Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 30th July 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 July 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: Jessamy Baird - Designated Non Executive Director & Lizzie Peers - Non Executive Financial Advisor to the Trust Board		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**	**Chairman's Update**				
	2.1	The Chairman will make a statement about recent activity		Chair	Receive	Verbal
09:40	**3**	**Chief Executive's Update**				
	3.1	The Chief Executive will make a statement on recent local, regional and national activity.		CEO	Receive	Enc A
09:45	**4**	**Patients & Staff**				
	4.1	Presentation of this month's Patient Story	Quality and Performance Management	CEO	Receive	Pres
	4.2	Employee Recognition of Achievement Awards	Culture & Workforce	CEO	Receive	Pres
	4.3	Bi Monthly Staff Story	Culture & Workforce	EDNW	Receive	Pres
10:15	**5**	**Minutes of Previous Meetings**				
	5.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 2nd July 2014 and the Schedule of Actions.		Chair	Approve	Enc B
	5.2	Chairman to sign minutes as true and accurate record				
	5.3	Review Schedule of Actions		Chair	Receive	Enc C
10:20	**6**	**Items for the Board**				
	6.1	Quarterly Mortality Update	Quality and Performance Management	EMD	Receive	Pres
	6.2	Capital Programme 2014/15 Including: Business Case – Endoscopy (Revised)	Strategy and Business Planning	EDTI	Approve	Enc D
	6.3	Business Case - Disposal of Swanmore Road Properties	Strategy and Business Planning	EDTI	Approve	Enc E
	6.4	Performance Report	Quality and Performance Management	EDF	Receive	Enc F

	6.5	Minutes of the Quality & Clinical Performance Committee held on 23rd July 2014	Quality and Performance Management	QCPC Chair	Receive	Enc G
	6.6	Minutes of the Finance, Investment & Workforce Committee held on 23rd July 2014	Quality and Performance Management	FIWC Chair	Receive	Enc H
	6.7	Reports from Serious Incidents Requiring Investigation (SIRIs)	Quality and Performance Management	EDNW	Receive	Enc I
	6.8	Monthly Safer Staffing Update	Culture & Workforce	EDNW	Approve	Enc J
	6.9	FT Programme Update	Strategy and Business Planning	FTPD	Receive	Enc K
	6.10	FT Self Certification	Strategy and Business Planning	FTPD	Approve	Enc L
	6.11	Board Assurance Framework (BAF) Monthly update	Governance and Administration	Comp Sec	Approve	Enc M
	6.12	Statutory & Formal Roles 2014/15 - revised	Governance and Administration	Comp Sec	Approve	Enc N
11:25	**7**	**Matters to be reported to the Board**		Chair		
	8	**Any Other Business**		Chair		
	9	**Questions from the Public**		Chair		
		To be notified in advance				
	10	**Issues to be covered in private**.		Chair		

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

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

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

Tenders - Update
Strategic Estates Partner - Update
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.

11:30 **11** **Date of Next Meeting:**

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on Wednesday 27th August 2014 in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

Enc A

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public) ON 30th JULY 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 July 2014	**Completed by: Andy Hollebon & Sarah Morrison,**					

NATIONAL

National Transplant Week

During National Transplant Week and it was great to see the Intensive Care Team and others promoting this important initiative. Some of our own staff have benefited from donated organs and it's important that we play our full part in promoting the organ and blood donation.

NICE Guidance on Staffing

The National Institute for Clinical Excellence (NICE) has published new guidance for 'red flag events' where nurses in charge of shifts must act immediately to ensure they have enough staff to meet the needs of patients on that ward. Red flag events include patients not being provided with basic care such as pain relief or help to visit the bathroom. We recently published our own assessment of inpatient ward and unit staffing as part of the national Safer Staffing initiative and you can find details on our website. A recruitment campaign to fill vacancies and strategy to develop the Island workforce are being put in place by the Nursing and Human Resources Teams.

LOCAL

Friends and Family Test for Staff

Over thirteen hundred staff responded to the quarter one (April to June) Friends and Family Test (FFT) for staff. That's a fantastic response and I'm really grateful that so many staff took the time to respond. Once the results have been analysed they will be shared with staff and Board members.

Listening into Action (LiA)

The Department of Health and the King's Fund have published the findings of a review of staff engagement in NHS organisations. The review stresses the need for a culture of high staff engagement and devolved decision-making, due to compelling evidence suggesting that this increases quality of care. We are implementing a new programme called Listening into Action (LiA) which is about fundamentally shifting how we as an organisation work and lead. It is part of a heartfelt effort to connect better with everyone who works for the Trust - to harness staff ideas about the changes we can make together to deliver the best outcomes for our patients, our staff, and our organisation. Listening into Action is specifically designed to help NHS organisations empower frontline staff from the grass roots. This approach has already delivered radical change to other NHS organisations. To start Listening into Action we are taking a 'pulse check' of the organization with staff asked to answer 15 short questions about how they feel. Already over 1,000 staff have responded to the survey which has a closing date of 31st July.

Patient Safety, Experience and Clinical Effectiveness Triumvirate

The Trust now has a trio of senior staff focused on a growing area of work - that of Patient Safety, Experience and Clinical Effectiveness. Together they are known as a Triumvirate and comprise Associate Medical Director Dr Sandya Theminimulle; Business Manager for the Quality Team, Theresa Gallard; and newly appointed Lead for Patient Safety; Experience & Clinical Effectiveness Deborah Matthews. You can read more about them in the July Staff News.

Isle of Wight Radio Wightfibre Local Hero Awards

Congratulations to Dr Ramesh Babu, Associate Specialist in the Breast Care Team who was announced last night as the Isle of Wight Radio Wightfibre Overall Local Hero and Damian Carson, Paramedic and retained fire fighter who was awarded 'Emergency Services Person of the Year'. Damian is the only paramedic firefighter on the Isle of Wight. When he is not doing his 12+ hour shifts on the ambulance, he is providing cover for Newport retained fire crew.

Work on acuity and dependency in community nursing.

Congratulations to Jeannine Johnson, Louise Windle, Jenni Edgington and the team for their work on acuity and dependency in community nursing. During a visit on Wednesday 25th June the CEO of the Queen's Nursing Institute described the work on the Island as 'cutting edge' and not seen anywhere else in the country.

Charity bake sale to raise money for Operation Smile

I am constantly amazed by the contribution Trust staff make to the Island community and to making the world a better place. Foundation Year 1 doctor **Husay Janebdar** organised a charity bake sale on Tuesday 1st July to raise money for Operation Smile – a cleft lip and palate charity. Husay arranged for around 20 doctors, nurses, AHPs and others to put their baking skills into practice with all the proceeds going to Operation Smile.

CQC Inspection

The Care Quality Commission (CQC) conducted their unannounced inspection on Saturday 21st June during the afternoon and into the evening. I'm pleased to say that the CQC did not raise any concerns with us following the second inspection. The CQC have been in touch to confirm the arrangements for the report from the main inspection. We now expect to receive the draft report on 28th July and will have 10 days to check it for factual accuracy. After this the report will be the subject of discussion at a 'Quality Summit' attended by the CQC, Isle of Wight Clinical Commissioning Group (CCG), Healthwatch Isle of Wight and Isle of Wight Council on 2nd September and we can expect the final report to be published within a week of this.

2014 Clinical Audit Prize

Many congratulations to Foundation Year 2 doctor Mazin Abdelaziz, the winner of the 2014 Clinical Audit Prize. The competition, which took place on 23rd June in the Education Centre, aims to stimulate excellence in a clinical audit presentation. Mazin presented an audit on the 'Appropriateness of usage of computed tomography pulmonary angiography (CTPA) in the investigation of suspected Pulmonary Embolism'. The runners up were:-

- Dr Amr Moussa FY2 - Cervical spine imaging in alert and stable trauma patients
- Dr Satpriya Marwaha FY2 - Malnutrition Universal Screening Tool Audit
- Dr Ron Tsun Mak FY1 - Diagnosis and management of suspected urinary tract infections (UTIs) in the general surgical wards

'Our Better Hospital' project

The 'Our Better Hospital' project is progressing well. The dementia friendly work on Appley Ward is now complete with new flooring, decoration, signage and lighting. A selection of bright colours have been used on the ward to help patients remember using colour references. For example yellow doors for shower rooms and toilet facilities. Dementia friendly work on Colwell Ward commenced on the 2nd June.

When the work is complete on Colwell, the Medical Assessment Unit (MAU) will decant to Colwell Ward in readiness for work starting to upgrade, reconfigure and extend MAU. This work will expand the current accommodation, providing additional storage, modernising the assessment area and provide opportunities for staff from different specialties to work together to ensure that the needs of patients are met.

All upgraded wards will benefit from automated medicines storage systems directly linked to electronic prescriptions to enable selection specific to patients, using keyless fingerprint access and automatic refilling through a link to the pharmacy robot. These are designed to improve safety and release nursing time for direct care for patients. This is possible due to £224,000 funding from the NHS Technology Fund for Safer Wards, Safer Hospitals.

Healthwatch Annual Report

Healthwatch Isle of Wight is the independent organisation operating on the Island which reports on both health and social care. They have the rights to 'enter and view' our services and they follow up on trends in complaints and issues reported to them by the public and patients. Healthwatch have recently published their Annual Report for 2013/14 which outlines their work. Healthwatch perform an important function and it is important for Trust staff to respond promptly to Healthwatch enquiries and initiatives.

Articles in national journals

Well done to:

- ICES Manager Brian Martin for an excellent article in Equipment News talking about how the Integrated Community Equipment Service (ICES) works on the Island for the benefit of patients; and
- Psychological therapist Simon Peck, Clinical Speech & Language Therapist Carrie Collins, Stroke Nurse Specialist Jeannine Johnson and Healing Arts Director Guy Eades have all contributed to an article in the Journal of Applied Arts & Health which highlights the brilliant arts in health programme we have on the Island.

These articles bring the Island to the attention of the rest of the healthcare world and show off our excellent practice here.

Wightlink Incident

On the evening of 18th July one of the mezzanine car decks on the St. Helen, which operates Wightlink's Fishbourne to Portsmouth route, collapsed. The Trust implemented well practiced plans for a significant incident. In the end only four patients were conveyed to St. Mary's. John Burrows, Chief Operating Officer at Wightlink has written to the Trust in the following terms:

I would like to record my thanks to The Isle of Wight Ambulance Service for the excellent support which it gave to Wightlink, its crew and customers when the mezzanine deck of St Helen collapsed last Friday evening in Fishbourne.

It was a very challenging situation which placed our crew under great pressure and we could not have asked for better support from the paramedics who attended the scene. They gave excellent care to our injured passengers and crew member, making sure that everyone else was well enough to make their own way home.

Please pass on my thanks to all of those who attended the scene.

AGM

The Trust AGM is being held on 30th July at 5:00p.m. at The Riverside Centre, Newport Quay, Newport. We hope to see many staff, Members, patients and the public at the meeting which will feature our Helipad Heroes, the children's respite care service and the NHS Nightingales. More information including how to register can be found at http://www.eventbrite.co.uk/e/isle-of-wight-nhs-trust-agm-tickets-8992588073

Key Points Arising from the Trust Executive Committee

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

23rd June
- CQC Action Plan approved
- Community Nursing Redesign proposal approved
- Organisational Development Strategy approved
- Shared Care Protocol for Prescribing for Adults with ADHD

30th June
- No meeting

7th July
- Restructured Capital Programme for 2014/15 discussed and business cases to be produced.
- Centralised Recruitment of Nursing to support Safer Staffing approved.
- Approval of Incident Reporting Policy and Treasury and Cash Management Policy.

14th July
- Podiatry Business Case approved
- Mental Health Reablement Pathway Business Case approved
- Operation Serenity in Adult MH continuation approved
- Disposal of Swanmore Road properties approved

Karen Baker
Chief Executive Officer
23rd July 2014

Enc B

Isle of Wight NHS Trust

Minutes of the meeting in Public of the Isle of Wight NHS Trust Board held on Wednesday 2nd July 2014
Conference Room, St Mary's Hospital, Newport, Isle of Wight

PRESENT:	Danny Fisher	Chairman
	Karen Baker	Chief Executive (CEO)
	Alan Sheward	Executive Director of Nursing & Workforce (EDNW)
	Mark Pugh	Executive Medical Director (EMD)
	Nina Moorman	Non Executive Director
	Charles Rogers	Non-Executive Director (Senior Independent Director)
	Jane Tabor	Non-Executive Director
	David King	Non-Executive Director
	Sue Wadsworth	Non-Executive Director
In Attendance:	Jessamy Baird	Designate Non-Executive Director
	Mark Price	FT Programme Director & Company Secretary
	Andy Heyes	Interim Director of Planning, ICT & Integration
	Andy Hollebon	Head of Communications
	Kevin Curnow	Deputy Director of Finance (deputising for Executive Director of Finance)
For item 14/185	Lynsey Burden	Learning Disability Liaison Nurse
For item 14/186	Maggie Hampson	Head of Mental Health & Learning Disabilities
	Jane Irwin	Team Leader, Woodlands
	Sarah Gladdish	Clinical Director
	Christine Cragg	Cleanliness Assistant
	John Pope	Care Taker
	Wendy Godsall	Domestic Supervisor
	Simon Laughton	Senior Supervisor – Hotel Services
	Charles Joly	Environmental, Waste and Sustainability Manager
	Julianna Hayward	General Manager
	Charlene Summerfield	Chronic Pain Administrator & Acting Anaesthetic Co-ordinator
	Ally Honey	Anaesthetic Co-ordinator
	Sandie Shorter	PA/Medical Secretary - Anaesthetics
For Item 14/187	Debbie Cotton	Action Lead Nurse PAAU
	Natasha Dibben	Department Clerk, PAAU
For Item 14/192	Theresa Gallard	Business Manager for Patient Safety, Experience & Clinical Effectiveness (BMSEE)
For item 14/190	Sarah Johnston	Deputy Director of Nursing
For Item 14/200	Brian Johnston	Head of Corporate Governance & Risk Management
Observers:	Nancy Ellacott	Patient Council
	Chris Orchin	Health Watch
	Cllr Lora Peacey Wilcox	Isle of Wight Council
	Leisa Gardiner	Listening into Action Lead
	Steve Young	Senior Information Analyst
Minuted by:	Lynn Cave	Trust Board Administrator

Members of the Public in attendance: There were 6 members of the public present

Minute No.	
14/180	**APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE**

Apologies for absence were received from Chris Palmer, Executive Director of Finance. She was represented by Kevin Curnow, Deputy Director of Finance.

Apologies were received from John Bowker. In addition, Kim Hayter, Tina Macleod and Kevin Almazan were unable to attend to receive their staff awards.

Declaration of Interest was given by Jessamy Baird relating to agenda item 6.3 – Annual Research Report 2013/14 – see min 14/190. Jessamy Baird works for Eli Lilly Co. Ltd - this interest has been formally declared and is logged in the Register of Interests.

The Chairman announced that the meeting was quorate.

14/181 PATIENT STORY

The Chief Executive advised the meeting that this month's patient story was filmed in the home of a patient who has a learning disability. The story centred around the care received by the lady and the involvement of the Learning Disability Liaison Nurse in the case.

The film highlighted issues related to pressure ulcers which developed whilst the patient was in hospital and the contributing factors which resulted in their development.

The Chief Executive stated that the details of this case had been fully discussed with the Executive Team and a review on how to provide the necessary resources to support patients with complex needs such as the lady shown in the film had been implemented.

A discussion took place in which the Non-Executive Directors stressed the need for a more flexible way of interviewing patients and in particular those with learning disabilities and mental health issues, so that their views could be clearly given.

Action Note: *The Executive Director of Nursing & Workforce to progress the revision of the interview scripts with the Patient Experience team.*

Action by: EDNW

Sue Wadsworth gave assurance in her capacity as Chair of the Quality & Clinical Performance Committee that the full version of this story had been seen at QCPC and a number of concerns had been raised about the transfer of care information provided by community care teams.

Lynsey Burden, the Learning Disability Liaison Nurse explained how in these cases a document called "This is Me" is provided giving information on specific needs of a patient. She emphasised the need in these cases for the care to be consistent so that patients when they return home can return to their normal routines without delay.

The Chief Executive thanked the Learning Disability Liaison Nurse for her contribution and for her work in this area.

The Isle of Wight NHS Trust Board received the Patient Story

14/182 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

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

Category 2 – Employee Role Model

Charlene Summerfield
Chronic Pain Administrator & Acting Anaesthetic Co-ordinator
Anaesthetics – Planned Directorate

Christine Cragg
Cleanliness Assistant – Hotel Services, Nursing & Workforce Directorate
Jane Irwin
Team Leader– Woodlands, Community Health Directorate
Kim Hayter
Senior Staff Nurse - Woodlands, Community Health Directorate

Category 3 – Going the Extra Mile

John Pope
Caretaker – Hotel Services, Nursing & Workforce Directorate
Tina Macleod
Cleanliness Assistant - Hotel Services, Nursing & Workforce Directorate
Kevin Almazan
Cleanliness Assistant - Hotel Services, Nursing & Workforce Directorate
Wendy Godsall
Cleanliness Assistant - Hotel Services, Nursing & Workforce Directorate

The Chief Executive congratulated all recipients on their achievements.

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

14/183 EMPLOYEE OF THE MONTH

The Chief Executive presented the award to:

- **June 2014** – Natasha Dibben
  Ward Clerk – Pre Assessment Unit

She confirmed that Natasha Dibben had been nominated for her excellent work by patients who felt she should be recognised for her work. The Chief Executive congratulated her.

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

14/184 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 28th May 2014 were approved.

Proposed by Nina Moorman and seconded by Jane Tabor

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 5th June 2014 were approved.

Proposed by Charles Rogers and seconded by Sue Wadsworth

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

14/185 REVIEW OF SCHEDULE OF ACTIONS

The following updates to the schedule of actions were noted:

a) **TB/059 – Flu:** Charles Rogers asked that details of the Flu Campaign, including Staff incentives, for autumn 2015 be brought to Board.

Action Note: *The Executive Director of Nursing & Workforce to arrange for details on the plans for the Flu campaign 2015 together with details of how the staff incentives would apply to be brought to the Board.*

Action by: EDNW

b) **TB/085 – Pressure Ulcers:** Sue Wadsworth requested more information on the external review.

Action Note: *the Executive Director of Nursing & Workforce to report back to Board on the progress of the external review on pressure ulcers.*

Action by: EDNW

c) **TB/087 – QUINCE:** It was confirmed that this had been to the FIWC[1]. This action is now closed.

d) **TB/092 – Mortality & Morbidity Review:** Nina Moorman advised that this item had not yet come to QCPC[2]. The Executive Medical Director confirmed that the Quarterly Mortality report would be coming to Board on 30th July and would also be presented to QCPC. Nina Moorman queried if the morbidity review in hospital was part of the clinical audit process. The Executive Medical Director advised that he would discuss this with the Clinical Lead for SEE[3] which would report to QCPC.

Action Note: *The Executive Medical Director to discuss Morbidity Review with the Clinical Lead for SEE.*

Action by: EMD

e) **TB/096 – NED involvement in Mental Health Hearings:** Charles Rogers requested that this action be reopened as a date for a suitable meeting was not yet set and he would like feedback on the outcome. This was agreed. It was also agreed for a seminar item to be arranged for the autumn on Mental Health Hearings and the role of hospital managers under the Mental Health Act.

Action Note: *The Company Secretary to arrange a seminar item on the role of NEDs at Mental Health Hearings.*

Action by: CS

f) **TB/099 – CIPS Rag Rating:** It was confirmed that the performance report had been updated. This action is now closed.

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

14/186 CHAIRMAN'S UPDATE

The Chairman reported on the following items:

a) CQC[4] Inspection: The Chairman thanked all staff for their effort during the recent CQC inspection and in the preparation period prior to it and acknowledged the huge amount of work which had been done. He advised that a letter containing a number of immediate actions had been received and these actions had been addressed. A follow-up inspection, as expected, had occurred and confirmed that the Trust is currently awaiting the final report.

b) Members meeting: A Medicine for Members had taken place last week with a keynote address on Dementia and there had been a very good attendance. He advised that these sessions were popular with the members from the feedback received and more were planned for the future.

c) FTN Conference: The Chairman reported on the recent FT Network Conference he attended. He highlighted the financial challenges facing all NHS Trusts and the desire for stability within the NHS as many Trusts felt that the constant demand for cost cutting and new incentives was undermining their organisations. He advised that compared to other Trusts the Isle of Wight Trust was performing well.

[1] Finance Investment & Workforce Committee
[2] Quality & Clinical Performance Committee
[3] Patient Safety, Experience & Clinical Effectiveness
[4] Care Quality Commission

d) **Executive Director of Transformation & Integration:** The Chairman advised that Katie Gray would be joining the Trust on 7th July in this role.

e) **Interim Director of Planning, ICT & Integration:** The Chairman thanked Andy Heyes for all his work during his secondment to this post. Andy Heyes would be returning to his substantive role as Head of Commercial Development.

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

14/187 CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented her report which included:

National

- I'm Worth It campaign
- B-cerus in Neonatal Units

Regional

- Research reduces risk of early development of asthma

Local:

- CQC Inspection – Initial Feedback
- Psychology Online - Online therapy pilot
- 'Clinical Strategy' consultation
- Toy Trust donation to Children's Ward
- Healthwatch Maternity Services Report
- Baby Friendly Initiative – Certificate of Commitment
- Integrated Clinical Waste Management
- Consultations on Island wide strategies
- Public Sector Strikes
- Key Points from Trust Executive Committee

- IDAS[5] Tender – The Chief Executive reported that she was pleased to be able to announce that the Trust had been successful in its bid to provide all IDAS services on the Island. Congratulations were given to the team for all their hard work on the successful tender process. The new service is planned to commence in October 2014.

The following areas were raised in discussion:

a) **Capital Programme:** Charles Rogers expressed concern that changes had been made to the capital programme and that the FIWC felt it was important to ensure that there was a stable programme to prevent a repeat of the uncertainty and delay on spend for capital work which occurred in the last financial year. The Chief Executive advised that an in depth analysis on the capital programme was being undertaken and would be advised to the Board.

Action Note: *The Company Secretary to arrange a seminar item on the Capital Programme 2014-15.*

Action by: CS

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

14/188 ANNUAL COMPLAINTS REPORT 2013/14

The Executive Director of Nursing & Workforce together with the Business Manager for Patient Safety, Experience & Clinical Effectiveness, presented the Annual Complaints Report for 2013/14.

He advised that this report is produced in line with section 18 of The Local Authority Social

[5] Island Drug & Alcohol Service

Services and National Health Service Complaints (England) Regulations 2009, noted that it would more appropriately be known as the Annual Patient Experience Report.

He outlined the change of direction and focus of the team which had resulted in a reduction in complaints. He advised that the process of proactive management of concerns had directly resulted in this reduction. Part of this process was also the sharing of feedback from patients with clinicians and this would now be included within doctors revalidation process.

He advised that the process now centred around the person raising the concern and the timescale for action was led by them. He noted that in the past there had been some overly ambitious timescales but these were now changing with clear expectations of staff being made.

The Business Manager for Patient Safety, Experience & Clinical Effectiveness advised the meeting that the PALS[6] office was now relocated on Level A by the main entrance to the hospital. This was to allow easy access to the team for all patients and visitors. She advised that some work was still ongoing as there was a gap between the walls and the ceiling which was allowing in noise from the café area.

Action Note: *The Executive Director of Nursing & Workforce to provide updates on progress of work to address this to the Board.*

Action by: EDNW

The Executive Director of Nursing & Workforce reported that the key priorities for 2014/15 were:

- Embed the new complaints management process further
- Provide relevant education and training for staff
- Improve the percentage of complaints managed within the agreed timescale
- Embed action plans and improve sharing of lessons learnt from complaints to provide opportunity to improve services

The following areas were raised in discussion:

a) **Sharing of Complaints & the Lessons Learned**: Nina Moorman commented that it would be helpful if some generic complaints could (with consent) be shared in a newsletter giving details of how the organisation had learnt from the experience. It was agreed that this would be looked into. The Executive Director of Nursing & Workforce confirmed that this was included in the newsletter distributed by the Corporate Governance and Risk Management department.

b) **National Benchmarking:** David King queried the benchmarking categories and asked for clarification. The Business Manager for Patient Safety, Experience & Clinical Effectiveness explained that the Island's integrated model effectively meant that we were 4 separate Trusts within the national benchmarking criteria which was the cause of the issue. She confirmed that data is submitted nationally and that PIDS were working towards building effective benchmarking comparisons.

a) **Learning from Complaints and Concerns:** Jane Tabor asked if the table in section 5 should include indicators on the impact of the complaint. She commented that a root cause summary trend would also be helpful. The Business Manager for Patient Safety, Experience & Clinical Effectiveness explained that an action plan for each complaint is now part of the regular complaints process; which will make the identification of trends and learning lessons easier to evidence and this would be reflected in the next annual report.

Proposed by Sue Wadsworth and seconded by David King

The Isle of Wight NHS Trust Board approved the Annual Complaints Report 2013/14

[6] Patient Advice and Liaison Service

14/189 ANNUAL MEDICAL REVALIDATION QUALITY ASSURANCE REPORT

The Executive Medical Director advised the meeting that this topic had previously been discussed at Board Seminar and outlined the revalidation process.

Nina Moorman confirmed that this paper had been seen at QCPC.

The Isle of Wight NHS Trust Board received the Annual Medical Revalidation Quality Assurance Report

14/190 ANNUAL RESEARCH REPORT 2013/14

Jessamy Baird declared an interest in this item due to her employment with Eli Lilly Co. Ltd who undertake research in the medical field. The Board agreed that in this instance it would be non-prejudicial for her to take part in this item.

The Executive Medical Director presented the Annual Research Report for 2013/14 and summarised the key points of the report including the range of studies undertaken, and financial implications.

He confirmed that a 6 monthly Research and Development update would be brought to Board.

Action Note: *The Company Secretary to add to the Board Forward plan.*

Action by: CS

Sue Wadsworth asked if any of the Serious Adverse Events had resulted in permanent harm to the participants. The Executive Medical Director stated that no patient had any significant adverse effect but all potential adverse events had to be investigated and reported.

The Executive Medical Director advised that the 5 year Research & Development Strategy would be due for review in 2015 and he would be asking the Executive Director of Transformation & Integration to review it and to develop more commercial opportunities within the research and development field.

Proposed by Sue Wadsworth and seconded by David King

The Isle of Wight NHS Trust Board approved the Annual Research Report 2013/14

14/191 MONTHLY UPDATE ON SAFER STAFFING

The Executive Director of Nursing & Workforce presented the report and advised that this report was now required to be published on the website monthly and that it was coming to Board for formal approval.

He gave an overview of the report which showed the May data and includes an evaluation of the overall position associated mitigating actions and impact on quality of patient care. He outlined the details of the local RAG rating which has been developed and applied to the data to enable the Trust to work to address shortfalls where identified. In addition clinical indicators are reviewed to triangulate staffing information to clinical outcomes. He confirmed that assurance has been sought where data indicates shortfalls and actions are in place to review these areas. The processes for reviewing and triangulating data is in place in the Directorates and there is ongoing work following this first report to improve assurance to the Board. He requested the Trust Board:

1. To note the Trust's status of compliance in relation to the National Quality Board's requirements.

2. To note the reporting process that the Trust is providing and the identification of shortfalls in staff and mitigating actions.

3. To note the urgent requirement for automation in the data collection, and reporting process to improve the quality assurance required.

4. To note the on-going progression towards reporting of quality, HR metrics with safe staffing indicators for benchmarking as these become available.

A discussion took place in which clarification was requested on how assurance could be given that areas which are currently not included within the national criteria – such as community outpatients etc., would not be forgotten. The Executive Director of Nursing & Workforce advised that whilst the national requirement was only to include Acute areas, the Trust had already included mental health and phlebotomy within is programme and there were plans to expand this across all areas. He stressed that all areas within the Trust would ultimately be treated the same.

Sue Wadsworth assured the meeting that this information would be reviewed at QCPC in greater detail on a regular basis.

Proposed by Sue Wadsworth and seconded by Charles Rogers

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

14/192 6 MONTHLY UPDATE ON SAFER STAFFING

The Deputy Director of Nursing explained that six monthly reporting is required to be provided to the Board and includes information on capacity and capability, following an establishment review using evidence based tools.

In addition a number of requirements are expected to be met in relation to developing robust proactive discussion around safe staffing, which is transparent and understandable for patients. The framework for ensuring specific requirements are met, including setting of establishments using evidence based tools, providing robust reports and demonstrating adequate review, has been set out by the National Quality Board. Expectations are identified for reporting by NHS England and the Care Quality Commission.

The Deputy Director of Nursing presented her report in two sections.

> Section 1: Summarises work already undertaken and reviewed by the Board relating to our nursing establishment review, and provides the costings to implement the new establishments. The report describes the next stages of funding the shortfall and how the Director of Nursing Team and Human Resources plan to recruit to the gap. The Executive Director of Nursing & Workforce is satisfied that no clinical area is "unsafe", but recognises that if patients are to experience first class care and treatment, in line with the Strategic Aims of the Trust "Quality Care for Everyone Every Time" we must aim to provide the best possible staffing levels we can.
>
> Section 2: Provides the workforce data and quality indicators to enable the Board to review the staffing situation over the past six months. This information supports the current position of safe staffing for current establishments.

The Chief Executive asked what was planned in the nursing recruitment campaign. The Deputy Director of Nursing advised that a wide range of media options, journals and traditional advertisements would be utilised. She also advised that European recruitment was be considered. She advised that the message will be that working for an integrated Trust is a positive career move. A discussion took place and it was agreed that this aspect of the Trust and the other positive aspects of living and working on the Island should be promoted. It was also suggested that links to other organisations on the island should be explored to encourage a partnership approach.

The Deputy Director of Nursing advised the meeting that the report was still being developed and would develop as the data is collected over the coming months. She advised that it would be seen at the FIWC before coming to Board

Proposed by Sue Wadsworth and seconded by Charles Rogers

The Isle of Wight NHS Trust Board approved the 6 Monthly Update on Safer Staffing

14/193 PERFORMANCE REPORT

The following areas were raised in discussion:

Highlights:

- Venous Thrombo-Embolism (VTE) risk assessment achievement is maintained
- Formal complaints down and compliment numbers up
- Total pay costs within plan

Lowlights:

- Governance Risk Rating (GRR) performance level decreased, currently highest level since assessment began
- 2 cases of Health care acquired Clostridium Difficile infection identified
- 2 x cancer targets underachieved
- Pressure Ulcers remain above plan
- Variable hours and staff sickness remain above plan

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

Safe:

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

Responsive:

- **Referral to Treatment Time (RTT)** - RTT Non Admitted was again below target in May, with a number of specialties not achieving the target bringing the overall Trust performance below 95%. A range of actions are planned to address this issue including additional outpatient clinics and the appointment of locums in challenged specialties.

- **Symptomatic Breast referrals seen within 2 weeks** - failed the 93% standard again during May although, unusually, this was due to local capacity issues. Work is ongoing to address these issues and prevent recurrence.

- **62 day cancer referral to treatment** - also failed due to patients with complex medical issues and late diagnosis but the low numbers exaggerate the percentages.

- **Care Programme Approach (CPA)** - patients receiving a formal review within 12 month of discharge - the performance against this target has increased this month due to work underway to collate the data necessary to manually report against this indicator but it has not reached the required level.

Caring:

- **Patient Satisfaction -** Complaints were down in May in comparison to April and within the planned 10% reduction target in month although just outside the year to date trajectory. Compliments, in the form of letters and cards of thanks, were considerably higher during May than in April.

- **Patient Advice & Liaison Service (PALS)** - As one of the CQUIN goals for this year, the PALS relocation to main reception has now been completed and is providing greater access to the public.

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

Well Led:

- **Pay Bill** - The pay bill for May including flexible hours is £9.70m, within the plan of £9.85m. The number of FTEs in post is currently below plan by 19 FTE. The HR Directorate are closely monitoring and supporting the Clinical directorates with their workforce plans, in particular their control over their spend on variable hours.

- **Sickness Absence** – This continues to improve during May (3.60%) but remains above the 3% plan. Specific problem areas are being identified for local investigation and are challenged at directorate performance review meetings.

- **Financial Surplus** - At the end of May the Trust is reporting a surplus of £337k against the actual planned financial position of £347k. The adjusted retained surplus shows £342k against a plan of £350k - £8k below plan. The Continuity of Service Risk Rating is 4.

- **Cost Improvement Programme (CIP)** - Showed a year to date overachievement of £237k against the target of £976k. Included within this performance is the recognition of full year savings amounting to £527k. Of the total £1,213k achieved, £819k was achieved recurrently and therefore the focus remains on the delivery of recurrent savings.

Effective:

- **Theatre Utilisation** - This is below plan for both Main Theatres and Day surgery giving a joint rate of 79%.

- **Bed Pressures** – These have had considerable effect on the lists with a reduction in elective admissions due to the high risk of cancellation as well as delays in admission processing.

The following areas were raised in discussion:

i. **Pressure Ulcers:** Sue Wadsworth asked if the review and action plan would be shared with the QCPC. The Executive Director of Nursing & Workforce confirmed that this would happen.

ii. **Bed Capacity:** Charles Rogers asked if there were enough beds available to ensure efficiency as he felt the report did not show this. The Executive Director of Nursing & Workforce advised that it was not just about the number of beds, the clinical skills needed to effectively cover the beds was a significant factor. He advised that surgical beds had a different requirement from that of a medical bed and that the focus would be changing in line with the safer staffing levels to ensure that all beds were used effectively using the appropriate skilled staff. He also confirmed that dementia estates work being undertaken in Appley Ward was now complete with Colwell Ward work now underway.

iii. **Cancer Appointments:** Jessamy Baird asked what was being done to improve cancer outpatient appointment uptake. The Executive Director of Nursing & Workforce confirmed that he had met with the surgical leads for discussion on what could be done to change surgical intervention times. He also confirmed that recruitment to the breast screening radiology team was now complete and this service was now back in house. He stressed that there had been a 30% increase in demand which had put pressure on the available clinic space. He confirmed that a review was in place which was looking at providing an appointment in week 1 so that if necessary there was an option to use week 2 for an alternative. However, the acceptance of an appointment was down to patient choice and therefore, was an unknown variable.

iv. **Governance Risk Rating (GRR):** The Chairman expressed concern over the deterioration in the GRR. The Executive Director of Nursing & Workforce advised that there were a number of factors involved - the changes within the Trust, the increased demand for services and also the small level of tolerance on the KPI's[7], some of which involved very small numbers.

v. **Contracted Activity:** Jane Tabor asked if this was based on year on year data or had the Trust been asked to deliver more against plan, and if we are below plan can this be maintained. The Deputy Director of Finance advised that 95% of services are based on last year's activity. The Executive Director of Nursing & Workforce advised that the Service Level Agreement with the CCG[8] did not include higher numbers of attendees in April and May together with higher numbers of trauma admissions which had resulted in bed capacity issues. The Chief Executive confirmed that there was a lot of work going on behind the scenes to improve these figures but it was not a simple fix.

vi. **Delayed Transfer of Care:** David King asked what caused a delay in transfer of care. The Chief Executive advised that the method of recording was key to the results. The Deputy Director of Finance advised that a number of factors were involved which included unscheduled care, changes in focus against agreed tariffs and a different mix of patient needs. The Executive Director of Nursing & Workforce reported that the Island records both internal delays as well as external ones which are different from the national benchmark. The Chief Executive advised that discussion would be undertaken with the CCG to clarify the report requirements.

