Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 1st October 2014

at

09.30am - Conference Room—Level B

St. Mary's Hospital, Parkhurst Road,

NEWPORT, Isle of Wight, PO30 5TG

Staff and members of the public are welcome to attend the meeting.

Key Trust Strategic Objectives & Critical Success Factors 2014/15

Strategic Objectives	Critical Success Factors	
1. QUALITY - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and positive experience of care	**CSF 1** - Improve the experience and satisfaction of our patients, their carers, our partners and staff	**CSF2** - Improve clinical effectiveness, safety and outcomes for our patients
2. CLINICAL STRATEGY - 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	**CSF3** - Continuously develop and successfully implement our Integrated Business Plan	**CSF4** - Develop our relationships with key stakeholders to continually build on our integration across health and between health, social care and the voluntary/third sector, collectively delivering a sustainable local system
3. RESILIENCE - Build the resilience of our services and organisation, through partnerships within the NHS, with social care and with the private and voluntary/third sectors	**CSF5** - Demonstrate robust linkages with our NHS partners, the local authority, the third sector and commercial entities for the clear benefit of our patients	**CSF6** - Develop our quality governance and financial management systems and processes to deliver performance that exceeds the standards set down for Foundation Trusts
4. PRODUCTIVITY - To improve the productivity and efficiency of the Trust, building greater financial sustainability within the local health and social care economy	**CSF7** - Improve value for money and generate our planned surplus whilst maintaining or improving quality	**CSF8** - Develop our support infrastructure to improve the quality and value of the services we provide
5. WORKFORCE - To develop our people, culture and workforce competencies to implement our vision and clinical strategy, engendering a sense of pride amongst staff in the work they do and services provided and positioning the Trust as an employer of choice	**CSF9** - Redesign our workforce so people of the right attitude, skills and capabilities are in the right places at the right time to deliver high quality patient care	**CSF10** - Develop our organisational culture, processes and capabilities to be an outstanding organisation and employer of choice

Isle of Wight NHS Trust

The next meeting in public of the Isle of Wight NHS Trust Board will be held on **Wednesday 1st October 2014** commencing at 09:30hrs.in the Conference Room, St. Mary's Hospital, Parkhurst Road, NEWPORT, Isle of Wight, PO30 5TG. Staff and members of the public are welcome to attend the meeting. Staff and members of the public are asked to send their questions in advance to board@iow.nhs.uk to ensure that as comprehensive a reply as possible can be given.

AGENDA

Indicative Timing	No.	Item		Who	Purpose	Enc, Pres or Verbal
09:30	**1**	**Apologies for Absence, Declarations of Interest and Confirmation that meeting is Quorate**				
	1.1	Apologies for Absence: Sue Wadsworth, Alan Sheward & Mark Pugh Sarah Johnston – Deputy Director of Nursing to deputise for Alan Sheward		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
	2	**Chairman's Update**				
	2.1	The Chairman will make a statement about recent activity		Chair	Receive	Verbal
	3	**Chief Executive's Update**				
	3.1	The Chief Executive will make a statement on recent local, regional and national activity.		CEO	Receive	Enc A
	3.2	Local Update from Hospital & Ambulance		DDN	Receive	Enc B
	3.3	Local Update from Community & Mental Health		CEO	Receive	Enc C
	4	**Patients & Staff**				
	4.1	Presentation of this month's Patient Story	Quality and Performance Management	CEO	Receive	Pres
	4.2	Employee Recognition of Achievement Awards	Culture & Workforce	CEO	Receive	Pres
	4.3	Employee of the Month	Culture & Workforce	CEO	Receive	Pres
	4.4	Staff Story	Culture & Workforce	DDN	Receive	Pres
	5	**Minutes of Previous Meetings**				
	5.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 27th August 2014 and the Schedule of Actions.		Chair	Approve	Enc D
	5.2	Chairman to sign minutes as true and accurate record				
	5.3	Review Schedule of Actions		Chair	Receive	Enc E
	6	**Items for the Board**				
	6.1	CQC Report	Quality and Performance Management	CEO	Approve	Enc F
	6.2	Performance Report	Quality and Performance Management	EDF	Receive	Enc G
	6.3	Minutes of the Quality & Clinical Performance Committee held on 17th September 2014	Quality and Performance Management	QCPC Chair	Receive	Enc H

	6.4	Revised Terms of Reference for Quality & Clinical Performance Committee	Governance and Administration	CS	Approve	Enc I
	6.5	Minutes of the Finance, Investment & Workforce Committee held on 17th September 2014	Quality and Performance Management	FIWC Chair	Receive	Enc J
	6.6	Revised Terms of Reference for Finance, Investment, Information & Workforce Committee	Governance and Administration	CS	Approve	Enc K
	6.7	Reports from Serious Incidents Requiring Investigation (SIRIs)	Quality and Performance Management	DDN	Receive	Enc L
	6.8	Monthly Safer Staffing Update	Culture & Workforce	DDN	Receive	Enc M
	6.9	Minutes of the Charitable Funds Committee held on 9th September 2014	Culture & Workforce	CFC Chair	Receive	Enc N
	6.10	FT Programme Update	Governance and Administration	FTPD	Receive	Enc O
	6.11	Board Self Certification	Governance and Administration	FTPD	Approve	Enc P
	6.12	Board Assurance Framework (BAF) Monthly update	Governance and Administration	CS	Approve	Enc Q
	7	**Matters to be reported to the Board**	Chair			
	8	**Any Other Business**	Chair			
	9	**Questions from the Public**	Chair			
		To be notified in advance				
	10	**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:

Contract for the provision of Recovery Focused Integrated Substance Misuse Community Service for the Isle of Wight
Cost Improvement Plans (CIP) – Maximising efficiency and effectiveness by combining a transactional savings framework with a transformational approach.
Tenders - Update
Strategic Estates Partner - Update
Safeguarding Bi Monthly Update
Ratification report for the award of a Locum Master Vendor agreement
Employee Relations Issues

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

13:00	**11**	**Date of Next Meeting:**

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on Wednesday **29th October 2014** in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

Enc A

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 1st OCTOBER 2014

Title	Chief Executive's Report					
Sponsoring Executive Director	Chief Executive Officer					
Author(s)	Head of Communications and Engagement					
Purpose	For information					
Action required by the Board:	**Receive**		**P**	**Approve**		
Previously considered by (state date):						
Trust Executive Committee			Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee			Remuneration & Nominations Committee			
Charitable Funds Committee			Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee						
Foundation Trust Programme Board						
Please add any other committees below as needed						
Board Seminar						
Other (please state)						
Staff, stakeholder, patient and public engagement:						
This report is intended to provide information on activities and events that would not normally be covered by the other reports and agenda items.						
Executive Summary:						
This report provides a summary of key successes and issues which have come to the attention of the Chief Executive over the last month.						
For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	All Trust goals					
Critical Success Factors *(see key)*	All Trust Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None					
Date: 24th September 2014	**Completed by:** Andy Hollebon Head of Communications and Engagement & Sarah Morrison – Exec Assistant to Chief Executive					

NATIONAL

General Election

It is just over seven months to the next General Election which will be held on 7th May 2015. In the last week at the Labour Party conference and over the coming weeks at the Conservative and Liberal Democrat Party conferences we will see the political parties starting to set out their plans for health and social care.

Alongside this we will also see our representative organisations and think tanks publish their views on the priorities for the next Government. One such organisation, the King's Fund, have published their document titled 'Priorities for the next Government'. Whilst our focus as an organisation must remain trained on ensuring quality care for every one of our patients and improving our services, the forthcoming months will be a time of political scrutiny and focus on health and social care during which we must not lose sight of the great work our staff do every day.

Finances

In the last couple of weeks there has been media coverage on the current financial situation in the health service with a significant number of Trusts reporting deficits. The Foundation Trust Network (FTN) have produced a useful 'infographic' which I have appended to this report. It sets out the trend of more Trusts reporting deficits and the concerns expressed by a majority of Finance Directors about the financial position of their Trusts. Whilst we are currently forecasting a £1.5m surplus for 2014/15 this requires us to make £9m savings this year. This is a real challenge and we are still working on how this can be achieved.

Two publications have emerged in recent weeks which make interesting reading:

- The Health Foundation have published a report *More than money: closing the NHS quality gap* examining the implications of the NHS's 'financial gap' for quality of care. The Key messages are:
  - Financial constraint can be a key driver of transformational change.
  - There is a commitment from NHS providers to protect clinical quality and safety at all costs.
  - Difficult choices need to be made both politically and at local health economy levels.
  - To achieve faster change, collaborative leadership and effective management will be needed.
  - It is critical to ensure that national regulatory and policy frameworks enable and support local change.

- The Kings Fund have published 'A new settlement for health and social care'. This is the final report from the independent Commission on the Future of Health and Social Care in England. In it, the commission discusses the need for a new settlement for health and social care to provide a simpler pathway through the current maze of entitlements. The commission, chaired by Kate Barker, proposes a new approach that redesigns care around individual needs regardless of diagnosis, with a graduated increase in support as needs rise, particularly towards the end of life. The commission has concluded that this vision for a health and care system fit for the 21st century is affordable and sustainable if a phased approach is taken and hard choices are taken about taxation. The key messages are:
  - The commission recommends moving to a single, ring-fenced budget for the NHS and social care, with a single commissioner for local services.
  - A new care and support allowance, suggested by the commission, would offer choice and control to people with low to moderate needs while at the highest

levels of need the battle lines between who pays for care – the NHS or the local authority – will be removed.
- Individuals and their carers would benefit from a much simpler path through the whole system of health and social care that is designed to reflect changing levels of need.
- The commission also recommends a focus on more equal support for equal need, which in the long term means making much more social care free at the point of use.
- The commission largely rejects new NHS charges and private insurance options in favour of public funding

Regional

Shaping the future of local IVF services

When people living in the Southampton, Hampshire, Isle of Wight or Portsmouth (SHIP) areas seek treatment for infertility, their local Clinical Commissioning Group is responsible for funding fertility services (such as In-Vitro Fertilisation, or IVF) to help women become pregnant.

IVF is a high-cost treatment and so it is important to make sure that the Clinical Commissioning Groups (CCGs) across the area offer IVF in the most effective way for the local population. They must also ensure that they balance the funding for this treatment alongside the other pressures on local NHS funding.

The SHIP-wide 'Priorities Committee' has recently reviewed the most recent evidence of clinical and cost effectiveness for IVF and Intra-Cytoplasmic Sperm Injection (ICSI). *Please note that for this process the term 'IVF' is being used to describe both treatments*.

The Committee is now preparing a recommendation about the future commissioning of these services which will be considered by each of the CCGs. The local CCGs are keen to ensure they do this in light of the views of local people.

The NHS budget is limited so funding for any service or treatment must be balanced against the funding requirements for many other necessary local health services and treatments. There is a joint SHIP IVF Access Criteria which is available at (www.southeasternhampshireccg.nhs.uk/about-us/criteria-for-access-to-ivf.htm). The latest NICE guideline, a non-binding recommendation, is available on their website at www.nice.org.uk/guidance/CG156.

The CCGs covering the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) areas are undertaking a period of engagement to gather the views of local people, their representatives, GPs and interest groups on whether funding for IVF is a priority for the NHS and on the access criteria. Each CCG will then consider the recommendation from the SHIP Priorities Committee in light of this valuable feedback. The CCGs are inviting local people to share their views by completing an online survey www.surveymonkey.com/s/ivf-review-2014.

More information can be found on the Isle of Wight Clinical Commissioning Group website at www.isleofwightccg.nhs.uk. Responses must be received by October 19, 2014.

LOCAL

Care Quality Commission Reports

On Tuesday 2nd September we met with the Care Quality Commission (CQC) for the Quality Summit. This review, which was also attended by representatives from Health Education England, Isle of Wight Council, the Trust Development Authority, the General Medical Council, NHS England, Isle of Wight Clinical Commissioning Group, the Health Scrutiny Committee and Healthwatch Isle of Wight, heard from Joyce Fredericks, Head of Hospital Inspections at the CQC and the inspection leader Dr Jane Bartlett about the inspection findings. The Trust's presentation to the Quality Summit was shared with managers across the organisation on the 2nd so that they could brief staff ahead of publication of the reports.

The CQC published the reports at 00:01hrs on Tuesday 9th September 2014. The reports which are available on the CQC website at www.cqc.org.uk are:

- Hospital Services and Ambulance Services
- Community Health Services
- Mental Health Services
- Quality Report – summarising the above three reports

Since November 2013, when the first CQC reports under the new inspection regime were published, no Trust has achieved 'outstanding' and only four have achieved 'good. We are now amongst 24 rated overall as 'requiring improvement'. Another four have been rated as 'inadequate'.

Our score of seven out of ten is not bad but we have more work to do. The CQC found that all the services they inspected across the Trust were caring and that staff communicated with and supported people in a compassionate way. The inspectors identified many areas of good practice – 77 (75%) in total compared to 28 (23%) areas where improvement is required and only two (2%) which were 'inadequate'. Many patients told the Inspectors that their experience was positive.

Mental health services, the ambulance service and most hospital services did well. Our services are safe, however improvement is required in medical and end of life care and more broadly across community services, areas the Trust identified to the 79 Inspectors when they arrived for their announced four day inspection between 3rd and 6th June 2014.

These reports provide a fair and balanced assessment of our complex organisation and where we are right now. We acknowledge and accept that overall Isle of Wight NHS Trust requires improvement. We should take pride in the fact that there are a lot of positives in relation to the ratings themselves – seven out of ten of the individual areas inspected were rated as good. Our staff and the Trust as a whole approached the inspection in an open and honest way.

This is the first time the CQC have inspected all four services – ambulance, community, hospital and mental health – together and their methodology for ambulance inspections is still being developed. Although the overall rating – 'requires improvement' - is disappointing and means that we have more improvement work to do, the CQC have provided us with a clear view of what is required by our regulator to achieve a 'good' rating.

Now that we have this clear guide as to what is required I have asked all staff to put their support behind helping the areas 'requiring improvement' to reach 'good' and as the CQC have identified, we need to get better at spreading good practice from one area across the whole

organisation. We have action plans in place to address all the issues identified and will be reporting back to the CQC on 30th October 2014. Due to the 'Requires Improvement' rating our application to become a Foundation Trust will automatically be delayed by at least 6 months – time we will use to continue to improve services for patients and to further develop the arrangements for our Trust membership which now exceeds 4,000.

As part of our communications about this we prepared some online videos which I hope will answer some of the more obvious questions about this. You can find these at:

- Karen Baker, Chief Executive Officer - http://youtu.be/vlbMuQ-TPwM
- Dr Mark Pugh, Executive Medical Director - http://youtu.be/fT-w-y5AUQ4
- Alan Sheward, Executive Director of Nursing and Workforce – http://youtu.be/4E0vuZtBOE8

As the reports were being published we wrote to staff, stakeholders and Members. We made materials available to staff to support engagement with service users and carers. Briefings have been held for local media, staff, stakeholders, Members, the Health and Wellbeing Board, and the Health Scrutiny Sub Committee. We took advertising space in both the County Press and the October edition of the Isle of Wight Beacon Magazine (distributed to 65,000 households and businesses across the Island) to ensure that Islanders are aware of the reports and what we are doing about them.

As part of our action plan to address some of the concerns raised by the CQC, Fiona Hoskins, Divisional Head of Nursing at University Hospitals Southampton NHS FT has been supporting our CQC action plan with a particular focus on managing risk, learning from clinical incidents and our current clinical governance processes. Our action plan addressing the issues raised by the CQC reports has over 300 lines of action and it is important that all staff play their part in addressing the areas for improvement. For example we have asked staff in Mental Health where the services were rated 'good' to assist with the improvement required in Community Services.

Trust Awards

There has been so much work to do around the CQC Inspection and now the follow up to the reports along with the implementation of Listening into Action (LiA) that there has been little time for teams and Directorates to consider entering our annual awards. For that reason our Celebrations Group has decided to:

- Extend the date for entries to the Awards to 5th November 2014 – this is for both the main awards categories and the individual and team awards – more details and the entry forms can be found at www.iow.nhs.uk/awards

- Delay the Awards ceremony from November 2014 to early 2015 – this not only gives staff and volunteers more time to put entries in, it also gives the Celebrations Group more time to put the event together.

Recording Local Resolution Meetings

The Patient Safety; Experience & Clinical Effectiveness (SEE) Team has recently purchased recording equipment to enable the Trust to record Local Resolution Meetings held with complainants. With effect from 1st September 2014 the Trust has implemented the recording off all Local Resolution Meetings, where appropriate, as part of its complaints management process (with prior consent of participants). The recordings will then form part of the complaint

file and a copy provided to the complainant. We believe this is beneficial for the complainant, staff and the Trust.

Future of Health and Social Care on the Island

Together with our partners the Isle of Wight Council and Clinical Commissioning Group, we're considering the future of health and social care services on the Island and sharing ideas about accelerating our move to working more closely together and provide more co-ordinated, person-centred health and social care for locality working. It's part of our overall strategy to provide patients with an integrated service that works beyond boundaries to provide 'quality care, everyone every time'. Good progress is being made and while there is still much work to do, all of the organisations involved are focused on turning the vision into a reality. We will continue to keep you informed of developments as these important plans progress over the coming months.

Listening into Action

At the end of September and October I am personally hosting five listening events, at which frontline staff across all bands, positions and areas will work to establish the biggest priorities for action. Personal invitations have been issued to staff but all staff with an interest in improving patient care and the working environment have been encouraged to attend one of these important events. Enabling and encouraging change is the whole rationale behind Listening into Action (LiA). The ideas implemented through LiA may seem to be small but they are issues raised by staff and frequently it is the small things that make all the difference. We expect LiA to grow as they way we do business. We can't solve everything overnight but LiA is designed to remove some of the barriers to progress.

Cycle to Work Day

As anyone who knows me will know, I'm a great believer in the power of two wheels, and it's great that as a Trust supported Cycle to Work Day on Thursday 4 September . For those taking part, there was a free breakfast on offer.

Recruitment Summit

Recruitment to the Island is a challenge and Human Resources are organising a recruitment summit with partner organisations which takes place on 8th October. This will look at how we can work with our partners to promote the Island as a place to live and work and what incentives we need to offer to get people to our Island. We have bolstered support for Medical Recruitment with the return of Chris Jackson to the organisation to ensure that we provide the right support to teams recruiting doctors and the right support to new medical staff to make their integration into the organisation and Island life as smooth as possible.

Visit by Chris Hopson, Foundation Trust Network (FTN) Chief Executive

On Wednesday 17th September Trust Board Members met with Foundation Trust Network (FTN) Chief Executive Chris Hopson to find out more about national initiatives. As a representative body the FTN has huge influence and some key things to look out for in October are NHS England's 5 year strategy which is being written by their new Chief Executive Simon Stevens and the Dalton Review which will be reporting on future organisational models for the NHS.

In an open session at lunch time Chris spoke to staff about his views on the future of healthcare and there was a lively debate. He spoke about how Hinchingbrook Hospital, have liberated staff to make changes to the way they work and improve services for patients and the working environment for staff. At Sheffield Teaching Hospital they have developed a system to discharge patients quickly with immediate assessment in the community for ongoing needs. At

the Royal Free they are doing some innovative work with their Community Trust to remove the barriers to speedy discharge and in Airedale they have reduced admissions by a whopping 60% by introducing telemedicine links between hospital and nursing home.

Chris indicated that for the Island increased integration appeared to be the sensible way forward

Chris visited the Integrated Care Hub, Pharmacy and Beacon Health Centre/Emergency Department during his visit and was very impressed by what he saw. It is hoped that we can attract more prominent speakers and hold more sessions like this. If you have suggestions for speakers or contacts please contact the Communications team on 6175 or e-mail comms@iow.nhs..uk.

Key Points Arising from the Trust Executive Committee

The Trust Executive Committee (TEC) – comprising Executive Directors, Clinical Directors, and Associate Directors – meets every Monday. The following key issues have been discussed at recent meetings:

18th August

- Island Drug & Alcohol Service (IDAS) Project Initiation Document approved
- Strategic Estates Partner (SEP) decision process approved
- Theatre Racking Business Case approved
- Standards of Business Conduct approved
- District Valuer – Review of Non Property Asset Values approved

25th August

- No meeting

1st September

- Prison Memory Service Contract approved
- Terms Of Reference Patient Safety Experience Clinical Effectiveness Committee approved

8th September

- Capital Investment Group Update
- Referral to Treatment (RTT) Performance

15th September

- Better Care Fund update received
- Safer Staffing Phase One Business Case approved
- Community Nursing Business Case approved
- Car Parking Contract Tender Process commenced
- Norovirus Outbreak Debrief received and recommendations supported

Karen Baker
Chief Executive Officer
24th September 2014

at a glance

NHS provider sector finances

Foundation Trust Network

Since the formation of the NHS in 1948, health expenditure has increased by around **4 per cent** annually in real terms. However, since 2010/11, government expenditure on health has increased at only **0.1 per cent**. If this trend continues, and the NHS budget remains flat in real terms, this will have fundamental implications for provider sector finances and the care they are able to deliver to patients.

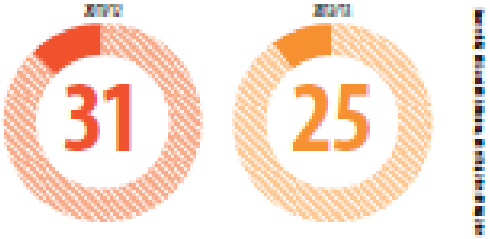
£130bn
Required health expenditure by 2020/21

30bn
Funding gap

100bn
Expected NHS England budget

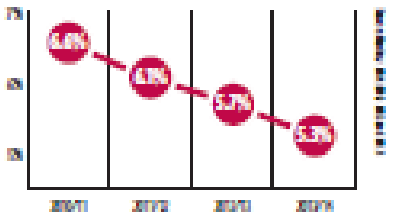
What does this mean for provider finances?

Number of providers in deficit



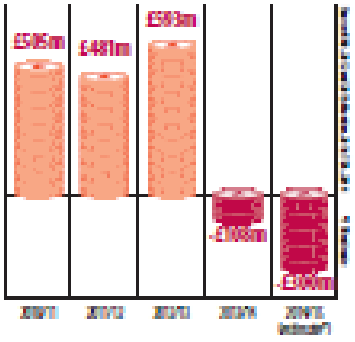
36%
Only one third of NHS providers are confident that their trust will be able meet their financial targets in 2014/15.

Financial performance (EBITDA for FT sector)

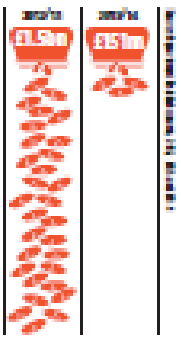


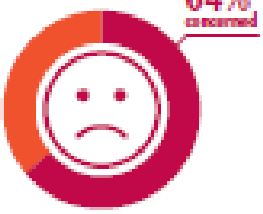
"I'm putting in the trust's first deficit plan for over twenty years"
Finance director at an NHS trust

Net provider financial position (trusts and FTs)



IDH revenue underspend

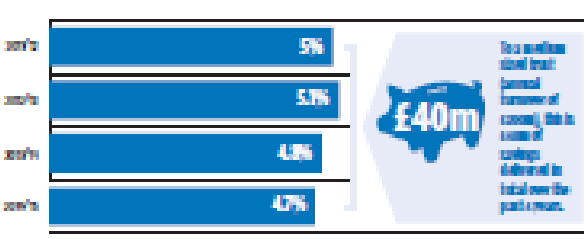




64% of providers are concerned about the financial and operational sustainability of their trust in the next 5 years.

NHS providers are still managing to deliver high quality care, despite unprecedented levels of efficiency savings

Financial savings delivered



Two-thirds of trusts' planned turnover of around £40bn is in terms of savings delivered in total over the past 4 years.

Staff numbers (FT sector)

Foundation trusts hired an additional 24,000 members of staff in 2013/14.

This a 4.2% increase since last year.

24,000 nurses at band 5 represents an additional annual cost pressure of £600m across the sector in salaries alone.

What needs to be done?

If current trends continue, the number of providers in deficit will continue to grow. It is unsustainable for NHS providers to keep absorbing cost pressures by going in to deficit or by cutting surpluses that would otherwise be used to improve patient services. We need:

A FUNDING AND PAYMENT SYSTEM for providers which more realistically matches resource to demand.

RECOGNITION that transforming services requires invest-to-save funding support rather than annual budget slicing.

A MULTI-YEAR SETTLEMENT for the NHS after the general election to give providers a stable platform to plan from.

Enc B

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 1st October 2014

Title	Hospital & Ambulance Directorate update						
Sponsoring Executive Director	Executive Director of Nursing and Workforce						
Author(s)	Associate Director – Hospital and Ambulance Directorate						
Purpose	For information						
Action required by the Board:	**Receive**	P	**Approve**				
Previously considered by (state date):							
Trust Executive Committee			Mental Health Act Scrutiny Committee				
Audit and Corporate Risk Committee			Remuneration & Nominations Committee				
Charitable Funds Committee			Quality & Clinical Performance Committee				
Finance, Investment & Workforce Committee							
Foundation Trust Programme Board							
Please add any other committees below as needed							
Board Seminar							
Other (please state)							
Staff, stakeholder, patient and public engagement:							
This report is provided as a regular update to the Trust Board from the Hospital & Ambulance Directorate.							
Executive Summary:							
This report gives an update on quality, finance, performance and key issues, successes for the Hospital & Ambulance Directorate.							
For following sections – please indicate as appropriate:							
Trust Goal *(see key)*	All Trust goals						
Critical Success Factors *(see key)*	All Trust Critical Success Factors						
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None						
Assurance Level ***(shown on BAF)***	Red		Amber		Green		
Legal implications, regulatory and consultation requirements	None						
Date: 17th September 2014 **Completed by:** Donna Collins, Associate Director – Hospital and Ambulance Directorate							

Directorate wide update for August 2014

Key Successes

- Completion of phase 1 Level C including Outpatient Parental Intravenous Therapy (OHPIT) service / Discharge Lounge facilities.
- Integration of management teams – Including managerial link across Ambulance and Hospital services
- Venous Thromboembolism standard – achieving 100%
- Lower respiratory disease audit following a trigger on the Dr Foster monitoring system – review undertake and no areas concern raised. This diagnosis group will continue to be monitored as part of the ongoing mortality review process using the Dr Foster system.

Areas requiring attention

- Ambulance response targets
- Paediatric assessment at the front door
- Patient access targets
- Pressure on the Outpatient Appointment and Records Unit (OPARU)
- Medical staffing recruitment pressure

Hospital

Quality

The Acute and Planned Directorate are now being reported as Hospital and Ambulance Directorate, and Datix has been amended accordingly.

Significant achievement in managing the volume of communications received from patients this month, with 87 communications being managed as concerns, and only 8 becoming formal complaints. Whilst the number of formal complaints remains low, there has been an increase in the number of concerns due in part to the relocation of the Patient Advice and Liaison Service (PALS) office and this month largely due to the problems being experienced in OPARU (Outpatient Appointments and Records Unit). Many of the concerns raised relating to OPARU have been resolved as they related to telephones not being answered. A problem was identified that two lines were not actually ringing and this has been resolved. Vacant posts are being interviewed for and extra resource has been put in to help the department catch up on the backlog of work. Concerns raised around cancelled or delayed appointments have also seen an increase in line with the additional pressures the hospital is experiencing.

Performance

Key patient access targets continue to fall in August below the expected national standards due to additional activity being undertaken during July to September to treat those patients waiting longest. This national scheme, funded by CGG monies, to reduce waits by the end of September will now be maintained over October to ensure we have no patients waiting over 18weeks. To support this priority within the Trust a bed management system has been established to monitor the daily position and quantify its impact on patient access, alongside ongoing validation and increased performance management at specialty, Directorate and Executive level to monitor daily progress. In addition, General Manager leads have been implemented for: elective care; non elective care & bed management; Cancer; Ambulance & ED; and, Projects. Revised plan for achievement of patient access targets to end November is being prepared, with updated action plans to manage achievement at speciality level.

Cancer two week wait target measuring appointment time from referral time has now achieved in August for both standard and breast symptomatic referrals following increased capacity provision to meet increasing demand.

Sickness in the Directorate is still being reported as two separate directorates. However, with continued individual manager escalation processes and ongoing monitoring, both elements of acute and planned have seen a slight improvement of around 1% reduction. One particular area of focus is the Ambulance service which is discussed further under the Ambulance section of this document.

Finance

The Acute and Planned Directorate are now being reported as Hospital and Ambulance Directorate.

Overall for the Hospital and Ambulance Directorate for August, was overspent by £1.8m. The main challenge we continue to face is the Cost Improvement Plan year to date variance of £1.5m underachievement. However when this factor is removed the true budget overspend is £300k year to date. This overspend is an improvement on last month by £100k and is mainly due to Non Contracted Activity income being received and focused budgetary control by service leads. The main financial challenge in the hospital is the high number of medical vacancies being covered by agency staff, which in turn attracts a premium over budget allocation.

Other service specific –update

Paediatric assessment at the front door

Following the CQC inspection a defined pathway has been put into place for children attending the Emergency Department and how their care is appropriately escalated to the Paediatric team. Work has also been undertaken to determine areas of redesign to enable the department to provide a designated Paediatric waiting and assessment area.

Children's Respite Care Team

The Trust is firmly on the map thanks to the work of our Children's Community Team who, working with the Clinical Commissioning Group and Earl Mountbatten Hospice and have been shortlisted in the 2014 Nursing Times Awards. Their entry *Isle of Wight 'Virtual' Hospice for* children and young people is a finalist in the Award for Integrated Approaches to Care category. Nursing Times say that this year's Awards have surpassed an impressive 700 entries and the competition was fierce, so well done.

OPARU (Outpatient Appointments and Records Unit)

The OPARU has seen significant pressure on systems and processes, resulting in risks being raised around case notes filing etc. In response, following immediate remedial action to reduce the risk, a full review of the OPARU is to be undertaken as part of the Outpatient Efficiencies project work stream.

Pharmacy

NHS England visited Pharmacy services and were amazed by our technology which supports safer and more efficient medicines management across the Trust – so well done Pharmacy.

Ambulance

Quality

The Ambulance Service received no complaints or concerns in August, and also have no complaints outstanding for resolution.
The Ambulance service had no SIRIs (Serious Incident Requiring Investigation) reported, and has 1 SIRI outstanding which has been investigated and is currently with the commissioners awaiting closure.

Performance

The Ambulance Service has constantly achieved the national standards of 75% of category A telephone calls responded to within 8 minutes and 95% of patients waiting less than 4hrs in A&E on a monthly basis for the last two years. August 2014 has seen the service standard of 75% drop to 72%. Although no greater activity than planned was witnessed, upon examination of the reduction in performance, it has been identified that a number of key factors influenced the services ability to reach and maintain the standards. The key area identified was during the month of June / July 2014 five individual members of staff tendered their resignations. This lead to a 8% shortage of staffing levels on the front line Ambulances in August whilst we awaited the arrival of the newly recruited staff, this coupled with higher than average sickness level of 7% meant there were difficulties in covering the available shifts to ensure we meet the targets. A full action plan has been implemented to prevent any further decline and measures are in place to give the service the best possible chance of achieving the required standards in September.

Our NHS 111 service has also seen a very slight dip in performance standards reaching 94% of the required 95 %, although this was still one of the best performing services in the UK for the month of August based on national statistics. On examination this was influenced by acute peaks in activity at key times of the day, combined with above average sickness of 4%. We have measures in place to address these performance issues and do not expect a repeat for September.

Finance

Year to date, Ambulance (including the Hub, Patient Transport Service, Switchboard and Hospital Car Service) are in a good financial position showing an £75k underspend combined. One area improving this position for the Ambulance Emergency Service budget is the income relating to road traffic collisions (standard payment received by the service as part of national legislation). However they are still being challenged to achieve their CIP savings (current achievement £192k against an 8% target £542k).

Integrated Care Hub to be showcased at Foundation Trust Network conference

Also well done to the Integrated Care Hub who are one of six teams from across the country who have been invited to exhibit at the Foundation Trust Network conference in Liverpool in November.

Published!

Many congratulations to one of our Paramedics, Kate Wood. Kate has recently completed a Masters in Clinical Research and she has had a literature review published in the Emergency Medicine Journal. These are great achievements so well done Kate.

Donna Collins
Associate Director Hospital & Ambulance Directorate

Alan Sheward
Executive Director of Nursing and Workforce
17th September 2014

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 1st OCTOBER 2014

Title	Community & Mental Health Directorate update			
Sponsoring Executive Director	Executive Medical Director			
Author(s)	Acting Associate Director – Community & Mental Health Directorate			
Purpose	For information			
Action required by the Board:	**Receive**	P	**Approve**	
Previously considered by (state date):				
Trust Executive Committee		Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee		Remuneration & Nominations Committee		
Charitable Funds Committee		Quality & Clinical Performance Committee		
Finance, Investment & Workforce Committee				
Foundation Trust Programme Board				
Please add any other committees below as needed				
Board Seminar				
Other (please state)				
Staff, stakeholder, patient and public engagement:				
This report is provided as a regular update to the Trust Board from the Community & Mental Health Directorate.				
Executive Summary:				
This report gives an update on quality, finance, performance and key issues, successes for the Community & Mental Health Directorate.				

For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	All Trust goals					
Critical Success Factors *(see key)*	All Trust Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None					

Date: 23rd September 2014 **Completed by:** Nikki Turner, Acting Associate Director Community & Mental Health Directorate

Service Delivery Updates

Retirement of Acting Head of Mental Health and Learning Disabilities

Maggie Hampson retired on 12th September after working in various roles in Mental Health Services since 1995. An appointment has been made to the substantive post. The new head of Mental Health and Learning Disability will be joining the Trust at the beginning of December from a Mental Health Foundation Trust in London. He will bring experience from both NHS and Private Mental Health providers and has headed up Women's, Men's and Forensic Services during his career. In the interim Lead Nurse for Mental Health & Learning Disabilities, Mo Smith, is covering this role.

Leading edge developments in Speech and Language Therapy (SLT)

Emma Pugh, Chief Speech and Language Therapist for Adults attended a certification course in Stafford to become one of the first of the UK SLT therapists trained to offer Neuromuscular Electrical Stimulation for swallow recovery (NMES). NMES works simultaneously with traditional techniques to optimise swallow function and increase neuroplasticity recovery and muscle strength reducing lifelong impairment.

In May 2014 the National Institute for Clinical Excellence (NICE) published guidance encouraging participation in research to build the evidence base for this technique. Evidence at this stage suggests that outcomes for NMES include:

- Improved swallow function (total swallow recovery is predicted for cortical strokes : depending on associated other conditions)
- Increased patient satisfaction
- Increased safety of swallow
- Reduction of length of stay in traditional rehab units by 2 days.

The company lent course participants equipment for 2 months to facilitate audit and research projects. The SLT department intend to liaise with medical and Clinical Governance leads to explore the feasibility of this.

Improving Access to Psychological Therapies (IAPT)/Primary Care Mental Health Team (PCMHT)

There has been an invitation from the national IAPT team to take part in an employment and mental health pilot run between the Department of Health (DH) and Department of Work and Pensions. This will be progressed over the next few weeks with the pilot starting when further negotiations around processes, such as data sharing, have been identified by the national IAPT team.

Learning Disabilities

The service has received positive service user feedback relating to patient's with learning disabilities, being supported by the LD hospital liaison service whilst an inpatient. Comments included: 18yr old with autism requiring dental surgery, advice offered and coordinated his hospital journey very anxious parents, Parents wrote to Staff Nurse on the ward thanking Lynsey for her involvement stating "it was a very positive admission, it all went smoothly and it was the best admission ever and Lynsey was an absolute star". Anaesthetist in dental surgery wrote to thank the LD liaison nurse and stated "without the input of the LD liaison nurse people with LD wouldn't have a positive experience". The Community LD service has received a telephone contact from a family carer regarding the Service provision and stated "that the quality of services delivered by the service are fantastic, you have got a good service here, thank you for your support and we love it here".

The service is continuing to support the Hospital by supporting the development of a number of easy read information leaflets with service user involvement. This has included: (Calling card, Appointment card, Consent to for sharing information, Diabetes leaflet, Psychology and Physiotherapy Leaflets).They have been ratified this month and will be included on the LD intranet page for all staff and services to access. This is an ongoing project and more will be developed. Service user involvement on interview process has been valuable in the recruitment process and ensures that we are engaging service user's as part of the essential standards.

Accreditation

Congratulations to Osborne Ward and the Crisis Resolution Home Treatment Team. Osborne Ward have achieved accreditation with the Royal College of Psychiatrists in their AIMS (Accreditation of Inpatient Mental Health Services) scheme. The Crisis Resolution Home Treatment Team has also been accredited as excellent by the Royal College of Psychiatrists' Special Committee for Professional Practice and Ethics. Well done to both teams. These results represent a lot of hard work and dedication by both teams who should be very proud of all they achieve.

CQC Updates

Community Nursing

CQC identified compliance issues with regards to the Out Of Hours on call service. We have responded by establishing a senior on call service to provide support and advice. Through resilience monies, the service has employed 2 further nursing staff on a 6 month contract. Senior On Call nursing services and current clinical demand have added to significant cost pressures. A future sustainable model is being explored with the CCG.

Community Inpatient Beds

Following the retirement of Marjory Martch, who had completed 50 years of nursing and was sister for the Stroke Unit for 3 years, Anna New from the rehabilitation service has been

appointed as Acting Sister. Anna brings a range of skills to the team including excellent leadership skills.

The main issues identified by CQC with regards community inpatient wards (particularly Stroke Unit) were centred on poor medical and nursing staffing levels and medical outliers.
In response to this, the Trust is introducing 2 middle grades to support the wards over next few months and an advert is out for a dedicated Stroke consultant physician. Stroke has been identified as a priority in the safer staffing initiative but this has yet to be finalised. In order to ensure safe staffing levels on ward additional staff are being provided by the nursing bank.

Meetings are in progress to explore solutions to reduce medical outliers on both Stroke and Rehab Units. Clinical Supervision is now embedded into all staff practice, using various clinical supervision tools.

In the media spotlight

It's great to see the Trust's work getting some recognition in the national media. Brian Martin, Integrated Community Equipment Service (ICES) Manager explained the benefits of the Island's telehealth scheme on You & Yours on BBC Radio Four (listen again here), and Prof Hasan Arshad from the David Hide Research Centre has taken part in the BBC's Horizon programme (watch again here).

It was announced recently by Isle of Wight Council that the Trust had won the contract to provide integrated drug and alcohol recovery services. A programme of engagement about the new integrated service has commenced and we will be welcoming to the Trust colleagues from Cranstoun and the Council who are transferring across from 1st October 2014 when the contract starts. If you want to know more about the plans for the service visit the Drug and Alcohol Services page on our website.

Finance

The Community and Mental Health Directorate is reporting an overspend of £243k. The directorate has identified an over accrual of £50k therefore it will reduce the position to £193k. Although we have achieved our Cost Improvement Plan year to date, a proportion of this has been achieved non recurrently. The main pressures areas are in medical staffing and for non pay spend in patient appliances.

Nikki Turner
Acting Associate Director Community and Mental Health Directorate

Mark Pugh
Executive Medical Director

17th September 2014

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Isle of Wight NHS Trust

Minutes of the meeting in Public of the Isle of Wight NHS Trust Board held on Wednesday 27th August 2014
Conference Room, St Mary's Hospital, Newport, Isle of Wight

PRESENT:	Danny Fisher	Chairman
	Karen Baker	Chief Executive (CEO)
	Chris Palmer	Executive Director of Finance (EDF)
	Alan Sheward	Executive Director of Nursing & Workforce (EDNW)
	Katie Gray	Executive Director for Transformation & Integration (EDTI)
	Jane Tabor	Non-Executive Director
	David King	Non-Executive Director
	Sue Wadsworth	Non-Executive Director
In Attendance:	Mark Price	FT Programme Director & Company Secretary
	Jessamy Baird	Designate Non Executive Director
	Emma Topping	Communications Manager
	Alison Toney	Communications Officer
	Fiona Hoskins	Divisional Head Nurse for Southampton University Hospital
For item 14/237	Kevin Bolan	Associate Director for Estates
	Justin Mason	IM & T Analyst
	Paul Dubery	Deputy Director of IM & T
	Stephen Trasler,	Maintenance Assistant, Estates,
	Phillip Lancey	Mechanical Craftsman, Estates
	Alan Yates	Maintenance Craftsman,Estates
	Marjorie Martch,	Ward Sister - Stroke Neuro
	Marie Gasior	Matron
For item 14/238	Sam Geldard,	Care Co-ordinator - Chantry House
	Su Tomkins	Service Lead - CMHS
Observers:	Leisa Gardiner	Lead for Listening into Action
	Chris Orchin	Health Watch
	Cllr Lora Peacey Wilcox	Isle of Wight Council
	Mike Carr	Patients Council
Minuted by:	Lynn Cave	Trust Board Administrator
Members of the Public in attendance:	There were 6 members of the public present	

Minute No.	
14/231	**APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE**

Apologies for absence were received from Nina Moorman, Non-Executive Director, Charles Rogers, Non-Executive Director and Mark Pugh, Executive Medical Director.

- The Executive Director of Nursing & Workforce introduced Fiona Hoskins who is Divisional Head Nurse for Southampton University Hospital and who will be working with our Quality Team for the next 6 weeks.

There were no declarations of interest.

The Chairman announced that the meeting was quorate.

14/232 CHAIRMAN'S UPDATE

The Chairman reported on the following:

a) **Annual General Meeting:** The Chairman confirmed that the Annual General Meeting for the Isle of Wight NHS Trust had taken place at the Riverside Centre on 30th July. He advised that the meeting had been well attended and the event, including entertainment provided by the NHS Nightingales, had been well received.

b) **CQC Report:** He confirmed that the Executive team had been very busy following the receipt of the draft report and that the Chief Executive would expand on this in her report.

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

14/233 CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented her report and highlighted the following areas:

National
- CQC Inspections

Regional
- Health Education England

Local
- Listening to our staff
- Trust Awards
- Trust Executive Committee feedback

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

14/234 LOCAL UPDATE FROM HOSPITAL & AMBULANCE

The Executive Director of Nursing & Workforce presented the update for the Hospital & Ambulance Directorate. Areas covered included:

- Interim structure
- Performance
- Finance
- Quality
- Service Specific Update
- OPARU (Outpatient Appointments & Records Unit)
- Pharmacy
- Pathology
- Ambulance
- Nursing Times Awards

Sue Wadsworth stated that she found this new report very useful and suggested they also reflect the highlights and lowlights from the Performance Report data. The Executive Director of Nursing & Workforce confirmed that these local updates from the directorates would be developed over the coming months.

