The next meeting in **Public** of the Isle of Wight NHS Trust Board will be held on **Wednesday 26th June 2013** commencing at **09:30hrs**.in the Conference Room, St. Mary's Hospital, Parkhurst Road, NEWPORT, Isle of Wight, PO30 5TG. Staff and members of the public are welcome to attend the meeting.

Staff and members of the public are asked to send their questions in advance to board@iow.nhs.uk to ensure that a comprehensive reply can be given at the meeting.

Mark Price,
Company Secretary

AGENDA

Indicative Timing	No.	Item	Who	Purpose	Enc, Pres or Verbal
09:30	**1**	**Apologies for Absence, Declarations of Interest and Confirmation that meeting is Quorate**			
	1.1	Apologies for Absence: Chris Palmer (Iain Hendey to attend), Peter Taylor	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
09:35	**2**	**Patients Story**			
	2.1	Presentation of this month's Patient Story film	CEO	Receive	Pres
09:50	**3**	**Minutes of Previous Meetings**			
	3.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 29th May 2013	Chair	Approve	Enc A
	3.2	To approve the minutes from the extraordinary meeting of the Isle of Wight NHS Trust Board held on 5th June 2013	Chair	Approve	Enc B
	3.3	Chairman to sign minutes as true and accurate record	Chair	Approve	Verbal
	3.4	Review Schedule of Actions	Chair	Receive	Enc C
09:55	**4**	**Chairman's Update**			
	4.1	The Chairman will make a statement about recent activity	Chair	Receive	Verbal
10:00	**5**	**Chief Executive's Update**			
	5.1	The Chief Executive will make a statement on recent local, regional and national activity.	CEO	Receive	Pres
	5.2	Certificates of Achievement	CEO	Receive	Pres
10:20	**6**	**Quality and Performance Management**			
	6.1	Performance Report	EDSCD	Receive	Enc D
	6.2	Data Quality Report	EDF Dep	Approve	Enc E
	6.3	Self Assurance Quality Checklist - Reference Costs (2nd iteration)	EDF Dep	Approve	Enc F
	6.4	Quality Goals 2013-14	EDNW	Approve	Enc G
	6.5	Quality Accounts 2012/13 formal sign off	EDNW	Approve	Enc H
	6.6	Board Walkabouts Action Tracker	EDNW	Receive	Enc I
	6.7	Staff Story	EDNW	Receive	Pres

11:10	**7**	**Strategy and Business Planning**			
	7.1	NHS Constitution - endorsement by Trust Board	CEO	Approve	Enc J
	7.2	FT Programme Update	FTPD	Receive	Enc K
	7.3	FT Self Certification	FTPD	Approve	Enc L
11:30	**8**	**Governance & Administration (8.1 as Corporate Trustee)**			
	8.1	Amendments to Charity Commission Registration	EDSCD	Approve	Enc M
	8.2	Statutory & Formal Roles - 2013	CS	Approve	Enc N
11:35	**9**	**Board Sub Committee Minutes & Reports – to receive and approve**			
	9.1	Minutes of the Foundation Trust Programme Board held on 28th May 2013	FTPD Chair	Receive	Enc O
	9.2	Minutes of the Extraordinary Audit & Corporate Risk Committee meeting held on 5th June 2013	ACRC Chair	Receive	Enc P
	9.3	Minutes of the Charitable Funds Committee held on 11th June 2013	CFC Chair	Receive	Enc Q
	9.4	Minutes of the Quality & Clinical Performance Committee held on 19th June 2013	QCPC Chair	Receive	Enc R
11:50	**10**	**Matters to be reported to the Board**	**Chair**		
11:50	**11**	**Questions from the Public**	**Chair**		
		To be notified in advance			
11:55	**12**	**Any Other Business**	**Chair**		
12:00	**13**	**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:

- *Estates Update*
- *Reports from Serious Incidents Requiring Investigation (SIRIs)*
- *Safeguarding Update*
- *Board Assurance Framework (BAF) Monthly Update*

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.

14 Date of Next Meeting:

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on **Wednesday 31st July 2013** in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

The Annual General Meeting of the Isle of Wight NHS Trust will also be held on Wednesday 31st July at 5.00p.m. in the Conference Room at St Mary's Hospital, Newport, Isle of Wight, PO30 5TG

Enc A

Isle of Wight NHS Trust

Minutes of the meeting in **Public** of the Isle of Wight NHS Trust Board held on **Wednesday 29th May 2013** in the Conference Room, St Mary's Hospital, Newport, Isle of Wight commencing at 10:30

PRESENT:	Danny Fisher	Chairman
	Karen Baker	Chief Executive (CE)
	Felicity Greene	Executive Director of Strategy and Commercial Development (EDSCD)
	Mark Pugh	Executive Medical Director (EMD)
	Chris Palmer	Executive Director of Finance (EDF)
	Alan Sheward	Executive Director of Nursing & Workforce (EDNW)
	John Matthews	Non Executive Director
	Nina Moorman	Non Executive Director
	Peter Taylor	Non Executive Director
	Sue Wadsworth	Non Executive Director
	Nick Wakefield	Non Executive Director (Senior Independent Director)
Observers:	Chris Orchin	Health Watch
	Cllr John Howe	Chair of Children & Young People Scrutiny Panel – IW Council
In Attendance:	Mark Price	Foundation Trust Programme Director/Company Secretary (FTPD/CS)
	Andy Hollebon	Head of Communication (HC)
	Iain Hendey	Assistant Director, PIDS *(for Item 13/100)*
	Carol Ogilvie	Snr Finance Manager – PbR & Costing *(for item 13/100)*
Minuted by:	Lynn Cave	Acting Trust Board Administrator (BA)

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

Minute No.

13/077 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.

13/078 MINUTES OF PREVIOUS MEETING OF 24th APRIL 2013

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 24th April 2013 were approved.

Proposed by John Matthews and seconded by Peter Taylor

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

13/079 REVIEW OF SCHEDULE OF ACTIONS

a) **TB/002:** Out of Hours scheme – New timetable has been sent to all Exec's & NED's

b) Sue Wadsworth confirmed that her intention was that the NED's would be encouraged to join her. Action now closed

c) **TB/006:** Dr Foster - Mark Pugh confirmed that this report did not need to go to all NEDS as mentioned in the Action plan – Action now closed
d) **TB/007:** Mortality Update – this would be amended to a quarterly review, next due July – Action now closed

13/080 CHAIRMAN'S UPDATE

The Chairman welcomed Dr Nina Moorman who had now joined the Board as a Non Executive Director and with her clinical expertise would be joining the Quality & Clinical Performance Committee, Charitable Funds Committee and the Mental Health Act Scrutiny Committee in the first instance.

He reported that the Helipad was now operational and there were plans to formally open it during Cowes Week.

He extended a welcome to the new Isle of Wight Council members as a whole and in particular Cllr Howe who was attending in his capacity as the new Chair of IWC Children & Young People Scrutiny Panel. He stressed the importance of briefing the council on the Trust's activities and stated that a special meeting would be arranged to facilitate this.

111 and Accident & Emergency were performing well which is against the national trend. It was noted that this was due to the excellent relationships the Trust has with the local GP's, the front line Beacon Centre and also the HUB. Having all services available locally such as Ambulance, Mental Health and Acute services provided a good model for the services to work with. Well Done to all concerned.

A new Employee of the Month scheme is to be commenced shortly and this will be open to all staff, both clinical, non clinical and cover all roles. More information on this will be given later in meeting.

Foundation Trust programme is still progressing well and again a full report will be provided later in meeting.

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

13/081 CHIEF EXECUTIVE'S UPDATE

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

13/082 <u>National & Regional Issues</u>

a) NHS 111 and GP Out of Hours – the subject of continued national debate and our response rates are comparatively good. Communications Department were working hard at promoting the island as an attractive place to work.

b) Academic Health Science Network: The purpose of this is to bring research into the community earlier (currently takes up to 30 years to reach community). Island is aiming to be at the forefront of this initiative and further reports on progress will follow in the future months.

c) Foundation Trust Network Report on Providing Value – the economic and social value of Foundation Trusts – Foundation Trusts around the country are providing a significant economic boost to the economy at around

£30billion per year. Foundation Trusts demonstrate improved governance, patient and employee engagement as well as improved health and wellbeing of the local population. Being a FT can enable the organisation to join with others in joint ventures which can benefit the local community and leads to becoming an excellent organisation. There is a paper available if more information is required.

d) Francis Report – Stakeholder engagement panel of 90 people (cross section of staff and public), met to discuss and contribute to the Trust's response to the report. Robert Jones, Deputy Chair of the Patient Council, was Chair of the panel.

e) Deaths from surgery – with the recent report about mortality outcomes if your surgery is on a Friday, it was noted that statistically the difference between Monday and Friday is 1in10,000 rising to 1.4 in10,000.

Sue Wadsworth mentioned that it would be interesting to compare local statistics with risk factors and trends at the Quality & Clinical Performance Committee. The Executive Director of Finance will ask the PIDs department to review the trends and compare with our figures and report back at a future meeting

Action by EDF

13/083 Local Issues

a) Difficult Easter weekend for operational services but two May Bank holiday weekends went well. Confirmed that as a Trust positive progress has been made to cover these periods. Well Done to our staff.
b) Top Trust in Wessex for Friends and Family Test – again well done to everyone for making us the top trust.
c) Hosting NHS Creative – they are producing the graphics which are appearing around the Trust and will work towards creating some income as well.
d) New Helipad – operational from 17/5/13 and several operational landings since then. There is a need to monitor activity and to ensure that it is being used appropriately.
e) Council Elections – looking forward to working with the new Council & will provide briefings for them. Contact is being made with the leader of the Council to facilitate this.
f) Our plans for next 5 years booklet. The leaflet is widely available throughout the organisation and will be included within the new membership packs.
g) CQC Mental Health Act inspection at Woodlands. It was confirmed that the visit went well.
h) It's 'OK to Ask' about Clinical Research. This is a national campaign and is aimed at encouraging people to ask about joining clinical trials for their conditions. Very positive response.
i) Shackleton St. Mary's – open afternoon on 31st May and patients move in 3rd June. It was explained that the unit was for extreme cases of dementia and that staff had played a key role in the design and organisation of the unit. Questions around its location on 1st floor were discussed and members reassured that risk assessments had been undertaken.
j) Prison Healthcare – handover at midnight on 31st May to Harmoni for Health, part of Care UK. It was noted that the prison healthcare were an excellent team and the Trust was very sorry to be losing them. It was confirmed that all services had been recompensed and that this area was being carefully monitored to ensure 100% compliance.
k) Changes to the Executive Director portfolios – the new role responsibilities

were highlighted and it was noted that these would be kept under review to ensure that no director would become overloaded.

l) Matron's Development Programme – this is being based on the format of the director's development programme and is aimed at ensuring that they are able to ensure their development.

Peter Taylor asked if the death rate on the island was rising. It was discussed and felt that it would be appropriate to approach Jennifer Smith in Public Health to request data on the increasing island population, increasing age of population compared to increasing death rate.

Action by EMD

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

13/084 Certificates of Achievement

The Executive Director of Nursing and Workforce advised the meeting that there was to be a two part nomination structure to look at internal and external staff achievements. The internal would be nominated by directorates and would be looking at 1 person per month. There would be a background given on the persons achievement and why they are being presented with their certificate.

The external would be in the form of an Employee of the Month. This would cover all areas of staff and they would appear with their photo etc at the entrance to the hospital and on a permanent area to be determined.

The Isle of Wight NHS Trust Board received the Certificates of Achievement update

13/085 STRATEGY AND BUSINESS PLANNING

FT Programme Update
A brief report and update was given by the Foundation Trust Programme Director

a) Timeline – TDA declared view on all NHS Trusts - we are in a group of Trusts expected to bring forward an application to TDA this year.

b) Integrated Business Plan & LTFM refresh for submission 31 August 2013 – Much work is going on to achieve this deadline.

c) Plans in place to meet TDA requirements - with the full programme plan being developed to ensure Trust Development Authority (TDA) compliance.

d) Membership Recruitment campaign - Membership recruitment was going well with 1346 public members to date. These need to be representative of the various areas of the island to ensure balance.

Sue Wadsworth congratulated the membership figures but questioned what response members were receiving as she had received a query from a member. It was agreed that she would provide details of the member and this would be followed up.

Action by SW/HC

The Executive Medical Director questioned why members from the mainland were being recruited. It was explained that a proportion of the patients using the Trust had mainland addresses. This covered people on holiday as well as people with second homes. Target was 250 for the mainland constituency compared with 1500 for island

residents.

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

13/086 FT SELF CERTIFICATION

The Foundation Trust Programme Director presented the self certification report for the month of April 2013. It was explained that there were changes from Strategic Health Authority (SHA) to Trust Development Authority (TDA) requirements. This was now focused on Board Statements, Monitor Licence Conditions and FT Milestones only and not Governance Risk Rating (GRR), Financial Risk Rating (FRR)/Risk Triggers, Contractual information Quality data or the Governance declaration.

He confirmed that his team were working with PIDs to ensure that all appropriate areas which TDA will monitor are covered in our reporting.

The Board statement on Board composition can be deemed compliant from May with Dr Moorman having joined the board.

TDA Accountability Framework – it was recommended that compliance be agreed for Condition G7. All others would need to be taken through the board sub committees for approval prior to resubmission to the board.

FT Milestones – these were discussed yesterday and it has been agreed that 8 milestones will be put forward for approval to the TDA.

Action by FTPD

Proposed by Sue Wadsworth and Seconded by Peter Taylor.

The Isle of Wight NHS Trust Board approved the FT Self Certification report.

13/087 BUDGET UPDATE

The Executive Director of Finance (EDF) discussed the paper, highlighting the fact that these were provisional figures. Final figures would be submitted to the extraordinary board meeting on 5th June 2013.

She reported that the planned surplus for 2012/13 of £500k had been surpassed by £9k which included a refund dividend. The budget framework for 2013/14 has been submitted to the TDA.

The EDF discussed the various aspects of the report for the benefit of the members and outlined the plan for the new financial year. Nick Wakefield asked what the cost improvement plans had been based against. The EDF responded that they had been set against last year's baseline but included an increase.

The Chairman congratulated the Finance team and the Trust for achieving such a good end of year result.

Proposed by Sue Wadsworth and Seconded by Peter Taylor.

The Isle of Wight NHS Trust Board approved the Budget Update report.

13/088 QUALITY AND PERFORMANCE MANAGEMENT

13/089 Performance Report

The Executive Medical Director presented the Performance Report.

Key points:

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.

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.

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

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 are held.
- 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.

Sue Wadsworth asked about the reasons for patient unavailability within Cancer

care. She asked if "choose and book" would be a suitable vehicle for these appointments. The meeting was advised that this was being reviewed as part of the service development. Peter Taylor also asked if the term "unavailability" could be redefined for future reports to allow for more detailed reasons to be factored in for greater clarity. The Executive Director of Finance agreed to ask PIDS to do this.

Action by EDF

Nick Wakefield asked why there were NIL response allowed within the Data Quality for Ethnicity. It was explained that not completing also counted as being a return but that it was not compulsory to state ethnicity on forms.

Nick Wakefield also asked for the definition of CQUINS and how they affected income. An overview of CQUINS (Commission for Quality and Innovation payment framework) was reviewed for the members and public and the affects that the payments received by the Trust under this framework would have.

Peter Taylor confirmed that the Finance, Investment and Workforce Committee had seen and approved these figures.

The Isle of Wight NHS Trust Board received the Performance Report

13/090 Patient Story

The Chief Executive introduced the Patient Story. She outlined the plan for future meetings that this item would appear at the beginning of each meeting from June.

Today's films covered Children's Ward and Coronary Care Unit. She noted that there were 3 other areas which had been filmed and it was agreed that all 5 films would be available via the website for everyone to view including the public. Sue Wadsworth asked that feedback be obtained from people viewing the films and also from the staff within the areas concerned.

Action by EDNW

Both films were very well received by the meeting and Peter Taylor stated that it gave a good example of what "excellence looks like" within the Trust. The Executive Director of Nursing & Workforce mentioned that it was difficult to find patients who were willing to take part in filming but that it could be linked to those who had made complaints and this would give them a chance to talk to the board. Other items and concerns highlighted within the films would be followed up.

Action by EDNW

The Isle of Wight NHS Trust Board received the Patient Story

13/091 Staff Story

The Executive Director of Nursing and Workforce presented the staff story about the Stonewall Healthcare Equality Index. In March 2013, we submitted an application to join the Stonewall Health Champions programme; this was successful. The Executive Director of Nursing and Workforce and Sue Wadsworth are the executive and non executive sponsors.

He outlined the principles of the index and it measured progress on quality treatments for lesbian, gay and bisexual patients, families and carers. Of the 32 healthcare organisations that have entered we are currently 30th which indicates that there is still considerable work to do in this area.

Sue Wadsworth reported that she was pleased to see how this initiative was developing and that it will aid equality within the Trust.

The Company Secretary reported that there would be a Board Seminar on stakeholder engagement including hard to reach groups later in the Board programme today.

Sue Wadsworth expressed her interest in working with youth groups within these areas.

Peter Taylor requested that an Equality and Diversity topic be included in a future seminar.

Action by BA

The Isle of Wight NHS Trust Board received the Staff Story

13/092 Board Walkabouts Action Tracker

The Executive Director of Nursing and Workforce presented the action tracker and confirmed that the outstanding RED items were going to performance review with the directorates.

Danny Fisher asked that the return forms for the visits be returned as soon as possible so that the action tracker could be kept up to date.

Action by ALL Board members

The Isle of Wight NHS Trust Board received the Board Walkabout Action Tracker

13/093 GOVERNANCE & ADMINISTRATION

13/094 2012/13 Governance Statement

The Company Secretary presented the Governance Statement to the Board and requested that it was approved. He confirmed that it had been approved by the Audit & Corporate Risk Committee.

It was agreed that the formal signing of the Governance Statement by the Chief Executive would be undertaken at the Extraordinary Board meeting on 5th June 2013

Action by CS

Proposed by Sue Wadsworth and Seconded by Nick Wakefield.

The Isle of Wight NHS Trust Board approved the 2012/13 Governance Statement

13/095 Transfer of Assets update

The Executive Director of Strategy & Commercial Development confirmed that email confirmation of the successful transfer of assets had been received. She confirmed that official confirmation is still awaited.

Action by EDSCD

Nick Wakefield asked whether the insurance cover needed to be amended. He was advised that this was not the case as the correct level of cover was already in place.

The Isle of Wight NHS Trust Board received the Transfer of Assets Update

13/096 Review of Board Performance

The Company Secretary presented the board performance review and outlined the contents of the report to the meeting.

A discussion was held regarding the report and the Executive Director of Finance requested that more clarity within the actions was needed to show areas which were not compliant. The Executive Director of Nursing and Workforce confirmed that the Quality team was currently reviewing the data to establish the exact criteria which would be used in future.

Proposed by Sue Wadsworth and Seconded by Peter Taylor

The Isle of Wight NHS Trust Board approved the Review of Board Performance

13/097 Minutes of the Audit & Corporate Risk Committee held on 22nd May 2013

Peter Taylor reported that the meeting had not been quorate and therefore the Board needed to approve the minutes.

The Isle of Wight NHS Trust Board received and approved the Minutes of the Audit & Corporate Risk Committee

13/098 Recommendations from the Audit & Corporate Risk Committee held on 22nd May 2013

Peter Taylor reported the recommendation of the committee to the board as follows:

a) 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

b) 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

c) Review of Achievement of Corporate Objectives:
- The Trust Board to determine the assessment criteria for success for the current year

d) 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

e) Legal Service Agreement:
- The service should go out to tender no later than the end of October 2013

A discussion was held regarding storage of patient records and it was confirmed that various initiatives including the ISIS programme were being currently actioned. The Executive Director of Strategy & Commercial Development confirmed that there were a number of business cases in progress and she would report back on the progress

of the project group in this area.

Action EDSCD

It was agreed that the Annual Report needed to be reduced in length.

Proposed by Sue Wadsworth and Seconded by John Matthews

The Isle of Wight NHS Trust Board approved the recommendations of the Audit & Corporate Risk Committee

13/099 Minutes of the Finance, Investment & Workforce Committee held on 22nd May 2013

Peter Taylor presented the minutes of the Finance, Investment & Workforce Committee held on 22nd May 2013

The Isle of Wight NHS Trust Board received the Minutes of the Finance, Investment and Workforce Committee

13/100 2012-13 Reference Costs – Self Assurance Quality Check – Position Report

The Executive Director of Finance introduced the report and confirmed that due to national changes the Trust Board needed to formally receive the Reference Costs. She handed over to Iain Hendey, Performance Manager & Carol Ogilvie, Snr Finance Manager – PbR & Costing, who presented the highlights to the meeting:

- National drive to improve both costing standards and data quality
- Changes to the 2012/13 Reference Costs guidance
- Self Assurance Quality Checklist
- National standards required
- Supply a brief on organisations readiness
- Request approval for the Finance Director's sign off.

The milestones for the submission were confirmed and that the Executive Director of Finance would be required to sign off the final submission.

It was confirmed that the draft submission would be presented to the June board for approval.

Action EDF

Proposed by Peter Taylor and Seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the 2012-13 Reference Costs-Self Assurance Quality Check - Position Report

13/101 Minutes of the Foundation Trust Programme Board held on 23rd April 2013

The Chief Executive presented the Minutes of the Foundation Trust Programme Board held on 23rd April 2013.

The Isle of Wight NHS Trust Board received the Minutes of the Foundation Trust Programme Board

13/102 Minutes of the Mental Health Act Scrutiny Committee held on 1st May 2013

John Matthews reported that the main concern was the lack of doctors able to cover

the S12 criteria. The Executive Medical Director confirmed that this was a serious issue and one which NHS England and CCG were financially liable and obligated to provide suitable personnel. He confirmed that there were several hundred assessments per year and discussions were to be held over appropriate cover.

Action by EMD

John Matthews also reported that Community Treatment Orders were under attack nationally but on the Island they have been used with no problems. He also confirmed that an audit of these would be undertaken.

He mentioned that the Mental Health Act data needed to have greater interplay between the Trust and the police.

The Isle of Wight NHS Trust Board received the Minutes of the Mental Health Act Scrutiny Committee

13/103 Matters to be reported to the Board

NHS TDA request for Board Papers
The Company Secretary advised the meeting that the NHS Trust Development Authority had requested copies of all our board papers both parts 1 (public) and part 2 (private).

It was agreed that both parts 1 and 2 would be sent to NHS TDA via email.

Proposed by Nick Wakefield and Seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the NHS TDA request for Board Papers

13/104 QUESTIONS FROM THE PUBLIC

There were no formal questions received from the public. However, the Chairman recognised the member of public who had attended the meeting. She asked about the order of the agenda and if the date of next meeting could be moved to before the Issues to be covered in private. She also asked if there was going to be a membership pack for new members of the trust. The Head of Communications responded that there was a pack being prepared at present which would go out to all members, which included a membership card.

The Chairman thanked the lady for attending the meeting.

13/105 ANY OTHER BUSINESS

Peter Taylor asked about the mandatory training figures on the risk register which was showing at only 70%. The Executive Director of Nursing & Workforce advised that this area of staff training was under review to ensure that the whole Trust was effectively covered.

13/106 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:

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

13/107 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 26th June 2013 in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 13:00

Signed…… Chair Date:……

Enc B

Isle of Wight NHS Trust

Minutes of the Extraordinary meeting in public of the Isle of Wight NHS Trust Board held on **Wednesday 5th June 2013** in the Conference Room, St Mary's Hospital, Newport, Isle of Wight commencing at 10:00

PRESENT:	Danny Fisher	Chairman
	Chris Palmer	Executive Director of Finance
	Alan Sheward	Executive Director of Nursing & Workforce
	Peter Taylor	Non Executive Director
	Sue Wadsworth	Non Executive Director
Attended via Conference Call:	Felicity Greene	Executive Director of Strategy and Commercial Development
In Attendance:	Mark Price	Foundation Trust Programme Director/Company Secretary
	Richard Sharpe	Deputy for Clive Woodbridge, Deputy Director of Finance
	Andy Hollebon	Head of Communications
Minuted by:	Lynn Cave	Acting Trust Board Administrator

Members of the Public in attendance: There were none present

Minute No.

13/107 APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE

Apologies were received from:

Karen Baker, Chief Executive; John Matthews, Non Executive Director; Nick Wakefield, Non Executive Director; Nina Moorman, Non Executive Director; Mark Pugh, Executive Medical Director

There were no declarations of interest

The Chairman announced that the meeting was quorate.

13/108 ACCOUNTS 2012/13

The Chairman confirmed that this meeting was an extraordinary board meeting to discuss and approve the audited accounts and annual report and passed the meeting to the Executive Director of Finance who proceeded to present the Accounts for 2012/13.

She confirmed that the end of year surplus was £509k against a target of £500k. The additional £9k being public dividend. The financial position at the end of the year was as planned.

Peter Taylor as Chairman of the Audit and Corporate Risk Committee confirmed that they had discussed the report in full and approved its contents.

The Chairman asked about overpayments. The Executive Director of Finance advised that she had discussed this with the Auditors and they were happy not to

include these within the report. Peter Taylor confirmed that they were covered under the Letters of Reference.

Proposed by Sue Wadsworth and Seconded by Peter Taylor

The Isle of Wight NHS Trust Board approved the Accounts 2012/13

13/109 AUDITORS REPORT ON ANNUAL ACCOUNTS 2012/13

The Executive Director of Finance highlighted to the meeting the Significant findings of the Auditors and their conclusions. She confirmed that the Auditors had commended the team on their thorough processes and had agreed the Trust's accounting treatment to the manual for accounts guidance.

The JAC query was down to timing of reconciliations against ledger. These needed to be run in a very specific time frame to ensure reconciliation. The Finance, Investment and Workforce Committee would be following up and monitoring this process in the months to come to ensure compliance was met.

There were no errors of risk of fraud. She confirmed that the Trust had a very strong link with the counter fraud specialist.

Issues with HR providing information would be looked into by the Finance, Investment and Workforce Committee to ensure that the recommendations from the Audit were put into place. They would also ensure that the vacant posts and temporary staff issues within the Finance team were resolved to ensure sufficient staff were in place to ensure FT status.

The Isle of Wight NHS Trust Board received the Auditor's report on the Annual Accounts 2012/13

13/110 DIRECTORS CERTIFICATES

The Executive Director of Finance confirmed that these were of a standard format and wording. She confirmed that the Chief Executive and she would be signing these as well as the notes on the Annual report.

Proposed by Peter Taylor and Seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the Directors Certificates

13/111 TO RECEIVE AND APPROVE 2012/13 GOVERNANCE STATEMENT

The Company Secretary reported that this report had been approved by both the Audit committee and the Board at its meeting last week and was here to complete the papers for the end of year and they only needed to be received by the meeting.

The Isle of Wight NHS Trust Board received the 2012/13 Governance Statement

13/112 HEAD OF INTERNAL AUDIT OPINION

The Executive Director of Finance discussed the key points of the internal auditors overall opinion confirmed that they could provided substantive assurance that the Assurance Framework was sufficient to meet the requirements of the 2012/13 AGS.

She confirmed that there was no opinion as yet regarding Information Governance as it had yet to go through the final stages of audit but that there was no anticipated

changes.

The Chairman asked if the slightly negative comments within the report were cause for concern. The Executive Director of Finance advised him that these comments were not reason for major concern. She confirmed that there had been significant improvements across the assurance grades shown on page 5 of the report. The Company Secretary confirmed that this report was satisfactory in terms of our aspiration for FT status.

The Executive Director of Nursing and Workforce highlighted the area of Safeguarding Children and Vulnerable Adults and stated that this statement was taken at that particular point in time and that changes had been put onto an Action Plan for progressing.

The Isle of Wight NHS Trust Board received the Head of Internal Audit Opinion

13/113 STATEMENT ON TRUST AS A GOING CONCERN

The Executive Director of Finance confirmed that the statement on the Trust as a Going Concern included the statement of financial position which indicated that the organisation would continue for the foreseeable future and for a minimum of 12 months after this was signed.

She further outlined the contents of the report and Peter Taylor confirmed that the Audit and Corporate Risk Committee had approved this statement.

The Executive Director of Finance gave her appreciation to the finance team for all their huge efforts in achieving the successful year end and also the Auditors for the way in which they had supported the Trust throughout the audit process.

Proposed by Sue Wadsworth and Seconded by Peter Taylor

The Isle of Wight NHS Trust Board approved the Statement on Trust as a Going Concern

13/114 ANNUAL REPORT 2012/13 INCORPORATING THE QUALITY ACCOUNT 2012/13

The Head of Communications went through the Annual Report and brought the following amendments to the attention of the members.

