Isle of Wight NHS
NHS Trust

The next meeting in public of the Isle of Wight NHS Trust Board will be held on **Wednesday 27th March 2013** commencing at 09:30hrs.in the Conference Room, St. Mary's Hospital, Parkhurst Road, NEWPORT, Isle of Wight, PO30 5TG. Staff and members of the public are welcome to attend the meeting. Staff and members of the public are asked to send their questions in advance to board@iow.nhs.uk to ensure that as comprehensive a reply as possible can be given.

AGENDA

Indicative Timing	No.	Item	Who	Purpose	Enc, Pres or Verbal
09:30	**1.**	**Apologies for Absence, Declarations of Interest and Confirmation that meeting is Quorate** *Apologies: Dr Mark Pugh, Executive Medical Director* *No business shall be transacted at a meeting of the Board of Directors unless one-third of the whole number is present including:* • *the Chairman;* • *one Executive Director; and* • *two Non-Executive Directors.*	Chair	Receive	Verbal
09:35	**2.**	**Launch of Membership Recruitment Drive and Video Question and Answer Session**	FTPD	Receive	Verbal
10:05	**3.**	**Minutes of Previous Meetings** 3.1 To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 27th February 2013 with the schedule of actions.	Chair	Approve	Enc A
10:15	**4.**	**Chair's Update** 4.1 The Chair will make a statement about recent activity *{Strategy}*	Chair	Receive	Verbal
10:25	**5.**	**Chief Executive's Report**			
		5.1 The Chief Executive will make a report on recent national, regional and local activity *{Strategy}*	CEO	Receive	Pres
		5.2 Patient Story *{Assurance}*	EDN&W	Receive	Pres
10:40	**6.**	**Strategy and Business Planning**			
		6.1 FT Programme Update *{Strategy}*.	FTPD	Receive	Enc B
		6.2 FT Self Certification *{Assurance}*	FTPD	Approve	Enc C
	7.	**Quality and Performance Management**			
11:00		7.1 Quality/ Performance/ Workforce/ Finance *{Assurance}*	EDSCP	Receive	Enc D
11:30		7.2 Staff Story – Ryan Small, Business Apprentice *{Culture}*	EDN&W & AD OD	Receive	Pres
	8.	**Governance and Administration**			
		To receive and approve the following: *{Assurance}*			
11:45		8.1 Financial Plan (Budget) 2013/14	EDF & DDF	Approve	Enc E
12:15		8.2 Isle of Wight NHS Trust Business Plan 2013/14	EDSCP	Approve	Pres

12:30		8.3 Definition of Senior Managers for the purposes of reporting remuneration in the 2012/13 Annual Report.	EDF & DDF	Approve	Enc F
12:35		8.4 Minutes of the Finance, Investment and Workforce Committee held on 20/3/13 and:	FIWC Chair	Approve	Enc G
		• Transfer of property and assets	EDSCP	Approve	Enc H
12:45		8.5 Minutes of the Quality and Clinical Performance Committee held on 20th February and 20th March 2013	Q&CP Chair	Approve	Enc I1 Enc I2
12:50		8.6 Minutes of the Mental Health Act Scrutiny Committee held on 23rd January 2013	MHASC Chair	Approve	Enc J
12:55		8.7 Minutes of the Foundation Trust Programme Board held on 26th February 2013.	FTPB Chair	Approve	Enc K
13:00	**9.**	**Questions from the public** (notified in advance – see above)	Chair		
13:10	**10.**	**Any Other Business**	Chair		
	11.	**Issues to be covered in private**	Chair		

The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to issues concerning individual people (staff or patients). On this occasion the Chairman will ask the Board to resolve:

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.

Items which will be discussed and considered for approval in private due to their confidential nature are:

- Update on the business case for the transfer of hosting arrangements for NHS Creative
- Board Assurance Framework – end of year review
- Clinical negligence claims

The Chairman or Chief Executive will indicate if there are any other issues which may be discussed in private without entering into detail about them. Members of the public, the press and members of staff will then be asked to leave the room.

13:15	**12.**	**Date of next meeting**	Chair

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on Wednesday 24th April 2013 in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

Isle of Wight NHS
NHS Trust

Minutes of the meeting in public of the Isle of Wight NHS Trust Board held on Wednesday 27 February 2013 in the Conference Room, St Mary's Hospital, Newport, Isle of Wight commencing at 09:30

PRESENT:	Danny Fisher	Chairman
	Karen Baker	Chief Executive
	Felicity Greene	Executive Director of Strategic Planning and Commercial Development
	John Matthews	Non Executive Director
	Chris Palmer	Executive Director of Finance & IM&T
	Mark Pugh	Executive Medical Director
	Alan Sheward	Executive Director of Nursing & Workforce
	Peter Taylor	Non Executive Director
	Sue Wadsworth	Non Executive Director
	Nick Wakefield	Non Executive Director
Observers:	Mike Carr	Patient Council
	Chris Orchin	Local Involvement Network (LINk)
	Nancy Ellacott	Joint Deputy Chairman Patient Council
	Stuart Hutchinson	Cabinet Member, IOW Council
Media:	None	
In Attendance:	Mark Price	Foundation Trust Programme Director
	Andy Hollebon	Head of Communications
Minuted by:	Julie Benson	PA to FT Programme Director/Executive Director of Strategy and Commercial Development

Members of the Public in attendance: None

13/020 APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE

John Matthews confirmed that he was the Assistant Deputy Coroner and a Deputy District Judge.
Danny Fisher announced that the meeting was quorate.

Action

13/021 MINUTES OF PREVIOUS MEETING OF 30TH JANUARY 2013

The Executive Director of Nursing and Workforce asked that Minute 13/007 be corrected by removing the words "on the trial" and with this correction in place the Minutes of the meeting of the Isle of Wight NHS Trust Board held on 30th January 2013 were approved. Proposed by Sue Wadsworth and seconded by Nick Wakefield.

13/022 CHAIRMAN'S UPDATE

To receive the Chairman's update

The Chairman reported to the Board:

- that the position for a new Non-Executive Director had now been advertised and there had been a good response to this.
- The Chief Executive and the Chairman had had a meeting with SHA South and although there had been excellent achievements there were still areas of improvement required.

The Isle of Wight NHS Trust Board received the Chairman's Statement

13/023 CHIEF EXECUTIVE'S REPORT

The Chief Executive gave the following update on recent national, regional and local activity:

National and Regional Issues

- The Francis Report/Public Inquiry into Mid Staffs Hospital – this would be reported on later in the meeting.
- Changes to the organisation of the NHS from 1st April i.e. PCTs to CCG and the local area team. Public Health has now moved to the local authority.

Local issues

- Increased Board Member walkabouts – these are now held on a weekly basis on a more structured basis and had been well received by staff.
- Foundation Trust progress – it was reported that we were still aiming for April 2014 although some delay may occur. This would be confirmed at a meeting on Friday.
- Car Parking – it was confirmed that 194 new parking spaces for staff would be ready by the end of March, thereby making freeing up patient parking nearer to the hospital.
- The building of the Helipad was progressing and it was hoped that after tests it should be ready for use by the end of April/early May. The works done within the Emergency Department had made a huge improvement to the environment with the department.
- My Life a Full Life (MLAFL) – was a programme that had commenced in partnership with the local authority to enable people to manage their own long term conditions much better.
- Prison Healthcare – It was confirmed that Camphill Prison was now being closed with prisoners already moving out. Richard Knowles was commended for his handling of the move to working with Harmoni and keeping all staff informed about what was going on. The Chief Executive has met with the Governor of the prison who confirmed that the other two prisons would not be closing.

The Chairman asked about the Emergency Department and his understanding that there were more beds in the Department. The Executive Medical Director confirmed that there were 2 further beds and these were observation beds where patients did not need hospitalisation but further treatment before being allowed to go home.

The Isle of Wight NHS Trust Board received the Chief Executive's Report

Patient's Story

The Executive Director of Nursing and Workforce outlined the patient story:

A young person in last year of A levels requiring dental treatment, in a community Dental service. Treatment plan was not explained properly and it was probably not made clear that there were capacity issues around dentistry, which if explained, may have helped the patient with her expectations.

- Dentist unable to speak good English so communication was felt to be poor.
- No explanation of what needed to happen once Dentist left the country and patient felt her treatment plan was lost.
- Long waits to be seen and treatment then changes to surgery – impression is that patient felt this was due to long wait.
- Patient's outcome was different to her brother's who was having similar treatment in a different surgery.

- Long wait for surgery which had to be arranged at Portsmouth – potentially affecting patients move to university.

