

PUBLIC BOARD MEETING

Thursday 9 October 2025, 10am

Ground Floor Conference Suite, Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
67/25	10.00	Apologies for Absence		Information
68/25	10.00	(i) Quoracy Statement (ii) Declarations of Interest in items on the agenda	1	Assurance
69/25	10.00	Minutes of the last meeting: (i) 7 August 2025	1	Assurance/ Approval
70/25	10.05	Matters Arising from the Action Log	1	Assurance
71/25	10.10	Any urgent items to be taken at the discretion of the Chair		
72/25	10.10	Patient Story: Paediatric Bladder and Bowel Service – presented by Emma Godfrey, Team Leader	2,3	Information
73/25	10.40	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Approval
74/25	10.50	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				
75/25	11.05	(i) IQPR – presented by Executive Leads (ii) Report from the Quality and Safety Committee held on 28 August 2025 – presented by the Committee Chair (iii) Winter Plans and Board Assurance Statements – presented by the Chief Operating Officer (iv) Responsible Officer Report – presented by the Medical Director (v) Learning from Deaths Report - presented by the Medical Director (vi) Freedom to Speak Up Update Report – presented by the Chief Nurse	1 2,3 1, 2 2,4,6 2,3 1-6	Assurance Assurance Assurance Approval Assurance Assurance

Ref	Time	Item Title	BAF Ref	Action
RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
76/25	12.05	(i) Reports from the Finance, Sustainability and Performance Committee in Common held on 26 August and 22 September 2025 - presented by the BCH Committee Chair	5	Assurance
		(ii) BCH Update from the Delivery Unit – presented by the Director of the Delivery Unit	2	Assurance
		(iii)Finance Report - presented by the Director of Finance	5	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				
77/25	12.25	(i) Reports from the Strategic People Committee in Common held on 20 August (including WRES and WDES and Terms of Reference for final ratification) and 17 September 2025 – presented by the BCH Committee Chair (ii) Organisational Strategy and Values – presented by the Chief Strategy and Partnerships Officer and WHH Director of Communications and Engagement (iii)NHS England’s 2025 Annual Self-Assessment for Placement Providers – presented by the Interim Assistant Director of People and Organisational Development	4,6	Assurance
CLOSING ITEMS				
78/25	12.50	Review of meeting and Items to be added to the Board Assurance Framework	1	Information
79/25		Opportunity for questions to the Board from staff, media or members of the public at the discretion of the Chair	1	Information
DATE AND TIME OF NEXT MEETING				
Thursday 4 December 2025, 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 7 August 2025, 10.00am

Ground Floor Meeting Room, Spencer House, Dewhurst Road, Birchwood, Warrington

Present

Martyn Taylor, Trust Chair
Nikhil Khashu, Chief Executive
Lynne Carter, Director of Delivery Unit and Deputy Chief Executive
Paul Fitzsimmons, Medical Director
Nick Gallagher, Director of Finance
Elaine Inglesby, Non-Executive Director
Ali Kennah, Chief Nurse
Dan Moore, Chief Operating Officer
Tina Wilkins, Non-Executive Director
Paula Woods, Director of People and Organisational Development

In Attendance

Jan McCartney, Director of Corporate Governance
Amena Patel, NeXT Director
Lynda Richardson, Board and Committee Administrator

For Patient Story (item 58/25 only)

Leanne Cain, Clinical Lead, Widnes Urgent Treatment Centre

53/25 APOLOGIES FOR ABSENCE

Gail Briers, Non-Executive Director
Bob Chadwick, Non-Executive Director
Abdul Siddique, Non-Executive Director

54/25 (i) QUORACY STATEMENT

The Chair confirmed that the meeting was quorate.

(ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No Declarations of Interest were made in respect of the items on the agenda.

55/25 MINUTES OF THE LAST MEETING

(i) BOARD MEETING HELD 5 JUNE 2025

The minutes were approved as an accurate record.

(ii) EXTRAORDINARY BOARD MEETING HELD ON 25 JUNE 2025

The minutes were approved as an accurate record.

56/25 MATTERS ARISING FROM THE ACTION LOG

84/24 Patient Story – Neuro-development Service

PF provided a verbal update: The firebreak period had now concluded. Reviews of long waits and the impact had been completed, with no moderate or severe harm reported. All cases on the waiting list, as well as those excluded from education had been discussed. Current capacity within the service was sufficient for high and medium-risk patients, however low-risk children would be unlikely to be seen in a timely manner. A discussion with commissioners was planned, with the Trust's intention to adopt the Portsmouth model. Benchmarking on the waiting list had been positive, but there was a drive for the Trust to improve further.

The Board discussed the determination of low-risk patients, and it was clarified that the Portsmouth model included assessment at referral, and assessments were also carried out with health visitors and social services. It was not yet clear whether a separate service for low-risk patients would be commissioned or if other solutions would be used. The risks associated with low-risk children were noted, particularly regarding disruptive behaviours impacting access to the curriculum, with potential disproportionate effects on girls and women. Quality Impact Assessments would be important, and the triage criteria are to be reviewed to ensure appropriate risk stratification. PF also confirmed to TW that discussions would need to take place around neuro development support for those aged 18 plus. He commented that the Trust must take a clear line should clinicians within the service retain patients after this point.

The Board noted the update and reporting on the findings and discussions with commissioners would be taken through EMT, the Quality and Safety Committee and into the Board as required.

41/25ii Report from Quality and Safety Committee on 14 May

A formal action plan on the community paediatrics and neurodevelopment service would be taken into the Quality and Safety Committee. Feedback would be provided via the Committee Chair's report back into the Board once received. This action would remain on the log for the meantime.

45/25ii Fit Proper Annual Review

The Board noted that this report was included on the agenda today.

The following items were rated as blue (completed) and could be removed from the action log:

85/24 Board Assurance Framework

42/25ii Finance Report – Comms Plan for savings

57/25 ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE TRUST CHAIR

MT confirmed that he had not been made aware of any urgent items of business to be taken.

58/25 PATIENT STORY – CHILDREN'S SERVICES – GP Connect Collaboration

Leanne Cain presented on the pilot project for the Urgent Treatment Centre (UTC), which supported community services and local patients. The pilot, which began in October 2024, aimed to provide same-day primary care to all patients, improving satisfaction post-COVID by offering the UTC as an alternative route to care.

The service operated from 10am to 6pm, promoting same-day care and offering appointments. Attendances and activity data were outlined, with 3,470 patients seen in one month and 146 GP Connect appointments offered, facilitating booking into GP practices. The

service included clear inclusion and exclusion criteria, dealing with acute issues and referring longer-term cases to GPs. Referrals to A&E were minimised, and staff were undertaking further training to ensure appropriate referrals. Patient feedback had been positive, with improved access and communication highlighted. The service aligned with the NHS 10-year plan, supporting a shift from hospital to community care, and included a DVT pathway and review of hypertension management. Collaboration with secondary care was ongoing, with future pathways under consideration.

There were currently 14 GPs involved in the pilot, with potential for this to be further expanded. The UTC had some capacity constraints and provided a walk-in service, with relationships with primary care being key to introducing new services. The GP Connect system had improved access to appointments and triage, with same-day or 72-hour appointments available. Feedback regarding the commissioning scope and service delivery was ongoing, with data collection and analysis planned to support further model development. The Board commended the service, its excellent work and its role in preventing hospital admissions.

Leanne Cain confirmed to AK that there would be additional GPs to be included in this work in the future, but that there had been 14 included as part of the pilot. She explained that the service had been asked to provide further appointment slots which was currently challenging. LC commented that positive relationships and mutual support between the Trust and Primary Care were of key importance, and the Trust would have a role to introduce Primary Care to other services such as the Halton HICAFs, encouraging the use of key services.

Leanne Cain advised TW that the service had been working effectively with positive feedback as patients were able to obtain appointments via this route, opposed to contacting their GP Surgery at 8am each day. She confirmed that those with long term/more complex conditions would be routed through GPs, with work ongoing to educate people on the best places to access the care they needed whether this would be via the UTC or GP. Concerning the outcomes of the same day appointments, Leanne Cain advised DM that there had been no issues raised. She confirmed that the appointment bookings were made directly onto an IT system.

NK referred to the areas that were in scope and out of scope for the service and noted that this was considerably detailed. He suggested that this may be complicated for the services and service users and asked how compliant the service was with the scope. Leanne Cain confirmed that the scope was agreed across Widnes and Runcorn services and was finalised by operational managers and clinical leads. She noted that there were occasions where a patient presented that was deemed to be outside of the scope, but the service did not turn any patients away and would attend to them as much as possible and/or signpost them to the appropriate service. LC confirmed to NK that the areas in scope were within the commissioning contract and the scope of the UTC.

MT suggested that it would be beneficial to have sight of any data around admission avoidance. He considered this was important in terms of building the model. LC confirmed that this information would be available and was collected within the UTC data set.

The Board thanked Leanne Cain for her presentation, and she left the meeting.

59/25 BOARD ASSURANCE FRAMEWORK (BAF)

JMC outlined a number of minor amendments, included at section two of the circulated report, for approval.

LC suggested three areas which may require inclusion within the BAF:

BAF4 (staff) - reflection on headcount and workforce challenges

BAF5 (resources) - delivery unit prevent or detect control reflecting the vacancy panel

BAF7 - to include the UEC and virtual ward as well as the system challenges.

NK advised that those areas would be discussed by the Executive Management Team. In terms of BAF 4, PW highlighted the RCN ballot which was anticipated in Autumn 2025. This would be discussed further at the next Strategic People Committee in Common on 20 August 2025.

No changes to the risk ratings were currently proposed. The Board approved the amendments to be made to the BAF.

60/25 KEY CORPORATE MESSAGES

NK presented the report and highlighted the following key points:

Activity undertaken during the period by Executive and Non-Executive Directors was noted. NK reported on a number of NHS leadership events that he had attended and made particular reference to a session with the Chief Executive of NHS England, Jim Mackey. A discussion took place at that session on the progress made since Jim Mackey's appointment. NK attended this session with GB in her capacity as Deputy Trust Chair. NK also took part in a visit to the Paediatric Bladder and Bowel Services based at Sandy Lane, Warrington,

On 2 July, the Bridgewater Board attended a joint session with the Board of Warrington and Halton Hospitals with the CQC. The CQC provided an overview of the most up to date Well Led Framework. This was followed by a formal Board to Board meeting where the Strategic Case for change was approved, along with the integration milestone plan. Both Trust Boards also approved the Joint Committee of the Boards terms of reference.

MT and NK had opened the Altrincham Hub on 22 July: Located in the Altrincham Health and Wellbeing Centre, this modern clinic served as a "one stop shop" for specialist dental care. It featured advanced treatment rooms and on-site X-ray facilities, specifically designed for patients with complex needs who could not access standard NHS dental services. The space was tailored to reduce anxiety and supported the NHS 10 Year Health Plan's goal of personalised care.

Positive staff engagement sessions had taken place in relation to Better Care Together focussed on the integration of Bridgewater and Warrington and Halton Hospitals. The most recent session had focussed on the future culture plan for the new organisation.

The NHS Oversight Framework was discussed, noting a provisional segment three status for the Trust. PWC would be meeting with organisations across the patch. Bridgewater would take part in its first financial performance meeting with PWC on 13 August 2025.

MT asked Non-Executive Director colleagues to attend as many Time to Talk sessions with staff and services as possible, in order to support executive and clinical and non-clinical colleagues. EI observed that there had been a number of repeat visits undertaken and

shared her concerns that some services had not been included in the programme. MT advised that he would ensure review of the current programme of visits to ensure accurate capture of all services.

61/25 **QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered**

(i) IQPR

The Chief Operating Officer presented the key highlights from the circulated report:
Operational performance:

- Dermatology cancer 31-day waits were now limited to a few patients awaiting an appointment with a specific clinician with one case related to patient choice.
- The percentage of patients referred to A&E from UTC remained high and was under review to determine the underlying causes.
- Children's services - an action plan was being devised to reduce referral percentages, and this would be taken through local meetings with teams.
- Audiology performance had been tracked over a number of months; this had not improved or deteriorated. There were vacancies and sickness absence within the service, however there were staff expected to commence in post imminently. There was an action plan in place, and in addition, considerations were being given to seeking mutual aid from the system.
- Recruitment in dental services was progressing: A paper had been taken into the Finance, Sustainability and Performance Committee in Common and EMT, with approval given to recruit to clinical vacancies within the service. This recruitment would bring services back to the contractual capacity threshold to meet standards, with 80% of sessions covered and work continuing to reduce waiting times.
- Dermatology 65-week waits remained a regional concern, with a plan in development to clear the backlog, including moving or arranging additional sessions. There were currently 270 patients over the threshold, with the potential for this to increase to 1,180 by the year end on the current trajectory. A paper had been taken into EMT to discuss the position with a further paper to be taken in a fortnights time. Discussions were also continuing with GPs and commissioners regarding the use of Advice and Guidance. A further update would be included within the next report to the October Board.

PF advised that AI use in dermatology had improved efficiency, with most referrals now managed through this route. 85% plus suspected skin cancer referrals were being taken through AI which was ahead of the ICS trajectory. Whilst further work was needed, this would help to ensure patient safety. PF commented that a move was required to a mandatory Advice and Guidance service with there being an important clinical safety case for this. PF advised that he intended to progress this and to cease the ERF referral for dermatology cases. Whilst this would not bridge a gap in services, it would support additional resource. DM advised that a paper would be taken into the EMT and later into the Board around this matter. He anticipated that it would take approximately three months to clear the backlog and it would be important for a plan to be agreed by October to operationalise at the end of the current financial year.

DM confirmed to EI that referrals had not been capped. Following EI sharing some recent observations around this, DM agreed to check the current position on this outside of the meeting. He confirmed that no instruction had been given for the dermatology service to cap referrals.

DM confirmed to TW that commissioners were in step with the Trust on dermatology and engaging in discussions. The Board welcomed the approach being taken on dermatology

services and noted the need for action to address 65-week waits, recognising the associated clinical risks. Currently this also had national significance. Concerns were shared about the current trajectory for waiters by year end and potential clinical risks associated with significant waits. NK commented that he would be keen for PF to escalate the position to the ICB Clinical Director. DM confirmed to EI that Bridgewater was not an outlier within the system; he noted that there was no residual capacity or mutual aid available, with similar issues across other organisations. MT commented that this was a significant issue, recognising the current level three CIP of £0.5m, he emphasised that more radical action was required and there could not be continued salami slicing.

AK presented the key highlights in terms of Quality Indicators: Challenges were continuing with pressure ulcers. Whilst all appropriate interventions had been undertaken, the numbers were prevalent and would need to be understood with the teams. Conversations were taking place on the measures in place and the learning. A pressure ulcer priority group was in place to support monitoring and met on a weekly basis, alongside a weekly incident group. NK asked AK to consider the frequency of the priority group and to increase this if required. **Following a query from EI, it was agreed that benchmarking information on pressure ulcers compared with other Community Services Trusts would be provided. Information should include if performance is positive or negative in comparison.**

EI suggested that it would be helpful for indicators demonstrating no changes/usual variation to have a 'Toyota' benchmark. **NK asked that this be taken through the Quality and Safety Committee.**

People and Finance (updated financial position included in the finance report) elements of the report were noted by the Board. **NK requested that regarding the workforce metrics, regional and national comparators would be beneficial for sightedness and asked that these be shared if available.**

NK questioned why the Board was considering month two data and asked whether month three information should be available. **NK advised that he would raise this matter for discussion at EMT. MT also highlighted that the report contained considerable factual data but with no information provided around actions being taken to improve areas. He asked that this be included going forwards.**

The Board received the report for assurance.

(ii) REPORT FROM THE QUALITY AND SAFETY COMMITTEE HELD ON 26 JUNE 2025

The Board received a report from the June meeting of the Quality and Safety Committee meeting from Non-Executive Director and Committee Chair, EI for assurance.

(iii) LEARNING FROM DEATHS REPORT

The Board noted that this update report had been deferred to October 2025.

(iv) LEARNING FROM DEATHS ANNUAL REPORT

PF presented the Annual Report for 2024/25. He reported that there had been 96 deaths, none of which had been as a result of any failures on behalf of the Trust. There had been four child deaths within this number and 23 deaths reviewed as part of the leader programme. PF referred to work that was being undertaken to consolidate the current learning processes into one process, which would be beneficial. He noted that the report for the current quarter would be the final report for Bridgewater as a separate organisation and

this would be a consolidated report with WHH going forwards, including the annual report for 2025/26. Conversations would be undertaken with Corporate Governance colleagues as to whether this would be a joint report or a report in common.

PF confirmed to EI that the medical examiner did not provide reports for individual organisations and would need to ensure they retained independence. The medical examiner would decide if there were any lessons from their findings or recommendations which would then be taken forwards at a lower level via a route such as MDT, with higher level concerns taken forwards via coronial process.

The Board received the report for assurance.

(v) FREEDOM TO SPEAK UP UPDATE REPORT

The Board noted that the update report had been deferred to October 2025.

(vi) FREEDOM TO SPEAK UP ANNUAL REPORT

The FTSU overview for 2024/25 was presented by AK. She reported that there were 17 champions in place with aspirations to increase to 50 with work progressing to recruit. 28 concerns were raised (an increase from the previous year), mostly from nursing staff as the largest organisational group. 20 of those were confidential or anonymous. FTSU training compliance was reported at 89%, with progress in self-assessment action planning. Work would be continued to encourage open reporting.

The Board agreed that there was a need to refresh FTSU to focus on patient care and safety related concerns and ensuring that staff were aware of and utilising proper channels for reporting other concerns. FTSU should also be considered alongside other areas such as Listening to Staff Voices and concerns raised in informal environments such as team meetings where concerns may be raised which needed to be documented. Induction materials were being refreshed to further promote FTSU and would include this important information. The FTSU Annual Report would be submitted to the National Guardian's Office.

62/25 RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(i) REPORT FROM THE FINANCE AND PERFORMANCE COMMITTEE HELD 23 JUNE 2025

The Board received a report for assurance from the final meeting of the Finance and Performance Committee held in June 2025 from Non-Executive Director and Committee Chair, TW.

(ii) REPORT FROM THE FINANCE, SUSTAINABILITY AND PERFORMANCE COMMITTEE IN COMMON HELD ON 28 JULY 2025

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

(iii) FINANCE REPORT

NG presented the key elements of the report:

- At month three, the Trust was reporting a £1.25m deficit, with level one and two savings and CIP schemes on track to month three.
- The Board noted the improved cash position at month three.

- There had been variations across income expenditure in month and income was below plan. There had been a reduction in spend and corresponding reduction in income. Within plan there had been the inclusion of Local Authority National Insurance impact on the pay award – this would not be recognised in the actuals for month three until this was formally agreed.
- An overspend on pay was noted, which was greater than the 5% savings expectation. CIP schemes were aligned with some due later in the year due to slight delays.
- Agency spending: a positive position was noted with minimal spending – there had been a 30% reduction and 10% on bank. The Trust was in the process of converting agency to bank, however strict controls would be maintained on the use of bank staff. Bank, agency and overtime were reviewed collectively to ensure performance was in line with or better than plan.
- CIP: NG reported a continuous improvement with the 'hopper' total amount identified with opportunities at £6.7m. Areas of this were still to be specified and PIDs to be completed. Should schemes not be delivered to time, this would be reviewed. Forecast position: Work was being undertaken on this with PWC. The Trust did not have savings identified for the system stretch. Consideration will need to be given as to how this is supported.
- Working capital remained positive with improvement noted as a result of larger debts being settled.
- PSPP: The Trust continued to be in line with the target and expected to pay 100% of invoices.
Creditors: The position was stable, larger aged creditors were in relation to properties with CHP and NHSPS working with both to resolve and settle queries.

NK corrected a number of areas within the report:

Statements in relation to Board financial performance on level one and two CIPs – the instruction that this must not exceed 5% was given by the Trust Board and not the ICB. At section 2.6. point three this stated: *'Level 3 – System 'stretch' savings – These savings are to be delivered across the system. System workstreams have been formed to identify opportunities. The system is expected to deliver these savings.'* NK advised that this was incorrect. The levers were system wide, but the Trust itself would be taking actions to support this.

The Board received the report for assurance and noted the above amendments to be made.

(iv) REPORT FROM THE AUDIT COMMITTEE HELD ON 12 JUNE, 25 JUNE (EXTRAORDINARY MEETINGS) AND 31 JULY 2025

The Board received reports for assurance from the June and July meetings from Non-Executive Director and Deputy Chair of the Audit Committee, TW.

TW confirmed to MT that debrief meetings had taken place with the Trust Auditors.

(v) ANNUAL DIGIT REPORT INCLUDING SIRO REPORT

The Board received the report which had also been taken through the Finance, Sustainability and Performance Committee in Common.

63/25 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) REPORTS FROM THE STRATEGIC PEOPLE COMMITTEE IN COMMON HELD ON 18 JUNE AND 16 JULY 2025

The Board received reports from Strategic People Committee in Common meetings held in June and July 2025, presented by the BCH Deputy Committee Chair, EI. The Board noted that the Committee in Common was progressing well.

The Board also finally ratified the Annual Workforce Assurance Report and the Facilities Time Off Annual Report. EI confirmed that the Strategic People Committee in Common had taken assurances from the reports and approved them at the meeting held on 16 July.

A discussion took place concerning the definition of fragile services for both Bridgewater and WHH. PF commented that a definition of fragile services had not been determined for Bridgewater and there was a need to revisit this for WHH.

EI suggested that going forwards further joint reporting should take place between both organisations to support understanding of key areas such as sickness absence as integration work continued. MT highlighted that due regard would need to be given to areas where this was not possible, recognising that both organisations were currently separate sovereign entities.

64/25 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) FIT AND PROPER PERSONS REPORT

JMC confirmed that all 10 Board members had successfully passed the requisite testing, with all deemed to be Fit and Proper. It was noted that the joint directors testing had been robustly undertaken previously by WHH. The Trust had reported its position on Fit and Proper at the end of June 2025 as per requirements to NHS England.

The Board received the report.

(ii) BOARD COMMITTEES: TERMS OF REFERENCE AND BUSINESS CYCLES INCLUDING COMMITTEES IN COMMON AND THE JOINT EXECUTIVE COMMITTEE

The Board received and approved the Terms of Reference and Business Cycles. **It was agreed that updates would be made to Chief Nurse and Deputy Chief Executive/Director of Delivery Unit titles. This information needed to be correct across both BCH and WHH Terms of Reference.**

(iii) CHESHIRE AND MERSEYSIDE PROVIDER COLLABORATIVE LEADERSHIP BOARD TERMS OF REFERENCE - PRESENTED BY THE DIRECTOR OF CORPORATE GOVERNANCE

JMC introduced the Collaborative Leadership Board Terms of Reference, which was now covering two provider collaboratives as one. This was approved in principle, pending further discussion. The vision, function, structure, and priorities of the collaborative were outlined. Communication and value from the collaborative would be addressed further outside the meeting.

65/25 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

The Board agreed that there were no further items to be reflected within the Board Assurance Framework following the discussions held.

66/25 OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

No questions raised/no staff, media or members of the public present.

DATE AND TIME OF NEXT MEETING

Thursday 9 October 2025, 10am at Spencer House, Dewhurst Road, Birchwood, Warrington

MOTION TO EXCLUDE

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

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

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
05.12.24	84/24	Patient Story – Neuro-development Service	The Board requested that the Associate Director of Children's Services discuss closer working with partner organisations to look to resolve some of the issues raised for the future, recognising that the Neurodevelopment/ADHD pathway was complex with many different partners involved at different points and that there was a lack of resources. The story would also be shared with the Trust's Neuro Development Group for consideration of future learning.	Paul Fitzsimmons/ Dan Moore	AMBER August 2025	February 2025: Update: Halton borough have a multi-agency programme of work underway which will develop an approach to supporting a child / young person's presenting needs rather than a focus on referral for diagnostic assessment. Halton and Wirral have been identified as pilot sites across cheshire and Merseyside to pilot this approach Warrington are planning to take a "fast follower" approach in due course. For families living in Frodsham and Helsby this is a little more complex in that the trust is commissioned to deliver ASD diagnostic assessment only – all other services are commissioned by Cheshire West Place ICB with providers including, Cheshire West and Chester Council (Family Hubs, Children's Services etc), Cheshire and Wirral Partnership NHS Foundation Trust (Health services) and Frodsham, Helsby and Elton Primary Care Network. We have however, since the board meeting been able to schedule meetings with cheshire west commissioners and requested a review the wider multi agency neurodevelopmental assessment pathway. August 2025: A verbal update was provided by the Medical Director to detail the outcomes of the recent firebreak. Reporting on the findings and discussions with commissioners would be taken through EMT, the Quality and Safety Committee and into the Board as required.

05.06.25	41/25ii	Report from Quality & Safety Committee on 14 May	Chief Operating Officer to provide an update on the 'firebreak' for the community paediatrics and Neurodevelopment Pathway at the next Quality & Safety Committee meeting	Dan Moore	GREEN December 2025	August 2025: This matter is ongoing. A formal action plan will be taken into the Quality and Safety Committee. Verbal update to be provided by the Medical Director.
05.06.25	45/25ii	Fit Proper Annual Review	Formal report to be presented to the August Board	Jan McCartney	BLUE	August 2025: Item included on the agenda.
07.08.25	61/25	IQPR	Benchmarking of pressure ulcers compared with other Community Services Trusts to be provided. Information should include if performance is positive or negative in comparison.	Ali Kennah	GREEN October 2025	
			Indicators showing no change/usual variation to have Toyota benchmark – this would be taken into the Quality and Safety Committee.	Ali Kennah	GREEN December 2025	August 2025: this action has been taken into the Quality and Safety Committee to be progressed.
			Regarding workforce metrics – regional and national comparators to be shared for context.	Paula Woods	BLUE	September 2025: Information and Performance Team added a slide to the IQPR. Data accessible as guided by the ICB. Performance Council aware as per September meeting.
			Month three IQPR information should have been provided to the August Board – discussion to take place on this at EMT. Report should also include actions being taken to improve areas.	Nik Khashu Dan Moore	GREEN October 2025	

07.08.25	61/25	Board Committee Terms of Reference and Business Cycles	Updates to be made to Chief Nurse and Deputy Chief Executive/Director of Delivery Unit titles. This information needed to be correct across both BCH and WHH ToRs.	Jan McCartney	GREEN October 2025	

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	73/25		
Report Title	BOARD ASSURANCE FRAMEWORK		
Executive Lead	Nikhil Khashu, Chief Executive Officer		
Report Author	Jan McCartney, Director of Corporate Governance		
Presented by	Jan McCartney, Director of Corporate Governance		
Action Required	☒ To Approve	☐ To Assure	☐ To Note
Executive Summary			
The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework. The BAF is the key mechanism which the Board uses to hold itself to account. It provides a structure to focus on risks that might compromise the Trust in achieving its strategic objectives and confirms to the Board of Directors that there is sufficient assurance on the effectiveness of controls.			
Previously considered by:			
☐ Audit Committee ☒ Quality and Safety Committee ☒ Finance, Sustainability and Performance Committee-in-Common ☐ Remuneration and Nominations Committee ☒ Strategic People Committee-in-Common ☐ EMT			
Strategic Objectives			
☒ Equality, Diversity and Inclusion - We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☒ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☒ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.			
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.			
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.			

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

☒ BAF 1	☒ BAF 2	☒ BAF 3	☒ BAF 4	☒ BAF 5	☒ BAF 6	☒ BAF 7	
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships Failure to work in close collaboration with partners and staff in place and across the system	

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



BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	73/25		
Report Title	BOARD ASSURANCE FRAMEWORK		
Report Author	Jan McCartney, Director of Corporate Governance		
Purpose	The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.		

1. EXECUTIVE SUMMARY

- 1.1 The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.
- 1.2 The BAF is the key mechanism which the Board uses to hold itself to account. It provides a structure to focus on risks that might compromise the Trust in achieving its strategic objectives and confirms to the Board of Directors that there is sufficient assurance on the effectiveness of controls.
- 1.3 The Board Assurance Framework is received at the Board, all the Committees of the Board and other key decision-making / operational meetings. It is a working document that is used in Committees and meetings to ensure the meeting agendas remain focused and proactive on strategic objectives. The recommended changes can be found in section 2.
- 1.4 Each BAF has also been updated with their corporate risks rated 12 and above from the risk register produced for the September Risk Management Council. The document has also been updated to reflect the newly established Strategic People Committee-in-Common and the Finance, Sustainability and Performance Committee-in-Common.

2. CHANGES TO THE BOARD ASSURANCE FRAMEWORK

2.1 **BAF 1: Governance**

The Audit Committee has not met since the last Board meeting, therefore there are no updates to report.

2.2 **BAF 2: Quality**

The Quality and Safety Committee met on 28 August 2025. The Committee did not identify any changes to be made to BAF2 and there were no proposed changes to the scoring.

2.3 **BAF 3: Health Equity**

The Quality and Safety Committee met on the 28 August 2025. The Committee did not identify any changes to be made to BAF3 and there were no proposed changes to the scoring.

2.4 **BAF 4: Staff**

The Strategic People Committee-in-Common met on 20 August and 17 September 2025. The Committee recommend the following updates.

Principal risk

- Add 'national, regional and system finance and workforce targets and work programmes and targets to reduce headcount, bank, agency, overtime and sickness.

Prevent Controls and Assurance

- Executive Vacancy Control Panel
- Delivery Unit
- E-roster System – Agency, Bank and Overtime Approval Process
- Finance & Workforce Principles
- Migration of Agency to NHSP

Detect Controls

- E-roster
- ESR reporting
- Overtime, Bank & Agency Reports

Emerging Risk

- Put RCN Industrial Action / Before proposed pay offer
- Take Apprenticeship Levy off

There was no proposed change to the scoring of the risk ratings.

2.5 **BAF 5: Resources**

The Finance, Sustainability and Performance Committee-in-Common met on 26 August and 22 September 2025. National Oversight Framework Segment 3 is now reflected on the rational

No change to the current risk rating is recommended.

2.6 **BAF 6: Equality, Diversity & Inclusion**

The Strategic People Committee in Common met on 20 August and 17 September the Committee did not identify any changes to be made and there were no proposed changes to the scoring.

2.7 **BAF 7 – Partnerships**

There have been no updates to this BAF.

3. RECOMMENDATION

3.1 The Board is asked to approve the changes recommended by the Committees.

Appendix 1: Board Assurance Framework



BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 24 September 2025

STRATEGIC OBJECTIVES

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

BAF 1 Governance	BAF 2 Quality	BAF 3 Health Equity	BAF 4 Staff	BAF 5 Resources	BAF 6 Equality, Diversity & Inclusion	BAF 7 Partnerships / Integration with WHH
Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Failure to deliver quality services and continually improve	Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Failure to create an environment for staff to grow and thrive	Failure to use our resources in a sustainable and effective way	Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Failure to work in close collaboration with partners and staff in place and across the system
Risk Rating Inherent risk rating 4 (C) x 4 (L) = 16 significant Current risk rating 4 (C) x 2 (L) = 8 medium Target risk rating 4 (C) x 2 (L) = 8 medium	Risk Rating Inherent risk rating 5 (C) x 5 (L) = 25 significant Current risk rating 5 (C) x 3 (L) = 15 significant Target risk rating 5 (C) x 2 (L) = 10 high	Risk Rating Inherent risk rating 3 (C) x 5 (L) = 15 significant Current risk rating 3 (C) x 4 (L) = 12 high Target risk rating 3 (C) x 2 (L) = 6 medium	Risk 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 1 (L) = 4 low	Risk Rating Inherent risk rating 4 (C) x 5 (L) = 20 significant Current risk rating 4 (C) x 4 (L) = 16 significant Target risk rating 4 (C) x 2 (L) = 8 medium	Risk Rating Inherent risk rating 4 (C) x 4 (L) = 16 significant Current risk rating 4 (C) x 3 (L) = 12 high Target risk rating 4 (C) x 1 (L) = 4 low	Risk Rating Inherent risk rating 3 (C) x 4 (L) = 12 high Current risk rating 3 (C) x 4 (L) = 12 high Target risk rating 3 (C) x 2 (L) = 6 low
Risk Appetite: Cautious	Risk Appetite: Cautious	Risk Appetite: Open	Risk Appetite: Seek	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Seek

Board Assurance Framework (BAF) October 2025 – DRAFT

BAF 1: Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	RELATED OBJECTIVES: - Quality - Health Equity - Staff - Resources - Equality, Diversity and Inclusion - Partnerships	RISK RATING: Inherent risk rating: 4 (C) x 4 (L) = 16 significant Current risk rating: 4 (C) x 2 (L) = 8 medium Target risk rating: 4 (C) x 2 (L) = 8 medium		RISK APPETITE: CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		
Audit Committee last review: July 2025 Risk Ratings review: July 2025	If the Trust is unable to put in place and maintain effective corporate governance structures and implement and maintain sound systems of Corporate Governance, then there may be poor oversight of Board level risks and challenges, resulting in failure to deliver the strategy. Risks on register 15 plus No risks at this level	Prevent Controls - Accountability Framework in place - Board Assurance Framework & Risk Register - Board development - Standing Financial Instructions - Scheme of Reservation and Delegation - Operational management structure and policies and procedures are in place - Trust Board scrutiny	Detect Controls - Board development - Board Members working within wider system - Committees receive by exception reports from operations leads, these are reported to the Board - Contributing to work across the system in relation to developing Children's Services - Council structure, reporting to Committees - Engagement internally / externally with partners - Execs carrying out SRO roles within system - Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint - Joint working on a number of projects with commissioners and local authority - Performance framework – enabling strategies - operation delivery plans - Regular Exec meetings with commissioners and other key stakeholders - Senior Leadership Team meeting monthly - Senior staff involvement with borough based integrated care partnerships visions; 'Warrington Together' and 'One Halton' - Staff engagement - Targeted action planning on Staff Survey results - Compliance with ICB requirements	Assurances - Annual Review of Effectiveness of Audit Committee - Annual Review of Effectiveness of External Audit Service - Annual Review of Effectiveness of Internal Audit & Anti-Fraud - Annual Reports received from Committees of the Board - Board, Committees (Audit, Quality & Safety, Finance, Sustainability & Performance Committee-in-Common, and Strategic People Committees-in-Common) - Clean Unmodified Audit Opinion & clean VFM opinion 2024/25 - Substantial Assurance rating from Internal Audit 2024/25 - Daily automated data reporting - Declarations of Interests Register - Emerging integrated governance structures with partners - External independent Well Led review 2023 - Internal Audit Plan agreed for 2025/26 - Anti-fraud plan agreed for 2025/26 - ICB Provider Collaborative member - MIAA governance checklists - MOU in place where services are delivered in conjunction with other partners - PWC Investigation & Intervention Report Audits 2023/24 Risk Management Core Controls – High DSPT – Substantial 2024/25 Risk Management Core Controls – High DSPT – Substantial EPRR – Substantial
Risks on register 12 2428 Data Security Protection 3161 EPRR Training Compliance 3173 EPRR On Call Arrangements	Rationale for current score - Governance structure approved by Board and audited by internal and external auditors. - Substantial Assurance – Heads of Internal Audit opinion 2023/24 - Triangulation with Risk Register, Incidents, items on Committee agendas. - Trust Strategy 2023 'Communities Matters', now approved by Board with enabling strategies - Well Led 2023 report and recommendations accepted and action plan completed and signed off by the Audit Committee April 2024.			
Gaps in controls and assurance: 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. - Integration / Acquisition programme with WHH in progress		Mitigating actions: Board oversight		Emerging risks: Ability to resource the integration programme NHS and system financial risks impacting on the Trust. Operational Planning Guidance impact Shift in direction of Trust Strategy

Board Assurance Framework (BAF) October 2025 – DRAFT

BAF 2: Quality Failure to deliver quality services and continually improve.	RELATED OBJECTIVES: - Health Equity - Resources - Staff		RISK RATING: Inherent risk rating: 5 (C) x 5 (L) = 25 significant Current risk rating: 5 (C) x 3 (L) = 15 significant Target risk rating: 5 (C) x 2 (L) = 10 high		RISK APPETITE: CAUTIOUS Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent to patient safety and effectiveness.
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Chief Nurse last review: August 2025 Q&S Committee last review: August 2025 Risk Ratings review: August 2025 <i>In collaboration with</i> Strategic People Committee in Common	If we fail to deliver safe and effective services, then there may be potential harm to patients and their outcomes. Risks on register 15 plus 3376 Community Paediatrics demand, Warrington & Halton (<i>x-ref BAF 3,4,5,6</i>) 3341 Failure to provide contracted Dental Services within GM (<i>x-ref BAF 5</i>) Cross-referenced with BAF 5, Resources	Prevent Controls - Clinical policies, procedures & pathways - Weekly Senior Safety Huddle - Directorate Team Meetings - Freedom to Speak Up Guardian in place - Quality Impact Assessment Process - Risk Management, Quality, Performance & Transformation Councils in place - Trust Strategy – Communities Matter - Winter Plan - Statutory & Mandatory Training	Detect Controls - Clinical & Internal Audit Programme - Clinical Quality and Performance Groups (CQPGs) in place with all NHS commissioners. - E-roster monitoring - End of Life group - Equality Impact Assessments - Health and Safety group - Increased reporting of incidents, including medication incidents - IQPR & quality dashboards - Learning from Deaths report - Quality Council - Performance Council - Quality & Safety Committee bi-monthly meetings - Quality Impact Assessments - Quality Visits - Trust Transformation Programme (BOOST) - Patient experience scores - Listening to staff voices - Revalidation & registration	Assurances - Regular engagement with CQC - External Well Led review - IQPR & quality dashboards - Consistency of reporting patient safety incidents (measured nationally) - Deep dives at Committee - Clinical Peer Safety Review - Neurodevelopment pathway work commenced	
Risks on register 12 2428 Data Security Protection 2985 – Dental GM, waiting lists 3398 – Equipment Stores, equipment not being tested when received 3258 – EoL – demand / capacity					Rationale for current score
					- Winter plan - Enabling strategies: - Medicines Management - Safeguarding - Engagement - Risk - People strategy - EDI strategy - Industrial action (BMA) - Number of quality risks - Quality & Safety governance structure in place. - Robust QIA process for service changes - Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports. - Waiting list pressures
Gaps in controls and assurance: - Paediatric Audiology - Clinical leadership strategy – in development - Recruitment & Retention - CIP 2025/26		Mitigating actions:		Emerging risks: Neurodevelopment pathway – 6 week pause in activity to review service Paediatric Audiology	

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BAF 3: Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients.	RELATED OBJECTIVES: - Equality, Diversity, and Inclusion - Partnerships - Quality	RISK RATING: Inherent risk rating: 3 (C) x 5 (L) = 15 significant Current risk rating: 3 (C) x 4 (L) = 12 high Target risk rating: 3 (C) x 2 (L) = 6 medium	RISK APPETITE: OPEN Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.	
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		
Medical Director last review: June 2025 Q&S Committee last review: June 2025 Risk Ratings review: June 2025 In collaboration with: Finance, Sustainability & Performance Committees in Common Strategic People Committees in Common	If we fail to understand health inequity with our communities, we may fail to deliver services in an equitable way, which could contribute to health inequity and our patient's ability to improve their health. Risks on register 15 plus 3376 Community Paediatrics demand, Warrington & Halton (x-ref BAF 2,4,5,6)	Prevent Controls - Board development - Chair working within wider system - Contributing to work across the system in relation to developing Children's Services - Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint - Health Inequalities and Prevention Pledge Trust Board Oversight – engagement and delivery of Health & Care Act & strategic milestones - Performance framework – enabling strategies - operation delivery plans - Embedding an expectation of improving health equity in board, committees and Trust groups.	Detect Controls - Execs carrying out SRO roles within system - Joint working on a number of projects with commissioners and local authority - Patient Satisfaction Surveys - Regular Exec meetings with commissioners and other key stakeholders - Senior staff involvement with borough based integrated care partnerships visions including: 'Warrington Together', 'One Halton' and Dental Networks - Understanding activity and referral data in relation to access to services - Health & Wellbeing Boards - CIPHA - Childrens and Adults safeguarding Boards	Assurances - Emerging integrated governance structures with partners - Engagement internally / externally - Executive Directors hold regular meetings with all key partners and stakeholders - Implementing Dental Strategy with partners - Mental Health, Community and Learning Disability Provider Collaborative member – Trust is host, including employing staff – C&M Health and Care provider collaborate including employing and hosting staff - MOU in place where services are delivered in conjunction with other partners - Programme Director – Collaboration and Integration - Achieving Anchor status - Developing health equity indicators in IQPR
Risks on register 12	Rationale for current score - Enabling strategies: - Prevention Pledge - JSNA - Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports. - Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. Increased assurance from system relationships and partnerships - Health equity will be influenced by national, regional and local policies. The Trust will influence some elements of health equity but cannot be singularly responsible for improving health equity where we work.			
Gaps in controls and assurance: - Health equity improvement is a system responsibility - Mature health equity indicators - Quality Impact Assessment Panels		Mitigating actions:		Emerging risks:

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BAF 4: Staff Failure to sustain an environment for staff to develop, grow and thrive.	RELATED OBJECTIVES: - Equality, Diversity and Inclusion - Health Equity - Partnerships - Resources - Quality		RISK RATING: Inherent risk rating: 4 (C) x 4 (L) = 16 significant Current risk rating: 4 (C) x 4 (L) = 16 significant Target risk rating: 4 (C) x 1 (L) = 4 low		RISK APPETITE: SEEK - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Director of People & OD last review: September 2025 Strategic People Committees in Common last review: September 2025 Risk Ratings review: September 2025	If we fail to sustain an environment for staff to develop, grow and thrive, in a safe, inclusive environment then it may result in low staff morale, less effective teamwork, reduced compliance with policies and standards; high levels of staff absence; and high staff turnover rates. National regional and system finance and workforce targets to reduce headcount, agency, overtime and sickness. Risks on register 15 plus 3376 Community Paediatrics demand, Warrington & Halton (x-ref BAF 2,3,5,6)	Prevent Controls - Apprenticeship Programme - Bi-monthly meetings with Staff Side - Freedom to Speak Up & Listening to staff voices - In-house Resilience Training Programme - Local Negotiating Committee, Joint Negotiation & Consultative Committee - North West Person-Centred approach to absence management - Occupational Health Service & Staff Health & Wellbeing Officer/Board Health & Wellbeing Guardian - Onboarding surveys - People Organisational and local Staff engagement plan - People Plan, Promises & NHS Long Term Workforce Plan - POD Council - Culture and Leadership - Recruitment & Retention - Health & Wellbeing programme - Education & Professional development - PPDR and Statutory & Mandatory Training compliance report - Talent Management process and Succession Planning Tool (Scope For Growth) - Reward and recognition packages - Exec vacancy control panel - Vacancy Management (standing agenda item DLTs) - Workforce planning and plans - Staff governors - Choose Kindness campaign and initiatives - Sexual safety campaign and initiatives - Delivery Unit	Detect Controls - Strategic People Committees-in-Common with WHH - Feedback from Quality and Safety Committee on workforce issues - Safer staffing - Monthly Time to Talk including CEO Q&A sessions - Freedom to Speak Up & Listening to staff voices - National Staff Survey - North West Person-Centred approach to absence management (early adopter Trust) - Onboarding surveys - People Indicators / KPIs - POD Council (operational plans) - Culture and Leadership - Recruitment & Retention - Health & Wellbeing programme - Education & Professional development - PPDR and Statutory & Mandatory Training compliance report - Exit interview questionnaire - Staff Friends and Family Test (SFFT) and Staff Engagement Surveys - Staff Networks - Staff Stress Audit Survey - Delivery Unit - E.Roster system - ESR reporting	Assurances - Employee Relations Activity Report - Outcome of Staff Survey – sustained score for staff engagement - Responsible Officer’s Board report - Staff Survey and ‘temperature check’ surveys - Triangulation of People Indicators - Improved staff survey scores (2024) - Improved KPI indicators - Bronze accreditation – North West Anti Racist Framework - Finance & Workforce Principles - Overtime, bank and agency reports Audits 2023/24 Stress Risk Assessments – Limited 2024/25 Freedom to Speak Up – High Bank & Agency – Moderate	
Risks on register 12 3296 Podiatry waiting lists	Rationale for current score - Enabling strategies: - People - EDI Strategy - Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports. - Vacancy management rates				
Gaps in controls and assurance: - Staff morale and resilience (inc. cost of living crisis) – ongoing monitoring, communication, engagement and health and wellbeing services and programmes - Lack of national system for talent management – Trust has local processes in place		Mitigating actions:		Emerging risks: Ability to resource the integration programme System wide commitment to level playing field on incentives National shortage of key staff groups Proposed pay offer, RCN Industrial Action	

Board Assurance Framework (BAF) October 2025 – DRAFT

BAF 5: Resources Failure to use our resources in a sustainable and effective way	RELATED OBJECTIVES: - Equality, Diversity and Inclusion - Health Equity - Quality - Staff		RISK RATING: Inherent risk rating: 4 (C) x 5 (L) = 20 significant Current risk rating: 4 (C) x 4 (L) = 16 significant Target risk rating: 4 (C) x 2 (L) = 8 medium		RISK APPETITE: OPEN Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Director of Finance last review: September 2025 Finance, Sustainability & Performance Committees in Common last review: September 2025 Risk Ratings review: September 2025 <i>In collaboration with</i> Strategic People Committees in Common	Failure to use our resources in a manner to delivery our operational plan. Failure to achieve the CIP target and the additional system savings required (Resources include workforce, finance, estates and digital) Risks on register 15 plus 3376 Community Paediatrics demand, Warrington & Halton (x-ref BAF 2,3,4,6) 3341 Failure to provide contracted Dental Services within GM (x-ref BAF 5) Cross-referenced with BAF 2, Quality	Prevent Controls Careful utilisation of our resources will enable us to invest and transform our services to ensure continued sustainability of the services we provide. This will be achieved through: Finance - National and regional financial planning and management arrangements, Trust Financial Plan and planning process, Accountability Framework and Standing Financial Instructions with limits approved by the Board, Agreed medical and nursing revalidation protocols, preparation and remedial processes. People - Agreed recruitment and selection policies and processes (safer recruitment / FPPT). Bi-monthly meetings with staff side between JNCC, HR Policies and working groups, People Strategy & NHS Long Term Workforce Plan, POD Council, DLT discussions including HR Business Partners, Business continuity plans in place, Robust temporary staffing expenditure control and monitoring – MIAA follow up in progress Digital - Trust Digital Strategy, project governance and assurance, DSP Toolkit, GDPR Cyber Security standards, Service Management standards (ITIL, ISO etc) Estates - Capital Plan, Estates Strategy Trust hybrid working Green Plan, Process around Capital and Revenue Business Cases Operations - Transformation Council etc Vacancy approval process in place Increased scrutiny by Committee	Detect Controls - Delivery Unit (Pay, non pay, productivity) - Variable staff/pay reporting (bank, agency & overtime) - Staff sickness reporting - Audit Committee receives reports from internal audit and external audit - Capital Group monthly review - CIP plus QIA/EQIA process - Committees receive Audit Recommendations tracker - FS&P Committees-in-Common review monthly financial performance - Strategic People Committees-in-Common review KPIs - ICB control and reporting (finance, workforce and activity) - NHSE monthly returns - Staff survey / Pulse Survey results - Turnover rate reporting - Vacancy control panels - Digital - Estates	Assurances - Board review of internal audit plan - Board review of external audit plan and annual accounts - Escalation from Quality & Safety Committee - Health Rostering / Safer Staffing Report - Integrated Quality Performance Report includes workforce metrics including training levels and ‘heat map’ - Monthly Finance Report including - Financial position / Forecast Position - Cash & Capital - Working Capital - CIP - Performance report indicating number of lapsed registrations each month - Review of Winter Plans - Workforce approval panel - Vacancy approval process reviews use of variable staff – regular review of staffing levels - Workforce plans developed for all services - Apprenticeship Levy Audits 2023/24 Accounts Payable – High Accounts Receivable – High Treasury Management – High General Ledger – Substantial DSPT – Substantial 2024/25 General Ledger – High Accounts Payable – High Accounts Receivable – High Treasury Management – High EPRR – Substantial Bank & Agency – Moderate	
Risks on register 12 2428: Data Security Protection 3161 EPRR Training Compliance 3173 EPRR On Call Arrangements 3332 Dermatology Capacity 3372 Wheelchair service – reduced capacity 3387 – Trust financial plan		Rationale for current score - Triangulation with the various areas of resource including; financial, physical, digital and staff. - Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports. - Governance arrangements in place - Committees of the Board - Current forecast is off the original plan but in line with revised outturn agreed with ICB - Enabling strategies: - Digital - Finance - Estates & Development - Green Plan - People - EDI Additional place integration savings ask alongside the CIP challenges National Oversight Framework – Segment 3			
Gaps in controls and assurance: - The 2025/26 Trust challenging CIP as not all programmes have not been finalised and implemented. Contingency schemes not yet identified - Reduction in variable pay spend targets. The Trust is focussing on supporting all teams to deliver the planned savings and spend reductions and support and advice sessions will be included in the Senior Leadership Team meeting.		Mitigating actions: 2024/25 Financial recovery plan actions to continue 2025/26. - Delivery Unit established		Emerging risks: - Ability to resource the integration programme - ICB management of system deficit - Review of Trust estate	

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BAF 6: Equality, Diversity & Inclusion Failure to build a culture that champions ED&I for staff	RELATED OBJECTIVES: - Health Equity - Resources - Staff		RISK RATING: Inherent risk rating: 4(C) x 4 (L) = 16 significant Current risk rating: 4 (C) x 3 (L) = 12 high Target risk rating: 4 (C) x 1 (L) = 4 low		RISK APPETITE: OPEN Willing to consider all potential delivery options and choice while also providing and acceptable level of reward
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Director of People & OD last review: September 2025 Strategic People Committees in Common last review: September 2025 Risk Ratings review: September 2025 <i>In collaboration with</i> Finance, Sustainability & Performance Committees in Common Quality & Safety Committee	If we fail to continue to build a culture that champions EDI for staff, (the baseline) then: - we will not meet the diverse needs of our workforce, adversely impacting on the provision of compassionate care to our diverse population, representative of the communities we serve. - staff with protected characteristics may have a poor experience Risks on register 15 plus 3376 Community Paediatrics demand, Warrington & Halton (x-ref BAF 2,3,4,5)	Prevent Controls - Bronze accreditation – North West Anti-Racist Framework - Bi-monthly meetings with Staff Side with regard to the NHS EDI Improvement Plan - Equality delivery system 2 - Education & Professional development - Health & Wellbeing programme - Local Negotiating Committee and Joint Negotiation & Consultative Committee - North West Person-Centred approach to absence management (one of 4 Trusts piloting this) - Strategic People Committees-in-Common - Organisational and local Staff engagement plan - POD Council - Public Sector Equality Duty - Recruitment & Retention processed (EDI focused) - Talent Management process and Succession Planning Tool (Scope For Growth) - Just Culture - WDES - WRES - Choose Kindness campaign and initiatives - Sexual safety campaign and initiatives	Detect Controls - Feedback from Quality and Safety Committee on workforce issues - Freedom to Speak Up process - Employee relations activity/case loads - Gender Pay Gap Report - HR Policies & Procedures - In-house Resilience Training Programme - Key Operational Delivery Controls - National Staff Survey - NW EDI Group - NW BAME Assembly Support - POD Council - Revised exit interview questionnaire and processes - Staff Friends and Family Test (SFFT) and Staff Engagement Surveys - Staff Stress Audit Survey - Staff survey feedback	Assurances - Outcome of Staff Survey – sustained score for staff engagement - People Operational Delivery Actions Plans - Public Sector Equality Duty - Staff Networks - Staff Survey and ‘temperature check’ surveys - People Indicators and KPIs	
Risks on register 12 2985 Dental GA Paediatric Access	Rationale for current score - Current risk rating reflects that the Board acknowledges that, despite the controls and assurances in place, this will be ongoing: - Organisational restructures, service redesigns and reorganisations - Patient experience may be adversely affected (links to Q&S Committee) - Restoration and recovery programmes / post covid effects - Recovery from Industrial Action - Uncertainty / Impact of national change programmes – Health & Care Act integration and collaboration - Enabling strategies: - Equality, Diversity & Inclusion - Strategic People Committees-in-Common ensure governance and holds to account. - Triangulation with Risk Registers, incidents, employee relations activity, items on Committee agendas, Council Chair's Reports, IQPR People Indicators and KPIs				Audits
Gaps in controls and assurance: Engagement with staff groups including BAME and LGBT+ staff (remain until all established and Networks are embedded)					

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BAF 7: Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system	RELATED OBJECTIVES: - Quality - Health Equity - Staff - Resources - Equality, Diversity and Inclusion - Partnerships	RISK RATING: Inherent risk rating: 3 (C) x 4 (L) = 12 high Current risk rating: 3 (C) x 3 (L) = 9 medium Target risk rating: 3 (C) x 2 (L) = 6 low	RISK APPETITE: SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		
Chief Executive last review: May 2025 Executive Management Team last review: May 2025 Risk Ratings review: May 2025	If we fail to work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities, then: - we will fail to work with partners to champion patient care, resulting in failure to optimise outcomes and failure to effectively use resources If the Trust fails to successfully integrate services with WHH in a timely manner, there is a risk that: - The system remains clinically and financially unsustainable - We will not make the sustained improvements needed to the local urgent and emergency care system and pathways . Risks on register 15 plus No risks at this level	Prevent Controls - Better Care Together programme with WHH 'Communities Matter' Trust Strategy - Contributing to work across the system in relation to developing services - Emerging integrated governance structures with partners - Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint - Mental Health, Community and Learning Disability Provider Collaborative member – Trust is host, including employing staff – C&M Health and Care provider collaborate including employing and hosting staff - Voluntary and Community Link Workers providing targeted support to contribute to the overall enhancement of well-being - SLA in place with GP Health Connect	Detect Controls - Ongoing Board development - Contributing to work across the system in relation to developing services - Joint working on a number of projects with commissioners and local authorities - Performance framework – enabling strategies - operation delivery plans - Senior staff involvement with borough based integrated care partnerships visions; 'Warrington Together', 'One Halton' and dental managed clinical networks - Clinical engagement with Dental managed clinical networks - Place-based maturity assessments (Warrington Together and One Halton) - Joint CEO with WHH - Joint Medical Director with WHH - Joint Chief Operating Officer with WHH - Data sharing agreement with WHH - Summary case for change approved	Assurances - Implementation of dental strategy with partners - SLAs and MOUs in place where services are delivered in conjunction with other partners - Programme activity of the Mental Health, Community and Learning Disability Provider Collaborative - Public and community engagement - Place-based leadership and influence - ICB Virtual Ward programme - PCN developments and relationships - Progress on Family Hubs with Halton Council and partners - EDI Strategy in place - Public & Community Engagement Group
Risks on register 12 None	Rationale for current score - Better Care Together programme - Enabling strategies: - Dental - Increased assurance from system relationships and partnerships - Triangulation with Risk Register, Staff Survey, reports from Partner organisation, items on all Committee agendas, Council Chair's Reports and EDI Improvement Plan. - Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. - Current level of investment in Place-based set up - Contribution to Warrington based adaptive reserve fund			
Gaps in controls and assurance: - Lack of integration governance systems - Maturity of place-based relationships - Impact of pressures (inc. finance)		Mitigating actions: - Better Care Together programme - Joint executive roles		Emerging risks:

Board Assurance Framework (BAF) October 2025 – DRAFT
Appendix 1: Risk grading criteria

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

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

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

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

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	74/25		
Report Title	KEY CORPORATE MESSAGES		
Executive Lead	Nikhil Khashu, Chief Executive		
Report Author	Jan McCartney, Director of Corporate Governance		
Presented by	Nikhil Khashu, Chief Executive		
Action Required	☐ To Approve	☐ To Assure	☒ To Note
Executive Summary			
The Board is asked to note the content of the report			
Previously considered by:			
☐ Audit Committee ☐ Quality and Safety Committee			
☐ Finance, Sustainability and Performance Committee-in-Common ☐ Remuneration and Nominations Committee			
☐ Strategic People Committee-in-Common ☐ EMT			
Strategic Objectives			
☒ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☒ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☒ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.			
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.			
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.			



How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☐ BAF 2	☐ BAF 3	☐ BAF 4	☐ BAF 5	☒ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	74/25		
Report Title	KEY CORPORATE MESSAGES		
Report Author	Jan McCartney, Director of Corporate Governance		
Purpose	To update the Board concerning key matters within the Trust and the NHS as a whole.		

1. NON-EXECUTIVE DIRECTOR UPDATES

1.1 Since the last update, the Chair has attended the following meetings during the reporting period:

- National Community Chairs meeting
- GGI Seminar
- EDI Group
- National NHSE meeting regarding the acquisition
- Chief Executive, Chief Finance Officer and Chairs meeting with the ICB

The Chair, along with the Chair of Warrington & Halton Teaching Hospitals Trust met with the Chief Executive, Cllr McLaughlin and the Director of Adult Services at Warrington Borough Council.

The Chair also held 1-1 meetings, one with the Chief Operating Officer and one with the Chief Nurse. He also met with Amena Patel regarding the NExT Programme.

1.2 Non-Executive Director, Bob Chadwick attended a pre PWC meeting with the Chair and Chief Executive and on 13 August attended the M3 PWC Financial Performance meeting. He also attended the Cheshire & Merseyside Audit Chairs meeting on 23 September and on 29 September attended Bridgewater's Annual Members meeting.

On 11 August, Bob met with the Chair for his appraisal as part of the annual appraisal process.

1.3 Non-Executive Director, Gail Briers attended the Council of Governors meeting on 27 August and on 3 September attended the Non-Executive Directors meeting. Gail had a 1-1 meeting with the Lead Governor on 11 September.

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

- Accompanied the Director of Corporate Governance on two Time to Talk visits, one to Padgate House on 15 August, and one to Halton Adults Speech and Language Team on 26 August.
- On 15 August, Brookvale Baby Shower event, which was also attended by Dame Andrea Leadsom.
- Council of Governors meeting on 27 August.
- Met with the Trust Chair, Chief Nurse and Chief Operating Officer on 28 August.
- A service visit to the Patient Engagement Team with the Lead Governor on 11 September
- Attended the Annual Members meeting at Spencer House on 29 September.
- On 2 October, attended the Association of NHS Groups (AoG) in London.
- On 23 September, had a 1-1 meeting with the Chief Nurse.

1.5 Non-Executive Director, Tina Wilkins attended the Annual Members meeting on 29 September.

2. EXECUTIVE DIRECTOR UPDATES

2.1 During August, individual Directors' appraisals have been undertaken by the Chief Executive.

2.2 On 15 September, the Chief Executive attended an NHS Leadership event in London.

2.3 On 16 September, the Chief Executive attended a Chief Executive's meeting in London.

Executive and Senior Team Engagement

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



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

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

2.7 The following Time to Talk sessions have taken place:

2.7.1 The Director of Corporate Governance held two Time to Talk sessions during the reporting period:

15 August – met with the team at Padgate House.

26 August – met with the Speech & Language Therapy Services based at Lister Road, Runcorn.

Non-Executive Director, Elaine Inglesby joined both sessions.

2.8 Board Sessions/Events

An Executive Away Day took place on 4 and 5 September to discuss key topics.

Bridgewater's Annual Members meeting took place on 29 September. Key presentations were provided by the Chair, Chief Executive and the Director of Finance. This event was well attended.

3. EXTERNAL PUBLICATIONS, REPORTS & LOCAL NEWS

3.1 Correspondance from Sir James Mackey

In September the Chairs and CEOs of provider trusts received a letter from Sir James Mackey on the approach to the second half of the 2025/26 financial year. This can be found in Appendix A.

3.2 NHS oversight framework – NHS trust performance league tables process and results

NHS England has launched a new interactive dashboard under the [NHS oversight framework 2025/26](#).

The dashboard provides a view of how NHS trusts are performing in key services including urgent and emergency care, elective services, mental health and more.

3.3 National Cyber Security Centre – Principles for building a cyber security culture

The National Cyber Security Centre (NCSC) has published a set of six principles for building a cyber security culture within an organization:

<https://www.ncsc.gov.uk/collection/cyber-security-culture-principles>

3.4 Joint executive team to be set up across DHSC and NHS England

A single joint executive team will be established at the Department of Health and Social Care and NHS England as part of the transition to one organisation. The team will manage directors from related work areas from 3 November 2025 and will begin to combine resources.

[Joint executive team to be set up across DHSC and NHS England - GOV.UK](#)

4. RECOMMENDATIONS

- 4.1 The Board is asked to note the report.

To: ICB and NHS trust/foundation trust:

- chief executive officers
- chairs

cc. NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 September 2025

Dear colleagues,

Building on our progress in the second half of 2025/26

When we met on 16 September, I committed to writing out to summarise the key priorities that we discussed for the rest of this year.

Firstly, to reiterate my thanks to each of you and your teams for the tireless efforts to drive improvement and reform across the NHS on so many fronts, and at the same time as having to manage significant change. This is an unprecedented time, both in terms of the depth of the challenges we face and the scale of the actions that we need to take to address them.

As I outlined when we met, progress since April has been astonishing. To move from a predicted end year deficit of £6 billion to the system position being in balance in final plans and at Month 5, whilst at the same time, continuing to improve waiting times in electives, cancer and for emergency care, has required a herculean effort for which I am hugely grateful.

As we look to the rest of this year, the pace, ambition, and determination which you have demonstrated in the first half of the year must continue. This letter seeks to provide clarity on the expectations of all providers and every system in key areas of finance and performance, and in relation to laying the foundations for longer term reform and delivery of the 10 Year Health Plan. It explains how we will work within our new operating model to support and challenge you to deliver, guided by the new Oversight Framework.

Maintaining financial discipline

Thank you for your continued professionalism and grip, which has been instrumental in ensuring the NHS is broadly on financial plan at Month 5. We recognise that many plans are backloaded and so a continued focus is essential to maintain delivery momentum through the second half of the year.

The half-year mark is a critical point. Boards must have a clear view of actual spend, run rate, and the underlying drivers of financial performance. Where run rates are off-plan, now

is the time to act decisively and take the decisions that will enable you to manage risk and implement credible recovery trajectories.

From close working with the CEO and CFO communities, we understand that organisations falling behind are typically struggling to deliver planned efficiencies or manage unplanned workforce costs – these remain key pressure points that need decisive executive action and board support.

The mid year review process outlined below will test assumptions in plans and seek assurance that steps are being taken to maintain financial discipline to the end of the financial year.

Delivering our priorities

Following a strong start to the year, elective and UEC performance has drifted a little over the summer, and we need to take urgent action to ensure delivery returns to plan by the end of Q3. While industrial action has made a significant contribution, it is not the only factor in this drift, which insight and analysis from providers and systems shows is also being driven by higher than expected demand, financial pressures, and challenges on rates of pay.

On electives, trusts that are significantly off plan on activity, RTT and long-waits standards will be required to submit revised trajectories for return to plan by December. While maintaining their focus on 18 weeks performance and managing the size of the list, all providers are expected to eliminate their remaining 65 week waits by mid-December and meet the planning guidance requirements for 52 week waits by the end of March 2026. ICBs will be required to ensure there are plans in place to address demand growth above that assumed in activity plans, and also ensure that Advice and Guidance is optimised across their system. At a regional level, control totals will be set for waiting list size and long waits, and the leadership across the region collectively held to account for delivery of activity plans.

On UEC, we need to improve our position on 4 hours, 12 hours, and ambulance handovers ahead of winter. As part of the winter planning Board Assurance Statement (BAS) process, you will already be confirming that existing trajectories are deliverable in conjunction with winter surge. However, for those trusts consistently off-track, the key actions that sit behind the BAS will need to be submitted to NHS England and they will be tested through the mid year review process to ensure there are realistic plans in place to return to trajectory. Where aspects of the plan are reliant on community and mental health providers, we know you will be working together on your collective system response. As discussed in Tuesday's event, we all need to step up our focus on 4 hours again, and make some significant shifts in this so that we can start to impact on crowding in our EDs. This will be followed by a separate communication on next steps.

Continuing our focus on access to primary care is an important part of managing system pressures. Patients need to be able to contact their GP practice by phone, online or by walking in, and for people to have an equitable experience across these access modes. As part of dealing with the 8am scramble, from 1 October 2025 practices will be required to keep their online consultation tool open for the duration of core hours for non-urgent

appointment requests, medication queries and admin requests. ICBs should ensure practices are following these requirements.

In addition, ICBs should also continue to support community pharmacy to meet the thresholds of performance for Pharmacy First.

On dentistry, the Government's manifesto commitment is that the NHS will deliver an extra 700,000 urgent dental care appointments. ICBs should urgently ensure that all necessary capacity is commissioned to meet their share of this commitment, that local pathways are in place to effectively match capacity with demand (for example, through 111), and that contractors are delivering on their obligations.

On these key primary care priorities, NHS England will be following up with systems in the coming weeks.

Mid year review process

Led by regions, and underpinned by the Oversight Framework, NHS England will be carrying out mid-year reviews with ICBs and providers over the next 6 weeks. For a small number of systems and providers, I will personally carry out their mid year review.

These discussions will focus on where you are on our key priorities, where there might be risks that need mitigation and opportunities that could be expedited. They will focus on the range of priorities that we all share including finance, quality and performance.

You should prepare for this scrutiny, ensuring that, at organisation and system level, you are ready to articulate a clear and credible financial position for the remainder of this year which delivers operational standards.

Positively, all but one system has confirmed their expectation that they can deliver the operational performance targets set for this year within their financial envelopes, and so, through mid year reviews, we look forward to exploring assumptions.

Resilience during winter

You have been working hard to prepare for this coming winter during the summer months and testing your plans during a series of regional exercises held over the last 2 weeks. We would like to thank you for the time and consideration that you have put into this preparation.

We now have data from the UK Health Security Agency suggesting this winter we may experience circumstances similar to the moderate to severe scenario that we tested in the winter planning exercise. This means that fine tuning our plans and completing preparation is critical.

Over the next 2 weeks, plans must be tightened up and any gaps exposed during the exercise need to be closed, with Board Assurance Statement completed and returned by the end of September.

Working with the COO and EPRR communities, key areas of learning for providers and systems that we have identified include:

- the need for robust plans to maximise vaccination rates across all cohorts, including health and social care workers, and achieve our collective aim of improving frontline staff uptake by at least 5 percentage points
- having a paediatric specific plan for when respiratory viruses cause a surge in demand for primary care, 111 and A&E
- ensuring primary care access is maintained over the Christmas period
- engaging with local authorities and social care providers so that discharge capacity surges at times of peak demand
- having senior clinical decision-maker enhanced rotas in place ready to be activated.
- targeted occupancy reductions in the run-in to the Christmas period
- stepping up personal visibility and leadership, including from CEOs, CMOs, and CNOs, to help lead and support our people through a challenging winter

As we move into delivery of our winter plans, we are asking that a special focus is placed on reducing bed occupancy to below 80% ahead of the Christmas period to give ourselves the best chance of managing the early weeks of January.

During periods of pressure, OPEL escalation level action cards should be consistently applied, and critical incidents only used for short periods to get ahead of further escalation.

To support providers and commissioners, and ensure join up across the system, NHS England will commence its own national and regional operational coordination response 7 days a week from 27 October. This will use data and intelligence to maintain an overview of ambulance response times, OPEL levels, and long waiting times, moving to support when systems are not able to decompress in a timely way.

We know that this will be a challenging period, but we also know that personal leadership – in particular from chief executives, medical and nurse directors, as well as the senior operational team – makes a significant impact on flow, safety and performance. We ask that you make this a priority throughout winter, but particularly during the Christmas, new year and early January period.

Leadership and our people

We discussed on Tuesday the need for us all to step up and lead our people through this challenging period. We have specific actions in place regarding the implementation of the 10 Point Plan for Resident Doctors between now and the end of the year, but we need to redouble our efforts to be mindful of the experience of all staff, especially during periods of high demand and pressure. The best performing organisations make this an organisation wide priority and I would like us to make this more of a central focus for all of us, sitting alongside the focus on patient experience set out in Penny Dash's work and the 10 Year Health Plan.

More will follow on this but, in the meantime, please ensure that this is a central focus for your board and broader leadership team. We all know the impact that regularly walking the

floor and spending time in A&Es and other pressured areas of your organisation has on staff morale, and your ability to understand and manage services.

Looking ahead to 2026/27

As you continue to implement your plans for 2025/26, closing gaps where you have fallen behind, you also need to be shaping your strategy for the following years and how we bring the intent of the 10 Year Health Plan to life.

We shared the foundational elements of the Planning Framework over the summer, and further elements will be published in the coming weeks. Ahead of that, now is the time to begin to prepare for next year and beyond.

In particular, we encourage you to plan for the crucial local service transformations that are needed to improve outcomes and deliver your longer term plans, informed by the demand and capacity analysis that you have been doing over the summer.

Technology and digital solutions are going to be vital for longer term transformation and unlocking our productivity. Cutting back on investments in these areas to help with short term challenges will undermine longer term sustainability and improvement.

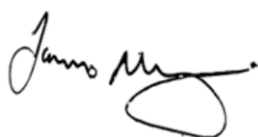
On workforce transformation, we are working with you to build the 10 year workforce plan that will enable the delivery of the 10 Year Health Plan. That will be ready in the coming months and will help us all to plan for the longer term.

Finally, and as discussed on Tuesday, you have responded so well to the challenges we faced together in the spring and you should take pride and hope from that. We all know that there is still a lot to do, and we must ensure that we can deliver our short term operational and financial imperatives while also building for the future. The spirit and energy in the room on Tuesday was very powerful, and I know from many conversations over recent weeks that you really want to engage and shape this all locally with your teams and partners.

Thanks for all you have done so far. Let's all continue to pull together to deliver what we have discussed and set out in this letter, and in the way we have worked together over these past months.

Keep going....

Yours sincerely

A handwritten signature in black ink, appearing to read 'James Mackey', with a stylized flourish at the end.

Sir James Mackey
Chief Executive Officer
NHS England

Communities Matter

Creating stronger, healthier, happier communities.



Bridgewater
Community Healthcare
NHS Foundation Trust

Integrated Quality and Performance Report

Information Team

Reporting Period: July 2025 (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.

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

This month's report describes activity in July 2025.



Within this Report

1. KPI Amendments:

No amendments within Month 4.

2. Recommendations:

The Finance & Performance committee are asked to:

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

Trust Overview

Executive Summary

Responsive (Operations)

There are 13 Green indicators and 20 Red indicators in month 4.

- Zero Red to Green indicators
- Two Green to Red indicators:
 - Warrington Dermatology Cancer 2 week referrals (urgent GP)
 - Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears)
- 10 indicators have shown an in-month improvement
- 23 indicators have shown an in-month deterioration
- 0 indicators have shown no in-month changes

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 22 green indicators and 9 red indicators in month 4.

- Zero Green to Red indicators:
- Zero Red to Green indicators
- 9 indicators have shown an in-month improvement
- 9 indicators have shown an in-month deterioration
- 13 indicators have shown no in-month changes

Trust Overview

Executive Summary

People

There are 2 green indicators and 2 red indicators in Month 4.

- Zero Red to Green indicators
- One Green to Red indicator
 - % of staff with a current PDR
- 0 indicators have shown an in-month improvement
- 4 indicator has shown an in-month deterioration

Making Good Use of Resources (Finance)

- The Trust is reporting a deficit at Month 4 of £1.62m, in line with plan.
- The Trust is reporting a savings achievement of £1.60m against a plan of £1.59m

Operations

Executive Summary

Of the 33 Operations indicators which are reported; 20 are red and 13 are green.

