AGENDA
for a Meeting of the Board
Part I

Venue:	Rowan East Meeting Room, Chippenham Community Hospital
Date:	Friday 27th July 2018
Time:	10:00 – 13:00

WHC Board Members		
Carol Bode	Chair	CB
Douglas Blair	Managing Director	DB
Lisa Hodgson	Chief Operating Officer	LH
Annika Carroll	Head of Finance	AC
Sarah-Jane Peffers	Head of Quality	SJP
Lawrence Arnold	Deputy SFT Board Representative	CC-B
Francesca Thompson	RUH Board Representative	FT
Kevin McNamara	GWH Board Representative	NV
Richard Barritt	Non Executive Member	RB
Celia Grummitt	Non Executive Member	CG
Adibah Burch	Non Executive Member	AB

In Attendance		
Katy Hamilton Jennings	Head of Legal and Corporate Governance II Board Secretary	KHJ
Lianna Bradshaw	Executive Assistant	LB
Giles de Burgh	Head of Resilience	GDB
Apologies		
Lisa Thomas	SFT Board Representative	LT

	Agenda Item	Lead	Paper	For Decision/ Discussion/ Information
1	**Welcome, Apologies and New Declarations of Interest**	Chair	Verbal	Information
2	**Minutes, Actions and Matters Arising:** • **Minutes of Meeting of 22nd June 2018** • **Action Tracker** • **Matters Arising**	Chair	Attached	Decision
3	**Patient Story**	SJP	Verbal	Information
4	**Safeguarding Statement**	SJP	Attached	Decision
5	**EPPR Report**	GDB	Attached	Decision
6	**15+ Risks Review** **Risk Appetite**	KHJ	Attached	Information Discussion
7	**Approve Board Members Code of Conduct**	KHJ	Attached	Decision
8	**Register of Interests**	KHJ	Attached	Information
9	**Quality, Performance and Finance**	SJP/AC/LH	Attached	Information
10	**Any Other Business**			
	Date of Next Meeting: 2 November 2018			

Welcome, Apologies and New Declarations of Interest

VERBAL ONLY

MINUTES
Of a Wiltshire Health and Care
Board Meeting Part I

Venue	Training Room 1, Chippenham Community Hospital
Date	Friday 22nd June 2018
Time	10:00 to 13:00

WHC Board Members		
Richard Barritt	Chair	RB
Douglas Blair	Managing Director	DB
Annika Carroll	Head of Finance	AC
Sarah-Jane Peffers	Head of Quality	SJP
Francesca Thompson	RUH Board Representative	FT
Nerissa Vaughan	GWH Board Representative	NV
Adibah Burch	Non-Executive Member	AB

In attendance		
Katy Hamilton Jennings	Head of Legal & Corporate Services, Board Secretary	KHJ
Lianna Bradshaw	Executive Assistant (minutes)	LB

Apologies		
Carol Bode	Chair	CB
Lisa Hodgson	Chief Operating Officer	LH
Cara Charles-Barks	SFT Board Representative	CCB
Celia Grummitt	Non-Executive Member	CG

Item	Title/Notes	Actions
1	**Welcome, Apologies and New Declarations of Interest**	
	Richard Barritt welcomed everyone to the meeting and noted apologies from Carol Bode, Lisa Hodgson, Cara Charles-Barks and Celia Grummitt. It was noted that the meeting was not quorate, as there was not a full complement of Member Board Representatives. The meeting would therefore be making recommendations for decisions, which would be formally ratified following receipt of written approval of CCB, as the absent Member Board Representative. There were no new declarations of interest.	

2	**Part I Minutes, Actions and Matters Arising** The minutes of the last meeting held on 25 May 2018 were agreed as a true and accurate record of the meeting. **Action Tracker Item 80:** AC noted on-going issues in setting up WHC's new financial ledger. The systems upgrade went live on 11 June 2018, but issues have delayed implementation. At the last Board, AC advised that external consultancy was viewed as the solution. AC updated that this was no longer the case. Instead, the WHC finance team were putting in place supplementary reporting mechanisms and would continue the current manual ordering processes to insulate WHC from the problems caused by the upgrade. WHC is working closely with RUH to try and resolve the issues. The risks presented by this situation were discussed. It was noted that internal reporting was the area most affected. However, as long as WHC continues to have access to the raw data in the general ledger, reports could be produced. There was no risk of clinical services not receiving their supplies. It was noted that the current interim ordering process is working well. AC advised that a new financial dashboard is being created that will not be reliant on the new system – this will come to the next Board in July. It was noted that **this needs to be added to the Risk Register. The Risk Register is to be brought to Board in July and then quarterly thereafter.** **Action Tracker Item 84:** Physio waiting times – we now have an agreement on MSK services and associated investment from the CCG; therefore this action can be closed. LB to update Action Tracker and circulate with papers for July. **Matters Arising** It was noted that the final accounts were signed off and have now been submitted.	**AC & LB** **LB**
3	**Patient Story** SJP presented a patient story whereby a gentleman had sustained complex multiple injuries after falling 30 feet onto solid concrete, and had been cared for in Chippenham Community Hospital for 5 months during his recovery. SJP noted that this gentleman's care had made an appropriate use of a community hospital bed, and highlighted the importance of MDT working, and the benefits of consistent staff throughout a period of care. This story also highlighted the benefits of encouraging self-management, involving the patient in setting their own goals, and getting the patient home at the earliest opportunity.	

	Learning – recognition of the transition needs after a long hospital stay, and the support we can give to mental health as well as physical health. The length of stay for this patient puts the 20 day target into context. Ensuring that therapy intervention occurs at the earliest possible opportunity. It was noted that we would write back and thank the patient for his account, and wish him luck in the future.	**SJP**
4	**Quality Accounts 17/18** The Board was invited to review and agree the 2017/18 Quality Accounts. WHC is obliged to produce this document annually, but the content does not have to follow the same format as required for an NHS Foundation Trust. We are required to upload the Quality Accounts to NHS Choices by 30 June 2018. The Board noted the references to amendments required prior to the document being finalised. The members also noted the priorities for 18/19, and the statements from other bodies. SJP emphasised how particular effort had been put into ensuring that the enthusiasm of our staff had been captured in this document. Discussion points: • It was noted that stakeholder views are included in the Quality Accounts, but there was a question as to whether we had sufficient breadth in the stakeholders consulted. SJP welcomed this point, and advised that this was being addressed as part of the work to develop our Public and Patient Involvement Plan. Further ideas were also considered at a recent stakeholder engagement event held in Devizes. • It was suggested that producing a summary of the Quality Account would be a nice way to highlight our quality achievements to the public in a more accessible way. The Board recommended that the Quality Account for 2017/18 be signed off – subject to the amendments highlighted within the document and a subsequent summary being produced and published. This recommendation was subsequently ratified by the confirmation of written approval from CCB.	**SJP**

5	**Business Plan** The Board considered the Wiltshire Health and Care delivery plan: update on progress. This had been brought back to the Board as, in line with feedback received from the Board, a timeline had been added to show quarterly milestones. In response to questions about the involvement of staff in the refresh of the delivery plan, DB confirmed that staff Open Forums were being used to canvas staff views on what has gone well, and to seek feedback to feed into the development of the Business Plan. It was planned to re-produce the one page summary with the updates and share with all staff and for display in staff areas. The Board considered the monitoring of the delivery plan and it was suggested that monitoring of the quarterly milestones should be a feature of Board meetings on a quarterly basis. The Board recommended that the refresh of the Delivery Plan be approved, and quarterly updates against delivery milestones should be provided to the Board. This recommendation was subsequently ratified by the confirmation of written approval from CCB.	**DB**
6	**WHC Governance Arrangements** The Board reviewed the proposal for WHC Board membership and sub-committee composition for 2018-19. The key points of the proposal were that: • A total of four sub-committees are in place: Remuneration Committee, Integration Committee, Audit Committee and Quality Assurance Committee. • All Member Non-Executive Board Representatives sit on one committee, and all independent Non-Executive Board Representatives (including Board Chair) sit on two committees. • An additional Non-Executive Board Member with recent and relevant financial experience is recruited. • Member's organisations may look to replace their current representative on the Board, with a different individual to free up the time of their Chief Executives to contribute to STP/developing Integrated Care Alliance matters. The Board members discussed whether WHC needed the proposed level of infrastructure given the size of the organisation. It was noted that, despite its size, as an NHS-Controlled provider, WHC is subject to rigorous regulatory obligations, and meeting those requires it to have certain governance measures in place. These cannot be avoided if we are to meet our obligations. However, in terms of implementing the proposed governance	

	structure, we would achieve this is a proportionate manner, with a tight process of reporting, and a reasonable number of coordinated meetings. It was noted that the proposal suggested that formal Board meetings moved to quarterly instead of monthly. This rescheduling would create time for the sub-committees of the Board to meet. The addition of an Integration Committee will provide the opportunity for non-executive scrutiny of our progress against joint integration objectives with the Council. It was noted that independent non-executive board representatives would require additional training when taking on their responsibilities in the new structure. The Board recommended that the structure be approved. This recommendation was subsequently ratified by the confirmation of written approval from CCB.	
7	**NHSI Corporate Governance Statement** It was noted that since 1 April 2018, WHC has been an NHS-Controlled Provider, and is subject to additional licence conditions under NHSI's regulatory framework. One of the additional licence conditions requires WHC's Board to submit an annual Corporate Governance Statement, confirming that WHC has sound corporate governance measures in place. In order to inform the Board, a draft document setting out an internal review of WHC's performance against NHSI's Well-Led KLOE's was uploaded to Glasscubes. It was noted that there are some areas where we are developing our approach. These are: • Risk management • Financial reporting • Public and patient involvement • Reviews of board member/ committee performance Actions to improve these areas have been defined, and are assigned to members of the Executive team to pursue. The board considered the information provided and the content of the self declaration. It was agreed that there was sufficient assurance in terms of WHC's corporate governance, and it was recommended that the statement was approved.	

	This recommendation was subsequently ratified by the confirmation of written approval from CCB.	
8	**Finance, Quality and Performance Report by Exception**	
	In relation to Quality, it was noted that final notification of performance against CQUIN targets for 2017/18: • CQUIN 1A Improvement in Staff Health and Wellbeing: 100% • CQUIN 1B Healthy food for staff and patients: 100% • CQUIN 1C Improving the uptake of flu vaccinations for frontline clinical staff within Providers: 100% • CQUIN 8B Supporting proactive and safe discharge – Community Providers: 100% • CQUIN 9 Preventing ill health by risk behaviours – alcohol and tobacco: 96.5% • CQUIN 10 Improving the assessment of wounds: 100% • CQUIN 11 Personalised care and support planning 61% The Board noted the continuing positive downward trend in reducing of DTOCs in community wards. It was noted that Health coded DTOCs for GWH had not come down in that period. There was a request to include the recording of stranded and super stranded patients on the dashboard going forward given the status this target has at present. In relation to Finance, it was noted that there are continuing issues with the upgrade of financial ledgers. Recent issues with the RUH's upgrade poses further risk to the timeline and consequential delay in establishing fuller financial reporting. The Board discussed the recent report into the Gosport War Memorial Hospital and sought assurance around the 'could it happen here?' question. Although no organisation could ever say that all risks would never materialise, the addition of a Medicines Optimisation Pharmacist had strengthened the approach to medicines management, the levels and encouragement of incident reporting were mitigating factors which provided some assurance. It was agreed that it would be helpful to have an assessment against the key lessons to learn from the report into Gosport War Memorial hospital at a future Board meeting.	**SJP**

9	**Any Other Business** There was no further business.	
10	**Date of Next Meeting: 27 July 2018, 10:00 – 13:00**	

Wiltshire HEALTH AND CARE

Wiltshire Health Care Board
Action Tracker Part I

NHS

No	Date Entered	Action	Assigned to	Status	Date completed	Notes
51	27.06.17	Ensure that the NHSPS prioritise the safety of buildings and provide appropriate assurance. This should include further inspections and involvement of the fire service advice.	SJP/DB	Open		21.09.17 Further assurance work undertaken but further assurance being sought from NHSPS before being brought back to Board. 13.11.17 meeting with fire lead at NHSPS took place in November – awaiting formal report in December of actions being taken. Will report back to Board once received. 09.03.18 Awaiting feedback from Jo Woodward. Update 15.03.18 Further assurance has been provided by NHSPS, the risk register has been updated to reflect reduced risk and fuller details will be provided in the annual report due in May
67	28.11.17	improvements to financial reporting should be made in line with the changes to new financial systems from April 2018. After initial improvements have been implemented for April 2018, a plan should be presented for further cost analysis and service line reporting.	AC	Open		
79	23.01.18	Liaise re independent Audit and Assurance Committee chair	CB	Open		
80	23.01.18	A strategic risk on financial information should be added to the Board Assurance Framework. Complete. Upon establishment of the new clinical risk system (anticipated end of May/June 2018), the Board Secretary will review the format of risk registers and re-structure the approach. The Audit and Assurance Committee should review proposals for redesign of the risk management process.	KHJ	Open		
81	23.01.18	H&S, Fire and Security: Assess incidents of violence and aggression on patient to patient or patient to staff change categories in information – This change to categorisation will be taken forward as part of the planning for a new clinical risk system. 09.03.18 In line with DATIX build, to be carried out during 2018-19	SJP	Open		
82	23.01.18	Update mandatory training table and identify and implement training mechanisms – 13.11.17 to be picked up by KHJ. 13.03.18 KHJ & LB to meet with Hanna Mansell/Nicky Shipman to discuss setting up of mandatory training	KHJ	Open		

83	23.01.18	Board members would be interested to see an analysis of the relative costs of providing a higher intensity care intervention as opposed to inpatient care. Further work to be done as timescale has slipped	DB	Open		
84	23.01.18	Report back on Physio waiting times – Discussions with CCG ongoing, no decision made on future pathway, waiting time position unchanged. Report back when commissioning decision reached – 25.07.17 No decision has been made so will bring back to Board.	DB	Open		
96	22.06.18	A lack of capital funding within WHC could lead to limited funds being available for future investment requirements, potentially causing inability to invest in necessary upgrade of infrastructure and equipment needed to provide patient care. - To be added to risk register	AC	Open		
97	22.06.18	SJP to write thank you letter to Patient who provided story for Board	SJP	Open		
98	22.06.18	Summary of Quality Account to be produced for the Quality Accounts	SJP	Open		
99	22.06.18	Quarterly updates against delivery milestones from Delivery Plan should be made to Board	DB	Open		
100	22.06.18	Assessment against the key lessons to learn from the report into Gosport War Memorial Hospital at a future board meeting	SJP	Open		

Patient Story

VERBAL ONLY

Wiltshire Health and Care Board	For information
Subject:	**Working Together to Safeguard Children, Declaration of Statutory Compliance**
Date of Meeting:	**27 July 2018**
Author:	**Netty Snelling, Children's Safeguarding Lead**

1. Purpose

Each year, Wiltshire Health and Care's Board is required to publish a statement that it is assured with respect to the arrangements in place for safeguarding children. This statement sets out what arrangements Wiltshire Health and Care has in place to meet its responsibilities in this regard.

The Board is invited to consider the statement, and confirm it is assured by the measures in place for safeguarding children.

Impacts and Links

Impacts	
Quality Impact	None
Equality Impact	None
Financial implications	None
Impact on operational delivery of services	None
Regulatory/ legal implications	The Board is required to approve a statement confirming that it is assured by the measures in place to safeguard children on an annual basis.
Links	
Link to business plan/ 5 year programme of change	None
Links to known risks	None
Identification of new risks	None

Wiltshire Health and Care Board

Working Together to Safeguard Children

Declaration of Statutory Compliance

The Board of Wiltshire Health and Care (WHC) is assured that the following requirements are in place in line with the recommendations of the Care Quality Commission to ensure that systems and processes are in place to safeguard children and young people.

Section 11 of the Children Act 2004 places a duty on every provider to have arrangements in place to ensure that the organisation and all staff working within it have regard to the need to safeguard and promote the welfare of children. WHC will:

- Do all that it can to ensure that WHC staff work within the current policy and procedures.
- Regularly reviews its arrangements against these requirements and remain compliant with them.

Wiltshire Health and Care's principle philosophy is that 'safeguarding' is everybody's business:

- WHC employment arrangements meet all statutory requirements in relation to Disclosure and Barring Service (DBS) checks and are committed to 'safer staffing' recruitment.

- WHC has a nominated HR lead for dealing with allegations relating to children who works closely with the Local Area Designated Officer (LADO) if concerns arise.

- WHC staff will work within the Safeguarding Children & Young People's policy which meets with the requirements of *Working Together to Safeguard Children 2018*.

- In addition to following the South West Child protection procedures WHC staff will follow current processes, pathways and policies to safeguard children:

    - Safeguarding Children and Young People Policy
    - Managing Child Missed Health Appointments Policy
    - Safeguarding Supervision Policy
    - Managing Allegations Against Staff and Volunteers who Work with Children Policy
    - Female Genital Mutilation Policy
    - Domestic Abuse Policy

- A rolling programme of Safeguarding Children's training and development is in place, including training at induction. A Training Needs Analysis is regularly reviewed to identify the requirements for WHC staff, and will develop the training to reflect the need.

- WHC has designated named safeguarding professionals in place to fulfil the requirements as detailed in *Working Together to Safeguard Children 2018*.

- The Board level Executive Lead with the responsibility for safeguarding in WHC is The Head of Quality

WHC Safeguarding Forum (children and adults) monitors the Safeguarding activities on behalf of the Board and will comply with requests to participate in the Section 11 audit for Wiltshire Local Safeguarding Children's Boards, as requested to do so.

