Risk Management Council • Staff Survey – improving position • **Assurances** • Clean Unmodified Audit Opinion & clean VFM opinion 2022/23 • Board, committees (Quality & Safety, Finance & Performance, and People) • Trust continuous improvement plan in place • Internal Audit Plan agreed for 23/24 • External independent 2023 Well Led review • Daily automated data reporting • Declarations of Interests Register • MIAA governance checklists • Annual Review of Effectiveness of Audit Committee • Annual Review of Effectiveness of Internal Audit & Anti-Fraud • Annual Review of Effectiveness of External Audit Service • Annual Reports received from Committees of the Board • Committee Effectiveness Review (2020/21) • Effectiveness Review of External Audit and Anti-Fraud (2020/21) • Board Assurance Framework Review – (2020/21) • Risk Management Audit – substantial assurance (2021/22) • DSPT Audit – substantial / moderate assurance (2022/23)	
Gaps in controls and assurance: (and mitigating actions) 2018 CQC rating ‘requires improvement’ remains due to changes to inspections. CQC not due to inspect as no concerns have been raised in relation to the Trust.				

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

BAF 2: **Failure to deliver safe and effective patient care**	**TRUST OBJECTIVES:** • Quality		**RISK RATING:** Inherent risk rating: 5 (C) x 5(L) = 25, **significant** Current risk rating: 5 (C) x 3(L) = 15, **significant** Target risk rating: 5(C) x 2 (L) = 10, **high**	**RISK APPETITE:** **MINIMAL**
Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**	
Chief Nurse / Deputy CEO / Last reviewed: August 2023 Quality & Safety Committee Last reviewed: August 2023 Risk Ratings reviewed: August 2023	**Failure to deliver safe & effective patient care.** There is a risk that the Trust may be unable to achieve and maintain the required levels of safe and effective patient care. This could be caused by multi-faceted risks such as a) challenges in relation to recovery, restoration, and service reset b) National recruitment challenges (inc. accessibility to specialist training) c) Geographical recruitment pressures d) Potential industrial action e) Seasonal pressures If this were to happen it may result in instances of avoidable patient harm, this in turn could lead to regulatory intervention and adverse publicity that damages the Trust's reputation and could affect CQC registration. **Risks on register 15 plus** 3145 – District Nursing, demand and capacity 3064 – Safeguarding, demand and capacity	Quality & safety governance structure in place. Robust QIA process for all services Number of ongoing high risks Industrial action (Cross ref. with BAF3) Additional winter capacity	**Prevent Controls** • Clinical policies, procedures & pathways • Risk Management Council & Quality Council in place • Quality Impact Assessment Process • Trust Strategy – Quality and Place • Freedom to speak up guardian in place • Winter Plan • Daily Ops Huddle & Daily sit rep • Directorate Team Meetings **Detect Controls** • Quality & Safety Committee bimonthly meetings • Clinical & Internal Audit Programme • IQPR & quality dashboards • Quality Council • Performance Council • Learning from deaths report • Clinical Quality and Performance Groups (CQPGs) in place with all NHS commissioners. • Increased reporting of incidents, including medication incidents • Equality Impact Assessments • Quality Impact Assessments • End of Life group • Health and Safety group • Deep Dives at Committee • Ockenden Report to Committee • E-roster monitoring • Trust transformation programme (BOOST) • Quality Summits **Audits** • Risk Management Substantial Assurance (2020/21) • Quality Spot Check – Significant Assurance (2021/22)	
Gaps in controls and assurance: (and mitigating actions) Staff compliance with mandatory and service specific training - training trajectory in place, monitoring related incidents System pressures – involvement in system pressure meetings and System Sustainability Group (SSG) Agency Cap – mitigating actions in place				

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

BAF 3: Managing demand and capacity	**TRUST OBJECTIVES:** • People • Quality	**RISK RATING:** Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4 (C) x 4(L) = 16**, significant** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**RISK APPETITE:** **CAUTIOUS**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Chief Operating Officer Last reviewed: August 2023 Quality & Safety Committee last reviewed: August 2023 Risk Ratings reviewed: August 2023	**Managing demand & capacity** If the Trust is unable to manage the level of demand. It may result in sustained failure to achieve constitutional standards in relation to access; substantial delays to the treatment of multiple patients; increased costs; financial penalties; unmanageable staff workloads. **Risks on register 15 plus** 3145 – District Nursing, demand and capacity 3064 – Safeguarding, demand and capacity	Quality & Safety Committee Risk Management Council meets monthly. Performance Council meets monthly. Daily joint operations and nursing meetings. Managed risk with approval from the Board. Quality and safety under constant review to ensure no patient harm.	**Prevent Controls** • Quality & Safety Committee • Waiting list management via Performance council and Directorate Leadership Teams (DLTs) • Patient pathway management arrangements • System One PAS – Patient Administration System • RTT lists to track 6 week and 18-week access standards, national weekly submission • Executive management performance dashboard • Risk management council • Monthly workforce information reports • Winter plans • IQPR • Daily Operations and Nursing meetings • EPPR • Health roster implementation **Detect Controls** • Borough Quality & FWP meetings to gain overview of risks in relation to capacity at local level • Weekly Operational Management Team meetings • Contract meetings with commissioners • Daily system pressure calls • Workforce Strategy in place / Workforce POD • Daily joint operations and nursing meetings **Assurances** • Audits monitored at each relevant Board Committee, exception reports to Audit Committee • Performance Council reports to Finance & Performance Committee • Deep dives at Committee • Winter Plans • Emergency Preparedness, Resilience and Response Plans (EPPR) • Quality Summits • Rapid Improvement Events

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

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

BAF 4: Financial sustainability	**TRUST OBJECTIVES:** • Sustainability	**RISK RATING:** Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4 (C) x 2(L) = 8, **medium** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**RISK APPETITE:** **OPEN**

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

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

BAF 5: Staff engagement and morale	TRUST OBJECTIVES:	RISK RATING:	RISK APPETITE:
Staff engagement and morale	• Equality, Diversity & Inclusion • People • Quality	Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4 (C) x 3(L) = 12, **high** Target risk rating: 4(C) x 1 (L) = 4, **very low**	**OPEN**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Director of People and OD Last reviewed: September 2023 People Committee Last reviewed: September 2023 Risk Ratings reviewed: September 2023	**Staff engagement & morale** If the Trust loses the engagement of a substantial sector or sectors of its workforce. Caused by uncertainty of internal and/or external factors, influences and conditions i.e cost of living crisis. Impact on leadership and management practices, winter pressures, system incentives It may result in low staff morale, leading to poor outcomes and experience for large numbers of patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover rates. **Risks on register 15 plus** No risks at this level	People Committee ensure governance and holds to account. Current risk rating reflects the Board acknowledges that, despite the controls and assurances in place, staff are currently fatigued; Restoration and recovery programmes / post covid effects Patient experience adversely affected (links to Q&S Committee) Uncertainty / Impact of national change programmes – Health & Care Act integration and collaboration Organisational structures and service redesigns and reorganisations	**Prevent Controls** • People Committee Organisational and local Staff engagement plan • Managers' Key brief/ communication, Time to Talk and CEO Q&A sessions • Local Negotiating Committee, Joint Negotiation & Consultative Committee • Occupational Health Service & Staff Health & Wellbeing Officer/Board Health & Wellbeing Guardian • Talent Management process and Succession Planning Tool • Revised Exit interview questionnaire / In house Resilience Training Programme • People Hub and POD Groups • Recruitment & Retention • Health & Wellbeing • Education & Professional development • Northwest Person-Centred approach to absence management • Bi-monthly meetings with Staff Side • Agreement and implementation of pay deal for AfC staff **Detect Controls** • National Staff Survey. • Feedback from Quality and Safety Committee on workforce issues • Staff Friends and Family Test (SFFT) and Staff Engagement Surveys • E-rostering project plan and implementation PDR reporting • Staff Stress Audit Survey **Assurances** • Staff Survey and 'temperature check' surveys • DAWN – Disability and wellbeing Network • LGBT+ and Race Inclusion Networks • The Employee Relations Activity Report • Staff Survey – sustained score for staff engagement • Temporary increase in milage payments, national increases now in place **Internal Audit MIAA Substantial Assurance** • Freedom to Speak Up (2020/21) • Induction (2020/21) • Payroll Feeder System Review (2022/23)

Gaps in controls and assurance: (and mitigating actions)
Engagement with staff groups including BAME and LGBT+ staff (remain until all established Networks are considered to be embedded)
PDR Compliance and mandatory training (to remain until processes embedded)
Staff morale and resilience (inc. cost of living crisis) – ongoing monitoring, communication, engagement and health and wellbeing services and programmes
Warrington Adults staff survey results – engagement ongoing
Pay deals agreed for Agenda for Change staff, no further negotiations being offered

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

BAF 6:	TRUST OBJECTIVES:	RISK RATING:	RISK APPETITE:
Staffing levels	• Equality, Diversity and Inclusion • People • Quality	Inherent risk rating: 5 (C) x 4(L) = 20, **significant** Current risk rating: 5 (C) x 3(L) = 15, **significant** Target risk rating: 5(C) x 2 (L) = 10, **high**	**CAUTIOUS - OPEN**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Operating Officer Last review: September 2023 Quality & Safety Committee Last review: August 2023 People Committee: September 2023 Risk Ratings reviewed: September 2023	**Staffing levels** If the Trust fails to have an appropriately resourced, focused, resilient workforce in place that meets service requirements; Caused by an inability to recruit, retain and/or appropriately deploy a workforce with the necessary skills and experience; or caused by organisational change; It may result in extended unplanned service closure and disruption to services, leading to poor clinical outcomes & experience for large numbers of patients; unmanageable staff workloads; and increased costs **Risks on register 15 plus** 3145 – District Nursing, demand and capacity 3064 – Safeguarding, demand and capacity	Robust operational management structures in place. Adverse impacts to consider include: winter pressures, system wide incentives causing instability in recruitment and retention, potential for industrial action. (Cross ref. with BAF2) With consideration to local employment opportunities and competing with local employers.	**Prevent Controls** • Business continuity plans in place • Organisational Development Strategy • Agreed medical and nursing revalidation protocols, preparation and remedial processes • Agreed recruitment and selection policies and processes • People Strategy & People Delivery Plan • HR Policies and working groups • Fortnightly meetings with staff side • People Hub & PODs / Culture & Leadership / Recruitment & Retention / Health & Wellbeing / Education & Professional Development **Detect Controls** • Agency staff reporting / Staff sickness reporting • Turnover rate reporting • Premium Pay and Spend reporting • Daily Ops Huddles x 3 per week • Staff survey / pulse survey results **Assurances** • Quality & Safety Committee • Integrated Performance Report includes workforce metrics including training levels • Vacancy approval process reviews use of agency staff – regular review of staffing levels • Performance report indicating number of lapsed registrations each month • E-rostering / Safer Staffing Report • Key workforce metrics 'heat map' now received at Board via the IQPR • Workforce plans developed by service to support recruitment **Audits – Substantial Assurance** Induction audit (2020/21)

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

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

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

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

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

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

BAF 8: Digital services which do not meet demands of the organisation	**TRUST OBJECTIVES:** • Innovation and collaboration • People • Quality • Sustainability • Equality, diversity & inclusion	**RISK RATING:** Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4 (C) x 3 (L) = 12**, high** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**RISK APPETITE:** **SEEK**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Director of Finance Last reviewed: September 2023 F&P Committee Last reviewed: September 2023 Risk Ratings reviewed: September 2023	**If the Trust does not maintain and develop and adopt digital services to meet the current and future needs of the Trust.** This could impact in our ability to; • deliver the Digital Strategy • meet operational, regulatory, contractual & reporting requirements • embrace innovative and existing clinical service models • collaborate in system place-based developments • keep the Trust safe from Cyber-related threats **Risks on register 15 plus**	Cyber risks. Assurance received from DIGIT, Risk Council and Performance Council. Consideration of resource to deliver Digital Strategy and system requirements. Lack of stability in the system. Cyber risks. CNIO remains vacant Issues with EMIS patient record system	**Prevent controls** Digital Strategy 2022–25 approved by Board Multi layers cyber solutions All current software and hardware solutions supported by the provider Continued migration of services to cloud based solutions Digital technology assessment criteria (DTAC) and Data Protection Impact Assessment (DPIA) routinely completed **Detect Controls** DIGIT and Digital Programmes Groups Participation and membership of ICS and Place based digital development groups High Severity Care Cert notifications from the National Cyber Security Centre **Assurances** Finance & Performance Committee Audit Committee The Board receives reports from the F&P Committee which receives regular IT reports Relevant MIAA audit reports. SIRO & Caldicott Guardian Data, Security & Protection (DSP) Toolkit Cyber Essentials – on site assessment Business Continuity Management (BCM) and Cyber Incident Response Plan (CIRP) plans Password penetration test tools MIAA – Internal Audit Cyber Security – Moderate assurance (2022/23) **Audits – Substantial Assurance**: IT Threats & Vulnerability (2020/21) DSP Toolkit (2022/23)
Gaps in controls and assurance: (and mitigating actions) Digital Services team capacity			

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

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

Appendix 2: Risk grading criteria

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

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

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

Likelihood score & descriptor with examples				
Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Less than 1 chance in 1,000 Statistical probability below 0.1% Very good control	Between 1 chance in 1,000 and 1 in 100 Statistical probability between 0.1% - 1% Good control	Between 1 chance in 100 and 1 in 10 Statistical probability between 1% and 10% Limited effective control	Between 1 chance in 10 and 1 in 2 Statistical probability between 10% and 50% Weak control	Greater than 1 chance in 2 Statistical probability above 50% Ineffective control

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS		Date	5 October 2023
Agenda Item	70/23			
Report Title	KEY CORPORATE MESSAGES			
Executive Lead	Colin Scales – Chief Executive			
Report Author	Jan McCartney – Trust Secretary			
Presented by	Colin Scales – Chief Executive			
Action Required	☐ To Approve	☐ To Assure	☒ To Note	

Executive Summary
The Board is asked to note the report.

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

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

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	5 October 2023
Agenda Item	70/23		
Report Title	KEY CORPORATE MESSAGES		
Report Author	Jan McCartney		
Purpose	To update the Board concerning key matters within the Trust and the NHS as a whole.		

1. NON-EXECUTIVE DIRECTOR UPDATES

1.1 The Trust Chair, Karen Bliss attended the following meetings:

- Race Inclusion Network on 25 July.
- NHSE Chairs & Chief Executive with NHSE leadership team, in the wake of the Lucy Letby verdict on 6 September in London.
- North West Leadership Academy Festival of Leadership in Manchester on 11 September.
- Good Governance Institute on Freedom to Speak Up on 15 September.
- Annual Members Meeting and Thank You Awards on 20 September.

On 15 August Karen had a 1-1 meeting with Raj Jain, Chair of the Cheshire & Merseyside ICB.

Karen met with the Trust's Freedom to Speak Up Guardian, Helen Young and the Chief Executive on 24 August and on 10 August, Karen accompanied the Chief Executive on the Time to Talk session with the Halton 0-19 Team/Family Hub based at Kingsway Children's Centre.

1.2 Non-Executive Director, Linda Chivers participated in the monthly meeting with MIAA regarding progress on the internal Audit programme and also the regular Non-Executive Director meetings. Linda also attended the virtual Trust Council of Governors meeting and the recent Trust Annual Members meeting and Thank You Awards event.

In addition, Linda chaired an extra-ordinary meeting of the Audit Committee to consider procurement of the External Audit function for 2023/24, and deputised for the Chair at the Time to Talk session with Warrington Podiatry service held on 6 September with the Trust Secretary. Linda also met with the Director of People & OD as part of the buddying arrangements.

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

- 31 July, Time to Shine meeting, which focused on non-medical prescribing
- 1 August, Local Governors meeting

- 31 August Time to Shine meeting, which focused on FTSU, Safeguarding

Martyn had a 1-1 meeting with the Lead Governor on 7 August and attended the Time to Talk session with Warrington Community Services, Matrons team at Orford Jubilee on 14 September, with the Trust Secretary.

1.4 Non-Executive Director, Gail Briers attended the Governors meeting held on 1 August. The Extraordinary BAF meeting on 18 September and the Annual Members Meeting & Thank You Awards on 20 September. Gail also met with the Freedom to Speak Up Guardian on 12 September.

1.5 Non-Executive Director, Tina Wilkins attended the Time to Shine meetings held on 31 July and 31 August. Tina also attended the Annual Members Meeting and Thank You Awards held on 20 September.

Tina met with the Deputy Director of Finance and the Deputy Chief Operating Officer to discuss the Cost Improvement Programme on 18 August.

Tina undertook a service visit to the Community Equipment Stores on 8 September and as part of the buddying arrangements, had 1-1 meetings with the Chief Nurse on 1 August and 1 September.

1.6 Non-Executive Director, Abdul Siddique has held two reciprocal mentoring meetings with staff member and attended the Annual Members meeting & Thank You Awards on 20 September.

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

- Quality Committee
- People Committee
- Council of Governors
- Non-Executive Directors Network event
- Halton & Rest of England Governors meeting

Elaine had a number of 1-1 meetings, one with the Chief Operating Officer, one with the Medical Director and one with the Chair, which also included an initial PDR.

Elaine accompanied the Medical Director on the Time to Talk session with the St Helens Community Dental Team.

2. EXECUTIVE UPDATES

2.1 An Exec to Exec meeting took place on 22 August with colleagues from the C&M ICB – Warrington Place to discuss key topics.

2.2 On 30 August, the Chief Executive opened the Apprentice Welcome Breakfast event in Spencer House, to welcome and meet and greet apprentices, including the new hires that

were joining the Trust as Health Care Support Workers (nursing and AHP), Business Administration, Trainee Nursing Associates and Physiotherapists.

2.3 The Chief Executive, along with the Medical Director and the Programme Director for Integration & Collaboration met with the Chief Executive, and members of his team, from Halton Borough Council. The purpose of the meeting was to discuss more collaborative ways of working in Halton, with a view of commencing this work for children's services.

2.4 **Executive and Senior Team Engagement**

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

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

2.4.1 On 10 August, the Chief Executive met with the Specialist Perinatal Health Visiting Service based at Kingsway Children's Centre in Widnes. The Chair accompanied the Chief Executive on this visit.

2.4.2 The Director of People & OD held a face to face meeting with the Infection, Prevention Control Team on 7 August.

2.4.3 The Chief Operating Officer met with teams based at Widnes Urgent Care Centre on 14 September. Non-Executive Director, Gail Briers accompanied the Chief Operating Officer on this visit.

2.4.4 On 30 August, the Medical Director, accompanied by Non-Executive Director, Elaine Inglesby visited the St Helens Dental Team.

2.4.5 On behalf of the Chief Executive, the Trust Secretary met with the Podiatry Team based at Warrington Wolves on 6 September. Non-Executive Director, Linda Chivers also attended the session. On 14 September, the Trust Secretary also met with the Warrington Community Nurses based at Orford Jubilee and was accompanied by Non-Executive Director, Martyn Taylor on this visit.

2.5 Board Sessions/Events

2.5.1 A Board Time-Out session took place on 7 September. Key topics discussed were The Green Plan, Emergency Preparedness Resilience & Response (EPRR), Reduction in Violence, and Safeguarding.

2.5.2 The Annual Members meeting and Thank You Awards took place on 20 September at Haydock Park Racecourse.

3. DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

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

"Enthusiasm and dedication to community dentistry."

"The team appear to be very well connected, supportive of each other and very proud of the service they provide. They mentioned wellbeing and gave examples of how they ensure staff wellbeing in the team. I had such a lovely visit and the team should be so proud of themselves."

4. TRUST NEWS

4.1 NHS England Sexual Safety Charter - On the 4th September, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. As a signatory to this charter, we are committed to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours in the workplace. There are 10 core principles and actions to help us achieve this, with all ten commitments being met by July 2024.

There will be a review of our Domestic Abuse Policy in addition to the above and all associated work will be routed through the POD Council, with alignment to our Dignity & Respect Programmes.

Quarterly webinars to support the implementation of the charter will take place from 17th October.

We are committed to ensuring a safe space for staff and patients alike and we will work together with our Staff-side Colleagues to achieve this.

5. EXTERNAL PUBLICATIONS AND REPORTS

5.1 NHS England Fit and Proper Person Test Framework for board members - NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. These changes will be taken to the next Audit Committee who will have oversight of its implementation.
NHS England » NHS England Fit and Proper Person Test Framework for board members

5.2 HFMA Briefing - System decision-making and governance - This briefing explores issues around system governance and decision-making. It explores the tensions that can arise due to competing financial duties and identifies the key questions to be asked in shaping local governance arrangements.
System decision-making and governance (hfma.org.uk)

5.3 NHS Confederation - Delivering more joined-up care for local communities
This briefing highlights how community providers are well placed to provide more integrated care with partners across the health and care system, to deliver more

person-centred care in the community. Delivering more joined-up care for local communities | NHS Confederation

6. RECOMMENDATIONS

6.1 The Board is asked to note the report.

Integrated Quality and Performance Report

Information Team

Reporting Period: July 2023 (Month 4)

Contents

- Section 1: Trust Overview
- Section 2: Operations – Responsive
- Section 3: Safe, High-Quality Care
- Section 4: People
- Section 5: Finance - Making Good Use of Resources

Introduction

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

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

This month’s report describes activity in July 2023.

Within this Report

1. KPI Amendments

KPI	Change	Rationale

2. Recommendations:

The Board are asked to:

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

Trust Overview

Executive Summary

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

Responsive (Operations)

There are 13 green indicators in month 4. There is one new red indicator this month pertaining to the 'Referrals to Plan' indicator and there is one new green indicator relating to Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment. All of the cancer indicators are now green.

Performance within the red and green indicators is variable, largely due to the impact of the seasonal pressures and the impact of annual leave and less onward referrals into services from referrers such as schools.

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 42 green indicators in month 4. There is one new red indicator pertaining to 'DOC (Duty of Candour) - 10-day compliance'. There is an increase in the number of risks and the number of 'High 12' risks.

People

Three out of the five people indicators are red in month 4. Compliance with PPDR is now green and above target.

Making Good Use of Resources (Finance)

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

Operations

Executive Summary

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

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

- Referrals to plan – New in month
- Cancellations by service – Increase in month
- Cancellations by patient – Increase in month
- Percentage of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway) – Increase in month
- Warrington Audiology - Number of 6 weeks diagnostic breaches – Decreased from 77 to 73 breaches.
- Warrington Activity Variance – Increase in month

Overall, there is not a significant change in the position in relation to the operational indicators reported against, there is one indicator which has moved from red to green in relation to the 31 day to 1st treatment for the cancer indicators and one from green to red for referrals to plan.

Operations

Actions

Indicator	Action	Target date	Responsible Committee
% of patients waiting under 18 weeks	Three services now showing breaches of the 18-week RTT – dermatology and community paediatrics, in Warrington and in Halton. Additional resources are already supporting the delivery of these services, but they will be monitored closely to ensure that the RTT is achieved as soon as possible.	October 2022 – Revised date for achievement of waiting times. It is likely that this date will need to be revised further due to the increasing number of referrals into these services	Chief Operating Officer / Finance and Performance Committee

The current financial position will impact our ability to achieve compliance with this indicator as we are not able to maintain the current levels of locum activity. It is therefore unknown when we will be able to achieve compliance with this indicator.

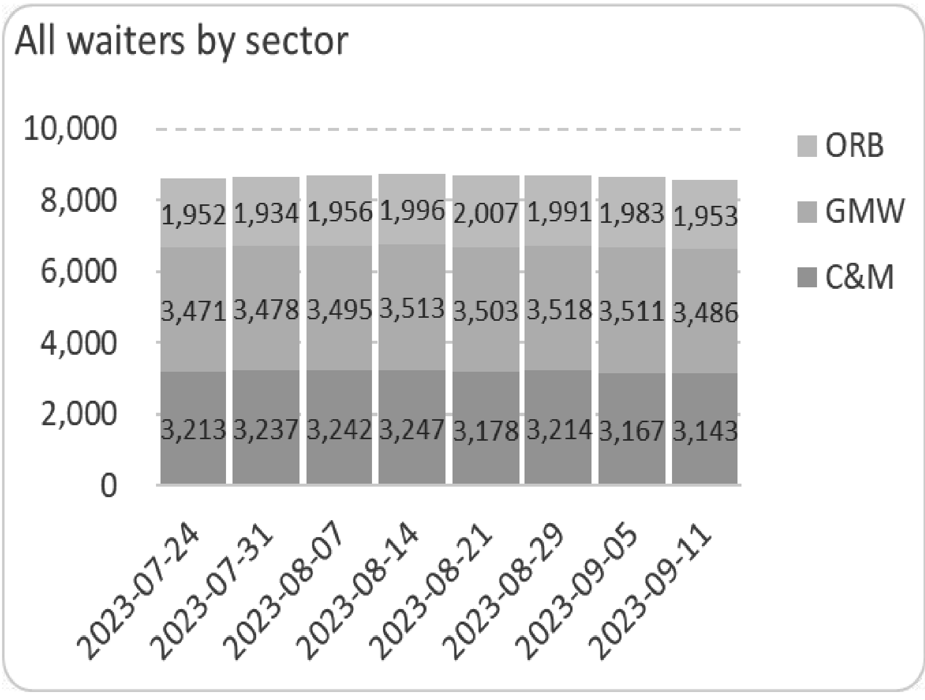
Operations

Trust Scorecard

Operations																
Code	KPI Name	Target	Trend Line	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
OP01	KPIs / Achievements Locally agreed KPIs	100.00%														
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93.00%		93.19% (▼)	91.34% (▼)	93.93% (▲)	31.25% (▼)	92.34% (▲)	94.39% (▲)	98.84% (▲)	99.55% (▲)	98.16% (▼)	96.82% (▼)	97.78% (▲)	98.59% (▲)	98.67% (▲)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94.00%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	83.33% (▼)	100% (▲)	75% (▼)	100% (▲)	100% (▶)	71.43% (▼)	100% (▲)	100% (▶)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96.00%		100% (▲)	92.86% (▼)	100% (▲)	80% (▼)	100% (▲)	100% (▶)	100% (▶)	83.33% (▼)	100% (▲)	100% (▶)	100% (▶)	92.86% (▼)	100% (▲)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85.00%		85.71% (▼)	87.5% (▲)	92.31% (▲)	100% (▲)	100% (▶)	100% (▶)	93.33% (▼)	87.5% (▼)	75% (▼)	77.27% (▲)	86.67% (▲)	95.83% (▲)	90% (▼)
OP22	28 day faster diagnosis	75.00%		72.73% (▲)	68.67% (▼)	75.19% (▲)	79.17% (▲)	73.02% (▼)	75.29% (▲)	75.95% (▲)	81.14% (▲)	91.01% (▲)	86.96% (▼)	82.91% (▼)	84.47% (▲)	87.57% (▲)
OP06	Referrals to plan	95.00%		87.27% (▼)	87.03% (▼)	84.88% (▼)	95.85% (▲)	90.53% (▼)	75.66% (▼)	91.08% (▲)	81.22% (▼)	85.83% (▲)	83.5% (▼)	91.43% (▲)	96.88% (▲)	86.27% (▼)
OP07	Cancellations by service	5.00%		12.43% (▼)	11.67% (▲)	12.56% (▼)	10.61% (▲)	10.56% (▲)	12.22% (▼)	10.89% (▲)	11.16% (▼)	10.77% (▲)	13.71% (▼)	12.25% (▲)	9.43% (▲)	10.45% (▼)
OP08	Cancellations by Patient	5.00%		6.32% (▼)	5.16% (▲)	5.3% (▼)	5.81% (▼)	5.66% (▲)	5.73% (▼)	5.39% (▲)	5.22% (▲)	5.79% (▼)	4.98% (▲)	4.86% (▲)	5.69% (▼)	6.08% (▼)
OP09	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92.00%		59.05% (▼)	53.34% (▼)	43.21% (▼)	39.74% (▼)	35.29% (▼)	34.75% (▼)	39.76% (▲)	41.49% (▲)	57.99% (▲)	58.67% (▲)	67.55% (▲)	69.21% (▲)	65.29% (▼)
OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		96.3% (▼)	98.66% (▲)	96.48% (▼)	92.66% (▼)	87.43% (▼)	82.48% (▼)	93.72% (▲)	96.01% (▲)	98.1% (▲)	96.8% (▼)	97.53% (▲)	98.42% (▲)	97.2% (▼)
OP12	Total time in A&E - 95th Percentile	4 Hrs		03:56 (▼)	03:32 (▲)	03:55 (▼)	04:31 (▼)	05:11 (▼)	06:06 (▼)	04:27 (▲)	03:57 (▲)	03:31 (▲)	03:51 (▼)	03:52 (▼)	03:40 (▲)	03:51 (▼)
OP13	A&E Time to treatment decision (median) <=60 mins	60 Mins		00:10 (▲)	00:09 (▲)	00:09 (▼)	00:10 (▼)	00:12 (▼)	00:14 (▼)	00:10 (▲)	00:08 (▲)	00:08 (▼)	00:09 (▼)	00:09 (▲)	00:08 (▲)	00:09 (▼)
OP14	A&E Unplanned re-attendance rate <=5%	5%		0.03% (▼)	0% (▲)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0.03% (▼)	0% (▲)	0.03% (▼)
OP15	A&E left without being seen <=5%	5%		0.28% (▼)	0.44% (▼)	0.23% (▲)	0.08% (▲)	0.27% (▼)	0.89% (▼)	0.13% (▲)	0.03% (▲)	0.09% (▼)	0.09% (▼)	0.18% (▼)	0.19% (▼)	0.06% (▲)
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches	0		1 (▲)	0 (▲)	3 (▼)	2 (▲)	4 (▼)	4 (▶)	1 (▲)	5 (▼)	9 (▼)	67 (▼)	85 (▼)	77 (▲)	73 (▲)
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score	95%		99.8% (▲)	99.77% (▼)	95.36% (▼)	99.83% (▲)	99.83% (▶)	99.82% (▼)	99.71% (▼)	99.71% (▶)	99.73% (▲)	99.73% (▶)	99.7% (▼)	99.7% (▶)	99.72% (▲)
OP18	Halton Maternity Dashboard - Number of red rated areas	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
OP19	Warrington Activity Variance	3%		-16.68% (▲)	-17.26% (▼)	-17.81% (▼)	-16.77% (▲)	-16.37% (▲)	-17.02% (▼)	-16.95% (▲)	-17.1% (▼)	-17.28% (▼)	-21.99% (▼)	-18.25% (▲)	-14.95% (▲)	-15.28% (▼)
OP20	Halton Activity Variance	3%		17.27% (▼)	17.39% (▼)	15.15% (▲)	13.85% (▲)	12.36% (▲)	11.08% (▲)	10.92% (▲)	10.36% (▲)	9.18% (▲)	0.31% (▲)	2.51% (▼)	3.3% (▼)	1.83% (▲)

Operations: Exception Reporting

Chart



Issue

Dental - Patients waiting by Sector

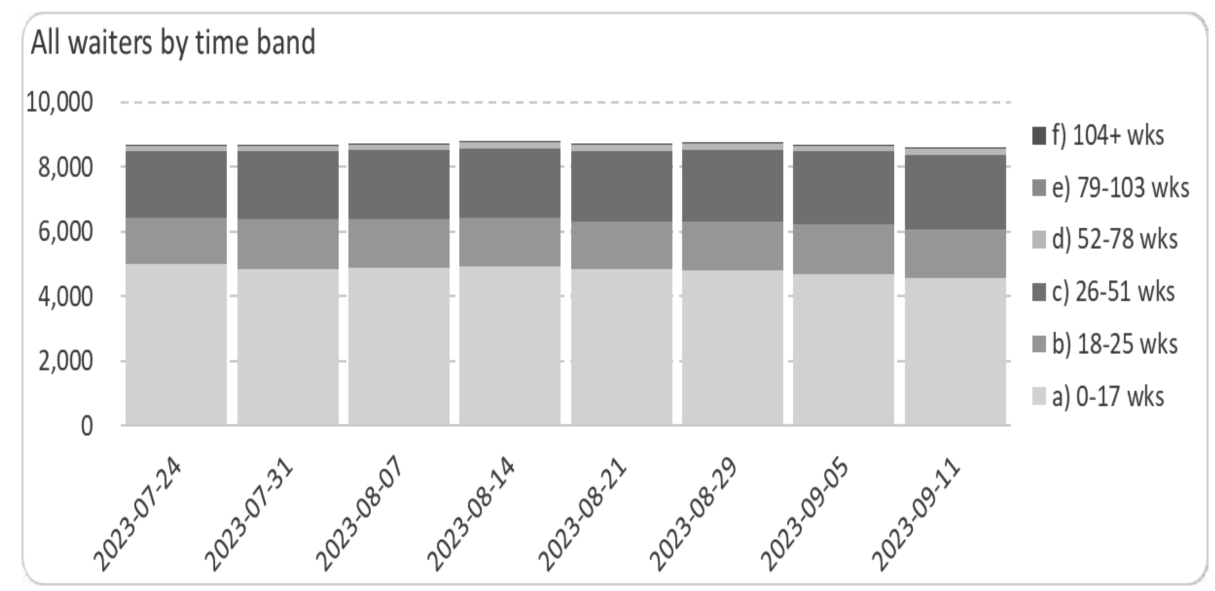
The number of patients waiting for dental treatment has remained relatively static across all of the sectors.

There are a number of task and finish groups in place to manage the waiting list pressures in both Cheshire and Merseyside – particularly for minor oral surgery and in Greater Manchester for inhalation sedation and paediatric exodontia. Additional support is being provided from the Operational Management team to support these groups.

Two new Heads of Service are now also in place – one in Cheshire and Merseyside and one in Greater Manchester alongside the additional posts in the clinical leadership structure.

Operations: Exception Reporting

Chart



Issue

Dental – Waiters by time band

There is one patient waiting over 104 weeks and 3 patients waiting over 79 weeks. These patients are being monitored by the Directorate Leadership Team and there are individual circumstances as to why these patients have not yet been seen. There is however an increasing number of patients waiting over 52 weeks which are also being monitored so we can ensure that we have no patients waiting over 65 weeks from 1st April 2024.

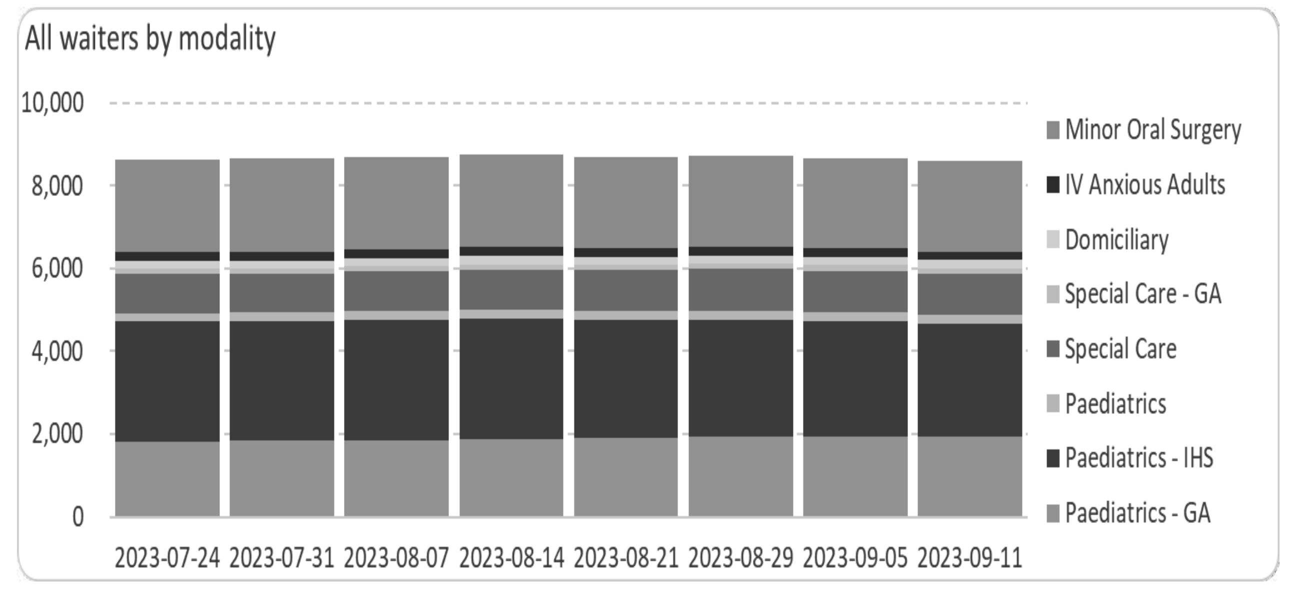
Operations: Exception Reporting

Dental – Waiters by time band

	Waiters by time band					
Snapshot Date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2023-07-24	5,011	1,404	2,070	148	2	1
2023-07-31	4,837	1,546	2,102	161	2	1
2023-08-07	4,883	1,497	2,153	157	2	1
2023-08-14	4,915	1,512	2,151	174	2	2
2023-08-21	4,822	1,475	2,191	194	4	2
2023-08-29	4,813	1,490	2,223	193	3	1
2023-09-05	4,697	1,518	2,249	193	3	1
2023-09-11	4,578	1,502	2,297	201	3	1

Operations: Exception Reporting

Chart



Issue

Dental - Patients waiting by treatment

Patients waiting for paediatric GA has increased, paediatric inhalation sedation, IV anxious adults and minor oral surgery has decreased over the last few months.

Actions are in place via all of the task and finish groups to address the waiting list pressures.

Quality

Executive Summary

There are 3 Quality indicators reporting as red and 42 green indicators in July 2023.

The 3 indicators which were red in July are as follows:

- % Of Incidents Low impact Level 1-2 – Increase in month
- DOC (Duty of Candour) - 10-day compliance – New in month
- Percentage of risks identified as High – Increase in month

Quality

Actions:

Indicator	Action	Target date	Responsible Committee
Safeguarding Level 3 – Children's and Adults	• Staff to be supported to participate in training. • Additional sessions to be delivered as capacity permits • Regular reminders at Daily Ops Huddle • Education and Training team sharing regular lists of staff who are compliant and non compliant	• Children's Level 3 is now compliant Previous target was to have Adults Level 3 compliant by end of June 2022 **TARGET DATE EXTENDED TO 26th September**	Associate Directors / Director of Nursing and Operational Managers

This action can now be closed as we are now compliant with all of the Safeguarding Adults and Childrens Training Modules

Quality: Exception Reporting

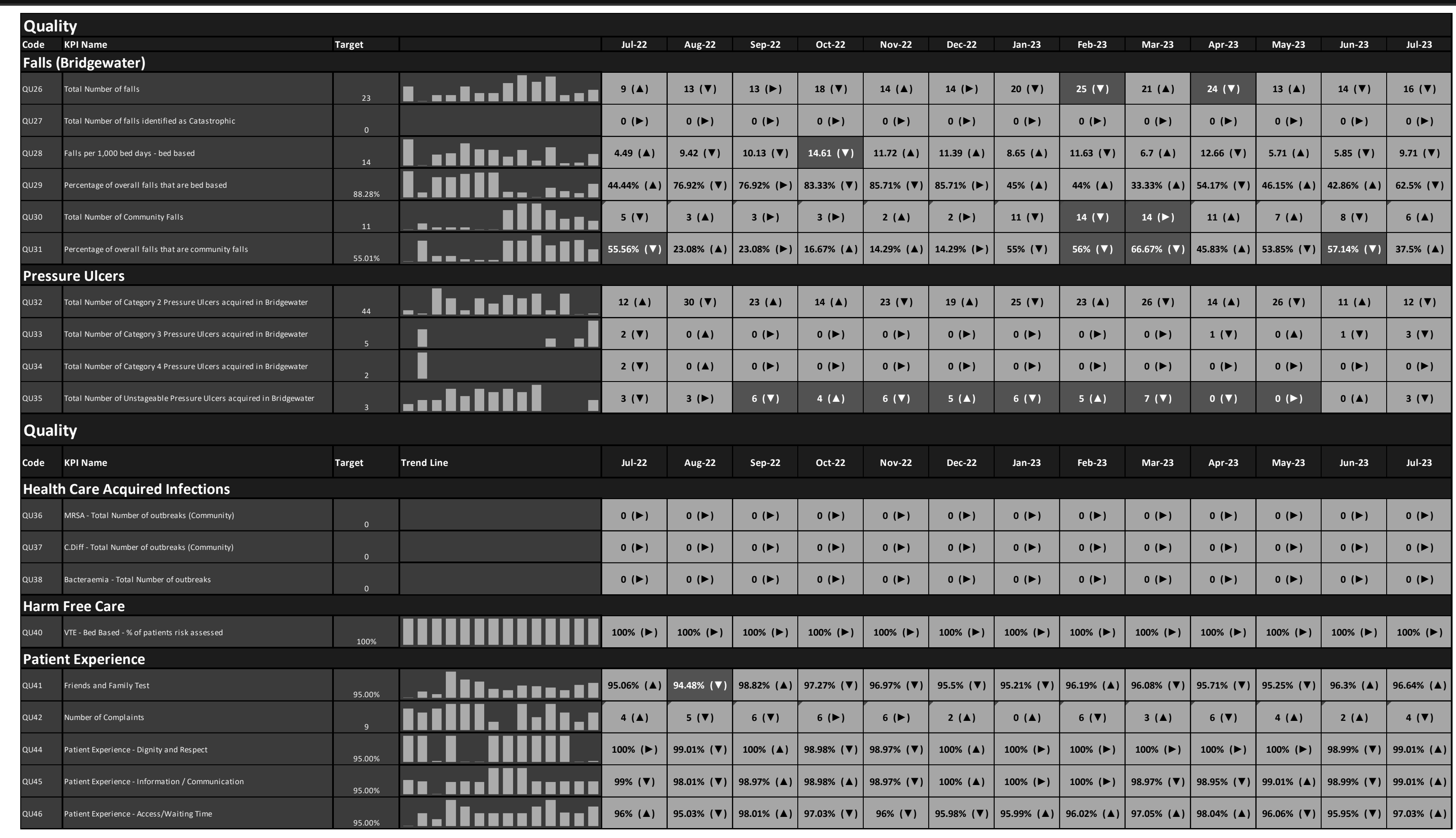
Trust Scorecard

Quality

Code	KPI Name	Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Incidents																
QU01	Number of Never Events	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
QU02	Number of patient safety incidents reported	97-217		102 (▲)	139 (▼)	140 (▼)	148 (▼)	156 (▼)	112 (▲)	128 (▼)	128 (▶)	138 (▼)	109 (▲)	125 (▼)	112 (▲)	153 (▼)
QU03	% of incidents High impact Level 3-5	7.88%		4.9% (▼)	3.6% (▲)	5% (▼)	3.38% (▲)	3.85% (▼)	4.46% (▼)	5.47% (▼)	6.25% (▼)	6.52% (▼)	1.83% (▲)	0% (▲)	2.68% (▼)	3.27% (▼)
QU04	% Of Incidents Low impact Level 1-2	68.97%		86.27% (▼)	87.77% (▼)	91.43% (▼)	85.81% (▲)	81.41% (▲)	84.82% (▼)	88.28% (▼)	86.72% (▲)	84.78% (▲)	88.07% (▼)	88.8% (▼)	85.71% (▲)	88.24% (▼)
QU05	Number of Serious Incidents Reported	9		8 (▼)	4 (▲)	9 (▼)	3 (▲)	8 (▼)	6 (▲)	5 (▲)	11 (▼)	2 (▲)	4 (▼)	1 (▲)	4 (▼)	4 (▶)
QU06	Percentage of Serious Incidents Reported - Compliance with reporting time frames for StEIS within 48 hours	100.00%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
QU07	RCA investigations compliance submitted within 60 day time frame	100.00%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
QU08	DOC (Duty of Candour) - 10 day compliance	100.00%		100% (▶)	88.89% (▼)	100% (▲)	100% (▶)	75% (▼)	75% (▶)	100% (▲)	100% (▶)	100% (▶)	100% (▶)	50% (▼)	100% (▲)	85.71% (▼)
QU09	CAS Alert Compliance	100.00%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
QU10	Total Number of Medication Errors	33		7 (▲)	12 (▼)	12 (▶)	18 (▼)	12 (▲)	9 (▲)	8 (▲)	9 (▼)	9 (▶)	9 (▶)	11 (▼)	9 (▲)	22 (▼)
QU11	Medication Errors That Caused Harm	6		1 (▼)	0 (▲)	0 (▶)	2 (▼)	1 (▲)	0 (▲)	1 (▼)	1 (▶)	1 (▶)	1 (▶)	2 (▼)	0 (▲)	3 (▼)
QU12	Medical Device Incidents	14		9 (▼)	6 (▲)	5 (▲)	13 (▼)	6 (▲)	4 (▲)	6 (▼)	3 (▲)	6 (▼)	7 (▼)	8 (▼)	8 (▶)	9 (▼)
Training Compliance																
QU13	Information Governance	95.00%		95.5% (▲)	93.94% (▼)	92.67% (▼)	92.37% (▼)	91.21% (▼)	91.47% (▲)	90.79% (▼)	88.59% (▼)	89.31% (▲)	88.86% (▼)	90.23% (▲)	91.83% (▲)	97.22% (▲)
QU14	Safeguarding Childrens Level 1	85.00%		89.07% (▲)	90.45% (▲)	90.85% (▲)	92.04% (▲)	92.55% (▲)	92.32% (▼)	92.68% (▲)	93.76% (▲)	93.99% (▲)	92.69% (▼)	93.89% (▲)	96.13% (▲)	98.46% (▲)
QU15	Safeguarding Childrens Level 2	85.00%		80.84% (▲)	85.4% (▲)	85.3% (▼)	85.96% (▲)	84.87% (▼)	85.94% (▲)	87.15% (▲)	89.61% (▲)	91.23% (▲)	89.97% (▼)	91.8% (▲)	94.24% (▲)	97.4% (▲)
QU16	Safeguarding Childrens Level 3	85.00%		85.86% (▲)	85.08% (▼)	82.84% (▼)	83.44% (▲)	83.77% (▲)	89.37% (▲)	86.44% (▼)	89.19% (▲)	93.13% (▲)	93.84% (▲)	94.6% (▲)	97.17% (▲)	98.18% (▲)
QU17	Safeguarding Adults Level 1	85.00%		88.95% (▲)	90.07% (▲)	89.72% (▼)	92.45% (▲)	92.9% (▲)	92.87% (▼)	93.49% (▲)	94.43% (▲)	94.79% (▲)	93.57% (▼)	94.82% (▲)	96.32% (▲)	98.39% (▲)
QU18	Safeguarding Adults Level 2	85.00%		76.27% (▲)	81.83% (▲)	71.19% (▼)	76.22% (▲)	77.18% (▲)	80.67% (▲)	83.45% (▲)	86.47% (▲)	88.86% (▲)	88.79% (▼)	90.83% (▲)	92.41% (▲)	97.07% (▲)
QU19	Safeguarding Adults Level 3	85.00%		58.88% (▲)	65.79% (▲)	67.24% (▲)	69.36% (▲)	69.21% (▼)	77.16% (▲)	76.26% (▼)	78.45% (▲)	76.09% (▼)	79.72% (▲)	83.6% (▲)	84.43% (▲)	92.01% (▲)
Risks																
QU20	Total Number of risks	258		187 (▼)	177 (▲)	164 (▲)	145 (▲)	147 (▼)	151 (▼)	157 (▼)	165 (▼)	171 (▼)	173 (▼)	181 (▼)	178 (▲)	196 (▼)
QU21	Total Number of risks identified as High	111		92 (▼)	85 (▲)	73 (▲)	71 (▲)	62 (▲)	65 (▼)	71 (▼)	75 (▼)	79 (▼)	75 (▲)	83 (▼)	82 (▲)	93 (▼)
QU22	Percentage of risks identified as High	44.02%		49.2% (▼)	48.02% (▲)	44.51% (▲)	48.97% (▼)	42.18% (▲)	43.05% (▼)	45.22% (▼)	45.45% (▼)	46.2% (▼)	43.35% (▲)	45.86% (▼)	46.07% (▼)	47.45% (▼)
QU23	Total Number of risks identified as High 12	57		22 (▲)	22 (▶)	20 (▲)	16 (▲)	22 (▼)	22 (▶)	15 (▲)	16 (▼)	19 (▼)	26 (▼)	24 (▲)	22 (▲)	25 (▼)
QU24	Percentage of risks identified as High 12	15.17%		11.76% (▲)	12.43% (▼)	12.2% (▲)	11.03% (▲)	14.97% (▼)	14.57% (▲)	9.55% (▲)	9.7% (▼)	11.11% (▼)	15.03% (▼)	13.26% (▲)	12.36% (▲)	12.76% (▼)
QU25	Total Number of risks identified as Extreme	21		3 (▼)	1 (▲)	2 (▼)	1 (▲)	3 (▼)	3 (▶)	5 (▼)	3 (▲)	3 (▶)	2 (▲)	2 (▶)	2 (▶)	5 (▼)
QU52	Percentage of risks identified as Extreme	4.69%		1.6% (▼)	0.56% (▲)	1.22% (▼)	0.69% (▲)	2.04% (▼)	1.99% (▲)	3.18% (▼)	1.82% (▲)	1.75% (▲)	1.16% (▲)	1.1% (▲)	1.12% (▼)	2.55% (▼)