The 20 indicators which were red in July are as follows:

- Warrington Dermatology Cancer 2 week referrals (urgent GP) – Deterioration in Month
- Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery – Deterioration in Month
- Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment – Improvement in Month
- Percentage referred onto A+E (UTC) – Deterioration in Month
- Data Quality Maturity Index (DQMI) (monthly internal reporting) – Deterioration in Month
- Data Quality Maturity index (DQMI) Monthly published score (3 months in arrears) – Deterioration in Month
- Percentage of was not brought – Childrens – Deterioration in Month
- Audiology - Number of 6 weeks diagnostic breaches – Improvement in Month
- Referrals to plan - Childrens – Deterioration in Month
- Referrals to plan - Warrington Adults – Improvement in Month
- Referrals to plan - Halton Adults – Deterioration in Month
- Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears) – Deterioration in Month
- Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears) – Deterioration in Month
- Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears) – Deterioration in Month

Operations

Executive Summary – Continued

Red indicators (continued):

- All waiters - % waiting over 52 weeks (awaiting initial access)
 - All waiters - % waiting under 18 weeks (awaiting initial access)
 - Warrington Adults Activity Variance
 - Warrington Children's Activity Variance
 - Halton Adults Activity Variance
 - Halton Children's Activity Variance
- Deterioration in Month
 - Deterioration in Month
 - Improvement in Month
 - Improvement in Month
 - Deterioration in Month
 - Improvement in Month

Operations

Trust Scorecard

Operations															
KPI Name	Target	Trend Line	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Warrington Dermatology Cancer 2 week referrals (urgent GP)	93%		93.31% (▼)	95.07% (▲)	95.72% (▲)	99.35% (▲)	97.86% (▼)	98.47% (▲)	99.17% (▲)	97.29% (▼)	98.92% (▲)	95% (▼)	95.61% (▲)	95.32% (▼)	88.32% (▼)
Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94%		100% (▲)	100% (►)	66.67% (▼)	0% (▼)	83.33% (▲)	100% (▲)	100% (►)	100% (►)	100% (►)	66.67% (▼)	50% (▼)	85.71% (▲)	75% (▼)
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%		92.86% (▲)	100% (▲)	100% (►)	90.91% (▼)	61.54% (▼)	100% (▲)	94.12% (▼)	83.33% (▼)	100% (▲)	94.74% (▼)	100% (▲)	56.25% (▼)	89.47% (▲)
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%		93.75% (▼)	93.48% (▼)	93.33% (▼)	100% (▲)	82.35% (▼)	92.31% (▲)	88.1% (▼)	89.47% (▲)	90.91% (▲)	93.75% (▲)	91.18% (▼)	90.48% (▼)	94.74% (▲)
28 day faster diagnosis	75%		87.5% (▲)	81.27% (▼)	91.69% (▲)	89.33% (▼)	88.82% (▼)	82.01% (▼)	83.53% (▲)	82.69% (▼)	91.89% (▲)	84.26% (▼)	89.53% (▲)	85.94% (▼)	83.19% (▼)
A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		98.67% (▼)	98.84% (▲)	99.14% (▲)	98.92% (▼)	97.72% (▼)	95.06% (▼)	98.68% (▲)	94.5% (▼)	96.88% (▲)	94.49% (▼)	98.56% (▲)	98.83% (▲)	97.86% (▼)
Total time in A&E - 95th Percentile (Mins)	4 Hrs		03:41 (▼)	03:24 (▲)	03:29 (▼)	03:45 (▼)	03:51 (▼)	03:59 (▼)	03:44 (▲)	04:11 (▼)	03:54 (▲)	04:11 (▼)	03:49 (▲)	03:38 (▲)	03:45 (▼)
Total time in A&E - Median (Mins)	4 Hrs		01:30 (▲)	01:13 (▲)	01:22 (▼)	01:24 (▼)	01:27 (▼)	01:36 (▼)	01:28 (▲)	01:37 (▼)	01:19 (▲)	01:38 (▼)	01:26 (▲)	01:26 (▼)	01:18 (▲)
A&E Time to treatment decision (median) <=60 mins (Mins)	60 Mins		00:08 (▼)	00:06 (▲)	00:07 (▼)	00:07 (▼)	00:07 (▲)	00:08 (▼)	00:06 (▲)	00:07 (▼)	00:09 (▼)	00:07 (▲)	00:07 (▲)	00:07 (▼)	00:07 (▼)
A&E Time to treatment decision 95th percentile <=60 mins (Mins)	60 Mins		00:23 (▼)	00:14 (▲)	00:14 (▲)	00:15 (▼)	00:15 (▼)	00:21 (▼)	00:15 (▲)	00:16 (▼)	00:23 (▼)	00:18 (▲)	00:14 (▲)	00:14 (▲)	00:15 (▼)
A&E Unplanned re-attendance rate <=5%	5%		7.81% (▼)	8.42% (▼)	6.47% (▲)	7.38% (▼)	4.55% (▲)	4.45% (▲)	4.42% (▲)	4.79% (▼)	5.38% (▼)	5.24% (▲)	3.82% (▲)	4.12% (▼)	4.73% (▼)
A&E left without being seen <=5% (left before trx completed)	5%		0.06% (▼)	0% (▲)	0.14% (▼)	0.15% (▼)	0.13% (▲)	0.31% (▼)	0.06% (▲)	0.04% (▲)	0.22% (▼)	0.16% (▲)	0.09% (▲)	0.03% (▲)	0.24% (▼)
Percentage referred onto A+E (UTC)	3%		12.45% (▼)	11.09% (▲)	11.04% (▲)	9.81% (▲)	8.74% (▲)	11.33% (▼)	12.81% (▼)	12.41% (▲)	10.33% (▲)	11.17% (▼)	6.13% (▲)	5.61% (▲)	5.98% (▼)
Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%		89.12% (▼)	88.86% (▼)	90.24% (▲)	90.37% (▲)	90.92% (▲)	90.95% (▲)	91.78% (▲)	91.46% (▼)	90.42% (▼)	92.03% (▲)	91.46% (▼)	91.65% (▲)	91.31% (▼)
Data Quality Maturity index (DQMI) Monthly published score (3 months in arears)	95%		87% (▼)	86.7% (▼)	87.1% (▲)	85.8% (▼)	27% (▼)	88.9% (▲)	89.1% (▲)	89.8% (▲)	90.1% (▲)	90.5% (▲)	90.2% (▼)	89.1% (▼)	88.1% (▼)



Operations

Trust Scorecard

Operations															
KPI Name	Target	Trend Line	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Percentage of was not brought - Childrens	3%		7.31% (▼)	8.79% (▼)	5.83% (▲)	6.31% (▼)	6.36% (▼)	9.15% (▼)	6.96% (▲)	6.46% (▲)	5.87% (▲)	6.8% (▼)	6.45% (▲)	6.85% (▼)	8.67% (▼)
Percentage of DNAs/Was not brought - Warrington Adults	3%		3% (▼)	2.31% (▲)	2.09% (▲)	2.33% (▼)	2.23% (▲)	2.27% (▼)	2.24% (▲)	1.95% (▲)	2.07% (▼)	2.1% (▼)	2.13% (▼)	2.36% (▼)	2.09% (▲)
Percentage of DNAs/Was not brought - Halton Adults	3%		1.36% (▲)	1.11% (▲)	1.28% (▼)	1.25% (▲)	1.37% (▼)	1.06% (▲)	1.14% (▼)	0.89% (▲)	0.91% (▼)	1.02% (▼)	1.06% (▼)	0.86% (▲)	1.01% (▼)
Proportion of Urgent Community Response referrals reached within two hours	70%		85.4% (▼)	90% (▲)	81.3% (▼)	81.5% (▲)	76.5% (▼)	80% (▲)	78.5% (▼)	77% (▼)	81.1% (▲)	87% (▲)	91.5% (▲)	91.1% (▼)	89.6% (▼)
Audiology - Number of 6 weeks diagnostic breaches	0		192 (▲)	149 (▲)	100 (▲)	88 (▲)	71 (▲)	76 (▼)	53 (▲)	43 (▲)	32 (▲)	57 (▼)	63 (▼)	98 (▼)	93 (▲)
Referrals to plan - Childrens	95%		109.84% (▼)	104.92% (▲)	105.92% (▼)	106.71% (▼)	106.7% (▲)	105.95% (▲)	107.37% (▼)	107.77% (▼)	107.6% (▲)	105.12% (▲)	104.07% (▲)	107.45% (▼)	109.6% (▼)
Referrals to plan - Warrington Adults	95%		86.74% (▲)	83.34% (▼)	82.15% (▼)	82.21% (▲)	81.32% (▼)	80.87% (▼)	80.74% (▼)	79.91% (▼)	78.36% (▼)	74.33% (▼)	74.02% (▼)	74.53% (▲)	75.33% (▲)
Referrals to plan - Halton Adults	95%		81.48% (▲)	83.25% (▲)	83.19% (▼)	84.25% (▲)	84.04% (▼)	83.69% (▼)	84.76% (▲)	85.08% (▲)	84.62% (▼)	91.54% (▲)	89.6% (▼)	88.92% (▼)	88.9% (▼)
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)	92%		68.42% (▼)	67.32% (▼)	66.05% (▼)	65.63% (▼)	65.1% (▼)	63.4% (▼)	63.84% (▲)	62.84% (▼)	61.39% (▼)	63.53% (▲)	59.56% (▼)	60.62% (▲)	58.99% (▼)
Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)	0%		4.51% (▼)	5.57% (▼)	5.19% (▲)	5.96% (▼)	6.58% (▼)	7% (▼)	7.74% (▼)	9.01% (▼)	10.51% (▼)	10.87% (▼)	12.31% (▼)	12.36% (▼)	16.3% (▼)
Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears)	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.01% (▼)	0.01% (▲)	0% (▲)	0.03% (▼)	0.03% (▲)	0% (▲)	0% (►)	1.13% (▼)
All waiters - % waiting over 52 weeks (awaiting initial access)	0%		4.3% (▼)	3.43% (▲)	3.09% (▲)	3.67% (▼)	4.65% (▼)	5.26% (▼)	5.69% (▼)	6.51% (▼)	7.42% (▼)	9.52% (▼)	10.43% (▼)	11.86% (▼)	12.9% (▼)
All waiters - % waiting under 18 weeks (awaiting initial access)	92%		64.78% (▼)	61.87% (▼)	61.46% (▼)	59.01% (▼)	57.31% (▼)	56.86% (▼)	57.46% (▲)	58.19% (▲)	59.56% (▲)	56.87% (▼)	57.84% (▲)	57.08% (▼)	55.89% (▼)
Warrington Adults Activity Variance	3%		-13.26% (▲)	-16.66% (▼)	-17.85% (▼)	-17.79% (▲)	-18.68% (▼)	-19.13% (▼)	-19.26% (▼)	-20.09% (▼)	-21.64% (▼)	-25.67% (▼)	-25.98% (▼)	-25.47% (▲)	-24.67% (▲)
Warrington Childrens Activity Variance	3%		28.67% (▼)	19.23% (▲)	19.89% (▼)	22.49% (▼)	23.76% (▼)	21.87% (▲)	24.01% (▼)	24.43% (▼)	24.38% (▲)	26.94% (▼)	23.24% (▲)	26.87% (▼)	26.52% (▲)
Halton Adults Activity Variance	3%		-18.52% (▲)	-16.75% (▲)	-16.81% (▼)	-15.75% (▲)	-15.96% (▼)	-16.31% (▼)	-15.24% (▲)	-14.92% (▲)	-15.38% (▼)	-8.46% (▲)	-10.4% (▼)	-11.08% (▼)	-11.1% (▼)
Halton Childrens Activity Variance	3%		-24.15% (▲)	-22.22% (▲)	-20.93% (▲)	-22.73% (▼)	-24.35% (▼)	-23.78% (▲)	-23.8% (▼)	-23.69% (▲)	-24.14% (▼)	-30.06% (▼)	-28.63% (▲)	-26.17% (▲)	-20.94% (▲)



Operations

Trust Scorecard

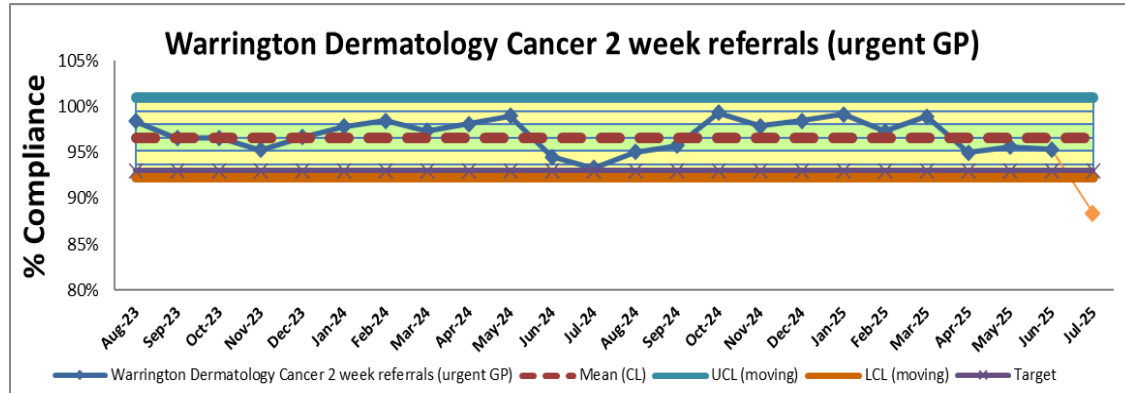
Operations																			
KPI Name	Target	Trend Line				Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Halton							86 (▼)			104 (▲)			101 (▼)			112 (▲)			
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Halton	95%						87.58% (▲)			88.78% (▲)			92.2% (▲)			92.16% (▼)			
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Halton	90%						91.44% (▲)			90% (▼)			92.23% (▲)			90.51% (▼)			
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Halton	85%						86.33% (▲)			87.59% (▲)			85.99% (▼)			88.7% (▲)			
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Halton	85%						89.58% (▲)			91.33% (▲)			90.94% (▼)			91.42% (▲)			
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton	90%						80.92% (▼)			81.27% (▲)			90.78% (▲)			89.07% (▼)			
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton	90%						71.67% (▼)			82.2% (▲)			90.71% (▲)			82.52% (▼)			
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Warrington							312 (▲)			346 (▲)			319 (▼)			333 (▲)			
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington	95%						92.94% (▲)			94.25% (▲)			91.81% (▼)			93.68% (▲)			
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Warrington	90%						95.95% (▼)			96.58% (▲)			95.47% (▼)			96.33% (▲)			
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Warrington	85%						94.5% (▲)			94.21% (▼)			96.16% (▲)			93.72% (▼)			
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Warrington	85%						97.13% (▼)			97.9% (▲)			97.37% (▼)			98.45% (▲)			
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Warrington	90%						95.34% (▲)			95.64% (▲)			97.07% (▲)			96.58% (▼)			
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Warrington	90%						94.7% (▼)			93.19% (▼)			100% (▲)			94.15% (▼)			
Available Virtual Ward Capacity per 100,000 head of population							5.25 (▲)	5.97 (▲)	3.94 (▼)	1.05 (▼)	4.17 (▲)	5.18 (▲)	0.83 (▼)	4.18 (▲)	2.67 (▼)	3.85 (▲)	3.95 (▲)	5.66 (▲)	3.4 (▼)

Operations: Exception Reporting

Flagged Indicators

Warrington Dermatology Cancer 2 week referrals (urgent GP)		Points below lower control limit
Percentage referred onto A+E (UTC)		Points below lower control limit
Referrals to plan - Childrens		Points above upper control limit
Referrals to plan - Warrington Adults		Points below lower control limit
Referrals to plan - Halton Adults		Points below lower control limit
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)		Points below lower control limit
Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)		Points above upper control limit
Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears)		Points above upper control limit
All waiters - % waiting over 52 weeks (also include Dental)		Points above upper control limit
All waiters - % waiting under 18 weeks(also include Dental)		Points below lower control limit
Warrington Adults Activity Variance		Points below lower control limit
Halton Adults Activity Variance		Points above upper control limit
Halton Childrens Activity Variance		Points above upper control limit

Operations: Exception Reporting



Analytical Narrative

There has been no previous significant change to the Dermatology Cancer 2 week referrals, however for June 2025 (reported one month in arrears), the performance is below target and outside of control measures. We would usually expect the variation to range between 93% and 99%. Seasonal breaches are expected due to patients choosing to wait longer during holiday period. Additionally, we have limitations relating to control of annual leave from our insourcing model. 2 week wait is no longer monitored as part of cancer standards.

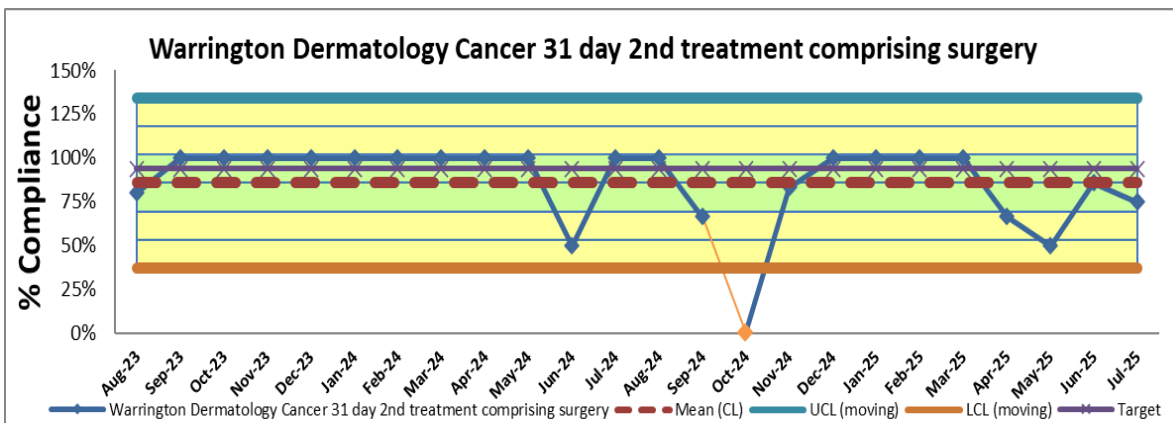
Warrington Dermatology Cancer 2 week referrals (urgent GP)

National Target is 93% (June Performance reported in arrears: 88.32%)

Operational Narrative

- Service have engaged with the cancer alliance to carry out an in -depth review of processes. This will enable us to identify bottle necks and potential solutions. Once the report is submitted the service expect to be able to report results from that in 6 months time.
- Review of new 2WW skin analytics pathway occurring mid September.
- The service are able to mitigate risks by ensuring that patients still receive diagnosis within the 28 days standard where possible.

Operations: Exception Reporting



Analytical Narrative

The data for this indicator remains mostly consistent within normal variation and intermittent achievement of target, which sits close to the mean.

Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery

National Target is 94% (June Performance reported in arrears: 75%)

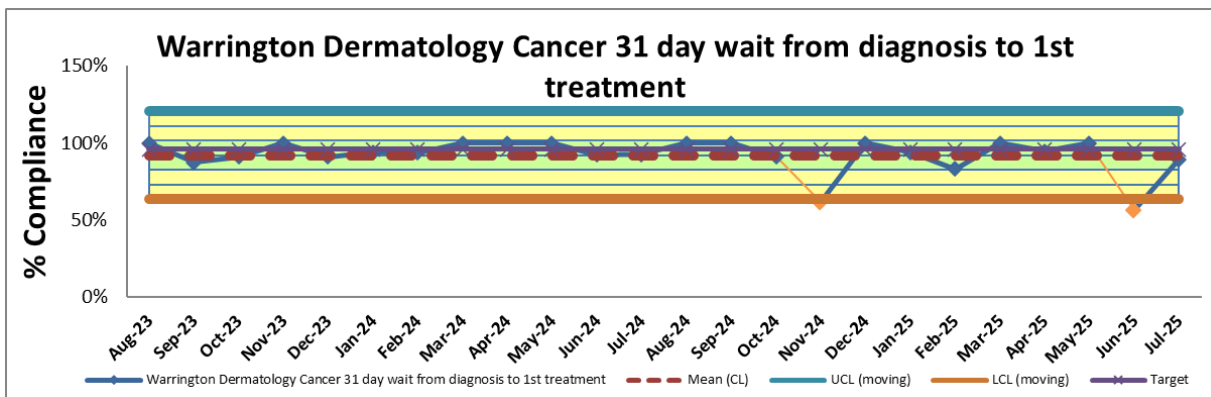
Operational Narrative

The breach for this indicator is related to patient choice.

There is a risk that this indicator may continue to breach due to resource and increased demand.

There were no harms resulting from these delays.

Operations: Exception Reporting



Analytical Narrative

The data for this indicator remains largely consistent within normal variation and intermittent achievement of target, which sits close to the mean.

Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment

National Target is 96% (June performance reported in arrears: 89.47%)

Operational Narrative

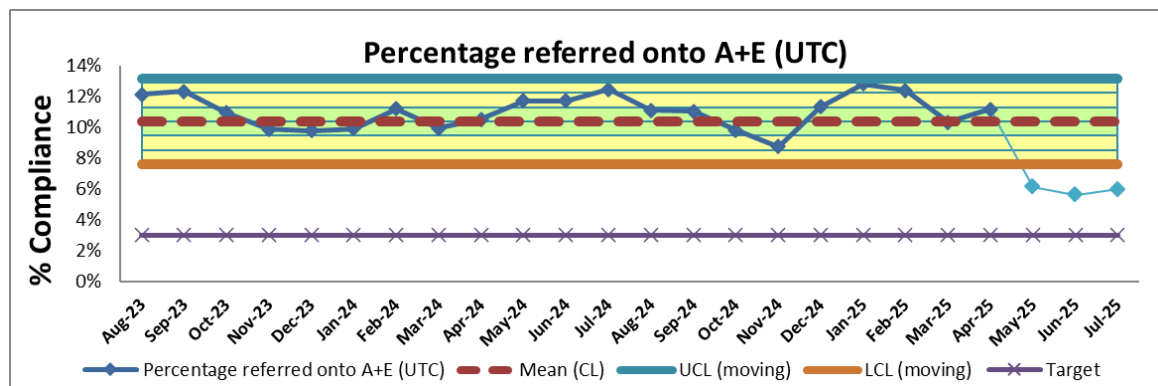
Breaches are normally wholly related to patient choice, however this month we have seen two breaches relating to staffing issues.

There is a risk that this indicator may continue to breach due to resource and increased demand.

Actions: Engagement with EMT regarding possibility of additional resource. We expect this indicator to be impacted by limited resource issues and increased referrals into the service.

There were no harms resulting from these delays.

Operations: Exception Reporting



Percentage referred onto A+E (UTC)

Local target is 3%

Performance in July – 5.98%.

Analytical Narrative

Work to align local and ICB calculation logic has been taking place and the results of this can be seen in the significant change in variation for this indicator from the month of May 25.

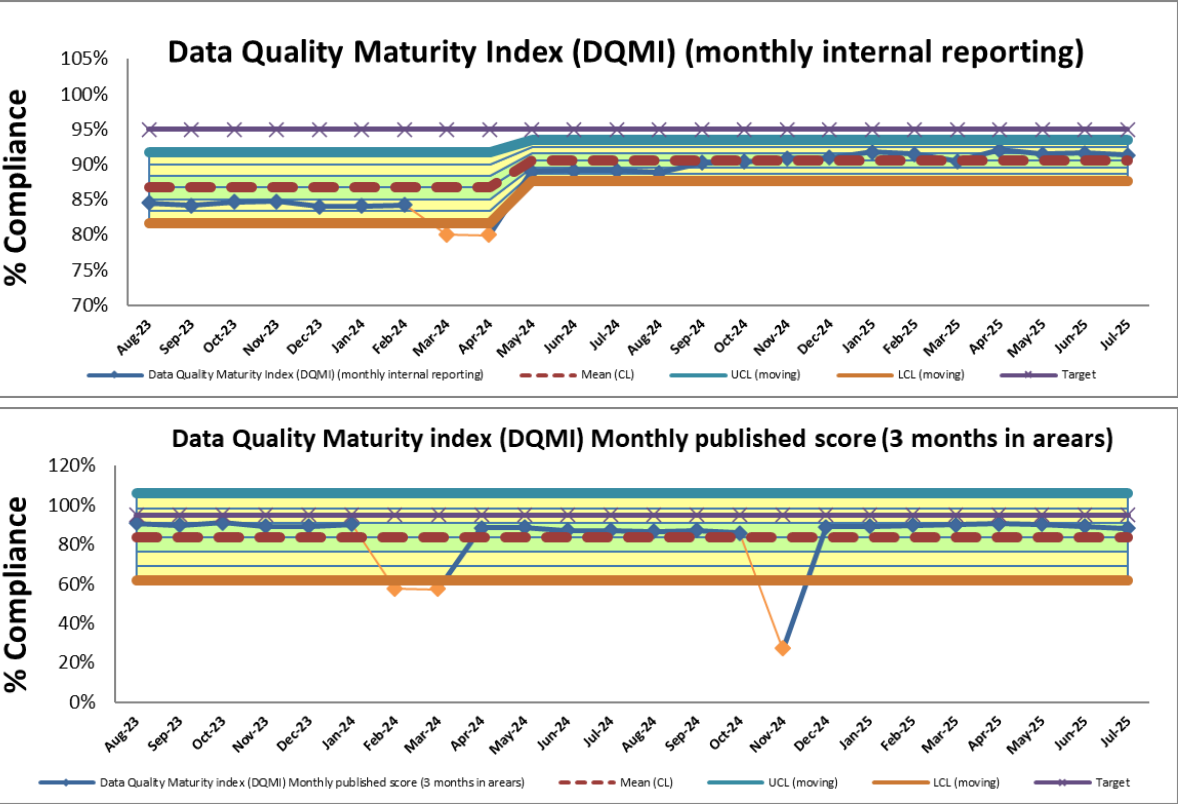
Operational Narrative

The Information team and service lead have been working with the ICB to align understanding and calculation of the A+E indicators. This is evident in the shift in level of compliance for this indicator.

We are still almost 3% away from target, the service receive regular reports to enable validation of these patients.

Operations: Exception Reporting

Data Quality Maturity Index (DQMI) monthly internal reporting and monthly published score (3 months in arears) National Target: 95%



The National Data Set score of all Data Sets and providers in England across all Data Items is displayed in the card below. The table visual on the right is a break down of each Data Set's contribution to the overall National Data Set Score.



National DQMI Score

69.3

Experimental National DQMI Score

63.5

Data set	National Data Set Score	National Data Set Score Experimental
APC	88.5	88.5
CSDS	65.6	61.5
ECDS	79.3	79.3
IAPT	94.3	85.5
MHSDS	44.7	40.1
MSDS	96.1	96.1
OP	85.3	85.3

Operations: Exception Reporting

Data Quality Maturity Index (DQMI) monthly internal reporting and monthly published score (3 months in arrears)
National Target: 95%

Standard	APC (%)	CSDS (%) 91.1	DID (%)	ECDS (%) 86.0	IAPT (%)	MHSDS (%) 90.0	MSDS (%)	OP (%)	DQMI Score (%) 88.1

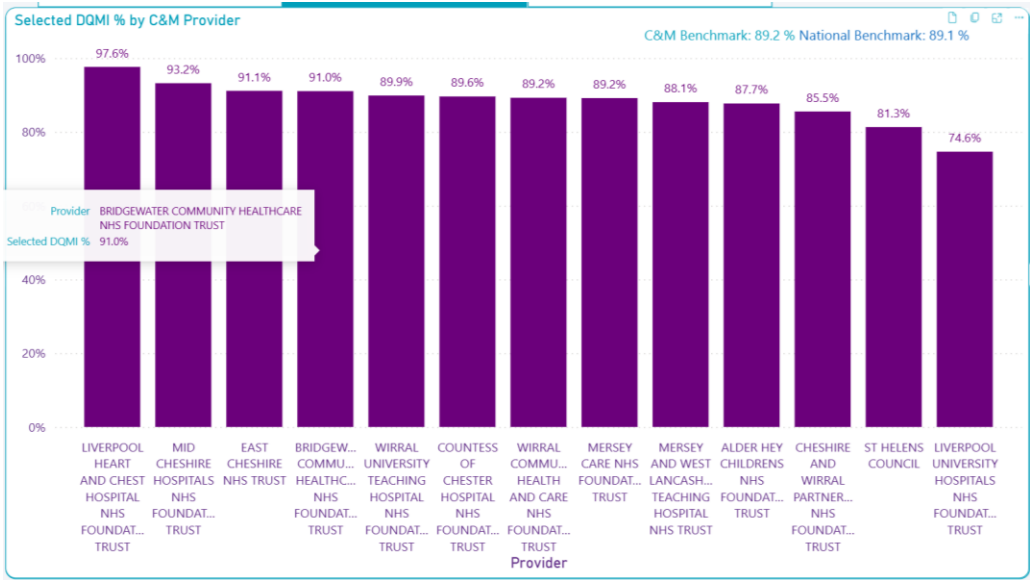
Analytical Narrative / Operational Narrative

There has been no significant change in the published DQMI score since November 24. Variation can be expected between 80% and 95%.

The ICB have set each of the trusts across Cheshire & Merseyside an improvement target. For Bridgewater, the target is to improve the 'Activity location' compliance rate to 75%. We have achieved this target in Q1.

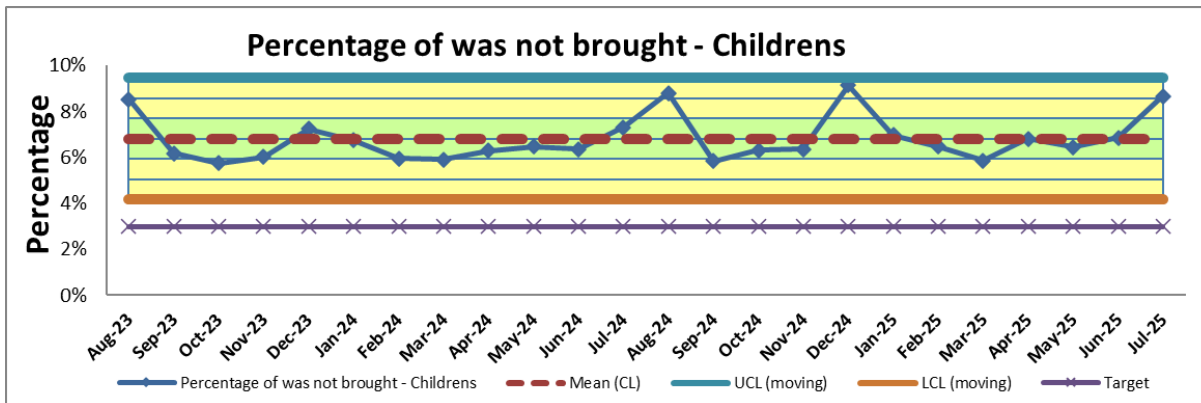
The DQMI for Bridgewater is based upon completeness, validity and timeliness of 3 datasets: ECDS, CSDS, MHSDS. Of these 3 submissions ECDS is currently the worse performer.

Bridgewater is above the C+M target of 89.2% and the National Benchmark of 89.1%



C+M comparison taken from ICB BIP dashboard. Data in arrears (latest BIP published month April 2025)

Operations: Exception Reporting



Percentage of "Child not brought " Children's Services

Local Target: 3%

July compliance – 8.67%

Analytical Narrative

The significant increases for the number of children not brought are seasonal in line with school holidays. Outside of these times we would expect variation to be between 5% and 7%.

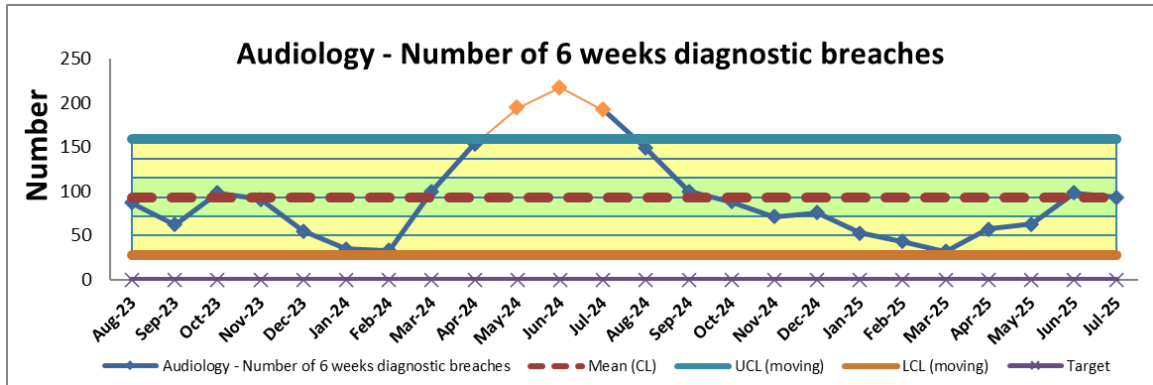
The number of children not brought to their appointment has continued to rise in month four despite a number of actions being implemented such as telephone and text reminders.

The trusts aspirational target is to achieve 1.6% DNA / Child Not Brought.

Operational Narrative / Actions / Risks

- Develop service specific actions plans for services with higher Was Not Brought percentages. (Plans to be monitored via DLT)
- Directorate facilitated workshop on 30th July to investigate the issue, share experiences and to agree actions going forward.
- Follow up workshop to be scheduled for October 2025 - Include Digital services to look at technology solutions.
- Digital teams may not have capacity to support and implement solutions from the follow up workshop in a timely manner.
- Increasing complexity/ vulnerability of child and family needs may result in more children being offered 3rd appointments following DNA (Patient Access to Services Policy)

Operations: Exception Reporting



Analytical Narrative

Performance has decreased since April 2025. We would expect the variation to range between 30 and 100 breaches. The Target sits outside of normal process limits, the data suggests that it is unlikely to be met within current operational processes.

Bridgewater are working with the regional diagnostic analytical team to monitor Audiology diagnostic pathways.

Warrington Audiology - Number of 6 weeks diagnostic breaches

National Target: 0

July compliance - 93 breaches

Operational Narrative / Actions / Risks

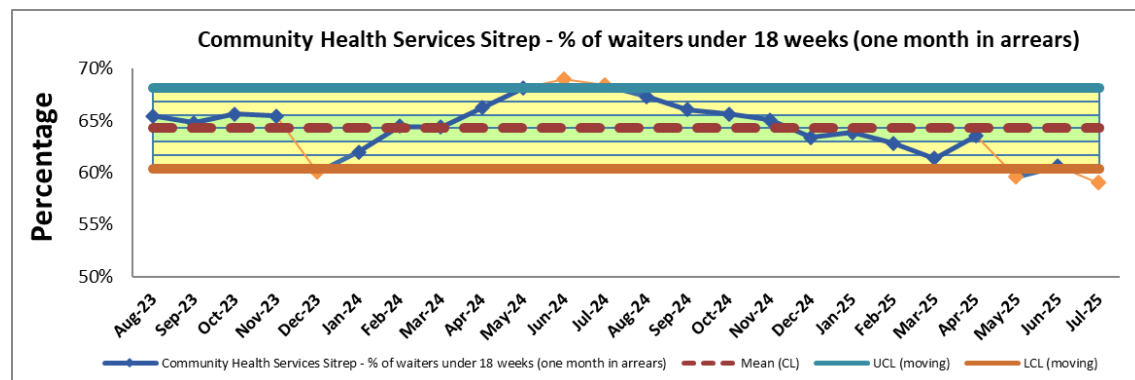
The breaches are relating in the main to Warrington Paediatric Audiology. Additionally, Halton Paediatric Audiology had 3 breaches and St Helens had 1 breach. We expect performance to decrease in August due to staff annual leave and planned sickness absence.

- Warrington Audiology – Recruit to vacancy
- Halton / St Helens / Knowsley (all same team) – Recruit to vacancies.
- In all areas of Audiology we are reviewing efficiencies of pathway, such as DNA reduction, 1st to follow up ratios. The Operational leads will lead on this work and we will monitor outcomes of this exercise and feedback in Q3.
- Bridgewater have submitted request for mutual aid.
- School hearing screening will commence in September, from past experience we expect to see an increase in failed screenings referred into the Audiology service.
- We may struggle to recruit to vacant posts, as this is a specialist role

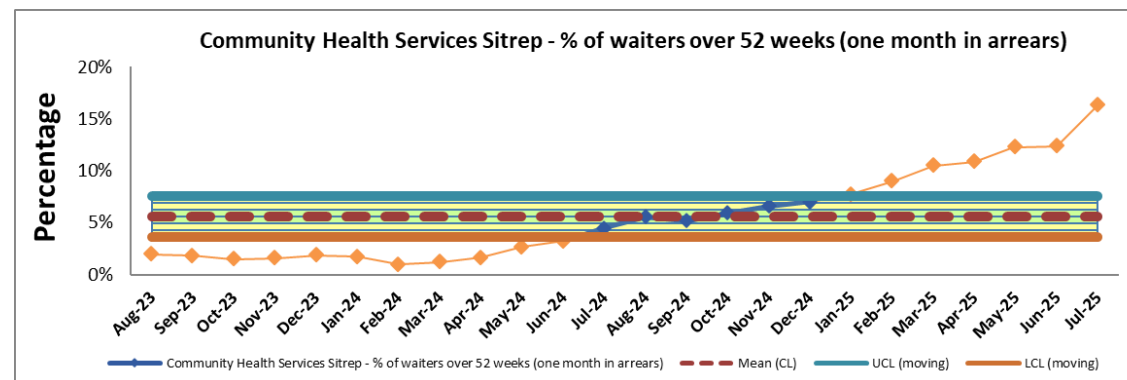
Operations: Exception Reporting

Community Health Services Sitrep – Published data (one month in arrears)

June % under 18 weeks – 58.99%



June % over 52 weeks – 16.30%



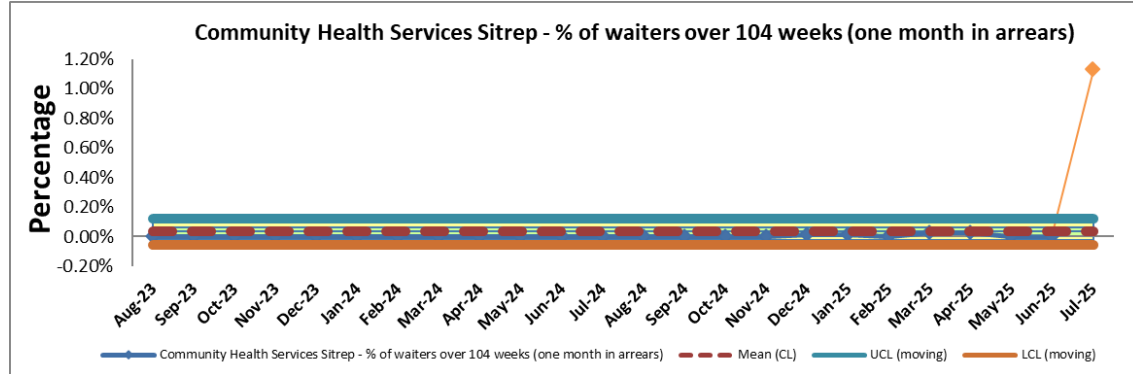
The Community Health Services (CHS) SitRep collects monthly data on waiting lists and waiting times for Children and Young People's (CYP) and Adult's community health services. Providers submit aggregated information for service lines, irrespective of the number of ICBs or regions they provide services under. The SitRep includes a broad range of NHS commissioned community health services. It may not cover all services in some systems. This publication contains management data which is collected on a rapid turnaround basis, allowing only minimal validation to be undertaken.

Note: Community Health Services Sitrep submission does not include Dental or Dermatology waiting times.

Operations: Exception Reporting

Community Health Services Sitrep – Published data (one month in arrears)

June % over 104 weeks – 1.13%



CHS Sitrep performance has been deteriorating since Summer 2024. The variation can be expected to range between 59% and 69% for 18 week waits and 5% to 16% for over 52 weeks.

Bridgewater is one of 15 trusts working with the national team to develop waits directly from daily Faster Data Flows submissions. Not all services are required to flow via CHS - Dermatology and Dental as an example are excluded from this submission.

Bridgewater score quite poorly in relation to the percentage of patients waiting above 52 weeks. (NOF Access domain score) Carrying out the actions described in the indicator (all waiters %under 18 weeks / % above 52 weeks) will improve this score.

The CHS scores are attributed to the National Oversight Framework Access domain scores. Changes to how community waits are calculated may directly affect this score.

Operations: Exception Reporting

Community Health Services Sitrep – Published data (one month in arrears) – Adults waiting / Cheshire & Mersey Comparison

Organisation Name	Total waiting list	Number of patients waiting:							
		0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD	13,704	2,360	1,398	2,161	4,553	1,854	1,216	152	10
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	465	36	8	60	326	12	23	0	0
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	249	41	59	32	69	10	3	0	1
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	147	42	20	29	40	7	9	0	0
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST									
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	5,984	923	640	1,099	2,659	473	189	1	0
EAST CHESHIRE NHS TRUST	4,485	473	342	631	1,367	717	954	1	0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST									
MERSEY CARE NHS FOUNDATION TRUST	21,104	3,519	2,407	3,879	8,013	2,231	1,054	1	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST									
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	3,685	343	335	535	1,301	408	692	71	0
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	4,467	362	543	649	1,691	791	431	0	0

Analytical Narrative for June 2025 data:

- Total adults reported on Bridgewater waiting lists in June 2025: **3685** (increase of **2.90%** on May 2025)
- Long waits for adults on Bridgewater waiting lists in June 2025: **408** waiting **>12-18 weeks**, **692** waiting **>18-52 weeks**, **71** waiting **>52-104 weeks**, and **0** waiting over **104 weeks**.
- Adults waiting over **52 weeks** on Bridgewater waiting lists has increased by 6 to **71** from last month.

Operations: Exception Reporting

Community Health Services Sitrep – Published data (one month in arrears) – Children & Young People waiting / Cheshire & Mersey Comparison

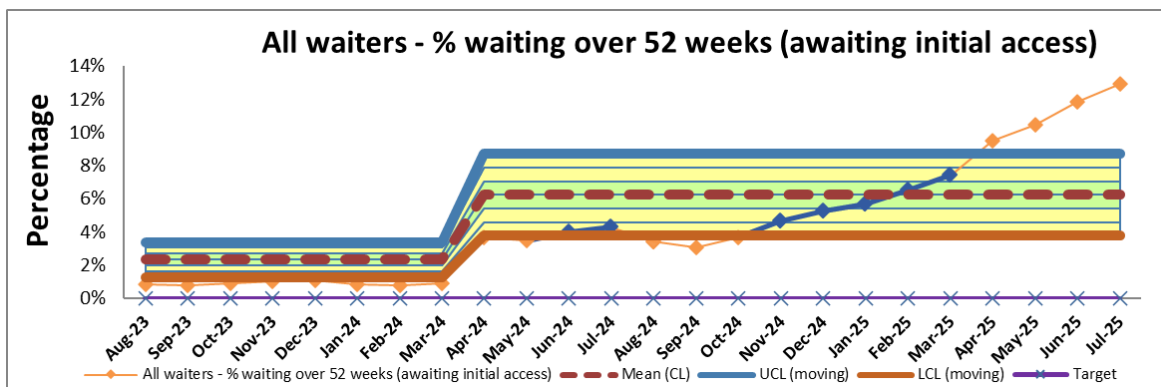
Organisation Name	Total waiting list	Number of patients waiting:							
		0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD	2,866	154	128	293	967	517	643	120	44
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	5,490	76	82	126	638	431	1,553	1,870	714
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	731	60	36	50	163	85	306	31	0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST									
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4,800	192	233	485	1,299	798	1,739	54	0
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2,731	70	60	169	475	394	934	625	4
EAST CHESHIRE NHS TRUST	536	32	20	42	176	88	176	2	0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1,359	33	35	70	251	206	620	144	0
MERSEY CARE NHS FOUNDATION TRUST	1,139	120	114	213	484	149	59	0	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST									
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	4,749	96	231	283	830	613	1,392	1,209	95
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	205	19	41	51	84	4	6	0	0

Analytical Narrative for June 2025 data:

- Total children & young people reported on Bridgewater waiting lists in June 2025: **4749** (increase of **9.20%** on May 2025)
- Long waits for children & young people on Bridgewater waiting lists in June 2025: **613** waiting **>12-18 weeks**, **1392** waiting **>18-52 weeks**, **1209** waiting **>52-104 weeks**, and **95** waiting over **104 weeks**.
- Children & young people waiting over **52 weeks** on Bridgewater waiting lists has increased by **389** to **1304** from last month.

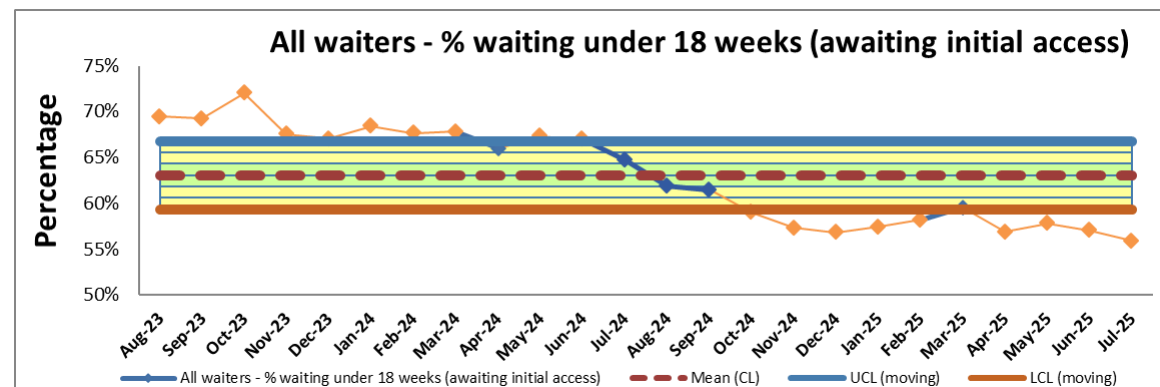
Operations: Exception Reporting

All Bridgewater patients waiting awaiting initial access to service – Including Dental and Dermatology Services.



Over 52 weeks	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Warrington	214	248	299	432	517	639	816	1044	1289	1556	1676	1738
Halton	162	175	192	214	255	285	313	360	409	287	606	794
Dental	220	110	127	140	126	64	29	25	42	31	15	13
Total Over 52 weeks	596	533	618	786	898	988	1158	1429	1740	1874	2297	2545

Percentage of patients waiting over 52 weeks in July is 12.90%.



Under 18	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Warrington	5057	4881	4705	4672	4756	4710	4701	5459	4655	4855	5042	5276
Halton	1931	1967	1726	1600	1542	1725	1704	1824	1518	1553	1645	1746
Dental	3774	3755	3498	3416	3407	3548	3943	4185	4221	3979	4365	4004
Total Under 18	10762	10603	9929	9688	9705	9983	10348	11468	10394	10387	11052	11026

Percentage of patients waiting under 18 weeks in July is 55.89%.

Paediatric OT – Recruit to vacant post. (active)

Community Paediatrics - Appointments offered to highest risk of stratified caseload. Liaise with commissioners re future trajectories.

Dermatology - Engagement with NHSE regarding 65+ week waits. EMT paper submitted relating to utilisation of resources.

Podiatry Warrington – Recruit to vacancies. (active) NHSP sourced as interim solution.

Podiatry

Operations: Exception Reporting

All Bridgewater patients waiting awaiting initial access to service – Including Dental and Dermatology Services.

Analytical Narrative / Operational Narrative:

The percentage of patients waiting 18 weeks and above is in a state of steady decline. For waiters under 18 weeks, we would expect variation to range between 55% and 65%. For waiters over 52 weeks, we would expect variation to be between 4% and 13%.

If we aspire to align with elective targets, we would need to achieve 65% of patients waiting less than 18 weeks by March 2026.

Operational narrative - Services with over 52 week waits

Paediatric OT – Recruit to vacant post. (active)

Community Paediatrics (Warrington and Halton)- Appointments offered to highest risk of stratified caseload. Liaise with commissioners re future trajectories.

Dermatology - Engagement with NHSE regarding 65+ week waits. EMT paper submitted relating to utilisation of resources.

Podiatry Warrington – Recruit to vacancies. (active) NHSP sourced as interim solution.

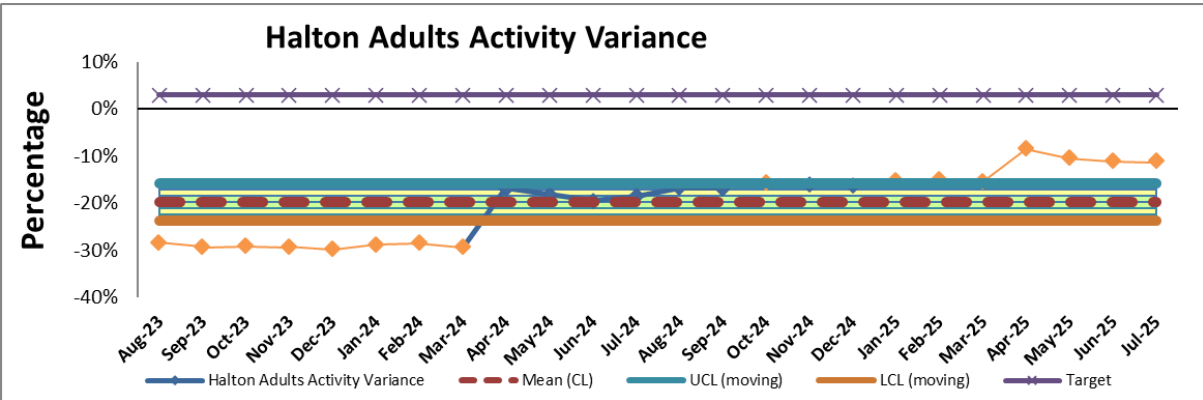
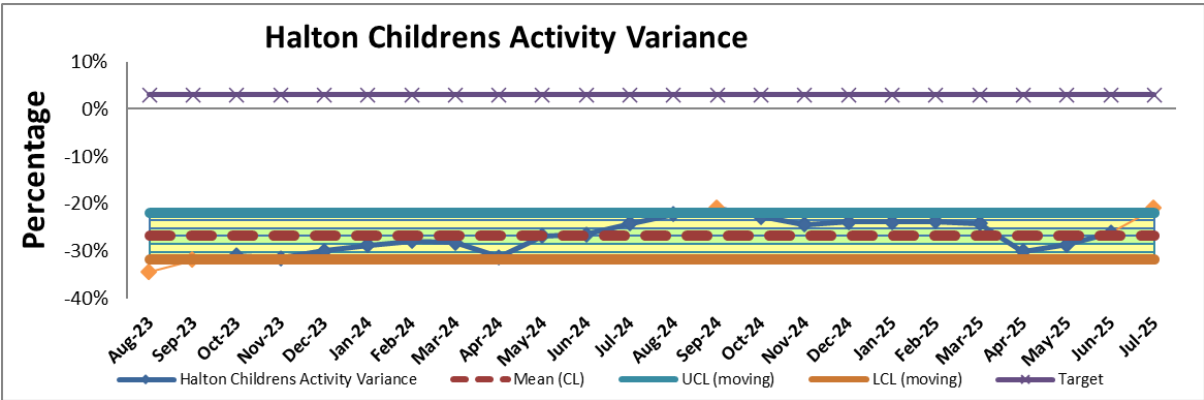
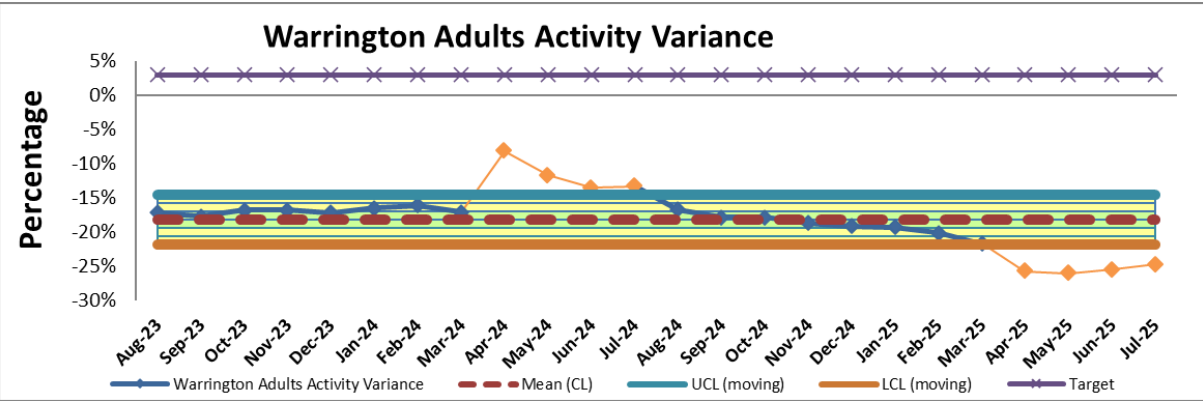
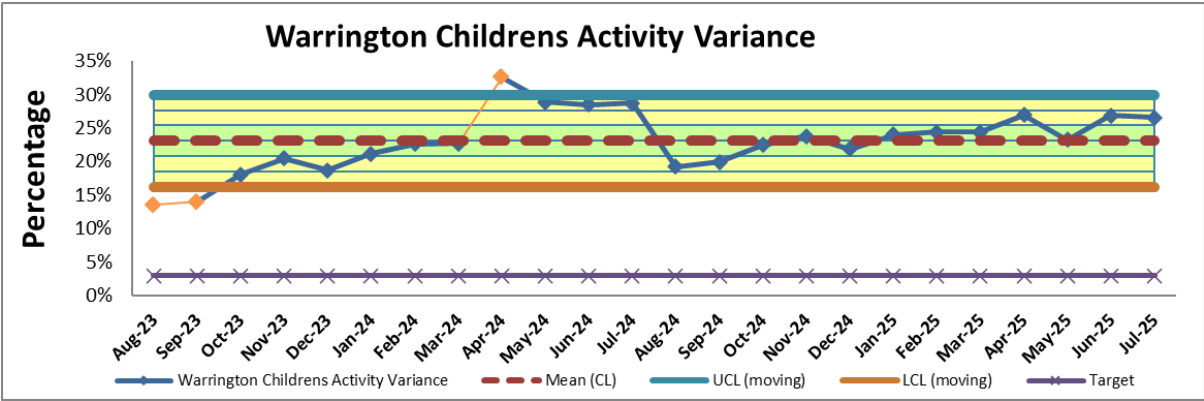
Halton Podiatry –The volume of waits has reduced due to a change in service criteria. Plans are in place to reduce the existing list through the application of the revised eligibility criteria on those who have been referred in the last 3 months.

Dental Greater Manchester - High waiters in GM are being offered other clinics with more capacity if patients are happy to travel.

Dental Cheshire & Merseyside - Operational flexibility enabled allowing targeting of areas where demand is high/staff booking at alternative sites to reduce waits.

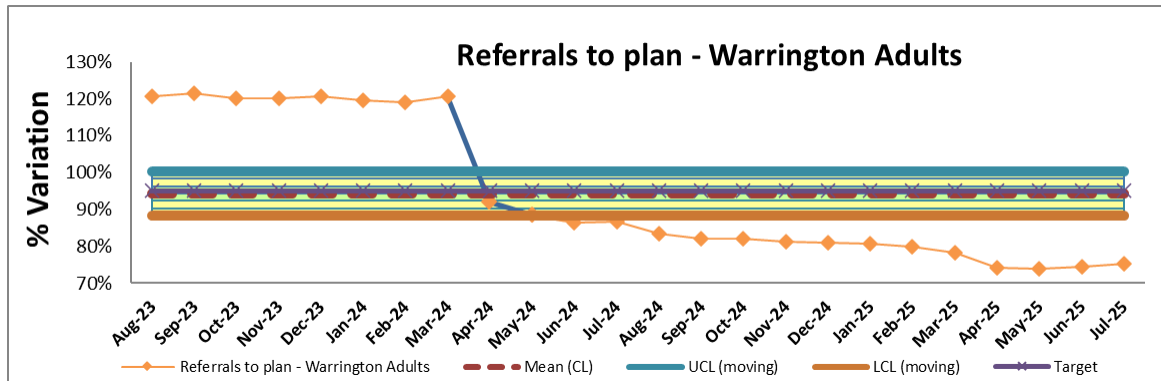
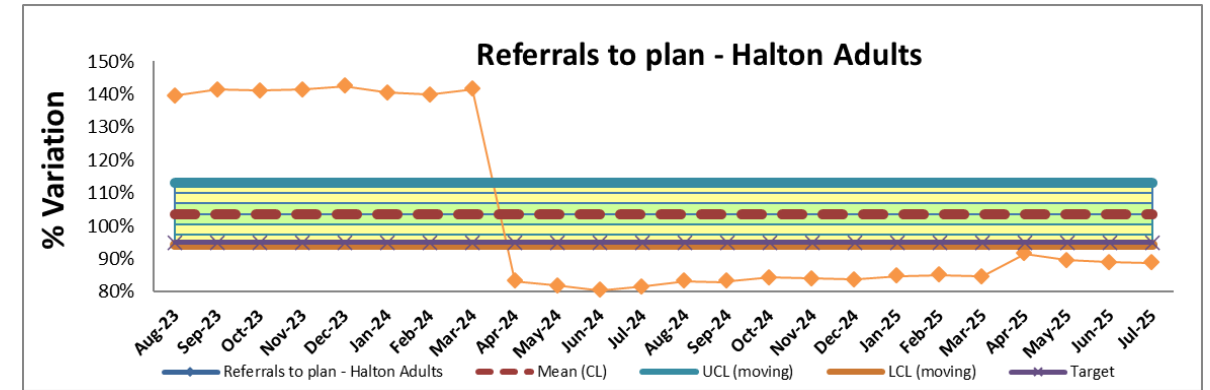
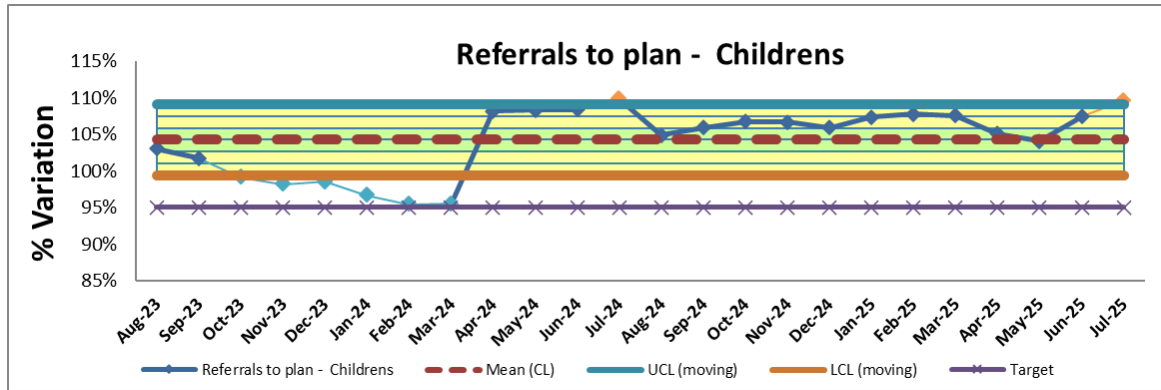
Operations: Exception Reporting

Activity Variances Local Target: 3%



Operations: Exception Reporting

Referrals to plan Local Target 95%



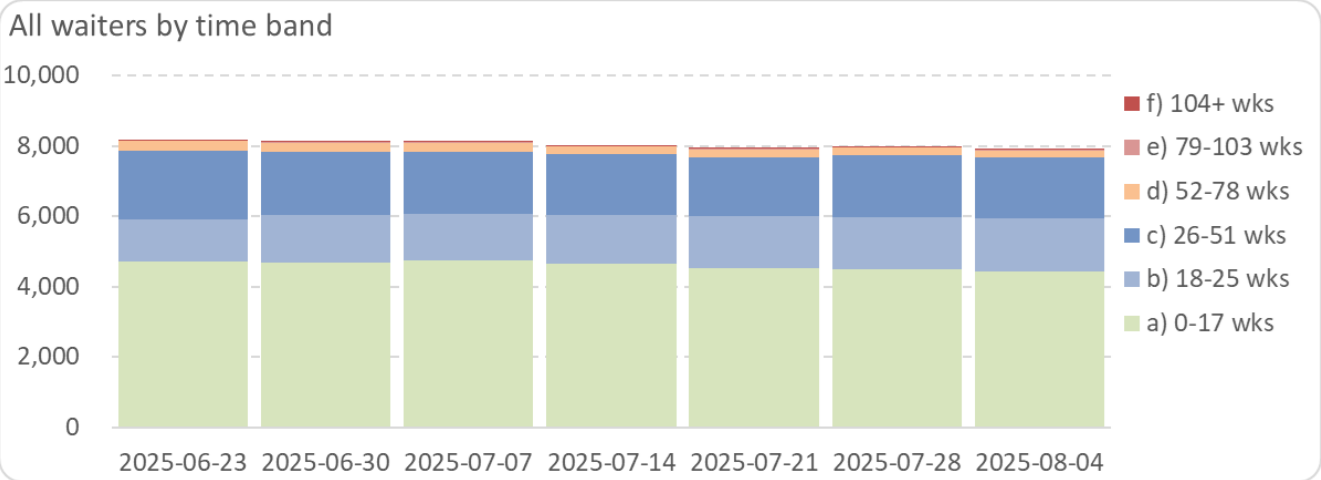
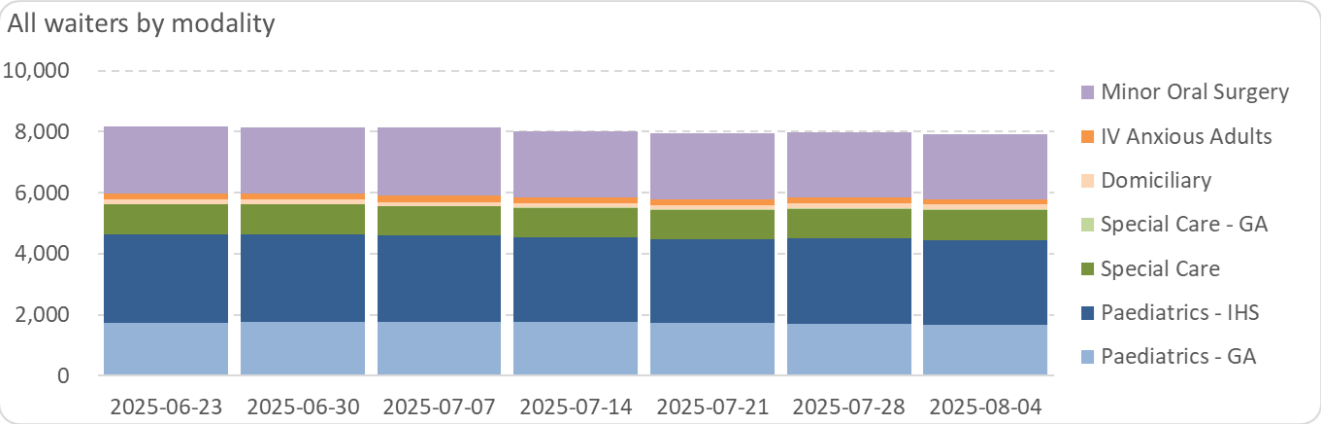
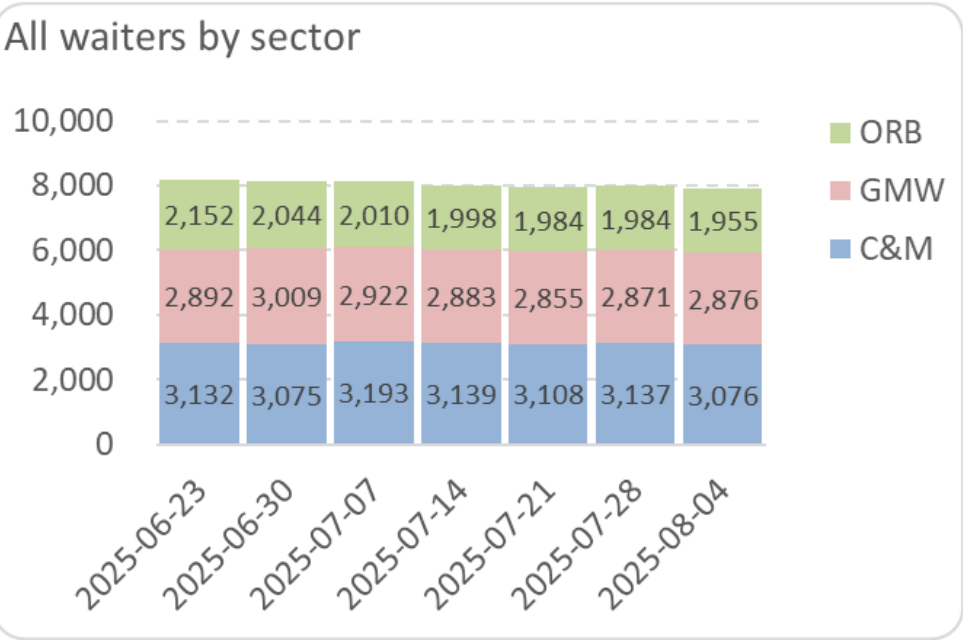
Analytical / Operational Narrative for Activity Variance and Referrals to Plan

In line with the request from the ICB to review current activity variance targets a working group has been established comprising of operations, Informatics and finance to agree methodology and to consider any individual service-line changes relating activity targets.

The timeline for completion of this work is end Q2

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality



Operations: Exception Reporting

Dental – All 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
2025-06-23	4699	1223	1940	266	28	20
2025-06-30	4674	1356	1790	259	26	23
2025-07-07	4730	1347	1762	238	25	23
2025-07-14	4644	1385	1722	221	26	22
2025-07-21	4529	1459	1695	215	26	23
2025-07-28	4478	1487	1775	204	26	22
2025-08-04	4412	1517	1734	195	27	22

Analytical / Data Quality Narrative

The numbers of waiters within each time band has remained consistent, although decreased in patients waiting 0-17 weeks and a slight increase in 18-25 weeks, decrease in 26-51 weeks, weeks 52-78 and above have remained consistent to last month with a slight reduction each month. The performance team are in the process of visualising this data via SPC's.. The high waiters >104 are for Paeds GA in greater Manchester, due to theatre capacity.

Greater Manchester commissioners have recently asked for additional data relating to activity. It is clear there are data quality issues relating to referral and activity data due to limitations of the Dentally system. We are currently mitigating the impact of this with some manual data collection whilst the Information team explore best options to improve electronic reporting. We are confident that waiting lists in Dentally is accurate although the BI informed Dental of an issue with not being able to pull through all information from the data warehouse. Need reassurance from BI team that we are accurately captured and all measures to manage the continued reduction of long waiters are in place for both sectors.

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality **Cheshire & Mersey Operational Narrative**

Over 65 week waits - Cheshire & Mersey have 1 waiter over 65 weeks due to a clerical delay only.

Waiters are targeted via opt ins, early assessment appointments and a minimum wait for treatment. This is evident in a reduction of waiters over 52 weeks being offered treatment , even in the most challenging pathway- Minor Oral Surgery. (MOS)

We currently have just 3 waiters over 52 weeks across all pathways- all with treatment appointments booked.

A session of theatre slots for children has been dedicated to GM so their high waiters can be seen, due to a fall in demand from C and M.

An existing session dedicated for children requiring pre -meds has been trialled and awaits commissioner feedback re potential extra funding to support this pathway.

The following actions are contributing to performance improvement:

- Performance data contributes to weekly waitlist management meetings with HOS, DNTM and DNTL reps, and Data analyst. This includes scrutinising discharges/cancellations/DNAs and prioritising patient lists to target/apply resources in key areas.
- Parameters set for assessing MOS referrals is 35 weeks maximum. Offered treatment appointment by 45 weeks.
- Weekly booking efficiency meetings assist managing patient flow and maximising activity proving successful – eg clinic hours unbooked last week of July- 45 mins.
- Performance Dashboard now in place to monitor activity against contractual targets monthly.
- Operational flexibility enabled allowing targeting of areas where demand is high/staff booking at alternative sites to reduce waits.

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality

Greater Manchester Operational Narrative

Over 65 week waits - Greater Manchester (GM) have 90 patients waiting over 65 weeks. This has decreased by 2 since last month due to GM sending 5 patients per week to Whiston hospital.

84 are for Paediatric General Anaesthetic, 5 are for Inhalation Sedation (due to patients cancelling appointments) and 1 Special Care GA patients (adults) for General Anaesthetic, this patient was on SC Paed list but has now turned 16 so will be seen sooner on adults GA SC waiting list.

Managers book assessments in order of receiving referral or clinical priority. all GM managers have been asked to book in patients from other clinics that have more pressures.

The following actions are contributing to performance improvement:

- High waiters in GM are being offered other clinics with more capacity if patients are happy to travel.
- Assessments are booked before 45 weeks in all clinics for assessments, to ensure all treatments completed by 52 weeks. Not always possible due to appointments available. The aim is to reduce to 6 weeks for assessments
- Monthly calls with Managers including Clinical director and BI team to go through high waiters, cancellations, discharge and to discuss any issues with reports.
- Following acceptance and discharge criteria to reduce waiting lists from 65 weeks to 45 weeks in proving successful. However, the total volume on waiting list is reducing slightly since previous months, due to more efficient booking.
- Regular meetings with commissioners and ICB for mutual aid to reduce General Anaesthetic waiters as we do not have much theatre capacity in GM – We are now sending 5 patients per week to Whiston in C&M since June. Emailed all GM hospitals to find more GA capacity, still no extra theatre availability.
- Commissioners are focussing on reviewing delivery of contracted number of sessions rather than high waiters and activity. Greater Manchester are not delivering the full number of contracted sessions
- Reviewing admin time, time out of clinics, meetings etc to increase capacity
- W&S see more patients per month and receive more referrals than N&E and have equally same the amount of clinicians, currently reviewing.

Quality

Executive Summary

There are 9 Quality indicators reporting as red and 22 green indicators in July 2025.

The 9 indicators which were red in July are as follows:

▪ % Incidents reported within 48 hrs of discovering an incident has occurred	– Improvement in Month
▪ % of incidents causing moderate harm (Score 3)	– Improvement in Month
▪ DOC (Duty of Candour) for moderate harms and above 10-day compliance	– Improvement in Month
▪ Information Governance Training	– Deterioration in Month
▪ % of BCHFT risks managed in line with policy i.e. risks with in date reviews	– Improvement in Month
▪ BCHFT patient safety Falls per 1,000 bed days - bed based	– Deterioration in Month
▪ Total number of BCHFT acquired pressure ulcers	– Improvement in Month
▪ % of Cat 3 Pressure Ulcers acquired in Bridgewater	– Improvement in Month
▪ IPC assurance audit compliance	– Improvement in Month

Quality: Exception Reporting

Trust Scorecard

Quality															
KPI Name	Target	Trend Line	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of Never Events	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
% Incidents reported within 48 hrs of discovering an incident has occurred	87%		83.42% (▼)	84.14% (▲)	84.62% (▲)	86.53% (▲)	82.22% (▼)	83.21% (▲)	85.07% (▲)	90.99% (▲)	85.12% (▼)	85.8% (▲)	85.89% (▲)	82.35% (▼)	86.47% (▲)
% of incidents causing moderate harm (Score 3)	1%		0% (▲)	2.76% (▼)	3.33% (▼)	1.03% (▲)	0% (▲)	0% (▶)	0% (▶)	0% (▶)	0.84% (▼)	0.62% (▲)	0.61% (▲)	5.29% (▼)	2.35% (▲)
% of incidents causing severe/fatal harm (Score 4-5)	0%		0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
Patient Safety Incident Investigations compliance submitted within 90 days	90%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
DOC (Duty of Candour) for moderate harms and above 10-day compliance	100%		0% (▼)	50% (▲)	100% (▲)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	33.33% (▼)	66.67% (▲)
% of BCHFT patient safety incidents that are medication incidents	7%		7.81% (▲)	10.34% (▼)	8.89% (▲)	8.76% (▲)	10.14% (▼)	7.58% (▲)	3.65% (▲)	9.82% (▼)	5.04% (▲)	6.17% (▼)	9.2% (▼)	5.88% (▲)	4.12% (▲)
% of Patient safety medication incidents causing moderate harm (Score 3)	0%		0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
% of Patient safety medication incidents causing severe/fatal harm (Score 4-5)	0%		0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
Information Governance Training	95%		93.87% (▼)	95.65% (▲)	96.2% (▲)	95.39% (▼)	95.73% (▲)	95.51% (▼)	94.51% (▼)	94.87% (▲)	95.44% (▲)	95.55% (▲)	95.43% (▼)	94.57% (▼)	93.69% (▼)
Safeguarding Childrens Level 1	95%		98.76% (▲)	98.31% (▼)	98.19% (▼)	98.34% (▲)	98.71% (▲)	98.51% (▼)	98.38% (▼)	98.05% (▼)	98.29% (▲)	98.19% (▼)	98.19% (▲)	98.19% (▲)	98.25% (▲)
Safeguarding Childrens Level 2	95%		99.31% (▲)	98.8% (▼)	98.05% (▼)	98.41% (▲)	98.48% (▲)	98.57% (▲)	98.9% (▲)	98.47% (▼)	98.89% (▲)	98.61% (▼)	98.27% (▼)	97.92% (▼)	97.74% (▼)
Safeguarding Childrens Level 3	95%		98.47% (▼)	98.47% (▼)	96.55% (▼)	98.97% (▲)	99.3% (▲)	98.3% (▼)	98.65% (▲)	98.64% (▼)	98.99% (▲)	99.66% (▲)	99.66% (▲)	98.97% (▼)	98.97% (▼)
Safeguarding Adults Level 1	95%		98.85% (▲)	98.4% (▼)	98.6% (▲)	98.3% (▼)	98.79% (▲)	98.21% (▼)	98.2% (▼)	97.88% (▼)	98.43% (▲)	98.21% (▼)	98.15% (▼)	98.28% (▲)	98.14% (▼)
Safeguarding Adults Level 2	95%		99.49% (▲)	99.14% (▼)	98.38% (▼)	98.32% (▼)	98.72% (▲)	98.89% (▲)	98.97% (▲)	98.88% (▼)	99.05% (▲)	99.04% (▼)	98.87% (▼)	99.04% (▲)	98.77% (▼)
Safeguarding Adults Level 3	95%		97.79% (▼)	98.35% (▲)	97% (▼)	97.05% (▲)	98.12% (▲)	97.64% (▼)	97.93% (▲)	97.64% (▼)	99.22% (▲)	99.48% (▲)	98.96% (▼)	98.16% (▼)	97.66% (▼)
% of BCHFT risks managed in line with policy ie risks with in date reviews	92%		73.33% (▼)	89.94% (▲)	100% (▲)	94.29% (▼)	85.96% (▼)	85.64% (▼)	97.06% (▲)	83.23% (▼)	100% (▲)	96.23% (▼)	96.15% (▼)	83.44% (▼)	85.06% (▲)
Percentage of BCHFT risks identified as 12 or above	11%		15.56% (▼)	13.97% (▲)	15.34% (▼)	16% (▼)	14.61% (▲)	14.92% (▼)	15.29% (▼)	15.57% (▼)	12.1% (▲)	9.43% (▲)	9.62% (▼)	9.27% (▲)	8.44% (▲)

Quality: Exception Reporting

Trust Scorecard

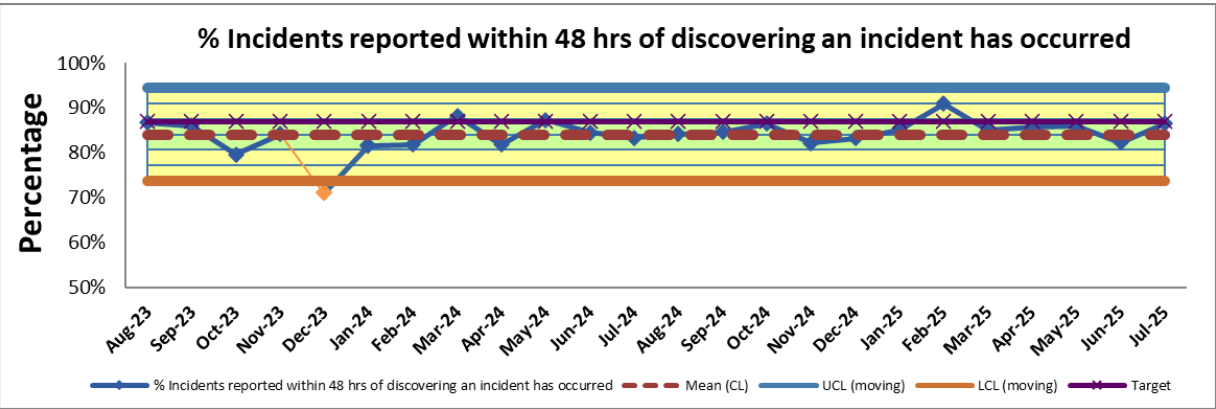
Quality															
KPI Name	Target	Trend Line	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
% of BCHFT patient safety falls identified as serious	0%		0% (▶)	5.88% (▼)	11.11% (▼)	12.5% (▼)	0% (▲)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
BCHFT patient safety Falls per 1,000 bed days - bed based	8		22.53 (▼)	15.44 (▲)	18.32 (▼)	16.71 (▲)	8.43 (▲)	6.46 (▲)	14.34 (▼)	12.79 (▲)	12.83 (▼)	13.1 (▼)	5.2 (▲)	12.48 (▼)	14.57 (▼)
Total number of BCHFT acquired pressure ulcers	15		18 (▼)	14 (▲)	21 (▼)	19 (▲)	12 (▲)	20 (▼)	24 (▼)	13 (▲)	22 (▼)	21 (▲)	25 (▼)	25 (▶)	20 (▲)
% of Category 4 Pressure Ulcers acquired in Bridgewater	0%		0% (▲)	0% (▶)	4.76% (▼)	5.26% (▼)	0% (▲)	0% (▶)	4.17% (▼)	0% (▲)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
% of Cat 3 Pressure Ulcers acquired in Bridgewater	3%		16.67% (▼)	21.43% (▼)	9.52% (▲)	15.79% (▼)	8.33% (▲)	25% (▼)	4.17% (▲)	15.38% (▼)	13.64% (▲)	23.81% (▼)	8% (▲)	24% (▼)	20% (▲)
MRSA - Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
C.Diff - Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
E Coli- Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
Bacteraemia - Total Number of outbreaks	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
Complaints that are managed within the policy timelines	100%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
National Patient Safety Alerts opened and managed in line with policy timescales	100%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
% of all policies within review date	90%		92.02% (▲)	92.78% (▲)	95.82% (▲)	95.82% (▶)	95.06% (▼)	95.13% (▲)	97.38% (▲)	95.56% (▼)	96.67% (▲)	97.41% (▲)	98.89% (▲)	97.75% (▼)	97.05% (▼)
IPC assurance audit compliance	90%		88.8% (▲)	89.4% (▲)	77.4% (▼)	79.8% (▲)	87.4% (▲)	80.4% (▼)	83.6% (▲)	82% (▼)	83% (▲)	79% (▼)	73.2% (▼)	84.2% (▲)	89% (▲)
Record keeping Audit completion compliance	90%				100% (▲)			100% (▶)			100% (▶)			100% (▶)	
Overall CQC rating (Yearly)	Good							Requires Improvement (▶)							
Assessment, diagnosis and treatment of lower leg wounds (CQUIN13)	50%			81.4% (▲)			83.08% (▲)			61.76% (▼)			93.94% (▲)		

Quality: Exception Reporting

Trust Scorecard

Information Governance Training		Points below lower control limit
Safeguarding Childrens Level 2		Points below lower control limit
Percentage of BCHFT risks identified as 12 or above		Points below lower control limit

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
% Incidents reported within 48 hrs of discovering an incident has occurred	Num	122	154	167	111	109	114	101	103	139	140	140	147
	Denom	145	182	193	135	131	134	111	121	162	163	170	170

Analytical Narrative

We were seeing a mostly consistent trend of data points sitting close to the mean, yet below target. In February 2025 there was a significant improvement, yet the past five months have fallen back below target.

% Incidents reported within 48 hrs of discovering an incident has occurred

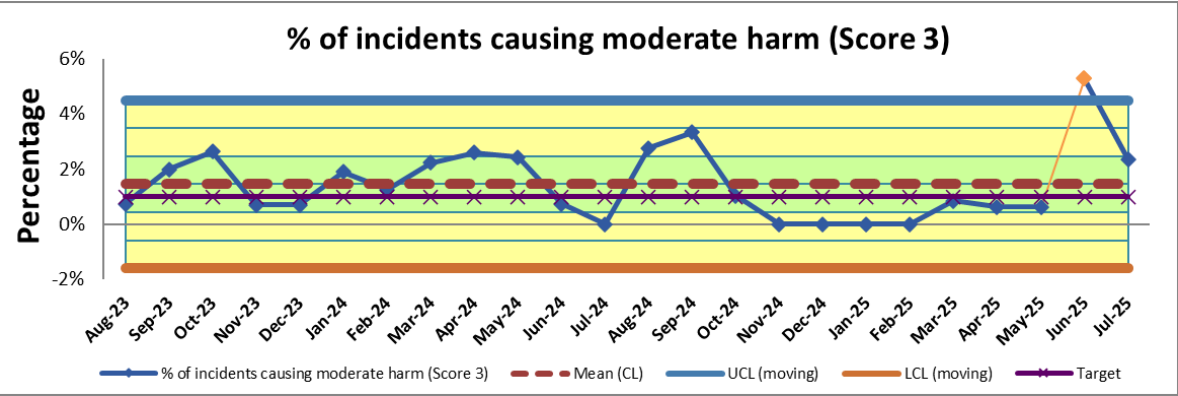
Target: 87% Compliance in July – 86.47%

Operational Narrative

In July 2025, the compliance rate was 86.47% compared to 82.94% in June 2025. This is a positive increase in compliance, with the current compliance sitting just below the target of 87%. The July performance remained within the upper and lower control limits.

The need to report incidents within 48 hours of discovery, is a key element of the Trust's Incident Reporting Policy and is covered in the Trust's in house training offers. In order to improve the standards for reporting and management of incidents, the existing programme of training has been increased.

Quality: Exception Reporting



	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
% of incidents causing moderate harm (Score 3)	Num	4	6	2	0	0	0	0	1	1	1	9	4
	Denom	145	180	194	138	132	137	112	119	162	163	170	170

Analytical Narrative

We were beginning to see a trend of points below the mean, yet the past two months has seen a spike of moderate harm incidents. We often see fluctuations around the mean and with incidents being reviewed and regraded.