The Isle of Wight NHS Trust Board received the Local Update from Hospital & Ambulance Directorate

14/235 LOCAL UPDATE FROM COMMUNITY & MENTAL HEALTH

The Executive Director of Nursing & Workforce presented the update for the Community & Mental Health Directorate. Areas covered included:

- Work on Acuity & Dependency in Community Nursing
- Award for Cervical Screening
- Nursing Home Liaison – Trust Assessment Pilot
- Rehabilitation & Reablement
- Rehabilitation Ward Summer Fayre
- Mental Health Accreditation Programme
- Mental Health Collaboration

The Isle of Wight NHS Trust Board received the Local Update from Community & Mental Health Directorate

14/236 PATIENT STORY

The Chief Executive advised the meeting that this month's story related to Alverstone Ward. The Executive Director of Nursing & Workforce advised that as an outcome of this story the following actions had been identified and taken:

Actions Taken Immediately:

- Doctor was spoken to immediately by the Ward Sister
- Doctor apologised to patient
- Doctors Clinical Supervisor was informed of the 'bedside manner' issue

Ongoing actions:

- Sister has been monitoring Doctors 'bedside manner' which has significantly improved
- Clinical Supervisor is also continuing to monitor the doctor
- Video has been put on to the intranet, and staff involved asked to view it
- Patient was discharged home and no further issues raised

The Isle of Wight NHS Trust Board received the Patient Story

14/237 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

The Chief Executive presented Employee Recognition of Achievement Awards: This month under the Category:

Category 2 – Employee Role Model

- Justin Mason, IM & T Analyst, Information Technology, Strategic & Commercial Directorate

Category 3 – Going the Extra Mile

- Stephen Trasler, Maintenance Assistant, Estates, Strategic & Commercial Directorate
- Phillip Lancey, Mechanical Craftsman, Estates, Strategic & Commercial Directorate
- Alan Yates, Maintenance Craftsman,Estates, Strategic & Commercial Directorate

Category 6 – Long Service

- Marjorie Martch, Ward Sister - Stroke Neuro, Community & Mental Health Directorate

The Chief Executive congratulated all recipients on their achievements.

The Isle of Wight NHS Trust Board received the Employee Recognition of Achievement Awards

14/238 EMPLOYEE OF THE MONTH

The Chief Executive presented the Employee of the Month Awards.

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Employee of the Month – July 2014

- Sam Geldard, Care Co-ordinator - Chantry House , Community & Mental Health Directorate

Employee of the Month – August 2014

- Barbara Barmeyer, Midwife/Sonographer - Ante Natal Clinic, Hospital & Ambulance Directorate

The Chief Executive explained that Barbara Barmeyer was unable to attend the meeting and her award would be presented to her in the Maternity unit in the near future.

The Isle of Wight NHS Trust Board received the Employee of the Month Award

14/239 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 30nd July 2014 were approved.

Proposed by Sue Wadsworth and seconded by David King

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

14/240 REVIEW OF SCHEDULE OF ACTIONS

The following updates to the schedule of actions were noted:

a) TB/092 – Mortality & Morbidity Review: The Executive Medical Director had met with the Clinical Lead for SEE[1] and a process had been agreed with a report going to the SEE Committee monthly. It was confirmed that he would continue to report the Dr Foster data to Board in the usual way. This action is now closed.
b) TB/103 – PALs Office: It was confirmed that funding had been approved and work would commence in early September. This action is now closed.

The Isle of Wight NHS Trust Board received the Review of Schedule of Actions

14/241 PERFORMANCE REPORT

The Executive Director of Nursing & Workforce presented the performance report.

Highlights:

- No cases of Clostridium Difficile during July
- Emergency care standard within target
- Venous Thrombo-Embolism (VTE) risk assessment achievement maintained
- Stroke patients (90% of stay on stroke unit) maintained
- 100% Mental Health patient admissions with access to Crisis Resolution / Home Treatment Teams (HTTs)

Lowlights:

- Overall Theatre Utilisation below target
- 86.6% Symptomatic Breast Referrals Seen <2 weeks*
- Referral To Treatment Time Admitted and Non-Admitted below target
- Staff sickness remains above plan

[1] Safety, Experience & Effectiveness

Within the CQC Key Line of Enquiry (KLOE) format the following was reported:

Safe:

- **Pressure ulcers:** We continue to under achieve our planned local reduction across all grades of pressure ulcers, both in the hospital setting and the wider community. A range of actions are in place to support improvements in this priority indicator in all areas.

Responsive:

- **Referral to Treatment Time (RTT):** Admitted and Non admitted were below target in July, with a number of specialties not achieving target bringing the overall Trust performance to 87.3% for Admitted (2.7% below target) and 92.3% for Non-Admitted (2.7% below target). Work continues to validate existing pathways and has resulted in significantly less issues with the incomplete return. The Non-Admitted remains a data quality concern.

- **Symptomatic Breast referrals seen within 2 weeks:** Failed the 93% standard during July (86.6%). Work is ongoing to address the increased capacity issues and prevent recurrence. The diagnosis to treatment < 31 days wait also underachieved during July (95.7%), 3 patient breaches.

- **Care Programme Approach (CPA):** Patients receiving a formal review within 12 months - the performance against this target has increased again this month due to continuing work to manually report against this indicator. The figure reported (100%) is the improved position according to data available as at 14th August. It is expected that the roll out of PARIS will rectify the data collection issue.

Caring:

- **Patient Satisfaction:** Complaints remain low in July in comparison to April although slightly increased since June again and outside the year to date trajectory. Compliments, in the form of letters and cards of thanks, were slightly higher during July than in June.

- **Patient Advice & Liaison Service (PALS):** As one of the CQUIN goals for this year, the PALS relocation to main reception has now been completed and is providing a higher profile access to the public although further work is being undertaken to improve soundproofing.

- **Friends & Family Test:** The response rate continues to be challenging and work is ongoing to improve access.

Well Led:

- **Pay Bill**: The pay bill for July including variable hours is £9.574m, within the plan of £9.578m. The number of FTEs in post including variable FTEs (2,766) is currently above plan by 13 FTE. The HR Directorate are closely monitoring and supporting the Clinical directorates with their workforce plans, in particular their control over their spend on variable hours.

- **Sickness Absence:** This has increased from 3.49% to 3.72% during July and remains above the 3% plan. Detailed analysis of all long-term Sickness Absence is sent to Occupational Health, Health and Safety, Back Care and also to the Associate Directors, Quality and Finance. Actions are followed up at Performance Review and Directorate meetings. Short-term absence is being monitored using the Bradford Score. The capability policy has been streamlined and review periods are being scrutinised. Education sessions for Bradford Score are being cascaded.

- **Financial Surplus**: At the end of July the Trust is reporting a surplus of £772k

against the actual planned financial position of £759k. The adjusted retained surplus shows £783k against a plan of £766k - £17k ahead of plan. The Continuity of Service Risk Rating is 4.

- **Cost Improvement Programme (CIP)**: Shows a year to date overachievement of £951k against the target of £2,260k. Included within this performance is the recognition of forward banked savings amounting to £1,683k. Of the total £3,211k achieved, £2,324k was achieved recurrently and therefore the focus still remains on the delivery of recurrent savings.

Effective:

- **Theatre Utilisation** – This has improved for Main Theatres, but declined for Day Surgery Unit from 82.7% to 75.8% giving a joint rate of 77.9% in July.

- **Bed Pressures** - These continue to effect performance with a reduction in elective admissions due to the high risk of cancellation as well as delays in admission processing.

The following areas were raised in discussion:

i. **Friends & Family:** Jessamy Baird stated that there had been discussion at QCPC about the Friends & Family survey which had identified the need to widen the scope to include all patient feedback. The Executive Director of Nursing & Workforce confirmed that the new Lead for Patient Experience would be undertaking this as part of her role with updates going to QCPC.

ii. **Theatres:** Sue Wadsworth asked for an update on the review of Theatres. The Executive Director of Nursing & Workforce confirmed that he would be meeting with the Executive Medical Director and would report the outcome to QCPC in September.

iii. **Sickness Absence:** The Chairman stated that he was pleased to see the progress in this area but queried that there seemed to be particular parts of the organisation with high sickness. The Executive Director of Nursing & Workforce advised that HR had reviewed individual cases and there did not appear to be any specific cause for this pattern. He confirmed that through use of the Bradford Index it was showing earlier progression into the capability process. He advised that work was being undertaken with the directorates but the reason for the peak in July was not apparent.

Jessamy Baird queried if it could be related to work related stress and the increase in annual leave. She also stated that she would like to see a separate Community & Mental Health report. The Executive Director of Nursing & Workforce advised that the rostering procedure would ensure that this should not occur. He also advised that it was planned for the safer staffing model to be extended into clerical, ambulance and other areas.

Action Note: *The Executive Director of Finance to arrange for separate community & mental health sickness absence data to be included within the PIDS report.*

Action by: EDF

iv. **Pressure Ulcers:** Jane Tabor stated that this area appeared each month and she did not feel assured that the actions given in the report were being effective.

v. **Benchmarking:** Jane Tabor stated that she felt that the content showing in the report is worrying as the Trust was benchmarking lower nationally that we would like to be. She stated that it was important for the organisation to agreed where it wanted to be and how it intended to get there. The Board all agreed that this was an important point and that it would be addressed via the review of the Trust's strategy due to commence in early September.

The Isle of Wight NHS Trust Board received the Performance Report

14/242 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Sue Wadsworth reported on the key points raised at the last meeting held on 20th August 2014.

a) Min No 14/283 – The Committee discussed the need for a Mental Health Service Users Involvement Policy. This requires submission in September.

b) Min No. 14/287 – The Committee received an update from the EMD regarding the CQC report.

c) Min No. 14/302 and 14/303 – The Committee reviewed the Infection and Prevention and Control Annual Report and the TDA External Report Action Plan

d) Min No. 14/311 – The Committee approved the SEE[2] Committee terms of reference.

e) Min No. 14/312 – The Committee did not discuss TDA Self Certification due to lack of time.

Jessamy Baird stressed the need for an effective Mental Health Service User Involvement policy. She advised that a consultation had occurred and it was important to approve the policy as soon as possible. The Company Secretary suggested that this policy could have a wider scope and further consultation would be necessary including the Mental Health Service User Involvement forum. Sue Wadsworth requested that he come to the QCPC to discuss in more depth and the Company Secretary agreed.

Action Note: *The Executive Director of Nursing & Workforce to arrange for the Mental Health User Involvement Policy to go to QCPC and to arrange for the Company Secretary to attend that meeting to discuss the wider scope of this policy.*

Action by: EDNW

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

14/243 MINUTES OF THE FINANCE, INVESTMENT & WORKFORCE COMMITTEE

David King reported on the key points raised at the last meeting held on 20th August 2014.

a) **Min No. 14/129 – CIPs**: The Trust is reporting CIP achievement of £3.211m against a target of £2.260m. This is c.£951k ahead of plan. Although, this is after £1.683m of future banking. This recognises the full budget removal of achieving CIP plans in advance of the original schemes phasing. The work of the Transformation Management Office (TMO) and supporting resource is tasked with providing the Board with assurance of the achievable savings this financial year.

b) **Min No. 14/127(c) - Drug and Alcohol Policy:** The Committee has learnt and is very concerned that the Trust does not have a Drug and Alcohol Policy.

c) **Min No. 14/133 - Self Certification:** The Committee did not have sufficient understanding of the reasons for the change to Board statements and therefore were unable to agree the Self Certification return or recommend these to the Trust Board.

d) **Business Cases:** The Committee has made recommendations for two business cases that are to be presented to Part 2 of the Board.

David King also advised that the title of this committee is proposed to change to Finance, Investment, Information & Workforce Committee and that the revised Terms of Reference had been updated and approved by the committee and would be presented to Board on

[2] Safety, Experience & Effectiveness

1st October for approval.

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

14/244 MINUTES OF THE MENTAL HEALTH ACT SCRUTINY COMMITTEE

Jessamy Baird reported on the key points raised at the last meeting held on 6th August 2014.

a) **Min No. 14/018 - Terms of Reference:** This meeting was not quorate and the future quoracy needs to be reviewed.

b) **Min No. 14/020b) - MH/005 Lack of Section 12 qualified doctors:** One General Practitioner (GP) has completed Section 12 training and applied for approval. Approved Mental Health Professionals (AMHPs) often experience difficulty obtaining the services of a GP for a Mental Health Act Assessment (MHAA). A representative of the Clinical Commissioning Group (CCG) is to attend the next AMHP meeting on 18th August. Jessamy Baird asked that this be added to the Risk Register.

Action Note: *The Company Secretary to arrange for this item to be added to the Risk Register.*

Action by: EMD

c) **Min No. 14/020d) - MH/012 Service User Involvement Policy:** Service User and Carer Link Co-ordinator (SUCLC) is to meet with Communications Department for re-drafting of this policy. The Committee agreed that it is essential to support this policy to ensure genuine involvement of service users in our mental health services.

d) **Min No. 14/021 - Operation Serenity:** Funding has been made available by Commissioners from mid-June onwards for another year. This will maintain the existing level of Operation Serenity which is for Wednesday, Friday and Saturday nights to be covered by the Crisis team. The Operation Serenity benefits are not realised the remaining days of the week, but Crisis Team members work to support the partnership on those nights through other mechanisms as best as they can. An ongoing evaluation of the impact of this is underway.

e) **Min No. 14/022 - The implications of the Mental Capacity Act:** This was discussed regarding the usage and level of knowledge that is apparent in areas of the hospital outside the Mental Health Services. Staff are not sufficiently trained in the Mental Capacity Act and the implications it has on day to day care of patients. An action has been raised to ensure linkage of the MH team to the dementia liaison and safeguarding team, placing mental capacity within mandatory training for all staff.

f) **Min No. 14/023 - Care Planning and Paris:** Care plan and risk assessments are currently unavailable on Paris thereby hampering recording and subsequent review.

Proposed by Sue Wadsworth and Seconded by David King

The Isle of Wight NHS Trust Board approved the minutes of the Mental Health Act Scrutiny Committee on this occasion as the meeting had been deemed not quorate

14/245 REPORTS FROM SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs)

The Executive Director of Nursing & Workforce presented an overview of the report and advised that the Trust reported 8 Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG) and are all currently under investigation using Root Cause Analysis (RCA) methodology.

He advised that those SIRIs which had been closed by the QCPC had been summaried into themes and lessons learnt, and he expanded on the Modified Early Warning Score

(MEWS) system used in critical care which was mentioned within this section.

Jane Tabor asked if the incidents which go to QCPC are triangulated between environmental, non-environment factors and staffing and does this happen quickly. Sue Wadsworth confirmed that QCPC does go into depth with each report and if they are not assured by the outcome they reject it for further review.

The Isle of Wight NHS Trust Board received the report from Serious Incidents Requiring Investigation (SIRIs)

14/246 QUARTERLY BOARD WALKABOUTS ACTION TRACKER

The Executive Director of Nursing & Workforce presented the report.

He advised the Board that a number of the feedback sheets had not been received and investigation showed that the visits were deemed as pastoral rather than a formal assessment which made the feedback sheets inappropriate. He advised that this process was being reviewed by the Lead for Patient Experience. He also confirmed that feedback on actions 9, 10 and 11 had been received this morning and would be added to the report.

This action tracker continues to be reviewed at the directorate performance reviews.

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

14/247 QUARTERLY PATIENT STORY ACTION TRACKER

The Executive Director of Nursing & Workforce presented the report and advised that 2 actions remain overdue against timescales as per the attached exception report.

These are related to wider organisational change / capital bid issues and work continues to ensure that the issues that were raised via the Patient Story programme are addressed.

To date 10 stories have been shown at Trust Board meetings with 17 actions being monitored. Work is underway to review the Patient Story Process and monitoring to provide greater assurance to the Board on lessons learnt and actions taken.

The Isle of Wight NHS Trust Board received the Patient Story Action Tracker

14/248 ANNUAL REPORT FROM DIRECTOR OF INFECTION PREVENTION & CONTROL 2013/14

The Executive Director of Nursing & Workforce presented the report and advised that the annual Director of Infection Prevention and Control (DIPC) report is a review of infection prevention and control arrangements and the state of Healthcare Associated Infection (HCAI) in the Isle of Wight NHS Trust. It reports on the infection prevention and control programme for the year 2013/2014 and gives a summary of performance, including:

- Performance against key objectives to reduce HCAI (using indicators such as MRSA bacteraemia and *Clostridium difficile*).
- Quality improvement as measured by a continued planned audit programme of both clinical practice and environmental standards.
- Overview of some of the specific elements of IPC including antimicrobial stewardship

The Chief Executive stated that this was a good report and asked how the recommendations could be implemented and monitored. The Executive Director of Nursing & Workforce confirmed that the Infection Prevention Committee (IPC) which reported to the Safety Experience & Effectiveness Committee,(SEE) would be managing this.

Jane Tabor stated that she had a number of areas of concern. What are the loopholes and how quickly can they be closed and how was lack of engagement and ownership being addressed. The Executive Director of Nursing & Workforce advised that some processes needed organisation change to be implemented to ensure a change in practice

and secondly that emails would be issued to relevant areas citing details of patient cases with the IPC monitoring to ensure that policies are being adhered to and allocating ownership.

Jane Tabor also asked if the Trust was ready to respond in the event that the Ebola virus comes to the island. She was assured that measures were in place to deal with such an event.

The Isle of Wight NHS Trust Board received the Annual Report From Director Of Infection Prevention & Control 2013/14

14/249 MONTHLY UPDATE ON SAFER STAFFING

The Executive Director of Nursing & Workforce presented the report outlining the changes and improvements that had been made to the report.

He advised that following a review of the national guidance it was only necessary for the Board to receive this report and not approve as shown on the agenda. He confirmed that from October there would be a revised report which will demonstrate the levels of staffing in a clearer manner.

Sue Wadsworth asked if he was satisfied that the data shown on stakeholders was accurate. The Executive Director of Nursing & Workforce confirmed that he was assured that they reflected against the plan.

Jane Tabor queried the ward occupancy rates. The Executive Director of Nursing & Workforce confirmed that the orthopaedic data would be split into Luccombe and Alverstone wards for greater clarity and explained the need to keep certain beds for specific services and when these are not in use the staff are redeployed.

Jane Tabor asked if there were plans to include medical staff and other relevant staffing areas. The Executive Director of Nursing & Workforce advised that there was no national requirement but locally the Trust will consider expanding the areas covered over time.

David King asked what the vacancy rate for consultant positions was within the Trust. The Executive Director of Nursing & Workforce advised that it was currently approximately 12% and advised that recruitment processes for the vacant posts were underway. He confirmed that a 5 year plan for consultant posts was being developed with the Deanery to plan for the future. He advised that a workforce summit including the CCG, Local Authority, General Practitioners and the Trust would review both Trust and primary care recruitment.

The Isle of Wight NHS Trust Board received the Monthly Update on Safer Staffing

14/250 STAKEHOLDER ENGAGEMENT STRATEGY

The Executive Director of Transformation & Integration advised that this strategy sets out how the Trust will engage with stakeholders in the future.

It reflects both our statutory duties and our Trust values and corporate objectives, and is of special relevance to a number of different groups, including our external stakeholders, our internal stakeholders, our Trust Staff and our service users.

It is now submitted for approval and then for consultation with Island stakeholder groups – both external and internal. It is also proposed that further action on the strategy is delegated to the Trust Executive Committee

Chris Orchin, representative from Health Watch asked how would engagement with the stakeholders take place. The Executive Director of Nursing & Workforce advised that a summary would be prepared in clear language and this would be circulated to the stakeholders.

Jane Tabor suggested that the stakeholder community (page 11) should include additional external influencers such as the Department of Health and the Emergency Services. She also asked what is seen as the priority for this consultation. The Executive Director of Transformation & Integration stated that section 10. What will Success Look Like? How Can We Measure It? was very important (page 20) as it would be through this that the organisation would assess the outcomes for this strategy.

Proposed by Sue Wadsworth and Seconded by David King.

The Isle of Wight NHS Trust Board approved the Stakeholder Engagement Strategy to go out to consultation with Stakeholders, and the delegated authority for further action to the Trust Executive Committee.

14/251 NOTES OF THE FT PROGRAMME BOARD

The Chief Executive reported on the key points raised at the last meeting held on 22nd July 2014.

a) **Note No. 089/14 – CQC Inspection Report:** The CQC's draft inspection report was scheduled to be received on 28th July and the Trust would have 10 working days to respond.

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

14/252 BOARD SELF CERTIFICATION

The FT Programme Director presented the monthly update. He advised that this item would now be referred to as the Board Self-Certification as opposed to the FT Self Certification. He advised that following the receipt of the draft CQC report it was deemed appropriate to amend the status of certain Board Statements which resulted in there being 5 Statements now showing as "at risk" (amber).

He advised that that the report had been not been approved by both QCPC and FIWC on this occasion as the Programme Manager - Business Planning & Foundation Trust Application had not been able to be present at these meetings.

Proposed by Jane Tabor and seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the Board Self Certification

14/253 MINUTES OF THE AUDIT & CORPORATE RISK COMMITTEE

David King reported on the key points raised at the last meeting held on 19th August 2014.

a) **Min No. 14/090 - Counter Fraud – Central England Audit Consortium (CEAC) new management arrangements:** TIAA Ltd have initially been asked to provide a managerial role to CEAC which hopefully will lead to a fusion between CEAC and TIAA Ltd in the near future. TIAA Ltd has a significant Counter Fraud and Security Management Directorate

b) **Min No. 14/091 - Environment Agency Clinical Waste Audit Update:** Assurance could be provided to the Trust Board that Clinical Waste practices were now fully compliant with current statutory regulations

c) **Min No. 14/095 - External Audit –** Annual Audit Letter 2013/14 confirming unqualified opinion and value for money conclusion

d) **Min No. 14/096 – Internal Audit Report – NHS Creative – Limited Assurance:** Committee of the opinion that in future decisions to host a service or department needs to be more carefully considered and related to the organisation's Business Strategy

e) **Min No. 14/104 - Internal Audit Contract Tender 2015/18:** Contract to go out to tender

f) **Min No. 14/105 - Procurement Services Contract:** A year's extension with a review date and process to be implemented for the future tendering of the service

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

14/254 RECOMMENDATIONS OF THE AUDIT & CORPORATE RISK COMMITTEE

David King presented the recommendations of the Audit & Corporate Risk Committee held on 19th August 2014.

Min. No. 14/093 - Review of NHS Audit Committee Handbook 2014, Committee Objectives Update and Review Of Integration With Other Committees Which Review Risk

Items deferred for discussion at a future Board Seminar. In order to ensure that the assurances the Committee receives are appropriate, the Committee recommended that a Board Seminar be held in the very near future to discuss:

- Timings of sub-committees
- Membership of Audit & Corporate Risk Committee
- Alignment of sub-committees' terms of reference to ensure they are correctly structured to meet the needs of the organisation
- The level of assurance required and how this is provided
- Enhancement of Audit Committee's role and effectiveness – section of Action Plan to be discussed

The Company Secretary confirmed that this recommendation would be discussed at Board Seminar on 9th September.

Proposed by Jane Tabor and seconded by Sue Wadsworth

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

14/255 MATTERS TO BE REPORTED TO THE BOARD

There were no matters raised

14/256 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

14/257 ANY OTHER BUSINESS

a) **Car Parking:** David King asked if our car parking arrangements comply with the national guidelines. The Chief Executive confirmed that this was the case. She also highlighted that concessions available to patients and visitors were available on the website[3] but that she would arrange for these to be made visible around the Trust.

Action Note: *Communications team to arrange for details of the concessions to be made freely available around the organisation.*

Action by: HC

14/258 DATE OF NEXT MEETING

The Chairman confirmed that the next meeting of the Isle of Wight NHS Trust to be held in public is on **Wednesday 1st October 2014** in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 12.10pm

Signed…… Chair Date:……

[3] http://www.iow.nhs.uk/Patients-and-Visitors/visiting-a-patient/car-parking/car-parking.htm

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ISLE OF WIGHT TRUST BOARD Pt 1 (Public) - April 14 - March 15

ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

Key to LEAD: Chief Executive (CE) Executive Director of Finance (EDF) Executive Director of Transformation & Integration (EDTI)

Executive Medical Director (EMD) Executive Director of Nursing & Workforce (EDNW) Deputy Director of Nursing (DDN)

Foundation Trust Programme Director/Company Secretary (FTPD/CS) Trust Board Administrator (BA) Head of Communication (HC) Executive Director of Finance Deputy (EDF Dep)

Interim Director of Planning, ICT & Integration (IDPII) Head of Corporate Governance & Risk Management (HCGRM)Business Manager for Patient Safety, Experience & Clinical Effectiveness (BMSEE)

Non Executive Directors: Danny Fisher (DF) Sue Wadsworth (SW) Charles Rogers (CR) Nina Moorman (NM) David King (DK) Jane Tabor (JT)

Designate Non Executive Directors: Jessamy Baird (JB) Non Executive Financial Advisor: Lizzie Peers (LP)

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
26-Mar-14	14/091 i)	TB/085	**Pressure Ulcers:** Charles Rogers commented how helpful it was to show the rolling averages and how the revised charts demonstrated areas of resistance. He asked what was being done to rectify these. The Executive Director of Nursing & Workforce advised that the education campaign to show patients in the community what to look for and how to prevent pressure ulcers was going well. Public Health were involved to promote preventative measures. The initial training had reached 50% of registered nurses, and when complete would be rolled out to cover Health Care Workers and other community staff. Charles Rogers asked if feedback from Public Health could be provided on their programme.	EDNW	The Executive Director of Nursing & Workforce to request update from Public Health on their pressure ulcer prevention initiative. **23/04/14** - The Tissue Viability Specialist Nurse is in discussions with Public Health. **28/05/14** - The Executive Director of Nursing & Workforce confirmed that the Tissue Viability Nurse Specialist had met with Public Health and work was going ahead to roll out a programme of training by the end of this financial year. There would be a stakeholder event with both health care representatives and members of the public involved. He stated that it was important to get the message on how to prevent pressure ulcers forming across as many people as possible. **02/07/14** - Sue Wadsworth requested more information on the external review. The Executive Director of Nursing & Workforce to report back to Board on the progress of the external review on pressure ulcers. **18/07/14** - Full report and actions reviewed at QCPC in June 2014 **18/07/14** - Glenn Smith (Nutrition & Tissue Viability Nurse Specialist is currently finalising the action plan, so will be preparing an update for the August QCPC; where he will present an update and the associated action plan. **19/08/14** - This topic has been added to the Board Seminar forward plan. **23/09/14** - Pressure ulcer stakeholder event has taken place	28-May-14	09-Dec-14	Progressing		Open
30-Apr-14	14/124	TB/092	**Mortality & Morbidity Reviews:** Nina Moorman asked if the Mortality & Morbidity reviews could go to QCPC. Dr Sandya stated that this would be encouraged and suggested that it be added to the June QCPC agenda. The Executive Director of Nursing & Workforce suggested that due to the volume of items which go to QCPC it would be more appropriate for this to be discussed at a separate forum with Dr Sandya and the summary report which results from this to be presented to QCPC. This was agreed.	EMD	Executive Director of Nursing & Workforce to identify a separate forum to discuss the Mortality & Morbidity report and to arrange for summary report to go to QCPC. **28/05/14** - The Executive Director of Nursing & Workforce confirmed that a standard mortality template had been put into place and that these would be reviewed by the Quality & Clinical Performance Committee on a regular basis. This action is now closed. **02/07/14** - This action is reopended - Nina Moorman advised that this item had not yet come to QCPC. The Executive Medical Director confirmed that the Quarterly Mortality report would be coming to Board on 30th July and would also be presented to QCPC. Nina Moorman queried if the morbidity review in hospital was part of the clinical audit process. The Executive Medical Director advised that he would discuss this with the Clinical Lead for SEE which would report to QCPC. The Executive Medical Director to discuss Morbidity Review with the Clinical Lead for SEE. **20/08/14** – Meeting set up with Clinical Lead for SEE and Medical Director to discuss Mortality on Friday 22nd August, verbal update to be given at the Trust Board meeting. **27/08/14** - The Executive Medical Director had met with the Clinical Lead for SEE and a process had been agreed with a report going to the SEE Committee monthly. It was confirmed that he would continue to report the Dr Foster data to Board in the usual way. This action is now closed.	28-May-14	27-Aug-14	Completed	27-Aug-14	Closed

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Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
30-Apr-14	14/125	TB/093	**Board Walkabout Timings:** The Chairman stated that he had undertaken walkabouts on Sundays and he encouraged members to vary the times they make their visits to include out of hours times including weekends and late evenings to get a wider picture of how the organisation functions during these times. There was a discussion surrounding the timings of the Board day walkabouts and it was requested that these be reviewed.	CS	Company Secretary to review timings and adjust Board day programme accordingly. **16/05/14** - Scheduled at lunchtime for May Board meeting. Timings to be adjusted following feedback. **28/05/14** - The Company Secretary advised that this item had been left open to allow for feedback on the new timings of these walkabouts within the Board programme.	14-Oct-14	14-Oct-14	Progressing		Open
02-Jul-14	14/181	TB/100	**Interviewing Scripts:** A discussion took place in which the Non-Executive Directors stressed the need for a more flexible way of interviewing patients and in particular those with learning disabilities and mental health issues, so that their views could be clearly given.	EDNW	The Executive Director of Nursing & Workforce to progress the revision of the interview scripts with the Patient Experience team. **18/07/14** - Patient Experience lead working with Sunshine Radio and Volunteer Service to agree format of questions. **23/09/14** - Patient Experience Lead has developed a toolkit for undertaking patient stories, including revising the script to ensure that all patients are able to contribute and provide their views. This action is now closed	01-Oct-14	01-Oct-14	Completed	23-Sep-14	Closed
02-Jul-14	14/185a)	TB/101	**Flu Campaign:** Charles Rogers asked that details of the Flu Campaign, including Staff incentives, for autumn 2015 be brought to Board.	EDNW	The Executive Director of Nursing & Workforce to arrange for details on the plans for the Flu campaign 2015 together with details of how the staff incentives would apply to be brought to the Board. **18/07/14** - This will come to the Board in August 2014. **19/08/14** - this item has been deferred to 1st October Board. **23/09/14** - A staff flu vaccination programme is being rolled out at the beginning of October. Open sessions will be communicated to all staff and vaccinators will be trained in a number of areas to deliver the vaccine. The target for this year is 75% uptake. Clinical frontline staff will be a key priority group. There are no specific incentives but access to the vaccine is aimed to be as convenient as possible. This action is now closed.	27-Aug-14	01-Oct-14	Completed	23-Sep-14	Closed
02-Jul-14	14/188	TB/103	**PALs Office** - Business Manager for Patient Safety, Experience & Clinical Effectiveness advised that some work was still ongoing as there was a gap between the walls and the ceiling which was allowing in noise from the café area.	EDNW BMSEE	The Executive Director of Nursing & Workforce to provide updates on progress of work to address this to the Board. **07/07/14** - Scheme to address this approved at Trust Executive Committee on 7th July. **18/07/14** - Estates to confirm timeline for work to be complete. Updated Business Case to go back to the Charitable Funds Committee. **19/08/14** - Funding to be confirmed as business case will now not be going to Charitable Funds Committee. **27/08/14** - It was confirmed that funding had been approved and work would commence in early September. This action is now closed.	01-Oct-14	01-Oct-14	Completed	27-Aug-14	Closed
30-Jul-14	14/218iv	TB/104	**Cost Improvement Programme:** Nina Moorman queried whether the CIPs were being viewed across services/pathways and could this be broken down into directorates. The Executive Director for Transformation & Integration advised that as part of the hospital redesign there would be a review of how the data is presented and it was planned to show a breakdown of the data to show how the programme was working. She also advised that the TDA had requested this information and had provided a format which would show a confidence indicator.	EDTI	The Executive Director of Transformation & Integration to provide a report to the Board on 27th August on the progress of the TDA report format. **19/08/14** - This item would be covered in the 1st October Board. **22/09/14** - The TDA submission was acceptable to them. We will not use that reporting format in the future as it has now been superseded by a more robust project reporting mechanism. CIPs can be viewed at a per Directorate level. There is also the ability to view CIPs by Programme, Project and Work Stream for large or complex projects. CIPs cannot be viewed across services or pathways and after consideration by the Programme Management Office, it was considered too resource intensive to set this up bearing in mind the limited additional visibility or assurance this would provide. We now have a RAG status on all projects and each project is scored on a 26-point checklist to ensure viability, robustness of plans and finance verification, among other checks. This action is now closed.	27-Aug-14	01-Oct-14	Completed	22-Sep-14	Closed

Enc E

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
27-Aug-14	14/241(iii)	TB/107	**Sickness Absence Data for Mental Health Staff:** Jessamy Baird queried if it could be related to work related stress and the increase in annual leave. She also stated that she would like to see a separate Community & Mental Health report. The Executive Director of Nursing & Workforce advised that the rostering procedure would ensure that this should not occur. He also advised that it was planned for the safer staffing model to be extended into clerical, ambulance and other areas.	EDF	The Executive Director of Finance to arrange for separate community & mental health sickness absence data to be included within the PIDS report. **19/09/14** - This is within the PIDS report for 1st October meeting. This action is now closed.	01-Oct-14	01-Oct-14	Completed	19-Sep-14	Closed
27-Aug-14	14/242	TB/108	**Mental Health Service User Involvement policy:** Jessamy Baird stressed the need for an effective Mental Health Service User Involvement policy. She advised that a consultation had occurred and it was important to approve the policy as soon as possible. The Company Secretary suggested that this policy could have a wider scope and further consultation would be necessary including the Mental Health Service User Involvement forum. Sue Wadsworth requested that he come to the QCPC to discuss in more depth and the Company Secretary agreed.	EDNW	The Executive Director of Nursing & Workforce to arrange for the Mental Health User Involvement Policy to go to QCPC and to arrange for the Company Secretary to attend that meeting to discuss the wider scope of this policy. **17/09/14** - Company Secretary attended QCPC with draft policy. This action is now closed.	17-Sep-14	17-Sep-14	Completed	17-Sep-14	Closed
27-Aug-14	14/244b)	TB/109	**Section 12 Provision** - GP has completed Section 12 training and applied for approval. Approved Mental Health Professionals (AMHPs) often experience difficulty obtaining the services of a GP for a Mental Health Act Assessment (MHAA). A representative of the Clinical Commissioning Group (CCG) is to attend the next AMHP meeting on 18th August. Jessamy Baird asked for this to be added to the Risk Register.	CS	The Company Secretary to arrange for this item to be added to the Risk Register. **17/09/14** - This risk is on the Risk Register - see BAF report for 1st October Board meeting. This action is now closed.	17-Sep-14	17-Sep-14	Completed	17-Sep-14	Closed
27-Aug-14	14/257	TB/110	**Car Parking**: David King asked if our car parking arrangements comply with the national guidelines. The Chief Executive confirmed that this was the case. She also highlighted that concessions available to patients and visitors were available on the website but that she would arrange for these to be made visible around the Trust.	HOC	Communications team to arrange for details of the concessions to be made freely available around the organisation. **22/09/14** - Leaflet and poster in production. Discussions underway with areas who send out appointment letters about getting details of car parking included (i.e. printed on the back) in those letters. The web site is being updated.	01-Oct-14	01-Oct-14	Progressing		Open

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 OCTOBER 2014

Title	Care Quality Commission Inspection Reports and our Improvement Plan			
Sponsoring Executive Director	Karen Baker, Chief Executive			
Author(s)	Dr Sandya Theminimulle, Theresa Gallard & Deborah Matthews – Patient Safety, Experience & Clinical Effectiveness Triumvirate			
Purpose	To receive the outcome of the recent CQC Inspection report and approve the internal governance arrangements for the approval, monitoring and oversight of the improvement plan			
Action required by the Board:	**Receive**		**Approve**	ü

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

This paper presents the Board with information in relation to the Care Quality Commission (CQC) inspection that took place on 4, 5 and 6 June and the unannounced visit on 21 June 2014. The report provides the high level results from the inspection. The Trust was given an overall rating of 'requires improvement.' The CQC assess against 5 key domains, which are safe, effective, caring, responsive and well led. The trust scored 'good' against the domain of care and 'requires improvement' against the other 4 domains. The Trust received 12 areas of immediate concern. Following the inspection the Trust has been issued with a Warning Notice in relation to Regulated Activity: Treatment of Disease, Disorder or Injury. There were also many areas of good practice found and examples of these are provided in the paper. A Quality Improvement Programme (QIP) has been developed to enable the Trust and governance processes for managing the delivery of the QIP have been developed.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Quality					
Critical Success Factors *(see key)*	CSF1					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	1.15					
Assurance Level ***(shown on BAF)***	Red	ü	Amber		Green	
Legal implications, regulatory and consultation requirements	Failure to provide a satisfactory and acceptable response to the CQC Warning Notice and achieve compliance with the relevant requirements within the given timescale then we will become subject to further enforcement action.					

Date: 19 September 2014 **Completed by:** Theresa Gallard
Business Manager – Patient Safety, Experience & Clinical Effectiveness

Isle of Wight NHS Trust

Care Quality Commission Inspection Reports and our Improvement Plan

Version 1

Contents

1. EXECUTIVE SUMMARY

This paper presents the Board with information in relation to the planned Care Quality Commission (CQC) inspection that took place on 4, 5 and 6 June and the unannounced visit on 21 June 2014.

The report provides the high level results from the inspection. The Trust was given an overall rating of 'requires improvement.' The CQC assess against 5 key domains, which are safe, effective, caring, responsive and well led. The trust scored 'good' against the domain of care and 'requires improvement' against the other 4 domains.

The Trust received 12 areas of immediate concern.

Following the inspection the Trust has been issued with a Warning Notice in relation to Regulated Activity: Treatment of Disease, Disorder or Injury

There were also many areas of good practice found and examples of these are provided in the paper.

A Quality Improvement Plan (QIP) has been developed to enable the Trust and governance processes for managing the delivery of the QIP have been developed.

2. INTRODUCTION

The Care Quality Commission (CQC) conducted a comprehensive inspection of the Isle of Wight NHS Trust due to our position as an aspirant Foundation Trust, prioritised by Monitor. The inspection took place on the 4, 5 and 6 June 2014 with an unannounced visit on 21 June, between 4pm and 11pm. During this time they inspected the following core services:

SERVICES	
Accident and emergency	End of life care
Medical care (including older people's care)	outpatients services
Surgery	the ambulance service
critical care	older adults
Maternity and family planning	community adult services
Services for children and young people	community inpatient services
Primary Mental Health Services	learning disability services
Children and Adolescent Mental Health Services(CAMHS)	Acute
PICU and S136 Place of Safety	drug and alcohol services
Community mental health and crisis resolution services	Community health services for children, young people and their families
Rehabilitation inpatient services	

The Trust received the final reports on 29th August 2014 in the form of 4 separate reports; 1) an overarching summary quality report, 2) Hospital and Ambulance; 3) Community and 4) Mental Health. The findings were subsequently published in the public domain on 9th September 2014 via the CQC website.

The reports describe the CQC's judgement of the quality of care at the Isle of Wight NHS Trust and are based on a combination of what they found when they inspected, information from their 'Intelligent Monitoring' system, and information given to them by patients, the public and other organisations.

3. CARE QUALITY COMMISSION FINDINGS

3.1 Report Findings

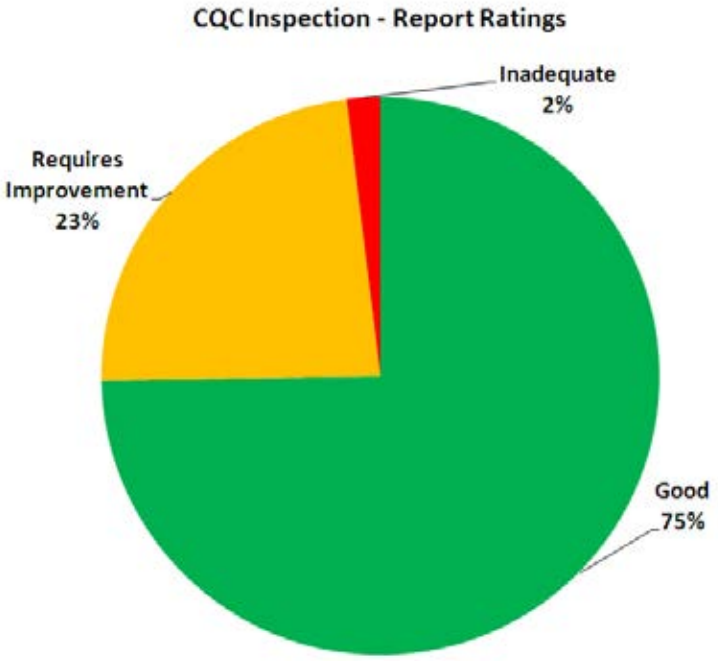
Overall, the CQC found that staff were caring and compassionate, and treated patients and people using our services with dignity and respect. Staff were also found to be highly motivated and treated people as individuals.

The overall rating for the Trust was assessed as Requires Improvement

A breakdown of the Trust's assessment against the 5 domains is outlined in the table below.
Ambulance and Mental Health were each assessed overall as good, with Acute and Community both receiving

Overall rating for this trust	Choose a rating
Are services at this trust safe?	Choose a rating
Are services at this trust effective?	Choose a rating
Are services at this trust caring?	Choose a rating
Are services at this trust responsive?	Choose a rating
Are services at this trust well-led?	Choose a rating

a 'requires improvement' assessment. The chart below summarises the ratings received.



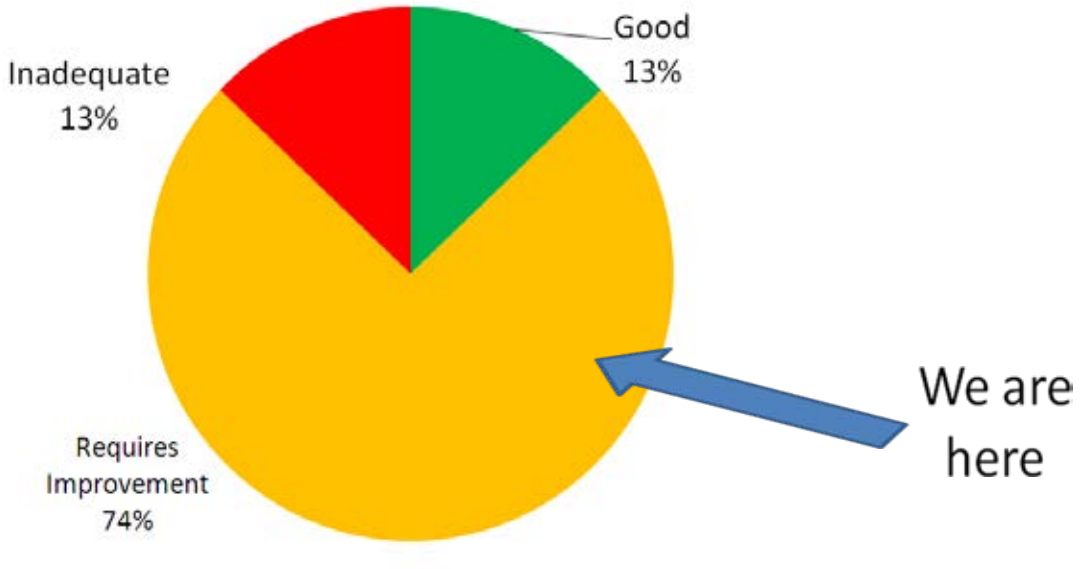
Acute

Ambulance

Mental Health

Community

The chart below sets the trust's assessment against the national picture.



