Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 30th April 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 30th April 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: Mark Pugh & 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
09:35	**2**	**Patients Story**			
	2.1	Presentation of this month's Patient Story	CEO	Receive	Pres
09:50	**3**	**Minutes of Previous Meetings**			
	3.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 26th March 2014 and the Schedule of Actions.	Chair	Approve	Enc A
	3.2	Chairman to sign minutes as true and accurate record	Chair	Approve	Verbal
	3.3	Review Schedule of Actions	Chair	Receive	Enc B
09:55	**4**	**Chairman's Update**			
	4.1	The Chairman will make a statement about recent activity	Chair	Receive	Verbal
10:00	**5**	**Chief Executive's Update**			
	5.1	The Chief Executive will make a statement on recent local, regional and national activity.	CEO	Receive	Enc C
	5.2	Employee Recognition of Achievement Awards	CEO	Receive	Pres
	5.3	Employee of the Month	CEO	Receive	Pres
10:25	**6**	**Quality and Performance Management**			
	6.1	Performance Report	EDF	Receive	Enc D
	6.2	Minutes of the Quality & Clinical Performance Committee held on 16th April 2014 including the Quality Goals 2014/15	QCPC Chair	Receive	Enc E
	6.3	Minutes of the Finance, Investment & Workforce Committee held on 16th April 2014	FIWC Chair	Receive	Enc F
	6.4	Quarterly Mortality Update	CEO	Receive	Pres
	6.5	Monthly Board Walkabouts Action Tracker Update	EDNW	Receive	Enc G
	6.6	Annual Report - Board Walkabout Action Tracker	EDNW	Approve	Enc H
	6.7	Quarterly Patient Story Action Tracker	EDNW	Receive	Enc I
	6.8	Annual Report - Patient Story Action Tracker	EDNW	Approve	Enc J
	6.9	Staff Story	EDNW	Receive	Pres
11:30		**COMFORT BREAK**			
11:40	**7**	**Strategy and Business Planning**			
	7.1	Academic Health Science Network (AHSN) Membership	CEO	Approve	Enc K
	7.2	Annual Capital Programme approval	EDF	Approve	Enc L
	7.3	Emergency Preparedness, Resilience and Response (EPRR) Annual Report to the Board	EDNW	Receive	Enc M

	7.4	FT Programme Update	FTPD	Receive	Enc N
	7.5	FT Self Certification	FTPD	Approve	Enc O
12:00	**8**	**Governance and Administration**			
	8.1	Board Assurance Framework (BAF) Monthly update	Comp Sec	Approve	Enc P
	8.2	Interests, Gifts, Hospitality, Sponsorship and Bribery Act Policy	Comp Sec	Approve	Enc Q
	8.3	Statutory & Formal Roles 2014-15 approval	Comp Sec	Approve	Enc R
	8.4	Quality & Clinical Performance Committee Terms of Reference	CS	Approve	Enc S
	8.5	Notes of the FT Programme Board held on 25th March 2014	CEO	Receive	Enc T
	8.6	Minutes of the Mental Health Act Scrutiny Committee held on 16th April 2014	MHASC Chair	Receive	Enc U
	9	**Matters to be reported to the Board**	Chair		
	9.1				
12:20	**10**	**Any Other Business**	Chair		
	11	**Questions from the Public**	Chair		
		To be notified in advance			
	12	**Issues to be covered in private**.	Chair		

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

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

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

Strategic Estates Partner - Update
Safer Staffing Levels
Reports from Serious Incidents Requiring Investigation (SIRIs)
Safeguarding 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.

12:30	**13**	**Date of Next Meeting:**

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on Wednesday 28th May 2014 in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

Enc A

Isle of Wight NHS Trust

Minutes of the meeting in Public of the Isle of Wight NHS Trust Board held on Wednesday 26th March 2014 at the Innovation Centre, St Cross Business Park, Newport, IW

PRESENT:	Danny Fisher	Chairman
	Karen Baker	Chief Executive (CEO)
	Mark Pugh	Executive Medical Director (EMD)
	Chris Palmer	Executive Director of Finance (EDF)
	Alan Sheward	Executive Director of Nursing & Workforce (EDNW)
	Nina Moorman	Non Executive Director
	Charles Rogers	Non-Executive Director (Senior Independent Director)
	Peter Taylor	Non-Executive Director
	Sue Wadsworth	Non-Executive Director
In Attendance:	Jessamy Baird	Designate Non-Executive Director
	David King	Designate Non-Executive Director
	Jane Tabor	Designate Non-Executive Director
	Mark Price	FT Programme Director & Company Secretary
	Andy Hollebon	Head of Communications
	Stephen Wheeler	Quality Manager – Planned Directorate *(For item 14/089)*
	Annie Hunter	Head of Midwifery *(For item 14/089)*
	Rowena Bennett	Midwife *(For item 14/089)*
	Lesley Harris	Former Head of Clinical Services – Planned Directorate *(For item 14/089)*
	Iain Hendey	Assistant Director - Performance Information & Decision Support *(For item 14/092)*
	Michael Head	Hotel Services Manager *(For item 14/096)*
	Jean Witney	Cleanliness Supervisor *(For item 14/096)*
	Kevin Wilkins	Principal Analyst *(For item 14/097)*
	Glenis Sturgess	Clinical Nurse Manager – Endoscopy *(For item 14/097)*
	Leann Hetherington	General Manager – Planned Directorate *(For item 14/097)*
	Dr Leonie Greiller	Consultant Gastroenterologist / Clinical Lead for Endoscopy *(For item 14/097)*
	Andy Shorkey	Foundation Trust Programme Management Officer *(for item 14/099)*
	Kevin Curnow	Deputy Director of Finance *(For item 14/100)*
	Fiona Brothers	Risk & Litigation Officer *(For item 14/103/104*
	Connie Wendes	Assistant Director Health & Safety and Security*(For item 14/105)*
Observers:	Chris Orchin	Health Watch
	Nancy Ellacott	Patient Council
	Sarah Goodson	Senior Consultant, Kings Fund
Minuted by:	Lynn Cave	Trust Board Administrator
Members of the Public in attendance:	There were three members of the public present	

Minute No.	
14/083	**APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE**

The Chairman welcomed everyone to the meeting.

Apologies for absence were received from Andy Heyes – Interim Director of Planning, ICT & Integration and

Apologies were also received from Isle of Wight County Press, Mr Roy Murphy and Mrs Rose Wiltshire

There were no declarations of interest.

The Chairman announced that the meeting was quorate.

14/084 PATIENT STORY

The Chief Executive introduced the patient story. She advised that this month's story for the first time was filmed at a patient's home for the first time. The patient explained his experiences of receiving care in the community and issues arising when he had to attend for appointments. He outlined some problems which arose from his condition and areas which would make the situation easier for him.

The Executive Director of Nursing & Workforce presented the following outcomes from this film.

Actions Agreed:

- Continuing education of staff relating to the needs of patients who have disability including use of video interviews.
- Meeting called with the various professionals involved to review the patient story. This included district nursing sister, commissioner, sister in charge of respiratory services, senior sister Coronary Care Unit (CCU) and Intensive Care Unit (ICU).

Actions taken so far:

- Oxygen tubing kept on site now and was handed to the District Nursing Sister at the meeting to take to patient.
- Team agreed that they need to investigate the use of a different ventilator when the "Nippy" reaches the end of its usable life.
- Agreement reached on joined up working to enable a sharing of expertise on the island in support of ventilated patients.
- Clear pathway of care agreed to be developed.
- Patients to be advised of an alternative parking area near respiratory department when disabled spaces are all full.
- Patient to be advised about the useful physiotherapy services at the John Cheverton Centre, Earl Mountbatten Hospice.

Organisational issues that need to be explored:

- When patients with complex needs are booked for multiple appointments with different hospital departments could there be a system of flagging up that the appointments need to be booked on the same day to prevent multiple journeys.
- Although there is some expertise in the area of ventilated patients there was a feeling that there needed to be further physiotherapy input.

The Chairman stated that there were a number of areas where lessons could be learnt and in particular he asked whether a portable generator could be purchased by Estates to loan out to patients in emergency situations which would allow the patient to remain at home.

Action Note: *The Executive Director of Nursing & Workforce to discuss with Estates about purchasing a portable generator.*

Acton by: EDNW

Sue Wadsworth confirmed that the full version of the film was shown at the Quality & Clinical Performance Committee. She advised that the clinical directorates did not always

focus on the holistic care of the patient. They would be reviewing processes. The Chief Executive echoed this stating that work was needed to change the way staff think about viewing a situation in relation to a solution rather than potential problems. She stated that it was good that patients could now live in their homes with health problems which as little as 4 years ago would have meant they would have needed to be in hospital.

Peter Taylor asked if IT expertise could be brought in to review ways of linking the appointment systems and asked if there was a strategy for this. The Executive Director of Nursing & Workforce advised that the OPARU team as well as others should view this film as it highlighted the need to view patients as individuals who use a range of services which need to be linked together.

Jane Tabor stated that there was a need for a single patient record with a single point of contact who would be responsible for co-ordinating care across the Trust. The Executive Medical Director confirmed that other Trusts were bringing in care co-ordinators for patients with complex health needs and he would like the ICU team to also view the film.

The Chairman asked that all staff making calls to patients as part of their job also view as they need to understand how communications can be perceived by patients as negative at the end of a phone.

Sue Wadsworth stated that there was a national move towards holistic care and the need to build this into our culture and to treat people as individuals and not as a series of conditions.

Action Note: *The Executive Director of Nursing & Workforce to arrange for the film to be viewed by the relevant teams, in particular OPARU, Cardiology, Out Patients, ICU and call handlers.*

Action by: EDNW

The Isle of Wight NHS Trust Board received the Patient Story

14/085 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 26TH February 2014 were approved with the following amendments:

a) **Min No. 14/058** - Jessamy Baird asked that for clarity under action 14/058 that the comments discussed at the Quality & Clinical Performance Committee on 19th February (Min no. 14/076) had included a broader discussion on nutritional issues including naso-gastric tube feeding, nutrition appropriate to clinical needs and levels of support with issues around patient preferences and patient consent within the organisation.

b) **Min No. 14/065** – Note that it was the Executive Medical Director who presented the January performance report.

c) **Min No. 14/065 i)** para 4 – Change wording from health visitors to “health careworkers”.

d) **Min No. 14/065 iv)** para 2 **–** Jessamy Baird asked for an additional action to be added which reviewed the risks in more detail and applied due dates. Company Secretary to carry forward.

e) **Min No. 14/065 vii)** – amend text to read “use of the word”.

Proposed by Peter Taylor and seconded by Charles Rogers

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

14/086 REVIEW OF SCHEDULE OF ACTIONS

The following updates to the schedule of actions were noted:

a) **TB/059 – Flu Incentives:** The Executive Director of Nursing & Workforce to provide revised forecast date for incentives. He also confirmed that during this seasons Flu campaign a total of 1328 staff had received the vaccine.

b) **TB/069 – LTFM:** New forecast date of 20th June 2014

c) TB/070 – Mortality Data: The Executive Medical Director confirmed that these are age adjusted before the data is released. Action now closed.

d) **TB/075 – Patient Information Board:** The Executive Director of Nursing & Workforce confirmed these were now ordered and in the process of being installed. Action now closed.

e) **TB/080 – Falls:** It was confirmed that data on the ratio of falls would be added and not the number of falls to the Performance report and would come into effect from 30th April. Action now closed

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

14/087 CHAIRMAN'S UPDATE

The Chairman reported on the following items:

a) **Non-Executive Director Recruitment** – The Chairman confirmed that the recruitment process to appoint a Non-Executive Director with Financial experience was going well with 3 potential candidates identified. He confirmed that interviews would take place in the next few weeks.

b) **Norovirus Outbreak** – The Chairman advised that whilst co-ordination within the Trust was going well there seemed to have been a lack of co-ordination within the larger community and that work needed to be done to re-establish working links with Public Health who were now under the guidance of the Local Authority instead of being part of the NHS.

c) **Trust Development Authority (TDA)** – He confirmed that he would be meeting with the TDA in London next week.

Peter Taylor asked if in the case of a Norovirus Outbreak, using the hand gel was ineffective and hand washing was needed to prevent further contamination, would it be advisable to invest in wash basins at the entrances to the hospital. The Chief Executive advised that hand gels do help against most viruses but not Norovirus. She advised that "pop up" portable wash basins had been considered but were not suitable and the Estates team were looking in to installing wash basins around the Trust. The Executive Director of Finance confirmed that staff had been present at all entrances to advise visitors to wash their hands. The Executive Medical Director stated that the Public Health service had been reduced since their move to the Local Authority and it was necessary for the Trust to ensure that an effective Public Health service was available.

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

14/088 CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented her report. Areas covered were:

National

- NHS pay
- NHS Change Day

Local

- Care Quality Commission inspection
- My Life A Full Life – Spring Newsletter
- Norovirus Outbreak

- Allergy and Asthma Centre
- Hospital Porters raise money for Cancer Clinical Nurse Specialists

Jane Tabor commented on the good work by staff during the Norovirus outbreak and said that there would be areas of learning for any future outbreaks. The Chief Executive stated that it was important to get the message out to the wider population about how they can help by understanding how viruses are transmitted and what they can do to reduce bringing any potential viruses into the Trust. The Executive Director of Nursing & Workforce confirmed that this outbreak had been recorded as a serious incident which required investigation (SIRI) and would be fully investigated to ensure all possible lessons are captured for future learning opportunities. He also confirmed that there would be an internal de-brief to staff.

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

14/089 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

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

a) **Quality Care & Innovation** – Stephen Wheeler
b) **Long Service** – Lesley Harris and Rowena Barrett

The Chief Executive congratulated all recipients on their achievements.

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

14/090 EMPLOYEE OF THE MONTH

The Chief Executive explained that due to the current restrictions within the hospital this award would be presented to the Employee of the Month at the next Board meeting on 30th April.

QUALITY AND PERFORMANCE MANAGEMENT

14/091 PERFORMANCE REPORT

The Executive Director of Nursing & Workforce presented the Performance report for February 2014 and confirmed that with effect from 1st April 2014 the report would appear in its new revised format.

Highlights

- All Cancer indicators maintaining year to date position
- Emergency Care 4 hour standard performance remains above target
- Number of C.Diff cases are on track to achieve year end stretched target
- Reduction in formal complaints during February
- Marked improvement in Venous Thrombo-Embolism (VTE) risk assessment recording

Lowlights

- Drop in Admitted 18 weeks referral to treatment time for January
- Staff absenteeism due to sickness remains above target
- Pay costs/variable hours remain challenging
- CIP targets remain challenging
- Drop in Non-admitted 18 weeks RTT for February.

Key Points:

a) **Patient Safety, Quality & Experience:**

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

Venous Thrombo-Embolism **(VTE) risk assessment** figures from 4th February show an underperformance (94% vs 95% target), this figure is based on the final month of manual data capture. Pharmacy are now confident that the new upgrade to their system during February has eliminated previous data collection problems and we are now achieving 100%, exceeding both the local and national targets of 95%.

Health Care Acquired Infection (HCAI): We are currently within both our nationally set threshold and our local stretched target for Healthcare Acquired Clostridium Difficile infection, remaining at 6 YTD, with no cases reported during February. There were no cases of Healthcare Acquired MRSA bacteraemia identified in February, remaining at 2 YTD.

Mental Health: There was a single breach in Child & Adolescent Mental Health but the extremely low numbers have an exaggerated impact on percentages.

b) **Operational Performance:**
Performance against our key operational performance indicators is again mainly green for the month, the only red flag being referral to treatment times for non-admitted patients. TIA reporting figures are not yet available for February.

All cancer targets are again green for month and year to date. Provisional figures indicate that 40% of breaches during February were due to capacity issues.

From April 2014 this Performance report will be revised to include a wider range of measures and a clearer reporting structure for Acute, Community and Mental Health and Ambulance services which will give a more balanced reflection on our performance as the only fully integrated Trust in the country.

c) **Workforce:**
The total pay bill for February (£9.83m) is above plan (£9.55m). The number of FTEs in post is also currently higher than plan (10). 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 increased again in February (4.65%) and remains above plan at 3.77% YTD. Specific problem areas are being identified for investigation and are challenged at directorate performance review meetings.

d) **Finance & Efficiency:**
Overall we have slightly over-achieved our financial plans for February by £214k and based on the new measure, the Continuity of Service Rating, introduced by Monitor on 1st October, our overall rating is 4.

The target YTD CIP target of £7,547k has been under-achieved by £1,151k, and recurrent savings of £1,478k still need to be identified. However, there is an increasing risk that this carry forward figure is significantly higher. Directorates are continuing to review opportunities to mitigate this balance with a view to eliminating any carry forward into next financial year.

The following areas were raised in discussion:

i. **Appraisals:** Jessamy Baird noted that the data provided on the Balanced Scorecard seemed to differ from the data given later in the report. The Executive Director of Nursing & Workforce advised that this figure represented the whole

Trust whereas the other data was representative of the directorates individually.

ii. **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.

Action Note: *The Executive Director of Nursing & Workforce to request update from Public Health on their pressure ulcer prevention initiative.*

Action by: EDNW

iii. **Electronic Prescribing:** Nina Moorman commented that she had visited other NHS Trusts with the Executive Director of Nursing & Workforce and had received favourable comments on our success with electronic prescribing.

iv. **Complaints:** Nina Moorman advised that this area had been discussed at Quality & Clinical Performance Committee who queried if the targets for complaints should be set at Zero. She wondered if the new targets had been set. The Executive Director of Nursing & Workforce advised that the focus for 2014/15 would be on themes of complaints and one of the key aims for the year would be to reduce the number of complaints relating to appointments. Jessamy Baird commented that some areas of the population might find it difficult to complain – such as those with learning difficulties for example, and the report did not highlight which sector of the public they were received from – she queried if this could be factored into the report. The Executive Director of Nursing & Workforce explained that Health Watch was very supportive in helping patients with a range of difficulties to make their feelings known. The Executive Medical Director also commented that Patient Voices should have sight of any complaint data which was being passed through PIDS. The Executive Director of Nursing & Workforce confirmed that a full quarterly report would be submitted to the Quality & Clinical Performance Committee.

v. **Benchmarking Update – Safety Thermometer**: Jane Tabor commented how useful this item was but felt that the trends across the ranges appeared to be rising. The Executive Director of Nursing & Workforce explained that this was due to the cyclical nature of higher sickness in the winter months. He advised that national data uses the Datix system but the Trust uses local systems which are better. The Executive Medical Director confirmed that none of the VTE patients who have not been covered had developed any problems. Jane Tabor stated that it should be an aim to reverse the trend for the same period next year.

vi. **Discharge Summaries:** Sue Wadsworth confirmed that she had discussed this area with the Executive Director of Finance and was concerned that a number of consultants are still not producing discharge summaries for patients when they leave hospital. The Executive Medical Director stated he was confident that all patients get a discharge summary, but a small number of these are produced many weeks after the patient has left the Trust. He reported on the development of a project to move to discharge summary on the day. The aim is to have this in place before the new intake of junior doctors in August.

vii. **Staff Sickness**: Nina Moorman asked if there was a record of how many staff were off with Norovirus. The Executive Director of Nursing & Workforce advised that approximately 20 relevant staff had been off sick but none had been confirmed with a positive diagnosis.

viii. **Cost Improvement Programme (CIP):** The Chairman suggested that the CIP programme needed to be planned more realistically in future. Jessamy Baird queried the lack of Research & Development contribution and stated that this needed to be shown as investment in the organisation. The Executive Medical Director advised that the Research & Development Strategy was being reviewed at present. Jessamy Baird asked if she could be more involved in this area. This was agreed.

Action Note: The Executive Medical Director to pass on Jessamy Baird's interest in being more involved in the Research & Development area of the Trust.
Action by: EMD

The Isle of Wight NHS Trust Board received the Performance Report

14/092 UPDATE ON DATA QUALITY UNDERPINNING KPI'S

The Assistant Director - Performance Information & Decision Support presented the update and advised that last year 70 key performance indicators (KPI's) had been assessed for data completeness, timeliness and validity.

Following the reassessment in February he could confirm that the Trust was in an improved position. He presented the Information Assurance Directory which provided details of the outcome of each KPI with 96% being considered Good. He advised that the introduction of data capture IT systems such as QUINCE has reduced the risk of incorrect data entry and contributed to more accurate reporting.

Jessamy Baird asked if the mortality data was age adjusted. The Executive Medical Director confirmed that the data when received by the Trust had already been adjusted.

It is recommended that an annual assessment of KPIs and associated development plans is produced to provide long-term assurance. The Board will receive an update of the Information Assurance Directory at the beginning of each financial year. This will include an assessment of any new measures included in the Trust Board Performance Report prior to inclusion.

The Chairman thanked the Assistant Director - Performance Information & Decision Support for his attendance and confirmed that the Board will receive another update next year.

The Isle of Wight NHS Trust Board received the Update on Data Quality Underpinning KPI's

14/093 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Sue Wadsworth reported on the key points raised at the last meeting held on 19th March 2014.

a) **Min No. 14/106 - Safe Staffing:** The Committee received an update on the Safe Staffing paper and noted that this will also be reviewed at the Finance, Investment & Workforce Committee before being reported to Board.

b) **Min No. 14/107 - Out of Hours Discharge Audit**: The Committee received assurance as a result of receiving a presentation and discussing the report on the deep dive review on out of hours discharges

c) **Min No. 14/109 - SIRIs; Quality Performance Report and Directorate Reports**: The Committee received assurance that the focus on reducing pressure ulcers is having a positive impact in the Acute and Planned Directorates. It noted the extensive training being undertaken in the Community and outcomes will continue to be reviewed on a monthly basis.

d) **Min No. 14/116 - Ophthalmic Casenote Risk**: The Committee recommended that this be risk be reviewed by the Trust Executive Committee and any action taken reported back to QCPC for assurance in April

Sue Wadsworth also commented that, in conjunction with Charles Rogers and Peter Taylor, she was reviewing the way the minutes of the sub committees were reported back to Board.

Nina Moorman commented that pressure ulcers often originate within the community and asked if training was being offered to the care homes and other providers, as this would fit in with the My Life A Full Life ethos. The Executive Director of Nursing & Workforce confirmed that the Trust would be supporting Islandwide training within the community. The Chief Executive advised that some care homes were currently not engaging in the training and it may need to be taken through a regulatory route to ensure full coverage.

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

14/094 MINUTES OF THE FINANCE, INVESTMENT & WORKFORCE COMMITTEE

Peter Taylor reported on the key points raised at the last meeting held on 19th March 2014

a) **Min No. 14/041 - 2 Year Plan:** The EDF explained the draft plan had been submitted to the Trust Development Authority (TDA) on the 5th March 2014 and the final plan is due for submission on the 4th April 2014. The final plan was not yet fully developed as additional information with respect to CIP forecast outturns and detailed plans was required to ensure it was robust.

b) **Min No. 14/042 - Workforce Strategy:** The Committee agreed to recommend the strategy to the Trust Board.

c) **Min No. 14-043 - Cost Improvement Programme:** The Committee was concerned about the level of non-recurrent CIPs and the impact that would have on the 2014/15 budget.

d) **Min No. 14/046 - Endoscopy Business Plan:** This case is reliant on the ITU/CCU going ahead and the Committee were in agreement that this case should be recommended to the Trust Board for approval.

e) **Min No. 14/046 – Island Drug & Alcohol Services (IDAS) Tender:** The Committee debated in great detail the proposed structure and resource changes along with all of the financial implications that may occur as a result of this tender.

Peter Taylor also mentioned NHS Creative and suggested that their potential income levels be reviewed. He advised that the Interim Director of Planning, ICT & Integration would be undertaking a new strategy and business plan for NHS Creative which would be coming to the April FIWC meeting.

He stated that it would be helpful if the QUINCE programme could be demonstrated so that its potential could be fully understood.

***Action Note**: The Interim Director of Planning, ICT & Integration to arrange for Board members to receive a demonstration of the QUINCE system.*

Action by: IDPII

Peter Taylor also stressed that the committee felt that it would be useful to have a meeting with the Clinical Commissioning Group to ensure plans were aligned between the two organisations. He also mentioned that the committee would like an update on the IT position within the Trust. The Chairman advised that this would be undertaken within the new ICT & Integration Committee.

Peter Taylor echoed the comments made by Sue Wadsworth regarding reviewing the sub

committee's Board Report. Nina Moorman asked if the Board felt that it would be useful to allow a rotation of Non-Executives within the sub committees. The Company Secretary advised that the Non-Executive Directors could attend any sub-committee meetings as observers but that it was advantageous for them to have specific committees where they could develop their knowledge and allow greater assurance through this. The Chairman felt that the status quo should remain at present.

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

14/095 BOARD WALKABOUT ACTION TRACKER

The Executive Director of Nursing & Workforce presented the report and advised that at the time of reporting, 183 visits have taken place (147 Clinical, 36 non-clinical). From these 175 actions have been identified:

- 160 are complete,
- 7 are still within timescale,
- 8 remain overdue against the original date for completion set, with 1 showing as overdue against both board and directorate revised timescale, this action is progressing.

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

14/096 STAFF STORY

The Executive Director of Nursing & Workforce introduced Michael Head, Hotel Services Manager who would be presenting this month's staff story. He was accompanied by Jean Witney who on of the Cleanliness Supervisors.

The Hotel Services Manager outlined the work of the cleanliness team stating that the cleanliness team had been very focused on achieving the NHS Cleaning Standards 2007. They had recently completed their 2014 PLACE[1] assessment. He confirmed that the team delivered an average score of 98% against a 95% target for Cleanliness in the Trust Ward areas. He explained that according to ERIC[2] returns the Trust is in the bottom quartile for cost.

He also highlighted the work the staff had been doing during the Norovirus outbreak. The Team had seen a 200% rise in barrier cleans in the last week and they had responded by organising late and weekend teams to cover this demand. Team work between supervisors has delivered a Gold standard performance.

The Executive Director of Nursing & Workforce stated how pleased he was that cleanliness team were working so well with the clinical team to produce such excellent results. He asked that a big thank you go to all members of the team for all their hard work which has been exceptional during the recent outbreak. The Chief Executive echoed this thanks and asked for suggestions on how this remarkable achievement could be recognised.

Action Note: *The Chief Executive to liaise with the Hotel Services Manager to agree on how this recognition could best be achieved.*

Action by: CEO

The Isle of Wight NHS Trust Board received the Staff Story

[1] Patient-led assessments of the care environment (PLACE)

[2] ERIC - Estates Return Information Collection

STRATEGY AND BUSINESS PLANNING

14/097 BUSINESS CASE - ENDOSCOPY

The Executive Director of Nursing & Workforce advised that this business case was a robust case which had been approved at Finance, Investment & Workforce Committee and was now coming to Board for formal approval.

Dr Leonie Grellier, who is the Clinical Lead for Endoscopy, updated the Board on the number of cases seen by the Endoscopy team over the course of a year. She advised the Board that without the approval for the case there was a significant risk that the Trust would fail its JAG[3] accreditation inspection in July. She outlined the effects this would have on patients and the problems which they would experience. She advised that a number of options were considered and scrutinised for their ability to deliver maximum quality and improved patient care within an affordable financial envelope. The preferred option is the one that gives maximum quality benefit whilst being most economically advantageous, and therefore delivers best value for money. The preferred option is 4A – Move to refurbished ITU.

Peter Taylor stated that this was an exemplary business case and should be used as the model for all business cases to follow within the Trust. He fully endorsed the plan.

Jane Tabor asked if the CCG funding for the unit was protected. The Chief Executive assured her that this was confirmed with the condition that the JAG accreditation was achieved.

A discussion took place and it was agreed that this business case should be approved and was fully supported by the Board. Vote was taken and carried unanimously.

Charles Rogers asked that in the interim period before the new accommodation was available there were some items which he felt should be actioned by Estates for the benefit of the staff and patients in the existing location. Jane Tabor supported this. The Executive Director of Nursing & Workforce agreed that an action plan for the short term period could now be developed.

Action Note: *The Executive Director of Nursing & Workforce to arrange for an action plan to cover the areas which require immediate work within the existing Endoscopy accommodation to be produced by the Estates Department for immediate action.*

Action by: EDNW

Proposed by Peter Taylor and seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the Business Case for Endoscopy

14/098 WORKFORCE STRATEGY

The Executive Director of Nursing & Workforce advised the meeting that the Workforce Strategy had been revised in line with national standards and is a supporting strategy within the Integrated Business Plan (IBP). He confirmed that the strategy was in two sections which covered the strategy and the delivery framework respectively. He confirmed that approval was required for section 1 – Strategy only as Section 2 – Workforce Framework was provided for information only.

A discussion took place surrounding this document and a number of specific queries were raised:

- Charles Rogers stated that he had concerns on how this document would be disseminated to staff. The Executive Director of Nursing & Workforce advised that a condensed version would be provided to all staff.

[3] The Joint Advisory Group on GI Endoscopy (JAG) ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.

- There was also concern on how the key performance indicators would be measured and reported. In particular there were concerns that the target levels set for Appraisals and Mandatory Training were not set at 100%.

- Jessamy Baird asked for clarity on how data is measured as this differed in the Performance Reports. The Executive Director of Nursing & Workforce explained that the dates shown in the Performance Reports were shown by service which gave a range of results. He agreed that within the Strategy the targets should be 100%. The Executive Director of Finance advised that Appraisals and Mandatory are usually operated on a rolling programme which do not operate within a financial year format and this can reflect in the overall targets.

- David King queried the Diversity & Equality section and the Trusts provision for employing people with learning disabilities and the added value they could provide to the organisation.

- The Executive Medical Director stated that one of the key findings in the recent Staff Survey had been communications and he felt that as a result this should have a higher profile throughout the strategy.

- Jane Tabor stated that she felt that within the organisational development – staff development plan it was not clear who and what would be monitored.

- Jane Tabor also stated that within the Equality & Diversity section there was nothing about having zero bullying/harassment tolerance. David King mentioned that this was included within the Equality Act but felt that it should be specifically highlighted and not just implied.

The Board declined to approve the Workforce Strategy as this stage and requested that the document be subject of a further discussion at the Board Seminar on 8th April. The outcome of this would then allow an amended document to be returned to the Finance, Investment and Workforce Committee on 16th April for formal approval. It was agreed that following approval on 16th April it would not be necessary for the strategy and workforce framework to be resubmitted to the Board.

The Isle of Wight NHS Trust Board approved the decision to delegate the authority to approve the Workforce Strategy to the Finance, Investment & Workforce Committee

14/099 OPERATING PLAN 2014/15 & 2015/16 INCLUDING CORPORATE OBJECTIVES 2014 (VISION, OBJECTIVES & CRITICAL SUCCESS FACTORS)

The FT Programme Management Officer presented the 2 year Operating Plan for 2014 – 2016 financial period. He outlined the criteria for the document and the processes:

- Joint requirement by *Trust Development Authority (TDA), Monitor, NHS England (NHSE), Local Government Association (LGA)*
- It is expected that all NHS Trusts will produce:
  - Ø Board-approved, commissioner-aligned two year plans
  - Ø two year plans will form the first two years of the five year strategic plan
  - Ø A document setting out the two year plan should be publicly available early in the new financial year 2014/15.
  - Ø The TDA will review the two year plan and follow up delivery issues and risks through the regular Integrated Delivery Meetings with Trusts.

The Deputy Director of Finance presented the Long Term Financial Model which he advised was still in the process of having final entries prior to submission to the TDA. He advised that FT status required a 2% annual surplus and confirmed that the model does include this provision.

David King stated that he felt that in order to make the plan fully comprehensive he would have expected to see external statements from the Clinical Commissing Group (CCG), NHS England (NHSE), Healthwatch and other stakeholders on how they perceive the Trust and its activities. He would also like to see reference from internal commissioners.

The Chairman agreed that this would be a good way to ensure the Island was fully compliant. The Executive Director of Finance reminded the Board that there was a tight deadline for this report to be submitted and advised that it was essential to ensure that the data was an accurate as possible to avoid any variances from the plan during the working life of the plan.

Charles Rogers stated that he would like to see work being carried out on the Cost Improvement Programme from day 1 and this was echoed by Peter Taylor who also stated that assurance would be needed for Monitor.

The Executive Medical Director asked if the Joint Mission Statement agreed with the CCG and the Council could be included.

Jessamy Baird stated that she would have liked to have seen more detail about IT areas within the document. The Executive Director of Finance advised that there was to be a separate Information Management & Technology Strategy and that considerable funds had been spent in this area over the past few years.

Jane Tabor felt that the summary could have been more positive.

It was requested that delegated approval was given to allow the Chief Executive to sign the final submissions on 4th April 2014. The Board approved this and requested that the comments made by Board members were taken into account for the final submission.

Proposed by Charles Rogers and seconded by Peter Taylor

The Isle of Wight NHS Trust Board approved the delegated authority for the Chief Executive to sign the 2 Year Operating Plan

14/100 FORMAL APPROVAL OF FINANCIAL BUDGETS FOR 2014/15

The Deputy Director of Finance presented the budget for 2014/15.

The budgets reflect a planned surplus of £1.7m and a CIP plan of £9.2m including an expected carry-over of £3m unachieved on a recurring basis in 2013/14. The opening reserve figure is £11.3m set for expected CCG investments, pass through costs of non-PbR[4] drugs, service developments and risks and opportunities.

Proposed by Peter Taylor and seconded by Charles Rogers

The Isle of Wight NHS Trust Board approved the Financial Budgets for 2014/15

14/101 FT PROGRAMME UPDATE

The FT Programme Director presented the monthly update:

- Timeline
  a. Chief Inspector of Hospitals visit will take place June 2014 - preparations underway
  b. FT status still achievable by March 2015
  c. IBP/LTFM work ongoing to deliver final submission on 20 June 2014
- Current Membership at 3957 public members and 2,889 staff members.

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

14/102 FT SELF CERTIFICATION

The FT Programme Director presented the monthly update stating that
Board Statements (14)

- 14 = compliant
- Responsibility for Statements will be reassigned to the Chief Executive

[4] Payment by Results

Licence Conditions (11)

- 1 = at risk (G4) targeted assurance of compliance by 31 March 2014
- 10 = compliant

FT Milestones (7)

- 2 = complete
- 5 = on track

Proposed by Peter Taylor and seconded by Sue Wadsworth

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

GOVERNANCE & ADMINISTRATION

14/103 BOARD ASSURANCE FRAMEWORK (BAF) DASHBOARD & SUMMARY REPORT

The Company Secretary presented the summary BAF status report.

The dashboard summary includes summary details of the key changes in ratings: there are no Principal Risks now rated as Red; 3 new Risks have been added since the February 2014 report; and 3 Risks with reduced scores, two of which have since been removed from the Register.

The exception report details TWO recommended changes to the Board Assurance RAG ratings of Principal Risks: 2 changes from Amber to Green for 3.9 and 8.6; and confirmation of the retention of 8.2 at Amber status (as agreed by Trust Board in February 2014).

Sue Wadsworth asked if the vacancies in Speech and Language Therapy reflected a national recruitment issue. The Company Secretary responded that this was the case but there had been successful recruitment to these posts.

Proposed by **Sue** Wadsworth and seconded by Charles Rogers

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

14/104 CORPORATE GOVERNANCE FRAMEWORK

The Company Secretary presented the revised Corporate Governance Framework documents which comprise of the Standing Orders, Scheme of Delegation and Standing Financial Instructions.

Jane Tabor requested the following amendments:

Standing Orders:
P31, 8.4.2 – change the word spouse to partner.

She requested that all new Board appointees should receive a copy of the Standing Financial Instructions. The Company Secretary agreed to ensure this was actioned.

Action Note: The Company Secretary to ensure all new Board appointees receive a copy of the Standing Financial Instructions.

Action by: CS

Proposed by Peter Taylor and seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the Corporate Governance Framework documents with above amendments.

14/105 HEALTH & SAFETY POLICY

The Chief Executive presented the Health & Safety Policy and confirmed that it had been approved at the Trust Executive Committee, and advised that it was here for formal approval.

There were no comments.

Proposed by Peter Taylor and seconded by Charles Rogers

The Isle of Wight NHS Trust Board approved the Health & Safety Policy

14/106 NOTES TO THE FT PROGRAMME BOARD

The Chief Executive reported on the meeting held on 25th February 2014.

a) **Note No. 006/14 - Chief Inspector of Hospitals (CIH):** Visit to be undertaken during June 2014

b) **Note No. 009/14 - Project established to manage logistics of Chief Inspector of Hospitals (CIH)**: Visit to be led by the Executive Medical Director working closely with the Executive Director of Nursing and Workforce

The Chairman stated that there had been a number of these meetings which had been cancelled in 2013/14 and stressed the need to ensure that these meetings were held regularly in the future.

The Isle of Wight NHS Trust Board received the Notes of the FT Programme Board

14/107 MINUTES OF THE CHARITABLE FUNDS COMMITTEE

Nina Moorman reported on the meeting held on 11th March 2014

a) **Min No. 14/004 - Terms of Reference**: Membership: Resignation of Peter Taylor thereby creating a NED vacancy on the Committee.

b) **Min No. 14/014 - Friends of St. Mary's**: Funding for 24 bids totalling £132,000. Their generous contribution to the Trust enhances the wellbeing and care not only of patients, but staff alike.

The Executive Director of Nursing & Workforce asked what process was in place to notify applicants for funding of the committees decision. Nina Moorman advised that they were notified after the meeting.

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

14/108 MATTERS TO BE REPORTED TO THE BOARD

None

14/109 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

14/110 ANY OTHER BUSINESS

Sue Wadsworth reported on the Lesbian, Gay, Bisexual and Transgender (LGBT) Group. She confirmed that the separate staff and patient groups had combined by agreement. She also reported that the Trust's Stonewall national ranking had risen from 29th out of 32 to 19th out of 44.