Actions taken were:

- Clinical lead for dental services reviewed the case and gave full explanation to patient around treatment plan and decisions made.
- The delay for receiving treatment at St Mary's was acknowledged and explained as this was due in part to clinical needs and information required from Portsmouth.
- The amount was able to be brought forward 3 months following discussion with Portsmouth.

The Isle of Wight NHS Trust Board received the Patient's Story.

13/024 STRATEGY AND BUSINESS PLANNING

FT Programme Update

A brief report and update was given by the Foundation Trust Programme Director which highlighted:

- The final submission of the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) and supported products was made on 1st February to the SHA.
- Quality Governance Framework assessment outcome was positive.
- Historical Due Diligence assessment outcome highlighted further work required.
- FT Membership was moving forward.
- The revised timeline had made things more challenging and the Francis Report may require us to meet further requirements on the FT journey.

It was confirmed that a new relationship was being established with the Trust Development Authority (TDA)

The Isle of Wight NHS Trust Board received the Foundation Trust (FT) Programme Report.

13/025 SELF CERTIFICATION

The Foundation Trust Programme Director presented the self certification for the month of January 2013.

Performance had declined since the Trust Board considered the last self-certification return for the month of December 2012 in January. The GRR had moved from GREEN to AMBER/GREEN status with indicators for cancer 2 week waits (3d) and A&E waiting times (3e) falling below compliance thresholds. The Financial Risk Rating and contractual data remained on track. Low numbers of service users and breadth of services delivered by the Trust remained as key threats to ongoing compliance.

Rolling action plans were in place to maintain performance and deal with underlying issues within realistic timescales to ensure that a focus is maintained on improving performance in all areas. Action plans were monitored as part of the performance review process and plans for those indicators that had demonstrated volatility within the previous 3 months were submitted to Board sub-committees for assurance purposes.

As part of the assurance process sub-committees provided feedback on the return. Sue Wadsworth confirmed that the Quality and Clinical Performance Committee recommended that the proposal to revise Board Statement 11 from

non-compliance to compliance not be approved due to current underperformance against key GRR and quality indicators. Peter Taylor confirmed that the Finance, Investment and Workforce Committee recommended that Contractual Data indicator number 8 be revised from compliance to non-compliance as 'contract query notices' were now used in place of 'performance notices'. EDF

The weaknesses identified aligned the Trust's assurance status with Governance Declaration 2: - "*At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements."* It was therefore recommended that:

1. Sub-committee feedback be accepted and self-certification return be amended accordingly;
2. Trust Board approve the sign off of Governance Declaration 2 by the Chairman and Chief Executive.

The Isle of Wight Trust Board approved the recommendations with regard to Self Certification.

13/026 QUALITY AND PERFORMANCE MANAGEMENT

Quality/Performance/Workforce/Finance

The Executive Director of Finance presented the Quality/Performance/Workforce and Finance Report.

Highlights:

- No new cases of MRSA for the 4th consecutive month.
- No falls resulting in significant injury during January this was for the 2nd consecutive month.
- Excellent performance for Stroke patients 90% of stay on Stroke unit sustained.
- Breast Cancer referrals seen within 2 weeks achieved 100% in month.
- Cancer 31 day subsequent Chemo/drug treatment achieved 100%.
- Cancer 31 day diagnosis to treatment achieved 100%.
- Cancer 62 day treated after screening referral achieved 100%.
- Financial position achieved to plan.

Lowlights:

- Pressure Ulcers still above target reduction of 25% based on 2011/12 baseline.
- 1 further case of Clostridium Difficile in January, however 1 further case in February.
- Complaints remain above plan
- Emergency Care 4 hour standard not met in January.
- Capital expenditure (invoices paid).
- Debtors over 90 days.
- Level of non-recurrent CIP at month 10.

Pressure Ulcers – This had improved but work is ongoing to reduce these further.

Nick Wakefield asked about Antibiotic prescribing and the Executive Director of Nursing and Workforce confirmed that we have received assurances from GPs. With regard to the pressure ulcers it was accepted it was more difficult to deal with if patients had come in from the community already with pressure ulcers. However, training was taking place to try and improve this.

Complaints - The Executive Director of Nursing and Workforce commented that from 1st April a new complaints and PALS process will be in place where we will contact the complainant within 48 hours to agree a plan of resolution.

C.Diff - Further cases of C.Diff despite the actions already underway.

Caesarean Section – The report was discussed and it was recognised that we do reflect peaks at times with our rate which it is easily affected with small numbers. Sue Wadsworth thought it might be helpful to have midwife input as part of our Performance Report. EDN&W

Emergency Care 4 hour standard – This standard saw a disappointing dip in January and is representative of the performance and pressure within the hospital as a whole. Despite the slip in performance the staff within A&E should be commended for maintaining services during the building works.

Transient Ischaemic Attack – Although still meeting the national control total of 60%, one patient breached in January as they declined to attend within the 24 hour target.

Data Quality – This remains an area of focus throughout the organisation to improve.

Workforce – Pay costs in month were £270k above plan contributed by the use of variable hours. This also exceeds the YTD plan by £1.968m. The sickness level has achieved an amber rating in month at 4.73% against a plan of 3% - performance reviews focus on both long and short term sickness, which is also reviewed at Finance, Investment and Workforce Committee.

Financial Summary - Our financial position was achieved in January with an in month surplus of £41k and a YTD surplus of £416K. Forecasting achievement of our £500K surplus at the end of March.

CIPs – The YTD CIP plan was overachieved by £473k. At this stage, the forecast non-recurring CIP is £1,593k. This should be offset by the full year effect of recurring plans implement part way through 12/13 and additional plans, making the January forecast carried forward risk £1,182k.

Capital Schemes - £15.4m now fully committed all works are being managed carefully to ensure no under spend and also to manage the cash position.

Nick Wakefield commented that it was a good quality report and questioned whether we would meet the target for capital spend at year end. The Executive Director of Finance responded that each scheme was being closely monitored and any reduction in expected costs would be utilised for additional schemes if necessary.

Peter Taylor questioned whether there were patients being treated but that we do not get paid for. The Executive Director of Finance responded by saying that that we are recording all activity appropriately. A report would be prepared for future discussion. EDF

The Isle of Wight NHS Trust Board received the Performance Report for September 2013.

Staff Survey Management Report
The Executive Director of Nursing and Workforce introduced Dr Reg Race who then presented the Staff Survey. He started by saying that there was an overall improvement in our scores. The ambulance score was the best in the country.

Management Recommendations

- To keep up the pressure on coverage of appraisals and PDPs – review effectiveness of appraisals; volume high but content not seen as effective by some.
- Training levels were up but coverage in some areas needs review, i.e. Health & Safety, handing violence/aggression, infection control (all Ambulance).
- Ensure staffs get feedback on their performance on day to day basis outside the appraisal system.
- Prioritise stress at work as levels have increased – possible damage to health and retention of staff problems – the major negative movement in 2012.
- Reporting of violent incidents low in Ambulance and Acute settings; HBA reporting low in all settings.
- Communications scores had improved but they were still low; a major challenge in the NHS is to engage the staff and motivate them to support change: c. 2 in 3 staff not prepared to say that communication between senior manages and staff is effective.
- Drill down into data to analyse the different perspectives on, and awareness of, Trust policies and practice by different occupational groups and take specific action to improve awareness among key groups.
- Celebrate significant successes: improved scores in all sectors.
- Map recommendations against pledges in NHS Constitution, Operating Framework, Mandate for NCB.

The Next Steps

- Pick 3 or 4 key issues and run with them – no lengthy action plans.
- Map them to corporate objectives. Take urgent action to improve performance. Key aim is continuing to bring ambulance scores up to the rest of the Trust.
- Recognise the importance of communicating the Trust's values, policies, actions, to disparate groups of staff with different views.
- Never consider communication as "completed"; repeat messages
- Engage with the staff side and get their support. Key issue is communicating with staff outside the corporate centre.
- Ensure that all staff are plugged into the appraisal system. Make sure that Executive Directors and line manages have achievement of very high level appraisals in their areas of responsibility built into their own Personal Objectives.
- The Executive team needs to performance manage the key issues and make them happen. Strong evidence from all patient and staff surveys that exhortation alone does not work. Weak or badly managed teams will drag down Trust scores unless the Executive maximises performance.
- Combine strong leadership with good staff management,

The Isle of Wight NHS Trust Board received the Staff Survey Management Report

Francis Report
The Executive Director of Nursing & Workforce introduced the Francis Report to the Board.

- In June 2010 the Secretary of State launched a full public inquiry into Mid Staffordshire Foundation NHS Trust chaired by Robert Francis QC.
- It produced 290 recommendations in 3 volumes and 164 witnesses gave oral evidence.