Douglas Blair
Managing Director.
July 2018

Link to Wiltshire Local safeguarding Board http://www.wiltshirelscb.org/

Wiltshire Health and Care Board Choose board paper purpose

Subject:	**Resilience**
Date of Meeting:	**27 July 2016**
Author:	**Giles de Burgh – Head of Resilience**

1. Purpose

To present the outcome of the 2017/18 NHS England Cores Standards annual assurance

2. Background

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet. NHS England conducts an annual assurance process in line with these core standards (see Appendix A for complete list of Core Standards). There is a requirement as part of this process to submit an annual board report detailing the return to the Board.

3. Recommendation

3.1 The Board is invited to:

(a) Acknowledge the 2017/18 EPRR assurance return in awareness that the 2018/19 round of assurance is already underway and the Board will receive this report within the next quarter.

Impacts and Links

Impacts	
Quality Impact	NA
Equality Impact	NA
Financial implications	NA
Impact on operational delivery of services	NA
Regulatory/ legal implications	NA
Links	
Link to business plan/ 5 year programme of change	NA
Links to known risks	NA
Identification of new risks	NA

1.1 Introduction

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet. NHS England conducts an annual assurance process in line with these core standards (see Appendix A for complete list of Core Standards). There is a requirement as part of this process to submit an annual board report detailing the return to the Board.

1.2 Summary of return

The assurance process is based on a RAG rated self-assessment. There are a total of 43 core standards applicable to community services. RAG descriptors appear in the summary table below.

RAG	Descriptor	2017/18
Green	Green = fully compliant with core standard.	41
Amber	Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	2
Red	Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.	0

1.3 Improvement Plan 2017 /2018

As part of the NHS England assurance process GWH will submit an improvement plan focussing on areas that are not currently green.

Core standard	Current self-assessed level of compliance (RAG rating)	Remaining actions required to be fully compliant	Planned date for actions to be completed	Lead name	Further comments / date published
8b - corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Amber	Acknowledging progress from 2016 there are a number of key checklists in development that are require to meet this. • 02:000 BC Coordination checklist • 02:tbcSystem One failure • 02:017 Medway • 02:015 Ward Relocation Options	• Oct 2017 • May '18 • Dec '17 • Feb 2018	GdB SO	• 14/01/18 • TBC • 18/01/2018 • 18/01/2018
32 – Incident Coordination Centre	Amber	Basic Incident Coordination Centre arrangements have been in place for some time. However with the further development of Major Incident arrangements (system and organisational), formal split form GWH arrangements as well as Business Continuity processes a more comprehensive set of arrangements for establishing an ICC are being developed.	Oct '18	SO GdB	

Appendix A: NHS England Core Standards for EPRR

Core standard	Community providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)	Y	1) Douglas Blair - Managing Director of Wiltshire Health & Care
Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Y	1) iRespond checklist tracker (white board)
Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Y	1) WH&C EPRR Policy
The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	Y	1) EPRR Policy (ref 2.1.2)
Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Y	Risks assessed as part of the BIA process. Involved in monthly risk assessment process through LRF / LHRP reviewing (on an annual cycle) key community risks.
There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	Y	1) As above

Core standard	Community providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Y	1) As above
Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Y	04:000 Major Incident Overview 04:001 Major Incident Cascade 04:002 System Major Incident- Single Points of Contact 04:003 ETC Overview 04:004 ETC TRD Role 04:005 System Major Incident_System Overview
	Y	02:001 Building workbase loss 02:002 Door failure Trowbridge Hospital 02:003 Electricity failure mains and generator 02:004 Equipment failure clinical 02:005 Loss of Gas supply or Gas Leak 02:006 Loss of Heating and/or Hot Water 02:007 Major Water Leak 02:008 Major Water Loss 02:009 Phone Failure (landlines) 02:010 Mobile Phone Failure 02:011 Winter or Incident Staffing 02:012 Medvivo use of Wiltshire Health and Care premises 02:013 MIU Closure 02:014 Call bell System failure
	Y	03:001 CBRN Overview 03:002 CBRN Reception 03:003 CBRN Contaminated Patient 03:004 CBRN Cleaning & Waste
	Y	00:025 Heatwave 02:001 Winter Incident staffing GWH Emergency Transport Plan (Snow and Fue)
	Y	03:007 Pandemic Flu Plan Overview 03:008 Pandemic Flu: Chair of Pandemic Control Team 03:009 Pandemic Flu: MIU 03:010 Pandemic Flu: Community Wards 03:011 Pandemic Flu: Community Teams 03:012 Pandemic Flu: Specialist Services 03:013 Pandemic Flu: ACP Overview 03:014 Pandemic Flu: Possible ACP Locations WHC

Core standard	Community providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
	Y	Support the activation of LHRP Communicable Disease plan
	Y	Checklists 04:003 - 04:004 Emergency Treatment Centre
	Y	No bunkered fuel stocks will mange as a business continuity incident as with snow.
	Y	01:001 WHC Surge and Escalation 01:002 Escalation: CCG led System Escalation Teleconference
	Y	00:019 Influenza (potential) on a Ward 00:020 D&V on Wiltshire Community Wards
	Y	Fire Evacuation Policy
	Y	03:006 Lockdown
	Y	02:002 Door failure Trowbridge Hospital 02:003 Electricity failure mains and generator 02:005 Loss of Gas supply or Gas Leak 02:006 Loss of Heating and/or Hot Water 02:007 Major Water Leak 02:008 Major Water Loss 02:009 Phone Failure (landlines) 02:010 Mobile Phone Failure 02:014 Call bell System failure
Ensure that plans are prepared in line with current guidance and good practice which includes:	Y	10:001 Toolkit: Operational Checklist Portrait iRespond Operational Checklists incorporate owner, review date, version control, purpose, key information, notification / activation; operational detail split by staff groups. iRespond Governance Record (linked to each operational checklist by

Core standard	Community providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
		the same serial number) contains detail of risk which identified the need for a checklist, planning group, consultation, sign off, amendment history.
Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Y	05:001 Impact Assessment
Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Y	Business Impact Analyses have priority of against each service.
Arrangements explain how VIP and/or high profile patients will be managed.	Y	03:006 Lockdown
Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content	Y	See iRespond Governance Records for list of key parties that were consulted or involved in the planning group.
Arrangements include a debrief process so as to identify learning and inform future arrangements	Y	EPRR Policy 10:002 Template Debrief Feedback 10:003 Template Debrief Report
Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Y	24/7 on call manager and Director
Those on-call must meet identified competencies and key knowledge and skills for staff.	Y	07:000 iRespond Training Exercise Schedule

Core standard	Community providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	Y	07:010 iRespond On Call Responsibilities & Induction
Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.	Y	04:000 Major Incident Overview
Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	Y	04:014 Incident & Major Incident Role of ICC Room Manager checklist 06:004 NHSE Sitrep checklist
Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Y	See checklist Incident Community Teams 03:005 for informing vulnerable patients.
Arrangements ensure the ability to communicate internally and externally during communication equipment failures	Y	02:016 Phone Failure Landline 2) Phone failure mobile community teams 2:017, 3) IM&T business continuity plans.
Arrangements contain information sharing protocols to ensure appropriate communication with partners.	Y	LHRP - LRF Information Sharing Protocol and LRF-LHRP Vulnerable Individuals Plan
Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)	Y	LHRP representation on the LRF is from NHSE.
Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA	Y	Local Health Resilience partnership attended by COO at the Executive level and by Head of Resilience and Resilience Officer at the Business Group Level.
Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	Y	LHRP Health Community Response Plan
Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Y	LHRP Health Community Response Plan

Core standard	Community providers	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level	Y	Accountable Emergency Officer
Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Y	07:000 iRespond Training Exercise Schedule
Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Y	See above
Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises	Y	See above
Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	Y	See above

Wiltshire Health and Care Board	For discussion
Subject:	**15+ Risks, Risk Appetite**
Date of Meeting:	**27 July 2018**
Author:	**Tom Blowers, Risk and Complaints Manager**
	Katherine Hamilton Jennings, Head of Legal and Corporate Governance and Board Secretary

15+ Risks

1. Purpose

In recognition of the requisition and implementation of DATIX to support Wiltshire Health and Care in managing patient safety, necessary work has been undertaken to ensure that our risk management processes have robust governance to ensure that all risks relating to Wiltshire Health and Care are appropriately reported and managed.

The work undertaken so far includes, recruiting a risk and complaints manager, drafting a strategic risk management framework, and scrutinising our current risk management process to identify gaps, areas for improvement and scoping more efficient risk management techniques in line with best practice.

The Board of Wiltshire Health and Care has overall responsibility for managing risks. In line with the both the current and risk management framework currently under development, all risks scoring 15+ will be reported to the Board and reviewed on a quarterly basis. This report explains the current 15+ risks for Wiltshire Health and Care, and the actions being taken to reduce, or, eliminate those risks.

The Board is asked to **discuss** and **note** the contents of the 15+ risks.

Risk Appetite

1. Purpose

Meeting our strategic objectives involves us taking risks (i.e. exposing Wiltshire Health and Care to danger, harm or loss). However, in taking those risks, we must not expose ourselves to more harm or loss than we can cope with. To control the level of harm or loss Wiltshire Health and Care is exposed to, it is recommended that the Board approves a Risk Appetite statement. The Risk Appetite statement will define the amount of risk the Board is happy for Wiltshire Health and Care to take in pursuit of its strategic objectives. Strategic decisions must then be taken with consideration to the Risk Appetite, so that exposure is managed in a controlled and considered manner.

In light of the above, a draft Risk Appetite has been produced for consideration by the Board. This has been drafted in the context of a wider piece of work being undertaken within Wiltshire Health and Care to review the organisation's approach to risk management generally and redefine our approach.

The Board is asked to **discuss** the draft Risk Appetite.

Impacts and Links

Impacts	
Quality Impact	None
Equality Impact	None
Financial implications	None
Impact on operational delivery of services	None
Regulatory/ legal implications	Under our current risk management framework, the Board is required to note the 15+ risks quarterly. A principle of good governance is for the Board to agree a Risk Appetite.
Links	
Link to business plan/ 5 year programme of change	None
Links to known risks	None
Identification of new risks	None

Wiltshire Health and Care Board **For discussion**

Subject: **15+ Risks, Risk Appetite**

Date of Meeting: **27 July 2018**

Author: **Tom Blowers, Risk and Complaints Manager**

Katherine Hamilton Jennings, Head of Legal and Corporate Governance and Board Secretary

15+ Risks

Overview

There are four 15+ risks on Wiltshire Health and Care's operational risk register at this point in time. Three of these have been identified in the last month regarding Information and Communication Technology issues.

15+ Risks Dashboard

Risk No.	Risk description	Risk score	Target risk score	Movement since last Board review	Mitigating actions	Executive Lead
2093	**Ailesbury Ward** • Lack of staffing, high use of agency staff and the physical layout of the Ailesbury ward has the potential to impact on patient care & safety, leading to; complaints, poor ratings from CQC, poor reputation with commissioners, stress on substantive staff - possibly leading to increased vacancies, increased adverse incidents, potentially leading to litigation.	**16**	**8**	↔	• Ailesbury transformation project.	Sarah Jane Peffers, Head of Quality

2142	**Finance** • New requisition software has not performed to expectations raising concerns that requisition of clinical goods might fail due to length of software update and reliance on weak interim processes.	**15**	**5**	Newly added	• Scenario plan to be developed ensuring that current and future issues regarding development of purchase ledger are identified. • Consideration by Executive Committee around seeking alternative cloud based service for providing financial infrastructure appropriate to WHC. • Assess and monitor interim process and create ability to send monthly reports to budget managers.	Annika Carroll, Head of Finance
2150	**ICT** • Due to poor internet connectivity, ageing hardware and poor reception areas in the county, patient information is not recorded within adequate timeframes into relevant databases. This could lead to unavailability of patient information, resulting in patient care being compromised and harm occurring to patients on the caseload.	**15**	**6**	Newly added	• Recruit Head of ICT to drive forward improvements to WHC infrastructure, including requisition of smart phones for all relevant community staff. • All relevant community staff to be issued with smart mobile phone with the capability to add into databases whilst out in the community.	Douglas Blair, Managing Director

Risk Appetite

Risk Appetite Overview and Statement

Definitions

- **Risk Appetite** - means the amount of risk the Board is happy for Wiltshire Health and Care to take in pursuit of its strategic objectives.
- **Risk Tolerance** - is specifically to do with the maximum amount of risk that the Board is prepared to let Wiltshire Health and Care be exposed to. This may be less than the Risk Capacity.
- **Risk Capacity** - is the maximum amount of risk that Wiltshire Health and Care could be exposed to without putting its viability at stake.

Overview

Wiltshire Health and Care's appetite for risk is informed by its ambition to provide patients with seamless care, and to remove the cultural and contractual barriers to achieving this.

In doing this, Wiltshire Health and Care aims to modernise systems and processes, improve existing infrastructure, and reduce the fragmentation of the sector. It aims to integrate health and social care provision, and engage with and host transformation resource to support a broad provider partnership for Wiltshire - enabling broader system change and transformation.

Wiltshire Health and Care's Board is responsible for ensuring that these objectives are achieved without the organisation spending more money than our commissioner gives us each year. We must also ensure that in delivering our objectives, we satisfy our contractual, regulatory, and statutory obligations, whilst meeting the expectations of our patients and the local population.

Meeting our objectives involves us taking risks (i.e. exposing Wiltshire Health and Care to danger, harm or loss). However, in taking those risks, we must not expose ourselves to more harm or loss than we can cope with. To control the level of harm or loss Wiltshire Health and Care is exposed to, Wiltshire Health and Care's Board approves a **Risk Appetite**. The Risk Appetite defines the amount of risk the Board is happy for Wiltshire Health and Care to take in pursuit of our strategic objectives. It is acknowledged that, on occasion, Wiltshire Health and Care may need to make a strategic decision that is outside of its Risk Appetite. However a strategic decision should never take place where this would pose a risk that is outside of Wiltshire Health and Care's **Risk Tolerance**.

Our Risk Appetite is set by our Board, and reviewed at least annually. It forms a key element of our governance and reporting framework.

Consideration is also given to the likely aggregation of risks at any point in time.

Wiltshire Health and Care's (WHC's) Risk Appetite is also linked to the risk scoring matrix illustrated below. Our appetite for net risk is set by the red line. We are averse to any risk scoring above this line.

Net risk appetite boundary (marked with a bold red line)

Impact	Net risk = impact x likelihood				
Catastrophic	5	10	15	20	25
Major	4	8	12	16	20
Moderate	3	6	9	12	15
Minor	2	4	6	8	10
Almost none	1	2	3	4	5
Likelihood	**Rare**	**Unlikely**	**Moderate**	**Likely**	**Almost certain**
Likelihood score	**1**	**2**	**3**	**4**	**5**

At every Risk Review the Executive Committee will ensure that where there are risks rated 12 or above, there are plans in place to attempt to reduce that risk to a level below 12. This may involve considering whether the practices/circumstances giving rise to the risk are stopped.

Risk attitude levels

Risk attitude		Definition
(0) "Averse"	Avoid/ No appetite	• Avoidance of risk and uncertainty is a key organisational objective
(1) "Cautious "	Low appetite	• Preference for safe delivery options that have a low degree of residual risk and many only have limited potential for reward
(2) "Open"	Medium appetite	• Willing to consider all potential delivery options and choose the one that is most like to result in a successful delivery while also providing acceptable level of reward (and value for money) at an acceptable level of risk
(3) "Seek"	High appetite	• Eager to be innovative and to choose options offering potentially higher rewards, but with which a greater degree of uncertainty.

Risk Appetite

- **Risk Appetite (the amount of risk WHC should aim to be exposed to)** – WHC's Risk Appetite in each area is indicated by a **turquoise** box. It is the role of the Executive Committee to ensure that all strategic risks that Wiltshire Health and Care is exposed to, align with the defined Risk Appetite.

- **Risk Tolerance (the maximum amount of risk WHC is prepared to be exposed to)** – Tolerance levels are described within the chart. WHC's Risk Tolerance in each area is indicated by a **grey** box. It is acknowledged that, on occasion, the Executive Committee may need to make a strategic decision that is outside of its Risk Appetite. However a strategic decision should never take place outside of Wiltshire Health and Care's risk tolerance.

Area for consideration	"Averse" No appetite	"Cautious" Low appetite	"Open" Medium appetite	"Seek" High appetite
Risk to patients	Avoidance of harm to patients is a key objective. We are not willing to accept any risk to patient safety, outcomes, or experience.	Only prepared to accept the possibility of minimal risk to patient safety, outcome, or experience if essential.	Prepared to accept the possibility of some risk to patients. Patient safety is the primary concern but this is balanced against other considerations such as the best interest of the patient or public health.	
Financial risk	WHC is averse about committing to spend more than the funds available. We do not approve a project, scheme, or post, without having sufficient identified funds identified.	WHC may approve funding a project, scheme, or post without having sufficient recurrent funding available within the budget, providing that the funding is likely to be identified on a non-recurrent basis for the minimum period of commitment to the project, scheme or post, and that the commitment is not more than £200,000.		
Integration/ diversification of services			WHC is open to opportunities to integrate and/ or provide services in a joint way with health and social care partners. WHC is open to diversifying the services that it provides (within health/social care) where this is viable and in line with our strategic objectives.	
Geographical coverage	WHC is averse about expanding the geographical area within which it provides any of its services.	WHC may consider expanding the geographical area within which it provides one or a small number of its services where there is sufficient additional corporate resource to support a small level expansion.		
Compliance and regulatory risk		WHC is generally cautious of breaching any of its statutory, regulatory, or contractual obligations. WHC would want to be reasonably sure it would win any challenge.	However because WHC is a relatively small organisation within the NHS community, with an extremely lean management structure, it may have conversations with its commissioners and regulators with regard to taking a proportionate approach to fulfilling obligations.	
Reputational risk		WHC is cautious of exposure to circumstances that could result in the organisation being perceived in a negative way by its stakeholders.	WHC may consider publically challenging a national decision that does not take into account its unique status as an NHS provider, where this is supported by a well-developed communication plan.	
Stakehdoler engagememt				WHC proactively seeks opportunities to engage with its stakeholders to understand how it can improve its approach to best meet the needs of its local population
People - skills		WHC is cautious about loss of collective competencies, knowledge and skills.		
People - behaviours	WHC is averse to behaviours that do not meet WHC's Values and Behaviours and take very seriously any breaches of our code of conduct			
Strategic risk		WHC is cautious of any risk which comprimises any one of the priority goals set out in WHC's Business Plan.		