14/111 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Isle of Wight NHS Trust to be held in public is on **Wednesday 30th April 2014** in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 1pm

Signed…… Chair Date:……

Enc B

ISLE OF WIGHT TRUST BOARD Pt 1 (Public)
ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

Key to LEAD: Chief Executive (CE) Executive Director of Finance (EDF)

Executive Medical Director (EMD) Executive Director of Nursing & Workforce (EDNW) Deputy Director of Nursing (DDN)
Foundation Trust Programme Director/Company Secretary (FTPD/CS) Trust Board Administrator (BA) Head of Communication (HC) Executive Director of Finance Deputy (EDF Dep)

Interim Director of Planning, ICT & Integration (IDPII) Head of Governance & Assurance (HOG)

Non Executive Directors: Danny Fisher (DF) Sue Wadsworth (SW) Peter Taylor (PT) Charles Rogers (CR) Nina Moorman (NM)

Designate Non Executive Directors: David King (DK) Jane Tabor (JT) Jessamy Baird (JB)

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
08-Jan-13	13/288vi	TB/059	**Flu Incentives:** The Executive Director of Nursing & Workforce commented that Hull Trust used incentives to get staff to take up the vaccine and had almost 100% staff covered. He stated that if staff have 0% sickness absence, all mandatory training completed and flu vaccine they get the incentive which he wanted to explore.	EDNW	The Executive Director of Nursing & Workforce to explore staff incentives linked to flu vaccination. 21/01/14 - DDW reviewing this suggestion. **26/02/14** - The Executive Director of Nursing & Workforce confirmed that the HR team were working on the scheme at present. **26/03/14** - The Executive Director of Nursing & Workforce to provide revised forecast date for incentives. He also confirmed that during this seasons Flu campaign a total of 1328 staff had received the vaccine. **23/04/14 Update** - we have reviewed data for 2013 and have found 51 staff who have had the flu vaccine, 0% sickness and 100% mandatory training. This data, we feel, should be validated by line managers ahead of any incentive award. Also, risk that many more staff will become compliant in 2014 if incentive scheme is announced.	26-Feb-14	28-May-14	Progressing		Open
08-Jan-13	13/293	TB/061	**Board Walkabouts Action Tracker**: Annual report requested.	EDNW	The Executive Director of Nursing & Workforce to arrange for an annual report be submitted to Board in April 2014. **20/04/14** - Annual report will be presented at Board on 30th April	30-Apr-14	30-Apr-14	Completed	20-Apr-14	Closed
29-Jan-14	14/037-ix	TB/069	**Long Term Financial Model (LTFM) –** Peter Taylor requested that the revised version of this document be presented to the Finance, Investment & Workforce Committee.	EDF	The Executive Director of Finance confirmed that once the LTFM has been updated this would happen. **19/02/14** - confirmed that this will return to FIWC once produced. **26/02/14** - The Executive Director of Finance confirmed that the final document would be taken to the next Finance, Investment & Workforce Committee in March. **26/03/14** - New forecast date of 20th June 2014. **22/04/14** - On Agenda for Board Seminar on 10th June 2014.	26-Mar-14	20-Jun-14	Progressing		Open
29-Jan-14	14/044	TB/073	**Patient Story Action Tracker** - These were reviewed by the Quality & Clinical Performance Committee monthly and an end of year report would be made to the Board.	EDNW	The Executive Director of Nursing & Workforce to present the End of Year Patient Story report at the April Board meeting. **19/03/14** - Patient Story action Tracker to be reviewed to ensure it encompasses the actions taken, and a year end position will be submitted to Board. **20/04/14** - Annual report will be presented at Board on 30th April	30-Apr-14	30-Apr-14	Completed	20-Apr-14	Closed
26-Feb-14	14/058	TB/074	**Diabetic Meal Choices** - Peter Taylor raised the question of the suitability of the Diabetic options within the patients menu choices. The Executive of Nursing & Workforce confirmed that the dieticians would be asked to review the current choices. Jessamy Baird also confirmed that this had been discussed at the Quality & Clinical Performance Committee at which an update from the Executive Director of Nursing & Workforce was pending.	EDNW	The Executive Director of Nursing & Workforce to follow up with the dieticians and report back on the outcome of the review of diabetic patient meal options. **20/03/14** - Menu choices are assessed by Dieticians for there suitability, and diabetic patients are able to choose from the main menu. Additional items have been added to the menu some of which are suitable for Diabetics. The patient menu has been the subject of review from the speech and language service and it has been agreed to review the menu with the input of SALT, Dietetics and catering. **23/04/14** - menus have been assessed and all the menu options are compliant with a diabetic diet. Further review with key stake holders will be taking place in the near future, dependent on resources.	26-Mar-14	30-Apr-14	Completed	23-Apr-14	Closed

Enc B

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
26-Feb-14	14/065 (iv)	TB/077	**Risk Register Definitions** - Jessamy Baird stated that some of the description of the risks were very generic and could result in a permanent position on the risk register. She asked if these could be reviewed. The Executive Medical Director advised that when staff-assess a risk it is on a local level which to them will seem a high risk but at Board level it may not rate as high. The Executive Director of Nursing & Workforce advised that the directorates had been asked to review these more rigorously to ensure that appropriate risk scores were made. Peter Taylor stated that he felt that this part of the performance report needed further development. David King agreed and stated that it should be showing the strategic imperative of each to Board against operational and strategic risk. The Executive Director of Finance confirmed that the Capital Investment Group did undertake a full risk review on capital schemes. Peter Taylor stated that an additional area showing the actions approved by the Capital Investment Group would be helpful.	EDF	The Executive Director of Finance to review possible additional data to be included for future reports. **22/04/14** - Revised dashboard layout being developed for April Board.	30-Apr-14	30-Apr-14	Completed	23-Apr-14	Closed
26-Feb-14	14/065 (ix)	TB/081	**Compliments –** The Company Secretary asked on behalf of Jane Tabor, if in future the level of compliments could be added to the report. The Executive Director of Finance confirmed that this was in hand and would appear in the next report.	EDF	The Executive Director of Finance to ensure that the level of compliments be added to the performance report. **22/04/14** - Revised report being developed for April Board	30-Apr-14	30-Apr-14	Completed	23-Apr-14	Closed
26-Mar-14	14/084	TB/084	**Patient Story: Home to Board:** The Chairman asked whether a portable generator could be purchased by Estates to loan out to patients in emergency situations which would allow the patient to remain at home.	EDNW	The Executive Director of Nursing & Workforce to **a)** discuss with Estates about purchasing a portable generator **b)** arrange for the film to be viewed by the relevant teams, in particular OPARU, Cardiology, Out Patients, ICU and call handlers. **20/04/14** - Estates Dept has been asked to investigate the purchase of a portable generator. The Patient film has been shared as requested. **23/04/14** - Medical Devices have confirmed that with regard to patient use ventilators used at home it is possible to provide batteries which would provide continued power in the event of a power failure.	30-Apr-14	30-Apr-14	Completed	20-Apr-14	Closed
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-May-14	28-May-14	Progressing		Open
26-Mar-14	14/091 viii)	TB/086	**Research & Development:** Jessamy Baird queried the lack of Research & Development contribution and stated that this needed to be shown as investment in the organisation. The Executive Medical Director advised that the Research & Development Strategy was being reviewed at present. Jessamy Baird asked if she could be more involved in this area. This was agreed.	EMD	The Executive Medical Director to pass on Jessamy Baird's interest in being more involved in the Research & Development area of the Trust. **23/04/14** - Executive Medical Director has passed this on to Alex Punter, Research & Development Manager, who will contact Jessamy Baird	30-Apr-14	30-Apr-14	Completed	23-Apr-14	Closed
26-Mar-14	14/094	TB/087	**QUINCE:** Peter Taylor stated that it would be helpful if the QUINCE programme could be demonstrated so that its potential could be fully understood.	IDPII	The Interim Director of Planning, ICT & Integration to arrange for Board members to receive a demonstration of the QUINCE system. **23/04/14** - More work being undertaken on QUINCE. Demonstrations to be scheduled in one month.	31-May-14	31-May-14	Progressing		Open
26-Mar-14	14/096	TB/088	**Cleanliness Team:** The Executive Director of Nursing & Workforce stated how pleased he was that cleanliness team were working so well with the clinical team to produce such excellent results. He asked that a big thank you go to all members of the team for all their hard work which has gone over and above during the recent outbreak. The Chief Executive echoed this thanks and asked for suggests on how this remarkable achievement could be recognised.	CEO	The Chief Executive to liaise with the Hotel Services Manager to agree on how this recognition could best be achieved	30-Apr-14	30-Apr-14	Progressing		Open
26-Mar-14	14/097	TB/089	**Endoscopy Small Works Items:** Charles Rogers asked that in the interim period before the new accommodation was available there were some items which he felt should be actioned by Estates for the benefit of the staff and patients in the existing location. Jane Tabor supported this. The Executive Director of Nursing & Workforce agreed that an action plan for the short term period could now be developed.	EDNW	The Executive Director of Nursing & Workforce to arrange for an action plan to cover the areas which require immediate work within the existing Endoscopy accommodation to be produced by the Estates Department for immediate action. **23/04/14** - Estates to undertake a PEAT style visit with Quality Manager to ensure all remedial actions have been taken.	28-May-14	28-May-14	Progressing		Open
26-Mar-14	14/104	TB/090	**Standing Financial Instructions:** Jane Tabor requested that all new Board appointees should receive a copy of the Standing Financial Instructions. The Company Secretary agreed to ensure this was actioned.	CS	The Company Secretary to ensure all new Board appointees receive a copy of the Standing Financial Instructions. **23/04/14** - This will be actioned for next new Board appointee.	30-Jun-14	30-Jun-14	Completed	23-Apr-14	Closed

Enc C

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 30TH APRIL 2014

Title	Chief Executive's Report					
Sponsoring Executive Director	Chief Executive Officer					
Author(s)	Head of Communications and Engagement					
Purpose	For information					
Action required by the Board:	**Receive**		**P**	**Approve**		
Previously considered by (state date):						
Trust Executive Committee			Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee			Remuneration & Nominations Committee			
Charitable Funds Committee			Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee						
Foundation Trust Programme Board						
Please add any other committees below as needed						
Board Seminar						
Other (please state)						
Staff, stakeholder, patient and public engagement:						
This report is intended to provide information on activities and events that would not normally be covered by the other reports and agenda items.						
Executive Summary:						
This report provides a summary of key successes and issues which have come to the attention of the Chief Executive over the last month.						
For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	All Trust goals					
Critical Success Factors *(see key)*	All Trust Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None					
Date: 23rd April 2014	**Completed by: Andy Hollebon**					

NATIONAL

Risk rating lowered for Isle of Wight NHS Trust

Improvements to patient safety at the Trust have led to the organisation's risk rating being lowered by the independent health regulator, the Care Quality Commission (CQC). The CQC uses six risk ratings for hospitals, with a score of one being the worst and six the best. Last year, the Isle of Wight NHS Trust received a score of four, but in their latest Intelligent Monitoring (IM) report the CQC has lowered the Trust's risk to a five – just one below the top level rating. The report can be downloaded by visiting the CQC website.

Rising demand for unscheduled care

According to the King's Fund. across England for many years, the number of people attending A&E remained essentially unchanged at around 14 million a year. In 2003/4, the number of attendances jumped – by nearly 18 per cent – to 16.5 million. This reflected the introduction around this time of walk-in centres and minor injuries units, which aimed to divert less serious cases away from major A&E units.

At the same time, the way the statistics were collected changed to record attendances separately for type 1 (major A&E units), type 2 (single specialty units) and type 3 units (walk-in centres and minor injuries units). So, much of the increase in 2003/4 was due to previously unrecorded attendances being collected and additional – but less serious – work being carried out in new types of units. Since then, the overall number of attendances has increased significantly to 21.7 million in 2013/14, a rise of more than 30 per cent over the decade. However, most of this growth has been in attendances at type 2 and type 3 units, indicating a degree of supply-induced demand as these new routes into emergency care have opened up.

The number of attendances at type 1 units has increased at a much lower rate, from 12.6 million in 2003/4 to 14.2 million in 2013/14. While this is an increase of only 12 per cent, it is still a significant number of attendances to absorb for a system operating close to capacity. This reflects our local position where over the same period we have seen increasing demand for unscheduled care services including rising demand for the NHS 111 service.

New NHS England Chief Executive

On 1st April 2014 the new Chief Executive of NHS England, Simon Stevens, spent his first morning as Chief Executive at the hospital where he started in the NHS 26 years ago.
On the same day in his first speech Mr Stevens said that the NHS is facing the biggest challenge in its history because of the squeeze on its budget. He warned that navigating the next few years will require a huge effort and that only by 'radically transforming services' will the NHS continue to thrive. During his speech he said: "I know that for the NHS the stakes have never been higher. Service pressures are intensifying, and longstanding problems are not going to disappear overnight. Successfully navigating the next few years is going to take a team effort - involving the biggest team in the biggest effort the NHS has ever seen. Our traditional partitioning of health services - GPs, hospital outpatients, A&E departments, community nurses, emergency mental healthcare, out-of-hours units, ambulance services and so on - no longer makes much sense."

LOCAL

Sport Relief

Well done to Theatre staff (DSU & Main Theatres) who did the Sports Relief fun run with support from Stores, Theatre Practitioners, Anaesthetists, Ambulance and Resus. There was even a contribution from Theatres own STIG! They had a great time and the money raised will buy three TV's to go into patient areas.

Surprise Surprise

On 30th March, in a Mother's Day Special, the Trust's Neonatal Intensive Care Unit featured on ITV's Surprise Surprise when the spotlight was turned Island mum Paula Smith, founder of Pop 'n' Grow. Paula invented a special baby grow for new-borns in neonatal units which was tested at St. Mary's. Greetings card manufacturer Carte Blanche presented Paula with 1,000 Tiny Tatty Teddy soft toys wearing Pop 'n' Grows in our NICU on 23rd April for Paula to either sell to raise money or send directly to the hospitals for young babies needing care.

Midwives retire after 200 years of NHS working

Six midwives, who have delivered hundreds of thousands of babies between them, have retired from the Trust. In total, they have amassed an incredible 217 years of working within the NHS and are estimated to have seen the delivery of approximately 200,000 babies. Several generations of Island families will have been cared for by these midwives. A special retirement event was held for the women at the Maternity Department at the end of March.

Membership Recruitment

We have recently recruited our 4,000th public member (pictured right with Mark Price) achieving our first membership target on schedule. We are seeking to recruit a further 2,000 members (aged 11 and over) by April 2017.

Norovirus Outbreak

We're very grateful to patients, visitors, volunteers and staff who through their continued hand hygiene and other actions have helped to control and pretty much eradicate the recent outbreak of Norovirus at St Mary's Hospital. We were able to lift our restrictions on visiting just before Easter. We are however still seeing a few cases admitted to the hospital and hearing about cases in the Community. It is vitally important that everyone – staff, volunteers, patients and the public – continue to maintain good hand hygiene

System Pressures

Between Friday 18th and Monday 21st April all GP Practices on the Island were closed for the Easter weekend. Advice was issued before the weekend urging Islanders to make requests for repeat prescriptions well in advance and make appropriate use of services. Demand on 'out of hours' services has however continued to rise and the Easter weekend and immediately after were no exception. Many staff worked above and beyond the call of duty over the Easter weekend.

Celebratory cakes recognise exceptional Ambulance Service performance

Performance figures for the 2013 -2014 year show that the Ambulance Service received over 23,000 emergency calls with ambulances reaching 80% of life threatening calls and 76.40% of the most seriously ill and injured patients within 8 minutes and 96.75% within 19 minutes (the national response standards are 75% and 95% respectively). The service met this target for every month of the year. The NHS 111 service which is also delivered by the Ambulance Service continues to deliver some of the best care in the country in meeting or exceeding all the performance targets despite receiving over 55,500 calls, an increase of over 12% from last year. To celebrate this and say thank you to staff Ambulance Service managers have paid from their own money for special cakes to be shared with staff. The cakes were made Paul Tomlinson, a Clinical Adviser working in the Integrated Care Hub.

First anniversary celebrations for NHS Nightingales

NHS Nightingales

As I write this report the Island's NHS Nightingales choir are preparing for their first anniversary concert at St Mary's Hospital on Sunday 27 April 2014. The group is made up entirely of current or retired staff and volunteers from the Isle of Wight NHS Trust and was inspired by Gareth Malone's BBC TV series, 'Sing While You Work', which aims to find the best workplace choir. All levels of singing ability are represented in the 30-strong group, with some members having never publicly performed before joining the choir. The choir meets every Tuesday evening at the Riverside Centre in Newport and anyone who has retired, currently works or volunteers for the Isle of Wight NHS Trust is welcome to join the group.

CQC Inspection

We're just over five weeks away from the CQC Inspection on 3rd June. Around 60 inspectors from the CQC will be reviewing data about the Trust on Monday 2nd June. The actual inspection takes two days – Tuesday 3rd and Wednesday 4th June – with the right reserved for the CQC to return at any time during in the following two weeks. Substantial preparatory work is underway for the inspection which will include a 'listening event' for Islanders to let the CQC know what they think of services.

Major Building Works

'Our Better Hospital' is a major programme of work to improve facilities at St. Mary's. The works are outlined in the 'Our Better Hospital' newsletter which is being circulated widely to staff and stakeholders. Copies are available on our website.

Trauma Audit and Research Network (TARN) report

The Trust has recently received the Trauma Audit and Research Network (TARN) report. This shows that an additional 3.86 patients per hundred survived their injuries and St. Marys is in the top 5 performing Trusts in the country. The Helipad has contributed to additional patient survival with timely and appropriate transfers. In house training and education along with Trauma team activation and initial diagnosis has also contributed to this achievement. The data accreditation for the Island is 97.7% which is the best in the region. Time to CT scan has improved and is now an average 30 minutes from arrival. This is great news and we can all be very proud of this achievement.

Pre-Pip Sepsis Project

Our innovative project to deliver high dose antibiotics as early as possible to patients with a suspected diagnosis of sepsis has now treated around 40 patients and was featured on BBC South on 14th April. For every hour that sepsis is not treated the risk of death increases by over 7 per cent. A substantial number of patients are admitted to intensive care because they have sepsis. This nationally important development was started in September 2013. It's swift development and implementation was made possible by the integrated nature of the Trust.

Friends and Family Test for Staff

In the last week the Trust has implemented the Friends and Family Test for staff via an e-mail sent to staff at their preferred e-mail address. The survey is open until the end of June but in the first week alone over 700 members of staff had participated. The survey will be repeated on a quarterly basis. All the information collected is anonymous and will be reviewed by the Trust's Culture, Health and Wellbeing Group.

Leon Hamman

Many will have seen the report in local media about the tragic death of Leon Hamman. I would like to reiterate our sincere condolences and sympathy to Leon's family and apologise that on this occasion we clearly failed to provide the quality of care that we aspire to. The Coroner recognised that the Trust has thoroughly investigated the incident. Leon was a child with a serious condition who had been cared for by our staff over a long period of time. Many have been deeply affected by his death and it is essential that we make sure that the measures put in place to stop this happening again are effective.

Karen Baker
Chief Executive Officer
24th April 2014

Enc D

Isle of Wight NHS Trust Board Performance Report 2013/14

March 14

Isle of Wight NHS Trust

Title	**Isle of Wight NHS Trust Board Performance Report 2013/14**				
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		16/04/2014
Finance, Investment & Workforce Committee		16/04/2014	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 2013/14. 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: Thursday 24th April	**Completed by: Iain Hendey**				

Isle of Wight NHS Trust Board Performance Report 2013/14

March 14

Executive Summary

Isle of Wight NHS Trust

Patient Safety, Quality & Experience:

Pressure ulcers: We continue to under achieve our planned 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 area.

VTE: Risk assessment recording. The new upgrade to the pharmacy system during February has eliminated previous data collection problems and we are now achieving 100%, exceeding the target of 95%.

HCAI: We are currently within both our nationally set threshold and local stretched target for Healthcare Acquired Clostridium Difficile infection, at 7 YTD, with 1 case reported during March. There were no cases of Healthcare Acquired MRSA bacteraemia identified in March, performance remaining above our target of zero tolerance at 2 cases.

Mental Health:There was a single breach in Child & Adolescent Mental Health 18 week referral to treatment target (95%), but the extremely low numbers have an exaggerated impact on percentages.

Workforce:

The total pay bill for March (£9.16m) is above plan (£9.08m). The number of FTEs in post is also currently higher than plan (9). 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 decreased slightly in March (3.91%) but remains above plan at 3.78% YTD. Specific problem areas are being identified for local investigation and are challenged at directorate performance review meetings.

Operational Performance:

Performance against our key operational performance indicators is primarily green for the month and fully green for the year.

All cancer targets are again green for the month and show that we have met all the targets for the financial year. Provisional figures indicate that 67% of all breaches against these measures during March were patient led, with 24% being as a result of capacity issues.

From April 2014 this Performance report will be revised to include a wider range of measures and reporting structure for all services which will give a more balanced reflection on our performance as the only fully integrated Trust in the country.

Finance & Efficiency:

At the end of the financial year, the draft (unaudited) position shows a slight overachievement of plan by £15k i.e. an actual retained surplus of £1,837k, offset by £224k to take account of donated assets, to show an adjusted retained surplus of £1,613k. The Continuity of Service Rating continued through to the year end as a 4.

The final CIP finished at £8,733k, an overachievement in total of £89k against the target of £8,644k. However, of this, only £4,595k was achieved recurrently and means that recurrent savings of £3,036k still needs to be brought forward to 2014/15.

Isle of Wight NHS Trust Board Performance Report 2013/14

March 14

Balanced scorecard

Isle of Wight NHS Trust

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

GRR ref:	Patient Safety, Quality & Experience	Annual Target	Actual Performance		YTD	Performance Month Trend	Sparkline	Year end forecast
	Quality Acct #1 Summary Hospital-level Mortality Indicator (SHMI)* Jul-12 - Jun-13	1.00	1.1160	Q3	N/A	↗		1.105
	Quality Acct #1Hospital Standardised Mortality Ratio (HSMR) Jul-12 - Jul-13	100	103.47	Q3	N/A	↗		102.90
	Quality Acct #2 Patients admitted that develop a grade 4 pressure ulcer	0	3	Mar-14	19	↘		19
	Quality Acct #2 Patients admitted that develop a grade 2 or 3 pressure ulcer	60	13	Mar-14	103	↘		103
	Quality Acct #3 Reduction in communication complaints/concerns	150	11	Mar-14	162	↗		162
	Quality Acct #4 Amber care bundle (now implemented - no audited results as yet)	-	-	-	-	-		-
	Child & Adolescent Mental Health (CAMHS) seen within 18 weeks referral to treatment	100%	95%	Mar-13	98%	↔		98%
	VTE (Assessment for risk of)	>95%	100%	Mar-14	90%	↗		90%
	MRSA (confirmed MRSA bacteraemia)	0	0	Mar-14	2	↔		2
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)	8	1	Mar-14	7	↘		7
	Clinical Incidents (Major) resulting in harm (confirmed & potential, includes falls & PU G4)	48	3	Mar-14	56	↘		56
	Clinical Incidents (Catastrophic) resulting in harm (confirmed & potential)	8	2	Mar-14	10	↘		10
	Falls - resulting in significant injury	11	0	Mar-14	8	↗		8
	Delivering C-Section	<25%	16%	Mar-14	20%	↗		20%
	Normal Vaginal Deliveries	>70%	69%	Mar-14	68%	↘		68%
	Breast Feeding at Delivery (Target reduced from 85% in February 2014)	>80%	75%	Mar-14	75%	↗		75%
	Formal Complaints	<276	12	Mar-14	194	↗		194
	Patient Satisfaction (Friends & Family test - aggregated score)	Q3>Q1	71	Mar-14	68	↘		68

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

Workforce	In Month	Actual Performance		YTD	Performance Month Trend		YTD plan
Total workforce SIP (FTEs)	2,669.0	2,678	Mar-14	n/a	↗		
Total pay costs (inc flexible working) (£000)	£9,080	£9,159	Mar-14	£116,847	↗		£113,276
Variable Hours (FTE)	139	209.00	Mar-14	1,799	↘		1680
Variable Hours (£000)	£209	£1,196	Mar-14	£7,335	↘		£884
Staff sickness absences	3%	3.91%	Mar-14	3.78%	↗		3%
Staff Turnover	5%	0.87%	Mar-14	9.66%	↘		
Mandatory Training	80%	78%	Mar-14	78%	↗		
Appraisal Monitoring (cumulative)	100%	65.2%	Mar-14	65.2%	↗		
Employee Relations Cases	0	59	Mar-14	181			

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

	Operational Performance	Annual Target	Actual Performance		YTD	Performance Month Trend	Sparkline	Year end forecast
4	Emergency Care 4 hour Standards	95%	96%	Mar-13	97%	↘		97%
12	Ambulance Category A Calls % < 8 minutes	75%	76%	Mar-13	76%	↗		76%
13	Ambulance Category A Calls % < 19 minutes	95%	96%	Mar-13	97%	↘		97%
	Stroke patients (90% of stay on Stroke Unit)	80%	84%	Feb-14	91%	↘		90%
	High risk TIA fully investigated & treated within 24 hours (National 60%)	95%	73%	Feb-14	83%	↘		81%
8b	Symptomatic Breast Referrals Seen <2 weeks*	93%	94%	Mar-14	93%	↗		93%
6b	Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100%	Mar-14	98%	↔		98%
6a	Cancer Patients receiving subsequent surgery <31 days*	94%	100%	Mar-14	94%	↔		94%
5a	Cancer Patients treated after screening referral <62 days*	90%	100%	Mar-14	90%	↔		90%
	Cancer Patients treated after consultant upgrade <62 days*	85%	100%	Mar-14	85%	↔		85%
7	Cancer diagnosis to treatment <31 days*	96%	100%	Mar-14	96%	↔		96%
5b	Cancer urgent referral to treatment <62 days*	85%	94%	Mar-14	85%	↗		85%
8a	Cancer patients seen <14 days after urgent GP referral*	93%	96%	Mar-14	93%	↘		93%
1	RTT:% of admitted patients who waited 18 weeks or less	90%	92%	Mar-14	91%	↗		91%
2	RTT: % of non-admitted patients who waited 18 weeks or less	95%	93%	Mar-14	96%	↘		96%
3	RTT % of incomplete pathways within 18 weeks	92%	96%	Mar-14	96%	↘		96%
	No. Patients waiting > 6 weeks for diagnostics	100	0	Mar-14	44	↗		44
	%. Patients waiting > 6 weeks for diagnostics	1%	0.00%	Mar-14	0.39%	↗		0.39%
	Elective Activity (Spells) (M10 target - 715)	7,569	766	Feb-14	7,321	↗		8,054
	Non Elective Activity (Spells) (M10 target - 1,211)	13,384	1,070	Feb-14	12,353	↔		13,468
	Outpatient Activity (Attendances) (M10 target - 10,048)	108,010	9,022	Feb-14	107,251	↗		117,040
	Data Quality (see detail sheet for explanation of scoring)		2	Feb-14		↔		

Cancer figures are provisional for March

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

Finance & Efficiency	Annual Target	Actual Performance		YTD	Performance Month Trend		
Achievement of financial plan	£1.6m	£1.6m	Mar-14	£1.6m	↔		
Underlying performance	£1.6m	(£1.2m)	Mar-14	(£1.2m)	↔		
Net return after financing	0.50%	28.56%	Mar-14	28.56%	↘		
I&E surplus margin net of dividend	=>1%	1.09%	Mar-14	1.09%	↘		
Liquidity ratio days	=>15	28	Mar-14	28	↘		
Continuity of Service Risk Rating	3	4	Mar-14	4	↔		
Capital Expenditure as a % of YTD plan	=>75%	100%	Mar-14	100%	↗		
Quarter end cash balance (days of operating expenses)	=>10	28	Mar-14	28	↗		
Debtors over 90 days as a % of total debtor balance	=<5%	2.1%	Mar-14	2.1%	↗		
Creditors over 90 days as a % of total creditor balance	=<5%	0.17%	Mar-14	0.17%	↗		
Recurring CIP savings achieved	100%	53.17%	Mar-14	53.17%	↘		
Total CIP savings achieved	100%	100%	Mar-14	100%	↗		
Contract Penalties				£28,539			

						Sparkline	Year end forecast
Theatre utilisation	83%	81%	Mar-14	84%	↘		84%
Cancelled operations on day of / after admission		0.7%	Mar-14	0.5%	↘		0.50%
Average LOS Elective (non-same day)	variable*	3.09	Mar-14	3.13	↘		3.14
Average LOS Non Elective (non-same day)	variable*	9.33	Mar-14	8.20	↘		8.21
Outpatient DNA Rate	variable*	7.5%	Mar-14	7.5%	↘		7.5%
Emergency Readmissions <30 days (with exclusions)	4%	4.29%	Mar-14	4.38%	↗		4.38%
Daycase Rate	68%	77%	Feb-14	72%	↗		73%

**** Individual specialties have different targets***

Highlights

- All Cancer indicators achieving month and year end targets
- Emergency Care 4 hour standard performance remains above target
- No of C.Diff cases within year end stretched target
- Reduction in formal complaints during March, full year target reduction achieved
- VTE risk assessment recording now showing 100%

Lowlights

- Staff absenteeism due to sickness remains above target
- Pay costs/variable hours above target
- CIP targets - 47% delivered non-recurrently
- 1 C Diff case identified during March

Isle of Wight NHS Trust Board Performance Report 2013/14

March 14

Pressure Ulcers

Isle of Wight NHS Trust

Commentary:

General: There has been a change in the reporting process whereby numbers are reviewed for both the current and previous month and there may be changes to previous figures once validated. These figures are also included within the clinical incident reporting and where any rise is also reflected.

Hospital acquired:There were 3 x grade 4 pressure ulcers reported in the hospital during March, showing an end of year position of 19 against 22 last year. Grade 2 numbers stand 99 against 103 with grade 3 numbers achieving the planned 50% reduction on last year at 4 at year end against 17 in 2012/13.

Explanation of RAG Rating

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

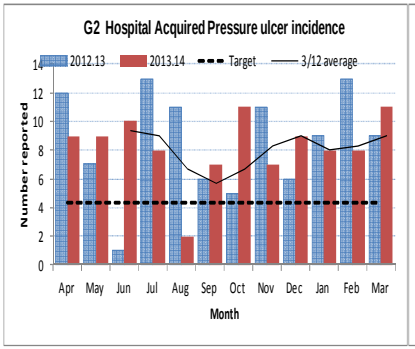
Amber=1G3 or increase/no change in G2 in rolling 3 month period

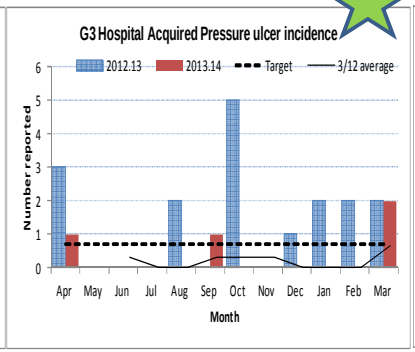
Green=No G3 or G4 and decrease in G2 or 2 or less of any grade (1&2) in rolling 3 month period

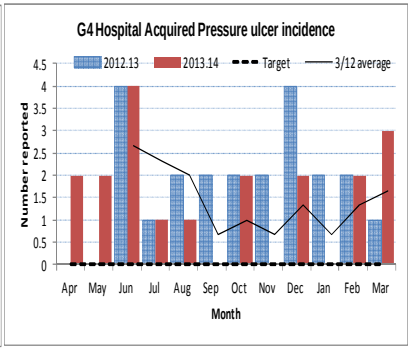
Community acquired: Despite an increase during March, there has been marked improvement in grade 4 incidence over recent months although insufficient to negate the poor start to the year. (26 at year end against 18 in 2012/13). The planned reduction of 50% has not quite been met in incidence of grade 3 (19 in 2013/14 against 26 in 2012/13, 48%). Grade 2 pressure ulcers continue to underachieve with a smaller reduction of 109 against 126 previously.

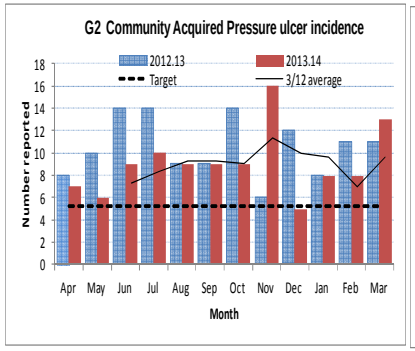
Thresholds for the coming year have been agreed and are set at zero tolerance for grade 4 in hospital setting with 50% reduction on 2013/14 baseline for 1,2 & 3 with an overall reduction of 25% in development of all pressure ulcers. Community targets are 50% reduction on 2013/14 baseline and to develop incidence reporting model. Audit of nutritional assessment and care planning is planned quarterly together with tissue viablility. Development of incident reporting of all moisture lesions is also to be established.

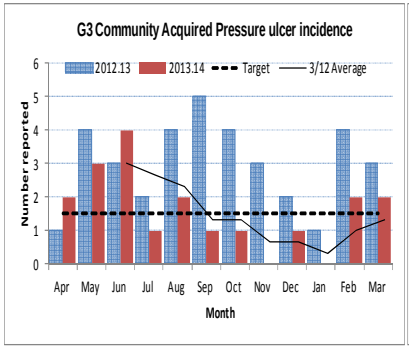
Analysis: **Quality Account Priority 2 - Prevention & Management of Pressure Ulcers**

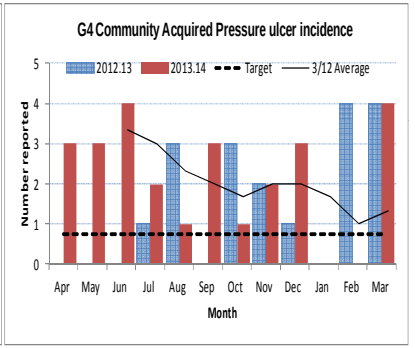












Action Plan:	Person Responsible:	Date:	Status:
A 'deep-dive' exercise has reviewed all Community grade 4's over the past months. One area of concern is patient compliance. Action plans are being developed from this.	Executive Director of Nursing & Workforce/ Tissue Viability Specialist Nurse	Mar-14	In progress
The Trust has now received and distributed an uplift to the alternating pressure mattress stock, utilisation of which will contribute to the preventative agenda.	Executive Director of Nursing & Workforce/ Tissue Viability Specialist Nurse	Apr-14	Completed
Issues have been highlighted,relating to the use of appropriate care plans and this will form part of the ward accountability process. Matrons are working to summarise care delivery standards for patients at risk, in order to streamline analysis of PUs once identified.	Executive Director of Nursing & Workforce/ Tissue Viability Specialist Nurse	Mar-14	In progress
The Clinical Nurse Specialist & Director of Nursing are working with Communication & Engagement to develop a Pressure Ulcer Campaign across the wider healthcare economy.	Executive Director of Nursing & Workforce/ Tissue Viability Specialist Nurse	Spring 14	In progress

Commentary:

Clostridium difficile

There was 1 Healthcare Acquired Clostridium Difficile (C Diff) case in March (YTD = 7) and we remain within our planned control total for the national threshold of 12 for the year.

Our local stretched target for 2013/14 was 8. This threshold is weighted across the year to take account of the historically expected winter increase and we have remained within our stretched trajectory.

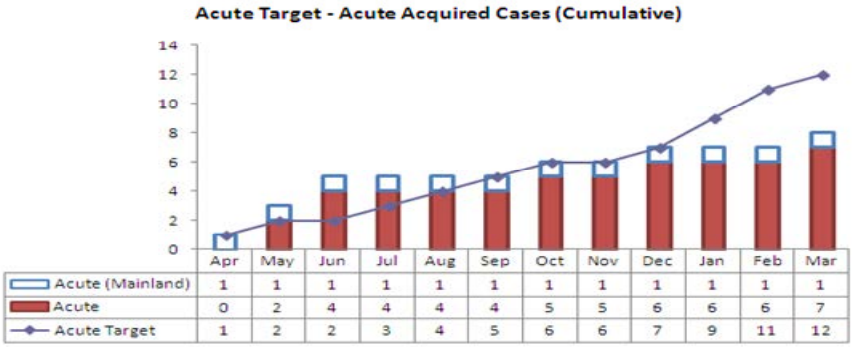
The national threshold for the coming year (2014/15) has been reduced to 6 and we are setting our local stretched target to 4 as part of the drive toward achieving zero tolerance.

Methicillin-resistant Staphylococcus Aureus (MRSA)

There have been no cases of Healthcare Acquired MRSA bacteraemia in the Acute hospital during March and we remain at 2 for the year, above our zero tolerance target.

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

Analysis: **Clostridium Difficile infections against national target**



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	1	0	0	0	0	0	0	1	0	0	2

Action Plan:	Person Responsible:	Date:	Status:
A risk register entry for this target is under development by the Director of Infection Prevention & Control (DIPC) in conjunction with the Infection Prevention & Control Team.	Executive Director of Nursing & Workforce	Apr-14	In progress
An external Healthcare Acquired Infection expert (currently working with the Trust Development Authority) visited during February to oversee our current policies & procedures to offer advice on improvement. The report has yet to be received.	Executive Director of Nursing & Workforce	Apr-14	Report expected
All cases continue to be subject to root cause analysis to identify actions necessary to ensure the trajectory remains achieved.	Executive Director of Nursing & Workforce	Apr-14	Ongoing

Isle of Wight NHS Trust Board Performance Report 2013/14

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Formal Complaints

Commentary:

There were 12 formal Trust complaints received in March 2014 (17 previous month) with 345 compliments recieved by letters and cards of thanks across the same period. There were over 23,000 consultant led contacts during March.

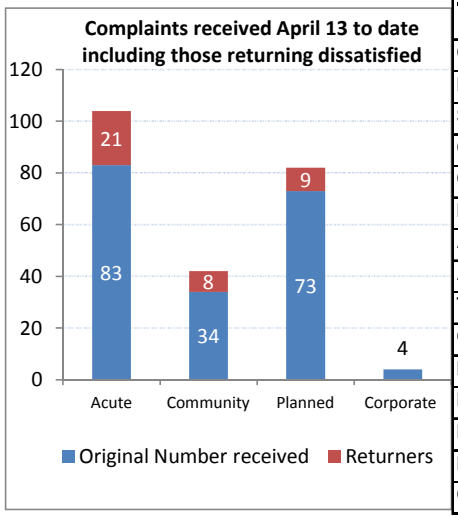
Across all complaints and concerns in March 2014:
Top areas complained about were:
- Emergency Department (7)
- General Surgery & Urology (7)

Across all complaints and concerns in March 2014:
Top subjects complained about were:
- Clinical care (30)
- Out-patient appointment delay/cancellation (19)
- Communication (9)

Quality Account Priority 3 - Improving Communication

The target of a 20% reduction in both complaints & concerns across the year regarding communication is being monitored. This is has been achieved for Year to Date complaints although concerns continue to exceed the planned trajectory. This could be due to increased awareness and accessibility addressing concerns before reaching conversion to formal complaint level.

Analysis: Complaints



Primary Subject	January 14	February 14	March 14	CHANGE	RAG rating
Clinical Care	12	11	11	0	→
Nursing Care	2	1	1	0	→
Staff Attitude	1	0	0	0	✓
Communication	3	2	0	-2	✓
Outpatient Appointment Delay/ Cancellation	2	1	0	-1	✓
Inpatient Appointment Delay / Cancellation	0	1	0	-1	✓
Admission / Discharge / Transfer Arrangements	0	0	0	0	✓
Aids and appliances, equipment and premises	1	0	0	0	✓
Transport	0	1	0	-1	✓
Consent to treatment	0	0	0	0	✓
Failure to follow agreed procedure	0	0	0	0	✓
Hotel services (including food)	0	0	0	0	✓
Patients status/discrimination (e.g. racial, gender)	0	0	0	0	✓
Privacy & Dignity	0	0	0	0	✓
Other	3	0	0	0	✓

Quality Account Priority 3 - Improving communications

KPI Description	Target (cumulative)	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total ytd
Reduction in complaints relating to communication	↓20%	2012/13	3	4	6	3	4	6	8	7	1	7	5	2	56
		2013/14	4	1	3	5	2	2	3	2	4	5	5	1	37
Reduction in concerns relating to communication	↓20%	2012/13	20	19	12	14	8	10	11	6	6	10	8	8	132
		2013/14	17	12	8	8	7	5	18	10	11	9	10	10	125

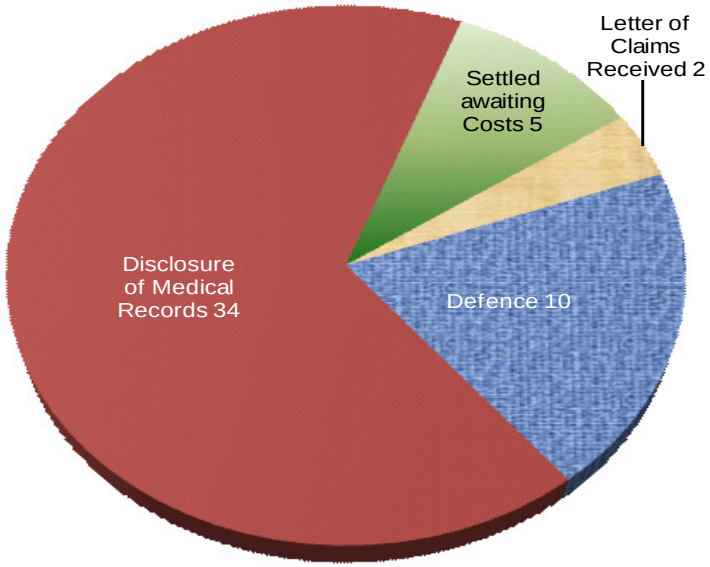
Individual months are colour rated for their achievement of the target for that month.
The Year to Date figure for 2013/14 shows the cumulative position against the equivalent YTD position for 2012/13

Action Plan:	Person Responsible:	Date:	Status:
Following the review of complaints, recommendations have been made relating to complaints management. Resources will be allocated to Clinical Directorates to assist them in owning their complaints and managing them closer to the point of care. Resource to be identified through organisational change.	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Apr-14	In progress

Q3 Isle of Wight NHS Trust Claims Dashboard

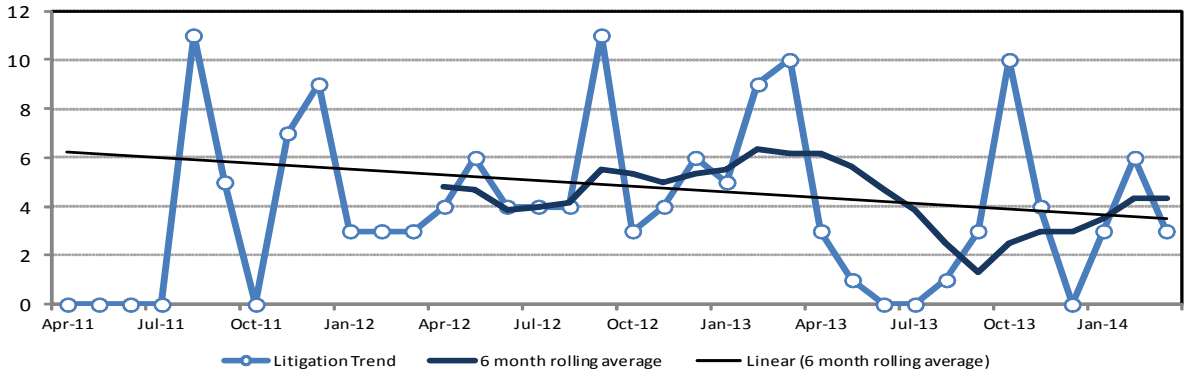
Current number of open claims 51

Number of Open Claims by Category

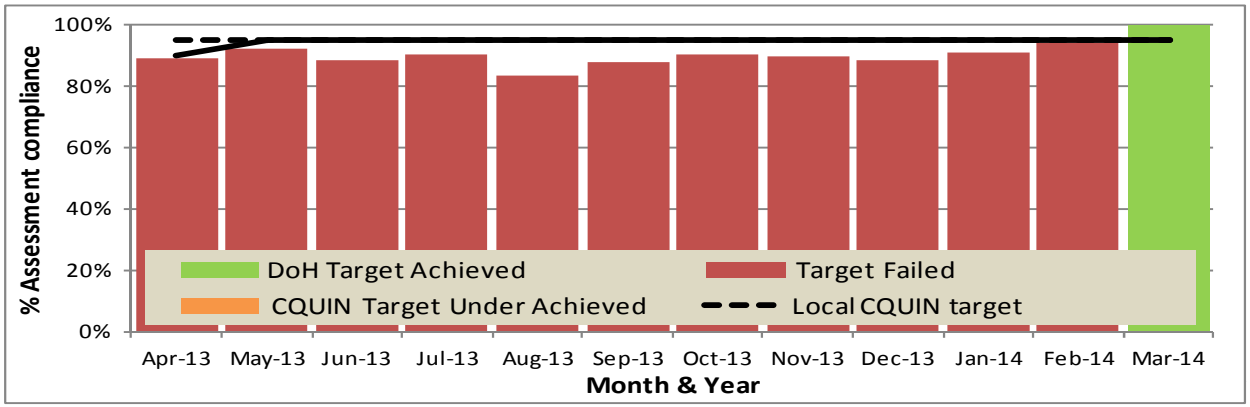


NPSA Category	Ligigation Received				
	Q4 12/13	Q3 13/14	Q4 13/14	Change	RAG
Access, Appointment, Admission, Transfer, Discharge	7	3	0	-3	✔
Accident that may result in personal injury	0	0	0	0	✔
Consent, Confidentiality or Communication	0	0	0	0	✔
Infrastructure or resources (staffing, facilities, environment)	0	0	0	0	✔
Medication	0	0	2	2	↑
Implementation of care or ongoing monitoring/review	4	4	2	-2	↓
Treatment, procedure	13	7	8	1	↑
Total	24	14	12	-2	↓

Litigation Received



Venous ThromboEmbolism Assessment (VTE)

Commentary:	**Analysis:**
The long awaited upgrade to the Pharmacy system went live during February and VTE risk assessment results are now recorded automatically for all new admissions on participating wards. March is our first full month of automatic recording and results show that all eligible patients are being assessed. Achievement against this measure has been badly affected by data collection problems whilst awaiting the upgrade and, now that these are resolved, this level of compliance is expected to continue.	VTE Risk Assessment 12 month 

Action Plan:	**Person Responsible:**	**Date:**	**Status:**
The Executive Medical Director will be continuing to monitor achievement of this measure.	Executive Medical Director	Apr-14	Continuing

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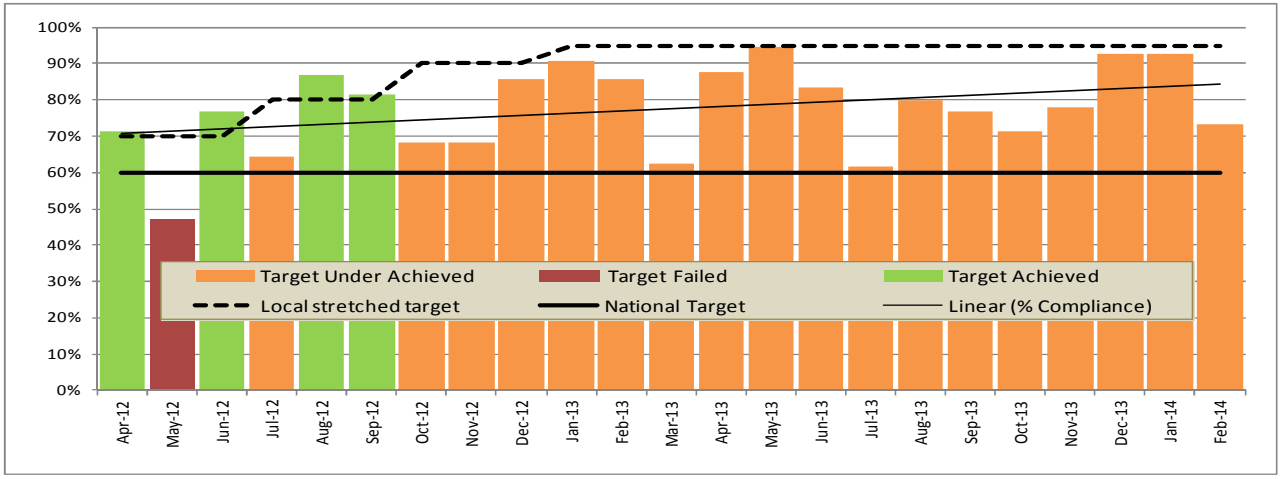
Stroke & Transient Ischemic Attack (TIA)

Isle of Wight NHS Trust

Commentary:	Analysis: TIA December 2013
Proportion of people with high risk TIA fully investigated and treated within 24 hours: The national target of 60% continues to be exceeded. 11 of the 14 TIA patients in February were contacted and seen within the required timescale, resulting in a 73% achievement this month. Of the 4 not seen, 1 had no transport, 1 declined the appointment and 2 were unable to be contacted. Figures for March are not currently available. The trend over the past 2 year shows an increasing level of performance but the small numbers in this patient group have an exaggerated effect on the percentages.	