Key Themes of the Recommendations are

- Putting the patient first
- Leadership
- Common culture
- Regulating healthcare systems
- Nursing
- Standard of service
- Professional regulation of fitness to practice
- Complaints handling
- Performance management
- Medical training and education
- Openness, transparency and candour.

The Next Steps are:

- Government to respond within one month
- All commissioning, service provision regulatory and ancillary organisations in healthcare have to consider the findings/recommendations of the report and decide how to apply them to their own work.
- Each of these organisations must announce "at the earliest practicable time" their decision on whether they accept the recommendations and what they intend to do to implement those accepted, and after that, on a regular basis but not less than once a year, publish in a report information regarding the progress in relation to its planned actions.
- The House of Commons Health Select Committee will review the performance of organisations taking actions with regard to the recommendations in the report.
- An internal review of the report using a cross diagonal team. This will be led by a Senior Doctor (Dallas Price) and Nurse (Deborah Matthews) with input from patients, administrative and facilities.
- Any actions arising out of the review will be monitored through the Quality and Clinical Performance Committee (QCPC), via a monthly update and standing agenda item.
- There will be emphasis on talking to staff regularly.

Chris Orchin commented that greater involvement with the community via organisations such as Healthwatch would help. Danny Fisher said that what really matters is local issues and what we do about them.

Sue Wadsworth proposed and Peter Taylor seconded.

The Isle of Wight NHS Trust Board approved the Francis Report

Rent/Cost of Capital
The Executive Director of Finance presented the rental charge due to the PCT.

Under the terms of the Business Transfer Agreement (BTA) between the Trust and the PCT the estate remained with the PCT with the Trust occupying the Premises as licensee only up to 31 March 2013. There was to be an annual occupation fee payable as agreed with the Owner.

The budget set for this was £9.6m and was approved by the Board in April 2012. The payment of this would occur once the final cash settlement of the balance sheet split was finalised. This has now taken place and the Trust has been invoiced for the rent up until the end of December in the sum of £7,536,000. This figure has been planned for.

Sue Wadsworth proposed and this was seconded by Peter Taylor.

The Isle of Wight NHS Trust Board approved the report on Rent/Cost of Capital.

13/027 GOVERNANCE AND ADMINISTRATION

- **Finance Investment and Workforce Committee held on the 20th February 2013.**
- **Quality and Clinical Performance Committee held on 20th February 2013**
- **Foundation Trust Programme Board held on 23rd January 2013**

The Isle of Wight NHS Trust Board received the minutes of the sub-committees.

13/028 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

13/029 ANY OTHER BUSINESS

The Chairman invited any other business but there was none.

12/030 ISSUES TO BE COVERED IN PRIVATE

Danny Fisher announced that the public meeting would now close and the private meeting would now commence.

13/031 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Isle of Wight NHS Trust to be held in public is on Wednesday 27 March 2013 in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

Signed as a true record of the meeting:

…………………………………………………………………………Chairman

Date

………………………………………………………………………….

Isle of Wight NHS Trust Board Schecule of Actions

Meeting Date	Public/Private	Minute No	Raised By	Action Required	Who	Action Taken / Update	Date Closed
27/03/2013	Public	13/025	PT	Contractual data indicator 8 to be revised from compliance to non compliance	EDF		
27/03/2013	Public	13/026	SW	Midwifery input to performance report	EDN&W		
27/03/2013	Public	13/026	PT	Report on patients for whom tratments are provided but payment is not made to be prepared.	EDF		

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD ON 27 MARCH 2013

Title	FOUNDATION TRUST PROGRAMME UPDATE
Sponsoring Director	Foundation Trust Programme Director
Author(s)	Foundation Trust Programme Director
Purpose	To note.
Previously considered by (state date):	
Acute Clinical Directorate Board	
Audit and Corporate Risk Committee	
Charitable Funds Committee	
Community Health Directorate Board	
Executive Board	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Planned Directorate Board	
Finance, Investment and Workforce Committee	
Quality & Clinical Governance Committee	
Remuneration Committee	
Staff, stakeholder, patient and public engagement:	
A programme of internal and external stakeholder engagement has been initiated and is ongoing to deliver change within the organisation and generate the support required across the locality and health system to deliver a sustainable FT. Briefing sessions have been undertaken with Patients Council, the Ambulance service, Isle of Wight County Press and Health and Community Wellbeing Scrutiny Panel. A formal public consultation on becoming an NHS Foundation Trust has been undertaken. A membership recruitment campaign will be launched in March 2013.	
Executive Summary:	
This paper provides an update on work to achieve Foundation Trust status by April 2014. The key points covered include: • Progress update • Communications and stakeholder engagement activity • Key risks	
Related Trust objectives	**Sub-objectives**
Reform	9 - Develop our FT application in line with the timetable agreed with DH & SHA
Risk and Assurance	CSF9, CSF10
Related Assurance Framework entries	Board Governance Assurance Framework within BAF
Legal implications, regulatory and consultation requirements	A 12 week public consultation is required and concluded on 11 January 2013.
Action required by the Board: (i) Note this progress update report	
Date	18 March 2013

ISLE OF WIGHT NHS TRUST
NHS TRUST BOARD MEETING WEDNESDAY 27 MARCH 2013
FOUNDATION TRUST PROGRAMME UPDATE

1. Purpose

To update the Trust Board on the status of the Foundation Trust Programme.

2. Background

The requirement to achieve Foundation Trust status for NHS provider services has been mandated by Government. All NHS Trusts in England must be established as, or become part of, a NHS Foundation Trust.

3. Communications and Stakeholder Engagement

On 14th March the FT Programme Director and Head of Communications presented the outcome to the Foundation Trust consultation and plans for the membership recruitment campaign to the GP Practice Managers Forum. On 15th March 2013 a double page spread on the outcome to the FT consultation appeared in the March edition of One Island Magazine distributed with the County Press. On 19th March the Trust had a Membership stall at the 'My Life A Full Life' Pre-Launch at Cowes Yacht Haven attended by around 250 people.

The membership recruitment campaign will be formally launched at the beginning of the Board meeting on 27th March. Materials have been developed in discussion with both staff and patient representatives. These include:

- A film featuring staff and volunteers which will be premiered at the meeting.
- One hundred thousand leaflets printed of which 65,000 will be delivered to every household on the Island with the May edition of the Beacon Magazine. The balance of the leaflets will be made available in public locations – both NHS and non NHS (e.g. libraries, schools, community centres, etc) – across the Island.
- The large panel at the entrance of St. Mary's Hospital which has been changed from the Barely Born Appeal to the membership campaign
- Banners to place on railings and fences (e.g. at Morrisons, Newport)
- Pull up banners to place in entrances and public locations
- The Membership Card
- A radio advert to be played on Isle of Wight Radio
- Adverts for magazines including Island Business, One Island and Island Life

The key message of the campaign is that becoming a member will help to keep services local. We expect that the number of people applying to become members will dramatically increase over the next few months with the campaign and these will be reported to future Board meetings using the new Membership database which will provide reports to the standards prescribed by Monitor. Initial plans are being put in place for the first round of Medicine for Members meetings which we are scheduling for late June / early July.

4. Programme Plan

The SHA Phase is now drawing to an end and work is ongoing to transition to a new detailed programme plan that is being developed for the TDA phase. There are a number of points that we are seeking clarification on from the TDA that will inform detailed planning.

FT Application timeline

The risk to our schedule associated with the constrained timeframe in which the organisation has been working to achieve FT status in line with the Government target of April 2014 has matured and the our FT Application Submission to the SHA/TDA, scheduled for 31 March 2013, has been deferred to 31 August with a potential referral date to Monitor of October 2013. This deferral is primarily to afford the Trust sufficient time to ensure that a full and comprehensive application submission, with external assurances, is developed that will withstand the rigorous Monitor assessment regime.

Instead of the Board to Board meeting scheduled for the 1 March 2013 an informal readiness review meeting with the TDA was undertaken involving a small team representing the Trust Board led by the Chairman and Chief Executive. The TDA have recognised that the Trust has demonstrated 'good progress in a number of areas with a sense of momentum and ambition' and have indicated that our overall trajectory is not affected as a consequence of the deferral. However, the capacity of Monitor and TDA to process applications, given the number of NHS Trusts still in existence and in light of the potential impact of the *Francis Report,* also needs to be taken into account, given that new applications are the lowest priority in the assessment batching process and only two Trusts have been authorised by Monitor to date in 2012/13. In this context the Government target of April 2014 looks increasingly unsustainable. Close liaison will be maintained with the TDA to ensure that we remain responsive to any requirements in order to maintain our trajectory and a detailed programme plan is being prepared for the TDA phase to ensure that we deliver against TDA requirements.