The Isle of Wight NHS Trust Board received the Performance Report

14/194 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Sue Wadsworth reported on the key points raised at the last meeting held on 18th June 2014.

a) **Min No. 14/197 – Audit Programme**: The SEE triumvirate to review the clinical Audit Programme

b) **Min No. 14/198 – Rolling Programme:** Changes to this will be implemented when the SEE Committee is in place

c) **Min No. 14/226 – Serious Incidents Requiring Investigation (SIRIs):** The Planned Clinical Directorate to arrange a Risk Summit to review two SIRIS

d) **Min No. 14/230 – Patient Story:** A review is being undertaken and this story will be presented to Trust Board on 2 July 2014

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

14/195 MINUTES OF THE FINANCE, INVESTMENT & WORKFORCE COMMITTEE

Charles Rogers reported on the key points raised at the last meeting held on 18th June 2014.

a) **Min No. 14/092c - Safer Staffing Status Update:** The Committee gave broad support for the business case to start the recruitment process. The Committee requested confirmation is sought from the CCG that the funding will be recurrent and that the costings for 2014/15 and beyond will be reflected in the IBP.

[7] Key Performance Indicators
[8] Clinical Commissioning Group

b) **Min No. 14/093a – CIPs[9]:** Year-to-date CIPs achieved £1213k against plan of £976k. 68% is recurrent. There are risks to full delivery at this stage which need to be quantified.

c) **Min No. 14/099 - Self Certification:** With respect to Board Statement 10 the Committee were assured the financial performance indicators are sufficiently robust but would defer judgement on the status of the GRR[10] and related improvement plans to the Quality and Clinical Performance Committee (QCPC) in accordance with their terms of reference.

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

14/196 MINUTES OF THE AUDIT & CORPORATE RISK COMMITTEE

The Company Secretary reported on the key points from the meeting held on 5th June 2014.

a) **Min No. 14/074 - Annual Accounts 2013/14:** The draft Annual Accounts for 2013/14 were recommended for approval and adoption by the Trust Board.

b) **Min No. 14/075 - Directors' Certificates:** The Certificates were recommended for approval by the Trust Board.

c) **Min No. 14/076 - Annual Governance Statement (AGS):** The AGS was recommended for approval by the Trust Board

d) **Min No. 14/079 - Annual Report 2013/14:** The Annual Report for 2013/14 was recommended for approval by the Trust Board.

e) **Min No. 14/080 - Quality Account 2014:** The Quality Account for 2014 was recommended for approval by the Trust Board.

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

14/197 MINUTES OF THE CHARITABLE FUNDS COMMITTEE

Sue Wadsworth reported on the key points raised at the last meeting held on 10th June 2014.

a) **Min No. 14/021 - Quoracy:** Meeting not quorate; Corporate Trustee to ratify minutes

b) **Min No. 14/022 - Declarations of Interest:** 2 Declarations declared and completed notification form provided to the Trust Board Administrator

c) **Min No. 14/013 - Terms of Reference – Membership:** Proposed that the Deputy Director of Nursing be appointed to the Committee

d) **Min No. 14/033 - Approval of items over £15k:** Further Education Awards approved to the value of £46k

e) **Min No. 14/022 - Declarations of Interest:** David King declared an interest as a charitable trustee of UKSA and Vincent Thompson declared an interest as Manager of Friends of St. Mary's which operates the Unity Lottery. The Committee agreed that the interests declared were non-prejudicial to the business of the meeting, and authorised the members to remain in the meeting.

Nina Moorman advised the meeting that the Finance team were contacting all fund managers for updates on their plans to spend the funds. A discussion took place and it

[9] Cost Improvement Programme
[10] Governance Risk Rating

was agreed that the profile of the availability of funds should be raised and it was noted that this was currently being reviewed by the committee.

Sue Wadsworth requested that the Board as Corporate trustees approve the minutes of the Charitable Funds Committee held on 10th June and ratify the decisions as the meeting had not been quorate.

Proposed by Charles Rogers and Seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board acting as Corporate Trustees approved the Minutes and ratified the decisions of the Charitable Funds Committee

14/198 NOTES OF THE FT PROGRAMME BOARD

The FT Programme Director reported on the key points from the meeting held on 27th May 2014.

a) **Note No. 062/14** – **Risk Management:** Three risks moved to red status to reflect the current position of the Governance Risk Rating and Cost Improvement Programme

b) **Note No. 060/14** - **Board Governance Assurance Framework**: Self-assessment reviewed

The FT Programme Director reported on the key points from the meeting held on 17th June 2014.

a) **Note No. 076/14** - I**ntegrated Business Plan (IBP) and supporting documents for approval:** FT Programme Board approved submission of draft Integrated Business Plan to Trust Development Authority (TDA), subject to Long Term Financial Model sign off by Finance, Investment and Workforce Committee

b) **Note No. 076/14** – **Delegated Authority for IBP:** FT Programme Board approved delegated authority to the Chief Executive (or their deputy) to incorporate any additional changes identified that would add value in advance of submission to TDA on 20 June 2014

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

14/199 FT PROGRAMME UPDATE

The FT Programme Director presented the monthly update:

- CQC report was due at the end of July and following a review of the report there would be a quality summit in late August/early September. This would mean that the TDA meeting to consider passing the Trust to Monitor could be delayed until November. This could have a significant consequence on the FT timeline.

  A discussion took place and it was agreed to challenge the CQC and TDA on the potential delays.

  Action Note: *The Company Secretary to challenge potential delay to the timeline with CQC and TDA.*

  Action by: CS

- Board 2 Board date is set for 3rd September and would be held in London

- Public membership was now 4,229 with staff members at 2,832.

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

14/200 FT SELF CERTIFICATION

The FT Programme Director presented the monthly update stating that the current status was green across all categories.

However, since the production of the performance report the Executive Directors had discussed if Board Statement 10 on the GRR[11] was fully compliant and the FT Programme Director proposed to alter the recommended compliance against Statement 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*.

The Board agreed to down grade this from 'Compliant' to 'At risk'.

Action Note: *The FT Programme Director to arrange for the status to be amended and submitted to TDA.*

Action by: FTPD

Proposed by Sue Wadsworth and seconded by David King

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

14/201 BOARD ASSURANCE FRAMEWORK (BAF) DASHBOARD & SUMMARY REPORT

The Head of Corporate Governance & Risk Management presented the BAF and reported on the key changes in ratings:

There are no BGAF Principal Risks now rated as Red; 3 new Risks have been added since the May 2014 report; and 2 Risks with changed scores. The exception report details 8 recommended changes to the Board Assurance RAG ratings of Principal Risks, all from Amber to Green.

The Head of Corporate Governance & Risk Management advised that the full BAF needed to be presented to Board once a year for formal approval as part of the governance process.

Proposed by Charles Rogers and seconded by Sue Wadsworth

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

14/202 MATTERS TO BE REPORTED TO THE BOARD

None

14/203 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

14/204 ANY OTHER BUSINESS

a) **Haematology Consultant Vacancy:** Nancy Ellacott – Patient Council, asked with the Chairman's permission, for an update on the vacant position. The Executive Medical Director advised that there was a national shortage of suitable candidates and that to date no suitable candidates had been identified. He confirmed that discussions for consultant support with both University of Southampton NHS FT and Portsmouth Hospitals NHS Trust had taken place.

The Executive Director of Nursing & Workforce also advised that partnership working with mainland Trusts to provide specialist consultant clinics on the island were in place with other services such as Oncology.

[11] Governance Rise Rating

14/205 DATE OF NEXT MEETING

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

The **Annual General Meeting** will be held on Wednesday 30th July 2014. The meeting will be held at the Riverside Centre, Newport Quay, Newport, Isle of Wight and will commence at 5pm.

The meeting closed at 12.55pm

Signed…… Chair Date:……..

Enc C

ISLE OF WIGHT TRUST BOARD Pt 1 (Public) - April 14 - March 15
ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

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

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

Interim Director of Planning, ICT & Integration (IDPII) Head of Governance & Assurance (HOG)Business Manager for Patient Safety, Experience & Clinical Effectiveness (BMSEE)

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

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

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
26-Mar-14	14/091 i)	TB/085	**Pressure Ulcers:** Charles Rogers commented how helpful it was to show the rolling averages and how the revised charts demonstrated areas of resistance. He asked what was being done to rectify these. The Executive Director of Nursing & Workforce advised that the education campaign to show patients in the community what to look for and how to prevent pressure ulcers was going well. Public Health were involved to promote preventative measures. The initial training had reached 50% of registered nurses, and when complete would be rolled out to cover Health Care Workers and other community staff. Charles Rogers asked if feedback from Public Health could be provided on their programme.	EDNW	The Executive Director of Nursing & Workforce to request update from Public Health on their pressure ulcer prevention initiative. **23/04/14** - The Tissue Viability Specialist Nurse is in discussions with Public Health. **28/05/14** - The Executive Director of Nursing & Workforce confirmed that the Tissue Viability Nurse Specialist had met with Public Health and work was going ahead to roll out a programme of training by the end of this financial year. There would be a stakeholder event with both health care representatives and members of the public involved. He stated that it was important to get the message on how to prevent pressure ulcers forming across as many people as possible. **02/07/14** - Sue Wadsworth requested more information on the external review. The Executive Director of Nursing & Workforce to report back to Board on the progress of the external review on pressure ulcers. **18/07/14** - Full report and actions reviewed at QCPC in June 2014 **18/07/14** - Glenn Smith (Nutrition & Tissue Viability Nurse Specialist is currently finalising the action plan, so will be preparing an update for the August QCPC; where he will present an update and the associated action plan.	28-May-14	27-Aug-14	Progressing		Open
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. **10/06/14** - The Interim Director of Planning, ICT & Integration absent from 10th June Seminar and will discuss scheduling of this with Chairman of Finance, Investment & Workforce Committee. **02/07/14** - It was confirmed that this had been to the FIWC[1]. This action is now closed.	31-May-14	02-Jul-14	Completed	02-Jul-14	Closed
30-Apr-14	14/120iii	TB/091	**Benchmarking of Key National Performance Indicators:** Nina Moorman stated that the Clinical Commissioning Groups form clusters in which comparability is possible. The Executive Director of Finance agreed that it would be good to compare with similar areas although we are the only integrated Trust.	EDF	The Executive Director of Finance to develop possible cluster benchmarking for the Trust in conjunction with PIDS. **28/05/14** - The Executive Director of Finance confirmed that work was underway and was planned to be completed by the end of July.	28-May-14	30-Jul-14	Progressing		Open

Enc C

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
30-Apr-14	14/124	TB/092	**Mortality & Morbidity Reviews:** Nina Moorman asked if the Mortality & Morbidity reviews could go to QCPC. Dr Sandya stated that this would be encouraged and suggested that it be added to the June QCPC agenda. The Executive Director of Nursing & Workforce suggested that due to the volume of items which go to QCPC it would be more appropriate for this to be discussed at a separate forum with Dr Sandya and the summary report which results from this to be presented to QCPC. This was agreed.	EMD	Executive Director of Nursing & Workforce to identify a separate forum to discuss the Mortality & Morbidity report and to arrange for summary report to go to QCPC. **28/05/14** - The Executive Director of Nursing & Workforce confirmed that a standard mortality template had been put into place and that these would be reviewed by the Quality & Clinical Performance Committee on a regular basis. This action is now closed. **02/07/14** - This action is reopended - Nina Moorman advised that this item had not yet come to QCPC[2]. The Executive Medical Director confirmed that the Quarterly Mortality report would be coming to Board on 30th July and would also be presented to QCPC. Nina Moorman queried if the morbidity review in hospital was part of the clinical audit process. The Executive Medical Director advised that he would discuss this with the Clinical Lead for SEE[3] which would report to QCPC. The Executive Medical Director to discuss Morbidity Review with the Clinical Lead for SEE.	28-May-14	27-Aug-14	Progressing		Open
30-Apr-14	14/125	TB/093	**Board Walkabout Timings:** The Chairman stated that he had undertaken walkabouts on Sundays and he encouraged members to vary the times they make their visits to include out of hours times including weekends and late evenings to get a wider picture of how the organisation functions during these times. There was a discussion surrounding the timings of the Board day walkabouts and it was requested that these be reviewed.	CS	Company Secretary to review timings and adjust Board day programme accordingly. **16/05/1**4 - Scheduled at lunchtime for May Board meeting. Timings to be adjusted following feedback. **28/05/14** - The Company Secretary advised that this item had been left open to allow for feedback on the new timings of these walkabouts within the Board programme.	28-May-14	01-Oct-14	Progressing		Open
30-Apr-14	14/140	TB/096	**NED Involvment in Mental Health Hearings:** Charles Rogers queried whether the substantive NEDs should be more involved. The Company Secretary agreed to seek advice on the legal position from the Mental Health Act/Mental Capacity Act Lead.	CS	The Company Secretary to seek advice on the legal position from the Mental Health Act/Mental Capacity Act Lead. **20/05/14** - Company Secretary to arrange a meeting with the MHS/MCA Lead and new Chair of the Mental Health Act Scrutiny Committee. **28/05/14** - The Company Secretary advised that a meeting to facilitate this had been arranged for 5th June. This action is now closed. **02/07/14** - This action is reopened - Charles Rogers requested that this action be reopened as a date for a suitable meeting was not yet set and he would like feedback on the outcome. This was agreed. It was also agreed for a seminar item to be arranged for the autumn on Mental Health Hearings and the role of hospital managers under the Mental Health Act. The Company Secretary to arrange a seminar item on the role of NEDs at Mental Health Hearings.	28-May-14	01-Oct-14	Progressing		Open
28-May-14	14/154v	TB/099	**CIPS Rag Rating:** Peter Taylor also felt that it was inappropriate at this stage in the financial year to flag the Full Year Forecast (p 17) for CIPs as Green and requested that this be amended to Amber. This was agreed.	EDF	The Executive Director of Finance to arrange for this rating to be amended. **02/07/14** - It was confirmed that the performance report had been updated. This action is now closed.	02-Jul-14	02-Jul-14	Completed	02-Jul-14	Closed
02-Jul-14	14/181	TB/100	**Interviewing Scripts:** A discussion took place in which the Non-Executive Directors stressed the need for a more flexible way of interviewing patients and in particular those with learning disabilities and mental health issues, so that their views could be clearly given.	EDNW	The Executive Director of Nursing & Workforce to progress the revision of the interview scripts with the Patient Experience team. **18/07/14** - Patient Experience lead working with Sunshine Radio and Volunteer Service to agree format of questions.	01-Oct-14	01-Oct-14	Progressing		Open
02-Jul-14	14/185a)	TB/101	**Flu Campaign:** Charles Rogers asked that details of the Flu Campaign, including Staff incentives, for autumn 2015 be brought to Board.	EDNW	The Executive Director of Nursing & Workforce to arrange for details on the plans for the Flu campaign 2015 together with details of how the staff incentives would apply to be brought to the Board. **18/07/14** - This will come to the Board in August 2014.	27-Aug-14	27-Aug-14	Progressing		Open
	14/187	TB/102	**Capital Programme:** Charles Rogers expressed concern that changes had been made to the capital programme and that the FIWC felt it was important to ensure that there was a stable programme to prevent a repeat of the uncertainty and delay on spend for capital work which occurred in the last financial year. The Chief Executive advised that an in depth analysis on the capital programme was being undertaken and would be advised to the Board.	CS	The Company Secretary to arrange a seminar item on the Capital Programme 2014-15. **08/07/14** - Covered at Board Seminar on 8th July.	08-Jul-14	08-Jul-14	Completed	08-Jul-14	Closed

Enc C

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
02-Jul-14	14/188	TB/103	**PALs Office** - Business Manager for Patient Safety, Experience & Clinical Effectiveness advised that some work was still ongoing as there was a gap between the walls and the ceiling which was allowing in noise from the café area.	EDNW BMSEE	The Executive Director of Nursing & Workforce to provide updates on progress of work to address this to the Board. **07/07/14 -** Scheme to address this approved at Trust Executive Committee on 7th July. **18/07/14** - Estates to confirm timeline for work to be complete. Updated Business Case to go back to the Charitable Funds Committee.	01-Oct-14	01-Oct-14	Progressing		Open
02-Jul-14	14/190	TB/104	**Research & Development:** The Executive Medical Director confirmed that a 6 monthly Research and Development update would be brought to Board.	CS	The Company Secretary to add to the Board Forward plan.	30-Jul-14	30-Jul-14	Completed	19-Jul-14	Closed
02-Jul-14	14/199	TB/105	**FT Timeline:** A discussion took place and it was agreed to challenge the CQC and TDA on the potential delays.	CS	The Company Secretary to challenge potential delay to the timeline with CQC and TDA. **07/07/14** - Following dialogue woth both CQC and TDA the Quality Summit date confirmed as Tuesday 2nd September which maintains current FT timeline.	07-Jul-14	07-Jul-14	Completed	07-Jul-14	Closed
02-Jul-14	14/200	TB/106	**Board Statement 10:** The Board agreed to down grade this from 'Compliant' to 'At risk'.	FTPD	The FT Programme Director to arrange for the status to be amended and submitted to TDA. **04/07/14** - Amended Self Certification submitted to TDA	04-Jul-14	04-Jul-14	Completed	04-Jul-14	Closed

Enc D

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th July. 2014

Title	Capital Programme 2014-15 inc Endoscopy Business Case			
Sponsoring Executive Director	Chris Palmer, Executive Director of Finance Katie Gray, Executive Director of Transformation & Integration Alan Sheward, Executive Director of Nursing & Workforce			
Author(s)	Mark Price, Company Secretary			
Purpose	For approval			
Action required by the Board:	**Receive**		**Approve**	**P**

Previously considered by (state date):			
Trust Executive Committee	21.7.14	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee	23.7.14	Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar	8.7.14		
Other (please state)	Capital Investment Group Estates Strategy Group		

Staff, stakeholder, patient and public engagement:

Various

Executive Summary:

The covering paper outlines changes to the 2014/15 capital programme and the reasons for these changes . It also clarifies approvals already secured and what decisions the Board are being asked to make . The revised Endoscopy case needs Board approval due to the value of the scheme .

The revised scheme will provide Endoscopy facilities that meet the projected needs of the Isle of Wight population in a quality and sustainable way. This will achieve Joint Advisory Group (JAG) accreditation, required for ongoing service provision, benefiting from additional future income streams.
This will be achieved by delivering a facility, by March 2016 that:

- provides an appropriate patient environment in line with accreditation;
- improves patient flow throughout the department;
- appropriately protects the privacy and dignity of patients;
- is compliant with the Disability Discrimination act;
- provides capacity for future growth;
- provides a long term solution to current decontamination issues for Endoscopy.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Clinical Strategy					
Critical Success Factors *(see key)*	CSF3					
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: 22.7.14 **Completed by: Mark Price Company Secretary**

Capital Programme 2014/15

1. Introduction

The Board has been briefed in a Seminar session earlier this month on proposed changes to the 2014/15 Capital Programme. This paper explains the changes, seeks approval to the Endoscopy Scheme as the value of the scheme requires Board approval and outlines the approval status of other relevant schemes with the programme.

2. ICU/CCU Scheme

In January 2014 the Board approved a business case for a capital scheme with a value of £2.4 million to combine the Intensive Care Unit and Coronary Care Unit (ICU/CCU) together in the current CCU accommodation. Following progression of the design stage and further clinical engagement the Trust Executive Committee has endorsed the proposal that this scheme should not now be taken forward in the previously agreed way. Lessons have been learned and shared with the Board in a Seminar session for the future management of the capital programme. Work is currently underway to determine how the revised schemes may continue to benefit from previous expenditure incurred and any impact that may arise.

New schemes will be developed for the CCU to take high dependency medical patients and for the ITU to accommodate high dependency surgical patients but these will be considered for the 2015/2016 Capital Programme and are not expected to be above the value that requires Board approval.

3. Endoscopy Scheme

In March 2014 the Board approved a business case for a capital scheme with a value of £4.7 million for the reprovision of the endoscopy unit. The preferred option outlined in the case was to relocate the endoscopy unit to the current ICU footprint which is no longer available as outlined in section 2 above. The revised case is presented as Appendix 1 and outlines the preferred option for the endoscopy reprovision as St Helens ward footprint. This option can deliver the relocation earlier than the original case for a similar capital cost. The scheme is preferred by the clinical teams.

4. Reprovision of St Helens Ward

The transfer of St Helens ward to the vacant Newchurch ward has been approved by the Trust Executive Committee earlier this month but will not progress until the Board has approved the revised endoscopy case. The scheme will commence in August through to October 2014 at a cost of £357,000. This utilises capital freed up in 2014/2015 due to the ICU/CCU change and will leave St Helens vacant.

5. Revised Timeline

This is presented as Appendix 2.

6. Revised Capital Programme

This is presented as Appendix 3.

7. Recommendations

The Board is recommended to:

(i) Note the ICU/CCU scheme previously approved will not now progress and that revised schemes will be developed;

(ii) Approve the revised Endoscopy Business Case (Appendix 1) with the principal change of relocation from ITU/CCU to St Helens footprint;

(iii) Note the scheme to reprovide St Helens ward to enable the current St Helens ward to be utilised for the endoscopy unit;

(iv) Note the revised timeline and capital programme (Appendices 2 and 3).

Chris Palmer
Executive Director of Finance

Alan Sheward
Executive Director of Nursing & Workforce

Katie Gray
Executive Director of Transformation & Integration

Isle of Wight NHS Trust

Title	Reprovision of Endoscopy
Brief Description	To provide Endoscopy facilities that meet the projected needs of the Isle of Wight population in a quality and sustainable way. This will achieve Joint Advisory Group (JAG) accreditation, required for ongoing service provision, benefiting from additional future income streams. This will be achieved by delivering a facility, by March 2016 that: · provides an appropriate patient environment in line with accreditation; · improves patient flow throughout the department; · appropriately protects the privacy and dignity of patients; · is compliant with the Disability Discrimination act; · provides capacity for future growth; · provides a long term solution to current decontamination issues for endoscopy.

Financial Impact Summary		2014/15	2015/16	2016/17
Total Capital Cost	**£4,776,780**	£2,464,500	£2,312,280	£0
Revenue Cost Increase	Clinical (activity related expenditure)	£1,425	£4,059	£5,528
	Estates (cost of occupation)	£0	£0	£69,831
Additional Income (Assumes if Do Nothing loss of existing Screening Income)		(£284,854)	(£312,672)	(£335,453)
Total Costs / (Income)		£283,429)	(£308,613)	(£260,095)
Revenue impact of Capital	Depreciation	£0	£0	£159,226
	Capital Charges	£0	£0	£164,400
Subtotal Revenue Impact of Capital		£0	£0	£398,985
Total Revenue Impact Increase		(£283,429)	(£308,613)	£63,531

1	Local and National Context
1.1	Version 7 of the business case was approved at Trust Board on 26th March 2014 with the understanding that the agreed solution (Option 4A) was reliant upon the relocation of ITU. However, since that time, it has become apparent that it will not be possible to carry out the re-location as planned in this financial year. For this reason, this business case is being re-considered, with the inclusion of an additional option
1.2	The previously approved option was one of two which considered the reprovision of endoscopy primarily within the current footprint of the Trust but with some additional new build. Since this best met the needs of the patients, it was felt appropriate to look for additional similar options. Therefore, Option 4C has been added to the shortlist.
1.3	The Isle of Wight has a population of approximately 138,000 according to the 2011 census which is expected to grow by approximately 7% by 2020. Of the current population, 25.3% are aged 65 and over. This is expected to rise to over 27% by 2020. (source: Office of National Statistics, Age by Single Year (QS103EW)

1.4	The Endoscopy unit provides cross speciality outpatient diagnostic s that supports emergency access via acute wards, accident & emergency, cancer fast track pathways, surveillance, participation in national screening programmes and outpatient procedures. Out turn for procedures undertaken for 2013/14 was 7,901. Since April 2014 quarter one, 1,802 procedures have been undertaken which include: Emergency access for Gastrointestinal bleeds [GI] Urology Haematuria & Cystoscopy Colonoscopy & Flexible Sigmoidoscopy Oesophago-Gastro-Duodenoscopy [OGD] Endoscopic retrograde cholangiopancreatography [ERCP] Percutaneous Endoscopic Gastrostomy tube insertion [PEG] Bronchoscopy
1.5	Demand is increasing rapidly due to a growing demographic pressure from an ageing population and an increasing number of people living with multiple complex health needs
1.6	As published by the Department of Health's 'Rapid Review of Endoscopy Services' in March 2012, the demand for endoscopy for patients with symptoms is increasing alongside the need for surveillance of patients at enhanced risk. These increases in demand will affect every endoscopy service in the country.
1.7	In addition, the NHS Operating Framework for 2012/13, Access to Services outlines the NHS constitution's patient's right to access services within maximum waiting times. There is an expectation that less than 1% of patients should wait longer than six weeks for diagnostic tests, including diagnostic endoscopy
1.8	The NHS outcomes framework 2014/2015 sets corresponding indicators used to hold NHS England to account for improvements in health outcomes. This framework is specific to helping more people survive cancer, rolling out the bowel screening programme by 2016 to save 3,000 lives a year.
1.9	The NHS Bowel Cancer Screening Programme [NHSBCSP] is on track nationally to cut cancer deaths by 16%, introduced in April 2006, completing the first roll out in 2009. NHSBCSP provides bowel screening to detect bowel cancer at an early stage (in people with no symptoms), when treatment is likely to be more effective. Screening can also detect polyps that can easily be removed, reducing the risk of bowel cancer developing.
1.10	NHS England continues to include the Isle of Wight in the national programme and is committed to the final stages of the bowel screening campaign programmed to roll out to the local population in March 2016 which follows continued government commitment to invest a further £60million to increase screening and offer flexible sigmoidoscopy
1.11	The local CCG are in full support of this case for locally commissioned activity for the remaining specialities, a formal document outlining their commitment will be provided following approval at Trust Executive Committee and prior to formal sign-off by the Trust Board, the acute SLA has already increased in line with the forecast levels for 2014/15.
1.12	In addition to growth and changes in demographics, the national bowel screening programme final phases will impact on demand for both flexible sigmoidoscopy and colonoscopy when the roll out commences in March 2016. Applying the implications of this programme results in a further projected increase in demand to 9,059 procedures per year.
2	**External compliance and accreditation**
2.1	The Endoscopy unit is monitored and accredited externally by regulatory and legal bodies in addition to the Care Quality Commission [CQC] this includes: · The Joint Advisory Group [JAG] · Medicines and Healthcare Regulatory Authority [MHRA]
2.2	The Joint Advisory Group [JAG] of the Academy of Medical Royal Colleges monitors compliance in relation to activity, patient experience and suitability of an endoscopy environment and its facilities. Accreditation is a minimum requirement for entry into the National Bowel Cancer Screening programme.

2.3	Providing a service without JAG accreditation poses significant challenges and risks to the organisation key areas include: a) Compliance of core standards such as CQC, MHRA & JAG b) Exclusion from National Screening, jeopardising access to reduce cancer survival rates c) Adherence to NICE guidance for Gastroenterology services d) Ability to manage diagnostics for cancer pathways from other specialites e) Income loss on current activity levels f) The tariff cap of 5% would result in a potential income loss of £196k p.a. g) The inability to attract additional income from future phases of the NHSBCSP has a forecast value rising to £650k p.a. h) Potential to lose the ability to provide training lists for registrars on rotation to the Gastroenterology service, impacting trust reputation with Wessex Deanery.
2.4	JAG's main focus is quality of training, units and individuals. Performance report cards are submitted by the team on a quarterly basis which records the unit's performance against the delivery of core clinical standards which includes procedure completion rates.
2.5	Full JAG Accreditation is reviewed every 5 years by the inspection team, a review of our service is being held on 01 July 2014, following certification on 03 July 2009.
2.6	A pre inspection report conducted in February 2013 ahead of the formal review in July 2014 has clearly stated that JAG will not pass the unit in its current state due to the poor physical environment of the existing service, specifically in relation to the unit design and layout.
2.7	In 2010/11 a 'two facet' survey was carried out by the Trusts Estates Strategy group which categorised the current Endoscopy as "Condition C - Major repair or replacement needed within three years (buildings) / one year (engineering)".
2.8	The Endoscopy unit currently has in excess of £491,000 backlog maintenance to bring it up to Condition B this work includes: · Like for like replacement of the Modular element of Endoscopy · Includes associated engineering, fixtures and fittings
2.9	Addressing backlog maintenance will not address all of the capacity, quality and privacy and dignity issues identified by JAG in July 2009 and the pre inspection report in February 2013.
3	**Case alignment to the Trust's Strategic Objectives:**
3.1	*Objective 1: To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience* Addressing the environmental issues will help to achieve this objective. A new build would improve the environment which would remove the current issues that exist around privacy and dignity
3.2	*Objective 4: To improve the productivity and efficiency of the Trust, building greater Financial efficiency.* Re locating the Endoscopy unit in facilities that address the accreditation issues and support the required unit design and layout will improve access for patients and reduce waiting times
3.3	Patients will be less likely to seek an alternative provider. Replacing older facilities that that are at or near the end of their useful life will reduce the level of backlog maintenance required. The new development will be more cost effective to light and heat reducing the overall carbon footprint.
3.4	The preferred option described under this business case will re provide the endoscopy service in a purpose designed area that fully complies with JAG requirements and offers opportunities to future proof the service into the foreseeable future.

3.5	The option has been developed specifically to fit with both the Estates Strategy and the Clinical Strategy, aligned to the Trust's integrated business plan and addresses the key areas highlighted on the risk register with a current score of 20. Specifically, it: · provides an appropriate patient environment; · improves patient flow throughout the departments; · appropriately protects the privacy and dignity of patients; · is Disability Discrimination Act [DDA] compliant; · provides capacity for future growth; · provides a solution to current decontamination Issues for endoscopy; · addresses Risk on Trust Risk log; · Improving clinical adjacencies in line with the Estates Strategy.
4	**Financial Case:**
4.1	Projected demand and capacity analysis demonstrates a potential to achieve an additional £1m p.a. by 2020 due to a combination of National screening and local CCG income as per quality section above. The 1 million is demonstrated in the table in section 10, and is the difference between £3,420,039 income in 2013 and 2020 income of £4,400,973.
4.2	The impacts of a non accredited unit include a cap in tariff from the local CCG. This is currently 5% per patient and would equate to a loss in income of approximately £196k each year.
4.3	The service will be inspected in September 2014; it is expected to fail the accreditation due to the suitability of the environment. The preferred option would deliver a suitable environment by March 2016. JAG would inspect the unit three months after the relocation.
4.4	The trust would potentially be working without accreditation for a period of 13 months, if the local Clinical Commissioning Group does choose to implement the tariff cap this could result in a total loss of income of approximately £212k.
4.5	A non accredited unit will result in the Island being excluded from additional phases of the National screening campaign, impacting access to on Island services for patients and potentially at risk from future CCG activity.
4.6	The loss of ability to provide an Endoscopy unit would have a direct effect on the deliverability of acute medicine, gastroenterology and colorectal surgery.
5	**Options Appraisal**
5.1	Details of the options appraisal are included in a separate paper, which has been approved at the Trust's Executive Committee and Finance Investment & Workforce Committee. The long list of options are as follows: Option1 Do nothing Option 2 Stop providing Endoscopy Option 3 Refurbish services in current locations Option 4 Move to refurbished location elsewhere on site Option 4 (A) Reprovide in the location currently occupied by the ITU Option 4 (B) Move DSU into ITU, reprovide endoscopy in the vacated DSU space Option 4 (C) Move St Helens Ward and reprovide Endoscopy in vacated space Option 5 Move to a refurbished location off site Option 6 New build on site Option 6 (A) Ophthalmology on ground floor, 3 room Endoscopy on the 1st floor separate staff accommodation above Option 6 (B) As sub option 6A above but with shared staff accommodation Option 6 (C) As sub option 6A above but with a 4 room Endoscopy suite Option 6 (D) As sub option 6B above but with a 4 room Endoscopy suite Option 6 (E) As option 6C but with an additional floor, left empty for future expansion Option 7 New build off site

5.2 The results of the options appraisal are outlined in the table below

Option Number	Option Name	Gross Internal Floor Area	Capital Cost	Net Present Value	% of Best
Option 1	Do Nothing	413 m^2	1,684,471	-76,167,883	86%
Option 4A	Move to refurbished ITU	1,025 m^2	4,787,948	-87,488,814	99%
Option 4B	Move to refurbished DSU	1,025 m^2	4,325,870	-88,084,114	100%
Option 4C	Move to refurbished St Helens	1,024 m^2	4,776,779	-87,443,704	99%
Option 6B	New Build on site - 3 rooms	2,772 m^2	9,457,378	-77,102,661	88%
Option 6D	New Build on site - 4 rooms	2,888 m^2	9,837,763	-76,319,844	87%
Option 6E	New Build on site - 4 rooms + expansion space	4,332 m^2	13,237,231	-68,237,862	77%

Option Number	Option Name	Quality Score	% Quality Score	Combined Score*	Ranking
Option 1	Do Nothing	305	7%	39	7
Option 4A	Move to refurbished ITU	469	10%	46	5
Option 4B	Move to refurbished DSU	469	10%	46	4
Option 4C	Move to refurbished St Helens	625	14%	48	1
Option 6B	New Build on site - 3 rooms	850	19%	46	2
Option 6D	New Build on site - 4 rooms	873	19%	46	3
Option 6E	New Build on site - 4 rooms + expansion space	896	20%	43	6

6 Workforce Costs

6.1 Increased activity due to growth will be managed through more flexible working. In 2016 with the introduction of the bowel screening programme there will be a step change in demand which will require the additional workforce outlined in the table below:

Role	wte	16/17 £	17/18 £	18/19 £	19/20 £
Consultant	0.32	40,403	40,403	40,403	40,403
Registered Nurse Band 5	0.96	34,796	34,796	34,796	34,796
Support Worker	0.21	3,787	3,787	3,787	3,787
Total Increase	**1.49**	**78,986**	**78,986**	**78,986**	**78,986**

6.2 Due to the low numbers of additional staff required, it is not envisaged that there will be any issues with recruiting to these posts in the new unit and in respect of the increase in consultant, this would be undertaken through existing posts and job planning.

7 Other Costs Summary

7.1 The business case includes building revenue costs, cleaning, maintenance and depreciation

8 Savings and Cost Reductions

8.1 Not applicable

9 Activity

9.1 Applying the projected change in population profile and increases in demand due to national screening campaigns implies the following endoscopy demand for 2020

Projected Activity	2013	2014	2015	2016	2017	2018	2019	2020
Gastroscopy	2,638	2,678	2,710	2,754	2,790	2,840	2,870	2,915
Colonoscopy	2,099	2,132	2,164	2,199	2,233	2,273	2,296	2,332
Flexible Sigmoidoscopy	752	800	875	927	2,180	2,248	2,288	2,330
ERCP	106	107	109	113	112	115	119	120
Bronchoscopy	91	92	94	98	100	102	104	106
Cystoscopy	811	828	843	858	877	901	912	929
Bowel Screening Colonoscopy	174	182	196	204	280	293	298	304
Total	**6,671**	**6,819**	**6,991**	**7,153**	**8,572**	**8,772**	**8,887**	**9,036**
% Growth		2%	3%	2%	20%	2%	1%	2%

10 Income

10.1 Projected demand and capacity analysis demonstrates a potential to achieve increased income from £3,420,039 (2013) to £4,400,973 (2020).