Quality: Exception Reporting

Trust Scorecard



Quality

Code	KPI Name	Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Falls (Bridgewater)																
QU26	Total Number of falls	23		9 (▲)	13 (▼)	13 (▶)	18 (▼)	14 (▲)	14 (▶)	20 (▼)	25 (▼)	21 (▲)	24 (▼)	13 (▲)	14 (▼)	16 (▼)
QU27	Total Number of falls identified as Catastrophic	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
QU28	Falls per 1,000 bed days - bed based	14		4.49 (▲)	9.42 (▼)	10.13 (▼)	14.61 (▼)	11.72 (▲)	11.39 (▲)	8.65 (▲)	11.63 (▼)	6.7 (▲)	12.66 (▼)	5.71 (▲)	5.85 (▼)	9.71 (▼)
QU29	Percentage of overall falls that are bed based	88.28%		44.44% (▲)	76.92% (▼)	76.92% (▶)	83.33% (▼)	85.71% (▼)	85.71% (▶)	45% (▲)	44% (▲)	33.33% (▲)	54.17% (▼)	46.15% (▲)	42.86% (▲)	62.5% (▼)
QU30	Total Number of Community Falls	11		5 (▼)	3 (▲)	3 (▶)	3 (▶)	2 (▲)	2 (▶)	11 (▼)	14 (▼)	14 (▶)	11 (▲)	7 (▲)	8 (▼)	6 (▲)
QU31	Percentage of overall falls that are community falls	55.01%		55.56% (▼)	23.08% (▲)	23.08% (▶)	16.67% (▲)	14.29% (▲)	14.29% (▶)	55% (▼)	56% (▼)	66.67% (▼)	45.83% (▲)	53.85% (▼)	57.14% (▼)	37.5% (▲)
Pressure Ulcers																
QU32	Total Number of Category 2 Pressure Ulcers acquired in Bridgewater	44		12 (▲)	30 (▼)	23 (▲)	14 (▲)	23 (▼)	19 (▲)	25 (▼)	23 (▲)	26 (▼)	14 (▲)	26 (▼)	11 (▲)	12 (▼)
QU33	Total Number of Category 3 Pressure Ulcers acquired in Bridgewater	5		2 (▼)	0 (▲)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	1 (▼)	0 (▲)	1 (▼)	3 (▼)
QU34	Total Number of Category 4 Pressure Ulcers acquired in Bridgewater	2		2 (▼)	0 (▲)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
QU35	Total Number of Unstageable Pressure Ulcers acquired in Bridgewater	3		3 (▼)	3 (▶)	6 (▼)	4 (▲)	6 (▼)	5 (▲)	6 (▼)	5 (▲)	7 (▼)	0 (▼)	0 (▶)	0 (▲)	3 (▼)

Quality

Code	KPI Name	Target	Trend Line	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Health Care Acquired Infections																
QU36	MRSA - Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
QU37	C.Diff - Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
QU38	Bacteraemia - Total Number of outbreaks	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
Harm Free Care																
QU40	VTE - Bed Based - % of patients risk assessed	100%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
Patient Experience																
QU41	Friends and Family Test	95.00%		95.06% (▲)	94.48% (▼)	98.82% (▲)	97.27% (▼)	96.97% (▼)	95.5% (▼)	95.21% (▼)	96.19% (▲)	96.08% (▼)	95.71% (▼)	95.25% (▼)	96.3% (▲)	96.64% (▲)
QU42	Number of Complaints	9		4 (▲)	5 (▼)	6 (▼)	6 (▶)	6 (▶)	2 (▲)	0 (▲)	6 (▼)	3 (▲)	6 (▼)	4 (▲)	2 (▲)	4 (▼)
QU44	Patient Experience - Dignity and Respect	95.00%		100% (▶)	99.01% (▼)	100% (▲)	98.98% (▼)	98.97% (▼)	100% (▲)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	98.99% (▼)	99.01% (▲)
QU45	Patient Experience - Information / Communication	95.00%		99% (▼)	98.01% (▼)	98.97% (▲)	98.98% (▲)	98.97% (▼)	100% (▲)	100% (▶)	100% (▶)	98.97% (▼)	98.95% (▼)	99.01% (▲)	98.99% (▼)	99.01% (▲)
QU46	Patient Experience - Access/Waiting Time	95.00%		96% (▲)	95.03% (▼)	98.01% (▲)	97.03% (▼)	96% (▼)	95.98% (▼)	95.99% (▲)	96.02% (▲)	97.05% (▲)	98.04% (▲)	96.06% (▼)	95.95% (▼)	97.03% (▲)

People

Executive Summary

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

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

- Staff turnover (rolling) – Increase in month
- Percentage Overall organisation sickness rate (rolling) – Improvement in month
- Sickness absence rate (actual) – Increase in month

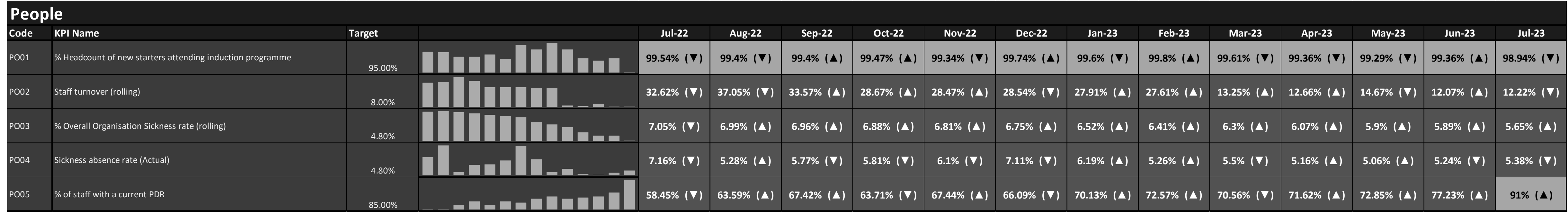
People

Actions

Indicator	Action	Target date	Responsible Committee

People

Trust Scorecard



People

Code	KPI Name	Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
PO01	% Headcount of new starters attending induction programme	95.00%		99.54% (▼)	99.4% (▼)	99.4% (▲)	99.47% (▲)	99.34% (▼)	99.74% (▲)	99.6% (▼)	99.8% (▲)	99.61% (▼)	99.36% (▼)	99.29% (▼)	99.36% (▲)	98.94% (▼)
PO02	Staff turnover (rolling)	8.00%		32.62% (▼)	37.05% (▼)	33.57% (▲)	28.67% (▲)	28.47% (▲)	28.54% (▼)	27.91% (▲)	27.61% (▲)	13.25% (▲)	12.66% (▲)	14.67% (▼)	12.07% (▲)	12.22% (▼)
PO03	% Overall Organisation Sickness rate (rolling)	4.80%		7.05% (▼)	6.99% (▲)	6.96% (▲)	6.88% (▲)	6.81% (▲)	6.75% (▲)	6.52% (▲)	6.41% (▲)	6.3% (▲)	6.07% (▲)	5.9% (▲)	5.89% (▲)	5.65% (▲)
PO04	Sickness absence rate (Actual)	4.80%		7.16% (▼)	5.28% (▲)	5.77% (▼)	5.81% (▼)	6.1% (▼)	7.11% (▼)	6.19% (▲)	5.26% (▲)	5.5% (▼)	5.16% (▲)	5.06% (▲)	5.24% (▼)	5.38% (▼)
PO05	% of staff with a current PDR	85.00%		58.45% (▼)	63.59% (▲)	67.42% (▲)	63.71% (▼)	67.44% (▲)	66.09% (▼)	70.13% (▲)	72.57% (▲)	70.56% (▼)	71.62% (▲)	72.85% (▲)	77.23% (▲)	91% (▲)

Finance

Month Four Finance Report

Scope

1.1 The purpose of this paper is to update the Committee on the financial position of the Trust at the end of July 2023 (Month 04).

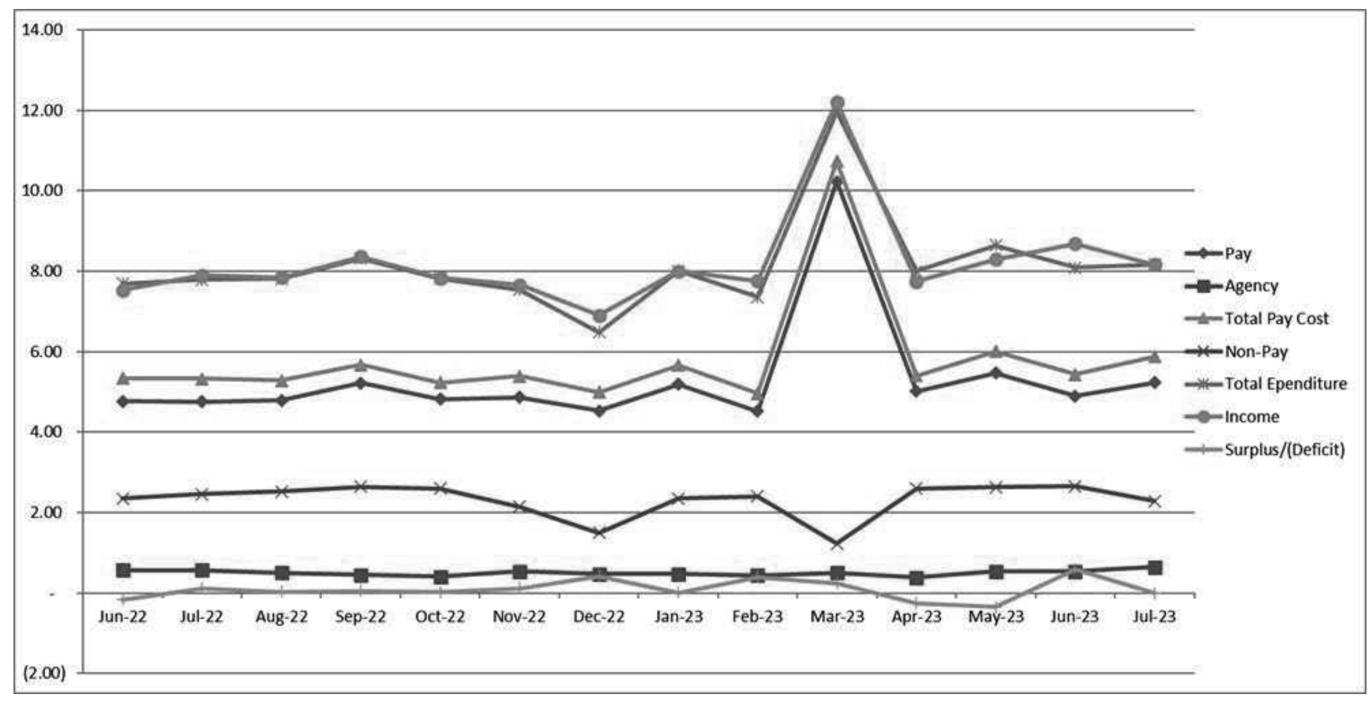
Summary Performance Month 04 2023-24	Month 4 Plan (£M)	Month 4 Actual (£M)	Month 4 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.00)	(8.16)	0.16	(31.84)	(32.90)	1.06	(95.83)	(98.67)
Expenditure - Pay	5.34	5.24	0.11	21.22	20.62	0.59	63.95	63.55
Expenditure - Agency	0.35	0.65	(0.29)	1.41	2.11	(0.70)	4.22	4.22
Expenditure - Non Pay	2.26	2.29	(0.03)	9.03	10.16	(1.14)	27.10	30.56
EBITDA	(0.05)	0.01	(0.06)	(0.19)	(0.00)	(0.18)	(0.55)	(0.33)
Financing	0.05	(0.01)	0.06	0.18	0.00	0.18	0.55	0.33
Normalised (Surplus)/Deficit	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	0.00	(0.00)
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	0.00	(0.00)
Other Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	0.00	(0.00)
CIP	0.43	0.47	0.04	1.72	1.52	(0.20)	5.15	5.15
Capital	0.02	0.04	(0.02)	0.02	0.30	(0.28)	2.10	2.10
Cash	24.31	18.04	(6.28)	24.31	18.04	(6.28)	24.65	24.65
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

Favourable Variance   Adverse Variance

Finance

Key Headlines

Rolling Run Rates 2022/23 to 2023/24



Finance

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

2.1 The key headlines for month four are as follows:

- The Trust is reporting a breakeven position, in line with plan.
- The Trust has a savings requirement of £5.15m (5.2%) in line with ICB instruction.
- The Trust is reporting a year-to-date achievement of £1.52m against a plan of £1.72m.
- Income is £32.90m for the year-to-date against a plan of £31.84m.
- Expenditure is £32.90m against a plan of £31,.84m.
- Pay is £20.62m against a plan of £21.22m.

Finance

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

- Agency spend £2.11m against a plan of £1.41m.
- Non pay expenditure is £10.16m against a plan of £9.03m.
- Capital charges are £0.18m below plan.
- Capital expenditure is £0.30m at month four, planned spend is £0.02m.
- Cash is £18.04m.

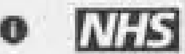
Appendix

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

NHS Oversight Framework

File created on: 17/08/2023

NHS Oversight Framework - Organisation Detail



Org Name Full	Aggregation Source	Indicator	Period Frequency	Period	Value	National value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S035a: Overall CQC rating	Month	2023 08	Requires improvement					[illegible]
	MH Provider	S038a: Consistency of reporting patient safety incidents	Month	Apr 2022 - Sep 2022	100%		100%			[illegible]
	MH Provider	S058a: CQC well-led rating	Month	2023 08	Requires improvement					[illegible]
	MH Provider	S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	Annual, calendar year	2022	7.15/10	6.94/10		↓		[illegible]
	MH Provider	S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	Annual, calendar year	2022	7.29%	11.1%		↑		[illegible]
	MH Provider	S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	Annual, calendar year	2022	13.4%	20%		↓		[illegible]
	MH Provider	S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	Annual, calendar year	2022	22.8%	27.5%		↑		[illegible]
	MH Provider	S067a: Leaver rate	Month	2023 04	7.86%	8.09%		↓	↓	[illegible]
	MH Provider	S068a: Sickness absence rate	Month	2023 02	5.29%	5.07%		↓		[illegible]
	MH Provider	S069a: Staff survey engagement theme score	Annual, calendar year	2022	7.18/10	6.79/10		↑		[illegible]
	MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual, calendar year	2022	10.7%		12%	↑	↑	[illegible]
	MH Provider	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	Annual, calendar year	2022	61.2%	58%		↑		[illegible]
	MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual, calendar year	2022	7.41/10	6.59/10		↑		[illegible]
	MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual, calendar year	2022	6.96/10	6.43/10		↓		[illegible]

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

Thank You

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BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS		Date	05 October 2023
Agenda Item	71/23ii			
Report Title	LISTENING TO STAFF VOICES AND FREEDOM TO SPEAK UP			
Executive Lead	Lynne Carter - Chief Nurse/Deputy CEO			
Report Author	Jeanette Hogan Deputy Chief Nurse Helen Young – Freedom to Speak Up Guardian			
Presented by	Lynne Carter - Chief Nurse/Deputy CEO			
Action Required	☒ To Approve	☐ To Assure		☐ To Note

Executive Summary

Whilst we await the outcomes of the national inquiry into the Lucy Letby case, this report includes details of the Trust response to the NHSE recommendations that Trusts urgently ensure the following:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up.
- Communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
- Boards are regularly reporting, reviewing, and acting upon available data.

The Bridgewater approach to improving how we effectively listen to staff voices will be to align with FTSU activities and strengthen the existing established systems and processes and review the mechanisms of connectivity, rather than creating a separate framework to ensure that we create a Trust culture whereby staff:

- Are encouraged to be ***curious.***
- Feel ***safe*** and supported to raise concerns.
- Feel ***listened to***.
- Know how to ***escalate*** any concerns and that they will be acted upon in a timely manner.

It is recognised that based on the data from the 2022 Staff Survey and the recent internal survey carried out, we have some work to do to ensure that staff, firstly feel safe to speak up, and secondly when they do, that their concerns will be acted upon, with strong mechanisms for responding to feedback and the sharing of learning.

This report provides a summary of the FTSU activity since the last report in August 2023 including: ➢ An overview of the internal anonymous survey regarding FTSU. ➢ Recent developments and any recommendations that will impact on FTSU. ➢ Self-assessment action plan update.	
Previously considered by:	
☐ **Flu Group** ☐ **Medical & Dental Professional Governance**	☐ **Freedom to Speak Up Guardian Group** ☐ **PEOPLE HUB**
Strategic Objectives	
☒ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.	
☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.	
☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.	
☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.	
☐ **Resources** - We will ensure that we use our resources in a sustainable and effective way.	
☒ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.	

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

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

BAORD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	71/23ii		
Report Title	LISTENING TO STAFF VOICES AND FREEDOM TO SPEAK UP		
Report Author	Jeanette Hogan Deputy Chief nurse Helen Young - Freedom to Speak Up Guardian		
Purpose	This report provides the Board with the Trust response to the NHSE recommendations following the outcomes of the Lucy Letby verdict and an update on Freedom to Speak Up activities.		

1. INTRODUCTION

1.1 On 18th August 2023, NHS England wrote a letter to all integrated care boards and NHS trusts in response to the verdict in the trial of Lucy Letby. Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working across the NHS to save lives and care for patients and their families. The Department of Health and Social Care have announced that there will be an independent inquiry into the events at the Countess of Chester Trust.

1.2 NHS leaders were reminded of the importance of listening to the concerns of patients, families and staff, and following whistleblowing procedures. They want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response. Last year a strengthened Freedom to Speak Up (FTSU) policy was rolled out and all organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest. This has already been adopted by Bridgewater and can be found on the HUB, with a link to it to be included when the new FTSU webpage is updated.

1.3 Trusts were asked to urgently ensure the following:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up.

- Communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
- Boards are regularly reporting, reviewing and acting upon available data.

1.4 Whilst we await the outcomes of the national inquiry, this report includes details of the Trust response to the above NHSE recommendations.

1.5 This report also provides a summary of the FTSU activity since the last report in August 2023 including:

- An overview of the internal anonymous survey regarding FTSU.
- Recent developments and any recommendations that will impact on FTSU.
- Self-assessment action plan update.

2. LISTENING TO STAFF VOICES

2.1 It is paramount for Trusts and staff within, to fully grasp that a culture of listening is central to providing safe, high-quality care and protecting patients. A culture where any frontline member of staff or patient is confident that they can raise a concern and that leadership teams will listen and consider whether they are an early warning sign about a systemic issue; a culture which promotes an organisation-wide openness to acknowledging problems and learning from them. The Bridgewater approach to improving how we effectively listen to staff voices will be to strengthen the existing established systems and processes and review the mechanisms of connectivity (see summary table two), rather than creating a separate framework to ensure that we create a Trust culture whereby staff voice is heard as staff:

- Are encouraged to be ***curious.***
- Feel ***safe*** and supported to raise concerns.
- Feel ***listened to***.
- Know how to ***escalate*** any concerns and that they will be acted upon in a timely manner.

Table one: Culture

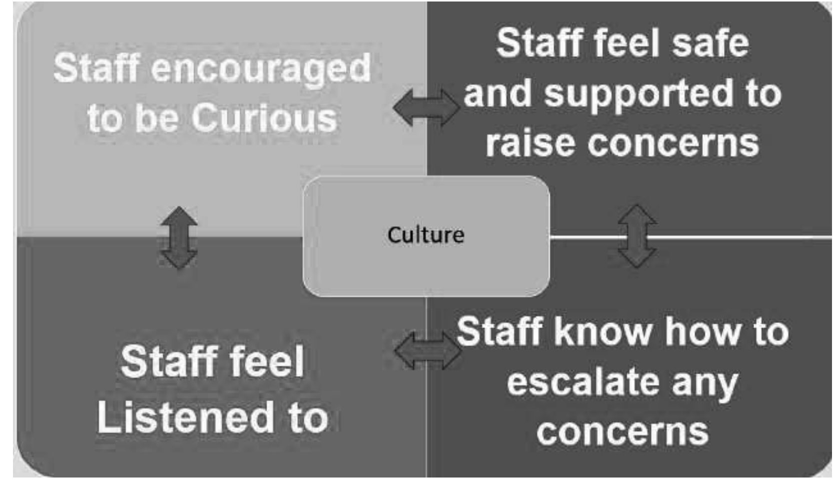
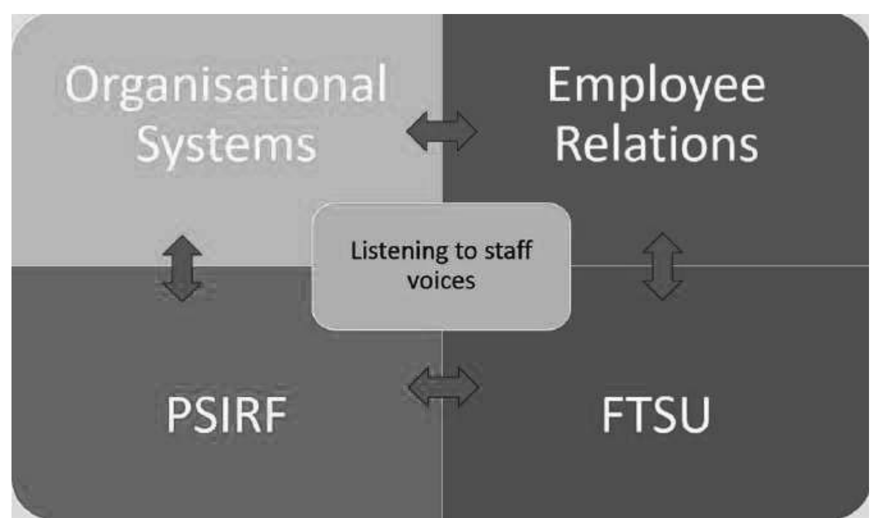


Table Two:

Creating a Listening Culture: Mapping and Strengthening Independencies



2.2 Systems and processes

2.2.1 There are numerous transactional systems and processes within the operational structure of the organisation applicable to all staff and at all levels that provide an opportunity to raise awareness and embed a culture of openness and listening and point of escalation. E.g., Directorate meetings, Team meetings, Performance Development Review meetings as well as professional forums, clinical supervision and quality improvement e.g., Time to Talk, Quality visits, Team Brief. Work will be undertaken with Trust leaders via the Senior leadership (SLT) meetings and People Operational Delivery Council to ensure accessible and effective speaking up arrangements within the organisational system as well as FTSU which are consistent, connected and communicated for staff.

2.1.2 These processes, whilst crucial will not ensure that the culture of speaking up and listening to staff voices is really encouraged and embedded in the trust. In all of the major incidents the NHS has investigated in recent years, there has been a recognition that it is not enough just to have a process. Staff need to be encouraged to speak up and to feel confident that they will be heard, and action taken as needed. On its own the FTSU process has not ensured this consistently happens in organisations.

2.1.3 Within the Trust we have embarked on our Just Culture journey where part of this is to encourage staff to report and speak up around concerns and we have seen increases in incidents reported which is some evidence that staff are confident to report. This relies on transparency and openness but also closing the loop when concerns are raised in a professional and timely fashion.

2.1.4 Within the Trust we will continue with our staff engagement plans but also add specific listening to staff voices elements. An example of this is ensuring that each team meeting, Time to Talk and Quality Visit has specific time and questions which encourage staff to talk to us and include a commitment to responding which can be evidenced. Further details regarding this framework which overlays and enhances existing systems and will be disseminated via Team Brief, with October being the FTSU month as a platform to launch the approach.

2.1.5 The senior nursing team is currently working on a schedule for the introduction of this more formal approach which will be introduced by the end of the calendar year across all such meetings. There will also be regular monitoring of issues raised and actions taken which will be triangulated and shard across the staff of the Trust via the Directorates.

2.1.6 One approach that has been successfully implemented through our existing patient safety meetings is that of "Professional curiosity". Professional curiosity has its origin in children's safeguarding services; it is where a person explores and understands what is happening within a situation rather than making assumptions or taking a single source of information and accepting it at face value. Therefore, we will incorporate this approach as applicable to all staff and "being curious" will be promoted in creating a culture change.

2.1.7 Listening to the opinions and feedback of patients is fundamental to improving quality and patient safety. Following a recent MIAA audit) of patient feedback (July 2023, there is currently an action plan already in place to improve sharing and learning from patient experiences.

2.3 Patient Safety Incident Response Framework

2.3.1 The new Patient Safety Incident Response Framework (PSIRF) that will be implemented in Bridgewater in October 2023 represents a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients. Changing the culture and perceptions of staff is a key component of PSIRF and a

significant amount of work is currently being undertaken engaging with teams locally in preparation of the PSIRF launch. Additionally, the FTSU Guardian and Head of Human Resources will be members of the Trust Patient Safety Incident Response Framework & Learning Panel to strengthen the triangulation of employee relations with incident and other data sources.

2.4 Employee Relations

2.4.1 Fundamental to growing a wider cultural change as part of building psychological safety within the workforce, which in turn encourages workers to Speak Up about anything concerning them include:

- Compassionate, inclusive leadership.
- Just and Learning Culture.
- We each have a voice that counts.
- Health and Wellbeing.
- Equality, Diversity and Inclusion.
- Civility and respect.
- Grievance procedures.
- Mediation.
- Reciprocal Mentoring.

These areas of focus currently align with work programmes being taken forward via the People Operational Delivery Council - these being Culture and Leadership, Health and Wellbeing, Education and Professional Development and Recruitment and Retention. It is proposed that if any work is identified as being needed from a culture change perspective following the FTSU self-assessment, then workplans and actions will be progressed via these established groups.

2.5 Freedom to Speak Up

2.5.1 In response to NHSE recommendations the FTSU guardian met with the Deputy Director of Communications and Engagement to discuss how FTSU could be promoted and further strengthen the existing media plan that is in place. The main discussion points were:

- To update and refresh the FTSU webpage with support and to be in place to coincide with the new extranet that will be in place by 30th October 2023. The FTSU section with have a prominent place on the new site with clear links under the People Promise of “We each have a voice that counts”.
- To share information and for the FTSU Guardian to update and inform communications with any NGO or regional network developments and to be informed of any information being shared centrally from NHSE communications especially as October is FTSU month.
- To produce a new online form for staff to complete to raise concerns and send to the Guardian and to devise a way that if the person wants to remain anonymous, they can.
- To reconsider the wording on the pull up banner currently in development, and to add in the FTSU Guardians contact details for further promotion of FTSU.

- Media plan discussed and for development of a newsletter and for further updates at Team Brief and in the Bridgewater Bulletin.

2.5.2 The anonymous internal survey regarding FTSU results suggest there are barriers that exist within the Trust and actions have started to be taken in response to this, and to assist in meeting some of the actions as cited above.

2.5.3 The NGO have not issued any further information in response to the Letby verdict however they have welcomed the news that an independent enquiry is to be held. To raise awareness the NGO had already chosen that the theme this year for Octobers FTSU month is 'breaking barriers' and plans are underway to promote FTSU within the Trust via:

- Trust Bulletin: Commentary from the Chief Nurse and Deputy Chief Executive to introduce FTSU month and planned activities.
- Newsletter
- Market place stand
- Posters
- Borough 'drop ins' from the FTSU Guardian and Senior Nurses / Professional Leads within the Trust.

2.5.4 We are currently reviewing the number of FTSU champions and Guardians within the Trust, who have a key role to play in the FTSU agenda, with the aim of alignment to each Directorate. We are developing a trajectory for improvement within all corporate and operational Directorates.

3. FREEDOM TO SPEAK UP

3.1 At the February 2023 meeting the Trust Board received assurance via a detailed Freedom to Speak Up report of plans and progress to support a Freedom to Speak Up improvement and development plan in line with the national requirements:

- Freedom to Speak Up: A guide for leaders in the NHS and organisation delivering NHS Services and the accompanying (NHSE 2022)
- Freedom to Speak Up: A reflection and planning tool (NHSE 2022)

3.2 The plan will be monitored via bi monthly reporting to the Peoples Committee.

4. CURRENT FREEDOM TO SPEAK UP ACTIVITY

4.1 Concerns being raised remain relatively low but comparable to other Trusts of a similar size.

4.2 Since the last report a further 2 collective concerns have been raised. However, for reporting purposes as per reporting guidance from the NGO it requires Trusts to log these as individual contacts rather than collectively as one. Therefore, in total there has been 12 members of staff in Warrington and 6 members of staff in Halton raising a concern.

4.3 The 12 members of staff from a non-clinical team in Warrington wanted anonymity and they had multiple concerns which would indirectly impact on patient care. These were escalated to the relevant manager and are being addressed. Their concerns were raised but no feedback can be directly given to them due to their wish to remain anonymous. Other ways to feedback to staff such as in a newsletter or open feedback to the wider service/team meetings are currently being scoped by the Lead FTSU Guardian.

4.4 In Halton the concern was about Patient Safety and Quality and the concerns were multi factorial in nature and have been shared with the relevant Operational Manager and Chief Nurse for response.

4.5 From a staff / worker category perspective, the main professional group reporting concerns continues to be registered nurses but more recently a number of clerical and administrative workers.

4.6 A concern that was highlighted was about how we as a Trust support workers who have a disability and any reasonable adjustments / equipment that needs to be put in place. This has been discussed with the Trusts Equality & Inclusion Manager and further updates to follow.

5. STAFF SURVEY RESULTS

5.1 In March 2023 the results for the 2022 staff survey were released (Appendix one). Feeling secure about raising a concern about clinical practice and feeling confident that it would be addressed showed a decline from the 2021/22 results. Bridgewaters results also mirror the national results as found by the NGO and that workers still feel there is a barrier to ‘speaking up’ and therefore more work need to be done.

5.2 A further survey was undertaken over a 4 week period during June and July 2023, the whole organisation was asked to complete an anonymous FTSU survey. (Appendix two) The method included a link to a TEAMs questionnaire which was promoted via the Bulletin, Team Brief and sent to managers to disseminate to their teams. The aim of the anonymous survey was to find out what Bridgewater staff knew about Freedom to Speak Up (FTSU) and to identify if there were any barriers to speaking up and how these could be overcome.

5.3 Although the number of staff who responded was relatively small (105) the results do give some valuable insight into what staff know about Freedom to Speak Up and any perceived barriers to speaking up**.** Whilst roughly 50% of a small survey sample stated that no barriers existed, for those who do believe barriers exist, these appear to be cultural or related to fear of detriment.

5.4 Previous internal surveys have been carried out and they have been directly emailed out to staff and a higher response rate was obtained. To improve uptake rates this approach will be taken in the future. A further survey will be undertaken within a 12 month period once the Guardian has been in post for a further length of time. This timeframe will also consider new staff / staff turnover within the trust and to take into account any internal and

external development that may impact on FTSU. The results of each survey will allow us to benchmark if improvements have been made or identify if barriers remain.

5.5 Tackling barriers to FTSU is an action as part of the self-assessment action plan, with identifying and tackling barriers to speaking up is a priority and progress will be monitored. The focus on this year's October FTSU month is 'breaking down barriers'.

5.6 It is recognised that based on the data we currently have available, we have some work to do to ensure that staff firstly feel safe to speak up, and secondly when they do, that their concerns will be acted upon, with strong mechanisms for responding to feedback and the sharing of learning.

6. FREEDOM TO SPEAK UP SELF ASSESSMENT ACTION PLAN UPDATE

6.1 Nationally all Trusts in England are asked to review their Speaking Up processes every two years and all Trusts have been asked to complete their reviews using a revised self-assessment tool and guidance by January 2024. This has been completed and as a result a 2 year FTSU action plan has been developed and progress will be presented at People Committee.

6.2 Progress has been made and one action is to replace the Freedom to Speak Up Strategy and replace it with a 12 month Freedom to Speak Up Plan incorporating actions from this self-assessment.

6.3 Executive and non-executive leads are aware of guidance from the National Guardian's Office (NGO); however, this could be further improved upon. Regular meetings have been scheduled with the Chief Nurse and with the NED and any NGO developments will be fed back to them and also be presented to Board.

6.4 The FTSU webpage on the HUB is currently in development in line with the new extranet and once agreed the page will be reviewed at regular intervals to ensure it remains current and up to date to meet staff needs.

6.5 A media action plan is in place and is also part of the actions to promote FTSU to ensure visibility and enable messages to reach hard to reach groups of staff.

6.6 Work is progressing with the Education & Professional Development Team to include freedom to speak up information in the local induction paperwork that is sent to managers to complete with new starters.

6.7 Further consideration needs to be given to how we can identify a mechanism for evaluation of speaking up experiences, including detriment and updates to follow.

6.8 The draft action plan was presented to Board in August and was endorsed in principle subject to further consideration of training proposals. However, given the recent heightened national concerns and the results of the Staff Survey 2022 (Appendix one)

and Internal Survey June- July 2023, (Appendix two) it is proposed that training will be included as part of the Trust mandatory training offer at Induction, and via FTSU E-learning to ensure all staff understand the vital role that they can play to encourage a healthy Speaking Up culture. The E Learning modules are targeted at three levels:

- Speak Up: Core training is for all staff.
- Listen Up - for all line and middle managers.
- Follow Up: for all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors.

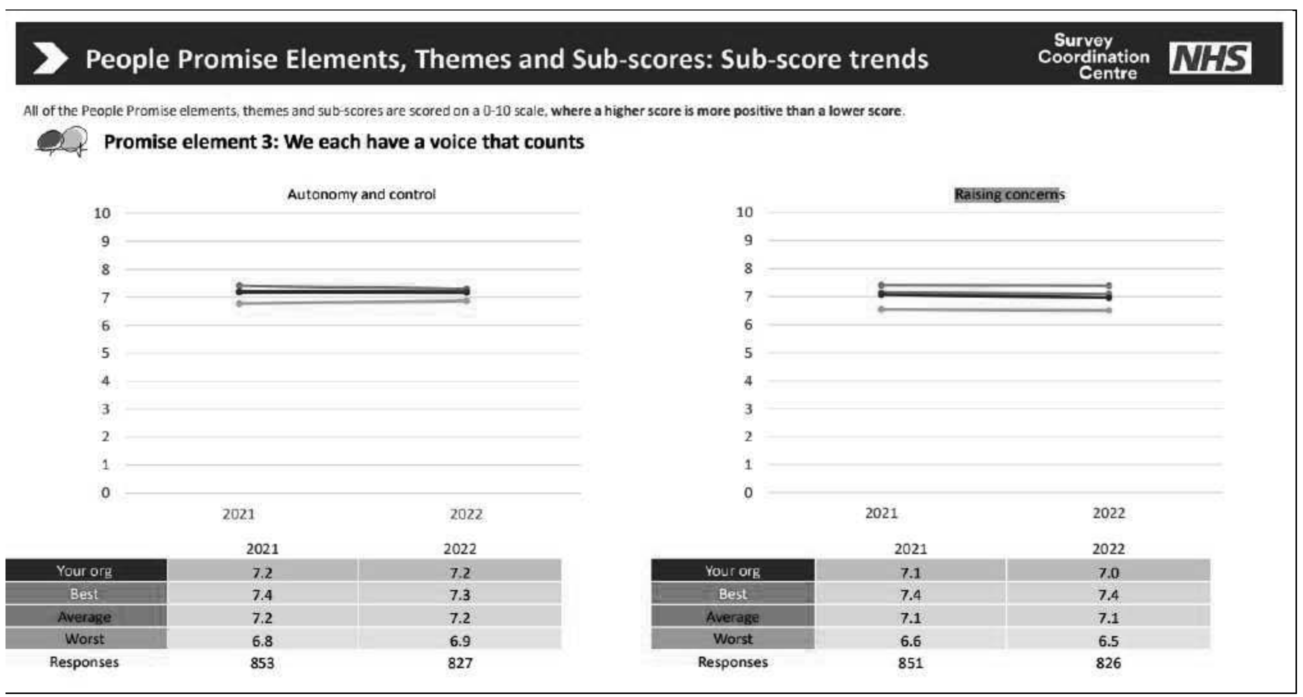
6.9 This training is a once only attendance and will be phased in reporting over a nine month period to reduce the risk of operational delivery pressures.

7. CONCLUSION

7.1 The Trust Board is asked to note the progress and activities of the FTSU Guardian and support the response and approach to the recommendations of NHSE letter of 18th August 2023 following the Lucy Letby verdict. It is recognised that based on the data from the 2022 Staff Survey and the recent internal survey carried out, we have some work to do to ensure that staff, firstly feel safe to speak up, and secondly when they do, that their concerns will be acted upon, with strong mechanisms for responding to feedback and the sharing of learning. By strengthening our existing systems and processes and focusing on creating a sustainable culture of listening will provide safe, high-quality care and protect our patients.

