Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 29th 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 29th 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: Danny Fisher (Sue Wadsworth to Chair Meeting), David King		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		EDNW	Receive	Enc B
	3.3	Local Update from Community & Mental Health		EMD	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
	5	**Minutes of Previous Meetings**				
	5.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 1st October 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	Quality Improvement Plan	Quality and Performance Management	EDNW	Approve	Enc F
	6.2	Performance Report	Quality and Performance Management	EMD	Receive	Enc G
	6.3	Minutes of the Quality & Clinical Performance Committee held on 22nd October 2014	Quality and Performance Management	QCPC Chair	Receive	Enc H
	6.4	Minutes of the Finance, Investment, Information & Workforce Committee held on 22nd October 2014	Quality and Performance Management	FIIWC Chair	Receive	Enc I

	6.5	Minutes of the Mental Health Act Scrutiny Committee held on 22nd October 2014	Quality and Performance Management	MHASC Chair	Receive	Enc J
	6.6	Reports from Serious Incidents Requiring Investigation (SIRIs)	Quality and Performance Management	EDNW	Receive	Enc K
	6.7	Safeguarding and Looked after Children Annual Report 2013-2014	Quality and Performance Management	EDNW	Approve	Enc L
	6.8	Monthly Safer Staffing Update	Culture & Workforce	EDNW	Approve	Enc M
	6.9	Quarterly Board Walkabouts Action Tracker	Quality and Performance Management	EDNW	Receive	Enc N
	6.10	Quarterly Patient Story Action Tracker	Quality and Performance Management	EDNW	Receive	Enc O
	6.11	Capital Planning	Strategy and Business Planning	EDTI	Approve	Enc P
	6.12	Board Self Certification	Governance and Administration	Comp Sec	Approve	Enc Q
	6.13	Board Assurance Framework (BAF) Monthly update	Governance and Administration	Comp Sec	Approve	Enc R
	6.14	Corporate Governance Framework: a) Standards of Business Conduct b) Code of Accountability for NHS Boards (incorporating Code of Conduct) c) Accountable Officer Memorandum	Governance and Administration	Comp Sec	Approve	Enc S
	6.15	Fire Safety Policy	Governance and Administration	EMD	Approve	Enc T
	7	**Matters to be approved by Corporate Trustees**				
	7.1	Charitable Funds Committee - Patient Council Representative		CS	Approve	Enc U
	8	**Any Other Business**				
	9	**Questions from the Public**				
		To be notified in advance				
	10	**Issues to be covered in private**.				

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:

- *Strategic Estates Partnership Contract Award*
- *Transformation Project Update*
- *Health & Social Care Integration Update*
- *Tenders Update*
- *Employee Relations Issues*
- *Quarterly Claims Report*

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

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 **3rd December 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 29th 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**	✓	**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: 22nd October 2014	**Completed by:** Andy Hollebon Head of Communications and Engagement & Sarah Morrison – Exec Assistant to Chief Executive					

NATIONAL

NHS five year forward view

As this report is being written we're anticipating publication of The NHS five year forward view – instigated by the NHS England chief executive, Simon Stevens, to set out the prospects for the service in the run-up to the general election. It is expected it will indicate the approach and policies which those leading the service believe are needed to make the NHS sustainable. The Health Service Journal reported online on 21st October that *the forward view, published by NHS England along with Monitor and other national health bodies, is expected to set a direction for the service on:*

- *The size of the financial gap facing the NHS until 2020-21, reviewing the £30bn figure published by NHS England last year.*
- *The potential consequences of continued curbs on NHS healthcare funding, and for longer-term financial settlements for the service.*
- *New models of delivering care, such as hospitals running general practice services, and GPs forming primary care based multispecialty provider groups, and how different models could apply in different areas of the country.*
- *How NHS incentives and rules may change to support new models, such as the role of competition or linking income more closely to care quality.*
- *How some areas could go faster in experimenting with new models, and might be helped to work around system rules which could be preventing them.*
- *Future approaches to commissioning, for example co-commissioning between CCGs and NHS England, links with local authorities, and personal health budgets.*
- *How mental healthcare can be improved more quickly.*
- *The impact of population trends and other factors on NHS demand, and how to better prevent illness.*
- *The role of non-NHS factors in improving health, including changes to taxation, employers incentivising their staff, and the role of councils and regional authorities, and the role of other government departments.*
- *The "hidden workforce" including individuals' own role and carers.*
- *International examples the NHS could learn from.*
- *A strategy for specialised services.*

We will need to review this important document and assess how it affects our strategies.

REGIONAL

Ebola

In the unlikely event of a possible case of Ebola being identified on the Island the patient would be isolated and staff will follow Trust and national policy on dealing with the patient. Arrangements have been put in place for blood samples to be fast tracked to a mainland laboratory to confirm whether or not Ebola is present. In the case of a confirmed case the patient would be transferred off the Island to a major hospital with the right facilities to provide the best care possible.

We have no reason to think that the Island is any more at risk than anywhere else in the UK but arrangements are being put in place to ensure that those treating suspected patients, for the short period of time they are on the Island, are protected. Posters produced by NHS England setting out what to do are being placed in public and staff areas of healthcare clinics, GP surgeries, and the Emergency Department at St. Mary's.

LOCAL

Trust Awards

The Trust Awards have been rescheduled to Friday 30th January 2015 and will be held at Cowes Yacht Haven. Further information about the categories for both the main awards and the individual and team awards can be found at www.iow.nhs.uk/awards. The closing date for entries is 5th November 2014.

Listening into Action

Listening into Action (LiA) (http://www.listeningintoaction.co.uk/) introduced our new way of working: acting together to bring about changes and improvements to benefit the patients we serve, and to improve our working lives. It aims to put staff at the centre of change and make sure that we all feel part of our organisation and have a sense of belonging as well as clearly unblocking the way in getting things done.

I am very clear that ultimately, everybody who works within our organisation will be expected to work this way. I have no doubt that this will make us an organisation that people really do want to work for and are happy to recommend. We can only do this by working together and breaking down barriers and boundaries, both perceived and real.

In the Listening Events staff made it clear that they want changes made and that they're willing to participate in making them happen. Following this we have chosen 10 projects to be completed over the next 20 weeks as follows:

1. Access to Community Mental Health Therapies
2. To Take Out medications: Improving TTO turnaround times
3. Discharge Planning on Admission in MAAU
4. Paediatric front door for emergencies
5. Orthopaedic Referral to Treatment
6. Ambulance Handover and Turnaround Times
7. Patient referrals – informed patients
8. Right Patient, Right Bed
9. Optimising Flow of the Right Patients through the Rehabilitation Ward back into the Community
10. Prevention of Clostridium Difficile

I would like to thank all members of staff who took the time to participate in the Listening Events and for their valuable feedback, for their openness and honesty.

Workforce Summit

Nationally the NHS is facing a shortage of trained staff across a number of areas including primary (GPs in particular) and secondary care (nursing in particular). Staff that were trained 40 years ago during a huge period of expansion in the health service are now starting to retire. Almost all NHS organisations are seeking to recruit additional nursing and medical staff.

Here on the Island we have additional problems persuading staff that the Solent is not a significant barrier to a good career and that the Island provides an excellent standard of living and lifestyle, which is why the Trust hosted a Workforce Summit on Wednesday 8th October with representatives from a wide range of interested organisations from across the Island. The Trust has over 230 whole time employed medical staff and all the evidence points towards the fact that a stable and directly employed medical workforce improves quality and continuity of care. We are struggling to recruit into some Consultant posts and more generally to nursing vacancies. Being located on an Island brings additional problems as well – for example we don't want to destabilise the nursing homes on the Island by recruiting all their nursing staff

when we rely heavily on those homes to facilitate discharges from hospital. Therefore we need to rethink our recruitment strategies and make the Island a more attractive place for healthcare staff so that we can better compete in a very competitive recruitment marketplace.

Safer staffing reports which are now received by the Trust Board have led the Trust to conclude that it needs to recruit 30 nurses to work at St. Mary's Hospital and more nursing staff to work in community and mental health services. Many NHS Trusts are recruiting from overseas because of the national shortage. We already have a well established Filipino community on the Island following a previous overseas recruitment exercise 10 years ago and we are making arrangements to recruit 30 nurses from the Philippines during the next couple of months. The new nurses, subject to their registration with the Nursing and Midwifery Council (NMC) and completion of a 'adaptation course' should be able to start work at St. Mary's early in 2015.

Infection Prevention and Control

There are some nasty bugs doing the rounds again. A number of our staff and patients have been suffering gastroenteritis symptoms but have not tested positive for Norovirus. It is important that everyone follows strict hand hygiene procedures. We are aware of anecdotal reports of community cases and would encourage Islanders to also maintain good hand hygiene.

Flu Vaccination

It's that time of year when **flu** starts to rear its head. For staff vaccination isn't just about keeping safe, it's about protecting colleagues, family and patients. Whether you are a member of staff or not you can carry and pass the virus on to others without having any symptoms yourself, so even if you consider yourself healthy, you might be risking the lives of others. Across the Island vaccination is available for a wide range of patients and individuals. It is also available privately. You are eligible to receive a free flu jab if you:

- are 65 years of age or over
- are pregnant
- have certain medical conditions (see below)
- are living in a long-stay residential care home or other long-stay care facility
- receive a carer's allowance, or you are the main carer for an elderly or disabled person whose welfare may be at risk if you fall ill
- are a healthcare worker with direct patient contact or a social care worker (see below)

More information can be found on the NHS Choices website at
http://www.nhs.uk/conditions/vaccinations/pages/who-should-have-flu-vaccine.aspx

Staff Surveys

There are two important surveys that staff are currently being asked to participate in:

- The **2014 NHS Staff Survey** has being sent to a sample of staff members which have been selected at random.

- The **'Friends and Family Test for Staff - Quarter 3** (October, November and December 2014)' has been sent to all staff.

Both surveys are important ways of benchmarking the Isle of Wight against other organisations. It's important that staff have their say in both these surveys. The results will be reviewed by the Trust and will help to determine how we develop the Trust for the future benefit of patients and staff.

Strike Action

The Trust worked closely with staff and their representatives to minimise the impact of industrial action on the quality of patient care. On Monday 13th October 2014, between 07:00hrs and 11:00hrs staff joined the national industrial action and formed a peaceful picket line at the entrance to St. Mary's. There was no significant impact on patient care apart from an antenatal clinic where the start was delayed by an hour. Staff returned to work at 11:00hrs as planned. The second strike on Monday 20th October by the Society of Radiographers did not affect the Trust.

Patient Advice and Liaison Service (PALS) moved to help

The Isle of Wight NHS Trust's Patient Advice and Liaison Service (PALS) has moved to offer patients and carers a much more accessible and visible presence at St Mary's Hospital. The PALS team, who offer confidential advice, support and information on all health-related matters and services provided by the Trust, were previously located in a non-public, general office area on the first floor of the main hospital. The service has relocated to the former discharge lounge on the ground floor, adjacent to the Friends of St Mary's Hospital Café area and just past the main reception.

The PALS office is open Monday to Friday (except Bank Holidays) between 9am – 4.30pm or alternatively can be contacted by email at pals@iow.nhs.uk or by telephone 01983 534850. You can visit their webpage at www.iow.nhs.uk/pals The move fulfils part of a Quality Goal for the Trust for 2014/15, which is to ensure the PALS service is in an accessible and central location.

Recycling is taking off at the Isle of Wight NHS Trust

The Trust is reducing its carbon footprint by encouraging its staff, patients and visitors to recycle at St Mary's Hospital as they do at home. The Trust has:

- introduced recycling bins in the main public areas of the hospital and other Trust buildings, thanks to a donation from the Friends of St Mary's Hospital.
- hosted an office recycling launch event at the beginning of September.
- worked closely on the improvement of its waste management practices and improving its recycling performance with local supplier Biffa waste services.

Over the last year the Trust has increased its domestic waste recycling from 18% to 27%. With the addition of office recycling, the Trust is set to go over the 50% recycling mark very soon.

Social Activities

The Trust has an active programme of social activities including the forthcoming events:

- 31st October - Grand Pumpkin Competition 2014 with judging by Claire Willis, Managing Director at Isle of Wight Radio and Alan Marriott, Editor, Isle of Wight County Press.
- 22nd November – the now annual DECADeANCE at Cowes Yacht Haven (https://www.facebook.com/pages/DECADeANCE/117365695045282) which is organised by the Trust's Information Governance Manager, Tony Martin and raises funds for Earl Mountbatten Hospice
- 1st December – the Movember parade of moustaches in the Full Circle Restaurant featuring staff who have taken part in this national awareness raising activity about men's cancers
- 4th December – the Trust's well supported fancy dress Christmas Quiz which will once again raise funds for the Isle of Wight Youth Trust.

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:

22nd September

- CQC First Draft Action Plan received
- Provision of a Medical Locum Master Vendor Ratification Report approved
- Operational Performance Concerns discussed

29th September

- Cost Improvement Plans (CIP) Proposal approved

6th October

- Planning for Industrial Action Monday 13 October
- Medical Staffing Concerns
- Financial Situation and Possible Solutions discussed

13th October

- Code of Conduct and Code of Accountability approved
- Board Walkabout Tracker approved
- IDAS Tender Update provided

Karen Baker
Chief Executive Officer
22nd October 2014

Enc B

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 29th 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**	✓	**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: 21st October **Completed by:** Donna Collins, Associate Director – Hospital and Ambulance Directorate							

Directorate wide update for September 2014

Highlights

- Ambulance Red 1 and Red 2 calls response time <8 minutes above target
- Emergency care 4 hour standard within target
- Venous Thrombo-Embolism (VTE) risk assessment achievement maintained
- No MRSA cases - we remain at 0, in keeping with the zero tolerance set for this year.

Lowlights

- Clostridium Difficile (C.Diff) - now level with the national threshold (6) for the whole year
- 87.5% Cancer - Patients receiving subsequent surgery <31 days (94% target)
- Referral To Treatment Time Admitted and Non-Admitted below target
- Staff sickness remains above plan

Hospital

Quality

The number of complaints remains low, 68 across the whole directorate year to date compared to 84 for the same period last year; however, there has been an increase in the number of concerns due in part to the relocation of PALs office, and for August and September largely due to the problems being experienced in OPARU. Recruitment is underway for OPARU, and issues concerning telephone lines have been resolved. Head and Neck is the biggest area of concern now within OPARU and support is being given to this area, with an additional experienced member of staff being freed up to assist.

The Directorate Quality Team have reviewed their process for managing complaints / concerns when they are first received to ensure a decision is made within the 24 hour guideline regarding how to manage the complaint where service leads have been unable to make contact. This should allow more time for the directorate to investigate and respond to issues within the 20 days required, as where there have been delays in the decision being made it has significantly reduced the time remaining in which to respond within the guidelines.

A revised process for managing SIRIs has also been agreed, with decisions being taken regarding SIRI reporting within the Directorate and fed back to the corporate quality team within 48 hours. Early feedback from the directorate has been extremely positive about this change, and decisions and reviews have taken place within required times.

The directorate had 2 SIRIs reported in September. 1 Grade 3 Pressure Ulcer on ICU which was investigated and the report submitted for closure within 10 days. There was some good learning from the report around whether a pressure ulcer is avoidable or not when in ICU receiving life sustaining treatment, the recommendations have been taken forward by Tissue Viability Nurse and a paper produced for proposed change to current process.
The other SIRI reported was also a grade 3 pressure ulcer, this time on Whippingham ward. The Root cause analysis meeting is scheduled for week commencing 20th October.

Performance

Performance against the cancer 2 week wait targets continued to improve in September at 96%, however the target for patients to receive subsequent surgery within 31days under performed at 87.5% (against a target of 94%). This was because there were 2 breaches out of 16 patients treated; 1 excisional biopsy was not booked as fast track and 1 excisional biopsy was not performed due to consultant not being available. Action plans are in place to ensure this is avoided in the future.

The national funding scheme for Trusts to undertake additional activity to reduce waiting lists, in particular those patients waiting longer than 18wks, has been extended till the end of November, therefore, performance against the admitted and non-admitted targets continues to under perform as planned. We are predicting this will continue for October and November as we continue to treat those patients with long waits alongside patients requiring urgent and cancer fastrack treatment.

Our performance against the incomplete target improved for September following significant improvements on pathway management and in particular, validation of all pathways.

The data quality issues highlighted by the forecasting tools developed by Performance Information & Decision Support (PIDS) continue to be addressed, with the result that in the region of an extra 400 reportable pathways were closed in the non-admitted section in September. Validation needs to continue and although there are indications that the incomplete waiting list is starting to grow again this will be addressed.

Sickness in the directorate has increased against the Trust target of 3%. This has been escalated with individual managers and ongoing monitoring is being undertaken to improve this position. Also medical workforce vacancies remain a challenge, with proactive management of cover being undertaken with the most cost effective resource available, such as NHS locum's instead of more expensive locum agency staff.

Finance

Overall for the Hospital and Ambulance Directorate for August, was overspent by £2.8m. The main challenge we continue to face is the Cost Improvement Plan and Vacancy Factor year to date variance of £2.1m underachievement. However when this factor is removed the true budget overspend is £703k year to date. 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. This accounts for £700k of the total overspend. Forecasting is an important tool which is being used alongside recovery plans to recover the position.

Other service specific –update

JAG Accreditation

The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) was established in 1994 under the auspices of the Academy of Medical Royal Colleges. It aspires to:

- set standards for individual endoscopists
- set standards for training in endoscopy
- quality assure endoscopy units
- quality assure endoscopy training courses

Congratulations to everyone in the Endoscopy Team who were involved in our JAG accreditation which demonstrates competency to deliver the service. The team were notified that the Trust has passed with flying colours. The inspection team were very complimentary about the Trust and said it was an accolade that the Trust had passed 'first time'.

Outpatients and Home Parenteral Infusion Therapy going from strength to strength

With a brand new clinic area on Level C at St Mary's, more nurses and flexible service, the Trust's Outpatients and Home Parenteral Infusion Therapy (OHPiT) Service is going from strength to strength. The service which started over four years ago delivers intravenous antibiotic therapy to patients that would have normally had to receive them as an inpatient. So for anyone who is on a hospital ward and has an infection and needs intravenous antibiotics, if they're well enough and don't need to be sat in an acute hospital bed, then we can deliver that treatment either in the patient's own home, or within our OHPiT Clinic.

OHPiT not only provide an opportunity for early discharge for patients who want to utilize the service, but can also avoid admission altogether through working closely with the General Practitioners and the Hospital's Emergency department. Since April 2014, the OHPiT service has reduced the need for Hospital bed occupancy by 961 days with 57 patients accessing the service.

Creating a peaceful environment for bereaved families

An environment for parents who have suffered early pregnancy loss and stillbirth has been newly refurbished at St. Mary's hospital. The facility situated between the Maternity Ward and the Labour Ward has been valued by parents who experience a loss during pregnancy or following birth since it was first made available in 2000.

Following feedback from parents the room has been given some tender loving care with the addition of a lilac and cream theme complete with matching soft furnishings and subtle lighting to give a modern, feminine and relaxing feel. A new television, two-seater sofa, iPod station and tea and coffee making facilities have also been added as well as new towels and toiletries in the matching en-suite toilet and shower room.

Ambulance

Quality

The Ambulance Service received no complaints or concerns in August, and also has 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 been able to turnaround the disappointing August results by achieving all three categories required in September; Red 1 (75%) Achieved 81%; Red 2 (75%) Achieved 75.6; 19 Min (95%) Achieved 95.7. This has been due to the shortage of staff being

addressed with additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall.

Our NHS 111 service has also seen a return to its usual achievement targets by showing a return of 96% on call answering and 97% on warm transfers to a clinician[1]

Finance

Year to date, Ambulance (including the Hub, Patient Transport Service, Switchboard and Hospital Car Service) are in a good financial position showing an £71k 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 £191k against an 8% target £542k).

In the media spotlight

The Isle of Wight County Press on Friday 12th October carried a complete page feature on our campaign to drive down pressure ulcers. Incredibly important as these nasty sores can be so terrible for patients. Thursday 16th October was Restart A Heart Day. Ambulance Commercial had a stand in the Main Entrance at St. Mary's and featured on Isle of Wight Radio.

Donna Collins
Associate Director Hospital & Ambulance Directorate

Alan Sheward
Executive Director of Nursing and Workforce
21st October 2014

[1] a warm transfer is when the patient phones through to NHS 111 service and after assessment with the call handler is required to be transferred to a clinician during the same call.

Enc C

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 23rd SEPTEMBER 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: 20th October 2014 **Completed by:** Nikki Turner, Acting Associate Director Community & Mental Health Directorate

Community and Mental Health Services

Highlights

- % of CPA patients receiving follow up within 7 days of discharge is at 97%, and above plan.
- No MRSA cases - we remain at 0, in keeping with the zero tolerance set for this year.
- Stroke patients with 90% stay on Stroke Unit is above plan.
- Community services sickness is decreasing, August was 3.77% and September was 3.6%.

Lowlights

- Delayed transfers of care for Shackleton, although below target of 7.5%, remain a concern, with 4 patients awaiting transfer to suitable placements.
- The proportion of people entering treatment with psychological therapies is lower than plan. September IAPT target was 11.0% against actual achievement of 8.55%.
- Staff sickness remains static for Mental Health Services.

Service Delivery Updates

Community Mental Health Services (CMHS)

Increased referrals to community mental health services is creating pressure on the assessment and filtering team who have to respond to urgent referrals within the same working day. The wider community team has responded by supporting this team with resources on a daily basis. In the longer term, a business case for growth funding will be presented to CCG within the next month.

CA12 (safeguarding alerts from the Police) have also risen drastically through the year. The Local Safeguarding Adult Board have been made aware of increase and the Police have started to analyse the data and appropriateness of the alerts.

Ofsted Inspection of IWC Children's Services

The Trust has contributed to the inspection of the Council's services particularly in the area of Looked After Children. This included support from Community Child and Adolescent Mental Health Service (CCAMHs), Adult MH, School Nursing and Safeguarding Team. The report is due on 18th November.

Falls Co-ordinator

Falls Co-ordinator has been recommissioned on a permanent basis following a successful pilot The postholder has developed a falls pathway and standardised the data collection. A Multiagency Falls Steering Group has been developed alongside improved links with the 3rd sector. Once of the key developments supported by the Falls Co-ordinator in the local community are the balance and strength falls prevention classes run by Age UK.

Serious Incidents Requiring Investigation (SIRI's)

The Directorate is working hard to improve our response to SIRI's within the expected timescale. Our process for monitoring responses from other services is being reviewed along with the root cause analysis process. To date, the directorate has 20 overdue SIRI's. 7 have been transferred to the CCG for final signoff, leaving 7 with the directorate and 6 with the Quality Team for review and submission to the CCG.

CQC Updates

Mental Health compliance

The CQC raised concerns that patients were unable to lock their bedroom doors in Shackleton. We have now completed works to provide all bedroom doors with locks and patients with keys to their rooms. The locking mechanism has the safety element of being overridden by using the door handle from inside the room so patients are not able to accidentally lock themselves in. Staff have reported an improvement in patient experience, privacy and dignity as their rooms can no longer be accessed by other patients.

Despite the pressures on CMHS, the service has complied with CQC recommendations around caseload management and supervision in the Psychotic Clusters.

Community Health compliance

The CQC found that community teams were under resourced and there were not effective operation systems to regularly assess and monitor the quality of the services provided, in order to identify and manage risks.

Specifically in Health Visiting and School Nursing were concerns around the system to raise concerns which have been addressed through meetings with teams and reviewing the use of Datix; and the importance of the Handler to ensure the feedback is given to the Reporter and lessons learnt shared at team meetings. There were concerns re School Nurses accessing appropriate Public Health Training and this has now been sourced and will commence in 2015.

The PARIS IT system was highlighted as an area of concern and a Project Meeting has been set up to address the issues raised.

The CQC raised concerns regarding the safety and supervision of the Community Nursing Service out of hours. Safety 'Skyguard Badges' were being implemented prior the CQC visit, however the Team have since reviewed the Standing Operating Procedures around Lone Working and all staff have had the documents provided to them. Immediately following the inspection senior nurse provision was put in place to ensure the community nurse has clinical support out of hours. A review of the out of hours service was undertaken and the criteria for visits reiterated with the team and colleagues in the HUB. Clinical Supervision is more robust and the practice of Doppler tests prior to compression bandaging is now in place.

There were a number of actions for the Community Wards which are all completed or in progress. Audits are in place to ensure actions are sustainable and are now in the process of being tested by peers from other areas.

Three main areas of concern for the wards were around medical and nursing staffing levels and patients being transferred for non clinical reasons. The Organisation has plans in place to support recruitment to these disciplines and clear criteria is in place to ensure that patients on the Stoke and Rehabilitation pathways are given priority for transfer to the appropriate area for their care.

In the media spotlight

In the media spotlight

The October edition of Island Life Magazine featured a two page article on the Primary Mental Health Care Team (PCMHT) based at The Gables.

World Mental Health Day

There was a Mental Health Awareness event in the foyer at St Marys on the 10th October. Volunteers from patient and carer groups joined trust staff to provide information to the general public and staff about the support and services available for mental health conditions. There was a significant amount of information given on the day and requests for further information is being followed up with individuals.

Finance

The Community and Mental Health Directorate is reporting an overspend of £261k which is a slightly worsened position from last month reported figure of £243k.

The main pressures areas reported last month were in medical staffing and for non pay spend in patient appliances. These areas have shown an improved position and are being closely monitored. Cost pressures associated with growth in service are being negotiated with CCG through business case development.

Although we have achieved our Cost Improvement Plan (CIP) year to date, a proportion of this has been achieved non recurrently. We are endeavouring to move non recurrent savings to into a sustainable recurring position.

Nikki Turner
Acting Associate Director Community and Mental Health Directorate

Mark Pugh
Executive Medical Director

20th October 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 1st October 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)
	Sarah Johnston	Deputy Director of Nursing & Workforce (DDN) *deputising for Executive Director of Nursing & Workforce*
	Katie Gray	Executive Director for Transformation & Integration (EDTI)
	Charles Rogers	Non-Executive Director (SID)
	Jane Tabor	Non-Executive Director
	David King	Non-Executive Director
	Nina Moorman	Non-Executive Director
	Sandya Theminimulle	Associate Medical Director for SEE (AMD) *deputising for Executive Medical Director*
In Attendance:	Mark Price	FT Programme Director & Company Secretary
	Jessamy Baird	Designate Non Executive Director
	Andy Hollebon	Head of Communications & Engagement
For item 14/262	Donna Collins	Associate Director – Hospital & Ambulance Directorate
For item 14/263	Nikki Turner	Acting Associate Director – Community & Mental Health Directorate
	Deborah Matthews	Lead for SEE and Deputy Director of Infection Prevention Control (IPC)
For item 14/265	Gina Ford	Cleanliness Assistant – Osborne Ward
	Vicki Haworth	Ward Sister
	Katy Pearse	Medical Rostering Officer
	Liz Nials	Equality & Diversity Lead
	Lara Watson	Pelvic Floor Specialist Physiotherapist
	Leeane Walsh	Acting Head of Physiotherapy
	Sarah Kingswell	Senior Administrator - Crisis Resolution Home Treatment Team (CRHT)
	Mark South	Clinical Lead - CRHT
	Yvonne Younie	Receptionist/Officer
	Alison Price	General Manager
For item 14/266	John Pike	Core Trainee Doctor – Emergency Department
	Louise Webb	Matron - Critical Care Services (ICU/CCU)
For item 14/267	Clare-Louise Sandell	Orthopaedic Nurse Specialist
	Sue Bradshaw	Matron
For item 14/281	Brian Johnston	Head of Governance & Risk Management (HGRM)
Observers:	Sarah Gladdish	Clinical Director – Community & Mental Health Directorate
	Chris Orchin	Health Watch
	Paul Thistlewood	Isle of Wight Council
	Mike Carr	Patients Council
Minuted by:	Lynn Cave	Trust Board Administrator
Members of the Public in attendance:	There were 5 members of the public present	

Minute No.

14/259 APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE

Apologies for absence were received from Sue Wadsworth, Non-Executive Director, Alan Sheward, Executive Director of Nursing & Workforce and Mark Pugh, Executive Medical Director.

The Chairman advised that Dr Sandya Theminimulle would be deputising for Mark Pugh and Sarah Johnston for Alan Sheward.

Apologies were also received from Cllr Peacey-Wilcox.

There were no declarations of interest.

The Chairman announced that the meeting was quorate.

14/260 CHAIRMAN'S UPDATE

The Chairman reported on the following:

a) **Allan Munds:** The Chairman advised the Board that Allan Munds, a former Chairman of the Isle of Wight Healthcare NHS Trust, had sadly passed away on 22 September following a long illness. Allan was Chair of the Isle of Wight Healthcare NHS Trust from 1997 – 2002 following which he joined the Earl Mountbatten Hospice as a Trustee.

He commented that during his Chairmanship he had provided vital leadership in successfully guiding the transition to integrate services from the former NHS Trusts, making enormous strides forward in delivering better healthcare services to the Island. The Chairman confirmed that a letter of condolence had been sent as the Isle of Wight NHS had many things to be thankful to Mr Munds for and that his legacy would live on.

b) **General Election:** The Chairman commented that the NHS was now in the forefront of the news and would be a major topic in the coming elections. He stated that this was a time for the Trust to keep calm and to continue making improvements where needed. He stated that the CQC[1] had stated that the Trust was doing lots well and that everyone needed to work together to co-ordinate plans to continue to improve our services.

c) **Board Continuity:** The Chairman advised that both Sue Wadsworth and himself have agreed to seek a further 2 years when their terms of office come to an end, and that there were no more Board changes planned. He advised that this would provide a stable base for the organisation.

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

14/261 CHIEF EXECUTIVE'S UPDATE

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

National

- **General Election** – NHS will feature highly in the run up to the elections on 7th May 2015, and the coming months will be a time of political scrutiny and focus on health and social care.

[1] Care Quality Commission

Finances – During 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) has produced a useful 'infographic' in which 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.

Regional

- **Shaping the future of local IVF services** – CCG[2] undertaking a period of engagement to gather views of local people and other stakeholders.

Local

- **Care Quality Commission Reports** – The Chief Executive advised that Frimley Park NHS Foundation Trust had just been rated as "Outstanding" following their CQC inspection. She advised that their very stable Board had contributed to their ability to attain this level. She recommended that the Board review their CQC report.
- **Trust Awards** – Date for entries extended to 5th November 2014 with Awards ceremony to be held in early 2015
- **Future of Health and Social Care on the Island** – The Trust is working closely with the Isle of Wight Council and CCG to plan for the future of health and social care on the Island.
- **Listening into Action** – Good attendance at 4 open meetings held recently with feedback being published to staff by 17th October 2014.
- **Recruitment Summit** – This is to take place on 8th October and will include representatives from Health Education Wessex, Isle of Wight Council, local General Practitioners and the Isle of Wight NHS Trust. The aim is to promote the Island as an attractive and positive place to work.
- **Visit by Chris Hopson, Foundation Trust Network (FTN) Chief Executive** – Board members met with Mr Hopson on 17th September 2014 as part of his visit to the Trust.

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

14/262 LOCAL UPDATE FROM HOSPITAL & AMBULANCE

The Chief Executive welcomed Donna Collins, Associate Director for the Hospital & Ambulance Directorate to support this item. Areas covered included:

Hospital

- Quality, Performance and Finance - £1,8m overspend as Directorate
- Paediatric assessment at the front door
- Children's Respite Care Team
- Outpatient Appointments and Records Unit
- Pharmacy

Ambulance

- Quality, Performance and Finance
- Integrated Care Hub to be showcased at FTN conference

Charles Rogers asked what action was being taken to replace the staff who had recently left the ambulance service. The Chief Executive advised him that there had been a number of retirements amongst the staff together with some relocating to the mainland. She also advised that overtime had been stopped, and this had led to the reported staff shortages outlined in the report.

[2] Clinical Commissioning Group

The Associate Director for Hospital & Ambulance confirmed that there was no particular trends and that sickness was all short term, and that this was being monitored appropriately.

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

14/263 LOCAL UPDATE FROM COMMUNITY & MENTAL HEALTH

The Chief Executive welcomed Nikki Turner, Acting Associate Director for the Community & Mental Health Directorate to support this item. Areas covered included:

- Head of Mental Health (MH) & Learning Disabilities – taking up post in December 2014
- Speech & Language Therapy - Leading edge developments
- Access to Psychological Therapies/Primary Care MH Team
- Learning Disabilities – positive service user feedback received
- Community MH Accreditation with Royal College of Psychiatrists
- Community Nursing - On Call Manager and more staff
- Community Inpatient Beds – New leadership and increasing staff
- Media spotlight – Telehealth and Drug & Alcohol Service
- Finance - £193k overspend

Jessamy Baird asked if a timeline for the additional funding for Community Nurses had been received from the CCG. The Acting Associate Director for the Community & Mental Health Directorate advised that by the end of October the Community Nurses would be staffed to full establishment. She also advised that a business case had been submitted to the CCG for an additional 15 nurses. It was anticipated that half would be appointed before the end of the financial year and the remainder in the next financial year.

Charles Rogers asked if Community Nursing was part of the safer staffing process. The Deputy Director of Nursing advised that through the process they had managed to get some of the Community Nurses included. However, this area was not part of the national programme which was focused on in patient care. Charles Rogers asked if once the CCG had given approval for the additional staff, could the Community Nurses be included within the safer staffing model. The Chief Executive advised that in order to do this fully it would be necessary to ensure that there would be community nursing cover 24/7.

Jessamy Baird requested an update on locality working. The Chief Executive advised that a paper on Integrated Locality Working would be coming to Board on 29th October 2014 which would cover this.

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

14/264 PATIENT STORY

The Chief Executive advised the meeting that this month's story related to a patient who she had met on the Stroke Unit and who had a less than favourable experience, but who had wanted to recount the very good experience he had whilst in the Emergency Department. She confirmed that his complaint had been fully dealt with.

The patient outlined how he had come to be in the Emergency Department and praised the care he had received whilst there. He particularly praised the excellent communication skills of the senior nurse in charge at the time. He

recounted how she had an excellent manner and kept everyone very calm in a very stressful situation, and he stressed that she was an excellent role model.

Charles Rogers stated that good communication was essential and that there were parts of the organisation in which this was very good. However, there were areas where the level of communication was not as good. He stated that the same excellent level of communication needed to be shown across the organisation.

Nina Moorman confirmed that this film had been shown at the recent QCPC[3] meeting and it demonstrated how important it was for traumatised patients to receive this type of care.

The Isle of Wight NHS Trust Board received the Patient Story

14/265 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

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

Category 1 – Quality Care & Innovation

- Yvonne Younie, Receptionist/Officer

Category 2 – Employee Role Model

- Sarah Kingswell, Senior Administrator - Crisis Resolution Home Treatment Team
- Lara Watson, Pelvic Floor Specialist Physiotherapist

Category 3 – Going the Extra Mile

- Gina Ford, Cleanliness Assistant – Osborne Ward
- Katy Pearse, Medical Rostering Officer

The Chief Executive congratulated all recipients on their achievements.

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

14/266 EMPLOYEE OF THE MONTH

The Chief Executive presented the Employee of the Month Award.

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Employee of the Month – September 2014

- Dr John Pike, Core Trainee Doctor – Emergency Department

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

14/267 STAFF STORY

The Staff Story was presented by Dr Clare-Louise Sandell who is an Orthopaedic Nurse Specialist.

She outlined how the organisations investment in her training had benefited patients and improved the innovation within orthopaedic care within the organisation. She gave an overview of where the service had been when she started her journey and how her role had developed against a background of reduced junior doctor hours, the development of the nurse specialist, the

[3] Quality & Clinical Performance Committee

emerging role of the non-medical prescriber, extended practice and new ways of working.

The Chairman asked Dr Sandell what were the barriers to innovation within the Trust and what were the barriers to other professionals joining the organisation. She felt that the Trust should do more to encourage staff to go out and promote our successes both nationally and internationally.

The Isle of Wight NHS Trust Board received the Staff Story

14/268 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 27th August 2014 were approved with the following amendments:

a) **14/234 p3:** The Executive Director of Finance requested that an action be added:

Action Note: *The Executive Director of Nursing & Workforce to ensure that highlights and lowlights shown in the Performance report are linked to the monthly directorate reports.*

Action by: EDNW

b) **14/241 iii) p6**: Jessamy Baird wished to clarify that the point she made at the meeting was that the allocation of annual leave can lead to lower staffing levels which can exacerbate staff sickness caused by stress shown in the data. She also asked that the sickness data within the Performance Report include the annual trend for comparison.

Action Note: *The Executive Director of Finance to arrange for the annual sickness trend to be included within the performance report.*

Action by: EDF

In response to this amendment the Deputy Director of Nursing advised that the new rostering policy was very clear on how annual leave should be given but agreed that there are some areas where this may not be applied strictly.

c) **14/244 f) p8:** Jessamy Baird also proposed an amendment to the minute from the MHASC[4] - Minute No. 14/023 to:

> **Care Planning and PARIS** - Care plans and risk assessments are currently not easy for staff to access, thereby hampering not only the recording and subsequent review of care plans, but more importantly, the ability of service users to be involved in and 'own' their care plans..

d) **14/252 p11:** The Executive Director of Finance requested the removal of the first use of the word "been" from first sentence, 2nd paragraph so that it reads:

> He advised that the report had not been approved by both QCPC and FIWC on this occasion as the Programme Manager - Business

[4] Mental Health Act Scrutiny Committee

Planning & Foundation Trust Application had not been able to be present at these meetings.

Proposed by Jane Tabor and seconded by David King

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

14/269 REVIEW OF SCHEDULE OF ACTIONS

The following updates to the schedule of actions were noted:

a) **TB/085 – Pressure Ulcers:** The Deputy Director of Nursing advised that the Trust benchmarks well in the National Safety Thermometer Data and shows a significant downward trajectory. However, the required improvement is not being demonstrated in the Trust current data viewed by the Board. She reported that the Matrons Group was reviewing competencies of staff, root causes of cases and trends as well as strategies to ensure that appropriate actions are put into place. These would be presented to a future Board Seminar.

Action Note: The Company Secretary to add to Pressure Ulcers as a topic on the Board Seminar Forward Planner.

Action by: CS

Jane Tabor asked if those nurses who demonstrate exemplary practice had been canvased for their input. The Deputy Director of Nursing advised that at this stage this had not happened but she would raise the suggestion with the Matrons Group.

Action: The Deputy Director of Nursing to raise the suggestion of canvassing nurses for their input with the Matrons Group.

Action by: DDN

Jessamy Baird suggested that a change in focus to increase early reporting of Grades 1 & 2 pressure ulcers would be appropriate and the reporting data widened to show all grades equally. The Deputy Director of Nursing advised that she would discuss this with the Lead for SEE and Deputy Director of IPC[5] to focus on specific wards and to ensure that all levels of pressure ulcers were reported.

Action Note: The Deputy Director of Nursing and Lead for SEE &Deputy Director of IPC to consider a different approach.

Action by: DDN

It was agreed that Action TB/085 would be closed and the above actions would succeed it.

b) **TB093 – Board Walkabouts:** The Company Secretary report that a new format for these was being trailed and that the action would be left open with a discussion due to be held at the next Board Seminar.

[5] Lead for Safety, Experience & Effectiveness & Deputy Director of Infection Prevention Control

c) **TB/110 – Car Parking:** The Head of Communications & Engagement reported that the information was now available on the website and requested that the action be left open to allow progress updates.

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

14/270 CQC REPORT

The Chief Executive welcomed Dr Sandya Theminimulle in her capacity of Associate Medical Director for SEE and Deborah Matthews, Lead for SEE and Deputy Director of IPC.

She presented the report and advised that the report included the high level results from the inspection.by the Care Quality Commission (CQC) which took place on 4th, 5th and 6th June 2014, and the subsequent unannounced visit on 21st June 2014.

The Chief Executive reported that the Trust was given an overall rating of 'requires improvement.' She advised that the Trust received 12 areas of immediate concern and following the inspection the Trust had been issued with a Warning Notice in relation to Regulated Activity: Treatment of Disease, Disorder or Injury.

She stressed that there were also many areas of good practice found within the organisation and that it was important not to forget these. The Trust had achieved 7/10 areas as good although this was not reflected in the overall rating given.

Lead for SEE and Deputy Director of IPC advised that a Quality Improvement Programme (QIP) had been developed following the CQC report which was a requirement from the Trust Development Authority (TDA).

A discussion on the content of the report took place and a number of concerns were raised.

- David King stressed the need to fully understand the systemic issues in order to analyse any failings within certain areas.

- Jane Tabor felt that internal governance should have a quantifiable assurance report such as a high level dashboard with clear KPI's to show progress being made against timelines and milestones. The Chairman also stressed the need for a concise report to come to Board. The Associate Medical Director for SEE advised that the document which was submitted to the CQC was large and that action plans had been created. She also confirmed that these would be RAG rated and that this would provide the basis for such a report.

- Nina Moorman stated that as well as the QCPC monitoring the detail of the QIP, she felt that the Audit & Corporate Risk Committee should be included within the internal governance process as it would challenge any aspect which it felt lacked clarity and assurance as part of its role. The Company Secretary agreed that this would be appropriate.

The Chief Executive advised the meeting that the Board was being asked 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. The Board felt that given the information provided and the comments outlined above, it could not approve this document but would only receive it for noting at this stage as work in progress.

The Isle of Wight NHS Trust Board noted the CQC Inspection Report and the proposed internal governance arrangements.

14/271 PERFORMANCE REPORT

The Executive Director of Finance presented the performance report which included the following summary items:

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 to1 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 To Treatment Time Admitted, Non-Admitted and Incompletes below target
- Staff sickness remains above plan

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):** 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:** 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 post continues to be advertised.

- **Care Programme Approach (CPA):** 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.

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.

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

Well Led:

- **Pay Bill**: 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 spend on variable hours.

- **Sickness Absence:** 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.

- **Financial Surplus**: 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.

- **Cost Improvement Programme (CIP)**: 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.

Effective:

- **Theatre Utilisation**: Theatre Utilisation has improved for both Main Theatres and Day Surgery Unit giving a joint rate of 79.2% in August.

- **Bed Pressures:** 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.

The Executive Director of Finance advised that the Balanced Scorecard (p2) which is aligned to the KLOE[6] criteria would continue to be expanded over the coming months.

Within the Performance Summary for Mental Health (p6) she made particular reference to the block contracts which currently fund Mental Health & Learning Disabilities and explained that there were moves towards changing to a payment by results system. It was also confirmed that levels of sickness absence within Community Mental Health services were being monitored by the Finance, Investment, Information & Workforce Committee.

The Executive Director of Finance highlighted the Ambulance Performance (p14) and advised the meeting by reviewing this data with that of the national benchmarking KPIs (p20) it showed that the ambulance service were consistently operating at levels which were higher than the national targets

The following areas were also raised during discussion:

i. **Community Services Contracted Activity p5:** David King asked if the data shown could include a variant level. The Executive Director of Finance advised that the service activity was spread over a year and depended on demand/delivery. The Chairman also asked if we were over performing against contract. She advised that more data could be given and that a business case for community nursing was being prepared to apply for additional funding.

Action Note: *The Executive Director of Finance to arrange for the data to reflect variance in demand and delivery within contacted activity within the performance summary reports.*

Action by: EDF

ii. **Mental Health RTT data p6:** Jessamy Baird asked why the Actual figure for RTT Non Admitted - % within 18 weeks was showing as Red when the figure shown was 95% and on target. The Executive Director of Finance advised that the figures shown in the report were rounded up and the true figure was 94.8% which was slightly under the target and hence shown as Red.

iii. **Ambulance Appraisals p7:** Jessamy Baird asked if the level of appraisals reported was a negative trend. She cited the recent Staff Survey report as having included concerns in this area within the results. The Executive Director of Finance advised that there was some under reporting in this area and that further work would be done to improve the reliability of the data which would be seen in future months.

Action Note*: The Executive Director of Nursing & Workforce to report back to the Board on progress and to provide assurance that the reliability of the data issue had been resolved.*

Action by: EDNW

iv. **Cancer Consultant Cover p13:** David King asked if the level of consultant cover in the period could be included within the report to add clarity and perspective. Nina Moorman also asked at what point a locum

[6] Key Line of Enquiry

position became permanent as there were locum consultants being used within this service. The Clinical Director for Community & Mental Health outlined the process of using a locum doctor and that the Trust did appoint locum consultants on a fixed term basis and this meant that they would not become permanent. She also advised that the Trust does on occasion use agency locums.

Action Note: The Executive Director of Finance to request that the level of consultant cover within the cancer service be shown within the report.

Action by: EDF

v. **Referral to Treatment Times p16:** Nina Moorman asked if any clinical oversight on cases meant that they would be brought forward for early assessment based on serious needs. The Chief Executive advised that the Trust operated a strict 'treated in turn' process. She did however state, that in the event of a cancellation the doctors could call in patients early following a review of the cases to fill these cancellations.

vi. **Risk Register p22:** Jessamy Baird felt that there was insufficient detail within this report and felt that the Risk Register was not discussed in detail at the Board. The Company Secretary advised that the Risks were incorporated within the Board Assurance Framework report which would be presented later in the meeting, and in which detail of the risk was contained.

vii. **Staff Sickness costs p24:** Jane Tabor asked that costs for sickness absence be included within the report to add perspective.

***Action Note**: The Executive Director of Finance to request that sickness costs incurred for staff whilst not at work be included within the monthly report.*

Action by: EDF

viii. **CIP by Directorates p27:** Charles Rogers asked that the format of this report be amended as the current presentation indicates a false positive. He felt that the targets are very challenging and a clearer representation of the current position would be helpful.

Action Note: *The Executive Director of Finance to review the report format and arrange for a revised format for future meetings.*

Action by: EDF

The Isle of Wight NHS Trust Board received the Performance Report

14/272 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Nina Moorman reported on the key points raised at the last meeting held on 17th September 2014

a) Min No. 14/320 – The Committee discussed the CQC Action Plan and suggested that this be renamed the Quality Improvement Programme.

b) Min No. 14/322 – The Committee noted that the Patient Safety, Experience and Effectiveness (SEE) Team were operational and making a huge difference.

c) Min No. 14/328 - The Committee discussed the Seven Day Service Review Report and asked for an update in 6 months' time.

d) Min No. 14/337 - The Committee discussed the Service Users Involvement Policy and agreed that it should be presented to the Trust Executive Committee for approval.

e) Min No. 14/338 - The Committee approved the Board Self Certification.

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

14/273 REVISED TERMS OF REFERENCE FOR QUALITY & CLINICAL PERFORMANCE COMMITTEE

The Company Secretary presented the revised terms of reference and requested that they be formally approved by the Board.

Jessamy Baird referred to the Appendix within the paper and asked where Research would report into the terms of Board sub-committees. It was agreed that this query would be discussed at the committee and clarified.

Action Note: *Company Secretary to raise the query of where Research would report into the terms of Board sub-committees and arrange for an addendum to the made to the relevant terms of reference.*

Action by: CS

Proposed by David King and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the revised Terms of Reference for the Quality & Clinical Performance Committee

14/274 MINUTES OF THE FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE

Charles Rogers reported on the key points raised at the last meeting held on 17th September 2014.

a) **Min No. 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.

b) Min No. 14/148 - Staff Recruitment: The Committee noted the continuing work being undertaken in order to improve recruitment of clinical staff and in particular Consultants.

c) **Min No. 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.

d) **Min No, 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.

e) **Min No. 14/154 - Self Certification:** Sufficient assurance has been provided for the committee to recommend that Trust Board approve the Self Certification returns as proposed.

David King advised that a review of NHS Creative had taken place and that he felt that they made a good contribution to the Trust. Charles Rogers confirmed that further feedback on the review was due at the FIIWC in four months.

The Chairman asked if Workforce could provide a detailed list of the consultants currently working within the Trust and their positions. The Chief Executive confirmed that this was currently being prepared by Medical Workforce. Nina Moorman also asked if the list could include the names of the lead clinician in each area as this would be helpful so that any queries the NEDs had could be addressed directly to that person.

Action Note: *The Chief Executive to request that the lead clinicians in each area be identified and a list be prepared and circulated to Board Members.*

Action by: CE

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

14/275 REVISED TERMS OF REFERENCE FOR FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE

The Company Secretary presented the revised terms of reference and requested that they be formally approved by the Board.

Jessamy Baird queried clause 6.6.4 which included reference to Information Management and Technology and asked if this clause could be divided so that Information Governance was separated for clarity. The Executive Director of Finance advised that the committee would not be including Information Technology within their remit and agreed that any reference to Information Technology would be removed from the terms of reference. She also agreed that clause 6.6.4 would be split so that information governance and information management were clearly defined as separate areas of responsibility.

Action Note: *The Company Secretary to arrange for clause 6.6.4 to be split and for all references to Information Technology to be removed from the terms of reference.*

Action by: CS

The Board agreed that with these amendments the terms of reference would be approved.

Proposed by Charles Rogers and seconded by David King

The Isle of Wight NHS Trust Board approved the revised Terms of Reference for the Finance, Investment, Information & Workforce Committee following amendments to remove all reference to Information Technology and the division of clause 6.6.4.

14/276 REPORTS FROM SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs)

The Deputy Director of Nursing presented an overview of the report and advised that 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. She also advised that in the case of the unexpected death that the patient had not been in the Trust's care at the time of death but as they were known to us we were required to report it.

She advised that 3 SIRIs had been closed by the QCPC and highlighted the lessons learnt.

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

14/277 MONTHLY UPDATE ON SAFER STAFFING

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

She advised that version 10 of the staff rostering software is being installed and that it was anticipated that it would assist in the improvement of the data received. She advised that some manual checking was still needed in areas and that the team was working with the ward sisters/managers to ensure that levels were monitored accurately. Where staffing levels were under scrutiny daily contact was being made to gain assurance of staffing levels

She reported a bank fill rate of 81% in August and advised that some gaps in cover had been filled with Health Care Assistants, but assured the Board that there had been no reduction of appropriate patient care in these areas. The Ward Sisters professional opinion had been sought to support data information.

The Deputy Director of Nursing advised that new areas were being reviewed to be included within the safer staffing model – these were in theatres and community. She assured the Board that whilst the electronic systems are taking time to get right, the team is working with staff and that the Trust does have safe staffing levels.

Charles Rogers commented that he felt that this was a very honest report and that he could clearly see where there were areas which need some work and where the potential problems were.

Jessamy Baird asked if there were any particular concerns. The Deputy Director of Nursing advised that interviews for paediatric nurses were taking place and it was anticipated that this area would be recruited to in order to support the changes in Emergency Department and the Paediatric pathway. Rehabilitation was now up to full establishment with all staff having a clear perception of what the expectations of staff are.

Nina Moorman queried the point that if staff levels were now adequate in areas would this allow staff to undertake training needs without lowering staff cover within the areas. The Deputy Director of Nursing advised that 22% headroom is built into new staffing levels and this enables additional activities to occur. This is within the NICE[7] guidance.

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

[7] National Institute for Health & Care Excellence

14/278 MINUTES OF THE CHARITABLE FUNDS COMMITTEE

Nina Moorman reported on the key points raised at the last meeting held on 9th September 2014.

a) **Min No. 14/047 Draft Annual Report & Accounts 2013/14:** Independent examination to be undertaken in October/November 2014

b) **Min No. 14/054 - Approval of Items over £5k:** Helipad Walkway Extension - £11,636.

c) **Min No. 14/059 - Patient Council Representative:** June Ring has stepped down and a new representative and deputy to be appointed by the Patient Council

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

14/279 FOUNDATION TRUST (FT) UPDATE

The FT Programme Director presented the update

He advised that following the outcome of the CQC inspection the FT application will be paused for a minimum of 6 months.

He advised that the forthcoming general election could have an impact on the future of the FT model and the Trust would be monitoring this carefully.

The Quality Improvement Programme will strengthen Quality Governance and Board Governance. It was also important that the Trust continues to address the need for recurrent cost improvement programmes.

The FT Programme Board will be meeting in the near future to agree the priorities for improvement work during the pause period.

The FT Programme Director advised that at this stage the election of governors could not take place but the membership programme would continue. He reported on the recent membership events and advised that these had been well attended. He stressed the importance of the Trust continuing as a membership organisation.

He advised that the monthly reports would be paused but that updates would be provided.

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

14/280 BOARD SELF CERTIFICATION

The Company Secretary presented the monthly update. He advised that the report had been approved by both QCPC and FIIWC.

Jessamy Baird queried why some Board statements were showing as amber and some still as green. She queried Board Statement 7 as she did not feel that the Board adequately considered all strategic risks. The Company Secretary advised that strategic risks had been discussed at recent Board Seminars, and that they were included within the Board Assurance Framework which is presented to Board monthly. He also confirmed that all risks are discussed in depth at the relevant sub-committee.

Proposed by Jane Tabor and seconded by David King

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

14/281 BOARD ASSURANCE FRAMEWORK (BAF) MONTHLY UPDATE

The Head of Corporate Governance & Risk Management presented the BAF and reported that there were currently 64 Principal Risks and 88 Aligned Risk Register Risks.

He confirmed that within the summary report the key changes in ratings are:

- 1 Principal Risk now rated as Red
- 11 new Risks have been added since the July 2014 report.
- 4 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.

a) **CSF7.15 – Lack of Financial Awareness Training for Staff:** Jane Tabor commented that following the CQC feedback meeting, there had been a desire for better financial understanding by the clinical staff of the Trusts financial situation. She asked what was being done to ensure this was available to them. The Executive Director of Finance advised that within the induction process a more detailed presentation had been developed. In addition there was budget training for managers and eLearning models which were available from the HFMA[8] which would result in accreditation of the budget holders. The Deputy Director of Nursing advised that a lack of management awareness in this area was a concern and how would competence be assured following training. The Executive Director of Finance advised that the training covered a range of areas and understanding was assessed as part of the qualification.

b) **CSF2 620-1 – Mandatory Resuscitation Training:** The Deputy Director of Nursing queried the high score on this risk. The Head of Corporate Governance & Risk Management advised that the score had been agreed and that it had been challenged at TEC[9] and ratified.

c) CSFS 624-1 – MaxFax Dental Carts & Compressor no longer fit for purpose: The Executive Director of Finance confirmed that this was being actioned.

d) **CSF9 625-1 – Availability of Doctors to support second opinions for mental health assessments:** Jessamy Baird queried why with a score of 9 was this item shown as green. The Head of Corporate Governance & Risk Management advised that within the risk assessment criteria this risk had scored 9 and within the matrix for assessing risk this was assessed as a low risk.

Proposed by Jane Tabor and seconded by David King

The Isle of Wight NHS Trust Board approved the Board Assurance Framework (BAF) Dashboard & Summary Report

[8] Healthcare Financial Management Association
[9] Trust Executive Committee

14/282 MATTERS TO BE REPORTED TO THE BOARD

There were no matters raised

14/283 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

14/284 ANY OTHER BUSINESS

a) **Strike Action:** The Chief Executive reported that there was national strike action planned for 13th October. She confirmed that contingency planning was underway in the Trust.

b) **Board Dates:** Jane Tabor asked when the dates of the Board meetings would be known. The Company Secretary advised that this would be discussed at the Board Seminar on 14th October.

c) **Emergency Communication Plan:** Jane Tabor asked if the Trust had resources in place to deal with an influx of calls should an incident such as the recent case of the child removed from University Hospital Southampton. She had been advised that the additional calls from the media and other parties around this case had overloaded their switchboard and prevented other calls getting through to the relevant areas. The Head of Communication & Engagement advised that he was in contact with his colleagues at University Hospital Southampton to discuss any relevant feedback on their experience. The Chief Executive advised that the Trust did have internal processes in place to deal with a situation such as this.

d) **International Recruitment:** The Deputy Director of Nursing confirmed that recruitment from the Philippines to existing nursing vacancies would be undertaken over the next few months.