Action Plan:	Person Responsible:	Date:	Status:
Patients declining appointments:- Contact is made with all patients where-ever possible to offer an appointment. Transportation within the required timescale remains challenging as patients are obviously unable to drive themselves and hospital transport requires 24 hours notice. The National Stroke Network is working on ways to help resolve this as these problems are nationwide. National Target remains at 60% due to these known problems.	Clinical Lead for Stroke	Mar-13	Ongoing nationally

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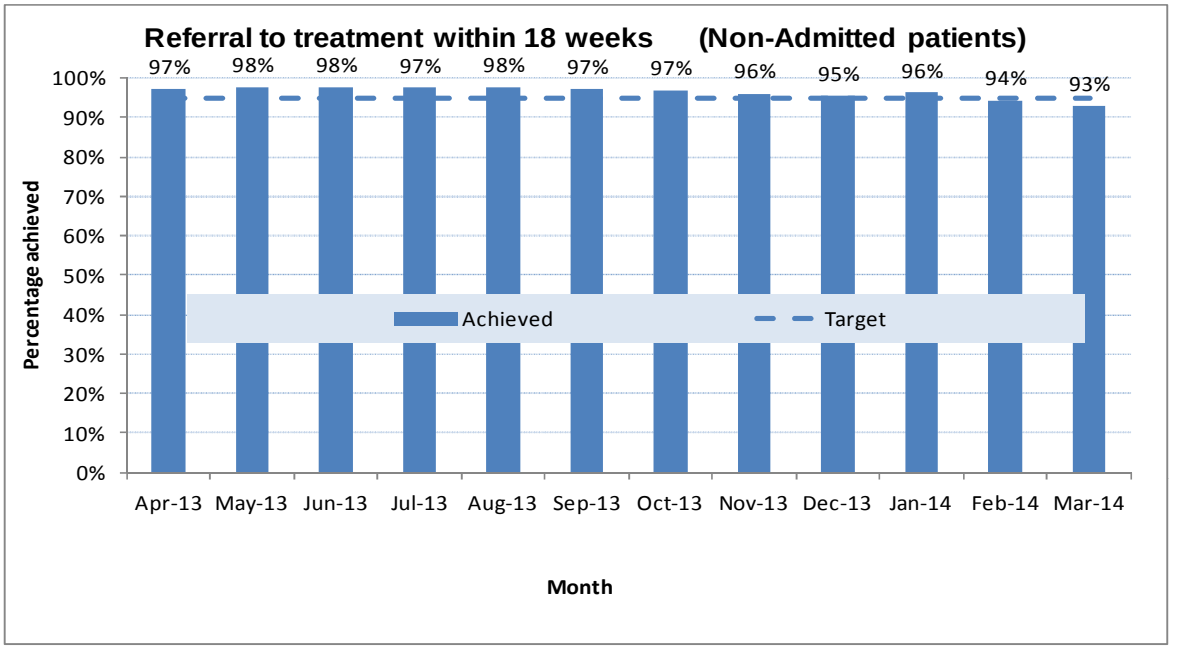
Referral to Treatment Times (RTT)

Commentary:

Whilst the Trust over-achieved the non-admitted target for services commissioned by the IOW CCG, significant failure of the target in Oral & Maxillofacial specialties, particularly dental service commissioned by NHS England brought overall Trust achievement below the 95% target.



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Benchmarking Update - National Performance Indicators

Isle of Wight NHS Trust

Periodically NHS England releases statistics on Key national performance indicators in order to provide transparency on NHS performance and outcomes. They are derived from data provided by NHS organisations in response to officially licenced data collections. The following table shows how the IW NHS Trust performed against other NHS & Foundation Trusts against these KPIs.

Benchmarking of Key National Performance Indicators:

	National Target	National Performance			IW Performance	IW Rank	IW Status	Data Period
		Best	Worst	Average				
RTT:% of admitted patients who waited 18 weeks or less	90%	100%	72%	90.6%	90.3%	98/166	Worse than national average	Feb-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	100%	88%	97.1%	94.3%	174/194	Bottom Quartile	Feb-14
RTT % of incomplete pathways within 18 weeks	92%	100%	72%	94.4%	96.6%	55/192	Better than national average	Feb-14
%. Patients waiting > 6 weeks for diagnostic	1%	0%	34%	0.2%	0.3%	105/185	Worse than national average	Feb-14
Emergency Care 4 hour Standards	95%	100%	86%	95.2%	96.8%	50/177	Better than national average	Qtr 4 13/14
Ambulance Category A Calls % < 8 minutes - Red 1	75%	82%	69%	75.1%	75.6%	6/11	Better than national average	Feb-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	85%	64%	75.0%	76.4%	4/11	Better than national average	Feb-14
Ambulance Category A Calls % < 19 minutes	95%	98%	92%	96.0%	96.7%	4/11	Better than national average	Feb-14
Cancer patients seen <14 days after urgent GP referral*	93%	100%	90%	95.6%	97.3%	45/159	Better than national average	Qtr 3 13/14
Cancer diagnosis to treatment <31 days*	96%	100%	92%	98.3%	98.6%	104/165	Better than national average	Qtr 3 13/14
Cancer urgent referral to treatment <62 days*	85%	100%	50%	85.8%	94.7%	9/162	Top Quartile	Qtr 3 13/14
Breast Cancer Referrals Seen <2 weeks*	93%	100%	82%	95.5%	97.0%	52/138	Better than national average	Qtr 3 13/14
Cancer Patients receiving subsequent surgery <31 days*	94%	100%	90%	97.0%	100.0%	=1/156	Top Quartile	Qtr 3 13/14
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100%	98%	99.8%	100.0%	=1/147	Top Quartile	Qtr 3 13/14
Cancer Patients treated after consultant upgrade <62 days*	85%	100%	0%	92.1%	No Data	n/a	n/a	Qtr 3 13/14
Cancer Patients treated after screening referral <62 days*	90%	100%	0%	94.5%	97.0%	60/141	Better than national average	Qtr 3 13/14
VTE Risk Assessment	95%	100%	75%	96.1%	90.8%	158/163	Bottom Quartile	Jan-14

- Source: Health & Social Care Information Centre
- Data relates to Feburary 2014
- Includes data from 221 NHS Trusts and Foundation Trusts that submitted data

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:

This data is the latest release based on the returns submitted nationally by the contributing trusts. It should be noted that the actual numbers vary considerably. VTE risk assessment data collection problems have now been resolved and we are now able to report 100% compliance, although this will not yet show in the national statistics.

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Data Quality

Isle of Wight NHS Trust

Commentary:

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

Overall our data quality reporting to SUS has improved in 2013/14 compared to the financial year 2012/13. Areas that still require attention in APC are Primary Diagnosis and HRG4, (Healthcare Resource Grouping) both of which will improve if we reduce delays in the completing discharge summaries and therefore ensure timely coding. The issue with the Site of Treatment code was due to a change in PAS in mid April meaning records prior to this date were submitted with our old (5QT) code and thus recognised as invalid. In the A&E data set we include Beacon data within our SUS submission, unfortunately the Adastra system has a large number of attendance disposal codes missing. A fix to this issue has recently been implemented and data sets will now be transmitted to SUS with the fix.

Total APC General Episodes: 27,497

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	499	98.2%	99.1%
Patient Pathway	555	93.5%	59.9%
Treatment Function	0	100.0%	99.7%
Main Specialty	0	100.0%	99.9%
Reg GP Practice	9	100.0%	99.9%
Postcode	2	100.0%	99.9%
Org of Residence	8	100.0%	97.8%
Commissioner	33	99.9%	99.1%
Primary Diagnosis	2,157	92.2%	98.6%
Primary Procedure	0	100.0%	99.8%
Ethnic Category	11	100.0%	97.9%
Neonatal Level of Care	0	100.0%	98.9%
Site of Treatment	810	97.1%	96.9%
HRG4	2,160	92.1%	98.3%

Total Outpatient General Episodes: 148,205

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	837	99.4%	99.3%
Patient Pathway	65,435	52.4%	49.6%
Treatment Function	0	100.0%	99.7%
Main Specialty	0	100.0%	99.8%
Reg GP Practice	9	100.0%	99.9%
Postcode	11	100.0%	99.8%
Org of Residence	11	100.0%	97.4%
Commissioner	52	100.0%	98.3%
First Attendance	0	100.0%	99.7%
Attendance Indicator	1	100.0%	99.6%
Referral Source	1,002	99.3%	98.3%
Referral Rec'd Date	1,002	99.3%	96.2%
Attendance Outcome	69	100.0%	98.7%
Priority Type	1,002	99.3%	97.3%
OP Primary Procedure	0	100.0%	98.3%
Ethnic Category	73	100.0%	92.8%
Site of Treatment	4,405	97.0%	97.9%
HRG4	3	100.0%	99.0%

Total A&E Attendances 55,193

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	956	98.3%	95.8%
Registered GP Practice	36	99.9%	99.1%
Postcode	26	100.0%	99.9%
Org of Residence	979	98.2%	96.6%
Commissioner	1,334	97.6%	98.4%
Attendance Disposal	18,008	67.4%	98.3%
Patient Group	0	100.0%	94.5%
First Investigation	682	98.8%	95.3%
First Treatment	1,606	97.1%	93.7%
Conclusion Time	455	99.2%	98.3%
Ethnic Category	0	100.0%	91.2%
Departure Time	267	99.5%	99.8%
Department Type	0	100.0%	99.6%
HRG4	883	98.4%	96.9%

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:
Resolve missing Attendance Disposal code in A&E dataset	Head of Information/Asst. Director - PIDS	Apr-14	Completed

Data Quality - February 2014

Dataset	Measure	IW Performance	National	Threshold G	Threshold A	Threshold R	Status	Weighting	Score	Notes
APC	Total Invalid Data Items	3	n/a	=<2	>2 =<4	>4	A	2	1.0	Performance relates to the no. of Red rated data
APC	Valid NHS Number	98.2%	99.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	R	1	1.0	
APC	Valid Ethnic Category	100.0%	97.9%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Invalid Data Items	1	n/a	=<2	>2 =<5	>5	G	2	0.0	Performance relates to the no. of Red rated data
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	100.0%	92.8%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Total Invalid Data Items	2	n/a	=<2	>2 =<4	>4	G	2	0.0	Performance relates to the no. of Red rated data
A&E	Valid NHS Number	98.3%	95.8%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Valid Ethnic Category	100.0%	91.2%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
	Total			= < 2	2 > = < 4	= > 4	G	12	2.0	

Source: Information Centre, SUS Data Quality Dashboard

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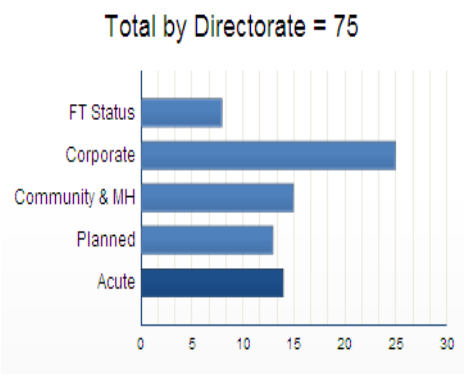
Risk Register -Situation current as at 23/04/2014

Analysis:



Data as at 23/04/2014 Risk Register Dashboard

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	%
PLANND	23/02/2011	Insufficient And Inadequate Endoscopy Facilities To Meet Service Requirements (Baf 6.10)	7	5	71.4%
PLANND	20/10/2011	Insufficient And Inadequate Ophthalmology Facilities To Meet Service Requirements (Baf 6.10)	6	4	66.7%
CORPRI	22/11/2011	Mandatory Training	6	4	66.7%
CORPRI	23/01/2012	Fire Compartments - Cause And Effect Of Fire Alarm System	6	3	50.0%
ACUTE	16/08/2012	Blood Sciences Out-Of-Hours Staffing (Baf 4.4)	4	3	75.0%
ACUTE	22/08/2012	Risk Due To Bed Capacity Problems (Baf 2.22 & 6.12)	4	3	75.0%
PLANND	24/10/2012	Failing Heating/Cooling System Impacting On Service Delivery (Baf 2.22)	2	1	50.0%
COMMH	22/11/2012	Low Staffing Levels Within Occupational Therapy Acute Team	6	2	33.3%
ACUTE	05/12/2012	Vacant Consultant Physician Posts (Baf: 10.73)	3	1	33.3%
CORPRI	26/03/2013	Pressure Ulcers	3	0	0.0%
ACUTE	28/08/2013	Radio Opaque Line On Pennine Ng Tubes	6	5	83.3%
PLANND	23/09/2013	Ophthalmic Casenotes - Poor Condition, Misfiling And Duplication Leading To Potential Clinical Error	4	2	50.0%
ACUTE	21/01/2014	Acquisition Of Mechanical Device For Chest Compressions	3	2	66.7%
COMMH	21/01/2014	Safeguarding Children Training: Level 2	4	1	25.0%
ACUTE	24/02/2014	Integrated Hub Call Vision Telephone Recorder Server	5	0	0.0%

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, the following page gives further detailed descriptions of each of the above risks.

Since the last report six new risks have been added to the register, although the table above shows only those with the highest level rating. These were (1) Theatre Walls and Floor Refurbishment required (2) Ambulance Service Vehicle Stock and Washers (3) Failure to achieve cost improvement programme (4) Staff issues relating to Physiotherapy in Community Rehab and Laidlaw (5) Any Qualified Provider Risk (6) Diseconomies Support/Local Modification to Tariff. Six risks have been signed off (1) Failure to achieve Cost Improvement Programme (2) Fragmentation of Commissioning Allocations in the new system (3) Substandard Windows in Sevenacres (4) Fair Price Tariff Top Up (5) Any Qualified Provider Risk (6) Segregation, Consigning and Collection of Clinical Waste

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Workforce - Key Performance Indicators

Isle of Wight NHS Trust

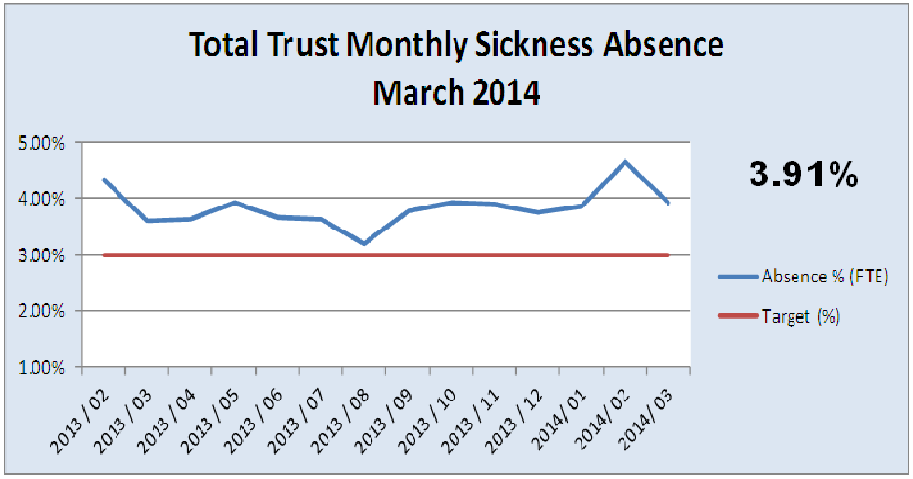
Measure	Period	Month Target/Plan	Month Actual	In Month Variance	RAG rating	In Month Final RAG Rating	Trend from last month
Workforce FTE	Mar-14	2669	2678	9			
Workforce Variable FTE	Mar-14	139	209	70			
Workforce Total FTE	Mar-14	2808	2887	79			
Finance	**Period**	**Month Target/Plan (£000's)**	Month Actual (£000's)	In Month Variance (£000's)	**RAG rating**	**Year-to Date Final RAG Rating**	
Total In Month Staff In Post Paybill	Mar-14	£9,080	£9,159	£79			
In Month Variable Hours	Mar-14	£209	£1,196	£987			
In Month Total Paybill	Mar-14	£9,289	£10,355	£1,066			
Year-to Date Paybill*	Mar-14	£113,276	£116,847	£3,571			
Includes £216k Winter Pressure Pay Costs							
Sickness Absence	**Period**	**Month Target/Plan**	**Month Actual**		**RAG Rating**		
In Month Absence Rate	Mar-14	3%	3.91%				

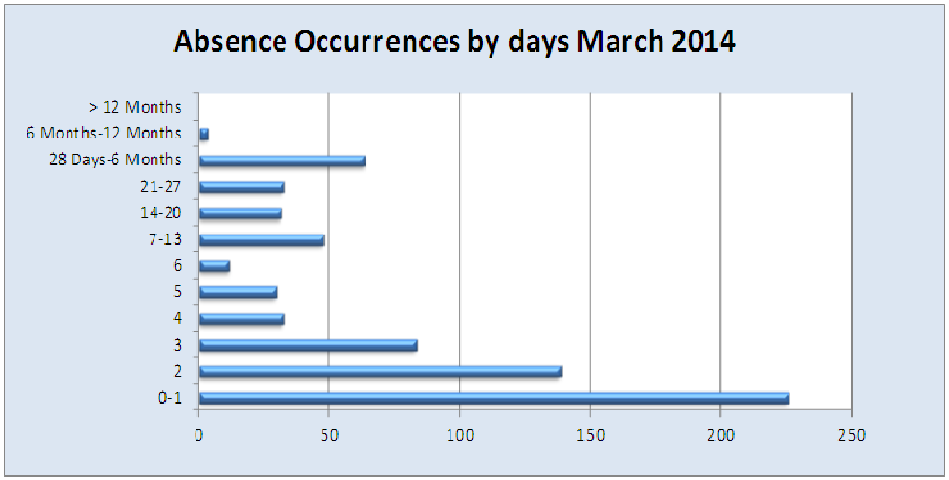
Commentary

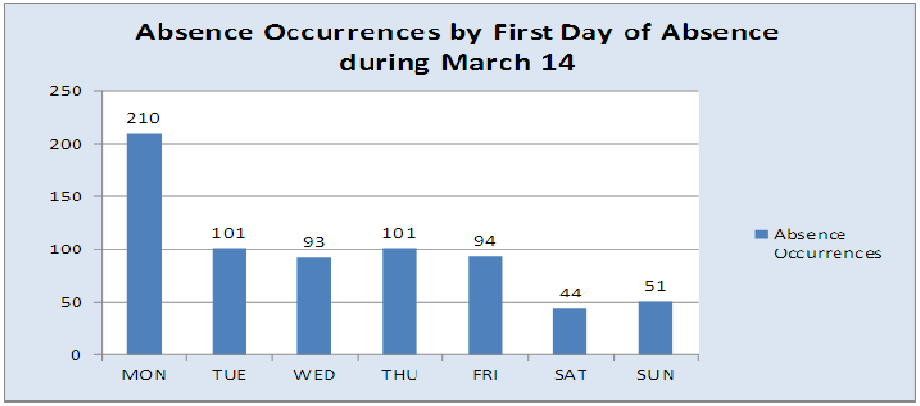
Key	
	Green - On Target
	Amber - Mitigating/corrective action believed to be achievable
	Red - Significant challenge to delivery of target

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

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







Top 10 Absence reasons by FTE Year To Date

Absence Reason
S25 Gastrointestinal problems
S10 Anxiety/stress/depression/other psychiatric illnesses
S12 Other musculoskeletal problems
S11 Back Problems
S13 Cold, Cough, Flu - Influenza
S28 Injury, fracture
S17 Benign and malignant tumours, cancers
S26 Genitourinary & gynaecological disorders
S15 Chest & respiratory problems
S98 Other known causes - not elsewhere classified

Data Source: ESR Business Intelligence

Performance Area	Commentary	RAG Rating In	RAG Rating YTD	RAG Rating Full
Continuity of Service Risk Rating (CoSRR)	• Overall Rating of 4 after normalisation adjustments.	Green	Green	Green
Summary	• The draft final year end position for the Trust is an adjusted surplus of **£1,613k**. This is in excess of the original plan, **£1,598k** & the forecast out-turn reported last month **£1,603k**.	Green	Green	Green
Cost Improvement Programme (CIP)	• Month 12 - CIPs achieved **£8,733k** against a plan of **£8,644k.** The RAG rating in month remains Amber due to the level of non recurrent plans.	Amber	Amber	Red
Working Capital & Treasury	• Cash 'in-hand' and 'at-bank' at Month 12 was **£13,358k.**	Green	Green	Green
Capital	• Total capital spend for the year was **£8,626k** compared to the total Capital Resource available of **£8,630k**.	Amber	Amber	Green

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Income & Expenditure - Key Highlights - Trust

Isle of Wight NHS Trust

(in £'000)	YTD		
I&E - TRUST	Budget	Actual	Actual v Budget (+ over / - under)
I&E by subjective:			
Income			
Income - Patient Care Revenue	144,514	144,284	(230)
Acute	3,836	8,795	4,959
Community Health	2,950	4,832	1,882
Planned	3,046	4,469	1,423
Corporate	4,762	8,545	3,782
Risk Share Income	0	688	688
Total Income	**159,108**	**171,611**	**12,504**
Pay			
Acute	(34,532)	(34,949)	(418)
Community Health	(31,854)	(32,262)	(408)
Planned	(30,348)	(32,300)	(1,952)
Corporate	(16,542)	(17,336)	(793)
Reserves	(0)	0	0
Total Pay	**(113,276)**	**(116,847)**	**(3,571)**
Non-Pay			
Acute	(12,034)	(17,142)	(5,107)
Community Health	(2,611)	(4,988)	(2,377)
Planned	(7,273)	(8,774)	(1,502)
Corporate	(11,660)	(14,874)	(3,214)
Reserves	(3,236)	0	3,236
Total Non-Pay	**(36,815)**	**(45,778)**	**(8,964)**
EBITDA	**9,017**	**8,986**	**(31)**
Income Received			
Receipt of Charitable Donations for Asset Acquisition	0	347	347
Total Income Received	0	347	347
Capital Charges			
Depreciation & Amortisation	(7,400)	(7,721)	(321)
PDC (reallocated to Non Pay FY13/14 only)	0	0	(0)
Profit/Loss on Asset Disp	0	11	11
Total Capital Charges	**(7,400)**	**(7,710)**	**(310)**
Other Finance Costs			
Interest Receivable	15	32	18
Interest Payable	(24)	(28)	(4)
Bank Charges	(10)	(15)	(5)
Foreign Currency Adjustments	(0)	0	0
Total Other Finance Costs	**(20)**	**(11)**	**9**
Net Surplus / (Loss)	**1,598**	**1,613**	**16**

Overall Position

Month 12 position shows a year to date surplus of **£1,613k**, which is **£16k** over plan for the year.

Income - The M12 position is over plan by **£12,504k.** Patient Related income is **£230k** under plan for the year - this is due to income being reallocated to directorates in M12 to cover costs related to winter pressures, 1:1 care, drugs costs etc. The variance of **£4,959k** in the Acute directorate is due largely to the prison extension contract in Apr-May, dermatology element within the Beacon contract, income transferred from CAT A for Healthcare @ Home services and drug cost recharges. Within the Planned area the variance of **£1,423k** is due to mainly R&D and Allergy funding being higher than plan and income transferred from CAT A for Winter Pressure activity. The Community Health income variance of **£1,882k** is due to over plan charges for Mental Health 1:1 activity and recharges for Health Visitor costs which have now been fully funded by the commissioners. Income relating to Corporate areas is showing a favourable variance of **£3,782k** mainly due to the adjustment to the EMH budget, income relating to NHS Creative and training income being above plan. In addition the below the line Receipt of Charitable Donations for Asset Acquisition of the **£250k** donation relating to the helipad and £97k received from 'Friends of St Mary's' is over plan.

Pay – The YTD position on pay budgets is over plan by **£3,571k.** This includes spend in the Acute directorate (variance **£418k**) attributable to the additional costs relating to the 2 month extension to the Prison Contract and the Beacon dermatology contract plus overspends due to locum usage within Pathology, General Medicine and Elderly Care; **£408k** over plan in Community which is due to Health Visitor Trainee costs funded by income and 1:1 supervision costs funded by Commissioners. An overspend of **£1,952k** in the Planned directorate is due to additional pay costs relating to the winter bed pressures and Locum Costs to cover vacancies and sickness; **£793k** in Corporate areas is mainly due to costs relating to NHS Creative and additional hotel services costs during March 2014 as a result of the norovirus outbreak.

Non Pay – The non pay budgets are overspent by **£8,964k**. All clinical directorates and Corporate area overspends are predominantly due to non-achievement of CIPs as per plan; within the clinical directorates are overspends on non PbR drugs offset by income and costs relating to the prison extension.

CIP – Plan of **£8,644k** was overachieved at month 12 by **£90k.**

Isle of Wight NHS Trust Board Performance Report 2013/14

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Cost Improvement Programme - CIP by Directorates

	Month			FULL YEAR						
Directorates	**Plan**	**Actual**	**Variance**	**Plan Recurrent**	**Actual - Recurrent**	**Actual - Non Recurrent**	**Total Actual**	**Variance Recurrent (CYE)**	**Total Variance**	**Full Year Effect**
Acute	327	777	450	2,575	2,057	252	2,309	(518)	(266)	49
Community Health	304	120	(184)	2,340	790	193	983	(1,550)	(1,357)	202
Finance and Performance Mgt	24	20	(4)	167	187	53	240	20	73	0
Nursing and Workforce	69	55	(15)	534	286	96	382	(248)	(152)	37
Planned	341	303	(38)	2,622	1,022	669	1,691	(1,600)	(931)	253
Strategic & Commercial Directorate	31	86	55	406	254	95	349	(152)	(57)	56
Trustwide Transformation Schemes	0	0	0	0	0	2,779	2,779	0	2,779	415
Total	**1,097**	**1,361**	**265**	**8,644**	**4,595**	**4,138**	**8,733**	**(4,048)**	**90**	**1,013**
Banked CIPs	0	(334)	(334)							
Total	**1,097**	**1,028**	**(69)**	**8,644**	**4,595**	**4,138**	**8,733**	**(4,048)**	**90**	**1,013**

Commentary:

The CIP plan for M12 is **£1,097k**. The actual savings totalled **£1,361k** and with the unwinding of **£334k** of banked CIPs in month there is an in month underachievement of **£124k**. Of the **£8,644k** annual target **£8,733k** of planned schemes have been achieved. The year end position is showing achievement of **£8,733k** which is a **£89k** overachievement against the annual plan with a **£3,036k** carry forward.

Isle of Wight NHS Trust Board Performance Report 2013/14

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Capital Programme - Capital Schemes

Isle of Wight NHS Trust

Source & Application of Capital Funding	YTD Spend £'000	F'cast to Year End £'000	Full Year £'000	Original Plan £'000
Source of Funds				
Initial CRL			7,560	7,560
Dementia Friendly			399	
Pharmacy Matched Funding - NHS Technology for Safer Wards (provisional)			224	
CCG Income (Hand Held Devices)			100	
Property Sales				
Cash Surplus				
Capital Resource Limit (CRL)	**0**	**0**	**8,283**	**7,560**
Other charitable donations			97	100
Charitable Funds - Dementia				
Donated Helipad Income			250	
VAT Recovery				
Total Anticipated Funds Available	**0**	**0**	**8,630**	**7,660**
Application of Funds				
12/13 Schemes Carried Forward				
2012 / 13 Backlog Maintenance	265		265	
Helipad works	42		42	
Replacement of two Main Hospital Passenger Lifts	255		255	300
Old HSDU Refurbishment (Phase 1)	147		147	
Shackleton to Newchurch Ward Move	68		68	
Improving Birthing Environment	58		58	
Personal Alarm System for Sevenacres	11		11	
Move Drop Safe to the Cashiers Office	6		6	
Modernisation of Pathology	56		56	
Emergency Dept Redevelopment	33		33	
Sub-total	**942**	**0**	**942**	**300**

Source & Application of Capital Funding	YTD Spend £'000	F'cast to Year End £'000	Full Year £'000	Original Plan £'000
13/14 Schemes - Approved				
Pathology Refurbishment Phase 2	867		867	860
Medical Assessment Unit Fees	26		26	
Medical Assessment Unit Extension	379		379	1,100
Ophthalmology/Endoscopy	-0		-0	
Ward Reconfiguration Level C	532		532	
Theatre Stock Inventory System	151		151	
Ryde Community Clinic Professional Fees	15		15	
Ryde Community Clinic	245		245	600
Backlog high/medium risk & fire safety 13.14	1,155		1,155	500
Other Backlog Schemes	265		265	
Infrastructure (e.g. underground services)	317		317	300
Staff Capitalisation	0		0	100
IM&T	412		412	500
PARIS - Staff Capitalisation	90		90	
ISIS Further Faster	630		630	
RRP - Equipment & Ambulances	275		275	500
Contingency :-				300
Purchase of letter folder stuffer	0		0	
Turnkey for DR Rooms	148		148	
Bed Store	70		70	
Other Bids	220		220	
Office Moves - Finance Relocation	53		53	
Dementia Friendly	216		216	
Upgrade of current ICE and LabComm servers	7		7	
Wireless Network and Infrastructure Upgrade	118		118	
Automation of medicines storage at Ward level	434		434	
Telephone Data Capture (Tiger Billing)	13		13	
P21+ Contractors Site Accommodation	100		100	
ICU/CCU	175		175	
Urodynamics Machine	21		21	
Orthopaedic Theatre Tool Set	61		61	
High Definition Camera System (Gynae & Urology)	71		71	
ENT Microscope	59		59	
Replacement Medical Grade Camera for the Ophthalmic Microscope	33		33	
Relocate Cancer Pathways Team	20		20	
Label Printers	9		9	
Immunostaining Machine	19		19	
POD Lockers	24		24	
South Block Reception Area	36		36	
Hand Held Devices (CCG Income)	97		97	
ED Trolleys	41		41	
Ride on Mower	13		13	
Pocelerator & IT Enabling	22		22	
Education Centre Refurbishment	60		60	
Simulation Equipment Mannequins	87		87	
CAJE System Maint	2		2	
Sub-total	**7,587**	**0**	**7,587**	**4,760**
13/14 Schemes - Awaiting TEC Approval				
Endoscopy Relocation	0		0	
Unallocated Funding	0		0	
Upgrade to Medical Gases System				
Ophthalmology				1,300
Dementia Wing				600
Maternity				600
Sub-total	**0**	**0**	**0**	**2,500**
Other charitable donations	97	0	97	100
Gross Outline Capital Plan	**8,626**	**0**	**8,626**	**7,660**

Commentary:

The final total Capital Resource Limit for the financial year is **£8,630k.** The total spend against this allocation is **£8,626k,** meaning **£6,239k** was spent during the month of March.

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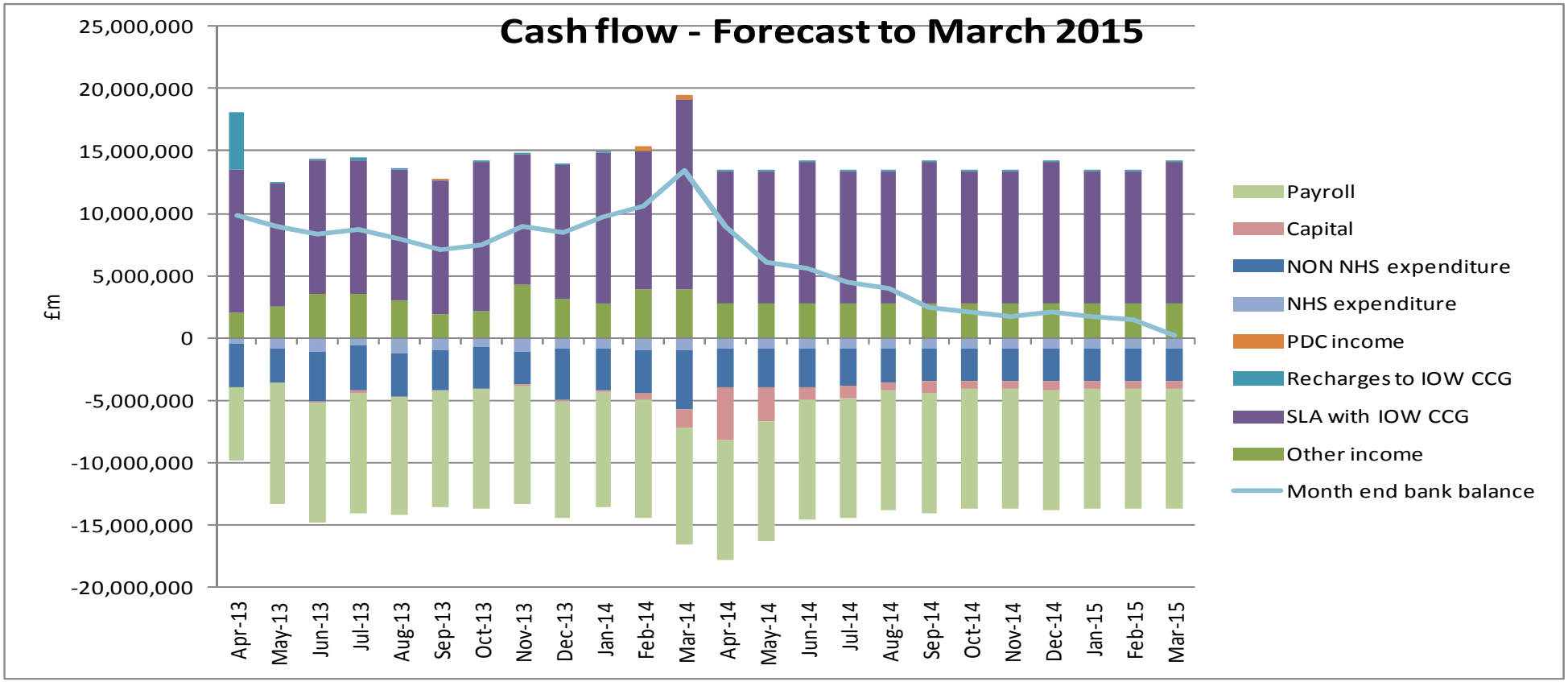
Monthly statement of Financial Position - March 2014

Isle of Wight NHS Trust

	Mar-14	Feb-14	Month-on-month Movement
PPE	116,014	109,525	6,489
Accumulated Depreciation	18,402	20,464	(2,062)
Net PPE	**97,612**	**89,061**	**8,551**
Intangible Assets	7,715	7,355	360
Intangible Assets Depreciation	3,563	3,497	66
Net Intangible Assets	**4,152**	**3,858**	**294**
Investment Property	0	0	0
Non-Current Assets Held for Sale	0	0	0
Non-Current Financial Assets	0	0	0
Other Receivables Non-Current	277	0	277
Total Other Non-Current Assets	**277**	**0**	**277**
Total Non-Current Assets	**102,041**	**92,919**	**9,122**
Cash	13,358	10,579	2,779
Accounts Receivable	7,130	12,964	(5,834)
Inventory	2,200	2,120	80
Investments	0	0	0
Other Current Assets			0
Current Assets	**22,688**	**25,663**	**(2,975)**
Total Assets	**124,729**	**118,582**	**6,147**
Accounts Payable	20,596	17,382	3,214
Accrued Liabilities	0	0	0
Short Term Borrowing	0	7	(7)
Current Liabilities	**20,596**	**17,389**	**3,207**
Non-Current Payables	0	0	0
Non-Current Borrowing	48	48	0
Other Liabilities	711	147	564
Long Term Liabilities	**759**	**195**	**564**
Total Net Assets/Liabilities	**103,374**	**100,998**	**2,376**
Taxpayers Equity:			
Revaluation Reserve	24,489	21,251	3,238
Other Reserves	76,539	75,856	683
Retained Earnings incl. In Year	2,346	3,891	(1,545)
Total Taxpayers Equity	**103,374**	**100,998**	**2,376**

Commentary

The revaluation of the estate at the end of March indicates that property indices have increased year-on-year by 18 points (from 120 to 138). Together, with the in-month capital expenditure this has increased tangible assets value by a total of **c£8.5m**. The **£277k** shown against other non current receivables relates to 2013/14 Injury Cost Recoveries which are not likely to be paid within the next year. The level of cash held, **c£13.4m**, can primarily be attributed to the increase in capital creditors. The considerable reduction in receivables (**c£5.8m**) is mainly because the entry to recognise brought forward CIPs through-out the year has been reversed. The increase in Other liabilities relates to the recognition of additional provisions including those for redundancies and employer liabilities.



Commentary:

The table above shows the actual cashflow for the year ended 31st March 2014 and the forecast to March 15. It shows both the in-flow and out-flow of cash broken down to the constituent elements. The cash held at the year end amounted to c£13.4m and primarily represents the invoices that remained unpaid at the year end. These were therefore included in the balance sheet to be brought forward to 2014/15 and paid during April . Investment in the short term deposit of the National Loans Fund totalled £8m at the year end. As cashflow projections allow, investments will continue on a monthly basis with the return of the principal taking place before the month end to enable the paybill to be discharged.

Isle of Wight NHS Trust Board Performance Report 2013/14

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Continuity of Service Risk Rating

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

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

Commentary:
Monitor introduced new risk rating metrics with effect from 1st October 2013. These now consist of two ratings: Liquidity and a Capital Servicing Capacity. At the end of January the Trust was achieving a rating of 4 in each category which is expected to continue through to the year-end.

Isle of Wight NHS Trust

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'.

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-13	Historic Data: Qtr to Sep-13	Historic Data: Qtr to Dec-13	Current Data: Jan-14	Current Data: Feb-14	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Actions
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	Yes	Yes	Yes	No	Yes	Yes	No	
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	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	Yes	Yes	Yes	
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	Yes	Yes	Yes	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	Yes	Yes	Yes	Yes	Yes	
			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	No	Yes	Yes	No	
			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	No	No	Yes	Yes	Yes	Yes	Yes	
			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	Yes	No	No	No	No	No	No	
			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	No	No	
	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	No	Yes	Yes	Yes	Yes	Yes	Yes	
			Red 2 calls	75%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	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	
			Is the Trust below the YTD ceiling	13		No	No	Yes	Yes	Yes	Yes	Yes	
	16	Minimising mental health delayed transfers of care		≤7.5%	1.0	Yes	Yes	Yes	Yes	No	No	No	
	17	Mental health data completeness: identifiers		97%	1.0	Yes	Yes	Yes	Yes	Yes	N/A	N/A	
	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	
	20	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Referral information	50%									
			Treatment activity information	50%									
			TOTAL			**2.0**	**4.0**	**1.0**	**3.0**	**2.0**	**3.0**	**5.0**	
						AR	R	AG	AR	AR	AR	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
Commentary	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
PAS	Patient Administration System - the main computer recording system used
PATEXP	Patient Experience
PATSAF	Patient Safety
PEO	Patient Experience Officer
PPIs	Proton Pump Inhibitors (Pharmacy term)
PIDS	Performance Information Decision Support (team)
Provisional	Raw data not yet validated to remove permitted exclusions (such as patient choice to delay)
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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FOR PRESENTATION TO PUBLIC BOARD ON: 30 April 2014

QUALITY & CLINICAL PERFORMANCE COMMITTEE
Wednesday 16 April 2014

Present:	Sue Wadsworth	Non Executive Director and Chair (Chair)
	Nina Moorman	Non Executive Director and Deputy Chair (DC)
	David King	Designate Non Executive Director (DK)
	Jessamy Baird	Designate Non Executive Director (JB)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Dr Mark Pugh	Executive Medical Director (EMD)
	Miss Sabeena Allahdin	Clinical Director – Planned Clinical Directorate (CDP)
	Dr Umama Khan	Consultant Psychiatrist – on behalf of Sarah Gladdish (UK)
In Attendance:	Brian Johnston	Head of Corporate Governance & Risk Management (HOCG)
	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM) - *attended up to item 14/107*
	Vanessa Flower	Quality Manager (QM)
	Shane Moody	Interim Head of Clinical Services – Planned Clinical Directorate (IHOCP) - *attended up to item 14/107*
	Deborah Matthews	Head of Clinical Services – Acute Clinical Directorate (HOCA) - *attended up to item 14/107*
	Kay Marriott	Acting Head of Clinical Services – Community Clinical Directorate (HOCC) - *attended up to item 14/107*
	Chris Orchin	Non-Executive Director (Governance and Compliance) Healthwatch IW (HIW)
	Ian Bast	Patient Representative (PR)
	Dr John Pike	Junior Doctor - *for item 14/125*
	Tholi Wood	Emergency Care Practitioner - *for item 14/125*
	Joanne Barry	Paramedic - *for item 14/125*
	Dr Rob Andrews	Consultant - *for item 14/125*
	Annie Hunter	Head of Maternity (HOM) – *for item 14/139*
	Amy Rolf	Senior Human Resources Manager (SHRM) - *for item 14/145*
	Emily Macnaughton	Consultant Microbiologist (CM) - *for item 14/146*
	Sue Bradshaw	Modern Matron (MM) - *for item 14/147*
	Anne Snow	Lead Cancer Nurse/Lead Clinician (LCN) - *for item 14/150*
	Andy Shorkey	Foundation Trust Programme Management Officer (FTPMO), *for item 14/154*
Minuted by:	Amanda Garner	Personal Assistant to EDNW (PA)

Key Points from Minutes to be reported to the Trust Board

- Item 14/125 – Sepsis. The Committee viewed a BBC interview regarding sepsis and also had an update from the team on the good progress being made, following an audit report in 2012.
- Item 14/129 – Annual Report. The Committee reviewed the draft Annual Report and agreed to feedback comments to the QM by Friday 25 April 2104.
- Item 14/152 - Clinical Audit Report. The Committee reviewed the draft Clinical Audit Report.
- Item 14/155 - Quality Goals – The EDNW asked that these be highlighted to Board following approval at the Committee meeting on 18 March 2014 (Quality Goals appended to the minutes).