APPENDIX ONE

Bridgewater Staff Survey Results 2022: We have a Voice that Counts

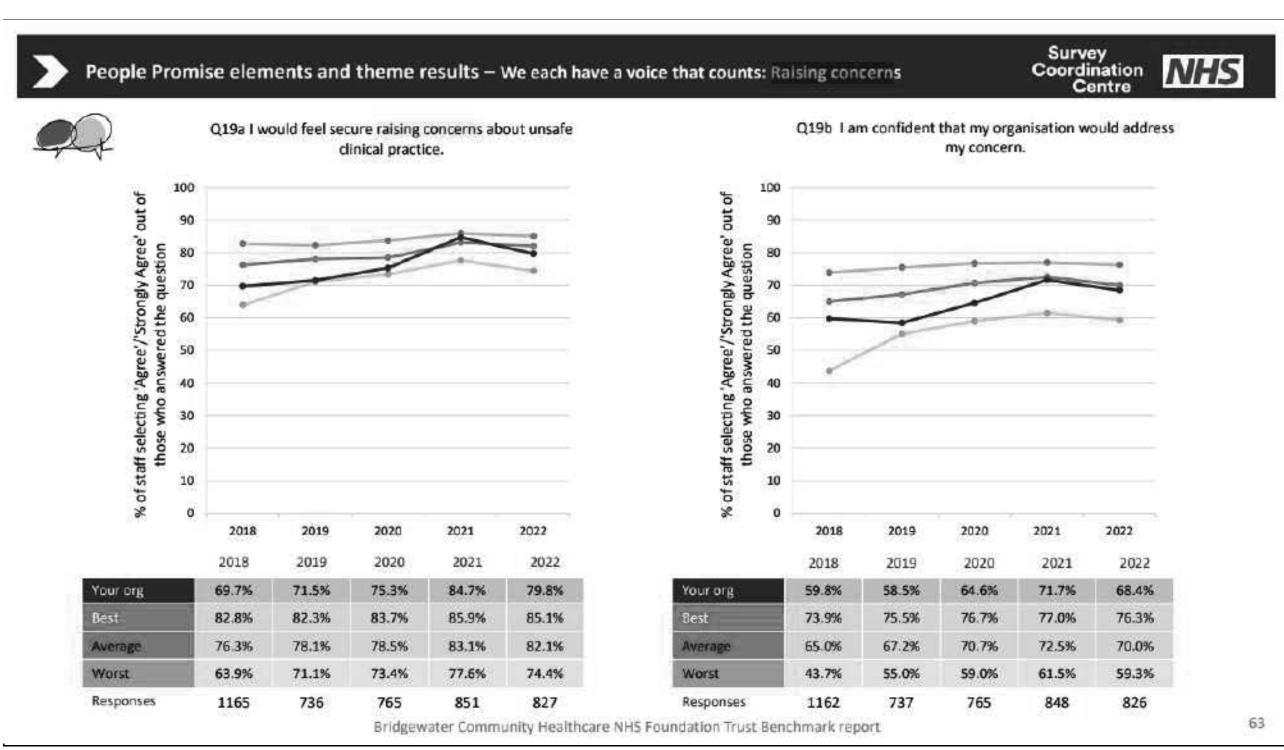


Autonomy and control

	2021	2022
Your org	7.2	7.2
Best	7.4	7.3
Average	7.2	7.2
Worst	6.8	6.9
Responses	853	827

Raising concerns

	2021	2022
Your org	7.1	7.0
Best	7.4	7.4
Average	7.1	7.1
Worst	6.6	6.5
Responses	851	826

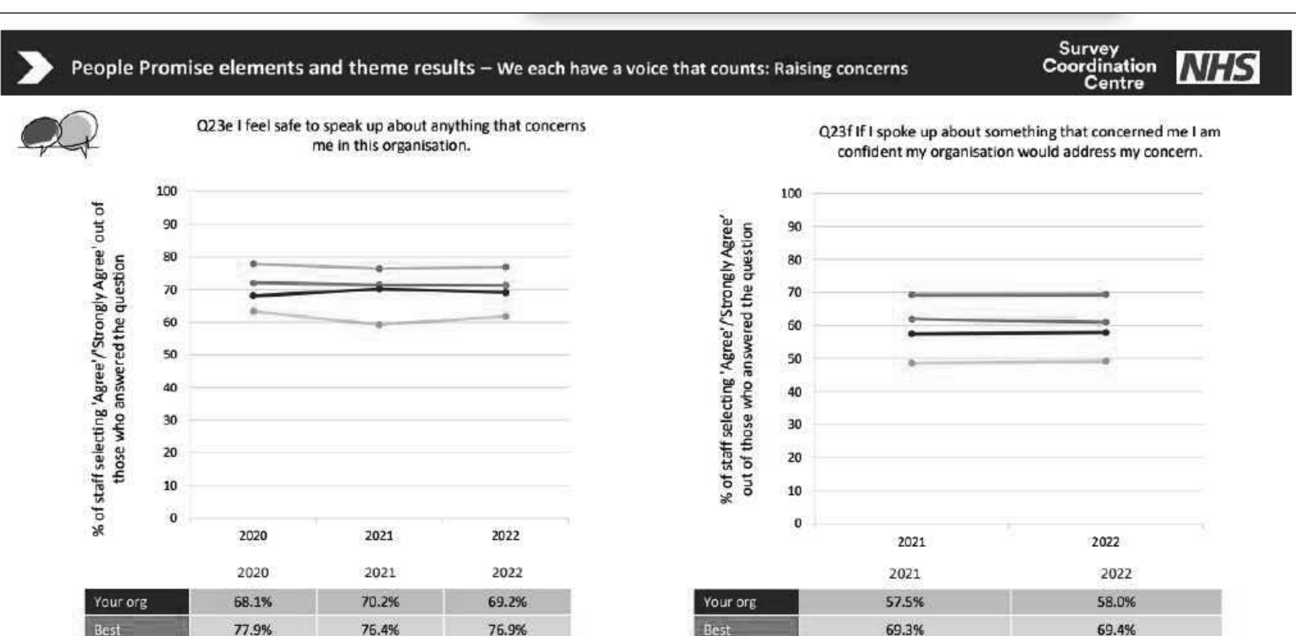


Q19a I would feel secure raising concerns about unsafe clinical practice.

	2018	2019	2020	2021	2022
Your org	69.7%	71.5%	75.3%	84.7%	79.8%
Best	82.8%	82.3%	83.7%	85.9%	85.1%
Average	76.3%	78.1%	78.5%	83.1%	82.1%
Worst	63.9%	71.1%	73.4%	77.6%	74.4%
Responses	1165	736	765	851	827

Q19b I am confident that my organisation would address my concern.

	2018	2019	2020	2021	2022
Your org	59.8%	58.5%	64.6%	71.7%	68.4%
Best	73.9%	75.5%	76.7%	77.0%	76.3%
Average	65.0%	67.2%	70.7%	72.5%	70.0%
Worst	43.7%	55.0%	59.0%	61.5%	59.3%
Responses	1162	737	765	848	826



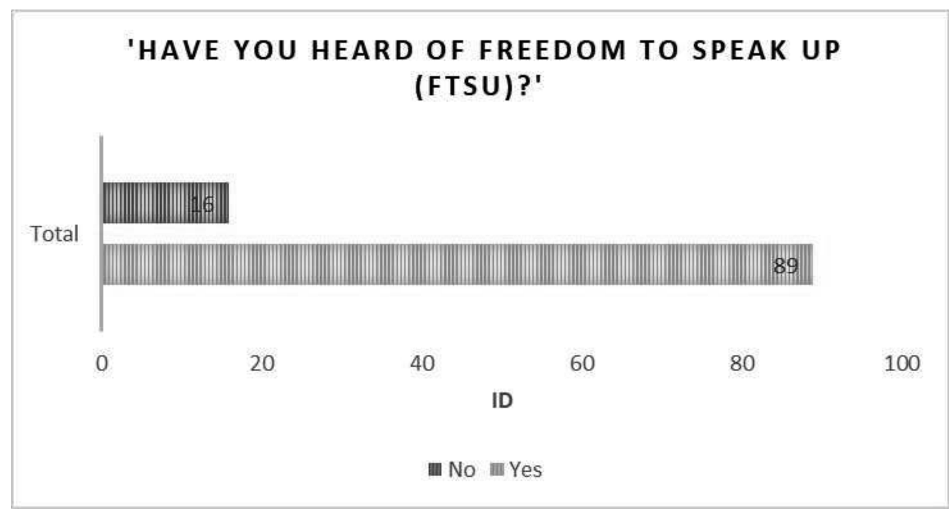
	2020	2021	2022
Your org	68.1%	70.2%	69.2%
Best	77.9%	76.4%	76.9%
Average	72.1%	71.4%	71.3%
Worst	63.4%	59.2%	61.8%
Responses	764	848	826

	2021	2022
Your org	57.5%	58.0%
Best	69.3%	69.4%
Average	62.0%	61.0%
Worst	48.6%	49.2%
Responses	850	825

APPENDIX TWO

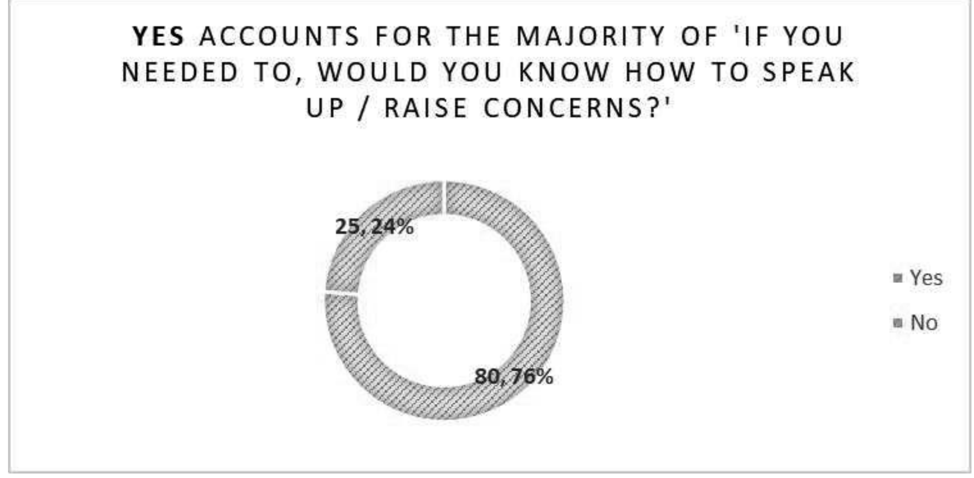
Internal Anonymous Staff Survey June – July 2023

The first question asked was to find out if staff had heard about FTSU.



Of the 105 respondents 89 staff had heard of FTSU and of those who responded and who had heard about FTSU, 16 staff (15%) answered that they had heard about FTSU via the bulletin, although responses did vary. Staff had also heard about FTSU from word of mouth, the dental symposium, induction day and team meetings.

When asked if staff knew that Bridgewater has a FTSU Guardian 82 staff did know this and 23 did not. When asked 'If you needed to, would you know how to Speak up / raise concerns?', of those who responded 76% knew how to raise a FTSU concern.



Question 5 asked staff 'Are there any barriers that would prevent you from speaking up and what are they?' In total 19 members of staff did not comment and left the question blank but 86 members of staff did comment, although responses were varied. In total 27 staff did not feel there were barriers and comments received:

"no barriers, I would be comfortable raising any concerns"

"I don't see any barriers for me to not connecting with speaking up guardians"

One person did comment that they would speak up if it was a concern about patient safety but that they would be concerned if they spoke up about a colleague due to repercussions.

In total 13 staff commented that they either did not know who to or how to raise a concern via FTSU or they had no reason to speak up at this time. Other comments received were to do with workload and also "fear of making fuss when not needed".

Of those remaining 27 staff who commented the main concern / barrier to speaking up was the repercussions and 4 staff members responded that "nothing would change". Three members of staff also cited managers as being blockers. Some of the free text comments received include:

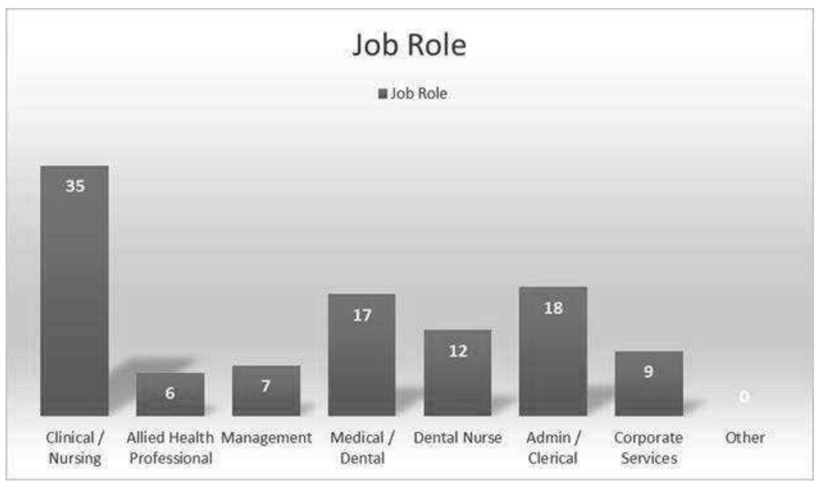
"Sometimes, fear of recriminations, other peoples view of you / where will it all lead for you if you spoke up"

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

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

The comments made by staff mirror opinions made by staff in other organisations and are commonly identified barriers to speaking up. Of the 50 respondents, 27 indicated that there were no barriers to speaking up and so the picture is mixed.

Questions 6 and 7 asked about job role and borough. This was to identify staff groups and to identify if a particular borough needed to be focused upon. This would enable a targeted approach to be taken to address any concerns raised / identified and to promote FTSU and to tackle any barriers.



The highest number of responses were from clinical / nursing services which would be expected as they make up the highest workforce number.

The final question asked staff 'Do you have any suggestions as to how we can improve letting staff know about Speaking up'. Only 69 staff responded to this question and 13 members of staff said 'no' and 2 members of staff left the question blank. One member of staff did comment "No you are doing a great job!!!"

Other comments include:

"Showing examples of you said, we did. This can still be done anonymously"

"More prominence on the staff website. It feels very hidden"

"Keep talking and reaching out to staff and teams"

There were common themes mentioned including attending team meetings and being more visible.

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	**72/23ii**		
Report Title	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT**		
Executive Lead	Sarah Brennan, Chief Operating Officer		
Report Author	John Morris, Deputy Director Estates / EPRR		
Presented by	Sarah Brennan, AEO		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary
To inform the Board of the outcome of the EPRR assurance process for 2023-24.

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

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

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	72/23ii		
Report Title	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT		
Report Author	John Morris, Deputy Director Estates / EPRR		
Purpose	To inform the Board of the outcome of the EPRR assurance process for 2023-24		

1. SCOPE

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

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

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

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

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

2. PURPOSE

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

- The results of the Trust's 2023-24 self-assessment against the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and the level of compliance achieved
- The results of the deep dive into Evacuation and Shelter
- The EPRR action plan resulting from the self-assessment

3. BACKGROUND AND DESCRIPTION OF THE ISSUE

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

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

3.3 The Board last received a report on the outcome of the 2022-23 assurance process at its meeting in October 2022. At this time the trust declared substantial compliance, with 6 of the 55 applicable standards assessed as partially compliant (amber) and these 6 were included in an improvement plan.

3.4 The assurance process for 2023-24 has been enhanced and now equates to 58 individual standards across 10 domains. These domains are;

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and Control
- Training and exercising
- Response
- Warning and informing
- Cooperation
- Business Continuity
- CBRN (Chemical, biological, radiological and nuclear defence)

3.5 The process is prescribed and is as follows:

1. Undertake a self-assessment against the relevant individual EPRR core standards and rate compliance for each according to the following definitions:

Non-compliant	Not compliant with the core standard. The organisation's EPRR work programme shows compliance will **not** be reached within the next 12 months.
Partially compliant	Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

An overall assurance rating and action plan is generated automatically, based on the percentage of core standards with which the organisation has assessed itself as being

substantially, partially, or non-compliant. The thresholds for each rating are shown in the table below:

Full	The organisation is **100% compliant** with all core standards they are required to achieve.
Substantial	The organisation is **89-99% compliant** with the core standards they are required to achieve.
Partial	The organisation is **77-88% compliant** with the core standards they are required to achieve.
Non-compliant	The organisation is compliant with **76% or fewer** of the core standards they are required to achieve.

2. Complete a statement of compliance identifying the organisation's overall level of compliance.
3. Submit a report to the Board detailing the results of the self-assessment, the level of compliance achieved, the EPRR action plan for the forthcoming period and the results of the deep dive (reviewing EPRR training arrangements) which does not affect the overall organisational rating.
4. The completed EPRR self-assessment tool, uploaded evidence, action plan and statement of compliance is required to be submitted to Cheshire and Merseyside ICB by 29th September 2023. (It is acknowledged that the statement of compliance may be draft subject to Board dates).
5. This organisational return will be subject to ICB assurance processes, including a review meeting, prior to final ICB sign off by the 29th of December 2023.

4. OUTCOME

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

4.2 For 2023-24, 47 of the 58 core standards have been assessed as *fully compliant*, 9 as *partially compliant and 2* as *non-compliant*. A summary of the scores is referenced below.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	1	1	0	0
Training and exercising	4	4	0	0	0
Response	5	5	0	0	2
Warning and informing	4	4	0	0	0
Cooperation	4	3	1	0	3
Business continuity	10	6	4	0	1
Hazmat/CBRN	10	6	2	2	9
Total	**58**	**47**	**9**	**2**	**15**

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

4.3 The 8 standards assessed as partially compliant this year are shown in the attached action plan (Appendix B):

- Core standard 16 relates to duty to maintain plans with specific reference to evacuation and shelter of patients, staff and visitors.
- Core standard 21 relates to Command and Control with specific reference to trained (as per national portfolio) on call staff.
- Core standard 39 relates to Cooperation with specific reference to documented mutual aid arrangements.
- Core standard 50 relates to Business Continuity and internal governance reporting.
- Core standard 51 relates to Business Continuity with specific reference to formal internal/external audit review.
- Core standard 52 relates to Business Continuity with specific reference to the internal continuous improvement process followings incidents, audit etc.
- Core standard 53 relates to Business Continuity with specific reference to assurance of commissioned supplier's business plans.
- Core standard 56 relates to Hazmat/CBRN with specific reference to departmental risk assessments
- Core standard 58 relates to Hazmat/CBRN with specific reference to departmental specific plans, training and operational procedures.

4.4 The 2 standards assessed as non-compliant this year are also shown in the attached action plan (Appendix B):

- Core standard 63 relates to Hazmat/CBRN with specific reference to staff training processes and procedures.
- Core standard 64 relates to Hazmat/CBRN with specific reference to staff training records.

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

Percentage Compliance	81%
Overall Assessment	Partially Compliant

4.6 As reported in 3.5 above, the results of the deep dive do not contribute to the overall compliance rating. Of the 10 applicable deep dive standards, 4 have been assessed as amber (partially compliant) and 0 red (non-compliant). Arrangements are in place to achieve full compliance over the next 12 months and are included in the action plan (Appendix B).

5. NEXT STEPS

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

5.2 The core standards action plan (Appendix B) will be monitored and kept under review by the Accountable Emergency Officer and the Deputy Director of Estates/EPRR, via the EPPR group. This group will also oversee in-year work-streams associated with the wider theme, including documentation review, exercise planning and formal reporting to the Board. The action plan will be incorporated into the Boost programme format and subject to the appropriate programme process and procedures.

5.3 A number of actions have already been taken to address the non-compliance including sourcing the HASMAT/CBRN training from Merseyside and Lancashire Teaching Hospitals, a refresh of the services business continuity plans has commenced and capacity is being reviewed to undertake the MIAA review of the business continuity plans in the 2023-4 Financial Year.

6. RECOMMENDATION

6.1 The Board / Committee is asked to receive this report and agree the following documents:

- The completed core standards self-assessment tool 2023-24
- The completed statement of compliance (**Appendix A)**
- The 2023-24 actions which need to be completed/actioned (**Appendix B**)
- Compliance Assessment framework (excel)

APPENDIX A

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

STATEMENT OF COMPLIANCE

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

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

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

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

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

Signed by the organisation's Accountable Emergency Officer

Date signed

05/10/2023	05/10/2023	02/09/2024
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

APPENDIX B

Action Plan				Overall Assessment	Partially Compliant		
Ref	**Domain**	**Standard name**	**Standard Detail**	**Supporting Information**	**Organisational Evidence**	**Self assessment RAG**	**Action to be taken**
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Documentation updated and accessed via TEAM's channel. Whilst lockdown procedure references evacuation process, the Trust needs to develop (and test) plans and alternative shelter arrangements. Acknowledge within the process, the Trust does not have any inpatient beds. The Trust occupies circa 60 sites so proportional response to building size.	Partially Compliant	Evacuation plans to be referenced as a separate policy and/or in business continuity plans
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Compared to the recently published competency portfolios, the majority of on call staff require additional training	Partially Compliant	Members do not meet mandated standards. TNA to be completed and annual training cycle will be developed for each individual/role.
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	PLACE based working arrangements are in place and where utilised throughout COVID, primarily for PPE arrangements. Regular meetings/calls are held within PLACE across various management portfolio's.	Partially Compliant	PLACE meetings to be established and agreed arrangements will be documented.
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Recent Industrial action resulted in business continuity plans being invoked across a range of services. Internal and external communication plan inherent within process. Local Incident Group established. Final report presented to the Board	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Inclusion in the 23/24 q4 inernal audit plan. EPRR group reviewing operational plans, updated for winter.	Partially Compliant	Discussions to be held with audit committee chair and audit contractors to include in future business cycle
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance	IA report to Board, winter planning preparation includes a baseline review of services. Internal improvement plans across a range of services. Re-configuration of services to ensure resilence of service offer also improves business contnuity arrangements.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Utilisation of NHS framework suppliers. Service specific arrangements in place i.e. facilities management. Arrangements in place during Covid. Supply chain BCP. Tender exercises include requirement.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board. The Trusts internal EPRR group will work with operational managers nad procurement to identify business critical suppliers and look to develop the formal process for inclusion in deparetmental business continuity plans
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Separate risk assessments in respect of buidling access and waste. Specific risk assessment in respect of Hazmat/CBRN response required.	Partially Compliant	Risk assessments to take place acknowledging building and training shortfall at present. Mitigating actions to be developed.
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance	Building plan needs to be agreed with landlord and associated tenants in respect of earmarking decontamination and isolation arrangements. Unit was designated PLACE site for recent management and treatment of Avian flu outbreak (local company managed the incineration of flocks of dead birds). Worked with ICB, UKHSA and partner organisatons to develop and implement local processes and procedures. PPE replacement processes well established. UTC needs to develop its own specific Hazmat/CBRN plan alongside landlord and other tenants within the building.	Partially Compliant	Building user group exists and will include on the agenda plans to specifically review EPRR arrangements and with particular regard to flexing building facilities to accommodate Hazmat requirements
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	TNA established for all on call members. Operational staff witihn the unit do not have identified specific training. No specific risk assessment.	**Non Compliant**	Training schedule to be delveloped in line with clinical guidelines. Job descriptions to be reviewed
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	TNA established for all on call members. Operational staff witihn the unit do not have identified specific training.	**Non Compliant**	Training schedule to be delveloped in line with clinical guidelines. Job descriptions to be reviewed
DD5	**EPRR Training**	**Access to training materials**	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Compendium of availible courses being developed to align to TNA requirements.	Partially Compliant	Compendium of available courses being developed to align to TNA requirements.
DD7	**EPRR Training**	**Monitoring**	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropriate. EPD will manage, monitor compliance via established processes utilising ESR and OLM.
DD9	**EPRR Training**	**Continuous Improvement process**	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements. Continuous improvement trackers.	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropriate
DD10	**EPRR Training**	**Evaluation**	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropriate

Version Control
2.1 28/07/23

Please choose your organisation type: Community Service Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	1	1	0	0
Training and exercising	4	4	0	0	0
Response	5	5	0	0	2
Warning and informing	4	4	0	0	0
Cooperation	4	3	1	0	3
Business continuity	10	6	3	1	1
Hazmat/CBRN	10	6	2	2	9
Total	**58**	**47**	**8**	**3**	**15**

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

Interoperable Capabilities for NHS Ambulance Service Providers only

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

Percentage Compliance	81%
Overall Assessment	**Partially Compliant**

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

Calculated using the number of FULLY COMPLIANT EPRR Core

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

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

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7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Member of Risk Council. Appropiate risks recorded on the system.	Fully Compliant				
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Member of Risk Council. Appropiate risks recorded on the system. Separate section in the Major Incident Plan and reference is made on the intranet pages of EPRR.	Fully Compliant				
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Contact made with PLACE organisations re Industrial Action action. Regular PLACE meetings take place to assess organisational capability. Joint executive meetings. PLACE updates at LHRP meetings. PLACE winter plans available to staff via TEAM's channel.	Fully Compliant				
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	24/7 365 on-call rota in place incorporating senior managers. Documentation access through dedicated TEAM's channel. Live command and control structure in place for COVID response. Incident team in place to deal with Industrial Action. Impact paper including lessons learnt submitted to the Board.	Fully Compliant				
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	All documentation accessed via TEAM's channel. Attendance at UKHSA launch and revised arrangements in corporated into heatwave/cold weather plans. Healthwatch emails cascaded via internal comms.	Fully Compliant				
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Documentation updated and accessed via TEAM's channel.	Fully Compliant				

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13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Documentation updated and accessed via TEAM's channel.	Fully Compliant				
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident	Documentation updated and accessed via TEAM's channel. Classed as a hospital hub site for Covid vaccine programme. Site assessment included operational capability for surge response. Cohot of vaccinators across multi services. Sites/rooms identified. Responded to Avian flu outbreak and worked with ICB/UKHSA to develop business processes.	Fully Compliant				
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Documentation updated and accessed via TEAM's channel.	Fully Compliant				
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Documentation updated and accessed via TEAM's channel. Whilst lockdown procedure references evacuation process, the Trust needs to develop (and test) plans and alternative shelter arrangements. Acknowledge within the process, the Trust does not have any inpatient beds. The Trust occupies circa 50 sites so proportional response to building size. The Trust has no inpatient facilities.	Partially Compliant	Evacuation plans to be referenced as a separate policy and/or in business continuity plans	AEO/EPRR	Dec-23	

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17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Updated lockdown policy circulated to staff and held on the staff intranet.	Fully Compliant				
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referenced in on-call documentation.	Fully Compliant				
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referenced as an appendix within the Major Incident Plan	Fully Compliant				
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	On call documentation all held on TEAMs channel.	Fully Compliant				
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Compared to the recently published competency portfolios, the majority of on call staff require additional training	Partially Compliant	members do not meet mandated standards. TNA to be completed and annual training cycle will be developed for each individual/role.	AEO/EPRR /EPD	Continous process	Managed through internal EPRR group and updates via internal governance
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	TNA established for all on call members.	Fully Compliant				

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23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Command and control structures were operated during COVID. Incident group established during Industrial Action (RGN) which included business continuity arrangements and action cards. Exercise Chester and Rogan trust communication exercises. Participant in Exercise Artic Willow and Hedrig coordinated by the ICB.	Fully Compliant				
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Training sub folder within TEAM's information. EPD maintain training record,s as per other mandatory training requirements, which is linked to ESR system. Info presented via Trust Qlik front end system.	Fully Compliant				
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Duties of on-call staff included within supporting information accessible via TEAM's channel.	Fully Compliant				
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Primary and Secondary ICC identified. Separate postcode areas. Separate IT link. Separate action cards referenced in on-call documents and Major Incident Plan.	Fully Compliant				
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Detail referenced in the Major Incident plan and separate arrangements for out of hours arrangements referenced. All available on the On-call/EPRR teams channel and intranet.	Fully Compliant				

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28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business Continuity policy. Separate intranet folder holding all business continuity plans.	Fully Compliant				
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	On-call staff have access to loggists in the event of a Major Incident. Details separately identified within the Team's channel.	Fully Compliant				
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Command and control structures including daily sit rep reporting in place during covid and recent Industrial Action.	Fully Compliant				
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Stakeholder documentation produced and circulated.	Fully Compliant				
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Major Incident Plan contains communication action cards.	Fully Compliant				
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Major Incident Plan contains communication action cards.	Fully Compliant				
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Major Incident Plan contains communication action cards. Internet and intranet access to social media.	Fully Compliant				

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37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Attendance at meetings	Fully Compliant				
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Attendance at meetings	Fully Compliant				
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	PLACE based working arrangements are in place and where utilised throughout COVID, primarily for PPE arrangements. Regular meetings/calls are held within PLACE across various management portfolio's.	Partially Compliant	PLACE meetings to be established and agreed arrangements will be documente	EPRR	31/10/2023	PLACE meetings to be arranged and documentation requirement on the agenda
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004		Fully Compliant				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Business Continuity policy. Separate intranet folder holding all business continuity plans.	Fully Compliant				
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Organisational policy in place and EPRR intranet page primary access source. Senior leadership agenda and standing item on directorate meetings. Dynamic business continuity plans considered during IA. Dynamic plans also considered as part of winter planning document.	Fully Compliant				

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46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Business Continuity policy. Separate intranet folder holding all business continuity plans. Plans include reference to business critical services.	Fully Compliant				
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Organisational policy in place and EPRR intranet page primary access source. Senior leadership agenda and standing item on directorate meetings. Dynamic business continuity plans considered during IA. Dynamic plans also considered as part of winter planning. Plans take into account BCP checklist.	Fully Compliant				
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Recent Industrial action resulted in business continuity plans being invoked across a range of services. Internal and external communication plan. Local Incident Group established. Final report presented to the Board . Separate presentation made to organisation Senior Leadership Team.	Fully Compliant				
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Statement of compliance and report referencing substantial compliance	Fully Compliant				
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	Recent Industrial action resulted in business continuity plans being invoked across a range of services. Internal and external communication plan inherent within process. Local Incident Group established. Final report presented to the Board	Partially Compliant	review to be established as part of the EPRR business cyle and report to be presented ot the Board	AEO	30/09/2024	cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee

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51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Consideration for inclusion in the 23/24 q4 inernal audit plan.	Non Compliant	Discussions to be held with audit committee chair and audit contractors to include in business cycle	AEO	31/03/2024	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	IA report to Board, winter planning preparation includes a baseline review of services. Internal improvement plans across a range of services. Re-configuration of services to ensure resilence of service offer also improves business contnuity arrangements.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Utilisation of NHS framework suppliers. Service specific arrangements in place i.e. facilities management. Arrangements in place during Covid. Supply chain BCP. Tender exercises include requirement.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board. The Trusts internal EPRR group will work with operational managers nad procurement to identify	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Operational manager for the UTC is responsible for the Hazmat/CBRN processes and procedures.	Fully Compliant				

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56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Separate risk assessments in respect of building access and waste. Specific risk assessment in respect of Hazmat/CBRN response required.	Partially Compliant	Risk assessments to take place acknowledging building and training shortfall at	EPRR	31/12/2023	Engagement and agreement required with CHP and other buiding tenants. Potential reconfiguration
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Internal processes include access arrangements for specialist signposting.	Fully Compliant				
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Building plan needs to be agreed with landlord and associated tenants in respect of earmarking decontamination and isolation arrangements. Unit was designated PLACE site for recent management and treatment of Avian flu outbreak (local company managed the incineration of flocks of dead birds). Worked with ICB, UKHSA and partner organisatons to develop and implement local processes and procedures. PPE replacement processes well established. UTC needs to develop its own specific Hazmat/CBRN plan alongside landlord and other tenants within the building.	Partially Compliant	Building user group exists and will include on the agenda plans to specifically review EPRR arrangements and with particular regard to flexing building facilities to accommodate Hazmat requirements	EPRR/Estates	31/12/2023	Engagement and agreement required with CHP and other buiding tenants. Potential reconfiguration of rooms required.
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Personal Protective Equipment stock is held for staff.EPRR Documentation is available on the Trust's TEAM's channel.	Fully Compliant				

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

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66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Avian flu outbreak and response alongside partner agencies including ICB, UKHSA and acute hospital. Specific Hazmat/CBRN training required. Review meetings held with partner agencies and processes updated. Initial response communicated via ICB EPRR into Trust's EPRR manager.	Fully Compliant				

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

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
	Action Plan			Overall Assessment	Partially Compliant					
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Documentation updated and accessed via TEAM's channel. Whilst lockdown procedure references evacuation process, the Trust needs to develop (and test) plans and alternative shelter arrangements. Acknowledge within the process, the Trust does not have any inpatient beds. The Trust occupies circa 50 sites so proportional response to building size. The Trust has no inpatient facilities.	Partially Compliant	Evacuation plans to be referenced as a separate policy and/or in business continuity plans	AEO/EPRR	Dec-23	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Compared to the recently published competency portfolios, the majority of on call staff require additional training	Partially Compliant	Members do not meet mandated standards. TNA to be completed and annual training cycle will be developed for each individual/role.	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	PLACE based working arrangements are in place and where utilised throughout COVID, primarily for PPE arrangements. Regular meetings/calls are held within PLACE across various management portfolio's.	Partially Compliant	PLACE meetings to be established and agreed arrangements will be documented.	EPRR	31/10/2023	PLACE meetings to be arranged and documentation requirement on the agenda
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Recent Industrial action resulted in business continuity plans being invoked across a range of services. Internal and external communication plan inherent within process. Local Incident Group established. Final report presented to the Board	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Consideration for inclusion in the 23/24 q4 inernal audit plan.	Partially Compliant	Discussions to be held with audit committee chair and audit contractors to include in business cycle	AEO	31/03/2024	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review	IA report to Board, winter planning preparation includes a baseline review of services. Internal improvement plans across a range of services. Re-configuration of services to ensure resilence of service offer also improves business contnuity arrangements.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
	Action Plan			Overall Assessment	Partially Compliant					
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Utilisation of NHS framework suppliers. Service specific arrangements in place i.e. facilities management. Arrangements in place during Covid. Supply chain BCP. Tender exercises include requirement.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board. The Trusts internal EPRR group will work with operational managers nad procurement to identify business critical suppliers and look to develop the formal process for inclusion in deparetmental business continuity plans	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Separate risk assessments in respect of buidling access and waste. Specific risk assessment in respect of Hazmat/CBRN response required.	Partially Compliant	Risk assessments to take place acknowledging building and training shortfall at present. Mitigating actions to be developed.	EPRR	31/12/2023	Engagement and agreement required with CHP and other buiding tenants. Potential reconfiguration of rooms required.
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance	Building plan needs to be agreed with landlord and associated tenants in respect of earmarking decontamination and isolation arrangements. Unit was designated PLACE site for recent management and treatment of Avian flu outbreak (local company managed the incineration of flocks of dead birds). Worked with ICB, UKHSA and partner organisatons to develop and implement local processes and procedures. PPE replacement processes well established. UTC needs to develop its own specific Hazmat/CBRN plan alongside landlord and other tenants within the building.	Partially Compliant	Building user group exists and will include on the agenda plans to specifically review EPRR arrangements and with particular regard to flexing building facilities to accommodate Hazmat requirements	EPRR/Estates	31/12/2023	Engagement and agreement required with CHP and other buiding tenants. Potential reconfiguration of rooms required.
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	TNA established for all on call members. Operational staff witihn the unit do not have identified specific training. No specific risk assessment.	Non Compliant	Training schedule to be delveloped in line with clinical guidelines. Job descriptions to be reviewed			
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	TNA established for all on call members. Operational staff witihn the unit do not have identified specific training.	Non Compliant	Training schedule to be delveloped in line with clinical guidelines. Job descriptions to be reviewed			
DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Compendium of availible courses being developed to align to TNA requirements.	Partially Compliant	Compendium of available courses being developed to align to TNA requirements.	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance

	Action Plan			Overall Assessment	Partially Compliant					
Ref	**Domain**	**Standard name**	**Standard Detail**	**Supporting Information**	**Organisational Evidence**	**Self assessment RAG**	**Action to be taken**	**Lead**	**Timescale**	**Comments**
DD7	**EPRR Training**	**Monitoring**	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropiate. EPD will manage, monitor compliance via established processes utilising ESR and OLM.	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance
DD9	**EPRR Training**	**Continuous Improvement process**	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements. Continuous improvement trackers.	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropiate	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance
DD10	**EPRR Training**	**Evaluation**	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropiate	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance

Winter Plan

2023/2024

September 2023

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Aim of the Winter Plan

This plan is presented to the Board to provide assurance of the Trust's operational resilience for the winter season of 2023/24. The Trust's primary aim is to ensure the safety and well-being of Trust staff and patients throughout the winter period and to ensure that there are plans in place to manage period of increased demand both from a service, place, and system perspective.

The plan covers all the expected areas in-line with NHS guidance and best practice, including escalation plans and the Trust's approach to the management of clinical risk. It supports the management of the following strategic risks in the Trusts Board Assurance Framework:

- BAF 1 Failure to implement and maintain sound systems of corporate governance
- BAF 2 Failure to deliver safe & effective patient care
- BAF 3 Managing Capacity and Demand
- BAF 4 Financial Sustainability
- BAF 5 Staff engagement and Morale
- BAF 6 Staffing Levels
- BAF 7 Strategy and Organisational Sustainability
- BAF 8 Digital Services

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The Trust's plan supports the local health and social care system winter resilience plans and links to the Trust's overall operational plan and other key plans, such as the workforce strategy and emergency preparedness, resilience, and response plans.

As in previous years the Trust will contribute to system-wide preparatory, reflection and best practice learning events.

Planning Assumptions

The planning assumptions for the Trust's 2023/2024 Winter Plan are that the Trust will be able to:

- Respond to a major incident during the winter period.
- Respond in a planned way to outbreaks, Covid-19 activity, seasonal flu, and other seasonal respiratory illnesses.
- Manage waiting list pressures.
- Support expansion and the joining up of health and care outside of acute trusts.
- Respond to predicable winter growth in activity with a reduced number of staff due to absences.
- Support our workforce to deliver over winter, taking steps to protect and improve their wellbeing.
- Support our partner organisations in the NHS, Social Care and VCSE, to effectively manage patients with the right clinicians at the right time and place.
- Enhance the reputation of Bridgwater Community Healthcare NHSFT.
- Manage the financial pressures within the current budgets and support the delivery of a balanced financial position.

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National Guidance

National guidance was received in July - NHS England » Winter Plan – 2023/24. The plan focuses on four core elements:

- Continue to deliver on the **UEC (Urgent and Emergency Care) Recovery Plan** by ensuring high-impact interventions are in place (for community, this means Intermediate Care, Virtual Wards, Urgent Community Response)
- **Complete operational and surge planning** to protect elective/cancer services/access to primary care (for community, to ensure our priority one services remain resilient)
- **Effective System Working**
- **Supporting our workforce -** improve retention and staff attendance, health and wellbeing, staff vaccination

The national plan is underpinned by a novel approach to how organisations in the NHS work together as set out in the Health and Care Act 2022 which has enshrined Integrated Care Systems in law.

Our Trust plan has I therefore been incorporated into the Place plans locally with agreed actions in the following areas:

- **Demand -** preparing for new variants of Covid-19, seasonal flu, and respiratory challenges.
- **Capacity** - ensuring adequate capacity outside of acute trusts – including virtual wards (VWs), intermediate care, urgent care response (UCR), urgent treatment centre (UTC) operating at "top of specification" and high intensity user services.
- **Frailty** - offering more joined-up care for older people living with frailty.
- **Discharge** - working jointly with all system partners to strengthen discharge processes implementing best practice from the 100-day challenge.
- **Prevention** - standardising and improving care and admission avoidance admissions - directory of service (DOS), same day emergency care (SDEC) and virtual wards (VWs).
- **Workforce** - implementing recruitment and retention plans including staff sharing and bank arrangements to develop more flexible and integrated teams.
- **Data and performance management** - making full use of data at a local, regional, and national level to inform operational decision-making and improve the delivery of services.
- **Communications** – collaborating with partners to implement the winter communications strategy and escalation processes to minimise pressures on urgent and emergency.

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Operational and Surge Planning - Priority One Services

The following services are deemed as Priority 1:

Service	Halton	St Helens	Warrington
Community Nursing Services	√		√
Treatment Rooms	√		√
Specialist Nursing Services	√		√
Urgent Treatment Centre	√		
Community Equipment Services	√	√	√
Intermediate Care Services	√		√
Enhanced Care Home Support Service			√
Community Matrons	√		√
Halton Integrated Care & Frailty Service - HICAF (UCR)	√		
Warrington Urgent Care Response Service (UCR)			√
Virtual Wards (VWs)	√		√
Padgate House			√
Children's Community Nursing Services			√

All Bridgewater Services have Business Continuity Plans which are currently in the process of being refreshed that support the Trust's overall response to winter pressures.

Optimising Capacity for Winter 223/2024

For 2023/24 we have continued to optimise capacity as in previous years, whilst recognising that there are no additional resources hypothecated for winter pressures. Throughout this plan we have used the latest activity data to forecast the position over the winter months and build our contingency planning.

For us to be able to manage business as usual and respond to surges in demand and acuity, our priority one services will therefore need to continue active recruitment of existing vacancies and identify additional capacity through bank/agency staffing whilst managing our financial pressures. It should however be noted that the workforce challenge we are facing today and going into winter are shared by our partners in the local health system, across the ICB and nationally.

Operational Management - Directorate Leadership Teams

Directorate Leadership Teams will play key role in the day-to-day management and response to operational pressures. Effective decision making within the DLT will ensure that our operational responses are rapid and that operational and corporate teams are fully engaged.

The weekly Operational Team Huddle (including corporate) can also be stepped up more frequently if necessary. These meetings can therefore be used to manage demand and capacity pressures between services and across Boroughs - effectively operating a mutual aid process to ensure that services remain resilient.

The Senior Leadership Team will also contribute to our Winter response via the sharing of good practice between DLTs, ensuring that System communication is shared and identifying new initiatives from existing ICB Networks.

Command and Control Structure for Winter - Escalation

Putting in place the effective day to day operational governance that can be flexed in response to surges in demand or capacity challenges, as described above becomes the Trust's first line response.

However, during times of severe pressure and when responding to significant incidents and emergencies, NHS organisations need a structure which provides:

- Clear leadership
- Accountable decision making
- Accurate, up to date and far-reaching communication

In recent years, the Trust implemented a command-and-control management structure to manage the Covid-19 Pandemic and winter pressures. The purpose of this approach was to ensure that a structured and coordinated response to pressures was delivered. The Trust is now very experienced in implementing this approach and will look to use these arrangements when required during Winter 2023/2024.

Command and Control Arrangements within the Trust

The Trust Command and Control Management structure is divided in to three levels:

Operational – Bronze Command

The 'Doers': manage front-line operations at the scene.

Tactical – Silver Command

Determine priorities in obtaining and allocating resources, plan, and co-ordinate overall response.

Strategic – Gold Command

Establish strategic objectives and overall management framework and ensure long-term resourcing/expertise.

The meetings that take place because of the implementation of the command and control structure will be used to discuss Winter related escalations. The meeting frequency can be flexed to respond to service pressures which will ensure that decisions are made as quickly as possible. Escalations from services will be reported using a Situation, Background, Assessment, Recommendation template (SBAR). (**Appendix 1)**

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As a result of changes to service delivery, a Quality Impact Assessment may be required to ensure that the impact of any changes is fully understood, and risks are mitigated and should a service need to be stopped or paused this would require reporting to the Trust Relationship Manager for the Care Quality Commission (CQC).

Winter Dashboard

We are in the process of developing a Winter Dashboard, which we aim to launch by the end of October. The dashboard will track in real time, daily and weekly referral and activity data (and trend data) for our priority one services as well as updates on sickness absence, services that are in business continuity, System data e.g. OPEL status.

System Management

Cheshire and Merseyside System Control Centre (SCC)

Last winter SCCs were quickly stood up as an operational platform and central co-ordination service across the ICB footprint. This winter will see the whole health economy benefitting as the SCC approach is more established. This means we can expect greater situational awareness, holistic and real-time management of capacity and performance, increased coordination, and opportunities for mutual aid.

The Cheshire and Merseyside System Control Centre meets 3 times a week, to share local partner information relating to patient flow. This enables collective understanding of the pressures faced by the Cheshire and Merseyside system. It allows the sharing to risk across providers and visibility of operational pressures. During period of increasing pressure these meetings are held more frequently and up to 4-5 times across the day and evening.

Currently we attend a bi-weekly winter planning meeting for all Trusts, led by Andy Thomas and Claire Sanders from C&M ICB. A daily Sit Rep, including weekends describing current operational pressures and capacity (for example, intermediate care occupancy, UCR performance) is submitted by all Community Trusts .Community Provider Daily Status Report C&M

Specifically, the SCC will provide the following:

- Visibility of operational pressures and risks across providers and system partners.
- Concerted action across the ICS on key systemic and emergent issues impacting patient flow, and other performance, clinical and operational challenges.
- Dynamic responses to emerging challenges and mutual aid.
- Increased efficiency and flows of information.

Warrington

Throughout the year there is a daily system pressures call, attended by Warrington and Halton Hospitals (WHH), Warrington Borough Council (WBC), Warrington and Halton ICB place and Bridgewater. Live data from WHH, including patients awaiting admission in A&E, the number of stranded and super stranded patients, Intermediate

Care at Home (ICAHT) activity, domiciliary care capacity and Padgate House occupancy is shared. Actions between partners to resolve issues on patient flow across the system and to manage future resilience are agreed. It is expected that these meetings will continue as normal through winter and that they will be escalated to twice daily when required.

There are good working relationships between the leadership teams within the different organisations and so there is frequent conversations which help to ensure that any challenges or difficulties are managed.

Halton

Weekly throughout the year St Helens and Knowsley host a system call focusing on escalation issues across system partners and winter planning. This includes discussion and exploration of the live data from system partners and provides an opportunity to work collaboratively across the system, promoting and supporting resilience ensuring concerted action across the system. These meetings are stepped up to daily when required. Daily Discharge Team Liaison (DTL) Meeting take place with the Operational Managers in Halton throughout the year, and these are continued during the winter period.

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Internal Escalation Status

The Trust has defined the status of a service using various trigger points which correlate to a Red, Amber, Green (RAG) status. This tool helps staff to describe the current position in relation to service delivery and to manage any significant emerging pressures or risks by asking for additional support in the form of staffing or leadership.