% of incidents causing moderate harm (Score 3)

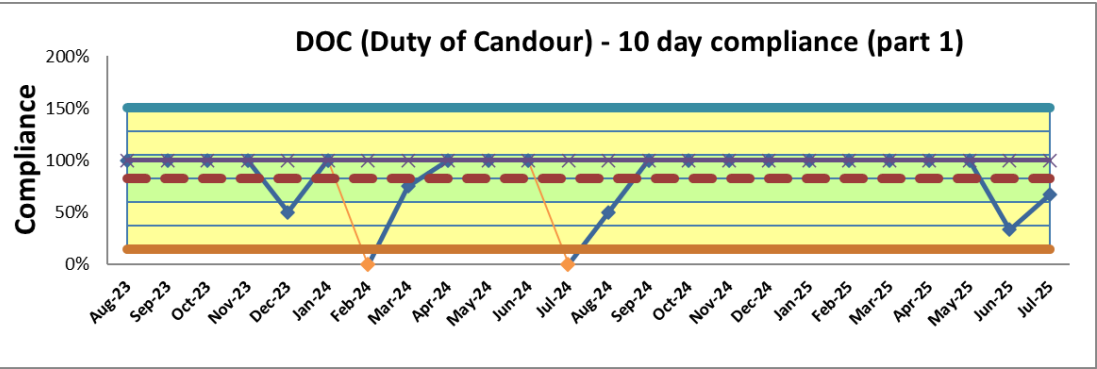
Target: 1% Compliance in July – 2.35%

Operational Narrative

70341 / 70405 / 70588 / 70662
All incidents, especially those that were initially reported as moderate harm are discussed and if necessary, challenged at the Directorate Incident Response and Learning Group(s). The purpose of this is to ensure as far as possible, that harm levels of incidents are in line with national guidance.

In July 2025 there were four incidents that were initially reported as moderate harm, three of these relate to category 3 pressure ulcers, there was one category 2 pressure ulcer initially reported as moderate harm which was subsequently downgraded to minor harm. All levels of harm are reviewed and confirmed at the DIRLG, to ensure correct gradings have been allocated to each incident.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
DOC (Duty of Candour) - 10 day compliance (part 1)	Num	1	6	4	1	1	1	1	1	1	1	1	6
	Denom	2	6	4	1	1	1	1	1	1	1	3	9

Analytical Narrative

We are seeing an inconsistent trend due to the low numbers of incidents. The target remains near the mean and within control limits and is achievable.

DOC (Duty of Candour) - 10-day compliance (part 1)

Target: 100% Compliance in July – 66.67%

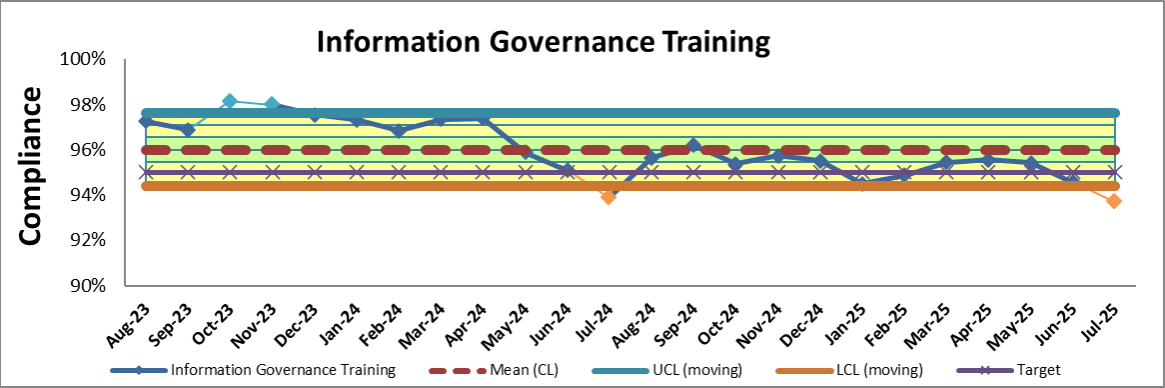
Operational Narrative

In July 2025, nine incidents required duty of candour as per this indicator. In six cases this was completed within the Trust's 10-day threshold.

It was not possible to complete this for two patients as at the time they were in hospital. A third case was completed outside of the Trust's 10-day threshold and is therefore considered not compliant with Trust policy.

The correct application and recording of duty of candour is included in the role specific training for staff at band 7. It is anticipated that with increased training compliance that this will improve compliance with this indicator.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Information Governance	Num	1496	1521	1531	1525	1512	1497	1499	1486	1460	1461	1445	1426
Training	Denom	1564	1581	1605	1593	1583	1584	1580	1557	1528	1531	1528	1522

Information Governance Training

National Target: 95% July Compliance – 93.69%

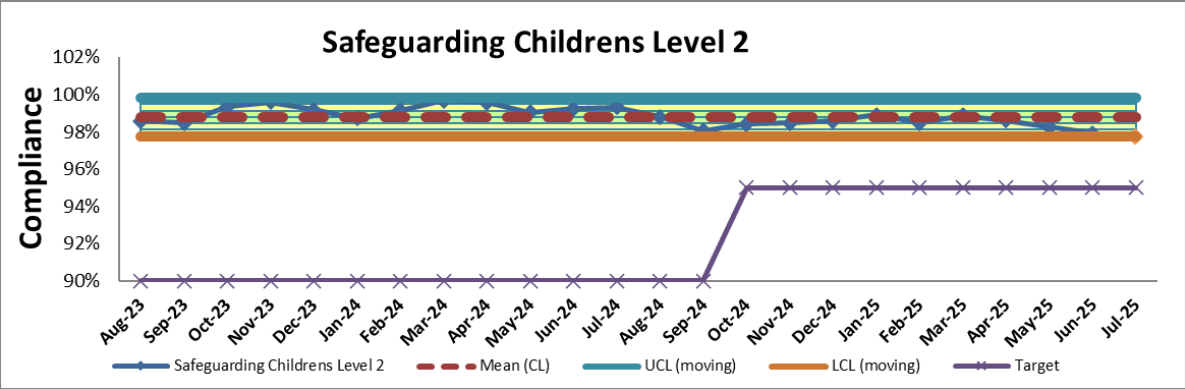
Operational Narrative

Compliance remains below target, staff compliance with mandatory training continues to be monitored within directorates. No trend in compliance can be identified as to a particular directorate. Operational managers to target teams that need to improve compliance

Analytical Narrative

The trend of data points below the mean has continued and is now outside of the control limits, with the target not being met three times in the last six months. If there is not a process change, we would expect this trend to continue and we are likely to see more data points below target and outside of control limits.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Safeguarding Childrens Level 2	Num	1151	1158	1174	1168	1169	1169	1159	1154	1134	1133	1128	1122
	Denom	1165	1181	1193	1186	1186	1182	1177	1167	1150	1153	1152	1148

Analytical Narrative

The data has sat below or near to the mean for the past year yet for July 2025 is now outside the lower control limit. The target remains below the control limits and is achievable.

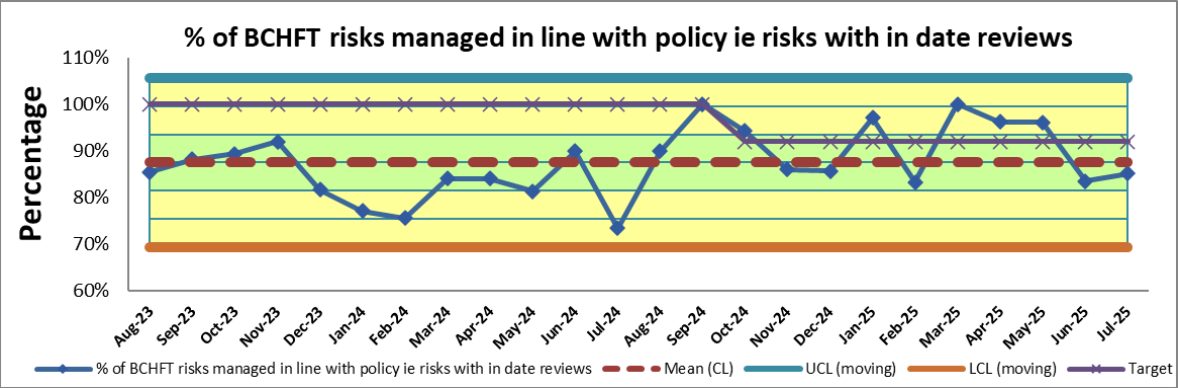
Safeguarding Childrens Level 2

Local Target: 95% July Compliance – 97.74%

Operational Narrative

Decline is likely reflective of combination is current staffing pressures and summer holiday period. This training is delivered via eLearning. Analysis of data indicates focus for improved compliance should be on Halton adult directorate - DN and Frailty services.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
% of BCHFT risks managed in line with policy ie risks with in date reviews	Num	161	176	165	153	155	165	139	157	153	150	126	131
	Denom	179	176	175	178	181	170	167	157	159	156	151	154

Analytical Narrative

Although all data points are within normal variation, we are seeing an inconsistent trend, with June and July 2025 dropping below the mean and target, after a brief improvement spell.

% of BCHFT risks managed in line with policy ie risks with in date reviews

Local Target: 92% Compliance in July - 85.06%

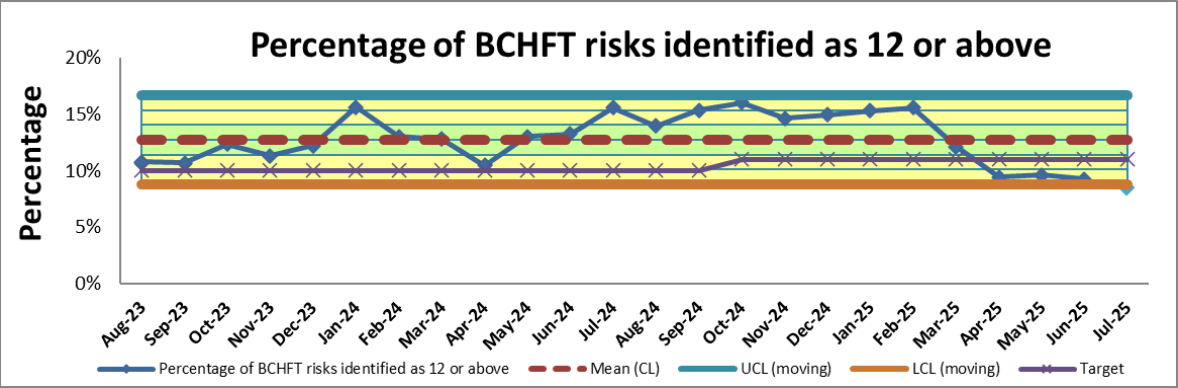
Operational Narrative

The level of compliance for July 2025 was noted to have improved to 85.06%, against a target of 92%.

Directorate specific compliance with this indicator is prepared monthly by the Risk Management Team and monitored by the Risk Management Council. The main factors in this were risks in the Dental and Corporate Services Directorates.

The need for risk owners to have robust arrangements in place to ensure that risks are reviewed in line with their review dates will be discussed at the July meeting of the Risk Management Council.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Percentage of BCHFT risks identified as 12 or above	Num	25	27	28	26	27	26	26	19	15	15	14	13
	Denom	179	176	175	178	181	170	167	157	159	156	151	154

Analytical Narrative

For the past four months the data has been below the mean and target which would signal a period of improvement, with the indicator now below the lower control limit for July 2025.

Percentage of BCHFT risks identified as 12 or above

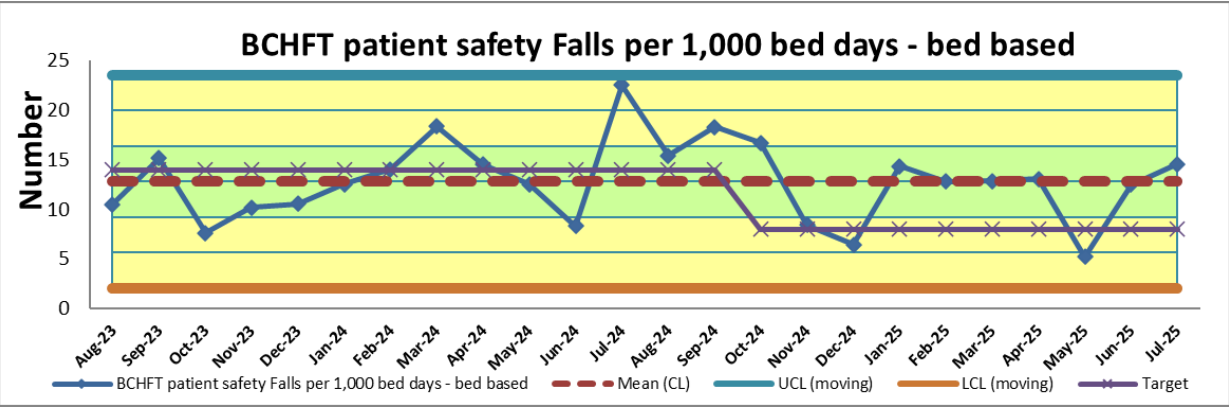
Local Target: 11% Compliance in July - 8.44%

Operational Narrative

This indicator has remained below the identified target of 11%, for the last 4 data points, with a July performance of 8.44%.

In view of the robust processes that are in place to challenge risks, it is likely that this level of performance will continue.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
BCHFT patient safety Falls per 1,000 bed days - bed based	Num	12	14	13	7	6	14	11	12	12	5	14	13
	Denom	777	764	778	830	929	976	860	935	916	961	1122	892

Analytical Narrative

There has been an inconsistent trend with numerous data points either side of the mean and target. However, the data points remain within control limits.

BCHFT patient safety Falls per 1,000 bed days - bed based

Local Target: 8
July Compliance – 14.57

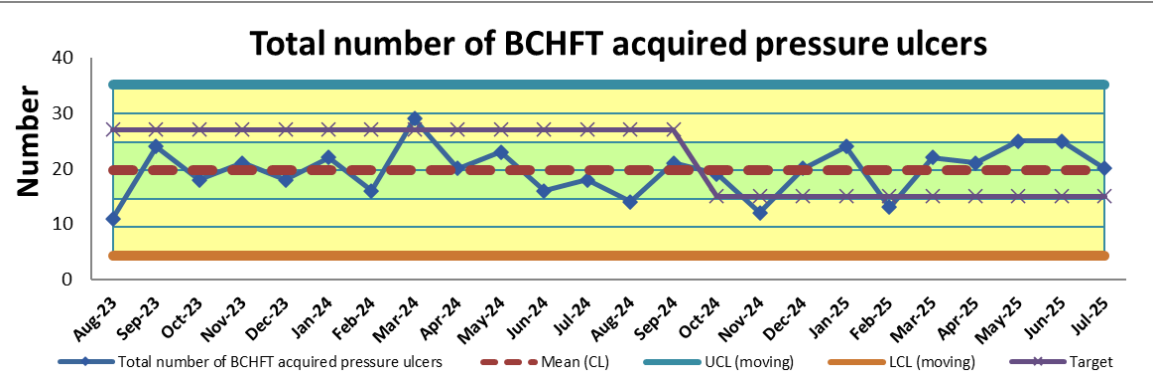
Operational Narrative

13 falls were reported in Padgate House in July. Seven of the falls resulted in insignificant / no harm, and six resulted in minor harm.

11 of the falls were unwitnessed, and two were witnessed

Appropriate actions were taken following the falls, and any learning will be reviewed by the Falls priority Group.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Total number of BCHFT acquired pressure ulcers	Num	14	21	19	12	20	24	13	22	21	25	25	20

Analytical Narrative

All data points remain within normal variation yet fluctuate around the mean. The target is within limits and is achievable.

Total number of BCHFT acquired pressure ulcers

Target: 15 Compliance in July - 20

Operational Narrative:

During this reporting period there has been a minimal change in the number of BCHFT acquired pressure ulcers reported.

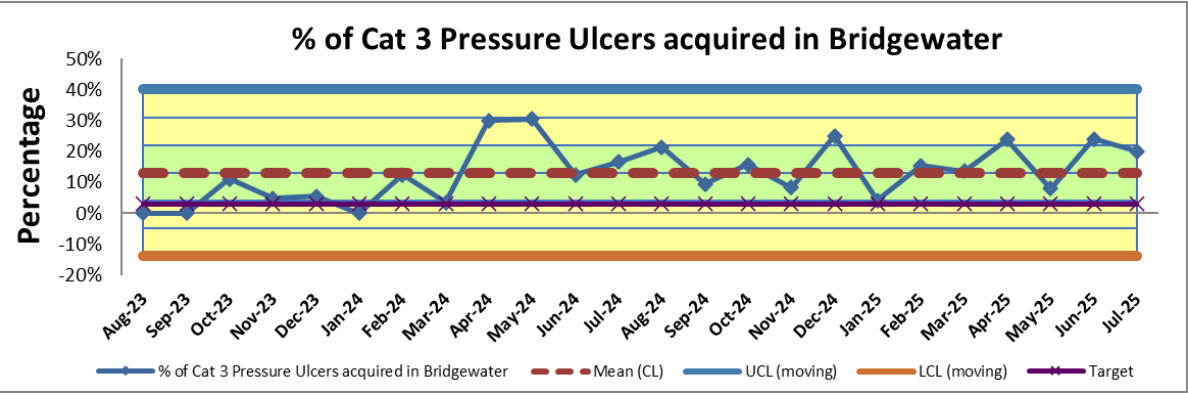
Of the 20 BCHFT acquired pressure ulcers, 5 of those reported were in Halton and 15 in Warrington. 16 of the 20 incidents related to category 2 pressure ulcers.

In **Halton**, all 5 were within the district nursing service, with equal distribution across the teams. 3 of the reported cases were patients with a palliative diagnosis whilst the other 2 involved reduced mobility secondary to exacerbation of underlying conditions.

Within **Warrington** 15 of the recorded incidents were within District Nursing with equal distribution across the teams. 6 of the reported patients were on the palliative pathway whilst the other 9 were of mixed causation including reduced patient mobility.

Work remains ongoing through the pressure ulcer priority group to identify any themes, learning and any areas of improvement.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
% of Cat 3 Pressure Ulcers acquired in Bridgewater	Num	3	2	3	1	5	1	2	3	5	2	6	4
	Denom	14	21	19	12	20	24	13	22	21	25	25	20

Analytical Narrative

We are continuing to see an inconsistent trend due to the low numbers of category 3 pressure ulcers reported. Pressure Ulcer incidents can also be regraded once reviewed. All data points are within standard variation, as is the target.

% of Category 3 Pressure Ulcers acquired in Bridgewater

Local Target: 3% Compliance in July – 20%

Operational Narrative:

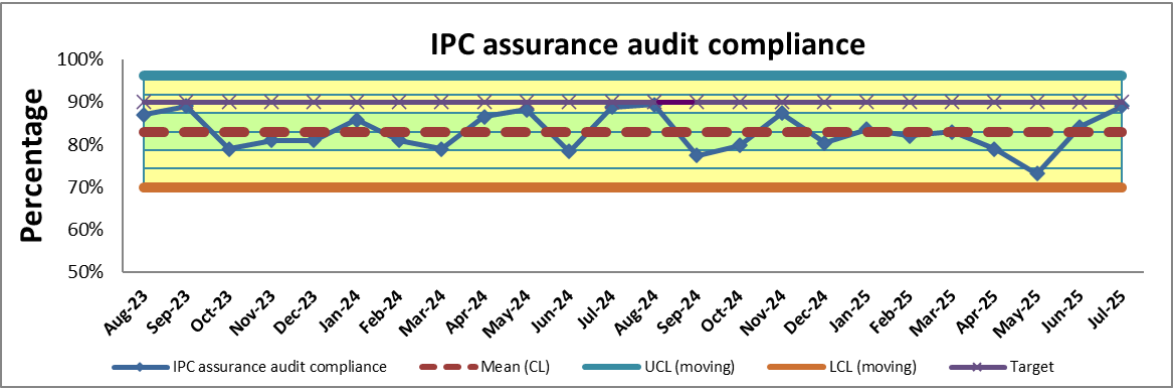
The inconsistent trend in category three pressure ulcer incidence continues in month with a decrease in reported category 3 ulcers. This has been recognised in the pressure ulcer priority group as an area for focused improvement in 2025/26.

In this reporting period there has been 4 reported category 3 Pressure Ulcers, 4 attributed to the Warrington borough.

The incidents relate to 2 patients who are on the palliative pathway and 1 paraplegic patient with underlying infection, and 1 who had deterioration in their general health which adversely effected their mobility and risk.

Work remains ongoing through the pressure ulcer priority group to identify learning and any areas for improvement.

Quality: Exception Reporting



KPI Name	Unit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
IPC assurance audit compliance	%	89.4%	77.4%	79.8%	87.4%	80.4%	83.6%	82.0%	83.0%	79.0%	73.2%	84.2%	89.0%

Analytical Narrative

We can see a consistent trend with all data points within normal variation. The target sits within limits and is achievable.

IPC assurance audit compliance

Local Target: 90% Compliance in July – 89%

Operational Narrative

Since the compliance collection method was amended in April, there has been a continued increase in teams reporting. The data also reflects the service assurance more accurately.

During the process additional teams were identified who are required to complete the assurance submission, which will be actioned through IPCG. This may cause a reduction in compliance initially, as the teams learn to input the correct data.

There were 6 services that did not submit data this month.

People

Executive Summary

Two out of four People indicators are shown as red in July 2025.

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

- Sickness absence rate (Actual) – Deterioration in Month
- % of staff with a current PDR – Deterioration in Month

People

Trust Scorecard

People															
KPI Name	Target	Trend Line	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Staff turnover (rolling)	12.00%		10.21% (▲)	10.47% (▼)	10.7% (▼)	10.75% (▼)	10.72% (▲)	10.81% (▼)	11.06% (▼)	11.28% (▼)	11.83% (▼)	11.38% (▲)	11.1% (▲)	11.46% (▼)	11.79% (▼)
Sickness absence rate (Actual)	5.50%		6.65% (▼)	6.19% (▲)	5.76% (▲)	6.49% (▼)	6.81% (▼)	7.32% (▼)	7.97% (▼)	6.23% (▲)	6.33% (▼)	6.91% (▼)	6.57% (▲)	6.96% (▼)	7.27% (▼)
% of staff with a current PDR	85.00%		86.33% (▼)	86.06% (▼)	85.77% (▼)	86.98% (▲)	87.63% (▲)	87.37% (▼)	87.12% (▼)	87.91% (▲)	88.18% (▲)	87.43% (▼)	86.68% (▼)	85.14% (▼)	82.06% (▼)
% Overall Mandatory Training Compliance	85.00%		95.61% (▲)	95.68% (▲)	95.93% (▲)	94.85% (▼)	95.78% (▲)	95.56% (▼)	95.77% (▲)	96.11% (▲)	96.58% (▲)	96.97% (▲)	97.13% (▲)	96.69% (▼)	96.35% (▼)

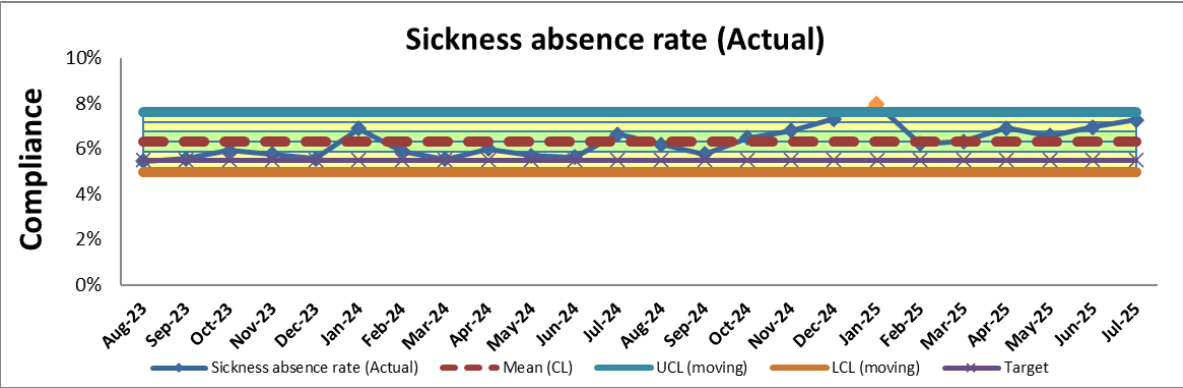
People

Trust Scorecard

% of staff with a current PDR		Points below lower control limit



People: Exception Reporting



Analytical Narrative

We are being to see an increasing trend yet still above target and within control limits. We will continue to monitor this.

Sickness absence rate (Actual)

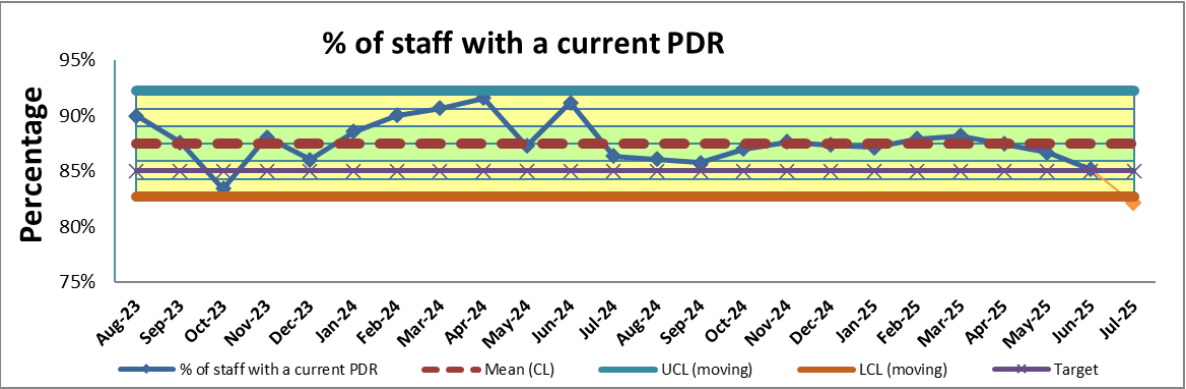
Local Target: Red: >5.50% Green: =<5.50%

July compliance – 7.27%.

Operational Narrative

Recommendations from the absence deep dive conducted in Q3 2024 are still progressing, with continued focus on early intervention and support in line with the new Policy. HR Team are currently considering how we can focus on stress support as our highest reason for absence and an increase in short term absence due to stress.

People: Exception Reporting



Analytical Narrative

The indicator has been on a downward trend since April 2025 and is now below the target and outside of control limits. The target remains within control limits and is still achievable.

% of staff with a current PDR

Local Target: 85%

July compliance – 82.06%

Operational Narrative

During month 4, there was a reported issue with the OLM system whereby system Administrators could not report on PDR completion – this has impacted on the reporting in month 4. Issue has now been resolved so we expect this indicator to be back above target in month 5, providing completion of newly expired PDR's remains on track.

Finance

Month Four Finance Report

Scope

The purpose of this paper is to update the Committee on the financial position of the Trust at the end of July 2025 (Month Four).

Summary Performance Month 04 2025-26	Month 4 Plan	Month 4 Actual	Month 4 Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Forecast Outtum M12
	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)
Income	(8.28)	(8.48)	● 0.20	(33.13)	(33.19)	● 0.06	(99.20)	(99.20)
Expenditure - Pay	5.99	6.13	▲ (0.13)	24.05	24.57	▲ (0.52)	71.30	71.30
Expenditure - Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Expenditure - Agency	0.10	0.03	● 0.07	0.43	0.12	● 0.31	1.10	1.10
Expenditure - Non Pay	2.53	2.73	▲ (0.20)	10.14	10.02	● 0.12	30.84	30.84
Expenditure - Non Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	(2.90)	(2.90)
EBITDA	0.34	0.40	▲ (0.05)	1.49	1.52	▲ (0.03)	1.14	1.14
Financing	0.03	(0.03)	● 0.06	0.13	0.10	● 0.03	0.39	0.39
Normalised (Surplus)/Deficit	0.37	0.37	● 0.00	1.62	1.62	● 0.00	1.53	1.53
Exceptional Costs	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.37	0.37	● 0.00	1.62	1.62	● 0.00	1.53	1.53
Other Adjustments	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.37	0.37	● 0.00	1.62	1.62	● 0.00	1.53	1.53

Savings - CIP Levels 1 & 2	0.43	0.44	● 0.01	1.58	1.60	● 0.01	5.48	5.48
Savings - CIP Level 3	0.00	0.00	● 0.00	0.00	0.00	● 0.00	2.90	2.90
Capital	0.16	0.04	● 0.12	0.16	0.23	▲ (0.07)	2.10	2.10
Cash	9.10	9.79	● 0.69	9.10	9.79	● 0.69	6.85	6.85
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

Finance

2025-26 Plan

2025-26 Plan

1. The Trust submitted a financial plan for 2025/26 with a deficit position of £4.42m. This plan reflected the underlying financial position and run rate of the Trust and was developed using the income and cost assumptions provided both nationally and by the local ICB. This was included in Cheshire & Merseyside ICB's overall draft plan submitted to NHSE. The ICB has a control total of £178m deficit and the consolidated plans submitted did not meet this value. The ICB plan was not accepted or approved.
2. As a result, the ICB were instructed to revisit all plans and asked all Trusts to include additional savings in their plan. These additional savings were labelled as 'placeholder savings' and allocated based on turnover. The ICB recognised that there would be a system solution required to deliver these savings. The ICB also recognised that the initial allocation may need to be revisited following the system led workstreams identifying additional savings opportunities to ensure equity and to match savings achieved to the additional stretch savings targets within organisations. This may require the reallocation of the savings targets across organisations later during the year.
3. Following agreement by the Board, a revised plan was developed to include an additional £2.89m savings, £0.5m is associated to service reduction, the remaining £2.39m is the BCH share of system-wide savings. This plan is reflected in the table in 1.7.

Finance

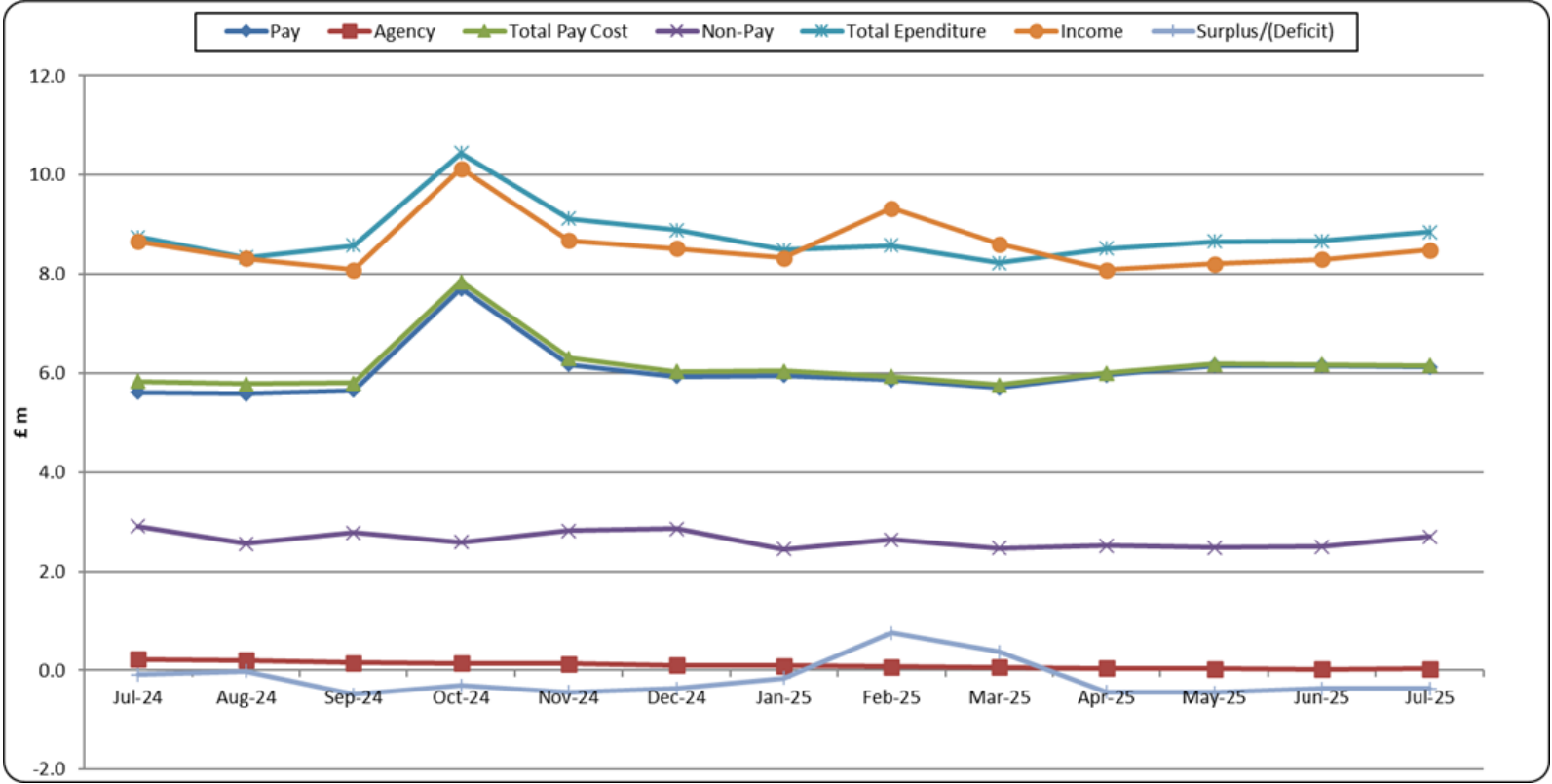
2025-26 Plan

4. The Trust has categorised the total savings required in 2025-26 at three levels:
 - i. Level 1 – Trust BAU CIP – These savings are part of the Trust 5% savings target and are solely the responsibility of the Trust to deliver.
 - ii. Level 2 – Trust and WHH – These savings are also part of the Trust 5% savings target and are the responsibility of the Trust to deliver, working in partnership with WHH.
 - iii. Level 3 – System ‘stretch’ savings – These savings are to be delivered across the system. System workstreams have been formed to identify opportunities. The system will support the delivery of these savings.
5. Following the submission of the final 2025-26 system plan, NHSE initiated an external review of the Cheshire and Merseyside system by PWC. This review focussed on the planning process, deliverability of plans, CIP planning and performance and governance in place for all organisations including the ICB.
6. Following the Trust meeting with PWC, NHSE and C&M ICB, the Trust has received additional information requests to support the current financial position reported and the forecast outturn. The Trust request is attached as Appendix 6.

Finance

Key Headlines

Rolling Run Rates 2024/25 to 2025/26



Finance

CUMULATIVE PERFORMANCE AGAINST NHSE PLAN - Key headlines month four

- The Trust is reporting a deficit at Month 4 of £1.62m, in line with plan.
- The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3).
- The Trust is reporting a savings achievement of £1.60m against a plan of £1.59m
- Income is £33.19m against a plan of £33.13m.
- Expenditure is £34.70m against a plan of £34.62m.
- Pay is £24.57m against a plan of £24.05m.
- Agency spend is £0.12m against a plan of £0.43m.
- Non pay expenditure is £10.02m against a plan of £10.14m.
- Capital charges are above plan by £0.03m.
- Capital expenditure is £0.23m at month four, planned spend is £0.16m.
- Cash is £9.79m.

FORECAST OUTTURN AND KEY POINTS TO NOTE

At month three, the Trust is reporting a deficit of £1.25m, in line with the planned deficit of £1.25m. At this stage, the forecast outturn position is equal to the plan – a deficit of £1.53m.

It should also be noted that as at month three, there are no savings recorded against integration. Joint workstreams with WHH continue to work on identifying integration savings opportunities. Any savings that can attributed to integration will be reported as such.

During 2024/25, all departments identified recovery plans. All budget managers have been instructed to continue with all recovery plans throughout 2025/26 to keep run rates in line with budgets. Any services who report an overspend position have been instructed that recovery plans will be required in the month following to identify what actions are being taken to recover the financial position. DLT's have been instructed to monitor and report on all recovery plans.

FORECAST OUTTURN AND KEY POINTS TO NOTE (continued)

The Trust has already implemented a revised robust workforce approval process in line with the ICB guidance. This process scrutinises all recruitment requests and includes consideration of joint / collaborative working opportunities with WHH. The Trust is continuing with all additional grip and control measures. Measures introduced include non-clinical agency / contractor removal, escalated non pay approval limits, reviewing the process and efficiency of rotas, discretionary spend freeze, resolution of non-contracted activity and service over performance. This list is not exhaustive and will continue to be added to in 2025/26.

Alongside the above, the Trust continues to review all non recurrent CIP delivered in 2024/25 to identify opportunities to convert savings to recurrent savings and include a focus on 2025/26 schemes. As part of the month end review process, all non recurrent savings delivered in 2025-26 are critically reviewed to establish if they can be converted to recurrent savings.

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 / Was not brought	A patient cancellation or rescheduling request occurs when the patient contacts the service to cancel their appointment. Short notice cancellations i.e.: within 3 hours of appointment time should also be recorded as cancellation.

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Bridgewater
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Monthly Clinical Harms Review Report

Information Team

Reporting Period: Month 4



52 + week waits and outstanding clinical harm reviews

Services with patients waiting over 52 weeks (data as at 01/08/2025)			
Directorate	Service Line	Total over 52 weeks	Number of outstanding
Warrington Adult	Dermatology Service	861	849
Warrington Adult	Podiatry Service	61	6
Halton Adult	Podiatry (Halton)	4	2
Warrington Child	Paediatric Community Medical Service	44	New
Warrington Child	WARRCCG Child community Neuro Development	771	90
Halton Child	Paediatric Occupational Therapy (Halton)	2	New
Halton Child	Community Paediatrics (Halton)	61	New
Halton Child	Neurodevelopmental Nursing Team (Halton)	61	New
Halton Child	Child Development Centre (Halton)	297	New
Halton Child	Halton Paediatric Neurodevelopment	639	346
Dental	Dental	12	9

Key

Worse than last month
Better than last month
Same as last month
New to report

Data Quality Issues

Harm reviews completed in month

Number of harm reviews completed in reported month										
Directorate	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Warrington Child	33	214	77	79	64	50	41	225	87	12
Halton Child	28	112	24	64	80	69	66	71	170	0
Warrington Adults	24	15	4	124	69	0	17	1	11	37
Halton Adults			9		0	0	0	6	7	4
Dental						24	105	28	75	18

Harm levels recorded in reported month					
Directorate	Low Harm	Moderate	Severe	Fatal	Total
Warrington Child	2	0	0	0	2
Halton Child	0	0	0	0	0
Warrington Adults	0	0	0	0	0
Halton Adults	0	0	0	0	0
Dental	1	0	0	0	1

Harms recorded as PSII's in reported month					
Directorate	Low Harm	Moderate	Severe	Fatal	Total
Warrington Child	0	0	0	0	0
Halton Child	0	0	0	0	0
Warrington Adults	0	0	0	0	0
Halton Adults	0	0	0	0	0
Dental	0	0	0	0	0

Dental data for CHR is still in development and not available electronically yet.



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NHS Oversight Framework

File created on: 20/08/2025



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
Org Type MH-PRV BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S000a: NHSOF Segmentation	Month	2025 01	2-Flexible support					
	MH Provider	S035a: Overall CQC rating	Month	2025 01	2-Requires improvement					46/62
	MH Provider	S059a: CQC well-led rating	Month	2025 01	2-Requires improvement					46/62
	MH Provider	S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual: calendar year	2023	6.78%	9.94%		↓		21/66
	MH Provider	S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual: calendar year	2023	13%	17.7%		↓		26/66
	MH Provider	S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users	Annual: calendar year	2023	16.4%	26.1%		↓		3/66
	MH Provider	S067a: Leaver rate	Month	2024 12	5.91%	5.94%		↓		7/67
	MH Provider	S068a: Sickness absence rate	Month	2024 09	5.81%	5.01%		↓		47/67
	MH Provider	S069a: Staff survey engagement theme score	Annual: calendar year	2023	7.29/10	6.89/10		↑		15/66
	MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual: calendar year	2023	10.7%		12%	↑	↑	26/64
	MH Provider	S071c: Proportion of staff in senior leadership roles who are disabled	Annual: calendar year	2023	7.14%		3.2%	↑		13/64
	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	Annual: calendar year	2023	60.8%	58.4%		↓		35/67
	MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual: calendar year	2023	7.56/10	7.09/10		↑		15/66
	MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual: calendar year	2023	7.1/10	8.45/10		↑		11/66
	MH Provider	S133a: Staff survey - compassionate and inclusive theme score	Annual: calendar year	2023	7.76/10	7.3/10		↑		13/66
	MH Provider	S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES)	Annual: calendar year	2023	1.4		1	↑		26/64
	MH Provider	S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual: calendar year	2023	1		1	↑		29/64

Rank Banding

- Highest performing quartile
- Interquartile range
- Lowest performing quartile



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Committee Chair's Report

Name of Committee/Group:	Quality and Safety Committee		Report to:	Board of Directors
Date of Meeting:	28 August 2025		Date of next meeting:	30 October 2025
Chair:	Elaine Inglesby, Non-Executive Director and Committee Chair		Quorate (Yes/No):	Partially (quoracy lost from Children in Care Annual Report (item 80/25v))
Attendance:	Present: Elaine Inglesby, Committee Chair and Non-Executive Director Gail Briers, Non-Executive Director Ali Kennah, Chief Nurse (to item 80/25v) Dan Moore, Chief Operating Officer (to item 71/25)	In attendance: Jeanette Hogan, Deputy Chief Nurse David Mills, Deputy Medical Director (for items 72/25 and 69/25) Susan Burton, Associate Chief Nurse Suzanne Mackie, Director of Quality Governance Jan McCartney, Director of Corporate Governance Tania Strong, Head of HR Jimmy Cheung, Head of Medicines Management (for item 80/25ii) Sarah Rhodes, Lead Nurse for Safeguarding Children (for items 80/25iii-v) Lynda Richardson, Board and Committee Administrator Observers: Claire Barton, Staff Governor Jonathan Berry, Public Governor	Key Members not present:	Apologies received from: Paul Fitzsimmons, Medical Director Abdul Siddique, Non-Executive Director Mel McLaughlin, Acting Director of Operations

Committee Chair's Report

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Serious incidents compliance report and update on any incidents of concern	2		Incident Categories and Harm Profile: The top three incident categories were moisture lesions, pressure ulcers, and falls. Most incidents resulted in no or minor harm. However, there was one moderate harm in May (pressure ulcer) and nine in June (six pressure ulcers, three treatment delays). The increase in moderate harms was due to previous inaccurate harm grading, which has now been addressed by recirculating NHS England guidance and focusing on accurate categorisation in review/learning groups. Incident reporting training had been made role-specific for all staff responsible for reviewing incidents: band seven staff across the Trust and band six staff within dental. This training was to be completed by all staff (approx.150) by the end of November 2025 and compliance would be able to be reported. The Committee expressed its concerns regarding the inaccurate grading and whether this had occurred historically. Pressure Ulcers: There was an increase in reported pressure ulcers (21 in April with 25 in May and 25 in June). In May there were two category three pressure ulcers reported with a rise in June with six reported. Category two pressure ulcers continued to be the highest reported pressure ulcer with 23 in May and 19 in June. Key learning themes included earlier intervention of proactive care for high-risk patients and senior reviews to ensure appropriate care was being implemented. The pressure ulcer priority group continued to review the learning responses from any incidents. The Committee queried the effectiveness of previous actions taken in respect of pressure ulcers, noting that an impact was not translating into practice. It was noted that a pressure ulcer improvement action plan report was included later in the agenda. Patient Falls: There was a significant spike in June outside the upper control limit (14 falls reported) in Padgate House and 18 within patients' homes. The increase was attributed to a focus on reporting, particularly for patient falls in their own homes. Meetings were held with Padgate House staff to reinforce appropriate care plans for at risk patients, and a pilot project was launched to improve admission criteria. The falls priority group would be liaising with other community providers on how they reported falls and any learning. Suggestions were made as part of discussions on whether falls in patients' homes should be recorded as incidents. Reporting such community falls would support targeted prevention efforts, all community services were encouraged to consider 'every contact counts' and how	The Committee requested a report for the next meeting on how harm grading issues occurred and whether a lookback was needed/if this would have value, as well as separate clarification on falls reporting and an explanation of the "Steady Now" bundle and how this may reduce falls. The Committee received the report for assurance, noting the issues raised and actions to be taken forward.

Committee Chair's Report

			this can be reported. The Committee emphasised the need for appropriate categorisation of falls as part of reporting. PSIRF and local plans: The local data was being reviewed to inform the second version of the PSIRF plan, aiming for completion by November.	
Community Paediatrics/Neurodevelopment Action Plan	2		Significant changes had been made to the risk register related to the neurodevelopmental pathway and community paediatrics. Therefore, the Committee discussed this item prior to consideration of the quality and safety risks paper as this would inform further discussions and support the Committee to take an informed view as to whether the changes were appropriate or not. The paper focused on outcomes from a service “pause” and six-week rapid intervention. The Committee noted the key highlights from the report: ▪ The pause had led to increased waiting times. ▪ The service continued some normal activity (e.g., child protection medicals) during the intervention. ▪ Stratification and harm review results were presented for Halton and Warrington, including numbers and percentages of patients referred categorised as “red” and breakdowns of harm levels (no harm, low, moderate, severe). ▪ Severe harms were attributed to recording errors. ▪ Risks addressed included number of doctors, waiting times, clinical harm reviews, and cumulative risk, with some risks closed, re-opened, continued, or reduced. The Committee agreed that the paper did not describe how the improvement plan would bring change or how risks would remain reduced. However, it agreed that it would accept the paper as a current position statement, noting waiting times, significant referral increases, and outputs from the rapid intervention.	The Committee did not accept the proposed reduction in risks until a revised paper with a revised improvement plan and rationale for risk reduction was provided. An improvement plan update would be presented to the next meeting, including timeframes, trajectories, and a clear link between actions and risk scores. The improvement plan would consolidate risk information and provide rationale for any changes in risk ratings.
Risks related to Quality and Safety	2		This item was taken following the neurodevelopment pathway report. Risk Register Overview: In June, there were 11 corporate risks (score 12+) related to quality and safety; in July, there were eight. ▪ The total number of risks in the organisation was 156 in June and 151 in July. ▪ No new risks of 12+ were reported in the period. ▪ The highest risk (score 20) was the neurodevelopmental pathway accumulative risk, which was recommended by the Risk Management Council for closure as it	The Committee received the report, noting that actions regarding neurodevelopmental pathway risks would be revisited at the next meeting. The current risk scores would be

Committee Chair's Report

			no longer reflected current issues. More targeted individual risks would be written to replace it. ▪ Five risks were closed in the period: four related to the neurodevelopmental pathway and one to equipment services (the latter was rewritten to focus on service and maintenance of bed levers). ▪ Four risks had limited assurance: three for the neurodevelopmental pathway and one for dental services (due to not meeting contracted session numbers, work was ongoing). Following concerns raised regarding prolonged 'limited assurance' ratings, particularly for the neurodevelopment pathway, and suggestion that the ratings should reflect positive ongoing proactive work, this would be taken into the Risk Management Council for further discussion on the assurance criteria.	maintained for the neurodevelopmental pathway until a revised improvement plan and risk rationale were presented. Assurance levels and new risk descriptions would be reviewed and updated, with further detail to be provided in the next report.
Report from Quality Council	2		The Committee noted the key highlights from the July Quality Council: Infection Prevention and Control (IPC): ▪ Update provided on Padgate House following a norovirus outbreak and post-infection review. ▪ Education sessions for Bridgewater and local authority staff were well received, focusing on PPE and timely sampling. ▪ Ongoing IPC support and annual report included progress on staff flu vaccination, training compliance, and quality improvement in areas like Warrington Wolves and Community Equipment Stores. Medicines Management: ▪ Q1 report showed increased medication incident reporting, mostly no or minor harm, this was viewed as a positive learning culture shift. ▪ Actions to reduce risk and improve training compliance were outlined. ▪ Quality Council now has access to monthly data for escalation and can pause prescribing rights for non-compliance. Patient Experience: ▪ Annual report noted a slight increase in formal complaints (by 5), mainly due to more joint complaints. ▪ Small reduction in PALS contacts, with most resolved locally. ▪ Of 151 informal concerns, only 10 escalated to formal complaints. ▪ 14,369 compliments received in the year. CQUINs and Transition:	The Committee received the report. It requested that outcomes from the ICB audiology reviews be included in the next Quality Council report, or that a separate report be provided if required.

Committee Chair's Report

			Final CQUIN report for 2024/25 described progress on two non-mandated sequins: lower leg wounds (to be monitored via clinical audit) and children's therapy transition to adult services (improvement plan ongoing). Directorate Reports: Children's Services: Initial findings from the rapid review and stratification/clinical harm reviews were shared. A further update was to be provided to the September Quality Council meeting. Emerging risk: Increased waiting times for paediatric audiology review appointments; action plan in development, with families being contacted to prioritise vulnerable children. ICB inspections in audiology: Positive verbal feedback, awaiting formal reports for both Warrington and Halton. UNICEF inspection feedback was reported as very positive. Dental: Ongoing issues with Greater Manchester GA waiting times; mutual aid reduced. Discussions were ongoing with commissioners. Due to reduced demand in Cheshire and Merseyside, a QIA was agreed by a panel, to allow a list to be opened for GM patients in June. This would be reviewed by the Quality Council and QIA panel.	
IQPR	2		There were 10 red and 22 green indicators for the month, with eight deteriorations and two improvements. Incident Reporting: - Incident reporting within 48 hours was at 82.9% (target: 87%), showing a consistent trend but needing a continued focus on improvement. - Moderate harm incidents were at 5.88% (target: 1%), with significant variation in June (10 reported, six of which were pressure ulcers). - A focused after-action review was being conducted on pressure ulcers to identify learning. Duty of Candour: Only one incident was downgraded in the month. Medication Incidents:	The Committee received the IQPR for assurance, noting the need for improved narrative, analysis, and clarity in future reports, and ongoing work to address key areas of concern.

Committee Chair's Report

			- Compliance was close to target and within normal control limits. - Minor harms related to medication issues in Halton led to targeted staff training. Risk Updates: - Risks updated within the required timeframe dropped to 83.4%, with issues in dental and corporate services. - JH reported that she had met with both areas, and subsequent improvement was now being observed. Falls: - Inconsistent trend in bed-based unit falls, but low levels of harm. - JH would be separating information for the bed-based and community based falls in future reports for clarity. Pressure Ulcers: 25 reported in month (target: 15), with a slight reduction in month but no significant improvement overall in terms of the total number of pressure ulcers. - Category three pressure ulcers were at 24% (target: 3%), with a special cause variation in month (six cases, all in one team). - A focused review was planned for those cases. IPC Assurance: Improvement noted after changes in data collection, allowing better targeting and assurance. The Committee noted that the senior nursing team had discussed the inclusion of more “so what” analysis and outcome-focused narrative in future IQPRs.	
Pressure Ulcer Learning Plan	2		The Committee had requested a detailed improvement/learning plan to address persistent high numbers of pressure ulcers. Key Findings and Data: - Despite intensive work, total pressure ulcers reduced by only 6% over the last 12 months, with numbers increasing since early 2024. - Previous improvement (noted two years ago) correlated with pandemic related changes and increased patient acuity/complexity. - The main problem area was noted as category three pressure ulcers. Learning Plan Structure: Four main priorities were detailed:	

Committee Chair's Report

			1. Data Access: Ensuring clinicians have timely access to information for proactive intervention. 2. Themes and Trends: Collecting and analysing data to inform learning. 3. Education and Competency: Providing staff education and ensuring competency/capability for pressure ulcer prevention. 4. Clinical Audit: Ongoing audit to understand and improve practice. Section four of the report focused on clinical leadership, supervision, and action learning sets to drive more meaningful visits and proactive care. Challenges and Observations: ▪ After-action reviews often fail to identify specific, actionable learning, despite benchmarking against NICE guidance. There would be an increased focus on clinical leadership and supervision, and action learning sets with clinicians to review incidences of pressure ulcers and explore further learning. ▪ Whilst there was significant improvement work ongoing across the Trust it was noted that there had been no real reduction in the number of pressure ulcers. ▪ Increased numbers of palliative and complex patients are a contributing factor. Work would continue to actively identify those patients more at risk of developing pressure ulcers.	The Committee endorsed a more focused QI approach, suggested by the Chief Nurse, and more actionable, targeted interventions. This should also include triangulation of staffing/capacity data to deliver an increasingly complex caseload, also in view of the 10-year plan.
Patient Experience Report	2		The Committee received the report for quarter one which included information on feedback, complaints, compliments, and lessons learned: Key Data and Findings: ▪ Increase in feedback responses: 12,381 in Q1 (up from 11,619 in Q4). ▪ 95.1% of Friends and Family Test respondents rated their experience as good or very good. ▪ Compliments increased to 6,690 (from 6,179 in Q4). ▪ PALS contacts rose to 272 (from 251 in Q4), with 49 logged as informal concerns. ▪ Formal complaints decreased to 15 (from 25 in Q4): eight related to adult services, seven to children's services. ▪ Two joint complaints involved community matrons and district nursing. ▪ Two MP letters received (in relation to paediatric community medical services and dermatology). ▪ No new cases referred to the Parliamentary Health Service Ombudsman. ▪ Details of lessons learned from complaints was provided within the report.	The Committee requested future reports to include more comprehensive patient experience insights, not just complaints. It was proposed that there be a review of lessons learned language to ensure this was patient-centred and improvement-focused.

Committee Chair's Report

Quality Impact Assessment (QIA) Report	2		QIA Panel Activity: 10 QIAs completed: Two related to CIP (Cost Improvement Programme) schemes (one approved, one closed). - Eight related to changes in service delivery (six approved, two closed). Vacancy Control Panel: 42 posts reviewed by the Vacancy Control Panel during May and June. - All 42 posts were approved to proceed to advert; none were rejected, so no full QIA was required for rejected posts. Deferred posts (requiring further information) were not included in the reported figures.	Governance process details for QIA sign off would be included in future reports for assurance and due diligence purposes.
Quality Priorities	2		An update was provided on the three quality priorities for 2025/26: - Moisture Associated Skin Damage - Review of Deteriorating Child Guidance - Personalised Care	It was agreed that a Quality Improvement (QI) approach would be incorporated into the delivery of the quality priorities, similar to the approach proposed for the pressure ulcer plan.
Strategies, Annual Reviews and Annual Reports	2		Medicines Management and Controlled Drugs Annual Report 2024/25 The Committee received the report and noted two areas of risk: MIAA audit at Padgate House identified seven key issues, mainly basic medicines management lapses; these have been addressed, including cabinet relocation. ADHD drug shortages and management. Priorities for next year included Continuing annual safe and secure handling audits and training, enhancing digital controls for prescribing (ePACT, Click, BI dashboard) and continuing escalation and work with commissioners on ADHD shared care. Safeguarding Adults Annual Report 2024-2025, Safeguarding Children Annual Report 2024-2025 and Children in Care Annual Report 2024-2025 The Committee commended the teams for their work, especially in a challenging year with continuing staffing and capacity pressures. The Children in Care report was particularly highlighted for its positive feedback from children and carers, and the impact of the teams' work on outcomes.	The Committee received the report, noted improvements and ongoing challenges, and acknowledged the robust processes and priorities for the coming year. The Committee accepted all three annual reports, acknowledged statutory compliance, noted achievements and ongoing challenges, and requested that the Committee's thanks be passed on to all staff within the teams for their dedication and the impact

Committee Chair's Report

				of their important work.
Assurance Reports	2		The Committee agreed that it did not require any additional assurance reports based on the items and discussions at today's meeting.	
Items to be shared/escalated with the Board or other Committees	1, 2		None this month	
Review of meeting	1		The Committee requested that the Risk Management Council ensured an increased level of focus on Quality and Safety risks, including the PSIRF process, incident management, appropriate guidance application on harms, paediatric audiology and the neurodevelopment pathway. An update would then be provided as part of the Quality and Safety risk report at the next meeting. This would then feed into the BAF. The Committee also agreed that the updated pressure ulcer improvement action plan would be presented back to the Committee at its next meeting in October. Governor observers shared their reflections on the meeting. They agreed that there had been a good level of challenge and important questions raised, as well as robust discussions	
Risks Escalated: None this month.				

	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

Winter Plan

2025/2026

July 2025



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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 2025-2026. 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 periods 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 Governance
 - Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy
- BAF 2 Quality
 - Failure to deliver quality services and continually improve
- BAF 3 Health Equity
 - Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients
- BAF 4 Staff
 - Failure to create an environment for staff to grow and thrive
- BAF 5 Resources
 - Failure to use our resources in a sustainable and effective way
- BAF 6 Equality, Diversity & Inclusion
 - Failure to build a culture that champions equality, diversity and inclusion for patients and staff
- BAF 7 Partnerships
 - Failure to work in close collaboration with partners and staff in place and across the system
- BAF 8 Integration with WHH
 - Failure to effectively integrate services with WHH

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 2025/2026 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, 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 predictable 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.

National Guidance

Winter and H2 planning priorities set out from NHS England 2025/26

- Urgent & Emergency Care (UEC) Plan 2025/26
- Winter planning Timeline & Assurance (July – October 2025)
- Operational Actions and Resources
- Cross-System Coordination at Regional Level

The overarching priority is to protect patient safety and maintain service resilience through the winter surge.

Additionally, NHS England recently published further evidence-based guidance in the following areas to support further optimisation of winter plans:

- [Same day emergency care service specification](#)
- [Single point of access hubs](#)
- [Virtual wards operational framework](#)
- Winter Planning & Preparedness (July 2025)
- Commons Library Briefing (August 2025)
- Supply Chain Winter Prep (August 2025)

Priority 1 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	✓		
Warrington Urgent Care Response Service (UCR)			✓
Virtual Wards (VWs)	✓		✓
Padgate House			✓

All Bridgewater Services have Business Continuity Plans that support the Trust's overall response to winter pressures.

Optimising Capacity for Winter 2025/2026

For 2025/2026 we have continued to optimise capacity like previous years, whilst recognising that there are no additional resources available for winter pressures. The latest activity data is included for each service within the plan and has been used to forecast the position over the winter months and build our contingency planning.

To be able to manage business as usual and respond to surges in demand and acuity, our priority one services will need to continue recruitment of existing vacancies and identify additional capacity through bank/agency staffing whilst managing our financial pressures. 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.

Command and Control Structure for Winter

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 2025-2026.

Command and Control Arrangements within the Trust

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

Operational – Bronze Command

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.

Where appropriate, the command-and-control structure will be implemented to monitor and manage winter related escalations. The meeting frequency will 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).

Where there are agreed changes to service delivery, a Quality Impact Assessment will be required to ensure that the impact of any changes is fully understood, and any risks are identified and mitigated.

System Management

Warrington

Throughout the year there are regular 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 there is frequent conversations which help to ensure that any challenges or difficulties are managed.

Halton

Daily throughout the year Cheshire and Merseyside Integrated Care Board (ICB) 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 relating to admissions, discharges, Intermediate care, Urgent Treatment Centre, and Virtual Ward capacity. This call provides an opportunity to work collaboratively across the system, promoting and supporting resilience ensuring patient flow across the system. It is expected that these meetings will continue as normal through winter and that they will be escalated to twice daily when required.

Across system partners, leadership teams work well together, effectively communicating to ensure challenges or difficulties are addressed.

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 Integrated OPEL Framework 2024-2026 replaces all previous versions and sets the definitive standards (updated May 2025). It provides a unified, systematic approach for detecting and assessing acute hospital UEC operating pressures.

As a non-acute provider, we are encouraged to continue localised escalation processes and responses, however monitoring of local Acute Trust's OPEL status will provide early warning of potential winter escalations and surge.

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, e.g., mental health issues due darker evenings, support with staying warm etc.

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

- Looking After You and Your Colleagues Workshop
- Positive Mindset Workshop
- REACT Mental Health Training
- Health & Wellbeing Leaders Programme
- Employee Assistance Helpline and Occupational Health and Counselling Service

Staff also have access to external support available such as:

- Able Futures
- NHS Discounts and offers
- Financial wellbeing support, including local support available
- Financial wellbeing charities, including grants, debt advice, tips, and advice.
- Physical wellbeing support
- Mental wellbeing support

All staff are offered at least one health and wellbeing conversation a year where a Wellbeing At Work Action Plan is completed. This is an opportunity for staff to discuss their wellbeing, reasonable adjustment requests, individual support needs, and anything else they wish to discuss about their wellbeing at work.

The Organisational Development Practitioner Health & Wellbeing Lead provides bespoke Organisational Development sessions, delivered to teams on request to support wellbeing, such as team development, team relationship building, stress and anxiety support, delivering internal sessions mentioned above, and communicating the Trust wellbeing offers.

During November 2024 the Trust will be holding its annual Health & Wellbeing Fortnight, providing online sessions from both internal and external providers to support staff wellbeing. Engagement with teams will also take place to encourage teams to engage with the fortnight by holding wellbeing events within their teams, such as tea and chat, lunchtime walks, reading clubs, craft, and exercise sessions.

The latest Health and Wellbeing information can be found in one place, on the health and wellbeing pages of the Trust Extranet, and within the Trust Health and Wellbeing Prospectus.

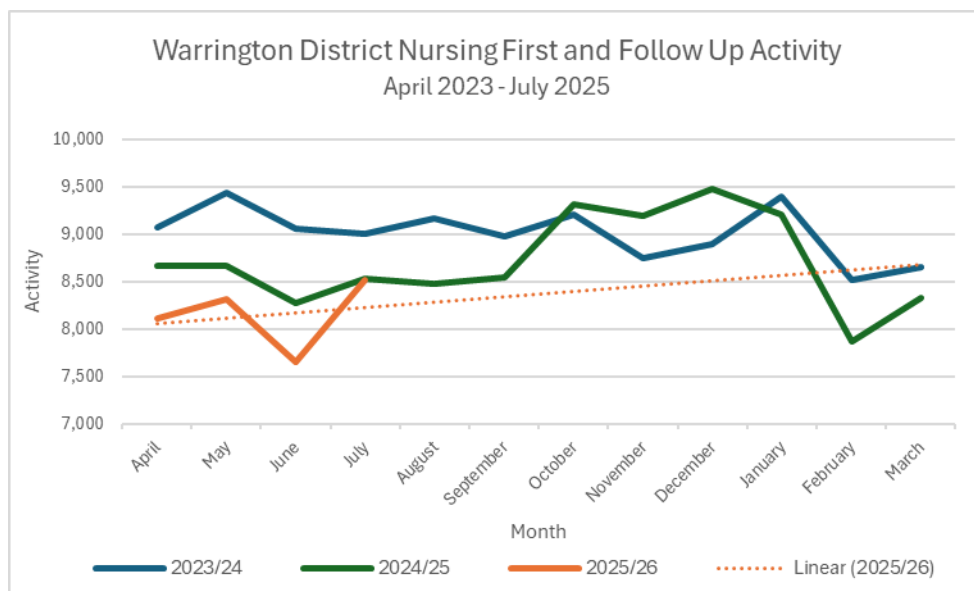
Staff are continuously encouraged to talk to their line managers should they be struggling with their Health & Wellbeing.

Community Nursing Services – Warrington

Identified Pressures:

District Nursing

The service has continued to make a high number of visits through last winter and with a significant decline February 2025. This is shown in the graph below. If the current year follows the trend from last year, we expect to see demand levelling off, however an increased surge in the winter months would be expected as it was in the previous years.



From a staffing perspective the service has:

- A high proportion of B5 staff are on preceptorship. 5 newly qualified staff started in September 25
- A number of staff are on maternity leave
- Workforce pressures in Specialist Nursing Service, SPA, and District Nursing.
- Bank nurses are utilised where required to ensure that the service continues to run effectively.

Staffing Levels:

The current established staffing for District Nursing in Warrington to provide the service 24 hours, 7 days a week is 91.23 WTE (Inclusive of 5.04 WTE admin staff)

Community Nursing	WTE
Staff in Post	85.13
Vacancies	6.1
Maternity Leave (included in staff in post)	2.92%
Establishment	91.23

Capacity Solutions:

- Daily escalation meeting will take place each day at 3pm (Community Nursing daily capacity huddle)
- In times of extreme pressure, cross cover, support and assistance to deliver care will be gained from other community services to assist with nursing tasks. Community Matrons, IV Therapy, Catheter, ECHSS, Bladder & Bowel, UCR, Palliative care & SPA will be expected to support the DN service in times of increased demand. The Specialist Community Nursing services will be expected to assist with tasks they have the competence to provide at the same time as visits, to reduce demand and footfall within a patient's home. Double handling of patients will be minimised between services.

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

Other Mitigation:

In times of increased pressure, the Community Matrons have all updated their basic nursing skills and can support District Nursing where required, thus minimising the number of patient contacts and supporting junior staff with senior clinical leadership.

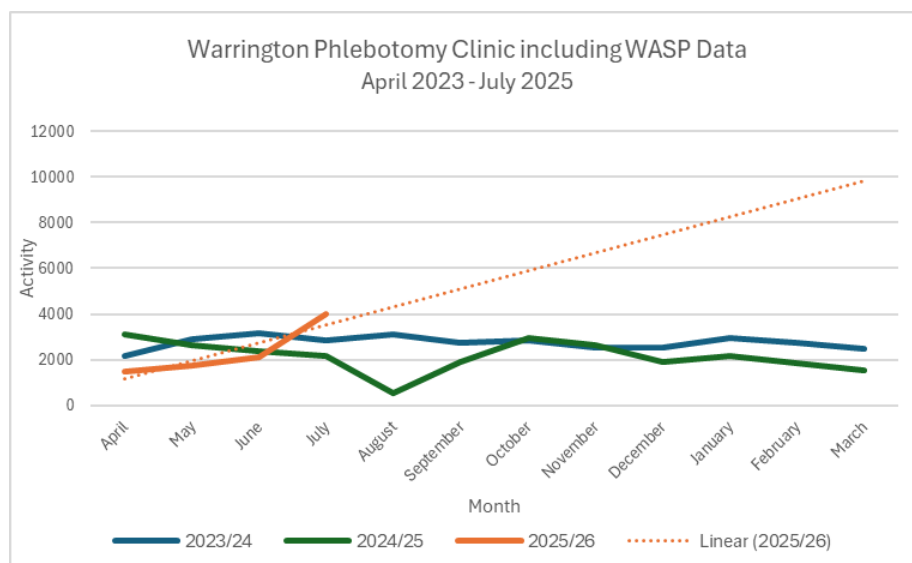
Leadership Resilience:

In the absence of the Operational Manager, the following staff will take leadership of the service, supported by the Head of Service and Clinical Lead for Adult Community Nursing

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

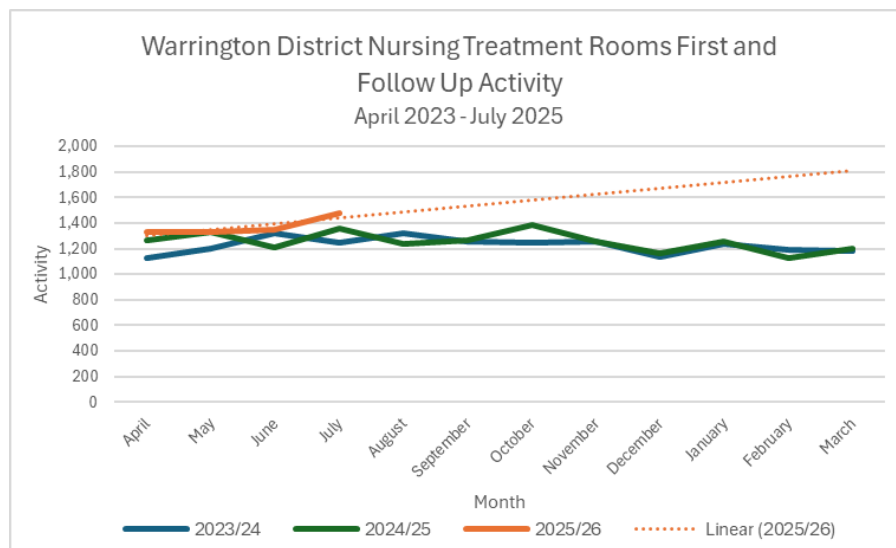
Phlebotomy

Phlebotomy activity in 2024/25 remained stable, mirroring the previous year. Despite a reduction in demand through August & September 24 demand has significantly increase in June and July 2025, this may be due to appointment times reducing from 10 minutes per patient to 7.5 minutes per patient. We will therefore be monitoring the position closely over the next couple of months to see if this emerging trend continues. The linear trend forecasts 10,000 contact by March 2026 if current growth continues.



Treatment Rooms

The activity profile for treatment rooms has followed a similar trend to the previous years. In the summer months of 25/26, there has been a slight increase, and the linear projection suggests a growing demand. The position will be closely monitored.



Staffing

	WTE
Staff in Post	12
Vacancies	0.4
Maternity Leave (included in staff in post)	0
Establishment	11.60

Capacity Solutions:

- Support and assistance to deliver care will be gained in times of extreme pressure from the Adult Community Nursing Service where capacity allows. This will be escalated through the daily escalation meeting that takes place within the Warrington Directorate (Community Nursing daily capacity huddle).
- In the event of significant service reduction for an undefined period, and in addition to planned uplift of capacity, use of bank staff will be explored.

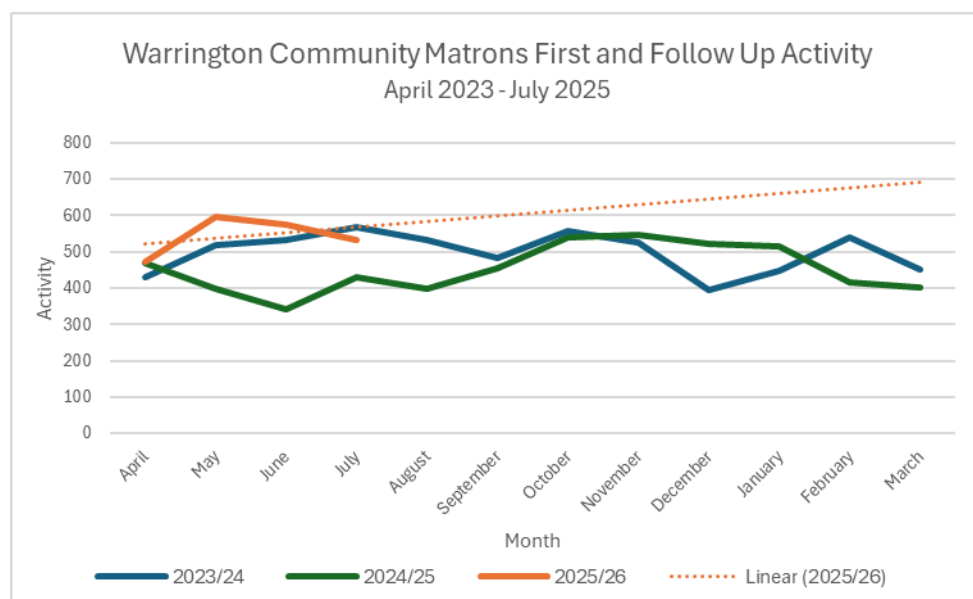
Other Mitigation:

DNAs will be continued to be managed with the assistance of Admin to support Treatment Room by ringing patients prior to appointment to ensure attendance. Where a patient no longer wishes to attend, this is escalated to the Treatment Room Team Leader where they will contact another patient on the waiting list to utilise appointment.

Community Matrons

Historically, Community Matron activity increases over winter due to higher-acuity referrals from GPs and Secondary Care. Current activity is slightly above the same

period last year, likely driven by Frailty Virtual Ward input. Forecast data shows a steady month-on-month increase across 2025/26. A focused project is underway with Central and West Warrington PCNs and Secondary Care to boost referrals, aiming to reduce avoidable hospital admissions and attendances.



Staffing

	WTE
Staff in Post	7.89
Vacancies	0
Maternity Leave (included in staff in post)	0
Establishment	7.9

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 one and two 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 in times of increased demand – District Nursing Service, IV Therapy, Catheter and Palliative Care services. The Community Matrons will 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.
- Community Matrons will provide support to the Virtual ward for those patients meeting the Community Matron criteria
- Daily escalation meeting will take place each day at 3pm (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 will be explored.

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.

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

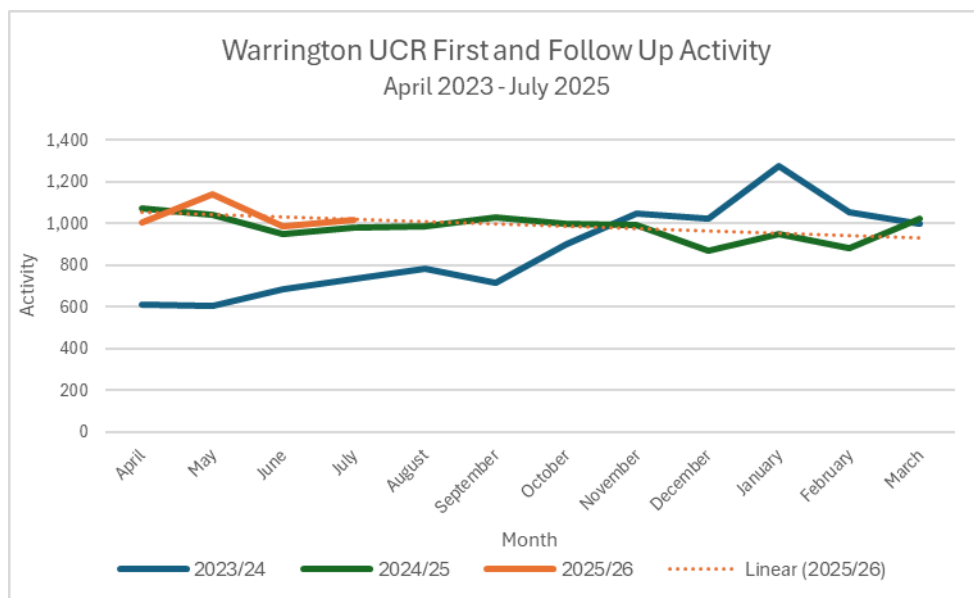
Urgent Community Response (UCR) – Warrington

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.

Activity

It is anticipated that demand will rise over the winter months as seen in previous years however this winter we expect an even greater volume of referrals as the service is now more established, and response times are high. The linear trend for 2025/26 suggests stable but slightly decreasing activity; however, historic data shows increased demand during winter months. We are working closely with NWAS, Primary & Secondary Care to streamline referrals into this service to avoid unnecessary hospital admissions and attendances. UCR is part of the Urgent & Emergency Care programme of work that will support Secondary Care to reduced hospital admissions, attendance and avoidances, ensuring the patient is cared for closer to home by the right person, at the right time in the right place.



The service actively accepts referrals directly from NHS 111, via secure SystmOne tasks, and takes telephone referrals from NWS crews on scene where patients are categorised a three in an attempt to avoid hospital admissions.

Staffing Levels:

UCR	WTE
Staff in Post	19.21
Vacancies	27.2
Maternity Leave (included in staff in post)	0
Establishment	21.93

The service is predicting a shortfall in funding for the 2025/26 financial year due to the service being funded through multiple non recurrent funding streams.

The UEC/UCR improvement work is underway – Prehospital workstreams in place to support the development of a robust, fit for purpose service in time for Winter 2025/26.

The service is integrated with Warrington Borough Council and will be the point of contact for any individual who rings the One Front Door contact centre.

Capacity Solutions:

- Daily escalation meeting will take place each day at 3pm (Community Nursing daily capacity huddle)
- Cross cover, support and assistance to deliver care will be gained in times of extreme pressure from other community services to assist with nursing tasks and assessments where required and where competency allows. Community Matrons, IV Therapy, Catheter, ECHSS, Bladder & Bowel, & Palliative Care, Virtual Ward & Intermediate Care will be expected to support the UCR service in times of extreme increased demand.
- Prioritisation of visits will be undertaken with all care being delivered to patients who require it most.

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

Other Mitigation:

- 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.

Virtual Wards (VW) – Warrington

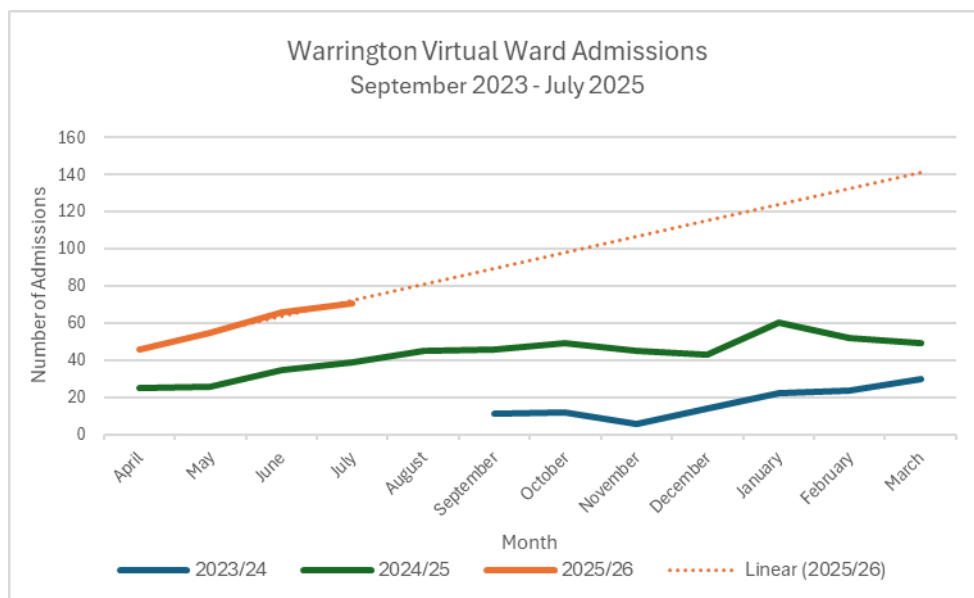
Virtual Ward

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. The Warrington Virtual Ward provides step down care from WHH and step up care from GPs & ECHSS. The current Frailty Virtual Ward has a capacity of 20 beds,

Identified Pressures

The Warrington Frailty Virtual Ward was established and launched in February 2023 and has seen a steady growth in referrals. To date it has treated 286 patients, with an average length of stay of 6 days. The Virtual Ward has seen a reduction on funding in 24/25 and will continue to see a further reduction in funding moving into the Winter period.