Relevant excerpts from the proposed Risk Management Framework for Wiltshire Health and Care, currently under development:-

Section 10: Risk Appetite

When should the Risk Appetite be considered?

10.1	The Risk Appetite statement (**Appendix B**) will be reviewed by the Board at least annually, as a precursor to any review or renewal of the Business Plan.
10.2	The Risk Appetite statement will be taken into account by the Executive Committee and Senior Management Team when drafting the annual Business Plan.
10.3	The Risk Appetite statement will be taken into account at Risk Reviews, and included as an appendix to each risk report presented to the Board.
10.4	The Risk Appetite statement will be taken into account when the Executive Committee is making a strategic decision that is not already set out within the agreed Business Plan for the year.
10.5	Any amendments to the Risk Appetite will be approved by the Board.

Risk scores are reviewed as set out below ("Risk Reviews"):

- **Operational risks** – during the quarterly risk review sessions, "*Community teams/ specialist services/ corporate functions risk review workshops*", and by the Executive Committee on a yearly basis for all risks, and on a monthly basis for 12+ risks.

- **Strategic risks** – on a quarterly basis by the Executive Committee, and twice yearly basis by the Board.

Wiltshire Health and Care Board **For information**

Subject:	**Board Code of Conduct - updated**
Date of Meeting:	**27 July 2018**
Author:	**Katherine Hamilton Jennings, Board Secretary**

1. Purpose

The Board is required to review its Code of Conduct annually.

This version has been updated in the following ways:

- AN expansion of the processes used for assuring ourselves that our Board Representatives are fit and proper. In the updated version of the Code of Conduct, these requirements have been organised into three clear categories:

Stage 1:	How WHC assures itself that its directors (or equivalent) are fit and proper on appointment
Stage 2:	How WHC assures itself that its directors (or equivalent) are fit and proper at regular intervals
Stage 3:	How WHC assures itself that its directors (or equivalent) are fit and proper if concerns are raised

  Our process is based upon the guidance from NHS Providers.

- A checklist for ensuring newly appointed Board Representatives are fit and has been developed and included within the document.

- The Fit and Proper Person self-declaration and Member Chair declaration are included as appendices to the document.

Impacts and Links

Impacts	
Quality Impact	None
Equality Impact	None
Financial implications	None
Impact on operational delivery of services	None
Regulatory/ legal implications	The Board is review its Code of Conduct annually.
Links	
Link to business plan/ 5 year programme of change	None
Links to known risks	None
Identification of new risks	None

BOARD CODE OF CONDUCT AND BEHAVIOURS

INTRODUCTION

The Board of Wiltshire Health and Care LLP (WHC) wishes to ensure high standards of corporate and personal conduct. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all Board members.

This code forms the framework designed to promote the highest possible standards of conduct and behaviour within WHC.

PRINCIPLES OF PUBLIC LIFE

All Board members are expected to abide by the Nolan principles of public life:

1	**Selflessness**	Board members should act solely in terms of the interests of WHC, its members and stakeholders. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
2	**Integrity**	Board members should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
3	**Objectivity**	Board members should make choices on merit when making appointments, awarding contracts or recommending individuals for rewards and benefits.
4	**Accountability**	Board members are accountable for their decisions and actions and must submit themselves to whatever scrutiny is appropriate to their office.
6	**Openness**	Board members should be as open as possible about all the decisions and actions they take; they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
7	**Honesty**	Board members have a duty to declare any private interests relating to the duties and to take steps to resolve any conflicts arising.
8	**Leadership**	Members should promote and support these principles by leadership and example.

GENERAL PRINCIPLES

Board members have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board and each Board member individually, is to act with a view to promoting the success of WHC so as to maximise the benefits for the members of WHC as a whole and for the public. The Board therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct.

The Board will lead in ensuring that the provisions of its Members Agreement, standing orders, financial standing orders, and scheme of delegation conform to best practice and serve to enhance standards of conduct. The Board expects that this code will inform and govern the decisions and conduct of all Board members.

CONFIDENTIALITY AND ACCESS TO INFORMATION

Board members must not disclose any confidential information, except in specified lawful circumstances and, advisably, only in consultation with WHC's Board Secretary.

Information on decisions made by the Board[1], and information supporting those decisions, should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information in accordance with the Freedom of Information Act 2000 and other applicable legislation, and Board members must not seek to prevent a person from gaining access to information to which they are legally entitled.

WHC has adopted policies and procedures to protect the confidentiality of personal information and to ensure compliance with data protection legislation, the Freedom of Information Act 2000, and other relevant legislation which will be followed at all times by the Board.

REGISTER OF INTERESTS

Board Members are required to register all relevant interests with the Board Secretary. It is the responsibility of each member to provide an update to the Board Secretary if their interests change. Failure to register a relevant interest in a timely manner may constitute a breach of this code.

TRANSFERS OF VALUE

Board members must not accept benefits from a third party unless they have been authorised by the members or cannot be reasonably regarded as giving rise to a conflict of interest. WHC maintains a record of all transfers of value, and Board members are expected to report these to the Board Secretary who will maintain the record.

FIT AND PROPER PERSONS

Each Board member must be and remain a 'fit and proper person', in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. If circumstances change so that a Board member can no longer be regarded as a fit and proper person, or if it comes to light that a Board member is not a fit and proper person, they will be suspended from being a Board member with immediate effect pending confirmation and any appeal. Where it is confirmed that a Board member is no longer a fit and proper person, their Board membership will be terminated. Further details on the arrangements for fulfilling the 'fit and proper person' requirements are attached at Appendices A, B, C and D.

[1] During its part 1 sessions.

CONFLICT OF INTEREST

Board members have a duty to avoid a situation in which they have (or *can* have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of WHC. Board members shall not accept a benefit from a third party by reason of being a Board member or doing (or not doing) anything in that capacity.

If a Board member has, in any way, a direct or indirect interest in a proposed transaction or arrangement with WHC, the Board member must declare the nature and extent of that interest to the other Board members. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before WHC enters into the transaction or arrangement.

The Chair of WHC will advise Board members in respect of any conflicts of interest that arise during Board meetings, including whether the interest is such that the Board member should withdraw from the meeting for the period of the discussion. In the event of disagreement it is for the Board to decide whether a Board member must withdraw from the meeting. The Board Secretary will provide advice on any conflicts that arise between meetings.

A register of interests will be maintained by the Board Secretary.

GIFTS AND HOSPITALITY

The Board will set an example with regards to the use of funds and the need to ensure good value when incurring expenditure. The use of WHC funds for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered.

All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of WHC in the eyes of the community.

WHC has a policy on gifts and hospitality which will be followed at all times by Board members. Board members must not accept gifts or hospitality other than in compliance with this policy.

RAISING MATTERS OF CONCERN OR WHISTLE-BLOWING

The Board acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. WHC has a freedom to speak up policy[2] on raising matters of concern, which Board members will support.

PERSONAL CONDUCT/ ACCOUNTABILITY

Board members are expected to conduct themselves in a manner that reflects positively on WHC, and will not conduct themselves in a manner that could reasonably be regarded as bringing their office into disrepute.

[2] This is sometimes referred to as the 'whistle blowing' policy.

Specifically Board members must:

- Act within their power as set out in the Members Agreement.
- Promote the success of Wiltshire Health and Care as an entity in its own right within the healthcare system.
- Act in the best interests of WHC, and adhere to its values and this code of conduct.
- Respect others and treat them with dignity and fairness
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the Board as a Board member in order for it to fulfil its role and functions. In doing so, exercise independent judgement.
- Recognise that the Board is collectively responsible for the exercise of its powers and the performance of WHC.
- Raise concerns and provide appropriate challenge regarding the running of WHC or a proposed action where appropriate.
- Recognise the differing roles of the Chair, Managing Director, executive and non-executive members.
- Make every effort to attend meetings where practicable.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Acknowledge the responsibility of Board members individually and collectively to account for the performance of the Board and represent the interests of the Members, public and partner organisations in the governance and performance of WHC.
- Not use their position for personal advantage or seek to gain preferential treatment, nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.

COMPLIANCE

Board members will satisfy themselves that the actions of the Board in conducting Board business fully reflect the values, general principles, and provisions in this code, and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon.

All Board members shall undertake to abide by the provisions of this code of conduct.

REVIEW

This code of conduct shall be reviewed by the Board at least annually.

Approved by the Board on [*please note that the last review was on 28th March 2017*]

Appendix A

Fulfilling the fit and proper persons requirements

Introduction

The Fit and Proper Persons Regulations (FPPRs), set out as part of *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,* require regulated providers to assure themselves that all executive and non-executive directors (or those in equivalent roles) on the Board are fit and proper individuals to carry out their role. The purpose of the FPPRs is not only to hold Board members to account in relation to their conduct and performance, but also to instil confidence in the public that the individuals leading regulated provider organisations are suitable to hold their position.

This policy has been written to ensure Wiltshire Health and Care LLP (WHC) complies with the requirements of the FPPRs, as well as meeting the expectations of the Care Quality Commission (CQC)[3].

Accordingly, this policy sets out *how* WHC shall assure itself that its directors (or those in equivalent roles) on its Board, are fit and proper.

Three key stages are considered:

1. On the appointment of a director (or equivalent person).
2. At regular intervals throughout a director (or equivalent person's) employment.
3. If concerns are raised about a director (or equivalent person).

Scope

The following roles at WHC (where occupied) fall within the scope of the FPPRs:

- Chair
- All non-executive members (including Member Board Representatives and alternate Member Board Representatives)
- Managing Director
- Clinical Director
- Chief Operating Officer
- Any other Board member (regardless of voting rights) not listed above
- Any other person who performs the functions of, or functions equivalent or similar to, those of a Board member

[3] The CQC holds providers to account in relation to the FPPRs through the well-led key question of its regulatory model. During a well-led review, CQC will always consider FPPRs issues. If CQC deems it necessary, it will assess whether providers have robust systems and processes in place to ensure all directors (or those in equivalent roles) meet the requirements of the FPPRs at the recruitment stage and subsequently throughout their employment. If CQC is concerned that a provider is not discharging its FPPRs responsibilities properly, it may take enforcement action against the provider, such as cancelling the provider's registration or prosecution.

Summary of the fit and proper persons requirements

The FPPRs specify that regulated providers must not appoint a person to an executive or non-executive director level post unless, as stated in Paragraph 5 (3) and Paragraph 5 (5), all of the following criteria are met:

- The individual is of good character**.
- The individual has the necessary qualifications, competence, skills and experience.
- The individual is able to perform the work that they are employed/appointed for after reasonable adjustments are made.
- The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
- None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.
- The information set out in Schedule 3 of the FPPRs can be supplied to CQC on request.

*** Schedule 4, Part 2 of the FPPRs provides a definition for "good character". However it is possible for a provider to deem an individual of good character where these criteria are not met. This is allowed because the concept of rehabilitation is encouraged. Where WHC deems a person to be of good character despite not satisfying the criteria of Schedule 4, Part 2 of the FPPRs, it will document the reasons for holding this view, and information about such a decision will be made available to those that need to be aware.*

It is an explicit condition of all WHC contracts of employment/appointment letters that executive and non-executive directors on the Board (or those in equivalent roles), *remain* fit and proper as required under the FPPRs and CQC guidance. Accordingly, in the event that an individual ceases to be a fit and proper person, that individual will be removed from their role on the Board, and may be summarily dismissed. Upon taking such action, WHC will notify the individual's professional regulator (if applicable), as well as NHS Improvement. At the same time, WHC will take steps to fill the vacated role with an individual who is deemed to be fit and proper.

Given the requirement to ensure that its directors (or those in equivalent roles), remain fit and proper throughout their term of appointment, WHC not only has a process for ensuring the FPPRs are met on appointment, it also has a process for ensuring the above criteria are met at regular intervals throughout the term of appointment, and a process for investigating concerns.

Responsibility for ensuring the organisation has fit and proper persons

Chair

- To take overall responsibility and accountability for ensuring all those required to confirm meet the requirements of the FPPRs do so at appointment and as an on-going requirement[4].

[4] In January 2018, the CQC published guidance on the FPPRs. The guidance places ultimate responsibility on chairs of regulated providers to discharge the requirements of the FPPRs.

- In respect of Member Board Representatives (and any appointed Deputies), to obtain written assurance from the chair of each Member that the Member Board Representatives (and any appointed Deputies) meet the requirements of the FPPRs, and that all applicable compliance checks have been carried out.
- To declare to CQC that Board members have been assessed as being fit and proper individuals.
- To receive notification by CQC of any non-compliance with the FPPRs, and hold responsibility for making any decisions regarding action that needs to be taken.

WHC is assured that the FPPRs are satisfied by overseeing the three-stage process set out below.

Those within the scope

- To hold and maintain suitability for the role they are undertaking.
- To respond to any requests of evidence of their on-going suitability.
- To disclose any issues which may call into question their suitability for the role they are undertaking.

HR

- To support the undertaking of all appointment checks (as outlined in Appendix 2), and ensure the results are recorded and evidenced within an individual's file.
- To support the undertaking of an annual refresh of suitability (as outlined below) for all individuals within scope.

How WHC shall assure itself that its directors (or those in equivalent roles), are fit and proper:

Stage 1:	How WHC assures itself that its directors (or equivalent) are fit and proper on appointment
Stage 2:	How WHC assures itself that its directors (or equivalent) are fit and proper at regular intervals
Stage 3:	How WHC assures itself that its directors (or equivalent) are fit and proper if concerns are raised

Stage 1: How WHC assures itself that its directors (or equivalent) are fit and proper on appointment

WHC has in place robust processes with regard to the appointment of Board members. The following processes apply to all executive director level posts, and will be applied as appropriate to non-executive level posts:

- Values based recruitment process (i.e. values tested through interview process).
- Confirmation of the status of specific qualifications as outlined within the relevant job descriptions / person specifications
- Identity checks
- Qualification and registration checks
- Right to work checks

- Disclosure and Barring Service (DBS) checks
- Satisfactory reference(s) covering at least the **previous year** of employment (if one than one reference obtained, one reference must be from the individual's current/most recent employer)
- Search of the following registers: bankruptcy and insolvency; disqualified directors; removed charity trustees
- Credit check
- Review of full employment history seeking explanation of any gaps in employment
- Health questionnaire and Occupational Health clearance
- A search of the individual through internet search engines to note any information in the public domain which WHC should be made aware of
- A search of ***relevant*** core public information sources (for example; public inquiry reports, serious case reviews, homicide investigations for mental health trusts, criminal prosecutions, and ombudsmen's' reports - as applicable to the individual role).
- A self-declaration from the individual (see Appendix C)

All of the above will be recorded and held within a file relevant to the individual.

An individual will only be appointed to a director level post on the Board where the Chair of WHC is content that there is sufficient evidence that the individual satisfies all of the requirements of the FPPRs.

To document the process described above, WHC utilises a comprehensive checklist ('checklist for ensuring each director (or equivalent) on the Board is fit and proper'). This checklist sets out the evidence that WHC expects to see to assure itself that each element of the FPPRs is satisfied and is included in this document as Appendix B.

Exception to the above for non-executive directors (or equivalent) of WHC, who are also appointed as an executive director at one of the three Foundation Trusts making up WHC's membership[5]

Where any non-executive director of WHC (or equivalent) is also appointed as an executive director at one of the three Foundation Trusts making up WHC's membership (Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, or Salisbury NHS Foundation Trust), the Chair of WHC will deem that individual to satisfy the FPPRs where:

1. the Chair of the Foundation Trust at which the individual is an executive director signs a declaration (updated annually), that he or she considers the individual to satisfy the FPPRs (Appendix D); and

2. the individual signs a self-declaration that they are a fit and proper person as defined by the FPPRs and CQC guidance (Appendix C).

WHC considers this a proportionate way to seek assurance in the circumstances, because a review of whether the individual satisfies the FPPRs will have *already* been performed by the

[5] Also known as a 'Member Board Representative', and referred to as the same within WHC's Members Agreement.

Foundation Trust employing the individual as an executive director. WHC therefore considers that it would not be the best use of NHS resources to repeat the same review process at WHC.

Stage 2: How WHC assures itself that its director's (or equivalent) are fit and proper at regular intervals

WHC is responsible for ensuring the continued compliance of individuals to whom the FPPRs apply.

At regular intervals (typically annually), each Board member will receive an appraisal conducted by either the Chair or the managing director of WHC.

In addition, at least annually, the Chair of WHC will review the *'Checklist for ensuring each director (or equivalent) is fit and proper'* applicable to that individual, and consider whether WHC needs to obtain any new or updated evidence to be assured that the individual in the director level post still satisfies the criteria set out in the FPPRs.