14/285 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 29th October 2014** in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 12.35pm

Signed……Chair Date:……..

Enc E

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)

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 **01/10/14** - It was agreed that Action TB/085 would be closed and the that separate actions requested at this meeting would succeed it. This action is now closed.	28-May-14	09-Dec-14	Completed	01-Oct-14	Closed
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. **16/05/1**4 - 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. **01/10/14** - The Company Secretary report that a new format for these was being trailed and that the action would be left open with a discussion due to be held at Board Seminar.	14-Oct-14	03-Dec-14	Progressing		Open
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. **01/10/14** - The Head of Communications & Engagement reported that the information was now available on the website and requested that the action be left open to allow progress updates.	01-Oct-14	03-Dec-14	Progressing		Open

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Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
27/08/14 (raised 01/10/14)	14/234	TB/111	**Directorate Monthly Reports to Board:** 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.	EDNW	The Executive Director of Nursing & Workforce to ensure that highlights and lowlights shown in the Performance report are linked to the monthly directorate reports. **22/10/14** - The reports from 29th October meeting will include the highlights and lowlights. This action is now closed.	01-Oct-14	29-Oct-14	Completed	22-Oct-14	Closed
27/08/14 (raised 01/10/14)	14/241 iii)	TB/112	**Allocation of Annual Leave and effect on sickness absence:** Jessamy Baird wished to clarify that the point she made at the meeting was that the allocation of annual leave can lead to lower staffing levels which can exacerbate staff sickness caused by stress shown in the data. She also asked that the sickness data within the Performance Report include the annual trend for comparison.	EDF	The Executive Director of Finance to arrange for the annual sickness trend to be included within the performance report. **22/10/14** - Additions made to the Workforce Report to reflect. This action is now closed.	01-Oct-14	29-Oct-14	Completed	22-Oct-14	Closed
01-Oct-14	14/269	TB/113	**Pressure Ulcers - Outcome of Matrons Group review into staff compentencies:** The Deputy Director of Nursing advised that the Trust benchmarking well in the National Safety Thermometer Data and shows a significant downward trajectory. However, the required improvement is not being demonstrated in the Trust current data viewed by the Board. She reported that the Matrons Group was reviewing competencies of staff, root causes of cases and trends as well as strategies to ensure that appropriate actions are put into place. These would be presented to a future Board Seminar.	CS	The Company Secretary to add to Pressure Ulcers as a topic on the Board Seminar Forward Planner. This action is now closed.	01-Oct-14	29-Oct-14	Completed	08-Oct-14	Closed
01-Oct-14	14/269	TB/114	**Exemplary Practice in the care of Pressure Ulcers:** Jane Tabor asked if those nurses who demonstrate exemplary practice had been canvased for their input. The Deputy Director of Nursing advised that at this stage this had not happened but she would raise the suggestion with the Matrons Group.	DDN	The Deputy Director of Nursing to raise the suggestion of canvassing nurses for their input with the Matrons Group.	01-Oct-14	03-Dec-14	Progressing		Open
01-Oct-14	14/269	TB/115	**Increased reporting on all grades of pressure ulcers:** Jessamy Baird suggested that a change in focus to increase early reporting of Grades 1 & 2 pressure ulcers would be appropriate and the reporting data widened to show all grades equally. The Deputy Director of Nursing advised that she would discuss this with the Lead for SEE and Deputy Director of IPC.	DDN	The Deputy Director of Nursing and Lead for SEE &Deputy Director of IPC to consider a different approach. **22/10/14** - Tissue Viability Nurse Specialist following discussions with the Deputy Director of Nursing is taking this forward. This action is now closed.	01-Oct-14	29-Oct-14	Completed	22-Oct-14	Closed
01-Oct-14	14/271 i)	TB/116	**Community Services Contracted Activity:** David King asked if the data shown could include a variant level. The Executive Director of Finance advised that the service activity was spread over a year and depended on demand/delivery. The Chairman also asked if we were over performing against contract. She advised that more data could be given and that a business case for community nursing was being prepared to apply for additional funding.	EDF	The Executive Director of Finance to arrange for the data to reflect variance in demand and delivery within contacted activity within the performance summary reports. **22/10/14** - Progressing for inclusion at 3rd December Board.	01-Oct-14	03-Dec-14	Progressing		Open
01-Oct-14	12/271 iii)	TB/117	**Ambulance Appraisals:** Jessamy Baird asked if the level of appraisals reported was a negative trend. She cited the recent Staff Survey report as having included concerns in this area within the results. The Executive Director of Finance advised that there was some under reporting in this area and that further work would be done to improve the reliability of the data which would be seen in future months.	EDNW	The Executive Director of Nursing & Workforce to report back to the Board on progress and to provide assurance that the reliability of the data issue had been resolved.	01-Oct-14	03-Dec-14	Progressing		Open
01-Oct-14	14/271 iv)	TB/118	**Cancer Consultant Cover:** David King asked if the level of consultant cover in the period could be included within the report to add clarity and perspective. Nina Moorman also asked at what point a locum position became permanent as there were locum consultants being used within this service. The Clinical Director for Community & Mental Health outlined the process of using a locum doctor and that the Trust did appoint locum consultants on a fixed term basis and this meant that they would not become permanent. She also advised that the Trust does on occasion use agency locums.	EDF	The Executive Director of Finance to request that the level of consultant cover within the cancer service be shown within the report. **17/10/14** - Cancer consultant cover to be included within the Workforce Report - for 3rd December Board.	01-Oct-14	03-Dec-14	Progressing		Open
01-Oct-14	14/271 vii)	TB/119	**Staff Sickness costs:** Jane Tabor asked that costs for sickness absence be included within the report to add perspective.	EDF	The Executive Director of Finance to request that sickness costs incurred for staff whilst not at work be included within the monthly report. **17/10/14** - Confirmed that the forthcoming reports would include 12 month sickness trend data, staff sickness costs with a further level of analysis to be provided in coming months. This action is now closed.	01-Oct-14	29-Oct-14	Completed	17-Oct-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
01-Oct-14	14/271 viii)	TB/120	**CIP by Directorates:** Charles Rogers asked that the format of this report be amended as the current presentation indicates a false positive. He felt that the targets are very challenging and a clearer representation of the current position would be helpful.	EDF	The Executive Director of Finance to review the report format and arrange for a revised format for future meetings. **22/10/14** - Updated report provide to FIIWC in October & will be presented to the subsequent board. This action is now closed.	01-Oct-14	29-Oct-14	Completed	22-Oct-14	Closed
01-Oct-14	14/273	TB/121	**Terms of Reference for QCPC:** Jessamy Baird referred to the Appendix within the paper and asked where Research would report into the terms of Board sub-committees. It was agreed that this query would be discussed at the committee and clarified.	CS	Company Secretary to raise the query of where Research would report into the terms of Board sub-committees and arrange for an addendum to the made to the relevant terms of reference. This action is now closed.	01-Oct-14	29-Oct-14	Completed	10-Oct-14	Closed
01-Oct-14	14/274	TB/122	**Consultant List:** The Chairman asked if Workforce could provide a detailed list of the consultants currently working within the Trust and their positions. The Chief Executive confirmed that this was currently being prepared by Medical Workforce. Nina Moorman also asked if the list could include the names of the lead clinician in each area as this would be helpful so that any queries the NEDs had could be addressed directly to that person.	CEO	The Chief Executive to request that the lead clinicians in each area be identified and a list be prepared and circulated to Board Members.	01-Oct-14	03-Dec-14	Progressing		Open
01-Oct-14	14/275	TB/123	**Terms of Reference for FIIWC:** Jessamy Baird queried clause 6.6.4 which included reference to Information Management and Technology and asked if this clause could be divided so that Information Governance was separated for clarity. The Executive Director of Finance advised that the committee would not be including Information Technology within their remit and agreed that any reference to Information Technology would be removed from the terms of reference. She also agreed that clause 6.6.4 would be split so that information governance and information management were clearly defined as separate areas of responsibility.	CS	The Company Secretary to arrange for clause 6.6.4 to be split and for all references to Information Technology to be removed from the terms of reference. **08/10/14** - Amendments completed. To be presented at FIIWC on 22nd October 2014. This action is now closed.	01-Oct-14	29-Oct-14	Completed	08-Oct-14	Closed

Enc F

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29 OCTOBER 2014

Title	Quality Improvement Plan			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing & Workforce			
Author(s)	Patient Safety, Experience & Clinical Effectiveness Triumvirate			
Purpose	To approve the Quality Improvement Plan			
Action required by the Board:	**Receive**		**Approve**	ü

Previously considered by (state date):			
Trust Executive Committee	20/10/14	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	22/10/14
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar	14/10/14		
Other (please state)	Patient Safety, Experience & Clinical Effectiveness Committee 15/10/14		

Staff, stakeholder, patient and public engagement:

Stakeholders have provided feedback which has been taken into account within the Quality Improvement Plan.

The Plan has been developed from information provided by staff from across the organisation.

Executive Summary:

Following the Care Quality Commissions (CQC) planned inspection to the Trust between 4th 6th June 2014 and the unannounced visit on 21st June 2014, the CQC issued the Trust an overall assessment of "requires improvement.

The CQC highlighted a number of compliance, enforcement, must do and should do actions that our services must make to ensure we deliver "good" quality care and progress to delivering "outstanding" quality care in all areas from which the following key themes have emerged:-

- Clinical Leadership, Staff Engagement and Culture
- Governance
- End of Life Care
- Recruitment and Retention
- Patient Caseload/Flow

The Trust was required to produce a Quality Improvement Plan to submit to the Care Quality Commission. The objective of this Quality Improvement Plan (QIP) is to support the Trust and its workforce to focus on achieving the required improvements to demonstrate our progression against the plan to achieve our aim to improve the quality of our clinical services. Our QIP is a high level summary of the detail within an underpinning Action Plan.

For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	Quality					
Critical Success Factors *(see key)*	CSF1 & CSF2					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	1.5 & 2.10					
Assurance Level ***(shown on BAF)***	Red	ü	Amber	ü	Green	
Legal implications, regulatory and consultation requirements						

Date: 17 October 2014 **Completed by:** Theresa Gallard
Business Manager
Patient Safety, Experience & Clinical Effectiveness

Isle of Wight NHS
NHS Trust

Isle of Wight NHS Trust

"Quality Care For Everyone Every Time"

Quality Improvement Plan

In response to the CQC report 2014

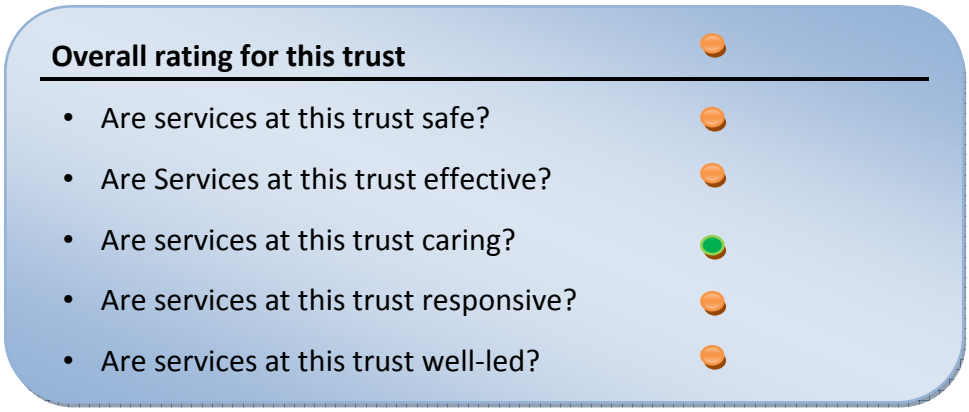
Version Control

Date of Issue	Version No.	Director Responsible for Change	Nature of Change
19/09/14	1.0	Mark Pugh, Executive Medical Director	Initial Draft
29/09/14	2.0	Mark Pugh, Executive Medical Director	Realignment under relevant themes
30/09/14	3.0	Mark Pugh, Executive Medical Director	Addition of Appendix
03/10/14	4.0	Mark Pugh, Executive Medical Director	Updated with feedback from Trust Development Authority
09/10/14	5.0	Alan Sheward, Executive Director of Nursing & Workforce	Updated with feedback from key stakeholders& re-circulated
10/10/14	6.0	Alan Sheward, Executive Director of Nursing & Workforce	Final Version

Table of Contents

1. Introduction

Following the Care Quality Commissions (CQC) planned inspection to the Trust between 4th 6th June 2014 and the unannounced visit on 21st June 2014, the CQC issued the Trust an overall assessment of "requires improvement."



The CQC highlighted a number of compliance, enforcement, must do and should do actions that our services must make to ensure we deliver "good" quality care and progress to delivering "outstanding" quality care in all areas from which the following key themes have emerged.

The key themes are summarised below:	
1.	Clinical Leadership, Staff Engagement and Culture
2.	Governance
3.	End of Life Care
4.	Recruitment and Retention
5.	Patient Caseload/Flow

Highlighted at the Quality Summit on 2nd September 2014 was the need for a Quality Improvement Plan (QIP). The objective of this Quality Improvement Plan (QIP) is to support the Trust and its workforce to focus on achieving the required improvements to demonstrate our progression against the plan to achieve our aim to improve the quality of our clinical services. Our QIP is a high level summary of the detail within an underpinning Action Plan. The detailed plan will identify more specific roles and responsibilities for the delivery of the actions aligned to the Responsibility, Accountability, Consulting and Informing (RACI) Model. Our QIP currently captures the required actions described by the CQC within the warning letter, compliance and enforcement actions and the must and should do's they describe in the reports. Going forward it will be an all encompassing transformational plan that will address other quality related actions the organisation is required to undertake. Our improvement work will address the requirements to deliver the Care Quality Commission framework of Safe, Effective, Caring Responsive and Well Led care. This plan will be delivered alongside our other existing quality improvement strategies, such as the Long Term Quality Plan (LTQP) and the Clinical Strategy.

Our Chief Executive, Karen Baker is ultimately responsible for implementing actions in this document. Other key staff are Alan Sheward, Executive Director of Nursing & Workforce, and Dr Mark Pugh, Executive Medical Director as they provide the executive leadership for quality, patient safety and patient experience.

Ultimately, our success in implementing the recommendations in the QIP will be assessed by the CQC, who will re-inspect our Trust in the coming months.

2. Governance around the implementation and monitoring of the QIP

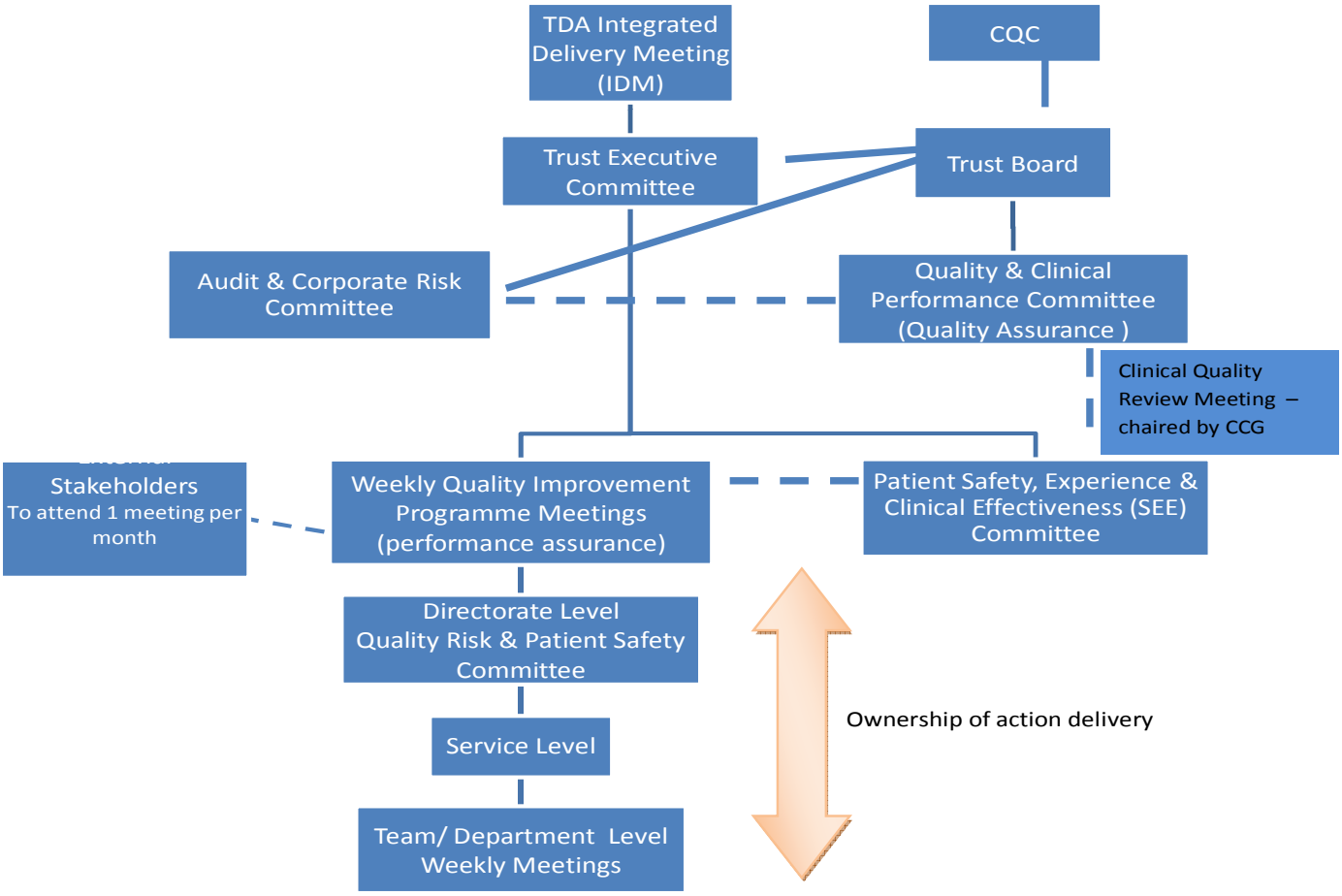
To monitor and support the delivery of our Quality Improvement Plan, regular weekly Quality Improvement Programme Meetings are being held, chaired by the Executive Director of Nursing & Workforce. This group has the responsibility of overseeing and contributing to the progress of the actions and will report directly to the weekly Trust Executive Committee (TEC). It is important that the work of these groups and the Trust Board is open and transparent. The representatives in this group include Directorate leads with the responsibility for improving quality monitoring at Directorate and Service level giving local ownership to teams. There is an expectation that within the Directorate there is a clear process for **at least** weekly review of progress in achieving the required actions and monitoring arrangements to ensure ongoing compliance and quality improvement. We plan to gain assurance that improvements are happening through a vigorous monitoring programme.

Our QIP will be monitored externally through the monthly Integrated Delivery Meetings (IDM) with the Trust Development Authority to which stakeholders are invited - the same stakeholders who attended the Quality Summit in September 2014, i.e. Healthwatch, CCG, NHS England, Health Education Wessex, GMC and Local Authority.

We will also utilise our key stakeholders for example Patients Council and Healthwatch to undertake support visits to clinical areas to evidence appropriate outcomes achieved against relevant actions.

It is also acknowledged that the Trust will need to utilise its support services, e.g. Performance Information Department, for the provision of quality performance data and also utilise existing quality assurance and quality monitoring mechanisms; which provide information relating to Key Performance Indicators related to complaints and serious incidents requiring investigation (SIRIs).

The formal structure is set out below.



3. How we will communicate our progress to our staff

We will provide a progress report every month which will be reviewed by TEC and received by the Trust Board. We will provide staff with an update on progress at our regular staff briefings. The progress report will be published on the Trust website and subsequent longer term actions may be included as part of a continuous process of improvement. We will let our staff and stakeholders know where the update can be found.

In return, we expect staff at all levels of the organisation to develop, share and own the actions. We believe that cultural and transformational change needs to occur to ensure the actions arising out of the visit are sustainable and demonstrate to our patients, staff and stakeholders that quality improvement is a way of life for the Trust and not just a response to the inspection.

We will be seeking the views of staff to ensure there is evidence of change as near to the patient as possible. This will be through a number of routes including:-

1. Quality Champions
2. Listening into action
3. Team and department assessments in the following areas;
    a. Ward and Department level
    b. Service level
    c. Directorate and Corporate service level.

We will also continue to communicate with staff when they are doing well. We will continue to build on the current arrangements for celebrating successes.

We will be using our high performing teams to share examples of best practice across the rest of the organisation and will provide weekly key messages on achievements to all staff.

4. Themes from the CQC Reports

Theme 1: Clinical Leadership, Staff Engagement & Culture

The drive for continuous quality improvement requires exceptional leadership at every level of the organisation. Our goal is to create a culture within our Trust where patient safety and reliable high quality care is central to everyday practice. The importance and need for re-setting the culture within our organisation cannot be underestimated. This can be a complex and lengthy process; however the Trust acknowledges the need for the urgent pace of change. Change will include the development of an environment where there are optimal systems and processes for reporting and learning from patient safety incidents and serious incidents requiring investigation (SIRIs). We will achieve this by engaging and communicating more effectively with frontline staff, ensuring staff understand what their responsibilities are and what is expected of them. We will also create an environment where staff know that we will listen to their concerns and support them in delivering quality services, by promptly following up on concerns raised.

Engaging with our Staff - Listening into Action

The CQC found that staff engagement is not effective, so that service changes & developments are owned and effectively implemented, to reduce risks to patients and people that use services.

We know…

Meaningful engagement is essential to create a culture where safety and high quality care is embedded in every day practice. Listening into Action (LiA), which was commenced in June 2014, is one vehicle for staff engagement within the organisation. LiA takes a conversation approach to engaging staff at all levels for positive and effective change. It helps make connections between people, services and functions and fosters collaboration to ensure collective ownership. This approach will support delivery of the Long Term Quality Plan by engaging staff to design quality improvement schemes and will complement the work of our Quality Champions and will allow us to develop a Trust where our staff own quality and are empowered to make the changes necessary to continuously monitor and improve quality.

The Trust needs to encourage staff to be open and honest, putting patient safety at the forefront of everything they do.

Ensuring the whole Trust is equally represented at Trust Board

The CQC found that many staff in Ambulance, Community & Mental Health felt 'disconnected' from the Trust or felt like satellite services.

We will…

Take steps to ensure that all four elements of the Trust namely the acute, ambulance, community and mental health teams will be clearly reviewed at Trust Board. Options include using whole Trust Board days on one of the different elements or making clearer the difference between the different elements. The Board will this do this in addition to overseeing the routine business. Integral to this will be to ensure we get more departmental representation at Trust Board, including front-line staff. We have made changes in this

respect already, recognising a revised directorate structure named Hospital & Ambulance and Community & Mental Health; our reporting is reflective of these changes

Clinical engagement in decision making and planning

The CQC stated that the clinical leadership of services needs to improve and that the Leadership Team and Senior Managers were changing services and policies, but these were not effectively implemented.

We are aware that…..

We have struggled to find the right forum to discuss decisions and planning with our staff at an early enough time point to allow them to be able to provide valuable input to Trust business. We will set up relevant groups to facilitate this with a clear link to the Trust Executive Committee.

KEY PERFORMANCE INDICATORS:

- **Progressively improve the image & perception of the Trust amongst staff, measured through the staff Friends & Family Test**
- **Increase the % of Lead Clinicians who have undertaken clinical leadership training**
- **Ensure staff understand their role & contribution to the patient experience and outcomes**

Theme 2: Governance

Quality Governance is the combination of structures and processes at and below board level and these include:

- A focus on ensuring that required standards are achieved
- Investigating and taking action on sub-optimal performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring the delivery of best practice
- Identifying and managing risks to quality of care

Governance Review

The CQC found that the Trust had comprehensive corporate governance processes, but needed a better clinical governance and assurance system.

We have…

Seconded a Divisional Head of Nursing from Southampton University Hospital Foundation Trust into the Isle of Wight NHS Trust for a six week period from 1st September 2014 with the aim of reviewing our governance structures and providing recommendations in respect of how we improve. The key elements of the review included; Identifying the current governance systems for managing clinical risks, identifying the directorate and Trust wide systems and processes for monitoring and managing risk; Reviewing the management of changes following a clinical incident ensuring there are robust systems to manage the implementation of change and that any changes are monitored. Identifying the current arrangement for the sharing of lessons learned, with a view to making recommendations of how the Trust could improve this very important aspect; Making recommendations on how the Trust, as an organisation, and its Board can gain greater assurance from visits to clinical areas.

NICE Guidance

The CQC highlighted there were not robust systems in place for the review of compliance with national guidance.

We will…
Ensure full compliance with relevant NICE guidance by tasking the Safety, Experience & Clinical Effectiveness (SEE) Team with gathering data on compliance with new guidance and audit of established guidelines. The SEE team are a new team that are overseeing the delivery of patient safety, experience & clinical effectiveness agenda within the Trust. Results will be reviewed by the Quality and Clinical Performance Committee (QCPC) to provide assurance to the Trust Board.

Managing Clinical & Corporate Risk

The CQC found that the Trust did not effectively assess and monitor risks to the quality of services for patients and for staff.

We will…
Take steps to improve our management of every day risks to ensure these are controlled and where this is not possible we have robust responses and plans to mitigate these. This will include the individual risks of patients, so that we can care to their specific needs. We acknowledge the risk posed by surroundings both to staff, such as lone workers, and our environments which can pose risks to patients and staff. It is also about ensuring we check vital pieces of equipment regularly maintain records of this and monitor the use and availability of controlled drugs. In addition we need to get better at predicting the potential risk in relation to new projects and manage better how we monitor these, such as when we roll out new computer systems. Once identified we need to take decisive action to deal with the risk and report back to those that have reported any risks what actions have been taken.

Community Wards and Community Teams

The CQC found that community teams were under resourced and there were not effective operation systems to regularly assess and monitor the quality of the services provided, in order to identify and manage risks.

We commit to…
Undertake a range of improvement activities on our community wards and within community teams to improve the patient experience in terms of safety of care received by patients in these areas. This will include full implementation of 'intentional rounding,' pressure area care, record completion, mixed sex monitoring, which will include weekly and three monthly audits. Work will also be undertaken within our Community Mental Health Team and we will seek the views of service users more assiduously than we have previously. We will ensure a full delivery of the healthy child programme in line with service agreements and will continue to release more time for community staff to see patients by continuing the "productive series." The Trust needs to work with partners to build in flexibility for staffing levels, in relation to acuity and dependency of patients.

Shared Learning

The CQC highlighted concerns about staff engagement and identified areas where this was not optimal.

We will:

Not only deliver the necessary improvements as outlined in the full action plan but create a culture of continuous quality improvement. Our goal is to continue to become a learning organisation in which every member of staff understands their role in delivering this aim and works towards that aim every day. We will improve timely communication to our staff about changes that are required, including those following the investigation of incidents.

Education and Training

The CQC highlighted a need for further training in a number of specific subjects such as End of Life Care (EoLC), Mental Capacity Act (MCA) and Paediatric Safeguarding in the Emergency Department. We recognise we need to do more to raise staff awareness and understanding about clinical and corporate governance.

We are…

Committed to staff education and training. Our Trust fully supports the release of staff to undertake mandatory, service specific and speciality training. We recognise on occasion this has not occurred and in the future we will build direct links between risk identification and reporting and the communication of issues and training requirements to our organisational Development and Training Department. We will monitor training attendance through Directorate performance reviews. We will reward those services and departments who achieve compliance in this respect. Similarly we will monitor closely the uptake of mandatory training by our staff to ensure it is undertaken and when it is not the reason why. The requirements surrounding mandatory training will be clarified to all Managers to ensure staff are released to undertake vital training.

Learning from others

We will maximise the opportunities to learn with and from other NHS provider organisations and international organisations to bring about measurable improvement. We will actively promote good practice across the Trust by learning from high performing teams from within our own Trust and from other organisations. We have set up a strategic partnership with Hertfordshire Partnership University Foundation Trust to facilitate this process in Mental Health and are keen to set up similar arrangements in other areas.

KEY PERFORMANCE INDICATORS:

- Make sure that all our staff understand the term ‘governance’
- Ensure there are clear governance processes within our wards, services, directorates and Boards
- Make sure there is comprehensive governance around the Trust’s performance against targets and goals and that staff are being appropriately held to account around poor performance

Theme 3: End of Life Care

We acknowledge that the processes that underpin our end of life care are not adequate.

End of Life care Improvements

The CQC found the Trust was 'inadequate' in response to delivering end of life care

We have…

Set up an end of life care task group under the leadership of one of our clinical directors to rapidly take forward the work we need to do. We will work closely and seek support from partner organisations, from our local hospice - Earl Mountbatten Hospice, the CCG and local third sector organisations to help deliver this. Key will be the establishment of a process to identify patients who are near the end of life as they are admitted and ensure they receive the correct care. We will also work with our partners in the local CCG to build on the work they have done in identifying patients in the community who may be suitable for an anticipatory care pathway, as they develop their strategy for End of Life Care. This information is already available to our ambulance team. We will put in place a new policy for End of Life Care by the end of 2014 and will ensure we have rolled out the necessary supporting learning through a recently appointed nurse lead across our Trust by June 2015.

The need for improvements in End of Life Care, some of which involve specific changes in behaviour to recognise and communicate End of Life Care decisions with regard to the use of DNACPR orders will be addressed. Every ward will be asked to identify a local End of Life Care Champion to take the project forward by the end of November 2014. A lead nurse has also been appointed to lead on End of Life Care across the Trust.

KEY PERFORMANCE INDICATORS:

- We will deliver 98% of patients requiring consideration for inclusion in the AMBER Care Bundle within 24 hours of admission
- There is a clear, comprehensive strategy in place to support the delivery of end of life care
- Work with partners to ensure an island Wide approach to delivering end of life care
- We will increase the number of deaths that occur in patients own home, where this is appropriate.
- We will reduce the number of death that occur in the hospital and work with local Primary Care Leads to improve the patient experience & decision making around their end of life care

Theme 4: Recruitment & Retention

Safer staffing levels – Medical and Nursing

The CQC found that staffing levels in some areas were insufficient to deliver the care required by patients.

Our response…

Lack of the right staff in the right place at the right time will always pose a risk for the delivery of high quality care. In response to the concerns raised by the CQC in relation to medical staffing a recruitment plan has been developed. We will, over time, reduce our reliance on

locum medical staff by developing innovative approaches to staff recruitment. It has been recognised that there is not a quick fix to our recruitment problems. We have already taken on additional support to help with medical recruitment. In recognition that the Trust has difficulties in attracting trainee doctors to come to the Island, we have signed up to participate in the Broad Based Training pilot. We are exploring workforce re-design options to enable us to fill hard to recruit to posts. Where we are unable to recruit the right staff to deliver services safely and sustainably we will work with local partners to refocus the service. We held a Workforce Recruitment Summit on 8th October 2014, with the involvement of key stakeholders, including Health Education Wessex.

Our Trust has recognised the value of the Safer Staffing principles to ensure we have correct nurse staffing levels. We have developed this further to allow assessment of community nursing levels and are working on further development to assess staffing levels in other Allied Health Professionals (AHPs). Part of the safer staffing initiative will be to recruit a cohort of nursing staff from overseas; our team is preparing to depart at the end of November 2014. Our Trust is fully committed to delivering safe and sustainable levels of staffing across the 4 areas of the Trust. We will work with our partners in The CCG and Local Authority to maximise the effectiveness of our recruitment campaigns and the staff we recruit.

KEY PERFORMANCE INDICATORS:

- Safer Nurse staffing principles have been fully implemented into inpatient wards by 31 March 2016
- The use of locum medical staff will have significantly reduced
- There is an increase in the number of Consultant Medical, Nursing, Midwifery & AHP posts
- The % of vacancies in any clinical area will not be greater than 5%

Theme 5: Patient Caseload and Patient Flow

Named Consultants

The CQC found that Patients had a number of bed moves and did not have a named consultant for the duration of their stay.

We will…

Ensure that all patients have a named consultant for the entire duration of their stay. If they are moved to the care of another Consultant, for instance for clinical reasons, we will ensure that patients are clearly informed of that change and that there is clear referral and acceptance criteria in place for these occurrences. We will ensure this is monitored and managed on a daily basis.

The Trust will ensure appropriate mechanisms and risk assessments are in place to minimise inappropriate bed moves and medical outliers.

We will also require support from our Local Authority on solutions to reducing delays in discharge, impacting on patient stay.

KEY PERFORMANCE INDICATORS:

- Patients identified as being in the last days of life / on the AMBER Care Bundle are not moved between wards for non clinical reasons
- To reduce timed delays to discharge for those requiring social care funded home packages of care or residential home placement
- Clear referral & acceptance criteria in place for moves relating to clinical reasons
- We will implement an escalation process when patients are changed to a 3rd consultant during a single admission

Conclusion

Our Trust is committed to developing a robust and sustainable process for the improvement of the services and care that we provide for those patients and carers who may need our Acute, Ambulance, Mental Health and Community Care Services through delivery of this Quality Improvement Plan. We recognise that this can only be achieved with input from our patients, their families and our staff, and the wider health and social care structure. Together we will be able to make changes that deliver real, meaningful and sustainable improvements for the benefit of everyone who uses our services. This Quality Improvement Plan outlines the key areas identified in the CQC report and describes at a high level how we intend to draw together the different components which are key to delivering safe, effective, caring, responsive and well led care for our patients, service users and their families. It also provides a clear set of goals which are challenging but crucial for the successful delivery of our vision of delivering **quality care for everyone, every time.**

APPENDIX 1

KEY

Code	Service / Report	Code	Action Type	Progress
AcS	Acute Services	**CA**	Compliance	Behind Target
CS	Community Services	**EA**	Enforcement	On Target
MH	Mental Health Services	**MD**	Must Do	Completed
AS	Ambulance Services	**SD**	Should Do	Tested
TW	Trust Wide	**WN**	Warning Notice	
Ac/AS	Acute & Ambulance			

Compliance Action 1: People who use services were not protected against risks of receiving care or treatment that is inappropriate or unsafe
Treatment of disease, disorder or injury (Acute; Community Health & Mental Health Services).

Ref	Area of Concern	Actions Required	Time scale	Exec Lead	Lead	Evidence Required	Outcome / Success Criteria	Progress
CA1.1 CA1.7 MD7 (AcS)	Risk assessments were not consistently completed in their entirety to inform the plan of care	- Risk assessments completed on every patient - Use of bed rails consistently risk assessed and patient consent obtained for their use - Back to the floor day will undertake regular documentation audits	31/10/14	Exec Director of Nursing & Workforce	Matron (TC)	Monthly audit of nursing risk documentation. Reported back through the directorate quality meeting for assurance	Risk assessments are completed consistently for the individual needs of patients Risk assessments in place for all uses of bed rails	G
CA1.2 MD9 (AcS)	Patients who had suffered a stroke could not be assured that the pathway of care was fully reflective of national guidance	- Review pathway in conjunction with Acute services - Complete review of service with Commissioner - Ensure compliance against national guidance	30/11/14	Exec Medical Director / Deputy Chief Officer (CCG)	Interim General Manager – Community Health CCG Commissioning Manager	KPI's as agreed with the CCG based on SNAP quarterly reports will be monitored through the SLA meetings.	The pathway of care for stroke patients will reflect national guidance and be supported with local commissioning	A
CA1.3 EA1.6 MD12 **WN** (AcS)	There was not a clear pathway for children to follow to gain access to health care in an emergency / No effective implementation & monitoring of paediatric admissions pathway or streaming & initial assessment of patients in	- Defined flow chart identifying how children come through one front door - SOP for open access children to access children's ward directly - Training for ED staff around safeguarding children and	31/10/14	Exec Director of Nursing & Workforce Deputy Chief Officer (CCG)	Head of Clinical Services – Hospital & Ambulance CCG Commissioning	Observations & questioning of staff in practice. Incidents of breaches reported. SOP available	All paediatric patients requiring urgent & emergency care will be brought via ED Single point of access in place	A

	A&E (single point of access in emergencies)	Paediatric Life support - Identify transitional funding stream through SDIP			Manager – Paediatric Commissioning (CCG)		Recognised admissions pathway in place 95% of staff will have completed safeguarding children training and paediatric life support	
CA1.4 (AcS)	The planning and delivery of end of life care did not meet national standards	Set up End of Life task group, under leadership of a Clinical Director	Completed	Exec Medical Director	Clinical Director – Community & Mental Health	Meeting minutes	Group meet as defined in the Terms of Reference	G
		· Aim to implement key recommendations from the national care of the dying audit for hospitals (May 14) · Complete review of commissioning in relation to End of Life Care (EoLC) · Agree End of Life Care strategy which reflects seamless transition from primary to secondary care · Provide Education on National Guidance and Best Practice - roll out the necessary supporting education & training through Trust	30/06/15	Exec Medical Director Deputy Chair (CCG)	Lead Nurse - End of Life Community Commissioning Manager	Use of training tracker will be used to ensure completion of mandatory elements	Improved training compliance	A
CA1.5 (CS)	Not carrying out an assessment of the needs of the service user	- Ad hoc & weekly documentation audits to be undertaken - Ensure Trust documentation is being used	31/10/14	Exec Medical Director	Ward Sister – Community Wards	Weekly/monthly documentation audit	Risk assessments are in place and well completed, representing individual patient needs	A
CA1.6 MD25 **WN** (CS)	An assessment of patients' skin condition was not made during the 'intentional rounding' introduced onto the stroke ward & the concept was applied only to selective	- Embed intentional-rounding on Stroke unit - All staff to view 'Rounding Queen' training video - Ensure all registered nurses have	31/10/14 28/11/14	Exec Medical Director	Matron – Community Wards	Audit compliance	Staff have comprehensive knowledge & intentional-rounding applied to all patients	A

	patients – staff need correct understanding	completed pressure ulcer competence package						
CA1.7 CA1.1 MD7 SD33 (CS)	Inaccuracies & inconsistencies in patient records affected risk assessment scores which shaped care – address inconsistencies in patient notes	- Weekly Tissue Viability & full documentation audits to be undertaken - Waterlow assessments completed on admission and/or transfer - Daily pressure area checks - Waterlow and MUST score to be reassessed routinely at weekends & more frequently where indicated	31/10/14	Exec Medical Director	Matron – Community Wards	Documentary evidence of audit. Matron to provide assurance to Community Service lead through weekly meetings. Monthly spot audit results. Peer Review	Improvement in completeness of documentation. Compliance with documentation requirements Risk Assessments are completed and are up to date	A
CA1.8 (CS)	Doppler assessments were not always carried out on patients with leg ulcers prior to use of compression Bandaging	- All patients to receive Doppler assessment prior to compression bandaging - Completion of competence training records demonstrating all relevant staff are competent	31/10/14	Exec Medical Director	Matron – Community Wards	Monthly audit to provide assurance to Directorate Quality Meeting that a Doppler assessment was carried out for patients before compression bandaging	Doppler assessments completed for all patients requiring compression bandaging	G
CA1.9 (CS)	Planning & delivery of care & treatment in order to meet service user's individual needs, ensure their welfare and safety & reflect published evidence & guidance	- Undertake review and gap analysis of current care - Develop plans for service redesign and implement	31/12/14	Exec Medical Director	Clinical Director Community & Mental Health	Monthly multidisciplinary team meetings held to support implementation of new plans	Care reflects published evidence and guidance	A
CA1.10 (CS)	Pressure ulcer risk assessments were updated at the weekend & therefore did not respond to any midweek changes in patients' skin conditions	- Daily checks of pressure areas by RNs. - Although re-assessments are routinely carried out at weekends additional/more frequent assessments must be carried out where the patients' condition indicates the need	Completed	Exec Medical Director	Matron – Community Wards	Weekly audits of documentation and monthly monitoring of compliance of intentional rounding	The frequency of re-assessments reflects the needs of the patient not ward routine	G
CA1.11 MD26 MD27 **WN** (CS)	Patient with Waterlow score of 24 was not on air mattress. Patient observed sitting on an inco sheet – standards for pressure area care should be followed with	- All patients to receive formal Waterlow assessment on admission and any equipment required is sourced within the	Complete	Exec Medical Director	Matron – Community Wards	Documentation audit of the provision of Tissue Viability equipment Staff survey results	Assessments completed on admission and the timely sourcing of equipment can be	G

	appropriate & timely reassessment / review inco sheet use *Links with action CA1.11*	timeframes described in the policy/in line with the patients needs - Reinforcement that inco sheets must only be used only where required - not 'just-in-case' - Staff survey to determine knowledge of staff around pressure ulcer management					evidenced through audit Staff demonstrate comprehensive knowledge of pressure ulcer management	
CA1.12 **WN** (MH)	Little evidence of health checks for people in Community Mental Health Services – outcome measures recommended for adult psychiatry patients	- Accelerate roll out of physical health clinics - All patients on the SMI (Serious Mental Illness) register should receive an annual health check	31/01/15	Exec Medical Director	Lead Nurse Mental Health	Expand current physical health check programme to all patients at full assessment	Outcome measures in use for adult psychiatry patients	A
CA1.13 MD31 SD22 (MH)	Care plans were not regularly reviewed to reflect people's progress in Community Mental Health Services / People's involvement in their care planning & their preferences, wishes and needs, including what recovery means to them, should be documented in records	- Embed caseload management ensuring care plans are reviewed with patient during care pathway	Completed Audit results 31/01/15	Exec Medical Director	Lead Nurse Mental Health	Results of Care Programme Approach audit to be reviewed and monitored	Care plans in place and well completed, including reference to patients' involvement Care plans are well completed for the needs of the individual patient	G
CA1.14 MD31 (MH)	People did not have timely review of their care planning approach (CPA) at least within the last 12 months in Community Mental Health Services	- Manual audit of CPA reviews - Date of last CPA review will be recorded on the patients electronic record - Care planning approach will be managed via monthly Caseload Management supervision with Care Co-ordinators	Completed	Exec Medical Director	Lead Nurse Mental Health	Monthly reports to monitor compliance	Care planning approach includes timely review, evidence through compliance reports Data will demonstrate achievement of the target. CPA audit will provide further assurance (95%)	G

Compliance Action 2: Service users, staff & others were not protected against the risks of acquiring a health care associated infection *Treatment of disease, disorder or injury (Trust Wide)*								
Ref	**Area of Concern**	**Actions Required**	**Time scale**	**Exec Lead**	**Lead**	**Evidence Required**	**Outcome / Success Criteria**	**Progress**
CA2.1 MD22 (CS / TW)	Appropriate cleanliness & hygiene standards in relation to equipment were inadequately maintained on community wards	- Damaged equipment should be removed from use and reported for repair or replacement. - Cleaning schedules for specific types of equipment must be in place (the schedule must highlight with whom the responsibility sits for cleaning which equipment - Cleanliness Team or ward staff. - A cleaning record book will be implemented for equipment that must be cleaned by the ward team. - Cleaning must be completed as per the schedule. - A system for routine checking of equipment cleanliness must be in place involving the Sister/nurse-in-charge and Matron	Completed	Exec Medical Director	Matron Community Wards	Review of equipment included in Infection Control audits Minimum monthly compliance monitoring by the Matron	A cleaning schedule for equipment is in place and there is evidence that the cleaning has been undertaken at the agreed frequency Infection Control audits concur with the ward reported cleanliness of equipment Equipment is clean	G
CA2.2 MD22 (TW)	Systems designed to assess the risk of & prevent, detect & control the spread of a health care associated infection were not effective	- Daily checks and cleaning record book in place on the ward - Daily bed space check undertaken on the ward - Risk identified reported to Ward Sister	Completed	Exec Medical Director	Matron Community Wards	Daily monitoring of cleaning record book and weekly monitoring bed space checks.		G
CA2.3 MD22 (TW)	Handover forms arriving with patients admitted to wards did not accurately record MRSA Status	- MRSA status included on patient transfer form - Ward Patient Status at a Glance (PSAG) board to be utilised to highlight MRSA status of patients	Completed	Deputy Director of Infection Prevention & Control	Matron Community Wards	Monthly monitoring of MRSA status, non compliance reported to Directorate Quality Meeting for assurance Audit comparing handover sheet with patients (MRSA) status	Patients' MRSA status evident on handover form and ward diary	G

CA2.4 MD22 (TW)	MRSA rescreening frequency was inadequate for the case-mix on the wards	- MRSA status on handover sheet - Our Trust MRSA policy is to be updated to reflect the latest DoH guidance (Sept 2014) - The frequency of screening on the ward will reflect this guidance	31/12/14	Deputy Director of Infection Prevention & Control	Matron Community Wards	Monthly monitoring of MRSA screening and compliance reported in Trust Quality report	MRSA screening undertaken in line with current national guidance Updated policy ratified & in place	A
CA2.5 MD22 (TW)	Yellow bin outside Stroke Ward was seen left open & unlocked	- Staff made aware yellow bins to be locked at all times - Faulty bins to be reported immediately - Keys to be kept in one location	Completed	Exec Medical Director	Ward Sister Community Wards	Daily checks of yellow bins by Ward Sister, with weekly checks by Matron	All yellow bins locked at all times	G
CA2.6 MD22 (TW)	A sharps box was seen left open	- Weekly sharps audit - Monthly infection control audit	Completed	Exec Medical Director	Matron Community Wards	Assurance provided through audit compliance to IPCC	No sharps boxes left open. 100% compliance on audit	G

Compliance Action 3: Patients could not be assured that they are protected against the risk associated with the unsafe obtaining, recording, handling, using, safe keeping & dispensing of medicines

Transport services, triage & medical advice provided remotely (Ambulance Service)

Ref	Area of Concern	Actions Required	Time scale	Exec Lead	Lead	Evidence Required	Outcome / Success Criteria	Progress
CA3.1 MD14 **WN** (AS)	Patients could not be assured that they are protected against the risk associated with the unsafe obtaining, recording, handling, using, safe keeping & dispensing of medicines	- Conditioning unit added to store area	Completed	Exec Director of Nursing & Workforce	Service Delivery Manager - Ambulance	Completion of plans for permanent solution Ambulance station visits to form part of quarterly board visits.	Plans implemented & medicines stored appropriately. In addition to this action – long term solution still being implemented with an Omnicell unit being fitted	G

Compliance Action 4: Suitable arrangements were not in place to protect service users & others from the use of unsafe equipment

Treatment of disease, disorder or injury (Community Health Services)

Ref	Area of Concern	Actions Required	Time scale	Exec Lead	Lead	Evidence Required	Outcome / Success Criteria	Progress
CA4.1 (CS)	Equipment had not been properly maintained. Maintenance checks were behind	- All blood pressure monitors are electronically PAT tested - Medical electronic equipment	Completed	Exec Medical Director	Ward Sister Community Wards	Monthly audits of equipment by Matron to provide assurance that it	Maintenance checks occur on time for all relevant equipment	G

		inventory updated - Medical Electronic department to be informed when equipment not fit for use				has been PAT tested. Any issues identified to be escalated to Directorate Quality Risk & Patient Safety Committee		
CA4.2 (CS)	The system in use by the equipment store could not provide full assurance that 7 items on rehabilitation & 12 on stroke had been disposed of	- Medical electronics disposal schedule in place - Prioritisation of medical electronic checks for equipment on Stroke and Rehab	31/10/14	Exec Medical Director	Ward Sister – Community Wards	Rolling equipment programme in place. Any issues identified to be escalated to Directorate Quality Risk & Patient Safety Committee	Equipment replaced in line with rolling programme Medical Electronics scheduled adhered to	A
CA4.3 MD23 (CS)	Equipment was not available in sufficient quantities to ensure the safety of service users and meet their assessed needs	- A full review of equipment required against equipment available will be undertaken - Non working equipment to be removed & replacements ordered	01/10/14	Exec Medical Director	Matron – Community Wards	Plans to address shortfalls implemented	Required quantities of equipment in place – no gaps	A

Compliance Action 5: Suitable arrangements for the obtaining & acting in accordance with the consent of service users in relation to the care & treatment provided for them

Treatment of disease, disorder or injury (Trust Wide)

Ref	Area of Concern	Actions Required	Time scale	Exec Lead	Lead	Evidence Required	Outcome / Success Criteria	Progress
CA5.1 MD28 (TW)	Suitable arrangements were not in place for obtaining the consent of service users to display their details on a computerised screen on display	- Review of Patient Status at a Glance Boards - Incorporate obtaining consent as part of admission process - Ensure the protocol for dealing with patients who decline to have information displayed is being followed - Information Leaflet for Patients implemented - The use of ward boards to display why this information is important	31/10/14	Exec Director of Nursing & Workforce	Head of Clinical Services	6 monthly audits undertaken with continual monitoring of compliance	Consent obtained for all patients where their information will be displayed Correct process followed for where consent not given	A

Compliance Action 6: Patients using the service were not protected against the risks of unsafe or inappropriate care *Treatment of disease, disorder or injury (Trust Wide)*								
Ref	**Area of Concern**	**Actions Required**	**Time scale**	**Exec Lead**	**Lead**	**Evidence Required**	**Outcome/ Success Criteria**	**Progress**
CA6.1 MD6 (TW)	Treatment, as decision relating to resuscitation were not being accurately recorded & reviewed to ensure they were kept current (DNACPR)	- Review of DNACPR Policy - Training on areas of non compliance with policy will be put in place - Develop escalation plan to improve communication and documentation - Monthly audit of compliance	31/10/14	Exec Medical Director	Lead Resuscitation Officer	Monthly audits with compliance report submitted to EMD and EDN&W for assurance. Grand round to ensure involvement of clinicians	Standardised DNA CPR (purple) form is always used for recording decision & is updated in line with national guidance	A
	Compliance Action 7: The health, safety & welfare of service users was not safeguarded because appropriate steps were not taken to ensure sufficient numbers of suitably qualified, skilled & experienced persons were employed *Treatment of disease, disorder or injury (Acute & Community Health Services)*							
Ref	**Area of Concern**	**Actions Required**	**Time scale**	**Exec Lead**	**Lead**	**Evidence Required**	**Outcome / Success Criteria**	**Progress**
CA7.1 MD13 MD18 (AcS)	Patients cannot be assured that at all times there are sufficient numbers of suitably qualified, skilled & experienced staff employed to carry on the regulated activity in A & E & on the Stroke Unit	- Daily safer staffing report template to be developed - Rota management policy to be revised - Review of Band 6 requirements - Recruitment underway for existing vacancies	31/03/16	Exec Director of Nursing & Workforce	Deputy Director of Nursing	Weekly reviews of staffing levels with monitoring of incidents via Datix system Recruitment into existing vacancies	Safer staffing requirements implemented in both areas and staff in post Band 6 review completed and agreed numbers in post Posts offered/staff in post Roster Policy in place	A
CA7.2 MD18 **WN** (CS)	There was insufficient medical & nursing staffing for the community inpatient wards, both numbers and skill mix	- Daily staffing planned versus actual displayed and reviewed - Plan to recruit to safer staffing levels - Review of medical workforce requirements with high level recommendations	31/03/16	Exec Medical Director	Matron – Community Wards	Daily monitoring of staffing levels by Matrons with weekly reviews by Executive Director of Nursing. Recruitment into existing vacancies	Safer staffing requirements implemented in both areas and staff in post	A

CA7.3 **WN** (CS)	Patients could not access carotid Doppler on Sundays in the TIA clinic	- Develop a 7 day Sonographer service	31/12/14	Exec Medical Director	Manager of Diagnostic Imaging	Monitor samples of patient records to ensure prompt access to Doppler when required	Patients accessing Carotid Doppler tests 7 days a week	
CA7.4 (CS)	The out-of-hours, on-call district nursing service was not always staffed	- On call rota overseen by Matrons - Senior Nurse on call supporting Out of Hours on call Nurse - Develop & utilise Standard Operating Procedure for the Hub	Completed	Exec Medical Director	Community Service Lead	Weekly monitoring of out of hours service. SOP developed & in place	No gaps in service provision / when cover provided revert to SOP for the Hub	B
	Compliance Action 8: The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver care & treatment to service users and to an appropriate standard by receiving appropriate training, professional development & supervision *Treatment of disease, disorder or injury (Acute, Community Health & Mental Health Services)*							
Ref	**Area of Concern**	**Actions Required**	**Time scale**	**Exec Lead**	**Lead**	**Evidence Required**	**Outcome / Success Criteria**	**Progress**
CA8.1 MD4 MD5 SD35 (AcS)	Staff were not fully informed of their responsibilities under the Mental Capacity Act (MCA)2005, or in the recognition of people at the start of the end of life journey, or how to support people through the use of tools designed to support end of life care – ensure staff trained in Deprivation of Liberty Safeguards (DoLS) & MCA	- Ensure MCA training delivered to relevant staff - Introduce Amber Care Bundle to MAU - Hospital Palliative Care Team to review admissions to MAU for support - Report monthly completion of MCA/DoLS assessment (added to performance report)	31/12/14	Exec Director of Nursing & Workforce	Head of Clinical Services – Acute & Ambulance	Training compliance records	All Senior ward nurses (band 6 & above) trained by end December 2014	A
CA8.2 MD18 MD21 **WN** (CS)	Junior doctors did not have sufficient support / professional development as there were not suitable levels of medical cover, & did not have sufficient supervision to treat patients who were medical outliers	- Substantive Trust Grade Registrar starting 17/11/14 - Medical Recruitment specialist to assist recruitment plans - Ensure Junior Doctor teaching time protected - Request support from Wessex Deanery to seek feedback on the experience of Junior Doctor placements	31/10/14	Mark Pugh (EMD)	Clinical Director Community & Mental Health	Training compliance records	New substantive Registrar in post	A
CA8.3 MD20 MD32 (CS)	Ward and district nursing staff received no formal supervision (include bank staff)	- Group supervision established - Personal clinical supervision folders issued	Completed	Executive Medical Director	Interim General Manager – Community /	Monthly monitoring of supervision dates	All relevant staff receive supervision	G

		- All supervision dates recorded and centrally held - Guidance developed for Bank Staff to receive clinical supervision			Human Resources (Bank)		Guidance circulated to all Bank Staff	
CA8.4 CA8.5 MD21 (CS)	Band 7 nurses were sometimes unable to attend development days because of staffing levels	- Bands 7 to be released to attend development days - Current band 7 vacancies recruited to - Training commitments to be entered into rostering system	31/10/14	Executive Medical Director	Modern Matron Community Wards	Training compliance records Attendance records	Increased attendance at development days for band 7 nurses	A
CA8.5 CA8.4 MD17 MD21 (CS)	District nurses had not attended training, or update training, on Doppler assessment / need to ensure regular & timely reviews of patients with leg ulcers	- Doppler training undertaken with refresher course available - Link nurses up-skilled to deliver training	31/10/14	Exec Medical Director	Interim General Manager - Community	Training compliance records	Increased attendance at training. Timely reviews undertaken for patients with leg ulcer	A
CA8.6 MD20 (CS)	Some school nurses were not enabled to obtain training & qualifications relevant to their role	- Funding obtained for 2 places for specialist practice degree - Year on year plan in place to ensure training available	31/10/14	Exec Medical Director	Service Lead for Health Visiting & School Nursing	Training Compliance Records	Training provided to include role specific training Uptake for the 2 specialist practice degrees, where funding is available	A
CA8.7 MD20 **WN** (MH)	Staff had high caseloads & did not have the appropriate levels of supervision to manage these	- Caseload management training provided to all staff - Review of Electronic Patient Record caseload management	Completed	Exec Medical Director	Lead Nurse for Mental Health	Monthly monitoring of caseload management	Staff have regular supervision; which reflects caseload management	G
CA8.8 (MH)	Staff had not attended mandatory training – Rehab & Recovery Team	- Mandatory training being prioritised - Risk assessments completed to allow staff to undertake training	Completed	Exec Medical Director	Lead Nurse Mental Health & Learning Disabilities	Training compliance records – report to Directorate Quality Risk and Patient Safety Meeting	Staff attend mandatory training in line with Trust's mandatory Training Policy & individual Mandatory Training Needs Analysis	B