Projected Income (£)	2013	2014	2015	2016	2017	2018	2019	2020
Gastroscopy	1,392,826	1,392,736	1,388,238	1,420,653	1,449,298	1,485,598	1,511,800	1,546,252
Colonoscopy	1,175,906	1,176,477	1,176,223	1,203,614	1,230,779	1,261,596	1,283,283	1,312,528
Flexible Sigmoidoscopy	256,882	269,180	289,999	309,384	732,663	760,805	779,763	799,635
ERCP	83,560	83,083	83,367	87,031	86,865	89,816	93,590	95,038
Bronchoscopy	34,911	34,766	34,989	36,733	37,745	38,769	39,806	40,856
Cystoscopy	378,475	380,612	381,694	391,206	402,668	416,583	424,621	435,563
Bowel Screening Colonoscopy	97,479	100,431	106,534	111,659	154,330	162,625	166,558	171,101
Total	**3,420,039**	**3,437,285**	**3,461,044**	**3,560,279**	**4,094,347**	**4,215,793**	**4,299,421**	**4,400,973**
% Growth		1%	1%	3%	15%	3%	2%	2%

11 Benefits Realisation Evaluation

11.1
a) A JAG accredited service
b) Improved estate, patient and staff environment
c) The ability to support the training of foundation doctors during rotation
d) Capacity to effectively manage waiting times
e) Maximising income potential through best practice tariffs and participation in National Bowel Screening programme

11.2 Benefits Realisation Indicators:

a) A JAG accredited service
Quarterly audits monitored by JAG Performance report cards and inspection visits

b) Improved estate, patient and staff environment
Inspection visits, staff and patient surveys and engagement events

c) The ability to support the training of foundation doctors during rotation
Deanery placements

d) Capacity to effectively manage waiting times
Diagnostic waiting time monitoring and JAG report cards

e) Maximising income potential through best practice tariffs and participation in National Bowel Screening programme
Contracting performance monitoring

11.3 Post Implemenetation Evaluation Plan
Quarterly programme reviews in line with the evaluation of outcomes and scheme deliverables.

12 Risk

12.1 The risk of a delay in starting the works for the preferred option and subsequent delay in opening the unit is both a service and financial risk.
Mitigation will be through careful management of project time frames as well as the use of the escalation process when necessary to ensure appropriate approval processes are in place to secure capital allocation.

12.2	The risk of not going with the preferred option is both a financial and service risk to Endoscopy and wider specialites such as Gastroenterology, Colorectal, Urology and Respiratory and Pathology Mitigation will be through strict management of the budget and service
12.3	The new build does not comply with JAG Accreditation is both a service and financial risk. Mitigation will be through a planned approach in line with the JAG accreditation documents and good communication with key staff that are knowledgeable in endoscopy and JAG accreditation
13	**Timescales and Management Plan**
13.1	

Milestone	Date
Capital Investment Group	04/07/2014
Trust Executive Committee Sign Off	14/07/2014
Finance Investment and Workforce Committee	23/07/2014
Trust Board	30/07/2014
P21+ Stage 3 (Detailed and GMP) start	25/08/2014
P21+ Stage 3 Complete	19/12/2014
JAG Accreditation Lapses	01/10/2014
P21+ Stage 4 (Construction) commences	02/02/2015
P21+ Stage 4 (Construction) complete	30/10/2015
JAC Accreditation Recommences	01/02/2016

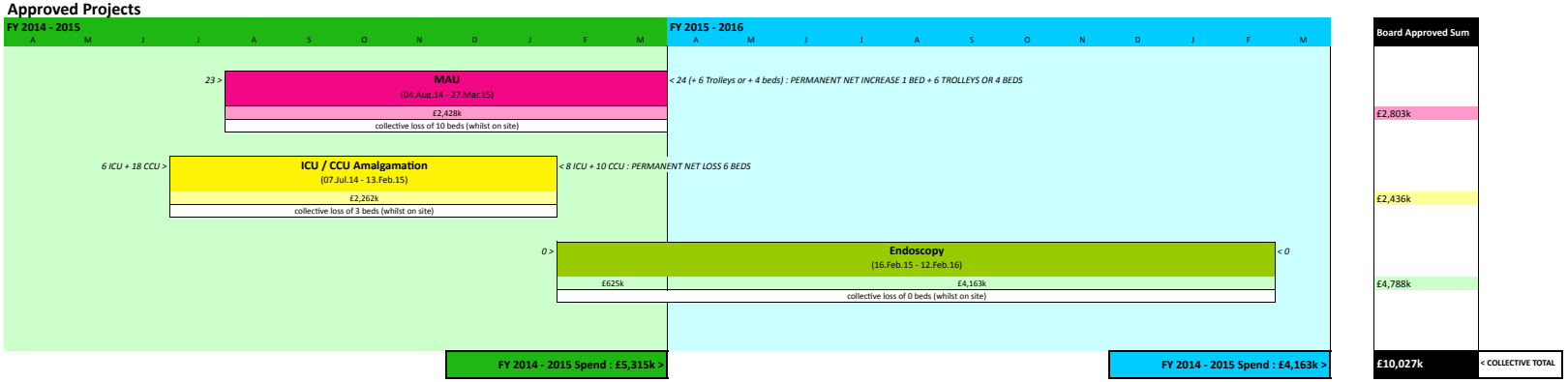
14	**Please state who (name and position) will be managing implementation of the case**
14.1	The Trust Board has formally approved the use of the Department of Health's P21+ for this project and has appointed Kier as Principal Supply Chain Partner (PSCP). Following the Business Case approval the PSCP will be appointed to undertake P21+ Stage 3 - Detailed Design and submission of Guaranteed Maximum Price.
14.2	Internal Trust support for this case is provided by:

Role	**Name**
Clinical Sponsor	Chris Sheen
Senior Responsible Officer	Alan Sheward
General Manager	Julianna Hayward
Estates Project Manager	Rob Graham
Trust Change Manager	Kevin Wilkins
Finance Manager	Natalie Klausch
Endoscopy Unit Manager	Glenis Sturgess

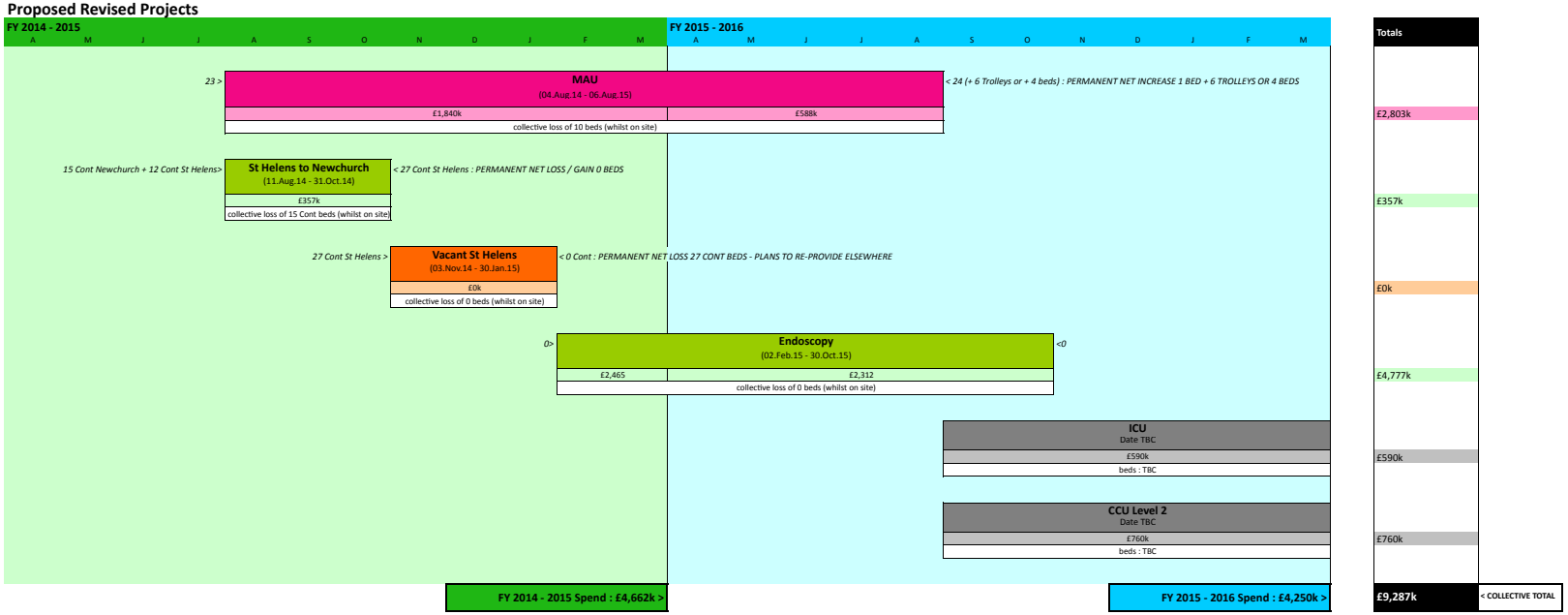
Appendix 2

Our Better Hospital Programme of Works

Approved Projects



Proposed Revised Projects



Appendix 3

Capital Allocations

Source & Application of Capital Funding	Original Plan £'000	Revised Plan / Budget £'000	Original Plan 2015/16 £'000	Revised Plan 2015/16
Source of Funds				
Initial CRL	7,460	7,460	6,927	6,927
Dementia Friendly		0		
Pharmacy Matched Funding - NHS Technology for Safer Wards (provisional)		0		
CCG Income (Hand Held Devices)		0		
Property Sales	648	648		
Cash Surplus			398	398
Anticipated Capital Resource Limit (CRL)	**8,108**	**8,108**	**7,325**	**7,325**
Other charitable donations	100	100	100	100
Charitable Funds - Dementia	9	9		
Donated Helipad Income	0	0		
VAT Recovery	100	100	100	100
Total Anticipated Funds Available	**8,317**	**8,317**	**7,525**	**7,525**
Application of Funds				
13/14 Schemes Carried Forward				
Backlog high/medium risk & fire safety 13.14	93	93		
Replacement of two Main Hospital Passenger Lifts	44	44		
Personal Alarm System for Sevenacres	0	0		
MAU Extension	2,428	1,840		588
Ward Reconfiguration Level C	142	142		
Ryde Community Clinic	1,225	1,225		
Dementia Friendly	192	192		
ISIS Further Faster	344	344		
ICU/CCU	2,262	126		
Endoscopy Relocation	625	2,465	4,163	2,312
Sub-total	**7,356**	**6,470**	**4,163**	**2,900**
14/15 Approved Schemes				
Endoscopy Backlog Maintenance	0	74		
Call Vision Call Recording Server	0	27		
Replacement Outpatient Desk	0	5		
Medicine Cabinet Installation	0	73		
Sub-total	**0**	**179**	**0**	**0**
14/15 Schemes - Requiring TEC Approval				
Backlog Maintenance	0	0	500	500
IM&T (balance)	156	129	500	500
RRP (Annual Plan adjusted by £45k to offset Endoscopy Backlog)	460	449	500	500
Contingency (Annual Plan adjusted by £28k to offset Endoscopy Backlog)	33	0	500	500
Infrastructure (e.g. underground services)	0	0	300	300
Staff Capitalisation	200	200	200	200
Upgrade to Medical Gases System	12	12		
Sub-total	**861**	**790**	**2,500**	**2,500**
New/Adjustments to Projects - Requiring TEC Approval				
St Helens Ward Relocation	0	357		
Carbon Energy Fund	0	421	0	625
Carbon Energy Fund Contingency	0	0		96
Unallocated	0	0	762	1,304
Sub-total	**0**	**778**	**762**	**2,025**
Other charitable donations	100	100	100	100
Gross Outline Capital Plan	**8,317**	**8,317**	**7,525**	**7,525**

Enc E

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th July 2014

Title	**Disposal of Swanmore Road Properties**			
Sponsoring Executive Director	Katie Gray, Executive Director of Transformation and Integration			
Author(s)	Kevin Bolan, Associate Director Estates			
Purpose	Seeking Approval in accordance with Estatecode			
Action required by the Board:	**Receive**		**Approve**	**P**

Previously considered by (state date):			
Trust Executive Committee	14/7/2014	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee	23/7/2014	Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Estates Prgramme Delivery Group	2/7/2014		
Capital Investment group	4/7/2014		

Staff, stakeholder, patient and public engagement:

Previous stakeholder engagement to relocate services from these properties has been undertaken and completed by the Community Directorate as part of the Ryde Community Clinic Business Case approved by the Board.

Executive Summary:

Clinical Services currently provided from the premises of 68-71 Swanmore Road, Ryde will relocate to the Ryde Community clinic early in 2015.
When the properties are vacated it is the intention that these should be disposed of to generate a capital receipt and ongoing-revenue savings as part of the trust's planned estate rationalisation programme as identified in the Trust's Estates Strategy.

The properties comprise of two pairs of semi-detached former dwellings with no disabled access to the first floor, poor functional suitability and poor quality for healthcare facilities.

For following sections – please indicate as appropriate:

Trust Goal To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience.	CSF-1. CSF-3, CSF-2, CSF - 7					
Critical Success Factors *(see key)*	CQC Standard 10 Safety and suitability of premises.					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***						
Assurance Level ***(shown on BAF)***	Red		Amber		Green	**P**
Legal implications, regulatory and consultation requirements	The title documents contain two registered restrictions in favour of the Secretary of State for Health; as such these will need written consent before completion.					

Date: 16/7/2014 **Completed by:** Kevin Bolan Associate Director Estates

Project Name: Estate Rationalisation

QuinCE Reference:343 [Subject]

Full Business Case

[Status]

30/06/2014

As Project Sponsor, I declare that all relevant assurances pertaining to this business case have been met and recommend that this project be implemented as per the enclosed Management Case.

Project Name: Disposal of 68-69 & 70-71 Swanmore Road Ryde

Signature	30/06/2014 date

Authorisation to Proceed

Signature or Meeting Reference	/ / date

Configuration Management

Version Control Current Version Number: Version 1.0

Number	Narrative	Issue Date	Author / Editor
Version 1.0	Disposal of Swanmore Road properties	30/06/2014	Kevin Bolan
Business Case Approval			
Meeting / Group	Comments	Date	Approved
Estates programme delivery group		01/07/2014	Yes
Capital Investment Group		04/07/2014	Yes
Trust Eexcutive Committee		14/07/2014	Yes
Finance Investment & Workforce Committee		23/07/2014	Yes
Trust Board		30/07/2014	

Contents

1. Executive Summary

The purpose of this business case is to seek approval to declare the freehold properties at 68-69 & 70-71 Swanmore Road Ryde surplus to the Trust's requirements when the services relocate to their new facilities at the Ryde Community Clinic early in 2015.

In accordance with Estatecode once the properties have been declared surplus they can then be marketed for disposal.

The properties comprise of two pairs of semi detached two storey former dwellings currently used as an Out Patient Clinic and a Mental Health Community clinic.

There is no lift access to the first floor of the properties

1.1 Benefits

- Capital receipt can be used to reinvest in clinical services
- Backlog maintenance requirement is reduced
- Re-occurring revenue savings are achieved
- Properties that are not-fit for purpose and are no longer required to provide patient services are disposed off

1.2 Preferred Option

Options	Description	Cost	Savings
Option 1	Do nothing	£0	£0
Option 2	Dispose of the properties	£23,900	£79,703

1.3 Timescale for implementation

The project will run from 1st August 2014 – 31st March 2015, dependant on there being a willing purchaser in a position to complete when the properties are put on the open market.

1.4 Risks

- Planning approval for a change of use back to residential is not given
- Planning approval for a development to the rear car park is not given, hence reducing amount of capital receipt
- Secretary of State for Health retains the capital receipt
- No willing purchaser for the properties is found

2. Introduction

Services currently provided from 68-69 & 70-71 Swanmore Road Ryde will be relocated to the new Ryde Community Clinic during February 2015.

The services to be relocated are shown below:

Service	Current Location	Proposed Location	Monthly Activity (contacts)
Podiatry	70/71 Swanmore Road	Ryde Community Clinic (formerly Shackleton House)	539
Physiotherapy · Musculoskeletal Physiotherapy · Pain Clinic · Acupuncture	70/71 Swanmore Road		150
Phlebotomy	70/71 Swanmore Road		520
Health Visiting	70/71 Swanmore Road		Base Only
Speech and Language	70/71 Swanmore Road		18
Mental Health Community clinics – includes Psychological Therapies	68/69 Swanmore Road		264

In accordance with Estatecode only land and properties that are required to enable the Trust to full fill its function of healthcare provider should be retained.

The purpose of the business case therefore is to demonstrate that the properties will become surplus to the Trust's requirements and therefore should be marketed for disposal.

Both 68-69 and 70-71 originally comprised of two pairs of semi detached two story dwellings constructed around the later part of the nineteenth century that have been extended and now form the Mental Health Community Clinic and Ryde Outpatients Department. In addition 70-71 includes the former ambulance station and car park to the rear of the site with its own frontage to Weeks Road, (refer to photograph below and location plan appendices page 20).

68-69 & 70-71 Swanmore Road Ryde

Prior to disposal a change of planning use from D1 (non-residential) to C3 (residential) will be required plus an application to construct additional dwellings on the rear car park to achieve best value.

It should be noted that the freehold title to the properties contains entries that affect the Trusts right to disposal as follows;

Title absolute: No disposition without written consent of the Secretary of State for Health
Charges Register: Right of pre-emption in favour of the Secretary of State for Health
PCT Estate: Future ownership and management of the estate in ownership of Primary Care Trusts in England 2011:

2.11 b Overage:
In the event that the Secretary of State decides not to proceed with Acquisition of the property, he will notify the Trust that they are free to dispose of the property.

2.12 Any disposal should be at market value, in accordance with the provisions of Estatecode. Under these circumstances,50% of the gain achieved, based upon gross sale proceeds less the lower of the NBV at the date of acquisition or the NBV before any revaluation prior to sale, will be payable to the Secretary of State.

2.1 Project Objective

To ensure that the Trust's assets are appropriately managed in accordance with Health Building Note 00-08: Estatecode

Achieving best value by ensuring the maximum capital receipt is realised to enable the re-investment for clinical services and that non-pay overheads expenditure is reduced.

Ensuring health care is provided from premises that are fit for purpose.

2.2 Purpose of the Business Case

The purpose of this business case is to state the preferred option for the delivery of the project objective, laying out the cost and benefits of that option and the proposed management case to ensure its successful completion

3. Strategic Case

The Trust's Estates Strategy sets out the plans for managing the Trusts estate. Over the next five years the trust has set a target of reducing the estate by 20% to ensure that overheads costs are kept to a minimum, retained assets are fit for purpose and that they are fully utilised.

Previously the Ryde Community Clinic business case set out the clinical strategy which supported the relocation of the services from 68-69 & 70-71 Swanmore road to the former Shackleton House also in Ryde; this was approved by the Trust Board early in 2014.

The Department of Health announced in March 2013 that they want to make £20 billion worth of efficiency savings by 2015, so that there are more funds for treating patients and to allow the NHS to respond to changing demands and new technologies. The disposal of these properties will support local plans to achieve the Trusts own efficiency targets and generate capital for re-investment into patient services.

Our Strategic Objectives

1. To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience
2. To deliver the Trust's clinical strategy, integrating service delivery within our organisation and with our partners, and providing services locally wherever clinically appropriate and cost effective
3. To build the resilience of our services and organisation, through partnerships within the NHS, with social care and with the private sector
4. To improve the productivity and efficiency of the Trust, building greater financial sustainability
5. To develop our people, culture and workforce competencies to implement our vision and clinical strategy

4. Economic Case - Options appraisal (value for Money)

The economic benefits of relocating the services to the new North East Locality have been demonstrated in the separate business case previously approved by the board.

Economic benefits of disposing of the properties include:

- Receiving a capital receipt to support the Trusts capital programme, estimated gross £650,000
- Cost avoidance against future backlog maintenance expenditure total £313,230 + VAT and fees
- Re-occurring revenue savings £79,703.

4.1 Non Financial Option Appraisal -

Option 1	Do Nothing – weighting score: 4
Benefits	No disposal costs incurred
Risks	No economical future use for the building is found Overheads expenditure is not reduced Requirement for backlog and normal maintenance expenditure will remain Re-investment of capital funds will not be available
Spend profile	0
Option 2	Dispose of the properties Weighting score: 10
Benefits	Reduced statutory compliance risk/backlog maintenance Services are relocated to premises that are fit for purpose Improved disabled access
Risks	Planning approval is not given Secretary of State for Health approval to retain the receipt is not given
Spend profile	£23,900 14/15 financial year

4.2 Preferred Option

Benefits to the Organisation
Reduced backlog maintenance Capital receipt to reinvest in patient services Reduced overheads expenditure Properties not fit for purpose disposed off
Benefits to Patient and Carer Groups
Improved disabled access in the new premises Services are provide from premises that are fit for purpose
Benefits to Staff
Improved suitability of new premises New facility is in a single story building Improved integration of services
Impact on Quality
Improved patient facilities
Impact on Productivity
Refer to North East Locality business case
Links to Strategic Goals / Critical Success Factors
Compliance with CQC standard 10 safety and suitability of premises **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**
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 **CSF7** - Improve value for money and generate our planned surplus whilst maintaining or improving quality

5. Commercial Case

Procurement - South of England Procurement Services

Has SoEPS commenced the procurement process for this project?	
What is the recommended procurement method?	
Have the costs in this bid been sourced by SoEPC?	
Are the costs provided in this bid preliminary / Indicative only?	
Is estimate prepared against full scheme details?	
What is the lead time for delivery of this project from the point of order receipt?	

Comment on status of procurement:
N/A

Procurement - Estates

Proposed Procurement Route	Competitive quotations
If formal tender – is OJEU required?	
Works (above £3,927k)	No
Services (Professional Fees) (above £101k)	No
Supplies (Equipment) (above £101k)	No
Have the costs in this bid been sourced by Estate Management Dept?	Yes
Are the costs provided in this bid preliminary / Indicative only?	Yes
Is estimate prepared against full scheme details?	Yes

What is the overall programme, including detailed design, tender and works period, following approval?
The overall programme from obtaining formal quotations to appointment is 4 weeks starting from 1st July

6. Financial Case (Affordability)

In preparation for disposal professional fees will be required to pay for the required reports, planning applications and legal fees, these costs will be offset against the capital receipt from the sale to provide a net receipt.

Estimated fees:

District Valuer report £1,500 + VAT
Change of use planning application £500 +VAT
Architect fees for planning application to develop the car park into an additional dwelling £5,000 +VAT
Estate agent fees £7,500 +VAT
Legal fees £5,000 +VAT
Contingency £500.00

Total estimated cost £23,900.00 Inc VAT

Capital receipt

Gross assuming full planning permission for the building plot £650,000.00

Please see below for the full financial appraisal

Financial Case - Disposal of Swanmore Road Properties

Valuation by District Valuer as at 31st March 2014

Area	Modern Equivalent Value	Life in Years	Annual Depreciation
68 & 69 Swanmore Road - Building	210,000.00	36.00	5,833.32
70 & 71 Swanmore Road - Building Structure	156,320.00	18.32	8,532.72
71 & 71 Swanmore Road - Building Engineering	124,282.00	17.45	7,122.14
72 & 71 Swanmore Road - External Works	14,030.00	17.93	801.72
68 & 69 Swanmore Road - Land	105,000.00		0.00
70 & 71 Swanmore Road - Land	110,000.00		0.00
NBV as at 1st April 2014	**719,632.00**		**22,289.90**
NBV as at 31st March 2015	697,342.10		
Average NBV for 2014/15	708,487.05		
3.5% for PDC (Capital Charges)	**24,797.05**		
Open Market Value	650,000.00		
Annual Savings available from Disposal			
Depreciation	22,289.90		
PDC (Capital Charges)	24,797.05		

Utilities (Based on 2013/14)	12,603.00
Maintenance	12,713.00
Cleaning	0.00
Rates (2014/15 Charge)	7,300.50
	79,703.45

Financial Implications for Disposal of Swanmore Road Properties

Open Market Value	650,000.00

Property Values as at 31st March 2015 (assuming this is when the properties will be sold)

Area	Modern Equivalent Value	Revaluation Reserves available for writing off the asset
68 & 69 Swanmore Road - Building	204,166.68	60,455.64
70 & 71 Swanmore Road - Building Structure	147,787.28	29,115.31
71 & 71 Swanmore Road - Building Engineering	117,159.86	59,473.33
72 & 71 Swanmore Road - External Works	13,228.28	15,458.44
	482,342.10	**164,502.72**
68 & 69 Swanmore Road - Land	105,000.00	68,294.00
70 & 71 Swanmore Road - Land	110,000.00	70,000.00
	215,000.00	**138,294.00**
	697,342.10	**302,796.72**

Accounting Transactions to write down the asset and receive the cash

Buildings	
Cr Fixed Assets	(482,342.10)
Dr Revaluation Reserve	164,502.72
Dr I&E (not enough Revaluation Reserve to cover)	317,839.38
Land	
Cr Fixed Assets	(215,000.00)
Dr Revaluation Reserve	138,294.00
Dr I&E (not enough Revaluation Reserve to cover)	76,706.00

Cash	
Dr Bank	650,000.00
Cr Profit on Sale of Fixed Assets	(650,000.00)
Net impact to I&E	
Profit on Sale of Fixed Assets	(255,454.62)

Amount Payable to the Secretary of State - 50% of gain achieved, based upon gross sale proceeds
less the lower of the NBV at the date of acquisition or the NBV before any revaluation prior to sale

Gross Sale Proceeds Less the NBV at Date of Acquisition 1st April 2013	
Gross Sale Proceeds	650,000.00
NBV at Date of Acquisition of 1st April 2013	697,223.00
Gross Proceeds / (Loss) less NBV at Date of Acquisition	(47,223.00)
50% of Gross Proceeds / (Loss) less NBV at Date of Acquisition	**(23,611.50)**

Gross Sale Proceeds less NBV at Date of Sale 31st March 2015 prior to Revaluation	
Gross Sale Proceeds	650,000.00
NBV at Date of Sale of 31st March 2015 before Revaluation	697,342.10
Gross Proceeds / (Loss) less NBV at Date of Sale	(47,342.10)
50% of Gross Proceeds / (Loss) less NBV at Date of Sale	**(23,671.05)**

The amount payable to the Secretary of State will be based upon the NBV at the Date of Acquisition as this had a lower value than at the Date of Sale

However, using the calculation, Gross Sale Proceeds less the NBV, a loss will accrue so no payment should be due to the Secretary of State

Financial Impact Option - Nothing		2014/15	2015/16	2016/17	2017/18	2018/19
Capital		N/A				
Revenue	Pay					
	Non Pay		32320	32320	32320	32320
Revenue Sub total						
Income						
Other i.e. Charity						
Notional Net Impact (deficit)			32320	32320	32320	32320

Financial Impact Option - 2		2014/15	2015/16	2016/17	2017/18	2018/19
Capital						
Revenue	Pay	23,900				
	Non Pay		79,703	79,703	79,703	79,703
Revenue Sub total						
Income		650,000				
Other i.e. Charity						
Notional Net Impact Surplus		626,100	79,703	79,703	79,703	79,703

7. Management Case

The Associate Director of Estate will oversee the project and follow the requirements of Estatecode section 7: disposal of freehold land and property.

Ensuring best value is achieved and that the disposal is monitored and reported via the Estate Programme Group.

Solicitors will be appointed to draft the contracts for sale and ensure due diligence is followed, including seeking the required approvals from the Secretary of State for Health.

The properties have been listed on the Department of Health surplus land register return 2014.

7.1 **Project Governance**

Project Manager: Kevin Bolan, Associate Director Estates
Project Sponsor: Andy Heyes, Interim Director of Planning ICT and Integration
Project Board members: Kevin Bolan, Robert Graham, Solicitor (to be named), Community Directorate lead, service user lead

7.2 Project Schedule

	Date
Project Start	June 2014
Case Approval	July2014
Staff Partnership Forum Approval	N/A
Begin 30 day staff consultation	N/A
End of 30 day staff consultation	N/A
Project Completion	March 2015
Post Project Evaluation Starts	April2015
Post Project Evaluation Completed	April 2015

8. Benefits Realisation

Benefits, including Improvements in Quality and Intellectual Property (IP)

Benefit Owner	Benefit description	Measurement			Target	Baseline
		How	When	Where		
Trust	Capital receipt re-invested in improved patient services	Amount of capital to re-invest	01/03/2015	Ryde Community Clinic	100%	0%
Trust	reduced backlog maintenance cost	Reduction in overall backlog cost	01/03/2015		100%	0%
Trust	Properties that are not functionally suitable for health care are disposed off	Patient and staff feed back	01/03/2015	Ryde Community Clinic		
Patients	Services are provided from fit for purpose locations	Patient and staff feed back	01/03/2015	Ryde Community Clinic		
Trust	Reduced overheads revenue expenditure	Budgets are reduced	01/04/2015			

Where there are truly innovative outcomes expected from the project consideration should be given to the management of Intellectual Property (IP) at this stage (guidance is given in the Intellectual Property Management Policy)

9. Risk Management

Project Disposal of 68-69 & 70-71 Swanmore Road
Ref 343
Version 1.0

Risk Log

Organisational Risk - These are the risks that the project is intended to address and those that will arise as a result

						Prior to Mitigation			Post Mitigation					
Ref	Author	Date Identified	Date Last Updated	Description	Proximity	Likelihood	Severity / Consequence	Mitigating actions	Likelihood	Severity / Consequence	Owner	Current Status	Current Risk Score	Future Risk Score
1	KB	26/06/14		No Planning permission for change of use	3 months	Possible	Major	Early discussions with planning	Rare	Minor	KB	Underway	12	2
2	KB	26/06/14		No planning permission for additional properties	3 months	Possible	Major	Early discussions with planning	Possible	Minor	KB	Underway	12	6
3	KB	26/06/14		SoSfH approval not given	6 months	Possible	Major	Robust business case and correct procedures	Possible	Minor	KB	Underway	12	6

Quality Impact - These are the risk that the implementation of the project will result in a detrimental effect on Quality

						Prior to Mitigation			Post Mitigation					
Ref	Author	Date Identified	Date Last Updated	Description	Proximity	Likelihood	Severity / Consequence	Mitigating actions	Likelihood	Severity / Consequence	Owner	Current Status	Current Risk Score	Future Risk Score
4	KB	26/06/14		Patient services remain in unsuitable premises	NOW	Certain	Moderate	relocate services to suitable premises	Unlikely	Minor	KB	Planned	15	4
5	KB	26/06/14		Disabled access is limited	NOW	Certain	Moderate	relocate services to suitable premises	Rare	Minor	KB	Planned	15	2

Project Delivery - These are the ongoing risks to the implementation of the project

						Prior to Mitigation			Post Mitigation					
Ref	Author	Date Identified	Date Last Updated	Description	Proximity	Likelihood	Severity / Consequence	Mitigating actions	Likelihood	Severity / Consequence	Owner	Current Status	Current Risk Score	Future Risk Score
6	KB	26/06/2014		Delay in receiving planning permission for change of use	3 months	Possible	Major	early discussions with Planners	Unlikely	Minor			12	4
7	KB	26/0614		Delay in receiving planning permission for additional properties	3months	Possible	Major	early discussions with Planners	Unlikely	Minor			12	4
8	KB	26/06/2014		Delay in receiving SoSfH approval	4 months	Possible	Major	Robust business case	Unlikely	Moderate			12	6
9	KB	26/06/2014		Delay in completion of North East Locality Hub	6 months	Possible	Moderate	Robust contingency plans	Unlikely	Moderate			9	6

Summary

	Organisational Risk	
	Current	**Future**
Total Green	0	3
Total Amber	3	0
Total Red	0	0
Max Score	12	6

	Quality Impact	
	Current	**Future**
Green	0	2
Amber	0	0
Red	2	0
	15	4

	Project Delivery	
	Current	**Future**
Green	0	4
Amber	4	0
Red	0	0
	12	6

10. Equality Considerations

Equality Group	**Impact (positive / negative / neutral)**	**Please explain impact**
Gender reassignment	neutral	Patient services have been relocated
Pregnancy and Maternity	neutral	Patient services have been relocated
Race or Ethnicity	neutral	Patient services have been relocated
Religion or Belief	neutral	Patient services have been relocated
Sex	neutral	Patient services have been relocated
Sexual Orientation	neutral	Patient services have been relocated
Other disadvantaged group not protected by The Equality Act 2010 e.g. Prisoners, Gypsies and Travelers, Socio-economic status	neutral	Patient services have been relocated

11. Stakeholder Engagement and Communications Plan

Stakeholder Engagement				Communications Plan		
Stakeholder	What is expected of Stakeholder	Stakeholder management strategy	Perceived attitudes and/or risks	Means of Communication	Frequency of Communication	Responsibility for communication
Estates Progamme group	Approval/monitorir	Regular updates	Supportive	Summary report	bi monthly	Kevin Bolan
Capital Investment Grou	Approval/monitorir	Regular updates	Supportive	Summary report	bi monthly	Kevin Bolan
DH surplus land return	Approval/monitorir	Regular updates	Supportive	EFM reporting site	6 monthly	Kevin Bolan
Trust Board	Approval	Robust case for change	Supportive	Business case	once	Kevin Bolan
Community Directorate	monitoring	Regular updates	Supportive	verbal	bi monthly	Kevin Bolan
Health & Safety/Fire	Support	Regular updates	Supportive	verbal	bi monthly	Kevin Bolan
ICT	Support	Regular updates	Supportive	verbal	bi monthly	Kevin Bolan

12. Assurances

Record of Stakeholder Assurances

Area	Name	Approved	Date	Evidence of approval	Comments
Finance	Carol Oglivie/Andrew Wheeler	Yes			
HR	N/A				
Health & Safety / Security	Connie Wendes	Yes			
Fire	Martin Keigthley				
IT	Paul Dubery	Yes			
Information Governance	N/A				
PIDS	N/A				
Contracts	N/A				
Acute Business Manager	N/A				
Planned Business Manager	N/A				
Community Business Manager					
Risk and Assurance	N/A				
Quality	N/A				
Estates					
Infection Control	N/A				
Medical Electronics	N/A				
Solent Supplies	N/A				

Area's shown in bold are mandatory and therefore must be included in the Assurance process for all Business Cases

13. Appendices

Privacy Impact Assessment Screening to be included as an appendix (if applicable)

PIA Screening Questions

Will person identifiable data be collected as part of the project and, considering the technology used, have potential for substatial intrusion to the individual's privacy?
N/A

What data will be collected? Who is the owner of the data? Why is this information being collected?
N/A

Will patients be asked for consent for collection or sharing?
N/A

Does the project involve new or significantly changed handling of personal data that is sensitive, or of particular concern to individuals?
N/A

Might the project have the effect of allowing staff not directly involved in the care of the patient access to information?
N/A

Does the project involve new of significantly changed handling of a considerable number or personal data about each individual in the database?
N/A

Does the project involve reporting requirements? If so, who will be able to run reports? Will data in the reports by anonymised or identifiable?
N/A

Does the project involve new or significantly changed consideration, inter-linking, cross-referring or matching of personal data from multiple sources?
N/A

Will the information be transferred outside of the organisation? Are sharing agreements in place?
N/A

Does the project involve systematic disclosure of personal data to, or access by, third parties that are not subject to comparable privacy regulation?
N/A

Does the project relate to data processing which is in any way exempt from legislative privacy protections?
N/A

Does the project's justification include significant contributions to public security measures?
N/A


MILLIGAN ROAD
Dairy Court
NURSERY GARDENS
WEST STREET
SWANMORE ROAD
OSBORNE ROAD
Osborne Mews
Milligan House
Nightingale Cottages
Victoria Terrace
Hospital Out Patients and X Ray Department
PH
50.5m
47.4m
48.8m
D Fn
Promap

Enc F

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Isle of Wight NHS Trust

Title	**Isle of Wight NHS Trust Board Performance Report 2014/15**				
Sponsoring Executive Director	Chris Palmer (Executive Director of Finance) Tel: 534462 email: Chris.Palmer@iow.nhs.uk				
Author(s)	Iain Hendey (Assistant Director of Performance Information and Decision Support) Tel: 822099 ext 5352 email: Iain.Hendey@iow.nhs.uk				
Purpose	To update the Trust Board regarding progress against key performance measures and highlight risks and the management of these risks.				
Action required by the Board:	**Receive**		**X**	**Approve**	
Previously considered by (state date):					
Trust Executive Committee			Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee			Nominations Committee (Shadow)		
Charitable Funds Committee			Quality & Clinical Performance Committee		23/07/2014
Finance, Investment & Workforce Committee		23/07/2014	Remuneration Committee		
Foundation Trust Programme Board					
Please add any other committees below as needed					
Other (please state)					
Staff, stakeholder, patient and public engagement:					
Executive Summary:					
This paper sets out the key performance indicators by which the Trust is measuring its performance in 2014/15. A more detailed executive summary of this report is set out on page 2.					
For following sections – please indicate as appropriate:					
Trust Goal *(see key)*	Quality, Resilience,Productivity & Workforce				
Critical Success Factors *(see key)*	CSF1, CSF2, CSF6, CSF7, CSF9				
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***					
Assurance Level ***(shown on BAF)***	☐ Red		☐ Amber		☐ Green
Legal implications, regulatory and consultation requirements	None				