When considering whether any new or updated evidence should be obtained to assess whether the individual still satisfies the criteria set out in the FPPRs, the Chair of WHC will consider the recent performance of the individual in their role as a Board member of WHC; the amount of time that has passed since the last review of the evidence; and any additional information that has been brought to the Chair's attention regarding the individual's character or actions as relevant to their role as Board member of WHC.

As a minimum, the following information would be sought during the review process:

- The completion of an annual self-declaration by the Board member.
- Check of the following registers:
  - Bankruptcy and Insolvency;
  - Disqualified Directors; and
  - Removed Charity Trustees.
- Health questionnaire/ check, including mental health, and occupational health clearance (where deemed to be appropriate).
- Assurance that the register of interests is up to date.

Once in possession of updated evidence, the Chair of WHC will review whether each individual in a director level post remains a fit and proper person.

Exception to the above for non-executive directors (or equivalent) of WHC, who are also appointed as an executive director (or equivalent) at one of the three Foundation Trusts making up WHC's membership

Where any non-executive director of WHC (or equivalent) is also appointed as an executive director (or equivalent) at one of the three Foundation Trusts making up WHC's membership (Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, or Salisbury NHS Foundation Trust), the Chair of WHC will deem that individual to satisfy the FPPRs where:

1. the Chair of the Foundation Trust at which the individual is an executive director signs a declaration (updated annually), that he or she considers the individual to satisfy the FPPRs (Appendix D); and

2. the individual signs a self-declaration that they are a fit and proper person as defined by the FPPRs and CQC guidance (Appendix C).

Stage 3: How WHC assures itself that its director's (or equivalent) are fit and proper if concerns are raised

Overview

This section outlines how WHC will address concerns raised regarding the fitness of a director (or person in an equivalent position). It describes what WHC will take into account when considering whether to undertake an investigation, and what WHC will be mindful of at each stage of the process.

It is acknowledged that CQC guidance places a duty on regulated providers to investigate (in an appropriate, timely and proportionate manner), any concerns raised about a director's fitness or ability to carry out their duties. If concerns are substantiated through evidence, CQC expects the regulated provider to take proportionate and timely action, and to investigate the concerns thoroughly under either the FPPRs or through the provider's capability processes (such as performance management) - depending on what is most appropriate.

An investigation is the process through which the WHC Board assures itself, and subsequently the CQC, that any concerns raised about an individual do not render them unfit for their role. It is noted that CQC judges the process followed by a provider, not the fitness of the individual.

CQC's guidance states that if a provider concludes, based on the available facts, that a director does not meet the requirements of Paragraph 5 (3) of the FPPRs, then the director *must* be dismissed from their position. If, on the other hand, a provider concludes that the director does meet the requirements of Paragraph 5 (3) of the FPPRs, the provider is not required to relieve the director of their responsibilities, and dismissal is not necessary. However, providers *may still take another form of disciplinary action as appropriate*.

WHC acknowledges that investigations conducted under the FPPR are complex and unique, and therefore different approaches will be needed depending on individual circumstances. For that reason, neither NHSI or CQC dictate a *specific* procedure for how providers should act when concerns arise. Nevertheless, WHC will always ensure that a clear, robust, fair and transparent process is being followed to retain the confidence of both staff and the public. A framework for the process followed by WHC is described below. This is based on the 2018 guidance issued by NHS Providers[6].

[6] Fit and Proper Persons Investigations: A ten step guide (https://nhsproviders.org/fit-and-proper-persons-regulations-in-the-nhs/fit-and-proper-persons-investigations-a-ten-step-guide)

Oversight

WHC's Chair will have oversight of all FPPRs investigations. This is with the exception of when a concern relates to the Chair.

When a concern relates to WHC's Chair, alternative arrangements will be made for who will take the leading role in the investigation. It is acknowledged that what will be most appropriate in this scenario will be dependent on the circumstances.

Investigation process

Step 1	Receiving concerns in relation to a director (or equivalent)

How CQC notifies providers of fitness concerns

It is noted that matters that cause concern regarding the fitness of a director (or person in an equivalent role) may be raised via CQC to either WHC's Chair or directly to WHC. It is also noted that on receipt of information from a third party regarding an alleged lack of fitness of a WHC director (or equivalent), CQC will pass on all information that falls under FPPR to WHC, and inform the director to whom the case refers. CQC will seek consent from the person providing the information to do this, and will protect their anonymity if necessary; however, if consent is not given and there is potential risk to service users, CQC will proceed regardless.

What CQC expects from providers following notification of a fitness concern

If CQC shares information of concern with WHC, it will ask WHC to detail the steps it has taken to assure itself of the fitness of the director (or equivalent), and what action it intends to take. This information will be provided by WHC's Board Secretary, overseen by WHC's Chair. It is acknowledged that the timescale for the provision of this information to CQC is 10 days.

WHC will provide assurance to CQC that it has used a robust and thorough process to come to a reasonable conclusion about the fitness of a director (or equivalent). The framework for this process is described below.

Alternative ways that WHC may become aware of a fitness concern, and the responsibilities of senior managers

In addition to concerns brought to WHC's attention by CQC, it is noted that concerns regarding the fitness of a director (or equivalent) may come directly from patients, whistle-blowers, or by way of criticism of directors in Employment Tribunal judgements. If WHC's Chair judges any of these concerns to be significant, WHC will consider these in the same way as concerns received from CQC. It will be incumbent upon the senior managers within WHC to bring such concerns to the attention of the Chair either directly or by raising their concerns with a member of the senior management team who will subsequently raise these with the Chair.

Step 2	Deciding whether an investigation is necessary

The FPPRs set out the expectation that a provider must investigate and take appropriate and proportionate action when concerns are raised about an individual director under FPPR.

Lead role/ determining whether an investigation is required (preliminary review)

WHC's Chair will lead on addressing fitness concerns on a case by case basis, and will consider whether an investigation to determine 'fitness' is necessary or appropriate by carrying out a preliminary review of the situation.

A preliminary review of the situation may determine that no further investigation is required. For example, where:

- There has already been consideration of the issues to which the allegations relate as part of the fit and proper person checks carried out at the appointment stage;
- The preliminary review has considered undisputed evidence proving that the allegation(s) were without substance;
- The matter does not fall under the scope of the FPPRs; or
- WHC's Chair considers that the findings of a previous employment tribunal to be sufficient to resolve the concern (depending on the case and the amount of time passed since the ruling was made).

Determining the approach to investigate fitness

Where a preliminary review determines that an investigation is required, WHC's Chair may choose to consult with any of the Member Board Representatives and/or the person in the most senior role within the Human Resources team at WHC to determine the appropriate process to follow and action to take[7].

Once the most appropriate process has been determined, WHC will clearly document the process being followed, and the reasons upon which the decision to follow that process was made.

If it is decided that an investigation under the FPPRs should take place:

- This will, at all times, comply with WHC's disciplinary processes (as applicable).
- Clear timescales for the stages of the investigation will be set-out.
- The investigation will commence promptly.

[7] E.g. whether a capability process (such as performance management) is being followed, or whether a fit and proper person's investigation is necessary. Alternatively, WHC may consider other options such as a governance review into the board, or a review of the organisational culture of the organisation.

Step 3	Choosing who should carry out the investigation

Determining who should carry out the investigation

In choosing who should carry out the investigation, WHC will take into account the level of independence necessary of the investigator to:

- Ensure an impartial investigation and assessment of the facts takes place.
- Reassure the individual(s) who raised the concern.

WHC acknowledges that investigations must have the necessary level of independence, robustness, thoroughness, and transparency so that the public and staff can have confidence that due process has been followed.

The seriousness and/or complexity of the concern raised will be taken into account when determining who should investigate the concern. Where the concern is serious in nature and/or highly complex, it would be more appropriate for the investigation to be externally-led.

The table below will be used as a guide when determining which type and level of investigation is applicable:

Level of independence	**Guiding factors**
Internal investigation	Likely to be required if: • the concerns raised are in relation to events that occurred within WHC.
Internal investigation including an independent element	Likely to be required if: • the concern relates to either WHC's Chair, Managing Director or others who would normally have a role or be involved in carrying out the investigation • it is necessary to investigate events that have occurred at a different organisation
External investigation undertaken by an entirely independent investigator	Likely to be required if: • the integrity of the investigation is likely to be challenged by the individual(s) who raised the concerns • the scale, severity or overall complexity of the concerns means the investigation cannot be managed internally by WHC (e.g. due to capacity/capability available). Examples include potential gross misconduct or mismanagement in office, and serious case reviews • in some circumstances, if the concern raised was about the Chair.

WHC will take into account the financial cost of appointing an external advisor, and balance the need for fairness with the drive to be cost-effective and efficient.

In light of the above, a decision will be made by WHC's Chair as to whether the investigation should be conducted internally, or include an external element.

Internal investigation

Where it is determined that it would be appropriate to carry out an internal investigation, this will typically be led by WHC's Chair, supported by the Board Secretary. As part of an internal investigation into fitness, WHC's Chair will collect evidence, and review that evidence to make a determination as to whether the director (or equivalent) remains fit and proper.

If WHC's Chair is assured by the internal investigation, then no further action will be taken. However, if concerns remain, WHC's Chair may seek legal and/or HR advice on removing the individual.

Investigation including external input

Where it is determined that it is most appropriate to have external input into the investigation, WHC will appoint an individual or advisory body independent to the organisation (and with no conflict of interest) to support the investigation.

The 'independent element' of the investigation could include, but is not limited to:

- legal advice
- expert HR advice
- independent expert, such as a patient safety expert
- non-executive directors from a trust (excluding the trust where the director (or equivalent) is an executive director - if applicable)
- peer review
- barrister
- external investigator.

The type of independent input chosen will depend upon the nature of the concern, and the skills and competencies required to investigate that concern.

An independent advisor may be instructed to lead the investigation on behalf of WHC, or provide expert opinion to be taken into account by an internal investigator - depending on what is most appropriate in the circumstances as described above. The role of any external advisor will be clearly set-out at the start of the investigation.

Any independent advisor(s) involved in the investigation will follow the agreed remit of the investigation (see below).

Step 4	Deciding the remit of the investigation

Before carrying out an investigation into fitness, WHC will agree the scope, remit and terms of reference.

Terms of reference

The terms of reference will clearly explain what the investigation is required to examine, and which of the requirements under the FPPR are relevant. If new matters come to light during an investigation, it may be necessary to amend the original terms of reference.

Scope and remit

Investigators will only conduct a reasonable investigation, i.e. they will not investigate every detail of the matter; only what is reasonably likely to be important and relevant.

WHC will take a reasonable approach in deciding what the scope of the investigation should be. Investigations will not to reinvestigate issues that have already been considered and settled (for example if the issue has already been decided by an employment tribunal case).

When concerns are reported to WHC by the public or whistle-blowers, the investigation will, wherever possible, interview all individuals who have raised concerns about a director (or equivalent). Those conducting the investigation may propose that all witnesses (including the whistle-blower) sign a confidentiality agreement to protect the integrity of the investigation.

Step 5	Deciding who to engage in the investigation

WHC's Chair will oversee all investigations that relate to fitness, unless the concerns relate to the Chair. When a concern relates to WHC's Chair, alternative arrangements will be made for who will take the leading role in the investigation. It is acknowledged that what will be most appropriate in this scenario will be dependent on the circumstances.

WHC's Board and remuneration committee will be kept appraised of the investigation, and input from the Board/ remuneration committee members will be sought where this is relevant and reasonable in the circumstances.

It is noted that where concerns relate to the Managing Director, consideration should be given to involving the executive Board members in an investigation relating to their line manager. It is noted that involving executive Board members in commissioning or conducting an investigation in this scenario may lead to an actionable loss of confidence (i.e. that the Managing Director's authority would be undermined to the extent that their position would become untenable - this may lead to a constructive dismissal claim).

Step 6	Agreeing an interim action

Interim action may be taken to minimise any risk to people who use WHC's services.

For example, consideration will be given to whether there are any grounds for suspension of the director (or equivalent) in question while the investigation is underway.

Any decision to take interim action will be informed by whether there is any risk to patient safety.

If the above action is taken, it will be made clear that that suspension is not an assumption of guilt or a disciplinary sanction, but an action to mitigate likely disruption to WHC's business.

However, it is noted that suspending a director (or equivalent) may be potentially destabilising. As such, if, on review of the circumstances, this is determined to be the case, WHC will instead consider less drastic action, such as temporary variation or restriction of the director's responsibilities in areas directly linked to the concerns.

It is acknowledged that fit and proper persons allegations and investigations can have a significant emotional impact on the director (or equivalent) in question through increased pressure and stress. WHC will therefore adhere to the principles of duty of care, natural justice, and procedural fairness. WHC acknowledges that even knowledge of an investigation can affect a person's reputation in the workplace and can influence the way they are treated by their colleagues. As such WHC will consider how the director (or equivalent) in question should be supported throughout the investigation - and then offer that support, or take steps to ensure that support is provided.

Key factors to consider when supporting directors subject to an investigation

The type and level of support for directors during an investigation will depend on individual circumstances but may include, for example:

- providing information about the different stages of the investigation and their contribution throughout the process
- supported time off to receive external advice about the investigation (e.g. to meet with professional bodies).

Trusts should bear in mind that the director in question has the right to a hearing of their case in front of the decision maker, to ask questions of witnesses, to make representations to the investigator and bring witnesses themselves, and to be properly represented.

Step 7	Gathering evidence

It is acknowledged that every investigation will be different. As such, the facts and information required to establish the continued fitness or otherwise of the individual against whom an allegation is made will vary. However, in gathering evidence, WHC will take into account the general themes set-out below.

Obtaining information from previous employers

CQC's national guidance states that if the concerns relating to the director (or equivalent) occurred while with another employer, the current employer will need to "*make sufficient attempts to obtain the relevant information from the previous employer(s)".*

However, it is acknowledged that WHC has no legal powers to compel witnesses to give evidence or disclose documents when undertaking a fit and proper person investigation. As such, WHC is reliant on the good will of other organisations to cooperate in the investigation, which risks being a significant constraint.

Given this position, where relevant, WHC (or those carrying out the investigation on its behalf) will do everything within its power to demonstrate that it has made sufficient attempts to obtain relevant information from a previous employer, and to corroborate the validity and reliability of that evidence.

Large scale or complex issues

It is acknowledged that investigations can range from involving only small scale issues to those that relate to large scale or complex issues that require a large number of people to be interviewed and/or a great deal of documentation to be reviewed.

- In all cases, WHC (or those carrying out the investigation on its behalf) will identify the people that they wish to speak to at the earliest possible opportunity. This is to ensure that arrangements can be made as quickly as possible, and the investigation is carried out without delay.

- It is acknowledged that evidence will often be available in many forms, so WHC may also give weight to other sources of information related to the events under investigation, such as findings from reports produced from related investigations or tribunal rulings.

Ensuring the integrity of the investigation

WHC will ensure that it preserves the integrity of any investigation. This will include:

- Ensuring that documents and materials generated in the course of the investigation are properly labelled and stored.
- Recording all interviews conducted by the investigator and producing full transcripts for each interview. This may include sharing the transcript with the witness.
- It is acknowledged that most of the information collected by WHC during an investigation will be confidential. However, in some cases, forgoing this confidentiality may be necessary – such as in order to assess the reliability of evidence from a witness by assessing how it contrasts with information already collected.

Unless in exceptional circumstances, all evidence gathered regarding the individual in question will be shared with them so they have an opportunity to comment on it.

Following the evidence gathering phase, WHC will analyse the evidence collected, and arrive at a factual conclusion (step 9).

Step 8	Managing competing factors during the investigation

It is acknowledged that conducting an investigation into fitness brings challenges in balancing the competing obligations of transparency and confidentiality.

For example, providing information that an investigation is being undertaken should help give confidence to complainants and the public that the allegation is taken seriously and addressed appropriately. However, at the same time, a director (or equivalent) whose conduct has been called into question has the right to privacy and to expect that information will not be unreasonably disclosed, nor their reputation unjustifiably damaged.

WHC will conduct investigations in compliance with its duty of confidentiality to the director (or equivalent) in question as their employer.

WHC will also be mindful that any premature or inappropriate disclosure of information into the public domain could affect the integrity and impartiality of the investigation and prejudice its findings, as well as potentially expose WHC to a constructive dismissal claim.

WHC will consider asking witnesses to sign confidentiality agreements during the course of an investigation so as to guard against premature disclosure of information prior to the publication of the summary of the investigation.

WHC will make the findings and outcome of the investigation available in an open and transparent manner as soon as it is appropriate and practicable.

Once an investigation is complete, WHC will consider what information should be provided about its outcome.

It is acknowledged that further difficulties may arise if implicated individuals resign before or mid-way through the investigation. If this were to happen, WHC may decide to continue with its investigation process and reach a conclusion in the individual's absence. WHC will weigh up public interest and transparency even in relation to individuals who it no longer employs.

Step 9	Making a final decision / Appeal

Following an investigation, it will be the Chair of WHC (or, where the investigation relates to the Chair, the person with responsibility for oversight of the investigation into the Chair's fitness), and not the investigator, who makes the final decision as to whether the facts bring the director (or equivalent) within any of the categories set out in Paragraph 5(3) of the FPPRs.

Once a final decision has been made and communicated to the director (or equivalent) to which the concerns related, there will be an opportunity to appeal the decision.

If a final decision is appealed, the reasons for the appeal should be made clear. For example:

- a challenge of the evidence on which the final decision was made;
- a challenge that, based on the evidence that was considered, the final decision was not reasonable; or
- provide new evidence.

