Avon and Wiltshire Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Trust Board - Part 1

Held on 26 July 2017, Fromeside, Blackberry Hill Hospital at 10.00am

These Minutes are presented for **Approval**

Members Present

Ruth Brunt (RB), Non-Executive Director
Andrew Dean (AD), Director of Nursing & Quality
Rebecca Eastley (RE), Medical Director
Charlotte Hitchings (CH), Chair
Sue McKenna (SMcK), Chief Operating Officer
Charlotte Moar (CM), Non-Executive Director
Mark Outhwaite (MO), Non-Executive Director
Malcolm Shepherd (MS), Non-Executive Director
Simon Truelove (STr), Director of Finance

Non-Voting members

Neil Auty (NA), Associate Non-Executive Director
Rachel Clark (RC), Director of Strategy
Julian Feasby (JF), HR Director

Staff In Attendance

Sarah Knight (SK), Interim Company Secretary
Jennifer Ward (JW), Corporate Governance
Eleanor Hogarth (EH), Specialist Registrar (part of the meeting)

Members of the Public in Attendance

No members of the public attended the meeting.

BD/17/088 Welcome and apologies

1. The Chair, Charlotte Hitchings (CH), welcomed member of staff and observers to the meeting. She also welcomed Julian Feasby (JF), the new Human Resources (HR) Director, to his first official Board meeting.
2. Apologies were received from Hayley Richards, Chief Executive, and Ernie Messer, Non-Executive Director.

BD/17/089 Declaration of Members' Interests

1. In accordance with AWP Standing Orders (s8.1) members present were asked to declare any conflict of interest with items on the Board meeting agenda.

2. **There were no declarations received or any conflicts of interest regarding items on the agenda.**

BD/17/090 Patient Experience story

1. Unfortunately due to unforeseen circumstances, the service user invited to speak to the Board was unable to attend the meeting, but hoped to attend at a later date.

BD/17/091 Minutes of the Part 1 Trust Board Meeting held on 31 May 2017

1. With the alteration of one small spelling mistake **The Board approved the Minutes of the meeting held on 31 May 2017**

BD/17/092 Matters Arising from the Previous Meeting

1. BD/16/274(b): Annual Operating Plan; Deep Dive on agency spend – work was continuing with SSG Health to produce a more detailed deep dive for discussion at the Finance & Planning and Quality & Standards Committees. It was agreed that Ernie Messer (EM), Non-Executive Director, Mark Outhwaite (MO), Non-Executive Director, Sue McKenna (SMc), Chief Operating Officer, and Andrew Dean (AD), Nursing & Quality Director, would define and scope the deep dive, and an update would be considered in Part 2. Item to be removed from the action list.

2. BD17/019: Chair's Report – an information pack was being developed which would include dates for all Clinical Commissioning Group (CCG) and Health & Wellbeing Boards, a list of stakeholders within a locality, and service business plans for those directors linked to a service. The pack would be available by the end of June 2017. The information was collated and circulated. Complete. Item to be removed from the action list.

3. BD/17/048: Finance Report month 1. MO and STr would meet to discuss a breakdown of CIPs into risk categories and further clarity on the programme would be provided to the Board. Complete. Item to be removed from the action list.

4. BD/17/048: Finance Report month 1. It was agreed that the deep dive would look into the costs of both bank/agency and substantive staff, with a detailed report being presented to the next meeting of the Board. It was agreed that MO would meet with AD and SSG Health to discuss the granularity required to fully understanding the issue. Complete. Verbal update to be given in part 2. Item to be removed from the action list.

5. BD/17/053: Whistleblowing Annual Report. MO raised concerns about the quality of case management files. The Board agreed to ask the incoming Director of HR to review the quality of case management files and report to a future Board meeting. This would be horizontally reported to Quality & Standards Committee and added to the agenda for October. Item to be removed from the action list.

6. BD/17/055: Trust Risk Register. The Board requested that risks relating to the workforce should be re-visited and included within the register. Complete. Item to be removed from the action list.

BD/17093 Chief Executive's Report

1. Andrew Dean (AD), Director of Nursing and Quality and Deputy Chief Executive, presented the report.

2. The report highlights included: - Care Quality Commission (CQC) mental health services review. The CQC had this month released the findings of its comprehensive inspection programme of all specialist mental health services, giving the most complete picture ever of the quality of mental health provision for people in England. AWP was already addressing all the issues highlighted in the report.

