

# WHC LLP Board Papers - PART I

4 February 2019



## AGENDA for a Meeting of the Board Part I

<b>Venue:</b>	Training Room 1, Chippenham Community Hospital
<b>Date:</b>	1 <sup>st</sup> February 2019
<b>Time:</b>	10:00 – 13:00

WHC Board Members		
Carol Bode	Chair	CB
Douglas Blair	Managing Director	DB
Lisa Hodgson	Chief Operating Officer	LH
Annika Carroll	Director of Finance	AC
Sarah-Jane Peffers	Director of Quality, Professions & Workforce	SJP
Lisa Thomas	SFT Board Representative	LT
Francesca Thompson	RUH Board Representative	FT
Kevin McNamara	GWH Board Representative	KM
Richard Barritt	Non Executive Member	RB
Celia Grummitt	Non Executive Member	CG
Adibah Burch	Non Executive Member	AB

In Attendance		
Katy Hamilton Jennings	Director of Corporate Governance & Company Secretary	KHJ

Agenda Item		Lead	Paper	For Decision/ Discussion/ Information
1.	Welcome, Apologies & Declarations of Interest	Chair	Verbal	
2.	Minutes, Actions & Matters Arising <ul style="list-style-type: none"> <li>Minutes of Meeting of 2 November 2018</li> <li>Action Tracker</li> <li>Matters Arising</li> </ul>	Chair	Attached	
3.	Patient Story	SJP	Verbal	Discussion
4.	Chair's Report	Chair	Verbal	Information
5.	MD Report	DB	Verbal	Information
<b>Strategy</b>				
<i>All strategic items for this Board meeting will be covered in Part II.</i>				
<b>Scrutiny</b>				
6.	Combined Quality, Performance and Finance report	SJP, LH and AC	Attached	
<b>Governance</b>				
7.	Risk Framework	KHJ	Attached	Decision
8.	Risk Report	KHJ	Attached	Discussion
9.	Quarter by Quarter review of performance against the Delivery Plan, 18/19	DB/ KHJ	Attached	Discussion
10.	EU Exit Assurance	KHJ	Attached	Discussion
11.	AOB	Chair	Verbal	Discussion

	<b>Date of Next Meeting:</b> <b>3<sup>rd</sup> May 2019, 10:00-13:00am, Training Room 1,</b> <b>Chippenham Community Hospital</b>			
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**'COMBINED' AGENDA**  
**Item 1**

**Welcome, Apologies, and Declarations of Interest**

**VERBAL**

**'COMBINED' AGENDA**  
**Item 2**

**Minutes, Actions, and Matters Arising**

**VERBAL**

## MINUTES Of a Wiltshire Health and Care Board Meeting Part I

<b>Venue</b>	Training Room 1, Chippenham Community Hospital
<b>Date</b>	Friday 2 <sup>nd</sup> November 2018
<b>Time</b>	10:00 to 13:00

### WHC Board Members

Richard Barritt	Non-Executive Member (Deputy Chair)	RB
Douglas Blair	Managing Director	DB
Lisa Hodgson	Chief Operating Officer (for item 11)	LH
Annika Carroll	Head of Finance	AC
Sarah-Jane Peffers	Head of Quality	SJP
Francesca Thompson	RUH Board Representative	FT
Carole Nicholl	Deputy GWH Board Representative	CN
Adibah Burch	Non-Executive Member	AB
Andy Hyett	Deputy SFT Board Representative	AH

### In attendance

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

### Apologies

Carol Bode	WHC Chair	CB
Lisa Thomas	SFT Board Representative	LT
Celia Grummitt	Non-Executive Member	CG
Kevin McNamara	GWH Board Representative	KM

Item	Title/Notes	Actions
1	<p><b>Welcome, Apologies and New Declarations of Interest</b></p> <p>Richard Barritt welcomed everyone to the meeting and noted apologies from Carol Bode, Lisa Hodgson, Lisa Thomas, Celia Grummitt and Kevin McNamara.</p> <p>There were no new declarations of interest.</p>	
2	<p><b>Part I Minutes, Actions and Matters Arising</b></p> <p>The minutes of the previous meeting held on 27<sup>th</sup> July 2018 were agreed as a true and accurate record of the meeting.</p> <p>The members reviewed the action tracker and agreed to close some actions and amend the wording of others. LB and CB are working on an updated action tracker which will be shared by circulation.</p>	

3	<p><b>Chair's Report</b></p> <p>There was nothing to report from the Chair.</p>	
4	<p><b>MD Report</b></p> <p>DB noted that the Wiltshire GP Alliance contract was signed with CCG and the improving access contract went live on 1<sup>st</sup> October. This, along with the integration of the W GPA into our governance structure was working well.</p> <p>The implementation of the Home First + pathway with Wiltshire Council was proceeding well, with broadly positive recruitment results. This had been most successful in West Wiltshire where all posts had been recruited to. There was ongoing recruitment activity in the North and East and South. A timeline was being agreed with Wiltshire Council on the phased implementation in line with the recruitment results.</p> <p>The new Musculoskeletal pathway was also going well, with strong recruitment results and a related reduction in waiting times for physiotherapy. The next phase of implementation was due in December.</p> <p>The last quarter had involved intensive work on the project to re-design inpatient services at Savernake hospital. The project was now entering the phase of implementing the zoning of the ward between therapy intensive focus and medical focus.</p> <p>In discussion of the MD Report, the following points were made:</p> <ul style="list-style-type: none"> <li>• AH questioned whether the implementation date for Home First expansion needed to be adjusted to reflect recruitment. DB said that the pace of implementation would be different in areas as it was linked to recruitment. Wiltshire Council were planning to block purchase care hours to mitigate the effects in areas in which recruitment was slower. FT noted that RUH had employed some Rehabilitation Support Workers who were on rotation between ward work and community work. This may be a model that SFT would wish to explore.</li> <li>• AB questioned whether physio patients would be able to self-refer for the whole of Wiltshire – DB agreed to confirm this following the meeting.</li> </ul>	

5	<p><b>Highlight Report from Quality Assurance Committee</b></p> <p>FT confirmed that the first meeting of the Quality Assurance Committee in its new structure had now been held. The Committee had reviewed its terms of reference and it was agreed that they needed to be aligned to the quality schedule. These will come to Board for full approval when ready. The Committee also agreed that it would operate on the basis of exception reporting, with more detailed scrutiny in specific areas when required.</p> <p>FT reported that specific items considered by the Committee included:</p> <ul style="list-style-type: none"> <li>• FT reported that the Committee had received a good report around Freedom to Speak Up and QAC took assurance from that with explanations for any incidents given.</li> <li>• The CQC Action Plan was reviewed and FT noted that the Committee felt that this was an area on which full board scrutiny and assurance was required, given the broad nature of the actions.</li> <li>• The Committee had noted that capacity around infection control microbiology support is a concern. Despite numerous attempts to secure permanent resource, a solution had not yet been found. FT said that, as a joint venture, it was a whole board responsibility to assist in finding a solution if and when operational attempts had been exhausted. SJP confirmed that temporary support was in place for emergencies. It was agreed that a further attempt will be made with Public Health England and any other provider. AH suggested contacting Dorset and will provide DB with contact details.</li> <li>• The Committee had noted exception reports for Wheelchair Services and Learning Disability and asked for deep dives on these areas. They have also asked to see a report on MIU staffing and operating model.</li> <li>• There was a discussion around quality impact assessments and QAC have asked for a paper on the QIA process to come to the next meeting.</li> </ul>	
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6	<p><b>Highlight Report from Integration Committee</b></p> <p>RB confirmed that the first Integration Committee has taken place and the terms of reference were reviewed. There had been discussion around whether AWP should be involved but it was agreed that, in these early stages for the Committee, it would be better to keep participation more limited. There was also discussion around what the responsibilities of the Committee were, recognising the risk that it could merely narrate system wide issues, rather than focus on practical action. The terms of reference will be brought to Board for approval.</p> <p>Lindsay Kinlin of the WPGA attended the meeting and provided an update on the improved access arrangements and how the WPGA is structured. Lindsay chairs the WPGA meetings and will be attending the Integration Committee. The Committee had noted the strategic benefits of the Alliance being hosted within the WHC structure.</p> <p>The Committee considered the extent of integration with social care services, noting that alignment had been pursued in preference to organisational integration. The focus was on including aligning pathways like intermediate care and noted the home first pathway is now aligned with Wiltshire Council's reablement pathway and is expanding.</p>	
7	<p><b>Patient Story</b></p> <p>SJP shared a patient story that came through as feedback on the Wiltshire Health and Care website relating to a patient that had experienced a painful blocked catheter issue during the night. The Out of Hours service was unable to assist the patient and had advised the patient to call the community team when it opened at 7am. There was positive feedback on the swift and caring response from the community team.</p> <p>The Board noted that, although the feedback about the service provided by the community team was positive, this case study highlighted a commissioning gap in relation to nursing services between 10pm and 7 am, something that needs to be raised with the CCG.</p> <p>It was also suggested that we think of a systematic way to compile these stories and share with our GP colleagues in the WPGA.</p>	

8	<p><b>EPRR Report</b></p> <p>The Board reviewed the EPRR Report for 18/19. It was noted that this report sought to respond to the requests from the Board when it had considered the 17/18 report. DB confirmed that the outcome of the assurance process had been endorsed by the CCG and NHS England. The Executive Committee had considered the report and was assured that the report showed how we are testing our plans with broader assurance.</p> <p>In discussion, FT noted that the RUH have been commended on their Loggist training and would be happy to share this with WHC.</p> <p>The Board noted the EPRR Report for 18/19.</p>	
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9	<p><b>Quarterly Finance, Quality and Performance Report</b></p> <p>SJP provided an update on quality and noted the following key aspects from the report:</p> <ul style="list-style-type: none"> <li>• Improved position with complaints compliance but further improvement required to improve on current position of 60%</li> <li>• Statutory and mandatory training requirements have been reviewed and the required changes to ESR and training tracker have been made – Figures will be available through the dashboard in the next quarter.</li> <li>• Appraisal compliance lower than expected, however this has been discussed with expectation that this will improve over next 2 months and mitigation action plans in place for hot spot areas.</li> <li>• WHC have served notice to WCCG on the delivery of FNC/CHC assessments and will serve 12 month notice period.</li> <li>• Ailesbury ward transformation on target for soft launch on 5<sup>th</sup> November – working on 20 bedded model with 6 additional beds at Bassett House initially – as recruitment progresses we will be able to reopen more beds with the expectation that all 6 beds will be reopened by mid-December.</li> <li>• Patient and Public Engagement Plan – a draft now being sent out to those that attended the workshop in June, as well as the website for public comment. The expectation is that the final plan will be completed in December.</li> <li>• An in-depth review is being carried out for Wheelchair Services, MIU and LD.</li> </ul> <p>The Board noted the following updates for performance:</p> <ul style="list-style-type: none"> <li>• An agreement has been reached with Medvivo for WHC to take responsibility for allocation of capacity for pathway 2. It has also been agreed that further changes to referral processes and the in reach function will be undertaken in 2019. This now required agreement with the CCG before implementation.</li> <li>• The new Head of Operations for Community Teams (Heather Kahler) was in post from 3<sup>rd</sup> October 2018. Further interim resource would join WHC next month to provide further resilience to the operational teams.</li> <li>• CTPLD services are experiencing performance challenges – there is lack of psychology support for this service.</li> </ul> <p>AC provided an update on finance and noted the following key points:</p>	
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	<ul style="list-style-type: none"> <li>• The development of richer financial reporting, particularly to budget holders, has been delayed and is putting pressure on the RUH financial systems team as well as both the RUH and WHC finance teams. AC has escalated with RUH and requested a meeting to clarify timescales.</li> <li>• Estates funding is still to be finalised. WHC is waiting for a response. It is assumed within the position that the CCG will fulfil its obligations in this regard.</li> <li>• WHC has received confirmation that national funding for the pay award will be made available, but the exact amount is not yet known.</li> <li>• Cash position and financial position continues to be healthy, however our pay is exceeding budget which is a concern. Agency spend is high, however we are in the middle of an internal audit on agency processes which is expected to provide further guidance on improvements to processes.</li> </ul> <p>The Board noted the quality , performance and finance report and associated dashboards and:</p> <ul style="list-style-type: none"> <li>• agreed that DB can sign off the Annual Statement of Commitment to Health, Safety, Fire and Security for 18/19.</li> <li>• suggested that the NEDs visit the new Ailesbury Unit and Chestnut Unit - LB to organise visits.</li> </ul>	
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10	<p><b>Learning from Independent Reviews</b></p> <p>SJP presented to the Board two papers which assessed lessons that could be drawn from recent external reviews.</p> <p><b>Liverpool Community Health report</b></p> <p>The findings of the Liverpool Community Health Independent report have been mapped against the characteristics of Wiltshire Health and Care. This shows that the majority of the findings do could not relate to our organisation structure but areas to note are:</p> <ul style="list-style-type: none"> <li>• WHC itself is a new organisation</li> <li>• Quality impact assessments is an area of improvement for WHC, however we have a revised internal governance structure with better scrutiny and monitoring</li> <li>• Clinical risk system is being improved.</li> <li>• Roles and responsibilities of our Executives are under review</li> <li>• Recognition that Executives were relatively new in post when WHC launched.</li> </ul> <p>The Board noted the report, and noted that the areas of potential similarities with Liverpool Community Health were areas for development rather than areas of concern.</p> <p><b>Gosport Memorial Hospital review</b></p> <p>SJP noted that the Board had discussed the Gosport review shortly after publication at its meeting in July. The paper provided the Board with further assurance as to what this means for WHC. The report didn't make any recommendations with regards to what other NHS organisations should be doing and what processes should be put in place. The findings of the report could relate to both inpatients and community teams. SJP noted that old style syringe pumps are not in use in Wiltshire. Our governance arrangements internally include medicines governance reviews with reports to the Executive Committee and mortality meetings that report to the Quality Assurance Committee.</p> <p>FT noted that the Gosport review mentions relationships with unions and asked what infrastructure was in place for staff side communication. SJP confirmed that we have just agreed the terms of reference for an Employee Partnership Forum with trade unions. A report will be brought to the next Board Meeting on the first formal meeting.</p> <p>The Board noted the report.</p>	
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11	<p><b>Winter Plan</b></p> <p>The Board reviewed the Winter Resilience and Cold Weather Plan for 2018/19 which outlined the systems and processes in place to effectively manage capacity to meet the demand for planned and non-planned demand from 1<sup>st</sup> December 2018 to 23<sup>rd</sup> April 2019.</p> <p>The plan details the lessons learnt from previous winters and the priorities for winter 18/19. It includes reminders of the OPEL status regime and our bed capacity.</p> <p>FT noted that it would be useful to have a sense of the level of risk around the delivery of priorities. It would also be useful to include a Flu or Norovirus Management Plan in order to provide assurance to the Board that WHC are prepared for this.</p> <p>It was also noted that the plan does not mention explicitly the extensive external reporting requirements. LH confirmed that we need to work out the requirement on us as a community provider to ensure we are responding to the requirements.</p> <p>CN asked whether the plan incorporated any of discussions which had been had at the Swindon A&amp;E Delivery Board about GWH's assessment of winter. DB confirmed that the plan was a consolidation of the elements which had been shared with all three of the A&amp;E Delivery Board. The Wiltshire Health and Care plans were part of a Wiltshire CCG overview plan shared with the Swindon A&amp;E delivery board in September and further discussions were held in October.</p> <p>The Board agreed the plan.</p>	
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12	<p><b>Process against WHC's Delivery Plan – Quarterly Update</b></p> <p>The Board reviewed the quarterly update of the business plan for Q2.</p> <p>KHJ noted that, largely, we have achieved what we wanted to achieve in this quarter, with only a few gaps and actions as follows:</p> <ul style="list-style-type: none"> <li>• Frailty strategy is below target. – WHC will support WCCG and WC to develop a county-wide frailty strategy, but progressing this WHC delivery goal is dependent on external organisations making strategic decisions.</li> <li>• Orthotics re-procurement – WHC needs to identify additional procurement support to carry out the proposed retendering exercise</li> <li>• Alignment with new urgent care services – WHC will support WCCG to develop its urgent care strategy, but aligning with new urgent care services will be dependent on WCCG defining the direction of travel for urgent care services in Wiltshire. As such, progressing this WHC delivery goal is dependent on WCCG making strategic decisions.</li> <li>• Intermediate Care Beds – Progressing this WHC delivery goal is dependent on WCCG making strategic decisions.</li> <li>• Rotational scheme for workforce – WHC will start rotations with physiotherapists around WHC's own services initially in January 2019.</li> <li>• Soft FM – Estates budgets need to be agreed with WCCG and the contractual mechanism for Soft FM.</li> <li>• Staff health and wellbeing CQUIN – it would be useful to consider non-traditional ways to proactively promote support for MSK and stress-related health issues within WHC to help staff feel well and supported.</li> </ul> <p>The Board noted the report, in particular noting that the format of the report was easy to follow and helped to provide a high degree of assurance.</p>	
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13	<p><b>Risk Report 15+</b></p> <p>The Board reviewed the Risk Report and noted the contents.</p> <p>The Board, linking its earlier review of the quality report, noted that the concerns around microbiology were not scored above 15 on the risk register. It was agreed that it is not a major risk due to the likelihood of the risk manifesting, but that the risk was not been tolerated as additional mitigations were being sought.</p> <p>It was noted that this version of the risk report did not display the impact and severity sub-scoring as it usually does, but that this would be included in all future reporting. This was particularly relevant to the review of the transport risk, as whilst 'likelihood' was low, the severity <i>if</i> the risk were to manifest was high – justifying focus.</p> <p>KHJ advised that a revised reporting template was under development for presentation at the next Board, which included the S and L sub-scoring methodology as per the usual presentation.</p> <p>The Board confirmed that it was satisfied with the management of the 15+ risks as presented.</p>	
14	<p><b>Any Other Business</b></p> <p>FT announced that she was leaving her role as Chief Operating Officer at the RUH in February and the February Board meeting will be her last Board meeting.</p>	
	<p><b>Date of Next Meeting: 1<sup>st</sup> February 2019</b></p>	



**‘COMBINED’ AGENDA  
Item 2**

**Board Action Tracker**

# Wiltshire Health and Care Board Action Tracker

Please note that this tracker may have a filter switched on so that only "open" actions are visible.

No	Date Entered	Action	Assigned to	Status	Date completed	Notes
67	28.11.17	<b>Financial reporting</b>  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		As per previous reports into the board (advise section), this remains under development.
79	23.01.18	<b>Audit Committee chair</b>  Agree a strategy for ensuring WHC can access an independent Audit and Assurance Committee chair.	CB	Open		In June 2018, the Board approved the proposal to appoint an additional non-executive with a financial/audit background due to the absence of this experience amongst the current non-execs. Interviews took place, and nominations were proposed. Subsequently, the member reps have requested that WHC does not increase the size of the Board. As such, we will not appoint a new board representative, and WHC will be unable to establish an audit committee with its

						current membership. The Board will act to oversee the annual report in 18/19, as per 17/18.
82	23.01.18	<b>Board mandatory training compliance</b>  Mechanisms for monitoring mandatory training for board members embedded.	KHJ	Open		The Company Secretary now receives a monthly report on board training compliance, and is supported by the WHC Learning & Development team to engage the board membership to complete any outstanding training where applicable. In Q3 of 18/19 all NEDs either completed their mandatory training or provided WHC with evidence of equivalent compliance. This is the one exception of local fire safety training - which remains outstanding for all NEDs. However this may not be a true requirement and the Company Secretary is seeking confirmation on this from our L&D Lead.
101	02.11.18	<b>Sharing patient stories with GP Alliance colleagues</b>  It was suggested that we think of a systematic way to compile our patient stories and share with our GP colleagues in the WGPA.	SJP	Open		Minutes from WHC's patient stories from WHC board, will be shared with Lindsay Kinlin to share with WGPA colleagues.

102	02.11.18	<b>Board member visit to Ailesbury</b>  Board members to be provided with the opportunity to visit the transformed Ailesbury and Chestnut units.	SJP	Open		This visit is due to take place on Tuesday 29th January 2019. Celia Grummitt and Jim O'Connell (acting on behalf of GWH) Will attend. Richard Barritt is arranging to visit on an alternative day.
103	02.11.18	<b>Keeping the board informed of progress with the EPF</b>  The board will be provided with an update after WHC's first formal Employee Partnership Forum meeting post-separating the workforce from GWH.	SJP	Open		First meeting scheduled for April 2019.

**'COMBINED' AGENDA**  
**Item 3**

**Patient Story**

**VERBAL UPDATE**

**'COMBINED' AGENDA**  
**Item 4**

**Chair's Report**

**VERBAL UPDATE**

**'COMBINED' AGENDA  
Item 5**

**Managing Director's Report**

**VERBAL UPDATE**

## Wiltshire Health and Care Board

**For information**

**Subject:** Quality, performance and finance monthly report  
**Date of Meeting:** 01 February 2019  
**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:

<b>ADVISE</b>	<ul style="list-style-type: none"> <li>• We have achieved CQUIN target for Flu vaccinations; 75.61% Compliance</li> <li>• Staff Survey has been completed (End date 9<sup>th</sup> December) the information will now be collated and presented at the next board meeting. The response rate to the survey was 36% of all staff, we have received more response this year because the survey was sent to all staff</li> <li>• Ailesbury transformation project has successfully completed and the ward is now split into two units. There is now an active recruitment pipeline and new starters arriving throughout January- March 2019, including a new Ward Manager</li> <li>• DATIX remains on target with all expected activity completed well within the expected timeframe. Training will be rolled out in the next month.</li> <li>• Complaints response target has not been achieved in month (44%), although target achieved in previous months. There are no outstanding complaints. The area receiving the most complaints is MIU. An interim Head of Ops started on the 14<sup>th</sup> January 2019 and has commenced a diagnostic and will triangulate quality, performance and finance information. The report is expected to be available in March 2019.</li> <li>• WHC remains above the national benchmark for falls on community wards. An action plan is now in place. The newly appointed senior Nurse and Head of Patient Safety and Quality will oversee the completion of the plan.</li> <li>• Sickness rates are at 5.35% against a target of 3.5%, this increase is due to long-term sickness. All cases are being managed in line with HR policy</li> <li>• Appraisal rate below target; 58.6% against a target of 80%. This has improved in month and all teams/ services have an 8 week recovery plan in place.</li> <li>• Stat and Mandatory training rate is below target; 75.13% against a target of 80%. This has improved in month and teams/ services are working to a 8 week recovery plan.</li> <li>• Allocate (Healthroster) to start rollout in Q4, this will be a 12 month project led by Interim Head of Ops and delivered by Workforce Optimisation Lead</li> <li>• Public and Patient Engagement Plan has been published.</li> <li>• Falsification of Medicines Directive- Specification for procurement signed off and proceeding. Expected date of delivery is the 9th February 2019. Further progress will not be made following the procurement exercise until there is further national</li> </ul>
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	guidance offering greater clarity, particularly in relation to Independent Healthcare Providers.
<b>ALERT</b>	Meetings have been held with independent OH organisations; however, this has not secured any new microbiology support. Further advice will be sought from other community providers; Gloucestershire Community and Hampshire/ Dorset community to identify if there are other delivery models.
<b>ACTION</b>	There are no issues on which Board action is required.

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

<b>ADVISE</b>	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.
<b>ALERT</b>	No alerts to be reported to the board
<b>ACTION</b>	There are no issues on which Board action is required.

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

<b>ADVISE</b>	<p>RTT performance has improved across all services with the exception of:</p> <ul style="list-style-type: none"> <li>Community Teams. Agreement has been reached with commissioners that the community teams will not meet the target in 2018/19, due to the level of escalation the system is in and the requirement for all resources to be focused on supporting discharges. However all waits over 35 weeks will be reviewed to ensure no breach is in excess of 52 weeks.</li> <li>Learning Disabilities: delays relates to therapy and psychology, psychology requires a commissioner discussion which is due to take place in February 2019. Additional therapy support to cover vacancies and sickness is actively being sought and an improvement is expected to be seen in Q1 of 2019/20.</li> <li>Wheelchairs is an improving picture and the trajectory in place will bring the service back within target by Q1 2019/20.</li> </ul> <p>It should be noted that significant RTT improvements have been made in all other services and the target will be met at organisational level.</p> <p>Flow: The Wiltshire Flow Hub was launched in December 2018, Wiltshire Health and Care is now responsible for flow from acute hospitals into community bedded capacity. Prior to the Christmas Holiday period there was relatively low demand for community capacity though, as expected, demand picked up during the first week in January 2019 with a number of systems experiencing high levels of escalation. WHC has maintained DToC in community wards within the target range 10-15% and discharges prior to mid day has improved. Flow into Pathway 2 beds has been maintained. This is a testament to the hard work of staff, however it should be noted that the level of scrutiny and the pace of flow is significant and care is been taken to support staff.</p> <p>Intermediate Care beds: It has been noted through the work of the Flow Hub, that there are a number of Intermediate Care Bed process improvements which could be considered which would improve flow, a task and finish group has therefore been</p>
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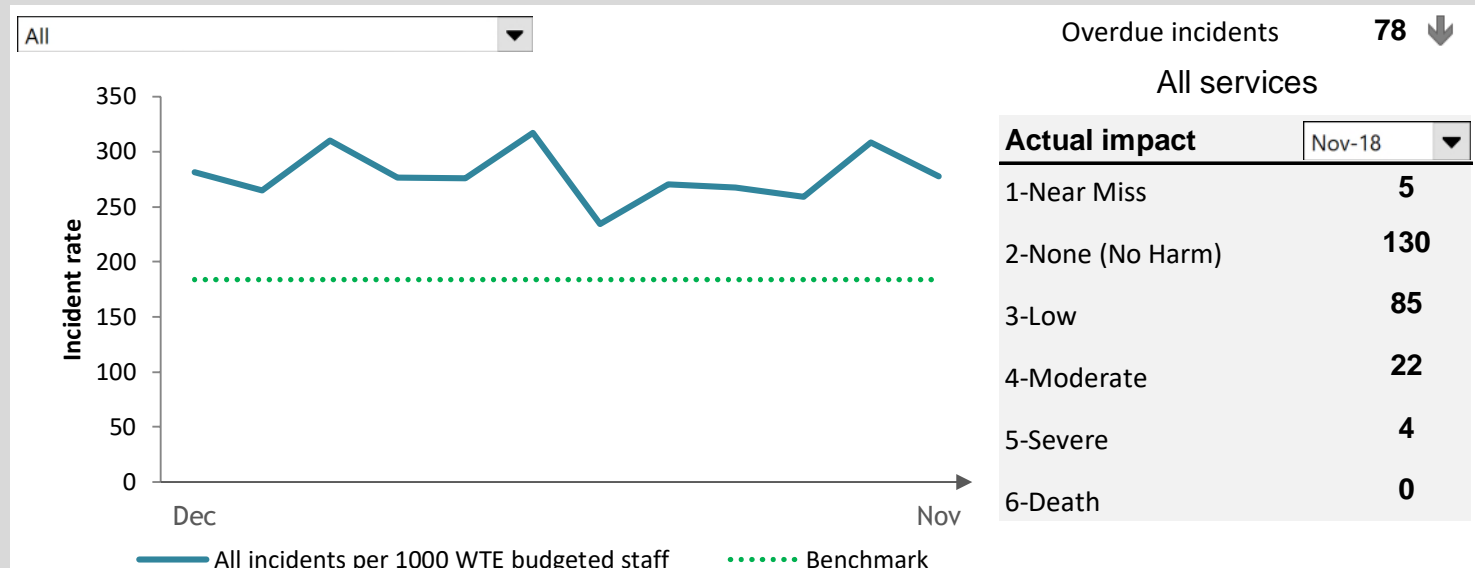


	<p>established with partners to review.</p> <p>MIU's: December saw 7% of patients requiring transfer to an acute trust, this was due to the acuity of patients and appropriate. Public education continues through the CCG.</p> <p>Inpatients assessments: The target was not met in December 2018, following review it would appear that this was due to the acuity of patients and workload. A review has been requested to ascertain the time it took to undertake the assessment to provide assurance that the assessment were undertaken and take a view on any potential impact.</p>
<b>ALERT</b>	<p>Wheelchair Services: A review of the Wheelchair service has now been completed and has been reviewed by the Executive Committee. A full briefing will be made available to the Board in Q1 of 2019.</p> <p>MIU's: Diagnostic work is currently being undertaken to better understand the problems experienced by both MIU's, this is been supported through a listening event with staff. The initial work is due to complete in early March 2019.</p>
<b>ACTION</b>	There are no issues on which Board action is required.