An appeal of a final decision into the fitness of a director (or equivalent) will be heard by an appeal panel. The composition of an appeal panel will meet the requisite level of independence. The appeal panel will decide whether to 'uphold' or 'not uphold' the final decision as to fitness.

Where there is sufficient evidence to support a conclusion that the individual is not or is no longer fit and proper:

- the individual will no longer be a director (or equivalent) of WHC
- a decision will be taken as to appropriate disciplinary action
- if the individual is registered with a professional regulator (General Medical Council, Nursing and Midwifery Council etc.), WHC will inform the regulator in question of the outcome of the investigation.

The person carrying out the investigation will produce a written report on findings. This will be based on fact and supported by the evidence including whether the findings led the investigator to believe that the fit and proper person criteria continue to be met or not.

The report will include:

- a brief summary of the concerns, including investigation methodology and evidence considered
- an account of events in chronological order
- clarification of findings based on an objective assessment of the evidence considered
- a clear statement as to whether or not the investigator(s) believe the fit and proper person criteria continue to be met
- witness statements, interview records, and any other evidence should be attached as appendices to the report.

Step 10	Managing the effects of the outcome

WHC will ensure it has a clear and transparent communications strategy both during an investigation process, and once the outcome of an investigation is known.

In terms of media queries in relation to an investigation, WHC will balance its commitment to be open and transparent, with the legal duty of confidentiality owed to the director (or equivalent) in question.

Where an individual is cleared of alleged misconduct, there is a potential risk of repeated allegations being made about the same individual in the future. If it is readily apparent that repeated allegations relate to issues that have already been investigated, and no additional matters are identified, WHC notes that it will not be expected to carry out any further investigations.

Review of arrangements

These arrangements will be reviewed on a three yearly basis or more frequently if changes are made to the FPPRs.

Appendix B

Checklist for ensuring each director (or equivalent) is fit and proper - on appointment/ annual review

Role:	**[Insert the title of the executive or non-executive role on the Board]**

Evidence compiled by:	[Insert the title of the person compiling the evidence]
Date evidence compiled:	[Date]

Checklist purpose:	**[On appointment/ Annual review]**

How to use this document:

Checks to be carried out on appointment are marked, "[on appointment]".
Checks to be carried out annually are marked, "[on annual review]".

Reference within The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Requirement	Evidence provided/ reviewed	Has satisfactory evidence been provided to meet the requirement?/ Note of where evidence located	Date evidence provided or updated/ Rationale if evidence 'not applicable'/ If satisfactory evidence not provided, steps being taken to seek satisfactory evidence
• **Paragraph 5(3)(a)**	• The individual is of good character[8].	• [On appointment] Evidence of at least two detailed reference checks[9] (one of which must be from the individual's most recent employer).	• [Yes/No]	• [.]

[8] Whilst there is no statutory guidance on what constitutes "good character", CQC has issued guidance that names the following features as ones that are "normally associated" with good character: honesty; trustworthiness; integrity; openness; ability to comply with the law; a person in whom the public can have confidence; prior employment history, including reasons for leaving; if the individual has been subject to any investigations or proceedings by a professional or regulatory body; any breaches of the Nolan Principles of Public Life; any breaches of the duties imposed on directors under the Companies Act; the extent to which the director has been open and honest with the provider; any other information which may be relevant, such as disciplinary action taken by an employer.

[9] Covering a minimum period of one year.

			• [On appointment] Evidence of a search of *Google* and online news archives to determine whether any information published on the internet over an appropriately relevant period contains evidence to indicate a breach of the Nolan principles of public life or other behaviours that would suggest that the individual is not of good character. Searches of other media will also be performed where deemed reasonable[10].	• [Yes/No/NA]	• [.]
			• [On appointment] A search of ***relevant*** core public information sources (for example; public inquiry reports, serious case reviews, homicide investigations for mental health trusts, criminal prosecutions, and ombudsmen reports - as applicable to the individual role).	• [Yes/No/NA]	• [.]
			• [On appointment] Self-declaration by the individual (Appendix C).	• [Yes/No/NA]	• [.]
	• The individual will generally not be of good character, if either of the below apply:		• See below.		
	• **Schedule 4, Part 2 (7)**	• Whether the person has been convicted in the UK of any offence or been convicted elsewhere of any offence which, if committed in any part of the UK, would	• [On appointment] Evidence of a clear DBS check[11].	• [Yes/No]	• [**NB:** When considering DBS checks, trusts should consider whether the level of the check is a

[10] If any concerning information is identified through this method of investigation, reasonable steps will be taken to verify the information before relying on its content.

[11] WHC would typically wish to see evidence of a ***standard DBS check*** where the scope of a non-executive director's normal duties (or person in an equivalent role) simply involved "walking the floor". WHC would typically wish to see evidence of an ***enhanced DBS check (without barred lists***) for non-executive director (or person in an equivalent role) where the scope of their duties involved the individual interacting with a vulnerable patient group in an independent and unsupervised way. WHC would typically wish to see evidence of an ***enhanced DBS check (including barred lists)*** for executive medical or nursing directors (or person in an equivalent role). The type of DBS check carried out/evidenced will be proportionate and appropriate to the level of risk posed by the individual role.

		constitute an offence.			proportionate measure and appropriate to the level of risk.]
	• **Schedule 4, Part 2 (8)**	• Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professional	• [On annual review] Proof of professional registration evidenced by presence on relevant register of professionals (if applicable).	• [Yes/No/ NA]	• [.]
	• **Where WHC deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2, the reasons should be recorded and information about the decision should be made available to those that need to be aware.**		• **Decisions and reasons for decisions recorded in minutes.** • **External advice sought as necessary.**		
• **Paragraph 5(3)(b)**	• The individual has the necessary qualifications, competence, skills and experience (to be able to deliver the role as outlined within the relevant job description/ person specification)		• [On appointment] Sight of, and, as deemed appropriate, verification of, any qualifications considered essential within the relevant job description/ person specification.	• [Yes/No]	• [.]
			• [On appointment] Assessment by appropriate means (typically by way of interview), demonstrating that individual has the necessary qualifications, competence, skills and experience to carry out the role as described within the	• [Yes/No]	• [.]

			relevant job description/ person specification[12]. • [On annual review] Assessment by appropriate means (typically by way of annual appraisal), demonstrating that individual has the necessary qualifications, competence, skills and experience to carry out the role as described within the relevant job description/ person specification.		
• **Paragraph 5(3)(c)**	• The individual is able to perform the work they are employed for after reasonable adjustments are made.		• [On appointment] Self-declaration by the individual (Appendix C) (covered above).[13]	• [Yes/No]	• [.]
• **Paragraph 5(3)(d)**	• The individual has not been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.		• [On appointment] Self-declaration by the individual (Appendix C) (covered above).	• [Yes/No]	• [.]
• **Paragraph 5(3)(e)**	• None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual:		• See below.		
	Schedule 4, Part 1 (1)	• The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.	• [On annual review] Clear check of the bankruptcy and insolvency register. • [On annual review] Clear credit check *if* concerns are raised by a review of the bankruptcy and insolvency register, or otherwise.	• [Yes/No]	• [.]
	Schedule 4,	• The person is the			

[12] It is noted that a provider may consider that an individual can be appointed to a role based on their qualifications, skills, and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe. Where this is the case, WHC will evidence this by way of minutes documenting the discussions and recommendations by the nominations committee/board.

[13] WHC will take steps in line with requirements to make reasonable adjustments for employees under the Equality Act 2010.

	Part 1 (2)	subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.			
	Schedule 4, Part 1 (3)	• The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986			
	Schedule 4, Part 1 (4)	• The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.			
	Schedule 4, Part 1 (5)	• The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	• [On appointment] Clear DBS check (covered above).	• [Yes/No/NA]	• [.]
	Schedule 4, Part 1 (6)	• The person is prohibited from holding the relevant office or position, or in the case	• [Annually] Clear check of the following registers: o Bankruptcy and Insolvency (covered above)	• [Yes/No]	• [.]

		of an individual from carrying on the regulated activity, by or under any enactment.	o Disqualified Directors o Removed Charity Trustees		

Additional pre-employment/on appointment checks

Requirement	Evidence provided/ reviewed	Has satisfactory evidence been provided to meet the requirement?	Date evidence provided/ Rationale if evidence 'not applicable'
• **Additional pre-employment checks**[14]	• Values based recruitment process (i.e. values tested through interview process). • Decisions and reasons for decisions recorded.	• [Yes/No/NA]	• [.]
	• Evidence of identify.	• [Yes/No/NA]	• [.]
	• Evidence of right to work in the UK.	• [Yes/No/NA]	• [.]
	• Review of full employment history seeking explanation of any gaps in employment.	• [Yes/No/NA]	• [.]
	• Health questionnaire/ check, including mental health, and occupational health clearance (where deemed to be appropriate)	• [Yes/No/NA]	• [.]
• **Declaration of interests**	• Register of interests completed	• [Yes/No/NA]	• [.]

Additional annual checks

Requirement	Evidence provided/ reviewed	Has satisfactory evidence been provided to meet the requirement?	Date evidence provided/ Rationale if evidence 'not applicable'
• **Annual appraisal**	• Annual appraisal	• [Yes/No/NA]	• [.]
• **Annual health check**	• Health questionnaire/ check, including mental health, and occupational health clearance (where deemed to be appropriate)	• [Yes/No/NA]	• [.]

[14] As required by the NHS employment standards

• **Declaration of interests**	• Register of interests updated/ maintained	• [Yes/No/NA]	• [.]

Exception to the above for non-executive directors (or equivalent) of WHC, who are also appointed as an executive director at one of the three Foundation Trusts making up WHC's membership

Evidence assuring WHC that a non-executive director of WHC, who is also appointed as an executive director at one of the three Foundation Trusts making up WHC's membership, satisfies the FPPRs	**Date evidence provided**
• Declaration (updated annually), signed by the Chair of the Foundation Trust at which the WHC non-executive director (or equivalent) is an executive director, with that declaration stating that the Chair considers the individual to satisfy the FPPRs[15].	• [.]
• Declaration (updated annually), signed by the individual stating that they consider themselves to satisfy the FPPRs.	• [.]

Information that may be requested by CQC

Requirement	**Evidence provided/ reviewed**			**Has satisfactory evidence been provided to meet the requirement?**	**Date evidence provided/ Rationale if evidence 'not applicable'**
• **Paragraph 5(5)(e)**	• The information in Schedule 3 (Information Required in Respect of Persons Employed or Appointed for the Purposes of a Regulated Activity) can be supplied to CQC		See below.		
	Schedule 3 (1)	• Proof of identity, including a recent photograph.	• [On appointment] Sight of, and verification of, original driving licence or passport (covered above).	• [Yes/No]	• [.]
			• [On appointment] Provision of recent	• [Yes/No]	• [.]

[15] Where any non-executive director of WHC (or equivalent) is also appointed as an executive director (or equivalent) at one of the three Foundation Trusts making up WHC's membership (Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, or Salisbury NHS Foundation Trust), the Chair of WHC will deem that individual to satisfy the FPPRs where the Chair of the Foundation Trust at which the individual is an executive director signs a declaration (updated annually), that he or she considers the individual to satisfy the FPPRs.

			photograph.		
	Schedule 3 (2)	• Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(1), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request).	• [On appointment] A copy of a criminal record certificate (if applicable).	• [Yes/No/ NA]	• [.]
			• [On appointment] Provision of barring information under the Safeguarding Vulnerable Groups Act 2006 (if applicable).	• [Yes/No/ NA]	• [.]
	Schedule 3 (3)	• Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.	• [On appointment] A copy of an enhanced criminal record certificate (if applicable).	• [Yes/No/ NA]	• [.]
			• [On appointment] Provision of suitability information relating to children or vulnerable adults (if applicable).	• [Yes/No/ NA]	• [.]
	Schedule 3 (4)	• Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to: (a) health or social care, or	• [On appointment] Satisfactory references (covered above).	• [Yes/No]	• [.]

		(b) children or vulnerable adults.			
	Schedule 3 (5)	• Where an individual has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why that individual's employment in that position ended.	• [On appointment] Satisfactory reference from *relevant* previous employment (if deemed proportionate and appropriate to the level of risk posed by the individual taking on the role).	• [Yes/No/ NA]	• [.]
	Schedule 3 (6)	• In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.	• [On appointment] Sight of, and verification of, any qualifications considered essential within the relevant job description/ person specification (covered above).	• [Yes/No/ NA]	• [.]
	Schedule 3 (7)	• A full employment history, together with a satisfactory written explanation of any gaps in employment.	• [On appointment] Provision of a full employment history, together with a satisfactory written explanation of any gaps in employment provided by the individual (covered above).	• [Yes/No/ NA]	• [.]
	Schedule 3 (8)	• Satisfactory information about any physical or mental health conditions which are relevant to the individual's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their appointment for the purposes of the regulated activity.	• [On appointment] Provision of written information about any physical or mental health conditions which are relevant to the individual's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment (if applicable).	• [Yes/No/NA]	• [.]

Declaration by Chair that appropriate checks have been made in reaching a judgement of fitness:	[Signature of Chair]
Date:	[Date]

Appendix C

PRE- APPOINTMENT AND ANNUAL FIT AND PROPER PERSONS: SELF-DECLARATION

Fitness to carry out the role of Board member (or equivalent post) in Wiltshire Health and Care LLP (WHC) is determined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (FPPRs).

"Fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Regulated providers must also abide by CQC's guidance regarding appointments to senior positions. The regulations include the test of good character.

It is a condition of appointment that those holding Board member (or equivalent) posts in WHC provide confirmation in writing, both on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post.

WHC shall not appoint, or permit to continue as a Board member (or equivalent), any person who is an unfit person. WHC's Board will ensure that its terms of appointment for Board members contain a provision permitting summary termination in the event of a Board member being, or becoming, an unfit person. WHC's Board will enforce that provision promptly upon discovering any Board member to be an unfit person.

When considering whether those appointed to Board member positions are fit and proper, NHS Improvement and CQC will assess WHC against the quality of evidence gathered by it, and whether that evidence has been taken into account (rather than attempting to second guess the decision as to whether an individual is a fit and proper person). It is therefore essential that WHC follows a robust, clear and transparent process to ensure on-going compliance with the FPPRs.

To support the test of determining whether a Board member is and continues to be, a "fit and proper" person, you are required to complete an annual declaration as set out below. By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

The **requirements are that: -**

(a) You are of **good character**, which includes:

1. whether you have been convicted in the UK of any offence or been convicted elsewhere of any offence which, if committed in any part of the UK, would constitute an offence; and
2. whether you have been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

(b) You have the **qualifications, competence, skills and experience** which are necessary for the relevant officer or position or the work for which you are employed or appointed by WHC.

(c) You are able by reason of your **health**, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which you are appointed or to the work for which you are employed.

(d) You have not been **responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement** (whether unlawful or not) in the course of carrying out a regulated activity or providing a service elsewhere which, if provided in England would be a regulated activity.

(e) **None of the grounds of unfitness** specified in Part 1 of Schedule 4 of the FPPRs apply to you namely:

1. You are an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
2. You are the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
3. You are a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986 (40);
4. You have made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
5. You are included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Adults Group Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
6. You are prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Assessment considerations

CQC's definition of good character is not the objective test of having no criminal conviction but instead rests upon a judgement as to whether the person's character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion in reaching a decision and allows for the fact that people can change over time.

Robust systems must be in place to ensure continuous assessment of the temperament, character and empathy of an individual. It is not possible to outline every character trait an individual should have but among them, the due diligence process should take account of honesty, trust and respect.

CQC expects WHC to take account of some core public information sources in making appointments and on-going appointment, for example information from public inquiry reports, serious case reviews and Ombudsmen reports.

Where a Board member is associated with serious misconduct or responsibility for failure in a previous role, CQC will have regard to the seriousness of failure, how it was managed, and the individual's role within that. There is no time limit for considering such misconduct or responsibility. Where any concerns about an existing Board member come to the attention of CQC, they may also ask WHC to provide the same assurances.

In the case of a Board member being convicted of breaching a health and safety requirement on the basis of the way the entire management team organised and managed the activities of their organisation, providers are expected to ascertain the role of the individual so that they can make a judgement about whether or not it means they are unfit. Where the evidence demonstrates that the breach is attributable to an individual's conduct, CQC would expect a provider to find that the individual is unfit.

Whilst CQC will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent', there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

CQC will examine the robustness and effectiveness of procedures rather than focussing on the individual Board members that are in post as a result of the procedures. However, CQC will assess whether WHC's judgement is reasonable.

Notes

"Serious misconduct or mismanagement" means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting the regulations or their component parts.

- Misconduct is described as a breach of "a legal or contractual obligation imposed on the director", such as an employment contract, criminal law or relevant regulatory requirements.

- Mismanagement is defined as "being involved in the management of an organisation [...] in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management". For example, failing to interpret data appropriately, failing to learn from incidents or complaints, and failing to model standards of behaviour expected of those in public life.

The above is not an exhaustive list and the legalistic language can be challenging to unpick. In plain English, "misconduct or mismanagement" is when a director does something wrong either by doing something, not doing something, or behaving in a certain way.

Providers have to decide whether any concerns reach the threshold of being "serious" in nature and determine the appropriate response. For example, CQC's national guidance states that while minor breaches of security or failure to follow agreed policies and processes with limited repercussions would not amount to serious misconduct or mismanagement, incidences such as fraud, theft, assault, sexual harassment and bullying would breach this threshold.

While a single incident of misconduct may amount to serious misconduct, an isolated incident is unlikely to constitute serious mismanagement unless it threatens public confidence in the organisation and individual concerned.

Serious mismanagement is rather a "course of conduct over time" and its seriousness can be assessed through the impact on quality and safety of care for service users, the safety and wellbeing of staff, and the organisation's viability.