P1 – Annex B	The headings "Statement of the Chief Executive's Responsibilities and Statement of Directors' Responsibilities" had been removed from the final version.
P3	The figure £159m in paragraph 2 should read £169m
P10	The total for Members in table at the bottom of page 10 will be updated prior to the Isle of Wight NHS Trust AGM on 31st July 2013.
P38	This diagram will appear as an A3 fold out. Also Income figure of £155m should read £157m and CIP figure of £8.3m should read £8.6m
P40 - 43	Danny Fisher, Sue Wadsworth and Peter Taylor's renewal date should be 31/03/2015. Dr Nina Moorman is to be removed as she joined after the 31 March 2013. The members of some sub commitees are to be confirmed as there have been some recent changes.
P45	Yellow highlighting and dotted lines are to be removed

Whole Document	The final document is to be checked for consistencies within the information given
Whole Document	Pictures are to be included throughout the document
Whole Document	Final formatting and Spell Checking will be carried out so that there is a uniform approach to whole document

It was confirmed that all changes to wording and numbers were to be carried out on 5th June 2013 as the Auditors would be signing off in the afternoon.

Proposed by Sue Wadsworth and Seconded by Peter Taylor

The Isle of Wight NHS Trust Board approved the Annual Report 2012/13 incorporating the Quality Account 2012/13

13/115 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

13/116 ANY OTHER BUSINESS

There was none.

13/117 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 26th June 2013 in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 10:45

Signed:…… Chair Date:……

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) Trust Board Administrator (BA) Head of Communication (HC)

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

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Date Closed	Status
29-May-13	13/082(e)	TB/012	**Death in Surgery vs Day of Week** - The Executive Director of Finance will ask the PIDs department to review the trends and compare with our figures and report back at a future meeting	EDF	Data to be confirmed by PIDS for July board		Open
29-May-13	13/083	TB/013	**Island Death Rate** - Peter Taylor asked if the death rate on the island was rising. It was discussed and felt that it would be appropriate to approach Jennifer Smith in Public Health to request data on the increasing island population, increasing age of population compared to increasing death rate.	EMD	EMD to approach Public Health and report back to board in July		Open
29-May-13	13/085	TB/014	**Membership** - Sue Wadsworth congratulated the membership figures but questioned what response members were receiving after joining as she had received a query from a member. It was agreed that she would provide details of the member and this would be followed up.	SW/HC	Follow up on outcome of members enquiry		Open
29-May-13	13/086	TB/015	**FT Milestones** – these were discussed yesterday and it has been agreed that 8 milestones will be put forward for approval to the TDA.	FTPD	These have now been sent to the TDA	18/06/2013	Closed
29-May-13	13/089	TB/016	**Patient Unavailability** - Peter Taylor also asked if the term "unavailability" could be redefined for future reports to allow for more detailed reasons to be factored in for greater clarity. The Executive Director of Finance agreed to ask PIDS to do this.	EDF	Report to be provided for the July Board		Open
29-May-13	13/091	TB/017	**Staff Story** - Peter Taylor requested that an Equality and Diversity topic be included in a future seminar.	BA	Added to the Seminar forward planner	14/06/2013	Closed
29-May-13	13/092	TB/018	**Walkabout Feedback** - Danny Fisher asked that the return forms for the visits be returned as soon as possible so that the action tracker could be kept up to date.	All Board Members	Vanessa Flower sent reminder as still not coming back 13/06/13		Progress
29-May-13	13/094	TB/019	**Governance Statement** - Formal signing of the Governance Statement by the Chief Executive would be undertaken at the Extraordinary Board meeting on 5th June 2013	CS	Completed	05/06/2013	Closed
29-May-13	13/095	TB/020	**Transfer of Assets** - official confirmation is still awaited.	EDSCD	Official Confirmation received	12/06/2013	Closed
29-May-13	13/100	TB/021	**Reference Costs** - It was confirmed that the draft submission would be presented to the June board for approval.	EDF	On June Agenda	14/06/2013	Closed
29-May-13	13/102	TB/022	**Lack of doctors able to cover the S12 criteria** - discussions were to be held over appropriate cover.	EMD	Report to be provided for the July Board		Open
29-May-13	13/090	TB/023	**Patient Story** - Sue Wadsworth requested feedback from patients and staff viewing the films.	EDNW	Report to be provided for the July Board		Open
29-May-13	13/090	TB/024	**Patient Story** - Concerns and items highlighted in films to be followed up.	EDNW	Report to be provided for the July Board		Open
29-May-13	13/090	TB/025	**Patient Story** - patients who would be willing to come and discuss their concerns/complaints with the board	EDNW	Suitable candidates would be looked into and an update given to the Board in July		Open

Isle of Wight NHS Trust Board Performance Report 2013/14

May 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 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
Trust Executive Committee	N/A
Foundation Trust Programme Board	N/A
Finance, Investment & Workforce Committee	
Mental Health Act Scrutiny Committee	N/A
Nominations Committee (Shadow)	N/A
Planned Directorate Board	N/A
Quality & Clinical Performance Committee	18/06/2013
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 26th June 2013

Isle of Wight NHS Trust Board Performance Report 2013/14

May 13

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 May (11) are higher than previous year. There were no Grade 3 pressure ulcers reported in May, 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. No new cases of MRSA were reported in May for the 8th consecutive month but there were 2 new cases of C-Diff. The new Route Cause Analysis process has been tested and agreed by the Matrons Action Group. The outcomes will focus on communicating best practice in relation to prescribing PPI's and Antibiotics, as well as the documentation of bowel habits and appropriate sampling

The number of complaints for May (14) is down on our previous position of 22.

Workforce:

The total pay bill is above plan for May. The number of FTEs in post is lower than plan. Agency staff pay is above planned levels.

Sickness absence was above plan in May (3.89%). 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 achieved the highest to date (94.74%) just short of our very challenging locally extended target of 95% althought it consistently achieves the national target of 60%.

Provisional data for May indicates that the 2 week cancer target for Breast Cancer referrals is below the target in month, together with the 2 week GP referral. Work has taken place in May 2013 to ensure that the first offered appointment is within the first week after referral. This will improve performance as alternative dates/times can be offered if not suitable.

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

Finance & Efficiency:

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

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 has improved and is now above target (May, 86.82%) and remains a focus area. Cancelled operations (0.21%) also shows an improving trend.

Isle of Wight NHS Trust Board Performance Report 2013/14

May 13

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	May-13	4	↔	
Patients admitted that develop a grade 2 or 3 pressure ulcer	60	9	May-13	19	↗	
Quality Account measure to be confirmed						
Quality Account measure to be confirmed						
Level 1 & 2 CAHMS seen within 18 weeks referral to treatment	>95%	100%	May-13	100%	↔	
VTE (Assessment for risk of)	>90%	91.96%	May-13	90.62%	↗	
MRSA (confirmed MRSA bacteraemia)	1	0	May-13	0	↔	
C.Diff (confirmed Clostridium Difficile infection - stretch target)	8	2	May-13	2	↘	
Clinical Incidents (Major) resulting in harm	TBC	7	May-13	14	↔	
Clinical Incidents (Catastrophic) resulting in harm	TBC	0	May-13	2	↗	
Falls - resulting in significant injury	10	0	May-13	2	↗	
Delivering C-Section	<22%	21.36%	May-13	20.19%	↘	
Normal Vaginal Deliveries	>70%	64.08%	May-13	64.79%	↘	
Breast Feeding at Delivery	>85%	78.18%	May-13	78.18%	↗	
Formal Complaints	<276	14	May-13	36	↗	
Patient Satisfaction (Friends & Family test - aggregated score)	Q3>Q1	61	May-13	62.5	↘	
Mixed Sex Accomodation	0	0	May-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	2,669.0	May-13	N/A	↗	
Total pay costs (inc flexible working) (£000)	£9,254	£9,971	May-13	£19,843	↘	£18,528
Variable Hours (FTE)	144.00	128.00	May-13	289.77	↗	144
Variable Hours (£000)	£60	£631	May-13	£1,292	↗	£161
Staff absences	3.00%	3.89%	May-13	3.68%	↘	3%
Staff Turnover	5.00%	2.10%	May-13	2.82%	↘	
Mandatory Training	80.00%	72.00%	May-13	72.00%	↔	
Appraisal Monitoring	100.00%	18.20%	May-13	18.20%	↗	
Employee Relations Cases	0	29	May-13	154		

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%	98.47%	May-13	95.57%	↗	
Ambulance Category A Calls % < 8 minutes	75%	75.17%	May-13	76.55%	↘	
Ambulance Category A Calls % < 19 minutes	95%	97.32%	May-13	97.31%	↗	
Stroke patients (90% of stay on Stroke Unit)	80%	88.46%	May-13	88.68%	↘	
High risk TIA fully investigated & treated within 24 hours (National 60%)	95%	94.74%	May-13	91.43%	↗	
Breast Cancer Referrals Seen <2 weeks*	93%	91.80%	May-13	92.24%	↘	
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100%	May-13	100%	↔	
Cancer Patients receiving subsequent surgery <31 days*	94%	100%	May-13	100%	↔	
Cancer Patients treated after screening referral <62 days*	90%	100%	May-13	100%	↔	
Cancer Patients treated after consultant upgrade <62 days*	85%	100%	May-13	100%	↔	
Cancer diagnosis to treatment <31 days*	96%	100%	May-13	99.22%	↗	
Cancer urgent referral to treatment <62 days*	85%	92.50%	May-13	88.74%	↗	
Cancer patients seen <14 days after urgent GP referral*	93%	91.95%	May-13	92.84%	↘	
RTT:% of admitted patients who waited 18 weeks or less	90%	92.34%	Apr-13	92.34%	↗	
RTT: % of non-admitted patients who waited 18 weeks or less	95%	97.12%	Apr-13	97.12%	↗	
RTT % of incomplete pathways within 18 weeks	92%	94.87%	Apr-13	94.87%	↗	
No. Patients waiting > 6 weeks for diagnostics	100	7	May-13	7	↘	
%. Patients waiting > 6 weeks for diagnostics	1%	0.73%	May-13	0.73%	↘	
Elective Activity (Spells) (M1 target - 682)	8683	596	Apr-13	596	↗	
Non Elective Activity (Spells) (M1 target - 1,220)	13,199	1,171	Apr-13	1,171	↔	
Outpatient Activity (Attendances) (M1 target - 9744)	136,390	9,811	Apr-13	9,811	↗	
Data Quality	TBC					

***Cancer figures are provisional for May**

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	£556k	May-13	£556k	↔	
Underlying performance	£1.6m	£556k	May-13	£556k	↔	
Net return after financing	0.50%	1.2%	May-13	1.2%	↔	
I&E surplus margin net of dividend	=>1%	2.0%	May-13	2.0%	↗	
Liquidity ratio days	=>15	62	May-13	62	↗	
Monitor Financial risk rating	3	3	May-13	3	↔	
Capital Expenditure as a % of YTD plan	=>75%	82.0%	May-13	82.0%	↗	
Quarter end cash balance (days of operating expenses)	=>10	56	May-13	56	↔	
Debtors over 90 days as a % of total debtor balance	=<5%	3.6%	May-13	3.6%	↗	
Creditors over 90 days as a % of total creditor balance	=<5%	0.00%	May-13	0.00%	↔	
Recurring CIP savings achieved	100%	100%	May-13	100%	↗	
Total CIP savings achieved	100%	100%	May-13	100%	↗	
Contract Penalties	TBC					
Theatre utilisation	83%	86.82%	May-13	83.57%	↗	
Cancelled operations on day of / after admission	TBC	0.21%	May-13	0.53%	↗	
Average LOS Elective (non-same day)	TBC	4.32	May-13	3.89	↘	
Average LOS Non Elective (non-same day)	TBC	7.52	May-13	8.08	↗	
Outpatient DNA Rate	TBC	7.45%	May-13	7.66%	↗	
Emergency Readmissions <30 days (with exclusions)	TBC	4.62%	May-13	5.14%	↗	
Daycase Rate	68%	68.69%	Apr-13	68.89%	↘	

Highlights

- **No new cases of MRSA (8th consecutive month).**
- **Stroke Patients 90% of stay on Stroke unit sustained for 11th month.**
- **Highest % of TIA assessment within 24 hours recorded (94.75%)**
- **5 cancer targets achieved 100% (3 for 4th consecutive month)**
- **Emergency Care 4 hour standard performance above target**
- **Formal complaints within reduced target**

Lowlights

- ***2*** **Cases of C Diff this month**
- **Breast cancer referrals seen within 2 weeks not achieved**
- **2 week wait from GP cancer referral not achieved**
- **Significant overspend on Variable Hours pay**
- **Grade 4 and 2 Preasure Ulcers above plan**

Commentary:

Whilst no patients in the hospital setting were reported as developing any grade 3s this month, there were still two patients with grade 4 pressure ulcers, and a slight increase of patients developing grade 2 ulcers on last year.

Incidence of patients with grade 2 ulcers in the community has dipped significantly on the previous year, and there was a modest reduction of patients with grade 3 ulcers. However three patients still developed grade 3 pressure ulcers in the community setting.

As part of holding wards and clinical teams to account for their standards, the Clinical Nurse Specialist is currently undertaking the competence assessment of senior clinical nurses of grade 7 and above, who will then be expected to clinically assess the competence of their own teams. Additional education is taking place to support this process. The Nutrition and Tissue Viability Service continue to audit the standards of hospital documentation in order to support clinical areas in raising their standards of care and documentation.

Analysis:

Quality Account Priority 2 - Prevention & Management of Pressure Ulcers

KPI No	KPI Description	Target (cumulative)	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total ytd
	Hospital Setting															
1	Grade 4 pressure ulcers	0	2012/13	0	0	4	1	2	2	2	2	4	2	2	1	22
			2013/14	2	2											4
2	Grade 2 pressure ulcers	↓50%	2012/13	12	7	1	13	11	6	5	11	6	9	13	9	103
			2013/14	9	9											18
	Grade 3 pressure ulcers	↓50%	2012/13	3	0	0	0	2	0	5	0	1	2	2	2	17
			2013/14	1	0											1
	Community Setting															
3	Grade 2 pressure ulcers	↓50%	2012/13	8	10	14	14	9	9	14	6	12	8	11	11	126
			2013/14	7	6											13
	Grade 3 pressure ulcers	↓50%	2012/13	1	4	3	2	4	5	4	3	2	1	4	3	36
			2013/14	2	3											5
	Grade 4 pressure ulcers	↓50%	2012/13	0	0	0	1	3	0	3	2	1	0	4	4	18
			2013/14	3	3											6

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/ Tissue Viability Specialist Nurse	Mar-13	Ongoing

Isle of Wight NHS Trust Board Performance Report 2013/14

May 13

Patient Safety

Isle of Wight NHS Trust

Commentary:

Clostridium difficile

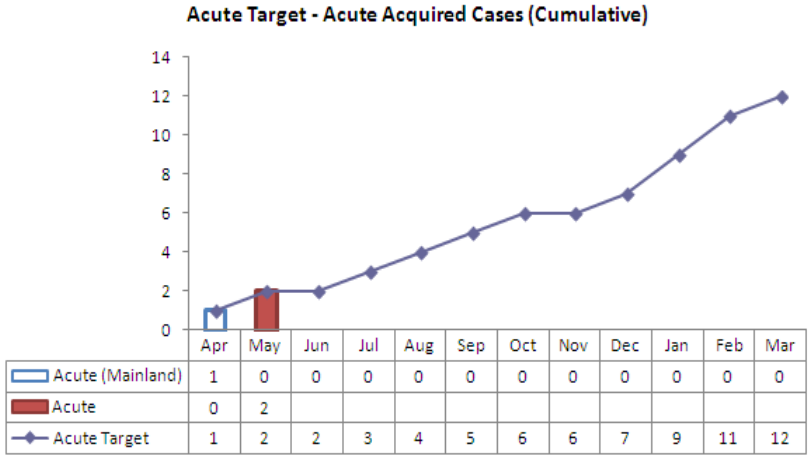
The Trust has 2 cases of C.difficile in May 2013; both attributed to the Community Health Directorate. This breaches their trajectory for the quarter and places increased pressure on all areas against the Organisations trajectory.

The new Route Cause Analysis process has been tested and agreed by the Matrons Action Group, co-ordination of the RCA reviews will be lead by the Modern Matrons with administrative support provided by the IPC Team. The first RCA meeting was well attended with good clinician engagement, clear outcomes and excellent reflective practice. The outcomes will focus of communicating best practice in relation to prescribing PPI's and Antibiotics, as well as the documentation of bowel habits and appropriate sampling

MRSA Bacteraemia

There were no new MRSA bacteraemia cases in May 2013

Analysis:



Isle of Wight NHS Trust

MRSA	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Acute Target	1	0	0	0	0	0	0	0	0	0	0	0	1
Actual	0	0											0

Action Plan:	Person Responsible:	Date:	Status:
All cases continue to be subject to root cause analysis to identify actions necessary to ensure the trajectory remains achieved. A risk register entry for this target is being prepared by the DIPC in conjunction with the infection prevention and control team.	Executive Director of Nursing & Workforce		Ongoing
An external review was undertaken by Prof. Janice Stevens on 19th November and a report and recommendations has been received. An action plan was generated and this was recommended by the Quality and Clinical Performance Committee in January.	Executive Director of Nursing & Workforce	Jan-13	In progress

Isle of Wight NHS Trust Board Performance Report 2013/14

May 13

Formal Complaints

Isle of Wight NHS Trust

Commentary:

There were 14 formal provider complaints received in May 2013 (22 previous month).

Across all complaints and concerns in May 2013:
Top 2 areas complained about were:
- General Surgery/Urology (9);
- Emergency Department (6)

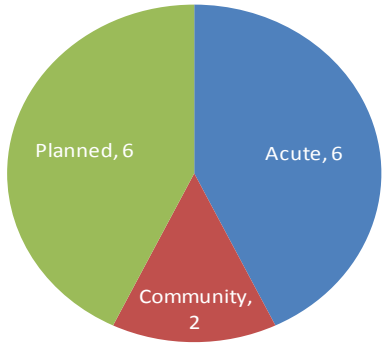
Across all complaints and concerns in May 2013:
Top 3 subjects complained about were:
- Out-patient delay/cancellations(29);
- Clinical Care (14);
- Communication (14)

Again this month, there were no complainants returning dissatisfied.

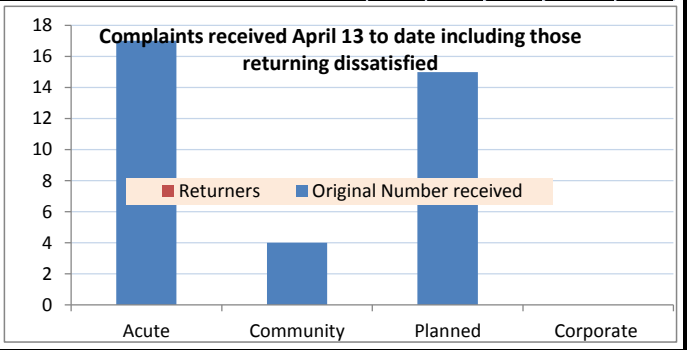
Quality Account Priority 3 - Improving Communication
The target of a 20% reduction in both complaints & concerns regarding communication is being monitored and this was achieved across both categories in May

Analysis:

Complaints by Directorate (May-13)



Primary Subject	May 2012	Apr 2013	May 2013	CHANGE	RAG rating
Clinical Care	11	12	6	-6	↓
Nursing Care	8	2	3	1	↑
Staff Attitude	5	1	0	-1	✓
Communication	2	2	1	-1	↓
Outpatient Appointment Delay / Cancellation	4	5	2	-3	↓
Inpatient Appointment Delay / Cancellation	0	0	0	0	✓
Admission / Discharge / Transfer Arrangements	1	0	1	1	↑
Aids and appliances, equipment and premises	0	0	0	0	✓
Transport	1	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	2	0	0	0	✓
Other	0	0	1	1	↑



KPI Description	Target (cumulative)	Year	Apr	May
Reduction in complaints relating to communication	↓20%	2012/13	3	4
		2013/14	4	1
Reduction in concerns relating to communication	↓20%	2012/13	20	19
		2013/14	17	12

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 Patient Experience Officers 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

Commentary:

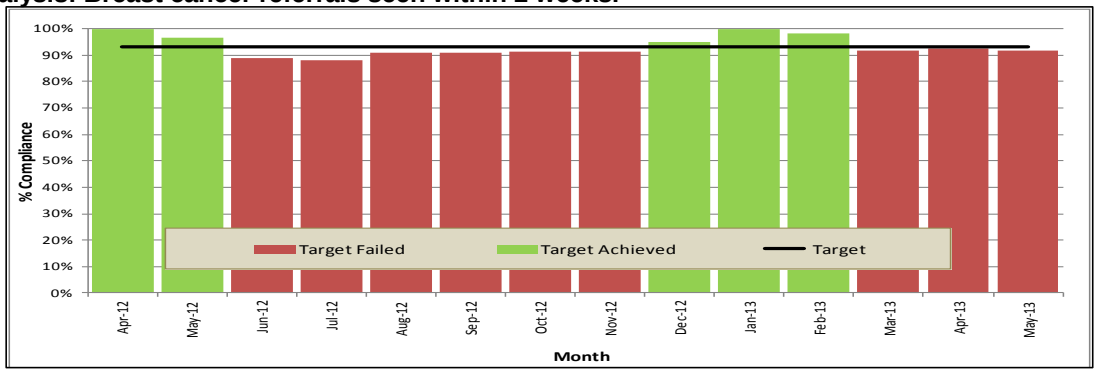
All May figures are still provisional.

Breast cancer referrals seen within 2 weeks.
All 5 breaches this month were patient -led.

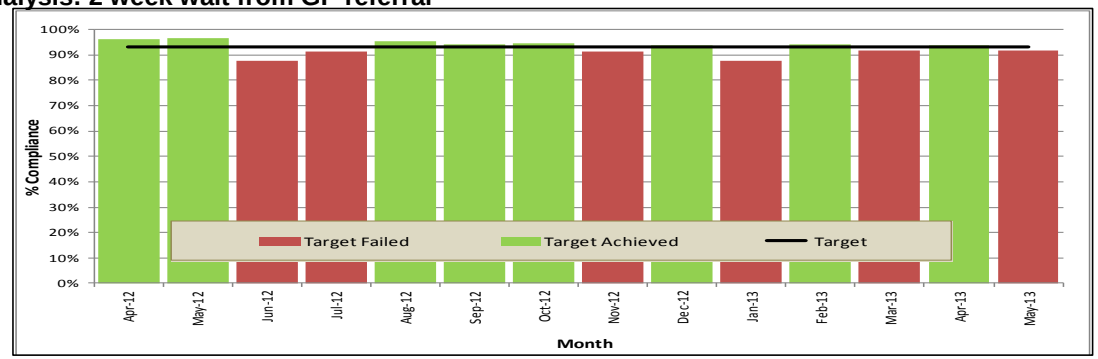
2 Week wait from GP referral
15 breaches were patient-led with 16 hospital-led.

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

Analysis: Breast cancer referrals seen within 2 weeks.



Analysis: 2 week wait from GP referral



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	May-13	2678	2669	-9	✓		⇩
Workforce Variable FTE	May-13	144	128	-16	✓		⇩
Workforce Total FTE	May-13	2822	2797	-25	✓	✓	⇩

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	May-13	£9,214	£9,340	£126	✗		⇩
In Month Variable Hours	May-13	£60	£631	£571	✗		⇩
In Month Total Paybill	May-13	£9,274	£9,971	£697	✗		⇩
Year-to Date Paybill	May-13	£18,528	£19,843	£1,315	✗	✗	

Sickness Absence	Period	Month Target/Plan	Month Actual		RAG Rating
In Month Absence Rate	May-13	3%	3.89%		✗

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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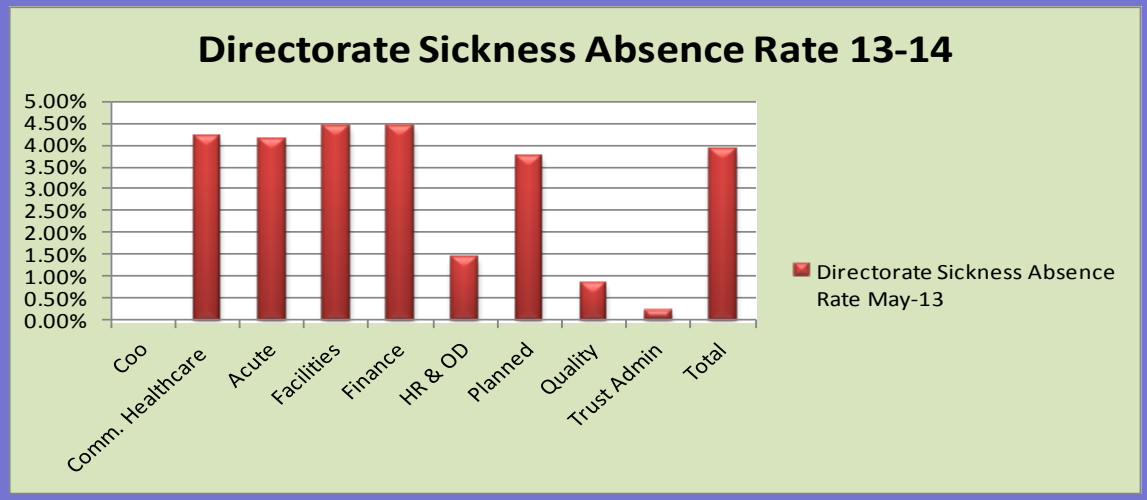
Sickness Absence - Monthly Sickness Absence by Directorate

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

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 2 Income & Expenditure position is on plan at a surplus of £556k	Green	Green	Green
Cost Improvement Programme (CIP)	• Month 2 - CIPs achieved 1,152k against a plan of £1,152k by recognising a risk rated element of the full year budget holder LEAN initiative savings	Amber	Amber	Green
Working Capital & Treasury	• Cash 'in-hand' and 'at-bank' at Month 2 was £7,805k	Green	Green	Green
Capital	• Capital YTD spend £596k . Forecast £7,560k to year end	Green	Green	Green

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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	12,846	12,891	46	24,604	24,988	384	145,971	145,971	-
Acute	311	366	55	617	1,357	739	3,815	3,815	-
Community Health	150	242	92	350	541	191	2,099	2,099	-
Planned	215	233	18	422	531	109	2,696	2,696	-
Corporate	206	568	362	408	1,063	655	2,445	2,445	-
Reserves	-	-	-	-	-	-	-		
Total Income	13,728	14,301	572	26,402	28,480	2,078	157,026	157,026	-
Pay									
Acute	2,820	3,139	319	5,618	6,210	592	33,953	33,953	-
Community Health	2,696	2,787	91	5,352	5,527	175	31,949	31,949	-
Planned	2,562	2,627	65	5,131	5,258	127	30,981	30,981	-
Corporate	1,196	1,417	222	2,427	2,848	421	14,641	14,641	-
Reserves	-	-	-	-	-	-	-	-	-
Total Pay	9,274	9,971	697	18,528	19,843	1,315	111,524	111,524	-
Non-Pay									
Acute	1,428	1,298	(129)	2,196	2,473	277	10,251	10,251	-
Community Health	369	354	(15)	724	764	41	4,124	4,124	-
Planned	732	742	10	1,334	1,411	76	7,040	7,040	-
Corporate	1,207	1,568	362	3,064	3,433	369	22,207	22,207	-
Reserves	-	-	-	-	-	-	7,313	7,313	-
Total Non-Pay	3,735	3,963	228	7,318	8,081	763	50,936	50,936	-
CIP's (unallocated)	352		(352)				(7,035)	(7,035)	-
Net Surplus / (Loss)	**367**	**367**	**(0)**	**556**	**556**	**(0)**	**1,600**	**1,600**	**0**

Overall Position:

Month 2 position is £367k surplus as per plan.
Income - Income in the month is £572k above plan, YTD £2,078. Patient care income is higher due to NCA income. Acute over performance of £739k 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 £697k, YTD £1,315k. The £592k overspend in Acute is due to prison contract extension and Beacon Dermatology costs. Overspend of £222k in Corporate is mainly the EMH pay costs.

Non Pay – In month the non pay is above plan by £228k. Acute spend above plan of £277k is due to the prison contract extension and drug costs incurred.

CIP – Plan of £1,152k achieved at month 2 with the recognition of the full year savings of all banked CIPs, £498k relates to LEAN initiatives.

Reserve - reserve allocated at M2 for cost pressures, service developments, CQUIN and Non pbr drugs £7,3135k

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Cost Improvement Programme - CIP by Directorates

Isle of Wight NHS Trust

	Month			YTD			Full Year		
Directorates	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Acute	169	317	148	333	375	42	2,461	2,461	0
Community Health	153	279	126	301	279	-22	2,236	2,236	0
Finance and Performnc Mgt	9	138	129	17	138	122	160	160	0
Nursing and Workforce	30	118	88	60	118	58	450	450	0
Planned	181	242	61	358	242	-116	2,506	2,506	0
Strategic & Commercial Directorate	41		-41	83	0	-83	448	448	0
Strategic & Commercial Directorate	**583**	**1,094**	**511**	**1,152**	**1,152**	**0**	**8,260**	**8,260**	**0**

The CIP plan for M2 is £583k. The actual in month savings totalled £1,094k. This includes the full year effect of schemes banked amounting to £596k. As Acute and Community are confident of delivering the savings relating to Budget Holder LEAN initiatives in full (£750k), a risk adjusted value of £498k is included in the YTD position.