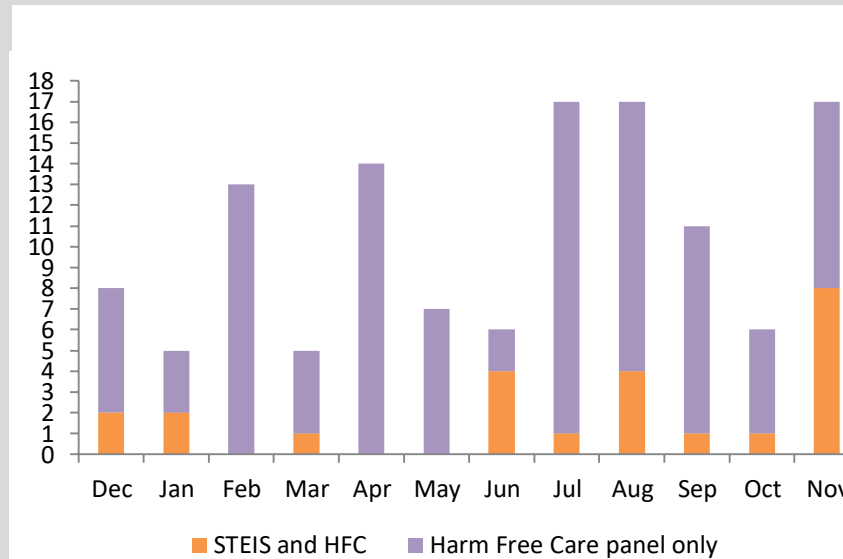
### 3. Recommendation

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

### Incidents

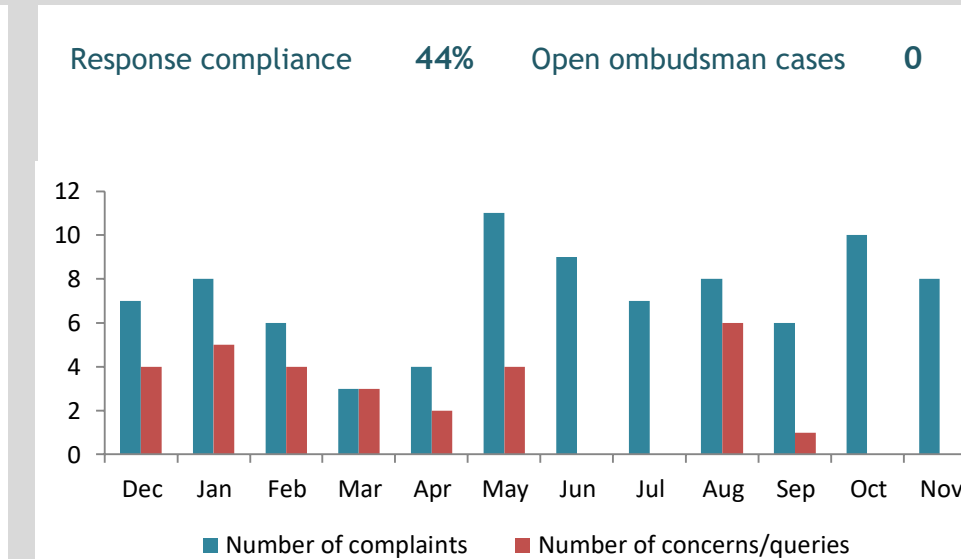


### Incidents Requiring Further Investigation

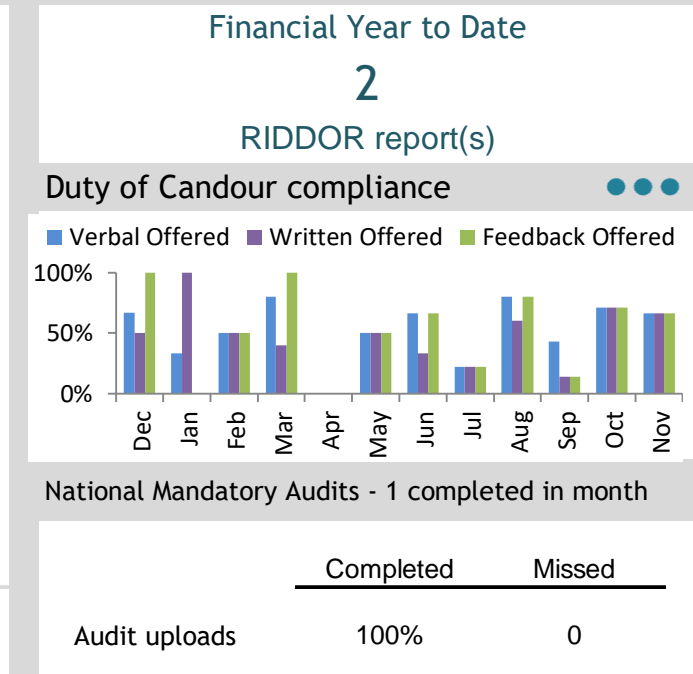


Benchmarking data does not include pressure ulcers

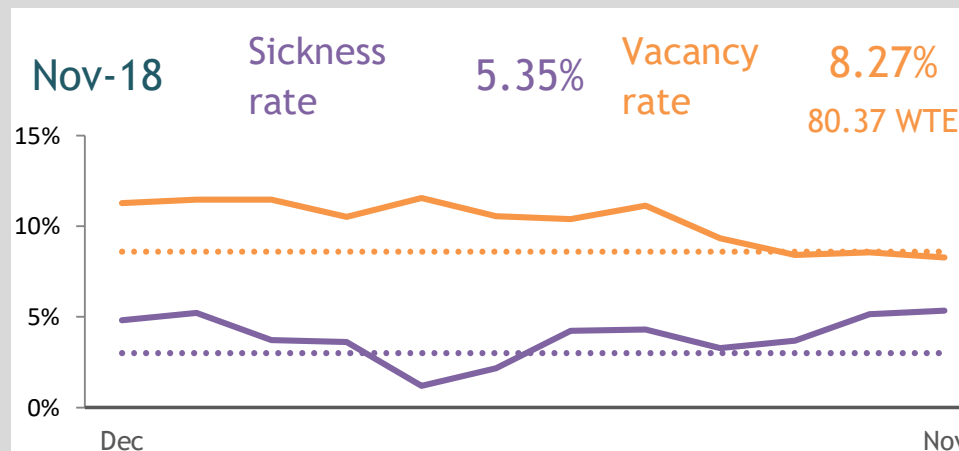
### Complaints/Concerns



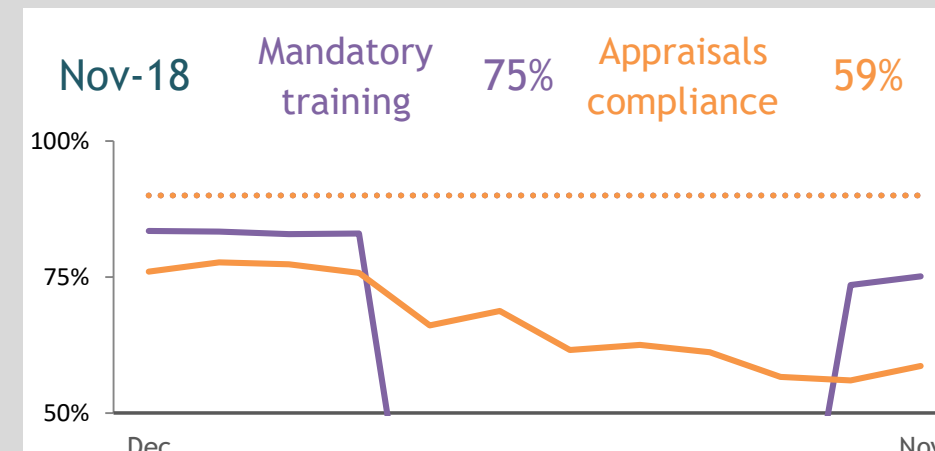
### RIDDOR



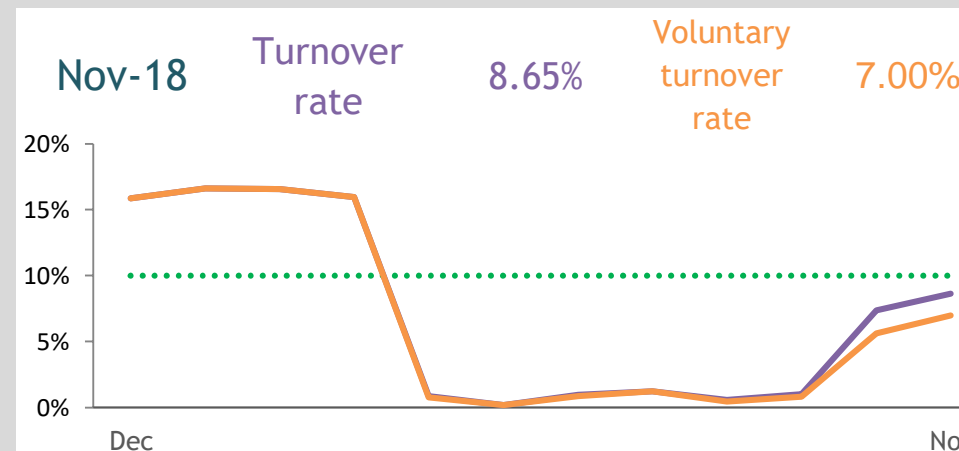
### Sickness/Vacancy



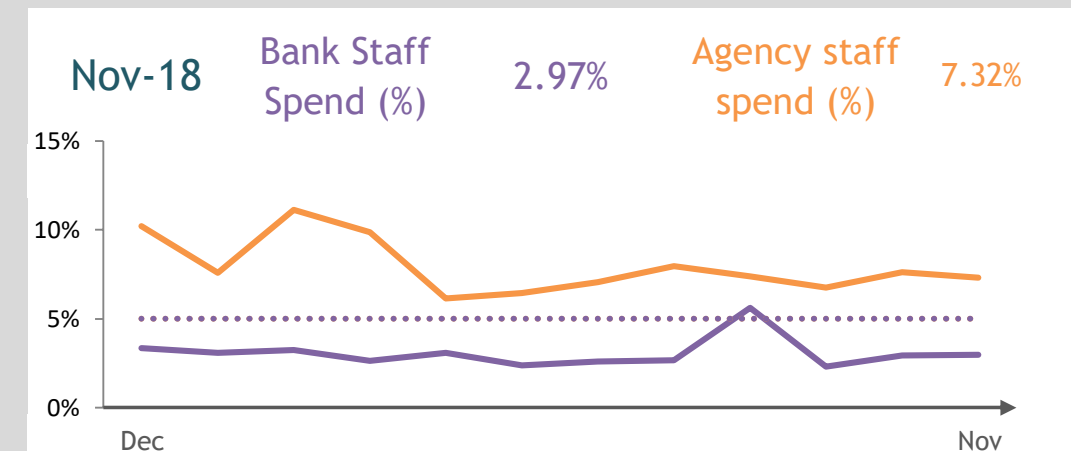
### Training/Appraisals



### Turnover



### Bank/Agency spend %



### Infection Prevention & Control

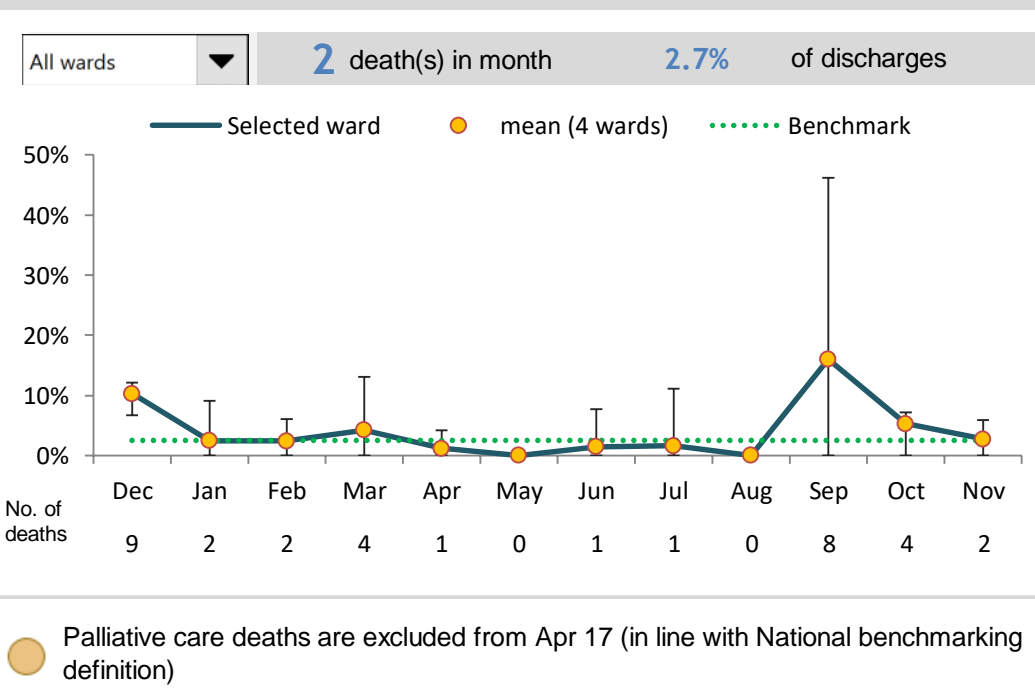
All wards

In month Prev 12 months

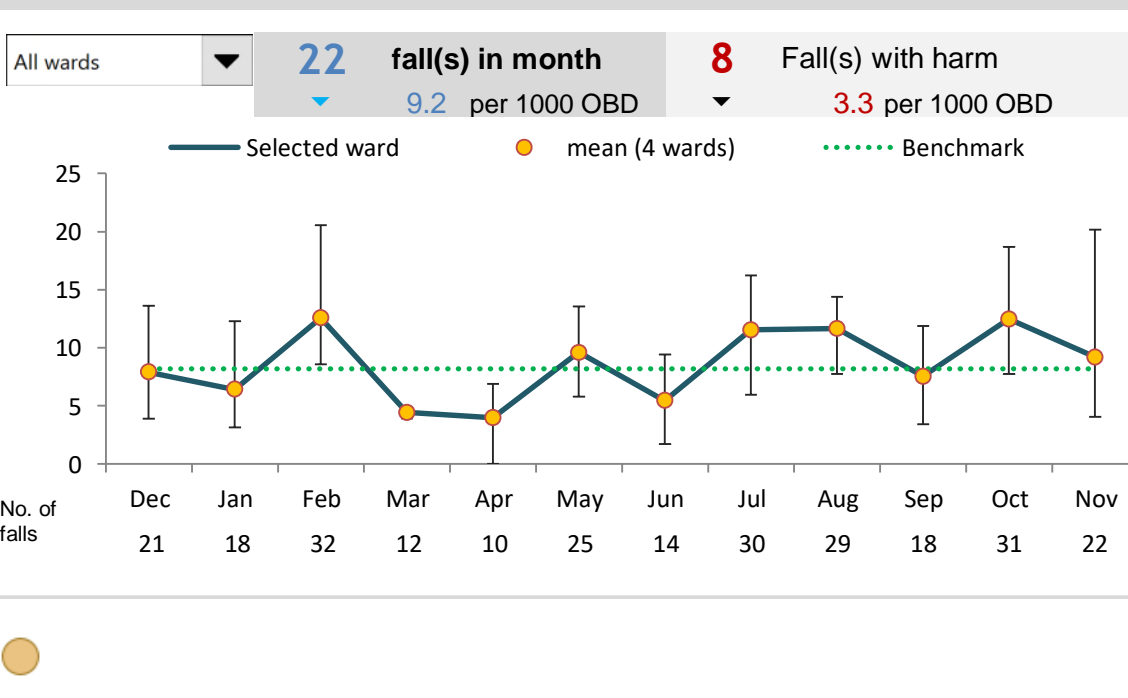
MRSA incidence	0	0
C diff incidence	0	1
E coli incidence	0	0
Bed days lost to norovirus	0	0



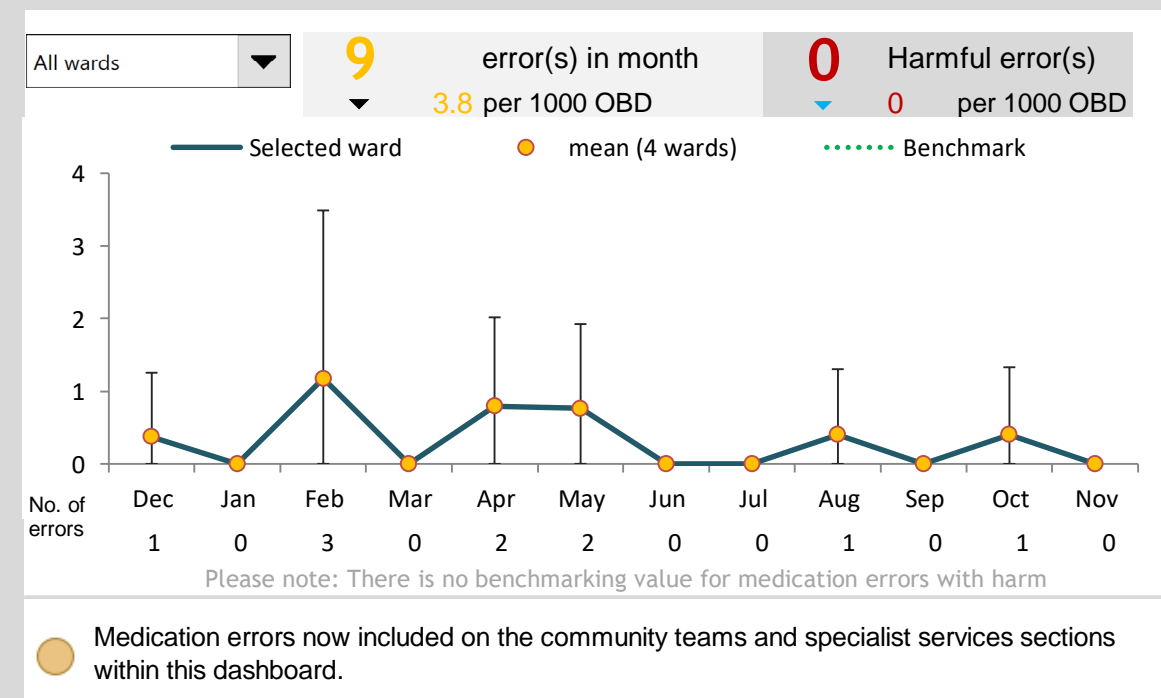
### Deaths



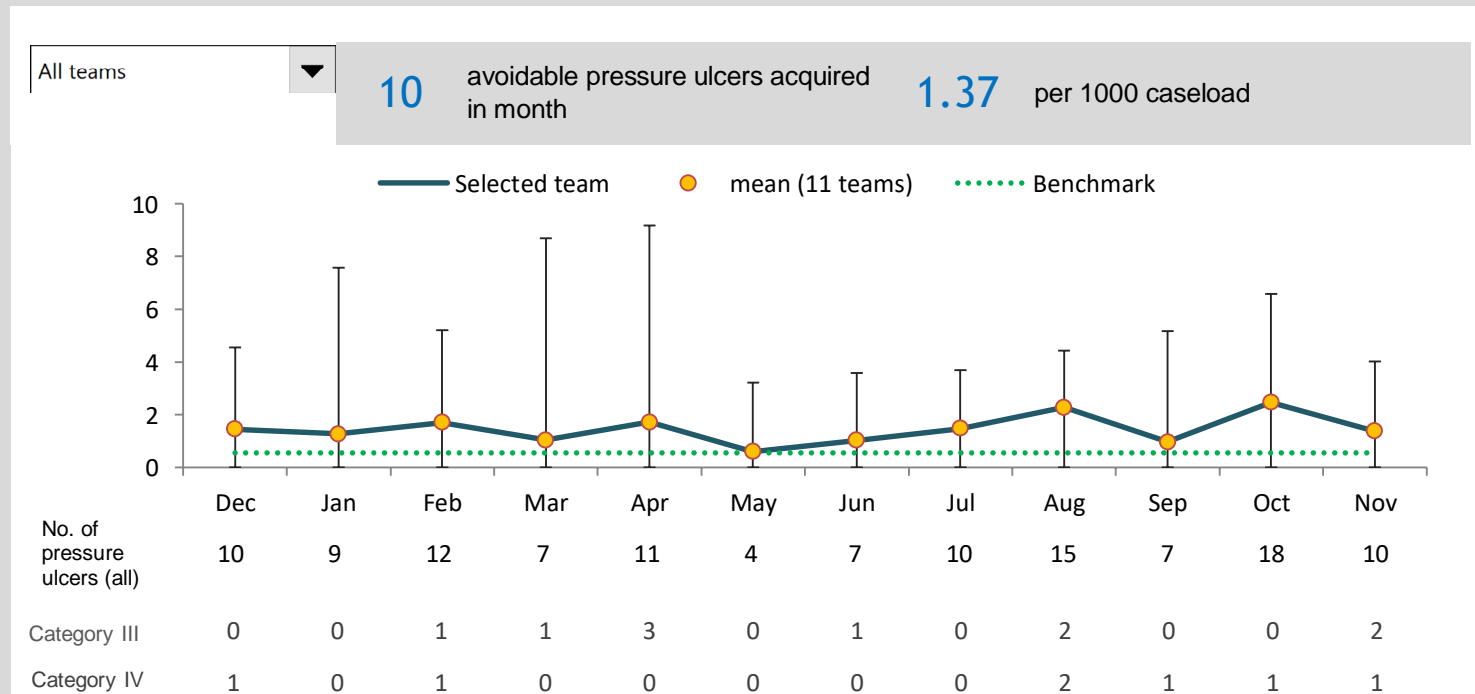
### Falls



### Medication errors

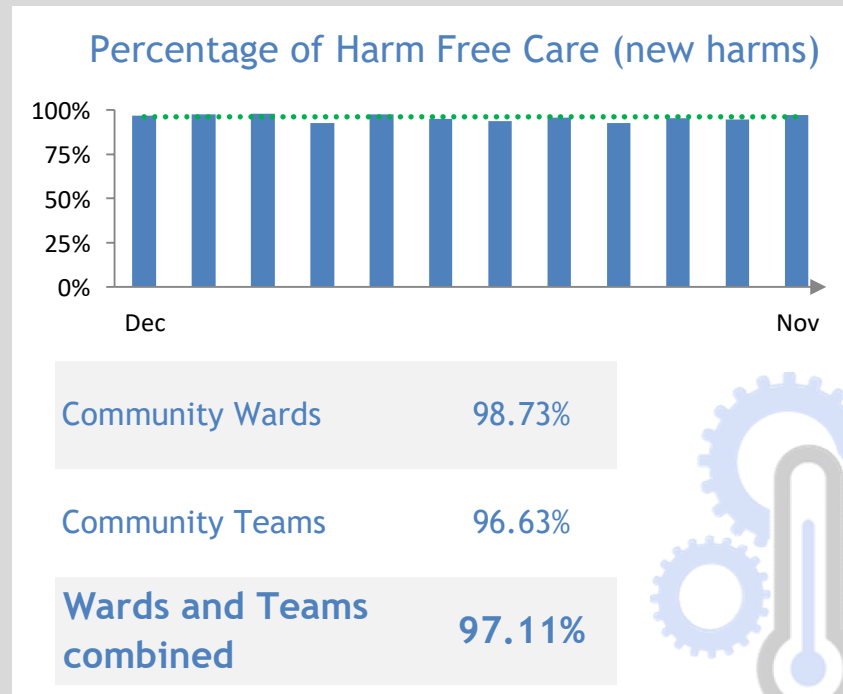


### Avoidable Pressure Ulcers



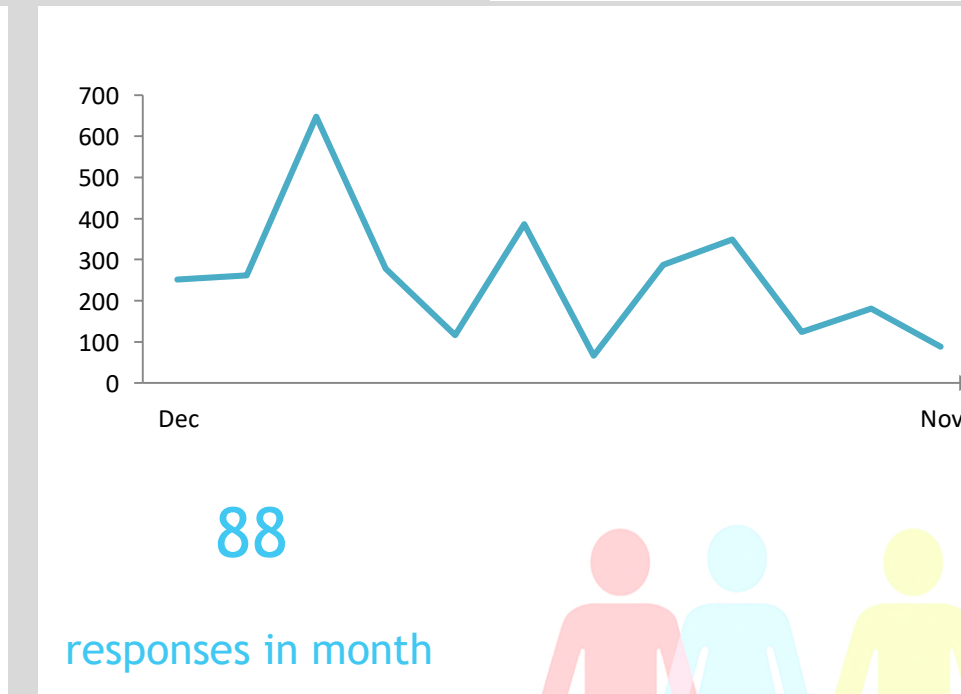
This graph shows the total verified Category III and IV avoidable pressure ulcers.