5. Key Risks

An additional risk has been added to the risk log that recognises uncertainties resulting from changes in oversight and regulatory arrangements with the transition from SHA to TDA. We had previously acknowledged the potential of the Transition of oversight arrangements from the SHA to the TDA to impact on the programme but we also need to fully understand the implications of Monitor's new role. It has already become apparent that many of the longstanding relationships established over a number of years will not continue beyond 1 April 2013. As such, work is ongoing to develop productive relationships with the new TDA team.

The transition from the SHA and DH of oversight responsibilities to the TDA, in relation to FT applications, together with a revised *Guide for Applicants* from Monitor, gives rise to a number of uncertainties around process and requirements that we are seeking to clarify in order to ensure that we plan effectively for the timely provision of defined products required to support our application.

The Trust's unique breadth of service provision and low numbers of service users remains a concern with respect to maintaining compliance with Monitor's *Compliance Framework* regime[1] as it gives rise to volatility in the Governance Risk Rating. This continues to be a key risk to the application as we are subject to more performance indicators across our Governance Risk Rating and therefore have a lower threshold for underperformance than single service Trusts. We have improved our position since last month's return and will achieve a score of 1.0 for the February 2013 monitoring period.

Risks to delivery have been documented and assessed and will continue to be highlighted to the FT Programme Board.

6. Recommendation

It is recommended that the Board:

[1] As a consequence of Monitor's new duties, Monitor's *Compliance Framework* is being replaced with a new regulatory tool, the *Risk Assessment Framework* and Monitor are currently consulting on this new framework.

(i) Note this update report

Mark Price
Foundation Trust Programme Director
18 March 2013

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD FOR CERTIFICATION BY THE CHAIRMAN AND CHIEF EXECUTIVE

Title	Self-certification
Sponsoring Director	Foundation Trust Programme Director
Author(s)	Foundation Trust Programme Management Officer
Purpose	For action

Previously considered by (state date):

Committee	Date
Acute Clinical Directorate Board	
Audit and Corporate Risk Committee	
Charitable Funds Committee	
Community Health Directorate Board	
Finance, Investment and Workforce Committee	20 March 2013
Executive Board	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Planned Directorate Board	
Quality & Clinical Performance Committee	20 March 2013
Remuneration Committee	

Staff, stakeholder, patient and public engagement:

Relevant Executive Directors, professional leads and internal data processors have been consulted and involved in the provision of data/supporting information and the identification of gaps, issues and actions.

Executive Summary:

This paper presents the January self-certification return covering December performance data for sign off on behalf of Trust Board by the Chairman and Chief Executive or designated deputies.

The key points covered include:

- Background to the requirement
- Assurance
- Governance Declaration
- Recommendations

Related Trust objectives	**Sub-objectives**
Reform	9 - Develop our FT applications in line with the timetable agreed with DH & SHA
Risk and Assurance	CSF9, CSF10
Related Assurance Framework entries	Board Governance Assurance Framework within BAF
Legal implications, regulatory and consultation requirements	Meeting the requirements of Monitor's *Compliance Framework* is necessary for FT Authorisation.

Action required by the Board:

(i) Review the self-certification return and Identify any Board action required
(ii) Determine whether sufficient assurance has been decided to approve the sign-off of Governance Declaration 2 by the Chairman and Chief Executive

Date	18 March 2013

ISLE OF WIGHT NHS TRUST

SELF-CERTIFICATION

1. Purpose

To provide assurance to the Trust Board prior to sign off by the Chairman and Chief Executive of the self-certification document (Appendix 1) for submission to the SHA on 29 March 2013.

2. Background

On 3 August 2012 the SHA launched the Single Operating Model (SOM) - Part 2. The SOM aims to drive a consistent approach across the country and to prepare for the establishment of the NHS Trust Development Authority (NTDA). It is also about driving delivery of the FT pipeline in 2012/13 which is a key year for building the momentum to support the objective for the majority of the remaining NHS Trusts to achieve FT status by 2014.

The SOM requires NHS Trusts to regularly self-certify governance and financial risk ratings on a monthly basis. NHS Trusts are also required to submit a template of quality and contractual information and provide an accurate self assessment against a series of Board statements drawn from the Monitor Compliance Framework. Self-certification will form part of the material for the monthly meetings between the SHA and the NHS Trust. Self-certification from Trust Boards is intended to promote Board ownership of issues and to prepare Trusts for the Monitor approach.

The standard timing for the submission of self-certification declarations from NHS Trusts will be on or before the last working day of each month. As a result of escalation an NHS Trust may be required to provide self-certification or other information on a more frequent basis.

All declarations and self-certification should have been robustly discussed and approved by the Trust Board with the discussion minuted. The self-certification submissions should be signed off on behalf of the Trust Board by the Chair and Chief Executive (or nominated deputies).

The guidance states that self-certifications should be submitted on time and in full. Late, incomplete or inaccurate self-certification will automatically be over-ridden to a red governance risk rating.

According to guidance: 'Where an issue of non-compliance is identified the Trust should submit the relevant Board approved action plan to rectify the issue. In line with the principle of avoiding duplication this would normally be the same level of detail that has been presented to the Board to provide them with assurance that an issue can be rectified. An action plan would normally include a clear timeline, accountable leads and resource requirements. The action plan should allow the Trust Board and the SHA to monitor progress and delivery.'

3. Assurance

The Foundation Trust Programme Management Office (FTPMO) has worked with relevant Executive Directors, PIDS, Finance, Governance, Quality, HR and Clinical Teams to ensure the provision of data/supporting information and the identification of gaps, issues and actions required to provide a sufficient degree of assurance to the Trust Board to enable sign-off of the self-certification return as an accurate representation of the Trust's current status.

Action plans have been requested to ensure that the activity required to improve performance can be monitored and a forecast can be made with respect to the achievement of compliance against the requirements of the self-certification return. Delivery of action

plans is monitored as part of the performance review process and where required are submitted to Board sub-committees for review.

Performance data and Board Statements are considered by Quality and Clinical Performance Committee, Finance, Investment and Workforce Committee and relevant senior officers and Executive Directors. Board Statements are considered with respect to the evidence to support a positive response, contra indicators and threats to current status together with action plans and activity to maintain or improve the current assessed position. The Trust Board may wish to amend the responses to Board Statements based on an holistic view of the complete self-certification return and feedback from Board sub-committee Chairs.

4. <u>Performance Summary and Key Issues</u>

Performance has improved since the Trust Board considered the last self-certification return in February. Although the GRR remains at AMBER/GREEN status the overall score has improved, moving from 1.5 to 1.0 with indicators for cancer 2 week waits (3d) and A&E waiting times (3e) recovered and C-difficile falling below compliance thresholds.

The Financial Risk Rating and contractual data remain on track. However, following clarification from the SHA around the interpretation of 'Performance Notices' in the Contractual Data return, we have concluded that we should have been stating that performance notices had been issued as they had now been superseded in contractual terminology by 'Contract Query Notices', which had been received by the Trust. This does not alter the overall position of our *Board Statements* or *Governance Declaration.*

Rolling action plans are in place to maintain performance and deal with underlying issues within realistic timescales to ensure that a focus is maintained on improving performance in all areas. Action plans are monitored as part of the performance review process and plans for those indicators that have demonstrated volatility within the previous 3 months are appended to this report for review.

Key issues arising from the self-certification return are set out below against the respective self-certification requirements and should inform decisions around the Board Statements and the overall Governance Declaration.