Escalation Status	Triggers
Green	▪ Service can meet the demands as described in the service specification or is able to deliver activity agreed at a national or local reduction in activity. ▪ Staffing is sufficient to deliver this – may be using additional hours, bank, agency, or redeployed staff. ▪ Capacity is available to accept new referrals. ▪ Service is experiencing no challenge in relation to IT, workspace, equipment, or supplies
Amber	▪ Service has reduced activity in-line with business continuity plans. ▪ Staffing is at minimum safe level – additional resources such as additional hours, bank agency or redeployed staff supporting service delivery. ▪ Reduced capacity to manage new referrals – referrals prioritised according to clinical need. ▪ Service is experiencing challenges in relation to IT, workspace, equipment, or supplies which is within tolerated limits.
Red	▪ Service can only deliver priority 1 or most urgent activity. ▪ Staffing has fallen below minimum acceptable levels – all additional resources are available to deliver support service delivery. ▪ No capacity to manage new referrals. ▪ Service is experiencing challenges in relation to IT, workspace, equipment, or supplies which exceeds tolerated limits

Operational Pressures Escalation Level (OPEL)

The OPEL Framework 2023/24 (NHS England » Operational Pressures Escalation Levels Framework) replaces all previous versions of the NHS OPEL Framework and provides a unified, systematic, and structured approach to detection and assessment of acute hospital UEC operating pressures.

As a non-acute provider, we are encouraged to continue localised escalation processes and responses, however ICS OPEL action cards make expectations and requirements clear in relation to a range of actions in which we are involved e.g., intermediate care, virtual wards, urgent community response (UCR).

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These include:

- **O1S-04:** Monitor UCR caseload size and ensure response times are being met. Confirm in-patient bed position for community providers and maintain plan to support early patient transfers.
- **O3S-04**: Where possible, SCC to seek extension or amendment of hours of UCR and intermediate care teams to meet demand and consider senior community presence on specified clinical areas to pull referred patients into community. The action will also ensure that patients who meet the potential for referral are considered alongside the clinical teams for selection into community care.
- **O3S-05**: SCC to support services to flex criteria for admission to community, rehabilitation or residential home settings and consider temporary increase in capacity. All actions should be risk assessed by the provider organisation, and where the request has been specified by the SCC, exception reported where the action is not completed.
- **O4S-04**: In the event of the hospital opening additional escalation capacity, the SCC will request that community and intermediate care providers re-assess their own capacity to maintain flow from the hospital. The ICS Director (or above) will request an options appraisal via the SCC based on community and intermediate care providers response.

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Staff Health and Wellbeing

Our Health & Wellbeing support throughout the winter months continues as it has throughout the year with a focus on those issues which are likely to be more prevalent i.e., mental health issues because of darker evenings, support with staying warm – this year there has/will be a real focus on the Cost of Living pressures and the associated impact on staff.

The Trust communicate and deliver internal interventions throughout the year which will continue to provide support throughout the winter months such as:

- Looking After Your Emotional Wellbeing
- How to have Safe and Effective Health & Wellbeing Conversations
- Employee Assistance Helpline and Occupational Health and Counselling Service

Staff are/will be signposted to various online resources such as:

- The Cheshire & Mersey Resilience Hub
- The Greater Manchester Resilience Hub
- NHS Discounts and offers
- Eating Well for Less
- Travel
- Childcare
- Financial wellbeing support, including local support available
- Financial wellbeing charities, including grants, debt advice, tips, and advice.

The latest Health and Wellbeing information can be found in one place - on the Health Hub pages. Anything health and wellbeing related can be recognised by the heart symbol for easy access.

Staff are continuously encouraged to talk to their line managers should they be struggling with their Health & Wellbeing.

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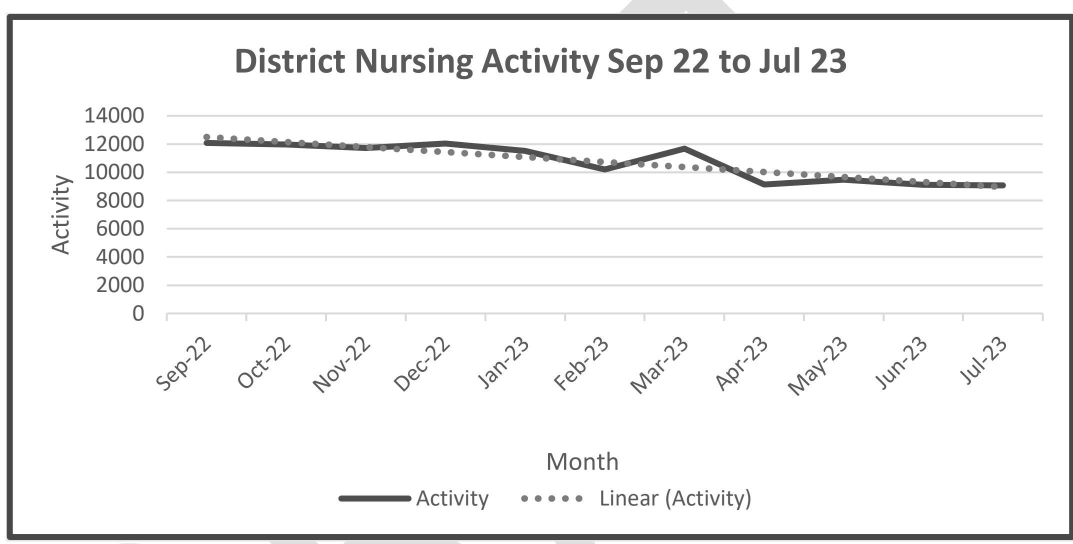
Community Nursing Services – Warrington

Identified Pressures:

District Nursing

The service has continued to make a high number of visits through last winter and into spring and summer of this year. This is shown in the graph below and reflects the year-to-date position for 2022/23. If the current year follows the trend from last year, we expect to see demand levelling off, however experience from previous years indicates that whilst activity levels may not surge in winter, the service is likely to see an increase in high acuity patients and those requiring palliative care.



From a staffing perspective the service has:

- A high proportion of B5 staff are on preceptorship.
- Staff on maternity leave (8% of establishment)
- Workforce pressures in specialist nursing service, SPA, and district nursing service demands
- A high number of vacancies in district nursing (24% of establishment)
- Limited availability of bank/agency.

Staffing Levels:

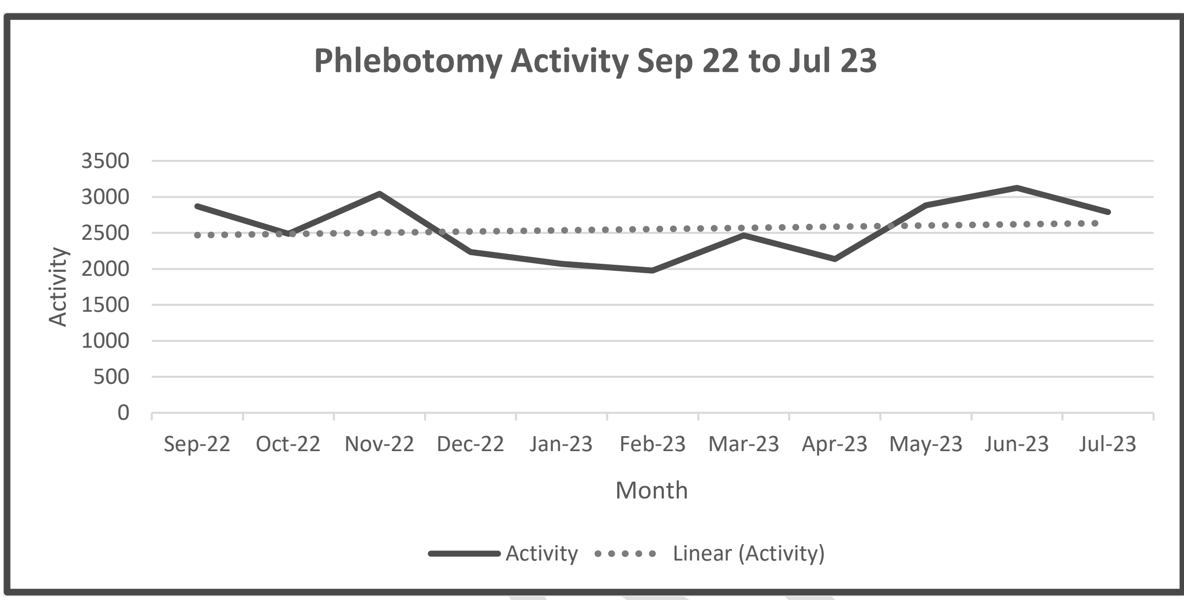
The current established staffing for District Nursing in Warrington to provide the service 24 hours, 7 days a week is 114.08 WTE.

Community Nursing	WTE
Staff in Post	89.45
Vacancies	24.63
Maternity Leave (included in staff in post)	7.0
Establishment	114.08

Treatment Rooms (including phlebotomy)

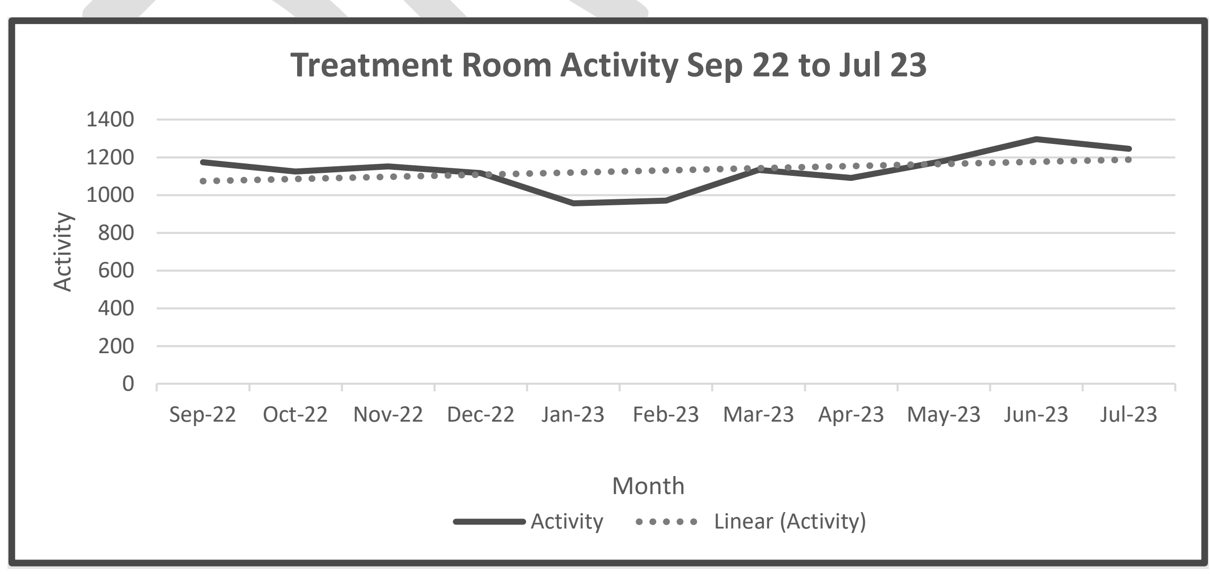
Phlebotomy

Phlebotomy activity in 2022/23 saw a significant increase in activity compared to previous years. Despite a reduction in demand through the early part of this year, there has been a significant increase in demand since Spring. We will therefore be monitoring the position closely over the next couple of months to see if this trend is sustained.



Treatment Rooms

The activity profile for treatment rooms has followed a similar path to phlebotomy. If this were to continue into winter, this would create additional pressure not experienced in recent years. The position will therefore be closely monitored.



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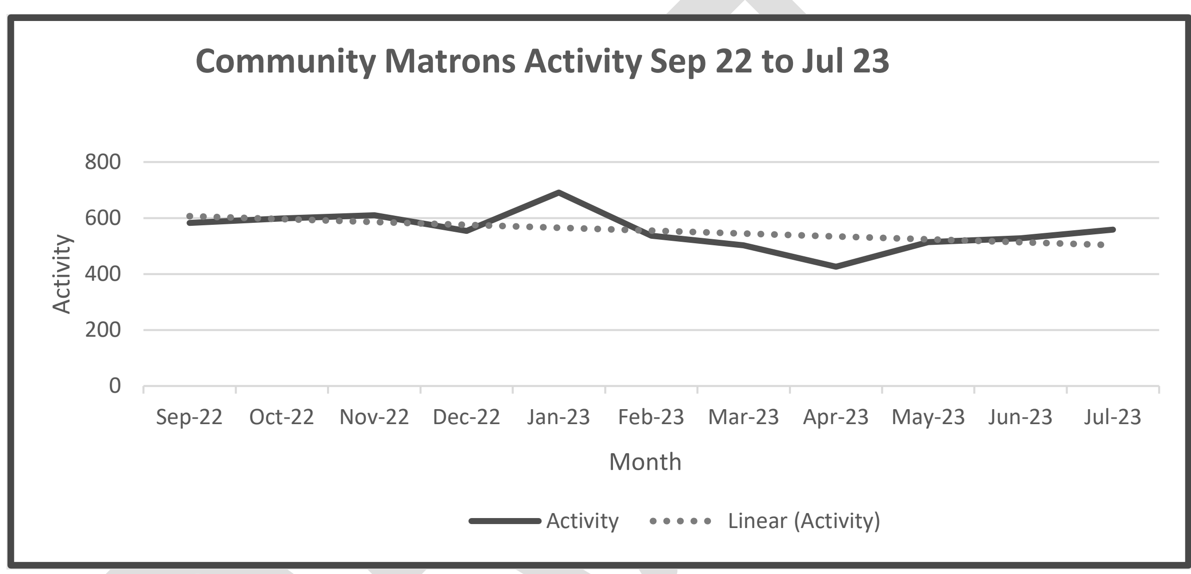
Staffing

	WTE
Staff in Post	10.80
Vacancies	0
Maternity Leave (included in staff in post)	1.0
Establishment	9.80

Community Matrons

Community matron activity historically increases over the winter as we see more higher acuity patients being referred in from GPs and secondary care. Current activity is slightly less that this time last year however we expect the forecast profile for the second half of the year to be broadly similar.



Staffing

	WTE
Staff in Post	7.91
Vacancies	0.0
Maternity Leave (included in staff in post)	0.0
Establishment	7.91

Capacity Solutions:

- Support and assistance to deliver care will be gained in times of extreme pressure from within the service. Caseload and prioritisation of visits will be undertaken with all care being delivered to patients who require it most. Priority 1 and 2 patients will be seen with no rescheduling of visits.
- Cross cover and support will be undertaken with additional support being offered from other community services to assist with nursing tasks. IV Therapy,

Catheter and Macmillan services may, in times of increased demand, be expected to assist with tasks they have competence to provide at the same time of visits thus to reduce demand and footfall within a patient's home. Double handling of patients will be minimised between services.

- Urgent Community Response Team will support the DN service where required.
- Daily escalation meeting (Community Nursing daily capacity huddle).
- In addition to planned additional capacity in the event of significant service reduction for an undefined period, use of agency staff (framework and non-framework by exception) will be explored.
- The service is also supported by the Specialist Nursing teams, who will undertake a portion of the District Nursing contacts if any spare capacity is available.

Other Mitigation:

In times of increased pressure, the Community Matrons have all updated their basic nursing skills and can support with service delivery, thus minimising the number of patient contacts and supporting junior staff with senior clinical leadership. There is ongoing transformation work within the district nursing service including skill mix review to ensure that the service has the correct staffing with the required skills to manage the increasing acuity of patients referred into the service.

Leadership Resilience:

In the absence of the Operational Manager, the following staff will take leadership of the service, supported by the Head of Service:

- District Nursing Coordinator from Orford Jubilee
- District Nursing Coordinator from Grappenhall clinic
- District Nursing Coordinator from West Team
- District Nursing Coordinator from Spencer House

Rapid Community Response Service (UCR) – Warrington

Identified Pressures:

Indicator	Impact	Target/Actual
Response Times 2 Hours & 48 Hours	Part of the NHS Long Term Plan to help support older people to remain well at home and avoid hospital admissions	Measurement of this target is split into two components: compliance against 2hr and 48hr response times. Both indicators are currently on or above plan.

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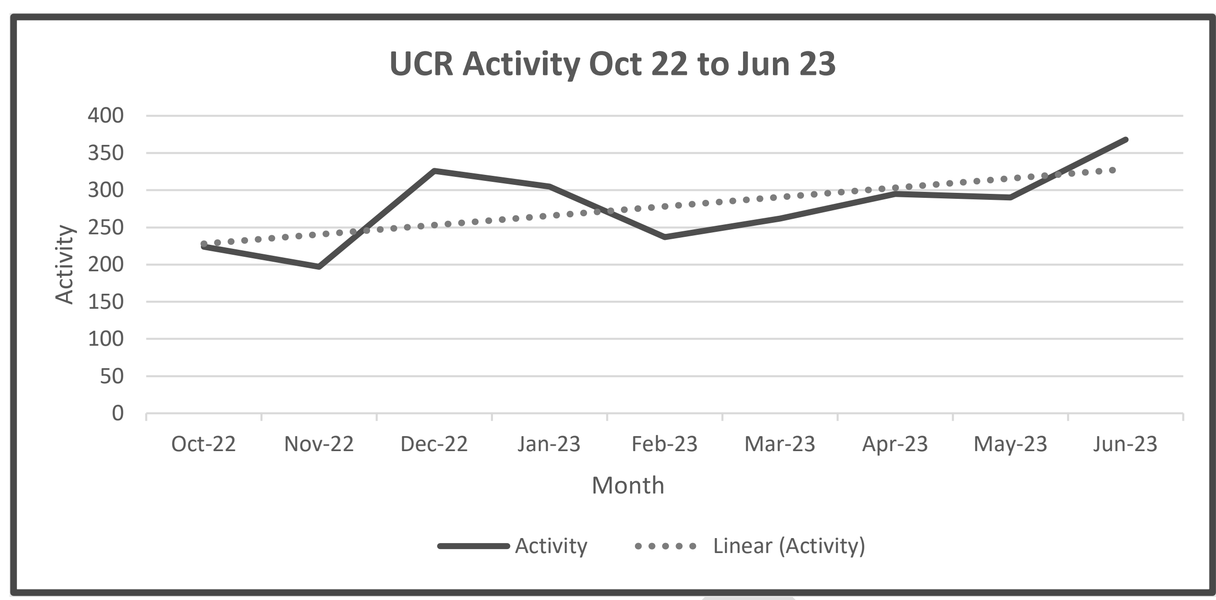

It is anticipated that demand will rise over the winter months as seen previously however this winter we expect an even greater volume of referrals as the service is now more established and response times are high. We are working with primary care to support referrals into this service to avoid hospital admissions.

Staffing Levels:

The service has been recruiting consistently over the past 12 months since it was launched. Workforce remains a challenge and recruitment is ongoing.

The table below shows current staffing levels, maternity leave, and vacancies.

RCRS	WTE
Staff in Post	23.22
Vacancies	5.14
Maternity Leave (included in staff in post)	0.0
Establishment	28.36

- The team have received additional monies in year to ensure that every Warrington adult can access the service, including those in care homes. These monies have allowed recruitment to increase staffing capacity and a rollout plan is in place to work alongside the ECHST to increase the offer to our Warrington care home residents. The UCR team will look to support the reactive element of care for acutely ill care home residents, to maintain them within the care home and reduce the number of out of hours hospital transfers. This will enable some of the available capacity in the ECHST to focus on the more proactive elements of care.

- The service is also working closely with WBC and will be the point of contact for any individual who rings the newly developed one front door contact centre. The one front door directs the call to UCR in a timely manner to allow UCR clinicians to provide a clinical triage and early assessment and signposting to

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prevent unnecessary A&E attendance. The one front door was launched on 16th August 2023 and is now accepting all referrals into the UCR service.

Virtual Wards (VWs) – Warrington

A Virtual Ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual Wards support people who would otherwise be in hospital to receive acute care, monitoring, and treatment in their own home. This includes preventing hospital admissions (admission avoidance) or early supported discharge back to the patient's own home. NHS England » Virtual wards
The Warrington Virtual Ward currently has 2 pathways - supporting care home residents to remain in their own home for treatment of pneumonia and postural hypotension with or without a fall. There is further development underway to ensure that falls with or without injury in a care home can be supported in time for winter 2023. The current Frailty Virtual Ward has a capacity of 5 beds, moving to 10 beds in Oct 23 and then to a total of 30 beds in 2024.

Identified Pressures: The Warrington Frailty Virtual Ward was established and launched in February 2023 and has funding secured until March 24. The Virtual Ward has seen a steady growth in referrals and to date has treated 27 patients successfully with a low readmission rate of one patient admitted to hospital whilst on the ward. The anticipated growth of the Virtual Ward is to achieve 80% capacity by the end of September 2023 with full capacity of beds being open by end of January 2024.

Staffing Levels: The service has been recruiting continuously over the past 8 months since it was launched, and workforce remains a challenge with recruitment ongoing. we are aiming at 80% staffing following the current recruitment initiative.

The table below shows current staffing levels, maternity leave, and vacancies.

RCRS	WTE
Staff in Post	2.8
Vacancies	3.5
Maternity Leave (included in staff in post)	0.0
Establishment	6.3

External Factors: The development of pathways and a robust governance structure within the model is being led by the lead provider WHH, who are also recruiting to additional case finder posts to support the initiative.

Other Factors: The development of a shared electronic patient record that supports management of patients is currently underway with an interim solution being in place. Work is also ongoing to develop a point of care testing hub and to roll out the remote monitoring element of the service which will be supported by Merseycare.

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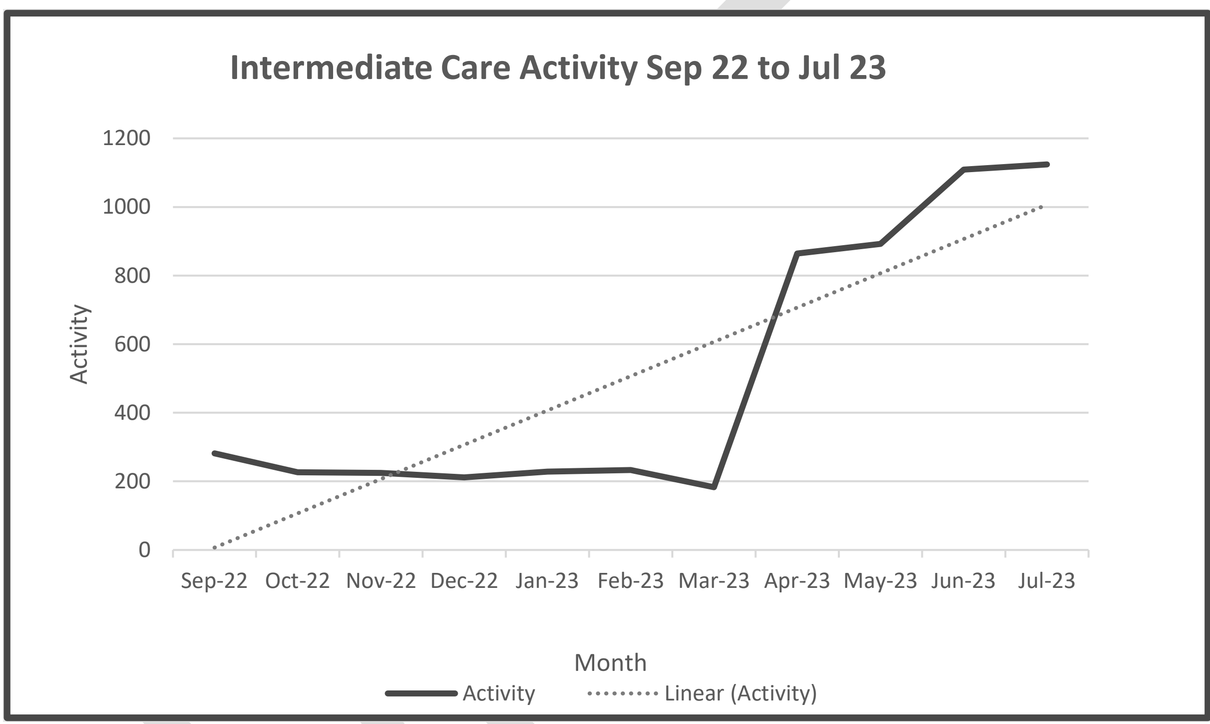
Community Intermediate Care – Warrington

Identified Pressures:

Demand for intermediate care has been significant throughout the year and is expected to continue to increase during the winter period. Average monthly activity in Quarter 1 2023/24 is 223% higher for the same period in 2022/23.

Intermediate Care therapies are supporting the additional beds that have been commissioned at Grappenhall and Statham Manor care homes as well as the existing bed bases of Padgate House and Brampton Lodge. These additional beds will be continuing throughout winter.



Staffing Levels:

The table below shows current staffing levels, including long term sickness, maternity leave, and vacancies.

The service is currently at 100% staffing complement with some over establishment to support increased demand which is currently being funded from Discharge to Assess monies.

Community Intermediate Care	WTE
Staff in Post	37.05
Vacancies	0.0
Maternity Leave (included in staff in post)	0.0
Establishment	33.85

External Factors:

When there are increased pressures on the hospital, packages of care for intermediate care patients are commissioned via care agencies (rather than waiting for (Intermediate Care at Home Team (ICAHT) to have capacity) and additional beds opened in care homes. These increases can impact on staff caseloads and response times to referrals. The beds are usually a set number for a fixed time, known at the start; however, the number of community patients can change daily. If additional beds are commissioned that require extra resources, additional therapy would be required to support these beds.

There are additional beds at Statham Manor and Grappenhall Manor care homes designated to support hospital discharge. A shared approach is being adopted to support these patients, through a pool of therapists offering an in-reach model. These are from WBC Assisted Living Team, WHH and Bridgewater.

Other Factors:

- Intermediate Tier redesign is on-going, with support from external consultants and AQUA. The aim is to enhance education and training to senior care staff in ICAHT to ensure a reablement model of care and reduce dependency.

Capacity Solutions:

- Staff rotation is now in place within the service. This provides more flexible workforce geared up to be responsive and cover both bed bases and community. If there are bed closures within intermediate care, bed-based staff will be redeployed to the community.

- Robust triage system to support clinical prioritisation and allocation to Assistant Practitioners, and delegation to Therapy Assistants, as appropriate.

- Daily duty practitioner implemented to provide immediate advice and respond to urgent cases if required to support discharges.

- If there is a shortage of staff in one discipline, a review of responsibilities would be undertaken, and tasks reassigned to ensure that skill mix is used efficiently and effectively.

- Use any additional therapy capacity in UCR to respond to more urgent cases, where a delay in therapy assessment and intervention could cause harm to patient and/or carers.

Discharge to Assess

This is now being implemented for relevant patients who are on Pathway 1 (patients who have additional rehabilitation or care needs that can safely be met at home).

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Other Mitigation:

- Weekly MDT meeting to review service caseload as a whole and identify any delays in assessment, interventions, or discharge to be escalated as required to appropriate services.

- Daily case management calls take place at 9.15am across Intermediate Tier and Discharge Team to ensure effective flow and patient allocation.

- Operational Manager cover – if the Operational Manager is absent, the integrated management structure within the tier will support the service in a seamless manner with support from the Head of Service.

Padgate House – Warrington

Service Pressures:

There is fixed bed capacity of 35 beds at Padgate. The pressure therefore is not about the demand for beds but on the flow of patients from admission to discharge. This is achieved by multi-disciplinary team working across all agencies.

Staffing Levels:

- **Therapy:** Fully staffed. Padgate House flexes between other areas of Intermediate Care depending on the number of patients, with the ratio 1 Therapist to 10 patients and 3 Therapy Assistants.

- **Health Care Assistants:** 4.28 WTE in post and 1.88 WTE on long- term sick. Some cover for HCAs can be compensated by staff from WBC.

- **Nurse leadership:** There is a current vacancy for a Band 7 Nurse Lead at Padgate House, active recruitment is underway. The post will be advertised as a 'developmental band 7' to allow internal staff development.

Padgate House Nursing Staff	B6 WTE	B5 WTE	Agency B5 (Long-Term)
Staff in Post	2.8	6.5	2.6
Vacancies	0	0	
Maternity Leave (included in staff in post)	0	0	
Establishment	2.8	7.5	

- Outbreaks of Covid-19 in the home can restrict admissions and flow through Padgate House. Advice and guidance from Public Health England and Infection Control Team is followed in outbreak situation. Where appropriate, system calls take place to discuss and agree shared risk.

Capacity Solutions:

The current workload benchmark and safe staffing for nurses is calculated on a basis of 1 nurse to 8 patients. Therefore, the staffing should be:

Safe staffing ratios			
Occupancy	**Early**	**Late**	**Night**
24-26 beds	3	3	2
35 beds	4	4	2

- The service can be managed in the short term with one less qualified Nurse on each shift during the day and evening. There are 2 qualified Nurses planned on night shifts, however, in emergency, the service can be managed safely with one Nurse.

- Current staff are asked to work extra hours or overtime.

- Agency.

Other Mitigation:

- Beds can be closed; new admissions not being accepted until bed numbers match safe staffing to levels. If the unit was unable to provide safe staffing, after having explored all options with partners to source nursing staff, the worst-case scenario would be to move patients to another facility and therapy would be provided as in-reach from the community team.

- Health Care Assistants – these are provided from Bridgewater and WBC. WBC has a pool to draw from, but if there was an acute shortage the service would look to use redeployed staff again. This would be agreed through the Trust command and control structure.

- UCR provide ANP and additional therapy support in the out of hours period.

- GP visits to the home for a minimum of 2.5 hours daily Monday to Friday provided by the Phoenix Healthcare plus with additional support being available if required by telephoning Fearnhead Practice to request an urgent call back. GP cover will be arranged from Fearnhead Practice to ensure that the minimum requirement of 5 days cover is met.

- Out of hours and weekends GP support can be sourced via PC24.

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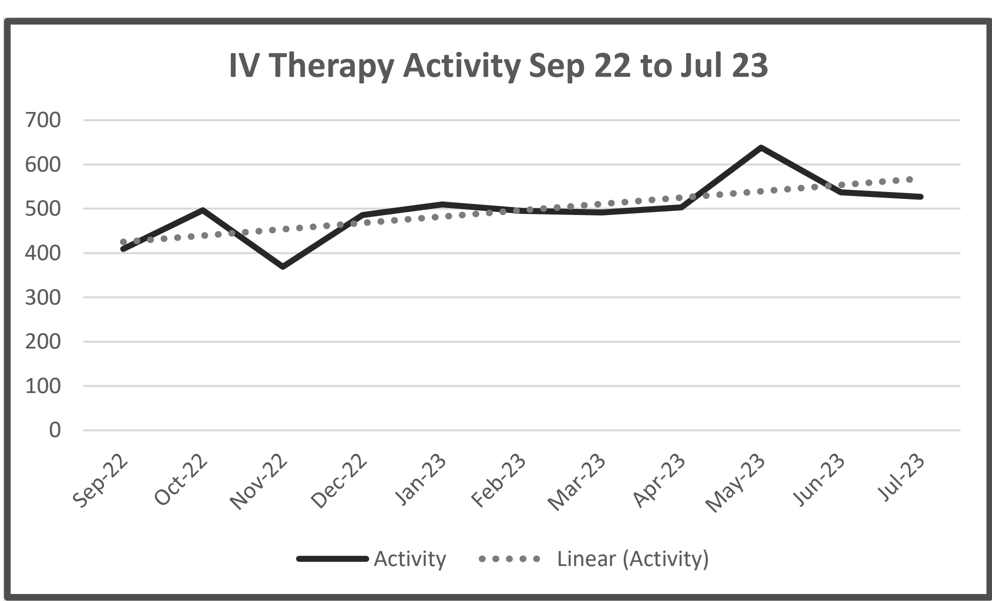
Specialist Nursing Services – Warrington

Identified Pressures:

IV Therapy - based on last year's activity trend, we expect to see a small rise in referrals over the winter months that is then sustained into spring. Providing NMABs will increase over winter, and this may impact on early discharges as we flex to meet NMAB demand.



ECHSS - demand for this service is rising year on year and we anticipate this will continue considering the new Enhanced Health in Care Homes (EHCH) delivery model, which moves away from traditional reactive models of care delivery towards proactive care.

Changes to the way this service reports its activity were made in March 2023 resulting a more accurate reflection of demand across care homes. To manage this increasing need, the team works flexibly across the reactive and proactive pathways. As a single team covering the whole of Warrington, the ECHSS delivers both proactive and reactive care and has vast experience of managing high volumes of all types of referrals, care planning and delivery.

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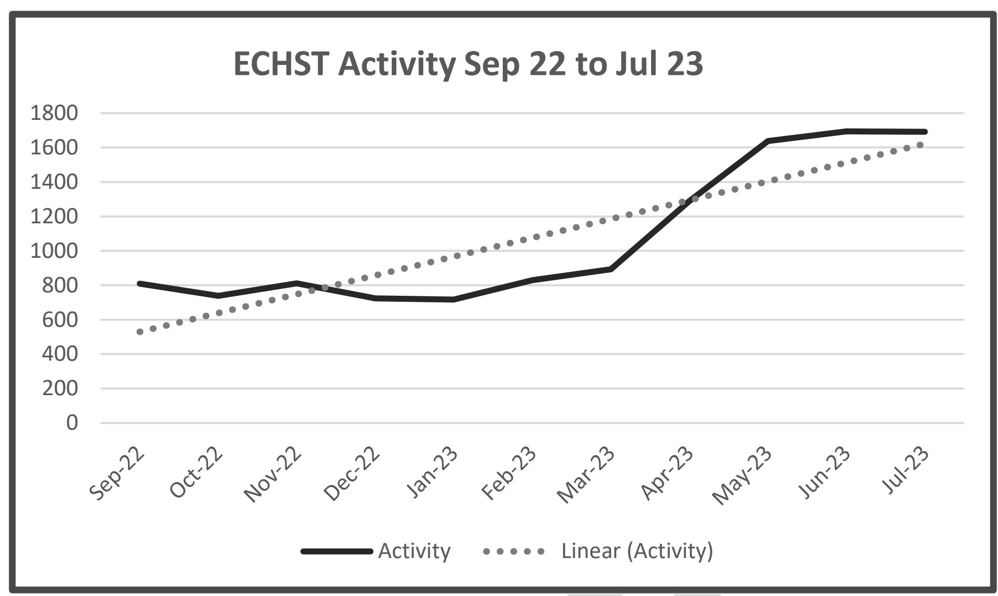
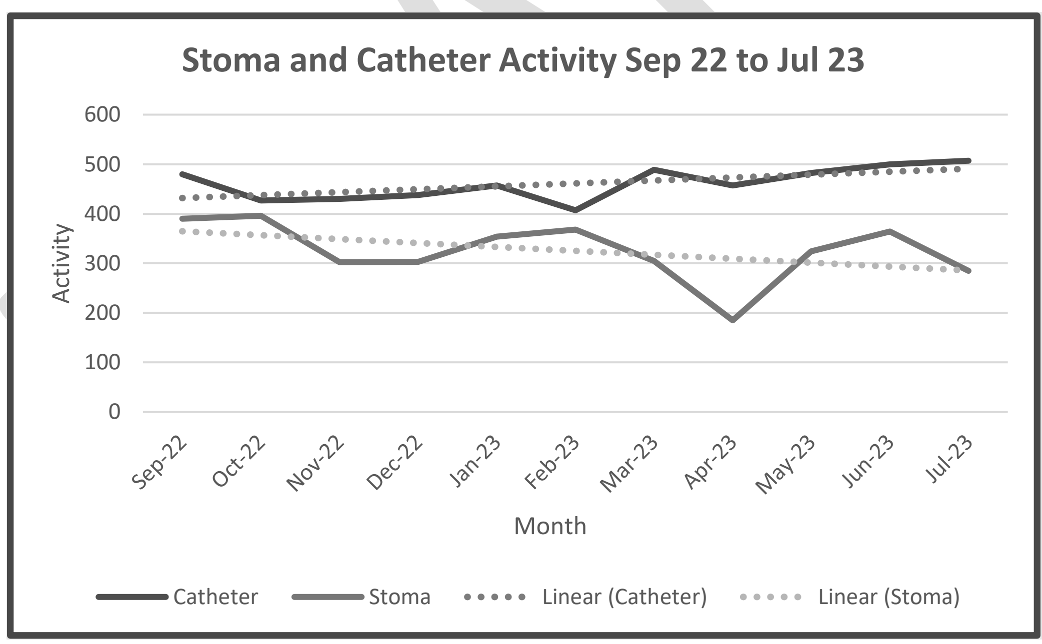
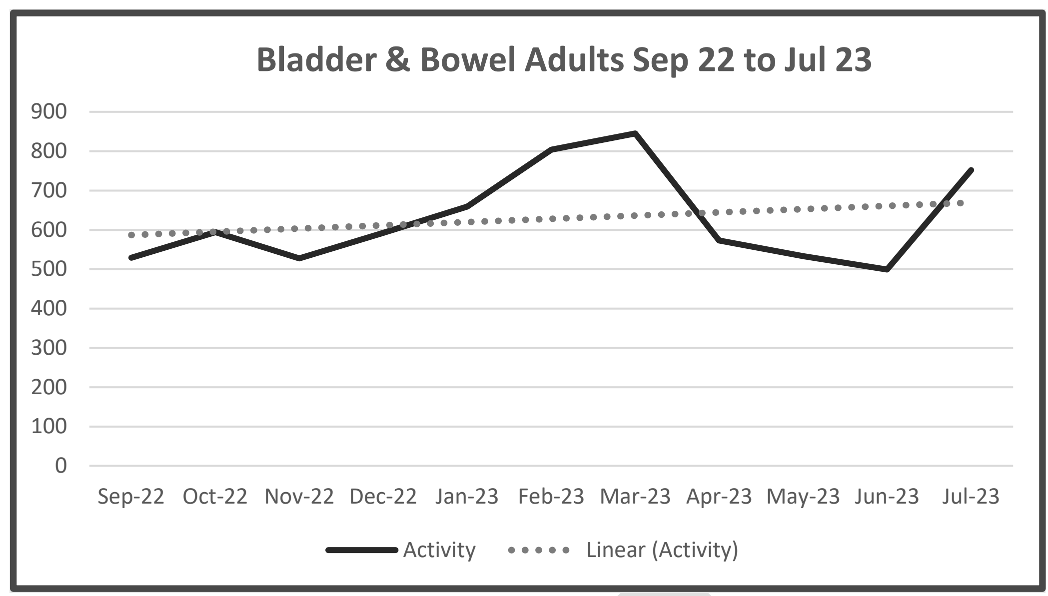


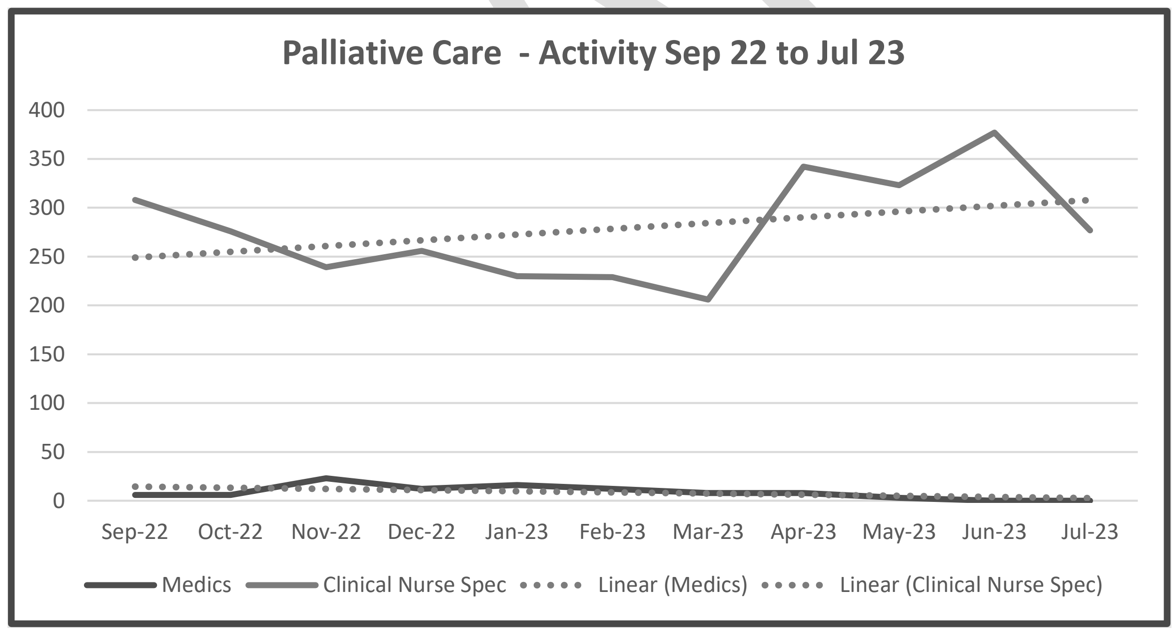
Stoma and Catheter Care – catheter activity trend is increasing slightly based on year-to-date activity in 22/23 however we expect the forecast profile for the second half of the year to be broadly similar to recent years. For our stoma service, their activity is fluctuating with a projected downward trend. However, based on previous winters we expect demand to increase therefore the position will be closely monitored.



Bladder and Bowel - demand for the adult service was high last winter. Referrals during autumn and winter 2022/23 increased by 46% compared to April-September 2022. The graph below shows demand September 2022 to July 2023 and depicts a fluctuation situation; however, we are seeing an unprojected uptick in demand in July 2023 not seen previously resulting in a 73% increase in referral on the same month last year.



Palliative Care – the palliative care service experiences increasing demand over the winter months compared to other times of the year as pressures on the hospital system increase. There will be additional pressures on the team this year as they are supporting the palliative virtual ward. They are full staffed for nursing staff but have a vacant speciality doctor post hence the reduced recent activity, this has been recruited to with a provisional start date agreed for October 2023.



Patient Acuity

Historical data mirrors that seen in other community services and indicates that, over the period of December/January all specialist services are predicted to see an increase in high acuity patients, complex patients.

Staffing Levels:

Service	Palliative Care	Bladder& Bowel Adult	Bladder & Bowel Paeds	ECHST	Stoma Team	Catheter	OPAT
	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Staff in Post	0.6 B8A Lead 5.8 B7 CNS 0.6 B7 Clinical Educator 0.8 Admin Consultant split between Warrington and Halton	1.0 B7 lead 2.0 B6 nurses 0.8 B5 nurse 0.8 HCA 1.8 Admin		1.0 B8a Clinical Lead 3.76 B7 ANP 4.4 B6 Visiting nurses 3.2 B6 Triage Nurses 0.8 B5 visiting nurses 1.44 B3 admin	2.0 B6 nurses 0.4 Admin	1.0 B7 Lead 3.2 B6 nurses 1.0 B5 nurses 0.6 Admin	1.0 B7 Lead 2.0 B6 nurses 5.0 B5
Vacancies	Speciality Doctor split between Warrington and Halton			0.6 B3 admin Oct / Nov - 0.8 B6 visiting nurse	0.8 B6 nurses	0.6 B5 WTE	1.6 B5 WTE
Maternity Leave (included in staff in post)	Nil	Nil		Nil	Nil	Nil	Nil
Establishment	7.2	6.8		16	3.2	6.4	9.6

Capacity Solutions:

- Palliative Care have recruited to the vacant speciality doctor who is due to start in post on the 9th of October 23. The newly created palliative educator is now in post, with the aim to roll out a comprehensive education programme across care homes and within the Warrington nursing service to support the care given to end-of-life patients in their chosen settings with confidence thus reducing hospital admissions. This is further supported by St Rocco's Hospice and the development of a Palliative Virtual Ward that has been piloted for 6 months in 2022, with further funding secured for a further 12 months through 2023/24 to ensure the best use of the virtual beds to support both patients and families both physically and psychologically in their preferred place of care.

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- The Bladder and Bowel Adult team have good, working relationships with the other specialist nursing teams with the Warrington Borough and will support each other, when necessary. The Bladder and Bowel team work closely across both boroughs, Halton and Warrington, ensuring joint Borough standard operating procedures are developed and implemented, the team also work closely with the catheter and Stoma team.

- Stoma Team will manage demand within the service with overtime hours where required, a band 6 nurse 0.8 WTE has been funded and will be recruited to in Q2/3 of 2023/24 to support the complexity of the patients in the community requiring stoma care, due to the pandemic the service has seen an increased demand within the service.

- Additional posts within the Catheter Service are being recruited to allow an increase in service capacity and provide support from 8am-7pm Monday – Friday and 9am-5pm on Saturdays. This support will relieve pressures in the community nursing service and A&E. The development of an acute urinary retention pathway is underway with the service forging closer working links with UCR to manage more patients in their own homes. The team is also completing TWOCs in the community, historically these have been done by the urology team in secondary care.