### Safety Thermometer



Concerns highlighted with senior managers regarding low submission rates.

### Friends and Family Test



### Inpatient assessments

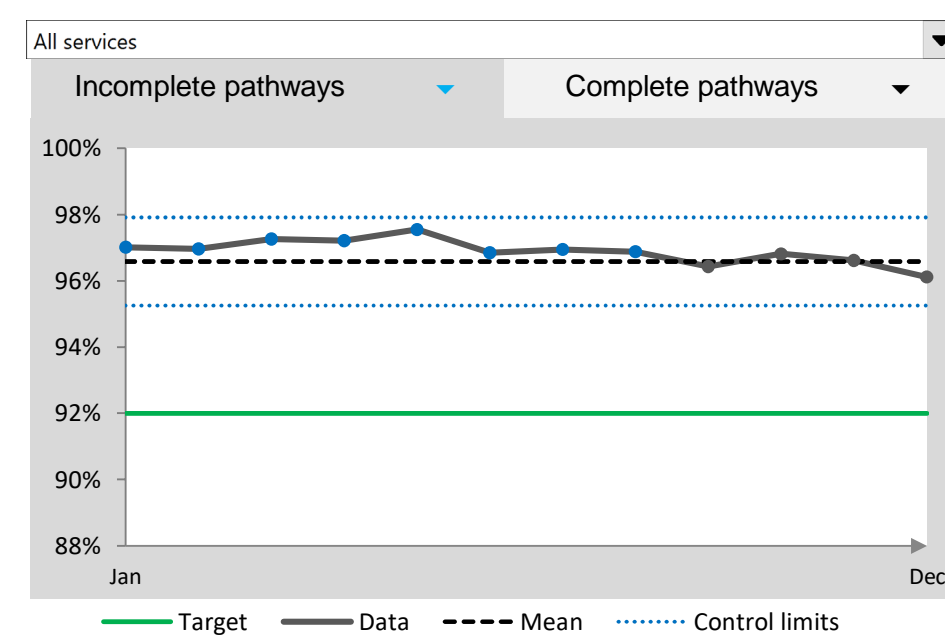
All wards

Oct-18 Nov-18

Early Warning Score	100%	100%
VTE assessment	100%	99%
VTE prophylaxis	100%	100%
Hospital Acquired Thrombosis	0	0
Falls assessment	96%	96%
MUST assessment	99%	96%



## RTT

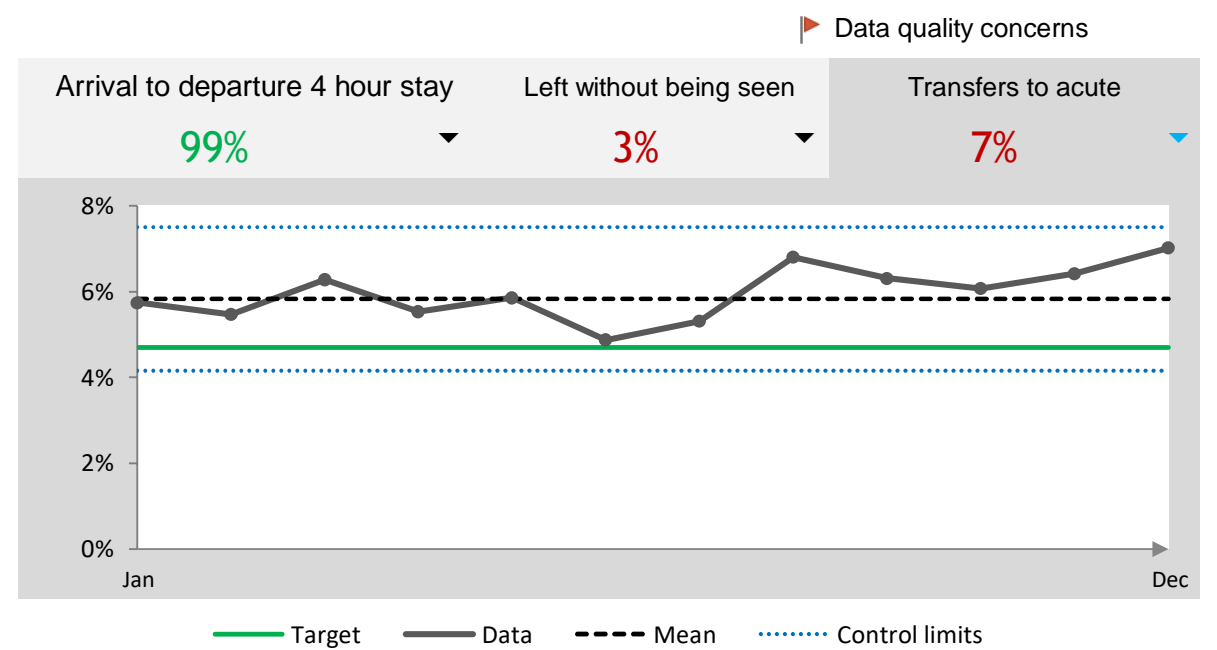


## Incomplete pathways month end position

	% under 18 weeks	Breaches
Community Teams	89%	155
Continence service	98%	6
LD	64%	21
Outpatient Physio	100%	11
Podiatry	100%	2
Wheelchair service	87%	43
WON	100%	2

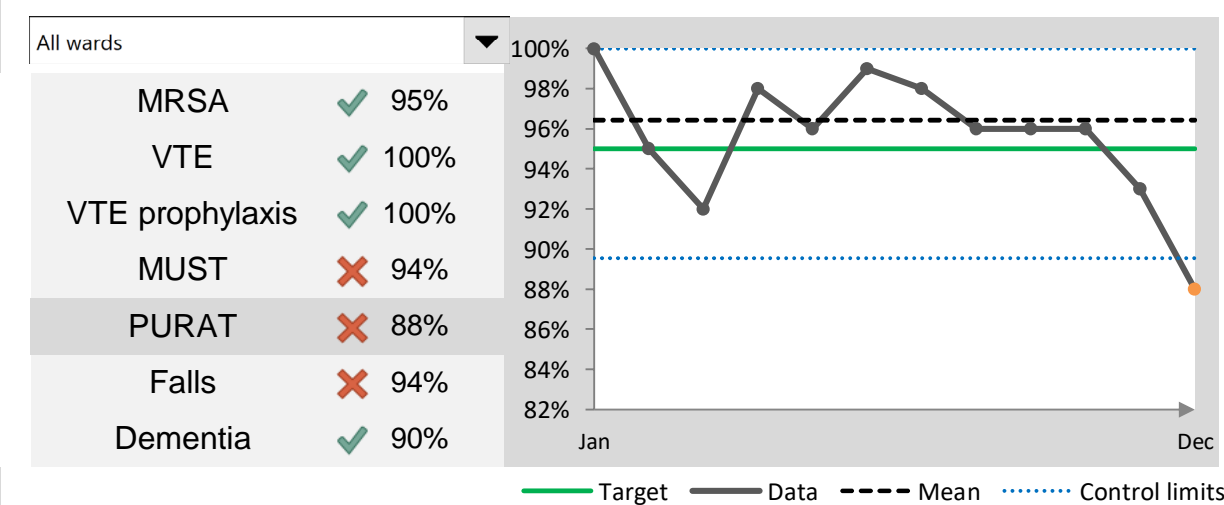
	On target	Action	
Normal variation	✓	No action needed	15 of the LD breaches are for AWP psychology, with 6 others awaiting other parts of the service. Orthotics show declining performance - capacity pressures at Chippenham. Some data quality issues in the incomplete Diabetes data being addressed.

## MIU



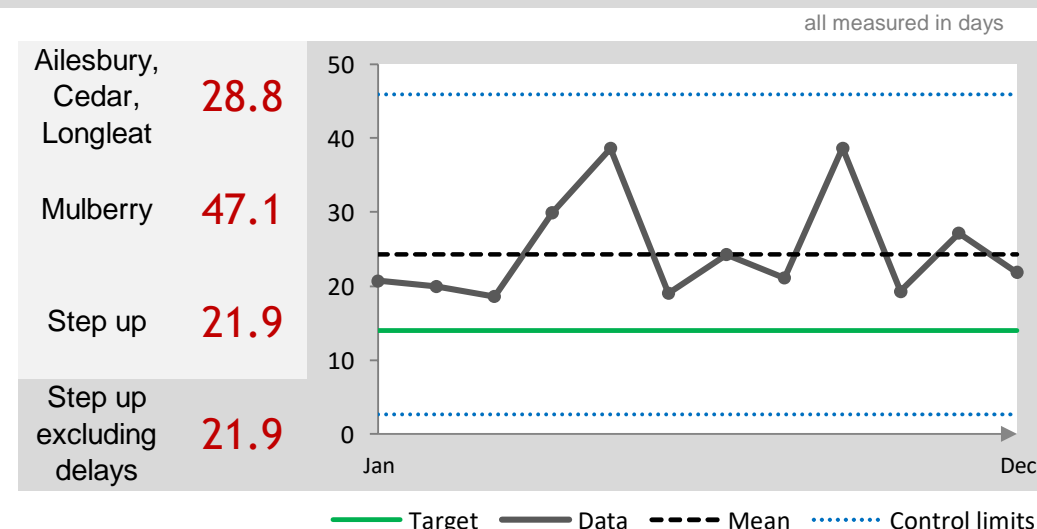
	On target	Action	
Normal variation	✗	Action needed	4 hour performance still well above target.

## Inpatient assessments



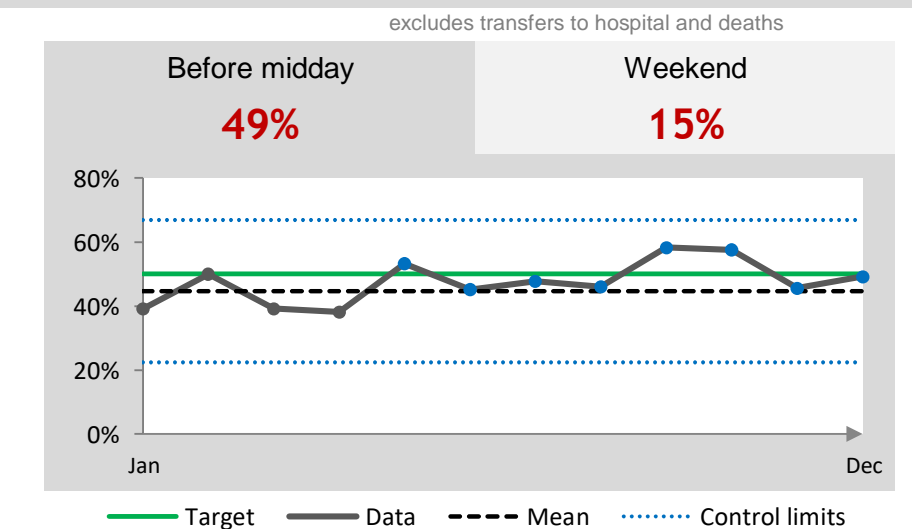
	On target	Action	
Notable variation	✓	Action needed	A number of measures below target this month.

## Mean Inpatient Length of Stay



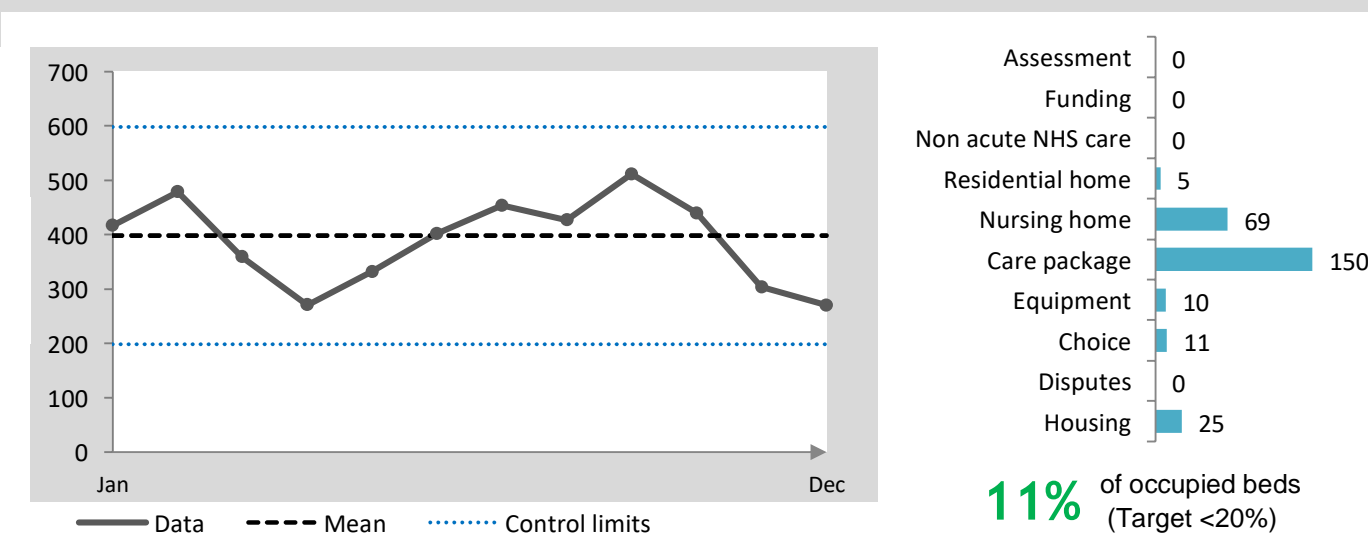
	On target	Action	
Normal variation	✗	Action needed	Action ongoing.

## Discharge timings



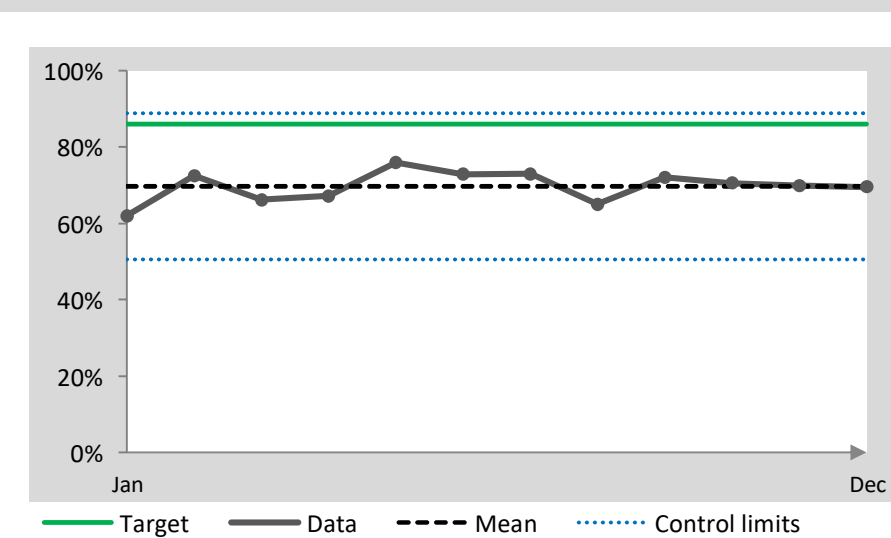
	On target	Action	
Notable variation	✗	Action needed	Continuing challenge. Significant improvement in before midday discharge performance.

## Delayed Transfers of Care - bed days lost



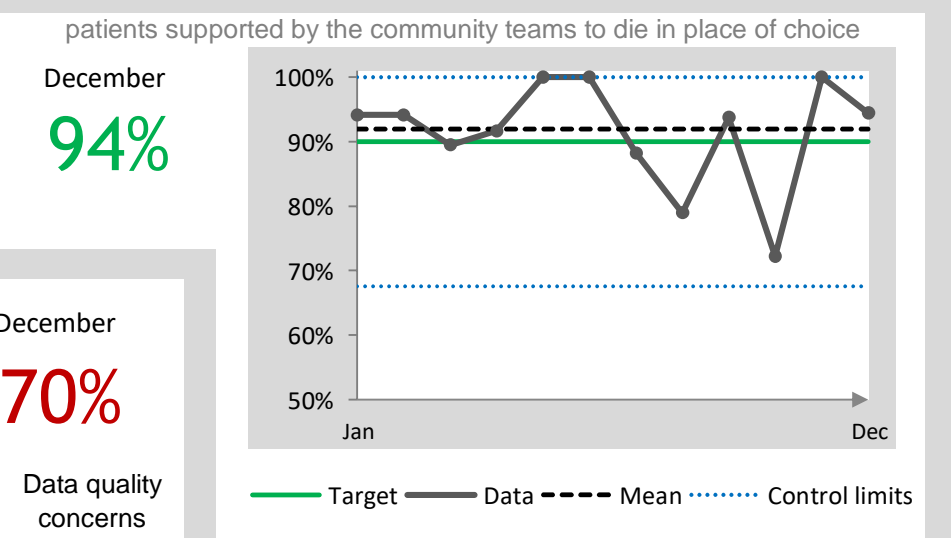
	On target	Action	
Normal variation	✓	No action needed	Process changes in December 2017 had a significant impact on the number of days lost to delays each month. Recent months show an increase in delayed days although system currently showing as in control and on target.

## Community teams 90 day reablement



	On target	Action	
Normal variation	✗	Action needed	All teams using new method of data recording for Home First which will filter into this reablement data over the next 3 months. Then we will be able to properly review performance against this indicator.

## End of life support



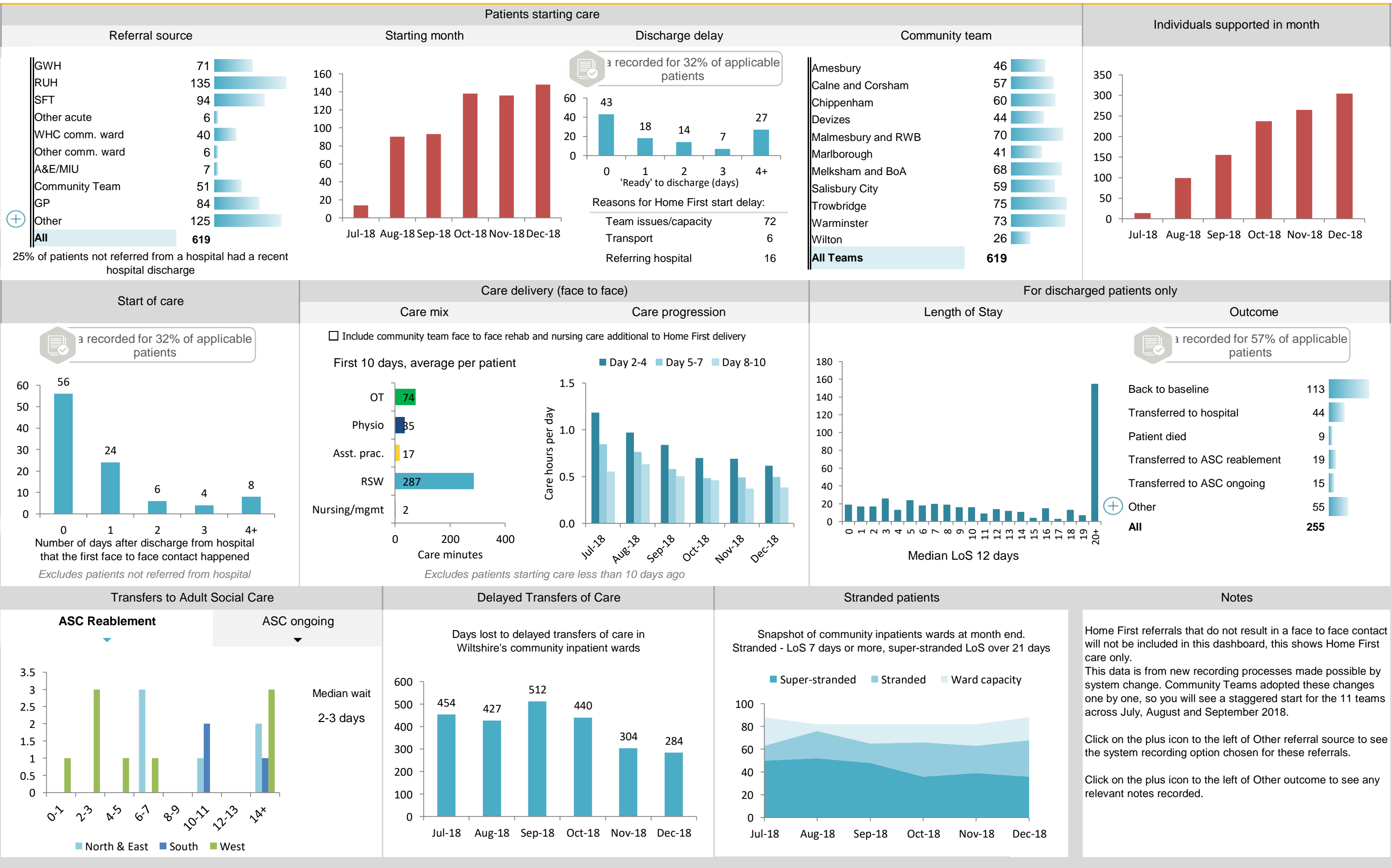
	On target	Action	
Normal variation	✓	No action needed	Excellent performance

Home First

Please Select > In Month  
Previous 6 months

This report has 3 controls, allowing you to filter the data you see. The controls are for referral source, community team, and an in month/previous 6 months option. Anything selectable has double lines to the left hand side. It is recommended you start by viewing data for all teams and all referral sources.

Current Selection: All Teams Referral Source: All Time scale: Previous 6 months



Transfers to Adult Social Care

ASC Reablement

ASC ongoing

Median wait 2-3 days

Delayed Transfers of Care

Days lost to delayed transfers of care in Wiltshire's community inpatient wards

Stranded patients

Snapshot of community inpatients wards at month end. Stranded - LoS 7 days or more, super-stranded LoS over 21 days

Notes

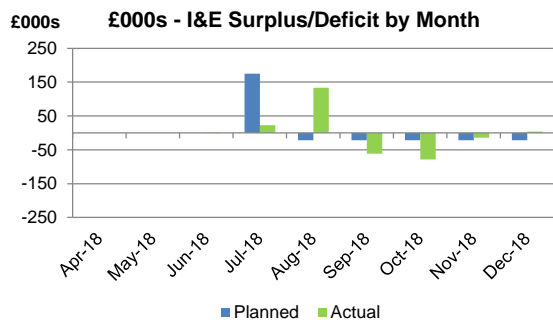
Home First referrals that do not result in a face to face contact will not be included in this dashboard, this shows Home First care only.

This data is from new recording processes made possible by system change. Community Teams adopted these changes one by one, so you will see a staggered start for the 11 teams across July, August and September 2018.

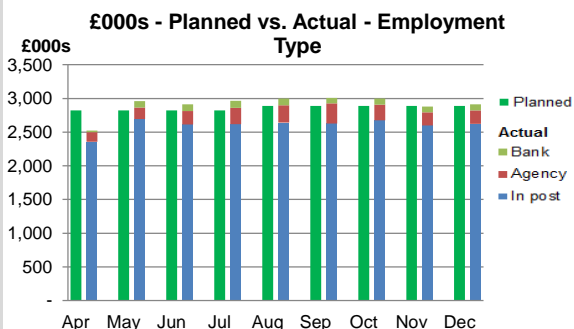
Click on the plus icon to the left of Other referral source to see the system recording option chosen for these referrals.

Click on the plus icon to the left of Other outcome to see any relevant notes recorded.

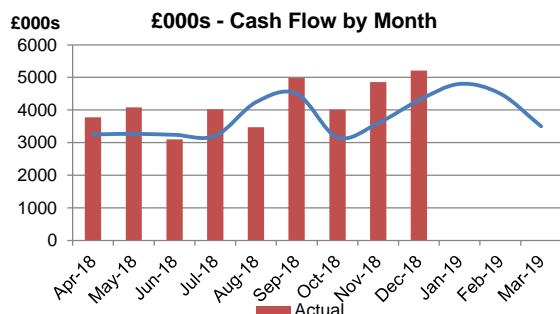
## Income &amp; Expenditure



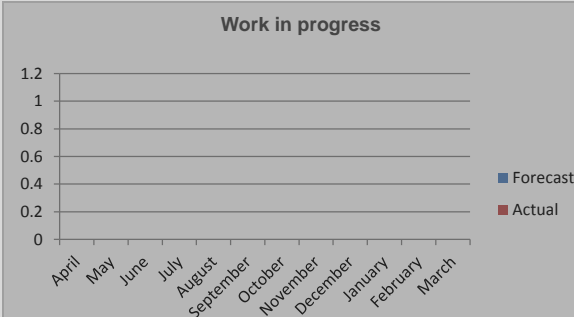
## Pay Expenditure - £ - Employment Type



## Cash



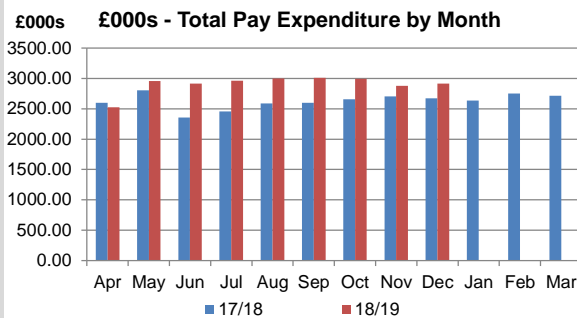
## Forecast



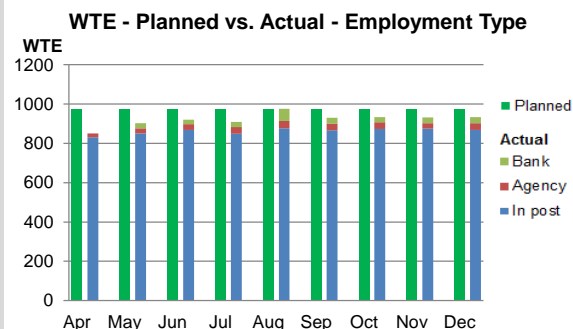
## Cost Improvement Plan (CIP)

	YTD (Cumulative)			Annual Plan £000s	Annual Forecast £000s
	Plan £000s	Actual £000s	Variance £000s		
<b>WH&amp;C 2018/19 Savings</b>					
Income	15	31	16	20	
Pay	742	246	(496)	990	
Non-Pay	223	466	242	298	
<b>Total income</b>	<b>980</b>	<b>743</b>	<b>(238)</b>	<b>1,307</b>	<b>1,307</b>

## Pay Expenditure - £ - Total



## Pay - WTE



## Best Practice Payment Code (BPPC)

BPPC % of bills paid in target	Current Month	Previous Month	Movement
By number	88%	90%	(2%)
By value	99%	98%	1%
<b>Average number of days to pay an invoice</b>			
Days	18	22	(4)

## NHSI Reporting

Metric	Definition	YTD	
		Plan Number	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			

## Commentary

**Overall:** The LLP reports a favourable £26k variance against the plan in December and a (£60k) adverse year to date variance against the plan of £66k surplus. The LLP continues to forecast a breakeven year end position as at December. The main trends continue, with community and specialist services reporting favourable financial positions, which is offset by the deficit reported for the wards and Minor Injury Units.

