The next meeting in public of the Isle of Wight NHS Trust Board will be held on **Wednesday 29th May 2013** commencing at **10:30hrs**.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 a comprehensive reply can be given at the meeting.

Mark Price,
Company Secretary

AGENDA

Indicative Timing	No.	Item	Who	Purpose	Enc, Pres or Verbal
10:30	**1.**	**Apologies for Absence, Declarations of Interest and Confirmation that meeting is Quorate**			
	1.1	Apologies for Absence	Chair	Receive	Verbal
	1.2	Confirmation that meeting is Quorate ***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
	1.3	Declarations of Interest	Chair	Receive	Verbal
10.35	**2.**	**Minutes of Previous Meetings**			
	2.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 24th April 2013 and the Schedule of Actions.	Chair	Approve	Enc A
	2.2	Chairman to sign minutes as true and accurate record	Chair	Approve	Verbal
	2.3	Review Schedule of Actions	Chair	Receive	Verbal
10:45	**3.**	**Chairman's Update**			
	3.1	The Chairman will make a statement about recent activity	Chair	Receive	Verbal
10:50	**4.**	**Chief Executive's Update**			
	4.1	The Chief Executive will make a statement on recent local, regional and national activity.	CEO	Receive	Pres
	4.2	Certificates of Achievement	CEO	Receive	Pres
11:05	**5.**	**Strategy and Business Planning**			
	5.1	FT Programme Update	FTPD	Receive	Enc B
	5.2	FT Self Certification	FTPD	Approve	Enc C
	5.3	Budget Update	EDOF	Approve	**Enc D** ***to follow***
11:25	**6.**	**Quality and Performance Management**			
	6.1	Performance Report	EMD	Receive	Enc E
	6.2	Patient story.	CEO	Receive	Pres
	6.3	Staff Story	EDNW	Receive	Pres
	6.4	Board Walkabouts Action Tracker	EDNW	Receive	Enc F

12:00	**7.**	**Governance and Administration**			
	7.1	To receive and approve 2012/13 Governance Statement	Comp Sec	Approve	Enc G
	7.2	Transfer of Assets update	EDSCD	Receive	Verbal
	7.3	Review of Board Performance	Comp Sec	Approve	Enc H
12:15	**8.**	**Board Sub Committee Minutes & Reports – to receive and approve**			
	8.1	Minutes of the Audit and Corporate Risk Committee held on 22nd May 2013*	ACRC Chair	Receive	**Enc I** ***to follow***
	8.2	Recommendations from the Audit and Corporate Risk Committee held on 22nd May 2013.	ACRC Chair	Approve	**Enc J** ***to follow***
	8.3	Minutes of the Finance, Investment and Workforce Committee held on 22nd May 2013	FIWC Chair	Receive	**Enc K** ***to follow***
	8.4	2012-13 Reference Costs – Self Assurance Quality Check – Position Report	EDOF	Approve	Enc L
	8.5	Minutes of the Foundation Trust Programme Board held on 23rd April 2013	FTPB Chair	Receive	Enc M
	8.6	Minutes of the Mental Health Act Scrutiny Committee held on 1st May 2103	MHASC Chair	Receive	Enc N
12:30	**9.**	**Matters to be reported to the Board**	Chair		
	9.1	NHS TDA request for Board Papers to be submitted via email	Comp Sec	Approve	Verbal
12.35	**10.**	**Questions from the Public**	Chair		
		To be notified in advance			
12:40	**11.**	**Any Other Business**	Chair		
12:45	**12.**	**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.

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

- Procure 21+ procurement approval
- Reports from Serious Incidents Requiring Investigation (SIRIs)
- Claims Report

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.

12:50	**13.**	**Date of Next Meeting:**

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on Wednesday 26th June 2013 in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

Isle of Wight NHS Trust

Enc A

Minutes of the meeting in public of the Isle of Wight NHS Trust Board held on Wednesday 24th April 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 Strategy and Commercial Development
	John Matthews	Non Executive Director
	Chris Palmer	Executive Director of Finance
	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 (SID)
Observers:	Mike Carr	Patient Council
	Chris Orchin	Local Involvement Network (LINk)
	Stuart Hutchinson	Cabinet Member, IOW Council
	Lynn Cave	Acting Board Administrator
In Attendance:	Mark Price	Foundation Trust Programme Director/Company Secretary
	Andy Hollebon	Head of Communications
	Suzanne Wixey	Lead – My Life a Full Life (for Item 13/050)
	Mark Elmore	Deputy Director – Human Resources (for item 13/060)
	Hilary Salisbury	Senior Human Resources Manager (for item 13/060)
	Jackie Humphries	Resourcing Manager (for item 13/060)
Minuted by:	Julie Benson	PA to FT Programme Director/Executive Director of Strategy and Commercial Development

Members of the Public in attendance: There were 3 members of the public present

Minute No.

13/049 APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE

There were no apologies for absence received.

John Matthews confirmed that he was the Assistant Deputy Coroner and a Deputy District Judge.

The Chairman announced that the meeting was quorate.

13/050 PRESENTATION ON MY LIFE A FULL LIFE

The Executive Medical Director introduced Suzanne Wixey, who is the appointed lead officer for the programme – My Life a Full Life, which is a joint programme between the Isle of Wight NHS Trust, Isle of Wight Clinical Commissioning Group and the Isle of Wight Council.

Suzanne Wixey outlined the scope of the project and its aims to improve the services for health and social care within the island and to promote a shared vision between the groups involved. A DVD had been produced which was then shown to the Board.
The Chairman thanked Suzanne Wixey for her presentation and opened the floor for questions.

John Matthews expressed great interest in the project and asked if patient motivation was considered a key element for success. Suzanne Wixey acknowledged that there were hard to engage groups and the programme was aimed at enabling an individual to prepare for their future health and was tailored to meet the various needs and situations which could arise. Karen Baker also confirmed that there were services in their own locality for the public rather than come into the hospital or other central site.

Suzanne Wixey confirmed that initially the group were focusing on 3 areas which include self care, locality working and crisis management but confirmed that mental health would certainly be included as the programme developed.

Sue Wadsworth gave her congratulations for the work so far and asked what plans had been made to receive feedback and had any thought been given to an annual conference/meeting for the programme. Suzanne Wixey confirmed that she was in communication with 500+ people who would be providing feedback through the year.

Nick Wakefield asked if any volunteer help/forum had been utilised. The Chairman asked if the Hospital volunteers could be used with a designated Volunteer Co-ordinator/Leader. Stuart Hutchinson confirmed that the Isle of Wight Council was funding the programme and had increased funding to be spread over the next 4 years. He also confirmed that liaison with local volunteer organisations; Age UK and the Good Neighbour scheme were in place.

The Chairman thanked Suzanne Wixey for her presentation. Copies of the DVD were left for the Board members.

Suzanne Wixey left the meeting.

13/051 MINUTES OF PREVIOUS MEETING OF 27th MARCH 2013

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 27th March 2013 were approved.

Proposed by Sue Wadsworth and seconded by John Matthews

The Chairman signed the minutes as a true and accurate record.

13/052 CHAIRMAN'S UPDATE

The Chairman reported to the Board that:

- He and Karen Baker had attended the CCG's launch earlier in the month, and it was apparent from this that the public had a lack of understanding about the different organisations responsible for commissioning and acute care.
- The hospital was busy and there had been many red alerts.
- Mark Price had been appointed as Company Secretary from a very strong field and Mark Price was congratulated.
- Nina Moorman had been appointed as a Non-Executive Director with a clinical background and would be starting on 20th May 2013.

The Finance Team were to be congratulated for the achievement in getting the accounts in on time.

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

13/053 CHIEF EXECUTIVE'S REPORT

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

13/054 National and Regional Issues

a) The Island's integrated care was in line with national policies.
b) Our Foundation Trust application was on track with Board to Board meeting expected to be in October 2013 and we are on track to become a Foundation Trust in autumn 2014.
c) Our response to the Francis Report – There was to be a Senior Staff Day on 13th May 2013 where Dr Dallas Price and Deborah Matthews would be leading on our response to the Francis Report.

13/055 Local issues

a) The Chief Executive reiterated that Nina Moorman has been appointed as a Non Executive Director with a clinical background.
b) Mark Price had been appointed as Company Secretary but would also continue is his role as Foundation Trust Programme Director until the point when we became a Foundation Trust.
c) Prison Healthcare – Sarah Bromley has been appointed National Medical Director, Offender Health for Care UK. Her time will be split between clinical work in the prisons on the Island, three days with Care UK and a day on CCG business.
d) Congratulations to **Steve Grieve** in Patient Transport Service who has just been awarded the Order of the St John Medal for his services to the community as a First Responder. Congratulations to all the **Porters** and **Charles Joly** in Estates who won this year's NHS Sustainability Day Award for the best waste and recycling initiative. Entries to HSJ and Efficiency and Nursing Times Awards were encouraged as will highlight the Isle of Wight NHS Trust nationally.
e) Car Parking – 194 mores spaces were now available with more spaces being available for patients near the hospital.
f) Helipad – this had now been handed over and was in the testing and training phase.
g) Pressures – it was mentioned that although there had been pressures the staff have done a good job managing a difficult situation, and as we were a

small trust a small number of people do make a difference to the situation.

At this point certificates of recognition were given to:

h) Tony Martin – Information Governance Manager
i) Angelo Cascarini and Harriet Jennings – Development and Training in recognition of their help in achieving the target for Information Governance mandatory training.
j) Andrew Shorkey – FT Programme Office in recognition of his work with regard to our submission of the IBP and TDA Plan.

Nick Wakefield asked if the care in the community will help with easing the pressures felt in the hospital. Karen Baker said that it would and My Life a Full Life would also help with this. Peter Taylor questioned whether the fact that A&E targets had been lowered from 98% to 95% was having an effect. It was acknowledged that we were still achieving a performance of 96% but we could still do better. Mark Pugh said that it was actually getting the patients through the system which was making the situation difficult. It was asked if 111 was causing any increase in admissions and it was confirmed that it was increasing attendance at A&E but not admissions.

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

13/056 Patient's Story

a) **Film** - A short film was present to the Board showing 2 patients giving details of their patient experience. They both indicated that they would be happy to recommend St Mary's to their friends and family as well as the favourable experiences they received during their stay. However, areas for improvement were highlighted in patient appointment communication. Concerns were raised about changes to clinics, who the patient would see, follow up appointment etc. The Executive Director of Nursing & Workforce (EDNW) expressed in his view, that the information given within the film was all valuable feedback and stated that the areas of concern highlighted would be reviewed with special focus on discharge planning.

Action by EDNW

b) **JAC System** - The Executive Director of Nursing & Workforce reported that the new JAC IT system in pharmacy would enable data to be retrieved on all patients receiving medication. The Chief Pharmacist would be demonstrating JAC to the ward sisters at upcoming development days.

c) **Executive On Call** – The Executive Director of Finance reported that during her period of "on call" she had occasion to visit MAAU with Julianna Hayward, General Manager – Planned Clinical Directorate, for an unannounced visit. She reported that the team were seen to be working in a calm, efficient manner with a very positive attitude from all staff. Patients spoken to confirm that they were well cared for and that meals were good. She also reported that the department had a low sickness absence of 1.07% with a year to date figure of 1.85%. Ward sister reflected that they tried not to move patients around the department except in case where the mixed sex breeches would occur. Overall she was very impressed.

d) **Future out of hours visits** – Sue Wadsworth reported that there would be a further 4-5 out of hours visits over the next few months and invited more Board members to attend with her.

Action by SW/ALL

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

13/057 STRATEGY AND BUSINESS PLANNING

FT Programme Update

A brief report and update was given by the Foundation Trust Programme Director which highlighted that the revised timetable for the FT journey in view of the new TDA Accountability Framework had been agreed and that we were currently at Stage 3 of the 3 stage process. A high level programme plan will be submitted to the FT Programme Board in May.

Action by FTPD/CS

Membership recruitment was going well with 650 public members to date. A range of summer events were planned with the first being the Robin Hill Garden Show on the weekend of 27th April 2013. The Beacon magazine would be carrying promotion material which is due to be published within the next 10 days.

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

13/058 FT SELF CERTIFICATION

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

There is still a degree of volatility in the Governance Risk Rating with the cancer 2 week waits indicator (3d) not achieving compliance. The A&E waiting times (3e) and C-Difficile (4a) targets have been recovered. The GRR remains at AMBER/GREEN status with the overall score improving and moving from 1.0 to 0.5. Contractual data and the Financial Risk Rating remain on track.

N.B. The Governance Risk Rating is incorrectly calculated in Appendix 1. According to Monitor's *Compliance Framework* both elements of 3(e) must be in breach for a score to be applied. Therefore, the correct overall score is 0.5 rather than 1.5. This has been confirmed with the TDA.

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 submitted to Board sub-committees for review.

Following discussion on the assurance available to the Board sub committees it was agreed that Board Statement No 11 is marked compliant and that Trust Board approve signing of self-certification return against Governance Declaration 2 by the Chairman and Chief Executive.

Proposed by Sue Wadsworth and Seconded by Peter Taylor.

The Isle of Wight NHS Trust Board approved the sign off of Governance declaration 2 on the Self Certification.

13/059 QUALITY AND PERFORMANCE MANAGEMENT

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

Highlights:

a) No new cases of MRSA (6th consecutive month)
b) Emergency care 4 hour standard achieved for year
c) All year end Cancer targets expected to be achieved after validation
d) Development of grade 3 & 4 pressure ulcers reduced by 11% on 2011l/12 figures
e) Excellent performance for Stroke Patients 90% of stay on Stroke unit sustained for 9th month
f) 100% achievement of Financial Plan

Lowlights:

a) Complaints target exceeded for year despite reduction in month
b) TIA locally stretched target not met, although national target achieved for year
c) Caesarean section rate high in March and exceeding target for the year
d) Total pay costs exceeded plan for March and for the year

Nick Wakefield questioned the overpayment in the staff pay. The EDOF explained that the overspend was covered within the year end by non contract activity income from a number of initiatives.

Sue Wadsworth asked about the progress on the Shackleton House relocation. The Executive Director of Strategy and Commercial Development reported that there had been some delays due to late specification changes and sub contractor stock delays but handover was planned for last week in May with patients moving in from the afternoon of 3rd June 2013.

A visit will be planned to view the new department between 30th May and 3rd June for Board to inspect.

Action by EDSCD

The Chairman asked for more clarification on the Caesarean Section data. The Executive Medical Director explained that these procedures came under two criteria – planned/elective and unplanned. A discussion was held regarding the various factors relating to the decision to opt for either a planned or unplanned procedure. John Matthews asked how unplanned caesareans could be foreseen and it was stressed that lots of factors during a birth could contribute but each event was different and therefore it was not possible to foresee when these would occur. The Chief Executive stressed that the national benchmark was 20% for emergency procedures and that our figures were within tolerance.

Peter Taylor questioned why the old steam pipe had been left in place during refurbishments to the landscaping at the rear of the site. It was agreed that Estates would look into this issue.

Action by EDSCD

The Isle of Wight NHS Trust Board received the Performance Report

13/060 Staff Story

The Executive Director of Nursing and Workforce introduced Mark Elmore, Hilary Salisbury and Jackie Humphries from the Human Resources department, to report on the transfer of staff following the closure of HMP Isle of Wight Camphill site. They

highlighted that:

a) 11th March the commissioners informed the provider that following the closure of Camphill the prison healthcare required restructuring resulting in the need for 8 staff to be redeployed.
b) Staff were met on 14th March and told of this need and given information on current vacancies.
c) 15th March individual meetings commenced to discuss the options for redeployment.
d) Week commencing 18th March dedicated resources were identified to support staff with Deborah Matthews, Head of Clinical Services and Jackie Humphries, Resourcing Manager assisting staff.
e) Monday 25th March 7 of the 8 staff commenced a trial period with 5 staff currently confirmed in their new post and work is continuing with the others to secure alternative employment.

Deborah Matthews was complimented on her sensitive handling of the situation and the team were congratulated on the successful outcome.

The Isle of Wight NHS Trust Board received the Staff Story

At this point the representatives from HR left the meeting

13/061 Mortality Update

The Executive Medical Director reported that mortality data was received 3 months in arrears. He discussed the Isle of Wight data compared to national levels and advised the Board that the data was within tolerance levels and had showed improvement. John Matthews asked if the Islands elderly population affected the figures. The Executive Medical Director advised that this was not the case. The data was taken from the risk assessments carried out on the patient's likely survival rate for that admission to hospital. The Chairman asked if hospital coding affected the data. It was stressed that the clinical staff needed to ensure that they use the correct wording on the medical reports to ensure accuracy.

It was agreed that the Non Executive Directors would be given access to Dr Foster information.

Action by EMD

A quarterly update would be prepared and submitted to the Board.

Action by EMD

The Isle of Wight NHS Trust Board received the Mortality Update

13/062 GOVERNANCE AND ADMINISTRATION

Use of the Board Seal

The Executive Director of Finance outlined the procedure for the use of the Board seal and went through each of the items for which the seal has been used since January 2013.

The Isle of Wight NHS Trust Board noted the use of the Board Seal

13/063 Responsible Officer

The Executive Medical Director explained the background to this role and its responsibilities. He also outlined the Trusts 5 year rolling revalidation programme for

doctors to ensure that they are fully compliant with the requirements of the General Medical Council. He outlined the plans for 2013/14 regarding appraisals and the programme to improve the data set to be used in consultant appraisals.

The Isle of Wight NHS Trust Board received the Responsible Officer Update

13/064 Certificates of Achievement

The Chief Executive welcomed the staff from Pathology who have successfully achieved NVQ levels 2 & 3 in Clinical Pathology support through the NVQ centre at Queen Alexandra Hospital in Portsmouth.

Phlebotomy: Alexandra Millar; Deborah Forsyth-Caffrey
Biochemistry: Jo Creaser; Kerri Deacon; Susan Kittle; Melanie Churchill
Haematology/Blood transfusion: Ewan Haigh; Susan Miles; Dean Fuller
Microbiology: Samantha Farmer; Janet Jones
Histology: Wendy Ewbank
Pathology Reception: Claire Nicholson

She also gave thanks to Ray Davison, Keith Thomas and Pete Stockman for their support of the candidates during their learning process.

The Board congratulated all of them on their achievement...

At this point the Pathology staff left the meeting

13/065 Minutes of the Audit and Corporate Risk Committee held on 8th March 2013

Peter Taylor presented the minutes of the meeting and discussed the highlighted areas as follows:

- IM&T Update
- Fire Service Audit – fire risk for medical records
- Counter Fraud Services tender 2013/16 – Contract awarded to CEAC
- Committee's Annual Report and checklist – attached to minutes for presentation to Trust Board
- Annual Report 2012/13

Peter Taylor highlighted a recommendation from the Audit & Corporate Risk Committee to the Board that assurance be required by Trust Board that the IM&T programme is on track and that a timeline has been included in the IBP aligned with the capital programme. It was agreed that the Executive Director of Strategy & Commercial Development should ensure that this is in place

Action by EDSCD

Proposed by John Matthews and Seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the minutes of the Audit and Corporate Risk Committee

13/066 Audit and Corporate Risk Committee Terms of Reference

Peter Taylor presented the amended terms of reference for the committee.

Proposed by John Matthews and Seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the terms of reference for the

Audit and Corporate Risk Committee

13/067 Audit and Corporate Risk Committee Annual Report

Peter Taylor presented the annual report for the committee

The Isle of Wight NHS Trust Board received the annual report for the Audit and Corporate Risk Committee

13/068 Minutes of the Finance, Investment and Workforce committee held on 17th April 2013

Peter Taylor presented the minutes of the meeting and discussed the highlighted areas as follows:

- Financial performance – Draft financial performance of £500k surplus for the year (subject to the external audit) to be noted by the Board.
- Workforce performance – The sickness absence figure has decreased significantly on the previous month from 3.89% to 3.05%.
- Self certification review – To be recommended for approval by the Board

He congratulated the Finance team for all their efforts in achieving the year-end target and for all their work behind the scenes to keep the Trust on track.

Proposed by Sue Wadsworth and Seconded by John Matthews

The Isle of Wight NHS Trust Board approved the minutes of the Finance, Investment & Workforce Committee

13/069 Capital Sign off Limits

The Executive Director of Finance explained the reasoning behind the need for this approval. The Trust Development Authority issued its Accountability Framework for NHS Trusts in April 2013. The Trust now has its own delegated authority for capital schemes. For a value up to £0.25m this to be approved by the Capital Investment Group. For a value from £0.25m up to £1m to be approved by the Executive Board and for a value from £1m up to £5m to be approved by the Trust Board.

Proposed by Peter Taylor and seconded by John Matthews.

The Isle of Wight NHS Trust Board approved the change in the Capital Sign off Limits

13/070 Minutes of the Quality and Clinical Performance Committee held on 17th April 2013

Sue Wadsworth presented the minutes of the meeting and discussed the highlighted areas as follows:

- Pressure Ulcer Report
- Dementia Report
- New Complaints Process
- CQC intelligence

She also reported that there was an agreed change to the frequency of the meetings for the committee. These would change to bi monthly decision making meetings with the alternate months being for discussion of specific areas of concern. She

confirmed that the committee's action plan would continue to be reviewed monthly to ensure no delays. John Matthews stated that in an emergency any discussion meeting could be changed to a decision making forum. It was also agreed that the self certification would be considered formally at each meeting. Sue Wadsworth confirmed that the Terms of Reference would be amended.

Action by EDNW

The Local Involvement Network representative asked if the Trust's complaints system was shared with outside organisations. The meeting was advised that this was being reviewed and would be discussed at the next meeting of the Quality & Clinical Performance committee.

Action by EDNW

Proposed by Peter Taylor and Seconded by Nick Wakefield

The Isle of Wight NHS Trust Board approved the minutes of the Quality & Clinical Performance Committee

13/071 Minutes of the Foundation Trust Programme Board held on 26th March 2013

The Chief Executive presented the minutes of the meeting and discussed the highlighted areas as follows:

- Timeline agreed for TDA phase of FT application process
- Action Plans to be reviewed in detail by Executive Team
- It was agreed that a 100% approach to performance targeting was required with clinical exceptions where required

Proposed by Sue Wadsworth and Seconded by Peter Taylor

The Isle of Wight NHS Trust Board approved the minutes of the Foundation Trust Programme Board

13/072 BOARD SITTING AS THE CORPORATE TRUSTEE
Minutes of the Charitable Funds Committee held on 12th March 2013

The Chairman presented the minutes of the meeting and discussed the highlighted areas as follows:

- Charitable Funds Strategy – alignment to IBP
- Memorandums of Understanding – to be referred for Board approval:
  - Juba Link
  - IOW Hospital Radio
  - Friends of St. Mary's
- Healing Arts Management Committee – no CFC NED representative
- Thoracoscopy Equipment - £5,000 agreed from Respiratory Fund

A discussion was held around whether issues from this meeting needed to be received by the Trust board or approved. It was agreed that on this occasion they would be approved but the matter would be reviewed.

Action: FTPD/CS

Proposed by Sue Wadsworth and Seconded by Peter Taylor

The Isle of Wight NHS Trust Board approved the minutes of the Charitable Funds Committee

13/073 QUESTIONS FROM THE PUBLIC

There were no questions from the public

13/074 ANY OTHER BUSINESS

The Chairman invited any other business but there was none.

13/075 ISSUES TO BE COVERED IN PRIVATE

Danny Fisher announced that the public meeting would now close and the private meeting would now commence by declaring *"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 1960".*

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

- Business case for refurbishment of Medical Assessment Unit
- Business case for Phase II Pathology
- Reports from Serious Incidents Requiring Investigation (SIRIs)
- Clinical negligence claims

13/076 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 29th May 2013 in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 12:30

Appendix 1

ISLE OF WIGHT TRUST BOARD Pt 1 - ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

Key to LEAD: Chief Executive (CE) Executive Director of Strategy and Commercial Development (EDSCD) Executive Director of Finance (EDF)

Executive Medical Director (EMD) Executive Director of Nursing & Workforce (EDNW)
Foundation Trust Programme Director/Company Secretary (FTPD/CS)

Non Executive Directors: Danny Fisher (DF) Sue Wadsworth (SW) John Matthews (JM) Peter Taylor (PT) Nick Wakefield (NW)

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Date Closed	Status
			PATIENTS STORY				
24/04/2013	**13/056(a)**	TB/001	The Executive Director of Nursing & Workforce (EDNW) expressed that the information given within the film was all valuable feedback and stated that the areas of concern highlighted would be reviewed with special focus on discharge planning.	EDNW	This is being managed by the Directorate	21/05/2013	Closed
24/04/2013	**13/056 (d)**	TB/002	**Future out of hours visits** – Sue Wadsworth reported that there would be a further 4-5 visits over the next few months and invited more Board members to attend with her.	All/SW	Schedule of visits to be presented to May board meeting		Open
			FT PROGRAMME UPDATE				
24/04/2013	**13/057**	TB/003	High level report would be submitted in May.	FTPD/CS	Report to the May FT Programme board meeting	20/05/2013	Closed
			QUALITY AND PERFORMANCE MANAGEMENT				
24/04/2013	**13/059**	TB/004	A Board member visit will be planned to view Shackleton House department between 30 May and 3 June for Board to inspect.	EDSCD	All Board members have been invited to attend the opening on 31st May	20/05/2013	Closed
24/04/2013	**13/059**	TB/005	Estates review of site to ensure that any unnecessary structures are assessed for removal – in particular Steam Pipe running from North hospital down rear road.	EDSCD	As remedial work is done along the route of the steam pipe, sections of the pipe are removed. To remove the whole pipe as a stand alone project would be extremely costly.	20/05/2013	Closed
			MORTALITY UPDATE				
24/04/2013	**13/061**	TB/006	It was agreed that the NED's would be given access to Dr Foster information.	EMD	Update on NED training for Dr Foster information for May board meeting		Open
24/04/2013	**13/061**	TB/007	A quarterly update would be prepared and submitted to the Board.	EMD	Quarterly update on Mortality rates for July Board meeting		Open
			AUDIT COMMITTEE RECOMMENDATIONS TO THE BOARD:				
24/04/2013	**13/065**	TB/008	Assurance required by Trust Board that the IM&T programme is on track and that a timeline has been included in the IBP aligned with the capital programme.	EDSCD	Covered by IM & T delivery group and Executive Board	20/05/2013	Closed
			QUALITY AND CLINICAL PERFORMANCE COMMITTEE				
24/04/2013	**13/070**	TB/009	Terms of Reference would be amended to reflect amendments to meeting timetable	EDNW	These have been shared with the members	21/05/2013	Closed
24/04/2013	**13/070**	TB/010	Trust's complaints system - being reviewed and would be discussed at the next meeting of the Quality & Clinical Performance committee.	EDNW	This has been discussed at the QCPC	21/05/2013	Closed
			CHARITABLE FUNDS COMMITTEE				
24/04/2013	**13/072**	TB/011	Should the minutes from this committee's meeting be received by the Trust board or approved.	FTPD/CS	An update will be given at the May Board meeting	20/05/2013	Closed

Isle of Wight NHS Trust

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REPORT TO THE TRUST BOARD ON 29 MAY 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 Performance 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 was launched in March 2013.