3. AD reported that Brigid Musselwhite had been appointed as interim Bath & North East Somerset (BaNES), Swindon & Wiltshire (BSW) Sustainable Transformation Partnership (STP) Programme Director for the next six months, while a new Senior Responsible Officer was appointed, and Linda Prosser, Director of Assurance and Delivery for Bristol, South Gloucestershire and North Somerset, NHS England, had been seconded to Wiltshire Clinical Commissioning Group (CCG) as

Interim Chief Officer.

4. Headlight's Dragon Boat Race. Glorious weather heralded Headlight's first major fundraising event as teams of staff, supporters, service users and friends took to the water in Dragon Boats. The teams together raised nearly £4,000 for the charity, the majority through sponsorship.

5. Child and Adolescent Mental Health Services (CAMHS) Riverside Adolescent Unit received an outstanding Quality Network for Inpatient CAMHS (QNIC) report for 2017. QNIC, the external national accreditation framework of the Royal College of Psychiatrists, scored Riverside 96% for care and treatment and 100% for young people's rights and safeguarding children.

6. AWP's Complex Intervention and Treatment (CIT) team in Swindon won the Social Work Placement of the Year Award 2017 from Oxford Brookes University.

7. The re-opening of Laurel Ward was planned with fewer beds initially.

8. A Listening into Action (LiA) Pulse Check was completed by 1381 members of staff in order to gather views about what it was like to work in our organisation. Initial results reveal that 58% of staff believed we were providing high quality services to our service users but that we needed to do more to improve how we communicated between staff and senior management.

The Board noted the report.

BD/17/094 Report of the Quality & Standards Committee Chair

1. Ruth Brunt (RB), Non-executive Director, presented the Chair's report of the Quality & Standards meeting held on 18 July 2017.

2. She informed the Board that the Bristol team had attended the meeting and given an update on Laurel Ward, Aspen Ward and the improvements to the crisis line. The Committee had noted the challenges for the Bristol team as Delayed Transfers of Care (DToC) and GP practices which were under pressure and possibly merging.

3. The Committee had received assurance on the following: the medicines audit demonstrated improved prescribing practice, the process for assessing and reporting the quality impact of the financial improvement plan, an updated position and action plan following partial assurance rating in the Internal Audit report on Unexpected Deaths – Incident Management, the progress with the Workforce Race Equality Standard (WRES), and the Service User and Carer Engagement Strategy Implementation Plan.

4. The Committee required further assurance regarding: the timescales for seeing improvements in 72 hour incident reporting, the impact of Safeward interventions, the trajectory for improving the number of missed doses/blank boxes on medication charts and the 15 month trends on key indicators to enable comparisons with last year. They also wanted a measure of the number of complaints against the level of activity.

The Board noted the report.

BD/17/095 Clinical Executive Report

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1. Rebecca Eastley (RE), Medical Director, presented the Clinical Executive report.

2. The Trust had reported fourteen serious untoward incidents in June, an increase from eleven reported in May 2017. The Trust had recently implemented an agreed process to identify serious incidents and this was reflected in an increase in the number reported on since January 2017.

3. The Care Quality Commission (CQC) had now completed their focused inspection of our services

and had given initial feedback to the Trust's senior management. The CQC spoke about the passionate staff they encountered "across the board". They spent time in a number of Trust teams between 19th and 30th June to check progress against areas that required improvement, as highlighted in their comprehensive inspection in 2016. These areas included: In-patient, Acute and Psychiatric Intensive Care Unit (PICU), Older people in-patient services, Intensive Services, Health Based Places of Safety, Rehabilitation and Well Led as an overall inspection of how the organisation operates leadership, vision, values, governance and assurance.

4. Twice weekly teleconference meetings had been taking place between the clinical executive directorate, operations and the triumvirate in Bristol around the issues in Laurel Ward. This aided communication and effective management of the situation and was chaired by the Associate Director of Nursing for Inpatients who was leading the project.

5. The number of reported missed doses between 4th June to 25th June was high, however, this was a reduction in the average when comparing to the previous reported period of 7th May to 4th June.

6. The Service User and Carer Engagement/Experience 2016 community survey identified four keys areas of improvement for the Trust. These were :- annual reviews, crisis care, other areas of life – build on improvements for offering help and advice to people for peer support, and community engagement, and carers – consistently provide appropriate support and information for carers. An action plan to address the issues had been developed; implementation would be monitored via the Quality Improvement Plan (QIP) and progress reported within this report.