When assessing whether a director's action(s) or omission(s) amount to "serious misconduct or mismanagement", providers should consider whether the director played a central or peripheral role, and this will determine how "seriously" it should be taken. Providers should also consider any mitigating factors.

"Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.

"Privy to" means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.

Declaration

I hereby declare that I have had regard to the assessment considerations set out above and confirm that I meet the requirements of a Fit and Proper Person.

I also:

- **confirm that I have disclosed to WHC all information that is relevant to consideration of this test**
- **confirm that there are no other grounds under which I would be ineligible to continue in post**
- **undertake to notify WHC's Board immediately if I no longer satisfy the criteria to be a "fit and proper person" or any grounds under which I would be ineligible to continue in post come to my attention.**

Name: .....

Signed: .....

Position: .....

Date: .....

Appendix D

FIT AND PROPER PERSONS
ASSURANCE AND CERTIFICATION

HEALTH & SOCIAL CARE ACT 2008 (REGULATED ACTIVITIES) REGULATION 2014
REGULATION 5

To: Carol Bode, Chair of Wiltshire Health and Care LLP

In accordance with the requirement introduced in November 2014, I am assured and hereby certify, on behalf of [Great Western Hospitals NHS Foundation Trust/Royal United Hospitals Bath NHS Foundation Trust/ Salisbury Foundation Trust] ('the Trust'), that [Name] acting as the Trust's [Alternate Member Board Representative/Member Board Representative] at Wiltshire Health and Care LLP ('WHC") is a "fit and proper person" in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('FPPRs").

I confirm that checks have been undertaken by the Trust using the toolkit developed by NHS Providers (working with the NHS Confederation and NHS Employers), adapted to reflect the specific policies and procedures of the Trust.

In addition, [Name] was asked to make a declaration that [he/she] had regard to the above assessment considerations, and met the requirements of being a fit and proper person. [Name] was also asked to confirm that he/she had disclosed all information which is relevant to consideration of this test. A returned self-declaration confirming the above is held within the individual's personal file, and forms part of the assurance of compliance with the regulations.

SIGNED by:

Chair of [Great Western Hospitals NHS Foundation Trust/Royal United Hospitals Bath NHS Foundation Trust/ Salisbury Foundation Trust]

.....

On this day of

Wiltshire Health and Care Board	**For information**
Subject:	**Register of Interests**
Date of Meeting:	**27 July 2018**
Author:	**Katherine Hamilton Jennings, Board Secretary**

1. Purpose

As is required on an annual basis, the Board is invited to note the updated Register of Interests.

Please note that the Register is displayed on Wiltshire Health and Care's Website.

The Register will be updated to include the interests of the Deputy Member Board Representative for Great Western Hospitals NHS Foundation Trust, once this person has been identified.

Impacts and Links

Impacts	
Quality Impact	None
Equality Impact	None
Financial implications	None
Impact on operational delivery of services	None
Regulatory/ legal implications	The Board is required to note the Register of Interests annually.
Links	
Link to business plan/ 5 year programme of change	None
Links to known risks	None
Identification of new risks	None

Board Members – Register of Interests

Wiltshire Health and Care LLP is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register of Interests which draws together Declarations of Interest made by members of the Board. In addition, at the commencement of each Board meeting, Members of the Board are required to declare any interests.

Board Members are required to register any relevant and material interests as soon as they arise or within seven clear days of becoming aware of the existence of the interest and also to make amendments to their register of interests as appropriate.

The Board will receive the Members' Register of Interests annually to assure the Board that the Register is being maintained and that there are no conflicts of interest which could adversely affect the LLP and its operations.

Independent Chair

CAROL BODE - Independent Chair – *updated 29 May 2018*

Title	*Organisation*	*Date of Commencement*
Group Chair	Radian Group Limited	July 2013
Chair Trustees	Basingstoke Voluntary Action	September 2017
Associate Trainer	NHS Providers	February 2012
Presiding Justice	Magistrates Court (N. Hants)	April 2006

Executive Board Representatives

DOUGLAS BLAIR - Managing Director (Executive) – *updated 29 May 2018*

Title	*Organisation*	*Date of Commencement*
None Identified	-	-

LISA HODGSON – Chief Operating Officer (Executive) – *updated 8 June 2018*

Title	*Organisation*	*Date of Commencement*
Sole trader	Lisa Hodgson, Healthcare Solutions	June 2013
Pool member	IMAS	June 2017

SARAH JANE PEFFERS - Executive Board Member (Head of Quality) – *updated 4 June 2018*

Title	*Organisation*	*Date of Commencement*
None Identified	-	-

ANNIKA CARROLL - Executive Board Member (Head of Finance) – *updated 21 June 2018*

Title	*Organisation*	*Date of Commencement*
None Identified	-	-

Independent Board Representatives

RICHARD BARRITT - Non-Executive Board Member – *updated 29 May 2018*

Title	*Organisation*	*Date of Commencement*
Chief Executive Officer	Solent Mind	Lapsed
Conference Chair (Future of Mental Health)	MIND	Lapsed
OD/Leadership training	The Wellbeing Collective, working with clients including Sussex Partnership NHS Trust, Huntercombe Group and Somerset CCG	July 2017

Dr CELIA GRUMMITT - Non-Executive Board Member – *updated 30 May 2018*

Title	*Organisation*	*Date of Commencement*
GP Partner	Cross Plain Health Centre *The Practice is a member of Wiltshire CCG and is in receipt of the services of the LLP*	2003
Military and Veterans Champion	Wiltshire	2007
Co-Chair	SW Armed Forces Forum - Wiltshire CCG	2007
Managing Director	Rainbow 2 Limited - *R&D family company*	2007

Dr ADIBAH BURCH - Non-Executive Board Member – *updated 4 June 2018*

Title	*Organisation*	*Date of Commencement*
GP Associate	Whitehorse Health Centre, Westbury *The Practice is a member of Wiltshire CCG and is in receipt of the services of the LLP*	January 2018
Company Director	Health and Vitality Solutions Limited	October 2017

Great Western Hospitals NHS Foundation Trust Member Board Representative

NERISSA VAUGHAN - Non-Executive Member Board Representative (until July 2018) – GWH – *updated 21 June 2018*

Title	Organisation	*Date of Commencement*
Board Member	GWH NHS FT	3 October 2011
Partner is a Consultant Paediatrician	Northampton General Hospital	

KEVIN MCNAMARA - Non-Executive Member Board Representative (from July 2018, previously Deputy) – GWH – *updated 27 June 2018*

Title	*Organisation*	*Date of Commencement*
Director of Strategy/Executive Director	Great Western Hospitals NHS FT	April 2014
Executive Lead	Swindon Community Health Services	October 2016

[TBC] – Deputy Non-Executive Member Board Representative – GWH – *TBC*

Title	*Organisation*	*Date of Commencement*

Royal United Bath NHS Foundation Trust Member Board Representative

FRANCESCA THOMPSON - Non-Executive Member Board Representative – RUH – *updated 29 May 2018*

Title	*Organisation*	*Date of Commencement*
Trustee	Dorothy House	July 2017

CLARE O'FARRELL - Deputy Non-Executive Member Board Representative – RUH – *updated 27 June 2018*

Title	*Organisation*	*Date of Commencement*
None Identified	-	-

Salisbury Foundation Trust Member Board Representative

LISA THOMAS - Non-Executive Member Board Representative – SFT – *19 July 2018*

Title	*Organisation*	*Date of Commencement*
Director	Salisbury Trading Limited	1 September 2017

LAURENCE ARNOLD - Deputy Non-Executive Member Board Representative – SFT – *updated 29 May 2018*

Title	*Organisation*	*Date of Commencement*
Director of Corporate Development	Salisbury NHS Foundation Trust	1 April 2011

Wiltshire Health and Care Board	**For information**
Subject:	**Quality, performance and finance monthly report**
Date of Meeting:	**27 July 2018**
Author:	**Sarah-Jane Peffers, Lisa Hodgson, Annika Carroll**

1. Purpose

1.1 To provide an overview of the main issues arising from review of information about the quality and performance of Wiltshire Health and Care services and alert and advise the Board to issues by exception.

2. Issues to be highlighted to Board

2.1 The quality and performance dashboards are attached for the Board's information. The following issues are highlighted to the Board in relation to the quality of services:

ADVISE	There has been no significant changes in the overall quality measures in month; There has been no change in the rate of clinical incident reporting overall, approximately 13% of complaints are related to third parties. We are currently reviewing the internal process to ensure feedback is received. DATIX project on target, with expected roll out from January 2019, training to commence in November 2018. This project is interdependent of the rollout of smartphones to clinical staff. An attached report offers comparable data from Q1 17/18 to Q1 18/19. This identifies areas for improvement and this will be managed through the DATIX project. The revised approach to Duty of Candour has been well received and understood by clinicians; however, in month we have not achieved the expected target due to the team not being able to contact the patient. 10 complaints in month, the key theme highlighted is staff values and behaviours (=4). This has been discussed at this month's Performance and Planning and will be addressed though the safer caseloads work stream. Friends and Family test is now available and has shown an increase in reporting in month. Update on incident reporting - See Appendix 1
ALERT	Ailesbury ward- Staffing levels and current allegations raised by Oxford Brookes University and subsequent referral to NMC and CQC. WHC has recognised the need to close beds (6) and is working with the CCG and other providers to recognise the impact on flow and to propose and implement mitigations – See Appendix 2
ACTION	There are no issues on which Board action is required.

2.2 There are no specific issues to highlight or escalate to the Board in relation to the maintaining performance.

2.3 The following issues are highlighted to the Board in relation to the financial performance:

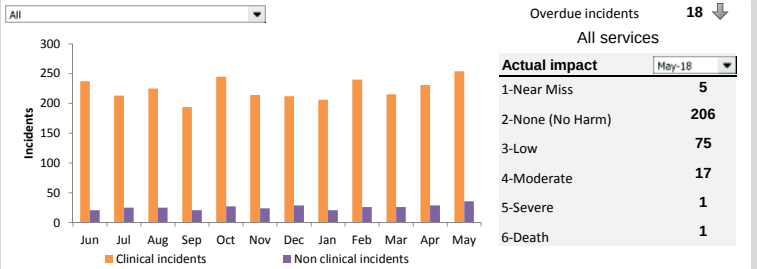
ADVISE	There are continuing issues with the upgrade of financial ledgers. Recent issues with the RUH's upgrade poses further risk to the timeline and consequential delay in establishing fuller financial reporting. The main mitigation remains the addition of further consultancy support. Although not yet presenting as breaches there is a growing number of people waiting for chairs within wheelchair services. Concerns have also been from within the service relating to compliance with all Health and Safety legislation. As this is such a specialised area external support is been sourced to undertaken a review into current service provision and to assist WHC in developing an options appraisal for future management of the service.
ALERT	No alerts to be reported to the board
ACTION	There are no issues on which Board action is required.

3. Recommendation

3.1 The Board is invited to note the contents of this report.

Wiltshire HEALTH AND CARE — Quality Dashboard — May 2018

Incidents

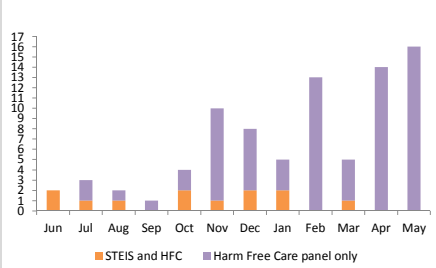


Overdue incidents 18

All services

Actual impact	May-18
1-Near Miss	5
2-None (No Harm)	206
3-Low	75
4-Moderate	17
5-Severe	1
6-Death	1

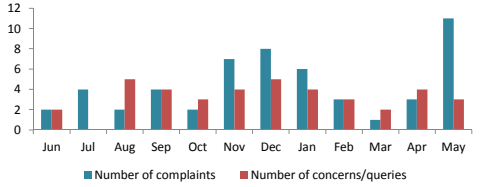
Incidents Requiring Further Investigation



Benchmarking data does not include pressure ulcers

Complaints/Concerns

Response compliance 66% Open ombudsman cases 0



RIDDOR

Financial Year to Date

3

RIDDOR report(s)

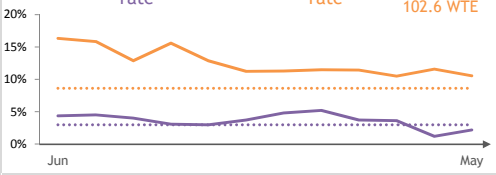
Duty of Candour compliance

National Mandatory Audits - 1 completed in month

	Completed	Missed
Audit uploads	100%	0

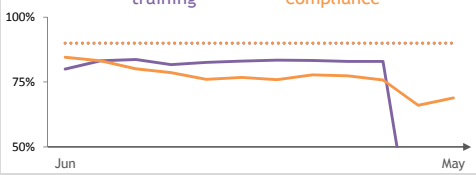
Sickness/Vacancy

May-18 Sickness rate 2.18% Vacancy rate 10.56% 102.6 WTE



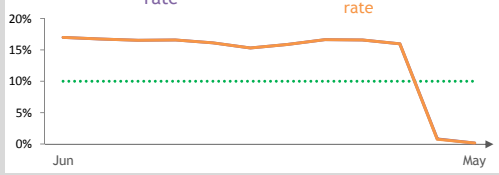
Training/Appraisals

May-18 Mandatory training 0% Appraisals compliance 69%



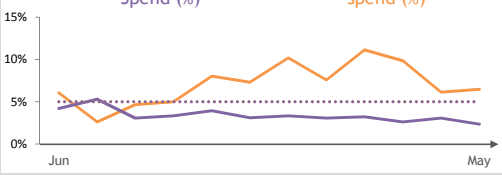
Turnover

May-18 Turnover rate 0.19% Voluntary turnover rate 0.19%



Bank/Agency spend %

May-18 Bank Staff Spend (%) 2.37% Agency staff spend (%) 6.47%



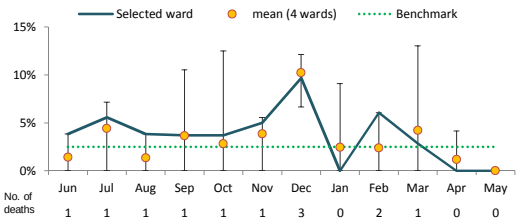
Infection Prevention & Control

All wards	In month	Prev 12 months
MRSA incidence	0	0
C diff incidence	0	2
E coli incidence	0	0
Bed days lost to norovirus	0	0

The patient was recorded as C.difficile colonisation in Aug 17 whilst in RUH, however they were asymptomatic and did not require isolation or treatment

Deaths

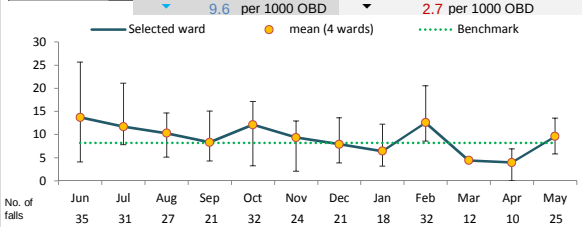
Ailesbury 0 death(s) in month 0.0% of discharges



Palliative care deaths are excluded from Apr 17 (in line with National benchmarking definition)

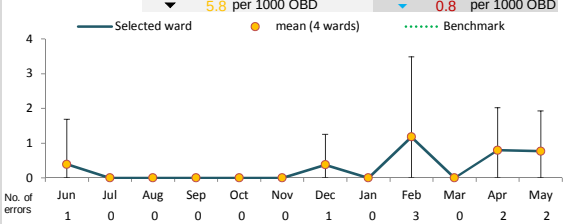
Falls

All wards 25 fall(s) in month 9.6 per 1000 OBD 7 Fall(s) with harm 2.7 per 1000 OBD



Medication errors

All wards 15 error(s) in month 5.8 per 1000 OBD 2 Harmful error(s) 0.8 per 1000 OBD

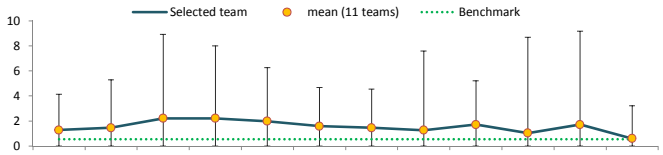


Please note: There is no benchmarking value for medication errors with harm

Medication errors now included on the community teams and specialist services sections within this dashboard.

Avoidable Pressure Ulcers

All teams 4 avoidable pressure ulcers acquired in month 0.60 per 1000 caseload

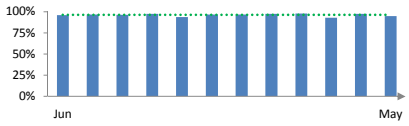


	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
No. of pressure ulcers (all)	9	10	15	15	14	11	10	9	12	7	11	4
Category III	0	1	1	1	1	2	0	0	1	1	3	0
Category IV	1	0	1	1	0	0	1	0	1	0	0	0

This graph shows the total verified Category III and IV avoidable pressure ulcers.

Safety Thermometer

Percentage of Harm Free Care (new harms)

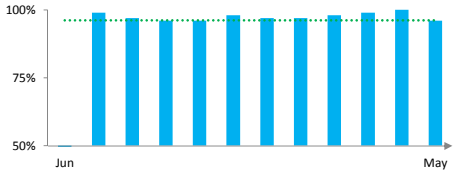


Community Wards	100.00%
Community Teams	93.42%
Wards and Teams combined	94.70%

A slight decrease in return for May falling just below the benchmarking level.