Executive Summary:

This paper provides an update on work to achieve Foundation Trust status in late 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	20 May 2013

ISLE OF WIGHT NHS TRUST
NHS TRUST BOARD MEETING WEDNESDAY 29 MAY 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

The Trust has 1,346 members registered on the database. Every member has been sent an acknowledgement either via e-mail or by post. In terms of constituencies we have the following:

Constituency	Membership	Required before election
North & East Wight	433	500
South Wight	372	500
West and Central Wight	508	500
Elsewhere	33	250
Total	**1,346**	**1,750**

Our first profile raising event was the Isle of Wight Garden Festival at Robin Hill over the weekend of 27/28 April. Around 83 people were signed up at the weekend and many more membership leaflets handed out. There was substantial recognition amongst those we spoke to of the campaign and recollection of receiving a leaflet with the Beacon Magazine. Bundles of membership applications continue to arrive in the Communications office each day. Our programme of advertising is continuing with print and radio.

A constructive meeting has been held with Hovertravel who have agreed to recruitment at their terminals. We hope to shortly press release the 1,000th member joining subject to their agreement.

Planning has started on 'Medicine for Members' sessions. The first sessions, to be held in late June/July will focus on emergency care (ambulance, emergency department, etc). It is proposed to focus on mental health in October to coincide with World Mental Health Day. A members pack and members newsletters are also planned.

Margaret Eaglestone joins the Trust at the beginning of June as Membership and Engagement Officer based in the Communications Team. Margaret has a background in engagement work in Oxfordshire and South London. Lisa Street, who has done an excellent job since Jo Cram went on Maternity Leave will return to the Project Management Office (PMO). We would not have progressed this far without being able to draw on Lisa's past experience.

4. Programme Plan

Work on the Integrated Business Plan and Long Term Financial Model (LTFM) refresh is underway to meet the 31 August 2013 Trust Development Authority (TDA) submission deadline and the IBP Steering Group is in place and meeting weekly to drive the process. The Historical Due Diligence Stage 2 refresh has been tentatively scheduled for early September and discussions are ongoing with the TDA to ensure that the scope of the assessment is appropriate to our organisation.

Work has commenced with workstream leads to ensure that the requirements of the TDA phase are understood and the necessary capacity and resources are in place to deliver. A consolidated action plan including TDA and Monitor requirements and recommended action from formal and informal reviews has been developed to ensure all activity required to be FT ready is visible and tracked to delivery. The action plan contains approximately 350 cross-cutting activities and includes the recent Board development action recommended by the Trust's Board Development advisors Foresight Partnership. A high level programme plan is going to the May 2013 FT Programme Board meeting and will be presented to Trust Board in future months.

The TDA Board have received a paper outlining the current status and batching of the remaining 101 NHS Trusts. We have been advised that we are within a batch of 13 NHS Trusts 'that may bring forward an FT application to the NHS TDA later in 2013/14…. subject to development of applications and successful assessment'. This aligns with our current timeline.

A recommendation from a number of external reviews in relation to Board governance and capacity was to recruit to the Board a non executive director with clinical experience. On 20 May Nina Moorman will join the Trust Board to meet this requirement and further strengthen the Board to ensure quality governance is sustained and continually improved going forward.

5. Key Risks

Changes in regulatory and oversight arrangements with respect to TDA and Monitor have been recognised as a risk with respect to maintaining our timeline. An effective relationship is being built with the TDA and our first monthly oversight meeting was held on 15 May 2013. The TDA have also been in discussion with Monitor and will be arranging introductory meetings in early June to look at how Monitor will assess our unique organisation and to take forward tariff modification work. The implications of the *Francis Report* are still not fully understood in the context of the FT application process and work is ongoing across the organisation to test our current levels of compliance. Addressing the *Francis Recommendations* was the theme of the Organisation Day that took place on 13 May 2013.

With respect to capacity, the loss of key personnel in the Finance team gives rise to risk around our capacity to deliver the refreshed LTFM and its impact on the IBP.

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 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 maintained our position since last month's return and will achieve a score of 0.5 (Amber/Green) for the April 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:

(i) Note this update report

Mark Price
Foundation Trust Programme Director
20 May 2013

TDA Accountability Framework - FT Milestones

Appendix - 3

	Milestone (all including those delivered)	Milestone date	Performance	Comment where milestones are not delivered or where a risk to delivery has been identified
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Isle of Wight NHS Trust

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REPORT TO THE TRUST BOARD 29 MAY 2013

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

Previously considered by (state date):	
Acute Clinical Directorate Board	
Audit and Corporate Risk Committee	
Charitable Funds Committee	
Community Health Directorate Board	
Finance, Investment and Workforce Committee	22 May 2013
Executive Board	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Planned Directorate Board	
Quality & Clinical Performance Committee	
Remuneration Committee	

Staff, stakeholder, patient and public engagement:

Executive Directors and Performance Information for Decision Support (PIDS) have been consulted.

Executive Summary:

This paper presents the May 2013 self-certification return covering April 2013 performance period for approval by Trust Board.
The key points covered include:

- Background to the requirement
- Assurance
- 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) Note the changes to self-certification arrangements

(ii) Approve the submission of a partial return acknowledging current gaps in assurance relating to our ability to certify against elements of the revised requirements at this stage

(iii) Identify if any Board action is required

Date	20 May 2013

ISLE OF WIGHT NHS TRUST

SELF-CERTIFICATION

1. Purpose

To provide an update to the Board on changes to the self-certification regime and seek approval of the proposed self-certification return for the April 2013 reporting period, prior to submission to the Trust Development Authority (TDA).

2. Background

Since August 2012, as part of the Foundation Trust application process the Trust has been required to self-certify on a monthly basis against the requirements of the SHA's Single Operating Model (SOM). The Trust Development Authority (TDA) have now assumed responsibility for oversight of NHS Trusts and FT applications and the oversight arrangements outlined in the recently published *Accountability Framework for NHS Trust Boards* came into force from 1 April 2013.

According to the TDA:

> The oversight model is designed to align as closely as possible with the broader requirements NHS Trusts will need to meet from commissioners and regulators. The access metrics replicate the requirements of the NHS Constitution, while the outcomes metrics are aligned with the NHS Outcomes Framework and the mandate to the NHS Commissioning Board, with some adjustments to ensure measures are relevant to provider organisations. The framework also reflects the requirements of the Care Quality Commission and the conditions within the Monitor licence – those on pricing, competition and integration – which NHS Trusts are required to meet. Finally, the structure of the oversight model Delivering High Quality Care for Patients. The Accountability Framework for NHS Trust Boards reflects Monitor's proposed new Risk Assessment Framework and as part of oversight we will calculate shadow Monitor risk ratings for NHS Trusts. In this way the NHS TDA is seeking to align its approach wherever possible with that of the organisations and to prepare NHS Trusts for the Foundation Trust environment.[1]

Although oversight arrangements for NHS Trusts, as outlined within the *Accountability Framework,* consist of some 115 indicators, only 26 together with agreed FT milestones are specified within the appendix 4 of the *Accountability Framework* for inclusion within the monthly self-certification process. These consist of a revised set of Board Statements together with a selection of Monitor's Licence Conditions and are attached at Appendix 2. The Governance Risk Rating (GRR), Financial Risk Rating (FRR) and other components, including the Governance Declaration, of the SHA's self-certification regime are no longer considered as part of this process, although many of the indicators are considered as part of the 'Routine Quality and Governance indicators' and 'Financial Indicators' within the oversight framework. The GRR and FRR are included in the Board performance report and we expect that the vast majority of the other indicators are also included. A gap analysis is underway to identify where this is not the case.

At the point of writing this report access to submission templates via an internet portal have been provided by the TDA and have been populated against our position for March 2013, by agreement with the local TDA team. This has been necessary due to the submission deadline imposed by the TDA for the April 2013 position (17 May 2013). Concern has been expressed to the TDA that the timing is not consistent with the requirement for the Trust Board to assure the return prior to submission. To provide a return that had not been assured by the Board would be a regressive step with respect to the ethos of the *Single*

[1] Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards, (2013/14), p15

Operating Model that was centred around achieving Board ownership and accountability through the self-certification process.

Where non-compliance is identified, an explanation is required together with a forecast date when compliance will be achieved.

3. Assurance

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

Draft self-certification returns have been considered by 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 and this process is being extended to include Monitor Licence Conditions. 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. Performance Summary and Key Issues

Board Statements

1. Board Statements have been reduced from 15 to 14. Five of which are affected by revisions that in the main consist of references relating to ensuring compliance with the TDA's Oversight Model and/or Accountability Framework. Furthermore, there are a number of indicators that were not part of the previous self-certification and/or SHA oversight regime where further detailed guidance is required with respect to definitions and performance thresholds. The lack of clarity at this stage will impact on the ability of the Board to respond affirmatively to the Board Statements affected by the revisions referred to above, in particular against Board Statements 5, 6, 7 and 10. Undertaking this exercise is consistent with the compliance requirements of Board Statement 1.

Licence Conditions

2. Licence Conditions are a new requirement and additional systems and processes will be required to provide assurance to the Board that compliance has been achieved or effective plans are in place to achieve compliance. At the point of writing Executive Directors are reviewing these requirements. There are some Licence Conditions such as G7, Registration with the Care Quality Commission, that will be relatively easy to assess against. Whereas others such as G4, Fit and proper persons as Governors and Directors, will be more difficult to initially assess against and will require systems and processes to be implemented.

Foundation Trust Milestones

3. *Pending agreement by FT Programme Board on 28 May 2013.* An update will be provided at the Trust Board meeting on 29 May 2013.

5. Recommendations

It is recommended that the Trust Board:

(i) Note the changes to self-certification arrangements;

(ii) Approve the submission of a partial return acknowledging current gaps in assurance relating to our ability to certify against elements of the revised requirements at this stage;

(iii) Identify if any Board action is required

Mark Price
Foundation Trust Programme Director
20 May 2013

6. Appendices

1 – Board Statements
2 – Licence Conditions
2 – Foundation Trust Milestones

7. Supporting Information

- *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards,* TDA, 05 April 2013
- *Compliance Framework 2013/14,* Monitor*,* 28 March 2013
- *Draft Risk Assessment Framework,* Monitor, 10 January 2013
- *Delivering the NHS Foundation Trust Pipeline: Single Operating Model,* SHA, 3 August 2012

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD ON 29th MAY 2013

Title	Budget Update
Sponsoring Director	Executive Director of Finance
Author	Chris Palmer
Purpose	For Information

Previously considered by (state date):	
Acute Clinical Directorate Board	
Audit and Corporate Risk Committee	
Finance Investment and Workforce Committee	March 2013
Charitable Funds Committee	
Community Health Directorate Board	
Executive Board	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Planned Directorate Board	
Quality & Clinical Performance Committee	
Remuneration Committee	

Staff, stakeholder, patient and public engagement:

N/A.

Executive Summary:

The attached paper reports the formal budget position updated from the provisional figures approved by the Board in March 2013.

The budgets reflect a planned surplus of £1.6m and a CIP plan of £8.6m including a carry-over of £300k unachieved on a recurring basis in 12/13.

The opening reserve figure is £8.1m set for expected CCG investments, pass through costs of non-PbR drugs, service developments and risks and opportunities. Any release from reserves will be signed off by the Executive Director of Finance and reported to the FIWC.

Related Trust objectives	**Sub-objectives**
Quality, Innovation, Productivity, Prevention, Reform	1) Improve the experience and satisfaction of patients, carers, partners and staff. 3) Continuously develop and implement our Business Plan. 4) Redesign our workforce so people of the right skills & capabilities are in the right places to deliver our plans. 5) Improve value for money and generate a surplus. 6) Develop our estate and technology to improve the quality and value of the services we provide. 7) Improve services & achieve objectives by creating and working within robust strategic commercial partnerships. 8) Develop our relationships with key stakeholders to improve our patient services & collectively deliver a sustainable local health system. 9) Develop our Foundation Trust application in line with the timetable set out in our agreement with the TDA. 10) Develop our organisational culture, processes and capabilities to be a

	thriving FT dedicated to our patients
Risk and Assurance	Delivery of financial, operational performance and strategic objectives, FT application, CQC ratings
Related Assurance Framework entries	5.1 Key Financial Risks; 5.7 failure to achieve plan; 5.11 changes to plan5.15 / 5.44 – CIP schemes ; 6.3 / 6.4 - capital expenditure
Legal implications, regulatory and consultation requirements	None
Action required by the Board: Ratify the updated budgeted plan	
Date	

ISLE OF WIGHT NHS TRUST
FINANCIAL PLAN (BUDGETS) 2013-14

1. The Purpose of this Paper

The purpose of this paper is to update the Board of the final budget position for the Isle of Wight NHS Trust for 13/14. The Board approved the indicative budgets in March recognising that there was still some uncertainty around the final income position with the local Commissioners. The final risk share agreement has been agreed and a contract signed. This paper sets out the budgets based on this final agreement.

2. 2012/13 Financial Performance

The 2012/13 financial plan, approved by the NHS IoW Board on 4th April 2012, set out robust budgetary plans to generate **£500k surplus**. The unaudited outturn is a £509k surplus, which includes a refund of dividend that was not required to be paid in 2012/13. A technical movement for donated income and the impairment of pharmacy stock results in an adjusted retained surplus of **£543k.**

3. Financial Strategy

2013/14 Trust budgets have been set within the context of both the 2013/14 Integrated Business Plan (IBP)and the IoW NHS Trust's Long Term Financial Model.

The financial strategy, in line with the approach set out in the IoW NHS Trust Integrated Business Plan (at Section 5), tackles the service developments identified by the Trust, including:

- Further development of the Hub
- Patient pathway redesign
- Integrated locality teams
- New and innovative business ideas

Budgets have been set within the terms of the Budget Setting Framework agreed by the Finance Investment and Workforce Committee earlier in the year. The budgets reflect the plan submitted to Trust Development Authority in April.

4. Summary Income and Expenditure Budgets

The following tables show the summary Statement of Comprehensive Income.

Table 1 shows the unadjusted deficit of £198k for the year. However for performance management there are adjustments made for impairments and income from donated assets that means the Trust will report a surplus of £1.6m. This is shown in Table 2 and is consistent with the surplus reported in the January IBP and LTFM submissions.

Table 3 presents the Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA). To achieve a financial risk rating of 3 the Trust is required to have an EBITDA of at least 5% of its operating income. The Trust makes an EBITDA of just over £9m which represents 5.76% of its operational income.

Table 1: Retained Surplus Before Adjustments

Statement of Comprehensive Income	2012/13 Full Year FOT £000s	2013/14 Full Year £000s	2014/15 Full Year £000s
Gross Employee Benefits	(117,562)	**(108,734)**	(104,985)
Other Operating Costs	(50,747)	**(48,150)**	(43,838)
Revenue from Patient Care Activities	159,729	**150,901**	148,804
Other Operating Revenue	9,094	**5,822**	5,540
OPERATING SURPLUS/(DEFICIT)	**514**	**(161)**	**5,521**
Investment Revenue	19	**0**	
Other Gains and Losses	(1)	**0**	
Finance Costs (including interest on PFIs and Finance Leases)	(23)	**(37)**	(30)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	**509**	**(198)**	**5,491**
Dividends Payable on Public Dividend Capital (PDC)	0	**0**	(3,436)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR PER THE ACCOUNTS	**509**	**(198)**	**2,055**

Table 2: Reported Financial Position after Adjustments

Reported NHS Financial Performance	2012/13 Full Year FOT £000s	2013/14 Full Year £000s	2014/15 Full Year £000s
Retained surplus/(deficit) for the year	509	**(198)**	2,055
Impairments excluding IFRIC12 impairments		**2,000**	2,100
Impairments - Excluding IFRIC12 impairments recorded above	112		
donation/grant receipts and depreciation of donated/grant funded assets)	(78)	**(204)**	(205)
Adjusted Financial Performance Retained Surplus/(Deficit)	**543**	**1,598**	**3,950**

Table 3; Earnings Before Interest, Tax Depreciation and Amortisation

Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA)	2012/13 Full Year FOT £000s	2013/14 Full Year £000s	2014/15 Full Year £000s
Retained Surplus / (Deficit) for the Year	509	**(198)**	2,055
Depreciation	0	**6,564**	6,600
Amortisation	0	**996**	1,000
Impairments (including IFRIC 12 impairments)	112	**2,000**	2,100
Interest Receivable	(19)	**(24)**	(30)
Finance Costs (including interest on PFIs and Finance Leases)	24	**37**	30
Dividends	0	**0**	3,436
Donated/Government grant assets adjustment (donation income element of SC 380)	(78)	**(350)**	(345)
EBITDA	**548**	**9,025**	**14,846**

The following summary table shows the opening position by Directorate after the full allocation of CIPs based on the current templates. Where the CIP is cross-organisational a proportional allocation has been made. This may change as further detail on the schemes is developed.

Directorate	Income	Pay	Non-Pay	CIP	Total
Acute	(3,793)	33,822	9,531	(2,167)	37,393
Planned	(2,738)	31,757	4,260	(2,075)	31,204
Community Health	(2,123)	31,035	6,888	(1,963)	33,837
Corporate Services	(2,098)	14,863	21,905	(830)	33,840
Reserves	0		8,100		8,100
Income	(145,971)				(145,971)
Net Surplus	**(156,723)**	**111,477**	**50,684**	**(7,035)**	**(1,598)**
CIPs already included in opening budgets above				(1,535)	
Total CIP for 13/14				**(8,570)**	

The movement from £8.3m identified in the IBP and the £8.6m required for the budget represents the unachieved element from last year.

5. Savings Plans

The total savings plan is currently £8.6m as explained above. In addition, Directorates have an annual 'vacancy factor' target, currently **£2.6m**, to reflect the level of slippage historically achieved on appointing to vacancies. The £2.6m has been allocated to directorates based on total revised pay budgets for 2013/14, prior to CIP allocation.

The table below summarises the main schemes over £100k by each Directorate for 2013/14:

CIP programme over £100k	Directorate		£ '000s
Pharmacy - Ex-tariff	Acute	Non Pay	163
Pharmacy Outpatient prescribing	Acute	Non Pay	200
Pathology (incl. Consortium)	Acute	Pay	144
Productives - reductions relating to Lean	Community	Non pay	162
Medical Staffing Efficiencies	All Directorates	Pay	516
Directorate Wide Transport Review	Community	Non Pay	105
Estates	Corporate	Non Pay	285
Review of Corporate Resources	Corporate	Pay	128
Vacancy non replacement	Corporate	Pay	350
Procurement-Consumables-Inv Mgmt	Cross Organisational	Non Pay	480
Market Testing	Cross Organisational	Pay	150
Increased efficiency of Staff Management	Cross Organisational	Pay	1,786
Redesign of Directorate Mgt Structures	Cross Organisational	Pay	133
Reduce Locum / Doctor Bank	Cross Organisational	Pay	400
Patient Pathway Review	Planned	Pay & Non-Pay	262
St Helens - 5 day working model	Planned	Pay	109
Theatres efficiency	Planned	Pay	156
Brought Forward CIP 12/13	Cross Organisational	Pay & Non-Pay	300
Budget Holder LEAN Initiatives	All Directorates	Pay & Non-Pay	740
Schemes <£100k			1,991
CIP Total			8,560

Inflation, cost pressures and service development costs have been identified in the budget setting process. These are summarised below:

Cost Pressures - Cross organisational	£
Incremental Drift	1,015,120
1% pay award	1,126,389
Total	**2,141,509**

A summary of cost pressures included within budgets is as follows:

Item	Directorate	£'000s
Theatres	Planned	113
Realignment of pay budgets for medical staff in post	Planned	104
Opthalmology	Planned	112
Mau Medical staff revised job plans	Acute	124
Critical Care Outreach funding gap	Acute	160
General Medicine Drugs	Acute	175
Acute Consumables	Acute	118
Pharmacy Contracts	Acute	109
GP led Health Centre OOH	Acute	506
Pay Protection	Community	100
CNST Premiums	Corporate	328
Total Funded Cost Pressures Over £100k		**1,949**

Cost Pressures associated with service developments which are expected to be offset against income are listed below:

Service Developments	Directorate	£'000s
SPARRC's - Pay	COMMUNITY	451,349
Home Oxygen	ACUTE	232,457
Shackleton	COMMUNITY	192,276
Shackleton - Non-pay	COMMUNITY	30,000
Woodlands - confirmation of continue of pilot required	COMMUNITY	80,241
OHPiT	ACUTE	78,802
Total		**1,065,125**

7. Reserves

The table below sets out the starting reserve position for the Trust. All reserve releases will be authorised by the Executive Director of Finance.

Reserves	£'000
Pass Through Costs - PbR	4,402
Investments	2,490
Risks & Opportunities	1,208
Total Reserves	**8,100**

8. Summary

The Board approved the indicative budget in March and this paper updates the overall opening financial budgeted position set for the year and reported to the Trust Development Authority and signed off by the Executive Director of Finance.

The Board are asked to NOTE the updated opening budgets for the 13/14 financial year.

Chris Palmer
Executive Director of Finance
28th May 2013

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD ON 29th MAY 2013

Title	Isle of Wight NHS Trust Board Performance Report 2013/14
Sponsoring Director	Executive Medical Director
Author	Iain Hendey (Assistant Director of Performance Information and Decision Support)
Purpose	To update the Trust Board on progress against key performance measures and highlight risks and the management of these risks.

Previously considered by (state date):	
Acute Clinical Directorate Board	
Audit and Corporate Risk Committee	
Charitable Funds Committee	
Community Health Directorate Board	
Executive Board	
Finance, Investment & Workforce Committee	22/05/2013
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Planned Directorate Board	
Quality & Clinical Performance Committee	
Remuneration Committee	

Staff, stakeholder, patient and public engagement:

Executive Summary:

This paper sets out the key performance indicators by which the Trust is measuring its performance in 2013/14. A more detailed executive summary of this report is set out on page 2.

Related Trust objectives	**Sub-objectives**
Quality, Innovation, Productivity, Prevention, Reform.	1) Improve the experience and satisfaction of patients, carers, partners and staff. 2) Continuously develop and implement our Business Plan. 3) Redesign our workforce so people of the right skills & capabilities are in the right places to deliver our plans. 4) Improve value for money and generate a surplus. 5) Develop our estate and technology to improve the quality and value of the services we provide. 6) Improve services & achieve objectives by creating and working within robust strategic commercial partnerships. 7) Develop our relationships with key stakeholders to improve our patient services & collectively deliver a sustainable local health system. 8) Develop our Foundation Trust application in line with the timetable set out in our agreement with the SHA.

	9) Develop our organizational culture, processes and capabilities to be a thriving FT dedicated to our patients.
Risk and Assurance	Delivery of financial, operational performance and strategic objectives, FT application, CQC ratings
Related Assurance Framework entries	2.21 - HCAI ; 1.1 - complaints trends ; 2.22 - Mixed sex accommodation ; 3.8 - key national targets ; 5.15 / 5.44 - CIP schemes ; 6.3 / 6.4 - capital expenditure
Legal implications, regulatory and consultation requirements	None
Action required by the Board: The Trust Board is asked to receive the Performance Report and the exception reports provided for indicators that are either 'red' in month, or at risk year to date	
Date	22/05/13

Isle of Wight NHS Trust Board Performance Report 2013/14

April 13

Isle of Wight NHS Trust

Title	**Isle of Wight NHS Trust Board Performance Report 2013/14**
Sponsoring Director	Chris Palmer (Executive Director of Finance) Tel: 534462 email: Chris.Palmer@iow.nhs.uk
Author(s)	Iain Hendey (Assistant Director of Performance Information and Decision Support) Tel: 822099 ext 5352 email: Iain.Hendey@iow.nhs.uk
Purpose	To update the Trust Board on progress against key performance measures and highlight risks and the management of these risks.

Previously considered by (state date):	
Acute Clinical Directorate Board	N/A
Audit and Corporate Risk Committee	N/A
Charitable Funds Committee	N/A
Community Health Directorate Board	N/A
Executive Board	N/A
Foundation Trust Programme Board	N/A
Finance, Investment & Workforce Committee	22/05/2013
Mental Health Act Scrutiny Committee	N/A
Nominations Committee (Shadow)	N/A
Planned Directorate Board	N/A
Quality & Clinical Performance Committee	
Remuneration Committee	N/A

Staff, stakeholder, patient and public engagement

Executive Summary

This paper sets out the key performance indicators by which the Trust is measuring its performance in 2013/14. A more detailed executive summary of this report is set out on page 2.

Related Trust Objectives	**Sub-objectives**
Quality, Innovation, Productivity, Prevention, Reform.	1) To achieve the highest possible quality standards for our patients in terms of outcome, safety and experience. 2) To deliver the Trust's clinical strategy, integrating service delivery within our organisation and with our partners, and providing services locally wherever clinically appropriate and cost effective. 3) To build the resilience of our services and organisation, through partnership within the NHS, with social care and with the private sector. 4) To improve the productivity and efficiency of the Trust, building greater financial sustainability. 5) To develop our people, culture and workforce competencies to implement our vision and clinical strategy.
Risk and Assurance	Delivery of financial, operational performance and strategic objectives, FT application, CQC ratings
Related Framework Entries	2.21 - HCAI ; 1.1 - complaints trends ; 2.22 - Mixed sex accommodation ; 3.8 - key national targets ; 5.15 / 5.44 - CIP schemes ; 6.3 / 6.4 - capital expenditure
Legal implications, regulatory and consultation	None

Action required by board:

The Trust Board is asked to receive the Performance Report and the exception reports provided for indicators that are either 'red' in month, or at risk year to date

Date	Wednesday 29th May 2013

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Executive Summary

Patient Safety, Quality & Experience:

Overall performance against our key safety and quality indicators is good. Focus areas include:

Pressure ulcers, hospital acquired pressure ulcers for April (12) are lower than previous year. Grade 3 (1) pressure ulcers are below the 50% stipulated by the performance indicator, but there is still some work required on grades 2 (9) and 4 (2) pressure ulcers to bring them in line with the desired trajectory.

Healthcare Acquired infections remain a focus area. We ended 2012/13 above our trajectory for MRSA. However no new cases were reported in April for the seventh consecutive month. Also no new cases of C-Diff were reported in April.

The low performance this month in VTE assessment is being reviewed and this target will continue to be monitored through the directorate performance meetings.

The number of complaints for April (22) has exceeded our previous month position of 18 and a range of actions are in place to reduce this during this year.

Workforce:

The total pay bill is above plan for April. The number of FTEs in post is also slightly higher than plan. Agency staff pay is above planned levels. Sickness absence was above plan in April (3.48%). Specific problem areas are identified and challenged at directorate performance review meetings.

A significant proportion of the pay and non-pay variance is due to the prison contract extension and will be offset by additional income received.

Operational Performance:

High Risk TIA fully investigated and treated within 24 hours (87.5%) did not meet our very challenging locally extended target of 95% but has consistently achieved the national target of 60%.

Provisional data for April indicates that the 2 week cancer target for Breast Cancer referrals is below the target in month.

Action plans to improve our data quality performance continue to be developed.

Finance & Efficiency:

Overall we have achieved our financial plans for April and our Monitor Financial Risk Rating remains 3.

Our % debt over 90 days (8%) is above target, however, it has improved from recent levels.

Monthly Performance meetings continue for each directorate with Exec Directors (Medical, Nursing, Finance and HR) to review performance. Separate finance meetings are undertaken to provide a more detailed finance review. Monthly Capital Investment Group meetings held with Facilities, Finance and all directorates.

Theatre Utilisation remains a focus area with overall utilisation for April (80.3%) below the target performance (83.0%) and % cancelled operations (0.88%) showing an upward trend.

General:

A separate benchmark report on Emergency Care performance has been added providing a breakdown of the Emergancy Care standard indicator.