The Trust has been given 12 areas for immediate action, listed below.

AREAS FOR IMMEDIATE ACTION	
1	Incident investigations resulting in changes
2	review of compliance against national guidance - application of NICE guidance for Kidney injury
3	Named Consultant for the duration of a patients stay
4	Medical outliers and Bed Moves
5	Paediatric single point of access
6	Staffing community inpatient wards & District Nursing Out of Hours Service
7	Risk following implementation of community IT system
8	Emergency Department Non-Clinical screening
9	Medicines management in Ambulance station
10	Mental Health Caseload Management
11	Environmental issues on Dementia Ward
12	End of Life Care

Within the reports the following themes were identified.

THEMES	
1	Lack of Staff Engagement and concerns about culture
2	Patient Caseload/Flow
3	End of Life Care
4	Recruitment and Retention
5	Governance: • National Guidelines • Shared learning • Risk management • Structure for a complex organisation

During the inspection the Care Quality Commission identified many areas of good practice across many areas of the organisation.

OUTSTANDING AREAS	
1	The hospital at night team provided an excellent service led by a medical registrar and an advanced nurse practitioner.
2	The pharmacy service was innovative for example with pharmacy electronic prescribing and the pharmacy advice line.
3	The sepsis pre-hospital anti-microbial work and audit was innovative.
4	There was flexible thinking around recruitment, such as the recruitment of nurse consultants.
5	There was good mental health rehabilitation patient safety information and the unit was good at forward planning and liaison of services across the island.
6	The male and female garden on Afton ward was excellent. The flag pole that was also intended for use to identify the garden for patients living with dementia was an example of innovative thinking around what was not an ideal environment.
7	Drug and Alcohol services were good and there were good examples of patient and family support.
8	The Operation Serenity project for mental health patients in crises provided outstanding home support and patient safety and was preventing acute admissions.
9	The Hub was an example of coordinated work with services across health and social care to ensure patients received appropriate services prior to admission and to prevent patient admissions to hospital.
10	Child Safeguarding Team effectively managing large increase in referrals
11	The practice development plans for paramedics was innovative - it was not something the team had seen anywhere else.
12	The maternity and paediatric services were good and providing effective care.
13	Sexual health services were excellent.
14	Improving Access to Psychological Therapy (IAPT) services were excellent
15	Community Stroke Rehabilitation Team provide an excellent service

3.2 Warning Notice

Following the Inspection, the Trust has been served with a Warning Notice, under Section 29 of the Health and Social Care Act 2008, relating to Treatment of Disease, Disorder or Injury.

The Trust is required to become compliant with Regulation 10 (1) (a) (b) (2) (b) (iv) (c) (i) (ii) (d) (i) (e) by 12 December 2014.

If we fail to provide a satisfactory and acceptable response to the CQC Warning Notice and achieve compliance with the relevant requirements within the given timescale then we will become subject to further enforcement action.

4. TRUST RESPONSE

The Isle of Wight NHS Trust accepts the reports, noting the following key points:-

- Overall “Requires Improvement” is a fair assessment
- The Trust was sighted on most of the areas highlighted in terms of the main themes
- Strengthened assurance systems
- Showcases good services:25 areas of ‘outstanding practice’
- Realistic about our challenges ahead

A Quality Improvement Plan (QIP) has been developed, with the involvement of all Directorates, to ensure the Trust delivers on achieving the required standard relating to the 12 immediate concerns, 31 ‘must dos’, 50

'should dos' and a total of 201 areas that 'require improvement,' as outlined in the reports. In addition, the QIP includes all requirements issued within the Warning Notice. Key leads have been allocated to each action and are responsible for driving them forward and an appropriate governance process developed, see section 6. The immediate focus needs to on the actions relating to the Warning notice so that the trust can ensure compliance by 12 December 2014. The Trust has also been requested to provide a copy of the QIP to the Trust Development Authority by Thursday 25 September 2014.

5. QUALITY SUMMIT

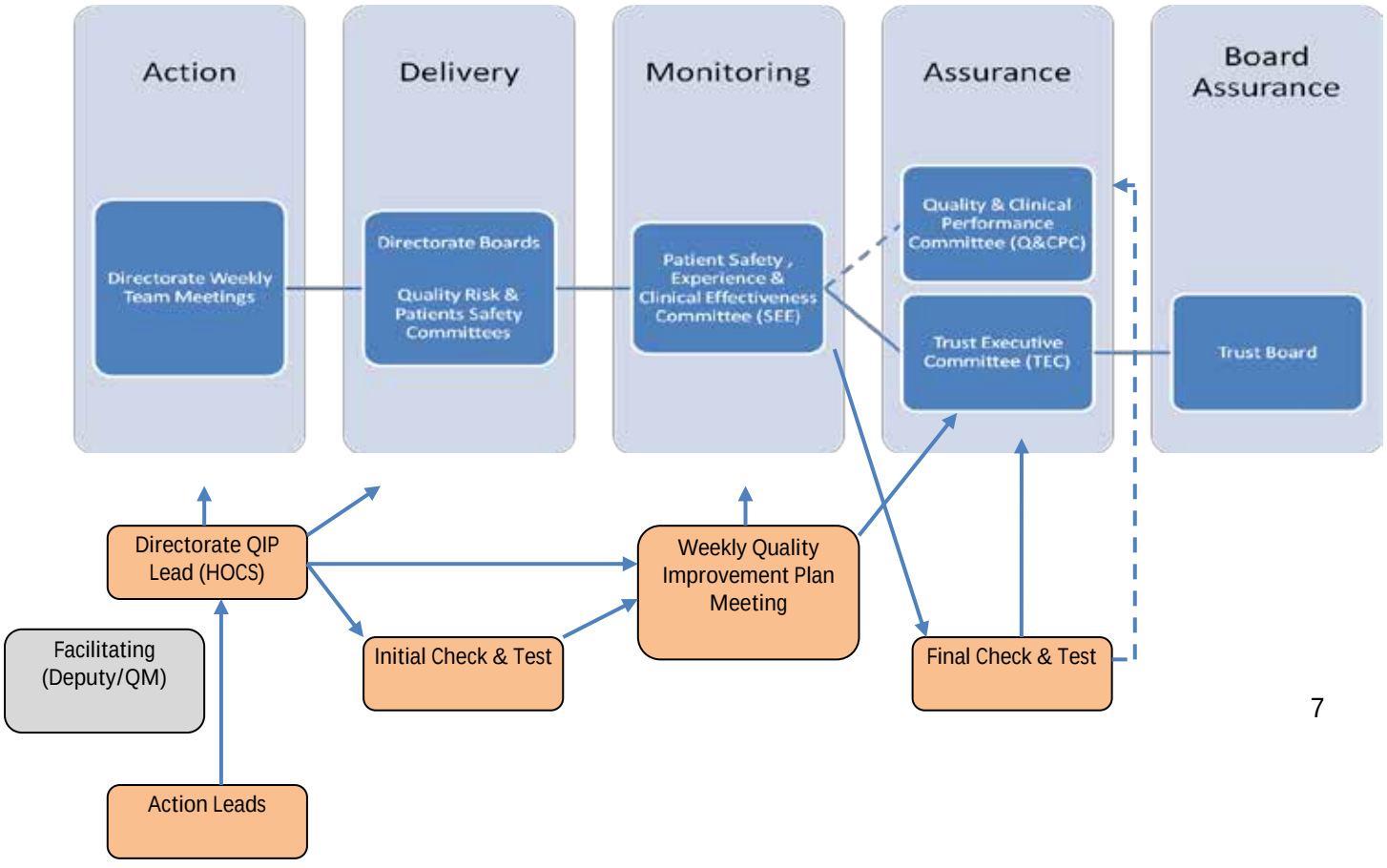
An important part of the process of a Chief Inspector of Hospitals inspection is a Quality Summit which takes place after the report has been finalised and is led in 2 parts, firstly by the CQC feeding back on their report and their findings and secondly by the TDA on the future process and the required actions for the Trust and others. Our Quality Summit took place on Tuesday 2nd September 2014 in the Conference Room at St Mary's Hospital and was attended by representatives from CQC, TDA, the Trust, with local stakeholders which comprised the Clinical Commissioning Group, NHS England, Health Education Wessex, Isle of Wight Council local Healthwatch and the General Medical Council. In general participants felt that this was a fair assessment and the Chairman of the CQC inspection stated that she felt all of the areas that required improvement identified by the CQC could be put right by the Trust with their current leadership. The CQC also stressed the importance of developing a comprehensive improvement plan, rather than just chasing all of the individual actions as a result of the inspection.

The Trust Development Authority led the second part of the meeting focussing on the areas of improvement required and confirmed support from all stakeholders present for the Trust in putting in place the improvement plan.

6. GOVERNANCE ARRANGEMENTS

6.1 Proposed Local Arrangements

The Patient Safety, Experience & Clinical Effectiveness Triumvirate and Committee have been given the responsibility for ongoing review of the QIP to track delivery and highlight any potential failings. Proposed governance arrangements are set out below.



The above diagram outlines the formal governance reporting arrangements within the Trust (blue), relevant to delivery of the QIP. It also highlights the additional requirements (orange & grey) and responsibilities of the Directorates due to the short timeline for delivery. This relates specifically to activity that is required on an ongoing basis in between formal meetings.

6.2 Trust Development Authority (TDA) – Oversight of the Trust

The TDA has written to the Trust proposing that it escalates their oversight arrangements in 2 respects:

- Monthly meetings with the Trust will now be face to face rather than by a teleconference.
- An additional meeting will be attached to the monthly meeting which will focus on the improvement plan as a result of the CQC Report and the other stakeholders present at the Quality Summit will also be invited to attend.

The proposed increase in oversight arrangements have been recommended to the TDA Board which meets on Thursday 18th September 2014.

7. RECOMENDATIONS

i. The Board is recommended to receive the CQC Inspection Report.
ii. The Board is recommended to approve the internal governance arrangements for the approval monitoring and oversight of the improvement plan following the CQC Inspection.

DR SANDYA THEMINIMULLE, DEBORAH MATTHEWS & THERESA GALLARD
Patient Safety, Experience & Clinical Effectiveness Triumvirate

19 September 2014

Enc G

Isle of Wight NHS Trust Board Performance Report 2014/15

August 14

Isle of Wight NHS Trust

Title	**Isle of Wight NHS Trust Board Performance Report 2014/15**			
Sponsoring Executive 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 regarding progress against key performance measures and highlight risks and the management of these risks.			
Action required by the Board:	**Receive**	**X**	**Approve**	
Previously considered by (state date):				
Trust Executive Committee		Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee		Nominations Committee (Shadow)		
Charitable Funds Committee		Quality & Clinical Performance Committee	17/09/2014	
Finance, Investment & Workforce Committee	17/09/2014	Remuneration Committee		
Foundation Trust Programme Board				
Please add any other committees below as needed				
Other (please state)				
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 2014/15. A more detailed executive summary of this report is set out on page 2.				
For following sections – please indicate as appropriate:				
Trust Goal *(see key)*	Quality, Resilience,Productivity & Workforce			
Critical Success Factors *(see key)*	CSF1, CSF2, CSF6, CSF7, CSF9			
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***				
Assurance Level ***(shown on BAF)***	☐ Red	☐ Amber	☐ Green	
Legal implications, regulatory and consultation requirements	None			

Date: Wednesday 1st October 2014 **Completed by: Iain Hendey, Assistant Director of Performance Information and Decision Support**

Isle of Wight NHS Trust Board Performance Report 2014/15

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Balanced Scorecard - Aligned to 'Key Line of Enquiry' (KLOEs)

Isle of Wight NHS Trust

Safe

GRR ref		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
	Patients that develop a grade 4 pressure ulcer	TW	12	3	Aug-14	7	↔	
	Reduction across all grades of pressure ulcers (25% on 2013/14 Acute baseline, 50% Community)	TW	203	30	Aug-14	145	↗	
	VTE (Assessment for risk of)	AC	>95%	100%	Aug-14	99.8%	↘	
	MRSA (confirmed MRSA bacteraemia)	AC	0	0	Aug-14	0	↔	
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)	AC	6	0	Aug-14	5	↗	
	Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	TW	48	3	Aug-14	26	↗	
	Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	TW	9	0	Aug-14	0	↔	
	Falls - resulting in significant injury	TW	7	0	Aug-14	2	↗	

Effective

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Summary Hospital-level Mortality Indicator (SHMI) Jan-13 - Oct-13	TW	1	1.099	Published Jul 2014	N/A	↗	
Hospital Standardised Mortality Ratio (HSMR) Oct-12 - Sep-13	TW	100	96	Published Apr 2014	N/A	↗	
Stroke patients (90% of stay on Stroke Unit)	CM	80%	94%	Jul-14	92%	↘	
High risk TIA fully investigated & treated within 24 hours (National 60%)	CM	60%	61%	Jul-14	68%	↘	
Cancelled operations on/after day of admission (not rebooked within 28 days)	AC	0	1	Aug-14	6	↔	
Delayed Transfer of Care (lost bed days)	TW	N/A	128	Aug-14	675	↗	
Number of Ambulance Handover Delays between 1-2 hours	AM	N/A	6	Aug-14	24	↘	
Theatre utilisation	AC	83%	79%	Aug-14	79%	↗	

Caring

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Patient Satisfaction (Friends & Family test - Total Inpatient response rate)	AC	30%	44%	Aug-14	37%	↗	
Patient Satisfaction (Friends & Family test - A&E response rate)	AC	20%	23%	Aug-14	17%	↗	
Mixed Sex Accommodation Breaches	TW	0	0	Aug-14	0	↔	
Formal Complaints	TW	<175	13	Aug-14	79	↗	
Compliments received	TW	N/A	370	Aug-14	1,583	↗	

Responsive

		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
1	RTT:% of admitted patients who waited 18 weeks or less	AC	90%	84%	Aug-14	91%	↘	
2	RTT: % of non-admitted patients who waited 18 weeks or less	AC	95%	88%	Aug-14	93%	↘	
3	RTT % of incomplete pathways within 18 weeks	AC	92%	91%	Aug-14	93%	↘	
8b	Symptomatic Breast Referrals Seen <2 weeks*	AC	93%	93.1%	Aug-14	86.0%	↗	
6b	Cancer patients seen <14 days after urgent GP referral*	AC	93%	95.5%	Aug-14	94.7%	↗	
6a	Cancer Patients receiving subsequent Chemo/Drug <31 days*	AC	98%	100%	Aug-14	100%	↔	
5a	Cancer Patients receiving subsequent surgery <31 days*	AC	94%	100%	Aug-14	100%	↔	
	Cancer diagnosis to treatment <31 days*	AC	96%	100.0%	Aug-14	97.5%	↗	
7	Cancer Patients treated after screening referral <62 days*	AC	90%	67%	Aug-14	85.7%	↘	
5b	Cancer Patients treated after consultant upgrade <62 days*	AC	85%	100%	Aug-14	100%	↔	
8a	Cancer urgent referral to treatment <62 days*	AC	85%	89.7%	Aug-14	87.4%	↘	
	No. Patients waiting > 6 weeks for diagnostics	AC	<100	0	Aug-14	7	↔	
	%. Patients waiting > 6 weeks for diagnostics	AC	<1%	0.0%	Aug-14	0.1%	↔	
4	Emergency Care 4 hour Standards	AC	95%	97%	Aug-14	96%	↗	
12	Ambulance Category A Calls % < 8 minutes	AM	75%	72%	Aug-14	76%	↘	
13	Ambulance Category A Calls % < 19 minutes	AM	95%	95%	Aug-14	96%	↘	
9a	% of CPA patients receiving FU contact within 7 days of discharge	MH	95%	100%	Aug-14	97%	↔	
9b	% of CPA patients having formal review within last 12 months	MH	95%	100%	Aug-14	N/A	↔	
10	% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	MH	95%	100%	Aug-14	99%	↔	

**Cancer figures for August are provisional.*

Well-Led

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Total workforce SIP (FTEs)	TW	2616.6	2622.9	Aug-14	N/A	↗	
Total pay costs (inc flexible working) (£000)	TW	£9,612	£9,616	Aug-14	£48,351	↗	
Variable Hours (FTE)	TW	136.7	140.15	Aug-14	699.6	↘	
Variable Hours (£000)	TW	£13	£636	Aug-14	£3,098	↗	
Staff sickness absences	TW	3%	3.64%	Aug-14	3.67%	↗	
Staff Turnover	TW	5%	0.89%	Aug-14	3.50%	↗	
Achievement of financial plan	TW	£1.7m	£990	Aug-14	£990	↘	
Underlying performance	TW	-£0.8m	(£869k)	Aug-14	(£869k)	↔	
Net return after financing	TW	0.50%	39.71%	Aug-14	39.71%	↗	
I&E surplus margin net of dividend	TW	=>1%	3.50%	Aug-14	3.50%	↗	
Liquidity ratio days	TW	=>15	25	Aug-14	25	↗	
Continuity of Service Risk Rating	TW	3	4	Aug-14	4	↔	
Capital Expenditure as a % of YTD plan	TW	=>75%	26%	Aug-14	26%	↗	
Quarter end cash balance (days of operating expenses)	TW	=>10	28	Aug-14	28	↔	
Debtors over 90 days as a % of total debtor balance	TW	=<5%	3.18%	Aug-14	3.18%	↗	
Creditors over 90 days as a % of total creditor balance	TW	=<5%	0.6%	Aug-14	0.6%	↘	
Recurring CIP savings achieved	TW	100%	69.6%	Aug-14	69.6%	↘	
Total CIP savings achieved	TW	100%	116%	Aug-14	116%	↘	

Notes

Delivering or exceeding Target		Improvement on previous month ↗
Underachieving Target		No change to previous month ↔
Failing Target		Deterioration on previous month ↘

Key to Area Code
TW = Trust Wide
AC = Acute
AM = Ambulance
CM = Community Healthcare
MH = Mental Health

Sparkline graphs are included to present the trends over time for Key Performance Indicators

Isle of Wight NHS Trust Board Performance Report 2014/15

August 14

Executive Summary

We have made a number of changes to the Trust Board Performance Report. Currently the most notable changes in the report are to the balanced scorecard. You will note that we have realigned our suite of Key Performance Indicators to the CQC Key Lines of Enquiry (KLOE). The next stage is to complete a review of KPIs to ensure that we have the right measures to provide the board with necessary assurance that the Trust is Safe, Effective, Caring, Responsive and Well Led. Another notable change is the addition of balanced scorecards for Acute, Community, Mental Health Services and Ambulance. Further work is required to refine these pages in particular to ensure we have appropriate measures and targets for all services, we also need to review data to access workforce and finance information at this level.

Safe:

Pressure ulcers: We continue to under achieve our planned local reduction across all grades of pressure ulcers, both in the hospital setting and the wider community. A range of actions are in place to support improvements in this priority indicator in all areas.

Responsive:

All RTT Indicators were below target in August, with a number of specialties not achieving target bringing the overall Trust performance to 84.2% for Admitted (5.8% below target), 87.9% for Non-Admitted (7.1% below target) and 91.3% for Incompletes (0.7% below target). Significant resource has been put into validation of 18 week pathways and increasing Out Patient and Inpatient capacity in order to achieve these targets.

Cancer - Patient treated after screening referral <62 days failed the 90% standard during August (66.7%). Note this was 0.5 of a breach (breach shared with Portsmouth) out of a total 1.5 patients. At the present time there are 3 Locum Consultants employed until December 2014 providing stability for 3 months. The substantive Haematology Consultant posts continues to be advertised.

CPA patients receiving a formal review within 12 months - 100% performance against this target has been maintained again this month due to continuing work to manually report against this indicator. The figure reported (100%) is the position according to data available as at 14th August. It is expected that the roll out of PARIS will rectify the data collection issue.

Well Led:

The pay bill for August including variable hours is £9.616m, slightly above the plan of £9.612m. The number of FTEs in post including variable FTEs (2,763) is currently above plan by 10 FTE. The HR Directorate are closely monitoring and supporting the Clinical directorates with their workforce plans, in particular their control over their spend on variable hours.

Sickness absence has decreased from 3.72% to 3.64% during August and remains above the 3% plan. Detailed analysis of all long-term Sickness Absence is sent to Occupational Health, Health and Safety, Back Care and also to the Associate Directors, Quality and Finance. Actions are followed up at Performance Review and Directorate meetings. Short-term absence is being monitored using the Bradford Score. The capability policy has been streamlined and review periods are being scrutinised. Education sessions for Bradford Score are being cascaded.

At the end of August the Trust is reporting a surplus of £990k against the actual planned financial position of £1,079k. The adjusted retained surplus shows £1,004k against a plan of £1,088k - £84k behind plan. The Continuity of Service Risk Rating is 4.The Cost Improvement Programme showed a year to date overachievement of £658k against the target of £2,984k. Included within this performance is the recognition of forward banked savings amounting to £1,556k. Of the total £3,642k achieved, £2,411k was achieved recurrently and therefore the focus still remains on the delivery of recurrent savings..

Caring:

Patient Satisfaction: Complaints remain low in August in comparison to April and slightly decreased since July. Compliments, in the form of letters and cards of thanks, were slightly higher during August than in July. The Friends & Family Test response rate continues to be challenging and work is ongoing to improve access.

Effective:

Theatre Utilisation has improved for both Main Theatres and Day Surgery Unit giving a joint rate of 79.2% in August. Bed pressures continue to effect performance with a reduction in elective admissions due to the high risk of cancellation as well as delays in admission processing.

Isle of Wight NHS Trust Board Performance Report 2014/15

August 14

Performance Summary - Hospital

Isle of Wight NHS Trust

Balance Scorecard - Hospital

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Grade 1&2 Pressure Ulcers	Aug-14		5		25	
No. of Grade 3&4 Pressure Ulcers	Aug-14		1		9	
VTE	Aug-14	95%	99.9%	95%	99.8%	
MRSA	Aug-14	0	0	0	0	
C.Diff	Aug-14		0	4	3	
No. of Reported SIRI's	Aug-14		1		12	

Responsive*	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Care 4 hour Standards	Aug-14	95%	97.3%	95%	95.9%	
RTT Admitted - % within 18 Weeks	Aug-14	90%	83.7%	90%	91.2%	
RTT Non Admitted - % within 18 Weeks	Aug-14	95%	89.7%	95%	92.8%	
RTT Incomplete - % within 18 Weeks	Aug-14	92%	91.5%	92%	92.5%	
No. Patients waiting > 6 weeks for diagnostics	Aug-14	< 8	0	100	7	
%. Patients waiting > 6 weeks for diagnostics	Aug-14	1%	0.00%	1%	0.11%	
Cancer 2 wk GP referral to 1st OP	Aug-14	93%	95.5%	93%	94.7%	
Breast Symptoms 2 wk GP referral to 1st OP	Aug-14	93%	93.1%	93%	86.0%	
31 day second or subsequent (surgery)	Aug-14	94%	100%	94%	100%	
31 day second or subsequent (drug)	Aug-14	98%	100%	98%	100%	
31 day diagnosis to treatment for all cancers	Aug-14	96%	100%	96%	97%	
62 day referral to treatment from screening	Aug-14	90%	67%	90%	86%	
62 days urgent referral to treatment of all cancers	Aug-14	85%	89.7%	85%	87.4%	
Emergency 30 day Readmissions	Aug-14		5.1%		5.1%	

Contracted Activity**	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Spells	Jul-14	1,154	1,182	4,575	4,322	
Elective Spells	Jul-14	729	654	2,664	2,474	
Outpatients Attendances	Jul-14	10,600	11,024	38,743	39,606	

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Delayed Transfers of Care (lost bed days)	Aug-14	N/A	128	N/A	675	
Cancelled operations on/after day of admission (not rebooked within 28 days)	Aug-14	0	1	0	6	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Aug-14	3%	2.90%			
FTE vs Budget						
Appraisals	Aug-14		4.0%		36.4%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
FFT Hospital - % Response Rate	Aug-14	30%	44.1%	30%	37.1%	
FFT Hospital - % Recommending	Aug-14	95%	97.6%	95%	96.4%	
FFT A&E - % Response Rate	Aug-14	20%	23.2%	20%	17.5%	
FFT A&E - % Recommending	Aug-14	95%	90.2%	95%	92.2%	
Mixed Sex Accommodation Breaches	Aug-14	0	0	0	0	
No. of Complaints	Aug-14		8		49	
No. of Concerns	Aug-14		88		192	
No. of Compliments	Aug-14	N/A	254	N/A	1091	

**Cancer figures for August 2014 are provisional*

***The Acute SLA reports a month behind, therefore figures are from July 14.*

RTT performance – Across admitted, non-admitted and incomplete – Review undertaken across all pathways and all service areas with recovery plans in place to ensure performance is back on track for October/November.

Breast Symptomatic – Action plan in place to increase capacity along with twice weekly monitoring of referrals to highlight and action any shortfalls. Improvement already being noted.

62 day referral to treatment from screening – Action plan in place to minimise delays at different stages of the pathway (including close working with tertiary centres). Also includes increased capacity in one stop clinics.

Cancelled operations – A combination of bed pressures, patients unfit on day of operation and staff sickness has impacted on performance in August, along with capacity issues for cancer making rebooking difficult for some specialities. All cancellations are audited and lesson learnt implemented on a regular basis.

Friends and Family Test – Action plan shared with CCG around improving response rate for all areas.

Isle of Wight NHS Trust Board Performance Report 2014/15

August 14

Performance Summary - Community

Balance Scorecard - Community

Safe	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
No. of Grade 1&2 Pressure Ulcers	Aug-14		18		87	
No. of Grade 3&4 Pressure Ulcers	Aug-14		5		30	
MRSA	Aug-14	0	0	0	0	
C.Diff	Aug-14		0	2	2	
No. of Reported SIRI's	Aug-14		2		23	

Effective	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Stroke patients (90% of stay on Stroke Unit)	Jul-14	80%	93.8%	80%	91.9%	
High risk TIA fully investigated & treated within 24 hours (National 60%)	Jul-14	60%	61.1%	60%	67.6%	

Responsive	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	

Well-Led	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
% Sickness Absenteeism - C Directorate	Aug-14	3%	3.77%	3%	4.12%	
FTE vs Budget - Community Directorate						
Appraisals	Aug-14		1.8%		84.5%	

Contracted Activity	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Community Contacts	Jul-14	16,514	17,969	66,081	72,235	
Health Visitors	Jul-14	2,899	2,521	11,596	12,778	
Sexual Health	Jul-14	855	1,041	3,420	3,734	

Caring	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
FFT - % Response Rate	Aug-14	30%	39.0%	30%	32.8%	
FFT - % Recommending	Aug-14	95%	90.6%	95%	92.4%	
No. of Complaints	Aug-14		5		20	
No. of Concerns	Aug-14		8		58	
No. of Compliments	Aug-14	N/A	116	N/A	492	

For Community the sickness rate is above target. This is due to long term sickness within the Stroke Unit and Community Nursing which is being closely managed via Occupational Health and HR processes.

Community Services is based on a block contract and consistently overperforming. Negotiations with CCG continue around demand and capacity, particularly around community nursing and therapy services.

Isle of Wight NHS Trust Board Performance Report 2014/15

August 14

Performance Summary - Mental Health

Isle of Wight NHS Trust

Balance Scorecard - Mental Health

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% of CPA patients receiving FU contact within 7 days of discharge	Aug-14	95%	100%	95%	97%	
% of CPA patients having formal review within 12 months	Aug-14	95%	100%	95%	N/A	
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	Aug-14	95%	100%	95%	99%	
RTT Non Admitted - % within 18 Weeks	Aug-14	95%	91%	95%	95%	
RTT Incomplete - % within 18 Weeks	Aug-14	92%	100%	92%	99%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Aug-14	3%	5.69%	3%	4.10%	
FTE vs Budget						
Appraisals	Aug-14		0.9%		60.8%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast

Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Mental Health Inpatient Activity	Aug-14	N/A	39	N/A	230	
Mental Health Outpatient Activity	Aug-14	N/A	372	N/A	2,512	

For mental health and learning disabilities, the sickness rate is above target. This is mainly long term sickness in the Community Mental Health Services which is being closely managed via Occupational Health and HR processes.

Mental Health/Learning Disabilities is currently funded on a block contract. We are in the process of moving to payment by results (PBR) and cluster based activity hence activity data is not representative.

Isle of Wight NHS Trust Board Performance Report 2014/15

August 14

Performance Summary - Ambulance and 111

Isle of Wight NHS Trust

Balance Scorecard - Ambulance & 111

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Category A 8 Minute Response Time (Red 1)	Aug-14	75%	72.5%	75%	82.0%	
Category A 8 Minute Response Time (Red 2)	Aug-14	75%	72.2%	75%	74.7%	
Category A 19 Minute Response Time	Aug-14	95%	95.2%	95%	95.9%	
Ambulance re-contact rate following discharge from care by telephone	Aug-14	3%	2.9%	3%	4.6%	
Ambulance re-contact rate following discharge from care at scene	Aug-14	2%	5.1%	2%	3.8%	
Ambulance time to answer call (in seconds) - median	Aug-14	1	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 95th percentile	Aug-14	5	3	N/A	N/A	
Ambulance time to answer call (in seconds) - 99th percentile	Aug-14	14	21	N/A	N/A	
NHS 111 Call abandoned rate	Aug-14	5%	2.9%	5%	2.1%	
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	Aug-14	95%	94.6%	95%	96.2%	
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	Aug-14	95%	97.3%	95%	97.3%	
NHS 111 Where the above is not achieved callers should be called back within 10 mins	Aug-14	100%	50.0%	100%	46.3%	

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Number of Ambulance Handover Delays between 1-2 hours	Aug-14		6		24	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Aug-14	3%	7.36%	3%	5.35%	
Appraisals	Aug-14		11.9%		45.7%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast

The Ambulance Service has consistently achieved the national standards of 75% and 95% on a monthly basis for the last two years however August 2014 saw the service standard of 75% drop to 72%. Although activity levels were no greater than planned, upon examination of the failure it has been identified that a number of key factors influenced our ability to reach and maintain these standards. The key area identified; during the month of June / July 2014 five individual members of staff tendered their resignations. This led to an 8% shortage of staffing levels on the front line Ambulances in August whilst we awaited the arrival of the newly recruited staff, coupled with a higher than average sickness level of 7% meant we were unable to cover the available shifts to ensure we met the targets. A full action plan has been implemented to prevent any further decline and measures are in place to give the service the best possible chance of achieving the required standards in September. Our NHS 111 service has also seen a very slight dip in performance standards achieving 94 % of the required 95 %, however this was still one of the best performing services in the UK for the month of August based on national statistics. On examination this was influenced by acute peaks in activity at key times coupled with above average sickness 4%. We have measures in place to address these performance issues and do not expect a repeat for September.

Highlights

- **No cases of Clostridium Difficile during August**
- **Emergency care 4 hour standard within target**
- **Venous Thrombo-Embolism (VTE) risk assessment achievement maintained**
- **Stroke patients (90% of stay on stroke unit) maintained**
- **100% Mental Health patient admissions with access to Crisis Resolution / Home Treatment Teams (HTTs)**

Lowlights

- **Category A 8 minutes ambulance response time is below the 75% target**
- **66.7% Patient treated after screening referral <62 days**
- **Referral ToTreatment Time Admitted, Non-Admitted and Incompletes below target**
- **Staff sickness remains above plan**

Commentary:

General: Numbers are reviewed for both the current and previous month and there may be changes to previous figures once validated. Pressure ulcer figures also contribute to the Safety Thermometer and are included within the clinical incident reporting, where any change is also reflected.

Hospital acquired*:* Although there were slight reductions to the numbers of grade 1 Pressure Ulcers, (with no reduction to other grades) the overall target of 25% reduction is still within trajectory for the year to date. There were no reductions to incidence of other grades and the monthly target reductions have not been achieved. The grade 4 lesions were recorded on Stroke Unit and Whippingham ward.

Community acquired: No improvement on baseline in grades 1 or 2 pressure ulcers were achieved during August, and grade 3 and 4 pressure ulcers were the same level as last year. The grade 4 lesions were recorded from Cowes and Ryde District Nursing areas.

Incidence figures are starting to be produced for community caseloads, but this is highly retrospective as it relies on the collation of a large quantity of data from all the district nursing bases.

A small number of pressure ulcers during July and August have been reported as "Ungradable" (meaning that they are indeterminate in grade, but usually at least grade 3 or 4) and their final grade will be determined once patient tracking has finished.

Explanation of RAG Rating

Red = Any G4 or 2 G3 or 5 any in rolling 3 months period

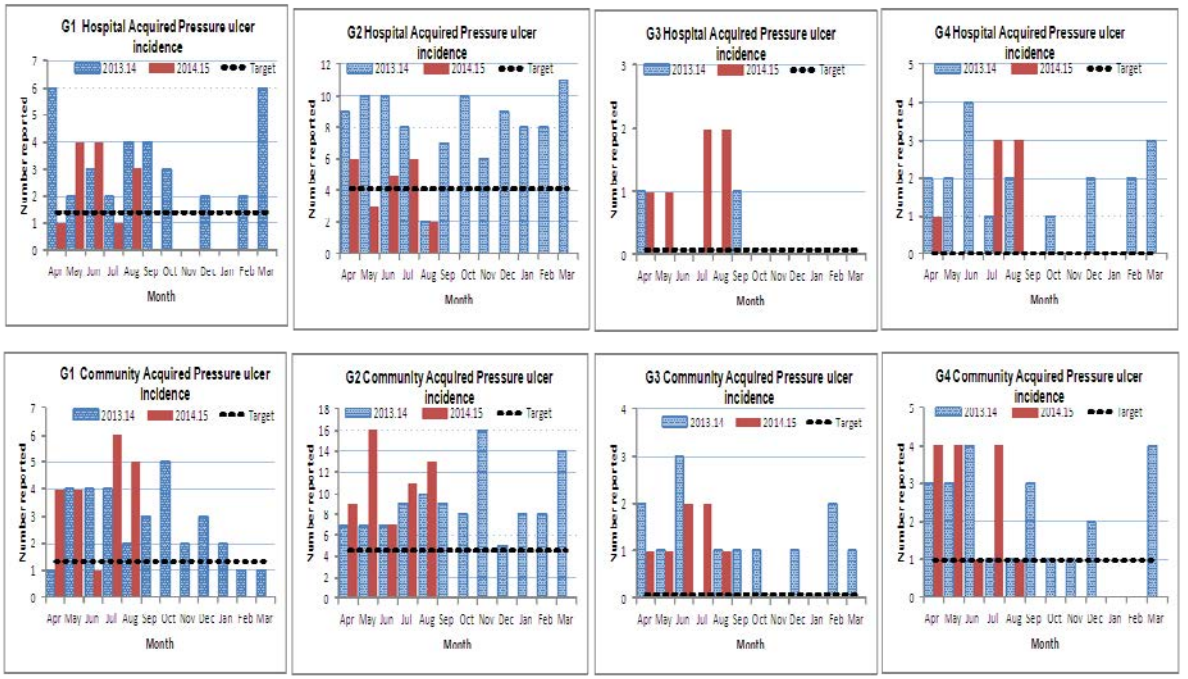
Amber = 1 G3 or increase/no change in G2 in rolling 3 months period

Green = No G3 or G4 and decrease in G2 or 2 or less of any grade (1&2) in rolling 3 months period

Analysis:

~~Quality Account Priority 2 & National Safety Thermometer CQUIN Schemes~~

Prevention & Management of Pressure Ulcers



Action Plan:	Person Responsible:	Date:	Status:
Ward care plans are reviewed as part of tissue viability auditing process. Results are being fed back to individual ward areas to support ward improvement. The auditing has widened to include the Malnutrion & Undernourishment Screening Tool (MUST).	Executive Director of Nursing & Workforce/ Tissue Viability Specialist Nurse	Aug-14	Continuing
The public awareness campaign has started with the inclusion of awareness posters in the free Isle of Wight Health & Wellbeing Directory which has been widely distributed recently. The aim is to inform and encourage mobility and prevention of pressure injury at all levels.	Executive Director of Nursing & Workforce/ Tissue Viability Specialist Nurse	Aug-14	Continuing

Isle of Wight NHS Trust Board Performance Report 2014/15

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Patient Safety

Commentary:

Clostridium difficile

There were no cases of Healthcare Acquired Clostridium Difficile (C. Diff) in the hospital during August 2014, howewer an additional case has been attributed to the Trust for July giving a YTD of 5. This exceeds the planned trajectories for both our nationally set year threshold (6) and our local stretched target (4). Maintaining zero tolerance for the rest of year to remain within these targets will be particularly challenging.

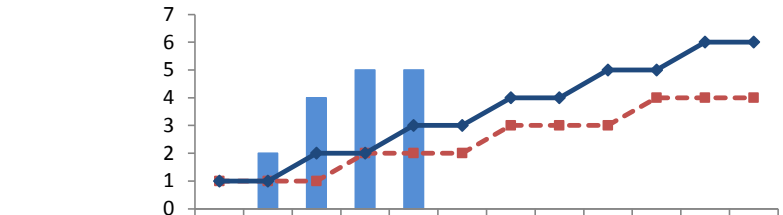
Major work is underway ensuring awareness of lessons learned from the investigations is disseminated along with additional bowel care training and heightened communications where appropriate.

Methicillin-resistant Staphylococcus Aureus (MRSA)

There have been no cases of Healthcare Acquired MRSA bacteraemia in the Acute hospital during August and we remain at zero, in keeping with the zero tolerance set for this year.

Analysis: **Clostridium Difficile infections against national and local targets**

Isle of Wight NHS Trust C. Difficile cases (Cumulative)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total cases	0	2	4	5	5							
Local Target	1	1	1	2	2	2	3	3	3	4	4	4
National Target	1	1	2	2	3	3	4	4	5	5	6	6

Isle of Wight NHS Trust

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

Action Plan:	Person Responsible:	Date:	Status:
Additional bowel care training and heightened dissemination of lessons learned from investigations	Executive Director of Nursing & Workforce	Aug-14	In progress
Increased infection control audits and commode checks have been instigated and are monitored by Modern Matrons and ward sisters across the acute hospital.	Executive Director of Nursing & Workforce	Aug-14	Onging
All cases continue to be subject to root cause analysis to identify actions necessary to ensure the trajectory remains achieved.	Executive Director of Nursing & Workforce	Aug-14	Ongoing

Commentary:

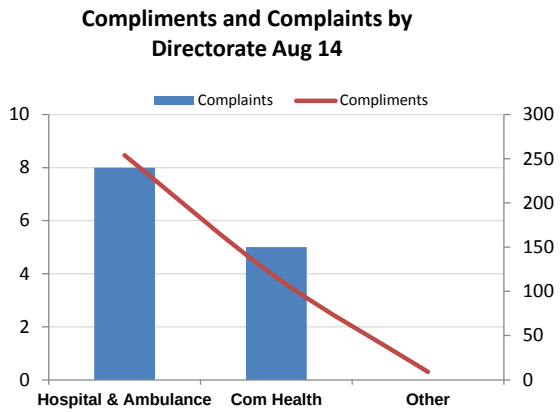
There were 13 formal Trust complaints received in August 2014 (17 in the previous month) against approximately 45,000 patient contacts (Inpatient episodes, all outpatient, A&E attendances and community contacts), with 379 compliments received by letters and cards of thanks across the same period.

Across all complaints and concerns in August 2014:
Top areas complained about were:
- Outpatient appointments/records unit (27)
- Orthopaedics (7)
- Emergency Department (7)
- Pre-assessment unit and admissions (5)

Across all complaints and concerns in August 2014:
Top subjects complained about were:
- Clinical care (31)
- Out-patient appointment delay/cancellation (11)
- Communication (35)

These are the same top subjects as last month.