Minute No.

14/122 APOLOGIES FOR ABSENCE

Apologies were received from Dr Sarah Gladdish Clinical Director – Community Clinical Directorate (CDC), Dr Ma'en Al-Mrayat, Interim Clinical Director – Acute Clinical Directorate (ICDA) and Sarah Johnston, Deputy Director of Nursing (DDN).

14/123 CONFIRMATION OF QUORACY

The Chair confirmed the meeting was quorate.

14/124 DECLARATIONS OF INTEREST

There were no declarations of Interest.

The Chair welcomed all to the meeting and introductions were made.

14/125 SEPSIS PRESENTATION

The Committee viewed a video of a news story on the BBC website from BBC South regarding "Isle of Wight paramedics in new septic shock training".

http://www.bbc.co.uk/news/uk-england-hampshire-27029541

The Chair advised that this was a good news story and would also be shown to Board on 30 April 2014.

JP presented an update presentation to the Committee regarding the achievements in the last six months of this pioneering treatment adding that early treatment made a huge difference to patients. JP advised that this is a unique integrated sepsis service from first contact all the way through to discharge with 40 to 50 patients being treated so far. JP added that there is funding required for further training and for intravenous infusion pouches. JP advised that the team are involved with National Institute for Health and Clinical Excellence (NICE), have been asked to present at national conferences and are engaging with NHS England however a proper outcome based research project is required and someone will be required to co-ordinate this. The EMD said that he could not praise the team highly enough adding that this will make a difference and genuinely save lives. The DC added that it was a very impressive piece of work and it was essential that this was done as a research project and that the Trust should support this. The EMD suggested that the Lead Research & Development Officer could help with this and also suggested that some of the processes could be copyrighted. The IHOCP congratulated the team and advised that he could provide the funding for the further training and intravenous infusion pouches and just needed the correct cost centre to do this.

14/126 MINUTES OF THE LAST MEETING – 19 March 2014

The minutes of the last meeting held on 19 March 2014 were agreed and approved.

14/127 REVIEW OF ACTION TRACKER

The Committee reviewed the Action Tracker.

- Action QCPC0135 – The EMD advised that the Clinical Effectiveness and Outcomes report would be presented to the Committee at the meeting on 21 May 2014.
- Action QCPC0136 – The EDNW advised that the Matrons' Development Programme was still not operational however there was a provisional arrangement and asked for this action to be left open.

- Action QCPC0140 – CCG Commissioned Amber Care Bundle Report. The EDNW advised that this report had not yet been published.
- Action QCPC0144 – Clinical Incidents. The EDNW advised that he had met with the

Head of Clinical Services for the Community Directorate and that this action was now completed.

- Action QCPC0145 – Healthcare Associated Infection. The EDNW advised that this had been completed and lessons learned shared across the organisation.
- Action QCPC0149 – MRSA Screening. The EDNW advised that this action was complete.
- Action QCPC0173 – JB advised that she had raised a couple of issues regarding this. The EDNW added that the Trust does not have a nutritional lead and that it had recently been agreed to create a nutritional lead post hosted in one of the directorates. The EDNW advised that a business case will be submitted and that this action was complete.
- Action QCPC0177 – Outpatient Appointments and Records Unit (OPARU) - the IHOCP advised that the Assistant General Manager had presented this paper to the Trust Executive Committee and that there needs to be a further audit however this action was complete.
- Action QCPC0178 – The EDNW advised that he is preparing a discussion document for governance following the visit to Frimley Park and that this item will be covered as part of the report.
- Action QCPC0187 – CQC Visits. The HOCG advised that Mental Health Services have an ongoing action plan and that this action is closed. The EDNW added that the team were required to audit the actions to ensure they were attainable. The EMD added that the actions and been audited and he was assured that there were improvements.

14/128 REVIEW OF ROLLING PROGRAMME

The Committee reviewed the Rolling Programme.

The DC added that she had requested that some changes be made to this document. The EDNW added that the Committee's Rolling Programme will be discussed at Trust Board Seminar on 13 May 2014 and that some items would possibly go to the Patient Safety Experience and Effectiveness Triumvirate Meeting instead of this Committee.

14/129 Annual Report

The QM presented the draft Annual Report to the Committee advising that it was an update on last year's report. The Committee discussed the timeliness of this information being requested for Audit Committee. The SEEBM suggested that a Quality Governance item be added to the report. The Chair asked that the Committee forwarded any comments back to the QM by Friday 25 April 2014.

***Action Note**: The Committee to feedback comments on Draft Annual Report to QM by Friday 25 April 2014.*

Action by All

The Committee reviewed the checklist on page 5 of the Annual Report and agreed that all items were "yes" except for "are Committee papers distributed in sufficient time for members to give then due consideration?". The Committee agreed that this was not always the case. JB advised that she was concerned that the reports were well written however the quantity and timeliness meant that she was concerned that something would be missed. The DC agreed and advised that the format needs to be reviewed and for the Committee to be clearer on what they need to see in the reports. The EDNW added that the PA had permission to send the papers out by the deadline even if they had not all been received.

UPDATE OF LOCAL / NATIONAL ISSUES

14/130 UPDATE FROM NATIONAL QUALITY AGENDA

The QM advised that this was for the Committee's information and the information was taken from the Health and Social Care Information Centre and included guidance published by

National Institute for Health and Clinical Excellence (NICE) during March and April 2014.

QUALITY

14/131 QUALITY REPORT

The EDNW presented the Quality Report for March 2014 to the Committee and highlighted the following:

- MRSA screening – this had been getting better but has decreased. The HOCA advised that some are genuinely being missed however each one is being reviewed and that there is work being done on this. The EDNW advised that he cannot see this being referred to in the minutes of the directorate meetings. SM advised that this is being addressed but is evidenced in other areas and added that although it was not an excuse the movement of patients had had an impact. JB added that this was a quick process and suggested the something be done on the system to improve this. The EDNW added that the way the data is being captured may be affecting this as there are a cohort of patients who should not be screened and that they may be being counted. The DC added that this should be part of the patient's assessment when they were admitted. The EDNW advised that he needed greater levels of assurance around this.

***Action Note**: The Directorates to provide greater levels of assurance regarding MRSA screening.*

Action by HOCA, IHOCP, HOCC

- VTE – The EMD queried the information on slide 7 relating to VTE regarding the percentage of patients assessed. The QM advised that she would review this.

***Action Note**: The QM to review the VTE information on Slide 7*

Action by QM

- Breastfeeding – improvements have been made.
- Review and Stop Date – this information is incorrect and needs to be validated.
- Friends and Family Test – disappointing for the Emergency Department as they had achieved 22% in November 2014. The EDNW added that this needed to improve and for patients to be encouraged to feedback. JB added that it would be worth considering other surveys and collecting the information via different mechanisms. The QM added that there was a lot of work being done around this and will report to the Committee at the next meeting in May 2014 regarding this.
- Healthcare Associated Infection – a further Clostridium difficile case had been reported on 31 March 2014 taking the total to 7 for the year. The EDNW added that he had some concern over this as it was on a ward where hand hygiene compliance was poor. The EDNW advised that he would discuss this with the HOC.
- Appraisals and Sickness Rate – The Chair asked why there was no data available for these items. The SEEBM advised that the data was not available yet but would be included before the report is published.
- Harm Free Care – The HOCC advised that there was a lot of work being undertaken regarding the Catheter Care Bundle and that a group had been set up with their first meeting taking place today. JB suggested that the addition of percentages on this slide would make the information clearer and the SEEBM advised that she would add this in.

***Action Note**: The SEEBM to add percentages into the Safety Thermometer (Harm Free Care) for the next meeting.*

Action by SEEBM

- SIRIs – these are down to a more manageable level. The EDNW added that a clinician had suggested the use of the Simulation Suite to re-enact SIRIs. The EMD agreed that

this was a good idea.

- Clinical Incidents – there has been a reduction however the data needs to be validated.
- Slips, Trips and Falls – there is a piece of work being done on this and there will be an update at the meeting to be held in May 2014.
- Standardised Hospital Mortality Index (SHMI) – The EMD advised that this is continuing to fall which is encouraging.
- Prevention & Management of Pressure Ulcers – progress was not as hoped. The EDNW added that there will be investment from the CQINS and there will be an Island Wide Campaign.
- Amber Care Bundle – The Chair asked how this was progressing. The SEEBM advised that this had been achieved as part of the CQIN. The EDNW added that he and the EMD had met with the team in December and it was improving. The EMD added that there was a lot of work going on around this. The EDNW added that this is being monitored by the directorates. The EMD added that there would be an update late on in the year and advised the Committee that the group has their first meeting in June 2014.

14/132 QUALITY GOVERNANCE ACTION FRAMEWORK - RESCORING

The SEEBM advised the Committee that the organisation is required to undertake a self assessment again Monitor's Quality Governance Framework as part of the Foundation Trust application process. The SEEBM explained that this is done by a panel (EDNW, EMD, Deputy Director of Nursing and the FT Programme Director/Company Secretary) who reviewed and reassessed the evidence and performance against the 10 questions and that this is the current position. The SEEBM advised that the score was 2.5 last time and this time is 2 due to item 2b being rescored. The SEEBM highlighted that the score in July 2012 was 24 and that to be a Foundation Trust the score has to be 3 or below. The SEEBM advised that the score in January 2013 had been 3.5 and this had been validated by the external review. The SEEBM added that the self assessment had been sent to the directorates and also to the non executive directors to complete. The SEEBM advised that she would be meeting with the EDNW in May to review the evidence and then reassess when a further improvement should be seen. The EDNW added that he wants this to be organisationally driven and feedback from the directorates is important.

14/133 CQC INTELLIGENT MONITORING ACTION PLAN SUMMARY REPORT

The HOCG advised that this is a quarterly update from the CQC and there had been one improvement with VTE reaching 100%. The HOCG advised that there are 3 risks with the Trust scoring 3 points out of a possible 180 which would put it in the top CQC Band 6. The Committee discussed the inpatient survey and how it was scored. The Committee also discussed pain control and how there is a piece of work being undertaken to address this. The EMD agreed that a modified approach was required to this.

14/134 CIPS: QIAS - UPDATE

The EDNW updated the Committee and advised that all of the Quality Impact Assessments (QIA) have been completed. The EDNW added that there is a quarterly directorate meeting to review these and they will be reported to the Committee. The Committee discussed getting feedback from patients to see if there has been an impact on patient care and agreed that a variation on the Friends and Family Test would be helpful. The EDNW advised that some CIPS have been stopped before being put in place and some have been stopped or changed as they have progressed.

REPORTS FROM DIRECTORATES

ACUTE CLINICAL DIRECTORATE

14/135 QUALITY, RISK AND PATIENT SAFETY COMMITTEE

The HOCA advised the Committee that there had not been an Acute Quality, Risk and Patient Safety Meeting in March as it had been cancelled due to the Norovirus outbreak.

The HOCA presented the Ambulance Clinical and Quality Effectiveness Group (CQEG) Minutes to the Committee and highlighted backfill for SEPSIS training and the Anticipatory

Care Plan Procedure.

The DC advised that it was very helpful to have the key messages at the beginning of the minutes and suggested that a paragraph also be included.

***Action Note**: The HOCA to contact the CQEG administrator to ask for a paragraph to be included with the key messages.*

Action by HOCA

14/136 CQC MOCK INSPECTION – AMBULANCE SERVICE

The HOCA updated the Committee on the recent Mock CQC inspection of the Ambulance Service carried out by the North West Ambulance Service (NWAS). The HOCA advised that there had been a lot of positives from this and that the NWAS team had given constructive feedback. The HOCA advised that the Team were working on an Action Plan following the visit.

14/137 ACTIONS BEING TAKEN IN REVIEWING OR ACTION PLANNING AROUND CLINICAL AREAS OF CONCERN

The HOCA updated the Committee on the improvement works to be undertaken as part of the "Our Better Hospital" scheme. The HOCA advised that Appley Ward had been closed and the team knew that this was going to be a challenging time however it will be an improvement.

The HOCA updated the Committee on the Human Factors Training taking place on 19 May 2014 and advised that there are places available if anyone would like to attend.

PLANNED CLINICAL DIRECTORATE

14/138 QUALITY, RISK AND PATIENT SAFETY COMMITTEE

The CDP presented the minutes of the Planned Directorate's Quality, Risk and Patient Safety Committee meeting held on 31 March 2014 and highlighted the following:

- IG Compliance Rate for the directorate has increased significantly
- Endoscopy Capital Bid has been approved
- Freedom of Information Requests – The HOCP added that the Directorate was looking to share more detail at the Quality Meeting regarding trends.

The HOCP updated the Committee on the Ophthalmology Risks currently on the Corporate Risk Register. The HOCP added that there are actions in place and that this fits in with the transformation work. The HOCP advised that the vision is to create a Head and Neck Department and will further update the Committee in the summer. The CDP added that the directorate was also looking at how to improve patient flow to avoid clusters and this is being actively reviewed.

The PR advised that he is a member of the Volunteer Eye Clinic Liaison Team and agreed that the environment is not ideal and will only get busier as time goes on. The Chair asked that a further update be provided at the July 2014 meeting. The PR added that if it was not for the hard work of the staff then the department would be in a lot worse position. The EDNW suggested that the PR be involved in the review. The PR agreed to be part of the review to give a patient perspective.

14/139 MATERNITY FAILSAFE ACTION PLAN

The HOM updated the Committee on the Maternity Failsafe Action Plan from 2012 and advised that a lot of work has been done on this including recruitment, a new tracker system and infectious disease screening. The DC suggested that if this is a national system that benchmark figures are added. The HOM added that the Trust is now fully complaint and she will send a further update out in June 2014.

***Action Note**: The HOM to provide a further update in June 2014.*

Action by HOM

The HOCC advised that the Sexual Health Department had previously had issues with infectious disease screening and suggested to the HOM using a "dry blood spot" test.

COMMUNITY CLINICAL DIRECTORATE

14/140 QUALITY, RISK AND PATIENT SAFETY COMMITTEE

The HOCC advised the Committee that there had not been a Community Quality, Risk and Patient Safety Meeting in March as it had been cancelled due to the Norovirus outbreak. The HOCC added that there had been a Mental Health Meeting and presented the minutes of the meeting held on 18 March 2014. The HOCC highlighted the following

- Mental Health Service Users & Carer's Policy – needs to be revisited
- ECT Service maintains their excellent rating from ECTAS.
- Number of Falls on Shackleton – "Deep Dive" into falls being undertaken with the support from the local security specialist.

The Chair queried the information on page 2 of the summary report regarding adequate assurance being in place for pressure ulcers however there had been three SIRIs – one grade 3 pressure ulcer and two grade 4 pressure ulcers. The HOCC advised that this data had not yet been verified and advised that the assurance was around there being a move forward regarding incident monitoring.

14/141 ACTIONS BEING TAKEN IN REVIEWING OR ACTION PLANNING AROUND CLINICAL AREAS OF CONCERN

The HOCC updated the Committee on the Directorate's progress with HealthAssure and advised that there are still seven services at yellow. The HOCC added that there had been a delay due to IT issues but that these have now been addressed. The DC commented that there had been an impressive amount of work being done around this and queried all staff having access to the system. The QM advised that the Risk and Litigation Officer was working on this and that a generic login will be supplied to staff. The HOCC added that training will be cascaded to the teams.

PATIENT SAFETY

14/142 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – NEW

The QM updated the Committee on SIRIs reported in March 2014 and advised that the Norovirus Outbreak SIRI had been attributed to Acute and Community had 2 SIRIs (one of which is a potential never event). The QM advised that all are under investigation. The QM highlighted the downward trend of SIRIs and advised that there were currently 24 open SIRIs with 7 being overdue. The EDNW commented that this demonstrated twelve months of hard work and offered his personal thanks to everyone who had been involved to get to this position. The EDNW added that in April 2013 there had been 158 open SIRIs and that there was now a better understanding of the process. The EMD agreed that there had been good progress and this allowed more time to discuss and feedback findings making the organisation much safer.

14/143 SERIOUS INCIDENTS REQUIRING INVESTIGATION – FINAL SIGN OFF

The Committee reviewed the following SIRIs:

Community
2013/25553 – sign off was approved
2013/31951 – sign off was approved
2013/30240 – the Committee agreed that they were not clear on this SIRI from the Executive Summary provided and asked to see further information for the next meeting.

***Action Note**: Further information to be provided for the May 2014 meeting.*

Action by QM

Planned
2011/22911 – sign off was approved
2013/5226 – sign off was approved
2012/28929 – sign off was approved. The DC advised that she would like feedback on the protocols and audit regarding this SIRI regarding the action for the Tissue Viability Nurse to review compliance in Theatre.

***Action Note**: Feedback to be provided to a future meeting.*

Action by DDN

2013/18682 – sign off was approved

14/144 CLINICAL NEGLIGENCE CLAIMS RECEIVED

The HOCG presented the Quarter 4 report on Clinical Negligence Claims/Potential Claims received in January to March 2014. The HOCG advised that there had been 17 new claims with 6 of these relating to the previous (PCT) organisation. The HOCG advised that 10 of the new claims related to the Acute Directorate (7 were requests for health records and 3 were actual claims) and 7 related to the Planned Directorate (6 requests for health records and 1 was an actual claim).

The HOCG advised that the 17 claims received had been analysed to see if they had been previously reported as an incident or a complaint/concern. He advised that 25% (11) had been reported as an incident or a complaint/concern. The others had been further reviewed and it had been identified that three could have been expected to have been reported.

The HOCG advised that there had been one closed claim. The EDNW queried this figure as he said that he receives an email when a claim is closed and thought that there had been more than one. The HOCG advised that he would review this.

***Action Note**: The HOCG to review the number of closed claims.*

Action by HOCG

14/145 STAFF RAISING CONCERNS

The SHRM presented the quarterly update report on Raising Concerns at work. The SHRM advised that there had been one incident recorded as “whistle blowing” and two concerns raised via the confidential dedicated email. The Committee discussed the whistle blowing incident and the associated recruitment issues.

14/146 INFECTION CONTROL UPDATE

The CM presented the quarterly update report on Infection Control and highlighted the following

- 1 Clostridium difficile case
- 1 MRSA bacteraemia
- 1 MSSA bacteraemia
- 4 E.coli bacteraemia

The CM advised that investigations being undertaken and lack of urinary catheter care has been a theme. The CM advised that a Catheter Care Task Group is meeting today to review this and added that training needed to be improved.

The CM advised that the Norovirus outbreak had had a major impact on the Trust and issues arising from this will be investigated.

The CM advised that Carbapenemase producing Enterobacteriaceae (highly antibiotic resistant organisms) outbreaks are increasing in the UK including a recent cluster of hospital acquired

cases in Southampton General Hospital. The CM advised that there are procedures in place ie screening patients however there is a potential risk with issues with side room capacity.

The CM advised that the Team are working on developing an audit programme and are working with the Directorates on this. The PR noted that during the recent Norovirus outbreak there had been additional staff at the Main Entrance to the Hospital encouraging visitors and patients to use the hand gel and asked why this was not in place all the time. The EDNW advised that a year round rota is being developed, which will include corporate members of staff, and that this will be an outcome of the investigation that is taking place.

14/147 SAFE STAFFING

The MM presented the Safe Ward Staffing Levels report to the Committee and advised that the principles had been implemented following the recommendations of the Francis and other associated reports. The MM advised that there are some areas which are outside of the principles and these are the specialist areas ie CCU. The MM added that the Ward Managers and Matrons had been consulted and asked for the Committee to approve the principles.

The Committee approved the principles.

PATIENT EXPERIENCE

14/148 PATIENT STORY

This was covered under Item 14/125. The QM advised the Chair that she would try to contact the patient that had been interviewed by the BBC to see if she could attend the Trust Board Meeting.

14/149 PATIENT STORY ACTION PLAN

The QM presented the Patient Story report to the Committee and advised that this was an exception report with the full report being presented to the Committee at the May 2014 meeting.

14/150 NATIONAL CANCER PATIENT EXPERIENCE SURVEY - UPDATE

The LCN presented the updated National Cancer Patient Experience Survey 2012-13 Action Plan to the Committee. The LCN advised that there has been a lot of work carried out with the GPs and Ward Teams to move the actions forward. The LCN advised that there was an issue with putting MacMillan information leaflets into large print and that her only concern was patients not being made aware of clinical trials available. The LCN added that the Cancer Research Nurses link closely with Southampton and Portsmouth regarding this but that they were reliant on the Oncologist having the conversation with the patient. The Committee discussed this and the LCN agreed to raise this again at the Oncology Monthly Meeting.

***Action Note**: The LCN to raise concern regarding patients being made aware of clinical trials.*

Action by LCN

The DC advised that it would be helpful if the action plan included what the survey had picked up and asked if this could be included for next time. The EMD suggested that leaflets could be put into electronic format for the Trust to print in large print for patients. The LCN advised that she would suggest this to MacMillan.

***Action Note**: The LCN to contact MacMillan regarding receiving the information leaflets electronically.*

Action by LCN

CLINICAL AUDIT AND GOVERNANCE

REVIEW OF CLINICAL AUDIT

14/151 2013/14 ANNUAL CLINICAL AUDIT REPORT

The QM presented the Draft Annual Clinical Audit Report to the Committee and advised that this provided an overview of the Clinical Audit Activity in the Trust during 2013/14. The QM advised that not all National Audits have been completed and there was a lack of feedback to the Central Team. The QM added that there was still a lot of work to be done to robustly manage this.

The DC commented on Appendix 1 and suggested that this include a report on progress, which audits were national and mandatory and which speciality the audits related to. The DC added that a summary when the results were available would be helpful. JB added that it would be useful to have the audits RAG rated.

***Action Note**: The QM to revise Appendix 1*

Action by QM

The QM advised that the directorates hold the schedule and this will be presented to the Committee on a quarterly basis.

14/152 2014/15 ANNUAL CLINICAL AUDIT PROGRAMME

The QM presented the Draft 2014/15 Annual Clinical Audit Programme to the Committee. The QM added that there had been a delay in setting the local plans due to the postponed directorates Quality, Risk and Patient Safety meetings. The QM advised that by the end of the quarter a full plan will be in place.

SUB COMMITTEE GROUPS

14/153 JOINT SAFEGUARDING STEERING GROUP MINUTES OF APRIL 2014 MEETING

The Chair suggested that as the DDN was not in attendance that these minutes be reviewed at the Committee meeting to be held in May 2014.

CLINICAL PERFORMANCE AND RISK

14/154 TDA SELF CERTIFICATION

The FTPMO presented an update to the Committee and advised that all Board Statements and Licence Conditions were marked as compliant. The FTPMO advised that a new Accountability Framework had been published and that this will be included in the next report. The FTPMO advised that confirmation had been received from the Care Quality Commission that a Chief Inspector of Hospitals inspection of the Trust will be undertaken on 3 June 2014 and the Trust is on trajectory to receive a referral to Monitor in September 2014.

The Committee approved the TDA Self Certification.

14/155 ANY OTHER BUSINESS

The EDNW suggested that item 1.2 of the Terms of Reference (TOR) be reviewed by the Committee. The Committee discussed the changes and the EDNW advised that he would send out a revised copy for feedback by the end of the day.

***Action Note**: The EDNW to send out a revised copy of the TOR for feedback today*

Action by EDNW

The EDNW asked if the Quality Goals had been reviewed at the March 2014 Committee Meeting. TG confirmed that they had been signed off. The EDNW asked that they be highlighted to board. (copy of Quality Goals attached).

14/156 TOP ISSUES

- Item 14/125 – Sepsis. The Committee viewed a BBC interview regarding sepsis and also had an update from the team on the good progress being made, following an audit report in 2012.

- Item 14/129 – Annual Report. The Committee reviewed the draft Annual Report and agreed to feedback comments to the QM by Friday 25 April 2014.

- Item 14/152 - Clinical Audit Report. The Committee reviewed the draft Clinical Audit Report.

- Item 14/155 - Quality Goals – The EDNW asked that these be highlighted to Board following approval at the Committee meeting on 18 March 2014 (Quality Goals appended to the minutes).

14/157 DATE OF NEXT MEETING

Wednesday 21 May 2014
9 am to 12 Noon
Conference Room

Signed: _____ Chair

Date: _____

Isle of Wight NHS Trust
Nursing & Workforce Directorate

Quality Goals 2014/15

PURPOSE

This paper provides an outline of the quality goals that have been identified for 2014/15, to be included in the Trust's Quality Account.

BACKGROUND

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

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

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

PRIORITY GOALS FOR IMPROVING QUALITY 2014/145

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

A wide range of stakeholder consultation has been undertaken prior to the development of the Isle of Wight NHS Trust's 2014 Quality Account, including a questionnaire to support the identification of the quality goals for 2014/15.

An initial long list of suggested quality goals was pulled together using information from the CQC Key Lines of Enquiry (KLOEs); themes from complaints and concerns and information provided by; which provided the basis for consultation with key stakeholders.

A questionnaire, utilising Survey Monkey® was developed in order to obtain and analyse feedback, which asked stakeholders to rank in order of priority the suggested quality goals. A question was also included asking for individuals to propose other quality goals that they felt should be an organisational priority for 2014/15. This questionnaire was circulated to key stakeholders, including:-

Staff Member	Isle of Wight Council
Message in Members Magazine	Local Dental Committee
IOW Youth Trust	Local Medical Committee
Clinical Commissioning Group (CCG)	Local Pharmaceutical Committee
Echotech Ltd	Patients Council
Andrew Turner MP	Practice Based Commissioning (PBC) Consortium

GPs, GP Practice Managers and GP Practice Staff	Professional Executive Committee
Chamber of Commerce	Portsmouth Hospitals NHS Trust
Children's Trust	Riverside Centre
Cardiovascular Disease Network	Action on hearing Loss (formerly RNID) Isle of Wight
Friends of St. Mary's	Rural Community Council
Hampshire Partnership Trust	Salisbury NHS Trust
Hampshire Police	Scio Healthcare
Hampton Trust	Island Business Magazine Editor
IOW Dental Committee	Town and Parish Councils
Isle of Wight Anglican Churches c/o Portsmouth Diocese	

Following a review of the feedback received, the results of the consultation have revealed the quality goals, as we move forward to 2014/15. These are outlined below:-

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

2. **CLINICAL EFFECTIVENESS**
   Reduction in cancelled or re-arranged Outpatient Appointments

3. **PATIENTS EXPERIENCE**
   Improving Communication

PUBLICATION OF QUALITY GOALS

The quality goals for 2014/15 will be published in the Trust's Quality Account; which will form part of the Isle of Wight NHS Trust's Annual Report and posted on the Trust's website. The Trust also has a legal duty to send a copy of the final agreed Quality Account to the Secretary of State and make it publically available on the NHS Choices website.

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

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

The above quality goals were endorsed by the Quality & Clinical Performance Committee on Wednesday 19 March 2014 and the Trust Executive Committee on Monday 31 March 2014.

RECOMMENDATIONS

The Trust Board is asked to endorse the decision of the Quality & Clinical Performance Committee and Trust Executive Committee in relation to the quality goals for 2014/15 to be published in the Trust's 2014 Quality Account.

Theresa Gallard
Business Manager – Patient Safety; Experience & Clinical Effectiveness
27 March 2014

Isle of Wight NHS Trust

For Presentation to Trust Board on 30th April 2014

FINANCE, INVESTMENT & WORKFORCE COMMITTEE MEETING

Minutes of the Isle of Wight NHS Trust Finance, Investment & Workforce Committee (FIWC) meeting held on Wednesday 16th April 2014 in the Large Meeting Room.

PRESENT:	Charles Rogers	Non-Executive Director (Chair) (CR)
	Peter Taylor	Non-Executive Director (PT)
	Jane Tabor	Designate Non-Executive Director (JT)
	David King	Designate .Non-Executive Director (DK)
	Chris Palmer	Executive Director of Finance (EDOF)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Andrew Heyes	Interim Director of Planning, ICT & Integration (IDPII)
In Attendance:	Kevin Curnow	Deputy Director of Finance (DDOF)
	Lauren Jones	Interim Assistant Director of Finance (IADF)
	Mark Elmore	Deputy Director of Workforce (DDW)
	Heather Cooper	Development & Training-Training Manager (DTTM) *(Item 14/058)*
	Iain Hendey	Assistant Director-Performance Information & Decision Support (ADPIDs) *(Item 14/060-62)*
Minuted by:	Sarah Booker	PA to Executive Director of Finance (PA-EDOF)

To be Received at the Trust Board meeting on Wednesday 30th April 2014 Key Points from Minutes to be reported to the Trust Board	
14/058	**Workforce Strategy – The Committee approved the Strategy subject to minor amendments advised by the Committee.**
14/058	**Safer Staffing Update – The Committee agreed to give their approval and assurance to the Trust Board on the Safer Staffing paper.**
14/ 059	**Financial Performance – The draft final year end position for the Trust is a surplus of £1,613k. This is in excess of the original plan £1,598k.** **Total Capital spend for the year was £8,626k compared to a Capital Resource Limit of £8,630k.**

14/052 APOLOGIES

No apologies of absence were received as all members of the Committee were present.

14/053 CONFIRMATION OF QUORACY

The Chairman confirmed that the meeting was quorate, with all Committee members in attendance.

14/054 DECLARATIONS OF INTEREST

There were no declarations.

14/055 APPROVAL OF MINUTES

The minutes of the meeting held on the 19th March 2014 were agreed by the Committee and signed by the Chairman.

14/056 SCHEDULE OF ACTIONS

The Committee received the schedule of actions taken from the previous meeting on 19th March and noted the following:

14/008 LTFM Status Update: This item is on the agenda for today's meeting. Action closed.

14/010 Month 9 Workforce Performance Report: This action is still progressing as the item will be included on the May agenda.

14/042 Cost of Living Supplement: The DDW noted the consultation period has been extended and the paper will be taken back to the Partnership Forum next week. The DDW will update the Committee further during the May FIWC meeting. Action progressing.

14/057 LONG TERM STRATEGY AND PLANNING

Long Term Financial Model (LTFM) 20th June Submission:

The Non Executive members of the Committee requested sight of the LTFM which the DDOF confirmed will be presented to Executive Directors and Non Executive Directors during the 10th June Board Seminar.

Action: DDOF to present the LTFM to the Executive Directors and Non Executive Directors during the 10th June Board Seminar.

2 Year Operating Plan:

The 2 Year Operating Plan was submitted during the beginning of March and was in line with the LTFM submission.

14/058 WORKFORCE

Workforce Performance Report:

The DDW presented the Report highlighting the following:

Key Performance Indicators Summary:

- There are currently 73.61 full time equivalent (FTE) vacancies with the highest number still being in the registered nursing group.
- The total number of overpayments this month is £74,783 which is a £21,569 decrease on February.

- Underpayments in March £23,093.
- Appraisals total 65.2%.
- 30 Revalidations completed by the end of March.
- Mandatory training is at its highest recorded figure of 78%.

The workforce numbers are up on plan and although these figures include the Winter Pressures further work will be undertaken to reduce the totals.

The sickness in month absence rate is again over the target of 3% but has reduced from last month's 4.65% to 3.91% during March.

Twelve cost centres failed to finalise their rosters and therefore were not sent through to payroll, resulting in all bank shifts, enhancements and expenses not being paid until the following month. All budget holders were informed of this as they are responsible for verifying and signing off their cost centres each month.

PT noted his concern at the large overspend against budgets as no allowances have been made for this. There are a number of vacant consultant posts which will become locum posts which puts an immediate pressure on the budget.

CR questioned how these clinical vacancies can be filled.

The EDNW has met with Clinical Directors and discussed the vacant posts and the possibility of bringing in locums for one year to cover the posts with a view to becoming substantive staff members. The EDNW now has regular one-to-one meetings with the Clinical Directors to address issues.

The EDNW noted the sickness absence for March is likely to be significantly higher due to the Viral Gastro outbreak.

CR requested a breakdown of the Community sickness absence so it includes ambulance and mental health. The EDNW confirmed the sickness levels are shown in the quality reports.

JT was concerned at the high number of absences on Mondays. The EDNW explained Occupational Health did not previously receive this data but now they do they will be able to drill down into the area.

CR requested a quarterly focussed report on sickness absence.

Action: DDW to provide quarterly in-depth report on sickness absence.

DK queried the disability percentage of the Trust and how this information is recorded. The DDW will investigate this.

Action: The DDW to investigate the disability percentage of the Trust and how this information is recorded.

Key Performance Indicators Bank & Agency Spend & Overtime Costs:

There has been an increase in the bank, agency and overtime spend this month with agency spend more than double the amount compared to last month.

Employee Relations Cases:

There have been an additional 40 Employee Relations Cases during March, bringing the total number of cases to 159.

Workforce Strategy:

The DDW has made the recommended changes to the Strategy as requested during this month's Board Seminar. JT suggested the Strategy includes a summary table noting the amendments made to the document as the paper has been sent to a number of Committees.

Action: DDW and other Committee members to include a summary table to this and future documents being brought to the Committee clearly showing where amendments to papers have been made.

The Committee recommended removing point 7:1 and ensuring point 6:3 is both current and future focussed. The Committee agreed to approve the Strategy subject to those amendments made.

CR requested the Committee have sight of the plan for each Key Performance Indicator (KPI) detailed on the Strategy and a regular quarterly update of progress in meeting the KPIs.

Action: The PA-EDoF to include this on the June FIWC agenda. The DDW to agree detailed reporting against KPI's identified as part of the Strategy.

Occupational Health – Staff Survey Action Plan:

CR welcomed the DTTM to the meeting who provided the Committee with an update from the Staff Survey Action Plan. The DTTM explained the report in February from the Staff Survey was split into three parts; work related stress, Communication and quality of appraisals. The Health and Wellbeing Group will merge with the Culture Group and they have undertaken a stress audit. The draft action plan for this has been set up. The governance behind this group is currently being finalised and some issues have already been addressed to change from a reactive to a proactive approach.

Action: The Committee requested sight of the action plan during next month's meeting (PA-EDoF to add to the May FIWC agenda.) The plan will go to the Trust Executive Committee (TEC) for operational performance and to FIWC for assurance.

CR noted this process shows the good work being undertaken at the Health and Wellbeing Group and the DDW thanked Non-Executive Director, Nina Moorman for highlighting this group.

Culture/Progress Against Cultural Indicators:

The DTTM updated the Committee on the work being undertaken by the Culture Group:

- The Quality Champions have met three times so far focussing on the Trust's quality goals and governance integrated action plan.
- The organisational temperature survey is being replaced by the Staff friends and family survey.
- New, more constructive paperwork in place for appraisals.

The Organisational Development (OD) Strategy will be reviewed by the FIWC in June which will include the Key Performance Indicators.

Action: PA-EDoF to include the OD Strategy on the June FIWC agenda.

JT queried the number of conduct cases during March and whether this is an indicator of culture within the Trust? The EDNW explained there is now a greater level of governance to ensure patients and not staff are put first and therefore any negative behaviour is not being tolerated. The Non-Executive Directors requested to see evidence of conduct issues and how they have been resolved.

Action: The DDW to provide evidence of conduct issues and how they have been resolved.

Safer Staffing Status Update:

The EDNW presented the Safer Staffing paper and explained to the Committee members that the principles of this were agreed at the last Trust Board meeting. He advised the committee this was an iterative process. The paper shows where we are currently and methodology used to reach that point and how to then take this further.

The ward managers have signed an agreement for these numbers. The EDNW met with Unions to discuss appropriate grading for staff members.

The costings are still being worked through and the IADF has undertaken detailed work around these to enable the prioritisation of investment and the funding for the year. These will be presented to the FIWC and Trust Board in May.

Action: PA-EDoF to add the Safer Staffing costings item to the May agenda.

The EDoF recommended the Committee is updated every 6 months. Once the figures have been locked down any future changes will have to go back through the tool. The EDNW advised once ward budgets have been locked down, if further CIPs were to be applied this would require a reduction in beds and reallocation of staff to vacant posts.

The DDW noted the staff contracts now state employee of IW NHS Trust as

opposed to specific wards.

DK questioned whether seasonality plays any part in these staffing figures? The EDNW concluded a centralised team would allow for this to be managed better and that the loyalty of staff needs to be balanced with the ward requirements. Staff will be contracted to work flexibly to ensure adequate cover during the winter months and summer months. The ward managers will be held to account for their ward pay budgets.

The Committee agreed to give their approval and assurance to the Trust Board on the Safer Staffing paper.

14/059 FINANCIAL PERFORMANCE

Financial Performance Report

Continuity of Service Risk Rating:

Overall Rating of 4 after normal adjustments.

The IADF presented the Finance Report and highlighted the following:

Summary:

The draft final year end position for the Trust is a surplus of £1,613k. This is in excess of the original plan, £1,598k and the forecast out-turn reported last month £1,603k.

Cost Improvement Programme (CIP):

Month 12 - CIPs achieved £8,733k against a plan of £8,644k. The RAG rating remains Amber due to the level of non recurrent plans.

Working Capital & Treasury:

Cash 'in-hand' and 'at-bank' at Month 12 was £13,358k which was due to a large number of capital schemes not being invoiced and cash physically paid until April. Additionally cash had been received prior to the end of March from the CCG in relation to the settlement of several outstanding issues.

Capital:

Total capital spend for the year was £8,626k compared to a Capital Resource Limit of £8,630k.

Overall Position:

Month 12 position shows a year to date surplus of £1,613k, which is £15k over plan for the year.

Income:

The Committee discussed the income position for Month 12 which is over plan by £12,504k.The areas which are also over plan were highlighted by

the IADF.

DK questioned whether the Commissioners query any treatments provided at the Trust? The EDOF replied as a Trust we are transparent so they are assured there is no 'gaming'.

Pay:

The YTD position on pay budgets is over plan by £3,571k. The IADF briefed the Committee on which areas were over plan and the reasons for this.

Non-Pay:

The non pay budgets are overspent by £8,964k. All clinical directorates and Corporate area overspends are predominantly due to non-achievement of CIPs as per plan; within the clinical directorates are overspends on non PbR drugs offset by income and costs relating to the prison extension.

Better Payment Practice Code (BPPC):

The total number of invoices paid in the year is slightly below target at 94.8% in terms of the number processed. In terms of the value the 95% target has been exceed by 1.16%.

Capital Plan & Reports:

The IADF reported that we are on plan in year and the financial statements will be submitted on the 23rd April. We will be within the Capital Resource Limit (CRL). The paper detailing what has been committed next year will be going to the TEC meeting and to the Trust Board meeting in April. JT requested an extra column is added to include the planned month of the spend.

Action: IADF to ensure an extra column is added to include the planned month of the spend.

CIP Allocations by Directorates:

The DDOF presented this paper which sets out the allocation of the Cost Improvement Target for 2014/15 financial year.

The initial starting point was a 5% target, this is then adjusted to reflect the unachievement of CIPs for 2013/14 by directorate.

The Committee discussed the challenging CIP requirements for 2014/15 requesting greater levels of assurance over their delivery.

The CIP schemes are to be developed and the DDOF will ensure higher level schemes are brought to the attention of this Committee along with any schemes which are off track.

The IDPII will bring an overview of the QUINCE system to the FIWC and the

Trust Board (dates to be determined).

The EDNW suggested the Committee is provided with a quarterly summary showing savings and the impact on services.

The Committee to be provided with a quarterly summary showing the impact of savings on services via Quality Impact Assessment review. Action: EDNW

A monthly report of CIP target and delivery will be provided from the IADF and IDPII to show variances against plan. Action: IADF & IDPII

90 Day Debtors List:

The DDOF presented the 90 day debtors list and highlighted the main points.

The outstanding debts owed by NHS bodies are less of a concern as the balances are agreed as part of the year end Agreement of Balances.

More work is required to recover the debts owed by the private healthcare companies.

Cash Flow & Investments Update:

We continue to invest short term with the National Loans Fund (NLF) which is administered by the Treasury. As at the 26th March 2014 the total expected interest accrued so far is £8086.44. Further investments will be made at other times of the month depending on available cash surplus.

Losses & Compensation:

This paper has returned to the Committee this month as it totals the amount of losses and compensation awarded for the year. The Pharmacy write off is due to slow moving and obsolete stock. The Committee had no further questions on this paper.

Transformation Management Update Report:

The IDPII will bring this report to the Committee in May and will include the structure and governance around the Transformation Management Office.

14/060 CONTRACT PERFORMANCE

Contract Status Report:

The DDOF briefed the Committee on the report as the Assistant Director of Contracting was unable to attend the meeting.

- 2014/15 CCG Heads of Agreement (HoA) and the 2014/15 contract

have been signed in line with the Trust Development Authority guidelines. The HoA and the contract are underpinned by the Trust and the CCG Financial Framework Agreement (FFA) which has been also signed.

- NHS England (NHSE) contract has been finalised and is ready to sign in line with the Trust Development Authority guidelines. However nationally Local Area Teams have been advised to wait for other providers to finalise so that no provider is disadvantaged. The Secondary Care Dental and Offender Health baselines have been agreed and finalised as part of this contract.