**Positives:** The overall financial and cash position remains strong. The data quality issues within the general ledger continue to improve.

**Negatives:** Agency expenditure, has increased in the month, and remains above funded vacancy levels, with the need for close support continuing.

Recurrent saving plans have not been identified to close the gap, which means savings are met with non recurrent under spends.

Estates funding is still to be finalised with Wiltshire CCG, funding adjustments are assumed in the YTD financial position.



## Wiltshire Health and Care Board

For decision

**Subject:** New Risk Management Framework – proposal

**Date of Meeting:** 01 February 2019

**Author:** Katherine Hamilton Jennings

### 1. Purpose

This paper sets out:

- A proposal for a new Risk Management Framework for Wiltshire Health and Care (WHC)

### 2. Background

- On its inception, the services delivered by WHC continued to operate under the risk management system operated by GWH. As part of ensuring a risk management system that better reflects the management of risk in community services, a move to DATIX is planned for April 2019. This is an opportune time to implement a risk management framework that works optimally for WHC services.
- In light of the above, a tailored risk management framework has been written.

### 3. Proposal

- Please see accompanying document, “**WHC Risk Management Framework**”. It is proposed that this framework be implemented at WHC.
- It is proposed that the risk management framework noted above be implemented in a staged manner as set out below:
  - **Project risk approach** – straight away (no change)
  - **Organisational risk approach** – straight away (only minor changes)
  - **Mechanism of surveying for risk through operational scrutiny** – April 2019 (in line with the introduction of the “Combined Dashboard” (quality/ finance/ workforce/ performance data).
  - **Strategic risk approach** - (no change)
- To support the implementation of the above, the Risk and Complaints Manager will “roll out” training to all relevant staff, and a timetable for this is currently being put in place.

#### **4. Recommendation**

The Board is invited to:

- **Consider the proposed approach, and AGREE that it is satisfied that the proposal meets the needs of WHC at this point in time.**

## Impacts and Links

Impacts	
<b>Quality Impact</b>	<p>The proposed new Risk Management Framework contributes to organisational quality objectives of continuously improving –</p> <ul style="list-style-type: none"> <li>- <b>Safety</b></li> <li>- <b>Clinical Effectiveness</b></li> <li>- <b>Patient Experience</b></li> <li>- <b>Workforce</b></li> </ul> <p>This will be achieved by –</p> <ul style="list-style-type: none"> <li>- More regular reviews of the risk register and assessments</li> <li>- SMART actions where risks are identified that will impact on Clinical Effectiveness and Patient Experience.</li> <li>- Triangulation between organisational and operational risks. E.g. the monthly risk monitoring of the 6 operational themes.</li> <li>- Triangulation between complaints and incidents related to the 6 operational themes.</li> </ul>
<b>Equality Impact</b>	<p>The creation of the interim risk register and the eventual implementation of the DATIX risk module will meet the Equality and Diversity Objectives of-</p> <ul style="list-style-type: none"> <li>- <b>Better health outcomes for all.</b> This will be achieved by more robust organisational and operational risk management reporting and monitoring.</li> <li>- <b>Improved patient access and experience.</b> The risk register and the associated assessments will enable rigorous monitoring of risks by key groups and committees within Wiltshire Health and Care.</li> <li>- <b>Empowered engaged and included staff.</b> Operational Teams will have the ability to regularly monitor and assess local risks relevant to their areas.</li> <li>- <b>Inclusive leadership at all levels.</b> The structure of the Risk Management Framework encourages all leaders within Wiltshire Health and Care to monitor and report on risk regularly.</li> </ul>
<b>Financial implications</b>	N/A
<b>Impact on operational delivery of services</b>	Staff will require training from the Risk and Complaints Manager regarding how to record/report and monitor operational risks. January to March 2019.
<b>Regulatory/ legal implications</b>	<p>The proposed new risk approach is in line with the suggestions made by CQC during their inspection in June and July 2017.</p> <p>An easier to use, refined, and tailored system, will provide us with an enhanced level of assurance.</p>
Links	
<b>Link to business plan/ 5 year programme of change</b>	<p>The change in approach to risk management links with the objective in Wiltshire Health and Care's business plan.</p> <p><i>'Going forward, our approach to strategic risk management will change. Specifically, the format and alignment of our strategic, corporate, and service delivery risks will be reviewed as part of a broader project to move to Datix as the new system for reporting incidents and recording risk. During 18/19, the risk management system used by Wiltshire Health and Care LLP for service delivery risks will be upgraded from Ulysses to Datix. When this happens, we plan to simultaneously upgrade the system used for strategic and corporate risks to Datix also.'</i></p>



<b>Links to known risks</b>	N/A
<b>Identification of new risks</b>	N/A

## **Risk Management Strategy and Framework**

**DRAFT – V0.30**

<b>Approved by:</b>	<b>Wiltshire Health and Care Board</b>
<b>Approval date:</b>	<b>TBC 2019</b>
<b>Review date:</b>	<b>TBC 2021</b>

### **1. Contents**

1. Contents.....	1
2. Document Definition .....	2
3. Definition of Risk Management .....	3
4. Responsibilities.....	4
5. Definitions .....	7
6. Risk Management Process: Project Risks .....	10
7. Risk Management Process: Organisational Risks.....	11
8. Mechanism of surveying for risk through operational scrutiny .....	18
9. Risk Management Process: Strategic Risks .....	22
10. Risk Management Tool.....	24
11. Horizon scanning .....	26
12. Risk Appetite.....	27
13. Culture .....	27
14. Resources.....	27
15. Monitoring Compliance and Effectiveness of Implementation.....	28
Appendix A: How to Assess Risk .....	30
Appendix B: Risk Appetite Overview and Statement .....	32

Version:	V0.30
Review due:	[Date] 2021
Document owner:	Katherine Hamilton Jennings, Director of Governance and Company Secretary

## 2. Document Definition

### 2.1 Introduction

Wiltshire Health and Care is committed to implementing the principles of good governance, defined as the system by which the organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet best practice standards in accountability, probity and openness. Wiltshire Health and Care recognises that the principles of governance must be supported by an effective risk management system.

Failure to implement a strategy for managing risk could have a severe impact on Wiltshire Health and Care's ability to delivery safe and effective care, the health and safety of staff and visitors, financial control, and reputation. It would also be a breach of Wiltshire Health and Care's statutory obligations, and could also have serious financial consequences. Wiltshire Health and Care's Risk Management Strategy is integral to delivering Wiltshire Health and Care's objectives and annual Business Plan.

### 2.2 Document Description

2.2.1 This is a strategy. A strategy document is defined as a plan of action intended to accomplish a specific goal. All strategies are agreed by the Board of Wiltshire Health and Care.

### 2.3 Purpose

2.3.1 Effective risk management is an essential element in ensuring Wiltshire Health and Care's objectives are achieved and its on-going viability assured. By strategically implementing an effective risk management strategy, Wiltshire Health and Care aims to assure that the management of risk is applied to all aspects of the duties that it undertakes.

2.3.2 This framework document sets out Wiltshire Health and Care's approach to risk management.

2.3.3 The aims of our risk management process are to:

- Assess Wiltshire Health and Care's tolerance for risk, to establish a financial risk appetite within that tolerance, and to ensure that the aggregate exposure to risk remains within both appetite and tolerance.
- Establish a qualitative risk appetite, setting out limits on the activities that the executive management are authorised to take without further recourse to the Board.
- Maintain the delivery of safe and effective care.
- Identify all material adverse outcomes that Wiltshire Health and Care could face (in the context of its financial position, legal and regulatory requirements, impact

Version:	V0.30
Review due:	[Date] 2021
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on the clinical outcomes of patients, reputational damage, impact on health and safety of patients, staff and all those engaging with our services), and to understand and document the risk drivers that could lead to those outcomes.

- Use a consistent framework to assess the probability and impact of these risks, and to prioritise them for action accordingly.
- Triangulate risk management and forecasting with Wiltshire Health and Care's incident management process and patient experience strategy.
- Allocate responsibility to individual managers for the management of each risk, and for operation of associated management controls and implementing agreed actions.
- Gather and document assurance that the controls against each risk are in place and effective, and provide an evaluation of that assurance for the Board in terms of the level of operational management, internal, and external oversight (the three lines of defence model). As part of this process – support Wiltshire Health and Care to understand gaps in assurance or control.
- Monitor changes in the risks and their drivers, regularly re-assessing and responding accordingly.
- Ensure that arrangements to manage risks and mitigate their effects are implemented and maintained.
- Identify future scenarios that could affect the financial performance of Wiltshire Health and Care and the achievement of its objectives.
- Consider the effect on individual risks and the overall risk profile of Wiltshire Health and Care, arising from all strategic decisions, including new business.

## 2.4 Scope

- 2.4.1 This document applies to all Wiltshire Health and Care employees and those that work for Wiltshire Health and Care but are not directly employed by our organisation such as agency, locum, volunteers and students (this list is not exhaustive). It also applies to those people working for Wiltshire Health and Care through service level agreements.

## 2.5 Regulatory position

- 2.5.1 This strategy provides a structured approach to the management of risk as required by the NHS Resolution and NHS Improvement.

## 3. Definition of Risk Management

- 3.1 Risk management is a systematic and cyclical process, in which potential risks are identified, assessed, managed, monitored and reviewed. It is applicable at all levels – corporate, service, team and individual.

Version:	V0.30
Review due:	[Date] 2021
Document owner:	Katherine Hamilton Jennings, Director of Governance and Company Secretary

### 3.2 Risk management is a proactive approach which:

- Identifies the various activities of the organisation;
- Identifies the hazards that exist within those activities and the risks associated with those hazards;
- Assesses those risks for likelihood and potential impact;
- Eliminates the risks that can be eliminated;
- Reduces the effect of those risks that cannot be eliminated;
- Acknowledges those risks that can be accepted;
- Seeks to engage with staff to understand risks and explain tolerated risks; and
- Regularly monitors and reviews all risks.

## 4. Responsibilities

### 4.1 The table below sets out the responsibilities for risk management within Wiltshire Health and Care.

Position	Responsibilities
<b>Wiltshire Health and Care Board</b>	<ul style="list-style-type: none"> <li>▪ Overarching accountability for risk.</li> <li>▪ Confirms that Wiltshire Health and Care has an effective, appropriate, robust, and prudent business planning, risk, and controls framework (annually).</li> <li>▪ Ratifies the Risk Management Strategy.</li> <li>▪ Approves Wiltshire Health and Care's Risk Appetite Statement (annually).</li> <li>▪ Reviews the Board Assurance Framework (twice a year) – to ensure that strategic risks are appropriately controlled and managed.</li> <li>▪ Ensures Wiltshire Health and Care's management team manages risk within the defined risk appetite approved by the Board.</li> <li>▪ Reviews organisational risks scoring 15+ (quarterly).</li> <li>▪ May refer oversight of specific clinical risks to the Quality Assurance Group (which in turn will provide assurance back to the Board on the management of those specific risks).</li> </ul>
<b>Executive Committee</b>	<ul style="list-style-type: none"> <li>▪ Reviews the Board Assurance Framework (twice a year) – to ensure that strategic risks are appropriately controlled and managed.</li> <li>▪ Scrutinises and challenges: <ul style="list-style-type: none"> <li>○ 16+ project risks (at a frequency agreed by the Executive Committee dependant on the</li> </ul> </li> </ul>

4

Version:	V0.30
Review due:	[Date] 2021
Document owner:	Katherine Hamilton Jennings, Director of Governance and Company Secretary

	<p>nature of the project)</p> <ul style="list-style-type: none"> <li>○ 12+ <b>organisational</b> risks (quarterly)</li> <li>○ All <b>organisational</b> risks (annually)</li> </ul> <p>to oversee and ensure that risks are being appropriately controlled and managed.</p> <ul style="list-style-type: none"> <li>▪ Surveys to identify any <b>organisational</b> or <b>strategic</b> risks that have not otherwise been identified.</li> <li>▪ Checks that risks are scored appropriately and consistently in accordance with the 'How to Assess Risk' document (<a href="#">Appendix A</a>).</li> </ul>
<b>Operational Planning and Performance Committee</b>	<ul style="list-style-type: none"> <li>▪ Acts to survey the "Combined Dashboard" (a dashboard setting out monthly performance, finance, quality, and workforce data), alongside an assessment of risk posed by six key areas affecting the provision of safe and effective services by each operational team/service. Is responsible for ensuring that any risks identified during this process are managed appropriately, and where relevant these are recorded on the organisational risk register.</li> <li>▪ Is the responsible group for overseeing all organisational risks of an operational nature with a risk score up to 11. It will also receive all risks up to 11 from the risk oversight groups via highlight reports, and consider these and provide feedback.</li> <li>▪ Assures the Executive Committee that risks of an operational nature are being managed appropriately, and alerts the Executive Committee if operational risks cannot be controlled.</li> </ul>
<b>IG Policy &amp; Oversight</b>	<ul style="list-style-type: none"> <li>• Oversees organisational risks aligned with the sub-groups speciality area.</li> <li>• Is responsible identifying new risks relevant to the speciality area, and where relevant these are recorded on the organisational risk register.</li> <li>• As applicable, acts as the responsible group for overseeing risks with a risk score up to 11. All risk oversight groups will include risk updates to the Operational Performance and Planning committee.</li> <li>• Assures the Executive Committee that risks aligned to the particular sub-group are being managed within appropriate levels, and alerts the Executive Committee if certain risks cannot be controlled.</li> </ul>
<b>Workforce Development Policy &amp; Oversight</b>	
<b>Medicines Management</b>	
<b>H&amp;S</b>	
<b>Harm free care</b>	
<b>Safeguarding</b>	
<b>IPC</b>	
<b>E&amp;D Group</b>	
<b>Team leaders/ Heads of Service</b>	<ul style="list-style-type: none"> <li>▪ Perform monthly reviews of the key risk areas affecting their service/team.</li> </ul>
<b>Project Executive Leads</b>	<ul style="list-style-type: none"> <li>▪ Works with the project manager and members of the project team to identify and ensure that there are appropriate actions in place to effectively manage</li> </ul>

	<p>project risks.</p> <ul style="list-style-type: none"> <li>▪ Report significant project risks to the Executive Committee.</li> <li>▪ Work with the project manager and members of the project team to take informed decisions about whether to escalate any significant project risks into an <b>organisational</b> or <b>strategic</b> risk.</li> </ul>
<b>Project Managers</b>	<ul style="list-style-type: none"> <li>▪ Supports Project Executive Leads to manage project risks.</li> </ul>
<b>Director of Finance</b>	<ul style="list-style-type: none"> <li>▪ Ensures the financial plan is reviewed at least annually to determine the level of Wiltshire Health and Care's risk capacity.</li> <li>▪ Undertakes a sensitivity analysis in relation to the financial plan at least annually.</li> </ul>
<b>Company Secretary</b>	<ul style="list-style-type: none"> <li>▪ Defines, and propose updates to, the organisation's Risk Strategy for agreement by the Board.</li> <li>▪ Oversight of the implementation of the organisation's Risk Strategy.</li> </ul>
<b>Risk and Complaints Manager</b>	<ul style="list-style-type: none"> <li>▪ Responsible for overseeing the Implementation of the organisation's Risk Strategy. Ensures organisational understanding of this Risk Strategy.</li> <li>▪ Leads regular review workshops with senior managers and other groups as required.</li> <li>▪ Supports staff members to report on risk in accordance with the reporting schedule in this framework.</li> <li>▪ Provides risk training as required.</li> </ul>

## 5. Definitions

### Issues and Risks

5.1 Risks can be distinguished from issues in the following way:

An issue is something that IS happening and a risk is something that MIGHT happen.

With an issue, you must figure out how to resolve it now so you can move forward.

With a risk, you establish mitigation plans that will (hopefully) eliminate the possibility of the risk occurring or reduce the impacts if it does occur.

Once a risk occurs, it becomes an issue. However, there may remain the risk of something happening again.

### Control and Actions

5.2 Risk management processes may be broadly divided into controls and actions.

- **Controls** - Controls are on-going activities, sometimes operating at a regular frequency, sometimes triggered by a specific event that is expected to remain in place for the foreseeable future.
- **Actions** – Actions are projects or tasks that have a clear beginning and end; they may involve the implementation of an additional control or perhaps a strategic change, such as withdrawal from a particular activity.

### Risk Appetite

5.3 Our Board has the responsibility to govern Wiltshire Health and Care in the interests of our patients, members, and the local health economy.

Part of this responsibility is to:

- Decide the objectives and strategic direction for Wiltshire Health and Care.
- Approve the detailed Business Plan proposed by the Executive Team in collaboration with the staff and volunteers of Wiltshire Health and Care, and to review the implementation of that plan.

Wiltshire Health and Care's Board is responsible for ensuring that the organisation's strategic objectives are achieved without the organisation spending more money than our commissioner(s) allocate to the organisation 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 Wiltshire Health and Care 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 the 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**.

Whilst the Board has overall responsibility for risk, all services areas within Wiltshire Health and Care will be supported to understand Risk Appetite and Tolerance to ensure that our service delivery aligns with these.

## Risk Tolerance

- 5.4 **Strategic Risk Tolerance** – Risk Tolerance in the context of strategic risks 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

- 5.5 Risk Capacity is the maximum amount of risk (typically financial) that Wiltshire Health and Care could be exposed to without putting its viability at stake.

## Risk Exposure

- 5.6 Risk Exposure is the current amount of risk being taken.

## Risk Assessment

- 5.7 All staff members are accountable for identifying and managing risk and are trained as part of their process of induction to complete risk assessments. Staff will also have access to the How to Assess Risk document ([Appendix A](#)). If the staff member still feels they are not able to adequately assess the risk themselves, they should report the risk to their line manager. The line manager will then conduct the risk assessment and consider if further training is required. The Risk and Complaints Manager will also be available to support any staff members in assessing a risk.

## Risk Scoring

- 5.8 Wiltshire Health and Care uses the National Patient Safety Agency (NPSA) Risk Management Matrix scoring methodology to assess the potential size of the risks identified.
- 5.9 This process takes into account the fact that the expected losses that could occur from an adverse event depend on the:
- Probability that the risk will materialise, “likelihood”.
  - Size of the loss if the risk were to materialise, “impact”.
- 5.10 These two values are multiplied to create an overall risk score (1-25).

- 5.11 Risks are scored in accordance with their categorisation and the scoring scheme tabulated in [Appendix A](#).
- 5.12 The purpose of scoring is to identify those risks that are of greatest concern, and to allow trends and changes to be monitored between reviews.
- 5.13 The current risk score is decided first. This reflects the risks to the operations/organisation with the present mitigations in place.
- 5.14 A target risk score is subsequently determined. This is the score that those owning the risk are aiming to achieve by completing a set of actions that are also recorded in the risk register.

### Types of risk

- 5.15 The risks identified and managed under this framework can be grouped under one or more of the following headings:

#### A. Project risks

#### B. Organisational risks

#### C. Strategic risks

#### • A. Project Risks

Project risks are risks that are identified at project management level, and are defined as those which impact directly on the success or failure of a particular project being undertaken.

#### • B. Organisational Risks

Organisational risks are risks that affect Wiltshire Health and Care fulfilling its contractual, statutory, and regulatory obligations to provide safe and effective care to the population of Wiltshire.

The risks falling into this category are those that have an organisational-level impact. The risk themes for organisational risks are:

1. Financial
2. Quality (Patient Safety, Clinical effectiveness, Patient experience)
3. Legal/ Regulatory compliance
4. Reputational
5. Health, Safety, Fire, and Security

#### • C. Strategic Risks

Strategic risks are risks that affect Wiltshire Health and Care achieving the specific strategic objectives set out in its Business Plan or otherwise agreed by its Board.

## 6. Risk Management Process: Project Risks

### Oversight of Project Risks

- 6.1 Project risks are managed within the project management process throughout the life of a project, and are not placed on Wiltshire Health and Care's main risk register.
- 6.2 Where the success or failure of a project poses a risk to Wiltshire Health and Care achieving one of its strategic aims, this will be recorded on Wiltshire Health and Care's Board Assurance Framework.
- 6.3 Where the implementation of a project poses a risk to the day to day running of the business of Wiltshire Health and Care, this should be added to the organisational risk register, and managed as an organisational risk. Such risks will usually have been considered prior to the initiation of a project, and a decision made by the Executive Committee that the benefits of implementing the project outweighed the risks caused by implementing the project. The effectiveness of the controls to mitigate the risks of implementing the project will have been considered as part of this exercise.
- 6.4 Where project risks are ranked highly after mitigation (i.e. project risks actively scoring 16+), these will be reported to the Executive Committee at a frequency agreed by the Executive Committee (which may vary from project to project). It will be the responsibility of the Executive Lead overseeing the project to ensure that significant Project risks are escalated to the Executive Committee.
- 6.5 Where project risks are escalated to the Executive Committee, the Executive Committee will consider the actions being taken to mitigate those risks, and may direct that additional/alternative actions are taken.
- 6.6 Project risks may be reported to the Operational Planning and Performance Committee in a manner and at a frequency deemed appropriate by the Executive Committee.

### Project Risk Oversight

Oversight	Level of oversight	Frequency
<b>Project managers</b>	All	At least monthly
<b>Operational Planning and Performance Committee</b>	As applicable	As applicable
<b>Executive Committee</b>	16+	As agreed by the Executive Committee to ensure the risks are de-escalated as soon as possible. At least quarterly.

## 7. Risk Management Process: Organisational Risks

### Identifying organisational risks

7.1 All staff members will be responsible for identifying organisational risks.

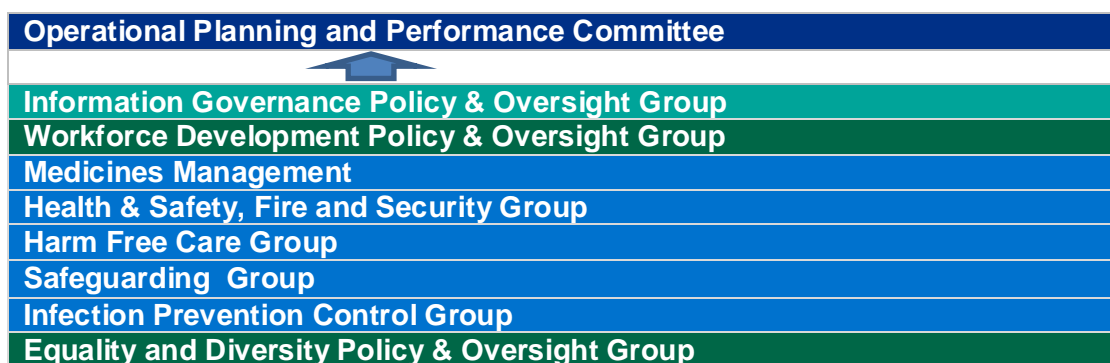
### Documenting organisational risks

7.2 Each organisational risk will have the following data set:

- Reference number
- Date risk added to the risk register
- Risk categorisation
- Theme of the root cause
- Risk consequence description
- Factors contributing to the risk
- Current risk score
- Target risk score
- Risk owner
- Key control(s)
- Monitoring group/ committee
- Action(s) to mitigate the root cause/ factors contributing to the risk, with due dates, progress reports, and action leads

### Risk oversight groups

7.3 The following are Wiltshire Health and Care's risk oversight groups. These groups oversee the management of risks up to 11.