	Enforcement Actions: Patients could not be assured that they are protected against the risk of inappropriate or unsafe care & treatment by means of effective operation of systems designed to enable the person to regularly assess & monitor the quality of services & identify & manage risks to health, welfare & safety of service users & others *Treatment of disease, disorder or injury (Acute, Community Health & Mental Health Services)*						
Ref	**Area of Concern**	**Actions Required**	**Time scale**	**Exec Lead**	**Lead**	**Evidence Required**	**Outcome / Success Criteria**	**Progress**
EA1.1 SD11 **WN** (AcS)	Changes required following the investigation of incidents were not always implemented in a timely manner	- Investigation outcomes to be driven locally and at Directorate Quality Meetings - Establish structured agenda for sharing information at team meetings - Await outcome of report into current governance structures - Provide generic reporting structure and lessons learned evidence	31/10/14	Exec Director of Nursing & Workforce	Head of Clinical Services	Review of regular reports from logging system include lessons learnt / evidence of cascade to front line staff	Datix entry completed with feedback information for all incidents Staff reporting incidents can demonstrate they have received feedback	A
EA1.2 MD10 (AcS)	There were not robust systems in place for the review of compliance with national guidance (gap analysis & improvement plans)	Review and update system in place to disseminate & manage process for implementation of national guidance	31/10/14	Exec Director of Nursing & Workforce	Lead for Patient Safety, Experience & Effectiveness	Quarterly review of compliance against NICE guidance	Gap analysis completed Procedure updated and communicated	A
EA1.3 **WN** (AcS)	The action plan to address the mortality outlier for unspecified renal failure was not implemented. Staff were not using NICE guidance for treating kidney injury & the sepsis care bundle had not been rolled out across the trust	- Roll out Sepsis suite of policy and procedures - Implement Acute Kidney Injury (AKI) NICE guidance - Include AKI risk assessment in clerking information	01/11/14	Exec Director of Nursing & Workforce	Head of Clinical Services – Acute & Ambulance	Audit of compliance of AKI cases. Audit of suite of sepsis policy Central database evidences completion of corporate process for roll out of national guidance Draft Sepsis policy & AKI risk assessment form	Sepsis bundle rolled out & embedded AKI NICE guidance implement Compliance audit	A
EA1.4 MD8 SD7 **WN** (AcS)	Patients had a number of bed moves & did not have a named consultant for the duration of their stay. Changes to a patient's consultant were being made for nonclinical	- Review of bed management systems - All patients to have named Consultant from point of admission for the duration of	31/10/14	Exec Director of Nursing & Workforce	Clinical Director – Community Health	Reviewing data from Performance Information Departments (PID), cross referencing with patients notes. Demonstrating	All patients have named consultant for duration of stay Written SOP in place	A

	reasons depending on the ward they were located on rather than clinical condition (need clear referral & acceptance criteria for change of consultant for clinical need	their stay - We will monitor number of bed moves for non clinical reasons - Develop clear written Standard Operating procedure (SOP) for admission & discharge from all ward areas				patient move only for clinical reasons		
		Review and take action to minimise the number of patient bed moves for non clinical reasons out of hours	31/10/14	Exec Director of Nursing & Workforce	Senior Clinical Capacity Manager	Monitor through Senior manager on call report – sent to Execs	Bed moves for clinical reasons can be evidenced	A
EA1.5 **WN** (AcS)	Patients receiving end of life care that had several bed moves for non-clinical reasons and were being cared for on wards where the understanding of their condition was limited	- No patient identified as receiving end of life care is to be selected for transfer - Ensure staff are aware of which patients are receiving end of life care	31/10/14	Exec Director of Nursing & Workforce	Senior Clinical Capacity Manager	Twice weekly meetings to review patients. Review of all non clinical transfers	No end of Life patients will be moved for non clinical reasons whilst in hospital	A
EA1.6 (AcS)	See CA1.3							
EA1.7 **WN** (CS)	Medical outliers - there were no systems in place to identify, assess & manage risks relating to their health, welfare & safety & no systems to regularly assess & monitor the quality of service provided to them	- Medical outliers to be assessed against agreed criteria, by transferring senior doctor before handed over to transferring ward. - Patient must be medically stable to transfer - Once transferred, the patient is the responsibility of the receiving consultant and team	31/10/14	Exec Medical Director	Clinical Director Community & Mental Health	Non Rehab or Stroke patients to be regularly assessed by accepting Consultant Team Audit of medical outliers to provide assurance patients are being regularly reviewed	Appropriate risk assessment completed in all relevant cases	A
EA1.8 **WN** (CS)	There were not established mechanisms to ensure that decisions in relation to the provision of care & treatment for service users who were medical outliers on community wards were taken at the appropriate level & by the appropriate person	- Medical outliers to be assessed against agreed criteria, by transferring senior doctor before handed over to transferring ward.	30/11/14	Exec Medical Director	Clinical Director for Community & Mental Health	Review of medical notes to ensure transfer documentation complete	Patients meet agreed criteria	A
EA1.9 MD18	There was not effective implementation & monitoring of	- Identification of correct number of nursing staff through MAPS	31/03/15	Exec Medical Director	Matron – Community	Actions following daily monitoring of staffing, with	Appropriate daily reports in place,	A

WN (CS)	medical and nursing staffing levels and skills mix on the stroke rehabilitation & general rehabilitation wards, TIA clinic	- Daily staffing planned v actual displayed and reviewed - Early identification of patients that require 1:1 supervision - Review of Band 6 requirements on Stroke Unit			Wards	weekly reviews of staffing levels by Exec Director of Nursing Team	feeding into wider staff reporting	
EA1.10 WN (CS)	District Nurse Out of Hours Service - no effective or appropriate implementation & monitoring of the service to ensure that people did not receive inappropriate or unsafe care	- Senior Nurse on Call to support out of hours on call nurse - Available out of hours 7 days a week - SOP in place to support Hub in case of short notice sickness	Completed	Exec Medical Director	Community Modern Matrons	Weekly review of out of hours service, test calls to the Senior Nurse out of hours to provide assurance Links with CA7.4	No gaps in service provision / when cover provided revert to SOP for the Hub	B
EA1.11 MD15 WN (CS)	There had not been adequate response to concerns raised by staff. Views of staff were not regularly sought to come to an informed view in relation to the standard of care and treatment provided to service users (incl. locks & hand rails on Shackleton Ward)	- Implementation of new response system following incident raised on Datix system	31/10/14	Exec Medical Director	Head of Clinical Services Community & Mental Health	Quarterly seek views from staff, review results of staff Friends and Family Test Links with MD15	Datix entry completed with feedback information for all incidents Staff reporting incidents can demonstrate they have received feedback Reported issued resolved	A
EA1.12 MD15 WN (CS)	Risks as a result of implementation of the IT project were not monitored at all times	- Review escalation process of incidents raised on Datix System	31/10/14	Exec Medical Director	Associate Director - Community	Monthly report on Datix forms raised with quarterly audit on Datix forms raised and contact with manager	Datix entry completed with feedback information for all incidents Staff reporting incidents can demonstrate they have received feedback Reported issued resolved	A
EA1.13 WN	No action was taken in response to external review of caseload	- Undertake rounds of Caseload management with all staff	Completed	Exec Medical Director	Lead Nurse Mental Health &	Records will show that supervision has occurred.	Records will show supervision has taken	G

(MH)	management in August 2011; which identified community teams did not focus on people presenting with the highest clinical risk who had severe & enduring mental health issues. Staff did not have regular supervision & this meant trust's own guidelines were not being met in the Rehab & Recovery Team.	- Ensure regular management supervision is in place for relevant staff			Learning Disabilities	Monthly reports being received by Lead Nurse for 1st 3 months then quarterly thereafter.	place Audit results show compliance Staff trained in caseload management	
EA1.14 SD24 **WN** (MH)	The risk register in the Community Mental Health Team had not been reviewed since July 2012 (need regular reviews of risks & issues raised at Board)	Ensure the Risk Register is up to date with the correct review date	Completed	Exec Medical Director	Lead Nurse Mental Health & Learning Disabilities	Review of Directorate Quality Meeting minutes	Risk register has monthly reviews	G
	Must Do Actions: Other actions identified as MUST do's in the CQC Quality report but not translated into compliance actions							
Ref	**Area of Concern**	**Actions Required**	**Time scale**	**Exec Lead**	**Lead**	**Evidence Required**	**Outcome / Success Criteria**	**Progress**
MD1 (TW)	Improve clinical leadership of services improve & there must be operational support & coordination to cope with service demands & to manage effective integration	- Engagement with Aston OD/Kings Fund for development of collective leadership strategy and involvement in implementation of Michael West research - Development of Leadership competency profiles in collaboration with the MLAFL workforce development team and 'Talent Works' - Development & Training to provide Clinical Leadership Sessions	31/10/14	Exec Medical Director	Associate Director of Medical Education	Training attendance registers Meeting minutes	Increased clinical participation in integrated activity Increased attendance at service & directorate level meetings	A
MD2 (TW)	Staff engagement should be effective, so that service changes & developments are owned & effectively implemented, to reduce	- Continue roll out of Listening into Action - Quality Champions - induction for new champions to increase	31/10/14	Exec Director of Transformation &	Deputy Director of Organisational Development	Staff FFT results LiA feedback	Staff FFT results shows improvement	A

	risks to patients & people that use services	network - Implementation of the Communications and Engagement Strategy - Undertake development events for 'Managing the effects of change' and 'successfully implementing change - Roll out a series of Innovation café sessions		Integration				
MD3 (TW)	Complaints need to be responded to within agreed timescales	- Embed new complaints process - Weekly review meetings in place - Support the Trust with a quarterly review of complaints	31/03/15	Exec Director of Nursing & Workforce	Patient Experience Lead Healthwatch	Increase in % complaints managed in time – DATIX report	Month on month increase – target >95%	A
MD4-10	MD4&5 – see CA8.1 MD6 – see CA6.1 MD7 – see CA1.1 / CA1.7 MD8 – see EA1.4 MD9 – see CA1.2 MD10 – see EA1.2							
MD11 (AcS)	Ensure there is a lead nurse qualified in the care of children & sufficient registered (Children) nurses are employed to provide 1 per shift in A&E	- Ward Manager to review template on MAPS & create rule for skill on each shift (liaising with roster team) - Create rota to allow for department training needs & maintenance of general paediatric nursing competencies - Recruitment of Paediatric Nurse	30/11/14	Exec Director of Nursing & Workforce	Matron – MAAU / A&E	Rosters identify this nurse is in place for each shift MAPS template to show skill required on each shift	Recruitment to post Each shift filled with a nurse qualified in the care of children	A
MD12-14	MD12 – see EA1.6 MD13 – see CA7.1 MD14 – see CA3.1							
MD15	Staff did not report all risks & near misses & the trust was not responding to risks & near misses, particularly regarding levels of medical & nursing staff	- Expand reporting risk section on Risk Register Briefing Note for managers and staff & re-issue via various communication networks & via Quality & Risk Committees - Add extra guidance to Risk Assessment training programme	31/10/14	Exec Director of Nursing & Workforce	Head of Corporate Governance & Risk Management	- Revised risk register briefing note - E-bulletin notification to staff - Minutes of Directorate Quality and Risk Committees	Increase in number of risks identified & reported onto directorate and corporate risk registers, outside of the annual risk	A

		- Promote importance of risk identification & management - Further promote the purchase of the Datixweb risk module to ensure risk management systems are ' live ' and immediate , including the processes for reporting and managing both local and corporate risks, subject to approval of funding	30/11/14			- Risk Management intranet pages - Completed and submitted capital bid form	assessment process	
MD16 **WN** (CS)	Effective & reliable measures & support is required to protect safety of staff working alone & out of hours in the community	- Review & update Lone Worker Policy - Develop out of hours Standard operating procedure (SOP)	Completed	Exec Medical Director	Interim General Manager – Community / Assistant Director Health, Safety & Security	Updated Lone worker policy; monitoring of Sky Guard devices (activation) where In use SOP in place	Less incidents reported – lone working SOP in use / all relevant staff aware Updated policy in place	A
MD17-18	MD17 – see CA8.5 MD18 – see CA 1.9, 7.1, 7.2, 8.2,							
MD19 **WN** (CS)	There are clear admission policies to community inpatient wards, & adherence to these must be monitored. Patients placed on stroke rehabilitation & general rehabilitation wards must meet the criteria for admission	- Ensure robust admission guidance in place - Undertake daily monitoring of medical outliers - Liaise with Bed Management Team to minimise numbers of non stroke/rehab patients to these areas	Completed	Exec Medical Director	Matron – Community Wards	Available protocol Criteria sent to all stakeholders, including Bed Management Data collected & inputted into ward quality & standards diary & on daily bed management ward state Daily Rehab lists kept within shared drive for reference	Admission criteria in use / all relevant staff aware All patients identified as being suitable are prioritised for admission	G
MD20-23	MD20 – see CA8.3, CA8.6-8.7 MD21 – see CA8.2, CA8.4-8.5 MD22 – see CA2.1-2.6 MD23 – see CA4.3							
MD24 (CS)	Trip hazards from electric leads in the ward corridors are eliminated	All trip hazards identified, assessed and eradicated	Completed	Exec Medical Director	Matron – Community Wards	Daily walk round to ensure safety compliance	No trip hazards identified on walk rounds	G

MD25-28	MD25 – see CA1.6 MD26 – see CA1.11 MD27 – see CA1.11 MD28 – see CA5.1							
MD29 SD37 (CS)	Wards display a contact point for access to information & complaints regarding the use of CCTV on wards	- Display camera picture on ward entrance - Develop Patient Information Leaflet around use of CCTV	31/10/14	Exec Medical Director	Matron – Community Wards	Sign on display	Sign in place on all ward where CCTV is present	A
MD30 (CS)	The trust must update the DNA CPR policy & ensure wards audit their adherence to this policy	Policy to be reviewed & updated	31/10/14	Exec Medical Director	Senior Resuscitation Officer	Publication of policy	Ratified Policy in place Ward Audit compliance reports	A
		Develop Audit tool to audit adherence to DNA CPR policy	31/11/14	Exec Medical Director	Senior Resuscitation Officer	Audit results	Audit tool developed & in use / audit results	A
MD31-32	MD31 – see CA 1.13-1.14 MD32 – see CA 8.3							
	Should Do Actions: Other actions identified as SHOULD do's in the CQC Quality report but not translated into compliance actions							
Ref	**Area of Concern**	**Actions Required**	**Time scale**	**Exec Lead (Accountable)**	**Lead (Responsible)**	**Evidence Required**	**Outcome / Success Criteria**	**Progress**
	Theme: Clinical Leadership, Culture & Staff Engagement							
SD3 (Ac/AS)	Consultants have protected time for outpatient clinics, so they are not cancelled at short notice when they are called to emergencies	- To investigated any incident where a cancellation occurs - Directorates to consider mitigation plans should such an incident occur at short notice - Job plans to be reviewed to structure clinics and on call requirements separately, where and if possible.	Completed	Exec Director of Nursing & Workforce	General Manager (AP)	Reduction in cancellations of clinics	Mitigation plans in place No outpatient clinics cancelled due to consultants being called to emergencies	A
SD26 (MH)	Staff engagement with mental health teams should be improved, as many staff in mental health teams felt "disconnected" from senior managers and the leadership of the	Implement Listening into Action, ensuring Mental Heath areas are well involved	31/01/15	Chief Executive	Listening into Action (LiA) Lead)	Staff survey results LiA attendance records	Mental Health staff attending LiA events Increase in performance within	A

	trust						surveys	
SD27 (MH / AS)	Mental health & Ambulance services should be appropriately represented at the Trust Board to reflect the workings for an integrated trust	- Discuss with Trust Board representatives how this can be implemented - Plan to be developed	31/10/14	Chief Executive	Company Secretary / Board Support Officer	Greater Board focus on mental health , ambulance and community services	Appropriate representation at Board meetings	A
SD40 (CS)	Review staff engagement & staff access to senior leaders within the organisation, to ensure equity of value and involvement	Continue roll out of Listening into Action	31/10/14	Karen Baker (CEO)	Leisa Gardiner (Listening into Action (LiA) Lead)	Listening into Action (LiA) taking place within teams Staff survey results	Attendance of Community Health staff at LiA events Improvement in performance in staff survey results	A
	Theme: Governance							
SD15 Ac/AS)	Patient information held by the ambulance service is securely stored at all times	- Removal of documents, stored incorrectly, that are out of date & appropriately destroy - Remind staff of Trust & / or Service agreed policies and procedures - Ambulance Service patient records are electronic – any paper records will be secured to the patients notes at the earliest opportunity	Complete	Exec Director of Nursing & Workforce	Head of Ambulance	Radom checks by officer to ensure compliance	All papers notes are held securely No incidents relating to information governance issues	G
SD16 (Ac/AS)	There is a clear and current system in place to 'red flag' addresses where there are concerns about safety, so ambulance crews can use make informed choices & manage risk when attending these locations	- Review of current 'red flag' system currently in place – ensure accuracy - Group existing flags together to match type and risk - Revise current listing and develop a robust process for adding / deleting flags - Produce "Stand Procedure" for the management of all flagging issues - Implement a monitoring process	30/11/14	Exec Director of Nursing & Workforce	Health & Emergency Communications Centre Manager	All flags now group together to match type and risk	Existing flags grouped Standard procedure in place Monitoring established and being undertaken Red flag system in place	A

		to ensure data held is current and reviewed regularly						
SD29 (CS)	Audit readmission rates to the community wards, to identify whether provision is effective	- Performance Information Dept. to identify relevant patients in order for audit to take place - Ward Sisters to review information from PIDS - Undertake audit - Provide report with results	31/10/14	Exec Medical Director	Matron – Community Wards	Audit evidence / results	Audit report / results show effectiveness of provision	A
SD30 (CS)	Audit time of day or night patients are admitted to the community wards, to identify inappropriate transfer times	- Liaise with the performance information department to provide relevant data	31/10/14	Exec Medical Director	Matron – Community Wards	Audit evidence / results	Audit report / results show appropriateness of transfer times	A
SD31 (CS)	Implement audits to assess the care of pressure ulcers on the community inpatient wards, before & after an ulcer has developed	In liaison with the Tissue Viability Nurse, develop and implement audit tool to be used throughout the trust.	Completed	Exec Medical Director	Matron – Community Wards	Audit results, Safety Thermometer results, results and action plans from Root cause analysis	Results provide an adequate overview of pressure area care	G
SD38 (CS)	Review the selective completion of the 'This is me' folder, to identify whether this adequately meets patients' needs, including those with dementia	In partnership with Dementia Team develop audit tool and audit compliance for monthly reviews	31/10/14	Exec Medical Director	Matron – Community Wards	Audit results	Audit results identify if patients' needs are being met	A
SD41 (CS)	Review effectiveness of IT systems in community services, to ensure that staff have safe & efficient access to & use of computerised records	- Improving management and governance process around IT roll out to community services - Provide centralised support systems	31/03/15	Exec Medical Director	Deputy Director for IM&T	Evidence of support provided / support logs	List of mobile devices deployed will exist Services being supported centrally by the Information Systems Team for: - Support Desk - Training - Data validation - Service and back office maintenance requests	A
SD43 (CS)	Review clinical audit in the community children's & families	- Clinical Audit programme to be populated to include: Hand	31/12/14	Exec Medical Director	Clinical Lead for Health Visiting &	Audit evidence	Audits evidence the quality of service	A

	service, to provide assurance of the quality of service provision	Hygiene Audit, Recording Keeping, Quality, National Standards Audit - Audits to run from September 14 - March 15 - Team Leads / Band 7's to access recently advertised Audit Training 15 Sept)			School Nursing	Training records	provision Training undertaken by Band 7 / team Leaders Clinical Audit Programme	
SD1 (Ac/AS)	Use of bed rails is risk assessed & patients' consent obtained. Where the patient is unable to consent, there should be a clear assessment of capacity & clear reason for use	- Risk assessments routinely completed on every patient - Use of bed rails consistently risk assessed and patient consent obtained for their use	31/10/14	Exec Director of Nursing & Workforce	Tracy Cloke (Matron)	Monthly audit of nursing risk documentation. Reported back through the directorate quality meeting for assurance	All patients that require bed rails will have a risk assessment	A
SD2 (Ac/AS)	The environment of the eye clinic is reviewed to ensure it is fit for purpose & safely meets the need of the patients visiting the department	- Department placed on Risk Register - Review of Estates Strategy for opportunity of re-siting Department - Review patient journey to improve patient safety where required	Complete	Exec Director of Nursing & Workforce	General Manager (AP)	Patient pathway reconfigured, to ensure patient journey safe as possible	Environment fit for purpose & safety needs of patients met	G
SD4 (Ac/AS)	Nursing staff are not disturbed while undertaking medication rounds	- Implement safer staffing levels - Use red tabards when doing drug rounds - Audit of compliance to be undertaken - Put in place a process whereby drug rounds are not disturbed on all inpatient areas	31/03/16	Exec Director of Nursing & Workforce	Matron (CC)	Audit results	No nurses disturbed during medication round Reduction in medication errors	A
SD6 **WN** (Ac/AS)	All medication & intravenous fluids are stored in line with current guidance in all areas	- Move IV fluids to same secure room as all other medicines - All medication will be stored in line with the current guidance	Completed	Exec Director of Nursing & Workforce	Service Delivery Manager	Temperature check results (recorded from twice daily checks) Pharmacy audit	Medication & IV fluids stored appropriately at all times/	B
SD8 SD10	In all outpatient areas where	- Reconfigure outpatient areas to	31/10/14	Exec	Matron (SB) /	Dedicated area available in	Children will be seen in	A

(Ac/AS)	children are seen, there is a dedicated children's waiting area / Consider the provision of a separate children's area in A&E in line with national buildings guidance	provide dedicated children's area - Review use of the already placed Children's Outpatients area to ascertain if clinics could be relocated		Director of Nursing & Workforce	Matron – MAAU & A&E	all outpatient areas where children are seen. Separate area available in A&E	designated area in outpatients and the Emergency Department	
SD9 (Ac/AS)	All resuscitation equipment is checked on a daily basis, unless an area is closed	- Ward Sister to make daily checks of resuscitation equipment is mandatory - All staff informed of requirements - Checks to be dated and documented in the log book by the nurse completing the checks	Completed	Exec Director of Nursing & Workforce	Ward Sister	Resus equipment log book	Daily checks evidence in log & on night check forms	A
SD12 (Ac/AS)	The provision of controlled drugs in the resuscitation area in A&E is reviewed	Matron to undertake review of how controlled drugs are stored in the Reus room in the Emergency Department	31/10/14	Exec Director of Nursing & Workforce	Ward Sister	Pharmacy audits	Controlled drugs will be stored in line with local guidance & policy	A
SD19 (MH)	Door locks on Shackleton Ward & PICU need to be fixed, to ensure people feel safe & their privacy & dignity is protected	Small works request submitted to be submitted to estates for completion of required works	Completed	Exec Medical Director	Ward Sister Shackleton	Estates have completed all works	Locks replaced	B
SD28 (CS)	Review how they regularly seek the views of community service users & persons acting on their behalf, to inform them in relation to the standard of care & treatment provided, as this is not currently done across all the services	Full review of all community service user tools used across Community services Ensure Rehabilitation and Stroke Ward areas consistently use current tools to seek views	Completed	Exec Medical Director	Matron – Community Wards	Documented information in the quality and standards diary on both wards and Matrons Quality assurance diary.		G
SD32 (CS)	Ensure spare mattresses are not kept on the ward & are always returned to the equipment store for full decontamination	Undertake daily checks & weekly audits by Sisters and Matron.	Completed	Exec Medical Director	Ward Sisters	Finding from checks / audit results	Spare mattresses not on wards	G
SD46 (CS)	Review the condition of buildings identified on various risk registers, to ensure clear programmes are developed, with timeframes, demonstrating when improvements or changes will be made	- Review of building issues identified on the risk registers - Develop programme (with timeframes) for completion of required works - Ensure required works are	31/03/15	Exec Medical Director	Associate Director - Community	Programme of works	Work fully completed	A

		completed within timescales						
SD47 (CS)	Monitor safe handover of hospital discharges to community staff, ensure right care & treatment is implemented when patients go home		31/03/15	Exec Director of Nursing & Workforce / Exec Medical Director	Head of Clinical Services / Interim General Manager			A
SD48 (CS)	Continue the work started by implementing the 'Productive Community Series' and ensure that a wider range of services are being benefited by it	Roll out programme to the wider range of community services	31/03/15	Exec Medical Director	Productive Care Lead	Programme roll out information	Wider range of services have benefitted from roll out of series	A
	Theme: End of Life Care							
	All relevant actions are within the compliance / enforcement actions							
	Theme: Patient Caseload / Flow							
SD5 (Ac/AS)	Patients have protected meal times	· Implement protected meal teams in Wards · Discuss at Ward Sisters meeting to ensure action is clearly understood · Monitoring to be undertaken by Ward Sisters · Ward sister will keep documented evidence that patients can be easily identified as being high risk	31/10/14	Exec Director of Nursing & Workforce	Matron (TC)	Evidence documented by Ward Sisters	Patients have protected mealtimes	A
SD13 **WN** (As/AS)	The process for streaming patients in the A&E department is reviewed to ensure the decisions are being made by staff who have knowledge & skill required to do so.	- Discontinue current process - Provision of Registered Nurse to stream patients reporting to the department	31/10/14	Exec Director of Nursing & Workforce	Matron – MAAU/A&E	Evidenced by internal assurance visits	All patients streamed by appropriately skilled person	A
SD14 (Ac/AS)	Continue to develop 7 day services, particularly for patients requiring emergency care	- Identify areas that need to develop 7 days services at speciality level (in line with local patient need & national	31/03/15	Executive Director of Nursing & Workforce	Lead Physician / General Manager	Increase in provision of services 7 days a week	7 days services developed where need identified	A

		requirements) - Develop services as required						
SD17 (Ac/AS)	Review the specialist medical care available for patients who have had a stroke	- Undertake a review of the availability of specialist care for stroke -	31/03/14	Exec Medical Director	General Manager – Hospital / Ambulance & Interim General Manager - Community	Designated specialist medical posts in place to provide this cover	All patients that had had a stroke will have access to specialist stroke medical care	A
SD20 (MH)	Access to Section 17 leave needs to be improved, when this is deemed appropriate	Implement the Safe Staffing Project to improve provision of staff to facilitate leave	31/01/15	Executive Director of Nursing & Workforce	Lead Nurse Mental Health & Learning Disabilities	Section 17 audit planned for Q3 2014/15	Ward fully established in line with safer staffing template Audit evidences improvement in access	A
SD21 (MH)	The reasons for discharge delays for older adults with complex needs should be identified & procedures improved	Undertaken required work, linking with Clinical Commissioning Group and LA commissioners to ensure that discharge delays on Shackleton are reduced and escalation process in place.	31/10/14	Exec Medical Director	Matron – Sevenacres CCG Local Authority	Formal process agreed with the Clinical Commission Group (CCG) / Local Authority (LA)	Revised procedures in place meeting patient needs	A
SD23 (MH)	There should be a clear strategy for the development of mental health services, in particular the future of older adults services should be determined	Develop local level strategies to support organisational wide strategy to ensure Mental Health are reflected as part of an integrated Trust	31/10/14	Exec Medical Director	Lead Nurse Mental Health & Learning Disabilities	An agreed strategy in place developed with all partners	Relevant Strategy in place	A
SD25 (MH)	The community mental health team should have an up-to-date operational policy, or information available to people on how use the service, which describes its function & what people should expect from the service	Update current policy	31/10/14	Exec Medical Director	Clinical Nurse Manager	Policy update / Information available to those who require it	Updated policy in place	A
SD39 (CS)	Monitor that guidance on mixed sex accommodation is appropriately followed on community inpatient wards	- Agree monitoring requirements - Undertake monitoring as agreed	31/10/14	Exec Medical Director	Matron – Community Wards	Monitoring results	Zero mixed sex breaches Guidance adhered to	A

SD36 **WN** (CS)	Ensure any wards or additional beds that are reopened are adequately staffed without reducing cover on the ward or other wards	Develop robust protocol and pathway	Completed	Exec Medical Director	Matron – Community Wards	Criteria	Criteria adhered to Beds appropriately staff if opened	B
SD44 (CS)	Review the components of the Healthy Child Programme & share the plans for working towards implementation of the full programme with community staff	- All levels of the Healthy Child programme (Universal / Universal Plus & Partnership Plus) to be built into the Paris record - Report the number of children receiving an enhanced level of service from health visiting & school nursing - Submit monthly performance to NHS England - Pace of Change document submitted to NHS England - Develop Transformation plan	15/03/15	Exec Medical Director	Clinical Lead for Health Visiting & School Nursing CCG	Plan in place and agreed with Commissioners for full delivery of HCP by March 2015	Implementation of full programme	A
SD45 (CS)	Review pathways of care in children and family services, to ensure that all staff are aware of them, their use & their role in each pathway	- Finalise care pathway - Ensure pathway group meetings are facilitated - Monitor progress & outstanding pathways	30/12/14	Exec Medical Director	Clinical Lead for Health Visiting & School Nursing	Pathway documentation	Pathways developed Staff have full understanding of role in each pathway	A
SD49 (CS)	Review processes & pathways for managing postnatal depression, ensure practice is the same for all relevant community staff & appropriate emotional support is provided for mothers & families	· Currently a commissioning CQUIN with NHS England for 2014-15 with monthly monitoring in place from Q3 · Devise a revised Care Pathway in line with the Healthy Child Programme / NICE guidance – to include pathway for identification, response and intervention for low maternal mood. · Pathway to be included in local Induction · Completed pathway to be hosted on a shared drive for easy access	31/03/15	Exec Medical Director	Health Visitor Team Leader NHS England	The Commissioning for Quality and Innovation (CQUINs) scheme monitored by Directorate Board and Clinical Quality Review Meeting (CQRM)		A

	Theme: Recruitment & Retention							
SD18 (MH)	Continue to ensure turnover of locum staff is minimised in specific areas, to ensure people receive consistent care	- Scope the recruitment issues, produce recruitment plan - Implement recruitment plan - Fill current vacancies	31/03/15	Exec Medical Director	Associate Director of Workforce	Reduction in number of locums used / Review of Datix incident reported / escalation procedure in place	Reduction in locum spend Successful recruitment to medical vacancies	A
SD34 (CS)	Review levels of therapist staffing, particularly occupational therapists, on community wards & whether there is sufficient cover for annual leave	- Undertake full review of Therapy staff on inpatient wards - Ensure appropriate interim measures are in place whilst addressing recruitment issues (which may encounter national shortages) - Recruit to current vacancies	31/10/14	Exec Medical Director	General Manager (PJ)	Review completed and plan in place Interim staff in place Recruitment to posts underway	Staff in post Effective annual leave allocation process in place	A
SD42 (CS)	Review staffing levels, skill mix & caseloads of the community teams, to ensure delivery of safe & effective care & to release staff for training & development	- Implement the agreed safer staffing nursing numbers - Undertake review of staffing levels, skill mix & caseloads - Develop a tool to ascertain acuity, demand &V capacity of services - Recruit to current vacancies	31/03/16	Exec Director of Nursing & Workforce	Deputy Director of Nursing	Staffing implemented as outlined in safer staffing proposal Training records	Staff in post / safer staffing numbers implemented Appropriate skill mix in place Staff released for training	A
SD1 (AcS/AS)	See CA1.1							
SD7 (AcS)	See EA1.4							
SD11 (AcS/AS)	See EA1.1							
SD22 (MH)	See CA1.13							
SD24 (MH)	See EA1.14							
SD33 (CS)	See CA1.7							
SD35 (CS)	See CA8.1							
SD37 (CS)	See MD29							
All actions that are shown as completed will be subject to testing and ongoing monitoring to ensure they are sustainable								

Enc G

Isle of Wight NHS Trust Board Performance Report 2014/15

September 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	22/10/2014	
Finance, Investment & Workforce Committee	22/10/2014	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 23rd 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	4	Sep-14	10	↘	
	Reduction across all grades of pressure ulcers (25% on 2013/14 Acute baseline, 50% Community)	TW	203	51	Sep-14	196	↘	
	VTE (Assessment for risk of)	AC	>95%	100%	Sep-14	99.8%	↗	
	MRSA (confirmed MRSA bacteraemia)	AC	0	0	Sep-14	0	↔	
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)	AC	6	1	Sep-14	6	↘	
	Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	TW	48	12	Sep-14	39	↘	
	Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	TW	9	0	Sep-14	0	↔	
	Falls - resulting in significant injury	TW	7	1	Sep-14	3	↘	

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%	Aug-14	92%	↔	
High risk TIA fully investigated & treated within 24 hours (National 60%)	CM	60%	63%	Aug-14	67%	↗	
Cancelled operations on/after day of admission (not rebooked within 28 days)	AC	0	1	Sep-14	7	↔	
Delayed Transfer of Care (lost bed days)	TW	N/A	129	Sep-14	804	↘	
Number of Ambulance Handover Delays between 1-2 hours	AM	N/A	6	Sep-14	30	↔	
Theatre utilisation	AC	83%	80%	Sep-14	79%	↗	

Caring

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Patient Satisfaction (Friends & Family test - Total Inpatient response rate)	AC	30%	35%	Sep-14	36%	↘	
Patient Satisfaction (Friends & Family test - A&E response rate)	AC	20%	9%	Sep-14	16%	↘	
Mixed Sex Accommodation Breaches	TW	0	0	Sep-14	0	↔	
Formal Complaints	TW	<175	16	Sep-14	95	↘	
Compliments received	TW	N/A	278	Sep-14	1,861	↘	

Responsive

		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
1	RTT:% of admitted patients who waited 18 weeks or less - IoW CCG	AC	90%	79%	Sep-14	88%	↘	
2	RTT: % of non-admitted patients who waited 18 weeks or less - IoW CCG	AC	95%	93%	Sep-14	93%	↗	
3	RTT % of incomplete pathways within 18 weeks - IoW CCG	AC	92%	95%	Sep-14	93%	↗	
	RTT:% of admitted patients who waited 18 weeks or less - NHS England	AC	90%	83%	Sep-14	89%	↘	
	RTT: % of non-admitted patients who waited 18 weeks or less - NHS England	AC	95%	75%	Sep-14	76%	↗	
	RTT % of incomplete pathways within 18 weeks - NHS England	AC	92%	90%	Sep-14	90%	↗	
8b	Symptomatic Breast Referrals Seen <2 weeks*	AC	93%	96.8%	Sep-14	87.6%	↗	
6b	Cancer patients seen <14 days after urgent GP referral*	AC	93%	96.4%	Sep-14	95.0%	↗	
6a	Cancer Patients receiving subsequent Chemo/Drug <31 days*	AC	98%	100%	Sep-14	100%	↔	
5a	Cancer Patients receiving subsequent surgery <31 days*	AC	94%	88%	Sep-14	98%	↘	
	Cancer diagnosis to treatment <31 days*	AC	96%	100.0%	Sep-14	98.4%	↔	
7	Cancer Patients treated after screening referral <62 days*	AC	90%	100%	Sep-14	88.0%	↗	
5b	Cancer Patients treated after consultant upgrade <62 days*	AC	85%	No patients	Sep-14	100%	↔	
8a	Cancer urgent referral to treatment <62 days*	AC	85%	86.1%	Sep-14	87.1%	↘	
	No. Patients waiting > 6 weeks for diagnostics	AC	<100	1	Sep-14	8	↘	
	%. Patients waiting > 6 weeks for diagnostics	AC	<1%	0.1%	Sep-14	0.1%	↘	
4	Emergency Care 4 hour Standards	AC	95%	95%	Sep-14	96%	↘	
12	Ambulance Category A Calls % < 8 minutes	AM	75%	76%	Sep-14	76%	↗	
13	Ambulance Category A Calls % < 19 minutes	AM	95%	98%	Sep-14	96%	↗	
9a	% of CPA patients receiving FU contact within 7 days of discharge	MH	95%	95%	Sep-14	97%	↘	
9b	% of CPA patients having formal review within last 12 months	MH	95%	99.6%	Sep-14	N/A	↘	
10	% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	MH	95%	100%	Sep-14	99%	↔	

**Cancer figures for September are provisional.*

Well-Led

	Area	In Month Target	Actual Performance		YTD Target	YTD Actual	Month Trend
Total workforce SIP (FTEs)	TW	2628.9	2,613.0	Sep-14	N/A	N/A	↗
Total pay costs (inc flexible working) (£000)	TW	£9,686	£9,922	Sep-14	£58,020	£58,273	↘
Variable Hours (FTE)	TW	136.7	151.7	Sep-14	824.8	851.3	↘
Variable Hours (£000)	TW	£29	£743	Sep-14	£215	£3,841	↘
Staff sickness absences	TW	3%	4.55%	Sep-14	3%	3.81%	↘
Staff Turnover	TW	5%	0.83%	Sep-14	5%	4.33%	↘
Achievement of financial plan	TW	N/A	N/A	Sep-14	£1.7m	£1,084	↗
Underlying performance	TW	N/A	N/A	Sep-14	-£0.23m	(£2,713)	↘
Net return after financing	TW	N/A	N/A	Sep-14	0.50%	0.51%	↗
I&E surplus margin net of dividend	TW	N/A	N/A	Sep-14	=>1%	1.68%	↘
Liquidity ratio days	TW	N/A	N/A	Sep-14	=>0	4	↔
Continuity of Service Risk Rating	TW	N/A	N/A	Sep-14	3	4	↔
Capital Expenditure as a % of YTD plan	TW	N/A	N/A	Sep-14	=>75%	31%	↗
Quarter end cash balance (days of operating expenses)	TW	N/A	N/A	Sep-14	=>10	17	↘
Debtors over 90 days as a % of total debtor balance	TW	N/A	N/A	Sep-14	=<5%	4.20%	↗
Creditors over 90 days as a % of total creditor balance	TW	N/A	N/A	Sep-14	=<5%	0.2%	↗
Recurring CIP savings achieved	TW	N/A	N/A	Sep-14	100%	82.3%	↗
Total CIP savings achieved	TW	N/A	N/A	Sep-14	100%	112%	↗

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

September 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. We have also made improvements to Finance and Workforce Reporting. Further work is required to refine these pages in particular to ensure we have appropriate measures and targets for all services.

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 public awareness campaign is in place to highlight prevention within the wider community and encourage regular mobilisation for those at risk.
C.diff: We had 1 additional case during September and have now reached our full year target of 6.

Responsive:

As planned the admitted and non admitted RTT Indicators were below target in September, with a number of specialties not achieving target bringing the overall Trust performance to 79.64% for Admitted (both IoW CCG and NHS England), and 92.19% for Non-Admitted. In line with the national initiative to reduce the RTT backlog significant resource has been put into validation of 18 week pathways and increasing Out Patient and Inpatient capacity in order to achieve these targets from December 2014.

Cancer - Patients receiving subsequent surgery <31 days failed the 94% standard during September (87.5%). 2 breaches - due to an administrative error, 1 due to consultant availability.

Ambulance Red 1 and Red 2 calls response time <8 minutes - achieving all targets during September;
The staff shortage has been through and addressed. Additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall.

Well Led:

The pay bill for September including variable hours is £9.922m, above the plan of £9.686m. The number of FTEs in post including variable FTEs (2,737) is currently below plan by 28 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 increased from 3.64% to 4.55% during September 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.

The cumulative Trust plan was to deliver a surplus of £1.089m, after normalising items (e.g. impairments and cost associated with donated assets). The actual position is a cumulative surplus of £1.084m, an adverse variance of £5k. This position has £1.9m of forward banking recognised to the end of month 6.
The Trusts planned forecast out-turn surplus remains at £1.7m but the current directorate performances continues to increase the risk of this delivery. This position is actively being managed through financial deep dive meetings and performance reviews & where necessary more frequent finance assessments.

Caring:

Complaints were low in September in comparison to April but slightly increased since August. Compliments, in the form of letters and cards of thanks, were slightly lower during September than in August. The Friends & Family Test response rate continues to be challenging and work is ongoing to improve access.

Effective:

Theatre Utilisation has improved for Main Theatres (83.1%) but decreased for Day Surgery Unit (76.9%) giving a joint rate of 80.4% in September.There was 1 cancellation on the day, this was due to bed capacity, however, reduced impact in September compared to previous months.

Isle of Wight NHS Trust Board Performance Report 2014/15

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Performance Summary - Hospital

Isle of Wight NHS Trust

Balanced Scorecard - Hospital

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Grade 1&2 Pressure Ulcers developing in hospital	Sep-14		14		48	
No. of Grade 3&4 Pressure Ulcers developing in hospital	Sep-14		5		15	
VTE	Sep-14	95%	100.0%	95%	99.8%	
MRSA	Sep-14	0	0	0	0	
C.Diff	Sep-14		1	4	4	
No. of Reported SIRI's	Sep-14		2		15	
Physical Assaults against staff	Sep-14		1			
Verbal abuse/threats against staff*	Sep-14		81			

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Delayed Transfers of Care (lost bed days)	Sep-14	N/A	129	N/A	804	
Cancelled operations on/after day of admission (not rebooked within 28 days)	Sep-14	0	1	0	7	

Responsive**	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Care 4 hour Standards	Sep-14	95%	95.1%	95%	95.8%	
RTT Admitted - % within 18 Weeks	Sep-14	90%	79.2%	90%	89.2%	
RTT Non Admitted - % within 18 Weeks	Sep-14	95%	93.0%	95%	92.9%	
RTT Incomplete - % within 18 Weeks	Sep-14	92%	94.5%	92%	92.8%	
No. Patients waiting > 6 weeks for diagnostics	Sep-14	< 8	1	100	8	
%. Patients waiting > 6 weeks for diagnostics	Sep-14	1%	0.08%	1%	0.11%	
Cancer 2 wk GP referral to 1st OP	Sep-14	93%	96.4%	93%	95.0%	
Breast Symptoms 2 wk GP referral to 1st OP	Sep-14	93%	96.8%	93%	87.6%	
31 day second or subsequent (surgery)	Sep-14	94%	88%	94%	98%	
31 day second or subsequent (drug)	Sep-14	98%	100%	98%	100%	
31 day diagnosis to treatment for all cancers	Sep-14	96%	100%	96%	98%	
62 day referral to treatment from screening	Sep-14	90%	100%	90%	88%	
62 days urgent referral to treatment of all cancers	Sep-14	85%	86.1%	85%	87.1%	
Emergency 30 day Readmissions	Sep-14		4.2%		4.9%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Sep-14	3%	4.34%	3%	3.48%	
Appraisals	Sep-14		2.8%		38.2%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
FFT Hospital - % Response Rate	Sep-14	30%	34.1%	30%	36.6%	
FFT Hospital - % Recommending	Sep-14	95%	97.7%	95%	96.6%	
FFT A&E - % Response Rate	Sep-14	20%	8.6%	20%	16.0%	
FFT A&E - % Recommending	Sep-14	95%	82.0%	95%	91.2%	
Mixed Sex Accommodation Breaches	Sep-14	0	0	0	0	
No. of Complaints (inc. Ambulance Services)	Sep-14		12		49	
No. of Concerns (inc. Ambulance Services)	Sep-14		79		359	
No. of Compliments (inc. Ambulance Services)	Sep-14	N/A	169	N/A	1260	

Contracted Activity***	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Spells	Aug-14	1,142	1,058	5,704	5,369	
Elective Spells	Aug-14	634	597	3,298	3,070	
Outpatients Attendances	Aug-14	9,228	8,517	47,971	48,152	

**Number reflects actual threats so e.g. in September A&E reported 1 incident with 75 threats on it, other threats reported in A&E, Whippingham and Colwell Wards and Medical Assessment and Admission Unit*

***Cancer figures for September 2014 are provisional*

****The Acute Service Level Agreement performance reports a month behind, therefore figures are from August 14.*

RTT performance – Admitted and non-admitted targets continue to under perform as planned due to current national funding scheme for Trusts to undertake additional activity to reduce waiting lists, in particular those patients waiting longer than 18wks.

31 day second or subsequent surgery – 2 breaches out of 16 patients treated due to incorrect booking & unavailable consultant; action plans are in place to ensure avoided in the future.

Cancelled operations – 1 cancellation unfortunately due to bed pressures has been rebooked before the end of October. All cancellations are audited and lesson learnt implemented on a regular basis.

Sickness absenteeism - this has been escalated with individual managers and ongoing monitoring is being undertaken to improve this position.

Friends and Family Test – Emergency Department have now got a tablet device and a volunteer in the department asking patients for F&F feedback which should have a significant impact on the response rate. Spot checks were carried out in the initial stages and responses had improved. The reduction in recommendation has been analysed and the new triage system continues to have a negative impact; this is being addressed in plans going forward to redesign the area.

Isle of Wight NHS Trust Board Performance Report 2014/15

September 14

Performance Summary - Community

Isle of Wight NHS Trust

Balanced Scorecard - Community

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Grade 1&2 Pressure Ulcers developing in the community	Sep-14		19		96	
No. of Grade 3&4 Pressure Ulcers developing in the community	Sep-14		13		37	
MRSA	Sep-14	0	0	0	0	
C.Diff	Sep-14		0	2	2	
No. of Reported SIRI's	Sep-14		7		30	
Physical Assaults against staff	Sep-14		1			
Verbal abuse/threats against staff	Sep-14		3			

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Stroke patients (90% of stay on Stroke Unit)	Aug-14	80%	93.8%	80%	92.2%	
High risk TIA fully investigated & treated within 24 hours (National 60%)	Aug-14	60%	63.2%	60%	66.7%	

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

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism - C Directorate	Sep-14	3%	3.60%	3%	4.07%	
Appraisals	Sep-14		1.8%		80.3%	

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Community Contacts	Aug-14	16,515	17,222	82,740	88,679	
Health Visitors	Aug-14	2,899	2,099	14,495	14,877	
Sexual Health	Aug-14	855	788	4,275	4,522	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
FFT - % Response Rate	Sep-14	30%	48.5%	30%	34.9%	
FFT - % Recommending	Sep-14	95%	84.8%	95%	91.0%	
No. of Complaints (inc. MH activity)	Sep-14		4		24	
No. of Concerns (inc. MH activity)	Sep-14		10		68	
No. of Compliments (inc. MH activity)	Sep-14	N/A	109	N/A	601	

Responsive - Data for this section is in development and will be presented at the next Trust Board.

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

Well Led - Whilst beneath the Trust's target, the September 2014 sickness rate has improved from 3.77% (August 2014)to 3.60%. Sickness rates are due to long term sickness within the Stroke Unit and Community Nursing which is being closely managed via Occupational Health and HR processes.

Caring - Please note that these figures are directorate wide figures and are not split between Community and Mental Health.

Isle of Wight NHS Trust Board Performance Report 2014/15

September 14

Performance Summary - Mental Health

Isle of Wight NHS Trust

Balanced Scorecard - Mental Health

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Physical Assaults against staff	Sep-14		2			
Verbal abuse/threats against staff	Sep-14		3			

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	Sep-14	95%	95%	95%	97%	
% of CPA patients having formal review within 12 months	Sep-14	95%	100%	95%	N/A	
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	Sep-14	95%	100%	95%	99%	
RTT Non Admitted - % within 18 Weeks	Sep-14	95%	99%	95%	96%	
RTT Incomplete - % within 18 Weeks	Sep-14	92%	100%	92%	99%	

Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Mental Health Inpatient Activity	Sep-14	N/A	44	N/A	267	
Mental Health Outpatient Activity	Sep-14	N/A	571	N/A	3,093	

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

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Sep-14	3%	5.68%	3%	4.12%	
Appraisals	Sep-14		0.3%		65.6%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Complaints (inc. Community activity)	Sep-14		48.5%		34.9%	
No. of Concerns (inc. Community activity)	Sep-14		84.8%		91.0%	
No. of Compliments (inc. Community activity)	Sep-14	N/A	109	N/A	601	

Mental Health RTT

Learning Disabilities – Learning Disability Consultant Led activity – all referrals into service are screened by Multi-Disciplinary Team and if identified as appropriate will be passed to consultant for initial assessment. 18 weeks module not implemented for this service – waiting times monitored via PAS data. Work will be undertaken to implement 18 week pathways for this service.

Adult Mental Health – this includes new patients referred into Community MH Services. All referrals into service are screened by Multi-Disciplinary Team and patient may be identified as requiring initial assessment at consultant led out-patient clinic. 18 weeks pathway implemented for patients identified as appropriate for Consultant-led Psychiatrist assessment.

Older Persons Mental Health – All new patients referred to Memory Service are seen in Consultant-led out-patient clinic for assessment, diagnosis and treatment if appropriate. 18 weeks pathway implemented for all new referrals.

Unfortunately due to difficulties earlier in the year with securing consistent locum Consultant cover service capacity was reduced and waiting times increased. A number of patients cancelled their first appointments and it was not possible to rebook these within the 18 week period. The Memory Service now has permanent consultant cover and is working to address long waiting times and avoid future breaches.

CAMHS - All referrals into service are screened by MDT and patient may be identified as requiring initial assessment at consultant led out-patient clinic. 18 weeks pathway implemented for patients identified as appropriate for Consultant-led Psychiatrist assessment.

Well Led - Whilst beneath the Trust's target, the September 2014 sickness rate has held firm at 5.68% (August 2014 - 5.69%) Sickness rates are due to long term sickness and vacancies within the Community Mental Health Service which is being closely managed via Occupational Health and HR processes.

Activity - 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.

Effective - Data for this KLOE is being developed and will be presented at the next Trust Board.

Caring - Please note that these figures are directorate wide figures and are not split between Community and Mental Health.

Isle of Wight NHS Trust Board Performance Report 2014/15

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Performance Summary - Ambulance and 111

Isle of Wight NHS Trust

Balanced Scorecard - Ambulance & 111

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Physical Assaults against staff						
Verbal abuse/threats against staff						

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Number of Ambulance Handover Delays between 1-2 hours	Sep-14		6		30	

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Category A 8 Minute Response Time (Red 1)	Sep-14	75%	81.8%	75%	81.9%	
Category A 8 Minute Response Time (Red 2)	Sep-14	75%	76.1%	75%	74.9%	
Category A 19 Minute Response Time	Sep-14	95%	98.2%	95%	96.2%	
Ambulance re-contact rate following discharge from care by telephone	Sep-14	3%	6.0%	3%	4.8%	
Ambulance re-contact rate following discharge from care at scene	Sep-14	2%	4.4%	2%	3.9%	
Ambulance time to answer call (in seconds) - median	Sep-14	1	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 95th percentile	Sep-14	5	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 99th percentile	Sep-14	14	6	N/A	N/A	
NHS 111 Call abandoned rate	Sep-14	5%	2.3%	5%	2.1%	
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	Sep-14	95%	96.5%	95%	96.3%	
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	Sep-14	95%	97.9%	95%	97.4%	
NHS 111 Where the above is not achieved callers should be called back within 10 mins	Sep-14	100%	40.0%	100%	45.5%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Sep-14	3%	6.77%	3%	5.59%	
Appraisals	Sep-14		2.4%		53.8%	

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

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Calls Answered	Aug-14	2,196	2,518	11,064	12,185	
Hear & Treat / Refer	Aug-14	352	414	1,774	1,884	
See & Treat / Refer	Aug-14	516	565	2,600	2,629	
See, Treat and Convey	Aug-14	1,200	1,168	6,042	6,035	

The Ambulance Service has been able to turnaround the disappointing August results by achieving all three categories required In September; Red 1 (75%) achieved 81.8%, Red 2 (75%) achieved 76.1% and 19 Min (95%) achieved 98.2%. This has been due to the shortage of staff being addressed, additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall.

Our NHS 111 service has also seen a return to its usual achievement targets by showing a return of 96% on call answering and 97% on warm transfers to a clinician.

Highlights

- **Ambulance Red 1 and Red 2 calls response time <8 minutes above target**
- **Emergency care 4 hour standard within target**
- **Venous Thrombo-Embolism (VTE) risk assessment achievement maintained**
- **MRSA maintained at 0**

Lowlights

- **Clostridium Difficile (C.Diff) - now level with the national threshold (6) for the whole year**
- **87.5% Cancer - Patients receiving subsequent surgery <31 days (94% target)**
- **Referral ToTreatment Time Admitted, Non-Admitted and Incompletes below target**
- **Staff sickness remains above plan**
- **Theatre Utilisation below target**

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: During September, there was an overall increase in reported pressure ulcers in the hospital setting with 2 grade 4 pressure ulcers developing in Intensive Care (although grading may change on investigaton) and others in Whippingham & Luccombe wards. The Tissue Viability Nurse continues to support ward staff with recognition and management of patients at risk.

Community acquired: Incidence of pressure ulcer development continues to cause concern and remain challenging with District Nurses experiencing increasing caseloads within the community. Although the numbers are higher this month, overall incidence as a percentage of the number of contacts over the month remains less than 0.003%.

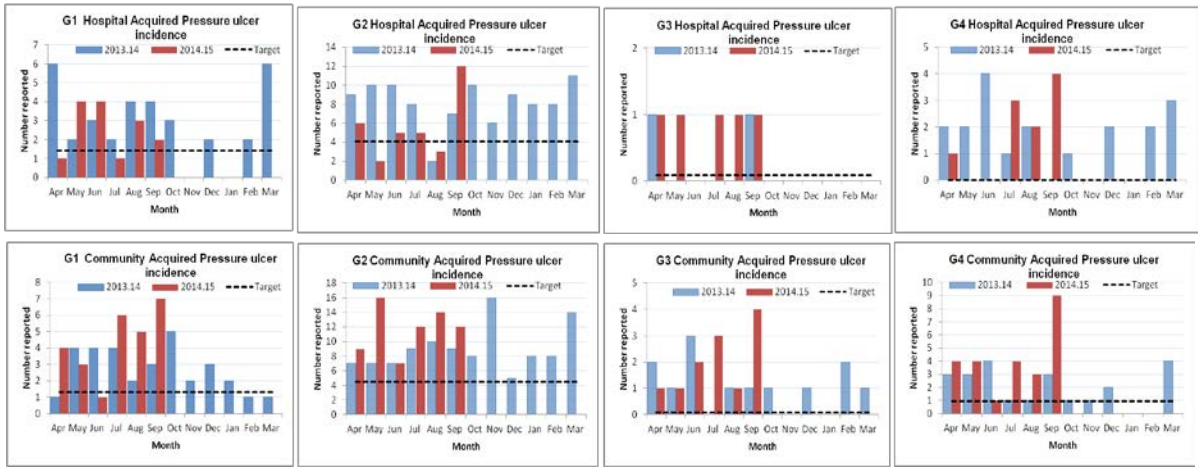
A public awareness campaign is continuing to highlight prevention within the wider community and encourage regular mobilisation for those at risk.