Admissions have grown year-on-year, with 2024/25 consistently above 2023/24. Early 2025/26 figures are significantly higher than both previous years, reflecting expansion and increased utilisation.



Staffing Levels.

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

RCRS	WTE
Staff in Post	6.88 wte
Vacancies	2 wte
Maternity Leave (included in staff in post)	0
Establishment	8.8 wte

External Factors

The development of pathways and a robust governance structure within the model is being led by the lead provider WHH, with significant input from Bridgewater, to implement a collaborative approach to care.

Other Factors

The development of a shared electronic patient record that supports management of patients has now been implemented and has been very successful, with very positive feedback from all partners.

The service has access to a VW pharmacist based in WHH two days a week. Initial feedback has been positive, and the expectation is that the role and support will develop moving forward. In addition, a GPSI has been appointed to the FAU team within WHH, which will further encourage positive working relationships with Primary Care.

Community Intermediate Care – Warrington

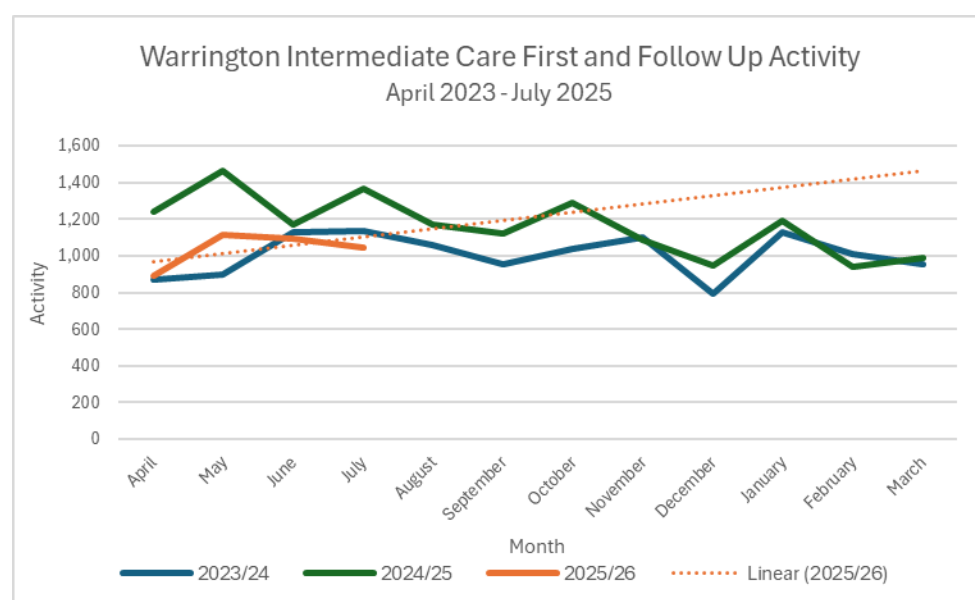
Identified Pressures:

Activity across 2023/24 and 2024/25 within Intermediate Care shows seasonal fluctuations, with notable dips in December and rebounds in January.

Early 2025/26 activity mirrors previous years and is forecasted to increase steadily month-on-month.

The linear trend for 2025/26 suggests activity will steadily increase. The team will monitor the activity closely.

Intermediate Care therapies are supporting the Discharge to Assess(D2A) beds that have been commissioned at Grappenhall and Statham Manor care homes as well as the existing bed bases of Padgate House and the new contract for Intermediate Care beds at Statham Manor. These beds will be continuing throughout winter.



Staffing Levels

Community Intermediate Care	WTE
Staff in Post	27.39 WTE
Vacancies	0.81 WTE
Maternity Leave (included in staff in post)	1.0 WTE
Establishment	28.20WTE

External Factors

Historically, 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. This action is undertaken by the Local Authority in consultation with the operational leads for the service to ensure staffing can meet the demands. The increased work across the IMC tier to support more patients to journey through the service has reduced the anticipated requirement for this to happen during the winter period of 2024/25. However, these increases can impact on staff caseloads and response times to referrals. The service has reviewed process for management of allocation and, alongside the Social Care element of ICHT, the service has introduced a new waiting list management process that has reduced wait times for first contact by a therapist to 0 weeks.

Any additional care home 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.

Other Factors

Intermediate Tier redesign is on-going with support from project leads in both organisations. The aim is to enhance education and training to all staff in ICAHT to ensure a reablement model of care and reduce dependency.

Capacity Solutions

- Staff rotation is now in place within the service, providing a 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. The demand and capacity is managed within the therapy team daily during the 09:30 capacity call chaired by the Team Leader or person with delegated responsibility.
- A robust triage system is in place 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 to support same day discharges.
- If there is a shortage of staff in one discipline, a review of responsibilities will be undertaken, and tasks reassigned to ensure that skill mix is used efficiently and effectively.

Discharge to Assess

This is well established for relevant patients who are on Pathway 1, to allow a period of assessment and planning to take place to support the residents of Warrington to independently, or by means of care support, to return to home or a place they call home, rather than being placed in long term care facilities.

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.

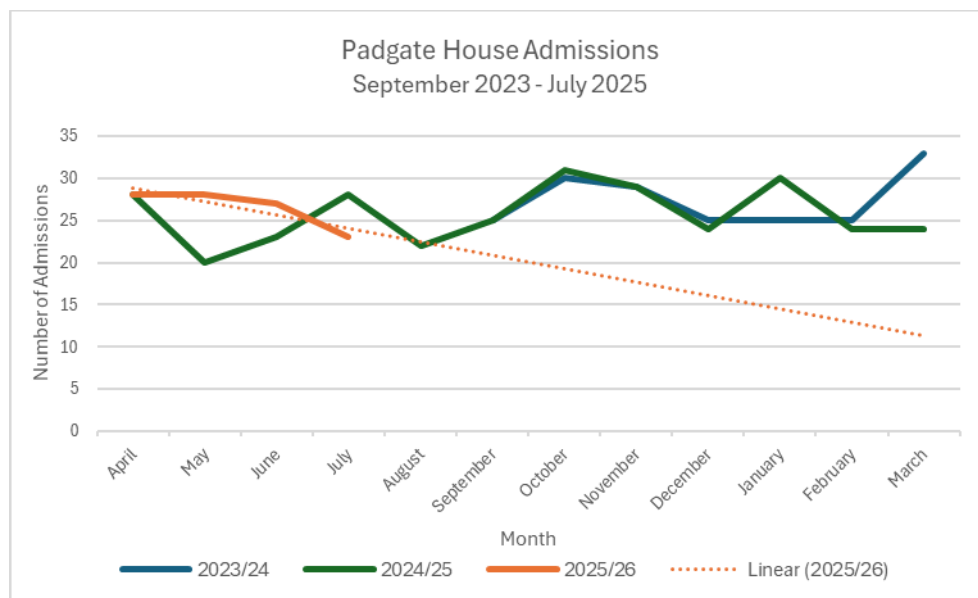
- Operational Manager cover – if the Operational Manager is absent, the integrated management structure within the tier will support the service in a seamless manner with support from the Head of Service.

Padgate House – Warrington

Identified Pressures:

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

Data from 2023/24 and 2024/25 shows stable admissions, generally ranging from 22–30 per month, with peaks in October and March. 2025/26 early activity is consistent with previous years,



Staffing Levels

- Therapy:** Fully staffed. Padgate House flexes between other areas across Intermediate Care depending on the number of patients, with the ratio one Therapist to 10 patients and three Therapy Assistants.
- Health Care Assistants:** 5.7 WTE in post and 0.8 WTE on long- term sick.
- Nurse leadership:** There is a Band 7 Team Leader in post at Padgate House who is supported by 0.4 WTE Quality Matron to support Nursing professional leadership.

Padgate House Nursing Staff	GP	B7 WTE	B6 WTE	B5 WTE	B4 (Trainee Associate Nurses)	B3 HCA
Staff in Post		0	1.8	9.72	3.0	5.7
Vacancies	0	1	0	1.96	0	0.8
Maternity Leave	0	0	0	0	0	0

Establishment		1.0	1.8	11.68	3.0	6.27

- Infectious diseases 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

Safe staffing ratios			
Occupancy	Early	Late	Night
35 beds	3	3	2
35 beds	3	3	2

- There are two qualified Nurses planned on night shifts. However, in emergencies the service can be managed safely with one Nurse.
- Current staff are asked to work extra hours or overtime.
- NHSP are utilised where required.

Other Mitigation

- Beds can be closed; new admissions not being accepted until bed numbers match safe staffing 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 when required.
- The Adult Community Nursing Service and Specialist Community Nursing teams will provide support to patients in Padgate House who require nursing care.
- The GP service will provide daily clinical support for at least 23 hours a week between Monday to Friday. The 23 hours will include input into the weekly multi-disciplinary team meeting. The GP service will be provided by the Phoenix Group, with additional support being available 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.

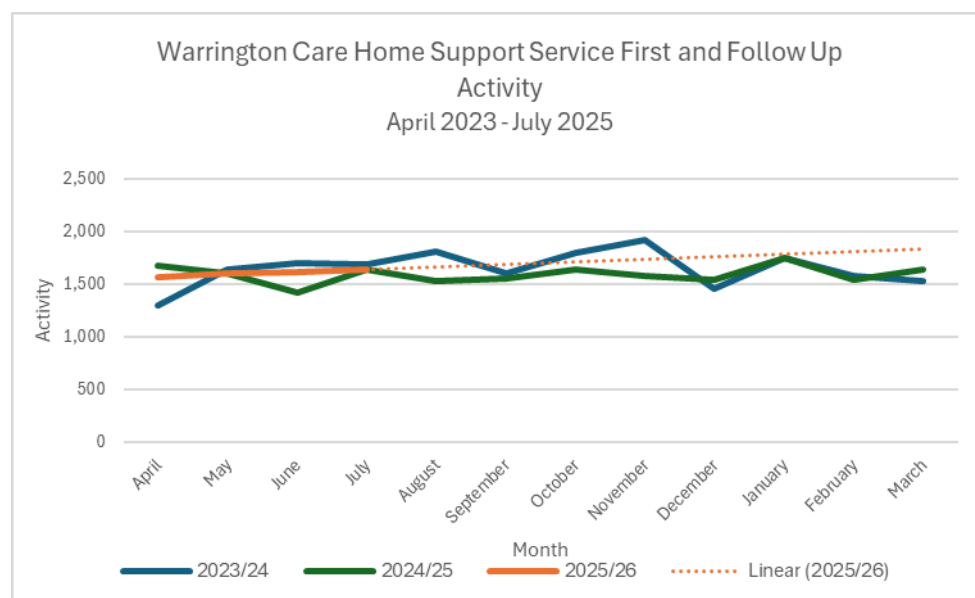
Specialist Nursing Services – Warrington

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.

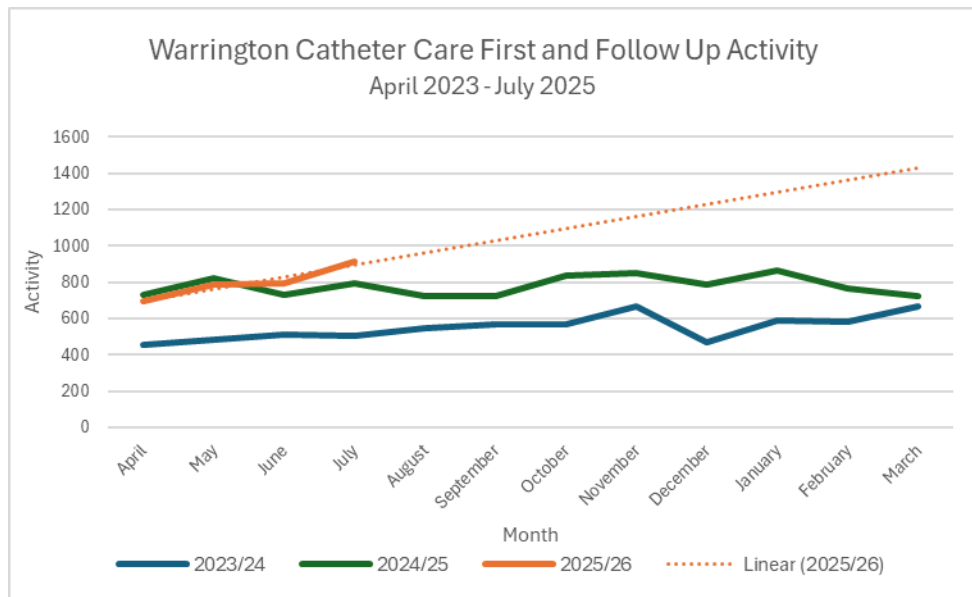
ECHSS – Demand for this service is rising year on year and we anticipate this will continue throughout 24/25. The team will continue to support the proactive approach of reducing hospital admissions/attendances whilst driving the new Enhanced Health in Care Homes (EHCH) delivery model, which moves away from traditional reactive models of care delivery towards proactive care. The service has embraced the EHCH delivery model and flexes its day-to-day activity around reactive and proactive care to meet the needs of the Warrington population.

Changes to the way this service reports its activity were made in March 2023, with further changes made in early 2024, resulting in a more accurate reflection of demand across care homes. The service is now able to report clearly on the triaging element of the service, thus knowing what is arriving at the ‘front door’ and flexing the service to meet the needs of the population. 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.

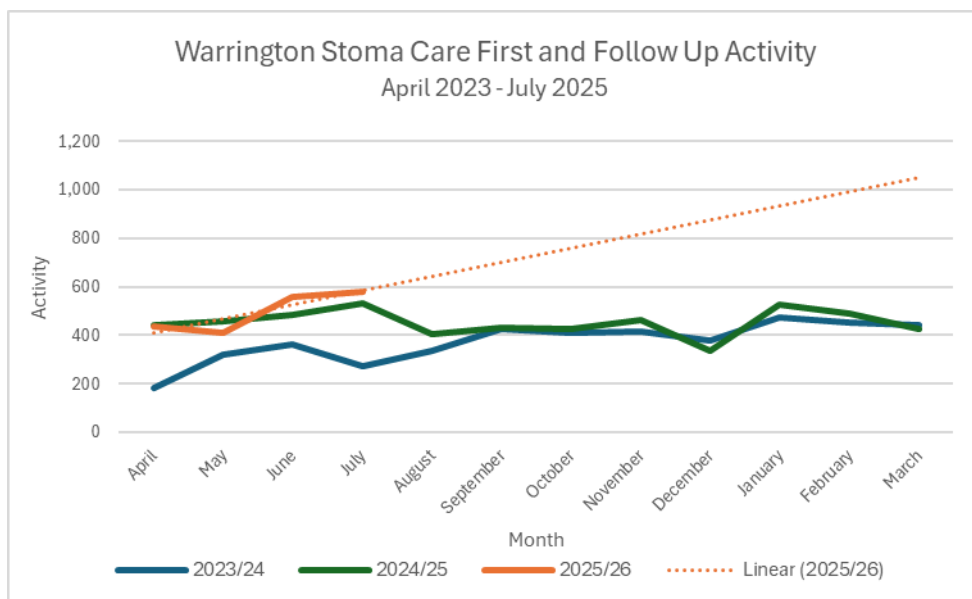
The service is increasing the number of staff who have prescribing capabilities, thus reducing the impact on Primary Care and the need for a GP to prescribe in the future. The service continues to engage with Primary Care around attendance at GSF meetings and practice MDT's.



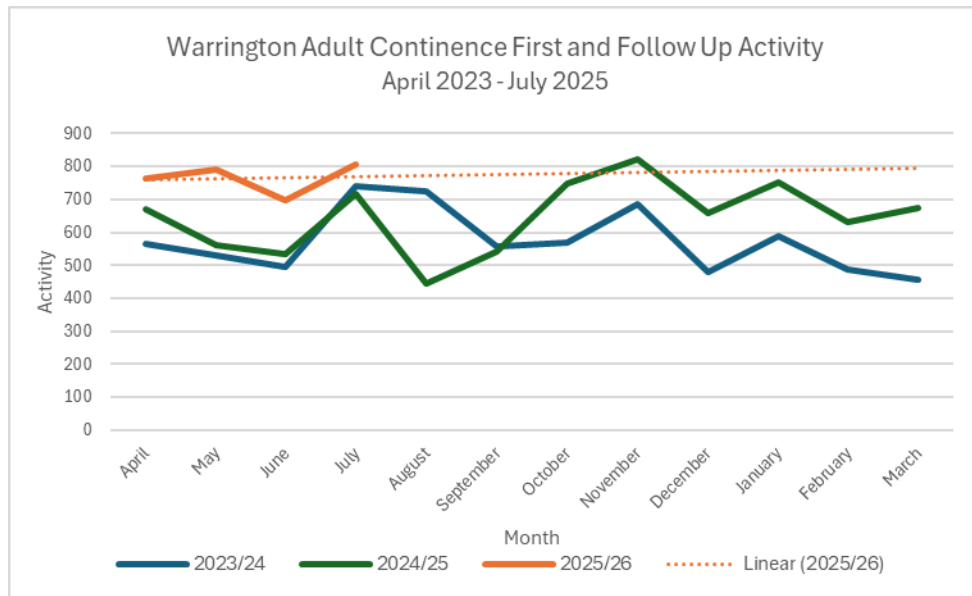
Catheter Care –The activity trend has significantly increased based on 23/24 activity; this is due to the increasing demand for ‘trial without catheter’ (TWOC) in the community being performed. This procedure has historically been performed in Secondary Care. The team are also managing an increased number of patients in acute retention where clinically appropriate. The team have excellent relationships with the hospital Urology team.



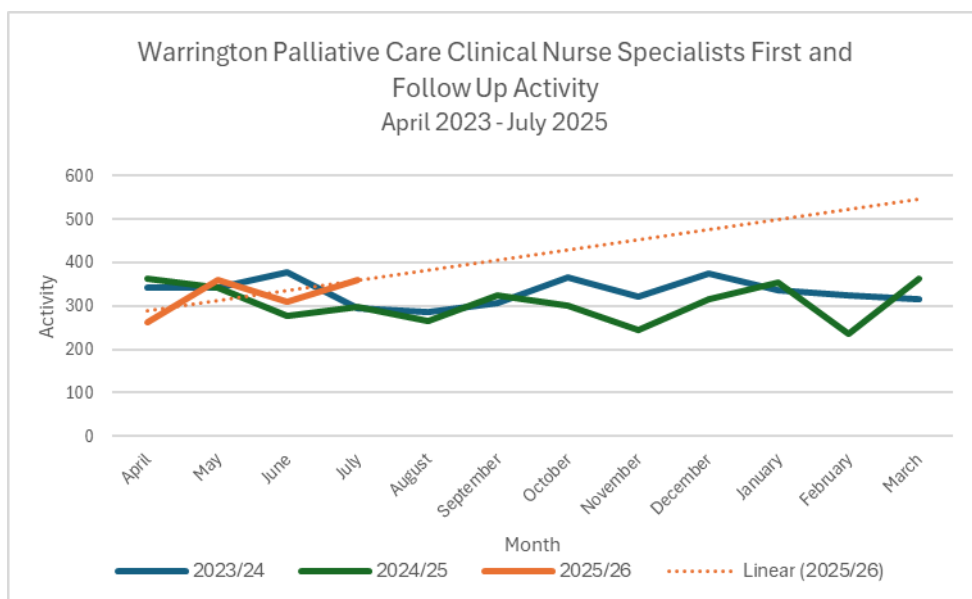
Stoma – The stoma service activity trend is increasing based on 23/24 activity, 24/25 is following a similar trajectory to that of 23/24



Bladder and Bowel – The graph below depicts a fluctuating situation, which is due to a vacancy and sickness in the team. We expect this to increase now that all vacancies are filled.



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 the team will be supporting the palliative care virtual ward. They are full staffed for nursing and medical staff but have a vacant administration post.



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 complex patients.

Staffing Levels:

Service	Palliative Care	Bladder& Bowel Adult	ECHSS	Stoma Team	Catheter	OPAT
	WTE	WTE	WTE	WTE	WTE	WTE
Staff in Post	Nurses 0.6 B8a 6.20 B7 1.0 Consultant 0.5 speciality Doctor	1.0 B7 2.0 B6 0.6 B5 1.63 Admin	13.35	2.6 B6	1.0 B7 3.6 B6 1.8 B5 1.0 B3 Admin	1.0 B7 3.0 B6 8.2 B5
Vacancies	0.8 admin	0	2.6 (Band 7 0.8, band 6 0.8, band, 1 band 3	0	New 0.6 WTE (Split post with DNs)	0
Maternity Leave	0	0	0	0	0	0
Establishment	9.1	5.23	15.95	2.6	7.4	12.2

Capacity Solutions:

- The Palliative Care Team is fully staffed for medics and nurses but are carrying an administrative vacancy. The team have a Palliative Care Nurse Educator in post, rolling out a comprehensive education programme across care homes, and the Warrington Adult Nursing service, to support the care given to end-of-life patients in their chosen settings, reducing hospital admissions. This is further supported by St Rocco's Hospice and the development of a Palliative Virtual Ward, that was piloted for 6 months in 2022, with further funding secured for a further 12 months through 2024/25 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.
- The Bladder and Bowel Adult Team have good working relationships with the Specialist Nursing Teams within Bridgewater NHS Foundation Trust and our local partner organisations, supporting each other when necessary. The Bladder and Bowel team work collaboratively with the Catheter and Stoma Teams.
- Stoma Team manage demand within the service, a band 6 0.6 WTE nurse was recruited in 2023/24 to support the numbers and complexity of the patients in the community requiring stoma care.
- ECHSS will flex the service as required to prioritise reactive visits and service demand to reduce hospital admissions and decrease pressure on Primary Care. The service is actively recruiting to a Band 7 visiting nurse post and have

successfully recruited to the vacant triaging nurse post. The successful candidate will commence in post in October. The team are also based alongside the Virtual Ward Team, thus forging stronger relationships and ensuring that appropriate patients are seen in the right place, at the right time and by the right person.

- An additional post within the Catheter Service is 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 one dedicated NMABs slot daily, to allow treatment of the highly vulnerable, to reduce the acute effects of the virus. The number of appointments is likely to increase into the winter due to the extension of the NMAB's criteria to include all patients over the age of 70. 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.

Children's Community Nursing – Warrington

The Children's Community Nursing (CCN) Service delivers a range of interventions Monday – Friday 8am-6pm including:

- Nursing care, advice and support for children with complex health needs.
- End of Life care
- Nursing care to children with medical needs attending a special school
- Phlebotomy Service - Monday - Friday 8.30am -7pm (last appointment is 6.30pm)
- One to one tracheostomy care and support for individual children in schools and nurseries.
- Children's Continuing Care
- Contribute to the Paediatric Acute Response Team provision in partnership with Warrington and Halton Teaching Hospitals Trust - this service is Monday-Friday 9.30-7 and Saturday 10-2

Predicted Increase in Demand

The potential increase in respiratory infections in children during winter months may 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.

Staffing Levels

The service is currently fully staffed:

- 1.0wte x Band 7 team leader
- 3.4 WTE x Band 6 Senior Children's Community Nurses
- 2.8.0 WTE x Band 5 Children's Community Nurses
- 3.0 WTE x Band 4 (Head Count 5) One to one HCAs supporting children with tracheostomies in schools and nursery / Community Nursery Nurses.
- 0.6 WTE Band 3 Health Care Support Worker
- 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.

Leadership Resilience:

In the absence of the Team Leader the Senior Community Nurses/Senior Special School Nurse will provide leadership for the service. Support would also be available from the Children's Services Senior Leadership/Management Team.

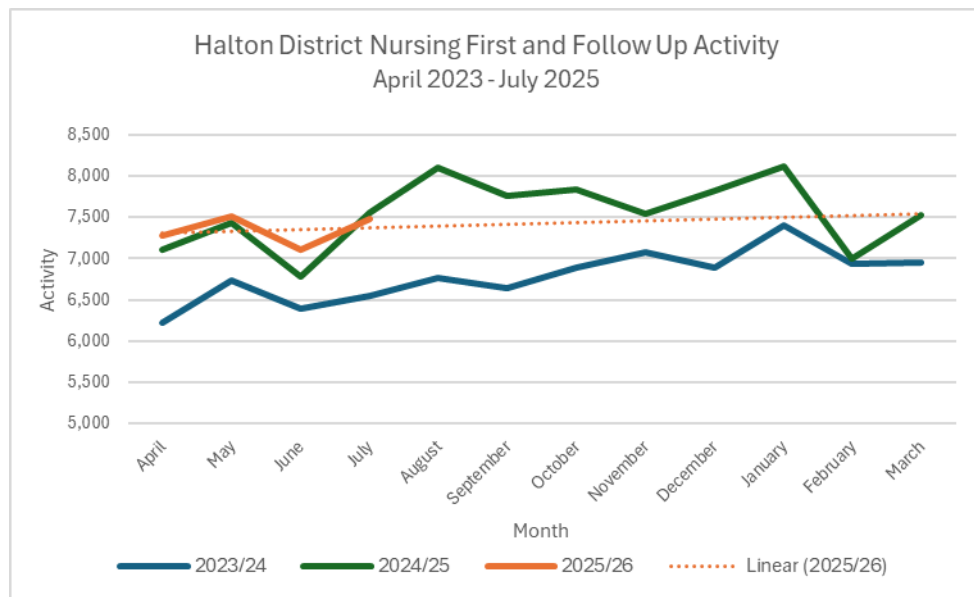
Community Nursing Services – Halton

District Nursing

Identified Pressures:

Annual activity for Halton District Nursing services (first and follow up) remains higher to date in 2024 compared to 2025. The activity data indicates increasing numbers of referrals to the service. We envisage this will continue into 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:

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	B8a Clinical Lead x 1wte B7 nursing x 5wte B6 nursing x 18.4 wte B5 nursing x 36.4wte B4 Trainee Nurse Associate x 3.6wte B4 HCA x 0.8wte B3 HCA x 6.6 wte B2 Admin x 1wte B2 HCA x 8.1wte	B7 nurse x 1wte B6 x 1.97wte B5 nursing x 7.05wte HCA B4 x 0.37wte B2 HCAx 0.67wte	B8a Nurse x 1.0wte B6 x 2.0wte
Vacancies	0wte – all posts in recruitment.	0wte	0
Maternity Leave	4wte	0	0
Establishment	81	11.51wte	3.0wte

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 one and two 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.
- All staff training will be prioritised to maximise clinical capacity within this period.
- As appropriate double handling of patients between nursing services will be minimised between Halton services to maximise clinical capacity.
- 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, and in the event of significant service reduction for an undefined period, use of agency staff will be explored.

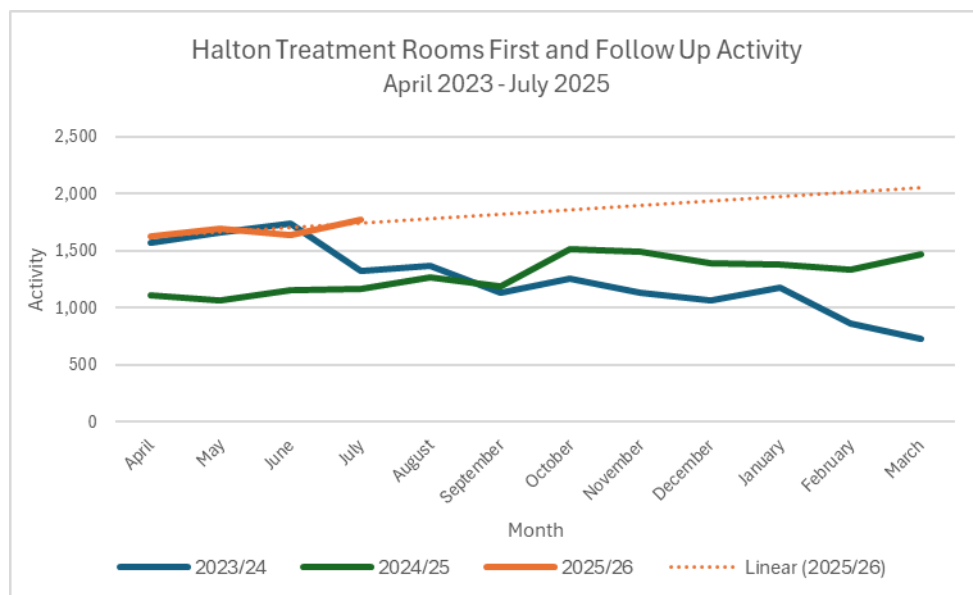
Leadership Resilience:

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:

The first and follow up data indicates overall increased activity in 2025-2026 in the first quarter compared to the previous year. This can be directly attributed to reduced staffing and vacancies within the service. Service gaps have been resolved, and activity is expected to continue to rise throughout 2025-2026.



Staffing Levels:

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

Treatment Rooms	WTE
Staff in Post	Band 7 nursing x 1.5 wte Band 6 nursing x 1.2 wte Band 5 nursing x 5.73 wte Band 3 admin x 1 wte Band 2 admin x 1.6wte
Vacancies	1 Band 2 admin
Maternity Leave	0
Establishment	10.83wte

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.
- All staff training will be prioritised to maximise clinical capacity within this period.
- 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 NHS professionals will be explored.

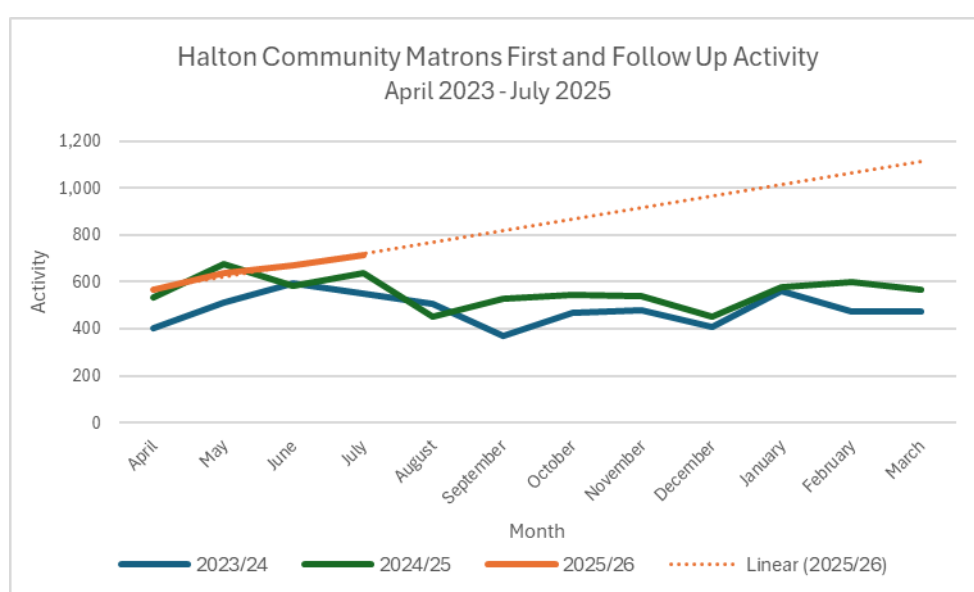
Matrons

Identified Pressures

-

Based on quarter one first and follow up data and the overall increase in activity, the Community Matron Service is 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	8a Nurse x 6.4wte Band 4 RNA x 0.8wte Band 3 HCA x 2.6wte
Vacancies	0
Maternity Leave (included in staff in post)	0
Establishment	10.20 WTE

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

- Individual qualified Matrons can see up to four patients per day, with a combination of new and follow-up patients (five per day if only follow-up

patients). However, this can be dependent on planned meeting such as GP MDTs/ GSF, these can be time consuming, albeit essential to the patients care and the service provided by the community matrons.

- Patients per day can also increase due to the ad-hoc calls the team receives from on the day acutely unwell patients or patients experiencing and exacerbation of their LTC that needs a clinical review.
- Health Care Assistants can see five to six 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.
- 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.
- All staff training will be prioritised to maximise clinical capacity within this period.
- 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, and in the event of significant service reduction for an undefined period, use of agency staff will be explored.

Intermediate Care and Frailty Service – Halton

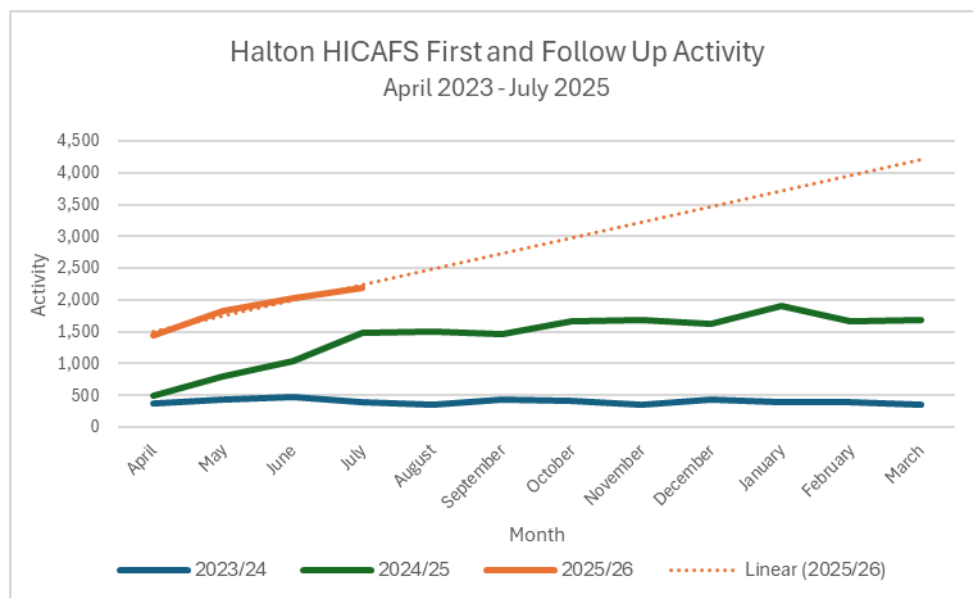
Identified Pressures:

During the 2025/2026 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 first and follow up activity, illustrating the rise in overall activity for the service.

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



Staffing Levels:

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

HICAF	WTE
8a	
Band 7	10.8
Band 4	1.8
Band 3 HCA	1.0
Band 4 Admin lead	1.0
Band 3 Admin	2.0
Vacancies	
Band 3 Admin	1.0

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).

- Nursing covers the 8-8 seven-day service.
- Therapy team work 8-5 Monday – Saturday ex BH.
- Admin work 8-6 Monday to Saturday.

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:

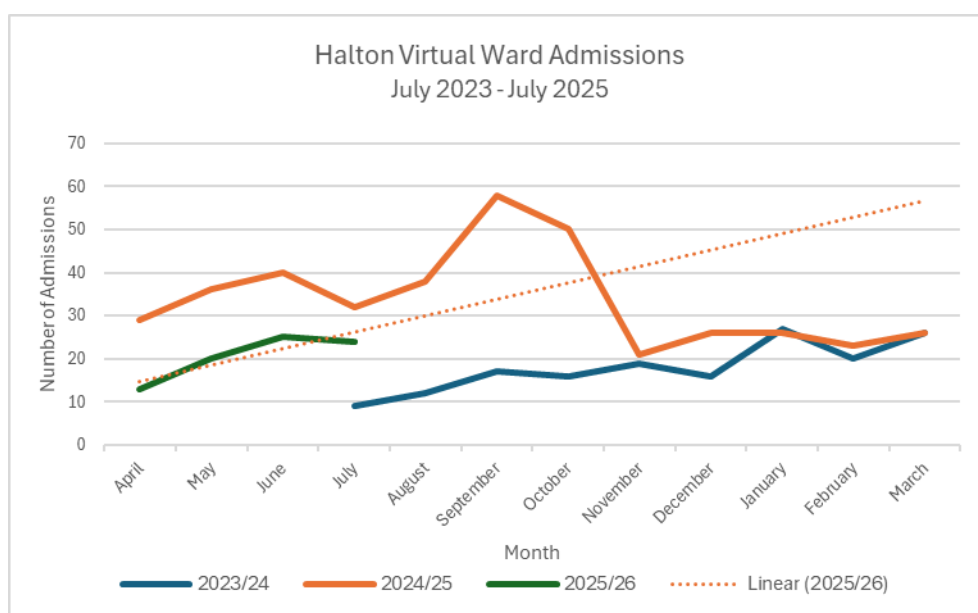
- The HICAF Service has, and continues to undergo, a redesign that will see an overhaul in packages of care and capacity linking with both hospital Trust partners and Social Care.
- The team continues to collaborate with partners within the integrated service, meeting to develop the service, monitor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

Frailty Virtual Ward – 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. Halton's Virtual Ward launched in July 2023, with the provision of 4 beds initially. This was increased in August 2024 to 12 beds then dropped down to 12 beds in November 2024.

During the 2025/2026 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:

Staffing is utilised across Urgent Care Response and Virtual Ward to support the discharge and prevention of admissions across Halton.

Staffing for the Virtual Ward in Halton during the 25/26 winter period is as follows:

Virtual Ward	WTE
Staff in Post – band 8a	2.8
Band 7	1.0
Band 3- HCA	3.0
Band 3 Admin	1.0
Vacancies	0
Maternity Leave (included in staff in post)	0

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.

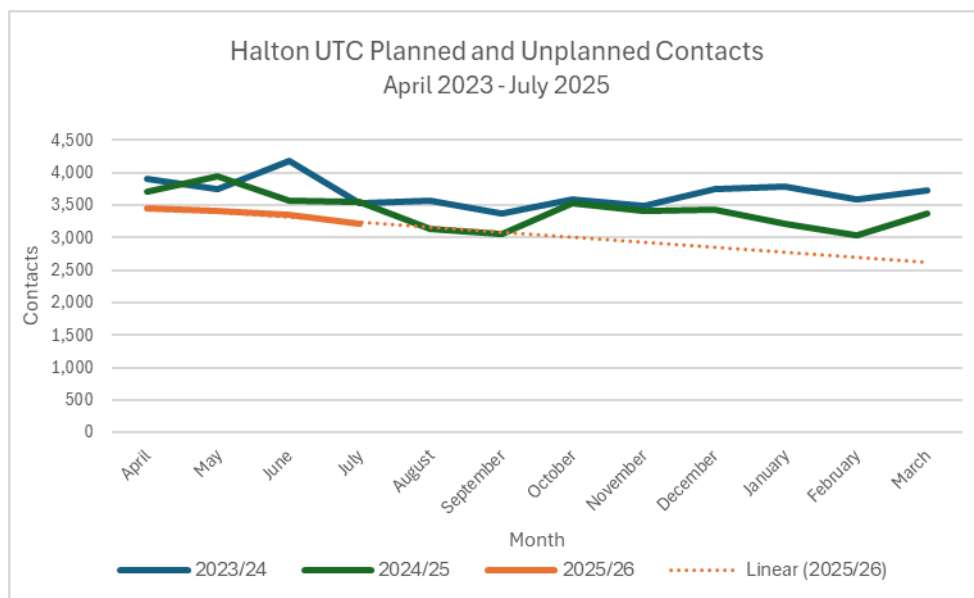
Other Factors: Work is underway to develop point of care testing and to rollout the remote monitoring element of the service which will be supported by Mersey care.

Funding for the Frailty Virtual Ward in Halton has been capped and the number of beds to be funded has reduced to five.

Urgent Treatment Centre – Halton

Identified Pressures:

The graph below shows the activity profile for the service through last winter and into summer.



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 six to eight weeks.

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

UTC	WTE
Staff in Post	Band 8a-band 5 – 18 wte Band 4 1.0 wte Band 3 1.6 wte Band 2 1.0 wte 21.6 wte
Vacancies	3.0
Maternity Leave (included in staff in post)	1.0
Establishment	24.2

Capacity Solutions:

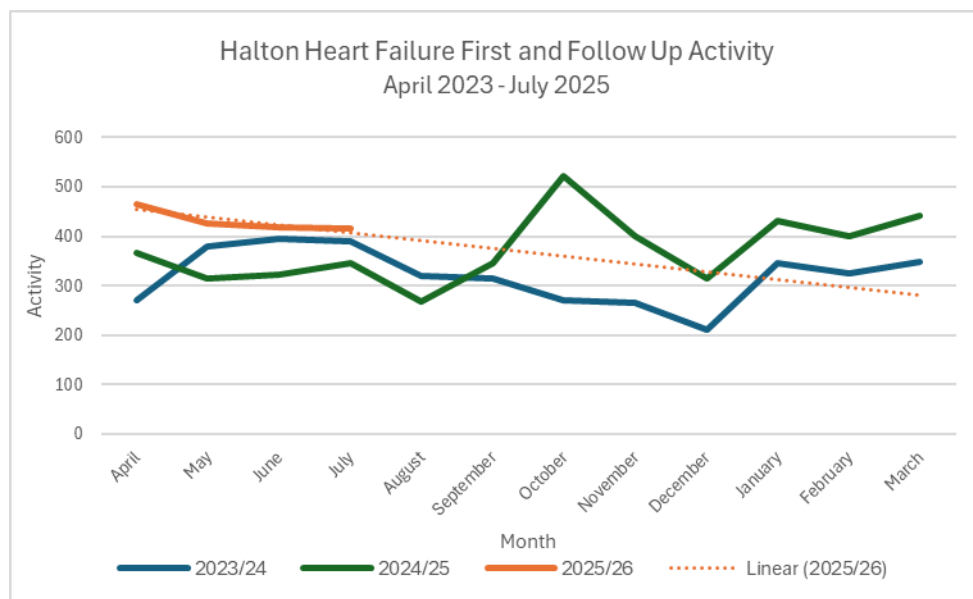
- The service will continue to ensure clinical capacity is maximised by ensuring recruitment strategies are in place to on-board appropriately skilled staffing.
- The service will consider increasing the number of GPs to support UTC activity should there not be the nursing support available.
- The service has implemented GP Connect in 2024. This allows local GP practices to book patients directly into the GP provision within the Urgent Care Centre via an electronic system and for the UTC to book into allocated GP appointment slots.
- In addition to planned extra capacity, and in the event of significant service reduction for an undefined period, use of NHS Professionals will be explored.

Specialist Nursing Services - Halton

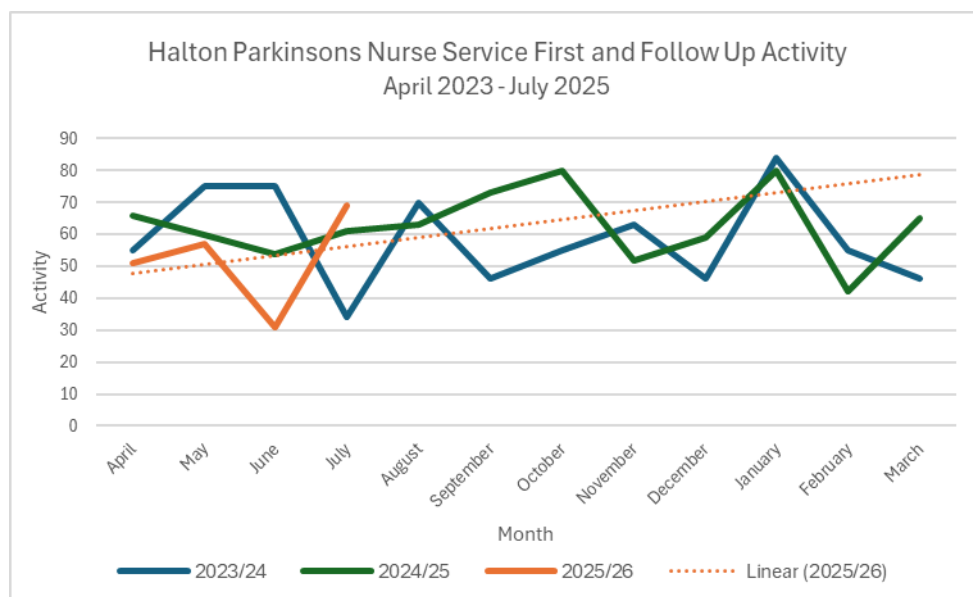
Identified Pressures:

Halton Specialist Nursing Services include:

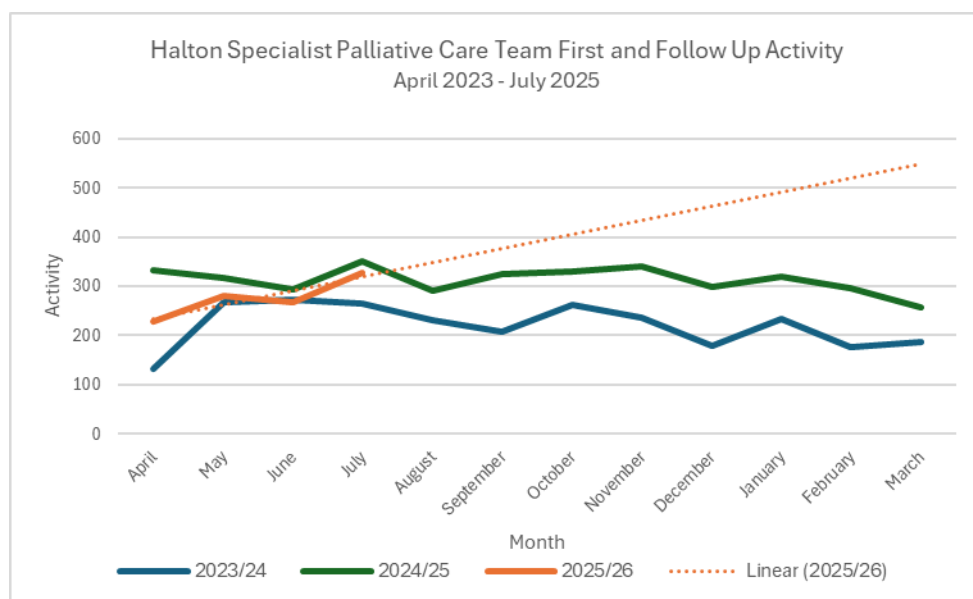
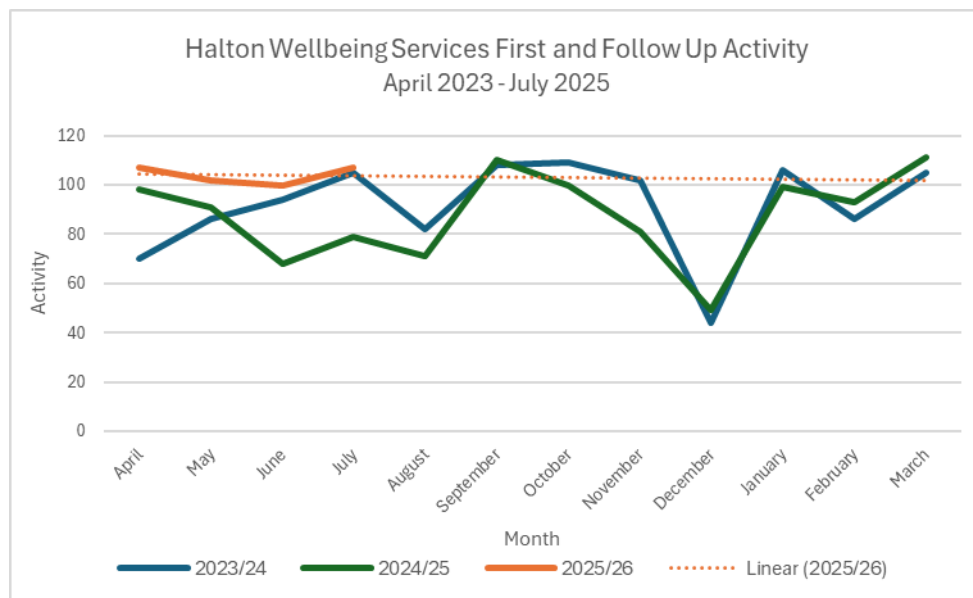
- Heart Failure
- Parkinsons
- Wellbeing
- Palliative Care
- Bladder and Bowel
- Stroke
- Infection, Prevention and Control.



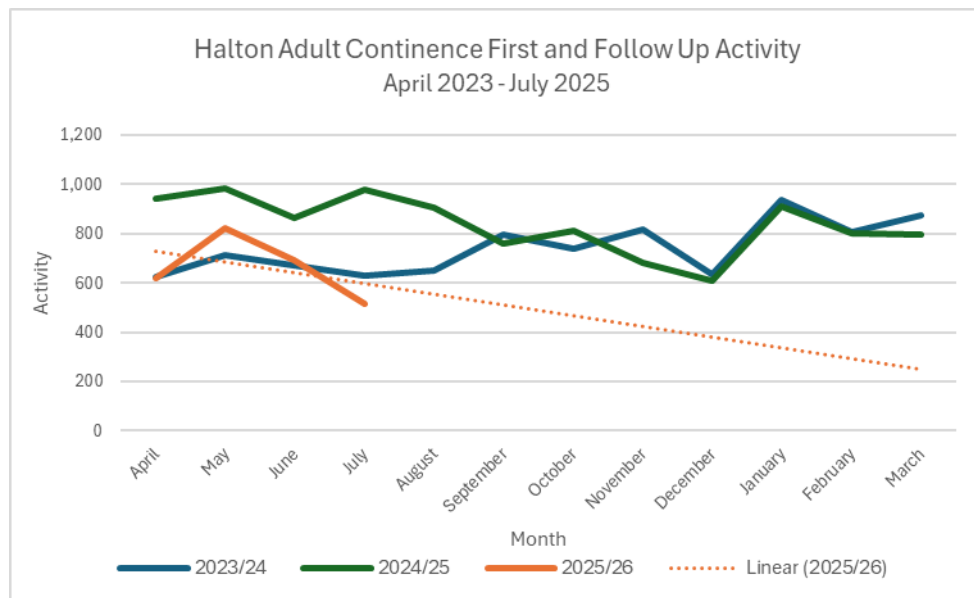
Heart Failure – The Heart Failure service have experienced an increase in activity in the first quarter of 2025-2026 when compared to previous years. This can be attributed in part to the development of the MDT Heart Failure Hub.



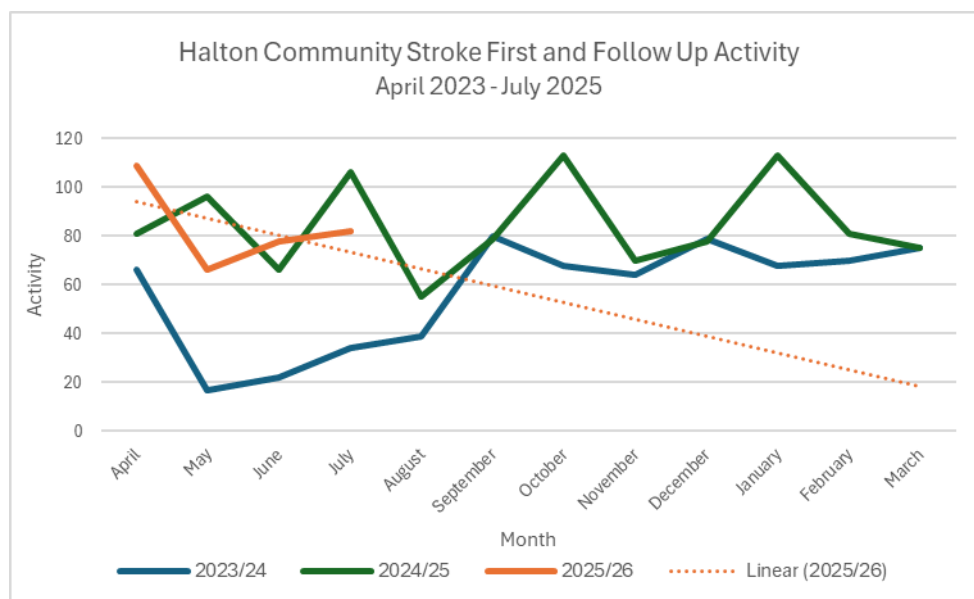
Parkinsons Service- Overall the data indicates that whilst there has been variability in the nursing service in the last two years, early data from 2025-2026 suggests a positive trend with an overall expected increase in activity levels.



Palliative Care Service: Overall, the palliative care data highlights first and follow up activity over time. The Quarter one data suggests a positive trend with an overall increase in activity levels expected as we move into winter 2025-2026.



Adult Continence Service: The early data from the adult continence service suggests a decline in activity, this can be directly attributed maternity leave within the service which has reduced the capacity of the team. A plan has been implemented to support increased capacity within the team which will support waits management.



Community Stroke: The decline in activity in early 2025-2026 can be directly attributed to sickness. This is expected to increase in quarter two, this can be seen reflected in July 2025 data.

Within Specialist Nursing services, It is anticipated that, for 2025/26 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 2024-2025

Specialist Nursing	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Heart Failure	316	270	265	209	344	374	397	507	444	470	394	349
Wellbeing	107	107	101	44	106	85	104	98	91	68	79	71
Stroke	80	68	64	79	68	70	74	81	96	66	107	55
Bladder and Bowel	795	738	815	634	935	807	979	932	1068	863	1012	921
Parkinsons	46	55	63	46	84	55	46	66	60	53	61	63
Palliative care	211	266	234	179	231	171	181	331	317	293	353	585

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	Band 7 nurses x 3.8 wte Admin band 4 x 1wte Band 4 RNA x 1wte	Band 7 nurse Team Lead x 0.72wte Band 6 nursing x1.6 wte	Band 7 nurses x 1.4wte Band 4 Admin 0.4 wte	Band 7 nurse x 1wte Band 6 nurse x 3.11wte Band 4 admin 0.96wte Band 3 HCA x 0.84wte	0.4 Nurse wte	Consultant x 0.6wte Speciality Doctor 0.4xwte Band 7 x 3.4 wte Band 6 x 0.8 wte Admin band 4 x 1.03wte Admin band 3 x 0.8wte HCA band 3 – 0.8wte
Vacancies FTE	0	Band 7 x 0.6wte Team Lead	0	0	0	0
Maternity Leave	0	0	0	0	0	0
Establishment	6.4wte	3.19wte	1.48wte	6.2wte	0.4wte	8.2wte

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.
- 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.
- All staff training will be prioritised to maximise clinical capacity within this period.
- As appropriate double handling of patients between nursing services will be minimised between Halton services to maximise clinical capacity.

Community Equipment Stores

Identified 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 increase on the average of urgent orders per month in two out of the three boroughs the service covers. In year 24-25 these referrals were from Hospital Discharge Teams across the boroughs, and, in the last eight months of the year, these requests were coming from varying Health & Social teams within the community. This has continued into 25-26.

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 a demand and capacity project completed in early 2024 which suggests that the service does not have the required headcount to effectively deliver the needs of the service. This forms part of the service's improvement plan but would need additional funding from the three commissioners moving forward. The potential increase in headcount would help to reduce or mitigate pressure the service is currently experiencing. We continue to run the service with a similar budgeted headcount as winter 2023-24. The service successfully transferred all agency staff to NHS contracts to mitigate agency spending during 2024.

There have been examples of supply issues throughout this financial year 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', supporting a more robust process for servicing equipment that will support demand, and reduce

the need for purchasing new equipment. The service manager is currently working on a number of projects that will be cost effective and streamline the service.

Deliveries data

Total deliveries	2023/2024	Avg per month	2024/2025 to date	Avg per month
Warrington	12492	1041	5285	1057
Halton	7709	642	3518	704
St Helens	5598	467	2608	522

Urgent Deliveries*	2023/2024	Avg per month	2024/2025 to date	Avg per month
Warrington	1900	158	806	161
Halton	2029	169	1036	207
St Helens	1817	151	895	179

*Urgent deliveries are a part of total deliveries above.

Compared to previous years, there remains a marked increase in the percentage in deliveries and urgent orders.

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	44
Vacancies	2
Maternity Leave	0
Establishment	46

Currently, there are currently high levels of unplanned absence within the service, which has been a trend for several months already this financial year. Overtime is currently being used to cope with effective delivery of the service. This level of unplanned absence that the service has experienced so for this year, and if it stays around the current level, could 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, the service has the opportunity to plan overtime at the following times:

- 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, there is the option to implement the following contingency arrangements:

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

Capacity Solutions:

- 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. This is subject to an increase in funding from Local Authority.
- Ongoing route planning reviews to maximise the efficiency of delivery and collection slots.

Community Dental Service

Identified Pressures

External influences that may affect service delivery include:

- Lack of access within Acute Hospitals to deliver Paediatric Exodontia within Whiston, Royal Bolton, Oldham and Tameside General Hospitals.
- 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.
- Fluctuating workforce capacity.
- Commissioner decisions impacting on patient pathways i.e., changes to referral pathways, resulting in increasing demand for our services.

Staffing Levels

Community Dental	WTE

Staff in Post	179.2
Vacancies	14.8
Maternity Leave	10
Establishment	194.0

Capacity and Demand Management Solutions:

- 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, linked to presentation of clinical need (pain).
- Managing treatment plans involving multiple visits.
- Increasing and consolidating GA Paediatric access by:
 - Working in partnership with Oldham and Tameside General to secure additional access to deliver GA services from their day case unit as well as additional sessions on a Saturday
 - Engaging with relevant NHS Trusts and Greater Manchester Oral Surgery Clinical Reference Group to secure weekend theatre access.
- Time limited waiting list initiatives to reduce waiting times.
- With other Greater Manchester Community and Acute Providers exploring the how we can work collaboratively together
- Considering all our regional GA access.

Flu and Covid Booster Vaccination Programme

Staff influenza programme (flu)

The staff flu vaccination programme is due to commence on 3rd October 2024. The IPC team will be the identified vaccinators across the Trust providing a roving model.

Updates on numbers of staff vaccinated will be reported into the People Committee. Staff that receive their vaccination outside of the Trust will be asked to inform IPC so the data can be included.

Staff Covid-19 Autumn/Winter 2024 booster

BCHFT staff will be directed to local vaccination centres, details and locations are yet to be confirmed.

School-Aged Immunisation Programme

Warrington - Flu

Target population numbers:

- School-aged Children – 32 837(estimated) is cohort.

Year Group	Target Warrington Uptake
Reception	64.3 %
Year 1	68.4%
Year 2	66.8 %
Year 3	66.8 %
Year 4	67.9 %
Year 5	66.9 %
Year 6	65.2 %
Year 7	53.9 %
Year 8	52.6%
Year 9	51.0 %
Year 10	47.6 %
Year 11	36.6 %

- 2 and 3 year olds 836 (estimated) eligible children. No target.
- 16 and 17 year olds in Special Schools. No Target.
- Start dates – 23rd September – 13th 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 – 18,580 (estimated) is cohort.

Year Group	Target Halton uptake
Reception	55.7 %
Year 1	57.0 %
Year 2	59.8 %
Year 3	57.8 %
Year 4	57.7 %
Year 5	58.5 %
Year 6	54.2 %

Year 7	47.6 %
Year 8	41.1 %
Year 9	41.8 %
Year 10	37.4 %
Year 11	32.7 %

- 2 and 3 year olds – 317 (estimated) eligible children. No target.
- 16 and 17 year olds in Special schools. No target.
- Start dates – 23rd September – 13th December 2023.
- Service locations – Schools and community clinics.
- Staffing – Average of 6 immunisers a day (Tue – Fri) required plus 3 support staff. 3 immunisers and 1 support staff required to deliver a Saturday session each month.

Emergency Preparedness, Resilience and Response (EPRR)

This Winter Plan is published on [the Hub and the on call/EPRR](#) teams channel, sitting alongside several other Trust plans and documents:

Adverse Weather and Health Plan

The Trust's Adverse Weather and Health Plan, which is linked to the Adverse Weather and Health 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 updates to the current plan scheduled for early October 2024.

[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 health alerting 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 have been reviewed in preparation for winter. 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](#).

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 24/25 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.

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 Cheshire and Merseyside and NHS England North West. This is in addition to updates from the UK Health Security Agency (UKHSA) 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 extranet 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 extranet.

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS		Date	9 OCTOBER 2025
Agenda Item	75/25iv			
Report Title	ANNUAL SUBMISSION TO NHS ENGLAND NORTHWEST [1/4/24 to 31/3/25] FOR MEDICAL APPRAISAL, REVALIDATION AND MEDICAL GOVERNANCE			
Executive Lead	Dr Paul Fitzsimmons Medical Director			
Report Author	Dr Anne Robinson, Responsible Officer & Medical and Dental Appraisal Lead Dr David Mills, Deputy Medical Director Brittney Chu, Business Manager to Medical Director			
Presented by	Dr Paul Fitzsimmons			
Action Required	☒ To Approve	☐ To Assure	☐ To Note	
Executive Summary				
This report provides an overview of the Trust’s compliance with the Medical Profession (Responsible Officers) Regulations 2010, covering appraisal, revalidation, and medical governance for the period 1 April 2024 – 31 March 2025. It demonstrates governance oversight and supports ongoing quality improvement. During this year, Bridgewater Community Healthcare NHS Foundation Trust (BCHFT) had 13 doctors with a prescribed connection, 100% of whom had their annual appraisal during this period. No revalidation recommendations were required during this year. One concern was raised which was managed internally but did not require GMC referral. Key developments included the appointment of a new medical and dental appraisal lead. [Sept 2024] This post had previously been vacant for a couple of years. A new responsible officer was appointed following the departure of the previous medical director/responsible officer in November 2024. The medical appraisal policy was updated in line with GMP2024, and an SLA with intermediate care providers ensured consistent governance for doctors not directly employed by BCHFT. All policies, governance structures, and appraisal systems were actively monitored, including induction, professional development, and employment checks for locum and short-term doctors. The Trust maintained engagement with peer review programmes and regional RO networks to ensure national standards were met. Preparation work has been undertaken introducing the new electronic appraisal platform SARD into the Trust with a go live date of August 2025 for doctors. The SARD platform and the planned medical appraisal quality assurance tool [ASPAT tool] will further enhance the quality of medical appraisals. Preparatory work is underway for integration with Warrington and Halton Hospitals NHSFT in April 2026, focusing on standardising appraisal and revalidation processes. Ongoing training, peer review, and participation in regional RO networks will continue. Monitoring and reporting systems for professional standards, induction, and appraisal—including for locum doctors—will be maintained. Bridgewater Community Healthcare NHS Foundation Trust demonstrates strong medical governance, robust compliance, and a proactive approach to continuous improvement in appraisal, revalidation, and professional standards, while preparing for future organisational integration.				



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

How does the paper address the strategic risks identified in the BAF?						
☐ BAF 1	☒ BAF 2	☐ BAF 3	☒ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	75/25iv		
Report Title	ANNUAL SUBMISSION TO NHS ENGLAND NORTHWEST [1/4/24-31/3/25] FOR MEDICAL APPRAISAL, REVALIDATION AND MEDICAL GOVERNANCE.		
Report Author	Dr Anne Robinson, Responsible Officer & Medical and Dental Appraisal Lead Dr David Mills, Deputy Medical Director Brittney Chu, Business Manager to Medical Director		
Purpose	This report provides assurance to the Trust that it has met its statutory responsibilities in regard to medical appraisal and revalidation for the period 1/4/24 to 31/3/25		

1. SCOPE

- 1.1 This report covered Bridgewater Community Healthcare NHS Foundation Trust's compliance with the Medical Profession (Responsible Officers) Regulations 2010, including medical appraisal, revalidation, and governance arrangements for the period 1 April 2024 to 31 March 2025.
- 1.2 It also provides assurance to the Board and NHS England North West that statutory responsibilities had been met, governance processes reviewed, and continuous improvement made.

2. INTRODUCTION

- 2.1 This report outlined how the Trust discharged its responsibilities in relation to medical appraisal and revalidation, ensuring adherence to national standards and regulatory requirements.
- 2.2 It highlighted activity undertaken to support doctors with prescribed connections to the Trust, developments in governance systems, and improvements made during the year to strengthen oversight.
- 2.3 The report also set out preparations for organisational integration with Warrington and Halton Hospitals NHS Foundation Trust in 2026, focusing on alignment of appraisal and governance processes.

3. MEDICAL APPRAISAL AND REVALIDATION COMPLIANCE

- 3.1 For the period 1 April 2024 to 31 March 2025, there were 13 doctors employed and aligned to Bridgewater for appraisal.

- 3.2 During the reporting period, the Trust demonstrated full compliance with medical appraisal requirements. 13 doctors attached to BCHFT completed their appraisal within the required timescales, ensuring full compliance. The appraisals were conducted in line with the Trust's updated medical appraisal policy, which incorporated a new supporting toolkit and was aligned with the 2024 Good Medical Practice (GMP2024) framework.
- 3.3 Governance oversight of appraisal activity was maintained throughout the year, with systems in place to monitor compliance and address any issues promptly.
- 3.4 In relation to revalidation, there were no recommendations required during the 2024/25 reporting year. The Responsible Officer ensured continuous oversight of medical performance and confirmed compliance with statutory revalidation responsibilities.
- 3.5 One concern was raised involving a doctor, but this was managed locally and did not meet the threshold for referral to the GMC. This demonstrated that the Trust's governance processes remained effective in identifying and appropriately handling matters related to medical practice.
- 3.6 Engagement with peer review programmes, regional responsible officer (RO) networks, and quality assurance activities ensured that revalidation processes remained aligned with national standards and best practice.

4. RESPONSIBLE OFFICER ANNUAL REPORT

- 4.1 The 2023/2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance report is submitted today for its approval by the Board, before it is submitted to NHS England.

5. CONCLUSION

- 5.1 This report provides assurance that the Trust is meeting its statutory responsibilities regarding medical appraisal and revalidation and medical governance, and that these matters are discussed and monitored on a regular basis at the Medical & Dental Professional Governance meeting.
- 5.2 The Trust maintained robust compliance with statutory requirements for medical appraisal and revalidation throughout the reporting period. All appraisals were completed within the required timeframe, no revalidation concerns arose, and governance processes remained effective in managing professional standards. The outcome reflected the strength of the Trust's oversight arrangements and its commitment to ensuring safe, high-quality medical practice.
- 5.3 The introduction of the SARD platform will provide enhanced opportunities for quality assurance and alignment with neighbouring organisations ahead of planned integration in 2026. Alongside system developments, the appointment of an appraisal lead further strengthened continuity and leadership within medical governance.

2024-2025 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2025**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2024-2025 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 (1 Apr 2024 to 21 Nov 2024) Dr Anne Robinson (22 Nov 2024 to present)	Ted.adams@nhs.net anne.robinson29@nhs.net
Medical Director	Dr Ted Adams (1 Apr 2024 to 21 Nov 2024) Dr Paul Fitzsimmons	Ted.adams@nhs.net paul.fitzsimmons1@nhs.net
Medical Appraisal Lead	Dr Anne Robinson (2 September 2024 to present)	anne.robinson29@nhs.net
Appraisal and Revalidation Manager	Brittney Chu	poyan.chu@nhs.net
Additional Useful Contacts	David Mills (Deputy Medical Director)	david.mills6@nhs.net

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

This report concerns Bridgewater doctors only. We provide responsible officer services to 2 hospices Separate reports are provided for each hospice, who share the same Responsible Officer.

If yes, who is this with?

Organisation
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of [Bridgewater Community Healthcare NHS Foundation Trust](#) can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	No actions
Comments:	Dr Ted Adams was the Responsible Officer (RO) for Bridgewater from 24 April 2023 to 21 Nov 2024. Dr Adams undertook appropriate training for the RO role in March 2023. He attended the regional RO Network meetings in July 2024 to ensure he remained up-to-date with the knowledge required for the role. Dr Anne Robinson was appointed as Responsible Officer from 22 November 2024 and completed R/O training in September 2021. Dr Robinson reports to the Deputy Medical Director David Mills who is a dentist by background The acting Medical Director, Dr Paul Fitzsimmons, has an alternative R/O provided by Liverpool University Hospitals to avoid an inverse reporting relationship with BCHFT R/O. Bridgewater Community Healthcare Trust will unite with Warrington and Halton Hospitals in April 2026.

Action for next year:	Dr Robinson attended the virtual Responsible Officer Network on 5 February 2025 and will join the regional RO Network meetings in 2025/26 to ensure she remains up-to-date with the knowledge required for the role.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	No actions
Comments:	Sufficient resources have been provided by the Designated body to allow the RO to complete her responsibilities. The R/O is employed for 6 hours per week and is also the medical and dental appraisal lead. The R/O is supported by 1 WTE medical manager MS Brittney Chu The Trust has used Premier IT, an online platform for the management of doctors appraisals with a separate arrangement with Edgumbe for 360 degree MSF. Going forward, the Trust is moving to SARD which has an integral 360-degree feedback tool as part of the electronic platform. This mirrors the system used at WHH. Appraisers are supported with initial and refresher training and 2/3 update forums per year.
Action for next year:	Ensure integration work with Warrington and Halton Hospital includes review of RO responsibilities together with medical and dental appraisal responsibilities.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	No actions
Comments:	Accurate records have been maintained throughout this reporting period. This includes appraisal / revalidation records, investigation/ management of concerns. Electronic Staff Records, E Roster 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. A year's extension to the designated body's web-based appraisal system (PremIT) was agreed whilst other electronic appraisal systems were researched.
Action for next year:	Introduce the new SARD electronic appraisal platform into Bridgewater Community Healthcare FT together with appropriate training for medical staff. Work has commenced with the relevant supplier (SARD) to facilitate the users' training and data transfer.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Medical Appraisal Policy and Job Planning Policy was in place.
Comments:	A revised Medical Appraisal Policy and Job Planning Policy was approved by the Joint Negotiating and Consultative Committee (JNCC) in December 2024. This incorporated feedback from an external review of the job planning process by Mersey Internal Audit Agency. The Trust has also recently revised its Education and Professional Development Study Support Policy and Framework which supports Medical revalidation. The HR team have a robust process in place to review and monitor all HR Policies. All policies are reviewed on a 3 years basis unless national or legal changes require an earlier review. All policies and procedures can be viewed via the Trust's intranet.
Action for next year	To upload Medical Appraisal policy and job planning policy to new SARD appraisal platform when SARD platform goes live.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	NO
Action from last year:	No action
Comments:	The appraisal and revalidation manager joins the Appraisal & Revalidation Administrators/Managers Network Group Meeting regularly to update her knowledge and ensure processes were reflective of our peers. The Medical Appraisal Policy was widely consulted on throughout the Trust and across multi-disciplinary services. All policies are signed off by the JNCC which reports to the Trust People Committee. The Trust now operates a joint Committee with Warrington and Halton Hospital NHS Trust in advance of the Trust's merger in April 2026. There will be further opportunity to peer review the appraisal and revalidation process and incorporate areas of best practice through the alignment of the processes Dr Anne Robinson is leading the peer review process for large designated bodies across Cheshire and Merseyside and will take any learning from that peer review process that applies to BW. Dr Robinson attends the yearly updates for small designated bodies and applies any learning from peer small designated bodies
Action for next year:	Ensure continued attendance at yearly small designated body update Apply any appropriate learning from large body peer review to BW processes.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes

Action from last year:	To update Trust appraisal and revalidation policy with form for doctors to complete with their BCHFT manager which covers the scope of their work at BCHFT. The doctor takes the completed form to their own appraisal. This action was completed in Dec 2024 when the Trust appraisal and Revalidation policy was updated.
Comments:	All locum doctors have a comprehensive local departmental induction on starting work at Bridgewater. The Trust has a Temporary Staffing Policy and Mandatory Training and Induction Policy which outline the induction requirements for temporary staff including doctors. Doctors have a local review of their work at BCHFT and are provided with evidence to take to their appraisal at their relevant designated body. A new Service Level Agreement (SLA) with our intermediate care provider who includes provision to receive details of relevant appraisers and appraisal dates to ensure Bridgewater's RO can influence development needs if required.
Action for next year	To continue with current processes

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	No actions
Comments:	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. This is being replaced by a new electronic appraisal system called SARD The Medical Appraisal Policy has recently been reviewed and a supporting toolkit produced which clearly outline the information that is required at appraisal. Information on complaints and concerns are fed into the review process by the doctor. Going forward this will be completed by the Governance department at BCHFT.
Action for next year:	To work with governance department at Bridgewater and two hospices to ensure that all relevant information about significant events and complaints is proactively uploaded to SARD system prior to a doctor's appraisal

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	NA
Action from last year:	NA
Comments:	NA
Action for next year:	NA

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Medical Appraisal Policy was reviewed and updated in June 2024 in accordance with the Good Medical Practice Guide 2024 and the Medical Appraisal Guide 2022. The policy was signed off by the JNCC in June 2024 following approval at the LNC. The JNCC reports to the People Committee which is a sub committee of the Board.
Comments:	All policies and procedures can be viewed via the Trust's intranet.
Action for next year:	To upload the medical appraisal policy to the new electronic appraisal platform-SARD

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Opportunities for changes to appraisers training would be available by virtue of the integration between the designated body and Warrington and Halton Hospital NHSFT.
Comments:	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.
Action for next year:	To offer new appraisal training to doctors at BCHFT in conjunction with training for new appraisers at Warrington and Halton Hospitals on 5 November 2025.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Y/N	Yes
Action from last year:	Ensure there are sufficient trained appraisers in place and that annual update training is provided
Comments:	The Trust appointed Dr Anne Robinson as appraisal lead at the Trust. Dr Robinson started at the Trust on 2nd September 2024. 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. The Trusts medical and dental appraisal lead has organized an update for BCHFT medical staff on 1/5/2025 which included training on the new SARD appraisal system. In addition, Trust appraisers are invited to appraiser updates in conjunction with Warrington and Halton Hospitals. These are being held on 3 April 2025, 11 April 2025 and 22 October 2025.
Action for next year:	Continue to ensure there are sufficient trained appraisers in place and that update training is provided to all appraisers 3 times per year.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	No actions
Comments:	Updates regarding appraisal compliance and quality are presented to the Trust's People Committee, which is a subcommittee of the Board, twice a year. There has not been any quality assurance of appraisals this year due to the implementation of the new electronic appraisal platform
Action for next year:	Continuing with current processes of reporting appraisal compliance to Board Introduce the use of the ASPAT tool into the SARD electronic appraisal. This will provide feedback to individual appraisers on the quality of their appraisals and will be included in Board reports.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	No action
Comments:	No doctors were referred to the GMC with concerns about fitness to practice. The responsible officer makes effective use of the opportunities presented by NHS Resolution and discussion with the regional GMC liaison.
Action for next year:	To continue with current practices

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

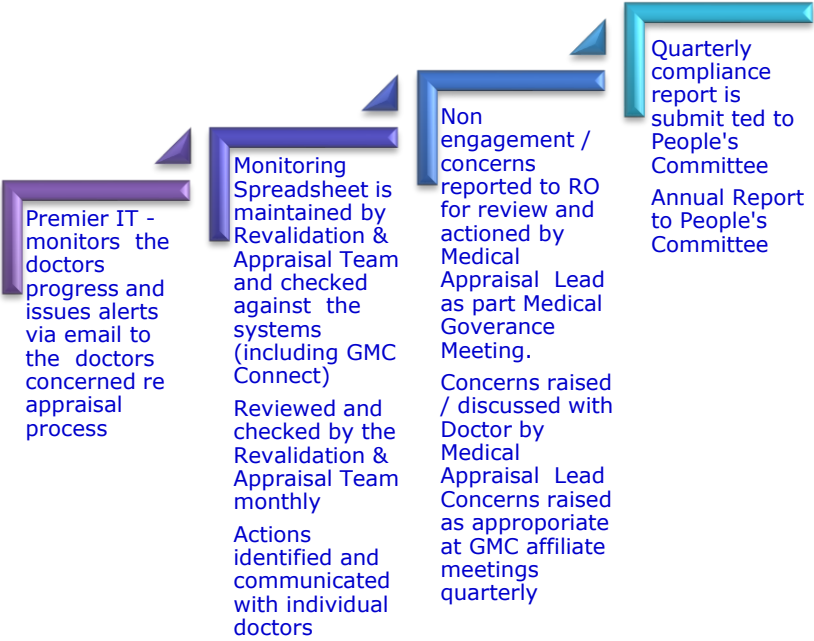
Y/N	Yes
Action from last year:	No action
Comments:	There have been no reported non-engagements within this reporting period. All recommendations to revalidate were made to the GMC within the proscribed timeframes and doctors who were revalidated were informed of those decisions.
Action for next year:	To continue to make timely recommendations to the GMC and to discuss with the doctor if the recommendation is one of deferral or non-engagement.

1D – Medical governance

- 1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	To continue with the same governance arrangements

Comments:	The Trust has a clearly defined organisational structure. The Board receives regular information regarding clinical governance information regarding doctors through the Strategic People Committee and Quality & Safety Committee. This includes information about incidents, complaints and litigation in addition to appraisal and revalidation information. Clinical directors and team managers meet regularly with their teams to discuss learning from complaints, incidents and litigation .There are weekly departmental governance meetings and monthly learning meetings for all staff when incidents, complex cases etc are discussed. Doctors are expected to take part and contribute to improvements and to lead their teams in these improvements. One to one meetings between the deputy medical director and clinical directors occur when governance issues are discussed[DIRG and PSIRFalp] Senior team leaders [clinical directors] meet with the deputy medical director and appraisal lead on a monthly basis to discuss current clinical and non-clinical issues with actions agreed and monitored. 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. All doctors at the Trust currently use the online appraisal system provided by PremierIT. 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.