### Organisational risk categorisation

7.4 Risks are categorised under the most relevant of the following headings:

Risk category	Detail
Financial	<ul style="list-style-type: none"> <li>• If the risk were to materialise, it would impact significantly on Wiltshire Health and Care's income or expenditure, our ability to access sufficient funding, or our ability to</li> </ul>

	otherwise maintain our financial viability.
<b>Quality (Patient Safety, Clinical effectiveness, Patient experience)</b>	<ul style="list-style-type: none"> <li>If the risk were to materialise, it would directly impact the quality of service Wiltshire Health and Care offers to patients.</li> </ul>
<b>Legal/ Regulatory compliance</b>	<ul style="list-style-type: none"> <li>If the risk were to materialise, Wiltshire Health and Care would fail to comply with one or more legislative or regulatory requirement.</li> </ul>
<b>Reputational</b>	<ul style="list-style-type: none"> <li>If the risk were to materialise, Wiltshire Health and Care's reputation and brand may be negatively impacted, leading to reduced patient, commissioner, staff, or partner satisfaction, or the loss of opportunity to work with others.</li> </ul>
<b>Health, Safety, Fire, and Security</b>	<ul style="list-style-type: none"> <li>If the risk were to materialise, it would affect the health or safety of one or more individuals, such as a member of staff, volunteer, patient, carer, or visitor.</li> </ul>

### Identifying the “theme” of the root cause of the risk

7.5 The root cause of the risk (i.e. the bit that we need to solve to have the greatest impact on lowering the likelihood or severity of the risk), will typically fall into one of six categories:

1. Financial
2. Quality
3. Workforce
4. Governance
5. Infrastructure
6. Operational

### Organisational risk identification and escalation

7.6 Organisational risks must be escalated using the framework below:

<b>1-3 (Low risk)</b>	<ul style="list-style-type: none"> <li>If any staff member identifies an organisational risk that they consider may be of low risk, they must:</li> <li>Add this to Wiltshire Health and Care's risk management tool if they are unable to mitigate the risk immediately. No escalation is required.</li> <li>1-3 risks can be owned by any staff member.</li> <li>Oversight of 1-3 risks is described below.</li> </ul>
<b>4-7 (Moderate risk)</b>	<ul style="list-style-type: none"> <li>If any staff member identifies an organisational risk that they consider may be of moderate risk, they must:</li> <li>Inform their line manager so that their line manager can add the risk to Wiltshire Health and Care's risk management tool – identifying the most</li> </ul>

	<p>appropriate risk owner and risk oversight group.</p> <ul style="list-style-type: none"> <li>• 4-7 risks can be owned by the line manager/team leader.</li> <li>• Oversight of 4-7 risks is described below.</li> </ul>
<b>8-12 (High risk)</b>	<ul style="list-style-type: none"> <li>• If any staff member identifies an organisational risk that they consider may be of high risk, they must inform the most relevant Community Services Manager, Head of Service or senior manager (defined as Band 8A or above for this purpose) as soon as possible. This person will then discuss the risk with Risk and Complaints Manager, who will enter the risk onto Wiltshire Health and Care's risk management tool – identifying the most appropriate risk owner and risk oversight group.</li> <li>• 8-11 risks can only be owned by a Community Services Manager (CSM), Head of Service, or senior manager.</li> <li>• Risks rated 12, must be owned by a member of the Executive Committee.</li> <li>• Oversight of 8-12 risks is described below.</li> </ul>
<b>15+ (Extreme risk)</b>	<ul style="list-style-type: none"> <li>• If any staff member identifies an organisational risk that they consider may be extreme, they must inform their line manager straight away, who will inform a member of the Executive Committee urgently. If the risk is identified out of hours, please see the red box below.</li> <li>• The risk will be discussed at Executive level, and added to Wiltshire Health and Care's risk management tool where it cannot be resolved that day – identifying the most appropriate risk owner (all 15 plus risks are monitored by the Board).</li> <li>• 15+ risks can only be owned by a member of the Executive Committee.</li> <li>• Oversight of 15+ risks is described below.</li> </ul>
<b>20+ (Catastrophic risk)</b>	<ul style="list-style-type: none"> <li>• If any staff member identifies an organisational risk that they consider may be catastrophic, they must inform their line manager straight away, who will inform a member of the Executive Committee urgently. If the risk is identified out of hours, please see the red box below.</li> <li>• The risk will be discussed at Executive level, and added to Wiltshire Health and Care's risk management tool where it cannot be resolved that day – identifying the most appropriate risk owner</li> </ul>

	<p>(all 15 plus risks are monitored by the Board).</p> <ul style="list-style-type: none"> <li>• 20+ risks can only be owned by a member of the Executive Committee.</li> <li>• For any organisational risk identified with a score of 20+, an action plan to mitigate and reduce this risk must be urgently agreed at Executive level. The Board will be notified of the identification of the risk, and the action plan to address the risk on an urgent basis.</li> <li>• Oversight of 20+ risks is described below.</li> </ul>
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Where there is an **immediate risk to the health and wellbeing of patients**, staff or visitors, this should be escalated immediately. If outside of normal working hours, the risk should be reported to the on-call manager for assistance.

## Oversight of organisational risks

7.7 All staff members will be responsible for identifying organisational risks.

	Risk Score	Method of oversight	How oversight is carried out	Review frequency
	Up to 8	Managed at team level, with support from the Risk and Complaints Manager	<p>Risk managed locally.</p> <p>Once a quarter the Risk and Complaints Manager will meet with the risk holder to:</p> <ul style="list-style-type: none"> <li>• Review the organisational risks assigned to the risk owner.</li> <li>• Identify any new or emerging risks affecting that area of the business.</li> <li>• Review the controls in place to mitigate these risks.</li> <li>• Consider what assurances are being received against the controls.</li> <li>• Identify any actions required to build additional controls or assurances.</li> <li>• Where a risk review identifies that a risk that is presently being managed as an “up to 8” risk should be escalated to an “8-12” risk, the Risk and Complaints Manager will facilitate a conversation to ensure that the risk is appropriately reassigned so that it is owned by a Community Services Manager (CSM), Head of Service, or senior</li> </ul>	<p>At least monthly</p> <p>Quarterly</p>



		manager, and that the risk is overseen by an appropriate monitoring group.	
8-11	Operational Planning & Performance Committee	Each organisational risk that is 8-11, will be assigned to one of WHC’s specialist groups for oversight and action. The Operational Planning and Performance Committee will have oversight for all risks scoring 8 – 11 that are being managed by the various sub groups	At least quarterly
	IG Policy & Oversight		
	Workforce Development Policy & Oversight	The group to which the risk is assigned for oversight will depend on the theme of the root cause of the risk.	
	Medicines Management	The relevant specialist group will be responsible for reviewing the 8-11 risks applicable to their area of expertise, and:	
	H&S		
	Harm free care	<ul style="list-style-type: none"><li>Identifying issues, themes and trends common across the risks in that specific area;</li></ul>	
	Safeguarding		
	IPC		
E&D Group	<ul style="list-style-type: none"><li>Considering the success/ effectiveness of the mitigating actions associated with the presenting risks, and whether further/ alternative actions need to be taken.</li><li>Escalating any concerns to the Executive Committee.</li></ul>		
12+	Executive Committee	12+ organisational risks will be formally reviewed by the Executive Committee on a quarterly basis.  The Executive Committee will: <ul style="list-style-type: none"><li>Scrutinise and challenge the 12+ risks.</li><li>Consider whether any of the 12+ risks are likely to have an impact on Wiltshire Health and Care achieving its strategic objectives - therefore justifying an addition or amendment to the organisation’s strategic risk register (i.e. consider risks for escalation to the Board Assurance Framework).</li><li>Ensure that relevant information relating to risk actions and controls are identified, captured, and communicated to the people who</li></ul>	Quarterly



		<p>need it.</p> <ul style="list-style-type: none"><li>• Report to the Board on the 15+ risks quarterly.</li><li>• Update the Board on progress against the actions being taken to mitigate the 20+ risks weekly (or as frequently as agreed by the Board).</li></ul> <p>Where the Executive Committee considers that a 15+ risk should be accepted, this should be reported to the next Board by the Chair of Executive Committee, for formal agreement that the 15+ risk can be accepted with no further action to be taken.</p>	
All	Executive Committee	All organisational risks will be scrutinised and challenged by the Executive Committee once a year.	Once a year
15+	Board	<p>A risk report setting organisational risks rated 15+ will be reviewed by the Board on a quarterly basis.</p> <p>The Board will:</p> <ul style="list-style-type: none"><li>• Challenge and hold the executive to account in relation to the management of the risks – particularly if any of these are outside of the risk appetite, or approaching the risk tolerance.</li></ul>	Quarterly
All	Board	All corporate risks will be presented to the Board once a year as a measure (barometer) of the overall health of the organisation.	Once a year

**Diagram 3: Organisational Risk Oversight**

Oversight	Level of oversight	Frequency
Risk owner	Up to 8	At least monthly
Operational Performance and Planning Committee Risk oversight groups	8-11 ( <i>formally</i> )	Every meeting (i.e. at least quarterly)
Executive Committee	12 and above	Quarterly
	All	Annually

Board	15 and above	Quarterly
	All	Annually

## 8. Mechanism of surveying for risk through operational scrutiny

### Overview

- 8.1 To support the identification of risks, Wiltshire Health and Care will implement a mechanism of surveillance that is linked to the data circulated to staff in the '**Combined Dashboard**' (a dashboard sent to all services/ teams, comprising performance, finance, quality, and workforce metrics).

There will be a 'Combined Dashboard' for each of the following:

- **Community Teams** (1 dashboard)
- **Intermediate Care Teams** (1 dashboard)
- **MIUs** (1 dashboard)
- **Wards** (1 dashboard)
- **Specialist services** (multiple dashboards - 1 dashboard per specialist service)

### Active consideration of issues impacting operational delivery

- 8.2 To form part of the 'Combined Dashboard', each team/ specialist service will be asked to consider a set of six key operational risk areas (see below) and determine whether there is anything either currently affecting these areas (or imminently about to effect these areas) that has the potential to impact on their team/specialist service being able to deliver services to patients safely and effectively in the next three months.

Key operational risks areas
1. Staffing
2. Training and Development Support
3. Clinical equipment
4. ICT equipment
5. Estates
6. Attitude and behaviour

### How to analyse the operational risk areas

- 8.3 The grid below sets out how to analyse the six key operational potential risk areas:

#	Key operational risks areas	How to analyse the operational risk areas
1	Staffing	To analyse this risk category, consideration should be given to: <ul style="list-style-type: none"> <li>Whether the staffing within the team is sufficient to provide</li> </ul>

18

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		<p>safe and effective care, or whether the situation poses a risk. Consideration should be given to factors such as vacancy levels within the team and whether the staff skills mix is requisite for providing safe care.</p> <ul style="list-style-type: none"> <li>• Risk should be considered in terms of both the current staffing position, and the anticipated staffing position over the next three months (i.e. horizon scanning should be taken into account so that actions can be taken to mitigate upcoming risks.). Consideration should be given to the wellbeing of staff, and any known imminent parental leave or sickness absence.</li> </ul>
2	<b>Training and Development support</b>	<p>To analyse this risk category, consideration should be given to factors such as:</p> <ul style="list-style-type: none"> <li>• Whether staff members within the team have undertaken appropriate training for their role.</li> <li>• Whether there is sufficient capacity within the team for all staff members to receive appropriate 1:1 support.</li> </ul>
3	<b>Clinical equipment</b>	<p>To analyse this risk category, consideration should be given to:</p> <ul style="list-style-type: none"> <li>• Whether the clinical equipment available to the team at the present time (equipment that is permanent or where hired on a long term basis) is sufficient to provide safe and effective care. Or whether the situation poses risk.</li> </ul>
4	<b>ICT</b>	<p>To analyse this risk category, consideration should be given to:</p> <ul style="list-style-type: none"> <li>• Whether the ICT available to the team at the present time is sufficient to carry out the tasks of the team to enable the provision of safe and effective care. Or whether the situation poses risk.</li> </ul>
5	<b>Estates</b> <i>(the building(s) that you work in)</i>	<p>To analyse this risk category, consideration should be given to:</p> <ul style="list-style-type: none"> <li>• Whether the physical infrastructure available to the team sufficient to provide safe and effective care. Or whether the situation poses risk.</li> </ul>
6	<b>Attitude and Behaviour</b>	<p>To analyse this risk category, consideration should be given to:</p> <ul style="list-style-type: none"> <li>• Whether the culture in the team represents Wiltshire Health and Care's Values and Behaviours. Whether there are any risks to safe and effective care posed by attitudes and behaviours of staff.</li> </ul>

8.4 For each key operational risk area (staffing, training and development, clinical equipment, ICT equipment, estates, attitudes and behaviour), each team/ specialist service will analyse the data that is made available to them via the 'Combined Dashboard' for their service, and combine this with "soft intelligence" (i.e. information that is known to the team leaders that is not necessarily part of the dashboard – for example, knowledge of staff members due to go on maternity leave, behaviours of

staff, wellbeing indicators not currently forming part of any Wiltshire Health and Care data collection), to comprehensively determine an appropriate Red-Amber-Green (RAG) rating.

The following three categories will be used:

<b>Green</b>	The key operational risk area presents <u>no</u> risk to the team/service being able to deliver their services to patients in the next three months.
<b>Amber</b>	The key operational risk area presents <u>some</u> risk to the team/service being able to deliver their services to patients in the next three months.
<b>Red</b>	The key operational risk area presents <u>significant</u> risk to the team/service being able to deliver their services to patients in the next three months.

- 8.5 The above information will be presented on the Combined Dashboard as a: “**Service Barometer**” (example below), together with a narrative describing *why* the team believes that there is a risk to them being able to provide their service to patients safely and effectively within the next three months.

<b>Service Barometer</b>	Staffing	ICT	Training & development	Clinical equipment	Estates	Attitude & behaviour
<b>[Community Team, Melksham]</b>	Red	Amber	Amber	Green	Amber	Green
<b>Comments:</b>	[Description for why the team/service considers there is a risk to their ability to provide their service within the next 3 months.]					

There will be a Service Barometer for each team/MIU/ward/specialist service. As such, some ‘Combined Dashboards’ may contain multiple barometers.

A mechanism to ensure that this does not become unwieldy will be implemented where there are a large number of relevant Service Barometers applicable to a Combined Dashboard.

- 8.6 The above approach will ensure that teams consider the data presented to them on their ‘Combined Dashboard’ (which sets out the historic position), and analyse this alongside their soft intelligence (information that they know will impact on future service provision) to ultimately provide a comprehensively informed analysis of potential future risk.

### Triangulation with complaints and incidents

- 8.7 The above six key operational risk areas (staffing, training and development, clinical equipment, ICT equipment, estates, attitudes and behaviour), are also the overarching themes for Wiltshire Health and Care's complaints and incidents. This will allow our organisation to assess the nature of incidents and complaints in one service area, and triangulate this information with the information contained in the Service Barometer.

#### Using the information from the 'Service Barometer' to inform risk reporting

- 8.8 The Combined Dashboards, incorporating the Service Barometers, will be reviewed at the monthly Operational Performance and Planning Committee.
- 8.9 During this monthly review, it will be the role of the Operational Performance and Planning Committee to determine whether there are any new operational risks that need to be managed, and recorded on Wiltshire Health and Care risk register.

## 9. Risk Management Process: Strategic Risks

### What is the Board Assurance Framework?

- 9.1 Wiltshire Health and Care's Board Assurance Framework sets out the risks that have the potential to prevent Wiltshire Health and Care from delivering the strategic objectives detailed in its annual Business Plan, together with the plans to manage those risks within the Risk Appetite.
- 9.2 The Board assurance process ensures that risks to achieving Wiltshire Health and Care's objectives are actively identified and managed.

### When are strategic risks reviewed?

- 9.3 When drafting the annual Business Plan (or updating a multi-year business plan for a subsequent year), the Executive Committee will carry out a robust assessment of the principal risks to Wiltshire Health and Care achieving its strategic objectives, and determine the approach to manage those risk within the Risk Appetite set by the Board. This will be recorded as the Board Assurance Framework for approval by the Board.
- 9.4 Following the Board's approval of the new or updated Business Plan and the accompanying Board Assurance Framework, these documents will be reviewed, with reference to the Risk Appetite, by:
- The Executive Committee, on at least a quarterly basis - for the purpose of ensuring that progress is being made in relation to implementing the mitigating actions.
  - The Board, twice a year – for the purpose of oversight, and assurance.
- 9.5 Any new risks to the strategic objectives of Wiltshire Health and Care identified by the Executive Committee will be taken to the Board for consideration as to whether these are incorporated onto the Board Assurance Framework.

### Diagram 4: Strategic Risk Oversight

Oversight	Level of oversight	Frequency
Executive Committee	All	Quarterly
Board	All	Twice a year

### Documenting strategic risks

- 9.6 Each risk identified in the Board Assurance Framework will have the following data set:

- Reference number
- Date risk added to the risk register
- Nature or theme of the risk
- Risk consequence description
- Factors contributing to the risk
- Current risk score
- Target risk score
- Action(s) to mitigate the root cause/ factors contributing to the risk, with due dates, progress reports, and action leads
- Key control(s)
- Source of assurance on those controls (internal and external)

9.7 The Board Assurance Framework will be reviewed by the Company Secretary who will add details of:

- Positive assurances received since the last review
- Any negative assurances received
- Gaps in control (where identified)
- Gaps in assurances (where identified)

9.8 Based on the assurances received in the preceding quarter the Executive Committee will review the risk score, requesting amendments where necessary.

9.9 A copy of the Board Assurance Framework shall be available from the Company Secretary.

### **Relationship between the Business Plan, Board Assurance Framework, and the Risk Appetite**

9.10 The Board agrees the Risk Appetite for the forthcoming year.

9.11 The Executive Committee drafts the annual Business Plan and considers the strategic risks to the achievement of the objectives within the Business Plan. The Executive Committee considers how to manage those risks to achieving the strategic objectives, and whether it is possible to manage those risks within the Risk Appetite. Where it is not possible to manage those risks within the Risk Appetite, the Board must decide whether to either adjust its Risk Appetite or accept a risk that is within its Risk Tolerance, or adjust the strategic objectives within the Business Plan. The Board will then approve the Business Plan and the related strategic risks and their plan for management – together the Board Assurance Framework.

9.12 A review of the progress against the delivery of the objectives within the Business Plan, and the management of the strategic risks (documented in the Board Assurance Framework) is carried out quarterly by the Executive Committee. The Executive Committee then report this to the Board quarterly.



## 10. Risk Management Tool

### Purpose of the risk management tool

- 10.1 Wiltshire Health and Care uses a risk management tool to enable oversight and scrutiny of risks identified within the organisation, and to ensure mitigating action is taken to reduce the risk. The additional purpose of the risk management tool is a centralised system to manage all aspects of an individual risk.
- 10.2 All risks which cannot be mitigated or resolved immediately should be added to the risk management tool.

### Interrogating risk themes, features, areas

- 10.3 The search function within the risk management tool can be used to enable risk reports to be generated that interrogate particular themes, features, or areas of concern.

### Source of risk

- 10.4 Risks are identified through the following processes (by way of examples), and are added to the risk management tool:
- Complaints
  - Freedom to Speak Up reporting
  - Incident reports
  - Surveys
  - Analysis
  - Root Cause Analysis
  - Audit
  - Risk assessments
  - External recommendations
- 10.5 Wiltshire Health and Care will not keep any element of its risk management tool on paper records.
- 10.6 Risks added first to the risk management tool do not need a duplicate paper risk assessment, but should a staff member wish to have a copy of the assessment to make it available to staff in their area, they can print a single risk report from the tool.
- 10.7 Wiltshire Health and Care does not operate local risk registers separate to the risk management tool however, the tool can be filtered by team and service.

### Accepting risk

- 10.8 It is recognised that it is not possible to eliminate all risks, and systems and controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health benefits. The high costs of eliminating a risk in

comparison with the potential impact of the risk being realised mean that risks will not always be eliminated.

10.9 When all reasonable and proportionate control measures have been put in place, some residual risk will remain in many processes. This level of risk will be accepted if the risk:

- (i) Is minor in nature, with minimal potential for financial loss or damage to structure, persons, equipment or property; and/or
- (ii) Will occur rarely and might cause serious harm, damage or loss but which would take disproportionate resources to eliminate or reduce; and/or
- (iii) The target risk score has been reached, and that target risk score is within the organisation's risk tolerance (see Appendix B, "Net risk appetite boundary").
- (iv) The target risk score has not been reached, but all reasonable and proportionate control measures that are capable of being put in place at the given time, have been put in place, and the current risk score is within the organisation's risk tolerance.

A risk that is outside of Wiltshire Health and Care's risk tolerance may only be accepted by the Executive Committee (up to 12) or the Board (over 12). The rationale for doing so must be reasonable and rationale in the circumstances and the decision making must be documented.

10.10 The table below sets out which individuals or specialist group/Committee within Wiltshire Health and Care's governance structure can accept a risk:

Risk score	Identify of who can accept this level of risk
1-3	<ul style="list-style-type: none"> <li>○ Risk owner</li> </ul>
4-7	<ul style="list-style-type: none"> <li>○ Community Services Manager, Head of Service or senior manager (defined as Band 8A or above for this purpose)</li> </ul>
8-11	<p>The relevant specialist group:</p> <ul style="list-style-type: none"> <li>○ Operational Planning &amp; Performance Committee</li> <li>○ IG Policy &amp; Oversight</li> <li>○ Workforce Development Policy &amp; Oversight</li> <li>○ Medicines Management</li> <li>○ H&amp;S</li> <li>○ Harm free care</li> <li>○ Safeguarding</li> <li>○ IPC</li> <li>○ E&amp;D Group</li> </ul>
12	<ul style="list-style-type: none"> <li>○ Executive Committee</li> </ul>
15+	<ul style="list-style-type: none"> <li>○ Board</li> </ul>

**According, all risks that score 15 or above can only be deemed 'accepted' by the Board.**

- 10.11 Where risks are deemed 'accepted', they should be reviewed periodically to ensure that no further action could be taken to mitigate them. The frequency of that review will depend on the level of risk. The minimum review frequency for accepted risks is set out below:

Risk score	Level of risk	Review frequency
1-3	Low risk	Yearly
4-6	Moderate risk	Yearly
8-12	High risk	Quarterly
15+	Extreme risk	Quarterly
20+	Catasrophic risk	Monthly (NB: a risk of this level is unlikely to be accepted)

- 10.12 All risks that have been accepted on the risk management tool must link to evidence that records the decision to accept the risk.
- 10.13 Where an accepted risk is reviewed, and its risk rating has increased, fresh consideration must be given to whether the organisation can continue to accept the risk, based on the criteria that make accepting a risk appropriate (set out at 10.9).

### Continuity and transferring risk/ Existing staff members

- 10.14 To ensure that risk management continuity is maintained, it will be a requirement of all line managers to ensure that as part of the process of overseeing the exit of a staff member, the line manager checks whether the "exiting staff member" is a risk owner. Where the exiting staff member is a risk owner, the line manager will be responsible for reallocating the risk into the name of an alternative risk owner prior to the departure of the staff member.

### Queries regarding reporting or managing risks

- 10.15 If any staff member is in doubt about how to manage or report a risk, they should contact the Risk and Complaints Manager on 01249 456416 or email [whc.riskqueries@nhs.net](mailto:whc.riskqueries@nhs.net).

## 11. Horizon scanning

- 11.1 The Executive Committee will, on at least a quarterly basis, give thought to emerging potential threats and opportunities within the local health and care economy, and within WHC's operating processes.
- 11.2 Consideration is given to:
- Risks that arise from changes in the general business environment (inflation, VAT, estates costs, etc.)
  - Risks that arise with the NHS and local government (risks posed by commissioning decisions, risks posed by the decisions of our partners that are out of our control).

- Risks from unexpected actions by major competitors (the potential launch of new initiatives by private sector providers/ local community providers).

## 12. Risk Appetite

### When should the Risk Appetite be considered?

- 12.1 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.
- 12.2 The Risk Appetite statement will be taken into account by the Executive Committee and Senior Management Team when drafting the annual Business Plan.
- 12.3 The Risk Appetite statement will be taken into account at Risk Reviews (see above), and included as an appendix to each risk report presented to the Board.
- 12.4 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.
- 12.5 Any amendments to the Risk Appetite will be approved by the Board.

## 13. Culture

### How do we ensure that all staff and volunteers of Wiltshire Health and care recognise the importance of risk management?

- 13.1 All staff members receive training on risk management as part of their induction process, to introduce and increase familiarity with the process. This will include Board members.
- 13.2 WHC's Risk and Complaints Manager regularly visits all teams to provide specific training sessions on risk management, and to develop understanding. For clinical teams, these training sessions include clear guidance on how to analyse the six key operational risk areas (see section 8). This is a rolling training programme.
- 13.3 Risk reviews are an embedded part of the operations of Wiltshire Health and Care.

## 14. Resources

- 14.1 Wiltshire Health and Care has dedicated staff resource within its Quality team to:
  - Implement and maintain this framework
  - Schedule and facilitate Risk Reviews
  - Advise on risk management
  - Produce appropriate risk reporting reports for the Board and other groups
  - Provide risk training as required
- 14.2 Wiltshire Health and Care uses dedicated software to compile and review its risk register. All risk is recorded.

## 15. Monitoring Compliance and Effectiveness of Implementation

15.1 The following is a list of consultees involved in formulating this document:

The arrangements for monitoring compliance are outlined in the table below: -

<b>Measurable strategy objectives</b>	<b>Monitoring / audit method</b>	<b>Monitoring responsibility (individual / group / committee)</b>	<b>Frequency of Monitoring</b>	<b>Reporting arrangements (Committee / groups the monitoring results are presented to)</b>	<b>What action will be taken if gaps are identified?</b>
Adequacy of Terms of Reference of Committees with overarching responsibility for risk (Executive Committee)	Review of terms of reference – consideration by respective committees	Board	At least once per year	Board	Terms of Reference will be amended by the Company Secretary
Compliance with Terms of Reference of Committees with overarching responsibility for risk	Review of compliance – report to Committee Reporting arrangements through the Committees to the Board	Company Secretary	At least once per year	Board	Terms of Reference will be amended by the Company Secretary.
Maintenance of a Board Assurance Framework	Audit conducted by internal auditors	Company Secretary	Yearly	Board	Company Secretary will be responsible for ensuring actions from the audit report are completed and providing assurance to the Board.
15+ Risk Dashboard review and scrutiny	Scrutinised and challenged at committee	Executive Committee	Quarterly  At least 3 times a year	Board	The Company Secretary will be responsible for acting on recommendations and reporting back to the auditors.

<b>Measurable strategy objectives</b>	<b>Monitoring / audit method</b>	<b>Monitoring responsibility</b> (individual / group / committee)	<b>Frequency of Monitoring</b>	<b>Reporting arrangements</b> (Committee / groups the monitoring results are presented to)	<b>What action will be taken if gaps are identified?</b>
Risk review and scrutiny	Scrutinised and challenged by meetings / committees	Committee/ group meetings  Executive Committee	Monthly  At least once per year	Executive Committee	Actions minuted, followed-up at future Executive Committee meetings.
95% compliance with risk management training for Board Members and senior managers.	Training records Training material Attendance sheet	Risk and Complaints Manager	Ad hoc. Following group training session or following commencement of employment.	Executive Committee	Slides and signature sheet sent out for completion. Followed up with line manager if non-compliance.