Analysis: Complaints only



Primary Subject	Jul-14	Aug-14	CHANGE	RAG rating
Clinical Care	8	10	2	↑
Nursing Care	1	1	0	→
Staff Attitude	1	1	0	→
Communication	3	1	-2	↓
Outpatient Appointment Delay/ Cancellation	1	0	-1	✓
Inpatient Appointment Delay / Cancellation	0	0	0	✓
Admission / Discharge / Transfer Arrangements	1	0	-1	✓
Aids and appliances, equipment and premises	1	0	-1	✓
Transport	0	0	0	✓
Consent to treatment	0	0	0	✓
Failure to follow agreed procedure	0	0	0	✓
Hotel services (including food)	0	0	0	✓
Patients status/discrimination (e.g. racial, sex)	0	0	0	✓
Privacy & Dignity	0	0	0	✓
Other	1	0	-1	✓

Action Plan:	Person Responsible:	Date:	Status:
Patient Experience Officers have now relocated to the main reception area of the hospital to improve accessability. Scoping has been undertaken on Estates Works required (including sound proofing) and quotes received. Works are ahead of schedule and are likely to finish early (before end September 2014)	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Oct-14	In progress

Isle of Wight NHS Trust Board Performance Report 2014/15

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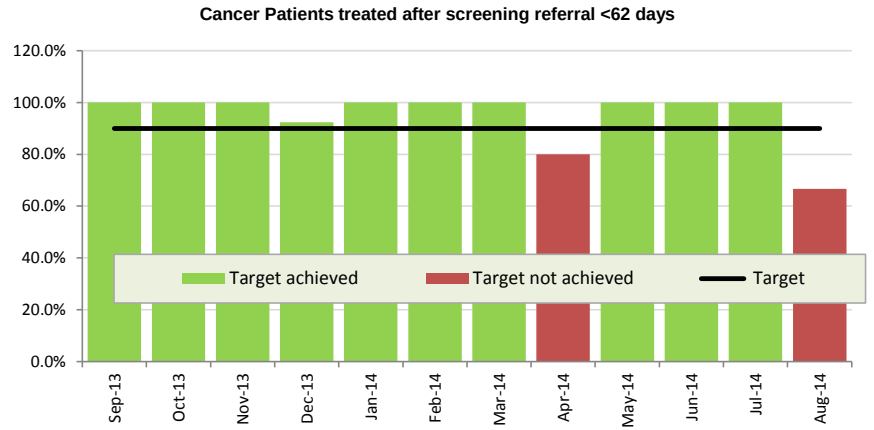
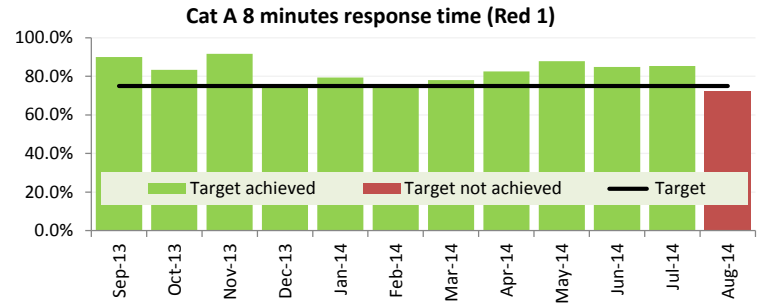
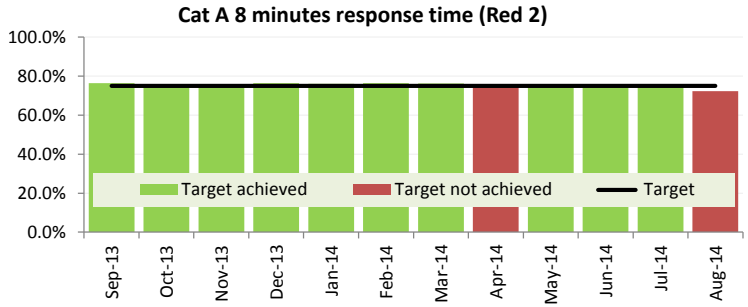
Cancer - Patient treated after screening referral <62 days

Isle of Wight NHS Trust

Commentary:	Analysis:
All August figures are still provisional. 20 of the total 24 breaches (83%) during August were patient led with a further 1 hospital led breach. **Cancer Patients treated after screening referral <62 days (90% target)** 0.5 colorectal breach (breach shared with Portsmouth) - Complex diagnostic pathway and patient choice to defer surgery	

Action Plan:	Person Responsible:	Date:	Status:
At the present time there are 3 Locum Consultants employed until December 2014 providing stability for 3 months. The substantive Haematology Consultant posts continues to be advertised.	General Manager, Pathology	Dec-14	Continuing

Commentary:	Analysis:
The percentage of Category A 8 minutes response time is below the 75% target for both Red 1 (72.5%) and Red 2 (72.2%) categories during August 2014 (79.2% total). The Ambulance Service has consistently achieved the national standards of 75% and 95% on a monthly basis for the last two years however August 2014 saw the service standard of 75% drop to 72%. Although activity levels were no greater than planned, upon examination of the failure it has been identified that a number of key factors influenced our ability to reach and maintain these standards. A full action plan has been implemented to prevent any further decline and measures are in place to give the service the best possible chance of achieving the required standards in September.	 

Action Plan:	Person Responsible:	Date:	Status:
Continuous monitoring of performance targets, amending REAP (Resourcing Escalatory Action Plans) level as appropriate and sharing status with fellow Senior Managers and increase staffing levels	Service Delivery Manager, Performance Support Officers, Clinical Support Officers	Aug-14	Ongoing
Increased availability of Clinical Support Desk (CSD) – all CSD trained staff to be logged on and available to take calls, support crews, and assist with clinically smart dispatch	Lead Clinical Support Officer and NHS 111 Lead	Aug-14	Ongoing
Documented Performance Review Meetings (PRM) increased from once daily to three times daily	Service Delivery Manager, Performance Support Officers (Operational) & Performance Support Officers (Hub)	Aug-14	Ongoing
Monitor resource “on-scene” times and turnaround times at St Mary's Hospital	Clinical Support Desk, Dispatcher & Performance Support Officers (Hub)	Aug-14	Ongoing

Isle of Wight NHS Trust Board Performance Report 2014/15

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Theatre Utilisation

Isle of Wight NHS Trust

Commentary	**Analysis:**
The percentage utilisation of theatre facilities remains below the 83% target for both Main (79.8%) and Day theatres (78.4%) during August 2014 (79.2% total). The main contributory factor to this has been bed capacity. Delays are continuing to be experienced with patients being admitted in timely fashion into beds, as elective admissions have been reliant on discharges occuring on the day of admission. Orthopaedic elective ward has been limited to one bay of 6, and up to 4 side rooms if available to manage single sex throughput, limiting orthopaedic activity. Cancellations on day have also occured due to bed capacity. In addition Pre-Assessment Unit admission booking staff continue from last month to have low staffing levels, impacting on utilisation being booked due to sickness, leave and unfilled vacancy. The reports remains similar to that provided in July 2014. There were two whole lists cancelled due to unavailable anaesthetists despite efforts made to find cover for the General Anaesthetic cases. The microscope for Ophthalmic patients also failed impacting on list utilisation in day surgery.	

Action plan	**Person Responsible:**	**Date:**	**Status:**
1)Review of Pre-Assessment Unit staffing levels 2) Speciality based action plans developed by each general manager to review 18 weeks activity	General manager- Planned Directorate	Jul / Aug-14	Continuing
Ongoing discussion on review of bed capacity for elective surgery. No identified changes to estates plan due to schedule risks. Ongoing monitor of inpatient delays for discharge with significant incident/bed management meetings.	General manager- Planned Directorate	Aug-14	Continuing

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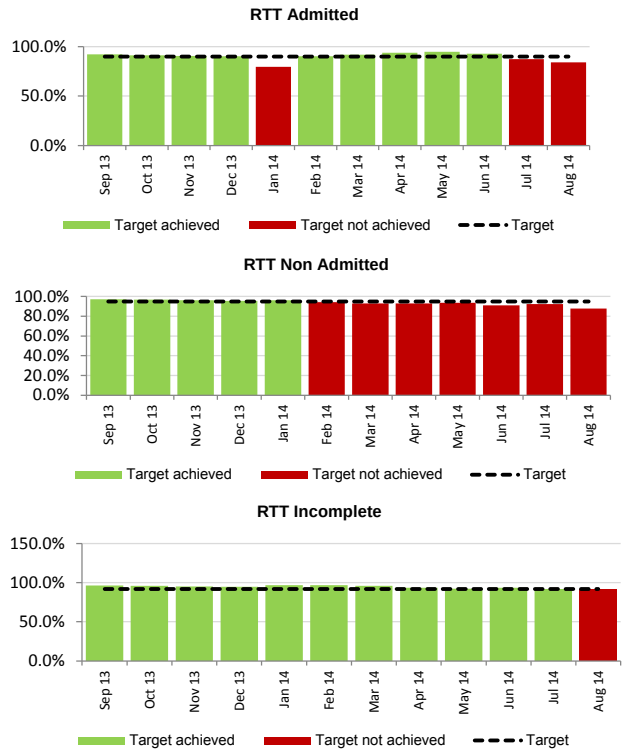
Referral to Treatment Times

Isle of Wight NHS Trust

Commentary:

We are moving towards the end of the period that The National Funding described in recent reports to reduce waiting times over 16 weeks covered. We are predicting Non-Admitted recovery in October and Admitted recovery in November. Significant resource has been put into validation of 18 week pathways and increasing Out Patient and Inpatient capacity in order to achieve these targets.
The data quality issues highlighted by the forecasting tools developed by Performance Information & Decision Support (PIDS) have been addressed, with new procedures in place in most Out Patient clinics and daily validation taking place in the booking teams. Over 2000 pathways have been closed as a result of validation and it is anticipated that the position in Septembers will be an accuracte reflection of our capacity to treat in turn.
The Admitted return continues to fail due to a build up of over 18 week waits in Urology and Trauma & Orthopaedics especially as a result of bed pressures 3 months ago. Plans are in place to address this but continued pressures in the Orthopaedic wards means that we do not expect the Admitted RTT target to be achieved for this specialty until March.

Analysis:



	Person Responsible:	Date:	Status:
Further development of forecasting tools to match demand and capacity and highlight further data quality issues. This is an ongoing development but is already successful in some areas.	Senior Information Analyst (PIDS)	Sep-14	In progress
Engagement with clinicians to ensure that accurate data is communicated to administrators for data capture through revision of Referral to Treatment coding forms. Implemented and in trial period.	OPARU Lead/ Clinical Leads	Sep-14	In progress
Additional capacity for Non admitted & Admitted patients will be put in place to reduced patients waiting over 16 weeks funded via additional CCG Referral To Treatment monies which has been made available nationally. Ongoing.	General Access Lead & General Managers	Sep-14	Planned
Referral To Treatment times awareness session with Portsmouth Hospital Trust and General Managers. Completed.	Access Lead / General Managers	Sep-14	Completed
Development of robust processes and documentation to enable training and awareness of 18 week procedures. Still to be implemented.	Information Systems	Aug-14	In progress

Isle of Wight NHS Trust Board Performance Report 2014/15

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Benchmarking of Key National Performance Indicators: Summary Report

Isle of Wight NHS Trust

	National Target	National Performance			IW Performance	IW Rank	IW Status	Data Period
		Best	Worst	Eng				
Emergency Care 4 hour Standards	95%	100%	78%	94.5%	97.2%	47 / 174	Better than national average	Aug-14
RTT:% of admitted patients who waited 18 weeks or less	90%	100%	0%	88.4%	87.3%	121 / 168	Amber Red	Jul-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	100%	67%	95.8%	92.3%	181 / 197	Bottom Quartile	Jul-14
RTT % of incomplete pathways within 18 weeks	92%	100%	57%	93.3%	92.0%	166 / 194	Bottom Quartile	Jul-14
%. Patients waiting > 6 weeks for diagnostic	1%	0%	19%	1.7%	0.0%	1 / 183	Top Quartile	Jul-14
Ambulance Category A Calls % < 8 minutes - Red 1	75%	85%	66%	70.8%	85.3%	1 / 11	Top Quartile	Jul-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	76%	60%	68.7%	75.6%	1 / 11	Top Quartile	Jul-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	76%	60%	68.9%	76.1%	1 / 11	Top Quartile	Jul-14
Ambulance Category A Calls % < 19 minutes	95%	97%	89%	94.0%	96.2%	2 / 11	Top Quartile	Jul-14
Cancer patients seen <14 days after urgent GP referral*	93%	100%	76%	93.5%	94.2%	97 / 156	Better than national average	Qtr 1 14/15
Cancer diagnosis to treatment <31 days*	96%	100%	91%	97.8%	98.4%	87 / 160	Better than national average	Qtr 1 14/15
Cancer urgent referral to treatment <62 days*	85%	100%	65%	84.1%	85.7%	82 / 156	Better than national average	Qtr 1 14/15
Symptomatic Breast Referrals Seen <2 weeks*	93%	100%	17%	90.6%	83.3%	126 / 138	Bottom Quartile	Qtr 1 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	100%	75%	96.2%	100.0%	1 / 157	Top Quartile	Qtr 1 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100%	94%	99.7%	100.0%	1 / 148	Top Quartile	Qtr 1 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	100%	0%	90.5%	100.0%	1 / 150	Top Quartile	Qtr 1 14/15
Cancer Patients treated after screening referral <62 days*	90%	100%	29%	93.8%	85.7%	125 / 145	Bottom Quartile	Qtr 1 14/15
VTE Risk Assessment	95%	100%	87%	96.0%	99.7%	7 / 164	Top Quartile	Q1 14/15

Key:

Better than National Target =	Green
Worse than National Target =	Red

Top Quartile =	Green
Median Range Better than Average =	Amber Green
Median Range Worse than Average =	Amber Red
Bottom Quartile	Red

Commentary:

Breat Cancer Referrals Seen<2 weeks - target failing primarily due to capacity issues. This has now been rectified and we have achieved the target in August 2014

Cancer Patients treated after screening referral <62 days - during the last 12 months we have failed the target twice. 80% in April 2014 - 1 pt led breach - pt declined offer of admitted care and returned to local provided for treatment outside of target date. 66.7% in August 2014 - 0.5 breach (breach shared with Portsmouth) - Complex diagnostic pathway and patient choice to defer surgery

Detailed plans have been developed to tackle problems with the RTT target. These include extensive validation of patients on the incomplete waiting list along with increasing capacity to reduce the number of patients waiting over 16 weeks. As a result of these actions we expect to be delivering against the non admitted target in October, the admitted target in November and be in a position to sustain performance going forward.

Isle of Wight NHS Trust Board Performance Report 2014/15

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Benchmarking of Key National Performance Indicators: IW Performance Compared To Other 'Small Acute Trusts'

Isle of Wight NHS Trust

Other Small Acute Trusts	National Target	IW	RA3	RA4	RBD	RBT	RBZ	RC1	RC3	RCD	RCF	RCX	RD8	RE9	RFF	RFW	RGR	RJC	RJD	RJF	RJN	RLQ	RLT	RMP	RN7	RNQ	RNZ	RQQ	RQX	Data Period
Emergency Care 4 hour Standards	95%	97.2% 6	89.1% 26	95.4% 20	97.2% 5	95.4% 19	96.6% 9	96.7% 7	98.2% 1	98.0% 3	95.8% 15	92.9% 25	93.7% 24	97.9% 4	96.3% 11	98.1% 2	95.4% 21	96.3% 10	86.0% 27	96.0% 14	94.8% 22	85.3% 28	94.8% 23	95.7% 17	95.7% 16	96.6% 8	95.6% 18	96.1% 12	96.1% 13	Aug-14
RTT:% of admitted patients who waited 18 weeks or less	90%	87.3% 21	83.7% 26	88.8% 19	83.9% 25	94.0% 9	91.4% 13	90.1% 17	77.7% 28	94.7% 6	92.5% 10	90.3% 16	94.1% 8	95.9% 2	94.9% 5	96.4% 1	89.5% 18	91.0% 15	91.3% 14	81.8% 27	86.8% 22	86.5% 23	91.5% 12	87.7% 20	91.8% 11	95.9% 3	86.5% 24	95.5% 4	94.3% 7	Jul-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	92.3% 28	95.5% 24	95.1% 26	97.7% 9	95.5% 25	96.3% 18	96.0% 22	92.7% 27	97.1% 15	96.1% 21	97.8% 7	96.3% 19	98.5% 4	97.7% 10	97.4% 12	98.1% 5	96.2% 20	97.1% 14	98.8% 3	96.5% 17	99.5% 1	95.7% 23	98.1% 6	97.7% 8	97.2% 13	97.0% 16	99.5% 2	97.5% 11	Jul-14
RTT % of incomplete pathways within 18 weeks	92%	92.0% 26	86.4% 27	95.2% 18	94.6% 20	96.3% 9	93.2% 24	94.0% 22	94.7% 19	97.3% 4	92.1% 25	94.6% 21	95.7% 16	94.0% 23	96.2% 11	96.2% 10	96.5% 7	96.0% 12	97.5% 3	95.8% 15	96.0% 14	96.0% 13	95.4% 17	N/A	96.3% 8	98.3% 2	96.5% 6	98.6% 1	96.8% 5	Jul-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.0% 1	0.0% 1	0.5% 19	6.9% 28	0.1% 12	0.2% 13	0.4% 18	0.0% 1	0.4% 17	0.0% 1	0.9% 24	0.6% 21	0.4% 16	6.4% 27	0.0% 1	0.0% 9	0.9% 25	0.9% 26	0.0% 1	0.2% 14	0.8% 22	0.1% 10	0.8% 23	0.1% 11	0.6% 20	0.0% 7	0.3% 15	0.0% 8	Jul-14
Cancer patients seen <14 days after urgent GP referral*	93%	94.2% 20	96.1% 11	93.2% 23	95.2% 15	95.0% 16	76.7% 28	82.3% 27	91.5% 25	98.6% 1	97.6% 6	97.2% 9	94.1% 21	96.5% 10	93.7% 22	94.7% 18	98.6% 4	93.1% 24	95.6% 14	97.2% 8	98.6% 3	89.9% 26	95.7% 13	97.6% 5	94.3% 19	97.5% 7	94.9% 17	98.6% 2	95.9% 12	Qtr 1 14/15
Cancer diagnosis to treatment <31 days*	96%	98.4% 23	99.4% 13	97.0% 26	100.0% 1	99.6% 10	99.1% 15	100.0% 1	98.8% 19	100.0% 1	98.9% 17	99.3% 14	96.7% 27	100.0% 1	99.5% 11	100.0% 1	100.0% 1	94.0% 28	100.0% 1	97.4% 24	98.9% 17	98.6% 21	99.4% 12	98.8% 20	100.0% 1	100.0% 1	97.3% 25	98.4% 22	98.9% 16	Qtr 1 14/15
Cancer urgent referral to treatment <62 days*	85%	85.7% 18	86.6% 16	89.3% 10	81.8% 24	89.7% 9	79.6% 26	87.6% 14	85.9% 17	93.8% 1	90.5% 7	88.5% 11	84.0% 20	88.2% 13	88.3% 12	77.3% 27	91.6% 4	80.8% 25	90.0% 8	85.7% 19	91.8% 3	77.0% 28	83.8% 22	92.6% 2	91.0% 5	83.2% 23	86.9% 15	90.8% 6	83.9% 21	Qtr 1 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	83.3% 24	87.2% 23	93.1% 19	94.8% 13	94.9% 12	26.5% 27	51.1% 26	93.7% 16	97.4% 6	97.2% 7	96.0% 9	93.1% 17	N/A	95.3% 11	98.4% 3	96.4% 8	91.1% 22	94.4% 15	98.7% 1	91.6% 21	68.8% 25	92.1% 20	97.5% 5	94.8% 14	98.6% 2	93.1% 18	97.7% 4	95.7% 10	Qtr 1 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	100.0% 1	100.0% 1	97.6% 21	94.4% 25	100.0% 1	95.8% 22	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	94.7% 24	100.0% 1	86.2% 27	100.0% 1	75.0% 28	100.0% 1	95.7% 23	91.7% 26	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	Qtr 1 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	95.5% 28	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	99.3% 27	100.0% 1	100.0% 1	100.0% 1	Qtr 1 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	N/A	68.8% 23	90.0% 15	N/A	93.3% 10	87.5% 17	100.0% 1	96.6% 6	100.0% 1	92.9% 11	80.0% 20	100.0% 1	50.0% 24	94.1% 9	78.6% 22	100.0% 1	90.9% 14	100.0% 1	0.0% 25	95.8% 7	82.4% 19	85.7% 18	95.1% 8	91.7% 13	80.0% 20	92.3% 12	N/A	88.1% 16	Qtr 1 14/15
Cancer Patients treated after screening referral <62 days*	90%	85.7% 20	100.0% 1	66.7% 24	100.0% 1	96.9% 14	71.4% 23	90.0% 18	80.0% 21	100.0% 1	100.0% 1	98.3% 10	90.3% 17	N/A	97.3% 12	62.5% 25	96.9% 13	89.3% 19	100.0% 1	100.0% 1	97.9% 11	100.0% 1	94.4% 16	N/A	100.0% 1	95.2% 15	100.0% 1	80.0% 21	N/A	Qtr 1 14/15
VTE Risk Assessment	95%	99.7% 1	96.6% 14	97.6% 10	95.9% 18	99.2% 4	95.8% 20	93.2% 25	95.9% 19	97.7% 8	N/A	97.5% 11	96.6% 15	97.6% 9	N/A	95.1% 24	99.9% 1	96.5% 16	97.0% 13	N/A	98.9% 5	95.2% 22	95.2% 23	95.6% 21	96.0% 17	98.4% 6	99.3% 3	98.3% 7	97.2% 12	Qtr 1 14/15

Key: Better than National Target = Green
Worse than National Target = Red
Target Not Applicable for Trust = N/A

Note the large font figure represents the Trusts performance and the small font figure represents the Trust Ranking out of the 28 other small acute trusts

R1F	ISLE OF WIGHT NHS TRUST
RA3	WESTON AREA HEALTH NHS TRUST
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST
RC1	BEDFORD HOSPITAL NHS TRUST
RC3	EALING HOSPITAL NHS TRUST
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST
RCF	AIREDALE NHS FOUNDATION TRUST
RCX	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS TRUST
RD8	MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST
RFW	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
RGR	WEST SUFFOLK NHS FOUNDATION TRUST
RJC	SOUTH WARWICKSHIRE GENERAL HOSPITALS NHS TRUST
RJD	MID STAFFORDSHIRE NHS FOUNDATION TRUST
RJF	BURTON HOSPITALS NHS FOUNDATION TRUST
RJN	EAST CHESHIRE NHS TRUST
RLQ	WYE VALLEY NHS TRUST
RLT	GEORGE ELIOT HOSPITAL NHS TRUST
RMP	TAMESIDE HOSPITAL NHS FOUNDATION TRUST
RN7	DARTFORD AND GRAVESHAM NHS TRUST
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
RNZ	SALISBURY NHS FOUNDATION TRUST
RQQ	HINCHINGBROOKE HEALTH CARE NHS TRUST
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

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Isle of Wight NHS Trust

Benchmarking of Key National Performance Indicators: IW Performance Compared To Other Trusts in the 'Wessex Area'

	National Target	IW	R1C	RBD	RD3	RDY	RDZ	RHM	RHU	RN5	RW1	Data Period
Emergency Care 4 hour Standards	95%	97.2% 5	100.0% 1	97.2% 4	92.6% 8	99.9% 2	95.6% 6	88.7% 9	85.0% 10	93.5% 7	99.1% 3	Aug-14
RTT:% of admitted patients who waited 18 weeks or less	90%	87.3% 8	99.1% 1	83.9% 9	95.2% 4	96.4% 3	88.7% 7	82.9% 10	91.9% 5	91.0% 6	98.3% 2	Jul-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	92.3% 10	99.2% 2	97.7% 5	96.5% 8	98.1% 4	98.2% 3	94.0% 9	97.1% 6	96.9% 7	99.5% 1	Jul-14
RTT % of incomplete pathways within 18 weeks	92%	92.0% 10	99.1% 1	94.6% 8	97.0% 4	98.8% 3	94.8% 7	92.0% 9	95.5% 6	95.8% 5	98.9% 2	Jul-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.0% 1	0.0% 1	6.9% 9	0.3% 7	0.1% 4	0.2% 6	0.1% 5	12.4% 10	0.6% 8	0.0% 1	Jul-14
Cancer patients seen <14 days after urgent GP referral*	93%	94.2% 6	N/A	95.2% 3	94.3% 5	N/A	92.9% 7	94.9% 4	97.1% 2	97.3% 1	N/A	Qtr 1 14/15
Cancer diagnosis to treatment <31 days*	96%	98.4% 5	N/A	100.0% 1	99.1% 3	N/A	98.4% 4	96.0% 7	98.2% 6	99.1% 2	N/A	Qtr 1 14/15
Cancer urgent referral to treatment <62 days*	85%	85.7% 5	N/A	81.8% 6	88.9% 3	N/A	87.4% 4	80.0% 7	89.3% 2	90.3% 1	N/A	Qtr 1 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	83.3% 7	N/A	94.8% 3	93.4% 5	N/A	96.7% 1	93.6% 4	92.6% 6	95.7% 2	N/A	Qtr 1 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	100.0% 1	N/A	94.4% 6	98.0% 3	N/A	94.1%	94.8% 5	97.1% 4	100.0% 1	N/A	Qtr 1 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% 1	N/A	100.0% 1	100.0% 1	N/A	100.0% 1	99.6% 7	100.0% 1	100.0% 1	N/A	Qtr 1 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	N/A	N/A	N/A	100.0% 1	N/A	100.0% 1	94.9% 3	94.4% 4	88.0% 5	N/A	Qtr 1 14/15
Cancer Patients treated after screening referral <62 days*	90%	85.7% 7	N/A	100.0% 1	94.0% 5	N/A	94.5% 4	95.0% 3	93.8% 6	97.9% 2	N/A	Qtr 1 14/15
VTE Risk Assessment	95%	99.7% 1	N/A	95.9% 5	97.4% 3	N/A	95.2% 8	95.6% 7	96.5% 4	95.8% 6	97.5% 2	Qtr 1 14/15

Key: Better than National Target = Green
Worse than National Target = Red

Note the large font figure represents the Trusts performance and the small font figure represents the Trust Ranking out of the 10 other trusts in the Wessex area

R1F	Isle Of Wight NHS Trust
R1C	Solent NHS Trust
RBD	Dorset County Hospital NHS Foundation Trust
RD3	Poole Hospital NHS Foundation Trust
RDY	Dorset Healthcare University NHS Foundation Trust
RDZ	The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust
RHM	University Hospital Southampton NHS Foundation Trust
RHU	Portsmouth Hospitals NHS Trust
RN5	Hampshire Hospitals NHS Foundation Trust
RW1	Southern Health NHS Foundation Trust

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Benchmarking of Key National Performance Indicators: Ambulance Performance

	National Target	IW Performance	RX9	RYC	RRU	RX6	RX7	RYE	RYD	RYF	RYA	RX8	Data Period
Ambulance Category A Calls % < 8 minutes - Red 1	75%	85.3% 1	70.7% 7	66.3% 11	70.3% 8	70.7% 6	68.5% 10	75.5% 3	72.5% 5	73.7% 4	77.7% 2	69.2% 9	Jul-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	75.6% 1	71.6% 6	59.6% 11	60.4% 10	72.9% 5	69.2% 8	73.8% 4	71.0% 7	74.1% 3	74.2% 2	68.0% 9	Jul-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	76.1% 1	71.5% 6	60.0% 12	60.7% 12	72.9% 7	69.2% 10	73.9% 6	71.0% 9	74.0% 4	74.3% 3	68.0% 11	Jul-14
Ambulance Category A Calls % < 19 minutes	95%	96.2% 2	93.2% 10	89.3% 11	93.3% 9	94.7% 5	94.2% 7	95.7% 3	93.4% 8	94.6% 6	96.7% 1	95.1% 4	Jul-14

Key: Better than National Target = Green
Worse than National Target = Red

RX9	East Midlands Ambulance Service NHS Trust
RYC	East of England Ambulance Service NHS Trust
R1F	Isle of Wight NHS Trust
RRU	London Ambulance Service NHS Trust
RX6	North East Ambulance Service NHS Foundation Trust
RX7	North West Ambulance Service NHS Trust
RYE	South Central Ambulance Service NHS Foundation Trust
RYD	South East Coast Ambulance Service NHS Foundation Trust
RYF	South Western Ambulance Service NHS Foundation Trust
RYA	West Midlands Ambulance Service NHS Foundation Trust
RX8	Yorkshire Ambulance Service NHS Trust

Commentary:

The information centre carry out an analysis of the quality of provider data submitted to Secondary Uses Service (SUS). They review 3 main data sets - Admitted Patient Care (APC), Outpatients (OP) and Accident & Emergency (A&E).

The latest information is up to June 2014. We have no red rated indicators in either the outpatient or A&E datasets but there are four in the Admitted Patient Care Dataset. In the APC dataset records with an invalid or missing NHS number has gone from amber to red this month, this is however a relatively small number and is likely to relate to prisoners as their NHS number is often unknown and difficult to trace. There is also a relatively small number of invalid or missing postcodes the reasons for this anomoly are unclear and will be reviewed and where possible corrected. The Primary Diagnosis and HRG4, (Healthcare Resource Grouping) are linked as you need the diagnosis to generate the HRG, the number missing has improved this month which reflects improvements to the timeliness of coding.

Analysis:

Total APC General Episodes: 6,227

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	95	98.5%	99.1%
Patient Pathway	124	93.7%	60.1%
Treatment Function	0	100.0%	99.7%
Main Specialty	0	100.0%	99.9%
Reg GP Practice	3	100.0%	99.9%
Postcode	50	99.2%	99.8%
Org of Residence	2	100.0%	98.8%
Commissioner	2	100.0%	99.5%
Primary Diagnosis	751	87.9%	97.7%
Primary Procedure	0	100.0%	99.5%
Ethnic Category	4	99.9%	97.4%
Site of Treatment	0	100.0%	96.7%
HRG4	765	87.7%	96.7%

Total Outpatient General Episodes: 40,899

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	216	99.5%	99.3%
Patient Pathway	18,364	51.5%	49.9%
Treatment Function	0	100.0%	99.8%
Main Specialty	0	100.0%	99.8%
Reg GP Practice	1	100.0%	99.9%
Postcode	2	100.0%	99.8%
Org of Residence	7	100.0%	95.1%
Commissioner	9	100.0%	99.3%
First Attendance	0	100.0%	99.7%
Attendance Indicator	0	100.0%	99.5%
Referral Source	236	99.4%	98.9%
Referral Rec'd Date	236	99.4%	96.0%
Attendance Outcome	9	100.0%	98.3%
Priority Type	236	99.4%	97.2%
OP Primary Procedure	0	100.0%	99.5%
Ethnic Category	27	99.9%	92.7%
Site of Treatment	0	100.0%	96.2%
HRG4	0	100.0%	99.2%

Total A&E Attendances 16,315

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	274	98.3%	95.1%
Registered GP Practice	4	100.0%	99.1%
Postcode	2	100.0%	98.9%
Org of Residence	171	99.0%	95.3%
Commissioner	237	98.5%	98.9%
Attendance Disposal	109	99.3%	98.0%
Patient Group	0	100.0%	95.5%
First Investigation	129	99.2%	94.0%
First Treatment	320	98.0%	92.8%
Conclusion Time	103	99.4%	97.6%
Ethnic Category	0	100.0%	92.6%
Departure Time	47	99.7%	99.7%
Department Type	0	100.0%	99.9%
HRG4	190	98.8%	95.7%

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:
Address backlog in clinical Coding	Head of Information / Asst. Director - PIDS	Sep-14	Ongoing
Review missing commissioner codes in A&E dataset		Sep-14	Ongoing

Data Quality - June 2014

Dataset	Measure	IW Performance	National	Threshold G	Threshold A	Threshold R	Status	Weighting	Score	Notes
APC	Total Invalid Data Items	4	n/a	=<2	>2 =<4	>4	A	2	1.0	Performance relates to the no. of Red rated data
APC	Valid NHS Number	98.5%	99.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	R	1	1.0	
APC	Valid Ethnic Category	99.9%	97.4%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Invalid Data Items	0	n/a	=<2	>2 =<5	>5	G	2	0.0	Performance relates to the no. of Red rated data
OP	Valid NHS Number	99.5%	99.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Valid Ethnic Category	99.9%	92.7%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Total Invalid Data Items	1	n/a	=<2	>2 =<4	>4	G	2	0.0	Performance relates to the no. of Red rated data
A&E	Valid NHS Number	98.3%	95.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Valid Ethnic Category	100.0%	92.6%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
	Total			= < 2	2 > = < 4	= > 4	G	12	2.0	

Source: Information Centre, SUS Data Quality Dashboard

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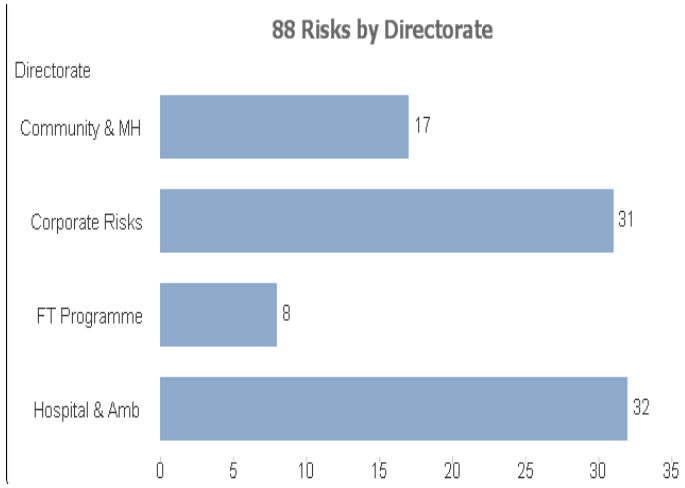
Risk Register -Situation current as at 23/09/2014

Isle of Wight NHS Trust

Analysis: This extract from the Risk register dashboard shows the highest rated risks (Rating of 20) across all Directorates and includes both clinical and non-clinical entries. Entries have been sorted according to the length of time on the register and demonstrate the number and percentage of completed actions.



Directorate	Added	Title	Actions	Done	%
HOSAMB	23/02/2011	Insufficient And Inadequate Endoscopy Facilities To Meet Service Requirements	9	7	78%
HOSAMB	20/10/2011	Insufficient And Inadequate Ophthalmology Facilities To Meet Service Requirements	6	4	67%
CORPRI	22/11/2011	Mandatory Training	6	5	83%
HOSAMB	16/08/2012	Blood Sciences Out-Of-Hours Staffing	4	3	75%
HOSAMB	22/08/2012	Risk Due To Bed Capacity Problems	4	3	75%
HOSAMB	24/10/2012	Failing Heating/Cooling System Impacting On Service Delivery	2	2	100%
COMMH	22/11/2012	Low Staffing Levels Within Occupational Therapy Acute Team	6	2	33%
HOSAMB	05/12/2012	Vacant Consultant Physician Posts	3	1	33%
CORPRI	26/03/2013	Pressure Ulcers	4	2	50%
HOSAMB	23/09/2013	Ophthalmic Casenotes - Poor Condition, Misfiling And Duplication Leading To Potential Clinical Error	4	2	50%
HOSAMB	21/01/2014	Acquisition Of Mechanical Device For Chest Compressions	4	3	75%
HOSAMB	30/04/2014	Maternity Theatre Inadequate Airflow Leading To Potential Infection Control Risk	3	1	33%
CORPRI	24/07/2014	Mandatory Resuscitation Training	6	0	0%
CORPRI	24/07/2014	Air Conditioning Unit In Network Core Room	5	1	20%
COMMH	28/08/2014	Safeguarding Children Team Capacity	6	0	0%
CORPRI	28/08/2014	Unsupported Desktop Environment	6	0	0%
HOSAMB	28/08/2014	Maxfax Dental Carts And Compressor No Longer Fit For Purpose	6	3	50%
HOSAMB	28/08/2014	Computer Aided Dispatch (Cad) Server And Software Update	4	0	0%

Data as at 23/09/2014 Risk Register Dashboard

Commentary

The risk register is reviewed monthly both at Trust Executive Committee/Directorate Boards and relevant Trust Executive sub-committee meetings. All risks on the register have agreed action plans with responsibilities and timescales allocated. The 'Open Risks' dashboard runs from a live feed and is updated daily. All Execs/Associate Directors/Senior Managers have access with full details of all risks, actions and progress available at all times. This report provides a 'snapshot' overview.

Since the last report eight new risks have been added to the register, although the table above shows only those with the highest level rating. These are (1) Computer Aided Dispatch Server and Software - Ambulance (2) Safeguarding Children Team Capacity (3) Unsupported Desktop Environment - IT (4) Maxfax Dental Carts and Compressors (5) Availability of Doctors to Support Second Recommendations for Assessments under Mental Health Act (6) Lack of Substantive Consultant Psychiatrist In Sevenacres (7) Coronary Care Unit Monitoring System (8) Osborne Ward Bathrooms. No risks have been signed off the risk register however RR540 Failing Heating/Cooling System Impacting on Service Delivery - will be going to the Hospital and Ambulance Quality and Risk meeting for sign off.

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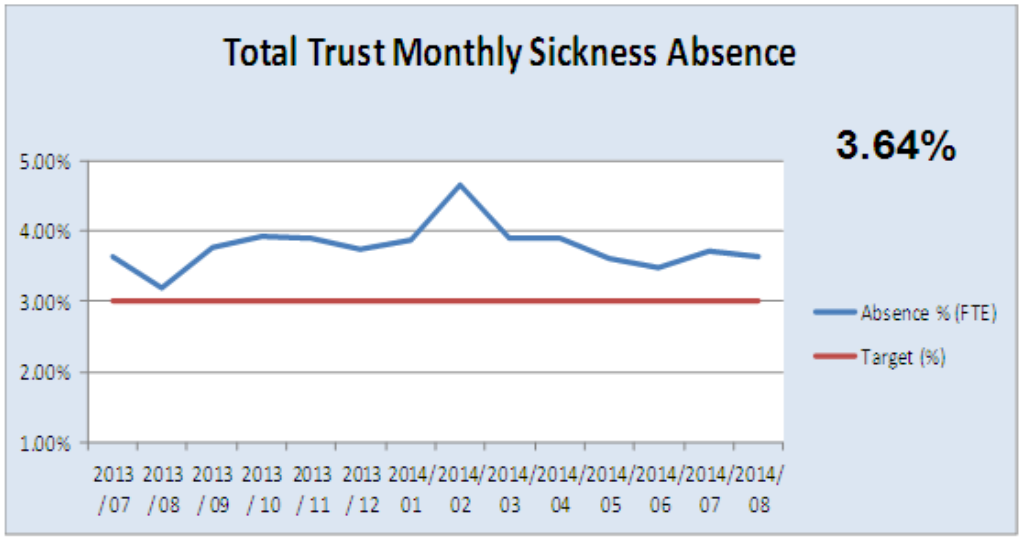
Workforce - Key Performance Indicators

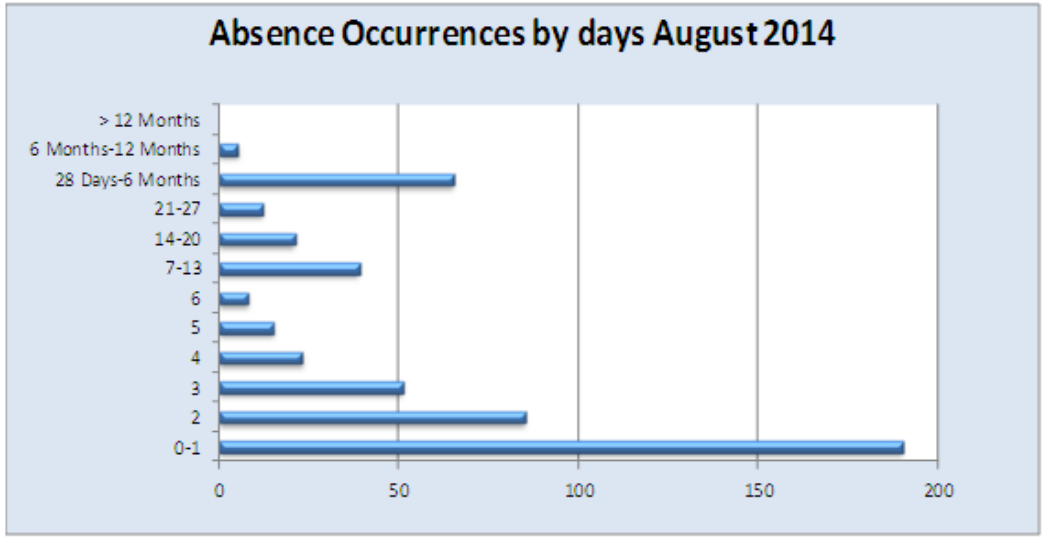
Measure	Period	Month Target/Plan	Month Actual	In Month Variance	RAG rating	In Month Final RAG Rating	Trend from last month
Workforce FTE	Aug-14	2616.64	2622.92	6.28			
Workforce Variable FTE	Aug-14	136.70	140.15	3.45			
Workforce Total FTE	Aug-14	2753.34	2763.07	9.73			
Finance	**Period**	**Month Target/Plan (£000's)**	Month Actual (£000's)	In Month Variance (£000's)	**RAG rating**	**Year-to Date Final RAG Rating**	
Total In Month Staff In Post Paybill	Aug-14	£9,599	£8,980	-£620			
In Month Variable Hours	Aug-14	£13	£636	£624			
In Month Total Paybill	Aug-14	£9,612	£9,616	£4			
Year-to Date Paybill	Aug-14	£48,334	£48,351	£17			
Sickness Absence	**Period**	**Month Target/Plan**	**Month Actual**		**RAG Rating**		
In Month Absence Rate	Aug-14	3%	3.64%				

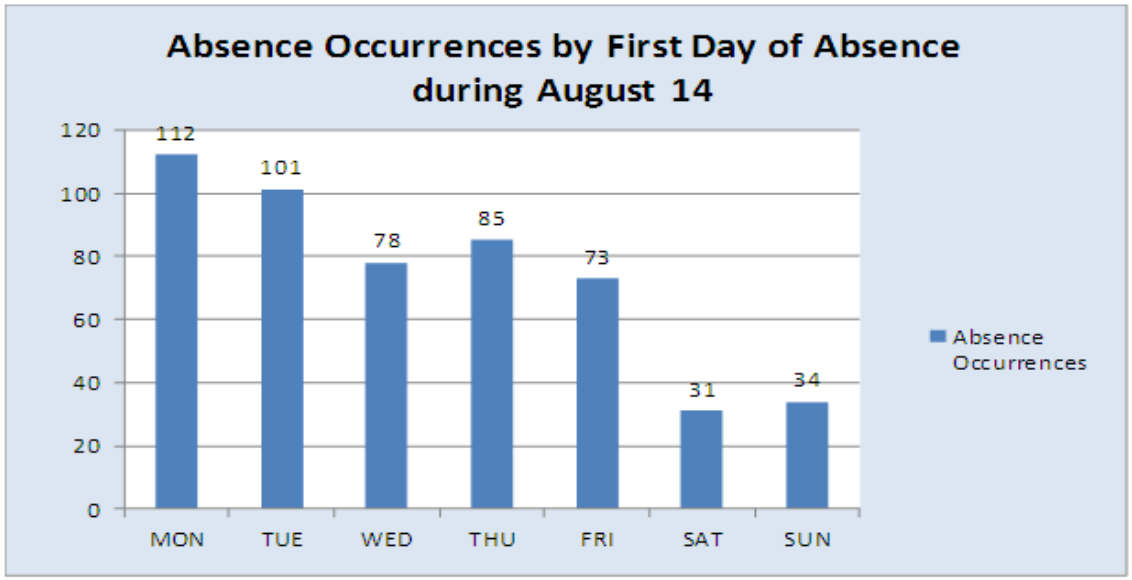
Key	
	Green - On Target
	Amber - Mitigating/corrective action believed to be achievable
	Red - Significant challenge to delivery of target

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

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.