Explanation of RAG Rating

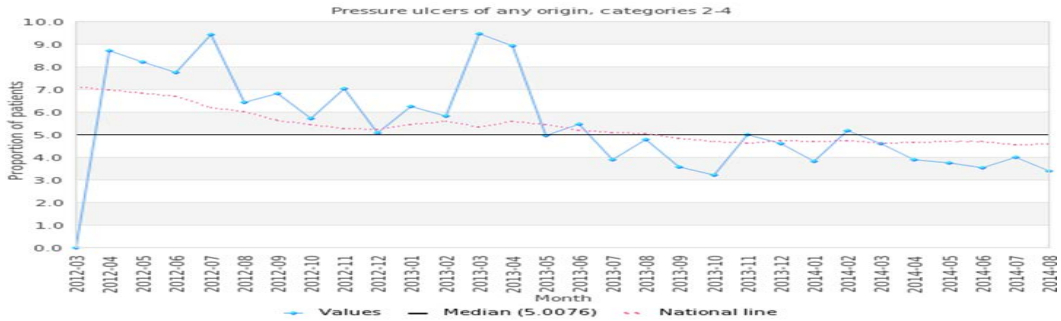
Red = Any G4 or 2 G3 or 5 any in rolling 3 months period
Amber = 1 G3 or increase/no change in G2 in rolling 3 months period
Green = No G3 or G4 and decrease in G2 or 2 or less of any grade (1&2) in rolling 3 months period

Analysis:

Prevention & Management of Pressure Ulcers



Pressure Ulcers benchmark



The graph shows improving trend. In August the Trust has been below the national average.

Action Plan:	Person Responsible:	Date:	Status:
The Tissue Viability Nurse Specialist continues to support ward staff with recognition and management of patients at risk of developing pressure ulcers.	Tissue Viability Specialist Nurse	Oct-14	Ongoing
The Tissue Viability Nurse Specialist is working with the Communications team on a public awareness campaign to encourage prevention and self help in the community.	Tissue Viability Specialist Nurse / Communications Team	Oct-14	Ongoing

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Patient Safety

Commentary:

Clostridium difficile

There was one case of Healthcare Acquired Clostridium Difficile (C. Diff) in the hospital during September 2014, giving a YTD of 6. This identified case is currently under investigation and further action plans may be initiated following conclusion. We have exceeded our local stretched target (4) and are now level with the national threshold (6) for the whole year. Maintaining zero tolerance for the rest of year to remain within these targets will be particularly challenging.

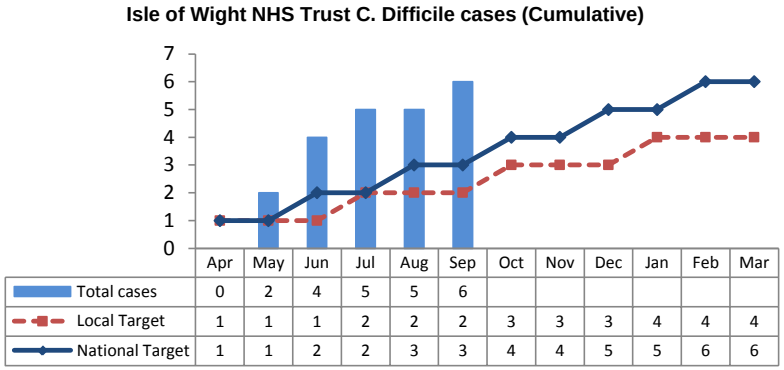
Work is underway to continue to raise awareness and highlight actions on suspected cases, including intranet and poster campaigns.

Methicillin-resistant Staphylococcus Aureus (MRSA)

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

The Action Plan for MRSA is progressing and work continues on the Healthcare Associated Infection agenda.

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



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							0

Action Plan:	Person Responsible:	Date:	Status:
Increasing education regarding timely sampling of loose stool events	Infection Control Team	Oct-14	Ongoing
Highlighted awareness campaign including intranet and posters	Infection Control Team	Oct-14	Ongoing
Increased auditing of commode cleaning on individual wards	Ward managers	Oct-14	Ongoing

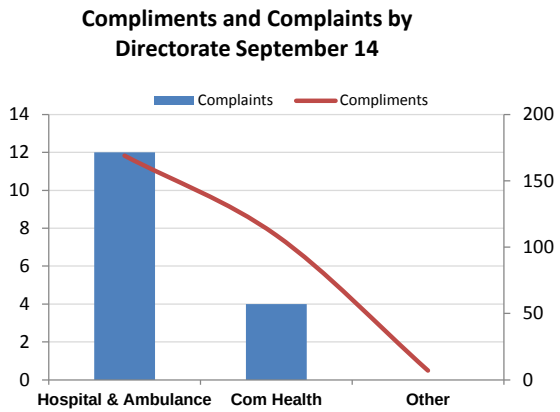
Commentary:

There were 16 formal Trust complaints received in September 2014 (13 in the previous month) against approximately 47,000 patient contacts (Inpatient episodes, all outpatient, A&E attendances and community contacts), with 285 compliments received by letters and cards of thanks across the same period.

Across all complaints and concerns in September 2014:
Top areas complained about were:
- Outpatient appointments/records unit (24)
- General Surgery (10)
- Emergency Department (10)

Across all complaints and concerns in September 2014:
Top 5 subjects complained about were:
- Clinical care (26)
- Out-patient appointment delay/cancellation (11)
- Communication (31)
- In-patient appointment delay/cancellation (7)
- Staff attitude (11)

Analysis: Complaints only



Primary Subject	Aug-14	Sep-14	CHANGE	RAG rating
Clinical Care	10	9	-1	↓
Nursing Care	1	3	2	↑
Staff Attitude	1	1	0	→
Communication	1	1	0	→
Outpatient Appointment Delay/ Cancellation	0	1	1	↑
Inpatient Appointment Delay / Cancellation	0	1	1	↑
Admission / Discharge / Transfer Arrangements	0	0	0	✓
Aids and appliances, equipment and premises	0	0	0	✓
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	0	0	0	✓

Action Plan:	Person Responsible:	Date:	Status:
Following relocation and re launching of the Patient Advice and Liaison Serivce work has been completed to improve office area in respect of sound proofing and lighting. Patient Experience Officers returned to the office on 17 October 2014.	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Oct-14	Complete

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Cancer - Patients receiving subsequent surgery <31 days

Isle of Wight NHS Trust

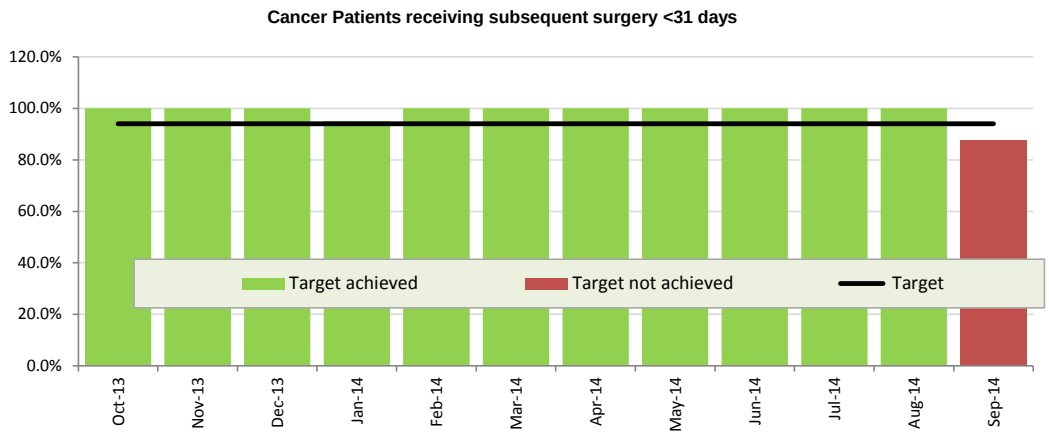
Commentary:

All September figures are still provisional.

Cancer Patients receiving subsequent surgery <31 days (94% target)

2 x Skin breaches:-
1 x Excisional biopsy not booked as fast track
1 x No consultant available to perform excisional biopsy

Analysis:



Action Plan:	Person Responsible:	Date:	Status:
Excisional biopsy not booked as fast track – administrative error. Process to be reviewed No consultant available to perform excisional biopsy – clarification of service delivery in absence of appropriate specialist	General Manager for Surgery Beacon Practice Manager	Nov-14	Continuing

Isle of Wight NHS Trust Board Performance Report 2014/15

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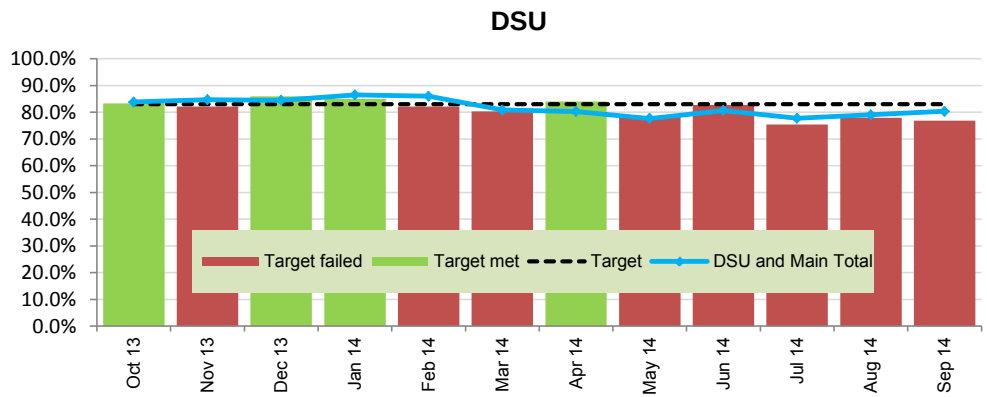
Theatre Utilisation

Isle of Wight NHS Trust

Commentary	Analysis:
The percentage utilisation of theatre facilities remains below the 83% target for Day surgery Unit (76.9%). Main Theatres utilisation has increased during September 2014 (83.1%). Overall we have achieved 80.4%. Delays continue to be experienced with patients being admitted in timely fashion into beds to start theatre lists on time. Elective admissions continue to be reliant on discharges occuring on the day of admission. Cancellations on the day have occured due to bed capacity, however, reduced impact this month. Overall cancellations on day lower that previous month (42 - including unfit/unwell patients) but numbers reduced in September compared to previous months.	

Action plan	Person Responsible:	Date:	Status:
1) Review of Pre-Assessment Unit staffing levels - increased senior support to area planned for October 2) Speciality based action plans developed by each general manager to review 18 weeks activity - ongoing through into November to monitor RTT	General manager- Planned Directorate	Oct / Nov-14	Ongoing
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 - continuing through October.	General manager- Planned Directorate	Oct-14	Ongoing

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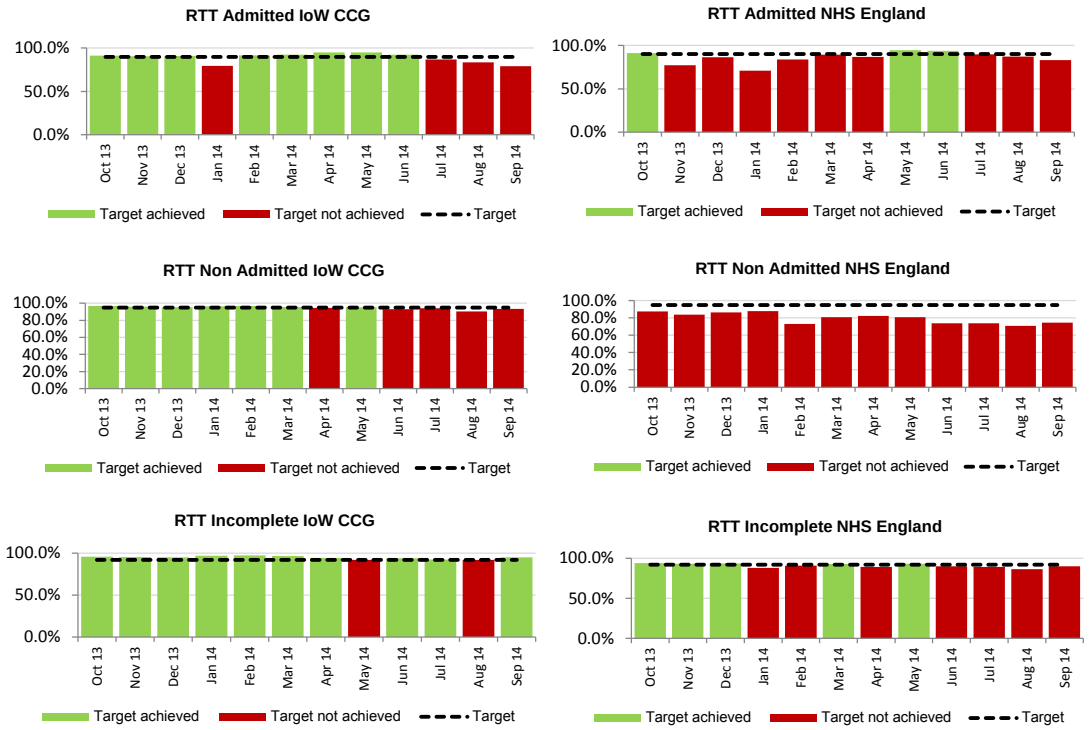
Referral to Treatment Times

Isle of Wight NHS Trust

Commentary:

We have reached the end of the first 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.
During this second period of extra funding the majority of resource will be put into reducing Inpatient waiting times.
The data quality issues highlighted by the forecasting tools developed by Performance Information & Decision Support (PIDS) continue to be addressed, with the result that in the region of an extra 400 reportable pathways were closed in the non-admitted section in September.
Validation needs to continue and although there are indications that the incomplete waitinglist is starting to grow again this will be addressed.
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)	Oct-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.	Access Lead & General Managers	Oct-14	Planned
Referral To Treatment times awareness session with Portsmouth Hospital Trust and General Managers. Ongoing	Access Lead & General Managers	Sep-14	In progress
Development of robust processes and documentation to enable training and awareness of 18 week procedures.	Information Systems Manager & Access Lead	Sep-14	Planned

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%	79%	95.0%	96.4%	54 / 174	Better than national average	Q2
RTT:% of admitted patients who waited 18 weeks or less	90%	100%	0%	86.8%	84.2%	124 / 167	Amber Red	Aug-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	100%	50%	95.3%	87.9%	191 / 196	Bottom Quartile	Aug-14
RTT % of incomplete pathways within 18 weeks	92%	100%	0%	92.7%	91.3%	166 / 194	Bottom Quartile	Aug-14
%. Patients waiting > 6 weeks for diagnostic	1%	0%	31%	1.9%	0.0%	1 / 184	Top Quartile	Aug-14
Ambulance Category A Calls % < 8 minutes - Red 1	75%	82%	69%	73.2%	72.5%	7 / 11	Bottom Quartile	Aug-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	77%	61%	70.9%	72.2%	7 / 11	Bottom Quartile	Aug-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	76%	62%	71.0%	72.2%	8 / 11	Bottom Quartile	Aug-14
Ambulance Category A Calls % < 19 minutes	95%	97%	90%	94.9%	95.2%	8 / 11	Better than national average	Aug-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.

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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%	96.4% 9	91.3% 26	95.7% 13	96.6% 8	95.0% 19	97.3% 3	94.5% 20	96.3% 10	97.8% 2	96.0% 12	93.6% 23	93.7% 22	98.1% 1	97.0% 5	96.9% 7	95.1% 18	97.1% 4	84.0% 28	96.2% 11	95.3% 17	86.9% 27	94.1% 21	93.2% 25	95.5% 14	96.9% 6	95.4% 15	93.6% 24	95.4% 16	Aug-14
RTT:% of admitted patients who waited 18 weeks or less	90%	84.2% 21	81.4% 23	86.7% 17	79.3% 25	93.6% 6	92.0% 9	90.3% 12	77.5% 27	94.3% 5	86.6% 18	87.3% 16	92.9% 7	97.3% 2	90.5% 10	94.7% 4	84.9% 20	90.2% 13	90.1% 14	78.1% 26	75.7% 28	82.1% 22	90.4% 11	80.2% 24	85.0% 19	94.8% 3	89.95% 15	97.6% 1	92.3% 8	Aug-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	87.9% 28	96.3% 18	95.7% 22	97.1% 13	95.5% 23	97.6% 7	93.7% 26	93.3% 27	97.2% 12	95.2% 25	96.0% 21	96.2% 20	98.5% 4	97.1% 14	97.4% 10	98.0% 6	95.4% 24	96.3% 17	98.7% 3	96.6% 16	98.8% 2	98.2% 5	96.2% 19	97.6% 9	97.3% 11	97.6% 8	99.4% 1	97.0% 15	Aug-14
RTT % of incomplete pathways within 18 weeks	92%	91.3% 26	85.0% 27	95.3% 17	95.5% 16	95.9% 12	94.5% 20	95.8% 13	95.7% 14	97.0% 6	93.1% 23	94.0% 22	95.2% 18	94.1% 21	96.4% 10	95.5% 15	97.0% 8	94.9% 19	97.1% 5	97.3% 2	96.4% 11	92.1% 25	92.6% 24	N/A	97.2% 4	98.1% 1	97.0% 7	96.8% 9	97.3% 3	Aug-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.0% 1	0.2% 13	0.2% 14	9.3% 28	0.3% 15	0.4% 18	0.5% 19	0.0% 1	0.2% 12	0.0% 1	2.5% 25	0.3% 17	0.0% 1	6.8% 27	0.0% 8	0.1% 11	1.0% 23	0.7% 21	0.0% 1	1.0% 22	5.3% 26	0.1% 9	0.6% 20	0.1% 10	1.6% 24	0.0% 7	0.3% 16	0.0% 1	Aug-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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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%	96.4% 5	99.9% 2	96.6% 4	93.8% 8	99.9% 1	93.9% 7	91.8% 9	84.2% 10	94.5% 6	98.9% 3	Aug-14
RTT:% of admitted patients who waited 18 weeks or less	90%	84.2% 9	100.0% 1	79.3% 10	94.3% 4	99.1% 2	86.8% 7	85.6% 8	89.7% 6	90.2% 5	96.2% 3	Aug-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	87.9% 10	98.5% 3	97.1% 5	95.0% 8	100.0% 1	97.4% 4	91.6% 9	96.6% 6	96.1% 7	99.2% 2	Aug-14
RTT % of incomplete pathways within 18 weeks	92%	91.3% 10	98.6% 2	95.5% 6	96.9% 4	98.7% 1	94.1% 8	92.0% 9	96.0% 5	95.3% 7	98.2% 3	Aug-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.0% 1	0.0% 1	9.3% 10	0.2% 4	0.2% 5	0.2% 6	0.2% 7	3.9% 9	0.9% 8	0.0% 1	Aug-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%	72.5% 7	70.6% 9	69.1% 10	68.7% 11	79.5% 2	72.7% 6	76.6% 3	76.2% 4	75.7% 5	81.9% 1	71.3% 8	Aug-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	72.2% 7	72.5% 6	61.1% 11	61.8% 10	75.9% 2	72.1% 8	75.7% 4	74.4% 5	76.5% 1	75.8% 3	70.3% 9	Aug-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	72.2% 8	72.3% 6	61.5% 12	62.1% 12	76.0% 3	72.2% 10	75.7% 6	74.5% 7	76.5% 1	75.9% 4	70.4% 11	Aug-14
Ambulance Category A Calls % < 19 minutes	95%	95.2% 8	94.2% 9	90.3% 11	93.9% 10	95.8% 4	95.3% 7	95.9% 3	95.4% 5	95.4% 6	97.2% 1	96.1% 2	Aug-14

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

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 July 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 is red this month, this is mostly related 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 improved in June and that has been sustained in July which reflects improvements to the timeliness of coding. Further improvements are expected in the results in future months.

Analysis:

Total APC General Episodes: 8,519

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	131	98.5%	99.1%
Patient Pathway	155	94.3%	57.7%
Treatment Function	0	100.0%	99.9%
Main Specialty	0	100.0%	99.9%
Reg GP Practice	1	100.0%	99.9%
Postcode	65	99.2%	99.8%
Org of Residence	5	99.9%	99.0%
Commissioner	11	99.9%	99.1%
Primary Diagnosis	797	90.6%	98.0%
Primary Procedure	0	100.0%	99.5%
Ethnic Category	7	99.9%	97.5%
Site of Treatment	0	100.0%	97.5%
HRG4	802	90.6%	97.6%

Total Outpatient General Episodes: 56,742

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	323	99.4%	99.3%
Patient Pathway	25,400	51.6%	48.9%
Treatment Function	0	100.0%	99.8%
Main Specialty	0	100.0%	99.8%
Reg GP Practice	2	100.0%	99.9%
Postcode	2	100.0%	99.8%
Org of Residence	9	100.0%	94.4%
Commissioner	25	100.0%	99.3%
First Attendance	0	100.0%	99.4%
Attendance Indicator	1	100.0%	99.6%
Referral Source	339	99.4%	98.9%
Referral Rec'd Date	339	99.4%	95.9%
Attendance Outcome	9	100.0%	98.3%
Priority Type	339	99.4%	97.2%
OP Primary Procedure	0	100.0%	99.5%
Ethnic Category	46	99.9%	92.9%
Site of Treatment	0	100.0%	96.0%
HRG4	0	100.0%	98.8%

Total A&E Attendances 22,582

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	494	97.8%	95.1%
Registered GP Practice	4	100.0%	99.2%
Postcode	10	100.0%	98.9%
Org of Residence	265	98.8%	95.7%
Commissioner	399	98.2%	98.7%
Attendance Disposal	138	99.4%	98.1%
Patient Group	0	100.0%	96.0%
First Investigation	167	99.3%	94.0%
First Treatment	445	98.0%	93.0%
Conclusion Time	131	99.4%	98.3%
Ethnic Category	0	100.0%	92.8%
Departure Time	63	99.7%	99.8%
Department Type	0	100.0%	100.0%
HRG4	263	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 - July 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 items
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%	97.5%	> = 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 items
OP	Valid NHS Number	99.4%	99.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Valid Ethnic Category	99.9%	92.9%	> = 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 items
A&E	Valid NHS Number	97.8%	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%	92.8%	> = 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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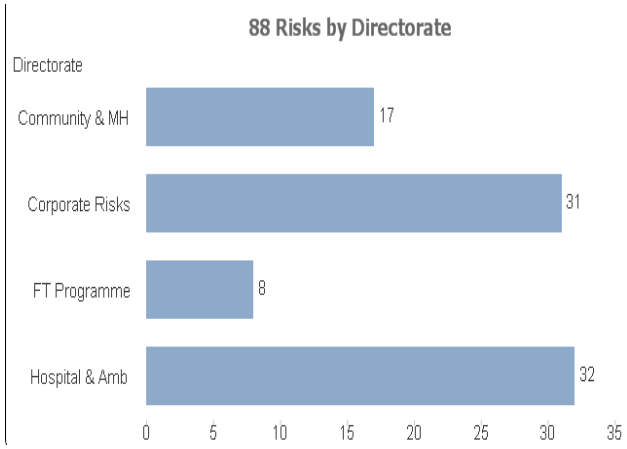
Risk Register - Situation current as at 15/10/2014

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	%
Hospital & Amb	23/02/2011	Insufficient And Inadequate Endoscopy Facilities To Meet Service Requirements	9	7	78%
Hospital & Amb	20/10/2011	Insufficient And Inadequate Ophthalmology Facilities To Meet Service Requirements	6	4	67%
Corporate Risks	22/11/2011	Mandatory Training	6	6	100%
Hospital & Amb	16/08/2012	Blood Sciences Out-Of-Hours Staffing	4	3	75%
Hospital & Amb	22/08/2012	Risk Due To Bed Capacity Problems	4	3	75%
Hospital & Amb	24/10/2012	Failing Heating/Cooling System Impacting On Service Delivery	2	2	100%
Community & MH	22/11/2012	Low Staffing Levels Within Occupational Therapy Acute Team	6	2	33%
Hospital & Amb	05/12/2012	Vacant Consultant Physician Posts	3	1	33%
Corporate Risks	26/03/2013	Pressure Ulcers	4	2	50%
Hospital & Amb	23/09/2013	Ophthalmic Casenotes - Poor Condition, Misfiling And Duplication Leading To Potential Clinical Error	4	2	50%
Hospital & Amb	21/01/2014	Acquisition Of Mechanical Device For Chest Compressions	5	4	80%
Hospital & Amb	30/04/2014	Maternity Theatre Inadequate Airflow Leading To Potential Infection Control Risk	3	1	33%
Corporate Risks	24/07/2014	Air Conditioning Unit In Network Core Room	7	1	14%
Corporate Risks	24/07/2014	Mandatory Resuscitation Training	6	0	0%
Hospital & Amb	28/08/2014	Computer Aided Dispatch (CAD) Server And Software Update	5	2	40%
Hospital & Amb	28/08/2014	Maxfax Dental Carts And Compressor No Longer Fit For Purpose	7	5	71%
Community & MH	28/08/2014	Safeguarding Children Team Capacity	6	0	0%
Corporate Risks	28/08/2014	Unsupported Desktop Environment	6	0	0%

Data as at 15/10/2014 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 no new risks have been added to the register. No risks have been signed off the risk register however we are awaiting the signing off forms for RR540 Failing Heating/Cooling System Impacting on Service Delivery and RR476 Mandatory Training.

- **Key messages**

- Total paybill exceeds budgeted expenditure in month by £237k in month and £253k year to date.
- Overspend is within Hospital sub group of Hospital & Ambulance Directorate.
- Community & Mental Health and Corporate directorates as a group continue to operate within budget.
- In month sickness rate increases to 4.55% from 3.64 in August and against a target of 3%
- Unfilled budgeted positions increase to 8% of total funded establishment from 6.4% in August

- **Key risks identified:**

- *Increased Sickness Absence*
- *Reduction in in-post budgeted establishment*
- *Increase in Agency & Bank Spends*

- **Key Successes:**

- *Appointment of Agency Master Vendor*

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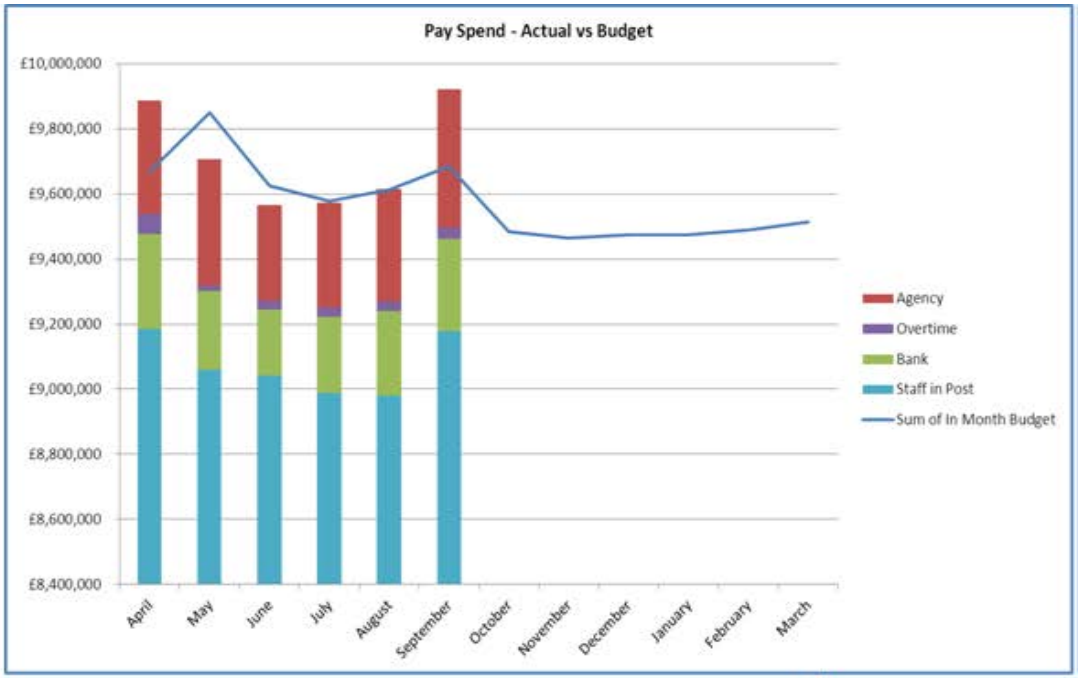
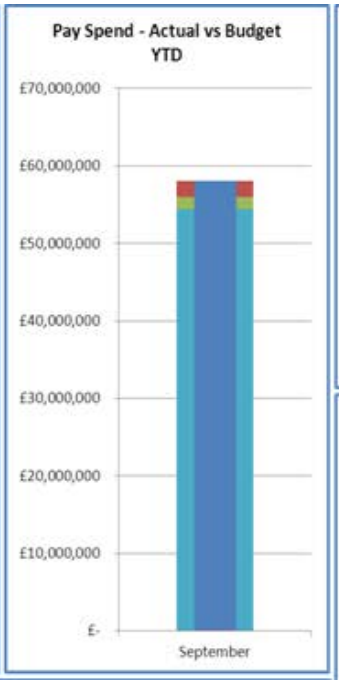
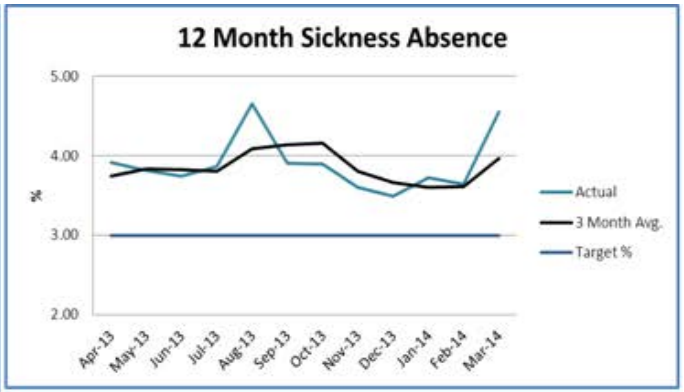
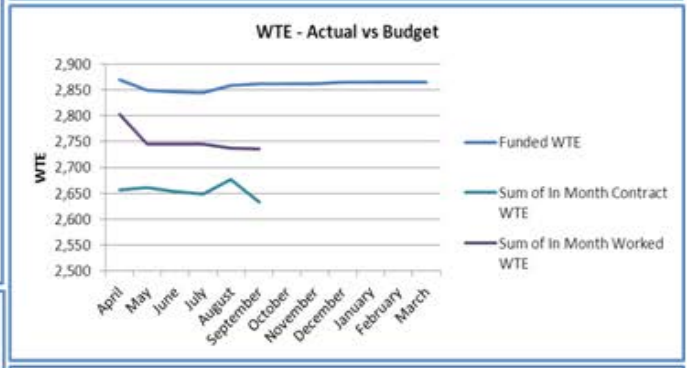
Workforce - Pay Spend (Total Trust)

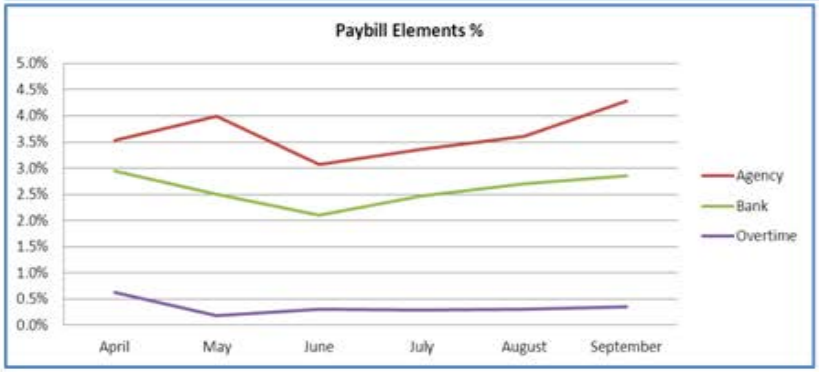
Isle of Wight NHS Trust

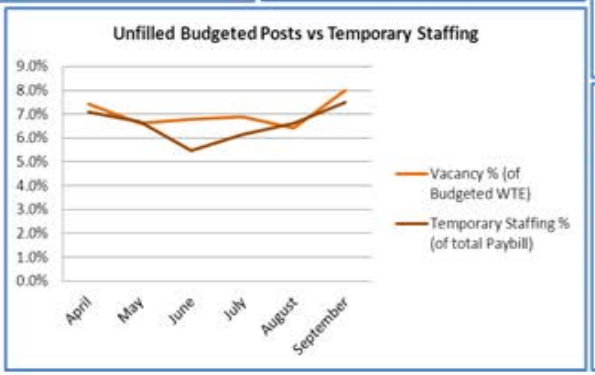












In month pay expenditure for the organsation exceeds the plan by £237k.
Year to date pay expenditure exceeds the plan by £253k.
The in month variance is driven by:

- Additional activity due to RTT resulting in the need for additional staff.
- In month cost of the independant panel junior doctor banding appeal (£75k)
- In month cost of bank holiday and weekend enhancements for final (5th) weekend in August - paid in September (£93k)
- An increase in sickness incidence of 4.55%, up from 3.64% in August.
- Increase in unfilled budgeted established from 6.4% to 8%.
- A resultant increase in Agency, Bank, & Overtime Spend.

Isle of Wight NHS Trust Board Performance Report 2014/15

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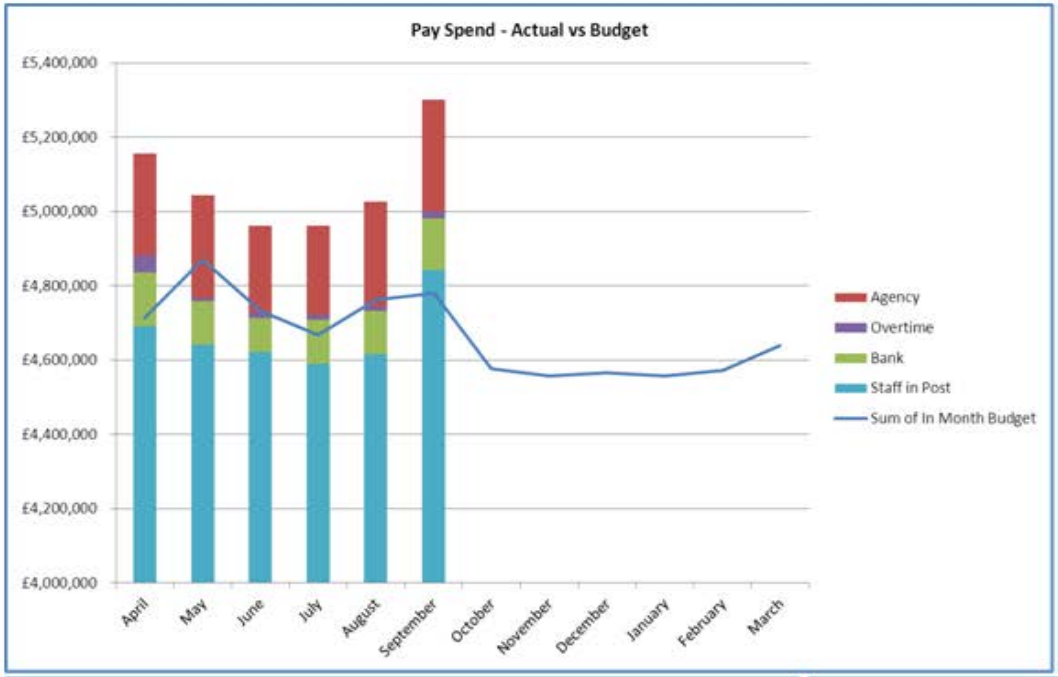
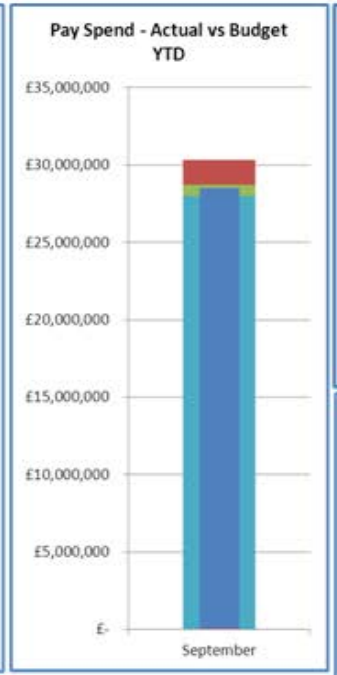
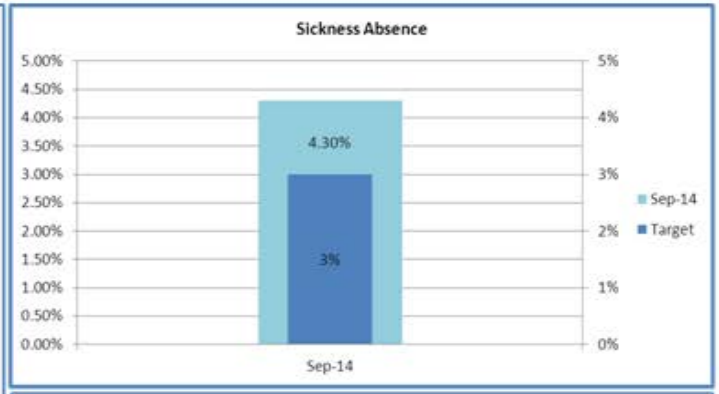
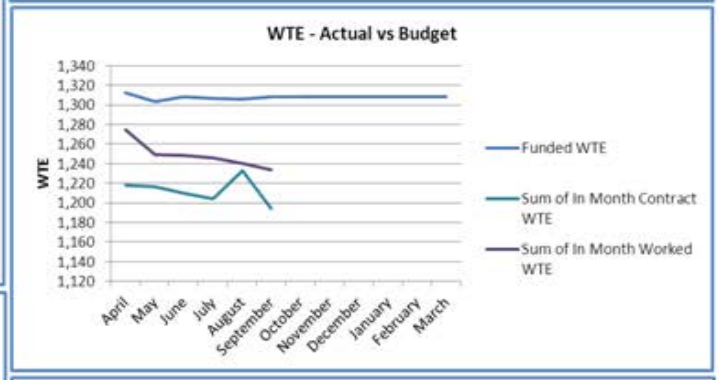
Workforce - Pay Spend (Hospital)

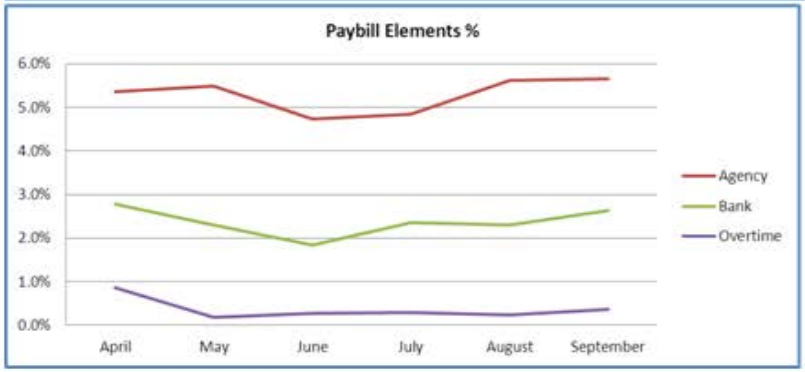
Isle of Wight NHS Trust

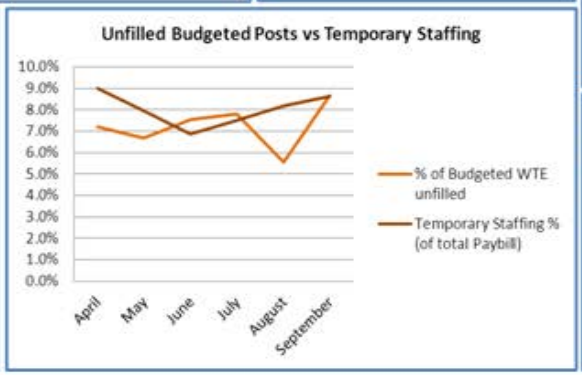






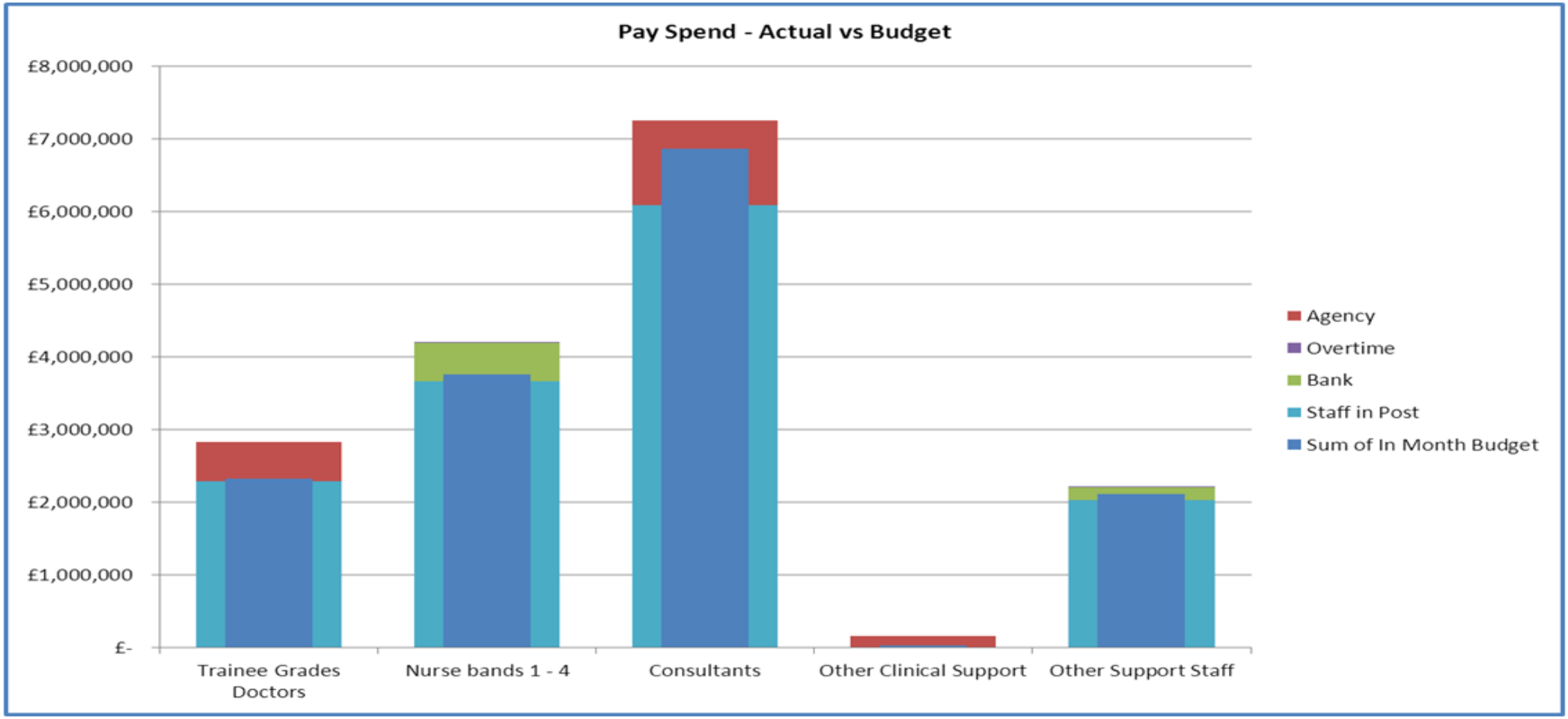






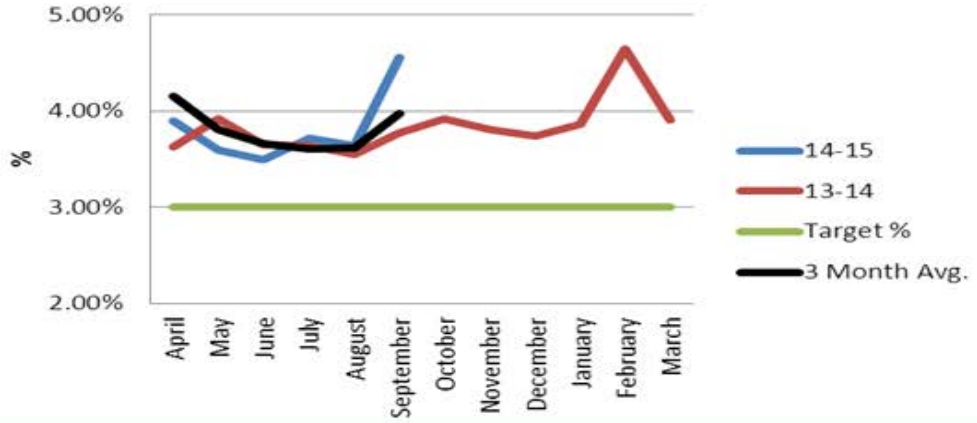
In month pay expenditure for the area exceeds the plan by £521k.
Year to date pay expenditure exceeds the plan by £1.9m.
This is driven predominantly by under achievemet of CIP and also by:

- Additional activity due to RTT resulting in the need for additional staff.
- In month cost of the independant panel junior doctor banding appeal (£75k)
- In month cost of bank holiday and weekend enhancements for final (5th) weekend in August - paid in September
- Sickness incidence in excess of 4.3% against a target of 3%.
- Increase in unfilled budgeted establishment from 5.6% to 8.7%.
- A resultant and continued increase in Agency, Bank, & Overtime Spend.

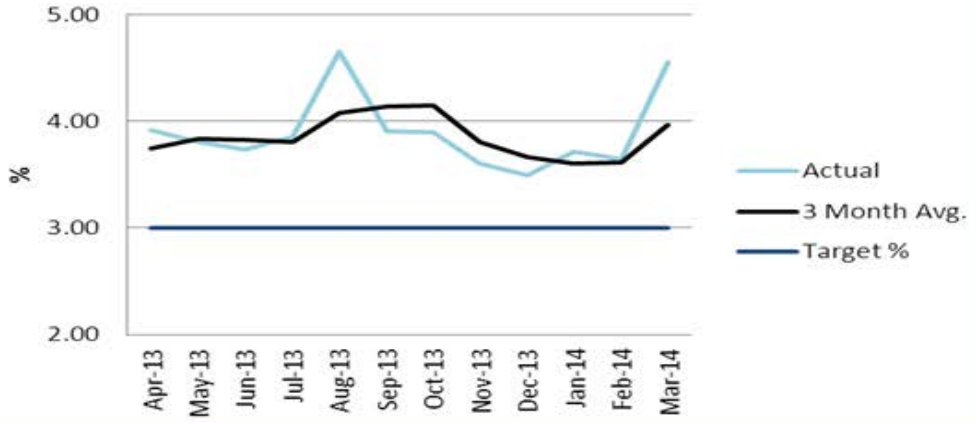


Note: Difference between inner bar (budget) and outer bar (actual) represents overspend). Graph shows top 5 overspending staffing group by £ budget variance.

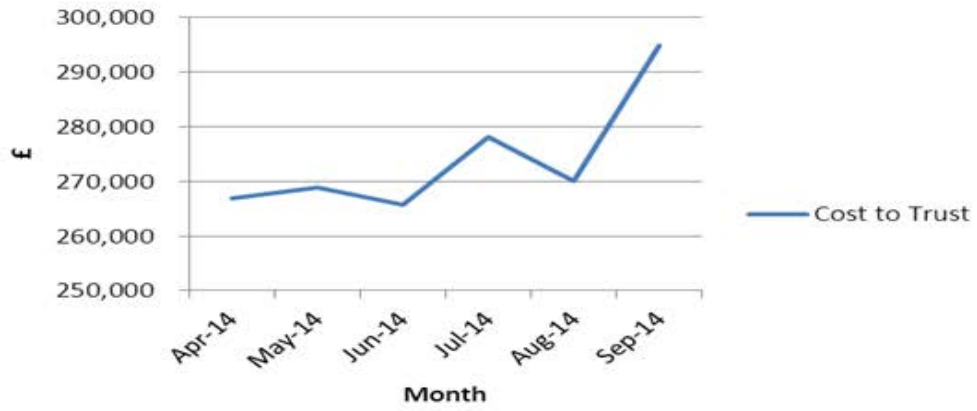
Year on Year Sickness Absence



12 Month Sickness Absence



Cost of Sickness Absence



Absence Reason	Sum of FTE Days Lost	Sum of Days Available FTE	Sum of Sickness Value
S10 Anxiety/stress/depression	896	10,223	8.77%
S25 Gastrointestinal problems	476	11,164	4.26%
S11 Back Problems	373	6,556	5.69%
S28 Injury, fracture	313	4,700	6.65%
S12 Other musculoskeletal problems	235	4,874	4.83%

Sickness Absence	Period	Month Target/Plan	Month Actual
In Month Absence Rate	Sep-14	3%	4.55%

Sickness incidence has increased to 4.55% in September, up from 3.64% in August. This has been contributed to by a recent increase in the numbers suffering with gastontestinal problems.

Isle of Wight NHS Trust Board Performance Report 2014/15

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Summary - RAG Rating based on Out-turn position

Isle of Wight NHS Trust

Summary

The Trust is reporting a £1.084m surplus in the year to September 2014, which is £5k less than the Plan submitted to the Trust Development Authority. The position is based on the contracts agreed and signed with commissioners and also reflects activity levels to September however these variances are largely mitigated by the Risk Share Agreement with the local Clinical Commissioning Group (CCG). An additional pressures has been incurred year to date relating to Referral To Treatment (RTT) extra activity being scheduled, amounting to c.£200k. Negotiations are ongoing with the local CCG to reimburse this cost.

Continuity of Service Rating — G

	Plan	Actual
Year to date	4	4

The Trust is currently reporting a Continuity of Service Rating (CoSR) of '4' which is consistent with the operational plan. Additionally the expected out-turn rating is also 4.

Financial Criteria	Weight %		Metric to be scored	Definition	Rating categories 4	3	2	1
Liquidity Ratio	1	50%	Liquid Ratio (days)	Working capital balance x 360 / Annual operating expenses	0.0	-7.0	-14.0	<-14
Capital Servicing Capacity Ratio	1	50%	Capital servicing capacity (time)	Revenue available for capital service / Annual debt service	2.5x	1.75x	1.25x	<1.25x

Surplus — G

	Plan	Actual / Forecast	Variance
Year to date £k	1,089	1,084	(5)
Year end forecast £k	1,702	1,702	(0)

The Trust planned for a surplus of £1k in September, after adjustments made for normalising items. The reported position is a surplus of £80k in the month, a favourable variance of £79k.
The cumulative Trust plan was to deliver a surplus of £1.089m, after normalising items. The actual position is a cumulative surplus of £1.084m, an adverse variance of £5k. This position has £1.9m of forward banking recognised to the end of month 6.
The Trusts planned forecast out-turn surplus remains at £1.7m but the current directorate performances continues to increase the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.

Income — G

	Plan	Actual / Forecast	Variance
Year to date £k	85,162	84,264	(898)
Year end forecast £k	170,079	169,966	(113)

The Trust planned income in September was £14.104m. The actual reported income is £13.802m in month, an adverse variance of £302k. £180k of this is a result of the worsening performance of the NHS England contract against plan.
The cumulative income plan is £85.162m. The actual position is a cumulative income of £84.264m, an adverse variance of £898k. Included within this variance is income from the directorates, this is a positive variance of £1.829m. Excluding this, the income position would be a adverse forecast variance of £1.942m

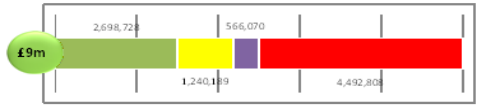
Operating Costs — G

	Plan	Actual / Forecast	Variance
Year to date £k	(69,399)	(67,543)	1,856
Year end forecast £k	(139,324)	(137,279)	2,045

The Trust is reporting an underspend against an expenditure budget ytd of £1.856m. The forecast year end position is an underspend of £2.045m. Including additional forecast costs relating to the Public Dividend Capital Charge the adjusted positive expenditure variance is £1.942m.

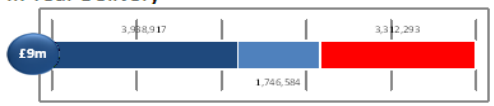
CIP — G

Recurring Forecast Outturn



	Current Month	Previous Month
Complies with all Audit Criteria and Finance Validated	2,698,728	2,698,728
Complies with some Audit Criteria and Finance Validated	1,240,189	1,035,707
Part year effect of Recurring Savings	566,070	566,070
Does not comply with any Audit Criteria and / or Finance not Validated	4,492,808	4,697,290

In Year Delivery



	Current Month	Previous Month
Recurring forecast outturn	3,938,917	3,734,435
Non Recurring forecast outturn	1,746,584	1,746,584
Gap remaining	3,312,293	3,516,775

Cash — G

	Plan	Actual / Forecast	Variance
Year to date £k	5,228	8,078	2,850
Year end forecast £k	5,407	10,320	4,913

The cash balance held at the end of September is considerably more than was planned and is due to:
i) the actual spend on capital being less than the planned spend in the first six months of the year
ii) the movement in working balances
iii) the reduced cost of depreciation

Capital — G

	Plan	Actual / Forecast	Variance
Year to date £k	4,610	1,416	(3,194)
Year end forecast £k	8,318	7,689	(629)

The total Capital Resource for this year was originally approved at £8.3M. This included property sales of £648k, but these are expected to be sold during 2015/16 bring the forecast expenditure to £7.7M for 2014/15.

Indicators of Forward Financial Risk — G

	Plan	Forecast
Number of indicators breached	2	0
Number of indicators	11	11

Indicators breached are:
i) Unplanned decrease in EBITDA margin in two consecutive quarters
ii) Capital expenditure <75% of plan for the year

Isle of Wight NHS Trust Board Performance Report 2014/15

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Surplus

Isle of Wight NHS Trust

The Trust planned for a surplus of £1k in September, after adjustments made for normalising items. The reported position is a surplus of £80k in the month, a favourable variance of £79k.
The cumulative Trust plan was to deliver a surplus of £1.089m, after normalising items. The actual position is a cumulative surplus of £1.084m, an adverse variance of £5k. This position has £1.9m of forward banking recognised to the end of month 6.
The Trusts planned forecast out-turn surplus remains at £1.7m but the current directorate performances continues to increase the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Surplus / (Deficit)	**1,089**	**1,084**	**(5)**

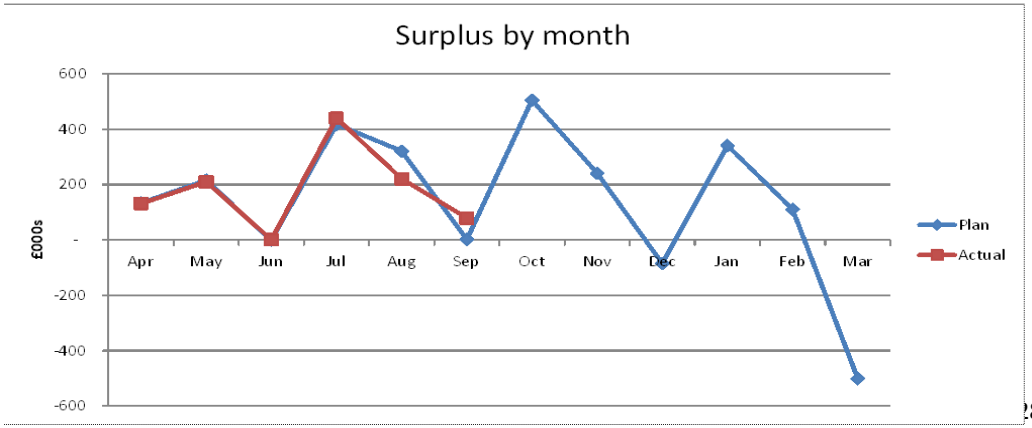
	Full Year		
	Plan £000s	Forecast £000s	Variance £000s
Surplus / (Deficit)	**1,702**	**1,702**	**(0)**

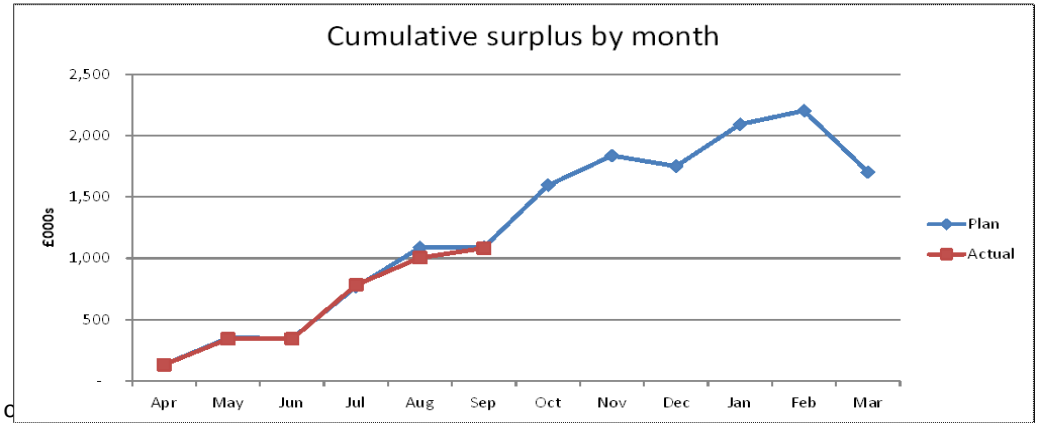
The Category A income position includes contract penalties and contractual under performance. The balance relates to contract variations that have yet to be agreed, but are offset by a corresponding balance in revenue reserves.