## Appendix A: How to Assess Risk

### Risk scoring

Risk = Impact x Likelihood

Impact		Net risk = impact x likelihood				
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5
Likelihood		Rare	Unlikely	Moderate	Likely	Almost certain
Likelihood score		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

### Likelihood

	1	2	3	4	5
	Rare	Unlikely	Moderate	Likely	Almost certain
Description	Unlikely to occur within the next three years	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur - possibly frequently
Probability	0-3%	3-10%	10-50%	50-90%	90-100%

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Document owner:	Katherine Hamilton Jennings, Director of Governance and Company Secretary

## Impact

Impact category/ Score description	Finance value	Quality (Encompassing Patient Safety, Clinical effectiveness, Patient experience)	Legal/regulatory compliance	Reputational	Strategic	Health & Safety
<b>5 (Catastrophic)</b>	£1,000,000	<ul style="list-style-type: none"> <li>Totally unacceptable level or quality of treatment/service</li> <li>Gross failure of patient safety if findings not acted on</li> <li>Gross failure to meet national standards</li> </ul>	<ul style="list-style-type: none"> <li>Multiple breaches in statutory duty</li> <li>Complete systems change required</li> <li>Zero performance rating</li> </ul>	<ul style="list-style-type: none"> <li>Total loss of public confidence</li> </ul>	<ul style="list-style-type: none"> <li>Unable to meet strategic objective(s)</li> </ul>	<ul style="list-style-type: none"> <li>Death or a long term chronic health condition that is likely to lead to reduced lifespan. That could be death from an accident or incident or could be the diagnosis of an occupational disease e.g. occupational lung cancer. It could also include injuries so severe that they are permanently life changing (e.g. loss of limbs).</li> </ul>
<b>4 (Major)</b>	£500,000	<ul style="list-style-type: none"> <li>Gross failure to meet national standards</li> <li>Non-compliance with national standards with significant risk to patients if unresolved</li> <li>Multiple complaints/ independent review</li> <li>Low performance rating</li> <li>Critical report</li> </ul>	<ul style="list-style-type: none"> <li>Enforcement action</li> <li>Multiple breaches in statutory duty</li> <li>Improvement notices</li> <li>Low performance rating</li> <li>Severely critical report</li> </ul>	<ul style="list-style-type: none"> <li>Long-term reduction in public confidence</li> </ul>	<ul style="list-style-type: none"> <li>Re-prioritisation of objective</li> </ul>	<ul style="list-style-type: none"> <li>Injury or health condition that has significant, long term impact on ability to carry out day to day activities (i.e. definition of a disability according to Single Equality Act formerly DDA). Could include development of a condition that is not life limiting but severe enough to have a significant long term health issue (e.g. development of a type 1 latex allergy).</li> </ul>
<b>3 (Moderate)</b>	£250,000-£500,000	<ul style="list-style-type: none"> <li>Treatment or service has significantly reduced effectiveness</li> <li>Formal complaint (stage 2) complaint</li> <li>Local resolution (with potential to go to independent review)</li> <li>Repeated failure to meet internal standards</li> <li>Major patient safety implications if findings are not acted on</li> </ul>	<ul style="list-style-type: none"> <li>Single breach in statutory duty</li> <li>Challenging external recommendations/ improvement notice</li> </ul>	<ul style="list-style-type: none"> <li>Significant impact on public confidence</li> </ul>	<ul style="list-style-type: none"> <li>Achievement of objective delayed</li> </ul>	<ul style="list-style-type: none"> <li>Injury or health condition that is significant but should not have a permanent impact on health or ability to carry out day to day activities. Typically musculoskeletal disorders and conditions can fall into this category. Usually injuries in this category would require some clinical expertise at the time of the incident.</li> </ul>
<b>2 (Minor)</b>	£50,000	<ul style="list-style-type: none"> <li>Overall treatment or service suboptimal</li> <li>Formal complaint</li> <li>Local resolution</li> <li>Single failure to meet internal standards</li> <li>Minor implications for patient safety if unresolved</li> <li>Reduced performance rating if unresolved</li> </ul>	<ul style="list-style-type: none"> <li>Breach of statutory legislation</li> <li>Reduced performance rating if unresolved</li> </ul>	<ul style="list-style-type: none"> <li>Short-term reduction in public confidence</li> <li>Elements of public expectation not being met</li> </ul>	<ul style="list-style-type: none"> <li>Some impact on objective, not recoverable</li> </ul>	<ul style="list-style-type: none"> <li>Injury or health condition that may be acute but recovery would in general occur relatively quickly (within 3 days of onset or the incident) with or without intervention. Usually injuries in this category would need some basic first aid from a first aider at the time of the incident. A mild sprain to wrist or ankle could fall into this category.</li> </ul>
<b>1 (Negligible)</b>	Less than £5,000	<ul style="list-style-type: none"> <li>Peripheral element of treatment or service suboptimal</li> <li>Informal complaint/inquiry</li> </ul>	<ul style="list-style-type: none"> <li>No or minimal impact or breach of guidance/ statutory duty</li> </ul>	<ul style="list-style-type: none"> <li>Rumours</li> <li>Potential for public concern</li> </ul>	<ul style="list-style-type: none"> <li>Negligible effect on objective(s)</li> </ul>	<ul style="list-style-type: none"> <li>Injury or health condition that will fix itself with minimal intervention or with the passage of time. The injury or health condition is not serious in the short term e.g. abrasion, cut, bruise. Usually injuries in this category can be self-treated with access to a first aid kit.</li> </ul>



## Appendix B: 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, the 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) 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				
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5
Likelihood		Rare	Unlikely	Moderate	Likely	Almost certain
Likelihood score		1	2	3	4	5

This means that 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	<ul style="list-style-type: none"> <li>Avoidance of risk and uncertainty is a key organisational objective</li> </ul>
(1) "Cautious"	Low appetite	<ul style="list-style-type: none"> <li>Preference for safe delivery options that have a low degree of residual risk and many only have limited potential for reward</li> </ul>
(2) "Open"	Medium appetite	<ul style="list-style-type: none"> <li>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</li> </ul>
(3) "Seek"	High appetite	<ul style="list-style-type: none"> <li>Eager to be innovative and to choose options offering potentially higher rewards, but with which a greater degree of uncertainty.</li> </ul>

### 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
<b>Risk to patients</b>	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.	
<b>Financial risk</b>	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.		
<b>Integration/ diversification of services</b>			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.	
<b>Geographical coverage</b>	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.		
<b>Compliance and regulatory risk</b>		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.	
<b>Reputational risk</b>		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.	
<b>Stakeholder engagement</b>				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.
<b>People - skills</b>		WHC is cautious about loss of collective competencies, knowledge and skills.		
<b>People - behaviours</b>	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			
<b>Strategic risk</b>		WHC is cautious of any risk which compromises any one of the priority goals set out in WHC's Business Plan.		

**Wiltshire Health and Care Board**
**For information**
**Subject:** Wiltshire Health and Care Risk Management Report, Q3

**Date of Meeting:** 01 February 2018

**Author:** Katherine Hamilton Jennings

**1. Purpose**

This paper sets out:

- An update on risk movement through Quarter 3, 2018 – 2019
- An update on risk themes
- An update on risks 15+

**2. Information**
**Risk profile, Q3**
**Headlines:**

- As at the end of Q3, WHC's risk register has 56 open risks on its risk register, 6 of those are accepted risks.
- In Q3, 17 new risks were added to the WHC risk register, and 11 were closed.
- As at Q3, WHC has 6 accepted risks

**Total risks – Profile**

This data shows all open risks on the risk register – including accepted risks.

Total risk profile – Q3	Total	0-3	4-6	8-12	15+
All open risks, split by total risk score	56	0	11	41	4

**Active risks – Profile**

This data shows all risks except those that have been accepted (see below).

Active risk profile – Q3	Total	0-3	4-6	8-12	15+
All active risks, split by total risk score	50	0	5	41	4

### Accepted risks – Profile

Accepted risk profile – Q3	Total	0-3	4-6	8-12	15+
Accepted risks, split by total risk score	6	0	6	0	0

### Accepted risks – Narrative

The accepted risk profile has not changed since Q2.

There were 6 accepted risks scoring 4-6 in Q2, and this remains in Q3.

### New risks – Profile

New risks added in Q3	Total	0-3	4-6	8-12	15+
New risks added, split by total risk score	10	0	0	9	1

### New risks – Narrative

Ten new risks have been added in Q3. This is a very high number, but is likely to reflect the new reporting formats required by community and specialist teams into the Operational Performance and Planning meetings (putting risk at the start of every report), and the engagement with staff in relation to the development of the new risk framework for Wiltshire Health and Care.

As such, this is likely to be due to an increase in reporting, rather than an increase in actual risks. We will keep this under review.

### Closed risks – Profile

Closed risks in Q3	Total	0-3	4-6	8-12	15+
Risks closed, split by total risk score	8	0	4	3	1

### Closed risks – Narrative

#### Risk closures as a result of risk register ‘cleanse’

A large number of risks were closed in Q3. This was on account of a comprehensive review of the risk register as a whole being undertaken by the Company Secretary and Director of Governance as part of the exercise to transfer the risk register from Ulysses to an Excel spreadsheet temporarily in readiness for the transfer to DATIX in April 2019. Whilst in Excel, we have had the opportunity to play with the presentation, layout, and theming of the risk register to determine what works optimally for WHC. As part of this review of the register as a whole, a number of very similar risks were identified, and it seemed most pragmatic for these to be managed as a single risk going forward.

## Risks over 15+ closed in Q3

### Risk 2093/ 26 (Risk Score 16, now closed) – Splitting Ailesbury Ward

One 15+ risk has been closed in Q3. This is the risk relating to the Ailesbury project (Ulysses reference – 2093, new risk register reference – 26). This project closed in Q3, and, as such, the risk associated with the project itself is no longer applicable. There remains residual risk around the running of WHC's wards, and to reflect this a new risk has been added to the risk register to reflect, and show how we are managing this.

Risk Number	Issue	Risk	L	S	Risk Score	Closure reason
26	<b>Ailesbury Ward</b>  Lack of staffing, high use of agency staff and the physical layout of the wards has the potential to impact on patient care & safety in Ailesbury Ward, Savernake Community Hospital, 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.	<b>Service quality</b> - Service delivery affected because of poor staff retention, and difficulty in recruitment due to working environment.  <b>Legal/ Regulatory</b> - Culture and quality of care concerns, if realised, may impact on CQC rating. Complaints/ litigation as a result of quality of care. Reputational - The above impacting on patient and public perception.	4	4	16	Ailesbury has been through a change project and operational recovery work. As a result of both pieces of work, the units are now almost fully staffed, remodelled, and beds are being re-opened in phases. As such, this risk can be closed down and a new risk around inpatients across the organisation will be opened.

## Risk scoring

### Changes to ensure consistent scoring

We would like to bring to the Board's attention the fact that during our recent exercise to transfer risks from Ulysses to Excel, we amended target risk scores for seven of our risks. The purpose of making these amendments was to apply consistency across WHC's risk register.

## Risk themes

### Changes to ensure consistent scoring

The graph below shows the themes of risks recorded on the risk register, and how many risks fall into each theme.

During quarter 4, WHC will adopt themes of risks that are congruent with CQC risk themes.

In Q3, the themes (aligning to the portfolios of the executive team), were to ensure strong executive ownership during the transition from Ulysses to Excel whilst we await onwards transfer to DATIX, at a period in time when more "human" input into risk management has been needed as the prompts, automation, and alerts generated by a specialist risk management tool are not available.

### Themes – Open Risks

Infrastructure	12
Quality	14
Operations	14
Governance	5
Workforce	4
Finance	7
Total	56



## Review of 15+ risks

#	Issue	Risk	Risk Owner	Q2			Risk movement in quarter	Q3			L	I	Target Risk Score	Risk controls	Actions	Action Target date
				L	I	Risk Score		L	I	Risk Score						
33	<b>Network Connectivity</b>  Access to electronic patient records is stifled by slow network connections.	<b>Service Quality</b> - Risk of impact on clinical productivity and delays in the provision of care - impacting on patient experience and staff frustration.	DB	5	3	15	↔	5	3	15	1	3	3	Head of ICT appointed so that dedicated resource is available to address ICT issues.  Network topology has been created to identify the problem areas.  Staff advised to take actions to lower the burden on the network- such as hold meetings off site, and not to use Outlook at CCH.	1. A business case for the implementation of a better network across all WHC sites has been agreed. Now the solution for a faster and more robust network (HSCN) needs to be implemented across all WHC sites. A project timeline for this is agreed. Current plan is for the line to go in at the most severely affected sites in April 2019. <b>[Action Owner - Kelsa Smith, Head of ICT]</b>	31.03.2018
50	<b>Shortfall in estates budget</b>  The total required sum to cover estates is £5.7m. £3.3m - hard FM, and £2.4m is soft FM. We have £4.325 overall in funding for estates. This	<b>Financial</b> - Risk of being significantly overspent and being able to continue and viable entity.  <b>Service Quality</b> - Risk of being unable to deliver elements of the contract due to lack of available finance,	AC	4	4	15	↑	4	4	16	1	4	4	Continuing dialogue with Wiltshire CCG to resolve issue. WCCG have sought advice from KPMG.	1. Ongoing dialogue with WCCG to seek resolution. WCCG pressed to confirm position. WHC to continue to press CCG to confirm their position. <b>[Action Owner – Annika Carroll, Director of Finance]</b>  2. Escalation under	14.02.2019  14.02.2019





	However, GWH no longer wish to carry out this service and could serve notice. This would result in a gap in catering, cleaning, reception, and medical record services. As a consequence, WHC may be unable to put in place alternative provision to enable continuous provision of these services - resulting in an inability to feed patients, clean clinics, etc.	<p>patient experience.</p> <p><b>Legal/ Regulatory</b></p> <p>- Risk of being unable to feed patients, clean wards and clinics is likely to breach H&amp;S regulations, and numerous other standards of care set by our regulators (CQC/NHSI). In addition, this is likely to amount to breach of contract.</p> <p><b>Health, Safety, Fire &amp; Security</b></p> <p>- Risk of being unable to feed patients, clean wards and clinics is likely to breach H&amp;S regulations.</p>											negotiations with a new provider.	<p><b>Douglas Blair, Managing Director]</b></p> <p>2. Scoping options for the provision of soft FM with alternative providers. <b>[Action Owner – Victoria Hamilton, Director of Infrastructure]</b></p>	31.03.2019	
64	<p><b>MIU incidents</b></p> <p>The increase in number of serious incidents and complaints in the two MIU is giving cause for concern. There have been 4 serious incidents reported to STEIS since June 2018. There has also</p>	<p><b>Service Quality</b></p> <p>- High risk of patient harm if current trends continue. High risk of impact on staff wellbeing if supervision and guidance is inadequate.</p> <p><b>Legal/ Regulatory</b></p> <p>- High risk of litigation, (based on current litigation), poor ratings from CQC regarding patient care. Loss</p>	LH	-	-	-	New risk	4	4	16	2	3	6	10/01/2019 - Children’s safeguarding lead has commenced safeguarding supervision with staff from Chippenham MIU. This will be implemented in Trowbridge via diary invites to individuals.	<p>1. Interviews for Band 8a clinical lead occurring on 23.01.2019 <b>[Action Owner – Lisa Hodgson, COO]</b></p> <p>2. Quality Improvement Project Commencing in January 2019. <b>[Action Owner – Lisa Hodgson, COO]</b></p> <p>3. Interim Head of</p>	<p>23.02.2019</p> <p>31.03.2019</p>

	<p>been an increase in the number of complaints received in this area - 16 complaints in the last quarter. The complaints have mostly been regarding attitude and behaviour or clinical treatment. One complaint relating to clinical treatment is in the litigation process.</p> <p>It has also been identified that there is an inconsistent approach and application of safeguarding processes, including domestic abuse recognition and safeguarding supervision for staff.</p>	of contract.													<p>Operations (MIU and CTPLD) appointed – Clare Robinson. Staff will be supported and provided with leadership. A diagnostic review will occur, leading to a recovery plan to be published by 28/02/2019. <b>[Action Owner – Clare Robinson]</b></p> <p>4. Senior staff from Trowbridge MIU to spend time at Chippenham MIU to provide leadership/informal supervision. <b>[Action Owner – Clare Robinson]</b></p> <p>5. Review training of all staff to ensure clinical skills in diagnoses. <b>[Action Owner – Clare Robinson]</b></p>	<p>28.02.2019</p> <p>Immediate</p> <p>28.02.2019</p>
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### 3. Recommendation

The Board is asked to:

- a) Note the 15+ risks, and confirm that it is satisfied that WHC's key risks are being appropriately managed.

## Wiltshire Health and Care Delivery Plan: Milestones for 2018/19, Q3 Update

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
Standardise and systemise to reduce variation		<ul style="list-style-type: none"><li>Higher intensity care recognised in system care delivery framework.</li></ul>		<ul style="list-style-type: none"><li>Frailty scoring rate increased to 80% (Q4).</li></ul>	<u>Frailty scoring</u> <ul style="list-style-type: none"><li>At the end of 17/18, WHC's average frailty scoring rate was 64%. As at the end of Q2, WHC's frailty scoring rate was 67%. The Q4 target is 80%. – <b>Q2 goal delivered.</b> – <b>Some risk to WHC achieving Q4 goal</b></li></ul>	
		<ul style="list-style-type: none"><li>Wounds assessment CQUIN target of 60% (Q2) achieved.</li></ul>		<ul style="list-style-type: none"><li>Wounds assessment CQUIN target of 80% (Q4) achieved.</li></ul>	<u>Higher Intensity Care</u> <ul style="list-style-type: none"><li>Higher Intensity Care is now a recognised feature of the Wiltshire Care Model. The SDIP (the Service Development Improvement Plan, which sits within WHC's contract with Wiltshire CCG), reflects this. – <b>Q2 goal delivered.</b></li></ul> <u>Wound assessments</u> <ul style="list-style-type: none"><li>The percentage of wounds being assessed at the end of Q2 was 64%. As at the end of Q3, WHC's wound assessment rate was 67%. The Q4 target is 80%, and this is on track for delivery. – <b>Q2 goal delivered, on track for Q4 goal.</b></li></ul>	
Respond to increased demand and maintain performance	RTT performance maintained				<u>RTT</u> <ul style="list-style-type: none"><li>Overall RTT performance has been maintained above target. Q1: 97.2%, Q2: 96.8% and Q3: 96.5 – <b>On track to delivery goal for full year.</b></li></ul>	
		Orthotics service re-procured			<u>Orthotics re-procurement</u> <ul style="list-style-type: none"><li>In order to be able to carry out a re-tendering exercise for the orthotics service in 18/19, WHC will need to identify additional procurement support to support this. It will be very difficult to achieve in Q4 unless additional support is identified. – <b>Material risk that goal for Q4 goal is not achieved.</b></li></ul>	<u>Orthotics re-procurement</u> <ul style="list-style-type: none"><li>WHC would need to identify additional procurement support to carry out the proposed retendering exercise.</li></ul>
Improve system flow	Home First pathway further embedded across all sites throughout 2018/19				<u>Home First</u> <ul style="list-style-type: none"><li>There is now a joint clinical lead post between WHC and SFT - responsible for working with SFT services on site to embed Home First, and to align the early supported discharge services. Work with Swindon community services has aligned pathway for GWH.</li></ul>	

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
					<b>– Q4 goal achieved.</b>	
		<ul style="list-style-type: none"> <li>Improved data collection for ESD stroke pathway</li> </ul>	<ul style="list-style-type: none"> <li>New reablement pathway aligned with Home First.</li> <li>Real time data collection for Home First.</li> </ul>	<ul style="list-style-type: none"> <li>Requirements of safe and proactive discharge CQUIN achieved.</li> </ul> <p>This is now stroke collaborative involvement at 'Place' level.</p>	<p><u>ESD stroke pathway</u></p> <ul style="list-style-type: none"> <li>Changes to the ESD data collection method were made in as part of the split unit project between July and September 2018 to address some of the data quality concerns previously encountered. These changes are bedding in but are expected to improve data collection.</li> </ul> <p><b>– Q2 goal delivered.</b></p> <p><u>New reablement pathway</u></p> <ul style="list-style-type: none"> <li>A new reablement pathway aligned with Home First has now been designed, agreed, and signed-off by the Joint Commissioning Board (JCB).</li> <li>Implementation of this pathway is well underway; however recruitment challenges will delay the full implementation in the South.</li> </ul> <p><b>– Q3 goal achieved in some localities. We anticipate the goal being achieved county-wide by the end of Q4.</b></p> <p><u>Real time data collection for Home First</u></p> <ul style="list-style-type: none"> <li>WHC now has real time data collection for Home First. This was the result of the 'split units' System1 project. The September 2018 dashboard is the first data from this new way of recording. It also means that WHC can share weekly numbers of patients starting care on Home First with the CSU/CCG.</li> </ul> <p><b>- Q3 goal delivered (ahead of schedule).</b></p> <p><u>Requirements of safe and proactive discharge CQUIN</u></p> <ul style="list-style-type: none"> <li>It has been nationally decided that this CQUIN has been suspended for 18/19. Instead of payment against this CQUIN, the CCG has placed payment against stroke collaboration. WHC is actively participating in the Wiltshire stroke collaborative.</li> </ul> <p><b>- Q4 goal re-scoped.</b></p>	
Bring community provision together	Cross working and integration between community services continues				<p><u>Cross working and integration between community services continues</u></p> <ul style="list-style-type: none"> <li>WHC has identified that it needs further discussions on the medium-term strategy for LD with Wiltshire CCG and Wiltshire Council. These meetings are happening, and WHC's interim Head of Operations will be responsible for progressing</li> </ul>	

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
					<p>these conversations in Q4.</p> <ul style="list-style-type: none"> <li>Adult Social care colleagues now attend the Wiltshire Patient Flow Hub on a regular basis. Further work is required in 19/20 to further embed this joint working. WHC is looking at combined flow coordinators.</li> <li>The opportunity for providing a service in an integrated manner with primary care to support complex wound care is currently under discussion. - <b>Q4 goal on track.</b></li> </ul>	
Implement new approaches to promote self management and proactive care		<ul style="list-style-type: none"> <li>New MSK Pathway commences.</li> </ul>	<ul style="list-style-type: none"> <li>SMS based text system implemented for MSK services.</li> </ul>	<ul style="list-style-type: none"> <li>Further development of new MSK pathway, with addition of more Extended Scope Practitioners</li> <li>Reporting arrangements for MSK reviewed by commissioners and WHC in light of the new strategy and associated actions. New reporting arrangements to be in place in 2019/20 quality schedule</li> <li>Requirements of personalised care and preventing ill health CQUIN achieved</li> </ul>	<p><u>New MSK pathway</u></p> <ul style="list-style-type: none"> <li>Phase 1 of the new MSK pathway has mobilised. Phase 2 is on track, having commenced mobilisation in December 2018. The new pathway has received positive stakeholder feedback. - <b>Q2 goal delivered.</b></li> </ul> <p><u>SMS text messages</u></p> <ul style="list-style-type: none"> <li>The roll-out of SMS messages for the Wiltshire Orthopaedic Network (WON) is in progress. - <b>Q3 goal delivered.</b></li> </ul> <p><u>Development of MSK pathway</u></p> <ul style="list-style-type: none"> <li>A number of Extended Scope Practitioners (ESPs) have been added to the MSK service. WHC will work with Wiltshire CCG to review the service specification for this pathway, and will add further ESPs where this makes sense along the pathway. - <b>Q4 goal on track.</b></li> </ul> <p><u>Reporting arrangements MSK</u></p> <ul style="list-style-type: none"> <li>Discussions relating to the reporting arrangements for the MSK pathway are being undertaken. - <b>Q4 goal on track.</b></li> </ul> <p><u>Requirements of personalised care and preventing ill health CQUIN</u></p> <p>- <b>Q4 goal on track.</b></p> <p><u>Frailty strategy</u></p> <ul style="list-style-type: none"> <li>WHC's Frailty Strategy is currently in draft and has been shared extensively throughout WHC. A large number of clinicians have been actively engaged in the development of the draft strategy. The development has aligned to the STP frailty programme. This will be shared with WCCG in Q4 and implemented during Q4 18/19 and continued into 19/20.- <b>Q2 goal not achieved, but on track to be delivered at the end of Q4, and into 19/20.</b></li> </ul>	
		<ul style="list-style-type: none"> <li>Frailty strategy for Wiltshire Health and Care finalised and action plan shared with commissioners.</li> </ul>				

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
Review services	<ul style="list-style-type: none"> <li>Alignment with new urgent care service</li> </ul>	<ul style="list-style-type: none"> <li>Clear agreement on approach to patient flow support reached with CCG.</li> </ul>	<ul style="list-style-type: none"> <li>Implement the agreed approach to patient flow.</li> </ul>		<p><u>Alignment with new urgent care service</u></p> <ul style="list-style-type: none"> <li>The CCG has not yet published their urgent care strategy, so WHC is currently continuing with processes 'as is', whilst simultaneously remaining engaged with Wiltshire CCG in relation to the development of their strategy.</li> <li>WHC has commenced an internal review of its MIUs - to be led by the interim Head of Operations. <ul style="list-style-type: none"> <li><b>- Q1 goal not delivered, but is dependent on system partners to progress.</b></li> </ul> </li> </ul> <p><u>Clear agreement on approach to patient flow</u></p> <ul style="list-style-type: none"> <li>WHC agreed the approach for patient flow with Wiltshire CCG. It was agreed that WHC would take a number of the functions delivered by Access to Care and deliver these directly. E.g. in winter 2018, Access to Care handed over responsibility for bed allocation, production of the sit rep, and patient flow. <ul style="list-style-type: none"> <li><b>- Q2 goal delivered.</b></li> </ul> </li> </ul> <p><u>Implementation of the agreed approach to patient flow</u></p> <ul style="list-style-type: none"> <li>Since December 2018, WHC has taken responsibility for bed allocation, sit reps, and patient flow (by developing the WICC into the "Wiltshire Patient Flow Hub"). <ul style="list-style-type: none"> <li><b>- Q3 delivered.</b></li> </ul> </li> </ul>	<p><u>Alignment with new urgent care services</u></p> <ul style="list-style-type: none"> <li>WHC will support Wiltshire CCG to develop its urgent care strategy, but aligning with new urgent care services will be dependent on Wiltshire CCG defining the direction of travel for urgent care services in Wiltshire. As such, progressing this WHC delivery goal is dependent on Wiltshire CCG making strategic decisions.</li> </ul>
Develop and strengthen partnerships	<ul style="list-style-type: none"> <li>Joint Programme Committee established to oversee integration of Home First and reablement pathway</li> </ul>		<ul style="list-style-type: none"> <li>Resources in place for integrated pathway.</li> <li>Revised approach to the management of intermediate care beds agreed</li> </ul>		<p><u>Joint Integrated Programme Committee</u></p> <ul style="list-style-type: none"> <li>Completed. <ul style="list-style-type: none"> <li><b>- Q1 goal delivered.</b></li> </ul> </li> </ul> <p><u>Resources in place now for integrated pathway.</u></p> <ul style="list-style-type: none"> <li>Additional resources for Home First and reablement signed off by Joint Commissioning Board in August 2018. Recruitment underway. The plan is for the majority of staff to be in place by the end of Q3, so that the joint pathway can be up and running during Q4. <ul style="list-style-type: none"> <li><b>- Q3 goal delivered in part of the county, put not county-wide. On track for delivery county-wide by the end of Q4.</b></li> </ul> </li> </ul>	