1. Governance Risk Ratings	Score = 1.0 (AMBER / GREEN): 2 indicators breached that collectively result in a score being applied: • C-Difficile breach of de-minimis threshold • C-Difficile breach of year to date trajectory
2. Financial Risk Ratings	Score = 3.0 (GREEN): I&E surplus margin % score = 1 (RED) due to low surplus target for current outturn. Compliant surplus margin planned from 1 April 2013. Assessment based on the assumption that the estate will transfer as planned on 1 April 2013.
3. Contractual Data	GREEN: 7 indicators = GREEN 2 indicator = RED: Contract Queries: - Phlebotomy Over Performance; Ambulance Handover times; Healthcare; Acquired Infections (Cdiff and MRSA); Stroke Services
4. Financial Risk Triggers	GREEN: 7 indicators = GREEN 1 indicator = RED: 4 – 'Debtors > 90 days past due account for more than 5% of total debtor balances'. N.B. Based on Sales Debtors, currently 14.7% of the total is > 90 days. Even if total debtors presented in the SOFP are taken into account, it is unlikely that <5% will be achieved until such time that

	legacy debts are cleared (e.g. staff overpayments and Insurance Companies re: Private Patients).
5. Quality	3b – Non-elective MRSA – off target, but improved position. 8 – CAS alerts – increased since last month 11 – Pressure Ulcers – off target, but improved position. 15 – Sickness absence – off target, but improved position.
6. TFA Progress	Milestone 18 at risk due to volatility of Governance Risk Rating indicators.
7. Board Statements	3 statements not assured ('NO'): Clinical Quality: Finance: Governance: 11, 12, 14 Controls being implemented to improve assurance. 11 – Rolling action plans in place to maintain/improve performance 12 – Compliance targeted for achievement in 31 March 2013 to meet DH requirement. 14 – Board development work ongoing; recruitment underway for clinical NED.
8. Governance Declarations	Weaknesses: • Compliance with Board Statements • *Clinical Quality* - performance against GRR/Quality targets, C-Difficile breaches, MRSA breaching annual target • *Governance* – Compliance with targets; IG toolkit; Trust Board and management capacity and capability

5. Governance Declaration

The weaknesses identified above align the Trust's assurance status with Governance Declaration 2:

> *At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.*

6. Recommendations

It is recommended that the Trust Board:

(iii) Review the self-certification return and Identify any Board action required

(iv) Determine whether sufficient assurance has been decided to approve the sign-off of Governance Declaration 2 by the Chairman and Chief Executive

Mark Price
Foundation Trust Programme Director
18 March 2013

7. Appendices

Appendix 1 – Self-certification Return

8. Supporting Information

- *Delivering the NHS Foundation Trust Pipeline: Single Operating Model, 3 August 2012*
- *Compliance Framework 2012/13, Monitor, 30 March 2012*

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation.

Enclosure D

<u>To Follow</u>

Enclosure E

<u>To Follow</u>

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD ON 27th MARCH 2013

Title	2012-13 Annual Report & Accounts - Disclosure of Senior Managers' Remuneration
Sponsoring Director	Exec Dir of Finance
Author	(Interim) Assistant Finance Director (Financial Accounting)
Purpose	To consider and approve the recommendation shown below
Previously considered by (state date):	
Not previously considered	
Staff, stakeholder, patient and public engagement:	
Executive Summary:	
The guidance on good governance in the NHS does require each NHS body to annually consider the appropriate definition of a "senior manager" for the purposes of disclosing their remuneration in the Remuneration Report (part of the Annual Report). It is standard practice in the NHS to show either, all members of the board or, all members of the board plus any very senior managers (on the VSM pay-scale). However, the former option is easily the most common. I am asking the Board to consider this matter and agree that we should disclose all members of the board (voting and non-voting members) in the first reporting year of the NHS Trust. NO PAPER IS REQUIRED TO BE ATTACHED	
Related Trust objectives	**Sub-objectives**
.	
Risk and Assurance	
Related Assurance Framework entries	
Legal implications, regulatory and consultation requirements	It is quite likely Ernst & Young, our external auditors, will seek this board minute during their final audit.
Action required by the Board: The recommendation (to minute) is that "The Board has considered the appropriate boundaries to disclose senior managers' remuneration in the 2012-13 Annual Report & Accounts and considers that these persons should be restricted to members of the Board of Directors (whether voting or non-voting members).	
Date	7th March 2013

Enclosure G

<u>To Follow</u>

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD ON 27th March 2013

Title	Transfer of Property & Assets
Sponsoring Director	Director of Strategy & Commercial Development
Author(s)	Associate Director Facilities
Purpose	To approve
Previously considered by (state date):	
Acute Clinical Directorate Board	
Audit and Corporate Risk Committee	
Charitable Funds Committee	
Community Health Directorate Board	
Executive Board	29th October 2012
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Planned Directorate Board	
Quality & Clinical Governance Committee	
Remuneration Committee	
Staff, stakeholder, patient and public engagement:	
N/A	
Executive Summary:	
As part of the implementation of the Health and Social Care Act properties are required to transfer from the Isle of Wight & Primary Care Trust to either the Isle of Wight NHS Trust or NHS Property Services Ltd (NHS PS) on the 1st April 2013. The Isle of Wight NHS Trust will have the properties listed and associated assets transferred from the Isle of Wight PCT. The transfer scheme is the legal instrument of transfer and will be signed by a Senior Civil Servant on behalf of the Secretary of State.	

Related Trust objectives	Sub-objectives
Risk and Assurance	
Related Assurance Framework entries	CQC essential standards outcome 10 Safety & Suitability of premises & outcome 11 Safety & Suitability of Equipment
Legal implications, regulatory and consultation requirements	The transfer scheme is a legal instrument of transfer and as such will transfer all liability in relation to these properties to the Trust.
Action required by the Board: The Board is asked to approve the property transfer list.	
Date	15/03/2013

Transfer of Property & Assets

Background

As part of the implementation of the Health and Social Care Act, properties are required to transfer from the PCT to either the Isle of Wight NHS Trust or NHS Property Services Ltd (NHS PS) on the 1st April 2013.

The transfer of properties will be completed through the Property Transfer Schemes made under provision in the Health and Social Care Act.

The purpose of this paper is to confirm and for the board to approve the list of properties and assets to transfer from the Isle of Wight Primary Care Trust to the Isle of Wight NHS Trust.

Current Position

The PCT and Trust have agreed the list of properties that will either transfer to the NHS IOW Trust or be retained and transfer to the NHS PS.

I have been in constant communication with the DH responding to requests for information and replying to queries relating to specific properties, the schedule has been agreed by both the SHA and Department of Health (DH).

Previous directions from the DH stated the programme of key dates to enable the transfer to take place on the 1st April 2013, the programme has fallen behind, and the Board should have received from the DH the final sign off list of properties to transfer on the 31st December 2012.

Even though the final list from the DH was not received on the 31ST December it is still expected that the transfer will take place as the assets have to transfer from the PCT on the 1st April 2013.

Property list to transfer to the Isle of Wight NHS Trust

Property Name/Description	Freehold/Leasehold/Licence
Ryde Outpatients	Freehold
68 & 69 Swanmore Road	Freehold
Arthur Webster Clinic	Freehold
Buccleuch House	Freehold
The Gables	Freehold
Newport Clinic (6-8 Pyle Street)	Freehold
Shackleton House	Freehold
Chantry House	Leasehold
Cowes Medical Centre	Leasehold

Ventnor Neightbourhood Office	Leasehold
Woodlands	Leasehold
Brookside Health Centre	Leasehold
3 Daish Way Newport	Leasehold
Sandown Health Centre	Leasehold
St. Mary's Hospital	Freehold
Albany prison	Licence (will transfer to new provider)
Oak House	Leasehold
Medical Records Store	Leasehold
Barry Way	Leasehold
Moa Place	Leasehold
Carisbrooke Dental	Leasehold
60 Pyle Street	Leasehold

Property List to Transfer to NHS PS

Tower House	Leasehold
Denbigh House	Leasehold
East Cowes Health Clinic	Freehold
Meadowbrook	Leasehold
East Cowes Medical Centre (new)	Leasehold
Innovation Centre	Leasehold
Apex centre	Leasehold

Next Steps

The draft transfer schemes will be emailed to the SHIP Cluster when it is ready, these will include drafting questions by lawyers which the PCT will be required to answer. The PCT will have two working days to respond to these drafting questions; check the accuracy of the draft scheme and to raise any final change requests.

Once updated the transfer scheme will be returned to the DH and finalised by lawyers. The Final transfer scheme, in PDF will be sent back to the PCT for board/ delegated authority sign off.

The PCT will have no later than midday on Monday 25th March to have returned the signed document.

Once the signed document is received the transfer scheme will be signed by a Senior Civil Servant in the DH on behalf of the Secretary of State. The signed transfer scheme is the legal instrument of transfer and will take effect on the 1st April 2013.

Recommendation

The board is recommended to approve the list of properties above and the associated assets that will transfer with the properties.