Isle of Wight NHS Trust Board Performance Report 2013/14

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Balanced scorecard

Isle of Wight NHS Trust

To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience

Patient Safety, Quality & Experience	Annual Target	Actual Performance		YTD	Month Trend	13/14 Forecast
Summary Hospital-level Mortality Indicator (SHMI)* Oct11-Sept12	N/A	1.0609	Q4	N/A		
Hospital Standardised Mortality Ratio (HSMR) Dec11 - Dec12	TBC	102.80	Q4	N/A		
Patients admitted that develop a grade 4 pressure ulcer	3	2	Apr-13	2	↘	
Patients admitted that develop a grade 2 or 3 pressure ulcer	60	10	Apr-13	10	↗	
Level 1 & 2 CAHMS seen within 18 weeks referral to treatment	>95%	100%	Mar-13	100%	↔	
Number of children 16 or under admitted to an Adult MH Ward	0	0	Apr-13	0	↔	
28 Day readmission rate in MH	9%	15%	Mar-13	13%	↘	
VTE (Assessment for risk of)	>90%	89.21%	Apr-13	89.21%	↘	
MRSA (confirmed MRSA bacteraemia)	1	0	Apr-13	0	↔	
C.Diff (confirmed Clostridium Difficile infection - stretch target)	8	0	Apr-13	0	↔	
Clinical Incidents (Major) resulting in harm	TBC	7	Apr-13	7	↘	
Clinical Incidents (Catastrophic) resulting in harm	TBC	2	Apr-13	2	↘	
Falls - resulting in significant injury	TBC	2	Apr-13	2	↘	
Delivering C-Section	<20%	19.09%	Apr-13	19.09%	↗	
Normal Vaginal Deliveries	>65%	65.45%	Apr-13	65.45%	↗	
Breast Feeding	>75%	78.18%	Apr-13	78.18%	↘	
Formal Complaints	<276	22	Apr-13	22	↘	
Patient Satisfaction (Friends & Family test - aggregated score)	Q3>Q1	64	Apr-13	64	new	
Mixed Sex Accomodation	0	0	Apr-13	0	↔	

To develop our people, culture and workforce competencies to implement our vision and clinical strategy

Workforce	In Month	Actual Performance		YTD	Month Trend	13/14 Forecast
Total workforce SIP (FTEs)	2,678.0	2,719.30	Apr-13	N/A	↗	
Total pay costs (inc flexible working) (£000)	£9,254	£9,872	Apr-13	£9,872	↘	£9,254
Variable Hours (FTE)	144	161.80	Apr-13	161.80	↘	144
Variable Hours (£000)	£101	£661	Apr-13	£661	↗	£101
Staff absences	3%	3.48%	Apr-13	3.48%	↗	3%
Staff Turnover	5%	0.72%	Apr-13	0.72%	↗	
Mandatory Training	80%	72%	Apr-13	72%	↗	
Appraisal Monitoring	100%	6.00%	Apr-13	6.00%	↗	
Employee Relations Cases	0	21	Apr-13	104		

To build the resilience of our services and organisation through partnerships within the NHS, with social care and with the private sector

Operational Performance	Annual Target	Actual Performance		YTD	Month Trend	13/14 Forecast
Emergency Care 4 hour Standards	95%	96.59%	Apr-13	96.59%	↗	
Ambulance Category A Calls % < 8 minutes	75%	77.95%	Apr-13	77.95%	↗	
Ambulance Category A Calls % < 19 minutes	95%	97.31%	Apr-13	97.31%	↗	
Stroke patients (90% of stay on Stroke Unit)	80%	88.89%	Apr-13	88.89%	↘	
High risk TIA fully investigated & treated within 24 hours	95%	87.50%	Apr-13	87.50%	↗	
Breast Cancer Referrals Seen <2 weeks*	93%	92.73%	Apr-13	92.73%	↗	
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100%	Apr-13	100%	↔	
Cancer Patients receiving subsequent surgery <31 days*	94%	100%	Apr-13	100%	↔	
Cancer Patients treated after screening referral <62 days*	90%	100%	Apr-13	100%	↔	
Cancer Patients treated after consultant upgrade <62 days*	85%	No Patients	Apr-13	No Patients	↔	
Cancer diagnosis to treatment <31 days*	96%	98.28%	Apr-13	98.28%	↘	
Cancer urgent referral to treatment <62 days*	85%	85.71%	Apr-13	85.71%	↘	
Cancer patients seen <14 days after urgent GP referral*	93%	93.80%	Apr-13	93.80%	↗	
RTT:% of admitted patients who waited 18 weeks or less	90%	91.71%	Mar-13	93.4%	↘	
RTT: % of non-admitted patients who waited 18 weeks or less	95%	96.61%	Mar-13	97.3%	↘	
RTT % of incomplete pathways within 18 weeks	92%	94.46%	Mar-13	95.6%	↗	
No. Patients waiting > 6 weeks for diagnostics	100	7	Apr-13	7	↘	
%. Patients waiting > 6 weeks for diagnostics	1%	0.73%	Apr-13	0.73%	↘	
Elective Activity (Spells) (M12 target - 724)	8683	766	Mar-13	9,142	↘	
Non Elective Activity (Spells) (M12 target - 1,183)	13,199	1,220	Mar-13	13,617	↔	
Outpatient Activity (Attendances) (M12 target - 11,378)	136,390	10,783	Mar-13	142,158	↗	
Data Quality	TBC					

***Cancer figures are provisional for April**

To improve the productivity and efficiency of the trust, building greater financial sustainability

Finance & Efficiency	Annual Target	Actual Performance		YTD	Month Trend	13/14 Forecast
Achievement of financial plan	£1.6m	£189k	Apr-13	£189k	↔	
Underlying performance	£1.6m	£189k	Apr-13	£189k	↔	
Net return after financing	0.50%	1.1%	Apr-13	1.1%	↔	
I&E surplus margin net of dividend	=>1%	1.3%	Apr-13	1.3%	↔	
Liquidity ratio days	=>15	60	Apr-13	60	↔	
Monitor Financial risk rating	3	3	Apr-13	3	↔	
Capital Expenditure as a % of YTD plan	=>75%	0	Apr-13	0	↔	
Quarter end cash balance (days of operating expenses)	=>10%	69	Apr-13	69	↔	
Debtors over 90 days as a % of total debtor balance	=<5%	8.09%	Apr-13	8.09%	↔	
Creditors over 90 days as a % of total creditor balance	=<5%	1.85%	Apr-13	1.85%	↔	
Recurring CIP savings achieved	100%	0	Apr-13	0	↔	
Total CIP savings achieved	100%	0	Apr-13	0	↔	
Contract Penalties	TBC		Apr-13			
Theatre utilisation	83%	80.31%	Apr-13	80.31%	↘	
Cancelled operations on day of / after admission	TBC	0.88%	Apr-13	0.88%	↗	
Average LOS Elective (non-same day)	TBC	3.39	Apr-13	3.39	↘	
Average LOS Non Elective (non-same day)	TBC	8.63	Apr-13	8.63	↘	
Outpatient DNA Rate	TBC	7.84%	Apr-13	7.84%	↘	
Emergency Readmissions <30 days (with exclusions)	TBC	5.69%	Apr-13	5.69%	↘	
Daycase Rate	68%	79.24%	Apr-13	76.53%	↗	
Project Management - Due milestones met	80%	40%	Mar-13	84%	↘	

Highlights

- **No new cases of MRSA (7th consecutive month)**
- **No new cases of C Difficile this month**
- **Stroke Patients 90% of stay on Stroke unit sustained for 10th month**
- **3 cancer targets achieved 100% for 3rd consecutive month**
- **Performing well against the Emergency Care standard**
- **Improving performance of pressure ulcers**
- **Formal complaints within reduced target**

Lowlights

- **Increased level of Clinical incidents resulting in harm**
- **VTE assessment target not achieved**
- **TIA stretch target not achieved (National target exceeded)**
- **Breast cancer referrals seen within 2 weeks not achieved**

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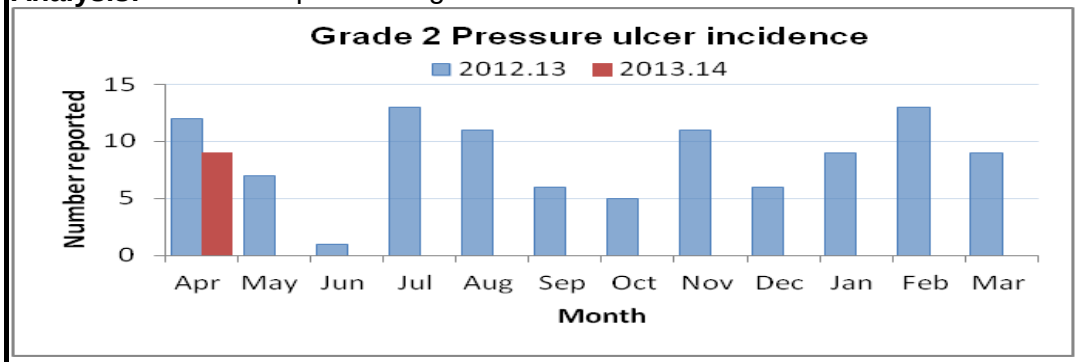
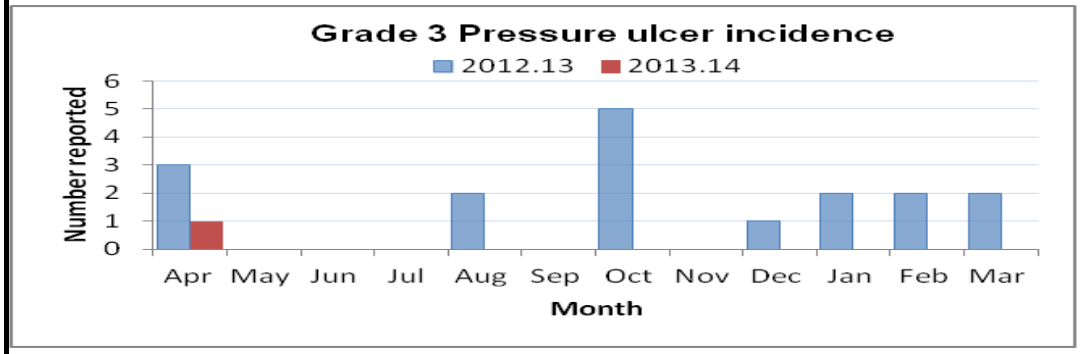
Pressure Ulcers

Isle of Wight NHS Trust

Commentary:	**Analysis:** Hospital setting
Hospital acquired pressure ulcers for April were below baseline for the previous year. Grade 3 pressure ulcers are below the 50% stipulated by the performance indicator, but there is still some work required on grades 2 and 4 pressure ulcers to bring them in line with the desired trajectory. The target for grade 4 pressure ulcers is to reduce incidence to 3 in total across the year in the hospital setting with a 50% reduction on the previous year in the wider community.	 

Action Plan:	**Person Responsible:**	**Date:**	**Status:**
There is ongoing work to ensure trained nurse competency in all patient settings to ensure competency and confidence of all trained nurses at the patient bedsides. This complements the continuing work of the Nutrition and Tissue Viability Service to highlight areas where documentation and care planning can be improved.	Executive Director of Nursing & Workforce	Mar-13	Ongoing

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Formal Complaints

Isle of Wight NHS Trust

Commentary:

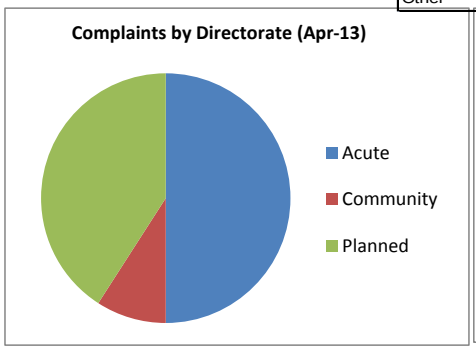
There were 22 formal provider complaints received in April 2013 (18 previous month).

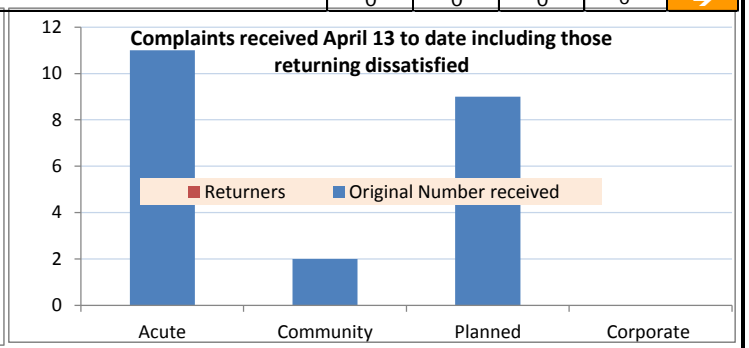
Across all complaints and concerns in April 2013:
Top 2 areas complained about were:
Orthopaedics (8);
General Surgery/Urology (7)

Across all complaints and concerns in April 2013:
Top 3 subjects complained about were:
Out-patient delay/cancellations(32);
Clinical Care (22);
Communication (19)

Analysis: Table showing complaints by primary subject:

Primary Subject	April 2012	March 2013	April 2013	CHANGE	RAG rating
Clinical Care	7	8	12	4	↑
Nursing Care	5	0	2	2	↑
Staff Attitude	4	1	1	0	→
Communication	0	1	2	1	↑
Outpatient Appointment Delay / Cancellation	1	3	5	2	↑
Inpatient Appointment Delay / Cancellation	2	1	0	-1	↓
Admission / Discharge / Transfer Arrangements	0	3	0	-3	↓
Aids and appliances, equipment and premises	0	1	0	-1	↓
Transport	0	0	0	0	→
Consent to treatment	0	0	0	0	→
Failure to follow agreed procedure	0	0	0	0	→
Hotel services (including food)	0	0	0	0	→
Patients status/discrimination (e.g. racial, gender)	0	0	0	0	→
Privacy & Dignity	0	0	0	0	→
Other	0	0	0	0	→





Action Plan:	Person Responsible:	Date:	Status:
The internal management of complaints has been reviewed to ensure that we are working to drive down the number of formal complaints being managed by the Trust, with Clinical Directorates taking greater ownership on the initial reciept of written complaints.	Executive Director of Nursing & Workforce / Quality Manager	Jun-13	Ongoing
As part of the change in how we work, we will be looking at the PEOs supporting and educating staff in dealing and managing the concerns and being more visible in relation to Patient Experience.	Executive Director of Nursing & Workforce / Quality Manager	Jun-13	Ongoing

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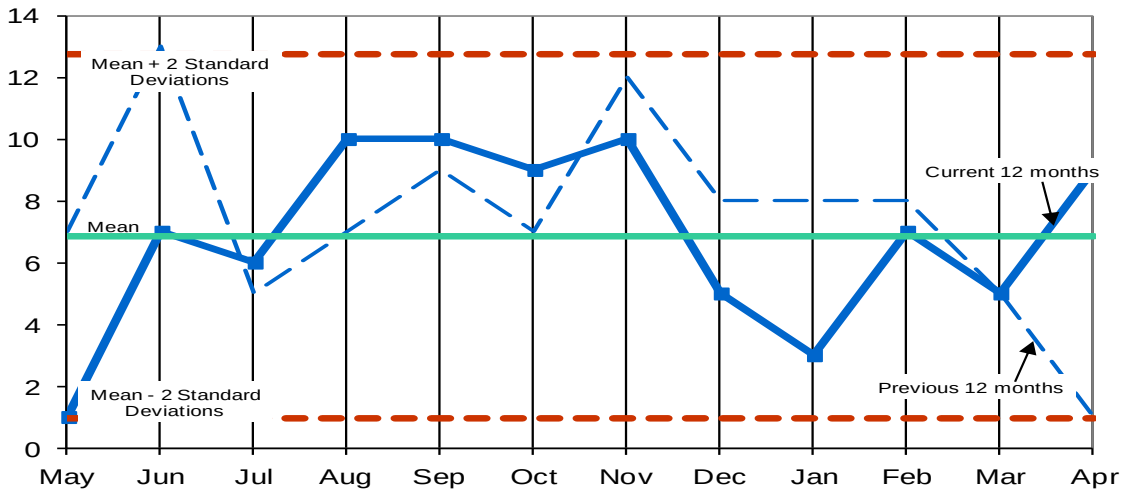
Clinical Incidents

Isle of Wight NHS Trust

Commentary:	**Analysis:** Major or catatstrophic incidents
In April 2013 there were a total of 9 incidents resulting in harm which met the severity criteria of Major or Catastrophic. Major:- 2 x patient fall resulting in fractured neck of femur. 5 x grade 4 pressure injury (includes community) Catastrophic:- 2x unexpected deaths (includes community)	

Action Plan:	**Person Responsible:**	**Date:**	**Status:**
The Quality and Clinical Performance committee has oversight of the Serious Incident Requiring Investigation (SIRI) process and reviews the incidents via clinical directorate reports to the committee.	Executive Director of Nursing & Workforce / Quality Manager	May-13	Ongoing
All incidents are fully investigated in the SIRI process	Executive Director of Nursing & Workforce / Quality Manager	May-13	Ongoing

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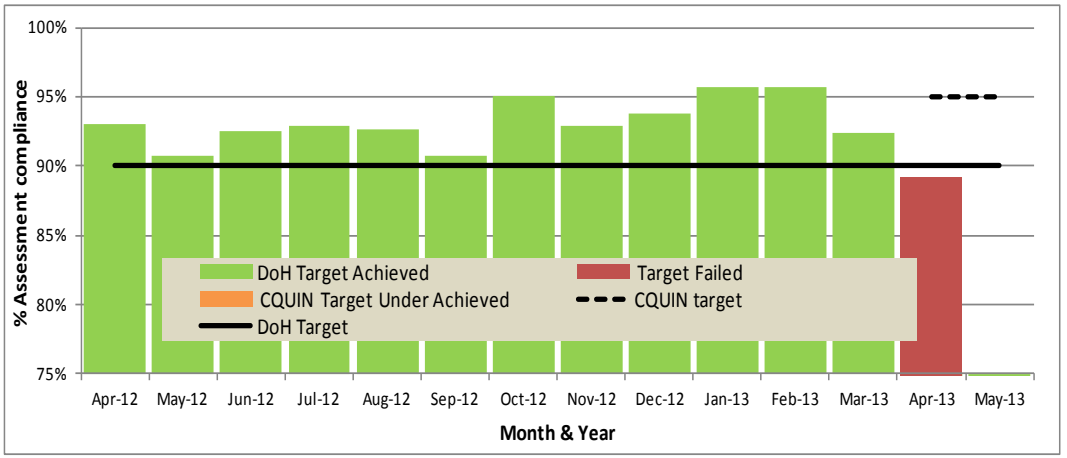
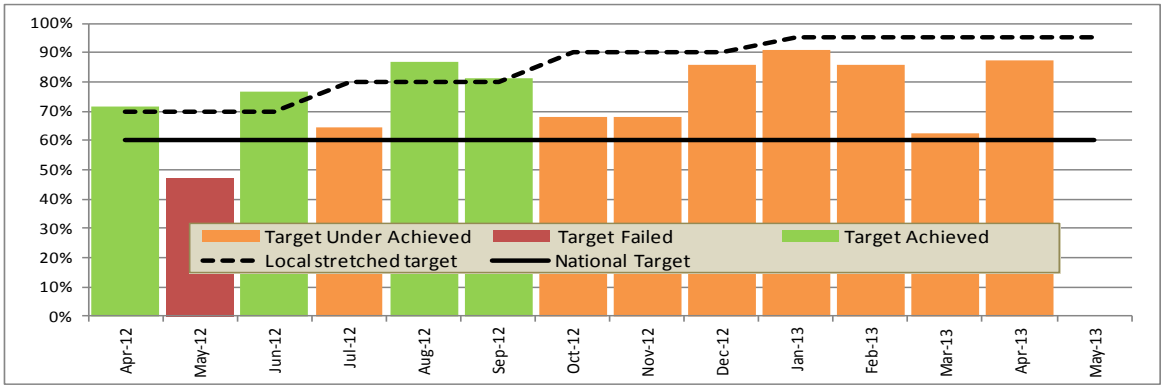
Venous ThromboEmbolism Assessment (VTE)

Isle of Wight NHS Trust

Commentary:	**Analysis:**
In April 2013 the Trust achieved an overall percentage of 89.2%. This now also shows performance against the local CQUIN target, which was set at 95% from April 2012. The low performance this month in VTE assessment is being reviewed and this target will continue to be monitored through the directorate performance meetings.	

Action Plan:	**Person Responsible:**	**Date:**	**Status:**
Review low performance and develop actions to address	Executive Medical Director/ Quality Manager	Apr-13	

Commentary:	**Analysis: TIA April 2013**
Performance continues to fluctuate in both of these key stroke KPIs, with occasional months where the target is not achieved. Actions are underway to ensure sustainable delivery of these targets. **Proportion of people with high-risk TIA fully investigated and treated within 24 hours:** The trust is meeting the National target for this indicator of 60%. The 2 breaches this month were due to 1 patient not being able to be contacted and 1 patient having no transport available.	

Action Plan:	**Person Responsible:**	**Date:**	**Status:**
Patients declining appointments - Requires guidance from National Stroke Network about how to resolve this, as it felt it is unachievable due to patient decline of appointment and small numbers seen on the IOW.	Clinical Lead for Stroke	Ongoing	19.03.2013 National team contacted: These problems are nationwide, hence why National Target was kept at 60%
Frequent deviance from identified TIA pathway which can lead to delay in referral - Action Lead(s) conduct monthly data analysis to monitor compliance with pathway and liaise with medical team as appropriate to improve compliance.	Clinical Lead for Stroke	07/09/2012	17/12/12 Audit ongoing. JJ and PIDs working with Regional Stroke data analyst to look at whole years figures and develop action plan from this 19.03.2013 Data analysed and Action plan in place
Ambulance service to commence direct referrals to TIA Clinic	Clinical Lead for Stroke / Clinical Practice Development Officer (Ambulance)	Feb-13	19.03.2013 Ambulance Audit to commence end of March for 2 months to look at potential impact on service

Commentary:

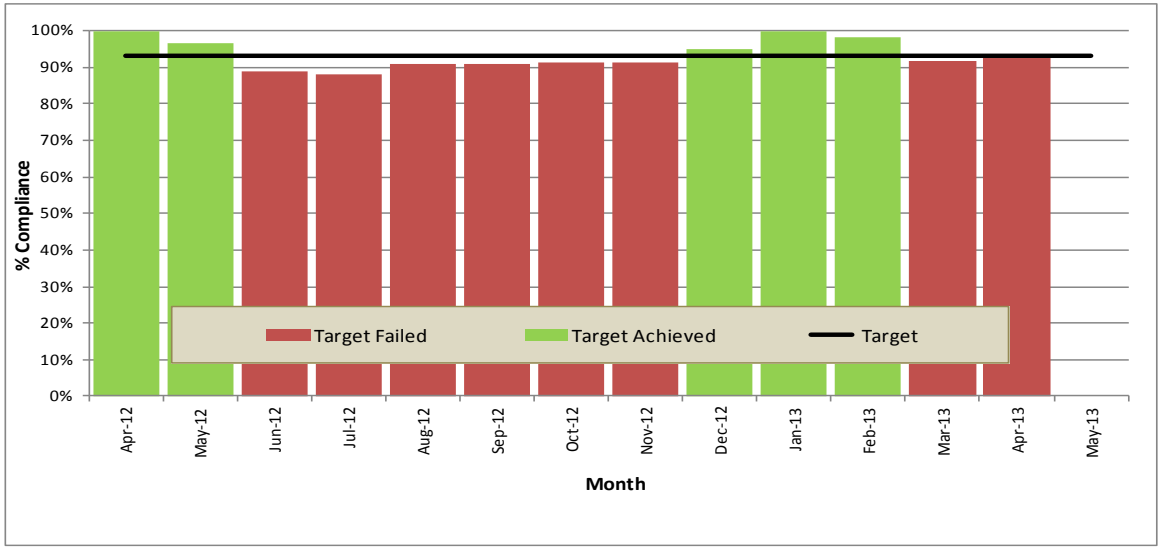
Breast cancer referrals seen within 2 weeks.

The April 2 week wait was not achieved for breast cancer referrals.

Patient unavailability was the root cause for all breaches this month

Cancer Nurse Specialists continue to contact patients who decline appointments within the 2 week time period.

Analysis: Breast cancer referrals seen within 2 weeks.



Action Plan:	Person Responsible:	Date:	Status:
Choice of appointment for patients has been raised as a constraint and work has taken place in May 2013 to ensure that 1st offered appointment is within 1st week after referral. This will improve performance as alternative dates/times can be offered if not suitable.	Lead Cancer Manager Lead Cancer Nurse /OPARU	May-13	in progress

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Data Quality

Isle of Wight NHS Trust

Commentary:

The information centre carry out an analysis of the quality of provider data submitted to SUS. They review 3 main data sets - Admitted Patient Care, Outpatients and A&E.

Based on this analysis there are a number of areas within each data set where we show as having invalid records in excess of the national average. One area of particular concern is the high proportion of records with an invalid Ethnic category in the OP & A&E datasets as this is the focus of a national target. However this appears to have been due to a technical issue with mapping the correct field in the CDS. This has now been resolved and will continue to steadily improve through the year.

Analysis:

Total APC General Episodes: 30,807

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	525	98.3%	99.1%
Patient Pathway	7,397	16.8%	56.1%
Treatment Function	0	100.0%	99.8%
Main Specialty	0	100.0%	100.0%
Reg GP Practice	3	100.0%	99.9%
Postcode	6	100.0%	99.9%
PCT of Residence	3,774	87.7%	98.0%
Commissioner	50	99.8%	99.7%
Primary Diagnosis	1,713	94.4%	98.8%
Primary Procedure	0	100.0%	99.9%
Ethnic Category	0	100.0%	98.3%
Neonatal Level of Care	0	100.0%	98.9%
Site of Treatment	0	100.0%	96.4%
HRG4	1,717	94.4%	98.5%

Total Outpatient General Episodes: 138,050

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	1,107	99.2%	99.3%
Patient Pathway	130,862	7.5%	45.5%
Treatment Function	0	100.0%	99.8%
Main Specialty	0	100.0%	99.8%
Reg GP Practice	3	100.0%	99.9%
Postcode	9	100.0%	99.9%
PCT of Residence	6,687	95.2%	98.5%
Commissioner	36	100.0%	99.8%
First Attendance	0	100.0%	99.8%
Attendance Indicator	2	100.0%	99.7%
Referral Source	1,489	98.9%	98.9%
Referral Rec'd Date	1,489	98.9%	95.7%
Attendance Outcome	62	100.0%	99.0%
Priority Type	1,489	98.9%	97.4%
OP Primary Procedure	0	100.0%	99.5%
Ethnic Category	37,485	75.6%	92.2%
Site of Treatment	1	100.0%	98.0%
HRG4	9	100.0%	99.3%

Total A&E Attendances 47,183

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	1,009	97.9%	95.1%
Registered GP Practice	18	100.0%	99.7%
Postcode	8	100.0%	99.8%
PCT of Residence	71	99.8%	98.6%
Commissioner	341	99.3%	99.5%
Attendance Disposal	5,038	89.3%	99.2%
Patient Group	1	100.0%	95.1%
First Investigation	662	98.6%	95.2%
First Treatment	2,465	94.8%	93.2%
Conclusion Time	452	99.0%	98.7%
Ethnic Category	13,024	72.4%	88.1%
Departure Time	355	99.2%	99.8%
Department Type	0	100.0%	98.8%
HRG4	852	98.2%	96.7%

Key:

- % valid is equal to or greater than the national rate
- % valid is up to 0.5% below the national rate
- % valid is more than 0.5% below the national rate

Action Plan:	Person Responsible:	Date:	Status:
Undertake a detailed review of the information provided by the IC and compare with our local data sources. Identify and implement 'quick wins' Develop a detailed action plan to improve quality of data submitted to SUS.	Head of Information / Asst. Director - PIDS	Jun-13	Ongoing

Data Quality - April - March 2013

Dataset	Measure	IW Performance	National	Threshold G	Threshold A	Threshold R	Status	Weighting	Score	Notes
APC	Total Valid Data Items	5	n/a	=<2	>2 =<4	>4	R	2	2.0	Performance relates to the no. of Red rated data
APC	Valid NHS Number	98.3%	99.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	R	1	1.0	
APC	Valid Ethnic Category	100.0%	98.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Valid Data Items	3	n/a	=<2	>2 =<5	>5	A	2	1.0	Performance relates to the no. of Red rated data
OP	Valid NHS Number	99.2%	99.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	A	1	0.5	
OP	Valid Ethnic Category	75.6%	92.2%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	R	1	1.0	
A&E	Total Valid Data Items	3	n/a	=<2	>2 =<4	>4	A	2	1.0	Performance relates to the no. of Red rated data
A&E	Valid NHS Number	97.9%	95.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Valid Ethnic Category	72.4%	88.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	R	1	1.0	
			Total	= < 2	2 > = < 4	= > 4	R	12	7.5	

Source: Information Centre, SUS Data Quality Dashboard

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Workforce - Key Performance Indicators

Isle of Wight NHS Trust

Measure	Period	Month Target/Plan	Month Actual	In Month Variance	RAG rating	In Month Final RAG Rating	Trend from last month
Workforce FTE	Apr-13	2678	2719	41	⊗		⇧
Workforce Variable FTE	Apr-13	144	162	18	⊗		⇩
Workforce Total FTE	Apr-13	2822	2881	59	⊗	⊗	⇧

Finance	Period	Month Target/Plan	Month Actual	In Month Variance	RAG rating	Year-to Date Final RAG Rating	
Total In Month Staff In Post Paybill	Apr-13	£9,153	£9,211	£58	⊗		⇩
In Month Variable Hours	Apr-13	£101	£661	£560	⊗		⇩
In Month Total Paybill	Apr-13	£9,254	£9,872	£618	⊗		⇩
Year-to Date Paybill	Apr-13	£9,254	£9,872	£618	⊗	⊗	

Sickness Absence	Period	Month Target/Plan	Month Actual		RAG Rating		
In Month Absence Rate	Apr-13	3%	3.48%		!		