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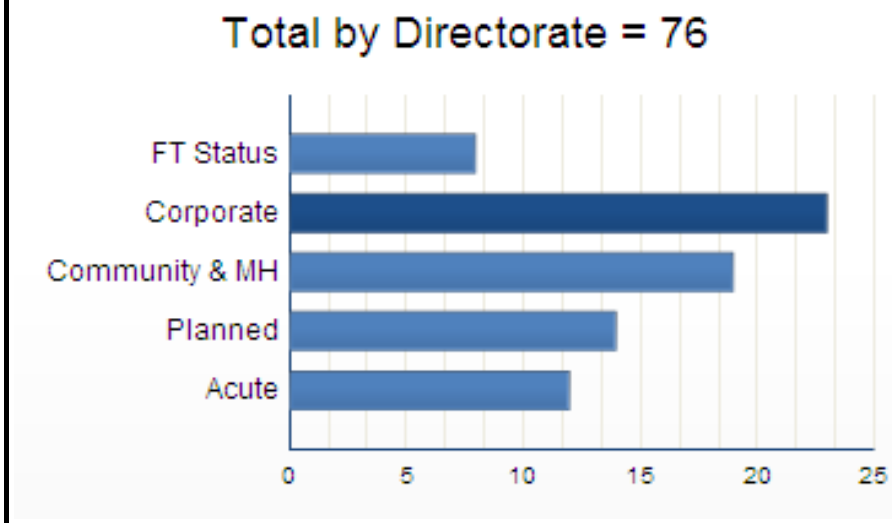
Capital Programme - Capital Schemes

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	200	102	302
Onsite Helipad	31	7	37
Replacement of 2 Main Hospital Passenger Lifts	0	296	296
Old HSDU Refurb (Phase 1)	81	1	82
Shackleton Newchurch Move	63	3	66
Improving Birthing Environment	35	6	41
Pit Alarms - Personal Alarm System - Sevenacres	29	1	30
Cashiers Drop Safe Location		7	7
Community Health System	70	11	81
Modernisation of Pathology	43	43	86
Emergency Dept Redevelopment	9	1	10
Approved Schemes for 13.14			
Pathology Phase 2	0	857	857
MAU Extension Fees	0	25	25
Ophthalmology/Endoscopy Fees	0	50	50
ISIS - IT Partner Project Management	6	11	17
CT Scanner	0	57	57
Endoscopy Camera and Insufflator	0	95	95
JAC Symphony Interface	0	15	15
Theatre Stock Inventory	0	144	144
Schemes not yet approved but in the revised Plan for 13.14			
Ophthalmology/Endoscopy	0	1,250	1,250
MAU Extension (now in 14.15)	0	0	0
Maternity Upgrade	0	456	456
Dementia Wing	0	0	0
Community Health Hub	0	700	700
Stroke & Rehab Ward Reconfiguration (Nth Wing)	0	600	600
Backlog high/medium risk &fire safety	0	900	900
Information Technology	0	468	468
Rolling Replacement Programme – Equipment / Ambulances	0	348	348
Infrastructure (e.g. underground services)	0	300	300
Staff Capitalisation	29	71	100
Contingency	0	141	141
Gross Outline Capital Plan	**596**	**6,964**	**7,560**

Commentary:
Year to date spend now being captured
AD's met to reconsider Priorities this year which is reflected above (main impact MAAU into 14.15)

Analysis:



	Risk Title	Directorate	Type	Rating
1	OPHTHALMOLOGY DEPARTMENT (BAF 6.10)	PLANND	PATEXP	25
2	ENDOSCOPY NEW BUILD (BAF 6.10)	PLANND	QCE	25
3	MANDATORY TRAINING (BAF 10.13)	CORPRI	GOVCOM	20
4	BLOOD SCIENCES OUT-OF-HOURS STAFFING (BAF 4.4)	ACUTE	QCE	20
5	VACANT CONSULTANT PHYSICIAN POSTS (BAF: 10.73)	ACUTE	QCE	20
6	BREAKDOWN OF 4 SLICE CT SCANNER (BAF 2.26)	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 '	COMMH	PATSAF	20
11	END OF CURRENT PACS CONTRACT 2013 (BAF 6.10)	ACUTE	GOVCOM	20
12	OCCUPATIONAL THERAPY EXTENDED WAITING TIMES (BAF: 2.26)	COMMH	PATSAF	20
13	FIRE COMPARTMENTS - CAUSE AND EFFECT OF FIRE ALARM SYSTE	CORPRI	GOVCOM	20
14	SEGREGATION, CONSIGNING AND COLLECTION OF CLINICAL WAS	CORPRI	GOVCOM	20
15	SUBSTANTIAL FIRE RISK TO BUILDING 02 (Old Social Club) (BAF 6.:	CORPRI	GOVCOM	20
16	PRESSURE ULCERS (BAF 2.22)	CORPRI	PATEXP	20
17	INFECTION CONTROL RISK DUE TO UNEXPECTED SHORTAGE OF DI	CORPRI	PATSAF	20
18	DECONTAMINATION MACHINES (Links with 428)(BAF 2.21)	PLANND	GOVCOM	20
19	HEATING IN NICU (BAF 2.22)	PLANND	PATSAF	20
20	VACANCIES IN ADULT SPEECH & LANGUAGE THERAPY TEAM (BAF:	COMMH	PATSAF	20

Data as at 17/6/2013 Risk Register Dashboard

Commentary

The risk register is reviewed monthly both at Trust Executive Committee/Directorate Boards and relevant Trust Executive 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 - May (month 2)

Isle of Wight NHS Trust

								Insert the Score (1-5) Achieved for each Criteria Per Month				
			Risk Ratings					Reported Position		Normalised Position		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	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**	

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Performance Summary - Acute Directorate

Isle of Wight NHS Trust

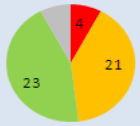
Performance on a Page - Acute Directorate

Governance Risk Rating M01: 0 - G

Risk Register Summary: As at 11/06/2013

Risk Title	Risk Score	Type
Breakdown of 4 slice CT scanner	20	QCE
Vacant Consultant Physician Posts	20	QCE
Blood Sciences out-of-hours staffing	20	QCE
End of current PACS contract 2013	20	GOVCOM

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	May-13	98.5%	98.5%	98.5%	98.5%
MRSA	May-13	0	0	0	0
CDIFF	May-13	2	0	2	0
RTT Admitted - % within 18 Weeks	Apr-13	92.3%			
RTT Non Admitted - % within 18 Weeks	Apr-13	97.1%	97.9%		
RTT Incomplete - % within 18 Weeks	Apr-13	94.9%	94.8%		
RTT delivery in all specialties	Apr-13	0	0		
Diagnostic Test Waiting Times	May-13	7	0	14	0
Cancer 2 wk GP referral to 1st OP	May-13	91.95%		92.84%	
Breast Symptoms 2 wk GP referral to 1st OP	May-13	91.80%		92.24%	
31 day second or subsequent (surgery)	May-13	100.0%		100.0%	
31 day second or subsequent (drug)	May-13	100.0%		100.0%	
31 day diagnosis to treatment for all cancers	May-13	100.0%		99.2%	
62 day referral to treatment from screening	May-13	100.0%		100.0%	
62 days urgent referral to treatment of all cancers	May-13	92.5%		88.7%	
Delayed Transfers of Care	Q4 12/13	0.03%		0.02%	
Mixed Sex Accommodation Breaches	May-13	0	0	0	0
VTE Risk Assessment	May-13	92.0%		90.6%	
% of Category A calls within 8 minutes (Red 1)	May-13	68.2%	68.2%	71.1%	68.2%
% of Category A calls within 8 minutes (Red 2)	May-13	75.4%	75.4%	76.7%	75.4%
% of Category A calls within 19 minutes	May-13	97.3%	97.3%	97.3%	97.3%

*Cancer figures for May are provisional

Workforce Headlines:

As at M02:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
% Sickness Absenteeism	3.89%	4.13%	3.68%	3.92%
FTE vs Budget			-100.0	-18.0
Appraisals			42.3%	20.7%

Finance Headlines:

£000

As at M02:	YTD Org	YTD Directorate	Forecast Outturn Org	Forecast Outturn Directorate
Actual vs Budget	-0.4	TBC	0.0	TBC
CIP	0.0	TBC	0.0	TBC

Quality Headlines:

As at M02:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
SIRIs	14	3	25	7
Incidents	406	136	805	284
Complaints	14	6	36	17

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 M1:	Activity Actual	Activity Var to Plan	Income - £000 Actual	Income - £000 Var to Plan
Emergency Spells	701	-56	1,341	-16.0
Elective Spells	9	-7	16	-8.8
Outpatients Attendances	2,190	106	340	12.6
Total			1,696	-12.2

Isle of Wight NHS Trust Board Performance Report 2013/14

May 13

Performance Summary - Planned Directorate

Isle of Wight NHS Trust

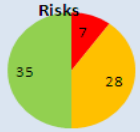
Performance on a Page - Planned Directorate

Governance Risk Rating M01: 0.5 - G

Risk Register Summary: As at 11/06/2013

Risk Title	Risk Score	Type
Endoscopy new build	25	QCE
Ophthalmology Department	25	PATEXP
Heating in NICU	20	PATSAF
Decontamination Machies	20	GOVCOM

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	May-13	98.5%		98.5%	
MRSA	May-13	0	0	0	0
CDIFF	May-13	2	0	2	0
RTT Admitted - % within 18 Weeks	Apr-13	92.3%	92.3%		
RTT Non Admitted - % within 18 Weeks	Apr-13	97.1%	96.6%		
RTT Incomplete - % within 18 Weeks	Apr-13	94.9%	94.8%		
RTT delivery in all specialties	Apr-13	0	0		
Diagnostic Test Waiting Times	May-13	7	7	14	14
Cancer 2 wk GP referral to 1st OP	May-13	91.95%	91.95%	92.84%	92.84%
Breast Symptoms 2 wk GP referral to 1st OP	May-13	91.80%	91.80%	92.24%	92.24%
31 day second or subsequent (surgery)	May-13	100.0%	100.0%	100.0%	100.0%
31 day second or subsequent (drug)	May-13	100.0%	100.0%	100.0%	100.0%
31 day diagnosis to treatment for all cancers	May-13	100.0%	100.0%	99.2%	99.2%
62 day referral to treatment from screening	May-13	100.0%	100.0%	100.0%	100.0%
62 days urgent referral to treatment of all cancers	May-13	92.5%	92.5%	88.7%	88.7%
Delayed Transfers of Care	Q4 12/13	0.03%		0.02%	
Mixed Sex Accommodation Breaches	May-13	0	0	0	0
VTE Risk Assessment	May-13	92.0%		90.6%	
% of Category A calls within 8 minutes (Red 1)	May-13	68.2%		71.1%	
% of Category A calls within 8 minutes (Red 2)	May-13	75.4%		76.7%	
% of Category A calls within 19 minutes	May-13	97.3%		97.3%	

*Cancer figures for May are provisional

Workforce Headlines:

As at M02:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
% Sickness Absenteeism	3.89%	3.73%	3.68%	3.25%
FTE vs Budget			-100.0	-20.0
Appraisals			42.3%	32.6%

Finance Headlines:

£000

As at M02:	YTD Org	YTD Directorate	Forecast Outturn Org	Forecast Outturn Directorate
Actual vs Budget	-0.4	94.2	0.0	0.0
CIP	0.0	17.7	0.0	0.0

Quality Headlines:

As at M02:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
SIRIs	14	1	25	3
Incidents	406	86	805	179
Complaints	14	6	36	15

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 M1:	Activity Actual	Activity Var to Plan	Income - £000 Actual	Income - £000 Var to Plan
Emergency Spells	410	7	952	51.4
Elective Spells	587	-79	976	-147.3
Outpatients Attendances	5,701	26	759	15.9
Total			2,688	-80.0

Isle of Wight NHS Trust Board Performance Report 2013/14

May 13

Performance Summary - Community Health Directorate

Isle of Wight NHS Trust

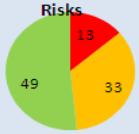
Performance on a Page - Community Directorate

Governance Risk Rating M01: 0 - G

Risk Register Summary: As at 11/06/2013

Risk Title	Risk Score	Type
Occupational Therapy Entended Waiting Times	20	PATSAF
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	May-13	98.5%		98.5%	
MRSA	May-13	0	0	0	0
CDIFF	May-13	2	2	2	2
RTT Admitted - % within 18 Weeks	Apr-13	92.3%			
RTT Non Admitted - % within 18 Weeks	Apr-13	97.1%	97.8%		
RTT Incomplete - % within 18 Weeks	Apr-13	94.9%	96.1%		
RTT delivery in all specialties	Apr-13	0	0		
Diagnostic Test Waiting Times	May-13	7	0	14	0
Cancer 2 wk GP referral to 1st OP	May-13	91.95%		92.84%	
Breast Symptoms 2 wk GP referral to 1st OP	May-13	91.80%		92.24%	
31 day second or subsequent (surgery)	May-13	100.0%		100.0%	
31 day second or subsequent (drug)	May-13	100.0%		100.0%	
31 day diagnosis to treatment for all cancers	May-13	100.0%		99.2%	
62 day referral to treatment from screening	May-13	100.0%		100.0%	
62 days urgent referral to treatment of all cancers	May-13	92.5%		88.7%	
Delayed Transfers of Care	Q4 12/13	0.03%		0.02%	
Mixed Sex Accommodation Breaches	May-13	0	0	0	0
VTE Risk Assessment	May-13	92.0%		90.6%	
% of Category A calls within 8 minutes (Red 1)	May-13	68.2%		71.1%	
% of Category A calls within 8 minutes (Red 2)	May-13	75.4%		76.7%	
% of Category A calls within 19 minutes	May-13	97.3%		97.3%	

*Cancer figures for May are provisional

Workforce Headlines:

As at M02:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
% Sickness Absenteeism	3.89%	4.20%	3.68%	4.14%
FTE vs Budget			-100.0	-33.0
Appraisals			42.3%	59.3%

Finance Headlines:

£000

As at M02:	YTD Org	YTD Directorate	Forecast Outturn Org	Forecast Outturn Directorate
Actual vs Budget	-0.4	TBC	0.0	TBC
CIP	0.0	TBC	0.0	TBC

Quality Headlines:

As at M02:	In Month Org	In Month Directorate	YTD Org	YTD Directorate
SIRIs	14	10	25	15
Incidents	406	134	805	230
Complaints	14	2	36	4

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 M1:	Activity Actual	Activity Var to Plan	Income - £000 Actual	Income - £000 Var to Plan
Community Contacts			n/a	n/a
Mental Health Community	4,259	-1,094	n/a	n/a
Mental Health Consultant Led Outpatients	553	36	n/a	n/a
Mental Health Inpatients	73	-12	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
CDS	Commissioning Data Sets
DNA	Did Not Attend
DIPC	Director of Infection Prevention and Control
LOS	Length of stay
MRSA	Methicillin-resistant Staphylococcus Aureus (bacterium)
PEO	Patient Experience Officer
PPIs	Proton Pump Inhibitors (Pharmacy term)
PIDS	Performance Information Decision Support (team)
Provisional	Raw data not yet validated to remove permitted exclusions (such as patient choice to delay)
RCA	Route Cause Analysis
RTT	Referral to Treatment Time
SUS	Secondary Uses Service
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

ESR	Electronic Staff Roster
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 (Part 1 – Public)

ON 26th June 2013

Title	IW NHS Trust Board - Data Quality Report
Sponsoring Director	Executive Director of Finance
Author(s)	Iain Hendey – Assistant Director – Performance Information & Decision Support
Purpose	This paper has been developed in response to the various external assessments undertaken to review Board Governance and forms part of the Trust Board assurance process

Previously considered by (state date):	
Executive Board	
Audit and Corporate Risk Committee	
Finance, Investment & Workforce Committee	
Charitable Funds 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	
Patient Confidentiality	
Other (please state)	

Staff, stakeholder, patient and public engagement:

Executive Summary:

This report aims to provide an assessment of the data quality of each of the KPIs presented within the Trust Board Performance Report and where necessary identify areas for improvements in data quality. The report will also outline controls in place to ensure there is ongoing assurance of data quality.

For following sections – please indicate as appropriate:					
Trust Goals 2013/2018:	✓ **Quality**	☐ **Clinical Strategy**	✓ **Resilience**	✓ **Productivity**	✓ **Workforce**
Board Objectives 2012/13:					
Related Trust objectives	✓ **Quality**	☐ **Innovation**	✓ **Productivity**	✓ **Prevention**	✓ **Reform**
Priorities & Targets	1. **Improve the experience and satisfaction of patients, carers, partners and staff** 2. **Improve clinical effectiveness and the safety and outcomes for patients**				

(delete as appropriate)	**3. Continuously develop and implement our business plan** **4. Develop our Foundation Trust application in line with the timetable set out in our agreement with the SLA** **5. Develop our organizational culture, processes and capabilities to be a thriving FT dedicated to our patients**		
Risk and Assurance - items below relate to the Board Assurance Framework 2012/13 ***(please see document for details)***			
Critical Success Factor *(eg CSF1)*	CSF5 - Improve the value for money we offer and generate a surplus		
Principal Risks ***(please enter applicable numbers – eg 1.1; 1.6)***	5.5 There is little routine validation of key knowledge capturing systems		
Assurance Level ***(shown on BAF)***	☐ Red	✓ Amber	☐ Green
Legal implications, regulatory and consultation requirements			
Action required by the Board:	☐ Receive	✓ Approve	
Date: 18th June 2013	**Completed by: Iain Hendey**		

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Isle of Wight NHS Trust

Isle of Wight NHS Trust Board - Data Quality Report

Background

This paper has been developed in response to the various external assessments undertaken to review Board Governance and forms part of the Trust Board assurance process. Each of the Board assessors identified that until now there was no mechanism or procedure in place to allow the board to make a judgement on the data quality of the main Key Performance Indicators (KPIs) included within the Trust Board Performance Report (TBPR).

It should be emphasised that this report focuses only on the quality of the data used to underpin the main KPIs reported to the Board and does not intend to cover organisation wide data quality for which there is an approved Data Quality Policy and assessed as part of the TBPR.

There were a number of recommendations made to the board to assess and understand the quality and robustness of the data provided within the TBPR, as follows:

- The TBPR should contain a RAG rated assessment of the data quality of each metric. This would assess: Timeliness, Data Source and Sign off Arrangements.
- The Trust would benefit from an Information Assurance Directory for the indicators that appear in the TBPR. This framework would include definitions of calculations and sources of data. Such a document would increase the common understanding throughout the Trust and drive data completeness and accuracy.
- Processes are in place for providing assurance to the Board that the evidence underpinning the self – assessment and ongoing self certification is robust.

This report therefore aims to provide an assessment of the data quality of each of the KPIs presented within the TBPR and where necessary identify areas for improvements in data quality. The report will also outline controls in place to ensure there is ongoing assurance of data quality.

In order to achieve these aims each KPI has been given a data quality rating, based on the following categories:

Poor – Quality of the source data underpinning the KPI may have high error rates, is not complete, or is subject to significant delays in reporting; as such, the degree of confidence in the reported KPI is low.

Fair – Quality of the source data underpinning the KPI may have some errors, have moderate completeness or is reported in a reasonably timely fashion; as such the degree of confidence in the reported KPI is moderate.

Good – Quality of the source data underpinning the KPI is good, is complete, and is not subject to reporting delays; as such the degree of confidence in the reported KPI is high and can be relied upon as a true measure of performance.

Information Assurance Directory

In line with recommendations and according to good practice an Information Assurance Directory has been developed. This document details the main KPIs included in the TBPR. It is intended to serve as a point of reference for Board members, but it will also provide a useful document for staff who may view the performance report.

KPIs contained within the TBPR are set by the Trust or are required by external organisations, such as the CCG, TDA or Monitor.

The following table offers a guide to the content of the Information Assurance Directory:

Data Element	Purpose
Ref.	The reference number of the selected indicator
Indicator description	The Indicator name
Data Item	Describes the data that is used to underpin the KPI, this maybe multiple if there is a numerator and a denominator.
Sources of data	Identification of where the data underpinning the indicator comes from
Data Collection Method	Describes whether the data is recorded electronically or manually
RAG Threshold	Describes the parameters against which the RAG rating is applied
Target	Indicates the minimum standard to be achieved
Indicator Calculation Methodology	Describes how the indicator is calculated and how it is expressed
Monitoring Frequency	How often is the indicator measured
Indicator Data Quality Rating	Good, Fair or Poor (see above guidance)

Due to the ever-changing environment in which the Trust operates particularly due to contractual requirements, change in policy or focus area the board should expect to see the KPIs in the TBPR reflect this. Therefore, the Information Assurance Directory will be adapted to those changes, so it will be dynamic in nature, rather than a one off process of production. This will be used to provide ongoing assurance of data quality to the Board.

Methodology for Establishing DQ of KPIs

In order to make a judgment as to the data quality, for each indicator the following elements of data quality have been assessed:

- Data Completeness – Are all the required data items present?
- Timeliness – Are the data available at the right time
- Validity – Is the information within the expected range

For each of these elements, each indicator has been assigned a rating 'Good', 'Fair' or 'Poor', Good meaning high or good quality data and poor meaning low or poor quality data. These rating have been determined using the following criteria:

	Good	Fair	Poor
Data Completeness	All data known to be present	High probability that all data is present	Data known to be incomplete or unknown level of data completeness
Timeliness	Reporting Period no more than 1 month old	Reporting period no more than 3 months old	Reporting period greater than 3 months old.
Validity	Data has been fully validated	Data has been partially validated	Data is un-validated

A scoring system has then been used to allow an overall assessment of data quality for each indicator. For each of the three elements a score is assigned as follows:

- Good = 1
- Fair = 2
- Poor = 3

Finally these scores are added up to form an overall score between 3 and 9, it is this score is used to determine overall quality of each of the indicators as follows:

- Less than or equal to 4 is considered Good Quality
- Greater than 4 but less than or equal to 7 is considered Fair Quality
- Greater than 7 is considered Poor Quality

Findings

Overall the data quality of the information reported to the Board within the TBPR is of a good standard there are no indicators currently assessed that are considered poor. The table below summarises the current data quality rating.

Domain	Good	Fair	Poor	TBC
Patient Safety, Quality & Experience	14	4	0	1
Operational Performance Targets	18	3	0	0
Workforce performance Targets	6	3	0	0
Finance & Efficiency Performance Targets	15	4	0	2
Total	53	14	0	3

A more detailed assessment of findings can be found in appendix 1 and appendix 2 of this report.

Recommendation

Following this assessment it is recommended that an action plan for areas of fair data quality is developed to ensure the data quality for all metrics is of good quality by December 2013. Furthermore it is proposed that the Board receive regular updates on data quality on a quarterly basis, along with progress against the action plan. It is also recommended that all new indicators are assessed for data quality utilising the above methodology. Finally the Board should give consideration to gaining an external assessment of the data quality of the KPIs in order to provide further assurance.

Iain Hendey
Assistant Director – Performance Information & Decision Support
11th June 2013

Appendix 1 – Information Assurance Directory

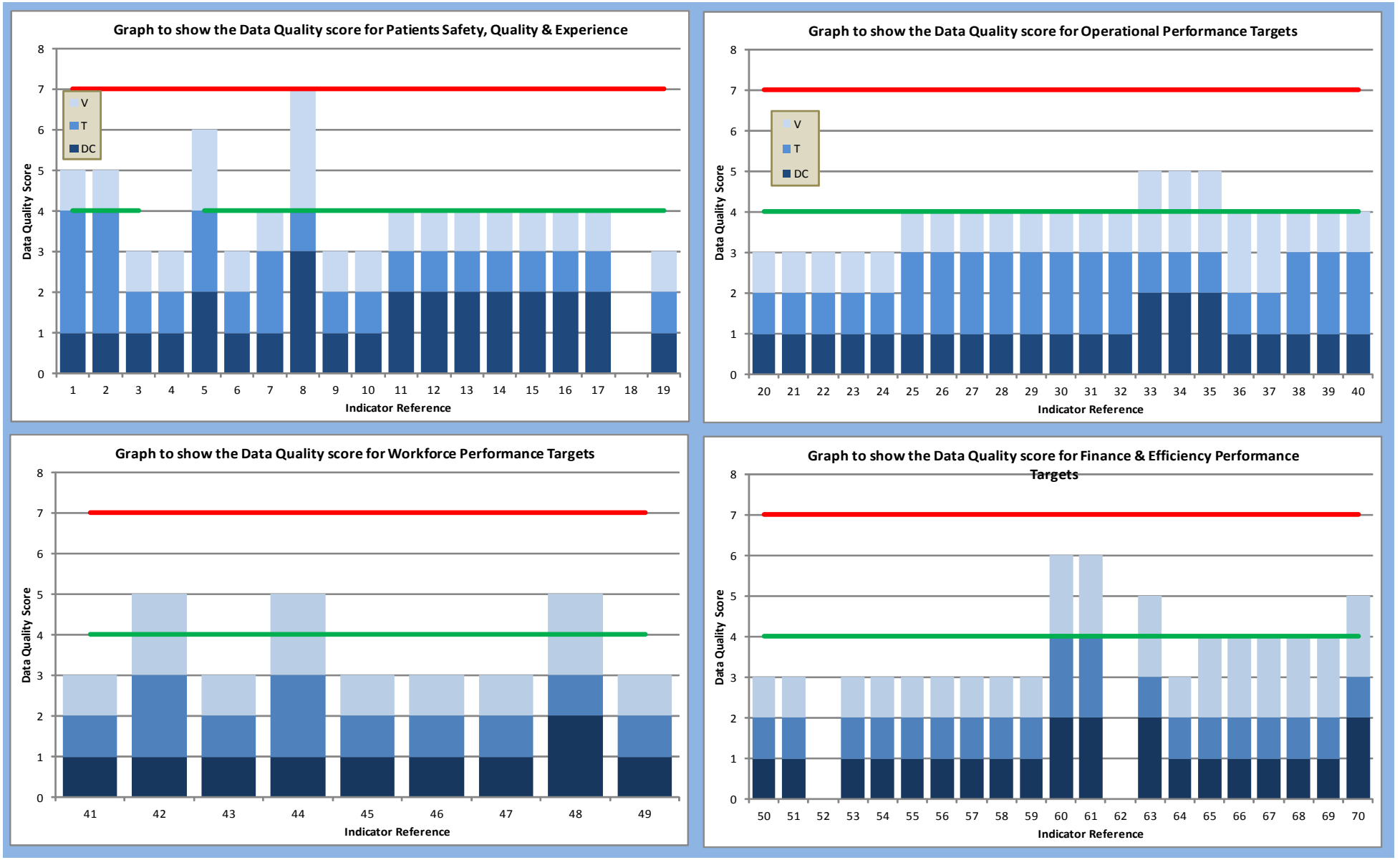
Ref	Indicator Description	Data item 1	Data Source 1	Data Item 2	Data Source 2	Data Collection Method	RAG Threshold	Target	Calculation Methodology	Monitoring Frequency	Overall Indicator Data Quality
	Patient Safety, Quality & Experience										
1	Summary Hospital-level Mortality Indicator (SHMI)*	SHMI Score	Health & Social Care Information Centre			Electronic	R=Above Expected A=As Expected but above plan G=As Expected but on or below plan	1.0856	Calculated externally using the number of observed deaths / number of expected deaths and then standardised	Quarterly	Fair
2	Hospital Standardised Mortality Ratio (HSMR) (Dec 11 to Nov 12)	HSMR Score	Dr Foster			Electronic	TBC	TBC	Calculated externally using the number of observed deaths / number of expected deaths and then standardised	Quarterly	Fair
3	Patients admitted that develop a grade 4 pressure ulcer	Number of cofirmed hospital acquired cases	Datix			Electronic	TBC	0	Number of cofirmed hospital acquired cases	Monthly	Good
4	Patients admitted that develop a grade 2 or 3 pressure ulcer	Number of cofirmed hospital acquired cases	Datix			Electronic	TBC	50% of 12/13 Baseline	Number of cofirmed hospital acquired cases	Monthly	Good
5	Level 1 & 2 CAHMS seen within 18 weeks referral to treatment	CAHMS patients who waited 18 weeks or less	PAS	Total CAHMS patients onWaiting list	PAS	Electronic	R = <95% A = 95% or > but < 100% G = 100%	100%	Number of patients waiting < 18 weeks / Total number waiting	Monthly	Fair
6	Number of children 16 or under admitted to an Adult MH Ward	Number of children 16 or under admitted to an Adult MH Ward	PAS			Electronic	R = >2 A = 2 or < but >0 G = 0	0	Number of children 16 or under admitted to an Adult MH Ward	Monthly	Good
7	28 Day readmission rate in MH	Number of 28 Day readmission in MH	PAS	Total number of Amissions in MH	PAS	Electronic	TBC	Improvement on 12/13 Baseline	28 Day readmission rate in MH calculated by dividing the number of 28 day readmissions in MH by the total admissions in MH	Monthly	Good
8	VTE	Number of Admissions Screened for VTE	e-prescribing	Number of Admissions	PAS	Electronic	R - Below plan G - Above plan or equal to plan	90%	(Number of VTE Screens + Number of Daycase) / (Number of inpatient admissions + Number of daycases)	Monthly	Fair
9	MRSA	Number of cofirmed hospital acquired cases	Pathology			Manual	R - Below plan G - Above plan or equal to plan	1	Number of cofirmed hospital acquired cases	Monthly	Good
10	C.Diff	Number of cofirmed hospital acquired cases	Pathology			Manual	R - Below plan G - Above plan or equal to plan	12	Number of cofirmed hospital acquired cases	Monthly	Good
11	Clinical Incidents (Major) resulting in harm	Number of Clinical Incidents (Major) resulting in harm	Datix			Electronic	TBC	TBC	Number of Clinical Incidents (Major) resulting in harm	Monthly	Good
12	Clinical Incidents (Catastrophic) resulting in harm	Number of Clinical Incidents (Catastrophic) resulting in harm	Datix			Electronic	TBC	TBC	Number of Clinical Incidents (Catastrophic) resulting in harm	Monthly	Good
13	Falls - resulting in significant injury	Number of Falls - resulting in significant injury	Datix			Electronic	R - Above plan G - Below plan or equal to plan	24	Number of Falls - resulting in significant injury	Monthly	Good
14	Delivering C-Section	Total Births by Planned & unplanned C-Section	Labour Ward Database	Total Births	Labour Ward Database	Electronic	R - More than 21% A - Between 19-21% G - Less than 20% changed sept12	<20%	% of births by C-Section calculated by the total births by C-section / total number of births	Monthly	Good
15	Normal Vaginal Deliveries	Total normal vaginal deliveries	Labour Ward Database	Total Births	Labour Ward Database	Electronic	R - 64% or below G - 65% or above	>65%	% of spontaneous vaginal delivery rate calculated by total number normal vaginal deliveries / total number of births	Monthly	Good
16	Breast Feeding	Total breastfeeding at delivery	Labour Ward Database	Total Births	Labour Ward Database	Electronic	R - Less than 70% A - Between 70% and 74% G - More than or equal to 75%	>75%	% of babies breastfeeding at birth calculated by the total number breastfeeding at birth / total number of births	Monthly	Good
17	Formal Complaints	Number of formal complaints	Datix			Electronic	R - More than last year A - Same as last year G - Less than last year	<276	Number of formal complaints	Monthly	Good
18	Patient Satisfaction (Friends & Family test - aggregated score)					Manual	TBC	TBC		Monthly	
19	Mixed Sex Accomodation	Number cases of Mixed Sex Accomodation				Manual	R - Above plan G - Below plan or equal to plan	0	Number cases of Mixed Sex Accomodation	Monthly	Good