Kevin Bolan
Associate Director Facilities

15/03/2013

QUALITY & CLINICAL PERFORMANCE COMMITTEE

20 February 2013

PRESENT:	Sue Wadsworth (SW) (Chair)	Non Executive Director
	John Matthews (JM)	Non Executive Director
	Sarah Johnston (SJ)	Deputy Director of Nursing
	Alan Sheward (AWS)	Executive Director of Nursing and Workforce
	Brian Johnston (BJ)	Head of Corporate Governance & Risk Management
	Sabeena Allahdin (SA)	Clinical Director, Planned Director
	Lisa Reed (LR)	Head of Clinical Services – Community and Health on behalf of Sarah Gladdish
	There was no representative from the Acute Directorate.	
	Ian Bast	Patient Representative

MINUTED BY: Amanda Garner (AG) Personal Assistant to AWS

IN ATTENDANCE:

Lesley Harris (LH)	Head of Clinical Services – Planned Directorate for item 14/5/2
Deborah Matthews (DM)	Head of Clinical Services – Acute Directorate for item 14/5/3
Martin Robinson (MR)	Associate Director – Planned Directorate for item 14/5/2
Donna Collins (DC)	Associate Director - Medical, Emergency & Diagnostic Services for item 14/5/3
Andrew Shorkey (AS)	FT Programme Management Officer

FOR PRESENTATION TO PUBLIC BOARD ON:

ACTION

14/01 APOLOGIES FOR ABSENCE

Apologies were received from Mark Pugh (MP), Executive Medical Director, Sarah Gladdish (SG), Clinical Director, Community Health Directorate, Vanessa Flower (VF), Quality Manager, and Christopher Sheen (CS), Clinical Director, Acute Directorate.

14/02 DECLARATIONS OF INTEREST

Declaration made by JM - Assistant Deputy Coroner and Deputy District Judge.

14/03 MINUTES OF THE LAST MEETING – 16 January 2013

JM advised that his title was incorrectly noted.

The Quality & Clinical Performance Committee approved the Minutes of the meeting held on 16 January 2013 with the above amendment.

MATTERS ARISING

Page 1:

13/004: Quality Report - SW advised that all have the Quality Report this month. AWS advised that he had spoken about aligning QCPC with Board and therefore there may be some date changes for future meetings. SA advised that if there were any changes to the date it would be helpful if the meeting stayed on a Wednesday. SW advised that it was the dates and not the day that had changed and that the revised dates would be sent out with the minutes. **AWS**

Page 2:

13/005: Acute Clinical Directorate Presentation - AWS advised that A&E are currently working on performance and that this had improved over the last 3 weeks. AWS advised that he will be spending time in A&E and will pull together a longer term action plan and will feedback to this meeting in June. **AWS**

Page 3:

13/006: Patient Story (Complaints Process) – AWS advised that he is presenting the revised process to the next Executive Board and once this is agreed he will bring to this committee. SA advised that the current process involves much duplication which wastes time. SW hoped that the new process would reduce complaints. JM added that the new process will help to differentiate between concerns and complaints.

13/009: Grade 1 – Summaries and Action Plans – SJ advised that she had met with VF regarding the closure of the Patient Quality and Clinical Safety Meeting and will report back regarding this at the next committee meeting. **SJ**

AWS advised that there is a weekly quality review which reviews SIRI's and serious complaints. The process for SIRI management will come to the QCPC in March 2013.

Page 4:

13/011: Strategic Health Authority Self Certification - SJ advised that this would be covered under the agenda. SJ advised that the criteria was being made more robust. **SJ**
AWS advised that the Quality Dashboard is still not operating in "real time" however a Task and Finish Group had been set up to look at this and he will provide a progress report in April. **AWS**

Page 5:

13/016: Care Quality Commission (CQC) Visit 10 to 11 January 2013 – SW advised that this item would be covered on the agenda.

14/04 AGENDA

14/04/01 Care Quality Commission (CQC) Inspection Report

AWS advised that the CQC had visited on 10 and 11 January 2013 and that this was an annual compliance inspection which was unannounced. AWS submitted the CQC Inspection Report to the committee advising that all the standards had been met as follows:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Staffing
- Complaints

AWS advised that the CQC spent a lot of time looking at the surgical pathway and spoke with 21 patients and relatives and 14 members of staff focussing on good practice. AWS advised that on day 2 of the visit CQC focussed on safeguarding. SW said that she was pleased that CQC has remarked on the strong ethos of the Trust and that the outcome was very good. SW said well done to all. AWS advised that the more minor points in the report are being picked up with the respective directorate leads.

14/04/02 Francis Report – Executive Summary & IOWNHS Trust Actions

AWS presented a PowerPoint presentation which he advised he had prepared for the Board following the publications of the results of the Francis Report last week. AWS advised that there had been 290 recommendations and that the report was in three volumes.

AWS advised that the Government to respond in one month of the publication of the report and that all organisations had been asked to consider the findings and recommendations. AWS advised that there will be an internal review for the Trust to test current compliance and that this review would be lead by a consultant and a nurse. AWS also advised that the Trust was looking at how staff can volunteer information via an email address as part of a “Staff Raising Concerns Policy”.

SW suggested that the Francis Report be a standing item on the agenda for the Committee.

AWS advised that he was looking to involve 2 or 3 patients in the review for their input to include their interpretations of the findings. SA suggested the volunteers could be approached.

14/4/03 Patient Experience – Patient Story

SJ updated the Committee on the patient Story from the last meeting and advised that she had telephoned the patient regarding her feedback being videoed. SJ said that the patient was happy to do this but because of her illness this will not be ready for Board

but that she would pursue this.

SJ advised that the patient story for this month regarded a community patient who was in her second year of A Level study having dental treatment. SJ advised that the complaint was regarding timings and organisation of the process and how the patient was confused about her plan. SJ advised that she would pick this up with LR regarding the expectations of patients and communication of their care plan. SJ advised that the patient's appointment had been able to be rearranged to an earlier date. SW advised that it was important to get feedback from patients.

Patient Safety

14/4/04 Grade 2 SIRI WF17859 Action Plan

SJ gave a verbal update on this SIRI which related to child safeguarding and the failure to recognise a vulnerable young mother. SJ advised that there were two ongoing actions relating to this. SW advised that she had met with Annie Hunter, Head of Midwifery, who had advised her that there was an increase in the number of vulnerable young mothers and added that it was important to have processes in place to deal with this.

14/4/05 Infection Control Action Plan

SJ advised that as part of an external review at the end of 2012 there had been some recommendations and there were 4 items which would be focussed upon as follows

- Competence for Aseptic techniques
- Isolation
- Governance and Assurance – hand hygiene
- RCA process

SJ advised that the plan was for named people to take these forward through the Infection Control Committee and report back to this Committee to approve. SW advised that she was really disappointed that the Trust was not compliant with hand hygiene regarding bare below the elbows. **SJ**

14/4/06 Falls Action Plan Update

SJ reported that there had been a drop in falls and the next progress was to reduce the number of falls causing harm. SW asked for clarification on what was being aimed for and by when. SW asked that this item be fed back quarterly to the Committee. AWS agreed regarding a quarterly updated to review performance against the plan. LR advised that the Trust needed to accept that some patients will fall. AWS advised that this was about addressing preventable falls. **SJ**

14/4/07 Pressure Ulcer Action Plan Update

SJ advised that there was a lot of work going on in the Trust regarding pressure ulcers and that grade 3 and 4 pressure ulcers were the main focus area. SJ confirmed that work was being done regarding criteria and added that the focus needed to be on

prevention. SA added that the data needed to be accurate. AWS advised that he is working on a rolling programme regarding quarterly feedback and will present a schedule for this at the next meeting. SW asked for an update on the 14 indicators for the next meeting. **AWS SJ**

14/4/08 Term Birth Admissions to NICU – Assurance on actions taken

AWS advised the committee regarding a letter that had been received that the CEO had responded to. AWS advised that an action plan had been drawn up and following revision the number of term birth admissions to NICU will be tracked on a monthly basis. SA added that other hospitals had three areas including a transitional areas but the Trust only had two. AWS advised that this is being monitored monthly and that the Trust was currently at 11% but its target was 5% and this was being worked on. AWS advised that there should be an update available for the next meeting. **AWS**

Safeguarding

14/4/09 To receive Assurance Report for Safeguarding to Vulnerable Adults (VA)

SJ advised that this was a new style report providing assurance to the Committee for Quarter 3. SJ highlighted information on page 2 of the report advising that there had been 33 cases YTD for the Trust with the main themes being;

- Communication:
  SJ advised that this related to the discharge process and documentation was being reviewed regarding this.

- Staff Attitude:
  SJ advised that this related to care and compassion and that the Trust needed to get on top of this.

- Food and Drink:
  SJ advised that complaints regarding access to food and drink were often taken to safeguarding.

SJ advised that there had been 1 case substantiated and 2 cases partially substantiated. SJ advised that regarding the substantiated case actions had been taken as a result of this.