Key	
✓	Green - On Target
!	Amber - Mitigating/corrective action believed to be achievable
⊗	Red - Significant challenge to delivery of target

Action:
All data is monitored with the Finance team, weekly, fortnightly and monthly. Extraordinary meetings are held with Clinical Directorates to discuss variances and courses of action. The HR Directorate is closely monitoring and supporting clinical directorates with their workforce plans, in particular their control over their spend of variable hours. This will form the basis of the summary workforce actions and plans for this month to enhance progress and monitoring individual schemes. Significant action has been taken by directorates to reduce hours spend.

Data Source:
FTE data, and Absence data, all taken directly from ESR,
Financial Data, provided by Finance

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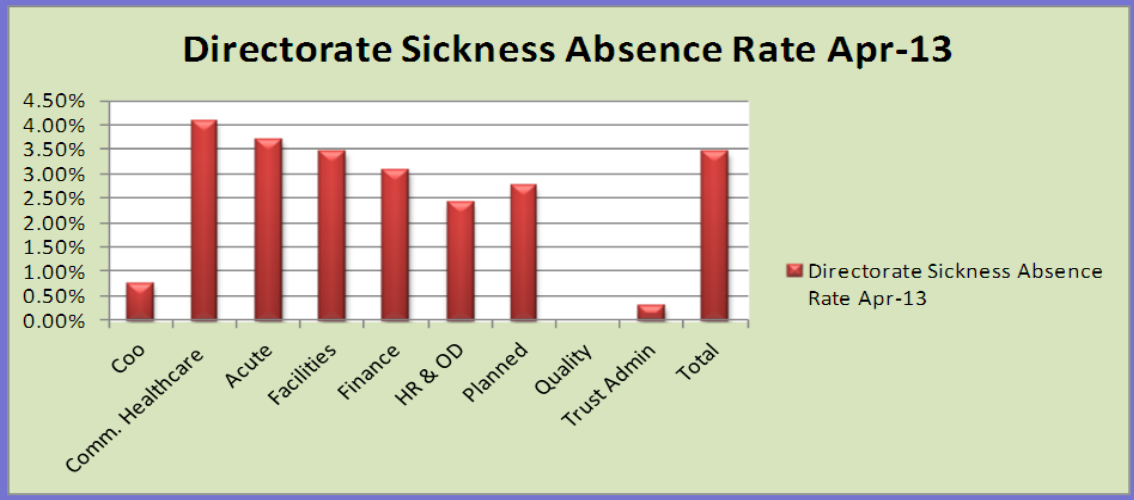
Sickness Absence - Monthly Sickness Absence by Directorate

Commentary:

Detailed Analysis of all long term sickness absence is sent to Occupational Health, Health & Safety and Back Care. Associate Directors, Quality and Finance are also informed.

Actions are followed up at Performance Review and Directorate Meetings.

The Bradford Score is now being used as an additional tool to assist with managing short term absence.



Action	Person Responsible	Date	Directorate monitoring
Actively promoting the Bradford Score System, focussing on areas with high absence rates, to encourage a timely return to work. Any issues referred to Occupational Health Department for review. Occupational Health are trying to reduce referral times.	Departmental Managers	Ongoing	All
HR are working closely with Planned to ensure Mandatory refresher training on sickness is carried out, alongside a two week focus on holding absence review meetings – (triggered from 3 episodes in 3 months sickness absence) and a RTW audit for compliance by matrons / general managers.	Departmental Managers/HR	Ongoing	Planned

Data Source: ESR/PID dashboard/Allocate E-Rostering System

Isle of Wight NHS Trust Board Performance Report 2013/14

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Key Performance Indicators - April

Performance Area	Commentary	RAG Rating In Month	RAG Rating YTD	RAG Rating Full Year Forecast
Financial Risk Rating	• Overall Rating of 3 after normalisation adjustments.	Green	Green	Green
Summary	• Month 1 Income & Expenditure position is on plan at a surplus of £189k	Green	Green	Green
Cost Improvement Programme (CIP)	• Month - Achievement of CIPs yet to be fully validated against milestones	Amber	Amber	Green
Working Capital & Treasury	• Cash 'in-hand' and 'at-bank' at Month 1 was £9,638k	Green	Green	Green
Capital	• Capital spend projected to be £7.56m. No YTD spend to report	Green	Green	Green

Isle of Wight NHS Trust Board Performance Report 2013/14

Isle of Wight NHS Trust

April 13

Income & Expenditure - Key Highlights

(in £'000)	Month			YTD			Full Year		
	Budget	Actual	Actual v Budget (+ over / - under)	Budget	Actual	Actual v Budget (+ over / - under)	Budget	Forecast	Forecast v Budget (+ over / - under)
I&E by subjective:									
Income									
Income - Patient Care Revenue	11,759	12,097	338	11,759	12,097	338	145,971	145,971	-
Acute	307	991	684	307	991	684	3,793	3,793	-
Community Health	200	299	99	200	299	99	2,123	2,123	-
Planned	207	298	91	207	298	91	2,738	2,738	-
Corporate	202	495	293	202	495	293	2,449	2,449	-
Reserves	-	-	-	-	-	-	-		
Total Income	12,674	14,180	1,506	12,674	14,180	1,506	157,074	157,074	-
Pay									
Acute	2,797	3,070	273	2,797	3,070	273	33,822	33,822	-
Community Health	2,656	2,740	83	2,656	2,740	83	31,757	31,757	-
Planned	2,569	2,631	62	2,569	2,631	62	31,035	31,035	-
Corporate	1,231	1,431	200	1,231	1,431	200	14,863	14,863	-
Reserves	-	-	-	-	-	-	-	-	-
Total Pay	9,254	9,872	618	9,254	9,872	618	111,477	111,477	-
Non-Pay									
Acute	768	1,175	406	768	1,175	406	9,531	9,531	-
Planned	355	410	55	355	410	55	4,260	4,260	-
Community	602	669	67	602	669	67	6,888	6,888	-
Corporate	1,857	1,865	7	1,857	1,865	7	22,254	22,254	-
Reserves	-	-	-	-	-	-	8,100	8,100	-
Total Non-Pay	3,583	4,118	536	3,583	4,118	536	51,032	51,032	-
CIP's (unallocated)	(352)	-	352	(352)	-	352	(7,035)	(7,035)	-
Net Surplus / (Loss)	**189**	**189**	**0**	**189**	**189**	**0**	**1,600**	**1,600**	**0**

Overall Position:

Month 1 position is £189k surplus as per plan.
Income - Income in the month is £1,506k above plan. Patient care income is higher due to NCA income. Acute over performance of £684k is due to the prison contract extension income and Beacon Dermatology contract income and drug cost recharge. EMH income is the positive variance in Corporate.
Pay – In month total pay is overspent by £618k with a £273k overspend in Acute due to prison contract extension and beacon dermatology costs. Overspend of £200k in Corporate is mainly the EMH pay costs.

Non Pay – In month the non pay is above plan by £536k. Acute spend above plan of £406k is due to the prison contract extension and drug costs incurred.

CIP – As at month 1, £7,035k remain to be specifically allocated to directorate as some major projects are cross-directorate. From month 2 these will have been allocated. £1.3m has been included in Directorate budgets.

Reserve - £8,100k reserve identified for cost pressures, service developments, CQUIN and Non pbr drugs.

Isle of Wight NHS Trust Board Performance Report 2013/14

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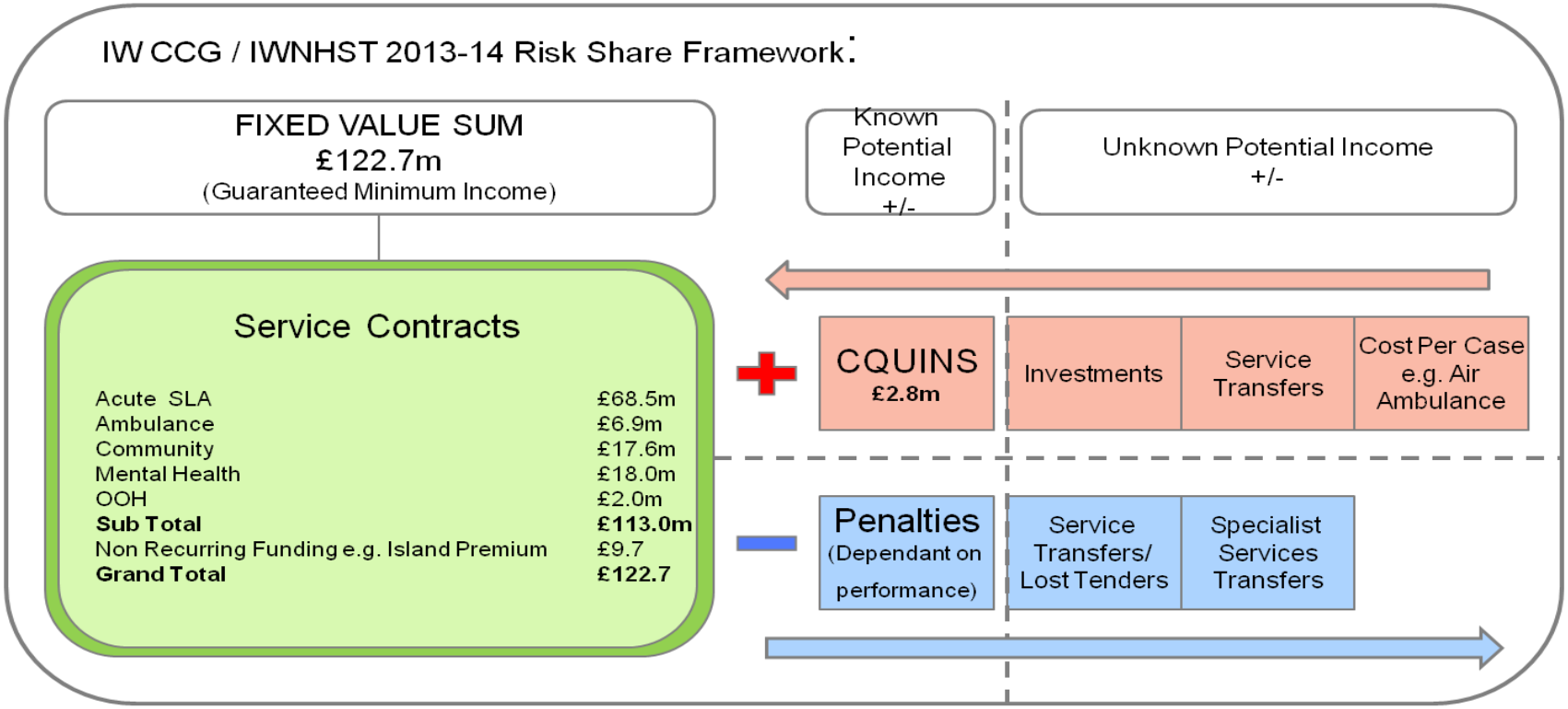
Capital Programme - Capital Schemes

Isle of Wight NHS Trust

Capital Scheme	YTD Spend £'000	F'cast to Year End £'000	Full Year Cost £'000
Carried forward from 12.13			
2012 / 13 Backlog Maintenance/ Chillers		302,371	302,371
Onsite Helipad		37,270	37,270
Replacement of 2 Main Hospital Passenger Lifts		296,300	296,300
Old HSDU Refurb (Phase 1)		81,547	81,547
Shackleton Newchurch Move		66,028	66,028
Improving Birthing Environment		41,164	41,164
Pit Alarms - Personal Alarm System - Sevenacres		29,548	29,548
Cashiers Drop Safe Location		6,740	6,740
Community Health System		80,878	80,878
Modernisation of Pathology		85,737	85,737
Emergency Dept Redevelopment		9,569	9,569
Approved Schemes for 13.14			
Pathology Phase 2		856,966	856,966
MAU Extension Fees		25,000	25,000
Ophthalmology/Endoscopy Fees		50,000	50,000
ISIS Extension of Change Management Costs		14,500	14,500
Schemes not yet approved but in the Plan for 13.14			
Ophthalmology/Endoscopy		1,250,000	1,250,000
MAU Extension		1,075,000	1,075,000
Maternity Upgrade		600,000	600,000
Dementia Wing		600,000	600,000
Community Health Hub		300,000	300,000
Stroke & Rehab Ward Reconfiguration (Nth Wing)		300,000	300,000
Backlog high/medium risk &fire safety (reduced by b/f balance)		297,629	297,629
Information Technology (reduced by ISIS & Community b/f balance)		404,622	404,622
Rolling Replacement Programme – Equipment / Ambulances		500,000	500,000
Infrastructure (e.g. underground services)		300,000	300,000
Staff Capitalisation		100,000	100,000
Contingency		0	0
Current Overspend if all Schemes move forward as planned		-150,868	-150,868
Gross Outline Capital Plan	**0**	**7,560,000**	**7,560,000**

Commentary:
No ytd spend reported due to ledger transfer
Demand against RRP £3m with just £500k budget



Other Income:

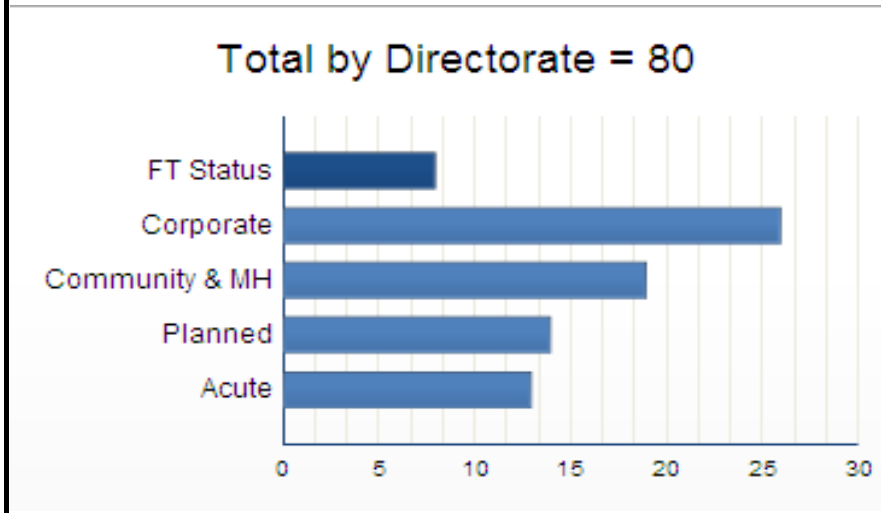
- NHS England – £11.6m *(including Specialised Services / Dental & Prisoners)*
- Local Authority - £1.7m *(including GUM / Screening)*
- New Investments - £3m
- Other - £15.2m *(including NCAs / Private Patients / Support Services to CCG / Other commercial)*

TOTAL INCOME = £157m

- 5,035 Elective Day case Spells
- 3,129 Elective Inpatient Spells
- 13,754 Non Elective Spells
- 31,488 New Outpatient Attendances
- 72,533 Follow Up Outpatient Attendances
- 20,431 Outpatient Procedures
- 39,060 A&E Attendances

* Note figures do not include activity now commissioned by NHS England outside of the RSFA.

Analysis:



	Risk Title	Directorate	Type	Rating
1	REPROVISION OF SHACKLETON HOUSE DEMENTIA UNIT (BAF 6.10	COMMH	QCE	25
2	ENDOSCOPY NEW BUILD (BAF 6.10)	PLANND	QCE	25
3	RISK DUE TO BED CAPACITY PROBLEMS (BAF 2.22 & 6.12)	ACUTE	PATSAF	20
4	BLOOD SCIENCES OUT-OF-HOURS STAFFING (BAF 4.4)	ACUTE	QCE	20
5	RISK OF NOT ACHIEVING THE A&E 4 HOUR TARGET (BAF 3.8)	ACUTE	QCE	20
6	VACANT CONSULTANT PHYSICIAN POSTS (BAF: 10.73)	ACUTE	QCE	20
7	INCREASED DEMAND ON ORTHOTICS (BAF: 8.2)	COMMH	GOVCOM	20
8	IMPLEMENTATION OF PRODUCTIVE COMMUNITY SERVICES (BAF :	COMMH	GOVCOM	20
9	FAILING PIT SYSTEM (BAF 6.4)	COMMH	PATSAF	20
10	LOW STAFFING LEVELS WITHIN OCCUPATIONAL THERAPY ACUTE T	COMMH	PATSAF	20
11	END OF CURRENT PACS CONTRACT 2013 (BAF 6.10)	ACUTE	GOVCOM	20
12	MANDATORY TRAINING (BAF 10.13)	CORPRI	GOVCOM	20
13	TRACK AND TRACE OF RE-USABLE MEDICAL DEVICES TO PATIENT I	PLANND	QCE	20
14	FIRE COMPARTMENTS - CAUSE AND EFFECT OF FIRE ALARM SYSTE	CORPRI	GOVCOM	20
15	ORGANISATIONAL FINANCIAL RISK (BAF: 5.26 & 9.67)	CORPRI	GOVCOM	20
16	SEGREGATION, CONSIGNING AND COLLECTION OF CLINICAL WAS	CORPRI	GOVCOM	20
17	SUBSTANTIAL FIRE RISK TO BUILDING 02 (Old Social Club) (BAF 6.:	CORPRI	GOVCOM	20
18	PRESSURE ULCERS (BAF 2.22)	CORPRI	PATEXP	20
19	INFECTION CONTROL RISK DUE TO UNEXPECTED SHORTAGE OF DI	CORPRI	PATSAF	20
20	OPHTHALMOLOGY DEPARTMENT (BAF 6.10)	PLANND	PATEXP	20

Data as at 17/5/2013 Risk Register Dashboard

Commentary

The risk register is reviewed monthly both at Executive Board/Directorate Boards and relevant Trust Board sub-committee meetings. The Risk Register dashboard is now live and Execs/Associate Directors/Senior Managers all have access.
All risks on the register have agreed action plans with responsibilities and timescales allocated.

Take up of mandatory training remains under close scrutiny at performance review meetings and this is helping to improve compliance levels.

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Finance Risk Rating

Isle of Wight NHS Trust

Month 1 - FINANCIAL RISK RATING

Isle of Wight NHS Trust

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position: Year to Date	Normalised Position: Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	3	3	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**3.2**	**3.2**	**3.2**	**3.2**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

GOVERNANCE RISK RATINGS

Isle of Wight NHS Trust

See 'Notes' for further detail of each of the below indicators

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-13	Board Actions
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	yes	Yes	Yes			Yes	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: (may be introduced later)	Patient identifier information	50%									
			Patients dying at home / care home	50%									
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/A	N/A	Yes	N/A			N/A	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	Yes	Yes	Yes	Yes			Yes	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes			Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes			Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes			Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	yes	Yes	Yes			Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	No	No	yes	Yes			Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes			Yes	
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	no	yes	Yes	Yes			Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	No	No	No	No			No	Quality and Clinical Performance Ctte to closely monitor delivery of cancer action plans
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	no	No	No	Yes			Yes	Quality and Clinical Performance Ctte to monitor delivery of improvement activity
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	no	yes	Yes	Yes			Yes	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	Yes	Yes	Yes	Yes			Yes	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	yes	Yes	Yes	Yes			Yes	

GOVERNANCE RISK RATINGS

Isle of Wight NHS Trust

See 'Notes' for further detail of each of the below indicators

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-13	Board Actions
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	No	yes	Yes	Yes			Yes	
	3j	Category A call – emergency response within 8 minutes	Red 1	80%	0.5	no	yes	Yes	Yes			Yes	
			Red 2	75%		Yes	Yes	Yes	Yes			Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	Yes	Yes	Yes	Yes			Yes	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	12	1.0	Yes	Yes	no	Yes			Yes	Progress against control action plans to be reported to Quality and Clinical Performance Ctte
			Is the Trust below the YTD ceiling	12		No	No	No	Yes			Yes	
	4b	MRSA	Is the Trust below the de minimus	6	1.0	Yes	Yes	Yes	Yes			Yes	Progress against control action plans to be reported to Quality and Clinical Performance Ctte
			Is the Trust below the YTD ceiling	1		no	No	No	Yes			Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0%	2.0	No	No	No	No			No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0%	4.0	No	No	No	No			No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0%	2.0	No	No	No	No			No	
				TOTAL		**6.5**	**2.5**	**2.5**	**0.5**	**0.0**	**0.0**	**0.5**	
						R	AR	AR	G	G	G	G	

RAG RATING :

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score** [redacted]
AMBER / RED	**= Score** [redacted]
RED	**= Score greater than or equal to 4**

Isle of Wight NHS Trust Board Performance Report 2013/14

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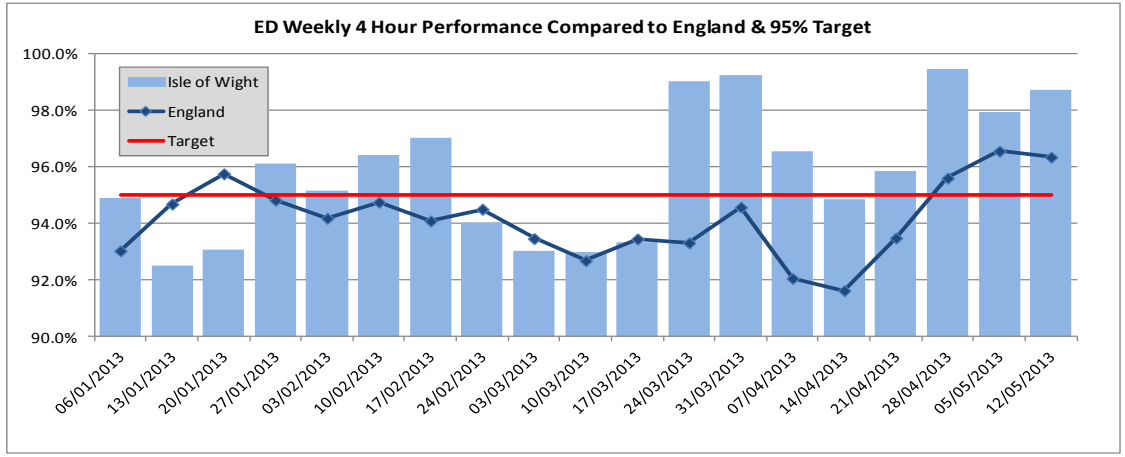
Benchmarking Update

Isle of Wight NHS Trust

ED 4 Hour Performance

2013/14 YTD Performance as at 12/05/2013:

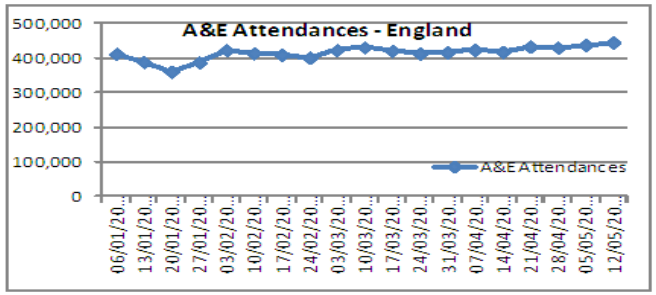
England	Isle of Wight	Peer 1	Peer 2
94.3%	97.3%	89.4%	88.8%

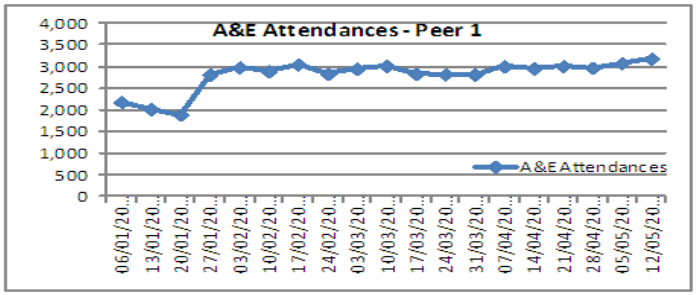


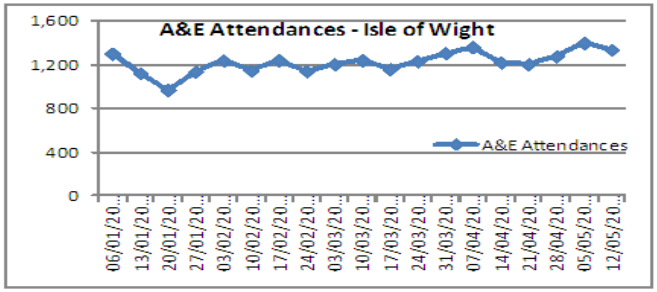
During the first part of this calendar year the ED 4 hour performance on the Isle of Wight was fairly consistent with the England Average hovering around but frequently falling below the 95% target.

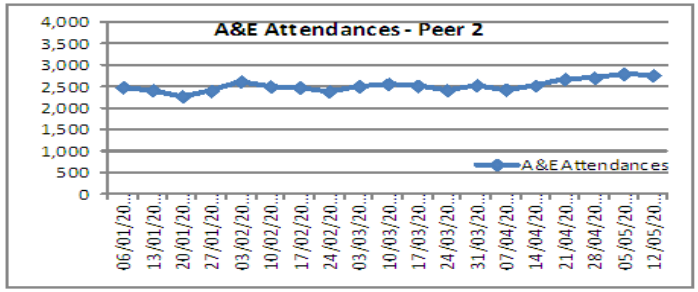
Whilst this remains the case for the England Average performance on the IW improved in late March and has remained above target in all but one week of the last eight weeks as a result we are currently achieving the target and doing far better than other local peer organisations.