	 Premier IT - monitors the doctors progress and issues alerts via email to the doctors concerned re appraisal process Monitoring Spreadsheet is maintained by Revalidation & Appraisal Team and checked against the systems (including GMC Connect) Reviewed and checked by the Revalidation & Appraisal Team monthly Actions identified and communicated with individual doctors Non engagement / concerns reported to RO for review and actioned by Medical Appraisal Lead as part Medical Governance Meeting. Concerns raised / discussed with Doctor by Medical Appraisal Lead Concerns raised as appropriate at GMC affiliate meetings quarterly Quarterly compliance report is submitted to People's Committee Annual Report to People's Committee
Action for next year:	Continuing with current Trust processes Introducing the new medical appraisal system SARD into the Trust Introduction of uploading governance reports into doctor's appraisal portfolios

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	No actions
Comments:	Conduct, Capability, Ill-Health and Appeals Policy is currently being reviewed. 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. There were conduct concerns in relation to one doctor which was managed through an informal action plan with support from PPA. This was formally closed in April 2024 and the Doctor left in August 2024 All policies and procedures can be viewed via the Trust's intranet.
Action for next year:	To continue to use the systems in place at BCHFT to monitor conduct and performance of all doctors in organisation

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Review of the Trust's electronic appraisal system.
Comments:	The Trust has reviewed the appraisal systems and introduced SARD appraisal system into the Trust from Aug 2025
Action for next year:	To provide training on the new appraisal system to doctors at the Trust To work with governance team to upload governance reports onto doctors' portfolios prior to their appraisal

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	No actions
Comments:	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 2024/25, discussing doctors about which there have been performance concerns and ensuring that appropriate action plans and support are in place as necessary. There have been no formal investigations of doctors within this reporting period. Any concerns raised are taken seriously and results fed back to those who have raised concerns. Trust policies include measures in support of a just and learning culture with timeline requirements for review to ensure minimal case delays. Support for hearing chairs, case managers and case investigators is provided by HR professionals. An annual HR dashboard is fed into the Trusts Strategic people committee which includes case themes and protected characteristics.
Action for next year:	To continue with the established process for responding to concerns about a doctor's fitness to practice

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	No actions
Comments:	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. Whilst no formal investigations have been undertaken about doctors, the system at the Trust has been tested in 2023/24 by the investigation under the same policy of a dentist. Changes were made around ensuring individuals are supported appropriately during investigations.
Action for next year:	To continue with same processes

1D(vi) There is a 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](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	No actions
Comments:	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. The Trust engages with this provision. Where concerns have arisen about locum doctors, the supplying agency and/ or the doctor's RO have been informed accordingly. There has been one issue with a locum doctor in relation to the recording of data on system one and concerns about the use of smart cards. This has been addressed informally through learning objectives.
Action for next year:	To continue to use MPIT forms in communicating with other Trusts To review process for gathering information on locum doctors when commencing work in Trust

1D(vii) 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 (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	No actions
Comments:	The Trust's Conduct, Capability, Ill-Health and Appeals Policy and Procedure for Medical and Dental staff includes the following: 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. There have been no concerns expressed within this reporting period. There are 10 members of staff trained as case investigators across the Trust
Action for next year:	To continue to use the Trust policies when dealing with concerns about doctors

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	No actions
Comments:	If there are changes in National Guidance/law/clinical guidance the guidance is disseminated to the relevant executive lead /subject matter expert who is responsible for integrating it into BCHFT policies and then appropriate operational leads/clinical directors/medical director responsible for operationalising the guidance. The Trust implemented the Patient Safety Incident Response Framework in November 2023 with the development of a policy and plan. Incidents are reviewed within Directorates before discussion at PSIRF Alp which then feeds into the Quality & Safety Council which is a subcommittee of the Board. The Trust has a number of processes in place to capture learning which is shared across the Trust. Incident reports are discussed at would be shared and reported to the Trusts' Quality Council Meeting.
Action for next year:	To continue with current Trust processes

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	No actions
Comments:	Systems outlined in 1D[viii] apply to this section also Examples include the launch of GMP2024 This document was published by the GMC and the medical appraisal and revalidation policy was reviewed to incorporate the changes /updates to GMP.

	The Trust is in the process of developing a new behavioral framework and it is anticipated that some of the behaviours described in GMP2024 will be referenced in this policy.
Action for next year:	To continue to update BCHFT policies in line with national/local guidance ensuring consistency amongst all healthcare professionals To complete the Trust behavioural framework ensuring GMP2024 is referenced.

1E – Employment Checks

1E(i) A system 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.

Y/N	Yes
Action from last year:	No actions
Comments:	The Trust carries out pre-employment checks in accordance with its Recruitment & Selection Policy and the NHS Employment Check Standards. The policy was reviewed and updated in December 2024. 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 are reviewed at Executive level and by the Trust's HR team. Locum Doctors are provided by an Agency or an in-sourcing company. The Trust has agreements with both to undertake full pre-employment checks, and these are routinely checked by the Trust.
Action for next year:	To continue pre-employment checks in line with NHS Employment check standards

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	No actions
Comments:	The Trust has the following guidelines and policies in place 1. A Just Culture Guide 2. Civility and Respect Policy 3. Conduct, Capability, Ill-Health and Appeals Policy and Procedures for Medical and Dental Staff

	4. Equal Opportunities Policy 5. Patient Safety Incident Response Framework (PSIRF) Concerns are monitored through the Quality Committee and shared with the Chief Executive/ Trust Board if deemed necessary by the Responsible Officer. Any outcomes from Patient Safety Incidents will be used to assist the Directorates and the Trust with its Quality Improvement work. The improvement work will be shared across the organisation via Committee and Board Papers, newsletters, Time to Shine meetings and the annual Quality Report.
Action for next year:	To continue with current Trust processes

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	No actions
Comments:	• Just Culture underpins all HR policy and practice, including disciplinary, grievance, wellbeing and sickness absence. Where appropriate policy includes medical workforce, or where specific policy exists the fundamentals of Just Culture are used. • Equal Opportunities and Dignity at Work provide the overarching policy and commitments to equality, diversity, and inclusion and anti-discrimination and harassment cultures. • The EDI Strategy establishes the framework for delivery of the EDI Priorities Action Plan led by the EDI Working Group. • New Behavioural Framework launched in 2024, used from recruitment throughout the employment journey. • Choose Kindness is the main Trust campaign for civility, respect, and anti-bullying and harassment. This is supported by the Creating Kinder Cultures programme. • People Promise Champions provide the leadership and direct team interface for all work around the NHS Our People Promise activities. • Staff Inclusion Networks provide a space and voice for minoritised voices, including members of the medical workforce. • A universal as well as individual level training and development offer is open to all staff.
Action for next year:	To continue to promote compassion, fairness, respect, diversity and inclusivity across the Trust in all that we do.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	No actions
Comments:	The Trust adopted the national policy of Freedom to Speak Up. There has a named freedom to speak up guardian of the Trust, who works

	alongside the Trust leadership teams to support open and transparent working where all workers are actively encouraged and enabled to speak up safely. A Freedom to Speak Up guardian sit on the Trust PSIRF Panel to share and triangulate learning. The Trust has also developed a behavioural framework and Code of Conduct to articulate the expected standards from its employees. The Trust has recently agreed a new Behavioural Framework which outlines the expected behaviours from all staff. To complement this the Trust's Dignity at Work policy is currently being reviewed to clarify the process when behaviours are not appropriate or acceptable.
Action for next year:	To continue implementing the Trust behavioural framework

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	No actions
Comments:	The annual staff survey includes feedback from doctors and utilization of this data can be used to inform staff voices. There is also a quarterly pulse survey to which doctors can provide feedback anonymously
Action for next year:	To review feedback from medical staff completing staff survey and compare with feedback from other staff groups

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	No actions
Comments:	• Just Culture underpins all HR policy and practice, including the conduct, capability, ill-health, and appeals policy for medical and dental practitioners. • All managers/staff involved in an employee relations case complete the relevant HR Skills training, and are supported throughout by the Trust's HR team. • Equal Opportunities and Dignity at Work provide the overarching policy and commitments to equality, diversity, and inclusion and anti-discrimination and harassment cultures. • Equal opportunities qualitative data is also monitored through the annual NHS Staff Survey, with data available by ethnicity, international recruits, staff group and other disaggregation. • The Trust published employee relations data in the Medical Workforce Race Equality Standard report in 2023 - the reporting was stood down nationally in 2024 and 2025. In addition, the Trust publishes data on all staff involved in formal disciplinary processes in the annual Workforce Race Equality Standard Report, with numbers for both reports too small for providing actual numbers
Action for next year:	To continue with current Trust processes

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	No actions
Comments:	Responsible Officer (RO) attended regional RO Network meetings in 2024/25 to ensure he/she remained up-to-date with the knowledge required for the role. The RO met the GMC Liaison officer regularly throughout the period. The RO had regular meetings with NHS Resolution about the doctor who presented concerns and who had an ongoing action plans in place. The R/O attends the annual update for small designated bodies
Action for next year:	RO will continue to attend regional RO Network meetings in July 2025 and Employer Liaison Adviser Meetings in 2025/2026.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	13
Total number of appraisals completed	13
Total number of appraisals approved missed	0
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	0
Total number of late recommendations	0
Total number of positive recommendations	0
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	10
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer ²	1
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days) ³	0
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	1
Total number of new employment checks completed before commencement of employment	0
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The main actions in the past year include the appointment of a new Responsible Officer following on from the departure of the previous RO. In addition a medical and dental appraisal lead has been employed working 6 hours per week. The existing electronic platform for medical appraisal [premier IT] has been replaced by the SARD system, mirroring the system used by Warrington and Halton Teaching Hospitals FT. This system needs to be embedded at BCHFT following training during the upcoming year. The medical appraisal policy has been updated to include a supporting toolkit which outlines information required at appraisal. In addition a form is included to be used by doctors who are not attached to BCHFT designated body. This allows the doctor working at BCHFT to have a review of their work which can be taken to their appraisal with their own designated body. GMP2024 has been incorporated into the medical appraisal policy An SLA has been developed with providers of intermediate care to ensure that the SLA currently in place can be better managed, particularly around doctors providing services to Bridgewater, but who are not connected to the Trust via the Trust's responsible officer e.g. they are general practitioners who are not attached to BCHFT. Of the 13 doctors attached to BCHFT designated body there was 1 concern raised which did not reach the threshold for GMC referral. None of the 13 doctors attached to BCHFT were due for revalidation during 2024/25. All doctors had a timely appraisal.
Actions still outstanding
Strengthening communication with external designated bodies – Processes need to be embedded for doctors employed at BCHFT but appraised through external designated bodies, ensuring consistent documentation and quality assurance.
Current issues
The Designated Body is in a period of integration with its neighbouring acute trust Warrington and Halton Hospitals NHSFT. Work is currently being undertaken to align the electronic appraisal systems of the two organisations as a first step and then going forward will require a review and standardisation of systems and processes
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1. Ensure integration work with Warrington and Halton Hospital includes review of RO responsibilities, appraiser resources together with standardization of processes 2. RO to attend regional RO Network meetings in July 2025 and Employer Liaison Adviser Meetings in 2025/2026 3. Continue to introduce new SARD appraisal system into BCHFT, facilitating data transfer across from previous electronic system Premier IT. 4. Ensure that governance reports are pro-actively loaded onto appraisees documentation prior to appraisal allowing opportunity for full reflection and learning. 5. Apply any learning from large, designated body peer review to BCHFT

6. Offer new appraiser training to doctors at BCHFT and continue to offer appraiser updates 3 times per year.
7. Introduce the ASPAT tool to BCHFT appraisals to quality assure appraisal process
8. Review process for gathering information about locum doctors when commencing work at BCHFT.
9. Continue implementing Trust behavioural framework
10. Review feedback from staff survey focussing on medical staff and use feedback to inform further decision making
11. Continue with all other Trust processes.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The Trust has achieved a high level of compliance with the standards for medical appraisal and revalidation over the past year. Current processes have been maintained and the new electronic platform SARD procured with the transfer of all appraisal information for medical staff. A new appraisal and revalidation lead as well as a new R/O has been appointed

The next year will focus on the consolidation of the new SARD system, ensuring all governance reports are uploaded prior to medical staff appraisal. Introduction of the ASPAT tool will ensure quality assurance of the appraisal.

The Trust has worked closely with its local acute Trust-Warrington and Halton Hospitals over the past 6 months and as part of the preparation for integration in April 2026, appraisal and revalidation systems and processes will be reviewed to ensure consistency across the two organisations

Section 4 – Statement of Compliance

The Board/executive management team have 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 the designated body:

Bridgewater Community Healthcare NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Anne Robinson Brittney Chu Amanda Gregory
Email address:	Anne.robinson29@nhs.net

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	75/25v		
Report Title	LEARNING FROM DEATHS QUARTER ONE 2025/26		
Executive Lead	Paul Fitzsimmons Executive Medical Director		
Report Author	Andi Sizer Principal Lead for Public Health		
Presented by	Paul Fitzsimmons 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 were, overseen by our Directorate Incident Review and Learning Group (DIRLG) and Patient Safety Incident Response Framework and Learning Panel (PSIRPaLP). In quarter one 30 deaths met the LFD policy criteria, none of which were, after review in line with the LFD policy, found to be related to a deficit in care provided by Bridgewater. Examples of good practice and areas identified for learning along with the outcomes are detailed in section three of this report. No feedback was received back with regards to LeDeR referrals within quarter one made to the Cheshire and Merseyside LeDeR Steering Group. 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. Board is asked to note that this report is usually considered at Quality and Safety Committee before being presented at Board, on this occasion asynchronicity with committee and Board cycles and previous deferral has meant that it has been considered at EMT prior to Board. Recommendation: Trust Board is asked to receive assurance from this report that the Trust's Learning from Deaths process has been effective in discharging the organisation's responsibilities as outlined by the National Quality Board in Q1 2025			



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

How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☒ BAF 2	☒ BAF 3	☐ BAF 4	☐ BAF 5	☒ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships Failure to work in close collaboration with partners and staff in place and across the system

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	75/25v		
Report Title	LEARNING FROM DEATHS QUARTER ONE 2025/26		
Report Author	Andrea Sizer Principal Lead for Public Health		
Purpose	The purpose of this paper is to provide assurance to Trust Board in relation to quarter one Learning from Deaths.		

1. SCOPE

1.1 Bridgewater becomes aware of deaths from several sources including:

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

Each reported death to the Trust prompts an incident report, and if appropriate, a Learning from Death's review and report, the analysis of which contributes to this report.

- 1.2 Death incident reports are reviewed in the weekly Directorate DIRLG meetings (Warrington Adults, Halton Adults, Children's Services and Dental). The DIRLGs consider each incident against the Trust Learning from Death Policy and decide as to whether an LFD review is needed.
- 1.3 Each LFD report, once completed, is reviewed, agreed and signed off in the appropriate DIRLG then presented to the fortnightly PSIRFaLP meeting for final approval. This process allows the Trust to be confident that it proactively seeks to improve care provided at the end of life and is sharing lessons learned.

2. INTRODUCTION

- 2.1 The Trust PSIRFaLP meet fortnightly, and service leads provide reports on each death that the Trust had been notified of, and that met the criteria for investigation as detailed in the policy.
- 2.2 30 deaths met the criteria set out in the Trust Learning from Deaths Policy in quarter one and were investigated by the relevant DIRLGs then reviewed and approved by the Trust PSIRFaLP.
- 2.3 None of the 30 deaths (27 adults and three children) in quarter one was found to be related to a deficit in care provided by Bridgewater.
- 2.4 Of the 27 adult deaths reviewed in quarter one, 25 were unexpected and two expected.
- 2.5 Of the three child deaths, two were unexpected and one expected.
- 2.6 One of the adult deaths in quarter one was a death of patient with a Learning Disability diagnosis, and this was reported to the Cheshire and Merseyside LeDeR Steering Group.
- 2.7 In quarter one there were no concerns raised from deceased family/carers and no concerns raised by staff about the care that Bridgewater delivered to patients who died.
- 2.8 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 3.2.

3. INFORMATION LFD and Inquests

Summary of Thematic Learning from LFD

- 3.1 Each 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 After PSIRPaLPs review, the panels opinion was that none of the 30 deaths in quarter one was attributed to a deficit in care provided by Bridgewater services.
- 3.3 Examples of good practice and areas for improvement were identified as detailed in the table 1 below.

Table 1: Good practice identified and areas of improvement.

	Good Practice	Areas of Improvement	Dissemination
Adult death expected Learning Disability	Patient had a stable care home staff team who understood their needs and how they communicated. Good communication and relation between the care home and District Nursing. GP attended advanced planning best interest meeting at home and allowed time for thorough discussions with family and staff team. GP provided time for family to discuss patients' needs throughout last weeks of life.	None	N/A
Child death unexpected	Good antenatal information sharing process, history of family available from booking information with Team River. Prompt birth notification and booking of home visit within 1 day of birth. Persistence with contacting family following no access visits.	Record keeping No siblings or father recorded in groups and relationships on child record. Safe sleep discussed but assessment template not completed. Inconsistent/incorrect documentation of level of intervention, caseload stated Universal when family were	Learning circle

		targeted and on enhanced pathway.	
Child death expected	The electronic patient record held excellent narrative in respect of the complex care plan for this young person, all the relevant information from secondary care and the community was available for all professionals to be able to oversee their care. The correct specialist services led and managed his care needs.	A gap in demographics on SystmOne	Team meetings

Quarter one 2025/26 information from the Coroner's Office

- 3.4 In quarter one 2025/26 the Trust received no information on the causes of deaths and Coroner outcomes/comments relating to Trust patients.
- 3.5 It is noted that inquest information can take a considerable length of time to be reported back to the Trust.

4. RECOMMENDATION

Trust Board is asked to receive assurance that all 30 deaths in Q1 25/26 meeting the criteria for a Learning from Deaths review have been reviewed in line with Trust policy

Trust Board is asked to note that none of these deaths have been attributed at review to a deficit in care provided by Bridgewater services.

Trust Board is asked to receive assurance from this report that the Trust's Learning from Deaths process has been effective in discharging the organisation's responsibilities as outlined by the National Quality Board in Q1 2025

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	7525vi		
Report Title	FREEDOM TO SPEAK UP REPORT OCTOBER 2025		
Executive Lead	Ali Kennah - Chief Nurse		
Report Author	Helen Young – Lead Freedom to Speak Up Guardian		
Presented by	Helen Young – Lead Freedom to Speak Up Guardian		
Action Required	☐ To Approve	☐ To Assure	☒ To Note
Executive Summary			
This summary presents the key findings and highlights of the Freedom to Speak Up (FTSU) activity within the Trust for the reporting period from 1st April 2025 to 31st August 2025. The report demonstrates the Trust's continued commitment to fostering a culture of openness, transparency, and psychological safety for staff wishing to raise concerns. During this period, the Trust recorded a total of 15 concerns, marking an increase from the 11 concerns raised in the same timeframe in 2024, an approximate 36% rise. This upward trend may indicate growing awareness of, and confidence in, the FTSU process. Following National Guardians' Office (NGO) reporting guidance, each individual who speaks up is counted as a separate case; thus, collective concerns brought by teams are reflected in the overall figures. Specifically, 8 concerns were raised individually, while 7 concerns emerged collectively from teams, involving 56 staff members. According to NGO guidance, this equates to 64 cases for the period. The apparent increase in reported concerns is largely attributed to team-based disclosures, suggesting that issues are being experienced and addressed collectively within teams. The Guardian continues to monitor these developments to identify potential emerging trends and ensure appropriate responses. The Trust maintains ongoing collaboration with regional peers and the National Guardians' Office, ensuring alignment with best practices and up-to-date guidance. The FTSU Guardians will continue to report themes and trends bi-annually to the Board, with oversight from the named Executive and Non-Executive Leads. In summary, the report provides assurance that the FTSU process remains effective, accessible, and supportive, reinforcing the Trust's dedication to a safe environment where all staff are empowered to raise concerns openly, confidentially, or anonymously.			
Previously considered by:			
☐ Audit Committee ☐ Quality and Safety Committee ☐ Finance, Sustainability and Performance Committee-in-Common ☐ Remuneration and Nominations Committee ☐ Strategic People Committee-in-Common ☐ EMT			



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

How does the paper address the strategic risks identified in the BAF?						
☐ BAF 1	☒ BAF 2	☐ BAF 3	☒ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system
CQC Domains:		☐ Caring	☒ Effective	☐ Responsive	☒ Safe	☐ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	7525vi		
Report Title	FREEDOM TO SPEAK UP REPORT OCTOBER 2025		
Report Author	Helen Young – Lead Freedom to Speak Up Guardian		
Purpose	The purpose of this report is to provide assurance regarding Freedom to Speak Up activity and learning during the reporting period 1 st April 2025 – 31 st August 2025.		

1. SCOPE

- 1.1 This Freedom to Speak Up (FTSU) Annual Report is a summary of the FTSU activity between 1st April 2025 and 31st August 2025, and FTSU activity since the Annual Report May 2025.
- 1.2 This report provides an overview of the actions taken to improve speaking up within the Trust, the number and themes of concerns raised, and the learning and recommendations derived from these activities.
- 1.3 The report also highlights the ongoing collaboration with regional peers and the National Guardians' Office (NGO), and the continuous efforts to monitor and address the concerns raised by staff. The report aims to provide assurance regarding the effectiveness of the FTSU process and its impact on fostering a culture of openness and transparency within the Trust.

2. INTRODUCTION

- 2.1 This Report provides an overview of the activity that took place between 1st April 2025 and 31st August 2025 across the Trust to deliver our commitment to Freedom to Speak Up. It will also include any actions that have been taken to improve speaking up, and an overview of the number and themes of concerns that have been raised and any learning and recommendations.
- 2.2 The FTSU Guardians will continue to collaborate with their peers across the region and at this time work with the National Guardians' Office (NGO) and will attend regional meetings and relevant seminars and conferences.
- 2.3 Speaking up activity, themes and trends of concerns raised to the FTSU Guardian/s will be reported bi-annually to Board and continued oversight from the named Executive Lead and named Non-Executive Lead.

3. ACTIVITY OVERVIEW

- 3.1 For this reporting period a total of 15 concerns were raised, compared to 11 concerns being raised in the same reporting period in 2024. This represents an increase of approximately 36%, and this upward trend may reflect increased confidence in the Freedom to Speak Up process or greater awareness across the Trust.
- 3.2 In accordance with NGO reporting guidance, each individual speaking up through this route should be counted as a separate case, even if they are speaking up about the same issue, together or separately. A total of 8 concerns were reported by individuals, and 7 concerns were brought forward collectively by teams.
- 3.3 It is important to take into account NGO reporting guidance to gain an accurate picture of the number of concerns being raised, to identify if there are causes for concern within the organisation. In total 7 teams came forward involving 56 members of staff and considering NGO reporting guidance this will equate to a total of 64 concerns being raised for this reporting period.
- 3.4 As a result of this reporting method, there appears to be a significant increase in reported concerns, however, this is attributable to teams' raising concerns during this period. While this could still be considered a cause for concern, the issues are a shared concern within each team. The Guardian will continue to monitor the situation to determine if it develops into a trend.
- 3.5 Staff can continue to raise concerns openly and in confidence and anonymously and have the option of using the online reporting form, Table 1.
- 3.6 Of the 15 concerns raised 2 of the concerns went straight to the grievance process but came in via the FTSU route and also involved Human Resources (HR).

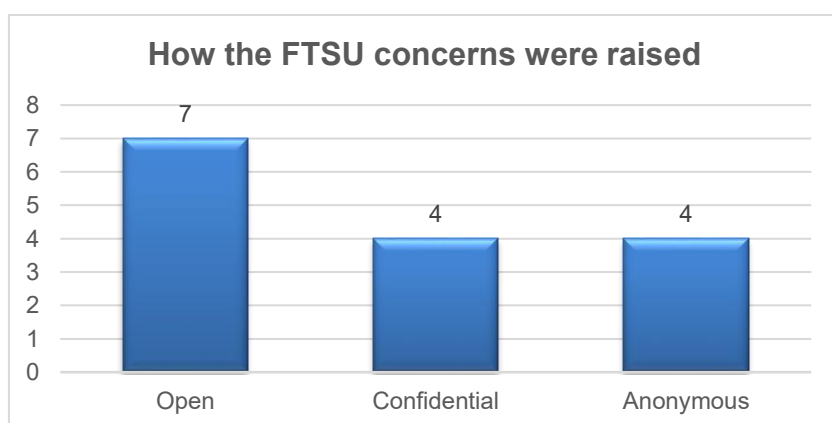


Table 1.

- 3.7 Of the concerns raised and for reporting purposes, concerns are categorized by themes, with each concern assigned to a specific category. For this period, system / process themes were raised the most, followed by behaviour / relationship themes, please see (Table 2). Staff safety and patient safety / quality were also raised during this period, and all concerns continue to be multi factorial in nature.



Table 2- concerns by theme.

Themes

Staff Safety: not being able to use the NHSP Bank and safe staffing levels.

Patient Safety / Quality: impact due to staff vacancies, long waiting lists and increased complexity of patients.

Systems / process: being told conflicting information. Plans put in place but changed and staff not informed / poor communication.

- 3.8 Staff have reported that they are reluctant to speak up as they fear the process is not confidential. For reporting purposes and to protect confidentiality only limited themed information will be shared within this report. To assure the Board all concerns that are raised are directed to the most appropriate lead within the organisation for timely action. The Guardian receives support from the Chief Nurse and Non-Executive Director (NED), who provide advice when necessary.
- 3.9 Table 3 highlights that more staff in Halton have reported concerns, reflecting multiple collective issues rather than increased individual problems. The Guardian will monitor this to determine if it is an early sign of a cause for concern.

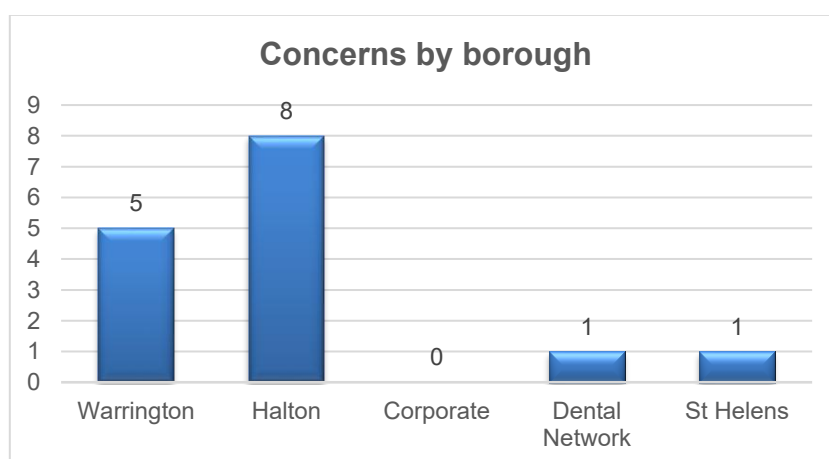


Table 3 – concerns by borough.

- 3.10 For this reporting period there has been an increase in the number of Allied Health Professionals (AHP) reporting concerns, which may also be due to more staff voicing concerns collectively. Registered Nurses however remain the professional group raising the most concerns (see Table 4), which could still be attributed to their workforce numbers.

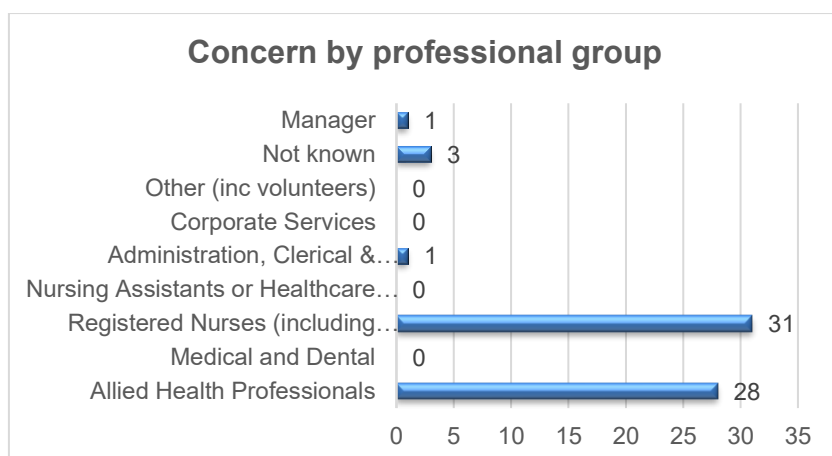


Table 4 – concern by professional group.

3.11 Learning: In response to multiple concerns raised within their borough, a senior lead has scheduled regular meetings with staff. These meetings are intended to address current issues and reduce the need for escalation by resolving matters promptly. Meeting with staff can also help ensure clear communication and minimize misunderstandings. Additionally, the manager will provide 'drop in' sessions to support early identification of concerns, especially in the use of Bank Staff and safe staffing levels.

4. FTSU INFORMATION

4.1 Staff Survey Results:

The 2024 NHS Staff Survey results were released on Thursday, 13th March 2025, and from a FTSU point of view the overall results were mixed. Question 20a showed a slight increase, while Questions 20b, 25e, and 25f showed a slight decrease (table 5).

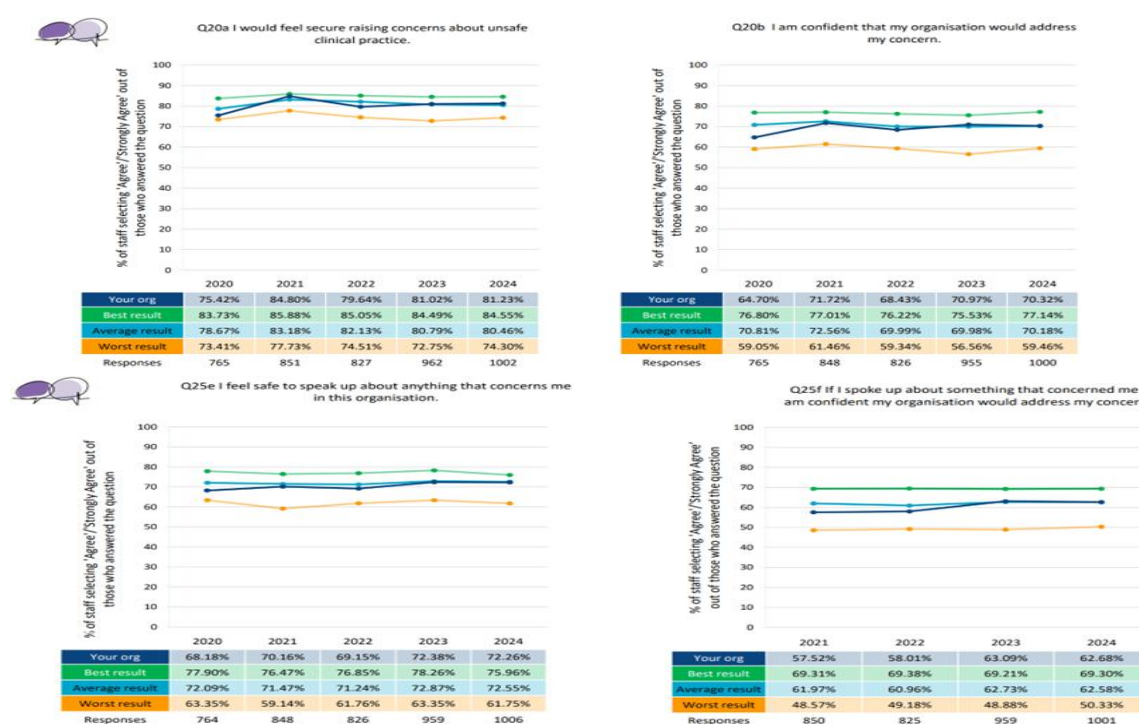


Table 5.

4.2 The Trust wide breakdown of the NHS Staff Survey indicates how each of the directorates look and there has been a mixed response. The directorates that scored red for 'we each have a voice that counts'.

- Corporate Estates – no change as 6.7 in 2023.
- Dental Cheshire & Merseyside – slight increase to 5.9 in 2024 but still red.
- Dental Greater Manchester NE – decrease from 7.1 to 6.5.
- Dental Greater Manchester W&S - decrease from 6.8 to 6.4.
- Warrington Adults – remains the same at 6.8.
- Halton Children – slight decrease from 7.1 to 7.

4.3 To gain deeper insight into staff perspectives and to identify barriers to speaking up, the Guardian has been attending team meetings and has been out and about talking with staff to gather information.

Key themes identified by staff include:

- What is the point of speaking up as nothing changes.
- Have spoken up in the past but not listened to / disregarded.
- Poor communication from leaders.
- Top down approach to decision making and don't discuss or include staff who actually do the role and could offer ideas and suggestions.
- Feeling undervalued.

4.4 The July 2025 National Quarterly Pulse Survey (NQPS) results which included questions about 'We each have a voice that counts' and speaking up, received 243 responses. Although this is a small proportion of total staff, the results provide useful insights into how staff are feeling.

4.5 The results indicated that staff have reported speaking up and would do so to their line manager. Some respondents who indicated they had spoken up also answered "yes" when asked whether there was a negative impact (see table 6), with some noting that speaking up resulted in negative consequences for them.

4.6 Survey results and staff feedback show that while staff do raise concerns, barriers like fear of being ignored or facing backlash remain. The Guardian partners with others to share these insights, enabling targeted interventions and supporting a culture where staff feel safe to speak up.

National Quarterly Pulse Survey (NQPS)

Results and Insights – Wave 64 (Quarter 2 – July 2025)

Flexible questions in the People Pulse change each month. They provide an opportunity to measure and understand topical areas of interest. The following results are for the latest flexible questions: **We each have a voice that counts.**

Those who responded 'Yes' were asked: If there was a negative impact, what was it? (35)

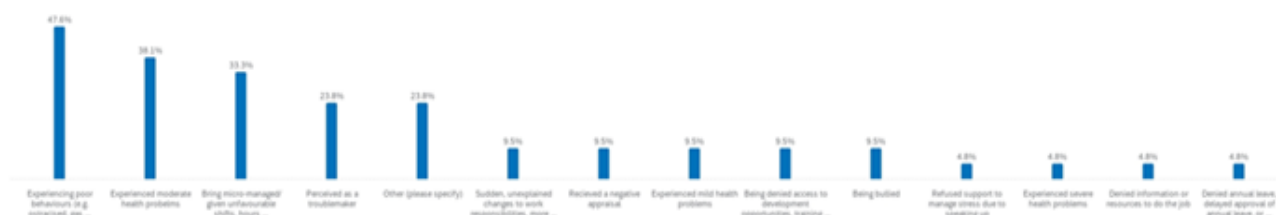


Table 6.

- 4.7 Barriers to speaking up continue to exist within the organisation. To identify these barriers and potential solutions, the Guardian has developed an 'Understanding Barriers to Speaking Up at Work' comments/suggestion form. Staff may complete the form anonymously to provide feedback to the Guardian. The form will be accessible on the FTSU webpage, and information about it will be included in the bulletin. Its launch coincides with the invitation to participate in 'The 2025 NHS Staff Survey: Your voice counts'.
- 4.8 We have seen an increase in the number of concerns being raised but the trends and themes are consistent with those seen in other NHS organisations, please see 5.5.
- 4.9 **FTSU Champions:** Champions work closely with the FTSU Guardians to help address barriers to speaking up and to promote the speaking up process and they will be provided with information and promotional material to support October FTSU week.
- 4.10 There are currently 18 champions, and the target remains at 50 champions in total. The aim is to recruit champions from staff within our network groups to ensure that marginalized staff have the support and confidence to speak up if needed. This will help ensure that everyone's voice counts and make speaking up a regular part of our culture and business as usual.
- 4.11 The recruitment of Champions is an ongoing process, and this process will be reassessed in 2026, once we are operating as a single organisation, to determine if any amendments are necessary.

5. NATIONAL GUARDIAN OFFICE UPDATE (NGO)

- 5.1 The NGO was set up in October 2016 as part of recommendations from the Francis Freedom to Speak Up Review (2015). The office leads, trains and supports a network of Freedom to Speak Up Guardians (FTSUG) in England and there are now 1,400 Freedom to Speak Up Guardians supporting thousands of organisations across the healthcare sector.
- 5.2 Following the publication of the 10 year plan and Patient Safety Landscape Review, the NGO's functions will be aligned with the other staff voice functions in National Health Service (NHS) England and the NGO will cease to exist and NHS England will take on the National Guardian's national functions.
- 5.3 On the 13th August 2025, NHS England wrote to Chief People Officers in organisations to take the opportunity to reaffirm the vital role that Freedom to Speak Up Guardians continue to play across the NHS. Guardians are instrumental in ensuring that staff voices are heard and that patients are protected from harm, and in supporting the development of safer, fairer, and more transparent healthcare systems. As outlined in the recommendations of the review, the functions of the NGO will be transferred to NHS England. Until such time, the NGO will remain the primary support and main point of contact for Guardians.
- 5.4 It was also confirmed that Freedom to Speak Up, and the role of Guardians, will be incorporated into the NHS Standard Contract for 2026/27 and it is envisaged that the NGO will cease to exist after the 31st March 2026.
- 5.5 **Speaking Up Annual Report August 2025:** The NGO published the latest annual speaking up data report, which summarised the themes and learning from the speaking up data shared by FTSUG from 1 April 2024 – 31 March 2025, (Please see appendix 1).

Key findings:

- 2024/25 saw the highest number of cases reported to guardians since the programme began.
 - Workers continue to express positive views about the FTSUG role.
 - Inappropriate attitudes and behaviours remain the most common theme of concern.
 - Concerns related to worker safety and wellbeing are increasing.
 - Confidence in organisations to address concerns is in decline.
 - NHS trusts are showing a positive shift, with more full-time guardians being appointed.
- 5.6 **October FTSU Month:** Following feedback from Guardians, this year's FTSU month will be condensed into a week-long event, taking place during the week commencing 13th October 2025.
- 5.7 The theme this year is 'Follow Up in action' and key messages:

I'm Following Up: How we must all take personal responsibility, by acting on what we've heard. Building on the psychologically safe culture we've created means workers can see their voices translated into meaningful change.

Follow Up: Managers can turn listening into lasting change. There is power when managers act on concerns raised to drive continuous improvement. Last year we listened up – now is the time to follow up and act. Following up on what we hear creates the improvements workers need and deserve.

Follow up with workers who don't speak up: Be aware of seldom heard from workers, those who face barriers to speaking up. Follow up actively with groups of workers who face barriers to speaking up. Show them that when they raise concerns, you'll take action.

- 5.8 The FTSU Champions have all been informed and they will be supplied with promotional material to promote the week. Information will go out in the bulletin to inform staff and to promote 'Wear Green Wednesday' during October 2025.

6. RECOMMENDATION

- 6.1 The Board are asked to note the contents of this report as assurance of the work undertaken within the Trust to ensure inclusive and consistent speaking up arrangements are in place that will drive learning through listening to our staff.

Appendix 1

Speaking Up Annual Report August 2025.

Culture is a patient safety issue

A SUMMARY OF SPEAKING UP TO FREEDOM TO SPEAK UP GUARDIANS

01 April 2024 – 31 March 2025



National Guardian

Freedom to Speak Up

August 2025

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Introduction

About the National Guardian's Office

The National Guardian's Office leads, trains, and supports a national network of Freedom to Speak Up guardians, who play a pivotal role in fostering a culture of openness and transparency across the healthcare system in England.

The National Guardian's Office delivers significant impact through four core functions:

- Leadership and support: Providing expert guidance and continuous support to Freedom to Speak Up guardians.
- Training and development: Offering learning opportunities to strengthen speaking up practices.
- System learning and challenge: Sharing insights and offering constructive challenge to promote improvement.
- Independent Speak Up reviews: Conducting reviews where barriers to speaking up exist, with the aim of identifying learning, recognising innovation and supporting improvement.

The National Guardian's Office champions a culture where every voice matters and is guided by its mission "to work in partnership to make speaking up business as usual across the health and care sector in England".

This year's data report includes a selection of performance highlights from the National Guardian's Office (see 'Performance highlights from the National Guardian's Office' section in this document), reflecting its ongoing work to support guardians, deliver training, and share learning across the system. These achievements demonstrate the continued commitment to ensuring that speaking up is encouraged, supported, and acted upon.

The role of Freedom to Speak Up guardians

The Freedom to Speak Up guardians provide a vital, trusted channel for raising concerns that might otherwise go unheard. Freedom to Speak Up guardians help to ensure issues are addressed constructively. Guardians support organisations in building cultures of openness, learning, and continuous improvement. Listening to worker's voice is essential for delivering safe, effective and compassionate care.

Guardians are required to report non-identifiable information about the cases they receive - both locally to their boards and senior leadership, and nationally to the National Guardian's Office. This data is essential for understanding the impact of the guardian role and identifying trends across the system.

This report summarises the data shared by Freedom to Speak Up guardians between 1 April 2024 and 31 March 2025, offering valuable insights into the speaking up landscape across health and care.

Using data to drive cultural change

The National Guardian's Office shares this data with NHS England, where it is incorporated into the [Model Health System](#). This integration enables healthcare leaders to compare speaking up data with other organisational metrics, helping inform reflections on workplace culture and improvement planning.

Joint guidance from the National Guardian's Office and NHS England on [Freedom to Speak Up](#) provides practical suggestions for using this data to support meaningful conversations and drive change. While numbers tell part of the story, behind each case is the human experience of workers who are striving to do their best for patients, colleagues, and the system.

Executive summary

Purpose

This report examines all speaking up cases brought to Freedom to Speak Up guardians throughout 2024/25. Its aim is to provide insights into the speaking up landscape and culture across organisations, highlighting key trends, challenges, and areas for improvement.

Key findings

- 2024/25 saw the highest number of cases reported to guardians since the programme began.
- Workers continue to express positive views about the Freedom to Speak Up Guardian role
- Inappropriate attitudes and behaviours remain the most common theme of concern.
- Concerns related to worker safety and wellbeing are increasing.
- Confidence in organisations to address concerns is in decline.
- NHS trusts are showing a positive shift, with more full-time guardians being appointed.

Challenges

- Fear of detriment or a belief that speaking up will not make a difference remains a key barrier of speaking up.
- Prolonged investigations and rigid human resource processes contribute to anxiety and negatively impact the wellbeing of those raising concerns.
- A lack of outcomes, delayed feedback, and breakdowns in communication weaken trust between workers and organisations.
- A perceived lack of compassionate responses from line managers and senior leaders when concerns are raised reinforces the belief that “nothing will change”.

Call to Action

Creating a culture where speaking up is a routine part of organisational life requires deliberate and timely action. While the data highlights meaningful progress, it also reveals ongoing challenges that call for unified leadership and a strong, system-wide commitment.

For senior leaders:

- Champion psychological safety by modelling openness, transparency, and responsiveness.
- Invest in full-time guardian roles, in line with recruitment framework recommendation.
- Act on feedback by closing the loop with workers and demonstrating visible change.

For line managers:

- Prioritise compassionate leadership by developing the skills to listen, support, and act.
- Create safe spaces for informal resolution and early intervention.
- Engage in training to understand your role in fostering a culture of trust.

For organisations:

- Embed speaking up into strategy priorities, aligning it with patient safety, workforce wellbeing, and quality improvement.
- Strengthen data use to inform proactive interventions.
- Ensure accountability by monitoring resolution rates and follow through on concerns.

Performance highlights from the National Guardian's Office

The following information provides an overview of key performance highlights and activities undertaken by the National Guardian's Office between 1 April 2024 – 31 March 2025.

Operational



- A total of 1,378 guardians were actively serving in various organisations.
- 497 new guardians were successfully onboarded.
- 246 guardians stepped down from their roles during the year.
- 792 organisations were registered with the National Guardian's Office.

Training and development

- 287 mentor conversations were facilitated to support peer learning and development.
- 497 guardians completed their year one foundation training, ensuring a strong start in their roles.
- 932 refresher training sessions were undertaken by guardians with over two years of experience, reinforcing continued professional development.

Feedback and learning

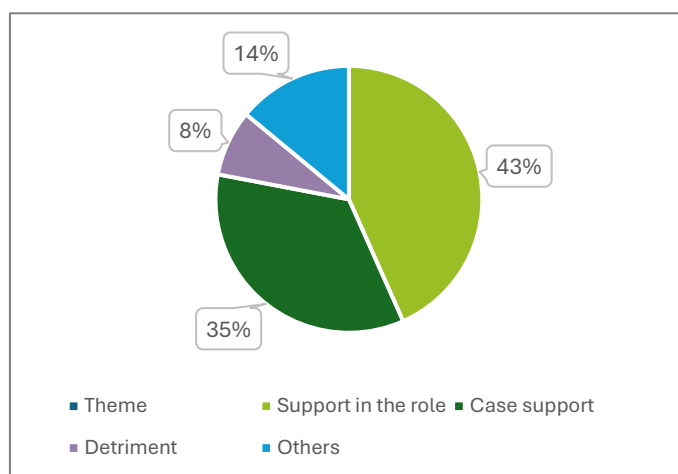
- 89.5% of Freedom to Speak Up guardians reported that the e-learning effectively met its stated aims and objectives.
- 86% of participants expressed satisfaction with the quality of course materials and resources provided.
- On average, 88.4% of responses indicated that the e-learning content supported meaningful reflection, learning, and professional stimulation.

Support calls

The Freedom to Speak Up Guardian Support and Policy Team handled a total of 150 support calls.

- 43% of support calls were from guardians seeking support in the guardian role – with themes including lack of organisational leadership support and lack of ringfenced time or resource.
- 35% of support calls related to support with specific cases being managed by guardians.
- 8% of support calls were associated with concerns involving detriment.

The remaining 14% of support calls addressed a range of other support needs, such as clarity on the guardian role, data, and wellbeing.



Enquiries

Emails

During the 2024/25 financial year, the Enquiry Team handled a total of 3,692 enquiries, representing a 6.5% decrease compared to the previous year.



- 81.1% of these enquiries were received via email.
- 56% originated from Freedom to Speak Up guardians seeking guidance and support.
- 14.9% were related to training requests submitted to the office.

Sector engagement

- A significant proportion of enquiries came from NHS Trusts, accounting for 40.1% of the total volume.
- The Social Care sector saw the most notable growth, with a 73.3% increase in enquiries compared to 2023/24.
- The Primary Care sector followed closely, with a 71.8% increase in enquiry volume.



Service responsiveness

The Enquiry team maintained strong operational performance throughout the year, with over half of all enquiries resolved on the same day they were received. Overall, 92% of enquiries were successfully resolved, reflecting the team's ongoing commitment to delivering timely, effective, and high-quality support.

Growing visibility and engagement



In 2024/25, the National Guardian's Office Communications Team delivered a wide range of activities to enhance visibility and engagement across all platforms.

By the end of the financial year, the National Guardian's Office's LinkedIn following had grown to 2,348, marking a 34.3% increase compared to the previous year.

Engagement with the Freedom to Speak Up bulletin also improved, with an open rate of 58.6%, up 1.1 percentage points from the previous year.

There were 45 network meetings and eight board development sessions.

These results reflect the team's continued efforts to strengthen awareness, foster community, and amplify the voice of the Freedom to Speak Up movement.

Digital reach and engagement

In 2024/25, the National Guardian's Office continued to grow its digital presence and foster meaningful engagement through a variety of platforms and events:

- The National Guardian's Office website received 545,532 visits, reflecting sustained interest in resources and guidance.
- The YouTube channel recorded 25,271 views, a 12.5% increase compared to the previous year.
- The office hosted six webinars on key topics including:
 - Equality, Diversity, Inclusion & Belonging Module



- Detriment Guidance
- Protected Disclosures

These sessions attracted a total of 967 attendees, with an average of 161 participants per session.

Key publications

The National Guardian's Office published resources designed to provide practical guidance, challenge the status quo, and promote environments that are open, inclusive, and free from fear.

Key publications were:

- **Non-Executive Director (NED) information video**

This video was developed to help Freedom to Speak Up Non-Executive Directors and Trustees understand their role and remit, and how to develop positive working relationships with their Freedom to Speak Up guardians. This was welcomed by guardians and Non-Executives/Trustees, and positive feedback was received. (Please see the full video [here](#))

"This is really good and a BIG WELL DONE This really resonates and will be incredibly helpful to so many Freedom to Speak Up guardians and non-executive directors!"

"It's brilliant! This film is going to make such a difference to guardians and non-executive directors."

- Guardian feedback

- **Equity Diversity Inclusion and Belonging - Guardian refresher training**

Aimed at reinforcing inclusive practices and supporting guardians in creating psychologically safe spaces.

- **Employment Tribunal fact sheet**

A practical guide to help guardians understand their role as a guardian in employment tribunal processes. (Please see the full guidance [here](#))

"I think that it is extremely helpful and not too high level at all. I think it really gives a clear picture of our role as a Guardian in the process and so glad I have this now so I know how best to proceed and what to do next time from the offset."

- Guardian feedback

- **Detriment Guidance**

A resource to help guardians and organisations identify, prevent, and respond to detriment experienced by individuals who speak up. (Please see the full guidance [here](#))

"I just wanted to say thank you for the Detriment Guidance. As the FTSUG, I have been developing a presentation and a SOP on detriment. This work was very welcome and came at a pivotal time, to align the work and ensure best practise. I particularly found the responding to detriment and the checklist, which helps to simplify, useful."

- Guardian feedback

- **Guardian handbook**

A comprehensive reference tool for guardians at all stages of their journey. (Please see the full guidance [here](#))

- **Speaking up in healthcare: has progress plateaued – and what must be done?**
A thought-provoking publication exploring the current state of speaking up culture and the actions needed to drive further progress. (Please see full report [here](#))

During 2024/25, the National Guardian's Office worked on two significant projects, which were published in April 2025:

- **Listening and learning: Amplifying the voices of overseas-trained workers, a review of the speaking up experiences of overseas-trained workers in England.**
The review aimed to explore the barriers faced by the overseas-trained workers in speaking up, identify good practices, and recommend improvements. It found that, beyond general workplace challenges, overseas-trained workers face unique challenges that prevent them speaking up about patient safety. Four key themes were identified:
 - The transition challenges of settling into the UK.
 - The influence of national culture and societal norms on speaking up perceptions and behaviours.
 - The enablers and barriers of speaking up.
 - The speaking up arrangements and support.
 Based on these themes, four key recommendations were made, including the need for cultural intelligence for NHS leaders, managers and staff. Notably, one recommendation - "Review and enhancement of the international recruitment guide" has been successfully actioned by NHS employers. A recommendation steering group has been established to oversee progress, and the review team has engaged with various stakeholder groups and senior boards, including the National Quality Board. The implementing these recommendations will help ensure that every NHS worker, regardless of where they trained, feels confident to speak up about safety concerns in the workplace. (Please see full report [here](#))
- **Requirements for recruiting and embedding Freedom to Speak Up guardians – a framework for organisations and leaders**
A framework to support leaders, organisations, and guardians alike, to clarify expectations, standardise recruitment, and ensure the role is understood, supported, and effective within organisations. (Please see full report [here](#))

Data transformation

The National Guardian's Office also undertook a significant data system transformation, integrating multiple data points into a single, unified platform. This marks an important step toward enabling more effective analysis, generating deeper insights, and providing stronger support for the Freedom to Speak Up network. It also reflects a broader ambition to develop into a data-intelligent organisation, one that uses information strategically to drive improvement and impact.

Data submission 2024/25 summary



Total cases

38,158 cases were raised with Freedom to Speak Up guardians in 2024/25.

The highest number of cases recorded. A 18.6% increase from 2023/24.

Patient safety and quality

Concerns related to patient safety or quality comprised 17.8% of cases in 2024/25, a further decreasing from 18.7% in 2022/23 and sustaining a downward trajectory



Bullying and harassment

Bullying or harassment was a factor in 18.4% of cases, representing a 1.5% drop compared to 2023/24 and marking a continued decline since 2022/23



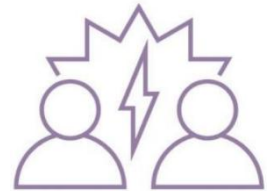
Worker safety and wellbeing

Concerns related to worker safety or wellbeing rose by a significant 36.2% to 14,171 cases, representing 38.9% of all cases raised.



Inappropriate behaviours

Inappropriate behaviours and attitudes were the most commonly reported issue for the second consecutive year, featuring in 39.7% of all cases



Anonymous cases

The proportion of cases raised anonymously rose to 11.6%, up from 9.5% in 2023/24, a 44.9% increase in volume from 2023/24, the largest percentage change across all themes



Detriment

Only 2.9% of cases in 2024/25 indicated detriment for speaking up, a 1.1% decrease from 4% in 2022/23



Feedback

9,369 pieces of feedback received in total, 79.9% of the workers who spoke up would speak up again



Professional groups

Workers from a range of professional groups spoke up to Freedom to Speak Up guardians. Registered nurses and midwives accounted for the biggest portion (28.3%) of cases raised, followed by the administrative and clerical workers with 21% of the cases raised.



Total cases received over time¹

Freedom to Speak Up guardians received 38,158 cases in 2024/25, reflecting an 18.6% increase from the 32,167 cases reported in 2023/24. (see chart 1)

Since the programme’s launch in 2016, a total of 171,723 cases have been reported, demonstrating a continued upward trend in speaking up activity across the healthcare sector.

Quarter 3 (October to December) has consistently recorded the highest number of cases each year since 2018/19. This recurring peak is likely influenced by increased awareness generated during Speak Up Month in October. In 2024/25, this pattern persisted, with quarter 3 reaching a record high of 10,010 cases, the largest number reported in a single quarter since data collection began in 2016/17.

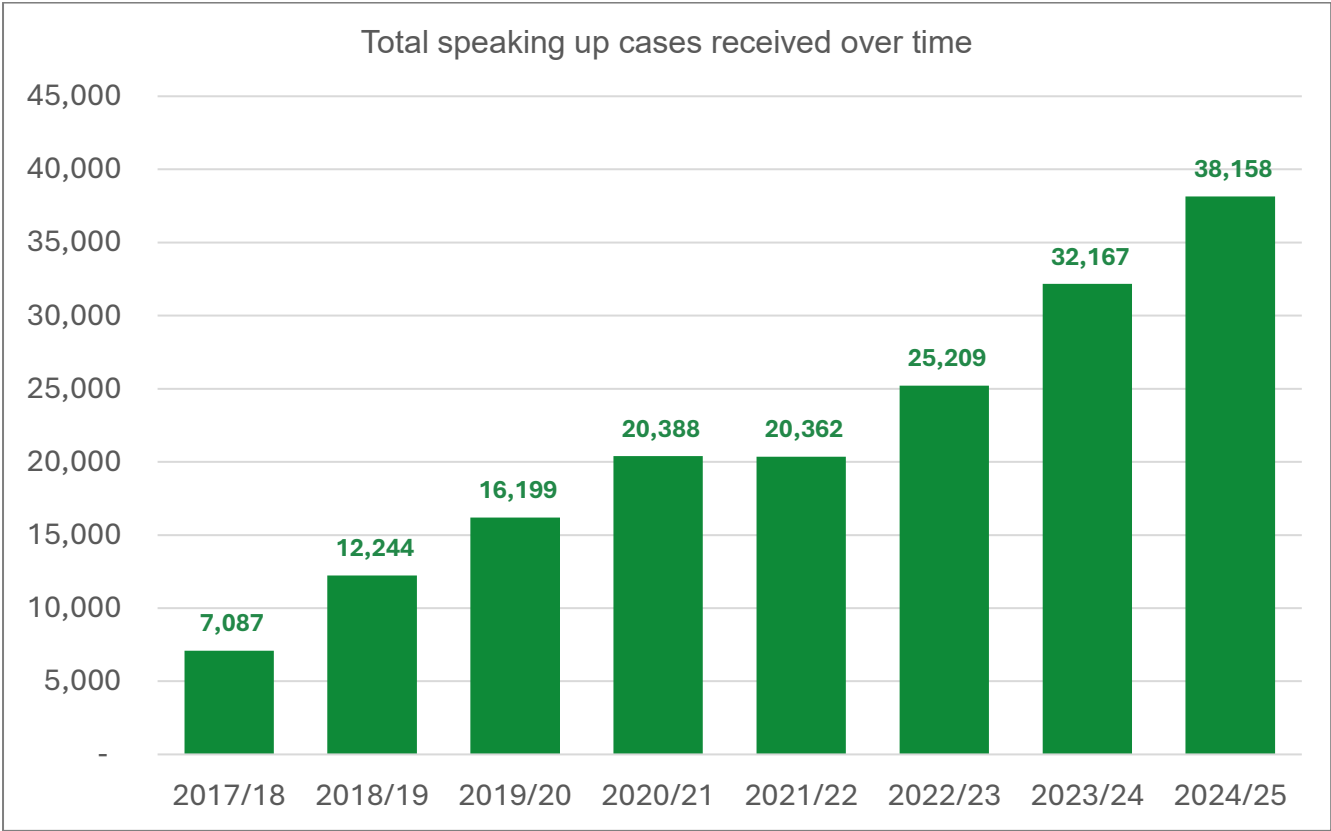


Chart 1. Total cases raised with Freedom to Speak Up guardians

¹ The yearly quarter data submissions can be found on the National Guardian’s Office website – [here](#).

What has changed?

Overall

In 2024/25, the number of cases received by guardians reached the highest level since the programme's inception. (see chart 2)

NHS trusts continued to submit the majority of data, reflecting the earlier establishment and deeper integration of the guardian role within these organisations. However, their share of total cases declined by 2% compared to the previous year.

In contrast, other sectors experienced a modest increase in their share of cases, though the growth remained below 1%.

Organisation Type	24/25	23/24	Change from last FY
Arm's length body (ALB)	1.2%	1.1%	0.1%
Hospice	0.6%	0.6%	-
Integrated care board (inc. Integrated care systems)	1.7%	0.9%	0.8%
Independent	5.6%	5.5%	0.1%
NHS trust	88.8%	90.8%	-2.0%
Primary care	1.1%	0.8%	0.3%
Professional body	0.3%	0.0%	0.3%
Social care	0.1%	0.1%	-
Other	0.5%	0.3%	0.2%

Chart 2: proportion of the cases received by guardian breakdown by organisation types

Organisational participation² in quarterly data submissions declined overall in 2024/25.

NHS trusts experienced the largest drop, with a 4.5% decrease compared to the previous year. Conversely, the primary care sector recorded the highest increase in participation, rising by 3.9%.

Uptake of the guardian role declined in several sectors in 2024/25. (see chart 3)

Arm's length bodies and independent providers experienced a decline in the number of active guardians in 2024/25. In contrast, other organisation types showed modest growth, with primary care demonstrating the most notable increase at 4.4%. NHS trusts recorded the most significant decrease, with a 5.5% drop in active guardians. However, this reduction may reflect a positive development, as more trusts are now appointing full-time guardians. This shift suggests a move away from viewing the guardian role as an add on function to substantive roles, toward recognising it as a core component of organisational culture and staff support.

² Participation meaning organisation have submitted at least quarterly data submission. An organisation could submit all 4 quarters.

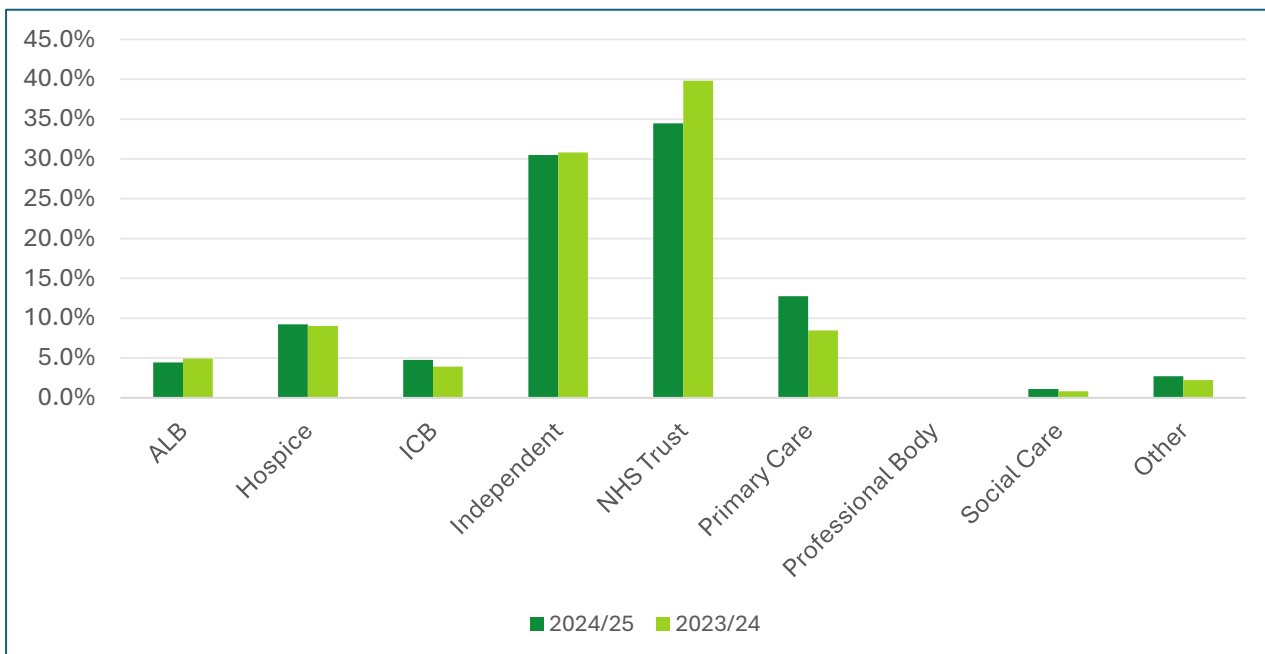


Chart 3: proportion of the active guardian breakdown by organisation types

Workers raise a wide range of concerns with Freedom to Speak Up guardians, grouped into four categories: patient safety/quality, worker safety or wellbeing, inappropriate attitudes and behaviours, and bullying or harassment.

In 2024/25, the most frequently reported concerns related to inappropriate attitudes or behaviours (39.7% or 15,130 cases), followed closely by worker safety or wellbeing (37.2%, or 14,171 cases). This pattern has remained consistent over the past three years.

Both NHS trusts and non-trusts organisations reflected the same trend as the overall, however, in non-trust organisations the proportion of cases concerning worker safety or wellbeing (34.6%, 1,297 cases) was nearly equal to those related to inappropriate attitudes or behaviours (35.4%, 1,330 cases) in 2024/25.

Speaking up confidently is one of the key measures of speaking up culture in an organisation, and workers may choose to speak up anonymously because they are concerned about detriment for speaking up.

Following a period of decline in previous years at overall level, the proportion of anonymous cases increased in 2024/25, rising to 11.6% overall.

The most significant increases were observed in ambulance trusts, where anonymous cases rose from 10.0% to 18.6%, and in Integrated care boards (including Integrated care systems) organisations, which saw an increase from 11.9% to 25.0%. While most sectors experienced an upward trend in anonymous reporting, the hospice sector was the only one to report a decline, with a 5.2% decrease from 28.6% in 2023/24.

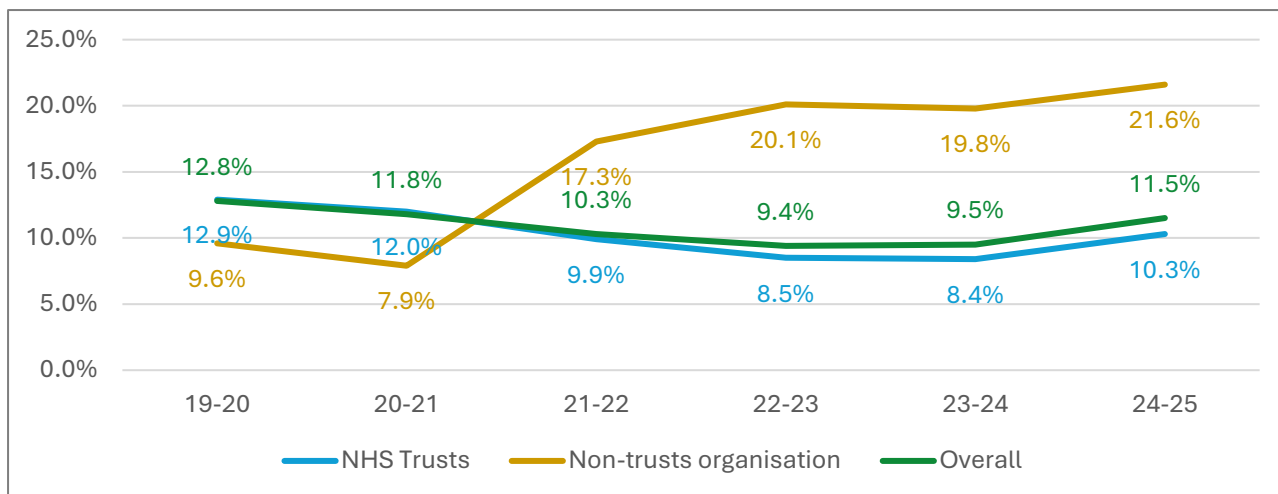


Chart 4: % of Anonymous cases over time by organisation types

Concerns about detriment continue to shape the speaking up experience, with contrasting trends between NHS trusts and non-trust organisations. (see chart 5)

In 2024/25, NHS trusts showed a slight improvement in this area, suggesting a more supportive speaking up culture. However, the picture was more concerning in non-trust organisations, where the proportion of cases involving reported detriment rose to 4.6%, the second highest on record (just below the 4.7% peak in 2021/22).

The most significant increase was observed in Integrated Care Boards (including Integrated Care Systems), where detriment cases surged from 4.2% in 2023/24 to 13.4% in 2024/25. This sharp rise may also help explain the corresponding increase in anonymous reporting within this group.

In contrast, Ambulance Trusts reported a substantial improvement, with detriment cases falling from 15.2% to 3.2%.

While a reduction in detriment cases is typically seen as a positive indicator of a healthy speaking up culture, the continued rise in anonymous reporting across sectors suggests that some workers may still lack confidence in the system, highlighting the need for ongoing efforts to build trust and psychological safety.

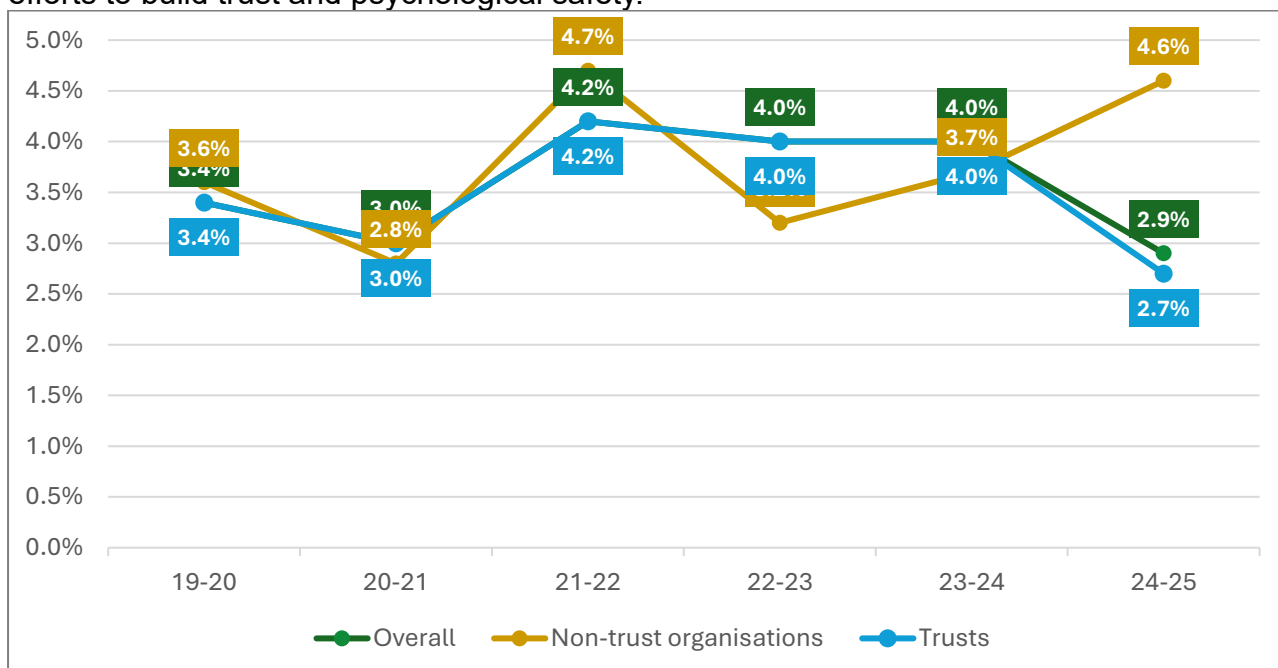


Chart 5: % of detriment cases received over time by organisation type

Professional group representation in speaking up cases remained broadly aligned with workforce composition in 2024/25. (see chart 6)

Registered nurses and Midwives accounted for 28.3% of speaking up cases, closely aligning with their 28.4% share of the NHS workforce as of March 2025, maintaining their position as the most represented professional group in speaking up activity.

The Additional Clinical Services group, which had previously raised concerns about underrepresentation, accounted for 11% of cases (4,202), a figure more proportionate to their current 16.1% workforce share, partly due to a reduction in headcount.

In contrast, Medical and Dental professionals remain underrepresented, contributing only 6.4% of cases despite comprising 10.3% of the workforce. While larger workforce groups such as registered nurses and midwives, administrative and clerical staff saw slight declines in speaking up activity. Smaller professional groups like estates and ancillary, medical and dental and additional professional scientific and technical demonstrated modest but positive increases. This indicates gradual progress in inclusivity and engagement across the wider workforce.

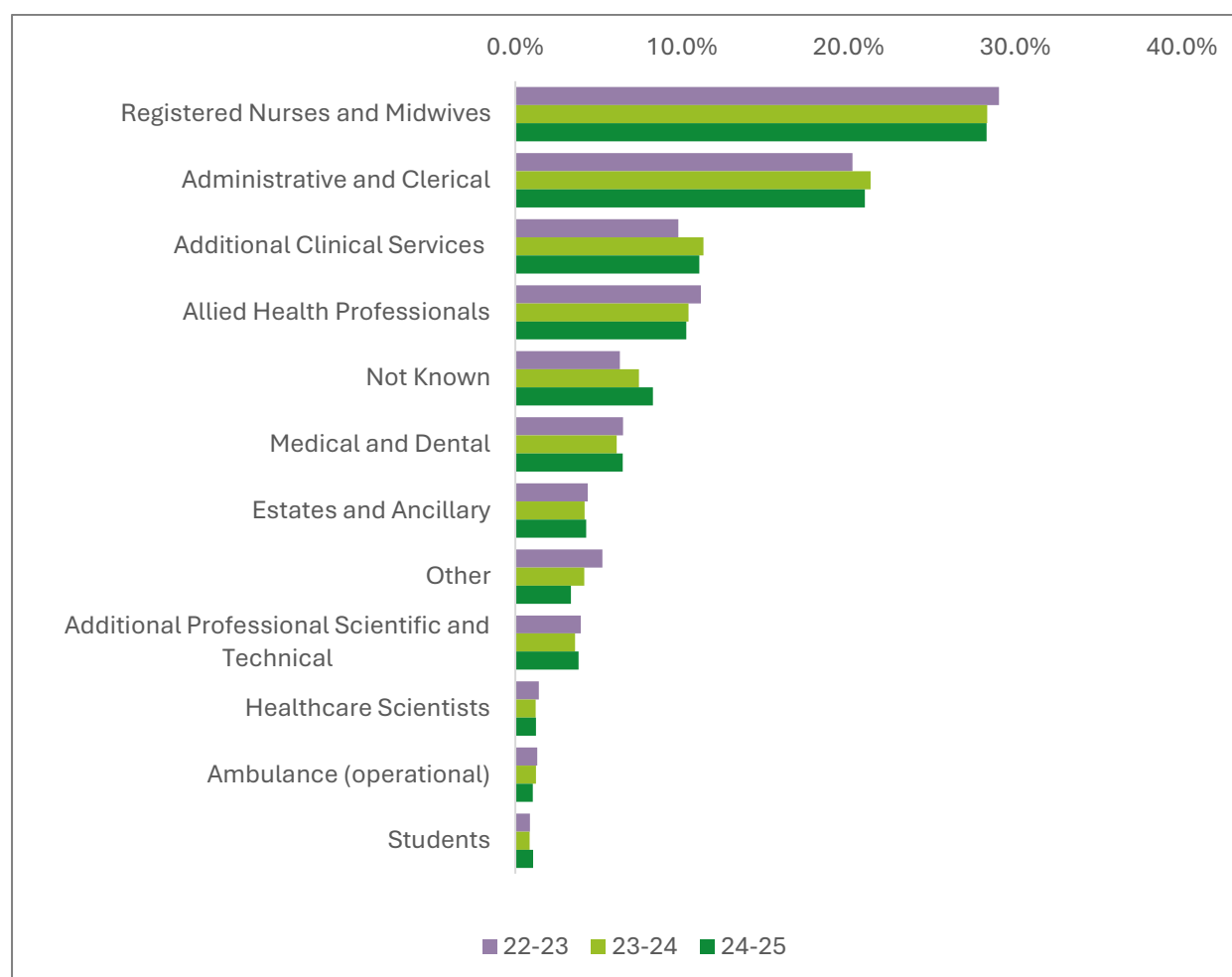


Chart 6: % of cases raised by professional or workers over time

NHS trusts

Within NHS trusts, Acute and Acute & Community Trusts consistently reported the highest number of cases.

In 2024/25, this trend continued, with one trust reporting a record 190 cases. The average

number of cases per trust in this group was 45.9, highlighting their central role in the Freedom to Speak Up landscape.

Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts remained the second-highest reporting group.

Despite dips in 2020/21 and 2021/22, one trust in this category reported 168 cases in 2024/25, with an average of 40.3 cases per submission³.

All NHS trust types reported an increase in average cases per submission in 2024/25, indicating a broadly positive trajectory in speaking up activity across the trust landscape. (see chart 7)

While the maximum number of cases reported in a single submission declined in both Acute and Acute & Community Trusts and Acute Specialist Trusts, the average number of cases per submission reached their highest levels to date. Acute Specialist Trusts reported an average of 21.1 cases per submission, while Ambulance Trusts averaged 42.7 cases, reflecting continued growth in speaking up activity within these sectors.

Community Trusts showed the most significant increase in average cases per submission across all three categories (21.2 in 24/25 and 18.3 in 2023/24).

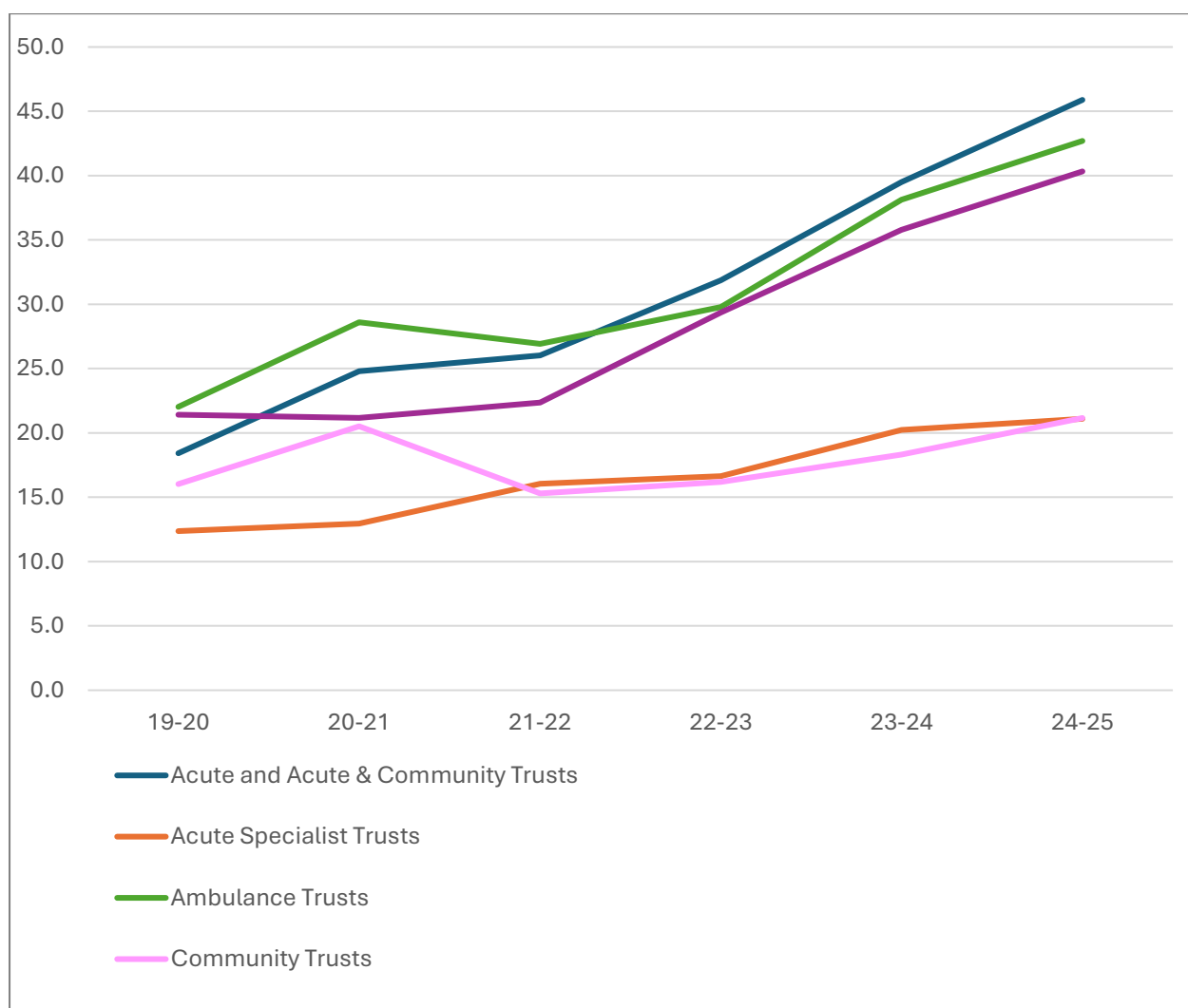


Chart 7: Average cases received per submission overtime breakdown by the type of trusts

³ A submission is a quarterly submission by an organisation; this is not an average for the whole year. We have used this approach due to organisations not submitting in every quarter.