JT queried who would be paying for the locum dermatologist at the Beacon? The EDNW confirmed the Commissioners will pay the full costs.

Contracting Timetable:

The DDOF confirmed there are two service specifications to be signed off which have no major risks involved and that the Contracts team are working closely with directorates.

The EDoF noted the timetable will begin again in October and the pre-planning will be more robust this year. CR asked that the Committee are advised of progress against timetable from October through to end of year.

Action: PA-EDoF to include this item on each agenda from October 2014.

Contracting Performance Notice – Stroke Markers:

The DDOF confirmed this has now been removed.

Operational Performance including SLA Activity:

The ADPIDs attended to report on a tabled presentation on the SLA Activity and performance. The notable variances were discussed in relation to elective and non-elective spells. The ADPIDs noted the CCG QIPP equates to £637k which will offset some of the performance below plan. The report also included details of performance against contract targets and associated contract penalties. The ADPIDs will include the performance against CQUINS to this section of the report in future.

JT queried whether patients are going elsewhere leading to the below plan performance? The ADPIDs noted there was an unusually high number of non-electives last year so the plan was set with those numbers taken into account and on reflection was probably a little high. Year on year comparisons will be included in future reports as well as comparisons against plan.

14/061 **AUDIT & GOVERNANCE**

Annual Accounts Timetable & Progress:

The DDOF confirmed the Trust is slightly ahead of the timetable and there are no issues with one week still to go.

External Audit Plan for 2013/14

The DDOF made the Committee aware that the external Auditors are due to commence their field work on the 24th April and will be on site during the following week.

Limited Assurance Updates:

- **Payroll Action Plan & Workforce Transactions:**

The DDW confirmed the outstanding changes have been made according to the plan and that new filing systems have been devised. The EDNW is undertaking spot checks in Human Resources to look at various files to provide assurance that the systems are more robust.

Internal Audit Plan 2014/15 Update:

The DDOF and EDOF met with the internal auditors who agreed to provide the Trust with an update with changes to the work plan which will need to be approved by the Audit Committee.

VAT Recovery:

The DDOF briefed the Committee on this paper regarding VAT recovery and the impact it will have on the capital spend next year. The finance team are working with the VAT liaison teams regarding the impact this will have.

FIWC Annual Report:

CR requested feedback from the Committee regarding the draft annual report:

JT and the EDNW suggested more emphasis on Workforce. The EDOF said the terms of reference will be re-written to incorporate all aspects to ensure it is current and reported it will also include Information. CR noted the terms of reference will change on a regular basis as the Committee is always trying to improve.

PT recommended the achievements are expanded to show efficacy.

JT recommended staff satisfaction and well being and workforce retention and recruitment is included in the year ahead.

The EDOF recommended Information and Data Quality is included.

Action: CR and PA-EDoF to amend the annual report.

14/062 INFORMATION

ICO Registration Confirmation:

The EDOF briefed the Committee on the paper to provide assurance that the Trust is licensed to hold patient and staff information. JT queried whether this included appraisal information, personal information and member information and whether this has the same data management requirements? The EDOF will check with the Company Secretary as he is also the SIRO for the Trust.

Action: The EDOF to check the ICO registration provides the correct level of assurance regarding information.

Data Quality:

The Data Quality Framework will be included on the May agenda.

RTT Pathways – Letter from David Flory:

The EDOF briefed the Committee on this letter and explained that it identified inconsistencies on recorded information and requested all Trusts ensure that data quality is reviewed through their internal audits.

Safer Staffing Reporting:

The DDW explained this is a summary of reporting required by the CQC and a detailed report will be discussed during the June FIWC meeting and a summary will be discussed at the Trust Board meeting in June. JT requested all amendments to documents are annotated to assist Committee members to understand where changes have been made.

The EDNW noted this will be rolled out to Mental Health and Ambulance in 2015. JT asked whether there is a shortage of Paramedics. The EDOF explained that there is a succession plan and many are recruited from Ambulance.

The IADF is currently working on the CIPs with the Deputy Director of Nursing.

Terms of Reference:

Revised terms of reference will be discussed during the May FIWC meeting.

14/063 INVESTMENT/ DISINVESTMENTS

Procurement Status Report:

This paper was provided by the EDOF for information to the committee as it details issues which are picked up during regular procurement meetings. Key members of the Procurement team attend the monthly Trust Capital Investment Group meetings.

The EDOF reported this is shared with the directorates and they are made aware of the risks, slippage, actions, cash release in savings delivered and the cost avoidance savings.

JT questioned why the report states some of the capital projects were awarded too late. The EDOF explained the circumstances underpinning this comment.

Personal Dental Services Re-tender :

The IDPII briefed the Committee on personal dental services re-tender. The IDPII will attend a meeting next week to see how to take this tender further and the IDPII will provide the Committee with a presentation during next month's meeting.

The school nurse service will also be discussed at next month's FIWC meeting.

Action: IDPII to provide the Committee with a presentation during next month's meeting. PA-EDoF to include on the May agenda.

14/064 TRADING ACCOUNTS

Mottistone Update:

The Month 12 Trading Account was received. This shows the trading account purely as a private account, i.e. after adjustments for beds used by NHS patients.

PT was very concerned that there were very few private patients using Mottistone and it was being used frequently by NHS patients. The EDNW clarified that private patients are very rarely cancelled.

The EDNW noted there is a new business manager in post. The IADF and DDOF noted next year Mottistone will have an increased private patient target to work towards.

Beacon Update:

The Month 12 Trading Account was received.

NHS Creative Performance and Budget Update:

The Month 12 Trading Account was received. PT questioned why the Trust continues to use NHS Creative as they have shown a very disappointing out-turn for the year and have only contributed a loss this year. The IDPII will be undertaking an operational project which will be reported to the Committee next month.

Action: The IDPII will bring the outline overview and case for change to the Committee next month.

The IDPII and IADF will be visiting NHS Creative on Tuesday next week to go through their accounts.

14/065 SELF CERTIFICATION REVIEW

The Committee received the Self Certification reports. JT questioned which Committees would provide the accountability for the FT milestones. This would be the role of the FT Programme Board.

The Committee approved the self-certification return and agreed to recommend this to the Trust Board.

14/066 COMMITTEES PROVIDING ASSURANCE

Minutes from the Capital Investment Group

These minutes are provided to the Committee for information.

Health & Wellbeing Group:

The DDW will review the Strategy paper with the Joint Head of Occupational Health and will bring back to this Committee.

JT recommended this paper should include a statement of intent rather than a vision.

The DDW will provide a further update during the May FIWC meeting.

14/067 ANY OTHER BUSINESS

Monitoring of External Agencies

The DDW updated the Committee on items 47 and 57 and confirmed these recommendations have been actioned.

CQC Key Lines of Enquiry:

The Committee requested further information regarding these enquiries. The PA-EDoF to invite the Company Secretary to the May FIWC meeting to

give further clarification.

Action: PA-EDoF to invite the Company Secretary to the May FIWC meeting to give further clarification.

14/068 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Finance, Investment & Workforce committee to be held is on Wednesday 21st May 2014 from 2.30pm – 5.30pm in the Large Meeting Room.

The meeting closed at 3.45pm.

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 APRIL 2014

Title	Trust Board Walkabouts – Patient Safety Assurance Visits			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing and Workforce			
Author(s)	Vanessa Flower, Quality Manager			
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	14/04/14	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		ICT & Integration 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 where appropriate are engaged during the walkabout undertaken.

Executive Summary:

The attached report shows the actions taken following the Board Assurance Walkround Visits that commenced in February 2013.

At the time of reporting, 183 visits have taken place 49 Clinical, 12 non-clinical, from these 179 actions have been identified,

166 are complete,

6 are still within timescale,

7 remain overdue against the original date for completion set, with 4 showing as overdue against both board and directorate revised timescale.

The Directorates now have an opportunity to input a revised date, following review of progress against actions which is captured in the spreadsheet and summary report presented this month.

All actions are monitored by the directorate and reported twice monthly and will be monitored until completion.

At the time of writing there are 10 feedback sheets outstanding following Board Walkabout Visits. Of these 4 are outstanding from 2013 walkrounds.

For following sections – please indicate as appropriate:

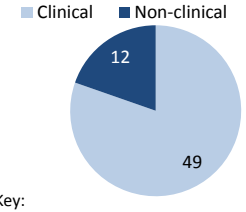
Trust Goal *(see key)*	Quality Goal		
Critical Success Factors *(see key)*	CSF1, CSF2 and CSF10		
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	10.75		
Assurance Level ***(shown on BAF)***	£ Red	£ Amber	P Green
Legal implications, regulatory and consultation requirements			

Date: 22 April 2014 **Completed by: Lisa House**

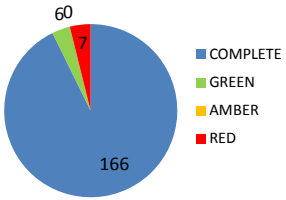
Board Walk Rounds Action Plan Status Report

Trust Overview

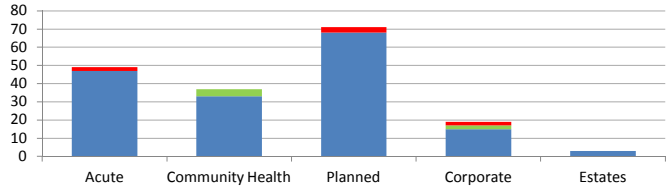
Areas visited



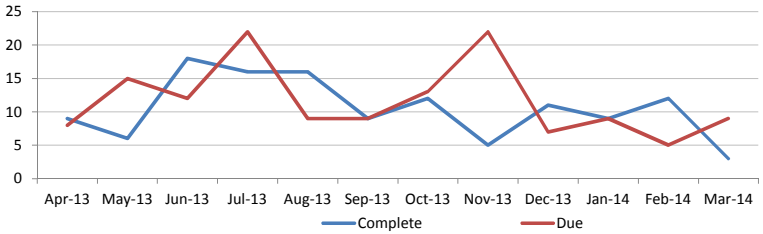
Status of actions



Directorate Profiles



12 month profile from: Apr-13 to Mar-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/002/2013/003	27-Feb-13	ENT	Ensure cleaning of scopes meets standards and consider decontamination of equipment instead	31-Mar-13	31-Jul-14	RED	GREEN	25 Feb: Estates able to contribute to progressing mid April onwards; meeting being arranged to progress works requirements & supporting bid 4 Mar: remains as above 17 Mar: remains the same 10 April - as above 22 April as above	Planned	Associate Director / General Manager
2	AT/024/2013/013	26-Jul-13	Main Outpatients / Fracture Clinic	There are concerns about potential breaches of confidentiality which could occur due to the close proximity of the patients waiting area to the reception desk. There's lots of open space between the waiting area and the actual consulting rooms, but little space between reception and the patients sitting area. Could an alternative placement for the patients seating be explored.	01-Oct-13	01-May-14	RED	GREEN	Update 14.02.14 - There is no further update as Associate Director Facilities' resources are fully taken by the capital programme, the earliest we can look at this is after April. Update 04.03.14 - remains as above 17 March - as above 10 April - as above 22 April as above	Planned	Associate Director Facilities
3	AT/037/2013/006	13-Sep-13	Pathology	Strong support for pathology paperless reporting. Develop plan for the implementation	15-Nov-13	30-Jun-14	RED	GREEN	update 25.03.14 - this remains an agenda item for the May meeting, Pathology department remain ready to go paperless as soon as approval from all relevant clinical areas is gained, and are happy to do so. 10 April - as above 22 April as above, remains on agenda for May meeting	Acute	GMS IT Business Manager/IM&T Projects Manager/Deputy Director for IM&T
4	AT/040/2013/001	30-Oct-13	Pharmacy	IT and Pharmacy to work together to repair a network issues related to a pharmacy payment machine in the Beacon Centre	29-Nov-13	31-Mar-14	RED	RED	update 03.03.14 - The lines for phone and network have been ordered by IT, awaiting installation. Update 19.03.14 ~ the line to the machine was approved by IT for installation on 17.03.14, and the ADSL has been ordered. 22 April update requested	Acute	Chief Pharmacist

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
5	AT/045/2013/001	30-Oct-13	OPARU	Questioning if staffing levels are correct	31-Jan-14	31-Mar-14	RED	RED	10 April - Staffing levels have been reduced in line with establishment, however this has put extra pressure on the team. A meeting with HR will take place the week of the 21st of April to discuss plans going forward 22 April as above	Planned	OPARU Departmental Manager
6	AT/044/2013/002	30-Oct-13	Development and Training	Review space utilisation and develop plan for 2014/15	31-Mar-14	31-Mar-14	RED	RED		Corporate	Assistant Director for Organisational Development
7	AT/044/2013/001	30-Oct-13	Development and Training	Review potential income for library in 2014/15 and develop plan to balance budget.	31-Mar-14	31-Mar-14	RED	RED		Corporate	Medical Education Manager

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 APRIL 2014

Title	Trust Board Walkabouts – Patient Safety Assurance Visits Annual Report			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing and Workforce			
Author(s)	Vanessa Flower, Quality Manager			
Purpose	To provide an annual report for the Board Walkabout Process for 2013 / 2014			
Action required by the Board:	**Receive**		**Approve**	**P**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		ICT & Integration 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 where appropriate are engaged during the walkabout undertaken.

Executive Summary:

The attached annual report provides an overview of the process and outcomes for the year 2013 / 2014 in relation to Trust Board Walkarounds.

The Board is asked to note the amended figure for areas visited in Appendix A of the 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: 21 April 2014 **Completed by: Vanessa Flower**

Isle of Wight NHS Trust

Patient Safety, Experience and Clinical Effectiveness Directorate

Quality Team

Annual Report to Trust Board – Trust Board Assurance Walkrounds

20 April 2014

SITUATION:

Board walkrounds (Non-Executive and Executive Board Members) offer the opportunity for the Trust Board to link directly with services delivered in all areas of the Organisation. This offers patients, relatives and staff the opportunity to discuss issues directly with the Trust Board. It also provides the opportunity for the Trust Board to seek assurance from all services. Trust Board walkrounds are seen as pivotal in organisations who seek assurance at the point of service delivery. They also demonstrate the Trust Boards leadership commitment of setting a culture to be fostered across the entire organisation.

BACKGROUND:

Trust Board Assurance Walk rounds visits are unannounced visits to both clinical and non-clinical areas of the organisation. Each week a member of the Executive and Non-Executive (where available) membership undertakes a Board Assurance walkround to support our quality, efficiency, and effectiveness improvement programme. This is in addition to the Trust Board visits which occur as part of the Trust Board meeting agenda. These visits also take the same approach. The visits provide an opportunity for the Trust Board to meet with patients and their families as well as staff, to talk to them about their experiences and the care we provide and to discuss any concerns they may have.

ASSESSMENT

During 2013/14 53 areas of the Organisation have received a visit; some areas have had a visit on more than one occasion. Of the 53 areas recorded on the central database, 12 visited were to non-clinical areas, the remaining 41 areas were clinical. Clinical areas are all those were patients visit, this includes Pharmacy and Pathology. Although more were scheduled only three visits were undertaken out of hours.

During the year a total of 151 issues were identified where action was required to address the issue, this was recorded centrally by the Quality Team, and progress monitored via the Trust Executive Committee and Trust Board until completed.

At the time of reporting 11 actions remain outstanding and overdue and will continue to be monitored through to completion. During the year, it has been established that some of the initial timescales set for completion of actions has been unrealistic, and it has been agreed that in future the areas will negotiate the timescales set with the visiting team, to ensure that all

actions are realistic and achievable, this should avoid unnecessary delays in the completion of actions going forward.

During the year 9 visits scheduled were cancelled due to conflicting priorities of the Executive Team. At the time of report 16 feedback sheets still remain outstanding, although it is believed that these visits did take place as scheduled.

Issues identified at the time of the visits have resulted in the following action being taken:

- improvements to environment, including minor estates issues being resolved, and areas being de-cluttered and alternative storage solutions found
- Improved information to patients / visitors and staff
- Improved access to equipment i.e Bed Sensors
- Better access to IT systems and review of software processes
- Review and improvements to systems and processes to aid the patient pathway
- Review of signage
- Raised awareness of confidentiality and security issues
- Review of staffing levels
- Replacement of lockers for staff in Theatres
- Space utilisation review for some areas
- Review of Uniforms including for Junior Doctors.

RECOMMENDATIONS:

It is recommended that the Executive Team ensure that feedback sheets are submitted promptly to the Quality Team following their visits. Not only does this allow a central record to be accurately maintained, and allow recommendations to be captured and tracked, it also ensures that areas visited receive feedback promptly on the findings of the Team, thus allowing the Quality Team to provide assurance to Trust Board and TEC on the progress of actions taken.

Consideration should be given to realigning the paperwork for the assessment to provide a stronger link to the Care Quality Commissions, Key Lines of Enquiry (KLOEs) so that the areas are assessed against Well-Led, Caring, Safe, Effective and Responsive.

Visits are scheduled to continue in 2014 / 2015, and it is essential that the teams endeavour to ensure that these are all undertaken as planned. At present there are no visits scheduled out of hours, i.e. between 5pm – 8am, or at weekends, and consideration should be given to planning some visits outside of 'normal office hours', this will enable staff working shifts to meet with members of the Board, and also enable the Board members to meet relatives and patients, during evening visiting hours in ward settings. More visits should also be undertaken to non-clinical areas.

It has been noted whilst compiling this report that an error has occurred whilst inputting information into the database used to record walkround visits. The Quality Team apologise for this error, and advise that this has now been rectified; the Board are asked to note this error. The regular Board Walk Rounds Action Plan Status Reports produced for Board, include an overview of the areas visited, and for 2013/14 reporting there has been an anomaly in the

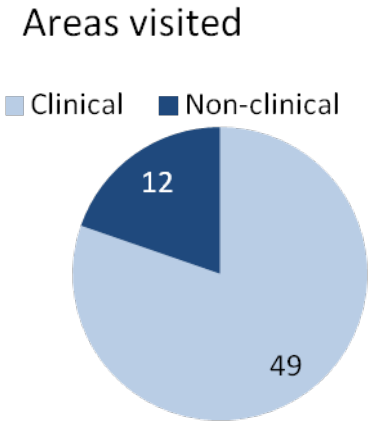
breakdown of clinical and non-clinical areas visited. The correct graph as at the time of reporting is attached in Appendix A.

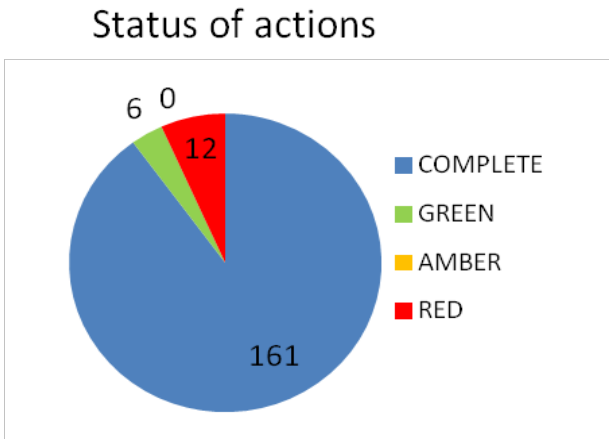
Vanessa Flower
Quality Manager
21 April 2014

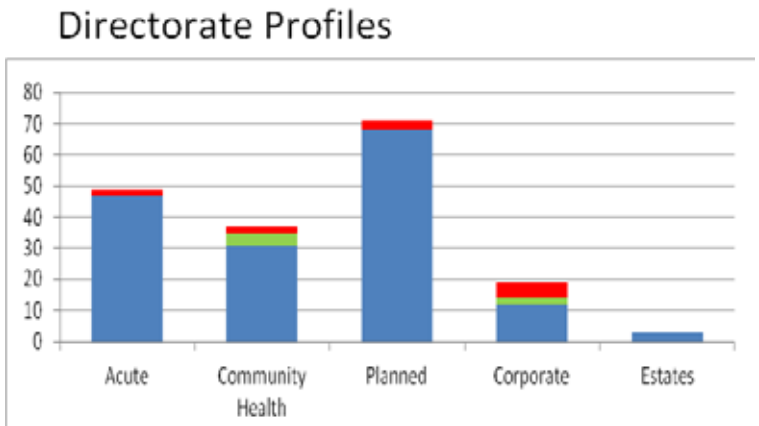
Corrected Board Walkrounds Action Plan

Appendix A

Status Report: (Corrected Areas visited figure)







Key:

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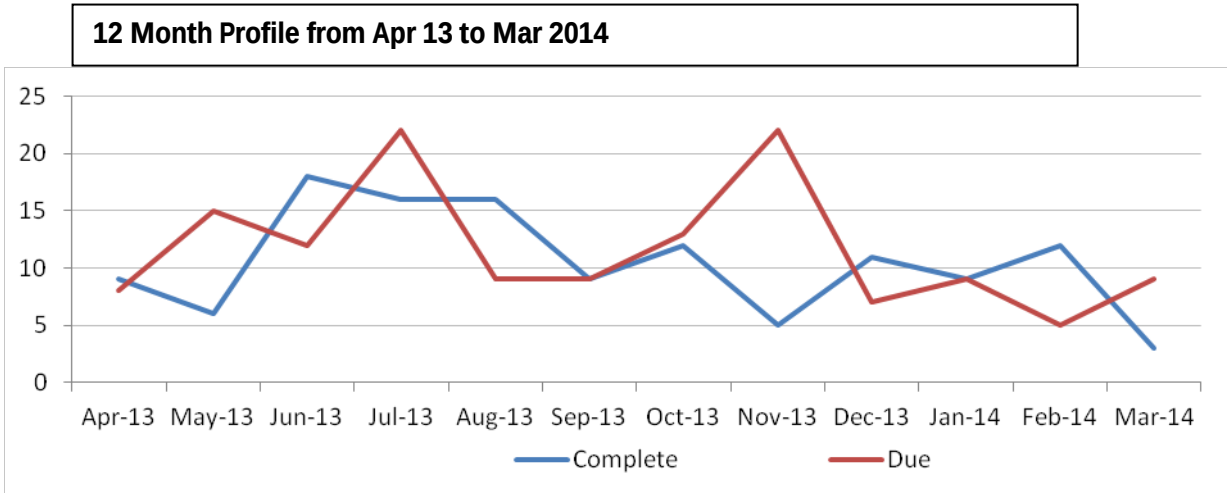

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 APRIL 2013

Title	Patient Stories Action Tracker			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing and Workforce			
Author(s)	Vanessa Flower, Quality Manager			
Purpose	To provide assurance of progress of actions identified following the Patient Story			
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		ICT & Integration 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:

Attached is the status report of the actions behind schedule, following the viewing of patient experience videos.

This remains work in progress as we ensure we implement a robust process for capturing lessons learnt and action taken in relation to patient feedback.

To date 32 actions have been captured and of these 5 are behind timescales. Directorates are required to update these on a regular basis to ensure that we are reflecting true progress with the individual actions.

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 22 April 2014 **Completed by: Vanessa Flower**

Log No.	Date of Video	Area	Key Issue (s) raised	Date Reviewed at QPSC	Date Reviewed at Trust Board	Theme	Action to be taken following Board /QCPC review	Nominated Lead for Action	Target Date	Date action complete	Current Status	Comments / Status	Lessons learned/action taken
28	26-Mar-13	Appley Ward	Formal Complaint (6666) Lack of initial medication, hydration & continued lack of nutrition. Alleged lack of basic care and poor communication with relatives	22-Jan-14	29-Jan-14	Clinical Care	Review the handover process between wards	Quality Manager - Acute Directorate	31-Mar-14		Behind	Update 16.4.14 Letter has been drafted and sent f or Signing.	
29	27-Mar-13	Appley Ward	Formal Complaint (6666) Lack of initial medication, hydration & continued lack of nutrition. Alleged lack of basic care and poor communication with relatives	22-Jan-14	29-Jan-14	Communication	Clearer communication process between clinical staff and relatives	Quality Manager - Acute Directorate	31-Mar-14		Behind	Update 16.4.14 Letter has been drafted and sent f or Signing.	
14	17-Jul-13	Chemotherapy	The Oncology Nurse only working one long day and 2 half days a week. When she was off on leave and then sick for a week there was a delay in getting back to the patient. There may have been an answering machine message added now but this may not be sufficient.		31-Jul-13	Workforce	Stop lone working of CNS posts.	Lead Cancer Nurse	30-Jan-14		Behind	15/01/14 - no change to cancer CNS structure at present. Business case for second urology nurse with AD. To also be discussed with commissioner Update 22.4.14 Business Case now to go to Directorate Board next week and will be submitted to TEC in due course.	
13	17-Jul-13	Chemotherapy	The patient complained there were not private rooms available in the Obs and Gynae Department when discussing their case. They complained the consulting rooms were poor.		31-Jul-13	Estates	Refurbishment for maternity clinic was at number 3 in capital plan for this year. This has been changed now due to other priority issues and is now not planned for this year.	Head of Midwifery	27-Jan-14		Behind	15.1.14 Update via Head of Midwifery. Unfortunately bid to Capital Plan 2013/14 was rejected. HoM has submitted an application to the DoH under the Privacy and Dignity Agenda for clinic refurbishment, which was submitted on 10.1.14 and is awaiting the outcome which should be available within 2 weeks. 9.4.14 Update HoM has advised that the bid to DoH was not successful, bid to be resubmitted to Capital Plan 2014/15. 22.4.14 Update No further movement on this at present still planning for resubmission to capital bid.	

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 April 2014

Title	Patient Stories Annual Report			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing and Workforce			
Author(s)	Vanessa Flower, Quality Manager			
Purpose	To provide assurance of progress of actions identified following the Patient Story			
Action required by the Board:	**Receive**		**Approve**	**P**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		ICT & Integration 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:

The Board is asked to note the annual report in relation to the Patient Story Programme. This is the first annual report produced since the implementation of patient story filming in March 2013. Since this programme was implemented there have been 23 Stories filmed resulting in 26 actions of which 7 remain in progress, with 5 of these behind schedule.

This programme continues to develop and be refined in order to ensure that valuable patient feedback is provided directly to the Board, and subsequent actions improve the patient and staff experience.

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 20 April 2014 **Completed by: Vanessa Flower**

Isle of Wight NHS Trust

Patient Safety, Experience and Clinical Effectiveness Directorate

Quality Team

Annual Report to Trust Board – Patient Stories

20 April 2014

SITUATION:

In order to ensure that we are fully utilising patient feedback to improve services and providing the opportunity for patients to provide feedback directly to the Trust Board, during 2013 / 2014 a monthly Patient Story to Board has been received.

These stories are filmed by members of the Quality Team in conjunction with Sunshine Radio, and are taken from across all of the Trust Services, and feature both positive and negative feedback from patients on the services provided.

BACKGROUND:

Initially when the programme of Patient Stories was implemented, a number of patients were filmed each month, the process has been refined during the year and only 1 film is recorded which is shown at Quality and Clinical Performance before being summarised for showing at Trust Board.

During the year the Trusts Quality Manager has maintained an action tracker relating to the actions to be taken to address issues identified from this very valuable patient feedback. This action tracker is monitored by both the Quality and Clinical Performance Committee and Trust Board monthly in relation to the actions that are overdue.

ASSESSMENT

Since March 2013 when the Patient Story Process commenced, 23 stories have been filmed, and have been shown at Board since May 2013; actions that are highlighted at the Board are tracked to ensure lessons are learnt. Films are shared via the Trusts Intranet page and staff are reminded to review the films with their Teams to ensure lessons are learnt and embedded.

The Tracker has so far captured 26 identified actions, not all of these from Trust Board, 4 of the stories filmed had no action identified as all feedback received was positive. Of the 26 actions recorded 7 remain in progress at the time of reporting;, 5 of these action are behind original timescales and will continued to be monitored via the Quality and Clinical Performance Committee.

Appendix 1 shows the breakdown of areas covered as part of the patient story programme, as well as the theme of the issue raised. This covers the period March 2013 to 1 April 2014.

During the year we have trained a number of volunteers to be part of the interviewing team, to ensure that the patients view the process as unbiased, although a member of the Quality Team is always in the vicinity for assistance if required.

It has been unfortunate that despite putting on training for volunteers including Healthwatch Isle of Wight we still have only a small number of people trained to do this.

RECOMMENDATIONS:

During the coming year, the team will continue to explore how we capture the breadth of services as part of the patient story programme, as well encouraging patients to personally attend board to relay their experience.

The team will also explore how to capture real time feedback on camera, from concerns / complaints raised; as well as identifying patients / carers to participate as part of the feedback mechanisms in place in the Trust.

The Team are also looking at how to ensure that the films are succinct to provide quality feedback; and are exploring the mechanisms used to track and monitor actions to an early conclusion.

There are plans in place to train more volunteers including HealthWatch Isle of Wight in participating in the interviewing, as well as asking HealthWatch to help us to identify patients or carers to be filmed.

It should also be considered how ‘staff stories’ can be used when they have been dealing with a ’patient incident’, as this has been seen as good practice, nationally Patient Voices has worked with Trusts in utilising this approach to support the improvement of the Patient and Staff Experience with very positive effects.

The Board is asked to note the progress of this programme of patient feedback, which will continue to grow and develop as we move forward with the patient experience agenda and embedding the Patient Experience Strategy.

Vanessa Flower
Quality Manager
20 April 2014

Appendix 1

Breakdown of Patient Story Programme

Areas visited/covered during filming:

- Colwell Ward
- Whippingham Ward
- Appley Ward
- Emergency Department
- Alverstone Ward
- Mottistone Suite
- Endoscopy Unit
- Day Surgery Unit
- Pre-assessment & Admissions Unit
- Community Patient - District Nursing
- Osborne Ward
- CHildrens Ward
- Neonatal Intensive Care
- Maternity
- Chemotherapy Unit
- Outpatients
- Coronary Care Unit
- Rehabilitation Ward
- St Helens Ward
- Medical Assessment & Admissions Unit

Themes of Issues raised:

Clinical Care (5)
Estates (4)
Hospital Services (4) (parking, catering)
Medical Care (3)
Nursing Care (3)
Appointments (1)
Workforce (1)
Communication (1)

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th April 2014

Title	Wessex Academic Health Science Network Membership			
Sponsoring Executive Director	Karen Baker, Chief Executive			
Author(s)	Mark Price, FT Programme Director/Company Secretary			
Purpose	Approval for the Trust to become a voting member of the Wessex Academic Health Science Network.			
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	8th April 2014		
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

The Board is recommended to:

(i) Approve the Trust becoming a Voting Member.

(ii) Approve payment of Year 1 membership free of £10,000. Subsequent years level of membership fees are to be set by the Wessex AHSN Board and approved by Voting Members on a 2/3 majority basis.

(iii) Approve the appointment of Karen Baker, Chief Executive, as the Trust's Authorised Representative to act on its behalf as a Voting Member. Please note, if the Authorised Representative is unable to attend a Voting Members' meeting, the Trust may provide for a deputy to attend instead of the Authorised Representative.

(iv) No limitations on the delegation of powers are proposed provided that the Authorised Representative should act in accordance with the Trust's Corporate Governance Framework and refer any concerns to the Board for guidance.

(v) Approve the receipt of regular updates from its Authorised Representative on the activities of Wessex AHSN.

For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	Clinical Strategy and Resilience					
Critical Success Factors *(see key)*	CSF4, CSF5					
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	Legal advice has been taken on the establishment and governance arrangements for the AHSN					

Date: 23rd April 2014 **Completed by: Mark Price**

ISLE OF WIGHT NHS TRUST

TRUST BOARD MEETING WEDNESDAY 30 APRIL 2014

WESSEX ACADEMIC HEALTH SCIENCE NETWORK

1. **Purpose**

The purpose of this paper is to seek the approval of the Trust Board to the Isle of Wight NHS Trust becoming a voting member of the Wessex Academic Health Science Network.

2. **Proposal**

At its last seminar earlier this month the Board received a briefing on the establishment of the Wessex Academic Health Science Network (WAHSN) from Martin Stephens, Chief Executive of WAHSN. Board members were able to ask questions and gain a greater understanding of the WAHSN. A Board briefing paper, based upon a template provided by WAHSN, is also enclosed as Appendix 1 to provide background information and further context to the recommendations put to the Board in Section 3 below.

It is important to note that membership of the WAHSN is in line with our strategy of working "Beyond Boundaries" .

3. **Recommendations**

The Board is recommended to:

(i) Approve the Trust becoming a Voting Member.

(ii) Approve payment of Year 1 membership free of £10,000. Subsequent years level of membership fees are to be set by the Wessex AHSN Board and approved by Voting Members on a 2/3 majority basis.

(iii) Approve the appointment of Karen Baker, Chief Executive, as the Trust's Authorised Representative to act on its behalf as a Voting Member. Please note, if the Authorised Representative is unable to attend a Voting Members' meeting, the Trust may provide for a deputy to attend instead of the Authorised Representative. No limitations on the delegation of powers are proposed provided that the Authorised Representative should act in accordance with the Trust's Corporate Governance Framework and refer any concerns to the Board for guidance.

(iv) Approve the receipt of regular updates from its Authorised Representative can on the activities of Wessex AHSN.

Karen Baker, Chief Executive

Mark Price, Company Secretary

23 April 2014

APPENDIX 1 **BOARD BRIEFING PAPER ON WESSEX AHSN**

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1 Background

Academic Health Science Networks (AHSNs) are a core element of 'Innovation Health and Wealth' (2011), the NHS contribution to the Government's 'Plan for Growth'. AHSNs are intended to improve the identification, adoption and spread of innovation and best practice across the NHS. Established as membership organisations with a geographical footprint, AHSNs encompass NHS commissioning bodies and providers, universities, industry, and other organisations.

The core purpose of the networks is to enable the NHS and academia to work collaboratively with industry to spread innovation, enhance patient care and generate wealth. The intention is that all NHS organisations should look to be affiliated to their local AHSN. AHSNs are expected to facilitate closer working relationships with industry to assess, commercialise and adopt health technologies.

AHSNs have been established through a designation process designed by NHS England that assessed whether they were 'fit for purpose'. Once designated AHSNs are granted a 5 year licence and contract with NHS England setting out the funding agreement and deliverables.

The Wessex AHSN covers a population of three million aligning with the local government areas of Bournemouth, Channel Islands, Dorset, Hampshire, Isle of Wight, Poole, Portsmouth, Southampton and Southern Wiltshire (a list of partners is available on request). The AHSN's prospectus and business plan set out the network's objectives, system of delivery, financial plan and programmes and are available at http://wessexahsn.org/.

Wessex AHSN's vision is to bring discovery and innovation into the Wessex health system so that the population has better health and benefits from a thriving health innovation sector. This will be driven through a focus on tackling key local health issues over individuals' whole life course and across entire patient pathways.

Wessex AHSN aims to:

- Ensure that people across the region can expect the same, high quality of care regardless of location or provider through collaborative service improvement and innovation programmes.

- Rapidly translate research into practice, promote adoption and spread of innovation – including timely implementation of NICE technology appraisals – through efficient knowledge exchange.

- Work with the NIHR research networks to support delivery of clinical trials to time and to target, by facilitating research initiation and supporting patient participation.

- Use information systems to support quality and care delivery improvements, improving access, understanding the impacts of our interventions and identifying emergent issues.

- Provide an open door to health and university expertise for industry, to enable the design, development and investment in new services and technologies.

- Work with Health Education England (Wessex) to ensure education and training programmes draw on emergent best practice, and foster an innovative, improvement–focused workforce.

The Wessex AHSN aims to promote a two-directional flow of influence between the AHSN and the Health and Wellbeing Boards in order to allow for the development of shared priorities and programmes.

Engagement of business and industry, both in co-production and direct investment will be central to the work of the AHSN. In providing clear engagement points for industrial partners and investors, the AHSN will enable rapid development of new commercially delivered solutions, generating local and national wealth through wider sales and adoption.

2 Programmes

Key initial support programmes have been developed in view of establishing the Wessex AHSN and fulfilling the outcomes outlined in the licence and business plan. Voting Members are expected to participate in programmes but levels of participation and contributions to be made to those programmes whether monetary or in kind are currently unclear.

The Wessex AHSN's key development priorities are:

- Developing a 'whole system' approach for older people (particularly in managing dementia) with a strong emphasis on rapid development of effective community-based care.
- Providing better services for people with a long term condition which:
  - (i) Are centred on improving care whilst reducing cost.
  - (ii) Build on Southampton's translational science capabilities and strong industry partnerships in nutrition, respiratory & cancer.
  - (iii) Catalyse industry engagement in the development of therapeutics and diagnostic, telehealth and telemed technologies.
- Improving health and life chances through a long term programme to improve nutrition and health across the local population, and nationally with other AHSNs and the food industry, through application of Southampton's world-leading nutrition and development research knowledge.
- Reducing alcohol misuse by linking clinical services, public health and government agencies, policy makers and researchers to develop holistic public health and care interventions, building on the Wessex Alcohol Research Collaboration platform to implement research knowledge in testing and prevention supported through a multi-partner training and education programme for health and social care professionals, public and carers.
- Optimising medicines and eliminating waste through collaboration with the Oxford AHSN to enable sharing of data, information and best practice whilst identifying key areas to target with safety and cost improvement programmes.
- Timely delivery of high impact innovations and implementation of NICE technology appraisals

- Ensuring patient centred information is at the core of the Wessex healthcare system by integrating and developing a system wide information infrastructure which builds on the Hampshire Health Record (HHR), and links in systems from IOW and Dorset.

Underpinning these health development priorities, the Wessex AHSN will establish long term activity-based programmes for continuing support of improvement and innovation.

3 WAHSN Governance Arrangements

The development of the WAHSN has been overseen by a Steering Group made up of partner organisation representatives. Partners' Meetings remain a key feature in the governance arrangements but there will be a Company Limited by Guarantee (CLG) Board to replace the Delivery Board once the CLG is formed on 1 April 2014. After that date, the Board will be made up of Directors nominated by the NHS provider organisations, CCGs and Universities.

Nomination of Directors must have the approval of a majority of the relevant group of Voting Members (i.e. NHS provider organisations, CCGs and Universities). Any nominees for appointment to the Board as Voting Member Directors must be approved by the Board (acting reasonably). Any person so nominated and appointed as a director holds office for a term not exceeding two years. A person may be re-elected for a further two terms (i.e. 6 years in total).

3.1 Articles and VMA

The CLG is governed by the Articles and VMA. These documents are essentially its constitution.

The Articles set out the CLG's basic management and administrative structure. They regulate its internal affairs including, for example, board and Guarantors' meetings, powers and duties of directors, borrowing powers and so on. The Articles create a contract between the CLG and each of the Guarantors. The Articles are subject to relevant provisions of the Companies Act 2006.

The VMA is a contract between the Voting Members and sets out their rights and obligations.

The Articles will be open to view by the public at Companies House. The VMA, on the other hand, will be a private agreement between the Voting Members. As a result, some of the sensitive detail for the CLG around membership fees, accounting matters and business plans has been kept out of the Articles and is in the VMA instead.

Both documents set out the CLG's mission to pursue such business and activities as are set forth or contemplated in or by the AHSN Licence.

3.1.1 Directors and Members

Normally, a company limited by guarantee distinguishes between "members" and "directors". The directors are responsible for the day to day management of a company and are accountable to the members.

Wessex AHSN makes a further distinction in terms of its "members". It distinguishes between guarantor members (i.e. the Guarantors) and Voting Members.

The Guarantors are the "members" in the traditional sense under the Companies Act 2006. Their details are registered at Companies House and their names are entered into the Register of Members. They also have certain statutory rights (see below).

Under the VMA, to be a Guarantor, you have to be a Voting Member first. Therefore, the CLG cannot have Guarantors who are not also Voting Members.

The Voting Members do not have their details registered at Companies House or entered into the Register of Members (unless they are also Guarantors). Further, they do not have the same statutory rights as the Guarantors (but, see below).

The distinction between Guarantors and Voting Members appears to have been created in order to allow NHS Trusts to participate in the CLG. This is because NHS Trusts cannot be members (Guarantors) of a company unless the company has been set up for income generation purposes and even then, they need approval from the NHS TDA.

This means that, whilst an NHS Trust can be a Voting Member, it cannot be a Guarantor (i.e. a member under the Companies Act). This does not apply to NHS Foundation Trusts who are not restricted in that way. A Foundation Trust can therefore become a Guarantor.

In order to ensure that NHS Trusts have the same say as other participants in the Company, the VMA has created a corporate governance structure which means that the Guarantors cannot pass resolutions without them first being ratified by the Voting Members (bearing in mind that the NHS Trusts can only ever be Voting Members). This means that the Voting Members control the Company and therefore, the participants that are NHS Trusts will not be precluded from having a say in the running of the Company, simply because they cannot be Guarantors.

See sections 4.1.3 and 4.1.4 for more about Guarantors and Voting Members.

The initial number of Guarantors has not yet been confirmed but it is proposed that upon incorporation of the CLG, only a limited number should exist, purely for administrative purposes (less paperwork to send to Companies House). However, once the CLG has been incorporated, guarantorship will be opened up to all Voting Members (who are eligible to be Guarantors) and all Voting Members will be encouraged to become Guarantors (assuming they have the statutory powers).

3.1.2 The Board of Directors

The Board is responsible for the management of the CLGs business in accordance with the CLG's mission. As with any company, the CLG's Board will be accountable to the members (i.e. the Guarantors and the Voting Members). The Board will govern the activities of the Wessex AHSN, determine the strategy and priorities of the network and performance manage delivery of objectives. It will be responsible for ensuring both financial and corporate governance and set the Network's culture. The Board has the power to take all executive decisions in relation to matters contained in the Business Plan.

The Board will comprise of the Independent Chair, Chief Executive and nominee Voting Member Directors from NHS providers (4), CCGs (3) and Universities (2).The Independent Chair shall account to the Voting Members on behalf of the Board for the actions of the Company.

Other AHSNs have included as non-voting member nominees from Health Education (HE), the National Institute for Health Research (NIHR) and CLARHRC. This is not proposed under the current Articles and VMA. The Chair may permit any persons who are not Directors or Guarantors to attend and speak at a Board meeting however is not obliged to do so. Further, such persons will not have a vote.

The NHS provider organisations, CCGs and Universities are left to determine the most appropriate means of nominating their directors to the Board provided that any nomination must have the approval of a majority of the relevant group of Voting Members. Any

nominees for appointment to the Board as Directors must be approved by the Board (acting reasonably). The Board approves the Voting Member director nominations. The Board must act reasonably and therefore it is anticipated that nominations would not be rejected.