Overall the pattern of attendances seems consistent across all organisations reviewed.









Source: http://www.england.nhs.uk/statistics/ae-waiting-times-and-activity/weekly-ae-sitreps-2012-13/

Peer 1 - University Hospitals Southampton Foundation Trust Peer 2 - Portsmouth Hospitals NHS Trust

Isle of Wight NHS Trust Board Performance Report 2013/14

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Performance Summary - Acute Directorate

Isle of Wight NHS Trust

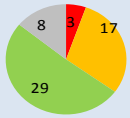
Performance on a Page - Acute Directorate

Governance Risk Rating M01: **0 - G**

Risk Register Summary: As at 13/05/2013

Risk Title	Risk Score	Type
Vacant Consultant Physician Posts	20	QCE
Risk of not achieving the A&E 4 hour target	20	QCE
Blood Sciences out-of-hours staffing	20	QCE
Risk due to bed capacity problems	20	PATSAF

Status of actions for all Acute Risks



Key Performance Indicators:

As at M01:	Latest Data	In Month Org	In Month Directorate	YTD Org	YTD Directorate
A&E Waits - Total time in A&E	Apr-13	96.6%	96.6%	96.6%	96.6%
MRSA	Apr-13	0	0	0	0
CDIFF	Apr-13	0	0	0	0
RTT Admitted - % within 18 Weeks	Mar-13	91.7%			
RTT Non Admitted - % within 18 Weeks	Mar-13	96.6%	97.4%		
RTT Incomplete - % within 18 Weeks	Mar-13	94.5%	95.9%		
RTT delivery in all specialties	Mar-13	0	0		
Diagnostic Test Waiting Times	Apr-13	7	0	7	0
Cancer 2 wk GP referral to 1st OP	Apr-13	93.80%		93.80%	
Breast Symptoms 2 wk GP referral to 1st OP	Apr-13	92.73%		92.73%	
31 day second or subsequent (surgery)	Apr-13	100.0%		100.0%	
31 day second or subsequent (drug)	Apr-13	100.0%		100.0%	
31 day diagnosis to treatment for all cancers	Apr-13	98.3%		98.3%	
62 day referral to treatment from screening	Apr-13	100.0%		100.0%	
62 days urgent referral to treatment of all cancers	Apr-13	85.7%		85.7%	
Delayed Transfers of Care	Q3 12/13	0.08%		0.03%	
Mixed Sex Accommodation Breaches	Apr-13	0	0	0	0
VTE Risk Assessment	Apr-13	89.2%		89.2%	
% of Category A calls within 8 minutes (Red 1)	Apr-13	75.0%	75.0%	75.0%	75.0%
% of Category A calls within 8 minutes (Red 2)	Apr-13	78.0%	78.0%	78.0%	78.0%
% of Category A calls within 19 minutes	Apr-13	97.3%	97.3%	97.3%	97.3%

*Cancer figures for April are provisional

Workforce Headlines:

As at M01:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
% Sickness Absenteeism	3.46%	3.70%	3.46%	3.70%
FTE vs Budget			-59.0	-18.0
Appraisals			17.9%	8.4%

Finance Headlines:

£000

As at M01:	YTD Org	YTD Directorate	Forecast Outturn Org	Forecast Outturn Directorate
Actual vs Budget	0.0	-4.7	0.0	0.0
CIP	352.3	-266.6	8,201.0	-1,003.8

Quality Headlines:

As at M01:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
SIRIs	11	4	11	4
Incidents	399	148	399	148
Complaints	22	11	22	11

Case for Change:

No. of Active Case for Change:	Red status	Green Status	% Green Status
32	4	28	88%

Note:
Red status is given to any case for change with an overdue milestone
Information presented is the worst case scenario as updated information may show that some of the actions have been completed.

SLA Performance:

As at M12:	Activity Actual	Activity Var to Plan	Income - £000 Actual	Income - £000 Var to Plan
Emergency Spells	8,639	649	16,537	1,566.1
Elective Spells	200	-9	307	-4.6
Outpatients Attendances	28,425	2,872	4,507	376.4
Total			21,351	1938.0

Isle of Wight NHS Trust Board Performance Report 2013/14

April 13

Performance Summary - Planned Directorate

Isle of Wight NHS Trust

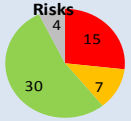
Performance on a Page - Planned Directorate

Governance Risk Rating M01: 0.5 - G

Risk Register Summary: As at 13/05/2013

Risk Title	Risk Score	Type
Endoscopy new build	25	QCE
Track and trace of re-usable medical devices to pa	20	QCE
Heating in NICU	20	PATSAF
Ophthalmology Department	20	PATEXP

Status of actions for all Planned Risks



Key Performance Indicators:

As at M01:	Latest Data	In Month Org	In Month Directorate	YTD Org	YTD Directorate
A&E Waits - Total time in A&E	Apr-13	96.6%		96.6%	
MRSA	Apr-13	0	0	0	0
CDIFF	Apr-13	0	0	0	0
RTT Admitted - % within 18 Weeks	Mar-13	91.7%	91.7%		
RTT Non Admitted - % within 18 Weeks	Mar-13	96.6%	96.1%		
RTT Incomplete - % within 18 Weeks	Mar-13	94.5%	94.0%		
RTT delivery in all specialties	Mar-13	0	0		
Diagnostic Test Waiting Times	Apr-13	7	7	7	7
Cancer 2 wk GP referral to 1st OP	Apr-13	93.80%	93.80%	93.80%	93.80%
Breast Symptoms 2 wk GP referral to 1st OP	Apr-13	92.73%	92.73%	92.73%	92.73%
31 day second or subsequent (surgery)	Apr-13	100.0%	100.0%	100.0%	100.0%
31 day second or subsequent (drug)	Apr-13	100.0%	100.0%	100.0%	100.0%
31 day diagnosis to treatment for all cancers	Apr-13	98.3%	98.3%	98.3%	98.3%
62 day referral to treatment from screening	Apr-13	100.0%	100.0%	100.0%	100.0%
62 days urgent referral to treatment of all cancers	Apr-13	85.7%	85.7%	85.7%	85.7%
Delayed Transfers of Care	Q3 12/13	0.08%		0.03%	
Mixed Sex Accommodation Breaches	Apr-13	0	0	0	0
VTE Risk Assessment	Apr-13	89.2%		89.2%	
% of Category A calls within 8 minutes (Red 1)	Apr-13	75.0%		75.0%	
% of Category A calls within 8 minutes (Red 2)	Apr-13	78.0%		78.0%	
% of Category A calls within 19 minutes	Apr-13	97.3%		97.3%	

*Cancer figures for April are provisional

Workforce Headlines:

As at M01:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
% Sickness Absenteeism	3.46%	2.77%	3.46%	2.77%
FTE vs Budget			-59.0	-11.0
Appraisals			17.9%	13.2%

Finance Headlines:

£000

As at M01:	YTD Org	YTD Directorate	Forecast Outturn Org	Forecast Outturn Directorate
Actual vs Budget	0.0	37.5	0.0	0.0
CIP	352.3	-26.6	8,201.0	-544.1

Quality Headlines:

As at M01:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
SIRIs	11	2	11	2
Incidents	399	93	399	93
Complaints	22	9	22	9

Case for Change:

No. of Active Case for Change:	Red status	Green Status	% Green Status
29	10	19	66%

Note:
Red status is given to any case for change with an overdue milestone
Information presented is the worst case scenario as updated information may show that some of the actions have been completed.

SLA Performance:

As at M12:	Activity Actual	Activity Var to Plan	Income - £000 Actual	Income - £000 Var to Plan
Emergency Spells	4,977	-232	11,020	-425.7
Elective Spells	8,942	469	13,122	-237.0
Outpatients Attendances	84,155	3,777	11,324	501.3
Total			35,466	-161.4

Isle of Wight NHS Trust Board Performance Report 2013/14

April 13

Performance Summary - Community Health Directorate

Isle of Wight NHS Trust

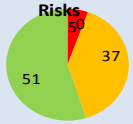
Performance on a Page - Community Directorate

Governance Risk Rating M01: 0 - G

Risk Register Summary: As at 13/05/2013

Risk Title	Risk Score	Type
Reprovision of Shackleton House Dementia Unit	25	QCE
Vacancies in adult speech & language therapy tea	20	PATSAF
Low Staffing Levels within Occupational Therapist	20	PATSAF
Failing PIT System	20	PATSAF

Status of actions for all Community Risks



Key Performance Indicators:

As at M01:	Latest Data	In Month Org	In Month Directorate	YTD Org	YTD Directorate
A&E Waits - Total time in A&E	Apr-13	96.6%		96.6%	
MRSA	Apr-13	0	0	0	0
CDIFF	Apr-13	0	0	0	0
RTT Admitted - % within 18 Weeks	Mar-13	91.7%			
RTT Non Admitted - % within 18 Weeks	Mar-13	96.6%	98.0%		
RTT Incomplete - % within 18 Weeks	Mar-13	94.5%	97.0%		
RTT delivery in all specialties	Mar-13	0	0		
Diagnostic Test Waiting Times	Apr-13	7	0	7	0
Cancer 2 wk GP referral to 1st OP	Apr-13	93.80%		93.80%	
Breast Symptoms 2 wk GP referral to 1st OP	Apr-13	92.73%		92.73%	
31 day second or subsequent (surgery)	Apr-13	100.0%		100.0%	
31 day second or subsequent (drug)	Apr-13	100.0%		100.0%	
31 day diagnosis to treatment for all cancers	Apr-13	98.3%		98.3%	
62 day referral to treatment from screening	Apr-13	100.0%		100.0%	
62 days urgent referral to treatment of all cancers	Apr-13	85.7%		85.7%	
Delayed Transfers of Care	Q3 12/13	0.08%		0.03%	
Mixed Sex Accommodation Breaches	Apr-13	0	0	0	0
VTE Risk Assessment	Apr-13	89.2%		89.2%	
% of Category A calls within 8 minutes (Red 1)	Apr-13	75.0%		75.0%	
% of Category A calls within 8 minutes (Red 2)	Apr-13	78.0%		78.0%	
% of Category A calls within 19 minutes	Apr-13	97.3%		97.3%	

*Cancer figures for April are provisional

Workforce Headlines:

As at M01:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
% Sickness Absenteeism	3.46%	4.08%	3.46%	4.08%
FTE vs Budget			-59.0	-11.0
Appraisals			17.9%	28.8%

Finance Headlines:

£000

As at M01:	YTD Org	YTD Directorate	Forecast Outturn Org	Forecast Outturn Directorate
Actual vs Budget	0.0	TBC	0.0	TBC
CIP	352.3	TBC	8,201.0	TBC

Quality Headlines:

As at M01:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
SIRIs	11	5	11	5
Incidents	399	96	399	96
Complaints	22	2	22	2

Case for Change:

No. of Active Case for Change:	Red status	Green Status	% Green Status
26	6	20	77%

Note:
Red status is given to any case for change with an overdue milestone
Information presented is the worst case scenario as updated information may show that some of the actions have been completed.

SLA Performance:

As at M12:	Activity Actual	Activity Var to Plan	Income - £000 Actual	Income - £000 Var to Plan
Community Contacts	228,069	12,237	n/a	n/a
Mental Health Community	57,860	-449	n/a	n/a
Mental Health Consultant Led Outpatients	6,776	-299	n/a	n/a
Mental Health Inpatients	872	45	n/a	n/a
Total			0	0.0

Terms and abbreviations used in this performance report

Quality & Performance terms

Ambulance category A	Immediately life threatening calls requiring ambulance attendance
CAHMS	Child & Adolescent Mental Health Services
DNA	Did Not Attend
LOS	Length of stay
MRSA	Methicillin-resistant Staphylococcus Aureus (bacterium)
Provisional	Raw data not yet validated to remove permitted exclusions (such as patient choice to delay)
RTT	Referral to Treatment Time
TIA	Transient Ischaemic Attack (also known as 'mini-stroke')
VTE	Venous Thrombo-Embolism
YTD	Year To Date - the cumulative total for financial year so far

Workforce and Finance terms

FTE	Full Time Equivalent
SIP	Staff in Post
CIP	Cost Improvement Programme
I&E	Income and Expenditure

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD ON 29th MAY 2013

Title	Board Walkabouts Action Tracker
Sponsoring Director	Executive Director of Nursing and Workforce
Author	Vanessa Flower – Head of Quality
Purpose	To review the progress against actions identified as part of the Board to Ward Assurance Visits programme

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	
Quality & Clinical Performance Committee	
Remuneration Committee	

Staff, stakeholder, patient and public engagement:
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Executive Summary:
Attached is the action tracker which is based on the actions identified from both the board and weekly board to ward assurance visits. This relates to the issues identified from the visits that have taken place since 27 February 2013. To date45 actions have been identified during the visit, of these 22 have been completed, 13 are in progress and 10 have either not progressed or no feedback has been received at the time of reporting.

Related Trust objectives	**Sub-objectives**
	Critical Success Factor 2 – Improve our clinical effectiveness and the safety outcome for our patients.
Risk and Assurance	
Related Assurance Framework entries	2.13
Legal implications, regulatory and consultation requirements	
Action required by the Board: To review the tracker in relation to actions taken following the board assurance visits.	
Date	17 May 2013

	BOARD WALKABOUTS ACTION TRACKER						
Date Visited	**Area Visited**	**Who Visited**	**Actions**	**Due Date**	**Person Responsible**	**Completion Status**	**comments from Directorate/area**
27 February 2013	Maxillofacial unit	Susan Wadsworth/John Matthews/Alan Sheward/Mark Price	**Issue 1.** 1. A system for explaining why patients are waiting should commence.	31.3.13	Martin Robinson		Update 23.4.13 Staff reminded to inform patients of delays giving apology and approximate time of delay in appointments.
			Issue 2. The shortage of alcohol gel dispensers needs to be resolved.	31.3.13	Sue Bradshaw		Update 23.4.13 Following improvement works alcohol gel dispensers sited.
27 February 2013	ENT	Chris Palmer/Nick Wakefield/Karen Baker	1. Relocate admint support from kitchen to main reception area	31.3.13	Martin Robinson		Update 23.4.13 Work being undertaken to relocate admin support to old dermatology office. Leann Hetherington leading on this piece of work. Storage and security of patient records is an issue in reception and purchase of lockable cupboard being sourced.
			2. Ensure appropriate storage of and security of patient records.	31.3.13	Martin Robinson		Update 23.4.13 Capital bid being compiled and aiming for August CIG that would resolve issue 2.
			3. Ensure cleaning of scopes meets standards and consider decontamination of equipment instead	31.3.13	Martin Robinson		Update 23.4.13 Capital bid being developed for complete refurbishment, aim for August CIG
27 February 2013	Luccombe	Danny Fisher/Peter Taylor/Felicity Green/Mark Price	**Issue 1**. Complaints being reviewed by Sister	25.3.13	Heidi Meekins		UPDATE 22 .4.13: Complaints reviewed at Quality meeting and feedback to staff via ward meetings
			Issue 2 Discharge planning - patient relatives need more information	25.3.13	Heidi Meekins		UPDATE 22.4.13 Information books being developed via Quality meeting to ensure up to date imparted to patients/ relatives **UPDATE 14.05.13** Work commenced on a Coming into Hospital and Home again book which will include information on discharge planning and planned date of discharge
27 March 2013	Shackleton	Mark Price/Peter Taylor	**Issue 1.** Review Housekeeping suppport as their was no cover due to sickness.	12.4.13	Mo Smith		Update 9.4.13 The housekeepers are in the MH&LD establishment and managed by us and not the cleanliness team, the establishment and shift pattern will change when they move to St Marys. MH&LD currently pay overheads to the cleanliness team however receive no service, the team are currently establishing what support we are paying for and how that support can be provided on-site.
			Issue 2 Confirm whether washing machines are transferring to St Marys	12.4.13	Mo Smith		Update 9.4.13 There issue of washing facilities has been addressed as part of the project to relocate Shackleton on site to St Marys. The staff have been involved. For patients own clothes there will be a washing machine and dryer on the new ward
			Issue 3 Concern for new unit on Newchurch lack of separate dedicated garden to be able to take patients.	12.4.13	Mo Smith		Update 9.4.13 Directorate response Each patient will have an individual activity plan detailing all activities including time off the ward, time out will be easier to arrange when the new staffing model is in place – still awaiting confirmation from the Trust that recruitment can begin.
			Issue 4. Review the one patient ready for discharge in December still not moved due to funding concerns.	12.4.13	Mo Smith		Update 9.4.13 Directorate Response Patient has since moved continuing care process adhered to

			Issue 5. Resolve how to ensure that bank staff are available to cover shifts and 1:1's	12.4.13	Mo Smith		Update 9.4.13 Directorate response It is always a challenge to have a sufficiently staffed MH bank; most of our existing staff also undertakes bank work. MS has suggested a dementia recruitment drive for the staff bank; this would also benefit Acute Hospital.
27 March 2013	Arthur Webster	Danny Fisher / Mr John Matthews / Mr Alan Sheward	**Issue 1** Submit bid to the charitable trustees to provide art and pictures for the consulting rooms.	26.04.13	Anthea Church		Update:5.4.13 Directorate response Anthea Church has raised this as a concern with the ICT as its been prohinbited in the past because they can be an Infection Control issue.
			Issue 2 The IPC procedures are in need of review with a particular focus on podiatry department, the hand wash and alcohol dispensers are out of date. The waste bins lack lids and are also very out of date. The consulting room smelt offensive. The directorate should ask for this to be remedied. This may require use of an air freshening device. The Trust Board would support a visit from the Head of Estates to review the property.	26.04.13	Lisa Reed / David Shields/Kevin Bolan		Update 5.4.13 Directorate Response David Shields will address the issies raised in relation to podiatry and IPC. Kevin Bolan has visited AW and is keen to review use as parts of the estates development programme. The unpleasant smell in the consulting room has been an issue since the changes to the building took place several years ago. The room is used for 1-1 consultations in the main by Mental Health. It has never been possible to determine where this is coming from although the carpet in the room has been clean on more than one occasion? The service has been prohibited in the past from using air fresheners of an effective kind as it was an infection control issue this has been queried with the ICT by Anthea Church
11 February 2013	Colwell	Danny Fisher/ Sarah Johnston	**Issue 1** Identify a method to ensure assurance is provided that all documentation for pressure ulcers is up to date and reflects appropriate care given	01-Apr-13	Tina Beardmore		Update: 08.05.13 (TB)When patient is being handed over from transferring ward information regarding waterlow and pressure areas is shared so as to ensure appropriate mattress in use from the point of transfer. All trained staff have been advised to assess patients pressure areas on transfer and to update Risk assessment and Tissue viability care plan Coordinator advised to check new patients documentation the following day to monitor compliance. Intentional rounding in progress on the ward. All staff have been advised to update TV care plan daily and to personalise this Patient s with a score above 10 are advised if they can change their own position to do so every 1 and a half hours and if assistance needed to change position staff record times of position change. This is reviewed by ward sister Glenn Smith TVN has been carrying out regular audits and reviews which also monitor compliance Nutritional aspects of skin integrity are also monitored and close working with the dietician.

07 March 2013	Luccombe	Danny Fisher/Mark Price/ Deborah Matthews	**Issue 1.** 1. Mark Price has agreed to contact estates to request urgent replacement of the ceiling tiles above the nurses station. (completed 10.3.13) 2. DM to ensure sister/Matron have a robust system in place for reporting urgent maintenance works and ensuring these are regularly pursued until concluded.	21-Mar-13	Sue Bradshaw		UPDATE 17/4/13 Ceiling tiles replaced as agreed. Book held by ward clerks and if unresolved escalated to Sister then Matron. UPDATE 17/4/13
			Issue 2. 1. Mark Price will raise this issue of cleaning the paving and erecting bird netting or some other device with Kevin Bolan. 2. DM will highlight this issue and the proposed actions to Sister/Matorn /HOCS and aks them how they might consider this area for the benefit of patients.	21-Mar-13	Sue Bradshaw		UPDATE 17/4/13 Estates will clean area on a regular basis. Area is used by patients and rubber mat ramp utilised to permit beds to be pushed outside.
			Issue 3. 1. The Ward Sister and matron should review the elements marked as no with the audit domanes and assocaiated comments and progress actions to improve compliance.	21-Mar-13	Sue Bradshaw		UPDATE 17/4/13 Sister working with staff to ensure NO's turned to YES's
			Issue 4. 1. Several patients made positive comments about the quality of the food. We would recommend consideration be given to how we might obtain real time feedback from patient on the quality of the food. DM to discuss with Jo Sheppard.	21-Mar-13	Deborah Matthews		Update 14.5.13: DM d/w Jo Sheppard, Catering Services Manager. 'To try and receive as near to real time as possible feedback from patients, the current menu is being re-designed, to provide an opportunity on the back of the menu for patients to send comments back to catering when their meal tray is returned. This system is currently on trial in one ward area.'
06 February 2013	Opthalmology Outpatients	Danny Fisher / Alan Sheward	**Issue 1.** The Directorate need to work up a Business Case to understand the future requirements of the Opthalmology Department	20-Feb-13	Jonathon Lochead		Update 23.4.13 Joint business case looking at opthalmology and endoscopy being undertaken
			Issue 2. Although far from ideal the current environment should be regualry assessed by the Directorate leads for cleanliness and IPC compliance.	20-Feb-13	Sue Bradshaw		Update 23.4. 13 Further to redecoration which was completed November 2012, cleanliness has improved although without relocation this will not be further improved to be fully compliant
			Issue 3. Provide Glove Holders to all Clinical Areas	20-Feb-13	Sue Bradshaw		Update 23.4.13 Supplies are sourcing and once painting in consultation rooms is undertaken these holders will be in place.
			Issue 4. Work with Sarah Finch to ensure all invoives to private Optomotrists use current IT PO system	20-Feb-13	Sarah Finch		No update received
			Issue 5. IPC to undertake an assessment of Hand Hygiene availability in the FFA room	20-Feb-13	Sanchia Chiverton		To ensure compliance staff will maintain monthly audit trail with any remedial action required.
			Issue 6. Purchase retractable Tapemeasure for use with viewing box instread of gauze ribbon	20-Feb-13	Judie McDowell		Feed back from dept - completed
			Issue 7 Staff food and Patient Food should be seperated.	20-Feb-13	Katherine Taylor		Feed back from dept - completed
			Issue 8 Assessment of equipment that has not been used for >18 months and whether this should be removed.	20-Feb-13	Jonathon Lochead		This is being undertaken with the assistance of the Consultants when consultation rooms are being redecorated.
			Issue 9 Staff drinks should be taken in a non clinical area. Reception should be free of hot drinks.	20-Feb-13	Katherine Taylor		Expectations that no drinks will be consumed at Reception area. For compliance Lead nurse will audit on a daily basis and Matron to undertake spot checks (at least twice monthly).

24 April 2013	Appley Ward	Mark Price / Nick Wakefield	**Issue 1** De-clutter ward	31.05.13	Jo Payne		
			Issue 2 Ensure patients are aware of the availability of snacks during evening especially in diabetic patients	Immediate	Jo Payne		Feedback received from sister, to advise that all staff have been reminded to offer patients snacks if appropriate to do so, a notice has been put up in kitchen to this effect.
			Issue 3 Review jnr dr rota to esnure adequate ward cover	31.05.13	Alison Price		Update from AP:I have collated the number of junior doctors per grade for each ward for a three month period from 1st Feb 2013 to 30th April 2013. I have also reviewed the rotas and have increased the numbers of doctors by 1 FY1 and 1 FY2 as a result of disbanding the outlier team.
			Issue 4 Review consultant attendance at MDT meetings	31.05.13	Chris Sheen		
			Issue 5: Organise fire practice	31.05.13	Jo Payne		
			Issue 6: Review and resolve issue of water leakage into food cupboard when it rains.	06.05.13	Kevin Bolan		
			Issue 7: Consider permanent use for bathroom space which is being used inappropriately for storage.	13.05.13	Deborah Matthews		
			Issue 8: Review medical gas provision to ensure it is available for all beds	13.05.13	Kevin Bolan		update from DM: Estates undertook a site survey in March and intend to put oxygen in early part of this year. Meanwhile double-ported oxygen is in place.
			Issue 9: As part of the existing service development plan in the IBP consider the development of a "step down" facility for appropriate acute patients	31.07.13	Donna Collins		
05 April 2013	Clinical Coding	Karen Baker/Danny Fisher Deborah Matthews	**Issue 1**: Need to ensure, in the absence of a Liverpool Care Pathway, that doctors where end of life is imminent specifically write the words 'Palliative Care' or this cannot be coded.	31.05.13	Mark Pugh		
			Issue 2: N/B - Dr Fosters mortality Data is compiled from 'Admission Diagnoses'. Whereas we code on Discharge Diagnoses.	31.05.13	Mark Pugh		This is a national standard and we have no influence over the way the Dr Foster data is compiled.
			Issue 3: Concerns expressed about the high number of outstanding Discharge Summaries – that come through late. Question: Why do we not code from the Electronic Discharge Summary, rather than wait for a paper copy to be delivered to the department?	31.05.13	Mark Pugh		Response recieved 14.5.13: There are many systems in which Discharge Summaries are currently completed and there is an aim to move to a corporate approach and utilise ISIS. Currently we only have General Medicine on ISIS, therefore we need to ensure that we have robust processes in place so that admissions / transfers / discharges are not missed. Longer term we will be looking at how we can streamline processes and the aim is indeed to code from the e-discharge summary rather than from paper copy. There are two issues here really that need to be reviewed - the timeliness of Discharge Summary completion for Coding purposes against the need for paper copies for validation of ATD processes. The second part is currently under review to see if we can remove this additional admin step but still be confident that both clinical data and revenue are not being missed due to poor recording. Regardless of whether the Coders code from electronic systems or not, they may be unable to do so currently unless the timeliness of Discharge Summary completion is improved.

Pathology	Chris Palmer / Sarah Johnston	Areas for improvement/review: In addition to the actions above: 1. Immediate action – the roof void area (known to estates, dept, and health and safety) was unlocked and filled with items that appeared to be from the contractors – this is a fire risk and needs to be reviewed and clarity sought on what the space can be safely used for – CP contacted estates on 3rd May and actions taken to remedy Actions • Address the roof void space as a matter of urgency Local Lead	10.5.13	Liz Thorne / Donna Collins		17.05.13: LT chased for update
		2. Notice boards were untidy and in one case personal notices had been added (advertising painting baby bumps)	10.5. 13	Liz Thorne / Donna Collins		17.05.13: LT chased for update
		3. General estate issues need to be addressed – paint peeling, screws in walls that had been removed, broken fittings – general appearance in some front line areas was shabby and could be improved quickly by estates	10.5.13	Liz Thorne / Donna Collins		17.05.13: LT chased for update
		4. Clean lab coats were stuffed on top of cupboards rather than inside	10.5.13	Liz Thorne / Donna Collins		17.05.13: LT chased for update
		5. Many storage areas/rooms were untidy and lacked order	10.5.13	Liz Thorne / Donna Collins		17.05.13: LT chased for update

Isle of Wight NHS
NHS Trust

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REPORT TO THE TRUST BOARD (Part 1 – Public)

29th May 2013

Title	Annual Governance Statement
Sponsoring Director	Chris Palmer/Karen Baker
Author(s)	Brian Johnston
Purpose	For the Board to agree and the Chief Executive to sign the Annual Governance Statement for 2012/2013

Previously considered by (state date):	
Executive Board	
Audit and Corporate Risk Committee	22nd May 2013
Patient Confidentiality	
Finance, Investment & Workforce Committee	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Quality & Clinical Performance Committee	
Remuneration Committee	
Please add any other committees in grey sections as needed	
Other (please state)	

Staff, stakeholder, patient and public engagement:

Draft Statement reviewed by SHA/TDA and External Auditors

Executive Summary:

The Governance Statement forms part of the Annual Accounts providing a record of the stewardship of the organisation in 2012/2013 to supplement the accounts. The statement draws together position statements and evidence on Governance, risk management and internal controls in place within the Trust for the year 2012/13

Related Trust objectives	**Sub-objectives**
Productivity	CSF5 Improve the value for money we offer.
Risk and Assurance	The statement provides assurance on the risk management and internal control arrangements operating within the Trust in year 2012/13
Related Assurance Framework entries	Risk 5.23
Legal implications, regulatory and consultation requirements	-

Action required by the Board: The Board are requested to review and agree the draft statement in order for the CEO to formally sign off the statement for the Annual Accounts and the Annual Report.