Other organisations

Participation rates in non-trust sectors have steadily improved over time. (see chart 8)

In 2024/25, a total of 512 organisations submitted data for at least one quarter, resulting in a 66% participation rate. While this marks continued progress, it remains some distance behind the NHS trust sector, which has maintained a 100% participation rate for the past two years.

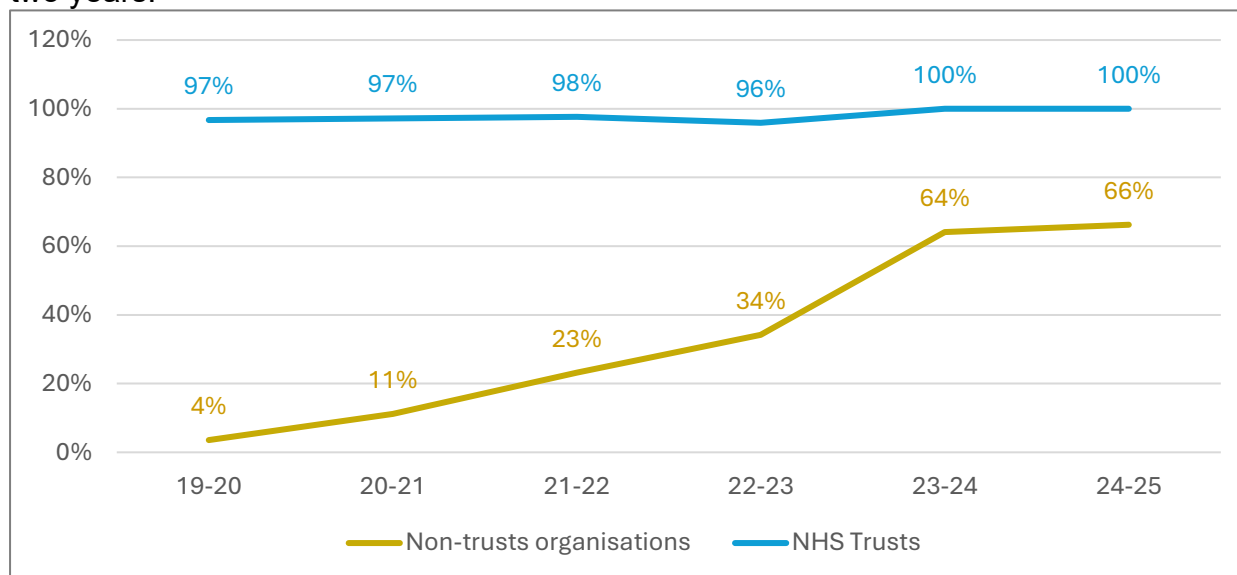


Chart 8: % of trusts and non-trusts participation in data submission over time

There was a notable increase in cases reported by organisations outside the NHS trust sector in 2024/25.

These organisations accounted for 11.4% of all cases, equivalent to 4,348 cases, compared to 9.2% (2,963 cases) in the previous year. Most non-trust organisation types experienced a general rise in the number of cases received by the guardians.

The most significant increase was observed in the Professional Body category, which rose from just one case in 2023/24 to 119 cases in 2024/25. However, this sharp increase appears to reflect an unusually low figure in 2023/24, as the 2024/25 total aligns more closely with figures reported in earlier years.

Independent providers⁴ accounted for the largest proportion of cases reported to Freedom to Speak Up guardians among non-trust organisations.

Nearly half of all cases from non-trust sectors originated from this group. However, despite their high overall contribution, independent providers were the only organisation type to experience a decline in the number of cases, falling from 126 in 2023/24 to 84 in 2024/25.

Most organisation categories outside NHS trusts showed either positive or stable trends in the number of cases received and average cases per submission in 2024/25. (see chart 9)

The exception to this was the social care category, which recorded a notable decline in both areas.

The total number of cases dropped by 6.4% compared to the previous year, while the average number of cases per submission fell by 36.8%, indicating a significant downturn in speaking up activity within this sector.

⁴ Independent providers cases numbers will be the combined number from all guardians and hospitals they have across the country, such as Spire, Nuffield, etc.

Organisation type	Total cases submitted (2024/25)	Average cases per submission (2024/25)
Arm's Length Body	557	15.9
Hospice	244	1.0
Integrated Care Board (inc. Integrated care systems)	665	4.6
Independent	2,114	3.9
Other	172	1.9
Primary Care	433	1.0
Professional Body	119	17.0
Social Care	44	1.3

Chart 9: Average number of cases per submission for non-trusts organisations

Zero submissions remain rare among NHS trusts but are more prevalent in non-trust organisations.

The Primary Care sector recorded the highest number of zero submissions in 2024/25, with 353 instances. This corresponds to 140 unique organisations submitting no data during at least one quarter of the year representing 90.3% of all organisations in this category that submitted quarterly data.

The Integrated Care Board (including Integrated Care Systems) category reported the lowest proportion of zero submissions among non-trust organisations. However, even in this group, 40.5% of organisations that submitted at least one quarter of data had at least one zero submission.

NHS staff survey 2024

Freedom to Speak Up Index shows continued decline in staff confidence. (see chart 10.1 & 10.2)

The Freedom to Speak Up Index, based on four NHS Staff Survey questions regarding raising concerns and organisational response, has continued its downward trend across both categories.

While quarterly data submissions show an increase in speaking up activity via the Freedom to Speak Up Guardian route within NHS trusts, the NHS staff survey results paint a contrasting picture, with workers feeling less encouraged to raise concerns and expressing declining confidence that their organisations will act on them.

Although some trust types reported minor improvements, these were not significant enough to reverse the overall decline. This growing disconnect between reported activity and staff sentiment highlights the need for targeted cultural and leadership interventions to rebuild trust and foster a more supportive speaking up environment.

Workers raising concern survey questions:

- I would feel secure raising concerns about unsafe clinical practice.
- I feel safe to speak up about anything that concerns me in this organisation.

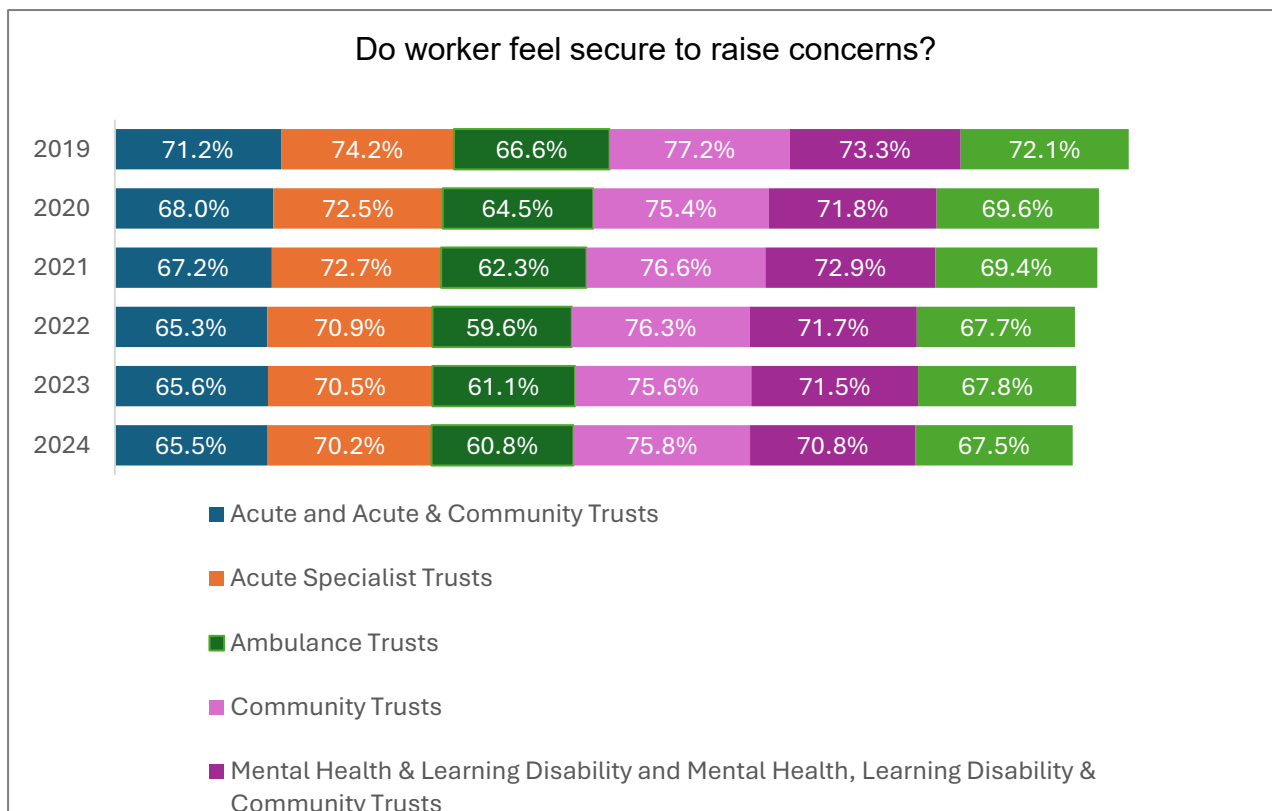


Chart 10.1: speaking up results in NHS staff survey over time – workers raising concerns

Will organisations address concerns raised survey questions:

- I am confident that my organisation would address my concern
- If I spoke up about something that concerned me I am confident my organisation would address my concerns

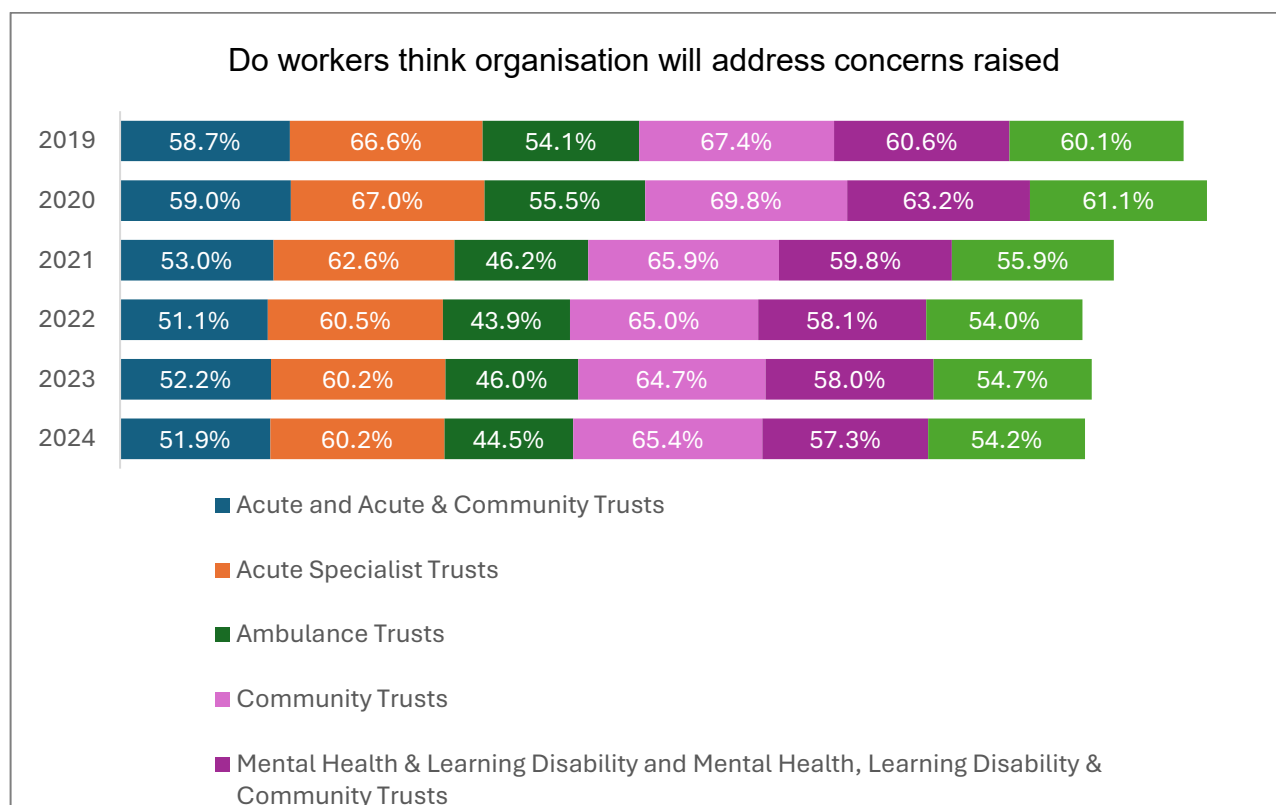


Chart 10.2: speaking up results in NHS staff survey over time – will organisation address my concerns?

Feedback

Feedback is a vital part of the speaking up process. Gathering feedback from workers about their speaking up experience helps organisations understand what is working well and where improvements are needed. These insights can then be used to drive learning, enhance the speaking up culture, and strengthen organisational responses to concerns.

‘Given your experience, would you speak up again?’ (see chart 11.1 & 11.2)

Nearly 80% of workers responded ‘Yes’ in 2024/25 for this question. While this remains a strong majority, it marks the lowest percentage in the ‘Yes’ category since 2019/20, continuing a gradual downward trend. Notably, 2024/25 also saw the highest number of feedback responses to date, with 9,432 feedback responses received, indicating growing engagement with the feedback process despite declining confidence.

Shifts were also observed in other response categories. The proportion of respondents selecting ‘Maybe’ declined slightly from 9% in 2023/24 to 8% in 2024/25. In contrast, those answering ‘I don’t know’ increased from 8% to 9% over the same period. These subtle changes suggest a need for continued focus on building trust and clarity around the speaking up process and its outcomes.

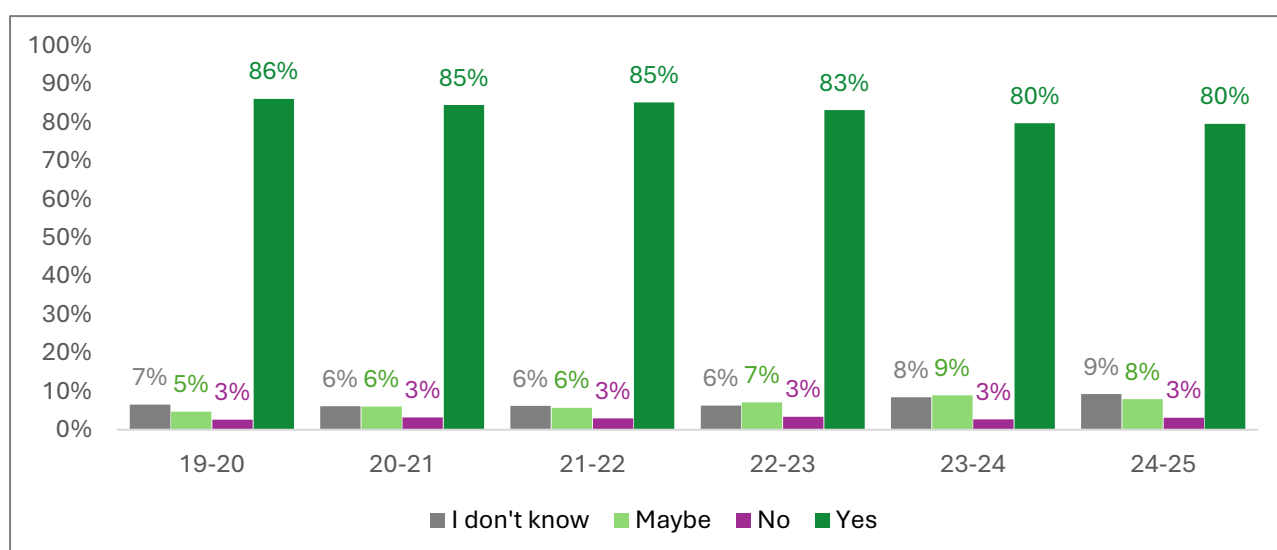


Chart 11.1: After the speaking up experience, % workers would speak up again on ‘Yes’, ‘No’, or ‘Maybe’

Year	I don't know	Maybe	No	Yes	Total
19-20	289	207	114	3,801	4,411
20-21	377	372	199	5,190	6,138
21-22	366	337	173	5,063	5,939
22-23	453	512	244	5,995	7,204
23-24	717	759	231	6,734	8,441
24-25	873	752	293	7,514	9,432

Chart 11.2: Number of feedback received per each financial year on each category on question – “Given your experience, would you speak up again?”

Overwhelmingly positive, consistent with previous years.

This year's feedback from workers about their experience with the Freedom to Speak Up Guardian provision remained overwhelmingly positive, consistent with previous years.

The unique characteristics of the guardian role, such as the ability to raise concerns anonymously and the guardian's independent and impartial position, continue to provide reassurance to workers engaging with the service.

Many workers reported feeling listened to and supported, even when the outcome was not as they had hoped.

"I felt listened to and supported. Thank you so much for listening to me. You have no idea how much it has helped me just being able to talk about it to someone."

"Given me a voice - clear plan of how to address concerns listened without judgement"

– Worker feedback

The impartiality of the guardian role was particularly valued, with workers expressing appreciation for being able to speak freely and without fear of judgment.

Recurring themes from this year's feedback highlight areas for improvement in the speaking up process.

A consistent theme in feedback was the need for more timely feedback and updates both from guardians and at an organisational level.

Delays in investigations and lengthy human resource processes, resulting in the person raising concerns losing faith in the process, were frequently cited as barriers to achieving meaningful outcomes.

A common sentiment among workers was a sense that the "situation won't change" even if they speak up, reflecting frustration with perceived

inaction or lack of seriousness from some managers and senior leaders.

This may help explain the decline in confidence in the "organisation will address my concern" response in the 2024/25 NHS Staff Survey, underscoring the need for stronger follow through and visible action when concerns are raised.

"Some feedback continues to express concern that some leaders trivialise concerns brought to them, do not commit to following up robustly and the behaviours of senior leadership and executives do not feel transparent, which deters colleagues from feeling that their concerns will be handled with integrity and in accordance with trust values of kindness, integrity and inclusivity."

– Freedom to Speak Up Guardian

Fear of detriment and a sense of futility remain two of the most significant barriers to speaking up.

The continued rise in anonymous cases suggests that many workers still lack confidence in the speaking up process and may fear negative consequences for raising concerns. This lack of trust can also make it difficult for guardians to gather meaningful feedback, as some workers disengage from the process after submitting their concerns.

“The fear of detriment directly impacted engagement with the speaking up process, with individuals withdrawing their concerns shortly after raising them and some prior to any formal meeting taking place. As a result, this also affected the ability to gather meaningful responses to follow-up feedback questions, limiting further insight into the experience of those who came forward”

– Freedom to Speak Up Guardian

To address these challenges, organisations must adopt a proactive and strategic approach. This includes engaging senior leaders to visibly champion speaking up, raising awareness across all levels of the workforce, and embedding best practices that foster a culture of psychological safety. Leaders must be approachable, responsive, and model the behaviours expected throughout the organisation.

Policies and processes should be regularly reviewed to ensure they are fair, transparent, and timely. Delays in investigations or unclear outcomes can erode trust and discourage future speaking up. Establishing clear, compassionate, and well

communicated feedback loops is essential, this is not only to close the loop with those who raise concerns but also to reduce anxiety and support worker wellbeing throughout the process.

Ultimately, raising concerns should be embedded as a routine part of organisational life, not viewed as a risk, but as a constructive tool for learning, improvement, and safeguarding both staff and service users. Creating an environment where speaking up is safe, supported, and acted upon is fundamental to building a truly open and accountable culture.

The role of the line manager is consistently highlighted in feedback as critical to the speaking up experience and overall staff wellbeing.

Line managers play a central role in supporting workers, addressing concerns, and fostering a psychologically safe working environment. A strong, trusting relationship between a worker and their line manager can significantly enhance day-to-day experiences and contribute to a more open and supportive culture.

Both workers and guardians recognised the need for further training and development for line managers, particularly in conducting compassionate, empathetic, and constructive conversations when concerns are raised. In one trust, a guardian reported that “33 cases indicated leadership training needed due to lack of compassion and communication issues”, as noted in a single quarter’s data submission.

“All individuals felt that their line managers weren’t aware of their responsibility.”

“Concerns raised that managers lack compassion and empathy when dealing with staff concerns”

– Freedom to Speak Up Guardian

Equipping managers with the tools and confidence to support staff through challenging situations, such as organisational change, managing reasonable adjustments, or navigating sensitive feedback, is essential to building trust and ensuring concerns are handled with care and professionalism. A well designed and structured training programme can help new managers quickly settle into their

responsibilities and understand their duty of care, while also enabling experienced managers to identify gaps and improve their leadership approach.

Guardians report a key learning point was to make speaking up training mandatory for all line managers, senior leaders, and employees. This ensures a consistent understanding of the importance of speaking up, the role of the guardian, and the responsibilities of leaders in responding to concerns. Embedding speaking up training as a core part of organisational development will help normalise the process, reinforce expectations, and contribute to a culture where raising concerns is seen as a positive and valued part of continuous improvement.

Communication is key

Communication continues to be a central theme in feedback from workers and guardians, with ineffective, unclear, or absent communication frequently mentioned as a key factor in concerns raised during 2024/25. Poor communication not only contributed to the escalation of issues that could have otherwise been resolved informally but also had a direct impact on staff wellbeing, leading to increased anxiety, stress, and feelings of being personally targeted.

“A high percentage of cases raised could have been resolved with improved/better communication.”

– Freedom to Speak Up
Guardian

Workers consistently highlighted the importance of clear, two-way communication with their line managers, noting that a lack of clarity and inconsistent messaging often created confusion and undermined trust. In some cases, the absence of professional boundaries and empathetic dialogue further exacerbated tensions, making it difficult for staff to feel heard or supported.

Organisations must prioritise communication as a core competency embedding it into leadership development, performance expectations, and cultural values. This includes providing regular feedback, involving staff in co-creating solutions, and ensuring that communication during periods of change is transparent, inclusive, and responsive to staff concerns. Improving communication is not only essential for resolving issues early, but also for building a speaking up culture is welcomed, valued, and acted upon with care and professionalism.

Summary and reflection

The 2024/25 data present a nuanced picture of the Freedom to Speak Up programme, highlighting both encouraging progress and areas requiring renewed focus. A record number of cases reported to guardians suggests a positive cultural shift: more workers are choosing to raise concerns, reflecting growing trust in the guardian role. This trend points to a maturing system where staff feel increasingly empowered to speak up, and where organisational responsiveness is becoming more consistent.

Notably, the 5.5% reduction in guardian uptake within NHS trusts may reflect a positive development, as more trusts are appointing full-time guardians. This shift marks a move away from treating the role as an add on to substantive roles and instead signals a growing recognition of the importance of speaking up and the need to embed it more deeply within organisational culture.

However, this progress is tempered by several challenges. A decline in organisational participation in data submissions, particularly from non-trust organisations, signals a need for more consistent sector-wide engagement and adherence to the National Guardian's Office guidance. Additionally, the rise in anonymous reporting suggests persistent fears of retaliation and a lack of psychological safety. While anonymity can provide a vital route for raising concerns, it also limits the ability to follow up, gather context, and resolve issues effectively. This can hinder effective resolution and learning.

These findings underscore the importance of:

- Strengthening organisational support structures to ensure guardians are well resourced, protected, and empowered.
- Targeted support and collaboration across sectors to address disparities in guardian engagement.
- Investing in data analysis to identify patterns, root causes, and opportunities for preventative action.
- Fostering psychological safety through consistent, inclusive leadership behaviours and transparent handling of concerns.

Looking ahead, it will be essential to measure not just participation, but also the impact of speaking up such as resolution rates, staff satisfaction, and organisational learning outcomes. Demonstrating the tangible value of the programme will help build further trust and engagement.

Ultimately, embedding speaking up as a routine, valued part of workplace culture requires strong leadership, empowered line managers, and a system-wide commitment to openness, learning, and accountability. While progress is evident, the journey continues and the need for courageous, compassionate leadership has never been greater.

Looking ahead with gratitude

Following the publication of the Dash review and the Government's acceptance of its recommendations, the National Guardian's Office will close, with its functions transitioning to NHS England. While this represents a structural change, the core mission of empowering workers to speak up remains a national priority. This commitment will continue through the integration of staff voice functions within NHS England, supported by the dedication, compassion, and resilience of Freedom to Speak Up guardians across the country.

We, at the National Guardian's Office, extend our deepest thanks to all guardians for your unwavering commitment, thoughtful contributions, and continued engagement. Your work has made a real and lasting difference in improving workplaces, strengthening cultures of openness, and helping to create safer environments for staff and service users alike. Your role remains essential, and we are truly grateful for everything you do.

Acknowledgements

With sincere thanks to the following contributors to this annual data report:

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Jo Callender – Senior Guardian Support Officer
Isabella Tetteh – Speak Up Review Manager
Ellie Staite – Senior Correspondence, Accountability & Information Governance Manager
Fiona Hughes – Senior Communications Officer

Annex

Number of cases brought to Freedom to Speak Up Guardian comparison over time	
Fiscal year /Quarter	Number of cases raised with Freedom to Speak Up guardians, as reported to the National Guardian's Office
Total 2017/18	7,087
Q1	1,447
Q2	1,515
Q3	1,939
Q4	2,186
Total 2018/19	12,244
Q1	2,500
Q2	2,651
Q3	3,634
Q4	3,459
Total 2019/20	16,199
Q1	3,531
Q2	3,764
Q3	4,486
Q4	4,418
Total 2020/21	20,388
Q1	5,212
Q2	4,927
Q3	5,334
Q4	4,915
Total 2021/22	20,362
Q1	4,876
Q2	4,557
Q3	5,705
Q4	5,224
Total 2022/23	25,209
Q1	5,488
Q2	6,146
Q3	6,947
Q4	6,628
Total 2023/24	32,167
Q1	6,836
Q2	7,548
Q3	9,138
Q4	8,645
Total 2024/25	38,158
Q1	8,872
Q2	9,291
Q3	10,010
Q4	9,985

Comparison by size of organisation over time								
Size of organisation	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Small (up to 5,000 workers)	3,088	5,450	6,553	6,719	6,201	6,490	9,071	10,798
Medium (between 5,000 and 10,000 workers)	2,960	5,100	6,717	9,678	10,203	13,084	15,244	16,024
Large (more than 10,000 workers)	1,039	1,648	1,919	2,914	3,668	5,598	7,839	10,831
Not Set	-	46	67	169	79	37	13	505
Grand Total	7,087	12,244	15,256	19,480	20,151	25,209	32,167	38,158

Comparison by type of organisation over time						
Type of organisation	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
NHS trusts	15,089	18,687	18,982	23,219	29,204	33,810
Other organisations	167	793	1,169	1,990	2,963	4,348
Grand Total	15,256	19,480	20,151	25,209	32,167	38,158

Comparison by professional group over time						
Professional group	2022/23 #Cases	2022/23 %Cases	2023/24 #Cases	2023/24 %Cases	2024/25 #Cases	2024/25 %Cases
Additional Clinical Services	2,465	9.8%	3,632	11.3%	4,202	11.0%
Additional Professional Scientific and Technical	988	3.9%	1,154	3.6%	1,446	3.8%
Administrative and Clerical	5,099	20.2%	6,856	21.3%	8,076	21.2%
Allied Health Professionals	2,809	11.1%	3,342	10.4%	3,904	10.2%
Ambulance (operational)	334	1.3%	400	1.2%	401	1.1%
Estates and Ancillary	1,093	4.3%	1,335	4.2%	1,618	4.2%
Healthcare Scientists	357	1.4%	391	1.2%	471	1.2%
Medical and Dental	1,631	6.5%	1,955	6.1%	2,451	6.4%
Registered Nurses and Midwives	7,313	29.0%	9,109	28.3%	10,765	28.2%
Students	222	0.9%	278	0.9%	408	1.1%

Anonymous cases		
Fiscal year /Quarter	# of cases received	% of cases received
Total 2017/18	1,254	17.7%
Q1	266	18.4%
Q2	292	19.3%
Q3	308	15.9%
Q4	388	17.7%
Total 2018/19	1,491	12.2%
Q1	285	11.4%
Q2	254	9.6%
Q3	436	12.0%
Q4	516	14.9%
Total 2019/20	2,037	12.6%
Q1	449	12.7%
Q2	510	13.5%
Q3	516	11.5%
Q4	562	12.7%
Total 2020/21	2,379	11.7%
Q1	644	12.4%
Q2	634	12.9%
Q3	532	10.0%
Q4	569	11.6%
Total 2021/22	2,120	10.4%
Q1	532	10.9%
Q2	451	9.9%
Q3	674	11.8%
Q4	463	8.9%
Total 2022/23	2,366	9.4%
Q1	607	11.1%
Q2	613	10.0%
Q3	599	8.6%
Q4	547	8.3%
Total 2023/24	3,046	9.5%
Q1	643	9.4%
Q2	682	9.0%
Q3	880	9.6%
Q4	841	9.7%
Total 2024/25	4,413	11.6%
Q1	994	11.2%
Q2	964	10.4%
Q3	1,141	11.4%
Q4	1,314	13.2%

Patient safety / quality cases		
Fiscal year /Quarter	# of cases received	% of cases received
Total 2017/18	2,266	32.0%
Q1	464	32.1%
Q2	529	34.9%
Q3	614	31.7%
Q4	659	30.1%
Total 2018/19	3,523	28.8%
Q1	772	30.9%
Q2	811	30.6%
Q3	992	27.3%
Q4	948	27.4%
Total 2019/20	3,732	23.0%
Q1	860	24.4%
Q2	985	26.2%
Q3	996	22.2%
Q4	891	20.2%
Total 2020/21	3,668	18.0%
Q1	973	18.7%
Q2	931	18.9%
Q3	948	17.8%
Q4	816	16.6%
Total 2021/22	3,838	18.8%
Q1	809	16.6%
Q2	907	19.9%
Q3	1,129	19.8%
Q4	993	19.0%
Total 2022/23	4,893	19.4%
Q1	1,152	21.0%
Q2	1,195	19.4%
Q3	1,374	19.8%
Q4	1,172	17.7%
Total 2023/24	6,006	18.7%
Q1	1,188	17.4%
Q2	1,452	19.2%
Q3	1,700	18.6%
Q4	1,666	19.3%
Total 2024/25	6,796	17.8%
Q1	1,519	17.1%
Q2	1,820	19.6%
Q3	1,671	16.7%
Q4	1,786	17.9%

Bullying or harassment cases		
Fiscal year /Quarter	# of cases received	% of cases received
Total 2017/18	3,206	45.2%
Q1	566	39.1%
Q2	630	41.6%
Q3	929	47.9%
Q4	1,081	49.5%
Total 2018/19	4,969	40.6%
Q1	1,046	41.8%
Q2	1,104	41.6%
Q3	1,489	41.0%
Q4	1,330	38.5%
Total 2019/20	5,813	35.9%
Q1	1,373	38.9%
Q2	1,364	36.2%
Q3	1,631	36.4%
Q4	1,445	32.7%
Total 2020/21	6,131	30.1%
Q1	1,456	27.9%
Q2	1,563	31.7%
Q3	1,636	30.7%
Q4	1,476	30.0%
Total 2021/22	6,471	31.8%
Q1	1,599	32.8%
Q2	1,512	33.2%
Q3	1,819	31.9%
Q4	1,541	29.5%
Total 2022/23	5,491	21.8%
Q1	1,268	23.1%
Q2	1,335	21.7%
Q3	1,451	20.9%
Q4	1,437	21.7%
Total 2023/24	6,369	19.8%
Q1	1,460	21.4%
Q2	1,434	19.0%
Q3	1,782	19.5%
Q4	1,693	19.6%
Total 2024/25	7,011	18.4%
Q1	1,661	18.7%
Q2	1,845	19.9%
Q3	1,786	17.8%
Q4	1,719	17.2%

Cases involving perceived detriment		
Fiscal year /Quarter	# of cases received	% of cases received
Total 2017/18	361	5.1%
Q1	97	6.7%
Q2	72	4.8%
Q3	100	5.2%
Q4	92	4.2%
Total 2018/19	564	4.6%
Q1	117	4.7%
Q2	133	5.0%
Q3	177	4.9%
Q4	137	4.0%
Total 2019/20	544	3.4%
Q1	133	3.8%
Q2	122	3.2%
Q3	161	3.6%
Q4	128	2.9%
Total 2020/21	632	3.1%
Q1	143	2.7%
Q2	136	2.8%
Q3	180	3.4%
Q4	173	3.5%
Total 2021/22	856	4.2%
Q1	179	3.7%
Q2	192	4.2%
Q3	256	4.5%
Q4	229	4.4%
Total 2022/23	997	4.0%
Q1	216	3.9%
Q2	196	3.2%
Q3	342	4.9%
Q4	243	3.7%
Total 2023/24	1,285	4.0%
Q1	264	3.9%
Q2	325	4.3%
Q3	358	3.9%
Q4	338	3.9%
Total 2024/25	1,106	2.9%
Q1	303	3.4%
Q2	294	3.2%
Q3	291	2.9%
Q4	218	2.2%

Worker safety or wellbeing cases		
Fiscal year /Quarter	# of cases received	% of cases received
Total 2021/22	2,757	13.5%
Q1	600	12.3%
Q2	612	13.4%
Q3	758	13.3%
Q4	787	15.1%
Total 2022/23	6,955	27.6%
Q1	1,434	26.1%
Q2	1,709	27.8%
Q3	1,879	27.0%
Q4	1,933	29.2%
Total 2023/24	10,404	32.3%
Q1	2,140	31.3%
Q2	2,346	31.1%
Q3	3,116	34.1%
Q4	2,802	32.4%
Total 2024/25	14,171	37.1%
Q1	3,034	34.2%
Q2	3,582	38.6%
Q3	3,797	37.9%
Q4	3,758	37.6%

Inappropriate attitudes or behaviours cases		
Fiscal year /Quarter	# of cases received	% of cases received
Total 2022/23	7,608	30.2%
Q1	1,696	30.9%
Q2	1,878	30.6%
Q3	2,035	29.3%
Q4	1,999	30.2%
Total 2023/24	12,389	38.5%
Q1	2,639	38.6%
Q2	2,793	37.0%
Q3	3,624	39.7%
Q4	3,333	38.6%
Total 2024/25	15,130	39.7%
Q1	3,547	40.0%
Q2	3,726	40.1%
Q3	3,956	39.5%
Q4	3,901	39.1%

Feedback received, responses to 'Would you speak up again?'					
Fiscal year /Quarter	Received Feedback	Yes	No	Maybe	I don't know
Total 2019/20	4,455	3,801	114	207	289
% of Total	-	85.3%	2.6%	4.6%	6.5%
Q1	1,052	849	26	50	92
Q2	982	844	23	53	53
Q3	1,256	1,083	35	57	81
Q4	1,165	1,025	30	47	63
Total 2020/21	6,138	5,190	199	372	377
% of Total	-	84.6%	3.2%	6.1%	6.1%
Q1	1,605	1,378	43	78	106
Q2	1,421	1,160	41	111	109
Q3	1,550	1,343	40	98	69
Q4	1,562	1,309	75	85	93
Total 2021/22	5,939	5,063	173	337	366
% of Total	-	85.3%	2.9%	5.7%	6.2%
Q1	1,390	1,219	39	67	65
Q2	1,295	1,108	40	70	77
Q3	1,693	1,401	58	133	101
Q4	1,561	1,335	36	67	123
Total 2022/23	7,204	5,995	244	512	453
% of Total	-	83.2%	3.4%	7.1%	6.3%
Q1	1,626	1,357	59	118	92
Q2	1,792	1,529	52	125	86
Q3	1,991	1,662	84	156	89
Q4	1,795	1,447	49	113	186
Total 2023/24	8,441	6,734	231	759	717
% of Total	-	79.8%	2.7%	9.0%	8.5%
Q1	1,753	1,349	51	135	218
Q2	1,939	1,593	70	94	182
Q3	2,416	1,863	62	278	213
Q4	2,333	1,929	48	252	104
Total 2024/25	9,435	7,514	293	752	873
% of Total	-	79.6%	3.1%	8.0%	9.3%
Q1	2,027	1,654	46	156	171
Q2	2,162	1,748	57	150	207
Q3	2,513	2,031	100	201	178
Q4	2,733	2,081	90	245	317

Contacts

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OFFICIAL - Recipients Have Full Control

Name of Committee/Group:	Finance, Sustainability and Performance Committee in Common:		Report to:	Trust Board
Date of Meeting:	26 August 2025		Date of next meeting:	22 September 2025
Chair:	BCH Chair, Tina Wilkins		Quorate (Yes/No):	Yes
Members present/attendees:	Committee Members Present: BCH: Tina Wilkins, Non-Executive Director and Committee Chair Bob Chadwick, Non-Executive Director Nick Gallagher, Director of Delivery Unit Lynne Carter, Director of Delivery Unit and BCH Deputy CEO BCH and WHH Joint Directors: Daniel Moore, Chief Operating Officer Ali Kennah, Chief Nurse WHH: Julie Jarman, Non-Executive Director Mike O'Connor, Non-Executive Director Jane Hurst, Chief Finance Officer John Culshaw, WHH Company Secretary Kate Henry, WHH Director of Communications and Engagement	In Attendance Hayley Heard, WHH Deputy Director of Strategy and Partnerships Eshita Hasan, WHH Deputy Medical Director Jennie Derryhouse, WHH Deputy Chief People Officer Jo Waldron, BCH Deputy Director of People and Organisational Development Gareth Pugh, BCH Director of Finance Jan Parker, WHH Deputy Chief Finance Officer Claire Leather, WHH Finance Lead for Efficiencies and Commercial Development Beth Scrivens, WHH Observers: BCH: Rita Chapman, Public Governor WHH: Sue Fitzpatrick, Lead Governor	Key Members not present:	Apologies received from: John Somers, WHH Non-Executive Director Paul Fitzsimmons, Medical Director Michelle Cloney, WHH Chief People Officer Paula Woods, BCH Director of People and Organisational Development Lucy Gardner, WHH Chief Strategy and Partnerships Officer

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Winter Plans			An update was provided on the process for sign off of the Winter Plans for WHH and BCH – plans were to be signed off by the end of September 2025, to align with the national	This has been taken through internal governance arrangements for sign off. Committee members had been invited to comment on the documents.

Committee Chair's Report

			operating plan requiring all winter plans to be signed off by this date. The plans would need to be stress tested. There were a series of assurance statements to be completed along with a system planning template as part of the planning round.	(A retrospective report detailing the Trust's submissions is included on the Board agenda).
Deep Dive – CIP Delivery Unit	5		The Committee received a presentation which outlined the functions of the delivery unit across both WHH and BCH. There were a number of areas of challenge including: CIP gaps, incomplete PIDs and QIAs which were being progressed as an urgent priority, monitoring of overspends and development of recovery plans, closer scrutiny of overtime and bank use along with activity and challenges in block contracts. There had been two meetings to date with PWC, ICB and NHS England to talk about 2025/26 plans for both organisations. This included financial performance, workforce position, efficiency, delivery and development. Minutes from the recent meetings of the delivery unit were included in the agenda pack for Committee members' oversight.	The Committee was assured that the delivery unit was progressing well, with positive engagement and feedback from staff across both organisations and sharing of ideas to be taken forwards. The most significant issue was noted as areas that were overspending with no recovery plans. Work would be undertaken to triangulate this. All relevant staff were included as part of work, including key clinical representatives and the Chief Nurse and Medical Director. An update on the work of the delivery unit is included as part of the Board agenda. The Committee also received a detailed update on the current CIP position for both Trusts as at month four. The current BCH position will be included within the finance report on the agenda. Discussion took place on the contribution that both organisations could make collectively, noting areas where some elements must be separate until integration took place, and contributions that could be made as part of the wider system. A number of suggestions had been shared with Cheshire and Mersey providers to support delivery of the system level CIP, in addition to

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

Committee Chair's Report

				having been considered internally by the EMT. Robust meetings and discussions were continuing with oversight from the ICB. A discussion took place on the confidence levels around delivery and concerns regarding identification of level 3 CIP. The Committee requested that the baseline programme for delivery be set out and circulated to all members for assurance.
Hot Topic – Tier One/Dermatology	5		An update was provided on the dermatology service: There had been improvements made including the introduction and use of AI and pathway changes to attempt to reduce demand. Proposed solutions were detailed which included additional sessions and working with commissioners around the Advice and Guidance route to reduce flow.	The proposals would be taken into the EMT for further considerations and discussions. The Committee would be updated following this on the next steps. The discussions would also include how the service would remain sustainable financially.
BCH IQPR	5		Dermatology 31 day waits were at 56.25% driven by short term capacity in May, however the position had since been recovered. Audiology six-week performance was deteriorating and was currently tracking at approx.40% against the 1% standard. The position was being monitored, and updates would be provided to the Committee.	It was proposed that a hot topic would be presented to a future Committee on the Audiology position.
Finance Report – month four	5		The Committee received the report which also included the month four CIP update. At month four 2025/26:	

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Committee Chair's Report

			• The Trust is reporting a deficit at Month 4 of £1.62m, in line with plan. • The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3). • The Trust is reporting a savings achievement of £1.60m against a plan of £1.59m • Income is £33.19m against a plan of £33.13m. • Expenditure is £34.70m against a plan of £34.62m. • Pay is £24.57m against a plan of £24.05m. • Agency spend is £0.12m against a plan of £0.43m. • Non pay expenditure is £10.02m against a plan of £10.14m. • Capital charges are above plan by £0.03m. • Capital expenditure is £0.23m at month four, planned spend is £0.16m. • Cash is £9.79m	
Review of meeting and items escalated to the Board/other Committees	1		The meeting was difficult to follow for those on teams due to connectivity problems at the beginning. The number and size of papers and the complexity of bringing the two meetings together was recognised.	It was agreed that that the Chairs, CFOs and Company Secretary would meet to further review the agenda and reprioritise content ahead of the next meeting.
Risks Escalated: None				

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OFFICIAL - Recipients Have Full Control

Name of Committee/Group:	Finance, Sustainability and Performance Committee in Common:	Report to:	Trust Board
Date of Meeting:	22 September 2025	Date of next meeting:	27 October 2025
Chair:	BCH Chair, Tina Wilkins (Meeting Chaired by John Somers)	Quorate (Yes/No):	Yes
Members present/attendees:	Committee Members Present: BCH: Tina Wilkins, Non-Executive Director and Committee Chair Bob Chadwick, Non-Executive Director Nick Gallagher, Director of Delivery Unit Lynne Carter, Director of Delivery Unit and BCH Deputy CEO BCH and WHH Joint Directors; Daniel Moore, Chief Operating Officer Ali Kennah, Chief Nurse	Key Members not present:	

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Deep Dive – Delivery Unit	5		The Committee was provided with a presentation detailing the functions and duties of the delivery unit, which is now fully operational. Principal responsibilities include, but are not limited to, the following: - Challenging and tracking the delivery of the financial plans, CIP delivery, productivity gains and overall financial plan - Oversight of pay controls, including variable pay and premium cost reduction - Non-pay controls, including off catalogue, and catalogue rationalisation - Oversight of vacancy control processes and WTE reduction vacancy reviews	The Committee assured that the delivery unit is fully established, monitors CIP achievement, oversees performance recovery plans, and maintains an escalation process. The committee requested a more detailed breakdown of the progress services were making in reducing budget overspends. This will be included in future finance papers.

Committee Chair's Report

			• Delivery of opportunities identified via external review, e.g. PWC and Newton • Robust QIA process to support change and identify/escalate associated quality risk • Challenge to budget holders and CIP scheme leads to ensure delivery is on track • Escalation of failure (or risk of failure) to deliver services within allocated budgets or CIPs • Incorporate Level 3 "Stretch" initiatives into BAU CIP and financial plans The latest update on CIP progress is as follows: • CIP targets still not fully met and/or delivering • Some outstanding PIDs and QIAs • Risk mitigation still required in some areas • Non recurrent delivery still an issue but reducing • Overspending budgets without recovery plans in some areas • Reliance on reserves in some areas • Income delivery not yet fully achieved Workforce • Still reliance on non-recurrent vacancy position • Industrial action impact • Increased sickness absence • Use of bank/agency in several areas due to short term absences	
Hot Topic – PWC Update (including level three CIP)	5		CFO gave a presentation to the Committee that described the position in relation to the Level £ CIP. Whilst level 1 and 2 CIP are wholly in the control of the Trusts with savings being achieved through efficiency and productivity, the level 3 CIP is a	The Committee concluded that based on current progress to date they were not assured that the Trust will achieve the level 3 CIP.

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Committee Chair's Report

			£3m stretch target agreed as part of our contract but based upon the system working differently which is partly out of the Trust's control. BCH is working with the ICB to identify and agree savings, which are in addition to those already in progress under level 1&2. The ICB has identified a 'long list' of potential savings which the Trust is working through, however, as many of the proposed savings are already contributing to the level 1&2 CIP to date only £0.54m CIP has been identified, leaving a shortfall of £2.46m which leaves the Trust with a significant gap.	The directorate teams are actively engaged in identifying further CIPs that will support the achievement of level 3 stretch savings. They are also assessing the associated risks and consequences for each scheme. Progress will be reported to the Committee and the Board.
Monthly CIP Updates BCH	5		Within the Trust 2025/26 plan, the Trust has a total savings target of £8.4m. This is made up of the £5.5m business as usual CIP target (5.2%) and the additional placeholder system stretch savings target of £2.9m (3%). The additional system stretch target is recorded as separate savings in the plan and does not form part of the CIP return information reported each month. These savings require system support to identification and delivery and cannot duplicate schemes already identified as part of the Trust CIP opportunities identified. The allocation of the CIP targets within the Trust have been weighted to require a greater savings requirement from corporate services. This recognises the national benchmarking data that indicates that when compared to other Trusts, Corporate services costs per £100m turnover are greater than the median cost and there is a greater opportunity for savings from corporate services. The Trust is committed to reducing corporate costs to meet the median cost as a minimum within the next 3 years.	Progress towards achieving level 1 and 2 savings remains on track; however, the Committee noted concerns regarding the achievement of the level 1, 2, and 3 CIP targets. These concerns stem from the ongoing reliance on some non-recurrent savings, combined with some services overspending their budget, and the absence of clearly identified level 3 CIP initiatives.
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Committee Chair's Report

			The weighting results in a net 5.87% (£2.20m) CIP requirement from corporate services and a net 4.58% (£3.28m) CIP requirement from operational services. As at month 5, £6.55m worth of recurrent saving opportunities have been identified. The in year impact of these savings is £5.47m. As at month 5, the Trust is reporting savings of £2.02m in line with the submitted plan. Of these cumulative savings £0.10m is non recurrent savings relating to vacancies. As part of the budget review process, DLT's will be reviewing these savings to identify opportunities to make these savings recurrent.	
Finance Report – Month Five	5		At Month 5 2025/26: • The Trust is reporting a deficit at Month 5 of £1.99m, in line with plan. • The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m • (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3). • The Trust is reporting a savings achievement of £2.02m against a plan of £2.01m • Income is £41.72m against a plan of £41.86m. • Expenditure is £43.70m against a plan of £43.85m. • Pay is £30.56m against a plan of £30.49m. • Agency spend is £0.14m against a plan of £0.53m. • Non pay expenditure is £12.80m against a plan of £12.67m. • Capital charges are above plan by £0.04m. • Capital expenditure is £0.32m at month five, planned spend is £0.29m. • Cash is £8.04m.	The Committee noted the report and progress to date including the continued use of established grip and control measures such as, 'Monthly Recovery Plan' meetings being held with each Directorate and the success of measures to reduce the negative impact of variable pay.

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Committee Chair's Report

			The Directorate position shows that there are areas of budget overspends. Whilst the Trust is on plan at month five, recovery plans are being implemented and further CIP savings are needed, as delivery of the plan will become more challenging as the year progresses.	
Performance Council and IQPR			Key Exceptions: - Warrington Dermatology Cancer 2-week referrals: Below national target (88.32% vs. 93%), with process reviews underway and a new pathway being piloted. - A&E Referrals: Local target 3%, July performance 5.98%. Calculation logic aligned with ICB; regular validation reports in place. - Community Health Services Waits: Increasing long waits for adults and children, with actions underway to improve access and reduce waits. - Audiology: 93 breaches in July, mainly in paediatric services; recruitment and pathway efficiency under review. - Dental: Waiters by sector/time band analysed; operational flexibility and mutual aid used to manage high waiters. Key Exceptions: - Incident Reporting: 86.47% compliance (target 87%), with increased training to improve standards. - Moderate Harm Incidents: 2.35% (target 1%), mostly pressure ulcers; all incidents reviewed and regraded as needed. - Duty of Candour: 66.67% compliance (target 100%), with some cases delayed due to patient circumstances. - Information Governance Training: 93.69% (target 95%), with operational focus on improvement.	Overall the IQPR was reporting amber across Quality, Performance, People and Finance. The Committee noted that the following actions were highlighted: ☐ Cancer Pathways: Process reviews and new pathways to address bottlenecks. ☐ Audiology & Dental: Recruitment and operational flexibility to manage breaches and long waits. ☐ Data Quality: Targeted improvements in data completeness and timeliness. ☐ Staff Wellbeing: Focus on stress support and early intervention for sickness absence.

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

Committee Chair's Report

			- Safeguarding Training: 97.74% (target 95%), but some directorates need focus. - Risk Management: Some indicators below target, but robust processes in place. - Patient Safety Falls & Pressure Ulcers: Monitored closely, with improvement actions ongoing. - IPC Audit Compliance: 89% (target 90%), with reporting changes affecting compliance. Key Exceptions: - Sickness Absence: Main reason is stress; early intervention and policy focus ongoing. - PDR Completion: System issue affected reporting; expected to recover next month. Key Headlines: - Income: £33.19m (plan: £33.13m) - Expenditure: £34.70m (plan: £34.62m) - Pay: £24.57m (plan: £24.05m) - Agency Spend: £0.12m (plan: £0.43m) - Non-pay Expenditure: £10.02m (plan: £10.14m) - Capital Charges: Above plan by £0.03m - Cash: £9.79m	
Winter Plans BCH	5		The Committee received an update that outlined the process for developing and signing off the combined winter plan and assurance statement for Warrington and Bridgewater. The Committee were asked to note the need for board approval by the end of the month.	The final document will be circulated for approval via 'EGOVERNANCE' prior to submission on 30 th September 2025.

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
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Committee Chair's Report

			The Trust has contributed to the ICB winter plan, which builds upon our local plan. This is to be submitted on Thursday 25 September 2025. In line with national guidance, both the Trust and ICB plans were stress-tested at the NHSE Winter Planning Event "AEGIS" held on 8 September. Key learning from the event has been incorporated into the plans. Both Trusts were represented at the event. The plan is compliant for 6/7 of the 8 areas.	
Operational Plan timeline Update BCH	5		The NHS 5 year planning framework was presented to the Committee and it is anticipated the timeline for the operational plane will be distributed at the end of September early October.	Noted.
BCH Procurement Report	5		Report Noted	
Audit Recommendations and Policy Update	5		Debbie presented updates on open audit recommendations, including progress on internal and external audit actions, and sought committee approval for the updated accounts receivable and debt management policy. Audit Recommendation Progress: There is one open internal audit report for finance with 11 recommendations, and two overdue external audit recommendations, one of which has been superseded by integration work.	Updated accounts receivable and debt management policy approved. An appendix was missing from the Audit report as presented to Committee therefore Debbie will update the report to include the appendix.
Risks Escalated: None BAF: Level 3 CIP to be shown as a gap in control.				

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Committee Chair's Report

Meeting Review: It was agreed that due to the large quantity of papers, that the Chairs, CFOs and Board Secretary would need to meet again and further review the agenda and reprioritise content ahead of the next meeting. This will be an ongoing requirement.

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

Lynne Carter

Director of Delivery Unit
Deputy CEO



**North Cheshire and Mersey
Healthcare Partnership**
Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

DELIVERY UNIT DEEP DIVE OCTOBER 2025

The Delivery Unit functions include, but are not limited to:

- Challenging and tracking the delivery of the financial plans, CIP delivery, productivity gains and overall financial plan
- Oversight of pay controls, including variable pay and premium cost reduction
- Non-pay controls, including off catalogue, and catalogue rationalisation
- Oversight of vacancy control processes and WTE reduction vacancy reviews
- Delivery of opportunities identified via external review, e.g. PWC and Newton
- Robust QIA process to support change and identify/escalate associated quality risk
- Challenge to budget holders and CIP scheme leads to ensure delivery is on track
- Escalation of failure (or risk of failure) to deliver services within allocated budgets or CIPs
- Incorporate Level 3 “Stretch” initiatives into BAU CIP and financial plans

POSITIVE ACTIONS

- Red CIP plans to green and amber
- PIDs and QIAs increased significantly
- Management of medical locum/bank and WLIs
- Vacancy control panels increased scrutiny
- Improved coding for income
- Delivery in Month 5
- Greater grip on overspend areas
- Greater control on reserve allocation
- Individual meetings set up with each care group for more detailed work
- Corporate areas over delivery of CIP

CURRENT POSITION

- CIP targets still not fully met and/or delivering
- Some outstanding PIDs and QIAs
- Risk mitigation still required in some areas
- Non recurrent delivery still an issue but reducing
- Overspending budgets without recovery plans in some areas
- Income delivery not yet fully achieved

WORKFORCE

- Still reliance on non-recurrent vacancy position
- Industrial action impact
- Increased sickness absence
- Flow and length of stay
- Use of bank/agency in several areas due to short term absences
- Validation of all current vacancies in progress

LEVEL 3 CIP

- “Stretch” initiatives from window cleaning to service decommissioning suggested by system
- Executive and PWC list under close review
- No fully worked plans yet
- Assessment of opportunities in each Trust
- All planned in Month 12

PRODUCTIVITY

- Greater scrutiny of activity including case mix and income levels
- Commissioner discussions relating to block contracts underway
- Commissioner meetings regarding underfunded services

RISKS

- Double/triple counting Trust/System/PWC etc
- 26/27 CIP plans need planning now
- Populating CIP plans pre integration
- Amount of non recurrent delivery

DELIVERY UNIT ACTIONS

- Combined workforce and non-pay meetings to include overspending areas
- Meetings with each care group to CBU level with finance support and scrutiny
- Additional operational grip relating to revenue reserve requests and ad hoc spend
- 26/27 CIP planning commencing October 2025



**North Cheshire and Mersey
Healthcare Partnership**
Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

QUESTIONS ?

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	76/25iii		
Report Title	FINANCE REPORT – MONTH FIVE (AUGUST 2025)		
Executive Lead	Nick Gallagher - Executive Director of Finance		
Report Author	Nick Gallagher - Executive Director of Finance		
Presented by	Nick Gallagher – Executive Director of Finance		
Action Required	☐ To Approve	☐ To Assure	☐ To Note
Executive Summary			
At month five 2025/26: • The Trust is reporting a deficit at Month 5 of £1.99m, in line with plan. • The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3). • The Trust is reporting a savings achievement of £2.02m against a plan of £2.01m • Income is £41.72m against a plan of £41.86m. • Expenditure is £43.70m against a plan of £43.85m. • Pay is £30.56m against a plan of £30.49m. • Agency spend is £0.14m against a plan of £0.53m. • Non pay expenditure is £12.80m against a plan of £12.67m. • Capital charges are above plan by £0.04m. • Capital expenditure is £0.32m at month five, planned spend is £0.29m. • Cash is £8.04m.			
Previously considered by:			
☐ Audit Committee		☐ Quality and Safety Committee	
☒ Finance, Sustainability and Performance Committee-in-Common		☐ Remuneration and Nominations Committee	
☐ Strategic People Committee-in-Common		☐ EMT	
Strategic Objectives			
☐ Equality, Diversity, and Inclusion - We will ensure that equality, diversity, and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☐ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☐ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☐ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers, and staff work together to continually improve how they are delivered.			
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.			



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

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

☐ BAF 1	☒ BAF 2	☐ BAF 3	☒ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:

☐ **Caring**

☐ **Effective**

☒ **Responsive**

☐ **Safe**

☐ **Well Led**

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	9 OCTOBER 2025
Agenda Item	76/25iii		
Report Title	FINANCE REPORT MONTH FIVE (AUGUST 2025)		
Report Author	Nick Gallagher - Executive Director of Finance		
Purpose	To brief the Board on the financial position as at Month three		

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

2. FINANCIAL POSITION AS AT MONTH FIVE

2.1 The purpose of this paper is to update the Board on the financial position of the Trust at the end of August 2025 (Month 5).

2.2 The key headlines for Month five are shown in the table 1.

2.3 The underlying deficit for the Trust was £5.6m. The Trust submitted a financial plan for 2025/26 with a deficit position of £2.4m. This plan reflected the underlying financial position and run rate of the Trust and was developed using the income and cost assumptions provided both nationally and by the local ICB. The underlying position of £5.6m, amended for changes requested by the ICB adjusted the planned deficit from £5.6 to £2.4m. The £2.4m deficit plan was included in Cheshire & Merseyside ICB's overall draft plan submitted to NHSE. The ICB has a control total of £178m deficit and the consolidated plans submitted did not meet this value. The ICB plan was not accepted or approved.

2.4 As a result, the ICB were instructed to revisit all plans and asked all Trusts to include additional savings in their plan. These additional savings were labelled as 'placeholder savings' and allocated based on turnover. The ICB recognised that there would be a system solution required to deliver these savings. The ICB also recognised that the initial allocation may need to be revisited following the system led workstreams identifying additional savings opportunities to ensure equity and to match savings achieved to the additional stretch savings targets within organisations. This may require the reallocation of the savings targets across organisations later during the year.

2.5 Following agreement by the Board, a revised plan was developed to include an additional £2.89m savings, £0.5m is associated to service reduction, the remaining £2.39m is the BCH share of system-wide savings. This plan is reflected in the table below.

2.6 The Trust has categorised the total savings required in 2025-26 at three levels:

- i. Level 1 – Trust BAU CIP – These savings are part of the Trust 5% savings target and are solely the responsibility of the Trust to deliver.
- ii. Level 2 – Trust and WHH – These savings are also part of the Trust 5% savings target and are the responsibility of the Trust to deliver, working in partnership with WHH.
- iii. Level 3 – System ‘stretch’ savings – These savings are to be delivered across the system. System workstreams have been formed to support the identification of additional.

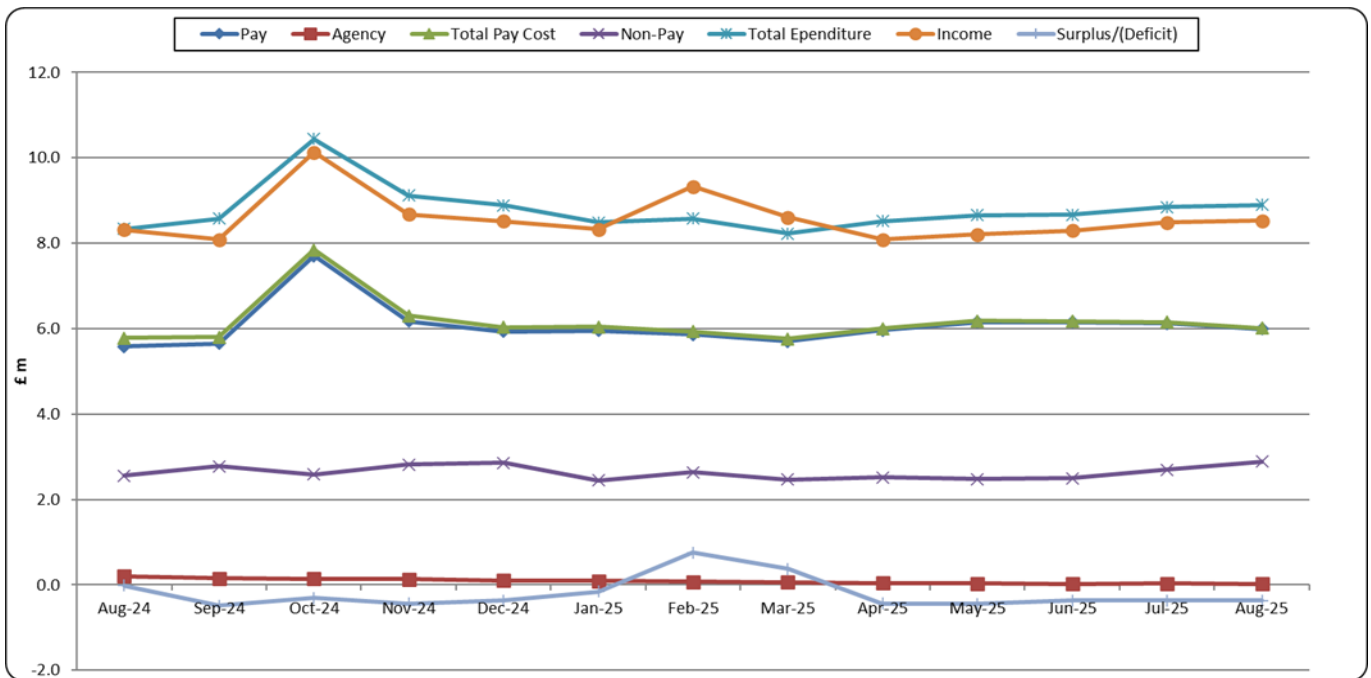
Table 1 – Summary of Financial Performance

Summary Performance Month 05 2025-26	Month 5 Plan	Month 5 Actual	Month 5 Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Forecast Outturn M12
	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)
Income	(8.73)	(8.53)	▲ (0.20)	(41.86)	(41.72)	▲ (0.14)	(100.27)	(100.27)
Expenditure - Pay	6.44	5.99	● 0.45	30.49	30.56	▲ (0.07)	72.37	72.37
Expenditure - Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Expenditure - Agency	0.10	0.02	● 0.08	0.53	0.14	● 0.38	1.10	1.10
Expenditure - Non Pay	2.53	2.79	▲ (0.26)	12.67	12.80	▲ (0.14)	30.84	30.84
Expenditure - Non Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	(2.90)	(2.90)
EBITDA	0.34	0.27	● 0.07	1.83	1.79	● 0.04	1.14	1.14
Financing	0.03	0.10	▲ (0.06)	0.16	0.20	▲ (0.04)	0.39	0.39
Normalised (Surplus)/Deficit	0.37	0.37	▲ (0.00)	1.99	1.99	▲ (0.00)	1.53	1.53
Exceptional Costs	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.37	0.37	▲ (0.00)	1.99	1.99	▲ (0.00)	1.53	1.53
Other Adjustments	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.37	0.37	▲ (0.00)	1.99	1.99	▲ (0.00)	1.53	1.53

Savings - CIP Levels 1 & 2	0.43	0.43	● 0.00	2.01	2.02	● 0.02	5.48	5.48
Savings - CIP Level 3	0.00	0.00	● 0.00	0.00	0.00	● 0.00	2.90	2.90
Capital	0.14	0.11	● 0.03	0.29	0.32	▲ (0.03)	2.10	2.10
Cash	7.54	8.04	● 0.50	7.54	8.04	● 0.50	6.85	6.85
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 2024/25 to 2025/26



The key performance headlines as at month five are:

Trust is reporting a cumulative deficit of £1.99m, which is in line with the submitted plan.

- **Income**

Cumulative income was below plan by £0.14m, predominantly due to inflationary uplifts (instructed to be included in plans by the ICB) for Local Authority income included in the plan but not recognised in actuals as they are not yet confirmed, and a lower than planned cumulative recharge for biologics (note: off set by lower than planned spend).

- **Pay**

Pay costs are below plan by £0.45m in month five as the impact of the pay award was slightly below the accrued value, cumulative pay costs are £0.07m adverse to plan.

- **Agency**

Year to date the Trust has incurred costs of £0.14m against the plan of £0.53m. Month on month the Trust has continued to reduce agency spend and spent £0.02m in month five against a plan of £0.10m.

There are now only two services utilising agency staff, these are:

- UTC Widnes – locum GP shifts.
- Community Paediatrics in both Halton and Warrington.

Agency costs incurred in month five equated to 1.23 whole time equivalent staff, all of these being medical locums.

The Trust has reduced its agency spend substantially over the past 18 months, initially by eradicating all off-framework usage towards the end of 2023/24 and the conversion of agency to bank. This has continued during 2024/25 and into 2025/26 as the Trust works towards the

national guideline of agency spend not exceeding 3.2% of the pay bill. At month five, agency equated to 0.38% of the pay bill in month and 0.47% year-to-date.

The impact of converting agency to bank expenditure may result in increased bank spend, but a net saving.

For month five, bank costs were £0.11m, slightly above the planned expenditure of £0.10m, and slightly higher than month four.

It should be noted that all agency and bank spend is subject to robust approval processes requiring senior management approval.

Performance is demonstrated in the graphs below:

Table 3 – Agency Spend

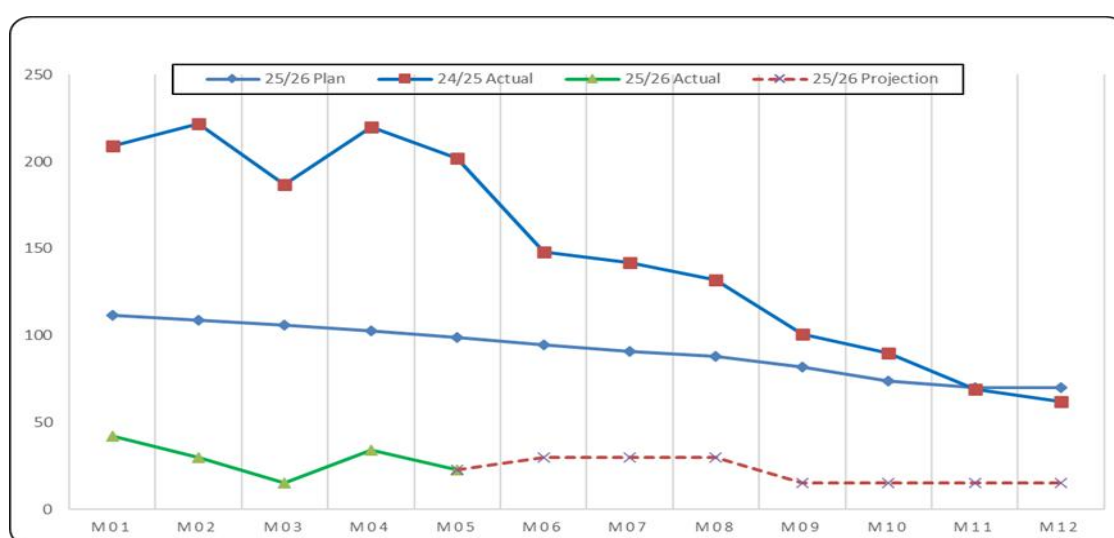


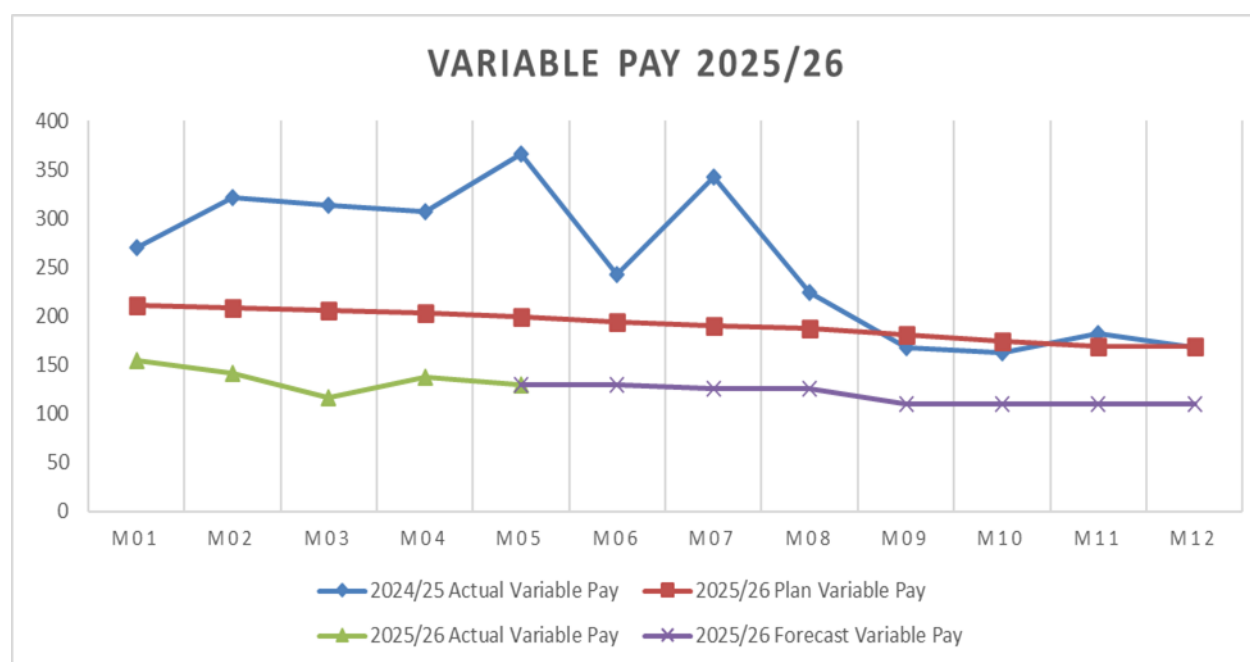
Table 4 - Bank Spend



Variable Pay

The Trust has implemented a tight grip and control regime for variable pay, all requests for additional hours now need to be approved by the Deputy Chief Operating Officer. The effects of this grip and control can be seen in the table and graphs below, covering a rolling 12 month period:

Variable Pay Plan	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Rolling 12 Months
Bank staff including on-costs	112	126	126	125	126	126	125	100	100	100	100	100	1,366
Agency/contract	146	81	69	69	70	71	71	112	109	106	103	99	1,106
Total Variable Plan	258	207	195	194	196	197	196	212	209	206	203	199	2,472
Variable Pay £'000	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Total
Bank	164	95	200	92	67	73	113	112	112	102	104	106	1,340
Agency	148	142	132	101	90	69	62	42	30	15	34	23	888
Overtime	19	31	15	14	9	15	6	10	2	2	2	0	125
Total Variable Pay	331	268	347	207	166	157	181	164	144	119	139	129	2,352
Overtime	19	31	15	14	9	15	6	10	2	2	2	0	125



- Non Pay**

- During month five the Trust has spent £2.79m on non-pay, £0.26m above plan predominantly due to an increase in biologic drug costs in Dermatology and Continence products (note these are offset by an increase to income), plus equipment costs.

3. COST IMPROVEMENT PLAN (CIP)

3.1 The Trust's annual BAU CIP target is £5.48m (5%). This relates to levels one and two savings referenced in 2.6 above.

- 3.2 The level three system dependant savings of £2.9m is phased in month 12 of 2025/26 as per Board discussions recognising that at the time of submitting the plan, no system savings or detailed delivery plans were known.
- 3.3 The detailed CIP tracker identifying all the savings schemes planned for 2025/26 was presented to the Finance & Performance Committee as part of month five performance reporting.
- 3.4 Level 1 and 2 annual CIP savings target is £5.48m (5%). Level 3 stretch savings target is £2.90m.
- 3.5 The Trust plan to month five is £2.01m, against which achievement of £2.02m is reported, of which £0.1m is non-recurrent vacancy slippage, this will be replaced by recurrent schemes as the year progresses.

4. FORECAST OUTTURN

- 4.1 Base on the run rate to month five, and assuming this run rate continues for the rest of the financial year, the following outturn scenarios are forecast.

4.2

	Best Case £m	Medium Case £m	Worst Case £m
Year to date Deficit	(2.00)	(2.00)	(2.00)
Straight Line Forecast deficit	(4.80)	(4.80)	(4.80)
CIP - Level 3 - Rev to Cap	0.80		
CIP - Level 3 - Service Redesign	0.50	0.50	
CIP - Level 3 - System stretch	1.60		
Additional CIP delivering after M05	0.40	0.40	0.40
Adjusted Outturn	(1.50)	(3.90)	(4.40)
Plan deficit	(1.53)	(1.53)	(1.53)
Variance to Plan	0.03	(2.37)	(2.87)

- 4.3 Best Case – the best case scenario assumes that the Trust can deliver additional savings in line with the full system deficit stretch target included in the original 2025-26 plan. The Trust will also deliver the additional savings identified for delivery in the second half of the financial year.
- 4.4 Worst Case – the worst case scenario assumes that the Trust does not deliver any of the additional system stretch target savings. As at month five, the Trust has been unable to implement any savings schemes to support this savings ask.

- Revenue to Capital Opportunities – The Trust has no spending planned in this financial year that would provide opportunities to deliver these savings. The ICB has been made aware of this position and a system wide review of this target is underway.
- Service Redesign – As part of the planning process, the Trust identified an opportunity to reduce spend in dermatology, recognising that any service risks would need to be mitigated with system support. As at month five, no agreement on these mitigations has been reached. Discussions with Commissioners are on going to secure additional funding which could then release capacity to deliver these savings.
- General system stretch – As at month 5, the Trust is continuing to explore any opportunities for savings to contribute to this target. To date, all system generated ideas have either already been included in the Trust Level 1 and 2 CIP programmes or have not been relevant to community Trusts. As a system additional ideas and opportunities are continually being developed, and these are all evaluated as they arise.
- This case recognises that there are additional savings that will reduce run rates in the second half of the financial year.

4.5 Medium Case – this scenario recognises the additional savings to delivery in the second half of the financial year and assumes that the additional funding will be secured to enable the service redesign in the dermatology service to proceed.

5. CAPITAL CASH AND BETTER PAYMENT PRACTICE CODE (BPPC)

5.1 The Trust spent £0.32m on capital schemes up to month five, against a plan of £0.25m. This reflects the acceleration of some schemes to avoid delays later in the financial year.

5.2 The latest list of all capital schemes for 2025/26 is presented to the finance committee every month.

5.3 In August 2025 there was a net cash outflow of £1.74m with a closing cash balance of £8.04m.

5.4 Invoiced debt has increased by £0.34m and of that, overdue debt has decreased by £0.20m.

5.5 Total debt has increased by £0.89m compared to prior month and this is primarily due to an increase in invoiced debt and accrued income.

5.6 Total trade and other payables as at 31st August are £8.43m, of which £5.04m relates to creditors.

5.7 Total payables have decreased by £0.64m compared to the previous month.

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

Month	Target to be paid %	No of Invoices %	Value of Invoices %
Apr-25	95.0	97.9	98.2
May-25	95.0	98.6	99.3
Jun-25	95.0	99.4	99.7
Jul-25	95.0	99.0	99.5
Aug-25	95.0	99.3	99.7
Year to date performance	95.0	98.9	99.3

6. RECOMMENDATION(S)

6.1 The Board is asked to:

- Note the contents of this report.
- Note the financial position.
- Note the forecast outturn scenarios.