Date: Friday 25th July 2014 **Completed by: Iain Hendey**

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

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

Isle of Wight NHS Trust

Safe

GRR ref		Area	Annual Target	Actual Performance		YTD	Month Trend
	Patients that develop a grade 4 pressure ulcer	TW	12	1	Jun-14	12	↗
	Reduction across all grades of pressure ulcers (25% on 2013/14 Acute baseline, 50% Community)	TW	203	21	Jun-14	82	↗
	VTE (Assessment for risk of)	AC	>95%	100%	Jun-14	99.7%	↗
	MRSA (confirmed MRSA bacteraemia)	AC	0	0	Jun-14	0	↔
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)	AC	6	2	Jun-14	4	↔
	Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	TW	50	7	Jun-14	19	↔
	Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	TW	9	0	Jun-14	0	↔
	Falls - resulting in significant injury	TW	7	2	Jun-14	2	↘

Responsive

		Area	Annual Target	Actual Performance		YTD	Month Trend
1	RTT:% of admitted patients who waited 18 weeks or less	AC	90%	93%	Jun-14	94%	↘
2	RTT: % of non-admitted patients who waited 18 weeks or less	AC	95%	91.1%	Jun-14	92.5%	↘
3	RTT % of incomplete pathways within 18 weeks	AC	92%	93%	Jun-14	93%	↗
8b	Symptomatic Breast Referrals Seen <2 weeks*	AC	93%	74%	Jun-14	83%	↘
6b	Cancer patients seen <14 days after urgent GP referral*	AC	93%	92.6%	Jun-14	94%	↘
6a	Cancer Patients receiving subsequent Chemo/Drug <31 days*	AC	98%	100%	Jun-14	100%	↔
5a	Cancer Patients receiving subsequent surgery <31 days*	AC	94%	100%	Jun-14	100%	↗
	Cancer diagnosis to treatment <31 days*	AC	96%	98%	Jun-14	98%	↘
7	Cancer Patients treated after screening referral <62 days*	AC	90%	100%	Jun-14	86%	↔
5b	Cancer Patients treated after consultant upgrade <62 days*	AC	85%	100%	Jun-14	100%	↗
8a	Cancer urgent referral to treatment <62 days*	AC	85%	86%	Jun-14	87%	↗
	No. Patients waiting > 6 weeks for diagnostics	AC	100	3	Jun-14	7	↗
	%. Patients waiting > 6 weeks for diagnostics	AC	1%	0.24%	Jun-14	0.19%	↘
4	Emergency Care 4 hour Standards	AC	95%	96%	Jun-14	95%	↘
12	Ambulance Category A Calls % < 8 minutes	AM	75%	76%	Jun-14	77%	↘
13	Ambulance Category A Calls % < 19 minutes	AM	95%	96%	Jun-14	77%	↘
9a	% of CPA patients receiving FU contact within 7 days of discharge	MH	95%	95%	Jun-14	95%	↘
9b	% of CPA patients having formal review within last 12 months	MH	95%	85%	Jun-14	56%	↗
10	% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	MH	95%	100%	Jun-14	99%	↔

Effective

	Area	Annual Target	Actual Performance		YTD	Month Trend
Summary Hospital-level Mortality Indicator (SHMI)* Oct-12 - Sep-13	TW	1.00	1.1026	Published Apr 2014	N/A	↗
Hospital Standardised Mortality Ratio (HSMR) Oct-12 - Sep-13	TW	100	96	Published Apr 2014	N/A	↗
Stroke patients (90% of stay on Stroke Unit)	CM	80%	93%	May-14	90%	↗
High risk TIA fully investigated & treated within 24 hours (National 60%)	CM	60%	69%	May-14	69%	↔
Cancelled operations on/after day of admission (not rebooked within 28 days)	AC	0	3	Jun-14	4	↘
Delayed Transfer of Care (lost bed days)	TW	N/A	106	Jun-14	471	↗
Number of Ambulance Handover Delays between 1-2 hours	AM	N/A	7	Jun-14	17	↗
Theatre utilisation	AC	83%	81%	Jun-14	80%	↘

Well-Led

	Area	Annual Target	Actual Performance		YTD	Month Trend
Total workforce SIP (FTEs)	TW	2,616.6	2,646.6	Jun-14	N/A	↗
Total pay costs (inc flexible working) (£000)	TW	£9,596	£9,043	Jun-14	£19,594	↗
Variable Hours (FTE)	TW	136.7	140.4	Jun-14	415.7	↘
Variable Hours (£000)	TW	£29	£524	Jun-14	£1,875	↘
Staff sickness absences	TW	3%	3.49%	Jun-14	3.66%	↗
Staff Turnover	TW	5%	0.59%	Jun-14	1.83%	↗
Achievement of financial plan	TW	£1.7m	£343k	Jun-14	£343k	
Underlying performance	TW	£862.00	£343k	Jun-14	£343k	
Net return after financing	TW	0.50%	5.51%	Jun-14	5.51%	
I&E surplus margin net of dividend	TW	=>1%	0.03%	Jun-14	0.03%	
Liquidity ratio days	TW	=>15	24	Jun-14	24	
Continuity of Service Risk Rating	TW	3	4	Jun-14	4	
Capital Expenditure as a % of YTD plan	TW	=>75%	24%	Jun-14	24%	
Quarter end cash balance (days of operating expenses)	TW	=>10	28	Jun-14	28	
Debtors over 90 days as a % of total debtor balance	TW	=<5%	12.97%	Jun-14	12.97%	
Creditors over 90 days as a % of total creditor balance	TW	=<5%	1.09%	Jun-14	1.09%	
Recurring CIP savings achieved	TW	100%	83.91%	Jun-14	83.91%	
Total CIP savings achieved	TW	100%	124.28%	Jun-14	124.28%	

Caring

	Area	Annual Target	Actual Performance		YTD	Month Trend
Patient Satisfaction (Friends & Family test - Total Inpatient response rate)	AC	30%	41%	Jun-14	33%	↗
Patient Satisfaction (Friends & Family test - A&E response rate)	AC	20%	22%	Jun-14	18%	↗
Mixed Sex Accommodation Breaches	TW	0	0	Jun-14	0	↔
Formal Complaints	TW	<175	15	Jun-14	49	↘
Compliments received	TW	N/A	350	Jun-14	863	↗

Notes

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

Key to Area Code

- TW = Trust Wide
- AC = Acute
- AM = Ambulance
- CM = Community Healthcare
- MH = Mental Health

Sparkline graphs and Year End forecasts will be included as appropriate once further data is collected to calculate developing trends.

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Executive Summary

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

Safe:

Pressure ulcers: We continue to under achieve our planned local reduction across all grades of pressure ulcers, both in the hospital setting and the wider community although we have achieved the national 25% reduction target in the hospital setting. A range of actions are in place to support improvements in this priority indicator in all areas.

Responsive:

RTT Non Admitted was again below target in June, with a number of specialties not achieving target bringing the overall Trust performance (91.1%) below 95% target. A range of actions are continuing to address this issue including additional outpatient clinics and the appointment of locums in challenged specialties.

Symptomatic Breast referrals seen within 2 weeks failed the 93% standard again during June (74%), reflecting the 30% increase in activity over the last 3 months. Work is ongoing to address the increased capacity issues and prevent recurrence. The two week wait from GP referral also underachieved during June (92.6%) and this was mainly due to breast patients and the same capacity issues.

CPA patients receiving a formal review within 12 months - the performance against this target has increased again this month due to continuing work to manually report against this indicator. The figure reported (85%) is the improved position according to data available as at 16th July. It is expected that the roll out of PARIS will rectify the data collection issue.

Well Led:

The pay bill for June including variable hours is £9.567m, within the plan of £9.625m. The number of FTEs in post is currently above plan by 30 FTE. The HR Directorate are closely monitoring and supporting the Clinical directorates with their workforce plans, in particular their control over their spend on variable hours.

Sickness absence continues to improve, (June, 3.49%) but remains above the 3% plan. Specific problem areas are being identified for local investigation and are challenged at directorate performance review meetings.

At the end of June the Trust is reporting a retained surplus of £341k against the actual plan of £343k. The adjusted retained surplus shows £343k against a plan of £349k - £6k below plan. The Continuity of Service Risk Rating is 4.The Cost Improvement Programme shows a year to date overachievement of £657k against the target of £1,605k. Included within this performance is the recognition of full year savings amounting to £1,280k. Of the total £2,261k achieved, £1,647k was achieved recurrently with £614k achieved non recurrently against a non reccurent target YTD of £412k.

Caring:

Patient Satisfaction: Complaints remain low in June in comparison to April although slightly increased since May and outside the year to date trajectory. Compliments, in the form of letters and cards of thanks, were slightly higher during June than in May. As one of the CQUIN goals for this year, the PALS relocation to main reception has now been completed and is providing a higher profile access to the public although further work is being undertaken to improve soundproofing. The Friends & Family Test response rate for June is encouraging but maintaining the increase continues to be challenging and work is ongoing to improve access.

Effective:

Theatre Utilisation has improved but is again below plan for both Main Theatres and Day surgery giving a joint rate of 81% in June. Bed pressures continue effect performance with a reduction in elective admissions due to the high risk of cancellation as well as delays in admission processing.

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Performance Summary - Community

Isle of Wight NHS Trust

Balance Scorecard - Community

Safe	Latest data	In month		YTD	
		Target	Actual	Target	Actual
No. of Grade 1&2 Pressure Ulcers	Jun-14		11		56
No. of Grade 3&4 Pressure Ulcers	Jun-14		5		18
MRSA	Jun-14	0	0	0	0
C.Diff	Jun-14		1	2	2
No. of Reported SIRI's	Jun-14		6		17

Effective	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Stroke patients (90% of stay on Stroke Unit)	May-14	80%	93.3%	80%	90.2%
High risk TIA fully investigated & treated within 24 hours (National 60%)	May-14	60%	68.8%	60%	68.8%

Responsive	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Well-Led	Latest data	In month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism - C Directorate	Jun-14	3%	3.31%	3%	3.88%
FTE vs Budget - Community Directorate	Jun-14	892.94	871.97	2686.82	2621.23
Appraisals					
Actual vs Budget (in £'000's)					
CIP (in £'000's)					

Contracted Activity	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Community Contacts	May-14	16,294	18,491	32,589	35,892

Caring	Latest data	In month		YTD	
		Target	Actual	Target	Actual
FFT - % Response Rate	Jun-14	30%	46.3%	30%	31.4%
FFT - % Recommending	Jun-14	95%	89.5%	95%	93.0%
No. of Complaints	Jun-14		5		10
No. of Concerns	Jun-14		11		36
No. of Compliments	Jun-14	N/A	88	N/A	225

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Performance Summary - Mental Health

Isle of Wight NHS Trust

Balance Scorecard - Mental Health

Safe	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Effective	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Responsive	Latest data	In month		YTD	
		Target	Actual	Target	Actual
% of CPA patients receiving FU contact within 7 days of discharge	Jun-14	95%	95%	95%	95%
% of CPA patients having formal review within 12 months of discharge	Jun-14	95%	85%	95%	56%
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	Jun-14	95%	100%	95%	99%

Well-Led	Latest data	In month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism (included in Community Directorate)	Jun-14	3%	3.31%	3%	3.88%
FTE vs Budget (included in Community Directorate)	Jun-14	892.94	871.97	2686.82	2621.23
Appraisals					

Activity	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Mental Health Inpatient Activity	Jun-14	N/A	42	N/A	137
Mental Health Outpatient Activity	Jun-14	N/A	533	N/A	1,579

Caring	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Performance Summary - Ambulance & 111

Isle of Wight NHS Trust

Balance Scorecard - Ambulance & 111

Safe	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Responsive	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Category A 8 Minute Response Time (Red 1)	Jun-14	75%	84.8%	75%	85.0%
Category A 8 Minute Response Time (Red 2)	Jun-14	75%	75.7%	75%	75.3%
Category A 19 Minute Response Time	Jun-14	95%	96.0%	95%	96.0%
Ambulance re-contact rate following discharge from care by telephone	Jun-14		4.7%		5.1%
Ambulance re-contact rate following discharge from care at scene	Jun-14		3.2%		3.2%
Ambulance time to answer call (in seconds) - median	Jun-14		1		
Ambulance time to answer call (in seconds) - 95th percentile	Jun-14		1		
Ambulance time to answer call (in seconds) - 99th percentile	Jun-14		9		
NHS 111 Call abandoned rate	Jun-14		1.3%		1.7%
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	Jun-14		97.1%		96.9%
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	Jun-14		97.5%		97.0%
NHS 111 Where the above is not achieved callers should be called back within 10 mins	Jun-14		64.7%		47.5%

Contracted Activity	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Effective	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Number of Ambulance Handover Delays between 1-2 hours	Jun-14		7		17

Well-Led	Latest data	In month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism	Jun-14	3%	4.33%	3%	4.68%
Appraisals					

Caring	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Performance Summary - Acute

Isle of Wight NHS Trust

Balance Scorecard - Acute

Safe	Latest data	In month		YTD	
		Target	Actual	Target	Actual
No. of Grade 1&2 Pressure Ulcers	Jun-14		7		15
No. of Grade 3&4 Pressure Ulcers	Jun-14		2		4
VTE	Jun-14	95%	100.0%	95%	99.7%
MRSA	Jun-14	0	0	0	0
C.Diff	Jun-14		1	4	2
No. of Reported SIRI's	Jun-14		3		8

Effective	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Delayed Transfers of Care (lost bed days)	Jun-14	N/A	147	N/A	512
Cancelled operations on/after day of admission (not rebooked within 28 days)	Jun-14	0	3	0	4

Responsive*	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Emergency Care 4 hour Standards	Jun-14	95%	95.9%	95%	95.1%
RTT Admitted - % within 18 Weeks	Jun-14	90%	92.6%	90%	94.1%
RTT Non Admitted - % within 18 Weeks	Jun-14	95%	92.5%	95%	93.9%
RTT Incomplete - % within 18 Weeks	Jun-14	92%	93.5%	92%	93.1%
No. Patients waiting > 6 weeks for diagnostics	Jun-14	8	3	100	7
%. Patients waiting > 6 weeks for diagnostics	Jun-14	1%	0.24%	1%	0.19%
Cancer 2 wk GP referral to 1st OP	Jun-14	93%	92.6%	93%	94.2%
Breast Symptoms 2 wk GP referral to 1st OP	Jun-14	93%	74.1%	93%	83.3%
31 day second or subsequent (surgery)	Jun-14	94%	100%	94%	100%
31 day second or subsequent (drug)	Jun-14	98%	100%	98%	100%
31 day diagnosis to treatment for all cancers	Jun-14	96%	98%	96%	98%
62 day referral to treatment from screening	Jun-14	90%	100%	90%	86%
62 days urgent referral to treatment of all cancers	Jun-14	85%	85.7%	85%	86.9%
Emergency 30 day Readmissions	Jun-14		5.2%		4.8%

Well-Led	Latest data	In month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism					
FTE vs Budget	Jun-14	1,485.9	1,422.81	4,493	4,271
Appraisals					
Actual vs Budget (in £'000's)					
CIP (in £'000's)					

Caring	Latest data	In month		YTD	
		Target	Actual	Target	Actual
FFT Acute - % Response Rate	Jun-14	30%	40.7%	30%	34.2%
FFT Acute - % Recommending	Jun-14	95%	97.1%	95%	96.3%
FFT A&E - % Response Rate	Jun-14	20%	21.7%	20%	17.5%
FFT A&E - % Recommending	Jun-14	95%	92.5%	95%	93.0%
Mixed Sex Accommodation Breaches	Jun-14	0	0	0	0
No. of Complaints	Jun-14		10		39
No. of Concerns	Jun-14		56		134
No. of Compliments	Jun-14	N/A	256	N/A	620

Contracted Activity**	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Emergency Spells	May-14	1,124	1,130	2,257	2,125
Elective Spells	May-14	635	597	1,270	1,219
Outpatients Attendances	May-14	9,228	9,561	18,457	18,739

**Cancer figures for June 2014 are provisional*

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

Highlights

- **Improvement in overall GRR performance**
- **Emergency care standard within target**
- **VTE risk assessment achievement maintained**
- **Stroke patients (90% of stay on stroke unit) maintained**
- **100% Mental Health patient admissions with access to Crisis Resolution / Home Treatment Teams (HTTs)**

Lowlights

- **2 cases of Healthcare acquired C Difficile infection identified**
- **74% Symptomatic Breast Referrals Seen <2 weeks***
- **Pressure ulcers remain above plan**
- **Variable hours and staff sickness remain above plan**

Commentary:

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

Hospital acquired:No reductions were achieved for grade 1 pressure ulcers in the hospital setting over June and whilst there were reductions in grade 2 pressure ulcers, these remained outside the 50% reduction target. No grade 3 or 4 pressure ulcers were reported during June in the hospital setting and although these are meeting the targets for the month, they remain outside the planned year to date trajectory for these grades.

The overall 25% reduction of incidence of newly acquired pressure ulcers rema[illegible] on target and continues to be exceeded.

Explanation of RAG Rating

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

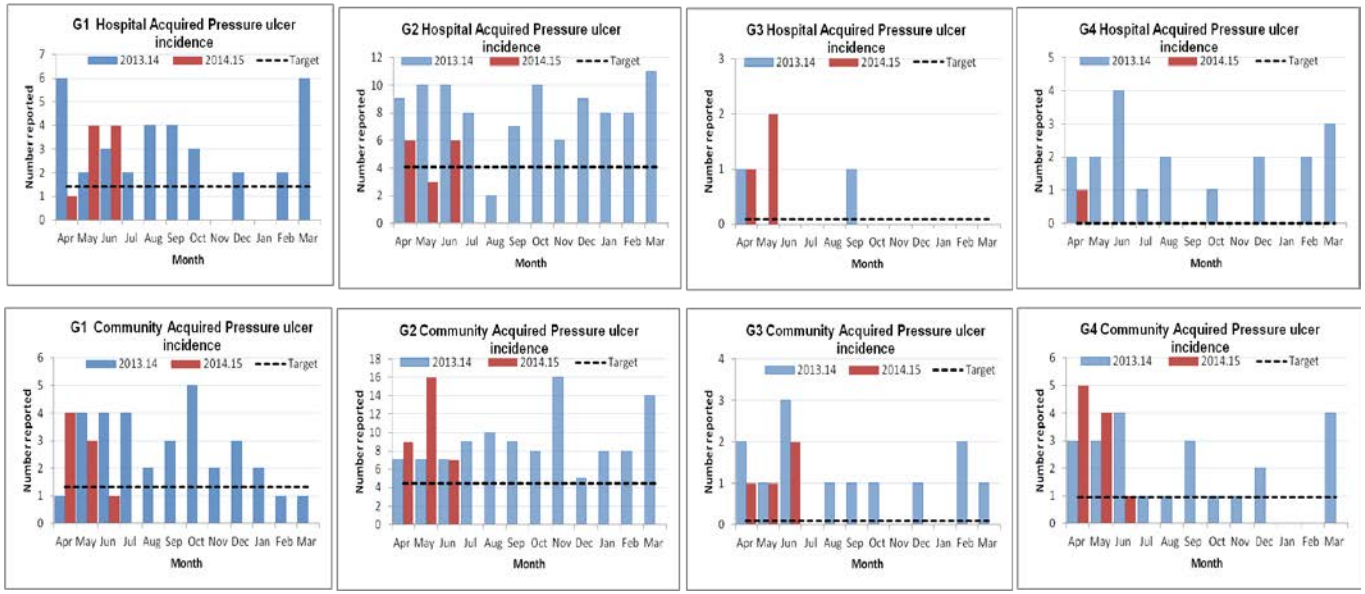
Amber=1G3 or increase/no change in G2 in rolling 3 month period

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: Community figures for all grades of pressure ulcer in the community remain above trajectory for the year to date position although a general reduction (with the exception of grade 2) is noted. The Trust directorates are working to understand the key issues that relate to these trends.

Analysis:

Prevention & Management of Pressure Ulcers



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

Commentary:

Clostridium difficile

There were 2 cases of Healthcare Acquired Clostridium Difficile (C Diff) in the hospital during June 2014, giving a YTD of 4. This exceeds the planned trajectories for both our nationally set year threshold (6) and our local stretched target (4). Maintaining zero tolerance for the rest of year to remain within these targets will be particularly challenging.

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

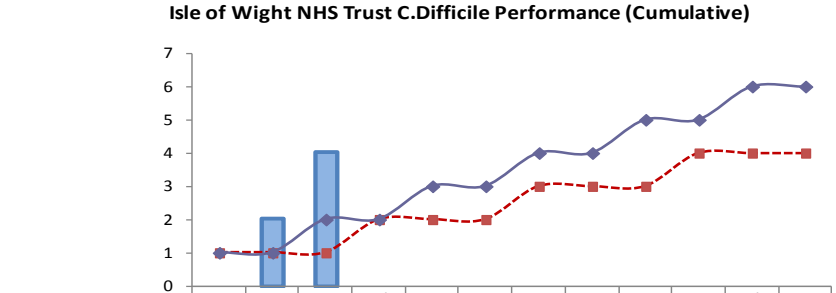
Methicillin-resistant Staphylococcus Aureus (MRSA)

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

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

Analysis:

Clostridium Difficile infections against national and local targets



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

Isle of Wight NHS Trust

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

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

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Formal Complaints

Commentary:

There were 15 formal Trust complaints received in June 2014 (14 in the previous month) with 350 compliments received by letters and cards of thanks across the same period.

Across all complaints and concerns in June 2014:
Top areas complained about were:
- Emergency Department (7)
- Colwell Ward (6)
- General Surgery (5) / Orthopaedics (5)

Across all complaints and concerns in June 2014:
Top subjects complained about were:
- Clinical care (22)
- Out-patient appointment delay/cancellation (14)
- Communication (15)

These are the same top subjects as last month.

Analysis: Complaints

Primary Subject	May-14	Jun-14	CHANGE	RAG rating
Clinical Care	6	8	2	↑
Nursing Care	3	1	-2	↓
Staff Attitude	3	1	-2	↓
Communication	1	2	1	↑
Outpatient Appointment Delay/ Cancellation	0	0	0	✓
Inpatient Appointment Delay / Cancellation	1	2	1	↑
Admission / Discharge / Transfer Arrangements	0	0	0	✓
Aids and appliances, equipment and premises	0	1	1	↑
Transport	0	0	0	✓
Consent to treatment	0	0	0	✓
Failure to follow agreed procedure	0	0	0	✓
Hotel services (including food)	0	0	0	✓
Patients status/discrimination (e.g. racial, sex)	0	0	0	✓
Privacy & Dignity	0	0	0	✓
Other	0	0	0	✓

Action Plan:	Person Responsible:	Date:	Status:
Following the review of the complaints processes, Clinical Directorates have identifed support for Quality Managers in the management of complaints.	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Jun-14	Completed
Complaints officers have now relocated to the main reception area of the hospital to improve accessability	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Jun-14	Completed

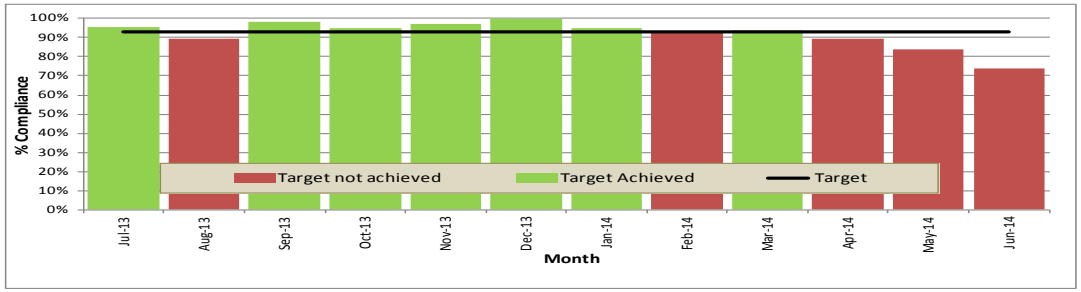
Commentary:

All June figures are still provisional. 23 of the total 47 breaches (49%) during June were patient led with a further 19 hospital lead.

Symptomatic Breast Referrals seen within 2 weeks (93% target)
Additional capacity has been identified to address the 30% increase the service has experienced in activity in the last 3 months.

Cancer patients seen<14 days after urgent GP referral (93% target):
There were19 patient led breaches and 9 hospital led breaches during June 2014. All 9 were Breast patients and as a result of capacity issues, as above additional capacity is being addressed.

Analysis: Symptomatic Breast Referrals seen within 2 weeks.



Analysis: Cancer patients seen <14 days after urgent GP referral

	Person Responsible:	Date:	Status:
Lead Cancer Nurse and CNSs working with OPARU Team to encourage patients to attend their 2 week cancer fast track appointments. Imaging and Surgical teams working together and have identified additional clinic and imaging capacity to meet the increased demand following national awareness and early detection initiative for Breast Cancer.	Lead Cancer Nurse Breast Care Team General Managers	Jul-14	Continuing

Isle of Wight NHS Trust Board Performance Report 2014/15

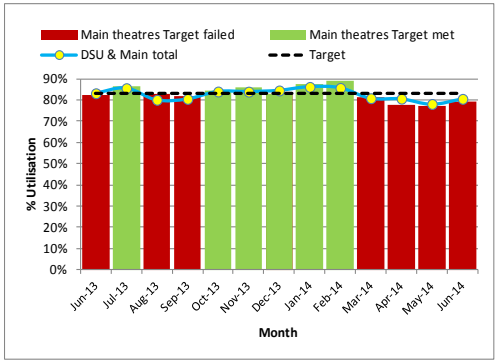
June 14

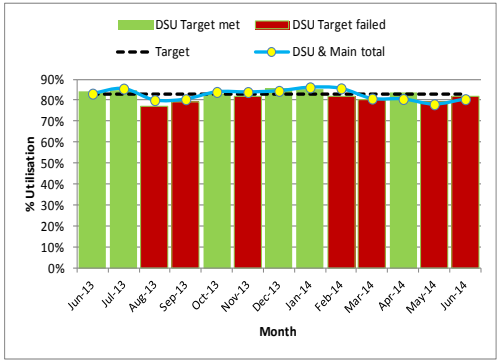
Theatre Utilisation

Commentary

The percentage utilisation of theatre facilities has improved during June but remains below the 83% target for both Main (79%) and Day theatres (82.73%) during June 2014 (80.65%). The main contributory factor to this has been bed capacity.

As last month, there were delays experienced getting patients to beds through the elective wards which subsequently delayed theatre start times, impacting on late starts and utilisation overall. Also, due to bed capacity problems predicted through bed management meetings, patient were not actually booked into available capacity as the risk was they would have been cancelled, therefore utilisation would have been impacted on by not booking cases that could not be accommodated.



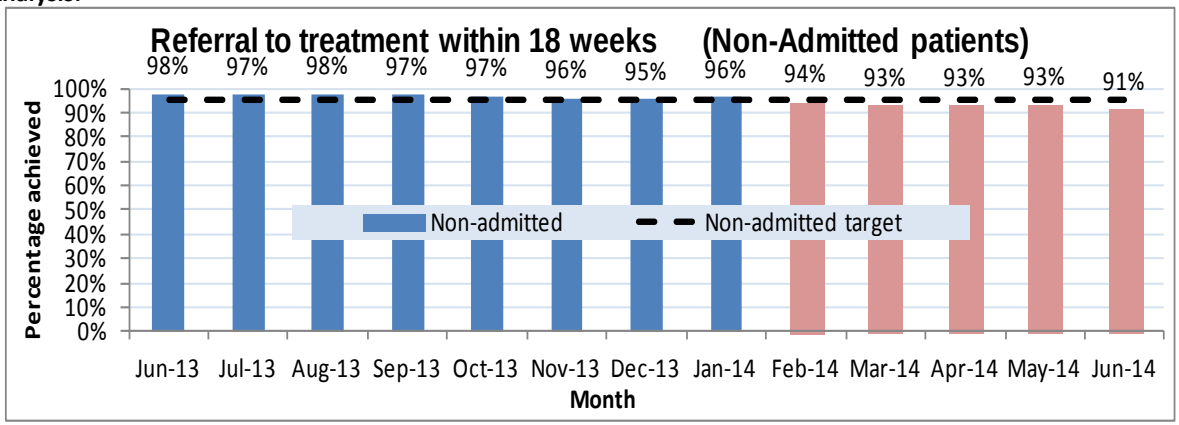


Action plan	Person Responsible:	Date:	Status:
1) Late starts in each area to be reviewed with Clinical Director 2) Audit and investigation of patients found unfit for surgery - undertaken - no identified changes to process	General manager- Planned Directorate	Jun-14	Continuing
Ongoing discussion on review of bed capacity for elective surgery. No identified changes to estates plan due to schedule risks. Ongoing monitor of inpatient delays for discharge with significant incident/bed management meetings.	General manager- Planned Directorate	Jun-14	Continuing

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Referral to Treatment Times (RTT)

Commentary:	**Analysis:**
The National Funding described in last months report to reduce waiting times over 16 weeks during July, August and September has been reduced and now will over cover July and August. Clinicial leave over this period must be taken into account and is having a corresponding impact on capacity at this time. The forecasting tools developed by Performance Information & Decision Support (PIDS) have highlighted that data quality is a significant issue at the moment and the figures being produced are not necessarily representative of our true performance. We are confident of our underperformance at IP level, but capacity in OP we believe is currently matching demand.	

	Person Responsible:	**Date:**	**Status:**
Further development of forecasting tools to match demand and capacity and highlight further DQ issues	Senior Information Analyst (PIDS)	Aug-14	In progress
Engagement with clincians to ensure that accurate data is communicated to administrators for data capture through revision of RTT coding forms.	OPARU Lead/ Clinical Leads	Aug-14	In progress
Additional capacity for Non admitted & Admitted patients will be put in place to reduced patients waiting over 16 weeks funded via additional CCG RTT monies which has been made available nationally.	General Access Lead & General Managers	Aug-14	Planned
RTT awareness session with PHT and General Managers	Access Lead / General Managers	Jul-14	Completed
Development of robust processes and documentation to enable training and awareness of 18 week procedures.	Information Systems	Aug-14	In progress

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Benchmarking Update - National Performance Indicators 1

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: Summary Report

	National Target	National Performance			IW Performance	IW Rank	IW Status	Data Period
		Best	Worst	Eng				
Emergency Care 4 hour Standards	95%	100%	84%	95.1%	95.4%	100 / 176	Better than national average	Q1 14/15
RTT:% of admitted patients who waited 18 weeks or less	90%	100%	73%	89.1%	94.8%	31 / 170	Top Quartile	May-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	100%	29%	96.4%	93.7%	185 / 199	Bottom Quartile	May-14
RTT % of incomplete pathways within 18 weeks	92%	100%	75%	93.6%	92.2%	164 / 194	Bottom Quartile	May-14
%. Patients waiting > 6 weeks for diagnostic	1%	50%	0%	2.4%	0.2%	63 / 186	Better than national average	May-14
Ambulance Category A Calls % < 8 minutes - Red 1	75%	88%	66%	73.3%	87.8%	1 / 11	Top Quartile	May-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	78%	61%	72.5%	75.5%	3 / 11	Top Quartile	May-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	78%	61%	72.6%	76.3%	3 / 11	Top Quartile	May-14
Ambulance Category A Calls % < 19 minutes	95%	97%	90%	95.3%	96.1%	3 / 11	Top Quartile	May-14
Cancer patients seen <14 days after urgent GP referral*	93%	100%	81%		96.5%	55 / 156	Better than national average	Qtr 4 13/14
Cancer diagnosis to treatment <31 days*	96%	100%	75%	98.0%	98.9%	69 / 161	Better than national average	Qtr 4 13/14
Cancer urgent referral to treatment <62 days*	85%	100%	0%	84.4%	92.0%	13 / 156	Top Quartile	Qtr 4 13/14
Breast Cancer Referrals Seen <2 weeks*	93%	100%	53%	94.0%	94.0%	80 / 137	Better than national average	Qtr 4 13/14
Cancer Patients receiving subsequent surgery <31 days*	94%	100%	85%	96.8%	98.3%	73 / 157	Better than national average	Qtr 4 13/14
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100%	86%	99.6%	99.2%	127 / 146	Bottom Quartile	Qtr 4 13/14
Cancer Patients treated after consultant upgrade <62 days*	85%	100%	0%	92.0%	No Data	N/A	N/A	Qtr 4 13/14
Cancer Patients treated after screening referral <62 days*	90%	100%	33%	94.1%	100.0%	1 / 119	Top Quartile	Qtr 4 13/14
VTE Risk Assessment	95%	100%	86%	96.1%	99.5%	11 / 164	Top Quartile	Apr-14

Source: Health & Social Care Information Centre
Includes data from 221 NHS Trusts & 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