	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
					<u>Intermediate care beds</u> <ul style="list-style-type: none"><li>Wiltshire CCG has recently carried out an interim review of the provision of intermediate care in the south of the county (care homes), and extended the current arrangements until April 2019. Conversations are currently in progress to review the model and agree a way forward from April 2019. <b>- Q3 goal is not on track, and is unlikely to be achieved within 18/19 since it is dependent on an external partner to progress</b></li></ul>	<u>Intermediate care beds</u> <ul style="list-style-type: none"><li>Progressing this WHC delivery goal is dependent on Wiltshire CCG making strategic decisions.</li></ul>
	Rotational scheme for workforce tested with primary care colleagues				<u>Rotational scheme for workforce</u> <ul style="list-style-type: none"><li>Focus in 18/19 has been placed on WHC's own workforce initially. Rotations were initially put in place for physiotherapists within WHC's own services, and this has now been expanded to CTPLD. Feedback from these areas will inform our approach going forward, which will hopefully involve more rotations with other partners – including primary care. We are building up the relationships with primary care through the GP Alliance partnership. <b>- Q4 goal is not on track in terms of rotations with primary care, instead the focus has been shifted to getting this to work internally in 18/19.</b></li></ul>	
Plan for change in estates	Part of STP Estates strategy and Wiltshire CCG estates work to deliver a plan for estates in Wiltshire				<u>Deliver a plan for estates in Wiltshire</u> <ul style="list-style-type: none"><li>Wiltshire Health and Care is engaged in estates strategy work, being led by Wiltshire CCG, including, for example, work on new facilities in Devizes and Trowbridge. <b>- Year 18/19 goal on track.</b></li></ul>	
	Work with WCCG and NHS PS to deliver more efficient use of space across the community including the new developments in Devizes and Trowbridge				<u>Use of space across the community</u> <ul style="list-style-type: none"><li>Schemes to improve use of Devizes, Trowbridge, and Salisbury estates have all been delivered by NHSPS.</li><li>Works in Chippenham and Warminster will commence in Q4. <b>- Year 18/19 goal on track.</b></li></ul>	
			New estates advisory arrangements in place.		<u>Estates advisory arrangements</u> <ul style="list-style-type: none"><li>WHC internal governance for estates developed and approved.</li><li>RUH have approval to develop a business case to deliver Estates Advisor Service for WHC. <b>- Delivery goal not achieved in Q3 as planned.</b></li></ul>	

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
					but likely to be delivered in Q4.	
	Sustainable approach to soft facilities management designed		Sustainable approach to soft facilities management delivered		<p><u>Soft facilities management - design</u></p> <ul style="list-style-type: none"> <li>Approach was designed by Q2, but due to contextual changes, it is likely that this will need to be revisited.</li> </ul> <p><b>- Q2 goal being revisited in Q4.</b></p> <p><u>Soft facilities management - delivered</u></p> <ul style="list-style-type: none"> <li>This is an area of uncertainty, reliant on decisions from the CCG and other providers. Therefore further work needs to be done to understand which provider will deliver, and the contractual mechanism for this.</li> </ul> <p><b>- Unlikely that this delivery goal will be achieved by the end of Q4.</b></p>	<p><u>Soft facilities management</u></p> <p>Q4:</p> <ul style="list-style-type: none"> <li>Agree estates budget with WCCG.</li> </ul> <p>19/20:</p> <ul style="list-style-type: none"> <li>Agree soft facilities management provider.</li> <li>Agree the contractual mechanism for soft FM services with WCCG.</li> <li>Negotiate with Soft FM provider(s).</li> </ul>
Transform the use of technology			MIUs moved onto SystmOne		<p><u>MIUs to System1</u></p> <ul style="list-style-type: none"> <li>Project started in Q3, but delivery of solution has slipped into Q1, 19/20.</li> </ul> <p><b>- Delivery goal likely to be delivered in Q1, 19/20 to align with improved network capability.</b></p>	
	Through engagement with STP wide-work, N3 network connections replaced with Health and Social Care Network solution for sites in the community				<p><u>N3 network connections replaced with HSCN solution across the community sites</u></p> <ul style="list-style-type: none"> <li>HSCN contract in place following STP-wide procurement process.</li> <li>WHC is engaged in the roll out of the new connections.</li> <li>Head of ICT has joined WHC in November 2018.</li> <li>HSCN orders for all sites were placed in November 2018.</li> <li>Delivery of new connections due to start from April 2019.</li> </ul> <p><b>- Delivery on track for early April 2019.</b></p>	
	New telephone system scoped and implementation in phases commenced				<p><u>New telephone system</u></p> <ul style="list-style-type: none"> <li>Delivery of new telephone system slipped into 19/20 due to interdependency on increased network capability (see above).</li> </ul> <p><b>- Cannot be delivered in 18/19. Being re-programmed as a 19/20 deliverable.</b></p>	
	Bid to move inpatient wards onto SystmOne as opportunities arise				<p><u>Bid to move wards to SystmOne</u></p> <ul style="list-style-type: none"> <li>New bid for moving inpatient wards to SystmOne was submitted in August 2018. Implementation will be planned in during 19/20.</li> </ul>	

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
					<u>Participation in STP Workforce projects</u> <ul style="list-style-type: none"> <li>LWAB - WHC participates in the Local Workforce Area Board (LWAB), and WHC is signed up to furthering the agreed objectives of the LWAB as these are articulated and agree upon.</li> <li>STP partnership forum – This has a staff side and a management component. WHC is a keen participant in this when the group is active.</li> </ul> <b>- Q4 goal on track.</b>	
Design the workforce for the future	<ul style="list-style-type: none"> <li>WHC dedicated staff bank established</li> </ul>			<ul style="list-style-type: none"> <li>WHC bank grown in size, providing greater proportion of flexible workforce</li> </ul>	<u>Staff bank – established</u> <ul style="list-style-type: none"> <li>The WHC staff bank has been established and operating since Q1.</li> </ul> <b>- Q1 goal delivered.</b> <u>Staff bank – developed</u> <ul style="list-style-type: none"> <li>Now that WHC has a bank in place, developing its size is the priority. In September 2018, WHC signed off a centralised bank recruitment plan. This is a 12 month rolling-programme where every month focus is placed on a different discipline – with emphasis on registered nursing being the focus on alternate months. To support this organisation-wide initiative, a team of representatives across the WHC specialities (specialist, community teams, in patients), will short list and interview. This centralised bank recruitment plan commenced in November 2018.</li> </ul> <b>- Q4 goal on track, but work will continue into 18/19.</b>	
Implement values and behaviours	<ul style="list-style-type: none"> <li>Internal survey on embedding of values and behaviours completed</li> </ul>			<ul style="list-style-type: none"> <li>Requirements of staff health and wellbeing CQUIN achieved.</li> </ul>	<u>Internal survey on values and behaviours</u> <ul style="list-style-type: none"> <li>An internal survey on values and behaviours was carried out in Q1.</li> <li>Awareness of WHC's values and behaviours has been recently promoted at the staff listening events undertaken with colleagues from specialist services. The staff supported these.</li> </ul> <b>- Q1 goal delivered.</b> <u>Staff Health and Wellbeing CQUIN</u> <ul style="list-style-type: none"> <li>Flu - WHC achieved its target of 75%.</li> <li>The 18/19 CQUIN measure was to achieve a 5% improvement on the 2016 staff survey results for two measures; staff having MSK issues and staff feeling supported for stress. Unfortunately this has not been achieved based on the reported results for 18/19.</li> <li>WHC has not had capacity to proactively to</li> </ul>	<u>Staff Health and Wellbeing CQUIN</u> <ul style="list-style-type: none"> <li>It would be useful to consider non-traditional ways of proactively promoting support for MSK and stress-related health issues within WHC to help staff feel well, and help staff feel supported.</li> </ul>

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
					<p>promote the support that is available to staff for MSK and/or stress-related issues in 18/19, although a mental health awareness event was organised for staff in Chippenham Community Hospital on national mental health awareness day, which was well received.</p> <p><b>– Unlikely to achieve Q4 goal.</b></p>	
Develop career pathways	Links to universities enhanced				<p><u>Link to universities</u></p> <ul style="list-style-type: none"> <li>WHC has a new Learning and Development Lead in post, who is carrying out a programme of work a portion of which focuses on improving WHC link with universities. .</li> <li><b>- Q4 goal achieved, but work will continue to build this further.</b></li> </ul>	
	Existing career development pathways reviewed and enhanced				<p><u>Career development pathways enhanced</u></p> <ul style="list-style-type: none"> <li>WHC's SPQ development pathway has been reviewed and we now have a post registration development pathway. This also enables WHC to utilise Annex U of A4C.</li> <li>WHC has utilised 100% of its apprenticeship levy in 18/19. It has also secured 10% of GWH's, and is approaching other businesses - including business outside of health.</li> <li>WHC has introduced a new trainee nurse associate development pathway (which when complete results in a band 4 registered nurse qualification).</li> <li>The cumulative effect of the above means that a school lever could be developed from GCSEs through to a registered nurse by undertaking training with WHC (initially by undertaking the apprentice schemes - NVQ levels 2 and 3, and then by undertaking the trainee nurse associate development pathway to become a registered nurse).</li> <li><b>- Q2 goal delivered.</b></li> </ul>	
			Leadership training rolled out		<p><u>Leadership training</u></p> <ul style="list-style-type: none"> <li>In patient ward part of this will be commenced in Q3. This programme has been designed by our L&amp;D lead.</li> <li>The remainder of this programme is in development. WHC is now hoping to roll-out leadership training in Q1 of 19/20. Scoping options for the delivery of the material is likely to continue to take place in Q4, with the intention of the material being signed off at the end of Q4.</li> <li><b>- An element of the Q3 goal was delivered, and the remainder will be progressed in 19/20.</b></li> </ul>	

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
Connect acute and community pathways	Further implementation work on discharge pathways taken forward as system transformation project.				<u>Discharge pathways</u> <ul style="list-style-type: none"> <li>This is incorporated into the flow and Home First work – see above.</li> </ul> <b>- Q4 goal on track.</b>	
	Continued development of Older Persons Pathway in South Wiltshire				<u>Older Persons Pathway</u> <ul style="list-style-type: none"> <li>WHC sits on the strategy group for the development of the Older Persons Pathway in South Wiltshire, and has representation at all the related operational groups. WHC is heavily engaged in the development of the MDT model.</li> <li>Further embedding of the MDT model and identification of patients risk stratification are tasks that will continue in Q4.</li> </ul> <b>- Q4 goal on track.</b>	
A quality focus	<ul style="list-style-type: none"> <li>Quality priorities published in Quality Account</li> </ul>		<ul style="list-style-type: none"> <li>Quality accounts bi-annual update to be reported through the Quality Schedule</li> </ul>		<u>Quality Account</u> <ul style="list-style-type: none"> <li>WHC's Quality Account was published in Q1.</li> </ul> <b>- Q1 goal delivered.</b> <u>Quality Account updates – through quality schedule.</u> <b>- Q3 delivered.</b>	
		New risk management and incident reporting system designed and implemented			<u>Risk management and Incident Reporting System</u> <ul style="list-style-type: none"> <li>WHC has a defined risk appetite signed off by the board, against which an assessment can be made about any new strategic proposal.</li> <li>A new risk management strategy tailored made for WHC has been drafted and is currently under consultation.</li> <li>Work towards the implementation of DATIX is underway, and on track to be implemented by April 2019.</li> </ul> <b>- Q4 goal on track.</b>	
A public and patient engagement plan	<ul style="list-style-type: none"> <li>Stakeholder engagement on public and patient engagement plan</li> </ul>	<ul style="list-style-type: none"> <li>A public and patient engagement plan published</li> </ul>		<ul style="list-style-type: none"> <li>Review of the plan to date</li> </ul>	<u>Stakeholder engagement plan</u> <ul style="list-style-type: none"> <li>A patient and public engagement event was undertaken in Q1, which was well attended and informed the content of the early draft of WHC's public and patient involvement plan.</li> <li>An updated draft of WHC's public and patient involvement plan is now ready to be presented for wider consultation.</li> </ul> <b>- Q2 goal missed, but delivered in Q3.</b>	

	Q1	Q2	Q3	Q4	Position at the end of Q3 (December 2018)	Actions needed to get back on track
Good use of resources	<ul style="list-style-type: none"> <li>Upgraded financial ledger and associated financial reporting developed</li> </ul>	<div> <div></div> <div></div> </div> <ul style="list-style-type: none"> <li>Upgraded financial ledger implemented along with new financial reporting</li> </ul>			<p><u>Financial ledger – developed</u></p> <ul style="list-style-type: none"> <li>Financial reporting in place for Board and Executive Committee (through Excel).</li> <li>Financial reporting through the Agresso system not yet in place</li> <li>- <b>Q1 goal achieved in part, with the remainder still being pursued.</b></li> </ul> <p><u>Financial ledger – implemented</u></p> <ul style="list-style-type: none"> <li>Unit 4 purchasing programme rolled out in Q2</li> <li>Financial reporting using the system still being developed</li> <li>- <b>Q2 goal only partially achieved, delivery goal likely to be completed Q1 2019/20.</b></li> </ul>	<p><u>Financial ledger</u></p> <ul style="list-style-type: none"> <li>Dedicated support required from Financial Systems Manager at RUH (limited resource) as well as Unit 4 Consultancy Support.</li> </ul>

<b>Title:</b>	<b>EU Exit Operational Readiness Assurance</b>
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<b>Meeting:</b>	<b>Board</b>
<b>Date:</b>	<b>1 February 2019</b>
<b>Author:</b>	<b>Katherine Hamilton Jennings</b>

### Introduction

On 21 December 2018, the Department of Health and Social Care (the Department) published the guidance, ***“EU Exit Operational Readiness Guidance, Actions the health and care system in England should take to prepare for a ‘no deal’ scenario”***.

EU Exit Operational  
Readiness  
Guidance



This guidance, developed and agreed with NHS England and NHS Improvement, lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal – a ‘no deal’ exit. This being designed to ensure organisations are prepared for, and can manage, the risks in such a scenario. This guidance has subsequently been supplemented and amended to reflect the work of the government. These updates are being communicated to WHC via our Managing Director, who is acting as our Senior Responsible Officer.

The government’s contingency planning initially focused on seven key areas. This has now been reduced to five key areas.

1	• Risk assessment – Supply of medicines and vaccines
2	• Risk assessment – Supply of medical devices and clinical consumables
3	• Risk assessment – Supply of non-clinical consumables, goods and services
4	• Risk assessment – Workforce
5	• Risk assessment – Data sharing, processing, and access

### Update/ Assurance

#### Compliance with instructions

- All providers of NHS services have been asked to follow a set of clear directions around not stock piling medicines and consumables.
- WHC has followed this guidance, and communicated this message to all staff. Relevant staff members are ensuring that these instructions are complied with and not breached.

#### Working in partnership

Great Western Hospitals NHS Foundation Trust  
Royal United Hospitals Bath NHS Foundation Trust  
Salisbury NHS Foundation Trust

- Business continuity plans have/ are being updated as requested.

### **Risk assessments**

- All providers of NHS services have been asked to provide their commissioning CCG with a set of risk assessments in the five areas described above. These risk assessments covered the following areas: Service Delivery, Quality, Financial, Reputation, and Sustainability.
- WHC duly completed the requested risk assessments in the above areas week commencing 21 January 2018, and these were forwarded to Wiltshire CCG.
- The risk assessments completed by WHC indicated that there was low risk in all areas. This is largely due to the contingency measures set up nationally by the Government, DHSC, and NHS England/NHS Improvement. It is also of note that WHC has only 22 European Nationals employed as substantive staff, with no hot spot areas. This represents circa 2.04% of the total workforce, and it is considered to be most likely that these staff members will be keen to apply and successful in their applications to become a UK citizen. WHC has offered support in this regard. As such, WHC does not intend to create a workforce business continuity plan specifically in relation to EU Exit with “no deal”.

*NB: Out of 105 active bank workers engaged with WHC, 10 are identified on our system as being EU/EAA Nationals. WHC will support these bank workers with attaining UK citizenship also.*

- Importantly, WHC considers there to be no specific risk from an EU Exit with “no deal” to it being able to deliver its contract for community services. WHC is currently seeking assurances from the Wiltshire GP Alliance in relation to the delivery of the IA contract.

### **Communication with staff/ supporting staff to attain UK citizenship**

- The national guidance requests that NHS providers communicate key information with staff, and offer support in applying to be a UK citizen. WHC has sent out the messages as requested, and offered help and support through numerous emails to ‘all staff’, and this message will be repeated throughout the year (if required). In addition, our HR team will be contacting each EU citizen personally to offer support.

### **Participation on the Local Health Resilience partnership**

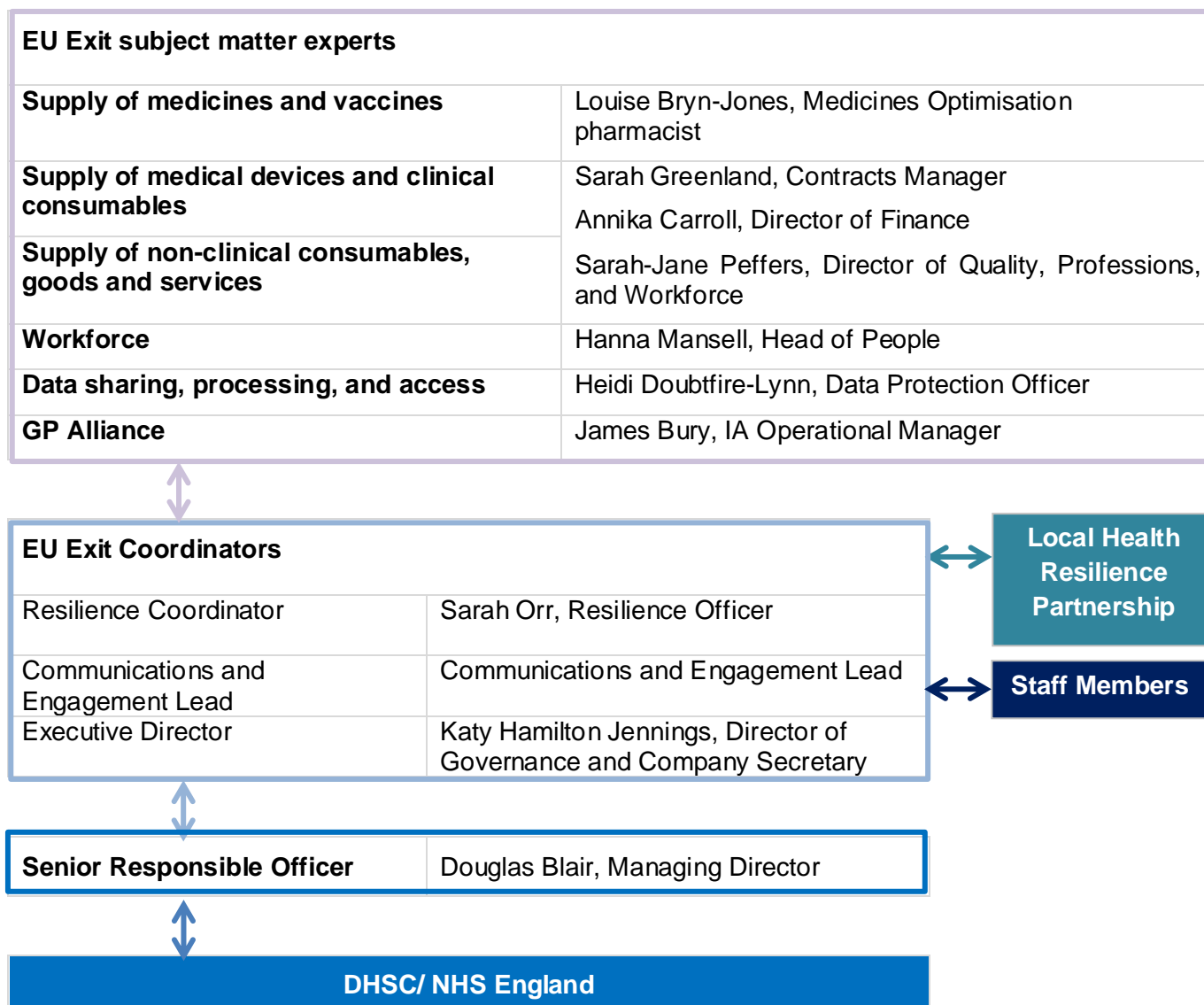
- WHC is part of the Local Resilience Partnership, and preparedness work is being coordinated through this forum.

### **Be ready for further national guidance**

- Further national guidance and returns will follow, and WHC has established a team to manage these requests – see Appendix 1.



## Appendix 1: Wiltshire Health and Care – EU Exit Preparedness





Department  
of Health &  
Social Care

# **EU Exit Operational Readiness Guidance**

**Actions the health and care system in England should  
take to prepare for a 'no deal' scenario.**

Published on 21 December 2018

# Contents

Purpose .....	3
Overview .....	4
Summary .....	6
Supply of medicines and vaccines.....	6
Supply of medical devices and clinical consumables .....	8
Supply of non-clinical consumables, goods and services .....	9
Workforce .....	10
Reciprocal healthcare .....	11
Research and clinical trials .....	11
Data sharing, processing and access.....	13
ANNEX A – Action cards .....	15
Card 1 – Action card for providers .....	16
Card 2 – Action card for commissioners .....	25
Card 3 – Action card for NHS England and Improvement regional teams.....	33

# Purpose

The EU Exit Operational Readiness Guidance, developed and agreed with NHS England and Improvement, lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal – a ‘no deal’ exit. This will ensure organisations are prepared for, and can manage, the risks in such a scenario.

This guidance has been sent to all health and care providers, including adult social care providers, to ensure the health and care system as a whole is prepared. Adult social care providers are advised to use this guidance as a prompt to test their own contingency plans. A further letter has also been sent in parallel to local authorities and adult social care providers to address specific adult social care issues.

# Overview

The EU Exit Operational Readiness Guidance summarises the Government's contingency plans and covers actions that all health and adult social care organisations should take in preparation for EU Exit.

All organisations receiving this guidance are advised to undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts. In addition, the actions in this guidance cover seven areas of activity in the health and care system that the Department of Health and Social Care is focussing on in its 'no deal' exit contingency planning:

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials; and
- data sharing, processing and access.

The impact of a 'no deal' exit on the health and adult social care sector is not limited to these areas, and the Department is also developing contingency plans to mitigate risks in other areas. For example, the Department is working closely with NHS Blood and Transplant to co-ordinate 'no deal' planning for blood, blood components, organs, tissues and cells (as detailed in the two technical notices on [blood](#) and [organs, tissues and cells](#) and the recent [letter](#) to the health and care system sent by the Secretary of State for Health and Social Care on 7 December 2018).

The actions in this guidance factor in the Government's revised border planning assumptions which were detailed in the Cabinet Office's [guidance](#) on 7 December 2018.

In preparation for a 'no deal' exit, the Department, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This will lead on responding to any disruption to the delivery of health and care services in England, that may be caused or affected by EU Exit. The Operational Response Centre will co-ordinate EU Exit-related information flows and reporting across the health and care system. The Operational Response Centre will also work with the devolved administrations to respond to UK-wide incidents.

The Operational Response Centre has been established to support the health and care system to respond to any disruption, and will not bypass existing local and regional reporting structures.

Working closely with the Operational Response Centre, NHS England and Improvement will also establish an Operational Support Structure for EU Exit. This will operate at national, regional and local levels to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required. Contact details for the regional EU Exit leads are below:

Region	Contact details for regional EU Exit lead
North East	<a href="mailto:England.euexitnortheast@nhs.net">England.euexitnortheast@nhs.net</a>
North West	<a href="mailto:England.euexitnorthwest@nhs.net">England.euexitnorthwest@nhs.net</a>
Midlands	<a href="mailto:England.mids-euexit@nhs.net">England.mids-euexit@nhs.net</a>
East of England	<a href="mailto:England.eoe-euexit@nhs.net">England.eoe-euexit@nhs.net</a>
London	<a href="mailto:England.london-euexit@nhs.net">England.london-euexit@nhs.net</a>
South East	<a href="mailto:England.se-euexit@nhs.net">England.se-euexit@nhs.net</a>
South West	<a href="mailto:England.sw-euexit@nhs.net">England.sw-euexit@nhs.net</a>

NHS providers and commissioners will be supported by local NHS teams to resolve issues caused or affected by EU Exit as close to the frontline as possible. These issues will be escalated to regional level, as required. Where issues are impacting across the health and care system at a national level, the Operational Response Centre will co-ordinate information flows and responses.

This guidance and the planning assumptions within it represent the most up to date information available. Further operational guidance will be issued and updated to support the health and care system to prepare for the UK leaving the EU prior to 29 March 2019.

## Summary

This section summarises seven areas where the government is focussing ‘no deal’ exit contingency planning in the health and care system, and where local action is required. Detailed actions for providers, commissioners and NHS England and Improvement regional teams are listed in Annex A (pages 15 to 33). Please read the summary and the action card that is applicable to your organisation.

Common to all of the groups of medical products listed below, it should be noted that government departments have also been working to design customs and other control arrangements at the UK border to ensure goods, including medical supplies, can continue to flow into the UK without being delayed by additional controls and checks.

However, the EU Commission has made clear that, in a ‘no deal’ exit, it will impose full third country controls on people and goods entering the EU from the UK. The cross-government planning assumption has therefore been revised to prepare for the potential impacts that the imposition of third country controls by member states could have. The revised assumption shows that there will be significantly reduced access across the short straits, for up to six months.

## Supply of medicines and vaccines

- The Government recognises the vital importance of medicines and vaccines, and has developed a UK-wide contingency plan to ensure the flow of these products into the UK in a ‘no deal’ scenario.
- The plan covers medicines used by patients and service users in all four nations of the UK, as well as the UK Crown Dependencies. The Department is working very closely with the devolved administrations, the Crown Dependencies and other government departments to explore specific issues related to the various supply chains for medicines in the UK, as well as potential mitigations. The plan covers medicines used by all types of providers, including private providers.
- Earlier this year, the Department undertook an analysis using Medicines and Healthcare Products Regulatory Agency and European Medicines Agency data, on the supply chain for all medicines (including vaccines and medical radioisotopes). This identified those products that have a manufacturing touch point in the EU or wider EEA countries.
- In August 2018, the Department for Health and Social Care [wrote to pharmaceutical companies](#) that supply the UK with prescription-only and pharmacy medicines from, or via, the EU or European Economic Area (EEA) to prepare for a no deal scenario.

Companies were asked to ensure they have a minimum of six weeks' additional supply in the UK, over and above their business as usual operational buffer stocks, by 29 March 2019. Companies were also asked to make arrangements to air freight medicines with a short shelf life, such as medical radioisotopes.