Committee Chair's Report

Name of Committee/Group:	Strategic People Committee in Common		Report to:	Board of Directors
Date of Meeting:	20 August 2025		Date of next meeting:	17 September 2025
Chair:	Abdul Siddique, Non-Executive Director		Parent Committee:	Board of Directors
Members present/attendees:	<u>Membership of the BCHT Committee</u> Elaine Inglesby, Non-Executive Director (Vice Chair) Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive Jo Waldron, Deputy Director of People and OD. <u>Membership of the WHH Committee</u> Julie Jarman, Non-Executive Director Michelle Cloney, Chief People Officer Mike O'Connor, Non-Executive Director (virtually via Microsoft Teams) Jennie Dwerryhouse, Deputy Chief People Officer Adam Harrison Moran, Head of Strategic Workforce Development Kate Henry, Director of Communications and Engagement <u>For WHH and BCH (Joint Directors)</u> Dan Moore, Chief Operating Officer and WHH Deputy Chief Executive (virtually via Microsoft Teams) Paul Fitzsimmons, Executive Medical Director Ali Kennah, Chief Nurse	<u>Attendees</u> Jan McCartney, BCH Director of Corporate Governance Hayley Heard, WHH Deputy Director of Strategy and Partnerships Ruth Besford, BCH Equality and Inclusion Manager Lynda Richardson, Board and Committee Administrator Carol Ann Kelly (CK) WHH Public Governor, Warrington Halton Kevin Goucher (KG) BCH Public Governor, Warrington	Quorate (Yes/No):	Yes
			Key Members not present:	Committee Member: Michelle Cloney WHH Chief People Officer Lucy Gardner WHH Chief Strategy and Partnerships Officer John Culshaw WHH Company Secretary Abdul Siddique Non-Executive Director Paula Woods BCH Director of People and Organisational Development Nick Gallagher BCH Director of Finance

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

<u>Committee Chair's Report</u> 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	
Better Care Together Integration Update (Workforce and Corporate Services) Organisational Change Framework	BAF 4 and 6		Hayley Heard, Deputy Director of Strategy and Partnerships and Adam Harrison-Moran, Head of Strategic Workforce Development & Culture. The Committee received an update on the workforce and corporate service integration for the Better Care Together programme. Strategic case now agreed and first draft of full business case is due to NHSE by mid-September. All workstreams are on track with the essentials needed prior to transaction. Clinical workstreams are all having follow up meeting from the summits. Workforce workstream has some ambers but these are in relation to some risks which are scoring a 9 but we have mitigations in place for all risks. The Committee noted the Organisational Change Framework which has been fully developed and approved by our staff side colleagues from both organisations. Some good guidance around organisational change and TUPE, including the differences. Hayley also updated on the plans to engage staff in what our values should be with a short survey which will go out for 3 weeks which will support the joint strategy and the requirements on the full business case. The full engagement on the strategy will take place next year. The Committee commended the openness and ease in how it's presented. The Committee suggested that additional clarity in relation to the processes for change and the fact that processes will be equitable and in line with TUPE regulations and employment law i.e sub-board level and below. Adam- Harrison Moran committed to including some detail around this and taking it back to joint staff-side meeting for oversight. Julie Jarman, SPC Chair asked for a follow up report to SPC post transfer on what we have done differently as a result of the consultation process. Agreed for that to come back to SPC in April 2026.	The Committee noted the update, with a request for a follow on update in April 2026	

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

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/ Assurance Given	Action/decision
BCH Workforce Race Equality Standard (WRES) including Bank and Medical Workforce Race Equality Standard	BAF 4 and 6		Ruth Besford, EDI Lead The Committee received a paper on our WRES data for escalation and overall approval at Trust Board. The following highlights were presented. Positive trend in terms of representation of the workforce has increased to 5.5% and today's census data representation is 5.9%. Access to non-mandatory training remains equitable. Disciplinary figures have improved, although numbers are really small. BAME staff experiencing Bullying and Harassment from patients has improved. Challenges around the ability to report on our recruitment figures and ability to report from shortlisting to recruitment continues due to limitations with NHS Jobs and this has been escalated to the national team. Bullying and Harassment from colleagues has deteriorated unfortunately and we have some work to do around that as that doesn't concur with our employee relations reporting internally. Working with OD colleagues to support engagement with staff to understand what is preventing people from speaking up. Discrimination has deteriorated which is reflected across the NHS.	The Committee approved the report for progression to Board.
BCH Workforce Disability Equality Standard (WDES)	BAF 4 and 6		Ruth Besford, EDI Lead The Committee received a paper on our WDES data for escalation and overall approval at Trust Board. The following highlights were presented.	The Committee approved the report for progression to Board.

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

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

Committee Chair's Report

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
			Lots of indicators have seen an improvement this year although disparity does remain in those identifying as having a disability in the staff survey and those reporting via ESR. Some really positive improvement in making reasonable adjustments for the disabled workforce. Very small deterioration in disabled staff feeling valued and engaged.	
Review of Terms of Reference	BAF 4 and 6		Jan McCartney, Director of Corporate Governance The Committee agreed to review the Terms of Reference after the coming together of the Strategic Committee in Common in April 2025. The Committee reflected and agreed that overall progress has been positive and to continue with the current terms of reference and review again after 12 months. The Committee noted that in the last quarter, it would be useful to consider bringing papers together to test how that would work in readiness for April 26. Agreed to have a discussion around Terms of Reference at EMT.	The Committee noted the report.
REVIEW OF MEETING ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			None.	
Risks Escalated			None.	

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

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

Strategic People Committee in Common

Agenda reference:	SPCIC/25/08/96ii			
Subject:	BCH Workforce Race Equality Standard 2025			
Date of meeting:	20 August 2025			
Action required:	For approval and submission to Trust Board for final approval			
Author(s):	Ruth Besford (Equality & Inclusion Manager)			
Executive director sponsor:	Paula Woods, Director of People and Organisational Development			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	Patients	Workforce	Public
			✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	Yes	No	N/A
		✓		
Further Information / Comments:				
The report provides an annual update on the experiences of racially minoritised staff in nine indicators that relate to the legal Trust equality requirements as established in the General Equality Duty of the Public Sector Equality Duty. The Specific Duties of the same are also supported through the publication of relevant data that demonstrates activity and progress. These indicators also align to the requirements of the NHS Equality, Diversity, and Inclusion Improvement Plan high impact areas for action. The indicators also support review of compliance as a public sector body with the Principles and Articles of the Human Rights Act 1998. As a report on changes to the workplace experience of racially minoritised staff in these nine indicators, and brief detail on associated action plans for the coming year, the				

	report can support decision makers discharge duties of due regard to equality and human rights.		
Executive summary:	To provide to this Committee the BCH Workforce Race Equality Standard 2025 report for approval. Information on the data for the nine indicators, ethnicity pay gap, and race disparity ratio 2025 are briefly provided in this cover sheet with full 2025 information within the appendix.		
Purpose: (please select as appropriate)	Approval ✓	To note	Decision
Recommendation:	That the Committee approves this report for submission to the Trust Board for final approval, allowing timely publication in line with mandated deadlines of 31 October 2025.		
Previously considered by:	Committee	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	<i>Submit to Trust Board</i>		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: (if relevant)	None		

1. Background/context

The Workforce Race Equality Standard (WRES) has been mandated within the NHS Standard Contract since 2015, with compliance monitored by NHS England and commissioning bodies. In addition, the reports may be considered as part of any Care Quality Commission review.

The indicators were developed following research undertaken by Roger Kline at the University of Middlesex, published in 2014 as *The Snowy White Peaks of the NHS*¹.

The nine indicators of the WRES consider the experiences of racially minoritised staff when compared to white staff, focusing on areas of nationally recognised disparity such as recruitment, formal disciplinary, and experiences of workplace harassment and bullying.

Within the WRES report there is also details about the BCH Ethnicity Pay Gap 2025 data, a requirement mandated within the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan from 2024, and an update on the mandated Race Disparity Ratio results for Agenda for Change staff.

There is a data submission deadline of 31st May 2025, which the Trust met through internal scrutiny of data and oversight by the People Operational Delivery (POD) Council. This report relates to the later deadline for publication of a report and action plan on the public facing website by 31st October 2025.

2. Key elements

The WRES indicator results for 2025 are as follows:

Indicator 1: Representation Representation of minoritised ethnicities in pay band clusters for non-clinical, clinical, and medical and dental staff	• Overall workforce representation of ethnically diverse staff has continued to increase since WRES reporting began in 2015, with representation now at 6.6%. • The percentage of unknown ethnicity staff representation has decreased further to 0.9% • Disaggregation by staff group shows: ○ Ethnically diverse staff represent 6.9% of the non-clinical workforce, a percentage that continues to increase. The non-clinical workforce is over-represented against the overall ethnicity profile of the workforce in Agenda for Change (AfC) band cluster 5 to 7

	but is under-represented in other pay bands. ○ The clinical workforce is under-representative against the overall workforce ethnicity figure, though percentage representation is increasing. Ethnically diverse staff are over-represented in AfC band cluster 8c to Very Senior Managers against the overall workforce. ○ The medical and dental workforce is over-represented by a significant amount, a similar pattern to that seen across the NHS.
Indicator 2: Recruitment Likelihood of appointment from recruitment shortlisting	• For the second year we have been unable to report the likelihood figure for ethnically diverse applicants progressing successfully through recruitment. This relates to a reporting issue in NHS Jobs, an issue that is affecting a number of NHS Trusts and that is being addressed nationally.
Indicator 3: Formal disciplinary Representation in formal disciplinary processes	• The likelihood of ethnically diverse staff being involved in formal disciplinary processes has improved to a figure of 1.13, while this still indicates disparity for ethnically diverse staff caution is urged due to the very small numbers of staff involved in formal disciplinary processes that affects statistical significance.
Indicator 4: Non-mandatory training and career and professional development opportunities	• At 1.05 the access to non-mandatory training and career development result for indicator 4 remains the same as 2024, and the result represents near equity, with a slight bias in favour of white staff.
Indicator 5: NHS Staff Survey data for harassment, bullying and abuse from: • Patients, families, or public	• At 20.8% the percentage of ethnically diverse staff experiencing harassment, bullying, or abuse from patients, family or public has improved by 7.8% and is 0.8% better than the average for comparator

	Trusts. However, the figure remains significantly higher than that for white staff.
Indicator 6: NHS Staff Survey data for harassment, bullying and abuse from: • Managers • Colleagues	• At 22.6% the percentage of ethnically diverse staff who have experienced harassment, bullying, or abuse from colleagues has deteriorated by 3.5%, and the Trust result is 5.5% worse than the average for comparator Trusts. The gap to white staff has also increased to 7.9%.
Indicator 7: NHS Staff Survey data for equality of opportunity in career progression	• At 44.2% the percentage of ethnically diverse staff who believe the Trust provides equity for career progression and promotion has increased by 10.0%, however there is a gap of 10.4% with the average for comparator Trusts, and there is a gap of 18.5% against white staff.
Indicator 8: NHS Staff Survey data for experiences of workplace discrimination	• At 13.2% the percentage of ethnically diverse staff who experienced discrimination at work in the last 12 months has deteriorated by 5.7%. There is a gap of 2.4% against the average for comparator Trusts, and 8.5% to white staff.
Indicator 9: Board ethnicity representation	• The Board remains over-representative of ethnically diverse staff.
Ethnicity pay gap	• The ethnicity pay gap for the overall workforce was in favour of ethnically diverse staff. The mean result was – 27.68%, or - £5.64 in favour of ethnically diverse staff, and the median result was – 8.00%, or - £1.49 in favour of ethnically diverse staff. More analysis by staff group can be found in the relevant section.
Race disparity ratio	• The race disparity results for the overall workforce has seen some deterioration since 2024, this is reflective of the movements of a very small number of staff making statistical significance difficult to determine. Further analysis is provided in the relevant section.

The full WRES report can be viewed as appendix 1 to this report.

3. Actions required/responsible officer

WRES action plans are managed through the EDI Working Group. From April 2025 updates from this Group have been formalised through submission of Chair reports to People Operational Delivery Council, verbal and ad hoc written reports having been submitted previously.

The responsible officer is the BCH Director of People and Organisational Development.

4. Measurements/evaluations

The WRES indicators use ESR data to establish patterns of representation and outcome from recruitment, to employee relations information, to Board; further indicators include annual NHS Staff Survey data/results.

Historically progress against the WRES indicators has been measured only through the annual WRES report; with the WRES results forming part of the annual Public Sector Equality Duty Report and informing outcomes for Domain 2 of the Equality Delivery System later within the financial year. With the development of a new EDI dashboard in QLIK it is anticipated that improved scrutiny of the ESR based indicators will be enabled through the EDI Working Group.

BCH also has a risk registered that reflects the disparity in reporting of incidents of bullying, harassment, and abuse when compared with NHS Staff Survey data. With actions being undertaken through the EDI Working Group to better understand racially minoritised staff experience so that activity can focus on creating safe and respectful cultures that support civility, respect, and intentional anti-racism.

Qualitative feedback is also valued and is provided through engagement with the BCH Race Inclusion Network. The implementation of staff networks in common with WHH offers opportunities for wider engagement, and enabling of a larger number of voices for race equity that should positively contribute to Trust strategy and equitable cultures.

The actions that contribute to the WRES also align to the commitments that both BCH and WHH have made to the NHS Anti-Racist Framework.

5. Trajectories/objectives agreed

The WRES 2025/26 action plan is briefly detailed within the report, with the SMART plan included within the EDI Priorities action plan for 2025/26 and managed through the EDI Working Group.

6. Monitoring/reporting routes

Monitoring and reporting is through the BCH People governance structure.

7. Timelines

The deadline for publication of the WRES 2025 Report is 31st October 2025, with agreed actions given timescales within the Report.

8. Assurance committee

People Operational Delivery Council Chair report to Strategic People Committee in Common.

9. Recommendations

That the Committee approves this report for submission to the Trust Board for final approval, allowing timely publication in line with mandated deadlines of 31 October 2025.

Appendix 1: Workforce Race Equality Standard 2025

ⁱ <https://repository.mdx.ac.uk/item/84qy7>

Workforce Race Equality Standard

2025

Date: April 2025



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Introduction

The Trust is committed to intentional anti-racism, taking action to identify and address the structural, systemic, and personal racism that impacts on racially minoritised staff in the workplace, and that contributes to an inequitable and exclusive society.

The Workforce Race Equality Standard has been mandated for all NHS providers since 2015. It was established to focus action to reduce the disparity in representation and experience of racially minoritised staff in the NHS, this followed the publication in 2014 of Roger Kline's The Snowy White Peaks of the NHS report¹.

The nine indicators look at difference in workplace experience for racially minoritised and white staff, from likelihood of being recruited, to career advancement, involvement in disciplinary processes, and experiences of bullying and harassment and discrimination from different sources.

The WRES is a mandatory requirement set out in the NHS Standard Contract, and in addition to online submission of results to NHS England all Trusts must publish an annual report detailing the results against the nine indicators and an action plan to address identified disparity in the results. The timeline for compliance is as follows:

- Submission of results against nine indicators by 31st May.
- Publication of full report and action plan by 31st October.

Data is collated from the electronic staff record and the annual NHS Staff Survey before being presented to stakeholder groups, in the case of this Trust the Race Inclusion Network, for co-design of action plans.

Responsibility for delivery of the report and action plan sits with the Equality, Diversity, and Inclusion Working Group, with oversight of the action plan ultimately resting with the Trust Board for sign off and approval.

In addition to being monitored by NHS England, compliance with the WRES and subsequent action plans are also monitored by Trust commissioners and by the Care Quality Commission (CQC), as local intelligence for the well-led domain of the new assessment framework.

In this report are detailed key findings from the 2025 WRES metrics; progress made in 2024/25 against the WRES action plan; and data for the nine indicators, including annual comparisons since 2019, for the race disparity ratio, and for the 2025 ethnicity pay gap reporting.

The WRES Action Plan 2025 - 2026 can be viewed at page 26 of this report.

Key findings

Key findings in brief are as follows.

Indicator 1:

- Overall workforce representation of ethnically diverse staff has continued to increase since WRES reporting began in 2015, with representation now at 6.6%.
- The percentage of unknown ethnicity staff representation has decreased further to 0.9%
- Disaggregation by staff group shows:
 - Ethnically diverse staff represent 6.9% of the non-clinical workforce, a percentage that continues to increase. The non-clinical workforce is over-represented against the overall ethnicity profile of the workforce in Agenda for Change (AfC) band cluster 5 to 7 but is under-represented in other pay bands.
 - The clinical workforce is under-representative against the overall workforce ethnicity figure, though percentage representation is increasing. Ethnically diverse staff are over-represented in AfC band cluster 8c to Very Senior Managers against the overall workforce.
 - The medical and dental workforce is over-represented by a significant amount, a similar pattern to that seen across the NHS.

Indicator 2:

- For the second year we have been unable to report the likelihood figure for ethnically diverse applicants progressing successfully through recruitment. This relates to a reporting issue in NHS Jobs, an issue that is affecting a number of NHS Trusts and that is being addressed nationally.

Indicator 3:

- The likelihood of ethnically diverse staff being involved in formal disciplinary processes has improved to a figure of 1.13, while this still indicates disparity for ethnically diverse staff caution is urged due to the very small numbers of staff involved in formal disciplinary processes that affects statistical significance.

Indicator 4:

- At 1.05 the access to non-mandatory training and career development result for indicator 4 remains the same as 2024, and the result represents near equity, with a slight bias in favour of white staff.

Indicator 5:

- At 20.8% the percentage of ethnically diverse staff experiencing harassment, bullying, or abuse from patients, family or public has improved by 7.8% and is 0.8% better than the average for comparator Trusts. However, the figure remains significantly higher than that for white staff.

Indicator 6:

- At 22.6% the percentage of ethnically diverse staff who have experienced harassment, bullying, or abuse from colleagues has deteriorated by 3.5%, and the Trust result is 5.5% worse than the average for comparator Trusts. The gap to white staff has also increased to 7.9%.

Indicator 7:

- At 44.2% the percentage of ethnically diverse staff who believe the Trust provides equity for career progression and promotion has increased by 10.0%, however there is a gap of 10.4% with the average for comparator Trusts, and there is a gap of 18.5% against white staff.

Indicator 8:

- At 13.2% the percentage of ethnically diverse staff who experienced discrimination at work in the last 12 months has deteriorated by 5.7%. There is a gap of 2.4% against the average for comparator Trusts, and 8.5% to white staff.

Indicator 9:

- The Board remains over-representative of ethnically diverse staff.

Ethnicity pay gap:

- The ethnicity pay gap for the overall workforce was in favour of ethnically diverse staff. The mean result was – 27.68%, or - £5.64 in favour of ethnically diverse staff, and the median result was – 8.00%, or - £1.49 in favour of ethnically diverse staff. More analysis by staff group can be found in the relevant section.

Race disparity ratio:

- The race disparity results for the overall workforce has seen some deterioration since 2024, this is reflective of the movements of a very small number of staff making statistical significance difficult to determine. Further analysis is provided in the relevant section.

Activities in 2024 - 2025

During the past year the following actions that should positively impact on the experiences of racially minoritised staff have been started and/or finished:

- Establishment of the EDI Working Group to deliver the NHS Anti-Racist Framework action plan. Racially minoritised staff representation on the Group is 13%, (overall workforce representation is currently 6.4%), and active recruitment from the Race Inclusion Network (RIN) continues.
- Implementation of the NHS Anti-Racist Framework foundation building action plan, which supported successful achievement of bronze level in April 2025.
- Completion of the Reciprocal Mentoring for Inclusion Programme, of which 30% of staff were recruited from the RIN.
- Continued embedding of Just Culture across the Trust, linking this to a HR equality objective for 2024 – 2026 to develop and implement an ‘equality representation in people processes’ project.
- Launch of the Trust’s Choose Kindness campaign and behavioural framework in July 2024 for promoting a culture of civility and anti-racism in all Trust spaces. Alignment to commitments for the NHS Anti-Racist Framework, the NHS Staff Survey, and Violence Prevention and Reduction Standard commitments.
- Regular communication about racism and anti-racism, particularly following the Southport incident in August 2024.
- Addition of racism data disparity to the corporate risk register to reflect difference in internal reports and that in the NHS Staff Survey, along with activities in progress to address this disparity.
- Publication of our first Ethnicity Pay Gap report within the [WRES 2024 report](#). Updated racist incident reporting through Ulysses system following RIN feedback on barriers to reporting and embedding of racism incident scrutiny at the EDI Working Group.
- Implementation of an ethnicity coding in clinical systems project to improve data quality and support health inequalities requirements.
- Launch of a new equality dashboard for workforce data, allowing real time analysis of ethnicity for sickness absence, leavers, pay banding, career progression, and other data. Work still ongoing for further triangulation of data

such as health and wellbeing data and as referenced above racist incident reporting.

- Refresh of the [Anti-racism and zero tolerance statement](#) following input and review by the RIN in 2025.
- Ongoing work to centre racially minoritised voice, for example in the EDI Working Group; in the recruitment of a Joint RIN Chair from within the membership; and in active recruitment of racially minoritised staff as Freedom To Speak Up Champions (now at 11%), the latter as a result of NHS Staff Survey 2023 results showing both an ongoing disparity in bullying and harassment, and a lack of confidence in speaking up procedures and outcomes.
- Implementing new Equality and Health Inequalities Assessment templates across the Trust – these include an anti-racism question.
- Enabling staff voice through the RIN will continue in 2025 following an engagement event in November 2024 attended

Data sets

Indicator 1

Indicator 1 reports the percentage of staff by pay band. This data is disaggregated by non-clinical, clinical, and medical and dental staffing groups, and reporting is by pay band clusters as follows:

- Cluster 1 = Agenda for Change (AfC) under band 1 to band 4
- Cluster 2 = AfC bands 5 to 7
- Cluster 3 = AfC bands 8a and 8b
- Cluster 4 = AfC band 8c to Very Senior Managers (VSM – Executive Board Members)

The percentage breakdown by non-clinical, clinical, and medical and dental staff is provided in tables 1 to 3.

Table 1: Showing the percentage of non-clinical staff by ethnicity, disaggregated by pay band cluster at 31st March 2025.

Non-clinical staff	Ethnically diverse	White staff	Unknown ethnicity
Cluster 1: AfC <1 to 4	4.1%	94.4%	1.5%
Cluster 2: AfC 5 to 7	14.6%	83.5%	1.9%
Cluster 3: AfC 8a and 8b	6.1%	93.9%	0.0%
Cluster 4: 8c to VSM	5.6%	94.4%	0.0%
Total for non-clinical workforce:	6.9%	91.7%	1.4%

Table 2: Showing the percentage of clinical staff by ethnicity, disaggregated by pay band cluster at 31st March 2025.

Clinical staff	Ethnically diverse	White staff	Unknown ethnicity
Cluster 1: AfC <1 to 4	5.7%	94.0%	0.3%
Cluster 2: AfC 5 to 7	4.4%	95.1%	0.5%
Cluster 3: AfC 8a and 8b	1.6%	96.8%	1.6%
Cluster 4: 8c to VSM	12.5%	87.5%	0.0%
Total for clinical workforce:	4.7%	94.8%	0.5%

Table 3: Showing the percentage of medical and dental staff by ethnicity, disaggregated by consultants, career grade medical and dental staff, and where relevant medical and dental staff as very senior managers, at 31st March 2025.

Medical and dental staff	Ethnically diverse	White staff	Unknown ethnicity
Consultants	44.4%	33.3%	22.2%
Of which very senior managers	0.0%	100.0%	0.0%
Non-consultant career grade	32.4%	66.2%	1.5%
Trainee	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%
Total for medical and dental workforce:	33.8%	62.3%	3.9%

Tables 4 to 7 to follow show the results for the overall workforce, and the three staff groups from 2015 to 2025, showing patterns of change of ethnic representation.

Table 4: Showing the ethnicity breakdown of the workforce from 2015 to 2025.

Full workforce	Ethnically diverse staff	White staff	Not known	Total Staff Number
2015	2.5%	95.6%	1.9%	3,325
2016	2.4%	93.5%	4.1%	3,251
2017	2.6%	90.8%	6.6%	3,305
2018	2.8%	90.6%	6.6%	3,005
2019	3.0%	89.9%	7.2%	3,016
2020	5.7%	89.1%	5.1%	2,048
2021	5.4%	90.5%	4.2%	1,730
2022	5.8%	90.7%	3.5%	1,722
2023	6.2%	92.0%	1.8%	1,541
2024	6.3%	91.8%	1.9%	1,660
2025	6.6%	92.5%	0.9%	1,652

Table 5: Showing the percentage of ethnic representation in non-clinical staff from 2015 to 2025.

Non- clinical staff	Ethnically diverse staff	White staff	Not known
2015	1.9%	96.1%	1.9%
2016	2.1%	94.3%	3.6%
2017	2.2%	89.5%	8.3%
2018	2.5%	89.4%	8.1%
2019	2.4%	91.8%	5.8%
2020	3.0%	92.1%	4.9%
2021	3.7%	91.6%	4.7%
2022	4.4%	91.6%	4.0%
2023	5.3%	92.7%	2.0%
2024	6.2%	91.1%	2.7%
2025	6.9%	91.7%	1.4%

Table 6: Showing the percentage ethnic representation in clinical staff from 2015 to 2025.

Clinical Staff	Ethnically diverse staff	White staff	Not known
2015	1.8%	96.3%	1.9%
2016	1.8%	93.8%	4.4%
2017	2%	92.3%	5.7%
2018	2.1%	92.0%	5.9%
2019	2.4%	90.0%	7.6%
2020	3.5%	91.6%	4.9%
2021	4.3%	91.9%	3.8%
2022	4.6%	92.2%	3.2%
2023	6.6%	91.8%	1.6%
2024	4.5%	94.1%	1.4%
2025	4.7%	94.8%	0.5%

Table 7: Showing the percentage ethnic representation of Medical and Dental staff from 2015 to 2025.

Medical and Dental Staff	Ethnically diverse staff	White staff	Not known
2015	18.4%	78.0%	3.6%
2016	18.4%	79.6%	2.0%
2017	19.3%	70.1%	10.5%
2018	22.3%	68.1%	9.6%
2019	20.5%	70.5%	9.0%
2020	36.6%	55.2%	8.2%
2021	30.5%	64.4%	6.1%
2022	30.1%	63.9%	6.0%
2023	34.5%	57.1%	4.8%
2024	34.7%	60.0%	5.3%
2025	33.8%	62.3%	3.9%

Indicator 2

The second indicator looks at recruitment and the likelihood of racially minoritised staff being successful in recruitment from shortlisting to appointment. As a likelihood figure the following applies to the results:

- A result below 1.0 indicates a greater likelihood of success for racially minoritised applicants.
- A result above 1.0 indicates a greater likelihood of success for white applicants.
- A result of 1.0 indicates equity between racially minoritised and white applicants.

Table 8: Showing the likelihood of ethnically diverse applicants being successfully recruited compared to white applicants from 2015 to 2025. Also showing the numbers of applicants recruited by ethnicity for this period.

	Likelihood	Total Ethnically Diverse Staff Recruited	Total White Staff Recruited	Total Not Stated Staff Recruited
2015	1.85	12	241	*
2016	1.72	24	532	160
2017	1.30	31	498	120
2018	1.24	24	418	30
2019	1.28	23	395	10
2020	1.39	13	224	17
2021	0.61	36	310	*
2022	1.17	23	276	*
2023	1.44	23	209	*
2024	Not available	22	272	*
2025	Not available	17	167	*

Indicator 3

Indicator 3 details the relative likelihood of racially minoritised staff entering formal disciplinary processes compared to not white staff.

A likelihood figure above 1 indicates that racially minoritised staff are more likely to enter formal disciplinary processes than white staff. A likelihood figure of 1 indicates equity between racially minoritised and white staff.

Table 9: Showing the likelihood of ethnically diverse staff entering formal disciplinary processes compared to white staff from 2015 to 2025.

	Likelihood
2015	6.46
2016	4.93
2017	3.83
2018	1.99
2019	2.72
2020	2.4
2021	0
2022	0
2023	2.46
2024	1.53
2025	1.13

Indicator 4

Likelihood of racially minoritised staff undertaking non-mandatory training and professional development compared to white staff.

A likelihood figure above 1 indicates that racially minoritised staff are more likely to enter formal disciplinary processes than white staff. A likelihood figure of 1 indicates equity between racially minoritised and white staff.

Table 10: Showing the likelihood of ethnically diverse staff accessing non-mandatory training and career development opportunities.

	Likelihood
2015	0
2016	0.55
2017	0.9
2018	1.1
2019	1.74
2020	0.6
2021	1.09
2022	0.57
2023	1.79
2024	1.05
2025	1.05

Indicators 5 to 8 are taken from the NHS Staff Survey 2024.

- For indicator 5 there were 53 ethnically diverse respondents, and 938 white respondents.
- For indicator 6 there were 53 ethnically diverse respondents, and 936 white respondents.
- For indicator 7 there were 52 ethnically diverse respondents, and 929 white respondents.
- For indicator 8 there were 53 ethnically diverse respondents, and 925 white respondents.
- In total 62% of all staff responded to the NHS Staff Survey 2024. When mapped against workforce totals at 49% the number of ethnically diverse respondents was slightly below that for the overall workforce.

Indicator 5 – Harassment, bullying, or abuse from patients, families, or the public

Table 11: Showing the percentage of ethnically diverse and white staff experiencing at least one incident of harassment, bullying, or abuse from patients, family members, or the public in the last 12 months.

	Bridgewater ethnically diverse staff	Bridgewater white staff	Benchmark Trusts ethnically diverse staff	Benchmark Trusts white staff
2015	0.0*	28.0%	25.0%	26.0%
2016	23.0%	29.0%	24.0%	24.0%
2017	28.6%	25.8%	26.9%	23.4%
2018	37.5%	26.0%	26.1%	25.7%
2019	28.0%	23.1%	23.7%	25.2%
2020	30.3%	18.2%	23.4%	21.9%
2021	22.2%	20.1%	24.3%	20.6%
2022	29.2%	21.6%	24.2%	21.5%
2023	28.6%	16.2%	22.6%	19.1%
2024	20.8%	13.5%	21.6%	17.6%
Trust Trend 2023 to 2024	Improved by 7.8%			
Against benchmark group for 2024	Positive by 0.8%	*Note: Figure too low to report in 2015		

Indicator 6 – Harassment, bullying, or abuse from managers or colleagues

Table 12: Showing the percentage of staff who have experienced at least one incident of harassment, bullying, or abuse from colleagues in the last 12 months.

	Bridgewater ethnically diverse staff	Bridgewater white staff	Benchmark Trusts ethnically diverse staff	Benchmark Trusts white staff
2015	0.0*	23.0%	24.0%	22.0%
2016	26.0%	24.0%	24.0%	18.0%
2017	21.4%	20.4%	21.8%	18.6%
2018	16.7%	17.5%	24.0%	19.6%
2019	20.0%	20.8%	23.8%	19.6%
2020	15.6%	17.8%	22.9%	16.9%
2021	13.3%	16.9%	20.0%	15.9%
2022	25.0%	16.9%	22.4%	15.6%
2023	19.1%	16.5%	19.4%	15.5%
2024	22.6%	14.7%	17.1%	14.2%
Trust Trend 2023 to 2024	Deteriorated by 3.5%			
Against benchmark group for 2024	Negative by 5.5%			

Indicator 7 – Belief that the Trust provides equal opportunities for career progression

Table 13: Showing the percentage of staff who believed the Trust provided equal opportunities for career progression.

	Bridgewater ethnically diverse staff	Bridgewater white staff	Benchmark Trusts ethnically diverse staff	Benchmark Trusts white staff
2017	50.0%	55.6%	47.3%	61.7%
2018	48.0%	59.1%	47.5%	60.7%
2019	48.0%	58.4%	47.8%	62.5%
2020	33.3%	60.1%	46.8%	66.3%
2021	51.1%	58.9%	50.3%	66.0%
2022	45.8%	62.0%	50.2%	65.9%
2023	34.2%	61.1%	53.7%	65.8%
2024	44.2%	62.7%	54.6%	63.4%
Trust Trend 2023 to 2024	Improved by 10.0%			
Against benchmark group for 2024	Negative by 10.4%			

Indicator 8 – Experiences of discrimination from line managers or colleagues

Table 14: Showing the percentage of staff experiencing discrimination from managers or colleagues in the last 12 months.

	Bridgewater ethnically diverse staff	Bridgewater white staff	Benchmark Trusts ethnically diverse staff	Benchmark Trusts white staff
2015	*	4.0%	12.0%	5.0%
2016	6.0%	7.0%	4.0%	11.0%
2017	11.1%	8.1%	12.1%	5.5%
2018	8.3%	4.4%	10.7%	4.9%
2019	16.0%	4.9%	12.2%	4.3%
2020	12.1%	4.4%	13.5%	4.3%
2021	13.3%	3.6%	12.7%	4.3%
2022	10.4%	3.8%	12.1%	4.2%
2023	7.5%	3.0%	10.8%	4.3%
2024	13.2%	4.7%	10.8%	4.4%
Trust Trend 2023 to 2024	Deteriorated by 5.7%			
Against benchmark group for 2024	Negative by 2.4%			

Indicator 9 – Board representation

Percentage difference between the organisation's Board overall membership and its overall workforce.

Table 15: Showing Board representation of ethnically diverse and white staff compared to the overall workforce from 2015 to 2025.

	Ethnically diverse	White	Not known
2015	*	*	*
2016	-2.5%	2.5%	0.0%
2017	-2.6%	9.2%	-6.6%
2018	-2.9%	-4.1%	7.0%
2019	-3.0%	-8.1%	11.0%
2020	3.4%	-25.6%	22.2%
2021	8.9%	-19.0%	10.1%
2022	7.6%	-17.4%	9.8%
2023	8.1%	-20.7%	12.6%
2024	0.8%	-6.0%	5.2%
2025	9.0%	-8.0%	-1.0%

Ethnicity Pay Gap March 2025

As part of the NHS EDI Improvement Plan all Trusts have been required to publish ethnicity pay gap data from April 2024.

Pay gap reporting is based on a set point in time every year, for ordinary pay this is all staff who were paid at 31st March – termed relevant staff. For bonus pay this is all staff paid bonus pay in the year from 1st April to 31st March, in the Trust this relates to clinical excellence awards.

Results for 2025 are to follow, and the results for 2024 can be found in the WRES 2024 reportⁱⁱ.

Ordinary pay

On 31 March 2025 we employed 1,551 staff who were relevant to ethnicity pay gap reporting, including bank staff paid for work in the relevant period, and excluding substantive staff on statutory sick or maternity pay only on that date for example.

Table 16 shows the number of ethnically diverse and white staff in each pay quartile, the division of female and male staff into four roughly equal groups based on hourly pay.

Table 16: Showing the numbers and percentage of ethnically diverse and white staff in quartiles based on hourly pay at 31st March 2025.

Ethnically diverse staff	Total	Percentage %	White staff	Total	Percentage %
1	17	4.4%	1	370	95.6%
2	20	5.2%	2	368	94.9%
3	26	6.7%	3	363	93.3%
4	36	9.3%	4	351	90.7%

The table to follow details the ethnicity pay gap as a monetary value and percentage.

A positive value indicates a pay gap in favour of white staff, a negative value indicates a pay gap in favour of ethnically diverse staff.

Table 177: Showing the ethnicity pay gap results at 31st March 2025 as a monetary figure, and a percentage, based on hourly rates of pay for ethnically diverse and white staff.

	Mean hourly rate of pay	Median hourly rate of pay
Ethnically diverse staff	£26.03	£20.15
White staff	£20.39	£18.66
Pay Gap monetary value	- £5.64	- £1.49
Pay Gap percentage value	- 27.68%	- 8.00%

It is observed in the table above that there is a positive pay gap in favour of ethnically diverse staff, particularly in relation to mean pay.

To understand this better the Trust has undertaken further analysis by staff group as we understand that the Medical and Dental staff is over-representative of ethnically diverse staff compared to the overall workforce, and with the larger percentage of this group in quartile 4 the figures overall can be impacted.

- Within the total relevant staff for ethnicity pay gap reporting 6.4% are ethnically diverse, and 93.6% are white.
- In the Trust 25.8% of the workforce are in non-clinical roles, this includes most Executive Directors and Non-Executive Directors.
- At 6.9% of the non-clinical workforce ethnically diverse staff representation is reflective of the overall workforce.
- Ethnicity pay gap analysis for non-clinical staff provides the following results:
 - A mean ethnicity pay gap of – 7.17% (equating to - £1.28) in favour of ethnically diverse staff.
 - A median ethnicity pay gap of – 42.09% (equating to - £5.53) in favour of ethnically diverse staff.
- The clinical workforce, excluding Medical and Dental represents 70.0% of the overall workforce.
- At 4.7% of the clinical workforce ethnically diverse staff representation is lower than the overall workforce.

- Ethnicity pay gap analysis for clinical staff provides the following results:
 - A mean ethnicity pay gap of 5.86% (equating to £1.18) in favour of white staff.
 - A median ethnicity pay gap of 3.98% (equating to £0.77) in favour of white staff.
- Medical and Dental roles represent 4.6% of the overall workforce, and at 33.8% ethnically diverse staff are over-representative of the overall workforce.
- Ethnicity pay gap analysis for clinical staff provides the following results:
 - A mean ethnicity pay gap of – 3.05% (equating to - £1.42) in favour of ethnically diverse staff.
 - A median ethnicity pay gap of 12.08% (equating to £5.52) in favour of white staff.

Bonus pay

There were no clinical excellence awards in the Trust awarded in 2024/2025, therefore the result is 0.00% or £0.00.

Workforce Race Disparity Ratio Results 2025

The race disparity ratio action plan was mandated for all Trusts in summer 2021. Nationally the WRES 2020 data was used to calculate individual Trusts race disparity ratio at 31st March 2020. This information was sent to all Chief Executives with instructions on what was expected next – the reduction of the ratio to a likelihood of 1.5 or below.

Trusts were required to understand their data in relation to race disparity in pay and career progression and set targets and actions to level up representation so that it is reflective across the whole Trust. In Bridgewater this target representation was 5.4%, reflective of the ethnicity profile of the Trust in 2020.

The disparity ratio looks at the likelihood of progression of white and ethnically diverse staff from the lower Agenda for Change (AfC) pay bands (bands 1 to 5) to middle pay bands (bands 6 to 7), and upper pay bands (bands 8a to 9). Very senior managers, and medical and dental staffing are excluded.

Table 18 shows the total race disparity ratio results at 31st March 2025. It is observed that in 2024 – 2025 there has been a slight deterioration in the results, this relates to very small staff changes:

- In 2025 ethnically diverse representation at AfC bands 1 to 5 was 5.21%, this was a 3.85% increase in staff numbers from 2024.
- In 2025 ethnically diverse representation at AfC bands 6 and 7 was 5.59%, this was a 14.29% increase in staff numbers from 2024.
- In 2025 ethnically diverse representation at AfC bands 8a – 9 was 3.48%, this was a 33.33% decrease from 2024.
- All of these figures equate to the movements of less than ten ethnically diverse staff in total.

Table 188: Showing race disparity ratio results from 2020 to 2025, detailing the progression of ethnically diverse staff from lower to middle to upper Agenda for Change pay bands.

All Staff	Lower to Middle	Middle to Upper	Lower to Upper
Mar-20	1.13	2.08	2.35
Mar-21	1.32	1.35	1.78
Mar-22	1.24	1.45	1.8
Mar-23	1.34	0.55	0.74
Mar-24	0.99	0.96	0.95
Mar-25	0.93	1.64	1.52

As has been referred to elsewhere within this report the Trust recognises that representation of ethnically diverse staff varies across staff groups, and while overall representation is increasing this differs by staff group and pay band.

As referenced above Very Senior Management and Medical and Dental staff are excluded from this mandated requirement as they are not paid within Agenda for Change pay scales, but a review of non-clinical and clinical workforces does highlight differences to the above overall results.

Non-clinical workforce

It can be observed in table 19, below, that there is a large disparity in non-clinical staff in progression from middle to upper pay bands, that is progression from Agenda for Change bands 5 to 7 up to bands 8a to 9. Progression from the lower to middle, or lower to upper bands are proportionate or positive for ethnically diverse staff.

Further analysis highlights the following:

- In 2025 ethnically diverse staff representation at AfC bands 1 to 5 was 4.65%, ethnically diverse staff numbers remained the same as 2024.
- In 2025 ethnically diverse staff representation at AfC bands 6 to 7 was 19.30%, this was a decrease by 10% in ethnically diverse staff numbers.
- In 2025 ethnically diverse staff representation at AfC bands 8a to 9 was 4.26%, ethnically diverse staff numbers remained the same as 2024.
- This equate to an actual staff number change of less than 5 for ethnically diverse staff, white staff reduced by 11 in total since 2024.

Table 19: Showing the race disparity ratio for non-clinical staff at 31st March 2025.

Non-clinical Staff	Lower to Middle	Middle to Upper	Lower to Upper
Mar-23	0.20	5.38	1.09

Clinical workforce

The final table, table 20 to follow, details the race disparity ratio for clinical staff within the AfC pay band clusters. It will be observed that while the disparity ratio is within the 1.5 tolerance, it is within the favour of white staff in lower to middle, and middle to upper ratios. There is a slightly larger disparity in the ratio for progression from lower to upper pay bands.

Further analysis highlights the following:

- In 2025 ethnically diverse staff representation at AfC bands 1 to 5 was 5.51%, this was an increase of 3.33% in ethnically diverse staff numbers.
- In 2025 ethnically diverse staff representation at AfC bands 6 to 7 was 4.08%, this was a increase by 16.67% in ethnically diverse staff numbers.
- In 2025 ethnically diverse staff representation at AfC bands 8a to 9 was 2.94%, this was a 50% decrease in ethnically diverse staff numbers since 2024.
- This equates to an actual staff number change of less than 5 for ethnically diverse staff, white staff increased by 13 in total since 2024.

Table 190: Showing the race disparity ratio for clinical staff at 31st March 2025.

Clinical Staff	Lower to Middle	Middle to Upper	Lower to Upper
Mar-23	1.37	1.40	1.92

2025 – 2026 action plan

The WRES Action Plan 2025 to 2026 can be viewed below:

Key action	Steps for action	Who	Updates due
Develop and launch new pastoral support and information resources for international staff	Finalise and launch welcome pack for international staff, following immigration law updates in 2025..	EDI Working Group	TBC – awaiting further immigration law updates in 2025
NHS Jobs reporting issue management	Continue to work with NHS Jobs to address the issues impacting on equality reporting.	EDI lead Workforce	September 2025
Equality in people processes project delivery	- Implementation of HR equality objective for 'equality in people processes' project. - Develop supportive equality in people processes training offer: - Unconscious bias - Equality, Diversity and Inclusion - Legislation	HR EDI lead	January 2026
Civility and respect research project delivery	Develop a use informed research project for racially minoritised staff	EDI Working Group	December 2025

	engagement on experiences of bullying, harassment, abuse, and discrimination in the workplace. • Implement research project. • Evaluate results and feedback. • Develop next steps project, for example a Choose Kindness focus or online reporting tool, based on participant feedback		
Develop refreshed and enhanced racism reporting and support project.	• Develop an online racism reporting tool. • Test with RIN. • Develop support package with RIN • Develop communications package with RIN • Launch reporting tool • Monitor and act via EDI W/G	EDI Working Group	September 2025
Career progression research project delivery	• Develop a use informed research project for racially minoritised staff engagement on experiences of career	EDI Working Group	December 2025

	progression and training in the workplace. • Implement research project. • Evaluate results and feedback • Develop next steps project, for example career coaching drop in sessions, based on participant feedback		
Improvements to ESR self-reporting to reduce the gap with NHS Staff Survey reported data	• Engage with communications team to develop a comms plan to target self-reporting within the workforce • Delivery of communications plan	EDI Working Group	November 2025

Contact details

Thank you for taking the time to read our 2025 WRES report.

Should you have any queries or questions or if you would prefer the contents of this report in another language or format, please contact our Equality & Inclusion Manager in the first instance, details below.

Paula Woods (*Director of People and Organisational Development*)
Ruth Besford (*Equality & Inclusion Manager*) ruth.besford@nhs.net

ⁱ <https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf>

ⁱⁱ <https://bridgewater.nhs.uk/aboutus/equalitydiversity/equality-reporting/>

Strategic People Committee in Common

Agenda reference:	SPCIC/25/08/96iv			
Subject:	BCH Workforce Disability Equality Standard 2025			
Date of meeting:	20 August 2025			
Action required:	For approval and submission to Trust Board for final approval			
Author(s):	Ruth Besford (Equality & Inclusion Manager)			
Executive director sponsor:	Paula Woods, Director of People and Organisational Development			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	Patients	Workforce	Public
			✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	Yes	No	N/A
		✓		
Further Information / Comments:				
The report provides an annual update on the experiences of disabled staff in 10 metrics that relate to the legal Trust equality requirements as established in the General Equality Duty of the Public Sector Equality Duty. The Specific Duties of the same are also supported through the publication of relevant data that demonstrates activity and progress. These metrics also align to the requirements of the NHS Equality, Diversity, and Inclusion Improvement Plan high impact areas for action. The metrics also support review of compliance as a public sector body with the Principles and Articles of the Human Rights Act 1998. As a report on changes to the workplace experience of disabled staff in these 10 metrics, and brief detail on associated action plans for the coming year, the report				

	can support decision makers discharge duties of due regard to equality and human rights.		
Executive summary:	To provide to this Committee the BCH Workforce Disability Equality Standard 2025 report for approval. Information on the data for the ten metrics and the disability pay gap are briefly provided in this cover sheet with full 2025 information within the appendix.		
Purpose: (please select as appropriate)	Approval ✓	To note	Decision
Recommendation:	That the Committee approve the report for submission to the Trust Board for final approval, allowing timely publication in line with mandated deadlines of 31 October 2025.		
Previously considered by:	Committee	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	<i>Submit to Trust Board</i>		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: (if relevant)	None		

1. Background/context

The Workforce Disability Equality Standard (WDES) has been mandated within the NHS Standard Contract since 2019, with compliance monitored by NHS England and commissioning bodies. In addition, the reports may be considered as part of any Care Quality Commission review.

The metrics were developed following research undertaken by the Universities of Middlesex and Bedfordshireⁱ published in 2015 and were drafted to align with the existing nine indicators of the Workforce Race Equality Standard.

The 10 metrics of the WDES consider the experiences of disabled staff when compared to non-disabled staff, focusing on areas of nationally recognised disparity such as recruitment and experiences of workplace harassment and bullying.

Within the WDES report there is also for the first time details about the BCH Disability Pay Gap data, a requirement mandated within the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan from 2025.

There is a data submission deadline of 31st May 2025, which the Trust met through internal scrutiny of data and oversight by the People Operational Delivery (POD) Council. This report relates to the later deadline for publication of a report and action plan on the public facing website by 31st October 2025.

2. Key elements

The WDES metric results for 2025 are as follows:

Metric 1: Disability representation in pay band clusters for non-clinical, clinical, and medical and dental staff	• The percentage of disabled staff in the overall workforce has continued to increase since WDES reporting began, with self-reporting through the Electronic Staff Record (ESR) at 31st March 2025 totalling 5.5% disabled staff. • Disaggregation by staff group shows: ○ Disabled staff represent 6.9% of the non-clinical workforce, a percentage that continues to increase. The non-clinical workforce is over-represented against the overall workforce percentage of disabled staff, except in Agenda for Change (AfC) band cluster 5 – 7. ○ Disabled staff represent 5.3% of the clinical workforce, a percentage that continues to increase. The clinical workforce is broadly representative of the overall workforce

	percentage of disabled staff, except at AfC band cluster 8a to 8b. ○ As in previous WDES reporting years there are no self-reported disabled staff in the medical and dental staff group, meaning under-representation by 5.5% against the overall workforce disability figure.
Metric 2: Likelihood of appointment from recruitment shortlisting	• For the second year we have been unable to report the likelihood figure for disabled applicants progressing successfully through recruitment. This relates to a reporting issue in NHS Jobs, an issue that is affecting a number of NHS Trusts and that is being addressed nationally.
Metric 3: Representation in formal capability processes	• We are unable to provide figures within the report as the very small number involved creates a data protection risk. However, there were staff who had self-reported disability involved in some of these cases leading to a likelihood figure of 7.2. This means that in this year disabled staff were more likely than non-disabled staff to be involved in formal capability related to performance.
Metric 4a: NHS Staff Survey data for harassment, bullying and abuse from: • Patients, families, or public • Managers • Colleagues	• Disabled staff experience of harassment, bullying, or abuse from patients/families/public has decreased to 16.4%, this is a continued improvement since WDES reporting began. This showed an improvement of 5.9% since the previous year and the result was 7.3% better than the average for comparator Trusts. • Disabled staff experience of harassment, bullying, or abuse from managers has decreased to 10.4%, this reflects the previous best result for the Trust some years ago. This figure has improved by 2.9% from the previous year, however the result was 0.2% higher than the average for comparator Trusts. • Disabled staff experience of harassment, bullying, or abuse from colleagues has decreased to 15.8%, this is the best result for the Trust since WDES reporting began and reflects a continued improvement in this indicator. The result was an improvement of 2.6% from the previous year, however the result was 0.2% higher than the average for comparator Trusts.
Metric 4b:	• Reporting of harassment, bullying, or abuse by disabled staff has improved by 12.6% this year, a

NHS Staff Survey data for reporting harassment, bullying, or abuse	figure of 57.3% that is the highest score the Trust has achieved in this metric. The result however is still 3.0% lower than that for comparator Trusts.
Metric 5: NHS Staff Survey data for equality of opportunity in career progression	Disabled staff belief that the Trust provides equity of opportunity for career progression has improved by 2.7% to 58.4%, the best result the Trust has achieved for this metric in WDES reporting. The result however is 0.6% lower than that for comparator Trusts.
Metric 6: NHS Staff Survey data showing pressure from manager to attend work while unwell	Presenteeism for disabled staff has improved by 6.6% this year, showing that 15.9% of disabled staff felt pressured to be in work while feeling unwell enough that they would struggle to perform their role. This is the best result for the Trust in this metric since WDES reporting began, and is 3.5% better than the average for comparator Trusts.
Metric 7: NHS Staff Survey data for feeling valued	The result for disabled staff feeling valued for their contribution in the workplace deteriorated by 0.9% this year to 42.4%. This result was also 1.5% below the average of comparator Trusts.
Metric 8: NHS Staff Survey data for having reasonable adjustments made in the workplace	At 88.3% the percentage of disabled staff stating that reasonable adjustments have been made to support them in the workplace has improved by 10.1%, reflecting the Trust's best ever score in this metric. The result was also 5.3% better than the average for comparator Trusts.
Metric 9: NHS Staff Survey data for engagement	Staff engagement with disabled staff has deteriorated by 0.1 to 6.9 this year. This is reflective of the result for comparator Trusts.
Metric 10: Board disability representation	At 11.0% the Executive membership of the Board is over-representative of disabled staff.
Disability pay gap:	The mean disability pay gap result at 31st March 2025 was 31.69% (equating to £6.58) in favour of not disabled staff. The mean disability pay gap result for the same period was 2.29% (equating to £0.44) in favour of not disabled staff. Further analysis is

	provided by staff group in the relevant section of this report.

The full WDES report can be viewed as appendix 1 to this report.

3. Actions required/responsible officer

WDES action plans are managed through the EDI Working Group. From April 2025 updates from this Group have been formalised through submission of Chair reports to People Operational Delivery Council, verbal and ad hoc written reports having been submitted previously.

The responsible officer is the BCH Director of People and Organisational Development.

4. Measurements/evaluations

The WDES metrics use ESR data to establish patterns of representation and outcome from recruitment, to employee relations information, to Board; and the metrics also includes annual NHS Staff Survey data/results.

Historically progress against the WDES metrics has been measured only through the annual WDES report; with the WDES results forming part of the annual Public Sector Equality Duty Report and informing outcomes for Domain 2 of the Equality Delivery System later within the financial year. With the development of a new EDI dashboard in QLIK it is anticipated that improved scrutiny of the ESR based metrics will be enabled through the EDI Working Group.

BCH also has a risk registered that reflects the disparity in reporting, both self-reporting of disability and reporting of incidents of bullying, harassment, and abuse when comparing Trust held and NHS Staff Survey data. With actions being undertaken through the EDI Working Group to better understand disabled staff experience so that activity can focus on creating safe and respectful cultures that support civility, respect, and bringing the whole self to work.

Qualitative feedback is also valued and is provided through engagement with the BCH Enabled Network. The implementation of staff networks in common with WHH offers opportunities for wider engagement, and enabling of a larger number of voices for disability equity that should positively contribute to Trust strategy and equitable cultures.

5. Trajectories/objectives agreed

The WDES 2025/26 action plan is briefly detailed within the report, with the SMART plan included within the EDI Priorities action plan for 2025/26 and managed through the EDI Working Group.

6. Monitoring/reporting routes

Monitoring and reporting is through the BCH People governance structure.

7. Timelines

The deadline for publication of the WDES 2025 Report is 31st October 2025, with agreed actions given timescales within the Report.

8. Assurance committee

People Operational Delivery Council Chair report to Strategic People Committee in Common.

9. Recommendations

That the Committee approve the report for submission to the Trust Board for final approval, allowing timely publication in line with mandated deadlines of 31 October 2025.

Appendix 1: Workforce Disability Equality Standard 2025

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https://repository.mdx.ac.uk/download/87284e08c8fb029c672fb73c0f7573f0c5ac6495fb52526ff8258646168ceb0b/1926413/FINAL_7-1-16.pdf

Workforce Disability Equality Standard

2025

Date: April 2025



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Introduction

Workplace disability equality is important as evidenceⁱ shows that an inclusive, engaged, and healthy workforce contributes positively to improved patient outcomes. Diversity in the workforce is also evidencedⁱⁱ to impact positively on innovation, collaboration, efficiency, and positive experiences for all.

The Workforce Disability Equality Standard (WDES) was introduced in 2019. Modelled on the Workforce Race Equality Standard it was established to focus action to reduce the disparity in experience of disabled staff in the NHS, evidenced nationally in areas such as the NHS Staff Survey, and the researchⁱⁱⁱ undertaken and published by Middlesex University, and the University of Bedfordshire.

The WDES is a mandatory requirement set out in the NHS Standard Contract, and in addition to online submission of results to NHS England all Trusts must publish an annual report detailing the results against ten metrics and an action plan to address identified disparity in the results. The timeline for compliance is as follows:

- Submission of results against 10 metrics by 31st May.
- Publication of full report and action plan by 31st October.

Data is collated from the electronic staff record and the annual NHS Staff Survey before being presented to stakeholder groups, in the case of this Trust the Enabled Staff Network, for co-design of action plans.

Responsibility for delivery of the report and action plan sits with the Equality, Diversity, and Inclusion Working Group, with oversight of the action plan ultimately resting with the Trust Board for sign off and approval.

In addition to being monitored by NHS England, compliance with the WDES and subsequent action plans are also monitored by Trust commissioners and by the Care Quality Commission (CQC), as local intelligence for the well-led domain of the new assessment framework.

In this report are detailed key findings from the 2025 WDES metrics; progress made in 2024/25 against the WDES action plan; and metric data, including annual comparisons since 2019.

The WDES Action Plan for 2025 - 2026 can be viewed at page 22.

Key findings

Key findings for 2025 are as follows.

Metric 1:

- The percentage of disabled staff in the overall workforce has continued to increase since WDES reporting began, with self-reporting through the Electronic Staff Record (ESR) at 31st March 2025 totalling 5.5% disabled staff.
- Disaggregation by staff group shows:
 - Disabled staff represent 6.9% of the non-clinical workforce, a percentage that continues to increase. The non-clinical workforce is over-represented against the overall workforce percentage of disabled staff, except in Agenda for Change (AfC) band cluster 5 – 7.
 - Disabled staff represent 5.3% of the clinical workforce, a percentage that continues to increase. The clinical workforce is broadly representative of the overall workforce percentage of disabled staff, except at AfC band cluster 8a to 8b.
 - As in previous WDES reporting years there are no self-reported disabled staff in the medical and dental staff group, meaning under-representation by 5.5% against the overall workforce disability figure.
- The Trust understands that there is a percentage gap between disabled staff records (5.5%) and the number of staff through the NHS Staff Survey stating they have a disability (30.0%). The definition in the NHS Staff Survey differs to the legal definition of disability in that it omits asking if an impairment or illness has a significant impact on daily life, but Bridgewater, in line with most NHS Trusts, is working to encourage self-reporting through awareness raising messages and guidance for staff.

Metric 2:

- For the second year we have been unable to report the likelihood figure for disabled applicants progressing successfully through recruitment. This relates to a reporting issue in NHS Jobs, an issue that is affecting a number of NHS Trusts and that is being addressed nationally.
- Applicants who report that they have a disability on their application form are flagged, via application reference number, to recruiting managers and the Trust's Disability Confident interview scheme guarantees an interview to all disabled applicants who meet the essential criteria for the role.
- Ongoing work in the Trust is ensuring that only the essential and desirable criteria for a role are included within job descriptions and person specifications, that is what are the requirements for the role, and these are

always considered alongside reasonable adjustments that would support disabled applicants to undertake the role immediately or following a period of training and support.

Metric 3:

- In 2024 – 2025 there were a very small number of capability cases related to staff performance managed through formal processes.
- We are unable to provide figures within this report as the very small number involved creates a data protection risk. However, there were staff who had self-reported disability involved in some of these cases leading to a likelihood figure of 7.2. This means that in this year disabled staff were more likely than non-disabled staff to be involved in formal disciplinary related to performance.
- Any issues related to health, disability and long-term illness would be managed through the Wellbeing and Absence Management Policy and Process, this has reasonable adjustments and support for the holistic health and wellbeing of all staff, but particularly disabled staff weaved throughout.
- Similarly reasonable adjustments for disabled staff, and the potential impact of disability would be considered in all capability cases related to performance.

Metric 4a:

- Disabled staff experience of harassment, bullying, or abuse from patients/families/public has decreased to 16.4%, this is a continued improvement since WDES reporting began. This showed an improvement of 5.9% since the previous year and the result was 7.3% better than the average for comparator Trusts.
- Disabled staff experience of harassment, bullying, or abuse from managers has decreased to 10.4%, this reflects the previous best result for the Trust some years ago. This figure has improved by 2.9% from the previous year, however the result was 0.2% higher than the average for comparator Trusts.
- Disabled staff experience of harassment, bullying, or abuse from colleagues has decreased to 15.8%, this is the best result for the Trust since WDES reporting began and reflects a continued improvement in this indicator. The result was an improvement of 2.6% from the previous year, however the result was 0.2% higher than the average for comparator Trusts.

Metric 4b:

- Reporting of harassment, bullying, or abuse by disabled staff has improved by 12.6% this year, a figure of 57.3% that is the highest score the Trust has achieved in this metric. The result however is still 3.0% lower than that for comparator Trusts.

Metric 5:

- Disabled staff belief that the Trust provides equity of opportunity for career progression has improved by 2.7% to 58.4%, the best result the Trust has achieved for this metric in WDES reporting. The result however is 0.6% lower than that for comparator Trusts.

Metric 6:

- Presenteeism for disabled staff has improved by 6.6% this year, showing that 15.9% of disabled staff felt pressured to be in work while feeling unwell enough that they would struggle to perform their role. This is the best result for the Trust in this metric since WDES reporting began, and is 3.5% better than the average for comparator Trusts.

Metric 7:

- The result for disabled staff feeling valued for their contribution in the workplace deteriorated by 0.9% this year to 42.4%. This result was also 1.5% below the average of comparator Trusts.

Metric 8:

- At 88.3% the percentage of disabled staff stating that reasonable adjustments have been made to support them in the workplace has improved by 10.1%, reflecting the Trust's best ever score in this metric. The result was also 5.3% better than the average for comparator Trusts.

Metric 9:

- Staff engagement with disabled staff has deteriorated by 0.1 to 6.9 this year. This is reflective of the result for comparator Trusts.

Metric 10:

- At 11.0% the Executive membership of the Board is over-representative of disabled staff.

Disability pay gap:

- The mean disability pay gap result at 31st March 2025 was 31.69% (equating to £6.58) in favour of not disabled staff. The mean disability pay gap result for the same period was 2.29% (equating to £0.44) in favour of not disabled staff. Further analysis is provided by staff group in the relevant section of this report.

Activities in 2024 - 2025

- Re-accreditation as Disability Confident Leaders following peer review in March 2025.
- Launch of the Trust's Choose Kindness^{iv} campaign for civility and respect in the workplace. The campaign includes:
 - Launch of a new behavioural framework, including embedding in recruitment.
 - Launch of new Kinder Cultures training led by the Organisational Development team.
 - Launch of Choose Kindness campaign resources, shared with other NHS Trusts as a free resource to use to promote civility and respect in their workplaces.
 - A communications campaign, including initial launch at the July 2024 Leader in Me event for over 100 Trust staff.
- Publication of the new North West Wellbeing and Sickness Absence Policy as part of an early adopter programme for new NHS sickness absence approaches, agreed with Management and Staff Side colleagues in North West Trusts. The policy includes:
 - New paid disability leave for planned absence.
 - Use of regular health and wellbeing conversations, risk assessment, and wellbeing at work action plans to ensure reasonable adjustments and workplace support is identified, recorded and implemented for disabled staff.
 - Collaboration with Occupational Health, and signposting to Access to Work to determine reasonable adjustments recommendations.
 - Removal of automatic triggers for sickness absence processes, moving towards 'cause for concern' management of applicable absence.
- Launch of a new equality dashboard for staff data, allowing triangulation of disability data against metrics such as sickness absence, recruitment, leavers, and internal progression.
- Addition of disability data to Trust risk register to reflect:
 - Disparity in self-reporting when compared to NHS Staff Survey.
 - Aligned to this, potential under-reporting of disability that may impact on WDES and Disability Pay Gap reporting.

- Establishment of the Neurodivergence and Disability Working Group to lead on all activities related to disability awareness and support in the workplace.
- Completion of the AccessAble project to support disabled patient access through the provision of accessibility information for Trust locations.

Data sets

Metric 1

Metric 1 reports the percentage of staff by pay band. This data is disaggregated by non-clinical, clinical, and medical and dental staffing groups, and reporting is by pay band clusters as follows:

- Cluster 1 = Agenda for Change (AfC) under band 1 to band 4
- Cluster 2 = AfC bands 5 to 7
- Cluster 3 = AfC bands 8a and 8b
- Cluster 4 = AfC band 8c to Very Senior Managers (VSM – Executive Board Members)

The percentage breakdown by non-clinical, clinical, and medical and dental staff is provided in tables 1 to 3.

Table 1: Showing the percentage of non-clinical staff by disability, disaggregated by pay band cluster at 31st March 2025

Non-clinical	Disabled	Not Disabled	Not known
AfC1 – 4	7.3%	77.4%	15.3%
AfC5 – 7	4.9%	83.5%	11.7%
AfC8a – 8b	9.1%	75.8%	15.2%
AfC8c – VSM	11.1%	77.8%	11.1%
Total non-clinical workforce %	6.9%	78.4%	14.7%

Table 2: Showing the percentage of clinical staff by disability, disaggregated by pay band cluster at 31st March 2025.

Clinical	Disabled	Not Disabled	Not known
AfC1 - 4	5.1%	78.4%	16.5%
AfC5 - 7	5.3%	79.8%	14.8%
AfC8a – 8b	4.8%	71.0%	24.2%
AfC8c - VSM	12.5%	75.0%	12.5%
Total clinical workforce %	5.3%	78.9%	15.8%

Table 3: Showing the percentage of staff by disability, disaggregated by consultants, and career grade medical and dental staff at 31st March 2025

Medical and Dental Grades:	Disabled	Not Disabled	Not known
Consultants	0.0%	88.9%	11.1%
Non-Consultant Career Grade	0.0%	79.4%	20.6%
Trainee Grades	0.0%	0.0%	0.0%
Total medical and dental workforce %	0.0%	78.9%	15.7%

Tables 4 to 6 to follow show the results for the overall workforce and the staff groups from 2019 to 2025, showing patterns of change of disability representation.

Table 4: Showing the disability breakdown of the total workforce from 2019 to 2025.

Full workforce	Disabled staff	Not disabled staff	Not known
2019	3.4%	63.9%	32.7%
2020	2.8%	74.2%	23.1%
2021	2.7%	75.0%	22.3%
2022	3.0%	74.4%	22.5%
2023	3.2%	80.5%	16.4%
2024	4.0%	80.7%	15.3%
2025	5.5%	78.9%	15.7%

Table 5: Showing the percentage of disability representation in non-clinical staff from 2019 to 2025.

Non-clinical Staff	Disabled	Not Disabled	Not Known
2019	3.9%	66.5%	29.5%
2020	2.8%	75.5%	21.7%
2021	2.7%	75.3%	21.9%
2022	3.3%	74.9%	21.9%
2023	4.5%	80.4%	15.1%
2024	4.9%	79.5%	16.0%
2025	6.9%	78.4%	14.7%

Table 6: Showing the percentage of disability representation in clinical staff from 2019 to 2025.

Clinical Staff	Disabled%	Not Disabled	Not Known
2019	3.3%	64.6%	32.1%
2020	3.1%	75.1%	21.8%
2021	2.8%	75.1%	22.0%
2022	3.1%	74.3%	22.6%
2023	2.8%	80.6%	16.6%
2024	4.1%	80.9%	14.9%
2025	5.3%	78.9%	15.8%

Medical and dental is not detailed, however between 2019 and 2025 WDES reporting shows that there were no staff who self-reported disability in the medical and dental group.

Metric 2

Metric 2 reports the likelihood of disabled applicants being successful in recruitment from shortlisting to appointment. As a likelihood figure the following applies:

- A result below 1.0 indicates a greater likelihood of success for disabled applicants.
- A result above 1.0 indicates a greater likelihood of success for non-disabled applicants.
- A result of 1.0 indicates equity between disabled and non-disabled applicants.

Table 7: Showing the likelihood of successful appointment following shortlisting and interview for disabled, not disabled, and not known applicants from 2019 to 2025.

	Likelihood	Total Disabled Staff Recruited	Total Non-Disabled Staff Recruited	Total Not Stated Staff Recruited
2019	1.45	13	352	-
2020	3.03	*	210	40
2021	1.50	*	174	55
2022	0.69	17	199	84
2023	1.00	11	183	42
2024	Not available	18	177	101
2025	Not available	*	92	85

Metric 3

Metric 3 details the relative likelihood of disabled staff entering formal capability processes compared to not disabled staff. This is for performance related capability only.

Table 8: Showing the likelihood of disabled staff entering formal capability processes compared to non-disabled staff, from 2019 to 2025.

	2019	2020	2021	2022	2023	2024	2025
Likelihood	0.0						7.2
	No disabled staff in formal capability processes						

NHS Staff Survey 2024

Metrics 4a to 9 are taken from the NHS Staff Survey 2024.

- For metric 4a there were 698 non-disabled staff responded to this question, and 298 disabled staff.
- For metric 4b there were 139 non-disabled members of staff, and 82 disabled members of staff responded to the question.
- For metric 5 there were 694 non-disabled staff, and 291 disabled staff responded to this question.
- For metric 6 there were 321 non-disabled staff, and 201 disabled staff responded to this question.
- For metric 7 there were 692 non-disabled staff, and 297 disabled staff responded to this question.
- For metric 8 there were 179 disabled staff responded to this question.
- For metric 9 there were 698 non-disabled staff, and 299 disabled staff responded to this question.

Metric 4a – Harassment, bullying, or abuse from patients, their families, or the public

Table 9: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who experienced harassment, bullying or abuse from patients, their families, of the public in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	31.1%	28.7%	27.4%	27.5%	25.4%	22.3%	16.4%	Improved by 5.9%	Positive by 7.3%
Not Disabled	25.3%	21.6%	16.6%	17.6%	20.8%	14.8%	13.3%		
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	31.2%	29.5%	26.6%	26.8%	26.5%	24.8%	23.7%		
Not Disabled	23%	23.3%	20.7%	19.5%	20.5%	17.3%	16.8%		

Metric 4a – Harassment, bullying, or abuse from managers

Table 70: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who experienced harassment, bullying, or abuse from managers in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	12.2%	15.2%	14.4%	12.8%	10.4%	13.3%	10.4%	Improved by 2.9%	Negative by 0.2%
Not Disabled	7.8%	9.8%	7.2%	5.1%	6.6%	4.4%	4.8%		
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	14.6%	15.1%	14.8%	12.2%	10.7%	10.3%	10.2%		
Not Disabled	8.6%	7.6%	6.9%	6.5%	5.5%	5.3%	4.4%		

Metric 4a – Harassment, bullying, or abuse from other staff

Table 81: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who experienced harassment, bullying, or abuse from colleagues in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	21.6%	20.7%	17.4%	18.7%	22.1%	18.4%	15.8%	Improved by 2.6%	Negative by 0.2%
Not Disabled	11.4%	11.2%	11.6%	12.6%	10.7%	11.8%	11.4%		
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	22.5%	22.3%	19.2%	19.0%	18.5%	18.7%	15.6%		
Not Disabled	12.8%	12.2%	11.6%	10.7%	10.0%	10.4%	9.3%		

Metric 4b – Reporting bullying, harassment, and abuse incidents

Table 92: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who reported incidents of harassment, bullying, or abuse in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	45.6%	47.6%	60.3%	40.5%	48.6%	44.7%	57.3%	Improved by 12.6%	Negative by 3.0%
Not Disabled	52.0%	51.7%	48.3%	55.6%	51.4%	57.1%	51.8%		
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	54.1%	53.7%	56.8%	55.7%	55.8%	57.6%	60.3%		
Not Disabled	55.3%	57.2%	57.5%	58.1%	57.8%	60.1%	61.9%		

Metric 5

Table 10: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who believe their organisation provides equal opportunities for career progression.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	51.0%	48.5%	55.1%	51.8%	56.2%	55.7%	58.4%	Improved by 2.7%	Negative by 0.6%
Not Disabled	60.9%	60.6%	59.6%	60.0%	62.0%	61.8%	61.7%		
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	55.6%	55.2%	59.2%	60.1%	60.5%	60.9%	59.0%		
Not Disabled	61.0%	61.2%	65.0%	65.1%	65.2%	65.6%	63.9%		

Metric 6 – Feeling pressure from a manager to attend work despite not feeling well enough to perform duties

Table 114: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who felt pressured to be in work while unwell.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	25.7%	27.2%	19.6%	28.3%	19.0%	22.5%	15.9%	Improved by 6.6%	Positive by 3.5%
Not Disabled	18.7%	16.7%	19.5%	10.1%	15.8%	12.8%	13.1%		
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	29.2%	25.8%	24.9%	22.4%	20.5%	19.2%	19.4%		
Not Disabled	18.9%	16.7%	17.9%	14.3%	14.0%	13.1%	13.6%		

Metric 7 – Satisfaction with how the Trust values their work

Table 125: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who reported feeling valued by their organisation in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	34.7%	32.9%	41.0%	35.5%	40.8%	43.3%	42.4%	Deteriorated by 0.9%	Negative by 1.5%
Not Disabled	45.4%	48.6%	49.1%	50.1%	48.3%	51.5%	48.4%		
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	39.8%	42.4%	47.5%	43.0%	44.7%	46.4%	43.9%		
Not Disabled	51.3%	53.8%	56.1%	54.2%	54.8%	56.5%	54.4%		

Metric 8 – Percentage of disabled staff who say reasonable adjustments have been made to support them in fulfilling their role

Table 136: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who reported that reasonable adjustments had been made to support them in their role in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	70.3%	75.8%	75.8%	73.4%	85.6%	78.2%	88.3%	Improved by 10.1%	Positive by 5.3%
Benchmark:	2018	2019	2020	2021	2022	2023	2024		
Disabled	77.4%	77.0%	81.5%	77.4%	78.5%	79.3%	83.0%		

Metric 9 – Staff engagement

Metric 9 looks at the staff engagement theme, and scores out of 10.0.

Table 147: Showing the staff engagement score, out of 10, for disabled and not disabled staff in Bridgewater and comparator Trusts from 2018 to 2024.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	Trust Trend 2023 to 2024	Against benchmark group for 2024
Disabled	6.6	6.6	6.8	6.7	6.9	7.0	6.9	Deteriorated by 0.1	Comparable result
Not Disabled	7.2	7.1	7.2	7.3	7.2	7.4	7.3		
Benchmark	2018	2019	2020	2021	2022	2023	2024		
Disabled	6.8	6.9	7.0	6.9	6.9	7.0	6.9		
Not Disabled	7.2	7.4	7.4	7.3	7.3	7.4	7.3		

Metric 10 – Board representation

Metric 10 shows the percentage difference between:

- The organisation's Board total membership and its overall workforce.
- The organisations' Board voting membership and its overall workforce
- The organisations' Board executive membership and its overall workforce

Table 158: Showing percentage Board level representation of disabled and not disabled staff from 2019 to 2024.

		2019	2020	2021	2022	2023	2024	2025
Board – overall workforce	Disabled %	-3.0%	-3.0%	-3.0%	-3.0%	-3.0%	10.0%	2.0%
	Not disabled %	-22.0%	-29.0%	-32.0%	-32.0%	-23.0%	-31.0%	-10.0%
	Not known %							7.0%
Voting membership – overall workforce	Disabled %	-3.0%	-3.0%	-3.0%	-3.0%	-3.0%	10.0%	2.0%
	Not disabled %	-22.0%	-29.0%	-32.0%	-32.0%	-23.0%	-31.0%	-10.0%
	Not Known %							7.0%
Executive membership – overall workforce	Disabled %	-3.0%	-3.0%	-3.0%	-3.0%	-3.0%	13.0%	11.0%
	Not disabled %	-4.0%	-8.0%	-4.0%	-3.0%	-9.0%	-31.0%	4.0%
	Not known %							-16.0%

Disability Pay Gap Report 31st March 2025

As part of the NHS EDI Improvement Plan all Trusts are required to publish disability pay gap data from April 2025.

Pay gap reporting is based on a set point in time every year, for ordinary pay this is all staff who were paid at 31st March – termed relevant staff. For bonus pay this is all staff paid bonus pay in the year from 1st April to 31st March, in the Trust this relates to clinical excellence awards.

Results for 2025 are to follow.

Ordinary pay

On 31 March 2025 we employed 1,316 staff who were relevant to disability pay gap reporting, including bank staff paid for work in the relevant period, and excluding substantive staff on statutory sick or maternity pay only on that date for example. The data also excludes staff who have not stated whether they have a disability of not – not stated and unspecified records.

Table 19 shows the number of disabled and not disabled staff in each pay quartile, the division of staff into four roughly equal groups based on hourly pay.

Table 169: Showing the numbers and percentage of disabled and not disabled staff in quartiles based on hourly pay at 31st March 2025.

Disabled staff	Total	Percentage %	Not disabled staff	Total	Percentage %
1	23	7.0%	1	306	93.0%
2	22	6.7%	2	307	93.3%
3	15	4.6%	3	313	95.4%
4	22	6.7%	4	308	93.3%

The table to follow details the disability pay gap as a monetary value and percentage.

A positive value indicates a pay gap in favour of not disabled staff, a negative value indicates a pay gap in favour of disabled staff.

Table 20: Showing the ethnicity pay gap results at 31st March 2025 as a monetary figure, and a percentage, based on hourly rates of pay for disabled and not disabled staff.

	Mean hourly rate of pay	Median hourly rate of pay
Disabled staff	£14.18	£18.66
Not disabled staff	£20.76	£19.09
Pay Gap monetary value	£6.58	£0.43
Pay Gap percentage value	31.70%	2.29%

It is observed in the table above that there is a positive pay gap in favour of not disabled staff, particularly in relation to mean pay where there is a significant difference.

- This is likely as a result of the significant number of not disabled staff on higher salaries when compared to disabled staff on higher salaries.
- While the percentage representation of disabled staff in quartile 4 is broadly reflective, and individual quartile mean figures are largely similar between disabled and not disabled staff, the mean result is influenced by the cumulative contribution of these higher salaries to the final pay amount.
- The mean result is also impacted by the absence of self-reported disability in the medical and dental staff group, a group represented within quartile 4 and without any self-reported disabled staff.
- The median result allows for the balancing effect of the majority of staff in standardised Agenda for Change pay bands.

To understand disability pay gaps better the Trust has undertaken further analysis by two staff groups – non-clinical and clinical staff. Medical and dental have been excluded from further analysis as there are no staff who have self-reported a disability in this group.

- At 7.5% of the non-clinical workforce disabled staff representation is higher than the overall workforce.

- Disability pay gap analysis for non-clinical staff provides the following results:
 - A mean disability pay gap of 3.26% (equating to £0.59) in favour of not disabled staff.
 - A median disability pay gap of 2.44% (equating to £0.33) in favour of not disabled staff.
- At 6.15% of the clinical workforce disabled staff representation is similar to that in the overall workforce.
- Disability pay gap analysis for clinical staff provides the following results:
 - A mean disability pay gap of – 7.53%% (equating to - £1.51) in favour of disabled staff.
 - A median disability pay gap of 2.15% (equating to £0.42) in favour of not disabled staff.

Bonus pay

There were no clinical excellence awards in the Trust awarded in 2024/2025, therefore the result is 0.00% or £0.00.

2025 – 2026 action plan

Please find below the outline action plan for the WDES for 2025 – 2026:

Key action	Steps for action	Who	Updates due
Develop and launch new support resources for effectively managing and supporting disabled and neurodivergent staff	• Develop supporting disabled and neurodivergent staff guidance for within recruiting/line managers packs and training. • Review HR skills training and embed links to resources. • Agree webpage edits with communications team, supported by HWB team. • Engage with Network members to finalise content. • Launch resources.	EDI Working Group	October 2025
NHS Jobs reporting issue management	Continue to work with NHS Jobs to address the issues impacting on equality reporting.	EDI lead Workforce	September 2025
Equality in people processes project delivery	• Implementation of HR equality objective for 'equality in people processes' project. • Develop supportive equality in	HR EDI lead	January 2026

	people processes training offer: • Unconscious bias • Equality, Diversity and Inclusion • Legislation		
Civility and respect research project delivery	• Develop a use informed research project for disabled staff engagement on experiences of bullying, harassment, abuse, and discrimination in the workplace. • Implement research project. • Evaluate results and feedback • Develop next steps project, for example a Choose Kindness focus or online reporting tool, based on participant feedback	EDI Working Group	December 2025
Career progression research project delivery	• Develop a use informed research project for disabled staff engagement on experiences of career progression and	EDI Working Group	December 2025

	training in the workplace. • Implement research project. • Evaluate results and feedback • Develop next steps project, for example career coaching drop in sessions, based on participant feedback		
Improvements to ESR self-reporting to reduce the gap with NHS Staff Survey reported data	• Engage with communications team to develop a comms plan to target self-reporting within the workforce • Delivery of communications plan	EDI Working Group	November 2025

Contact details

Thank you for taking the time to read our WDES 2025 report. Should you have any queries or questions or if you would prefer the contents of this report in another language or format, please contact our Equality & Inclusion Manager in the first instance, details below.