Ref	Indicator Description	Data item 1	Data Source 1	Data Item 2	Data Source 2	Data Collection Method	RAG Threshold	Target	Calculation Methodology	Monitoring Frequency	Overall Indicator Data Quality
	Operational Performance										
20	Emergency Care 4 hour Standards	A&E Attendances less 4 hour breaches (Beacon included)	Symphony	A&E Attendances (Beacon included)	Symphony	Electronic	R - Below plan G - Above plan or equal to plan	95%	Number of A&E attendance Admitted, Discharged or Transferred within 4 hours / Number of A&E attendances	Monthly	Good
21	Ambulance Category A Calls % < 8 minutes	Number of Category A calls responded to within 8 minutes	Vivasta	Cat A calls resulting in an emergency response arriving at the scene	Vivasta	Electronic	R - Below plan G - Above plan or equal to plan	75%	Number of Cat A Calls responded to within 8 minutes / Number of Cat A calls resulting in an emergency response arriving at the scene	Monthly	Good
22	Ambulance Category A Calls % < 19 minutes	Number of Category A calls responded to within 19 minutes	Vivasta	Cat A calls resulting in an emergency response arriving at the scene	Vivasta	Electronic	R - Below plan G - Above plan or equal to plan	95%	Number of Cat A Calls responded to within 19 minutes / Number of Cat A calls resulting in an emergency response arriving at the scene	Monthly	Good
23	Stroke patients (90% of stay on Stroke Unit)	People who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	PAS	People who have had a stroke who are admitted to hospital	PAS	Electronic	R - Below plan G - Above plan or equal to plan	80%	People who have had a stroke who spend at least 90% of their time in hospital on a stroke unit / Total number of people who have had a stroke who are admitted to hospital	Monthly	Good
24	High risk TIA fully investigated & treated within 24 hours	Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are assessed and treated within 24 hours	PAS	Number of people who are referred with a suspected TIA who are at high risk of stroke	PAS	Electronic	R - Below plan G - Above plan or equal to plan	60%	Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are assessed and treated within 24 hours / Total number referred with a suspected TIA who are at high risk of stroke	Monthly	Good
25	Breast Cancer Referrals Seen <2 weeks*	Number of breast cancer referrals seen within 14-days	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	93%	Number of patients seen within 14 days / Total number seen	Monthly	Good
26	Cancer Patients receiving subsequent Chemo/Drug <31 days*	Number of patients receiving subs Chemo/Drugs treatment for cancer within 31-days	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	98%	Number of patients seen within 31 days / Total number seen	Monthly	Good
27	Cancer Patients receiving subsequent surgery <31 days*	Number of patients receiving subs surgery treatment for cancer within 31-days	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	94%	Number of patients seen within 31 days / Total number seen	Monthly	Good
28	Cancer Patients treated after screening referral <62 days*	Number of patients treated after screening referral within 62-days	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	90%	Number of patients seen within 62 days / Total number seen	Monthly	Good
29	Cancer Patients treated after consultant upgrade <62 days*	Number of patients treated after consultant upgrade within 62-days	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	85%	Number of patients seen within 62 days / Total number seen	Monthly	Good
30	Cancer diagnosis to treatment <31 days*	Number of patients receiving first definitive treatment within 31-days of a cancer diagnosis	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	96%	Number of patients seen within 31 days / Total number seen	Monthly	Good
31	Cancer urgent referral to treatment <62 days*	Number of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	85%	Number of patients seen within 62 days / Total number seen	Monthly	Good
32	Cancer patients seen <14 days after urgent GP referral*	Number of patients seen within 14-days of an urgent GP referral for suspected cancer	Open Exeter	Total nuber of patients seen in category	Open Exeter	Electronic	R - More than 5% below target A - Up to 5% below target G - On or above target	93%	Number of patients seen within 14 days / Total number seen	Monthly	Good
33	RTT:% of admitted patients who waited 18 weeks or less	Admitted patients who waited 18 weeks or less	PAS	Total on Admitted Waiting list	PAS	Electronic	R - Below plan G - Above plan or equal to plan	90%	Number of patients waiting < 18 weeks / Total number waiting	Monthly	Fair
34	RTT: % of non-admitted patients who waited 18 weeks or less	Non - Admitted patients who waited 18 weeks or less	PAS	Total on Non Admitted Waiting list	PAS	Electronic	R - Below plan G - Above plan or equal to plan	95%	Number of patients waiting < 18 weeks / Total number waiting	Monthly	Fair
35	RTT % of incomplete pathways within 18 weeks	Incomplete patients who waited 18 weeks or less	PAS	Total on Incomplete Waiting list	PAS	Electronic	R - Below plan G - Above plan or equal to plan	92%	Number of patients waiting < 18 weeks / Total number waiting	Monthly	Fair
36	No. Patients waiting > 6 weeks for diagnostic	Patients waiting > 6 weeks for diagnostic	CRIS / PAS			Electronic	R - Below plan G - Above plan or equal to plan	100	Number of patients waiting > 6 weeks	Monthly	Good
37	%. Patients waiting > 6 weeks for diagnostic	Patients waiting > 6 weeks for diagnostic	CRIS / PAS	Total patients waiting for diagnosis	CRIS / PAS	Electronic	R - Below plan G - Above plan or equal to plan	1%	Number of patients waiting > 6 weeks / Total number waiting	Monthly	Good
38	Elective Activity (Spells) (M11 target - 703)	Number of Elective Inpatients (Ordinary and Daycase) in moth	SLAM			Electronic	R - More than 5% below target A - Between 2% and 5% below plan		Number of Elective Inpatients (Ordinary and Daycase) in moth	Monthly	Good
39	Non Elective Activity (Spells) (M11 target - 1,063)	Number of Non Elective Inpatients in moth	SLAM			Electronic	R - More than 5% below target A - Between 2% and 5% below plan		Number of Non Elective Inpatients in moth	Monthly	Good
40	Outpatient Activity (Attendances) (M11 target - 11,049)	Number of Outpatient Attendances (Attendances and Procedures) in moth	SLAM			Electronic	R - More than 5% below target A - Between 2% and 5% below plan		Number of Outpatient Attendances (Attendances and Procedures) in moth	Monthly	Good

Ref	Indicator Description	Data item 1	Data Source 1	Data Item 2	Data Source 2	Data Collection Method	RAG Threshold	Target	Calculation Methodology	Monitoring Frequency	Overall Indicator Data Quality
	Workforce										
41	Total workforce SIP (FTEs)	Number of FTE	Electronic Staff Record (ESR)			Electronic	TBC	2678	Staff In Post at the end of the period	Monthly	Good
42	Total pay costs (inc flexible working) (£000)	Paybill YTD and In-Month	SBS			Electronic	TBC	TBC	Total Pay costs at the end of the period	Monthly	Fair
43	Variable Hours (FTE)	Variable hours used	Weekly Data Inpost Reports				TBC	TBC	Variable hours used a the end of the period	Monthly	Good
44	Variable Hours (£000)	Variable Hours costs (Excess, O/T, Bank)	SBS			Electronic	TBC	TBC	Total variable hours pay costs at the end of the period	Monthly	Fair
45	Staff absences	Staff absent (days lost)	Electronic Staff Record (ESR)	Total number of absences	Electronic Staff Record (ESR)	Electronic	TBC	3%	Number of absences (days lost) / days available represented as %	Monthly	Good
46	Staff Turnover	Staff leaving (headcount)	Inpost reports	Total number staff in post (headcount)	Electronic Staff Record (ESR)	Electronic	TBC	5%	Number of staff headount leaving/staff in post headcount, represented as %	Monthly	Good
47	Mandatory Training	Staff (headcount) having undertaken mandatory training	TmPro 4	Total number of staff required to undertake mandatory training (headount)	TmPro 4	Electronic	TBC	80%	Staff (Headcount) that have undertaken mandatory training/staff in post (headcount) within month	Monthly	Good
48	Appraisal Monitoring	staff (headcount) having undertaken an appraisal in month	Intranet	Total number of staff (headcount) available for an appraisal	Electronic Staff Record (ESR)	Electronic	TBC	100%	Staff (headcount) that have undertaken an Appraisal/Staff (headcount) available for an appraisal within month	Monthly	Fair
49	Employee Relations Cases	Number of ER cases in month	Provided by HR Portal			Electronic	TBC	TBC	Number of open Employee relation cases, downloaded from HR portal	Monthly	Good

Ref	Indicator Description	Data item 1	Data Source 1	Data Item 2	Data Source 2	Data Collection Method	RAG Threshold	Target	Calculation Methodology	Monitoring Frequency	Overall Indicator Data Quality
	Finance & Efficiency										
50	Achievement of financial plan	Actual monthly financial position	General Ledger	Monthly position as per plan	General Ledger/FIMS Plan	Electronic		£1.6m Surplus	Comparison of one to the other	Monthly	Good
51	Underlying performance	Actual monthly recurrent financial position	General Ledger	Monthly recurrent position as per plan	General Ledger/FIMS Plan	Electronic		£1.6m Surplus	Comparison of one to the other	Monthly	Good
52	Net return after financing							0.50%		Monthly	
53	I&E surplus margin net of dividend	I&E Surplus (net of impairment & other gains and losses)	General Ledger	Total income	General Ledger	Electronic		=>1%	I&E Surplus (net of impairment & other gains and losses)/Income s/be =>1	Monthly	Good
54	Liquidity ratio days	Calculated no.of days liquidity	General Ledger/SOFP	Total spend	General Ledger	Electronic		=>15	Total assets less inventories plus working capital facility/total spend x days in the year	Monthly	Good
55	Monitor Financial risk rating	Various	General Ledger			Electronic	Red = < 3 Green = 3 or more	3	The FRR is calculated from data extracted by the Finance Department from the financial system. Data is collected for each of the criteria from the month end performance results and calculations are performed according to Monitor's instructions to provide FRR	Monthly	Good
56	Capital Expenditure as a % of YTD plan	Actual monthly financial position	General Ledger	Monthly position as per plan	FIMS Plan	Electronic		=>75%	Actual spend/planned spend should be <75%	Monthly	Good
57	Quarter end cash balance (days of operating expenses)	Total cash in hand and at bank at end of quarter	Bank statements/General Ledger	Total non-pay spend in period	Cashbook	Electronic		>=10%	Actual cash balance should be => (total non-pay spend in period/days in period) x 10	Monthly	Good
58	Debtors over 90 days as a % of total debtor balance	Outstanding sales debtors > 90 days	Business Intelligence Aged Debtor report	Total sales debtors at end of period	Business Intelligence Aged Debtor report	Electronic		=<5%	Outstanding sales debtors > 90 days/total sales debtors at end of period should be=<5%	Monthly	Good
59	Creditors over 90 days as a % of total creditor balance	Outstanding creditors > 90 days	Business Intelligence Aged Payables report	Total creditors at end of period	Business Intelligence Aged Payables report	Electronic		=<5%	Outstanding creditors > 90 days/total creditors at end of period should =<5%	Monthly	Good
60	Recurring CIP savings achieved	Actual Recurrent CIP Savings	General Ledger/CIP Spreadsheet	Recurrent CIP Savings Plan	CIP/Savings Plan Spreadsheet/FIMS	Electronic		100%	Actual recurrent CIP Savings/ Recurrent CIP Savings Plan	Monthly	Fair
61	Total CIP savings achieved	Total actual CIP Savings	General Ledger/CIP Spreadsheet	Total CIP Savings Plan	CIP/Savings Plan Spreadsheet/FIMS	Electronic		100%	Actual CIP Savings/ CIP Savings Plan	Monthly	Fair
62	Contract Penalties										
63	Theatre utilisation	Start of operation for first patient on list to end of operation for last patient on list	Theatreman	Planned theatre list time	Theatreman	Electronic	R - Below plan G - Above plan or equal to plan	83%	Start of operation for first patient on list to end of operation for last patient on list / Planned theatre list time	Monthly	Fair
64	Cancelled operations on day of / after admission	Number of operations cancelled on day of / after admission for non clinical reasons by the hospital	Theatreman	Total Number of First Finished Consultant Episodes for G&A Specialties	PAS	Electronic	R - More than 2.29% of General & Acute FFCE's A - Between 0.42% and 2.29% of General & Acute FFCE's	TBC	Number of operations cancelled on day of / after admission for non clinical reasons by the hospital / Total Number of First Finished Consultant Episodes for G&A Specialties	Monthly	Good
65	Average LOS Elective (non-same day)	Sum of Elective Admission Length of Stay (MH and Maternity excluded)	PAS	Sum of Elective Admissions Staying > 0 Days (MH and Maternity excluded)	PAS	Electronic		TBC	Sum of Elective Admission Length of Stay (MH and Maternity excluded) / Sum of Elective Admissions Staying > 0 Days (MH and Maternity excluded)	Monthly	Good
66	Average LOS Non Elective (non-same day)	Sum of Non Elective Admission Length of Stay (MH and Maternity excluded)	PAS	Sum of Non Elective Admissions Staying > 0 Days (MH and Maternity excluded)	PAS	Electronic		TBC	Sum of Non Elective Admission Length of Stay (MH and Maternity excluded) / Sum of Non Elective Admissions Staying > 0 Days (MH and Maternity excluded)	Monthly	Good
67	Outpatient DNA Rate	Number of Outpatient appointments with an attendance status of DNA	PAS	Total Number of Outpatient Appointments	PAS	Electronic		TBC	Number of Outpatient appointments with an attendance status of DNA / Total Number of Outpatient Appointments	Monthly	Good
68	Emergency Readmissions within 30 days	Number of Emergency Readmissions within 30 days (with PbR exclusions)	PAS	Total number of admissions (with PbR exclusions)	PAS	Electronic		TBC	Number of Emergency Readmissions within 30 days (with PbR exclusions) / Total number of admissions (with PbR exclusions)	Monthly	Good
69	Daycase Rate	Number of elective General and Acute daycase FFCEs	PAS	Total General and Acute elective FFCEs	PAS	Electronic		68%	Number of elective General and Acute daycase FFCEs expressed as a proportion (%) of the total General and Acute elective FFCEs	Monthly	Good
70	Project Management - Due milestones met	Number of Milestones due that have been met	PMO	Number of Milestones due	PMO	Manual		80%	Number of Milestones due that have been met / Number of Milestones due	Monthly	Fair

Appendix 2 – Results of Data Quality Assessment



Enc F

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD ON …26th June 2013…….

Title	2013-13 Reference Costs Board approval paper
Sponsoring Director	Director of Finance
Author(s)	Iain Hendey, Assistant Director – Performance Information Decision Support, Carol Ogilvie, Senior Finance Manager
Purpose	Following a presentation on the 22nd May to inform the Board on changes to national standards for the annual Reference Costs submission, this presentation is to update the Board on the current position following the first draft submission on the 24th June 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	
Mental Health Act Scrutiny Committee	
Charitable Funds Committee	
Quality & Clinical Governance 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

Enc F

Isle of Wight NHS
NHS Trust

Self Assurance Quality Checklist - Reference Costs (2nd iteration)

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 process for the 2012/13 submission commenced during May 2013 and a paper explaining the process and a status report was presented to the Trust Board on the 22nd May. This paper, in conjunction with a presentation, aims to inform the Board on the organisations current position following the first draft submission on the 24th June and to request approval for the Finance Director's sign off of the final submission scheduled for the 16th July 2013.

Self-assessment quality checklist (Appendix 1)

The attached indicates the position as presented to the board on the 22nd May. Following planned first draft submission on the 24th June, this will be revised and an up to date version incorporated into the presentation on the 26th June. It should be noted that the final submission deadline is not until the 16th July, which allows any issues to be addressed.

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 final submission. This will mean that some of the actions will remain outstanding in order to comply with the national deadlines.

It is proposed that following the final submission a final iteration of the Self Assurance Quality Checklist is delivered to the Board on the 31st July 2013.

Iain Hendey, Assistant Director, PIDS

Carol Ogilvie, Snr Finance Manager

18th June 2013

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		

Check	Response	Current Response	Planned Final Response	Comments
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			

Check	Response	Current Response	Planned Final Response	Comments
Data quality: Assurance is obtained over the reliability of costing and information systems	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			
	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			

Check	Response	Current Response	Planned Final Response	Comments
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.		

Enc G

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 – Public)

ON 26 June 2013

Title	QUALITY GOALS
Sponsoring Director	Director of Nursing & Workforce
Author(s)	Director of Nursing & Workforce
Purpose	To approve / sign off the quality goals for inclusion in the 2013 Quality Account

Previously considered by (state date):	
Executive Board	3 June 2013
Audit and Corporate Risk Committee	
Finance, Investment & Workforce Committee	
Charitable Funds Committee	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Quality & Clinical Performance Committee	19 June 2013
Remuneration Committee	
Please add any other committees in grey sections as needed	
Patient Confidentiality	
Other (please state)	

Staff, stakeholder, patient and public engagement:

A wide range of stakeholder consultation has been undertaken prior to the development of the Isle of Wight NHS Trust's 2013 Quality Account, including a patient experience event held in November 2012 and questionnaire to support the identification of the quality goals for 2013/14.

Engagement has taken place with all staff; representatives from the Voluntary Sector; Councillors; Communication colleagues and Media colleagues.

Executive Summary:

This paper outlines the chosen quality goals, as part of the development of the 2013 Quality Account for the Isle of Wight NHS Trust.

It is important that the Quality Account reflects the quality improvement priorities of the organisation and the local community. Feedback from the consultation with stakeholders; feedback received from a patient experience event held in November 2012, along with information related to complaints and concerns has been used to inform the decision on the key quality goals that should form the focus for 2013/14.

The quality goals reflect the three domains of quality; patient experience; patient

safety and clinical effectiveness and reflect the diversity of the organisation.					
For following sections – please indicate as appropriate:					
Trust Goals 2013/2018:	☑ **Quality**	☐ **Clinical Strategy**	☐ **Resilience**	☐ **Productivity**	☐ **Workforce**
Board Objectives 2012/13:					
Related Trust objectives	☑ **Quality**	☐ **Innovation**	☐ **Productivity**	☐ **Prevention**	☐ **Reform**
Priorities & Targets	**1. Improve the experience and satisfaction of patients, carers, partners and staff** **2. Improve clinical effectiveness and the safety and outcomes for patients** **3. Develop our relationships with key stakeholders to improve our patient services & collectively deliver a sustainable local health system**				
Risk and Assurance - items below relate to the Board Assurance Framework 2012/13 ***(please see document for details)***					
Critical Success Factor *(eg CSF1)*	CSF2 and CSF5				
Principal Risks ***(please enter applicable numbers – eg 1.1; 1.6)***	2.18 & 2.19 – seeking assurance on Quality 2.23 2.3 5.33				
Assurance Level ***(shown on BAF)***	☐ Red	☐ Amber	☑ Green		
Legal implications, regulatory and consultation requirements	The Health Act 2009 requires all providers of health care services in England to publish an annual Quality Account from April 2010.				
Action required by the Board:	☐ Receive	☑ Approve			

Date: 26 June 2013 **Completed by: Theresa Gallard**

Business & Projects Manager

Enc G

Isle of Wight NHS Trust
Trust Board
May 2013
Quality Goals 2013/14

PURPOSE

This paper provides an outline of the quality goals that have been identified for 2013/14, to be included in the Trust's Quality Account.

BACKGROUND

In 'High Quality Care for All' published in 2008 the Department of Health proposed that all providers of NHS health care should produce annual quality accounts just as they publish financial accounts. The purpose of publishing quality accounts is to support the process for improving the quality of health care services provided.

The Health Act 2009 requires all providers of health care services in England to publish an annual Quality Account from April 2010.

The key priority is to deliver standards of care that are safe and compliant with the essential standards of quality and safety that is regulated by the Care Quality Commission (CQC) under the Health and Social Care Act 2008 (Regulated Activities).

Guidance on producing Quality Accounts, issued by the Department of Health, required all healthcare organisations to identify 3 priority goals for improving quality for (2012/13).

PRIORITY GOALS FOR IMPROVING QUALITY 2013/14

A toolkit for the production of Quality Accounts is provided by the Department of Health. This includes a requirement for each provider organisation to identify its 3-5 priority quality goals for the forthcoming year and to describe progress regarding the quality goals that were identified for the previous year that is being reported. The quality goals are identified under the headings in the 3 domains of quality: Safety, Effectiveness and Experience.

A wide range of stakeholder consultation has been undertaken prior to the development of the Isle of Wight NHS Trust's 2013 Quality Account, including a patient experience event held in November 2012 and questionnaire to support the identification of the quality goals for 2013/14.

An initial long list of suggested quality goals was taken from the organisation's Quality Improvement Framework for 2012/13; which provided the basis for consultation with key stakeholders.

A series of discussions were held with Clinicians and Managers to consider the priority goals for inclusion in 2013/14. This has involved discussion with the Trust Board at the Board Seminar on the 27th Feb 2013 and with directorate teams and corporate leads at the Executive Board Meeting in March 2013. Discussions have also been held with stakeholders, including Commissioners at the monthly Clinical Quality review meeting. A specific meeting was held with the local involvement network (LINks) in February 2013; where LINks were invited to comment on the proposed goals.

A questionnaire, utilising Survey Monkey® was developed in order to obtain and analyse feedback, which asked stakeholders to rank in order of priority the suggested quality goals. A question was also included asking for individuals to propose other quality goals that they felt should be an organisational priority for 2013/14. This questionnaire was circulated to all staff; representatives from the Voluntary Sector; Councillors; Communication colleagues and Media colleagues, to ensure they all had an opportunity to provide feedback.

The results of the questionnaire, along with information relating to complaints; concerns and feedback from the patients experience event have revealed the Quality Priorities as we move forward to 2013/14. These are outlined below:-

1. **PATIENT SAFETY**
   Prevention of Pressure Ulcers

2. **CLINICAL EFFECTIVENESS**
   Reducing Mortality Rates

3. **PATIENTS EXPERIENCE**
   Improving Communication

4. **STAKEHOLDER RECOMMENDED GOAL**
   Implementation of the End of Life Care (AMBER Care Bundle)

PUBLICATION OF QUALITY GOALS

The quality goals for 2013/14 will be published in the Trust's Quality Account; which will form part of the Isle of Wight NHS Trust's Annual Report and posted on the Trust's website. The Trust also has a legal duty to send a copy of the final agreed Quality Account to the Secretary of State and make it publically available on the NHS Choices website.

The quality goals will be communicated through the Trust's management structure to all levels of the organisation so that all staff are aware of these and their responsibility in supporting the plans to achieve the improvements identified.

Assurance on progress in achieving the improvements will be reported through the Trust's sub-committee structure and to the Quality & Clinical Performance Committee. A summary report will be provided to the Board through the minutes of the Clinical Performance Committee.

RECOMMENDATIONS

Trust Board is asked to endorse the quality goals for 2013/14 to be published in the Trust's Quality Account.

Alan Sheward
Executive Director of Nursing & Workforce
May 2013

Enc H

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 – Public)

ON 26 June 2013

Title	ANNUAL COMPLAINTS REPORT
Sponsoring Director	Director of Nursing & Workforce
Author(s)	Director of Nursing & Workforce
Purpose	To approve / sign off the Complaints Annual Report – requirement of the National Health Service Complaints (England) Regulations 2009
Previously considered by (state date): N/A	
Executive Board	
Audit and Corporate Risk Committee	
Finance, Investment & Workforce Committee	
Charitable Funds 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	
Patient Confidentiality	
Other (please state)	

Staff, stakeholder, patient and public engagement:

It is a requirement of National Health Service Complaints (England) Regulations 2009 that the Complaints Annul report is available to any person on request.

Executive Summary:

This paper outlines the Isle of Wight NHS Trust's performance in relation to complaints for the year 2012/13.

It adheres to the requirements of sections 17 and 18 of the National Health Service Complaints (England) Regulations 2009, which requires the Annual report to include the following information:-

- specify the number of complaints which the responsible body received;
- specify the number of complaints which the responsible body decided were well-founded;
- specify the number of complaints which the responsible body has been informed have been referred to the
  - (i) Health Service Commissioner to consider under the 1993 Act; or
  - (ii) the Local Commissioner to consider under the Local Government Act 1974; and

summarise

- (i) the subject matter of complaints that the responsible body received;
- (ii) any matters of general importance arising out of those complaints, or the way

in which the complaints were handled;

(iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

This report is required to be reviewed as part of the audit assurance process in relation to the Trust's Quality Account and has been highlighted as outstanding and, therefore, needs formal approval from the Trust Board in order for full assurance on the Quality Account to be provided by the external auditors.

For following sections – please indicate as appropriate:					
Trust Goals 2013/2018:	☑ **Quality**	☐ **Clinical Strategy**	☐ **Resilience**	☐ **Productivity**	☐ **Workforce**
Board Objectives 2012/13:					
Related Trust objectives	☑ **Quality**	☐ **Innovation**	☐ **Productivity**	☐ **Prevention**	☐ **Reform**
Priorities & Targets	**1. Improve the experience and satisfaction of patients, carers, partners and staff** **2. Develop our relationships with key stakeholders to improve our patient services & collectively deliver a sustainable local health system**				

Risk and Assurance - items below relate to the Board Assurance Framework 2012/13 ***(please see document for details)***			
Critical Success Factor *(eg CSF1)*	CSF1 / CSF10		
Principal Risks ***(please enter applicable numbers – eg 1.1; 1.6)***	1.1 1.4 1.6 1.7 1.8 10.27		
Assurance Level ***(shown on BAF)***	☐ Red	☑ Amber	☑ Green
Legal implications, regulatory and consultation requirements	National Health Service Complaints (England) Regulations 2009 requires all providers of health care services in England to publish an annual Complaints Report.		

Action required by the Board:	☐ Receive	☑ Approve

Date: 26 June 2013 **Completed by: Theresa Gallard**

Business & Projects Manager

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Isle of Wight NHS Trust

Annual Complaints Report 2012/2013

Complaints:

From 1 April 2009 The Local Authority Social Service Complaints (England) Regulations were put into effect with the principle objectives being to unify and simplify complaints handling arrangements across heath and social care within England. This allows greater complainant focus; and enables organisations to improve the way in which learn from complaints and use patient experience detailed in complaints to shape services.

In response to the new regulations and good practice guidance from the Department of Health, we have continually reviewed and developed the process for triage and management of every complaint we receive. In our acknowledgement letter, complainants are also invited to contact us to discuss how their complaint will be managed and the timescale for our investigation, depending on the severity and or the complexity of the complaint. During the latter part of the year, we have also commenced discussions with the clinical directorates to further improve the process, by ensuring that wherever possible initial contact is made by telephone by the most appropriate member of the clinical team nearest to the patient.