- OPAT has provided NMABs for Covid-19 patients since December 2021 and will continue to offer 1 dedicated NMABs slot daily to allow treatment of the highly vulnerable to reduce the acute effects of the virus. Work with the ICB has commenced to ensure an equitable service for OPAT is offered across the Cheshire and Merseyside region. The team hold a weekly OPAT MDT supported by acute trust microbiology and specialist pharmacist to ensure that all patients are maintained safely within their own homes preventing readmission to the hospital. Demand has continued to grow as the service has matured and developed further.

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Children’s Community Nursing – Warrington

The Childrens Community Nursing (CCN) Service delivers a range of interventions Monday – Friday 9-5pm including;

- Paediatric nursing care
- End of Life care
- Nursing care to children with medical needs attending a special school
- Phlebotomy Service
- One to one tracheostomy care and support for individual children
- Continuing Health Care
- Contribute to the Paediatric Acute Respiratory Team provision in partnership with Warrington and Halton Teaching Hospitals Trust.

Predicted Increase in Demand:

The potential increase in respiratory infections in children during winter months may well impact on the work of the CCN team.

The CCN team support children and their families to avoid hospital admission wherever possible and to facilitate timely hospital discharge. As the number of children with respiratory conditions increase over winter so does demand on the CCN team. The demand for phlebotomy often also increases over winter due to an increase in GP surgery demand.

Staffing Levels:

The service is currently fully staffed:

- 1.0 x Band 7 team leader
- 3.2 x Band 6 Senior Children’s Community Nurses
- 2.5 x Band 5 Children’s Community Nurses
- 1.7 x Band 4 Nursery Nurses.
- 2.0 x Band 2 Phlebotomists.

In the event of a significant increase in demand, our part time staff may be available to work additional hours. Bank/Agency staff have previously been difficult to source within this specialist area but would be explored as an option if staffing levels were significantly reduced. There are staff within the wider children's services workforce who are registered paediatric nurses who may be able to be utilised if deemed appropriate.

The CCN paediatric nursing caseload and Special School Nursing responsibilities would be prioritised along with support to the children with a tracheostomy. The service would continue to work closely with the paediatric medical and nursing teams at Warrington and Halton Hospitals Trust and Alder Hey Hospital to ensure all children's nursing needs were met.

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Leadership Resilience:

In the absence of the Team Leader the following staff would take leadership of the service: Senior community nurses/senior special school nurse. Support would also be available from the children's services senior leadership/management team.

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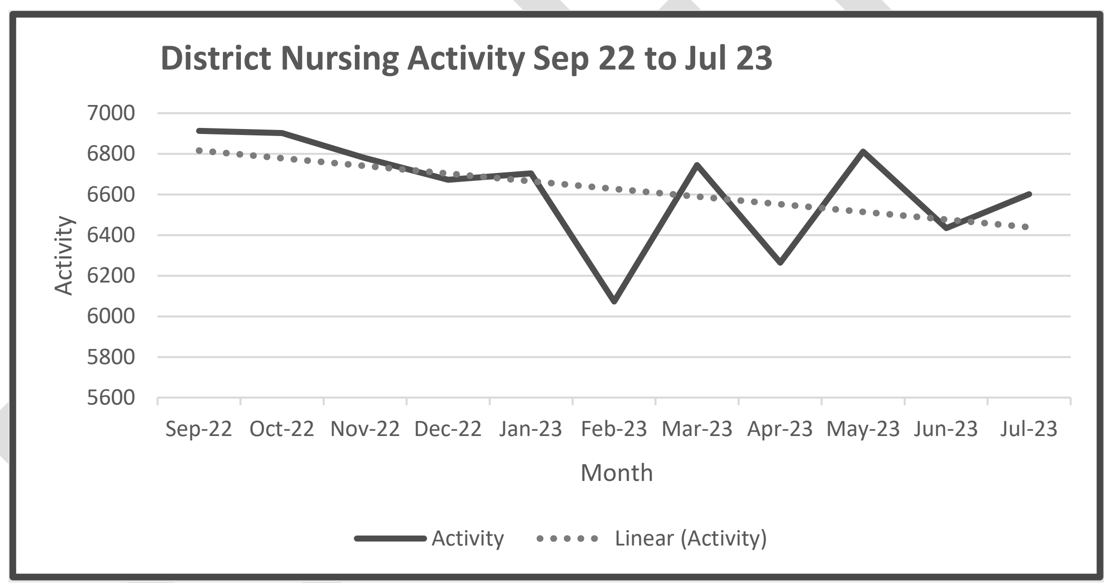
Community Nursing Services – Halton

District Nursing

Identified Pressures:

Annual activity for district nursing services was 8% higher in 2022 compared to 2021. The activity trend September 22 – July 23 shows shifting demand in some months to levels higher than last winter e.g., May 2023. Despite this, we should plan to see increased activity during winter based on previous years for reasons attributed to:

- Increases in the acuity of patients which has been identified in current caseloads.
- Escalation in hospital admissions within the local acute settings which impact on the length of stay in hospital and demand for rapid discharges as well as support for those requiring palliative care.



Staffing Levels:

A breakdown of the current established staffing WTE for Community Nursing Services can be seen in the table below. Our Community Nursing Services provide nursing services 24 hours, 7 days a week.

	District Nursing	Out of Hours	Tissue Viability
Actual	Total funded staffing: 81.9 wte 6x B7 District Nurses 8X B6 Nursing 47.5 wte B5 Nurses 2wte x B2 Administrative staff 4 wte x B4 HCAs 8.4 wte x B3 HCAs 6wte x B2 HCAs	Total funded staffing: 13.22 wte 1wte x B7 nurse 7.8 x B5 Nurse 0.5wte x B4 HCA 1.14 X B3 HCAs 0.53 X B2 HCAs	Total funded staffing: 1.6 wte 1wte x B8a Nurse 0.6 wte x B6 Nurse
Vacancies	Total vacancies: 13.9 wte	Total vacancies: 1.35 wte	
Maternity Leave (included in staff in post)			1x wte band 6 Nurse
Establishment	68	11.87	1.6 wte

The continued need to provide Community Nursing Support into Oakmeadow Care home during times of increased pressures are highly likely to impact on provision of services during the winter period. This increased risk will be mitigated by implementation of capacity solutions identified below.

Capacity Solutions:

A range of capacity solutions will be implemented to support the predicted increase in pressures arising from the winter period:

- Pro-active measures will continue, with daily reviews of the patient caseloads by the team leader. Community Nursing visits will be prioritised in times of extreme pressure allocated and delegated to the appropriately skilled staff. Priority 1 and 2 patients will be seen with no re-scheduling of visits.

- All existing planned visits will be reviewed and prioritised according to need to mitigate increased pressure on nursing services. Those patients identified as lower priority will be allocated to the nearest available appointment slot to ensure continuity of patient care.

- In line with existing prevention approaches advocated by Community Nurses the support of patient carers and/or self-management will be encouraged.

- As appropriate double handling of patients between nursing services will be minimised between Halton services to maximise clinical capacity.

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- Communication across boroughs will be undertaken between Operational Managers to support safe and effective delivery of care at times of increased pressure.

- In addition to planned additional capacity in the event of significant service reduction for an undefined period, use of agency staff (framework and non-framework when required) will be explored.

Other Mitigation:

- A planned programme of recruitment has commenced within Community Nursing to maximise recruitment to vacant priority one posts ahead of the winter period. This includes a social media campaign to promote recruitment including a drive to support those looking to return to practice and promotion of flexible working options. As per the Warrington service, there is a transformational programme being undertaken to review the current skill mix and to identify new roles for recruitment.

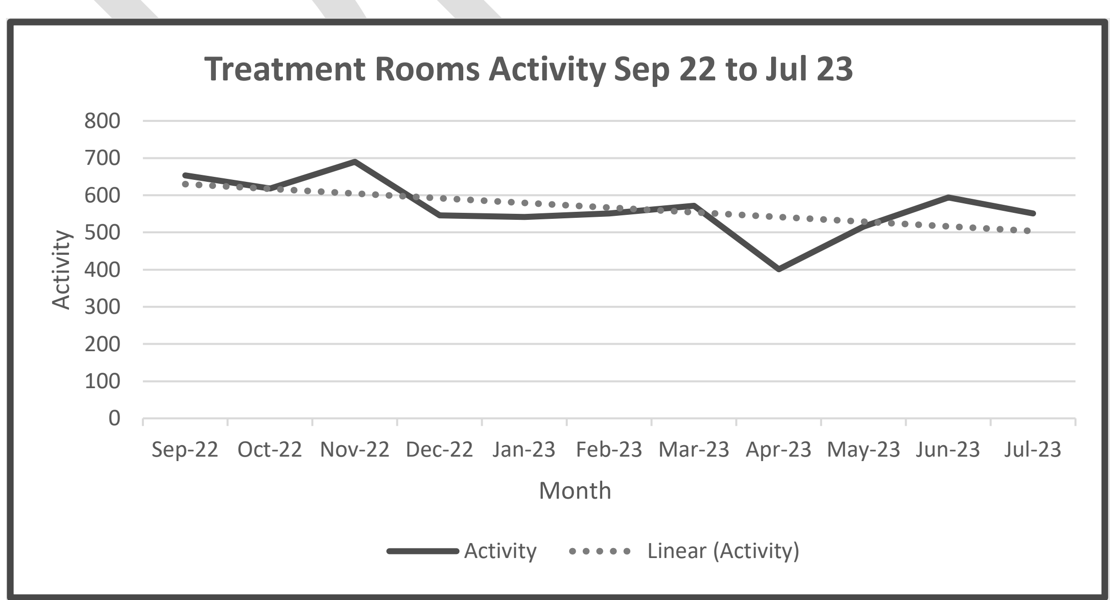
Leadership Resilience:

In the absence of the Operational Manager, District Nursing Coordinators will take leadership of the service, supported by the Head of the Halton Services.

Treatment Rooms

Identified Pressures:

Current activity shows slightly higher demand than for the same period September 2021-July 2022 - about 4%. The demand profile to date is similar and therefore if this continues into winter, we expect an increase in October/November as in previous years and then a levelling off. This places us in an advantageous position to deal with unexpected surges in demand.



Staffing Levels:

The following table illustrates the current staffing within the Treatment Room Service:

Treatment Rooms	WTE
Staff in Post	9.5
Vacancies	1.5
Maternity Leave (included in staff in post)	0
Establishment	10.49

Capacity Solutions:

A range of capacity solutions will be implemented to support the predicted increase in pressures arising from the winter period:

- Pro-active measures will continue, with daily reviews of the patient caseloads by the team leader. Treatment room operations will be prioritised in times of extreme pressure with patients allocated to the appropriately skilled staff.

- All existing operations will be reviewed and prioritised according to need to mitigate increased pressure on nursing services. Those patients identified as lower priority will be allocated to the nearest available appointment slot to ensure continuity of patient care.

- In line with existing prevention approaches advocated by Nurses within the Treatment rooms the support of patient carers and/or self-management will be encouraged.

- Communication across boroughs will be undertaken between Operational managers to support safe and effective delivery of care at times of increased pressure.

- In addition to planned additional capacity in the event of significant service reduction for an undefined period, use of bank / agency staff will be explored.

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Community Matrons

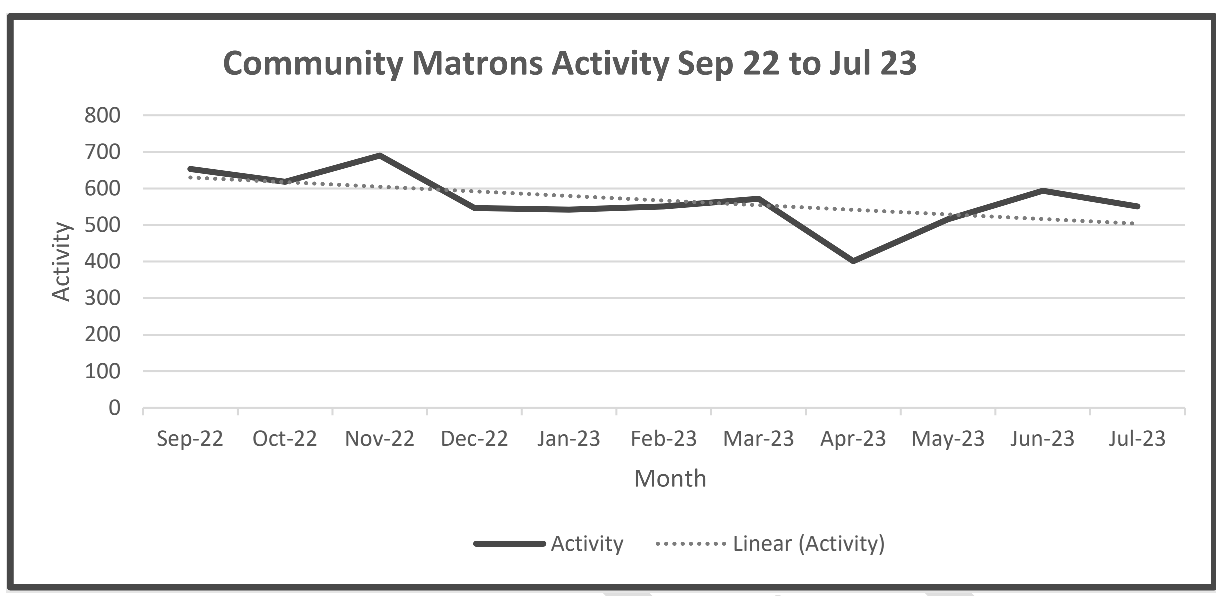
Identified Pressures

Demand over the last two winters (2021 and 2022) averaged over 600 referrals per month. If we follow a similar trajectory, we expect to see some additional demand at from September through November and then a levelling off into quarter four.

The Community Matron Service is therefore expecting a higher level of demand during the winter period due to:

- Increases in the acuity of patients which has been identified in current caseloads.

- Escalation in hospital admissions within the local acute settings which impact on the length of stay in hospital and demand for rapid discharges as well as support for those requiring palliative care.



Staffing levels:

The following table illustrates the current staffing WTE within the service:

Community Matrons	WTE
Staff in Post	5.6
Vacancies	1.2
Maternity Leave (included in staff in post)	0
Establishment	6.8

The current workload benchmark currently within the Community Matron Service comprises of:

- Individual qualified matrons can see up to 4 patients per day, with a combination of new and follow-up patients (5 per day if only follow-up patients).
- Health Care Assistants can see 5 – 6 patients per day.
- New patient assessments take between 60 – 90 mins each.

Capacity Solutions:

A range of capacity solutions will be implemented to support the predicted increase in pressures arising from the winter period:

- Patients can be referred onto Halton Integrated Care and Frailty Service for geriatrician review and therapy support to prevent hospital admissions.

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- Pro-active measures within the service will continue, with daily reviews of the patient caseloads by the team leader. Community Matron visits will be prioritised in times of extreme pressure allocated and delegated to the appropriately skilled staff.

- All existing planned visits will be reviewed and prioritised according to need to mitigate increased pressure on nursing services. Those patients identified as lower priority will be allocated to the nearest available appointment slot to ensure continuity of patient care.

- In line with existing prevention approaches advocated by Community Nurses the support of patient carers and/or self-management will be encouraged.

- As appropriate double handling of patients across nursing services will be minimised between Halton services to maximise clinical capacity.

- In addition to planned additional capacity in the event of significant service reduction for an undefined period, use of bank / agency staff will be explored.

Halton Integrated Care and Frailty Service (HICAF)

Identified Pressures:

During the 2023/24 winter period it is predicted that referrals to the team will increase as GP/hospital referrals aim to minimise hospital attendances for known frailty and chronic syndromes, which can be better managed in the community.

There will be further referrals where hospital in-reach and daily system meetings scope packages of care to minimise an acute admission or early discharge.

The graph below shows the annual activity profile September 2022-July 2023, and the rise in referral over the winter months. Compared to winter 2021 this represented a 15% increase in referral. Last winter the average monthly referral was 403, however for the period April-June 2023 this figure has already exceeded the winter referral average by 6%. In fact, if we compare April-Jun 2022 with the same period in 2023, the service experienced a 47% increase in referral.

Monitoring of referral demand will be important for this service in line with the predicted increase in pressures arising from the winter period.

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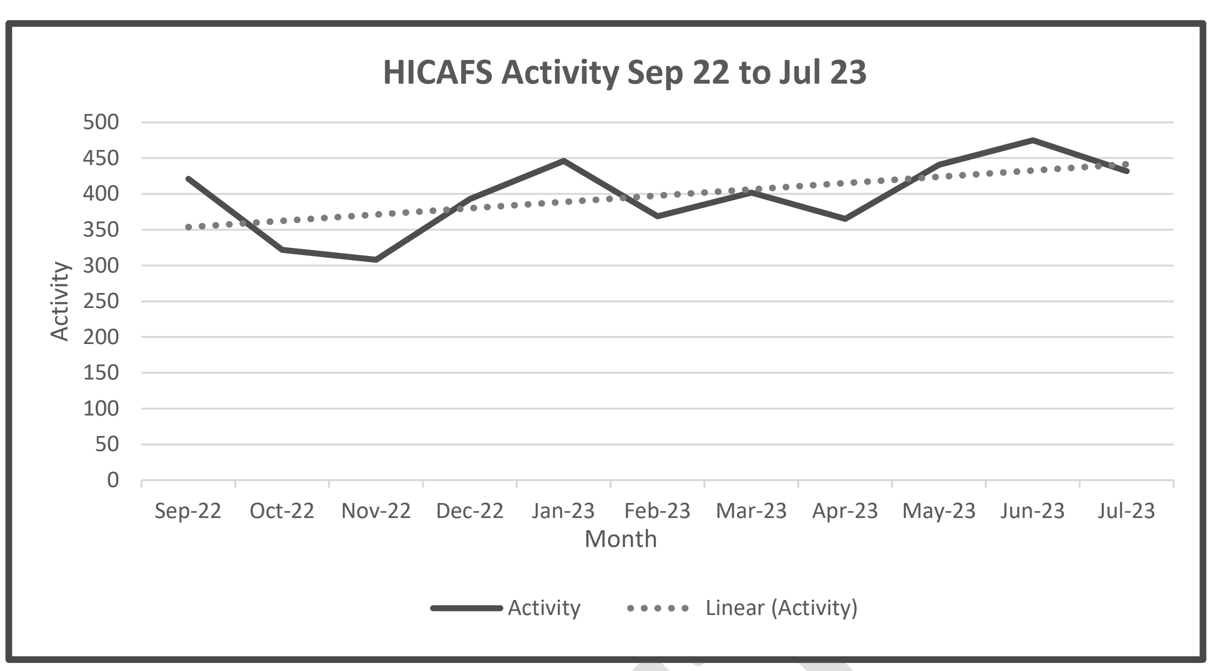

Staffing Levels:

The following table illustrates the staffing levels of the HICAF team.

HICAF	WTE
Staff in Post	18.59
Vacancies	3.21
Maternity Leave (included in staff in post)	0
Establishment	21.8

Nurses form one key element of the HICAF workforce, alongside therapies provided by Warrington and Halton Hospital NHS Foundation Trust and social care provided by Halton Borough Council (HBC).

Demand on the nursing element of the service is therefore impacted directly by the tri-party partnership e.g., vacancies within therapy and social care provision will impact operational opening hours and the provision of weekend services. This risk will be mitigated by implementation of capacity solutions identified below.

Capacity Solutions:

A range of capacity solutions will be implemented to support the predicted increase in pressures arising from the winter period:

- The HICAF Service has, and continues to undergo, a redesign that will see an overhaul in packages of care and capacity linking with both hospital Trust partners and social care.
- The team continues to collaborate with partners within the integrated service, meeting to develop the service, monitor performance and measure outcomes.

- Recruitment to senior nursing posts for the service, are currently underway to maximise the HICAF workforce capacity.

- The team continue to develop operational pathway arrangements with Halton's Neurorehabilitation, Speech and Language Therapy, Community Therapy Services, Parkinsons and Community Matrons. This has enabled effective multi-professional working and timely cross referrals.

- The HICAF service have developed a service level agreement with the Acute Trusts Specialist Frailty Consultant ensuring the service have in place key medical cover.

- A single point of access has been established as part of the HICAF model. This will remain critical during the increase pressures of the winter period as all referrals are triaged and prioritised.

- An established daily board round will continue within service to rapidly assess the progress of patients and addresses any delays and obstacles to treatment or discharge.

Leadership Resilience:

In the absence of the Operational Manager, Advanced Nurse Practitioners will take leadership of the service, supported by the Head of the Halton Adults Services.

Virtual Wards (VWs) – Halton

Identified Pressures:

The Virtual Ward offers a safe and efficient alternative to NHS bedded care. Virtual Wards support patients who would otherwise be in hospital to receive the acute care, monitoring, and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital. NHS England » Virtual wards

Halton's Virtual Ward launched in July 2023, with the provision of 4 beds initially with a plan to grow this once staff are recruited to support.

During the 2023/24 winter period it is predicted that referrals to Halton's Virtual Ward will increase as GP/hospital referrals aim to minimise hospital attendances for known frailty and chronic syndromes, which can be better managed in the community.

Staffing Levels:

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The Virtual Ward in Halton during the 23/24 winter period will be supported by existing staff resource within the Halton Integrated Care and Frailty Unit, until recruitment to Virtual Ward posts has been fully established. Recruitment is underway and being prioritised.

Virtual Ward	WTE
Staff in Post	3.8
Vacancies	9.7
Maternity Leave (included in staff in post)	0.0
Establishment	13.5

External Factors:

Increased pressures on the hospital during the winter period leads to an increased need to prevent avoidable admissions into hospital and an increased need to support early discharge out of hospital. This may impact on staff caseloads and response times to referrals.

The number of community patients can change daily during winter. As Virtual Wards are in their infancy and still in a process of recruitment, bed numbers are currently capped. However, should this increase extra resources, additional nursing, and therapy, would be required to support these beds.

Other Factors: The development of a shared electronic patient record that supports management of the patients is currently underway with an interim solution currently being in place. Work is also ongoing to develop a point of care testing hub and to rollout the remote monitoring element of the service which will be supported by Merseycare.

Urgent Treatment Centre - Halton

Identified Pressures:

The graph below shows the activity profile for the service through last winter and into summer 2023. As predicted demand started to increase in autumn into early 2023 before levelling off. There is no reason to suggest that this will be any different this winter.

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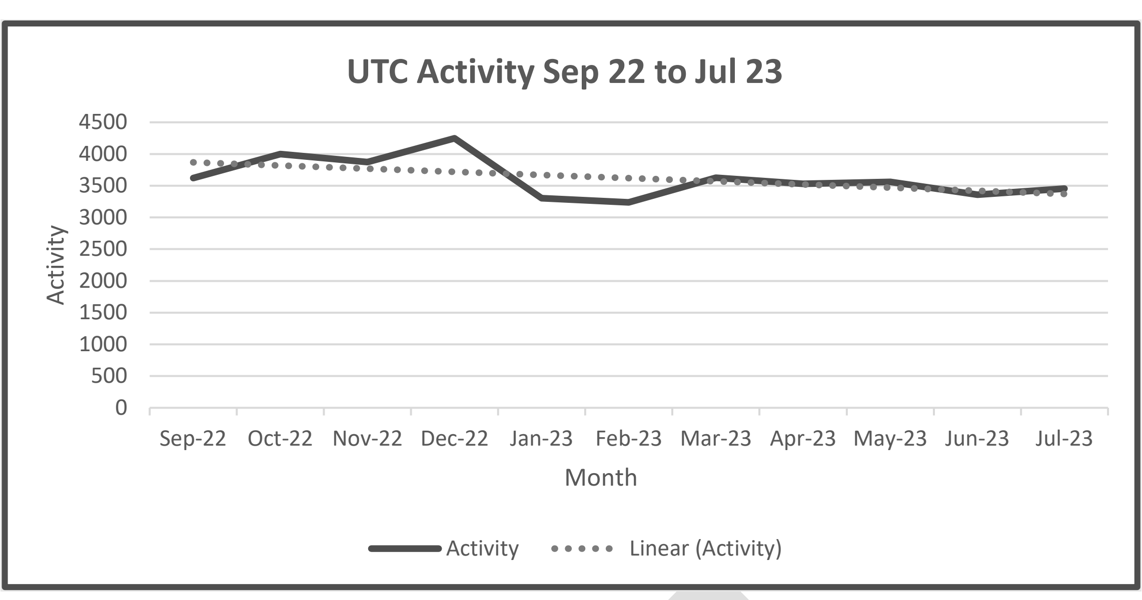

Staffing Levels:

The service continues to strive to ensure safe staffing levels for this service. All rotas are managed via the e-health roster system. This allows forward planning by 6-8 weeks.

The following table illustrates the current staffing within the Urgent Treatment Centre:

UTC	WTE
Staff in Post	27.4
Vacancies	1.3
Maternity Leave (included in staff in post)	0
Establishment	29.07

Capacity Solutions:

- The service will continue to ensure clinical capacity is maximised by ensuring recruitment strategies are in place to on-board appropriately skilled staffing.

- GP cover for the service will be increased if required to meet the identified demand and acuity of the patients presenting.

- The service has a plan in place to roll out GP Connect. This will allow local GP practices to book patients directly into the GP provision within the Urgent Care Centre via an electronic system.

- In addition to planned additional capacity in the event of significant service reduction for an undefined period, use of bank / agency staff will be explored.

Specialist Nursing Services - Halton

Identified Pressures:

Within Halton, specialist nursing services include:

- Heart Failure
- Parkinsons
- Wellbeing
- Palliative Care
- Bladder and Bowel
- Stroke
- Infection, Prevention and Control.

It is anticipated that for 23/24 winter, acute outpatients will move care quickly back into the community for follow-up to release capacity and reduce demand. The three services where this impacts most are Bladder and Bowel, Palliative Care, and Heart Failure.

There is evidence to support that more patients are dying in community settings either at home or nursing home rather than Acute and Hospice. With regards to Bladder and Bowel, more complex catheter changes are requested during the winter period as acute services move patients back into community. This has the potential to increase the referral rate for these teams and has been our experience in previous years.

All specialist nursing teams are vulnerable to capacity reduction as they are smaller teams. The services rely on continual rota management. Redeployment of staff within these smaller specialist services to other priority services during times of increased pressure would not be beneficial from these teams.

The table below shows the annual activity profile of each of the specialist nursing services September 2022 – July 2023.

Specialist Services: Halton	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Heart Failure	393	365	330	313	357	391	466	271	380	395	391
Wellbeing	34	78	95	70	115	111	103	21	73	111	101
Stroke	113	90	120	85	79	73	82	64	16	22	34
Bladder & Bowel	785	705	571	430	727	650	724	618	712	660	628
Parkinsons	57	36	48	57	67	52	68	55	75	75	34
Palliative Care	277	335	255	211	139	97	128	132	267	263	261

Staffing Levels:

The following table illustrates the staffing WTE for the specialist nursing services.

Service	Heart Failure	Wellbeing	Stroke	Bladder & Bowel	Parkinsons	Palliative Care
Staff in Post	6.12	3.19	1.4	6.0	0.4	7.33
Vacancies FTE	0.8	0.3	1.0	0.36	0	1
Maternity Leave (included in staff in post)	0	0	0	0	0	1
Establishment	6.4	3.49	2.4	6.36	0.4	8.33

Capacity Solutions:

- The Bladder and Bowel team have good, dependable working relationships with the Warrington service and have agreed emergency support in relation to certain types of assessment that can be called upon should this be necessary. Supervision/training for more complex catheter work has been undertaken within Whiston hospital for Band 6 nurses. Plans are in place to maximise recruitment to vacancies within the team ensuring clinical capacity to meet increased demand.

- Good working relationships are in place with the acute specialist teams at Warrington and Halton Teaching Hospitals and Merseyside and Lancashire Teaching Hospitals and so discussions would take place with them in relation to mitigation for any capacity challenges.

- The Heart Failure team has an HCA in post which releases capacity where phlebotomy only is required.

- In line with existing prevention approaches advocated by the Specialist Community Nurses the support of patient carers and/or self-management will be encouraged.

- As appropriate double handling of patients between nursing services will be minimised between Halton services to maximise clinical capacity.

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Community Equipment Stores

Service Pressures:

Community Equipment Stores is continually under increasing demand to support teams within the commissioning areas of Warrington, Halton, and St Helens. There has been a steady marked increase month on month in urgent requests. Last year these referrals were from Hospital Discharge Teams across the boroughs, but over the past 8 months these requests are coming from varying Health & Social teams within the community.

There has been an increased in requests to support same day delivery. The service is not commissioned for same day deliveries, but the service has always supported where possible palliative patients being discharge from hospital. This is an unplanned demand on the service and therefore impacts on staffing capacity.

There has been continuous demand and capacity work over the past 12 months as part of the CES improvement plan, but this has yet to be concluded. Potential increase in headcount to reduce or mitigate pressure. We continue to run the service with a similar budgeted headcount as winter 2021-22 with the transfer of agency staff to NHS contracts to mitigate agency spending.

There have been recent examples of supply issues that have impacted the timescales of delivery of equipment to patients. Stock deliveries can be unpredictable, as companies will not commit to specific delivery dates. Recycling of stock can also be delayed at times due to the availability of servicing engineers to complete servicing on the medical equipment.

The service is working on a project, to potentially bring servicing 'in house' to support a more robust process for servicing equipment which will support demand and reduce need for purchasing new equipment.

Activity Profile

September 2022 - July 2023	Total deliveries	Number of deliveries - urgent
Warrington	11,914 *11,693	1498 *1733
Halton	7247 *7383	2104 *2406
St Helens	6293 *5718	1705 *1850

* Activity for 01/09/22 – 31/08/23

Compared to the previous years, there remains a marked increase in the percentage of referrals.

Minimum staffing levels required:

- 6 WTE x Band 3 admin staff to cover Warrington, Halton & St Helens
- 1 WTE x Band 5 admin manager
- 1 WTE x Band 5 Store Manger
- 1 WTE x Band 4 store person
- 20 WTE x Band 3 drivers/store person
- 6 WTE x Band 2 dedicated to cleaning.

Current Staffing:

CES - Warehouse	**WTE**
Staff in Post	23 permanent staff (in addition the following 7 decon 2 warehouse operative, 2 driver/fitters currently going through recruitment fixed term contracts
Vacancies	0
Maternity Leave	0
Establishment	34

There is currently not sufficient staff to cope with the current workload and this will be impact on the service if the demand increases over the winter period.

Current experience shows us that there is a surge in late referrals and requests for equipment from varying teams on Fridays and Saturdays. To support this demand, we are currently working the following hours as overtime:

- Friday night late working 16.00 - 18.00.
- Saturday working – 8.00 – 12.00.
- Ad hoc overtime in the week - this will only be if there is absence in the workforce and urgent deliveries cannot be completed in the day.

If this pattern continues and increases over winter, the following contingency arrangements will be put in place:

- Ad hoc overtime in the week.
- Saturday working – 08:00 – 14:00
- Friday night late working - 16:00 – 20:00

Capacity Solutions:

- Demand and Capacity work to be concluded to support potential increase in headcount. This is currently with the transformation team and is expected to be complete by mid-October 2023.
- Offering training to referrers to support in ordering the correct equipment for patients.
- Internal project near completion on the ELMS ordering system, with the addition of images of equipment, links to 'accessories' to certain types of equipment and links to manufacturers, for specification of equipment, to support the ease of ordering equipment for referrers.
- Collaborating closely with commissioners on equipment pathways.
- Discussions are taking place with commissioners with regards to increase in demand, and types of demand year on year, and the required staffing levels to support the service.
- Ongoing route planning reviews to maximise the efficiency of delivery and collection slots.

Community Dental Service

Service Pressures:

Cheshire and Merseyside

Sector	Modality	Assessment Not Yet Completed	Assessed, but not yet offered a treatment appt	Patients offered a treatment appt	Total Patients on pathway
C&M	Paediatrics - GA	169	122	60	**351**
C&M	Paediatrics - IHS	150	4	111	**265**
C&M	Special Care	90	3	23	**116**
C&M	Special Care - GA	2	12	5	**19**
C&M	Domiciliary	20	3	4	**27**
C&M	IV Anxious Adults	176	6	33	**215**
C&M	Minor Oral Surgery	1,857	69	318	**2244**

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Greater Manchester

Sector	Modality	Assessment Not Yet Completed	Assessed, but not yet offered a treatment appt	Patients offered a treatment appt	Total Patients on pathway
GMW	Paediatrics - GA	733	96	39	**868**
GMW	Paediatrics - IHS	1,641	90	111	**1842**
GMW	Special Care	535	19	46	**600**
GMW	Special Care - GA	7	32	10	**49**
GMW	Domiciliary	103	8	8	**119**
GM NE	Paediatrics	201	6	6	**213**
GM NE	Paediatrics - GA	268	312	32	**612**
GM NE	Paediatrics - IHS	643	37	106	**786**
GM NE	Special Care	201	6	14	**221**
GM NE	Special Care - GA	3	47	4	**54**
GM NE	Domiciliary	12	31	5	**48**

Staffing Levels:

Community Dental	WTE
Staff in Post	188.60
Vacancies	5.41
Maternity Leave (included in staff in post)	5.68
Establishment	194.01

External influences that may affect service delivery include:

- Lack of access within Acute Hospitals to deliver Paediatric Exodontia within Whiston, Royal Bolton and Tameside Hospitals, Oldham General and Fairfield Hospital.
- Referral behaviours of General Dental Practitioners (GDPs).
- Increase in request for domiciliary visits.
- Availability of PPE and other key consumables or service providers e.g., STERIS decontamination provider.
- Commissioner decisions impacting on patient pathways i.e., changes to referral pathways, resulting in increasing demand for our services.

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Capacity and Demand Management Solutions:

- Established four task and finish groups within the network as part of our transformation agenda; which aim to better manage flow into (acceptance criteria) and out of the service (discharge criteria); impact on the IHS demand already within the service; and look at wider treatment planning

- Agreement with the commissioners regarding demand management and referrals.

- Implementation of clinical prioritisation framework – used during Covid-19 pandemic - to ensure those most clinically urgent and in uncontrolled pain are seen first.

- Clinical Prioritisation of the recall programme by case mix score, and presentation of clinical need (pain).

- Managing treatment plans involving multiple visits.

- Increasing and consolidating GA Paediatric access by:

    - Working in partnership with Royal Bolton Hospital to deliver GA services from their day case unit as well as additional sessions on a Saturday.
    - Working with Oldham general to secure additional access.
    - Engaging with NHS Trusts to secure weekend theatre access.

- Time limited wait list initiatives to reduce waiting times.

- Within Greater Manchester, exploring the how we can work collaboratively together.

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Flu and Covid Booster Vaccination Programme

Staff influenza programme (flu)

The staff flu vaccination programme is due to commence in October. The IPC team will be the identified vaccinators across the Trust providing a roving model. The flu vaccines will be offered alongside the Covid-19 autumn booster vaccinations. The updates on numbers of staff vaccinated will be reported into the People Committee and the CQUIN meeting. Staff that obtain their flu vaccine elsewhere are asked to report this so it can be monitored in line with the CQUIN.

Staff Covid-19 Autumn/Winter 2023 booster

The Covid-19 Autumn/Winter 2023 booster vaccinations for all staff will be offered at Spencer House from 10th to 13th October inclusive, with an additional session planned for the 30th and 31st October. This is only for booster vaccinations. Appointments will be released on simply book for staff to book appointments. The Covid-19 autumn booster will be co-administered with the flu vaccine.

School-Aged Immunisation Programme

Warrington - Flu

Target population numbers:

- School-aged Children - 31,434 (estimated) is cohort. Target is 66.4% uptake in primary school population and 38.1% in secondary school population.
- 2 and 3 year olds 1200 eligible children. No target.
- Start dates - 25th September – 15th December 2023.
- Service locations – Schools and community clinics
- Staffing – average of 9 immunisers a day (Mon – Fri) required plus 3 support staff. 4 immunisers and 2 support staff required to deliver a Saturday session each month.

Halton – Flu

Target population numbers:

- School-aged children – 18,517 (estimated) is cohort. Target is 55.9% uptake in primary school population and 29.2% in secondary school population.
- 2 and 3 year olds – 646 eligible children. No target.
- Start dates – 25th September – 15th December 2023.
- Service locations – Schools and community clinics.

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- Staffing – Average of 6 immunisers a day (Tue – Fri) required plus 3 support staff. 3 immunisers and 2 support staff required to deliver a Saturday session each month.

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Emergency Preparedness, Resilience and Response (EPRR)

This Winter Plan is published on the Hub and the on call/EPRR teams channel It sits alongside several Trust plans and documents:

Cold Weather Plan

The Trust's Cold Weather Plan, which is linked to the Cold Weather Plan for England, is available on the winter planning page of the Hub. In line with current planning guidelines this document will be updated following publication of the National Cold Weather Plan scheduled for early October 2023.

Severe weather warnings are issued by the Met Office throughout the year, advising of weather events such as flooding, storms, and high winds.

A Met Office Cold weather health watch system also operates in England from the 1 November to 31 March every year, comprising five levels of response based on cold weather thresholds. The thresholds have been developed to trigger an alert when severe cold weather is likely to significantly affect people's health. The alerts take account of temperature along with other winter weather threats such as ice and snow.

The information is available via links on the Hub but the Trust also receives these alerts and warnings direct, and staff are kept informed via the global email system, as necessary.

Major Incident Plan:

Bridgewater's Major Incident Plan is available on the emergency preparedness page of the Hub and the on call/EPRR teams channel

Business Continuity:

The Trust's Business Continuity Procedure is available on the business continuity page of the Hub. All Trust services have their own business continuity and escalation plans in place which are in the process of being reviewed. These are held within individual teams and are also available on the Hub and the on call/EPRR teams channel.

Outbreaks:

The Pandemic Influenza Plan and Community Outbreak Plan are published on the Hub.

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Covid-19:

The Trust's Coronavirus page holds links for staff to all the current plans, guidance, and materials.

Winter power supply disruption:

The Trust is not a protected site and therefore is at risk if national power supplies are disrupted. Updates recently received by the Electricity Network Operators indicate that 23/24 supplies are unlikely to be impacted. The Trust covers a wide geographical range and would look to re-locate services as appropriate and/or maintain working from home, however, if national supply is disrupted the current estate portfolio would be at risk of closure. Separate work identifying vulnerable patients, home based equipment etc has been commissioned.

Estate:

To ensure operational building capacity is maintained throughout the winter, estate (facilities management) actions plans have been developed to mitigate risk from cold weather adverse events and equipment failure.

On call arrangements

The Trust operates a well-tested, two-tier on call system, which operates 24/7, 365 days a year. The Trust has a tactical (1st on call) and a strategic (2nd on call) who, when contacted by the tactical on call if escalation is required, will co-ordinate the organisation's response to any major incidents or serious issues.

The tactical on call may be contacted on **01925 664000** (Mersey Care - Hollins Park switchboard). Callers should ask for the Bridgewater tactical on call.

All staff are aware of how to access the senior manager on call and a copy of the on call rota is available on the Hub and teams channel. The contact numbers are held by the relevant NHS England (NHSE) Area Teams, ICBs, other local NHS organisations and local authorities.

The Trust's on call information pack has contact details for the NHSEI and ICB Tactical (Silver) and Strategic (Gold) Commander.

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Communications

The Trust is an active partner in system-wide discussions about communications to support winter planning. These discussions take place via the regular and established forums across our geographies, ensuring consistency of message, approach and that lessons from previous years inform current year planning.

- The Trust will proactively support delivery of messages relating to the national campaigns, including for staff and external audiences, particularly using social media. Local campaigns will also ensure consistent messaging about e.g., self-care, mental health, and winter warmth.

- The Trust's Communication Team receives regular briefings from NHS England/NHS Improvement's Communications Network and Public Health England which ensures best use of resources in relation to winter planning campaigns.

- The in-house Flu Campaign is underway and is being promoted through multiple channels including the weekly bulletin, staff intranet, screen savers, posters etc.

- Operational Leads are ensuring communication updates are available and promoted within their services where appropriate including rotas, opening times and availability of contact details for health and social services.

- Information about on-call rotas and processes are available on the staff intranet.

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BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	71/23v		
Report Title	**Learning from Deaths**		
Executive Lead	Ted Adams Executive Medical Director		
Report Author	Andi Sizer Principal Lead for Public Health		
Presented by	Ted Adams Executive 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 are, overseen by our Serious Incident Review panel (SIRP).

41 deaths were reported to SIRP in quarter one. None of the 41 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.

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

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

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

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	71/23iv		
Report Title	Learning From Deaths		
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. INTRODUCTION

1.1 This 2023/24 quarter one 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). The SIRP meets weekly, and service leads provide individual reports on deaths that have occurred whilst patients are on the Bridgewater caseload or who die within 30 days of being seen by a Bridgewater member of staff. Each death prompts a learning from deaths 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.

1.2 The Learning from deaths policy is currently being reviewed. Changes are being made in order that the Bridgewater Policy aligns with other Community Trusts and avoids duplicative work across places and a meeting is set with the Directors of Nursing for 27th September to discuss these proposed changes. The national Learning from Deaths policy is very acute hospital focussed and refining the messages and requirements within it to make it suitable for a Community Trust is an ongoing challenge.

1.3 To anchor the report to our community, changes have been made to the Learning from Deaths report template to capture greater demographical data. For example, veteran status, place of death, age ranges and whether the deceased was known to mental health services. As such this paper should be viewed as an indicator of current practice as not all the data sets have been captured in their entirety because of the timing of the most recent changes to the report template.

1.4 It is noted that once a Learning from Deaths report is signed off by SIRP the document is attached to the Ulysses incident report as a Word document. As this is not an electronic capture of the data each report is accessed manually, and the data recorded in a excel master template.

2. INFORMATION

2.1 During quarter one **2023/24, 373** deaths were reported on the 'Qlik Sense' dashboard as pertaining to Bridgewater patients who had an open and active referral at date of death in Halton and Warrington place. It is noted that at any one time our services reach half of the population of our places, and this is reflected in these numbers. They include deaths from any cause including COVID.

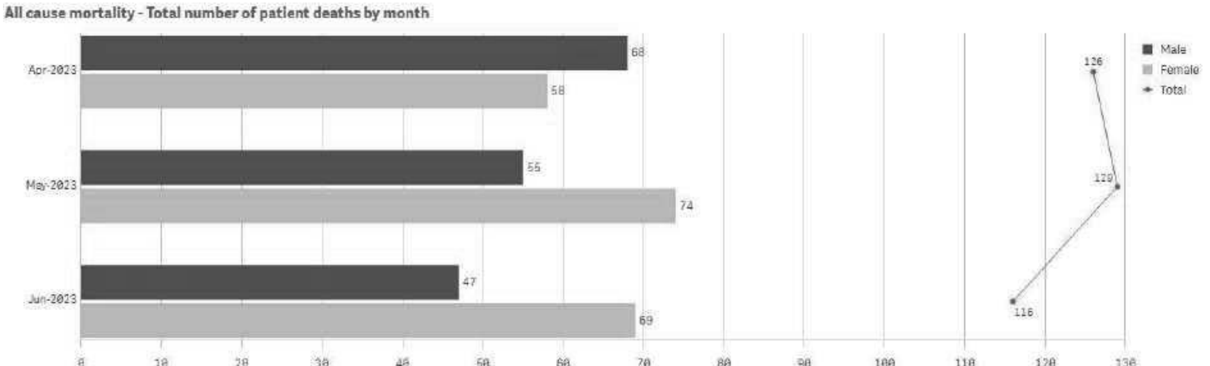


Figure 1. Number of deaths by month and Gender. (Extracted from 'Qlik Sense' 14:44 18/09/23)

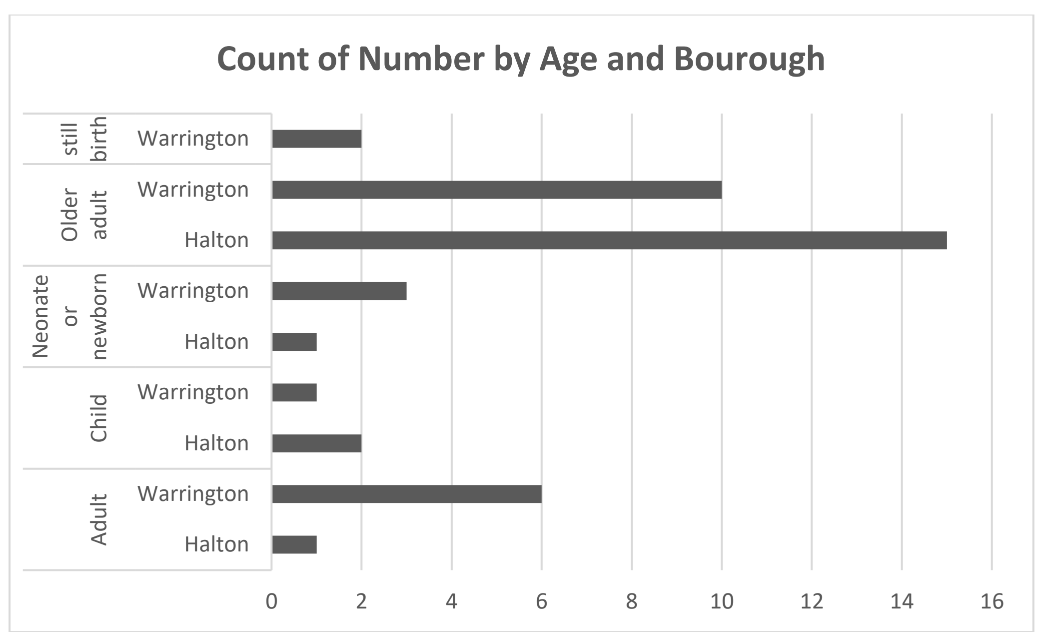
2.2 Of the **373** deaths **41** were reported to SIRP. None of the 41 deaths were related to a deficit in care provided by Bridgewater. SIRP did feel that there was learning for the Trust after reviewing the 41 deaths.