ANNUAL GOVERNANCE STATEMENT – 2012/13

Isle of Wight NHS Trust

Organisation Code – R1F

SCOPE OF RESPONSIBILITY

The Isle of Wight NHS Trust Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding public funds and the organisation's assets as set out in the Accountable Officer Memorandum.

All members of the Board have subscribed to the NHS Code of Accountability for NHS Boards, which identifies the Board's responsibilities and accountability arrangements, and to the Standards of Business Conduct.

Scrutiny by the Non-Executive Directors and our Auditors is undertaken through the Audit and Corporate Risk Committee which provides direct assurance to the Board in respect of our systems of internal control, including probity in the application of public funds and in the conduct of the organisation's responsibilities. The Audit and Corporate Risk Committee's reports and minutes are reviewed in public board meetings to ensure that the Trust takes an integrated and comprehensive approach to governance and risk management.

The Corporate Governance Framework comprises the systems and processes, and culture and values, by which the Trust is directed and controlled. It enables the Trust to monitor the achievement of its strategic objectives. The Board Assurance Framework and the system of internal control are significant parts of that framework and are designed to manage risk providing reasonable assurance of effectiveness. The Board Assurance Framework and the system of internal control are based on an on-going process to identify and prioritise for management the risks to the achievement of the Trust objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised.

A governance framework has been in place throughout the year ended 31 March 2013 and up to the date of approval of the annual accounts for 2012/13.

The Non-Executive Directors (NEDs) play an active part in the independent scrutiny of Trust

activities, through their role as 'portfolio' holders. NEDs hold positions as Chairs, vice-chairs and members of many of the Board-level committees and sub-committees.

The Governance Framework Of The Organisation

The Trust Board has a sub-committee structure currently consisting of eight formal sub-committees of the Board as shown below:

Audit and Corporate Risk Committee

Quality and Clinical Performance Committee

Finance, Investment and Workforce Committee

Charitable Funds Committee

Remuneration Committee

Mental Health Act Scrutiny Committee

Foundation Trust Programme Board

Nominations Committee (in shadow form)

All Board sub-committees produce annual reports for scrutiny by the Audit and Corporate Risk Committee. Reports include the number of meetings held in year, confirmation of compliance with Terms of Reference, key achievements of the committees and future plans.

Attendance records related to the board and board sub-committees are maintained and a summary of attendance for period April 2012 – March 2013 is included as an appendix to this statement.

In 2012/13 the Audit and Corporate Risk Committee was formally identified as the senior scrutiny committee of the Organisation.

The Internal Audit Programme for 2012/13 included a review of Risk Management and Board Assurance and significant assurance was identified in these areas.

The Board undertook a comprehensive self assessment of its own effectiveness at Board Seminar meetings in March and April 2013. The assessment evaluated the collective performance of the Board, the performance of the Board's committees and the individual performance of directors. Positive outcomes of the self assessment included improving patient care, achievement of patient access standards, achievement of financial targets,

improving workforce effectiveness, improving the quality of our buildings, delivering in-year service developments, maintaining and updating our Integrated Business Plan and developing relationships with stakeholders and partners. The Board also concluded that it's sub – committees were working effectively, providing good assurance to the Board; that the working of the Board has been to the best interest of the overall organisation and that the Board had met its statutory duties of care and quality.

A number of areas for improvement were also identified including delivering the workforce strategy, improving the clinical management information provided to the Board, improving the 'live' data available to assess quality of service delivery, an extra focus on organisational culture in 2013/14 and taking further action to stagger Non-Executive Director appointments as well as improving succession planning for Executive Directors.

It was agreed that action plans would be developed to cover all of these areas in order that the performance of the board directors would continue to be enhanced through ongoing board development plans, personal development plans and mentoring arrangements.

Furthermore, during 2012/13 the Trust Board has been subject to a number of internal and external assessments as part of the Foundation Trust application process. These assessments have been focused around the Department of Health Board Governance Assurance Framework (BGAF), Monitor's Quality Governance Framework (QGF) and the Historical Due Diligence (HDD) process. Informal assessments, peer reviews and internal self-assessments have been undertaken to prepare for formal external assessments that have been undertaken by KPMG, Ernst & Young, South Central Strategic Health Authority (SHA) and Grant Thornton. The Quality Governance Framework assessment undertaken by KPMG validated the Trust's self-assessment confirming a score compliant with Monitor's application requirements. These reviews have collectively identified strengths and weaknesses in governance arrangements and resulted in a number of actions that the organisation has implemented to ensure governance arrangements are robust.

Key observations include: the Board has very good self-awareness and insight; there are challenges around the embedding of new behaviours, practices and processes across the organisation; ensuring there is an appropriate mix of skills across the Board; ensuring the Board has access to timely and accurate information; and, the visibility of the Board to patients and staff.

Action taken to date includes: development of focused actions to embed new behaviours and planned and unannounced Board walk-rounds to visit wards and other parts of the

organisation; executive team and portfolio re-configuration; the recruitment of 2 new executive directors, including a strategy and commercial role, and the initiation of a recruitment process to secure a Company Secretary; recruitment of 2 new non-executive directors with legal and commercial backgrounds and more recently a non-executive director with a clinical background; review of Board sub-committee functions, establishment of a Finance, Investment and Workforce Committee and the realignment of sub-committee and Board meeting cycles to ensure provision of timely, assured information; and, the introduction of weekly flash reporting to all Board members.

Improvements to Quality Governance to date include: designated Non Executive Lead roles for safety, experience and clinical effectiveness; the use of patient stories at Board meetings; a rolling programme of Patient Safety Assurance visits involving Board members; quality reporting now includes serious and adverse event reporting, measurement of harm and provides qualitative and quantitative information; development of Quality Impact Assessment process for completion on all Projects/CIP plans; and, monthly Quality Reports are now made available on Trust Website.

On the recommendation of the SHA the Board are working with an external party, Foresight Partnership, to ensure that development activity undertaken is appropriate to meet the needs of the organisation.

The Isle of Wight NHS Trust has continued to deliver high standards of performance across a wide range of local and nationally defined key performance indicators including those outlined in the 2012/13 Operating Framework. The Trust Board has received a monthly update in the form of a balanced scorecard report in order to gain assurance that indicators are on course to be achieved. In addition to the balanced scorecard more detail has been provided for those indicators that were failing or at risk of failing including details of actions to address performance issues.

During 2012/13 there were a small number of key indicators that fell into this category. Most notable concerns were: Healthcare Acquired infections as we were above our Year to Date trajectory for both MRSA (2 cases) and Cdiff (13 cases). Emergency care 4 hour standard achieved in Quarters 1-3 but was below the national 95% target in quarter 4. Provisional data for the Cancer indicators suggested that we were on course to meet these targets but they continued to be closely monitored. Overall we remain on track against our financial plan and we still anticipate achieving at year end. Our Monitor Financial Risk Rating is 3.

All Executive Directors have clear objectives, and I have established a schedule of regular

one-to-one meetings with each member of the Executive team to oversee progress, culminating in a year-end appraisal of performance. Moreover, I further exercise internal management controls through my regular executive management team meetings and attendance at various Committees.

Through the operation of this governance framework I am not aware of any instances of non-compliance with relevant laws, regulations and governance codes. For example, papers to the Board and Committees are required to highlight legal implications and legal advice is sought by the Trust, as required.

Corporate Governance Code

It is the policy of the Trust to identify, minimise, control and where possible eliminate any risks that may have an adverse impact on patients, staff and the organisation. The Chief Executive carries ultimate responsibility for all risks within the organisation. The Trust's risk management strategy, policy and procedures describe the responsibilities for risk management from the organisational responsibility of the Board, through all managers, clinicians and staff ensuring their commitment to the principles of risk management which apply throughout all areas of the organisation regardless of the type of risk – organisational, financial, environment and facilities, clinical and non-clinical.

THE RISK AND CONTROL FRAMEWORK

The overall responsibility for the management of risk rests with the Chief Executive, supported collectively and individually by the Board of Directors. Specific risk management responsibilities for Executive Directors and Senior Managers have been agreed and are documented within the Board approved Risk Management Strategy, as well as in individual job descriptions as appropriate.

The Executive Board acts as the overarching committee with responsibility for risk management within the Trust and this responsibility is clearly reflected in the Executive Board's Terms of Reference. Reporting directly to the Executive Director of Finance, the Head of Corporate Governance and Risk Management provides leadership and management for the risk management function within the Trust.

Risk management is embedded within the Trust's activities in several ways:

- A revised and updated Board Assurance Framework (BAF), described in more detail below, was approved by the Trust Board in July 2012, together with an action plan to

address any gaps in controls and/or assurance.

- The Trust's internal auditors, Deloitte, have worked closely with senior managers to review and report on the organisation's systems of internal control and risk management.
- The Audit and Corporate Risk Committee conducts a regular review of the Trust's risk management systems, including the risk register and the board assurance framework.
- The Corporate Governance Framework has been revised and updated during 2012/13 following a comprehensive review of Standing Orders, Standing Financial Instructions, Scheme of Delegation and other relevant documents.
- The revised Corporate Governance framework has been formally approved by the Board and up to date copies of all the framework documents together with the terms of reference of all Board Sub – Committees are maintained on a Corporate Governance Framework intranet site for access as necessary by Trust staff.
- A number of sub committees and groups have reported monthly to the Executive Board throughout 2012/13, enabling the Board to be informed of any significant risk management issues occurring within the Trust.
- A departmental/service specific risk assessment and register system is in place which links to the corporate risk register, thus ensuring that all areas of the organisation are actively involved in the risk management activity of the Trust.
- At the time of this report there are 88 risks included on the Trust Corporate Risk Register covering all aspects of Trust business. New risks identified during 2012/13 include – Leadership; Segregation, consigning and collection of clinical waste; Pressure Ulcers; Balancing quality and money; Out of hours IT cover and Main hospital lifts. Furthermore a number of additional strategic level risks were also included in the Register towards the end of 2012/3 in recognition of our journey towards Foundation Trust status. These include – Capacity and capability; Tariff Changes; Failure to achieve cost improvement programme and lack of Capital / not securing a strategic business partner. All risks included within the corporate risk register are noted on the board assurance framework (BAF) linked to the most appropriate Trust objective and any new risks added to the risk register throughout the year are cross – referenced to the BAF at the time of entry. All risks on the register have action plans in place and underway which are regularly monitored and performance managed. Risks are only removed from the register following a formal sign-off process by an executive or associate director and an assessment of the

completed action plans by the appropriate sub-committee of the Board. During the year April 12 – March 13 a total of 32 risks were formally signed off the register following appropriate action taken to mitigate these risks.

- An electronic intranet-based incident reporting system is now embedded across the organisation, supported by a comprehensive training and awareness programme for staff.
- The Trust's maternity service was re-assessed against a series of revised and updated NHSLA risk management standards in January 2012 and successfully retained their level 1 accreditation. All other services (acute, mental health, ambulance, community) are currently accredited to Level 1 with the NHS Litigation Authority following a successful assessment in January 2013

Risk Management Strategy

The Trust's Strategy for Risk Management was updated and re-approved by the Board in December 2012. The Strategy sets out the organisation's attitude to risk, and defines the structures for the management and ownership of risk throughout the organisation. Specific sections within the Strategy include:

- Corporate responsibility and accountability.
- Values and principles underpinning service delivery with emphasis on patient safety, quality of care and patient and public involvement.
- Risk management systems in place within the Trust including the key stages of risk identification, risk analysis and evaluation, risk control and reduction, and processes for ongoing monitoring and review.
- Processes in place for ongoing performance review and learning, e.g. from incidents, complaints and claims.

Board Assurance Framework (BAF)

The Board has continued to maintain an up to date Assurance Framework. The latest formal revision of the framework, incorporating a series of new organisational objectives and critical success factors, was approved by the Board in July 2012. The Assurance Framework includes a set of principal objectives and principal risks linking directly to Care Quality Commission Essential Standards of Quality and Safety and an Executive Director lead has been identified for each principal objective/risk within the framework. The Assurance Framework is updated continuously and has been reported to the Board at least bi- monthly

throughout the year.

The Assurance Framework enables the Board to be properly informed about the principal risks to the achievement of the organisation's key objectives, and the controls in place which are intended to manage these risks. The framework document comprises;

- The organisation's principal objectives.
- The principal risks associated with achieving these objectives.
- The key controls/systems in place to minimise the risks.
- The positive assurances available to the Board in the form of internal and external assessments and reports.
- A cross-reference to all risks currently included within the corporate risk register

The framework also includes details of any gaps in controls and/or assurance and describes the specific actions designed to address these gaps. In 2012/13 the framework includes strategic risks relating to :

- Improving the experience and satisfaction of patients
- Improving clinical effectiveness and safety for patients
- Development and implementation of the Trust Business plan
- Redesigning our workforce
- Improving value for money
- Developing our Estate and Technology
- Improving services and achieving objectives through strategic commercial partnerships
- Developing relationships with key stakeholders
- Developing our Foundation Trust application
- Developing our organisational culture

The Assurance Framework, which includes all action plans for the management of the risks listed above, has been reviewed throughout the year at both public and private meetings of the Board and an end of year review of the Framework was undertaken by the Board in March 2013.

Risk Management Training

A risk management training programme for Trust staff is well established. Half day risk management/self assessment workshops provide senior staff with the necessary skills and tools to undertake risk self assessments within their own departments and services. A programme of annual refresher training sessions is also maintained. Our basic risk management training programme provides staff with information and guidance on how they can engage with the risk management process – for example by reporting accidents and incidents, participating in risk assessments or by highlighting operational risks for possible inclusion within local and corporate risk registers. Many E- learning programmes have also been developed and are now available for all staff to access. The programmes include Risk Management, Incident Reporting, Incidents, Complaints and Claims Management and Counter Fraud.

An annual programme of risk management training for Trust Board members is in place and risk assessment workshops were included as part of Board seminar meetings in both December 2012 and January 2013.

Our annual risk assessment programme, and the systems and training in place to support this, has been actively performance managed throughout 2012/13. Any areas of good practice identified through completed risk assessments are fed back to other assessment teams through the ongoing programme of training workshops.

Information Governance / Data Security

All reported information governance /data security incidents are logged on the Trust Incident reporting system and 387 such incidents were reported during 2012/13. The majority of these incidents (378) were reported as either moderate, minor or insignificant events and graded as either IG level 0 or 1 in accordance with the Information Governance reporting matrix, but 9 events were reported and investigated as serious incidents and these were duly reported to the office of the Information Commissioner and/or to the SHA via the STEIS system in accordance with our Serious Incidents Requiring Investigation (SIRI) policy. Brief details of the IG incidents reported to the SHA / Information Commissioner in 2012/3 are disclosed in the 'significant issues' section of this statement. It should be noted that some of the incidents were reported by the Trust to the SHA/Information Commissioners office

although the matters they relate to are 'owned' by other organisations outside of the Trust.

REVIEW OF EFFECTIVENESS

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:-

- Detailed reports from both Internal and External Auditors.
- Monthly activity, quality, finance and workforce performance reports to the Board.
- Quarterly governance and assurance reports to the Executive Board.
- Reports and minutes to the Board from the Audit and Corporate Risk Committee,
- Monthly updates on progress against the Assurance Framework and associated action plans.
- Monthly review of the Corporate Risk Register
- CQC confirmation of registration of all regulated activities with no compliance conditions attached.
- PEAT inspections
- Assessment against NHSLA risk management standards

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit and Corporate Risk Committee and the Executive Board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Specific responsibilities of Trust Committees in relation to the system of internal control, and operational throughout 2012/13 include:

The Trust Board

- Development and approval of the Board Assurance Framework and associated action plan.

- Receiving and reviewing the minutes of the Audit and Corporate Risk Committee and other sub-committees of the Board
- Receiving and reviewing monthly performance reports relating to activity, quality, finance and workforce.

The Audit and Corporate Risk Committee

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.
- Providing assurance to the Board through the minutes of the Committee in relation to: * the adequacy of all risk and control disclosure statements
  *the adequacy of Trust policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
  *the work of the committee in support of the system of internal control, specifically commenting on the fitness for purpose of the Assurance Framework.

The Executive Board

- Maintaining a constant review of corporate governance arrangements and ensuring the Board is fully briefed on any significant issues.
- Ensuring the Assurance Framework action plan is effectively performance managed.
- Ensuring the Corporate Risk Register is regularly reviewed and updated.
- Co-ordinating the work of all related groups and committees identified within the Risk Management Strategy.
- Overseeing the performance management and reporting arrangements relating to CQC registration and the Trust's Quality and Risk Profile.

Internal Audit

I am also assisted by the Trust's Internal Auditors, Deloitte, who provide assurance to the Board through reviews of the effectiveness of the organisation's management of risk. Between February and March 2013 an internal audit review examined the processes by which the Board obtains assurance on the effective management of key risks relevant to the organisation's strategic objectives. The audit opinion of the assessment of controls in place and of the level of compliance with these controls was 'substantial assurance'. Specifically the audit confirmed that:-

- The Trust has an up to date risk management strategy in place which outlines the strategic approach to risk management

- Risk management awareness training for Board members and senior managers has been undertaken
- Strategic objectives have been set and agreed by the Board
- Strategic objectives are defined and mapped to risks and assurances in the Board Assurance Framework (BAF)
- Objectives within the BAF are cross referenced to Care Quality Commission requirements where appropriate
- Risk registers are maintained setting out the key risks facing the Trust and the registers help enable the Trust to understand its comprehensive risk profile.
- Testing of a sample of 10 risks on the Board Assurance Framework confirmed controls identified as mitigating the risk had been recorded by the Trust in each case.

However there were two areas identified for further improvement, namely:

- Ensuring the review dates for action plans on the BAF are adhered to
- Ensuring that BAF risks rated as 'amber' or 'green' are always supported by positive assurance to the Board

A management action plan has been put in place to address these issues.

Other internal audits which are relevant to this Annual Governance Statement include reviews in respect of the CQC Essential Standards of Quality and Safety and the Trust's Risk Management and Assurance systems. For both of these reviews the auditors gave an opinion of 'substantial assurance'

Furthermore following an unannounced CQC inspection to St Marys Hospital in January 2013 the Trust received a report confirming full compliance against all standards assessed. There was no requirement for a formal action plan to be produced and submitted to the CQC.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes – ie the organisation's system on internal control. The Head of Internal Audit Opinion for the year ended 31st March 2013 is that 'significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently'

Significant Issues

As previously outlined in the information governance / data security section of this statement the following 9 information governance incidents were reported to the SHA and/or Information Commissioner during 2012/13 and this is disclosed as a significant control issue:

- 4 incidents related to 'mishandled' ward handover sheets
- 2 incidents involving laptops (1 stolen and 1 left unattended in a public location)
- 1 incident related to inappropriate access rights to a hospital computer system
- 1 incident related to a temporary loss of 2 clinic tapes (later found following search)
- 1 incident related to information published in a public board report which given the nature of the information could have been identifiable

All of these incidents have been subject to local investigation in order to identify 'root causes', to ensure plans are in place for improvement and to prevent the likelihood of recurrence. Specific actions taken in response to these incidents include:

- Ensuring staff involved undertake further information governance training
- Reviewing and improving data protection clauses within contracts
- Improved management controls related to public board reports
- Ensuring staff involved are fully aware of their responsibilities regarding the Data Protection Act

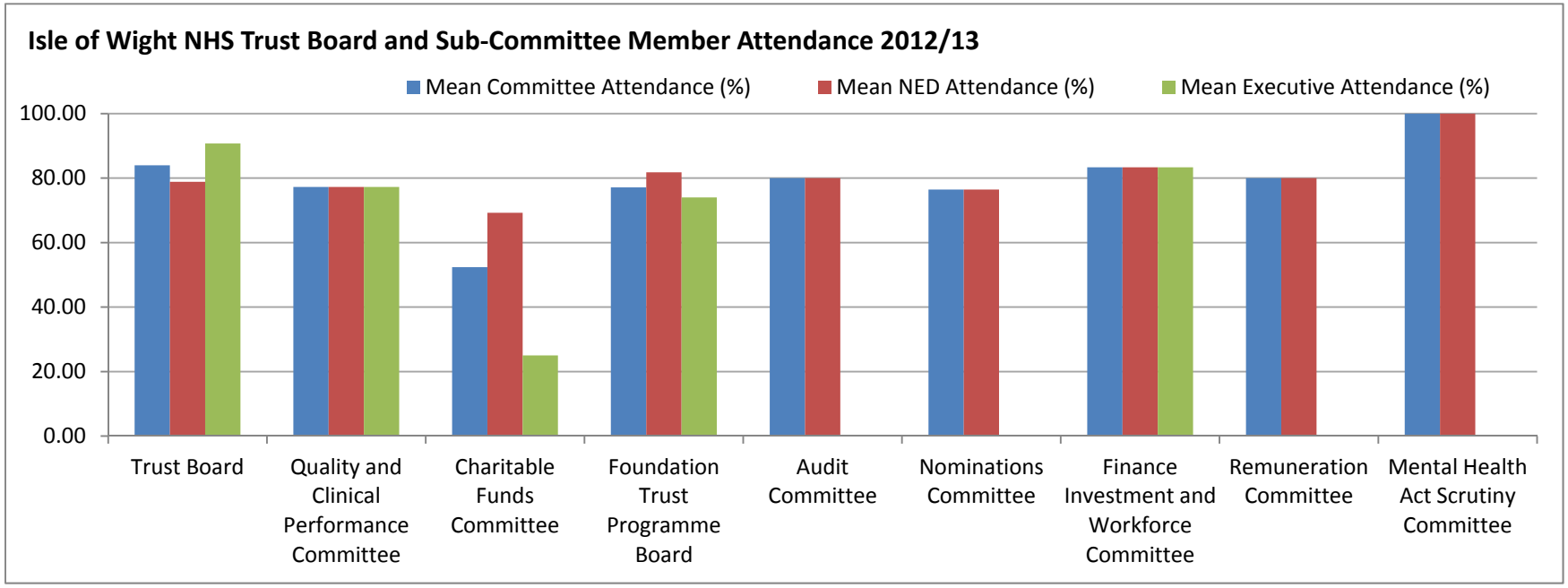
With the exception of the issues outlined above no other significant issues have been identified by the Trust and I believe that this Annual Governance Statement is a balanced reflection of the risks and controls operating within the Trust during 2012/13

Signed……Chief Executive Officer Date……

Accountable Officer : Karen Baker

Organisation: Isle of Wight NHS Trust

Analysis of Trust Board members' meeting attendance in 2012/13							**Appendix 1**
	Meetings (No.)	NEDs	Execs	Mean Committee Attendance (%)	Mean NED Attendance (%)	Mean Executive Attendance (%)	Notes
Trust Board	12	6	5	84.00	78.87	90.74	
Quality and Clinical Performance Committee	11	2	2	77.27	77.27	77.27	
Charitable Funds Committee	3	4	3	52.38	69.23	25.00	
Foundation Trust Programme Board	11	3	5	77.11	81.82	74.00	In the majority of instances when Executives are unable to attend deputies are in attendance
Audit and Corporate Risk Committee	5	4	0	80.00	80.00	N/A	
Nominations Committee	3	6	0	76.47	76.47	N/A	Meets on adhoc basis aligned with FT programme requirements.
Finance Investment and Workforce Committee	6	2	2	83.33	83.33	83.33	Established in November 2012
Remuneration Committee	4	4	0	80.00	80.00	N/A	
Mental Health Act Scrutiny Committee	4	1	0	100.00	100.00	N/A	Apart from one NED other attendees are not members of the Board



Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 – Public)

Enc H

ON 29TH MAY 2013

Title	Review of Trust Board Performance & Effectiveness 2012/13
Sponsoring Director	Foundation Trust Programme Director/Company Secretary
Author(s)	Brian Johnston, Head of Governance & Assurance
Purpose	Update Board on the outcome of the 2012/13 review

Previously considered by (state date):	
Executive Board	
Audit and Corporate Risk Committee	
Patient Confidentiality	
Finance, Investment & Workforce Committee	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Quality & Clinical Performance Committee	
Remuneration Committee	
Please add any other committees in grey sections as needed	
Trust Board Seminar	Feb & March 2013
Other (please state)	

Staff, stakeholder, patient and public engagement:

Executive Summary:

Board evaluation is a regulatory principle in Monitors Code of Governance. An annual self assessment enables the Board to review both itself and its sub committees in order to confirm good performance and also to create an action plan for further improvement where necessary. This report covers the collective performance of the Board, performance of the Board's committees and the individual performance of the directors for the year ending 31st March 2013.

Related Trust objectives	**Sub-objectives**
(please delete as appropriate) 1. Reform	***(please delete as appropriate)*** 10 – Develop our organizational culture, processes and capabilities to be a thriving FT dedicated to our patients
Risk and Assurance	CSF10
Related Assurance Framework entries	BAF risk 10.9
Legal implications, regulatory and consultation requirements	

Action required by the Board: Approve the outcome of the 2012/13 board self assessment

Date: 21 May 2013

Isle of Wight NHS
NHS Trust

REVIEW OF
TRUST BOARD PERFORMANCE AND EFFECTIVENESS
2012/13

Board evaluation is a regulatory principle in Monitor's Code of Governance as main principle D2. This regulatory principle has a clear purpose, namely that it is an important measurement of effectiveness at the top of the organisation and links closely to the duties owed by Directors.