Top 10 Absence reasons by FTE Year to Date

Absence Reason
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S25 Gastrointestinal problems
S12 Other musculoskeletal problems
S26 Genitourinary & gynaecological disorders
S28 Injury, fracture
S19 Heart, cardiac & circulatory problems
S17 Benign and malignant tumours, cancers
S15 Chest & respiratory problems
S13 Cold, Cough, Flu - Influenza

Data Source: ESR Business Intelligence

Performance Area	Commentary	RAG Rating	RAG Rating	RAG Rating
Continuity of Service Risk Rating (CoSRR)	• Overall Rating of 4 after normalisation adjustments. This maintains the Trust at the highest score achievable in the TDA ratings	Green	Green	Green
Income & Expenditure	• The YTD position is an adjusted surplus of £1,004k which is a £84k under-achievement against a plan of £1,088k. The Trust is expecting to achieve its forecast adjusted surplus of £1.7m	Green	Green	Green
Cost Improvement Programme (CIP)	• YTD CIPs achieved £3,642k against a plan of £2,984k. The RAG rating is Amber due to the level of non recurrent plans, however the FY15/16 full year effect of current year schemes is greater than the value of non recurrent savings in FY14/15.	Amber	Amber	Amber
Working Capital & Treasury	• Cash 'in-hand' and 'at-bank' at Month 5 was £9,724k.	Green	Green	Green
Capital	• Total year-to-date capital spend amounted to £941k against a planned spend of £3,642k.	Amber	Amber	Green

Isle of Wight NHS Trust Board Performance Report 2014/15

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Income & Expenditure - Key Highlights - Trust

Isle of Wight NHS Trust

Statement of Comprehensive Income	2014/15 Full Year BUDGET	Aug Budget	Aug Actual	Aug Variance	YTD Budget	YTD Actual	YTD Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Gross Employee Benefits	(115,265)	(9,612)	(9,616)	(4)	(48,335)	(48,351)	(16)
Other Operating Costs	(54,862)	(3,883)	(3,952)	(69)	(20,254)	(19,756)	498
Revenue from Patient Care Activities	160,335	13,233	13,264	32	66,673	65,581	(1,092)
Other Operating Revenue	9,569	854	798	(55)	4,414	4,883	469
OPERATING SURPLUS/(DEFICIT)	(223)	592	495	(97)	2,498	2,357	(141)
Investment Revenue	22	4	3	(1)	19	19	0
Other Gains and Losses	(125)	(1)	(1)	1	(7)	(4)	4
Finance Costs (including interest on PFIs and Finance Leases)	(48)	0	(4)	(4)	(62)	(9)	53
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	(374)	595	494	(101)	2,448	2,363	(85)
Dividends Payable on Public Dividend Capital (PDC)	(3,299)	(275)	(275)	0	(1,375)	(1,375)	0
Net gains/ (loss) on transfers by absorption (Roundings)	0			0	6	2	(5)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	(3,673)	320	219	(101)	1,079	990	(89)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR PER ACCOUNTS	(3,673)	320	219	(101)	1,079	990	(89)

Reported NHS Financial Performance	2014/15 Full Year	Aug Budget	Aug Actual	Aug Variance	YTD Budget	YTD Actual	YTD Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Retained surplus/(deficit) for the year	(3,673)	320	219	(101)	1,079	990	(89)
IFRIC 12 adjustment including impairments	0	0	0	0	0	0	0
Impairments excluding IFRIC12 impairments	5,347	0	0	0	0	0	0
Donated/Government grant assets adjustment (include donation/grant receipts and depreciation of donated/grant funded assets)	28	3	3	0	9	14	5
Adjusted Financial Performance Retained Surplus/(Deficit)	1,702	322	222	(101)	1,088	1,004	(84)

Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA)	2014/15 Full Year	Aug Budget	Aug Actual	Aug Variance	YTD Budget	YTD Actual	YTD Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Retained Surplus / (Deficit) for the Year per Accounts	(3,673)	320	219	(101)	1,079	990	(89)
Depreciation	6,158	497	477	(20)	2,383	2,378	(5)
Amortisation	1,302	84	104	20	520	520	0
Impairments (including IFRIC 12 impairments)	5,347	0	0	0	0	0	0
Interest Receivable	(22)	(4)	(3)	1	(19)	(13)	6
Finance Costs (including interest on PFIs and Finance Leases)	48	0	4	4	62	9	(53)
Dividends	3,299	275	275	(0)	1,375	1,375	(0)
Donated/Government grant assets adjustment (donation income element of SC 380)	(100)	8	8	0	42	42	0
(Gains) / Losses on disposal of assets	125	1	1	(1)	7	4	(4)
Net gains/ (loss) on transfers by absorption (Roundings)		0	0	0	6	10	4
EBITDA Sub Total	12,484	1,181	1,084	(97)	5,454	5,314	(141)
Restructuring costs	1,500	0	0	0	0	0	0
Normalised EBITDA	13,984	1,181	1,084	(97)	5,454	5,314	(141)

Commentary:

Income

£571k underplan YTD.

The income variance is a combination of the revenue from patient care activities, other operating revenue, investment revenue, finance costs & other gains & losses.

£5k overachieved Cost Improvement Plans.

£1,181k relates to phasing of investment schemes not yet being accessed from contracting authorities. The offset of some of these can be seen in reserves slippage above.

£315k overachievement of income targets from Corporate areas. The majority of this relates to two services, Earl Mountbatten Hospice (EMH) £226k & NHS Creative £287k. The spend related to these variances can be seen in the pay & non pay budgets.

Pay

£16k overspend YTD.

£540k unachieved Cost Improvement Plans.

£926k budget overspends - The majority of this relates to the premium costs of agency medical cover in excess of budget, and unachieved vacancy factor.

£1,450k reserves slippage - The Trusts reserved have not been committed to help offset cost pressures within the directorates & is slippage in planned investments not commencing.

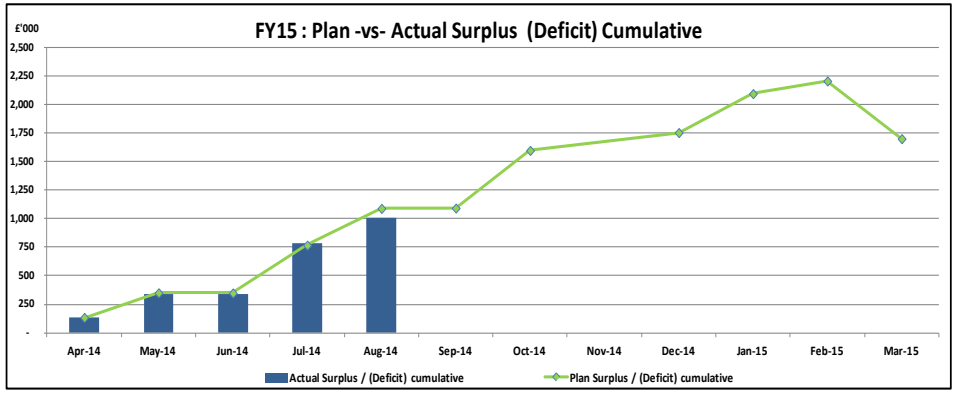
Non Pay

£498k underspend YTD.

£362k unachieved Cost Improvement Plans.

£1,244k budget overspends - £117k of this overspend relates to drug spend across numerous services. The Pharmacy lead is scoping how to better manage this spend/cost pressure. Additionally costs relating to the EMH service & NHS Creative explain the pressure on these budgets, although these are offset by overachievement on income.

£1,108k reserves slippage - The Trusts reserved have not been committed to help offset cost pressures within the directorates & is slippage in planned investments not commencing.



Isle of Wight NHS Trust Board Performance Report 2014/15

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Cost Improvement Programme - CIP by Directorates

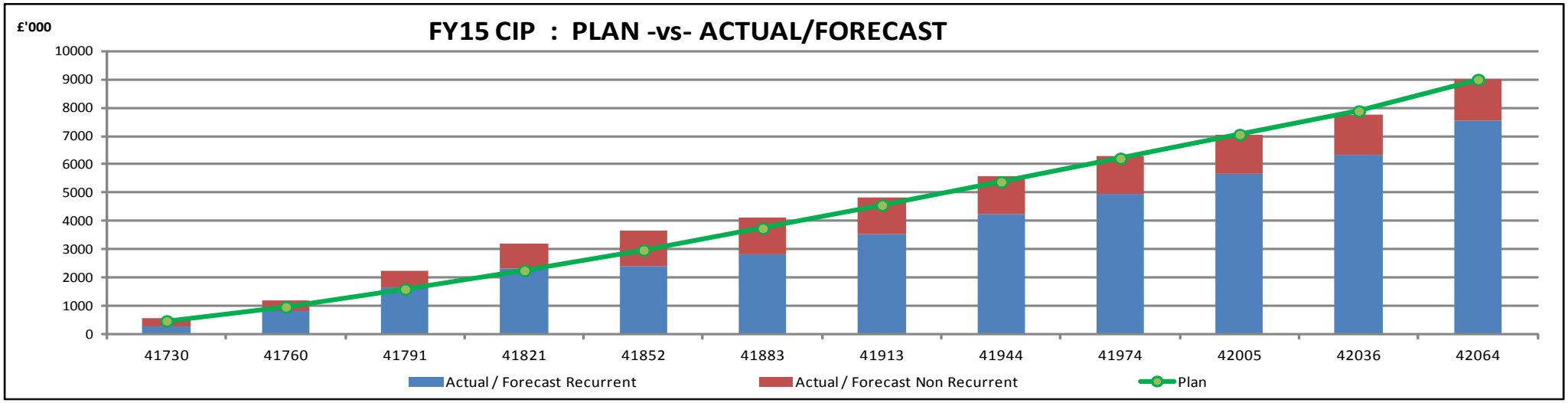
Isle of Wight NHS Trust

	Month			YTD			FULL YEAR		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
ACUTE	238	212	(26)	1,173	938	(235)	2,992	2,992	0
CHIEF OPERATING OFFICER	2	(41)	(43)	10	24	14	24	24	0
COMMUNITY	97	186	89	467	709	242	1,399	1,399	(0)
FINANCE & PERFORMANCE MANAGEMENT	15	47	32	76	584	508	183	183	(0)
NURSING & WORKFORCE	53	16	(37)	163	271	108	631	631	0
PLANNED	256	85	(171)	789	366	(423)	2,891	2,891	0
STRATEGIC & COMMERCIAL	36	28	(8)	182	453	271	582	582	(0)
TRUST ADMINISTRATION	25	25	0	124	297	173	297	297	(0)
Total	**722**	**558**	**(164)**	**2,984**	**3,642**	**658**	**8,998**	**8,998**	**0**

CIP Position Prior to forward banking of CIP	**2,984**	**2,085**	**(899)**

Commentary:

The YTD CIP plan is **£2,984k**. The actual savings total **£3,642k,** a YTD overachievement of **£660k**. The year end position is showing achievement of **£8,998k** which is on plan including **£1,452k** of non recurrent savings which is offset in 2015/16 by the full year effect of the schemes (**£1,526k** in FY15/16). This also includes **£1,556k** of forward banked schemes which will unwind over the year.



Isle of Wight NHS Trust Board Performance Report 2014/15

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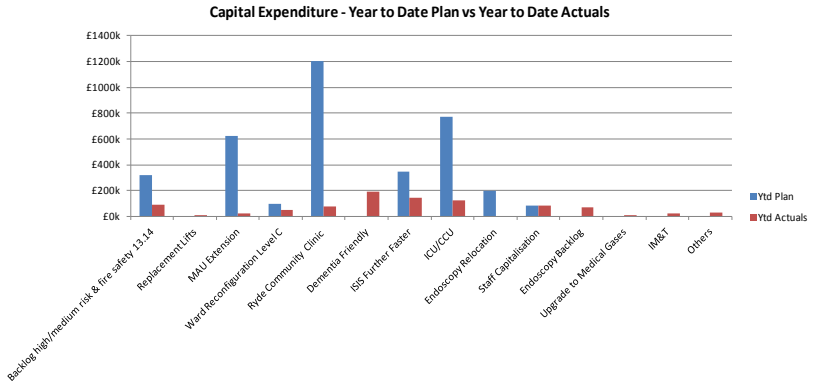
Capital Programme - Capital Schemes

Isle of Wight NHS Trust

Source & Application of Capital Funding	Original Plan £'000	Revised Plan / Budget £'000	YTD Plan	YTD Spend £'000	F'cast to Year End £'000	Full Year £'000
Source of Funds						
Initial CRL	7,460	7,460	0			7,460
Dementia Friendly		0				0
Pharmacy Matched Funding - NHS Technology for Safer Wards (provisional)		0				0
CCG Income (Hand Held Devices)		0				0
Property Sales	648	648	0			648
Proceeds from Disposals - Draeger Monitors		20				20
Cash Surplus						
Anticipated Capital Resource Limit (CRL)	**8,108**	**8,128**	**0**	**0**	**0**	**8,128**
Other charitable donations	100	100				100
Charitable Funds - Dementia	9	9				9
Donated Helipad Income	0	0				0
VAT Recovery	100	100				100
Total Anticipated Funds Available	**8,317**	**8,337**	**0**	**0**	**0**	**8,337**
Application of Funds						
13/14 Schemes Carried Forward						
Backlog high/medium risk & fire safety 13.14	93	93	320	92	0	93
Replacement of two Main Hospital Passenger Lifts	44	44		7	37	44
Personal Alarm System for Sevenacres	0	0		0	0	0
MAU Extension	2,428	1,840	620	25	1,815	1,840
Ward Reconfiguration Level C	142	142	100	51	91	142
Ryde Community Clinic	1,225	1,225	1,203	75	1,150	1,225
Dementia Friendly	192	192		192	0	192
ISIS Further Faster	344	344	344	143	201	344
ICU/CCU	2,262	126	770	126	-1	126
Endoscopy Relocation	625	2,465	200	0	2,465	2,465
Sub-total	**7,356**	**6,470**	**3,557**	**712**	**5,758**	**6,470**
14/15 Approved Schemes						
Endoscopy Backlog Maintenance	0	74		74	0	74
Call Vision Call Recording Server	0	27		27	-0	27
Replacement Outpatient Desk	0	5		4	1	5
Medicine Cabinet Installation	0	73		29	44	73
Bratt Pans	0	14		0	14	14
Internal Porters Tug	0	6		0	6	6
Air Conditioning for IT Network Room	0	25		0	25	25
Upgrade to Medical Gases System	12	12	0	12	-0	12
St Helens Ward Relocation	0	357		0	357	357
Theatre Racking	0	21		0	21	21
Carbon Energy Fund	0	24		0	24	24
Sub-total	**12**	**636**	**0**	**146**	**490**	**636**
14/15 Schemes - Requiring TEC/Board Approval						
Backlog Maintenance	0	0		0	0	0
IM&T (balance)	156	129		0	129	129
RRP (Annual Plan adjusted by £45k to offset Endoscopy Backlog)	460	404		0	404	404
Contingency (Annual Plan adjusted by £28k to offset Endoscopy Backlog)	33	0		0	0	0
Infrastructure (e.g. underground services)	0	0		0	0	0
Staff Capitalisation	200	200	85	83	117	200
Unallocated	0	397				
Sub-total	**849**	**1,130**	**85**	**83**	**651**	**734**
New/Adjustments to Projects - Requiring TEC Approval						
Unallocated	0	0		0	0	0
Sub-total	**0**	**0**	**0**	**0**	**0**	**0**
Other charitable donations	100	100		0	100	100
Gross Outline Capital Plan	**8,317**	**8,337**	**3,642**	**941**	**6,999**	**7,940**



Commentary : The initial Capital Resource Limit, plus expected proceeds from property sales and charitable donations, give the Trust a Source of Capital Funds of £8.3M.Capital Investments already approved in 2014/15 now total £7.2M. Previously approved funding to relocate ICU to CCU has now been reallocated due to the delay of thisproject. St Helens Ward will now be relocated to an area previously occupied by Newchurch Ward, which in turn will allow the relocation of the Endoscopy Unit to the space vacated by St Helens Ward, rather than into the area currently occupied by ICU. These changes also mean that there will be a shorter timescale for these two projects, bringing costs forward from 2015/16. These projects were approved at the July Trust Board meeting. The project to invest in energy efficiency and emissions reduction with the Carbon Energy Fund, has now been approved by the Trust Board, but will be delayed until 2015/16 as TDA approval isrequired. As approval is not expected for a few months, there will be insufficient time in 2014/15 to secure delivery of the generators on site by the end of the year.This means that there is currently £397k unallocated funding, which will be prioritised over the coming months.

For the property sales, our Commissioners want assurances around the clinical services provided at the Gables, and the Department of Health will not approve thedisposal until the Commissioners are satisfied. The Swanmore Road properties cannot be disposed of until the services have relocated into Ryde Community Clinic, expected by December, and the Department of Health have approved. Due to current market conditions, a higher value than previously thought could be achieved for these properties.

For the year to date position the major variances concern Ryde Community Clinic for which funding is committed and work has now started, Level C and MAU Extension,due to access issues to ward areas, ICU/CCU due to the delay of the project, and ISIS Further Faster, previously expected to be completed within the first few monthsof the year but now due for completion at a later date during 2014/15.

Isle of Wight NHS Trust Board Performance Report 2014/15

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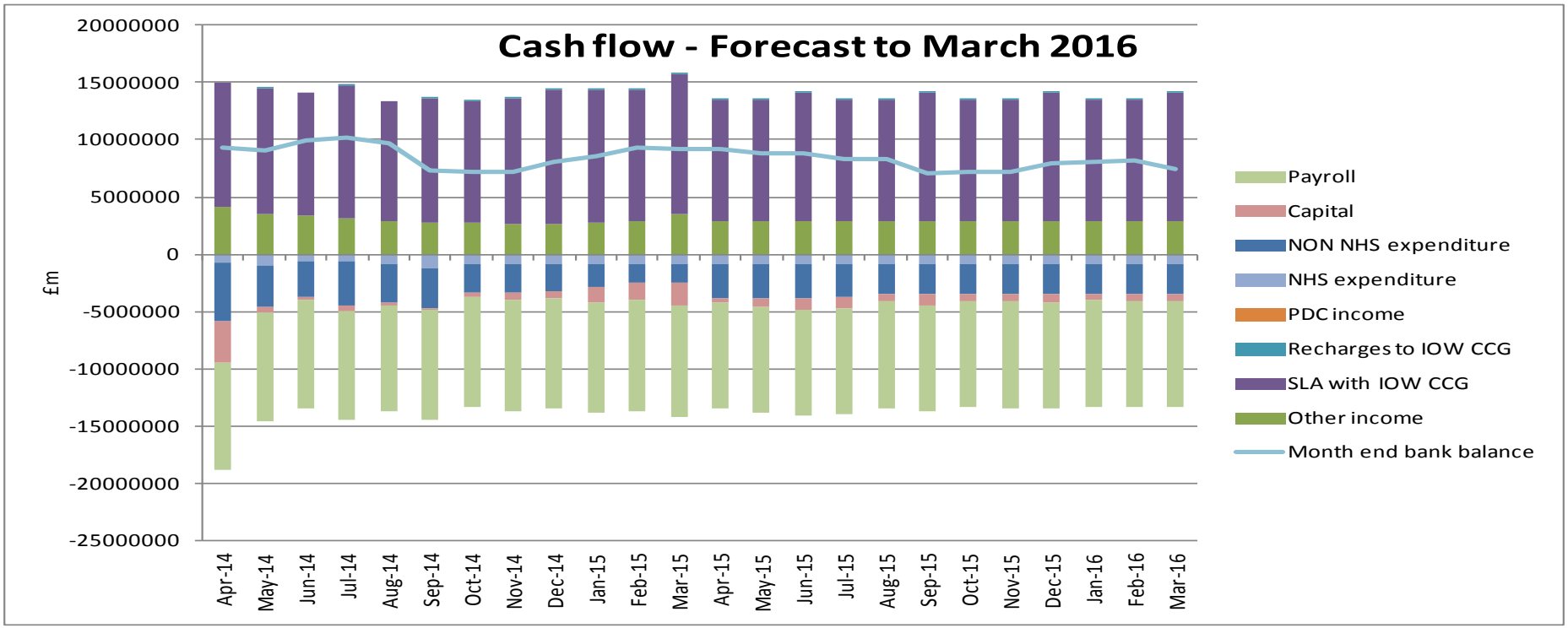
Monthly statement of Financial Position - August 14

Isle of Wight NHS Trust

	August-14	July-14	Month-on-month Movement
PPE	116,719	116,664	55
Accumulated Depreciation	20,779	20,290	489
Net PPE	**95,940**	**96,374**	**(434)**
Intangible Assets	7,883	7,854	29
Intangible Assets Depreciation	4,083	3,979	104
Net Intangible Assets	**3,800**	**3,875**	**(75)**
Investment Property	0	0	0
Non-Current Assets Held for Sale	0	0	0
Non-Current Financial Assets	0	0	0
Other Receivables Non-Current	212	227	(15)
Total Other Non-Current Assets	**212**	**227**	**(15)**
Total Non-Current Assets	**99,952**	**100,476**	**(524)**
Cash	9,724	10,140	(416)
Accounts Receivable	11,062	10,084	978
Inventory	2,269	2,309	(40)
Investments	0	0	0
Other Current Assets			0
Current Assets	**23,055**	**22,533**	**522**
Total Assets	**123,007**	**123,009**	**(2)**
Accounts Payable	18,264	18,470	(206)
Accrued Liabilities	0	0	0
Short Term Borrowing	13	27	(14)
Current Liabilities	**18,277**	**18,497**	**(220)**
Non-Current Payables	0	0	0
Non-Current Borrowing	0	0	0
Other Liabilities	368	368	0
Long Term Liabilities	**368**	**368**	**0**
Total Net Assets/Liabilities	**104,362**	**104,144**	**218**
Taxpayers Equity:			
Revaluation Reserve	24,489	24,489	0
Other Reserves	76,537	76,537	0
Retained Earnings incl. In Year	3,336	3,118	218
Total Taxpayers Equity	**104,362**	**104,144**	**218**

Commentary:

Only fixed assets to the value of £84k were purchased in-month and therefore because of depreciation, asset values have decreased by c£500k. Cash holdings have decreased by £416k since last and is because of the movement in cash-related debtors and creditors. The overall increase of £978k in receivables includes various accruals for invoices yet to be raised. These include amounts due from the IW CCG for additional contract variations, cancer drugs and the dermatology service and invoices to the IWC for IDAS.



Commentary:
The table above shows the forecast cash flow to March 2016. It shows both the in-flow and out-flow of cash broken down to the constituent elements.
Cash held at the end of August amounted to £9.7m.

Isle of Wight NHS Trust Board Performance Report 2014/15

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Continuity of Service Risk Rating

Isle of Wight NHS Trust

Month 04 - Risk Rating:

Scoring	Reported Position	Forecast to Year-end	Comments where target not achieved
Liquidity ratio score	4	4	
Capital servicing capacity score	4	4	
OVERALL Continuity of Service Risk Rating (CSRR)	4	4	

Risk Catagories for scoring				
1	2	3	4	
<-14	-14.0	-7.0	0	Liquidity ratio (days)
<1.25	1.25	1.75	2.5	Capital servicing capacity (times)

Commentary:
At the end of August the Trust achieved a score of 4 against both its Liquidity ratio and its Continuity of Service Risk Rating. This is expected to continue through to the year-end.

GOVERNANCE RISK RATINGS

Isle of Wight NHS Trust

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

With effect from the September report, the GRR has been realigned to match the Risk Assessment Framework as required by 'Monitor'.

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

	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data Q3 2013/14	Historic Data Q4 2013/14	Historic Data Q1 2014/15	Current Data Jul	Current Data Aug	Current Data Sep	Current Data Q2 2014/15	Notes
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	Yes	No	Yes	No	No		No	See exception report
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		95%	1.0	Yes	Yes	No	No	No		No	See exception report
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		92%	1.0	Yes	Yes	Yes	Yes	No		No	See exception report
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	Yes	Yes	No	Yes	Yes		Yes	
	5	All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	No	Yes	No		No	See exception report
			NHS Cancer Screening Service referral	90%									
	6	All cancers: 31-day wait for second or subsequent treatment, comprising:	surgery	94%	1.0	Yes	No	Yes	Yes	Yes		Yes	
			anti-cancer drug treatments	98%									
			radiotherapy	94%									
	7	All cancers: 31-day wait from diagnosis to first treatment		96%	1.0	Yes	Yes	Yes	No	Yes		No	
	8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93%	1.0	Yes	Yes	No	No	Yes		No	
			For symptomatic breast patients (cancer not initially suspected)	93%									
	9	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within seven days of discharge	95%	1.0	No	No	No	Yes	Yes		Yes	
			Having formal review within 12 months	95%									
	10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	Yes	No	Yes	Yes	Yes		Yes	
	11	Meeting commitment to serve new psychosis cases by early intervention teams		95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	12	Category A call – emergency response within 8 minutes, comprising:	Red 1 calls	75%	1.0	Yes	Yes	Yes	Yes	No		No	
			Red 2 calls	75%	1.0	Yes	Yes	Yes	Yes	No		No	
	13	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
Outcomes	14	Clostridium difficile – meeting the C. difficile objective	Is the Trust below the de minimus	12	1.0	Yes	Yes	Yes	Yes	Yes		Yes	See exception report
			Is the Trust below the YTD ceiling	2		Yes	Yes	No	No	No		No	
	16	Minimising mental health delayed transfers of care		≤7.5%	1.0	Yes	No	No	Yes	Yes		Yes	
	17	Mental health data completeness: identifiers		97%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	18	Mental health data completeness: outcomes for patients on CPA		50%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	19	Certification against compliance with requirements regarding access to health care for people with a learning disability		N/A	1.0	Yes	Yes	Yes	Yes	Yes		Yes	tbc
	20	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	tbc
			Referral information	50%									
			Treatment activity information	50%									
		TOTAL				1.0	5.0	6.0	4.0	6.0	0.0	8.0	
						AG	R	R	R	R	G	R	

Terms and abbreviations used in this performance report

Quality & Performance and General terms

Ambulance category A	Immediately life threatening calls requiring ambulance attendance
BAF	Board Assurance Framework
CAHMS	Child & Adolescent Mental Health Services
CDS	Commissioning Data Sets
CDI	Clostridium Difficile Infection (Policy - part 13 of Infection Control booklet)
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
DNA	Did Not Attend
DIPC	Director of Infection Prevention and Control
EMH	Earl Mountbatten Hospice
FNOF	Fractured Neck of Femur
GI	Gastro-Intestinal
GOVCOM	Governance Compliance
HCAI	Health Care Acquired Infection (used with regard to MRSA etc)
HoNOS	Health of the Nation Outcome Scales
HRG4	Healthcare Resource Grouping used in SUS
HV	Health Visitor
IP	In Patient (An admitted patient, overnight or daycase)
JAC	The specialist computerised prescription system used on the wards
KLOE	Key Line of Enquiry
KPI	Key Performance Indicator
LOS	Length of stay
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus (bacterium)
NG	Nasogastric (tube from nose into stomach usually for feeding)
OP	Out Patient (A patient attending for a scheduled appointment)
OPARU	Out Patient Appointments & Records Unit
PAAU	Pre-Assessment Unit
PAS	Patient Administration System - the main computer recording system used
PALS	Patient Advice & Liaison Service now renamed but still dealing with complaints/concerns
PATEXP	Patient Experience
PATSAF	Patient Safety
PEO	Patient Experience Officer - updated name for PALS 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)
QCE	Quality Clinical Excellence
RCA	Route Cause Analysis
RTT	Referral to Treatment Time
SUS	Secondary Uses Service
TIA	Transient Ischaemic Attack (also known as 'mini-stroke')
TDA	Trust Development Authority
VTE	Venous Thrombo-Embolism
YTD	Year To Date - the cumulative total for the financial year so far

Workforce and Finance terms

CIP	Cost Improvement Programme
CoSRR	Continuity of Service Risk Rating
CYE	Current Year Effect
EBITDA	Earnings Before Interest, Taxes, Depreciation, Amortisation
ESR	Electronic Staff Roster
FTE	Full Time Equivalent
HR	Human Resources (department)
I&E	Income and Expenditure
NCA	Non Contact Activity
RRP	Rolling Replacement Programme
PDC	Public Dividend Capital
PPE	Property, Plant & Equipment
R&D	Research & Development
SIP	Staff in Post
SLA	Service Level Agreement

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Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 1 OCTOBER 2014

QUALITY & CLINICAL PERFORMANCE COMMITTEE
Wednesday 17 September 2014

Present:	Sue Wadsworth	Non Executive Director and Chair (Chair)
	Nina Moorman	Non Executive Director and Deputy Chair (DC)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Mark Pugh	Executive Medical Director (EMD)
	Sarah Gladdish	Clinical Director, Community & Mental Health Directorate (CDC)
	Deborah Matthews	Lead for Patient Safety, Experience and Clinical Effectiveness (LSEE)
In Attendance:	Brian Johnston	Head of Corporate Governance & Risk Management (HOCG)
	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM)
	Cath Love	Quality and Clinical Performance Manager (QCPM) – on behalf of Sabeena Allahdin (CDHA)
	Sue Biggs	Modern Matron (MM) – on behalf of Sabeena Allahdin (CDHA)
	Fiona Hoskins	Interim Deputy Director of Nursing (IDDN)
	Vanessa Flower	Patient Experience Lead (PEL), *for items 14/329 to 14/333 (inclusive)*
	Andy Hollebon	Head of Communications (HC), *for item 14/337*
	Mark Price	FT Programme Director/Company Secretary (FTPD), *for item 14/337*
	Andy Shorkey	Business Planning and Foundation Trust Programme Management Officer (BPFTMO), *for item 14/338*
Minuted by:	Amanda Garner	Personal Assistant to EDNW (PA)

Key Points from Minutes to be reported to the Trust Board

- Item 14/320 – The Committee discussed the CQC Action Plan and suggested that this be renamed the Quality Improvement Programme.
- Item 14/322 – The Committee noted that the Patient Safety, Experience and Effectiveness (SEE) Team were operational and making a huge difference.
- Item 14/328 - The Committee discussed the Seven Day Service Review Report and asked for an update in 6 months time.
- Item 14/337 - The Committee discussed the Service Users Involvement Policy and agreed that it should be presented to the Trust Executive Committee for approval.
- Item 14/338 - The Committee approved the TDA Self Certification.

Minute No.

14/315 APOLOGIES FOR ABSENCE

Sabeena Allahdin, Clinical Director – Hospital and Ambulance Directorate (CDHA), Donna Collins, Associate Director – Hospital and Ambulance Directorate (ADHA), Ian Bast, Patient Representative (PR), Jessamy Baird, Designate Non Executive Director (DNED) and Chris Orchin, Healthwatch Isle of Wight (HIW)

14/316 CONFIRMATION OF QUORACY

The Chair confirmed the meeting was quorate.

14/317 DECLARATIONS OF INTEREST

There were no declarations of Interest.

The Chair welcomed Fiona Hoskins, Interim Deputy Director of Nursing (IDDN) to the meeting and introductions were made.

14/318 MINUTES OF THE LAST MEETING – 20 August 2014

The minutes of the meeting held on 20 August 2014 were agreed as a true record.

14/319 REVIEW OF ACTION TRACKER

The Committee reviewed the Action Tracker.

The PA will circulate a further updated copy of the Action Tracker with the minutes. The SEEBM added that she had spent a lot of time reviewing and updating the Action Tracker and asked that members get their updates back to the PA to ensure that the Action Tracker is up to date.

***Action Note**: Members and attendees to ensure updates are sent to the PA*

Action by All

***Action Note**: PA to circulate a further updated copy of the Action Tracker with the minutes.*

Action by PA

UPDATE OF LOCAL / NATIONAL ISSUES

14/320 INTEGRATED ACTION PLAN – SUMMARY REPORT

The SEEBM advised that this was the usual quarterly report to provide the Committee with an update on the integrated action plan. The SEEBM advised that there had been an increase of two compliant actions and that these related to the Francis Review. The SEEBM reported that progress had been slower this quarter but they were still progressing alongside the CQC action plan. The SEEBM added that the integrated action plan would be discussed at the SEE Committee meetings in detail.

The DC asked when the CQC action plan would be seen by the Board. The LSEE advised that the CQC action plan would be discussed at a meeting tomorrow as some more focussed work is required around ensuring that the actions have smart objectives before being submitted to the Trust Development Authority (TDA). The SEEBM added that there will be a paper submitted to Board which will include some of the governance around the CQC action plan. The DC advised that having seen the report she would like to be assured that everything has been picked up and added that there were some actions for Board. The DC also suggested that the action plan is called the Quality Improvement Programme once finalised. The Committee agreed that this sounded more engaging. The EMD advised that the whole action plan should be sent to the Chair and the DC next week.

***Action Note**: The CQC Action Plan/Quality Improvement Programme to be sent to the Chair and DC next week.*

Action by LSEE

The LSEE advised that the action plan will be reviewed weekly and an update provided to this Committee on a monthly basis. The EMD advised that detailed reports can be extracted from the action plan. The Committee discussed reporting arrangements and it was clarified that the SEE Committee will report to the Trust Executive Committee (TEC) and provide assurance to this Committee.

QUALITY

14/321 QUALITY GOVERNANCE FRAMEWORK – SUMMARY REPORT

The SEEBM presented the quarterly update of the Quality Governance Framework to the

Committee and advised that some of the actions had progressed to completed and some had progressed from Amber to Green. The SEEBM advised that progress had been slightly slower and that this action plan will also be reviewed by the SEE Committee to discuss the specifics. It was noted that there was a new red action relating to the warning notice and that this would not be green until all the actions are completed. The HOCG confirmed that the Trust will receive confirmation that the enforcement notice has been lifted. The EMD added that the Trust will not have to have fully delivered on the action plan however will need to demonstrate that there are robust actions in place. The EMD advised that the Trust Development Agency (TDA) will be involved and that the action plan will be sent to them by the end of next week.

The SEEBM added that the Foundation Trust (FT) Timeline has also been delayed and 15 of the actions were specific to this, ie appointing governors, and there will be no progress on these at this time.

The Committee discussed attendance of the Heads of Clinical Service at the meeting and noted that since the Terms of Reference had been amended they were not expected to attend. The DC expressed concern that some of the queries raised will not be able to be answered at the meeting. It was agreed that this Committee will receive assurance and that any feedback regarding membership should be given to the Chair.

***Action Note**: Members to provide feedback regarding membership to the Chair*

Action by All

14/322 QUALITY REPORT

The LSEE presented the August 2014 Quality Report to the Committee and advised that in future this report will be reviewed by the SEE Committee in conjunction with the directorates first. The LSEE added that the SEE Committee will meet one week prior this Committee. The LSEE highlighted the following;

1. Incidents resulting in harm – in future will be looking at levels of harm, themes and tracking trends. The Committee discussed falls, noting that falls resulting in injury had increased. The Committee were advised that falls in the Community were included as all Trust staff report falls when they occur. The HOCG added that the Falls Group pick these up and advised that he would run a Datix report for falls in the Community. The EMD advised that this would be very helpful.

***Action Note**: HOCG to provide EMD with a Datix report for Community falls.*

Action by HOCG

2. MRSA Screening – The QCPM advised that there were increasing data errors and that the directorate were working with the Performance, Information & Decision Support (PIDS) Team regarding this. The LSEE advised that Dr Macnaughton had redrafted the MRSA Screening Policy following advice received from Public Health England which will result in fewer patients requiring to be screened.

3. Maternity – the Committee reviewed the Maternity figures. The DC suggested that the national target for breastfeeding of 80% seemed quite high. The Committee suggested that this was a query for the Head of Maternity and asked that this be covered by the Directorate at the next meeting. The QCPM advised that this was a low numbers issue and advised that there were a number of things in place ie training and breastfeeding champions in place to address this.

***Action Note**: The Directorate to feedback to October 2014 meeting regarding national target for breastfeeding.*

Action by QCPM

4. Emergency Readmissions – The MM advised that she is currently working on a Patient Flow Project and that there was peak in July that related to discharge planning. The MM updated the Committee on this and advised that she is challenging staff at ward rounds ie on family and patient involvement and the discharge planning process. The LSEE advised that this will be reviewed by the SEE Committee in conjunction with the Directorates. The MM added that she is challenging what is in place to ensure that patients have everything they need when they go home. The CDC added that solutions

do change and patients need reviewing to ensure that what is planned is still required. The MM advised that electronic solutions may help. The Chair asked if there were training issues. The MM advised that training needed to be done on the "shop floor" and that she had asked wards for feedback on their issues, ideas and thoughts. The Chair suggested that discharge planning should be at the top of the agenda for the directorates. The Committee agreed that this was a large piece of work and asked for an updated report for March 2015.

***Action Note**: The MM to provide an update to the Committee in March 2014 and the PA to add to the action tracker.*

Action by MM and PA

5. Antimicrobial Stewardship – The LSEE updated the team on the HAPPI (Hospital Antimicrobial Prudent Prescribing Indicator), DIPPI (Doctor Inputting by Prescribing by Protocol) and NAPPI (Nurse Administration Prudent Practice Indicator) audits carried out by pharmacy staff on a monthly basis. The LSEE advised that this needs to improved especially around review and stop dates. The LSEE advised that this is not a helpful score at this stage and missed doses and their reasons need to be included ie delay due to stock or missed doses. The LSEE advised that refusals count as a missed dose.

6. Concerns – 101 concerns raised this month which is an increase.

7. Friends and Family Test – A&E have exceeded their target this month. Maternity Unit is still challenging.

8. Ward Indicators Dashboard – The Chair asked if the right things are being measured and noted one ward with seven reds. The LSEE advised that there were still some anomalies and the metrics will be reviewed. The LSEE added that for future meetings the SEE Committee will have met previously and discussed these with the directorates and will have feedback for this Committee. The QCPM added that these will also be discussed at the internal performance reviews. The EDNW advised that how well led a ward is is a determining factor and the measures need to be agreed with the directorates. He agreed that the SEE Committee will be asking the directorates for assurance to feedback to this Committee to either provide assurance or escalate as appropriate.

14/323 SEE UPDATE

Covered under Item 14/322.

REPORTS FROM DIRECTORATES

14/324 HOSPITAL AND AMBULANCE DIRECTORATE

The QCPM advised that the top risks had been identified at the Directorate's Quality & Clinical Performance Committee Meeting in August 2014 and would welcome feedback on the report. The Committee were concerned that the information in the minutes could be out of date and needed to be current. The Committee agreed that there needed to be assurance that the directorates were sighted on current concerns ie in the previous week. The LSEE asked the Chair what needed to be included. The Chair advised that she had recently chaired a deep dive meeting and there was nothing covering that. The DC advised that the Committee need to hear what is worrying the directorates and give feedback for assurance or for issues to be highlighted to the Board. The SEEBM advised that there may be enough detail in the SEE Committee report that covers all of this information. The DC added that the Committee does not hear about the good things that happen.

14/325 COMMUNITY AND MENTAL HEALTH DIRECTORATE

The CDC presented the directorate's report to the Committee and highlighted the top risks and areas of concern

Mental Health:

1. Seclusion room door – currently on the risk register.
2. Staff issues in CAMHS – currently on the risk register

Community:

1. Pressure ulcers – still not moving forward
2. Capacity within the Safeguarding Team – administration support has been provided to support the team.

The Committee discussed pressure ulcers. The CDC advised that GPs do not feel that they have been given a role however the vacant post has been recruited to and part of that role is to work with the GPs. The EDNW advised that there had recently been a peer to peer challenge arranged with Central and West regarding pressure ulcers and there had been a reduction in that area. The EDNW added that further meetings will be arranged with the North East and South Teams and that the teams are committed to meeting regularly and reviewing RCA's.

PATIENT SAFETY

14/326 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – ON LINE AND IN PROGRESS

The LSEE updated the Committee on SIRIs for August 2014 and advised that there had been 3 reported. One concerned a pressure ulcer, one a confidential information leak and one unexpected death.

The LSEE advised that there were currently 39 open cases; 27 in the Community and Mental Health Directorate and 12 in the Hospital and Ambulance Directorate. The EDNW advised that at 39 this was the highest number the Trust had had in recent months and that it would be useful to understand why there were so many open for so long. The EDNW added that the clock could stop if a SIRI was with the Commissioners but this needed to be managed. The Committee agreed that consultants and clinicians need to be involved and noted that they would have to be given 6 weeks notice to attend meetings or for the meeting to take place outside their working day. The LSEE advised that this is being scoped at the moment.

14/327 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – TO BE SIGNED OFF

The Committee discussed the following SIRIs

<u>Community</u>
2014/1582 – The Committee agreed that they were not assured that the SIRI had explored all areas. Sign off was not approved.

The QCPM advised that she would meet with her colleague in the Community and Mental Health Directorate to discuss the Executive Summaries provided to the Committee and explained that they had both been successful in securing funded training to attend an intensive SIRI course.

<u>Planned</u>
2013/22895 – The Committee discussed the signing off of paper results and the involvement of the patient in the process. Sign off was not approved. The EDNW noted that actions had been chased six times and suggested a more robust escalation process.

2012/24318 – The Committee agreed that they were not assured that the actions were complete. Sign off was not approved.

<u>Acute</u>
2013/11071 – The Committee approved sign off.

2013/24356 – The Committee approved sign off.

2014/11816 – The Committee approved sign off.

14/328 SEVEN DAY SERVICES REVIEW

The EMD tabled the Seven Day Services Review Report. He advised that each service had been RAG rated with regards to safety, effectiveness and patient choice and the services had been asked to review the ratings. The EMD added that the plan was to take this forward and review the actions in six months time and then review on a yearly basis. The Chair noted that this related to patient flow. The DC agreed that the report was very helpful. The EMD advised that the directorates will monitor the safety and that the MM could factor effectiveness into her patient flow project. The EMD added that the report will be reviewed at the directorate performance meetings. The Committee agreed that the report be presented again in six months time.

***Action Note**: The EMD to present an update at the March 2015 meeting and the PA to add to the action tracker.*

Action by EMD and PA

PATIENT EXPERIENCE

14/329 PATIENT STORY

The Committee viewed a video recording of a patient giving feedback on the care that had been received and how clearly they had been communicated with in a calm environment. The patient highlighted the importance of role models in the Trust. The Chair asked that A&E be formally thanked.

***Action Note**: A&E to be thanked formally by the PEL.*

Action by PEL

14/330 PATIENT STORY – UPDATE ON PATIENT STORY FROM JULY 2014 MEETING

The PEL advised that the RCA had not been undertaken yet but that this was in hand. The PEL updated the Committee on the current status of the patient.

14/331 PATIENT EXPERIENCE – QUARTER 1 REPORT

The PEL presented the Quarter 1 Patient Experience Report. The PEL advised that going forward she will link with the directorates for more input from them. The Chair noted that there were no dates in the "In Progress" column. The PEL added that she will review this going forward. The DC added that it was good to see all of this information in one place and suggested that a column be added to detail evidence.

***Action Note**: PEL to review information included in the report.*

Action by PEL

14/332 FRIENDS AND FAMILY TEST - ROLL OUT AND IMPLEMENTATION ACTION PLAN

The PEL advised this report detailed how the Trust was rolling out and implementing the Friends and Family Test (FFT) and she added that the Trust had received 11,655 responses to date. The PEL updated the Committee on the roll out of tablet devices with the Emergency Department opting for a touch screen PC. The PEL advised that areas will be expected to publish "you said… we did…" information.