The Board will be supported by an executive team run by the Chief Executive. The Executive Team may have a small number of "executive directors" appointed by the Chief Executive, who will not be Directors and will not have a vote on the Board.

The Company may set up one or more external groups , for example to engage with key stakeholders which are not Voting Members and/or industry, to give those entities the opportunity to be involved in shaping the Company's priorities.

As a general rule, any decision of the Board must be a decision taken by two-thirds of the eligible Directors at a meeting or a unanimous decision in the form of a resolution in writing. The Quorum for Board meetings is five unless determined otherwise by a decision of the Guarantors. The number of Directors shall not be less than 2 or more than 14 unless determined otherwise by an ordinary resolution of the Guarantors.

3.1.3 Guarantors

The rights and obligations of Guarantors are governed by the Articles and the VMA.

Each Guarantor's liability is limited to £1. This (together with membership fees payable as a Voting Member) is the sum that each Guarantor will contribute to the assets of the CLG if it is wound up while the Guarantor is a Guarantor or, within one year after it ceases to be a Guarantor.

Any person applying to be a Voting Member and capable of being a Guarantor has the right to be admitted as a Guarantor. Therefore, you cannot be a Guarantor unless you are a Voting Member.

A person can only cease to be a Guarantor on ceasing to be a Voting Member, ceasing to exist or on notice in writing to the Company if it becomes unlawful for that person to remain as Guarantor. In any other circumstances, a Guarantor can only be permitted to cease being a Guarantor with prior approval in writing from the Board.

The VMA states that the Guarantors have the right to vote on any matter which is required to be decided by them under company law. This means that they have specific statutory rights. The main ones being:

- To remove a Director from office (by way of ordinary resolution)
- To change the CLG's name (by way of special resolution)
- To change the Articles.

In addition, under the Articles, the Guarantors can direct the Board by special resolution to take or refrain from taking specified action

Therefore, whilst the Board has control over the day to day management of the Company, a limited number of decisions (such as those listed above) are reserved to the Guarantors. However, the Guarantors cannot pass resolutions without having them first ratified by the Voting Members. This is so that NHS Trusts (which cannot be Guarantors) are not precluded from decision making.

If the Guarantors wish to pass a special resolution, say to change the name of the CLG, they need at least 75% of the Voting Members to vote in favour of the resolution for it to be passed. If the Guarantors wish to pass an ordinary resolution, say to remove a director from office, they need at least two thirds of the Voting Members to vote in favour of the resolution for it to be passed.

After the Voting Members have determined a matter, the Guarantors shall take such actions and pass such resolutions as may be required in order to give effect to the determination of the Voting Members. For example, removal of a director under the Companies Act requires an ordinary resolution to be passed by the Guarantors. The Guarantors would have to pass that resolution once the Voting Members have passed their resolution.

3.1.4 Voting Members

It was anticipated there would be an eligibility criteria approved by the Voting Members and implemented by the Board to regulate which organisations may become members of Wessex ASHN. These criteria may appear in the business plan. As there is no criteria currently proposed the Board will approve who becomes Voting Members.

RBCH made representations that as NHS England provide that FTs should be members where there is government guidance for an NHS organisation to be a member we proposed that that organisation should be entitled to membership. Wessex would prefer the documentation to remain silent on this issue and the Board approve members.

The VMA records the relationship between the Voting Members. Voting Members should endeavour to consider all opportunities and issues that affect the Company in the light of what is in the best interests of the fulfilment of the Company's mission not solely in relation to the narrower interests of their own organisation. Voting Members commit to harmonising information governance arrangements, providing performance information on activities relevant to the Company, sharing best practice and adopting a 'mutual recognition agreement' for clinical trials so as to enable the CLG to fulfil its mission.

Voting Members commit to pay an annual membership fee (details of which are set out below under financial implications) and to remain Voting Members for at least two years.

In essence, the Voting Members vote on the business plan (the detail required for the business plan is summarised in 9.7 of VMA) and the membership fee. However it is anticipated in practice that the Board would respond to members views and concerns.

Voting Members' rights include the following:

- The approval of eligibility criteria with which an applicant must comply in order to be admitted as a Voting member.
- Approve Guarantors' special and ordinary resolutions.
- Each has one vote on matters to be decided.
- Power to nominate a Voting Member Director (as approved by simple majority of the relevant group) by notice in writing to the Company to act as a Voting Member Director for a term not exceeding two years and to nominate any replacement Voting Member Directors.
- Approval of the business plan by a two-thirds majority.
- Vote by two-thirds majority for approval of the membership fee separately from any vote on the business plan.

It is usual for VMAs to include a list of 'reserved matters' (for example loans and major purchases) for which approval of the Voting Members is necessary. Although this is sensible from a Voting Member's point of view, having to go back to the Voting Members for approval of day to day transactions would be onerous for the Wessex AHSN Board. A compromise has been reached to provide more flexibility. On the basis that Voting Members need to feel confident that the spirit would be one of engagement and consultation, the Board is required to use reasonable endeavours to consult the Voting Members on the following matters:

- Loans
- Major purchases
- New classes of membership or guarantorship
- Project funding and categorisation
- Sales of assets or of any part of the business

Therefore the Board is not under an obligation to consult on those matters but the clause does provide Voting Members with a lever should it be felt that consultation is lacking.

Voting Members can terminate their membership or have membership terminated in the following circumstances:

- At any time after the expiry of the lock in period (2 years) by giving no less than 12 months' notice.
- At any time (during or after lock in period) if two thirds of the Voting Members consent.
- At any time on notice to the company if it becomes ultra vires for that person to remain a Voting Member.
- At any time if in the reasonable opinion of the Board that person continuing to be a Voting Member is harmful to the company.
- After the 2 year lock in period, upon expiry of a fee notice: this notice is served if a Voting Member votes against a membership fee increase which has been approved by the 2/3 majority.
- For failure to pay membership fee.
- If they cease to exist.

As a Voting Member, the organisation will need to appoint an "Authorised Representative" to act on its behalf in relation to the CLG.
The organisation's Board of Directors will need to delegate the relevant powers to the Authorised Representative, to enable him/ her to take decisions on its behalf.

4. Financial Implications

AHSNs receive funding from NHS England but under the terms of the licence, are expected to raise matched funding. For 2013-14 Wessex AHSN raised resource in cash and kind but did not seek membership fees.

For 2014-15 and going forward Wessex AHSN needs to raise membership fees to add to licence and other funding to deliver on health and wealth for Wessex. After soundings last year and discussion at Partners meeting, a £10,000 fee per organisation for 2014-15 has been agreed. This is the lower end of the scale of AHSNs across the country.

The Wessex AHSN business plan states that the AHSN is expected to achieve significant value from health gains and generate substantial wealth both for the NHS and the wider economy through commercial rigour and the delivery of returns in excess of funding costs. In the early years, 'seed' funding will be used to build the operation with the skills, capabilities and infrastructure necessary to deliver outcomes. An early understanding and tracking of investment return is expected to assist the organisation towards reaching a robust self-sustaining model.

Return on Investment will be assessed across three key areas: Health gains, cost reductions and economic growth. It is expected that hard financial outcomes and softer more subjective outcomes will result from the activities of the Wessex AHSN.

Any surpluses generated by the CLG may be accumulated for re-investment in on-going 'pump-priming' activities or distributed to the parties or used to offset membership fees.

4.1 Funding

The funding provided by NHS England as part of the licence is seen as an investment which should see a return over the 5 year licence period. The year 1 annual report and subsequent Annual Business Plans and Annual Reports should provide detailed financial forecasting, ROI investment trajectories and eventually where appropriate profit and loss accounting.

The funding from NHS England has been disclosed for the first year. Any funding for subsequent years is to be agreed. The funding for each new financial year is conditional on satisfactory achievement of the service objectives for the proceeding financial year. NHS England has recently indicated that match funding will have to be significantly increased from year 2 (this is discussed further under 4.2).

The licence funding will be provided every year for 5 years. The level for 2013/2014 was £2,574,000. The level for subsequent years is to be confirmed.

Year 1 Programmes are covered by licence funding as follows:

Programme	**Funding allocated**
Quality Improvement Programme	£ 730,000
Building Partnerships	£ 250,000
Centre for Implementation Science	£ 438,000
Wealth	£ 700,000
NICE	£ 150,000
HII and Digital Health	£ 285,000
TOTAL	£2,553,000

The current budget plan for 2014-15 assumes £3million overall income (an uplift in NHS England funding is expected). Establishment costs include overheads and staff who undertake the various projects. Management and overhead costs are estimated at 14%.

4.2 Membership fees

The Membership fee has been set at £10,000 for 2014-2015. It will be set out in the updated business plan and deemed agreed by all Voting Members signing the VMA.
Subsequent membership fees will be notified to Voting Members 6 months in advance of the increase. The level of the fees will be recommended by the Board and approved by two thirds of Voting Members present and voting at any general meeting.

It is anticipated that match funding (from membership fees, any other external sources of funding or income generation) will have to be significantly increased after the first year. For this reason, the membership fee has not been capped beyond Year 1.

If the Membership fee is not approved by the required two-thirds majority in any one financial year, the membership fee for the previous year will stand unless Voting members agree a revised membership fee which is approved by the Board.

5. Legal implications

5.1 Membership fees

The level of membership fees for year 1 has been fixed at £10,000. After the first year, the Wessex AHSN Board will recommend the level of fees. The level recommended by the Board will be adopted if approved by a 2/3 majority of the Voting Members. As the Wessex AHSN will be expected to sustain itself, it is anticipated that membership fees will increase in the future. However, there is no indication of what those future levels may be. Wessex AHSN does not intend that subsequent membership fees would be substantially different from the annual membership fee levied in the preceding Financial Year without compelling reason (for example, a significant change in the funding available through the AHSN Licence or a change in expectations of locally "matched resource"). However, NHSE has indicated that matched funding should be significantly increased in year 2 and the Wessex AHSN is expected to sustain itself after 5 years. These may amount to compelling reasons to increase membership fees.

There is a lock-in period for the first 2 years. This means that Voting Members cannot terminate their membership during the first 2 years.

If year 2 membership fee is approved by the 2/3 majority but not by an individual organisation, the Trust will still be bound to pay a membership fee it does not agree with. This risk applies only to year 2 membership fees due to the lock in period.

For subsequent years, the risk has been addressed as follows:

- If an increase of the membership fee is approved by 2/3 of the Voting Members but an individual organisation voted against the increase, that organisation will be able to notify Wessex AHSN that it does not agree with the increase. The organisation then has two months from the date of the vote to notify the Company that it does not wish to pay the membership fee for the next Financial Year (this is a Fee Notice).
- The Fee Notice would take effect on the last day of the Financial Year which the organisation has paid for and would terminate the individual organisation

membership without incurring any further membership fees. The individual organisation can only terminate its membership on the basis of a fee notice if it votes against the fee increase.

5.2 Termination of Membership

At any time, the Trust can terminate membership with the consent of 2/3 of Voting Members or if it becomes ultra-vires for the Trust to remain as a Voting Member.

The circumstances in which it would be ultra vires for the Trust to remain a Voting Member are limited and it is not anticipated that the Trust would make use of this clause. The ability of the Trust to terminate its membership during the 2 year lock in period is therefore limited.

An individual organisation will be able to terminate its membership after the 2 year lock in period on giving 12 months' notice or if it serves a fee notice as detailed above at 5.1.

5.3 Funding

Under the terms of the licence, NHS England can terminate the contract for failure to meet the service objectives in accordance with the business plan and schedule 3 of the licence or at any time by serving no less than 12 months' notice.

Upon termination, the AHSN remains responsible for costs and liabilities. NHS England is entitled to recover the amount of any losses resulting from termination due to default of the AHSN (clause 16.1), including failure to meet the objectives. Losses which are recoverable include making alternative arrangements for the provision of service objectives and reasonable legal fees.

The AHSN may terminate the contract by serving 3 months' notice on the Authority if funding is withdrawn such that the Contractor is unable to meet the Service Objectives.

5.4 Vires

The Trust has the ability to terminate its membership at any time on notice in writing to the Company if it becomes ultra vires for it to be a Voting Member or a Guarantor. It is unlikely that the ultra vires clause will be used to terminate membership.

The Board has an option at this stage to limit the powers of the Authorised Representative. The Board could, for example, choose to cap the amount of membership fee that the Authorised Representative can approve, in which case:

(i) The Authorised Representative will have to refer the decision back to the Board if the level of membership fee proposed will exceed the limit placed on the Authorised Representative's authority.

(ii) If the Authorised Representative exceeds his authority and votes to approve a membership fee level in excess of the limitations placed on him, the Trust will only be able to rely on the ultra vires termination clause to terminate its membership if the required 2/3 majority vote would not have been achieved had the Authorised Representative not voted in favour.

The ultra vires clause therefore only has a limited application. It would not enable the trust to terminate membership only on the basis that its Authorised Representative had acted in excess of its authority.

5.5 Financial Exposure and Liability

If any organisation were to be a Voting Member of the CLG, it would need to pay the annual membership fees detailed above. The annual membership fees are essentially a capital contribution. They are not a repayable loan. Therefore, if any organisation ceased to be a Voting Member at any time, it would forfeit the membership fees paid and would not be entitled to have them repaid by the CLG. Further, if the CLG were to become insolvent and be wound up, the individual organisation would lose its membership fees, unless, of course, after creditors have been paid, there is any surplus remaining.

Any organisation's liability as a participant in the CLG will not extend beyond that of its membership fees and the £1 it pays to be a Guarantor. This is because the CLG is a separate legal entity whose members are only liable for what they contribute to the CLG in order to be members of it.

The financial risk in relation to year 2 membership fee has been identified above at 5.1. Although Wessex AHSN does not anticipate increasing the membership fee without compelling reason, such increase is likely and an individual organisation will be bound to pay without the ability to terminate its membership in year 2 if it was approved by a 2/3 majority of Voting members.

5.6 Programmes

Voting Members are expected to participate in programmes but levels of participation and contributions to be made to those programmes whether monetary or in kind are currently unclear. However, the Board is required to use reasonable endeavours to consult Voting Members on project funding and categorisation.

5.7 Return on Investment and wealth creation

Return on investment is set out for a number of programmes in the business plan, however it would be useful to have further clarity as to return for Wessex and individual members.

5.8 Directors' indemnity and insurance

The Articles contain an indemnity from the Company which indemnifies the Directors against any liability incurred by them as officers of the Company.

The Articles also allow the Directors to purchase insurance at the expense of the Company in respect of any loss suffered by the Company due to their acts or omissions. This is commonly referred to as Directors & Officers Insurance and is widely available in the marketplace. It is an accepted element of good corporate governance.

Under the Companies Act, the Company is permitted to purchase such insurance cover for the Directors, against any liability attaching to them in connection with negligence, default or breach of duty. It provides the funds to defend legal proceedings and investigations made against them as the Company's Directors. It also meets the costs of awards, damages and settlements incurred. However, it does not generally provide cover for fraudulent trading.

There is no guarantee that the insurance would cover all actions of the Trust's representative or that the Company would pay for this. The Articles say that "The Directors *may* decide to purchase and maintain insurance at the expense of the Company." As a result, the Trust may wish to provide insurance for any person acting as a representative or Director in connection with Wessex AHSN as this would clarify the parameters within which

such a person can act. The Trust may wish to consider giving a representative or Director an indemnity in connection with its role in Wessex AHSN.

5.9 Intellectual property

Any IP generated is currently available for free to NHS England under the terms of the Licence (the contract which outlines the conditions for funds). This may need to be reviewed if the Wessex AHSN is expecting to generate wealth from IP.

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 APRIL 2014

Title	Capital Programme 2014-15			
Sponsoring Executive Director	Chris Palmer, Executive Director of Finance			
Author(s)	Kevin Curnow, Deputy Director of Finance			
Purpose	Approve the Trust Capital Programme for 2014-15			
Action required by the Board:	**Receive**		**Approve**	ü

Previously considered by (state date):			
Trust Executive Committee	28/04/14	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)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

This paper shows the proposed capital spend of the Trust for the financial year 2014-15. The anticipated Capital Programme spend is £8.357m. The funds available for this spend is generated by £7.5m of internal funds (depreciation/amortisation), £648k of property sales, £100k charitable donations, £100k VAT recovery & £9k dementia funding from charitable funds.

Of the proposed spend, £7.655m has been classed as 'committed'. This is either because schemes are 'rolling over' from a previous financial year or business cases have been approved at board.

This paper seeks the approval from the board of the Capital Programme for 2014-15.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	All					
Critical Success Factors *(see key)*	CSF 1, 2 & 3					
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: 22 April 2014 **Completed by: Kevin Curnow**

Capital Programme Source & Application of Funds

Isle of Wight NHS
NHS Trust

Source & Application of Capital Funding Source	Annual Plan 2014/15	April	May	June	July	August	Sept	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Funds													
Initial CRL	7,500	625	625	625	625	625	625	625	625	625	625	625	625
Dementia Friendly													
Pharmacy Matched Funding - NHS Technology for Safer Wards (provisional)													
CCG Income (Hand Held Devices)													
Property Sales	648									648			
Cash Surplus													
Anticipated Capital Resource Limit (CRL)	**8,148**	**625**	**625**	**625**	**625**	**625**	**625**	**625**	**625**	**1,273**	**625**	**625**	**625**
Other charitable donations	100										50	50	
Charitable Funds - Dementia	9	9											
Donated Helipad Income													
VAT Recovery	100		50	50									
Total Anticipated Funds Available	**8,357**	**634**	**675**	**675**	**625**	**625**	**625**	**625**	**625**	**1,273**	**675**	**675**	**625**

Scheme Description Application	2014/15 Plan	April	May	June	July	August	Sept	October	November	December	January	February	March
Committed Schemes													
Replacement Lifts	44			44									
Medical Assessment Unit Extension	2,428			120	250	250	200	350	400	150	200	320	188
Ward Reconfiguration Level C	142	60	60	22									
Ryde Community Clinic	1,225	40	350	400	350	85							
Backlog high/medium risk & fire safety	93				50	43							
Endoscopy Relocation	625				100	100	95					80	250
Dementia Friendly	192	85	85	22									
ICU/CCU	2,262		120	250	200	200	250	250	250	180	340	222	
ISIS Further Faster	344	115	115	115									
Staff Capitalisation	200	17	17	17	17	17	17	17	17	17	17	17	17
Donated Assets	100										50	50	
Total Committed	**7,655**	**316**	**746**	**990**	**967**	**695**	**562**	**617**	**667**	**347**	**607**	**689**	**455**
Not Yet Committed													
IM&T	156						156						
RRP - Equipment & Ambulances	500						250			250			
Contingency	33												33
Upgrade to Medical Gases System	12		12										
Total Not Yet Committed	**701**	**0**	**12**	**0**	**0**	**0**	**406**	**0**	**0**	**250**	**0**	**0**	**33**
Total	**8,357**	**316**	**758**	**990**	**967**	**695**	**968**	**617**	**667**	**597**	**607**	**689**	**488**

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th April 2014

Title	Emergency Preparedness, Resilience & Response (EPRR) Annual Report			
Sponsoring Executive Director	Alan Sheward, Executive Director of Nursing & Workforce			
Author(s)	Keith Morey, Civil Contingencies Manager			
Purpose	Provide assurance to the Board.			
Action required by the Board:	**Receive**	X	**Approve**	

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

Staff, stakeholder, patient and public engagement:

Executive Summary:

Following request at the 11th February Board, an EPRR Annual report has been compiled.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Quality					
Critical Success Factors *(see key)*	CSF2					
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: 17th April 2014 **Completed by: Keith Morey**

Emergency Preparedness, Resilience & Response (EPRR)
Annual Report to Board, 2013-14

Background
Following the report to the board on the updated Trust Incident Response Plan, on 26th February 2014, it was requested that an EPRR Annual Report be presented to the board for assurance.
This report covers the period April 2013 – March 2014 and shows EPRR activity across the Isle of Wight NHS Trust.
The Emergency Planning Team consists of 2 WTE, who now sit within the Executive Director of Nursing & Workforce Directorate, following an organisational change in 2012.
This report outlines the activity of the trust and Emergency Planning Team, the meetings and governance structure around this activity.

Incidents
Over the 12 months of this report, the trust has categorised and dealt with 21 Significant Incidents. These can be categorised as –

- 8 Road Traffic Collisions of significant size or injury potential
- 1 Light Aircraft Crash
- 2 Significant Fires (Boat & House)
- 1 Adverse Weather Incident
- 1 Unexploded Ordnance
- 1 Firearms Incident
- 1 Man on Roof
- 1 Landslip
- 1 Chemical Contamination
- 1 Utility Failure (Water Main Disruption)
- 1 Potential Trust Building Evacuation
- 2 Severe Bed Pressure Incidents

The majority of these incidents were dealt with by the Integrated Care Hub, and were logged and recorded by the Ambulance Service Dispatcher. Liaison with Bed Management, Emergency Department and Estates were carried out as required.
The control logs for these incidents are reviewed for any learning points, and where required, incident debriefs and action plans are produced. The logs are held by the Emergency Preparedness Team for review.
The larger incidents are reviewed by multi agency debriefs, and our reports are fed into these as required. The Cowes Harbour boat fire and Undercliff Landslip have both had reports sent for multi agency debriefs this year.

Additional incidents planned and managed this year have been –

- Fire & Rescue Service Dispute
- Activation of Heat Wave Plan
- Flooding (Large regional response requiring liaison)

Events

Following the events of 2012, this year was relatively quiet.
We planned and provided cover at various levels, from full medical support to event control representation at the following –

- Round the Island Yacht Race (Event management)
- Isle of Wight Festival (Full medical provision, liaison with private providers)
- Cowes Week Fireworks (Event management)
- Bestival (Event management, integrated NHS and private provision)

A number of other events were given advice and guidance on required medical cover via our participation in the Safety Advisory Group, run under the Local Authority Licensing Department.

Exercises

The trust has participated in the following exercises –

- Festival (tabletop)
- Regional EPRR Workshop
- Regional Exercise Paladin
- Bestival (Tabletop)
- Bembridge Harbour Emergency Plan
- Needles Pleasure Park Emergency Plan

Planning was commenced for a large Fire & Rescue Service exercise, due for delivery in October 2013. Unfortunately this was postponed due to potential industrial action.

We have also held a live internal exercise, testing the new Emergency Department layout.

Debrief lessons from the multi agency exercises have been shared and implemented. The action plan from the Emergency Department exercise has been to the Trust Executive Committee and is being worked through and monitored by the Trust's Emergency Planning & Business Continuity Group.

Training

An Introduction to Emergency Planning e-learning module has been developed and is available on the trust intranet.

A small number of Loggists training sessions have been run to enable execs and senior managers to have their own support staff when managing an incident.

The trust has been involved in the planning for delivery of the Joint Emergency Services Interoperability Programme (JESIP). This is the national programme for joint training of emergency service commanders, and we will be delivering these sessions on the Isle of Wight to ensure local commanders train together.
The first local session was held in March, with further sessions planned through until the September deadline for completing this training.

Regular Meeting Schedule

The Trust Emergency Planning & Business Continuity Group (EP&BCG) meets quarterly to monitor the Trust's emergency planning activity. This group is made up of emergency planning leads from the directorates and representatives from specialist areas such as Emergency department and communications.
This group reviews and monitors the action plans from audits, exercises and incidents.

The emergency planning team also attend the following meetings to ensure the trust complies with it's duties under the Civil Contingencies Act –

- Hampshire & Isle of Wight Local Resilience Forum
  Health is represented on the main groups by NHS England Wessex Local Area Team; the trust still has a seat via the ambulance service representation. The sub groups it is currently active in are the Risk Assessment Group and the Fuel Group.
- Island Resilience Forum
- Emergency Preparedness and Resilience Group – This is the national ambulance leads meeting where we hold a seat.
- Local Health Resilience Partnership, Executive and Working Group. The Health Emergency planning Group, lead by NHS England Local Area Team.
- Safety Advisory Group this is lead by the Local Authority Licensing Department and reviews the larger events on the island. We will meet with organisers of events and advise and guide them to ensure their events are safe for the public.
  This is the process that ensures the planning for the IoW Festival and Bestival takes place at regular meetings, and other events are risk assessed and invited to attend if appropriate.

  As the Trust is now a Responsible Authority under the Licensing Act, the Emergency Planning Team receives and reviews all licence requests received by the Local Authority, and comments where required.

Audits and Assessments, Policy & Plan Updates

Business Continuity has received a peer review from the National Ambulance Service Business Continuity Group, as well as an audit by Deloittes. These have been used to update the Business Continuity Policy and Response Framework.

We have also completed a self assessment of the new NHS Emergency Preparedness Core Standards, feeding this back through the Clinical Commissioning Group to NHS England.
The Trust Incident Response Plan has been updated and approved through the Trust Board following this assessment.

These audits and the core standards are used to develop the work for the Emergency Planning Team for the coming year, which is reviewed at the Trust EP&BCG.

2014-15

The Trust Emergency Planning Manager has been seconded to the My Life a Full Life project for the year. Backfill has been provided, and this person will work on the Trust Business Continuity Plans, aiming to align us to the new ISO standard that has been introduced, whilst upgrading the departmental plans over the next 12 months.

We have seen a change to the provision of medical services to the IoW Festival from the IoW NHS Trust to a private provider. This will mean that the planning phase through the Safety Advisory Group is vital in ensuring a quality service is provided and St Mary's remains protected from any adverse demands from the event.

Table top exercises for both Festival and Bestival events will be participated in, and the Fire & Rescue Service exercise may be rescheduled for this year.

The Joint Emergency Services Interoperability Programme training schedule is demanding, but dates have been planned and will be delivered to the timescale requested by the Home Office.

The Board will receive an annual update of activity

Alan Sheward
Executive Director of Nursing & Workforce
April 2014

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 APRIL 2014

Title	FOUNDATION TRUST PROGRAMME UPDATE			
Sponsoring Executive Director	FT Programme Director / Company Secretary			
Author(s)	Programme Manager – Business Planning and Foundation Trust Application			
Purpose	To Approve			
Action required by the Board:	**Receive**	**✓**	**Approve**	

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

Staff, stakeholder, patient and public engagement:

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

Executive Summary:

This paper provides an update on work to achieve Foundation Trust status.

The key points covered include:

- Progress update
- Communications and stakeholder engagement activity
- Key risks

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	5					
Critical Success Factors *(see key)*	10 - Develop our organisational culture, processes and capabilities to be 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	A 12 week public consultation is required and concluded on 11 January 2013.					

Date: 19 April 2014 **Completed by: Andrew Shorkey**

ISLE OF WIGHT NHS TRUST
NHS TRUST BOARD MEETING WEDNESDAY 30 APRIL 2014
FOUNDATION TRUST PROGRAMME UPDATE

1. Purpose

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

2. Background

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

3. Programme Plan

Formal notification has now been received from the Care Quality Commission (CQC) advising the Trust that the Chief Inspector of Hospitals (CIH) inspection will be undertaken on 3 June 2014. Work is ongoing to prepare the Trust for this large scale inspection. An initial detailed request for information across Acute, Community and Mental Health services has been received from the CQC and work is ongoing to deliver against this requirement. The CQC's lead inspector, Joyce Fredericks, will be undertaking a pre-inspection visit on Thursday 24 April 2014 and a tour of St Marys including The Hub, Sevenacres, MAU/A&E, the Chemotherapy Unit and on site Community teams has been co-ordinated together with visits to proposed venues for the public listening event.

The Trust Development Authority (TDA) has now provided provisional dates for key milestones following the CIH visit: the Quality Summit which takes into consideration the findings of the CIH visit and the Board to Board meeting between the Trust's Board and the TDA's Board. The timing of these milestones will enable the Trust to maintain the current trajectory with a referral to Monitor in September 2014. Work is ongoing to deliver the Integrated Business Plan and other products required to support our application. Our next IBP submission is scheduled for 20 June 2014 to align with the national requirement for submission of 5 year strategic plans. Our current application schedule is attached at Appendix 1.

4. Communications and Stakeholder Engagement

A firm focus remains on membership recruitment activity. As at 16 April 2014 the Trust has 4,047 members and is now making progress towards the next target of 6,000 members by April 2017 agreed with the Trust Development Authority (TDA). The table below identifies the current membership breakdown by constituency (the figures in brackets are for the previous month):

Constituency	Membership	Required before election
North and East Wight	959 (1,101)	500
South Wight	892 (1,021)	500
West and Central Wight	1,278 (1,458)	500
Elsewhere ('Off Island')	368 (377)	250
Volunteers	550 (Not prev shown)	-
Total	**4,047 (3,957)**	**1750**

Since the last membership report in March we have recruited a further 90 members. We have now added into the above list the Volunteers constituency and retained the previous month's figures to show where the movement has been in the figures. The above demonstrates that the 550 volunteers were previously shown in the other constituencies.

As at 16 April 2014 a total of 2,861 staff are shown as Members. The change from the previous month (shown in brackets) when we reported the newly uploaded staff member numbers is the result of the removal of duplicates and clarification with staff around their period of contract. Only staff directly employed by Isle of Wight NHS Trust with permanent contracts longer than 12 months are eligible to become staff members. Letters are being sent to all staff with contracts of less than 12 months and all bank staff to encourage them to join as public members. The staff constituencies are:

Constituency	**Membership**
Administration and Estates Staff	877 (883)
Allied Health Professionals Scientists and Technicians	407 (410)
Healthcare Assistants and Other Support Staff	559 (564)
Medical & Dental	127 (131)
Nursing and Midwifery staff	891 (901)
Total	**2,861 (2,889)**

Current development work includes:

- Making the arrangements for further Medicine for Members and Governor Development events. The next Medicine for Members event has been booked for 23rd June 2014.
- Booking awareness stands into Island events over the summer and autumn. This includes the County Show (June), Chale Show (August), Scooter Rally and Classic Car Show (September). These are shows at which there is minimal cost to the Trust. The membership team were present at the Riverside Centre on 19th April for a Spring Living Fayre and have a stall at Sainsbury's in Newport on 23rd April.

5. Key Risks

Continuation on the current trajectory to achieve referral to Monitor will be dependent on a number of factors: the Trust will require a 'good' or 'outstanding' assessment from the CQC and, thereafter, the scheduling of quality summit and Board to Board meetings will need to be confirmed. We continue to test the organisation against the CQCs key lines of enquiry to identify potential weaknesses and are working to ensure meetings with CQC can be scheduled during the summer months.

With respect to the finalisation of the IBP, the compressed timeline for the delivery of service development plans gives rise to risk in respect of the robustness of some of the plans that have been put in place to date. A programme review is underway to test plans and ensure that they are robust and deliverable.

No external funding has been identified to date to support FT activities in 2014/15.

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

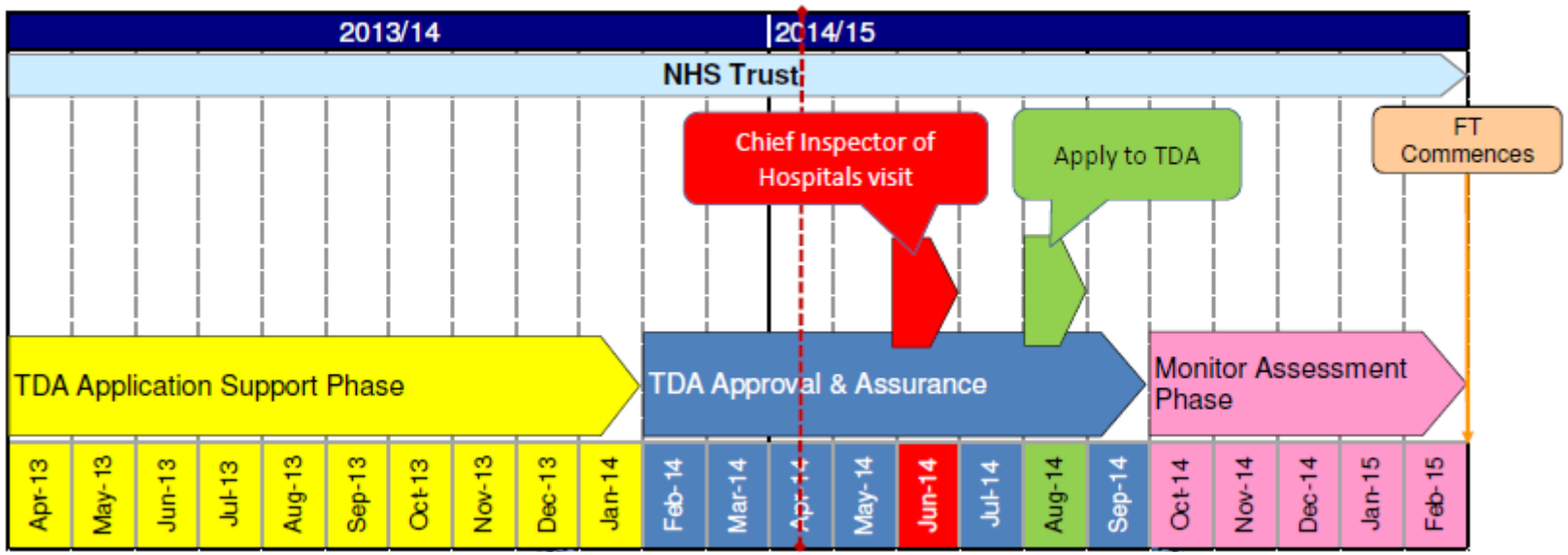
6. **Recommendation**

It is recommended that the Board:

(i) Note this update report

Mark Price
FT Programme Director/Company Secretary
22 April 2014

FT Application Timeline



Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 APRIL 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		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	16-Apr-14
Finance, Investment & Workforce Committee	16-Apr-14	ICT & Integration 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 April 2014 Trust Development Authority (TDA) self-certification return covering March 2014 performance period for approval by Trust Board.

The key points covered include:

- Background to the requirement
- Assurance
- Performance summary and key issues
- Recommendations

For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	5					
Critical Success Factors *(see key)*	10 - Develop our organisational culture, processes and capabilities to be a thriving FT					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***						
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	Meeting the requirements of Monitor's *Risk Assessment Framework* is necessary for FT Authorisation.					

Date: 22 April 2014 **Completed by: Andrew Shorkey**

ISLE OF WIGHT NHS TRUST

SELF-CERTIFICATION

1. Purpose

To provide an update to the Board on changes to the self-certification regime and seek approval of the proposed self-certification return for the March 2014 reporting period, prior to submission to the Trust Development Authority (TDA) in April 2014.

2. Background

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

According to the TDA:

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

Access to submission templates for Board Statements and Licence Condition returns have been provided via an internet portal by the TDA. No submission arrangements are as yet in place with respect to FT Programme Milestones. The timeframe for submissions has been revised from July 2013 onwards and now accords with our internal process to obtain Board Assurance prior to submission. This will now ensure that timely returns are provided to the TDA whilst demonstrating Board ownership and accountability through the self-certification process.

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

3. Assurance

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

Draft self-certification returns have been considered by the Quality and Clinical Performance Committee, Finance, Investment and Workforce Committee and relevant senior officers and Executive Directors. Board Statements and Monitor Licence Conditions are considered with

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

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

1. All Board Statements are marked as compliant. This position is reflected within the draft sample return document (Appendix 1a) and the Board Statement Assurance Documents (Appendix 2).

Licence Conditions

2. All Licence Conditions are marked as compliant following the implementation of Fit and Proper Person declarations for Trust Board members ensuring compliance with condition G4. This position is reflected within the draft sample return document (Appendix 1b) and the Licence Condition Assurance Documents (Appendix 3).

Foundation Trust Milestones

3. Confirmation has been received from the Care Quality Commission that a Chief Inspector of Hospitals inspection of the Trust will be undertaken on 3 June 2014. Milestones have been discussed with the TDA to reflect this position and form the basis of our current plan, putting the Trust on a trajectory to receive a referral to Monitor in September 2014. The Trust continues to meet agreed milestones. The draft return document is attached as Appendix 1c.

5. Recommendations

It is recommended that the Trust Board:

(i) Approve the submission of the TDA self-certification return;
(ii) Identify if any Board action is required

Andrew Shorkey
Programme Manager – Business Planning and Foundation Trust Application
22 April 2014

6. Appendices

1a – Board Statements
1b – Licence Conditions
1c – Foundation Trust Milestones

7. Supporting Information

- *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards,* TDA, 12 April 2013
- *Risk Assessment Framework,* Monitor, 27 August 2013

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

	For CLINICAL QUALITY, that:	Response	Comment where non-compliant or at risk of non-compliance	Timescale for Compliance	Executive Lead
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's Oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes			Alan Sheward Mak Pugh
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes			Mark Price
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes			Mark Pugh
	For FINANCE, that:	**Response**			
4	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes			Chris Palmer
	For GOVERNANCE, that:	**Response**			
5	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution at all times.	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	Yes			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.	Yes			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
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

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

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 plan; and the management structure in place is adequate to deliver the annual plan.	Yes			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	Fit and proper person declarations signed off by Trust Board members in March 2014.		Mark Price
2	Condition G7 – Registration with the Care Quality Commission	Yes			Mark Price
3	Condition G8 – Patient eligibility and selection criteria	Yes	National guidance accommodated in local access policy.		Alan Sheward
4	Condition P1 – Recording of information	Yes	Assessment by Assistant Director - PIDs confirms compliance		Chris Palmer
5	Condition P2 – Provision of information	Yes	Assessment by Assistant Director - PIDs confirms compliance		Chris Palmer
6	Condition P3 – Assurance report on submissions to Monitor	Yes	Assessment by Assistant Director - PIDs confirms compliance		Chris Palmer
7	Condition P4 – Compliance with the National Tariff	Yes	Assessment by Assistant Director - PIDs confirms compliance		Chris Palmer
8	Condition P5 – Constructive engagement concerning local tariff modifications	Yes	Work is ongoing with Monitor and the Isle of Wight CCG to concerning how local modifications are determined.		Chris Palmer
9	Condition C1 – The right of patients to make choices	Yes	*The majority (>80%) of IOW NHS Trust secondary care consultant-led services are available to view and access via the national Choose and Book (CAB) system. Using standard Directory of Services templates, the Trust is clear to patients about the type of services that it provides and through the CAB system is able to be compared with alternative services to provide patients with free choice.* *Once patients have made the initial choice for the IOW NHS Trust to provide health services to them, the Trust's Access Policy guarantees their right to choice, as per the NHS Constitution, when onward referral is required. If there is no clinical reason to send a patient to a particular provider, patients are made aware of their ability to choose and are given advice in clinic or are directed to external information such as NHS Choices.* *With regards to choice and maximum waiting times, if patients contact the Trust regarding a potential breach of 18 week waiting times, the Trust works alongside its lead CCG to identify and offer local alternative NHS providers.*		Alan Sheward
10	Condition C2 – Competition oversight	Yes	*Head of Commercial Development has provided positive assurance of compliance.*		Karen Baker

	Licence condition Compliance	Compliance (Yes / No)	Comment where non-compliant or at risk of non-compliance	Timescale for compliance	Accountable
11	Condition IC1 – Provision of integrated care	Yes	This provision relates to the Trust not doing anything that reasonably would be regarded as detrimental to the provision of integrated care. The Trust is proactively working to improve integrated care. Partnership work is ongoing with the IW Council (Unitary Authority) and the Island CCG to deliver an overarching project, My Life a Full Life, which will lead the integration of care pathways for residents on the Island. The Trust has also implemented a quality impact assessment process that would flag any activity detrimental to the provision of integrated care.		Alan Sheward Mark Pugh

Z2 - TDA Accountability Framework - FT Milestones

Appendix - 1(c)

	Milestone (all including those delivered)	Milestone date	Performance	Comment where milestones are not delivered or where a risk to delivery has been identified
1	Quality Governance Framework score at 2.5	30-Jun-13	Complete	
2	Draft IBP/LTFM Submission	30-Nov-13	Complete	
4	Chief Inspector of Hospitals visit	03-Jun-14	On target	
5	Final IBP/LTFM Submission	20-Jun-14	On target	
6	TDA Quality Summit	06-Aug-14	On target	
7	Board to Board meeting with TDA	early Sep 2014	On target	
8	TDA approval to proceed and application to Monitor	18-Sep-14	On target	

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 APRIL 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 April 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 2013/14 BAF document was approved by Board in August 2013, 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 are no Principal Risks now rated as Red; 6 new Risks have been added since the March 2014 report; 4 Risks with reduced scores, one of which has since been removed from the Register; and 1 Risk with an increased score.

The exception report details THREE recommended changes to the Board Assurance RAG ratings of Principal Risks: changes from Amber to Green for 3.3, 5.7 and 9.12.