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

Other Small Acute Trusts	National Target	IW	RA3	RA4	RBD	RBT	RBZ	RC1	RC3	RCD	RCF	RCX	RD8	RE9	RFF	RFW	RGR	RJC	RJD	RJF	RJN	RLQ	RLT	RMP	RN7	RNQ	RNZ	RQQ	RQX	Data Period
Emergency Care 4 hour Standards	95%	95.4% 24	97.0% 6	95.9% 13	95.5% 20	95.7% 16	97.5% 3	94.2% 25	97.3% 4	97.2% 5	96.0% 12	91.5% 26	95.5% 21	97.9% 2	96.9% 7	96.5% 8	95.5% 19	96.3% 10	85.6% 27	95.8% 14	95.4% 23	84.1% 28	96.4% 9	95.6% 17	95.8% 15	98.4% 1	95.5% 18	96.1% 11	95.4% 22	Q1 14/15
RTT:% of admitted patients who waited 18 weeks or less	90%	94.8% 5	89.7% 24	93.4% 9	91.8% 16	93.8% 8	93.0% 11	92.0% 15	77.3% 28	94.8% 4	90.7% 19	83.8% 26	86.1% 25	95.6% 1	92.9% 12	94.6% 6	90.3% 22	90.2% 23	83.8% 27	90.5% 20	92.1% 14	91.6% 17	91.3% 18	90.3% 21	93.2% 10	95.3% 2	92.3% 13	95.0% 3	94.3% 7	May-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	93.7% 28	95.2% 27	97.2% 17	97.2% 16	95.5% 26	98.3% 6	97.4% 12	96.5% 22	97.1% 18	96.3% 25	97.1% 19	97.0% 21	99.1% 2	98.1% 7	97.2% 15	99.0% 3	96.3% 24	97.7% 9	98.8% 4	96.4% 23	99.6% 1	97.3% 14	97.4% 13	97.4% 11	98.0% 8	97.7% 10	98.6% 5	97.1% 20	May-14
RTT % of incomplete pathways within 18 weeks	92%	92.2% 25	92.1% 26	95.4% 13	93.5% 21	96.2% 11	92.5% 24	94.8% 16	94.6% 17	97.5% 5	92.0% 27	97.3% 6	94.1% 19	94.2% 18	96.8% 8	96.1% 12	99.0% 2	93.0% 23	93.0% 22	94.0% 20	95.0% 14	96.7% 9	99.4% 1	N/A	96.5% 10	98.4% 3	97.2% 7	94.9% 15	97.6% 4	May-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.2% 12	0.3% 14	0.8% 23	12.0% 28	0.6% 21	0.4% 16	0.4% 18	0.0% 6	0.1% 9	0.0% 1	0.8% 24	0.8% 25	0.3% 15	7.0% 27	0.0% 1	0.0% 1	0.4% 17	0.5% 19	0.3% 13	0.6% 22	4.7% 26	0.1% 11	0.5% 20	0.1% 10	0.1% 8	0.0% 1	0.1% 7	0.0% 1	May-14
Cancer patients seen <14 days after urgent GP referral*	93%	96.5% 12	96.5% 14	93.2% 27	98.6% 3	95.8% 18	92.5% 28	93.8% 25	95.8% 19	99.5% 1	97.0% 9	98.7% 2	96.2% 16	97.2% 8	94.5% 22	93.6% 26	98.5% 4	94.3% 23	96.4% 15	97.3% 6	97.3% 7	95.6% 21	96.6% 11	97.0% 10	94.2% 24	95.6% 20	96.1% 17	98.3% 5	96.5% 13	Qtr 4 13/14
Cancer diagnosis to treatment <31 days*	96%	98.9% 19	98.7% 21	97.6% 26	99.2% 16	98.7% 20	100.0% 1	100.0% 1	99.1% 18	100.0% 1	100.0% 1	98.3% 23	96.1% 28	100.0% 1	100.0% 1	99.1% 17	100.0% 1	97.4% 27	99.6% 13	97.8% 25	100.0% 1	99.6% 12	99.4% 14	100.0% 1	100.0% 1	99.3% 15	97.9% 24	98.6% 22	100.0% 1	Qtr 4 13/14
Cancer urgent referral to treatment <62 days*	85%	92.0% 3	77.2% 26	88.1% 12	87.4% 13	90.3% 8	86.0% 17	88.9% 9	88.4% 10	91.9% 4	87.3% 14	79.0% 22	77.5% 25	84.0% 19	88.1% 11	75.4% 28	91.6% 5	78.7% 23	90.7% 7	86.6% 16	91.6% 6	78.3% 24	76.2% 27	93.7% 1	86.8% 15	81.9% 20	92.4% 2	86.0% 18	80.9% 21	Qtr 4 13/14
Breast Cancer Referrals Seen <2 weeks*	93%	94.0% 17	91.2% 24	95.1% 14	98.3% 3	96.3% 10	86.8% 27	89.4% 26	97.0% 8	97.1% 7	97.8% 4	95.0% 15	93.1% 23	N/A	93.9% 18	97.0% 9	99.0% 1	90.9% 25	97.8% 4	96.2% 11	93.8% 20	93.2% 22	93.3% 21	98.5% 2	94.6% 16	97.2% 6	93.9% 19	95.6% 13	96.1% 12	Qtr 4 13/14
Cancer Patients receiving subsequent surgery <31 days*	94%	98.3% 23	100.0% 1	100.0% 1	97.6% 25	98.0% 24	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	97.0% 26	100.0% 1	100.0% 1	100.0% 1	96.9% 27	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	90.9% 28	Qtr 4 13/14
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	99.2% 26	100.0% 1	100.0% 1	99.1% 27	100.0% 1	99.0% 28	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	Qtr 4 13/14
Cancer Patients treated after consultant upgrade <62 days*	85%	N/A	72.7% 24	91.7% 18	N/A	93.8% 16	94.3% 15	81.8% 22	95.2% 13	100.0% 1	71.4% 25	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	86.4% 21	100.0% 1	99.4% 12	66.7% 26	88.0% 20	91.7% 18	100.0% 1	95.1% 14	100.0% 1	78.6% 23	100.0% 1	100.0% 1	93.5% 17	Qtr 4 13/14
Cancer Patients treated after screening referral <62 days*	90%	100.0% 1	100.0% 1	100.0% 1	96.3% 14	94.0% 16	100.0% 1	100.0% 1	80.0% 25	95.0% 15	91.7% 21	100.0% 1	87.0% 24	N/A	100.0% 1	57.1% 26	98.3% 13	93.9% 17	100.0% 1	100.0% 1	100.0% 1	88.9% 22	93.1% 18	100.0% 1	92.9% 19	87.7% 23	100.0% 1	92.9% 19	N/A	Qtr 4 13/14
VTE Risk Assessment	95%	99.5% 1	94.9% 23	97.2% 12	96.5% 15	98.9% 5	95.5% 18	89.6% 25	95.1% 22	97.5% 9	N/A	97.2% 10	97.2% 11	97.7% 8	N/A	95.4% 19	99.7% 1	98.5% 6	95.6% 17	N/A	99.0% 4	95.3% 21	95.3% 20	93.6% 24	95.9% 16	97.1% 13	99.6% 2	98.3% 7	96.8% 14	Apr-14

Source: Health & Social Care Information Centre
Includes data from 221 NHS Trusts & Foundation Trusts that submitted data

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

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

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

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Benchmarking Update - National Performance Indicators 3

Isle of Wight NHS Trust

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

	National Target	IW	R1C	RBD	RD3	RDY	RDZ	RHM	RHU	RN5	RW1	Data Period
Emergency Care 4 hour Standards	95%	95.4% 6	100.0% 1	95.5% 5	95.4% 7	99.9% 2	94.6% 8	91.7% 9	85.0% 10	95.6% 4	98.6% 3	Q1 14/15
RTT:% of admitted patients who waited 18 weeks or less	90%	94.8% 5	100.0% 1	91.8% 6	95.4% 4	96.9% 3	90.2% 9	82.0% 10	91.7% 7	90.9% 8	97.4% 2	May-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	93.7% 10	99.9% 1	97.2% 6	96.9% 7	99.3% 2	98.8% 4	95.0% 9	96.2% 8	97.3% 5	98.9% 3	May-14
RTT % of incomplete pathways within 18 weeks	92%	92.2% 9	99.7% 1	93.5% 8	97.6% 3	97.5% 4	95.0% 7	92.0% 10	95.7% 6	96.1% 5	99.2% 2	May-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.2% 5	0.0% 1	12.0% 9	0.9% 7	0.0% 1	3.1% 8	0.1% 4	12.2% 10	0.3% 6	0.0% 1	May-14
Cancer patients seen <14 days after urgent GP referral*	93%	96.5% 3	N/A	98.6% 1	96.0% 5	N/A	95.1% 6	94.4% 7	96.3% 4	97.4% 2	N/A	Qtr 4 13/14
Cancer diagnosis to treatment <31 days*	96%	98.9% 3	N/A	99.2% 2	98.9% 4	N/A	93.9% 7	96.1% 6	97.6% 5	99.6% 1	N/A	Qtr 4 13/14
Cancer urgent referral to treatment <62 days*	85%	92.0% 2	N/A	87.4% 5	87.6% 4	N/A	79.9% 7	86.9% 6	88.5% 3	93.3% 1	N/A	Qtr 4 13/14
Breast Cancer Referrals Seen <2 weeks*	93%	94.0% 6	N/A	98.3% 2	94.1% 5	N/A	100.0% 1	93.3% 7	95.2% 4	96.5% 3	N/A	Qtr 4 13/14
Cancer Patients receiving subsequent surgery <31 days*	94%	98.3% 2	N/A	97.6% 3	97.5% 4	N/A	96.3%	95.1% 6	94.2% 7	99.0% 1	N/A	Qtr 4 13/14
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	99.2% 6	N/A	99.1% 7	100.0% 1	N/A	100.0% 1	100.0% 1	100.0% 1	100.0% 1	N/A	Qtr 4 13/14
Cancer Patients treated after consultant upgrade <62 days*	85%	N/A	N/A	N/A	95.0% 4	N/A	100.0% 1	96.2% 2	93.9% 5	95.7% 3	N/A	Qtr 4 13/14
Cancer Patients treated after screening referral <62 days*	90%	100.0% 1	N/A	96.3% 3	92.9% 5	N/A	91.8% 6	95.2% 4	98.6% 2	88.9% 7	N/A	Qtr 3 13/14
VTE Risk Assessment	95%	99.5% 1	N/A	96.5% 4	97.7% 2	N/A	95.3% 8	95.4% 7	96.1% 5	95.6% 6	97.5% 3	Apr-14

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

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

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

Source: Health & Social Care Information Centre
Includes data from 221 NHS Trusts & Foundation Trusts that submitted data

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).

This is the first month of reporting 2014/15 data. Overall our data quality reporting to SUS has improved slightly compared to 2013/14. Areas that still require attention in APC are Primary Diagnosis and HRG4, (Healthcare Resource Grouping) in order to address this we need to improve the timeliness of coding partly through more efficient completion of source documentation by clinicians and by addressing a current backlog in clinical coding capacity. We are aslo below average for recording of NHS numbers in APC, this relates to the treatment of prisoners. In the A&E data set we have a higher than average number of missing or invalid commissioner codes, this will be investigated and appropriate actions taken.

Analysis:

Total APC General Episodes: 4,213

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	57	98.6%	99.1%
Patient Pathway	80	93.5%	60.0%
Treatment Function	0	100.0%	99.7%
Main Specialty	0	100.0%	99.9%
Reg GP Practice	3	99.9%	99.9%
Postcode	29	99.3%	99.8%
Org of Residence	2	100.0%	98.6%
Commissioner	1	100.0%	99.2%
Primary Diagnosis	1,052	75.0%	96.3%
Primary Procedure	0	100.0%	99.4%
Ethnic Category	3	99.9%	97.4%
Site of Treatment	0	100.0%	95.8%
HRG4	1,074	74.5%	95.4%

Total Outpatient General Episodes: 26,889

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	140	99.5%	99.3%
Patient Pathway	12,205	50.9%	48.8%
Treatment Function	0	100.0%	99.7%
Main Specialty	0	100.0%	99.8%
Reg GP Practice	1	100.0%	99.9%
Postcode	2	100.0%	99.8%
Org of Residence	3	100.0%	95.5%
Commissioner	8	100.0%	99.3%
First Attendance	0	100.0%	99.7%
Attendance Indicator	0	100.0%	99.5%
Referral Source	163	99.4%	98.8%
Referral Rec'd Date	163	99.4%	95.3%
Attendance Outcome	3	100.0%	97.7%
Priority Type	163	99.4%	97.2%
OP Primary Procedure	0	100.0%	99.5%
Ethnic Category	19	99.9%	92.3%
Site of Treatment	0	100.0%	96.4%
HRG4	0	100.0%	99.1%

Total A&E Attendances 10,634

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	182	98.3%	95.8%
Registered GP Practice	3	100.0%	99.2%
Postcode	2	100.0%	99.9%
Org of Residence	387	96.4%	94.1%
Commissioner	419	96.1%	98.1%
Attendance Disposal	92	99.1%	98.9%
Patient Group	0	100.0%	96.1%
First Investigation	94	99.1%	94.8%
First Treatment	212	98.0%	93.6%
Conclusion Time	88	99.2%	97.4%
Ethnic Category	0	100.0%	91.5%
Departure Time	32	99.7%	99.8%
Department Type	0	100.0%	99.9%
HRG4	131	98.8%	95.2%

Key:

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

Action Plan:	Person Responsible:	Date:	Status:
Address backlog in clinical coding	Head of Information / Asst. Director - PIDS	Sep-14	Ongoing
Review missing commissioner codes in A&E dataset		Sep-14	Ongoing

Data Quality - May 2014

Dataset	Measure	IW Performance	National	Threshold G	Threshold A	Threshold R	Status	Weighting	Score	Notes
APC	Total Invalid Data Items	2	n/a	=<2	>2 =<4	>4	A	2	1.0	Performance relates to the no. of Red rated data items
APC	Valid NHS Number	98.6%	99.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	R	1	1.0	
APC	Valid Ethnic Category	99.9%	97.4%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Invalid Data Items	0	n/a	=<2	>2 =<5	>5	G	2	0.0	Performance relates to the no. of Red rated data items
OP	Valid NHS Number	99.5%	99.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Valid Ethnic Category	99.9%	92.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Total Invalid Data Items	1	n/a	=<2	>2 =<4	>4	G	2	0.0	Performance relates to the no. of Red rated data items
A&E	Valid NHS Number	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%	91.5%	> = 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

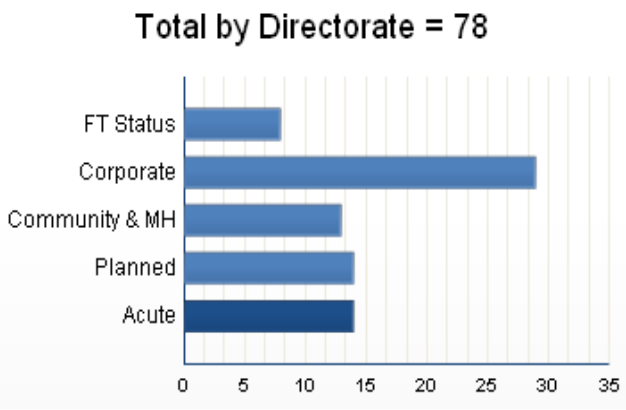
Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Risk Register -Situation current as at 21/07/2014

Analysis:

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



Directorate	Added	Title	Actions	Done	%
PLANND	23/02/2011	Insufficient and inadequate Endoscopy facilities to meet service requirements	9	6	67%
PLANND	20/10/2011	Insufficient and inadequate Ophthalmology facilities to meet service requirements	6	4	67%
CORPRI	22/11/2011	Mandatory Training	6	5	83%
ACUTE	16/08/2012	Blood Sciences Out-Of-Hours staffing	4	3	75%
ACUTE	22/08/2012	Risk due to bed capacity problems	4	3	75%
PLANND	24/10/2012	Failing heating/cooling system impacting on service delivery	2	1	50%
COMMH	22/11/2012	Low staffing levels within Occupational Therapy Acute Team	6	2	33%
ACUTE	05/12/2012	Vacant Consultant Physician posts	3	1	33%
CORPRI	26/03/2013	Pressure Ulcers	4	2	50%
PLANND	23/09/2013	Ophthalmic Casenotes - poor condition, misfiling and duplication leading to potential clinical error	4	2	50%
ACUTE	21/01/2014	Acquisition of mechanical device for chest compressions	4	3	75%
PLANND	30/04/2014	Maternity theatre inadequate airflow leading to potential infection control risk	3	0	0%

Data as at 21/07/2014 Risk Register Dashboard

Commentary

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

Since the last report three new risks have been added to the register, although the table above shows only those with the highest level rating. These are (1) RR615 Safe Staffing Levels in Paediatrics (2) RR616 CDifficile Infection Figures (3) RR617 Non-Compliancwith PSA Alert 003. One risk has been signed off the register - RR617 PSA Alert 003 as all actions were completed

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Workforce - Key Performance Indicators

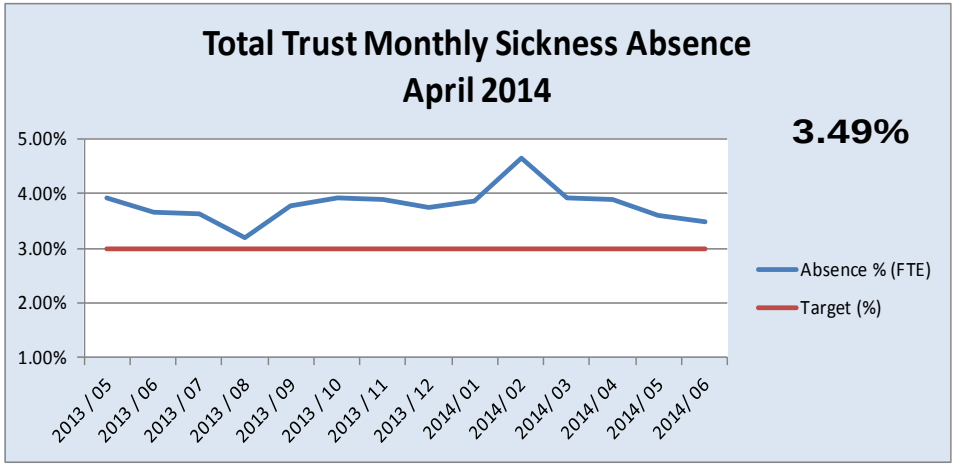
Isle of Wight NHS Trust

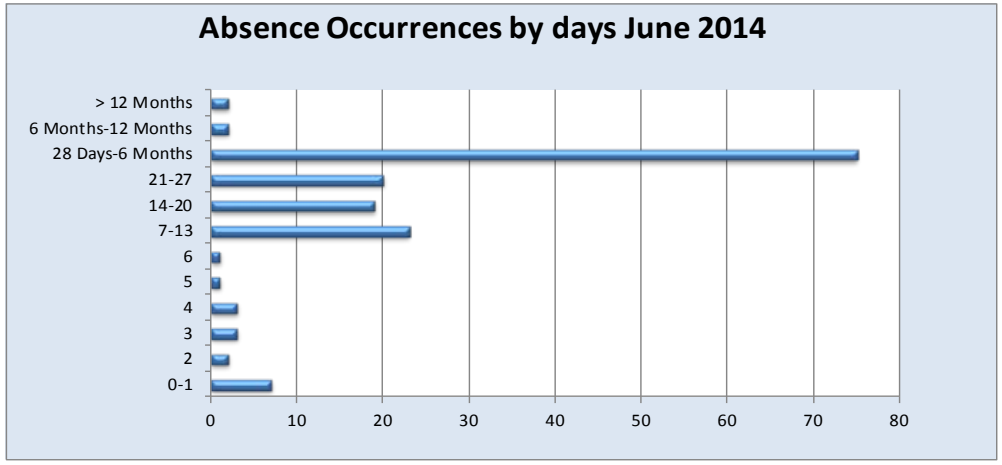
Measure	Period	Month Target/Plan	Month Actual	In Month Variance	RAG rating	In Month Final RAG Rating	Trend from last month
Workforce FTE	Jun-14	2616.64	2648.58	31.94	✗		⇩
Workforce Variable FTE	Jun-14	136.70	140.41	3.71	✗		⇧
Workforce Total FTE	Jun-14	2753.34	2788.99	35.65	✗	✗	⇧
Finance	**Period**	**Month 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	Jun-14	£9,596	£9,043	-£744	✓		⇩
In Month Variable Hours	Jun-14	£29	£524	£495	✗		⇩
In Month Total Paybill	Jun-14	£9,625	£9,567	-£58	✓		⇩
Year-to Date Paybill	Jun-14	£29,145	£29,161	£16	!	!	
Sickness Absence	**Period**	**Month Target/Plan**	**Month Actual**		**RAG Rating**		
In Month Absence Rate	Jun-14	3%	3.49%		✗		

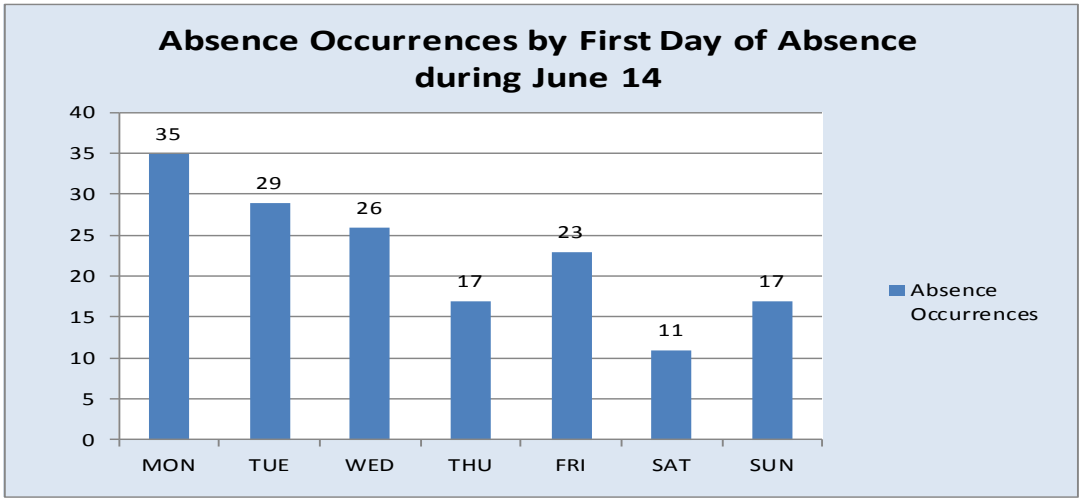
Key	
✓	Green - On Target
!	Amber - Mitigating/corrective action believed to be achievable
✗	Red - Significant challenge to delivery of target

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

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







Top 10 Absence reasons by FTE Year To Date

Absence Reason
S10 Anxiety/stress/depression/other psychiatric illnesses
S12 Other musculoskeletal problems
S11 Back Problems
S17 Benign and malignant tumours, cancers
S26 Genitourinary & gynaecological disorders
S25 Gastrointestinal problems
S15 Chest & respiratory problems
S28 Injury, fracture
S23 Eye problems
S13 Cold, Cough, Flu - Influenza

Data Source: ESR Business Intelligence

Performance Area	Commentary	RAG Rating In Month	RAG Rating YTD	RAG Rating Full Year Forecast
Continuity of Service Risk Rating (CoSRR)	• Overall Rating of 4 after normalisation adjustments.	Green	Green	Green
Summary	• The YTD position is an adjusted surplus of **£343k** which is a **£6k** underachievement against a plan of **£349k**. The Trust is expecting to achieve its forecast adjusted surplus of **£1.7m**	Green	Green	Green
Cost Improvement Programme (CIP)	• YTD CIPs achieved **£2,261k** against a plan of **£1,605k.** The RAG rating is Amber due to the level of non recurrent plans, however the FY15/16 part year effect of current year schemes is greater than the value of non recurrent savings in FY14/15.	Amber	Amber	Amber
Working Capital & Treasury	• Cash 'in-hand' and 'at-bank' at Month 3 was **£9,917k.**	Green	Green	Green
Capital	• Total year-to-date capital spend amounted to **£470k** against a planned spend of **£2,064k.**	Amber	Amber	Green

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Income & Expenditure - Key Highlights - Trust

Statement of Comprehensive Income	2014/15 Full Year BUDGET £000s	Jun Budget £000s	Jun Actual £000s	Jun Variance £000s	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s
Gross Employee Benefits	(115,265)	(9,625)	(9,567)	58	(29,145)	(29,161)	(16)
Other Operating Costs	(54,862)	(4,530)	(4,108)	422	(12,284)	(12,113)	171
Revenue from Patient Care Activities	160,335	13,573	12,889	(684)	39,981	39,206	(775)
Other Operating Revenue	9,569	868	1,062	194	2,670	3,228	558
OPERATING SURPLUS/(DEFICIT)	(223)	286	276	(10)	1,222	1,160	(61)
Investment Revenue	22	3	1	(2)	10	5	(5)
Other Gains and Losses	(125)	(1)	(1)	1	(4)	(3)	2
Finance Costs (including interest on PFIs and Finance Leases)	(48)	(16)	(2)	14	(62)	(6)	56
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	(374)	0	0	0	0	0	0
Dividends Payable on Public Dividend Capital (PDC)	(3,299)	272	275	3	1,165	1,157	(8)
Net gains/ (loss) on transfers by absorption (Roundings)	0	(275)	(275)	0	(825)	(825)	0
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	(3,673)	0	4	4	3	9	6
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR PER ACCOUNTS	(3,673)	(3)	4	7	343	341	(3)

Reported NHS Financial Performance	2014/15 Full Year £000s	Jun Budget £000s	Jun Actual £000s	Jun Variance £000s	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s
Retained surplus/(deficit) for the year	(3,673)	(3)	4	7	343	341	(3)
IFRIC 12 adjustment including impairments	0	0	0	0	0	0	0
Impairments excluding IFRIC12 impairments	5,347	0	0	0	0	0	0
Donated/Government grant assets adjustment (include donation/grant receipts and depreciation of donated/grant	28	2	(3)	(5)	6	2	(2)
Adjusted Financial Performance Retained Surplus/(Deficit)	1,702	(1)	1	3	349	343	(6)

Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA)	2014/15 Full Year £000s	Jun Budget £000s	Jun Actual £000s	Jun Variance £000s	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s
Retained Surplus / (Deficit) for the Year per Accounts	(3,673)	(3)	4	7	343	341	(3)
Depreciation	6,158	503	513	10	1,499	1,532	33
Amortisation	1,302	109	104	(5)	327	312	(15)
Impairments (including IFRIC 12 impairments)	5,347	0	0	0	0	0	0
Interest Receivable	(22)	(3)	(1)	2	(10)	(5)	5
Finance Costs (including interest on PFIs and Finance Leases)	48	16	2	(14)	62	6	(56)
Dividends	3,299	0	0	0	0	0	0
Donated/Government grant assets adjustment (donation income element of SC 380)	(100)	275	275	0	825	825	0
(Gains) / Losses on disposal of assets	125	8	14	6	25	31	6
Net gains/ (loss) on transfers by absorption (Roundings)		1	1	(1)	4	3	(2)
EBITDA Sub Total	12,484	0	0	0	0	0	0
Restructuring costs	1,500	0	4	4	3	9	6
Normalised EBITDA	13,984	906	915	9	3,079	3,052	(27)

INCOME - £207k underplan YTD

£775k relates to phasing of investment schemes not yet being accessed from contracting authorities. The offset of some of these can be seen in reserves slippage below.

£475k overachievement of income targets from Corporate areas. The majority of this relates to two services, Earl Mountbatten Hospice (EMH) £146k & NHS Creative £215k. The spend related to these variances can be seen in the pay & non pay budgets.

PAY - £16k overspend YTD

£664k unachieved Cost Improvement Plans

£307k budget overspends - The majority of this relates to the premium costs of agency medical cover in excess of budget.

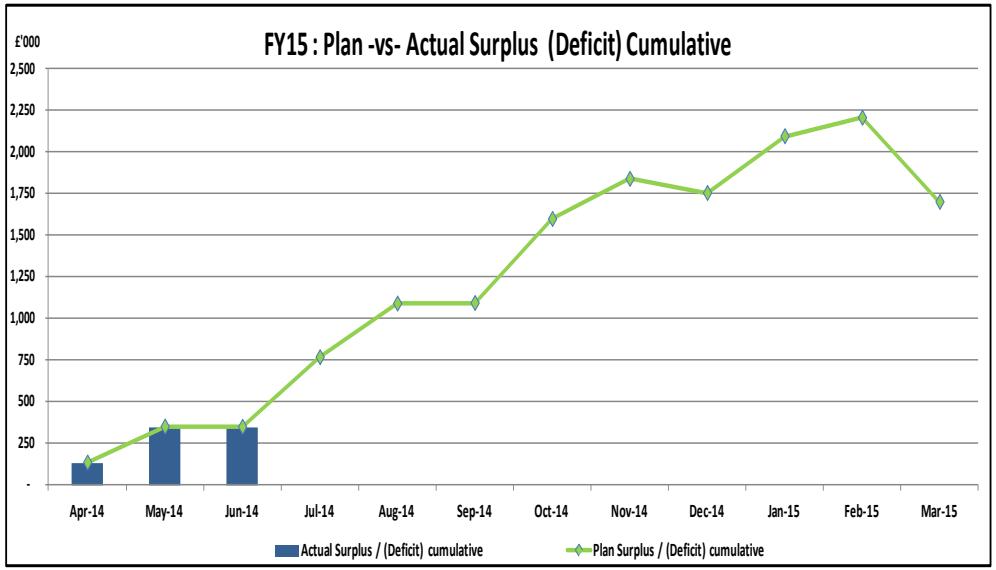
£955k reserves slippage - The Trusts reserved have not been committed to help offset cost pressures within the directorates & is slippage in planned investments not commencing.

NON PAY - £177k underspend YTD

£66k unachieved Cost Improvement Plans

£728k budget overspends - £157k if this overspend relates to drug spend across numerous services. The Pharmacy lead is scoping how to better manage this spend/cost pressure. Additionally costs relating to the EMH service & NHS Creative explain the pressure on these budgets.

£971k reserves slippage - The Trusts reserved have not been committed to help offset cost pressures within the directorates & is slippage in planned investments not commencing.



Isle of Wight NHS Trust Board Performance Report 2014/15

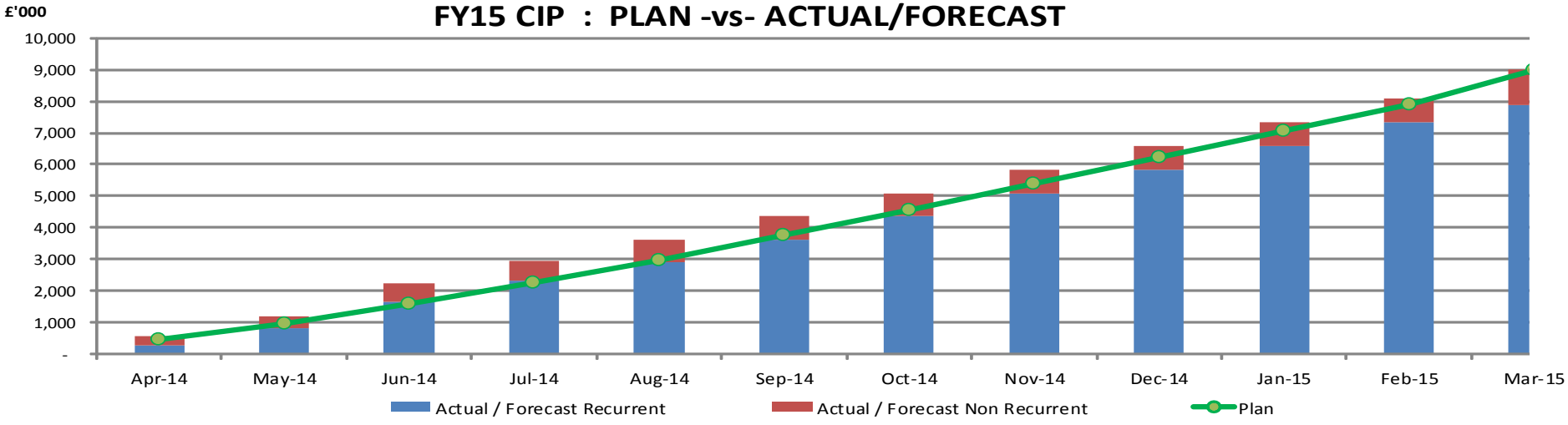
June 14

Cost Improvement Programme - CIP by Directorates

	Month			YTD			FULL YEAR		
Directorates	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
ACUTE	247	(47)	(293)	690	580	(110)	2,992	2,992	0
CHIEF OPERATING OFFICER	2	24	22	6	24	18	24	24	(0)
COMMUNITY	95	171	77	275	386	111	1,399	1,399	0
FINANCE & PERFORMANCE MANAGEMENT	15	154	139	46	185	139	183	183	0
NURSING & WORKFORCE	53	253	200	56	279	224	631	631	(0)
PLANNED	156	100	(56)	350	292	(57)	2,891	2,891	(0)
STRATEGIC & COMMERCIAL	36	145	109	108	217	109	582	582	(0)
TRUST ADMINISTRATION	25	247	222	74	297	223	297	297	0
Total	**629**	**1,048**	**419**	**1,605**	**2,261**	**657**	**8,998**	**8,998**	**0**

Commentary:

The YTD CIP plan is **£1,605k**. The actual savings total **£2,261k,** a YTD overachievement of **£657k**. The year end position is showing achievement of **£8,998k** which is on plan including **£1,123k** of non recurrent savings which is delivered in 2015/16 by the full year effect of the schemes (**£1,468k** in FY15/16). This also includes **£1,280k** of forward banked schemes which will unwind over the year.



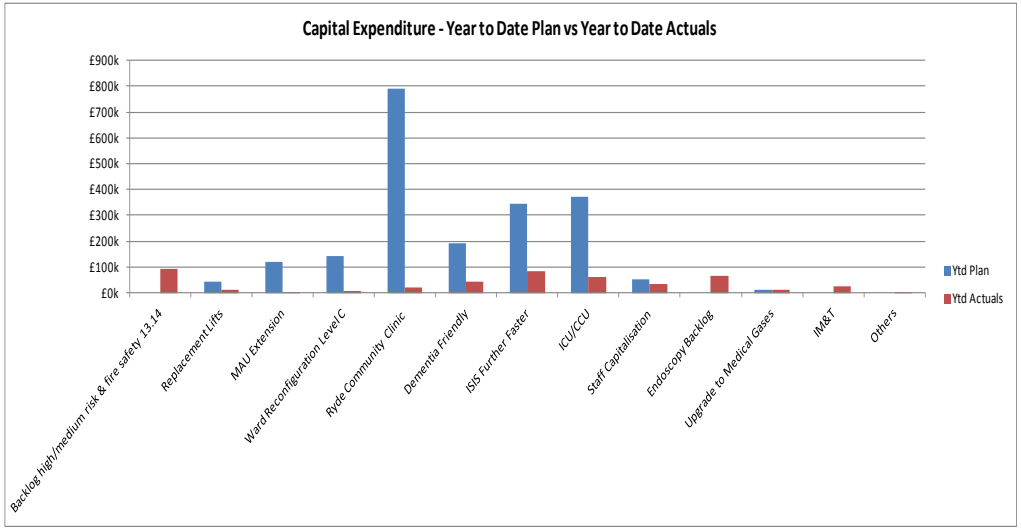
Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

Capital Programme - Capital Schemes

Isle of Wight NHS Trust

Source & Application of Capital Funding	Original Plan £'000	Revised Plan / Budget £'000	YTD Plan	YTD Spend £'000	F'cast to Year End £'000	Full Year £'000
Source of Funds						
Initial CRL	7,460	7,460	0			7,460
Dementia Friendly		0				0
Pharmacy Matched Funding - NHS Technology for Safer Wards (provisional)		0				0
CCG Income (Hand Held Devices)		0				0
Property Sales	648	648	0			648
Cash Surplus						
Anticipated Capital Resource Limit (CRL)	**8,108**	**8,108**	**0**	**0**	**0**	**8,108**
Other charitable donations	100	100				100
Charitable Funds - Dementia	9	9				9
Donated Helipad Income	0	0				0
VAT Recovery	100	100				100
Total Anticipated Funds Available	**8,317**	**8,317**	**0**	**0**	**0**	**8,317**
Application of Funds						
13/14 Schemes Carried Forward						
Backlog high/medium risk & fire safety 13.14	93	93		93	0	93
Replacement of two Main Hospital Passenger Lifts	44	44	44	13	31	44
Personal Alarm System for Sevenacres	0	0		0	-0	0
MAU Extension	2,428	1,840	120	2	1,838	1,840
Ward Reconfiguration Level C	142	142	142	7	136	142
Ryde Community Clinic	1,225	1,225	790	22	1,203	1,225
Dementia Friendly	192	192	192	44	148	192
ISIS Further Faster	344	344	344	82	262	344
ICU/CCU	2,262	126	370	63	62	126
Endoscopy Relocation	625	2,465		0	2,465	2,465
Sub-total	**7,356**	**6,470**	**2,002**	**325**	**6,145**	**6,470**
14/15 Approved Schemes						
Endoscopy Backlog Maintenance	0	74		67	7	74
Call Vision Call Recording Server	0	27		27	-0	27
Replacement Outpatient Desk	0	5		4	1	5
Medicine Cabinet Installation	0	73		0	73	73
Bratt Pans	0	14		0	14	14
Internal Porters Tug	0	6		0	6	6
Air Conditioning for IT Network Room	0	25		0	25	25
Upgrade to Medical Gases System	12	12	12	12	0	12
St Helens Ward Relocation	0	357		0	357	357
Carbon Energy Fund	0	421		0	421	421
Carbon Energy Fund Contingency	0	0			0	0
Sub-total	**12**	**1,012**	**12**	**110**	**903**	**1,012**
14/15 Schemes - Requiring TEC Approval						
Backlog Maintenance	0	0		0	0	0
IM&T (balance)	156	129		0	129	129
RRP (Annual Plan adjusted by £45k to offset Endoscopy Backlog)	460	405		0	405	405
Contingency (Annual Plan adjusted by £28k to offset Endoscopy Backlog)	33	0		0	0	0
Infrastructure (e.g. underground services)	0	0		0	0	0
Staff Capitalisation	200	200	50	35	165	200
Sub-total	**849**	**734**	**50**	**35**	**699**	**734**
Other charitable donations	100	100		0	100	100
Gross Outline Capital Plan	**8,317**	**8,317**	**2,064**	**470**	**7,847**	**8,317**



Commentary : The initial Capital Resource Limit, plus expected proceeds from property sales and charitable donations, give the Trust a Source of Capital Funds of £8.3M. Capital Investments already approved in 2013/14 total £7.4M, but the project to relocate ICU to CCU has been amended, and the approved £2.2M for this project will now be re-allocated to other projects.