Operating costs include considerable over spends in Hospital & Ambulance directorate. These are offset by under utilised reserves and over achievement of CIP (including forward banking) in corporate directorate.
During the month an impairment has been realised of c.£1.3m on assets subject to the District Valuers revaluation. The impairment has resulted in the planned retained surplus position having a negative variance of £1.3m. This is due to the impairment being recognised in advance of the planned budgeted impairment which was in March 2015. The forecast position at the year end corrects this position & in fact the current prediction is that impairments overall will be significantly less than anticipated due to the current upward trend in land & property values.
The adjusted reported performance for NHS monitoring purposes is not affected by this impairment charge as it is an adjusted item in that metric.

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Income	85,162	84,264	(898)
Pay	(58,020)	(58,273)	(253)
Non Pay	(21,497)	(20,364)	1,133
EBITDA	**5,646**	**5,627**	**(19)**
Depreciation & Amortisation	(2,890)	(2,871)	19
PDC	(1,650)	(1,650)	(0)
Impairment	0	(1,325)	(1,325)
Profit/Loss on Asset Disp	0	(19)	(19)
Interest Receivable	27	21	(6)
Interest Payable	(48)	(11)	37
Bank Charges	(8)	(3)	5
Foreign Currency Adjustments	(0)	(3)	(3)
RETAINED SURPLUS / (DEFICIT)	**1,077**	**(234)**	**(1,311)**
Receipt of Charitable Donations for Asset Acquisition	(50)	(50)	(0)
Impairment	0	1,325	1,325
Depreciation - Donated Assets	62	43	(19)
ADJUSTED RETAINED SURPLUS / (DEFICIT)	**1,089**	**1,084**	**(5)**

	Full Year		
	Plan £000s	Forecast £000s	Variance £000s
Income	170,079	169,966	(113)
Pay	(114,916)	(115,180)	(264)
Non Pay	(44,211)	(43,731)	480
EBITDA	**10,952**	**11,055**	**103**
Depreciation & Amortisation	(5,843)	(5,824)	19
PDC	(3,299)	(3,400)	(101)
Impairment	(5,347)	(2,953)	2,394
Profit/Loss on Asset Disp	(125)	(152)	(27)
Interest Receivable	54	48	(6)
Interest Payable	(48)	(20)	28
Bank Charges	(16)	(11)	5
Foreign Currency Adjustments	(1)	(3)	(3)
RETAINED SURPLUS / (DEFICIT)	**(3,673)**	**(1,260)**	**2,413**
Receipt of Charitable Donations for Asset Acquisition	(100)	(100)	(0)
Impairment	5,347	2,953	(2,394)
Depreciation - Donated Assets	128	109	(19)
ADJUSTED RETAINED SURPLUS / (DEFICIT)	**1,702**	**1,702**	**(0)**





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Income

The Trust planned income in September was £14.104m. The actual reported income is £13.802m in month, an adverse variance of £302k.

The cumulative income plan is £85.162m. The actual position is a cumulative income of £84.264m, an adverse variance of £898k.
This position includes an estimate of £521k relating to CCG contract penalties and NHSE contract under performance.

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Surplus / (Deficit)	**85,162**	**84,264**	**(898)**

	Full Year		
	Plan £000s	Forecast £000s	Variance £000s
Surplus / (Deficit)	**170,079**	**169,966**	**(113)**

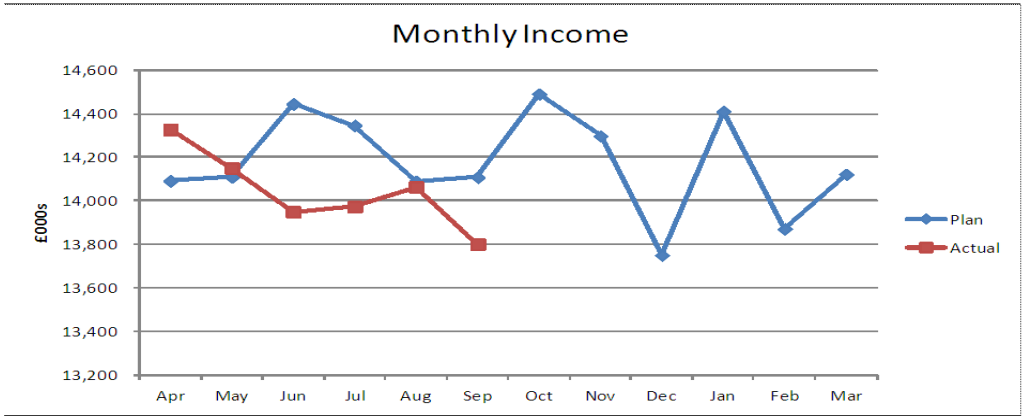
The NHS Isle of Wight CCG position to date includes £185k of contract penalties. The balance relates to contract variations that have yet to be agreed, but are offset by a corresponding balance in revenue reserves.

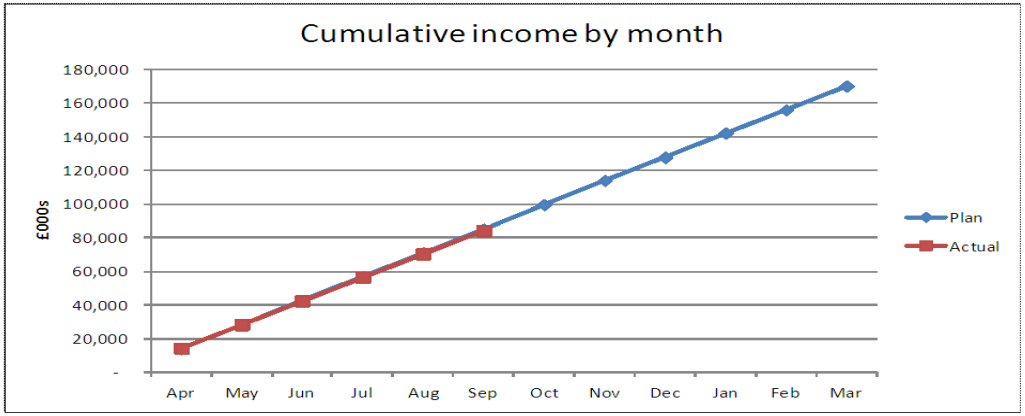
NHS England variance relates to under performance against contract on breast screening services and neonatal critical care. The year end position assumes an improvement in performance on these services.

Non contractual income has over recovered to date, but is expected to break even by year end as visitor numbers to the Island reduce over the winter months.

	Year to date		
Income	Plan £000s	Actual £000s	Variance £000s
NHS Isle of Wight CCG	67,376	65,683	(1,693)
NHS England	5,821	5,458	(364)
Isle of Wight Council	874	870	(4)
Commissioning Support Unit	178	178	(0)
Non Contractual Activity	750	930	180
Southampton University Hospitals FT	45	53	8
Income from Patient Care Activities	**75,044**	**73,170**	**(1,874)**
Other directorate income	10,118	11,094	976
TOTAL INCOME	**85,162**	**84,264**	**(898)**

	Full Year		
Income	Plan £000s	Forecast £000s	Variance £000s
NHS Isle of Wight CCG	134,985	133,601	(1,384)
NHS England	11,597	11,039	(558)
Isle of Wight Council	1,748	1,748	0
Commissioning Support Unit	355	355	0
Non Contractual Activity	1,500	1,500	0
Southampton University Hospitals FT	90	90	0
Income from Patient Care Activities	**150,276**	**148,334**	**(1,942)**
Other directorate income	19,803	21,632	1,829
TOTAL INCOME	**170,079**	**169,966**	**(113)**





Isle of Wight NHS Trust Board Performance Report 2014/15

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Directorate Performance

Isle of Wight NHS Trust

Hospital & Ambulance

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	4,614	4,860	246	939
Pay	(31,323)	(33,202)	(1,879)	(3,596)
Non Pay	(11,537)	(12,671)	(1,134)	(1,605)
TOTAL	**(38,245)**	**(41,012)**	**(2,767)**	**(4,262)**

Current being developed & commentary to follow in month 7

Community Health

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	2,071	2,102	31	91
Pay	(16,337)	(16,358)	(21)	(300)
Non Pay	(2,199)	(2,470)	(271)	(428)
TOTAL	**(16,465)**	**(16,726)**	**(261)**	**(636)**

Current being developed & commentary to follow in month 7

Corporate - Earl Mountbatten Hospice

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	1,010	1,288	278	277
Pay	(1,010)	(1,185)	(176)	(174)
Non Pay	(1)	(103)	(102)	(102)
TOTAL	**(1)**	**(1)**	**0**	**0**

Current being developed & commentary to follow in month 7

Corporate - Finance & Performance Management

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	112	110	(2)	(6)
Pay	(1,217)	(1,173)	44	605
Non Pay	(1,811)	(710)	1,102	2,157
TOTAL	**(2,916)**	**(1,773)**	**1,143**	**2,756**

Current being developed & commentary to follow in month 7

Corporate - Nursing & Workforce

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	505	638	133	(50)
Pay	(3,366)	(3,379)	(12)	(50)
Non Pay	(978)	(1,100)	(123)	66
TOTAL	**(3,838)**	**(3,840)**	**(2)**	**(34)**

Current being developed & commentary to follow in month 7

Corporate - Chief Operating Officer

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	44	54	9	(0)
Pay	(188)	(234)	(46)	(81)
Non Pay	(13)	(4)	9	20
TOTAL	**(156)**	**(184)**	**(28)**	**(61)**

Current being developed & commentary to follow in month 7

Corporate - Strategic & Commercial

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	1,694	1,959	265	560
Pay	(2,003)	(1,899)	104	233
Non Pay	(3,561)	(3,592)	(31)	(626)
TOTAL	**(3,869)**	**(3,532)**	**337**	**167**

Current being developed & commentary to follow in month 7

Corporate - Trust Administration

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	66	74	8	9
Pay	(871)	(843)	27	29
Non Pay	(1,729)	(1,700)	29	2
TOTAL	**(2,534)**	**(2,470)**	**64**	**40**

Current being developed & commentary to follow in month 7

Reserves

	Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	0	8	8	8
Pay	(1,706)	0	1,706	3,070
Non Pay	332	1,987	1,655	996
TOTAL	**(1,374)**	**1,996**	**3,370**	**4,075**

Current being developed & commentary to follow in month 7

The Trust is reporting an underspend against an expenditure budget ytd of £1.856m.
The forecast year end position is an underspend of £1.945m after adjusting for public dividend capital movements.

Hospital & Ambulance directorate is reporting an overspend of £2.767m. The full year forecast for the directorate is £4.262m, which includes a £1m spend reduction challenge.
The Trust forecast position offsets this by using reserves and over achievement of CIP in corporate directorate.

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Cash

The cash balance held at the end of September is considerably more than was planned and is due to:
i) the actual spend on capital being less than the planned spend in the first six months of the year
ii) the movement in working balances
iii) the reduced cost of depreciation

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Cash Balance	**5,228**	**8,078**	**2,850**

	Full Year		
	Plan £000s	Forecast Actual £000s	Variance £000s
Cash Balance	**5,407**	**10,320**	**4,913**

	Plan £000s	Year to date £000s	Variance £000s
Operating Surplus/(Deficit)	2,764	1,431	(1,333)
Depreciation and Amortisation	3,734	2,871	(863)
Donated Assets - non-cash	0	(50)	(50)
Interest Paid	(6)	(11)	(5)
Dividend (Paid)/Refunded	(1,650)	(1,650)	0
Movement in Inventories	0	98	98
Movement in Other Current Assets	0	0	0
Movement in Trade and Other Payables	(8,174)	(4,290)	3,884
Provisions Utilised	(250)	(225)	25
Movement in Non Cash Provisions	0	(198)	(198)
Cashflow from Operating Activities	**(3,582)**	**(4,118)**	**(536)**
Cashflow from Investing Activities	**0**	**0**	**0**
Closing Cash Balance	**5,228**	**8,078**	**2,850**

	Plan £000s	Full Year £000s	Variance £000s
Operating Surplus/(Deficit)	(223)	2,279	2,502
Depreciation and Amortisation	7,460	5,824	(1,636)
Donated Assets - non-cash	(100)	(100)	0
Interest Paid	(6)	(36)	(30)
Dividend (Paid)/Refunded	(3,299)	(3,299)	0
Movement in Inventories	250	472	222
Movement in Other Current Assets	0	0	0
Movement in Trade and Other Payables	(9,387)	(5,392)	3,995
Provisions Utilised	(466)	(711)	(245)
Movement in Non Cash Provisions	30	57	27
Cashflow from Operating Activities	**339**	**2,051**	**1,712**
Cashflow from Investing Activities	**0**	**0**	**0**
Closing Cash Balance	**5,407**	**10,320**	**4,913**

The cash balance held at the end of September amounted to £8,078k. This is considerably more than was planned and is largely attributable to actual spend on capital being less than the planned spend in the first six months of the year.

The forecast cash position is a positive variance on plan of £4.9m. The projected closing cash balance is £10.3m

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Statement of Financial Position

Isle of Wight NHS Trust

The Trust Balance Sheet is produced on a monthly basis, and reflects changes in asset values, as well as movements in liabilities.

	1st April 2014	Year to Date			
		Plan	Actual	Variance	Notes
	£k	£k	£k	£k	
Property, Plant and Equipment	97,613	93,468	95,208	1,740	
Intangible Assets	4,150	3,795	3,745	(50)	
Trade and Other Receivables	277	200	193	(7)	
Non Current Assets	**102,040**	**97,463**	**99,146**	**1,683**	
Inventories	2,200	1,978	2,102	124	
Trade and Other Receivables	6,930	8,177	10,346	2,169	
Cash and Cash Equivalents	13,358	5,228	8,078	2,850	
Sub Total Current Assets	22,488	15,383	20,526	5,143	
Non-Current Assets Held For Sale	0	0		0	
Current Assets	**22,488**	**15,383**	**20,526**	**5,143**	
Trade and Other Payables	(20,395)	(10,179)	(16,105)	(5,926)	
Provisions	(711)	0	(423)	(423)	
Liabilities arising from PFIs / Finance Leases	(48)	0	(5)	(5)	
Current Liabilities	**(21,154)**	**(10,179)**	**(16,533)**	**(6,354)**	
Provisions	0	(40)	0	40	
Non-Current Liabilities	**0**	**(40)**	**0**	**40**	
TOTAL ASSETS EMPLOYED	**103,374**	**102,627**	**103,139**	**512**	
FINANCED BY:					
Public Dividend Capital	6,762	6,762	6,762	0	
Retained Earnings Reserve	72,124	3,422	2,111	(1,311)	
Revaluation Reserve	24,488	21,251	25,623	4,372	
Other Reserves	0	71,192	68,643	(2,549)	
TOTAL TAXPAYERS EQUITY	**103,374**	**102,627**	**103,139**	**512**	

	Full Year			
	Plan	Actual	Variance	Notes
	£k	£k	£k	
Property, Plant and Equipment	88,794	98,133	9,339	
Intangible Assets	3,143	3,285	142	
Trade and Other Receivables	200	200	0	
Non Current Assets	**92,137**	**101,618**	**9,481**	
Inventories	1,728	1,728	0	
Trade and Other Receivables	8,177	7,000	(1,177)	
Cash and Cash Equivalents	5,407	10,320	4,913	
Sub Total Current Assets	15,312	19,048	3,736	
Non-Current Assets Held For Sale	0		0	
Current Assets	**15,312**	**19,048**	**3,736**	
Trade and Other Payables	(10,179)	(15,000)	(4,821)	
Provisions	(50)	(57)	(7)	
Liabilities arising from PFIs / Finance Leases	0	0	0	
Current Liabilities	**(10,229)**	**(15,057)**	**(4,828)**	
Provisions	0	0	0	
Non-Current Liabilities	0	0	0	
TOTAL ASSETS EMPLOYED	**97,220**	**105,609**	**8,389**	
FINANCED BY:				
Public Dividend Capital	6,762	6,762	0	
Retained Earnings Reserve	(1,327)	1,086	2,413	
Revaluation Reserve	20,868	25,623	4,755	
Other Reserves	70,917	72,138	1,221	
TOTAL TAXPAYERS EQUITY	**97,220**	**105,609**	**8,389**	

The non-current assets now reflect the net effect of the reduced values and depreciation following the District Valuer's review of plant, machinery and equipment. The increase in both receivables and payables, together with the movement in the I&E surplus, has had the effect of reducing the cash balance by c£2m from the figure reported last month.

At the planning stage the non-current asset values were based on an assumption that impairments of £2m would be applied to the assets at the end of 2013/14. In reality, when the District Valuer had completed the revaluation exercise at the end of 2013/14, asset values had increased by c£3m - a swing of £5m. Until the current time it has also been assumed that impairments of £5.3m would be applied to the current capital building programme in 2014/15. However, based on the latest forecast this has been reduced to £2.9m and therefore these two factors have contributed to the significant variance against plan.

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Capital

Isle of Wight NHS Trust

The total Capital Resource for this year was originally approved at £8.3M. This included property sales of £648k, but these are expected to be sold during 2015/16 bring the forecast expenditure to £7.7M for 2014/15.

Year to Date

	Plan	Actual	Variance
	£000s	£000s	£000s
Strategic Capital	3,782	1,051	(2,731)
Operational Capital	828	365	(463)
Total	**4,610**	**1,416**	**(3,194)**

Year End Forecast

	Plan	Forecast	Variance
	£000s	£000s	£000s
Strategic Capital	6,854	6,463	(391)
Operational Capital	1,464	1,226	(238)
Total	**8,318**	**7,689**	**(629)**

Strategic Capital schemes includes the larger capital projects. All schemes are progressing well and expected to complete within approved timescales, apart from Ryde Community Clinic. Additional funding has been bid for which will push the completion date of this project to the end of March. The ICU/CCU project has been paused, and the funding reallocated to bring the completion date of MAU Extension and Endoscopy Relocation projects forward. The RAG rating below reflect the position versus the revised capital plan.

Operational Capital - Bids for IM&T RRP and Equipment RRP are being prepared for discussion at Capital Investment Group in November.

All schemes are current RAG rated as Green because all are expected to be spent in the financial year as planned.

Strategic Capital	**Year to Date**			**Full Year**			**Risk**
	Plan	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**	**Rating**
Source of Funds	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	
Strategic Funds C/F			0			0	
External Funding			0			0	
Capital Investment Loans			0			0	
Operational Capital	3,782	3,782	0	6,854	6,854	0	
Donated Capital			0			0	
	3,782	**3,782**	**0**	**6,854**	**6,854**	**0**	
Application of Funds							
Strategic Capital Schemes							
MAU Extension	820	242	(578)	2,378	1,840	(538)	G
Ward Reconfiguration Level C	100	51	(49)	100	42	(58)	G
Ryde Community Clinic	1,203	77	(1,126)	1,203	1,280	77	G
Dementia Friendly		231	231		192	192	G
ISIS Further Faster	344	172	(172)	344	344	0	G
ICU/CCU	1,020	125	(895)	2,204	126	(2,078)	G
Endoscopy Relocation	295	123	(172)	625	2,259	1,634	G
St Helens Relocation		30	30		357	357	G
Carbon Energy Fund		0	0		24	24	G
	3,782	**1,051**	**(2,731)**	**6,854**	**6,463**	**(391)**	

Operational Capital	**Full Year**	**Year to Date**			**Full Year**			**Risk**
	Plan	**Approved**	**Actual**	**Variance**	**Approved**	**Forecast**	**Variance**	**Rating**
Source of Funds	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	
Depreciation	7,460	3,730	2,871	(859)	7,460	5,803	(1,657)	
Property Sales	0	0	0	0	0	0	0	
Donated Funds	100	50	50	0	100	100	0	
Other	110	55	0	(55)	110	110	0	
Transfer to Strategic Capital	(6,854)	(3,782)	(3,782)	0	(6,854)	(6,854)	0	
	816	**53**	**(861)**	**(914)**	**816**	**(841)**	**(1,657)**	
Application of Funds								
Operational Schemes								
Estates Schemes	320	320	218	(102)	320	301	(19)	G
IM&T RRP	156	156	27	(129)	156	156	0	G
Equipment RRP	500	250	23	(227)	500	469	(31)	G
Staff Capitalisation	200	102	97	(5)	200	200	0	G
Contingency/Unallocated	188	0	0	0	188	0	(188)	G
Donated Assets	100	0	0	0	100	100	0	G
	1,464	**828**	**365**	**(463)**	**1,464**	**1,226**	**(238)**	

NB - Please note the Year to Date and Full Year Plan figures are as per the original FIMS Return and not the revised Capital Plan

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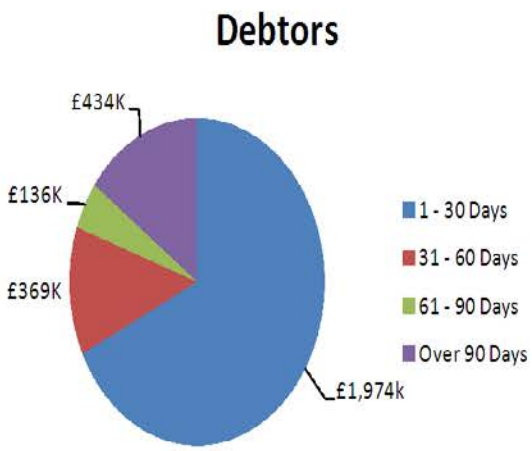
Debtors

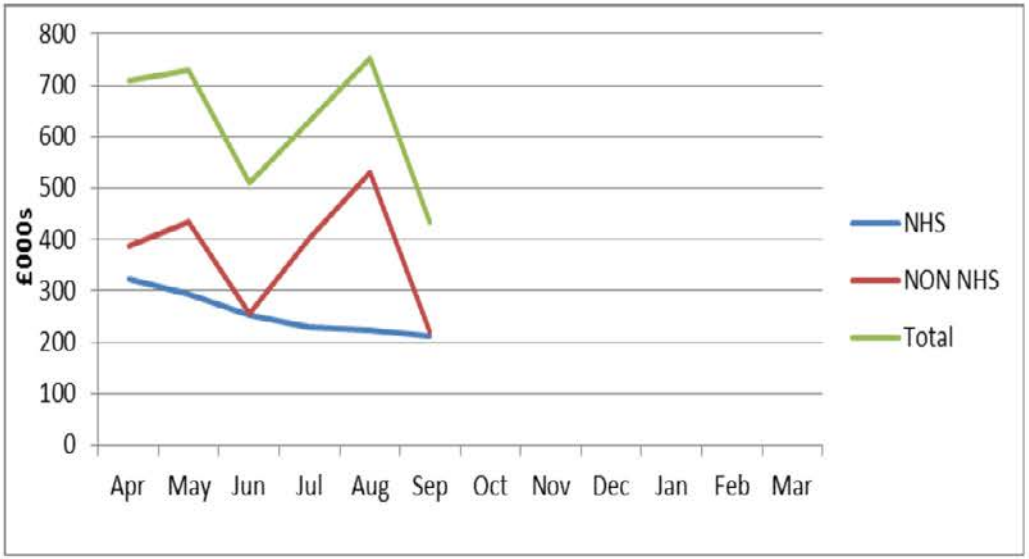
Isle of Wight NHS Trust

The Trust debtors are a combination of invoiced debtors, accrued income and prepayments as set out in the table below. This shows that the Trust has outstanding debtors over 30 days of more of £939k

Invoiced debtors	Within Terms	1 Month Overdue	2 Months Overdue	3 Months Overdue	Total	Current Month
	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days		Over 30 Days
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
CCGs	450	112	48	82	692	242
NHS England	2	0	0	3	5	3
Trusts	75	10	20	99	204	130
Foundation Trusts	111	51	28	28	218	108
Other NHS	193	2	0	0	195	2
Non NHS - Private Patie	73	25	30	50	178	105
Non NHS - Local Authority/Public Bodies	962	151	3	108	1,224	262
Non NHS - Other	108	18	6	65	196	88
Total	**1,974**	**369**	**136**	**434**	**2,914**	**939**
	68%	13%	5%	15%		
Provision for Bad Debts (including Injury Costs Recovery provision)					(429)	
Accrued Income					4,757	
Prepayments					1,865	
Other Debtors					1,432	
Total Trade and Other Receivables					**10,539**	



Total Debtors over 90 days



Accrued income and Other Debtors consists of VAT £233k, RTA £497k (11/12-13/14) plus accruals for invoices not yet raised.

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Better Payment Practice Code

Isle of Wight NHS Trust

The target is to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agree. Compliance is at least 95% of invoices paid (by the bank automated credit system or date and issue of a cheque) within thirty days or within agreed contract terms.

In Month

Supplier Classification	Invoice Count	Invoice Count	% Passed	BPPC Amount £000s	Invoice Amount (Passed) £000s	% Amount
NHS	**167**	**154**	**92.2%**	**1162**	**1062**	**91.4%**
NON-NHS OTHER	210	201	95.7%	204	190	93.2%
NON-NHS TRADE	2,687	2,618	97.4%	3789	3548	93.7%
TOTAL NON-NHS	**2,897**	**2,819**	**97.3%**	**3992**	**3738**	**93.6%**
IN-MONTH ALL	**3,064**	**2,973**	**97.0%**	**5,154**	**4,800**	**93.1%**

Year to Date

Supplier Classification	Invoice Count	Invoice Count	% Passed	BPPC Amount £000s	Invoice Amount (Passed) £000s	% Amount Passed
NHS	**888**	**772**	**86.9%**	**4,889**	**4,107**	**84.0%**
NON-NHS OTHER	1,297	1,227	94.6%	1,130	1,079	95.5%
NON-NHS TRADE	13,948	13,403	96.1%	24,668	23,821	96.6%
TOTAL NON-NHS	**15,245**	**14,630**	**96.0%**	**21,806**	**21,162**	**97.0%**
YTD ALL	**16,133**	**15,402**	**95.5%**	**26,695**	**25,269**	**94.7%**

Overall, the cumulative figures to September with regard to both the numbers and values processed are on target at 95%. There is an expectation that this can continue through to the year-end.

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MONITOR FINANCIAL RISK INDICATORS - Indicators of Forward Financial Risk

Isle of Wight NHS Trust

The indicators below have previously been identified by Monitor as indicators of forward financial risk against financial performance. Although new Monitor Risk Assessment Framework is now in place, the indicators below still provide a helpful indication of operational financial performance. The Trust will monitor performance against these as a helpful indicator of emerging risks in addition to the Continuity of Service Rating and delivery against the control total surplus.		YTD	Forecast
	Number of Indicators Breached	2	0

MONITOR FINANCIAL RISK INDICATORS	YTD RAG	Forecast Qtr RAG	Position	Explanation if Risk	Action if Risk
Unplanned decrease in EBITDA margin in two consecutive quarters	A	A	Marginal difference in Qtr 1 & Qtr 2 variance due to impairment recognition in advance of year end.		
Financial risk rating (FRR) may be less than 3 in the next 12 months	G	G	FRR rating replaced by CoSRR	Not applicable	Not applicable
FRR 2 for any one quarter	G	G	FRR rating replaced by CoSRR		
Working capital facility (WCF)Vused in previous quarter	G	G	No working capital facility	Not applicable	Not applicable
Debtors >90 days past due account for >5% of total debtor balances	G	G	Based on total debtors within the balance sheet		
Creditors >90 days past due account for >5% of total debtor balances	G	G	Based on total creditors within the balance sheet		
Two or more changes in Finance Director in a 12 month period	G	G		Not applicable	Not applicable
Interim Finance Director in place over more than one quarter-end	G	G		Not applicable	Not applicable
Quarter end cash balance <10 days of operation expenses	G	G	Currently the Trust holds approx. 17 days		
Capital expenditure <75% of plan for the year	A	A	Slippage against original plan	Capital plan reviewed monthly by CIG & expected to deliver to plan	
Any particular occurrences that could have an impact on the operation of the business of the Trust	G	G		No plans to undertake a major acquisition,	

	YTD RAG	Forecast Qtr RAG	IMPACT	MITIGATION	NEXT STEPS
Trust financial performance is on plan	G	G			
Trust financial performance is on plan and the focus is now on ensuring the delivery of the CIP programme.	A	A	Potential carried forward of recurrent CIP	Review of CIP plans underway	

Month 06 - Risk Rating:

The Trust is currently reporting a Continuity of Service Rating (CoSR) of '4' which is consistent with the operational plan. Additionally the expected out-turn rating is also 4.

Year To Date	Plan Rating	Actual Rating
Liquidity Ratio	4	4
Capital Servicing Capacity Ratio	4	4
Weighted Average Rating	**4**	**4**

Financial Criteria	Weight %		Metric to be scored	Definition	Rating categories 4	3	2	1
Liquidity Ratio	1	50%	Liquid Ratio (days)	Working capital balance x 360 / Annual operating expenses	0.0	-7.0	-14.0	<-14
Capital Servicing Capacity Ratio	1	50%	Capital servicing capacity (time)	Revenue available for capital service / Annual debt service	2.5x	1.75x	1.25x	<1.25x

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	No	The national funding scheme for Trusts to undertake additional activity to reduce waiting lists, in particular those patients waiting longer than 18wks, has been extended till the end of November, therefore, performance against the admitted and non-admitted targets continues to under perform as planned. We are predicting this will continue for October and November as we continue to treat those patients with long waits alongside patients requiring urgent and cancer fastrack treatment. Our performance against the incomplete target improved for September following significant improvements on pathway management and in particular, validation of all pathways.
	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	No	
	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	Yes	No	
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	Yes	Yes	No	Yes	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	Yes	No	0.5 colorectal breach (breach shared with Portsmouth) - Complex diagnostic pathway and patient choice to defer surgery
			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	No	No	2 x Skin breaches:- 1 Excisional biopsy not booked as fast track, 1 No consultant available to perform excisional biopsy
			anti-cancer drug treatments	98%									
			radiotherapy	94%									
	7	All cancers: 31-day wait from diagnosis to first treatment		96%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	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	Yes	No	11 breaches in total - 4 patient led and 7 due to capacity issues, 86.6% compliance which is an improvement from previous months
			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	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	Yes	
	11	Meeting commitment to serve new psychosis cases by early intervention teams		95%	1.0	Yes	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	Yes	No	August Red 1 achievement 72.5%, Red 2 achievement 72.2%. 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
			Red 2 calls	75%	1.0	Yes	Yes	Yes	Yes	No	Yes	No	
	13	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	Yes	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	Yes	One new case in September led to a YTD total of 6, above the local stretched target of 4 and level with the national threshold. Trust remains under the de minimus level of 12 - no score for this indicator because of this.
			Is the Trust below the YTD ceiling	3		Yes	Yes	No	No	No	No	No	
	16	Minimising mental health delayed transfers of care		≤7.5%	1.0	Yes	No	No	Yes	Yes	No	No	
	17	Mental health data completeness: identifiers		97%	1.0	Yes	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	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	Yes	tbc
	20	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	tbc
			Referral information	50%									
			Treatment activity information	50%									
		TOTAL				**1.0**	**5.0**	**6.0**	**3.0**	**6.0**	**4.0**	**9.0**	
						AG	R	R	AR	R	R	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: 29 OCTOBER 2014

QUALITY & CLINICAL PERFORMANCE COMMITTEE
Wednesday 22 October 2014

Present:	Nina Moorman	Non Executive Director (Chair)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Sarah Gladdish	Clinical Director, Community & Mental Health Directorate (CDC)
	Sabeena Allahdin	Clinical Director – Hospital & Ambulance Directorate (CDHAD)
	Deborah Matthews	Lead for Patient Safety, Experience and Clinical Effectiveness (LSEE)
	Jessamy Baird	Designate Non Executive Director (JB)
In Attendance:	Brian Johnston	Head of Corporate Governance & Risk Management (HOCG)
	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM)
	Chris Orchin	Non-Executive Director (Governance and Compliance) Healthwatch IW (HIW)
	Ian Bast	Patient Representative (PR)
	Katie Gray	Executive Director of Transformation and Integration (EDTI) - *for item 14/346*
	Emily Macnaughton	Consultant Microbiologist (CM) – *for item 14/355*
	Jenny Johnston	Clinical Lead for Health Visiting & School Nursing (CL) – *for item 14/356*
	Andy Shorkey	Business Planning and Foundation Trust Programme Management Officer (BPFTMO), *for item 14/359*
Minuted by:	Amanda Garner	Personal Assistant to EDNW (PA)

Key Points from Minutes to be reported to the Trust Board

1. ISIS rollout plan. Clinical engagement and compatibility with PARIS.
2. Monitoring of Quality Improvement Plan (QIP)
3. Lessons learnt from incidents and sharing with the trust.
4. Risk to RTT and quality of patient care. Its link to the Current Capital Improvement Plan.
5. TDA Self Certification approved with caveat around statements 13 and 14.

Minute No.

14/341 APOLOGIES FOR ABSENCE

Sue Wadsworth, Non Executive Director (SW), Mark Pugh, Executive Medical Director (EMD), and Vanessa Flower, Patient Experience Lead (PEL).

14/342 CONFIRMATION OF QUORACY

The Chair confirmed the meeting was quorate.

14/343 DECLARATIONS OF INTEREST

HIW advised that he was now a member of the Healing Arts Management Committee.

14/344 MINUTES OF THE LAST MEETING – 17 September 2014

The minutes of the meeting held on 17 September 2014 were agreed as a true record.

14/345 REVIEW OF ACTION TRACKER

The Committee reviewed the Action Tracker. The Chair highlighted that there were five actions that were "open" that were overdue. The Committee agreed that these were completed as part of other actions. The Chair asked that a brief note be send to the PA to confirm that this was the case. The EDNW added that he would review these actions with the PA.

***Action Note**: EDNW to review action tracker with PA.*

Action by EDNW

The Chair advised that group that the Mental Health Service Users Involvement Policy had been approved. JB expressed concern that the policy highlighted payment rather than it highlighting that being involved was a good thing to do. The EDNW advised that changes had been made to the Policy regarding this and that he would send a copy to JB for her to review. JB advised that she would take this to the next meeting of the Mental Health Act Scrutiny Committee.

***Action Note**: EDNW to send JB copy of Mental Health Service Users Involvement Policy.*

Action by EDNW

14/346 ISIS Roll Out Plan

The EDTI advised that she was attending the meeting following a request at a previous Committee meeting for her to attend and update the Committee on the ISIS Roll Out Plan. The EDTI advised that she had reviewed the minutes of the meeting and had identified that the Committee had concerns regarding MediTrax and the Patient Status at a Glance (PSAG) boards. The EDTI advised that MediTrax is a device for the recording of patient observations and confirmed that roll out has been delayed due to changes being requested and these nursing led changes needed to be tested.

The EDTI advised that regarding the PSAG boards that there were concerns about data protection and misleading information being displayed ie expected and actual discharge dates. The EDTI advised that she had spoken with nurses regarding the boards and the message is that they do not feel the current configuration meets the needs of the clinical teams. Work is required regarding this.

The EDTI advised that she had reviewed the ISIS roll out plan and it is evident that there had not been enough clinical engagement and that the actual roll out sequence needs work. The Chair advised that she was pleased that the programme is being reviewed and she shared the same concerns. The Committee discussed the information on the Boards and the CDC advised that what is displayed on them is what is in the system and that there is obviously a training issue. She added that the system is much better than the previous system. The EDTI advised that the Project Manager had identified how much better this system is. SG added that practice needs to change especially around inputting discharge dates. The EDNW advised that governance wise the system is much tighter ie all patients are recorded on the system however added that it is not built around clinical pathways and it needs to be made clinically suitable. JB enquired if MEWS (Modified Early Warning Score) and intentional rounding were included in MediTrax. The EDNW advised that MEWS is included and if a patient has a raised score then the pad that the doctor has is updated so that they are aware. The EDNW added that there are potential benefits for using the system. The EDNW advised that regarding intentional rounding the Trust had been assured that this could be added in addition pressure ulcers, MRSA could also be added. There should be an alert mechanism which would update the PSAG board.

The Committee discussed patients' names being displayed on the boards and also the position of the boards. The Chair advised that appropriate positioning of the boards may improve their use. JB added that when there had been a Board Assurance Visit that they were in the way of visitors when they had been viewing the board on one of the wards. The EDNW advised that each scheme should have a clinical reference group and the

Committee agreed.

The Committee discussed the Paris system which is a separate system. The EDTI advised that Allied Health Professionals are treating patients on the wards and when they are working on the wards they update the written case notes and also updating their own notes on Paris. She added that when paper case notes are eventually moved to ISIS there will be two systems running and a decision will have to be made about this. HIW agreed that duplication was not good practice. The Committee discussed how the Paris system and ISIS could integrate. KG added that staff will be able to launch Paris via ISIS.

NM advised that clinical engagement is important. The EDTI agreed and added that the user groups could be giving input. The CDHA agreed that clinical engagement is required with regards to what is wanted and how it is going to be done she added that a clinical lead is needed. The Committee discussed allowing consultants PA time to be involved. The CDC advised that it was important that all clinical staff understand what needs to be input onto the system. The EDNW advised that he now had concerns regarding Paris linking with ISIS. The EDTI suggested that she and the EDNW discussed this further offline.
***Action Note**: The EDTI and the EDNW to meet separately to discuss Paris linking with ISIS*
Action by EDTI

JB advised that the actions from this discussion were for timelines on clinical engagement forum; for QCPC to recommend to Board regarding the commitment and for assurance regarding data being input in the correct way. The Chair advised that there needed to be an agreement on when case notes will cease to be on paper. The EDTI advised that this will be in 2015.

QUALITY

14/347 QUALITY REPORT

The LSEE advised that the first two summary pages of the Quality Report were covered in the SEE Committee Report. The Committee agreed to move on to the SEE Committee Report.

14/348 REPORT FROM PATIENT SAFETY, EXPERIENCE AND EFFECTIVENESS (SEE) COMMITTEE

The LSEE advised that the first meeting had taken place on 15 October 2014 when the Quality Report had been reviewed and a number of concerns had been highlighted.

The LSEE advised that one of the concerns was that there had been a further case of C.difficile which had been reviewed in depth. The LSEE advised that the meeting had been extremely constructive and that plan going forward was to go back and review all the cases to identify learning. The LSEE advised that the issues identified had been identified before ie risk assessment form which she added will be reintroduced. The Chair asked how lessons learned are shared and the LSEE advised that they are shared with the physicians.

The EDNW added that all other Trusts in the region, with the exception of six, were over their trajectory already for the year. The EDNW explained how the trajectories for trusts is set and that this was dependent upon the results for the previous year. The CDHA advised that although there were clinicians at the meeting and it appeared that there was clinical engagement what have clinicians learned from this. She added that frontline staff should have ownership. The EDNW asked how quickly guidance is shared with teams and key lessons. He added that as clinical lead for SEE, Dr Sandya Theminimulle, should lead on communications to lead clinicians. The CDHA advised that Medicine for Members meetings are very useful and all departments should have them. She suggested that this Committee ask for assurance regarding this. The Committee discussed mandatory training. The EDNW advised that he would discuss information sharing with junior doctors with Dr Oliver Cramer, Associate Director of Medical Education. The Chair advised that it was clear that the Committee was not assured regarding lessons learned sharing.

The LSEE highlighted falls prevention and advised that the directorate were to action.

The LSEE also highlighted pressure ulcers and an increase in the number of pressure ulcers in the community. She advised that a review on how to progress this would be completed.

The Committee discussed how the SEE Committee will get assurance. DM advised that the Quality Managers and Head of Clinical Services are members and will be fed back to their own directorate meetings. The CDC advised that checks need to be in place. The SEEBM added that the directorates will be required to provide evidence regarding the actions that are being undertaken.

JB advised that she had had experience of teams reviewing feedback received from patients and this being cascaded up to Board. She suggested that this be implemented and suggested that all areas report on the feedback received. The Committee discussed this and agreed that it was important to collect meaningful information. The EDNW advised that a review of what is collected now is required and suggested that the Patient Experience Lead review this. The CDC added that it was important that the Trust got down to service level regarding what can be improved upon. JB advised that core questions could be asked regarding basic care ie did the staff member introduce themselves, was there a discussion around care, was care decent.

The Chair suggested that the Committee follow this up with the Patient Experience Lead and feedback to the Board regarding the gap.

***Action Note**: EDNW to discuss review of surveys and questionnaires with the Patient Experience Lead.*

Action by EDNW

14/349 QUALITY IMPROVEMENT PLAN

The LSEE reported that following the Care Quality Commission's (CQC) inspection and visit to the Trust in June 2014 a number of compliance, enforcement and "must do actions", "should do actions" have been identified. The LSEE advised that the Quality Improvement Plan (QIP) is a high level summary of the detail within an underpinning Action Plan. The LSEE added that the following key themes had been identified:

1. Clinical Leadership, Staff Engagement and Culture
2. Governance
3. End of Life Care
4. Recruitment and Retention
5. Patient Caseload/Flow

The LSEE advised that there are regular weekly meetings to review the actions and progress and also to review how departments are working together. The LSEE advised that the Trust has until 12 December 2014 to response to the Warning Notice issued by the CQC and the Trust is on target to meet this although it will be very challenging.

The EDNW advised that from a governance point of view the Trust had heard back from all its partners and that there will be a Confirm and Challenge meeting with Stakeholders. He added that there will be a Health and Partner Action Plan as a result of this.

The CDHA advised that clinical leadership underpins everything and updated the Committee regarding a meeting that she had recently attended with the clinicians. She added that it is culture that matters and it is important how this is being monitored and encouraged further. The Chair asked how this Committee would be assured. The EDNW reported that the Local Authority Overview and Scrutiny Committee along with stakeholders, commissioners, the local authority and Healthwatch. The Chair suggested that the outcome of these meetings is fed back to this Committee. JB suggested that the Research Team are engaged to do a small study of change over time from a staff perspective. The Committee discussed this and agreed that there were a number of ways to do this ie staff survey and service evaluation. The Chair confirmed that she would like to hear feedback from the Confirm & Challenge Meetings. The Committee discussed getting feedback from the

consultant body and agreed that HMSC was not representative of all consultants. The Committee agreed that feedback from lead clinicians would be useful. The Chair advised that it would be helpful to identify outstanding areas ie four star service. The EDNW advised that there was no finite plan and agreed that the Trust had not yet described the success criteria. The CDC agreed that some areas are doing really well and added that it was important that the whole pathway was recognised ie those feeding into services.

1. The LSEE needs to confirm the key success factors and evidence. Assurance on the delivery of these needs to be fed into the QCPC monthly.

Action: LSEE

2. The Medical Director needs to confirm the breadth and depth of Medical Engagement in the QIA providing evidence of Medical Leadership.

Action: EMD / CD's

3. The EDNW needs to provide the QCPC a monthly update on the actions arising out of the Confirm and Challenge meetings.

Action: EDNW

REPORTS FROM DIRECTORATES

14/350 HOSPITAL AND AMBULANCE DIRECTORATE

The CDHA advised that patient flow is a concern especially related to the Referral to Treatment (RTT) targets and added that the refurbishment of some of the hospital had been very disruptive. JB added that when Estates are planning such work that full clinical engagement is needed.

The CDHA updated the Committee on the KM&T project. The EDNW advised that this is to provide project support to medical staff in order for them to lead on the main projects. The EDNW advised that there are two key areas which are support with the governance structure and how the trust is managing and monitoring risks. The EDNW updated the Committee regarding one area where the clinical leader was absent due to long term sick leave and how this had had a negative effect. The EDNW advised that the Trust needed to have greater resilience for such events and the formalising of roles as part of safer staffing will help to achieve this. The EDNW added that there will be a review of sustainability planning over the coming months.

14/351 COMMUNITY AND MENTAL HEALTH DIRECTORATE

The CDC advised that the September 2014 Directorate Quality, Risk & Patient Safety Committee had been cancelled as it was not quorate and the October 2014 meeting had not taken place yet. The Committee discussed quoracy of meetings and agreed that meeting do not have to be quorate to take place. The CDC agreed and advised that she would review this. The Chair advised that she would raise this as a query with the Company Secretary.

***Action Note**: The Chair to discuss quoracy of meetings with the Company Secretary.*

Action by Chair

The Committee noted that the Directorates Training Compliance was at 87% and agreed that, although they recognised the work being put in to achieve this, it could be improved further. JB rasied the concern that if staff are not up to date with their mandatory training where are they with their other important training that is not mandatory. The LSEE advised that there is a Mandatory Training Group who are looking at key concerns. The Committee discussed mandatory training and the HOCG pointed out that they had been a lot of changes including moving training to e-learning which had increased take up.

The EDNW advised that the recent Governance and Clinical Risk Review recommendations and framework will help. The EDNW suggested that the report used CQC terms ie good or requires improvement rather than "assurance adequate". The EDNW advised that it was

important how key risk are monitored and managed. The Committee agreed that it was important to get front line staff to understand what their contribution to QIP is.

The CDC asked if it would be helpful for the Committee to know how many meetings had taken place in the Directorate, who has attended and what lessons have been shared. The Chair advised that SW had highlighted this previously and to just know that a meeting had taken place was not helpful however the Committee would like to hear about patient safety, effectiveness and experience. The EDNW advised that there is a need to be more prescriptive regarding the expectations, what is being done well and how risks are managed and monitored. The Chair advised that Audit & Corporate Risk Committee want to know about clinical risks. JB advised that it would be useful to have feedback on such things as 30 day readmissions and how well the Trust is engaging with the community ie GPs and nursing homes.

The SEE team will reconfirm the process for reporting of Clinical Governance in the Trust.

Action: SEE Triumvirate.

The Committee had a short break during which JB congratulated the team on reducing the number of papers presented to the Committee to a more manageable level.

PATIENT SAFETY

14/352 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – ON LINE AND IN PROGRESS

The LSEE advised the Committee that during September 2014 that there had been 9 SIRIs, 8 of which related to pressure ulcers. The LSEE advised that work is being done with the directorates to clear the backlog and this includes revising the process.

The EDNW advised that the Clinical Commissioning Group (CCG) had written to the Trust to raise concerns regarding the SIRI process and updated the Committee regarding this.

The LSEE advised that the Trust is trialling a new way of reviewing pressure ulcer incidents and this included a panel review. She reported that a panel review had taken place recently of three pressure ulcers and that there had been a greater understanding of what could have been done differently or earlier. The LSEE added that members of the teams had been in attendance and there had been a lot of learning shared.

The LSEE advised the Committee of the revised process and advised that the aim is to have all SIRIs completed and submitted to the Commissioners within the 45 day target. The CDHA advised that she was very supportive of this new process especially regarding the actions being fed back.

JB advised that all of the SIRIs submitted to the Committee at this meeting had elements of documentation issues within them and this is why it was so important for staff to report effectively as not doing so often leads to a direct clinical impact. The LSEE agreed and advised that there is a Policy and Documentation Group. The EDNW advised that it is about establishing standards and added that the software that the EDTI had described earlier in the meeting will help with this. The EDNW added that during the Back to Floor day that he has each month that the team review and audit patient health records.

The LSEE needs to provide future assurance on how Documentation will be Monitored and Managed as part of the lessons learned from SIRI's.

Action: LSEE

14/353 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – TO BE SIGNED OFF

The Committee discussed the following SIRIs

Acute
2014/6244 – The Committee approved sign off.
2014/18865 – The QCPC were not assured on the full investigation of this SIRI. The

Committee asked for further clarity on this SIRI as some elements were not clear. Sign off was not approved.

Planned
2013/12098 – The Committee approved sign off.

14/354 CLINICAL NEGLIGENCE CLAIMS RECEIVED – QUARTERLY REPORT

The HOCG presented the Quarterly Clinical Negligence Claims Report to the Committee and highlighted that there had been 8 new claims during the quarter from July to September 2014. He added that the new claims to incidents ratio was good and advised that 11 claims had been discontinued. The Committee noted the claims that had recently been settled.

14/355 INFECTION PREVENTION & CONTROL – QUARTERLY REPORT

The CM presented the Quarterly Infection Control Report to the Committee and highlighted that the Trust had had 2 further C.difficile cases during the Quarter July 2014 to September 2014. She added that the 2 cases related to the same patient who had relapsed and that any further cases would take the Trust over its target.

The CM advised that there are gaps in documentation and that Infection Control are assessing staff's compliance with the required documentation. The CM updated the Committee on the trialling of the use of a new stool chart.

The CM advised that there had been 1 Trust acquired case of E.coli and that this related to IV access. A business case to provide enhanced IV services is being submitted.

The CM reported that there are cases of viral gastroenteritis in the community. The Committee discussed this including whether visiting times should be reduced now or if there is anything else that can be done to reduce the risk to the Trust. It was agreed that communications could be improved including improving hand hygiene signs at the door.

Action: Communication Department

The CM advised that the Viral Haemorrhagic Fevers Policy will be updated again and measures and plans are in place. An assessment of the Trust preparedness is currently underway.

14/356 ANNUAL CHILD SAFEGUARDING REPORT

The CL presented the IOW NHS Trust Safeguarding and Looked After Children Annual Report to the Committee. She advised that this was a requirement of Section 11 of the Children's Act. The CL advised that the period covered by the report (1 April 2013 to 31 March 2014) had been a challenging time. She added that the CQC inspection had identified that procedures were good. The CL reported that the Trust had just had a 4 week Ofsted inspection and that the report was due on 18 November 2014.

The Chair advised that the report was very comprehensive and readable. The Committee noted that the CL will be retiring at the end of 2014 and commended her and her team on their work.

PATIENT EXPERIENCE

14/357 PATIENT STORY

The Committee viewed a video recording of a patient giving feedback on the care that had been received. The patient commended the Tissue Viability Team and also highlighted the number of times that they had been moved from ward to ward. The Committee discussed this and agreed that the moves may have been appropriate however could have probably been better communicated to the patient. The Committee agreed that the style of interviewing needed to improve with open questions.

CLINICAL AUDIT AND GOVERNANCE

14/358 CLINCIAL AUDIT PROGAMME – QUARTERLY REPORT

The SEEBM presented the Quarterly Update on the Clinical Audit Programme to the Committee. The Chair advised that it was difficult to gain assurance and would like to see that each service business unit is undertaking audits. The SEEBM advised that the full Clinical Audit Programme can be found on the intranet.

http://intranet/index.asp?record=2969

The Committee discussed audits and suggested a 6 monthly detailed review be carried out. It was agreed that the audits need to be valuable. The Chair added that the Audit and Corporate Risk Committee is interested in follow up audits.

CLINICAL PERFORMANCE AND RISK

14/359 TDA SELF CERTIFICATION

The BPFTPMO advised the Committee that there was no change to the status ratings with Board Statements 1, 2, 6 and 14 remaining "at risk" following the CQC visit. He advised that Board Statement 10 has been adjusted whilst also remaining "at risk". He advised that the Governance Risk Rating was at 9 and this measures the spread of non compliance across the quarter. The Committee discussed Board statements 13 and 14 and JB suggested that if 14 is at risk that 13 could also be considered at risk.

The BPFTPMO advised that the Licence Conditions were all still complaint however condition 7 could be at risk if the CQC action plan is not delivered to the satisfaction of the CQC.

The Committee approved the TDA Self Certification with the recommendation to Board to consider compliance on Board Statements 13 and 14.

14/360 MINUTES OF COMMITTEES AND WORKING GROUPS

The Committee received the minutes from the Joint Adult and Child Safeguarding Steering Group meeting held on 25 September 2014 and the Infection Prevention and Control Committee (IPCC) meeting held on 11 September 2014.

14/361 ANY OTHER BUSINESS

There were no any other business items discussed.

14/362 DATE OF NEXT MEETING

Wednesday 19 November 2014
9 am to 12 Noon
Conference Room

Signed: _____ Chair

Date: _____

Isle of Wight NHS
NHS Trust

For Presentation to Trust Board on 29th 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 22nd October 2014 in the Large Meeting Room.

PRESENT:	Charles Rogers	Non-Executive Director (Chair) (CR)
	Jane Tabor	Non-Executive Director (JT)
	Chris Palmer	Executive Director of Finance (EDOF)
	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)
	Mark Elmore	Deputy Director of Workforce (DDW)
In Attendance:	Stewart Churchward	Workforce Planning and Information Manager (WPIM) *(Item 14/165a)*
	Abolfazl Abdi	Assistant Director of Contracting (ADC) *(Item 14/164a & b)*
	Iain Hendey	Deputy Director of Informatics (DDOI) *(Items 14/164c, 14/167c & 14/169a)*
	Andrew Shorkey	Business Planning and Foundation Trust Programme Manager (BP&FT) *(Item 14/171)*
	Gary Edgson	Head of Financial Management (HFM)
Minuted by:	Sarah Booker	PA to Executive Director of Finance (PA-EDOF)
Observed by:	Mark Price	Company Secretary (CS) *(Item 14/169b)*

To be Received at the Trust Board meeting on Wednesday 29th October 2014
Key Points from Minutes to be reported to the Trust Board

14/165c **Culture, Health & Wellbeing Meeting Governance**
The Committee was concerned about the lack of progress against particular actions rising from last year's Staff Survey and the lack of visible plan and assurance around it.

14/167a **CIPs.**
The Trust is reporting CIP achievement of £5.036m against a target of £3.749m. This is c. £1.287m ahead of plan. Although, this is after £1.9m of future banking. This recognises the full budget removal of achieving CIP plans in advance of the original schemes phasing.

14/167d **Plant, Equipment and Machinery Asset Revalidation**
During the month a revaluation of the non-property asset was calculated by the District Valuers Office. This valuation resulted in an adjustment of £1.4m to the asset value and a resulting downward charge of depreciation by £1.3m.

14/171 **Self Certification.**
Sufficient assurance has been provided for the committee to recommend that Trust Board approve the Self Certification returns as proposed.

14/158 APOLOGIES

Apologies for absence were received from David King, Non-Executive Director (DK).

14/159 CONFIRMATION OF QUORACY

The Chairman confirmed that the meeting was quorate.

14/160 DECLARATIONS OF INTEREST

There were no declarations.

14/161 APPROVAL OF MINUTES

The minutes of the meeting held on the 17th September 2014 were agreed by the Committee and signed by the Chairman.

14/162 SCHEDULE OF ACTIONS

The Committee received the schedule of actions taken from the previous meeting on 17th September and noted the following:

A number of actions were closed.