7. New items added to the Trust Quality Improvement Plan in June included: - improvement in the quality of root cause analysis around community deaths and to review falls training and guidance provided to staff to include ensuring the post falls checklist was understood and used by staff.

8. The following actions were report as off track 'red' this month:- staffing in Wiltshire which was reported as 'red' last month and actions continued based on the action plan reported in last month's clinical executive report; Physical Emergency Response Training (PERT) training compliance where further actions were being explored to improve compliance.

The Board noted the report

BD/17/096 A Framework of Quality Assurance for Responsible Officers and Revalidation, Annual Board report & statement of compliance

1. Rebecca Eastley (RE), Medical Director, presented the report. NHS England has developed 'The Framework of Quality Assurance for Responsible Officers and Revalidation' (FQA). The purpose of the framework was to support designated bodies and responsible officers in providing assurance that systems and processes are in place, identifying areas in which development will be required over the coming year and engaging Boards and management teams.

2. All responsible officers have been asked by NHS England to present an annual report to their Board. Following this, a statement of compliance should be signed off by the Chairman or Chief Executive Officer of the designated body's Board and submitted to the Higher-Level Responsible Officer by 29th September 2017.

3. AWP had areas of good practice in relation to appraisal, monitoring performance and responding to concerns, and recruitment and engagement. We were well above national comparators in terms of medical appraisal for the previous four years and had continued to improve and push the parameter for excellence.

The Board noted the report.

BD/17/097 Integrated Performance Report

1. Sue McKenna (SMc), Chief Operating Officer, presented the Integrated Performance Report.

2. Delayed Transfers of Care (DToC):- the current figure was 13.9% against a target of 7.5% by this first month of reporting for 2017/18. DToC levels remained high in Bristol, at 18.6%, in comparison with the Trust wide position.

3. Inpatient Flow:-the number of Out of Trust placements throughout M3 fluctuated between 15 and 20. Temporary bed closures, levels of acuity and DToC continued to have an effect. The implementation of an Operational Hub, as part of Trust-wide transformation programme, was due to be piloted in July with an objective of enabling improved inpatient flow.

4. Workforce:-after levelling in month 2 statutory / mandatory training levels had improved, moving from red to amber (85.6%). Sickness levels had increased this month (to 4.2%) but remained green on the dashboard.

5. Bank & Agency: - the percentage of establishment filled or covered with bank and agency personnel had decreased by 0.6% during this month to 95% and this remained significantly down on Month 11 and 12 of 16/17.

6. Local Delivery Units (LDU):-LDU indicators showed all areas with performance issues - ranging from Bristol with five areas of non-compliance to South Gloucestershire, Secure, Specialised and CAMHS with one.

7. Sarah Elliott (SE), Non-Executive Director, asked if we have a clear trajectory for improvements on DToC. SMc reported that we have addressed everything we can. She would now be working with the leaders of the 6 CCGs and addressing each case individually. The CCGs would now be monitored nationally on the level of Mental Health DToCs in the same way as the acute hospitals were.

8. SMc reported that we had 53 DToC patients spread over a wide area, each with very different requirements. She had weekly meetings about them and was escalating each case to NHS Improvement (NHSI), the local authorities and the CCGs, as necessary.

9. There followed a discussion on whether or not any money from the Better Care Fund would be allocated to the issue of DToC, in light of the financial pressures experienced by the councils.

10. CH suggested that a report on the DToC process comes to Board; to include a description of the processes and categories, and that prior to this a deep dive should go to the Quality & Standards Committee (Q & S). SMc and Ruth Brunt (RB) would meet to discuss the requirement of this report. **ACTION SMc/RB.**

    The Board noted the report.

BD/17/098 Human Resources/Workforce report

1. Julian Feasby (JF), Human Resources (HR) Director, presented the report which noted the workforce position in months 1 and 2.

2. There was a vacancy factor of approximately 16.5% across month 1 and 2 with the gap being filled to approximately 95.4% of establishment. The Trust was not using more bank and agency staff than establishment in either in-patient or community registered nurses or unregistered health care workers. The Trust top three reasons for using temporary staff were vacancies, patient acuity and staff sickness. We were losing as many staff as we were recruiting across the first two months of 17/18.

3. There were approximately 440 whole time equivalent (WTE) vacancies within in-patient and community registered and unregistered staffing compliments for months 1 and 2. Bank and agency staff filled 408.55 WTE posts during April and 412.8 WTE posts during May. This was below the vacancy factor for each month.