The EDNW advised that the Citizens Advice Bureau (CAB) are looking at putting PCs into libraries and suggested that the PEL contacted them with a view to linking in with this.

***Action Note**: PEL to contact CAB*

Action by PEL

14/333 COMPLAINTS – QUARTER 1 REPORT

The SEEBM presented the Quarter 1 Complaints Report to the Committee. The SEEBM reported that the Trust was not quite meeting the target of a 10% reduction in complaints and there had been an increase in the number of concerns raised. The SEEBM added that since the PALS team had moved into the Main Reception area that there had been an

increase in PALS contacts.

The SEEBM highlighted the number of formal complaints managed within the agreed timescale which was 37%, The SEEBM added that the timescale had been reduced from 30 to 20 days and that the process was still being embedded. The SEEBM reported that there had been two complaints referred to the Parliamentary Health Service Ombudsman during Quarter 1 and neither had been upheld.

The SEEBM outlined the key priorities for the next quarter which includes monitoring actions and improving the percentage of complaints managed within the agreed timescale. The SEEBM advised that the priority of local resolution meetings being recorded was already in place. The QCPM added that there is a weekly meeting held with the Directorate Quality Managers and that this is proving very helpful. The Committee agreed that this was a comprehensive and helpful report and discussed recording complaint meetings and consent. The SEEBM advised that complainants are asked to sign a consent form to agree that their recording will be for personal use only.

CLINICAL AUDIT AND GOVERNANCE

14/334 GOVERNANCE AND ASSURANCE REPORT

The HOCG advised that this report covered Quarter 1 of 2014/15 and added that the two highlights were the implementation of NICE guidance and implementation of the new clinical audit templates.

14/335 TRUST RISK REGISTER

The Committee reviewed the report and agreed that it was important for this Committee to continue to have sight of the clinical risks and the key strategic risks.

14/336 BAF QUALITY OBJECTIVES

The HOCG presented the Quarterly updated of the Quality Section of the Board Assurance Framework (BAF) and highlighted the small number of ambers and no reds

14/337 SERVICE USERS INVOLVEMENT POLICY

The HC and FTPD presented the Service Users Involvement Policy to the Committee. The HC advised that the Policy attempts to set a framework for Trust Staff that patients can also reference. He added that the Policy does not include forms or proformas as these will evolve and adapt and will be available on the intranet. The HC advised that there was no central budget and outlined when individuals will receive payment ie when they are working on significant pieces of work. The HC advised that it had been suggested that payment was tied to the national minimum wage with a discretionary uplift of 35% to £12 for difficult to reach areas.

The FTPD advised that this Policy sat only in the Mental Health Directorate previously but now was Trust Wide. The FTPD added that the Patients Council had been involved as had the Policy Management Group. The FTPD reported that the feedback from the Policy Management Group was for a fixed rate to be set with no discretionary uplift. The DC advised that she had received feedback to share with the FTPD from the DNED who was unable to attend the meeting today. The FTPD advised that he had also seen the feedback from the DNED and her comments were clear and would be taken on board. The FTPD added that once all comments are received the Policy will be finalised and taken to the Trust Executive Committee (TEC) for approval.

The CDC advised that it was good that the Policy now covered the whole Trust. The DC agreed and added that patients can help develop services. The HC added that there were no leaflets for patients or carers for advice on how to get involved and these will be developed. The EDNW added that the Impact Assessment Implementation Checklist at Appendix 1 was confusing and seemed to be aimed at Mental Health.

The Chair asked that if there were any further comments for the Committee to forward these to the HC and she agreed that a flat rate was preferable which would avoid any confusion. The EMD added that the Trust was out of line by not currently having a Policy and welcomed this.

The Committee agreed that the Policy should be presented to TEC for approval.

CLINICAL PERFORMANCE AND RISK

14/338 TDA SELF CERTIFICATION

The BPFTPMO advised the Committee that as a consequence of the CQC visit that a number of Board Statements were now "at risk". He advised these were Board Statements 1, 2, 6 and 14 and these had previously been green. The FTPMO advised that the Board had approved that these should be put at risk with a view to compliance by 30 October 2014. The FTPMO added that Board Statement 10 remains "at risk". The Committee approved the TDA Self Certification.

14/339 ANY OTHER BUSINESS

Changes to Committee Dates

The Committee discussed the email from Lynn Cave, Trust Board Administrator, regarding proposed changes to the dates of the Committee meetings. The Committee agreed that it was not reasonable to have to hold two dates in their diaries and asked for this to be resolved as soon as possible. The Committee advised that due to clinical commitments the meeting had previously been agreed to be held on a Wednesday and that the last Wednesday of the month would be more suitable for clinical colleagues. The Chair asked that if there were any further comments to email them to Lynn Cave.

***Action Note**: Any further comments to be emailed to Lynn Cave.*

Action by All

***Action Note**: The PA to provide feedback to Lynn Cave.*

Action by PA

Terms of Reference

The PA advised that she had been contacted by a number of members regarding the revised Terms of Reference for clarification on their attendance. The Chair advised that it will be made clear to members when they are required to attend at the time that the agenda is set.

***Action Note**: PA to update members who have been asked to attend the meetings "as and when necessary"*

Action by PA

Next Meeting on 22 October 2014

The Chair gave her apologies for the meeting to be held on 22 October 2014 and advised that the DC will chair the meeting in her absence. The PA will invite the DC to the pre-meet.

***Action Note**: PA to invite the DC to the pre-meet*

Action by PA

14/ DATE OF NEXT MEETING

Wednesday 22 October 2014
9 am to 12 Noon
Conference Room

Signed: _____ Chair

Date: _____

Enc I

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 October 2014

Title	Quality & Clinical Performance Committee Terms of Reference			
Sponsoring Executive Director	Company Secretary			
Author(s)	Head of Corporate Governance & Risk Management			
Purpose	Revised Board Sub-Committee Terms of Reference submitted for Board review and approval			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	20/8/14
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

The Terms of Reference for QCPC required revision following implementation of the Patient Safety, Effectiveness and Experience Committee (SEE). These Terms of Reference were approved at the QCPC meeting held on Wednesday 20 August 2014.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*						
Critical Success Factors *(see key)*						
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***						
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements						

Date: 22nd September 2014 Completed by: Brian Johnston, Head of Corporate Governance & Risk Management

Quality & Clinical Performance Committee

Terms of Reference

Document Type:	Committee Terms of Reference
Date document valid from:	June 2014
Document review due date:	May2015

AUDIT TRAIL:

Dates reviewed:	June 2014	**Version number:**	V2 - 2013
Dates agreed:	June 2014	**Version number:**	V4
Details of most recent review: (*Outline main changes made to document*) .	· Update to accommodate Designate Non Executive Directors. · Updated subcommittee and working groups which report to the QCPC. · Update to Main Purpose of committee · Update to align to new Patient Safety, Experience &Clinical Effectiveness Committee (SEE Committee) Reviewed by Head of Corporate Governance and Risk Management / Executive Director of Nursing and Workforce / Executive Medical Director		

Signature of Chairman of Committee:

Print Name: Sue Wadsworth **Post Held:** Non Executive Director **Date: //2014**

Trust Board Approval Authorised Signature	
Authorised by:	**Danny Fisher**
Signed:	
Date:	**//14**
Job Title:	**Chairman of Trust**
Approved at:	**Trust Board**
Date Approved by Trust Board:	**//14**

Isle of Wight NHS
NHS Trust

QUALITY AND CLINICAL PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. MAIN PURPOSE

1.1 To act as the committee with overarching responsibility for assurance on Quality, Patient Safety, Clinical Effectiveness, and Patient Experience within the Organisation.

1.2 The Quality and Clinical Performance Committee will monitor and scrutinise the provided assurance to ensure the delivery of high quality care for all. The committee will seek confirmation of improvements with regard to the three elements of patient safety, clinical effectiveness and patient experience so that all are equally considered in quality initiatives and are measured appropriately.

1.3 The Quality and Clinical Performance Committee will agree the annual quality plan (patient safety, clinical effectiveness and patient experience) and continuously monitor progress against this. In addition, the Committee will be assured the long term quality plan is delivering against the quality improvement strategy.

1.4 The Committee will seek assurance that Key Clinical Performance Indicators are developed, agreed, aligned to the Trust's strategic objectives and clinical priorities, and monitored / performance managed throughout the Trusts performance management route.

1.5 The Committee will continue to seek assurance and monitor patient safety, quality and experience, including clinical governance, to ensure that this is maintained.

2. MEMBERSHIP & QUORUM

2.1 Members

2.1.1 The Committee will consist of 10 members

2.1.2 A Non-Executive Director will be appointed as chair of the committee as agreed by the Board.

2.1.3 The following membership will be approved by the Board

- Non Executive Director (Chair)
- Non Executive Director (Vice Chair)
- Non Executive Directors x 1 (nb the Board can determine that Designate Non-Executive Directors can become members of Board Sub-Committees)
- Executive Medical Director
- Executive Director of Nursing and Workforce
- Clinical Director of Hospital & Ambulance Directorate (or Associate Director, as deputy)
- Clinical Director of Community & Mental Health Directorate (or Associate Director, as deputy)
- Lead for Patient Safety, Experience and Clinical Effectiveness and Deputy DIPC
- Health Watch Representative
- Patient Representative

2.1.4 The following will attend as and when requested

- Head of Corporate Governance and Risk Management
- Patient Experience Lead
- Deputy Director of Nursing
- Assistant Director – Performance Information and Decision Support
- Chief Pharmacist
- Business Manager - Patient Safety, Experience & Clinical Effectiveness

2.2 Quorum

2.2.1 A quorum shall be 4 members including 1 clinical representative and 1 non-executive director. A designate NED can also be included as part of the quorum.

2.2.2 Committee members will nominate a deputy to attend in their absence as appropriate. These deputies to have full voting rights.

2.2.3 Attendees may also send deputies in their absence who are non-voting.

2.2.3 The Chairman, Chief Executive or other Executive Directors may attend at any time.

2.2.4 In line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting.

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3. ATTENDANCE AT MEETINGS

3.1 It is agreed that all members should attend a minimum of 8 out of the12 meetings per year.

3.2 When the Committee is discussing areas of risk or operation that are the responsibility of an Executive or Clinical Director, any other director, manager or employee may also be required to attend in order to present papers or to provide additional information in support of discussions.

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4. FREQUENCY OF MEETINGS

4.1 Meetings are to be held monthly

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5. DELEGATED AUTHORITY

5.1 The Quality and Clinical Performance Committee is a formal sub - committee of, and directly accountable to, the Trust Board.

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6. ROLES & RESPONSIBILITIES

6.1 <u>Governance & Compliance</u>

6.1.1 Seek assurance on Care Quality Commission registration requirements, including compliance with essential standards in respect of corporate and clinical directorates and services and ensure any issues of concern are followed up appropriately. Also seek assurance that any changes to any regulated activities or service locations are appropriately notified to the CQC.

6.1.2 Receive and seek assurance on all formal CQC inspection reports, action plans and outcomes advising the Trust Board / Trust Executive Committee of areas of good practice and of concern.

6.1.3 Receive and approve the Trust's annual Quality Account before its submission to the Trust Board

6.1.4 Review quality performance reports produced for review to the Trust Board, this committee and others to ensure information provided covers all Trust services - acute, community, mental health and ambulance

6.1.5 Take assurance from Board Performance Reports and ensure all clinical indicators showing less than optimal performance are appropriately assigned and followed up with robust action plans for improvement via the SEE committee

6.1.6 Develop and implement processes to ensure linkages between quality and financial performance are made explicit, including the regular monitoring of detailed quality risk assessments against all CIP schemes.

6.1.7 Review self-certification monthly returns relating to quality indicators prior to submission to Board

6.1.8 Seek assurance on the use of exception reporting and forecasting for non-financial key performance indicators

6.1.9 Receive assurance from the SEE committee on the introduction of an information quality framework that lists each KPIs, its definition, the data sets from which it is drawn and the source of assurance received that it is currently reported accurately.

6.1.10 Consider matters referred from the Trust Board, Trust Executive Committee, Audit and Corporate Risk Committee and other Board sub-committees as required.

6.1.11 Make recommendations to the Audit and Corporate Risk Committee concerning the annual programme of internal audit work, relating to quality and clinical governance within the scope of this committee.

6.1.12 To receive assurance on any licences relevant to clinical activity receiving reports as the committee considers necessary.

6.1.13 Assure the Trust Board that research and development governance is implemented and monitored via the R&D annual report

6.1.14 Seek assurance on Business cases and CIP schemes via quality impact assessments if there is likely to be a significant impact on quality

6.2 Quality & Clinical Effectiveness

6.2.1 Agree the Trust-wide clinical governance priorities and give direction to the clinical governance activities of the Clinical Directorates, reviewing and approving each Directorate's annual clinical governance plan.

6.2.2 Receive and review monthly performance reports relating to quality, including mortality rates. Make recommendations for action to the SEE Committee as appropriate..

6.2.3 Oversee the annual clinical audit programme and monitor its implementation, including:

- Review the clinical audit plan at the beginning of each year
- Confirm that clinical audit plans are derived from clear processes based on risk
- assessment with clear links to the Assurance Framework
- Receive periodic reports from the person responsible for clinical audit
- Effectively monitor the implementation of management actions arising from clinical audit reports
- Ensure that the person responsible for clinical audit has a direct line of access to the Committee and its Chair
- Review the effectiveness of clinical audit and the adequacy of staffing and resources available for clinical audit
- Evaluate clinical audit against the Healthcare Quality Improvement Partnership's publication *Clinical Audit: A simple guide for NHS Boards*
- Confirm that there are quality assurance procedures in place to whether the work of clinical auditors is properly planned, completed, supervised and reviewed

6.2.4 Seek assurance on Trust performance against CQUINS targets, Quality Account priorities and other quality standards.

6.3 Patient Safety

6.3.1 To ensure that risks to patients are minimised through the application of a comprehensive risk management system including:-

a) Review the Trust's Risk Management Strategy and Quality Governance Strategy prior to presentation to the Trust Board for approval
b) Identify areas of significant risk, set priorities and ensure these are fed into the Board Assurance Framework
c) Seek assurance that the Trust incorporates the recommendations from external bodies into practice and has mechanisms to monitor delivery e.g National Confidential Enquiry into Patient Outcomes and death, and applies the same principles to recommendations made internally, such as those arising from SIRI's and adverse incidents.
d) Escalate to the Trust Board any identified unresolved risks arising within the scope of these terms of reference that require actions beyond the remit of this committee and its members or that pose significant threats to the operation, resources or reputation of the Trust

6.3.2 Receive details of all clinical Serious Incident Requiring Investigation reports submitted to the TDA / CCG and be assured that all associated action plans have been fully implemented

6.3.3 Promote a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting incidents

6.3.4 Seek assurance that that there are robust processes in place that safeguard children and adults within the Trust

6.3.5 Seek assurance in relation to any wards or other clinical areas put into special measures

6.4 Patient Experience

6.4.1 Assure the Trust has reliable, real time, up to date information about what it is like to be a patient experiencing care provided by the Trust, so as to identify areas for improvement and ensure those improvements are effected

6.4.2 Receive and review quarterly reports detailing trends in clinical incidents, complaints, clinical claims, friends and family test outcomes and clinical effectiveness. Make recommendations to the SEE Committee for further action as appropriate.

7. REPORTING

7.1 The Quality and Clinical Performance Committee will report directly to the Trust Board. Copies of meeting minutes will be submitted to the Trust Board, Trust Executive Committee, the Audit and Corporate Risk Committee and the Finance, Investment and Workforce Committee for review and any necessary action.

7.2 The following committees and working groups will provide information to the Quality & Clinical Performance Committee by submitting their meeting minutes or summary reports and their top issues following every meeting to provide greater understanding clarity and understanding of their roles, as well as providing relevant assurance to the Quality & Clinical Performance Committee,

a) Clinical Directorate Boards
b) Patient Safety; Experience and Clinical Effectiveness Committee (SEE Committee)
c) Clinical Directorate Quality, Risk and Patient Safety Groups
d) Infection Prevention & Control Committee
e) Joint Safeguarding Committee
f) TV & Pressure Ulcer Group

7.3 In addition, the committee and working groups as listed in Appendix 1, may be asked to provide information and assurance to the Quality & Clinical Performance committee by sending their meeting minutes/notes and top issues reports on request.

8. DUTIES & ADMINISTRATION

8.1 It is the duty of the Committee to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour.

8.2 Furthermore, the Committee will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.

8.3 The committee will promote a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting incidents

8.4 The Committee shall be supported administratively by the PA to the Executive Director of Nursing and Workforce who will act as Committee Administrator, whose duties in this respect will include:

a) Agreement of agenda with Chairman and collation of papers
b) Circulate agenda papers a minimum of 5 working days in advance of the meeting
c) Take the minutes
d) In Line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting
e) Keeping a record of matters arising and issues to be carried forward
f) Maintaining an Action Tracking System for agreed Committee actions
g) In conjunction with the Chairman and Lead Executive Director, prepare an annual report on the effectiveness of the Committee for submission to the Audit & Corporate Risk Committee
h) Maintain an Attendance Register. The completed Register to be submitted to the Trust Chairman and attached to the Committee's annual report
i) Advising the Committee on pertinent areas.
j) To maintain agendas and minutes in line with the policy on retention of records

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9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

9.1 These Terms of Reference will be reviewed annually to ensure that the committee is carrying out its functions effectively.

9.2 The annual report to be submitted to the Audit & Corporate Risk Committee which will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Committee meetings.

9.3 Attendance and frequency of meetings will be monitored by the Committee Administrator and reported back to the Committee on a 6 monthly basis.

9.4 Work of other related committees will be reviewed via their minutes on a monthly basis. This will be monitored by the Committee Administrator and reported back to the Committee on an annual basis

9.5 Concerns highlighted when monitoring compliance with the above will be discussed at Quality and Clinical Performance Committee and referred to the Board immediately.

DRAFT - Head of Corporate Governance and Risk management – June 2014

Appendix 1

The following committees and working groups may be requested to provide information to the Quality and Clinical Performance Committee

CORPORATE

- Risk Management Committee
- Health and Safety Committee
- Food Hygiene and Nutrition Group
- Clinical Standards Group
- Health Records Committee
- Drugs Advisory Committee
- Medical Devices Group
- Matrons Action Group
- Clinical Nurse Leaders Forum

ACUTE DIRECTORATE

- Ambulance Clinical Effectiveness Group
- Hospital Transfusion Committee
- Critical care Delivery Group
- Falls Group
- Radiation Protection Committee

COMMUNITY HEALTH DIRECTORATE

- Safeguarding Report Group

PLANNED DIRECTORATE

- Perinatal (mortality and Morbidity) meeting
- Unexpected Outcomes / Labour Ward Forum
- Orthopaedic Mortality meeting
- Clinical Governance meeting – Paediatrics
- Unit Clinical Improvement Forum

Isle of Wight NHS
NHS Trust

For Presentation to Trust Board on 1st October 2014

FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE MEETING

Minutes of the Isle of Wight NHS Trust Finance, Investment, Information & Workforce Committee (FIWC) meeting held on Wednesday 17th September 2014 in the Large Meeting Room.

PRESENT:	Charles Rogers	Non-Executive Director (Chair) (CR)
	David King	Non-Executive Director (DK).
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Katie Gray	Executive Director of Transformation and Integration (EDTI)
	Kevin Curnow	Deputy Director of Finance (DDOF) *deputising for Executive Director of Finance*
	Mark Elmore	Deputy Director of Workforce (DDW)
In Attendance:	Stewart Churchward	Workforce Planning and Information Manager (WPIM) *(Item 14/148a)*
	Sarah Johnston	Deputy Director of Nursing (DDN) *(Item 14/148b)*
	Iain Hendey	Deputy Director of Performance, Information and Decision Support (DDPIDS) *(Items 14/147, 14/150c & 14/152)*
	Catherine Crocker	Senior Contract Manager (SCM) *(Item 14/153a)*
	Andrew Heyes	Head of Commercial Development (HoCD) *(Item 14/153b)*
	Andrew Shorkey	Business Planning and Foundation Trust Programme Manager (BP&FT) *(Item 14/154)*
	Gary Edgson	Head of Financial Management (HFM)
	John Cooper	Assistant Director of Finance (ADF)
Minuted by:	Sarah Booker	PA to Executive Director of Finance (PA-EDOF)

To be Received at the Trust Board meeting on Wednesday 1st October 2014
Key Points from Minutes to be reported to the Trust Board

14/148 **Ratification document for the provision of medical locums master vendor for the Trust.**
Although the Committee have not had sight of this report it was agreed in principle to recommend it is discussed and approved at the Trust Board meeting in order to start saving money.

14/148 **Staff Recruitment.**
The Committee note the continuing work being undertaken in order to improve recruitment of clinical staff and in particular Consultants.

14/150 **CIPs.**
The Trust is reporting CIP achievement of £3.642m against a target of £2.984m. This is c. £658k ahead of plan. Although, this is after £1.556m of future banking. This recognises the full budget removal of achieving CIP plans in advance of the original schemes phasing. The work of the Transformation Management Office is tasked with providing the Board with assurance of the achievable savings this financial year.

14/153	**Investments/Disinvestments - Approval of the Island Recovery and Integration Service (IRIS).** The Committee recommends the approval of the contract to the Trust Board.
14/154	**Self Certification.** Sufficient assurance has been provided for the committee to recommend that Trust Board approve the Self Certification returns as proposed.

14/141 APOLOGIES

Apologies for absence were received from Jane Tabor, Non-Executive Director (JT) and Chris Palmer, Executive Director of Finance (EDOF).

14/142 CONFIRMATION OF QUORACY

The Chairman confirmed that the meeting was quorate.

14/143 DECLARATIONS OF INTEREST

There were no declarations.

14/144 APPROVAL OF MINUTES

The minutes of the meeting held on the 20th August 2014 were agreed by the Committee and signed by the Chairman.

14/145 SCHEDULE OF ACTIONS

The Committee received the schedule of actions taken from the previous meeting on 20th August and noted the following:

A number of actions were closed.

- v 14/093i
- v 14/093ii
- v 14/094
- v 14/108
- v 14/109c
- v 14/111b
- v 14/125
- v 14/127a
- v 14/128a
- v 14/128c
- v 14/129a
- v 14/130

14/098 Trading Accounts – The Committee requested sight of a clear investment/disinvestment plan during the October FIIWC meeting. **Action: HoCD.**

14/127c Staff Survey Action Plan – This is being developed by Occupational Health and the Committee requested sight of this during the October FIIWC meeting. **Action: DDW.**

14/128b Capital Plan – The EDTI explained the risk is due to the work on Level C being stopped. Contractors have been taken off standby due to patients still occupying beds. Estates team need to be informed by directorates when the patients will be moved and the contractors can begin the work. **Action: EDNW to discuss with directorates and update the**

Committee in October.

14/146 LONG TERM STRATEGY AND PLANNING

v **Longer Term Financial Model (LTFM) & 2 year Operating Plan Update**

A planned refresh will take place in November 2014 due to the validation work that KPMG staff are undertaking. The Committee will be updated on this during the November meeting.

14/147 CONTRACTS AND ACTIVITY

(a) Contract Status Report Summary:

The DDOF noted the contract penalties as explained in this report have been accounted for.

There were no further comments on this report from the Committee members.

(b) Operational Performance including SLA Activity:

The DDPIDS discussed the report with the Committee and noted the following:

- v Planned Care – current position for Month 4 is £305k below plan which is a £30k increase from Month 3.
  - § Elective activity has moved a further £160k below plan in month.
  - § Previous coding issues in outpatients have now been rectified which caused a positive £50k movement in month across all points of delivery.
- v Unscheduled Care – current contract position is £430k above plan which is a £250k increase from Month 3.
  - § Accident and Emergency (A&E) activity – 908 attendances and £92k above plan which is an increase of £40k in month.
- v Key Performance/Penalties – July 2014 – there is still the issue around penalties for ambulance handovers as discussed during previous Committee meetings which the Trust is still negotiating with the Commissioners.

There were no further comments on this report from the Committee members.

14/148 WORKFORCE PERFORMANCE REPORT

(a) Workforce Performance Report including SBS Payroll Report:

The DDW discussed the ratification document for the provision of medical locums master vendor for the Trust which was tabled but will need to be approved and signed off at the next Trust Board meeting due to the contract

value. CR questioned how urgently the Trust needs to sign off this report and the DDW said as soon as the report is approved savings can be made.

Although the Committee have not had sight of this report it was agreed in principle to recommend it is discussed and approved at the next Trust Board meeting in order to start saving money.

The WPIM discussed the Workforce Report and noted the following:

- There has been a small paybill overspend in the month.
- Sickness is currently 3.64% - Trust target is 3%.
- This report will be revised and the Committee discussed which slides will be removed from the pack and which slides will be added to ensure the correct information is being provided each month.
- The DDOF suggested a slide showing the forward plan should also be included which would detail any gaps and show where the predicted biggest risks are. The DDW will circulate the new slides as discussed with the Committee after this meeting to all FIIWC members.

(b) <u>Safer Staffing Report:</u>

The DDN attended to update the Committee on the current position of Safer Staffing. The DDN explained the Trust Board has approved the development of a business case to start the implementation of the safer staffing model and to enable funding from reserves to be accessed via the Commissioners. For this work to progress the DDN recommended the Trust go 'at risk' in order to start the international recruitment and explained the 5 risks involved with the recruitment. The level of financial risk could be up to £990,210 if an additional 30 nurses were recruited to. This would relate to the recurrent costs in 2015/16 where there is no confirmation of funding from the Commissioners currently. The EDNW discussed the available funding from the Commissioners.

The DDN noted the Trust would recruit from the Philippines once with two dates to split the influx of the new staff. There are approximately 32 existing staff vacancies.

DK asked how the new staff will be accommodated. The DDW said an action group will start which will include current staff who have moved from the Philippines to work for the Trust and have therefore experienced the same situation who could discuss this further.

The DDW noted the Trust will be looking at targeted nursing fayres to recruit additional staffing.

The Committee were assured by this update and the reasons for the Trust going 'at risk' in order to progress the recruitment.

14/149 TRANSFORMATION MANAGEMENT OFFICE

(a) <u>Transformation Management Office (TMO) Report including QIAs, RAG rated milestones, benefits realisation</u>:

The EDTI explained the Trust Savings Plan Thermometer which details the breakdown of savings plan by directorates and the reconciliation to the

financial savings reported to date. The rag rating was explained to the Committee.

The DDOF noted the Finance team should validate the figures on these reports to ensure they reconcile with the ledger. Action: EDTI & Finance.

(b) Capital Planning:

The Committee discussed the reporting of Capital Planning for future meetings and the EDOF and EDTI will discuss this further outside of this meeting. Action: EDOF & EDTI.

(c) Recurrent/Non Recurrent CIP allocation by directorates & schemes:

This was discussed alongside the Trust Savings Plan Thermometer in item 14/149a.

14/150 FINANCIAL PERFORMANCE

(a) Financial Performance Report

The DDOF briefed the Committee on the report and noted the report will be modified imminently to ensure information is not being duplicated in other areas.

The following was noted:

- £90k behind plan in month although forward banking supports this position significantly (£1.5m forward banked this month). Although the Trust is forecast to hit its forecast adjusted surplus the risks are becoming greater and focus must remain on delivery of CIPs. The Continuity of Service Risk Rating (CoSRR) remains at green.
- Cash in bank is currently good at £9,724k but there is a Public Dividend Capital payment of £1.6m due in September which will have an impact on the position next month.
- The total year-to-date capital spend amounted to £941k against a planned spend of £3,642k.
  DK questioned when the Trust Savings Plan Thermometer will be a realistic document. The EDTI noted the project will finish tomorrow and will then be locked down. This should not significantly affect the current figures.

(b) Losses and Compensation

The DDOF presented this report and noted the Committee has sight of this biannually and this report is dated from 1st April 2014 – 31st August 2014. The majority of the losses are write off debts for non-recoverable items. The £7.5k was an out of court settlement which was signed off by 2 Executive Directors. **The EDOF can authorise Losses and Special Payments up to £1k and 2 Executive Directors will need to sign off from £1k - £5k.**

Greater losses will need to be signed off by the Trust Board. Action: ADF to check these figures in the Standing Financial Instructions (SFIs).

Post meeting note: DDOF confirmed the SFIs state the EDOF can sign off Losses and Special Payments up to £1k and 2 Executive Directors can sign off between £1k - £25k so the £7.5k out of court settlement will not need to be signed off by the Trust Board.

The DDOF noted it would be useful for this report to include figures from last year as a comparison. Action: DDOF to discuss with Senior Financial Accountant (SFA) who creates this report.

Post meeting note: The ADF discussed including comparative figures onto the next report with the SFA who will also include breakdowns by type and area.

The EDTI questioned why there are write off payments every month for private patients. CR noted the HoCD has been working on tightening up procedures for Mottistone so these payments should reduce as a result. **The DDOF recommended write off payments should be returned to cost centres accordingly. Action: DDOF & HoCD.**

(c) Reference Costs

The DDPIDS briefed the Committee on the report and noted the following:

- The 2013/14 Reference (RC) submission was produced and verified by the Service Line Reporting Team.
- As Reference Costs are produced from the latest SLR model, it uses costing allocations that have been developed by the costing team working as far as possible with our service leads.
- In line with good practice we made a number of pre-submissions of our reference costs in advance of the final deadline to ensure adherence to Department of Health validation processes. As a result of this, and because of improvements in processes and costing methodologies, this year's submission contained zero mandatory validations, and only 32 non mandatory validations (previous year was c.1,986 non mandatory validations), a vast improvement on last year.
- It should be noted that a significant number additional hours were required from the team in order to ensure the timely production of our reference costs submission.
- Changes from last year - Within the Acute services, there was a significant increase in activity for outpatient procedures of 33% accompanied by an increase in costs of 14%. There has been a small shift from day case & non-elective short stays to elective or non-elective long stays (2 or more days as an inpatient). Outpatient attendances increased slightly but there was a reduction in costs. Overall, this translates to an increase in cost by 2.6% due along with an increase in activity of 6.4%.

CR thanked the DDPIDS for this report. The DDPIDS will report back to this Committee with the national results in January 2015 when we will know our relative position compared to all other organisations.

Action: PA-EDoF to include on the agenda for January 2015.

14/151 AUDIT AND GOVERNANCE

Nothing to report on this month.

14/152 INFORMATION

(a) Data Quality:

The DDPIDS presented the report and noted the following:

- The latest information is up to June 2014.
- We have no red rated indicators in either the outpatient or A&E datasets but there are four in the Admitted Patient Care (APC) Dataset. In the APC dataset records with an invalid or missing NHS number has gone from amber to red this month, this is however a relatively small number and is likely to relate to prisoners as their NHS number is often unknown and difficult to trace.
- There is also a relatively small number of invalid or missing postcodes the reasons for this anomaly are unclear and will be reviewed and where possible corrected.
- The Primary Diagnosis and HRG4, (Healthcare Resource Grouping) are linked as you need the diagnosis to generate the HRG, the number missing has improved this month which reflects improvements to the timeliness of coding.

14/153 INVESTMENT / DISINVESTMENTS

(a) Approval of the Island Recovery and Integration Service (IRIS) :

The SCM attended to brief the Committee on the paper detailing the Island Recovery and Integration Service (IRIS). The Trust has been awarded the three year contract to start on 1st October 2014 to the value of £4.16m (£1.38m per year).

The SCM noted that we have designed this service and therefore we have control of the whole pathway and the lack of engagement from the previous service provider will be addressed.

The DDW said the 3 members of staff who will need to be TUPED over to the Trust will require a GAD certificate so they will be seconded initially until these certificates are received.

The Committee were in agreement to approve the contract to be signed off at the next Trust Board meeting.

(b) NHS Creative Strategic Review Update:

The HoCD attended to update the Committee on the current position of NHS Creative. Mazars Internal Auditors undertook an audit on NHS Creative in June 2014 which gave a limited assurance opinion and raised recommendations which have been listed in the audit report. The HoCD will

ensure these recommendations are carried out and can update this Committee on a monthly basis if required.

DK suggested the Committee has sight of their 5 year plan. Action: The HoCD to include this in a future update report to the Committee.

The ADF queried the £300k in receipts noted in the paper and the HoCD explained this is due to work being paid for in advance but the money cannot be banked until the work has been completed.

CR noted this is a more optimistic report and the Committee agreed to receive a further update during the January 2015 meeting. **Action: PA-EDoF to include on January agenda.**

14/154 SELF CERTIFICATION REVIEW

The self-certification report was received by the Committee. The BP&FT attended for this item and advised that the status had not changed since the August return. It could now be clearly communicated that in consideration of the formal outcome of the Chief Inspector of Hospitals' inspection undertaken by the Care Quality Commission (CQC) in June 2014, which resulted in the Trust receiving a 'Requires Improvement' rating, Board Statements 1, 2, 6 and 14 had been confirmed as 'at risk'. A detailed action plan had been developed to manage delivery of the required improvements. Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, remained 'at risk' until a positive trend towards recovery was established. It was noted that the Trust's Governance Risk Rating score had significantly declined since July. The Trust's Licence Conditions were all marked as compliant.

A query was raised as to which particular Board Statements the Committee should be focusing on and the BP&FT advised that 4, 6, 7, 8, 9, 11, 12, 13 and 14 were of particular interest to the Committee. However, the Committee were advised to comment on all statements if required. The BP&FT clarified that the Committee's monthly review of the self-certification return would not be affected by the pause in the Trust's Foundation Trust application and this would be an ongoing requirement under current arrangements agreed by the Board.

It was agreed to that the Committee would recommend to the Board that the self-certification return be submitted to the Trust Development Authority as set out in the report.

14/155 COMMITTEES PROVIDING ASSURANCE

(a) Minutes from the Capital Investment Group

The Committee agreed these minutes are very useful and there were no further comments.

(b) Quality and Clinical Performance Minutes from Meeting 20/08/14

There were no comments on these minutes.

14/156 ANY OTHER BUSINESS

(a) Approval of Finance, Investment, Information and Workforce Committee Terms of Reference:

The Committee were in agreement to approve the terms of reference for ratification at the next Trust Board meeting. **Action: Trust Board Administrator to include on the agenda.**

(b) Changes to Committee Dates:

The Committee discussed the proposed dates and were in agreement to move the FIIWC meetings from the 3rd Wednesday to the 4th Tuesday in every month as noted in the email proposal from the Trust Board Administrator to the PA-EDoF. This is on the agreement that these dates are suitable for Non-Executives' diaries.

(c) NHS Trusts – Off-Payroll Worker Reviews:

The DDW noted an email was received from Ernst & Young stating that 'all workers providing services to central Government departments and their arms-length bodies (such as the NHS) must have their contracts reviewed and the results of those reviews must be reported to Parliament as part of the annual reports process'. The DDW confirmed the Trust was not required to undertake a review as a statement had already been made in our published Annual Report and was only meant for Trusts who had not published this information in their Annual Reports.

14/157 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Finance, Investment & Workforce committee to be held is on Wednesday 22nd October 2014 from 12.30pm – 3.30pm in the Large Meeting Room.

The meeting closed at 3.50pm.

Enc K

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 OCTOBER 2014

Title	Finance Investment Information Workforce Committee Terms of Reference			
Sponsoring Executive Director	Company Secretary			
Author(s)	Head of Corporate Governance & Risk Management			
Purpose	Revised Board Sub Committee Terms of Reference for Board review and approval			
Action required by the Board:	**Receive**		**Approve**	**P**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee	17 September 2014	Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

The attached document sets out the newly agreed Terms of Reference for the Finance Investment Information Workforce Committee. Following the recent issue of the updated Audit handbook the ToR were reviewed & the 'roles & responsibilities' and the 'main purpose' have been updated to reflect these developments. They have been revised following agreement to include additional responsibilities for Information Management & Technology. These Terms of Reference were approved at the FIIWC meeting held on 23rd July 2014.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	All					
Critical Success Factors *(see key)*	All					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	5.21 – 5.36					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	X
Legal implications, regulatory and consultation requirements						

Date: 23 September 2014 **Completed by: Brian Johnston, Head of Corporate Governance & Risk Management**

FINANCE, INVESTMENT, INFORMATION AND WORKFORCE COMMITTEE

Terms of Reference

Document Type:	Committee Terms of Reference
Date document valid from:	1st October 2014
Document review due date:	June 2015

AUDIT TRAIL:

Dates reviewed	July 2014	**Version number**	V2/Sept 13
Dates agreed:	23 July 2014	**Version number:**	V3
Details of most recent review: (*Outline main changes made to document*)	· Updated members list. · Additional Responsibilities to include Information Management and Technology · Update Roles & Responsibities for all existing areas. Amendments undertaken by: · Head of Corporate Governance and Risk Management · Deputy Director of Finance		
Approved by the Committee on 23rd July 2014. **Print Name:** Charles Rogers **Post Held:** Non Executive Director **Date: 23/07/14**			

Trust Board Approval Authorised Signature	
Authorised by:	**Danny Fisher**
Job Title:	**Chairman of Trust**
Approved at:	**Trust Board**
Date Approved by Trust Board:	**1st October 2014**

FINANCE, INVESTMENT, INFORMATION AND WORKFORCE COMMITTEE

TERMS OF REFERENCE

1. MAIN PURPOSE

1.1 The overall aim of the committee is to undertake objective scrutiny of the Trust's longer term financial strategy, financial performance and major investment and workforce decisions. The committee is also responsible for the objective scrutiny of Information Management and Data Quality. This will include:

a) Consideration of the Trust's medium to longer term financial strategy and reviewing and monitoring financial plans

b) Monitoring financial performance against plan, reviewing and reporting any proposed remedial action to the Board as necessary

c) Scrutiny of major business cases, tenders and oversight of the capital programme

d) Maintaining oversight of the finance and investment functions, key financial policies and other financial or investment issues that may arise

e) Monitoring workforce performance and cost against plan, reporting any proposed remedial action to the Board as necessary.

f) Maintaining oversight of workforce related strategies and initiatives including culture, staff survey and health and wellbeing.

g) Maintaining oversight of Data Quality and Information Management.

2. MEMBERSHIP AND QUORUM

2.1 Members

2.1.1 The Committee will consist of 6 members

2.1.2 A Non-Executive Director will be appointed as chair of the committee as agreed by the Board.

2.1.3 The following membership will be approved by the Board
- Non-Executive Director (Chair)
- Non-Executive Director (Vice-chair)
- Non-Executive Director
- Executive Director of Finance (Director Responsible for Information)
- Executive Director of Transformation and Integration
- Executive Director of Nursing and Workforce

2.1.4 The following will be in attendance:
- Deputy Director of Finance
- Deputy Director of Workforce

2.2 Quorum

2.2.1 A quorum shall be three, one of whom shall be a non executive director.

2.2.2 A designate Non Executive Director can also be included as part of the quorum.

2.2.3 A Non-Executive Director will be appointed as Chair of the committee as agreed by the Board.

2.2.4 Committee members will nominate a deputy to attend in their absence as appropriate. These deputies to have full voting rights.

2.2.5 Attendees may also send deputies in their absence who are non-voting.

2.2.6 The Trust Chairman, Chief Executive and other Executive Directors may attend at any time.

2.2.7 When the Committee is discussing areas of risk or operation, any other director, manager or employee may also be required to attend in order to present papers or to provide additional information in support of discussions.

2.2.8 In line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting.

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3. ATTENDANCE AT MEETINGS

3.1 All members should attend a minimum of 9 of the 12 monthly meetings

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4. FREQUENCY OF MEETINGS

4.1 The Committee will meet monthly.

4.2 The Chair of the Committee may call for additional meetings should the need arise.

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5. DELEGATED AUTHORITY

5.1 The Finance, Investment, Information and Workforce Committee is a sub-committee of, and directly accountable to, the Trust Board.

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6. ROLES AND RESPONSIBILITIES

6.1. Longer Term Strategy and Planning

6.1.1 Review the annual budget, prior to submission to the Board and the development of a 3 to 5 year financial strategy and the Longer Term Financial Model (LTFM) ensuring it is aligned with clinical, estates, workforce, ICT and other business strategies, making a clear link with the assumptions on allocations, activity, investment and disinvestment, and consistency with Monitor and Department of Health guidance.

6.2 Financial performance

6.2.1 Review the Trust's financial reporting performance including the delivery of revenue and capital plans, cost improvement plans and comparison against activity and SLA targets in addition to monitor the adequacy and effectiveness of the Trust's financial performance reporting and make recommendations to the Board.

6.2.2 Monitor the efficient use of the Trust's financial resources for the provision of services and to commission and consider risk based, in-depth reviews of financial performance (in particular service areas/Divisions or Trust-wide), including the relationship between underlying activity, workforce performance and utilisation, income and expenditure and budgets.

6.2.3 Monitor the efficient use of the Trust's financial resources for the provision of services

6.2.4 Monitor the delivery of the achievement of the agreed Cost Improvement Programme, seeking opportunities for further cost improvements and recommending the Cost Improvement Programme to the Board obtaining assurance that no cost improvement has an unforeseen detrimental impact on quality of care; and to make recommendations as necessary to the Board about action required in-year.

6.2.5 On behalf of the Board, regularly review the performance of the Trust against the Monitor Compliance Framework

6.3 Finance functions

6.3.1 Oversee the development and implementation of business systems across the Trust that have a significant impact on income and expenditure

6.3.2 Review the key policies and business strategies that have a financial implication for the organisation (e.g. Estates, ICT, Workforce and Organisational Development)

6.3.3 Maintain an oversight of, and receive assurances on the robustness of the Trust's key income sources and contractual safeguards

6.3.4 Review key cost drivers such as procurement practice and human resources assets

6.3.5 Act as an Assurance Committee of the Trust's business and financial risks via the Board Assurance Framework, providing such assurance to the Audit and Corporate Risk Committee.

6.3.6 Approve the quarterly returns of the Trust to the independent regulator, Monitor (once authorised as a Foundation Trust)

6.3.7 Review self certification monthly returns prior to submission to Board

6.3.8 Ensure appropriate capacity and capability is available to support financial decision-making within the Trust

6.3.9 Review the Balance Sheet and in particular the factors relating to liquidity and financial risk triggers.

6.3.10 Review Reference Costs and Service Line Reporting

6.3.11 Review the planning, delivery and the financial implications of any business cases, commercial tenders and the Trust's Capital Programme.

6.4 **Investment**

6.4.1 Ensure development of the Trust's Investment Policy to oversee the development of and review the application and adequacy of the Trust's investment and disinvestment strategy on a regular basis and ensure this is maintained in accordance with best practice. Recommend the adoption of the Investment Policy by the Board.

6.4.2 Review business cases for major investments , defined as greater than £500,000, against the Trust's strategy and test compliance with the investment policy

6.4.3 Maintain an oversight of the Trust's investments, ensuring compliance with Trust policy.

6.4.5 Consider post project evaluation reports on significant capital investments and monitor delivery of action plans developed from lessons learnt.