Friends and Family Test

Show response numbers



96%

recommend score

Although Picker are not sending us through the data in the format we were used to, we have been able to get our results via a spreadsheet direct from them. As we can see our percentage rating remains high. Our response numbers have fluctuated but this is possibly due to uncertainty on when we

Inpatient assessments

Mulberry	Apr-18	May-18
Early Warning Score	100%	100%
VTE assessment	100%	100%
VTE prophylaxis	100%	100%
Hospital Acquired Thrombosis	0	0
Falls assessment	100%	100%
MUST assessment	100%	86%

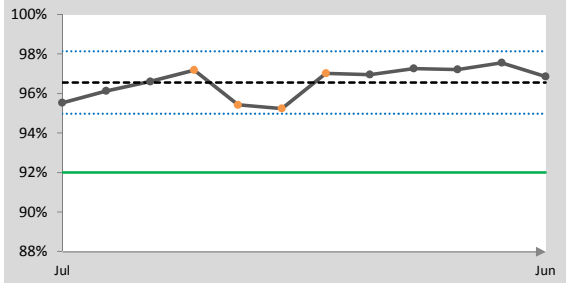
Wiltshire HEALTH AND CARE

Performance Dashboard June 2018

RTT

All services

Incomplete pathways | Complete pathways



Incomplete pathways month end position

	% under 18 weeks	Breaches
Community Teams	89%	114
Continence service	98%	5
LD	65%	22
Outpatient Physio	99%	54
Podiatry	100%	2
Wheelchair service	92%	18
WON	98%	12

In Control	On target	Action	
✓	✓	No action needed	LD psychology provision remains an area of concern - previously flagged to commissioners. 14 of the 22 LD breaches are due to psychology. Community Teams flagging as not in control with declining performance - likely to include some data quality errors - system design work ongoing to lessen likelihood of this in future. Sustained improvement in WON service.

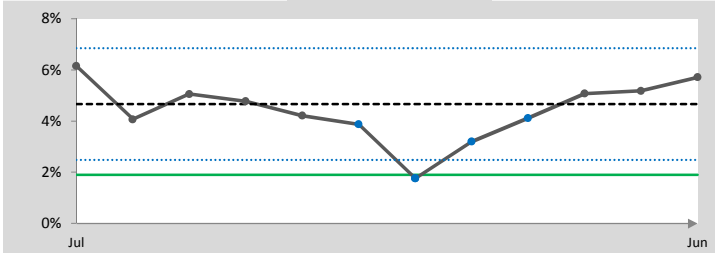
MIU

Data quality concerns

median 35 minutes

95th centile 156 minutes

Arrival to departure 4 hour stay	Left without being seen	Transfers to acute
98%	6%	5%

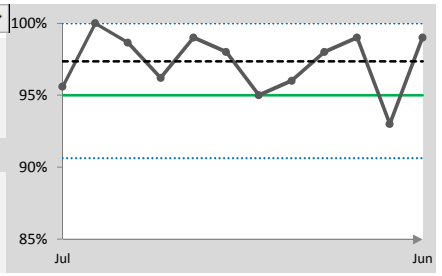


In Control	On target	Action	
✓	✗	Action needed	4 hour performance still well above target but flagging as out of control due to small but significant increase in proportion of breaches. Linked to sustained significant increase in attendance numbers. A deep dive into data is being carried out to understand this increase. Ongoing project to put MIU on SystmOne to address data quality concerns in LWBS and transfer data.

Inpatient assessments

All wards

MRSA	✓ 99%
VTE	✓ 99%
VTE prophylaxis	✓ 100%
MUST	✓ 99%
PURAT	✓ 99%
Falls	✓ 100%
Dementia	✓ 100%

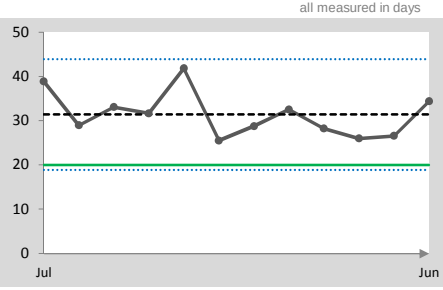


In Control	On target	Action	
✓	✓	No action needed	MUST missed target in May. System still in control and on track to deliver targets.

Mean Inpatient Length of Stay

all measured in days

Ailesbury, Cedar, Longleat	34.4
Mulberry	32.5
Step up	21.3
Step up excluding delays	19.0

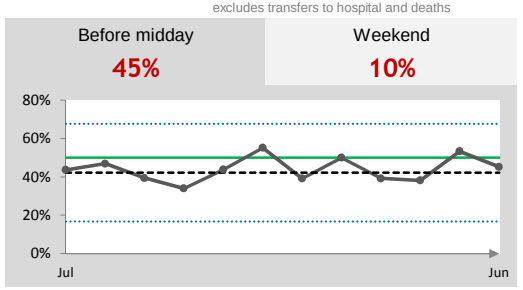


In control	On target	Action	
✓	✗	Action needed	Progress on DToCs has not yet translated into significant LoS reduction. Action ongoing - focus to incorporate stranded patients.

Discharge timings

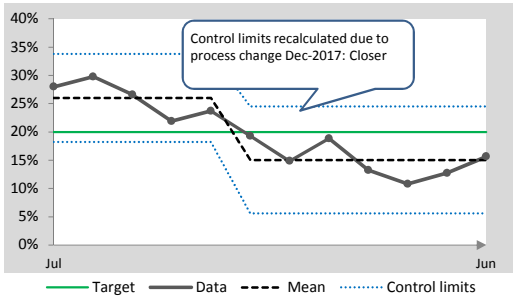
excludes transfers to hospital and deaths

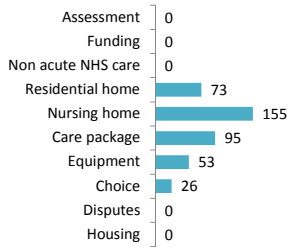
Before midday	Weekend
45%	10%



In control	On target	Action	
✓	✗	Action needed	Continuing challenge -Care homes reluctant to take in morning and at weekends.

Delayed Transfers of Care - bed days lost

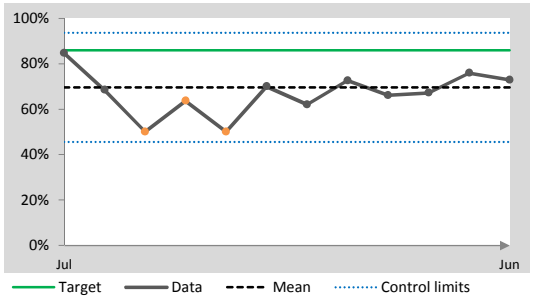




16% of occupied beds (Target <20%)

In Control	On target	Action	
✓	✓	No action needed	Process changes in December 2017 have had a significant impact on the number of days lost to delays each month. Care package delays continue to be the biggest cause of lost days each month.

Community teams 90 day reablement



June 73%

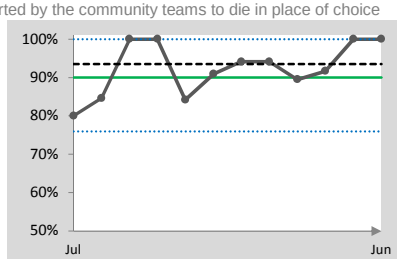
Data quality concerns

In Control	On target	Action	
✓	✗	Action needed	Significant data quality concerns affecting both cohort and performance. Action: System project underway to address cohort concerns and to allow transparent performance review.

End of life support

patients supported by the community teams to die in place of choice

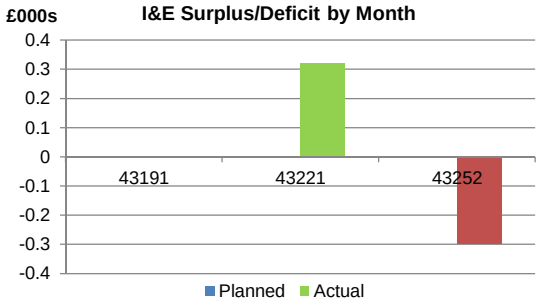
June 100%



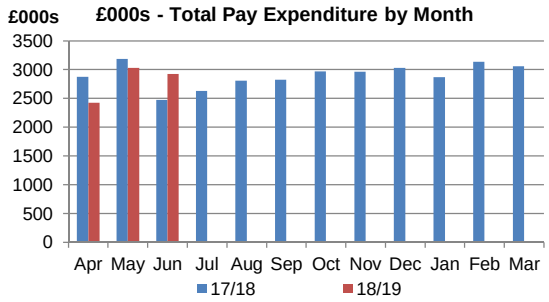
In control	On target	Action	
✓	✓	No action needed	Excellent performance continues.

Finance Dashboard - June 2018

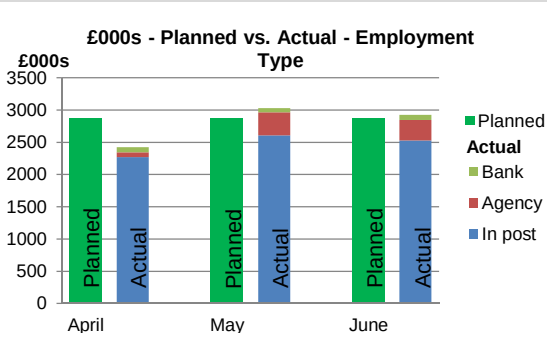
Income & Expenditure



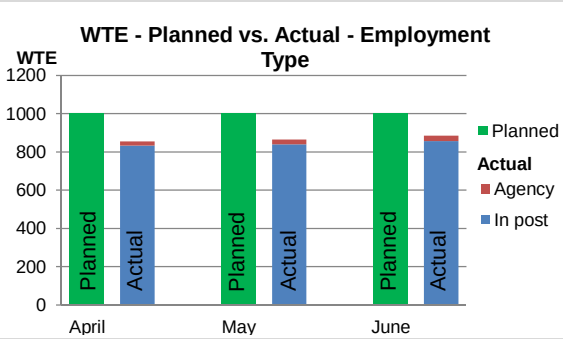
Pay Expenditure - £ - Total



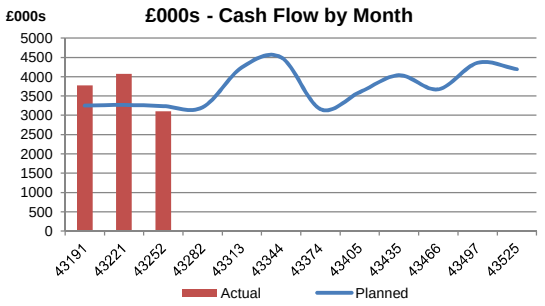
Pay Expenditure - £ - Employment Type



Pay - WTE



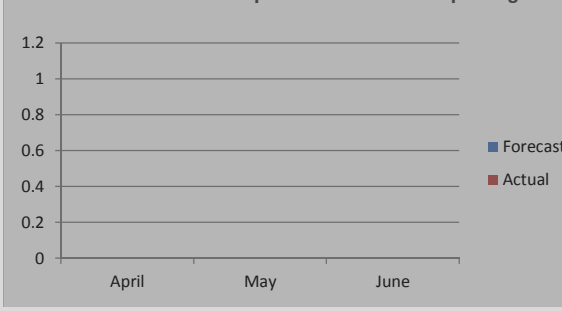
Cash



Best Practice Payment Code (BPPC)

BPPC % of bills paid in target	Current Month	Previous Month	Movement
By number	80.4%	55.9%	24.5%
By value	63.7%	26.8%	37.0%
Average number of days to pay an invoice			
Days	35	45	-10

Forecast



NHSI Reporting

NHSI Reporting to be completed for month 4 reporting

Metric	Definition	YTD Plan Number	YTD Actual Number
Capital service cover rating	Degree to which income covers financial obligations		
Liquidity rating	Days of operating costs held in cash		
I&E margin rating	I&E surplus/deficit / total revenue		
I&E margin: distance from financial plan	YTD actual I&E surplus/deficit compared to YTD plan		
Agency rating	Distance from cap		
Risk rating after overrides			

Cost Improvement Plan (CIP)

	YTD (Cumulative) Plan £000s	YTD (Cumulative) Actual £000s	YTD (Cumulative) Variance £000s	Annual Plan £000s
WH&C 2018/19 Savings				
Income	5	0	(5)	21
Pay	259	223	(36)	1,038
NonPay	78	37	(41)	312
Total income	**343**	**260**	**(83)**	**1,371**

Commentary

Overall: The LLP reports a balanced financial in-month and year to date position.

Positives: The overall vacancy rate has reduced in month to 8.6% (from a reported 9.6%). The cash and financial position continues to be maintained and a reduction of creditor payment days of 10 days, down from 45 days to 35 days can be seen in June.

Concerns: Temporary staffing spend continues to exceed vacancies, particularly on the wards where off-framework agencies continue to be used, albeit at a reduced rate.
Data quality issues remain to be resolved in the new financial ledger in July and August.
Additional savings plans are required as unidentified saving targets remain as at June.

Appendix 1

Quality Team

For information

Subject: **Board of Directors Incident Report Q1 18/19**

Date of Report: **17 July 2018**

Author: **David Chodkiewicz**

1. Purpose

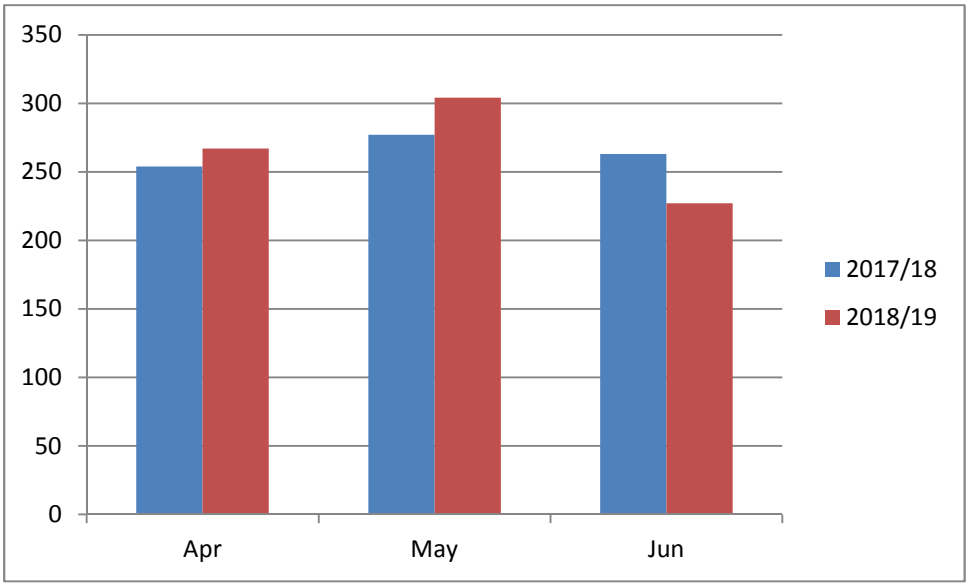
To provide a comparison and analysis of incident data between quarter 1 of 2017/18 and quarter 1 of 2018/19

2. Background

In preparation for the roll out of DATIX across the organisation, it has been deemed necessary to report to the board our themes, findings and outcomes of reported incidents. A comparison has been provided between quarter 1 of 2017/18 and quarter 1 of 2018/19.

3. Current Situation – Alert/Advise/Action

Fig a.