4. The Trust recruitment processes continued to be effective with 128 offers of employment made in April 2017 and a further 130 offers made in May. The number of leavers remained a cause for concern, particularly resignations among nursing staff. JF said he would be addressing the reasons for staff leaving.

5. RE suggested that the figures on medical staff were reported separately. Mark Outhwaite added that some details on the skill group/nursing groups and agency skills that were being used would be useful.

6. AD also presented the agency self certification checklist. He noted that this needed more work. The Board discussed the report and suggested that there needed to be more narrative included on the yes or no awarded to each item. It was agreed that the level of reporting needed would be discussed outside of the meeting and the report would go back to Quality & Standards Committee. **ACTION. AD**

The Board noted the report.

BD/17/099 Report of the Finance & planning Committee Chair

1. Mark Outhwaite (MO), Non-Executive Director, presented his report.

2. The Committee had noted the current financial position at month 3 - the Trust was £1.9m overspent and £706k overspent against a planned deficit of £1,234k. The main driver for the overspends remained the premium costs of agency staff. MO expressed concern that we were not assured on being able to hit our targets, although the work on going to manage agency spend was evident.

3. The Committee had asked for a breakdown of CIP achievement by risk category to better understand achievement. Underperformance on low-risk CIPs would provide early warning on capacity and capability challenges.

4. The Committee noted the continuing position on DToCs and that the CCGs had DToC targets for Mental Health as well as the acute DToC targets and that this would provide greater incentive for commissioner focus.

5. The Board agreed that the report would be discussed in more detail in part 2 of the Board meeting.

The Board noted the report.

BD/17/100 Finance report month 3

1. Simon Truelove (STr), Finance Director, presented the month 3 Finance report. The Board discussed whether the detail included in the report was at the right level and agreed it was.

2. At month 3 the Trust was £1.9m overspent and £706k overspent against a planned deficit of £1,234k. Main drivers for the overspend were high premium agency costs as well as over commitments of staff over funded establishment in secure, Bristol and Swindon; however there had been improvements compared to previous months.

3. Savings fell short of the month 3 plan by £2m. Of this £710k related to the unidentified savings, £490k for the components associated with safer staffing and £300k for savings not identified at a Local Delivery Unit. Savings in corporate services were being delivered by vacancies however work needed to occur to remove the vacancies permanently.

4. Some of the cost pressures had been mitigated by additional income from Health Education England.

5. Based on the current trends and assuming no delivery of additional savings on the Financial

Improvement Plan (FIP) the Trust would be overspent by £9.9m. Additional savings from the (FIP) were required in order to reduce this risk.

6. Cash for month 3 was better than plan however the cash position was forecast to deteriorate as the financial position worsened. This could be mitigated if savings started to take traction.

7. The Better Payment Practice Code performance dipped in June due to payment of old year invoice which had now been resolved. £531k of expenditure had been incurred on the capital programme at the end of the first quarter.

8. The Trustwide expenditure position was driven by pay costs, which were £244k higher than plan in month (£1.0m higher year-to-date). Agency costs were continuing to rise. At month end the Trust had 718 WTE vacancies of which 499 WTEs were covered by temporary staff.

9. The key contributors to the non-pay overspend were out of Trust bed usage, which had cost £1m year-to-date. In month the usage was equivalent to 10.1 beds. In addition, there were one-off FIP report charges of £355k. The underspend in establishment costs noted in prior months was now reducing and related to a lag in business expense claims following the introduction of the Health Roster system for expenses.

10. STr reported that installation of the Dragon system was being delayed as the Trust was not yet ready for it in terms of system compatibility and the costs were higher than previously thought.

11. The cash position at the month end was £4.370m. The average year to date volume of invoices was good for both NHS and non-NHS. The dip in month on the value for NHS was due to the CQC invoice delayed authorisation due to changes in personnel. This skewed the NHS in month down to 37% on value but rising to 90% on volume of invoices.

12. The reason for the spike in the 61-90 days debt was due to the Salford CCG client dispute. .

13. The Trust's revolving working capital facility was currently at £9.193m with a decision made not to draw cash in July or August from the Department of Health (DoH), given the latest projected cashflow forecast. The latest plan submitted to NHSI for 17/18 showed a further cash borrowing requirement of £3.056m against the agreed control total.

14. A further scenario model considering a reduced savings programme suggested a further £6.714m of cash borrowing which would take the total requirement to £13.064m for 17/18. This would give a potential loaned cash position of £18.963m by the end of 17/18, which was all currently borrowed at an interest rate of 3.5%.