Following investigation of a complaint, any actions arising or lessons learned are drawn together and shared with relevant senior managers to ensure what we tell complainants we will do actually happens. Learning is also shared across the organisation through anonymised reports to various committees and through a quarterly staff bulletin 'Learning Lessons'.

Between April 2012 and March 2013 the Isle of Wight NHS Trust received **333** complaints and **2561** recorded compliments (see appendix 1 for further data)

The most common themes for complaints were:

Clinical care
Nursing care
Communication
Staff attitude
Appointments delay (outpatient)

Of the 333 complaints received during the year 231 of these were upheld.

Principles of Remedy:

The Parliamentary and Health Service Ombudsman requires NHS organisations to consider and provide where appropriate, remedies for injustice or hardship resulting from maladministration or poor service guided by the following principles

- Getting it right
- Being customer focussed
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Where hardship has occurred as a result of the subject of a complaint every effort is made to redress the injustice or hardship. NHS Isle of Wight will acknowledge and apologise for maladministration and poor service, explaining, if it can be determined, why the failure occurred. In addition to receiving a written response from us, a complainant may be offered a meeting with clinical or managerial staff, depending on the nature of the complaint.

Examples of redress include financial reimbursement for treatment, travel, parking and lost property, complimentary parking permits, making or bring forward hospital appointments or treatment and changes to policy, procedure and staff training.

During 2012/13 the Isle of Wight NHS Trust received 22 requests for information for independent review from the Parliamentary and Health Service Ombudsman

During 2012 /13 the Isle of Wight NHS Trust received 2 reports from the Ombudsman upholding complaints and requesting the Trust take further action under the principles of remedy. In both cases appropriate action has been taken in line with the recommendations of the Parliamentary and Health Service Ombudsman.

Concerns:

Throughout the year the Patient Experience Officers have listened to patients and/or their advocates and provided relevant information and support to help resolve their concerns quickly and efficiently. Together with other staff and managers, they try to find a solution through a variety of means. Patient Experience Officers also signpost people to others who

may be able to offer more specialised information and support such as the Citizens Advice Bureau or ICAS – Independent Complaints Advocacy Service or provide support to manage concerns via the formal complaints process.

Between April 2012 and March 2013 Patient Experience officers handled 847 concerns

The most common themes for concerns were:

Appointment delays / cancellation inpatient
Appointment delays / cancellation outpatient
Clinical care
Communication
Staff attitude
Nursing Care

Learning from Complaints and Concerns; Contributing to Service Improvement

Below are examples of work that has been undertaken in the Trust from the lessons learned from complaints:

- Urology consent form has been reviewed to enable patients to be given a copy to take home.

- Process of providing copies of clinic letters in line with national guidelines has been reviewed to ensure patients are given this option.

- Information literature has been reviewed and has been located to a more prominent and accessible position for patients and carers.

- A system has been introduced on the ward to ensure that senior staff are available to meet with relatives at a dedicated time to discuss any concerns / queries that relatives may have about the care and treatment of patients.

- The appointments team introduced a new method for the management of long term appointments to ensure that if appointments are cancelled the clerk is alerted to the planned follow up date and what the appointment is for to avoid patients slipping through the process and missing appointments

- Several clinical services have reviewed or developed patient information literature that ensures patients have written information to supplement conversations, are therefore fully informed and that this is given at the correct point in the patient pathway.

- The Community Equipment Store now ensure that they stock extra long crutches to be able to cater for all patients. .

- The Pathology Department are exploring the ability of having an electronic system for staff to request tests.

- Work is underway to improve current processes to ensure that complaints are responded to as close to the patient as possible and this work will continue into 2013/14.

- A number of medical wards have introduced intentional rounding which ensures that patients are checked regularly to ensure safety and comfort whilst in the care of the Trust.

- A number of initiatives have been put in place across the Trust to ensure that all staff always work in a professional and courteous manner.

Prepared by:

Vanessa Flower
Quality Manager
20 June 2013

2012 - 2013	Q1		Q2		Q3		Q4	
	COMPLAINTS	COMPLIMENTS	COMPLAINTS	COMPLIMENTS	COMPLAINTS	COMPLIMENTS	COMPLAINTS	COMPLIMENTS
QUARTER TOTAL	**77**	**596**	**84**	**584**	**98**	**723**	**74**	**658**
Acute Clinical	35	239	40	294	37	382	30	277
Planned Clinical	33	109	30	71	41	162	35	120
Community Health	8	233	10	187	17	139	8	235
Quality & Clinical Standards	1	1	0	19	1	31	1	11
Non clinical corporate functions	0	14	4	13	2	9	0	15
PERFORMANCE OF COMPLAINTS								
Managed within AGREED timescale	**53% (41)**		**61% (51)**		**57% (54)** *so far		**89% (25)** *so far	
BREACH of agreed timescale	**36**		**33**		**40**		**3**	
No. still under review (some with agreed time extensions)	**0**		**0**		**4**		**46**	
COMMENTS & CONCERNS								
Comments	13		7		18		56	
Concerns (including those transferred to 'formal')	471 (8)		386 (3)		300 (3)		311 (5)	
HEALTH SERVICE OMBUDSMAN REVIEWS								
Final stage INDEPENDENT REVIEW requests via Parliamentary Health Service Ombudsman	3		4		6		9	

*** Interim % performance (calculation based on total number of complaints completed at the date of the report)**
When all complaints in quarter are closed a final % performance figure can be presented in the following quarterly report

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 – Public)

ON 26 June 2013

Title	Trust Board Walkabouts – Patient Safety Assurance Visits
Sponsoring Director	Alan Sheward – Executive Director of Nursing and Workforce
Author(s)	Vanessa Flower, Quality Manager
Purpose	To provide assurance on the progress of actions following patient safety assurance visits undertaken.

Previously considered by (state date):	
Executive Board	
Audit and Corporate Risk Committee	
Finance, Investment & Workforce Committee	
Charitable Funds 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	
Patient Confidentiality	
Other (please state)	

Staff, stakeholder, patient and public engagement:

Executive Summary:

Since February 2013 a total of 61 actions have been identified following the 25 Patient Safety Assurance Visits, both by Board, and during the weekly scheduled visits. Of these 36 are rag rated green, 19 are amber, and 6 remain red.

The attached report shows the status of the actions as of 17 June 2013.

For following sections – please indicate as appropriate:

Trust Goals 2013/2018:	√ **Quality**	☐ **Clinical Strategy**	☐ **Resilience**	☐ **Productivity**	☐ **Workforce**
Board Objectives 2012/13:					
Related Trust objectives	√ **Quality**	☐ **Innovation**	☐ **Productivity**	☐ **Prevention**	☐ **Reform**
Priorities & Targets ***(delete as appropriate)***	**1. Improve the experience and satisfaction of patients, carers, partners and staff** **2. Improve clinical effectiveness and the safety and outcomes for patients** **3. Develop our organizational culture, processes and capabilities to be a thriving FT dedicated to our patients**				

Risk and Assurance - items below relate to the Board Assurance Framework 2012/13 ***(please see***

document for details)			
Critical Success Factor *(eg CSF1)*	Critical success factor CSF10 Develop our organisational culture, processes and capabilities to be a thriving FT dedicated to our patients		
Principal Risks ***(please enter applicable numbers – eg 1.1; 1.6)***	10.75		
Assurance Level ***(shown on BAF)***	☐ Red	☐ Amber	√ Green
Legal implications, regulatory and consultation requirements			
Action required by the Board:	√ Receive	☐ Approve	
Date: 18 June 2013 **Completed by: Vanessa Flower, Quality Manager**			

ACTION TRACKER - Amended 20 June 2013

Date Visited	Area Visited	Who Visited	Actions	Due Date	Directorate	Person Responsible	Completion Status	comments from Directorate/area
27-Feb-13	Maxillofacial unit	Susan Wadsworth/John Matthews/Alan Sheward/Mark Price	**Issue 1.** 1. A system for explaining why patients are waiting should commence.	31-Mar-13	Planned	Martin Robinson	GREEN	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-Mar-13	Planned	Sue Bradshaw	GREEN	Update 23.4.13 Following improvement works alcohol gel dispensers sited.
27-Feb-13	ENT	Chris Palmer/Nick Wakefield/Karen Baker	1. Relocate admint support from kitchen to main reception area	31-Mar-13	Planned	Martin Robinson	AMBER	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-Mar-13	Planned	Martin Robinson	AMBER	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-Mar-13	Planned	Martin Robinson	AMBER	Update 23.4.13 Capital bid being developed for complete refurbishment, aim for August CIG
27-Feb-13	Luccombe	Danny Fisher/Peter Taylor/Felicity Green/Mark Price	**Issue 1**. Complaints being reviewed by Sister	25-Mar-13	Planned	Heidi Meekins	GREEN	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-Mar-13	Planned	Heidi Meekins	AMBER	UPDATE 22.4.13 Information books being developed via Quality meeting to ensure up to date imparted to patients/ relatives
27-Mar-13	Shackleton		**Issue 1.** Review Housekeeping suppport as their was no cover due to sickness.	12-Apr-13	Community Health	Mo Smith	AMBER	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-Apr-13	Community Health	Mo Smith	GREEN	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-Apr-13	Community Health	Mo Smith	GREEN	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-Apr-13	Community Health	Mo Smith	GREEN	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-Apr-13	Community Health	Mo Smith	AMBER	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.

Date Visited	Area Visited	Who Visited	Actions	Due Date	Directorate	Person Responsible	Completion Status	comments from Directorate/area
27-Mar-13	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-Apr-13	Community Health	Anthea Church	AMBER	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. **Update:** Request has been submitted to Charitable funds 31/5/13 as yet no response from Linda Mowle 14.6.13 AC.
			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-Apr-13	Community Health	Lisa Reed / David Shields/Kevin Bolan	GREEN	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 **UPDATE**: Visit made by Kevin Bolan estates source of smell still uncertain, not present at the time of visit due to overriding smell of perfume from member of staff present in the room at the time. Air Freshner has now been placed in the room 14/6/13 AC
11-Feb-13	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	Acute	Tina Beardmore	GREEN	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.

Date Visited	Area Visited	Who Visited	Actions	Due Date	Directorate	Person Responsible	Completion Status	comments from Directorate/area
07-Mar-13	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	Planned	Sue Bradshaw	GREEN	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	Planned	Sue Bradshaw	GREEN	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 associated comments and progress actions to improve compliance.	21-Mar-13	Planned	Sue Bradshaw	GREEN	**UPDATE 17/4/13** Sister working with staff to ensure NO's turned to YES's **Upate 14/6/1**3 This is being continually monitored to ensure compliance
			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	Planned	Deborah Matthews	AMBER	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-Feb-13	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	Planned	Jonathon Lochead	AMBER	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	Planned	Sue Bradshaw	AMBER	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 **UPDATE 14/06/2013** - Painting of area continues and ICPT working with department on new audit tool or this department.
			Issue 3. Provide Glove Holders to all Clinical Areas	20-Feb-13	Planned	Sue Bradshaw	AMBER	Update 23.4.13 Supplies are sourcing and once painting in consultation rooms is undertaken these holders will be in place. **UPDATE 14/06/2013** Painting continues so glove holders are not yet in situ
			Issue 4. Work with Sarah Finch to ensure all invoices to private Optomotrists use current IT PO system	20-Feb-13	Planned	Sarah Finch/Leanne Hetherington	AMBER	**Update received 19.6.13:** This is to do with Opticians invoicing the Trust through me for glasses provided to children via the HES1 forms. Leanne Hetherington and I are discussing ways round this to see if we can change the route the invoices take.
			Issue 5. IPC to undertake an assessment of Hand Hygiene availability in the FFA room	20-Feb-13	Planned	Sanchia Chiverton	GREEN	Hand Hygiene Monitor will undertake a monthly audit of FFA Clinics in addition to normal monthly monitoring of hand hygiene.
			Issue 6. Purchase retractable Tapemeasure for use with viewing box instread of gauze ribbon	20-Feb-13	Planned	Judie McDowell	GREEN	Feed back from dept - completed
			Issue 7 Staff food and Patient Food should be seperated.	20-Feb-13	Planned	Katherine Taylor	GREEN	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	Planned	Jonathon Lochead	GREEN	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	Planned	Katherine Taylor	GREEN	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).

Date Visited	Area Visited	Who Visited	Actions	Due Date	Directorate	Person Responsible	Completion Status	comments from Directorate/area
24-Apr-13	Appley Ward	Mark Price / Nick Wakefield	**Issue 1** De-clutter ward	31-May-13	Acute	Jo Payne	GREEN	Update 20.6.613 There has been a change of use to the Matrons room which has enabled the storage areas to be relooked at. As a consequence, the ward has been decluttered although this will be work in progress as well
			Issue 2 Ensure patients are aware of the availability of snacks during evening especially in diabetic patients	Immediate	Acute	Jo Payne	GREEN	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-May-13	Acute	Alison Price	GREEN	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-May-13	Acute	Chris Sheen	GREEN	17.6.13 Feedback from CS not sure what action is required to make this happen Update from DM HOCS 20.6.13 Medical/Consultant representation at MDT Board meetings in improved and attendance is constantly under review
			issue 5: Organise fire practice	31-May-13	Acute	Jo Payne	GREEN	Update 20.6.13 Fire practice has taken place and this has highlighted issues that are being adressed by the fire officer. The ward fire marshall is cascading training and awareness of fire safety
			Issue 6: Review and resolve issue of water leakage into food cupboard when it rains.	06-May-13	Acute	Kevin Bolan	GREEN	Response received from Kevin Bolan 19.6.13 issue has now been rectified
			Issue 7: Consider permanent use for bathroom space which is being used inappropriately for storage.	13-May-13	Acute	Deborah Matthews	AMBER	Storage space is extremely limited on Appley Ward and consideration has been given to the use of the Bathroom for additional formal storage. The preference is for en-suite facilitates to be added within the current 6 bedded bays – similar to the arrangements on the surgical wards. This will negate the need for the separate bathroom. Estates have undertaken an initial survey of space utilisation and potential for re-design n the ward. However, plans going forward are dependent upon the decisions around the reconfiguration of acute in-patient beds and are also linked to the Dementia friendly refurbishment intentions. DM 14.06.13
			Issue 8: Review medical gas provision to ensure it is available for all beds	13-May-13	Acute	Kevin Bolan	AMBER	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-Jul-13	Acute	Donna Collins	GREEN	

Date Visited	Area Visited	Who Visited	Actions	Due Date	Directorate	Person Responsible	Completion Status	comments from Directorate/area
05-Apr-13	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-May-13	Acute	Mark Pugh	RED	No update received
			Issue 2: N/B - Dr Fosters mortality Data is compiled from 'Admission Diagnoses'. Whereas we code on Discharge Diagnoses.	31-May-13	Acute	Mark Pugh	GREEN	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-May-13	Acute	Mark Pugh	AMBER	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.
03-Apr-13	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-May-13	Acute	Liz Thorne / Martin Robinson	GREEN	20.05.13 (LT): The interstitial space is restricted access only, so remains locked at all times and the key is held by Estates. The door should have been locked. This area was cleared and checked by MK before the key was handed over to Estates.
			2. Notice boards were untidy and in one case personal notices had been added (advertising painting baby bumps)	10-May-13	Acute	Liz Thorne / Martin Robinson	GREEN	20.05.13 (LT): Notice boards have been tidied. Staff have been reminded to keep them tidy
			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-May-13	Acute	Liz Thorne / Martin Robinson	AMBER	20.05.13 (LT): This should have been painted as part of Pathology painting programme as part of the Trust. This area won't be affected by the refurbishment so will still need painting, although the Trust painter has now been moved to another department. Contact Estates
			4. Clean lab coats were stuffed on top of cupboards rather than inside	10-May-13	Acute	Liz Thorne / Martin Robinson	AMBER	20.05.13 (LT): The THOD have been informed. Shelves need to be found In existing storage cupboards or a new cupboard needs to be ordered for the overflow coats
			5. Many storage areas/rooms were untidy and lacked order	10-May-13	Acute	Liz Thorne / Martin Robinson	AMBER	20.05.13 (LT): THOD to ensure that the storage facilities for their areas are tidy and ordered
29-May-13	Orthotics / Prosthetics	Chris Palmer / Nick Wakefield	1. Promote understanding of the service with the GPs.	31-Jul-13	Community Health	Carol Mabey	GREEN	
			2. Promote Wig Service.	31-Jul-13	Community Health	Carol Mabey	GREEN	
			3. Pursue sub lamination of design transfers with Print room / NHS Creative	31-Jul-13	Community Health	Carol Mabey	GREEN	
24-Apr-13	DSU	Alan Sheward/Sue Wadsworth	Staff not wearing ID	30-Jun-13	Planned	Mandy Webb	GREEN	
			Standard operating procedure for the undressing of patients	30-Jun-13	Planned	Mandy Webb	GREEN	
			Privacy and dignity – patients not undressed	30-Jun-13	Planned	Mandy Webb	GREEN	
			Confirm the process for parents escorting patients	30-Jun-13	Planned	Mandy Webb	GREEN	

Date Visited	Area Visited	Who Visited	Actions	Due Date	Directorate	Person Responsible	Completion Status	comments from Directorate/area
06-Jun-13	ITU	Sue Wadsworth/Mark Pugh/Sarah Johnston	Ensure elements of sluice that were needing cleaning are addressed	30-Jun-13	Acute	Laura Moody	GREEN	Completed 13/6/13 Sluice was cleaned immediately after visit and cleanliness assistant informed that this area requires more frequent attention. LM
			Ensure public poster areas are up to date - i.e. clinical audit data	30-Jun-13	Acute	Laura Moody	GREEN	Complted 13/6/13 Productive Ward data is no longer being collected and will be replaced with up to date data regarding performance LM
			Focus on pressure ulcers and provide demonstrable actions are in place to address this issue	30-Jun-13	Acute	Laura Moody	GREEN	Completed 13/6/13 Pressure ulcer audit data on door of ICU office for Nurse-in charge to complete daily. Intentional rounding documents for every patient kept at bedside with all other patient documentation.
			Ensure tile in ceiling is recitified	30-Jun-13	Acute	Laura Moody	AMBER	Awaiting completion 13/6/13 This tile has been reported 4 times, awaiting estates to repair.
			Storage areas look cluttered - probably not any more suitable place ot keep kit but please check this is the case.	30-Jun-13	Acute	Laura Moody	GREEN	Completed 13/6/13 ICU has limited space and has a lot of equipment. All equipment possible kept in ICU storeroom and storage areas within the unit kept as tidy as possible. Vital equipment only kept in unit. All stored equipment is covered and has green cleanliness sticker attached.
06-Jun-13	Stroke Rehab	Sue Wadsworth/Mark Pugh/Sarah Johnston	Reiterate dress code policy to all staff	Immediate	Community Health	Marjorie Martch	GREEN	**Update 17.6.13**: The uniform policy has been printed out and all staff have been asked to read and sign it to reiterate the dress code.
			Can a more suitable place be found for large items of kit	30-Jun-13	Community Health	Marjorie Martch	GREEN	**Update 17.6.13:** Phase 1 of the upgrading may start this year. In the meantime the shower room which is not used is being utilised as the store room for large items of equipment a temporary sign has been put up to indicate this.
			Ensure all staff are aware of key indicators and that notice boards displaying this type of information are up to date.	30-Jun-13	Community Health	Marjorie Martch	GREEN	**Update 17.5.13**: The notice boards are not used for key performance indicators the information is now on the quality dashboard which is in the process of being updated.
			Review possibilities of gaining more kit i.e. charitable funds and League of Friends.	30-Jun-13	Community Health	Marjorie Martch	AMBER	**Update 17.5.13**: More equipment could be purchased through charitable funds. There is a business case being put together for specialist chairs.

Enc J

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 – Public)

ON 24th June 2013

Title	NHS Constitution
Sponsoring Director	Karen Baker, Chief Executive
Author(s)	Brian Johnston, Head of Governance and Assurance Jackie Skeel, Assistant Director for Organisational Development
Purpose	The Board is requested to endorse the NHS Constitution and approve the specific actions proposed in the Executive Summary.

Previously considered by (state date):	
Executive Board	
Audit and Corporate Risk Committee	
Finance, Investment & Workforce Committee	
Charitable Funds 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	
Patient Confidentiality	
Other (please state)	

Staff, stakeholder, patient and public engagement:

Executive Summary:

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this constitution in their decisions and actions.

The NHS Constitution was re-issued in March 2013 and the Trust Development Authority monthly self-certification states ' The Board will ensure that the Trust remains at all times compliant with regard to the NHS Constitution '

In response to this, and to ensure we are in a position to make a positive statement in our monthly self – certification returns , the following arrangements are proposed :

a) References to the Trust Board and all of its sub-committees endeavoring to uphold the principles and values as set out in the Constitution to be included in all Terms of Reference
b) References to be included in the Trust's Standing Orders
c) References to be included in the next version of the ' Plan on a Page '
d) Compliance with the Constitution to be included within Board sub-committees annual reports
e) A sentence to be included within future Trust Board agenda's confirming that the NHS

Constitution has been taken into account in the Trust's decisions and actions

f) The Audit and Corporate Risk Committee to review these arrangements annually as part of its Corporate Governance Framework review.

g) The NHS Constitution is already included in the Organisation's appraisal paperwork and it is a requirement that appraisers have a discussion with appraisees about the content of the constitution.

h) The NHS Constitution will be embedded into Appraisal training, Corporate Induction and leadership development events.

i) The Trust Board are asked to agree to the Vision, Values and Behaviours document (attached) for adoption across the Organisation. This will replace LSWC and EQF and will be embedded into recruitment, leadership development, appraisal and culture development days (specifically for A4C bands 1-7) to be held later in the year.

j) A measurement tool will be adopted to test the culture of the Organisation and will include elements of the Constitution.

Related Trust objectives	**Sub-objectives**
1. Quality 2. Innovation 3. Productivity 4. Prevention 5. Reform	
Risk and Assurance	
Related Assurance Framework entries	
Legal implications, regulatory and consultation requirements	

Action required by the Board: To endorse the NHS Constitution and approve the actions proposed in the Executive Summary.

Date: 19 June 2013

Completed by: Brian Johnston, Head of Governance and Assurance
Jackie Skeel, Assistant Director for Organisational Development
Mark Price, Foundation Trust Programme Director and Company Secretary

Glossary: *Let's Show We Care (LSWC)*
Employee Qualities Framework (EQF)
Agenda for Change (A4C)

THE NHS CONSTITUTION
the NHS belongs to us all

NHS
Isle of Wight

Our vision *is that we provide -* ***"Quality care for everyone, every time".***

Our values *are the same as those written within the NHS Constitution, which establishes the principles and values of the NHS in England.*

Working together for patients – Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity – We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care – We earn the trust places in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion – We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person' pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives – We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts – We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

Our behaviours, *aligned to the NHS values –*

Nice – I will always be compassionate, kind, polite, courteous and respectful to others. I will make eye contact and maintain good communication with staff, colleagues, patients, visitors and relatives. I will make sure that I take the time to listen and value others' views and opinions.

Health and wellbeing – I will make sure that the health and wellbeing of staff, colleagues and patients is my number one priority. Our jobs can be difficult and stressful at times, so we must support each other.

Safety- I will make sure that I do everything with safety in mind.

Innovate – I will always try new ways of doing things to make my work processes more efficient, improve services and experience for staff and patients. I will do my best to simplify processes and reduce waste.

Open – I will have the courage to be honest and transparent and act with a 'duty of candour'. If I see or hear bad behaviour or practice towards patients, staff or others I will make sure that I raise concerns appropriately.

Work hard – I will always act professionally and do my best and encourage others to do the same. I will maintain my competency through training and development to ensure that my clinical and/or technical knowledge remains as up to date as possible.

THE NHS CONSTITUTION

the NHS belongs to us all

for England
26 March 2013

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health.
It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

This Constitution establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities**, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution.

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

1. Principles that guide the NHS

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. These values are set out in the next section of this document.

1. The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The NHS aspires to put patients at the heart of everything it does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively

encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves. The NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

2. NHS values

Patients, public and staff have helped develop this expression of values that inspire passion in the NHS and that should underpin everything it does. Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Working together for patients. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity. We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives. We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

3a. Patients and the public – your rights and NHS pledges to you

Everyone who uses the NHS should understand what legal rights they have. For this reason, important legal rights are summarised in this Constitution and explained in more detail in the Handbook to the NHS Constitution, which also explains what you can do if you think you have not received what is rightfully yours. This summary does not alter your legal rights.

The Constitution also contains pledges that the NHS is committed to achieve. Pledges go above and beyond legal rights. This means that pledges are not legally binding but represent a commitment by the NHS to provide comprehensive high quality services.

Access to health services:

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds.

You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

The NHS also commits:

- to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution (pledge);
- to make decisions in a clear and transparent way, so that patients

and the public can understand how services are planned and delivered (pledge); and

- to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them (pledge).

Quality of care and environment:

You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.

You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

The NHS also commits:

- to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice (pledge);
- to identify and share best practice in quality of care and treatments (pledge); and
- that if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution (pledge).

Nationally approved treatments, drugs and programmes:

You have the right to drugs and treatments that have been recommended by NICE[1] for use in the NHS, if your doctor says they are clinically appropriate for you.

You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.

1 NICE (the National Institute for Health and Care Excellence) is an independent organisation producing guidance on drugs and treatments. 'Recommended for use by NICE' refers to a type of NICE recommendation set out in legislation. The relevant health body is obliged to fund specified NICE recommendations from a date no longer than three months from the publication of the recommendation unless, in certain limited circumstances, a longer period is specified.

The NHS also commits:

- to provide screening programmes as recommended by the UK National Screening Committee (pledge).

Respect, consent and confidentiality:

You have the right to be treated with dignity and respect, in accordance with your human rights.

You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.[2]

You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.

You have the right of access to your own health records and to have any factual inaccuracies corrected.

You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.

You have the right to be informed about how your information is used.

You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.

The NHS also commits:

- to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively (pledge);
- to anonymise the information collected during the course of your treatment and use it to support research and improve care for others (pledge);
- where identifiable information has to be used, to give you the chance to object wherever possible (pledge);
- to inform you of research studies in which you may be eligible to participate (pledge); and
- to share with you any correspondence sent between clinicians about your care (pledge).

Informed choice:

You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.

2 If you are detained in hospital or on supervised community treatment under the Mental Health Act 1983 different rules may apply to treatment for your mental disorder. These rules will be explained to you at the time. They may mean that you can be given treatment for your mental disorder even though you do not consent.

You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.

You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.

The NHS also commits:

- to inform you about the healthcare services available to you, locally and nationally (pledge); and
- to offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available (pledge).

Involvement in your healthcare and in the NHS:

You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers.

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

The NHS also commits:

- to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge);
- to work in partnership with you, your family, carers and representatives (pledge);
- to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); and
- to encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).

Complaint and redress:

You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.

You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.

You have the right to compensation where you have been harmed by negligent treatment.

The NHS also commits:

- to ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment (pledge);
- to ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again (pledge); and
- to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge).

3b. Patients and the public – your responsibilities

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.

Please treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.

Please provide accurate information about your health, condition and status.

Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

Please participate in important public health programmes such as vaccination.

Please ensure that those closest to you are aware of your wishes about organ donation.

Please give feedback – both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

4a. Staff – your rights and NHS pledges to you

It is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High-quality care requires high-quality workplaces, with commissioners and providers aiming to be employers of choice.

All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress. Care professionals should be supported to maximise the time they spend directly contributing to the care of patients.

The Constitution applies to all staff, doing clinical or non-clinical NHS work – including public health – and their employers. It covers staff wherever they are working, whether in public, private or voluntary sector organisations.

Staff have extensive **legal rights**, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS Constitution. In addition, individual contracts of employment contain terms and conditions giving staff further rights.

The rights are there to help ensure that staff:

- have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;
- have a fair pay and contract framework;
- can be involved and represented in the workplace;
- have healthy and safe working conditions and an environment free from harassment, bullying or violence;
- are treated fairly, equally and free from discrimination;
- can in certain circumstances take a complaint about their employer to an Employment Tribunal; and
- can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.

In addition to these legal rights, there are a number of **pledges**, which the NHS is committed to achieve. Pledges go above and beyond your legal rights. This means that they are not

legally binding but represent a commitment by the NHS to provide high-quality working environments for staff.

The NHS commits:

- to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability (pledge);
- to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge);
- to provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential (pledge);
- to provide support and opportunities for staff to maintain their health, wellbeing and safety (pledge);
- to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge);
- to have a process for staff to raise an internal grievance (pledge); and
- to encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998 (pledge).

4b. Staff – your responsibilities

All staff have responsibilities to the public, their patients and colleagues.

Important legal duties are summarised below.

You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.

You have a duty to take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.

You have a duty to act in accordance with the express and implied terms of your contract of employment.

You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

You have a duty to protect the confidentiality of personal information that you hold.

You have a duty to be honest and truthful in applying for a job and in carrying out that job.

The Constitution also includes **expectations** that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care.