- 14/099
- 14/109a
- 14/110e
- 14/113a
- 14/149a
- 14/150b

14/098 Trading Accounts – action to be split – HOCD will provide an update on NHS Creative in January 2015 and the EDTI will monitor the Mottistone action.
14/109e OD Strategy – the Chief Executive will decide where Organisational Development will sit and will agree the process to gain assurance. December FIIWC meeting.
14/127a Workforce Performance Report – the information has still not been received. November FIIWC meeting.
14/127c Staff Survey Action Plan - the Chief Executive will decide where Organisational Development will sit and will agree the process to gain assurance. December FIIWC meeting.
14/127c Drug and Alcohol Policy – to be included on the November FIIWC agenda.
14/128b Level C work – a formal update to be received from the EDNW and the Associate Director for the Hospital and Ambulance Directorates (ADHAD) to include reasons for and costs and the delay.
14/129b Private Patient Policy to be included on the November FIIWC agenda.

14/163 LONG TERM STRATEGY AND PLANNING

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

The DDOF noted there is a new planning timetable for the LTFM and we are not expecting to refresh until later in the year. The Trust Development Authority (TDA) will be attending the Board Seminar in November to present an example of a good downside mitigation model and there will be follow up workshops for the Non-Executive Directors and Executive Directors. The DDW asked whether other staff who input information into the LTFM can attend the Board Seminar.

The Operating Plan timetable takes into account all of the key steps and the key dates for the submission and the sign off. CR questioned whether the Trust is on track with the LTFM submission. The DDOF said we are in the early stages still and the services are currently required to submit the business plans although engagement from some services is an issue. JT commented on how complex the process is and asked whether we have taken a step back to see how this could be more streamlined. The DDOF noted this is the streamlined version.

14/164 CONTRACTS AND ACTIVITY

(a) Contract Status Report Summary:

The ADC presented the Contracts Status Report and highlighted the following Commissioning intentions and updates:

- Integration of Community and Mental Health services.
- Transformation of Health and Social Care in line with the Better Care Fund.
- Discussed outcome based and pathway based contract and the Commissioners would like to explore alliance contracting.
- NHS England – best value excluded high cost drugs. The ADC noted this should not be an issue as our prices are below the national average.
- Core commissioning with the Commissioners.
- NHS England introduced the concept of the National Prioritisation Framework in terms of service development. It will be released in December 2014 for ratification in January 2015.

JT queried the variance amount in the 'not yet in the contract' on the Service Line Agreement (SLA) slide and how much of a risk that is. The ADC explained it is a negative variance but there is no risk as the expected income reduction is equally offset by expected expenditure reduction.

(b) Contracting Timetable:

The ADC briefed the Committee on the timetable and explained that internal workshops were held by the Contracting team with stakeholders and they looked at what went well last year, what to improve on and the national 2015/16 implications. Once this timetable has been approved it will be adhered to. The sign off process will be in February 2015 and a Trust Board meeting will be scheduled to allow sign off contracts. This is included in this

timetable to take place on the 25th February 2015. The ADC noted there are no major differences to the timetable last year and everything is currently on track.

The EDOF noted achievement against this timetable can now be reported to this Committee by exception in the same way the financial year end timetable is reported to this Committee once approved.

The EDNW would like to have dedicated time with the Commissioners to be clear about the timeline of delivery of the Quality Improvement Plan.
Action: The ADC will include a line in the timetable to capture the need to formally liaise with Commissioners in how to resource actions from the Care Quality Commission (CQC) review which are gathered in the Quality Improvement Plan.

(c) <u>Operational Performance including SLA Activity:</u>

The DDOI presented the report to the Committee and noted the following:

- Planned Care – current position for Month 5 is £538k below plan which is an increase of £230k from Month 4.
    - Elective activity has moved a further £45k below plan in month.
    - There has been significant under performance in Trauma and Orthopaedics with 102 spells and £440k; Surgery with 57 spells and £65k and Gynaecology with 23 spells and £48k.

JT asked what the root cause of this is and whether plans are in place to take this forward. The EDNW said this is being closely monitored every day. The backlog is being cleared but the delays can be multi factorial, for example, staff sickness, departments losing key members of staff and demands being placed on us non-electively. The position is still fragile but the plans in place are more sustainable.

Action: The EDNW is involved in the weekly Executive challenge meetings and will report back to this Committee in November with a detailed plan of why this has happened and how to move this forward.

The EDOF noted the Performance and Information Decision Support team are requesting compliance confirmation from the Commissioners against the QIPP plan to reduce footfall into Accident and Emergency.

The DDOI explained the Key Performance Indicators and the penalties for Month 5 and noted the Trust planned to fail the 18 week target in August, September, October and November and therefore the Governance Risk Rating position will improve in December. The Commissioners confirmed the Trust will not be fined during this time and the total year-to-date penalties have been reduced to £29,485k for this element.

Action: Narrative to be included to show projection on charts. DDOI

(d) <u>VAT Contract Update:</u>

The DDOF informed the Committee that the Trust is in negotiations with Portsmouth for a combined tender process and hope to go out to tender

soon.

14/165 WORKFORCE PERFORMANCE REPORT

(a) Workforce Performance Report including SBS Payroll Report:

The DDW presented the revised report and pointed out that a meeting was held this morning which included some Committee members and the report will be amended as discussed. The Committee recognised the benefits of this new style of reporting and the huge amount of work which had been undertaken by the team.

The DDW noted there has been a rise in sickness this month which is in trend with past years but the Workforce team will be investigating the reasons for the absences and which areas they occur in. There has also been an increase in bank and agency spend and further analysis will show where this is occurring. The DDW noted the word 'vacancy' is used in the wrong context in the report and will be changed as discussed during the earlier meeting.

JT commented that the root cause is an issue with recruitment. The WPIM will include further information in the slides next month detailing priorities and actions to be taken. Action: WPIM.

The EDOF said the new style of reporting provides more assurance for this Committee but the Trust Executive Committee will require more insight.

CR questioned why there is no sickness data for Medics. The DDW said there is data but it is not held in the same place as other data and that a member of the Workforce team will be recording this data onto MAPs in the future. **Action: DDW to provide this information at the December FIIWC meeting.**

JT queried why there is an increase in the number of full time staff when the number of bank and agency staff are not reducing. The DDW said the Workforce team will be investigating this further. Action: DDW.

The EDOF suggested the report should include sickness absence in different areas and highlight the alignment between the Culture, Health and Wellbeing Group and how staff can be supported. Action: WPIM to include this information into the next report.

The DDW noted the numbers of staff unavailable to work on both Union strike days and the only delay caused by this which was a one hour delay in an antenatal clinic.

(b) Workforce Strategy including KPIs:

The DDW said work is currently being carried out to look into the Key Performance Indicators and the Committee agreed this can be brought the November meeting. **Action: PA-EDOF to include on November agenda.**

(c) Culture, Health and Wellbeing Meeting Governance:

The EDOF noted the report has been received and the Executives will discuss this further outside of this meeting. Action: The Chief Executive as responsible lead will take forward the allocation of where Organisational Development sits and will oversee the reporting structure to gain assurance of moving this forward. JT suggested this should be an item to be discussed during a Board meeting as it is a long time on from the Staff Survey and there is no visible plan or assurance. Action: PA-EDOF to send request to Board Administrator to schedule.

(d) Safer Staffing Report:

The EDNW briefed the Committee on the report and highlighted the longer term actions, noting the international recruitment is underway and the anticipation is that we will recruit the additional staff for placement by March rather than January or February as previously anticipated. The Committee were asked to approve and acknowledge the monthly staffing figures as detailed in the report along with the other recommendations which were made.

The fill rate is worse this month due to the number of starters and leavers and the absence rates. The staffing levels are being monitored daily with attention paid to those particular areas.

CR queried what affects the staffing figures in Afton. The EDNW explained sometimes patients are required to have one-to-one support and a discussion has been held with the Commissioners around this. This will have an impact on the staffing levels on the ward.

Action: The FIIWC will receive the investment plan next month. DDW

JT asked whether staff are able to move into another role before backfill is in place. The EDNW said we would look at the staff who are available within the Trust. The old contracts used to say which ward staff members should work on but the contracts now state staff work for the Trust and can therefore move around more easily.

(e) Recruitment and Retention Procedure:

The DDW briefed the Committee on the Procedure and noted this could now apply to doctors also. The Committee discussed which other Committees have sight of this paper and the process around applying the procedure.

Action: JT requested the Committee have sight of the net summary of how often this has been used in the past and how often it is likely to be needed in the future. DDW

The DDW said we know where there are issues in gaining additional staff and this procedure could be built in to an offer to make it appear more attractive to future employees.

CR noted this Committee will look at individual cases but will not approve them and asked who will approve each case. The EDNW

noted the directorates will look at each case and decided whether to approve or not. CR suggested the exact wording must be clear in terms of governance around the approval of the cases. Action: DDW.

The FIIWC will agree the process and the Trust Executive Committee will manage against the agreed process.

14/166 TRANSFORMATION MANAGEMENT OFFICE

(a) Performance of Directorate Savings Schemes:

The EDTI presented the report to the Committee and noted the following figures have now changed to:

Trust's Gap in Savings Target
- £3.312m in year
- £4.492m recurring forecast out-turn.

The EDTI explained the thermometers used to show the forecast out-turns. The EDTI noted the good performance in Finance and Trust Admin and COO directorates mask the other underperforming directorates.

JT noted these are good visuals and it would be useful to say who the Executive leads are for each directorate. The EDTI said narrative will be added to the reports as they evolve and that the previous month's thermometers will be included on the bottom of each slide to show progress made since the previous month. The EDOF recommended these reports should be included in the performance review packs.

The EDTI said the Transformation Office is now on the rollout schedule of the Programme Management Office and the governance framework and training is being delivered by Trust staff for which there is a waiting list and mentioned the high percentages of positive feedback received for this.

The Committee had no further questions on this report.

(b) Capital Planning Update:

The EDTI presented this report and explained this is split into operational and strategic capital. There was a discussion around various projects including the Medical Assessment Unit (MAU), Ryde Community Clinic, the Intensive Care Unit/Coronary Care Unit (ICU/CCU) and the Endoscopy Unit.

JT noted this is a good report with a clear layout but questioned what will happen in March 2015 in terms of delivery of schemes. The EDOF noted the ability for directorates to change their plans are significantly more difficult this year as the plans are a lot clearer. JT asked whether any variances can be used elsewhere. The DDOF confirmed they are used in other areas.

CR commented on how useful it is for the Committee to have sight of the Capital Investment Group minutes to keep updated. JT requested the Committee is updated on what is being done and in what timescale and the impact that will have on the movement of beds as this will have a massive

impact on the bed numbers. The EDOF noted the Quality and Clinical Performance Committee (QCPC) should also be sighted on this information from a quality perspective and any capacity issues should be a part of business planning.

Action: JT requests this is a (Board Part 2) item for discussion and will discuss this further with the Company Secretary outside of this meeting. Additionally, it was felt a graphical representation of the capital spend would be useful.

14/167 FINANCIAL PERFORMANCE

(a) Financial Performance Report:

The DDOF presented the re-formatted Financial Performance report to the Committee and highlighted the following:

- The strong cash position due to the change in the capital spend profile.
- Surplus position is £5k behind plan however forward banking of CIPs is reflected in the position. CR questioned whether we should still be forward banking at this stage. The EDOF noted there is no more to forward bank from now on and directorates must deliver the schemes they said they would deliver now.
- The EDOF noted the TDA are maintaining oversight of our position given the difficulty regarding CIPs. This would continue to be closely monitored and actions strengthened to minimise any discretionary spend to support delivery.
- The neonatal and breast screening services are currently behind plan both services operate on a payment by results basis and if the Trust does not deliver we will not be paid. The breast team have given their assurance that this will recover but an underperformance has been assumed at this stage.

CR noted that although there are considerable pressures the focus should be maintained to deliver the CIPs between now and the end of the year.

(b) Procurement Update:

The EDOF briefed the Committee on the paper and noted there was a quarterly review meeting held yesterday. At some time in the near future the Trust will be looking at going out to tender for this service as this had not been undertaken for a number of years.

JT requested the report has a cover sheet attached to summarise the main points. Action: DDOF.

(c) Reference Costs Draft Report:

The DDOI briefed the Committee on the report and highlighted the following:

- The draft position of 104.
- The total movement from the 2012-13 submission to the 2013-14 is 8.7 points. This indicates that as a Trust we made a significant move towards the mean results across the country and are providing services

at a reduced cost compared to this mean.

Action: The DDOI will bring this back to the November FIIWC meeting once further analysis has been undertaken.

JT asked what our intent is with the Reference Costs. The DDOI explained it is to get as close to the national average as possible.

Action: Through cost based review work look at how representative the indices are. DDOI.

(d) Plant, Equipment and Machinery Asset Revaluation:

The Committee received the report and had no comments to make.

14/168 AUDIT AND GOVERNANCE

(a) Standing Financial Instructions (SFIs) Update:

The DDOF explained the SFIs are currently under review and will be sighted by the Audit Committee, the FIIWC and the Trust Board in January 2015.

(b) Report to the Audit and Corporate Risk Committee:

The EDOF explained we will be looking at the methodology of providing assurance to the Audit and Corporate Risk Committee and the PA-EDOF, CR and EDOF will be drafting a reporting template prior to the next Audit Committee meeting in November.

Action: Once the draft report is completed the PA-EDOF will circulate it to the Committee members for their comments and approval.

(c) Terms of Reference – Final Version:

JT questioned the section in the terms of reference which state the number of sessions each member should attend. The CS has raised this issue with the Chairman of the Trust Board and has had conversations with other Non-Executive Directors. **Action: The CS will discuss this further outside of this meeting.**

The Committee approved all other areas of the revised terms of reference.

14/169 INFORMATION

(a) Data Quality:

The DDOI presented the report and noted that our data is good compared to national figures. There are 4 red indicators which include NHS numbers, for example, prisoners, missing postcodes, primary diagnosis and the timeliness of coding. CR asked how much of an issue this is. The DDOI said it was just a data issue and had little impact on funding.

The EDNW asked whether overseas or mainland patients are charged back to their own GPs. The DDOI confirmed they are charged back to their own

GPs.
Action: The DDOI will put the data into a graph format to chart improvements.

The Governance Risk Ratings for Quarter 2 shows a score of 9 due to a number of factors. The Referral to Treatment (RTT) standards failed, which was a planned fail and will continue to fail into Quarter 3 and there were a number of isolated breaches of standards in month which result in failing the quarter.

The Committee noted this additional paper is a very useful way of finding out exactly where issues are around the Trust.

(b) Information Governance – SUI

The CS briefed the Committee on the letter written to Wessex Deanery surrounding the actions by the individual who was spoken to directly and now understands their actions were wrong. Wessex Deanery pointed out this should be covered in staff training and the Associate Director of Medical Education will include this in the staff induction. CS will request Associate Director of Medical Education that this topic is covered in the local induction training.

14/170 INVESTMENT / DISINVESTMENTS

(a) Strategic Estates Partner (SEP) Update:

The EDTI updated the Committee on the steps now being undertaken including the project plan. Everything is on track and the only risk is non-approval from the TDA. The DDW noted the Estates team are very anxious about the SEP. As soon as formal approval has been received from the TDA this can be progressed.

(b) Carbon Energy Fund Update:

The EDTI noted there has been a delay in receiving approval from the TDA for the preferred bidder. The tariffs are changing so until the letter has been signed the Trust will not be locked into any agreements. The EDTI is awaiting the final signature from Bob Alexander, Director of Finance at the TDA before work can commence.

14/171 SELF CERTIFICATION REVIEW

The BP&FT attended the meeting to brief the Committee on the following:

Board Statements 1, 2, 6 and 14 remain 'at risk' as a consequence of the CQC inspection undertaken in June 2014. A detailed quality improvement action plan has been developed to manage delivery of the required improvements and improvement actions are being implemented accordingly. The target date for compliance set by the CQC is 12 December 2014 and these statements will remain at risk until the CQC has confirmed compliance.

Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, also remains 'at risk' and the decline in the governance risk rating score in August 2014 has pushed the forecast compliance date into quarter 3 to allow for a positive trend towards recovery to be established. The quarterly GRR score is currently at 9.0 and is at its highest level since the self-certification process was initiated in 2012.

All Licence Conditions remain marked as compliant. Condition G7 (Registration with the Care Quality Commission (CQC)) 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.

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.

14/172 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 17/09/14

There were no comments on these minutes.

14/173 ANY OTHER BUSINESS

(a) Finance Department Benchmarking:

The DDOF explained the report provided to the Committee. The Trust joined the process in the later stages and therefore missed the induction process. The information gives an indication of where the department is currently. A new exercise will be launched in February 2015.

CR and JT noted this is a useful exercise.

(b) Integration of CEAC with TIAA:

The EDOF noted the smooth transfer of CEAC to TIAA and that she will be meeting with one of their representatives next week for an introductory discussion.

14/174 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Finance, Investment, Information & Workforce committee to be held is on Wednesday 19th November 2014 from 1.00pm – 4.00pm in the Large Meeting Room.

The meeting closed at 3.45pm.

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Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 29 OCTOBER 2014

Minutes of the Isle of Wight NHS Trust **Mental Health Act Scrutiny Committee** held on Wednesday 22nd October 2014 in the Family Therapy Room, Sevenacres

PRESENT:	**Jessamy Baird**	**Chair, Designate Non Executive Director (JB)**
	Nina Moorman	**Non Executive Director (NM)**
	Stephen Ward	**Mental Capacity Act & Mental Health Act Lead (MML)**
	Tracey Hart	**Approved Mental Health Professional (AMHP)**
	Simon Dixey	**Consultant Psychiatrist, Memory Service (CP)**
	Tim Higginbotham	**Service User & Carer Link Coordinator**
Minuted by:	**Alison Hounslow**	**Administrator**

Key points from Minutes to be reported to the Trust Board

14/027 i) MH/024 - Terms of Reference to go to Audit Committee for approval

The Terms of Reference for the Mental Health Act Scrutiny Committee require further amendment and will go to Audit Committee for approval in November and to the Trust Board for approval in December.

Action by JB

k) MH/026 – Care Planning and Paris

A review of Paris has been commissioned by Katie Gray, Executive Director of Transformation and Integration. JB will follow this up with her. It was also suggested that there is a visit to the Hertfordshire NHS Trust to see the implementation of Paris there.

Action by JB

14/028 **Operation Serenity** - Sgt Paul Jennings and MML attended a meeting at which senior stakeholders were present. Karen Baker, Chief Executive and Sue Lightfoot, Head of Mental Health/Learning Disability Commissioning attended. Sgt Jennings delivered a presentation about Operation Serenity which was received positively. The response from those present was that further requirements were to be identified and met; if the resources were not there to meet these requirements then applications for funding were to be made and would be considered favourably.

14/029 **Deprivation of Liberty Safeguards** - The number of applications for Deprivation of Liberty Safeguards (DoLS) authorisations is increasing steadily. In 2013/14 there were 29 applications. From April 2014 to the present 185 applications have been received.

The risk of prosecution to the Trust as a result of unlawful detention is minimal as the majority of patients do not stay in hospital for very long. However, on occasions DoLS authorisations are required and it is the responsibility of staff to identify DoLS cases and provide the evidence required.

14/025	**Apologies for Absence, Declarations of Interest and Confirmation that Meeting is Quorate**

Apologies for absence were received from:

Mark Pugh, Christine Gardner, Julia Coles, Jane Tabor, Jan Gavin.

The meeting was declared quorate.

14/026	**Minutes of the previous meeting – 6th August 2014**

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

14/027	**Review Schedule of Actions**

a) MH/002 - Audit of Section 17 leave

Dr Yoganathan will be invited to attend the next meeting and present this audit.
Action Note: CP to invite Dr Yoganathan.

Action by CP

b) MH/005 - Lack of Section 12 qualified doctors

This matter is now on the Trust Risk Register.

This action has now been closed.

c) MH/006 - Community Treatment Order Audit

Dr Yoganathan will be invited to attend the next meeting and present this audit.
Action Note: CP to invite Dr Yoganathan.

Action by CP

d) MH/012 - Service User Involvement Policy

The Service User and Carer Involvement in Healthcare Policy has been drafted and approved by the Trust Executive Committee on 20th October 2014. This is to be presented to the Service User and Carer Forum and will be reviewed after 6 months

This action has now been closed.

e) MH/020 - Development of Service User & Carer Forum

Mo Smith, Lead Nurse for Mental Health & Learning Disabilities, and SUCLC are the leads for reviewing with the Forum the current Terms of Reference.

Action by SUCLC

f) MH/021 - Audit of risk assessments

The data available has been given to the Mental Health Act Manager (MM) who will be completing the audit report.

Action by MM

g) MH/022 - Scrutiny of Mental Health Act Section papers

Dr Sharif and MML have undertaken an audit of medical recommendations and this should be available for the next meeting.

Action by MML

h) MH/023 - Implementation of meetings for Hospital Managers

There will be a four hour training session at the Board Seminar on 9th December to which Associate Hospital Managers and Non Executive Directors will be invited.

Action by MML

i) MH/024 - Terms of Reference to go to Audit Committee for approval

The Terms of Reference for the Mental Health Act Scrutiny Committee require further amendment and will go to Audit Committee for approval in November and to the Trust Board for approval in December.

Action by JB

j) MH/025 – Mental Capacity Act Training

MML is undertaking training for nursing staff at Band 6 and above throughout the Trust. There will be six sessions available.

Action by MML

k) MH/026 – Care Planning and Paris

A review of Paris has been commissioned by Katie Gray, Executive Director of Transformation and Integration. JB will follow this up with her. It was also suggested that there is a visit to the Hertfordshire NHS Trust to see the implementation of Paris there.

Action by JB

14/028 Operation Serenity

Sgt Paul Jennings and MML attended a meeting at which senior stakeholders were present. Karen Baker, Chief Executive and Sue Lightfoot, Head of Mental Health/Learning Disability Commissioning attended. Sgt Jennings delivered a presentation about Operation Serenity which was received positively. The response from those present was that further requirements were to be identified and met; if the resources were not there to meet these requirements then applications for funding were to be made and would be considered favourably.

It is hoped that Operation Serenity will be extended to cover 7 days a week.

MML also attended a Mental Health Crisis Care Concordat covering Hampshire and Isle of Wight. Regionally, there is a steering group and peer review, with individual action plans for local areas.

The key measure for the success of Operation Serenity is the number of Section 136 detentions. For each Section 136 detention (under the auspices of Operation Serenity) another 10 are avoided – this indicates that the right people are being brought to hospital, assessed and detained.

There is a joint management project involving health/ambulance/police/GPs for frequent service users – the Integrated Recovery Programme. This programme, albeit working with low numbers of patients, is beginning to have success.

14/029 Deprivation of Liberty Safeguards

The number of applications for Deprivation of Liberty Safeguards (DoLS) authorisations is increasing steadily. In 2013/14 there were 29 applications. From April 2014 to the present 185 applications have been received.

Once an application has been received, it is processed and two assessments have to take place. One assessment is by a Consultant Psychiatrist and the second is by a Best Interests Assessor (BIA). There are eleven BIAs, all of whom are fully employed. Of the applications received 120 have not yet been assessed. Nationally, 35% of applications are unassessed.

The risk of prosecution to the Trust as a result of unlawful detention is minimal as the majority of patients do not stay in hospital for very long. However, on occasions DoLS authorisations are required and it is the responsibility of staff to identify DoLS cases and provide the evidence required.

14/030 Audit & Corporate Risk Committee

The Scheme of Reservation and Delegation under the Mental Health Act 1983, as amended by the Mental Health Act 2007 was submitted to this Scrutiny Committee for approval.

It was agreed that amendments are to be made regarding a more comprehensive description of the authority/duties delegated to the Non Executive Directors and Hospital Managers.

Action by MML

ANY OTHER BUSINESS

14/031 Hospital Managers

It was agreed that following Hospital Manager's seminars, a formal governance and structure is to be developed. Non Executive Directors and Associate Hospital Managers are to meet twice a year.

Action by MML

DATES OF NEXT MEETING

The next meeting of the Mental Health Act Scrutiny Committee is to be held on Tuesday 13th January 2015 in the Seminar Room, Sevenacres.

Meeting closed at 17.10

Glossary:	BIA	Best Interest Assessor
	DoLS	Deprivation of Liberty Safeguards

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29 October 2014

Title	Serious Incidents Requiring Investigation (SIRI) Report			
Sponsoring Executive Director	Alan Sheward, Executive Director of Nursing & Workforce			
Author(s)	Deborah Matthews, Lead for Patient Safety, Experience & Clinical Effectiveness			
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	22/10/14
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Patient Safety, Experience & Clinical Effectiveness Committee (SEE)	15 October 2014		
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 9 Serious Incidents reported during 2014, as well as identifying the lessons learnt from SIRIs closed by the commissioner during September2014.

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						

Date: 21 October 2014 **Completed by:** Deborah Matthews, Lead for Patient Safety, Experience & Clinical Effectiveness

Isle of Wight NHS Trust

Isle of Wight NHS Trust
Serious Incident Requiring Investigation (SIRI) Report
Isle of Wight NHS Trust Patient Safety, Experience & Clinical Effectiveness Committee 15 October 2014
Reports of SIRIs for September 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 September 2014 the Trust reported **9** Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG). Below is a summary of these incidents:

2.2 Grade 3 and 4 pressure ulcers:

8 Pressure ulcer incidents were reported, two were a grade 4 (most severe) with 6 being a grade 3. All were developed whilst under care of the IOW NHS Trust

The Trust takes pressure ulcer prevention seriously; reduction of pressure ulcers has been a priority Quality Goal for the Trust for the last 4 years, and whilst we have seen improvements, the Trust remains committed to reducing avoidable pressure ulcers to zero.

2.3 Medication issue:

Severe infection in an immuno-compromised patient

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.

At the 22 October 2014 meeting the Quality and Clinical Performance Committee approved the completed action plans related to 2 incidents.

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

Theme	Learning
Patient fall; fractured neck of femur	
Communication	· There is a need to focus on improving the 'completeness' of nursing documentation and risk assessments. · The assessment of Mental Capacity should be undertaken in a wider group of patients and there is a need to more accurately and consistently record conversation of any discussion being held with patient where non-compliance with advice could result in the patient being at higher risk · When refurbishment of ward areas is being carried out, consideration of the views of staff/patients and outcome of any incidents should be taken into account. This incident identified the need for an additional handrail · Ensure all staff are aware of the guidance within the falls policy with regard to risk assessment and share this investigation outcomes and learning with staff
Training	· There is a need to ensure all staff have completed the falls e-learning module
Grade 3 Pressure Ulcer	
Communication	· There is a need for timely Datix completion which leads into a thorough investigation regarding root causes. · Ensure pressure area competency checks are up to date
Documentation	· There is a need to utilise photography more frequently · Reinforcing with the team to do regular pressure area checks and Waterlow score · There will be regular documentation audits to ensure this is happening · Ensure pressure area competency checks are up to date
Education	· Utilise peer review more frequently to ensure consistency in grading.
Grade 4 pressure ulcer	
	· Ensure communication within teams and between team at the point of handover to other agencies is robust. · Make sure the team follow the correct process for requesting equipment and district nursing visits. · Ensure the teams documentation accurately reflects skin vulnerability
Safeguarding Level 4: clinical management of patient	
	· Reinforce the need for thorough documentation of actions taken and omitted, to support the review of cases and to provide evidence of care delivered. Documentation needs to be robust to ensure accurate timings of events can be gathered when reviewing clinical cases. · There will be a review of training given to staff in view of a discrepancy between what training was documented as being delivered and what was perceived to be delivered · Clarity is needed around the use of 'Recognition of Life Extinct' protocol. There is to be a review of the procedure and the awareness of staff in its

	use and its limitations to ensure future use can be justified, documented and audited against clinical decision making. · More robust documentation will be developed to support the care delivered and decision making. Good communication is essential and decisions must be documented and considerations evidenced.

Alan Sheward
Executive Director of Nursing & Workforce
22 October 2014
Prepared by: Deborah Matthews, Interim Lead for Patient Safety, Experience & Clinical Effectiveness

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29th October 2014

Title	**Safeguarding Children & Young People Annual Report 2013-14**			
Sponsoring Executive Director	**Alan Sheward, Executive Director of Nursing & Workforce**			
Author(s)	**Jenny Johnston: Head of Safeguarding Children**			
Purpose	**To give Trust Board assurance**			
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	22/10/2014
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:

Executive Summary:

Purpose of report:

- To set the local context for safeguarding children in respect of IOW NHS Trust
- To set out the key safeguarding children achievements for 2013 – 2014
- To fulfil the statutory requirements to report on safeguarding performance to the Board on an annual basis.
- To provide Board assurance that IOW Trust is compliant with its statutory responsibilities
- To outline the key tasks for 2014-2015

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	**Quality & Resilience**					
Critical Success Factors *(see key)*	**CSF2 / CSF5**					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	RR622 – within objective 5, workforce.					
Assurance Level ***(shown on BAF)***	Red	x	Amber		Green	
Legal implications, regulatory and consultation requirements	**Statutory Safeguarding children requirements (Section 11 of the Children Act 2004)**					

Date: 16/10/2014 Completed by: Jenny Johnston: Head of Safeguarding Children

Isle of Wight NHS
NHS Trust

IOW NHS TRUST SAFEGUARDING & LOOKED AFTER CHILDREN ANNUAL REPORT

1st April 2013 – 31st March 2014

Author:

Jenny Johnston

Head of Safeguarding Children

2013 - 2014

Purpose of report:

- **To set the local context for safeguarding children in respect of IOW NHS Trust**
- **To set out the key safeguarding children achievements for 2013 – 2014**
- **To fulfil the statutory requirements to report on safeguarding performance to the Board on an annual basis.**
- **To provide Board assurance that IOW Trust is compliant with its statutory responsibilities**
- **To outline the key tasks for 2014-2015**

Contents

IOW NHS TRUST SAFEGUARDING & LOOKED AFTER CHILDREN ANNUAL REPORT

1: Safeguarding Children and Young People Statement

SAFEGUARDING CHILDREN – EVERYBODY'S RESPONSIBILITY

Isle of Wight NHS Trust is committed to safeguarding and promoting the welfare of children and young people (aged 0-18 yrs of age) on the Isle of Wight.

All organisations that work with children and their families share a commitment to safeguard & promote children's welfare and this is underpinned by a statutory duty under Section 11 Children Act 2004 and Working Together to Safeguard Children 2013.

2: Safeguarding Children Workforce

Working Together to Safeguard Children 2013 requires Provider Trusts to have a number of statutory posts including:-

- Named Nurse for Safeguarding Children
- Named Midwife if the Trust delivers Maternity services.
- Named Doctor

During 2013-14 IOW NHS Trust had all the required statutory posts although capacity within the safeguarding children team decreased with the retirement of a previous Named Nurse.

The current Named Midwife took an additional hours to undertake the Named Nurse responsibilities alongside the existing part time Head of Safeguarding Children / Named Nurse.

Recruitment to a supporting post of Specialist Nurse for Safeguarding Children (Band 7) remains outstanding.

The role of the Named Nurse / Midwife is:

- To provide a vital source of professional advice on safeguarding and child protection matters for frontline staff.
- The promotion of good professional practice which safeguards and promotes the welfare of children backed up by sound policies and procedures.
- Influencing, developing, delivering and monitoring of safeguarding children training.
- Representing the Trust at multi agency operational meetings including Multi Agency Risk Assessment Conference (MARAC) for high risk Domestic Abuse .
- Working with the Isle of Wight Local Safeguarding Children's Board (LSCB). Including representing the Trust on LSCB subgroups
- Working daily with partnership agencies including Children's Social Care
- Overseeing the Paediatric Liaison Service which includes the following up of children who are not brought for health appointments or for whom there are safeguarding concerns.
- Working to ensure safer recruitment procedures are in place.

The Lead Nurse for Mental Health & Learning Difficulties has a specific safeguarding children responsibility within those services.

The Named Nurse / Doctor team are professionally suported by the Designated Nurse & Designated Doctor employed by the IOW CCG. During 2013-14 both Designated Professionals resigned and new members of staff came into post.

To avoid isolated professional practice the IOW Named Nurses are regularly involved with mainland network meetings to share good practice and to aid learning.

3: Governance & Assurance for Safeguarding Children

Working Together to Safeguard Children 2013 requires all Provider Trusts to identify a board executive lead for safeguarding children to take responsibility for governance systems and provide an organisational focus on safeguarding children & young people.

The IOW NHS Trust has an accountable Executive Lead, Alan Sheward (Executive Director of Nursing and Workforce).

During 2013 the Joint Safeguarding Steering Group was established to improve internal accountability within the Trust on all aspects of safeguarding (both children & adults). The Steering Group met monthly during 2013-14 and reports to the Trust Executive Committee (TEC).

A joint safeguarding report is tabled at Trust Board by the Executive Lead.

4: IOW Safeguarding Children Board (IOWSCB)

The LSCB is the key statutory mechanism for agreeing how relevant organisations across the Island will co-operate to safeguard and promote the welfare of children and to ensure the effectiveness of what they do. IOW NHS Trust comes under this scrutiny and challenge.

The IOW NHS Trust is a proactive partner of the IOW LSCB. The Executive Lead attends LSCB meetings as the Trust representative and we have representation on every LSCB sub group; these include:

- IOWSCB Business Management Group
- Serious Case Review Sub Group
- Quality & Assurance Sub Group
- Child Sexual Exploitation Sub Group
- Education & Schools Sub Group

A number of joint 4LSCB (Hampshire / Portsmouth/ Southampton & the IOW) groups include:

- Training Subgroup
- Policy & Procedures
- Child Death Overview Panel

The IOWSCB Board Manager and Independent Chair resigned during the reporting period with interim positions being filled until full recruitment. The current Independent Chair, Maggie Blythe, took up post in Oct 2013.

The IOWSCB produces its own annual report which can be found on the LSCB website http://www.iowscb.org.uk/

5: IOWSCB Serious Case Review (SCR) process

During 2013 – 2014 IOW NHS Trust participated in:-

- Three full Serious Case Reviews
- One single Agency review (Health only)
- Two partnership reviews
- One partnership Reflection led by the LSCB chair.

2013-14 saw a period of unprecedented number of safeguarding children reviews on the Island, the majority of which reflect the findings of the recent IOW Ofsted Inspection & national Serious Case Reviews.

These include:-

- A greater emphasis on male partners and their role within the family
- Improved robust supervision that challenges professionals and allows time for reflection in complex cases
- The importance of ensuring staff are aware of and have confidence in a robust escalation policy
- Increased universal ante natal contacts by the health visiting team working alongside Community Midwives for complex cases with high vulnerability.
- A universal health needs assessment that includes both parents social and health history
- Greater emphasis on adult mental heath issues and the impact on parenting
- Improved more formalised Information Sharing including between GP's with regular practice based safeguarding meetings being held.

The implementation of all the action plans devised is the responsibility of the individual agencies but they are also overseen by the LSCB Serious Case Review Working Party, of which health is represented by the Designated Nurse for Safeguarding Children.

Reports and action plan progress are also reviewed at the Trust Joint Safeguarding Steering Group. Learning Lessons events for staff are being arranged by the LSCB.

6: External Inspections

During Dec 2012 (reporting in Jan 2013) Ofsted undertook an unannounced inspection of "front door" safeguarding children in respect of the Isle of Wight Local Authority.

The Ofsted inspection concluded that the local authority safeguarding procedures were unsafe and failed to protect children on the IOW. The Inspection also found that the Isle of Wight Safeguarding Children's Board (IOWSCB), of which the Isle of Wight NHS Trust is a key partner, was not fulfilling its statutory function.

The outcome of the late 2012 Ofsted inspection led to a directive of improvement from the Minister for Education and the resultant partnership arrangements with Hampshire County Council. As of 1st July 2013 Hampshire County Council took over the running of IOW children's services including safeguarding & education.

Major changes post inspection included the move to HantsDirect Central Referral Team (Fareham) as the new "front door" for all safeguarding children referrals for IOW children This was further enhanced in March 14 by the formation of the HantsDirect Multi Agency Safeguarding Hub (MASH) from which health information is requested from the Named Nurse on every safeguarding children referral made to HantsDirect. The impact of this additional work on a small safeguarding team is yet to be assessed but is likely to be significant and will require additional resources.

As part of the need to ensure that rapid improvement took place, the Minister also directed the setting up of a Children's Improvement Board, chaired by Professor Ray Jones, to ensure services for children on the Isle of Wight are fit for purpose. The Children's Improvement Board is a multi agency Board of which the IOW NHS Trust is a key member and is represented by the Chief Executive.

Monthly reports are submitted to the Improvement Board to evidence progress & sustainability of improvement. This will continue until the minister is confidant of sufficient progress including the ability of the LSCB to ensure adequate challenge & scrutiny.

In the progress report to the Dept of Education Minister in Jan 2014, Prof Jones reported that he was "*impressed by the contribution of the IOW NHS Trust Named Nurses for the safeguarding of children on the IOW".*

The progress of improvement is steady but more work is required before safeguarding services for children on the Isle of Wight can be considered "fit for purpose" and all professionals must be fully engaged in ensuring these changes are embedded in everyday practice.

For the IOW NHS Trust one of the biggest lessons learnt was our failure to fully escalate to the Executive Lead concerns identified. Individual cases were escalated and challenged to children social care managers but systematic concerns were not adequately raised within the Trust when local authority responses were not robust.

This has been fully addressed with revised guidance from the IOWSCB and included in all internal training, at supervision and will be reflected in the revised safeguarding children policy.

7: Care Quality Commission (CQC) Core Standard Declaration (Outcome 7)

IOW NHS Trust has declared compliance against the Core CQC Outcome 7 (Safeguarding people who use services from abuse) and evidence of compliance is included within the organisations statutory declaration. This will be assessed during the forthcoming CQC inspection.

8: Section 11 Audit

Section 11 of the Children Act 2004 places a duty on a range of organisations, including health, to make arrangements to ensure that in discharging their function, the organisation has regard to the need to safeguard and promote the welfare of children and young people.

The IOWSCB requires partners to submit annual Section 11 audits to evidence the organisations compliance against these standards.

During 2013-14 IOW NHS Trust submited the required audit to the IOWSCB declaring compliance. The LSCB process during this period meant this was not externally assessed.

IOW NHS Trust will be completing the required Section 11 audit during 2014 -15 at the request of the IOWSCB and assessed by a multi agency panel.

This will be included in the 2014-15 annual report.

9: Child Death Overview Process (CDOP)

Working Together to Safeguard Children 2013 clearly sets out the process to be followed in relation to any child death (expected or unexpected) within a given area including ensuring bereavement support to the family.

As a sub group of the LSCB, the Child Death Overview Panel (CDOP) reviews all notified deaths, identifying and examining both local and national trends and sharing any lessons learnt.

The IOW NHS Trust has a Consultant Paediatrician as the Designated CDOP lead and fully engages with the CDOP Rapid Response process in conjunction with Police & Social Care colleagues.

During 2013-14 the Trust reported 5 child deaths:

- 6 year old child with life limiting oncology condition (expected death)
- Sudden and unexplained death of a one day old baby and managed under Rapid Response Procedures. (subsequently subject to Serious Case Review)
- One week old baby with congenital liver disease, transferred to and subsequently died at Kings College Hospital, London.
- 5 year child with life limiting condition (expected death)
- 15 year old young person who tragically died in Road Traffic Incident

The 4LSCB CDOP Annual Report is available on http://www.4lscb.org.uk/cdop/ and includes all the IOW child death data.

10: Policy & Procedures

The IOW NHS Trust child protection policy requires updating and this is included in the coming years work plan for the safeguarding children team. The Policy applies to all Board members, managers, staff and volunteers working in both commissioning and provision of healthcare services.

The policy covers all aspects of the organisation's responsibility for all levels of staff and includes a section on the professional's response to children's failed attendance at health appointments; children not registered with a GP and adult service users who are parents / carers.

During 2010 - 2011 the IOWSCB ratified the new Threshold Document in relation to the levels of planned intervention to children & their families. The Common Assessment Framework (CAF / Early Help Offer)) process is firmly embedded in universal services and all children's community nursing staff are now CAF trained and able to take on the role of the Lead Professional.

11: Safeguarding Children Training

	As of 7th Feb 2014	As of 10th March	As of 31st March 14	As of Feb 2013
Safeguarding Children Level 1	80%	83%	**85%**	61%
Safeguarding Children Level 2	50%	54%	**53%**	Not monitored until April 13 then 5%
Safeguarding Children Level 3	38%	40%	**50%**	Not monitored until June 13 then 14%

Safeguarding children training requirements for IOW NHS are set out in the current training policy which sets out the training requirements for every member of staff within NHS Isle of Wight according to their role and level of contact with children and their parents.

The policy sets out the requirements for Safeguarding Children training under 5 levels as outlined within the Royal College of Paediatrics & Child Health (RCPCH) Intercollegiate Document - "Safeguarding Children and Young People: Roles and Responsibilities for Health Care Staff" [2010] , recently revised to match Working Together to Safeguard Children 2013.

Safeguarding training attendance is recorded and monitored via the Training Manager Pro 4 programme and reviewed at yearly appraisal.

During 2013 – 2014 **Level 1** safeguarding children training (via e -learning) reached and exceeded the target of 80% of all staff employed by the organisation.

Level 2 training is managed and delivered by the safeguarding children team with a rolling programme of dates as well as service specific training as required. This includes a twice yearly session with the new junior medics.

Level 2 safeguarding training compliance did not meet the required compliance at only 46% and was added to the Corporate Risk Register in Jan 2104 as an organisational risk.

Actions taken to increase Level 2 compliances included:

- Delivery of additional training sessions by the safeguarding team
- Increasing the maximum attendance at each session
- Introducing a shorter 3 yearly update for staff who only require training to Level 2 (as per the Trust training policy)
- Working with Training & Development to ensure staff competences are correctly recorded on their training record.

At the 31st March 2014 Level 2 compliance had increased to 53% and further work to increase compliance continued.

Internally **Level 3 training** is delivered via the Trust Continuing Vocational Educational (CVE) Contract with Southampton University. Topics are agreed each year and included:

- Fabricated & Induced illness
- Neglect
- Health Needs Assessment

Level 3 training for frontline practitioners in regular contact with children & young people should also include multi agency training to allow safeguarding partners to work together to ensure sound joined up safeguarding practice. One of the functions of the IOWSCB is to commission multi agency training; however due to internal issues there was an absence of LSCB commissioned training during 2013-14 which negatively affected the Trust Level 3 compliance. This has now been addressed and a full calendar of Level 3 training is available and being accessed by Trust staff.

Named Safeguarding Children professionals are required to access training at level 4 appropriate to their role. Both Named Nurses completed a 10 day Level 4 Contemporary Risk Assessment Training alongside children social care colleagues.

Safeguarding children training compliance will continue to be regularly monitored and reported to the Joint Safeguarding Steering Group.

12: Safeguarding Supervision

Effective child protection supervision is vital to ensuring good standards of practice and supporting individuals and groups of staff in their work with complex, vulnerable families. The absence of sound supervision arrangements are frequently highlighted in national & local SCR's.

The Named Nurses for Safeguarding Children provide formal bi- monthly supervision to health visiting and school nursing teams as well as providing support for child protection conferences and court statements. The Named Midwife is developing similar arrangements for community midwifery teams.

A member of the safeguarding children team is available within office hours by phone or pager to respond to queries and offer immediate child protection support as required.

13: Safer Recruitment

The Trust has robust recruitment procedures in place which are in line with the statutory requirements of the Section 11 Audit.

The Trust has a compliance statement confirming the procedures for dealing with any allegation against a professional working with children and the Trust Human Resource Department and Service Managers work closely with the Local Authority Designated Officer (LADO) who oversees any such allegation.

14: Intranet Folder

The Safeguarding Children & Young People Intranet folder has been completed and updated to include all the relevant contacts, key documents/ policies & links as well as training opportunity details for easy access by all staff.

Regular safeguarding children information and updates are added to the weekly E Bulletin that is sent to all Trust staff.

15: Looked after Children (LAC)

Children in Care are looked after by the Local Authority. Only after exploring every possibility of protecting a child in its own home has failed will the local authority seek parental consent, or a court order to remove a child from his or her family.

During 2013-14 195 children were deemed “looked after” which is statistically higher than expected for the Island population.

There is statutory guidance on the health needs of Looked after Children (2009) and the NHS has a clear Corporate Parenting responsibility to these children.

In order to meet the statutory requirement IOW NHS Trust has a full time Children in Care Nurse to meet the health care needs of this vulnerable group. The Child in Care Nurse also supports Care Leavers during what can be a difficult transition period.

Working in partnership with children’s social care colleagues the Children In Care Nurse coordinates the required statutory health reviews as well as providing ongoing support to the young people. The Children In Care Nurse also has a key role in supporting foster carers as well as raising the health needs of this vulnerable group of children across the Trust.

Initial Health Reviews must be undertaken by a medical practitioner within 28 days of coming into care. For the Island this is undertaken by a member of the Paediatric Medical Team.

Review Health Assessments are required 6 monthly for children under the age of 5 years and yearly for children & young people over 5.

The completion of a robust health care plan ensures the child or young person’s physical and emotional health needs are addressed by the multi agency team.

The Children in Care Nurse is accountable to the Named Nurse for Safeguarding Children.

16: National issues

In line with the national picture IOW safeguarding children partners in the coming year are focused on emerging areas of safeguarding concerns including

- Child Sexual Exploitation
- Female Genital Mutilation
- Trafficked Children

17: Actions for 2014 – 2015

- Ensuring the changes required by the Children's Improvement Board are embedded & sustained in practice.
- Recruiting to the existing vacancies within the safeguarding children team & further succession planning.
- Full review of current safeguarding training provision and the re writing of existing programmes to update method of delivery.
- Ensuring safeguarding children training compliance is improved & sustained.
- Ensuring frontline practitioners receive regular supervision and feel supported on a daily basis with safeguarding matters.
- Updating of the safeguarding children & young people policy and the safeguarding children training policy
- Embedding Serious Case Review "lessons learnt" in practice.
- Build on partnership relationships with Hampshire County Council safeguarding children service managers including the commencement of bi monthly partnership meetings.
- Assess the impact of the formation of the HantsDirect Multi Agency Safeguarding Hub (MASH) on the Trust safeguarding children team.
- Improve performance and activity data to more accurately reflect workload.

Jenny Johnston
Head of Safeguarding Children

Enc M

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29th October 2014

Title	Safer Staffing Monthly Report			
Sponsoring Executive Director	Executive Director of Nursing & Workforce			
Author(s)	Deputy Director of Nursing			
Purpose	To provide the Trust Board with detailed information of planned nurse staffing and actual nurse staffing for September 2014, to ensure safer staffing is considered by the Board and actions taken as required			
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		Nominations Committee (Shadow)	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee	22nd October 2014	Remuneration Committee	
Foundation Trust Programme Board			
Please add any other committees below as needed			

Staff, stakeholder, patient and public engagement:

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

Executive Summary:

This report forms one of the compliance requirements, and details actual staffing against planned levels on a shift by shift basis 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 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: 16th October 2014 **Completed by: Deputy Director of Nursing**

Isle of Wight NHS Trust Board
Safer Staffing
Monthly Report
Wednesday 29th 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 September 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.

2.4. Future reporting
It is planned that going forward the monthly safer staffing report will be incorporated into the monthly performance report as part of the workforce report. This is following review of other organisational approaches. The 6 monthly report will contain the more detailed information. A draft report is planned for 3rd December for the Board to review.

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 (Duty Managers out of hours.

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.

3.4. Staff are encouraged to report staffing issues on Datix as an incident. It is recognised that the Datix incidents relating to staffing are increasing and the perception of staffing for the people in the ward areas is not as indicated by data and current reporting mechanisms. This has instigated deep dive into bank data and discussions with the Matrons via the new Bank User group and will be reported on in the 6 monthly report in January

4. Reasons for shortfalls during September 2014

4.1 The information provided *directly* by Ward Sisters/Charge Nurses in relation to rationale for identified shortfalls is not available for the written report this month due to timings of data availability and board report deadlines. A verbal report will be given from an updated report by the EDoN&W.

Current known reasons for shortfalls include

- Vacancies
- High sickness rates in some areas
- Vacancies or sickness not being able to be filled with bank staff
- Poor rota management
- Non fill of bank staff for registered nurses, particularly for 1:1 care for dementia patients

NB The new version of MAPS has been put in place and sessions on how best to manage this have been circulated around the organisation

4.2 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

5. Actions to mitigate

5.1 Monitoring and assurance

- The new rostering policy is expected to be received by the policy group for final ratification on 28th October. This will then be circulated with supportive training to enable staff to work with this.
- 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 taking on weekly oversight and review. A daily reporting tool has been established at time of report and is established as a working tool.

5.2 Ensuring staff availability

- Staff sickness in some areas is higher than the Trust target. This will be discussed at Director of Nursing Team meeting and needs to be addressed within the Directorate teams
- Bank nurses are being requested but there is limited availability of registered nurses at times. A bank user group has been set up to gain more robust oversight of the nurse bank system. Recruitment to the bank and how best to boost this has been under discussion. In addition, the group is reviewing use of an agency for nursing in order to develop a relationship and planned approach to nursing requirements for the future which is anticipated to be a challenging time. This will be scoped and recommended to Trust Executive Committee.

Bank Shifts		
Staff Grade	HCA	RN
Total Shifts	1183	750
Unfilled	207	172
Filled	976	578
% Fill Rate	82.5%	77.1%

- Utilising non registered for registered roles or vice versa is occurring if there is not the required level of staff available. This occurs anecdotally more with non registered being utilised for registered roles. The data relating to this is being sought, and the daily reporting tool will support improved oversight of this.

- New rostering policy and training for rota management will support more effective management.

- General proactive recruitment drive is in place:

Newly recruited staff Sep 2014	
RMN	2
Community	5
RGN	1
Safer Staffing	2

5.3 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 by March rather than January or February as originally anticipated. Recruitment lead and a Matron are planning to fly to Philippines on 28th November.
- There is ongoing work to drive down sickness in the organisation and this needs to continue and/or change focus to improve rates as much as possible particularly going into the winter period

6. Risks and issues the Trust is seeking to address

6.1 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.

6.2 There is a risk that staff are not physically available to us in the future, via our current bank set up or through recruitment. We are looking at alternative ways to address this through the Bank User Group.

7. Triangulation Quality Indicators

7.1 Appendix 3 shows the aggregated quality indicators that are used to assess staffing impact on the quality of care delivered in that area.

7.2 The dashboard indicates the higher than expected sickness rate currently.

7.3 It is noted that those areas with two red clinical indicators particularly falls and pressure ulcers have also higher rates of sickness in the main alongside red ratings on the hourly planned v actual data.

8. 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 remains amber** to indicate that the reason for the gap is not identified robustly enough to provide adequate assurance of safe staffing. A daily reporting tool is established and it is anticipated this will be available for Trust Board in November	
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 **remains amber** until the DNT can assure the Board that this review can be evidenced. The roster policy and daily reporting tool are required for this and it is anticipated that this will be addressed by the November Board.	

Recommendations

The Trust Board is asked:

1. To receive the Trust's monthly staffing figures for planned and actual for Inpatient areas.

2. To recieve the identification of shortfalls in staff and mitigating actions.

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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

3. To receive the Trust's status of compliance in relation to the National Quality Board's requirements.

4. To receive the urgent requirement for automation in the data collection, and reporting process to improve the quality assurance required.

5. To **approve** the intention to move this report into the integrated performance and workforce report (see 2.4)

Sarah Johnston
Deputy Director of Nursing
Oct 2014

Appendix 1 Monthly actual figures by ward as uploaded on the Unify return

	Day				Night				Day		Night	
	Registered		Care Staff		Registered		Care Staff					
Ward name	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 (%)
SHACKLETON	450	491.92	1350	1168.33	285	311.25	570	595	109.3%	86.5%	109.2%	104.4%
ORTHOPAEDIC UNIT	2250	1781.76	1890	1597.5	1200	1159.25	900	900	79.2%	84.5%	96.6%	100.0%
SEAGROVE	900	891.81	900	1012.34	600	570	600	739.25	99.1%	112.5%	95.0%	123.2%
OSBORNE	1290	938.75	735	863.75	900	696.75	285	556.5	72.8%	117.5%	77.4%	195.3%
MOTTISTONE	900	780.25	390	345.5	600	591.75		10	86.7%	88.6%	98.6%	
ST HELENS	1620	1232.83	1215	1222	600	580	600	540	76.1%	100.6%	96.7%	90.0%
STROKE	1800	1468	1575	1801.75	600	602.75	600	1066.75	81.6%	114.4%	100.5%	177.8%
REHAB	1575	1290	1575	1425	600	600	600	500	81.9%	90.5%	100.0%	83.3%
WHIPPINGHAM	1620	1423.91	1440	1303	900	720	600	726.75	87.9%	90.5%	80.0%	121.1%
COLWELL	1350	1109.5	1740	1589.5	600	600	600	590	82.2%	91.4%	100.0%	98.3%
INTENSIVE CARE UNIT	3150	2434.77	450	306.25	1942.5	1683.25	277.5	138.5	77.3%	68.1%	86.7%	49.9%
CORONARY CARE UNIT	2250	1809	675	655.67	1500	1360.5	300	320	80.4%	97.1%	90.7%	106.7%
NEONATAL INTENSIVE CARE UNIT	1020	923.5	405	677.25	600	638.25	300	360	90.5%	167.2%	106.4%	120.0%
MEDICAL ASSESSMENT UNIT	2287.5	1885	1065	854.5	900	888.75	600	650	82.4%	80.2%	98.8%	108.3%
AFTON	900	949.25	900	1146.77	300	300	600	780	105.5%	127.4%	100.0%	130.0%
PAEDIATRIC WARD	1677	1404.5	450	395	600	604.5	300	300	83.8%	87.8%	100.8%	100.0%
MATERNITY	2025	1893	1110	1200	1200	1200	600	600	93.5%	108.1%	100.0%	100.0%

Overall percentage fill rates as calculated by the Unify return – Sept 2014 data

Day				Night				Day		Night	
Registered midwives/nurses		Care Staff		Registered midwives/nurses		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	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
27064.5	22707.75	17865	17564.11	13927.5	13107	8332.5	9372.75	83.9%	98.3%	94.1%	112.5%

Appendix 2

Unify data for Oct 2014 – Rag rated with locally set RAG rating

	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 (%)
Paula Smith	Shackleton	109.3%	86.5%	109.2%	104.4%
Heidi Meekins/Caroline Moul	Orthopaedic Unit	79.2%	84.5%	96.6%	100.0%
Andy Tate	Seagrove	99.1%	112.5%	95.0%	123.2%
Vicky Haworth	Osborne	72.8%	117.5%	77.4%	195.3%
c/o Sue Biggs	Mottistone	86.7%	88.6%	98.6%	
Mandy Webb	St Helens	76.1%	100.6%	96.7%	90.0%
Anna New	Stroke	81.6%	114.4%	100.5%	177.8%
Natalie Mew	Rehab	81.9%	90.5%	100.0%	83.3%
Fiona Mitchell	Whippingham	87.9%	90.5%	80.0%	121.1%
Tina Beardmore	Colwell	82.2%	91.4%	100.0%	98.3%
Laura Moody	Intensive Care Unit	77.3%	68.1%	86.7%	49.9%
Marcia Meaning	Coronary Care Unit	80.4%	97.1%	90.7%	106.7%
Jacky Harry	Neonatal Intensive Care Unit	90.5%	167.2%	106.4%	120.0%
Jessy Gulati	Medical Assessment Unit	82.4%	80.2%	98.8%	108.3%
David Stratton	Afton	105.5%	127.4%	100.0%	130.0%
Matthew Powell	Paediatric Ward	83.8%	87.8%	100.8%	100.0%
Annie Hunter	Maternity	93.5%	108.1%	100.0%	100.0%

95% -100+%	
90-94.9% and ward sister opinion +ve	eg care was maintained safely, acuity and dependancy managable, staff moved to cover etc
90-94.9% and ward sister opinon -ve	eg below 95% regualrly, no cover able to be obtained, care could be compromised etc
<90%	

Appendix 3

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	1	11.1%	5.58%	84.3%	1	0	n/a	0	0	n/a	n/a	0	0
Osborne Ward	1	13.8%	0.53%	77.8%	0	0	n/a	0	0	n/a	n/a	0	0
Seagrove Ward	1	3.4%	3.17%	85.7%	0	0	n/a	0	0	n/a	n/a	0	0
Shackleton Ward	1	3.1%	6.21%	88.0%	2	0	n/a	0	0	n/a	n/a	0	0
Community													
Community Stroke Rehabilitation Team	-2	0.0%	0.22%	89.8%	0	0	n/a	0	0	n/a	n/a	0	0
Stroke Neuro Rehab	7	22.7%	6.37%	82.4%	1	0	n/a	0	0	40.9%	88.9%	1	2
General Rehab and Step Down Unit	-1	11.1%	1.27%	89.9%	1	0	n/a	0	0	62.5%	80.0%	0	1
Hospital & Ambulance													
Medical													
Cardiac Investigation Unit	-2	0.0%	1.09%	73.6%	0	0	n/a	0	0	n/a	n/a	0	0
Chemotherapy Unit	0	0.0%	0.98%	81.5%	0	0	n/a	0	0	n/a	n/a	0	0
Colwell Ward	1	8.8%	1.60%	83.3%	2	1	n/a	0	0	23.1%	100.0%	0	0
Emergency Department	-3	6.5%	14.85%	90.2%	0	3	n/a	0	0	8.6%	82.0%	0	10
MAAU	0	4.8%	3.88%	89.8%	2	2	n/a	0	0	48.2%	98.1%	0	1
Respiratory Department	-1	0.0%	0.37%	86.0%	0	0	n/a	0	0	n/a	n/a	2	1
Surgical													
Mottistone Ward	-1	9.5%	6.02%	83.8%	0	1	n/a	0	0	18.8%	90.5%	0	0
St Helens Ward	-3	0.0%	12.06%	69.6%	2	2	n/a	0	0	5.1%	75.0%	0	3
Whippingham Ward	2	10.5%	5.96%	67.6%	1	3	n/a	1	0	19.5%	100.0%	0	1
Crititcal care													
Intensive Care Unit	-4	0.0%	4.01%	89.7%	0	2	n/a	0	0	n/a	n/a	0	1
Coronary Care Unit	-8	7.9%	3.96%	76.9%	2	0	n/a	0	0	83.0%	98.6%	0	2
Endoscopy													
Endoscopy Unit	-1	4.2%	2.78%	75.5%	0	0	n/a	0	0	n/a	n/a	0	0
Theatres													
Main Theatres	1	1.8%	6.53%	67.4%	0	0	n/a	0	0	n/a	n/a	0	0
Day Surgery Unit	3	6.1%	10.29%	69.3%	0	0	n/a	0	0	n/a	n/a	0	0
Maternity													
Maternity Services	2	4.3%	6.45%	70.5%	0	0	n/a	0	0	10.8%	100.0%	0	0
Neonatal Intensive Care Unit	0	5.0%	8.80%	76.7%	0	0	n/a	0	0	n/a	n/a	0	0
Orthopaedic Unit													
Orthopaedic Unit	0	5.9%	4.83%	69.8%	1	1	n/a	0	0	47.6%	100.0%	1	3
Childrens													
Paediatric Ward	-2	0.0%	1.46%	76.5%	0	0	n/a	0	0	n/a	n/a	0	1
Pathology													
Phlebotomy	4	20.0%	5.77%	82.2%	0	0	n/a	0	0	n/a	n/a	0	0
Earl Mountbatten Hospice	-5	0.0%	2.59%	67.3%	0	0	n/a	0	0	n/a	n/a	0	0

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 17 OCTOBER 2014

Title	Trust Board Walkabouts – Patient Safety Assurance Visits			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing and Workforce			
Author(s)	Vanessa Flower, Patient Experience Lead			
Purpose	To provide assurance of progress of actions identified as part of the Patient Safety Assurance Visits Programme			
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	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Staff and patients where appropriate are engaged during the walkabout undertaken

Executive Summary:

The attached summary report identifies the number of visits undertaken since the process was implemented in February 2013, and includes the overdue actions that continue to be progressed following the visits undertaken.