SJ advised that she will update the committee further in July 2013. SW advised that she would like to see a single sheet report with targets and an action plan. **SJ**

14/4/10 To receive highlight report on the recent IOW CC OFSTED Report and Agree actions

SW advised that this had been very sober reading. AWS advised that OFSTED had reviewed IOW Local Authority arrangements for the protection of children and delivered a damning report. AWS advised that the Trust was a fully signed up member of this Board but on reviewing membership the Trust's attendance had been sporadic and that going forward he will be a Board member and update the Committee quarterly. AWS **AWS**

advised that the Trust had acknowledged the report and that Ian Anderson would be presenting his findings to Executive Team. AWS advised that SJ will chair a Trust Wide Steering Group which will be 90 minutes long – 45 minutes for adult and 45 minutes for child safeguarding. AWS advised that he would report back to the Committee quarterly as part of the rolling programme. LR advised that there had been increased demand on the Safeguarding Team recently and that an email from the Executive Team would be good acknowledging the increased focus on the team and thanking them for their work. **AWS**

AWS

14/4/11 Recommendation for Joint Safeguarding Committee

The Quality & Clinical Performance Committee was in favour of the recommendation for Joint Safeguarding Committee with quarterly reporting to the Quality and Clinical Performance Committee.

Clinical Audit and Governance

14/4/12 Transfer section from Audit Committee Terms of Reference to Quality and Clinical Governance Terms of Reference

AWS presented the terms of reference to the Committee and asked that the Committee consider the points and agree which areas should be reported to the Committee. SW advised that she was happy for all to be incorporated. SW advised that this will be consulted over the next four weeks for agreement for 1 April 2013 and Terms of Reference and discussion regarding Clinical Audit to be reported at the April or May Committee. **AWS**

Clinical Performance

14/4/13 Quality Report

AWS advised that the report is going to Board at the end of the month and highlighted the information on slides 10 and 11 regarding the changes to the way data is collected. SW said that the Committee was not giving this report the time it warranted and advised that it was a central piece of information that comes to the Committee. JM asked that a 20 or 30 minute slot be allocated for the next Committee meeting and that it be allocated the time earlier in the meeting. AWS advised that if the Committee raised any concerns then he would expect the directorate presentations to address these at the next Committee meeting with an update on what has been done. It was agreed that this item will be allocated 30 minutes at the next Committee meeting. **AG**

14/4/15 Quality Governance Framework Action Plan

AWS advised that following a visit by KPMG an action plan had been drawn up to get the Trust on target following the recommendations. AWS highlighted the reds and ambers on the action plan:

- Screensavers to be used to communicate “message of the day”
  AWS advised that this has not started yet but that he will chase this up with the communications team.

- Need for ongoing monthly review of staff satisfaction
  AWS advised that the Trust is to focus on three quality goads and that Theresa Gallard is currently setting up a staff questionnaire to confirm these.
- Patient stories
  AWS advised that 5 patients will be filmed regarding their patient experiences and this will be presented at the opening of the Trust Board commencing in March.

SW asked that the Committee be updated regarding progress on these at the meeting to be held in May 2013.

14/4/16 Quality Account Timeline

SW advised that this needs to refer back to the terms of reference and relate to the rolling programme. AWS will ensure the Quality Account reflects the TOR of the QCPC. **AWS**

14/5 Reports From Key Committees

14/5/2 Acute Directorate Quality, Risk and Patient Safety Committee

DM presented the Acute Directorate's report highlighting the headline information regarding red and amber risk ratings

Red risk ratings:

Patient Safety
- Bed capacity problems

Clinical Effectiveness
- Blood sciences out of hours staffing
- Risk of not achieving the A&E 4 hour target
- Vacant Consultant Physician posts

Patient Experience
- Diagnostic imaging waiting area
- Mortuary fridges and freezers

Governance Compliance
- End of current PACS contract
- ICU capacity reduced to 6 beds

Amber risk ratings:

Patient safety
- Main trauma digital imaging room

Patient Experience
- Risk of not delivering single sex accommodation

LR advised that the directorate had seen a reduction in formal complaints and had already tried that new process regarding complaint resolution and the directorate had

had good results. LR advised that a complaint theme was staff attitude and this was of great concerns but this was being working on. LR reported that the directorate was managing SIRIs well.

SW asked that in future this is linked in with the Quality Report.

14/5/03 Planned Directorate Quality, Risk and Patient Safety Committee

LH presented the Planned Directorate's report. LH advised that over the last 3 months the Planned Clinical Directorate – Quality, Risk & Patient Safety Committee meetings had completed their report looking at the following areas:

- Assurance Review – including:
  - Quality Improvement
  - Patient Safety
  - Clinical Effectiveness
  - Patient Experience

- Actions being taken
- Summary of Progress on Annual Work Plan
- Recommendations for Quality & Clinical Performance Committee

AWS asked LH for clarification regarding the 18 outstanding Serious Incidents Requiring Investigation (SIRI)s. LH advised that she thought this was less now and that these would be discussed at their meeting on Monday. LH advised that the directorate was pleased that the complaint process was changing. LH suggested that the directorate take the responsibility for signing off complaint response letters also.

Martin Robinson advised that work is ongoing to achieve their objectives and details of this will be included in the Directorate's end of year Quality Report and Business Plan.

14/5/04 Community Health Directorate Quality, Risk and Patient Safety Committee

LR presented the Community Health Directorate's report.

LR highlighted the services that are currently RAG rated red

- Shackleton
  Environment not fit for purpose. Relocation expected 25.03.13.
- Orthotics & Prosthetics
  Demand outweighs capacity.
- Speech and Language Therapy. (SALT)
  Demand outweighs capacity.
- Occupational Therapy (OT)/Physiotherapy
  Oak House accommodation notice has been served to vacate premises. Staff to move into new location March/April 2013.
- Occupational Therapy
  Lack of staff - Band 6 cover commenced 11.02.13.
- Safeguarding Children

Unprecedented number of incidents. Implementing new government initiative to identify children subject to plan and looked after children.

LR highlighted the services that are currently RAG rated amber

- Woodlands
  Staffing levels and estates issues around bathrooms. Moved from red to amber. Refurbishment and building works have commenced.

- Community Mental Health Services
  Currently undergoing service redesign which could impact on MH Acute Services. Redesign progressing with contingency measures to minimise impact on MH Acute Services.

- Community Beds and Mattresses
  Risk to delayed discharges and risk to Pressure Ulcer NICE guidelines are not being met. Case for Change developed to re-align equipment budget with activity and demand levels. Still awaiting IWC match funding.

SA advised that because of time constraints the three directorate's reports were rushed and it seemed the work that they had done was not been recognised and should these reports be presented quarterly. SW said that there was a huge amount of value from sharing information with colleagues from other directorates. AWS agreed and said that it was good that the directorates were working on the same things. AWS suggested that the reports be refined. JM suggested that the reports are moved up the agenda and given 15 minutes each. LR said that it was about reporting on concerns, what progress was being made and what the plans were. SW advised that she would work with AWS to refine the Committee's agenda for future.

14/4/14 SHA Self Certification

AS presented to the Committee and advised that this was part of the SHAs oversight regarding the FT journey. AS gave an overview of January's data for February return and advised that the Trust may breach the 1.5 threshold. AS highlighted the quality indicators where the Trust was underperforming or there was a decline in trend. AWS advised that he would like to see reported at this meeting from the directorates what they are doing about these five areas.

AS suggested that the Committee reviewed items 1 and 11. The Committee reviewed area 1 and all agreed that they were happy to shift this to a "yes". The Committee reviewed area 11. AWS reported that the Trust was likely to have another Cdiff and if even if plans are in place the Trust cannot provide assurance that that will not be another case. The Committee agreed to leave this item as a "no". AS advised that if 18 weeks and A&E were satisfactory regarding their target the Trust would be more assured. AS advised that this does not have an impact on the Trust's FT journey at the moment.

14/5 Reports from Key Committees

14/5/01 Quality and Patient Safety Committee (minutes 3 Jan 2013)

AWS and SJ are to review these minutes regarding assurances separately to this meeting.

14/6 Top Issues for the attention of the Executive Board (EB) and the Trust Board (TB)

SW advised that the top issues were:

- Francis Report - actions to be taken by the Trust
- Action Plans – the Committee have asked for feedback regarding these
- IOW CC OFSTED report – the Committee reviewed the report and discussed initiating a joint committee.
- Self-certification

14/7 Any Other Business

14/7/1 Media Releases

AWS advised of two items of interest for the Committee

- Report in the Daily Mail regarding the Trust's mortality rates and have this was inaccurate.
- Dentist from Ryde in court this week which the IOW NHS PCT removed from the performance list.

13/020 DATE OF NEXT MEETING:

Wednesday 20 March 2013 (9:30 am to 12:30 pm)
Large Meetings Room, South Block.