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

Isle of Wight NHS Trust Board Performance Report 2014/15

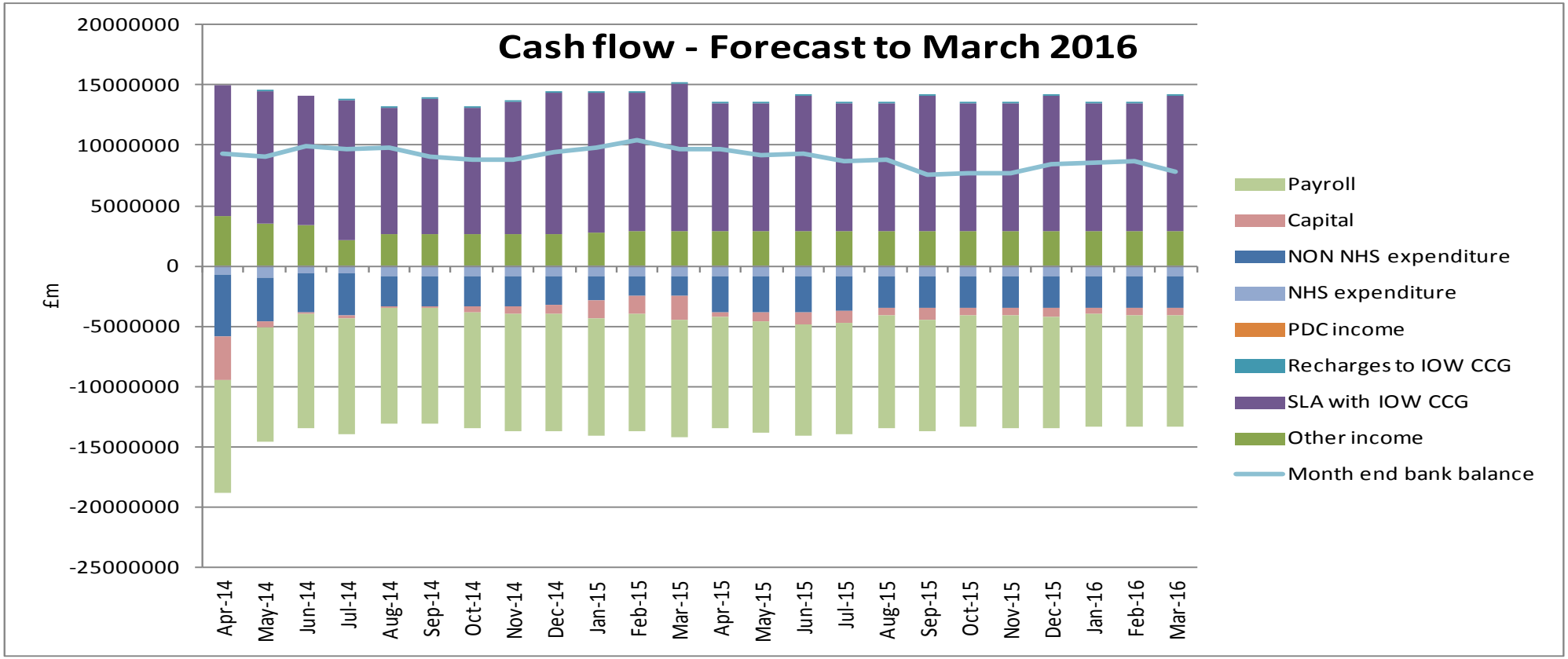
June 14

Monthly statement of Financial Position - June 2014

	June-14	May-14	Month-on-month Movement
PPE	116,327	116,182	145
Accumulated Depreciation	19,929	19,453	476
Net PPE	**96,398**	**96,729**	**(331)**
Intangible Assets	7,821	7,771	50
Intangible Assets Depreciation	3,875	3,771	104
Net Intangible Assets	**3,946**	**4,000**	**(54)**
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	242	252	(10)
Total Other Non-Current Assets	**242**	**252**	**(10)**
Total Non-Current Assets	**100,586**	**100,981**	**(395)**
Cash	9,917	9,021	896
Accounts Receivable	9,683	8,629	1,054
Inventory	2,514	2,420	94
Investments	0	0	0
Other Current Assets			0
Current Assets	**22,114**	**20,070**	**2,044**
Total Assets	**122,700**	**121,051**	**1,649**
Accounts Payable	18,364	16,700	1,664
Accrued Liabilities	0	0	0
Short Term Borrowing	27	34	(7)
Current Liabilities	**18,391**	**16,734**	**1,657**
Non-Current Payables	0	0	0
Non-Current Borrowing	0	0	0
Other Liabilities	596	597	(1)
Long Term Liabilities	**596**	**597**	**(1)**
Total Net Assets/Liabilities	**103,713**	**103,720**	**(7)**
Taxpayers Equity:			
Revaluation Reserve	24,488	24,488	0
Other Reserves	76,539	76,550	(11)
Retained Earnings incl. In Year	2,686	2,682	4
Total Taxpayers Equity	**103,713**	**103,720**	**(7)**

Commentary

Minimal capital spend has occurred in June and therefore the downward movement in fixed asset values can be attributed to depreciation charges. The movement in debtors and creditors has resulted in an increase in cash of c£900k.



Commentary:
The table above shows the forecast cash flow to March 2016. It shows both the in-flow and out-flow of cash broken down to the constituent elements.
Cash held at the end of June amounted to c£10m. During the month the Trust was able to invest an average of £10m in the short term deposit of the National Loans Fund.

Isle of Wight NHS Trust Board Performance Report 2014/15

June 14

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 Sep-13	Historic Data: Qtr to Dec-13	Historic Data: Qtr to Mar-14	Current Data: Apr-14	Current Data: May-14	Current Data: Jun-14	Current Data: Qtr to Jun-14	Notes
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	Yes	Yes	No	Yes	Yes	Yes	Yes	
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		95%	1.0	Yes	Yes	Yes	No	No	No	No	See exception report
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		92%	1.0	Yes	Yes	Yes	Yes	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	No	Yes	No	See May exception report
	5	All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	No	No	Yes	No	
			NHS Cancer Screening Service referral	90%									
	6	All cancers: 31-day wait for second or subsequent treatment, comprising:	surgery	94%	1.0	No	Yes	No	Yes	Yes	Yes	Yes	
			anti-cancer drug treatments	98%									
			radiotherapy	94%									
	7	All cancers: 31-day wait from diagnosis to first treatment		96%	1.0	Yes	Yes	Yes	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	Yes	Yes	No	No	No	No	All urgent referrals =92.6% Symptomatic breast referrals= 74% See exception report
			For symptomatic breast patients (cancer not initially suspected)	93%									
	9	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within seven days of discharge	95%	1.0	No	No	No	No	No	No	No	Follow up within 7 days = 95% Formal Review within 12 months =85% (Improvement due to manual working through files - work continues to include in PARIS reporting)
			Having formal review within 12 months	95%									
	10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	No	Yes	No	Yes	Yes	Yes	Yes	
	11	Meeting commitment to serve new psychosis cases by early intervention teams		95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	12	Category A call – emergency response within 8 minutes, comprising:	Red 1 calls	75%	1.0	Yes	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	See exception report. National threshold set =12, YTD threshold=2
			Is the Trust below the YTD ceiling	2		No	Yes	Yes	Yes	No	No	No	
	16	Minimising mental health delayed transfers of care		≤7.5%	1.0	Yes	Yes	No	No	No	Yes	No	Specific problems have now been resolved and forecast is better for next period.
	17	Mental health data completeness: identifiers		97%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Data validity is measured against actual submitted data. However, we have noticed that one of the required data items is missing from the submission. Whilst this does not impact on the validity of the indicator we are working to address this Paris reporting issue to ensure completeness of future submissions.
	18	Mental health data completeness: outcomes for patients on CPA		50%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	19	Certification against compliance with requirements regarding access to health care for people with a learning disability		N/A	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	TBC
	20	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	TBC
			Referral information	50%									
			Treatment activity information	50%									
				TOTAL		**4.0**	**1.0**	**5.0**	**5.0**	**6.0**	**3.0**	**6.0**	
						R	AG	R	R	R	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
KLOE	Key Line of Enquiry
KPI	Key Performance Indicator
LOS	Length of stay
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus (bacterium)
NG	Nasogastric (tube from nose into stomach usually for feeding)
OP	Out Patient (A patient attending for a scheduled appointment)
OPARU	Out Patient Appointments & Records Unit
PAS	Patient Administration System - the main computer recording system used
PALS	Patient Advice & Liaison Service now renamed but still dealing with complaints/concerns
PATEXP	Patient Experience
PATSAF	Patient Safety
PEO	Patient Experience Officer - updated name for PALS officer
PPIs	Proton Pump Inhibitors (Pharmacy term)
PIDS	Performance Information Decision Support (team)
Provisional	Raw data not yet validated to remove permitted exclusions (such as patient choice to delay)
QCE	Quality Clinical Excellence
RCA	Route Cause Analysis
RTT	Referral to Treatment Time
SUS	Secondary Uses Service
TIA	Transient Ischaemic Attack (also known as 'mini-stroke')
TDA	Trust Development Authority
VTE	Venous Thrombo-Embolism
YTD	Year To Date - the cumulative total for the financial year so far

Workforce and Finance terms

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

Enc G

Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 30 JULY 2014

QUALITY & CLINICAL PERFORMANCE COMMITTEE
Wednesday 23 July 2014

Present:	Sue Wadsworth	Non Executive Director and Chair (Chair)
	Nina Moorman	Non Executive Director and Deputy Chair (DC)
	Alan Sheward	Executive Director of Nursing and Workforce
	Sabeena Allahdin	Clinical Director – Planned Clinical Directorate (CDP)
	Sarah Gladdish	Clinical Director – Community Clinical Directorate (CDC)
In Attendance:	Brian Johnston	Head of Corporate Governance & Risk Management (HOCG)
	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM)
	Vanessa Flower	Quality Manager (QM)
	Deborah Matthews	Head of Clinical Services – Acute Clinical Directorate (HOCA)
	Kay Marriott	Acting Head of Clinical Services – Community Clinical Directorate (AHOCC)
	Gill Honeywell	Chief Pharmacist (CP)
	Ian Bast	Patient Representative (PR)
	Chris Orchin	Non-Executive Director (Governance and Compliance) Healthwatch IW (HIW)
	Chris Couch	Modern Matron (MM), deputising for Shane Moody, Interim Head of Clinical Services – Planned Clinical Directorate (IHOCP)
	Jan Ward	Locum Information Officer (LIO), *for item 14/245*
	Shane Moody	Interim Head of Clinical Services – Planned Clinical Directorate (IHOCP) – *attended for 14/256 onwards*
	Di Adams	Manager – Diagnostic Imaging (MDI), *for item 14/256*
	Lynne Baldry	Community Nurse (CN), *for item 14/258*
	Amy Rolf	Senior HR Manager (SHRM), *for item 14/264*
	Emily Macnaughton	Consultant Microbiologist (CM), *for item 14/265*
	Carol Foley	Business Continuity Manager (BCM), *for item 14/266*
	Andy Shorkey	Foundation Trust Programme Management Officer (FTPMO), *for item 14/2*
Minuted by:	Amanda Garner	Personal Assistant to EDNW (PA)

Key Points from Minutes to be reported to the Trust Board

1. Item 14/274 - SEE Committee Terms of Reference – the Committee discussed and agreed that further work was required on how the SEE committee reports into the QCPC.

2. Item 14/254 – Planned Directorate Area of Concern – the Committee were updated on reviews and deep dive meetings taking place.

3. Item 14/269 – Nutrition Review – the Committee will receive a further report at their September meeting.

4. Item 14/246 – Quality Report – the Committee noted that there had been zero Grade 3 and Grade 4 pressure ulcers reported in June 2014 for patients within the Hospital setting.

5. Item 14/256 Breast Screening Arrangements – the Committee received an update on the new arrangements in place.

Minute No.

14/239 APOLOGIES FOR ABSENCE FROM MEMBERS AND ATTENDEES

Apologies were received from Jessamy Baird, Non Executive Director (JB), Mark Pugh, Executive Medical Director (EMD), Ma'en Al-Mrayat, Interim Clinical Director – Acute Clinical Directorate (ICDA) and Shane Moody, Interim Head of Clinical Services – Planned Clinical Directorate (IHOCP). Shane Moody attended from item 14/256 onwards.

14/240 CONFIRMATION OF QUORACY

The Chair confirmed the meeting was quorate.

14/241 DECLARATIONS OF INTEREST

There were no declarations of Interest.

14/242 MINUTES OF THE LAST MEETING – 18 June 2014

The minutes of the meeting held on 18 June 2014 were agreed.

14/243 REVIEW OF ACTION TRACKER

The Committee reviewed the Action Tracker.

The Chair asked that members and attendees make an asserted effort to close off as many actions as possible for the next meeting.
***Action Note**: Members and attendees to close off as many actions as possible for the next meeting on Wednesday 20 August 2014.*

Action by All

QCPC0238 – ISIS roll out timeline - The EDNW confirmed that there is an ISIS roll out plan and that this will be presented to the Committee at the August 2014 meeting.
***Action Note**: PA to add to agenda for August 2014 meeting.*

Action by PA

UPDATE OF LOCAL / NATIONAL ISSUES

14/244 UPDATE FROM NATIONAL QUALITY AGENDA

The EDNW presented an update from the National Quality Agenda to the Committee and suggested that for future that areas pertinent to the Trust are highlighted and it is reported what we are doing in response to national stories and recommendations. The Chair advised that the SEE Committee will oversee these. The DC agreed that the published report that are relevant need to be highlighted and for it to be confirmed who will lead on the actions. The DC added that benchmarking also needed to be included and if benchmarking was not possible, eg due to high numbers, then this needed to be clear. HIW added that for example "Domestic Violence and Abuse – how services can respond effectively" was not just for the Trust. The EDNW agreed and advised that this would be picked up through the Joint Safeguarding Steering Group. The EDNW advised that he and the QM would be meeting prior to the next Committee meeting to discuss this further.
***Action Note**: The EDNW and QM to meet prior to the next Committee meeting to discuss further.*

Action by EDNW & QM

The CP added that the Technical Appraisals have to be responded to within 90 days and monitored. The DC added that the Committee does not have to see the detail but be clear on who follows up this guidance.

14/245 NICE IMPLEMENTATION – PROGRESS REPORT

The QM advised the Committee that the Clinical Guidelines had been omitted from the

report in error. The QM advised that the report provided an overview of all NICE published guidance since 1 April 2012 to June 2014. The QM advised the Committee that on a number of areas feedback had not been received and therefore the Trust did not have assurance regarding these. The QM advised that the guidance is now available on the Intranet for monitoring and will be robustly reported to the SEE Committee (SEEC). The QM added that she was concerned regarding Quality Standards and the lack of central feedback. The DC added that the Guidelines need to be reviewed by specialities and it needed to be clear if the Trust would implement and if not, why not. The CDC advised that there is some guidance that is not relevant to the Trust. The QM advised that if this was the case then feedback was required. The EDNW advised that the SEE Triumvirate will review this and he agreed with the QM regarding Quality Standards. The EDNW advised that a named lead for each guidance was key and that the SEE Triumvirate will identify these leads. The Chair asked that this item be referred to the SEE Committee and for that Committee to update QCPC in September 2014.

***Action Note**: SEE Committee to provide update to QCPC at September 2014 meeting*

Action by SEEBM

QUALITY

14/246 QUALITY REPORT

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

1. SIRIs – there was a local target this year to reduce SIRIs however there has been an increase in June 2014. The EDNW advised that this improved reporting needed to be triangulated with the outcome for patients.
2. Falls – local action plans in place
3. MRSA screening – improvements but still not at 100%
4. Pressure Ulcers – no Grade 3 or 4's in the hospital setting however Community remains an issue. The DC advised that the team should be commended on zero Grade 3 or 4 pressure ulcers during June 2014.
5. The Chair enquired when the Ward Indicators Dashboard will be available. The EDNW added that the Dashboard is live and available and the next piece of work to be done is to agree a matrix and triggers. The Chair advised that it had been highlighted to her that the indices do not relate to paediatrics very well. The EDNW advised that the matrices can be set to be sensitive to such services. The Chair added that the CQC Inspection Team were impressed with the Dashboard and suggested that it be put forward for an award. HIW enquired if this would be available on the Internet for public viewing. The EDNW confirmed that it would be and agreed that where there were areas of "red" that a narrative should be included and advised that the Ward Sisters would provide this information. The Chair asked that a brief paper be written on how this will develop to ensure transparency and accessibility.
6. Safety Thermometer – 95.06% which is a slight increase on May 2014.
7. Clinical Incidents – The DC enquired regarding the reporting of "catastrophic incidents". The EDNW advised that any catastrophic incidents will be classed as "unconfirmed" until confirmed and catastrophic incidents will be reported to this Committee. The HOCG advised that serious incidents will be reported to Part 1 of Trust Board and unconfirmed will be reported to Part 2 then Part 1 if confirmed. The LIO advised that there had not been any catastrophic incidents reported in June 2014. The DC asked that a "nil" return is included for clarity.

***Action Note**: "Nil" returns to be included*

Action by LIO

8. Slips, trips and falls – above target.

9. Healthcare Associated Infection (HCAI) – Clostridium Difficile – total of 4 exceeds our year to date internal target.

10. Maternity Scorecard – the EDNW advised that he had concerns regarding this coupled with the low Friends and Family Test Scores. The Committee discussed this and suggested that the Head of Maternity (HOM) provide an update to the Committee at the meeting on 20 August 2014.

***Action Note**: PA to invite HOM to August 2014 meeting.*

Action by PA

11. Falls – The Chair suggested that a update report on Falls be presented to the Committee in September 2014.

***Action Note**: PA to invite Viv Tomlinson to present the current position to September 2014 meeting.*

Action by PA

12. Emergency Readmissions – have increased but overall trend satisfactory.
13. Antimicrobial Stewardship – dashboard to be set up. The CP added that there is a dashboard for some elements however we are looking to get a better picture.
14. Complaints – similar to last month. The EDNW advised the Committee that the current timeframe for closing complaints is 30 days and this will be reduced to 20 days. The EDNW added that the SEEBM is leading on the review of procedure and electronic management.
15. Friends and Family Test – generally better this month with concerns in Midwifery
16. Complaints – The CDC highlighted slide 23 regarding complaints relating to contacts and advised that this needs to include all contacts. The LIO advised that she was working on this.
17. PALS Office – The Chair enquired if the soundproofing had been put in place yet. The SEEBM updated the Committee on this and advised that she would update the Chair when the timeline has been confirmed once the glitch with cabling in the wall has been assessed.

***Action Note**: SEEBM to update Chair on timeline of soundproofing to PALS office.*

Action by SEEBM

18. Cancelled or Re-arranged Outpatient Appointments – the DC noted that this was a quality goal and that the figures appeared very high. The LIO advised that there are some errors in the data ie rearranged appointments are being counted as cancelled in some cases.

14/247 TRUST QUALITY ACCOUNT - TIMETABLE

The SEEBM advised that this report provided the proposed timeline for the Directorates for the development of the Trust's Quality Account. The SEEBM added that this would be updated if any new national guidance was given.

The Chair noted that the Quality Goals were presented to the Committee after they had been agreed. The Chair and SEEBM discussed this and agreed that the Committee would be involved in the consultation process.

***Action Note**: SEEBM to involve Committee in consultation process for the Quality Goals.*

Action by SEBBM

14/248 INTELLIGENT MONITORING

The HOCG advised that the latest version of the CQC Intelligent Monitoring would be issued on the CQC website on Thursday 24 July 2014. The HOCG advised that the Trust had had one risk removed as it was no longer an issue and the 4 remaining risks were not elevated. The HOCG added that the banding had temporarily been abandoned as the Trust had recently been inspected however if this was not the case the Trust would be at Band 6 which is the lowest risk. The Committee agreed that this was a really good report. The HOCG added that one of the risks relates to VTE which the Trust has made significant steps forward with however the CQC is behind with capturing data in this respect.

14/249 CQC MH ACTION PLAN

The HOCG advised that this action plan included actions from all CQC inspections visits to the Mental Health Service and are RAG rated. The HOCG advised that the majority of the actions were "green" with a small number of "amber". The Chair noted that one action related to a nursing station and action was awaited from Estates. The HOCG advised that he had chased this and the Chair asked that Estates were advised that the Committee were concerned about the delay on this action.
***Action Note**: HOCG to chase Estates and advise them that the Committee are concerned regarding the delay on this action.*

Action by HOCG

The Chair highlighted an action from the visit in June 2013 relating to meals. The EDNW advised that he had met with Catering and Transport recently and there is a plan however a Health and Safety Assessment is required before it can be put into place. The Chair asked that a post-meeting note be added to the minutes if this was achieved.
***Action Note**: EDNW to add post-meeting note.*

Action by EDNW

HIW noted the action relating to Section 136 and how this is a key area for Healthwatch this year. The HOCG advised that the policy has been redrafted and will be presented to the Policy Management Group on 16 September 2014.

The DC enquired regarding the use of Care Programme Approach (CPA) and Service Users Involvement Policy. The AHOCC advised that she would review these and report back to the Committee.
***Action Note**: The AHOCC to review the implementation of the Care Programme Approach and Service Users Involvement Policy and report back to the Committee.*

Action by AHOCC

The EDNW advised that the Quality Dashboard does not reflect Mental Health (MH) and asked that the SEE Committee meet with MH leads and bring forward their Quality matrix.
***Action Note**: SEEC*

Action by SEEC

14/250 CQC INSPECTION – ACTION PLAN

The EDNW advised that following the CQC inspection in June 2014 that their report is due to be available to the Trust on 28 July 2014. The Trust will then have two weeks to review the report for accuracy. The EDNW added that a Quality Summit will be held on 2 September 2014. The EDNW advised that the CQC had identified 5 areas for immediate action. They had also identified 11 areas of concern which were being reviewed. The EDNW advised that this was the current action plan and added that Action Number 1 – Paediatric Emergency Care Pathway had an interim solution however this was not sustainable and that there would be a meeting with the Commissioner to review this. The EDNW advised that there had been 2 complaints received due to patients not having direct access to Paediatrics.

The EDNW advised that the biggest risk was staffing. The CDC advised that there were unfilled Registrar and Consultant posts and there was no quick fix. She added that this was adding to bed pressures. The EDNW advised that a Medical Recruitment Lead has been recruited to "head hunt" staff and that this area had need to be improved for a long time.

REPORTS FROM DIRECTORATES

ACUTE CLINICAL DIRECTORATE

14/251 QUALITY, RISK AND PATIENT SAFETY COMMITTEE

The HOCA presented the Minutes of the Acute Clinical Directorate's Quality, Risk and Patient Safety Committee held on 19 June 2014 and highlighted the following:

- Switchboard – on the corporate risk register and has been escalated as the system is not able to be upgraded.
- JAC in the Emergency Department (ED) – JAC not meant for use in an ED environment and a paper drug chart is in use. This will be kept under review. The CP added that there is an issue with the legality of saving scanned prescriptions and shredding the actual signed one. The DC added that there is a proposed Board Sub-Committee which will lead on IT issues and suggested that they would be interested in this. The Chair asked that this be referred to the proposed IT Sub-Committee.

***Action Note**: Issues with JAC in ED to be referred to the proposed IT Sub-Committee.*

Action by EDNW

- Wholesale Dealers Licence and Authorisation – The CP updated the Committee and advised that there are associated costs and a huge amount of work. The Chair asked that this be referred to the new IT Sub-Committee.

***Action Note**: Issues with Wholesale Dealers Licence and Authorisation to be referred to new Sub-Committee.*

Action by EDNW

- C Diff – no cases reported at the time of the Directorate's meeting on 19 June 2014, however subsequently there had been one new case. The HOCA advised that a Root Cause Analysis had been completed and lessons learned had been shared. The CDC highlighted the need to recognise that findings apply to the whole Trust. The EDNW added that it had been noted that most C Diff cases were patients who had been an inpatient at the Trust for a long period of time and taking antibiotics for a long time also.
- HSDU Equipment – there had been issues with equipment however staff worked hard to ensure business continuity. The Committee asked that special thanks be passed to the Team. The EDNW advised that he would write to the Team. The Chair asked that this be referred to the proposed Board IT Sub-Committee

***Action Note**: The EDNW to write to the Team thanking them for their efforts.*

Action by EDNW

***Action Note**: This issue to be referred to the proposed IT Sub-Committee.*

Action by EDNW

The HOCA presented the Minutes of the Isle of Wight Ambulance Clinical & Quality Effectiveness Group held on 11 June 2014 and highlighted the following:

- Paediatric Hospital Admissions – this had changed following the CQC visit

The Chair noted that the CQC had raised a concern regarding the temperature of the storage of drugs in this area. The CP advised that a temporary measure had been put in place however this was being reviewed for a longer term solution.

The QM noted the items relating to Clinical Audit and advised that these were not on the register. The QM asked that the Team be reminded that these need to be logged.

***Action Note**: The HOCA to remind the Team to log Clinical Audits.*

Action by HOCA

14/252 ACTIONS BEING TAKEN IN REVIEWING OR ACTION PLANNING AROUND CLINICAL AREAS OF CONCERN

The HOCA updated the Committee on progress made in the department and that the directorate was happy with progress however will continue to monitor.

The Committee discussed a previous area of concern and the HOCA updated on progress on the action plans. The Chair asked that a summary of key learning be presented to the Committee at the August 2014 meeting.

***Action Note**: A summary of key learning to be presented to the Committee at the August 2014 meeting.*

Action by HOCA

PLANNED CLINICAL DIRECTORATE

14/253 QUALITY, RISK AND PATIENT SAFETY COMMITTEE

The CDP presented the Minutes of the Planned Clinical Directorate's Quality, Risk and Patient Safety Committee held on 19 June 2014 and highlighted the following:

- Risk Register – being monitored.
- Patient Property – check list for wards has been implemented and will be monitored.
- SIRIs – two have been sent for closure

14/254 ACTIONS BEING TAKEN IN REVIEWING OR ACTION PLANNING AROUND CLINICAL AREAS OF CONCERN

The CDP updated the Committee on the Planned Directorate's area of concern and advised that there had been a Risk Summit when it had been decided to review the structure. The CDP advised that the structure had been put in place and was being monitored. The Chair advised that she had chaired the Risk Summit meeting and that a Deep Dive meeting will also be taking place and a lot of work is being done with a further meeting to be held in two weeks time. The EDNW advised that he was pleased with the Directorate's response and agreed that the Deep Dive should be carried out with support from other areas as part of a multi disciplinary approach outlined in the Trust guidance.

The Chair added that the impetus for this had come from the Directorate. The Committee discussed this and agreed that support was needed. The CDP added that the department concerned had been through major changes recently including organisational change and this needed to be acknowledged.

14/255 2013/14 PLANNED DIRECTORATE QUALITY REPORT

The MM presented the Planned Directorate's Quality Report to the Committee and advised that as requested at the last meeting Quarter 4 had been added.

The EDNW advised that there needed to be clear requirements regarding the Directorates' Quality Reports and suggested that a template be implemented for next year. The SEEBM advised that the timetable will help.

***Action Note**: A template to be implemented for the Directorates to use for their Quality Reports.*

Action by SEEBM

14/256 REGIONAL BREAST SCREENING

The MDI updated the Committee regarding the Breast Screening service and that it was no longer linked with Southampton. The MDI advised that this was due to an increase in costs and the cutting of the service that Southampton could provide from 52 to 42 weeks. The MDI explained that there was a rising demand for imaging and after consulting with various agencies the change was approved. The MDI explained that there had then been some difficulties with Southampton however these had now been resolved. The MDI advised that there are two full time Consultant Radiologists in post and the Service had been given the go ahead to re-start from the end of June 2014. The CDP commended the MDI on her work and added that credit should also be given to Richard Sainsbury. The Chair thanked the MDI for the work that she had done and asked that thanks be passed to the whole team.

COMMUNITY CLINICAL DIRECTORATE

14/257 QUALITY, RISK AND PATIENT SAFETY COMMITTEE

The CDC presented the presented the Minutes of the MHLD and Community Clinical

Directorate's Quality, Risk and Patient Safety Committee meetings held in June 2014 and highlighted the following:

Mental Health

- Risk Register Process – the AHOCC added that there had been a data collection issue but this had been resolved.
- NICE guidelines – system to be developed to evidence dissemination and compliance.

Community

- Business Continuity Plans – full review under way.
- Incidents arising from OT staffing issues – plan in place
- Clinical Audit Programme – on going.

HIW declared an interest in OT as a member of his family is a member of staff. He enquired regarding when the plan was in place for OT will the Department be removed from the risk register. The CDC advised that this will be reviewed once everyone is in post.

The EDNW enquired regarding pressure ulcers in the Community Directorate minutes of the meeting held on 18 June 2014 (Page 3 of Enc K2) and asked if the figure of 32 was the Trust figure. The AHOCC confirmed that the figure was the Trust figure not the directorate figure. The AHOCC advised that Community pressure ulcer information is reviewed on a weekly basis with the matrons in the three localities. The EDNW suggested that this be made clearer in the minutes.
***Action Note**: The AHOCC to ask for information in the minutes to be clearer.*

Action by AHOCC

The AHOCC added that concerns had increased and there had been a review of this and it had been noted that a third were general enquires and not concerns.

14/258 PRESSURE ULCERS – UPDATE ON COMMUNITY DIRECTORATE'S ACTION PLAN

The CN presented the Community Directorate's Pressure Ulcer Action Plan to the Committee and highlighted the following:

- Step by step guide in place to completing Datix.
- Pain predictor now include in health assessment
- Community Nursing Health Assessment Booklet – clear requirement on when this is completed ie by the second visit to the patient
- Local review/SIRI meetings – other professionals/agencies ie residential homes are now invited to attend.

The Chair advised that this was very useful and that she will be presenting this to the Trust Board. The EDNW advised that enormous progress has been made and enquired how will the Trust know if these actions are making a difference and when will the Trust start to see a reduction. The CN will liaise with the AHOCC regarding this together with cross referencing the CQUIN.
***Action Note**: The AHOCC to liaise with the CN to review and cross reference with the CQUIN.*

Action by AHOCC

PATIENT SAFETY

14/259 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – ON LINE

The QM advised that this is a new version of the monthly report however the data needs to be revalidated. The QM reported that there were 9 SIRIs reported in June 2014, 5 of which related to pressure ulcers.

14/260 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – IN PROGRESS

The QM reported that at the time the report was written there were 38 open SIRIS however she advised that a number of these have since been closed. The Committee agreed that the summary sheet was very helpful.

14/261 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – TO BE SIGNED OFF

The QM reported that there were three SIRIs to be presented to the Committee for sign off.

Acute Directorate
2013/25470 – the HOCA advised that this SIRI was being withdrawn for final sign off and that a review meeting had been set up. The HOCA advised that this SIRI will be presented to the Committee for sign off next month.

Community Directorate
2013/17028 – the AHOCC advised that all the recommendations had been completed. Sign off was approved.

Other Corporate Areas
2014/17065 – the Committee discussed this and agreed that it would be useful for the new Executive Director of Transformation and Integration (EDTI) to review this SIRI. The CDC and EDNW raised concerns and agreed that the IT Sub Committee should have sight of this SIRI. Sign off was approved on the proviso that the details be forwarded to the EDTI and the IT Sub Committee and the Chair asked that comments were provided back.
***Action Note**: The QM to forward SIRI 2014/17065 to the EDTI and the IT Sub Committee.*
Action by QM

The IHOCP advised that there had been two SIRI's relating to the Planned Directorate that had been discussed by the Committee at the meeting in June 2014 and had not been approved for sign off. The IHOCP explained that an independent review had taken place to look at the processes. The IHOCP explained that new root causes had been identified and actions were now in place. The MM gave the following update:

2012/18540 – the recommendations were appropriate and the key problem was timescales
2012/24507 – there were revised recommendations.

The EDNW advised that he was not assured and asked that further information be provided for the August 2014 meeting.
***Action Note**: The IHOCP to provide further information for the August 2014 meeting.*
Action by IHOCP

14/262 AUDIT OF SIRIs

The QM advised that she had carried out a random audit of 15 SIRI actions (5 from each directorate) from completed investigations during 2013/14. The QM advised that the audit showed that 8 actions were fully implemented, 6 were partially compliant and 1 was no longer applicable. The Committee discussed who should lead on this audit and agreed that it should be carried out externally to the Directorates. The Committee agreed this level of audit confirmed the assurance required.

14/263 CLINICAL NEGLIGENCE CLAIMS RECEIVED – QUARTERLY UPDATE

The HOCG presented the quarterly update to the Committee and reported that there had been three claims closed and 3 new actual claims. The HOCG advised that there had been 15 actual incident forms received against an expected 18 and that this was being reviewed.

14/264 RAISING STAFF CONCERNS – QUARTERLY UPDATE

The SHRM advised that she had met with Gretel Ingham, Locality Manager at Healthwatch regarding staff contacting Healthwatch and this raised the question why. The SHRM advised that there will be further Trust wide communication in September regarding raising concerns.

The Chair and the DC agreed that this report could be presented to the Committee every 6 months in future unless there were any particular concerns.
***Action Note**: The PA to update the rolling programme.*

Action by PA

14/265 INFECTION, PREVENTION & CONTROL – QUARTERLY UPDATE

The CM presented the quarterly infection control update to the Committee and highlighted that Clostridium difficile rates were the biggest concern for the Trust. The CM advised that the action plans from the 2014 Norovirus outbreak will be followed up at the Infection, Prevention and Control Committee meeting to be held in August 2014. The CM highlighted that there had been no hospital acquired cases of Carbapenemase producing Enterobacteriaceae (CPE) and there had been an investigation into increased incidence of orthopaedic site infections the results of which were awaited.

14/266 NOROVIRUS OUTBREAK REPORT

The BCM presented the Business Continuity Debrief Report for the Norovirus Outbreak to the Committee and advised that there are a number of recommendations to be taken forward. The EDNW advised that the action plan will be monitored through the Infection, Prevention and Control Committee (IPCC). The CDC highlighted that there had been a disconnect with Public Health however a forum had since been set up by Public Health to improve communication. The DC enquired if the Trust Executive Committee (TEC) see this report. The EDNW advised that the report will be presented to TEC soon.
***Action Note**: EDNW to present the report to TEC*

Action by EDNW

PATIENT EXPERIENCE

14/267 PATIENT STORY

The Committee viewed a video recording of a patient's relative giving feedback on the care that had been received.

The IHOCP acknowledged that the patient and family had been let down. He advised that the Ward Manager had reviewed the video and had drafted an action plan to ensure that lessons were learned and shared. The PR advised that training for staff for dealing with patients with disabilities was not compulsory but suggested that it should be. HIW added that it was very sad and should not have happened. The Committee discussed and agreed that it related to culture and leadership. The Committee agreed that the patient's impairments were contributory but the patient received bad care and that other parts of the organisation needed to be assessed. The EDNW advised that he wanted to meet with the patient and the family to discuss the issues with them face-to-face. The Chair expressed concern regarding a potential institutionalised culture issue. The PR advised that he is a member of the Disability Group and most staff do excellent work however incidents like this should not happen.

14/268 PATIENT STORY ACTION TRACKER & LESSONS LEARNED – QUARTERLY UPDATE

The QM presented a quarterly update of the patient story action tracker and lessons learned to the Committee and highlighted that there were three actions which were behind schedule but these were reliant on business cases.