Of the 79 visits to date the majority have been to clinical settings with only 16 to non clinical areas, from the visits a total of 204 actions have been identified.

At the time of reporting 8 actions remain overdue, 4 of which are green against the directorates revised timescale.

Currently there are 13 feedback sheets outstanding on walkrounds that have taken place since the beginning of April 2014.

For following sections – please indicate as appropriate:

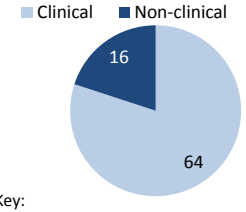
Trust Goal *(see key)*	Quality Goal					
Critical Success Factors *(see key)*	CSF1, CSF2 and CSF10					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	10.75					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	P
Legal implications, regulatory and consultation requirements						

Date: **17 October 2014** **Completed by:** **Lisa House – Quality Advisor**

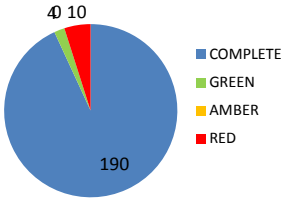
Board Walk Rounds Action Plan Status Report

Trust Overview

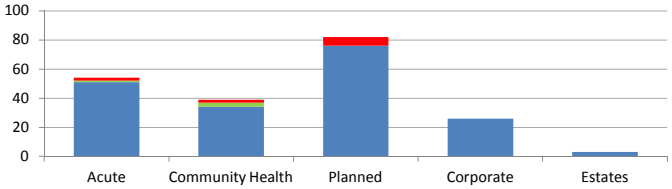
Areas visited



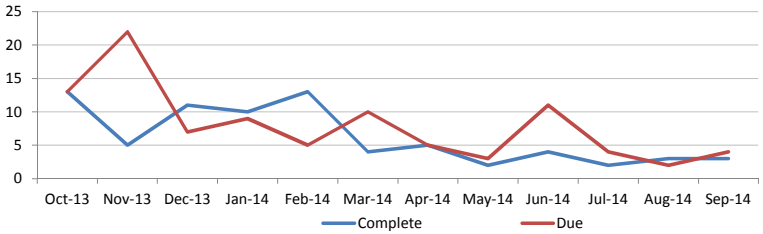
Status of actions



Directorate Profiles



12 month profile from: Oct-13 to Sep-14



Key:
Blue = Complete; Green = action not due; Amber = overdue against due date by < 14 days; Red = Overdue against due date by >14 days

Exception Report

No.	Action Reference	Walk Round	Area Visited	Action	Date for completion set by board	Directorate revised date	Status against date set by board	Progress against directorate revised date	Status Comments	Directorate	Responsible
1	AT/037/2013/006	13-Sep-13	Pathology	Strong support for pathology paperless reporting. Develop plan for the implementation	15-Nov-13	31-Mar-15	RED	GREEN	Update: 20.05.14 As a result of extensive discussions and an understanding of hospital processes, the turning off of paper results is now scheduled to tie in with the roll out of Electronic requesting (Order Communications) which is expected by the the end of this financial year. update 01.10.14 - as above 16.10.14 - Pathology are ready to go and awaiting sign off by Dr Mark Pugh	Acute	Deputy Director for IM&T
2	AT/02/2014/002	07-Feb-14	Early intervention in psychosis	Review issue of timely access to psychological therapist in view of the work going on with Capita	20-Jun-14	31-Oct-14	RED	GREEN	Update 27.08.14 - Capita Clinical Report signed off by CCG and Trust on 16th July 2014. Business cases for clinical roles going to TEC in September. Psychology provision currently under review but all psychologists and psychological therapist are working together to provide access to psychological therapy to all patients in Cluster 4 – 17 and this includes Cluster 10 (Early Intervention in Psychosis). MH update 01.10.14 - as above	Community Health	Acting Head of MH, LD and Community Patnerships
3	AT/07/2014/005	25-Apr-14	DSU	Pursue improved patient information leaflets	30-Jun-14	31-Oct-14	RED	GREEN	Update 28.07.14 Ward sister is currently in the process of ordering some up to date leaflets for patients for the reception area however many of the patient information leaflets/ guidelines on the intranet flag up as requiring updating. Ward Sister is going to delegate the design of a day surgery leaflet to senior members of staff. update 01.10.14 - as above	Planned	Sarah Nolan - Ward Sister
4	AT/07/2014/004	25-Apr-14	DSU	Check requirements for kitchen area to improve IPC environmental audit	30-Jun-14	30-Nov-14	RED	GREEN	29/09/2014 The kitchen is as previously discussed meeting infection control criteria as far as not having the finances to have the walls etc re- decorated.	Planned	Sarah Nolan - Ward Sister
5	AT/07/2014/001	25-Apr-14	DSU	Stagger admissions to avoid patients waiting all day for planned procedure which is sometimes cancelled at last minute impacting on patients nutritional needs.	30-Jun-14	30-Nov-14	RED	GREEN	29/09/2014 SOP's have been written for sending day cases away following initial assessment to be telephoned when they are required for theatre. Miss Allahdin is currently discussing with Consultants. GMO has stated that there is no money for phones/ bleeps.. Not all patients have mobiles. We are hoping to continue taking this forward with a hopeful implementation date of end of Oct/ Nov.	Planned	Sarah Nolan - Ward Sister

No.	Action Reference	Walk Round	Area Visited	Action	Date for completion set by board	Directorate revised date	Status against date set by board	Progress against directorate revised date	Status Comments	Directorate	Responsible
6	AT/02/2014/001	07-Feb-14	Early intervention in psychosis	Move to South Block only expected to be a temporary move. Identify alternatives for their accommodation.	31-Aug-14	17-Nov-14	RED	GREEN	Update 13.10.14 - Associate Director Facilities to meet with Ass. Director for Community Health to work up plan to ensure utilisation of space within EIP team in South Block and identify permanent office space for the team. Plan hoped to be in place by mid-November depending on finance availability.	Community Health	Associate Director Facilities
7	AT/11/2014/002	25-Jul-14	MAAU	Explore physios being able to initiate BiPAP whilst patient awaiting transfer to ward. Dr Wooley currently reviewing guidelines around NIV so may be an opportune time to discuss	30-Sep-14	31-Dec-14	RED		update 17.10.14 - handed over to the SPARRCS team as MAAU don't have say over SPARRCS services. MAAU did point out that it isn't just about setting up the process its staying and managing the patient in the early stages - this is why Whippingham has extra staff to achieve this. LF	Acute	Senior Physio SB/ Ward Sister/ Modern Matron/ HOC

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29 October 2014

Title	Patient Stories Action Tracker			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing and Workforce			
Author(s)	Vanessa Flower, Patient Experience Lead			
Purpose	To provide assurance of progress of actions identified following the Patient Stories			
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		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			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Staff and patients are engaged in the process of patient stories allowing us capture patients experience. Volunteers and Patient Council Members have been trained to undertake the interviews.

Executive Summary:

This report provides the assurance to the Board that the actions identified in response to the Patient Stories have been reviewed and monitored to completion.

There are currently no outstanding actions to report.

For following sections – please indicate as appropriate:			
Trust Goal *(see key)*	Quality Goal		
Critical Success Factors *(see key)*	CSF1, CSF2 and CSF10		
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	10.75		
Assurance Level ***(shown on BAF)***	£ Red	£ Amber	P Green
Legal implications, regulatory and consultation requirements			

Date 16.10.14 **Completed by: Vanessa Flower** Patient Experience Lead

Isle of Wight NHS Trust

Patient Safety, Experience and Clinical Effectiveness Team

Patient Story Walkround

16 October 2014

SITUATION:

This report provides an overview of the actions that have been taken in response to the patient stories.

BACKGROUND:

The patient story programme commenced in March 2013. Patient stories aim to bring the patients voice to the heart of transforming services through recorded interviews. They provide a rich insight into experiences of care – giving patients and family members the opportunity to directly tell their stories of an illness or condition – which in turn can be used to help improve services.

Patient stories are shown to the clinical teams as well at the Quality and Clinical Performance Committee and Trust Board.

ASSESSMENT

Since the commencement of the programme we have undertaken a total of 29 stories, of these 13 videos have been shown at board.

These videos have resulted in 15 actions which have been monitored and reviewed by Trust Board through to completion. At the time of reporting there are no outstanding actions from the stories that have been reviewed by board.

RECOMMENDATIONS:

Future amendments are planned to the way in which Patient Stories are reviewed by clinical staff caring for the patients, and a new toolkit has been produced for undertaking patient stories. This will ensure that action is taken in a timely manner, which will enable assurance to be provided at the time of the video being shown at board that where necessary steps have been taken to address the issues raised by the patients.

This new process will commence during November 2014, with the first video in this process to be shown at the December Board.

Alan Sheward
Executive Director of Nursing and Workforce
Prepared by:
Vanessa Flower
Patient Experience Lead
16 October 2014

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29th October 2014

Title	Capital Planning			
Sponsoring Executive Director	Katie Gray, Executive Director of Transformation & Integration			
Author(s)	Rob Graham, Capital Planning and Development Manager and Sarah Gorbutt, Capital and Treasury Accountant			
Purpose	To seek board approval that the disposal of the Swanmore Road properties be moved to the 2015/16 financial year, approval of a further £54k funding for Ryde Community Clinic and approve the revised capital plan.			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee	06/10/2014	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)	Capital Investment Group 03/10/2014		

Staff, stakeholder, patient and public engagement:

Executive Summary:

The Trust Board has previously approved the disposal of the Swanmore road properties when services relocate to the former Shackleton House, planned for February 2015; this has now slipped into April 2015 due to delays in the refurbishment work to create the new Ryde Community Clinic.

The purpose of this paper is to highlight the effect this delay will cause to the 2014/15 capital programme due to the loss of disposal income, show how this can be mitigated and seek approval for an additional £54k to the previously approved £1.458M, in order to complete the project.

Board approval is now sought for the revised capital plan and the additional funding which is within the Trust's Capital Funding envelope for 2014/15.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	4					
Critical Success Factors *(see key)*	CFS 1 & 2 CSF 3 CSF 7 & 8					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	Mitigation of Health & Safety, Infection Control & Information Governance issues					
Assurance Level ***(shown on BAF)***	Red		Amber	**X**	Green	
Legal implications, regulatory and consultation requirements						

Date: 08/10/2014 **Completed by:** Sarah Gorbutt, Capital and Treasury Accountant

Isle of Wight NHS
NHS Trust

RYDE COMMUNITY CLINIC (H3463) - UPDATE AND REQUEST FOR ADDITIONAL CAPITAL FUNDING

BACKGROUND

This Trust Board approved project was approved on the basis of a £1,468,259 Capital budget and completion in FY 2014.15. Since approval was granted the project has progressed through detailed design and an enabling phase of works and the main contract works proper commenced on 1st September 2014.

During the different stages of the project we have identified additional requirements that have impacted on both the programme and budget, as such this briefing paper seeks agreement of additional capital funding and confirms a revised completion date and the consequential impact of this.

INCREASE IN CAPITAL

Approved Sum -	£1,468,259* see attached pre-tender estimate
Additional Capital Required -	£ 54,106 - this equates to 3.7% uplift
Uplifted Approved Sum -	£1,522,365* see attached completion estimate

Reasons for increase in Capital Budget;

1. During the enabling phase of works we identified that circa 30% of the concrete roof tiles had cracked and as such required replacement. The cost associated with this is £18,000.
2. Increase in BT's fibre costs following survey is £8,400.
3. During detailed design several user led design changes were required and this led to an increase in design costs. The cost associated with this is £16,800.
4. Reduction in VAT recovery has led to increased VAT costs of circa £36,000.

Please note that the above stated increases in cost amount to a total of £79,200, significantly more than our requested increase of £54,106. This scenario has been achieved by re-working the budget and reducing our contingency.

IMPACT ON PROGRAMME

Our planned completion date was 20th February 2015 but unfortunately the delays caused by items 1 and 3 have impacted on the programme and as such we are predicting a completion date of 15th March 2015.

We anticipate relocating services to the new facility during late March/early April 2015, the exact date will be determined by the completion of BT's fibre work, we have been requesting a completion date for sometime now but to date they have not provided or committed to a completion date.

CONSEQUENTIAL IMPACT

The delay in completing this project will have a direct impact on the sale of the Swanmore Road properties. At present our Capital Plan assumes an income of £648K against the disposal of the Swanmore Road properties in 14.15.

Given the potential to achieve a greater income than we have planned for, the uncertainty around when we will actually vacate the Swanmore Road properties and the risk/uncertainties around completing a sale in the latter stages of the financial year, I recommend that we push forward the sale of the Swanmore Road properties and thus the capital receipt into 15.16.

I have discussed this with Andrew Wheeler, Senior Capital Accountant and we have re-worked the capital plan to show the impact of this scenario and this also takes into account the delayed spend on the Carbon Energy Fund (CEF) Project during 14.15.

SUMMARY

The Trust Board is asked to recommend approval of the following;

1. Uplift in Ryde Community Clinic capital budget by £54,106.
2. Acknowledge the delay in completion and consequential impact.
3. Push forward the Swanmore Road Property Disposal capital receipt into 15.16.

ROBERT GRAHAM

Capital Planning & Development Manager – Estate Management Department

26TH SEPTEMBER 2014

Month 6 - 2014/15 Capital Programme:

Isle of Wight NHS
NHS Trust

Source & Application of Capital Funding	Original Plan £'000	Revised Plan / Budget £'000	YTD Plan M1-6 1415	YTD Spend £'000	F'cast to Year End £'000	Full Year £'000	Original Plan 2015/16 £'000	Revised Plan 2015/16		Annual Plan 2016/17 £'000	Annual Plan 2017/18 £'000	Annual Plan 2018/19 £'000
Source of Funds												
Initial CRL	7,460	7,460	0			7,460	6,927	6,927		6,659	6,411	5,916
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	0	0			0		648				
Proceeds from Disposals - Draeger Monitors		20				20						
Cash Surplus							398	398		205	1,512	3,584
Anticipated Capital Resource Limit (CRL)	**8,108**	**7,480**	**0**	**0**	**0**	**7,480**	**7,325**	**7,973**		**6,864**	**7,923**	**9,500**
Other charitable donations	100	100				100	100	100		100	100	100
Charitable Funds - Dementia	9	9				9						
Donated Helipad Income	0	0				0						
VAT Recovery	100	100				100	100	100				
Total Anticipated Funds Available	**8,317**	**7,689**	**0**	**0**	**0**	**7,689**	**7,525**	**8,173**		**6,964**	**8,023**	**9,600**
Application of Funds												
13/14 Schemes Carried Forward												
Backlog high/medium risk & fire safety 13.14	93	93	320	45	48	93						
Replacement of two Main Hospital Passenger Lifts	44	44		10	34	44						
Personal Alarm System for Sevenacres	0	0		0	0	0						
MAU Extension	2,428	1,840	820	242	1,598	1,840		588				
Ward Reconfiguration Level C	142	42	100	51	-9	42		100				
Ryde Community Clinic	1,225	1,280	1,203	77	1,202	1,280						
Dementia Friendly	192	192		231	-39	192						
ISIS Further Faster	344	344	344	172	172	344						
ICU/CCU	2,262	126	1,020	125	1	126						
Endoscopy Relocation	625	2,259	295	123	2,136	2,259	4,163	2,517				
Sub-total	**7,356**	**6,219**	**4,102**	**1,076**	**5,143**	**6,219**	**4,163**	**3,206**		**0**	**0**	**0**
14/15 Approved Schemes												
Endoscopy Backlog Maintenance	0	74		72	2	74						
Call Vision Call Recording Server	0	27		27	0	27						
Replacement Outpatient Desk	0	5		4	1	5						
Medicine Cabinet Installation	0	73		75	-2	73						
Bratt Pans	0	14		14	0	14						
Internal Porters Tug	0	6		6	0	6						
Air Conditioning for IT Network Room	0	25		4	21	25						
Upgrade to Medical Gases System	12	12	0	12	0	12						
St Helens Ward Relocation	0	357		30	327	357						
Theatre Racking	0	21		0	21	21						
Carbon Energy Fund	0	24		0	24	24	0	1,193				
Sub-total	**12**	**636**	**0**	**242**	**394**	**636**	**0**	**1,193**	**0**	**0**	**0**	**0**
14/15 Schemes - Requiring TEC/Board Approval												
Backlog Maintenance	0	0		0	0	0	500	500		1,500	4,000	4,500
IM&T (balance)	156	129	156	0	129	129	500	500		1,500	500	500
RRP (Annual Plan adjusted by £45k to offset Endoscopy Backlog)	460	404	250	0	404	404	500	500		500	500	500
Contingency (Annual Plan adjusted by £28k to offset Endoscopy Backlog)	33	0		0	0	0	500	500		1,400	1,500	1,500
Infrastructure (e.g. underground services)	0	0		0	0	0	300	0		0	0	
Staff Capitalisation	200	200	102	97	103	200	200	200		200	200	500
Unallocated	0	0			0	0						
Sub-total	**849**	**734**	**508**	**97**	**636**	**734**	**2,500**	**2,200**		**5,100**	**6,700**	**7,500**
New/Adjustments to Projects - Requiring TEC Approval												
Unallocated	0	0		0	0	0	762	1,475		1,764	1,223	2,000
Sub-total	**0**	**0**	**0**	**0**	**0**	**0**	**762**	**1,475**		**1,764**	**1,223**	**2,000**
Other charitable donations	100	100		0	100	100	100	100		100	100	100
Gross Outline Capital Plan	**8,317**	**7,689**	**4,610**	**1,416**	**6,273**	**7,689**	**7,525**	**8,173**		**6,964**	**8,023**	**9,600**
Surplus / (Deficit)	**0**	**0**				**(0)**	**0**	**(0)**		**0**	**0**	**0**
Other Potential Schemes												
ENT Decontamination (Cost and Year to be confirmed)												
Theatre Walls and Floors (Cost and Year to be confirmed)												
PTS System		40										
Ophthalmoloy							2,775					
Dementia Wing												4,000
Maternity										1,114	923	
Maternity - Antenatal upgrade		383										
Theatres										1,000	1,000	
Inpatient Areas										1,990	2,100	
Inpatient Admission Areas												400
A&E Phase 3											1,500	
Improvements to Childrens Ward												400
Outpatient Changes											1,000	1,000
Relocation of South Block Community Services												1,500
Total Other Potential Schemes	**0**	**423**	**0**	**0**	**0**	**0**	**2,775**			**4,104**	**6,523**	**7,300**
Potential Surplus / (Deficit)	**0**	**(423)**				**(0)**	**(2,775)**			**(4,104)**	**(6,523)**	**(7,300)**

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29 OCTOBER 2014

Title	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	22-Oct-14
Finance, Investment & Workforce Committee	22-Oct-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 October 2014 Trust Development Authority (TDA) self-certification return covering the September 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)*	3					
Critical Success Factors *(see key)*	6 - 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	Develop our quality governance and financial management systems and processes to deliver performance that exceeds the standards set down for Foundation Trusts.					

Date: 21 October 2014 **Completed by:** Andrew Shorkey, Programme Manager – Business Planning and Foundation Trust Application

ISLE OF WIGHT NHS TRUST
SELF-CERTIFICATION

1. Purpose

To seek approval of the proposed self-certification return for the September 2014 reporting period, prior to submission to the Trust Development Authority (TDA) in October 2014.

2. Background

From 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*.

In March 2014 the TDA published a revised *Accountability Framework* for 2014/15. There are no fundamental changes with respect to the self-certification requirements.

The Trust must continue to make monthly self-certified declarations against prescribed Board Statements and Monitor Licence Conditions.

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

3. Assurance

Lead professionals across the Trust have been engaged 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, Information 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

Board Statements

Board Statements 1, 2, 6 and 14 remain 'at risk' as a consequence of the CQC inspection undertaken in June 2014. A detailed Quality Improvement Plan has been developed to manage delivery of the required improvements and improvement actions are being implemented accordingly. The target date for compliance set by the CQC is 12 December 2014 and these statements will remain at risk until the CQC has confirmed compliance.

Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, also remains 'at risk' and the decline in the governance risk rating score in August 2014 has pushed the forecast compliance date into quarter 3 to allow for a positive trend towards recovery to be established. The quarterly GRR score is currently at 9.0 and is at its highest level since the self-certification process was initiated in 2012. This position is reflected within the draft return document (Appendix 1a).

Licence Conditions

All Licence Conditions are marked as compliant. 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
21 October 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
- *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 and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-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 and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-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 and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-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 declined significantly across quarters 1 & 2 2014/15. Indicator recovery plans are being implemented.	30-Nov-14	Alan Sheward Mark Pugh
11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes			Mark Price

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

12	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies	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 and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-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	This indicator could be but at risk if the CQC action plan is not implemented as required by the CQC.		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 29 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 October 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		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)	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; no new Risks have been added since the August 2014 report.

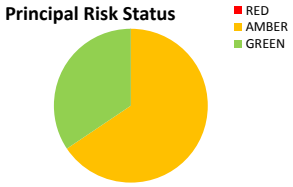
The exception report details FOUR recommended changes to the Board Assurance RAG ratings of Principal Risks: changes from Amber to Green for 10.4, 10.14 and 10.16; one change from Green to Amber for 2.19.

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					

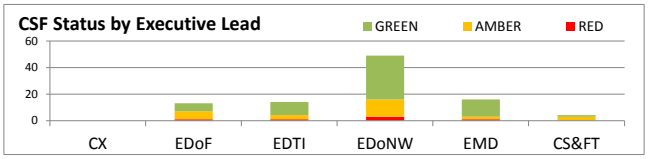
Date: 20 October 2014 **Completed by:** Brian Johnston Head of Corporate Governance and Risk Management

BAF Status Report

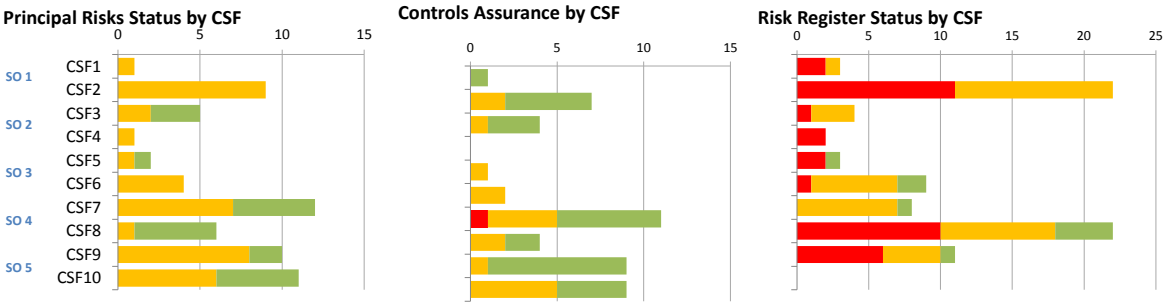
Isle of Wight NHS Trust



Principal Risks:	62	Aligned Risk Register Risks:	88



Strategic Objective & Critical Success Factor Status Overview



BAF
Increased Scores

1

Reduced Scores

3

Commentary

Principal Risks:
3 Principal Risks are recommended for changes from Amber to Green
1 Principal Risk is recommended for change from Green to Amber

No New Risks were added to the Risk Register this month

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
CSF10.4	EDoNW	10.4 (10.2) There is not sufficient knowledge of the quality agenda and NEDs cannot provide sufficient challenge (Q11) Executive Director of Nursing and Workforce	Amber	Green
CSF10.14	EDoNW	10.14 (10.24) It is difficult to hold individuals to account (Q44) Executive Medical Director/ Executive Director of Nursing and Workforce	Amber	Green
CSF10.16	EDoNW	10.16 (10.30) There are consistent red-flags for performance (Q62) Executive Medical Director/ Executive Director of Nursing and Workforce	Amber	Green
CSF2.19	EDoNW	2.19 (2.8) Audit is primarily focussed on finance with a non-mature quality audit function (Q30) Executive Director of Finance/ Executive Director of Nursing and Workforce/Company Secretary	GREEN	Amber

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 CSF2</u> **Lead: Executive Director of Nursing and Workforce** **<u>Improve clinical effectiveness, safety and outcomes for our patients</u>** **Links to CQC Regulations: 9, 10, 12, 13, 14, 17, 18, 20, 21, 22, 23**					MEASURES: **VTE compliance** **HAPPI audit results** **HMSR stats.** **Pressure Ulcer indicators** **CQUIN outcomes** **MRSA and Cdiff stats.** **Approved departmental clinical governance plans:** **- National performance targets** **- Participation in screening programmes** **- Participation in Health improvement programmes for children and young people**			TARGETS: **Board approved quality account within DH deadline** **90% compliance against all HAPPI indicators** **Zero MRSA cases in 2014/15** **Achieve rebased HMSR and SHMI of <108 by end March 2015** **Zero Grade 4 pressure ulcers in a hospital setting** **50% reduction in grades 1,2 and 3 pressure ulcers in hospital setting, from a 2013/14 baseline** **25% reduction in overall incidence of patients developing pressure ulcers in hospital** **50% reduction in grades 1 to 4 pressure ulcers in a community setting, from a 2013/14 baseline** **Centralise PALS service by 31st May 2014** **Trust-wide action plan (from national patient/staff surveys) developed by 31st May 2014** **Ward Boards in place in all identified areas by 31st December 2014** **10% reduction in hospital led outpatient cancellations from a 2013/14 baseline** **100% achievement of CQUINS** **>95% VTE assessments throughout 2014/15**		
2.19 *(2.8)* Audit is primarily focussed on finance with a non-mature quality audit function (Q30) Executive Director of Finance/ Executive Director of Nursing and Workforce/Company Secretary	**4**			There is a clear audit framework at the Trust: There is an enhanced audit function at the Trust and clearly defined plans, actions and performance, which are linked to the Board Assurance Framework (BAF) and high-level operational risks. Re-audits show that improvement have been made. There is broad representation for quality governance on the Audit Committee. Both internal audits and national audits are included in forward plans. Outcomes of audits are clearly described. There is clear evidence of audits leading to improvements.	Assurance is driven by Audit Committee reporting by both internal audit and the report of outstanding recommendations compiled by the finance department. Quality and Clinical Performance Committee Only around 20% of the 12/13 audit plan is directly related to financial audits. The audit plan is discussed and approved at Executive Board and at Audit Committee. This consultation is directly influenced by the Board and the Head of Internal Audit's assessment of audit risk. There is a clear quality audit framework at the Trust Re-audits show that improvements have been made Internal audits and national audits are included in forward plans Outcomes of audits are clearly described Audit data base includes set field to capture BAF links	Minutes of the Audit Committee; Report by the Head of Internal Audit and the annual report of the Chair of the Audit Committee; all reports with limited assurance are presented to the Audit Committee. Continued failure to meet recommendations would result in officer attendance at Audit Committee. Quality audit database being set up.	**Amber**			Review current processes and agree actions to improve links Sarah Johnston/Brian Johnston/Vanessa Flower Update December 2013: (VF) Governance advisors well aware of need to link to BAF. Current audit database under development includes a set field to capture this and ensure that all audit outcomes are linked to BAF. Action Complete Change of assurance rating to Green approved December 2013 Review date: November 2014 Consider quality governance representation at Audit and Corporate Risk Committee Chris Palmer/Sarah Johnston/Alan Sheward Update April 2013: Work in progress and aiming to complete by end May 2013 Update June 2013: Clinical Audit list now reported to Audit and Corporate Risk Committee - Action Complete Update October 2014: CP viewed narrative as out of date, noting from clinical audit perspective recommend this is Amber. AS noted that this needs to link to CQC action plan. Recommend change of assurance rating to Amber
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 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**		
10.4 *(10.2)* There is not sufficient knowledge of the quality agenda and NEDs cannot provide sufficient challenge (Q11) Executive Director of Nursing and Workforce	**6**	**6**		Board members are well inducted, trained and supported and there are ongoing opportunities to develop and increase knowledge of Quality issues. All Executives are held to account for the delivery of quality outcomes. Board members have clear insight into the quality agenda. Awareness of Quality Governance Framework (QGF). Foresight training also focussed on this. NED walkrounds and action tracker	Board induction programme. Board development programme. Executive job/role descriptions. Performance reviews.	Board Development Plan Board minuts evidence NED challenge on quality.	**Green**			**Alan Sheward/Mark Price** Update December 2013: Appointment of 3 new designate NEDs will mean we have 4 NEDS as members of the Quality and Clinical Performance Committee and this will increase the level of challenge in relation to the Trust quality agenda. Quality Governance Framework Self assessment and action plan being reviewed as part of Quality Governance Self Assessment. NED induction to be part delivered by new NEDS. Update April 2014: NED attended FTN event specifically on NED Board Challenge Update July 2014: 2nd NED to attend FTN event on NED Board challenge. Board report from external auditor regarding Board challenge and action plan developed from this. **Update October 2014:** CQC report has given a baseline in which challenge is ardent. **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
10.14 *(10.24)* It is difficult to hold individuals to account (Q44) Executive Medical Director/ Executive Director of Nursing and Workforce	**9**	**9**		There is service line management (SLM) at the Trust and all roles are clearly identified: SLM functions intuitively and all staff are aware of how to escalate issues; and There is a robust service-line reporting structure. Directorates developed lead clinician/modern matron/ departmental leads as "mini triumvirates" Three Performance meetings occur weekly at various levels, designed to support the tier structure in the Performance Management Framework in which we seek to obtain understanding, accountability and assurance.	Organisational structures, roles and responsibilities, KSF framework,	Directorate Board Minutes	**Green**			Implement Service Line Management **Chris Palmer** Review policies which support performance management **Alan Sheward/Mark Elmore** Update April 2014: OD work with J.Skeel ongoing Update July 2014: Developing service level quality, activity and financials matrix **Update Sept 2014: (IH)** Three Performance meetings now occur weekly at various levels, these have been designed to support the tier structure in the Performance Management Framework in which we seek to obtain understanding, accountability, and assurance. At the lowest levels these involve reviewing patient level data to decide appropriate actions. At the next level managers and other relevent staff are held to account on delivery and finally at the highest level assurance is sought to ensure appropriate actions are in place and on track to deliver. **Action complete and recommend change of assurance rating to Green**
10.16 *(10.30)* There are consistent red-flags for performance (Q62) Executive Medical Director/ Executive Director of Nursing and Workforce	**9**	**9**		The Board monitors its own performance and knows where is needs to improve effectiveness. The Board enlists external support to make rapid improvements Forward looking assessment of performance robust under the new process for the production of the Trust Board Performance Report	Board Performance Report, PIAG	Trust Board minutes, TEC minutes	**Green**			Review opportunities for introducing future trends and predictions within Board performance reports. **Chris Palmer/Iain Hendey** Update March 2014: (IH) Trustwide Performance Framework has been drafted. Aiming to implement April 14. Update June 2014: (IH) Trustwide Performance Framework includes escalation process, the framework is currently in the process of implementation. **Update September 2014: (IH)** Weekly Performance Assurance Meetings are taking place to seek assurance appropriate action plans are in place to rectify underperformance. In addition PIDS have developed a range of reports to assess predicted performance for key performance areas such as RTT, cancer and A&E. These reports coupled with closer scrutiny on performance are helping to improve the current performance concerns. **Action complete and recommend change of assurance rating to Green**

Board Assurance Framework column headings: Guidance for completion and ongoing review (N.B. Refer to DoH publication 'Building an Assurance Framework' for further details)

Principal Risks: 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.
RISK LEVEL = 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

Controls in Place: To include all controls/systems in place to assist in the management of the principal risks and to secure the delivery of the objectives.

Assurances on Controls: 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.

Assurance Level RAG ratings:
Effective controls in place and Board satisfied that appropriate positive assurances are available 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 = 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)

Gaps in Control: 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.

Gaps in Assurance: 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.

Action Plans: 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)

Assurance Framework 2013/14 working document - August 2013. Guidance last updated December 2009.

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
								No new Risks added since 22.09.2014								

Key for Assurance Level for Risk Register Entries: GREEN - A adequate controls; AMBER - I inadequate controls; RED - U uncontrolled risks

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29th October 2014

Title	Corporate Governance Framework			
Sponsoring Executive Director	Mark Price, Company Secretary			
Author(s)	Brian Johnston, Head of Corporate Governance & Risk Management			
Purpose	To Approve these three Corporate Governance Framework documents: a) Trust Standards of Business Conduct b) Code of Accountability for NHS Boards (incorporating Code of Conduct) **c)** Accountable Officer Memorandum			
Action required by the Board:	**Receive**		**Approve**	√

Previously considered by (state date):			
Trust Executive Committee	18/08/14, 06/10/14 & 13/10/14	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)	Policy Management Group		

Staff, stakeholder, patient and public engagement:

-

Executive Summary:

The Board is requested to approve the Code of Accountability & Code of Conduct and the Standards of Business Conduct, both for a period of one year. The Board is also requested to approve the Accountable Officer Memorandum for a period of three years – with a next review date of October 2017. If the Department of Health issue any updates to the Memorandum within this 3 year period then a revised version will be brought back to Board as necessary.

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: 17/10/2014 **Completed by:** Brian Johnston, Head of Corporate Governance & Risk Management

Isle of Wight NHS
NHS Trust

STANDARDS OF BUSINESS CONDUCT

A Guide for Employees

Document Author	Authorised Signature
Written By: Head of Corporate Governance & Risk Management **Date**: September 2014	**Authorised By:** Chief Executive **Date:** 29th October 2014
Lead Director: Company Secretary	
Effective Date: 30th October 2014	**Review date:** September 2015
Approval At: Trust Board	**Date Approved:** 29th October 2014

Approval process

Committee	Status	Date
Policy Management Group	Agreed	29/07/2014
Trust Executive Committee	Agreed with amendments requested	18/08/2014
Trust Board	Approved	29/10/2014

Introduction

Circular HSG (93)5 was issued in 1993 and set out the standards of business conduct expected of NHS Staff. The circular still applies but due to numerous organisational and staff changes since that date the arrangements for ensuring these standards are known and upheld by all staff have been reviewed. A copy of the circular is available from the Trust's Library or from your Director. The responsibilities placed upon each employee are as follows:

1. Guiding principle in the conduct of public business

a. It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an employee corruptly to accept any inducement or reward for doing or refraining from doing anything, in his or her official capacity, or corruptly showing favour or disfavour, in the handling of contracts.

b. You will need to be aware that a breach of the provisions of the Bribery Act renders you liable to prosecution and may also lead to loss of employment and superannuation rights in the NHS.

c. The use and management of public funds entrusted to you must be such as to be for the best advantage of the Trust and always be shown to represent best value for money.

2. You are required to do the following

a. Make sure you understand the guidelines on standards of business conduct as set out in this document. Discuss the situation with your line manager if you are not clear.

b. Ensure you are not placed in a position which risks, or might appear to others to risk, conflict between your private interests and NHS duties. This primary responsibility applies to all NHS staff, but those of you who commit NHS resources directly (e.g. by the ordering of goods or services) must take special care to ensure you understand and apply the requirements as set out in this document.

Examples of situations to be avoided are:

Ø Authorising the discharge of a patient into a nursing home in which you, your family, friend or business acquaintance has a financial interest.

Ø Purchasing, or authorising or persuading another Trust employee to purchase or authorise the purchase of, goods or services from an organisation in which you, your family, friends or business acquaintances have a financial interest.

c. Declare to your manager any relevant financial interests on the form at Appendix 2 of this document. **'Nil returns' are required if you have no financial interests to declare.** The return should be submitted annually following review as part of the staff appraisal process.

The form should be completed either on starting employment or on acquisition of the interest, in order that it may be known to your line manager and in no way promoted to the detriment of the Trust. 'Financial interests' include interest in a business (including a private company, public sector organisations, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which might reasonably become involved in the supply of goods or services to the Trust.

If any member of staff is unsure as to whether an interest should be declared then he or she should seek guidance from the Company Secretary or the Head of Corporate Governance and Risk Management

Following receipt of the Declaration of Interest, the nature, scale or complexity of the interest declared will be considered along with the risk that the conflict of interest may adversely influence the interests of patients, taxpayers or the Trust – see appendix 3

d. If your responsibility extends to signing Purchase Orders or placing contracts for goods or services you are still expected to adhere to professional standards of the kind set out in the Ethical Code of the Institute of Purchasing and Supply (IPS), reproduced at Appendix 1.

e. If in doubt whether you have a financial interest that should be declared ask yourself:

- Ø Am I, or might I be in a position where I (or my family/friends/associates) could gain from the connection between my private interests and my employment?
- Ø Do I have access to information which could influence a purchasing decision?
- Ø Could my outside interest be in any way detrimental to the NHS or to the interests of patients of the public?
- Ø Do I have any other reason to think I may be risking a conflict of interest?

f. You should also:-

- Ø Seek your manager's written permission before taking on outside work, if there is any possibility of it adversely affecting your NHS duties or becoming a conflict of interest.
- Ø Obtain your manager's permission before accepting any commercial sponsorship. (See also paragraph d))
- Ø When working with suppliers, follow the Procurement Processes as detailed in the Solent Supplies section of the website and contact the Procurement Service for any further guidance required.

4. You should not:

a. Accept any gifts, inducements or inappropriate hospitality (articles of low intrinsic value such as diaries or calendars, often offered by contractors at

Christmas, need not necessarily be refused). (Lunches in the course of working visits may be acceptable if they are similar in scale of hospitality which the NHS as an employer would offer).

b. Abuse your past or present official position to obtain preferential rates for personal gain or to benefit family friends or associates. Unfairly advantage one competitor over another or show favouritism in awarding work or contracts.

c. Misuse or make available official "commercial in confidence" information to persons or organisations not reasonably needing access, particularly if its disclosure would prejudice the principle of a purchasing system for the Trust based on fair competition.

d. Enter into the commercial sponsorship of posts, events or other services, unless it is made abundantly clear in writing to the company concerned that the sponsorship will have no effect on purchasing decisions of the Trust. The decision whether to accept such sponsorship must be taken by the Board, minuted and subsequently recorded in the hospitality register maintained by the Head of Corporate Governance & Risk Management. The Executive Director of Finance will be responsible for implementing monitoring arrangements to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement. Under no circumstances can a 'linked deal' be agreed whereby sponsorship is linked to the purchase of particular products, or to supply from a particular source.

APPENDIX 1

Organisations adopting the Code will need to commit to the following:

Understanding and commitment

- ensure consistent understanding of business ethics across the organisation at all levels
- continually enhance knowledge of all relevant laws and regulations in the countries in which the organisation operates, either directly or indirectly
- commit to eradicating unethical business practices including bribery, fraud, corruption and human rights abuses, such as modern slavery and child labour

Ethical practice

- conduct all business relationships with respect, honesty and integrity, and avoid causing harm to others as a result of business decisions
- treat all stakeholders fairly and impartially, without discrimination or favour
- actively support and promote corporate social responsibility (CSR)
- avoid any business practices which might bring the procurement profession into disrepute.

Professionalism

- use procurement strategies to drive unethical practices from the supply chain
- ensure procurement decisions minimise any negative impact on human rights and the environment whilst endeavouring to maximise value and service levels
- put ethical policies and procedures in place, regularly monitored and updated, and ensure compliance
- mandate the education and training of all staff involved in sourcing, supplier selection and supplier management to professional standards
- practise due diligence in all business undertakings.

Accountability

- accept accountability and take ownership of business ethics
- foster a culture of leadership by example
- take steps to prevent, report and remedy unethical practices
- provide a safe environment for the reporting of unethical practices

APPENDIX 2

REGISTER OF INTERESTS DECLARATION

To be completed by **ALL STAFF** and retained on the staff member's personal file and **a copy is to be sent to the Risk Administrator, Risk Office, 2nd Floor GMO, St Mary's Hospital** for inclusion in the central register.

Name:	
Department:	
Job Title:	
Partnership:	
Directorship:	
Shareholdings:	**Company:** **Shares held:**
Private Practice:	**Capacity:** **Annual earnings:**
Commercial Interests (please state whether self or state relationship if personal or business relation)	**Body:** **Interest:**
Interest in Other Public Bodies (e.g. school governor, local councillor)	
Links to Other NHS:	
Ownership of land or rental property (e.g. accommodation used by Trust)	
Charitable/Voluntary	
Outside Employment (please specify)	
Other Consultancy Work (please specify)	
Other (please specify)	
GP: (for Board Members only)	

I ……..(name) declare that I **do not have any financial interest/have the above financial interest*** which may have an effect on the Organisation's policies or decisions (*please delete as required).

Signed …… Date ……

APPENDIX 3

Declaration of Interest Form – Responsibilities

All staff members

Form to be completed and submitted by employee to Risk Management Department

- At start of Employment
- On acquisition of interest
- At annual appraisal

Risk Management Department

- Add all submitted Declarations of Interest (including nil returns) to Trust register of interests and update the register annually.
- Ensure the register is made available for scrutiny at all meetings of the Audit & Corporate Risk Committee

Company Secretary / Head of Corporate Governance & Risk Management

- Review all financial interests declared by staff to determine whether the interest is in any way prejudicial to the interests of the Trust
- Take further advice as necessary and advise staff member and their manager of any further action or assurance recommended in relation to the interest declared

Isle of Wight NHS
NHS Trust

CODE OF ACCOUNTABILITY FOR NHS BOARDS

Document Author	Authorised Signature
Department of Health	**Authorised By: Danny Fisher** **Signed:** **Date 29th October 2014**
Lead Director: Company Secretary	**Job Title: Chairman**
Effective Date: 1st November 2014	**Next review date : October 2015**
Approved At: Trust Board	**Date approved 29th October 2014**
Reviewed: October 2014	

CODE OF ACCOUNTABILITY

for NHS BOARDS

CODE OF CONDUCT

Public Service Values

General Principles

Openness and Public Responsibilities

Public Service Values in Management

Public Business and Private Gain

Hospitality and Other Expenditure

Relations with Suppliers

Staff

Compliance

CODE OF ACCOUNTABILITY

Status

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Statutory Accountability

The Board of Directors

The Role of the Chair

Non-Executive Directors

Reporting and Controls

Declaration of Interests

Employee Relations

CODE OF CONDUCT

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is funded from public money, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

There are three, crucial public service values that must underpin the work of the NHS.

Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS:
integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

General Principles

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board directors.

Openness and Public Responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that there is consultation on major changes before decisions are reached. Information supporting those decisions should be made available to the public in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As large employers in the local community, NHS organisations should forge open and positive relationships with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisation's activities on the environment.

The confidentiality of personal and individual patient information must be respected at all times.

Public Service Values in Management

It is unacceptable for the board of any NHS organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board directors have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS boards.

Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports published in good time and made publically available, to allow full consideration by those wishing to attend public meetings on local health issues.

Public Business and Private Gain

Chairs and board directors should act impartially and not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the board director should withdraw and play no part in the relevant discussion or decision.

Hospitality and Other Expenditure

Board directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

Relations with Suppliers

NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship.

Staff

NHS boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board must establish a climate:

- that enables staff who have concerns to raise these reasonably and responsibly with the right parties;
- that gives a clear commitment that staff concerns will be taken seriously and investigated;

and

- where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

Compliance

Board directors should satisfy themselves that the actions of the board and its directors in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct.

……

CODE OF ACCOUNTABILITY

This Code is the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

Status

NHS trusts are established under statute as corporate bodies to ensure that they have separate legal personalities. Statutes and regulations prescribe the structure, functions and responsibilities of their boards and prescribe the way their chairs and directors are to be appointed.

Code of Conduct

All chairs and non-executive directors of NHS trusts are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct should be drawn to the attention of the NHS Trust Development Authority, (NHS TDA).

NHS managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and non-executive directors of NHS boards are responsible for taking firm, prompt and fair disciplinary action against any executive director in breach of the Code of Conduct for NHS Managers.

Statutory Accountability

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS organisations who are thus accountable to him and to Parliament.

NHS trusts provide services to patients (these may be acute services, ambulance services, mental health or other special services, e.g. for children) and must ensure that they are of high quality and accessible.

National standards of quality and safety

NHS trusts providing care in hospitals are required to register with the Care Quality Commission (CQC). It is a condition of registration that hospitals meet five national standards of quality and safety. They mean that patients can expect:

- to be respected, involved and told what's happening at every stage

- care, treatment and support that meet their needs
- to be safe
- to be cared for by staff with the right skills to do their job properly
- hospitals to routinely check the quality of its services

Boards are required to ensure that hospitals continue to meet these minimum standards.

Financial accountability

NHS trusts are subject to external audit by the Audit Commission. NHS boards must co-operate fully with the NHS TDA and the Audit Commission when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State. The Chief Executive/ Permanent Secretary of the Department of Health, as Accounting Officer for the NHS, is accountable to Parliament.

The work of the Department of Health and its associated bodies is examined by the House of Commons Health Committee. Its remit is to examine the expenditure, administration and policy of the Department of Health. Two other Parliamentary Committees, the Public Accounts Committee and the Public Administration Select Committee, scrutinise the work of the Department of Health and the health service.

The Board of Directors

NHS boards comprise executive directors together with non-executive directors and a chair appointed by the NHS TDA on behalf of the Secretary of State for Health. Together they share corporate responsibility for all decisions of the board. The chief executive is directly accountable to the board for meeting their objectives, and as Accountable Officer, to the Chief Executive of the NHS TDA for the performance of the organisation.

Boards are required to meet regularly and to retain full and effective control over the organisation; the chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health, through the NHS TDA, for the discharge of these responsibilities.

The NHS TDA provides the line of accountability from local NHS trusts to the Secretary of State for the performance of the organisation.

The duty of an NHS trust board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation.

The role of an NHS board is to:

- be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs
- provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed

- set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

Further information is available in *The Healthy NHS Board: Principles for Good Governance.*

The Role of the Chair

The overarching role of the chair is one of enabling and leading, so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the chair are:

- leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda
- ensuring the provision of accurate, timely and clear information to directors
- ensuring effective communication with staff, patients and the public
- arranging the regular evaluation of the performance of the board, its committees and individual directors and
- facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

A complementary relationship between the chair and chief executive is important. The chief executive is accountable to the chair and non-executive directors of the board for ensuring that the board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action. The chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the board.

Further information is available in *The Healthy NHS Board: Principles for Good Governance*

Non-Executive Directors

Non-executive directors are appointed by the NHS TDA on behalf of the Secretary of State for Health to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability, through the NHS TDA to Ministers and to the local community.

The duties of non-executive directors are to:

- constructively challenge and contribute to the development of strategy
- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance
- satisfy themselves that quality and financial information is accurate and that controls and systems of risk management are robust and defensible
- determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning and

- ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Non-executive directors also have a key role in a small number of permanent board committees such as the Audit and Corporate Risk Committee, Remuneration and Nominations Committee, the Quality and Clinical Performance Committee and the Finance, Information, Investment and Workforce Committee.

Further information is available in *The Healthy NHS Board: Principles for Good Governance.*

Reporting and Controls

It is the board's duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation's performance
to:

- the Department of Health, on behalf of the Secretary of State
- the NHS Trust Development Authority
- the Audit Commission and its appointed auditors and
- the local community.

Detailed financial guidance, including the role of internal and external auditors, issued by the Department of Health must be observed. The Standing Orders of boards should prescribe the terms on which committees and sub-committees of the board may be delegated functions, and should include the schedule of decisions reserved for the board.

Declaration of Interests

It is a requirement that chairs and all board directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS organisations maintain a register of member's interests to avoid any danger of board directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All board members are therefore expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should normally also include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

Employee Relations

NHS boards must comply with legislation and guidance from the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The board should ensure through the appointment of remuneration and terms of service committee, that executive board directors' remuneration can be justified as reasonable. Board directors' remuneration for the NHS organisation should be published in its annual report

Links to other Trust Policy documents

- Standards of Business Conduct – a Guide for Employees
- Interests, Gifts, Hospitality, Sponsorship and Bribery Act Policy

Originally published April 1994
First revision April 2002
Second revision July 2004
Third revision April 2013

Isle of Wight NHS
NHS Trust

ACCOUNTABLE OFFICER MEMORANDUM

Document Author – Department of Health	Authorised Signature
Lead Director – Mark Price Date: October 2014	Authorised by: Danny Fisher Signed: Date – 29th October 2014
Job Title: Company Secretary	Job Title: Chairman
Effective Date: 30th October 2014	
Approved at: Trust Board meeting	Date approved 29th October 2014
Reviewed: October 2014	Next review date – October 2017

ACCOUNTABLE OFFICER MEMORANDUM

1. You are hereby appointed as the NHS officer responsible and accountable for funds entrusted to your Trust. This memorandum describes your responsibilities as an Accountable Officer, and relates them to my overall responsibility for funds voted by Parliament for the National Health Service. In fulfilling your role as Accountable Officer you will also wish to bear in mind your responsibilities to the Trust Board of which you are a member. The corporate role of the Board is clearly set out in the Codes of Conduct and Accountability issued by the Secretary of State in April 1994.

a. Functions of NHS Trusts

2. The functions of NHS Trusts are:-

   a. To enter into and fulfill service agreements with commissioning bodies;

   b. To meet their statutory duties;

   c. To maintain and develop their relationships with patients, local partner organisations and the wider local community, their commissioning agencies and their suppliers.

   d. The essence of your role as Accountable Officer is to see that the Trust carries out these functions in a way which ensures the proper stewardship of public money and assets. The paragraphs below set out this responsibility in more detail.

Relationship between the Accounting Officer and Accountable Officers

3. My responsibilities as Accounting Officer are set out in a memorandum sent to me on appointment. In essence, I am responsible for the propriety and regularity of pubic finances in the NHS; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; and for the efficient and effective use of all the resources in my charge.

4. Your role as Accountable Officer for your Trust is very similar to mine as Accounting Officer for the NHS in England. I require you to observe the same general requirements are laid on me, and to ensure that the Trust's officers also abide by them. Your Trust is an integral part of the NHS and is largely dependent on public funding even though this is routed through contracts with purchasers.

5. Trusts have the following key relationships:-

   a. With commissioning bodies, through service agreements to deliver health services to agreed specifications;

b. With their local partners and wider communities, through working in partnership to promote the objectives of the local Health Improvement Programme, holding at least one public meeting a year, through publishing business plans, an annual report and accounts; and through compliance with the Code of Practice on Openness in the NHS issued in 1995;

c. With patients, through the management of standards of patient care;

d. Accountability to the Secretary of State and to Parliament for the performance of their functions and meeting statutory financial duties.

6. This Memorandum deals with the final relationship. The first three are covered in other guidance.

7. NHS Trusts are directly accountable to the Secretary of State of Health, who delegates to me responsibility for the supervision of trust performance. I am accountable both to the Secretary of State and, in my Accounting Officer role, directly to Parliament. A similar dual accountability applies to the Chief Executives of Trusts, who are responsible both to their Boards and, via the Accounting Officer, to Parliament. You are therefore accountable through me to Parliament for the stewardship of resources within your Trust.

Statutory Accounts

8. I sign the Summarised Accounts of health bodies in England, and the Resource Accounts of the Department of Health, and by virtue of this responsibility I can be summoned to appear before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or from reports made to Parliament by the Comptroller and Auditor General.

9. The summarised accounts are derived from the statutory accounts of individual Trusts. You are, together with the Director of Finance, responsible for ensuring that the accounts of the Trust which are presented to the Board for approval are prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury. These accounts must disclose a true and fair view of the Trusts income and expenditure, and of its state of affairs. You will sign these accounts, along with the Director of Finance, on behalf of the Board.