Paula Woods (*Director of People and Organisational Development*)
Ruth Besford (*Equality & Inclusion Manager*) ruth.besford@nhs.net

ⁱ https://assets.publishing.service.gov.uk/media/5a7c8e0d40f0b62aff6c27d9/dh_129662.pdf

ⁱⁱ <https://www.mckinsey.com/featured-insights/diversity-and-inclusion/diversity-matters-even-more-the-case-for-holistic-impact>

ⁱⁱⁱ <https://repository.mdx.ac.uk/item/86196>

^{iv} <https://bridgewater.nhs.uk/choose-kindness/>

TERMS OF REFERENCE STRATEGIC PEOPLE COMMITTEE IN COMMON

1. PURPOSE

The Strategic People Committee in Common (the "Committee") is established to enable collaboration, strategic alignment, and efficient decision-making between Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees the Trusts' people and organisational development strategies to enhance patient care, operational efficiency, and resource use, aligning with NHS regulations and local priorities.

The Committee Supports:

WHH's Strategic Objective 2:

- *We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future* the Committee will ensure that there are arrangements in place to enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

BCHT's Strategic Objective 3, 5 and 6:

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

The Committee provides assurance to both sovereign Trust Boards that people strategies align with quality aims, overseeing the development and implementation of a joint People Strategy, Workforce Equality, Diversity and Inclusion Strategy, and Culture Plan as the Trusts progress toward integration by April 2027.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly at either the Warrington Hospital site or Spencer House.

3. MEMBERSHIP

3.1. Membership of the WHH Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Warrington)
- Chief People Officer (WHH)
- Deputy Chief People Officer (WHH)
- Chief Finance Officer (WHH)
- Chief Nurse (WHH)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director

- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Company Secretary
- Head of Strategic Workforce Development & Culture

3.2. Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Director of People and Organisational Development (BCHT)
- Deputy Director of People and Organisational Development
- Director of Finance (BCHT)
- Chief Nurse and (Deputy Chief Executive BCHT)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director
- Director of Corporate Governance (BCH)

The Joint Chief Executive and other staff members may also be invited/ expected to attend for appropriate agenda items; however, there is no requirement to attend the whole meeting.

3.3. Observers:

- Council of Governors' representative from WHH and BCHT
- Other staff members may also observe the meeting with prior permission of the Committee Chairs.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. However, attendance in person at the meeting is strongly encouraged to facilitate more effective collaboration, engagement, and decision-making. Should the need arise, the Committee in Common may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members NHS email account.

4. QUORUM

A quorum requires four members: two from each Trust, including one Non-Executive Director per Trust and the Chief People Officer/ Director of People and Organisational Development (or nominated Deputy) If a Non-Executive Director is unavailable, a substitute Non-Executive Director from the respective Trust may attend and count toward the quorum.

The Committee shall be quorate provided each Trust each Trust's Committee is quorate; however, if a single Committee of one Trust is quorate, it can undertake business exclusive to that Trust. Each single Committee will reserve the right during a committee meeting to unilaterally decide matters pertaining only to their Trust, should agreement on the matter not be possible across both Committees.

For the avoidance of doubt, a person can count as a member of both committees provided they hold a related in common role.

5. AUTHORITY

The Committee in Common is authorised by both sovereign Trust Boards to investigate matters within its remit, request information from employees (who must comply), and escalate issues requiring further assurance to either Trust's Audit Committee.

The Committee in Common may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee at WHH or BCHT.

The Committee in Common must comply with the provisions of the respective Trust's Schemes of Reservation & Delegations and Standing Financial Instructions, including the declarations concerning conflicts of interest.

The CiC does not inherently make joint decisions that legally bind the sovereign boards of both organisations. It is a governance arrangement where separate statutory bodies meet together to coordinate decision-making. Each committee remains accountable to its own sovereign board, and decisions made within a CiC are technically separate but synchronised to achieve a unified outcome.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair(s) of the Committee will provide a written Committee assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee (at BCHT or WHH) any issues that require disclosure to it, approval or require executive action.

The Committee will report to the Trust Boards at WHH and BCHT annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Committee by the Trust Boards.
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Boards.
- To provide overview and scrutiny to the development of the WHH and BCHT People Strategies.
- To ensure the WHH and BCHT People Strategies are designed, developed, delivered, managed and monitored appropriately.
- To ensure the WHH and BCHT Workforce Equality, Diversity and Inclusion Strategies are designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the WHH and BCHT People Strategies are provided.
- To receive, agree and monitor progress on the WHH and BCHT People Strategies through receipt of exception reports and updates.
- To ensure that the Trusts attract and retain their workforce using the principles of Model Employer to become the employers of choice.
- To review the consultation, negotiation and approval of all employment policies on an annual basis, including:

- Details of any delays in consultation timeframes which impact on the maintenance of a current valid policy,
- Details of any employee relations negotiations delaying policy approval,
- Details of extensions to policy dates,
- Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and,
- Details of any trends or employment issues associated with external factors influencing policy content.
- To receive the annual National Staff Survey results and to provide a set of recommendations for action by the Trusts.
- To receive, agree and monitor the staff engagement activity at both Trusts, including reward and recognition programmes. Ensuring the effectiveness of these activities on improved morale, increased Quarterly People Pulse scores and subsequent impact on patient experience.
- To ensure that all statutory and regulatory obligations are met in relation to equality, diversity and inclusion. The Committee holds the delegated responsibility on behalf of the Trust Board at BCHT and WHH for the approval of all equality, diversity and inclusion regulated reporting where the Committee is quorate.
- To receive, agree and monitor the Health and Wellbeing activity in both Trusts to be assured of the effectiveness of these activities on improving staff experience.

Duties – advisory:

- Consider any relevant ‘people’ risks within both Board Assurance Frameworks and corporate level risk registers as they relate to the remit of the Committee, as part of the reporting requirements,
- To ensure that there is a framework in place for Education Governance to support the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor both Trusts’ performance against national standards so far as they relate to employment.
- To monitor the effectiveness of both Trusts’ workforce performance reporting systems ensuring that the Trust Boards are assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Integrated Performance Indicators relevant to the remit of the Committee.
- To report any areas of significant concern to the Trust Boards as appropriate via the Committee Assurance Report.
- To monitor the implementation of Improving People Practices principles for WHH and BCHT through the adoption of a Just and Restorative Culture, including
 - Details of Employee Relations Cases in respect of numbers,
 - Summary of workforce demographics,
 - Analysis and impact assessment of emerging themes,
 - Identification of any risks associated with complex case work such as Employment Tribunal cases, Subject Access Requests, and costs,
 - Overview of lessons learned and actions taken to address these,
 - Specific information on those cases where suspension/exclusion is involved, including any Supporting Attendance dismissals/appeals.
- To monitor the progress with Internal Audit recommendations where there is limited or no assurance identified.

- To monitor the delivery of staff engagement reports, including the NHS Staff Survey results and action plans.
- Monitor ward and maternity staffing data.

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented.

The following Sub-Committees/ Groups will report directly to the Committee:

WHH:

- Operational People Sub Committee
- Workforce Inclusion and Culture Sub-Committee
- Workforce Review Group

BCHT:

- People Organisational Delivery Council (the “POD”)
- Medical and Dental Professional Governance
- Flu Group

Each Sub-Committee will submit a Chair Log Report to their respective Boards detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

- The Committee will be supported by a member of the Corporate Governance Team from either WHH or BCHT
- The Terms of Reference will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm one week preceding the Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate and equality and diversity considerations included
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / People Professional Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting unless otherwise agreed with the Chair of the Committee
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair(s) of the Committee.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. By standard, these Terms of Reference will be reviewed

annually by the Committee. From April 2025, these Terms of Reference will be reviewed within three months.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Strategic People Committee in Common
Version:	V1
Implementation Date:	April 2025
Review Date:	March 2026
Approved by:	TBC
Approval Date:	TBC – April 2025

REVISIONS			
Date	Section	Reason on Change	Approved
February 2025	Terms of Reference	Revised Terms of Reference developed to create a Strategic People Committee in Common	TBC – April 2025

TERMS OF REFERENCE OBSOLETE		
Date	Reason	Approved by:
April 2025	WHH v7.1 Strategic People Committee to be replaced by v1 Strategic People Committee in Common	TBC – April 2025
April 2025	BCHT v2.3 People Committee to be replaced by v1 Strategic People Committee in Common	TBC – April 2025

Committee Chair's Report

Name of Committee/Group:	Strategic People Committee in Common		Report to:	Board of Directors
Date of Meeting:	17 September 2025		Date of next meeting:	15 October 2025
Chair:	Abdul Siddique, Non-Executive Director		Parent Committee:	Board of Directors
Members present/attendees:	<u>Membership of the BCHT Committee</u> Abdul Siddique, Non-Executive Director (in the Chair) Elaine Inglesby, Non-Executive Director Nick Gallagher, Director of Finance Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive <u>Membership of the WHH Committee</u> Julie Jarman, Non-Executive Director Michelle Cloney, Chief People Officer Mike O'Connor, Non-Executive Director (virtually via Microsoft Teams) Jennie Dwerryhouse, Deputy Chief People Officer Adam Harrison Moran, Head of Strategic Workforce Development John Culshaw, Company Secretary Kate Henry, Director of Communications and Engagement <u>For WHH and BCH (Joint Directors)</u> Dan Moore, Chief Operating Officer and WHH Deputy Chief Executive Paul Fitzsimmons, Executive Medical Director	<u>Attendees</u> Neil Gregory, WHH Assistant Director for Planned Care Laura Hilton, WHH ACPO Carl Roberts, WHH ACPO Tracy Fennell, Deputy Chief Nurse and Director of Quality Tania Strong, Assistant Director of People and OD Kathryn Sharkey, Assistant Director of Workforce and EPD Lynda Richardson, Board and Committee Administrator <u>Observers:</u> Carol Ann Kelly, Public Governor, Warrington and Halton Audrey Fitzpatrick, BCH Public Governor	Quorate (Yes/No):	Yes
			Key Members not present:	Jane Hurst, Chief Finance Officer Ali Kennah, Chief Nurse

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

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/ Assurance Given	Action/decision
BCH Director of People Report	BAF 4 and 6		Paula Woods, Director of People and OD provided headline updates on the staff survey launch, veteran accreditation, with additional details on survey content and support for teams undergoing change. The staff survey has been launched with a target response rate of 62%, supported by a coordinated communications plan. New questions on socioeconomic background have been added, and efforts are being made to maximise participation and use the results to inform future interventions. Veteran Accreditation and Leadership Development: Bridgewater is due for veteran accreditation in February, with plans to work in parallel with WHH. The Northwest Leadership Academy is offering monthly sessions for leadership and OD professionals, providing opportunities for sharing best practices and influencing regional programmes. Bridgewater is due to meet the regional lead on the 2nd October. The NHS North West Leadership Academy has invited OD and L&D professionals from its member organisations to a monthly informal drop-in session featuring national leadership development updates, local insights, support offers, and an open Q&A. Each drop-in will be designed to support professionals in their roles, and will include: • a national update on leadership developments • local membership news and highlights • open Q&A and discussion	The Committee noted the update

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/ Assurance Given	Action/decision
			Domestic Abuse and Sexual Safety Allies - the development of a Community of Practice and Steering Group – ICB Cheshire & Merseyside Bridgewater has representation on all of the associated Cheshire & Merseyside Groups. Tania Strong, Assistant Director of People & OD has a place on the Programme Steering Group which has its inaugural meeting on the 29 September.	
Nursing and Midwifery Job Evaluation and Profile Review	BAF 4 and 6		Laura Hilton and Tania Strong Assistant Director of People and OD and Laura Hilton, Associate Chief People Officer led a detailed discussion on the national and local review of nursing and midwifery job profiles, outlining the data analysis, risk assessment, and collaborative actions being taken to ensure up-to-date, equitable job descriptions and to address emerging risks around banding. Discussion was held about opportunities for efficiencies and quality improvement alongside the job description workstream. BWCH shared details of the planned work programme and development of competencies to sit alongside Job Descriptions, which has slowed because of the priority shifting to job description development. The committee would continue to be updated as the work programme progressed.	The Committee noted the presentation.
Workforce Integrated Performance Reports	BAF 4 and 6		Kathryn Sharkey, Assistant Director of Workforce and EPD and Tania Strong, Assistant Director of People and OD reported on workforce performance metrics, highlighting rising sickness absence—particularly due to stress and anxiety—turnover, and the impact of integration, with discussions on	The Committee noted the 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
			interventions, policy reviews, and the need for enhanced managerial support and communication. Both Bridgewater and Warrington reported increased sickness absence rates, with stress and anxiety as leading causes. Bridgewater data showed rising absence across all staff groups, including traditionally low-absence managerial grades, and a correlation with integration-related anxieties. Actions include targeted support for high-absence teams, earlier intervention, targeting behaviours and coaching frameworks, and providing more support to managers on early identification of concerns – a RAG rating tool is being implemented to support this. Debate was had on the respective organisations sickness absence policies — particularly the absence of triggers at Bridgewater, which is under scrutiny due to ongoing high absence rates. Concerns were raised about the low rate of return-to-work conversations and the need for more direct communication between managers and staff, especially regarding integration. Efforts are underway to improve reporting, provide managers with resources, and prioritise one-to-one support for staff off with stress or anxiety. Turnover figures were contextualised by recent staff transfers and headcount reductions. Apprenticeship numbers remain strong despite financial controls, with ongoing efforts to support career development and internal progression.	

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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
Workforce Brief on National, Regional, ICB or Local Workforce Issues	BAF 4 and 6		Jennie Dwerryhouse, Deputy Chief People Officer Financial Control and Oversight Group Cheshire and Mersey ICB, facing financial challenges, has established a Financial Control and Oversight Group Meeting bi-weekly, the group focuses on key areas including Workforce, Corporate Services, Medical Optimisation, Procurement, Planned Care, and Transport Cost Improvement. Current priority programmes include: • Reducing medical spend on waiting list initiatives by 25% • Standardising medical bank rates for junior doctors • Cutting nursing overtime by 50%, • Aligning car parking charges regionally Additionally, the Chief People Officer group is scoping initiatives targeting sickness absence reduction (1% reduction in sickness absence), cessation of non-clinical bank work, headcount reduction, non-clinical overtime control, and non-nursing clinical pay reductions. These efforts support level 3 Cost Improvement Plans (CIP), provided they do not overlap with existing CIP schemes. Transforming People Services – Target Operating Model Aiming to tackle inefficiencies in current HR services, this initiative seeks to transform people services from transactional and fragmented processes into a streamlined, automated, and strategic function.	The Committee noted the 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
			KPMG has been commissioned to develop a strategic business case and target operating model options. Mutually Agreed Resignation Scheme (MARS) Approved by the Executive Management Team on 9th September 2025, the MARS scheme is planned for both BCH and WHH to manage workforce reductions voluntarily. The scheme follows national guidelines and requires multiple levels of internal and NHS England approvals before launch. Key dates include: • Staff engagement and governance approvals through September-October 2025. • Application window from November 2025 to January 2026. • Resignation completions by March 2026, with potential scheme operation extending to April 2027. The Committee approved the MARS approach for onward submission and NHSE clearance.	
Better Care Together Integration (Workforce and Corporate Services)	BAF 4 and 6		Adam Harrison-Moran, Head of Strategic Workforce Development & Culture. The Committee received an update on the workforce and corporate service integration for the Better Care Together programme. Due Diligence and Business Case Development: The workforce aspect of due diligence is being led internally, supported by KPMG, with a plan to conclude by mid-october. The full business case includes detailed workforce content, such as	The Committee noted the 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
			staff consultation, engagement strategies, and the people strategy for the merged organisation. Transitional Structures and Staff Engagement: Draft transitional structures are being developed detailing how 'Day 1' will look like, with clear communication to staff about the 'lift and shift' model and future organisational form. Engagement sessions and case studies are being used to clarify changes, and staff side input is being sought to ensure legal and procedural compliance. NHSE review of strategic case is in progress with outcome expected in mid-October Shared Values and Behavioural Framework: A joint values engagement exercise achieved high response rates, with feedback informing the development of a new behavioural framework. The aim is to ensure that new values are relatable, lived, and embedded across the combined organisation from April. Operational Readiness and Risk Management: Key operational projects include the demerger and migration of the electronic staff record (ESR), the implementation of a single finance ledger, and the launch of a combined corporate induction in November 2025. A joint vacancy approval process has been agreed, this will be live from September 2025, and the first joint panel will take place in November 2025. Risks are being closely monitored, particularly around legalities and the impact of integration on staff well-being and service delivery.	

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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
			Community EPR: An options appraisal has been developed and shared with BCH procurement and programme colleagues recommending option to run a mini-competition via the LPP framework. WWH People Directorate have proposed to stand down organisational change and job evaluation leading up to the transfer date, subject to EMT approval. A similar priority assessment is being undertaken within BWCH. Resus and Occupational Health contracts are planned to be integrated and should deliver efficiencies.	
Culture Plan 2025-2027 Bi-Annual Update	BAF 4 and 6		Adam Harrison-Moran, Head of Strategic Workforce Development & Culture and Tania Strong, Assistant Director of People and OD. An overview and update was provide on the activities linked to the WHH Culture Plan. Highlights of the equivalent culture/OD/HWB offer was provided for BWCH. The paper highlighted the evolution of the "We are WHH: Culture Plan" which has now been superseded by a Joint Culture Plan for both organisations, reflecting a shared commitment to embedding a cohesive organisational culture as a foundation for successful integration. Staff voice forums, culture champions, and staff networks in common will be used to gather feedback and ensure that interventions are responsive to staff needs.	The Committee noted the report.

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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
Safe Staffing Assurance Report – July 2025	BAF 4 and 6		Tracy Fennel Deputy Chief Nurse and Director of Clinical Governance and Jeanette Hogan, Deputy Chief Nurse Safe Staffing Report Highlights: Operational pressures persisted in July, with increased use of escalation beds and short-term sickness. Recruitment campaigns have reduced vacancies, especially in nursing and ED. Red flags and falls have increased, prompting targeted quality improvement work. Apprenticeship programmes are supporting internal development. Community and Inpatient Staffing Data: Bridgewater's inpatient unit, Padgate House, reported high fill rates but ongoing vacancies in leadership roles. Falls remain the main harm, with pressure ulcers monitored trust-wide. Bank staff usage continues, with no agency use reported.	The Committee noted the report.
BCH and WHH General Medical Council (GMC) Revalidation Annual Report/Responsible Officer Annual Reports	BAF 4 and 6		Paul Fitzsimmon, Joint Medical Director Paul presented the annual appraisal and revalidation submission for WHH and Bridgewater, noting high compliance and positive benchmarking at WHH, but identifying concerns and improvement actions for Bridgewater doctors. WHH Appraisal Rates: Out of 359 doctors at Warrington Halton, 88% had an appraisal in the last 12 months, with 9% having allowable misses due to reasons like long-term sickness or maternity leave, and only 0.6% (6 individuals) with unallowable missed appraisals.	The Committee noted the report and asked for BWCH compliance rates to be addressed.

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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
			Revalidation Outcomes: There were 76 revalidation decisions at WHH, with 93 positive recommendations and 3 deferrals, two due to appraisal status and one for another reason, reflecting strong performance against national benchmarks. Bridgewater had 17 associated doctors, with only 47% completing appraisals and 53% having missed appraisals, which Paul identified as an area of concern. No revalidations were required this year, but future compliance is a risk. Bridgewater doctors have been moved to the same electronic appraisal system as WHH to improve oversight, and plans are on place to bring Bridgewater doctors under the same governance and practices to raise compliance rates. Paul described quality assurance measures, including regular appraiser training sessions, feedback collection and review, and external peer review, which provided positive assurance of the appraisal process. Paul outlined the items for escalation to the respective Trust Boards, including GMC revalidation, governance approvals, and action log points, ensuring that key metrics and decisions are monitored and reported. The Committee requested that the low appraisal completion rate for	

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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
			Bridgewater doctors be addressed via the suggested integration into the electronic system and aligning processes with WHH, aiming for 100% compliance. Update: Further to the Committee a correction to the BWCH data was received by Paul Fitzsimmons and has identified that compliance is at 100%.	
BOARD ASSURANCE FRAMEWORK	BAF 4 and 6		Paula Woods presented the BAF. No changes were made to BAF 6. For BAF 4 the following was agreed: Principal risk - Add 'national, regional and system finance and workforce targets and work programmes and targets to reduce headcount, bank, agency, overtime and sickness'. Prevent Controls & Assurance - Executive Vacancy Control Panel - Delivery Unit - E-roster System – Agency, Bank and Overtime Approval Process - Finance & Workforce Principles - Migration of Agency to NHSP	The Committee noted the updates to the BAF.

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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
			Detect Controls - E-roster - ESR reporting - Overtime, Bank & Agency Reports Emerging Risk - Add RCN Industrial Action Risk Closed - Remove Apprenticeship Levy	
REVIEW OF MEETING ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			For BAF 6 'national, regional and system finance and workforce targets and work programmes and targets to reduce headcount, bank, agency, overtime and sickness was added, and an emerging risk of RCN Industrial action linked to the pay award was added.	
Risks Escalated			None.	

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Organisational Strategy Development

Lucy Gardner, Chief Strategy and Partnerships Officer

Kate Henry, Director of Communications and Engagement

Adam Harrison-Moran, Head of Culture and Inclusion

Better Care Together

Home · Community · Hospital

Ask of Trust Board today

- Approve interim mission, vision, aims and strategic objectives, April 2026 – December 2026
- Approve proposed values for enlarged organisation, from 1st April 2026

Context

- Overarching strategy needed for the integrated organisation
- Strategy development to align with accelerated transaction timeline and continue through 2026
- Current WHH and BCH strategies valid to end of 2026
- FBC needs to include vision, values, aims and objectives for our integrated organisation by mid September
- Staff feedback suggests areas for immediate prioritisation are around the TUPE and organisational change processes and the development of our values
- Phased approach to strategy development to respond to:
 - staff feedback
 - acceleration requirements
 - the need for full and extensive engagement on future strategy

Local priorities/opportunities

Regional priorities/opportunities

National priorities/opportunities



**North Cheshire and Mersey
Healthcare Partnership**

Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

5-year organisational plan

Organisational Strategy

Clinical Strategy

Financial Strategy

Estates development plan

Enabling strategies

Annual Operational Plans

Better Care Together

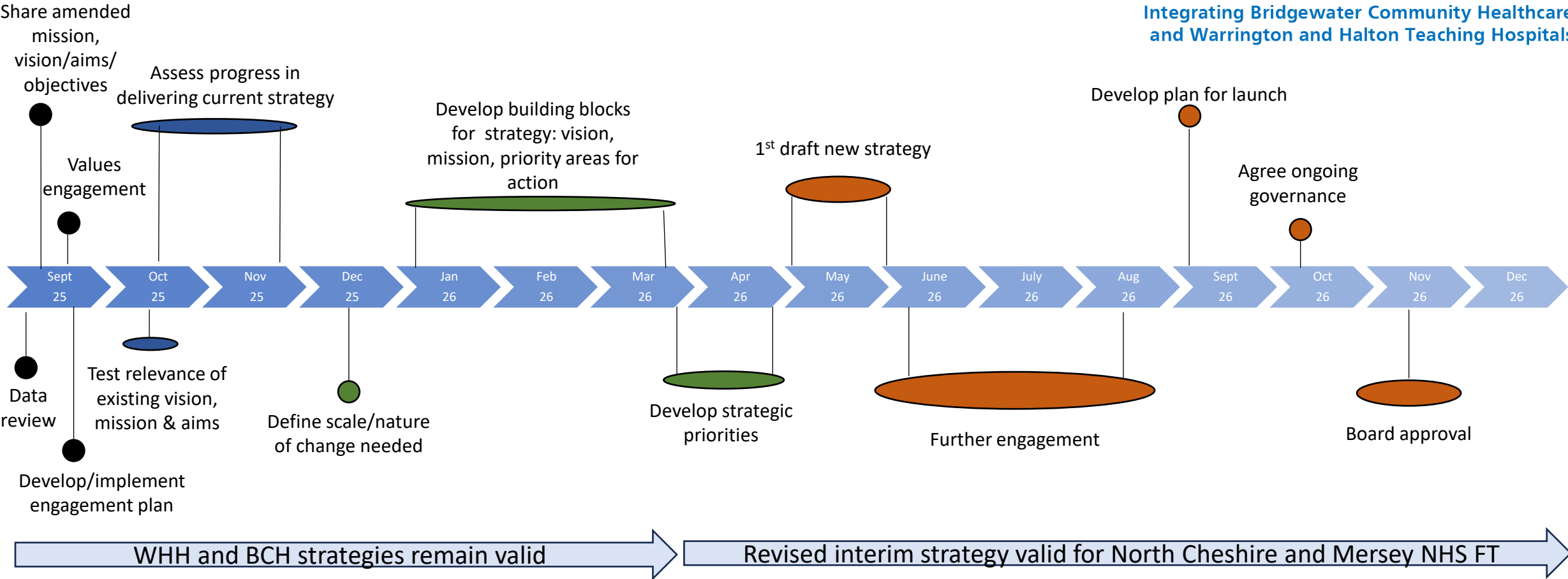
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Strategy Development Timeline



**North Cheshire and Mersey
Healthcare Partnership**

Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals



Approach to developing Organisational Strategy

Phase 1- by mid September 2025:

- Review current strategies, data, national/regional/local priorities
- Where required revise current WHH mission, vision, aims and strategic objectives in line with BCH
- Engage on values: existing forums and staff survey - to include staff, governors and NEDs
- Develop full engagement programme (internal and external) for implementation in 2026
- Share updated mission, vision, aims and objectives, new values, and wider engagement plan

Phase 2 - mid September 2025 onwards (12-15 months):

- Implementation of full engagement programme - overarching strategy and enabling strategies
- Review and rationalize enabling strategies
- Communicate new strategy internally and externally

Proposed revised Mission, Vision and Aims

Our Mission

We will be Exceptional for our patients, our communities and each other

Our Vision

We will be a great organisation providing excellent healthcare and opportunities to work and learn

Our Aims

QUALITY

We will always put our patients first delivering safe, compassionate, inclusive and effective care and an excellent patient experience

PEOPLE

We will be the best place to work by creating an environment where every employee feels valued, supported, and inspired to develop, grow, and thrive—today and in the years ahead

SUSTAINABILITY

We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes.

Proposed revised Strategic Objectives

Quality	People	Sustainability
Patient safety	Looking after our people	Working in partnership
Clinical effectiveness	Innovating the way we work	Working responsibly
Patient experience	Growing our workforce for the future	Sustainable estate and digitally enabled
Research, development and innovation	Belonging in our organisation	Financial sustainability

Values- approach to development



North Cheshire and Mersey
Healthcare Partnership

Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

Engagement:

- A three-week staff engagement exercise has been undertaken from August 2025 through a staff survey which was shared through forums such as the Good Morning Message to additionally include Governors
- The survey highlighted the current values of both Trusts and examples of other NHS organisations and asked stakeholders what is important to them

Current WHH and BCH values										
Working together	Excellence	Inclusive	Kind	Embracing change	Person centred	Empowered	Open and honest	Professional	Local	Efficient

- Qualitative information has been obtained through discussion at internal and external forums
- Survey results and qualitative data have been triangulated to identify a future set of values which resonate with staff
- The findings of this engagement will feed into the Full Business Case for Better Care Together

Better Care Together
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Values- Results output



North Cheshire and Mersey
Healthcare Partnership

Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

A total of 183 people completed the survey, representing a split of:

- WHH colleagues – 55% | BCH colleagues – 44% | External – 1%

The aggregated survey responses reveal several key initial insights:

- The values of 'working together', 'kindness' and 'person centred' are the most frequently quoted as resonating with staff, indicating a strong preference for collaboration, compassion and individualised care.
- Many respondents emphasise the importance of values being demonstrated in practice, not just stated, with recurring calls for leadership accountability, better communication and a culture where values are consistently lived by all levels of staff.
- There is a notable desire for values to be simple, memorable and actionable, with some staff expressing concern that too many or overly broad values can dilute their impact and make them harder to embed in daily work.

Better Care Together

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Values- Results output



North Cheshire and Mersey
Healthcare Partnership

Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

From the analysis of feedback, several themes have been identified:

- **Clarity and Simplicity:** Values should be straightforward, memorable and actionable.
- **Culture Focus:** Emphasise a welcoming and inclusive culture, aligning with workforce aspirations and national priorities.
- **Clear Distinctions:** Define and communicate values, behaviours and objectives clearly to avoid confusion.
- **Behavioural Alignment:** Ensure a direct link between values and behaviours, supported by accountability mechanisms.

Better Care Together

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Values- Proposed new values for approval



North Cheshire and Mersey
Healthcare Partnership

Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

Following the analysis of the results and free-text comments, the following values are proposed for North Cheshire and Mersey NHS Foundation Trust, effective from 1 April 2026

- **Kind** – We are caring, supportive and respectful to everyone
- **Open** – We are honest, transparent and open to new ways of working
- **Fair** – We listen, value our differences and are inclusive to all
- **One team** – We work together to deliver the best care for patients

A refreshed behavioural framework will follow to align against the new values.

Better Care Together

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Ask of Trust Board today

- Approve interim mission, vision, aims and strategic objectives, April 2026 – December 2026
- Approve proposed values for enlarged organisation, from 1st April 2026

Appendix 1

Strategy “Products”



**North Cheshire and Mersey
Healthcare Partnership**

Integrating Bridgewater Community Healthcare
and Warrington and Halton Teaching Hospitals

Strategy	High-level description	Timeframe
Five year organisational plan	Internal and regional use. Aligned to NHS 10-year plan, to set out the long-term objectives for the organisation. Detailed plans on annual basis, including impact measures.	December 2025
Organisational strategy	Public facing. Vision, values and objectives and priorities to deliver strategic goals.	December 2026
Clinical strategy	Public and internal facing. Including responsibilities to address health inequalities and wider determinants of health. Supported by service level clinical priorities and plans.	December 2026 (December 2025)
Financial strategy	Internal and regional use. Plan to break-even from current deficit position and maintain financial sustainability.	December 2025
Estates development plan	Internal use. To describe estate requirements to deliver clinical strategy in fit for purpose facilities. Supported by detail to inform investment cases and deliver cost improvement.	October 2026
Enabling strategies	Internal use. Approaches to provide support, resources and conditions to enable delivery of the 10-year plan and overarching strategy.	December 2026

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Appendix 2

Current Strategies

Bridgewater Community Healthcare NHS Foundation Trust

MISSION

We will improve health, health equity, wellbeing and prosperity across local communities by providing person centred care in collaboration with our partners

VISION

We will create stronger, healthier, happier communities

VALUES

P

Person Centred

We are passionate about individual needs and promote independence in the healthcare that we provide

E

Empowered

We empower our people and encourage new ideas to deliver improvements in community care

O

Open & Honest

We behave in a way that develops relationships based on trust, openness, honesty and respect

P

Professional

We support our people, so everyone has the right skills and training to deliver outstanding patient care

L

Local

We are always learning about our communities and show great pride in being a local provider of health and care

E

Efficient

We use our resources wisely to provide sustainable and value for money healthcare for our patients

AIMS

COMMUNITY

Improve the health and wellbeing of local people and communities

PEOPLE

Improve the health and wellbeing of our staff

QUALITY

Improve the quality of services provided

SUSTAINABILITY

Improve the sustainable and efficient use of resources

6

Our mission, vision, aims and values

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Aims

QUALITY

We will... Always put our patients first delivering safe and effective care and an excellent patient experience.

PEOPLE

We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future.

SUSTAINABILITY

We will... Work in partnership with others to achieve social and economic wellbeing in our communities.

Our Values

Working Together

Excellence

Inclusive

Kind

Embracing Change

NHS England Self-Assessment for Placement Providers 2025

1.

Introduction

The NHS England Self-Assessment (SA) for Placement Providers is a process by which providers carry out their own quality evaluation against a set of standards. Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most questions to provide comments to support your answer.

Completing the Self-Assessment

- **Your region and trust name has been pre-populated - do not amend this.**
- The SA saves your progress at the end of each page - **click save** and next page button.
- **You can amend/change your responses any time prior to completing the final submission** box in section 12 (click save after any changes).
- Anyone completing any part of the SA can do so using the same link supplied by your regional NHS England Workforce, Training and Education (WT&E) quality team. **Only one person should use the link at any one time.** You must close the weblink for someone else to access the survey to avoid overwriting previous entries.
- **To print the SA**, prior to/after submission, skip through to the last page and use the print button. Only questions with responses will print.
- You can move around the SA without being forced to complete questions/sections before moving to another section. **Save each update even if only partially completed.**
- **All sections are mandatory**, please undertake a final check that every question has been completed prior to submission. If a question/section has not been answered after submission, the SA will be returned to you for completion.
- Where free text comments are available the word or character limits are shown within each question. Where a limit is described as

'characters', this means all letters, numbers, spaces, or other symbols.

- The SA does not support the upload of attachments. If we require any evidence as part of your submission, we will contact you separately after submission.

****This submission should be completed for the whole organisation. It's important that those responsible for each section feed into and contribute to the response.****

Sections of the Self-Assessment

Section 1: Provide details of (up to) 3 challenges within education and training that you would like to share with us.

Section 2: Provide details of (up to) 3 achievements or good practice within education and training that you would like to share with us.

Section 3: Confirm your compliance with the obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation.

Section 4: Confirm your compliance with the Quality, Library, Reporting Concerns, and Patient Safety training obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas feed into this section.

Section 5: Confirm your policies and processes in relation to Equality, Diversity and Inclusion (EDI). This should normally be completed by your placement provider EDI Lead.

Section 6 - 11: Self-assess your compliance against the Education Quality Framework and Standards. Each section must be completed once on behalf of the whole organisation. You are asked to confirm whether you meet the standard for all professions / learner groups or provide further details where you do not meet or partially meet the standard(s). Where you are reporting exceptions, you are asked to provide the professions impacted and a summary of the challenges you face in meeting the standard. There are opportunities to share good practice examples.

Section 12: Final sign-off.

Further Questions

If you have any queries regarding the completion of the SA, please review the FAQ document. If you still require further information, you can contact your regional NHS England (WT&E) Quality team.

Privacy Notice

Our Privacy Notice is available to view [here](#).

Your Privacy: Protected

The Care Act, 2014, outlines our responsibility for securing continuous improvement in the quality of education and training provided for the health and care workforce; and via this continuous improvement in the quality of the health service. As a responsible organisation it is our duty to remind you of your rights under the General Data Protection Regulation (GDPR) Data Protection Act 2018 (DPA). Information pertaining to the Self-Assessment survey is outlined below:

We have commissioned SmartSurvey to process the responses to the survey. Further information on how SmartSurvey will use your data can be found in the [SmartSurvey Privacy Policy](#). The legal basis for processing of your data falls under Article 6(1)(e) of GDPR – Public Task. This survey respects the privacy of those taking part with individual responses kept confidential and stored securely. If a serious concern is identified in the survey, we will disclose personally identifiable information (name, organisation, and email address) to NHS England Quality teams to allow immediate action to be taken. The data provided in the survey will be retained securely by NHS England and SmartSurvey in accordance with organisational Records Management policies.

10. Training profession selection

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

2. Please select from the list below the professional groups which your organisation currently trains. Please select 'yes' or 'no' for each row.

	Yes, we train this professional group	No, we do NOT train this professional group
Advanced Practice	☒	☐
Allied Health Professionals	☒	☐
Dental	☒	☐
Dental Undergraduate	☒	☐
Healthcare Science	☒	☐
Medical Associate Professions	☐	☒
Medicine Postgraduate	☐	☒
Medicine Undergraduate	☒	☐
Midwifery	☐	☒
Nursing	☒	☐
Paramedicine	☐	☒
Pharmacy	☐	☒
Psychological Professions	☐	☒
Social Workers	☐	☒

11. Section 1 - Provider challenges

This section asks you to provide details of up to three challenges related to education and training within training within your organisation. Please consider whether any of the challenges affect your ability to meet the education quality framework standards. For each challenge:

- Select the category that best describes the challenge.
- Provide a brief description of the challenge (up to 300 words, including spaces).
- If you cannot find a suitable category, please select "Other" and begin your narrative by stating the appropriate category.

3. Example 1: Please choose the most appropriate category for your challenge.

- ☐ Apprenticeships
- ☐ Burnout / Wellbeing
- ☐ Culture
- ☐ Curricula / Training Standards
- ☐ Educational Governance & Strategy
- ☐ Equality, Diversity, and Inclusion (EDI)
- ☐ Funding - Requirements / Unpredictability / Timeliness
- ☐ Increase in LTFT / Reasonable Adjustment Requests
- ☐ IT Systems
- ☐ NHS England Issues/ Processes
- ☐ Placement Management / Capacity
- ☐ Supervisors / Educators (investment)
- ☐ Supervisors / Educators (recruitment / retention)
- ☐ Supervisors / Educators (training)
- ☒ Training affected by service pressures (cannot release staff)
- ☐ Training Equipment / Systems
- ☐ Training Space / Facilities
- ☐ Trust Merger or Reconfiguration
- ☐ Workforce Challenges (recruitment / retention)

☐ Other

Please provide a brief description of this challenge in the comments box

Challenge 1:

Ensuring staff are supported with protected time to attend their own training and development sessions and to have capacity to support learners in practice is an ongoing challenge. Increasing workloads with increasingly complex patient needs, workforce shortages, financial pressures, and service delivery pressures are all impacting factors.

Work is ongoing to provide staff with protected time to support learners in practice and to attend role essential training as a priority while ensuring service continuity.

4. Example 2: Please choose the most appropriate category for your challenge.

- ☐ Apprenticeships
- ☐ Burnout / Wellbeing
- ☐ Culture
- ☐ Curricula / Training Standards
- ☐ Educational Governance & Strategy
- ☐ Equality, Diversity, and Inclusion (EDI)
- ☐ Funding - Requirements / Unpredictability / Timeliness
- ☐ NHS England Issues/ Processes
- ☐ Increase in LTFT / Reasonable Adjustment Requests
- ☐ IT Systems
- ☐ NHS England Issues/ Processes
- ☒ Placement Management / Capacity
- ☐ Supervisors / Educators (investment)
- ☐ Supervisors / Educators (recruitment / retention)
- ☐ Supervisors / Educators (training)
- ☐ Training affected by service pressures (cannot release staff)
- ☐ Training Equipment / Systems
- ☐ Training Space / Facilities

- ☐ Trust Merger or Reconfiguration
- ☐ Workforce Challenges (recruitment / retention)
- ☐ Other

Please provide a brief description of this challenge in the comments box

Challenge 2:

Maintaining Learner Capacity and finding new ways to increase learner capacity across the Trust continues to be a challenge.

We are continuing to work collaboratively, both internally and with external stakeholder partners and NHS colleagues to develop innovative and solution focussed processes and initiatives to ensure placement experiences remain of the highest quality while sustaining and expanding learner capacity.

5. Example 3: Please choose the most appropriate category for your challenge.

- ☐ Apprenticeships
- ☐ Burnout / Wellbeing
- ☐ Culture
- ☐ Curricula / Training Standards
- ☐ Educational Governance & Strategy
- ☐ Equality, Diversity, and Inclusion (EDI)
- ☐ Funding - Requirements / Unpredictability / Timeliness
- ☐ Increase in LTFT / Reasonable Adjustment Requests
- ☐ IT Systems
- ☐ NHS England Issues/ Processes
- ☐ Placement Management / Capacity
- ☐ Supervisors / Educators (investment)
- ☐ Supervisors / Educators (recruitment / retention)
- ☐ Supervisors / Educators (training)
- ☐ Training affected by service pressures (cannot release staff)

- ☐ Training Equipment / Systems
- ☐ Training Space / Facilities
- ☐ Trust Merger or Reconfiguration
- ☐ Workforce Challenges (recruitment / retention)
- ☒ Other

Please provide a brief description of this challenge in the comments box

Challenge 3:

As a community healthcare provider, we cover a wide geographical area with 66 community sites across Warrington, Halton, Cheshire, Merseyside and Greater Manchester. It is our commitment to ensure training is easily accessible for all our staff across all areas to maintain and develop their own knowledge, skills and competencies, as well as ensuring they have accessible support on hand to provide quality learning experiences for learners, preceptees and colleagues in their placement areas. The use of digital technology has helped with this, however ensuring appropriate training facilities are made available for staff across these areas for essential face to face sessions, both training and other interactive support requirements, taking into account any personal issues, travel restrictions and cost implications for our staff, continues to be an ongoing challenge.

12. Section 2 - Provider achievements and good practice

This section asks you to provide details of up to three achievements related to education and training within training within your organisation. Please consider how the achievements enable your ability to meet the education quality framework standards. For each achievement:

- Select the category that best describes the achievement.
- Provide a brief description of the achievement (up to 300 words, including spaces).
- If you cannot find a suitable category, please select "Other" and begin your narrative by stating the appropriate category.

6. Example 1: Please choose the most appropriate category for your achievement.

- ☐ Collaboration / Partnerships
- ☐ CPD
- ☐ Culture
- ☐ Development of TEL Provision
- ☐ Equality, Diversity, and Inclusion (EDI)
- ☐ Increased SIM for Training
- ☐ Innovative Training / Course Development
- ☐ Learner / Trainee Support or Wellbeing
- ☐ Multi-professional Initiatives
- ☐ New/Improved Strategy or Governance
- ☐ Placement Capacity / Expansion
- ☐ Quality - Improvement Initiatives, response to data, positive feedback
- ☐ Recruitment / Retention Initiatives
- ☐ Supervisors / Educators (investment)
- ☐ Supervisors / Educators (training)
- ☒ Other

Please provide a brief description of this achievement in the comments box

We have been able to fully utilise our apprenticeship levy in 2024/25 and we are now accessing levy transfer from our local acute Trust which additionally supports them to address their underspend and risk of fund expiration.

We continue to be exceptionally proud of the local nature of the recruitment into our apprenticeship positions, providing those living in our communities the opportunity to start and develop a career in the NHS, ensuring our workforce is also increasingly representative of the communities we serve. Enhanced Pastoral support offer is available to all, but specifically focused on young apprentices, new to NHS, those from disadvantaged background such as care experienced young people, neurodiverse apprentices, or those who may have joined our workforce following a period of long-term unemployment.

7. Example 2: Please choose the most appropriate category for your achievement.

- ☐ Collaboration / Partnerships
- ☐ CPD
- ☐ Culture
- ☒ Development of TEL Provision
- ☐ Equality, Diversity, and Inclusion (EDI)
- ☐ Improved Facilities
- ☐ Increased SIM for Training
- ☐ Innovative Training / Course Development
- ☐ Learner / Trainee Support or Wellbeing
- ☐ Multi-professional Initiatives
- ☐ New/Improved Strategy or Governance
- ☐ Placement Capacity / Expansion
- ☐ Quality - Improvement Initiatives, response to data, positive feedback
- ☐ Recruitment / Retention Initiatives
- ☐ Supervisors / Educators (investment)
- ☐ Supervisors / Educators (training)
- ☐ Other

Please provide a brief description of this achievement in the comments box

Work has continued to ensure role specific training requirements are appropriately allocated to positions, and this has allowed more accurate and improved reporting within the Trust. It has also enabled accurate reporting to Trust committees and Board meetings. We continue to be commended regionally and nationally for our effective use of the Oracle Learning Management (OLM) System by the national ESR team.

We have further developed a sophisticated data visualisation tool which enables us to concisely display training requirements, activity, and compliance data, in real time and at service level, which is easily accessible to managers. This has supported improved compliance rates timely targeted support for areas of low compliance as required.

8. Example 3: Please choose the most appropriate category for your achievement.

- ☒ Collaboration / Partnerships
- ☐ CPD
- ☐ Culture
- ☐ Development of TEL Provision
- ☐ Equality, Diversity, and Inclusion (EDI)
- ☐ Improved Facilities
- ☐ Increased SIM for Training
- ☐ Innovative Training / Course Development
- ☐ Learner / Trainee Support or Wellbeing
- ☐ Multi-professional Initiatives
- ☐ New/Improved Strategy or Governance
- ☐ Placement Capacity / Expansion
- ☐ Quality - Improvement Initiatives, response to data, positive feedback
- ☐ Recruitment / Retention Initiatives
- ☐ Supervisors / Educators (investment)
- ☐ Supervisors / Educators (training)
- ☐ Other

Please provide a brief description of this achievement in the comments box

The Trust is particularly proud of our successful collaboration and partnership working with our local and regional FE and AEI colleagues.

Our Apprenticeship and Careers Team have been successful in winning the 'Apprenticeship Lead' of the year 2024 with LJMU and have been nominated for a number of awards with local FE colleagues for our partnership working.

Our PEF team also have been nominated for awards both internally and externally with our regional AEI partners.

We continue to work successfully with our education partners to provide quality placement experiences for all our learners. This is reflected in our learner evaluations and feedback.

13. Section 3 - Contracting and the NHS Education Funding Agreement

This section asks you to confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the [NHS Education Funding Agreement \(2024-27\)](#). This section should only be completed once on behalf of the whole organisation. There is an option to provide additional comments to support your answer, this is restricted to 300 words including spaces.

9. Please confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the NHS Education Funding Agreement (EFA).

This should be completed once on behalf of the whole organisation. Please select only one option for each row.

	Yes	No
There is board level engagement for education and training at this organisation.	☒	☐
The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education and training is used explicitly for this purpose.	☒	☐
We undertake activity in the NHS EFA which is being delivered through a third party provider.	☒	☐
We or our sub-contractor(s) did not have any	☒	☐

	Yes	No
breaches to report in relation to the requirement of the NHS EFA.		
We are compliant with all applicable requirements of the Data Protection Legislation and with the requirements of Schedule 5 of the NHS EFA.	☒	☐
We did not have any health and safety breaches that involve a learner to report in the last 12 months - Please note that this question pertains exclusively to breaches that have been, or would be, investigated by the Health and Safety Executive.	☒	☐
We facilitate a cross-system and collaborative approach, engaging the ICS for system learning.	☒	☐
We have collaborative relationships	☒	☐

Yes

No

with our stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.

If you selected 'yes' for any of the above, please add comments to support your answer; if you selected 'no' for any of the above, please provide further detail

We continue to build and nurture collaborative relationships with partner NHS organisations, training providers (private, charitable, and any other) and other local health and social care provider colleagues to share specialist training provisions with the intention to improve patient experiences and ensure safe quality care is provided.

10. Please provide the name and email address of the board named individual responsible for education and training.

Name

Paula Woods

Email Address

Paula.woods1@nhs.net

11. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie.richards1@nhs.net – Adie Richards – Education and Professional Development Lead

14. Section 4 - Education Quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the [NHS Education Funding Agreement \(EFA\)](#). This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas are able to feed into this section. There is an option to provide additional comments to support your answer, this is restricted to 300 words including spaces.

12. Please select only one option for each row.

Can you confirm as a provider that you...

	Yes	No	N/A
Are aware of the requirements and process for an education quality intervention, including who is required to attend.	☒	☐	☐
Are reporting and engaging with the requirements and process to escalate issues, in line with NHS England's education concerns process.	☒	☐	☐
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services.	☒	☐	☐
Actively promote, to all learners, use of the national clinical decision support tool funded by NHS England (https://access.bmjgroup.com/nhse/)?	☐	☐	☒
Have a Freedom to Speak Up Guardian who actively promotes the process for raising concerns through them to their learners.	☒	☐	☐
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained) who actively promotes the process for raising concerns through them to their learners.	☐	☐	☒

If you selected 'yes' for any of the above, please add comments to support your answer; if you selected 'no' for any of the above, please provide further detail

The SLEC is disseminated to all placement areas and displayed on student notice boards locally. The SLEC is also included in all placement supervisor and placement assessor training and update sessions and any other multi-professional development programmes delivered by the PEF team and included within our Clinical Placement Policy and Toolkit.

Bridgewater do not support undergraduate or postgraduate medical students (other than a very small number- less than 10 per year- who visit for community exposure spoke placements from Lancaster University). For this reason we have responded 'no' to the 2 sections above relating to support of medical students/learners.

13. In the last 12 months, has your organisation been referred to a regulator for concerns relating to education and training (GMC, GDC, HCPC, NMC, or other relevant regulatory bodies, with or without conditions imposed)?

Note: we are not seeking information about the referral of an individual learner.

☒ No - We have not been referred to a regulator

☐ Yes - We have been referred to a regulator

☐ I am not aware whether the organisation has been referred to a regulator.

If yes, please provide more details (including the regulator, profession and a brief description)

14. Please rate your organisation's status on actively implementing and embedding the [Safe Learning Environment Charter \(SLEC\)](https://www.england.nhs.uk/long-read/safe-learning-environment-charter/) multi-professionally.

<https://www.england.nhs.uk/long-read/safe-learning-environment-charter/>

☒ Fully Implemented

☐ Partially Implemented

☐ Not Yet Started to Implement

15. Have you reviewed, at Board Level, and where appropriate, taken action on the outcome of the results of 2024's National Education and Training Survey (NETS).

☒ Yes

☐ No

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

The NETS is promoted via:

- Emails to teams who have learners either employed or on a pre/post registration program
- Student/learner forums – learners are given the opportunity at the end of each session to complete the survey
- Trust Bulletin – advertised weekly throughout the duration of the survey.

Despite attempts to promote and encourage learners to complete the survey the Trust received only 11 responses last year

Actions in response to the results from the survey included raising awareness of Trust Freedom to Speak Up guardians and processes to all learners across the Trust via a number of avenues (posters, learners forums, practice supervisor/assessor/educator workshops, and liaising with HEI partners). In addition

16. 2025's NETS will be open between 7 October 2025 and 2 December 2025. How will your organisation increase their [NETS response rate](#) for 2025?

For 2025 our focus is to improve our responses via all forums with a focus on quality improvement, communication, and continuous improvement of our learners' experience. In addition we aim to address some of the barriers within teams and provide dedicated time in which learners will be directed to complete the survey.

17. Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address
of your Board
representative for Patient
Safety

Jeanette Hogan – Jeanette.hogan@nhs.net

Name and email address
of your non executive
director representative for
Patient Safety

Gail Bryers – gail.bryers1@nhs.net

Name and email address
of your Patient Safety
Specialist/s

Alan Lee – alan.lee5@nhs.net

What percentage of your
staff have completed the
patient safety training for
level 1 within the
organisation (%)

99.24%

18. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and Professional Development Lead

Adie.richards1@nhs.net

15. Section 5 - Equality, Diversity and Inclusion

This section asks about your policies and processes in relation to equality, diversity and inclusion (EDI). We recommend that this section should be completed by your nominated EDI lead or equivalent. There is an option to provide additional comments to support your answer, this is restricted to 300 words including spaces.

19. Does your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

☒ Yes

☐ No

If 'yes' please provide the name and email address of your EDI lead for education and training; if 'no' please provide further detail.

Ruth Besford – Equality & Inclusion Manager

Ruth.besford@nhs.net

20. Please select only one option for each row.

Does your organisation:

Yes

No

Ensure reporting mechanisms and data collection take learners into account?

☒

☐

Implement reasonable adjustments for learners with a disability?

☒

☐

Ensure policies and procedures do not negatively impact learners who may have a protected characteristic(s)?

☒

☐

	Yes	No
Ensure international graduates (including international medical graduates) receive a specific induction into your organisation?	☐	☒
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	☒	☐
Ensure a policy is in place to manage sexual harassment in the workplace?	☒	☐
Have initiatives to support reporting of sexual harassment?	☒	☐
Confirm it has signed up to the NHS England Sexual Safety in Healthcare - Organisational Charter	☒	☐
Have a designated sexual safety lead, such as a Domestic Abuse and Sexual Violence (DASV) lead?	☒	☐

If you selected 'yes' for any of the above, please add comments to support your answer; if you selected 'no' for any of the above, please provide further detail

The Trust completes annual reporting for the Workforce Race and Disability Equality Standards, for Gender Pay Gap, Equality Delivery System, and Public Sector Equality Duty. Only the WRES has a specific indicator relating to learning, but for all the experience of learners in practice are taken into account.

The Trust provides reasonable adjustments for all staff, including learners in practice, and work is nearing completion on a defined pathway, procedure, and tools to support effective provision of adjustments. Trust teams have worked actively in the last 12 months to resolve the challenges that rise as a result of late or no receipt of learners RAPP documents before commencing placements.

All policies undergo consultation as part of design or review, and the EDI lead is a core part of the consultation group, completing an Equality and Health Inequalities Assessment (EHIA) that ensures no negative differential impact on any member of staff, including learners in practice from protected characteristic and vulnerable groups. This EHIA is reviewed as part of governance for policies.

The Trust has policies in place for equity of opportunity, dignity and respect at work, and violence and aggression from staff/patients/families/public. In 2024 the Choose Kindness campaign was launched to highlight the expectation from staff, patients, family members, and any visitors for respect towards all in Trust services. This is further supported through the new behavioural framework for staff, which sets out the expectations of all staff, including learners in practice, in our workplaces.

The Trust is a signatory to the NHS Sexual Safety In Healthcare Charter. During 2024 and 2025 a new policy, toolkit, staff support, training, reporting processes, and a Trust wide communications campaign has been launched and is ongoing. The Trust has a dedicated lead for this campaign.

In relation to the single no response - The Trust does not undertake international recruitment exercises as we can't provide the required pastoral support being a community provider without staff accommodation etc; but overseas born and trained staff/learners would be given extra support as required. The Race Inclusion Network identified support for IMG/IEN as a gap within the Trust; working in partnership with the Network the Trust is about to launch a new welcome pack for overseas staff covering many aspects of pastoral advice and signposting, and overseas staff are considered in all EHIA on policy, strategy, and change projects.

21. How does your organisation manage sexual harassment reports?

The Trust have a Sexual Safety Toolkit and Policy which provide guidance for staff who experienced sexual misconduct. These documents include information about support that can be accessed, who to contact, and how to make a report.

22. Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share examples of EDI initiatives or successes that are specific to or have an impact on education and training in your organisation. Please include the email address for someone we can contact to discuss this further.

Max 1000 words

The Trust has been re-awarded three voluntary accreditations in 2024/25 – Disability Confident Leader, NHS NW Anti-Racist Framework Bronze, and Navajo LGBT+ Charter. In addition, we were successful re-assessed for the Veteran Aware scheme and were successful in our application to Defence Employer Recognition Scheme Silver Level.

While none of these accreditations are specific to learners in practice we work hard to ensure this cohort of staff, for however long they are with us, are included and supported by the work we have undertaken and continue to take to support these schemes. For example, in activities to embed intentional anti-racism within our workplaces, and to ensure reasonable adjustments are provided for all our staff.

In 2024/25 we began a project in partnership with AccessAble to survey and then provide disability access information to our estates. With some existing provision in spaces that we rent from other organisations we can now offer learners in practice accessibility information for most of the areas where they may work, appreciating that for many the role is a domiciliary one, visiting patients in their own homes.

The apprenticeships programme in the Trust, and the engagement work undertaken by the People Directorate teams in recruitment continue to support the success of diverse candidates entering the Trust on various learning programmes.

The Trust is an active partner in the Cheshire and Warrington Pledge (for opportunities for young people).

Collaboration between EPD and our EDI lead ensures all education and training provided (including eLearning packages created internally) across the Trust meets EDI quality assurances and is developed and delivered to support any additional requirements that may be identified. Notifications included within booking confirmation emails/notifications specifically invite all delegates to disclose any additional or specific requires they may have and all efforts and reasonable adjustments are made to ensure training is inclusive for all.

23. Please select the most appropriate categories for the examples of EDI good practice or initiatives you shared above. Please select all that apply.

☒ Awards	☐ Awareness raising	☒ Data (Equality monitoring, Increasing disclosure, Improving data sets, Data for decision making)
☒ Development Programmes (Career Development, Comprehensive programs, Mentoring, Coaching)	☒ Employer engagement, outreach, and partnership (Partnerships with HEIs and community groups, Provider events for staff, Community events)	☐ Funding
☒ Improving staff experience (Staff networks, Affinity Groups, Listening sessions, Facilities)	☐ Learning resources or tools	☐ Organisational review or assessment of EDI
☐ Recruitment	☐ Strategies, policies, or processes	☐ Training (Mandatory, Non-mandatory, Skills development)

24. For education and training, what are the main challenges for EDI in your organisation?

Max 1000 words

Providing timely reasonable adjustments for some learners in practice if adjustments are not flagged by the training provider or discussed by the learner in practice as they start placement; or, as happens, a learner in practice has a previously undiagnosed neurodivergent condition or a disability; then timely support may not always take place, though we continue to work to address any identified difficulties through ongoing engagement with the learner and HEI and FE colleagues.

Pre reg learner/student immunisation and vaccination status has become problematic across Cheshire and Merseyside due to some student/learner's reluctance to be immunised. Safe placement provision can be significantly impacted as a result of this regionally. This continues to be reported via our quarterly quality NHSE reporting tool submissions. We continue to work to address any identified

difficulties through ongoing engagement with the learner and HEI and FE colleagues.

25. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and Professional Development Lead

Adie.richards1@nhs.net

16. Section 6 - Assurance Reporting: learning environment and culture

For each standard, please confirm whether you meet the following standards from the [Education Quality Framework](#). There is an option to provide additional comments to support your answer. This is restricted to 300 words, including spaces, per text box. **This section should be completed once on behalf of the whole organisation**, however it is important that those responsible for these areas are able to feed into this section.

26. Quality Framework Domain 1 - Learning environment and culture

Please select whether you meet the standard or have exceptions to report for each row.

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
The learning environment is one in which education and training is valued and championed.	☒ y	☐
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	☒ y	☐
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	☒ y	☐
There is a culture of	☒ y	☐

We meet the standard
for all professions / learner
groups we train

We have exceptions to report
and provided narrative below

continuous
learning, where
giving and
receiving
constructive
feedback is
encouraged and
routine.

Learners are in
an environment
that delivers
safe, effective,
compassionate
care and
prioritises a
positive
experience for
patients and
service users.

The
environment is
one that
ensures the
safety of all
staff, including
learners on
placement.

All staff,
including
learners, are
able to speak
up if they have
any concerns,
without fear of
negative
consequences.

The
environment is
sensitive to both
the diversity of
learners and the
population the
organisation
serves.

☐ y

☐

☐ y

☐

☐ y

☐

☐ y

☐

We meet the standard
for all professions / learner
groups we train

We have exceptions to report
and provided narrative below

There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.

☐ y

☐

There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.

☐ y

☐

The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to knowledge and library specialists.

☐ y

☐

The learning environment in my organisation promotes

☐ y

☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
human-centred and dynamic multi- professional learning opportunities (See "Guidance for Providers" p11).		
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	☒	☐
The learning environment provides opportunities for learners to apply for flexibility within their placements.	☒	☐
It is Trust policy for Learners to apply for flexibility within their placements.	☒	☐

27. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below. Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box. If required you can add the details of the sub professions / specific specialties in the comments box.

☐ All professions	☐ Site specific	☐ Dental Postgraduate
☐ Dental Undergraduate	☐ Medicine Postgraduate	☐ Nursing
☐ Midwifery	☐ Allied Health Professionals	☐ Pharmacy
☐ Paramedicine	☐ Medical Associate Professions	☐ Advanced Practice
☐ Psychological Professions	☐ Healthcare Science	☐ Medicine Undergraduate
☐ Social Workers		

Please provide the details of the sub professions/specific specialities (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

28. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from NHS England Workforce, Training and Education.

No exceptions identified

29. We are keen to hear about initiatives and good practice related to the learning environment and culture of your organisation, that are

specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

(max 1000 words)

Our research lead engages and supports learners to participate in quality improvement, research and innovation.

Monthly 'Time to shine' sessions allow clinical teams the opportunity to showcase their work and any case studies/best practice.

We have a yearly Staff Education Quality Survey to capture data from PAs/PSs/Educators to ascertain their views on practice placements/learning/support required and inform QI actions.

We have a Clinical Placement Policy and Toolkit which includes guidance if complaints or concerns are raised.

We offer exciting and innovative learner opportunities, including corporate spoke placements, multi-professional learner forums, simulation training opportunities with local partner FEI's and recruitment opportunities for 2nd & 3rd year learners which include support with application and interview skills and career conversations.

30. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and Professional Development Lead

Adie.richards1@nhs.net

17. Section 7 - Assurance Reporting: educational governance and commitment to quality

For each standard, please confirm whether the you meet the following standards from the [Education Quality Framework](#). There is an option to provide additional comments to support your answer, this is restricted to 300 words per text box. **This section should be completed once on behalf of the whole organisation**, however it is important that those responsible for these areas are able to feed into this section.

31. Quality Framework Domain 2 - Educational governance and commitment to quality

Please select whether you meet the standard or have exceptions to report for each row.

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.	☒	☐
There is active engagement and ownership of equality, diversity and inclusion in education and	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
training at a senior level.		
The governance arrangements promote fairness in education and training and challenge discrimination.	☒	☐
Education and training issues are fed into, considered and represented at the most senior level of decision making.	☒	☐
The provider can demonstrate how educational resources (including financial) are allocated and used.	☒	☐
Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
education and training.		
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	☒	☐
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including WT&E and Education Providers).	☒	☐

32. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below. Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box. If required you can add the details of the sub professions / specific specialties in the comments box.

☐ All professions	☐ Site specific	☐ Dental Postgraduate
☐ Dental Undergraduate	☐ Medicine Postgraduate	☐ Nursing
☐ Midwifery	☐ Allied Health Professionals	☐ Pharmacy
☐ Paramedicine	☐ Medical Associate Professions	☐ Advanced Practice
☐ Psychological Professions	☐ Healthcare Science	☐ Medicine Undergraduate
☐ Social Workers		

Please provide the details of the sub professions/specific specialities (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

33. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Not applicable- all professions employed within the Trust are included in the above governance provisions.

34. We are keen to hear about initiatives and good practice related to the educational governance and commitment to quality in your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

(max 1000 words)

Our Education Governance Group meet bimonthly. Our PEF team, AHP Lead, and Clinical Practice Educators provide update reports to this group. In addition all elements of education and training across the Trust are discussed and reported through this group. This group reports directly into our People Operational Delivery (POD) Council, which in turn reports to People Committee, and through that Committee on to Board. Learner evaluations and any issues related to practice education across the Trust are reported through this route.

Our Apprenticeship Lead reports directly into POD Council following the above process up to Board level.

Members of our Collaborative Education Group attend all quality and governance groups across the Trust. The collaborative education group meet monthly to share ideas, priorities, challenges, support each other and ensure a streamlined efficient approach is applied to all aspects of education, training, and staff development across the Trust. This sub-group reports into the Education Governance Group.

A project to develop and embed internal education quality assurance processes was introduced in 2024/25. The project is aligned with the NHSE Education Standards and Self-Assessment Tool and intended to provide an internal framework of SOPs to assure the quality of training delivered, support for all trainers (including tools and resources for creating, delivering, and evaluating training), and a robust process for evaluation and feedback to ensure continuous improvement. Progress of this project is reported through the Education Governance Group and through to Board via this channel. The project is currently ongoing.

The Trust practices a collaborative workforce planning approach, involving workforce, education, HR, the PEF team, Executive Nursing Team and our operational services, to plan education and training through the year and ensure the education offer is relevant and appropriate for service requirements.

35. Signature

☒ x

I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and Professional Development Lead

Adie.richards1@nhs.net

18. Section 8 - Assurance Reporting: developing and supporting learners

For each standard, please confirm whether you meet the following standards from the [Education Quality Framework](#). There is an option to provide additional comments to support your answer, this is restricted to 300 words per text box (excluding good practice). This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

36. Quality Framework Domain 3 - Developing and supporting learners

Please select whether you meet the standard or have exceptions to report for each row.

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	☒	☐
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	☒	☐
Supervision arrangements enable learners in difficulty to be identified and supported at the	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
earliest opportunity.		
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	☒	☐
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☒	☐
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
learning outcomes.		
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	☒	☐
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	☒	☐
Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	☒	☐
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	☒	☐

We meet the standard
for all professions / learner
groups we train

We have exceptions to report
and provided narrative below

Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.

☒ x

☐

37. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below. Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box. If required you can add the details of the sub professions / specific specialties in the comments box.

☐ All professions

☐ Site specific

☐ Dental Undergraduate

☐ Dental Postgraduate

☐ Medicine Postgraduate

☐ Nursing

☐ Midwifery

☐ Allied Health Professionals

☐ Pharmacy

☐ Paramedicine

☐ Medical Associate Professions

☐ Advanced Practice

☐ Psychological Professions

☐ Healthcare Science

☐ Medicine Undergraduate

☐ Social Workers

Please provide the details of the sub professions/specific specialities (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

38. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions identified

39. We are keen to hear about initiatives and good practice related to how you develop and support learners within your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

(max 1000 words)

Our clinical placement policy includes a range of resources for supervising staff and learners to utilise.

Our supervision policy supports the provision of supervision for staff and learners across the Trust.

We have two clinical practice educators who lead on the nursing preceptorship programme. Both are qualified PNAs. Our AHP Lead, who has led on the development of our AHP/multiprofessional preceptorship programme, is a trained clinical supervisor currently and links with our senior clinical skills trainer and EPD lead in the delivery of multiprofessional supervisor workshops across the Trust.

Monthly multi-professional student forums which incorporate numerous training sessions including health and wellbeing, resilience, and just culture training are facilitated by our PEF team. Students are encouraged to attend appropriate and

relevant internal training and study days. In addition, late availability places on internal training sessions are circulated weekly for learners and placement educators/supervisors/assessors to consider and access if relevant and capacity allows. This includes any health and wellbeing sessions delivered internally.

Learners are all included on eRoster and are a valued part of the team within their placement area. Spoke opportunities are available to follow patient journeys/pathways through MDT services as well as externally with other organisations.

40. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and Professional Development Lead

Adie.richards1@nhs.net

19. Section 9 - Assurance reporting: developing and supporting supervisors

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the [Education Quality Framework](#). There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box (excluding good practice). This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

41. Quality Framework Domain 4 - Developing and supporting supervisors and educators

Please select whether you meet the standard or have exceptions to report for each row.

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
Formally recognised supervisors and educators are appropriately supported with <u>protected time</u> in job plans/ job descriptions, to undertake their roles.	☐	☒
Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
expectations of partner organisations (e.g. Education Provider, WT&E).		
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	☒	☐
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.	☒	☐
Clinical supervisors and educators are supported to understand the education, training and any other support	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
needs of their learners		
Supervisor and Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.	☒	☐
Supervisors and educators can easily access resources to support their physical and mental health and wellbeing.	☒	☐

42. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below. Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box. If required you can add the details of the sub professions / specific specialties in the comments box.

☐ All professions

☐ Site specific

☐ Dental Undergraduate

☐ Dental Postgraduate	☐ Medicine Postgraduate	☒ Nursing
☐ Midwifery	☒ Allied Health Professionals	☐ Pharmacy
☐ Paramedicine	☐ Medical Associate Professions	☐ Advanced Practice
☐ Psychological Professions	☐ Healthcare Science	☐ Medicine Undergraduate
☐ Social Workers		

Please provide the details of the sub professions/specific specialities (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

43. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

The challenges we are facing across BCHFT are in keeping with recognised and well publicised national challenges relating to staff capacity, long patient waiting lists, and the increasing demand on staff to provide care for complex and poorly patients in community settings. In addition, placement providers and educators are under increased pressure to support additional learners in practice to meet capacity demands from HEIs and NHSE.

44. Please confirm your organisation ensures educators/supervisors have formal development to undertake this role.

- ☒ Yes
- ☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Annual Student Standards for Supervision and Assessment in practice (SSSA) updates are mandated for NMC registrants within the Trust.

Internal Practice Assessor Development Workshops are delivered regularly.

AHP and other multi-professional practice educators are able to access updates provided by their partner AEI colleagues the frequency requirements of which are guided by the relevant governing bodies.

BCHFT are in the process of developing a multiprofessional educator update programme in partnership with WHH which will be promoted as an annual requirement once available.

45. Which of the following statements best describes how distributed funds are allocated for defined educator and education activities in your organisation.

- ☒ All funding is tracked and reported (to the accountable officer) as being directly spent on educators and education activities.
- ☐ Over 75% of the funding is tracked and reported as being directly spent on educators and education activities.
- ☐ Between 50-75% of the funding is tracked and reported as being directly spent on educators and education activities.
- ☐ Less than 50% of the funding is tracked and reported as being directly spent on educators and education activities.
- ☐ The funding for educators is not currently tracked and reported.

46. What approaches are used to ensure educators across all professions consistently use protected time set aside for their educational duties?

- ☐ We have a formal scheduling system and leadership to support and prioritise protected educator time.
- ☒ Educators manage their own schedules without formal oversight.
- ☐ Protected time is offered but often redirected to clinical or administrative duties.

- ☐ There is no consistent approach to supporting access to protected educator time across all professions.

47. Do you hold a record of educators in your organisation?

- Yes, for all professions
☒
☐
☐ Yes, for some professions
☐ No

48. Please provide the name and e-mail address(es) of Senior Educator(s) or Educator Leaders responsible or accountable for education and training for professions below as appropriate.

We would like to use the data to:

- Share region-specific data with the Educator Workforce Programme regional leads, to enable them to build their networks of educator leaders.
- Share profession-specific data with the national professional leads, to enable them to build their networks of educator leaders, anticipated by cascade to regional leads.
- Enable the cascade of communication on the educator workforce programme via these key stakeholders.

	Allied Health Professionals	Dental	Healthcare science	Medical	Non-clinical roles	Nursing and Midwifery	Pharmacy	Psychological Professions
Name(s)	Philip Mumberson	Kate Woolford	Alison Rimmer	David Mills		Susan Burton		
Email Address(es)								
Comment:								

To contact any of the above please contact/email bchft.education@nhs.net

49. We are keen to hear about initiatives and good practice related to how you develop and support supervisors within your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

(max 1000 words)

Annual Student Standards for Supervision and Assessment in practice (SSSA) updates are mandated for NMC registrants within the Trust.

AHP and other multi-professional practice educators are able to access updates provided by their partner AEI colleagues the frequency requirements of which are guided by the relevant governing bodies.

BCHFT are in the process of developing a multiprofessional educator update programme in partnership with WHH which will be promoted as an annual requirement once available.

A pilot project focussed on SLEC to raise and maintain placement standards and excellent learning cultures across the Trust was started in 2024/25 and has carried on into 2025/26. The project involves learners across the Trust scoring placements areas against the quality matrix and offering their suggestions for quality improvements.

Within our monthly student study day/student forums time is allocated for students to feedback and provide quality improvement suggestions relating to their placement area and experience.

50. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and professional Development Lead

Adie.richards1@nhs.net

20. Section 10 - Assurance reporting: delivering programmes and curricula

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the [Education Quality Framework](#). There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box (excluding good practice). This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

51. Quality Framework Domain 5 - Delivering programmes and curricula

Please select whether you meet the standard or have exceptions to report for each row.

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	☒	☐
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	☒	☐
Placement providers collaborate with professional bodies, curriculum/	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.		
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	☒	☐
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	☒	☐
Timetables, rotas and	☒	☐

We meet the standard
for all professions / learner
groups we train

We have exceptions to report
and provided narrative below

workload enable
learners to
attend planned/
timetabled
education
sessions
needed to meet
curriculum
requirements.

52. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below. Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box. If required you can add the details of the sub professions / specific specialties in the comments box.

☐ All professions	☐ Site specific	☐ Dental Postgraduate
☐ Dental Undergraduate	☐ Medicine Postgraduate	☐ Nursing
☐ Midwifery	☐ Allied Health Professionals	☐ Pharmacy
☐ Paramedicine	☐ Medical Associate Professions	☐ Advanced Practice
☐ Psychological Professions	☐ Healthcare Science	☐ Medicine Undergraduate
☐ Social Workers		

Please provide the details of the sub professions/specific specialties (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

No exceptions

53. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are

impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

54. We are keen to hear about initiatives and good practice related to the delivery of programmes and curricula in your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

(max 1000 words)

Subject matter experts deliver clinical training and overview sessions within monthly student study days/forums. These include catheter care, IVT, Pressure Ulcer Prevention and wound care, Venepuncture etc.

Services are informed in advance of in-house student study days and forums so that students can be released / encouraged to attend. In addition, they are invited to attend internal training sessions relevant to their practice experience and level of learning.

The PEF team and Apprenticeship and Careers team collaborate in FE and AEI faculties and programme board meetings and SNA steering group meetings for all our regional AEI partners.

The PEF team also attend steering groups such as REPAIR and Annexe B, CPEP, placement toolkit project and participate in the Cheshire and Merseyside PEF Network.

Learners on placement are included on E-Roster.

55. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and Professional Development Lead

Adie.richards1@nhs.net

21. Section 11 - Assurance reporting: developing a sustainable workforce

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the [Education Quality Framework](#). There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box (excluding good practice). This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

56. Quality Framework Domain 6 - Developing a sustainable workforce

Please select whether you meet the standard or have exceptions to report for each row.

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☒	☐
Learners in my organisation are well supported to learn using modern methods and technologies.	☒	☐
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues.	☒	☐

	We meet the standard for all professions / learner groups we train	We have exceptions to report and provided narrative below
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☒	☐
Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.	☒	☐

57. For the exceptions selected in the previous question, please select which professional group(s) are impacted from the list below. Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box. If required you can add the details of the sub professions / specific specialties in the comments box.

☐ All professions	☐ Site specific	☐ Dental
☐ Dental Undergraduate	☐ Medicine Postgraduate	☐ Nursing
☐ Midwifery	☐ Allied Health Professionals	☐ Pharmacy

☐ Paramedicine

☐ Medical Associate
Professions

☐ Advanced Practice

☐ Psychological
Professions

☐ Healthcare Science

☐ Medicine
Undergraduate

☐ Social Workers

Please provide the details of the sub professions/specific specialities (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

58. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

59. How would you rate your organisation's awareness of evidence-based principles for modernising healthcare education?

- Modern evidence-based education ensures that healthcare learning is effective, inclusive, and aligned with real-world impact. Modern healthcare demands collaborative, person-centred care that is supported by equally collaborative and inclusive education environments.
- These questions ask you to reflect on how well your organisation enables learners to engage with contemporary educational approaches, such as hybrid, digital, immersive and AI-assisted tools. It considers

whether learners feel equipped and supported to navigate these methods in ways that enhance their practice and professional growth.

- ☐ Highly aware and actively applying them
- ☒ Aware but not consistently applying them
- ☐ Somewhat aware
- ☐ Minimally aware
- ☐ Not aware at all

Please add comments to support your answer.

Laptops are available for learners to access on placement, if they are not already Trust employed staff. These are allocated through learner applications and as devices are available.

Access to Trust eLearning modules and online learning opportunities is available to all learners.

As a community Trust we have adopted a multi-faceted approach to education and training in order to support our entire workforce (including all learners) to engage with learning opportunities. This includes face to face sessions at our main training suite, hybrid sessions, bespoke training sessions delivered across various sites, practice-based learning/training in a clinic setting, online instructor led sessions, bespoke eLearning packages created internally as well as national modules, and bespoke animation/AI training videos created internally.

60. To what extent do you agree or disagree with this statement: My organisation actively addresses barriers to modernising healthcare education (e.g., technological, cultural, structural).

- ☐ Strongly Agree
- ☒ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

Please add comments to support your answer.

Please see information included throughout the above report.

61. We are keen to hear about initiatives and good practice related to developing a sustainable workforce within your organisation, that are specific to or have an impact on education and training. If you would like to share any examples, please provide:

- **A brief description of the initiative/good practice**
- **The professional group(s) this relates**
- **The email address for someone we can contact to discuss this example further**

(max 1000 words)

Our Multi-professional preceptorship policy supports our preceptorship programmes as described in section 2.

As a Trust we work collaboratively across services/directorates and practice open channels of communication and have numerous collaborative workstreams including recruitment (including apprenticeships) and supporting the transition of students into their 1st post, Trust wide workforce planning projects, annual training needs analysis data collation and CPD expenditure planning and education and training quality assurance processes.

Our PEF team and Careers Team have established strong relationships with HEI and FE colleagues and fully engage with initiatives and projects aimed to mitigate avoidable learner attrition from programmes.

Support for staff and learners with regards to future planning and career progression include support with application and interview skills, access to Maths and English functional skills qualifications, and 1-1 career/scope for growth conversations with members of the LOD or Careers Teams.

Contact:

Adie.richards1@nhs.net

62. Signature

☒ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adie Richards – Education and Professional Development Lead

Adie.richards1@nhs.net

22. Section 12 - Final Submission

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Before completing your final submission please ensure you have:

1. Completed all questions within the Self-Assessment (including the free text sections)
2. Received Board level sign off for your submission

63. Board level sign-off (Premises, Learning Environment, Facilities, and Equipment)

- ☐ I confirm that our premises, learning environments, facilities and equipment are: suitable for the performance of the Services; accessible, safe and secure; comply with any applicable Health and Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant Regulator; and are sufficient to enable the Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.

64. Board level sign-off

- ☐ I confirm that the responses in this SA have been signed off at board level
Name, email address and role of Board representative for education and training

65. Please confirm the date that board level sign off was received:

*

66. Final Submission (please only tick this box when you ready to submit your self-assessment)

- ☐ I confirm that all sections of this self-assessment have been completed and that this is the final version for submission

23. Thank you for your time

Thank you for your time on the NHS England Self-Assessment for Placement Providers

You can continue to update this self-assessment using the link supplied to you by your regional NHS England WT&E education quality team.

If you would like to print a version of your draft submission at any time, please use the print button on the next page (note that you will only print those sections currently completed)

Once you have completed all sections in full of this self-assessment please ensure that you complete section 12 final submission and tick the box Complete Submission. At which point your final response will be sent to your regional NHS England WT&E education quality team.