14/269 COMPLAINTS – NUTRITION & HYDRATION FEEDBACK REGARDING ACTIONS

The SEEBM advised that this report related to complaints and concerns relating to nutrition and/or hydration since 1 April 2013. The Committee discussed this regarding a nutritional specialist. The EDNW advised that there will be a business case put forward for a dedicated speciality lead including setting up governance and an update would be provided to the Committee in September 2014.
***Action Note**: The EDNW to provide an update on the Business Case to the Committee in September 2014.*

Action by EDNW

14/270 ANNUAL HEALTHWATCH REPORT – SUMMARY REPORT

The EDNW presented the Healthwatch Isle of Wight Annual Report for 2013/14 to the Committee and added that the Trust relies on Healthwatch as a third party for external support. HIW advised that safeguarding is not a specific target area but was touched upon during visits. He added that HIW won a national award for their maternity review and this will be included in Healthwatch England's annual report. The CDP added that staff on St Helens ward had been mentioned in the report as doing a lot of good work.

CLINICAL AUDIT AND GOVERNANCE

14/271 CLINICAL AUDIT PROGRAMME – QUARTERLY REVIEW

The QM advised that this report provided a quarterly review of the audit programme. The QM advised that this report is available on the intranet and is updated. http://intranet/index.asp?record=2969

The QM advised that the directorates were aware of the 4 areas of concern. The Committee discussed two national audits that the Trust is not participating in. The CP will review this and report back to the Committee.

***Action Note**: The CP to review the two national audits the Trust is not participating in.*

Action by CP

14/272 CLINCIAL AUDIT 2013/14 INTERNAL REPORT – UPDATE ON PROGRESS

The QM advised that this action plan was developed following the internal audit on Clinical Audit 2013/14 and this report showed progress against the agreed actions.

14/273 MORTALITY / SHMI UPDATE

The EDNW presented an update on SHMI (Summary Hospital-level Mortality Indicator) to the Committee advising that the Trust's indicator remained at 1.10. The EDNW added that there had been significant improvements in reporting HSMR (Hospital Standardised Mortality Ratio). The DC noted that outcomes from mortality review meetings are not shared with the Committee. The CDP advised that this is being reviewed and should be in place soon. The DC added that lessons learned and actions need to be captured. The CDP advised that she would provide the Committee with an update for the September 2014 meeting. The CDC added that it was difficult to find the cause of death of outpatients and would discuss this with the EMD.

***Action Note**: CDC to review with the EMD regarding finding out the cause of death of outpatients.*

Action by CDC

SUB COMMITTEE GROUPS

14/274 SEE COMMITTEE AND QCPC TERMS OF REFERENCE

The HOCG advised that the SEE Committee will report formally to TEC and will send their minutes and highlight their key issues to this Committee. The Committee discussed the terms of reference and the DC suggested that there were lots of repetition in them. The Committee agreed that there was more work to be done on these.

***Action Note**: Further review required of the Terms of Reference of both the SEE and Quality & Clinical Performance Committees.*

Action by HOCG

14/275 QUALITY CHAMPIONS – ASSURANCE AGAINS INTEGRATED ACTION PLAN

The SEEBM updated the Committee on the work being done with the Quality Champions. The CD advised that this report had been very helpful in understanding how the Quality Champions were being used.

CLINICAL PERFORMANCE AND RISK

14/276 TDA SELF CERTIFICATION

The FTPMO advised that there had been a change to Board Statement 10 adding that the Board had elected to amend this to "at risk". The FTPMO advised that this were plans in place to put this back on track by the end of September 2014. The FTPMO advised that there were no further changes and that all Licences were "green". The FTPMO reported that the Quality Summit would be held on 2 September 2014 and the timeline was currently on target subject to the CQC report.

The Committee approved the TDA Self Certification.

14/277 ANY OTHER BUSINESS

1. The DC reported that she had recently attended an FT Network Workshop which covered Quality Governance and that she would discuss the ideas with the EDNW.
2. The EDNW advised that the directorate updates next month would come from the Hospital and Ambulance Directorate and the Community and Mental Health Directorate.
3. The PR advised that there had been changes to the categories of visual impairment to include severely visually impaired. The PR advised that he had been invited to visit Colwell ward and had suggested some changes.

***Action Note**: AWS to meet with the DC.*

Action by EDNW

14/278 DATE OF NEXT MEETING

Wednesday 20 August 2014
9 am to 12 Noon
Conference Room

Signed: _____ Chair

Date: _____

Isle of Wight NHS Trust

For Presentation to Trust Board on 30 July 2014

FINANCE, INVESTMENT & WORKFORCE COMMITTEE MEETING

Minutes of the Isle of Wight NHS Trust Finance, Investment & Workforce Committee (FIWC) meeting held on Wednesday 23rd July 2014 in the Large Meeting Room.

PRESENT:	Charles Rogers	Non-Executive Director (Chair) (CR)
	Jane Tabor	Non-Executive Director (JT)
	Chris Palmer	Executive Director of Finance (EDOF)
	Katie Gray	Executive Director of Transformation and Integration (EDTI)
	Kevin Curnow	Deputy Director of Finance (DDOF)
	Mark Elmore	Deputy Director of Workforce (DDW)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
In Attendance:	Stewart Churchward	Workforce Planning and Information Manager (WPIM) *(Item 14/109)*
	Liz Nials	Equality and Diversity Lead (EADL) *(Item 14/109d)*
	Martin Robinson	Associate Director for Strategy and Commercial (ADSC) *(Item 14/109e)*
	Carol Ogilvie	Senior Finance Manager (SFM) *(Item 14/110g & 114e)*
	Nikki Turner	Interim Associate Director Community(IADC) *(Item 14/114e)*
	Iain Hendey	Assistant Director-Performance Information & Decision Support (ADPIDS) *(Item 14/111a & 113a)*
	Charles Joly	Environmental, Waste and Sustainability Manager (EWSM) *(Item 14/114b)*
	Kevin Bolan	Associate Director of Facilities (ADoF) *(Item 14/114d)*
	Andrew Heyes	Head of Commercial Development (HCD) *(Item 14/114e)*
Minuted by:	Sarah Booker	PA to Executive Director of Finance (PA-EDOF)

To be Received at the Trust Board meeting on Wednesday 30th July 2014
Key Points from Minutes to be reported to the Trust Board

14/110	**<u>CIPs.</u> The Trust is reporting £2.261m against a target of £1.605m. This is circa £600k ahead of plan. However, this is after £1.2m of future banking. This is the common practise of recognising the full budget removal of achieving CIP plans in advance of the original schemes phasing. The Trust must now ensure that the schemes that have slipped to date are recovered in the coming period and deliver the equivalent full year effect so as not to impact on next year's financial plans.**
14/114	**<u>Investments/Disinvestments.</u>** **A) Disposal of Swanmore Road Properties. The Committee agreed to support the business case for the disposal of these properties.**

	B) Dental Services Contract. The business case for bidding for the new contract was still being developed at the time of the meeting and the Committee were able to offer advice on the progress of the work, but not enough information was available to provide recommendation for approval. **C) Endoscopy Business Case. As there was no one available to present the business case, it was not discussed.**
14/116	**<u>Self Certification.</u> Sufficient assurance had been provided for the Committee to recommend that Trust Board approve the self-certification returns as proposed.**

14/103 APOLOGIES

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

14/104 CONFIRMATION OF QUORACY

The Chairman confirmed that the meeting was quorate.

14/105 DECLARATIONS OF INTEREST

There were no declarations.

14/106 APPROVAL OF MINUTES

The minutes of the meeting held on the 18th June 2014 were agreed by the Committee and signed by the Chairman.

14/107 SCHEDULE OF ACTIONS

The Committee received the schedule of actions taken from the previous meeting on 18th June and noted the following:

14/042 Cost of Living Supplement: On going and awaiting a final report from the EADL. **Action: EADL.**

14/058 Workforce Key Performance Indicators Summary: Voluntary figures have been gathered and will be circulated. **Action EADL/DDW.**

14/081 NHS Creative Performance & Budget Update: The final Internal Audit report will be reviewed at the Audit and Corporate Risk Committee on 19 August and will be reviewed by the FIWC at the next meeting.

14/092 Workforce Performance Report: The EDOF again raised concern at the level of overpayments. The WPIM will look into the process of overpayment recovery to enable immediate repayment. **Action WPIM.**

14/093 Financial Performance Report & CIP Allocation by Directorates and Schemes: The EDTI will produce dashboards which include both recurrent and non-recurrent schemes. **Action: EDTI.**

14/094 Contract Status Report: The EDNW has written to the

Commissioners explaining the reasons for the system not being able to record all figures regarding the Ambulance handovers. The EDOF is still querying whether the Trust should be fined. The Contracting team are investigating this. **Action: EDNW/EDOF/Contracts Team.**

14/099 Self Certification Review and additional details relating to the Governance Risk Rating (GRR): There is an issue around timings for reporting- the ADPIDS will request explanations from departments in breach. **Action: ADPIDS.**

14/108 LONG TERM STRATEGY AND PLANNING

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

The DDOF briefed the Committee on the Downside Scenarios. These were not required to be included in the recent IBP submission but are a requirement for the Mock Board to Board session on 30th July. The 3 Downsides modelled are the loss of non-recurrent Commissioning income from 2015/16, CIPS underachieve by 25% in 2014/15 and 10% per year thereafter and the loss of Acute Commissioning income of 1% per year, marginal rate impact. The EDOF and DDOF will be visited by 2 representatives of the NHS Trust Development Authority (TDA) on 24 July and will discuss the potential issues that could be raised during the Mock Board to Board as the Trust will want to have full Board engagement behind the mitigations.

Action: EDOF to discuss requirements with the TDA representatives during the meeting on 24 July.

The Committee discussed whether this will need to be included at an extraordinary Board meeting to gain full Board engagement prior to submission.

Action: PA-EDoF to discuss with the Company Secretary.

14/109 WORKFORCE

(a) Workforce Performance Report:

The DDW noted the sickness absence has reduced to 3.49% and the temporary staffing has reduced also. Overtime is still being used which is being closely monitored. The Committee agreed to have sight of the "Christmas trees" bi-annually for a strategic view. The DDW noted that Mondays are still the most common absence days and the WPIM will be looking into these trends. JT queried why the FTE Bank covering sickness and annual leave had increased and the DDW confirmed more work will be carried out to ensure correct data is captured.

The DDW suggested changing the way in which the Workforce is reported to the Committee and will send out a revised reporting format to the Committee members prior to the August meeting for their comments.

Action: DDW to send out a revised report to the Committee members prior to the August meeting for their comments.

The EDOF questioned why the mandatory training percentage for Bank staff is so low. The DDW reported that the Bank manager is regularly pushing Bank staff to complete their mandatory training and if they do not they will not be requested to work. The EDNW requested the DDW writes to the Bank staff to notify them that if their Information Governance training is not completed they will also not be asked to work for us.

Action: The DDW will write to Bank staff notifying them of the importance of completing their mandatory training and make them aware of the consequences of not doing so.

The EDOF queried why only 9 doctors have been revalidated up to the end of June 2014. **Action: The DDW will discuss this with the Executive Medical Director and report back to the Committee next month.**

CR was concerned at the level of sickness in the range 28 days to 6 months. The EDOF assured the Committee that these issues are raised and discussed during each directorate's performance review meetings. The absences are usually for significant health reasons.

(b) <u>Workforce Strategy including Key Performance Indicators (KPIs)</u>

The Committee recommended the KPIs include a narrative explaining the plan of how things can be achieved where they are underachieving. Action: DDW.

The Committee discussed the overtime figures and the EDNW explained there will always be certain areas within the Trust which will have to use overtime, for example if an ambulance team are called out 10 minutes before their shift is due to end they will have to claim overtime for the additional time they will work over their allocated shift times. The EDNW noted overtime should not be pre-arranged under any circumstances.

The Committee requested each KPI is rag rated. Action: DDW.

(c) <u>Safer Staffing Status Update and Action Plan:</u>

The DDW updated the Committee on Safer Staffing and explained the report is a requirement of the Care Quality Commission (CQC) and the Trust Development Authority (TDA). The DDW highlighted the additional amount of work the Modern Matron of Alverstone Ward and the Operational Lead for E Rostering have undertaken to ensure ward requirements are reflected correctly on the system.

The report will also include staff recruitment and which areas will be recruited to each month.

The EDNW noted there will be a formal bid sent to the Commissioners to enable funding to enable recruitment. Written confirmation of this

agreement will be sought from the Commissioners. Action: EDNW.

CR queried whether the Trust is achieving rapid deployment. The EDNW confirmed the system is in place but the policy requires additional wording to note that staff may be moved to any ward as required for the need of the patient. The DDW confirmed all new contracts of employment do not state a particular ward the staff member will work on.

(d) Recruitment and Retention Protocol

The EADL attended to present this paper for consultation by the Committee. The EADL explained the maximum amount awarded for recruitment and retention will be 30% of the basic salary. There was a discussion around the policy and the EDNW requested the governance of this policy is looked into as if budgets are already being overspent how can additional payments be made? **The EADL will take this report and policy to the next Human Resources meeting to discuss the points raised.**

JT suggested the Trust is proactive rather than reactive around recruitment.

The Committee agreed this paper would need to be discussed and approved at a Trust Executive Committee meeting.

(e) Organisational Development (OD) Strategy

The ADSC attended to brief the Committee on the OD Strategy. He outlined the 11 organisation-wide development goals which will enable the Trust to become an outstanding organisation.

CR commented that the paper was lengthy and questioned how this paper can be taken to every individual working for the Trust. The ADSC explained a simplified version of this paper would be produced for staff.

JT suggested this paper should be very clear to the target audience and queried whether all risks have been considered as the greatest risk is that staff will not 'buy in' to it.

The EDNW suggested Consultants should read the document. The EDNW questioned where the actions are being monitored and how we will know that actions have been completed. The strategy should be very clear about how the strategic objectives will link to the Trust objectives. The EDOF suggested further narrative is included on how we are going to achieve this, what we are going to do to achieve this and how we will know when it has been achieved? The EDOF also asked how it links in with what the Trust is already doing. The DDW recommended the Workforce Strategy KPIs are linked in to this strategy with regard to staff engagement. Action: ADSC to consider these points and make amendments as necessary.

The EDTI noted this is a long term not short term vision for the Trust.

CR thanked the ADSC for his attendance and for the progress that has been made on this paper.

14/110 FINANCIAL PERFORMANCE

(a) Financial Performance Report, CIP Allocation by Directorates and Schemes and Capital Schemes Update:

The DDOF presented the performance report and highlighted the year-to-date (YTD) position of £343k which is an underachievement of £6k against the plan. The Trust is expecting to achieve its forecast adjusted surplus of £1.7m. There is currently nearly £10m cash-in-hand at the bank and the total YTD capital spend amounted to £470k against a planned spend of £2,064k.

YTD CIPs achieved £2,261k against a plan of £1,605k. The RAG rating is Amber due to the level of non-recurrent plans; however the financial year 2015/16 part year effect of current year schemes is greater than the value of non-recurrent savings in the financial year 2014/15.

Almost £1.3m CIPs have been forward banked. The DDOF recommends that although we are currently 'on plan' because of the forward banking, the underlying position should be communicated to directorates explaining the importance of delivering the required savings. The EDOF recommends there must be more scrutiny and challenge around what is not being done and why things have not been completed. All budget holders must own their budgets and be held to account when plans are not completed.

(b) 90 Day Debtors List:

The DDOF briefed the Committee on the 90 day debtors list and explained this is improving and every effort is being made to recover these outstanding debts.

The DDOF will find out what the target number is for outstanding debts and report back to the Committee in August. Action: DDOF.

JT asked how the Trust can be assured that outstanding debts will not occur again from the same customers. The DDOF assured that all correct processes are followed in the Standing Financial Instructions (SFIs).

The Committee were assured that the outstanding debtors list is reducing each month.

(c) Cash Flow & Investments Update:

The Committee received the report and were asked whether they had any questions. No questions received.

(d) Capital Schemes Update:

The Committee agreed it is useful to see the revised Capital Plan as it is regularly updated.

(e) Transformation Management Office Report:

The EDTI briefed the Committee on the paper provided and explained that as she is new to this post she needs to find out exactly how much of the savings target has yet to be supported and she can then provide a true report. The DDOF again emphasised concern regarding cash for the second month running. **The EDTI will find a way of conveying the sense of urgency out to the Trust and will discuss this further at the Trust Executive Committee meeting on Monday. Action: EDTI.**

(f) Accredited Budget Holder

The DDOF explained this is a Listening into Action 'quick win' which will give more freedom than normal to budget holders.

The Committee had no questions on this.

(g) Education Costings

The SFM attended to brief the Committee on the paper provided regarding education costings. The Department of Health are working towards developing tariffs for all activities delivered by the NHS. A national pilot started in 2012/13 to identify the cost of training salaried (Medics) and non-salaried (Nursing and Allied Health Professionals) trainees within the NHS. Under the current annual reference costs submission these costs and the income relating to it, are included within the costs of each HRG (Healthcare Resource Group) and therefore impact on the clinical procedure tariff cost, the aim of this process is to separate the clinical and training costs.

The EDOF commended the SFM and the team on their input into this as it is a huge task to undertake.

JT queried whether there will be any system support. The SFM noted that it will take a lot of resources to build this into the system which we will need to ensure will be possible.

The Committee had no further questions on this.

14/111 CONTRACT PERFORMANCE

(a) Contract Status Report:

The EDOF briefed the Committee on the report who had no questions on the report.

(b) Operational Performance including Service Level Agreement (SLA) Activity:

The ADPIDS attended the meeting to present the SLA Activity and performance.

The ADPIDS highlighted the number of emergency spells is above plan which would suggest patients are more sick than usual. The EDNW noted this could explain the bottle neck in the system and patients are needing to stay for longer and are therefore not able to flow through the system. The EDOF noted there are more patients being admitted through the Emergency Department. The EDNW said more beds could be opened at additional costs but we try to manage the number we already have.

The EDOF suggested the Committee should monitor Trauma and Orthopaedic meeting the 18 week target.

JT was concerned at the wording used by the Commissioners regarding clinical leadership. The EDOF explained the partnership with Hertfordshire which will be in place by December to the Committee. The EDOF stressed that Hertfordshire will have as much to gain from working with us as we will have working with them.

The DDOF noted that this report should include an explanation of what assurances are given to this Committee as they need to be aware of the impact of variances. Action: ADPIDS.

14/112 AUDIT & GOVERNANCE

(a) **Procurement Strategy**

The DDOF confirmed this strategy now contains e-procurement as requested by CR.

The EADL noted this Strategy does not seem to take into account equality matters relating to procurement. The DDOF will discuss this with the EADL. Action DDOF/EADL.

14/113 INFORMATION

(a) Data Quality:

The Governance Risk Rating (GRR) was discussed and the ADPIDS explained that if the Trust fails a target in month it will fail in quarter also.

The EDOF suggested the ADPIDS requests a narrative to include in the report from each service to update the Committee on if it is not possible to include reasoning in the report. Action: ADPIDS.

(b) Terms of Reference:

The EDOF discussed the revised terms of reference (TOR) for this Committee which will now be called the Finance, Investment, Information and Workforce Committee. The revised TOR include Information Governance and data issues which are not monitored though any other sub-committee. The Non-Executive Financial Advisor to the Trust Board submitted amendments to the TOR which were explained by the EDOF.

The Committee discussed the amendments to be made. The PA-EDoF will confirm where these TOR should be sent to for approval with the Company Secretary. Action: PA-EDoF.

14/114 INVESTMENT/ DISINVESTMENTS

(a) Procurement Status Report:

The DDOF confirmed the majority of abbreviations have been removed as requested by the Committee. There were no questions on this report.

(b) Carbon Energy Fund Update:

The EWSM attended the meeting to inform the Committee on the status of the Carbon Energy Fund. The business case has just been updated and the TDA requested a risk allocation matrix should be included. The EWSM discussed the incentives for taking this case forward. The Committee had no questions on this update.

(c) Endoscopy Business Case:

There was no attendance by a representative to discuss this and therefore the Committee did not discuss this business case.

(d) Disposal of Swanmore Road Properties:

The ADoF attended to discuss the disposal of Swanmore Properties. The Committee discussed the implications this could have on the Capital Plan. The Committee approved this paper and recommended it to the Trust Board meeting next week.

(e) Dental Services Contract:

The HCD, SFM and IADC attended the meeting to brief the Committee on the contract. The HCD noted the Trust should submit a tender by the end of this month. The HCD explained the contract and the current performance. The IADC explained this service has been turned around and is part of a team which provides business continuity and has added value for high needs clients.

CR questioned whether the IADC agrees with the approach that is

requested to be taken? The IADC absolutely agrees with this approach.

The EDOF suggested including the impact on other services of failing to win this contract. The SFM confirmed revenue implications will be built into the model along with any staff retention rates. The EDNW noted there is no quality impact detailed in the contract.

The Committee agreed to delegate the authority to the Chief Executive to submit this tender on the basis that requested amendments have been made by the 30th July 2014. The HCD will email the final version to the Committee for comment and review. The EDNW suggested this is discussed in more length during the Informal Executives' meeting on Monday next week.

Action: The HCD to make all recommended amendments to the tender and email the final version to the Committee to gain their electronic approval.

14/115 TRADING ACCOUNTS

(a) Mottistone Update:

The DDOF briefed the Committee on the Month 3 status and noted the paper should say it is making a surplus not a loss. Action: DDOF to make amendment.

Mottistone is trading well and is forecasting to be on plan by the end of the year.

(b) Beacon Update:

The DDOF noted Beacon is trading well and is delivering ahead of plan at Month 3.

(c) NHS Creative Performance and Budget Update:

The DDOF reported a small loss at the end of Month 3. The Committee will continue to monitor the performance.

14/116 SELF CERTIFICATION REVIEW

The Committee received and briefly discussed the Self Certification report. **Action: After a discussion the Committee approved the self-certification return and agreed to recommend this to the Trust Board.**

14/117 COMMITTEES PROVIDING ASSURANCE

(a) Minutes from the Capital Investment Group

No minutes available from the previous meeting. The ADoF will ensure the minutes are included in the papers for subsequent meetings as requested. Action: ADoF.

14/118 ANY OTHER BUSINESS

- Counter Fraud – The EDOF met with Counter Fraud Specialist and the Director of The Internal Audit Association (TIAA) which is proposing to take over CEAC which is the internal audit, governance, risk management and consultancy firm that is currently used.
- The DDW noted the next Workforce Summit will take place on the 8th October.
- JT and other Committee members discussed the volume and the timings in which the papers are received for this meeting. CR and JT will discuss this further outside the meeting and decide how to take this forward to allow Committee members enough time to read the papers prior to each meeting.

14/119 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Finance, Investment & Workforce committee to be held is on Wednesday 20th August 2014 from 3.00pm – 5.30pm in the Large Meeting Room.

The meeting closed at 3.42pm.

Enc I

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 July 2014

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

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	23 July 2014
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

This report provides an overview of the 9 Serious Incidents reported during June 2014, details of the incidents closed at the Quality and Clinical Performance Committee in May 2014 including the lessons learnt from these.

For following sections – please indicate as appropriate:

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

Date: **24 July 2014** **Completed by:** **Vanessa Flower** Quality Manager

Isle of Wight NHS Trust

Isle of Wight NHS Trust
Serious Incident Requiring Investigation (SIRI) Report
Isle of Wight NHS Trust Board – 30 July 2014
Reports of SIRIs for June 2014

1. Background:

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

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

2. New Incidents:

2.1. During June 2014 the Trust reported **9** Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG) and are all currently **under investigation** using Root Cause Analysis (RCA) methodology.

2.2. The incidents reported by category were:

2.2.1. Category 3 and 4 Pressure Ulcers:

2.2.2. 5 Pressure ulcer incidents were reported, three were a grade 4 (most severe) with two being a grade 3.	3 X Grade 4 Pressure Ulcer to Sacrum developed whilst under care of the IOW NHS Trust. 2 X Grade 3 pressure ulcer to sacrum developed whilst under care of the IOW NHS Trust.
2.2.3. Concerns over the care of Deteriorating Patient:	1 X Potential delay in receiving anaesthetic support for patient in the Emergency Department (ED).
2.2.4. Clostridium Difficile (CDiff)	1 X Death Certificate noted to include C Diff which in line with National SIRI reporting guidance states must be reported to commissioners and investigated.
2.2.5. Safeguarding Vulnerable Adults	2 X incidents have been reported and are under investigation under the Safeguarding vulnerable adults policy

3. SIRIs to be signed off:

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

4. At their meeting on 18 June 2014, the Quality and Clinical Performance Committee approved the completed action plans related to 6 previous incidents.

5. Lessons Learnt from SIRIs closed during May by Quality and Clinical Performance Committee.

4 incidents related to Grade 3/4 Pressure Ulcers	
Theme	**Learning**
Documentation	· Revised documentation for District Nursing Teams developed containing precise guidance on measuring pressure injuries. · Revised documentation developed for use in Emergency Department and Medical Assessment and Admission Unit to ensure all pressure area information and care given is clearly documented and follows patient pathway. · Specific wound care plan has been developed and rolled our across the Trust following pilot period.
Training	· Pressure Ulcer Competency Pack to be completed by all registered nursing staff. The areas concerned in these particular incidents reported 100% of staff completed and deemed competent. · Formal training session to be developed for Care Home Staff in relation to mattress systems / pressure relieving equipment.
1 Patient fall resulting in injury	
Ambulance Transfers	· Laminated crib sheets provided to staff to ensure that correct procedure for requesting transport is followed to avoid delay in transferring patients to Emergency Department**.** · Anti-ligature grab rails now in place and a procedure written on their usage.
1 Incident managed under the Safeguarding Adults Policy	
Training	· Centralisation of all mandatory training - Mental Capacity Act Training is held in the Training and Development Team.
Assessment of Patients	· Improvement in compliance with assessment – this has improved since the introduction of the generic risk assessment pack and is monitored as part of ongoing audit.

Alan Sheward
Executive Director of Nursing & Workforce
17th July 2014
Prepared by: Vanessa Flower, Quality Manager

Enc J

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th July 2014

Title	Safer Staffing Monthly Report			
Sponsoring Executive Director	Executive Director of Nursing			
Author(s)	Deputy Director of Nursing			
Purpose	To provide the Trust Board with detailed information of planned nurse staffing and actual nurse staffing for June 2104, to ensure safer staffing is considered by the Board and actions taken as required			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Nominations Committee (Shadow)	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee	23rd July 2014	Remuneration Committee	
Foundation Trust Programme Board			
Please add any other committees below as needed			
Board Seminar			

Staff, stakeholder, patient and public engagement:

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

Executive Summary:

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

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

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

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

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

For following sections – please indicate as appropriate:

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

Date: 14th July 2014 **Completed by: Deputy Director of Nursing**

Isle of Wight NHS Trust Board
Safer Staffing
Monthly Report
Wednesday 02 July 2014

1. EXECUTIVE SUMMARY

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

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

1.3. This report forms one of the compliance requirements, which details actual staffing against planned levels on a shift by shift basis and advises those wards where there were shortfalls. This is the Unify report. (Appendix 1)

1.4. The report includes an evaluation of the overall position associated mitigating actions and impact on quality of patient care. The Trust is currently using data collected from the Roster Management System (MAPS).

1.5. For areas that are rated red (Appendix 2) under our own local rating the Executive Director of Nursing & Workforce has sought assurance that areas are aware understand the reasoning behind this, and action plans are in place to address this. Weekly reporting is in place to enable more detailed information to be provided to the Board in future monthly reports.

1.6. There is ongoing work to be able to provide assurance of daily oversight of our planned versus actual staffing levels. This includes reviewing the roster policy, working to get timely information into the MAPS system and we are considering purchasing the Allocate 'Safer Staffing' software, which provides this information, for the different needs of staff, very easily.

1.7. There is still some work to do to ensure all rota's, form which MAPS pulls its information, are correct. This means there are still some issues that appear as a low staffing level i.e. maternity, which are not truly reflective of our postion.

2. Monthly Report of Safer Staffing

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

2.2. The current method of collecting actual staffing data against planned establishment is undertaken through ward staff inputting into the MAPS© database and making a Professional Judgement following a discussion with the Matron or Head of Clinical Service (HOC). We are currently developing a rating system which the mitigation decision can be taken against a pre-defined template of thresholds, as to whether

the staffing level is '**agreed'**, '**minimum safe**, or requires '**escalation'**. This is moderated through their Professional Judgement dependent upon the activity and dependency in the ward or department at the time.

2.3. The report gives some indication as to where there has been substitution i.e. a Registered Nurse (RN) shift replaced by a Health Care Assistant (HCA) shift. This will be reported in more detail in future months.

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

3. Reporting of Shortfalls

3.1. The Director of Nursing team (DNT) are continuing work on the rostering procedure which clearly articulates the expectation not only in safe roster production, but also the expected actions to be taken when rosters fall short.

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

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

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

This is reflected in rating action E as amber in the Timetable of Actions identified by NHS England

Reasons for shortfalls

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

- Vacancies or sickness not being able to be filled with bank staff
- Sudden sickness with limited time to request bank
- Rota's not reflective of true requirements

Actions to mitigate

- Our recruitment drive will support the addition of staff to vacancies, staff to new posts and additions to the bank however this is not without its own risks relating to being able to deliver a successful recruitment programme.

- There is ongoing work to drive down sickness in the organisation

- Templates on the MAPS system have been thoroughly reviewed and this will continue over the month of July and August

Risks and issues the Trust is seeking to address
The current method of collecting actual staffing data against planned establishment is through MAPS database which is underutilised, open to user error but able to provide data on a shift by shift basis. In order to improve the robustness of data collection and reporting arrangements, the Trust is collaborating with Allocate Software who are the main provider of the rostering system. Support has been requested on the following areas;

1. Use of MAPS for the management of safe staffing. Rota allocation and an even spread of the resource available.
2. The use of roster perform – This identifies rota compliance against 4 core standards
    a. Safety
    b. Effectiveness
    c. Fairness
    d. Unavailability

The Trust is working to improve the quality and staffing metrics in order to triangulate the impact of staffing levels.

Triangulation Quality Indicators

Appendix 3 shows the aggregated quality indicators that will be used to assess staffing impact on the quality of care delivered in that area. Early analysis suggests that those areas that have a higher number of unachieved indicators (Emergency Department & Maternity Services) are not necessarily those with the highest rate of fill. Future reports will detail the quality indicators set against the fill rate for each clinical area.

The Trust's compliance with the Timetable of Actions
The details of the overall requirement for the Trust against the 'Timetable of Actions' included within the documents published on the 31 March 2014: is indicated in Table 2

Table 2

A Six monthly reports to the Trust Board on staffing capacity and capability, through a review of the staffing establishments using an evidence based tool. This review of establishment was last undertaken in January 2014 and is next planned for June 2014. This will be reported to the December 2014 Trust Board. We expect to see NICE guidance later this financial year which will prompt further reviews of patient acuity and dependency. This is an iterative process. As such the total numbers of staff required will be fine tuned at regular intervals throughout the year. The 6 monthly report is provided in the Board papers for June 2014.	
B Shift by shift display of actual staff numbers against expected by designation i.e. Registered or Health Care Assistant, on boards on the wards – this is in place across the Trust.	
C The Trust Board receives a report update detailing actual staffing against planned on a shift by shift basis and is advised of those wards where there are shortfalls. This includes the reasons for the gap and the impact on quality of care as well as action taken to address the gap1	
D The Trust will publish the report in a form accessible to patients and the public on its website and on NHS Choices, under an accessible site entitled 'Nurse Staffing' – Board reports are available to the public via our webpage's on 24th June 2014 as per national timescales.	
E The planned and actual staffing should be reviewed on a shift by shift basis. This occurs for each shift and actions are put in place i.e. requesting bank staff, moving staff from one area to another or making a professional judgement as to whether the ward can provide care with the reduce number of staff for that shift (i.e. tasks may be allocated to a later shift or non urgent activities postponed. This is rated amber currently as there is ongoing work to enable us to capture this information in order to provide assurance to the Board.	

Recommendations

The Trust Board is asked:

1. To note the Trust's monthly staffing figures for planned and actual for Inpatient areas.

2. To note the identification of shortfalls in staff and mitigating actions.

3. To note the Trust's status of compliance in relation to the National Quality Board's requirements.

4. To note the urgent requirement for automation in the data collection, and reporting process to improve the quality assurance required.

5. To note the on-going progression towards reporting of quality, HR metrics with safe staffing indicators for benchmarking as these become available.