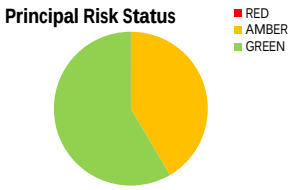
For following sections – please indicate as appropriate:

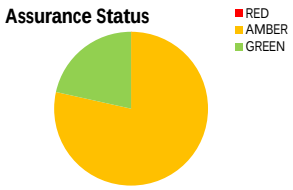
Trust Goal *(see key)*	All five goals					
Critical Success Factors *(see key)*	All Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	All Principal Risks					
Assurance Level ***(shown on BAF)***	Red	X	Amber	X	Green	X
Legal implications, regulatory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

Date: 22 April 2014 **Completed by: Brian Johnston**

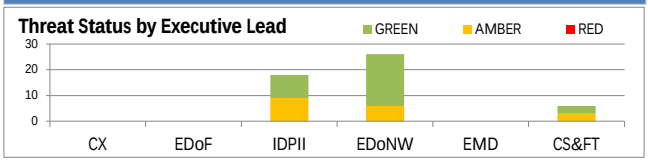
BAF Status Report

Isle of Wight NHS Trust

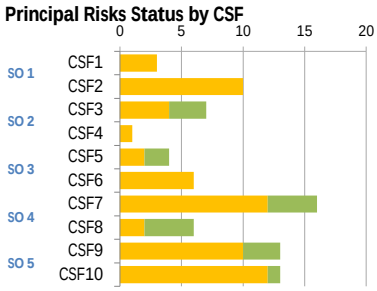


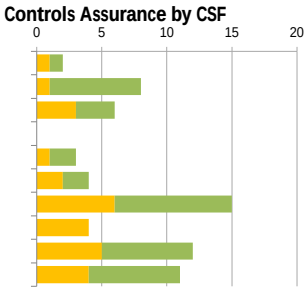


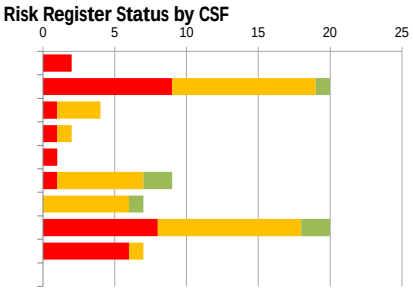
Principal Risks:	79	Aligned Risk Register Risks:	75



Strategic Objective & Critical Success Factor Status Overview







BAF
Increased Scores

0

Reduced Scores

3

Commentary

Principal Risks:

3 Principal Risks are recommended for change from Amber to Green

6 **New Risks, one of which is rated Red:**

Ref.	Directorate	Title
601	Planned	Theatres walls & floor refurbishment
602	Acute	Ambulance Service staffing of 'Stockers & Washers'
603	Community	Physiotherapy staffing issues in Community Rehab & Laidlaw Outpatient
604	Corporate	Failure to achieve CIP in 2014/15
605	Corporate	Risk of any qualified Provider
606	Corporate	Diseconomies Support/Local Modification to Tariff not achieved

Changes to previously notified Risk scores since the last report:

365, 491 & 584 Changes from Red to Amber
512 Change from Amber to Red
542 Change from Amber to Green

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
CSF3.3	IDPII	3.3 (9.13) There is no mention of the values of the organisation (O12) Chief Executive	Amber	Green
CSF5.7	IDPII	5.7 (8.5) There is a history of insufficient planning, or plans causing performance exceptions. (Q37) Executive Medical Director/ Executive Director of Nursing and Workforce	Amber	Green
CSF9.12	EDoNW; EMD	9.12 (3.7) Implementing workforce elements of the Business Plan Executive Director of Nursing and Workforce	Amber	Green
CSF8 365 - 1	EMD	DATA QUALITY / DATA RECORDING / SWIFT INFORMATION SYSTEM	16	12
CSF8 491 - 1	EMD	FAILING PIT SYSTEM	16	12
CSF8 584 - 1	EMD	PARIS COMMUNITY INFORMATION SYSTEM	16	12
CSF2 542 - 1	EMD	REHAB/SUPPORTIVE CARE KITCHEN IN STATE OF DISREPAIR	15	6
CSF4 512 - 1	EMD	MENTAL HEALTH PAYMENT BY RESULTS / CMHS REDESIGN / HEALTH & SOCIAL CARE INTEGRATION	12	16
CSF7 604 - 1	EDF	FAILURE TO ACHIEVE COST IMPROVEMENT PROGRAMME	16	16

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 committee: Trust Executive Committee
Principal Objective 2: CLINICAL STRATEGY - To deliver the Trusts clinical strategy, integrating service delivery within our organisation and with our partners, and providing services locally wherever clinically appropriate and cost effective **Exec Sponsor: Executive Medical Director**										
Critical success factor CSF3 **Lead: Interim Director of Planning, IT and Integration/ Executive Medical Director/ Executive Director of Nursing and Workforce** **Continuously develop and successfully implement our Business Plan** Links to CQC Regulations: 10, 22					MEASURES: **Integrated Trust Business plan** **Directorate business plans** **Directorates delivery of Value Improvement Programmes** **National key performance targets**				TARGETS: **Integrated Trust Business Plan approved by February 2014** **Clinical Directorate Business Plans agreed by April 2014/Corporate Enabler (IM&T/Estate/PIDS) Business Plans agreed by May 2013** **Meeting NHS outcomes framework plans by the year end**	
3.3 *(9.13)* There is no mention of the values of the organisation (O12) Chief Executive	**5**	**5**	**5**	Quality Care for everyone, every time Business plan states objectives Values of the organisation added into Strategy section within IBP	Trust Executive Committee		**Green**	Vision statement needs to be aligned to a defined set of agreed values		Take action to confirm our values and align these to the vision statement **Andy Heyes/Mark Price/Martin Robinson** Update February 2013: T.Hart culture project underway Update July 2013: NHS Constitution values taken to June 2013 Board and will be included in November refresh of IBP Update December 2013: Updated vision and values included in latest IBP submission. Update March 2014: Latest values to be inserted in IBP (Martin Robinson leading). Final submission of IBP will be approved in May 14 for June 14 submission. **Update April 2014: (MR)** New IBP draft version has had new values of the organisation added into Strategy section. Suggested ammendment also made to MP re: clinical strategy. **Recommend change of assurance rating to Green** **Review date: July 2014**
Principal Objective 3: RESILIENCE - To build the resilience of our services and organisation, through partnerships within the NHS, with social care and with the private sector **Exec Sponsor: Chief Executive**										
Critical success factor CSF5 **Lead: Interim Director of Planning, IT and Integration** **Demonstrate robust linkages with our NHS partners, the local authority, the third sector and commercial entities for the clear benefit of our patients** **Links to CQC Regulations:**					MEASURES: **Enhanced procurement service with Solent Supplies** **Volunteer working performance** **IWC working partnership performance** **EMH partnership performance** **CCG partnership performance** **Commercial Business team performance** **PHT / UHS partnership performance**				TARGETS: **Partnerships contributing £250K savings** **Further evidence of clinical influence on non-pay spend by March 14** **Pathology Consortia proceeding to plan** **All formal partnerships to have agreed terms of reference, joint objectives and shared risk registers** **All key partnerships meet their stated objectives and terms of reference**	
5.7 *(8.5)* There is a history of insufficient planning, or plans causing performance exceptions. (Q37) Executive Medical Director/ Executive Director of Nursing and Workforce	**4**	**4**	**4**	The Board is assured of the organisation's performance via the Performance Report and high-level RAG rating of performance. The organisation has demonstrated a consistently good level of performance in the past 12 months across most of its key indicators and targets. Demand Plans are set with commissioners and matched to capacity plans to identify potential areas to be addressed. There is a systematic system for undertaking Market Analysis Board ensures that key information is assimilated into key aspects of strategy Annual business planning signed off via IBP steering group. Directorate Business plans presented to Board March 2014	Performance Reviews, Board COO reports, Demand & Capacity Plan and SLA contract monitoring	Board Performance Report, Performance Dashboards, Monthly SLA reviews Directorate Business plans presented to Board March 2014	**Green**			Market analysis and competitor assessment required Update: An annual business planning cycle aligned to IBP to be developed - work in progress. **Action complete** **Karen Baker/Andy Heyes** Update December 2012: Proposed template to Exec. Directors in November 12 and to Directorates in December 12. Update January 2013: Business plan template for 13/14 issued. Business Plan meetings with CDs and ADs. Plans to Exec. Board and summary plan to Trust Board in March 2013 Update March 2013: Clinical directorate presenting their plans on 13th March and non-clinical directorates on 15th March. Action complete Change of assurance rating to Green approved March 2013 Update January 2014: (AS) Need to establish when directorates will present their business plans. **Change of assurance rating from Green to Amber approved January 2014** Update February 2014: Annual business planning signed off via IBP steering group. Directorate business plans enable presentation of directorate plans. **Update April 2014:** Directorate Business plans presented to Board March 2014. **Action complete** **Recommend change of assurance rating to Green**

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committee: Trust Executive Committee
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**										
Critical success factor CSF9 **Leads: Executive Director of Nursing and Workforce, Executive Medical Director** **Redesign our workforce so people of the right skills and capabilities are in the right places to deliver high quality patient care** Links to CQC Regulations: 15, 22, 24					MEASURES: **Workforce productivity measures including:** **Staff Turnover** **Occupational Health** **Relationship with Staff partnership Forum** **Redundancy rate reduced** **Increased opportunity for internal deployment**			TARGETS: **5 year workforce plan complete by September 2013. Recruitment strategy complete by October 2013. Trust job descriptions updated by March 2014. Workforce costs reduced by 5% (120 posts) by 31/3/14** **- Locum spend reduced by 10% by 31/3/14** **- Sickness rates under 3% by 31/3/14** **- Mandatory training compliance over 80% by 31/3/14** **- Benchmarking with peers especially around performance report**		
9.12 *(3.7)* Implementing workforce elements of the Business Plan Executive Director of Nursing and Workforce	**5**	**5**	**6**	Monthly Performance Reviews QIPP work streams Finance Plan Workforce strategy completed and agreed Chapter 8 of IBP includes 5 year workforce plan Transformational Scheme	Executive Board - monthly review	Monthly performance reports to Board	**Green**			Plan in place for formal workforce reduction scheme (if required) Finalise draft plan and implement **Alan Sheward** Update November 2012: Chapter 8/workforce strategy completed. Subject to feedback the strategy will be on the agenda for board approval on 28th November. Change of assurance rating to Green approved January 2013 Update October 2013: action plan to follow **Change of assurance rating from Green to Amber approved October 2013** Update November 2013: More robust workforce reports required. Setting up programme of workforce intelligence . Update January 2014: Assurance remains at Amber pending roll out plan. Transformation review of schemes. Update March 2014: Revised workplan commenced. **Update April 2014:** Transformational scheme to deliver. **Action complete** **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
601		PLANND	QCE	27/03/14	31/08/14	Theatre walls & floor refurbishment required to address potential infection control risk	DCOLL	* Repair to recovery floor * Repair to walls and floor theatre 1 * Repair to walls and floor theatre 2	9	9	LOW	Infection control audit undertaken to reduce risks Floor repairs discussed and agreed for recovery over weekend period Need to plan closure of each theatre for one week, with impact on operating	A	27.03.14 Approved by RMC members via voting buttons circulated 20.03.14.	Planned closure of theatre 2 one week; Planned closure of theatre 1 one week; Recovery floor repair weekend completion planned when weekend working ended.	EDONW
602		ACUTE	PATSAF	27/03/14	30/06/14	AMBULANCE SERVICE - VEHICLE "STOCKERS & WASHERS"	DCOLL	Hotel Services employs 5 (five) staff as Ambulance Service Vehicle "Stockers & Washers" * Those five staff operate a rota system, but if one is on annual leave or sick they are often not replaced with a suitably trained substitute * If a substitute is sent: 1. They are not assessed as able to drive our vehicles - essential for the role 2. They are not trained in the stocking process - critical for safe service delivery * We are not aware of when staff will or will not be working, as we do not line manage them	12	12	MOD	* Only control method in place is to report absence of staff to their Line Manager, and submit a Datix form. * We have no control of substitute staff that are sent	A	27.03.14 Approved by RMC members via voting button circulated on 20.03.14. Reviewed RB (31/03/14) Staff to transfer line management responsibility to Ambulance early April - to review if budgets require transfer after 3 months.	Transfer 5 x staff from Hotel Services to Ambulance Service allowing direct line management, and official training; A Datix form to be submitted for every time a member of the team is absent, or a non-suitable substitute is sent.	EDONW
603		COMMH	PATSAF	04/04/14	31/05/14	STAFF ISSUES RELATING TO PHYSIOTHERAPY AVAILABILITY IN COMMUNITY REHAB & LAIDLAW OUTPATIENTS	NT	* Physio vacancy F/T Band 6 * Physio maternity leave vacancy * Unable to recruit Locum cover with appropriate clinical skills/experience of rehabilitation.	12	12	MOD	* Paperwork for Band 6 recruitment completed. Awaiting post to go to advert. * Expressions of interest for secondment opportunity for x 2 Band 6 Physios circulated. These can be backfilled with bank Band 5 physios. * Flexible working across teams optimised. * Guidance on prioritisation and realistic workloads given to staff members to reduce stress levels.	A	04.04.14 Approved by RMC via voting button on 27.03.14.	Band 6 due to return from maternity leave; Recruitment of x1 FTE Band 6 to vacant post; Determine options for addressing backlog of patients; Second 2 Band 6 physios.	EMD
604		CORPRI	GOVCOM	17/04/14	31/03/15	FAILURE TO ACHIEVE COST IMPROVEMENT PROGRAMME	CP	Insufficient CIP schemes to achieve financial surplus whilst maintaining or improving quality. Insufficient Recurrent CIP schemes leading to future year impact Inefficient service delivery making services unaffordable compared to funding received.	16	16	HIGH	Quince system introduced to provide closer monitoring Transformation Management Office Scrutiny by Finance Investment and Workforce Committee Weekly financial deep dives to monitor performance			Provide reports by high level scheme to FIWC and Transformation and Quality Improvement Board/TEC; Pursue enhanced Transformation Management Office monitoring and Governance reporting structure under Director of ICT.	EDF
605		CORPRI		17/04/14		ANY QUALIFIED PROVIDER RISK (POLICY DRIVEN)	CP	Indiscriminate loss of business to another provider. Issue of "cherry picking" easiest cases leaving us with complex cases with decrease in revenue - we could become unviable. Increased use of tendering causing loss of contribution and therefore making remaining services unaffordable due to diseconomies of scale.	12	12	MOD	3 year contract for services signed with Isle of Wight CCG from 14/15 NHSE contract finalised for 14/15			Work with Commissioners re services which may be tendered well ina dvance to enable appropriate response via EDTI; Horizon scanning for service opportunity by EDTI; Delivery of Quality services to mitigate requirements to go out to tender.	

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
606		CORPRI		17/04/14		DISECONOMIES SUPPORT/LOCAL MODIFICATION TO TARIFF	CP	Future financial risk if Diseconomies Support/Local Modification to Tariff/Local Price Variance not achieved and contained within future pricing mechanisms	12	12	MOD	Financial Framework Agreement with IOW CCG incorporating Diseconomies Support NHSE contract agreed including Island Premium			Continued work towards Local Modification to Tariff via Monitor regime with CCG *Continued pursuance of the IOWCCG/IOWNHST/IOWLA ; Vision for co-ordinated Care and Funding.	IDPII

Key for Assurance Level for Risk Register Entries: GREEN - A adequate controls; AMBER - I inadequate controls; RED - U uncontrolled risks

CHANGED RISK RATINGS SINCE 17.03.2014

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
365	RA	COMMH	GOVCOM	14/08/09	30/09/14	DATA QUALITY / DATA RECORDING / SWIFT INFORMATION SYSTEM	NT	* Clinical risks to patients * failure to meet contracting requirements * financial penalty	16	12	MOD	* Manual data collection. * Snap audits.	A	31.07.13 Data Exchange Agreement has been developed and is awaiting formal sign off. The Paris 'go live' date for the CMHT has been delayed due to data migration failure. 'Go live' will be rescheduled when interface is in place. SN. 30.08.13 Awaiting confirmation of 'go live' date for CMHS. Expected to be mid September 2013. Data Exchange Agreement has been signed by the LA and is now awaiting Trust sign off. SN. 30.09.13 Go Live date not yet confirmed but anticipated to be mid October 2013. SN. 08.04.14 All Community Mental Health Inpatient Services and Inpatient Areas now using Paris. Work ongoing to ensure complete data and to develop reports to meet SLA local and national requirements. Working on 'read only' access to SWIFT for Mental Health staff. SN.	13 areas of work now completed	EMD
491	IR	COMMH	PATSAF	21/12/11	30/06/14	FAILING PIT SYSTEM	NT	* Staff/patient safety risk. * Finance required to replace system. * Current technology relies on line of sight.	20	12	MOD	* Battery operated personal alarms have been distributed. * Security Nurse tests each PIT Alarm each morning. * Should there be a failure the further tests are carried out on the specific area with support from the Estates Department.	A	18.10.13 update from RJ. end of December 13 deadline for new software to be loaded and tested. 31.12.13 Project 75% complete. 12 further wireless nodes to be installed at Sevenacres. Business Case to be developed to secure funding for additional costs. SN. 28.02.14 Integration works expected to commence week commencing 17 March 2014 for a period of two to three days. System should then be up and running and will run parallel with the old system for one week to identify snagging. SN. 31.03.14 Works are currently ongoing to install the remaining antennae necessary to ensure full coverage for the new system - additional loft access is required to enable Navigate to complete the installation works. Loft hatches have been ordered and we are awaiting delivery. Antennae installation expected to be complete by 27th March. Ascom and Pinpoint scheduled to be on site 31st March - 2nd April to complete integration works, commission and test the new system. The new system will run alongside the existing system for approximately one week to enable "soak testing" and for any issues to be identified/resolved. SN. 08.04.14 Integration works carried out as planned. Successful commissioning of system and test period ongoing. No issues to date. SN.	4 areas of work now completed	EMD
584	IR	COMMH	QCE	04/09/13	30/06/14	PARIS COMMUNITY INFORMATION SYSTEM	NT	* Child Health unable to submit Newborn Blood Screening KPI returns to NHS England * LA staff unable to access Paris which places joint working at risk	16	12	MOD	* Working towards integration with PAS to download NN4B into Paris * Discussions ongoing between LA and Trust regarding LA accessing Paris	A	04.09.13 Approved by RMC team via Voting buttons on email on 03.09.13. 30.09.13 School Nurse scheduling on target for deadline. Mental Health Community going live within the next few weeks. LD & CAMHS due to start within the next two weeks. JCD. 31.03.14 All services scoped for Paris. SALT will reach 'go live' by May 2014 with the other services going live by 30 June 2014. JCD.	5 areas of work now completed	EMD
542	INTAUD	COMMH	PATSAF	24/10/12	30/06/14	REHAB/SUPPORTIVE CARE KITCHEN IN STATE OF DISREPAIR	NT	* Failure to achieve compliance with infection control requirements. * Failure to comply with H&S standards	15	6	LOW	* Ensure cleanliness measures are strictly upheld. * Water heater now repaired.	A	31.07.13 No further update at this stage. NM. 30.08.13 Still awaiting final North Hospital Redesign. NME. 30.09.13. Still awaiting North Hospital re-design. NME. 28.02.14 No further update. NME. 08.04.14 Works to kitchen now completed.	6 areas of work now completed	EMD
512	RA	COMMH	QCE	17/08/12	31/03/15	MENTAL HEALTH PAYMENT BY RESULTS / CMHS REDESIGN / HEALTH & SOCIAL CARE INTEGRATION	NT	* No Finance and Contracts support as both Managers on secondment. Awaiting replacements. * Delay in Capita recommendations to produce an Action Plan currently sitting with CCG. * Additional staff required to produce data on schedule. * Reduction in service provision. * Redundancy/ displacement risks.	12	16	HIGH	* Project manager in place * Project plan in place * meetings with commissioners and SHA	I	31.07.13 DOH 88 steps from new guidance is now the Action Plan for 2013-2014. CAPITA has been agreed by Execs and Commissioners to carry out an indepth report on PbR. Funding by Commissioners agreed to extend PIDS/Finance support for 2013-2014. LK. 30.08.13 CAPITA are now auditing patient files and talking with clinicians as part of the Project. Paris CMHS 'go live' date has been delayed until mid September 2013 which could be a risk to the project. LK. 30.09.13 Paris CMHS 'go live' has been further delayed. CAPITA and RES Consortium final reports for CCG available later November 2013. Local tariffs continue to be built for March 2014. LK. 31.03.14 No Finance Manager involved with the project at present due to secondment and soon to lose the Contracts Manager to secondment who both have a wealth of experience of PbR. Capita project now expanded to LD, IAPT and CCAMHS. Await recommendations to provide an Action Plan to Execs in May 2014. LK.	6 areas of work outstanding and 2 completed	EMD

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 30th April 2014

Title	Isle of Wight NHS Trust – Interests,Gifts, Hospitality, Sponsorship and Bribery Act Policy			
Sponsoring Executive Director	Company Secretary			
Author(s)	Head of Corporate Governance and Risk Management			
Purpose	For Trust Board to review and agree above Policy			
Action required by the Board:	**Receive**		**Approve**	√

Previously considered by (state date):			
Trust Executive Committee	28/04/14	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 15/04/2014 Trust Executive Committee 28/04/2014		

Staff, stakeholder, patient and public engagement:

N/A

Executive Summary:

The Trust Board are requested to review and approve changes to the Interests, Gifts, Hospitality, Sponsorship and Bribery Act Hospitality Policy

Main changes – section 3.1 updated by Local Counter Fraud Specialist

- Section 3.12 extended to include additional guidance regarding declarations of interest
- Some responsibilities for aspects of the policy transferred to the Company Secretary
- General updating of job titles and committee names

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	N/A					
Critical Success Factors *(see key)*	N/A					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	N/A					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	Statutory requirement for this policy to be regularly updated and approved by the Board					

Date: **16.04.14** **Completed by:** **Brian Johnston**

Interests, Gifts, Hospitality, Sponsorship and Bribery Act Policy

Document Author	Authorised Signature
Written By: Brian Johnston **Signed:** **Date:** March 2014	**Authorised By:** Danny Fisher **Signed:** **Date:** 30th April 2014
Job Title: Head of Corporate Governance & Risk Management	**Job Title:** Chairman
Policy Lead Director: Mark Price **Job Title:** Company Secretary	
Effective Date: 1st May 2014	**Review Date:** April 2016
Approval at: Trust Board	**Date Approved:** 30th April 2014

Version Control History

Version:	Date:	Author:	Status:	Comment:
1.0	02.11.11		Approved	Provider Board
2.0	01.03.12		Approved 4/4/12	IW NHS Trust Board
2.1	April 2014		Agreement	Risk Management Committee
2.1	April 2014		Agreement	Trust Executive Committee
3.0	April 2014		Approval	IOW NHS Trust Board

NB This Policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust.

CONTENTS PAGE

APPENDICES

1. INTRODUCTION

The Trust aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all Trust transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the organisation will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

As a public body, the organisation has a duty to ensure fairness and honesty in its relationships with suppliers, contractors, service providers and service users. All employees and others acting on behalf of the Trust must uphold the highest standards of business conduct within such relationships.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

This policy covers all business activities of the Trust and all employees or others acting on behalf of the Trust. This policy provides guidance and advice on the offer and or receipt of gifts, hospitality, sponsorship, or the provision of gifts, hospitality or sponsorship to others in connection with business activities. It also provides guidance on the application of the Bribery Act 2010 and declarations of interests to be made by employees.

This policy applies to the following:

- All staff employed by the Trust
- Agency staff
- Independent contractors and/or other departments/staff providing services to the Trust via a contracted arrangement or Service Level Agreement.
- Staff on honorary contracts whose payroll costs are partially or fully funded by a third party under a formal arrangement
- Trainee professionals and students hosted by the organisation for the provision of work or vocational experience

2. DEFINITIONS

The following terms are used in this document:

Hospitality

Hospitality includes, for example, offers of food, refreshments, transport, accommodation and the use of facilities, equipment or services.

Gifts

Gifts include, for example, offers of cash or cash equivalents (e.g. gift vouchers or lottery tickets) and non cash gifts e.g. pens, diaries, wine and spirits, food products, electrical goods offered by suppliers, contractors service users or their relatives.

Sponsorship

Events for which sponsorship is received from any non NHS source or events organised by other parties which are sponsored by the Trust.

Bribery

The "Compact Oxford English Dictionary" defines "to bribe" as to "dishonesty persuade (someone) to act in one's favour by paying them or giving other inducement". Bribery is further defined under the Bribery Act 2010 and any reference to bribery in this document relates to offences under that enactment.

Interests

Interests include, for example, commercial interests, shareholdings, partnerships, consultancies', education, other NHS work, outside employment, directorships or political affinities which may be deemed to be a conflict of interest or detrimental to the NHS or to the Trust.

These lists are not exhaustive and necessary clarification should be sought from the Corporate Governance & Risk Management Department.

3. PROCEDURES AND GUIDELINES

The intention of this policy is to outline the behaviours required to maintain the highest standards of probity and provide assurance that any relationships entered into lead to a clear benefit for the Trust and represent value for money.

This policy is also intended to contribute to maintaining the highest standards of business conduct and ensure compliance with the seven principles of public life drawn up by the Nolan Committee (see appendix 1).

All employees and others acting on behalf of the Trust must apply the following principles:

- Not accepting gifts, hospitality or benefits of any kind from a third party which might be perceived as compromising their personal judgement or integrity

- Not using their official position to further their private interests or those of others
- Declaring any relevant private interests relating to their work with the Trust.
- Base all procurement decisions and negotiations of contracts solely on achieving best value for money for the tax payer
- Always referring to their line manager when faced with a situation for which there is no adequate guidance
- If in any doubt, seeking advice from the appropriate Executive Director / Associate Director or The Corporate Governance & Risk Management Department.

3.1 Legal and statutory responsibilities

The Bribery Act 2010

The Bribery Act became effective as of the 1st of July 2011 and encompasses many practices not previously covered by legislation. The Act expects a significant level of care to be exercised when considering, for example, the acceptance of gifts or hospitality.

The Basic Offences are as follows.

Under the Act a person would be guilty if they:

- Offered
- Promised
- Gave

a financial or other advantage to another person to induce them to;

- perform a function or activity improperly,

or

- to reward that person or another person for such activity furthermore;

A person would be guilty of bribery if they

- Requested
- Agreed to receive
- Accepted

a financial or other advantage intending that a function or activity should be performed improperly, or
undertakes the activity above as a reward for himself or another for improper performance of a relevant function or activity
or
in anticipation of or in consequence of a person requesting, agreeing to receive or accepting a financial reward or other advantage, a function or activity is performed improperly.

The Act also introduced a new corporate criminal offence which places a burden of proof on Trusts to show they have adequate procedures in place to prevent bribery.

The Corporate Offence
A commercial organisation (includes NHS Trusts) is guilty of an offence if an 'associated person' carries out an act of bribery in connection with its business, (an associated person could include an employee, subsidiary, intermediary or supplier.

The Corporate Defence
To avoid liability the trust has to ensure that it has in place adequate procedures (policies etc) designed to prevent persons associated with it from undertaking bribery.

In setting out the requirements of this policy the Board is publically declaring a zero tolerance of bribery.

(For additional information re the implication of the Bribery Act refer to the Trust Counter Fraud and Corruption Policy and Reporting Procedure)

3.2 Hospitality – offered or received by the organisation, its employees or others acting on its behalf (see appendix 2 for examples)

3.2.1 The Trust or individual receiving the hospitality should never put themselves in a position where there could be any suspicion that their business decisions could have been influenced by accepting hospitality from others.

3.2.2 There is a need to distinguish between simple, low cost hospitality of a conventional type, for example, a working lunch or evening meal compared with more expensive and elaborate hospitality. There is clearly a need for a sense of balance. Modest hospitality is an accepted courtesy of a business relationship. As a general principle, the frequency and/or scale of any hospitality accepted should not be significantly greater than what the Trust would normally provide for others in similar circumstances. There is concern that acceptance of frequent, regular or annual invitations to events or functions, particularly from the same source and where a considerable degree of hospitality is involved, may severely test the principles stated earlier and should be refused. However, there may be instances where staff receive invitations to events run by voluntary organisations such as annual conferences or dinners. Attendance at such events is considered an integral element in building and maintaining relationships with these sectors and any hospitality received is likely to be reasonable and proportionate, and therefore acceptable.

3.2.3 The offer and/or acceptance of hospitality which goes beyond simple low cost or conventional type refreshments provided at meetings should be recorded in the gifts, hospitality and sponsorship register.

3.2.4 The main point is that in accepting hospitality, staff need to be aware of, and guard against, the dangers of misrepresentation or perception of favouritism. It is easier to justify meetings which relate directly to work, but where these happen outside working hours and on purely social occasions then they need to be justified as not being a personal gift or benefit. Where a contract is being negotiated, hospitality of any kind, including attendance of staff at seasonal events hosted by suppliers or contractors, should not be accepted.

3.3 Hospitality offered by the organisation to others

This would be in circumstances where hospitality is provided to other organisations. The use of the Trust funds for hospitality should be carefully considered. All expenditure on these items should be capable of justification to both internal and external auditors as reasonable in the light of accepted practice in the public sector. Any hospitality provided would need to be recorded in the gifts, hospitality and sponsorship register.

3.4 Gifts – cash or cash equivalents (see appendix 2 for examples)

Offers of cash or cash equivalents made by suppliers, contractors, patients or their relatives to employees or individuals acting on behalf of the Trust should be declined. Instead, the supplier, contractor, service user or relative should be made aware of the charitable fund to receive cash donations for general or specific purposes. Details of charitable funds are available from the Finance Department on extension 6593.

3.5 Non cash gifts (see appendix 2 for examples)

Gifts of a small or inexpensive nature such as calendars, pens or diaries or other simple or inexpensive items such as flowers and chocolates can be accepted but should be declared. This type of gift can be easily distinguishable from more expensive or substantial items which cannot on any account be accepted. These should be firmly but politely declined. If there is any doubt as to whether the acceptance of such an item is appropriate, the matter should be referred to your Line Manager or relevant Director (see also paragraph 3.11.2).

3.6 Exceptional cases

It is recognised that there are exceptional cases where refusal of a gift will clearly offend a donor, cause embarrassment or appear discourteous. In these cases the donor should be advised that the permission of management will have to be sought as to whether or not the gift can be accepted. The relevant director should be asked to decide whether to:

- Allow the recipient to accept the gift

- Return the gift to the donor with a suitably worded letter explaining why the gift cannot be accepted

If it is decided that the gift should be accepted then this will need to be declared using the appropriate declaration form (see appendix 3).
For further advice contact either the Head of Corporate Governance and Risk Management or the organisations Local Counter Fraud Specialist.

3.7 Sponsorship

3.7.1 Where the organisation organises seminars, conferences etc for which sponsorship is received from any non-NHS source, the organiser of the event must record details of the sponsorship received (including the date and title of the event, the name of the sponsoring organisation and the nature and extent of sponsorship received) in the gifts, hospitality and sponsorship register. Where there is any possibility of an impression being created of improper influence on policies or decision making, an Executive or Associate Director must be consulted.

3.7.2 There is a clear approach in relation to potential pharmaceutical industry partners. The aim is to enable the creation of ongoing relationships with the pharmaceutical industry that:

- Benefit the local population by improving and maintaining the quality of healthcare

- Develop education, training and service opportunities for local healthcare professionals

- Are transparent and open to public scrutiny and challenge

- Meet the highest standards of financial, professional and ethical probity

Any such sponsored events must be agreed by the relevant director and recorded in the gifts, hospitality and sponsorship register.

For further information refer to The ABPI Code of Professional Conduct relating to hospitality from the pharmaceutical industry.

3.8 Lectures, conferences and broadcasts

Where gifts by the way of fees, *ex gratia* payments or book tokens or gift vouchers for lectures, broadcasts or similar occurrences are offered, their acceptance should be based on how much of the preparatory work for the event was done in the employee's own time, how much in official working time and the extent to which the resources, other than for example, use of an officially issued laptop at home, were used in the preparation. The guiding principle would be to seek to recover the costs

of publicly funded resources used for any non-NHS related events. The following illustrations are by way of example:

- If the preparation was carried out entirely in the individual's own time (for example outside fixed sessional commitments for medical or other clinical staff) and the event took place in the individual's own time at no expense to the Trust, it would be acceptable for the individual to retain the whole fee, token or other gift and observe appropriate inland revenue guidelines

- If the preparation was performed wholly in work time, with the use of work related resources, the Executive Director of Finance or a Senior Finance Manager should be consulted to determine the need to charge the organisation or body a fee based on the salary costs of the individual and or the use of resources. If the event is carried out in the individual's own time then in addition to any charge for the use of resources, the individual may retain any fee, token or other gift for presenting at the event. It is the employee's responsibility to declare any taxable benefits received to the Inland Revenue

- If the preparation was carried out and the presentation delivered in the individual's own time but work related facilities or equipment were used, then The Executive Director of Finance or a Senior Finance Manager should be consulted to determine the need to charge the organisation or body a fee based on the use of resources. In addition to any charge for use of any work related resources, the individual may retain any fee, token or other gift for presenting at the event. If further guidance is needed in this area, the Executive Director of Finance or Assistant Director of Finance should be contacted.

3.9 Trade or discount cards

Trade or discount cards (other than those negotiated by the Trust on behalf of its staff) by which an individual might benefit from the purchase of goods or services at a reduced price are classified as gifts and should be politely declined and, if already accepted, returned to the sender.

3.10 Bribery (see also section 3.1 above)

3.10.1 Any member of staff suspected of any inappropriate activity will be reported to the Trusts Local Counter Fraud Specialist in line with The Counter Fraud and Corruption Policy and investigated under the organisations Disciplinary and Dismissal Policy. Where appropriate, staff will be prosecuted in accordance with the Bribery Act 2010.

3.10.2 On summary conviction, the penalties for these offences include a fine of up to £5,000 and (in the case of individuals) imprisonment for up to 12 months. On conviction on indictment, these penalties increase to an unlimited fine and (in the case of individuals) imprisonment for up to 10 years.

3.10.3 All members of staff have a responsibility to report any instances of bribery, or suspected bribery, as outlined in 3.10.1, to their line manager. If necessary also refer to the Trusts Raising Concerns Policy for further guidance. Staff wishing to report an offence of bribery should also refer to the Counter Fraud and Corruption Policy for further details of how the offence of bribery is committed. See also the 'frequently asked questions' section for further explanation of the bribery offence.

3.11 Gifts, hospitality and sponsorship register

3.11.1 A gifts, hospitality and sponsorship register has been established and is held by the Corporate Governance & Risk Management Department. An example register is shown in appendix 4. The register is used to record all offers of, and acceptance of, gifts, hospitality or sponsorship in accordance with this policy, whether accepted or declined.

3.11.2 It is not necessary for small, simple, low cost hospitality received e.g. tea, coffee, and buffet lunches to be recorded, nor is it necessary to record items of an advertising nature received at training courses, conferences, seminars or part of a "promotional" exercise, e.g. pens, books, folders, etc.

3.11.3 All other offers or receipts of gifts, hospitality or sponsorship, see section 3.1 to 3.7 above, need to be declared and recorded. The proforma, see appendix 3, should be completed and returned along with any other correspondence, including emails to the Corporate Governance & Risk Management Department, preferably prior to the event. The proforma can be down loaded from the intranet or obtained through the Corporate Governance & Risk Management Department.

3.11.4 Where in doubt about whether an offer or receipt of a gift, hospitality or sponsorship is acceptable, advice should be sought from the relevant director or Corporate Governance & Risk Management Department.

3.11.5Completed forms are held on file in The Risk Management office and the information provided may be disclosed if material in accordance with Department of Health requirements.

3.12 Declaration of interests by employees

The Trust needs to have in place principles and procedures for minimising, managing and registering potential conflicts of interests that could be deemed or assumed to affect the decisions made by those involved in the business of the Trust. These decisions could include awarding contracts, procurement, policy, employment and other decisions.

Staff covered by this policy should not allow their judgement or integrity to be compromised but should be, and be seen to be, honest and objective in the exercise of their duties and responsibilities.

Staff are required to declare any personal interests that may arise in connection with the business of the Trust.

A member of staff is considered to have a personal interest in a matter of Trust business as set out in Appendix 5.

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, if relevant, from the committee or sub-committee chairperson.

Following receipt of the Declaration of Interest, the nature, scale or complexity of the interest declared should be considered along with the risk that the conflict of interest may adversely influence the interests of patients, taxpayers or the Trust, to determine whether the interest is:

- Non-prejudicial to the public interest so as to allow the staff member to remain a member of the meeting and to continue to be involved in discussions regarding that element of business in which the staff member has an interest
- A prejudicial interest and whether the committee is willing to authorise the staff member to remain involved in the business on a conditional basis:
    - They shall be entitled to make representations, answer questions and give evidence, however they will be expected to leave the room as soon as they have finished making representations, giving evidence or answering questions and before any debate starts and/or
    - They shall not be entitled to cast a vote on that item of business in which they have an interest
- So significant as to be deemed as a prejudicial interest and to require the staff member to be prohibited from all discussions related to the business that gave rise to the conflict

When a declared interest ceases to be relevant, the staff member will inform the Corporate Governance & Risk Management Department so that it can be removed from the Register of Interests.

All staff, including bank staff, should read this guidance and appendix 5. Each member of staff should complete a Register of Interests Declaration annually (appendix 6) and return it, signed. All staff must ensure that a new form is completed and submitted whenever any changes or additions are required, and the form should be revised annually. The form is also available on the Intranet at: http://intranet/uploads/Corporate/pdfs/Register_of_Interests.pdf as part of the approved process. All line managers should cover the declaration of Interests requirements at staff appraisal and ensure that a copy of the completed declaration form is sent to the Trust Risk Management Department.

4. ROLES AND RESPONSIBILITIES

4.1 Trust Executive Committee

The Trust Executive Committee has delegated responsibility from the Trust Board for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such

documents. The Trust Executive Committee should also ensure that this policy is appropriately implemented and followed, as well as, reviewing any significant breaches of the policy. The Gifts, Hospitality and Declaration of Interests registers will be reviewed by The Trust Executive Committee on an annual basis.

4.2 Chief Executive

The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that the Trust meets all statutory duties in relation to this policy.

4.3 Company Secretary

The Company Secretary is the sponsoring director for this document and is responsible for ensuring that:

- The document is drafted and approved in accordance with the Policy Management policy
- The necessary training or education needs and methods required to implement this policy are identified and resourced.
- Mechanisms are in place for any serious breaches of the policy to be appropriately reviewed and investigated.

4.4 Head of Corporate Governance & Risk Management

The Head of Corporate Governance & Risk Management will:

- Identify the appropriate process for evaluation of the implementation and effectiveness of this policy
- Identify and implement revisions to this policy and liaise with the Quality Manager to arrange for superseded versions of this policy to be retained in accordance with Records Management: NHS Code of Practice (2009)
- Ensure the policy, once approved, is appropriately disseminated to staff and added to the Trusts policy database and Intranet.
- Ensure any training requirements, as identified by the Company Secretary, are appropriately implemented.

4.5 All staff

All staff, including temporary and agency staff, are responsible for:

- Compliance with the relevant processes as described in this policy. Failure to comply may result in disciplinary action being taken

- Compliance specifically with the requirement to declare any interests, gifts or hospitality offered or received in accordance with this policy.

- Reporting any breaches of the policy in line with the Trusts incident policy and Whistleblowing procedures.

- Attending any training / awareness sessions as and when provided

5. DISSEMINATION

This policy will be made available to all Staff via the E-Bulletin and the organisations policy intranet page.

All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

6. TRAINING IMPLICATIONS

The corporate induction programme will be used to highlight the key areas of the policy to new staff.

Existing staff are expected to access, read and follow this policy following its approval and dissemination on the E-Bulletin.

Further anti-bribery training may be arranged following risk assessment

This Interests, Gifts, Hospitality, Sponsorship and Bribery Act Policy does not have a mandatory training requirement or any other specific training needs.

7. DOCUMENTATION

7.1 Other related Policy documents.

In accordance with our Standing Financial Instructions, we are required to maintain a register of interests and a register of gifts and hospitality. Further information, if required, can be found on the Internet/Intranet as follows:

- Standing Financial Instructions

- Standards of Business Conduct

- Code of Accounting for NHS Boards

- Counter Fraud and Corruption Policy

- Nursing and Midwifery Council Standards of Conduct, Performance & Ethics – see www.nmc-uk.org/Documents/Standards/The code

- Raising Concerns (Whistleblowing) Policy

- ABPI Code of Professional Conduct

7.2 Legislation and Statutory Requirements

Cabinet Office (2010) Bribery Act 2010. London. HMSO.

7.3 Best Practice Recommendations

Cabinet Office (1995) First Report of the Committee on Standards in Public Life. London. HMSO.

7.4 References

Department of Health (1993) HSG(93)5 Standards of Business Conduct for NHS Staff. London. DH.

Department of Health (2002) Code of Conduct for NHS Managers. London. DH.

8. MONITORING, REVIEWING AND ARCHIVING

8.1 Monitoring

The Company Secretary, as sponsoring director, will agree with the Head of Corporate Governance & Risk Management,
a method for monitoring the dissemination and implementation of this policy. Monitoring information will be reviewed, periodically, at The Trust Executive Committee and will be made available at each Audit and Corporate Risk Committee Meeting.

8.2 Review

8.2.1 The Company Secretary will ensure that the policy is reviewed in accordance with the timescale specified at the time of approval.

8.2.2 Managers or staff who become aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives that affect, or could potentially affect this policy document, should advise the sponsoring director as soon as possible, via line management arrangements. The sponsoring director will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

8.2.3 For ease of reference for reviewers or approval committees, changes should be noted in the 'document history' table on the front page of this document.

NB: If any changes / amendments are to an appendix only then approval may be given by the sponsoring director and a revised document may be issued. All reviews to the main body of the policy must always follow the original approval process.

8.3 Archiving

The Trust Quality Manager will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

Appendix 1

THE NOLAN COMMITTEE'S SEVEN PRINCIPLES OF PUBLIC LIFE

The Nolan Committee set out seven core principles inherent in the ethics of public service that should reflect the expected values and behaviour for the operation of the public sector. These 'principles of public life' have been endorsed by the Government and are set out below:

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

Appendix 2

EXAMPLES OF GIFTS AND HOSPITALITY TO BE DECLARED

The following table provides some practical examples of gifts and hospitality that should be declared for inclusion in the register. Gifts and hospitality provided under the sponsorship of research and development should be included:

Type	Examples
Alcoholic gifts	Bottle of wine or champagne
Lunches/hospitality	Drug Companies, Suppliers/Contractors, Insurance Companies, Banks
Small gifts	Stationery, chocolates, flowers, calendars, clocks
Other hospitality	Invitations by a supplier to an event, i.e. race day, football match or theatre tickets. Overseas attendance at conferences paid for by drug companies. Membership or use of a sports or leisure facility
Other gifts	Crystal glassware, M&S vouchers
Charitable funds donation	Gifts of money up to and including £5,000 may be accepted by staff without reference to the Charitable Funds Trustees. Cheques should be made payable to Isle of Wight NHS Charitable Funds and sent to the Cashiers Office
Sponsorship	Seminars, conferences etc for which sponsorship is received from any non-NHS source, details should be recorded, including the date and title of the event, the name of the sponsoring organisation and the nature and extent of sponsorship received For all gifts offered over the value of £5,000 contact the Finance Department on telephone extension 6593 for further advice and guidance.

The above list is not exhaustive. if you require further clarification regarding your particular interest please contact the Risk Administrator, Risk Office,2nd Floor GMO, St Marys Hospital on extn 2137 or 4637.