6.4.6 Consider the Trust's procurement policy and strategy and ensure this is maintained in accordance with best practice.

6.5 Workforce

6.5.1 Review the Workforce Performance Reports including compliance in respect of sickness, appraisals and mandatory training and adequacy and reliability of this reporting.

6.5.2 Monitor the annual and five year workforce plans and the HR and OD strategy and action plan

6.5.3 Receive updates on Culture, Staff Survey and Health & Wellbeing.

6.5.4 Receive ad-hoc reports and/or presentations on key performance indicators

6.5.5 Review financial implications of any significant workforce changes

6.5.6 Receive updates on finance, workforce and ESR systems

6.5.7 Receive updates on outsourced services

6.5.8 Receive the Education and Training annual report

6.5.9 Receive the minutes and key issues of the Strategic Workforce Group

6.6 Information Management and Technology

6.6.1 Ensure the integrity of financial, clinical and other Information

6.6.2 Ensure that relevant metrics, measures and milestones are developed and reported so as to understand the progress and delivery of performance

6.6.3 Oversight of Data Quality and receive updates on any required improvements

6.6.4 Oversight of the Trust's compliance with Information Governance requirements and to review the IM&T strategy and recommend it to the Board and to monitor progress against and risks associated with the strategy and monitor other IM&T related improvement plans.

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7. REPORTING

7.1 The Finance, Investment and Workforce Committee will report directly to the Trust Board.

7.2 All recommendations of the Finance, Investment, Information and Workforce Committee to also be reported to the Trust Executive Committee (IBP Assurance).

7.3 Copies of meeting minutes will be submitted to the Trust Board, Trust Executive Committee, the Audit and Corporate Risk Committee and the Quality and Clinical Performance Committee for review and any necessary action.

7.4 The Committee shall refer to the Audit and Corporate Risk Committee any matters requiring review or decision making in that forum.

7.5 Attendance and frequency of meetings will be monitored by the Committee Secretary and reported back to the Committee on an annual basis.

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8. DUTIES AND ADMINISTRATION

8.1 It is the duty of the Committee to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour.

8.2 The Committee will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.

8.3 The Committee shall be supported administratively by the PA to the Executive Director of Finance, the Committee Administrator, whose duties in this respect will include:

a) Agreement of agenda with Chairman and collation of papers
b) Circulate agenda papers a minimum of 5 working days in advance of the meeting
c) Take the minutes
d) In Line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting
e) Keeping a record of matters arising and issues to be carried forward
f) Maintaining an Action Tracking System for agreed Committee actions
g) In conjunction with the Chairman and Lead Executive Director, prepare an annual report on the effectiveness of the Committee for submission to the Audit & Corporate Risk Committee
h) Maintain an Attendance Register. The completed Register to be submitted to the Trust Chairman and attached to the Committee's annual report
i) Advising the Committee on pertinent areas.
j) To maintain agendas and minutes in line with the policy on retention of records.

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9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

9.1 These Terms of Reference will be reviewed annually to ensure that the committee is carrying out its functions effectively.

9.2 The annual report to be submitted to the Audit & Corporate Risk Committee which will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Committee meetings.

9.3 Attendance and frequency of meetings will be monitored by the Committee Administrator and reported back to the Committee on a 6 monthly basis.

9.4 Work of other related committees will be reviewed via their minutes on a monthly basis. This will be monitored by the Committee Administrator and reported back to the Committee on an annual basis.

9.5 Concerns highlighted when monitoring compliance with the above will be discussed at Finance, Investment, Information & Workforce Committee and referred to the Board immediately.

APPENDIX

LEGAL GUIDANCE

- Department of Health's Manual for Accounts
- Standing Financial Instructions (SFIs)
- Standing Orders (SOs)
- Scheme of Reservation and Delegation
- Cash Management in the NHS
- Statutory responsibility for Annual Revenue and Capital Resource Limits
- Department of Health's 'Costing' Manual
- EU Public Procurement Rules
- HSG(93)5 Standards of Business Conduct for NHS Staff
- Estatecode and Concode
- NHS Act 2006
- CIPFA Guide Pooled Budgets: A practical guide for Local and Health Authorities
- HSC(1999)246 – delegated limits for capital schemes
- Data Protection Act 1998
- Code of Conduct for NHS Managers 2002
- ABPI Code of Professional Conduct relating to hospitality/gifts
- Secretary of State's Directions in the NHS Counter Fraud and Corruption Manual
- Managing Public Money
- Treasury Financial Reporting Manual (FReM)
- International Financial Reporting Standards (IFRS)
- Prudential Borrowing Code where appropriate

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 October 2014

Title	Serious Incidents Requiring Investigation (SIRIs) Report			
Sponsoring Executive Director	Sarah Johnston Deputy Director of Nursing			
Author(s)	Vanessa Flower Patient Experience Lead			
Purpose	To provide assurance to the Board in relation to the process for reporting, investigating and learning from SIRIs			
Action required by the Board:	**Receive**	P	**Approve**	

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	17 September 2014
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Lessons learned are shared with teams after analysis is completed.

Executive Summary:

This report provides an overview of the 3 Serious Incidents reported during August 2014, as well as identifying the lessons learnt from SIRIs closed by the commissioner during August 2014.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	1					
Critical Success Factors *(see key)*	CSF2					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	2.6					
Assurance Level ***(shown on BAF)***	Red		Amber	P	Green	
Legal implications, regulatory and consultation requirements						

Date22 September 2014 **Completed by: Vanessa Flower, Patient Experience Lead**

Isle of Wight NHS Trust

Isle of Wight NHS Trust
Serious Incident Requiring Investigation (SIRI) Report
Isle of Wight NHS Trust Board – 1 October 2014
Reports of SIRIs for August 2014

1. Background:

1.1. A serious incident is defined as an incident that occurred where a patient, member of staff or the public has suffered serious injury, major permanent harm, and unexpected death or where there is a cluster / trend of incidents or actions which have caused or are likely to cause significant public concern.

1.2. Near misses may also constitute a serious incident where the contributory causes are serious and may have led to significant harm. Reporting and investigating serious incidents can ensure that the organisation can learn and improve from identified systems failures.

2. New Incidents:

2.1. During August 2014 the Trust reported 3 Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG) and are all currently under investigation using Root Cause Analysis (RCA) methodology.

2.2. The incidents reported by category were:

2.2.1. **Grade 4 Pressure ulcer:** Pressure ulcer deteriorated whilst under NHS Trust services.

2.2.2. **Confidential Information Leak:** Email sent from personal unsecure email to number of recipients including external unsecure email address, which contained personal identifiable data.

2.2.3. **Unexpected death:** Unexpected death of community patient known to Trust Services.

3. SIRIs to be signed off:

3.1. The Quality and Clinical Performance Committee (QCPC) are responsible for signing off the completed SIRI reports at the point that the action plans are fully completed.

4. At their meeting on 17 September 2014, the Quality and Clinical Performance Committee approved the completed action plans related to 3 incidents.

5. Lessons Learnt from SIRIs closed during August 2014 by Commissioners.

Subject/Learning
Failure to act on abnormal test results
Lessons Learned: · Any abnormalities observed by the radiologists should be flagged up immediately and direct contact made to the referring clinician with the results, either by a telephone conversation or e-mail. In this case paper reports were sent to the department and filed in notes without being seen or signed by a member of clinical staff. · Robust Audit trail has been put in place to ensure that any clinical abnormalities that are identified on an x-ray are directly reported to the referring clinician, until electronic solution is in place.
Piece of retained ribbon gauze found in a wound during surgical procedure.
Lessons Learned: · Theatre staff must always retain inappropriate packing material whenever this is removed during a surgical procedure. · When changing any packing materials theatre staff and clinicians must be consulted and involved in the decision making process. · Always consult with product standardisation group to identify alternatives when products normally used are not available for any reason. Theatres should also have an agreed 'back-up' or substitute for whenever a product normally used is not available for any reason. · Product used was not appropriate for packing surgical wounds. This product has since been removed from theatre product list so is no longer available for selection for procedures where a radio-opaque product is required. This will prevent any further similar incidents occurring in future. · Theatre notes need to be more detailed to include clear descriptions of actual packing used in all procedures relating to the type of wound being packed
Grade 3 avoidable pressure ulcer
Lessons Learned: · All registered nurses to undertake pressure ulcer competencies · The ward to consider the use of intentional rounding · All patients returning from theatre should have a repeat risk assessment for pressure areas carried out

Sarah Johnston
Deputy Director of Nursing
23 September 2014
Prepared by: Vanessa Flower, Patient Experience Lead

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1st OCTOBER 2014

Title	Safer Staffing Monthly Report			
Sponsoring Executive Director	Executive Director of Nursing and Workforce			
Author(s)	Deputy Director of Nursing			
Purpose	To receive information related to planned nursing hours versus actual nursing hours to obtain oversight of nurse staffing within the organisation. To receive assurance of actions being taken to address shortfalls			
Action required by the Board:	**Receive**	X	**Approve**	

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

The report information is sent to Ward sisters and matrons and comments provided

Executive Summary:

The details of the compliance requirements against the National Quality Board's standards are highlighted in ***'How to ensure the right people, with the right skills, are in the right place at the right time'*** (National Quality Board November 2013) and the recent document ***'Hard Truths Commitments regarding the publishing of staffing data'*** sent to Trust CEOs and Directors of Nursing on 31 March 2014.

This report forms one of the compliance requirements, and details actual staffing against planned levels. The report includes an evaluation of the overall position associated mitigating actions and impact on quality of patient care.

A local RAG rating has been developed and discussed at the 3rd July Trust Board, and this is applied to the data to enable the Trust to work to address shortfalls where identified. In addition clinical indicators are reviewed to triangulate staffing information to clinical outcomes.

The Executive Director of Nursing & Workforce has sought assurance where data indicates shortfalls and actions are in place to review these areas.

The processes for reviewing and triangulating data is in place in the Directorates and there is ongoing work following this first report improve assurance to the Board.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Quality					
Critical Success Factors *(see key)*	CSF1 CSF2 CSF 9					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***						
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	The report meets new requirements identified by NHS England					

Date: 19/09/2014 **Completed by: Deputy Director of Nursing**

Isle of Wight NHS Trust Board
Safer Staffing
Monthly Report
Wednesday 1st October 2014

1. EXECUTIVE SUMMARY

1.1. This paper is to provide a report to the Trust Board on the status of Nursing and Midwifery safe staffing at the Isle of Wight NHS Trust during August 2014.

1.2. The details of the compliance requirements against the National Quality Board's standards are highlighted in ***'How to ensure the right people, with the right skills, are in the right place at the right time'*** (National Quality Board November 2013) and the recent document ***'Hard Truths Commitments regarding the publishing of staffing data'*** sent to Trust CEOs and Directors of Nursing on 31 March 2014.

1.3. This report forms one of the compliance requirements, and details planned nursing hours both registered and unregistered, by day and night, against actual hours delivered. This is the Unify report. (Appendix 1)

1.4. The report includes an evaluation of the overall position associated mitigating actions and impact on quality of patient care. The Trust is currently using data collected from the Roster Management System (MAPS). The accuracy of the MAPS system is not consistent and this is being addressed.

1.5. For areas that are rated red (Appendix 2) under our own local rating the Executive Director of Nursing & Workforce has sought assurance that areas are aware of this, understand the reasoning behind this, and actions are taken to address this.

1.6. To ensure robust reporting the senior nursing team are putting in place weekly review of staffing position at the Director of Nursing Team meeting.

1.7. Daily reporting is in the process of being instigated with the Inpatient wards with a focus on Stroke, General Rehabilitation and Supportive Care, and A&E which are areas highlighted by the CQC as areas of concern.

1.8. There is still work to do to ensure all rota's, from which MAPS pulls its information, are correct. This has been slower than anticipated with technical issues not being able to be resolved which impacts on accurate monitoring. Maternity rosters remain difficult to report on in an accurate way due to a disconnect between managing a rota that supports the flexible way midwives work, and being able to accurately reflect hourly input to care on the electronic system. This does pose a risk that we are inaccurately reflecting our care input in some areas on the Unify report which may be misleading to the public when this information is displayed on NHS Choices and our web pages. There has been no realisation of that risk since the report has been in place.

2. Monthly Report of Safer Staffing

2.1. The Trust is reporting on the "actual against planned" staffing levels for each month. The wards where staffing pressures have been identified are highlighted, (Appendix 2) and the potential impact on patient care are assessed using the Quality indicators (Appendix 3).

2.2. The current method of collecting actual staffing data against planned establishment is undertaken through ward staff inputting into the MAPS© database and making a Professional Judgement following a discussion with the Matron or Head of Clinical Service (HOC).

2.3. Professional Judgement is used to determine 'whether the actual staff used was safe or of concern. We have used the RAG rating as described at June Board.

3. Reporting of Shortfalls

3.1. Minimum staffing and escalation levels are addressed locally then escalated as required through Matrons, Heads of Clinical Service, Deputy Director of Nursing, Executive Director of Nursing and (Duty Managers out of hours) as outlined in the Trusts Rostering Procedure.

3.2. Ward Boards are updated daily and reviewed by the Matron. Rapid deployment is sometimes required at the discretion of the Matron or Head of Clinical Service. This will be captured in the MAPS system for future reporting.

3.3. It was not always possible to fill all escalation shifts. On these occasions various steps are taken to ensure patient safety. These actions include: adjusting planned workload; admitting emergencies to other wards; adding the ward sister to the rostered numbers on the wards; moving staff to other areas.

Reasons for shortfalls during August 2014

The following information is provided by Ward Sisters/Charge Nurses in relation to rationale for identified shortfalls

- Vacancies or sickness not being able to be filled with bank staff
- Rota's not reflective of true requirements
- Non fill of bank staff for registered nurses, particularly for 1:1 care for dementia patients

NB A new version of MAPS software is being put in place during September and October with a planned date of mid October to go live with this system

- There is limited assurance that rostering is done well, adhering to rules for provision of leave or enough proactive management of rotas to best manage staff availability effectively

Actions to mitigate

Monitoring and assurance

- The new rostering policy will make clear expectations for rota management
- The new version of MAPS is being put in place and it is expected that technical anomalies will be eradiated
- The Director of Nursing team are taken on weekly oversight and review.

Ensuring staff availability

- Bank nurses are being requested but there is limited availability of registered nurses at times. Recruitment to the bank and longer term strategy to manage this needs to be considered in conjunction with additional recruitment

- Utilising non registered for registered roles or vice versa is occurring if there is not the required level of staff available. This occurs more with non registered staff being more frequently available

- New rostering policy and training for rota management will support more effective management.

- Recruitment drive is in place – vacancies have been recruited to during August. GRSC are now up to full complement of staff against current establishment.

Longer term actions

- Our recruitment drive will continue to resource to vacancies and includes a more proactive approach to recruiting students.

- Our international recruitment is under way and we anticipate being able to recruit additional staff for placement in January and February

- There is ongoing work to drive down sickness in the organisation

Risks and issues the Trust is seeking to address

The current method of collecting actual staffing data against planned establishment is through MAPS database which is underutilised, open to user error but able to provide data on a shift by shift basis. In order to improve the robustness of data collection and reporting arrangements, the Trust is collaborating with Allocate Software who are the main provider of the rostering system. Support has been requested on the following areas;

1. Use of MAPS for the management of safe staffing. Rota allocation and an even spread of the resource available.

2. The use of roster perform – This identifies rota compliance against 4 core standards
    a. Safety
    b. Effectiveness
    c. Fairness
    d. Unavailability

The Trust is working to improve the quality and staffing metrics in order to triangulate the impact of staffing levels.

Triangulation Quality Indicators

Appendix 3 shows the aggregated quality indicators that will be used to assess staffing impact on the quality of care delivered in that area. Analysis suggests that those areas that have a higher number of unachieved indicators (Emergency Department & Maternity Services) are not necessarily those with the highest rate of fill.

The Trust's compliance with the Timetable of Actions

The details of the overall requirement for the Trust against the 'Timetable of Actions' included within the documents published on the 31 March 2014: is indicated in Table 2

Table 2

A Six monthly reports to the Trust Board on staffing capacity and capability, through a review of the staffing establishments using an evidence based tool. This review of establishment was last undertaken in January 2014 and is next planned for June 2014. This will be reported to the December 2014 Trust Board. We expect to see NICE guidance later this financial year which will prompt further reviews of patient acuity and dependency. This is an iterative process. As such the total numbers of staff required will be fine tuned at regular intervals throughout the year. The 6 monthly report was provided in the Board papers for June 2014.	
B Shift by shift display of actual staff numbers against expected by designation i.e. Registered or Health Care Assistant, on boards on the wards – this is in place across the Trust.	
C The Trust Board receives a report update detailing actual staffing against planned on a shift by shift basis and is advised of those wards where there are shortfalls. This includes the reasons for the gap and the impact on quality of care as well as action taken to address the gap1 **This item has changed** from green to amber to indicate that the reason for the gap is not identified robustly enough to provide adequate assurance of safe staffing. Further assurance will be sought.	
D The Trust will publish the report in a form accessible to patients and the public on its website and on NHS Choices, under an accessible site entitled 'Nurse Staffing' – Board reports are available to the public via our webpage's on 24th June 2014 as per national timescales.	
E The planned and actual staffing should be reviewed on a shift by shift basis. This occurs for each shift and actions are put in place i.e. requesting bank staff, moving staff from one area to another or making a professional judgement as to whether the ward can provide care with the reduce number of staff for that shift (i.e. tasks may be allocated to a later shift or non urgent activities postponed. This is rated amber currently as there is ongoing work to enable us to capture this information in order to provide assurance to the Board.	

1 Subsequent to the National Quality Board reporting guidance, there has been a shift to reporting in hours rather than shifts. This can be seen in the Trusts Unify Submission Report (Appendix 2)
2013) http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
2. ***'Hard Truths Commitments regarding the publishing of staffing data'*** (March 2014)
http://www.england.nhs.uk/wp-content/uploads/2014/03/timetable-actions.pdf

Recommendations

The Trust Board is asked:

1. To note the Trust's monthly staffing figures for planned and actual for Inpatient areas.

2. To note the identification of shortfalls in staff and mitigating actions.

3. To note the Trust's status of compliance in relation to the National Quality Board's requirements.

4. To note the urgent requirement for automation in the data collection, and reporting process to improve the quality assurance required.

Sarah Johnston
Deputy Director of Nursing
Sept 2014

Appendix 1 Monthly actual figures by ward as uploaded on the Unify return

Ward name	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Shackleton	465	488.5	1395	1302.5	294.5	301.33	589	609	105.1%	93.4%	102.3%	103.4%
Orthopaedic Unit	2325	1824.5	1953	1742.5	1240	1200	930	977.25	78.5%	89.2%	96.8%	105.1%
Seagrove	930	965.6	930	1203.34	620	546	620	843.5	103.8%	129.4%	88.1%	136.0%
Osborne	1440	1173.25	1005	1049.25	930	682.5	294.5	621	81.5%	104.4%	73.4%	210.9%
Mottistone	930	927.75	397.5	356	620	590	20	14	99.8%	89.6%	95.2%	70.0%
St Helens	1632	1577.5	1255.5	1101.5	620	620	620	580	96.7%	87.7%	100.0%	93.5%
Stroke	1860	1630	1627.5	1874	620	620	620	780	87.6%	115.1%	100.0%	125.8%
Rehab	1627.5	1649	1627.5	1571	620	620	620	620	101.3%	96.5%	100.0%	100.0%
Whippingham	1674	1479.25	1488	1292	930	780	620	690	88.4%	86.8%	83.9%	111.3%
Colwell	1395	1426.83	1785	1845.25	620	610	620	620	102.3%	103.4%	98.4%	100.0%
Intensive Care Unit	3255	2966.75	465	335.51	2007.25	1813.75	286.75	195.5	91.1%	72.2%	90.4%	68.2%
Coronary Care Unit	2325	2117.75	697.5	705.5	1550	1365.25	310	420	91.1%	101.1%	88.1%	135.5%
Neonatal Intensive Care Unit	1054	867.1	418.5	477.5	620	610	310	290	82.3%	114.1%	98.4%	93.5%
Medical Assessment Unit	2355	2609.75	1087.5	1131.5	930	930	620	620	110.8%	104.0%	100.0%	100.0%
Afton	930	961	930	956.01	310	320	620	667.5	103.3%	102.8%	103.2%	107.7%
Paediatric Ward	1632.5	1226.5	415	366.5	620	626.75	310	290	75.1%	88.3%	101.1%	93.5%
Maternity	1860	1371.25	710	461	1240	1242.5	620	600	73.7%	64.9%	100.2%	96.8%

Overall percentage fill rates as calculated by the Unify return – Aug 2014 data

Day				Night							
Registered midwives/nurses		Care Staff		Registered midwives/nu		Care Staff		Day		Night	
Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
27690	25262.28	18187.5	17770.86	14391.75	13478.08	8630.25	9437.75	91.2%	97.7%	93.7%	109.4%

Appendix 2

Unify data for Aug 2014 – Rag rated with locally set RAG rating

95% -100+%	
90-94.9% and ward sister opinion +ve	e.g. care was maintained safely, acuity and dependency manageable, staff moved to cover etc
90-94.9% and ward sister opinon -ve	e.g. below 95% regularly, no cover able to be obtained, care could be compromised etc
<90%	

	Ward	Day		Night		
		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Professional Opinion
Paula Smith	Shackleton	105.1%	93.4%	102.3%	103.4%	No cover able to be obtained. Care was managed safely with staff moved to cover deficits.
Heidi Meekins/Caroline Moul	Orthopaedic Unit	78.5%	89.2%	96.8%	105.1%	Templates are currently not reflective of the actual rota utilised true picture
Andy Tate	Seagrove	103.8%	129.4%	88.1%	136.0%	Inaccurate data - 2:1 care utilised during part of August
Vicky Haworth	Osborne	81.5%	104.4%	73.4%	210.9%	Inaccurate data - registered nursing staff cover has been adequate to provide safe care.
c/o Sue Biggs	Mottistone	99.8%	89.6%	95.2%	70.0%	staff were moved from other areas to ensure safe cover
Mandy Webb	St Helens	96.7%	87.7%	100.0%	93.5%	
Anna New	Stroke	87.6%	115.1%	100.0%	125.8%	1:1's requried for patients during August
Natalie Mew	Rehab	101.3%	96.5%	100.0%	100.0%	
Fiona Mitchell	Whippingham	88.4%	86.8%	83.9%	111.3%	Hca's used to cover some vacant RN shifts, to help maintain patient safety. When possible staff moved to cover vacant shifts. Patient care and safety maintained.
Tina Beardmore	Colwell	102.3%	103.4%	98.4%	100.0%	

	Ward	Day		Night		
		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Professional Opinion
Laura Moody	Intensive Care Unit	91.1%	72.2%	90.4%	68.2%	During this period of time the number of patients to staff ratio was within the safe staffing ratio for Intensive Care level 3 patients.Nursing staff worked very flexibly to ensure that they changed shifts to cover days when the unit had more patients or shifts were short due to both long and short term sickness.2 WTE vacancies currently advertised .There were no short staffing Incident forms during this period.
Marcia Meaning	Coronary Care Unit	91.1%	101.1%	88.1%	135.5%	We have permanently recruited 2.5wte who were in post from 24/8/14, we have appointed an additonal 1.6 wte and are awaiting references and CRB to confirm start date. We have spread bank requests across the week to ensure a balance of ward to bank staff. Ward sister and clinic staff have back filled where safety was a concern.Where no registered nurse available we have utilised HCA to help maintain numbers if skill mix was unattainable. We have continued to incident report staffing concerns.
Jacky Harry	Neonatal Intensive Care Unit	82.3%	114.1%	98.4%	93.5%	x1 WTE Band 6 vacancy unfilled. X1 0.8WTE long term sick. No headroom to allow for sickness and annual leave. Very little specialist bank available. Managed by Band 7 and deputy working clinically, paying excess hours and staff rotas rearranged to mitigate any risk.Care maintained.
Jessy Gulati	Medical Assessment Unit	110.8%	104.0%	100.0%	100.0%	No further comments to add.

	Ward	Day		Night		
		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Professional Opinion
David Stratton	Afton	103.3%	102.8%	103.2%	107.7%	Futher assurance required on accuracy of data. 1:1's used when required
Matthew Powell	Paediatric Ward	75.1%	88.3%	101.1%	93.5%	Care maintained safely through B7 / B8 stepping into numbers . Acuity and dependency managed appropriately. No alternative cover arrangements available.
Annie Hunter	Maternity	73.7%	64.9%	100.2%	96.8%	Technical difficulties with demonstrating adequate rota coverage

Appendix 3

Ward Summary Dashboard - August 2014

KPIs by Location

Location	Staff Levels	% Bank Staff	Staff Sickness	Mandatory Training	Falls with harm	Pressure Ulcers	VTE Risk Assmt	C. Diff.	MRSA	FFT Survey	Likely to Recommend	Formal Complaints	Concerns
Community & Mental Health													
Mental Health													
Afton Ward	3	13.8%	5.48%	86.6%	0	0	0.0%	0	0	n/a	n/a	0	0
Osborne Ward	0	7.1%	0.63%	87.4%	0	0	39.3%	0	0	n/a	n/a	0	0
Seagrove Ward	3	9.7%	4.93%	91.6%	0	0	0.0%	0	0	n/a	n/a	0	0
Shackleton Ward	0	3.2%	5.97%	91.6%	0	0	0.0%	0	0	n/a	n/a	0	0
Community													
Stroke Neuro Rehab	3	15.0%	5.12%	87.1%	0	0	100.0%	0	0	24.0%	100.0%	1	2
General Rehab and Step Down Unit	-2	11.4%	0.41%	89.8%	1	0	100.0%	0	0	62.5%	85.0%	0	0
Hospital & Ambulance													
Medical													
Colwell Ward	1	8.8%	4.85%	84.0%	0	2	100.0%	0	0	50.0%	97.1%	0	0
Emergency Department	-1	6.3%	5.01%	92.4%	0	1	n/a	0	0	23.2%	90.2%	1	6
MAAU	-3	0.0%	0.66%	93.9%	1	0	97.8%	0	0	59.7%	97.3%	1	1
Surgical													
Mottistone Ward	0	13.6%	8.17%	80.9%	0	0	98.7%	0	0	24.7%	95.0%	0	2
St Helens Ward	14	11.4%	3.84%	72.2%	1	2	97.9%	0	0	26.4%	93.0%	0	1
Whippingham Ward	9	0.0%	7.17%	75.3%	1	2	100.0%	0	0	25.3%	100.0%	0	4
Crititcal care													
Intensive Care Unit	-4	0.0%	2.85%	90.6%	0	0	50.0%	0	0	n/a	n/a	0	0
Coronary Care Unit	-9	10.8%	1.17%	84.2%	1	0	99.0%	0	0	79.4%	100.0%	0	0
Endoscopy													
Maternity													
Maternity Services	0	1.5%	4.69%	77.6%	0	0	34.0%	0	0	n/a	n/a	0	1
Neonatal Intensive Care Unit	0	5.0%	2.87%	81.8%	0	0	n/a	0	0	n/a	n/a	0	1
Orthopaedic Unit													
Orthopaedic Unit	4	12.7%	5.40%	75.2%	2	1	100.0%	0	0	46.1%	98.3%	0	5
Childrens													
Paediatric Ward	-3	0.0%	0.62%	84.4%	0	0	n/a	0	0	n/a	n/a	0	2

Isle of Wight NHS Trust

FOR PRESENTATION TO TRUST BOARD ON 1 OCTOBER 2014

CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee held on the 9th September 2014 at 8.30 a.m. in Seminar Room 4, Education Centre, St. Mary's Hospital, Newport.

PRESENT:	Nina Moorman	Non Executive Director (Chair)
	John Cooper	Interim Head of Financial Services (Deputising for Executive Director of Finance)
	Katie Gray	Executive Director for Transformation & Integration
	Annie Hunter	Head of Midwifery (Staff Representative)
	Sarah Johnston	Deputy Director of Nursing
	Lizzie Peers	NED Financial Advisor to Trust Board
	June Ring	Patient Council Representative
	Vincent Thompson	Friends of St. Mary's
	Sue Wadsworth	Non Executive Director
In Attendance:	Mark Price	Company Secretary
	Richard Dent	Volunteer Co-ordinator
	Katie Parrott	Senior Financial Accountant
	Tracey Thompson	Financial Accountant
	Jenny Honeyman	Business Manager, Education, Training & Development (Item 14/045)
	Di Eccleston	Joint Head of Occupational Health (Item 14/050)
	Andy Heyes	Commercial Manager (Items 14/049 & 14/050)
Minuted by:	Linda Mowle	Corporate Governance Officer

Min. No.	Top Key Issues
14/047	**Draft Annual Report & Accounts 2013/14:** Independent examination to be undertaken in October/November 2014
14/054	**Approval of Items over £5k:** Helipad Walkway Extension - £11,636
14/059	**Patient Council Representative:** June Ring has stepped down and a new representative and deputy to be appointed by the Patient Council.

14/040	**APOLOGIES** for absence were received from David King, Chris Palmer and Kevin Curnow.
14/041	**QUORACY:** The Chair confirmed that the meeting was quorate.
14/042	**WELCOME:** The Chair, on behalf of the Committee, welcomed Lizzie Peers, Katie Gray and Sarah Johnston to their first meeting of the Committee.
14/043	**DECLARATIONS OF INTEREST:** There were no declarations.
14/044	**MINUTES:** The minutes of the meeting held on the 10th June 2014 were agreed and signed by the Chair as a true record, subject to the following amendment: · **Min. 14/027 Charitable Funds Annual Report 2013/14:** to be renamed 'Charitable Funds Sub-Committee Annual Report 2013/14'.

14/045	**MATTERS ARISING FROM PREVIOUS MEETINGS:** The Committee reviewed the schedule of actions and agreed that the Chair review the schedule to see what items can be closed. **Action: NM** **Min. No. 13/036(c) Charitable Funds Leaflet and Posters:** The draft leaflet and poster prepared by Andy Hollebon, Head of Communications and Engagement, was tabled. Following review, the Committee was of the opinion that the photograph and text needed to be revised and agreed that: · Text - the Senior Financial Accountant to update **Action: SFA** · Photograph - the Deputy Director of Nursing, in conjunction with Andy Hollebon, to select a photograph which is more representative of the whole organisation **Action: DDN** · Distribution – the Volunteer Co-ordinator to arrange distribution via a group of volunteers together with a list of the distribution locations **Action: VC** · Final version of Leaflet and Poster – to be emailed to Committee members for agreement and Chairman's Action **Action: HOC** · Update to be presented to the December meeting of the Committee. **Action: HOC** **Min. No. 14/033 Further Education Awards:** The 5 year summary and evaluation of the Further Education Awards was introduced by the Business Manager for Education, Training and Development. The Committee noted that over the 5 year period 99 members of staff have received support for courses covering both clinical and non clinical subjects, enabling career progression. The Committee was cognisant that the Trust was a training organisation which promoted further development through training, research and education and which, in turn, benefited greatly from the enhanced expertise acquired through such further development. The Committee considered that the training opportunities available should be encouraged within the Trust and promoted more widely, particularly in the recruitment and retention of staff, and that a section be included within the Organisational Strategy. **Action: EDTI**
14/046	**REVIEW OF CHARITABLE FUNDS STRATEGY 2014-2017/18:** The revised Strategy, which included comments submitted by CFC members, was received. The Committee was of the view that the Strategy was too lengthy and needed to be more focused, and the Chair agreed to undertake a refresh of the document taking into account comments by Lizzie Peers and Mark Price. **Action: NM/LP/MP** The Committee reflected on how the Strategy would be implemented without a dedicated resource, and that possibly small working groups of the Committee could be utilised to take forward a specific project. The Chair to present the revised Strategy to the December meeting of the Committee following email circulation to CFC members for agreement. **Action: NM**
14/047	**DRAFT ANNUAL REPORT & ACCOUNTS 2013/14 (CHARITY COMMISSION):** The Senior Financial Accountant presented the draft Charitable Funds Annual Report and Accounts for the year ended 31st March 2014. The Committee noted that the Independent Examination by Ernst & Young is to be undertaken during October/November and will be presented to the December meeting and

	included within the Report. The Chair requested that comments and/or amendments to the Annual Report and Accounts be emailed direct to the Senior Financial Accountant. The final Report and Accounts to be presented to the December meeting for agreement before approval by the Corporate Trustee. The deadline for the submission of the Accounts and Annual Report is the 31st January 2015. **Action: SFA**
14/048	**INTERNAL AUDIT REPORT – CHARITABLE FUNDS 2014/15:** The Committee received and noted the internal audit report providing 'Substantial Assurance' on the Trust's Charitable Funds. The Senior Financial Accountant reported that of the 6 recommendations, 2 recommendations have been completed (immediate and 31 August 2014). With regard to recommendation 1.3 Awareness of Gift Aids in Wards/Departments, the SFA tabled a draft revised letter, with the Committee making the following comments for inclusion: · 'UK tax payer' to be included in the reply slip · Gift aid does not impact on your tax and it costs you nothing · Email address and telephone extension to be added The Committee agreed that the SFA email the updated letter to the Chair for final agreement. **Action: SFA** An updated action plan on the implementation of the recommendations to be presented to the December meeting of the Committee. **Action: SFA** The Company Secretary advised that, as a point of principle, the Chair of the Committee should be included within the circulation of relevant draft reports and that he will recommend this to the Internal Auditors. **Action: CS**
14/049	**FRIENDS OF ST. MARY'S MEMORANDUM OF UNDERSTANDING (MOU):** The Commercial Manager, Andy Heyes, and Vincent Thompson presented the MOU between the Friends of St. Mary's and the IOW NHS Trust, outlining that the MOU recognises the Friends of St. Mary's as a valued partner who will support the Trust where possible in achieving the Charitable Funds objectives. The MOU is aligned to the Friends of St. Mary's Constitution and captures the additional responsibilities for the Friends, whilst adhering to Trust policies. The Chairman requested that comments be emailed direct to the Commercial Manager within the next week, and to take into account mandatory training for all volunteers. The updated MOU to be circulated to CFC members for agreement by the end of September in order that the formalised MOU can be signed by the Chief Executive. **Action: ALL/CM/VT**
14/050	**2014/15 FUNDRAISING APPEALS/PROJECTS:** The Committee was updated on the following initiatives: · **Friends of St. Mary's Lottery:** The Committee was cognisant of The Unity Lottery as this had been discussed at two previous CFC meetings and were, in principle, supportive of the introduction of the Lottery. However, how this would be implemented through the Friends of St. Mary's and communicated to staff required to be clarified in a written proposal with clear recommendations. The Commercial Manager to take forward with Vincent Thompson and present a proposal to the December meeting of the Committee. **Action: CM/VT** · **Toy Trust – Toys & Crafting Supplies:** The Committee noted for information the donation of toys and craft supplies as a result of the

	Toy Trust's annual charity fundraiser held on the Isle of Wight on the 8th June 2014. · **Outdoor Gym Survey:** Di Eccleston, Joint Head of Occupational Health, presented the results of the survey on the use of the outdoor gym. The Committee noted that the learning disability clients of the Phoenix Project use the gym on a weekly basis but that overall there needed to be more publicity to encourage staff to use the gym. Di Eccleston advised that rubber matting had been purchased to reduce mud on the access path and that there is to be a focus on advertising the gym's location via leaflets, a map on the intranet and photos of the gym and sign marking the access path. It was felt that lighting would be a potential health and safety risk for becoming a 'hang out' spot after dark, as were litter bins a potential fire risk. A further survey is to be undertaken later in the year following the advertising. However, the main concern was that females felt that the gym was too isolated and were therefore worried about their security. The Committee considered that the following options could be planned and included in the advertising: · Supervised 'taster/getting started' sessions to be organised with possibly volunteers providing supervised training · Designated session once or twice a week after 3.00 p.m. with trainer · Keep fit sessions – beginners, intermediate, advance · A fund raiser event/staff team building session · Health buddy service – exercise with a friend The Committee requested that an update be provided to the Committee following the advertising campaign and survey in order to monitor usage. **Action: JHOH/VC**
14/051	**HEALING ARTS:** The update report prepared by Guy Eades, Healing Arts Director, was received and the following noted: · **Healing Arts Repair and Conservation Fund**: Current framing of artworks is being undertaken for the Discharge Unit, Ante Natal Clinic, Diagnostic Imaging, Sevenacres – Osborne and Seagrove Wards, Orthotics, Breast Care Clinic and Education Centre · **Healing Arts Management Committee**: The re-established Committee, which will report to TEC, will be meeting on 9th October 2014 to agree and confirm its terms of reference, membership and cycle of future meetings · **Maintenance and Gardens**: Healing Arts, linking with the Trust's Volunteers Team and the Trust's Estates Department, is preparing a proposal for future gardens maintenance on the St. Mary's site based on the discussions at the June CFC meeting. It will seek to include gardens at the Chemotherapy/Mottistone Unit, Seagrove/Osborne/ Afton Wards at Sevenacres, Shackleton Unit, Stoke/Rehabilitation ward, and Workhouse Burial Ground. This proposal will outline the work of the volunteer team currently being established, the potential and role for including other partners from the Community and a request for funding towards enabling this work to be delivered in 2025/16 with the support of the horticultural skills and knowledge of the contractor, CAR Gardens. This application for funding will be made to the December meeting of the CFC.

14/052	**FUND MANAGERS' EXPENDITURE PLANS 2014/15:** The Senior Financial Accountant presented the Fund Managers' Expenditure Plans for 2014/15 advising that currently 5 funds do not have a spending plan 4 of which are under £1,600 and one is £22,000 and which has been escalated to the Associate Director for action. The Committee noted that fund managers are required to provide supporting evidence/written justification that items to be purchased are an enhancement to services and not required in order to provide 'core' services, which includes approval from medical devices, infection control and health and safety. The Committee considered that a review of the processes and procedures for purchasing items of equipment, etc. should be undertaken and agreed that the Chair, Executive Director of Finance, Senior Financial Accountant and Company Secretary meet to discuss the efficacy of the process. **Action: NM/EDF/CS/SFA** The Committee to be updated at its December meeting on the outcome of the discussions which would provide a governance assurance trail on why it is an enhancement to service and following this, in order to provide assurance, a sample of purchases could be scrutinised to ensure the processes and procedures have been implemented. **Review of Funds:** The report prepared by the SFA dated 2nd September 2014 on the review of funds as at 31st July 2014 was received. The Committee noted that generally there was good coverage of areas with funds but that there were 13 departments currently without a fund. Applications to the General Fund are open to any area of the Trust. A fund is not opened unless there is a minimum donation of £500 in order to minimise administration and eliminating the need to create funds unnecessarily. The SFA advised that in reviewing the current funds there are 11 funds with balances of less than £500 and that in the coming months, these funds will be encouraged to utilise their balances with a view to closing the funds if it is unlikely that further donations will be received. An update report to be presented to the CFC meeting in December. **Action: SFA**
14/053	**BALANCES, INCOME AND EXPENDITURE:** The SFA reported on the current income, balances and expenditure for the period May-July 2014 with no items over £5,000 needing approval. With regard to NICU and Barely Born Fund, Annie Hunter agreed to discuss with SFA, outside of the meeting, alignment of the funds as the priorities for the Unit have now been achieved. **Action: AH/SFA**
14/054	**REQUESTS FOR CONSIDERATION:** The following bids were considered: **<u>Annual Awards Ceremony</u>:** **Electronic Voting Equipment –** For the 2014 Trust Awards agreed to hire the equipment at an approximate cost of £4,350 and that a full business case for the purchase, marketing and management of electronic voting equipment be developed for consideration at a future CFC meeting. **Action: HOC** *Post meeting note: The cost of the voting equipment hire charge to be included within the overall funding of £5,700 and sponsorship monies.*

	Filming – The purchase of 3 iPads and associated equipment/accessories at a cost of £2,488 deferred for further investigation by the EDT&I and Chairman's action, if required. **Action: EDT&I/NM** *Post meeting note: The cost of the iPads and associated equipment/accessories, should Chairman's action be to purchase the iPads, will be in addition to the overall funding of £5,700 from General Fund.* **Radio Communications -** Purchase of 6 two way radios with ear pieces at a cost of £200 agreed with the proviso that EDT&I checks the availability of walkie-talkies and advises the Chair if required in order for Chairman's action to be taken. **Action: EDT&I/NM** *Post meeting note: Should Chairman's action be to purchase the two-way radios and ear pieces, the cost will be funded from within the overall funding of £5,700 and sponsorship monies.* **Patient Christmas Present Contribution 2014:** Agreed £5 per patient and those wards without their own fund can apply for funding from the General Fund. **Helipad Walkway Extension:** Retrospective agreement of £11,636 from General Fund (approved by email voting at the end of June 2014) for approval by Corporate Trustee. **Action: NM**
14/055	**FRIENDS OF ST. MARY'S – BIDS UPDATE:** The Committee noted that the Friends Trustee's meeting to consider the bids was being held on the evening of the 9th September 2014 and that the outcome of the discussions will be emailed to the SFA. **Donated Equipment on Rolling Replacement Programme:** The extract from the Trust's Rolling Replacement Programme, sorted by location, was received. The SFA advised that the donated items are included within the Trust's Asset Register. The Committee noted that the list has been circulated to Associate Directors and Business Managers/Heads of Performance for review and updating and that the updated list will be presented to the next meeting of the CFC in December in order to consider how best to fund any items requiring replacement. **Action: SFA**
14/056	**INVESTMENT POLICY REVIEW:** The Committee received the extract of the Investment Strategy which outlines the policy that is currently adhered to. The Committee agreed that a formal Investment Strategy be prepared which incorporates: · the investment paragraph contained within the overall CFC Strategy · ethical policy to be expanded to include alcohol In addition, the Committee asked to review the Reserves Policy and the Cash Policy. The two Policies to be submitted to the December meeting of the Committee. **Action: DDF/SFA**
14/057	**LEGACIES UPDATE:** The SFA presented the update on restricted and unrestricted legacies for the period May – July 2014. With regard to the restricted legacy for the Intensive Care Unit, the Committee noted that the plan to purchase a new clinical information system has been

	postponed until next year whilst it is being investigated in conjunction with IT. The Committee requested the detail to support whether a new clinical information system was an enhancement to core services. **Action: SFA**
14/058	**e-BULLETIN ITEMS:** The Committee agreed that the following items be included in e-Bulletin in order to promote the work of Charitable Funds: · Publicity for staff and patient bids · Funding for the Annual Awards Ceremony · Charitable Funds Leaflet and Poster – available soon on all wards and departments · Outdoor Gym **Action: SFA/HOC**
14/059	**PATIENT COUNCIL REPRESENTATIVE:** June Ring advised that this would be her last meeting as she was stepping down from the Committee. It was expected that a new Patient Council Representative and deputy would be appointed shortly. The Chair, on behalf of the Committee, thanked June for her contribution to the work of the Committee and wished her well for the future.
14/060	**DATES OF 2014/15 MEETINGS:** 09 December 2014 – apologies received from Sue Wadsworth 10 March 2015

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 01 OCTOBER 2014

Title	FOUNDATION TRUST PROGRAMME UPDATE				
Sponsoring Executive Director	FT Programme Director / Company Secretary				
Author(s)	Programme Manager – Business Planning and Foundation Trust Application				
Purpose	To Approve				
Action required by the Board:	**Receive**	**✓**	**Approve**		
Previously considered by (state date):					
Trust Executive Committee		Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee		Nominations Committee (Shadow)			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee		Remuneration Committee			
Foundation Trust Programme Board					
Please add any other committees below as needed					
Board Seminar					
Other (please state)					
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 Foundation Trust. 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. The key points covered include: · Progress update · Communications and stakeholder engagement activity · Key risks					
For following sections – please indicate as appropriate:					
Trust Goal *(see key)*	5				
Critical Success Factors *(see key)*	10 - Develop our organisational culture, processes and capabilities to be an outstanding organisation and employer of choice				
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***					
Assurance Level ***(shown on BAF)***	Red		Amber		Green
Legal implications, regulatory and consultation requirements	A 12 week public consultation is required and concluded on 11 January 2013.				
Date: 22 September 2014	**Completed by: Andrew Shorkey**				

ISLE OF WIGHT NHS TRUST
NHS TRUST BOARD MEETING WEDNESDAY 1 OCTOBER 2014
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. Programme Plan

The Trust's trajectory towards Foundation Trust status has been impacted by the outcome of the Chief Inspector of Hospitals visit undertaken by the Care Quality Commission (CQC) in early June 2014. The outcome was confirmed following the Quality Summit held with key stakeholders on 2 September 2014 and is the subject of a separate report to this Board meeting. The Trust received a **'requires improvement'** rating and this has resulted in a pause in the Trust's FT application - a minimum delay of 6 months.