15. Sue McKenna (SMc) reported to the Board that the transformation plans were progressing as planned with some scopes of the projects being altered in order to enact them in a timely way. She added that the main focusses would be Out of Area (OOA), DToC, workforce and agency. The processes would be agreed in the week following Board.

16. RB suggested that a report on the quality impact of delaying the work on Riverside would be useful. It was agreed that this would go to Q & S. **ACTION SMc**

The Board noted the report.

BD/17/101 Annual Objectives

1. Rachel Clark presented the report. This was the first quarterly report that demonstrated delivery against planned objectives.

2. Overall progress against quarter 1 objectives had been good. Considerable work had been carried out in the first quarter to support the CQC inspection in June, which had an impact on delivery of some objectives. More detailed analysis of baselines and trajectories was underway, and would be

reported to Quality and Standards Committee.

3. Actions had been implemented to achieve planned improvements in the Staff Survey, but the percentage improvement could not be measured until the survey was completed in the latter part of the year.

4. Cost Improvement Plans (CIPs) had not been delivered in line with plans. The Transformation Board, supported by the Project Management Office (PMO) and SSG Health, were working with project leads to review all plans and revise trajectories accordingly.

The Board noted the report.

BD/17/102 Report of the Audit & Risk Committee Chair

1. Charlotte Moar (CM), Non-Executive Director, presented her report. She noted that she had already given a verbal update to the Board in June.

2. The key decisions of the Committee were noted as: - the Committee approved the annual report, annual governance statement and letter of representation for 2016/17; approved the Charitable Funds annual report and accounts for 2016/17; agreed 2017/18 Counter Fraud plan and the 2016/17 self-assessment; and discussed the risk element of the self-assessment against the Well Led Framework of Strategy and Risk.

3. The Committee had noted the key action now was to confirm the plan to update the risk management policy and risk appetite matrix, finalise the system changes to Riskweb and agree the training plan and develop further the plan to ensure that all staff understood how to identify, mitigate and escalate risks.

The Board noted the report.

BD/17/103 Strategy

1. Rachel Clark (RC) presented the strategy.

2. The AWP Corporate Strategy built on the significant progress we had made in recent years improving care quality and service user experience. The strategy took account of our internal challenges, the introduction of Sustainability and Transformation Partnerships and publication of the national mental health strategy, and also noted the pressures in the health and care systems of which we were part.

3. The outline strategy was presented to the Extended Executive Team (EET) in July and was amended in the light of feedback received. Following approval of the Strategy, a programme of engagement would commence. We would invite staff, service users and carers, and wider stakeholders to comment on the journey we have described and to get involved in bringing the strategy to life. A range of communication resources were being provided and the presentation of documents would be improved. Patient stories would be included as recommended by EET.

4. RE suggested that one of the symbols should be altered as it resembled a religious symbol. RC requested that any comments go to her.

5. SE suggested that a log showing how the changes and service developments in the strategy link with the national guidelines on consultation was included. SE and RC would meet to discuss this. **ACTION RC/SE.**

6. CH thanked RC and her team for their work on the Strategy.

The Board approved the Strategy and endorsed the planned engagement events and opportunities.

BD/17/104 Staff Engagement Action plan

1. Julian Feasby (JF) presented the report, which captured and monitored actions to improve the experience of staff, following the 2016 National Staff Survey results.

2. Six key themes were identified by the group; these were IT systems, communication, workforce and resource planning, staff engagement, workload duplication and staff wellbeing.

3. JF noted that the report showed good engagement with the teams but that he wanted to see more input from line managers. He said he would be trying to meet with them to address this. CH suggested that he start in the areas with poor results first.

4. RB suggested that the staff themselves receive more feedback from the action plans so they are aware of the actions that have been taken in. AD said that communication around this was planned.

5. MO also wanted to see how the action plan and results were aligned with the Transformation and Financial Improvement Plans (FIP). AD said that work was already underway and actions were being undertaken by different groups to ensure alignment.

The Board noted the report

BD/17/105 Learning from Experience Assurance report

1. Andrew Dean presented the report. The report summarised the learning activity related to patient experience across the Trust in quarter one 2017/18. AD noted that this was work in progress and that future reports would have a clearer triangulation of information to identify learning.

2. The report reviewed key themes identified from a variety of information during Q1. The key themes were: interpretation and translation and cultural awareness, risk assessment, sand care planning.