On review of the 41 cases, our recommended areas of focus for the Trust are:

- All Bridgewater staff should ensure that they complete Mental Capacity assessments with patients who lack capacity and complete a Best Interest decision with appropriate others.
- All staff to have professional curiosity, especially around understanding the reasons for the patient declining recommended advice e.g., not wanting to attend hospital, not wanting chest drain, and to document summary of discussion.
- That GP Tasks are sent to the appropriate generic Warrington 'doctors' mailbox which will be picked up the same day by the duty doctor. When the task is urgent it should be followed up with a phone call to the surgery to check it has been received and actioned.

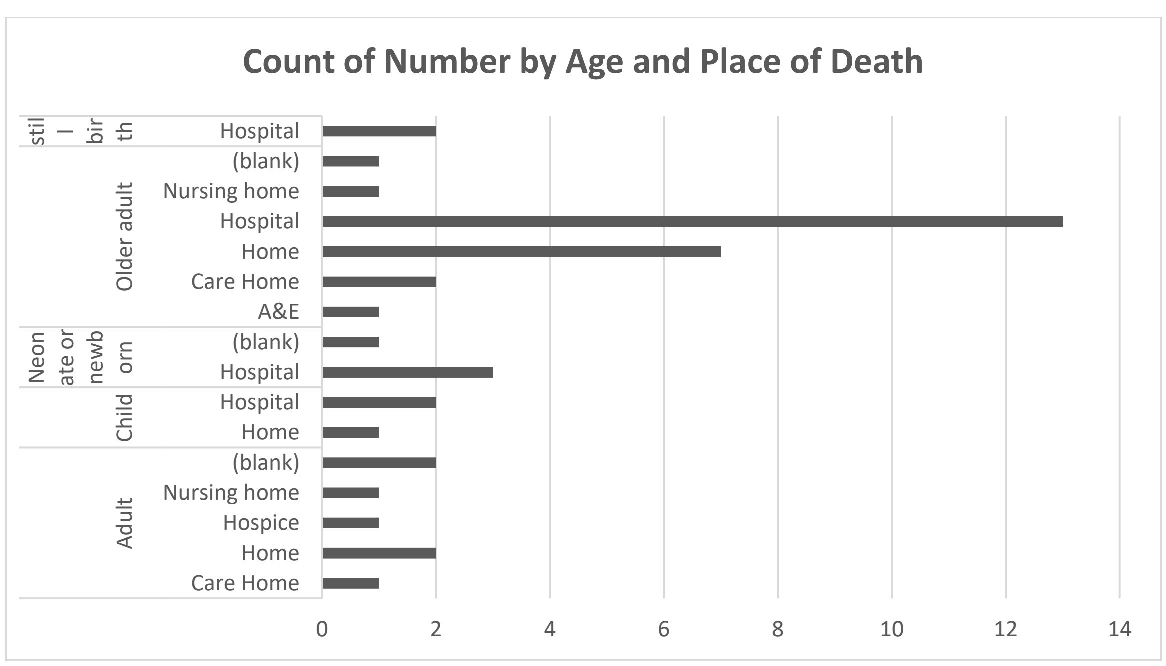
2.3 In quarter one there were no concerns raised from the deceased family/carers and no concerns raised by staff about the care that Bridgewater delivered to patients who died.

2.4 The chart below illustrates the number of deaths by age cluster. These clusters have been added to the data record as only the date of birth is recorded on the Learning from Death template. This allows data to be analysed and presented in age clusters as previously age was omitted from reports.

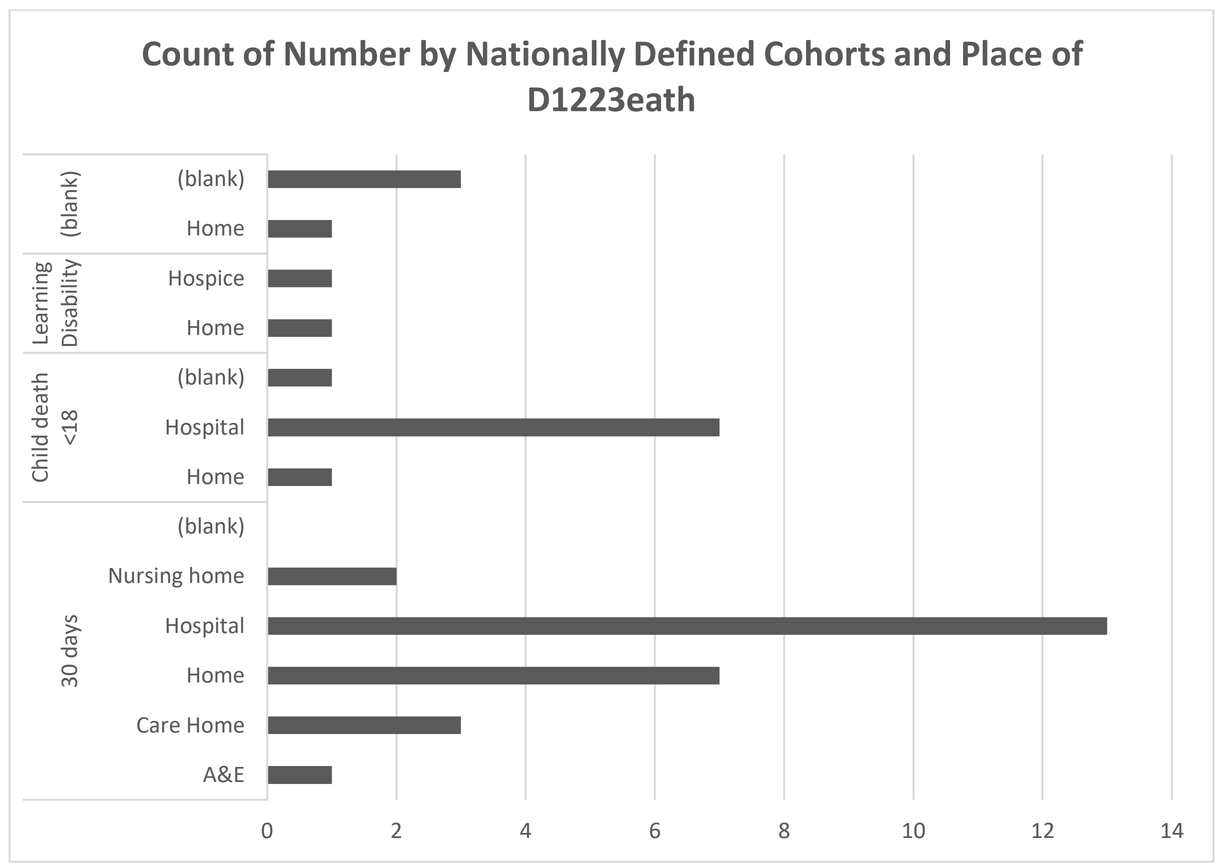


The age ranges applied are still birth, neonate, or newborn to one month, infant one moth to one year, child one year to 12 years, adolescent 13 years to 17 years, adult18 years or older and older adult 65 years or older.

2.5 The chart below shows the number of deaths recorded against place of death by age cohort. Highlighting that higher number of hospital deaths within the older adult cohort.



2.6 The chart below shows the criteria for reporting the death against the Trust policy. It is noted that as a trust we are required to report/contribute on all child deaths and learning disability at Place with partner agencies namely the LeDeR and Child Death Reviews. There were two deaths that were reported to LeDeR.



Deaths that occurred in Hospital are the higher number of deaths reported by Bridgewater.

3. INFORMATION

Summary of Thematic Learning

3.1 Each unexpected death reported during quarter one 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 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. Themes have been identified as learning areas for the Trust – see 2.2.

3.3 Given that health disparities adversely affect groups of people who have systematically experienced greater obstacles to heath such as health rated behaviours it is important that as a Trust, we understand the needs of our communities.

3.4 We fully recognise that health related behaviours can result in some communities, groups or people living in certain areas continuing to spend more of their lives in poor health and dying sooner than others.

3.5 It is noted that there are still data omissions within the Learning from Deaths report template. Examples being gender, ethnicity, place of death along with omissions in content such as: cause of death and year of birth. The template now includes the health inequalities and demographic information that will support the Trust's understanding of the socioeconomic equalities in mortality rates at Place and will allow for a more structured thematical analysis in future reports and reviews.

3.6 It is noted that all the 41 deaths were not all necessarily in scope with the Learning from Deaths Policy guidelines. Still birth and neonatal deaths are reported to the 0-19 services but not always known to the services as the service will never have met the child. Work to familiarise the services with the policy is ongoing.

3.7 The deaths being reported as a hospital death are being discussed with the Directors of Nursing and the Medical Director to agree who is the main provider and who should be leading the reviews. Once agreed the correct criteria will be communicated to services.

4. RECOMMENDATION

4.1 The Trust Board is asked to receive this paper for assurance of the processes undertaken at SIRP and subsequent learning for the trust.

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Committee Chair's Report

<table>
<tr><td>Name of Committee/Group:</td><td colspan="2">Quality and Safety Committee</td><td>Report to:</td><td>Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="2">Thursday 24 August 2023</td><td>Date of next meeting:</td><td>Thursday 26 October 2023</td></tr>
<tr><td>Chair:</td><td colspan="2">Martyn Taylor (Deputy Committee Chair)</td><td>Quorate (Yes/No):</td><td>Yes</td></tr>
<tr><td>Members present/attendees:</td><td>Committee Members Present:
Martyn Taylor, Non-Executive Director (Chairing)
Elaine Inglesby, Non-Executive Director
Abdul Siddique, Non-Executive Director
Lynne Carter, Chief Nurse
Sarah Brennan, Chief Operating Officer</td><td>In attendance:
Jeanette Hogan, Deputy Chief Nurse
Susan Burton, Deputy Chief Nurse
Mark Charman, Assistant Director of Transformation
Tania Strong, Head of Human Resources
David Mills, Deputy Medical Director
Sarah Wilson, Head of Safeguarding
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

Observers:
Andrew Mortimer, Public Governor, Warrington</td><td>Key Members not present:</td><td>Apologies received from:
Gail Briers, Non-Executive Director and Committee Chair
Ted Adams, Medical Director
Sue Mackie, Director of Quality Governance
Christine Stankus, Public Governor, Rest of England</td></tr>
</table>

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
PSIRF Plan and Policy	2, 3		The Committee approved the PSIRF policy and plan.	This would be circulated immediately to the Board by the Head of Corporate Governance via e-governance for final endorsement to ensure the ICB timescales were met.
Deep Dive – Dental Services	2, 3		The Committee received a deep dive in relation to clinical aspects of the Trust's dental services. This provided information on the dental leadership structure and a number of recent appointments which would strengthen operational management and improve clinical leadership. This included two recently appointed operational managers in Cheshire, Merseyside and Greater Manchester, a new Clinical Director for dental	The Committee requested an update to be provided to the deep dive to include: a focus on leadership challenges, how this was impacting on patient care and the impact on the

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			services in Greater Manchester, along with a specialist in special care dentistry. Work was underway to further improve special care services. A lead had been appointed for oral surgery, with a vacancy for a paediatric specialist to be recruited to. The Deep Dive also focussed on inhalation sedation and general anaesthesia and how decision making was applied around each. The Committee noted that the feedback being received from patients on the service they had received was positive, however the number of returns and therefore the value of them could not be accurately quantified at the meeting. This information would be provided by the Deputy Medical Director. The Committee received the report and was assured of the processes in place concerning inhalation sedation and general anaesthesia.	quality of patient care including long waiters. The report would include work of task and finish groups around improvements being made from a quality and safety perspective and reduction in waiting times, including impact on health inequalities. This could provide assurances in areas within the service which were experiencing challenges such as the minor oral surgery pathway and special care caseload with patients who did not have the right case mix score, as well as the volume of paediatric activity into the dental network. It was agreed an updated report on this would be provided to the Committee in due course.
Serious Incidents Compliance Report	2, 3		An overview of activity during 1 June and 31 July 2023 was presented. Within this time, there had been seven incidents reported and managed as serious incidents. The Trust had remained fully compliant with the reporting of incidents and submissions of investigations during the required time frame. Pressure ulcers continued to be the most commonly reported type of serious incident. A serious incident was being investigated into the management of a suspected case of sepsis in Halton. The Trust had submitted four completed serious incident investigation reports to the ICB during the period, those remained open awaiting feedback. There had been two additional meetings held to review the serious incident action plans and	The Committee received the report for assurance.

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Committee Chair's Report

			evidence of completion: 17 of the 20 action plans that had passed their last target date had been reviewed: two plans had been approved subject to some minor changes, eight plans demonstrated progress with an additional seven actions plans not being reviewed as they were not ready for review or the presenter was unavailable. Further additional meetings were planned for the coming months to support the completion and approval of those plans. Whilst there was some Non-Executive Director challenge concerning the progress being made on the action plans, the Deputy Chief Nurse described the work in train to take those forward with the support of the quality matrons. A number of the plans were historic with additional learning identified since the first investigations were completed. An action was being progressed to review all the actions and explore how those could be assimilated. The report included a description of the work to implement PSIRF. This had included fortnightly implementation group meetings and progress was continuing at pace. Following the incident where a patient had developed sepsis as a result of an indwelling catheter, a discussion took place as to whether a further audit was required for NEWS2. The Committee agreed that the Chief Nurse and Deputy Chief Nurse would review this and report back to the Committee on any further actions that may be required.	
Summary Report for Risks Relating to Quality and Safety	2, 3		The Committee noted that between 3 June and 3 July 2023 there were 17 risks scoring 12 or above related to quality and safety that had been identified during the period. All of the risks had been updated by the risk owners and in July there were no risks scoring 12 or above that had not been reviewed. In June 2023 there were two risks that had passed their target dates, both related to children's services in Warrington, with extended target dates of 30 September. In July 2023, one risk had passed the target date, this related to Dental	The Committee received the report but noted that there were some issues with the risk register appendix to the report where information pertaining to risks and controls were out of alignment. It was suggested that this should not be

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			Services in Manchester and this was reviewed with an amended target to be identified. Work continued to be supported by the Risk Management team who supplied the Directorate Leadership teams with frequent reports to show when the review dates were due. The majority of the risks scoring 12 or above had a scoring of 12. During June there were two risks scoring 15 in relation to dermatology and the delay in receipt of histopathology results. In July there were two risks scoring 15 in relation to district nursing capacity in Warrington and the volumes of patients waiting for dental services. The Committee also noted that a dental risk on urgent triage reported as scoring 15 had been downgraded from 15 to 12 during the period, however the circulated report had stated that there had been no downgrades to risks. Themes from the risks were noted with the most significant being demand, capacity and resource. There were no risks closed or new risks relating to quality and safety reported to the Risk Management Council during the period. There had also been one risk reporting as low assurance in relation to paediatric physiotherapy: although the paper reported improvements in capacity in the service via the usage of agency, there had not been any further recruitment to substantive posts. This was expected to commence in August 2023.	provided going forwards as it was an extract from the risk management system at a point in time and may not accurately reflect the most up to date position. The Committee requested that information provided going forwards must be accurate and as up to date as possible.
Patient Experience Report	2,3		The Committee received the quarter one report. There was a slight decrease in patient feedback in comparison to quarter four of the previous year, with 8,574 people provided feedback during quarter one compared to 9,078 in quarter four. Of those responses in quarter one, 8,530 people had rated the Trust as 'very good' or 'good' giving the Trust a Friends and Family Test rating of 95.7%. There was a total of 12 formal complaints, which was a slight increase from nine in quarter four. Eight of the complaints related to adult services (four in Halton and four in Warrington) and four in relation to Children's Services (two complaints for	The Committee received the report and was assured that the Trust reviewed feedback and complaints and took action and made changes as a result of them, demonstrating that it was listening to its patients and their families.

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			Halton and two for Warrington). She reported that a total of 285 PALS contacts had been reported for Bridgewater for this period compared to 270 received during quarter four last year, with 259 during the same period last year. Of the 285, including 52 informal concerns, only two formal concerns led onto formal complaints: one within the District Nursing service and the other for Halton Community Paediatrics. The report also referenced an informal concern from March of this year which had since progressed to a formal complaint regarding the driveability service. There was one joint complaint received during this period relating to the Urgent Treatment Centre, Halton and one MP letter received relating to the Paediatric SaLT Service in Warrington. The report also detailed lessons learned from patient feedback. Some examples included a review of triage processes, strengthening of communication whilst awaiting an appointment and identification of additional training opportunities for staff. There was a total of 3,532 compliments received about Bridgewater services. The Trust was continuing to explore opportunities to gather patient feedback and involve patients, children and families in the development of its services and the care it delivers. Some examples of those areas were included within the circulated report. A description of some feedback given to the Halton and Warrington Children's Therapies Team was also included. Advice lines were open for parents and teachers with advertisements of this on social media. Dental services were also piloting the use of an electronic tablet for children to provide feedback, as well as a video explaining what would take place during appointments.	
New format IQPR Report	2,3,6		The Chief Operating Officer presented the report which detailed the proposed quality indicators to be removed, changed or amended. It was	The Committee approved the indicators and acknowledged

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			proposed that the indicators would be retained in relation to incident reporting but the impact of embedding PSIRF would need to be considered going forwards and how those indicators may need to change in the future.	the position concerning PSIRF as this was not yet fully implemented. It was agreed that the IQPR would be a fluid document with indicators to be removed and added as when matters progressed. It was also agreed that where information was not yet available for the indicators a date would be provided as to when this would be available.
IQPR	2, 3, 6		The Committee noted that there were five indicators reporting as red with improvements observed in month for all but one: Information Governance and Safeguarding adults level three training, percentage of incidents with low impact, percentage of risks identified as high and percentage of overall community falls. The Chief Operating Officer highlighted that the increase being observed in relation to risks over the last months was reflective of the challenges the Trust was experiencing at this point in time including in relation to dermatology, district nursing and staffing, dental and children's services waiting times. The Trust had achieved the safeguarding adults level three training compliance target of 85%. The Committee welcomed this achievement and thanked all of the staff involved.	The Committee received the report for assurance.
Report from the Quality Council	2, 3		A report from the Quality Council on 24 July 2023 was received by the Committee for assurance. Highlights from the report included: Lone worker devices: positive progress had been made with work undertaken following the historic poor uptake of the use of the devices. There was now a joint action plan in place with a gap analysis completed to understand the need for clinical services around the devices and the	The Committee received the report and was assured that the Quality Council was undertaking its role to review quality elements in depth. Non-Executive Directors

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			process of ensuring they were available to them. Work was also being undertaken with procurement to explore if there were better/improved devices available that may be more suitable. The work had taken on board clinician's feedback as to what worked well for them and ensuring that every service has a standard operating procedure in place so that they were safe whilst lone working. Work would be ongoing and monitored through the Quality Council until there was an understanding of the device needed within the organisation that was acceptable for staff, with robust standard operating procedures in place for every member of staff. There was a focus on the district nursing improvement plan and alleviating the pressures within the service. Work was ongoing around the treatment rooms, with dedicated staff and considerations around how the Trust delivered its out of hours service across district nursing and better utilising the in hours service. There would be a more detailed report in this regard presented to the Committee in October. Matters in relation to paediatric physiotherapy had been reviewed robustly at the Risk Management Council. A quality assurance approach had been taken around understanding the risks in the service which were improving. Posts had been recruited to with postholders to commence in September and due to the improving position, the risks were reducing with the waiting list expected to be on a reducing trajectory. There had been long waiters, however two locums were in place, with this arrangement extended to November to attempt to address further waiters. The report referred to risks in terms of the significant challenges within the Speech and Language Therapy Services and advised that there was a focussed piece of work within that service to target additional resources. It was hoped that this would steer a reduction in waits over the next month. A positive element from the report was highlighted related to work being undertaken by the palliative and end of life steering group and the creation of an advocate role within the organisation that had been	commented that the report was very detailed with good context, setting out the actions that had been taken in relation to key matters.

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			positively received. The advocates would support staff with education and training in this area. An End of Life Practice Educator was now in post as a dedicated resource which would provide support to all community nurses and clinicians to ensure they had the required knowledge and skills. There were no issues escalated from a quality point of view to the Quality Council in relation to incidents or impact on quality.	
Safeguarding Annual Reports	2, 3		The Committee received the annual safeguarding reports for assurance. The reports had been reviewed by the STAG and the Quality Council prior to presentation at Committee. The reports would now be shared with Cheshire and Merseyside ICB.	The Committee thanked the safeguarding teams for all of their work over the year recognising the challenging nature and environments in which they operated.
Quality Priorities	2, 3		The Committee noted three priorities for 2023/24 with work continuing on those areas from 2022/23: universal in reach; personalised in response - a modernised universal health visiting and school nursing service delivery model; Core20Plus5 and; implement the pilot for the community accreditation scheme.	The Committee noted the priorities and noted that the three elements were supported by the Council of Governors at its meeting on 16 August.
Paediatric Audiology Incident Update			It was reported that all of the children affected by the incident had been through the MDT process and that all of the cases had been reviewed. The Trust was now in the process of recalling any children into the service who would need to be seen and required further testing. Letters would be sent to those families. The Chief Operating Officer confirmed that the Trust had internally reviewed the incident and this had been stepped down from a serious incident as no incidences of harm had been identified by the Trust to date, the quality of the service provided had not	A final update would be presented to the Committee in October, however it may be the case that children would need to be reviewed by the Trust more than once but a clearer picture would be

			been called into question and the risk of reputational damage has now been assessed as low. Actions were ongoing and the external service review document was expected imminently from which there would be some recommendations to be enacted. The Trust has now moved to bi-monthly system meetings on this matter and there had been an exec to exec discussion with commissioners to explore how the service would be delivered effectively and safely moving forwards. An internal meeting was to take place on 25 August to review the current position and a meeting had been held with Place who were satisfied with the actions taken by the Trust.	available by this time. After this update, it was agreed that the matter would become business as usual.
CQC Update Report			The Committee noted that no issues had been raised with the Trust by the CQC and no requests for information had been received or communications to raise any urgent matters with the Trust's relationship manager. The Trust's relationship with the CQC remained positive, supportive and transparent.	The Trust was in contact with the CQC in the event of any issues and was undertaking internal work concerning overarching preparation moving forward and would liaise with recently inspected similar Trust's to gain any learning or feedback.
Trust Improvement Plan Update	2, 3		The Assistant Director of Transformation presented the report to the Committee which set out that of the 28 current plans within the programme there were: seven plans demonstrating positive progress, with an increase in overall blue and/or green actions: six plans had no movement in overall status with some progress made, but not sufficient to adjust any progress indicators; one plan had demonstrated an increase in red rated indicators. 14 plans were still in development. An update was provided on two red rated areas: North West Driveability Service – accreditation was awaited after which appropriate premises would need to be identified for the service, with some locations in mind and; insulin aggregate review – the rating for this	The Committee noted the position with the improvement plans and approved a proposal for reconfiguration of reporting arrangements through the various Councils and those would be reported once per reporting cycle.

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			would be updated and improved following a district nursing handover standard operating procedure (SOP) being provided for evidence.	
Report from the Transformation Council - Terms of Reference			The Committee received the Terms of Reference and considered the content to ascertain if the Transformation Council should report to the Quality and Safety Committee, given its focussed approach around transformation. Committee members agreed that reporting could fit across a number of Committees due to the nature of the Council's work including finance and performance elements.	It was agreed that a further discussion would take place including the Committee Chair, Finance and Performance Committee Chair, the Chief Nurse and Deputy Chief Nurse, Jeanette Hogan to make a decision on the reporting route for the Transformation Council
Review of MIAA and Clinical Audits with Limited or Moderate Assurance			The Committee noted that there were no current audits to be reviewed.	
Strategies	2,3		No strategies presented this month.	
Committee Terms of Reference and Business Cycle			Discussions had taken place on the length of the Committee's meetings and the Committee Chair, Gail Briers had proposed that this be reviewed in six months time. It was proposed that a review could be undertaken of the information being received by Committees, ensuring a focus on assurance on key matters of business and areas of challenge. This would be timely recognising that the governance structure had matured with the robust embedding of the underpinning Councils, this presented an opportunity to consider business going through the Councils and what would be received by the Committees and refreshing the business cycles. It was suggested that there may be some good examples that the Trust could learn from via other organisations which would be taken forward by the Trust Secretary.	The length of meetings would be reviewed in January 2024.

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Committee Chair's Report

Board Assurance Framework (BAF) and New Board Assurance Framework	2,3,6		The Committee reviewed BAF2, 3 and 6 agreed a number of minor changes to BAF2, 3 and 6 with no changes to be made to the scorings. The Committee reviewed the new format of the BAF with updated strategic objectives. This would be implemented from the next Board meeting in October 2023.	
Items for Deep Dive	1, 2, 3, 6		The Committee agreed that it had not identified any areas requiring a deep dive report to a future meeting from the discussions and items on the agenda today. The Trust Secretary proposed that a criterion for future deep dives be established; that a subject must be scored as high on the risk register, be an emerging risk or have a compelling rationale to be brought to the Committee. This would ensure that the rationale for the requests for a deep dive was robust. This was agreed by the Committee. Non-Executive Director, Martyn Taylor advised that this would be raised with the Chair as this should be rolled out across all Committees.	
Items to be shared with the Board or other Committees	1		The Committee would ask the Board to approve the PSIRF policy and plan via e-governance following today's meeting.	This has now been approved by the Board and has been submitted to Cheshire and Merseyside ICB.
Review of meeting	1		All participants and observers were invited to comment on the meeting.	
Risks Escalated: **None from this meeting**				

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BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS		Date	05 October 2023
Agenda Item	**72/23(i)**			
Report Title	**FINANCE REPORT – MONTH 5 (AUGUST 2023) including update on NATIONAL COST COLLECTION (NCC)**			
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 five

- The Trust is reporting a breakeven position, in line with the plan.
- The Trust has a savings requirement of £5.15m (5.2%) in line with ICB instruction.
- The Trust is reporting a year-to-date achievement of £1.99m against a plan of £2.14m.
- Income is £41.17m for the year-to-date against a plan of £41.17m.
- Expenditure is £41.17m against a plan of £41.17m.
- Pay is £25.89m against a plan of £25.92m.
- Agency spend £2.61m against a plan of £2.56m.
- Non pay expenditure is £12.63m against a plan of £12.56m.
- Capital charges are £0.09m below plan.
- Capital expenditure is £0.29m at month five, planned spend is £0.28m.
- Cash is £19.18m.

The Board is requested to approve the plan to achieve the mandatory cost submissions for 2022/23

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	72/23(i)		
Report Title	FINANCE REPORT MONTH 5 (AUGUST 2023) including update on NATIONAL COST COLLECTION (NCC)		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the financial position as at Month Five To request the Board to approve the plan to achieve the mandatory cost submissions for 2022/23.		

1. SCOPE

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

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

1.2 The Board is requested to approve the plan to achieve the mandatory cost submissions for 2022/23.

2. FINANCIAL POSITION AS AT MONTH FIVE

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

2.2 The purpose of this paper is to update the Committee on the financial position of the Trust at the end of August 2023 (Month 05).

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

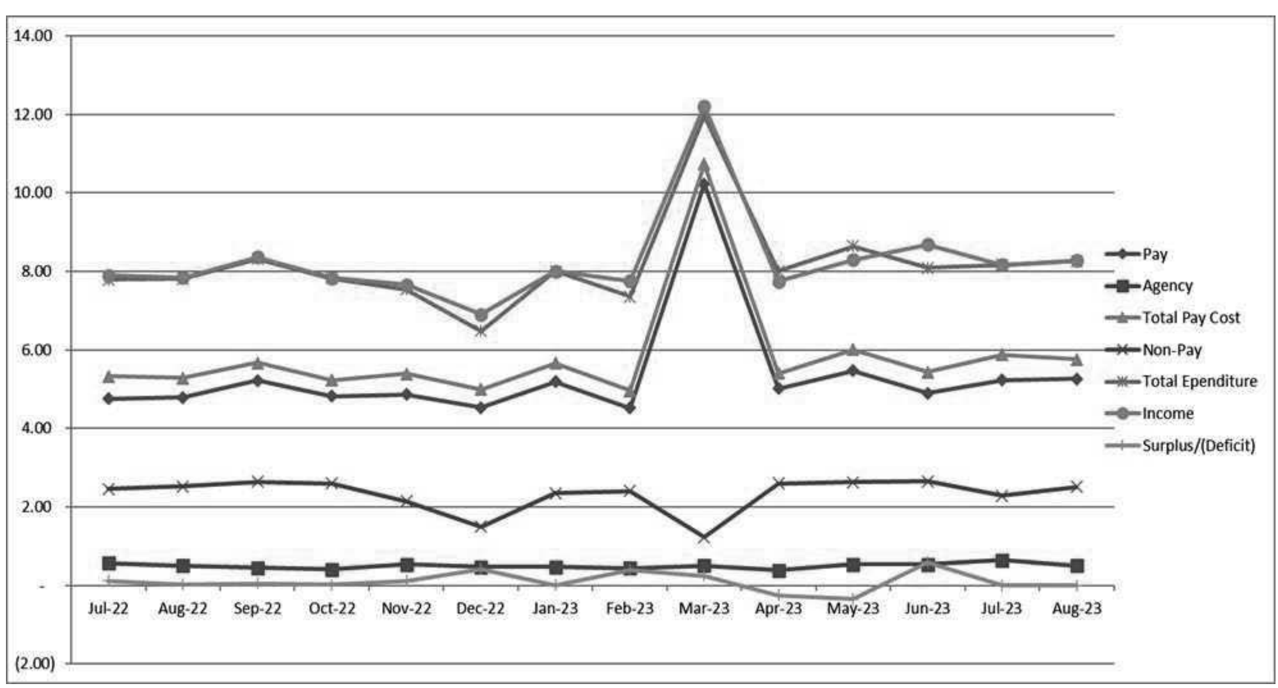
2.4 No change has been made to the overall breakeven planned position. All references in this report will be to the updated plan.

Table 1 – Summary of financial performance

Summary Performance Month 05 2023-24	Month 5 Plan (£M)	Month 5 Actual (£M)	Month 5 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(9.33)	(8.27)	△ (1.05)	(41.17)	(41.17)	● 0.01	(97.94)	(97.94)
Expenditure - Pay	4.70	5.26	△ (0.56)	25.92	25.89	● 0.03	64.15	64.15
Expenditure - Agency	1.16	0.50	● 0.66	2.56	2.61	△ (0.04)	4.22	4.22
Expenditure - Non Pay	3.53	2.47	● 1.07	12.56	12.63	△ (0.08)	29.26	29.26
EBITDA	0.06	(0.04)	● 0.10	(0.13)	(0.05)	△ (0.08)	(0.31)	(0.31)
Financing	(0.06)	0.04	△ (0.10)	0.13	0.04	● 0.09	0.55	0.33
Normalised (Surplus)/Deficit	0.00	(0.00)	● 0.00	(0.00)	(0.00)	● 0.00	0.31	0.31
Exceptional Costs	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.00	(0.00)	● 0.00	(0.00)	(0.00)	● 0.00	0.31	0.31
Other Adjustments	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.00	(0.00)	● 0.00	(0.00)	(0.00)	● 0.00	0.31	0.31
CIP	0.43	0.48	● 0.05	2.14	1.99	△ (0.15)	5.15	5.15
Capital	0.26	(0.01)	● 0.27	0.28	0.29	△ (0.01)	2.10	2.10
Cash	26.56	19.18	△ (7.39)	26.56	19.18	△ (7.39)	22.36	22.36
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

● Favourable Variance △ Adverse Variance

Table 2 - Rolling Run Rates 2022/23 to 2023/24



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

Income

- Income was below plan by £1.05m in month, due to the in month plan being increased to reflect the cumulative funding for the pay award.

Pay

- Pay costs are above plan by £0.56 in month five primarily due to the plan for pay being reduced to reflect current run rates and anticipated expenditure.

Agency

During month five, the Trust has incurred costs of £0.50m against the plan of £1.16m. This in month variance is due to the cumulative effect of the reprofiling of agency expenditure to reflect the significant planned reductions in the second half of the year.

The month-on-month expenditure has decreased by £0.15m. The full year plan and forecast remains at £4.22m. Each directorate has a recovery plan to achieve the plan position by year-end.

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

- Dermatology – locum consultants. This is activity driven and locum usage was front loaded to reduce waiters – the service now has no over 45 week waiters.
- Halton District Nursing – high cost off framework agency use and covering vacancies.
- Warrington Community Paediatrics – locum consultants. This is activity driven to prevent waiting lists from increasing and is partially funded by the ICB as part of the Neuro Developmental pathway.
- Intermediate Care Bed Based (Padgate House) – high cost off framework agency use.

The Director of Finance has met with all Directorate Leadership Teams (DLT) and corporate service budget managers to discuss individual service agency usage and reduction targets for all areas. Detailed agency reduction plans from all services currently utilising agency staff have been presented to EMT and will be monitored by them over the remainder of the year. Initial plans reduce the forecast full year spend by c£1m, with an additional reduction of £0.5m required to meet the planned agency spend.

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

EMT have instructed that all existing off framework agency usage is to be ceased from 1 September (ensuring clinical safety is maintained) with, in the absence of recruitment to existing vacancies, the utilisation of bank and on framework agency as the only short term solution. Working with operational staff, work is ongoing increasing the number of staff registered with and available on the Trust bank.

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

- Agency costs incurred in month five equated to 74.97 whole time equivalent staff.

Non Pay

During month five the Trust has spent £2.47m on non pay, £1.07m below plan. The in month underspend is driven by the cumulative effect of the plan reprofiling undertaken in month.

The underlying (adjusted for the cumulative reprofiling impact) overspend on non pay is largely due to:

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

These overspends are largely offset by additional income.

Financing Costs

- Additional interest received and an improved statement of financial position have contributed to reduced financing costs and a £0.09m variance favourable to plan.

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

3. COST IMPROVEMENT PROGRAMME (CIP)

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

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

3.3 This results in total savings for 2023/24 of £5.14m (5.2%) in line with ICB instruction, of which £1.50m is covered by working capital adjustments in year.

3.4 The Trust plan to month five is £2.14m, against which achievement of £1.99m is reported.

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

3.6 Further detail is provided in the table below:

CIP / Savings Analysis

Category	Scheme	Recurren	M5 £'000	Recurrent	Non recurrent
PAY	Vacancy Management - Childrens directorate	NR	224		224
PAY	Vacancy Management - Adults	NR	81		81
PAY	Vacancy Management - Dental	NR	57		57
PAY	Vacancy Management - Corporate	NR	125		125
PAY	Vacancy Management - IPC	NR	32		32
PAY	Vacancy Management - HR	R	10	10	
NON PAY	MMDA withdrawal scheme	R	25	25	
INCOME	Income generation - IPC Team for staff flu incentive	NR	5		5
INCOME	AQP Continence	R	101	101	
INCOME	Biologics	R	161	161	
PAY	Reduction in COVID spend - pay	R	87	87	
NON PAY	Reduction in COVID spend - non pay	R	23	23	
NON PAY	Reduction in COVID spend - non pay	R	142	142	
INCOME	Bank interest	NR	165	165	
PAY	Balance Sheet provision release	NR	355		355
INCOME	Income generation - Estates	NR	400		400
			1,993	**714**	**1,279**

4. SYSTEM IMPACT ON FINANCIAL OUT TURN & RISK

4.1 NHSE/I guidance expects systems to deliver a cumulative breakeven position at the end of the financial year. The Cheshire and Merseyside ICS currently has an underlying planned deficit. As at month 5, the ICS is reporting an adverse variance from plan of £50m.The ICS has requested recovery plans from all places, and individual providers reporting adverse variances from plan are subject to recovery meetings.

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

5.1 Total capital expenditure as at 31st August was £0.29m against a plan of £0.28m.

5.2 The proposed capital programme includes a contingency of £0.32m which consists of £0.10m general contingency and £0.22m for schemes which are either awaiting approval through the Trust's governance process or the capital prioritisation template has not yet been received. Should these schemes not progress then schemes on the reserve list will be deployed.

The prioritisation order for schemes is as follows:

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

5.3 Following approval from Trust Board, schemes are currently going through procurement and expected completion dates confirmed.

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

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

5.6 In August 2023 there was a net cash inflow of £1.14m with a closing cash balance of £19.18m. The inflow is primarily due to pay overs (Tax and NI) returning to normal levels following the increase seen in July 2023 associated with the backdated pay award for 2023/24.

5.7 Total debt as at 31st August is £8.68m excluding bad debt and credit note provisions, of which £5.75m relates to invoiced debt. Overall debt has increased by £0.28m from July and overdue debt has decreased by £1.60m. The primary reason for the reduction in overdue debt is that, to facilitate payment and at the request of St Helens Council, all pre 22/23 invoices were cancelled and re-raised at the contract value in August 2023.

5.8 Total trade and other payables as at 31st August are £9.84m, of which £5.92m relates to creditors.

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

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

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

5.11 NHSE continues to focus on BPPC performance relating to the value of non-NHS invoices paid within terms in the coming months. The Trust has improved approval and payment times.

6. NATIONAL COST COLLECTION (NCC)

6.1 The Board is asked to review the high level costing plan provided to ensure that it meets the expected requirements noted in the Approved Costing Guidance.

6.2 The data collected is the source data for work by the Model Health System (this was previously the Model Hospital). Therefore, the Board assurance process has been reflected to update the importance of cost submissions and raise the profile of costing across the organisation, especially at a senior level.

6.3 For 2022/23 the Trust will be submitting one collection only - namely a patient level submission for the majority of services, with an aggregate data feed for items which cannot be submitted at patient level.

6.4 The Approved Costing Guidance published by NHS England requires an increased level of board assurance. The Guidance includes the costing principles, healthcare costing standards for England and a range of tools to support the costing process.

6.5 This is the first of two reports being taken to the Finance and Performance Committee on the process for producing the National Cost Collection (NCC) required under the NHS Provider Licence.

6.6 The second report will update the committee on the progress, issues which will be addressed before the final submission and any areas where the trust is still working to implement the costing standards required under patient level costing. This is likely to be issued via e governance due to submission timings.

6.7 As a result of issues experienced nationally, there have been some delays to the National Cost Collection.

6.8 The collection window now opens on 16th October 2023 and remains open until 3rd November 2023. During this time trusts may make multiple submissions and make use of the collection tools to assess data quality.

6.9 Between the 6th to 9th November 2023 is the named day submission period. During this time there will be dedicated support for each cohort on their named day. On this day, each trust must make their final submission of data and board reports if they haven't already done so in the previous three week window. For North West trusts the named day is 6th November 2023.

6.10 Between the 13th to 24th November 2023 is the data quality checking window. During this time NHS England will assure the quality of the data submitted by all trusts and, where appropriate, contact trusts to arrange a re-submission. NHS England will aim to make re-submission decisions quickly during this time to allow trusts to plan their re-submission date. Trusts can also use this time to check the quality of their own data using the analytical tools and, where appropriate, contact NHS England to request a re-submission.

6.11 The final resubmission window is from 27th November through to 1st December 2023. During this time, any trusts identified as requiring a re-submission during the data quality checking window will be scheduled in to make their resubmission.

6.12 The high level plan (Appendix 1) is sufficient to meet the requirements to produce the required costing submission by the deadline date. This includes:

- Senior review and sign off to ensure the return has been prepared in accordance with the Approved Costing Guidance.

- Processes to validate the activity and costing data with services

- The finance and information teams involved in the submission are sufficiently resourced to produce and validate the submissions with the planned timeline.

7. RECOMMENDATIONS

7.1 The Board is asked to:

- Note the contents of this report.
- Note the financial position.
- Approve the process in place as sufficient to provide assurance to the Board on the plan to complete the mandated costing submissions for 2022/23 2023/24.

Appendices

1. High Level Costing Plan

Appendix 1 – High Level Costing Plan

Quantum reconciliation – (this can only be completed once Annual Accounts have been fully audited and submitted (post 28th June 2023))

This is partially completed with any final adjustments to be made to the quantum to reflect excluded services

Direct costs and overheads allocated in accordance with the costing standards

Clinical income applied in accordance with the guidance

Activity - Validation and Reconciliation

Outstanding mandatory validations addressed and corrected

Non mandatory validations reviewed and verified:

- Any required adjustments validated with services

Data run through the **Data Validation Tool (DVT)** and any issues addressed

Submission window

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS		Date	05 October 2023
Agenda Item	72/23ii			
Report Title	GREEN PLAN			
Executive Lead	Nick Gallagher, Director of Finance			
Report Author	John Morris, Deputy Director Estates			
Presented by	John Morris, Deputy Director Estates			
Action Required	☐ To Approve	☐ To Assure	☒ To Note	

Executive Summary

To update the Board in respect of the progress made in delivering the Green Action Plan.

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	☐ BAF 8
Failure to implement and maintain sound systems of corporate governance	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	72/23ii		
Report Title	GREEN PLAN		
Report Author	John Morris, Deputy Director Estates		
Purpose	To update the Board in respect of the Green Action Plan.		

1. SCOPE

1.1 The NHS launched the NHS "journey to net zero" document in 2021. This committed the NHS to achieving a net zero carbon footprint by 2045, in line with government commitments to the Greenhouse Gas Protocol (GHGP).

1.2 The scope of the challenge for the NHS is:

- GHGP scope 1: Direct emissions from owned or directly controlled sources, on site. Applicable to fossil fuels, NHS facilities, NHS Fleet and lease vehicles.
- GHGP scope 2: Indirect emissions from the generation of purchased energy, mostly electricity.
- GHGP scope 3: All other direct emissions that occur in producing and transporting goods and services, including the full supply chain. Applicable to medical devices, staff commuting, waste management, business travel and water usage.

1.3 All NHS organisations were mandated to produce a board approved 3-year Green Action Plan and this document was approved by the Board in December 2021.

2. PURPOSE

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

- The Trust's carbon footprint and the journey to net zero.
- An update on the action plans contained within the document and next steps.

3. BACKGROUND AND DESCRIPTION OF THE ISSUE

3.1 Since the publication of the NHS "Journey to net zero" document the commitments contained within it have now been embedded in legislation via the 2022 Health and Social Care Act.

3.2 Consequently the NHS standard contract has been updated and the 23/24 contract under service condition 18 "Green NHS and Sustainability has the following requirements for Trusts to action:

- Minimise adverse impact and deliver the commitments set out in delivering a net zero NHS
- Maintain and deliver a Green Plan, providing annual updates to the ICB and via the organisation’s annual report.
- Have plans with regard to air pollution, phasing out fossil fuels, promote sustainable travel choices, promote electric vehicles and develop a electric charging infrastructure.
- Have plans with regard to climate change e.g., reduce greenhouse gas emissions from premises, reduce impact from the use of nitrous oxide (dental), premises adaptations to reduce risks associated with climate change and severe weather.
- Have plans to reduce waste and single use plastic products e.g., reduce waste and water usage, reduce single plastic products and maximise rate of return of walking aids.
- Procured electricity is generated from renewable sources.
- Comply with the requirements of the NHS net zero supplier roadmap and consideration to secure wider social, economic, and environmental benefits for the local community (anchor institution).