- Since then, there has been very good engagement from industry to ensure the supply of medicines is maintained in a 'no deal' exit.
- The Department will support manufacturers taking part in the contingency planning and is already providing funding for the provision of additional capacity for the storage of medicines.
- In October, the Department invited wholesalers and pre-wholesalers of pharmaceutical warehouse space to bid for government funding to secure the additional capacity needed for stockpiled medicines, and funding for selected organisations has now been agreed.
- On 7 December 2018, the Department [wrote](#) to UK manufacturers of medicines currently using the short straits crossings of Dover and Folkestone as they will want to review supply arrangements in light of the Government's updated planning assumptions.
- Whilst the six-week medicines stockpiling activity remains a critical part of the Department's UK-wide contingency plan, it is now being supplemented by additional national actions.
- The Government is working to ensure there is sufficient roll-on, roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK.
- The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of all these products will continue unimpeded after 29 March 2019. This includes all medicines, including general sales list medicines.
- In the event of delays caused by increased checks at EU ports, the Department will continue to develop the UK-wide contingency plan for medicines and vaccines with pharmaceutical companies and other government departments.
- UK health providers – including hospitals, care homes, GPs and community pharmacies – should not stockpile additional medicines beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions and the public should be discouraged from stockpiling.



- Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
- The Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines; arrangements are also likely to be put in place to monitor the unnecessary export of medicines.
- The Department is putting in place a “Serious Shortage Protocol”. This will involve changes to medicines legislation that will allow flexibility in primary care dispensing of medicines. Robust safeguards will be put in place to ensure this is operationalised safely, including making authoritative clinical advice available.
- Public Health England (PHE) is leading a separate UK-wide programme ensuring the continuity of supply for centrally-procured vaccines and other products that are distributed to the NHS for the UK National Immunisation Programme or used for urgent public health use. In addition to the national stockpiles that PHE has in place to ensure continued supply to the NHS, PHE continues to work alongside contracted suppliers on their contingency plans to ensure that the flow of these products will continue unimpeded in to the UK after exit day.

## Supply of medical devices and clinical consumables

- On 23 October 2018, the Secretary of State for Health and Social Care [wrote](#) to all suppliers of medical devices and clinical consumables updating them on the contingency measures the Department is taking to ensure the continuity of product supply.
- One of these measures is to increase stock levels of these products at a national level in England.
- The Department is working with the devolved nations and Crown Dependencies to ensure that national contingency arrangements are aligned and able to support specific preparedness measures necessary to meet the needs of their health and care systems.
- The Department is also developing contingency plans to ensure the continued movement of medical devices and clinical consumables that are supplied from the EU directly to organisations delivering NHS services in England.

- The Department has asked all suppliers that regularly source products from EU countries to review their supply chains and determine what measures they need to take to ensure the health and care system has access to the products it needs.
- NHS Supply Chain officials are also contacting suppliers who routinely import products from the EU to establish what measures are required to ensure they can continue to provide products in a 'no deal' scenario. Products are already being ordered.
- The Government is working to ensure there is sufficient roll-on/roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK. This will help facilitate the flow of products to both NHS and private care providers.
- The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of these products will continue unimpeded after 29 March 2019.
- There is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and, if the situation changes, will provide further guidance by the end of January 2019.
- The Department continues to engage directly with industry suppliers, trade associations, NHS providers and other government departments to develop its contingency planning approach and ensure the continued supply of medical devices and clinical consumables into the UK.

## **Supply of non-clinical consumables, goods and services**

- The Department has identified categories of national suppliers for non-clinical consumables, goods and services that it is reviewing and managing at a national level. Examples of relevant categories include food and laundry services.
- For these categories, the Department is engaging with suppliers and industry experts to identify and plan for any supply disruption. Where necessary, there will be cross-government work to implement arrangements at the point of EU Exit to ensure continued supply.
- On food, for example, the Department is engaging with both suppliers and health experts to identify and plan for any food items that might suffer supply disruption in the event of a 'no deal'. Standard guidelines will be developed for health and adult social care providers on suitable substitution arrangements for any food items identified as being at risk.

- The Department is also conducting supply chain reviews across the health and social care system to assess commercial risks. This includes reviews for high-risk non-clinical consumables, goods and services, and a self-assessment tool for NHS Trusts and Foundation Trusts. The results of these self-assessments were received at the end of November, and the Department is conducting analysis of the data, that will be used to provide additional guidance to Trusts and Foundation Trusts in January 2019.

## Workforce

- The current expectation is that there will not be a significant degree of health and care staff leaving around exit day. Organisations can escalate concerns through existing reporting mechanisms to ensure there is regional and national oversight.

## EU Settlement Scheme

- Through the EU Settlement Scheme, EU citizens will be able to register for settled status in the UK if they have been here for five years, or pre-settled status if they have been here for less than five years. This will ensure the rights of EU citizens are protected in the UK after EU Exit, and guarantee their status and right to work.
- Some EU citizens working in the health and care system would have been able to register for EU settled status under the pilot scheme that was open between the 3rd and 21st December 2018. People that did not register under the pilot scheme do not need to worry as the scheme will be fully open by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register.
- More information, including where to register, can be found on this [website](#).

## Professional regulation (recognition of professional qualifications)

- Health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.
- Health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019 will be subject to future arrangements.

## Reciprocal healthcare

- These plans are without prejudice to the rights and privileges available to Irish citizens in the UK, and UK citizens in Ireland, under the Common Travel Area arrangements.
- In a 'no deal' scenario, UK nationals resident in the EU, EEA and Switzerland may experience limitations to their access to healthcare services. The Government is therefore seeking to protect current reciprocal healthcare rights through transitional bilateral agreements with other member states.
- The Government has recently introduced the [Healthcare \(International Arrangements\) Bill](#) to ensure we have the legal powers to enter into such agreements in a 'no deal' scenario. The Bill could support a broad continuance of the existing reciprocal healthcare rights under current EU regulations (such as the European Health Insurance Card).
- The Government will issue advice via [www.gov.uk](http://www.gov.uk) and [www.nhs.uk](http://www.nhs.uk) to UK nationals living in the EU, to UK residents travelling to the EU and to EU nationals living in the UK. It will explain how the UK is working to maintain reciprocal healthcare arrangements, but this will depend on decisions by member states. It will set out what options people might have to access healthcare under local laws in the member state they live in if we do not have bilateral agreements in place, and what people can do to prepare. These pages will be updated as more information becomes available.
- As is currently the case, if UK nationals living in the EU face changes in how they can access healthcare, and if they return permanently to the UK and take up ordinary residence here, they will be entitled to NHS-funded healthcare on the same basis as UK nationals already living here.
- It is not possible to quantify how many people might return due to changes in reciprocal healthcare, and it is important to note that people might return to the UK for many other reasons such as changes in legal status or costs of living.

## Research and clinical trials

### EU research and innovation funding schemes

- The Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after EU Exit, until the end of 2020.

- This means that successful bids for EU programme funding until the end of 2020 will receive their full financial allocation for the lifetime of the project.

### **Clinical networks**

- In a 'no deal' scenario, UK clinicians would be required to leave European Reference Networks (ERNs) on 29 March 2019. However, the UK will seek to strengthen and build new bilateral and multilateral relationships – including with the EU – to ensure clinical expertise is maintained in the UK.
- The Department and NHS England are in contact with the ERNs and no action is required at this stage. Further information will be communicated to the NHS and professional bodies in due course.

### **Clinical trials and clinical investigations**

- The Government has issued [guidance](#) on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario.
- The Department continues to engage with the life sciences industry regarding contract research and clinical trials of IMPs and medical devices. The Department is working closely with the NHS and is undertaking a comprehensive assessment of the potential impact of 'no deal' exit on clinical trials and investigations, to gain a greater understanding of those which might be affected by supply issues. This includes examining supply chains for IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA. This assessment aims to conclude in January 2019 and, if necessary, further guidance will be issued thereafter.
- All organisations participating in and/or recruiting patients to clinical trials or clinical investigations in the UK should contact their relevant trial sponsors for confirmation of plans for supply chains for IMPs and medical devices as soon as possible.
- The Department has communicated with Sponsors of trials to emphasise their responsibility for ensuring the continuity of IMP supplies for their trials. The Government will monitor for any clinical trials or clinical investigations impacted due to disruptions to clinical trial supplies. Organisations should therefore continue to participate in and/or recruit patients to clinical trials and clinical investigations from 29 March 2019, unless they receive information to the contrary from a trial sponsor, organisation managing the trial or investigation, or from formal communications.

## Clinical Trial Regulation

- For EU-wide trials, the new EU Clinical Trial Regulation (CTR) will not be in force in the EU on 29 March 2019 and so will not be incorporated into UK law.
- However, the Government has stated the UK will align where possible with the CTR without delay when it does come into force in the EU, subject to usual parliamentary approvals. This will provide certainty for organisations conducting trials in the UK.
- Those organisations carrying out clinical trials should follow the normal process for seeking regulatory approval.

## Data sharing, processing and access

- It is imperative that personal data continues to flow between the UK, EU and EEA member states, following our departure from the EU. The Department for Digital, Culture, Media and Sport and the Information Commissioner's Office (ICO) have released guidance on data protection in a 'no deal' scenario, which can be viewed on [gov.uk](https://www.gov.uk) and the ICO [website](https://ico.org.uk).
- The European Commission is unlikely to have made a data protection adequacy decision regarding the UK before EU Exit. An adequacy decision is where the European Commission is satisfied that a transfer of personal data from the EU/EEA to a country outside the EU/EEA would be adequately protected.
- Transfers of personal data from the UK to the EU/EEA should not be affected in a 'no deal' scenario. This is because it would continue to be lawful under domestic legislation for health and adult social care organisations to transfer personal data to the EU/EEA and adequate third countries in the same way we do currently.
- At the point of exit, EU/EEA organisations will consider the UK a third country. This will mean the transfer of personal data from the EU/EEA to the UK will be restricted unless appropriate safeguards are put in place.
- In order to ensure that personal data can continue to be transferred from organisations in the EU/EEA to the UK in the event there is no adequacy decision, alternative mechanisms for transfer may need to be put in place. This is the case even if organisations are currently compliant with the GDPR.
- One solution you could consider, which the ICO states that most businesses find to be a convenient safeguard, particularly when dealing with non-public organisations, is to use one of the standard contractual clauses (SCCs) approved by the EU Commission. Guidance on these SCCs can be found in the links to [gov.uk](https://www.gov.uk) and the ICO website

above. Further information will be issued in due course. For now, health and adult social care organisations should follow the instructions detailed in Annex A to identify data flows that may be at risk in a 'no deal' exit.

# ANNEX A – Action cards

Card	Audience	Page
1	<p>Providers:</p> <ul style="list-style-type: none"> <li>• NHS Trusts and Foundation Trusts (acute, mental health, community and ambulance services)</li> <li>• Independent providers of NHS services</li> <li>• GP practices</li> <li>• NHS dentists</li> <li>• Community pharmacies</li> <li>• Opticians</li> <li>• NHS 111 providers</li> </ul>	16
2	<p>Commissioners:</p> <ul style="list-style-type: none"> <li>• Clinical Commissioning Groups</li> <li>• Sustainability and Transformation Partnerships/Integrated Care Systems</li> <li>• Specialised commissioning regional teams and hubs</li> <li>• Health and Justice national and regional teams</li> <li>• Armed Forces and their families commissioning team</li> <li>• Local authorities commissioning NHS services</li> </ul>	25
3	NHS England and Improvement regional teams	33



## **Card 1 – Action card for providers**

### **Role**

All providers of NHS services – including NHS Trusts and Foundation Trusts, primary care organisations and independent sector organisations who provide NHS services – must consider and plan for the risks that may arise due to a ‘no deal’ exit.

All providers should continue with their business continuity planning, taking into account the instructions in this national guidance, incorporating local risk assessments, and escalating any points of concern on specific issues to regional NHS EU Exit or departmental mailboxes listed in this guidance. Officials monitor these mailboxes and will respond to queries. Contact details for the regional NHS EU Exit Teams are included in the overview on page 5.

Clinical Commissioning Groups and NHS England should agree the handling of communications with general practice in line with existing delegation arrangements.

### **Actions for providers**

#### **Local EU Exit readiness preparations**

#### **Risk assessment and business continuity planning**

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:
  - The seven key areas identified nationally and detailed below.
  - Potential increases in demand associated with wider impacts of a ‘no deal’ exit.
  - Locally specific risks resulting from EU Exit.
- Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.
- Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

## **Communications and escalation**

All providers to:

- Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
- Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.
- Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.
- Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.

NHS providers to:

- Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document.
- Note your nominated regional NHS lead for EU Exit and their contact details (included in the overview on page 5).
- Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.
- Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

## **Reporting, assurance and information**

NHS providers to:

- Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS

organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.

- Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.
- For queries relating to specific topic areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox

### **Supply of medicines and vaccines**

All health and adult social care providers to:

- Follow the Secretary of State's [message](#) not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the continued supply of medicines and vaccines from the moment we leave the EU is being developed alongside pharmaceutical companies and other government departments.
- Note that there is no need to contact suppliers of medicines directly.
- Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.
- Note that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
- Note that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.
- Be aware that UK-wide contingency plans for medicines supply are kept under review, and the Department will communicate further guidance as and when necessary.
- Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

Regional pharmacists and emergency planning staff to:

- Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.

## **Supply of medical devices and clinical consumables**

- Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance by the end of January 2019.
- Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.
- Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.
- Send queries regarding medical devices and clinical consumables to [mdcc-contingencyplanning@dhsc.gov.uk](mailto:mdcc-contingencyplanning@dhsc.gov.uk).

## **Supply of non-clinical consumables, goods and services**

All providers to:

- Be aware that NHS Trust and Foundation Trust procurement leads have been asked to undertake internal reviews of purchased goods and services to understand any risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously.
- Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.
- Continue to update local business continuity plans to ensure continuity of supply in a 'no deal' scenario. Where appropriate, these plans should be developed in conjunction with your Local Health Resilience Partnership. All health organisations should be

engaged in their relevant Local Health Resilience Partnership, which should inform Local Resilience Forum(s) of local EU Exit plans for health and care.

- Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care.
- Await further advice from the Department on what actions should be taken locally.

NHS Trusts and Foundation Trusts to:

- Submit the results of their self-assessment on non-clinical consumables, goods and services to [contractreview@dhsc.gov.uk](mailto:contractreview@dhsc.gov.uk), if not done so already.
- Act upon further guidance to be issued by the Department in January 2019. This will be based on analysis of NHS Trusts and Foundation Trusts' self-assessments.

### Workforce

- Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.
- Publicise the EU Settlement Scheme to your health and care staff who are EU citizens. The scheme will open fully by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register. Further information can be viewed [here](#).
- Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with your Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the impact that would have on your organisation.
- Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.
- Ensure your board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.
- Notify your local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.

- Escalate concerns through existing reporting mechanisms.
- Send queries on workforce to [WorkforceEUExit@dhsc.gov.uk](mailto:WorkforceEUExit@dhsc.gov.uk).

### **Professional regulation (recognition of professional qualifications)**

- Inform your staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.
- Inform your staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.

### **Reciprocal healthcare**

All providers to:

- Note that, in a no deal scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.
- Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).
- Note that the Department will provide updates and further information on reciprocal healthcare arrangements prior to 29 March 2019.

NHS Trusts and Foundation Trusts to:

- Maintain a strong focus on correctly charging those who should be charged directly for NHS care. Information on implementing the current charging regulations can be viewed on the webpage [here](#).
- Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.

- Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.

### GP practices to:

- Promote completion of the supplementary questions section of the GMS1 form, and then, as appropriate, send the form to NHS Digital ([NHSDigital-EHIC@nhs.net](mailto:NHSDigital-EHIC@nhs.net)) or the Department for Work and Pensions' Overseas Healthcare Team ([overseas.healthcare@dwpgsi.gov.uk](mailto:overseas.healthcare@dwpgsi.gov.uk)). The response on a person's non-UK EHIC/S1 helps the Department seek reimbursements from EU member states for those who are covered by the reciprocal healthcare arrangements. More information on the GMS1 form can be found [here](#). Further information for primary care staff on providing healthcare for overseas visitors from the EU/EEA can be found [here](#).

## Research and clinical trials

### EU research and innovation funding schemes

- Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after exit, until the end of 2020.
- Provide information about your Horizon 2020 grant [here](#). This should be actioned as soon as possible. Further guidance can be found [here](#) and all queries should be sent to [EUGrantsFunding@ukri.org](mailto:EUGrantsFunding@ukri.org).
- Contact officials at [EU-Health-Programme@dhsc.gov.uk](mailto:EU-Health-Programme@dhsc.gov.uk) with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.

### Clinical trials and clinical investigations

- Follow the Government's [guidance](#) on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario, if you sponsor or lead clinical trials or clinical investigations in the UK.
- Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical

consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.

- Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.
- Respond to any enquires to support the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.
- Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.
- Send queries concerning IMPs or medical devices to [imp@dhsc.gov.uk](mailto:imp@dhsc.gov.uk)

## Data sharing, processing and access

- Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.
- Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.
- Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on [gov.uk](https://www.gov.uk) and on the ICO [website](https://ico.org.uk), in particular to determine where to use and how to implement standard contractual clauses.
- Ensure that your data and digital assets are adequately protected by completing your annual [Data Security and Protection Toolkit](#) assessment. This self-audit of compliance



with the 10 Data Security Standards is mandatory to complete by the end of March 2019, but completing it early will enable health and adult social care providers to more quickly identify and address any vulnerabilities.

- Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.

### Finance

- Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.

### Queries

For queries relating to specific topics areas, providers should contact the departmental mailboxes listed in this guidance:

- Medicine shortage queries should be raised by business as usual routes
- Medical devices and clinical consumables to [mdcc-contingencyplanning@dhsc.gov.uk](mailto:mdcc-contingencyplanning@dhsc.gov.uk).
- NHS Trusts and Foundation Trusts' self-assessment on non-clinical consumables, goods and services to [contractreview@dhsc.gov.uk](mailto:contractreview@dhsc.gov.uk).
- Workforce to [WorkforceEUExit@dhsc.gov.uk](mailto:WorkforceEUExit@dhsc.gov.uk).
- Third Health Programme grants to [EU-Health-Programme@dhsc.gov.uk](mailto:EU-Health-Programme@dhsc.gov.uk).
- [Horizon 2020 grants to EUGrantsFunding@ukri.org](mailto:Horizon2020grants@ukri.org)
- IMPs or clinical devices to [imp@dhsc.gov.uk](mailto:imp@dhsc.gov.uk).

Any immediate risks or concerns relating to continuity of NHS service provision should be escalated to the relevant regional NHS EU Exit mailbox.

## **Card 2 – Action card for commissioners**

### **Role**

In addition to current responsibilities, commissioners – including Clinical Commissioning Groups, Primary Care Commissioning and specialised commissioning – should ensure that their contracted health and care services are ready to manage the risks arising in a ‘no deal’ exit.

Commissioners should continue with their business continuity planning, taking into account the instructions in this national guidance, incorporating local risk assessments and escalating any points of concern on specific issues to the relevant mailboxes.

Commissioners should also liaise with providers of services that they commission, to ensure they are taking account of the actions for providers outlined in this guidance. EU Exit and its implications on health and care services should be discussed at commissioner board level on a regular basis to ensure sufficient oversight.

### **Actions for commissioners**

#### **Local EU Exit readiness preparations**

##### **Risk assessment and business continuity planning**

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:
  - The seven key areas identified nationally and detailed below.
  - Potential increases in demand associated with the wider impacts of a ‘no deal’ exit.
  - Locally specific risks resulting from EU Exit.
- Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, including taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.
- Support providers to test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

### **Communications and escalation**

All commissioners to:

- Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
- Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.
- Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.
- Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019.

NHS commissioners to:

- Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit, into the regional NHS EU Exit teams listed in this document.
- Note your nominated regional NHS lead for EU Exit and their contact details (included in the overview at page 5).
- Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.
- Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

### **Reporting, assurance and information**

NHS commissioners to:

- Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS

organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.

- Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.
- For queries relating to specific topics areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox.

## Supply of medicines and vaccines

- Promote the Secretary of State's [message](#): healthcare providers should not stockpile medicines beyond their business as usual stock levels, and no clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the supply of medicines and vaccines is being developed alongside pharmaceutical companies and other government departments.
- Advise providers that there is no need to contact suppliers of medicines directly.
- Ensure providers are encouraging staff to reassure patients that they should not store additional medicines at home as the Government is working with industry to ensure a continued supply of medicines from the moment we leave the EU.
- Inform providers that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
- Inform providers that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.
- Be aware that the UK-wide contingency plan for medicines and vaccines is kept under review, and the Department will communicate further guidance as and when necessary.
- Share letters from the Department aimed at an NHS and wider health and care provider audience (such as the third sector, private sector and home care).

- Note that the Department has engaged directly with specialist commissioning leaders about prisons and defence. This is to address their specific needs and concerns relating to medicine supply.
- Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

Regional pharmacists and emergency planning staff to:

- Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.

### **Supply of medical devices and clinical consumables**

- Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, we will provide further guidance by the end of January 2019.
- Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.
- Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.
- Send queries regarding medical devices and clinical consumables to [mdcc-contingencyplanning@dhsc.gov.uk](mailto:mdcc-contingencyplanning@dhsc.gov.uk).

### **Supply of non-clinical consumables, goods and services**

- Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care, adult social care and public health services.

- Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.
- Check your providers continue to update their local business continuity plans to ensure continuity of supply in a 'no deal' scenario.
- Await further advice from the Department on where actions should be taken locally by commissioners and providers of NHS-commissioned services.

## **Workforce**

- Ensure healthcare providers that deliver your commissioned services publicise the EU Settlement Scheme to their health and care staff who are EU citizens, and support them to apply for the scheme.
- Monitor the workforce impacts of EU Exit in your primary and secondary care providers' business continuity plans and highlight risks to [WorkforceEUExit@dhsc.gov.uk](mailto:WorkforceEUExit@dhsc.gov.uk).
- Ensure your providers' board-approved business continuity plans include workforce planning.
- Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.
- Publicise the EU Settlement Scheme to your staff who are EU nationals and actively support them to apply for the scheme when it opens in March 2019. Further information can be viewed [here](#).
- Monitor the impact of EU Exit on your own workforce regularly, and update your local business continuity plans as necessary.
- Send workforce queries to [WorkforceEUExit@dhsc.gov.uk](mailto:WorkforceEUExit@dhsc.gov.uk)

## **Professional regulation (recognition of professional qualifications)**

- Inform your staff and healthcare providers that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.

- Inform your staff and healthcare providers that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.

### **Reciprocal healthcare**

- Note that, in a 'no deal' scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.
- Inform NHS Trusts and Foundation Trusts that they should continue to maintain a strong focus on correctly charging those who should be charged directly for NHS care.
- Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.

### **Research and clinical trials**

- Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after Exit, until the end of 2020.
- Ensure your providers who receive Horizon 2020 grants input basic information about their awards into a portal, which can be accessed [here](#), as soon as possible. Further guidance can be found [here](#) and all queries should be sent to [EUGrantsFunding@ukri.org](mailto:EUGrantsFunding@ukri.org).
- Ensure your providers who receive Third Health Programme grants contact officials at [EU-Health-Programme@dhsc.gov.uk](mailto:EU-Health-Programme@dhsc.gov.uk) with information regarding their awards and any queries that they have, as soon as possible.

## Clinical trials and clinical investigations

- Support your providers to respond to the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.
- Support your providers who run clinical trials or investigations in the UK to consider their supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA as soon as possible. Providers should contact relevant trial Sponsors, and if multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.
- Support your providers to participate in and/or recruit to clinical trials and investigations up to and from 29 March 2019. This should occur unless providers receive information to the contrary from a trial Sponsor, organisation managing the clinical trial or investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.
- Send queries concerning IMPs or medical devices to [imp@dhsc.gov.uk](mailto:imp@dhsc.gov.uk).

## Data sharing, processing and access

- Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.
- Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.
- Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on [gov.uk](https://www.gov.uk) and on the ICO [website](#), in particular to determine where to use and how to implement standard contractual clauses.
- Ensure that your data and digital assets are adequately protected, by completing your annual [Data Security and Protection Toolkit](#) assessment. This self-audit of compliance with the 10 Data Security Standards is mandatory, to be completed by end March



2019, but early completion will enable health and adult social care organisations more time to identify and quickly address any vulnerabilities.

- Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.

### Finance

- Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Commissioners should discuss these costs with their regional NHS EU Exit support team. Feedback from commissioners will inform decisions on whether further guidance on cost collection is required.

### Queries

For queries relating to specific topics areas, commissioners should contact the departmental mailboxes listed in this guidance:

- Medicine shortage queries should be raised by business as usual routes
- Medical devices and clinical consumables to [mdcc-contingencyplanning@dhsc.gov.uk](mailto:mdcc-contingencyplanning@dhsc.gov.uk).
- NHS Trusts and Foundation Trusts' self-assessment on non-clinical consumables, goods and services to [contractreview@dhsc.gov.uk](mailto:contractreview@dhsc.gov.uk).
- Workforce to [WorkforceEUExit@dhsc.gov.uk](mailto:WorkforceEUExit@dhsc.gov.uk).
- Third Health Programme grants to [EU-Health-Programme@dhsc.gov.uk](mailto:EU-Health-Programme@dhsc.gov.uk).
- [Horizon 2020 grants to EUGrantsFunding@ukri.org](mailto:Horizon2020grants@ukri.org)
- IMPs or clinical devices to [imp@dhsc.gov.uk](mailto:imp@dhsc.gov.uk).

Any immediate risks or concerns relating to continuity of NHS service provision should be escalated to the relevant regional NHS EU Exit mailbox.

## **Card 3 – Action card for NHS England and Improvement regional teams**

### **Role**

In addition to current responsibilities, NHS regional teams will be required to provide regional system oversight in a 'no deal' scenario. The forthcoming NHS EU Exit Operational Support Structure will operate at a national and regional level, and support existing regional teams. Its functions will include monitoring local preparations, responding to the escalation of issues, and co-ordinating assurance and reporting arrangements at regional level.

NHS regional teams should communicate the necessary actions to providers and commissioners, and ensure that these instructions are being followed. This assurance should be gained through reporting on resilience and business continuity plans, and through existing meetings with providers and commissioners in your area. Once the dedicated NHS EU Exit regional teams are established, they will undertake assurance of local business continuity plans in relation to EU Exit.

Regional NHS leads and mailboxes for EU Exit have been established. Further details of the structure and function of the regional operational support teams will be communicated as the functions are implemented.

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Global and Public Health Directorate / EU and International Health / EU Exit Preparedness

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**'COMBINED' AGENDA**  
**Item 18**

**AOB**

**VERBAL**

## **'COMBINED' AGENDA**

**Date of next meeting of the Board**

**Friday 3<sup>rd</sup> May 2019, 10:00-13:00**  
**Training Room 1, Chippenham Community Hospital**