Sarah Johnston
Deputy Director of Nursing
July 2014

---

1 Subsequent to the National Quality Board reporting guidance, there has been a shift to reporting in hours rather than shifts. This can be seen in the Trusts Unify Submission Report (Appendix 2)
2013) http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
2. ***'Hard Truths Commitments regarding the publishing of staffing data'*** (March 2014)
http://www.england.nhs.uk/wp-content/uploads/2014/03/timetable-actions.pdf

Appendix 1 Monthly actual figures by ward as uploaded on the Unify return

Ward name	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Shackleton	450	507.5	1350	1259	285	290	570	596.5	112.8%	93.3%	101.8%	104.6%
Orthopaedic Unit	1845	1786	1845	1735.83	1200	1151	820	860	96.8%	94.1%	95.9%	104.9%
Seagrove	960	1006.57	1125	1081.81	600	597.5	600	773.5	104.9%	96.2%	99.6%	128.9%
Osborne	1410	1314.5	967.5	1315.5	900	727.75	285	658	93.2%	136.0%	80.9%	230.9%
Mottistone	810	861.51	351	343.75	600	572.25	0	0	106.4%	97.9%	95.4%	#DIV/0!
St Helens	1566	1712.5	1161	1047.5	600	600	600	600	109.4%	90.2%	100.0%	100.0%
Stroke	1440	1413.5	1440	1882.5	600	600	600	600	98.2%	130.7%	100.0%	100.0%
Rehab	1580	1413	1440	1621.33	600	618.5	600	610	89.4%	112.6%	103.1%	101.7%
Whippingham	1845	1697.34	1462.5	1384.76	900	820	600	630	92.0%	94.7%	91.1%	105.0%
Colwell	1350	1291	1732.5	1680.5	600	600	600	579.75	95.6%	97.0%	100.0%	96.6%
Intensive Care Unit	3059	3380	405	327.25	1872.5	1757.5	175.75	170	110.5%	80.8%	93.9%	96.7%
Coronary Care Unit	2250	2077.5	675	676.5	1500	1350	300	450	92.3%	100.2%	90.0%	150.0%
Neonatal Intensive Care Unit	1020	939.25	405	389	600	673	300	261.5	92.1%	96.0%	112.2%	87.2%
Medical Assessment Unit	2250	2190.5	1047	1017	900	889.25	600	579.25	97.4%	97.1%	98.8%	96.5%
Afton	1057.5	1042	1125	903	300	310	600	587.5	98.5%	80.3%	103.3%	97.9%
Paediatric Ward	1425.5	1337.75	397.5	374	600	610.5	300	290	93.8%	94.1%	101.8%	96.7%
Maternity	1800	1875	1350	858.75	1200	1207	600	600	104.2%	63.6%	100.6%	100.0%

Day				Night			
Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff	
Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours
26118	25845.42	18279	17897.98	13857.5	13374.25	8150.75	8846

Overall percentage fill rates as calculated by the Unify return – June 2014 data

Day		Night	
Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
99.0%	97.9%	96.5%	108.5%

Appendix 2 **Unify data for June – Rag rated with locally set RAG rating**

Green 95% - 100%	Safer Staffing Level Achieved
Amber 90% - 94.99%	'minimum', i.e. minimum level compatible with safe care
Red <90%	Below minimum and 'escalation, requiring action to ensure safe care

	Day		Night		
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Professionl Opinion
Shackleton	112.8%	93.3%	101.8%	104.6%	
Orthopaedic Unit	96.8%	94.1%	95.9%	104.9%	
Seagrove	104.9%	96.2%	99.6%	128.9%	
Osborne	93.2%	136.0%	80.9%	230.9%	1:1 care in place for whole admission for 2 highly vulnerable patients - additional funding for staffing supplied by CCG in these cases
Mottistone	106.4%	97.9%	95.4%	#DIV/0!	
St Helens	109.4%	90.2%	100.0%	100.0%	
Stroke	98.2%	130.7%	100.0%	100.0%	Long term sickness, Maternity leave, Secondment and vacancy are currently being managed, 1:1 cover is in place where reqrueid.
Rehab	89.4%	112.6%	103.1%	101.7%	Long term sickness, vacancy and staff manemegent are in place. 1:1's being utilised for patients where requried
Whippingham	92.0%	94.7%	91.1%	105.0%	HCA's have had to cover RN vacancies this month but no impact on overall safe numbers
Colwell	95.6%	97.0%	100.0%	96.6%	

	Day		Night		
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Professionl Opinion
Intensive Care Unit	110.5%	80.8%	93.9%	96.7%	Maternity leave in place - staff retruning in August and September
Coronary Care Unit	92.3%	100.2%	90.0%	150.0%	We continue to have high bank usage and are utilising excess hours to fill vacant hours. In cases where skill mix is unsafe or numbers fall below safe minimum overtime has been discussesd with matron and given where essential.Substantive staff are spread equally acrosss the roster to ensure patient safety.We have recently interviewed and recruited 2.5 wte and actively recruiting supported by safe staffing recruitment process
Neonatal Intensive Care Unit	92.1%	96.0%	112.2%	87.2%	Red ratings under review
Medical Assessment Unit	97.4%	97.1%	98.8%	96.5%	
Afton	98.5%	80.3%	103.3%	97.9%	Red ratings under review
Paediatric Ward	93.8%	94.1%	101.8%	96.7%	Short term sickness and long term absence being managed.
Maternity	104.2%	63.6%	100.6%	100.0%	Red ratings under review

Appendix 3

KPIs by Location

Location	Staff Levels	% Bank Staff	Staff Sickness	Mandatory Training	Falls with harm	Pressure Ulcers	VTE Risk Assmt	C. Diff.	MRSA	FFT Survey	Likely to Recommend	Formal Complaints	Concerns
Afton Ward	0	7.7%	0.00%	88.9%	0	0	12.5%	0	0	n/a	n/a	0	0
Cardiac Investigation Unit	-2	0.0%	0.00%	76.3%	0	0	n/a	0	0	n/a	n/a	0	0
Chemotherapy Unit	1	0.0%	2.57%	88.7%	0	0	n/a	0	0	n/a	n/a	0	0
Colwell Ward	1	8.8%	3.29%	80.9%	0	0	100.0%	0	0	26.4%	94.7%	0	0
Community Stroke Rehabilitation	-1	0.0%	0.00%	96.2%	0	0	n/a	0	0	n/a	n/a	0	0
Coronary Care Unit	-6	17.5%	1.60%	85.0%	0	0	97.8%	1	0	74.7%	97.3%	0	0
Day Surgery Unit	0	3.3%	0.00%	74.6%	0	0	100.0%	0	0	n/a	n/a	0	0
Earl Mountbatten Hospice	-5	0.0%	0.00%	68.8%	0	0	n/a	0	0	n/a	n/a	0	0
Emergency Department	-4	0.0%	5.86%	91.8%	0	1	n/a	0	0	21.7%	92.5%	0	0
Endoscopy Unit	-1	4.2%	0.00%	82.3%	0	0	n/a	0	0	n/a	n/a	0	0
General Rehab and Step Down Unit	2	15.4%	0.00%	93.4%	1	0	100.0%	1	0	67.6%	84.0%	0	0
Intensive Care Unit	-4	0.0%	3.34%	92.2%	0	0	61.5%	0	0	n/a	n/a	0	0
MAAU	0	4.8%	0.59%	96.7%	0	0	98.4%	0	0	71.3%	94.0%	0	0
Main Theatres	1	1.8%	0.00%	74.2%	0	0	n/a	0	0	n/a	n/a	0	0
Maternity Services	-1	1.5%	0.00%	74.4%	0	0	18.8%	0	0	9.7%	95.7%	0	0
Mottistone Ward	1	8.7%	0.00%	83.8%	0	0	100.0%	0	0	18.2%	100.0%	0	0
Neonatal Intensive Care Unit	0	5.0%	0.00%	83.8%	0	0	n/a	0	0	n/a	n/a	0	0
Orthopaedic Unit	0	5.9%	0.00%	74.8%	0	1	98.6%	0	0	41.4%	100.0%	0	0
Osborne Ward	0	10.7%	0.00%	85.6%	0	0	10.5%	0	0	n/a	n/a	0	0
Paediatric Ward	-1	0.0%	0.00%	83.3%	0	0	n/a	0	0	n/a	n/a	0	1
Phlebotomy	4	13.3%	12.40%	91.8%	0	0	n/a	0	0	n/a	n/a	0	0
Respiratory Department	0	0.0%	0.34%	95.7%	0	0	n/a	0	0	n/a	n/a	0	0
Seagrove Ward	0	0.0%	0.00%	89.8%	0	0	20.0%	0	0	n/a	n/a	0	0
Shackleton Ward	-2	0.0%	0.00%	94.4%	0	0	0.0%	0	0	n/a	n/a	0	0
St Helens Ward	13	5.9%	0.00%	73.6%	1	1	98.8%	0	0	21.4%	96.8%	0	1
Stroke Neuro Rehab	3	15.0%	0.00%	86.3%	1	0	95.8%	0	0	28.9%	100.0%	0	0

Enc K

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 JULY 2014

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

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Nominations Committee (Shadow)	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		Remuneration Committee	
Foundation Trust Programme Board	22-Jul-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 an outstanding organisation and employer of choice					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***						
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	A 12 week public consultation is required and concluded on 11 January 2013.					

Date: 21 July 2014 Completed by: Andrew Shorkey
Programme Manager – Business Planning and Foundation Trust Application

ISLE OF WIGHT NHS TRUST
NHS TRUST BOARD MEETING WEDNESDAY 30 JULY 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

With respect to the outcome of the Chief Inspector of Hospitals visit undertaken by the Care Quality Commission, the Trust has been informed that the CQC's report will be sent to the Trust on 28 July 2014. Arrangements have been put in place to ensure that the report is fully reviewed and any issues of accuracy are identified and responded to within the allotted timeframe (by 8 August 2014). The action plan to deal with the initial issues raised is being implemented and will now formally be monitored by the Trust's Quality and Clinical Performance Committee. The provisional date for the Trust's Quality Summit has now moved to 2 September 2014, one day before the provisionally scheduled Board to Board meeting with the TDA. Work is progressing to prepare for both activities.

The Trust's FT application to the TDA is scheduled for 8 August 2014 and work is ongoing to deliver the products required to support the application. This will include a resubmission of the Integrated Business Plan (IBP), details of the Trust's cost improvement programme for the next two years and associated quality impact assessments along with a number of other products to provide assurance to the TDA Board.

The Trust remains on trajectory for a referral to Monitor in September 2014 and work is underway to prepare for the mock Board to Board meeting between the Trust's Board and the TDA's Board, scheduled for 30 July 2014. Key milestone dates are outlined below and our current application timeline is attached at Appendix 1.

FT Milestones

Chief Inspector of Hospitals Visit	3 - 6 June 2014	Complete
Final Draft Integrated Business Plan Submission	20 June 2014	Complete
Final Integrated Business Plan Submission	8 August 2014	On target
Quality Summit	2 September 2014	On target
Board to Board meeting	3 September 2014 (provisional)	On target
TDA Board meeting to approve application to Monitor	18 September 2014	On target

4. Communications and Stakeholder Engagement

Firm focus remains on membership recruitment activity. As at 17th July 2014 the Trust has 4,440 members which is an increase of 221 members since last report therefore steady progress is being made 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. Some change has occurred following the data cleanse ahead of distribution of the Summer 2014 Members Magazine. The Members Magazine (attached) has now been distributed to those members who prefer email and hard copies have been printed and distributed to others.

Constituency	Membership	Required before election
North and East Wight	1036	500
South Wight	949	500
West and Central Wight	1432	500
Elsewhere ('Off Island')	484	250
Volunteers	544	-
Total	**4,440**	**1750**

At 17th July 2014 a total of 2,915 staff are shown as members. Only staff directly employed by Isle of Wight NHS Trust with permanent contracts longer than 12 months are eligible to become staff members. The staff constituencies are:

Constituency	Membership
Administration and Estates Staff	892
Allied Health Professionals Scientists and Technicians	411
Healthcare Assistants and Other Support Staff	567
Medical & Dental	136
Nursing and Midwifery staff	909
Total	**2915**

Current development work includes:

- The Medicine for Members event held on 23 June 2014 had a focus on dementia. Chris Wittingstall of the Memory Service presented and we welcomed the attendance of the Alzheimer's Cafe, My Life a Full Life, Alzheimer's Society and Age UK IW.
- A Governor's Development Day is scheduled for 22 September 2014 and further Medicine for Members events are scheduled for 10 October 2014 and 30th January 2015.
- Recent recruitment activities have included the Isle of Wight Festival (June). Future plans include the AGM (July), Chale Show (August), Scooter Rally (August) and Ryde Catamaran terminal (September). The Membership Strategy has been refreshed and was discussed at 10 June 2014 Board Seminar.

5. Key Risks

Continuation on the current trajectory to achieve referral to Monitor remains dependent on a outcome of the CQC's assessment of the Trust. The TDA continue to support our current trajectory, subject to the outcome of the CQC report.

As a consequence of the Trust's recent performance against the Governance Risk Rating (GRR) the Board flagged Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, as at risk in its self certification return for June 2014. Compliance with these targets is one of six measures used by Monitor to determine whether further investigation is required into the performance

of Foundation Trusts. The Trust was advised by the TDA in March 2013 that 'a target of zero for GRR is the recommended and most robust approach'. Work is ongoing to deal with the relevant underperforming indicators.

Work continues to further develop service improvement plans and recurrent cost improvement plans to ensure that the Trust can demonstrate ongoing sustainability. This work is now being led by Katie Gray who has joined the Board as Executive Director of Integration and Transformation. The Board is now at full strength, with respect to substantive roles, in alignment with the requirements of the Department of Health's Board Governance Assurance Framework (BGAF).

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

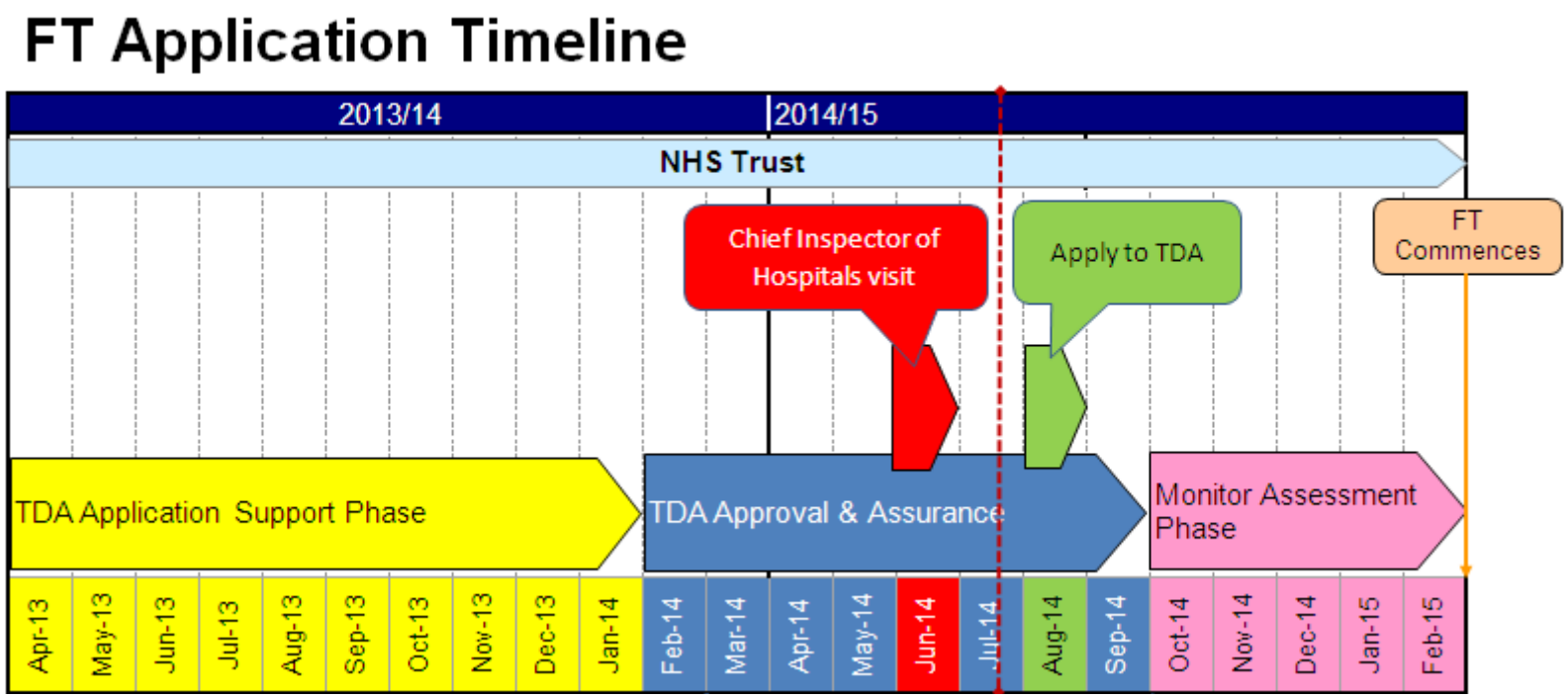
6. **Recommendation**

It is recommended that the Board:

(i) Note this update report

Mark Price
FT Programme Director/Company Secretary
21 July 2014

FT Application Timeline



Enc L

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 July 2014

Title	Self-certification			
Sponsoring Executive Director	FT Programme Director / Company Secretary			
Author(s)	Programme Manager – Business Planning and Foundation Trust Application			
Purpose	To Approve			
Action required by the Board:	**Receive**		**Approve**	**√**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Nominations Committee (Shadow)	
Charitable Funds Committee		Quality & Clinical Performance Committee	23-Jun-14
Finance, Investment & Workforce Committee	23-Jun-14	Remuneration Committee	
Foundation Trust Programme Board			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Directors, Performance Information for Decision Support (PIDS) and relevant lead officers have been engaged with to develop the assurance process.

Executive Summary:

This paper presents the July 2014 Trust Development Authority (TDA) self-certification return covering June 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: 21 June 2014 Completed by: Andrew Shorkey
Programme Manager – Business Planning and Foundation Trust Application

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 June 2014 reporting period, prior to submission to the Trust Development Authority (TDA) in July 2014.

2. Background

Since August 2012, as part of the Foundation Trust application process the Trust was required to self-certify on a monthly basis against the requirements of the SHA's Single Operating Model (SOM). The Trust Development Authority (TDA) assumed responsibility for oversight of NHS Trusts and FT applications in April 2013 and the oversight arrangements are outlined within its *Accountability Framework for NHS Trust Boards*.

According to the TDA:

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

In March 2014 the TDA published a revised *Accountability Framework* for 2014/15. There were no fundamental changes with respect to the self-certification requirements. It should be noted, however, that whereas milestones with respect to the 'Timeline toward achievement of FT status' were previously required, the language has now changed and this has been replaced with a requirement for milestones relating to the 'Timeline towards sustainability'. This will initially be the Trust's FT milestones. However, these milestones could be changed following the assessment of the Trust's 5 year strategic plan by the TDA when a sustainability score will be developed and assigned to the Trust.

Access to submission templates for Board Statements and Licence Condition returns were provided via an internet portal by the TDA for 2013/14. No submission arrangements are as yet in place with respect to FT Programme Milestones although progress is monitored monthly via oversight meetings with the TDA. There is no indication that submission arrangements will change for 2014/15.

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

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

to the Trust Board to enable approval of the self-certification return as an accurate representation of the Trust's current status.

Draft self-certification returns have been considered by the Quality and Clinical Performance Committee, Finance, Investment and Workforce Committee and relevant senior officers and Executive Directors. Board Statements and Monitor Licence Conditions are considered with respect to the evidence to support a positive response, contra indicators and threats to current status together with action plans and activity to maintain or improve the current assessed position. The Trust Board may wish to amend the responses to Board Statements based on an holistic view of the complete self-certification return and feedback from Board sub-committee Chairs.

4. Performance Summary and Key Issues

Board Statements

1. All Board Statements are marked as compliant with the exception of Board Statement 10 relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets. Following consideration the Board determined at its 02 July 2014 meeting that this indicator should be put at risk until a positive trend towards recovery is established. This position is reflected within the draft sample return document (Appendix 1a).

Licence Conditions

2. All Licence Conditions are marked as compliant. This position is reflected within the draft sample return document (Appendix 1b).

Foundation Trust Milestones

3. The Trust continues to meet agreed milestones. The Trust's trajectory could alter as a consequence of the Care Quality Commission's assessment of the Trust due to be received by the Trust on 28 July 2014. The draft return document is attached as Appendix 1c.

5. Recommendations

It is recommended that the Trust Board:

(i) Consider feedback from Board sub-committees and determine whether any changes to the declarations at 1a, 1b and 1c are required;
(ii) Approve the submission of the TDA self-certification return;
(iii) Identify if any Board action is required

Andrew Shorkey
Programme Manager – Business Planning and Foundation Trust Application
21 July 2014

6. Appendices

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

7. Supporting Information

- *Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards,* 31 March 2014
- *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards,* TDA, 12 April 2013
- *Risk Assessment Framework,* Monitor, 27 August 2013

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

	For CLINICAL QUALITY, that:	Response	Comment where non-compliant or at risk of non-compliance	Timescale for Compliance	Executive Lead
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's Oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes			Alan Sheward Mark Pugh
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	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.	At risk	The Trust's Governance Risk Rating (Monitor access and outcome measures) score has significantly declined. Issues impacting on performance are understood and indicator recovery plans have been reviewed. Early indications suggest that a number of these indicators will be recovered in advance of our next submission.	30-Sep-14	Alan Sheward Mark Pugh
11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes			Mark Price

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

12	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies	Yes			Mark Price
13	The board is satisfied all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes			Karen Baker
14	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	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			Mark Price
2	Condition G7 – Registration with the Care Quality Commission	Yes			Mark Price
3	Condition G8 – Patient eligibility and selection criteria	Yes			Alan Sheward
4	Condition P1 – Recording of information	Yes			Chris Palmer
5	Condition P2 – Provision of information	Yes			Chris Palmer
6	Condition P3 – Assurance report on submissions to Monitor	Yes			Chris Palmer
7	Condition P4 – Compliance with the National Tariff	Yes			Chris Palmer
8	Condition P5 – Constructive engagement concerning local tariff modifications	Yes			Chris Palmer
9	Condition C1 – The right of patients to make choices	Yes			Alan Sheward
10	Condition C2 – Competition oversight	Yes			Karen Baker
11	Condition IC1 – Provision of integrated care	Yes			Alan Sheward Mark Pugh

TDA Accountability Framework - Timeline Towards Sustainability 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	Complete	
5	Final IBP/LTFM Submission	20-Jun-14	Complete	
6	FT Application Submission	08-Aug-14	On target	
7	TDA Quality Summit	02-Sep-14	On target	
8	Board to Board meeting with TDA	03-Sep-14	On target	
9	TDA approval to proceed and application to Monitor	18-Sep-14	On target	

Enc M

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30 JULY 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 July 2014 recommended changes to Assurance RAG ratings.			
Action required by the Board:	**Receive**		**Approve**	X

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)	None		

Staff, stakeholder, patient and public engagement:

None

Executive Summary:

The full 2014/15 BAF document was approved by Board in June 2014, including the high scoring local risks from the Corporate Risk Register, together with associated controls and action plans.

It was agreed that the Board would receive dashboard summaries and exception reports only for the remainder of the year.

The dashboard summary includes summary details of the key changes in ratings: there are no Principal Risks now rated as Red; 2 new Risks have been added since the June 2014 report.

The exception report details FOUR recommended changes to the Board Assurance RAG ratings of Principal Risks: changes from Amber to Green for 1.1, 2.9, 5.2 and 10.22.

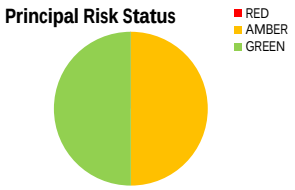
For following sections – please indicate as appropriate:

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					

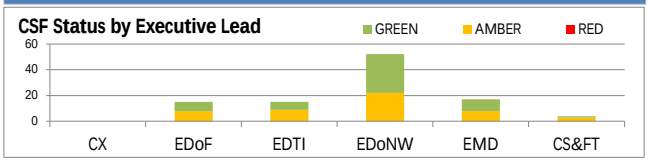
Date: **21 July 2014** **Completed by: Brian Johnston**
Head of Corporate Governance and Risk Management

BAF Status Report

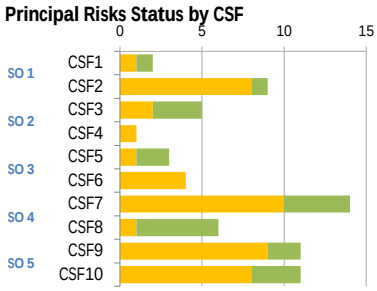
Isle of Wight NHS Trust

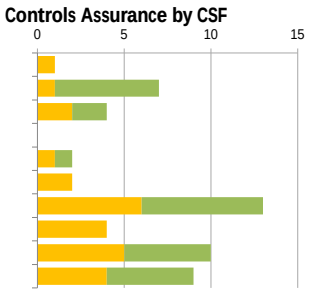


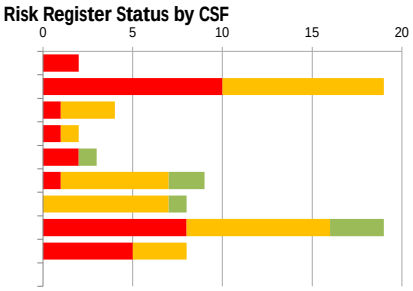
Principal Risks:	66	Aligned Risk Register Risks:	78



Strategic Objective & Critical Success Factor Status Overview







BAF
Increased Scores

0

Reduced Scores

4

Commentary

Principal Risks:
4 Principal Risks are recommended for changes from Amber to Green

2 New Risks, 1 of which is rated Red:

Ref.	Directorate	Title
615	Planned	Safe Staffing levels in Paediatrics
616	Corporate	C *Difficile* Infection figures

Changes to previously notified Risk scores since the last report: None

Recommended changes to BAF assurance ratings, NEW BAF entries, Risk Scores and identification of NEW risks

Ref.	Exec Lead	Title/Description	Assurance Rating Current	Assurance Rating Change to
CSF1.1	EDoNW	1.1 There is a failure to understand the root causes of complaints (Q36) Executive Director of Nursing and Workforce	Amber	Green
CSF2.9	EDoNW	2.9 (2.14) There are no service level scorecards or dashboards which detail performance against articulated goals (Q35) Executive Director of Nursing and Workforce	Amber	Green
CSF5.2	EDTI	5.2 (2.28) Reducing the total number of Elective and Non-Elective admissions Executive Medical Director/ Executive Director of Nursing and Workforce	Amber	Green
CSF10.22	EDoNW	10.22 (10.71) The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months (B34) Chief Executive/Executive Director of Nursing and Workforce	Amber	Green
CSF2 616 - 1	EDONW	C DIFFICILE INFECTION (CDI) FIGURES	16	16
CSF9 615 - 1	EDONW	SAFE STAFFING LEVELS IN PAEDIATRICS	12	12

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
Strategic Objective 1: QUALITY - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience **Exec Sponsor: Executive Director of Nursing and Workforce**										
<u>Critical Success Factor CSF1</u> **Lead: Executive Director of Nursing and Workforce** **<u>Improve the experience and satisfaction of our patients, their carers, our partners and staff</u>** **Links to CQC Regulations: 9, 12, 17, 19, 21, 22, 23**					MEASURES: **Improved patient and staff survey results** **Complaints/concerns from patients/carers and staff** **Compliments from patients/carers and staff** **CQC inspection/Trust inspection outcomes** **Culture, Health and Wellbeing strategy objectives achieved** **No service disruption occurs if Major incident or Business Continuity Plans are invoked** **Friends and Family test results** **Staff Friends and Family test results**			TARGETS: **Patient and staff survey results for 14/15 show better outcomes than results for 13/14** **Patient care complaints reduced by 10% on 2013/14** **All CQC key domains / essential standards met** **All services provided 365 days per year** **Increased patient involvement evidenced** **Achieve 30% response rate in patients friends and family test results by March 2015** **Achieve 20% response rate in staff friends and family test results by March 2015** **Greater alignment between patient and staff satisfaction**	
1.1 There is a failure to understand the root causes of complaints (Q36) Executive Director of Nursing and Workforce	**4**			All complaints are subject to Root Cause Analysis Complaints information relating to individual consultants is used as part of appraisal Qualitative and quantitative reports produced on a monthly basis Review by QCPC/Review by Board/ Execs Good high level review Action plans and learning lessons now completed on all complaints	Complaints reports to Board via Quality Report Quarterly G&A reports to TEC and Directorate Boards Review at high level	p	**Green**			Review Trust wide process with each directorate for identifying root causes and learning lessons **Alan Sheward** Update April 2013: Complaints process review underway from April 2013 Update June 2013: Review continues but in the meantime we have seen a reduction in the numbers of complaints received. Update August 2013: work ongoing - review again in 3 months Update November 2013: Lessons learned process commenced Update April 2014: Evidence now being seen at QCPC **Update July 2014:** Action plans and learning lessons now completed on all complaints. **Action complete** **Recommend change of assurance rating to Green**
<u>Critical Success Factor CSF2</u> **Lead: Executive Director of Nursing and Workforce** **<u>Improve clinical effectiveness, safety and outcomes for our patients</u>** **Links to CQC Regulations: 9, 10, 12, 13, 14, 17, 18, 20, 21, 22, 23**					MEASURES: **VTE compliance** **HAPPI audit results** **HMSR stats.** **Pressure Ulcer indicators** **CQUIN outcomes** **MRSA and Cdiff stats.** **Approved departmental clinical governance plans:** **- National performance targets** **- Participation in screening programmes** **- Participation in Health improvement programmes for children and young people**			TARGETS: **Board approved quality account within DH deadline** **90% compliance against all HAPPI indicators** **Zero MRSA cases in 2014/15** **Achieve rebased HMSR and SHMI of <108 by end March 2015** **Zero Grade 4 pressure ulcers in a hospital setting** **50% reduction in grades 1,2 and 3 pressure ulcers in hospital setting, from a 2013/14 baseline** **25% reduction in overall incidence of patients developing pressure ulcers in hospital** **50% reduction in grades 1 to 4 pressure ulcers in a community setting, from a 2013/14 baseline** **Centralise PALS service by 31st May 2014** **Trust-wide action plan (from national patient/staff surveys) developed by 31st May 2014** **Ward Boards in place in all identified areas by 31st December 2014** **10% reduction in hospital led outpatient cancellations from a 2013/14 baseline** **100% achievement of CQUINS** **>95% VTE assessments throughout 2014/15**	
2.9 *(2.14)* There are no service level scorecards or dashboards which detail performance against articulated goals (Q35) Executive Director of Nursing and Workforce	**6**			There are service level mechanisms for monitoring quality: There are developed and aligned service level risk register; There are developed and aligned service level dashboards or scorecards; There is an emphasis on real-time reporting and alerting; There is evidence of quality dashboards being used as a key mechanism for monitoring quality; Staff know how performance against local goals relates to the performance against trust wide goals; Local goals are visible in ward areas along with clear improvement plans. Nursing Dashboard in place for Wards, include performance against articulated goals including key quality indicators Service level risk registers are in place which feed up into directorate level risk registers which feeds up into the corporate risk register Directorate level dashboards are in place and a number of these go down to service level Ward Sisters attend a monthly meeting with Executive Director of Nursing and Workforce to review performance against the Nursing Dashboard Incident reporting and alerting takes place in real time Ward - score card Then monitored	QCPC QCGC - minutes	Monthly report to Board by Executive Director of Nursing and Workforce Board Performance Reports	**Green**			Develop consultants dashboard **Mark Pugh** Update October 2013: Appraisal system in place and ongoing. Service level dashboards are in development. Update December 2013: Target for department level dashboard by end March 2014. Update April 2014: Department level dashboards now in development - roll-out expected May 2014 **Update June 2014:** Balanced scorecard for department teams now in development **Review date: August 2014** Develop community teams dashboard **Sarah Johnston** Update April 2013: Now focusing on live dashboard for all areas. Development day on 25th April will help to engage teams. Update June 2013: Indicators set and PIDs developing dashboards for launch in July 2013 Update November 2013: Electronic dashboard is up and running - ongoing work on implementation. Has been to Development Day. Update February 2014: Quality dashboard incomplete on intranet but usable for acute areas. Now on hold for new IT software 'clickview' - installation April and will then transfer over. Update May 2014: Dashboard development ongoing **Update July 2014:** Dashboard development complete and now embedding utilisation. **Action complete** **Recommend change of assurance rating to Green**

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
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: Executive Director of Transformation 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**				TARGETS: **Further evidence of clinical influence on non-pay spend by March 2015** **All formal partnerships to have agreed terms of reference and joint objectives** **All key partnerships meet their stated objectives and terms of reference** **Ongoing delivery of existing partnerships**
5.2 *(2.28)* Reducing the total number of Elective and Non-Elective admissions Executive Medical Director/ Executive Director of Nursing and Workforce	**9**			Urgent Care Hub development Acute Care Project being managed with Prince 2 principles Good evidence now availableon reducing admissions, and nationally we compare well on admissions and re-admissions. GP ambulatory care bay in MAAU is planned which will help further and QIPP plans are showing early signs of delivery.	Trust Board Trust Executive Committee	Monthly updates to Board on all admissions Low level of Elective admissions per head of population	**Green**			Acute Assessment Unit developing **Karen Baker/Mark Pugh/Alan Sheward** Update May 2013: Now opened ambulatory care bads in MAAU and work ongoing to further improve day case rates. Update September 2013: Work ongoing, no further change Update December 2013: GP working in ED project looking to reduce Acute admissions. Update February 2014: Crisis response team now operational via the Hub. Data now available to show reduced admissions. Update April 2014: Comprehensive programmes of information/ data gathering are ongoing. **Update July 2014:** Good evidence now availableon reducing admissions, and nationally we compare well on admissions and re-admissions. GP ambulatory care bay in MAAU is planned which will help further and QIPP plans are showing early signs of delivery. **Action complete** **Recommend change of assurance rating to Green**
Principal Objective 5: WORKFORCE - To develop our people, culture and workforce competencies to implement our vision and clinical strategy **Executive Sponsors: Executive Director of Nursing and Workforce, Executive Medical Director**										
Critical success factor CSF10 **Lead: Executive Director of Nursing and Workforce** **Develop our organisational culture, processes and capabilities to be a thriving FT** Links to CQC Regulations: 9, 10 , 17						MEASURES: **Monitor ratings for governance, including quality and finance** **Board Development** **Stakeholder engagement** **Organisational Thermometer** **Staff survey results** **Staff raising concerns** **Staff friends and family test**				TARGETS: **Achieve top Monitor ratings for governance by March 2015** **Achieve 25% response rate in staff friends and family test results by March 2015** **Percentage of vacancies to be under 11.7% by 31/3/15** **Staff survey results for 14/15 show better outcomes than results for 13/14:** **- survey response rate over 60% in 2014/15** **- Over 60% of staff would recommend the Trust as a place to work** **- Over 93% of staff feel satisfied with the quality of patient care they deliver** **- Over 60% of staff would be happy for us to provide care to a relative or friend**
10.22 *(10.71)* The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months (B34) Chief Executive/Executive Director of Nursing and Workforce	**9**			The Trust has a Communications Engagement and Membership team that monitors and responds to negative publicity as and when it arises or brought to the attention of the team by others Now pre-empting this by improved local engagement with local media.		The Trust invested in a management system called VUELIO which records media coverage and the responses given	**Green**			Action plan to be created in response to negative publicity as received **Alan Sheward/Andy Hollebon** Update June 2014: The Comms Team continues to respond to any media comment or enquiry in a timely fashion. A summary of media coverage is not now presented formally to any Trust committee, having previously been listed under Q&CPC before April 2014. **Update July 2014:** Now pre-empting this by improved local engagement with local media. **Action complete** **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
615	IR	PLANND	PATSAF	30/06/14	30/09/14	SAFE STAFFING LEVELS IN PAEDIATRICS	DCOLL	* CQC" immediate change" notice for children attending ED * Lack of appropriately trained staff in ED * Safe staffing for inpatient ward not in place yet.	12	12	MOD	* Neonate Resuscitaire loaned to ED from Labour Ward. * Bleep system to off-site senior paediatric Nurse and Paediatric Consultant out of hours * Baton bleep for on-site Registrar for attendance to ED * Records will be kept regarding time spent in ED by Children's Ward staff and impact on inpatient care	I	30.06.14 Approved at RMC on 18.06.14.	Equipment check for age specific resuscitation. Recruitment to Paediatric Nurse establishment. Recruitment to ED Consultant Establishment or recruitment to Paediatric service medical establishment.	EDONW
616		CORPRI	PATSAF	30/06/14	31/03/15	C DIFFICILE INFECTION (CDI) FIGURES	ASW	* Likely breach of trajectory for C diff	16	16	HIGH	* Antibiotic stewardship * Policy (decontamination, diarrhoea management, hand hygiene, standard precautions) * Training (mandatory IPC & e learning c difficile package) * Commode spot checks by IPCY, monthly audit and daily checks by ward * C difficile education package availability (e learning) * RCAs undertaken for hospital acquired CDI cases * Share lessons learned in organisation	A	30.06.14 Approved at RMC on 18.06.14.	Make lessons learnt sharing more robust in organisation. Continue Controls.	EDONW

Key for Assurance Level for Risk Register Entries: GREEN - A adequate controls; AMBER - I inadequate controls; RED - U uncontrolled risks

Enc N

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 30th July 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	09/06/2014	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

The Trust Board are requested to review and approve changes to the Statutory and Formal Roles

- Care of the Dying – line added
- End of Life Care – line added
- Deputy DIPC changed to Deborah Matthews
- Emergency Preparedness added
- Change to Review Annually for Decontamination & Medicines Management
- Senior Independent Director (SID) changed to Charles Rogers

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: 08/07/2014 **Completed by: Brian Johnston**
Head of Corporate Governance and Risk Management

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	Deborah Matthews	Lead for Patient Safety, Experience and Clinical Effectiveness	*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	*Review annually
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

Directorate	Statutory (*)/ Formal Role	Name	Job Title	Deputy/cover	Job Title	Review date (if applicable)
Corporate	Mental Health Act Managers Lead (Chairman of Mental Health Act Scrutiny Committee)	**Jessamy Baird**	Non Executive Director	Nina Moorman	Non Executive Director	*On change of Post holder
Corporate	Health & Safety Manager	**Connie Wendes**	Assistant Director Health & Safety and Security	Martin Keightley	Deputy Health, Safety & Security 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	*Review annually
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
Corporate	Director responsible for Clinical Information Systems	**Katie Gray**	Executive Director of Transformation and Integration	David Arnold	Head Strategic partnerships	*On change of post holder
Corporate	Lead for Emergency Preparedness	**Alan Sheward**	Executive Director of Nursing and Workforce	Sarah Johnston	Deputy Director of Nursing	Reviewed annually.
Corporate	End of Life Care	**Nina Moorman**	Non-Executive Director	Mark Pugh	Executive Medical Director	*On change of post holder
Corporate	Care of the Dying	**Mark Pugh**	Executive Medical Director	Nina Moorman	Non Executive Director	*On change of post holder