There are many sound reasons for establishing an annual culture of Board evaluation. It allows the Board a chance to benchmark itself against its own objectives and assess its rate of progress, it allows an assessment of the Board's skill mix for succession planning and it provides for a measurement of overall effectiveness. The following areas should be evaluated:

- The collective performance of the Board
- The performance of the Board's committees
- The individual performance of the directors

	Issue	Yes	No	Evidence
THE COLLECTIVE PERFORMANCE OF THE BOARD				
Principal Objective One – Licence to Operate *(Linked to performance target categories: Quality, Access, Finance, Management and Productivity)*				
A	Maintain clinical excellence: Have we improved patient care by reducing avoidable infections and providing a clean, safe environment? Have we provided efficient, safe and effective care, improving patient experience and clinical productivity?	**Y** **Y**		We have improved. Small number of infections control targets breached and pressure ulcers are still prevalent. Reducing rates of C.diff & MRSA. CQC assessment/assurance. Reduction in harm to patients through HCAI, Falls and Pressure Ulcers. Complaints in line with previous years trend with marginal reduction. • Infection Control Action Plan • Performance trend data against relevant indicators • Mortality data (SHMI/HSMR) • Patient satisfaction data
B	Have we achieved patient access national standards?	**Y**		On the whole all performance targets have been achieved. • Performance data against national access targets: 18 weeks, A&E, cancer waits
C	Have we achieved financial targets and delivered transformation programme?	**Y**		• Finance performance report • CIP progress report
D	Have we improved workforce engagement? Have we improved workforce effectiveness?	**Y**	**N**	There is a great deal of work to be done on the delivery of workforce effectiveness and engagement. The workforce will be fit for purpose if we deliver against the

				strategy. • Staff engagement: Big Discussion, Staff Survey, Friday Flame, FT Consultation • Triangulation of training, performance management activity, performance reports against relevant metrics **Action: deliver strategy**
Principal Objective Two – Organisational Capability *(Linked to performance target categories: Quality, Access, Finance, Management and Productivity)*				
A	Have we improved the quality of our buildings and facilities? *(Linked to the Estates Strategy Implementation Plan, including redevelopment outline business cases)*	**Y**		Business case for re-development still awaited. Some estate remains in a poor state of repair. Still have more to do. • Delivery of Capital Plan • Needs to be evidenced by Capital Board/Estates
B	Have we received timely, accurate and comprehensive clinical management information? *(Linked to the IM&T Strategy Implementation Plan)*		**N**	• Flash reporting; Board Performance Reports But do not believe we are in a position to say we have comprehensive *clinical* management information **Action: improve clinical management information to the Board**
C	Have we improved the planning process to better integrate service provision, research and education? *(Linked to the Integrated Business Plan)*	**Y**		There are pockets of this. • IBP Business Planning Process/triangulation of strategies, including workforce strategy • Directorate Business Plans & Support Services Business Plans
Principal Objective Three – Strategic Direction *(Linked to performance category: Productivity)*				
A	Have we delivered planned in-year service developments and transformation programme targets? *(Linked to the Integrated Business Plan)*	**Y**		Need to be evidenced by PMO. • Board Performance Reports • CIP reports • Hub development • Enhanced Recovery
B	Have we maintained and updated an Integrated Business Plan, including 5 year clinical service, finance and estates plan? *(Linked to the Integrated Business Plan)*	**Y**		IBP last updated January 2013
C	Have we further developed relationships and partnerships? Have we informed and involved key stakeholders in the Board's work? Have we checked their views?	**Y** **Y** **Y**		There is clear evidence of partnership working with commissioners, other stakeholders and business partners. We need to do more work at gaining peer/3rd

	Has the Board considered how else they can engage with stakeholders in a manner that is likely to add value and be proportionate?	**Y**		party views on the services we deliver. • Refinement of Communications engagement plan • Consultation on FT application/membership & governance • Updates to O&S Committee • Meetings with Council CX; Director of Community Services • Meetings with CCG • Health and Wellbeing Board • Meetings with MP • Meetings with staff side • Attendance at Patients Council
D	Have we met Foundation Trust milestones for the year?	**Y**		The reasons for non achievement sit outside the organisation. • All products delivered to schedule to March 2013 • FT Programme Plan • TFA milestones deferred by TDA: Board to Board/Application to Monitor • Letter from Stephen Dunn to Danny Fisher (March 2013)
Meeting Infrastructure and Support				
A	Does the Board receive timely information, of the right quality and sufficiently concise? Is the information in the right form to enable the Board to make sound decisions?	**Y** **Y**		• Board Performance Reports • Board reports requiring decisions • Evidence of Board decisions based on reports provided, e.g. self-certification **Action: Further work is required on the live data available to assess the quality of services being delivered.**
B	Does the Board periodically review organisational culture and plan to maintain a positive culture?	**Y**		However, this needs to be more of a focus for the Board in 2013 • Workforce metrics and key performance metrics (cultural indicators) reported to Board monthly • Annual staff survey and action plan **Action: extra focus on organisational culture in 2013/14**
C	Is the agenda set by the chair/vice chair sufficient to allow the Board to carry out its functions? Does the agenda prioritise the right issues? Is the Board satisfied that sufficient time is	**Y** **Y**		• Agendas • Minutes • Alignment of agenda with strategic risk controls

	spent on each agenda item? Does the chair ensure that there is sufficient challenge on each issue on the Board's agenda?	**Y** **Y**		
D	Does the time spent on strategy result in defined proposals to be incorporated into the Business Plan? Is the Board satisfied that it has identified the strategic risks facing the organisation and that it has the controls to manage them?	 **Y**	**N**	We need specific time allocated to discussing strategy • Agendas • Minutes • Business Plan **Action: allocated time in seminars to discuss strategy**

Conclusions:
Do we achieve the 3 Principal Objectives? *The 3 Principal Objectives have not yet been fully achieved.*

Is the Board satisfied that it has identified the strategic risks facing the organisation, and that it has the controls to manage them? *Yes*

Is the Board Assurance Framework effective? *Yes*
What, if anything, is required to enhance the Board?
Board Development Plan
Recruitment of a Clinical NED
We have identified the risks to the organisation but the quality agenda still needs to be embedded in the culture among our staff. There is inconsistency in the delivery of quality in the organisation which is being addressed.

THE PERFORMANCE OF THE BOARD'S COMMITTEES

A	Are the Board's sub-committees established and working in accordance with their terms of reference and remit?	**Y**		• Trust Board report establishing committee structure • Terms of reference • Agendas and minutes
B	Do the sub-committees demonstrate assurance, challenge, scrutiny and monitoring in respect of supporting the effective work of the Board?	**Y**		• Self-certification process • Minutes
C	Has consideration been given as to whether the sub-committees have sufficient capacity and capability to fulfil their roles?	**Y**		• NED members have skills and experience appropriate for the areas of work and are supported by appropriate senior management and Executive Directors • Trust Board report establishing committee structure • Terms of reference

Conclusions:
Do the sub-committees support the effectiveness of the overall Board?
Yes. Detailed business is discussed at relevant sub-committee and assurance is provided to the Board.
Do the sub-committees' annual reports demonstrate their effectiveness?
Sub-committees have not been running for a year. Annual Reports from sub-committees currently being prepared which includes a self-assessment checklist.
What, if anything, is required to enhance the sub-committees?
Sub-committees will be enhanced by the timely provision of information required to undertake their duties.

THE INDIVIDUAL PERFORMANCE OF THE DIRECTORS				
A	Does the Board have the right balance of skills, knowledge and experience to deal with current and anticipated challenges? Is a succession plan in place?		**N** **N**	A Clinical NED needed • External assessment reports: KPMG, BGAF, HDD, Foresight, SHA – identified need for Clinical NED **Action: Clinical NED appointment pending** **Succession plans being developed for all directors** **Stagger NED appointments**
B	Are performance appraisals of individual directors in their capacity as Board members undertaken annually?	**Y**		• Annual appraisals undertaken and documented
C	Are the Nolan principles of public life applied and are NEDs provided with the training and support to ensure they perform their duties in accordance with established principles of probity and transparency?	**Y**		• Nolan Principles cited in Committee terms of reference • NED training records • Board development
D	Does the Board collectively and individually model behaviours consistent with organisational values and culture?	**Y**		• Ernst & Young observation (Dec-12): The Board has an explicit Code of Conduct, updated in March 2012, which clearly sets out the behaviours expected of Board members
E	Do Board members understand their statutory duties of care and quality both personally and collectively?	**Y**		• Strategic objectives • Business Plan • Integrated performance report • Risk management arrangements • Board committee structures • Agendas and minutes
F	Have Board members built up a picture of what it is really like to be a patient in the hospital? Have directors asked how patients' experiences have shaped decisions in the past three months and the implications?	**Y** **Y**		There is greater work required in this field. The focus on patient experience will support this. Much improved with ad hoc walk rounds. • Patient stories • Board walk rounds • Decisions taken following Board walk rounds • Response to patient complaints and feedback

Conclusions:

Does the Board uphold the values of the Nolan principles throughout the conduct of its business and is this reflected within the decision making process? *Yes*

Has the working of the Board been to the best interest of the overall organisation and to the services provided? *Yes*

Does the Board meet its statutory duties of care and quality? *Yes*

What, if anything, is required to enhance the performance of the Board directors?

The performance of the Board directors will be enhanced by continued development to prepare for FT status, which will include Board development and individual personal plans, including monitoring 'mystery shopping' volunteers.
Board development plan
The following to be included within the self assessment checklist:

- *Compliance with the national Code of Conduct for Directors*
- *Compliance with statutory Duty of Candour*
- *How do NEDs maintain their independence*
- *How do NEDs hold the Board to account*

March 2013 (FGO)

Isle of Wight NHS Trust

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FOR PRESENTATION TO TRUST BOARD ON 29 MAY 2013

AUDIT AND CORPORATE RISK COMMITTEE

Minutes of the meeting of the Audit and Corporate Risk Committee held on the 22nd May 2013 at 12.00 p.m. in the Conference Room, St. Mary's Hospital, Newport.

PRESENT: Peter Taylor (Chairman)

In Attendance:
Kevin Suter, External Audit Manager
Rhys Manning, Senior Internal Auditor
Barry Eadle, LCFS
Mark Price, Company Secretary
Brian Johnston, Head of Corporate Governance & Risk
Clive Woodbridge, Deputy Director of Finance
Connie Wendes, Asst. Director of Health & Safety (Item 049/13 only)
Louise Carrington, Interim Head of Clinical Standards (Item057/13 only)
Carol Ogilvie, Senior Finance Manager (Item 058/13 only)
Iain Hendey, Asst. Director, PIDS (Item 058/13 only)
Andy Hollebon, Head of Communications (Item 050/13 only)
Michelle Russell, Communications Team (Item 050/13 only)
Theresa Gallard, Business & Projects Manager (Item 050/13 only)

Minuted by: Linda Mowle, Finance Governance Officer

Min. No.	Recommendations
049/13	**Fire Service Audit Report Update:** • **That the digitalisation of patients' records is undertaken as soon as possible and a project team set up as a priority to take forward the fire safety issues, particularly surrounding the Social Club**
050/13	**Annual Report & Accounts 2012/13:** • **Accounts be formally signed off on the 5th June 2013** • **The Annual Report should be strategic, setting out how the Trust has met is corporate objectives, priorities and targets, and should be short and concise. Focus should be on the 8 page summary document** • **The Quality Account to be presented on the 5th June 2013 for sign off subject to Stakeholder Statements**
052/13	**Review of Achievement of Corporate Objectives:** • **The Trust Board to determine the assessment criteria for success for the current year**
059/13	**The NHS Constitution:** • **Options to be endorsed by the Trust Board at the June 2013 meeting** • **Brian Johnston to monitor implementation** • **Options to be presented to Executive Board to raise awareness with the Clinical Directors**
062/13	**Legal Service Agreement:** • **The service should go out to tender no later than the end of October 2013**

Top Key Issues/Risks	Subject
Min. No. 053/13	Sub-committees annual reports -2012/13: embedded and working effectively, contributing to the organisation's corporate objectives
Min. No. 058/13	Budgets 2013/14 Sign Off: concern raised that the budgets should be signed off in March following Board approval, for the start of the financial year. Still outstanding.
Min. No. 065/13	Central Register of External Visits: the Cancer external peer review report to be picked up by the Quality & Clinical Performance Committee.
Min. No. 067/13	Counter Fraud: Annual Report 2012/13 to be an agenda item for the June Trust Board meeting.

043/13 APOLOGIES for absence were received from Sue Wadsworth, John Matthews, Nina Moorman, Chris Palmer and Andy Jefford.

044/13 QUORACY: The Chairman confirmed that the meeting was not quorate. As a result, the minutes of the meeting to be ratified by the Trust Board.

045/13 DECLARATIONS OF INTEREST: There were no declarations. The Register of Interests and Register of Gifts and Hospitality were available for scrutiny.

046/13 TERMS OF REFERENCE – MEMBERSHIP: Noted that Dr. Nina Moorman has been appointed as a non executive director with effect from the 20th May 2013.

On behalf of the Committee, the Chairman thanked Clive Woodbridge for all the work undertaken on its behalf and wished him well in his new role.

047/13 MINUTES: The minutes of the meeting held on the 8th March 2013 were signed by the Chairman as a true record.

048/13 MATTERS ARISING FROM PREVIOUS MINUTES: The schedule providing progress against actions arising from previous minutes was noted.

- **Min. No. 028/13 Public Sector Internal Audit Standards:** Letter dated 10 May 2013 confirming compliance with the Standards was tabled.

049/13 FIRE SERVICE AUDIT REPORT UPDATE: Connie Wendes presented the progress report. Noted the improved progress on fire warden training and fire drills, together with the fire risk assessment of patients' records throughout the Trust. The area of concern continues to be the Social Club. Noted that the Executive Director of Strategy & Commercial Development is preparing an action plan on the Social Club risks and that the Trust is pushing ahead on the strategic direction of the digitalisation of patient records, which will alleviate some of the risks. Interim safety measures are currently being looked into particularly around the storage of legacy records.

Recommendation: that the digitalisation of patients records is undertaken as soon as possible and a project team is set up as a priority to take forward the fire safety issues, particularly surrounding the Social Club.

050/13 DRAFT ANNUAL REPORT AND ACCOUNTS 2012/13: The following papers were received:

- Draft Annual Accounts – work still being undertaken on the log of queries
- Review of Statement on Going Concern
- Draft Directors' Certificates

- Accounting Policies Update
- Head of Internal Audit Opinion – significant assurance
- AC Management Assurance process
- Draft Governance Statement
- Draft outline Annual Report incorporating the Quality Account – presented by Andy Hollebon, Michelle Russell and Theresa Gallard. Concern expressed that previous recommendations on the annual report have still not been actioned. The final Annual Reported needs to be with external auditor by the 31st May in order that the Auditors Opinion is available for the 5th June. Noted that the Quality Account sign off is later in June but that it will be incorporated into the overall Annual Report when published.

Recommendation: The Annual Report and Accounts for 2012/13 be formally signed off on the 5th June 2012.
The Annual Report should be strategic, setting out how the Trust has met its corporate objectives, priorities and targets, and should be short and concise. Focus should be on the 8 page summary document.
The Quality Account be presented on the 5th June 2013 for sign off subject to Stakeholder Statements.

051/13 FOUNDATION TRUST PROGRAMME UPDATE: The Company Secretary presented the self-explanatory progress report covering:

- Communications and stakeholder engagement activity
- Key risks
- Trajectory to achieve FT status in Autumn 2014

052/13 REVIEW OF ACHIEVEMENT OF CORPORATE OBJECTIVES: Brian Johnston tabled the updated schedule on how the organisation has measured achievement of the corporate objectives. Noted that this has been included in the Annual Report.

Recommendation: The Trust Board to determine the assessment criteria for success for the current year.

053/13 SUB-COMMITTEES' ANNUAL REPORTS 2012/13: The following reports were received:

- Remuneration Committee
- Executive Board
- Foundation Trust Programme Board
- Nominations Committee (Shadow)
- Finance, Investment & Workforce Committee
- Mental Health Act Scrutiny Committee
- Charitable Funds Committee

The Chairman confirmed that assurance could be provided to the Trust Board that the sub-committees were embedded and working effectively, and contribute to meeting the organisation's corporate objectives.

The Quality & Clinical Performance Committee to submit its report to the next meeting. **Action: BJ**

Sub-Committees' Terms of Reference: The Company Secretary advised that all terms of reference were to be reviewed to ensure consistency and that there is no duplication.

054/13 PROGRESS ON AUDIT AND FRAUD RECOMMENDATIONS: Clive Woodbridge presented the report, advising that Internal Audit will be undertaking a review of the outstanding recommendations to determine which recommendations are now not relevant, particularly around IM&T with the introduction of the ISIS Project.

055/13 EXTERNAL AUDIT PROGRESS REPORT: Kevin Suter provided an update on the status of the audit on the annual accounts and report, advising that it was on target for the statutory deadline.

Annual Audit Fee 2013/14: The letter dated 8 April 2013 was received. Noted that the fee has been set by the Audit Commission for 5 years.

056/13 INTERNAL AUDIT CONTRACT EXTENSION: Concern was expressed at the long process by Procurement in issuing the 2 year contract extension. Clive Woodbridge to take forward. **Action: CW**

057/13 INTERNAL AUDIT: The following reports were noted:

- Internal Audit Charter
- Annual report 2012/13
- Strategic Plan 2013/14 – 2014/15
- Progress Report:
  - Human Resources: Starters & Leavers – Substantial assurance
  - Pharmacy – Substantial assurance
  - Bed Management – Substantial assurance
  - Clinical Governance – Substantial assurance
  - CQC Requirements – Substantial assurance
  - Quality Accounts – Substantial assurance
  - Board Assurance Framework & Risk Management – Substantial assurance
  - Contracting – Substantial assurance
  - Safeguarding Children & Vulnerable Adults – Limited assurance: Louise Carrington presented the action plan for the implementation of the recommendations, advising that all the actions are being addressed and will feed into the IA follow up report.

058/13 FINANCIAL CONTROL: Clive Woodbridge presented the following items:

Decisions to Suspend SOs: None to date.

Budgets 2013/14 Sign Off: Budgets are continuing to be reconciled. Concern raised that the expectation was that budgets should be signed off in March, following Board approval, for the commencement of the financial year, and that they still have not been signed off by the directorates two months into the financial year. **Action: CW**

SBS Payroll & Financial Accounting Audit Reports 2012/13: Noted that the reports comply with the Auditing Standards. However, it was felt that it was difficult to take assurance from what appears to be a limited sampling.

Waivers to SFIs: Waivers Nos. 18-26 14.2/13 to 27/3/13 and Nos. 1-2 26/4/13 agreed.

Reference Costs 2012/13 Submission: Carol Ogilvie and Iain Hendey gave a presentation on the background to the submission. The report on the submission was

noted and that this was being submitted to the FIWC before approval by the Board on the 29th May.

059/13 THE NHS CONSTITUTION: The NHS Constitution has been reviewed and re-issued on the 26th March 2013. In order to ensure that the Trust remains compliant/has regard to the Constitution:

Recommendation: Options be endorsed by the Trust Board at the June 2013 meeting
Brian Johnston to monitor implementation
Present to Executive Board to raise awareness with the Clinical Directors

060/13 CORPORATE GOVERNANCE FRAMEWORK: Brian Johnston advised that the following Policies are due for review:

- Code of Openness
- Code of Accountability for NHS Boards
- Standards of Business Conduct
- Accountable Officer Memorandum
- Contractual Duty of Candour

061/13 REGISTER OF STATUTORY AND FORMAL ROLES 2013: Brian Johnston tabled the updated Register in respect of the new directors' portfolios, advising that any changes to Board roles will also be included.

062/13 LEGAL SERVICE AGREEMENT: Brian Johnston advised that the contract with Bevan Brittan is to be extended for a further 3 / 4 months.

Recommendation: that the service should go out to tender no later than the end of October 2013.

063/13 IG TOOLKIT 2012/13: Final assessment report at 28th March 2013 received, denoting levels 2 and 3 status. With regard to the IA draft report, Brian Johnston reported that some of the recommendations were being challenged. The final report will be presented to the next meeting of the Committee.

064/13 BOARD ASSURANCE FRAMEWORK – CORPORATE RISKS: The new high level corporate risks were received and noted. Brian Johnston confirmed that these had been cross-referenced as usual and for next year the aim is for the BAF to be both strategic and operational, making the Framework more meaningful.

065/13 CENTRAL REGISTER OF EXTERNAL VISITS: The report detailing the visits within the last quarter was received. Noted that the Cancer external peer review report will be picked up by the Quality & Clinical Performance Committee.

066/13 CLINICAL AUDIT ANNUAL REPORT 2012/13: Deferred to next meeting.

067/13 COUNTER FRAUD: Barry Eadle presented the comprehensive, self-explanatory progress report highlighting the current investigations.

Annual Report 2012/13: To be an agenda item for the next Trust Board meeting.
Action: MP

068/13 AUDIT COMMISSION – NATIONAL FRAUD INITIATIVE (NFI): The update report, presented by Clive Woodbridge, was received and noted that work is currently on going.

069/13 COMMITTEES PROVIDING ASSURANCE: Minutes received and noted.

070/13 KEY ISSUES FOR REPORTING TO TRUST BOARD: Please refer to Key Issues/Risks.

071/13 ITEMS FOR NOTING: The following items were noted having been previously circulated by email:

- NHS Protect: New guidance for the prevention and detection of procurement fraud
- Grant Thornton Payroll ISAE3402 Report

072/13 INFORMATION ITEMS: The Chief Executive Bulletins which had previously been emailed were received.

073/13 DATES OF MEETINGS: To be held in the Conference Room at 12.00 – 2.30 p.m.:
21 August 2013
20 November 2013

Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON 29/05/2013

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FINANCE, INVESTMENT AND WORKFORCE COMMITTEE MEETING
Wednesday 22nd May 2013
3.00pm – 4.50pm

Present:	Peter Taylor	Non-Executive Director (Chair) (PT)
	Nick Wakefield	Non–Executive Director (Vice-Chair) (NW)
	Chris Palmer	Executive Director of Finance (CP)
	Alan Sheward	Executive Director of Nursing and Workforce (AWS)
	Felicity Greene	Executive Director of Strategic Planning and Commercial Development (FG)
	Clive Woodbridge	Deputy Director of Finance (CW)
	Karen Jones	Workforce Planning & Information Manager (KJ)
In Attendance:	Abolfazl Abdi	Assistant Director of Contracting (AA)
	Nikki Turner	Deputy Associate Director (NT)
	Catherine Crocker	Contracts Manager (CC)
	Heather Cooper	Training Manager (HC)
	Kevin Bolan	Associate Director Facilities (KBo)
	Iain Hendey	Performance Manager (IH)
	Andrew Shorkey	Programme Management Officer – Transition Programme (AS)
Minuted by:	Sarah Booker	PA to Executive Director of Finance (SB)

Key Issues to be reported to the Trust Board:

Financial Performance

- The committee finds it unsatisfactory that at this point in time directorate budgets are still not signed off
- Month 1 performance will need more explanation on variances at Board.
- The committee recommends the use of Procure21 as set out in the minutes.

Workforce Performance

- There is still more work to do around workforce reporting and controls. AWS is taking this and the other observations of the committee forward.

Self Certification Review

- The committee recommends to the Board that the position presented i.e. “at risk” option should be followed as the parameters have changed from the previous month and the Trust needs to put procedures in place to do the necessary self assessment.

Action

094/12 APOLOGIES

Mark Elmore, Deputy Director of Human Resources (ME) (Karen Jones deputising); Mark Pugh, Executive Medical Director (MPu).

095/12 CONFIRMATION OF QUORACY

The quorum was confirmed with members including two Non-Executive Directors in attendance.

096/12 **DECLARATIONS OF INTEREST**

None were declared.

097/12 **APPROVAL OF MINUTES**

Minutes from the previous meeting on 17th April 2013 were approved by the Chair.

098/12 **SCHEDULE OF ACTIONS**

The schedule of actions taken from the previous meeting on 17th April was discussed. Outstanding actions will be considered at the next meeting to ensure completion.

099/12 **LONGER TERM STRATEGY AND PLANNING**

LTFM Status Update:

CW noted that we are awaiting Monitor to send a revised version of the LTFM template which is expected within the next fortnight. It will then be repopulated and reconciled back to the current position. The LTFM will be submitted at the end of August.

Action Plan:
The action plan was discussed. The LTFM post interviews will take place on the 4th June for the interim post. The committee discussed the action plan and noted the lead times for each area.

Review and Approve the Annual Budget:
CW is still working on this paper as there are outstanding issues with some CIPs. The Committee were therefore unable to recommend this to the May Trust Board meeting. A copy of the paper was requested prior to Board.

Action note: CW to provide this paper for the Board meeting. **CW**

100/12 **FINANCIAL PERFORMANCE**

Month 1 Financial Performance Report
Financial Risk Rating:
Overall ratings unchanged from prior month, overall rating of 3 after normalisation adjustments.

Summary:

- It was noted that the month 1 figures are indicative only because of the time constraints in producing year end accounts and uploading budgets into the ledger. Therefore some adjustments have not necessarily been reflected in the Month 1 position e.g. reversal of all agency accruals.
- Income - Month 1 Income and Expenditure (I & E) position is on plan at a surplus of £189k. Income in the month is £1,056k above plan. Patient care income is higher due to Non Contractual Activity (NCA) income. Acute over performance of £684k is due to the prison contract extension income and Beacon Dermatology contract income and drug cost recharge. EMH income is the positive variance in Corporate.
- Pay - In month total pay is above plan by £618k with a £273k spend above plan in Acute due to the prison contract extension and Beacon dermatology costs. Spend above plan of £200k in Corporate is mainly the EMH pay costs. The Month 2 position will accurately reflect the achievements in various areas.
- Non Pay – In month the non pay spend is above plan by £536k. Acute spend is above plan by £406k is due to the prison contract extension and drug costs incurred.

Cost Improvement Programme (CIP):
Achievement of CIPs yet to be fully validated against milestones. As at Month 1, £7,035k are unallocated as some major projects are cross-directorate but from Month 2 these will have been allocated to Directorates. £1.3m has been included in Directorate budgets.

Working Capital and Treasury:
Cash 'in-hand' and 'at-bank' at Month 1 was £9,638k.

Capital:
Capital spend projected to be £7.56m. No YTD spend.

Debtor Analysis:

- The total aged debt over 90 days fell to £167k. The top ten debts over 90 days represent 51% of this total.
- The total debt over 30 days to the end of March is £546k.
- HMP Prison debt is still expected to be paid off in May. SBS are chasing the payment.
- PT recommended interest is included on the terms of business as although the terms state immediate payment is expected there are no sanctions stated if payment is not received within a specific timeframe.

Action note: CW to look at including this on the terms of business. **CW**

Cashflow:

Action note: CW to send an electronic version to committee members after this meeting. **CW**

101/12 **FINANCE FUNCTIONS**

Contract Status Report:

CCG Heads of Agreement and Contract were signed. The Committee received the status report and discussed the update around the I.W C.C.G, NHS England – The Wessex Area Team, Local Authority and Commissioning Support South.

Risk Share Framework Agreement:

The Committee discussed and received the 2013/14 Risk Share Framework illustration which has been agreed by the Commissioners. AWS will ensure all CQUINS are delivered correctly this year.

Mental Health PbR

This was deferred to the next meeting when the service manager would be attending.

Community Services – developing an activity based contract

The Committee discussed any potential risks that may occur through this approach and ways of mitigating these risks. This paper could identify ways in which some areas could deliver care in a more cost effective way, however, the Committee wanted clarity around the provision of resources required to take this initiative forward. The Committee agreed to discuss this further at the next meeting.

Action note: CC and NT to find further evidence to support this paper. **CC/NT**

102/12 Self Certification Review

Andrew Shorkey identified changes to the self-certification process following the transfer of oversight arrangements from the SHA to the Trust Development Authority (TDA). Elements of self-certification such as the Financial Risk Rating, Financial Risk Triggers and Contractual data no longer formed part of the monthly return. The TDA's self-certification process was focused around Board certification in respect to defined Board Statements, a selection of Monitor's Licence Conditions and Foundation Trust Programme Milestones.

There was a lack of clarity around new performance measures within the TDA's *Accountability Framework* and systems and processes would need to be implemented to provide assurance to the Board around Monitor's Licence Conditions. Therefore, it was proposed that a number of elements within the return should be marked as 'at risk' until this was resolved. Chris Palmer advised that Board Statement 11 required review as it might be at risk due to issues with an area of compliance. AS would seek advice from Information Governance.

Members of the committee agreed that although an intuitive judgement could be made with respect to the Licence Conditions there was insufficient evidence available at present to support such a judgement and that further clarity was required with respect to the *Accountability Framework* to assure compliance with the Board Statements identified.
The committee agreed to recommend that Trust Board support submission as

proposed.