You should aim:

- to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole;
- to take up training and development opportunities provided over and above those legally required of your post;
- to play your part in sustainably improving services by working in partnership with patients, the public and communities;

- to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff[3] or the organisation itself, at the earliest reasonable opportunity;
- to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment;
- to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation;
- to contribute to a climate where the truth can be heard, the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made;
- to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care;
- to take every appropriate opportunity to encourage and support patients and colleagues to improve their health and wellbeing;
- to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care;
- to inform patients about the use of their confidential information and to record their objections, consent or dissent; and
- to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

3 The term 'staff' is used to include employees, workers, and, for the purposes of the Public Interest Disclosure Act (PIDA), agency workers and general practitioners who meet the wider PIDA definition of being a 'worker' (e.g. those performing general medical services under General Medical Services Contracts). Whilst volunteers are not covered by the provisions of PIDA, guidance to employers makes clear that it is good practice to include volunteers within the scope of organisations' local whistleblowing policies.

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD ON 26 JUNE 2013

Title	FOUNDATION TRUST PROGRAMME UPDATE
Sponsoring Director	Foundation Trust Programme Director
Author(s)	Foundation Trust Programme Director
Purpose	To note.

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

Staff, stakeholder, patient and public engagement:

A programme of internal and external stakeholder engagement has been initiated and is ongoing to deliver change within the organisation and generate the support required across the locality and health system to deliver a sustainable FT. Briefing sessions have been undertaken with Patients Council, the Ambulance service, Isle of Wight County Press and Health and Community Wellbeing Scrutiny Panel. A formal public consultation on becoming an NHS Foundation Trust has been undertaken. A membership recruitment campaign 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	17 June 2013

ISLE OF WIGHT NHS TRUST
NHS TRUST BOARD MEETING WEDNESDAY 26 JUNE 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

As of the date this report the Trust has 1721 public members on the membership database, exceeding the target of 1500 for October 2013 set by the Trust Development Authority in March 2013. Each member will receive an acknowledgement via email or post. The below table identifies the current membership breakdown by constituency:

Constituency	**Membership**	**Required before election**
North and East Wight	468	500
South Wight	551	500
West and Central Wight	667	500
Elsewhere	35	250
Total	**1721**	**1750**

The Isle of Wight Festival has proved a great opportunity for a member recruitment drive with 278 application forms completed by festival goers to be uploaded onto our database. Festival organiser John Giddings was also signed up as a member. Bestival organiser Rob da Bank is being approached for support at September's Bestival.

Planning for public events over the year is underway involving the Ambulance Service where possible to attract members of the public. Mail outs are being prepared for all staff and volunteers, who will automatically become members, to promote the benefits of becoming a member of the Foundation Trust and raise awareness of the upcoming elections in early 2014. Staff and volunteers have the option to opt out if preferred. The Friends of St Mary's, who have a membership of approximately 400, are also being contacted.

Invitations have been sent out for the Chamber of Commerce Business Breakfast on the 5th July being hosted by the Trust in Full Circle Restaurant and used as a platform to promote Foundation Trust membership to businesses across the Island. Karen Baker will be in attendance together with representatives from Ambulance Commercial Training, Design and Print Service, Occupational Health Commercial and Mottistone who have been invited to exhibit their services. A tour of the hospital and the St Mary's site has been arranged for attendees.

Our membership must be demographically representative and activity is underway to ensure we achieve a representative balance from across the Island. An FT membership recruitment road show will take place during NHS 65 week (1-7 July) focusing on the Ryde, Shanklin and Newport areas. This will include Community Clinics in Ryde, Shanklin and Newport, Newport Library, St Mary's (entrance), and working in partnership with the Stop Smoking Bus. We are also working with commissioning colleagues to more effectively engage with young people.

We also need to ensure that we have sufficient members within our 'elsewhere' constituency. Hovertravel have offered the use of their terminals for recruitment drives and Wightlink and Red Funnel have also been contacted for support in this regard.

4. Programme Plan

The high level programme plan is attached as appendix 1. This plan sits above the detailed FT integrated action plan and workstream plans and identifies key activity and deliverables to provide an overview of programme progress. Current gaps with respect to target dates are being addressed by work stream leads and confirmation of the overall timeline, and the potential Board to Board meeting date, is awaited from the TDA. Work continues to meet the 31 August 2013 target for our application to the TDA.

FT Pipeline

There is positive movement within the FT application pipeline. Two Trusts have been authorised by Monitor since 1 April 2013: Western Sussex Hospitals NHS Trust and Kingston Hospital NHS Trust. This equals the number of Foundation Trusts authorised in 2012/13 and takes the total number of Foundation Trusts to 147. Since 1 April 2013 only 1 application has been deferred by Monitor. The TDA Board at its 23 May 2013 meeting has also approved two applications for submission to Monitor, Bridgewater Community Healthcare NHS Trust and Solent NHS Trust, taking the total number of applications with Monitor to 16.

5. Key Risks

Capacity remains a key issue and is impacting on progress with the development of the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) with some activity running behind schedule. The IBP and LTFM remain on target but are put at risk in terms of both time and quality as resources are stretched. Recruitment activity is underway to ensure that key posts are filled and external support is in place as planned to ensure that the IBP consistent with Monitor requirements. Specialist assistance from Assista Consulting is in place to mitigate capacity constraints in the Finance Directorate in providing focused support in delivery of the LTFM.

There remains a lack of clarity with respect to new oversight arrangements and the reduced capacity of the TDA in relation to that of the previous SHA is becoming apparent. It has also been noted that productive network opportunities have diminished since the closure of the SHA.

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
17 June 2013

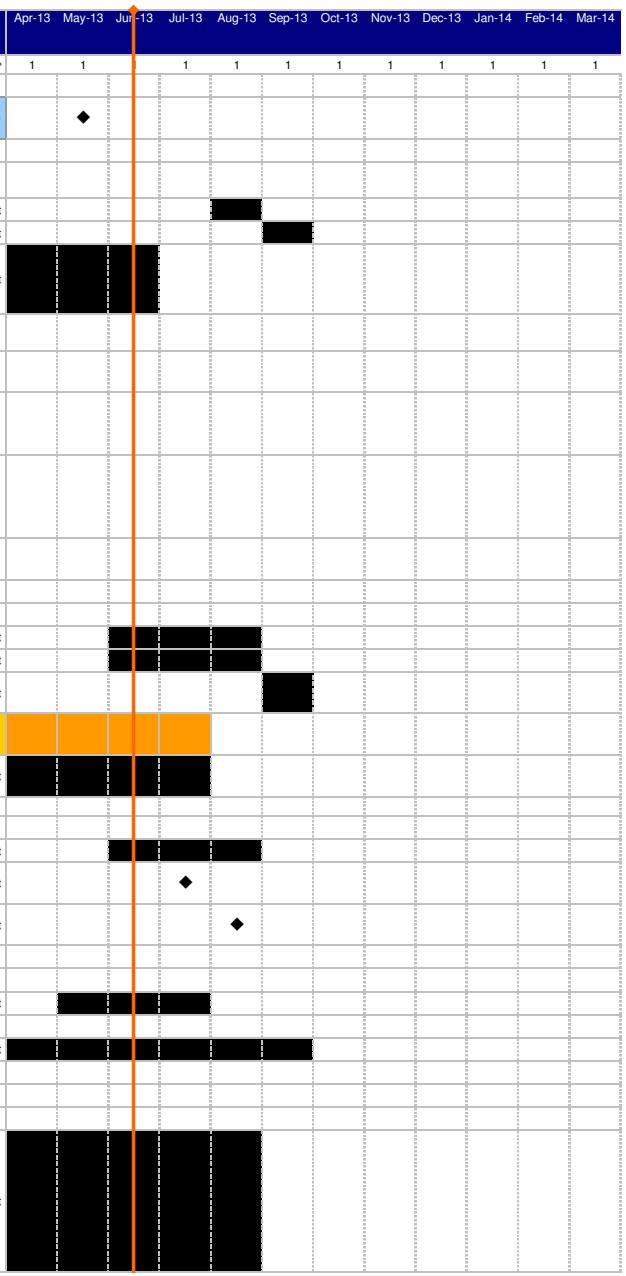
Appendix - 1

Foundation Trust - High Level Programme Plan

(Monthly View)

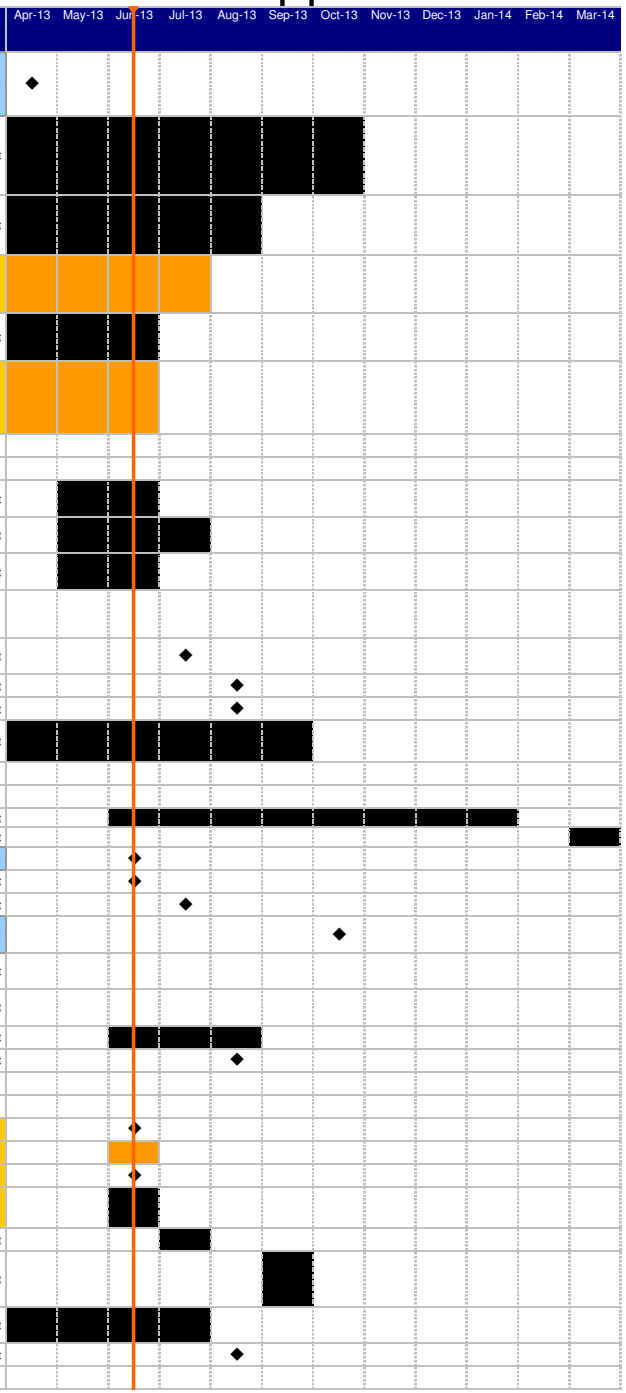
Key					
	Complete	◆	Milestone		Slipped Activity
	In Progress	⇨	Slipped Milestone		
D	Dependent	#	Has Dependents		

Ref.	Activity / Deliverables	◆	Responsible	Status Comment	Start	Planned	Forecast	Actual	Dur	Status
										Day ⇨
1	**Project Management**		Price Mark							
2	Develop TDA phase plans to monitor and manage delivery of application to TDA		Shorkey Andrew	Integrated action plan and high level programme plan in place monitored by FT Programme Board	28-May-13	28-May-13	28-May-13	28-May-13	0	Complete
3										
4	**Quality & Safety**		Alan Sheward Mark Pugh							
5	Internal review of quality information		TDA	Schedule to TBC	01-Aug-13	31-Aug-13	31-Aug-13		22	On Target
6	Rapid responsive review of quality		TDA	Schedule to TBC	01-Sep-13	30-Sep-13	30-Sep-13		21	On Target
7	A quality governance score of less than 4 - none of the four categories of the Quality Governance Framework are entirely Amber/Red [P7.0] [Monitor] [TDA Lttr - 5]		Alan Sheward Mark Pugh	Score of 2.5 being targeted for June 2013 by agreement with TDA. QGF action plan in place and being implemented.	01-Apr-13	30-Jun-13	30-Jun-13		65	On Target
8	Registered without compliance conditions [P8.0]		Alan Sheward Mark Pugh							
9	Continue to meet the quality threshold set by the Department of Health at the time of Secretary of State referral [P9.0]		Alan Sheward Mark Pugh							
10	The CQC's current judgement shows the overall level of concern is no worse than moderate concerns and high confidence in capacity [P10.1]		Alan Sheward Mark Pugh							
11	The CQC is not conducting or about to conduct a responsive review into compliance and no enforcement/investigation activity is ongoing or planned including preliminary investigations into mortality outliers [P10.2]		Alan Sheward Mark Pugh							
12	Quality dashboards - Acute Trust Quality dahsboard Midlands and East Quality Obersvertory		Alan Sheward Mark Pugh							
13										
14	**Corporate Governance**		Mark Price							
15	IBP Appendix 2 – Governance rationale refreshed		Shorkey Andrew		01-Jun-13	26-Aug-13	26-Aug-13		61	On Target
16	IBP Appendix 3 – Model Core Constitution refreshed		Johnston Brian		01-Jun-13	26-Aug-13	26-Aug-13		61	On Target
17	Provide evidence of third party assurance against BGAF through HDD and/or Board Development work [TDA - Lttr - 10]		Price Mark		01-Sep-13	15-Sep-13	15-Sep-13		10	On Target
18	Succession Plans to be put in place for all NED and ED Roles. [E&Y 8; HDD1-4; HDD2-24]		Fisher Danny Baker Karen		31-Jul-12	31-Mar-13	31-Jul-13		262	Slipped
19	Develop detailed plan to engage and develop the Council of Governors [E&Y 20]		Hollebon Andy		31-Jul-12	31-Jul-13	31-Jul-13		262	On Target
20										
21	**Leadership**		Baker Karen							
22	Implement Board development action plan [P12]		Price Mark		14-May-13	31-Aug-13	31-Aug-13		79	On Target
23	Compliance achieved against Board Governance Assurance Framework [P15]		Price Mark	Board Governance Action Plan being implemented	31-Jul-13	31-Jul-13	31-Jul-13		0	On Target
24	Compliance validated against Board Governance Assurance Framework [P15]		Price Mark	HDD 2 refresh and Foresight work to be used to validate compliance	31-Aug-13	31-Aug-13	31-Aug-13		0	On Target
25										
26	**Workforce**		Sheward Alan							
27	Refresh Workforce Strategy		Elmore Mark		01-May-13	26-Jul-13	26-Jul-13		63	On Target
28	Develop Staff Engagement strategy		Elmore Mark							
29	Implement staff engagement in response to staff survey		Elmore Mark		01-Apr-13	30-Sep-13	30-Sep-13		131	On Target
30	Workforce assurance tool in place		Elmore Mark							
31										
32	**Performance**		Pugh Mark							
33	Deliver GRR score of 0 [TDA - Lttr - 1; Mon-15]		Pugh Mark	GRR currently 1.5. whilst this is not the zero score recommended in the TDA letter it is within Amber – Green limits. The indicators which have historically fallen below trajectory within quarters all have recovery plans in place (symptomatic breast, CDiff and ED 4 hr ECS) for achieving during 13/14. These are monitored via the Clinical Directorate Performance Review structure. ON TARGET	01-Apr-13	01-Aug-13	01-Aug-13		89	On Target



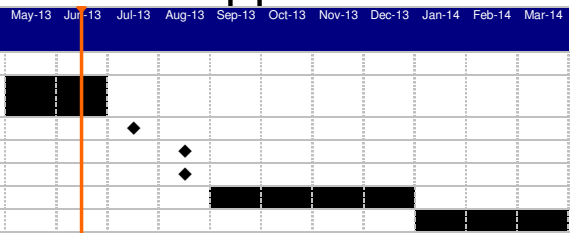
Appendix - 1

Ref.	Activity / Deliverables	◆	Responsible	Status Comment	Start	Planned	Forecast	Actual	Dur	Status
34	Directorate level KPIs formed i.e. targets for average LOS		Pugh Mark	KPIs – the Directorate monthly Performance reviews now contain directorate specific programmes such as LOS monitoring, Theatre efficiency etc.	30-Apr-13	30-Apr-13	30-Apr-13	30-Apr-13	0	Complete
35	Pilot service for SLM identified		Pugh Mark	Pilot service for SLM have been selected and steering group established. Oral Surgery/Maxio facial/Orthodontics, Theatre Efficiency tool, ITU, CCU, Urology for completion Oct 2013. IN PROGRESS	01-Apr-13	31-Oct-13	31-Oct-13		154	On Target
36	Formal benchmarking partners identified NHS & non-nhs		Pugh Mark	Formal benchmarking partners have not yet been selected. This would probably be achievable within a few months – is you could put an August end date. IN PROGRESS	01-Apr-13	31-Aug-13	31-Aug-13		110	On Target
37	Develop QIPP reporting. [E&Y - 13]		Iain Hendey	The detail of the 13/14 schemes is still being refined and once we have this we can implement a mechanism to monitor QIPP schemes and include in the report to Board (11-Apr-13).	31-Jul-12	31-Jan-13	31-Jul-13		262	Slipped
38	SLR into the Trust's standard reporting procedures [HDD - 2 - 24]		Mark Pugh	SLR into the Trusts standard reporting procedures . Not yet interated into the Performance Review structure SLIPPED	31-Jan-13	30-Jun-13	30-Jun-13		107	On Target
39	Establish a process for assuring the Board on data quality [KPMG-18]		Mark Pugh	Data Quality Policy approved by Exec Board 7th January 2013. Data quality now in monthly Board performance report. Board report to be provided to June meeting.	31-Jul-12	31-Mar-13	30-Jun-13		239	Slipped
40										
41	**Business planning**		Greene Felicity							
42	Context of strategy refreshed - Chapters 2-4 & 9		Vearncombe Bronwen		30-Apr-13	30-Jun-13	30-Jun-13		44	On Target
43	Chapters 6-8 refreshed		Vearncombe Bronwen		30-Apr-13	31-Jul-13	31-Jul-13		67	On Target
44	Service Developments refreshed - Chapter 5		Vearncombe Bronwen		30-Apr-13	30-Jun-13	30-Jun-13		44	On Target
45	Develop Clinical Strategy		Pugh Mark Sheward Alan	Board Seminar session planned on Clinical Strategy for 20 June 2013						
46	Executive Summary and chapter alignment		Vearncombe Bronwen		22-Jul-13	22-Jul-13	22-Jul-13		0	On Target
47	FT Programme Board approves IBP for submission to TDA		Greene Felicity		27-Aug-13	27-Aug-13	27-Aug-13		0	On Target
48	Final IBP submitted to TDA		Greene Felicity		28-Aug-13	28-Aug-13	28-Aug-13		0	On Target
49	Implement IBP stakeholder engagement plan [E&Y - 18]		Bronwen Vearncombe		31-Jul-12	30-Sep-13	30-Sep-13		305	On Target
50										
51	**Communications and engagement**		Price Mark							
52	Details of electoral process [Mon - 30 - a]		Hollebon Andy		01-Jun-13	31-Jan-14	31-Jan-14		175	On Target
53	Report on initial elections [Mon - 30 - b]		Hollebon Andy		01-Mar-14	31-Mar-14	31-Mar-14		21	On Target
54	Membership Manager in post		Hollebon Andy	Completed, Margaret Eaglestone in post on 3/6/13	03-Jun-13	03-Jun-13	03-Jun-13	03-Jun-13	0	Complete
55	New Trust Website launched		Hollebon Andy		30-Jun-13	30-Jun-13	30-Jun-13		0	On Target
56	Media analysis requirement agreed with TDA		Hollebon Andy		30-Jul-13	30-Jul-13	30-Jul-13		0	On Target
57	Members recruited = 1500		Membership Manager	Completed, 1,700 members recruited by 12/6/13	01-Oct-13	01-Oct-13	01-Oct-13	01-Jun-13	0	Complete
58	Members recruited = 4000		Membership Manager		01-Apr-14	01-Apr-14	01-Apr-14		0	On Target
59	Members recruited = 6000		Membership Manager		01-Apr-17	01-Apr-17	01-Apr-17		0	On Target
60	IBP Appendix 5 – Membership strategy refreshed [P3.6] [SoS]		Hollebon Andy		01-Jun-13	23-Aug-13	23-Aug-13		60	On Target
61	Proposals and timetable for initial elections [P4.1]		Hollebon Andy		23-Aug-13	23-Aug-13	23-Aug-13		0	On Target
62										
63	**Finance**		Palmer Chris							
64	LTFM Lead recruited and in post		Palmer Chris		03-Jun-13	03-Jun-13	18-Jun-13		12	Slipped
65	Revised Monitor LTFM Model reviewed and populated		LTFM Lead		28-May-13	31-May-13	30-Jun-13		24	Slipped
66	Base model for activity and manpower figures triangulated		LTFM Lead		07-Jun-13	07-Jun-13	30-Jun-13		16	Slipped
67	CIP modelling for LTFM across activity, manpower and costs developed		LTFM Lead		17-Jun-13	21-Jun-13	30-Jun-13		10	Slipped
68	LTFM lockdown		DDoF		22-Jul-13	31-Jul-13	31-Jul-13		8	On Target
69	Undertake HDD Stage 2 refresh [TDA - Lttr - 9]		DDoF	Informal agreement reached with TDA to reduce scope. TDA looking at ToRs previously used for refresh as basis. (15-May-13)	*09-Sep-13*	*23-Sep-13*	23-Sep-13		11	On Target
70	Ensure downside case is sufficiently severe [HDD - 2 - 18]		DDoF LTFM Lead		31-Jan-13	31-Jul-13	31-Jul-13		130	On Target
71	IBP Appendix 1 – Fully completed long-term financial model		LTFM Lead		31-Aug-13	31-Aug-13	31-Aug-13		0	On Target
72										



Appendix - 1

Ref.	Activity / Deliverables	◆	Responsible	Status Comment	Start	Planned	Forecast	Actual	Dur	Status
73	**Programme governance and approvals**		Price Mark							
74	Ensure processes in place to identify compliance with TDA self-certification process		Shorkey Andrew		01-May-13	30-Jun-13	30-Jun-13		43	On Target
75	Content of submission to FT Programme Board for review		Price Mark		23-Jul-13	23-Jul-13	23-Jul-13		0	On Target
76	Application documentation to FT Programme Board for approval		Price Mark		27-Aug-13	27-Aug-13	27-Aug-13		0	On Target
77	Submit application to TDA		Shorkey Andrew		31-Aug-13	31-Aug-13	31-Aug-13		0	On Target
78	TDA review of application		TDA		01-Sep-13	31-Dec-13	31-Dec-13		87	On Target
79	Application to Monitor		TDA		01-Jan-14	30-Jun-14	30-Jun-14		129	On Target



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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD 26 JUNE 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	
Executive Board	
Foundation Trust Programme Board	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Planned Directorate Board	
Quality & Clinical Performance Committee	19 June 2013
Remuneration Committee	

Staff, stakeholder, patient and public engagement:

Executive Directors, Performance Information for Decision Support (PIDS) and relevant lead officers have been consulted

Executive Summary:

This paper presents the July 2013 Trust Development Authority (TDA) self-certification return covering May 2013 performance period for approval by Trust Board.
The key points covered include:

- Background to the requirement
- Assurance
- Performance summary and key issues
- 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) Approve the submission of the TDA self-certification, return acknowledging current gaps in assurance relating to our ability to certify against elements of the revised requirements at this stage

(ii) Identify if any Board action is required

Date	17 June 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 May 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]

Access to submission templates for Board Statements and Licence Condition returns have been provided via an internet portal by the TDA. No submission arrangements are as yet in place with respect to FT Programme Milestones. As the timeframe for submission does not accord with our internal process to obtain Board Assurance we are, by agreement with the local TDA team, submitting returns one month in arrears. This has been agreed on the basis that 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 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.

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

Draft self-certification returns have been considered by the Quality and Clinical Performance 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 has been 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. As a new non executive director with clinical experience is now in post statement 13 has been marked as compliant. No further detailed guidance/information has as yet been provided by TDA with respect to the *Accountability Framework* and PIDs are reviewing the 'new' measures within the *Framework* to identify whether there are any risks to compliance. However, it is proposed that statements 6, 7 also marked as compliant as, although there are still gaps with respect to our understanding of the detailed requirements of the *Accountability Framework,* effective systems and processes are in place to identify and manage risk. It is also proposed that statement 10 is marked as compliant as performance management systems and processes are in place to ensure compliance with identified targets. Board Statement 11 has been flagged as 'at risk' as issues have arisen relating to compliance with IG toolkit requirements following an internal audit review. This position is reflected within the draft sample return document Appendix 1a.

Licence Conditions

2. The only area where compliance can be confirmed at present is against G7. Work is ongoing to implement systems and processes to identify compliance status and provide assurance of compliance against the required Licence Conditions to the Board. This position is reflected within the draft sample return document attached as Appendix 1b.

Foundation Trust Milestones

3. Milestones were agreed by the FT Programme Board on 28 May 2013. The draft return document is attached as Appendix 1c.

5. Recommendations

It is recommended that the Trust Board:

(i) Approve the submission of the TDA self-certification return, acknowledging current gaps in assurance relating to our ability to certify against elements of the revised requirements at this stage;

(ii) Identify if any Board action is required

Mark Price
Foundation Trust Programme Director
17 June 2013

6. Appendices

1a – Board Statements
1b – Licence Conditions
1c – 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

TDA Accountability Framework - Board Statements

Appendix - 1(a)

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response	Comment where non-compliant or at risk of non-compliance	Timescale for Compliance	Executive Lead
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes			Alan Sheward Mak Pugh
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes			Mark Price
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes			Mark Pugh
	For FINANCE, that:	**Response**			
4	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes			Chris Palmer
	For GOVERNANCE, that:	**Response**			
5	The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.	At risk	Formerly assessed as compliant. An assessment of new measures/indicators is required as part of the TDA oversight model/accountability framework before an affirmative Board declaration can made	30-Jun-13	Karen Baker Mark Price
6	All current key risks to compliance with the NTDA accountability framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes			Mark Price
7	The board has considered all likely future risks to compliance with the NTDA accountability framework and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes			Mark Price
8	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes			Felicity Greene
9	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes			Mark Price
10	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the NTDA oversight model; and a commitment to comply with all commissioned targets going forward.	Yes			Alan Sheward Mark Pugh
11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	At risk	Pending review following internal audit obsevations regarding pseudonymisation.		Mark Price

TDA Accountability Framework - Board Statements

Appendix - 1(a)

For each statement, the Board is asked to confirm the following:

12	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	Yes			Mark Price
13	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes			Karen Baker
14	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes			Karen Baker Alan Sheward

TDA Accountability Framework - Licence Conditions

Appendix - 1(b)

	Licence condition Compliance	Compliance (Yes / No)	Comment where non-compliant or at risk of non-compliance	Timescale for compliance	Accountable
1	Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	At risk	No contra indicators highlighted during recruitment processes. However, there is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Alan Sheward
2	Condition G5 – Have regard to Monitor guidance	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Mark Price
3	Condition G7 – Registration with the Care Quality Commission	Yes			Mark Price
4	Condition G8 – Patient eligibility and selection criteria	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Alan Sheward
5	Condition P1 – Recording of information	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Chris Palmer
6	Condition P2 – Provision of information	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Mark Price
7	Condition P3 – Assurance report on submissions to Monitor	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Mark Price
8	Condition P4 – Compliance with the National Tariff	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Chris Palmer
9	Condition P5 – Constructive engagement concerning local tariff modifications	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Chris Palmer
10	Condition C1 – The right of patients to make choices	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Alan Sheward
11	Condition C2 – Competition oversight	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Felicity Greene
12	Condition IC1 – Provision of integrated care	At risk	There is a requirement to implement systems and processes to identify and provide assurance of compliance status. Until work required to provide assurance is scoped a reliable compliance timescale cannot be determined.	31-Aug-13	Alan Sheward Mark Pugh

TDA Accountability Framework - FT Milestones

Appendix - 1(c)

	Milestone (all including those delivered)	Milestone date	Performance	Comment where milestones are not delivered or where a risk to delivery has been identified
1	Quality Governance Framework score at 2.5	30-Jun-13	On target	
2	Board Approved IBP and LTFM submitted to TDA	31-Aug-13	On target	
3	Historical Due Diligence stage 2 refresh commences	09-Sep-13	On target	
4	Historical Due Diligence at majority GREEN status	30-Sep-13	On target	
5	Board Governance Assurance Framework at majority GREEN status	30-Sep-13	On target	
6	Representative membership of 1500 achieved	30-Sep-13	On target	
7	Board to Board meeting with TDA	31-Oct-13	On target	
8	TDA approval to proceed and application to Monitor	31-Dec-13	On target	

Enc M

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 – Public)

ON 26 JUNE 2013

Title	Amendment to Charity Commission Registration
Sponsoring Director	Felicity Greene, Executive Director of Strategy & Commercial Development
Author(s)	Katie Parrott, Senior Financial Accountant
Purpose	To amend charity registration name from Isle of Wight PCT Charitable Funds to Isle of Wight NHS Trust Charitable Funds

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	
Charitable Funds Committee	11 June 2013
Other (please state)	

Staff, stakeholder, patient and public engagement:
N/A

Related Trust objectives	**Sub-objectives**
N/A	***(please delete as appropriate)***
Risk and Assurance	.N/A
Related Assurance Framework entries	N/A
Legal implications, regulatory and consultation requirements	To meet Charity Commission regulations
Action required by the Board: As Corporate Trustee – Approval of amendments as specified	
Date: 18/06/13	

Enc M

Isle of Wight NHS
NHS Trust

TRUST BOARD

26 JUNE 2013

Amendments to Charity Commission Registration

Summary of the Paper:

From 1 April 2012 the Isle of Wight NHS PCT Charitable Funds were transferred to Isle of Wight NHS Trust under the Business Transfer Agreement.