DECLARATION OF GIFTS, HOSPITALITY AND SPONSORSHIP FORM

NAME:		
DEPARTMENT:		
JOB TITLE:		
NAME OF DONOR:		
DESCRIPTION OF GIFT, HOSPITALITY OR SPONSORSHIP RECEIVED:		
DATE RECEIVED:		
VALUE OF GIFT, HOSPITALITY OR SPONSORSHIP RECEIVED:	**Under £10**	
	£10 - £50	
	Over £50	
REASON FOR GIFT, HOSPITALITY OR SPONSORSHIP:		
DETAILS OF ANY CONTRACT THE DONOR IS INTERESTED IN SECURING:		
WHETHER GIFT, HOSPITALITY OR SPONSORSHIP ACCEPTED:		
DETAILS OF ANY MANAGEMENT APPROVAL SOUGHT BEFORE ACCEPTANCE:		
OTHER: (please specify)		

Signed …… Date ……..…

Once completed, please return this form to The Risk Administrator, Risk Office, 2nd Floor GMO, St Marys Hospital, Parkhurst Road, Newport IW PO30 5TG.

GIFTS, HOSPITALITY AND SPONSORSHIP REGISTER

DECLARATIONS OF GIFTS & HOSPITALITY REGISTER													
First Name	Last Name	Department	Job Title	Name of Donor	Description	Year	Date Received	Value	Reason	Details of any contract donor is interested in	Accepted	Trust Approval	Other

EXAMPLES OF INTERESTS TO BE DECLARED

The following table provides some practical examples of interest that should be disclosed for inclusion in the register.

Type of Interest	Specific Examples
Commercial interests	A personal or family connection with a private, limited or public company e.g. work of family member connected with the organisation, supplier/personal acquaintance of company employee. Connection to a company invited to tender to supply goods or services to the Trust.
Shareholdings	Shares in a private hospital or supplier or potential supplier of the Trust
Partnerships	Links and contracts with both the public and private sectors
Consultants	Private practice
Education	School Governor, Trustee/Board member of College or University
Other NHS	Trustee/non-executive director of another Trust
Outside Employment	Trust employees must not engage in outside employment, which may conflict with their Trust work, or be detrimental to it. Staff must advise their manager if they think they may be risking a conflict of interest in this area. Activities which give rise to concern with regard to Health & Safety at work, e.g. over tiredness due to excessive hours to work, or which are likely to bring the Trust into disrepute or harm the public's confidence in the Trust and its services, will be treated as prima facie instances of conflict.
Directorships	Director of a company
Political	County Councillor
Land	Owner of land under negotiation or owner of rental accommodation
Charities	Active involvement in a charity.

The above list is not exhaustive. if you require further clarification regarding your particular interest please contact the Risk Administrator, Risk Office,2nd Floor GMO, St Marys Hospital on extn 2137 or 4637.

REGISTER OF INTERESTS DECLARATION FORM

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 organisations policies or decisions (*please delete as required).

Signed …….. Date ……

NOTES TO ALL LINE MANAGERS: This declaration should be completed as part of the annual appraisal for **ALL** staff. The form should be retained on the staff file members' personal file and **a copy sent to the Risk Administrator, Risk Office,2nd Floor GMO, St Marys Hospital** for the inclusion in the central register.

Exception Report from Board Sub Committee to Trust Board Declaration of Interest

Isle of Wight NHS
NHS Trust

Name of Sub-Committee	
Date of Meeting	

During the course of this meeting the following member declared an interest in accordance with clause 8.1.4 of the Isle of Wight NHS Trust's Standing Orders:

Extract from Isle of Wight NHS Trust's Standing Orders

8.1.4 Recording of interests in Board minutes

8.1.4.1 At the time Directors' interests are declared, they should be recorded in the Board minutes, or in the case of any Committee, in the Committee's minutes. Where interests are declared to any Committee, these should be formally reported to the Board at the earliest opportunity.

8.1.4.2 Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

Name of Committee Member	
Agenda Item	
Nature of interest: and whether: · Prejudicial, or · Non-prejudicial	
Minute No. evidencing declaration	

In line with the Trust's Interests, Gifts, Hospitality, Sponsorship and Bribery Act Policy, Section 3.12 Declaration of interests by employees extract:

"The Trust needs to have in place principles and procedures for minimising, managing and registering potential conflicts of interests that could be deemed or assumed to affect the decisions made by those involved in the business of the Trust. These decisions could include awarding contracts, procurement, policy, employment and other decisions.

Staff covered by this policy should not allow their judgement or integrity to be compromised but should be, and be seen to be, honest and objective in the exercise of their duties and responsibilities.

Staff are required to declare any personal interests that may arise in connection with the business of 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, if relevant, from the committee or sub-committee chairperson.

Following receipt of the Declaration of Interest, the nature, scale or complexity of the interest declared should be considered along with the risk that the conflict of interest may adversely influence the interests of patients, taxpayers or the Trust, to determine whether the interest is:

- *Non-prejudicial to the public interest so as to allow the staff member to remain a member of the meeting and to continue to be involved in discussions regarding that element of business in which the staff member has an interest*

- *A prejudicial interest and whether the committee is willing to authorise the staff member to remain involved in the business on a conditional basis:*
    - *They shall be entitled to make representations, answer questions and give evidence, however they will be expected to leave the room as soon as they have finished making representations, giving evidence or answering questions and before any debate starts and/or*
    - *They shall not be entitled to cast a vote on that item of business in which they have an interest*
- *So significant as to be deemed as a prejudicial interest and to require the staff member to be prohibited from all discussions related to the business that gave rise to the conflict*

When a declared interest ceases to be relevant, the staff member will inform the Corporate Governance & Risk Management Department so that it can be removed from the Register of Interests."

Please tick one of the one of the following:

a) Non-prejudicial to allow the member to continue to be involved in this item
b) A prejudicial interest and the member left the room for this item
c) A prejudicial interest with committee consent for the member to remain in the room but taking no part in the discussion or decision making process

Completed forms should be submitted with the sub-committee minutes to the Trust Board Administrator for presentation to the Trust Board.

Noted at Trust Board on ……

Minute No. ……

Forms to be sent to the Corporate Governance & Risk Management Department for retention on the Register of Interests.

DECLARATION OF INTERESTS REGISTER

DECLARATIONS OF INTEREST REGISTER															
First Name	**Last Name**	**Dept**	**Job Title**	**Partner-ships**	**Director-ships**	**Share-Holdings**	**Private Practice**	**Comm Interests**	**Interest in other Public Bodies**	**Links to other NHS**	**Owner of land / rental property**	**Charity / Voluntary**	**Outside Employ**	**Other**	**GP (for Board Members only)**

Appendix 8

IMPACT ASSESSMENT ON POLICY IMPLEMENTATION

Summary of Impact Assessment (see next page for details)

Policy Name	**Gifts, Hospitality, Sponsorship and Bribery Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**-**	**-**	**-**
Training Staff	**-**	**-**	**-**
Equipment & Provision of resources	**-**	**-**	**-**

Summary of Impact: No financial impact is expected in relation to the approval of this policy.

Risk Management Issues: The risk of the Trust being in breach of The Bribery Act 2010 will be significantly reduced through the Board approval of this policy document.

Benefits / Savings to NHS IOW:

Equality Impact Assessment

§ Has this been appropriately carried out? YES / ~~NO~~
§ Are there any reported equality issues? ~~YES~~ / 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			
Additional staffing required - by affected areas / departments:	**-**	**-**	**-**
Totals:	**-**	**-**	**-**

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Affected areas / departments		
e.g. 10 staff for 2 days	Not applicable-training will be incorporated in current Corporate Induction Programme	
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:	**N/A**
Signature & date of financial accountant:	**N/A**
Funding / costs have been agreed and are in place:	**N/A**
Signature of appropriate Executive or Associate Director:	**N/A**

IMPACT ASSESSMENT ON POLICY 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

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 – 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

NEW EQUALITY IMPACT ASSESSMENT (EqIA)

The purpose of the equality impact assessment (EqIA) process is to determine the potential or actual impact of the proposed change/policy on various groups

A completed EqIA must be attached to any new or amended policy; strategic document; or documentation where changes in practice or service are being proposed when submitted to the appropriate committee for consideration and approval.

Title:	
What are the aims of the policy?	This policy covers all business activities, employees or others acting on its behalf. The policy provides guidance and advice on the offer and/or receipt of gifts, hospitality, sponsorship, or the provision of gifts, hospitality or sponsorship to others in connection with business activities.
Why is the policy needed?	As a public body, Isle of Wight NHS Trust has a duty to ensure fairness and honesty in it's relationships with suppliers, contractors, service providers and service users. All employees and others acting on behalf of Isle of Wight NHS Trust must uphold the highest standards of business conduct within such relationships.
What will this policy achieve?	Staff awareness of the Trust requirements, in relation to, Interests, gifts, hospitality and compliance with the Bribery Act 2010.
Who will it benefit for the introduction of this policy?	All staff

Names and contact details of those responsible for completing this Equality Impact Assessment:
(document author plus an independent colleague)

Name: Brian Johnston
Job Title: Head of Corporate Governance & Risk Management
Telephone number: 534262

Date EqIA was completed:	August 2011

1.	**What is the <u>relevance</u> of this policy/procedure or change in practice on the following equality strands?**			
		High	**Medium**	**Low**
	· **Race**			ü
	· **Gender - male / female**			ü
	· **Religion and religious belief - looking at bias of many religious based stereotypes and incorrect views.**			ü
	· **Sex and sexual orientation including lesbian and bisexual people**			ü
	· **Age**			ü
	· **Disability (e.g. mobility, mental, sight, learning disabilities, speech or dyslexia)**			ü
2.	**What is the degree of differentiation this policy, procedure or change in practice affect any of the following equality strands?**			
		Differentiation is Positive (improvement)	**Stays the same**	**Differentiation is Negative (detrimental)**
	· **Race - ethnicity, tribal etc**		ü	
	· **Gender - male / female**		ü	

	· **Religion and religious belief - looking at bias of many religious based stereotypes and incorrect views.**		ü	
	· **Sex and sexual orientation including lesbian, gay and bisexual people**		ü	
	· **Age**		ü	
	· **Disability (e.g. mobility, mental, sight, learning disabilities, speech or dyslexia)**		ü	
3.	**If you have identified potential discrimination, are there any legal and / or justifiable reasons?**			
	N/A			
4.	**What action do you plan to take to reduce the areas of negative differentiation?**			
	N/A			
5.	**What alternatives are there to achieving the policy / guidance without the impact?**			
	N/A			
Approval of this policy, strategy or change in practice or service change;				
Approval Committee (where appropriate) IW NHS Trust		**Date of Approval**		

Sources of further help and guidance:

§ Local guidance document - see intranet under Quality Team
§ Member of the Quality team
§ Equality and Diversity Lead
§ Information Governance Manager
§ NHS Employers website; www.nhsemployers.com and follow the Equality and Diversity link.
§ Equality and Human Rights Commission website: www.equalityhumanrights.com

A summary of equality impact assessments will be made available to the public via the NHS IOW's intranet annually.

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th April 2014

Title	Isle of Wight NHS Trust – Statutory and Formal Roles – 2014/15			
Sponsoring Executive Director	Company Secretary			
Author(s)	Head of Corporate Governance and Risk Management			
Purpose	For Trust Board to review and agree updated schedule of Statutory and Formal Roles			
Action required by the Board:	**Receive**		**Approve**	√

Previously considered by (state date):			
Trust Executive Committee	28/04/14	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)			

Staff, stakeholder, patient and public engagement:

N/A

Executive Summary:

The Trust Board are requested to review and approve changes to the Statutory and Formal Roles

- MH Act Managers Lead – named Jessamy Baird as deputy
- Decontamination Lead – change of Post Holder – Change of Review date and name of Post holder title

Security NED Lead – deleted

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	N/A					
Critical Success Factors *(see key)*	N/A					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	N/A					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	The Trust is required to have named officers for certain statutory roles.					

Date: **16.04.14** **Completed by:** **Brian Johnston**

Isle of Wight NHS Trust – Statutory and Formal Roles - 2014/2015

Directorate	Statutory (*)/ Formal Role	Name	Job Title	Deputy/cover	Job Title	Review date (if applicable)
Corporate	Director of Infection Prevention & Control (DIPC)	**Alan Sheward**	Executive Director of Nursing and Workforce	Sarah Johnston	Deputy Director of Nursing	*Review annually
Corporate	Information Governance Registration Authorities	**Alan Sheward**	Executive Director of Nursing and Workforce	Mark Elmore	Deputy Director of Workforce	*Review annually
Corporate	Nominated Officer to Care Quality Commission (as registered provider of Services)	**Alan Sheward**	Executive Director of Nursing and Workforce	Brian Johnston	Head of Corporate Governance & Risk Management	*Review annually
Corporate	Safeguarding Adults	**Alan Sheward**	Executive Director of Nursing and Workforce	Sarah Johnston	Deputy Director of Nursing	*Review annually
Corporate	Safeguarding Children	Executive Lead **- Alan Sheward** Clinical Lead for Health Visiting & School Nursing - **Jenny Johnston** **Dr Arun Gulati** **Dr Andrew Watson** **Ann Stuart**	Executive Director of Nursing and Workforce Named Nurse for Safeguarding children Named Doctor for Safeguarding Children Named Doctor for Safeguarding Children Named Nurse / Midwife for Safeguarding children	Ann Stuart Dr Watson Dr Gulati Jenny Johnston	Named Nurse / Midwife Named Doctor for Safeguarding Children Named Doctor for Safeguarding Children Named Nurse / Midwife	*Review annually
Corporate	Counter Fraud Board Lead	**Chris Palmer**	Executive Director of Finance	Kevin Curnow	Deputy Director of Finance	*On change of post holder
Corporate	Director responsible for Information	**Chris Palmer**	Executive Director of Finance	Iain Hendey	Assistant Director of PIDS	*On change of post holder
Corporate	Decontamination Lead	**Alan Sheward**	Executive Director of Nursing and Workforce	Hilary Male	Operational Manager HSDU	*On appointment of replacement Executive Director of Transformation and Integration

Directorate	Statutory (*)/ Formal Role	Name	Job Title	Deputy/cover	Job Title	Review date (if applicable)
Corporate	Senior Information Risk Officer (SIRO)	**Mark Price**	Foundation Trust Programme Director/ Company Secretary	Chris Palmer	Executive Director of Finance	*Review annually
Corporate	Caldicott Guardian	**Mark Pugh**	Executive Medical Director	Alan Sheward	Executive Director of Nursing and Workforce.	*Review annually
Corporate	Human Tissue Act Licence Holder	**Mark Pugh**	Executive Medical Director	Dr Kamarul Jamil	Consultant Histopathologist	*On change of post holder
Corporate	Responsible Officer for Revalidation (RO)	**Mark Pugh**	Executive Medical Director	NHSE Medical Director		*On change of post holder
Corporate	Senior Independent Director (SID)	**Charles Rogers**	Non Executive Director	N/A	N/A	*Review annually
Corporate	Mental Health Act Managers Lead (Chairman of Mental Health Act Scrutiny Committee)	**Peter Taylor**	Non Executive Director	Jessamy Baird	Non Executive Director	31st March 2015
Corporate	Health & Safety Manager	**Connie Wendes**	Assistant Director Health & Safety and Security	Judy Green Martin Keightley	Principal Back Care Advisor/ Fire and Safety Manager	*On change of post holder
Corporate	Accountable Officer for the Distruction of Controlled Drugs	**Connie Wendes**	Assistant Director Health & Safety and Security	Rob Jubb	(Accountable destruction officer) Local Security Management Specialist	*On change of post holder
Corporate	Medicines Management	**Alan Sheward**	Executive Director of Nursing and Workforce	Gill Honeywell	Chief Pharmacist	*On appointment of replacement Executive Director of Transformation and Integration
Corporate	Local Counter Fraud Specialist	**Barry Eadle**	Local Counter Fraud Specialist	As notified during absence	Designated Member of CEAC	*Review annually and as part of contract award

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th April 2014

Title	Updated Quality and Clinical Performance Committee Terms of Reference			
Sponsoring Executive Director	Executive Director of Nursing and Workforce			
Author	Head of Corporate Governance and Risk Management			
Purpose	Seeking Board agreement of the revised Terms of reference for QCPC			
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	16/04/14
Finance, Investment & Workforce Committee		ICT & Integration Committee	
Foundation Trust Programme Board			
Please add any other committees below as needed			
Other (please state)			

Staff, stakeholder, patient and public engagement:

N/A

Executive Summary:

The Terms of Reference of the Quality and Clinical Performance Committee have been revised and updated. The changes were agreed at QCPC on 16th April and are now on the Board agenda for approval.

The main changes to the previous version are as follows :

- Revised ' Main Purpose ' section to strengthen the role of QCPC as an assurance committee
- Change of attendees to include Business manager for Patient Safety, Experience and Clinical Effectiveness
- Increased number of committees and working groups providing information to the QCPC to include the Infection Prevention and Control committee
- Addition of appendix 1 listing other groups who may be requested to provide information and assurance to the QCPC.

For following sections – please indicate as appropriate:			
Trust Goal *(see key)*	N/A		
Critical Success Factors *(see key)*	N/A		
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	N/A		
Assurance Level ***(shown on BAF)***	¢ Red	¢ Amber	¢ Green
Legal implications, regulatory and consultation requirements	The Trust is required to have named officers for certain statutory roles.		

Date **17th April 2014** **Completed by: Brian Johnston**

Quality & Clinical Performance Committee

Terms of Reference

Document Type:	Committee Terms of Reference
Date document valid from:	April 2014
Document review due date:	|January 2015

AUDIT TRAIL:

Dates reviewed:	January 2014	**Version number:**	V2 - 2013
Dates agreed:	March 2014	**Version number:**	V3
Details of most recent review: (*Outline main changes made to document*) .	· Update to accommodate Designate Non Executive Directors. · Updated subcommittee and working groups which report to the QCPC. . Reviewed by Head of Corporate Governance and Risk Management / Executive Director of Nursing and Workforce / Executive Medical Director		

Signature of Chairman of Committee:

Print Name: Sue Wadsworth **Post Held:** Non Executive Director **Date: 19/03/2014**

Trust Board Approval Authorised Signature	
Authorised by:	**Danny Fisher**
Signed:	
Date:	**30/04/14**
Job Title:	**Chairman of Trust**
Approved at:	**Trust Board**
Date Approved by Trust Board:	**30/04/14**

Isle of Wight NHS
NHS Trust

QUALITY AND CLINICAL PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. MAIN PURPOSE

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

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

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

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

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

2. MEMBERSHIP & QUORUM

2.1 Members

2.1.1 The Committee will consist of 9 members

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

2.1.3 The following membership will be approved by the Board

- Non Executive Director (Chair)
- Non Executive Director (Vice Chair)
- Non Executive Directors x 2 (nb the Board can determine that Designate Non-Executive Directors can become members of Board Sub-Committees)
- Executive Medical Director
- Executive Director of Nursing and Workforce
- Clinical Director of Acute Directorate (or deputy)
- Clinical Director of Planned Directorate (or deputy)
- Clinical Director of Community Health Directorate (or deputy)

2.1.4 The following will be in attendance:

- Head of Corporate Governance and Risk Management
- Quality Manager
- Deputy Director of Nursing
- Head of Clinical Services – Acute Directorate (or deputy)
- Head of Clinical Services – Planned Directorate (or deputy)
- Head of Clinical Services – Community Services Directorate (or deputy)
- Assistant Director – Performance Information and Decision Support
- Chief Pharmacist
- Business Manager - Patient Safety, Experience & Clinical Effectiveness
- Health Watch Representative

· Patient Representative

2.2 Quorum

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

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

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

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

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

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3. ATTENDANCE AT MEETINGS

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

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

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4. FREQUENCY OF MEETINGS

4.1 Meetings are to be held monthly

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5. DELEGATED AUTHORITY

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

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6. ROLES & RESPONSIBILITIES

6.1 <u>Governance & Compliance</u>

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

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

6.1.3 Maintain a constant review of clinical governance arrangements to ensure all the threads of quality, patient safety, patient experience, performance and finance are aligned and integrated.

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

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

6.1.6 Maintain a constant review of Board Performance Reports to ensure all clinical indicators showing less than optimal performance are appropriately assigned and followed up with robust action plans for improvement.

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

6.1.8 Further develop our board performance reporting to ensure reports are aligned to the data sets released by Monitor

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

6.1.10 Develop the use of exception reporting and forecasting for non-financial key performance indicators

6.1.11 Develop systems for assuring the data quality of clinical KPIs and addressing any weaknesses in this process.

6.1.12 Monitor and report on progress towards the introduction of an information quality framework that lists each KPIs, its definition, the data sets from which it is drawn and the source of assurance received that it is currently reported accurately.

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

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

6.1.15 To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity receiving reports as the committee considers necessary. Provide assurance to the Trust Board so that the Board may approve the annual governance statement.

6.1.16 Assure the implementation of all new procedures and technologies in line with Trust policy

6.1.17 Assure the Trust Board that research and development governance is implemented and monitored

6.2 <u>Quality & Clinical Effectiveness</u>

6.2.1 Ensure all statutory elements of clinical governance are adhered to and that the Board is fully briefed on any related matters of significant risk.

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

6.2.3 Receive and review monthly performance reports relating to quality, including mortality rates..

6.2.4 Receive and approve the annual clinical audit programme and monitor its implementation, including:

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

6.2.5 Review performance against CQUINS targets, Quality Account priorities and other quality standards.

6.2.6 Ensure that standards are set and monitored including (but not exclusively) NICE ; NSF's; CQC Essential Standards; NHSLA; IR(ME)R.

6.3 Patient Safety

6.3.1 Ensure implementation of the National Patient Safety Agency Reporting System (or its successor body).

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

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

6.3.3 Receive details of all clinical Serious Incident Requiring Investigation reports submitted to the SHA / CCG and approve all completed clinical SIRI investigation reports as part of the "sign off/close down" process.

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

6.3.5 Ensure that there are robust processes in place that safeguard children and adults within the Trust

6.4 Patient Experience

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

6.4.2 Receive and review quarterly reports detailing trends in clinical incidents, complaints, clinical claims and clinical effectiveness. Make recommendations for further action as appropriate.

6.4.3 Undertake a quarterly review of the Friends and Family test outcomes and make recommendations for improvements as necessary

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7. REPORTING

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

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

a) Clinical Directorate Boards
b) Clinical Directorate Quality, Risk and Patient Safety Groups
c) Infection Prevention & Control Committee

d) Joint Safeguarding Committee
e) TV & Pressure Ulcer Group

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

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8. DUTIES & ADMINISTRATION

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

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

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

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

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9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

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

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

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

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

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

Appendix 1

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

CORPORATE

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

ACUTE DIRECTORATE

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

COMMUNITY HEALTH DIRECTORATE

- Safeguarding Report Group

PLANNED DIRECTORATE

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

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FOR PRESENTATION TO PUBLIC BOARD ON 30/04/2014

ISLE OF WIGHT NHS TRUST

FOUNDATION TRUST PROGRAMME BOARD

TUESDAY 25 MARCH 2014 BETWEEN 11:00 – 12:30
LARGE MEETINGS ROOM, PCT HQ, SOUTH BLOCK

NOTES

PRESENT

Karen Baker (Chair)	Chris Palmer	Sue Wadsworth	Mark Price (MP)
Chris Palmer	Mark Pugh (MTP)	Alan Sheward (AWS)	Danny Fisher
Peter Taylor		(from 11.30hrs)	

1. APOLOGIES
Andy Heyes

IN ATTENDANCE
Andrew Shorkey Andy Hollebon (AH)

Top Key Issues	Subject
022/14	The CQC were planning for a combined inspection but uncertainty remained around an assessment of the Ambulance Service.
018/14	The timing of a Quality Governance Framework external review would be determined following the outcome of the CQC inspection to avoid incurring unnecessary expense.
022/14	43 new public members were required to meet our target of 4000 in April 2014.

ACTION

Notes and matters arising from 25 February 2013

017/14 The notes of the meeting were received and accepted as a correct record.

Action Tracker

018/14 423 – Quality Governance Framework self-assessment scoring would be undertaken by the end of the week (28 March 2014). AS would liaise with Theresa Gallard to ensure the self-assessment was re-circulated. MTP, MP and AWS would complete the self-assessment. The timing of the Quality Governance Framework external review would be determined following the outcome of the CQC inspection to avoid incurring unnecessary expense. AWS and MP would have a discussion with Sue Cordon with respect to timing. **AS** **MTP, MP, AWS** **AWS/MP**

019/14 437 – circulation of Monitor assessment requirements would be re-scheduled to 30 June 2014.

020/14 453 – agreed to amend date to 15 April 2014. **AS**

Future Timeline

020/14 MP advised that although we were targeting TDA referral to Monitor in September 2014 it was likely that we would not achieve referral to Monitor until November 2014. KB asked that Trust Board members' annual leave be logged to identify availability with respect to Board to Board meeting scheduling. MP advised that the Board Administrator had already started to gather this information. DF would also raise this matter at the Trust Board meeting on 26 March 2014. **DF**

021/14 CP stated that it would be advantageous if authorisation could be achieved from 1 April rather than in year. MP advised that this was not the way the Monitor process worked and FTs were authorised throughout the year. Our ability to influence this will be clearer later in the process.

Chief Inspector of Hospitals Visit (CQC Inspection)

022/14 MP advised that the CQC were checking on why the Trust had not yet received the formal notification letter. The CQC were planning for a combined inspection but uncertainty remained around an assessment of the Ambulance Service. For the CQC June was at present 'a long way off'. It was agreed that a letter would be sent to Bethan Graf advising that it would be a missed opportunity not to review all of the services and that we were looking forward to the preliminary visit on 24 April. This matter would also be raised with the TDA at the monthly oversight meeting. MP would brief DF with respect to the output of oversight discussions and DF would raise with Stephen Dunn on Monday 31 March 2014. There was a need to ensure that there were underlying key messages in communications with the CQC about the nature and embeddedness of integration. **MP/AS** **KB** **MP/DF**

023/14 MTP updated the group on preparations for the inspection. Fifty percent of teams had completed their internal peer inspections and the others had plans in place. Norovirus had impacted on progress and the planned feedback session required re-scheduling. SW was concerned that Directorates were not feeding back concerns to the Quality and Clinical Performance Committee. KB clarified that processes were being established as part of the project, they would be operationalised through Trust Executive Committee and FT Programme Board would provide governance and assurance.

Communications and Stakeholder Engagement

Membership Update

022/14 AH updated the Programme Board on current progress with the membership recruitment campaign. Forty-three new public members were now required to meet our target of 4000 in April 2014. AH further advised that 559 of the public membership were volunteers and that the Trust now had 2,889 staff members. Any staff leaving the Trust were being encouraged to become public members. MTP suggested that we could look into the viability of including membership forms in Walk the Wight information packs. With respect to recruitment in 2014/15, MP advised that we would be undertaking some summer events, more limited than 2013 and seeking to minimise any additional costs. There was support for this approach. **AH**

023/14 It was noted that 1 member had resigned and 1 staff member had 'opted out' to date and AH would be contacting them to understand the underlying issues that led to their resignation. **AH**

024/14 Interviews had been undertaken for the Membership Manager post and a decision was imminent.

025/14 A discussion took place in relation to the scheduling of Governor elections. It was noted that the process needed to run for 50 days and that an induction period would be required to ensure that Governors would be prepared prior to assuming their formal functions. It was agreed that this matter would be revisited following the CQC inspection in June 2014. Discussion to be scheduled for July 2014 meeting. AH advised that he would now initiate the procurement process with respect to election management in advance to ensure that we were ready to proceed when required.

026/14 AH advised that recruitment was currently being undertaken with respect to membership of the Patients Council. This was an opportunity to identify future prospective Governors.

Workstream Updates

027/14 Corporate Governance

MP advised that Board Development and Board Governance would be scheduled for a Board Seminar in May 2014.

Programme Governance and Approvals

(i) Integrated Action Plan Status Report

028/14 1 - A document would be produced to articulate arrangements in place for Board succession planning. **MP**

029/14 Actions 2, 3 and 4 would be included on the Board Seminar forward plan. **MP**

030/14 With respect to 4, partnerships, it was agreed that a report on *My life a full life* would be scheduled to go to Trust Board. DF added that we need to talk in simple terms about what we're doing to engage with stakeholders. AH advised that was completing a draft of the stakeholder engagement strategy. MTP suggested that the shared vision should be included at the front of the Trust Board papers. KB stated that it was important that we stayed focused on our achievements as well as the things that we needed to achieve. **MP** **AH** **MP**

The integrated action plan would be reviewed in greater detail at an Executive meeting in April. **MP/AS**

031/14 (ii) Risk Management

R007 relating to performance and finance would be changed to GREEN status. **AS**

032/14 (iii) Programme Budget

033/14 CP advised that costs associated with the CQC inspection would be set against the £200k allocated to the FT Programme for 2014/15. It was noted that this included additional staffing for CQC data preparation in PIDS. AS would identify the estimated cost for this work. **AS**

Feedback from FTN Events and FT Visits

034/14 SW had attended an FTN NED challenge event with Jessamy Baird and would circulate the slides when received. CP advised that EDs also needed to provide an effective challenge. SW advised that there was a consensus at the event that nationally, in general terms, EDs provided a limited challenge at present. **SW**

035/14 AWS provided detailed feedback on the FTN Quality Conference. A session on organisational culture had been run by Professor Mike West and AWS would be rolling out elements of this to his team. There were particular observations about the length of tenure of NEDs and EDs, a Board's role in supporting leadership rather than leading and the quality remit of all Board sub-committees. AWS would circulate his detailed notes. **AWS**

Any other Business

036/14 PT advised that he, SW and Charles Rogers had co-ordinated a Board sub-committee triangulation meeting and would in future be providing an update slide at Trust Board meetings.

Future Meetings

037/14 The next meeting was scheduled for 11:00-12:30hrs, Tuesday 22 April 2014, Large Meetings Room, South Block.

Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 30 APRIL 2014

Minutes of the Isle of Wight NHS Trust **Mental Health Act Scrutiny Committee** held on Wednesday 16th April 2014 in the Seminar Room, Sevenacres.

PRESENT:	**Peter Taylor**	**Chair, Non Executive Director (PT)**
	Jessamy Baird	**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)**
	Tim Higginbotham	**Service User & Carer Link Co-ordinator (SUCLC)**
	Christine Gardner	**Service User (SU)**
	Nadarasar Yoganathan	**Consultant Psychiatrist (CP)**
	Julia Coles	**Learning Disability Care Co-ordinator (LDC)**
Minuted by:	**Alison Hounslow**	**Administrator**

Key points from Minutes to be reported to the Trust Board

14/011 **Service User Involvement Policy** - There is a draft Service User Involvement Policy. There is a proposed visit to Hertfordshire NHS Trust by senior managers (although no service user) to observe their management and policy towards Service User Involvement. There will potentially be a return visit to the Isle of Wight NHS Trust. A decision about the local policy is on hold until after those visits but it would be helpful if this were in place by 3rd June.

14/012 **Care Quality Commission (CQC) - Action Statement** - The action statement arising from the visit feedback report (visit of 18th/19th December 2013) has been completed and returned to the Care Quality Commission (CQC).

Items that MML wished to highlight to the meeting were:

- The role of the Home Treatment Team and alternatives to admission - this will be achieved by clear, written guidance available for all professionals and that the Team Leader will attend the monthly Approved Mental Health Professional (AMHP) meetings which are minuted.
- Use of Section 136 of the Mental Health Act - people being detained using police powers. A new recording form has been introduced to aid monitoring and audits, in particular the mode of transport, use of force and injuries sustained.
- Involvement of carers during the admission/discharge of their relative or friend. MML will include, during mandatory training with staff, a session relating to confidentiality and information sharing. A Service User and Carer Forum has been established and is in the early stages of development.

14/013 **Mental Health Act Data for 2013/14** - The key points to note are that the use of the Mental Health Act has decreased from 414 assessments in 2012/13 to 370 for the year 2013/14. The number of Section 136 detentions has decreased from 190 to 130. This is as a result of Operation Serenity.

14/009 Apologies for Absence, Declarations of Interest and Confirmation that Meeting is Quorate

No apologies for absence were received. There were no declarations of interest. The meeting was confirmed to be quorate.

14/010 Minutes of the previous meeting - 22nd January 2014

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

14/011 Review Schedule of Actions

a) MH/002 - Audit of Section 17 leave

This has not yet been actioned due to pressure of workload. MML to discuss with CP and request a junior doctor to support. NM suggested this and other mental health audits to be included as part of the Trust clinical audit plan.
Action Note: MML to meet with CP. Report to MHASC in July meeting.
Action by MML

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

A small group of General Practitioners (GPs) are available for second recommendations for Mental Health Act assessments and will shortly be attending training to become qualified under Section 12 of the Mental Health Act. The Clinical Commissioning Group (CCG) is taking the lead on this issue. JB suggested that the lack of Section 12 qualified doctors should be put on the Trust Risk Register.
Action Note: MML to forward this matter to the Trust Risk Register.
Action by MML

c) MH/006 - Community Treatment Order Audit

This is still an outstanding issue. MML to meet with CP.
Action Note: MML to meet with CP. Report to MHASC in July meeting.
Action by MML

d) MH/010 - Service User Representative Role

The service user was present at the meeting and is keen to involve other service users in this role. Efforts are being made towards recruiting a small group of people who may be able to attend these meetings should SU be unable to. SU has made contacts with a bi-polar support group and is making efforts to contact other support groups.
This action has now been closed.

e) MH/012 - Service User Involvement Policy

There is a draft Service User Involvement Policy. There is a proposed visit to Hertfordshire NHS Trust by senior managers (although no service user) to observe their management and policy towards Service User Involvement. There will potentially be a return visit to the Isle of Wight NHS Trust. A decision about the local policy is on hold until after those visits.
Action Note: MML to report to MHASC in July meeting.

Action by MML

f) MH/014 - Operation Serenity

Operation Serenity was requested to be kept on the agenda.

This action has now been closed.

g) MH/016 - Action Statement delivered to the CQC

See Minute MH/012 below.

This action has now been closed.

h) MH/017 - Staffing levels to be reviewed

Alison Bishop has been acting Mental Health Act Manager in lieu of Elisa Stanley who is on maternity leave. As time has progressed her level of confidence has developed, and along with part time support, has been managing the workload.

This action has now been closed.

i) MH/018 - MML to undertake training with Doctors

MML confirms he has undertaken further training with Doctors in regard to the scrutiny of Mental Health Act (MHA) section papers. This is an ongoing issue.

This action has now been closed.

j) MH/019 - Extension of Operation Serenity

Sergeant Paul Jennings, lead for Operation Serenity, has made a bid to the Health and Wellbeing Board for further development of Operation Serenity.

This action has now been closed.

14/012 Care Quality Commission (CQC) - Action Statement

The action statement arising from the visit feedback report (visit of 18th/19th December 2013) has been completed and returned to the Care Quality Commission (CQC).

Items that MML wished to highlight to the meeting were:

- The role of the Home Treatment Team and alternatives to admission - this will be achieved by clear, written guidance available for all professionals and that the Team Leader will attend the monthly Approved Mental Health Professional (AMHP) meetings which are minuted.
- Use of Section 136 of the Mental Health Act - people being detained using police powers. A new recording form has been introduced to aid

monitoring and audits, in particular the mode of transport, use of force and injuries sustained.

- Involvement of carers during the admission/discharge of their relative or friend. MML will include, during mandatory training with staff, a session relating to confidentiality and information sharing. A Service User and Carer Forum has been established and is in the early stages of development.

At this point of the meeting, in relation to this third issue, SU distributed a document prepared by a carer of a patient admitted to Osborne Ward entitled 'Carers Perspective'. This is to be used for training purposes.
Action Note: Development of Service User & Carer Forum to be discussed in July meeting.

Action: SUCLC

14/013 Annual Data

a) Mental Health Act Data for 2013/14.

This data is collected from Approved Mental Health Professional (AMHP) assessment reports. An attempt was made to extract data from Paris which has not been successful and this is now with the Performance Management team to solve.

The key points to note are that the use of the Mental Health Act has decreased from 440 assessments in 2012/13 to 370 for the year 2013/14. The number of Section 136 detentions has decreased from 190 to 130. This is as a result of Operation Serenity.

There has been an increase in the number of sections and Community Treatment Orders. In recent years practice has shifted to use of Section 2 on admission with subsequent use of Section 3 when it becomes apparent treatment for a longer term is required. This is recorded as two separate sections being used, increasing the overall numbers. Patients sectioned under Section 2 of the Mental Health Act have quicker access to a tribunal as they can only be detained for 28 days. The data relating to Community Treatment Orders can be misleading as they are a relatively new section of the Mental Health Act.

An age breakdown of the data shows that patients over the age of 65 represent 20% of those assessed. 64% of assessments of the over 65 group result in an admission under section, compared to 42% of the younger age group. The reason for this is that more assessments are requested by medical staff and fewer result from Police action under section 136, which is associated with low admission numbers. It was agreed that the data should be available to the Board so that when questioned about the use of the Mental Health Act the Board was aware of the frequency with which its various sections were used and how that benchmarked to national statistics.

Data available will be distributed with these minutes (Appendix 1 - Mental Health Act Data 2013-2014).

b) The Annual Report was approved and will be sent to the Trust Board.

14/014 Audits

An audit of risk assessments undertaken as part of the Mental Health Act assessments was initiated by MML and Dr Simon Dixey. Dr Dixey audited the medical reports. This audit, due to pressure of workload, has yet to be completed and there is concern that some of the data collected may be out of date.

Action Note: MML to revisit data and complete report.

Action: MML

14/015 Scrutiny of Mental Health Act Section papers

Mental Health Act section papers are the legal authority to detain a patient. Two medical recommendations are required and should provide evidence that the criteria for detention of a patient are met. This takes the form of a handwritten report on the medical recommendation paperwork. The paperwork undergoes several levels of scrutiny: by the AMHP at the time of assessment; by the Mental Health Act Office; and by another doctor. Unfortunately, the authors of the reports have differing standards as do the scrutinising doctors. Amendments are often required causing considerable effort and delay for the Mental Health Act Office. The suggestion was made by NM to distribute anonymous (typed) copies of the reports to doctors during training for moderation purposes.

Action Note: MML to select and present anonymous reports to doctors during training.

Action: MML

14/016 Operation Serenity

The new S136 recording forms were presented to the Mental Health Act Scrutiny Committee. This form will aid monitoring and audits. MML has met with two junior doctors who are to audit S136 paperwork by looking at 20 - 30 records both before and after the introduction of the new form and comparing the data available.

SU raised her concern about how patients are transported to hospital and if this data is collected. If a patient is subject to S136, then method of transportation is recorded. However, if they are not subject to S136 then recording would be in the Approved Mental Health Professional (AMHP) assessment outcome and this data is not collected. This matter will be raised at the next AMHP meeting.

14/017 Implementation of meetings for Hospital Managers

Hospital Managers and Non Executive Directors have not met with MML for training for a year.

Action Note: MML to contact Executive Assistant to the Chairman of the Board to arrange meetings.

Action: MML

ANY OTHER BUSINESS

Peter Taylor, Chair is to leave the Trust on 6th June 2014. He has chaired the Mental Health Act Scrutiny Committee for 7 ½ years. He thanked all for

their attendance, in particular MML for his work and contribution to the Committee. In turn, MML thanked him for his work and commitment to raising awareness of the Mental Health Act Scrutiny Committee to the Board.

DATES OF NEXT MEETING

The next meeting of the Mental Health Act Scrutiny Committee is to be held on Wednesday 23rd July 2014 in the Family Therapy Room, Sevenacres.

Meeting closed at 17.00

Attachment: Appendix 1 - Mental Health Act Data 2013-2014

Glossary:	MHA	Mental Health Act
	CCG	Clinical Commissioning Group
	CTO	Community Treatment Order

REPORT ON USE OF THE MENTAL HEALTH ACT 2013-14

Mental Health Act Scrutiny Committee

April 2014

Outcome of MHA Assessments 2012/13 & 1013/14

		2012/13		2013/14	
		No.	**%**	**No.**	**%**
Total Assessments		**414**		**372**	
Outcomes	**Community**	**115**	**28%**	**113**	**30%**
	No admission	27	23%	30	27%
	Informal admission	15	13%	11	10%
	Section	73	64%	65	63%
	136 assessments	**182**	**44%**	**133**	**36%**
	No admission	112	62%	81	61%
	Informal admission	37	20%	33	25%
	Section	33	18%	18	14%
	Inpatients	**117**	**28%**	**126**	**44%**
	No Admission	3	3%	8	6%
	Section	103	88%	103	82%

Use of the Mental Health Act 2004-2014

- 2013-14 has seen the first drop in the overall use of the MHA:
  - 2005-06: 220 assessments, 273 'sections' used
  - 2012-13: 414 assessments, 497 'sections' used
  - 2013-14: 372assessments, 467* 'sections' used

(* estimate, based on first quarter)

- The year-on-year increase has been driven by increasing numbers of short-term detentions (doctors and nurses holding powers re inpatients and Police powers under section 136).
- The reduction 2013-14 results from reduced use of section 136:
  - 2012-13: 182 uses of 136, 2013-14 133 uses of 136.

Detention under MHA for Treatment

- The long term trend for detentions for treatment in hospital under sections 2 and 3 show only small variations:
  - 2004-05: 145
  - 2012-13: 191
  - 2013-14: 186
- Change associated with 3 policies:
  - Increased availability of alternatives to admission, eg. Home Treatment
  - Preference of section 2 for admission for assessment for up to 28, followed by section 3 if longer detention needed
  - Introduction of Supervised Community Treatment in 2008:

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Gender

- Between 2004-11 the gender split for assessments under the Act was around 50/50, or more men than women. Since 2011 the balance has shifted:
  - female/male ratio:

2008-09	127/162
2011-12	218/169
2012-13	236/178
2013-14	203/169

  - This reflects increasing prevalence of and engagement with patients with Personality Disorders
  - There is no evidence of gender bias in outcomes

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Age

- Low numbers of under-18s (around 5 per year)
- Patients over 65 account for 20-23% of assessments
- Patients over 65 are more likely to be detained than those under 65: under 65: 42% over 65: 77%
  - Likely causes:
    - Fewer patients over 65 are seen following Police use of s136, which is associated with low 'conversion' rates
    - Assessment of over 65s is more often at the request of health and social care professionals
    - Patients deemed to lack capacity to consent to informal admission are more likely to be detained

Ethinicity

- Most patients are of White British descent:

White British	352
White Other	13
Asian	4
Black	3

- In 2013-14 no assessed patients were recorded as non English speaking.