4. OUTCOME

4.1 The Trust, halfway through the timeline of its Green Action Plan, continues to invest resource to meet the commitments referenced above and regular updates have been reported to Finance and Performance Committee. There have been numerous schemes embedded into business processes, cultural changes, asset management, health and well-being commitments, supplier engagement etc and these have been supported, not only by national strategic documents, but also internal resource investment including additional capital and revenue funding. The outcome of the timeline is represented in the table below, which reports a strategic snapshot of the Trusts carbon dashboard.

Source		2019/20	2020/21	2021/22
		CO_2 tn	CO_2 tn	CO_2 tn
Clinical Waste		9.56	11.84	9.50
Electricity (contract)		67.89	69.67	0.00
Gas (contract)		126.33	104.07	82.08
Fleet Fuel*		66.86	66.89	77.44
Business Travel*		471.56	278.96	304.66
Total Emissions		**742.20**	**531.45**	**473.68**

*(The data calculation has been consistent across the timeline and assumes an average rate of reimbursement per mile, an average mpg etc)

4.2 The Trust, on a like for like basis, has achieved significant improvements in its carbon footprint, reducing its calculated emissions by a third over the timeline. Work continues, , to improve these numbers further, cognisant of both the timeline and national strategic direction in terms of achieving a net zero position.

5. NEXT STEPS

5.1 The Green Action Plan will be reviewed, and an updated/amended plan will be presented to the Board.

5.2 Actions will continue to be progressed, in line with current "Green" strategic objectives namely :

- The carbon dashboard and associated data sources will continue to be developed with an expectation to develop front end management reporting.
- Work-streams developed with suppliers e.g., waste management processes, digital technology and the wider supply chain.
- Investment in estates and facilities management structure and infrastructure.
- Health and Well being opportunities via POD council.

6. RECOMMENDATION

6.1 The Board is asked to receive this report.

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	72/23iii		
Report Title	RAAC CONCRETE ISSUES		
Executive Lead	Nick Gallagher, Director of Finance		
Report Author	John Morris, Deputy Director Estates / EPRR		
Presented by	John Morris, Deputy Director Estates / EPRR		
Action Required	☐ To Approve	☒ To Assure	☐ To Note

Executive Summary

To inform the Board in respect of the Trust estate and the potential presence of RAAC (reinforced aerated autoclave concrete).

Previously considered by:

☐ **Audit Committee**

☒ **Finance & Performance Committee**

☐ **People Committee**

☐ **Quality & Safety Committee**

☐ **Remuneration & Nominations 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	☐ BAF 8
Failure to implement and maintain sound systems of corporate governance	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	000/23		
Report Title	RAAC CONCRETE ISSUES		
Report Author	John Morris, Deputy Director Estates / EPRR		
Purpose	To inform the Board in respect of the Trust estate and the potential presence of RAAC (reinforced aerated autoclave concrete).		

1. SCOPE

1.1 Recent media coverage has highlighted building risk in public sector organisations where the presence of RAAC has been identified in buildings. This method of construction has been found to have inherent failure defects, potentially increasing the risk of collapse in buildings.

1.2 NHSE has previously communicated to NHS organisations in late 2019, seeking assessments in respect of the NHS Trust estate.

1.3 Following recent incidents in the education sector, NHSE have again written to all NHS organisations, including primary care, seeking further assurances regarding the presence of RAAC and/or the assurances in place to mitigate any risk.

2. PURPOSE

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

- Whether the Trust estate has RAAC present.
- The resultant action plans.

3. BACKGROUND AND DESCRIPTION OF THE ISSUE

3.1 In November 2019, the Trust received national communication from NHS Estates about RAAC outlining the potential risk to sites where RAAC construction methods had previously been used. This communication asked for Trusts to review their estate and highlight any concerns as part of this national data collection exercise.

3.2 The Trust engaged EWFM to survey its freehold sites and directly managed sites.

3.3 No RAAC was found to be present, and the Trust's Finance and Performance Committee was updated in early 2020.

3.4 In August 2023, following several incidents, primarily in the education sector, NHS Estates re-issued their guidance, seeking confirmation from all NHS organisations, including primary care, that all appropriate buildings had been risk assessed.

4. OUTCOME

4.1 The Trust has received confirmation from Community Health Partnerships and NHS Property Services that none of the buildings that the Trust occupies, contain RAAC.

4.2 The Trust has re-engaged EWFM to survey our freehold properties, to provide an updated level of documented assurance.

4.3 The Trust has contacted all other landlords, primarily primary care landlords, seeking assurances in line with the national documentation. It is noted that primary care have only recently been asked to survey their property and results are not yet known across a number of properties, albeit given the nature and age of the buildings, they are considered to be low risk based on the known building characteristics where RAAC has been found in other sectors.

5. NEXT STEPS

5.1 The remaining landlords will be approached to confirm the outcome of the individual surveys. An appropriate risk assessment will be entered on Ulysses.

5.2 A final position statement will be presented to Finance and Performance Committee.

6. RECOMMENDATION

6.1 The Board is asked to receive this report.

Committee Chair's Report

Name of Committee/Group:	Finance and Performance Committee		**Report to:**	Board of Directors
Date of Meeting:	21 September 2023		Date of next meeting:	23 October 2023
Chair:	Tina Wilkins		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Lynda R to add	**In Attendance & Observers:** Lynda R to add	**Key Members not present**:	**Apologies received from:** Lynda R to add

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
CIP Chair's Report			The Committee received the chair's report.	The Committee note that a significant amount of work is underway to identify potential recurrent savings and these will then need to go through the quality impact assessment to validate.
CIP Deep Dive			The Committee received the report and the presentation.	The Committee noted that the deep dive clearly highlighted the potential limitations to short term CIP delivery rather than a focus on longer term transformation. A short term approach to planning and budget setting is impacting on the ability to plan for transformation. The Committee noted that now recurrent and non recurrent plans had been identified to achieve the £5.1m CIP, the request to EMT was to have a discussion around now moving to transformational plans. The Committee discussed how transformation and longer term planning would come together given the focus on

	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

				annual plan currently. In order to deliver the transformation programme capacity needs to be created to start to review current contracts including review of capacity and demand management. The Committee discussed where Transformation Council sits - currently sits in Quality however whether this would be used to drive resource allocation and help us to manage our resources more effectively.
Finance	4		Month 5 finance report received and provided assurance. The Committee noted that: • Month 5 23/24 is breakeven and on plan • CIP remains behind plan • BPPC has dipped slightly – internal review underway • Healthy cash position, reduction in month but expected to increase again in coming months as income received back from ICS • Capital programme approved by Board and procurement now underway.	The Committee noted the financial position is on plan and that the plan had been reprofiled to take account of the additional funding for the pay award. This has had a knock on impact on cumulative spend compared to plan, run rates remain consistent. The Committee noted that CIP identified remains behind plan, although performance to date has improved. The Committee noted agency spend. The top four spend areas remain the same. The Committee noted the actions taken to date and planned. The Committee requested the high level agency plan that had been discussed at EMT to be circulated to the Committee. The Committee noted the capital position. The Committee recommended the financial report to the Board.

Committee Chair's Report

Finance	4		Annual Budget Setting Principles	The Committee noted the report and the inclusion of DLTs into the approval and sign off process.
	4		Charitable Funds Report	The Committee noted the report. The SLA is in process and the ability for potential additional services such as access to a fundraiser.
	4		National Cost Collection	The Committee noted the report and the submission deadlines. The Committee recommended the plan to the Board for approval.
	4		Service Line Reporting	The Committee noted the report. A more detailed report will be brought back to the Committee following submission of the National Cost Collection.
	4		Procurement Report	The Committee noted the report. Procurement is working hard to offset cost pressures and inflation.
Performance	4,8		IQPR New Indicators	A paper was presented that detailed the indicators currently in development for the new IQPR. The new indicators would feed through into September data for reporting at November's Committee. Further updates to be provided at future committee meetings.
Performance	4,8		IQPR for month 4 was received by the Committee.	The Committee noted the report. All the cancer targets are reporting green in month based on the June cancer performance. There is one new red indicator relating to referrals to plan which has been impacted by school holidays.

	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

				The 18-week RTT has deteriorated from 69% to 65% and this is due to an increase in dermatology and community paediatrics in Halton and Warrington. From a quality perspective, all the training indicators are reporting as green. There is one new red indicator in relation to duty of candour but the incident which breached was stepped down and not found to be a duty of candour. From a people perspective, there are small increases in turnover and actual sickness absence. PDRs are now reporting as green. From a finance perspective, a breakeven position is reported with a gap in CIP delivery and agency spend is above plan at £2.11m versus a plan of £1.41m.
Performance	4,8		The Chair's report from Performance Council for month 04 was received.	The Committee noted the report.
Performance	4,8		Drive Ability North West	The Committee received an update report detailing the process and progress to date in developing a financial sustainable model. The Committee requested that the detailed financial information that had been discussed at EMT be circulated.

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Committee Chair's Report

Digital	8		Chair's report from DIGIT	The Committee received the report. The Committee noted the change in the risk ratings relating to the privacy officer role.
Estates	4		No update this month	
Audit	4		MIAA and KPMG Audit recommendations	The Committee noted the report.
Risks	4		Risk paper	The Committee noted the report and the new risks added to the risk register.
BAF	4,7,8		BAF 4 BAF 7 BAF 8	The Committee requested that the narrative in the gap in control section of BAF 4 be reviewed and updated and split out agency and CIP. Risk rating unchanged No changes identified. Risk rating unchanged Risk rating increased to 12 (4*3) as a result of the increased risks highlighted in the DIGIT and risk report.
BAF			Review of new BAF	A meeting had previously taken place across People and Finance and Performance Committee members. This will be further reviewed at Board.
Governance	4,7,8		Review of meeting	It was recognised that 'the meeting was interesting and detailed and the level of scrutiny and discussion was impressive'.

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Committee Chair's Report

Risks Escalated: None from the meeting **Actions delegated to other Committees: EMT to discuss transformation and CIP prior to a discussion at Board** **Nothing delegated**				

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BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	5th October 2023
Agenda Item	73/23		
Report Title	INTEGRATION & COLLABORATION		
Executive Lead	Colin Scales – Chief Executive Officer		
Report Author	Rob Foster – Programme Director Collaboration and Integration Sarah Brennan – Chief Operating Officer		
Presented by	Rob Foster – Programme Director Collaboration and Integration		
Action Required	☐ To Approve	☐ To Assure	☒ To Note

Executive Summary
The purpose of this report is to provide insight and oversight to the Board about the progress with integration and collaboration development and opportunities across the Trust.

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

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

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

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	5th October 2023
Agenda Item	73/23		
Report Title	INTERGRATION & COLLABORATION		
Report Author	Rob Foster – Programme Director Collaboration and Integration		
Purpose	The purpose of this report is to provide insight and oversight to the Board about the progress with integration and collaboration development and opportunities across the Trust.		

1. Introduction

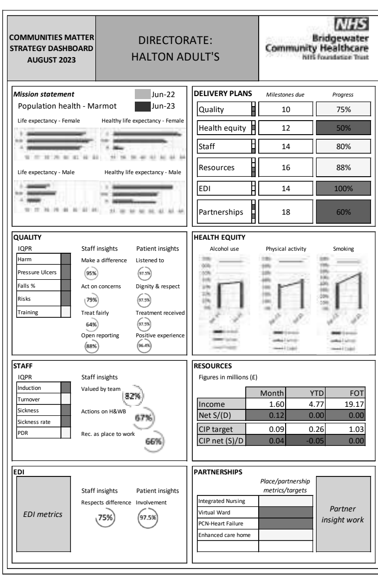
1.1 The purpose of this report is to present an update on progress with, and delivery of the Trust's Community Matters strategy (2023-2026).

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

2. Measuring and monitoring our new strategy

2.1 A first draft of the new strategy Performance Dashboard has been developed and is being used to discuss and shape the appropriate metrics to effectively monitor the strategy.

2.2 As previously reported, the dashboard has been designed to align with the current and emerging Performance Assurance Framework and Integrated Quality & Performance Report (IQPR), but with a clear focus on progress against our mission statement, objectives, workstreams and milestones, with individual Directorate and an overall Trust view.



2.3 The dashboard is divided into 8 sections:

- Population Health indicators – Marmot Beacon indicators (aligned to place)
- Delivery plan progress, split by objective
- 6 * Objective indicators, aligned to the IQPR, staff insights and patient insights.

2.4 All metrics are currently captured (albeit at different frequencies) and reported/used in different fora. However, the aim of this dashboard is to present a holistic view, by Directorate. It is acknowledged that the dashboard metrics will evolve.

3. Delivery focus

3.1 As previously reported, our Directorates have developed delivery plans and are working internally with their teams, and externally with partners, to develop and deliver a range of schemes. These schemes are governed throughout the Directorate Leadership Teams, our councils and partnership groups/committees. Progress highlights for this report include:

Children

- Mobilisation of the new Warrington 0-19(25) year old service specification, with partners, and improve outcomes and experiences for local children and young people.
- To continue to embed and develop our focus on the Voice of the Child, ensuring that the lived experiences and voices of all children and young people are heard, understood and advocated from every contact to improve their lifelong outcomes. Our Voice of the Child forum is setting up a lived experience panel for children's services. This will involve young people, their parents/carers, and staff from different children's services.
- Developing a suite of strategies and materials to aid communication for and with, young people, and their parents and carers who access our neurodevelopmental diagnostic assessment pathway.
- Continue to engage and co-produce new service models and partnerships in the Halton Family Hubs, with the Kingsway Family Hub in Widnes now live. Our services continue to take leadership roles across the partnership in relation to the development of perinatal and infant mental health, and infant feeding pathways.

Dental

- The introduction of an IV sedation pathway into Greater Manchester, to provide an additional adjunct treatment.
- The dental Directorate have also implemented the Clinical Leadership Model to provide clinical specialists across the network, who will provide additional specialist clinical leadership and senior operational management capacity.
- The relocation to the Altrincham Hub continues to be driven forward, bringing services into a newly refurbished singular clinic site.
- The service has commissioned and is now in the implementation/mobilisation phase of the newly procured Singular Patient Administration System (PAS)/Clinical System for the Dental Network.

Warrington adults

- The Directorate continue to develop and deliver the Warrington One Front Door project as part of a collaborative approach, to help those contacting local

services get to the best outcome in the timeliest manner. This has now gone live, with the Urgent Community Response team (UCR) the first team to roll out.

- Implementation of the Virtual Wards which will support patients who would otherwise be in hospital, to receive the care they need in their own home, through the onboarding and induction of VW staff into our teams.
- Ongoing roll out and expansion of the Dermatology Advice & Guidance (A&G) service in primary care to all 26 practices.
- Implementation of Electronic Patient Record (EPR) across Padgate House, further developing our intermediate care bed-based service

Halton adults

- A new community nursing model is in development, with engagement sessions with staff underway to co-design the approach.
- Working in partnership with Widnes Primary Care Network and other providers, our Heart Failure service have developed an enhanced Heart Failure pathway, designed to improve care and outcomes. The project has also involved accessing training for our staff, with MDT working the next area of focus for the team.
- As in Warrington, our Halton team have worked in partnership to implement a new Virtual Ward, which will support patients who would otherwise be in hospital.

Cross cutting

We are also delighted to have appointed our first two voluntary sector link workers, employed by the local Voluntary sector, designed to create seamless links and partnerships between Bridgewater services and the plethora of voluntary services, for patients and families. The staff commenced with the organisation last month.

4. Public & community engagement

4.1 As previously reported, to oversee and deliver the public and community engagement component of our strategy, we have set up a Communities Matter patient engagement group. This includes representation from our public governors, Non-Executive Directors and internal teams.

4.2 Discussions have also taken place with the local Healthwatch organisations, and local place-based colleagues to provide external and independent input, involvement and challenge. These conversations have been positive and continue.

4.3 The group have developed an action plan and are reporting progress into the Bridgewater Engagement Group (BEG), with discussions on-going to ensure the appropriate governance and monitoring arrangement are established for the group.

4.4 As part of the action plan, continued and expanded public and community engagement is a key focus, as are discussions with place-based colleagues about an integrated approach moving forward.

5. Partnerships

5.1 **Halton place**

- The Halton ICB team now have secured Programme Management Office (PMO) support (via NHS Midland and Lancashire Commissioning Support Unit (CSU)). This critical resource will provide a combination of delivery support to the priority themes (Starting Well, Living Well, Aging Well) and enablers, and assurance to the Board of programme set up and delivery. It should also enable an acceleration of the progress of the various schemes within the 'Wells' programme.
- A partnership workshop has been set up to progress the Integrated Neighbourhood Teams project, which is cross-cutting across the 3 'Wells' programmes. The PMO resource is a key enabler in now driving this forward.

5.2 **Warrington together**

- The new Communities Matter strategy was presented to the Warrington Health & Wellbeing Board in September and was well received.
- The approach to the recruitment of the independent chair of the Warrington Together Partnership Board is being reviewed and considered, after the first process did not result in a successful appointment.

5.3 **Provider Collaborative (PC)**

- The PC PMO has developed a monitoring and control strategy for the provider collaborative that describes the approach to managing and governing the 6 workstreams, within the newly set up governance infrastructure.
- The Integrated Care Board (ICB) have now formally asked the provider collaborative to adopt the virtual ward programme and manage this going forward.
- A mental health escalation framework has been developed that will provide visibility of MH pressures in the system that impacting on access and quality of care for patients. This framework will provide a clear route of escalation for MH delays as they arise.
- There is a workshop on the 18th October for Chairs and NED representatives from the 9 member organisations in the collaborative to discuss the work of the collaborative and focus on how we can ensure we benefit from NED involvement and experience from other sectors. This workshop will update on the work done so far but also the longer-term opportunities of the collaborative.
- The provider collaborative workstream looking at improving access to care for Children & Young People (CYP) is to be officially launched on the 9th October, chaired by Louise Shephard (CEO, Alder Hey). This will allow us to agree what the focus should be for the collaborative in the complex arena of improving CYP services.

6. RECOMMENDATIONS

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

Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	13 September 2023	Date of next meeting:	15 November 2023
Chair:	Abdul Siddique, Non-Executive Director	Parent Committee:	Board of Directors
Members present/attendees:	Members Abdul Hafeez Siddique, Non-Executive Director (Chair) Paula Woods, Director of People & Organisational Development (Lead Exec) Tina Wilkins, Non-Executive Director Linda Chivers, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director Sarah Brennan, Chief Operating Officer Dr Ted Adams, Medical Director In attendance Jo Waldron, Deputy Director of People and Organisational Development Mike Baker, Deputy Director of Communications and Engagement Tania Strong, Interim Head of Human Resources Kathryn Sharkey, Head of Workforce Adie Richards, Education and Professional Development Lead Ruth Besford, Equality and Inclusion Manager Jeanette Hogan, Deputy Chief Nurse, attending on behalf of Lynne Carter, Chief Nurse Jan McCartney, Trust Secretary Helen Young, Freedom to Speak Up Guardian Katherine Summers, Infection Prevention and Control Lead Nurse, joined part-way through the meeting Carl Dixon, Head of Leadership and Organisational Development Heather Roughley, Unison Bridgewater Branch Chair and Health & Safety Officer, attending on behalf of Denise Bradley	Quorate (Yes/No): Key Members not present:	Yes Member: Lynne Carter, Deputy Chief Executive and Chief Nurse Attendee: Helen Hollett, Head of Leadership and Organisational Development Attendee: Denise Bradley, Unison Bridgewater Branch Secretary and Staff Side Chair Observer: Rachel Game, Governor Observer

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	Nicola Handford, Adult Immunisation and IPC nurse, **Observers** Sarah Power, Governor Observer, joined part way through the meeting		

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
RISK REPORT UPDATES • **HR** • **OD/EPD** • **COMMUNICATION**	BAF 5 and 6		The Risk Reports for HR, OD/EPD and Communications were tabled for information and assurance purposes. The detail and discussions relating to the risks as presented, are addressed in more detail at the Trust's Risk Management Council (RMC). **HR Risk Report** During the reporting period there are a total of 2 Risks on the HR Risk Register in the reporting period, one of which was scored at a level of 12 as at 3rd of July 2023. **Risk No: 3059 - Ongoing Industrial/Strike Action** linked to National Pay award. Score of 12 at the time of reporting to Risk Management Council **Risk No: 1491 - Staff health and wellbeing:** risk of poor levels of staff wellbeing, presenteeism, and failure to meet the Trust's sickness absence target of 4.8% (noting pending update to 5.5%) - score of 6 at the time of reporting. In relation to risk 3059, strike dates have been confirmed as follows: **BMA Consultant Members: 7am on 19th – 7am on 21st September 2023.**	The Committee noted the content of the reports and were assured that the risks were being managed appropriately.

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Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			BMA Junior Doctors Members: 7am on 20th – 7am on 23rd September 2023. **BMA Consultant *and* Junior Doctors Members: 7am on 2nd October – 7am on 5th October 2023.** We'll operate at Christmas Day levels of service. We have consultants across Paediatrics, Audiology and Palliative care. Although we do not directly employ Junior Doctors, we do have a small number placed with us via the Lead Employer. The Industrial Action Planning group has been reestablished to evaluate the impact on the Trust and plans are in place. There are no intentions to submit derogations. Risk ID 3059 has subsequently been reduced to a score of 9 following recent strikes held by the BMA (Consultants and Junior Doctors) and review of the current and ongoing impact. Our Consultant numbers are small and the majority of Consultants have confirmed their intent to meet their booked appointments. The risk is dynamic and will continue to be monitored, along with any wider system issues and how they impact upon the delivery of services within the Trust for the forthcoming dates of industrial action. In relation to risk 1491: Under review and content has been circulated to the POD Council on the 23rd August for comment and engagement from operations and will subsequently be updated once feedback has been received.	

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Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

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			Abdul Siddique, Committee Chair asked what the Trust is doing to prepare for winter in terms of staff wellbeing. The Chief Operating Officer updated on the internal and systems approach to Winter Planning with regular internal Operational calls to assess absence levels which then feed into Systems calls. Sickness monitoring takes place daily and wellbeing support offered to staff at this time is focussed on seasonal issues such as the vaccination programmes and reminder around Infection Prevention Control. **Educational and Professional Development (EPD) and Organisational Development (OD) Risk Report** During the reporting period there is 1 risk detailed on the EPD and OD Risk Register: • Reduction in Mandatory Training compliance as a consequence of the pandemic response – current risk score of 9. It was recognised by the RMC that areas of low compliance within individual services should be recognised and managed locally. It was agreed that service specific risks should logged and assessed to address these areas as required. By way of providing the most up to date information to the Committee it was verbally noted that discussions had taken place at POD Council on 23rd August in relation to the potential additional risk around lack of forward planning. Messages have been sent throughout the organisation to remind managers and staff of their responsibility to forward	

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			plan mandatory training attendance, to avoid the Trust being in a similar situation next year with high numbers of staff becoming non-compliant during the summer of 2024. Discussions will take place at Risk Management Council in September to discuss the proposal for an additional risk. **Communications Risk Report** During the reporting period there is 1 risk detailed on the Communications Risk Register: • Bridgewater staff intranet – continuity of service The scoring of this risk has changed and has now lowered in severity. What was a score of 9 (high risk), is now a score of 6 (moderate risk). This reduction follows further assurance to the Communications and Engagement Team as the forthcoming extranet project develops. It is anticipated the risk score of 9 will fall further as completion nears for the project (late summer/early autumn 2023).	
IQPR – PEOPLE INDICATORS	BAF 5 and 6 WLR 9 PP 1-7		The 5 IQPR people indicators were presented to the Committee for month 8. Four of the five People Indicators were reporting as red – the exception being Induction which is reporting green – however all indicators had improved month on month with the exception of Actual Absence, which isn't uncommon for this time of year.	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings. A piece of work around workload management is to come to the next Committee, including a Case Study - to be

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Committee Chair's Report

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			Detailed reports in relation to Sickness and Statutory and Mandatory Training and PPDR rates were presented later in the agenda; however by way of providing the most up to date information to the Committee it was noted that PPDR compliance in Month 4 is at 91% and therefore will report green in month 4. Turnover has decreased since January 2023. Turnover presented in the IQPR since March 2023 now excludes turnover as a result of a large TUPE transfer in March 22 and has continued to decrease month on month to 12.07% in June 23 (Month 3). The Recruitment and Retention Pod actions are focusing on retention, recruitment, and workforce planning strategies including identifying areas of the new national retention toolkit that can support existing strategies, best practice, and resources to help NHS Trusts recruit and retain staff. Turnover data is provided to Borough leads each month to ensure that local plans can be put into place to address and improve retention. The report highlights the themes from Onboarding Surveys and Exit Interviews. It was noted that the target review that had recently been approved at Board would help to make the targets more achievable across the Trust.	included in the Staffing System Implementation Update Report in relation to the CNSST.

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
DIRECTOR'S UPDATE REPORT	BAF 5 and 6 WLR as highlighted in the report PP as highlighted in the report		The Director's Update Report was presented by Paula Woods, Director of People and OD, for information and assurance purposes. The following areas were highlighted to the Committee by Paula Woods, paying attention to any developments since the writing of the report by way of verbal updates and avoiding duplication in items delivered earlier or later in the agenda: The Director's update report additionally tabled the following: • Verdict in the Trial of Lucy Letby – Letter from Amanda Pritchard, CEO NHS England • Kark Review and Recommendations – Fit & Proper Persons Test (F&PPT) • Industrial Action Update – Consultants and Junior Doctors • NHS Long Term Workforce Plan (LTWP) • Chair and Non-Executive Director Salaries • Very Senior Manager (VSM) Framework and Pay Award • HSJ Awards 2023 – Shortlisted for Primary and Community Care Provider of the Year • The NHS Leaders' Wellbeing Programme – 3 Trust Nominations • National Preceptorship Interim Quality Mark Award (IQM) – Application Progress Update • NHS EDI Improvement Plan	The Committee noted the report and its comprehensive contents. Going forwards the work programmes will be highlighted by way of any challenges and impact assessments. The extensive people agendas and positive outcomes were noted.

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Committee Chair's Report

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			• The ESR Transformation Programme North West Team • Care Leavers Covenant (CLC) – Sign Up (including an update in the local section of the report) • Workplace Charter – Gambling Harm Sign Up • North West Wellbeing Policy Pledge – Early Adopter Update • CMAST and MHLDC Provider Collaboratives – Cheshire & Merseyside Workforce Groups • Efficiencies at Scale • North West Anti-racist Framework Update • Our Just Culture Journey – Community of Practice • Warrington Together Workforce & OD Enabling Group Update (WEG) • People Operational Delivery Council – Amalgamation of our 4 PODs • IQPR – People Indicators: Rates and Trust Targets • The Cheshire & Warrington Pledge and Bridgewater Partnership Working – Young People Opportunities • Staff Race Inclusion Network (RIN) Update • People Directorate Away Day – 14th September 2023 • Reciprocal Mentoring for Inclusion (FMfI) Programme – Midway Milestone • Health & Wellbeing Fortnight – 9th to 20th of October Dame Elaine Inglesby noted and commended the extensive work taking place across the People Directorate and enquired about the challenges this presented as well as the positive	

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Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

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			outcomes and impact. Paula Woods, Director of People and OD agreed to acknowledge this in her future reports. Jo Waldron, Deputy Director of People and OD highlighted that we are very much led by what our data is telling us, as there is a risk that we would try to tackle too much at once and achieve little. The work being overseen at the POD Council is very much led by what the data is telling us in terms of People and the regular report to the Committee will help to assure the group of the work taking place.	
REVIEW OF STAFF SICKNESS AGAINST TRUST TARGET OF 4.8%	BAF 5 and 6 WLR 8 PP 4		The Review of Sickness Absence against Trust Target report was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes. Trust sickness absence for the period 01 August 2022 to 31 July 2023 was 5.65% compared to the same period last year at 7.05%. The Trust sickness absence target is 4.8%. The Trust Target has been agreed to increase to 5.5% from the 1st of August 2023. This will be reflected in future reporting. Rolling absence has seen a month on month decrease since March 23 (6.30%) to 5.65% in July 2023. Actual absence has increased slightly in July 2023 which isn't uncommon for this time of year. As per the request at the last Committee, top reasons for absence by Directorate were presented. It was noted by the Committee that the top reason for absence across all Directorates was Stress/Anxiety/Depression and the feeling that we maybe need to do more targeted work around this.	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied.

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Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

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			The Committee were updated on the Stress Task and Finish Group which reports to POD, along with the work of the Wellbeing team offering targeted work in services where stress is a key concern. The regular POD report presented to the Committee gives a holistic overview of the work taking place to address the national issue around stress related absence. Overall support and programmes of work in relation to absence were presented to the Committee.	
EMPLOYEE RELATIONS REPORT	BAF 5 and 6 PP 3		The Employee Relations Report was presented by Tania Strong, Interim Head of HR for information and assurance on the management of employee relations cases. This report: • Detailed the employee relations activity and across the Trust at a high level including any potential higher risk situations including suspensions, employment tribunals and any referrals to professional bodies. • Described the developing relationship and embedding of the 'Just and Learning Culture' work programme and employee relations activity. • Sought to provide assurance to the People Committee that these areas of work are being appropriately managed. • Provided details of learning that has taken place as part of any investigations conducted, as part of steps for continuous improvement.	The report was noted by the Committee and they welcomed the additional information included in relation to lessons learned.

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Committee Chair's Report

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			Over the rolling 12 month period there have been 21 employee relations cases opened, and at present there are 15 cases currently open. Breakdown of cases by ethnicity of employee were provided in order to monitor for any potential bias within our processes. Breakdown of cases by area was provided so that any 'hot spots' or themes can be identified and put forward for triangulation across other workstreams – for example wellbeing, civility and respect and freedom to speak up. The report this time identified some lessons learned in relation to a number of employee relations cases which the Committee welcomed.	
FREEDOM TO SPEAK UP REPORT			The Freedom to Speak Up Report was taken as read due to the agenda timeframes overrunning at this stage of the Committee meeting. Brief headlines were presented by Helen Young, Freedom to Speak Up Guardian for information and assurance purposes. For the purposes of this Chair's report, key points have been taken from the report that provided a summary of the FTSU activity since the last report in July 2023 and in addition: • An overview of the internal anonymous survey regarding FTSU.	The report was noted by the Committee.

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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
			• Recent developments and any recommendations that will impact on FTSU. • Self assessment action plan update Concerns being raised still remain relatively low but comparable to other Trusts of a similar size. Since the last report a further 2 collective concerns have been raised. However, for reporting purposes as per reporting guidance from the NGO it requires Trusts to log these as individual contacts rather than collectively as one. Therefore, in total there has been 12 members of staff in Warrington and 6 members of staff in Halton raising a concern. The 12 members of staff from a non-clinical team in Warrington wanted anonymity and they had multiple concerns which would indirectly impact on patient care. These were escalated to the relevant manager and are being addressed. Their concerns were raised but no feedback can be directly given to them due to their wish to remain anonymous. Other ways to feedback to staff such as in a newsletter or open feedback to the wider service/team meetings are currently being scoped by the Lead FTSU Guardian. In Halton the concern was about Patient Safety and Quality and the concerns were multi factorial in nature and have been shared with the relevant Operational Manager and Chief Nurse for response.	

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Committee Chair's Report

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			The report included an overview of the internal anonymous survey regarding FTSU: Over a 4 week period during June and July 2023, the whole organisation was asked to complete an anonymous FTSU survey. The aim of the anonymous survey was to find out what Bridgewater staff knew about Freedom to Speak Up (FTSU) and to identify if there were any barriers to speaking up and how these could be overcome. Staff were asked 8 questions and in total 105 staff responded to the survey. This is a relatively small number of respondents compared to the number of staff in the organisation, but enough to give some valuable feedback. A large majority of respondents had an understanding of what FTSU was, who the FTSU Guardian was and how to raise concerns. 27 respondents indicated that there were no barriers; 19 respondents didn't answer the questions and 59 indicated that there were barriers. General themes in terms of barriers were fear of re-percussion, perception that nothing would change, difficulties with anonymity. The comments made by staff mirror opinions made by staff in other organisations and are commonly identified barriers to speaking up.	

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			Recent Developments and Recommendations On the 18th August 2023, NHS England wrote a letter to all integrated care boards and NHS trusts in response to the verdict in the trial of Lucy Letby. NHS leaders were reminded of the importance of listening to the concerns of patients, families and staff, and following whistleblowing procedures. Last year a strengthened Freedom to Speak Up (FTSU) policy was rolled out and all organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest. This has already been adopted by Bridgewater and can be found on the HUB, with a link to it to be included when the new FTSU webpage is updated. Trusts were asked to urgently ensure the following: ➢ All staff have easy access to information on how to speak up. ➢ Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme. ➢ Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not	

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			always be aware of or have access to the policy or processes supporting speaking up. ➢ Communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place. ➢ Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well. ➢ Boards are regularly reporting, reviewing and acting upon available data. On the 22nd August 2023, and in response to the above requirement, a meeting was held with the Deputy Director of Communications and Engagement and the following was agreed: ➢ To update and refresh the FTSU webpage with support and to be in place to coincide with the new extranet that will be in place by 30th October 2023. The ➢ FTSU section with have a prominent place on the new site with clear links under the People Promise of "We each have a voice that counts". ➢ To share information and for the FTSU Guardian to update and inform Communications with any NGO or regional network developments and to be informed of any information being shared centrally from NHSE communications especially as October is FTSU month. ➢ To produce a new online form for staff to complete to raise concerns and send to the Guardian and to	

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			devise a way that if the person wants to remain anonymous, they can. ➢ To reconsider the wording on the pull up banner currently in development, and to add in the FTSU Guardians contact details for further promotion of FTSU. ➢ Media plan discussed and for development of a newsletter and for further updates at Team Brief and in the Bridgewater Bulletin. The NGO have not issued any further information in response to the Letby verdict however they have welcomed the news that an independent enquiry is to be held. To raise awareness the NGO had already chosen that the theme this year for Octobers FTSU month is 'breaking barriers' and plans are underway to promote FTSU within the Trust **Self-Assessment and Action Plan Update** Nationally, all Trusts in England are asked to review their Speaking Up processes every two years and all Trusts have been asked to complete their reviews using a revised self assessment tool and guidance by January 2024. This has been completed and as a result a 2 year FTSU action plan has been developed and progress will be presented at People Committee.	

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			The draft action plan weas presented to Board in August and was endorsed in principle subject to further consideration of training proposals. A training options appraisal and plan is being developed and this will be taken to EMT for further discussion and progress against the action plan monitored via People Committee.	
SYSTEM STAFFING IMPLEMENTATION UPDATE	BAF 5 and 6 PP 4		The System Staffing Implementation Update report was presented by Jeanette Hogan, Deputy Chief Nurse for information and assurance purposes. The following update was provided since the last report: Within Bridgewater, a CNSST implementation group was set up in May 2023, led by the quality team with membership of clinical teams, operational managers and corporate teams i.e., performance and workforce. Current progress: • Training of staff has commenced – (all staff in teams need to be trained in care categorisation and must undergo inter rater reliability assessment). • Developing data collection and validation methodology. Testing in the use of the tool will commence in July 2023 with implementation in District Nursing and Community Matron services in September 2023.	The Committee noted the reports and were assured on the progress and plans.

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			The Trust has now also been successful in its application for a Safer Nursing Care Tool (SNCT) licence for use in Padgate House Intermediate Care Unit and will provide updates in future reports as to the progress in implementation. As per the request at the Committee in August 23, a case study was presented into how workload issues in our Community Nursing Service was being managed. The report identified the challenges and actions taken within District Nursing. Delivery of the District Nursing service within Bridgewater has been challenged for several years primarily due to difficulties in relation to recruitment and retention, reflective of the national challenges within the NHS. District Nurses have been relied on heavily during and after the COVID pandemic and their roles have evolved considerably during this period as we have moved towards the 'home first' model keeping patients in their own home for longer. The Quality and Safety Committee received a paper in June 2023 that describes the current challenges within the service and the actions being taken to address the issues impacting on quality and safety. The proposed improvements and actions were presented in the report to People Committee for assurance purposes. Further monitoring of the progress of the improvement plan will be provided in October 2023 to the Quality and Safety Committee. It was noted that there are a number of workstreams, in addition to the specific	

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			improvement plan, which are being taken forward in POD Council. These will equally impact on improving our approach to workforce planning in the District Nursing service.	
HR POLICIES AND PROCEDURES	BAF 5 PP 1-7		The progress with the review and approval of HR Policies and Procedures was presented by Tania Strong, Interim Head of HR for information and assurance purposes. There was one policy presented to HRPG since the last Committee as follows: • **Fixed Term Contracts Policy -** The policy was created to provide better transparency and guidance for those managers and employees when dealing with fixed term contracts. It was circulated to the consultation group for comment in July. Proposed amendments to the policy were discussed in August HR Policy Group with members recommending the policy be presented to JNCC for approval. The policy was ratified by JNCC members in August 2023	The Committee noted the content of the report.
COMMUNICATIONS UPDATE	BAF 5 and 6 PP 1 - 7		The Communications Update report was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes. **General Communication to Note** **Industrial Action** - Although this is action is now focussed on junior doctors and consultants, of which Bridgewater has small numbers, there remains to be a strong systemwide call	The Committee noted the content of the report and were assured on the progress of plans.

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NHS Bridgewater Community Healthcare NHS Foundation Trust

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			to arms on communicating the correct messaging to the public. **New extranet to replace the Hub** - The extranet project is now moving at speed and it is hoped to be live from mid to late October. **Communities Matter** – our updated Trust strategy - A rollout is underway of the new Communities Matter strategy now that it has been designed and finalised. **The #TeamBridgewater 'Thank You' Awards** - At the time of writing, full preparations are underway or the annual staff 'Thank You' awards and Annual Members' Meeting (AMM). **NHS Staff Survey** - A separate NHS Staff Survey report paper has been tabled at this committee. **Internal and External Communication** **Widnes Urgent Treatment Centre (UTC)** – Since the last reporting period a new external marketing campaign has now launched in Widnes town centre to promote the centre as we head towards the busy winter period. **National Quarterly Pulse Survey (NQPS)** - The NHS People Plan made a commitment to introduce a new National Quarterly Pulse Survey (NQPS). The results for the July NQPS are now available and can be found on the staff website. **Recruitment** - A recruitment guide has been drafted and is now in the design stage. This has been slightly delayed as the design was reliant on the creation of the new Trust strategy artwork.	

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			NHS 75 - 2023 is the 75th birthday of the NHS. A great deal of emphasis was given internally and externally around the actual birthday in July with lots of staff events taking place. Further focus will be given however at the annual staff 'Thank You' awards to be held later in September. **Paediatric Neurodevelopmental Assessment** Pathway - This piece of work for the Children's Directorate continues to progress. **Freedom to Speak Up** - Following recent events at the Countess of Chester Hospital around the conviction of Lucy Letby, there is great focus on the Freedom to Speak Up (FTSU) service. **Civility and Respect Campaign** - It is expected this campaign will begin a rollout in autumn. **Partnership Update** **System engagement** - The team continues to attend a joint One Halton and Warrington Together partnership call, although this has decreased over the summer holiday period. **Provider Collaborative** - As Bridgewater is the host of the Cheshire and Merseyside 'Mental Health, Learning Disability and Community Services' provider collaborative, the team is working with the collaborative over the creation of a brand identity. **Horizon Planning**	

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			Health & Wellbeing fortnight - Happening in October, Health & Wellbeing fortnight will take place. **Industrial Action** – work continues. **Freedom to Speak Up (FTSU)** - Work is underway over the planning of this year's FTSU month. **Patient Safety Incident Response Framework (PSIRF)** - A communications plan is in full development to support this important piece of work. **Covid-19 and Flu** - This autumn and winter, the Trust will be offering the Covid-19 booster to all staff as well as the annual flu vaccination. A thorough communications plan will soon follow for both.	
NATIONAL STAFF OPINION SURVEY – LAUNCH REPORT			The National Staff Opinion Survey – Launch Report was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes. Confirmed delivery date of Monday 11 September for surveys to land in the email inboxes of the Bridgewater workforce this year. The survey will remain open until Friday 24 November. Current Staff Survey Action Plans (as previously highlighted to the People Committee) will be used to create proactive communication that will be fed into the organisation in the form of a "You said… We did… We are doing" approach.	The Committee noted the content of the report and were assured on the progress and plans.

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			Similar to last year, a comprehensive communications, engagement and marketing plan will also be created to complement the survey period for 2023.	
VACCINATION CAMPAIGN AND NUMBERS - STAFF	BAF 5 and 6 PP 4		The Vaccination Campaign and Numbers Report was presented by Nicola Handford, Adult Immunisation and IPC Nurse for information and assurance purposes. The annual staff influenza vaccination programme will commence from 2nd October 2023 and will be delivered as a roving model. The CQUIN goal for 2023/24 is to achieve a flu vaccination uptake of 75% to 80% of frontline healthcare workers. The proportion of patient-facing NHS staff accessing seasonal flu vaccinations declined dramatically in the 2021/22 flu season and it is important that we do all we can to reverse this to protect staff and patients. On 20th May 2022, the Joint Committee of Vaccinations and Immunisations (JCVI) announced that the Covid-19 Autumn/Winter (AW) 2023/24 booster is to be offered to all frontline health and social care workers. The AW 2023/24 campaign started nationally on 05/09/2022 and will run for 15 weeks. During this time, all staff within Bridgewater Community Healthcare NHS Foundation Trust (BCHFT) will have the	The Committee noted the content of the report and were assured on the progress and plans.

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			opportunity to receive their vaccinations at Spencer House at a date and time to be confirmed. Co-administration of both flu and Covid-19 vaccinations will be promoted and encouraged as per public health advice to expedite the programme and increase the vaccination uptake. If staff receive their vaccinations elsewhere, they will be asked to inform the IPC team so the uptake rates can be captured.	
MEDICAL DIRECTOR UPDATES **(i) Responsible Officer Annual Report** **(ii) Medical Appraisal and GMC Revalidation Report (bi-annual Sept & March)** **(iii) Medical and Dental Professional Governance Meeting – Chairs Report**	BAF 5 and 6		The Medical Director Update Reports were presented by Ted Adams, Medical Director for approval purposes. During the period 1st March 2023 to 31st August 2023, six formal meetings of the Medical & Dental Professional Governance group have taken place. Issues discussed have included: • Medical appraisal compliance and revalidation recommendations • Medical and dental performance concerns • Governance of locum doctors • Governance of sessional GPs • Progress with the implementation of the 2023 Specialty Doctor and Specialist Grade Contracts • Allocation of the 2023/24 Clinical Excellence Awards.	The Committee noted the content of the report and approved escalation to Board for overall approval. Reports to be attached

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			• Progress with the Responsible Officer (RO) Action Plan At present there are three doctors and dentists who are employed substantively by Bridgewater (one doctor and two dentists) where there are concerns about their performance. These are being managed in accordance with Trust policy. As of September 2023, there were 17 doctors aligned to Bridgewater for appraisal. 11 of these 17doctors had had their 2023/24 appraisals by 31st August 2023, with two approved postponements, 4 doctors have their appraisal between September and February. Three positive revalidation recommendation was made during the period 1st March 2023 to 31st August 2023, with one deferral. Three more doctors are due for revalidation before the end of September 2023. The 2022/2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance report is to be submitted by 31st October 2023 upon its approval by People Committee. The report was presented and approved for onward submission to Board for overall approval purposes.	
ORGANISATIONAL DEVELOPMENT UPDATES:	BAF 5 and 6 PP 4 and 5		Two reports were presented for information and assurance purposes – PPDR & Mandatory and Statutory Training Compliance and Apprenticeship Scheme and Levy.	PPDR, S&MT compliance is being actively monitored and staff will be asked to prioritise safeguarding training and maintain overall compliance.