The registered name with the Charity Commission ref 1049606 currently remains as Isle of Wight NHS PCT Charitable Funds.

Following advice from the Charity Commission in accordance with their 'NHS Charities' guidance, section E and section F, there are two points to consider:-

- Agreement for the Charity name to be changed to Isle of Wight NHS Trust Charitable Funds
- Dissolution of the 'linked' charity 'Isle of Wight NHS PCT General Charity' – this relates to the original registration of the Charity whereby a 'sub' charity was created for the General Fund. This was common at the time for NHS Charities, however, the Charity Commission are now recommending the 'single charity' approach as per section F of their guidance and have advised that it would now seem unnecessary to retain the linked charity.

The complete 'NHS Charities' guidance can be found at:-
http://www.charity-commission.gov.uk/Charity_requirements_guidance/Specialist_guidance/NHS_charities/nhsguidance.aspx#e

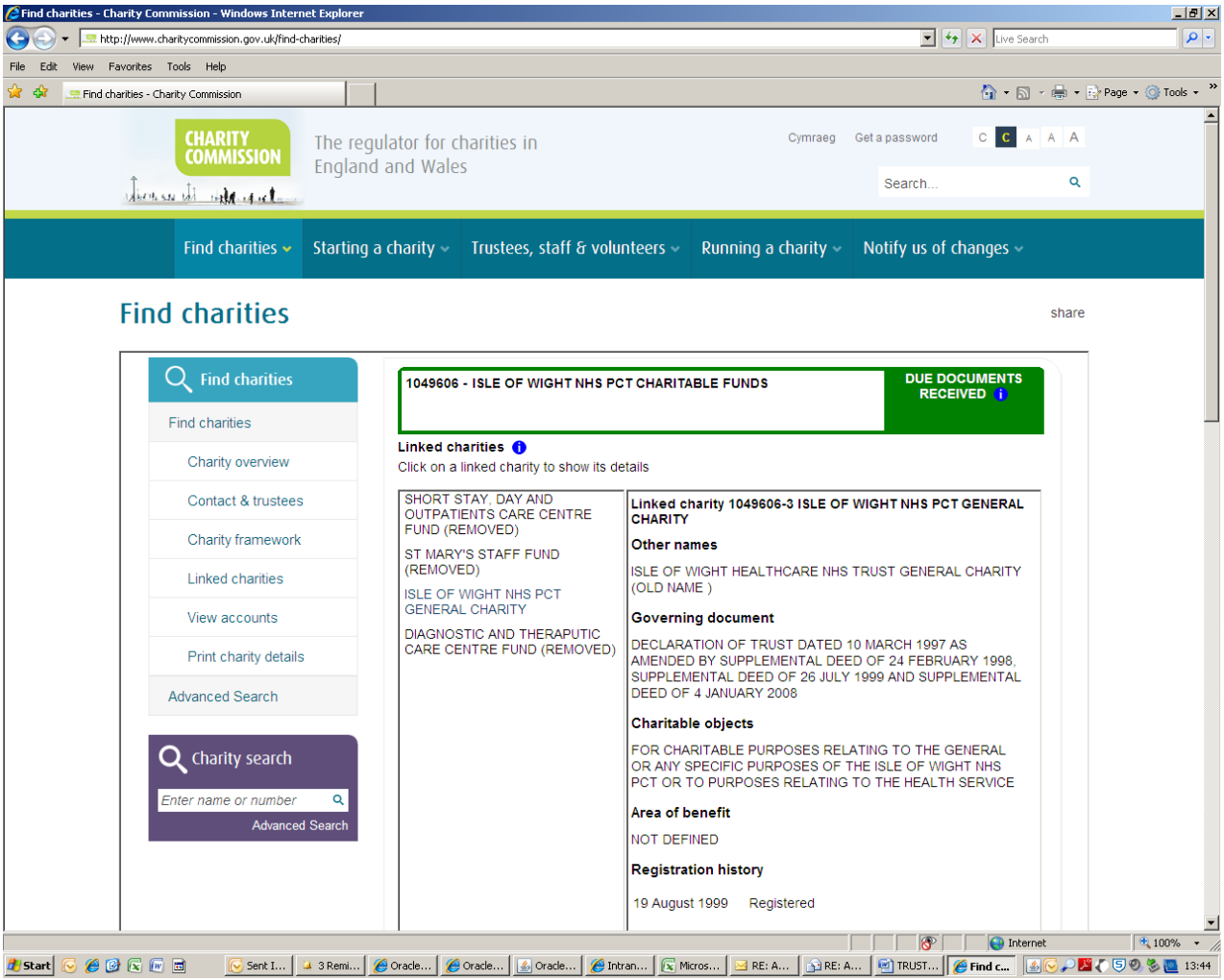
Screen print of our registration details attached showing the linked charity.

The CFC at its meeting on 11 June 2013 agreed to recommend to the Trust Board approval of the amendments.

Decisions Required:

The Corporate Trustee is asked to approve the change of charity name and the dissolution of the linked charity 'Isle of Wight NHS PCT General Charity'.

- Approval of Charity registration 1049606 to be re-named 'Isle of Wight NHS Trust Charitable Funds'
- Approval for dissolution of the linked charity 'Isle of Wight NHS PCT General Charity' to form a single charity approach.


Find charities - Charity Commission - Windows Internet Explorer
http://www.charitycommission.gov.uk/find-charities/
CHARITY COMMISSION
The regulator for charities in England and Wales
Cymraeg
Get a password
Search...
Find charities
Starting a charity
Trustees, staff & volunteers
Running a charity
Notify us of changes
Find charities
share
Find charities
Find charities
Charity overview
Contact & trustees
Charity framework
Linked charities
View accounts
Print charity details
Advanced Search
Charity search
Enter name or number
Advanced Search
1049606 - ISLE OF WIGHT NHS PCT CHARITABLE FUNDS
DUE DOCUMENTS RECEIVED
Linked charities
Click on a linked charity to show its details
SHORT STAY, DAY AND OUTPATIENTS CARE CENTRE FUND (REMOVED)
ST MARY'S STAFF FUND (REMOVED)
ISLE OF WIGHT NHS PCT GENERAL CHARITY
DIAGNOSTIC AND THERAPUTIC CARE CENTRE FUND (REMOVED)
Linked charity 1049606-3 ISLE OF WIGHT NHS PCT GENERAL CHARITY
Other names
ISLE OF WIGHT HEALTHCARE NHS TRUST GENERAL CHARITY (OLD NAME)
Governing document
DECLARATION OF TRUST DATED 10 MARCH 1997 AS AMENDED BY SUPPLEMENTAL DEED OF 24 FEBRUARY 1998, SUPPLEMENTAL DEED OF 26 JULY 1999 AND SUPPLEMENTAL DEED OF 4 JANUARY 2008
Charitable objects
FOR CHARITABLE PURPOSES RELATING TO THE GENERAL OR ANY SPECIFIC PURPOSES OF THE ISLE OF WIGHT NHS PCT OR TO PURPOSES RELATING TO THE HEALTH SERVICE
Area of benefit
NOT DEFINED
Registration history
19 August 1999 Registered

Enc N

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD ON 26TH June 2013

Register of Statutory and Formal Roles

Title	Register of Statutory and Formal Roles
Sponsoring Director	Foundation Trust Programme Director/Company Secretary
Author(s)	Brian Johnston Head of Corporate Governance & Risk Management
Purpose	To update the Board on the schedule of Statutory & Formal roles including deputy cover in the absence of named officer.

Previously considered by (state date):	
Acute Clinical Directorate Board	
Planned Directorate Board	
Community Health Directorate Board	
Audit and Corporate Risk Committee	
Charitable Funds Committee	
Mental Health Act Scrutiny Committee	
Nominations Committee (Shadow)	
Quality & Clinical Performance Committee	
Remuneration Committee	
Executive Board	17th June 2013

Staff, stakeholder, patient and public engagement:

Executive Summary:
The register of statutory & formal roles has been updated to include cover arrangements in place in the absence of named officers.

Related Trust objectives	**Sub-objectives**
Risk and Assurance	
Related Assurance Framework entries	
Legal implications, regulatory and consultation requirements	
Action required by the Board: The Board are requested to note & agree the updated register of statutory & formal roles.	
Date	31/06/2013

Enc N

Isle of Wight NHS Trust

Isle of Wight NHS Trust – Statutory and Formal Roles - 2013/14				
Directorate	**Statutory (*)/ Formal Role**	**Name/Title**	**Deputy/cover**	**Review date (if appropriate)**
Corporate Services	MENTAL HEALTH ACT MANAGERS LEAD (CHAIRMAN OF MENTAL HEALTH ACT SCRUTINY COMMITTEE)	**Peter Taylor** Non Executive Director	Any NED in the absence of Peter Taylor	31.03.2015
Corporate Services	CALDICOTT GUARDIAN	**Mark Pugh** Executive Medical Director	**Alan Sheward** Executive Director of Nursing and Workforce.	**Review annually*
Corporate Services	NOMINATED OFFICER TO CQC (as registered provider of Services)	**Alan Sheward** Executive Director of Nursing and Workforce	**Brian Johnston** Head of Corporate Governance & Risk Management	**Review annually*
Corporate Services	SENIOR INFORMATION RISK OWNER (SIRO)	**Mark Price** Foundation Trust Programme Director/ Company Secretary	**Chris Palmer** Executive Director of Finance	**Review annually*
Corporate Services	DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)	**Alan Sheward** Executive Director of Nursing and Workforce	**Sarah Johnston** Deputy Director of Nursing	**Review annually*
Corporate Services	HEALTH AND SAFETY MANAGER	**Connie Wendes** Assistant Director Health & Safety and Security	**Judy Green** Principal Back Care Advisor/ **Martin Keightley** Fire and Safety Manager	**On change of post holder*

Directorate	Statutory (*)/ Formal Role	Name/Title	Deputy/cover	Review date (if appropriate)
Corporate Services	SECURITY NED LEAD	**John Matthews** Non Executive Director	Any NED in absence of John Matthews	30.09.2016
Corporate Services	ACCOUNTABLE OFFICER FOR THE DESTRUCTION OF CONTROLLED DRUGS	**Connie Wendes** Assistant Director Health & Safety and Security	**Rob Jubb** (Accountable destruction officer) Local Security Management Specialist	**On change of post holder*
Corporate Services	COUNTER FRAUD BOARD LEAD	**Chris Palmer** Executive Director of Finance	**John Cooper** Assistant Director of Finance	**Until substantive Deputy Director of Finance appointed*
Corporate Services	LOCAL COUNTER FRAUD SPECIALIST	**Barry Eadle** Local Counter Fraud Specialist	As notified during absence	**Review annually and as part of contract award*
Corporate Services	SAFEGUARDING ADULTS	**Alan Sheward** Executive Director of Nursing and Workforce	**Sarah Johnston** Deputy Director of Nursing	**Review annually*
Corporate Services	INFORMATION GOVERNANCE REGISTRATION AUTHORITIES	**Alan Sheward** Executive Director of Nursing and Workforce	**Mark Elmore** Deputy Director of Workforce	**Review annually*
Corporate Services	SENIOR INDEPENDENT DIRECTOR (SID)	**Nick Wakefield** Non - Executive Director	**N/A**	**Review annually*

Directorate	Statutory (*)/ Formal Role	Name/Title	Deputy/cover	Review date (if appropriate)
Corporate Services	RESPONSIBLE OFFICER FOR REVALIDATION (RO)	**Mark Pugh** Executive Medical Director	**NHSE** **Medical Director**	**On change of post holder*
Corporate Services	SAFEGUARDING CHILDREN	Executive Lead **- Alan Sheward** Executive Director of Nursing and Workforce Clinical Lead for Health Visiting & School Nursing - **Jenny Johnston -** Deputy Director of Nursing Doctor: **Dr Arun Gulati** Nurse: **Sally Stewart** Midwife: **Ann Stuart**	**Dr Andrew Watson** Consultant Paediatrician **Catherine Powell** Consultant Nurse Safeguarding Children	**Review annually*
Corporate Services	DIRECTOR RESPONSIBLE FOR INFORMATION	**Chris Palmer** Executive Director of Finance	**Iain Hendey** Assistant Director of PIDS	**On change of post holder*
Corporate Services	HUMAN TISSUE ACT LICENCE HOLDER	**Mark Pugh** Executive Medical Director	Deputy Medical Director	**On change of post holder*
Corporate Services	DECONTAMINATION LEAD	**Felicity Greene** Executive Director of Strategy & Commercial Development	**Kevin Bolan** Associate Director of Facilities	**On change of post holder*

Directorate	Statutory (*)/ Formal Role	Name/Title	Deputy/cover	Review date (if appropriate)
Planned/ Acute Services Directorate	NONE	NONE	NONE	*NONE*

Enc O

ISLE OF WIGHT NHS TRUST

FOUNDATION TRUST PROGRAMME BOARD

TUESDAY 29 MAY 2013 BETWEEN 11:00 – 12:30
SMALL MEETINGS ROOM, PCT HQ, SOUTH BLOCK

NOTES

PRESENT

Karen Baker (Chair)	Mark Price	Peter Taylor	Danny Fisher
Chris Palmer	Mark Pugh	Felicity Greene	

1. APOLOGIES

Sue Wadsworth	Andy Hollebon	Andrew Shorkey	Alan Sheward

IN ATTENDANCE
Angie Squibb

Top Key Issues	Subject
2c	Definition of 'a significant transaction' as required by the FT Constitution considered.
6	Membership Manager appointed to drive membership recruitment

ACTION

2. **A. Notes and matters arising from** 23 April 2013
The minutes of the meeting were received and accepted as a correct record.
Action Plan Updates
287 – MPr advised AH is actioning re Council Induction.
292 – MPr to follow up status of HDD with GT. **MPr**
301 Quality Governance Framework – MPr said that he was hoping to have a version during this meeting however AWS was not able to be present.
319 – MPr advised that KPMG are booked to come in on 15 July to complete a third party self assessment with us. **ASh**
Need to recast date.
319 – Process complete, quarterly reports going to Quality & Clinical Performance Committee – need to recast date. **ASh**
2B. Action Tracker
2C. FT Constitution 'Significant Transaction' – MPr presented this paper with examples from 2 other FT's. He advised that Trust's may only apply for a merger, acquisition, separation or dissolution with the approval of more than half the members of the Council of Governors. Members favoured the Somerset example. CP suggested that we work through a version to demonstrate our assets in money terms which we would need by the end of July, Clive Woodbridge undertake this. Version to be brought back to July Programme Board to approve. CP to action with CW. **CP**

3. **FT Timeline**
There were no updates on the trajectory of other FT applications.

4. **Action Plan Assurance**
4A. Integrated Action Plan Exception Report – MPr presented the new format. He acknowledged that some exceptions are repeated in the report, and there are a small number of actions that can be closed down, i.e. Clinical NED, Quality Governance Framework, Board Development Plan. Updates on others still required. **ALL/ASh**
HDD2 (16 and 26) – MTP advised that the majority of QIA's have been approved, others have been sent back for additional information and are still outstanding but are being chased. He acknowledged monitoring of potential risks is the biggest issue for us. CP expressed concern around process for receiving back responses but was assured by MTP that there was back up via the Quality Risk Programme/Profile. Agreed ASh to go out to owners again as all due dates are past and update for next meeting. KB/MTP/MPr to discuss further offline. **ASh KB/MTP/ MPr**
4B. Refreshed Board Development Action Plan – Foresight Actions – MPr advised that accountability and responsibilities have been added. Members were given a month to update or amend – chase once approved. **ALL**
17. Board attendance at forthcoming events: CP raised diminishing network opportunities since demise of SHA. MPr advised that regional gaps have been highlighted. TDA Local Area Team to keep us briefed on where things are moving to. Agreed we need to ensure coverage of FTN events. PT asked whether we could explore setting up our own network with some high performing FT's. FG said that we have started already with Comms Heads from PHT, Solent, etc. MPr said that there was a local

Company secretary Network he had attended. DF said that we need to be selective in our attendance at meetings.

26. Recast date. PT to maintain Chair of Audit Committee. MPr to investigate requirement for Qualified Accountant to Chair the Finance, Investment and Workforce Committee. **MPr**

ASh to provide summary for each ED on a weekly basis. **ASh**

4C. Quality Governance Framework – 6 items red flagged as behind schedule. Need to see which 6 actions are behind and gain assurance that they are being progressed that they are to meet due date. ED's to pick up at Informal Exec Team Meeting. **ED's**

4D. HDD Stage 1 – 3 actions still behind schedule – Treasury Management – still not agreed at Audit Committee, further Policy Management Group meeting this Friday. Asset Transfer – need to see formal approval. Succession Planning for NEDs – MPr advised that he is sending out a skills grid. CP said that this does not take into account ED succession planning. KB agreed that we do need to consider this.

4E. HDD Stage 2 – Historical income and expenditure – links to Lisa Manson conversation and Monitor. **KB**

Agreed D and E to be amalgamated ASh to action. **ASh**

4F. Board Development Action Plan – Superseded by 4B.

4G. Board Governance Action Plan – MPr advised most actions in train. CP commented that there had not been much feedback to Clive Woodbridge (CW) on CIP's. ED's to follow up. CP to ask CW to resend email. Also need to schedule ED discussion. **CP**

5. **Workstream Updates**

Only one update provided by FG for IBP Workstream. FG advised that the Steering Group will meet every 2 weeks for Execs and ADs only. Bronwen Vearncombe arranging sub-groups for LTFM, Activity, Capacity Workforce, Finance, Downside Case and mitigation (to include Quality). FG to check with BV that dates have been confirmed. FG advised main concern was meeting the milestones, however an action plan is in place to address this. Programme Tracker falling behind – KB to pick with ED's at 08.30 meeting tomorrow (Wednesday) in the absence of ASh. **FG** **KB**

MTP queried the need for Workstream Updates to be an agenda item as these are being picked up elsewhere, and are fed in via the Draft Programme Plan. Agreed that this section of the agenda would be by exception reports – ASh to amend future agendas. **ASh**

6. **Communications and Stakeholder Engagement**

MPr presented a paper with a breakdown of membership numbers run off from the Capita database which at the time of the report showed a total of 1346 at the point that the paper was written. He is confident now that we will exceed the target for October set in the letter from the TDA.

MPr acknowledged that we will need to look at moving from purely recruiting members to targeting specific groups, e.g. ethnic minorities, we would need to achieve around 8% membership for this demographic, this will be a challenge for us and we need to look at other ways of achieving this. It was recognised that this could not be achieved entirely via Trust staff. KB asked what percentage of our staff fit that demographic and it was agreed that there was not sufficient numbers to meet this target.

It was felt that there is still a lack of understanding amongst the general public in terms of the literature and the information they receive about membership exactly what they are being asked to do – is there a way that we can simplify how we publish it outside? MPr advised that we have appointed Margaret Eaglestone as Membership Manager who starts next week. KB requested that Margaret attend the next FT Programme Board on 25 June. **MPr**

7. **Programme Governance and Approvals**

(i) <u>Programme Plan</u>

MPr presented the High Level Programme Plan as at 31 March which ASh has recast against the TDA Accountability Framework. CP requested ASh amend dates where applicable.

KB asked members to take this away, check leads are correct and provide feedback on any updates to MPr by 11 June in preparation for Trust Board on 26 June. Agreed need for Associate NED to support succession planning – MP to provide support. **ALL** **MPr**

(ii) <u>TDA Self-Certification Milestones</u>

MPr presented the 9 FT milestones linked to the TDA Accountability Framework explaining that this is the means of holding each other to account. He advised that 1 – 7 are taken from the TDA letter which was received following our Board to Board, with 8 and 9 being largely in the TDA gift. He said that we will be vulnerable if 1 – 7 are not achieved in line with the August timeline. CP said that the LFTM is biggest target, she will ask Clive Woodbridge to amend date in Action Tracker. It was agreed by members that 2 be taken out of the milestones. Members agreed the milestones as presented subject to the removal of 2. **CP** **ASh**

(iii) <u>Risk Management</u>

MPr advised there was no change to the current status or controlled status. ASh recommendation to downgrade R007 from Red to Amber risk. This was approved. CP requested point 6 in the summary analysis be included in Resources R001. ASh to action. **ASh**

PT asked when we will know TDA criteria for sign off of licences – MPr anticipates that this will be within a month.

(iv) Programme Budget
MPr presented the budget paper advising that funds are virtually committed although there may be some flexibility around Grant Thornton fees. CP advised that we are awaiting information from Lisa Manson following a recent teleconference. MPr is also writing to Loretta Outhwaite re non-recurrent funding from the CCG. **MPr**

8. **Feedback from FTN Events and FT Visits**
MPr said that he had attended a recent FTN event linked with Barclays looking at the economic and social value of FT's which he had found very informative. He was hoping to use examples to promote why we want to become an FT. He will circulate the report to the Board. **MPr**

9. **Any other Business**
CP highlighted the need to manage the expectations of the Commissioners and CCG going forward – 'what would the future be and how would we manage it'. KB said that this would be an iterative process mapping our relationship with them. She advised that she had asked FG to undertake a mapping exercise via a slide presentation around the prison - costs, internal and external through delays and to the conclusion which we would share with CCG. The same process could be applied to dermatology. This could also be presented at a future Board meeting.

10 **Future Meetings**
The next meeting was scheduled for 11:00-12:30hrs, Tuesday 25 June 2013, Small Meetings Room, South Block

Enc P

Isle of Wight NHS
NHS Trust

FOR PRESENTATION TO TRUST BOARD ON 26 JUNE 2013

AUDIT AND CORPORATE RISK COMMITTEE

Minutes of the meeting of the Audit and Corporate Risk Committee held on the 5th June 2013 at 9.00 a.m. in the Large meetings room, Trust HQ, St. Mary's Hospital, Newport.

PRESENT: Peter Taylor (Chairman)
Sue Wadsworth
Nick Wakefield (via telephone)

In Attendance: Chris Palmer, Executive Director of Finance
Mark Price, Company Secretary
Paul King, External Audit Engagement Lead
Kevin Suter, External Audit Manager
Andy Hollebon, Head of Communications
Richard Sharp, Interim Asst. Director of Finance

Observer: Lynn Cave, Acting Board Administrator

Minuted by: Linda Mowle, Finance Governance Officer

Min. No.	Recommendation
077/13	**Audit Results Report:** • **A report to be presented to the Finance, Investment & Workforce Committee detailing the HR processes in place for the annual accounts audit and the sign off of MAPS roster by managers** • **Appointments to Financial vacancies to be taken forward as a matter of urgency**
084/13	**Annual Report 2012/13 Incorporating The Quality Account:** • **The Annual Report to be a single, comprehensive and concise document** • **A timescale for the production of the Report to be prepared for commencement in January** • **A standardised template to be prepared with a deadline for receipt of completed templates (maximum number of words stated)** • **In anticipation of FT status next year, a dry run to be undertaken using the standard template** • **The timetable and draft outline to be presented to the Audit & Corporate Risk Committee at its November 2013 meeting**

Top Key Issues/Risks	Subject
Min. No. 077/13	Audit Results Report: Unqualified audit opinion for Financial Statements and value for money conclusion
Min. No. 078/11	Report on 2012/13 Accounts: Achievement of regulatory duties
Min. No. 082/13	Head of Internal Audit Opinion: Significant Assurance
Min. No. 083/13	Going Concern Statement: Concept reviewed and Accounts prepared on a going concern basis

074/13 APOLOGIES for absence were received from John Matthews, Nina Moorman and Clive Woodbridge.

075/13 QUORACY: The Chairman confirmed that the meeting was quorate. Nick Wakefield was in attendance via electronic communication and was able to communicate interactively and simultaneously with all parties for the whole duration of the meeting, and all members were able to hear each other throughout the meeting.

076/13 DECLARATIONS OF INTEREST: There were no declarations.

077/13 AUDIT RESULTS REPORT: Paul King presented the Audit results report for the year ended 31st March 2013, which summarises the preliminary audit conclusion to the Trust's financial position and results of operations for 2012/13. The final conclusion will be issued following the Audit & Corporate Risk Committee meeting. As the deadline for the Quality Account is 30th June, the conclusion will be issued at that time for the Quality Account. In presenting the report, Paul King confirmed:

Financial Statements

- An unqualified audit opinion
- No identified errors that affected the Trust's financial performance
- All primary misstatements amended
- Only one unadjusted misstatement which did not impact on the financial performance

Economy, Efficiency and Effectiveness

- an unqualified value for money conclusion

The following key areas were highlighted:

- JAC full reconciliation between the JAC system and the general ledger
- Managers to sign off MAPS roster instead of HR
- Finance resources to be maintained as Trust progresses towards FT status
- All HR queries should be resolved on a three day turn-around unless exceptionally agreed
- The Trust's annual report remains with significant scope for improvement and increased efficiency:
    - Begin the production process significantly earlier
    - Trust Board to provide a clear direction for content, focusing on its corporate objectives
    - Agree specific timetables for the inclusion of required information from officers throughout the Trust
- The summary of audit differences in Section 8 were agreed

Management's Response: The Director of Finance advised that the areas raised were being taken forward, highlighting the significant work undertaken by the Finance Team in ensuring that the Opening Balances were correct for the PCT and Trust. Chris Palmer thanked the auditors for the positive approach taken which provided for a smooth audit. An added benefit was the historical knowledge of the Trust brought to the audit by both Kevin Suter and the auditors.

Recommendation:

- **A report to be presented to the Finance, Investment & Workforce Committee detailing the HR processes in place for the annual accounts audit and the sign off of MAPS roster by managers**
- **Appointments to Financial vacancies to be taken forward as a matter of urgency**

The Chairman, on behalf of the Committee, formally thanked the auditors for their support which had enabled a positive and smooth audit, as well as Clive Woodbridge

and the Financial Accounts Team, resulting in a robust set of accounts and excellent partnership/team work. The External Auditors extended their thanks in particular to Katie Parrott, Senior Financial Accountant, who had supported the audit tremendously whilst still supporting the PCT.

078/13 LETTER OF REPRESENTATION: The draft Letter of Representation to the External Auditor in connection with the audit of the financial statements for the year ended 31st March 2013 was received. The Committee noted that the Letter takes account of the discussions and reasoning around the accounts statements.

The Committee approved the draft Letter of Representation for formal signing by the Director of Finance and the Committee Chairman.

078/11 REPORT ON 2012/13 ACCOUNTS: The Committee received and noted the contents of the report prepared by Clive Woodbridge (Deputy DOF), John Cooper and Richard Sharp (Assistant DOFs), which summarised the key features of the 2012/13 annual accounts process and highlighting the positive achievement of the following:

- The Accounts were submitted on the 22nd April 2013 in compliance with the noon deadline
- The Trust ended the year with a £509k surplus
- The regulatory duties were achieved:
    - Break-even duty
    - Kept within the EFL Limit of £486k
    - BPPC (payment of invoices within 30 days)

079/13 ANNUAL ACCOUNTS 2012/13: The post-audit Annual Accounts for 2012/13 were received. The Director of Finance advised that the Accounts followed the standard document with reference notes and explanations to support the accounts position.

The Committee agreed the Annual Accounts for 2012/13 for approval and adoption by the Trust Board and formal sign off by the Trust Chairman.

080/13 DRAFT DIRECTORS' CERTIFICATES: The Committee received and agreed the draft Directors' Certificates for approval by the Trust Board and formal sign off by the Chief Executive and the Director of Finance.

081/13 2012/13 GOVERNANCE STATEMENT: The Governance Statement, previously agreed by the Committee at its meeting on the 22nd May 2012, was received.

082/13 HEAD OF INTERNAL AUDIT OPINION: In presenting the HIAO for the year ended 31st March 2013, the Director of Finance highlighted the Chief Internal Auditor's opinion in that:

- Significant assurance given
- There is a generally sound system of internal control
- That controls are generally being applied consistently

083/13 GOING CONCERN STATEMENT: The Committee received the review of Statement on the Trust as a Going Concern prepared by Clive Woodbridge, Deputy Director of Finance. It was noted that, from the evidence presented in the report, the Trust is a 'Going Concern' and that it was appropriate for the 2012/13 Accounts to be prepared on this basis.

The Committee considered that assurance could be provided to the Trust Board that the Going Concern concept had been reviewed and agreed that it was appropriate for the Accounts to be prepared on that basis.