3. Future reporting within the Patient Experience report would triangulate information from the Patient Advice & Liaison Service (PALS) and complaints with serious incidents to further explore where key issues were across the organisation thus informing the operations and quality improvement teams.

4. There was a continued theme of communication raised through Trust wide complaints; as discussed previously future reporting will triangulate incident and complaint intelligence.

5. Initial theming of learning from incidents had identified issues in relation to risk assessments as a key area for focus. The patient safety team were developing processes to support the suicide prevention team inform specific areas of training needs and improvement.

6. Quarter 1 had seen a decrease in complaint numbers from the previous quarter. However, looking back to the same period in the previous year the figures were similar and seasonal variation in complaints received was observed.

7. PALS enquiries ranged from requests for information to complex concerns that needed resolving. Not all cases were negative; some would involve signposting or discussing care pathways with people for example. PALS were mostly giving advice and assistance to people who contacted us. In quarter 1 we had also received 202 items of praise. These were submitted by teams via an electronic form and themed by the PALS team. The majority of praise was about clinical care (100) and attitude of staff (96).

8. The Board agreed that the name of the report should revert to being the ‘Learning from Experience report’. They also discussed and agreed that some of the figures needed to be presented differently to provide a clearer picture on trends, triangulation was required as planned and in future the report should go to Quality and Standards before coming to Board.

The Board noted the report.

BD/17/106 Minutes of the Board Committees

1. Quality and Standards (16 May / 20 June 17)
2. Finance and Planning (19 May / 16 June 17)
3. Charitable Funds (10 March)

The Board noted the minutes.

BD/17/107 Freedom to Speak up Guardian

1. Sarah Knight (SK) presented the report.

2. In response to concerns about the culture in the NHS, the Secretary of State for Health commissioned Sir Robert Francis QC to carry out an independent review: 'Freedom to Speak Up' (FTSU). The review was asked to identify measures to foster a culture in the NHS in England where staff can feel safe to speak out about patient safety, as well as learning lessons by listening to those who have experiences to share, both positive and negative.

3. The role would help to ensure staff knew how to, and where to, raise concerns. Staff would feel entirely confident that their concerns would be listened to and acted upon as necessary and, most significantly, that they would not experience any negative treatment or consequences for having raised their concerns.

4. Petra Freeman, the AWP Freedom to Speak Up Guardian (FTSUG), had been in post since 21 April 2017 The FTSUG worked alongside Trust senior leaders to support the organisation in becoming a more open and transparent place to work, where staff were actively encouraged and enabled to raise concerns safely and without fear of repercussions.

5. The main aim of this role was to promote and reinforce best practice in supporting staff to speak up safely through either the FTSUG or (in future) a network of FTSUG Champions, which were planned to be developed across the Trust, to enable everyone to have easy access to someone outside their immediate line management chain who can advise and support them.

6. Seven members of staff had contacted the FTSUG relating to five issues, in this initial period. All seven people had already raised their concerns with their direct line managers. They contacted the FTSUG as they had some unanswered questions and concerns which they wanted followed through and to obtain closure, some were copying in the FTSUG, whilst raising the concern with their manager.

7. Further plans included assessing the FTSUG process, identifying barriers to the Speaking up process, further developing plans to 'normalise' speaking up in the culture of the Trust, including increasing staff confidence to raise concerns, celebrating good practice, working with the Communication team to share learning in the future and introducing learning packages.

8. The Board discussed whether this report should have come to part 2 of the meeting, but agreed that it only needed a degree of anonymization and in principle should be in part 1. They also agreed that an easy guide to reporting concerns should be produced. **ACTION SK/FTSUG**

The Board noted the report.

BD/17/108 Chairs report

1. CH presented her report which she took as read. She informed the Board of her discussion with Kirsty Bashforth who is looking at gender diversity on NHS Boards in the context of the NHS' aim to achieve 50:50 balance by 2020. CH noted that AWP's current Board member gender diversity appears to be unusual in the NHS.

2. MO asked for a small amendment to his activities during the month.

The Board noted the report.

BD/17/109 Any other business

1. No further items were raised.

BD/17/110 Board Digest

The Board noted the report

BD/17/111 Answers to written questions from members of the public about Board agenda items

1. The Board had not received any questions which required an answer in the Board meeting.

The Chair closed the meeting at 12.50 pm

The next Trust Board meeting was scheduled for 27 September at 10.00 am, at Jenner House, Chippenham