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PDR AND STATUTORY & MANDATORY TRAINING COMPLIANCE	BAF 5 and 6 WLR7 and 8 PP 1, 4 and 5		The PDR and Statutory and Mandatory Training Compliance Report was presented by Adie Richards, Education and Professional Development Lead for information and assurance purposes. The resulting M4 (latest available data when this paper was written) overall compliance with Mandatory Training shows 23 requirements now at green, all with percentage ratings above 90%, the majority above the 95% mark. There are still staff who remain non-compliant, and we agreed, in partnership, that we would apply non-compliance principles in instances where it is determined that there is a clear lack of acknowledgement of individual responsibilities (whether manager or employee) regarding mandatory training. If mandatory training has not been undertaken, then the aim will be to resolve the situation through an initial informal process of managerial support and guidance. As per our commitment to a Just & Learning Culture, this would be a last resort. The principles for consideration now are: • For those staff who are non-compliant as a result of their own actions, they will not be permitted to undertake their normal duties until all mandatory training is compliant. • Managers who do not execute their responsibilities in ensuring that their staff have the appropriate time away from duty to undertake their mandatory training, and that any breaches are appropriately	The Committee noted the reports and were assured on the progress and plans, as above. Positive compliance trends were noted.

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			incident reported, will also be subject to the same measures. On 4th September 2023, the Deputy Chief Executive Officer/Chief Nurse sent a communication to all Associate Directors (AD's) for Clinical Services with an updated list of clinicians who still remain non-compliant with Resuscitation, Safeguarding and Level 2 Moving and Handling i.e. those which present the most clinical risk. Associate Directors were advised of the following next steps: • Immediate booking for these staff should be prioritised no later than the end of September, at which point, if they remain con-compliant, they should be removed from clinical practice until they are compliant. • ADs were asked to flag should additional training sessions be required. • All other mandatory training should be completed by the end of October 2023. It's essential that the non-compliance reports are monitored on an ongoing basis to ensure that non-compliance is addressed, and sessions are booked before staff become non-compliant, so that we don't find ourselves in a similar situation in the future.	
APPRENTICESHIP SCHEME AND LEVY	BAF 5 and 6 PP 1, 4 and 5		The Apprenticeship Scheme and Levy Report was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes.	The Committee noted the reports and were assured on the progress and plans. There was a recognition of the significant work taking place in relation to this agenda.

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			• There are currently 59 employees registered as apprentices across the Organisation. • Additionally, the Trust have 47 further planned apprenticeships starts in September 2023. This high volume of starts, is attributed in part, to the recent entry level apprenticeship recruitment effort, which sees a number of new apprentices funded via a centralised talent pool, aimed at creating a sustainable pipeline for support workforce vacancies. • Of the 106 existing and planned apprenticeships, 32% were directly recruited into apprenticeship positions. • Of the 106 existing and planned apprenticeships, approximately 72% are or will be undertaking programmes that are clinical in nature, many leading to new or additional professional registration, with either the NMC or the HCPC. The Trust has maintained zero expiry from the apprenticeship levy account for 10 successive months with the last expiration of funds occurring in October 2022. The balance in the Trust's Digital Apprenticeship Service (DAS) account remains stable at £473,875 due to the mitigated risk of expiry. The Trust can expect the account balance to start to gradually decrease over the next 12 months as a result of the further significant increase in spend expected from September 2023 onwards.	

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			Apprenticeship levy projection work provides reassurance that the Trust has sufficient levy funds to support continued growth in numbers of apprentices over the coming years. The publication of the NHS Long Term Workforce plan affirms that there is an ambition to enhance the role of apprenticeships in designing the future NHS workforce.	
MIAA INTERNAL AUDIT UPDATE - **MANDATORY TRAINING AND APPRAISALS REVIEW** - **PAYROLL FEEDER SYSTEM REVIEW – REPORTED AS COMPLETE AT PREVIOUS MEETING**	BAF 5 and 6		The Mandatory Training and Appraisals Review report was presented by Adie Richards, EPD Lead for information and assurance purposes. All recommendations are progressing to plan and no concerns were raised in relation to implementation of the recommendations. The Payroll Feeder System Review – Kathryn Sharkey confirmed that all actions had been implemented and were now closed.	The Committee noted the reports and were assured on the progress.
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	BAF 5 and 6		A review of BAF 5 and 6 was undertaken. With regards to BAF 5, the 'Gaps in controls and assurance' were to be updated to reflect: • Pay deals now confirmed nationally and implemented. Industrial Action continues; however the government have confirmed the offer and are not in discussions with Trade Unions currently. The new BAF template was referred to by Linda Chivers, NED. Jan McCartney, Trust Secretary explained the status of this	The Committee were assured on the progress and governance around the monitoring of the BAF. The risk rating of 4 x 4 = 16, was reviewed by the Committee who after some discussion recommend a risk rating of 4 x 3 = 12

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			and its inclusion with the Committee papers. She referenced that it was agreed that an extra-ordinary meeting would be arranged to review this thoroughly before submission to Board.	
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 5 and 6		The Medical Director Reports, as presented, were approved for escalation to Board in October for overall final approval.	Medical Director Reports to be escalated to Board.
REVIEW OF MEETNG ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			Sarah Power, Staff Governor (Observer) reviewed the meeting as informative and welcomed the open and supportive discussions.	
Risks Escalated			None.	

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BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	05 October 2023
Agenda Item	74/23ii		
Report Title	2022-23 ANNUAL APPRAISAL AND REVALIDATION AND MEDICAL GOVERNANCE REPORT		
Executive Lead	Ted Adams, Medical Director		
Report Author	Ted Adams, Medical Director		
Presented by	Ted Adams, Medical Director		
Action Required	☒ To Approve	☐ To Assure	☐ To Note

Executive Summary
Following recommendation by the People Committee, the Board is requested to approve the 2022-23 Annual Appraisal and Revalidation and Medical Governance 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	☐ BAF 8
Failure to implement and maintain sound systems of	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

corporate governance							

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

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

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Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Bridgewater Community Healthcare NHS Foundation Trust
What type of services does your organisation provide?	Community Healthcare

	Name	**Contact Information**
Responsible Officer	Dr Ted Adams	ted.adams@nhs.net
Medical Director	Dr Ted Adams	ted.adams@nhs.net
Medical Appraisal Lead	Dr Neil Fisher	neilfisher@nhs.net
Appraisal and Revalidation Manager	Brittney Chu	poyan.chu@nhs.net
Additional Useful Contacts	PA to Medical Directors	victoria.whittle5@nhs.net

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ ~~No –~~ this report concerns Bridgewater doctors only. Separate reports are provided for each designated body.

If yes, who is this with?

Organisation:

1. St Rocco’s Hospice, Warrington
2. Halton Haven Hospice

Please describe arrangements for Responsible Officer to report to the Board:

A Memorandum of Understanding (MOU) is in place with each of the two hospices for which Bridgewater’s RO provides RO responsibilities. An annual report is provided by the Responsible Officer in conjunction with each organisation’s Chief Executive for each hospice to present to their Board.

Date of last RO report to the Board: September 2022 (for 2021/22 reports)

Action for next year: 2022/23 reports to be submitted to the hospice Boards by September 2023.

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	15
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	14
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	1
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	0
Total number of appraisers as at 31 March 2023?	8

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	5
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	2
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	3
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	0

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	1
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	0
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	1
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	0

Organisational Policies

List your policies to support medical appraisal and revalidation	Implementation date	Review date
Medical Appraisal Policy	Dec 2020	Dec 2023
Job Planning Policy	Mar 2021	Mar 2024

List your policies to support MHPS and managing concerns	Implementation date	Review date
Conduct, Capability, Ill-Health and Appeals Policy and Procedures for Medical and Dental Staff	Jun 2021	Jun 2024
Handling of Complaints, Compliments, Comments and Concerns Policy and Procedure	Jun 2023	Jun 2026

Other relevant policies	Implementation date	Review date
Incident Reporting Policy	Feb 2019	Feb 2022
Incident Investigation Procedure	Oct 2021	Aug 2022
Safeguarding Adults Policy	Feb 2022	Feb 2025
Safeguarding Children Policy	Nov 2022	Nov 2025

How do you socialise your policies?

All doctors who see/ treat Trust patients operate under our Clinical Governance Framework. The assurance process includes Serious Incident Review Panels, Quality and Risk Councils, and Quality and Safety Committee.

All policies and procedures can be considered valid when viewed via the Trust's intranet.

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes/~~No~~ (delete as applicable)
Action for next year (1 April 2023 – 31 March 2024). Dr Aruna Hodgson was Responsible Officer (RO) for Bridgewater from 9 April 2020 to 23 April 2023 and she has undertaken appropriate training for the RO role in 2020 (e-learning modules and virtual training). The RO role was handed over to Dr Ted Adams from 24 April 2023. Dr Adams has undertaken RO training in March 2023 and attended the regional RO Network meetings in June 2023 to ensure he remains up-to-date with the knowledge required for the role.

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/~~No~~ (delete as applicable)
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes/~~No~~ (delete as applicable)
If yes, how is this maintained? Accurate records have been maintained throughout this reporting period. This includes appraisal/ revalidation records, investigation/ management of concerns and HR processes relating to new starters. A web-based appraisal system (PremIT) is used to ensure that safe and secure documentation is held for all doctors who have a prescribed connection to Bridgewater.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024).

4.4 Do you have a peer review process arranged with another organisation?

Yes/~~No~~ (delete as applicable)
If yes, when was the last review?

Higher Level Responsible Officer Quality Review, conducted by NHS England, took place in December 2018.

An independent review of GP recruitment, appointment arrangements and alignment to the accountabilities of the Trust's Responsible Officer, conducted by D.F. Consultancy, took place in July 2020.

An action plan was developed to address the recommendations of these reviews. Substantial progress was made with the action plan during 2021/22, with only one action still in progress during 2022/23. This action pertains to robust performance management of a contract for medical provision for the Trust's intermediate care service with an external provider. Unfortunately, there has been a delay in completing this action for reasons outside of the RO's control. All doctors contracted through this arrangement are subject to appraisal and revalidation through other routes, not through Bridgewater.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes/~~No~~ (delete as applicable)

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

Staffing Levels and Temporary Staffing Solutions (including the use of Bank Staff, Self Employed Contractors and the Engagement of Agency Workers) Procedure – intermediate review completed January 2023.

All locum or short-term staff placement doctors working in the organisation, including those with a prescribed connection to another Designated Body, are supported in their continued professional development, appraisal, revalidation and governance as follows:

All locums working more than 3 months within the organisation have access to our appraisal process, including our web-based appraisal system, if required.

All locums and short-term staff have access to monthly service level quality performance reports through Qlik Sense dashboard via the service manager.

Staffing Levels and Temporary Staffing Solutions (including the use of Bank Staff, Self Employed Contractors and the Engagement of Agency Workers) Procedure to be amended to add additional information regarding addressing performance concerns pertaining to locum or short-term staff placement doctors, emphasising the need to inform the Trust's RO of any concerns in addition to the individual's RO.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes/~~No~~ (delete as applicable)

If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

~~Yes/~~No (delete as applicable)
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

A new Medical Appraisal Lead was appointed from July 2022 as the previous Lead left the Trust in May 2022.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

The current Medical Appraisal Lead was left the role in June 2023 and discussions have been taking place as to how the role will be fulfilled in future, recognising that there are fewer than 20 doctors aligned to Bridgewater for appraisal and revalidation (including those working in hospices, for whom external RO responsibilities are provided).

Continue to ensure there are sufficient trained appraisers in place and that annual update training is provided.

5.5 How do you train your appraisers?

An update session was delivered by the Medical Appraisal Lead for all appraisers and appraisees in February 2023.

5.6 How do you Quality Assure your appraisers?

There have been sufficient appraisers in place throughout this year. NHS England recommends that the ratio of appraisers to appraisees is no lower than 1:20 or higher than 1:5. Within the Trust the ratio of appraisers to appraisees is higher than 1:5 in order to ensure there is a sufficient pool of appraisers to enable compliance with the standard that no appraisee has the same appraiser for more than three consecutive appraisals. Current ratio is approximately 1:3.

Appraisers are encouraged to include an annual record of their participation in appraisal educational events and appraisal network meetings in their appraisal portfolios, including reflecting on their learning as part of their programme of Continuing Professional Development.

A Quality Audit of Trust appraisals was completed by the Medical Appraisal Lead for 2022/23 appraisals using the Appraisal Summary & PDP Audit Tool (ASPAT) tool.

Individual reports were sent to each appraiser with average scores and recommendations for areas of development.

5.7 How are your Quality Assurance findings reported to the board?

Updates regarding appraisal compliance and quality are presented to the Trust's People Committee, which is a subcommittee of the Board, twice a year.

5.8 What was the most common reason for deferral of revalidation?

- Patient / colleague feedback not completed within appropriate timeframe
- Doctors in "a process"

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

Non-participation by a doctor will be handled under the General Medical Council (Licence to Practise and Revalidation) Regulations 2012 and in accordance with the Conduct, Capability, Ill-Health, and Appeals Policy and Procedures for Medical and Dental Staff (last reviewed June 2021). Any concerns raised by the Medical Appraisal Lead will be investigated by the Responsible Officer in accordance with this policy. Where there is a failure to participate in the process, the doctor concerned is informed by Responsible Officer.

The Responsible Officer confirmed all revalidation recommendations to the doctor by email. Where deferral was being considered, this was discussed in advance with the doctor, including the reasons for this and the requirements for a successful revalidation.

There have been no reported non-engagements within this reporting period.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

Monthly Medical and Dental Professional Governance meetings take place, attended by the RO, Medical Appraisal Lead, Dental Clinical Director, HR Manager, Appraisal and Revalidation Manager and administrator. Any concerns about a doctor's performance are discussed at that meeting, actions agreed and monitored.

The Trust has purchased the online appraisal system provided by PremierIT for use by all doctors and appraisers within the Trust.

The administrator, Appraisal and Revalidation Manager, Medical Appraisal Lead and RO have access to all the appraisals, including dates and progress of the process within the system.

All doctors are offered support via the appraisal team on how to use the system and within the system itself there is training guidance/ video demonstrations to explain all the functions of the system.

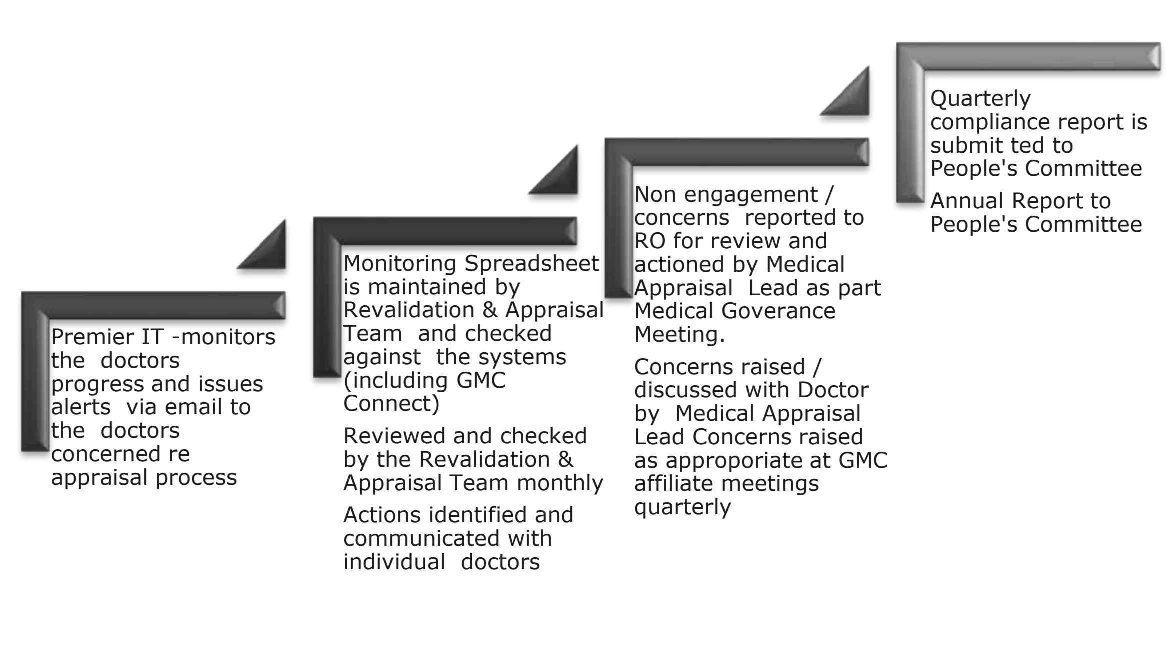
All doctors have access, via their Clinical Director/ Operational Manager, to relevant supporting information for their appraisal portfolio.

The information is updated via the Qlik dashboard monthly and includes routine performance data (e.g. contacts, DNAs, cancellations, waiting times).

Quality performance data is also made available monthly such as complaints, compliments, incidents, audits etc.

Colleague and patient feedback surveys are undertaken using the Edgecumbe system provided via PremIT. Service patient experience data is also collated and discussed at Team meetings.

Discussions have taken place with Clinical Directors as to how they can input relevant information to a doctor's appraisal in the most effective way.



6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

Concerns are monitored through the Medical and Dental Professional Governance Group, which reports to the People Committee, a sub-Committee of the Board. Data regarding any ongoing or completed investigations are presented to the People Committee, which meets every 2 months. Where such concerns have arisen, the number, type and outcome of the concerns, and consideration of protected characteristics, are reported.

6.3 How do you ensure that any concerns are managed with compassion?

Performance concerns have been managed in line with the Conduct, Capability, Ill-Health and Appeals Policy and in line with advice received from Practitioner Performance Advice (PPA).

The Trust is in the process of implementing a Just and Learning Culture Framework, and the Conduct, Capability, Ill-Health and Appeals Policy will need to be updated to incorporate this.

6.4 How do you Quality Assure your system for responding to concerns?

Conduct, Capability, Ill-Health and Appeals Policy – last reviewed June 2021 Advice is also taken from Practitioner Performance Advice (PPA) if there are any concerns about a doctor's performance.

Performance concerns have been managed in line with the Conduct, Capability, Ill-Health and Appeals Policy and in line with advice received from PPA.

6.5 How if this Quality Assurance information reported to the board?

Concerns are monitored through the Medical and Dental Professional Governance Group, which reports to the People Committee, a sub-Committee of the Board. Data regarding any ongoing or completed investigations are presented to the People Committee, which meets every 2 months. Where such concerns have arisen, the number, type and outcome of the concerns, and consideration of protected characteristics, are reported.

The Medical and Dental Professional Governance Group has continued to meet regularly during 2022/23, discussing doctors about which there have been performance concerns and ensuring that appropriate action plans and support are in place as necessary.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

Since April 2017, Medical Practice Information Transfer (MPIT) forms have been used when required to hand over information between ROs when a doctor transfers in or out of the Trust.

Information about locum doctors is obtained on engagement in accordance with the Staffing Levels and Temporary Staffing Solutions (including the use of Bank Staff, Self-employed Contractors and the Engagement of Agency Workers) Procedure. This policy has been revised during 2022/23 to strengthen the guidance on reporting of performance concerns regarding any locum doctors. This specifies the need to notify the Trust's RO as well as the supplying agency.

Where concerns have arisen about locum doctors, the supplying agency and/ or the doctor's RO have been informed accordingly.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The Trust's Conduct, Capability, Ill-Health and Appeals Policy and Procedure for Medical and Dental staff includes the following:

7.3 Equal opportunities

All managers and directors (whether internal or external to the Trust) who are involved in undertaking investigations or sitting on disciplinary/ capability panels or appeals panels shall have undertaken formal equal opportunities training prior to undertaking such duties.

Case Managers, Case Investigators and Panel Members shall be trained in the operation of the disciplinary and capability procedures.

The Equal Opportunities Policy details the Trust's commitment to equal opportunities in employment and service delivery and further supports this approach to ensure that processes are fair and free from bias.

All Trust HR policies undergo an Equality Impact Assessment.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

The Trust is in the process of implementing a Just and Learning Culture Framework, and the Conduct, Capability, Ill-Health and Appeals Policy will need to be updated to incorporate this.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Monthly Medical and Dental Professional Governance Group meetings will continue, with updates presented to the People Committee twice a year (September and March).

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

During 2022/2023 the Trust carried out pre-employment checks in accordance with its Recruitment & Selection Policy and Procedure and the NHS Employment Check Standards. These include 1. Employment references 2. Verification of identity 3. Eligibility to work in the UK and work permits 4. Qualifications 5. Registrations status with Regulatory and Professional Bodies 6. Disclosure and Barring Checks 7. References 8. Work Health Assessment/ Occupational Health Checks 9. Appraisal and revalidation status The Trust had an "Alert Notice System" in place to receive health professional alerts from Practitioner Performance Advice. All external alerts received in relation to health professionals were reviewed at Executive level and by the Trust's HR team.

Do you collate EDI data around recruitment and /or concerns information?

Yes/~~No~~ (delete as applicable)
If yes, how do you use this information?' As part of annual reporting for the mandatory Workforce Race and Disability Equality Standards, Gender Pay Gap, Equality Delivery System, and annual equality reporting, the Trust analyses and publishes information in relation to its workforce and service delivery. This includes looking at metrics such as representation at senior and executive leadership level, recruitment, representation in formal disciplinary and capability processes, and access to continuing professional development for staff from protected characteristic groups; and patient access and experience, including any incidents or complaints, for service users in our diverse communities. All reports are published at "Equality Reporting".

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

The Trust has achieved a high level of compliance with the standards for medical appraisal and revalidation over the past year. The Responsible Officer believes that Bridgewater has good systems in place in regard to medical appraisal and

revalidation, and that this report should provide assurance that the Trust is meeting the Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation.

Section 9: Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ………………………………………………………..…….

Name: ………………………………………………………………………………………

Role: ……………………………………………………………………………………..

Date: ……………………………………………………………………………………..

BOARD OF DIRECTORS

Title of Meeting	PUBLIC BOARD MEETING		Date	5 October 2023
Agenda Item	75/23i			
Report Title	SENIOR INFORMATION RISK OWNER (SIRO) REPORT			
Executive Lead	Nick Gallagher			
Report Author	Sharon Ormesher, Information Governance			
Presented by	Nick Gallagher			
Action Required	☐ To Approve	☒ To Assure	☐ To Note	

Executive Summary

To ensure that the Trusts is compliant within an effective legal framework this report provides a high-level summary of how information is managed within the Trust and the mechanisms that are in place to support this process.

- Two serious incidents were reported to the ICO both have been closed with a satisfactory outcome.
- “Approaching Standards” is now the status of the Data Security and Protection Toolkit (DSPT) on the NHS digital website. This is primarily due to additional testing required on the data security and cyber procedure.
- The MIAA audit on the DPST shows some areas of improvement, but overall shows significant assurance.
- 82% % of Freedom of information request (FOI) met the 20-working day standard and increase of 9% on the previous report.
- Six policies were reviewed or updated in 22/23.
- There were 230 access to records/Subject access requests from patients received in between April 2022 – 31st March 2023 there was one incident relating to record request being delayed beyond the one-month deadline.
- A detailed SIRO report was presented to Digital Information Governance and Information Technology (DIGIT) on the 14 June 2023. The report was also presented to the Finance and Performance Committee on 20 July 2023. This report is attached for information in Appendix 1.

Previously considered by:

☒ Finance & Performance Committee	☐ Estates Sub-Committee
☐ CIP Council	☐ H&S Sub-Committee
☒ DIGIT	☐ Performance Council

Strategic Objectives

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

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

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

BOARD OF DIRECTORS

Title of Meeting	**PUBLIC BOARD MEETING**	Date	**5 October 2023**
Agenda Item	**75/23i**		
Report Title	**SENIOR INFORMATION RISK OWNER (SIRO) REPORT**		
Report Author	Sharon Ormesher, Information Governance Manager		
Purpose	The report provides key highlights of the full SIRO report presented to DIGIT in June 2023.		

1. SCOPE

1.1 This report provides the Committee with an overview of the Trust's compliance with the Information Governance (IG) and security agenda both nationally and locally. The report has been updated in areas where appropriate real time information is available.

2. INTRODUCTION

2.1 Information governance is a legal framework governing the use of personal confidential data. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, and the Human Rights Act 1998.

2.2 Information Governance provides the framework for staff to deal consistently with the various legislation and guidance in relation to how information is managed. The Trust has numerous policies to support these processes. The Information Governance Framework Policy, the Data Protection and Confidentiality policy and the Information Security Policy are the pivotal documents and have all been reviewed within the last year.

2.3 The full SIRO report was presented at the Digital Information Governance and Information Technology (DIGIT) group on the 14th of June 2023, with no queries raised.

2.4 DIGIT ensures the delivery of the 'Digital Strategy' it is an effective productive meeting, inclusive, and collaborative. It allows subject matter experts to discuss complex issues and talk through ideas and solutions. It is easier to make better decisions when the group has enough information on key matters that affect the Trust. The IG regularly updates the group with IG developments at national and regional levels.

2.5 A subgroup of DIGIT is the Digital Programme Group (DPG), the information governance and procurement team form part of this group. The required Data protection Impact Assessments (DPIA) are initiated by this group at the development stage to enable a "privacy by design" approach.

2.6 The Data Security and Protection Toolkit (DSPT) Steering Subgroup is also a subgroup of DIGIT. This group is attended by contributors of the DSPT, and updates are provided to DIGIT.

3. INCIDENTS

3.1 There were two serious incidents requiring investigation (SIRI) reported through the DSPT portal.

- One relating to previously provided maternity services where the clear desk process was not followed.
- The other was in Warrington district nursing Services, where a staff member used a notebook to store personal information.

3.2 The incidents have both been investigated and were overseen by the Serious Review Panel.

4. RISKS

4.1 All risks are regularly reviewed at DIGIT, with all high risks being reported and discussed at the Risk Management Council, and risks with a score over 12 being reported into the Finance and Performance Committee.

4.2 All risks have a target date and a mitigation plan.

5. DATA SECURITY AND PROTECTION TOOLKIT (DSPT)

5.1. The DSPT Steering Group, was formed in 2021 and played a valuable role in this year's submission.

5.2. The DSPT submission complied with the deadline of the 30th of June 2023 the Trust status at that point stated 'Standards Not Met (improvement plan agreed). The NHS digital website will change to "Standards met" in October when the testing of the Serious Data Security Procedure has been undertaken.

5.3. The mandated internal audit to support the DSPT requirements the Trust achieve 'Moderate assurance' in 21/22 MIAA audit report. They also gave 'Substantial Assurance" overall for the 10 Data Guardian Standards.

6. INFORMATION ASSETS INCLUDING THIRD PARTY CONTRACTS

6.1. The team have now combined the registers. The Information Asset, Information Sharing, Record of Processing and DPIA are now in one register. Combining the register allows streamline the data fields and documents.

6.2. The IG team and the Procurement team worked together to ensure that the mandated Digital Technology Assessment Criteria (DTAC) for third party suppliers is embedded in the procurement process. This also links to the DPG group, where both the IG team and the Procurement team are represented.

6.3. There were 230 access to records/Subject access requests from patients received in between April 2022 – 31st March 2023 there was 1 incident relating to record request being delayed beyond the one-month deadline.

6.4. 20 DPIA were undertaken in 22/23 with none being identified as high risk of information being compromised.

6.5. Policies were updated to ensure that the now mandated Digital Technology Assessment Criteria (DTAC) for health and social care is embedded within the development of digital systems.

7. FREEDOM OF INFORMATION (FOI)

7.1. The Trust achieved 82% compliance for Freedom of Information (FOI) requests. A total number of 369 FOIs in 22/23. There were 2 internal reviews undertaken of which both were upheld.

8. POLICIES AND PROCEDURES

8.1. The DIGIT group reviewed and approved the following policies and procedures and leaflets:

- Review of the Freedom of Information and Environmental Information Regulations Policy.
- Development of a Photographing and Recording Consultations and Treatment Leaflet.
- Review of the Marking in Error and Permanently Deleting Information in TPP SystmOne Patient Records Procedure.
- Review of the Subject Access/Access to Health Records Policy.
- Review of the Health Records Policy that included the development of a record keeping audit procedure to help consistent auditing within community and dental services. This development was in association with the Record Keeping Group lead by the Clinical Audit Team.
- Developed a Third-Party Supplier Policy to ensure that trust upholds its data controller responsibilities.

9. RECOMMENDATION

9.1. The Board is asked to consider the report and be assured that the IG framework is established, and continual improvements will be made where needed.

Appendix 1

FINANCE & PERFORMANCE COMMITTEE

Title of Meeting	FINANCE & PERFORMANCE COMMITTEE	Date	20th July 2023
Agenda Item	000/22		
Report Title	DIGIT OVERVIEW FOR 22/23 INCLUDING SIRO REPORT		
Executive Lead	Nick Gallagher, Director of Finance/ Senior Information Risk Owner (SIRO)		
Report Author	Sharon Ormesher, Information Governance and Records Manager		
Presented by	Nick Gallagher, Director of Finance/SIRO		
Action Required	☐ To Approve	☒ To Assure	☐ To Note

Executive Summary

- This report summaries the work undertaken in DIGIT for 22/23.
- This report was presented at Digital Information Governance and Information Technology (DIGIT) on the 14th of June 2023. The report was accepted with no comments were received.
- The "Doing Digit@l" strategy is 12 months in, and the DIGIT group have worked towards embedding it into the groups digital work plan. The work plan has dedicated strategy reviews are embedded throughout the year.
- In the June meeting to support this paper there was a presentation delivered by the Assistant Director of IT, to support the digital strategy. The presentation compared matrixes in the trust digital strategy to the NHS digital maturity assessment. The draft results show that Bridgewater is a high ranking (third) digitally when compared to other community trusts within Cheshire and Merseyside.
- The multidisciplinary aspects of the group bring together the What Good Looks Like (WGLL) agenda.
- The group has streamlined its reporting requirements, this will ensure the group still has assurance from reporting subgroup but has the diversity to explore opportunities within the wider digital developments.
- The work programmes have endeavoured to alignment with ICS and Places, but this has been a challenge.
- Quarterly assurance reports were submitted from group members and associated reporting groups for scrutiny these are also used for escalation of any relevant issues.
- Reports were received from the Digital Programme Group (DPG) on the implementation and progress in delivering the implementation of clinical and corporate IT and/or Information Systems.
- DIGIT received updates on the Data Security and Protection Toolkit (DSPT) including identified gaps in evidence and participates in finding a resolution.
- DIGIT have tasked the development of Digital leads within the boroughs. This will provide the connectivity between services and the central Digital team. These dedicated digital clinical leads will enhance the support, knowledge, and awareness of needs within our teams, and identify gaps in training and enable more tailored and targeted support. It will also function as a pivotal role in ensuring updates, key messages and training activities will be communicated across the teams.

Previously considered by:	
☐ **Capital Group**	☐ **Estates Sub-Committee**
☐ **CIP Council**	☐ **H&S Sub-Committee**
☒ **DIGIT**	☐ **Performance Council**

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

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

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

FINANCE & PERFORMANCE COMMITTEE REPORT

Title of Meeting	FINANCE & PERFORMANCE COMMITEE	Date	20th July 2023
Agenda Item			
Report Title	DIGIT OVERVIEW FOR 22/23 INCLUDING SIRO REPORT		
Report Author	Sharon Ormesher, Information Governance and Records Manager		
Purpose	To provide an overview of the activity of DIGIT in 2022-23 to enable it to review and be assured that appropriate governance and processes are in place for the group to satisfactorily discharge its role and responsibilities.		

1 SCOPE

1.1 This report outlines DIGIT's activity for 2022-23 to provide assurance on its own governance and processes in adhering to and delivering against its Terms of Reference (TOR).

1.2 The group is asked to accept this report as assurance.

1.3 The DIGIT group reviews compliance with all Digital policies and procedures.

1.4 This report has been prepared by the Information Governance Team on behalf of DIGIT.

2 SUMMARY OF ACTIVITY 2022-2023

2.1 DIGIT meet bi-monthly and met five out of the six meeting session in 22/23, December was cancelled. All meetings were well attended and quorate.

2.2 DIGIT reviewed the Terms of Reference in January 2023, and it was finalised in April 2023.

2.3 Highlight reports are given to the Finance and Performance by the Chair the Chief Clinical Informatics Officer (CCIO) who is also the Trusts Medical Director.

2.4 The Senior Information Risk Owner (SIRO) who is also the Director of Finance is a core member of DIGIT, this ensures appropriate overview and assurances on risks with Information systems and processes. The Deputy Senior Information Risk Owner (SIRO) is also the deputy Chair this person is also the Assistant Director for IT (CIO).

2.5 The Data Protection Officer (DPO), who is the Trust Secretary and the Deputy Caldicott guardian who is also the Director of Quality Governance are also core members.

2.6 The multidisciplinary group have ensured that digital services and associated projects are safe, secure, and cost effective and aligned to the Trust strategic objectives.

2.7 The DIGIT group have monitored and made recommendations to the prioritisation and implementation of digital projects presented to the group by the Digital Programme Group (DPG). This also included the developments of the Robotic Automation Tool (RPA).

2.8 Agreed, and monitored audit plans and reports, including those from Internal Auditors.

2.9 Ensured serious incidents are investigated, actions completed, and lessons learned

are rolled out across the Trust.

2.10 The group reviewed a number of policies, procedures, and leaflets, including agreement to develop documents.

2.11 The group received reports that have identified, assessed, mitigated, and monitor plans in relation to risks and incidents. Included in the reports are the teams' areas of responsibility these are:

2.11.1 **Digital Program Group (DPG)** ensures DIGIT has an overview of any potential developments and projects including risks, costs, and resources and has input to what development should be a priority.

2.11.2 **IT services** included overview on service level agreements, core IT functions, information security aspects and risks associated changes to IT systems.

2.11.3 **Information Governance team** included the Data Security and Protection Toolkit, Data Protection Impact Assessments, agreements, Freedom of information and Subject access request functions. The reports included assurance from the Trusts Information Assets on behalf of the Information Asset Owners (IAO).

2.11.4 **Information Team** included data quality issues, performance information, and an overview of developments in the data warehouse and associated systems.

2.11.5 **IT Clinical systems** including the Caldicott Guardian function that monitors the use of clinical systems, the registration authority that ensures access to the systems is appropriate and monitored.

3 POLICIES, PROCEDURES AND LEAFLETS

3.1 The DIGIT group reviewed and approved the following policies and procedures and leaflets:

- Review of the Freedom of Information and Environmental Information Regulations Policy.
- Development of a Photographing and Recording Consultations and Treatment Leaflet.
- Review of the Marking in Error and Permanently Deleting Information in TPP SystmOne Patient Records Procedure.
- Review of the Subject Access/Access to Health Records Policy.
- Review of the Health Records Policy that included the development of a record keeping audit procedure to help consistent auditing within community and dental services. This development was in association with the Record Keeping Group lead by the Clinical Audit Team.
- Developed a Third-Party Supplier Policy to ensure that trust upholds its data controller responsibilities.

4 Digital Program Group (DPG)

4.1 The DPG is chaired by the Deputy Director of Finance.

4.2 The multidisciplinary group meet monthly and updated their Terms of Reference in June 2023.

4.3 DPG produced six highlight reports to DIGIT.

4.4 The DPG group gave DIGIT an update on the progress against the Digital and Clinical Systems Programme Plan for 2022/23 and associated key risks.

4.5 Notified the DIGIT group of any new projects and major change requests made by

services and for DIGIT to advise on strategic direction, prioritisation, and appropriateness of the requests.

4.6 Asked DIGIT to prioritise projects due changes in staff and the number of projects ongoing.

4.7 Update DIGIT on risks and benefits of each proposed change or development.

4.8 Gave assurance that each project deployment includes a roll-back plan to restore the state of the environment if issues arise.

4.9 Escalate any project risks to DIGIT where the impact has a long-term detrimental impact to the Trust.

4.10 Gave financial assurance for Digital services.

5 IT services/information security

5.1 IT services produce a report at each meeting.

5.2 The IT service have continued with infrastructure developments which is tracked against the workplan.

5.3 Procured and installed a further 250 replacement laptop devices as part of continued lifecycle management.

5.4 Migrated Pennine Dental Services clinical systems, devices, and staff into the Trust for internal support and compliance.

5.5 Migrated Halton Community Services devices and staff into the Trust for internal support and compliance, previously supported by Mid Mersey Digital Alliance.

5.6 Replaced end of life wireless infrastructure for staff and patients in clinical areas.

5.7 Refreshed all Warrington services onto Trust's internal telephony solution along with staff handset refresh.

5.8 Continued working with regional teams on a 24x7x365 security operations centre provision.

5.9 Enhancement of our IT service management toolset to offer other digital teams in optimising their user support function including business cases.

5.10 Migrated all Trust systems and applications onto latest operating systems for security, compliance, and risk mitigation.

5.11 Completed the national annual Data Security Protection Toolkit submission and mandatory internal/external audit reviews.

5.12 Provided assurance to DIGIT around risks in relation to BAF 8.

5.13 Notified DIGIT of High Severity CareCerts and Outcomes.

5.14 Reported service provision statistics and SLA measures.

5.15 Reported of ICS/National initiatives and funding.

6 Information Governance

6.1 There were two serious incidents requiring investigation (SIRI) reported through the DSPT portal, these where one in maternity services where the clear desk process was not followed. The other was in Warrington district nursing Services, where a staff member used a notebook to store personal information. The incidents have been investigated and was overseen the Serious Review Panel.

6.2 The team have now combined the registers. The Information Asset, Information

Sharing, Record of Processing and DPIA are now in one register. Combining the register allows streamline the data fields and documents.

6.3 The IG team and the Procurement team worked together to ensure that the mandated Digital Technology Assessment Criteria (DTAC) for third party suppliers is embedded in the procurement process. This also links to the DPG group, where both the IG team and the Procurement team are represented.

6.4 There were 230 access to records/Subject access requests from patients received in between April 2022 – 31st March 2023 there was one incident relating to record request being delayed beyond the one-month deadline.

6.5 The Trust achieved 82% compliance for Freedom of Information (FOI) requests. A total number of 369 FOIs in 22/23. There were two internal reviews undertaken of which both were upheld.

6.6 20 DPIA were undertaken in 22/23 with none being identified as high risk of information being compromised.

6.7 Policies were updated to ensure that the now mandated Digital Technology Assessment Criteria (DTAC) for health and social care is embedded within the development of digital systems.

7 INFORMATION TEAM

7.1 The Information Team provide DIGIT with assurance of completeness and timeliness of national submissions.

7.2 Assurances and updates of data warehouse development.

7.3 Raise awareness of risks or work relating to updates of NHS England dataset submissions.

7.4 Raise awareness and provide assurance of data improvement work programmes.

7.5 Report on Qlik sense (data visualisation software) usage.

7.6 Specific project updates such as Qlik roll out, Data Improvement events.

7.7 New projects were presented to DIGIT for discussion and subject matter exert advice.

8 CLINICAL INFORMATION SYSTEMS/RA

8.1 Clinical Safety report went to DIGIT regarding the clinical safety hazards arising from the roll out of EPMA within the Community Hospital Module for use in the intermediate care facility of Padgate House.

9 INTERNAL AUDITS 22/23

9.1 The DSPT now runs from 1st July to the 30th of June, previously it was fiscal year. The audit requirements are set by DPST.

9.2 The mandated internal audit to support the DSPT requirements the Trust achieve 'Moderate assurance' in 21/22 MIAA audit report. They also gave 'Substantial Assurance" overall for the 10 Data Guardian Standards.

9.3 The Trust published their DSPT baseline assessment on the 28/02/23.

9.4 The moderate scores were based on the newly implemented SIEM system not having a documented process. The back up and patching processes needed to improve. All have been actioned for 22/23 submission.

9.5 The IT Cyber Security – Organisational Controls Review the report was finalised in January 2023. The overall result was "moderate."

9.6 A training plan for staff regarding cyber security needs to be developed. Contingency

plans needed to be updated, for SIEM and the cyber response plan. A threat investigation process and re-certification of the cyber essential certificate was also recommended.

10 CONCLUSION

10.1 The DIGIT group have established reporting mechanisms that oversee digital development in the trust.

10.2 The DPG group and the reporting streams work well.

11 RECOMENDATION

11.1 This report is presented to the Committee for assurance regarding the operation of the systems and processes that facilitate and support digital agenda for the trust.

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	5 October 2023
Agenda Item	75/23ii		
Report Title	APPLICATION OF THE TRUST SEAL		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Jan McCartney – Trust Secretary		
Presented by	Jan McCartney – Trust Secretary		
Action Required	☐ To Approve	☐ To Assure	☒ To Note

Purpose

To record the use of the Trust Seal from 20 January 2023 to 22 September 2023.

Executive Summary

In the period from 20 January 2023 to 22 September 2023 there have been six applications of the Trust Seal. Detail of this is provided within the attached report for the Board's information.

Previously considered by:

☐ **Audit Committee**
☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**
☐ **Remuneration & Nominations Committee**
☐ **People 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	☐ BAF 8
Failure to implement and maintain sound systems of corporate governance	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	5 October 2023
Agenda Item	75/23ii		
Report Title	APPLICATION OF THE TRUST SEAL		
Report Author	Jan McCartney – Trust Secretary		
Purpose	To record the use of the Trust Seal from 20 January 2023 to 22 September 2023		

1. INTRODUCTION

1.1 Documents signed on behalf of the Trust, which must be executed under deed, are sealed as set out within the Trust's Standing Orders at Section 9, 'Custody of the Seal and Sealing of Document', and Section 10, 'Signature of Documents'. This is normally confined to land deals, including purchases, transfers, tenancy agreements and acquisitions.

2. INFORMATION

2.1 In the period 20 January 2023 to 22 September 2023 there have been six applications of the Trust Seal applied by the Trust Secretary or the Board and Committee Administrator on behalf of the Trust Secretary.

Table 1. Application of the Trust Seal

Seal Number/ Reference	Application of the Trust Seal	Date	Signed (Authorised officers)
01/23	Lease relating to rooms at Hallwood Health Centre, Link Road, Hallwood, Runcorn, WA7 2UT Between Johnathan David Benyon, Patricia Mary Abbott, Amy Danielle Turner and Lauren Moorcroft and Bridgewater Community Healthcare NHS Foundation Trust	2 March 2023	Nick Gallagher, Director of Finance and Paula Woods, Director of People Sealed (not witnessed) by Lynda Richardson, Board and Committee Administrator
02/23	Lease for Leigh Health Centre, The Avenue, Leigh, WN7 1HR Between Wrightington, Wigand and Leigh Teaching Hospitals NHS Foundation Trust and	24 March 2023	Signed by Paula Woods, Director of People and Nick Gallagher, Director of Finance Sealed (not witnessed) by Lynda Richardson, Board and Committee Administrator

	Bridgewater Community Healthcare NHS Foundation Trust		
03/23	Deed of Covenant relating to Leigh Health Centre, The Avenue, Leigh, WN7 1HR	24 March 2023	Signed by Paula Woods, Director of People and Nick Gallagher, Director of Finance Sealed (not witnessed) by Lynda Richardson, Board and Committee Administrator
04/23	Underlease between Community Health Partnership Limited and Bridgewater Community Healthcare NHS Foundation Trust for part of Lowe House, Healthcare Resource Centre, 103 Crab Street, St Helens, WA10 2DJ	3 April 2023	Nick Gallagher, Director of Finance and Paula Woods, Director of People Sealed (not witnessed) by Lynda Richardson, Board and Committee Administrator
05/23	Underlease relating to part of Oldham Integrated Care Centre, Oldham NHS LIFT, New Radcliffe Street, Oldham, Lancashire, OL1 1NL between Community Health Partnerships Limited and Bridgewater Community Healthcare NHS Foundation Trust	4 September 2023	Nick Gallagher, Director of Finance and Lynne Carter, Chief Nurse and Deputy Chief Executive Sealed (not witnessed) by Lynda Richardson, Board and Committee Administrator
06/23	Underlease relating to part of the Phoenix Centre, Church Street, Heywood, Lancashire, OL10 1LR between Community Health Partnerships Limited and Bridgewater Community Healthcare NHS Foundation Trust	4 September 2023	Nick Gallagher, Director of Finance and Lynne Carter, Chief Nurse and Deputy Chief Executive Sealed (not witnessed) by Lynda Richardson, Board and Committee Administrator

3. CONCLUSION

3.1 The Board is asked to note the use of the Trust Seal as set out in Table 1 above.