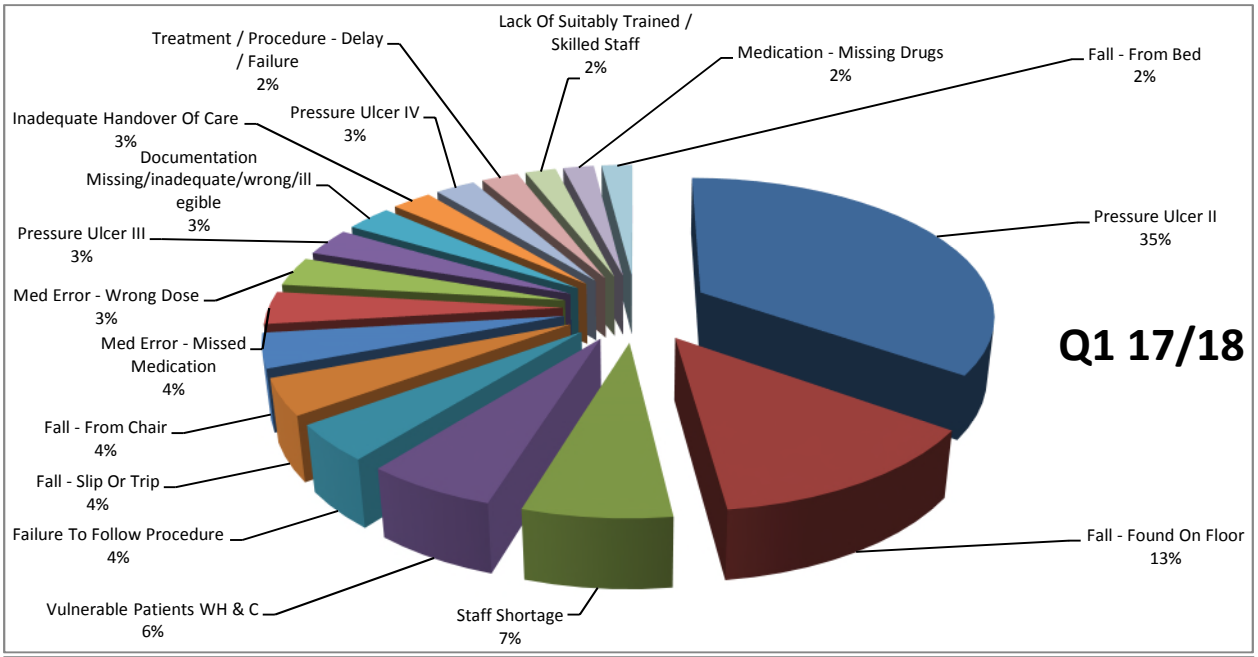


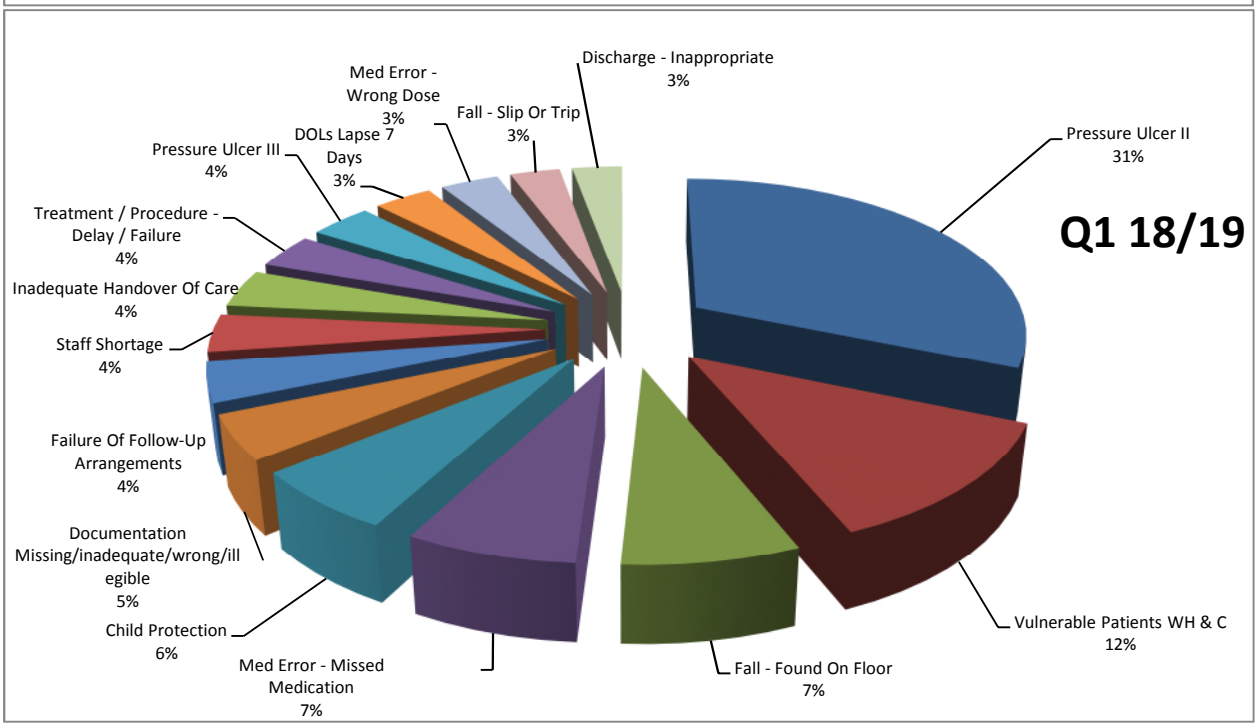
The graph above gives a breakdown of the number of incidents reported over the last in quarter 1 17/18 and quarter 1 18/19. On average the total number of incidents reported per month remains between 200 and 250.

The figures above represent all incidents reported and do not distinguish between WHC and incidents which are the responsibility of other providers such as Arriva or GWH. Unfortunately the current system in use does not allow us to separate these out. DATIX will have this capability

Safeguarding incidents, which are not always directly related to our care, are also included in the above data.

Fig b and c.





Between 17/18 and 18/19 there has been an increase in the number of DOLS Lapse incidents being reported. This has been due to increasing awareness by the safeguarding team, ensuring that DOLS Lapses are reported via the IR1 system to support discussions and decisions with commissioners and Wiltshire Council. The safeguarding team have also appointed an administrator which gives them more capacity to ensure these types of incidents get reported. The “vulnerable patients” and “child protection” categories have also now moved into the top 15 incidents, and again this is believed to be due to wider knowledge and support being provided by the safeguarding team. WHC appointed a Safeguarding Lead for Children in July 2017.

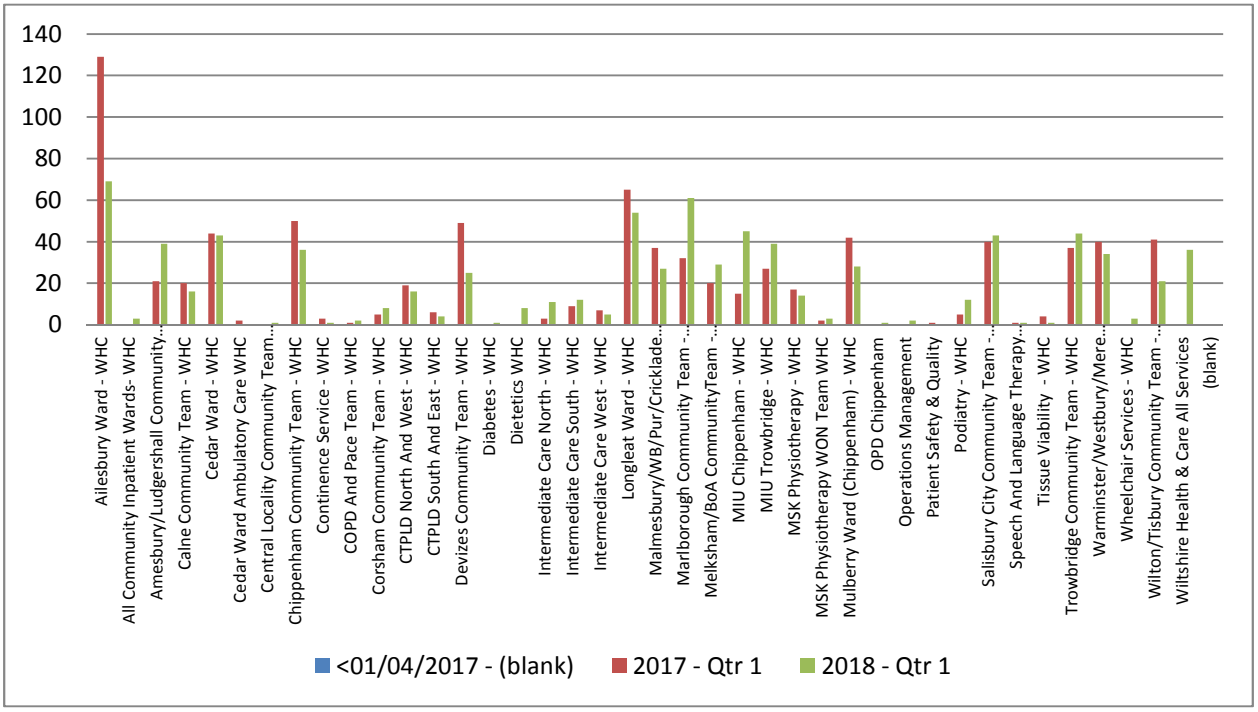
There has been a decrease in the percentage of grade 4 and grade 2 pressure ulcers. Grade 4 has dropped out of the top 15 incidents and grade 2 have dropped by 4%. This is positive and recognises the consistent approach adopted which includes effective clinical leadership (TV Nurse Consultant), supported by Nurse Specialist and Community Nurses with a Specialist Interest.

There has been a small increase of 1% in the number of category 3 pressure ulcers. Five of these were reviewed by WHC's post incident review panel and two of them have required further investigation through the root cause analysis methodology; general themes relates to documentation, staffing capacity and consistency and scheduling All of these items are being progressed through the safer caseloads project and SystmOne working group.

There has also been an increase in the number of medication incidents in recent months. This coincides with the appointment of WHC's Governance pharmacist, and it is believed that the presence of this individual along with a more active and visible quality team are the reasoning behind these incidents now being reported. All medicines incidents are discussed at the bi-monthly Medicines Governance Sub-Group. A separate report will be presented at Performance and Planning in August to identify themes and trends.

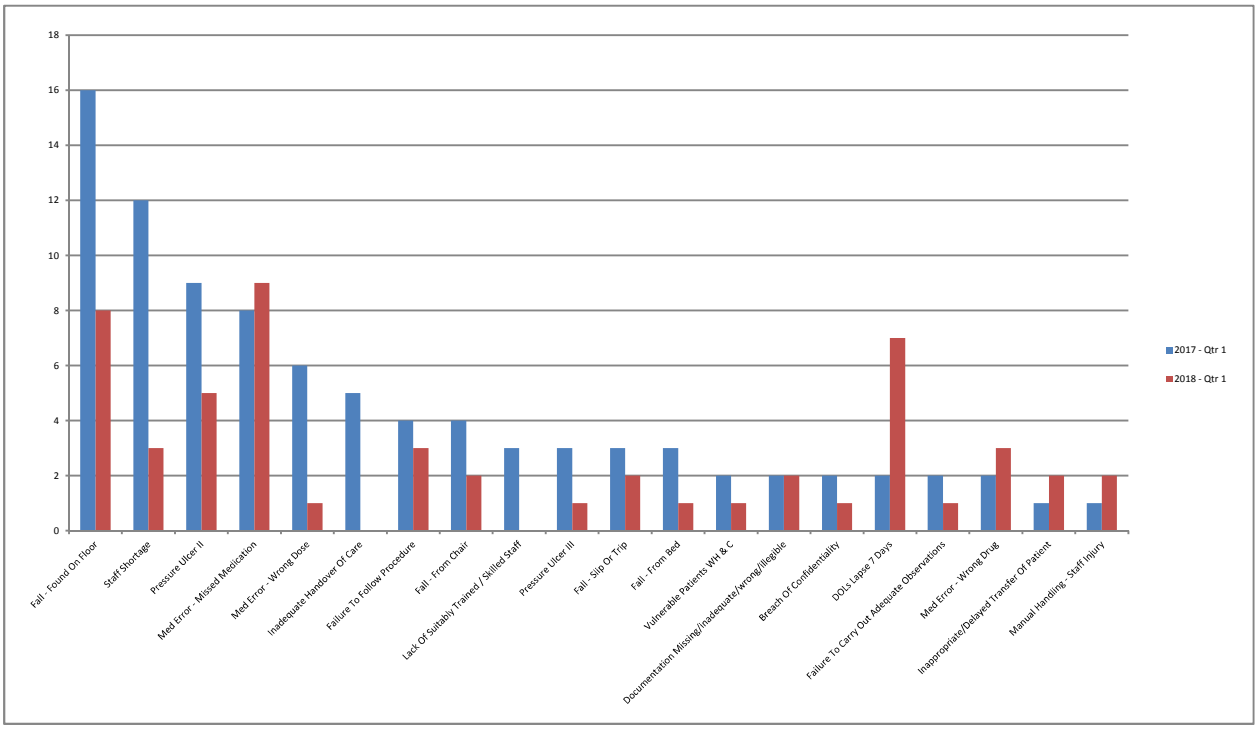
The percentage of incidents being reported as falls has reduced, especially with regards "Fall found on floor" which has dropped by 6% and "Fall from chair" which has dropped out of the top 15 incidents reported.

Fig d.



The above graph shows the number of incidents reported in quarter 1 of each year by the individual teams. Ailesbury Ward continue to report the largest amount of incidents however this has halved from the total 12 months ago, the most likely reason for this reduction is the increased use of agency staff rather than less incidents occurring? A breakdown of the categories of incidents reported by Ailesbury can be seen in the graph below;

Fig e.



The only increase is with DOLS lapses. We have identified a decrease in the number of staff shortage incidents being reported; 75% less in 2018, this does not reflect the true picture, although most vacant shifts are filled with agency staff and this adds another layer of complexity and can impact on the safe and effective delivery of care . The challenge is to increase recruitment and improve retention and this will be addressed through the Ailesbury transformation project. As a whole the organisations reporting has stayed static. When we compare 2017 Q1 with 2016 Q1 we saw an increase of 15% in the amount of incidents reported across the organisation. Through looking at the NRLS website we can see that other comparable organisations are also increasing their reporting on a year by year basis. With this in mind it would appear that we may be under reporting. We will utilise the roll out of DATIX to promote incident reporting.

The transfer of incident reporting function from GWH to WHC and therefore the investment in WHC employed staff has meant a review of the current process in the review and evaluation of clinical incidents, this alongside the development and roll out of DATIX is expected to help improve clinical incident reporting.
As expected for a community provider; pressure ulcers continue to be a highly reported incident. Recently published guidelines will help ensure accurate and more effective data capturing and reporting in the future.

The Future with DATIX
At present the organisation is utilising the incident reporting system hosted by GWH. As of 2019, DATIX patient safety software will be deployed across all areas as our incident reporting software. This will offer numerous benefits:-

- Filtering and reporting of external provider incidents
- Identification of themes in incidents, linked with any themes appearing from risks/complaints
- Simpler, more user friendly reporting system including mobile app reporting which should increase number of incidents being reported

The DATIX project team are now developing the modules that will form the new reporting system. It is intended to go live no later than the 1st of April 2019, however it is hoped that a usable version of the system will be available in the months leading up to this to allow time for training across the organisation.

As an organisation we need to be embedding a safety culture across all teams, promoting incident reporting and investigation at every opportunity. At present, our quality data analyst is visiting all teams to discuss the implementation of DATIX, gather opinions on current reporting systems and recruiting members of the teams to become “DATIX Champions”. These champions will be experts on reporting techniques and will dispense training and information across the teams.

Consistently teams/ wards report the inability to provide timely feedback to their staff about incidents; DATIX will make this process easier through the use of specifically designed dashboards for each team detailing not only themes, but also outcomes and learning to be taken from incidents, risk and complaints.

The Implementation of DATIX will enrich currently reporting throughout the organisations and provide an improved level of assurance to the board.

Appendix 2

Quality Alert: Ailesbury Ward	
Purpose of alerting the Board	Recent allegations by Oxford Brookes University which detail alleged abuse to patients and Bullying and Harassment by staff towards students Current staffing levels on Ailesbury ward has meant further increasing the use of agency staff to support safer staffing levels
Description of issue	Since the inception of WHC Ailesbury Ward has had challenges in recruiting and retaining staff and this was also evidenced by previous providers. The situation has become even more apparent in the last 2 months with the loss of further staff and no replacements in the pipeline. Loss of staff in post has included the ward manager, a junior sister and very recently an Advance Nurse Practitioner, this obviously means losing clinical leadership. WHC has tried a number of ways to increase and attract more staff, this has included, incentive payments and open days. Previous attempts of international recruitment have yielded no result. Oxford Brookes University (OBU) have also very recently highlighted a number of concerns raised to them by nursing students this has included allegations of abuse towards patients and bullying and Harassment towards students by staff. Whilst OBU have only just alerted our placement coordinator and Head of Quality at WHC, some of these allegations span 2 years. Currently there is investigations taking place and one substantive member of staff has been suspended.
How has issue arisen (and for how long)?	Staffing challenges have been a continual problem since 2016, however the problem has exacerbated recently with the loss of senior clinical staff and the use of agency exceed the number of substantive staff. Allegations of abuse and bullying and Harassment have been raised to senior leadership within WHC on the 5th July 2018
What is root cause of the problem?	Inability to recruit substantive staff including clinical leaders with the required level of competence and confidence
Does the issue suggest a need for improved systems of control?	This issue suggests the need to transform Ailesbury ward and a proposal to take this forward has been agreed by WHC Executive Committee. Alongside this, there is a need to reduce the number of beds so the current number of substantive staff can support safe and effective care delivery whilst also undertaking the transformation. This will reduce the reliance on agency staff and ensure there are the support mechanisms in place every shift. Currently senior clinical staff have been transferred from other community wards to support care delivery. The ward is being intensely monitored by the interim Clinical Services Manager An action plan is now in place to address the concerns raised by OBU and this is being led by the Head of Quality. Ailesbury Ward Transformation will also be over seen by the Head of Quality CQC and WCCG have been made aware and OBU have reported the allegations to the NMC. Students will not be placed on Ailesbury ward from September 2018 until there is assurance that actions have been implemented.
Assurance/ Oversight	

Views/findings from Committee oversight	Executive Committee are sighted on the challenges
Independent /external assurance	Monitoring through CAQC and WCCG CQRM
Impacts and implications	
Quality	Patients are potentially at risk because of lack of consistency in the safe and effective delivery of care and the over reliance on agency staff with limited capacity to ensure consistency support is given to temporary staff on each shift.
Equality	This is a problem identified on Ailesbury Ward but is currently not evident in other community ward areas.
Financial	Currently there is high agency spend with regular use of off framework agencies. The revised staffing model included in the transformation plans has required greater investment
Operational delivery	Staff morale is significantly reduced with the limited ability to recruit to vacant posts.
Regulatory/ legal/ contractual	CQC, WCCG and NMC are aware of the current pressures
Links	
Link to business plan/ 5 year programme of change	Skill mix review of wards
Links to known risks	Staffing levels on Ailesbury ward
Identification of new risks	Click here to enter text
Plan	
What actions are being taken?	Transformation of Ailesbury Ward in line with agreed service specification Action plan now in place to resolve the allegations raised by OBU students
How and when will issue be resolved?	The expected transformation of Ailesbury ward is likely to be in place at the beginning of November. WHC is working with GWH to review other bed capacity in the system to see if this can be utilised in the interim. The investigations into the allegations have commenced and are expected to be concluded within 1 month. This is in line with the action plan
When will Board be updated?	September 2018

Any Other Business

VERBAL ONLY