The Trust advised the CQC that it recognised and accepted the 'requires improvement' rating and will work with partners to ensure that the improvements made are the right ones and are sustainable. An action plan and governance arrangements have been put in place to address the CQC's findings. The action plan will be managed by the Patient Safety, Experience and Clinical Effectiveness Triumvirate (SEE), with oversight by the Trust Executive Committee and Board Assurance provided through the Quality and Clinical Performance Committee.

The Trust will need to ensure that it is both clinically and financially sustainable to progress its FT application. The Trust's quality governance assessment, governance risk rating (Monitor access and outcomes measures), and financial position will need to be delivered according to Monitor's required thresholds. Finances will continue to be strengthened through the development of the recurrent cost improvement programme. Work will also continue to strengthen the Trust's governance arrangements. Our membership will continue to be developed, but recruitment activity will be reduced and Governor elections will not be progressed until a firm timeline has been established. The revised timeline and milestones towards FT status will need to be determined with the Trust Development Authority (TDA).

The FT Programme Board will meet in October to agree what development work is required during the pause period and how this will be prioritised.

4. Communications and Stakeholder Engagement

Firm focus has remained on membership recruitment activity. As at 19 September 2014 the Trust has 4644 members which is an increase of 204 members since last report, therefore, steady progress is being made towards the next target of 6,000 members by April 2017 agreed with the TDA. The table below identifies the current membership breakdown by constituency.

Constituency	Membership	Required before election
North and East Wight	1510	500
South Wight	1085	500
West and Central Wight	981	500
Elsewhere ('Off Island')	483	250
Volunteers	585	-
Total	**4644**	**1750**

In addition 32 members were recently recruited and will be reflected in the above breakdown following an update of the Capita database. This will take the overall total to 4676 members.

At 19 September 2014 a total of 2883 staff are shown as members. Only staff directly employed by Isle of Wight NHS Trust with permanent contracts longer than 12 months are eligible to become staff members. The staff constituencies are:

Constituency	Membership
Administration and Estates Staff	137
Allied Health Professionals Scientists and Technicians	899
Healthcare Assistants and Other Support Staff	403
Medical & Dental	563
Nursing and Midwifery staff	881
Total	**2883**

Current development work includes:

- Membership meeting scheduled for 22 September 2014
- 13/10/14 - Medicine for Members – focus on maternity/obstetrics
- Late October – Autumn Members Magazine
- 30/01/15 - Medicine for Members – focus on orthopaedics/joint replacement

Engagement activity has also been undertaken to assure stakeholders in relation to the CQC assessment and its implications. This has to date included sessions with staff, Patients Council, Health and Wellbeing Board and the Health Scrutiny sub-committee.

5. Key Risks

The risk relating to the failure to achieve a good or outstanding rating from the CQC following the Chief Inspector of Hospitals assessment has matured and the Trust's FT application has been deferred. As outlined above a new trajectory will need to be agreed with the TDA. However, the Trust is unlikely to achieve FT status prior to General Election in 2015 and, in this context, may need to consider its option for health and adult social care

integration.

The Trust's governance risk rating (Monitor access and outcomes measures) has also significantly declined following an improved position in July. This, together with the CQC rating, has resulted in five of the Trust's self-certification Board Statements being flagged as at risk and significant work will need to be undertaken to deliver against the CQC action plan and performance targets to provide the necessary assurance to return to a compliant status.

Notwithstanding the need to address quality and performance issues, the Trust must also deal with significant financial challenges and deliver recurrent cost improvement plans which are currently off target. Work continues to further develop service improvement plans and recurrent cost improvement plans to ensure that the Trust can demonstrate ongoing sustainability. This work is supported by lean specialists KM&T, to identify further opportunities for efficiency and cost reductions.

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
FT Programme Director/Company Secretary
22 September 2014

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 OCTOBER 2014

Title	Board Self-certification			
Sponsoring Executive Director	FT Programme Director / Company Secretary			
Author(s)	Programme Manager – Business Planning and Foundation Trust Application			
Purpose	To Approve			
Action required by the Board:	**Receive**		**Approve**	**√**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Nominations Committee (Shadow)	
Charitable Funds Committee		Quality & Clinical Performance Committee	17-Sep-14
Finance, Investment & Workforce Committee	17-Sep-14	Remuneration Committee	
Foundation Trust Programme Board			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Directors, Performance Information for Decision Support (PIDS) and relevant lead officers have been engaged with to develop the assurance process.

Executive Summary:

This paper presents the September 2014 Trust Development Authority (TDA) self-certification return covering the August 2014 performance period for approval by Trust Board.

The key points covered include:

- Background to the requirement
- Assurance
- Performance summary and key issues
- Recommendations

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	5					
Critical Success Factors *(see key)*	10 - Develop our organisational culture, processes and capabilities to be a thriving FT					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***						
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	Meeting the requirements of Monitor's *Risk Assessment Framework* is necessary for FT Authorisation.					

Date: 18 September 2014 **Completed by: Andrew Shorkey**

ISLE OF WIGHT NHS TRUST
BOARD 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 August 2014 reporting period, prior to submission to the Trust Development Authority (TDA) in September 2014.

2. Background

Since August 2012, as part of the Foundation Trust application process the Trust was required to self-certify on a monthly basis against the requirements of the SHA's Single Operating Model (SOM). The Trust Development Authority (TDA) assumed responsibility for oversight of NHS Trusts and FT applications in April 2013 and the oversight arrangements are outlined within its *Accountability Framework for NHS Trust Boards*.

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

In March 2014 the TDA published a revised *Accountability Framework* for 2014/15. There were no fundamental changes with respect to the self-certification requirements.

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

3. Assurance

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

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

4. Performance Summary and Key Issues

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

Board Statements

1. In consideration of the formal outcome of the Chief Inspector of Hospitals' inspection undertaken by the Care Quality Commission (CQC) in June 2014, which has resulted in the Trust receiving a 'Requires Improvement' rating, Board Statements 1, 2, 6 and 14 have been confirmed as 'at risk'. A detailed action plan has been developed to manage delivery of the required improvements. Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, remains 'at risk' until a positive trend towards recovery is established. This position is reflected within the draft return document (Appendix 1a).

Licence Conditions

2. All Licence Conditions are marked as compliant. However, Condition G7 (Registration with the Care Quality Commission) could be put at risk if the CQC action plan is not delivered sufficiently to the satisfaction of the CQC. It is not presently recommended that this condition be put at risk. This position is reflected within the draft return document (Appendix 1b).

5. Recommendations

It is recommended that the Trust Board:

(i) Consider feedback from Board sub-committees and determine whether any changes to the declarations at 1a and 1b;
(ii) Approve the submission of the TDA self-certification return;
(iii) Identify if any Board action is required

Andrew Shorkey
Programme Manager – Business Planning and Foundation Trust Application
17 September 2014

6. Appendices

1a – Board Statements
1b – Licence Conditions

7. Supporting Information

- *Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards,* 31 March 2014
- *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards,* TDA, 12 April 2013
- *Risk Assessment Framework,* Monitor, 27 August 2013

Z2 - 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 (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.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed work to clarify gaps in assurance and test systems and processes is underway.	30-Oct-14	Alan Sheward Mark Pugh
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed work to clarify gaps in assurance and test systems and processes is underway.	30-Oct-14	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 has regard to the NHS Constitution.	Yes			Karen Baker Mark Price
6	All current key risks 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	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed work to clarify gaps in assurance and test systems and processes is underway.	30-Oct-14	Mark Price
7	The board has considered all likely future risks 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 operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes			Karen Baker
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 relevant GRR [Governance Risk Rating]; and a commitment to comply with all commissioned targets going forward.	At risk	The Trust's Governance Risk Rating (Monitor access and outcome measures) score has significantly declined. Issues impacting on performance are understood and indicator recovery plans have been reviewed. Early indications suggest that a number of these indicators will be recovered in advance of our next submission.	30-Sep-14	Alan Sheward Mark Pugh

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes			Mark Price
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	Yes			Mark Price
13	The board is satisfied 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 operating plan; and the management structure in place is adequate to deliver the annual operating plan.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed work to clarify gaps in assurance and test systems and processes is underway.	30-Oct-14	Karen Baker Alan Sheward

Z2 - 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)	Yes			Mark Price
2	Condition G7 – Registration with the Care Quality Commission	Yes			Mark Price
3	Condition G8 – Patient eligibility and selection criteria	Yes			Alan Sheward
4	Condition P1 – Recording of information	Yes			Chris Palmer
5	Condition P2 – Provision of information	Yes			Chris Palmer
6	Condition P3 – Assurance report on submissions to Monitor	Yes			Chris Palmer
7	Condition P4 – Compliance with the National Tariff	Yes			Chris Palmer
8	Condition P5 – Constructive engagement concerning local tariff modifications	Yes			Chris Palmer
9	Condition C1 – The right of patients to make choices	Yes			Alan Sheward
10	Condition C2 – Competition oversight	Yes			Karen Baker
11	Condition IC1 – Provision of integrated care	Yes			Alan Sheward Mark Pugh

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 OCTOBER 2014

Title	Board Assurance Framework			
Sponsoring Executive Director	Company Secretary			
Author	Head of Corporate Governance and Risk Management			
Purpose	To note the Summary Report, the risks and assurances rated as Red, and approve the September 2014 recommended changes to Assurance RAG ratings.			
Action required by the Board:	**Receive**		**Approve**	X

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee	14.08.19 Objective 5	Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	17.09.14 Objective 1
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)	None		

Staff, stakeholder, patient and public engagement:

None

Executive Summary:

The full 2014/15 BAF document was approved by Board in June 2014, including the high scoring local risks from the Corporate Risk Register, together with associated controls and action plans.

It was agreed that the Board would receive dashboard summaries and exception reports only for the remainder of the year.

The dashboard summary includes summary details of the key changes in ratings: there is one Principal Risk now rated as Red; 11 new Risks have been added since the July 2014 report.

The exception report details FOUR recommended changes to the Board Assurance RAG ratings of Principal Risks: changes from Amber to Green for 7.5, 7.12, 7.15 and 9.6. 10.22 returns to Amber as Trust Board in July did not approve that change to Green.

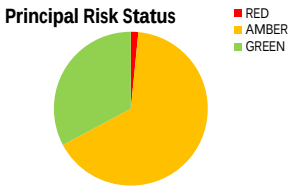
For following sections – please indicate as appropriate:

Trust Goal *(see key)*	All five goals					
Critical Success Factors *(see key)*	All Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	All Principal Risks					
Assurance Level ***(shown on BAF)***	Red	X	Amber	X	Green	X
Legal implications, regulatory and consultation requirements	None					

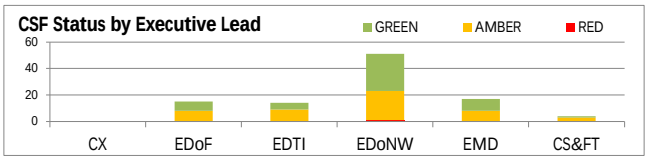
Date: 22 September 2014 **Completed by: Brian Johnston**

BAF Status Report

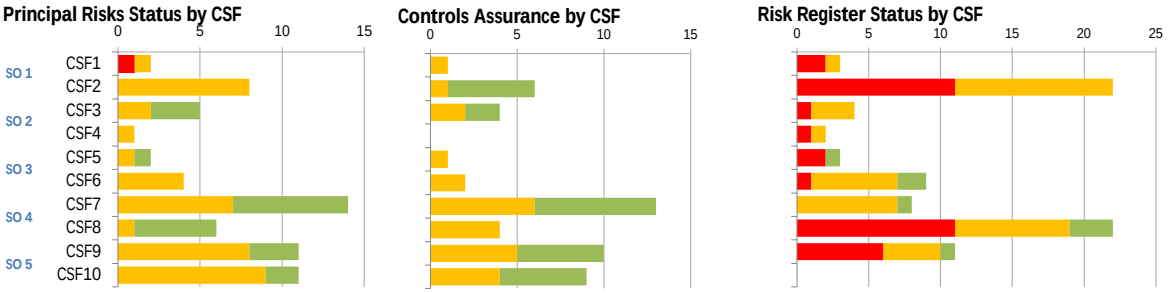
Isle of Wight NHS Trust



Principal Risks:	64	Aligned Risk Register Risks:	88



Strategic Objective & Critical Success Factor Status Overview



BAF
Increased Scores

2

Reduced Scores

4

Commentary

Principal Risks:

1 New Principal Risk has been added (1.15 - Red)

4 Principal Risks are recommended for changes from Amber to Green

1 Principal Risk was returned to Amber following the July 2014 Trust Board decision

11 **New Risks, 6 of which are rated Red:**

Ref.	Directorate	Title
618	Hosp/Amb	OHPiT increase of activity
619	Corporate	Air Conditioning in Network Core Room
620	Corporate	Mandatory Resuscitation Training
621	Hosp/Amb	CAD server and software updates
622	Community	Safeguarding Children capacity
623	Corporate	Unsupported Desktop Environment
624	Hosp/Amb	MaxFax dental carts and compressor no longer fit for purpose
625	Community	Availabilty of doctors re MHA assessments
626	Community	Lack of substantive Consultant Psychiatrist
627	Hosp/Amb	CCU Monitoring System
628	Community	Osborne Ward bathrooms

Changes to previously notified Risk scores since the last report: None

Recommended changes to BAF assurance ratings, NEW BAF entries, Risk Scores and identification of NEW risks

Ref.	Exec Lead	Title/Description	Assurance Rating Current	Assurance Rating Change to
CSF7.5	EDoF; EDoNW	7.5 (5.10) Activity is significantly in excess of plan during the first quarter of the current financial year (F14) Executive Director of Finance	Amber	Green
CSF7.12	EDoF; EDoNW	7.12 (5.17) Lengthy process of agreement and sign-off of annual service/departmental budgets (F22) Executive Director of Finance/ Company Secretary	Amber	Green
CSF7.15	EDoF; EDoNW	7.15 (5.38) Lack of financial awareness training sessions provided to staff within the organisation (F27) Executive Director of Finance	Amber	Green
CSF9.6	EDoNW; EMD	9.6 (4.13) No analysis of Board financial skills as part of wider analysis of the Board (F31) Executive Director of Finance	Amber	Green

CSF10.22	EDoNW	10.22 (10.71) The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months (B34) Chief Executive/Executive Director of Nursing and Workforce	Green	Amber
CSF1.15	EDoNW	1.15 Care Quality Commission Inspection - If we fail to provide a satisfactory and acceptable response to the CQC Warning letter and achieve compliance with the relevant requirements within the given timescale then we will become subject to further civil enforcement and/or criminal law action by the CQC (Ref - CQC Enforcement Policy - June 2013) Chief Executive/ Executive Medical Director/ Executive Director of Nursing and Workforce	NEW	Red
CSF8 619 - 1	EDTI	AIR CONDITIONING UNIT IN NETWORK CORE ROOM	20	20
CSF2 620 - 1	EDONW	MANDATORY RESUSCITATION TRAINING	20	20
CSF8 621 - 1	EDONW	COMPUTER AIDED DISPATCH (CAD) SERVER AND SOFTWARE UPDATE	20	20
CSF9 622 - 1	EMD	SAFEGUARDING CHILDREN TEAM CAPACITY	20	20
CSF8 623 - 1	EDTI	UNSUPPORTED DESKTOP ENVIRONMENT	20	20
CSF2 624 - 1	EDONW	MAXFAX DENTAL CARTS AND COMPRESSOR NO LONGER FIT FOR PURPOSE	20	20
CSF9 626 - 1	EMD	LACK OF SUBSTANTIVE CONSULTANT PSYCHIATRIST ON OSBORNE AND SEAGROVE WARDS	15	15
CSF2 627 - 1	EDONW	CCU MONITORING SYSTEM	15	15
CSF1 628 - 1	EMD	OSBORNE WARD BATHROOMS	15	15
CSF2 618 - 1	EDONW	OHPiT Increase of activity	12	12
CSF9 625 - 1	EMD	AVAILABILITY OF DOCTORS TO SUPPORT SECOND RECOMMENDATIONS FOR ASSESSMENTS UNDER THE MHA	9	9

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
Strategic Objective 1: QUALITY - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience **Exec Sponsor: Executive Director of Nursing and Workforce**										
<u>Critical Success Factor CSF1</u> **Lead: Executive Director of Nursing and Workforce** **<u>Improve the experience and satisfaction of our patients, their carers, our partners and staff</u>** **Links to CQC Regulations: 9, 12, 17, 19, 21, 22, 23**						MEASURES: **Improved patient and staff survey results** **Complaints/concerns from patients/carers and staff** **Compliments from patients/carers and staff** **CQC inspection/Trust inspection outcomes** **Culture, Health and Wellbeing strategy objectives achieved** **No service disruption occurs if Major incident or Business Continuity Plans are invoked** **Friends and Family test results** **Staff Friends and Family test results**			TARGETS: **Patient and staff survey results for 14/15 show better outcomes than results for 13/14** **Patient care complaints reduced by 10% on 2013/14** **All CQC key domains / essential standards met** **All services provided 365 days per year** **Increased patient involvement evidenced** **Achieve 30% response rate in patients friends and family test results by March 2015** **Achieve 20% response rate in staff friends and family test results by March 2015** **Greater alignment between patient and staff satisfaction**	
1.15 Care Quality Commission Inspection - If we fail to provide a satisfactory and acceptable response to the CQC Warning letter and achieve compliance with the relevant requirements within the given timescale then we will become subject to further civil enforcement and/or criminal law action by the CQC (Ref - CQC Enforcement Policy - June 2013) Chief Executive/ Executive Medical Director/ Executive Director of Nursing and Workforce		**20**		Executive and Senior Management leads identified for all aspects of the Quality Improvement plan CQC Project team in place meeting weekly Patient Safety, Experience and Clinical Effectiveness Committee (SEE Committee) given responsibility for ongoing review of the improvement plan to track delivery and highlight any potential failings TEC reviewing actions taken and ongoing progress reports weekly Links established with TDA to oversee and advise on the development of our improvement plans	Trust Executive Committee Quality and Clinical Performance Committee SEE Committee	Monthly updates from QCPC Monitoring and assurance reports - to be agreed	Red	Improvement Plan in respect of warning notice and inspection report not yet finailised. Resistance to some of the changes required to meet CQC requirements needs to be addressed Delivery of some of the actions/improvements required is not possible within the timescales stipulated by CQC		**Mark Pugh/Alan Sheward/Deborah Matthews** **Review date: October 2014** **Agree Executive Director/Clinical Director level responsibility for resolving any outstanding difficulties regarding the action we must take to deliver the warning notice requirements** **Karen Baker/Mark Pugh/Alan Sheward** **Review date: October 2014** **Continue to link with the TDA and CQC to ensure their agreement to the actions we are putting in place to meet CQC requirements for compliance actions where we are unable to meet the deadlines requested by the Commission.** **Karen Baker/Mark Pugh/Alan Sheward** **Review date: October 2014**
Principal Objective 4: PRODUCTIVITY - To improve the productivity and efficiency of the Trust, building greater financial sustainability **Exec Sponsor: Executive Director of Finance**										
<u>Critical success factor CSF7</u> **Leads: Executive Director of Finance, Executive Director of Nursing and Workforce** **<u>Improve value for money and generate our planned surplus whilst maintaining or improving quality</u>** Links to CQC Regulations: 24						MEASURES: **Achievement of revenue financial plan** **Achievement of capital financial plan** **Achievement of cash plan** **Achievement of surplus position** **Achievement of recurrent CIP plan** **Satisfactory Internal & External Audit Reports**			TARGETS: **£170m income 31/03/15** **£7.460m capital Resource Limit** **£5.407m 31/03/15** **Surplus of £1.7m 31/03//15** **Target of £8.998m 31/03/15** **Positive annual reports from Internal & External audit**	
7.5 *(5.10)* Activity is significantly in excess of plan during the first quarter of the current financial year (F14) Executive Director of Finance	**8**			A broad range of external stakeholders have been consulted in the development of the plan and there is alignment in the financial priorities, activity profiles and performance expectations with risks identified, quantified and reflected within the Financial Plan Appropriate systems are in place to monitor the activity levels against plan Reviewed monthly with CCG and Trust Board	Operating Plan process including SHA scrutiny and approval. Trust Board Papers and Sub Committee Papers. Trust's Financial plan (revenue and capital). Budget setting framework document.	Operating Plan process including SHA scrutiny and approval. Trust Board Papers and Sub Committee Papers. Trust's Financial plan (revenue and capital). Budget setting framework document.	**Green**			**Mark Pugh/ADs/Iain Hendey** Update February 2014: (IH) Activity now under plan, mostly within Scheduled care. No risk to income in 2013/14 as in 'risk-share'. Negotiations for 2014/15 underway. Update June 2014: (IH) The freeze contract position at the end of the financial year was £250K under plan. **Update September 2014:** Systems in place to monitor and review. **Action complete** **Recommend change of assurance rating to Green**
7.12 *(5.17)* Lengthy process of agreement and sign-off of annual service/departmental budgets (F22) Executive Director of Finance/ Company Secretary	**9**			The Board can demonstrate that there is ownership of the Financial Plan throughout the organisation and that responsibility for managing delivery has been appropriately assigned. Annual budget-setting has been informed by clinical and service professionals engaged in process & informed by Service Line Reporting. All directorates involved & signed off budgets in line with the proposed timetable	Trust's Budget Setting Procedures/ Process Trust's Standing Financial Instructions reflecting budgetary authority levels and accountability	Budget setting paper to Board and FIWC and monthly monitoring of Budget position via Performance Reporting with clear explanation of variances	**Green**			Evidence SLR plans, and supporting documentation **Chris Palmer** Update April 2014: Budgets have been set and final sign off during April 2014 including clinical approval of budgets and demand plan/capacity plan. Budgets have incorporated demand levels and contractual factors in determining inflationary uplifts and efficiencies. Update May 2014: (KC) The refinement of SLR continues coupled with additional focus in the next couple of weeks when the review of the Trusts cost base begins. Through the cost base review work the Trust's aim is to validate and/or gain greater confidence in the SLR data to enable it to be used to inform the budget setting process. Update July 2014: (KC) All directorates were involved & signed off budgets in line with the proposed timetable **Update September 2014: Action complete** **Recommend change of assurance rating to Green**

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
7.15 *(5.38)* Lack of financial awareness training sessions provided to staff within the organisation (F27) Executive Director of Finance	**12**			All staff members are introduced to financial awareness through the induction process and regularly informed of progress through cascade briefings Training sessions provided to staff on financial awareness	Induction programme coverage	Financial performance reported to FIWC and Board	**Green**			Finance training sessions to be developed and implemented by December 2012; FAST training sessions to be re-established; relaunch of HFMA certificate in NHS finance; Review of all budget holder levels and rationalisation of cost centres; Local induction to include basic financial training from finance managers **Kevin Curnow/Lauren Jones/John Cooper** Update April 2014: (KC) Quarterly finance training due to start in June 2014 Update July 2014: (KC) First formal training session held June 2014. Monthly budget holder meetings/surgeries held with each directorate to improve financial awareness across the organisation. **Update September 2014: Action complete** **Recommend change of assurance rating to Green**
Principal Objective 5: WORKFORCE - To develop our people, culture and workforce competencies to implement our vision and clinical strategy **Executive Sponsors: Executive Director of Nursing and Workforce, Executive Medical Director**										
<u>Critical success factor CSF9</u> **Leads: Executive Director of Nursing and Workforce, Executive Medical Director** **<u>Redesign our workforce so people of the right attitude, skills and capabilities are in the right places at the right time to deliver high quality patient care</u>** Links to CQC Regulations: 15, 22, 24						MEASURES: **Workforce productivity measures including:** **Staff Turnover** **Safe staffing levels** **Bank and agency usage** **Mandatory Training compliance**				TARGETS: **Meet workforce strategy KPI's** **- Long term sickness rates under 1.2% by 31/3/15** **- Short term sickness rates under 1.6% by 31/3/15** **- 98% staff appraisals undertaken period 1/4/14 - 31/3/15** **- reduction in bank/agency costs to <£250K by 31/3/14** **-100% staff fully compliant with mandatory training at some point within the year 1/4/14 -31/3/15** **- staff turnover under 4.5% by 31/3/15** **- achieve 80% actual against plan for safe staffing levels by March 2015**
9.6 *(4.13)* No analysis of Board financial skills as part of wider analysis of the Board (F31) Executive Director of Finance	**8**			The Trust Board has the required financial capacity and capability. The Trust has substantive appointments for all Board members (Executive and Non-Executive) with key roles within financial governance. Of these, at least two NEDs have a professional financial qualification and numerical literacy and experience in areas relevant to the delivery of the business strategy. The Board periodically undertakes an independent formal evaluation of its financial skills, capabilities and capacity. 2 Qualified Financial Advisors on Trust Board (EDOF and 1 NED). A Board Development Programme has been established to address any gaps identified at individual and collective levels. Job descriptions specify competency required; Interviews contained financial component; completion of HFMA certificate in finance by NEDs. There is evidence that all Board members adequately participate in active debate on financial matters. Independent formal evaluation of the Board's financial skills, capabilities and capacity by KPMG/Foresight. NED with financial qualifications attend Audit & Corporate Risk Committee	Board profiles and supporting qualifications/ experience. Board Development Programme and Finance Skills programme	Directors appraisal process; HFMA certification in NHS finance; attendance at finance seminars; current job descriptions describe a commitment to financial acumen. CCAB qualifications and CPD	**Green**			Actions arising from the recommendations contained within the KPMG report **Karen Baker/Chris Palmer/Mark Price** Finance seminar for Board members to be organised by Executive Director of Finance when new EDON commences. Completion of HFMA certificate in NHS finance for all Board Members to be considered when new EDON commences. Introduction of regular Finance, Investment and Workforce Sub-Committee to be implemented Update April 2014: Recruitment process for new NED resulted in no appointment being made. Currently exploring visiting NED/ joint appointment Update June 2014: Appointed financial advisor to the Board - starts end June 14. Board seminar items continue to include financial topics. **Update September 2014:** NED with financial qualifications now in place. **Action Complete** **Recommend change of assurance rating to Green**

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
<u>Critical success factor CSF10</u> Lead: Executive Director of Nursing and Workforce <u>Develop our organisational culture, processes and capabilities to be a thriving FT</u> Links to CQC Regulations: 9, 10 , 17						MEASURES: **Monitor ratings for governance, including quality and finance** **Board Development** **Stakeholder engagement** **Organisational Thermometer** **Staff survey results** **Staff raising concerns** **Staff friends and family test**			TARGETS: **Achieve top Monitor ratings for governance by March 2015** **Achieve 25% response rate in staff friends and family test results by March 2015** **Percentage of vacancies to be under 11.7% by 31/3/15** **Staff survey results for 14/15 show better outcomes than results for 13/14:** **- survey response rate over 60% in 2014/15** **- Over 60% of staff would recommend the Trust as a place to work** **- Over 93% of staff feel satisfied with the quality of patient care they deliver** **- Over 60% of staff would be happy for us to provide care to a relative or friend**	
10.22 *(10.71)* The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months (B34) Chief Executive/Executive Director of Nursing and Workforce	**9**			The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the IBP (e.g. campaigns in community vantage points, shopping centres, leisure centres; close links with academic institutions and schools; visits to 'hard to reach 'groups etc.). The Trust has constructive and effective relationships with its key stakeholders, especially Lead Commissioners. The Trust has a Communications Engagement and Membership team that monitors and responds to negative publicity as and when it arises or brought to the attention of the team by others Now pre-empting this by improved local engagement with local media.		The Trust invested in a management system called VUELIO which records media coverage and the responses given	Amber			Action plan to be created in response to negative publicity as received **Alan Sheward/Andy Hollebon** Update June 2014: The Comms Team continues to respond to any media comment or enquiry in a timely fashion. A summary of media coverage is not now presented formally to any Trust committee, having previously been listed under Q&CPC before April 2014. **Update July 2014:** Now pre-empting this by improved local engagement with local media. **Action complete** **Recommendation to change of assurance rating to Green rejected by Trust Board July 2014** **Review date: September 2014**

<u>Board Assurance Framework column headings: Guidance for completion and ongoing review</u> (N.B. Refer to DoH publication 'Building an Assurance Framework' for further details)

<u>Principal Risks:</u> All risks which have the potential to threaten the achievement of the organisations principal objectives. Boards need to manage these principal risks rather than reacting to the consequences of risk exposure.
<u>RISK LEVEL</u> = S (Severity where 1 = insignificant; 2 = minor; 3=moderate; 4=major; 5=catastrophic) X L (Likelihood where 1=rare; =unlikely; 3=possible; 4=likely; 5=certain)= RS(Risk Score). Code score: 1-9 GREEN; 10-15 AMBER; 16+ RED

<u>Controls in Place:</u> To include all controls/systems in place to assist in the management of the principal risks and to secure the delivery of the objectives.

<u>Assurances on Controls:</u> Details of where the Board can find evidence that our controls/systems on which we are placing reliance, are effective. Assurances can be derived from independent sources/review e.g. CQC, NHSLA, internal and external audit; or non-independent sources e.g. clinical audit, internal management reports, performance reports, self assessment reports etc.
NB 1: All assurances to the board must be annotated to show whether they are POSITIVE (where the assurance evidences that we are reasonably managing our principal risks and the objectives are being delivered) or NEGATIVE (where the assurance suggests there are gaps in our controls and/or our assurances about our ability to achieve our principal objectives)
NB 2: Care should be taken about references to committee minutes as sources of assurance available to the board. In most cases it is the reports provided to those committees that should be cited as sources of assurance, together with the dates the reports were produced/ reviewed, rather than the minutes of the committee itself.

<u>Assurance Level RAG ratings:</u>
Effective controls in place and Board satisfied that appropriate positive assurances are available <u>OR Effective controls in place with positive assurance available to Board and action plans in place which the Executive Lead is confident will be delivered on time</u> = GREEN (+ add review date)
Effective controls mostly in place and some positive assurance available to the board . Action plans are in place to address any remaining controls/assurance gaps = AMBER
Effective controls may not be in place or may not be sufficient. Appropriate assurances are either not available to Board or the Exec Lead has ongoing concerns about the organisations ability to address the principal risks and/or achieve the objective = RED
(NB - Board will need to periodically review the GREEN controls/assurances to check that these remain current/satisfactory)

<u>Gaps in Control:</u> details of where we are failing to put controls/systems in place to manage the principal risks or where one or more of the key controls is proving to be ineffective.

<u>Gaps in Assurance:</u> details of where there is a lack of board assurance, either positive or negative, about the effectiveness of one or more of the controls in place. This may be as a result of lack of relevant reviews, concerns about the scope or depth of any reviews that have taken place or lack of appropriate information available to the board.

<u>Action Plans:</u> To include details of all plans in place, or being put in place, to manage/control the principal risks and/or to provide suitable assurances to the board. NB: All action plans to include review dates (to enable ongoing monitoring by the board or designated sub-committee) and expected completion dates (to ensure controls/assurances will be put in place and made available in a timely manner)

<u>Assurance Framework 2013/14 working document - August 2013. Guidance last updated December 2009.</u>

ID	Source	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
618		HOSAMB	PATEXP	24/07/14	31/03/15	OHPiT Increase of activity	DCOLL	* Activity increasing month on month * Only three nurses covering seven day working * Risk of delayed/missed dose of antibiotic * Patient experience/quality of care	12	12	MOD	None	I	24.07.14 Approved at RMC on 16.07.14. (18/08/14) update RB - Percentage increase being assessed to inform business case going forward with CCG.	3 items listed to date, with latest completion date 30.09.14	EDONW
619		CORPRI	QCE	24/07/14	31/12/14	AIR CONDITIONING UNIT IN NETWORK CORE ROOM	KGY	* Existing Unit have failed twice. * Existing solution has not been maintained over it current life cycle. * If it fails the room will over heat and the network core will fail. * Both patient care and administration rely on the resources of the network core. * Potential fire risk through over heating.	20	20	HIGH	CIG Bid for approval at 04.07.14 meeting		16.09.14 Update received from RG (estates). We have commissioned a report from a A/C Specialist that will consider the condition of the existing units and their remaining life. At this stage we do not think that total replacement is required as the units are serviceable and as such can be bought back into use following some remediation works. We will feedback shortly. I assume that the risk can be reduced as we are out of summer and the temperature will reduce, we will have resolved this long before the end of the winter. 18/09/14 asked PD if score can be reduced.	7 items listed to date, with latest completion date 1.01.15	EDTI
620		CORPRI	PATSAF	24/07/14	31/12/14	MANDATORY RESUSCITATION TRAINING	ASW	* Current mandatory resuscitation training compliance is 54% for Adult Resuscitation training & 59% for Paediatric Resuscitation training * There is inadequate capacity to deliver enough mandatory resuscitation training to enable 100% compliance * The Resuscitation Policy states that ALL clinical staff must be trained yearly in mandatory resuscitation training * Mortality from cardiac arrest will increase if staff have not been trained in practical resuscitation techniques * Verbal feedback during a recent CQC inspection identified resuscitation training capacity & its consequent compliance as a significant concern	20	20	HIGH	In an attempt to increase capacity the Resuscitation Service are currently employing a resuscitation training on the bank. However owing to organisational change, early termination of secondment & staff sickness within the Resuscitation Service this 'control' is	I	25.07.14 Approved at RMC on 16.07.14. 16.09.14 requested an update from RY	6 items listed to date, with latest completion date 31.03.15	EDONW
621		HOSAMB	QCE	28/08/14	31/10/14	COMPUTER AIDED DISPATCH (CAD) SERVER AND SOFTWARE UPDATE	CS	* CAD Failure due to out of date Server software * Server Hardware requires Technology Refresh * CAD software version requires major Update	20	20	HIGH	Software patches have been carried out to address the identified issues where possible; however each patch has the potential to create another 'bug' in the system. Hardware disks within the server are changed when failures occur, however they cannot be reliably predicted, and so this is a reactive process rather than a proactive process. (It is not feasible to replace all disks before they fail.) Housekeeping tasks are carried out on the server hardware to minimise and foreseeable issues which may cause problems. Discussion with CAD supplier on improving local ownership and capability of housekeeping tasks. Changes to hardware and software have been agreed with system suppliers and the IT department to mitigate this risk for the existing life of the system (expected to be 3 years). Business Cases for capital funding to address risks are being prepared.	U	28.08.14 Approved at RMC on 20.08.14.	3 items listed to date, with latest completion date 30.09.14	EDONW

ID	Source	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
622		COMMH	PATSAF	28/08/14	31/12/14	SAFEGUARDING CHILDREN TEAM CAPACITY	NT	* All child protection activity is currently running high with a high levels of referrals and child protection conferences * The "new" HantsDirect Multi Agency Hub (MASH) has created additional daily work for the small safeguarding team as we now receive every IOW referral received by HantsDirect * The requirement for multi agency working has increased with extension of MARAC (Domestic Abuse Risk Assessment Conference) , Child Sexual Exploitation Operational meetings and regular multi agency LSCB audit * There is a clear need to increase capacity in order to review & deliver increased safeguarding children training across the organisation * There is a clear need to increase capacity to respond to the increased requirement of safeguarding supervision * At present the team is only able to ensure core function is maintained with no capacity for service development * Succession planning is required to ensure a safe service for the future * Ofsted Inspection of Safeguarding Children pending	20	20	HIGH	We have no control over internal or external demand The current 1.4 wte safeguarding children team are consistently working over their contracted hours to ensure service delivery. This is unsustainable.	U	28.08.14 Approved at RMC on 20.08.14.	6 items listed to date, with latest completion date 31.12.14	EMD
623		CORPRI	GOVCOM	28/08/14	30/09/15	UNSUPPORTED DESKTOP ENVIRONMENT	KGY	* Trust standard desktop environment (Win XP/Office 2003) no longer supported. * Support from key systems/supplier likely to be withdrawn through 2015-2016 * Increased vulnerability to malicious code (virus/malware). * Business case to CIG on 5th Sep to address hardware, licensing and human resourcing of migration project.	20	20	HIGH	The Cabinet Office and DH have negotiated transitional, extended support arrangements with MS for 12 months, ending on 15th April 2015. However, to benefit from the scheme the trust would need to subscribe to a MS PSA for £ 12,500 and must have a demonstrable migration plan in place. The Trust currently operates a multi layered anti-virus/malware software, firewall, e-mail and web content filtering solutions that provide good levels of protection and containment against known threats. These components are committed to support the Windows XP environment to 2016. All new equipment and rolling replacements are being deployed with Windows 7 or Windows 8 and Office 2010, unless precluded by application compatibility issues. A migration plan and business case is being developed to support a desktop migration plan and replacement of end user devices that are not of suitable specification. A separate business case is being prepared for the upgrade of MS Exchange Server, in line with new NHS Secure E-mail Guidelines.	A	28.08.14 Approved at RMC on 20.08.14.	6 items listed to date, with latest completion date 30.09.15	EDTI
624		HOSAMB	PATSAF	28/08/14	31/12/14	MAXFAX DENTAL CARTS AND COMPRESSOR NO LONGER FIT FOR PURPOSE	DCOLL	* Carts do not comply with HTM0105-13 * Unable to fully mitigate the risk of infection to patients from compressor air and waterlines * Compressor likely to fail therefore potential loss of activity	20	20	HIGH	Continue water line flushing as per recommended guidance from HTM01 05 Water line disinfection using chlorine dioxide as recommended by AED Monthly water sample testing. Capital bid to replace compressor 3 carts and compatible handpieces. Compressor and carts form part of a continuous circuit and as both no longer meet HTN0105 will need replacing together Estates carry out a weekly inspection of the compressor, checking the pressure generated Is adequate and the lines are blown down to remove moisture. There is an annual insurance inspection.	I	28.08.14 Approved at RMC on 20.08.14. 08/09/14 - Update - capital bid being prepared for next Directorate board in September and CIG in early October RB.	6 items listed to date, with latest completion date 30.11.14	EDONW

ID	Source	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
625		COMMH	PATEXP	28/08/14	31/03/15	AVAILABILITY OF DOCTORS TO SUPPORT SECOND RECOMMENDATIONS FOR ASSESSMENTS UNDER THE MHA	NT	* Assessments under the MHA require 2 doctors * First doctor is usually Consultant Psychiatrist * Historically most second doctors have been two now retired GPs. Since their retirement their has been a lack of available alternatives	9	9	LOW	The CCG has arranged for a number of GPs to be available for limited periods each day and is promoting their approval as section 12 doctors, to ensure appropriate knowledge and experience is available. These doctors availability is very limited and unreliable, resulting in ongoing extra work to find available cover and delays as stated above.	I	28.08.14 Approved at RMC on 20.08.14	2 items listed to date, with latest completion date 31.05.15	EMD
626		COMMH	PATSAF	28/08/14	31/12/14	LACK OF SUBSTANTIVE CONSULTANT PSYCHIATRIST ON OSBORNE AND SEAGROVE WARDS	NT	* No substantive Consultant Psychiatrist in place for Osborne or Seagrove PICU wards since September 2013 * Lack of continuity of care for patients * Affects morale of staff * No consistent clear leadership from a Senior medical role.	15	15	MOD	* Continue use of Locum Psychiatrist	I	28.08.14 Approved at RMC on 20.08.14.	Recruitment for substantive post by 31.12.14	EMD
627		HOSAMB	PATSAF	28/08/14	28/02/15	CCU MONITORING SYSTEM	DCOLL	* Monitoring system should have been replaced 14-15 RRP. * ICU/CCU Business case (version Dec 13) had CCU monitoring included within it. * ICU/CCU Business case - above version no longer happening and money now no longer secured to purchase new monitoring. * Monitoring system has failed on 2 occasions in the last few months and declared unsafe by Medical Electronics	25	15	MOD	There is no alternative as the CCU monitoring system is embedded		28.08.14 Approved at RMC on 20.08.14 - 21/08/14 Reviewed at QRPSG - urgent business case being developed for directorate board then CIG approval Sept /Oct 14 RB. 22.9.14 downgraded as MAU system available if necessary.	4 items listed to date, with latest completion date 28.02.15	EDONW
628		COMMH	PATEXP	28/08/14	31/10/14	OSBORNE WARD BATHROOMS	NT	* Showers leak and flood bathrooms. * Bathrooms floors need to be dug up and realigned to provide adequate water drainage * New flooring and doors needed as they currently present as an infection control risk	15	15	MOD	* Towels used to mop up excess water * Cleaners attempt to keep mould at bay.	I	28.08.14 Approved at RMC on 20.08.14	3 items listed to date, with latest completion date 31.10.14	EMD

Key for Assurance Level for Risk Register Entries: GREEN - A adequate controls; AMBER - I inadequate controls; RED - U uncontrolled risks