10. Reflecting your role as Accountable Officer, you will sign a statement in the accounts (as indicated in the Manual for Accounts) outlining your responsibilities as Accountable Officer.

11. The PAC will continue to regard me as the main respondent to any enquiries, especially where the issues are wider than the individual

Trust. The Committee may however call other witnesses, and I may require you to accompany me at a hearing. I shall in any event look to you for support and information in my dealings with the PAC.

Effective management systems

12. You should ensure that the Trust has in place effective management systems which safeguard public funds. You should assist the Chairman to implement the requirements of corporate governance as exemplified in the Codes of Conduct and Accountability. Managers at all levels should:-

    a. Have a clear view of their objectives and the means to assess achievements in relation to those objectives;

    b. Be assigned well-defined responsibilities for making the best use of resources;

    c. Have the information, training and access to the expert advice they need to exercise their responsibilities effectively.

    Managers should be appraised and held to account for the responsibilities assigned to them under (a) and (b) above.

13. You are responsible for achieving value for money from the resources available to the Trust, for avoiding waste and extravagance in the organisation's activities. You are also responsible for following through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO).

14. You should provide such information as is requested by the NAO. You should co-operate with external auditors in any enquiries into the use your Trust has made of public funds. I may also ask you to provide information on any point raised by external auditors that generate public or Parliamentary interest. Your arrangements for internal audit should comply with those described in the NHS Internal Audit Manual. You must ensure prompt action is taken in response to concerns raised by both external and internal audit.

15. Effective and sound financial management and information are of fundamental importance. Whilst this is the operational responsibility of the Director of Finance you, as the Chief Executive and Accountable Officer, have a primary duty to see that these functions are properly discharged. As the Chief Executive you are required to ensure the continuing financial viability of the Trust, in particular to ensure that expenditure is contained within available levels of income, and to achieve any other financial objectives set by the Secretary of State for Health with the consent of the Treasury, as appropriate. You should also ensure that the assets of the Trust are properly safeguarded.

Regularity and propriety of expenditure

16. You have a particular responsibility for ensuring that expenditure by the Trust complies with Parliamentary requirements. The basic principle that must be observed is that funds should be applied only to the extent and for the purpose authorised by Parliament. You must:-

    a. Draw the attention of Parliament to losses or special payments by appropriate notation of the statutory accounts;

    b. Obtain sanction from the Department of Health for any expenditure that exceeds the limit delegated to the Trust; this includes any novel, contentious or repercussive expenditure, which is by definition outside your delegation;

    c. Ensure that all items of expenditure, including payments to staff, fall within the legal powers of the Trust, exercised responsibly and with due regard to probity and value for money;

    d. Comply with guidance issued by the Department of Health on classes of payments that you should authorise personally, such as termination payments to general and senior managers.

17. The Codes of Conduct and Accountability issued to the NHS Boards by the Secretary of State under cover of EL (94) 40 on 28 April 1994 are fundamental in exercising your responsibilities for regularity and probity. As a Board member you have explicitly subscribed to the Codes; you must promote their observance by all staff.

18. As the Accountable Officer you have a responsibility to see that appropriate advice is tendered to the Board on all matters of financial probity and regularity, and more broadly on all considerations of prudent and economical administration, efficiency and effectiveness. The Director of Finance has a special responsibility to support you in this role; you should ensure that he or she is fully aware of this obligation and has the requisite skills and experience.

19. If the Board or the Chairman is contemplating a course of action which you consider would infringe the requirements of propriety and regularity, you should set out in writing to the Chairman and the Board your Objection to the proposal and the reasons for it. If the Board decides nonetheless to proceed, you should seek a written instruction to take the action in question. You should ensure that the Audit Committee, which has specific terms of reference and delegated powers to inquire into matters of propriety and regularity, and which may require your attendance before it at any time, receives copies of the documents that describe your objections.

20. You should also inform the Department of Health, if possible before the Board takes its decision or in any event before the decision is implemented so that the Executive can if necessary intervene with the Board and inform the Treasury.

21. If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects your responsibility for obtaining value for money from the Trust's resources, it is your duty to draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. If exceptionally you have given clear advice that the course proposed could not reasonably be held to represent good value for money and the Board seems likely to overrule you, you should inform the Department of Health so that it can intervene if necessary. In such cases, and in those described in paragraph 19 above, the Accountable Officer should as a member of the Board vote against the course of action rather than merely abstain from voting.

Accounting Officer

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29th October 2014

Title	Fire Safety Policy			
Sponsoring Executive Director	Mark Pugh, Executive Medical Director			
Author(s)	Martin Keightley, Deputy Head of Health & Safety & Security			
Purpose	To approve Policy			
Action required by the Board:	**Receive**		**Approve**	√

Previously considered by (state date):			
Trust Executive Committee	13/10/2014	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)	Health & Safety Committee, Fire Safety Committee, Policy Management Group, Risk Management Committee		

Staff, stakeholder, patient and public engagement:

Executive Summary:

To approve the Fire Safety Policy

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience					
Critical Success Factors *(see key)*	**CSF 1** - Improve the experience and satisfaction of our patients, their carers, our partners and staff					
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	Fire Safety Management in line with the Regulatory Reform (Fire Safety) Order 2005					

Date: 17/10/2014 **Completed by:** Martin Keightley, Deputy Head of Health & Safety & Security

Isle of Wight NHS
NHS Trust

Fire Safety Policy

Document Author	Authorised
Written By: Deputy Head of Health & Safety & Security **Date:** 14 August 2014	**Authorised By:** ***(job title only)*** **Date:**
Lead Director: Executive Medical Director	
Effective Date: November 2014	**Review Date: November 2017**
Approval at:	**Date Approved:**

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
20 May 2014	7.0	20 May 2014		Lead Director name changed	approved at PMG
12 August 2014	8.1	01 September 2014		Small amendments	Health & Safety Committee
20 August 2014	8.2	03 September 2014		Small amendments	Risk Management Committee
8 September 2014	8.3	16 September 2014			Policy Management Group
13 September 2014	8.3	13 October 2014			The Executive Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust.

Contents **Page**

1. EXECUTIVE SUMMARY

The Trust is committed to ensuring the health, safety and welfare of its staff, members of the public, patients, visitors and contractors and will do all that is reasonably practicable to ensure that this is achieved. The Trust acknowledges its responsibility to protect these people from fire and the dangers associated with fire and therefore aims to ensure that all reasonable measures will be undertaken to prevent fire occurring and effective safe systems are in place to ensure that all persons can remain safe in the event of a fire.

2. INTRODUCTION

The primary remit of NHS organisations with regard to fire safety is the safety of patients, staff and visitors. For all premises under their control, NHS organisations will need to select and effectively implement a series of measures to achieve an acceptable level of fire safety, taking into account:

• all relevant legislation and statutes;

• the guidance in the Health Technical Memorandum 05-01;

• the relevant guidance contained in other parts of Firecode; and

• the advice and approval of building control and fire and rescue authorities.

This policy forms part of the requirements necessary to fulfill the Trust's statutory duties under the Regulatory Reform (Fire Safety) Order 2005 (hereafter referred to as the Fire Safety Order).

A robust Fire Safety Policy is the key to ensuring a high standard of fire safety. This policy addresses the following:

- Fire Safety Strategy;
- Roles and Responsibilities;
- New Building Specifications;
- Fire Safety Manuals;
- Upgrading of Fire Precautions;
- Use and Layout of Departments e.g. cooking in appropriate areas etc;
- Alarm and Detection Systems;
- Fire Safety Training;
- Fire-fighting Equipment;
- Emergency Plans (including evacuation strategies);
- Procurement;
- Fire Safety Audits (FSA's);
- Dangerous Substances and Explosive Atmospheres Guidelines;
- Fire Safety and the Equality Act 2010;.

- Maintenance Fire Safety Systems;
- Records;
- Fire Risk Assessments (FRA's);
- Integrated Risk Management Plans (IRMP's);
- Fire Safety Advice Notes (FSAN).

Whilst this recommended list is not exhaustive, these are considered to be the core elements which cover Trust needs, other elements may be added in future.

This Fire Safety Policy sets out the approach to be taken by the Trust in relation to each of the points above, clearly and without ambiguity.

3. SCOPE

This policy applies to all Trust premises and all Trust staff. Some staff will be working in other buildings that are not owned by the Trust, the principles of this policy will still apply and the same standard of fire safety guarantees must be in place as per the Fire Safety Order and implemented by the landlord and/or the major employer in that premises.

4. PURPOSE

To provide an unambiguous statement of Fire Safety Policy applicable to the NHS on the Isle of Wight, and to premises where patients receive NHS funded treatment or care, excluding a single private dwelling.

5. ROLES AND RESPONSIBILITIES

Fire is a potential hazard to everyone working for the Trust. Because of the danger, there is an imperative need for all staff without exception – medical, nursing, technical, domestic and administrative, to understand what is required of them and co-operate effectively in order to ensure the patients' and their own safety in the event of a fire.

Involvement in fire precautions must therefore be a basic duty of all staff and an essential obligation for all management. All staff with line management responsibilities must ensure that fire safety instructions are brought to the attention of, and observed by, their own staff. (See Appendix D; Fire Safety Structure).

5.1 Trust Board

The Trust Board has overall accountability for the activities of the organisation, which includes fire safety.

The Trust Board should ensure that they receive appropriate assurance that the requirements of current fire safety legislation and the objectives of Department of Health Firecode are being met.

The Trust Board discharges the responsibility for fire safety through the Chief Executive.

5.2 Chief Executive

The Chief Executive will, on behalf of the Board, be responsible for ensuring that current fire legislation is complied with and where appropriate, DH Firecode guidance is implemented in all premises owned, occupied or under the control of the Trust.

The Chief Executive will ensure that all agreements for the provision of care and other services by third parties include sufficient contractual arrangements to ensure compliance with the Trust's Fire Safety Policy.

The Chief Executive discharges the day to day operational responsibility for fire safety through the Director with fire safety responsibility.

5.3 Board Level Director (with fire safety responsibility)

The Director with fire safety responsibility is the Executive Medical Director and is responsible for ensuring that fire safety issues are highlighted at Board level. This responsibility will extend to the proposal of programmes of work relating to fire safety for consideration as part of the business planning process. This will include the management of the fire related components of the capital programme and future allocation of funding.

At an operational level the Director with fire safety responsibility should be:

- Assisting the Chief Executive with Board level responsibilities for fire safety matters.
- Ensuring that the Trust has in place a clearly defined Fire Safety Policy and relevant supporting protocols and procedures.
- Ensuring that all work which has implications on fire precautions in new and existing Trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements (including DH Firecode).
- Ensuring that all proposals for new buildings and alterations to existing buildings are referred to the Fire Safety Manager before Building Control approval is sought.
- Ensuring that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept.
- Ensuring co-operation between other employers where two or more share Trust premises.
- Ensuring through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained.
- Ensuring that agreed programmes of investment in fire precautions are properly accounted for in the Trust's annual business plan.
- Ensuring that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board.

- Fully support the Fire Safety Manager function.

- In line with delegated authority, the Director with fire safety responsibility devolves day to day fire safety duties to the Fire Safety Manager.

5.4 Fire Safety Manager (This role has been integrated into the Deputy Head of Health & Safety and Security position).

It is not possible or desirable to fully define the roles and responsibilities of the Fire Safety Manager; however he/she is responsible for the following:

- The day to day implementation of the Fire Safety Policy.

- Reporting of non-compliance with legislation, policies and procedures to the Director with fire safety responsibility.

- Obtaining expert advice on fire legislation.

- Obtaining expert technical advice on the application and interpretation of fire safety guidance, including NHS Firecode.

- Raising awareness of all fire safety features and their purpose throughout the Trust.

- The development, implementation, monitoring and review of the organisation's fire safety management system.

- The development, implementation and review of the organisation's Fire Safety Policy and protocols.

- Ensuring that fire risk assessments are undertaken, recorded and suitable action plans devised.

- Ensuring that risks identified in the fire risk assessments are included in the Trust's risk register as appropriate.

- The operational management of fire safety risks identified by the risk assessments.

- The development, implementation and review of the Trust's fire emergency action plan.

- Ensuring that requirements related to fire procedures for less able staff, patients and visitors are in place.

- The development, delivery and audit of an effective fire safety training programme.

- The reporting of fire incidents in accordance with Trust policy and external requirements.

- Monitoring, reporting and initiating measures to reduce false alarms and unwanted fire signals.

- Liaison with external enforcing authorities.
- Liaison with Trust Managers.
- Liaison with the Authorising Engineer (Fire).
- Monitoring the inspection and maintenance of fire safety systems to ensure they are carried out.
- Ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported.
- Providing a link to the relevant Trust Committees
- Ensuring an appropriate level of management is always available by the establishment of fire response teams for Trust sites or premises.

Whilst this is not a comprehensive list, these are considered to be the core features of the role. There may be occasions where specialist solutions are necessary to resolve fire safety issues, for example, fire engineering. The Fire Safety Manager would not necessarily be expected to have specialist skills, however would be expected to have sufficient knowledge to realise when they require specialised skills e.g. fire engineered solutions to complex building types and schemes.

5.5 Competent Person (Fire)

Installers and maintainers of fire safety equipment will be commissioned by the Trust and must be able to demonstrate a sound knowledge and specific skills in the specialist service being provided. This may include the installation and/or maintenance of related fire safety equipment/services such as:

- Fire alarm and detection systems.
- Portable fire fighting equipment.
- Fire suppression systems.
- Fire dampers.
- Fire fighting hydrants etc

In cases where external parties provide services, the party concerned should be registered with an appropriate fire industry accreditation scheme.

5.6 Fire Response Team

The Fire Response Team (FRT) will consist of the following;

- Fire Safety Bleep holder or On-call Health & Safety Manager;

- Estates on-call staff;
- Members of staff of the security/parking team;
- Bed Managers;
- Porters.

On arrival at the scene of the incident they are to assist, advise and secure the area to enable the staff to deal with the fire situation in a safe and timely manner and allow the Isle of Wight Fire & Rescue Service clear access to the situation.

5.7 Local Management

Matrons, Heads of Service and Departmental Managers have responsibility for:-

- Monitoring fire safety within their respective workplaces and ensuring that contraventions of fire safety precautions do not take place.
- Ensuring local fire risk assessments are undertaken and maintained up to date.
- Notifying the Fire Safety Manager of any proposals for 'change of use', including temporary works that may impact on the risk assessment, within their area.
- Reporting any defects in the fire precautions and equipment in their area and ensuring that appropriate remedial action is taken.
- Ensuring that the local fire emergency action plans are developed, brought to the attention of staff and adequately rehearsed to ensure sufficient emergency preparedness.
- Ensuring that local fire emergency action plan is revised in response to changes, including temporary works, which may affect response procedures.
- Ensuring the availability of a sufficient number of appropriately trained staff at all times to implement the local fire emergency action plan.
- Ensuring that the duties outlined in this document and relevant fire safety instructions are brought to the attention of staff through local induction and ongoing staff briefings.
- Ensuring that every member of their staff attends fire safety training as set out in the Trust fire safety training matrix.
- Ensuring that all new staff, on their first day in the ward/department, are given basic familiarisation training within their workplace, to include:-
    - Local fire procedures and evacuation plan.
    - Means of escape.

- Location of fire alarm manual call points.
- Fire fighting equipment.
- Any fire risks identified.

· Keeping a record of staff induction and attendance at fire safety training.

· Ensuring staff at all levels understand the need to report all fire alarm actuations and fire incidents as detailed in the fire safety protocols.

· Ensuring that the staff record is completed and returned denoting how this document has been brought to the attention of staff.

· Where appropriate, ensuring that sufficient Fire Wardens are identified and appointed for their specific areas of responsibility.

5.8 Associate Director of Facilities

The Estates Team are a crucial element in the gathering of engineering information and knowledge of complex systems during a fire event and re-setting of engineering systems afterwards. Key tasks include;

· A procedure whereby:

  During normal working hours a supervisor or an electrician attends all Fire Alarm calls to "FIRE" or "FAULT".

  Outside normal working hours the Duty engineer and/or Duty electrician attends all Fire Alarm calls to "FIRE" or "FAULT".

· **Ensure that the Fire Safety Manager is consulted regarding all proposals for new buildings, alterations and changes in the use of existing buildings, and acceptance tests for fire alarm systems.**

· Ensure that where the Trust's premises are shared with other agencies, and the Trust is the landlord, they comply with the Fire Safety Policy.

· Ensure that where contractors or Estates staff are working on Trust premises, appropriate permits to work will be issued prior to the commencement of any works and that the forms issued under the Loss Prevention Council Guidance 'Fire Prevention on Construction Sites' are completed. These permits will include Hot Work Permits to cover any hot work, except in purpose designed work areas such as welding workshops, that involves the production of heat by open flame, hot air gun, welding (gas or electrical), cutting or grinding, or by any other means, issue and control fire compartment breaches by a Fire Compartment Penetration Permit and have in place any other systems to protect fire engineering solutions.

5.9 Switchboard

Has a procedure in place to alert the Fire Service and members of the FRT on activation of a fire alarm or a 2222 emergency call, this allows the procedure to deal with incidents to be fulfilled in a timely manner.

5.10 Fire Warden

All Departments/wards will require a trained Fire Warden who will be appointed to be the focal point for fire safety issues for local staff. The Fire Wardens essentially will be the 'eyes and ears' within that local area but will not have an enforcing role. They will report any issues identified to their Matron and/or Head of Service or Departmental Managers and if necessary to the Fire Safety Manager.

The Fire Warden should:

- Act as the focal point on fire safety issues for the local staff.
- Organise and assist in the fire safety regime within local areas.
- Raise issues regarding local fire safety with their line management.
- Support line managers in their fire safety issues.

5.11 All Staff, Contract Staff and Volunteers

All staff, contractors and volunteers shall:

- Comply with the Trust's fire safety protocols and fire procedures.
- Participate in fire safety training and fire evacuation exercises where applicable.
- Report deficiencies in fire precautions to Line Managers and Fire Wardens.
- Report fire incidents and false alarm signals in accordance with Trust's protocols and procedures.
- Ensure the promotion of fire safety at all times to help reduce the occurrence of fire and unwanted fire alarm signals.
- Set a high standard of fire safety by personal example so that members of the public, visitors and students when leaving Trust premises take with them an attitude of mind that accepts good fire safety practice as normal.

5.12 Fire Safety Committee

In NHS organisations, it is recommended that a Fire Safety Committee be formed. The committee should be responsible for the review of all fire safety matters. Standard agenda items might include fire incidents, false alarms, enforcement action, and staff training.

The Fire Safety committee in this Trust is a subcommittee of the Health and Safety Committee.

The Health & Safety Committee will act as a parallel conduit for reporting on fire safety issues to the Trust Board, and for conveying exception reporting of issues for which the Fire Safety Manager may consider himself to be professionally compromised.

6. POLICY DETAIL / COURSE OF ACTION

The Trust must meet all statutory requirements relating to fire safety within all the buildings for which they are responsible.

The Trust has in place a programme for installing and satisfactorily maintaining an adequate level of fire safety in line with current requirements.

The Trust has:

- nominated a Board Level Director accountable to the Chief Executive for fire safety;

- nominated a Fire Safety Manager to take the lead on all fire safety activities;

In addition to this overall policy, the Trust has an effective management strategy and has developed a framework of departmental Fire Risk Assessments, Fire Safety Plans and Procedures Documents which shall be reviewed when a Fire Safety Audit is being carried out in that area or whenever significant changes occur. These documents will be issued to Departmental Managers who shall ensure that all staff under their control read and understand them. A record will be maintained within the document of staff who has viewed the document.

The Trust provides facilities for the reporting and recording of all fires and fire alarms.
The Trust provides suitable and sufficient staff training on all aspects of Fire Safety as laid down in HTM 05-01: Managing Healthcare Fire Safety.

6.1 Fire Safety Audits.

In accordance with Firecode – Fire Safety in the NHS Health Technical Memorandum 05-01: Managing Healthcare Fire Safety: the Fire Safety Manager will carry out an audit of departments, wards, buildings in the Trust and any other buildings under SLA arrangement. The review will focus on the following areas:

- Current fire safety management procedures, including maintenance procedures;
- Changes in the use of premises;
- Effectiveness of communication systems, including fire alarm and detection systems;
- Local fire safety policies;
- Training and incident management and their related records;
- Action following local fire risk assessment.

The audits will form part of the annual fire safety report presented to the Board and will be taken into account by the Chief Executive when signing the annual statement of fire safety. The Fire Safety Audits will be carried out at the same time as the Fire Risk Assessment, see **6.15** for frequency of visits.

6.2 Fire Safety Advice Notes (FSAN's)

The Fire Safety Manager is responsible for providing advice to assist Directorates to put into place measures that will reduce the risk of fire. There is a 'frequently asked questions' page in the form of Fire Safety Advice Notes which can be accessed on the Health & Safety, Fire Safety page on the Intranet site.

6.3 Fire Fighting Equipment

Fire fighting equipment can reduce the risk of a small fire, e.g. a fire in a waste-paper bin, developing into a large one. The safe use of an appropriate fire extinguisher to control a fire in its early stages can also significantly reduce the risk to other people in the premises. **Note: fight fire only if it is safe to do so.**

In simple premises, having one or two portable extinguishers of the appropriate type, readily available for use is all that is necessary. In more complex premises, e.g. Hospitals, a number of portable extinguishers are available for use throughout the building, sited in suitable and similar locations on every level with extinguisher signs. Some premises will also have permanently installed equipment such as hose reels for use by trained staff or fire-fighters.

Staff with no training should not be expected to attempt to extinguish a fire. However, all staff should be familiar with the location and basic operating procedures for the equipment provided, in case they need to use it.

Extinguishers should primarily be used to protect life and facilitate escape. They should otherwise only be used if they can be operated safely and without risk of trapping the user.

Other fixed installations and facilities, such as wet rising mains for use by the fire service or automatically operated fixed fire suppression systems such as gas flooding systems, have been provided in areas of high fire risk.

It is the responsibility of the Estates Maintenance Department to maintain and service the fixed extinguishing systems. The Fire Safety Manager is responsible for the annual maintenance of portable fire extinguishers.

Fire Wardens are responsible for the monthly visual inspection to ensure that all fire fighting equipment is in its correct location and unobstructed. Check that there are no obvious defects, tamper seals are intact and that any previous faults have been rectified.

6.4 Procurement

All major items must be purchased/ procured through the Solent Supplies Team following the recommendations set out in the Standard Financial Instructions Policy.

Textiles and furniture:

The use of flame-retardant bedding and furnishings will substantially reduce the fire risk. Line Managers should ensure that curtains, drapes and other hanging textiles are inherently fire retardant or treated with a fire-retardant material.

On some occasions patients may provide items of their own clothing and furniture. Particular care should be taken to ensure that this does not introduce an additional risk.

Gifted items such as bedding, curtains, furniture etc. should meet the minimum requirements laid down in HTM 05-03: Operational Provisions Part C: Textiles and Furniture.

For healthcare premises, guidance on textiles and furniture provided by the Trust (including at local level by managers) can be found in HTM 05-03: Operational Provisions Part C: Textiles and Furniture, (Seek advice from the Fire Safety Manager). Such items include:

- Upholstered furniture;
- Loose covers;
- Textile fabrics for curtains (including nets, linings and blackout curtains);
- Roller blinds and
- Textile floor coverings.

Polypropylene chairs should have flame-retardant polypropylene shells.

Totally soft play environments, although not furniture, can contain a large volume of foam in various shapes. Where such environments are extensive, as in gymnasia, extra care must be taken and additional precautions may be necessary. If there are any doubts about the fire performance of any textiles or furniture, confirmation should be sought from the supplier that the items have been tested for flammability by a United Kingdom Accreditation Service organisation test facility

For healthcare premises providing treatment or care for dependent or very high dependency patients, the guidance HTM 05-03: Operational Provisions Part C: Textiles and Furniture, sets out appropriate standards to apply. (Seek advice from the Fire Safety Manager).

Bedding and sleepwear:
Bedding and sleepwear supplied by the Trust should be resistant to ignition. Guidance on the fire performance of bedding and sleepwear can be found in HTM 05-03: Operational Provisions Part C: Textiles and Furniture, (seek advice from the Fire Safety Manager). Such items include:

- Blankets;
- Counterpanes;
- Continental quilts/duvets;
- Mattresses;
- Pillows;
- Sleepwear (including dressing gowns).

Pressure relief products:
Many products such as mattress overlays, fleeces, under pads, electrical pressure mattresses, are used in the care of patients with, or with a pre-disposition to, pressure sores. They are usually used in conjunction with the bed assembly, or on easy chairs or wheelchairs. Where possible, these products should be resistant to ignition. Where this is not practicable, this should be recorded in the local fire risk assessment.

Toys:
All toys supplied in the UK must meet a list of essential safety requirements which are set out in the Toy (Safety) Regulations 2011 (previously the Toy Safety Regulations 1995 - updated in 2010 - and now revoked) and to prove that these requirements are met, all toys should also carry a CE Marking. The care and cleaning of any soft toys should be in accordance with the manufacturer's instructions in order to maintain the flame retardancy, similarly checks should be made of any soft toys donated to the premises to ensure that the flame retardancy requirements of the regulations are achieved.

If in doubt you should seek specialist advice about treatments and tests for these materials, which can reduce their flammability and/or combustibility, or seek confirmation from the supplier that the items have been tested for flammability by a United Kingdom Accreditation Service Organisation test facility.

Electrical Items:
All electrical items that are not classed as medical equipment and not hard wired but need plugging into an electrical socket must be PAT tested by the Estates Maintenance Department as per the Electrical Services Safety Policy, on initial purchase and on a regular basis thereafter.

6.5 Emergency Planning (Including Evacuation Strategy)

All staff must make themselves aware of the Major Incident and Emergency Planning Guides on the intranet home page.

Escape Routes and Strategies
The level of fire protection that should be given to escape routes will vary depending on the level of risk of fire within the premises and other related factors. Generally, premises that are simple, consisting of a single storey, will require fairly simple measures to protect the escape routes, compared with a large multi-storey building (St Mary's Hospital), which is required to have a more complex and inter-related system of fire precautions. Where occupants need assistance to evacuate, there must be sufficient staff to ensure a speedy evacuation. Each Department will have an individual evacuation plan that is highlighted in their Fire Plans & Procedures folder.

Once a fire has started, been detected and a warning given, everyone in the premises should be able to escape safely, either unaided or with assistance, but without the help of the **Fire and Rescue Service**. Where people with disabilities need assistance, staff will need to be designated for the purpose.

In all cases, escape routes are designed to ensure, as far as possible, that any person confronted by fire anywhere in the building should be able to turn away from it and escape (or be evacuated), either directly to a place of total safety (single stage evacuation) or initially to a place of reasonable safety (progressive horizontal or delayed evacuation), depending on the escape strategy adopted.

A place of reasonable safety can be a protected fire compartment (delayed evacuation) or an adjacent sub-compartment or compartment on the same level (progressive horizontal evacuation). From there, further escape should be possible either to another adjacent compartment or to a protected stairway (vertical evacuation) or direct to a final exit.

Evacuation Conditions:
Conditions which seriously threaten the safety of personnel and may require evacuation of the facility, could occur within the structure or from outside the structure and include but are not limited to: fire, explosion, flammable gas leak, toxic gas leak, flammable liquid leak or spill, hazardous material leak or spill, structural collapse, natural disaster, power outage, and severe weather.

Evacuation types:
There are four main stages of evacuation – *please note that these stages are not necessarily progressive and/or sequential*:

Stage 1 – horizontal evacuation from the sub compartment where the incident originates to an adjoining sub compartment or compartment;

Stage 2 – horizontal evacuation from the entire compartment where the incident originates to an adjoining compartment on the same floor;

Stage 3 – vertical evacuation to a lower floor substantially remote from the floor of origin of the incident (at least two floors below), or to the outside.

Stage 4 – whole site evacuation

At all the stages of evacuation consideration must be given to the needs of patients receiving specialist care, for example, those patients who are critically ill.

Horizontal Evacuation Procedure (Stage 1 & 2);
Horizontal evacuation may be called when necessary to clear a given area but the level of risk to the entire facility is such that personnel can be safely assembled within the structure.

Patients are to be evacuated in the following order;

- Patients in immediate danger;
- Ambulatory patients and visitors;
- Non-ambulatory patients.

Vertical Evacuation Procedure (Stage 3);

A vertical evacuation usually follows horizontal and is much more hazardous. Vertical evacuations will be ordered only when absolutely necessary. The evacuation lifts and stairways are to be used to move patients/visitors downward, away from the fire. Some wards have been furnished with ski-sheets where needed to help the movement of patients (Staff must be trained and in date on manual handling procedures) Always proceed down the stairs on the right side. This allows the left side of the stairs to remain clear for emergency personnel.

Patients are to be evacuated in the following order:

- Patients in immediate danger;
- Ambulatory patients and visitors should be grouped and taken down stairways in a single file by each area's designee;

- Medical staff shall be responsible for the non-ambulatory patients/visitors on wards and portering staff for non-ambulatory patients/visitors in public areas.

The use of evacuation equipment should be employed for the safe transfer of patients down a stairwell. An evacuation lift may be used in evacuating any non-ambulatory/wheel chair person or bariatric patients in the main hospital (grey clad building number 20).

If conditions permit, other personnel from each area may be required to assist in safe transport of non-ambulatory personnel to the designated area. (This also applies to any non-ambulatory employee).

Whole Site Evacuation Procedure (Stage 4):
Whole site evacuation will be a designated a Major Incident and the Major Incident plan will be called. Whole site evacuation requires the evacuation of all personnel from all areas of the facility with all personnel assembling at designated areas outside the building.

A whole site evacuation may be performed when conditions exists which seriously threatens the safety of all personnel within the building due to fire or any other infrastructure failure, such as:

- power or other utilities failure
- coastal flooding
- fluvial flooding
- gas leak
- internal contamination
- hostage taken
- conventional and/or non conventional terrorist attack or credible threat
- other

Follow the procedures for vertical evacuation until all persons have exited the building.

6.6 New Building Specifications

All new builds or refurbishments must be planned and constructed to the standards laid down in the relevant Building Regulations, British/European Standards, Codes of Practice, Health Guidance Notes, Health Building Notes, Health Technical Memorandums, Fire Practice Notes, Model Engineering Specifications and EC Regulations. Also the process must comply with the Trust Standing Financial Instructions.

On new developments and material alterations affecting the fire precautions the Trust will submit plans to building control which are complete in all fire precautionary detail for regulation approval. The Fire Safety Manager will check the drawings before they are submitted.

On minor works, which are not subject to building regulation approval, the plan will be submitted to the Fire Safety Manager who will carry out a fire risk assessment and check the drawings for approval.

All completed works that have a fire related element will be inspected and signed off by a third party accredited fire stop engineer.

6.7 Fire Safety Manual

A Fire Safety Manual is an essential tool in managing the fire safety of an occupied building. It should contain both design information and operational records for the premises.

The Manual will initially be created by the design team (for new builds), as it will need to provide details of assumptions and decisions made during the design stage which led to the final building design. This will include explicit assumptions made in respect of on-going management arrangements once the building has become occupied. Upon handover, responsibility for the Manual transfers to the Trust. It will be maintained by the Maintenance Department. The following information will be included:

- Planning arrangements for fire safety, construction and details of the fire safety systems installed (for example alarm and detection, fire suppression etc).

For new buildings, the Fire Safety Manual will be part of the Health and Safety Manual, developed to comply with requirements of the Construction (Design and Management) Regulations 2007.

The Fire Safety Manual will be available for inspection by an enforcement agency (Fire Service), auditor, regulator and for operational purposes, the Fire and Rescue Service.

6.8 Upgrading of Fire Precautions

The upgrading of fire precautions will be an ongoing process that will be identified by the Estate Strategy and the Fire Safety Manager when carrying out fire safety audits/ risk assessments. The work will be risk assessed and placed onto the Trust's risk register for inclusion in future capital works or a separate Capital bid submitted to the Capital Investment Group. Note: The capital works must be in line with the current Estate Strategy for the Trust.

6.9 Alarm and Detection Systems

In most buildings there is a fire alarm system, designed to give early warning to all occupants of a fire situation.

The fire alarm system consists of detectors and manual call points strategically situated throughout the building, which are connected to a control indicator panel.

In the case of conventional single stage systems “zone” indication will be given.

In the case of addressable two stage systems the location of the actuated detector or break glass point will be given at the control panel.

In the event of a fire, the control panel will identify which zone, detector or manual call point has been actuated and therefore the location of the fire. It will also actuate the fire alarm sounders.

Some buildings have got two stage addressable fire alarm systems. This system can operate in two modes which are:

- **Full Alarm**: this indicates there is a fire in that area, staff are to carry out their normal fire procedures.
- **Intermittent Alarm**: this means that there is a fire situation somewhere close to your area; staff are to carry out their normal fire procedures this may include sending a member of staff from the unit to their local fire control panel. It must be remembered that a minimum of 2 members of staff must be maintained at the unit. If the fire is impacting on your working environment close doors and windows, consideration must be given to early evacuation of patients.

Fully addressable fire alarm systems will also have a **Pre-Alarm** mode. When an address shows a Pre-Alarm indication the analogue data received from that sensor is moving towards the full fire alarm mode. This means that any increase in the level of contamination at that device could result in a **FIRE** signal, producing a general alarm indication.

In order to minimise the inconvenience of a false alarm the area around that device should be investigated by a member of staff and if necessary the reason for the pre-alarm (steam, hairspray, dust etc) removed. If after investigation nothing was found, the detector head may be very sensitive due to dust; inform the Estates helpdesk on 01983 534257 so that an engineer can investigate the pre-alarm condition.

The majority of the fire alarm systems on the St Mary’s site are linked to the switchboard. The majority of community sites are not linked to any control room and rely on staff phoning the emergency services on **‘999’ or ‘112’.**

Servicing and Testing
In order to ensure reliability of operation, fire warning systems will be serviced and tested in accordance with British Standard 5839 Part 1, by the Maintenance Department.

6.10 Maintenance of Fire Safety Systems

All Fire Safety Systems (Fire Doors, Fire Alarms, Emergency Lighting and Fire Fighting Equipment etc) will be maintained by the Estates Maintenance Department using the guidance under the relevant British Standard. All Line/Department Managers must inform the Maintenance Department helpdesk immediately via the intranet or ext. 4257 if a fault has been discovered with any of the Fire Safety Systems.

6.11 Dangerous Substances and Explosive Atmospheres Guidelines

All information regarding dangerous substances and explosive atmospheres is contained in the Dangerous Substances and Explosive Atmospheres Guidance on the intranet and forms part of COSHH Management COSHH (Control of Substances Hazardous to Health).

6.12 Fire Safety and the Equality Act

The Equality Act 2010 (EA) requires the adjustment of Policies, Practices and Procedures and, where necessary, the building fabric, so as not to discriminate against disabled people. The development of a fire strategy must take account of the requirements of the EA.

The EA places a duty on building managers/service providers to ensure access to services for all. From October 1999, service providers were required to make reasonable adjustments so that disabled people could access services. This could involve providing extra help or changing the way the service is provided. From October 2004, reasonable adjustments should have been made to the physical features of their premises to assist with access and egress.

It is not possible to precisely define the term “disabled” in this document. However, in the broadest context, it is any person with a physical or mental impairment which has substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. People who have had a disability in the past are also covered.

The term disability does have three distinct definitions:

- People who have an impairment that limits their ability to walk;
- People with impaired sight or hearing;
- People with a learning or mental impairment.

BS 8300 states that “health and welfare buildings should be fully accessible to disabled people” and such buildings include doctors’ and dentists’ surgeries, hospitals, health centres, opticians and older persons’ day centres.

It is important to provide a unified approach to developing appropriate strategies (for example fire and EA strategies). In order to achieve this unified approach, reference should be made to Health Building Note 40 – ‘Recurring spaces’ in addition to Firecode. BS 9999 will apply to the “non-patient” parts of the healthcare estate.

The main principle of fire safety is that all people should be evacuated from a building in the event of fire. In terms of healthcare premises, this may not necessarily be the case for all situations. In hospitals, the concept of progressive horizontal evacuation is the norm. Existing fire legislation requires suitable evacuation procedures to be in place for all people using the building.

The Department/Ward Manager must ensure that any staff required to assist with evacuation are adequately trained. Management must ensure that the portering staff are adequately trained to assist with evacuation in public areas; this may include use of evacuation equipment and/or alternative escape routes.

6.13 Records

Under the Fire Safety Order, Line/Department Managers must keep a record of all fire related events i.e. staff fire training (Pro4 Manager), staff fire drills, up to date managers' fire risk assessment; any fire related engineering reports will be held by the Estates Department. All records must be kept for at least three years in the department Fire Safety Manual.

6.14 Fire Risk Assessment (FRA)

The Fire Safety Manager will carry out an in-depth fire risk assessment of all buildings/ departments. The fire risk assessment must be reviewed regularly and/ or if there has been a significant change to the workplace. The FRA frequency regime is as follows;

- High Risk annually
- Medium Risk every three years
- Low Risk every five years

The aim is to complete 100%, of the FRA's above, however; at least 75% of the FRA's must be completed to comply with this Fire Safety Policy.

6.15 Integrated Risk Management Plan (IRMP)

The Isle of Wight Fire and Rescue Service (IOW F&RS) have carried out an Integrated Risk Management Plan for all sites on the IOW, it examines existing risks, how they plan to reduce those risks and identify opportunities for improving the service they provide. The aim of the document is to ensure that they use their resources in the most appropriate way to ensure an effective Fire and Emergency response. This will affect Trust properties in the type of response the IOW F&RS will provide in the future, this will be determined on risk. Unwanted Fire Signals (UwFS) will also have an impact on the type of response.

The NHS is required to reduce UwFS to the minimum, HTM 05-03: Operational Provisions Part H: Reducing Unwanted Fire Signals in healthcare premises; sets out recommendations and guidance for the reduction of UwFS's generated by automatic fire detection and alarm systems within healthcare premises.

The Trust is committed to reduce UwFS's, as part of the fire safety management of all Trust premises, the number of UwFS's should be minimised. Instances of UwFS's impact upon the treatment and care of patients and can result in the loss of appointments, disruption to care and treatment regimes, and can significantly affect staff morale.

7. CONSULTATION

Consultation has been undertaken with the H&S Committee, the Risk Management Committee and the Policy Management Group.

8. TRAINING

Fire safety training is essential for all staff and is a legal requirement under the Regulatory Reform (Fire Safety) Order 2005, the Health and Safety at Work etc Act 1974, the Management of Health and Safety at Work Regulations 1999 and Firecode – Fire Safety in the NHS HTM 05-01: Managing Healthcare Fire Safety.

Staff need to have an understanding of fire risks and know what to do in the event of a fire so that fire safety procedures can be applied effectively to keep patients safe.

All staff should receive induction training on or before their first day of employment. This may take the form of generic training. Where staff are working in areas where there are specific risks or hazards, the induction training must be supplemented by job-specific instruction as soon as their employment commences.

All staff should receive regular, updated training and instruction. The duration and frequency of the training should be determined by a training needs analysis. The training needs analysis should be formally recorded and periodically reviewed. It is expected that staff involved in the direct care of patients, who may need to help evacuate others, should receive instruction more frequently than those who may only be required to evacuate themselves from the building on the sounding of the fire alarm. See Appendix E staff fire safety training content.

9. DISSEMINATION

When approved this document will be available on the Intranet and will be subject to document control procedures. Approved documents will be placed on the Intranet within 5 working days of date of approval once received by the Risk Management Team.

When submitted to the Risk Management Team for inclusion on the Intranet this document will have fully completed document details including version control. Keywords and description for the Intranet search engine will be supplied by the author at the time of submission.

Notification of new and revised documentation will be issued on the Front page of the Intranet, through e-bulletin, and on staff notice boards where appropriate. Any controlled documents noted at the Trust Executive Committee will be notified through the e-bulletin.

Staff using the Trust's intranet can access all procedural documents. It is the responsibility of managers to ensure that all staff are aware of where, and how, documents can be accessed within their areas of work.

It is the responsibility of each individual who prints a hard copy of any document to ensure that the printed hardcopy is the current version. Current versions are maintained on the Intranet.

10 EQUALITY ANALYSIS

This procedure has undergone an equality analysis please refer to Appendix C.

11. REVIEW AND REVISION ARRANGEMENTS

This policy will be reviewed after 3 years.

12. MONITORING COMPLIANCE AND EFFECTIVENESS

12.1 Activity and issues related to fire safety will be reported and monitored by the fire safety and H&S committee on a monthly basis.

13. LINKS TO OTHER TRUST POLICIES/DOCUMENTS

Guidance on the Prevention of Arson.
Dangerous Substances and Explosive Atmospheres Guidelines.
Fire Safety Advice Notes (FSAN's)
Environmental Management Policy
Health and Safety Policy
Risk Management Strategy
Incident Reporting and Management Policy.
Induction Policy.
Smoke Free Policy.
Electrical Services Safety Policy.
Safety Guidance for dealing with bombs and similar risk and threats.

14. REFERENCES

Regulatory Reform (Fire Safety) Order 2005.
Health & Safety at Work etc Act 1974.
Equality Act 2010.
Care Quality Commission.
NHS Firecode. HTM 05-01: Managing Healthcare Fire Safety.
NHS Firecode. HTM 05-02: Guidance in support of functional provisions for Healthcare premises.
NHS Firecode. HTM 05-03: Operational provisions: Part C: Textiles and Furniture.
NHS Firecode. HTM 05-03: Operational provisions: Part H: Reducing Unwanted Fire Signals in Healthcare Premises.
Health Building Note 40. Common Activity Spaces
Building Regulations 2000, and subsequent amendments.
Construction (Design and Management) Regulations 2007.
The Management of Health & Safety at Work Regulations 1999.
Toy (Safety) Regulations 1995.
BS 5839-1.
BS 8300.
BS 9999

15. DISCLAIMER

It is the responsibility of all staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

Appendix A

CHECKLIST FOR THE DEVELOPMENT AND APPROVAL OF CONTROLLED DOCUMENTATION

Title of document being reviewed:		Y/N/ Unsure	Comments
1.	**Title/Cover**		
	Is the title clear and unambiguous?	Y	
	Does the title make it clear whether the controlled document is a guideline, policy, protocol or standard?	Y	
2.	**Document Details and History**		
	Have all sections of the document detail/history been completed?	Y	
3.	**Development Process**		
	Is the development method described in brief?	Y	
	Are people involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
4.	**Review and Revision Arrangements Including Version Control**		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so, is it acceptable?	Y	
	Are details of how the review will take place identified?		
	Does the document identify where it will be held and how version control will be addressed?	Y	
5.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N	
6.	**Consultation**		
	Do you have evidence of who has been consulted?	Y	
7.	**Table of Contents**		
	Has the table of contents been completed and checked?	Y	
8.	**Summary Points**		
	Have the summary points of the document been included?	Y	
9.	**Definition**		
	Is it clear whether the controlled document is a guideline, policy, protocol or standard?	Y	
10.	**Relevance**		
	Has the audience been identified and clearly stated?	Y	
11.	**Purpose**		
	Are the reasons for the development of the document stated?	Y	
12.	**Roles and Responsibilities**		
	Are the roles and responsibilities clearly identified?	Y	
13.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	

Title of document being reviewed:		Y/N/ Unsure	Comments
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
14.	**Training**		
	Have training needs been identified and documented?	Y	
15.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Y	
	Does the plan include the necessary training/support to ensure compliance?	Y	
16.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or Key Performance Indicators (KPIs) to support the monitoring of compliance with and effectiveness of the document?	U	
	Is there a plan to review or audit compliance within the document?	Y	
	Is it clear who will see the results of the audit and where the action plan will be monitored?	Y	
17.	**Associated Documents**		
	Have all associated documents to the document been listed?	Y	
18.	**References**		
	Have all references that support the document been listed in full?	Y	
19.	**Glossary**		
	Has the need for a glossary been identified and included within the document?	N	
20.	**Equality Analysis**		
	Has an Equality Analysis been completed and included with the document?	Y	
21.	**Archiving**		
	Have archiving arrangements for superseded documents been addressed?	Y	
	Has the process for retrieving archived versions of the document been identified and included within?	Y	
22.	**Format and Style**		
	Does the document follow the correct style and format of the Document Control Procedure?	Y	
23.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Y	

Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of Committee		Date	
Print Name		Signature of Chair	

Appendix B

IMPACT ASSESSMENT ON DOCUMENT IMPLEMENTATION

Summary of Impact Assessment (see next page for details)

Document title	**Fire Safety Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**0**	**0**	**0**
Training Staff	**0**	**0**	**0**
Equipment & Provision of resources	**0**	**0**	**0**

Summary of Impact: All staff will be able to understand their role in prevention of fires and their responsibilities in a fire evacuation to safeguard patient safety.

Risk Management Issues:

Benefits / Savings to the organisation: Reduces the likelihood of preventable fires which could potentially be a huge saving in cost to the organisation.

Equality Impact Assessment

§ Has this been appropriately carried out? YES
§ Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

IMPACT ASSESSMENT ON POLICY IMPLEMENTATION

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs	Health & Safety Department		
Additional staffing required - by affected areas / departments:	N/A		
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Affected areas / departments		
e.g. 10 staff for 2 days		
Totals:		

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

IMPACT ASSESSMENT ON DOCUMENT IMPLEMENTATION - CHECKLIST

Points to consider

Have you considered the following areas / departments?

- Have you spoken to finance / accountant for costing?
- Where will the funding come from to implement the policy?
- Are all service areas included?
  - Ambulance
  - Acute
  - Mental Health
  - Community Services, e.g. allied health professionals
  - Public Health, Commissioning, Primary Care (general practice, dentistry, optometry), other partner services, e.g. Council, PBC Forum, etc.

Departments / Facilities / Staffing

- Transport
- Estates
  - Building costs, Water, Telephones, Gas, Electricity, Lighting, Heating, Drainage, Building alterations e.g. disabled access, toilets etc
- Portering
- Health Records (clinical records)
- Caretakers
- Ward areas
- Pathology
- Pharmacy
- Infection Control
- Domestic Services
- Radiology
- A&E
- Risk Management Team / Information Officer – responsible to ensure the policy meets the organisation approved format
- Human Resources
- IT Support
- Finance
- Rolling programme of equipment
- Health & safety/fire
- Training materials costs
- Impact upon capacity/activity/performance

Appendix C

Equality Analysis and Action Plan

(This template should be used when assessing services, functions, policies, procedures, practices, projects and strategic documents)

Step 1. Identify who is responsible for the equality analysis.

Name: Martin Keightley
Role: Deputy Head of Health & Safety and Security
Other people or agencies who will be involved in undertaking the equality analysis:

Step 2. Establishing relevance to equality

	Relevance		
Protected Groups	**Staff**	**Service Users**	**Wider Community**
Age	X		
Gender Reassignment	X		
Race	X		
Sex and Sexual Orientation	X		
Religion or belief	X		
Disability	X		
Marriage and Civil Partnerships	X		
Human Rights	X		
Pregnancy and Maternity	X		

Show how this document or service change meets the aims of the Equality Act 2010?

Equality Act – General Duty	**Relevance to Equality Act General Duties**
Eliminates unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act.	Staff will be trained to evacuate patients.
Advance equality of opportunity between people who share a protected characteristic and people who do not share it	
Foster good relations between people who share a protected characteristic and people who do not share it.	

Step 3. Scope your equality analysis

	Scope
What is the purpose of this document or service change?	To ensure that staff and patients are treated equitable in relation to Fire Safety.
Who will benefits?	
What are the expected outcomes?	The organisation will have the staff trained to respond correctly in an emergency fire situation.
Why do we need this document or do we need to change the service?	As above

It is important that appropriate and relevant information is used about the different protected groups that will be affected by this document or service change. Information from your service users is in the majority of cases, the most valuable.

Information sources are likely to vary depending on the nature of the document or service change.

Listed below are some suggested sources of information that could be helpful:

- Results from the most recent service user or staff surveys.
- Regional or national surveys
- Analysis of complaints or enquiries
- Recommendations from an audit or inspection
- Local census data
- Information from protected groups or agencies.
- Information from engagement events.

Step 4. Analyse your information.
As yourself two simple questions:

- What will happen, or not happen, if we do things this way?
- What would happen in relation to equality and good relations?

In identifying whether a proposed document or service changes discriminates unlawfully, consider the scope of discrimination set out in the Equality Act 2010, as well as direct and indirect discrimination, harassment, victimization and failure to make a reasonable adjustment.

Findings of your analysis

	Description	**Justification of your analysis**
No major change	Your analysis demonstrates that the proposal is robust and the evidence shows no potential for discrimination.	
Adjust your document or service change proposals	This involves taking steps to remove barriers or to better advance equality outcomes. This might include introducing measures to mitigate the potential effect.	
Continue to implement the document or service change	Despite any adverse effect or missed opportunity to advance equality, provided you can satisfy yourself it does not unlawfully discriminate.	
Stop and review	Adverse effects that cannot be justified or mitigated against, you should consider stopping the proposal. You must stop and review if unlawful discrimination is identified	

5. Next steps.

5.1 Monitoring and Review.

Equality analysis is an ongoing process that does not end once the document has been published or the service change has been implemented.

This does not mean repeating the equality analysis, but using the experience gained through implementation to check the findings and to make any necessary adjustments.

Consider:

How will you measure the effectiveness of this change	
When will the document or service change be reviewed?	
Who will be responsible for monitoring and review?	
What information will you need for monitoring?	
How will you engage with stakeholders, staff and service users	

5.2 Approval and publication

The Trust Executive Committee / Policy Management Group will be responsible for ensuring that all documents submitted for approval will have completed an equality analysis.

Under the specific duties of the Act, equality information published by the organisation should include evidence that equality analyses are being undertaken. These will be published on the organisations "Equality, Diversity and Inclusion" website.

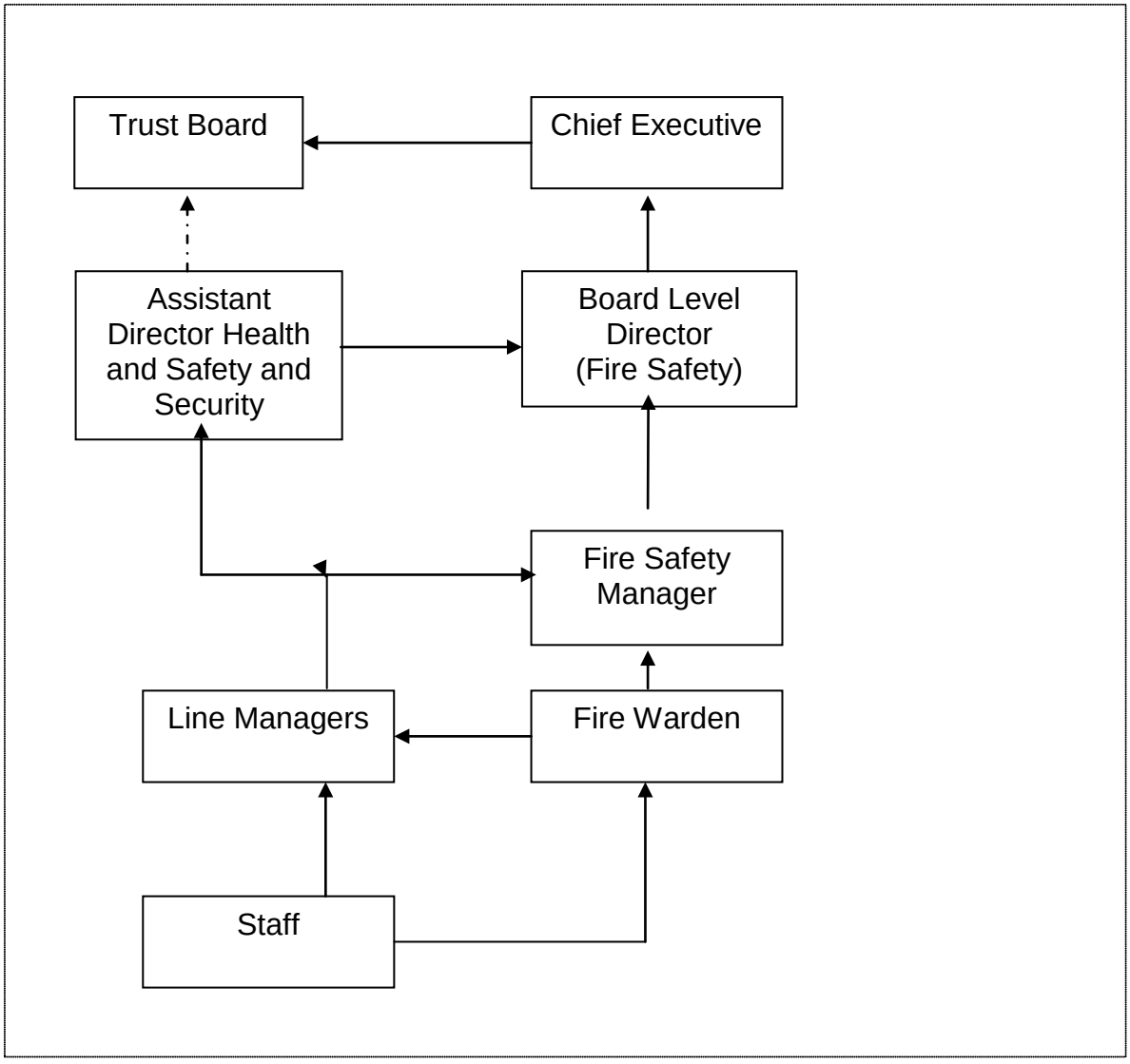
Useful links:

Equality and Human Rights Commission
http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/equality-act-guidance-downloads/

Appendix D

Fire Safety Structure

The following fire safety structure demonstrates functional accountability throughout the Trust.



Key:

Direct accountability for fire safety ⟶

Note:

The lines of accountability flow upwards. This emphasizes that everyone is responsible for fire safety.

Appendix E

Staff Fire Safety Training

All new staff to attend the Trust induction course, and be given a local induction on the first day of employment which includes the following:

- Raising the alarm in the event of a fire.
- Means of escape in the event of fire/fire exits.
- Use of extinguishers.
- Assembly points.

All staff are to receive fire training in accordance with a training needs analysis, however, no member of staff should go without a training sessions for longer than two years.

Basic fire safety awareness training is to include:

- The action to be taken upon discovering a fire.
- The action to be taken upon hearing the fire alarm.
- Raising the alarm, including the location of the alarm call points and alarm indicator panels. *
- The correct method of calling the fire brigade.
- The location and use of fire fighting equipment.
- Knowledge of the method of operation of any special escape door fastening. *
- Appreciation of the importance of fire doors.
- Stopping machines and processes and isolating power supplies where appropriate.
- Evacuation of the building to an assembly point at a place of safety. *
- Roll call procedures.
- Any special procedures appropriate to departments. *

* These subjects should be site specific and identified, where applicable, in the department's Fire Plans and Procedures document.

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 29 OCTOBER 2014

Title	Charitable Funds Committee – Patient Council Representatives			
Sponsoring Executive Director	Chris Palmer, Executive Director of Finance			
Author(s)	Mark Price, Company Secretary			
Purpose	To appoint a Patient Council Representative and deputy to the Charitable Funds Committee			
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	
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:

Patient Council

Executive Summary:

The current Patient Council Representative, June Ring, stepped down from the Charitable Funds Committee on the 9th September 2014. The Patient Council has nominated the following Council members to be their representatives on the Committee:

Dennis Ford – Member

Christine Barringer – Deputy

The Corporate Trustee is asked to approve the appointments to the Charitable Funds Committee.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	All					
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: 17 October 2014 **Completed by: Corporate Governance Officer**