Enclosure I2

<u>To Follow</u>

ISLE OF WIGHT NHS PRIMARY TRUST
MENTAL HEALTH & LEARNING DISABILITIES SERVICES

MENTAL HEALTH ACT SCRUTINY COMMITTEE

FOR PRESENTATION TO PUBLIC BOARD

Minutes of the meeting held on 23 January 2013, Family Therapy Room, Sevenacres

Present: Simon Dixey, Tim Higginbotham, Elisa Stanley, Stephen Ward Chair)

Key Issues for Trust Board and Community Health Directorate Board

1. Hospital Managers appraisals and 6-monthly meeting.
2. CQC reports on visits to Wards.

1. Apologies: Peter Taylor (Chair), Jan Gavin, Tracey Hart, Su Morris,

2. Minutes of the Meeting of 24 October 2012

The minutes were approved and signed as a correct record of the last meeting.

3. Matters Arising

Responsible Clinician reports to Tribunals: SW and SD had met with Dr Gladdish, Clinical Director, who endorsed the approach to ensure that issues of quality of reports are addressed with authors by the hearing (in particular at Hospital Managers' Hearings). If problems persist she will raise it with individual clinicians in supervision.
Dr Gladdish also suggested that RCs be offered support by reviewing their reports prior to submission. Both SW and SD are able to provide this support.

Medical Scrutiny of Section papers: ES and SD have reverted to sending paper copies for scrutiny as scanned copies cannot be annotated. In cases of urgency dorms can be scanned and emailed for urgent review.

Service User Representative: in the absence of JG there is no update on the proposed service user rep. This will be further discussed in April.

Action: SW to put on agenda for April meeting

MHA Scheme of Delegation: This has now been included in the Trust Scheme of Delegation, although on checking it is not in the version on the Intranet.

SW to raise with Brian Johnston

4. Associate Hospital Managers

Following a change in the law in September 2012 HR has no confirmed that Associate Hospital Managers do not fall into any of the categories for whom CRB checks can be requested.

All AMHs have been appraised by PT, who in turn was appraised by ES. Feedback was generally positive and the appraisals have identified a number of training issues (Chairing of meetings, confidentiality, use of jargon) to be addressed at the Hospital Managers next 6-monthly meeting on 29 January.

All AMHs have had new appointment letters and will be issued with ID Badges.

5. CQC Reports on visits to wards

Seagrove: the issues raised by CQC in their report were:

1. Consent to Treatment: “Ongoing recording of patients’ capacity and consent in accordance with Code of Practice Chapter 23 is not in evidence”. There was considerable discussion of this issue as the requirement appears to contradict the Mental Capacity Act first principle (presumption of capacity) and sets a different standard for patients with mental disorders to that for other patients. This is an issue previously raised with CQC but they continue to require such records. This is being addressed with a simple format for consideration of capacity to be recorded at ward rounds and will be audited by the modern matron.

   Action: David Sellers to monitor and audit
   SD to raise with RCs

2. Lack of therapeutic activities: this is being addressed through the Therapeutic Interventions Module of Productive Wards.
3. Explicit risk assessments before allowing patients to go on section 17 leave: this is problematic when patients have leave with few limitations, when they may come and go from the ward quite freely. However, the policy requires nurses to assess and record risks when allowing leave granted by the RC. A procedure needs to be developed which facilitates this in a proportionate manner.

   Action: SW to discuss with Acute Leads

Shackleton: issues raised:

1. Access to SHOs problematic due to remoteness from St. Mary’s Hospital.
2. Physical environment does not meet the Purpose Principle to minimise the undesirable effects of mental disorder: Both these issues will be resolved by the planned transfer of the unit to St. Mary’s Hospital.
3. Assessments of capacity not recorded in line with Code of Practice guidance. To be addressed as for Seagrove.

6. Section 136 Policy

This policy is currently under review and a number of suggestions for changes have been received from the Police Custody Inspector. It was felt the degree of detail suggested (eg on patients who need to be assessed at A&E prior to detention in a place of safety) was too much for a policy of this nature and should be addressed through operational guidance, which it appears the Police already have.

Action: SW to discuss with Acute Leads

7. Section 17 Leave Form

A patient’s leave was recently delayed because although the RC had granted leave the form had not been completed and staff were under the assumption that the form was a legal requirement. It was confirmed that the form is a non-statutory local form, based on guidance in the Code of Practice, which requires Trusts to have a standard process for recording leave. It was agreed that reminding staff that the form is not a legal requirement would be counter-productive as it may result in failure to complete forms. The new patient record system will have a facility to record leave, which will replace the current form.

MHASC Meeting Dates 2013:

23 January **24 April** **24 July** **23 October**

Approved as a correct record of the meeting:

Date:

DRAFT

FOR PRESENTATION TO PUBLIC BOARD ON 27/03/2013

ISLE OF WIGHT NHS TRUST
FOUNDATION TRUST PROGRAMME BOARD

TUESDAY 26 FEBRUARY 2013 BETWEEN 11:00 – 12:45
LARGE MEETINGS ROOM, PCT HQ, SOUTH BLOCK

NOTES

PRESENT

Karen Baker (Chair), Sue Wadsworth, Mark Price, Chris Palmer
Alan Sheward, Felicity Greene, Danny Fisher

1. APOLOGIES

Peter Taylor, Mark Pugh

IN ATTENDANCE

Andrew Shorkey, Andy Hollebon

Top Key Issues	Subject
3	Revised timeline proposal for FT readiness agreed to propose to TDA
4	Historical Due Diligence (stage 2) Action Plan received
5	Revised programme budget approved

ACTION

2. **Notes and matters arising from** 23 January 2013
The notes were accepted as a correct record of the meeting.

3. **Revised FT Timeline**
A detailed discussion took place in relation to defining a revised timeline as a consequence of the Board to Board deferral by the SHA/TDA. It was a TDA expectation that at the point of application the Trust would be Monitor ready. After factoring in the activity required to develop the robust LTFM it was agreed that a target submission date of 2 September 2013 would be proposed to TDA. Clarity would be required from TDA around the sequencing of activity. It was agreed that as clarity was required from TDA the Phase Plan would be removed from the TDA plan re-submission scheduled for 28 February 2013. **MP** **FG**
Post meeting note: TDA letter confirms submission required 'before 1 September'.

4. **Historical Due Diligence**
The HDD 2 Action Plan had been produced from an initial assessment of commentary within the Grant Thornton report. Programme Board members would review and feedback in relation to tasks, timelines and responsibilities by the end of the week. Thereafter, the plan would be distributed to task owners and for updates. The plan would also be forwarded to GT to obtain informal feedback to ensure that all required activity had been considered. Accountability for IT deliverables would be transferred to FG. **All** **AS** **AS**

5. **Board Governance**
The Board Governance Action Plan would be circulated to task owners for updating. **AS**

6. **Foundation Trust Programme Budget**
It was confirmed that £250K had been provided via commissioners to support transition for 2012/13 and an additional £300K had been made available by commissioners. The updated programme budget was presented identifying additional requirements for 2012/13 totalling £71.5K. Clarity was requested with respect to the security of display equipment and that connectivity had been taken into account. The revised budget was approved. Initial requirements for 2013/14 were identified and FG raised that additional support for the IBP in 2013/14 would also need to be included. Potentially £250K to support transition would be made available by the TDA in 2013/14. **AH** **FG/AS**

7. **Workstream Updates**
Workstream updates would be dealt with by exception.

8. **Enablers**
Enabler activity updates would now be reported to Thursday morning executive meetings.

9. **Communications and Stakeholder Engagement**
The outcome of the public consultation had been published in the local media. The membership recruitment campaign would be launched formally from 18 March 2013. A sample of material that would be used was circulated. A request had been made to attend a Youth Council meeting and it was proposed that a post election information/introductory session could be planned for IW Councillors. It was noted that this could be incorporated into the Council's induction programme for new and returning members. **AS**

10. **Programme Governance and Approvals**

(i) Programme Plan

The Programme Plan would need to be refreshed against the revised phasing once clarification had been received from TDA. **AS**

(ii) Risk Management

The updated risk report was presented with recommendations to reduce risk scores. The recommendations were accepted and an additional risk area would be incorporated reflecting risks arising from the transition in oversight and regulatory arrangements from SHA to TDA. It was noted that a consultation was currently underway on Monitor's *Risk Assessment Framework.* **AS**

11. **Feedback from FTN Events and FT Visits**

MP provided feedback on the recent Company Secretary Network event attended. At CP's request AH would link with Linda Mowle with respect to the Code of Conduct for Governors. **AH**

12. **Any other Business**

None

13. **Future Meetings**

The next meeting was scheduled for 11:00-12:45hrs, 26 March 2013, Small Meetings Room, South Block