084/13 ANNUAL REPORT 2012/13 INCORPORATING THE QUALITY ACCOUNT 2012/13: Andy Hollebon tabled version 11 of the draft Annual Report and Accounts for 2012/13 advising that the Report included the following requirements:

- Manual for Accounts
- Monitor Guidance for FTs
- Trust's notable achievements within the year

and highlighting the amendments within the latest version of the Report. The Summary Financial Statements had been included at Appendix B, with the Independent Auditors Report, along with the Quality Account to be included later before publication for the AGM on the 31st July 2013. It was noted that the Quality Account's deadline for sign off was the 30th June. One of the aims of the Annual Report was to be more forward focussed as the Trust moves towards FT status, and to provide a better understanding of the organisation's approach and vision for healthcare on the Island.

However, the Committee noted that minor amendments were still required, and as a result, the External Auditor advised that the signed audit opinion would be provided as soon as the final Annual Report had been received. This was agreed to be provided later that day.

The Committee was of the opinion that, going forward for FT status, the process for the production of the Annual Report needs to be sharper, therefore advising the following:

Recommendation:

- **The Annual Report to be a single, comprehensive and concise document**
- **A timescale for the production of the Report to be prepared for commencement in January**
- **A standardised template to be prepared with a deadline for receipt of completed templates (maximum number of words stated)**
- **In anticipation of FT status next year, a dry run to be undertaken using the standard template**
- **The timetable and draft outline to be presented to the Audit & Corporate Risk Committee at its November 2013 meeting**

The Committee agreed the draft Annual Report subject to the inclusion of the amendments, together with the Quality Account subject to inclusion of Stakeholder Statements.

085/13 DATE OF NEXT MEETING: 21 August 2013 in the Conference Room at 12.00 – 2.30 p.m.

Enc Q

Isle of Wight NHS Trust

FOR PRESENTATION TO TRUST BOARD ON 26 JUNE 2013

Minutes of the meeting of the Charitable Funds Committee held on the 11th June 2013 at 8.30 a.m. in the Rope Store, Quay Arts, Newport, Isle of Wight.

PRESENT: John Matthews (Chairman)
Danny Fisher, Trust Chairman
Felicity Greene, Executive Director of Strategic Planning & CD
Nina Moorman, Non Executive Director
Chris Palmer, Executive Director of Finance
Mark Pugh, Executive Medical Director (part meeting only)
June Ring, Patient Council
Alan Sheward, Executive Director of Nursing & Workforce
Peter Taylor, Non Executive Director
Sue Wadsworth, Non Executive Director

In Attendance: Nick Wakefield, Non Executive Director
Mark Price, Company Secretary
Clive Woodbridge, Deputy Director of Finance
Richard Dent, Volunteer Co-ordinator

Minuted by: Linda Mowle, Finance Governance Officer

Top Key Issues	Subject
Min. No. 24/13	Terms of Reference: Nina Moorman proposed as Vice Chair
Min. No. 26/13	Amendments to Charity Commission Registration: recommendation to approve the re-naming of the Charity and dissolution of the linked charity
Min. No. 28/13	Approval of Funding over £15k: Green Gym and Trim-Trail £21,623.60

21/13 APOLOGIES for absence were received from Vincent Thompson, Katie Parrott, Andy Hollebon and Jasmine Light.

22/13 QUORACY: The Chairman confirmed that the meeting was quorate.

23/13 DECLARATIONS OF INTEREST: The Chairman declared an interest as Assistant Deputy Coroner and Deputy District Judge.

24/13 TERMS OF REFERENCE: The Chairman welcomed Dr. Nina Moorman, Non Executive Director, to her first meeting of the Committee.

The Trust Chairman proposed Dr. Moorman be Vice Chair of the Committee, unanimously approved by the Committee and duly accepted by Dr. Moorman.

The Company Secretary advised that a review of all sub-committees' terms of reference, including membership, is to be undertaken. With regard to the membership of the Committee, it was agreed that membership be reviewed following receipt of the guidance from the DOH on Charities Governance and Regulation.

25/13 MINUTES: The minutes of the meeting held on the 12th March 2013 were agreed and signed by the Chairman as a true record.

26/13 AMENDMENTS TO CHARITY COMMISSION REGISTRATION: Clive Woodbridge presented the report prepared by Katie Parrott, Senior Financial Accountant, outlining the amendments required to the Charity Commission Registration Ref. 1049606.

Sue Wadsworth proposed, seconded by Peter Taylor and unanimously agreed to recommend to the Corporate Trustee at its meeting on the 26th June 2013 approval of:

- Charity Commission Registration 1049606 to be re-named 'Isle of Wight NHS Trust Charitable Funds'
- Dissolution of the linked charity 'Isle of Wight NHS PCT General Charity' to form a single charity approach.

Clive Woodbridge to take forward as an agenda item for the Corporate Trustee meeting on the 26th June 2013. **Action: CW**

27/13 CHARITABLE FUNDS STRATEGY 2013–2017/18: The Executive Director of Strategic Planning & CD in presenting the updated Strategy, advised that it had been aligned to the Trust's Integrated Business Plan (IBP). Following discussion, the Committee agreed to defer a definite decision on the Strategy to the next meeting on 9th July 2013 in order to take account of:

- Pending guidance on the DOH Regulation and Governance of NHS Charities
- Implementation of a CF Administrator/Fundraiser
- A more targeted approach of fundraising perhaps using volunteers
- Updating the Charitable Funds leaflet for a wider circulation
- Inclusion of a Communications Strategy
- Working in partnership with EMH as well as the Friends of St. Mary's
- The Volunteers Co-ordinator to explore and provide an update on using volunteers to assist with fundraising

The Charitable Funds Strategy to be an agenda item for the 9th July 2012, along with the Charitable Funds Leaflet, the Communications & Engagement Action Plan 2010/11, the Volunteers Co-ordinator's report and the DOH guidance should this have been issued. **Action: RD/LM**

28/13 REQUESTS FOR CONSIDERATION:

Green Gym and Trim-Trail: The Executive Director of Strategic Planning & CD presented the Business Case for the Trim-Trail and Outside Gym on the St. Mary's site which had been approved in principle at the meeting on the 12th March 2013 (Min. No. 16/13).

The Committee was of the opinion that the installation of a Green Gym and Trim-Trail would enhance the wellbeing of staff, and that the Trim-Trail could be included as a walk within the Island's annual Walking Festivals in May and October. Due to the Island's inclement weather, the Committee agreed to consider at a later date the provision of a shelter for staff using the Green Gym. **Action: LM**

Following email circulation of the Business Case to members of the Committee on the 15th May 2013, Sue Wadsworth proposed, seconded by Peter Taylor and unanimously agreed by the Committee the retrospective funding from General Fund of £21,623.60. The Committee noted that maintenance will be minimal as the equipment is robust and designed for outdoors, and that any costs will be covered by the Estates Department.

In order to publicise the facility, it was agreed that the Trust Chairman undertakes an Opening Ceremony for inclusion in the County Press and the Trust's E-Bulletin.

Action: MPr/AH

29/13 **VOLUNTEER SERVICES:** The Volunteers Co-ordinator advised that as the funding for the post will cease at the end of the month, his final report will be presented to the July meeting and thanked the Committee for all the support he had received.

Sue Wadsworth asked for assurance that the Volunteer Co-ordinator post had been picked up by recurrent funding and the Executive Director of Finance gave that assurance.

The Chairman, on behalf of the Committee, thanked Richard Dent for his outstanding contribution to the Volunteer Services. The Committee requested that he continues to attend meetings.

30/13 **DATE OF NEXT MEETING:** 9th July 2013 at 8.30 – 9.45 a.m. in the Conference Room, St. Mary's Hospital.

Enc R

Isle of Wight NHS Trust

QUALITY & CLINICAL PERFORMANCE COMMITTEE

19 June 2013

PRESENT:	Sue Wadsworth (SW) (Chair)	Non Executive Director
	Nina Moorman (NM)	Non Executive Director
	Sarah Johnston (SJ)	Deputy Director of Nursing
	Sarah Gladdish (SG)	Clinical Director, Community Clinical Directorate
	Chris Sheen (CS)	Clinical Director, Acute Clinical Directorate
	Deborah Matthews (DM)	Head of Clinical Services, Acute Clinical Directorate
	Sabeena Allahdin (SA)	Clinical Director, Planned Clinical Directorate
	Lesley Harris (LH)	Head of Clinical Services, Planned Clinical Directorate
	Gill Honeywell (GH)	Chief Pharmacist
	Vanessa Flower (VF)	Quality Manager
	Brian Johnston (BJ)	Head of Corporate Governance and Risk Management
	Ian Bast (IB)	Patient Representative

MINUTED BY:	Amanda Garner (AG)	Personal Assistant to Alan Sheward

IN ATTENDANCE:

Andrew Shorkey (AS)	FT Programme Management Officer
Vikki Crickmore (VC)	Acting Sister, Critical Care Services
Andy Hollebon (AH)	Head of Communications

FOR PRESENTATION TO PUBLIC BOARD ON: 26 JUNE 2013

Top Issues for the attention of the Trust Executive Committee (TEC) and the Trust Board (TB)

- Draft Long Term Quality Plan
- Quality Dashboard and Performance Approach
- Safeguarding Issues
- Pressure Ulcers – ongoing work
- Staff Capacity Issues – SIRIs, Media, Safeguarding, data availability

Action

13/105 APOLOGIES FOR ABSENCE

Mark Pugh, Executive Medical Director, Alan Sheward, Executive Director of Nursing and Workforce, John Matthews, Non Executive Director, and Lisa Reed, Head of Clinical Services, Community Health Clinical Directorate

13/106 **DECLARATIONS OF INTEREST**

No declarations were made.

13/107 **MINUTES OF THE LAST MEETING – 17 April 2013**

The Quality & Clinical Performance Committee approved the Minutes of the meeting held on 17 April 2013.

MATTERS ARISING

SW asked that for the next meeting actions were collated onto an action sheet. **AG**

The Committee discussed the need for deputies when CD's were unable to attend and it was agreed that this would be discussed further separately.

13/085 Patient Story – the Committee agreed that following presentation of a patient story that they are updated at future meetings on progress of actions. **VF**

13/089 Claims received in March – BJ advised that Mark Pugh, Executive Medical Director, would be taking on the protocol for vascular review.

AGENDA

Quality

13/108 **Quality Report**

SJ presented the quality report for May 2013 to the Committee highlighting the following:

Page 4 – SIRIs – SJ reported that there had been a significant decrease in the number of SIRIs reported and that this was in part due to a new, more robust, process in place for identifying true SIRIs. The Committee discussed how this significant drop might be perceived by external bodies. VF stated that the Trust had evidence to support to decision making process.

Page 6 – Falls – SJ commented on the improvement seen in this years falls compared to last years. The Falls Group is continuing to work well with their rapid response team in place.

Page 8 – Healthcare Associated Infection – SJ reported that the Trust was over its target for Clostridium difficile (C.diff) for the year. RCAs are being reviewed. NM questioned the use of antibiotics. GH advised that there is a review in hand with South Central regarding this which will include benchmarking. GH reported that the HAPPI audit is in place but we are still getting some instances of poor antibiotic prescribing. The Committee agreed that it was disappointing that the Trust was not of top of this. SW asked that for the next meeting it was reported what actions were being taken to address this. SJ advised that there is an annual plan, a list of key priorities and RCAs are in hand for the individual cases.

Page 17 – Complaints – SJ reported that the significant work in relation to the process is resulting in wards now taking ownership of complaints which has contributed to a significant drop in numbers.

Page 19 – Complaints – SJ highlighted that there had been no returners since April 2013 and that this was a significant achievement. SA agreed and added that the new system was extremely successful in allowing quick resolution.

Pages 30 and 31 – Quality Risk Profile (QRP) – SJ advised that there were currently no red areas. BJ advised that QRP was on the agenda for discussion and confirmed that there were no red areas with one amber areas which was good.

Page 27 – Pressure Ulcers – SJ reported that there is ongoing work on competencies which includes the Band 7's, wards and community areas. SJ advised that the Trust is doing better and despite still having some grade 3 and 4 pressure ulcers more ownership was being taken by staff and that there should be a continuing reduction seen. There will remain a priority focus on competencies for pressure ulcer care for all staff over the next few months.

Page 29 – Nursing Dashboard – The Committee noted that Newchurch Ward needs to be relabelled to "Appley Ward"

SJ advised that there was some missing data regarding appraisals and sickness rates and that the data was not available in time. SJ advised that she would discuss this with Mark Elmore as he was hoping to align meetings with data availability dates.

SJ advised that the Quality Dashboard would be launched in July 2013 and that this will contain real time information. The Committee discussed the inclusion of DSU, Theatres and Endoscopy. SJ advised that Theatres and Endoscopy are included in the Quality Dashboard. SA advised that there is already a monitoring process in place in theatres and this data is looked at by the Planned Care Teams. SJ advised that the Quality Dashboard could be viewed by the Quality and Clinical Performance Committee at their next meeting in August 2013.

13/109 Quality Goals

SJ advised that this paper provides an outline of the quality goals that have been identified for 2013/14 following a third party review and that these will be included in the Trust's Quality Account. SJ advised that a questionnaire was circulated to all staff to provide feedback. SJ advised that the Trust had identified four goals for this year which are:

1. Patient Safety - Prevention of Pressure Ulcers
2. Clinical Effectiveness - Reducing Mortality Rates
3. Patient Experience – Communication. SJ advised that an indicator is required.
4. Stakeholder Recommended Goal - End of Life Care (AMBER Care Bundle)

The Committee discussed the link between Reducing Mortality Rates and End of Life Care and agreed that this will need to be clarified in Quality Account.

13/110 Terms of Reference (TOR)

SW advised that the TOR had been amended and that the amendments were in red. The Committee noted that the Heads of Clinical Services had not been added to the membership. BJ advised that the Exec Board was now the Trust Executive Committee and that this needed to be changed throughout the document. SJ advised that she would speak with AWS regarding her membership as she was now not in the TOR. NM advised that as a new member of the Committee that she had found the terms and the setting out of the TOR a little confusing. SJ and NM agreed to meet separately to discuss this. **SJ/NM**

SW asked the Committee members to contact SJ if they had any further comments.

13/111 Quality Account

SJ advised that the Quality Account is an annual statutory requirement aimed at the public which includes an update on how the Trust performed against the quality goals for the previous year and setting out what they are for the coming year. SJ advised that once the governors are in place there will be a better sense of public input. SJ advised that the quality account is due to go to Board and asked that Committee members emailed Teresa Gallard with any comments and that the Quality Account links with the Quality Report. The Committee members discussed the layout of the Quality Account and SJ advised that the Trust is required to use a specific template.

SW referred to page 19 of the Quality Account regarding the Francis Review and asked that DM give an update to the Committee on this at the next meeting in August. **DM**

13/112 CQC Report

BJ updated the Committee regarding the additional registration for St Mary's which had come about due to the closure of Shackleton House in Ryde. BJ advised the Committee that St Mary's was not specifically registered previously for providing accommodation and treatment for persons detained under the mental health act and that this was formal confirmation. BJ added that following their visit the CQC had been very impressed with the new ward.

SG advised the Committee that the CQC had visited for a Mental Health Act visit earlier in the week and had been impressed with the changes that had been made to Shackleton.

BJ advised that following the visit to Woodlands the CQC had provided a report on their visit and that this was a very positive report. BJ added that there were only two low level recommendations and that an action plan had been prepared in response to these. BJ advised that the name of the responsible manager had now been added to the response which the Committee agreed was an appropriate response and should be returned to the CQC. **SG**

SG advised the Committee that staff do manage a high level of risk in the secure mental health unit. The Committee recognised this and asked that formal thanks and congratulations to sent to staff.

13/113 Quality Risk Profile (QRP)

BJ advised that this briefing has been drafted for the Trust Executive Committee this week and is an important document that gives a background on how the CQC are assessing the Trust. BJ added that there are between 600 and 800 items of data that make up the QRP each month. BJ advised the Committee that there is currently one area assessed as amber but that there is an action plan to address this. BJ added that this document demonstrated to the CCQ how the information provided by them is handled. GH added that the area in amber related to the management of medicines. BJ added that this will be looked at to determine what needs to be done to improve. BJ advised that he had put the information gathered together on one page and this showed the overall rating and progress. BJ advised that this will be updated monthly and he will update the Committee at each meeting. BJ added that there are some areas of concern regarding the QRP in that some of the information is difficult to get to the bottom of and sometimes the information presented is out of date and that the Committee needed to be aware that some of the information is not updated for sometimes up to a year. The Committee agreed that it was very useful to see the data all on one sheet set out clearly. BJ advised that low green was the best and high red is the worst reading and advised that some of the terminology used by the CQC was not standard ie sometimes they refer to amber and sometimes orange.

13/114 Long Term Quality Plan (LTQP)

SJ advised that the LTQP is replacing the Quality Improvement Strategy. The LTQP is more generic and will be underpinned by the annual selection of the key Quality Goals for each year. SG suggested that an addition was made to the plan which set out where this feeds in for clarification. The Committee agreed that this was a good idea. NM advised that some terms were confusing and suggested that standard terms be used. SJ advised that she would add in a flow chart and make the terms clearer. CS queried information on Page 10 with regards to the date and suggested that this be amended. SW asked that an updated version is presented to the Committee at the next meeting in August 2013. **SJ** **AWS**

13/115 Quality Governance Framework (QGF) Action Plan

SJ reported that the QGF is the standard set by Monitor for monitoring quality. SJ advised that the Trust needed to ensure that updates are received promptly on actions to ensure the organisation is as up to date as possible for our third party peer review. SW advised that she would discuss this at Board. **SW**

SJ advised that the document is reviewed at FT Board to ensure progression and that the status of the actions is mostly amber or green. SJ highlighted key items including the Whistleblowing Policy which staff will be asked for feedback on using a staff thermometer tool and the Quality Dashboard which the team are focussing on getting up to speed.

Reports from Directorates

13/116 **Acute Directorate – Quality, Risk and Patient Safety Committee**
Minutes of last meeting and top 3 issues

CS updated the Committee following the Acute Clinical Directorate Quality Risk and Patient Safety Committee on 23 May 2013. CS highlighted the following areas

- Dr Foster – Mortality review data
- Trust Risk Register
- Risk Assessment Log
- Speciality Feedback
- Incidents and Issues
- Complaints, Concerns and Compliments
- SIRIs
- Audits
- Clinical Claims
- Infection Control
- Appraisals and Mandatory Training

CS advised the Committee of the Top issues from other Trust meetings and advised that the top issues taken from this meeting for reporting to Directorate Board were:

- CT scanner – CS advised that this has been approved
- Blood Science – out of hours service
- Consultant Vacancies – the Committee discussed the difficulty to recruit to the Trust and how work was being done to improve this.
- Ultrasound room
- Equipment storage – SW advised that she thought that this seemed to be an issue across the Trust

13/117 **Actions being taken to address concerns on a low performing ward/service and update from previous actions**

DM updated the Committee on the Directorate's area of concern and advised that there was a lot of effort and work being done to improve and that there was now a better understanding of what was going on. DM added that there was a need to keep focus and that there were external people helping with this. DM advised that the lessons learned could be shared with other Directorates.

13/118 **Planned Directorate – Quality, Risk and Patient Safety Committee**
Minutes of last meeting and top 3 issues

LH updated the Committee following the Planned Clinical Directorate Quality Risk and Patient Safety Committee on 23 May 2013. LH advised that the Planned Directorate would present the minutes as a presentation for the next meeting. LH highlighted the following areas:

- Major incidents – RCAs completed

- Risk Register

LH advised the Committee of the top 3 issues raised

- Readmission rates
- Risk register
- Pressure ulcers

SA added that the figures regarding caesarean section had been reviewed as twins were recorded as two and also work was continuing on term admissions to NICU in accordance with the action plan.

13/119 Actions being taken to address concerns on a low performing ward/service and update from previous actions

LH updated the Committee on recent areas of concern and advised that a lot of work is being done to improve the areas which have already shown improvement

13/120 Community Health Directorate – Quality, Risk and Patient Safety Committee Minutes of last meeting and top 3 issues

SG updated the Committee following the Community and MHLD Clinical Quality Risk and Patient Safety Committee meetings in May 2013. SG highlighted the following areas

- Pressure Ulcers
- District Nurses – SG advised that the team were under a lot of pressure regarding pressure ulcers but are fully committed to the programme of actions. Work is due to start to ensure the DN are not picking up non-commissioned roles that further impacts on their work load.
- SIRIs
- Complaints – SG reported success with the new system
- Risk Register – assurance given
- Quality Surgeries – assurance given
- Health Assure – programme progressing but delays due implementation of other IT systems

SG advised the Committee of the top issue raised

- Pressure Ulcers – SG advised that this is putting a lot of pressure on Community Staff, but they are being supported through this.

SG added that clarification is needed regarding what is required to be reported by the Directorates at this meeting. The Committee agreed that the minutes were useful for detail and that a presentation as an overview for assurance would be helpful. SJ advised that she would take the opportunity to discuss this at the Executive Director of Nursing's Team Meeting for clarification. **SJ**

13/121 **Actions being taken to address concerns on a low performing ward/service and update from previous actions**

SG updated the Committee on the Directorate's area of concern and advised that a lot of work was being done to improve issues such as sickness and vacant posts

Patient Experience

13/122 **Patient Story**

Due to technical issues the DVD of the patient stories was unable to be shown. VF advised the Committee that these had already been shown at Board. SW agreed and said that the impact had been immense. VF advised that the process for interviewing patients for feedback was being reviewed and to try and get more honest feedback the Trust would be asking the volunteers to do this. VF added that there had been difficulty in finding people to be interviewed this month and that work was being done regarding sharing the feedback with the relevant areas.

13/123 **Media Interest**

AH updated the Committee on Media Monitoring for May and June 2013. AH circulated a spreadsheet which contained summaries of stories contained in local press and updated the team on the main issues raised in the County Press on the 14 June 2013. AH added that regarding the worker who was hurt that his company had reported that the Trust had been "brilliant".

SJ advised that following the recent media interest in face down restraint that the Trust was reviewing its policy for assurance. Immediate data review shows no concerns.

13/124 **Friends and Family Test**

VF advised that this had been on stream since 1 April 2013 for the Emergency Department (ED) and inpatients. VF added that for April the Trust was top for the area with 19% against 15% however feedback was still low from ED but that this appears to be a problem experienced nationally. VF advised that she has feedback to staff regarding this. VF advised that she has been in contact with other Trusts who are struggling to get feedback even the ones who have the facility for electronic feedback.

VF updated the Committee regarding new guidance for maternity and advised that this needs to be in place by October but the Trust was looking to be ahead of the game and have it in place in July 2013.

Patient Safety

13/125 **Serious Incidents Requiring Investigation – those coming on line**

VF updated the Committee on new SIRIs and advised that SIRIs are the subject of much more scrutiny at a weekly meeting. VF reported that as part of incident reporting and duty of candour the Trust has 10 days to inform patients or their relatives of any harm caused and this is being reviewed.

13/126 **Serious Incidents Requiring Investigation – final sign off (already closed by SHA & Action Plans Completed)**

VF advised that theses SIRIs had been closed off by the Commissioners. VF advised that regarding Prison SIRIs she is still awaiting confirmation of how these will now progress.

The Committee agreed to sign off the SIRIs and asked that four were sent to the next Board meeting for review.

13/127 **Adult Observation Chart Policy - Early Warning Scoring Systems Roll out**

VC presented the policy to the Committee and added that she was hoping to seek approval of this. VC updated the Committee on the changes that had been made including parameters, indicators for starting neuro observations, SBAR communication tool. VC added that the new electronic training tracker was now mandatory as historically attendance at the induction day had been poor. LH advised that she was concerned that this is now mandatory and added that she would rather this be targeted to specific members of staff initially. VC advised that the policy had been presented to the Mandatory Training Group twice which has where it had been approved. The Committee agreed that more work needed to be done on this before being formally agreed by the Committee including the prescription of oxygen, extra paperwork, prisons and scoring.

13/128 **Clinical Negligence Claims received in May 2013**

BJ presented the report to the Committee which gave the overall position together with new claims. BJ advised that there were 3 new potential claims received in May but these had not been received as formal claims yet. BJ reported that 4 claims had been closed down positively following robust defence and that the claims had been withdrawn. SJ suggested it would be useful to include in the report whether or not related incidents were raised at the time and this would be a good indicator for safety awareness. BJ reported that his team do always look to see if an incident was reported as if there has an investigation will have taken place. The Committee agreed that staff should continue to be encouraged to report incidents immediately.

Safeguarding

13/129 **Local Safeguarding Children Board (LSCB)**

SJ advised the Committee that the Director of Children's Services, Hampshire, would be visiting on 19 June 2012 to discuss the way forward.

SJ advised that with regards to the LSCB that there was an action plan in place and that the Trust would be working in Partnership with Hampshire regarding this. SJ updated the Committee on the running of the Board, budgets and responsible staff.

13/130 **Safeguarding Adults Board**

SJ advised the Committee that the Multi Agency Policy was finalised and would update

the Committee at a future meeting.

13/131 Joint Safeguarding Steering Group

SJ advised the Committee that one meeting had taken place and that there would be a follow up meeting next week. SJ added that the terms of reference would be agreed and that these would be available for the next Quality and Clinical Performance Committee meeting. SJ advised the Committee that there had been a substantial amount of work relating to safeguarding. The interim Adult Safeguarding Lead would be returning to her permanent position and a new structure is currently being consulted on and due to be implemented in the next few months. With the significant changes being made it was important to note that the capacity for safeguarding activities was stretched. With the current emphasis on improving children's services the organisation needs to be mindful of the additional work or scrutiny this may bring. This will be reviewed at the Joint Safeguarding Committee.

Clinical Audit and Governance

13/132 Governance and Assurance Q4 and End of Year Report

BJ highlighted the key elements to the Committee:

- Pressure ulcers
- Property claims
- Friends and Family Test
- Complaint Management
- Information Governance.

BJ advised that the Executive Committee had agreed that this should be taken to Board in July.

Audit

13/133 Final Audit Report – IOW Safeguarding

SJ advised that the report was very disappointing as it stated limited assurance was given. SJ informed the Committee that all the areas that were indicated as limited assurance were areas that we had decided to make improvements to but that the improvements had not yet been completed. SW commented that if the evidence is not there for assurance then "limited assurance" is the correct rating. SW advised the Committee that the organisation needed to recognise that this type of scrutiny will become more and more common in the future.

13/134 **Action Plan**

SJ presented the action plan to the committee and SW advised that this would need to go to the Audit Committee. SJ advised that she would raise with AWS concerns regarding the capacity to deliver. SW added that this would also need to be highlighted at Board. **SJ**

Clinical Performance

13/135 SHA Self Certification

AS presented the self-certification return for May 2013/14 to the Committee. This was the first time the Committee had received the self-certification return in its new form following the introduction of the Trust Development Authority's Accountability Framework. AS advised that detailed performance metrics no longer formed part of the self-certification return. The return now consisted of Board Statements, a selection of Monitor Licence Conditions and FT Milestones. However, the new regime had given rise to gaps in information that required specific systems and processes to be implemented in order to provide sufficient assurance to the Board.

Board Statements
AS advised that as a NED with clinical experience was now in place statement 13 could be signed off as compliant. Statement 5 was currently flagged as at risk reflecting gaps in our current understanding of the Accountability Framework and a clear definition of how 'having regard to the NHS constitution' should be interpreted in practical terms. Due to queries being raised with respect to our compliance with the requirements of the IG Toolkit, statement 11 had been flagged as 'at risk'.

Licence Conditions
AS advised that the new requirement to self-certify against Licence Conditions meant that systems and processes would need to be implemented to provide sufficient assurance to the Board. At present only 1 condition could be marked as compliant. All other conditions were flagged as 'at risk'.

FT Milestones
No mechanism had as yet been provided as part of the self-certification process. AS advised that the FT Milestones had been agreed by the FT Programme Board and were al currently on target.

SJ and NM identified that certain information within the Board Statement assurance documents required updating. AS advised that he would contact owners accordingly.

It was agreed that sufficient assurance had been provided for the Committee to recommend that Trust Board approve the self-certification returns as proposed.

13/136 NHS LA – Case for Change

BJ gave a verbal update to the Committee regarding a case for change to recruit a full time project lead to get the Trust from Level 1 to Level 2. BJ explained that this could save the Trust £270,000 per year and would be an 18 month project. BJ added that this should help to significantly improve patient safety also.

Reports from Key Committees

13/137 Pathology Consortium

The minutes and report giving assurance on quality items were received by the

Committee. SW advised that the next meeting was taking place on 20 June 2013.

13/138 R&D Committee

The Committee received the R&D Committee Annual Report

13/139 Top Issues for the attention of the Executive Board (EB) and the Trust Board (TB)

- Draft Long Term Quality Plan
- Quality Dashboard and Performance Approach
- Safeguarding Issues
- Pressure Ulcers – ongoing work
- Staff Capacity Issues – SIRIs, Media, Safeguarding, data availability

13/140 Any Other Business

None

13/141 DATE OF NEXT MEETING:

Wednesday 21 August 2013
9.00 am to 11.45 am
Conference Room