ASh

Action note: AS to seek advice from Information Governance.

103/12 Reference Costs Process

A paper was presented to the Committee regarding reference costs processes. As part of the national drive to improve both costing standards and data quality, and in particular within the Reference Costs submission submitted annually to the Department of Health (DOH), the changes to the 2012/13 Reference Costs guidance included the necessity for the organisation to complete a Self Assurance Quality Checklist and for the Board to be advised of the current position. The aim of the paper is to inform the Board on national standards required, to brief the Board on organisations readiness and request approval for the Executive Director of Finance's sign off.

Due to the timing of future Board meetings it will not be possible to provide a fully completed Self Assurance Quality Checklist prior to the first draft submission. This will mean that some of the actions will remain outstanding in order to comply with the national deadlines.

It is proposed that a second iteration of the Self Assurance Quality Checklist is presented at the Board on the 26th June in order to report an updated position.

The Committee gave their assurance to the Board on this.

104/12 **INVESTMENT**

Treasury Management Policy

The Treasury Management Policy was not approved at the last Policy Management meeting as there was no one attending to present it to the group. It will be re sent to the next Policy Management meeting and appropriate representation arranged.

Action note: CW to re-send this to the next Policy Management meeting and arrange to present. **CW**

105/12 **WORKFORCE**

Month 1 Workforce Performance Report:
Workforce:

- The workforce FTE, workforce variable FTE, workforce total FTE, the total in month staff in post paybill, in month variable hours, in month total paybill and the year-to-date paybill have been given a red rag rating. There has been a spend above plan of £618k on the in month total paybill with a significant increase in the in month variable hours. Note, the rag rating has been amended to Amber due to the recruitment of NHS Creative Services and substantive recruitment to posts previously filled by Agency.

Action note: PT requested a breakdown of this spend above plan to show **KJ**

how much is represented by, agency, locum and bank cover.

Sickness Absence:

- The sickness absence figure has increased slightly on the previous month from 3.05% to 3.48%.
- In April 38.41FTE bank was used to cover Long Term Sickness Absence and 55.7FTE for Short Term.
- In April 38.4FTE bank was used to cover annual leave which is a decrease of 16.6FTE on last month. The number of staff on leave during March could be due to them having to take their leave before the end of the financial year.

Action note: KJ to provide clarity around the number of staff on leave during March. **KJ**

There is no allocation in the budget to cover sickness and backfill only occurs in clinical areas. The ESR dashboard should highlight areas in which sickness is high. When Roster Perform comes into action it will indicate exactly where back fill is being used.

Action note: Pursue reporting from Roster Perform. **AWS/KJ**

Appraisals:

- A cumulative figure of 6.01% of renewed appraisals have been undertaken to date. We achieved 95.8% by the end of March 2013. When the competencies have been input into the roster system this will indicate how many have been undertaken and when they are due.

Turnover:

- In Month turnover for March 2013 was 0.79% against the Trust expectation of a minimum of 5%. The rolling annual NHS South ceiling is 15% and currently rolling annual turnover is 1.86%.
- Turnover/natural wastage will be used to identify skill mix or cost improvement opportunities.
- There are currently 61 outstanding vacancies. However further analysis needs to be undertaken to understand if this is against plan.

Action note: KJ to provide this committee with a breakdown of these vacancies and where they are situated within the Trust. **KJ**

Overpayment:

- Total outstanding overpayment for April 2013 is £120,528. New overpayments for April amount to £6139 attributed to:
    1. Manager errors £6139 due to 2 inputting errors which have been addressed.
    2. SBS £0
    3. HR Input £0

This figure is decreasing and the payments will continue to be chased.

Underpayment:

- Total outstanding underpayments for March 2013 is £14,612. Underpayments from July to March is £85,740. Late submission of increase in hours changes and incorrect termination dates on forms have attributed £5,000 to the underpayments total.

Employee Relations:

- 21 Employee cases in April, all of which are supported by Human Resources. There are 104 ongoing cases.

Action note: KJ to provide summary level details on these cases. **KJ**

Development and Training:

- Organisation wide compliance for core mandatory training is 72%, this indicates a 5% increase from last month. As a Trust we aim to reach an 80% compliance.

The Committee discussed how we can be assured the mandatory training is intelligently targeted to individuals.

Medics Data:

- 70% of job plans have been electronically signed off; 6% are awaiting 2nd Manager sign off; 7% awaiting 1st Manager sign off. These must be signed off urgently as the Reference Costs team use them to allocate costs and for SLR.

Action note: KJ to escalate this to staff involved. **KJ**

Health & Wellbeing:

- Outdoor Gym and Trim Trail – business case now with procurement, awaiting sign off and will be submitted to Charitable Funds.
- Planned staff HWB Open Days – Friday 28th June in the Conference Room and Wednesday 13th November will have topical themes and health checks i.e. blood pressure, weight etc.
- Free 12 week referral to weight management scheme – 99 staff have now taken up this opportunity.
- Staff HWB Strategy 2013/14 – to include weight management, physical activity and alcohol as main actions.
- Alcohol and substance misuse requires a robust and approved policy which will then meet a level of excellence. This is currently in draft format and under consultation. Smoking policy amended to reflect e-cigarette and en route for approval.

End of Year Redundancy Summary:
There were no redundancies.

106/12 **ANY OTHER BUSINESS**

Recommendation for continued use of ProCure 21+ (formerly Procure 21)
This is a procurement process that has been implemented and fully developed by the Department of Health (DOH). It is fully compliant with the OJEU tender process supported by the DOH, OGC, NAO and HM Treasury. The committee has approved the case and recommended it to be presented to the Trust Board next week.

107/12 **KEY ISSUES FOR REPORTING TO BOARD**

Financial performance

- The committee finds it unsatisfactory that at this point in time directorate budgets are still not signed off
- Month 1 performance will need more explanation on variances at Board.
- The committee recommends the use of Procure21 as set out in the minutes.

Workforce performance

- There is still more work to do around workforce reporting and controls. AWS is taking this and the other observations of the committee forward.

Self certification review

- The committee recommends to the Board that the position presented i.e. “at risk” option should be followed as the parameters have changed from the previous month and the Trust needs to put procedures in place to do the necessary self assessment.

108/12 **DATE OF NEXT MEETING:** Wednesday 19th June 2013, 1.30pm – 3.20pm in the Conference Room.

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD ON 29th MAY 2013

Title	2013-13 Reference Costs Board approval paper
Sponsoring Director	Executive Director of Finance
Author(s)	Iain Hendey, Assistant Director – Performance Information Decision Support, Carol Ogilvie, Senior Finance Manager
Purpose	To inform the Board on changes to national standards for the annual Reference Costs submission, to brief the Board on the organisations readiness and request approval for the Finance Director's sign off

Previously considered by (state date):	
Executive Board	
Audit and Corporate Risk Committee	22/05/13
Remuneration Committee	
Finance, Investment & Workforce Committee	22/05/13
Mental Health Act Scrutiny Committee	
Charitable Funds Committee	
Quality & Clinical Performance Committee	
Nominations Committee (Shadow)	
Foundation Trust Programme Board	

Staff, stakeholder, patient and public engagement:

Executive Summary:

As part of the national drive to improve both costing standards and data quality, and in particular within the Reference Costs submission submitted annually to the Department of Health (DOH), the changes to the 2012/13 Reference Costs guidance included the necessity for the organisation to complete a Self Assurance Quality Checklist and for the Board to be advised of the current position.

Related Trust objectives	**Sub-objectives**
3 – Productivity	Improving value for money we off and generating a surplus
Risk and Assurance	5.48 Policy and tariff regime threaten viable service provision
Related Assurance Framework entries	
Legal implications, regulatory and consultation requirements	

Action required by the Board:

Approval for the Finance Director's sign off of the 2012-13 Reference Costs submission

Isle of Wight NHS
NHS Trust

2012-13 Reference Costs Submission 16th July 2013

Aim and Purpose

As part of the national drive to improve both costing standards and data quality, and in particular within the Reference Costs submission submitted annually to the Department of Health (DOH), the changes to the 2012/13 Reference Costs guidance included the necessity for the organisation to complete a Self Assurance Quality Checklist and for the Board to be advised of the current position. The aim of this paper is to inform the Board on national standards required, to brief the Board on organisations readiness and request approval for the Finance Director's sign off.

Reference costs guidance for 2012-13

The onus on the production of sound, accurate and timely data that is right first time rests with each NHS organisation. In 2012-13, in addition to the existing requirement for Finance Directors to sign off the data, the Department of Health are adding a requirement for Boards to approve the costing process that supports the reference costs submission. The guidance recommends that Board confirmation should be obtained in advance of the reference costs submission, which is due at the latest on the 16th July 2013. This change is designed to raise the profile of costing and data quality.

The Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is therefore required to confirm that it is satisfied with the trust's costing processes and systems, and that the trust will submit its reference cost return in accordance with guidance.

In providing this confirmation, Boards may wish to satisfy themselves that procedures are in place to ensure that the self-assessment quality checklist can be completed at the time of the reference cost submission. Trusts that are unable to provide this confirmation should provide details of non-compliance. Specifically, Boards are required to confirm that:

(a) Costs will be prepared with due regard to the principles and standards set out in Monitor's Approved Costing Guidance

(b) Appropriate costing and information capture systems are in operation

(c) Costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance

(d) Procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return.

The Finance Director is required to sign off the reference costs return in Unify2, confirming that:

(a) The Board has approved the costing process ahead of the collection

(b) The return has been reconciled internally and is an accurate reflection of cost and activity terms of the services provided

(c) Finance teams have actively engaged clinicians and other relevant non-finance stakeholders in the costing process

(d) The self-assessment quality checklist has been completed and used to improve quality and to provide assurance to the Department about the accuracy of the return.

External assurance

The DOH has given notice that some trusts will be subject to external review as part of a wider external assurance programme.

Trusts will be selected for review based on an assessment of the risks of errors and the overall impact of these errors on reference costs as a whole. These external reviews are expected to cover:

(a) Board approval and Finance Director sign off

(b) Verification and reconciliation checks of the total costs and activity data included in the submission

(c) Review of outlying costs, both high and low

(d) Assessment of benchmarking information

(e) Analysis and review of variances and explanations for those variances

(f) An assessment of the quality of data from systems used to generate submissions, including a deeper dive into known areas of variation, such as chemotherapy and radiotherapy, and local anomalous areas

(g) Checks of the completeness and validity of the overall submission.

Self-assessment quality checklist (Appendix 1)

The attached indicates the current situation, however it should be noted that the 2012-13 model has only just been created and therefore the indicators at this stage reflect a 'work in progress' position. An additional column has been added to show the anticipated final position.

Summary

Due to the timing of future Board meetings it will not be possible to provide a fully completed Self Assurance Quality Checklist prior to the first draft submission. This will mean that some of the actions will remain outstanding in order to comply with the national deadlines.

It is proposed that a second iteration of the Self Assurance Quality Checklist is presented at the Board on the 26th June in order to report an updated position.

Iain Hendey, Assistant Director, PIDS

Carol Ogilvie, Snr Finance Manager

Self-assessment quality checklist

Appendix 1

The checklist incorporated within the following table, builds on the Audit Commission's quality checklist introduced in 2011-12, and must be completed in Unify2 by all trusts as part of their 2012-13 return.

Check	Response	Current Response	Planned Final Response	Comments
Total costs: The 2012-13 reference costs quantum has been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	o Fully reconciled to within +/- 1% of the signed annual accounts			Anticipated that the latest date for signing off is the 10th June with the Trusts submission date being the 16th July
	o Fully reconciled to within +/- 1% of the draft annual accounts [state reason]	Currently developing model		Until the model is finished to 1st draft this cannot be confirmed, as issues may need to be rectified, however this is unlikely to occur
Total activity: The activity information used in the reference costs submission to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	o Fully reconciled and documented			
	o Partly reconciled	Currently not all data is complete		Currently not all data is complete
	o Not reconciled			
	o n/a – reconciliation completed but to another source [state reason]			A planned reconciliation is to be undertaken between the reference costs source data and data extracted from the Secondary Uses Service (SUS)
	o n/a – no activity comparable to HES within the submission			
Sense check: All unit costs under £5 have been reviewed and are justifiable (direct access pathology services are exempt)	o All unit costs under £5 reviewed and justified [state reason]			
	o n/a – no costs under £5 within the submission	Until the model is finished to 1st draft this cannot be confirmed, as issues may need to be rectified, however this is unlikely to occur		
Sense check: All unit costs over £50,000 have been reviewed and are justified	o All unit costs over £50,000 reviewed and justified [state reason]			
	o n/a – no costs over £50,000 within the submission	Until the model is finished to 1st draft this cannot be confirmed, as issues may need to be rectified, however this is unlikely to occur		

Sense check: All unit cost outliers (defined as less than one-tenth or more than ten times the previous year's national mean average unit cost) have been reviewed and are justifiable	o All unit cost outliers reviewed and justified [state reason]	Until the model is finished to 1st draft this cannot be confirmed, as issues may need to be rectified, and then any outliers identified and reasons justified		
	o n/a – no unit cost outliers within the submission			

Benchmarking: Data has been benchmarked where possible (Allowing for the significant number of HRG changes in 2012-13.) against national data for individual unit costs and for activity volumes (the previous year's information is available in the Audit Commission's National Benchmarker)	o All cost and activity data within the submission has been benchmarked using the Audit Commission's National Benchmarker prior to submission			
	o All cost and activity data within the submission has been benchmarked using another benchmarking process [state]			
	o Some but not all cost and activity data within the submission has been benchmarked using the Audit Commission's National Benchmarker prior to submission	This is done as a matter of course within Service reviews throughout the year.		
	o Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state]			
	o No benchmarking performed on the cost data prior to submission			

Data quality: Assurance is obtained over the quality of data for 2012-13	o An external audit has been performed on data quality for 2012-13	An external audit is carried out annually on clinical coding		
	o An internal audit has been performed on data quality for 2012-13			
	o Internal management checks have provided assurance over data quality for 2012-13	As part of the Board performance report a section on data quality relating to activity recorded at patient level, is covered. Including completeness of various fields submitted to SUS		
	o Assurance has been obtained over data quality but not for 2012-13			
	o No assurance has been obtained over data quality			

	o An external audit has been performed on costing and information system reliability for 2012-13	An independent review is being carried during late May 2013		
	o An internal audit has been performed on costing and information system reliability for 2012-13			

Data quality: Assurance is obtained over the reliability of costing and information systems	o Internal management checks have provided assurance over costing and information system reliability for 2012-13	Since the external Audit in 2010/11, the system has undergone numerous rebuilds in order to incorporate updates in the HFMA Clinical Standards Costing Manual and the Monitor Approved Costing Guidance (published Feb 2013)		
	o Assurance has been obtained over costing and information system reliability but not for 2012-13	External Audit reviewed the costing system following it's implementation in 2010/11, as part of the 2009/10 Reference Costs Audit.		
	o No assurance has been obtained over costing and information system reliability			

Data quality: Where issues have been identified in the work performed on the 2012-13 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2012-13 reference costs submission	o All exceptions have been resolved and the risk of inaccuracy in the 2012-13 reference costs submission fully mitigated			
	o Some exceptions have been resolved but not all	We are currently undertaking a review of all previous exceptions and applying reasonable checks to eliminate exceptions where identified.		
	o Exceptions have all been resolved going forward but there is an historical risk to the accuracy of the 2012-13 reference costs submission due to resolution being during 2012-13 and not being applied retrospectively			
	o Exceptions have yet to be resolved			
	o n/a – no exceptions noted			

Data quality: All other non-mandatory validations as specified in the guidance and workbooks have been investigated and necessary corrections made	o All non-mandatory validations have been investigated and necessary corrections made			
	o All non-mandatory validations have been investigated and some but not all necessary corrections have been made [specify and state reason]	Until the first submission during the w/c 24th June it is impossible to predict what non-mandatory validations will occur. Following this submission all validation errors will be investigated and it is planned that corrections will be made.		

ISLE OF WIGHT NHS TRUST

FOUNDATION TRUST PROGRAMME BOARD

Enc M

TUESDAY 23 APRIL 2013 BETWEEN 11:00 – 12:30
SMALL MEETINGS ROOM, PCT HQ, SOUTH BLOCK

NOTES

PRESENT

Karen Baker (Chair)	Peter Taylor	Mark Price	Chris Palmer
Mark Pugh	Felicity Greene	Sarah Johnston (for Alan Sheward)	Sue Wadsworth

1. APOLOGIES

Danny Fisher, Alan Sheward

IN ATTENDANCE

Andrew Shorkey, Andy Hollebon, Dave Arnold (Item 6)

Top Key Issues	Subject
3	Concern on the current timeline to be raised with Trust Development Authority (TDA) and Monitor
5	Annual report and Terms of Reference approved
8	Our expectations with respect to transitional funding to be raised with TDA

ACTION

2. **Notes and matters arising from** 26 March 2013

The notes were accepted as a correct record of the meeting. Updates were provided against outstanding actions within the action tracker and the action tracker would be updated accordingly. With respect to action no. 298, a session on the Quality Governance Framework would also be included in the induction programme for the new Clinical NED starting on 20 May 2013. **AS** **SJ**

3. **FT Timeline**

Three of the 24 Trusts under the remit of NHS South were ahead of us in the FT application process and the TDA would be applying learning from the progress of these applications to our application timeline. MP advised that as a consequence the Board to Board meeting with the TDA would not happen before 4 October 2013 and a firm date could not yet be confirmed. MTP questioned the length of the TDA application phase and MP advised that the timeframe reflected the revised guidance from Monitor and work would be ongoing during this period to prepare for the Monitor assessment. CP raised concerns relating to the January 2014 submission date and the issues encountered during the January 2013 submission. KB advised that we would be in a better position in 2014 and that the expectations of TDA and Monitor would need to be managed accordingly. PT advised that it would be prudent to raise any issues relating to the timeline to both TDA and Monitor. A letter would be drafted by MP for KB to manage expectations and gain assurance to progress the current timeline. **MP**

AS introduced the work breakdown document and explained how it had been developed. Activity identified would be refined with workstreams and key milestones would be used to populate the next iteration of the high level programme plan that would be brought back to the May meeting. **AS**

4. **Action Plan Updates**

AS had developed exception reports against the 5 individual FT action plans and explained that the action plans were being merged into a single document together with the TDA and Monitor activity to create a comprehensive work programme. The exception reports identified action plan specific performance information and activities within plans requiring review. KB complemented the change in format and AS stated that they would be used at future meetings to provide assurance and highlight issues relating to action delivery. In some areas slippage appeared to be excessive and AS advised that he would review the data and report back. With respect to process, AS advised that he would continue to chase updates and evidence of delivery and would escalate appropriately if there were any issues. It was noted the updates against the Board Development plan would be superseded as Foresight would be recasting the plan following their recent work with the Board. This will be discussed at the Nominations Committee meeting next month. **AS** **AS** **AS** **MP/AS**

5. **Annual Report and Terms of Reference**

MP advised that as a sub-committee of the Board the FT Programme Board was required to provide an annual report. The annual report was approved subject to the identification of instances where deputies attended on behalf of members. **AS**

The Terms of Reference had been updated to reflect changes in oversight arrangements, executive portfolio changes and our current position in the application process. The Terms of Reference were approved subject to the inclusion of a sentence detailing vice chairing arrangements. **AS**

6. **Workstream Updates**

Business Planning

A project plan was being developed for the IBP refresh and the IBP would be included on the agenda for the May meeting. **AS**

Communications and Engagement

AH circulated a list of membership recruitment events and asked that Programme Board members consider their availability to support some of the events. A Chamber of Commerce business breakfast would be hosted in the Full Circle on 5 July as part of the recruitment drive. Membership had now reached 657 and a Membership Officer had now been appointed. Staff from across the Trust had been targeted to support membership recruitment. **All** **AWS/AH**

Finance

Dave Arnold attended to advise on the process for managing the delivery of CIPs. An assessment of current CIP plans had been undertaken and a risk assessment applied to CIPs accordingly. There was a lack of visibility of detailed plans and this gave rise to risk. Work was ongoing to ensure that sufficiently robust plans were in place to manage the delivery of CIPs. CP advised that as an organisation we need to refocus on value improvement rather than cost improvement. It was noted that the process for the quality impact assessment of CIPs should be submitted to the Audit Committee for ratification and reports on quality impact assessments should be submitted to Quality and Clinical Performance Committee for assurance. **DA** **SJ**

CP advised that Heads of Agreement with commissioners had been signed and the risk share agreement should be in place by the end of April.

7. **Communications and Stakeholder Engagement**

This item was substantially covered under item 6 above.

8. **Programme Governance and Approvals**

(i) Risk Management

AS introduced the risk report and advised that with the commencement of the new financial year arrangements relating to transitional funding would give rise to a degree of risk with respect to resourcing the programme. CP would provide information relating to the TDA position on transitional funding for 2013/14. Our expectation with respect to transitional funding would be flagged with the TDA area team. **CP** **CP/MP**
AS also identified that there was still a degree of risk relating to capacity in key areas and as a consequence the current risk rating for R001 was recommended to be downgraded from AMBER to AMBER/RED. This was approved by the Programme Board.

(ii) Programme Budget

AS advised that due to the year end closedown of accounts an update had not been available for this meeting. An update would be circulated as soon as the information was available from the finance team. **AS**

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

A number of events had been attended and in general members were pleased with events that had been attended. CP would be circulating notes from a recent event, particularly focusing on value improvement. AS would check whether AWS had access to the FTN Clinical Network. **CP** **AS**

10. **Any other Business**

A discussion took place relating to the *Francis Report* and vision and values. It was agreed that SJ would link with Terence Hart with respect to a bottom up approach around vision and values building on, but not replicating, previous work. **SJ**

AH advised that *My life a full life* and working with the Isle of Wight NHS featured in the Isle of Wight Conservative Party's local election manifesto.

With respect to communication, MTP suggested that it would be useful to be able to visually communicate our progress to date around FT. KB identified the exception report for the HDD 1 action plan as a good example. AS would prepare some visual material for consideration. **AS**

11. **Future Meetings**

The next meeting was scheduled for 11:00-12:30hrs, Tuesday 28 May 2013, Small Meetings Room, South Block

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

MENTAL HEALTH ACT SCRUTINY COMMITTEE

FOR PRESENTATION TO PUBLIC BOARD ON 29th MAY 2013

Minutes of the meeting held on 8 May 2013, Family Therapy Room, Sevenacres

Present: John Matthews (Deputy Chair), Stephen Ward, Tim Higginbotham, Elisa Stanley, Julia Coles, Alison Hounslow (Minutes)

Key Issues for Trust Board and Community Health Directorate Board

1. The lack of and urgent need for independent S12 approved doctors.
2. Assurance that CTOs are effective and appropriate on IOW.
3. MHA data.

1. Apologies: Peter Taylor (Chair), Simon Dixey, Su Morris

2. Minutes of the Meeting of 23 January 2013

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

3. Matters Arising

MHA Scheme of Delegation: This has now been included in the Trust Scheme of Delegation.

Risk assessment for S17 leave: This was an issue raised by CQC as there were no explicit risk assessments recorded when patients were going on leave. SW has discussed this issue with Ward Managers; a new procedure has been instigated and recording will be on Paris. Detail recorded will relate to overall perception of risk as some patients can leave and return several times during one day. Ward Managers have been handed CQC guidance.

This issue to be shared with the Quality Committee. **Action: ES**

Audit of S17 leave will include the use of risk assessments in the future. **Action: ES**

4. Service User Representative

In the absence of JG there is no update on the proposed service user representative. There was discussion surrounding the appropriateness of an advocate rather than a patient attending. This will be further discussed in July.

Action: SW to put on agenda for July meeting

5. CQC Report Monitoring the MHA in 2011/12

Increased use of compulsory detention: This report stated that nationally there was a rise of 5% on the previous years' figures. This is reflected locally. There has been a consistent year on year increase from 2007/08 – 2011/12. To clarify: the figures used were the number of admissions under section; not the number of sections (each admission could involve more than one section).

The use of CTOs has risen by 10% in the same period; their purpose being to reduce numbers in hospital and failing to achieve that ideal.

4% (nationally) of records showed irregularity in processes. This seems very high and we would be very concerned if our own figures were that high. Local CQC inspections very rarely find irregularities.

Reference was made to a 20 year study which indicated a 60% reduction in psychiatric bed numbers and a 60% increase in number of compulsory admissions during the same period. This may be coincidental rather than causative.

Care planning: CQC visits have noted improvements in care planning over the last 3 years on IOW, with improved levels of patient and family involvement and information sharing. The most recent service user survey showed improvement. Staff are making an effort to improve communication with carers. It was acknowledged that confidentiality can be used as a barrier to information sharing. The training of staff to include quality issues to be revised.

Action: SW

Capacity and Consent: There have been recurring comments from CQC on the lack of record of capacity assessments in discussions with patients of their treatment. This is now being addressed with a revised form for the recording of such discussions.

6. Independent S12 Approved Doctors

Dr Denman-Johnson and Dr Brand will stop their work with MH assessments at the end of May as they both retire. They participate in over 25% of all MH assessments. There is an urgent need for more doctors to be involved in this work; John Partridge is supporting this and promoting amongst existing doctors.

Contingency plans are that current psychiatrists are offering their help; this will lead to more MHAAs being OOH and increased expense. S4 can be used as only one doctor is required but this is limited to 72 hours detention.

The Clinical Commissioning Group need to be informed of the urgency of this matter.

Action: SW

7. OCTET CTO Trial

This trial looked at the efficacy of CTOs which were introduced to reduce repeated admissions into hospital. The conclusion was that there were no differences between patients discharged on a CTO or those cleanly discharged from hospital.

There has also been a study by North Staffordshire Combined Healthcare NHS Trust which concluded that CTOs do have benefits.

The IOW experience of CTOs is that they do seem to be working, although there are not currently any official statistics to confirm this. A CTO is effective if used as part of an effective care plan and has appropriate support and monitoring.

ES reported that patients, however, feel they are restrictive and on occasion staff use CTOs as a means to speed up discharge and enforce medication compliance. ES has looked at level of compliance with policy. Psychiatrists support the use of CTOs.

JM stated that the Board needs assurance that CTOs are being used effectively and within appropriate care plans. It was suggested that a further CTO audit take place.

Action: ES

8. MHA Data 2012/13

SW shared the analysis of the MHA assessment data collated over recent years. For the year 2012/13 there were 411 MHA assessments; 179 were as a result of S136 and of those, 108 were not admitted into hospital (60%).

There are considerable costs involved with each MHA assessment - £300-£600 per patient.

Operation Serenity is a relatively new project which involves joint patrols by Police and MH service staff. There are patrols on Friday and Saturday nights which reduce the number of people brought to Sevenacres inappropriately. From the beginning of June, there will be patrols every night of the week. Data currently shows an estimated 9 or 10 S136 admissions are avoided each month.

The number of sections used since 2005 has doubled. When short term sections (in particular Police powers under section 136) are excluded, the increase is much less. Some increase can be blamed on changes in police policies (guidance on the use of 'drunk and disorderly' and 'breach of the peace' arrest powers. Use of the Sevenacres place of safety in place of the police station reduces Police incentives to consider alternatives. Other factors discussed included varying life stresses such as the economy and isolation within the community.

9. Any Other Business

Annual Report to Trust Board and Community Health Directorate Board **Action: SW**

MHASC Meeting Dates 2013:

24 July 12.00 – 1.30pm Large meeting room, South Block
23 October 3.30 – 5.00pm Large meeting room, South Block

Approved as a correct record of the meeting:

Date: