



Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 3rd December 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

The next meeting in public of the Isle of Wight NHS Trust Board will be held on **Wednesday 3rd December 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: Executive Director of Finance (Iain Hendey, Assistant Director of Informatics will deputise) Executive Director of Nursing & Workforce (Deputy TBC)	Chair	Receive	Verbal
	1.2	Confirmation that meeting is Quorate <i>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 (or Vice Chairman); one Executive Director; and two Non-Executive Directors.</i>	Chair	Receive	Verbal
	1.3	Declarations of Interest	Chair	Receive	Verbal
	2	Chairman's Update			
	2.1	The Chairman will make a statement about recent activity	Chair	Receive	Verbal
	2.2	NED Membership of Sub Committees	Governance and Administration Comp Sec	Approve	Enc A
	3	Chief Executive's Update			
	3.1	The Chief Executive will make a statement on recent local, regional and national activity.	CEO	Receive	Enc B
	3.2	Local Update from Hospital & Ambulance	EDNW	Receive	Enc C
	3.3	Local Update from Community & Mental Health	EMD	Receive	Enc D
	4	Patients & Staff			
	4.1	Presentation of this month's Patient Story	Quality and Performance Management CEO	Receive	Pres
	4.2	Employee Recognition of Achievement Awards	Culture & Workforce CEO	Receive	Pres
	4.3	Employee of the Month	Culture & Workforce CEO	Receive	Pres
	4.4	Staff Story	Culture & Workforce CEO	Receive	Pres
	5	Minutes of Previous Meetings			
	5.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 29th October 2014 and the Schedule of Actions.	Chair	Approve	Enc E
	5.2	Chairman to sign minutes as true and accurate record			
	5.3	Review Schedule of Actions	Chair	Receive	Enc F
	6	Items for the Board			
	6.1	Performance Report	Quality and Performance Management ADI	Receive	Enc G

6.2	Minutes of the Quality & Clinical Performance Committee held on 19th November 2014	Quality and Performance Management	QCPC Chair	Receive	Enc H
6.3	Minutes of the Finance, Investment, Information & Workforce Committee held on 19th November 2014	Quality and Performance Management	FIIWC Chair	Receive	Enc I
6.4	Reports from Serious Incidents Requiring Investigation (SIRIs)	Quality and Performance Management	EDNW	Receive	Enc J
6.5	Mortality Update	Quality and Performance Management	EMD	Receive	Pres
6.6	Emergency Planning Core Standards 2014	Strategy and Business Planning	EDNW	Approve	Enc K
6.7	Strategic Partnership with the IW NHS Trust by IW Council	Strategy and Business Planning	CEO	Approve	Enc L
6.8	Capital Programme 2014/15 - Board Approvals	Strategy and Business Planning	ADI	Approve	Enc M
6.9	Capital Scheme - Proposal to Upgrade the Ambulance Computer Aided Dispatch (CAD) System	Strategy and Business Planning	EDNW	Approve	Enc N
6.10	Board Self Certification	Governance and Administration	Comp Sec	Approve	Enc O
6.11	Board Assurance Framework (BAF) Monthly update	Governance and Administration	Comp Sec	Approve	Enc P
6.12	Minutes of the Audit & Corporate Risk Committee held on 13th November 14	Governance and Administration	ACRC Chair	Receive	Enc Q
6.13	Audit & Corporate Risk Committee Revised Terms of Reference	Governance and Administration	Comp Sec	Approve	Enc R
6.14	Mental Health Act Scrutiny Committee Revised Terms of Reference	Governance and Administration	Comp Sec	Approve	Enc S
6.15	Trust Board Revised Terms of Reference	Governance and Administration	Comp Sec	Approve	Enc T
6.16	Trust Board & Sub Committee Meeting Dates for 2015/16	Governance and Administration	Comp Sec	Approve	Enc U
6.17	Summary of Remuneration & Nominations Committee Minutes	Governance and Administration	Comp Sec	Receive	Enc V

7 Any Other Business

8 Questions from the Public

To be notified in advance

9 Issues to be covered in private.

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

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.

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

- *IT Review*
- *Tenders Update*
- *Safeguarding Bi Monthly Update*
- *Employee Relations Issues*
- *Business Case - Implementation of Safer Staffing*

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.

10 Date of Next Meeting:

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on Wednesday **28th January 2015** in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 3rd December 2014

Title	Non-Executive Director Membership of Sub-Committees				
Sponsoring Executive Director	Company Secretary				
Author(s)	Company Secretary				
Purpose	To agree Non-Executive Director Membership of Sub-Committees with effect from 3 rd December 2014				
Action required by the Board:	Receive		Approve	P	
Previously considered by (state date):					
Trust Executive Committee		Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee		Remuneration & Nominations Committee			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee		Foundation Trust Programme Board			
ICT & Integration Committee					
Please add any other committees below as needed					
Board Seminar	11 th November 14				
Other (please state)					
Staff, stakeholder, patient and public engagement:					
Executive Summary:					
<p>The Non-Executive Membership of the Sub Committees has been amended to reflect the needs of the committees. Changes are applicable as follows:</p> <ul style="list-style-type: none"> Remuneration & Nomination Committee – reduced membership to 4 members Audit & Corporate Risk Committee – Reduced membership to 4 members Finance, Investment, Information & Workforce Committee – Reduced membership to 3 members 					
<i>For following sections – please indicate as appropriate:</i>					
Trust Goal (see key)	ALL				
Critical Success Factors (see key)					
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)					
Assurance Level (shown on BAF)	Red		Amber		Green
Legal implications, regulatory and consultation requirements					
Date: 24th November 2014 Completed by: Mark Price, Company Secretary					

Non-Executive Director Responsibilities - Proposed with effect from 3rd December 2014

SUB COMMITTEE	CODE	NON-EXECUTIVE DIRECTORS						Designate NED (Non Voting)	Non Executive Financial Advisor (Non Voting)
		Danny Fisher	Sue Wadsworth	Charles Rogers Senior Independent Director	Dr Nina Moorman	David King	Jane Tabor	Jessamy Baird	Lizzie Peers
Corporate Trustee		Yes	Yes	Yes	Yes	Yes	Yes		
TRUST BOARD	(TB)	Chair	Vice Chair	Member	Member	Member	Member	Attendee	Advisor (receive Papers)
TRUST BOARD SEMINAR	(TBs)	Chair	Vice Chair	Member	Member	Member	Member	Attendee	Attendee
1 REMUNERATION & NOMINATIONS COMMITTEE	(RNC)	Chair	Vice Chair	Member		Member			Advisor (receive Papers)
2 AUDIT & CORPORATE RISK COMMITTEE	(ACRC)			Vice Chair	Member	Chair	Member		Attendee
CHARITABLE FUNDS COMMITTEE	(CFC)		Vice Chair		Chair	Member			Member
3 FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE	(FIIWC)			Chair			Vice Chair		Member
QUALITY & CLINICAL PERFORMANCE COMMITTEE	(QCPC)		Chair		Vice Chair			Member	
FOUNDATION TRUST PROGRAMME BOARD	(FTPB)	Member	Member			Member			
MENTAL HEALTH ACT SCRUTINY COMMITTEE	(MHASC)				Vice Chair		Member	Chair	

1 Reduce to 4 members

2 Reduce to 4 members

3 Reduce to 3 members

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 4th DECEMBER 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	<input checked="" type="checkbox"/>	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: 25th November 2014 Completed by: Andy Hollebon Head of Communications and Engagement & Sarah Morrison – Exec Assistant to Chief Executive						

NATIONAL

Foundation Trust Network Annual Conference (<http://www.foundationtrustnetwork.org/home/>)

In his opening speech to the Foundation Trust Network (FTN) Annual Conference, Chief Executive Chris Hopson who recently visited the Island highlighted the Integrated Care Hub (<http://www.foundationtrustnetwork.org/news/chris-hopson-opens-ftn-annual-conference-and-exhibition/>) as an important development in Integrated Care. The Hub featured in the Conference brochure and as one of 12 NHS providers invited to exhibit developments in local health economies.

Some of the key messages from the conference included:

- Continued support for Foundation Trusts as the vehicle for delivering health services
- Continued support for the commissioner / provider split
- The importance of the Five Year Forward View – the Secretary of State for Health said he was committed to delivering this
- The national focus on duty of candour

The FTN now represents around 95% of all NHS Foundation Trusts and NHS Trusts. To ensure that the name of the organisation is representative of all its members it was announced that with effect from 1/12/14 it will be known as 'NHS Providers'.

Duty of Candour

New fundamental standards for all care providers will come into force in April 2015. However, two regulations for NHS bodies that form part of these come into force on 27 November 2014.

Regulation 5: Fit and proper persons: directors and Regulation 20: Duty of candour come into force for NHS bodies in November 2014. 'NHS bodies' means NHS trusts, NHS foundation trusts and special health authorities.

The fit and proper persons requirement outlines what providers should do to make clear that directors are responsible for the overall quality and safety of care. The duty of candour explains what they should do to make sure they are open and honest with people when something goes wrong with their care and treatment.

The fundamental standards, which will be implemented in April 2015, will replace the existing essential standards of quality and safety. They will include guidance for all sectors on the fit and proper persons requirement for directors and the duty of candour.

The CQC published guidance for NHS organisations on 20th November which is available at <http://www.cqc.org.uk/content/fit-and-proper-persons-requirement-and-duty-candour-nhs-bodies>

REGIONAL

Ebola

Our preparations for possible Ebola cases continue. Staff have attended regional training exercises and the Trust has invested in new Personal Protective Equipment (PPE). Guidance from national bodies is being made available as soon as it is received.

LOCAL

System Pressures

It's been a very difficult month with health systems across the South under pressure. This is not just confined to the hospital – mental health have also been under pressure and the knock on effect of hospital pressures is an increased need for community and ambulance services. The pressures were so great on the Island that for the first time in many years we declared a 'Black

Alert' for a short period of time. We also declared a significant incident and set up a control centre in the Conference Room. Staff have worked above and beyond the call of duty to ensure that patients were provided with the best care possible during this challenging period. The pressures continue and we must maintain the current tempo of work to ensure that we can continue to admit patients when they require in-patient treatment.

Wight Life Partnership

<http://www.iow.nhs.uk/about-us/Partnership-working/wight-life-partnership.htm>)

The Trust's Clinical Strategy, developed in 2013 and early 2014 with contributions from many Island organisations, indicates that we will in the future focus services in three areas – St. Mary's Hospital, three community clinic Hubs (the first one is due to open in Ryde in early 2015) and in people's homes. With changes in medical science and technology it is now possible to deliver many more treatments in or closer to a patient's home and this means that some of the buildings at St. Mary's – the older buildings including and south of the old Workhouse - will not be required in the future for the delivery of healthcare or as offices for support staff.

On 13/11/14, following a competitive tender, we signed an agreement with Ryhurst Ltd to provide us with specialist support and advice to develop our land and buildings. We've entered into a joint venture with Ryhurst, which we've called 'Wight Life Partnership'. The Estates team who manage our land and buildings do a great job but to develop our land and buildings in line with our Clinical Strategy we need this specialist external support to provide additional expertise in estate planning and also access to capital funds.

The announcement about the partnership has sparked some debate about whether this is privatisation of the NHS. I've written to all the County, Town and Parish Councillors and to our Members to set out why we have set up the partnership. As my letter states:

- This is not privatisation
- The Trust retains control
- This is about land and buildings not about the clinical services we provide

A project board, which includes representation from the Estates Department, is overseeing the partnership.

Flu Vaccination

The latest national figures (31/10/14) show that 578 (out of 2,372 involved with direct patient care) have had their flu vaccination via the Occupational Health team. More staff are being encouraged to take up the vaccination which protects them, their patients and their family and friends. The data for every Trust can be found at <http://www.nhsemployers.org/news/2014/11/340000-nhs-staff-vaccinated-against-flu>.

Black or Minority Ethnic (BME) Network

Did you know that 8% of staff come from a Black or Minority Ethnic (BME) background? We know that when applying for a job here on the Island, people from a BME background are less likely to be successful. I want to do something about this and I have met with Dr Vivienne Lyfar-Cissé, Chair of the NHS BME Network. We talked about some of the reasons why BME staff experiences are different to other staff groups. I gave her my commitment that I want to establish a staff network for BME staff early in 2015. If you want to get involved in this contact Liz Nials, Equality and Diversity Lead. We are really going to drive this agenda and further information will follow in December. More information about the diversity of our workforce is available on our website at <http://www.iow.nhs.uk/Downloads/Equality/Public%20Sector%20Duty%20Report.pdf>.

Volunteers

Well done to [Hannah Palmer-Davies](#) who as a young volunteer has devoted her time and energy to support young people across various projects for the Island's NHS has been recognised nationally as part of the #iwill programme supporting the involvement of more young people in voluntary and social action work. Hannah has been invited to be part of an online web chat with His Royal Highness, The Prince of Wales.

Carbon Energy Fund

The Trust Development Authority (TDA) have approved the Outline Business Case (OBC) for our bid to the Carbon Energy Fund for funds to help us reduce our energy use and improve our use of energy from sustainable sources.

Pressure Ulcer Awareness Day

The Tissue Viability Team held a Pressure Ulcer Awareness event at the Riverside Centre, Newport Quay, on Wednesday 19th November 2014 from 10am to 4pm, for patients, carers, nurses and the general public. This was well supported with lots of questions being asked and information available.

Isle Feel Good

'Isle Feel Good!' took place in central Newport on Saturday 22nd November 2014 and was a celebration of health and wellbeing on the Island which takes place in St. Thomas' Square, the Minster and Newport Methodist Church. If you're not already involved this is an excellent opportunity to engage with patients and the public

Listening into Action

The initial Listening into Action (LiA) projects have started. They have been chosen as our first priorities, they are by no means the only work streams that will benefit from the LiA approach. But we must recognise that we cannot do everything at once. The areas are:

- Access to Community Mental Health Therapies
- To take out medications – Improving TTO turnaround times
- Discharge Planning on Admission in MAAU
- Paediatric front door for emergencies
- Orthopaedic Referral to Treatment
- Ambulance Handover and Turnaround Times
- Patient referrals – informed patients
- Right Patient, Right Bed
- Optimising Flow of the Right Patients through the Rehabilitation Ward back into the Community
- Prevention of Clostridium Difficile

There are also five 'enabler' teams are working on projects that are beneficial to staff and act as Trust-wide unblockers:

- IT
- Intranet
- Effective Recruitment Process
- Reducing Bureaucracy/Paperwork
- Maximising Deployment of Volunteers

Winter Planning

Our operational planning for the Winter period is ongoing with a focus on capacity and resilience. A verbal update will be given at the Board meeting.

Infection Prevention and Control

Following a small outbreak of Norovirus the Trust put in place visiting restrictions for a small number of areas. A number of patients affected by diarrhoea and vomiting on Whippingham and Luccombe wards and the Medical Assessment Unit.

Visitors were being asked to help stop the spread of norovirus at St Mary's Hospital by staying away if they have had any symptoms of the illness within the last 48 hours.

Anyone wanting to visit either ward is being asked to do so only if essential, and only by prior arrangement with the ward Matron. No children (aged 16 and under) or elderly or vulnerable adults should visit either ward.

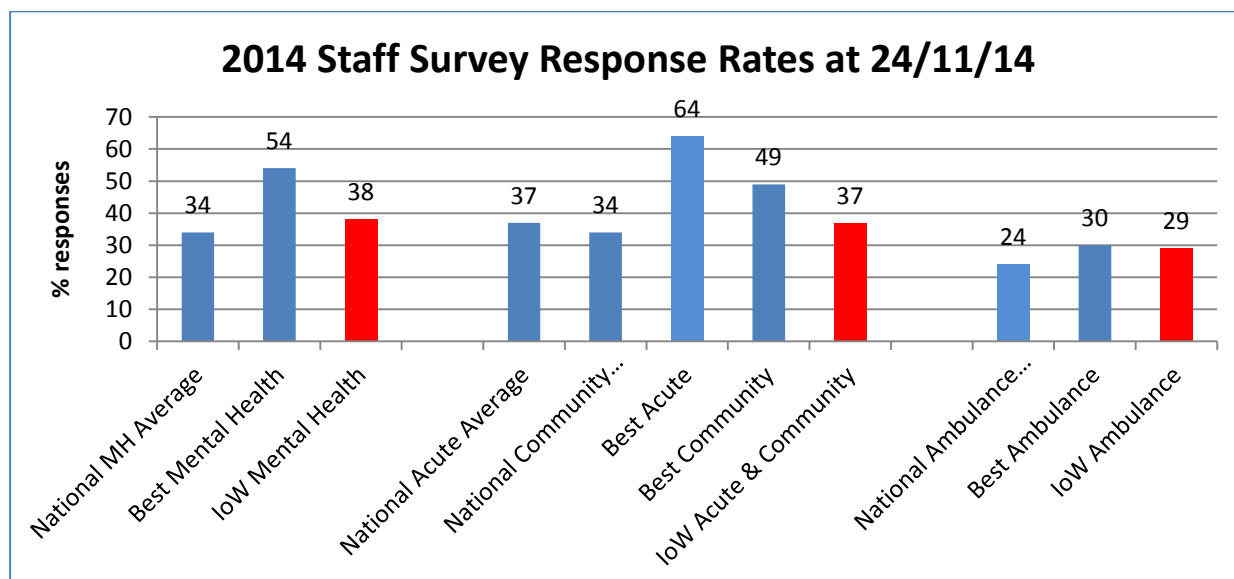
Good hand hygiene using soap and water is important during outbreaks of norovirus as it is highly contagious. Thorough cleaning of hard surfaces with a bleach solution, paying particular attention to the toilet and toilet area, will help to reduce the spread of the virus.

Quality Improvement Plan

The deadline – 12th December - for completion of the key actions from the CQC Inspection and the Warning Notice Actions is fast approaching. The Quality Improvement Plan isn't a tick box exercise, it's what we should be doing for our patients to improve their experience in our organisation. However we also need to make a response to the warning notice by 12th December. We have asked all staff to make sure that they understand the plan and know what their responsibilities are and how it affects them at speciality/ward/directorate level and how are implementation is being monitored. I will update the Board further at the meeting.

Staff Surveys

At the end of September around 850 staff across the organisation were sent the 2014 Staff Survey Questionnaires. The 2014 staff survey is underway. The chart shows the response rates for Isle of Wight NHS Trust compared to other Trusts using the service provided by Quality Health.



Strike Action

The Trust worked closely with staff and their representatives to minimise the impact of industrial action on the quality of patient care. On Monday 24th November 2014, between 07:00hrs and 11:00hrs staff joined the national industrial action and formed a peaceful picket line at the entrance to St. Mary's. There was no significant impact on patient care apart from Community Midwife visits being carried out later in the day. Staff returned to work at 11:00hrs as planned. The second strike on Monday 20th October by the Society of Radiographers did not affect the Trust.

Information

Stuart Squibb in the IT Department has been ensuring that we are compliant with our legal obligations for Microsoft Licensing. His diligence and hard work have ensured the Trust has avoided potentially huge costs for non-compliance that for some organisations could run into 7 figure sums. The auditor stated that he had never come across an organisation – private or public sector – who met our standard. As a result Microsoft have asked Stuart to help them develop a guidance for licensing compliance. Well done Stuart!

Key Points Arising from the Trust Executive Committee

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

20th October 2014

- CQC Quality Improvement Plan approved
- Ebola Preparation discussed and further preparations agreed
- Risk Management Strategy approved
- Service User and Carer Involvement Policy approved

27th October 2014

- Update on medical vacancies received
- Performance and planning for winter discussed
- Ebola Preparation discussed

3rd November 2014

- Space Utilisation Group Terms of Reference approved (with amendments)
- Interim Support on Organisational Restructure Tender Document received

10th November 2014

- Quality Improvement Plan discussed
- Nursing Technology Fund Bid supported
- IAPT Business Case approved
- Probationary Periods Discussion Paper

17th November 2014

- Ambulance CAD Computer Aided Dispatch (CAD) Upgrade & Technology Refresh Business Case approved
- Integrated Drug and Alcohol Service (IDAS) Project Update received
- Safer Staffing Business Case discussed

Karen Baker
Chief Executive Officer
25th November 2014

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 3rd December 2014

Title	Hospital & Ambulance Directorate update					
Sponsoring Executive Director	Executive Director of Nursing and Workforce					
Author(s)	Associate Director – Hospital and Ambulance Directorate					
Purpose	For information					
Action required by the Board:	Receive	<input checked="" type="checkbox"/>	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						
<i>Please add any other committees below as needed</i>						
Board Seminar						
Other (please state)						
Staff, stakeholder, patient and public engagement:						
This report is provided as a regular update to the Trust Board from the Hospital & Ambulance Directorate.						
Executive Summary:						
This report gives an update on quality, finance, performance and key issues, successes for the Hospital & Ambulance Directorate.						
<i>For following sections – please indicate as appropriate:</i>						
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: 19 th November Completed by: Chris Smith on behalf of Donna Collins, Associate Director – Hospital and Ambulance Directorate						

Directorate wide update for October 2014

Highlights

- Joint Advisory Group accreditation achieved for Endoscopy
- Clinical Pathology Accreditation achieved for the Laboratories
- Recruitment of Paediatric Nurses to cover 12 hours in Emergency Department – 7 days per week – supporting the single front door
- Ambulance Red 1 and Red 2 calls response time <8 minutes above target
- Venous Thrombo-Embolic (VTE) risk assessment achievement maintained
- No MRSA cases - we remain at 0, in keeping with the zero tolerance set for this year.
- Estates work for St Helen's to Newchurch ward move progressing well and on track
- First month use of Omnicel as shared storage Colwell / Medical Assessment Unit has reduced costs more than expected – Neonatal Intensive Care Unit – Nursing feedback – positive feedback on use of the system.
- New Breast Consultants recruited
- Recruitment of substantive Oral Surgeon

Lowlights

- Clostridium Difficile (C.Diff) - now level with the national threshold (6) for the whole year
- Referral To Treatment Time Admitted and Non-Admitted below target
- Staff sickness remains above plan
- Theatre utilisation below plan
- Emergency care 4 hour standard below target

Hospital

Quality

Complaints

Data to October shows that the cumulative combined total of concerns and complaints for the whole joint directorate remains lower than 2012/13 but due to a high level of concerns received for each of the last three months we now have an increased trajectory in comparison to last year.

The number of complaints remains low (15 this month), however, there has been an increase in the number of concerns due in part to the relocation of Patient Advice and Liaison service office, and for the last three months largely due to the problems being experienced in the Outpatient and Records Unit (OPARU). Recruitment is underway to address the staffing issues in OPARU and a system has been put in place to ensure phones are answered or answer phone message in place.

Reports detailing complaints managed in and out of time, and which areas these sit with are now being shared with the Executive Team, and Directorate Triumvirate. The most recent report shows an increase from 42% of complaints managed in time in April, to 60% managed in time in August and 100% managed in time in September.

The Directorate teams have been reminded that it is crucial that the timescale needed to investigate and respond is negotiated with the complainant when they are first contacted.

Serious Incidents Requiring Investigation (SIRIs)

The Directorate reported 10 SIRIs in October, and whilst this is an increase that is partly due to the change of process which has been implemented to ensure the timely reporting and investigation of incidents.

As of 11th November the Directorate had six overdue SIRIs. Of these four were with the commissioners for closure and the other two were still under investigation. The Directorate have been pro-active in seeking updates on the progress of the investigations and in trying to bring the cases to a close.

CQC Update

- The CQC report identified that there was not effective implementation and monitoring of the paediatric admissions pathway, or for the streaming and initial assessment of patients in the Emergency Department. The Trust response to this has been to develop, implement and monitor a pathway for emergency paediatric admissions. All paediatric patients requiring urgent/emergency care, transported to the hospital by ambulance, are now taken to the Emergency Department. There is a clear pathway, produced by Linda Fishburn describing the triage and initial treatment given by Emergency Department staff, followed by referral to paediatrics if required.
Children with chronic disease that require urgent treatment have a written Anticipatory Ambulance Care Pathway (AACP) should they need ambulance transport, directly to the Children's Ward. This is supported by a Standard Operating Procedure (SOP) for Paramedics, and a 'passport' held by the patient or carer. This has been successfully tested.
Paediatric Intermediate Life support has been undertaken by all Emergency Department nursing staff and there is a robust plan for annual updates. Middle grade doctors have time allocated in their job plans for training.
We also have regular inter-departmental meetings every Thursday afternoon, the last two of which have been minuted.
- The CQC also required that the review process for streaming patients in the Emergency Department be reviewed.
Progress to date has been that posters are currently being redesigned to be placed in reception indicating red flag symptoms.
Current systems in the Emergency Department do not meet the level of assurance needed and this continues to be explored to conform with both CQC and CCG requirements.
There may be a need for further financial investment in either systems or staffing in order to be able to offer the required level of assurance.
- The CQC report identified that patients had a number of bed moves and did not have a named consultant for the duration of their stay. Changes to a patient's consultant were being made for non clinical reasons depending on the ward they were located on rather than their clinical condition.

A system is being put in place for senior nursing staff and responsible Doctors on each ward to determine a list of patients that would be safe to be moved from the ward should a non clinical bed move be required.

An intra ward transfer form has been developed that covers clinical and non clinical patient bed moves which reduces the risks associated with moving a patient from one ward to another, and promotes the continuity of the patients care from a medical and nursing point of view. This transfer process will ensure that patients have a clear named Consultant remaining responsible for their care for the duration of their stay in hospital.

The first draft of the transfer form was circulated for use on the 5th October 2014 to all clinicians and senior nursing staff to implement via the Clinical Director and Interim Head of Clinical Services. Since then we have had comments and feedback on improving it and the new transfer process and form will be issued during the week of the 17th November 2014.

Performance

Emergency Care 4hr standard - The 95% target for October was again missed due to the increased pressure on community bed availability. Despite action plans being followed the increase in attendances at the Emergency department created a situation whereby towards the end of the month the target was not achievable. Although there have been failures to meet the target on individual days over past months, this is the first month where the target of 95% has not been achieved overall (94.2%) since May 2014. Increased efforts and focus throughout November will continue including increased focus on local authority bed situation and daily focus on bed states.

RTT performance – Admitted and non-admitted targets continue to underperform as planned due to current national funding scheme for Trusts to undertake additional activity to reduce waiting lists, in particular those patients waiting longer than 18wks. The admitted performance for October has increased slightly from 79.64% last month to 81.58% this month. The non admitted performance has increased from 92.19% last month to 93.89% in October. The focus on treating breaching patients has had the expected impact on the percentages as specialties work to improve their 18 week position.

The plan for delivering baseline activity plus additional in October was achieved to contribute towards the planned reduction of our waiting lists to 18wks by the end of November. Planning work has been taking place to maintain this performance sustainably from December onwards. Validation of pathways continues and extra resource is being implemented to increase capacity at admitted level. The data quality issues highlighted by the forecasting tools developed by Performance Information & Decision Support (PIDS) continue to be addressed.

Theatre Utilisation - The percentage utilisation of theatre facilities has decreased below the 83% target for Main Theatres (77.8%). Day Surgery Unit utilisation has increased during October 2014 (84.8%). Overall we have achieved 80.8%.

Delays continue to be experienced in theatres due to ongoing bed pressures delaying the start of theatre lists, with cancellations due to lack of beds also impacting on overall utilisation. Booking, particularly for orthopaedics has improved with additional support within the team to reduce impact of any non clinical reasons for cancellations.

Sickness in the directorate has worsened slightly against the previous month. This has been escalated with individual managers and ongoing monitoring is being undertaken to improve this position. The reporting of long term sickness has also been impacted through a change to the version of MAPS. The new version is now able to report information correctly across multiple months showing a true position for the Directorate. This change however, looks like the numbers have increased on previous reporting, where in fact there has been an improvement.

Going forward this will provide much better information for the Directorate. Also medical workforce vacancies remain a challenge, with proactive management of cover being undertaken with the most cost effective resource available, such as NHS locum's instead of more expensive locum agency staff.

Finance

As at 31 October the Hospital and Ambulance Directorate was overspent by £3.588m.

The main challenges we continue to face are the Cost Improvement Plan and Vacancy Factor for which the underachievement is causing a year to date adverse variance of £2.5m. In addition to this is the high number of medical vacancies being covered by locum and agency staff, which in turn attracts a premium over the budgeted allocation. This premium cost accounts for £1m of the total overspend.

Included in the position is £213k Referral To Treatment expenditure incurred for which we expect to receive funding for from the CCG.

The Directorate has secured System Resilience funding from the CCG for the following schemes:

Pilot for Step Down Beds to improve Patient Flow

Additional Porters – to improve Patient Flow and maintain the Emergency Department standard Ambulance schemes, detailed below

The Directorate continues to work on the finance forecasting to year end alongside recovery plans to recover the position.

'In the limelight'

The Trust is leading the way in how drugs are stored and accessed by clinical staff on hospital wards thanks to funding from the NHS England (NHSE) Technology Fund. In what is a UK first, 15 wards and departments at St. Mary's Hospital will have all their medicines stored in automated Omnicell cabinets which are linked to electronic prescribing. This means that medicines can be selected for specific patients using touch recognition technology such as keyless, fingerprint access.

The new drug cabinets on each ward are automatically refilled through a link with the 'pharmacy robot' which is based in the main Pharmacy Department. This not only releases time which can be better used caring for patients, but also improves patient safety on the wards. Ward staff no longer have to remember usernames and passwords but simply use the touch recognition technology; saving considerable time. The system provides 24 hour security and access for medicines and there is a clear record of who has issued which medicine.

Well done to Main Theatres who once again had their Children in Need bake week and raised £195 for this cause. And well done to the Tissue Viability Team who ran the Pressure Ulcer Awareness Day on Wednesday. The day was well supported by Practice and Nursing Home staff.

The Trust supported this year's European Antibiotic Awareness Day on 18th November (<http://www.iow.nhs.uk/default.aspx.locid-02gnew05n.Lang-EN.htm>). The aim in 2014 was for at least 10,000 healthcare professionals and members of the public to have committed to at least one pledge for prudent use of antimicrobials.

Congratulations to Biomedical Support Worker Keegan (Marc) Brown who caused a major upset in the Darts Grand Slam as featured on Sky News (<http://www1.skysports.com/darts/news/12040/9562026/grand-slam-of-darts-michael-van-gerwen-through-in-wolverhampton-as-keegan-brown-causes-an-upset>). Keegan, the reigning World Youth Darts Champion, is part of the Pathology Team - they and we as a Trust are all very proud of him.

Ambulance

Quality

The Ambulance Service received no complaints or concerns in October, and also has no complaints outstanding for resolution.

The Ambulance service had no SIRIs (Serious Incident Requiring Investigation) reported, and has 1 SRI outstanding which has been investigated and is currently with the commissioners awaiting closure.

CQC Update

The CQC expressed concerns around the storage of medicines used by the ambulance service.

By implementing the following actions we will ensure that patients are protected against risks associated with medicines management:

- The store area where the drugs are currently stored will be revamped to accommodate a full split air conditioning unit with the electronic equipment and battery management systems being relocated to a different store.
- A new Omnicell drugs storage unit will also be installed to ensure greater security around the storage and management of medicines. This will meet the regulation regarding storage of medicines

This means that the storage area will be solely for drug use and be maintained at a constant temperature through the 24/7 period.

Plans have been prepared by our Estates Department, which have now been approved by all relevant parties (Infection Prevention and Control, Pharmacy etc), but due to the costs involved the works will need to be put forward as a Capital Bid and so the work is delayed. Once approved, the work can begin within 2-4 weeks.

Performance

The Ambulance Service has been able to achieve all three categories required in October; Red 1 (75%) Achieved 76%; Red 2 (75%) Achieved 75.4%; 19 Min (95%) Achieved 96.4%. This has been due to the shortage of staff being addressed with additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall.

Our NHS 111 service has also been able to meet achievement targets by showing a return of 97% on call answering and 98% on warm transfers to a clinician¹

Finance

Year to date, the Ambulance Service (including the Hub, Patient Transport Service, Switchboard and Hospital Car Service) are in a good financial position showing a £36k underspend combined. In addition to this, the service has contributed £225k of savings towards the Cost Improvement Programme. (£177k recurrently)

The service has so far secured funding for Systems Resilience for Ambulance to maintain the Ambulance Response targets throughout the Winter Period, plus extended PTS service to improve the length of stay in ED for patients requiring discharge at night and 111 resilience.

'In the limelight'

On Saturday 22nd November staff from the Ambulance Service undertook a charity sleigh pull across the Island to raise money for Kissy Puppy and Isle of Wight Toy Appeals. The activity featured in the County Press (<http://www.iwcp.co.uk/news/news/pulling-together-to-help-isle-of-wight-children-70310.aspx>) and Island Echo (<http://www.islandecho.co.uk/news/responding-island-charity-needs>).

The Remembrance Day commemorations were truly special and no one can have failed to have been moved by the spectacular array of poppies at the Tower of London – one for every soldier who fell in the First World War. Thank you to Emergency Care Practitioner Alison Ball who represented the Ambulance Service and the Trust at the national Remembrance Service at the Cenotaph in London.

One of the Ambulance Service's Emergency Medical Call Assessors based in the Integrated Care Hub has been praised for her calmness whilst helping a dad to deliver his baby daughter, who arrived much more quickly than expected. The 999 call came through at around 3pm on Monday, 3 November, 2014, from father-to-be Kevin Apps whose wife Rachel was in the final stages of labour. Emma Tharme has been working with the Ambulance Service for nearly six years, but this was her first experience of assisting with the delivery of a baby over the phone.

Sabeena Allahdin

**Interim Clinical Director Hospital and Ambulance Directorate
& Consultant Obstetrician and Gynaecologist**

Donna Collins

Associate Director Hospital & Ambulance Directorate

Alan Sheward

Executive Director of Nursing and Workforce

21st November 2014

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

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 3 DECEMBER 2014

Title	Community & Mental Health Directorate update					
Sponsoring Executive Director	Executive Medical Director, Dr Mark Pugh					
Author(s)	Acting Associate Director– Nikki Turner					
Purpose	For information					
Action required by the Board:	Receive	<input type="checkbox"/>	P	<input type="checkbox"/>	Approve	<input type="checkbox"/>
Previously considered by (state date):						
Trust Executive Committee	<input type="checkbox"/>		Mental Health Act Scrutiny Committee	<input type="checkbox"/>		
Audit and Corporate Risk Committee	<input type="checkbox"/>		Remuneration & Nominations Committee	<input type="checkbox"/>		
Charitable Funds Committee	<input type="checkbox"/>		Quality & Clinical Performance Committee	<input type="checkbox"/>		
Finance, Investment & Workforce Committee	<input type="checkbox"/>			<input type="checkbox"/>		
Foundation Trust Programme Board	<input type="checkbox"/>			<input type="checkbox"/>		
<i>Please add any other committees below as needed</i>						
Board Seminar	<input type="checkbox"/>			<input type="checkbox"/>		
Other (please state)						
Staff, stakeholder, patient and public engagement:						
This report is provided as a regular update to the Trust Board from the Community & Mental Health Directorate.						
Executive Summary:						
This report gives an update on quality, finance, performance and key issues, successes for the Community & Mental Health Directorate.						
<i>For following sections – please indicate as appropriate:</i>						
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	<input type="checkbox"/>	Amber	<input type="checkbox"/>	Green	<input type="checkbox"/>
Legal implications, regulatory and consultation requirements	None					
Date: 21 November 2014						
Completed by: Nikki Turner, Acting Associate Director Community & Mental Health Directorate						

Community and Mental Health Services

Highlights

- % of Care Programme Approach (CPA) patients receiving follow up within 7 days of discharge is at 97%, and above plan.
- No MRSA cases - we remain at 0, in keeping with the zero tolerance set for this year.
- Stroke patients with 90% stay on Stroke Unit is above plan.

Lowlights

- Delayed transfers of care for Shackleton, although below target of 7.5%, remain a concern, with 4 patients awaiting transfer to suitable placements.
- The proportion of people completing treatment with psychological therapies and moving to recovery is lower than plan.
- Staff sickness remains static for Community and Mental Health Services.

Service Delivery Updates

Community Mental Health Services (CMHS)

Increased referrals to community mental health services continue to create pressure on the assessment and filtering team who need to respond to urgent referrals within the same working day. The wider community team has responded by supporting this team with resources on a daily basis. A business case for growth funding has been presented to CCG. Whilst interviews for permanent posts take place, 3 fte agency staff have been requested to underpin the service.

Psychological Therapy waiting lists within CMHS have increased and a Business Case is underway to address this.

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

Ofsted Inspection of IWC Children's Services

The Trust has contributed to the inspection of the Council's services particularly in the area of Looked After Children. This included support from Community Child and Adolescent Mental Health Service (CCAMHs), Adult MH, School Nursing and Safeguarding Team. The report has now been issued and the overall judgement is that Local Authority Children's Services require improvement.

The report states,

"The Local Authority is not yet delivering good protection and help and care for children, young people and families. The characteristics of good leadership are not in place but any widespread or serious failures have been identified by the local authority and are being effectively addressed. "

Serious Incidents Requiring Investigation (SIRI's)

The Directorate is working hard to improve its response to SIRI's within the expected timescale. The process for monitoring responses from other services is being reviewed along with the root cause analysis process. To date, the directorate has 16 overdue SIRI's. 6 have been transferred to the CCG for final signoff, leaving 8 with the directorate and 2 with the Quality Team for review and submission to the CCG.

CQC Updates

Mental Health compliance

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

Community Health compliance

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

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

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

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

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

In the media spotlight

'In the limelight'

Jenni Edgington, Modern Matron and Sharon Hopkins, Community Matron, were recognised by the Queen's Nursing Institute (QNI) as 'Queen's Nurses'. There was great interest in the Demand, Capacity and Acuity work undertaken by the Trust in relation to community nursing. The Trust has been asked to attend a sharing event for the QNI in February 2015. http://www.qni.org.uk/news_events/award_ceremony

Francis Johnson has been granted full membership for the College of Mental Health Pharmacy following her demonstration of high standard competency in psychiatric therapeutics. The College was impressed with his high level of input into patient care and involvement with audit and the implementation of action plans to improve practice. <http://www.cmhp.org.uk/>

Martin Hamilton was highly commended as a Steward of the Year Nominee at the Chartered Society of Physiotherapists 2014 Awards. Martin's citation says he has successfully negotiated on a number of difficult issues and was nominated by his colleagues for his excellent communication, timely support for members, commitment to staff health and wellbeing and his recruitment of support staff to the CSP. <http://www.csp.org.uk/news-events/events/csp-awards-2014>

Finance

The Community and Mental Health Directorate is reporting an over-spend of £328k at Month 7. Some costs are associated with growth in services and are being negotiated with CCG through business case development. Successful negotiations will improve the Directorate's overspend position. Six business cases have been approved which will result in investment in Community Nursing, Dietetics, IAPT, Podiatry, Orthotics and Pelvic, Obstetric and Gynaecological Physiotherapy (POGP).

The main pressure areas are within medical staffing and non pay spend in patient appliances. We are seeking additional funding through slippage of CCG funding.

Although we have achieved our Cost Improvement Plan (CIP) year to date, a proportion of this has been achieved non-recurrently. We need to identify sustainable recurring savings for the future.

Sarah Gladdish - Clinical Director, Community & Mental Health Directorate
Nikki Turner - Acting Associate Director, Community & Mental Health Directorate
Mark Pugh - Executive Medical Director

21 November 2014

**Minutes of the meeting in Public of the Isle of Wight NHS Trust Board
held on Wednesday 29th October 2014
Conference Room, St Mary's Hospital, Newport, Isle of Wight**

PRESENT:	Sue Wadsworth Karen Baker Chris Palmer Alan Sheward	Deputy Chair Chief Executive (CEO) Executive Director of Finance (EDF) Executive Director of Nursing & Workforce (EDNW) Executive Medical Director Executive Director for Transformation & Integration (EDTI) Non-Executive Director (SID) Non-Executive Director Non-Executive Director
	Mark Pugh Katie Gray	FT Programme Director & Company Secretary Designate Non-Executive Director Communications and Engagement Manager Caretaker Cleanliness Assistant Project Manager, Strategy & Commercial Dept. Volunteer Volunteer
	Charles Rogers Jane Tabor Nina Moorman	Head of Governance & Risk Management (HGRM) Deputy Head of Health & Safety & Security (DHHSS) Health Watch Patients Council PA to Mark Price/Katie Gray
In Attendance:	Mark Price Jessamy Baird Emma Topping <i>For item 14/292</i> Gary Driscoll John Pope Emma Lewin Chris Kendall Sam Sussmes <i>For item 14/308/309</i> Brian Johnston <i>For item 14/310</i> Martin Keightley	
Observers:	Chris Orchin Mike Carr	
Minuted by:	Julie Benson	
Members of the Public in attendance:	There were 4 members of the public present	

**Minute
No.**
14/286 APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE

Apologies for absence were received from Danny Fisher, Chairman, David King, Non-Executive Director

Chris Orchin declared that he was now a Trustee in the IW Citizens Advice Bureau and a member of the Healing Arts Management Committee.

The Chairman announced that the meeting was quorate.

14/287 CHAIRMAN'S UPDATE

The Chairman reported on the following:

- a) Reappointments:** It was reported that Danny Fisher and Sue Wadsworth are standing for reappointment for a further 2 years and their applications are being processed at the moment.
- b) General Election:** The Chair commented that the NHS was a major topic for the general election and the Trust needed to keep calm and continue

striving to make things better for our patients.

- c) **Memorandum of Understanding:** It was confirmed that a Memorandum of Understanding had been signed earlier today between the Friends of St Mary's and IOW NHS Trust. This had been a long time coming but was now completed.

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

14/288 CHIEF EXECUTIVE'S UPDATE

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

National

- **NHS Five Year Forward Plan** – The Chief Executive highlighted this plan now published by NHS England. The plan demonstrated closer working between Trust Development Authority (TDA), Monitor and NHS England. Public Health was emphasised to improve the health of people with particular emphasis on alcohol, smoking, fitness and obesity. New models of delivering care were proposed in the document with hospitals working more closely with GPs and with social care.

Regional

- **Ebola** – It was confirmed that the Trust was prepared in the unlikely event that a case of Ebola was identified on the Island. Blood samples would be fast tracked to a mainland laboratory to confirm whether Ebola is present. In the event of a confirmed case the patient would be transferred to a mainland hospital with the right facilities to provide the best possible care.

Local

- **Trust Awards** – The Trust Awards have been re-scheduled to Friday 30th January 2015 to be held at Cowes Yacht Haven. A different format is being adopted. Award nominations are open until 5th November.
- **Listening into Action** – Following on from the LiA Listening Events 10 projects had been identified to be completed over the next 20 weeks. These are:
 - Access to Community Mental Health Therapies
 - To Take Out Medications: Improving TTO turnaround times
 - Discharge Planning on Admission in MAU
 - Paediatric front door for emergencies
 - Orthopaedic Referral to Treatment
 - Ambulance Handover and Turnaround Times
 - Patient referrals – informed patients
 - Right Patient, Right Bed
 - Optimising Flow of the Right Patients through the Rehabilitation Ward back into the Community
 - Prevention of Clostridium Difficile
- **Workforce Summit** – Nationally the NHS is facing a shortage of trained staff across a number of areas. Almost all NHS organisations are seeking to recruit additional nursing and medical staff. On 8th October the Trust held a Workforce Summit to counter the additional problems we have in recruiting staff because we are an Island. Safer staffing reports indicate

that we need to recruit more nurses and as we have a well established Filipino community on the Island arrangements are being made to recruit more nurses from the Phillipines during the next couple of months.

- **Flu Vaccinations** – 500 staff have already been vaccinated but it is necessary for more staff to be vaccinated to protect colleagues, patients and family.
- **Staff Surveys** – This years Staff Survey has been sent out and it is important that these are returned as it is an important way of benchmarking against other organisations.
- **Strike Action** – Although there had been national industrial action on Monday 13th October, there had been minimal disruption to the patients on the Island.
- **Recycling** – The Trust is reducing its carbon footprint by encouraging staff, patients and visitors to recycle at St. Mary's as they do at home. Over the last year the Trust has increased its domestic waste recycling from 18% to 27%. With the addition of the office recycling, it is hoped that the Trust will go over the 50% mark very soon.
- **Black Alert** – The Trust had been on Black Alert since Monday however there had been a lot of work done and work with other organisations to ensure that patients get a timely discharge and it was hoped that the situation would be de-escalated to Red by the end of today.

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

14/289 LOCAL UPDATE FROM HOSPITAL & AMBULANCE

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

Highlights

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

Lowlights

- Clostridium Difficile (C.Diff) – now level with the national threshold (6) for the whole year
- 87.5% Cancer – Patients receiving subsequent surgery 1 days (94% target)
- Staff Sickness remains above plan.

The number of complaints remains low at 68 across the whole directorate. The Quality Team have reviewed their processes for managing complaints/concerns and this has significantly reduced the time remaining in which to respond within the guidelines.

A revised process for managing SIRIs has been agreed with decisions being

taken within the Directorate and fed back to the Quality Team. It was confirmed that the Executive Director of Nursing and Workforce and the Executive Medical Director review SIRIs weekly.

JAG Accreditation¹ had been received for the Endoscopy Unit. The Trust had passed with flying colours. The inspection team were complimentary about the Trust and said it was an accolade that the Trust had passed first time.

With regard to the Black Alert Charles Rogers asked what actions can be taken to move the situation forward. The Executive Director of Nursing and Workforce reported that a lot of work was going on at the moment to improve the situation with additional beds being opened this week. There were delays in discharge from the Trust and the reasons were complex and it was taking time to resolve them.

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

14/290 LOCAL UPDATE FROM COMMUNITY & MENTAL HEALTH

The Executive Medical Director presented the update from the Community and Mental Health Directorate to include:

Highlights

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

Lowlights

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

Community Mental Health Services – There had been increased referrals which is creating pressures but this was being supported.

The Trust had contributed to the Ofsted inspection of the IWCs Children's Services. A report is due on 18th November.

The Falls Co-ordinator has been re-commissioned on a permanent basis following a successful pilot.

CQC Updates

Mental Health Compliance - Staff have reported an improvement in patient experience, privacy and dignity since all bedroom doors have been fitted with locks. The service has complied with CQC recommendations around caseload management and supervision in the Psychotic Clusters.

¹ Joint Advisory Group on GI Endoscopy

With regard to safety and supervision of the Community Nursing Service out of hours since the inspection a review of the Standing Operating Procedures around Lone Working has been carried out and all staff have been provided with the documents. Following the inspection senior nurse provision was put in place to ensure out of hours clinical support for community nurses.

The actions for Community Wards are all completed or in progress and audits are in place to ensure actions are sustainable. Concerns for wards were around medical and nursing staffing levels and patients being transferred for non-clinical reasons. Plans are in place to support recruitment and clear criteria are in place to ensure that patients on Stroke and Rehabilitation pathways are given priority for transfer to the appropriate area for their care.

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

14/291 PATIENT STORY

The Chief Executive advised the meeting that this month's story was about a patient with an ulcerated leg who had been helped by the Tissue Viability Team, and in particular Glen Smith and June Attrill. The patient commented that if it had not been for the care she had received from Glen Smith she may have had to have her leg amputated. Glen Smith still visited her at The Orchards ensuring that she is still in good health. There was criticism about how many times she had been moved which she had found to be very stressful but overall she was very pleased with the care she had received.

The Isle of Wight NHS Trust Board received the Patient Story

14/292 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

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

Category 1 – Quality Care & Innovation

- Samantha Harrison – Healthcare Assistant, Outpatients

Category 2 – Employee Role Model

- Gary Driscoll - Caretaker
- John Pope – Cleanliness Assistant

Category 3 – Going the Extra Mile

- Georgina Tuckey – Team Leader, Island Drug and Alcohol Services
- Emma Lewin – Project Manager, Strategy & Commercial Department
- Coronary Care Team

Category 5 – Volunteers

- Chris Kendall
- Sam Sussmes

The Chief Executive congratulated all recipients on their achievements.

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

14/293 EMPLOYEE OF THE MONTH

The Chief Executive presented the Employee of the Month Award.

Employee of the Month – October 2014

- Alana Bell – Breast Care Nurse – Applegate Breast Care Unit

Unfortunately, due to clinical commitments, Alana Bell was not able to collect her award in person and the Chief Executive advised that it would be presented to her in the department.

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

14/294 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 1st October 2014 were approved with the exception of the following change:

- a) **14/261 p3:** "Recruitment" summit should read "Workforce" summit
- b) **14/264 p5:** Nina Moorman requested that the final paragraph should read "Nina Moorman confirmed that this film had been shown at the recent QCPC meeting and it demonstrated how easily usually competent patients can become traumatised".

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

14/295 REVIEW OF SCHEDULE OF ACTIONS

The Board received the schedule of actions and noted that there were no outstanding actions to review for this meeting.

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

ITEMS FOR THE BOARD

14/296 QUALITY IMPROVEMENT PLAN

The Executive Director of Nursing and Workforce presented the Quality Improvement Plan (QIP).

Following the Care Quality Commission's (CQC) planned and unannounced inspections to the Trust in June and the "requires improvement" assessment the Quality Improvement Plan had been produced.

The objective of the QIP is to support the Trust and its workforce to focus on achieving the required improvements to demonstrate our progression against the plan to achieve our aim to improve the quality of our clinical services. The QIP is a high level summary of the detail with an underpinning more detailed Action Plan.

Our QIP currently captures the required actions described by the CQC within the warning letter, compliance and enforcement actions and the "must and should do's" they describe in the reports.

Jane Tabor stated she was pleased that the individual designated to check and ensure that each action was being taken would be doing this on an ongoing basis and not as a one-off exercise.

Nina Moorman confirmed that it had been discussed in depth at Quality & Clinical Performance Committee.

Chris Orchin from Healthwatch confirmed that he was happy with the Quality Improvement Plan.

The Isle of Wight NHS Trust Board approved the Quality Improvement Plan

14/297 PERFORMANCE REPORT

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

Highlights:

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

Lowlights:

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

Safe:

- **Pressure Ulcers:** We continue to under achieve our planned local reduction across all grades of pressure ulcers, both in the hospital setting and the wider community. A public awareness campaign is in place to highlight prevention.
- **C.Diff:** We had 1 additional case during September and have now reached our full year target of 6.

Responsive:

- As planned the admitted and non-admitted RTT indicators were below target in September, with a number of specialities not achieving target bringing the overall Trust performance to 79.64% for Admitted (both IOW, CCG and NHS England), and 92.19% for Non-Admitted. In line with the national initiative to reduce the RTT backlog significant resources have been put into validation of 18 weeks pathways and increasing Out Patient and Inpatient capacity in order to achieve these targets from December 2014.
- **Cancer:** Patients receiving subsequent surgery <31 days failed the 94% standard during September (87.5%) with 2 breaches.
- **Ambulance Red 1 and Red 2 calls response time <8 minutes** - achieving all targets during September.

Caring:

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

Well Led:

- The pay bill for September including variable hours is £9.922m, above the plan of £9.686m. The number of FTEs in post including variable FTEs (2,737) is currently below plan by 28 FTE. The HR Directorate are closely monitoring and supporting the Clinical directorates with their workforce plans, in particular their control over their spend on variable hours.
- Sickness absence has increased from 3.64% to 4.55% during September and remains above the 3% plan. Detailed analysis of all long-term Sickness Absence is sent to Occupational Health, Health and Safety, Back Care and also to the Associate Directors, Quality and Finance. Actions are followed up at Performance Review and Directorate meetings. Short-term absence is being monitored using the Bradford Score. The capability policy has been streamlined and review periods are being scrutinised. Education sessions for Bradford Score are being cascaded.
- The cumulative Trust plan was to deliver a surplus of £1.089m, after normalising items (e.g. impairments and cost associated with donated assets). The actual position is a cumulative surplus of £1.084m, an adverse variance of £5k. This position has £1.9m of forward banking recognised to the end of month 6.
- The Trusts planned forecast out-turn surplus remains at £1.7m but the current directorate performance continues to increase the risk of this delivery. This position is actively being managed through financial deep dive meetings and performance reviews & where necessary more frequent finance assessments.

Effective:

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

The Executive Director of Transformation and Integration confirmed that Theatres usage was one of the projects starting with the support of KM&T. Sue Wadsworth requested that there be an update following the Theatre Review. Jane Tabor also commented on Theatre usage and questioned how far in advance operations, if cancelled, was the patient notified. It was noted that it had an impact not only on the patient but on the staff delivering the news. The Executive Director of Nursing and Workforce responded that wherever possible patients were given 24 hours' notice so as to reduce the potential stress caused.

Jane Tabor commented on the report that there was an increase in pressure ulcers and requested that a Winter Resilience Plan be discussed at the next Board Seminar.

Action Note: *A Winter Resilience Plan to be discussed at the next Board Seminar.*

Action by: CS

The Isle of Wight NHS Trust Board received the Performance Report

14/298 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Nina Moorman reported on the key points raised at the last meeting held on 22nd October 2014

1. ISIS Rollout Plan. Clinical engagement and compatibility with PARIS.
2. Monitoring of Quality Improvement Plan (QIP)

3. Lessons learnt from incidents and sharing with the Trust.
4. Risks to RTT and quality of patient care. Its link to the Current Capital Improvement Plan.
5. TDA Self Certification approved with caveats around statements 13 and 14.

She highlighted the length of the papers for QCPC. These had been reduced and it felt less congested, however improvement was still needed.

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

14/299 MINUTES OF THE FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE

Charles Rogers reported on the key points raised at the last meeting held on 22nd October 2014, these being:

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

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

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

Self-Certification: Sufficient assurance has been provided for the committee to recommend that Trust Board approve the Self Certification returns as proposed.

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

14/300 MINUTES OF THE MENTAL HEALTH ACT SCRUTINY COMMITTEE

Jessamy Baird reported on the key points raised at the last meeting held on 22nd October 2014.

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

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

Operation Serenity - Sgt Paul Jennings and MML attended a meeting at which senior stakeholders were present. Sgt Jennings delivered a presentation about Operation Serenity which was received positively. The response from those present was that further requirements were to be identified and met; if the resources were not there to meet these requirements then applications for funding were to be made and would be considered favourably.

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

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

The Executive Director of Transformation and Integration confirmed that the PARIS review was being commissioned by Nikki Turner. Jessamy Baird asked who is responsible for the change management implementation of the PARIS system. The Executive Medical Director advised that he would look into the matter.

***Action Note:** The Executive Medical Director to confirm who is responsible for the change management implementation of the PARIS system.*

Action by: EMD

Jessamy Baird also requested that the Board receive these Minutes with a lag of 1 month. It was felt that as they were quarterly this would not be a problem.

***Action Note:** The Company Secretary to plan Board agendas noting this change.*

Action by: CS

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

14/301 REPORTS FROM SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs)

The Executive Director of Nursing and Workforce provided an overview of the 9 Serious Incidents reported during September 2014, as well as identifying the lessons learnt from SIRIs closed by the commissioner during September 2014. Of the 9 reported 8 related to pressure ulcers. The Quality and Clinical Performance Committee are responsible for signing off the completed SIRI reports at the point that the actions are fully completed. As at the 22 October 2014 QCPC approved the completed action plan relating to 2 incidents.

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

14/302 SAFEGUARDING AND LOOKED AFTER CHILDREN ANNUAL REPORT 2013 - 2014

Jenny Johnston, Head of Safeguarding Children introduced the Safeguarding and Looked After Children Annual Report 2013 – 2014. The purpose of the report is:

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

Jane Tabor asked how the recruitment to the team was progressing and it was confirmed that a Band 7 Nurse had been recruited.

The Chairman noted that Jenny Johnston was retiring and she thanked her for all the work she had done as Lead for Safeguarding Children and wished her well for her retirement.

Proposed by Nina Moorman and seconded by Mark Pugh

The Isle of Wight NHS Trust Board approved the Safeguarding and Looked After Children Annual Report 2013-2014.

14/303 MONTHLY UPDATE ON SAFER STAFFING

The Executive Director of Nursing and Workforce presented the monthly update on safer staffing.

The Executive Director of Nursing and Workforce reported that there were shortfalls during September and current known reasons include, vacancies, high sickness rates in some areas, vacancies or sickness not being able to be filled with bank staff, poor rota management, non-fill of bank staff for registered nurses, particularly for 1:1 care for dementia patients.

High sickness levels will be discussed at the Directorate Nursing Team meeting and will be addressed within the Directorate teams. A bank user group has been set up to gain more robust oversight of the nurse bank system. A general proactive recruitment drive is in place.

The monthly report information would be included in the main performance report in the future but the Board would continue to receive a separate six monthly update report.

Proposed by Charles Rogers and seconded by Jane Tabor

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

14/304 QUARTERLY BOARD WALKABOUT ACTIONS

The Executive Director of Nursing and Workforce confirmed that this would be the last time that the report would come to the Board in the present format.

It was reported that of the 79 visits to date the majority have been to clinical settings with only 16 to non-clinical areas, from the visits a total of 204 actions have been identified. At the time of the report 8 actions remain overdue, 4 of which are green against the directorates revised timescale.

The Isle of Wight NHS Trust Board received the report on the Quarterly Board Walkabout Actions.

14/305 QUARTERLY PATIENT STORY ACTION TRACKER

The Executive Director of Nursing and Workforce reported that the report provides assurance to the Board that the actions identified in response to the Patient Stories have been reviewed and monitored to completion. It was reported that there are currently no outstanding actions.

The Isle of Wight NHS Trust Board received the report on the Quarterly Patient Story Action Tracker.

14/306 CAPITAL PLANNING

The Executive Director of Transformation and Integration explained that the Board had previously approved the disposal of the Swanmore Road properties when services relocated to the former Shackleton House, planned for February 2015; this has now slipped into April 2015 due to delays in the refurbishment work to create the new Ryde Community Clinic.

During the different stages of the project additional requirements have been identified that have impacted on both programme and budget. As agreement for an additional £54,106 capital requirement was sought.

The Executive Director of Finance explained that the delay in completion meant that the sale would now complete in April and therefore in the next financial year.

Proposed by Charles Rogers and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Capital Planning Report.

14/307 BOARD SELF CERTIFICATION

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

Jane Tabor questioned Board Statement 7 and the statement "The board has considered all likely future risks". She requested that the Board allocate sometime in a seminar to do this. This was supported.

Action Note: A Board Seminar session on likely future risks to be scheduled.

Action by: CS

Proposed by Charles Rogers and seconded by Nina Moorman

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

14/308 BOARD ASSURANCE FRAMEWORK (BAF) MONTHLY UPDATE

The Head of Corporate Governance & Risk Management presented the BAF. There is one Principal Risk now rated as Red; no new Risks have been added since August. The exception report details 4 recommended changes to the Board Assurance RAG ratings of Principal Risks: changes from Amber to Green for 10.4; 10.14 and 10.16; one change from Green to Amber for 2.19.

Proposed by Nina Moorman and seconded by Charles Rogers

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

14/309 CORPORATE GOVERNANCE FRAMEWORK

The Head of Corporate Governance & Risk Management presented the:

- a) Standards of Business Conduct
- b) Code of Accountability for NHS Boards (incorporating Code of Conduct)
- c) Accountable Officer Memorandum

It was advised that the changes made were in accordance with the wording for national models. It was requested that the Standards of Business Conduct and Code of Accountability for NHS Boards be approved for a period of one year with the Accountable Officer Memorandum being approved for a period of three years.

Proposed by Jane Tabor and seconded by Charles Rogers

The Isle of Wight NHS Trust Board approved the
(a) Standards of Business Conduct
(b) Code of Accountability for NHS Boards (incorporating Code of Conduct),
(c) Accountable Officer Memorandum.

14/310 FIRE SAFETY POLICY

Martin Keightley, Deputy Head of Health & Safety & Security attended to present the Fire Safety Policy. He explained that it was a refresh of the previous policy. The Executive Director of Transformation and Integration commented that the fire safety training that she had received was the best she had received in her career.

Jane Tabor asked if there was a summary of fires that had occurred in previous years. It was confirmed that this was included in the Annual Fire report and that this report is presented to TEC. The Company Secretary agreed to circulate this to Non-Executive Directors.

Action Note: The Company Secretary to circulate a copy of the Annual Fire Report to Non-Executive Directors.

Action by: CS

Charles Rogers asked if there was sufficient executive support to fire safety. The Deputy Head of Health & Safety & Security confirmed that the Executives had always taken their responsibilities seriously and there were no issues, and he felt confident that if there were he would be able to escalate them.

The Executive Medical Director asked what actions had been put in place in view of the imminent strike by firefighters. Martin responded that there would be extra people on site and there would be strong challenges should an alarm be raised. There were also retained firefighters that could be called upon if necessary.

Proposed by Jane Tabor and seconded by Charles Rogers.

The Isle of Wight NHS Trust Board approved the Fire Safety Policy.

14/311 MATTERS TO BE APPROVED BY CORPORATE TRUSTEES

It was confirmed that June Ring had stepped down from the Charitable Funds Committee in her role as Patient Council Representative and that the Patient Council had nominated Dennis Ford as Member with Christine Barringer as Deputy.

Proposed by Nina Moorman and seconded by Charles Rogers

The Isle of Wight NHS Trust Board approved the appointment of a Patient Council Representative and Deputy to the Charitable Funds Committee.

14/312 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

14/313 ANY OTHER BUSINESS

Chris Orchin mentioned that at the meeting next month the new Healthwatch manager would be joining him.

14/314 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 3rd December 2014** in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 12.30pm

Signed.....Chair Date:.....

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

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

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

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

Head of Corporate Governance & Risk Management (HCGRM) Business Manager for Patient Safety, Experience & Clinical Effectiveness (BMSEE)

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

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

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
30-Apr-14	14/125	TB/093	Board Walkabout Timings: The Chairman stated that he had undertaken walkabouts on Sundays and he encouraged members to vary the times they make their visits to include out of hours times including weekends and late evenings to get a wider picture of how the organisation functions during these times. There was a discussion surrounding the timings of the Board day walkabouts and it was requested that these be reviewed.	CS	Company Secretary to review timings and adjust Board day programme accordingly. 16/05/14 - Scheduled at lunchtime for May Board meeting. Timings to be adjusted following feedback. 28/05/14 - The Company Secretary advised that this item had been left open to allow for feedback on the new timings of these walkabouts within the Board programme. 01/10/14 - The Company Secretary report that a new format for these was being trailed and that the action would be left open with a discussion due to be held at Board Seminar. 24/11/14 - Principles for new process and timings for Walkabouts agreed at October Board Seminar including not scheduling them on Board days. New process to be proposed by EDNW.	14-Oct-14	28-Jan-15	Progressing		Open
27-Aug-14	14/257	TB/110	Car Parking: David King asked if our car parking arrangements comply with the national guidelines. The Chief Executive confirmed that this was the case. She also highlighted that concessions available to patients and visitors were available on the website but that she would arrange for these to be made visible around the Trust.	HOC	Communications team to arrange for details of the concessions to be made freely available around the organisation. 22/09/14 - Leaflet and poster in production. Discussions underway with areas who send out appointment letters about getting details of car parking included (i.e. printed on the back) in those letters. The web site is being updated. 01/10/14 - The Head of Communications & Engagement reported that the information was now available on the website and requested that the action be left open to allow progress updates.	01-Oct-14	03-Dec-14	Progressing		Open
01-Oct-14	14/269	TB/114	Exemplary Practice in the care of Pressure Ulcers: Jane Tabor asked if those nurses who demonstrate exemplary practice had been canvased for their input. The Deputy Director of Nursing advised that at this stage this had not happened but she would raise the suggestion with the Matrons Group.	DDN	The Deputy Director of Nursing to raise the suggestion of canvassing nurses for their input with the Matrons Group. 24/11/14 - Exemplary Practice in the care of Pressure Ulcers was discussed at Matrons Action Group on 6th November 14.	01-Oct-14	03-Dec-14	Completed	24-Nov-14	Closed
01-Oct-14	14/271 i)	TB/116	Community Services Contracted Activity: David King asked if the data shown could include a variant level. The Executive Director of Finance advised that the service activity was spread over a year and depended on demand/delivery. The Chairman also asked if we were over performing against contract. She advised that more data could be given and that a business case for community nursing was being prepared to apply for additional funding.	EDF	The Executive Director of Finance to arrange for the data to reflect variance in demand and delivery within contacted activity within the performance summary reports. 22/10/14 - Progressing for inclusion at 3rd December Board. 24/11/14 - Included within December report. This action is now closed.	01-Oct-14	03-Dec-14	Completed	24-Nov-14	Closed
01-Oct-14	12/271 iii)	TB/117	Ambulance Appraisals: Jessamy Baird asked if the level of appraisals reported was a negative trend. She cited the recent Staff Survey report as having included concerns in this area within the results. The Executive Director of Finance advised that there was some under reporting in this area and that further work would be done to improve the reliability of the data which would be seen in future months.	EDNW	The Executive Director of Nursing & Workforce to report back to the Board on progress and to provide assurance that the reliability of the data issue had been resolved.	01-Oct-14	03-Dec-14	Progressing		Open

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






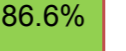







Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
01-Oct-14	14/271 iv)	TB/118	Cancer Consultant Cover: David King asked if the level of consultant cover in the period could be included within the report to add clarity and perspective. Nina Moorman also asked at what point a locum position became permanent as there were locum consultants being used within this service. The Clinical Director for Community & Mental Health outlined the process of using a locum doctor and that the Trust did appoint locum consultants on a fixed term basis and this meant that they would not become permanent. She also advised that the Trust does on occasion use agency locums.	EDF	The Executive Director of Finance to request that the level of consultant cover within the cancer service be shown within the report. 17/10/14 - Cancer consultant cover to be included within the Workforce Report - for 3rd December Board.	01-Oct-14	03-Dec-14	Progressing		Open
01-Oct-14	14/274	TB/122	Consultant List: The Chairman asked if Workforce could provide a detailed list of the consultants currently working within the Trust and their positions. The Chief Executive confirmed that this was currently being prepared by Medical Workforce. Nina Moorman also asked if the list could include the names of the lead clinician in each area as this would be helpful so that any queries the NEDs had could be addressed directly to that person.	CEO	The Chief Executive to request that the lead clinicians in each area be identified and a list be prepared and circulated to Board Members. 24/11/14 - List to be provided to Board members before next Board meeting on 3rd December 14.	01-Oct-14	03-Dec-14	Completed	24-Nov-14	Closed
29-Oct-14	14/297	TB/123	Winter Resilience: Jane Tabor commented on the report that there was an increase in pressure ulcers and requested that a Winter Resilience Plan be discussed at the next Board Seminar.	CS	A Winter Resilience Plan to be discussed at the next Board Seminar. 11/11/14 - Presentation given at Board Seminar. This action is now closed.	11-Nov-14	11-Nov-14	Completed	11-Nov-14	Closed
29-Oct-14	14/300	TB/124	PARIS System: Eexecutive Director of Transformation & Integration confirmed that the PARIS review was being commissioned by Nikki Turner. Jessamy Baird asked who is responsible for the change management implementation of the PARIS system. The Executive Medical Director advised that he would look into the matter.	EMD	The Executive Medical Director to confirm who is responsible for the change management implementation of the PARIS system.	03-Dec-14	03-Dec-14	Progressing		Open
29-Oct-14	14/300	TB/125	Minutes for Board Agenda: Jessamy Baird also requested that the Board receive these Minutes with a lag of 1 month. It was felt that as they were quarterly this would not be a problem.	CS	The Company Secretary to plan Board agendas noting this change. 24/11/14 - This will be implemented from January 2015. This action is now closed.	03-Dec-14	03-Dec-14	Completed	24-Nov-14	Closed
28-Oct-14	14/210	TB/126	Fire Summary: Jane Tabor asked if there was a summary of fires that had occurred in previous years. It was confirmed that this was included in the Annual Fire report and that this report is presented to TEC. The Company Secretary agreed to circulate this to Non-Executive Directors.	CS	The Company Secretary to circulate a copy of the Annual Fire Report to Non-Executive Directors. 24/11/14 - Completed after 29th October Board Meeting. This action is now closed.	03-Dec-14	03-Dec-14	Completed	24-Nov-14	Closed

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	<input checked="" type="checkbox"/> 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	19/11/2014
Finance, Investment & Workforce Committee	19/11/2014	Remuneration Committee	
Foundation Trust Programme Board			
<i>Please add any other committees below as needed</i>			
<i>Other (please state)</i>			
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.			
<i>For following sections – please indicate as appropriate:</i>			
Trust Goal <i>(see key)</i>	Quality, Resilience, Productivity & Workforce		
Critical Success Factors <i>(see key)</i>	CSF1, CSF2, CSF6, CSF7, CSF9		
Principal Risks <i>(please enter applicable BAF references – eg 1.1, 1.6)</i>			
Assurance Level <i>(shown on BAF)</i>	<input type="checkbox"/> Red	<input type="checkbox"/> Amber	<input type="checkbox"/> Green
Legal implications, regulatory and consultation requirements	None		
Date: Wednesday 3rd December 2014			
Completed by: Iain Hendey, Deputy Director of Performance Information and Decision Support			

Isle of Wight NHS Trust Board Performance Report 2014/15


October 14

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

GRR ref	Safe		Area	Annual Target	Actual Performance	YTD	Month Trend	Sparkline / Forecast
	Patients that develop a grade 4 pressure ulcer		TW	12	3	Oct-14	19	 
	Reduction across all grades of pressure ulcers (25% on 2013/14 Acute baseline, 50% Community)		TW	203	37	Oct-14	206	 
	VTE (Assessment for risk of)		AC	>95%	100%	Oct-14	99.8%	 
	MRSA (confirmed MRSA bacteraemia)		AC	0	0	Oct-14	0	 
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)		AC	6	0	Oct-14	6	 
	Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)		TW	48	3	Oct-14	35	 
	Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)		TW	9	0	Oct-14	0	 
	Falls - resulting in significant injury		TW	7	0	Oct-14	3	 
	Responsive		Area	Annual Target	Actual Performance	YTD	Month Trend	Sparkline / Forecast
1	RTT:% of admitted patients who waited 18 weeks or less - IoW CCG		AC	90%	82%	Oct-14	87%	 
2	RTT: % of non-admitted patients who waited 18 weeks or less - IoW CCG		AC	95%	94%	Oct-14	93%	 
3	RTT % of incomplete pathways within 18 weeks - IoW CCG		AC	92%	95%	Oct-14	94%	 
	RTT:% of admitted patients who waited 18 weeks or less - NHS England		AC	90%	77%	Oct-14	87%	 
	RTT: % of non-admitted patients who waited 18 weeks or less - NHS England		AC	95%	83%	Oct-14	76%	 
	RTT % of incomplete pathways within 18 weeks - NHS England		AC	92%	84%	Oct-14	89%	 
8b	Symptomatic Breast Referrals Seen <2 weeks*		AC	93%	98.7%	Oct-14	89.3%	 
6b	Cancer patients seen <14 days after urgent GP referral*		AC	93%	97.2%	Oct-14	95.3%	 
6a	Cancer Patients receiving subsequent Chemo/Drug <31 days*		AC	98%	100%	Oct-14	100%	 
5a	Cancer Patients receiving subsequent surgery <31 days*		AC	94%	100%	Oct-14	98%	 
	Cancer diagnosis to treatment <31 days*		AC	96%	100.0%	Oct-14	98.7%	 
7	Cancer Patients treated after screening referral <62 days*		AC	90%	100%	Oct-14	90.3%	 
5b	Cancer Patients treated after consultant upgrade <62 days*		AC	85%	No Patients	Oct-14	100%	 
8a	Cancer urgent referral to treatment <62 days*		AC	85%	86.2%	Oct-14	86.6%	 
	No. Patients waiting > 6 weeks for diagnostics		AC	<100	3	Oct-14	11	 
	% . Patients waiting > 6 weeks for diagnostics		AC	<1%	0.2%	Oct-14	0.1%	 
4	Emergency Care 4 hour Standards		AC	95%	94%	Oct-14	96%	 
12	Ambulance Category A Calls % < 8 minutes		AM	75%	76%	Oct-14	76%	 
13	Ambulance Category A Calls % < 19 minutes		AM	95%	98%	Oct-14	96%	 
9a	% of CPA patients receiving FU contact within 7 days of discharge		MH	95%	100%	Oct-14	97%	 
9b	% of CPA patients having formal review within last 12 months		MH	95%	99.0%	Oct-14	N/A	
10	% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)		MH	95%	100%	Oct-14	100%	

*Cancer figures for October are provisional.

Effective		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast	
Summary Hospital-level Mortality Indicator (SHMI) Apr-13 - Mar-14		TW	1	1.066	Published Oct 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%	88%	Oct-14	92%	↘		
High risk TIA fully investigated & treated within 24 hours (National 60%)		CM	60%	71%	Oct-14	68%	↘		
Cancelled operations on/after day of admission (not rebooked within 28 days)		AC	0	6	Oct-14	13	↘		
Delayed Transfer of Care (lost bed days)		TW	N/A	176	Oct-14	980	↘		
Number of Ambulance Handover Delays between 1-2 hours		AM	N/A	4	Oct-14	34	↗		
Theatre utilisation		AC	83%	81%	Oct-14	79%	↗		
Well-Led			Area	In Month Target	Actual Performance		YTD Target	YTD Actual	Month Trend
Total workforce SIP (FTEs)		TW	2629	2,645.9	Oct-14	N/A	N/A		↘
Total pay costs (inc flexible working) (£000)		TW	£9,677	£9,892	Oct-14	£67,697	£68,164		↗
Variable Hours (FTE)		TW	136.7	149.0	Oct-14	961.5	1000.3		↗
Variable Hours (£000)		TW	£29	£778	Oct-14	£244	£4,619		↘
Staff sickness absences		TW	3%	4.44%	Oct-14	3%	3.81%		↗
Staff Turnover		TW	5%	0.52%	Oct-14	5%	4.80%		↘
Achievement of financial plan		TW	N/A	N/A	Oct-14	£1.7m	£1,494		↘
Underlying performance		TW	N/A	N/A	Oct-14	-£0.23m	(£2,713)		↔
Net return after financing		TW	N/A	N/A	Oct-14	0.50%	0.64%		↗
I&E surplus margin net of dividend		TW	N/A	N/A	Oct-14	=>1%	2.27%		↗
Liquidity ratio days		TW	N/A	N/A	Oct-14	=>0	5		↗
Continuity of Service Risk Rating		TW	N/A	N/A	Oct-14	3	4		↔
Capital Expenditure as a % of YTD plan		TW	N/A	N/A	Oct-14	=>75%	31%		↗
Quarter end cash balance (days of operating expenses)		TW	N/A	N/A	Oct-14	=>10	17		↔
Debtors over 90 days as a % of total debtor balance		TW	N/A	N/A	Oct-14	=<5%	4.02%		↗
Creditors over 90 days as a % of total creditor balance		TW	N/A	N/A	Oct-14	=<5%	0.4%		↗
Recurring CIP savings achieved		TW	N/A	N/A	Oct-14	100%	84.0%		↗
Total CIP savings achieved		TW	N/A	N/A	Oct-14	100%	119%		↗

Caring		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Patient Satisfaction (Friends & Family test - Total Inpatient response rate)			AC	30%	41%	Oct-14	37%	↗
Patient Satisfaction (Friends & Family test - A&E response rate)			AC	20%	18%	Oct-14	16%	↗
Mixed Sex Accommodation Breaches			TW	0	4	Oct-14	4	↘
Formal Complaints			TW	<175	21	Oct-14	114	↘
Compliments received			TW	N/A	188	Oct-14	2,049	↘

Notes

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

Key to Area Code

TW = Trust Wide

AC = Acute

AM = Ambulance

CM = Community Healthcare

MH = Mental Health

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

<p>Safe:</p> <p>Pressure ulcers: We continue to under achieve our planned local reduction across all grades of pressure ulcers, both in the hospital setting and the wider community. A public awareness campaign is continuing to highlight prevention within the wider community and encourage regular mobilisation for those at risk.</p> <p>C.diff: We had 1 additional case during September and have now reached our full year target of 6.</p>	
<p>Responsive:</p> <p>Admitted and non admitted RTT Indicators were below target in October, with a number of specialties not achieving target bringing the overall Trust performance to 81.58% for Admitted (both IoW CCG and NHS England), and 93.92% for Non-Admitted. Validation of pathways continues and extra resource is still being implemented to increase capacity at Inpatient Level.</p> <p>Ambulance Red 1 and Red 2 calls response time <8 minutes - achieving all targets during October; The staff shortage has been addressed. Additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall.</p> <p>A&E Emergency care 4 hours standard was below target during October due to the increased pressure on community bed availability. Increased efforts and focus throughout November will continue.</p>	<p>Well Led:</p> <p>Total paybill exceeds budgeted expenditure in month by £214k in month and £467k year to date. The number of FTEs in post including variable FTEs (2,723) is currently below plan by 43 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.</p> <p>Sickness absence has decreased from 4.55% to 4.44% during October but remains above the 3% plan. Anxiety/Stress/Depression related sickness absence falls significantly in month but is offset by an increase in cold & flu, and chest & respiratory related sickness absence.</p> <p>The Trust planned for a surplus of £506k in October, after adjustments made for normalising items. The reported position is a surplus of £410k in the month, an adverse variance of £96k. The cumulative Trust plan was to deliver a surplus of £1.594m, after normalising items. The actual position is a cumulative surplus of £1.495m, an adverse variance of £99k. This position has £1.7m of forward banking of efficiencies recognised to the end of month 7. The Trusts planned forecast out-turn surplus remains at £1.7m but the current directorate performances continues to increase the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.</p>
<p>Caring:</p> <p>Complaints number has increased since September and it is slightly higher than in April 2014.</p> <p>Compliments, in the form of letters and cards of thanks, were lower during October than in September.</p> <p>The Friends & Family Test response rate continues to be challenging and work is ongoing to improve access.</p> <p>Mixed Sex Accommodation: there were 4 breaches during October due to extreme bed pressures partly due to the upgrading of MAAU reducing the numbers of beds available and partly due to an increase in attendance/admissions through the emergency department.</p>	<p>Effective:</p> <p>Theatre Utilisation has improved for Day surgery Unit (84.8%) but decreased for Main Theatres (77.8%) giving a joint rate of 80.8% in October. Delays continue to be experienced in theatres due to ongoing bed pressures delaying the start of theatre lists, with cancellations due to lack of beds also impacting on overall utilisation</p>

Isle of Wight NHS Trust Board Performance Report 2014/15

October 14

Performance Summary - Hospital

Balanced Scorecard - Hospital										
Safe		Latest data	In month		YTD		Sparkline / Forecast			
			Target	Actual	Target	Actual				
No. of Grade 1&2 Pressure Ulcers developing in hospital		Oct-14		11		56				
No. of Grade 3&4 Pressure Ulcers developing in hospital		Oct-14		1		14				
VTE		Oct-14	95%	99.9%	95%	99.8%				
MRSA		Oct-14	0	0	0	0				
C.Diff		Oct-14		0	4	4				
No. of Reported SIRI's		Oct-14		10		25				
Physical Assaults against staff		Oct-14		3						
Verbal abuse/threats against staff		Oct-14		49						

Effective		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
Delayed Transfers of Care (lost bed days)		Oct-14	N/A	176	N/A	980	
Cancelled operations on/after day of admission (not rebooked within 28 days)		Oct-14	0	6	0	13	

Responsive*		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
Emergency Care 4 hour Standards		Oct-14	95%	94.2%	95%	95.6%	
RTT Admitted - % within 18 Weeks		Oct-14	90%	82.1%	90%	87.3%	
RTT Non Admitted - % within 18 Weeks		Oct-14	95%	93.3%	95%	93.0%	
RTT Incomplete - % within 18 Weeks		Oct-14	92%	95.3%	92%	93.1%	
No. Patients waiting > 6 weeks for diagnostics		Oct-14	< 8	3	100	11	
% Patients waiting > 6 weeks for diagnostics		Oct-14	1%	0.21%	1%	0.12%	
Cancer 2 wk GP referral to 1st OP		Oct-14	93%	97.2%	93%	95.3%	
Breast Symptoms 2 wk GP referral to 1st OP		Oct-14	93%	98.7%	93%	89.3%	
31 day second or subsequent (surgery)		Oct-14	94%	100%	94%	98%	
31 day second or subsequent (drug)		Oct-14	98%	100%	98%	100%	
31 day diagnosis to treatment for all cancers		Oct-14	96%	100%	96%	99%	
62 day referral to treatment from screening		Oct-14	90%	100%	90%	90%	
62 days urgent referral to treatment of all cancers		Oct-14	85%	86.2%	85%	86.6%	
Emergency 30 day Readmissions		Oct-14		5.2%		5.0%	

Well-Led		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
% Sickness Absenteeism		Oct-14	3%	4.71%	3%	3.66%	
Appraisals		Oct-14		3.7%		41.7%	

Caring		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
FFT Hospital - % Response Rate		Oct-14	30%	39.8%	30%	37.1%	
FFT Hospital - % Recommending		Oct-14	95%	95.3%	95%	96.4%	
FFT A&E - % Response Rate		Oct-14	20%	17.7%	20%	16.2%	
FFT A&E - % Recommending		Oct-14	95%	90.7%	95%	91.2%	
Mixed Sex Accommodation Breaches		Oct-14	0	4	0	4	
No. of Complaints		Oct-14		15		83	
No. of Concerns		Oct-14		59		407	
No. of Compliments		Oct-14	N/A	90	N/A	1310	

Contracted Activity**		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
Emergency Spells		Sep-14	1,094	1,081	6,782	6,457	
Elective Spells		Sep-14	698	702	3,996	3,762	
Outpatients Attendances		Sep-14	10,143	10,617	58,115	58,824	

**Cancer figures for October 2014 are provisional*

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

Emergency Care 4hr standard - The 95% target for October was again missed due to the increased pressure on community bed availability. Despite action plans being followed the increase in attendances at the Emergency department created a situation whereby towards the end of the month the target was not achievable.

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

Cancelled operations – 4 cancellations were unfortunately due to bed pressures; all cancellations are audited and lesson learnt implemented on a regular basis.

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

Friends and Family Test – The response rate has more than doubled for October (from 8.6% in Sept 14) as tablets starts to have a positive impact; this remains the focus within the Directorate until we can be sure the changes are embedded. The % recommending has increased (from 82% in Sept 14) but continues to be influenced by the new triage system; this is being addressed in plans going forward to redesign the area.

Mixed sex accommodation breaches - During October we experienced the first Mixed Sex Accommodation breach since June 2012. This occurred in a bay (involving 4 people) on CCU to accommodate a patient's wellbeing; RCA being undertaken.

*Cancer figures for October 2014 are provisional







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

Isle of Wight NHS Trust Board Performance Report 2014/15

October 14

Performance Summary - Community

Balanced Scorecard - Community

Safe 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
No. of Grade 1&2 Pressure Ulcers developing in the community	Oct-14		18		106	
No. of Grade 3&4 Pressure Ulcers developing in the community	Oct-14		7		30	
MRSA	Oct-14	0	0	0	0	
C.Diff	Oct-14		0	2	2	
No. of Reported SRI's	Oct-14		10		40	
Physical Assaults against staff	Oct-14		1			
Verbal abuse/threats against staff	Oct-14		3			

Responsive 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Routine Waiting times	Sep-14		94.3%		9560%	

Contracted Activity	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Community Contacts	Sep-14	16,515	20,093	98,970	109,139	
Health Visitors	Sep-14	2,899	1,646	17,394	16,820	
Sexual Health	Sep-14	855	1,068	5,130	5,590	

Safe - No new MRSA or Cdiff cases in October 2014. Number of reported SIRIs reduces once review has taken place. SIRIs reported may not be attributable to the Directorate.




Responsive - As the Directorate has many diverse services we have given a percentage of patients waiting over the target. Those services regularly breaching targets are monitored with our Commissioners on a monthly basis. 96% of new routine patients have been seen within the service target time.


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







Effective - Stroke markers continue to be maintained and performing above target.

Well Led - The October 2014 sickness rate has increased from 3.60% in September 2014 to 3.76% in October 2014. Percentages are due to long term sickness within the Stroke Unit and Community Nursing which is being closely managed via Occupational Health and HR processes.

Caring - Please note that FFT figures are directorate wide figures and are not split between Community and Mental Health. The Directorate is working to improve its recommending percentage.

Effective 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Stroke patients (90% of stay on Stroke Unit)	Oct-14	80%	87.5%	80%	91.8%	
High risk TIA fully investigated & treated within 24 hours (National 60%)	Oct-14	60%	71.4%	60%	67.6%	


Well-Led 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
% Sickness Absenteeism - C Directorate	Oct-14	3%	3.76%	3%	3.98%	
Appraisals	Oct-14		1.3%		81.5%	







Caring 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
FFT - % Response Rate	Oct-14	30%	46.2%	30%	36.7%	
FFT - % Recommending	Oct-14	95%	88.4%	95%	90.5%	
No. of Complaints	Oct-14		5		17	
No. of Concerns	Oct-14		8		57	
No. of Compliments	Oct-14	N/A	85	N/A	593	



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Performance Summary - Mental Health





Safe		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
Physical Assaults against staff		Oct-14		4			
Verbal abuse/threats against staff		Oct-14		7			

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

Activity	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Mental Health Inpatient Activity	Oct-14	N/A	42	N/A	309	
Mental Health Outpatient Activity	Oct-14	N/A	647	N/A	3,743	

Effective		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
IAPT – Proportion of people who have completed treatment and moving to recovery		Sep-14	50%	41%	50%	43%	
New Cases of Psychosis by Early Intervention Team		Oct-14	2	3	11	25	

Well-Led		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
% Sickness Absenteeism		Oct-14	3%	5.48%	3%	4.67%	
Appraisals		Oct-14		1.0%		63.9%	

Caring		Latest data	In month		YTD		Sparkline / Forecast
			Target	Actual	Target	Actual	
No. of Complaints		Oct-14		1		13	
No. of Concerns		Oct-14		2		22	
No. of Compliments		Oct-14	N/A	9	N/A	102	

Mental Health RTT

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

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

Older Persons Mental Health – All new patients referred to Memory Service are seen in Consultant-led out-patient clinic for assessment, diagnosis and treatment if appropriate. 18 weeks pathway implemented for all new referrals. Unfortunately due to difficulties earlier in the year with securing consistent locum Consultant cover service capacity was reduced and waiting times increased. A number of patients cancelled their first appointments and it was not possible to rebook these within the 18 week period. The Memory Service now has permanent consultant cover and is working to address long waiting times and avoid future breaches.

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

Safe - Incidence of physical/verbal assault monitored on a monthly basis through the Quality Meetings and any identified trends investigated.

Responsive - MHLd overachieving against KPIs.

Activity - Mental Health/Learning Disabilities is currently funded on a block contract. We are in the process of working towards payment by results (PBR) and cluster based activity.

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

Effective - IAPT - Proportion of people who have completed treatment and moving to recovery is under target. This is being monitored closely. New Cases of Psychosis by Early Intervention Team is out performing target.


Caring - Complaints and concerns monitored closely and lessons learned shared through the MH Quality Group.



Isle of Wight NHS Trust Board Performance Report 2014/15














October 14


Performance Summary - Ambulance and 111





Balanced Scorecard - Ambulance & 111

Safe 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Physical Assaults against staff						
Verbal abuse/threats against staff	Oct-14		1			

Effective 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Number of Ambulance Handover Delays between 1-2 hours	Oct-14		4		34	





Responsive 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Category A 8 Minute Response Time (Red 1)	Oct-14	75%	80.5%	75%	81.7%	
Category A 8 Minute Response Time (Red 2)	Oct-14	75%	75.9%	75%	75.4%	
Category A 19 Minute Response Time	Oct-14	95%	97.5%	95%	96.4%	
Ambulance re-contact rate following discharge from care by telephone	Oct-14	3%	3.0%	3%	4.6%	
Ambulance re-contact rate following discharge from care at scene	Oct-14	2%	2.9%	2%	3.7%	
Ambulance time to answer call (in seconds) - median	Oct-14	1	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 95th percentile	Oct-14	5	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 99th percentile	Oct-14	14	6	N/A	N/A	
NHS 111 Call abandoned rate	Oct-14	5%	1.6%	5%	2.1%	
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	Oct-14	95%	97.0%	95%	96.4%	
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	Oct-14	95%	98.5%	95%	97.5%	
NHS 111 Where the above is not achieved callers should be called back within 10 mins	Oct-14	100%	30.0%	100%	44.2%	

Well-Led 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
% Sickness Absenteeism	Oct-14	3%	5.22%	3%	5.53%	
Appraisals	Oct-14		0.6%		53.5%	

Caring 	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
No. of Complaints	Oct-14		0		1	
No. of Concerns	Oct-14		6		17	
No. of Compliments	Oct-14	N/A	4	N/A	44	

The Ambulance Service has been able maintain its performance for October results by achieving all three categories required; Red 1 (75%) achieved 80.5%, Red 2 (75%) achieved 75.9% and 19 Min (95%) achieved 97.5%. This has been due to the shortage of staff being addressed, additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall. The area of sickness is still of concern and extra focus is now on the management of sickness over the winter period





Our NHS 111 service has also seen a return to its usual achievement targets by showing a return of 97% on call answering and 98.5% on warm transfers to a clinician. The call back within 10 min is always challenging due to the small volume of calls.

Contracted Activity	Latest data	In month		YTD		Sparkline / Forecast
		Target	Actual	Target	Actual	
Calls Answered	Sep-14	1,928	2,219	12,992	14,404	
Hear & Treat / Refer	Sep-14	309	400	2,083	2,284	
See & Treat / Refer	Sep-14	453	480	3,053	3,109	
See, Treat and Convey	Sep-14	1,053	1,102	7,095	7,137	

Highlights

- Ambulance Red 1 and Red 2 calls response time <8 minutes above target
- 90% of stay on Stroke Unit and High risk TIA fully investigated & treated within 24 hours above target
- MRSA maintained at 0

Lowlights

-  Clostridium Difficile (C.Diff) - now level with the national threshold (6) for the whole year
-  Referral ToTreatment Time for Admitted and Non-Admitted remain below target
-  Staff sickness remains above plan
-  Theatre Utilisation below target

Commentary:

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

Hospital acquired:During October there was an overall decrease in reported pressure ulcers in the hospital setting. Taking this in the context of the bed pressures during the month it demonstrates a greater improvement in recognition and prevention than is evident at first glance. The Tissue Viability Nurse continues to support ward staff with recognition and management of patients at risk.

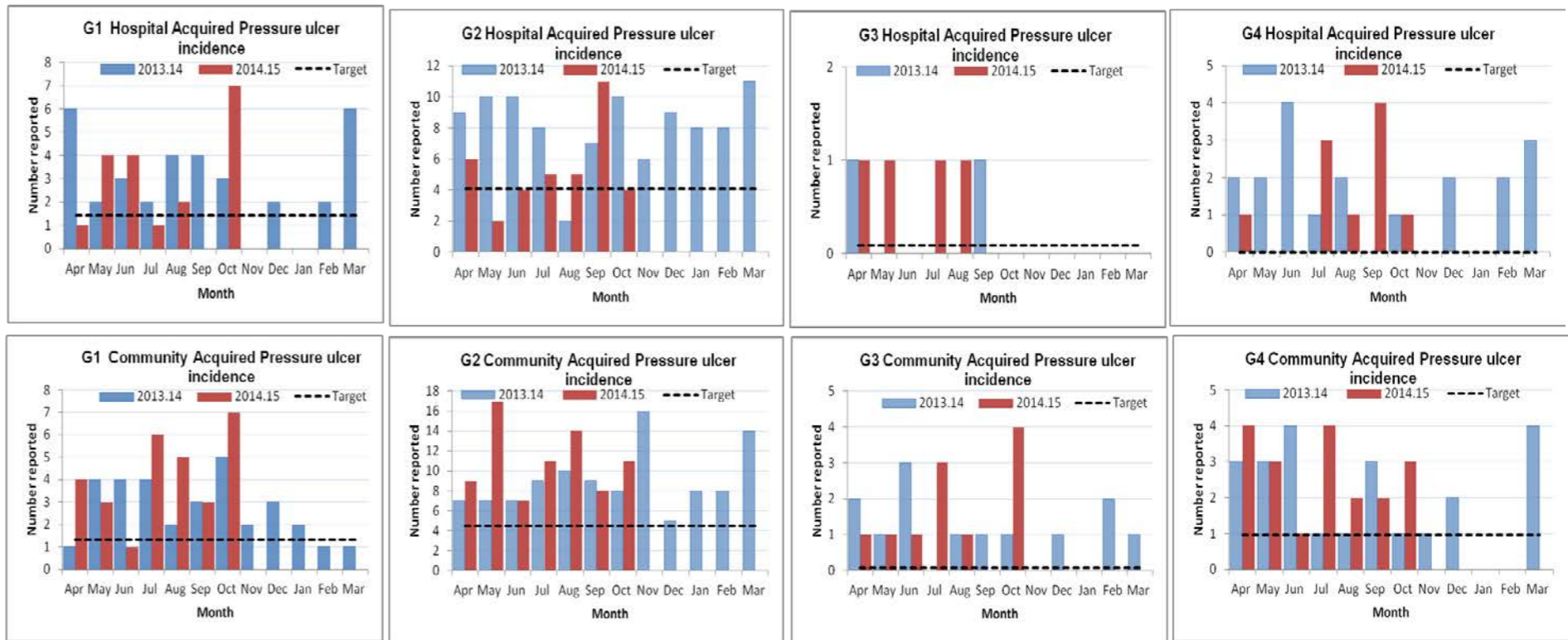
Community acquired:Incidence of pressure ulcer development continues to cause concern and remain challenging with District Nurses experiencing increasing caseloads within the community. Although the numbers are higher this month, overall incidence as a percentage of the number of contacts over the month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

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

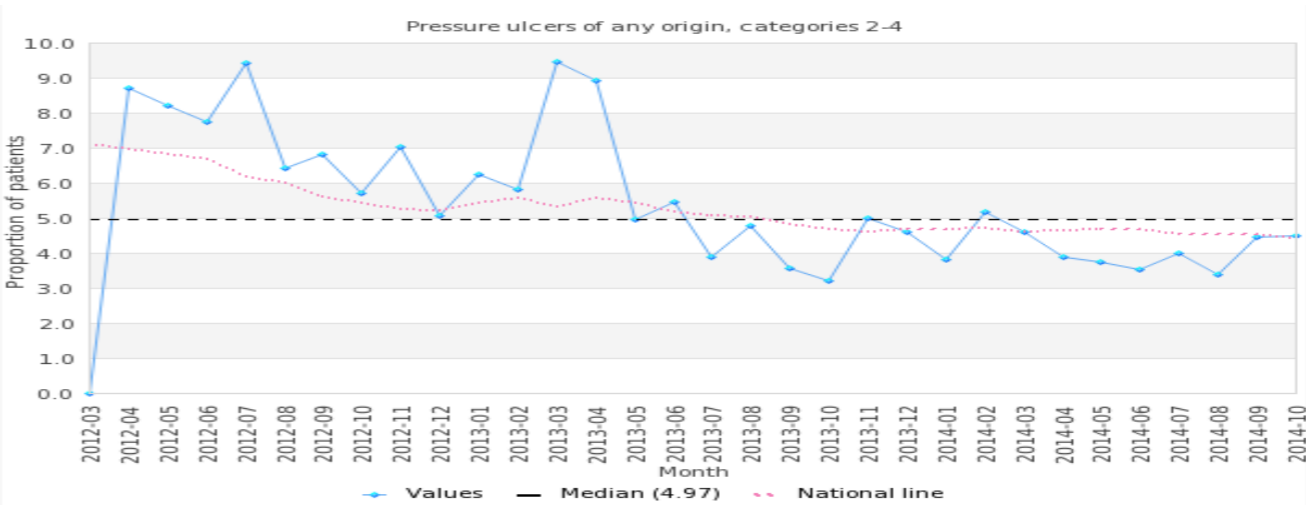
Explanation of RAG Rating

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

Analysis:



Pressure Ulcers benchmark



The graph shows improving trend. In October the Trust has been in line with the national average.

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

Commentary:

Clostridium difficile

There have been no further cases of Healthcare acquired Clostridium Difficile identified in the Trust during October. We have exceeded our local stretched target and are now level with the national threshold for the whole year.

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

Methicillin-resistant Staphylococcus Aureus (MRSA)

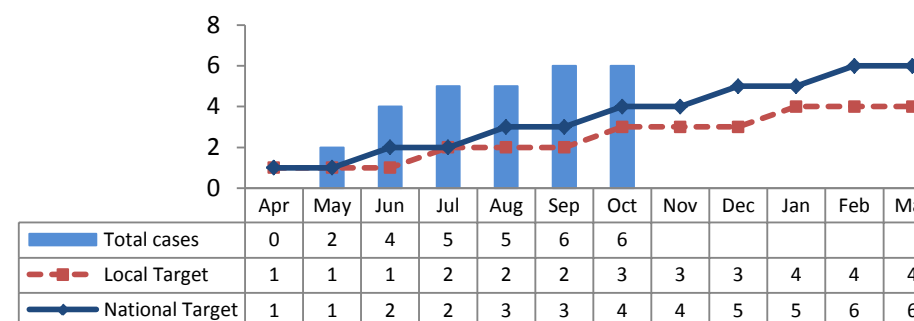
There have been no cases of Healthcare Acquired MRSA bacteraemia in the Acute hospital during September and we remain at zero, in keeping with the zero tolerance set for this year.

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

Analysis:

Clostridium Difficile infections against national and local targets

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



Isle of Wight NHS Trust

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

Action Plan:

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

Commentary:

There were 21 formal Trust complaints received in October 2014 (16 in the previous month) against approximately 71,000 patient contacts (Inpatient episodes, all outpatient, A&E attendances and community and Mental Health contacts), with 189 compliments received by letters and cards of thanks across the same period.

Across all complaints and concerns in October 2014:

Top areas complained about were:

- Outpatient appointments/records unit (14)
- General Surgery (7)
- Emergency Department (6)
- Ambulance Service (6)
- Rheumatology (5)

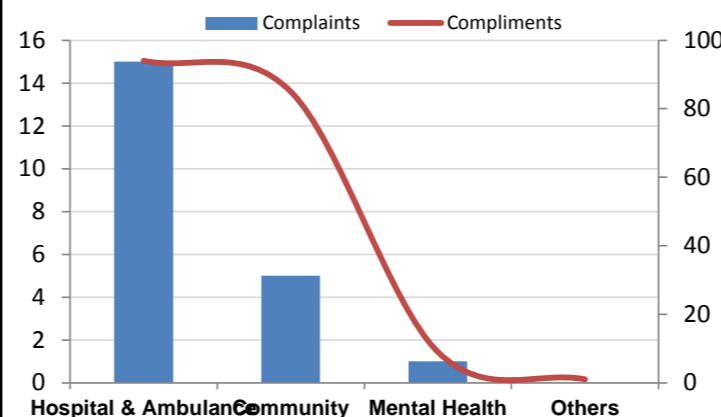
Across all complaints and concerns in October 2014:

Top 5 subjects complained about were:

- Clinical care (31)
- Out-patient appointment delay/cancellation (11)
- Communication (15)
- In-patient appointment delay/cancellation (8)
- Nursing Care (14)

Analysis: Complaints only

Compliments and Complaints by Directorate October 14



Primary Subject	Sep-14	Oct-14	CHANGE	RAG rating
Clinical Care	9	14	5	↑
Nursing Care	3	4	1	↑
Staff Attitude	1	0	-1	✓
Communication	1	0	-1	✓
Outpatient Appointment Delay/ Cancellation	1	1	0	→
Inpatient Appointment Delay / Cancellation	1	0	-1	✓
Admission / Discharge / Transfer Arrangements	0	0	0	✓
Aids and appliances, equipment and premises	0	0	0	✓
Transport	0	0	0	✓
Consent to treatment	0	0	0	✓
Failure to follow agreed procedure	0	0	0	✓
Hotel services (including food)	0	0	0	✓
Patients status/discrimination (e.g. racial, sex)	0	1	1	↑
Privacy & Dignity	0	0	0	✓
Other	0	1	1	↑

Action Plan:

Following relocation and re launching of the Patient Advice and Liaison Service work has been completed to improve office area in respect of sound proofing and lighting. Patient Experience Officers returned to the office on 17 October 2014.

Person Responsible:

Executive Director of Nursing & Workforce /
Business Manager - Patient Safety; Experience &
Clinical Effectiveness

Date:

Oct-14

Status:

Complete

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October 14

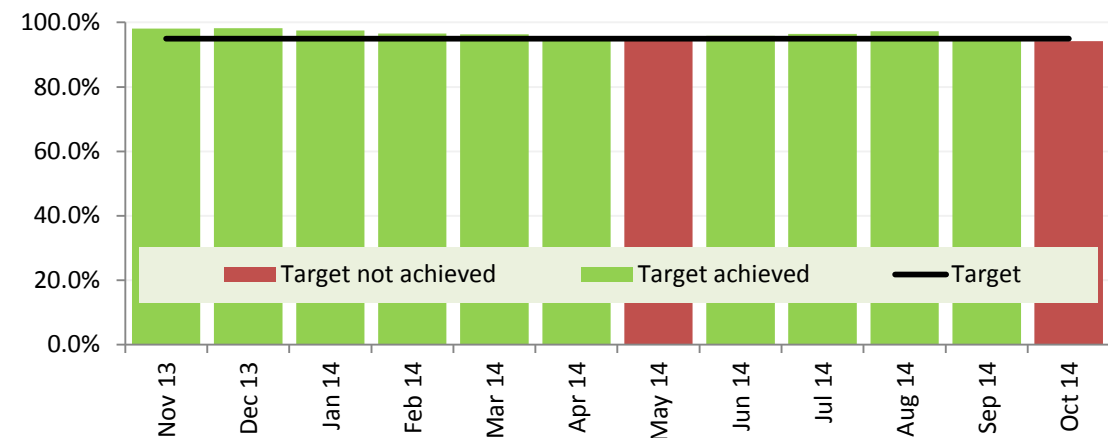
A&E Performance - Emergency Care 4 hours Standard

Commentary:

Although there have been failures to meet the target on individual days over past months, this is the first month where the target of 95% has not been achieved overall (94.2%) since May 2014.
The 95% target for October was again missed due to the increased pressure on community bed availability. Despite action plans being followed the increase in attendances at the Emergency department created a situation whereby towards the end of the month the target was lost. Increased efforts and focus throughout November will continue.

Analysis:

Emergency Care 4 hours Standard



Action Plan:

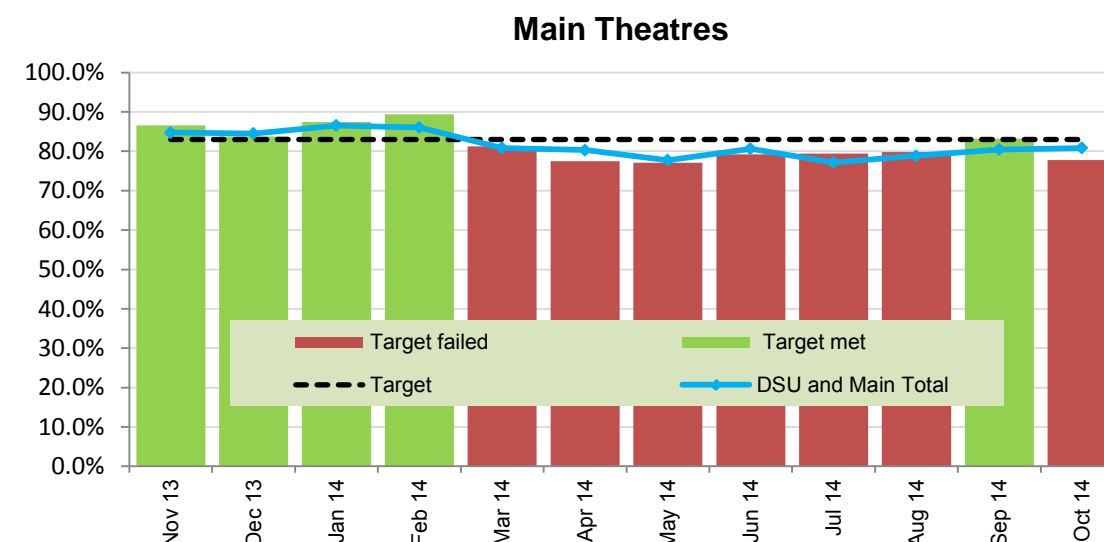
Action Plan:	Person Responsible:	Date:	Status:
Increase focus on local authority bed situation	Exec on call	Nov-14	Ongoing
Daily focus on bed states	Matrons	Nov-14	Ongoing

Commentary

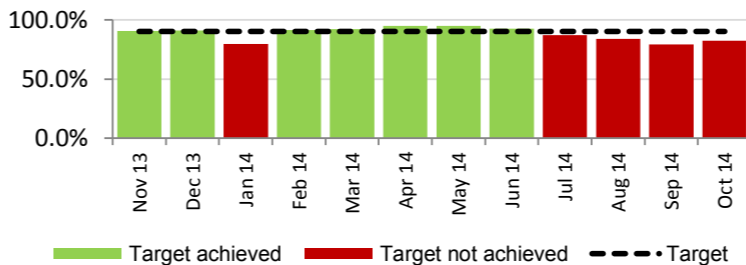
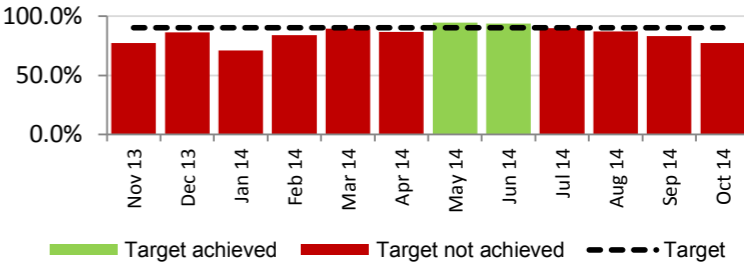

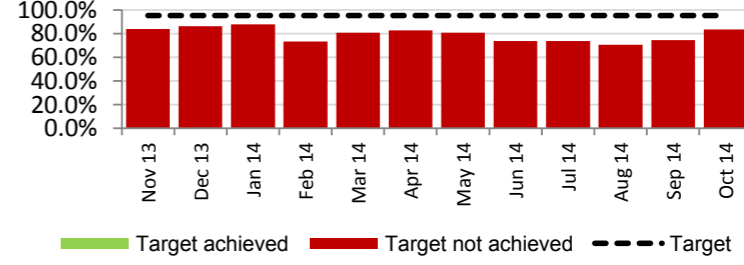
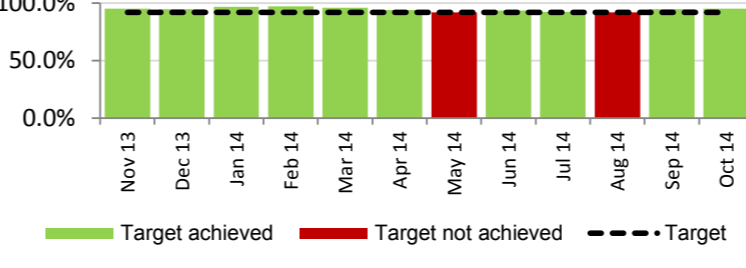
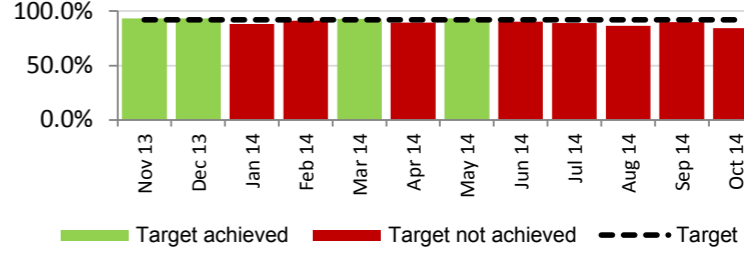
The percentage utilisation of theatre facilities has decreased below the 83% target for Main Theatres (77.8%). Day Surgery Unit utilisation has increased during October 2014 (84.8%). Overall we have achieved 80.8%.

Delays continue to be experienced in theatres due to ongoing bed pressures delaying the start of theatre lists, with cancellations due to lack of beds also impacting on overall utilisation. Booking, particularly for orthopaedics has improved with additional support within the team to reduce impact of any non clinical reasons for cancellations.

Analysis:



Action plan	Person Responsible:	Date:	Status:
1) Review of Pre-Assessment Unit staffing levels - increased senior support to area planned for October 2) Speciality based action plans developed by each general manager to review 18 weeks activity - ongoing through into November to monitor RTT	General manager- Planned Directorate	Oct / Nov-14	Ongoing
Ongoing discussion on review of bed capacity for elective surgery. No identified changes to estates plan due to schedule risks. Ongoing monitor of inpatient delays for discharge with significant incident/bed management meetings - continuing through October/November. Bed capacity action plan with earlier implementation of St Helens to old Newchurch ward and community beds are being taken forward to ease bed pressures overall.	General manager- Planned Directorate	Oct / Nov-14	Ongoing

<p>Commentary:</p> <p>Admitted and non-admitted targets continue to under perform as planned due to current national funding scheme for Trusts to undertake additional activity to reduce waiting lists, in particular those patients waiting longer than 18wks.</p> <p>The admitted performance for October has increased slightly from 79.64% last month to 81.58% this month. The non admitted performance has increased from 92.19% last month to 93.89% in October. The focus on treating breaching patients has had the expected impact on the percentages as specialties work to improve their 18 week position.</p> <p>The plan for delivering baseline activity plus additional in October was achieved to contribute towards the planned reduction of our waiting lists to 18wks by the end of November. Planning work has been taking place to maintain this performance sustainably from December onwards.</p> <p>Validation of pathways continues and extra resource is being implemented to increase capacity at admitted level. The data quality issues highlighted by the forecasting tools developed by Performance Information & Decision Support (PIDS) continue to be addressed.</p>	<p>Analysis:</p> <div><div><p>RTT Admitted IoW CCG</p></div><div><p>RTT Admitted NHS England</p></div><div><p>RTT Non Admitted IoW CCG</p></div><div><p>RTT Non Admitted NHS England</p></div><div><p>RTT Incomplete IoW CCG</p></div><div><p>RTT Incomplete NHS England</p></div></div>			
		Person Responsible:	Date:	Status:
	Further development of forecasting tools to match demand and capacity and highlight further data quality issues. This is an ongoing development but is already successful in some areas.	Senior Information Analyst (PIDS)	Nov-14	In progress
	Engagement with clinicians to ensure that accurate data is communicated to administrators for data capture through revision of Referral to Treatment coding forms. Implemented and in trial period. Certain areas have been identified as needing support in this area.	OPARU Lead/ Clinical Leads	Nov-14	In progress
Additional capacity for non admitted & admitted patients will be put in place to reduced patients waiting over 16 weeks funded via additional CCG Referral To Treatment monies which has been made available nationally. Ongoing.	Access Lead & General Managers	Nov-14	Planned	
Referral To Treatment times awareness session with Portsmouth Hospital Trust and General Managers. Ongoing	Access Lead & General Managers	Nov-14	In progress	
Development of robust processes and documentation to enable training and awareness of 18 week procedures.	Information Systems Manager & Access Lead	Dec-14	Planned	

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Mixed Sex Accommodation

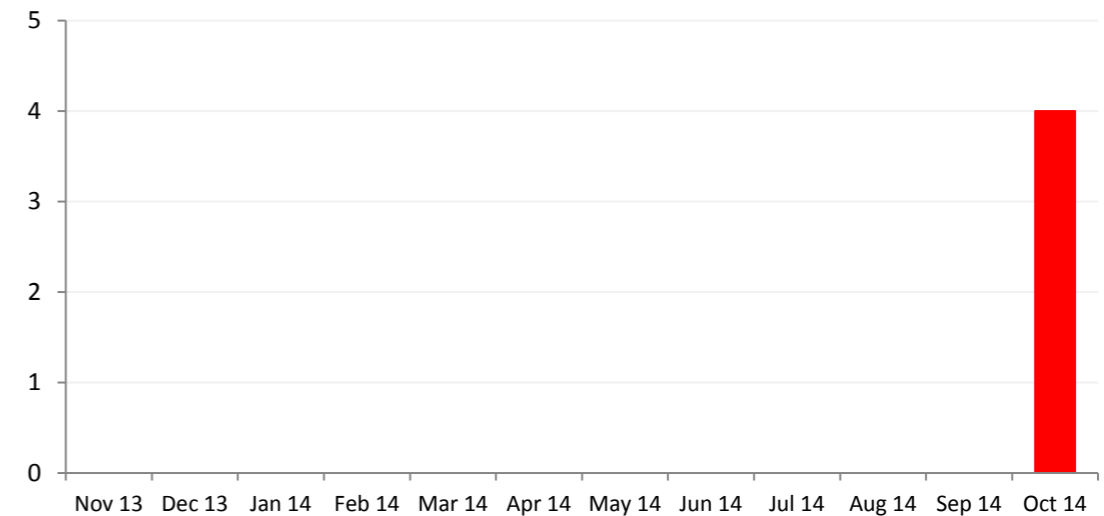
Commentary:

During October we experienced the first Mixed Sex Accommodation breach since June 2012.

The hospital has been experiencing extreme bed pressures partly due to the upgrading of MAAU reducing the numbers of beds available and partly due to an increase in attendance/admissions through the emergency department. The incident that occurred involved the placement of a single non-cardiology patient on CCU, an area that is classified as a mixed sex area for care, but which had the only available beds in the hospital at the time. Although it was a single medical patient, the Mixed Sex Accommodation breach affected all the patients on the ward at the time, resulting in the reported number of breaches as 4.

Analysis:

Mixed Sex Accommodation



Action Plan:

Action Plan:	Person Responsible:	Date:	Status:
Root cause analysis and review has been completed	Director of Nursing & Workforce	Oct-14	Completed
Recommendations are being drafted for future planning	Director of Nursing & Workforce	Nov-14	In progress
Reconfiguration and upgrade to MAAU area on ground floor is continuing as planned	Director of Nursing & Workforce	Nov-14	In progress

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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%	79%	95.0%	96.4%	54 / 174	Better than national average	Q2
RTT:% of admitted patients who waited 18 weeks or less	90%	100%	0%	87.2%	79.6%	153 / 166	Bottom Quartile	Sep-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	100%	21%	95.0%	92.2%	173 / 194	Amber Red	Sep-14
RTT % of incomplete pathways within 18 weeks	92%	100%	0%	93.2%	95.2%	94 / 192	Top Quartile	Sep-14
%. Patients waiting > 6 weeks for diagnostic	1%	0%	11%	1.5%	0.1%	50 / 184	Top Quartile	Sep-14
Ambulance Category A Calls % < 8 minutes - Red 1	75%	83%	62%	72.7%	81.8%	2 / 11	Top Quartile	Sep-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	77%	54%	70.0%	76.1%	3 / 11	Top Quartile	Sep-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	77%	54%	70.1%	76.4%	3 / 11	Top Quartile	Sep-14
Ambulance Category A Calls % < 19 minutes	95%	98%	90%	94.4%	98.2%	1 / 11	Top Quartile	Sep-14
Cancer patients seen <14 days after urgent GP referral	93%	100%	78%	93.6%	95.8%	50 / 156	Better than national average	Qtr 2 14/15
Cancer diagnosis to treatment <31 days	96%	100%	33%	97.7%	98.6%	82 / 162	Better than national average	Qtr 2 14/15
Cancer urgent referral to treatment <62 days	85%	100%	50%	80.5%	87.3%	56 / 157	Better than national average	Qtr 2 14/15
Symptomatic Breast Referrals Seen <2 weeks	93%	100%	46%	93.5%	91.7%	113 / 137	Bottom Quartile	Qtr 2 14/15
Cancer Patients receiving subsequent surgery <31 days	94%	100%	71%	96.0%	95.7%	113 / 154	Amber Red	Qtr 2 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	100%	93%	99.6%	100.0%	1 / 147	Top Quartile	Qtr 2 14/15
Cancer Patients treated after consultant upgrade <62 days	85%	100%	0%	89.8%	100.0%	1 / 151	Top Quartile	Qtr 2 14/15
Cancer Patients treated after screening referral <62 days	90%	100%	50%	94.0%	90.9%	106 / 141	Amber Red	Qtr 2 14/15

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

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

Commentary:

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

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

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

Other Small Acute Trusts	National Target	IW	RA3	RA4	RBD	RBT	RBZ	RC1	RC3	RCD	RCF	RCX	RD8	RE9	RFF	RFW	RGR	RJC	RJD	RJF	RJN	RLQ	RLT	RMP	RN7	RNQ	RNZ	RQQ	RQX	Data Period
Emergency Care 4 hour Standards	95%	96.4% ₉	91.3% ₂₆	95.7% ₁₃	96.6% ₈	95.0% ₁₉	97.3% ₃	94.5% ₂₀	96.3% ₁₀	97.8% ₂	96.0% ₁₂	93.6% ₂₃	93.7% ₂₂	98.1% ₁	97.0% ₅	96.9% ₇	95.1% ₁₈	97.1% ₄	84.0% ₂₈	96.2% ₁₁	95.3% ₁₇	86.9% ₂₇	94.1% ₂₁	93.2% ₂₅	95.5% ₁₄	96.9% ₆	95.4% ₁₅	93.6% ₂₄	95.4% ₁₆	Sep-14
RTT:% of admitted patients who waited 18 weeks or less	92%	79.6% ₂₇	91.4% ₁₅	87.9% ₂₁	84.4% ₂₄	94.3% ₃	93.9% ₄	90.1% ₁₆	80.7% ₂₅	93.7% ₈	86.2% ₂₂	87.9% ₂₀	92.0% ₁₃	98.6% ₁	93.9% ₆	93.2% ₁₁	91.9% ₁₄	88.6% ₁₈	93.6% ₉	88.4% ₁₉	84.4% ₂₃	79.7% ₂₆	89.5% ₁₇	76.2% ₂₈	93.4% ₁₀	93.1% ₁₂	95.8% ₂	93.9% ₅	93.7% ₇	Sep-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	92.2% ₂₈	97.4% ₁₀	97.0% ₁₆	97.4% ₁₁	95.6% ₂₅	97.5% ₈	97.0% ₁₄	94.6% ₂₇	96.7% ₁₉	96.4% ₂₁	96.7% ₁₈	96.0% ₂₃	98.6% ₂	97.4% ₉	96.7% ₂₀	97.9% ₆	95.9% ₂₄	96.9% ₁₇	98.1% ₅	97.0% ₁₅	98.5% ₃	97.0% ₁₃	95.1% ₂₆	97.7% ₇	96.3% ₂₂	98.2% ₄	98.7% ₁	97.1% ₁₂	Sep-14
RTT % of incomplete pathways within 18 weeks	92%	95.2% ₂₂	98.4% ₁	94.5% ₂₄	95.7% ₁₈	95.3% ₂₁	97.3% ₅	97.1% ₁₁	95.0% ₂₃	97.2% ₇	93.2% ₂₇	94.1% ₂₆	95.9% ₁₆	95.3% ₁₉	95.7% ₁₇	96.6% ₁₃	97.3% ₆	95.3% ₂₀	97.2% ₉	97.8% ₄	96.7% ₁₂	94.2% ₂₅	98.3% ₂	N/A	97.2% ₈	96.0% ₁₅	96.2% ₁₄	97.1% ₁₀	98.0% ₃	Sep-14
% Patients waiting > 6 weeks for diagnostic	1%	0.1% ₉	0.5% ₁₇	1.4% ₂₂	4.1% ₂₈	0.2% ₁₁	0.3% ₁₃	0.4% ₁₄	0.0% ₁	0.6% ₁₈	0.0% ₁	1.6% ₂₃	0.4% ₁₅	0.0% ₁	2.6% ₂₇	0.0% ₈	0.1% ₁₀	0.5% ₁₆	0.7% ₁₉	0.0% ₁	0.9% ₂₀	2.4% ₂₆	0.0% ₁	0.99% ₂₁	1.7% ₂₄	1.7% ₂₅	0.0% ₁	0.2% ₁₂	0.0% ₁	Sep-14
Cancer patients seen <14 days after urgent GP referral*	93%	95.8% ₁₂	98.2% ₂	93.2% ₂₄	96.4% ₉	95.5% ₁₆	79.1% ₂₈	89.1% ₂₇	94.3% ₁₉	98.2% ₃	97.6% ₅	97.4% ₆	93.9% ₂₃	95.9% ₁₁	93.1% ₂₅	93.9% ₂₂	96.9% ₇	94.2% ₂₀	96.0% ₁₀	95.5% ₁₅	98.2% ₁	92.8% ₂₆	94.2% ₂₁	96.8% ₈	95.5% ₁₇	95.7% ₁₃	95.0% ₁₈	98.0% ₄	95.6% ₁₄	Qtr 2 14/15
Cancer diagnosis to treatment <31 days*	96%	98.6% ₁₈	97.9% ₂₂	98.4% ₂₀	99.3% ₁₂	99.2% ₁₅	96.9% ₂₄	100.0% ₁	98.9% ₁₆	100.0% ₁	100.0% ₁	99.3% ₁₃	96.8% ₂₅	100.0% ₁	99.4% ₁₀	99.4% ₁₁	100.0% ₁	95.3% ₂₈	100.0% ₁	99.3% ₁₄	98.3% ₂₁	97.2% ₂₃	96.3% ₂₇	100.0% ₁	99.5% ₉	100.0% ₁	98.5% ₁₉	98.8% ₁₇	96.7% ₂₆	Qtr 2 14/15
Cancer urgent referral to treatment <62 days*	85%	87.3% ₁₃	78.9% ₂₆	91.3% ₇	84.0% ₂₂	93.6% ₃	75.5% ₂₈	90.3% ₉	85.3% ₁₉	90.9% ₈	95.2% ₁	84.9% ₂₀	84.2% ₂₁	86.0% ₁₇	87.7% ₁₂	78.7% ₂₇	87.1% ₁₄	82.5% ₂₃	89.4% ₁₀	86.1% ₁₆	92.8% ₄	80.5% ₂₅	81.9% ₂₄	94.8% ₂	88.0% ₁₁	86.1% ₁₅	92.5% ₅	91.6% ₆	86.0% ₁₈	Qtr 2 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	91.7% ₂₃	94.8% ₁₇	92.0% ₂₂	95.0% ₁₅	95.5% ₁₄	50.0% ₂₇	90.7% ₂₅	93.1% ₂₀	96.0% ₇	96.2% ₅	96.9% ₃	96.1% ₆	N/A	94.9% ₁₆	98.1% ₁	95.9% ₉	91.5% ₂₄	97.6% ₂	96.0% ₈	93.5% ₁₉	87.7% ₂₆	92.7% ₂₁	95.6% ₁₂	95.6% ₁₁	96.8% ₄	95.7% ₁₀	95.5% ₁₃	94.1% ₁₈	Qtr 2 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	95.7% ₂₆	97.0% ₂₅	97.2% ₂₃	98.4% ₂₀	100.0% ₁	94.1% ₂₇	100.0% ₁	100.0% ₁	97.4% ₂₂	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	97.1% ₂₄	100.0% ₁	100.0% ₁	97.9% ₂₁	100.0% ₁	94.1% ₂₇	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 2 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	100.0% ₁	94.4% 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	Qtr 2 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	100.0% ₁	83.3% ₂₄	92.7% ₁₇	100.0% ₁	87.9% ₂₂	76.6% ₂₅	95.9% ₁₂	92.2% ₁₉	66.7% ₂₆	92.9% ₁₆	100.0% ₁	100.0% ₁	N/A	89.3% ₂₁	95.2% ₁₄	100.0% ₁	96.3% ₁₁	97.6% ₁₀	57.1% ₂₇	87.5% ₂₃	94.4% ₁₅	100.0% ₁	90.2% ₂₀	100.0% ₁	92.6% ₁₈	100.0% ₁	100.0% ₁	95.8% ₁₃	Qtr 2 14/15
Cancer Patients treated after screening referral <62 days*	90%	90.9% ₂₀	N/A	100.0% ₁	97.2% ₉	97.6% ₈	71.4% ₂₃	91.7% ₁₈	80.0% ₂₂	100.0% ₁	92.9% ₁₇	96.9% ₁₁	95.0% ₁₅	N/A	100.0% ₁	90.6% ₂₁	95.6% ₁₄	96.7% ₁₂	100.0% ₁	96.0% ₁₃	97.8% ₇	100.0% ₁	100.0% ₁	N/A	97.0% ₁₀	93.8% ₁₆	91.7% ₁₈	71.4% ₂₃	N/A	Qtr 2 14/15
VTE Risk Assessment	95%	99.7% ₁	96.6% ₁₄	97.6% ₁₀	95.9% ₁₈	99.2% ₄	95.8% ₂₀	93.2% ₂₅	95.9% ₁₉	97.7% ₈	N/A	97.5% ₁₁	96.6% ₁₅	97.6% ₉	N/A	95.1% ₂₄	99.9% ₁	96.5% ₁₆	97.0% ₁₃	N/A	98.9% ₅	95.2% ₂₂	95.2% ₂₃	95.6% ₂₁	96.0% ₁₇	98.4% ₆	99.3% ₃	98.3% ₇	97.2% ₁₂	Qtr 2 14/15

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

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	BARNSELY 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

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

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

	National Target	IW	R1C	RBD	RD3	RDY	RDZ	RHM	RHU	RN5	RW1	Data Period
Emergency Care 4 hour Standards	95%	96.4% ₅	99.9% ₂	96.6% ₄	93.8% ₈	99.9% ₁	93.9% ₇	91.8% ₉	84.2% ₁₀	94.5% ₆	98.9% ₃	Sep-14
RTT:% of admitted patients who waited 18 weeks or less	90%	79.6% ₁₀	97.7% ₁	84.4% ₉	94.3% ₃	97.0% ₂	86.3% ₆	86.2% ₇	85.3% ₈	91.0% ₅	92.8% ₄	Sep-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	92.2% ₉	98.9% ₂	97.4% ₄	96.4% ₆	99.1% ₁	97.1% ₅	89.9% ₁₀	95.6% ₈	95.9% ₇	98.5% ₃	Sep-14
RTT % of incomplete pathways within 18 weeks	92%	95.2% ₇	99.3% ₁	95.7% ₆	97.3% ₄	98.7% ₂	95.0% ₈	93.3% ₁₀	96.7% ₅	93.6% ₉	97.6% ₃	Sep-14
% Patients waiting > 6 weeks for diagnostic	1%	0.1% ₃	0.0% ₁	4.1% ₁₀	0.1% ₅	0.1% ₄	0.2% ₆	1.4% ₉	0.5% ₇	1.3% ₈	0.1% ₂	Sep-14
Cancer patients seen <14 days after urgent GP referral*	93%	95.8% ₃	N/A	96.4% ₂	97.4% ₁	N/A	78.2% ₇	93.9% ₆	94.6% ₅	95.5% ₄	N/A	Qtr 2 14/15
Cancer diagnosis to treatment <31 days*	96%	98.6% ₄	N/A	99.3% ₂	99.3% ₁	N/A	96.1% ₇	96.2% ₆	97.9% ₅	98.7% ₃	N/A	Qtr 2 14/15
Cancer urgent referral to treatment <62 days*	85%	87.3% ₄	N/A	84.0% ₆	87.5% ₂	N/A	87.2% ₅	80.6% ₇	87.5% ₃	92.3% ₁	N/A	Qtr 2 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	91.7% ₆	N/A	95.0% ₃	100.0% ₁	N/A	68.8% ₇	94.4% ₅	95.2% ₂	94.5% ₄	N/A	Qtr 2 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	95.7% ₅	N/A	98.4% ₃	100.0% ₁	N/A	95.5% ₆	96.5% ₄	95.3% ₇	98.9% ₂	N/A	Qtr 2 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% ₁	N/A	100.0% ₁	100.0% ₁	N/A	100.0% ₁	99.3% ₇	100.0% ₁	100.0% ₁	N/A	Qtr 2 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	N/A	N/A	N/A	100.0% ₁	N/A	50.0% ₅	98.9% ₂	89.7% ₄	95.3% ₃	N/A	Qtr 2 14/15
Cancer Patients treated after screening referral <62 days*	90%	90.9% ₇	N/A	97.2% ₂	99.2% ₁	N/A	96.4% ₄	92.7% ₆	93.9% ₅	96.9% ₃	N/A	Qtr 2 14/15

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



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

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

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Benchmarking of Key National Performance Indicators: Ambulance Performance

	National Target	IW Performance	RX9	RYC	RRU	RX6	RX7	RYE	RYD	RYF	RYA	RX8	Data Period
Ambulance Category A Calls % < 8 minutes - Red 1	75%	81.8% ₂	72.7% ₇	71.1% ₉	61.9% ₁₁	76.2% ₅	71.5% ₈	75.9% ₆	78.7% ₃	77.6% ₄	83.0% ₁	68.7% ₁₀	Sep-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	76.1% ₃	71.9% ₈	62.6% ₁₀	54.0% ₁₁	75.4% ₅	73.3% ₇	76.4% ₂	74.6% ₆	76.9% ₁	75.6% ₄	70.7% ₉	Sep-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	76.4% ₃	72.0% ₈	63.1% ₁₁	54.3% ₁₃	75.4% ₇	73.2% ₉	76.3% ₄	74.8% ₈	76.9% ₁	75.8% ₆	70.6% ₁₁	Sep-14
Ambulance Category A Calls % < 19 minutes	95%	98.2% ₁	93.6% ₉	91.5% ₁₀	90.5% ₁₁	95.0% ₈	95.1% ₇	95.8% ₄	95.5% ₅	95.2% ₆	97.3% ₂	96.5% ₃	Sep-14

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

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

Commentary:

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

The latest information is up to August 2014. Overall we have 3 red rated indicators 2 of which are in the Admitted Patient Care Dataset with the third in the A&E dataset. The Outpatient dataset indicators are all green. The 2 indicators in the APC dataset are the Primary Diagnosis and the HRG4 (Healthcare Resource Grouping) these are linked as you need the diagnosis to generate the HRG. The position has improved month on month and relates to an issue with records not updating in SUS despite appearing in our CDS file, we are still trying to determince if the problem is with a translator service that coverts the file to the required format or with SUS processes.

Analysis:

Total APC General Episodes: 10,512				Total Outpatient General Episodes: 69,068				Total A&E Attendances: 28,528			
Data Item	Invalid Records	Provider % Valid	National % Valid	Data Item	Invalid Records	Provider % Valid	National % Valid	Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	153	98.5%	99.0%	NHS Number	396	99.4%	99.3%	NHS Number	673	97.6%	94.9%
Patient Pathway	202	94.0%	60.1%	Patient Pathway	30,850	51.6%	48.9%	Registered GP Practice	8	100.0%	98.9%
Treatment Function	0	100.0%	99.9%	Treatment Function	0	100.0%	99.8%	Postcode	15	99.9%	98.9%
Main Specialty	0	100.0%	99.9%	Main Specialty	0	100.0%	99.8%	Org of Residence	348	98.8%	96.2%
Reg GP Practice	2	100.0%	99.9%	Reg GP Practice	3	100.0%	99.7%	Commissioner	528	98.1%	99.0%
Postcode	74	99.3%	99.8%	Postcode	3	100.0%	99.8%	Attendance Disposal	222	99.2%	97.7%
Org of Residence	6	99.9%	99.0%	Org of Residence	11	100.0%	96.4%	Patient Group	7	100.0%	95.9%
Commissioner	16	99.8%	99.1%	Commissioner	37	99.9%	99.3%	First Investigation	270	99.1%	94.1%
Primary Diagnosis	759	92.8%	98.2%	First Attendance	0	100.0%	99.5%	First Treatment	675	97.6%	93.1%
Primary Procedure	0	100.0%	99.5%	Attendance Indicator	1	100.0%	99.2%	Conclusion Time	214	99.2%	98.4%
Ethnic Category	13	99.9%	97.5%	Referral Source	411	99.4%	98.4%	Ethnic Category	0	100.0%	93.0%
Site of Treatment	0	100.0%	97.5%	Referral Rec'd Date	411	99.4%	95.8%	Departure Time	126	99.6%	99.8%
HRG4	770	92.7%	97.7%	Attendance Outcome	4	100.0%	98.3%	Department Type	0	100.0%	99.9%
				Priority Type	411	99.4%	97.3%	HRG4	385	98.7%	95.8%
				OP Primary Procedure	0	100.0%	99.5%				
				Ethnic Category	52	99.9%	93.4%				
				Site of Treatment	0	100.0%	95.8%				
				HRG4	0	100.0%	98.8%				

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:

Determine cause of records not updating

Review missing commissioner codes in A&E dataset

Person Responsible:

Head of Information / Asst. Director - PIDS

Date:

Dec-14

Sep-14

Status:

Ongoing

Ongoing

Data Quality - August 2014

Dataset	Measure	IW Performance	National	Threshold			Status	Weighting	Score	Notes
				G	A	R				
APC	Total Invalid Data Items	2	n/a	=<2	>2 =<4	>4	G	2	0.0	Performance relates to the no. of Red rated data items
APC	Valid NHS Number	98.5%	99.0%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	A	1	0.5	
APC	Valid Ethnic Category	99.9%	97.5%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Invalid Data Items	0	n/a	=<2	>2 =<5	>5	G	2	0.0	Performance relates to the no. of Red rated data items
OP	Valid NHS Number	99.4%	99.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Valid Ethnic Category	99.9%	93.4%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Total Invalid Data Items	1	n/a	=<2	>2 =<4	>4	G	2	0.0	Performance relates to the no. of Red rated data items
A&E	Valid NHS Number	97.6%	94.9%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Valid Ethnic Category	100.0%	93.0%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
Total				= < 2	2 > = < 4	= > 4	G	12	0.5	

Source: Information Centre, SUS Data Quality Dashboard

Data item information:

Primary Diagnosis (ICD-10)

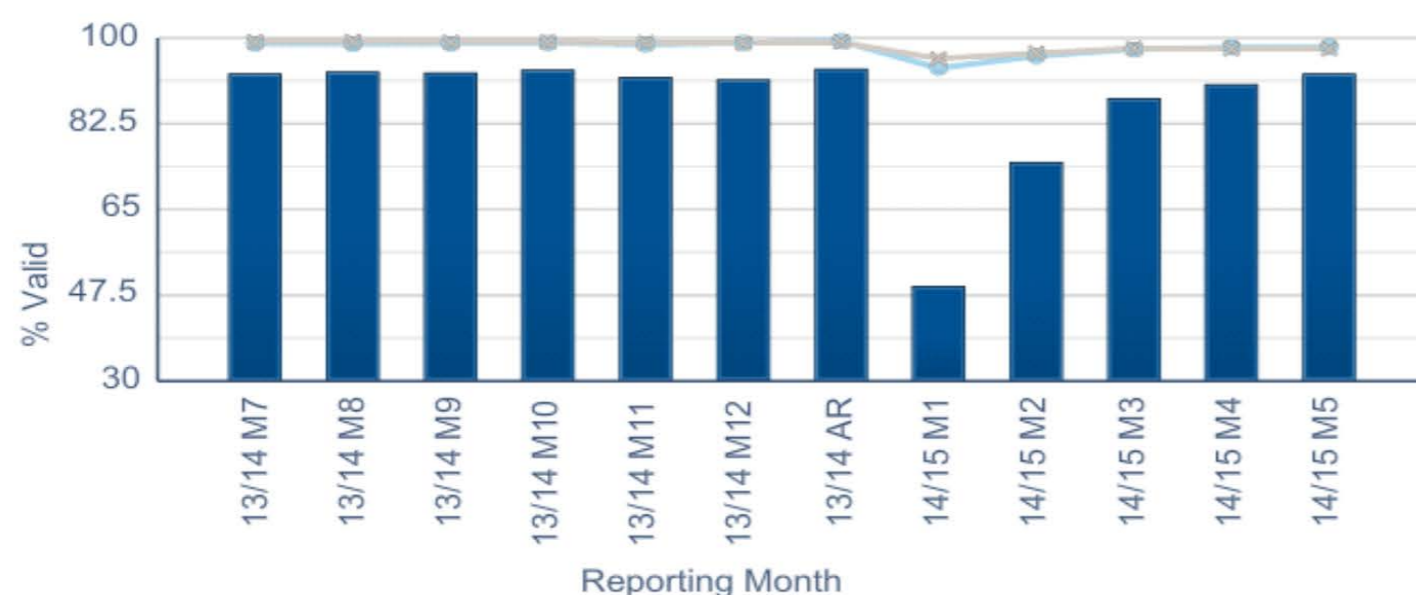
This is a clinical classification associated with the patient diagnosis.

The patient diagnosis is:

- the main condition treated or investigated during the relevant episode of healthcare, and
- where there is no definitive diagnosis, the main symptom,

Time Series - Primary Diagnosis

Show Summary



Provider National WESSEX

Time Series Help

Data item information:

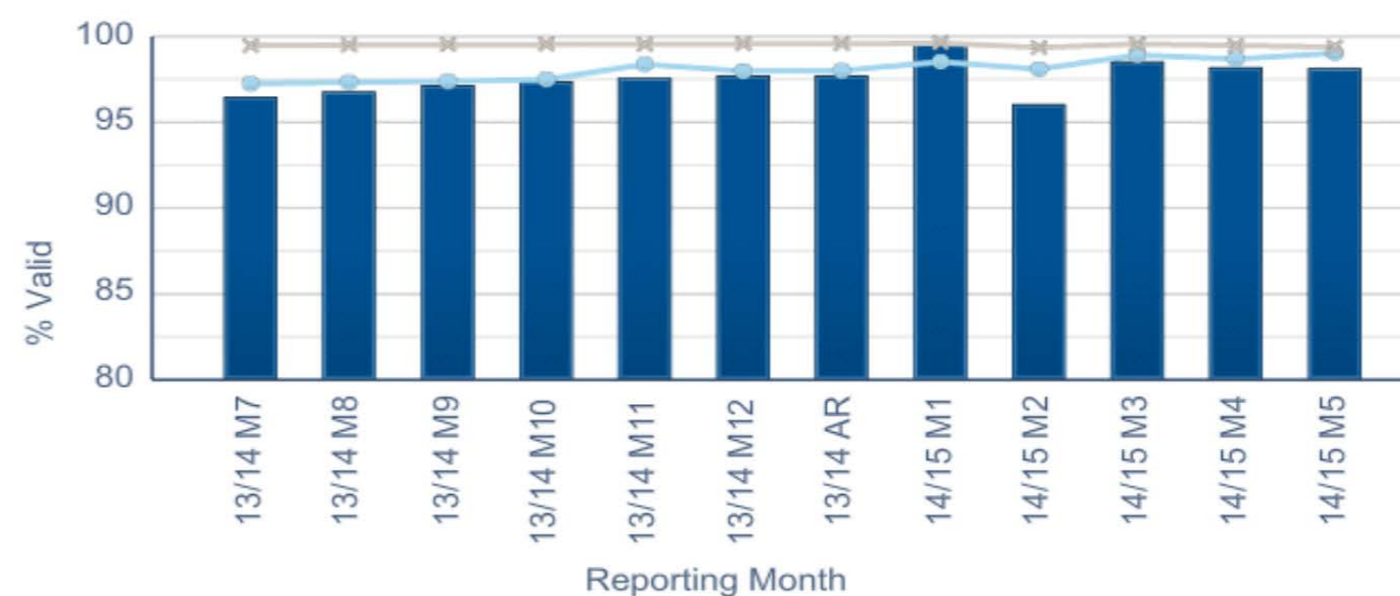
Organisation Code (Code of Commissioner)

This is the organisation code of the organisation commissioning healthcare. This should always be the organisation code of the original commissioner and is used by SUS PbR as the basis for payment.

Select the blue hyperlink above for the NHS Data Dictionary definition. You can navigate between CDS Versions 6.1 and 6.2

Time Series - Commissioner

Show Summary



Provider National WESSEX

Time Series Help

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Risk Register - Situation current as at 17/11/2014

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.



Data as at 17/10/2014 Risk Register Dashboard

Commentary

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

Since the last report 5 new risks have been added to the register - RR629 Consortium PACS - IW/RR630 SPARRCS Database Security and Governance/RR631 Inadequate Staffing Levels Community Mental Health Services/RR632 Seclusion Room on Seagrove/RR633 Appointment of Catering Manager. Four risks have been signed off the risk register - RR476 Mandatory Training/RR540 Failing heating/cooling system in NICU/RR560 Losing Services and Income/RR585 IT Issues Community Information Systems.

- **Key messages**

- Total paybill exceeds budgeted expenditure in month by £214k in month and £467k year to date.
- Overspend is within predominantly with Hospital sub group of Hospital & Ambulance Directorate but also Mental Health in month.
- Community & Mental Health and Non Clinical directorates as a group continue to operate close to or within budget.
- In month sickness rate reduced to 4.44% from 4.55 in September and against a target of 3%.
- Anxiety/Stress/Depression related sickness absence falls significantly in month but is offset by an increase in cold & flu, and chest & respiratory related sickness absence.
- Unfilled budgeted positions reduce to 7.2% of total funded establishment from 8% in September

- **Key risks identified:**

- *Sickness Absence over plan*
- *Reduction in in-post budgeted establishment*
- *Continued high level of Agency & Bank Spends*

- **Key Successes:**

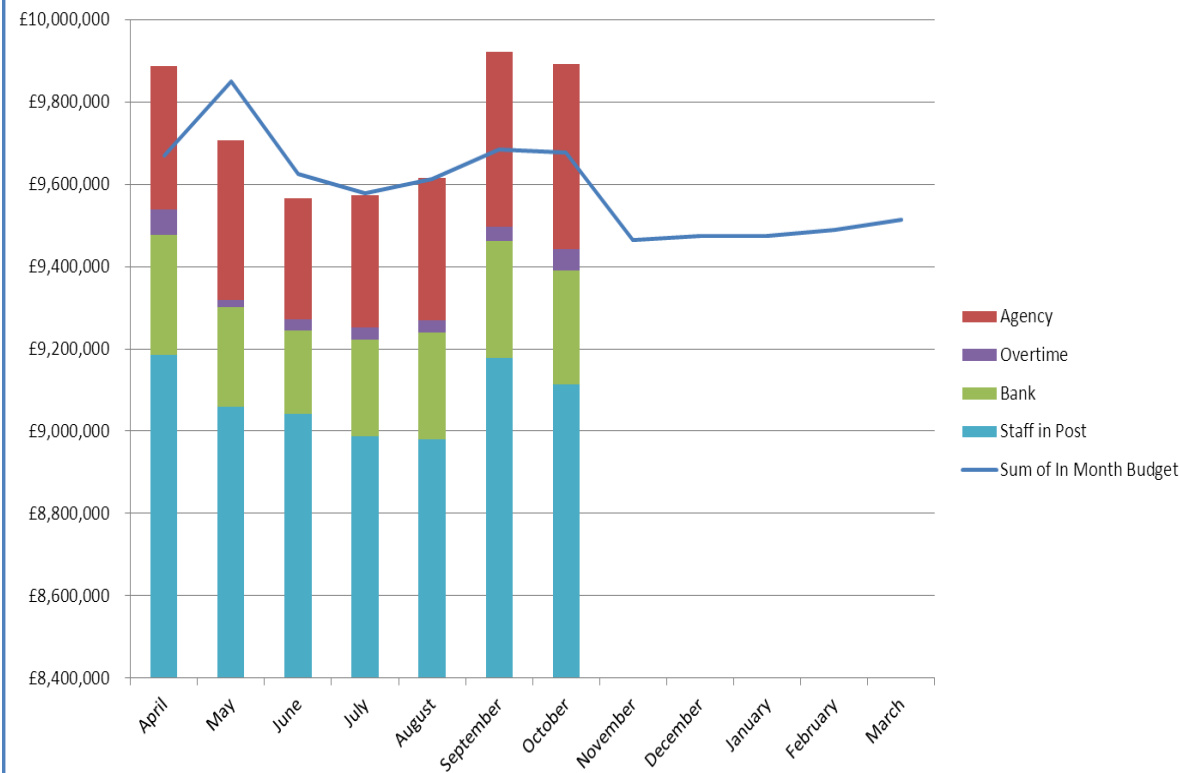
- *Upgrade of HealthRoster system which will enable better rostering and data analysis.*

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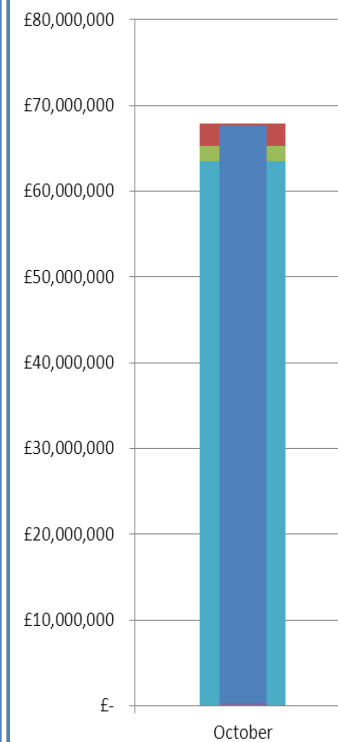
October 14

Workforce - Pay Spend (Total Trust)

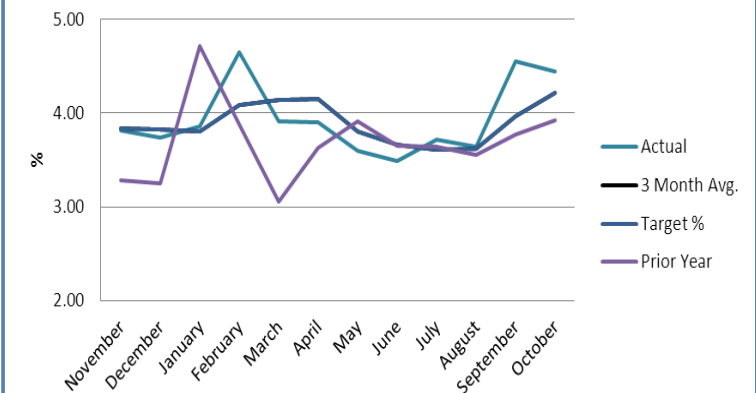
Pay Spend - Actual vs Budget



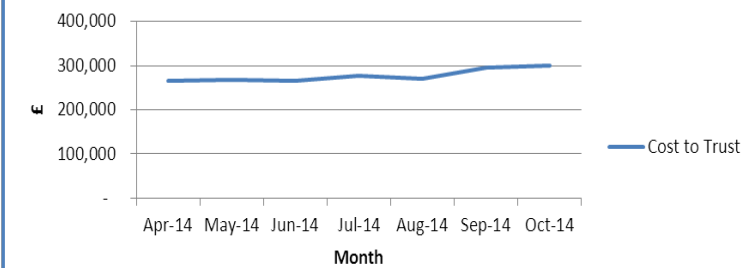
Pay Spend - Actual vs Budget YTD



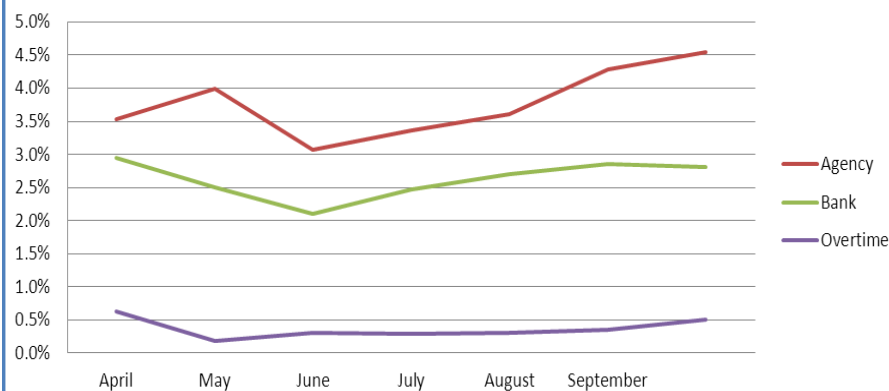
12 Month Sickness Absence



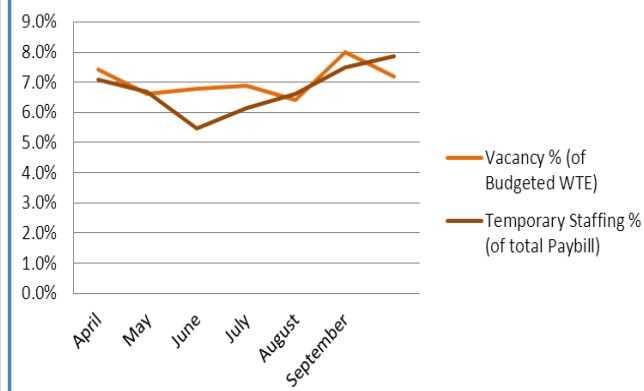
Cost of Sickness Absence



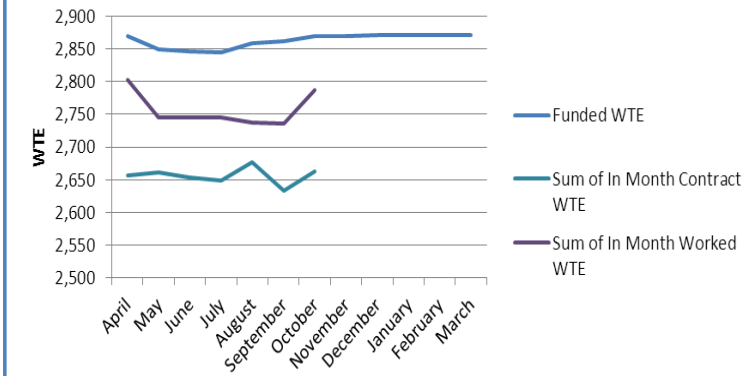
Paybill Elements %



Unfilled Budgeted Posts vs Temporary Staffing



WTE - Actual vs Budget



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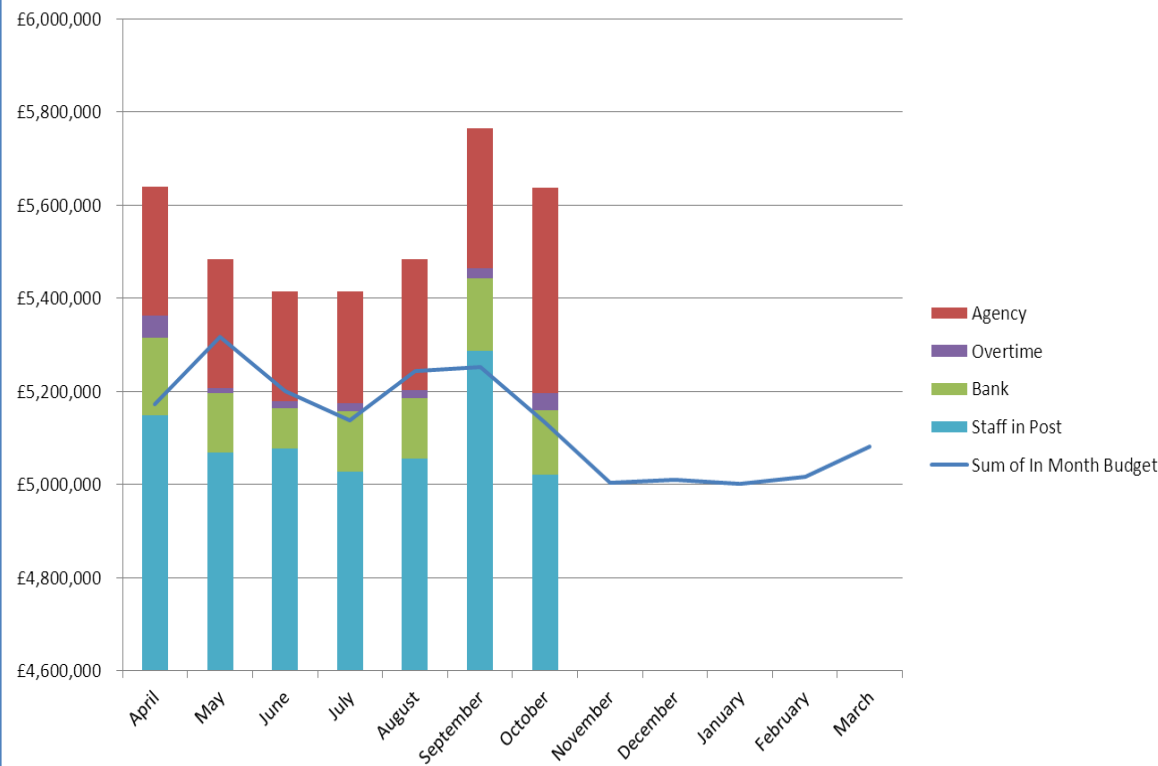
October 14

Workforce - Pay Spend (Hospital & Ambulance)

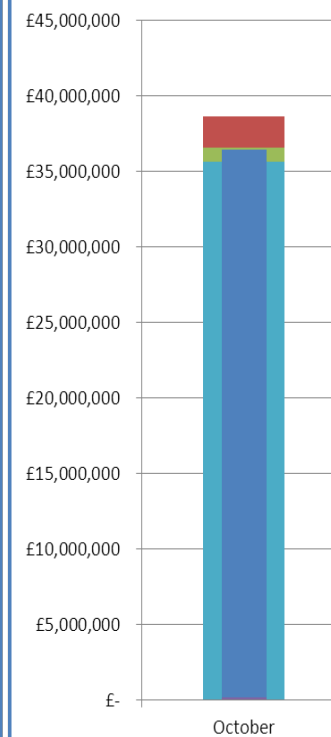
Isle of Wight **NHS**

NHS Trust

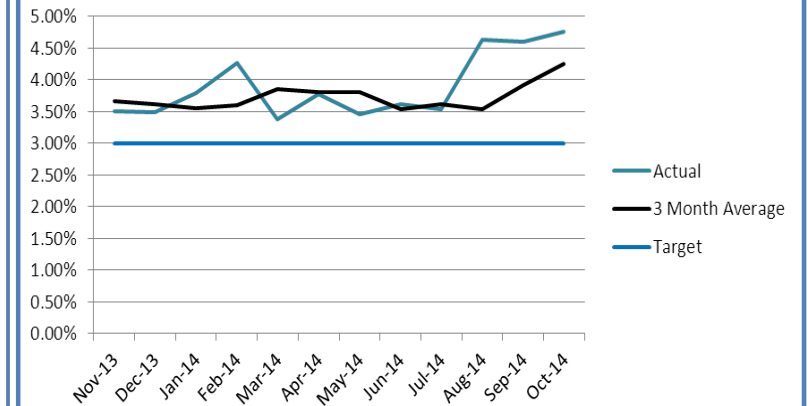
Pay Spend - Actual vs Budget



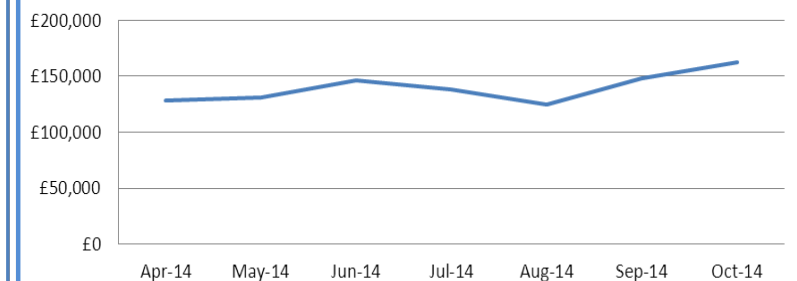
Pay Spend - Actual vs Budget YTD



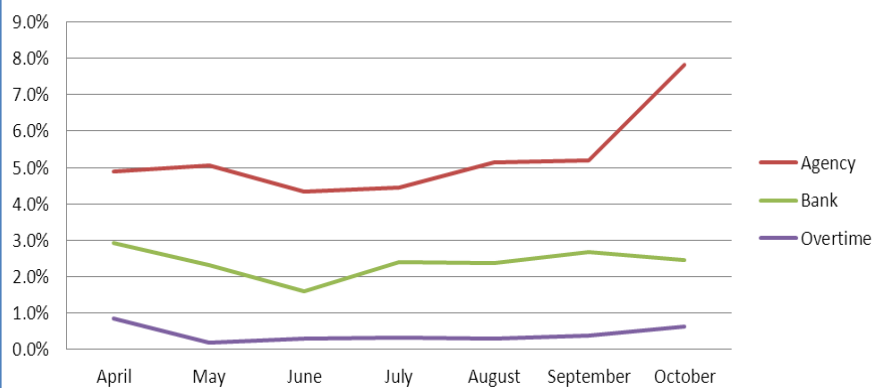
Sickness Absence



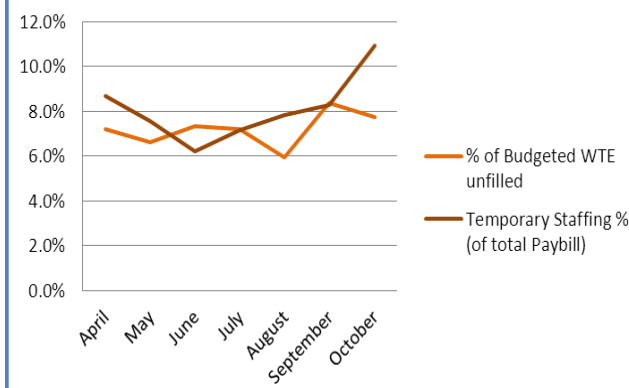
Cost of Sickness Absence



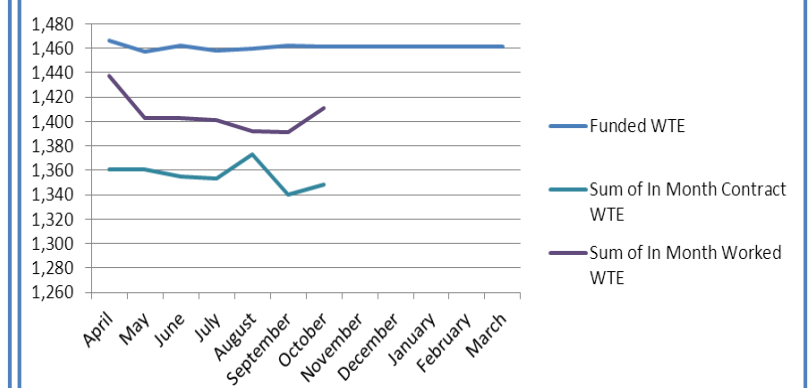
Paybill Elements %

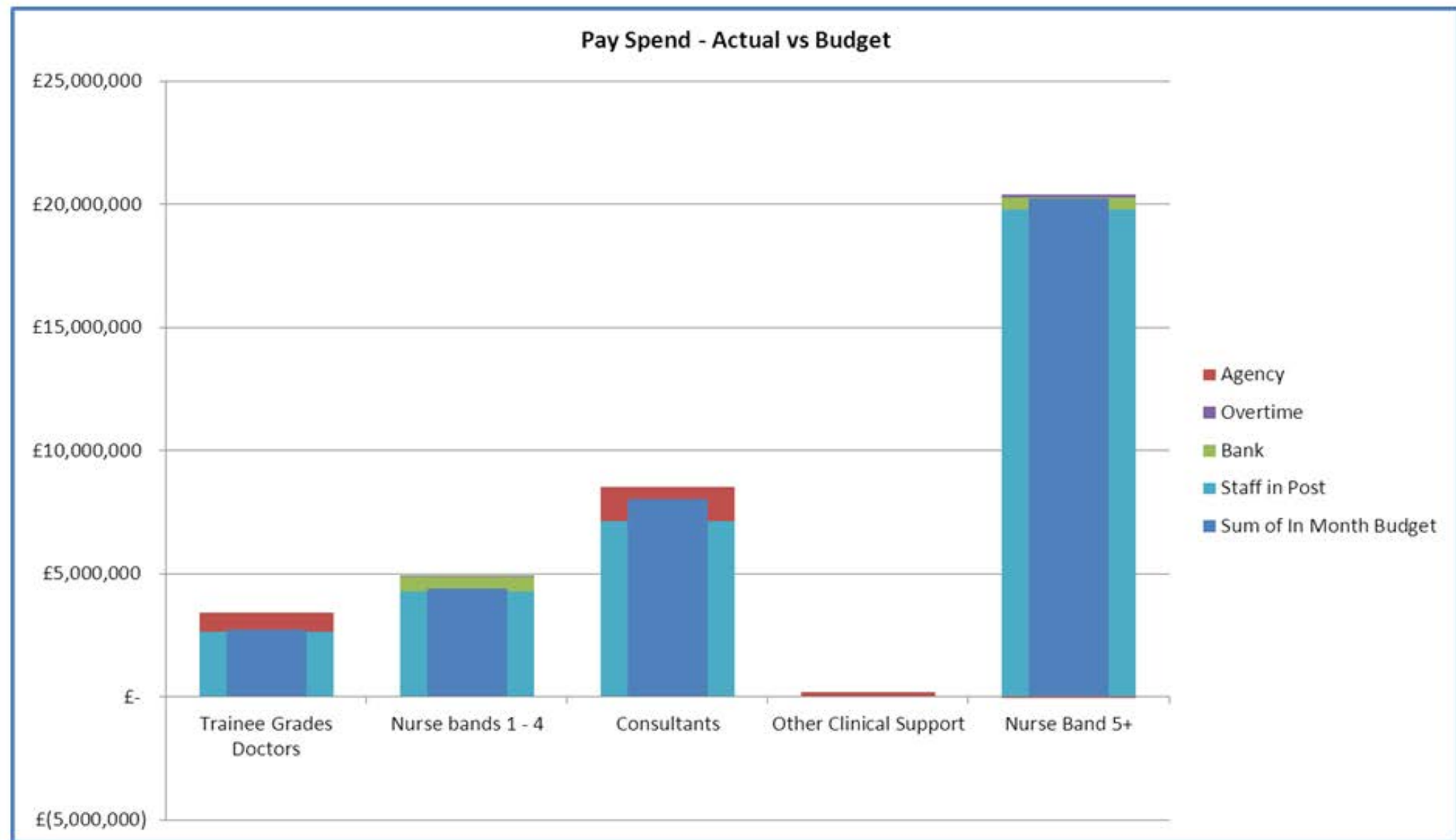


Unfilled Budgeted Posts vs Temporary Staffing



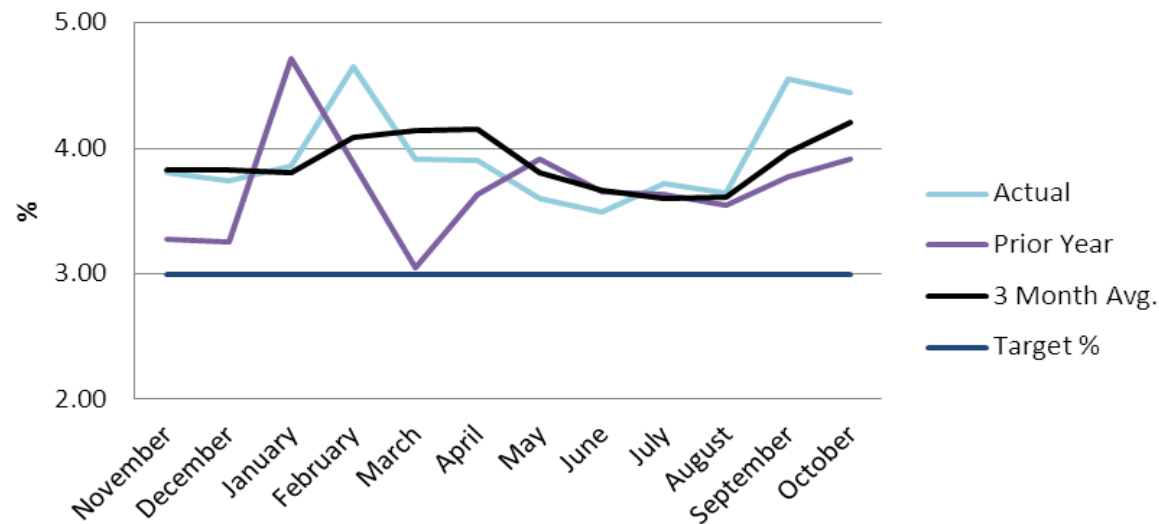
WTE - Actual vs Budget





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

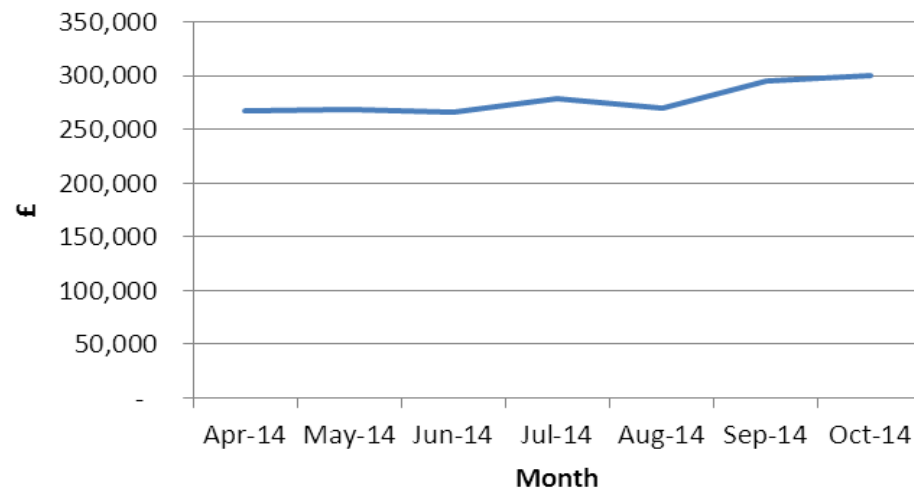
12 Month Sickness Absence



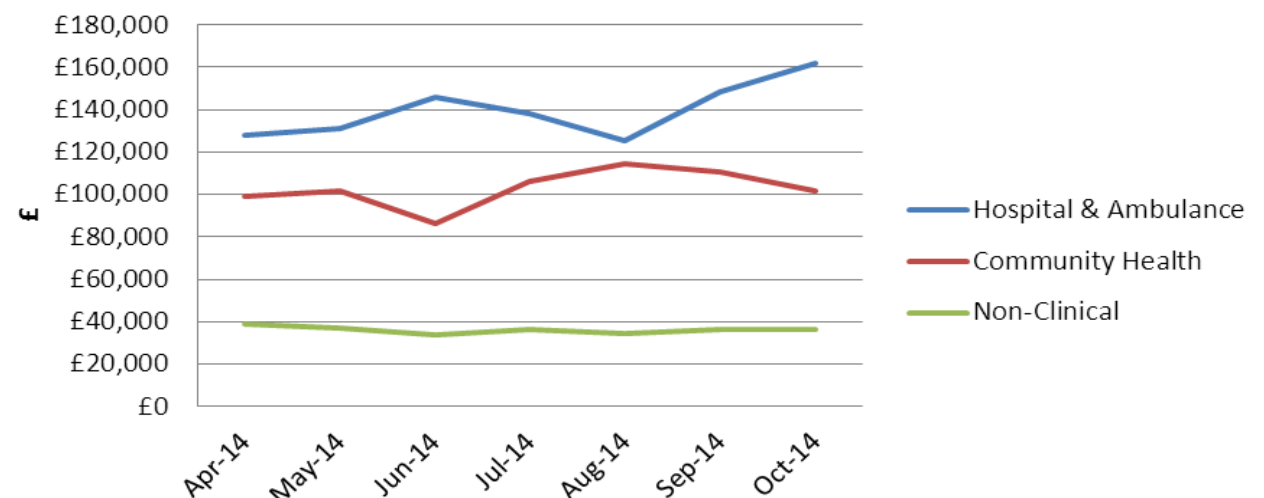
Sickness Absence	Period	Month Target/Plan	Month Actual
In Month Absence Rate	Oct-14	3%	4.44% ✗

Absence Reason	Sum of FTE Days Lost		
	Sep-14	Oct-14	Variance
S10 Anxiety/stress/depression/other psychiatric illnesses	896.13	729.56	-18.59%
S25 Gastrointestinal problems	475.63	482.65	1.48%
S11 Back Problems	373.34	419.21	12.29%
S13 Cold, Cough, Flu - Influenza	233.13	415.14	78.07%
S12 Other musculoskeletal problems	235.50	303.83	29.02%
S28 Injury, fracture	312.64	202.52	-35.22%
S15 Chest & respiratory problems	114.78	198.97	73.34%
S21 Ear, nose, throat (ENT)	111.43	139.67	25.34%
S26 Genitourinary & gynaecological disorders	214.73	137.87	-35.79%
S17 Benign and malignant tumours, cancers	147.20	126.13	-14.31%
Grand Total	3114.52	3155.56	1.32%

Cost of Sickness Absence



Cost of Sickness Absence - Directorate



Outstanding compliance with the Timetable of Actions in relation to National Quality Board requirements -

there are two items that remain amber in relation to the above – the nursing team are working to provide assurance that all tools and ways of working are in place and can be evidenced before this item is moved to green:

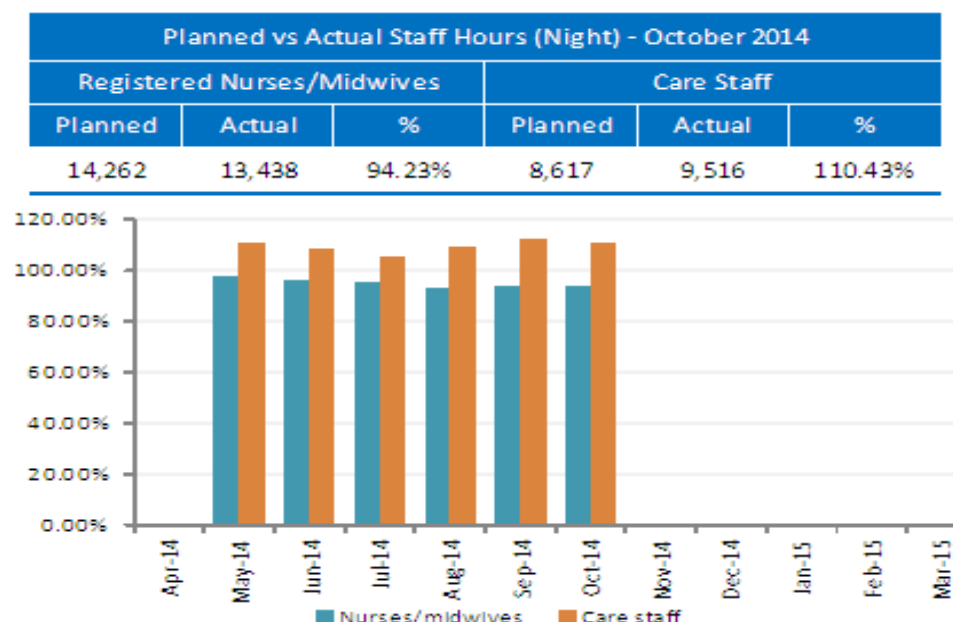
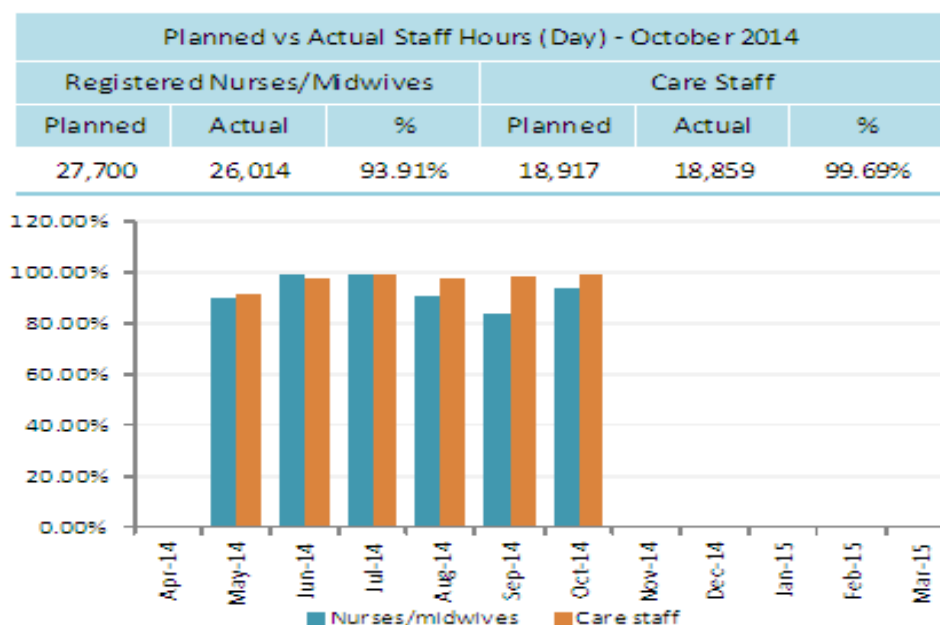
C The Trust Board receives a report update detailing actual staffing against planned on a shift by shift basis and is advised of those wards where there are shortfalls. This includes the reasons for the gap and the impact on quality of care as well as action taken to address the gap

This item remains amber to indicate that the detailed shift by shift data recording, in a format to be received by Board is in progress.

E The planned and actual staffing should be reviewed on a shift by shift basis. This occurs for each shift and actions are put in place i.e. requesting bank staff, moving staff from one area to another or making a professional judgement as to whether the ward can provide care with the reduce number of staff for that shift (i.e. tasks may be allocated to a later shift or non urgent activities postponed.

This **remains amber** until the DNT can assure the Board that this review can be evidenced. The roster policy and daily reporting tool are required for this. The rostering policy has been ratified and daily reporting tool is in pilot form.

- The Trust achieved 94% of Registered planned nursing hours for the day and 94 % for the night
- The Trust achieved 100% of non registered nursing hours for the day and night
- Additional non registered are usually required for 1:1 care or to fill registered nursing hours if registered nurses are not available
- Bank staff are booked for registered shifts however it is not always possible to fill these shifts as easily as the non registered shifts
- A bank user group is established to review better ways to manage the bank function



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Monthly actual figures by ward as uploaded on the Unify return RAG rated with locally set RAG rating

	Ward	Day		Night		
		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Professional Opinion
Paula Smith	Shackleton	103.3%	74.9%	104.7%	104.6%	Care was maintained safely. Staff were moved to cover. Please can this be turned blue. PS
Heidi Meekins/Caroline Moul	Orthopaedic Unit	79.1%	95.0%	95.2%	96.4%	Long term sickness + vacancy in Registered Nurse cover. Staff are rotating between Alverstone and Luccombe to ensure safe care is achieved
Andy Tate	Seagrove	101.2%	120.8%	90.2%	115.2%	
Vicky Haworth	Osborne	83.5%	119.5%	75.0%	204.4%	
c/o Sue Biggs	Mottistone	89.8%	130.1%	96.0%	-	No issues re safe care raised
Mandy Webb	St Helens	79.1%	100.9%	98.4%	90.3%	Prioritised bank cover for this area. Ward requiring additional support to ensure clinical
Anna New	Stroke	99.5%	115.5%	101.7%	161.5%	I am happy that this is a true reflection for Stroke. I am unable to add any comments in the box as it doesn't allow me to save and send back
Natalie Mew	Rehab	105.2%	109.4%	101.5%	115.5%	
Fiona Mitchell	Whippingham	79.4%	95.5%	76.3%	119.4%	4 Whole Time Equivalent Registered Nursing vacancies - not adequate bank resource, utilising non registered to cover Registered for night duty
Tina Beardmore	Colwell	106.3%	94.0%	96.8%	98.4%	registered at weekend. Additional registered staff
Laura Moody	Intensive Care Unit	89.0%	69.2%	85.3%	68.3%	ICU The % fill rate was safe for the amount of patients in ICU and their dependency at the time, no unsafe staffing incidents or harm reported LM.
Marcia Meaning	Coronary Care Unit	97.8%	96.7%	86.8%	122.6%	Long term sickness of night specific staff. Utilised ITU staff and additional hours for staff or non registered. Safe care delivered.
Jacky Harry	Neonatal Intensive Care Unit	94.0%	107.9%	116.8%	90.3%	Occupancy did not require full staffing compliment - levels adjusted.
Jessy Gulati	Medical Assessment Unit	113.6%	111.5%	117.4%	104.8%	
David Stratton	Afton	120.3%	73.1%	99.2%	99.6%	
Matthew Powell	Paediatric Ward	86.3%	79.2%	104.8%	100.0%	Ward safely managed by Charge Nurse and Matron stepping down into numbers to ensure safety. Acuity and dependency managed appropriately. Patient care not compromised. MAPS rotas need scrutiny to ensure correct data
Annie Hunter	Maternity	96.0%	102.0%	100.9%	100.0%	
		95% - 100+%				
		90-94.9% and ward sister opinion +ve		eg care was maintained safely, acuity and dependency manageable, staff moved to cover etc		
		90-94.9% and ward sister opinion -ve		eg below 95% regularly, no cover able to be obtained, care could be compromised etc		
		<90%				

We are progressing the Quality Dashboard indicators and linking them to ward staffing, work is ongoing to finalise overall RAG ratings to enable assessment of quality care provision

Ward	Day		Night		Key Nursing indicators			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	mandatory training %	falls with harm	PU	Complaints
Shackleton	103.3%	74.9%	104.7%	104.6%	96	1	0	0
Orthopaedic Unit	79.1%	95.0%	95.2%	96.4%	73	2	0	1
Seagrove	101.2%	120.8%	90.2%	115.2%	92	0	0	0
Osborne	83.5%	119.5%	75.0%	204.4%	83	0	0	0
Mottistone	89.8%	130.1%	96.0%	-				
St Helens	79.1%	100.9%	98.4%	90.3%	70	1	3	0
Stroke	99.5%	115.5%	101.7%	161.5%	87	5	0	0
Rehab	105.2%	109.4%	101.5%	115.5%	87	0	0	1
Whippingham	79.4%	95.5%	76.3%	119.4%				
Colwell	106.3%	94.0%	96.8%	98.4%	80	2	2	0
Intensive Care Unit	89.0%	69.2%	85.3%	68.3%	92	0	0	0
Coronary Care Unit	97.8%	96.7%	86.8%	122.6%	87	0	0	0
Neonatal Intensive Care Unit	94.0%	107.9%	116.8%	90.3%	85	0	0	0
Medical Assessment Unit	113.6%	111.5%	117.4%	104.8%	94	0	1	1
Afton	120.3%	73.1%	99.2%	99.6%	87	2	0	0
Paediatric Ward	86.3%	79.2%	104.8%	100.0%	82	0	0	0
Maternity	96.0%	102.0%	100.9%	100.0%	78	0	0	0

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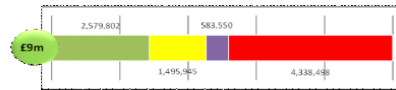
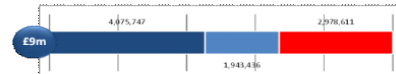
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Summary - RAG Rating based on Out-turn position

Summary

The Trust is reporting a £1.495m surplus in the year to October 2014, which is £99k less than the Plan.

Continuity of Service Rating G			Surplus G				Income G			
	Plan	Actual		Plan	Actual / Forecast	Variance		Plan	Actual / Forecast	Variance
Year to date	4	4	Year to date £k	1,594	1,495	(99)	Year to date £k	99,714	99,605	(109)
			Year end forecast £k	1,702	1,702	(0)	Year end forecast £k	169,976	169,962	(15)
The Trust is currently reporting a Continuity of Service Rating (CoSR) of '4' which is consistent with the operational plan. Additionally the expected out-turn rating is also 4.			The Trust planned for a surplus of £506k in October, after adjustments made for normalising items. The reported position is a surplus of £410k in the month, an adverse variance of £96k. The cumulative Trust plan was to deliver a surplus of £1.594m, after normalising items. The actual position is a cumulative surplus of £1.495m, an adverse variance of £99k. This position has £1.7m of forward banking recognised to the end of month 7. The Trusts planned forecast out-turn surplus remains at £1.7m but the current directorate performances continues to increase the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.				The Trust planned income in October was £14.552m. The actual reported income is £15.341m in month, a favourable variance of £789k. The cumulative income plan is £99.714m. The actual position is a cumulative income of £99.605m, an adverse variance of £109k. Included within this variance is income from the directorates (Category C income), this is a positive variance of £1.310m. Excluding this, the net income position (ie Category A Patient Care Activity income) would be a adverse variance of £1.419m			
Financial Criteria	Weight %	Metric to be scored	Definition	Rating categories						
				4	3	2	1			
Liquidity Ratio	1	50%	Liquid Ratio (days)	Working capital balance x 360	0.0	-7.0	-34.0	<-34		
				Annual operating expenses						
Capital Servicing Capacity Ratio	1	50%	Capital servicing capacity (time)	Revenue available for capital service	2.5x	1.75x	1.25x	<1.25x		
				Annual debt service						

Operating Costs				G	CIP				R	Cash				G												
	Plan	Actual / Forecast	Variance		Recurring Forecast Outturn						Plan	Actual / Forecast	Variance													
Year to date £k	(81,004)	(79,699)	1,305						<table><tr><th></th><th>Month 7 Close</th></tr><tr><td>Complies with all Audit Criteria and Powers validated</td><td>2,579,802</td></tr><tr><td>Complies with same Audit Criteria and Powers Validated</td><td>1,495,747</td></tr><tr><td>Part-year effect of Recurring Savings</td><td>583,550</td></tr><tr><td>Does not comply with any Audit Criteria and / or Powers not Validated</td><td>4,338,499</td></tr></table>		Month 7 Close	Complies with all Audit Criteria and Powers validated	2,579,802	Complies with same Audit Criteria and Powers Validated	1,495,747	Part-year effect of Recurring Savings	583,550	Does not comply with any Audit Criteria and / or Powers not Validated	4,338,499							
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Part-year effect of Recurring Savings	583,550																									
Does not comply with any Audit Criteria and / or Powers not Validated	4,338,499																									
Year end forecast £k	(139,324)	(137,365)	1,959		In Year Delivery																					
									<table><tr><th></th><th>Month 7 Close</th></tr><tr><td>Recurring forecast outturn</td><td>4,675,747</td></tr><tr><td>Non Recurring forecast outturn</td><td>1,978,611</td></tr><tr><td>Gap remaining</td><td>2,978,611</td></tr></table>		Month 7 Close	Recurring forecast outturn	4,675,747	Non Recurring forecast outturn	1,978,611	Gap remaining	2,978,611									
	Month 7 Close																									
Recurring forecast outturn	4,675,747																									
Non Recurring forecast outturn	1,978,611																									
Gap remaining	2,978,611																									
The Trust is reporting an underspend against an expenditure budget ytd of £1.305m. The forecast year end position is an underspend of £1.959m. Including additional forecast costs relating to the Public Dividend Capital Charge the adjusted positive expenditure variance is £1.980m.										The cash balance held at the end of October is considerably more than was planned and is due to: i) the actual spend on capital being less than the planned spend in the first six months of the year ii) the movement in working balances																

Capital G				Indicators of Forward Financial Risk G		
	Plan	Actual / Forecast	Variance		Plan	Forecast
Year to date £k	5,227	1,789	3,438	Number of indicators breached	2	0
Year end forecast £k	8,318	7,689	629	Number of indicators	11	11
The total Capital Resource for this year was originally approved at £8.3M. This included property sales of £648k, but these are expected to be sold during 2015/16 bringing the forecast expenditure to £7.7M for 2014/15.				Indicators breached are: i) Unplanned decrease in EBITDA margin in two consecutive quarters ii) Capital expenditure <75% of plan for the year		

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Surplus

The Trust planned for a surplus of £506k in October, after adjustments made for normalising items. The reported position is a surplus of £410k in the month, an adverse variance of £96k.

The cumulative Trust plan was to deliver a surplus of £1.594m, after normalising items. The actual position is a cumulative surplus of £1.495m, an adverse variance of £99k. This position has £1.7m of forward banking recognised to the end of month 7.

The Trusts planned forecast out-turn surplus remains at £1.7m but the current directorate performances continues to increase the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.

	Plan £000s	Year to date Actual £000s	Variance £000s
Surplus / (Deficit)	1,594	1,495	(99)

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

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

Operating costs include considerable over spends in Hospital & Ambulance directorate. These are offset by under utilised reserves and over achievement of CIP (including forward banking) in the corporate directorate.

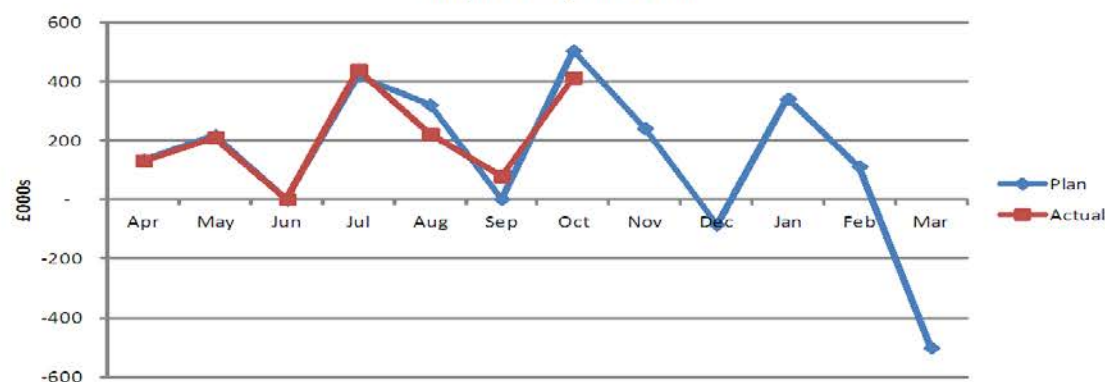
During September an impairment was realised of c.£1.3m on assets subject to the District Valuers revaluation. The impairment resulted in the planned retained surplus position having a negative variance of £1.3m. This is due to the impairment being recognised in advance of the planned budgeted impairment which was in March 2015. The forecast position at the year end corrects this position & in fact the current prediction is that impairments overall will be significantly less than anticipated due to the current upward trend in land & property values.

The adjusted reported performance for NHS monitoring purposes is not affected by this impairment charge as it is an adjusted item in that metric.

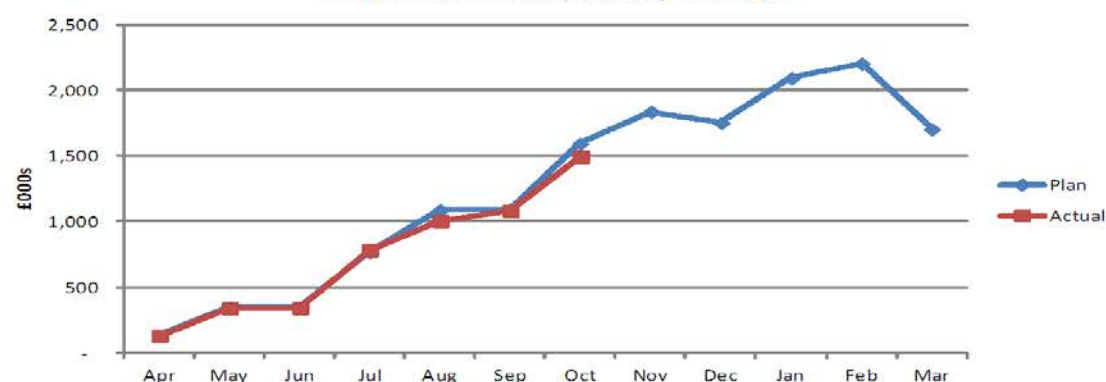
	Plan £000s	Year to date Actual £000s	Variance £000s
Income	99,714	99,605	(109)
Pay	(67,694)	(68,165)	(471)
Non Pay	(25,108)	(24,642)	466
EBITDA	6,912	6,798	(114)
Depreciation & Amortisation	(3,382)	(3,360)	21
PDC	(1,924)	(1,925)	(1)
Impairment	0	(1,325)	(1,325)
Profit/Loss on Asset Disp	0	(19)	(19)
Interest Receivable	31	32	1
Interest Payable	(48)	(17)	31
Bank Charges	(10)	(4)	6
Foreign Currency Adjustments	(1)	(3)	(2)
RETAINED SURPLUS / (DEFICIT)	1,579	178	(1,401)
Receipt of Charitable Donations for Asset Acquisition	(58)	(58)	0
Impairment	0	1,325	1,325
Depreciation - Donated Assets	73	50	(23)
ADJUSTED RETAINED SURPLUS / (DEFICIT)	1,594	1,495	(99)

	Plan £000s	Full Year Forecast £000s	Variance £000s
Income	169,976	169,962	(15)
Pay	(115,026)	(114,153)	873
Non Pay	(43,998)	(44,878)	(880)
EBITDA	10,952	10,931	(21)
Depreciation & Amortisation	(5,843)	(5,802)	40
PDC	(3,299)	(3,400)	(101)
Impairment	(5,347)	(2,953)	2,394
Profit/Loss on Asset Disp	(125)	(30)	95
Interest Receivable	54	55	1
Interest Payable	(48)	(24)	24
Bank Charges	(16)	(10)	6
Foreign Currency Adjustments	(1)	(3)	(2)
RETAINED SURPLUS / (DEFICIT)	(3,673)	(1,237)	2,436
Receipt of Charitable Donations for Asset Acquisition	(100)	(100)	0
Impairment	5,347	2,953	(2,394)
Depreciation - Donated Assets	128	86	(42)
ADJUSTED RETAINED SURPLUS / (DEFICIT)	1,702	1,702	(0)

Surplus by month



Cumulative surplus by month



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Income

The Trust planned income in October was £14.552m. The actual reported income is £15.341m in month, a favourable variance of £789k. The majority of this overperformance relates to an adjustment for budget phasing.

The cumulative income plan is £99.714m. The actual position is a cumulative income of £99.605m, an adverse variance of £109k.

This position includes an estimate of £395k relating to CCG contract penalties and NHSE contract under performance.

	Plan £000s	Year to date Actual £000s	Variance £000s
Surplus / (Deficit)	99,714	99,605	(109)

	Plan £000s	Full Year Forecast £000s	Variance £000s
Surplus / (Deficit)	169,976	169,962	(15)

The NHS Isle of Wight CCG position to date includes £141k of contract penalties. The balance relates to contract variations that have yet to be agreed, but are offset by a corresponding balance in revenue reserves.

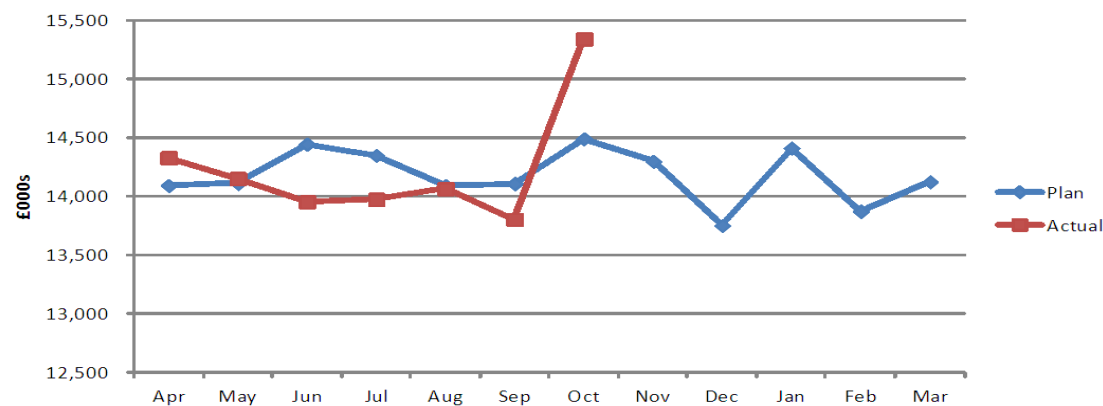
NHS England variance relates to under performance against contract on breast screening services and neonatal critical care. The year end position assumes an improvement in performance on these services.

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

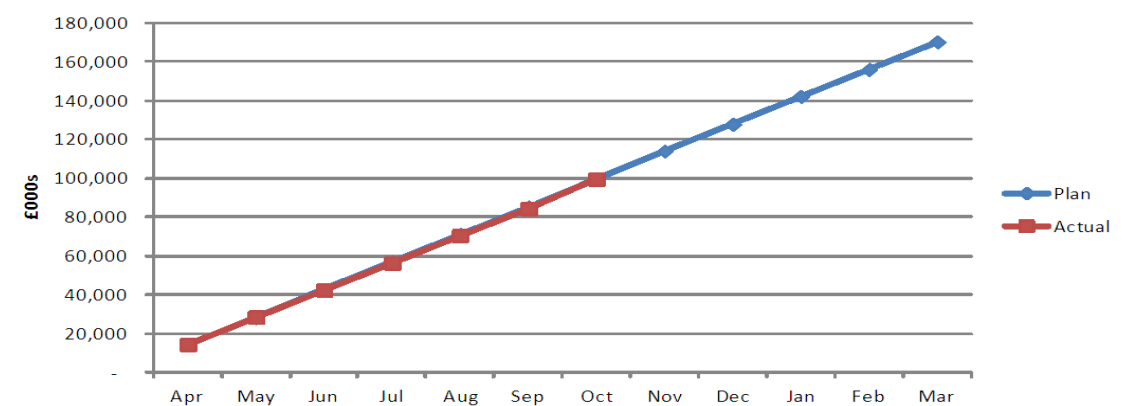
Income	Plan £000s	Year to date Actual £000s	Variance £000s
NHS Isle of Wight CCG	79,040	78,025	(1,015)
NHS England	6,721	6,086	(635)
Isle of Wight Council	1,020	1,035	15
Commissioning Support Unit	207	207	(0)
Non Contractual Activity	875	1,083	208
Southampton University Hospitals FT	53	62	9
Income from Patient Care Activities	87,916	86,497	(1,419)
Other directorate income	11,798	13,108	1,310
TOTAL INCOME	99,714	99,605	(109)

Income	Plan £000s	Full Year Forecast £000s	Variance £000s
NHS Isle of Wight CCG	134,985	134,038	(948)
NHS England	11,597	10,539	(1,058)
Isle of Wight Council	1,748	1,761	13
Commissioning Support Unit	355	355	0
Non Contractual Activity	1,500	1,500	0
Southampton University Hospitals FT	90	103	13
Income from Patient Care Activities	150,276	148,296	(1,980)
Other directorate income	19,700	21,666	1,965
TOTAL INCOME	169,976	169,962	(15)

Monthly Income



Cumulative income by month



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Directorate Performance

Hospital & Ambulance	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	5,108	5,260	152	690
Pay	(36,356)	(38,690)	(2,334)	(2,478)
Non Pay	(13,510)	(14,916)	(1,406)	(2,498)
TOTAL	(44,758)	(48,345)	(3,588)	(4,287)

The Hospital and Ambulance Directorate continues to report an overspend in M7. The main pressures the Directorate faces include unachieved CIP and Vacancy Factor of £2.5m ytd plus Agency Staff covering Medical Vacancies (£944k adverse variance ytd). The Directorate has also incurred additional expenditure of £232k for RTT to reduce the >18 week waiting list. No funding has been received or reported for this expenditure YTD.

Community Health	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	2,446	2,488	42	93
Pay	(18,931)	(18,977)	(46)	(248)
Non Pay	(2,559)	(2,893)	(334)	(442)
TOTAL	(19,044)	(19,382)	(338)	(596)

Community are cumulatively overspent by £338k, the directorate is carrying a vacancy factor of £200k to date. There are areas of concern due to high levels of expenditure - these are Orthotics & Prosthetics, Continence and Wheelchair. The Directorate is developing business cases to resolve the on-going pressure in these areas

Corporate - Earl Mountbatten Hospice	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	1,178	1,502	324	323
Pay	(1,178)	(1,388)	(210)	(209)
Non Pay	(1)	(115)	(114)	(114)
TOTAL	(1)	(1)	0	0

This budget will report a break even position as all costs are recharged.

Corporate - Finance & Performance Management	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	131	126	(5)	(11)
Pay	(1,528)	(1,368)	160	799
Non Pay	(2,001)	(818)	1,183	2,240
TOTAL	(3,398)	(2,060)	1,338	3,029

Finance & Performance Management is reporting a significant underspend to date and forecast. This is mainly due to the reporting of the impairment of assets which were subject to the District Valuers revaluation.

Corporate - Nursing & Workforce	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	351	319	(32)	(15)
Pay	(3,629)	(3,691)	(62)	(283)
Non Pay	(1,033)	(998)	34	255
TOTAL	(4,311)	(4,371)	(59)	(43)

Corporate - Chief Operating Officer	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	245	369	123	146
Pay	(242)	(311)	(68)	(219)
Non Pay	(7)	(51)	(44)	(44)
TOTAL	(3)	7	11	(118)

Corporate - Strategic & Commercial	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	2,261	3,023	762	799
Pay	(2,866)	(2,754)	112	595
Non Pay	(4,286)	(4,715)	(430)	(1,405)
TOTAL	(4,890)	(4,446)	444	(11)

Corporate - Trust Administration	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	77	87	10	5
Pay	(1,016)	(986)	30	9
Non Pay	(2,001)	(1,956)	45	131
TOTAL	(2,940)	(2,855)	85	145

Reserves	Year to date			Forecast Variance £000s
	Plan £000s	Actual £000s	Variance £000s	
Income	0	(66)	(66)	(66)
Pay	(1,947)	0	1,947	2,906
Non Pay	289	1,820	1,532	998
TOTAL	(1,659)	1,755	3,413	3,839

The variance to date on reserves includes £1.7m of forward banked CIP. The balance relates to commissioners contract variations that have yet to be agreed, but are offset by a corresponding balance in income.

The Trust is reporting an underspend against an expenditure budget ytd of £1.305m.

The forecast year end position is an underspend of £1.959m after adjusting for public dividend capital movements this variance is £1.980m.

Hospital & Ambulance directorate is reporting an overspend of £3.588m. The full year forecast for the directorate is £4.287m, which includes a £2m spend reduction challenge.

The Trust forecast position offsets this by using reserves and over achievement of CIP in corporate directorate.

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Cash

The cash balance held at the end of October is considerably more than was planned and is due to:

- i) the actual spend on capital being less than the planned spend in the first six months of the year
- ii) the movement in working balances

	Plan £000s	Year to date Actual £000s	Variance £000s
Cash Balance	5,536	8,142	2,606

	Plan £000s	Full Year Forecast Actual £000s	Variance £000s
Cash Balance	5,407	6,032	625

	Plan £000s	Year to date £000s	Variance £000s
Operating Surplus/(Deficit)	3,539	2,113	(1,426)
Depreciation and Amortisation	4,356	3,360	(996)
Impairments and Reversals	0	1,325	1,325
Gains /(Losses) on foreign exchange	0	(3)	(3)
Donated Assets - non-cash	0	(58)	(58)
Interest Paid	(6)	(32)	(26)
Dividend (Paid)/Refunded	(1,650)	(1,925)	(275)
Movement in Inventories	0	(136)	(136)
Movement in Receivables	0	(4,028)	(4,028)
Movement in Trade and Other Payables	(8,648)	(3,779)	4,869
Provisions Utilised	(250)	(61)	189
Movement in Non Cash Provisions	0	(357)	(357)
Cashflow from Operating Activities	(2,659)	(3,581)	(922)
Interest Received	14	24	(10)
Capital Expenditure - PPE	(4,836)	(1,424)	(3,412)
Capital Expenditure - Intangibles	(345)	(200)	(145)
Cashflow from Investing Activities	(5,167)	(1,600)	(3,567)
Cash Flows from Financing Activities	(7,826)	(5,181)	(2,645)
Capital Element of Finance Leases	(42)	(35)	(7)
Cashflow from Financing Activities	(42)	(35)	(7)
Net increase/decrease in cash	(7,868)	(5,216)	(2,652)
Opening Cash Balance	13,404	13,358	46
Restated Cash and Cash Equivalents (and Bank Overdraft)	13,404	13,358	46
Closing Cash Balance	5,536	8,142	2,606

	Plan £000s	Full Year £000s	Variance £000s
Operating Surplus/(Deficit)	(223)	2,175	2,398
Depreciation and Amortisation	7,460	5,802	(1,658)
Impairments and Reversals	5,347	2,953	(2,394)
Gains /(Losses) on foreign exchange	0	(3)	(3)
Donated Assets - non-cash	(100)	(100)	0
Interest Paid	(6)	(36)	(30)
Dividend (Paid)/Refunded	(3,299)	(3,399)	(100)
Movement in Inventories	250	472	222
Movement in Receivables	733	(1,993)	(2,726)
Movement in Trade and Other Payables	0	0	0
Provisions Utilised	(466)	(711)	(245)
Movement in Non Cash Provisions	30	57	27
Cashflow from Operating Activities	339	(2,339)	(2,678)
Interest Received	24	48	(24)
Capital Expenditure	(7,973)	(4,643)	(3,330)
Capital Expenditure - Intangibles	(345)	(344)	(1)
Cashflow from Investing Activities	(8,294)	(4,939)	(3,355)
Cash Flows from Financing Activities	(7,955)	(7,278)	(677)
Capital Element of Finance Leases	(42)	(48)	(6)
Cashflow from Financing Activities	(42)	(48)	(6)
Net increase/decrease in cash	(7,997)	(7,326)	4,959
Opening Cash Balance	13,404	13,358	(46)
Restated Cash and Cash Equivalents (and Bank Overdraft)	13,404	13,358	(46)
Closing Cash Balance	5,407	6,032	625

The cash balance held at the end of October amounted to £8,142k. This is considerably more than was planned and is largely attributable to actual spend on capital being less than the planned spend in the first six months of the year.

The forecast cash position is a positive variance on plan of £0.7m. The projected closing cash balance is £6.1m

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Statement of Financial Position

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

	1st April 2014	Year to Date			
		Plan	Actual	Variance	Notes
	£k	£k	£k	£k	
Property, Plant and Equipment	97,613	93,571	95,165	1,594	
Intangible Assets	4,150	3,686	3,673	(13)	
Trade and Other Receivables	277	200	186	(14)	
Non Current Assets	102,040	97,457	99,024	1,567	
Inventories	2,200	1,978	2,336	358	
Trade and Other Receivables	6,930	8,177	10,958	2,781	
Cash and Cash Equivalents	13,358	5,536	8,142	2,606	
Sub Total Current Assets	22,488	15,691	21,436	5,745	
Current Assets	22,488	15,691	21,436	5,745	
Trade and Other Payables	(20,395)	(10,179)	(16,616)	(6,437)	
Provisions	(711)	0	(293)	(293)	
Liabilities arising from PFIs / Finance Leases	(48)	0	0	0	
Current Liabilities	(21,154)	(10,179)	(16,909)	(6,730)	
Provisions	0	(40)	0	40	
Non-Current Liabilities	0	(40)	0	40	
TOTAL ASSETS EMPLOYED	103,374	102,929	103,551	622	
FINANCED BY:					
Public Dividend Capital	6,762	6,762	6,762	0	
Retained Earnings Reserve	72,124	74,916	72,301	(2,615)	
Revaluation Reserve	24,488	21,251	24,488	3,237	
Other Reserves	0	0	0	0	
TOTAL TAXPAYERS EQUITY	103,374	102,929	103,551	622	

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

	Full Year			Notes
	Plan	Actual	Variance	
	£k	£k	£k	
Property, Plant and Equipment	88,794	98,133	9,339	
Intangible Assets	3,143	3,285	142	
Trade and Other Receivables	200	200	0	
Non Current Assets	92,137	101,618	9,481	
Inventories	1,728	1,728	0	
Trade and Other Receivables	8,177	9,000	823	
Cash and Cash Equivalents	5,407	6,059	652	
Sub Total Current Assets	15,312	16,787	1,475	
Current Assets	15,312	16,787	1,475	
Trade and Other Payables	(10,179)	(12,839)	(2,660)	
Provisions	(50)	(57)	(7)	
Liabilities arising from PFIs / Finance Leases	0	0	0	
Current Liabilities	(10,229)	(12,896)	(2,667)	
Provisions	0	0	0	
Non-Current Liabilities	0	0	0	
TOTAL ASSETS EMPLOYED	97,220	105,509	8,289	
FINANCED BY:				
Public Dividend Capital	6,762	6,762	0	
Retained Earnings Reserve	69,590	70,887	1,297	
Revaluation Reserve	20,868	27,860	6,992	
Other Reserves	0	0	0	
TOTAL TAXPAYERS EQUITY	97,220	105,509	8,289	

At the planning stage the non-current asset values were based on an assumption that impairments of £2m would be applied to the assets at the end of 2013/14. In reality, when the District Valuer had completed the revaluation exercise at the end of 2013/14, asset values had increased by c£3m - a swing of £5m. Until month 6 it had been assumed that impairments of £5.3m would be applied to the current capital building programme in 2014/15. However, based on the latest forecast this has been reduced to £2.9m and therefore these two factors have contributed to the significant variance against plan.

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Capital

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

Year to Date			
	Plan	Actual	Variance
	£k	£k	£k
Strategic Capital	4,382	1,355	3,027
Operational Capital	845	434	411
Total	5,227	1,789	3,438

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

Year End Forecast			
	Plan	Forecast	Variance
	£k	£k	£k
Strategic Capital	6,854	6,463	391
Operational Capital	1,464	1,226	238
Total	8,318	7,689	629

Operational Capital - Bids for IM&T RRP and Equipment RRP were brought to the Capital Investment Group in November. Two bids are currently being re-worked to bring them into line with the available funding.

Strategic Capital	Year to Date			Full Year			Risk Rating
	Plan	Actual	Variance	Plan	Forecast	Variance	
Source of Funds	£k	£k	£k	£k	£k	£k	
Strategic Funds C/F			0			0	
External Funding			0			0	
Capital Investment Loans			0			0	
Operational Capital	3,782	3,782	0	6,854	6,854	0	
Donated Capital			0			0	
	3,782	3,782	0	6,854	6,854	0	
Application of Funds							
Strategic Capital Schemes							
MAU Extension	1,170	240	930	2,378	1,840	538	G
Ward Reconfiguration Level C	100	51	49	100	42	58	G
Ryde Community Clinic	1,203	231	972	1,203	1,280	(77)	G
Dementia Friendly		231	(231)		192	(192)	G
ISIS Further Faster	344	200	144	344	344	0	G
ICU/CCU	1,270	125	1,145	2,204	126	2,078	G
Endoscopy Relocation	295	114	181	625	2,247	(1,622)	G
St Helens Relocation		163	(163)		369	(369)	G
Carbon Energy Fund		0	0		24	(24)	G
	4,382	1,355	3,027	6,854	6,463	391	

Operational Capital	Full Year		Year to Date		Full Year			Risk Rating
	Plan	Approved	Actual	Variance	Approved	Forecast	Variance	
Source of Funds	£k	£k	£k	£k	£k	£k	£k	
Depreciation	7,460	3,730	3,310	420	7,460	5,824	1,636	
Property Sales	0	0	0	0	0	0	0	
Donated Funds	100	50	50	0	100	100	0	
Other	110	55	0	55	110	110	0	
Transfer to Strategic Capital	(6,854)	(3,782)	(3,782)	0	(6,854)	(6,854)	0	
	816	53	(422)	475	816	(820)	1,636	
Application of Funds								
Operational Schemes								
Estates Schemes	320	320	234	86	320	301	19	G
IM&T RRP	156	156	27	129	156	156	(0)	G
Equipment RRP	500	250	48	202	500	469	31	G
Staff Capitalisation	200	119	125	(6)	200	200	0	G
Contingency/Unallocated	188	0	0	0	188	0	188	G
Donated Assets	100	0	0	0	100	100	0	G
	1,464	845	434	411	1,464	1,226	238	

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

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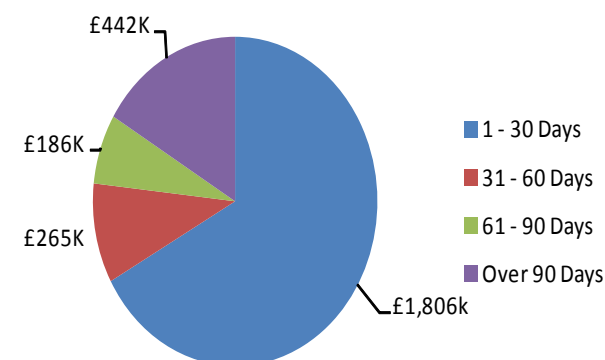
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Debtors

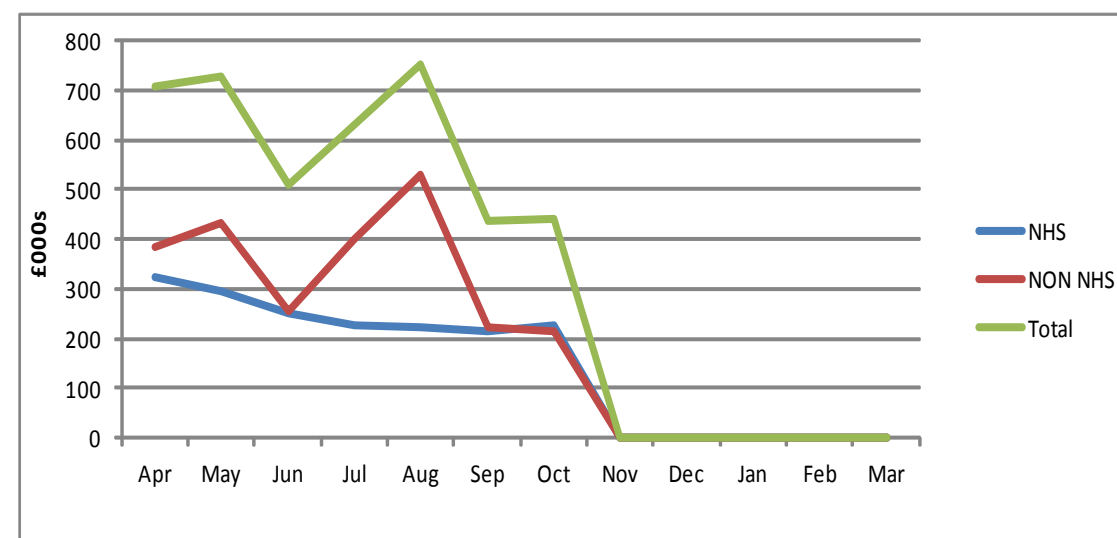
The Trust debtors are a combination of invoiced debtors, accrued income and prepayments as set out in the table below. This shows that the Trust has outstanding debtors over 30 days of more of £892k

Invoiced debtors	Within Terms	1 Month Overdue	2 Months Overdue	3 Months Overdue	Total	Current Month
	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days		Over 30 Days
	£000s	£000s	£000s	£000s	£000s	£000s
CCGs	780	148	92	75	1095	315
NHS England	220	0	2	3	225	5
Trusts	86	31	10	98	225	139
Foundation Trusts	142	33	39	50	264	122
Other NHS	71	0	0	0	72	1
Non NHS - Private Patients	68	36	23	58	185	118
Non NHS - Local						
Authority/Public Bodies	137	10	6	91	243	107
Non NHS - Other	302	6	14	65	388	85
Total	1,806	265	186	442	2,698	892
	67%	10%	7%	16%		
Provision for Bad Debts (including Injury Costs Recovery provision)					(428)	
Accrued Income					5,401	
Prepayments					1,736	
Other Debtors					1,737	
Total Trade and Other Receivables					11,144	

Debtors



Total Debtors over 90 days



Accrued income and Other Debtors consists of VAT £246k, RTA £301k (11/12-13/14) plus accruals for invoices not yet raised.

Balance Scorecard

Debtors over 90 days as a % of total debtor balance	Target	<5%
Based on total trade & other receivables with > 90 adjusted for bad debt provision	Actual	0.12%

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Better Payment Practice Code

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

In Month						
Supplier Classification	Invoice Count	Invoice Count	% Passed	BPPC Amount £000s	Invoice Amount (Passed) £000s	% Amount
NHS	117	104	88.9%	577	462	80.1%
NON-NHS OTHER	233	229	98.3%	204	200	98.1%
NON-NHS TRADE	2,552	2,470	96.8%	3,898	3,821	98.0%
TOTAL NON-NHS	2,785	2,699	96.9%	4,102	4,021	98.0%
IN-MONTH ALL	2,902	2,803	96.6%	4,679	4,484	95.8%

Year to Date						
Supplier Classification	Invoice Count	Invoice Count	% Passed	BPPC Amount £000s	Invoice Amount (Passed) £000s	% Amount Passed
NHS	1,005	876	87.2%	5,466	4,569	83.6%
NON-NHS OTHER	1,530	1,456	95.2%	1,334	1,279	95.9%
NON-NHS TRADE	16,500	15,873	96.2%	28,566	27,642	96.8%
TOTAL NON-NHS	18,030	17,329	96.1%	29,900	28,921	96.7%
YTD ALL	19,035	18,205	95.6%	35,367	33,490	94.7%

Overall, the cumulative figures to October with regard to both the numbers and values processed are on target at 95%. There is an expectation that this can continue through to the year-end. c.£82k of the total in-month underperformance on NHS payments is attributable to just two invoices.

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MONITOR FINANCIAL RISK INDICATORS - Indicators of Forward Financial Risk

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

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

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

Month 07 - Risk Rating:

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

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

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

GOVERNANCE RISK RATINGS				Isle of Wight NHS Trust			Insert YES (target met in month), NO (not met in month) or N/A (as appropriate) See separate rule for A&E				With effect from the September report, the GRR has been realigned to match the Risk Assessment Framework as required by 'Monitor'.		
See 'Notes' for further detail of each of the below indicators						Historic Data			Current Data				
	Ref	Indicator	Sub Sections	Thresh- old	Weight- ing	Q4 2013/14	Q1 2014/15	Q2 2014/15	Oct	Nov	Dec	Q3 2014/15	Notes
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	No	Yes	No	No			No	The admitted performance for October has increased slightly from 79.64% last month to 81.58% this month. The non admitted performance has increased from 92.19% last month to 93.89% in October. The focus on treating breaching patients has had the expected impact on the percentages as specialties work to improve their 18 week position.
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		95%	1.0	Yes	No	No	No			No	
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		92%	1.0	Yes	Yes	No	Yes			Yes	
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	Yes	No	Yes	No			No	The 95% target for October was again missed due to the increased pressure on community bed availability. Despite action plans being followed the increase in attendances at the Emergency department created a situation whereby towards the end of the month the target was lost. Increased efforts and focus throughout November will continue.
	5	All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	1.0	Yes	No	No	Yes			Yes	
			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	
			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	
	8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93%	1.0	Yes	No	No	Yes			Yes	
			For symptomatic breast patients (cancer not initially suspected)	93%									
	9	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within seven days of discharge	95%	1.0	No	No	Yes	Yes			Yes	
			Having formal review within 12 months	95%									
10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	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		
12	Category A call – emergency response within 8 minutes, comprising:	Red 1 calls	75%	1.0	Yes	Yes	No	Yes			Yes		
		Red 2 calls	75%	1.0	Yes	Yes	No	Yes			Yes		
13	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	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	
			Is the Trust below the YTD ceiling	3		Yes	No	No	No			No	
	16	Minimising mental health delayed transfers of care		≤7.5%	1.0	No	No	No	No			No	
	17	Mental health data completeness: identifiers		97%	1.0	Yes	Yes	Yes	yes			Yes	
	18	Mental health data completeness: outcomes for patients on CPA		50%	1.0	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	
	20	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes			Yes	
			Referral information	50%									
Treatment activity information			50%										
TOTAL						5.0	6.0	9.0	4.0	0.0	0.0	4.0	
						R	R	R	R	G	G	R	

Terms and abbreviations used in this performance report

Quality & Performance and General terms

Ambulance category A	Immediately life threatening calls requiring ambulance attendance
BAF	Board Assurance Framework
CAHMS	Child & Adolescent Mental Health Services
CDS	Commissioning Data Sets
CDI	Clostridium Difficile Infection (Policy - part 13 of Infection Control booklet)
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
DNA	Did Not Attend
DIPC	Director of Infection Prevention and Control
EMH	Earl Mountbatten Hospice
FNOF	Fractured Neck of Femur
GI	Gastro-Intestinal
GOVCOM	Governance Compliance
HCAI	Health Care Acquired Infection (used with regard to MRSA etc)
HoNOS	Health of the Nation Outcome Scales
HRG4	Healthcare Resource Grouping used in SUS
HV	Health Visitor
IP	In Patient (An admitted patient, overnight or daycase)
JAC	The specialist computerised prescription system used on the wards
KLOE	Key Line of Enquiry
KPI	Key Performance Indicator
LOS	Length of stay
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus (bacterium)
NG	Nasogastric (tube from nose into stomach usually for feeding)
OP	Out Patient (A patient attending for a scheduled appointment)
OPARU	Out Patient Appointments & Records Unit
PAAU	Pre-Assessment Unit
PAS	Patient Administration System - the main computer recording system used
PALS	Patient Advice & Liaison Service now renamed but still dealing with complaints/concerns
PATEXP	Patient Experience
PATSAF	Patient Safety
PEO	Patient Experience Officer - updated name for PALS officer
PPIs	Proton Pump Inhibitors (Pharmacy term)
PIDS	Performance Information Decision Support (team)
Provisional	Raw data not yet validated to remove permitted exclusions (such as patient choice to delay)

QCE	Quality Clinical Excellence
RCA	Route Cause Analysis
RTT	Referral to Treatment Time
SUS	Secondary Uses Service
TIA	Transient Ischaemic Attack (also known as 'mini-stroke')
TDA	Trust Development Authority
VTE	Venous Thrombo-Embolism
YTD	Year To Date - the cumulative total for the financial year so far

Workforce and Finance terms

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

FOR PRESENTATION TO PUBLIC BOARD ON: 3rd DECEMBER 2014

QUALITY & CLINICAL PERFORMANCE COMMITTEE

Wednesday 19th November 2014

Present:	Sue Wadsworth	Non Executive Director (Chair)
	Nina Moorman	Non Executive Director (Vice Chair)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Lisa Reed	Head of Clinical Services for the Community & Mental Health Directorate (Deputising for Sarah Gladdish) (HCSCMH)
	Sabeena Allahdin	Clinical Director – Hospital & Ambulance Directorate (CDHAD)
	Deborah Matthews	Lead for Patient Safety, Experience and Clinical Effectiveness (LSEE)
In Attendance:	Ian Bast	Patient Representative (PR)
	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM) <i>(for item 14/385)</i>
	Fiona Hoskins	Divisional Head of Nursing, University Hospitals Southampton NHS FT <i>(for item 14/377)</i>
	Victor Lawrence	Consultant in Diabetes and Endocrinology <i>(for item 14/366)</i>
	Vanessa Flower	Patient Experience Lead (PEL) <i>(for items 14/380, 381, 382, 383)</i>
	Brian Johnston	Head of Corporate Governance & Risk Management (HCGRM) <i>(for item 14/384)</i>
	Andy Shorkey	Business Planning and Foundation Trust Programme Management Officer (BPFTMO) <i>(for item 14/386)</i>
	Minuted by: Lynn Cave	Trust Board Administrator

Key Points from Minutes to be reported to the Trust Board

14/366	Acute & Unspecified Renal Failure Update Assurance – issues re medical staff training
14/371	Directorate Issues – pressure on beds and patient flow
14/374	QIP – Limited Assurance
14/376	RCPCH Review - Assurance
14/377	Clinical Governance Review – requirement for internal review of clinical governance structures and processes.
14/388	Concern raised re-redecoration of Stroke Unit which is now unsuitable for patients with visual impairment.

Minute No.

14/363 APOLOGIES FOR ABSENCE

- Sarah Gladdish, Clinical Director, Community & Mental Health Directorate (CDC)

- Mark Pugh, Executive Medical Director (EMD),
- Jessamy Baird, Non-Executive Director (JT)
- Chris Orchin, Non-Executive Director (Governance and Compliance)
Healthwatch IW (HIW)

14/364 CONFIRMATION OF QUORACY

The Chair confirmed the meeting was quorate.

14/365 DECLARATIONS OF INTEREST

There were no declarations of interest.

14/366 ACUTE & UNSPECIFIED RENAL FAILURE UPDATE

Dr Victor Lawrence gave a presentation on the re audit of Acute & Unspecified Renal Failure Following the action plan developed last year to address the mortality outlier for unspecified renal failure identified by Dr Foster. He advised that staff were now using NICE guidance for treating kidney injury. The sepsis care bundle is also in use on the medical wards but had not been rolled out consistently across the Trust at the time of the CQC visit. He discussed in detail the various elements of the action plan and how progress was being achieved. A further audit against the most recent NICE guidance was to be undertaken with specific focus on renal care.

The Chairman thanked Dr Lawrence for his presentation.

14/367 MINUTES OF THE LAST MEETING – 17 September 2014

The minutes of the meeting held on 22nd October 2014 were agreed as a true record.

14/368 REVIEW OF ACTION TRACKER

The committee reviewed the open and progressing actions and agreed to close the following actions:

- QCPC0251
- QCPC0341
- QCPC0342

The Committee requested that the Committee Administrator chase updates on the remaining actions and updated the schedule for the the next meeting.

14/369 TERMS OF REFERENCE

The HCGRM advised that following approval at Board, the requested amendments to the terms of reference to include research and development had been made. Section 6.1.13 and Appendix 1 refer.

NM felt that the terms of reference did not specifically focus on effectiveness assurance and that external assurance and accreditation should come to Committee to provide this assurance. She felt that the reports from external visits were directed to the Board instead of coming via QCPC and that this should be addressed within the terms of reference.

The HCGRM advised that these requirements could be included in the next review of the terms of reference. The Committee agreed that a discussion on governance be included in a future agenda which would link to discussions on governance to be held by the SEE committee and the Directorates. The Committee agreed that the

outcome of this review would be presented to Board for formal approval on 4th March following approval by the Audit & Corporate Risk Committee in February.

Action: Review of clinical governance structures and processes SW/NM/AS

QUALITY

14/370 QUALITY REPORT

The LSEE presented the quality report and advised that the results had been discussed with the directorates with particular focus on quality risks. The CDHAD requested that the Quality Managers from the directorates attend future QCPC meetings to directly answer any questions relating to the quality report. The Committee agreed that this would be appropriate and confirmed that invites would be issued for future meetings:

***Action Note:** Committee Administrator (CA) to invite the directorate Quality Managers to attend for this item at future meetings.*

Action by: CA

The LSEE confirmed that the SEE committee were undertaking review of the quality results within their remit.

14/371 HOSPITAL AND AMBULANCE DIRECTORATE

The CDHAD advised that following the merger of the acute and planned directorates the quality team were developing new systems. She highlighted the following from the Quality Report:

- C.Diff mortality – patient was medically fit for discharge but due to delays in transferring to a nursing home the patient died in hospital.
- SIRIs - Increase in Serious Incidents Requiring Investigation was welcomed as showed improved reporting was occurring.
- Mixed Sex Accommodation breach - The hospital has been experiencing extreme bed pressures partly due to the upgrading of MAU partly to an increase in attendance/admissions through the emergency department. The incident that occurred involved the placement of a single non-cardiology patient on CCU. A root cause analysis has been conducted and a meeting held to review the issues that resulted in this breach occurring.
- Complaints – these are higher but this is in response to more proactive feedback from patients and families and is seen as a positive increase.
- Readmission rates – Mostly due to bed pressures A full audit is planned for April to show any seasonal patterns.
- Beds – bed pressures are causing staff to be stretched although patient care is not being affected. The CDHAD stressed the importance of improving patient flow as these pressures could have effects on elective

services in the long term.

NM advised that the Board was aware of the pressures and highlighted the current project on patient flow. The EDNW agreed that the situation was cause for concern but stressed that it was not just about beds, there were a range of factors which contribute to the situation which needed to be looked at as a whole. The CDHAD stated that surgical patients should have a designated bed prior to going into surgery but at present this was not always occurring and that this situation needed to be resolved.

The EDNW gave an overview of the projects being undertaken to provide additional capacity and stressed that part of this was looking at the culture of moving patients through the organisation. Currently there is a passive attitude to pressure but there needs to be a proactive approach to patient flow throughout the Trust.

The CDHAD confirmed that all issues highlighted had assurance in place to provide appropriate reporting.

The Chairman asked that the Ward Dashboard Summary be deferred to the next meeting. The Committee agreed.

Top Risks were identified as Bed Pressures, CAD issues with Ambulance, CQC Report submission on 12th December.

14/372 COMMUNITY AND MENTAL HEALTH DIRECTORATE

The HCSCMH advised that the newly appointed quality team would be embedding changes over the next few months into the reporting and would be monitoring assurance. These would include daily, weekly and monthly monitoring.

There would be targeted work undertaken on SIRIs, pressure ulcers and healthcare assistant competency training.

District Nursing is only part of the community package but good input is being received from the nursing and care homes.

Mental Health are targeting high risk patients and project Serenity is working well. There has been an increase in staff sickness which mean that teams are feeling increase pressure. The new Head of Mental Health is starting in the next few weeks.

14/373 REPORT FROM PATIENT SAFETY, EXPERIENCE AND EFFECTIVENESS (SEE) COMMITTEE

The LSEE reported that a new system to review SIRIs was being implemented to ensure to identify earlier any potential cases and to process cases within 45 days to next stage. She confirmed that a 2 day training session was planned on root cause analysis with new guidance being provided also.

Ward Dashboards – The Chairman expressed concern over the red incidents showing for St Helens and Colwell Ward and asked what SEE was doing to reduce these. The LSEE advised that work us being undertaken to review the tolerance levels in the reporting format with PIDs and Clinical teams. The Chairman requested that the reports from SEE should include evidence of assurance.

The EDNW asked for update on SIRIs. The LSEE advised that the backlog of

cases was reducing significantly and that a report would be provided by SEE at the next meeting.

Action Note: *LSEE to bring status report on all SIRI cases to QCPC at the January meeting.*

Action by: LSEE

14/374 **QUALITY IMPROVEMENT PLAN (QIP)**

The LSEE confirmed that the QIP was currently on V6.1 and was available via the intranet to staff.

The action plan was being reviewed on 20th November with monthly stakeholder challenge meetings planned. She confirmed that once an action was deemed compliant it would be verified by testing. Any action not meeting the strict testing criteria would be returned for further review.

The EDNW advised that some actions would not be compliant by 12th December deadline due to the need for investment, funding and business cases to be developed. He confirmed that weekly meetings were being held to provided assurance. The Committee requested that copies of these be provided to the non - executive directors.

Action Note: *EDNW to send copies of the weekly QIP reviews to NM, JB and SW.*

Action by: EDNW

The EDNW advised that he had requested a discussion with the CQC to ascertain the position on non-compliance in certain areas so that any risks could be managed. He advised that as yet the CQC had not responded.

14/375 **EXTERNAL AGENCIES REPORT**

The HCGRM presented the report and advised that the report was grouped by lead manager for easy of reporting. He confirmed that there were no red flags at the time of reporting. He highlighted the following actions:

- CQC visit to Seagrove Ward & Woodlands – actions now dealt with
- Action 6 - Estates action still required to alter nursing office environment to ensure confidentiality.
- Action 64 & 65 – updates from Healthwatch are still outstanding.

NM stated that it would be helpful if specific services in the organisation could present a 6 monthly overview of visits to their area to the Committee.

Action Note: *The HCGRM agreed to arrange 6 monthly reports for January meeting.*

Action by: HCGRM

14/376 **ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH (RCPCH) SERVICE REVIEW**

The EDNW presented the report which had been received last week.

He advised that the review had taken place following some concerns raised by 3 SIRIs. The review had been welcomed by the team and showed that procedures were safe. The CDHAD confirmed that the department had welcomed the report

and felt that the comments made were fair. She stated that having clear terms of reference for the inspection had been critical.

The Chairman advised that she had been interviewed as part of the process and had been impressed by the team from RCPCH. She stated that having reviews such as this helps build a good relationship with the CQC.

The Chairman asked what was being done to standardise the mortality and morbidity meetings. The CDHAD advised that these were taking place but at present a standard format was not in place. She advised that this was being reviewed and the policy updated; they would be presented to the quality board and SEE for assurance.

14/377 **GOVERNANCE REPORT**

Fiona Hoskins presented an overview of her Six Week Review into Governance and Clinical Risk undertaken on behalf of the Trust.

She outlined the objectives of the review and gave a high-level overview of her findings. These were presented as areas of Good Practice and areas for improvement.

Areas of Good Practice:

- Establishment of the SEE triumvirate
- Core spine of Governance and risk processes present
- Datixweb incident reporting system particularly (falls and pressure ulcers)
- Annual risk assessments

Areas for Improvement:

- Clarity and transparency
- Documentation and process housekeeping
- Multi-professional engagement
- Internal Directorate governance and risk structures
- Compliance with NRLS SIRI reporting process
- Risk assessment and grading
- Independent clinical critique and challenge of potential risks

Fiona Hoskins advised the Committee that her full report would be presented to the EDNW for comment in the near future. However, the key recommendations were:

- Embedding of SEE triumvirate
- Review Directorate governance and risk processes
- Implementation of RACI model
- Implementation of SIRI scoping meetings
- Increase clinical involvement in Risk management processes

The EDNW confirmed that the report would ensure that there was clarity between corporate governance and clinical governance.

A discussion took place over the areas high-lighted and the Committee agreed that it would be essential for the recommendations to be linked through all the various levels of committee and reporting to ensure conformance to the core standards.

The Chairman expressed her desire to attend a meeting of the quality committee at

University Hospital Southampton. Fiona Hoskins advised that they would be happy for her to attend and would arrange for an invitation.

Action Note: *Committee Administrator to arrange with Fiona Hoskins for an invitation to UHS Quality Committee meeting for the Chairman.*

Action by: CA

PATIENT SAFETY

14/378 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – TO BE SIGNED OFF

The Committee discussed the following SIRIs

Hospital & Ambulance Directorate

- 2014/29547 - The Committee approved sign off

Acute (old directorate cases)

- 2014/21215 - The Committee approved sign off

Planned (old directorate cases)

- 2012/18540 - The Committee approved sign off
- 2012/24507 - The Committee approved sign off
- 2013/22895 - The Committee approved sign off
- 2012/24318 - The Committee approved sign off
- 2014/14260 - The Committee approved sign off
- 2013/33970 - The Committee approved sign off
- 2014/18091 - The Committee approved sign off
- 2013/33871 - The Committee approved sign off

Community

- 2014/1582 - The Committee approved sign off
- 2014/7460 - The Committee approved sign off
- 2014/2888 - The Committee approved sign off
- 2014/18838 - The Committee approved sign off
- 2014/18088 - The Committee approved sign off
- 2013/31052 – The Committee asked that this case be taken to the Directorate Nursing Team for review. Following this review case can be closed.

14/379 MORTALITY SHMI QUARTERLY UPDATE

The EDNW presented the mortality update:

- SHMI of 1.07 is 'within expected' range
- HSMR of 83.9 is 'lower than expected' – (but currently is not rebased and will go up when this is done)
- Rapid Review undertaken around Fluid and Electrolyte disorders and conclusion was that the issue was admission coding.
- Continued monitoring of Urinary Tract Infections required

PATIENT EXPERIENCE

14/380 PATIENT STORY

The Committee viewed a video recording of a patient giving feedback on the care that had been received during her attendance at Sevenacres. The patient had been admitted to both Seagrove and Osborne Wards at different times and highlighted the experiences received at both.

The Committee stated that it was very good to have patient feedback from the mental health services.

The HCSCMH stated that it would be of great help for the Quality Managers to view the film and requested that it be made available. The PEL advised that all the patient stories were available on the intranet.

14/381 PATIENT EXPERIENCE QUARTERLY REPORT

The PEL presented the quarterly report and highlighted the progress being made in relation to implementing the Friends and Family Test, and other national surveys, as well as the progress in relation to our achievement with the CQUINS.

Overall the feedback on Trust services is positive, and work needs to continue to ensure that we are learning from feedback but identifies some themes around need to improve communication and raise the awareness/deliver training to support caring for patients with a disability. The Trust needs to develop a centrally co-ordinated approach to surveys and patient experience activity to ensure we are capturing and reporting this to inform service improvement.

The SEEBM confirmed that other surveys would be included within the report.

14/382 FRIENDS & FAMILY TEST ROLL OUT - UPDATE ON ACTION PLAN

The PEL advised that the action plan provides assurance of the roll out / implementation plan in relation to Friends and Family Test (FFT). Whilst some of the original deadlines have slipped, we are still in line or ahead of national implementation dates. Currently the majority of feedback is via paper based surveys, but the Tablet devices are being used more proactively in the clinical areas, and it is anticipated that this will continue to develop as we continue to embed the FFT across the Trust.

PR advised that it would be helpful to liaise with the visually impaired to ensure that the revised format of the questionnaire was suitable. The PEL confirmed that there would be a discussion group involved and that this would be taken into consideration.

14/383 COMPLAINTS QUARTERLY REPORT

The PEL presented the report for quarter 2 activity and identifies that overall we have seen a slight decrease in complaints for quarter 2 compared to the same time last year. July received the highest number of complaints. 39% of the complaints received were managed within the timescale.

Key points from the report:

- General Surgery received the highest number of formal complaints during the quarter with 6, 14 returned complaints were received during the quarter across both clinical directorates
- 5 requests were received from the Parliamentary Health Service Ombudsman

- This quarter we have seen an increase of 75% compared to the same period last year on concerns managed.
- OPARU had the highest number of concerns with 54, and the Emergency Department received 25.
- Patient Advice and Liaison (PALs) contacts were 76 compared to 48 last year in the same period. Of those 46 were direct contacts using the new PALS office, compared to zero in 2013/14

The SEEBM advised that at the next SEE meeting there would be a full report with more directorate focus. The Chairman asked that she attend the January SEE meeting.

Action Note: *SEEBM to invite the Chairman to the January SEE meeting.*

Action by: SEEBM

CLINICAL AUDIT AND GOVERNANCE

14/384 GOVERNANCE & ASSURANCE REPORT

The HCGRM presented the report and highlighted the key issues:

- **Key issue 1** Significant increase in Staffing Levels Incident Reports this quarter (page 2), mainly relating to Sandown Health Centre, Stroke/Neuro, Whippingham Ward & St Helens Ward.
- **Key issue 2** Significant increase in Pressure Injury incidents (page 2) from Community / District Nursing.
- **Key issue 3** Significant increase in incident reporting from Stroke/Neuro this quarter (page 2), mainly Staffing Level Incidents and Verbal Abuse/Threat Incidents mainly regarding one patient.
- **Key issue 4** Increase in Unexpected death reports (page 3), possibly due to increased reporting from Mental Health Services following the CQC Inspection.
- **Key issue 5** CQC Inspection (page10) - Development of the Quality Improvement Plan, following the CQC Inspection in order to deliver the required actions to improve the quality of our services.
- **Key issue 6** NICE GUIDELINES (page 11) - The recent CQC inspection identified that the Trust did not have robust systems and processes in place for the review of compliance with national guidance. Work is required to improve our governance around NICE Guidance compliance

14/385 UPDATE ON CLINICAL AUDIT PROGRAMME

The SEEBM advised that the National Audits are comprised of all clinical audits for which the Isle of Wight NHS Trust should participate in and report on via the Quality Accounts (QA). The Trust is intending to participate in all relevant audits. There is also one additional audit, not required to be reported in the annual Quality Account submission, but the Trust will be participating in. These figures do not include audits that are not applicable to the Trust, due to the services not being offered on the Isle of Wight.

She confirmed that there was a meeting planned for later in the day with Nina Moorman to discuss how to provide assurance on Clinical Audit

CLINICAL PERFORMANCE AND RISK

14/386 BOARD SELF CERTIFICATION

The BPFTPMO presented the report and highlighted the following:

- **Board Statements 1, 2, 6 and 14** remain 'at risk' as a consequence of the CQC inspection undertaken in June 2014. At the Board Meeting in October 2014 the Board also determined to certify Board Statement 13 as at risk due to its close association with Board Statement 14. The target date for compliance set by the CQC is 12th December 2014 and these statements will remain at risk until the CQC has confirmed compliance. At the point of writing there are risks to delivery of the quality improvement action plan emerging which may result in compliance with these Board Statements not being achievable by 31st December 2014.
- **Board Statement 10**, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, also remains 'at risk' and the decline in the governance risk rating score (GRR) in August 2014 has pushed the forecast compliance date into quarter 3 to allow for a positive trend towards recovery to be established. Although the quarterly GRR for Quarter 2 was at 9.0, the worst position since the self-certification process was initiated in 2012, the monthly score moved favourably from the August position moving towards a positive trend. At the point of writing it is too early to obtain an indication of the GRR performance for October 2014.
- **Licence Conditions:** All Licence Conditions remain marked as compliant. Condition G7 (Registration with the Care Quality Commission) could be put at risk if the CQC action plan is not delivered sufficiently to the satisfaction of the CQC. It is not presently recommended that this condition be put at risk.

Recommendation: It is recommended that the Committee:

- Determine whether sufficient assurance has been provided to recommend that Trust Board approve the self-certification returns for submission to the TDA
- Where required, recommend additional assurance requirements to the Board

The Committee approved the TDA Self Certification with the recommendation to the Board

14/387 MINUTES OF COMMITTEES AND WORKING GROUPS

a) Infection Prevention & Control Committee

The Committee received the minutes from the Infection Prevention and

Control Committee (IPCC) meeting held on 9th October and 5th November 2014.

14/388 ANY OTHER BUSINESS

- a) **Visit to Stroke Rehabilitation Unit** - The PR advised the Committee that following a visit he would be preparing a report on his observations. He did comment that the colour scheme was not suitable for the visually impaired. The EDNW requested that he visit MAU which is currently on the Appley Ward site and provide his feedback. The PR agreed to do this.

14/388 DATE OF NEXT MEETING

Wednesday 17th December 2014
Time: 9 am to 12 Noon
Venue: Conference Room

14/390 MEETING SCHEDULE FOR 2015/16

Quality & Clinical Performance Committee

Meetings will be held monthly on the last Wednesday of the month unless otherwise stated.

Wednesday 21 st January 15	Wednesday 25 th February 15
Wednesday 25 th March 15	Wednesday 29 th April 15
Wednesday 27 th May 15	Wednesday 24 th June 15
Wednesday 29 th July 15	Wednesday 26 th August 15
Wednesday 30 th September 15	Wednesday 28 th October 15
Wednesday 25 th November 15	Wednesday 23 rd December 15
Wednesday 27 th January 16	Wednesday 24 th February 16
Wednesday 30 th March 16	

Signed: _____ Chair

Date: _____

For Presentation to Trust Board on 3rd December 2014
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FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE MEETING

Minutes of the Isle of Wight NHS Trust Finance, Investment, Information & Workforce Committee (FIWC) meeting held on Wednesday 19th November 2014 in the Large Meeting Room.

PRESENT:	Charles Rogers	Non-Executive Director (Chair) (CR)
	Jane Tabor	Non-Executive Director (JT)
	David King	Non-Executive Director (DK)
	Chris Palmer	Executive Director of Finance (EDoF)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Katie Gray	Executive Director of Transformation and Integration (EDTI)
	Kevin Curnow	Deputy Director of Finance (DDoF)
In Attendance:	Calum Robertson	Workforce Information Officer (WIO) <i>(For items 14/183 & 184)</i>
	Iain Hendey	Deputy Director of Informatics (DDoI) <i>(For item 14/190 197)</i>
	Sarah Johnston	Deputy Director of Nursing (DDN) <i>(For items 14/185 & 186)</i>
	Andy Heyes	Head of Commercial Development (HCD) <i>(For item 14/201)</i>
	Andrew Shorkey	Programme Manager - Business Planning & Foundation Trust Application (BP&FT) <i>(For item 14/203)</i>
Minuted by:	Lynn Cave	Trust Board Administrator
Observed by:		

To be Received at the Trust Board meeting on Wednesday 3rd December 2014	
Key Points from Minutes to be reported to the Trust Board	
14/185	Safer Staffing – The Committee supports the submission of the business case for safer staffing to the CCG for consideration of current funding.
14/192	CIPS – The Committee discussed the remaining CIP gap of £3.312m and had a full and wide ranging discussion surrounding the cost improvement process and the current levels within the directorates which included how the teams would be supported. Clinicians support was also flagged as an important factor in the success of any potential initiative.
14/195	Sub Committee's responsibilities: The Committee expressed concern as to where within the sub-committee structure Information Technology, Estates, Board Assurance Framework and Corporate Risk was reviewed. The Committee felt that it was not appropriate for these areas to go directly to the Audit & Corporate Risk Committee without prior discussion at sub-committee level.
14/200	Business Case – Ambulance CAD (Computer Aided Despatch): The Committee recommends the business case for the ambulance for computer aided despatch upgrade for formal approval.
14/203	Self Certification: the Committee requested that the statements be reviewed and revalidated by the owners of the reports with particular note to the wording used.

14/175 APOLOGIES

Apologies for absence were received from Mark Elmore, Deputy Director of Workforce, Stewart Churchward, Workforce Planning and Information Manager and Gary Edgson, Head of Financial Management

Calum Robertson attended as Deputy for Stewart Churchward.

14/176 CONFIRMATION OF QUORACY

The Chairman confirmed that the meeting was quorate.

14/177 DECLARATIONS OF INTEREST

There were no declarations.

14/178 APPROVAL OF MINUTES

The minutes of the meeting held on the 22nd October 2014 were agreed by the Committee and signed by the Chairman.

14/179 SCHEDULE OF ACTIONS

The Committee reviewed the schedule of actions taken from the previous meetings and following discussion on each action the following was agreed:

- a) 14/098 – Due date amended to January meeting
- b) 14/127a – Action Closed
- c) 14/127c – Drug & Alcohol Policy on agenda. Action Closed
- d) 14/128b – Renovations to Level C presented to TEC on 17th November. Action Closed
- e) 14/129b – Action Closed
- f) 14/153 – Business plans will be on agenda for January 2015 meeting.
- g) 14/164b – Audit completed. Action Closed
- h) 14/164c – SLA activity now part of weekly performance review and reported by PIDs team - Action Closed
- i) 14/164a – Action Closed
- j) 14/165a – Reporting development in progress - due date amended to December meeting
- k) 14/165b – Action Closed
- l) 14/165c – Responsibility for this action to be moved to the EDTI and the due date amended to December meeting
- m) 14/165d – Action Closed
- n) 14/165e – Due date amended to December meeting
- o) 14/166b – Agreed that EDTI would discuss with Company Secretary to arrange for Capital Planning to be taken to Board as a strategic seminar item. Action Closed.
- p) 14/167b – Procurement Update Report to come to December meeting so due date amended to December meeting
- q) 14/167c – Reference Costs will not be published until early December so due date amended to December meeting
- r) 14/168b – Action Closed
- s) 14/168c – Terms of Reference would be reviewed at December meeting and finalised in January 2015 prior to submission to the Audit & Corporate Risk Committee in February for approval; Formal approval to be at Trust Board on 4th March 2015
- t) 14/168a – Action Closed.

LONG TERM STRATEGY AND PLANNING

14/180 LONGER TERM FINANCIAL MODEL (LTFM) & 2 YEAR OPERATING PLAN UPDATE

The DDoF advised that the LTFM was progressing and a draft version would be available in January 2015 and would include activity, cost improvement plans and capital planning. The DDol confirmed that the reporting model would also be ready for January. The DDoF confirmed that the final version of the 2 year operating plan would be submitted at the end of March 2015 with the 5 year operating plan in June 2015.

The EDoF advised that the Board had received a presentation from Anne Dawson and Daniel Stephens from the TDA¹ on Downside Scenarios Planning and stressed the need for the Trust Board to have a robust plan in place. She advised that this had been previously discussed at Board Seminar on 2 occasions. She requested that the Board discuss and develop the Downside Scenarios and Mitigation Plans at their January seminar in order that a formal plan could be developed and finalised in preparation for the Trust's Business Plan.

Action Note: EDoF to arrange with the Company Secretary that a strategic seminar to discuss the LTFM Downside Scenarios be agreed for 13th January 2015.

Action by: EDoF

CONTRACTS AND ACTIVITY

14/181 CONTRACT STATUS REPORT SUMMARY

The DDoF presented the Contracts Status report and highlighted the following:

- The NHS England contract has under-performed by £416k to month 6. Forecast full year effect would be estimated at £633k of under-performance at the year end.

14/182 OPERATIONAL PERFORMANCE INCLUDING SLA ACTIVITY

The DDol presented the report and highlighted the following:

Planned Care Contract Performance M6:

- The Year to Date variance against the CCG current contract position is £527k below plan, which is a £10k decrease from M5.
- Elective activity has moved a further £54k below plan in month.
- Significant under performance in Trauma & Orthopaedics - 101 spells and £415k, Surgery - 67 spells and £85k, and Gynaecology - 26 spells and £67K.
- Large amounts of uncoded activity have led to a movement of £124k in outpatient procedures. Ophthalmology makes up the majority of this, a financial adjustment has been made of £74k below the line.
- Outpatient activity was £58k below plan in month – YTD position of £90k underperforming.
- General Surgery Activity, 724 attendances and £132k below plan.

¹ Trust Development Authority

- Paediatrics, 484 attendances & £66k under plan
- Pre-assessment activity 236 & £21k below plan

Unscheduled Care Contract Performance M6

- Current contract position is £518k above plan, £180k Increase from M5.
- Emergency spells are £61k above plan. A movement of £112k in month
- Trauma & Orthopaedics - 47 spells & £105k above plan
- Surgery - 243 spells & £370k below plan
- General Medicine - 63 spells below plan but £219k above budget
- Urology - 43 spells and £196k above plan
- Non Elective Non-Emergency Spells £241k over plan
- General Medicine - 35 spells, £104k
- Paediatrics - 71 spells, £56k – Corresponding underperformance in Well Baby activity.
- A&E activity- 1,172 attendances and £184k above plan
- Ambulance services are £71k above plan particularly in the Hear & Treat category
- Critical care activity is 10 bed days and £75k below plan.
- Small accrual of £13k is included
- £69k over performance in ward attendances specifically Paediatric and NICU attenders

The Chairman asked if it was anticipated that the underperformance levels would reach planned levels by year end. The EDNW advised that it was not anticipated that this would wholly occur due to patient choice of provider. If patients choose to go to another provider the funding would go with them. The DDoF advised that any underperformance against contract would be reviewed by the CCG during contract review and it was possible that funding could be reduced for next year. He stressed the need for the organisation to show that it had capacity to undertake the full contract provision even if at year end an under performance was reported. JT asked if any needs based reduction had been investigated. The EDoF advised that patients had in appropriate cases been offered treatment at another provider but some had chosen to wait for treatment on the island. The EDNW advised that a base line level of service provision across services was being looked at on a weekly basis. The DDol advised that currently a reporting model was being developed by consultants Draper & Dash which would show capacity across the organisation, including required staff levels, and he confirmed that this was anticipated to be completed within the next few weeks.

JT asked if over performance on activity was being monitored. The DDol advised that an audit was in process to review the variable factors on medical care which it was anticipated would show where changes could be made to balance capacity to undertake activity across the organisation.

WORKFORCE PERFORMANCE

14/183

WORKFORCE PERFORMANCE REPORT INCLUDING SBS PAYROLL REPORT

The WIO presented the report and highlighted the following:

- Total pay bill exceeds budgeted expenditure in month by £214k in

month and £467k year to date. He advised that the Master Vendor contract had commenced on 17th November and it was anticipated that this would show benefits in the coming months.

- Overspend is predominantly with the Hospital departments of Hospital & Ambulance Directorate but also Mental Health in month.
- Community & Mental Health and Non-Clinical directorates continue to operate close to or within budget.
- In month sickness rate reduced to 4.44% from 4.55% in September and against a target of 3%. Anxiety/Stress/Depression related sickness absence fell significantly in month but is offset by an increase in cold & flu, and chest & respiratory related sickness absence.
- Unfilled budgeted positions reduced to 7.2% of total funded establishment from 8% in September.

Key risks identified:

- Sickness Absence over plan
- Reduction in in-post budgeted establishment
- Continued high level of Agency & Bank Spends

The WIO highlighted the cost of overpayments to staff and advised the Committee that managers were being reminded of the importance of submitting timely change forms, late terminations etc., which can result in the overpayment of staff. He advised that recovery of these funds is agreed on a case by case basis. The EDoF stated that legally the organisation has no discretion and should aim to reclaim any overpayment immediately and in full unless hardship is proven and asked if details of repayment levels could be added to the report for the future.

Action Note: WIO to amend the Overpayment report to include levels of recovered funds and timeline to full recovery.

Action by: WIO

JT queried why the level of Cardiology Medics was showing higher than plan and why were agency staff being used. The EDNW advised that there was a staff member off with long term sickness and their colleagues were covering their workload. The over plan would include any agency staff used to cover absence by these staff members.

The DDoF asked that the WIO review the data extraction results on the Workforce – KPI for accuracy as there appeared to be a slight problem.

Action Note: WIO to review report for accuracy in data extraction.

Action by: WIO

14/184

WORKFORCE STRATEGY INCLUDING KPI'S

The WIO gave an overview of the Workforce Strategy KPI's. He confirmed that the ESR team were currently undertaking a system refresh and data audit.

JT queried the level of appraisals showing at 50%. The WIO advised that completion of appraisals should be advised via email by managers on completion and that a reminder was being circulated to improve returns.

JT asked if managers were fully aware of the process involved with staff who are being reviewed under the grievance, disciplinary, capability process and who were off sick during the process. He advised that there was still work to be done to ensure that these processes were embedded within the organisation but work was being undertaken with core groups to ensure that this was achieved.

The Chairman stated how important these KPI's were and requested further breakdown within the report for future meetings.

Action Note: *WIO to review the Workforce Strategy inc KPI report for future meetings.*

Action by: WIO

14/185 SAFER STAFFING - BUSINESS CASE

The DDN presented the business case for Safer Staffing to the Committee. She advised that there has been significant work undertaken in the last 6 months to create evidence based nursing establishments for all Inpatient Acute Wards and Units and for Mental Health inpatient wards. The National Institute for Clinical Excellence (NICE) recently produced guidelines which utilise the Safer Nursing Care Tool (Shelford Model) for acute care. This model has been used to underpin the Trusts Safer Staffing principles. Information derived from the application of the Safer Staffing Tool has been reviewed at the Trusts Quality & Clinical Performance (QCPC), Finance Investment, Information & Workforce Committee (FIWC) and the Trust Board. The revised establishments have been identified through a robust process of use of evidence based tools, working to underpinning principles agreed by the Trust Board, professional opinion and senior scrutiny and challenge.

The Board previously approved the development of a business case.

This business case sets out the options for implementation. At this stage it is unclear as to whether additional funding will be made available by the CCG. The Committee was reminded that 'safer staffing' is the responsibility of the organisation. NICE guidelines, National Quality Board, Care Quality Commission and NHS England have provided guidance, requirements, and expectations, which have been received by the Trust and their application previously supported by the Trust Board.

The recommendations aim to reduce clinical risk for those areas with a significant percentage gap on their new establishments. Those areas that are key service change areas – one front door staffing requirements (ED and paediatric) and psychiatric on call have been taken into account. The recommendations take into account the planned recruitment of 30 staff from overseas to fill existing vacancies which have been dispersed between the wards, and plan for additional staff to be recruited in June 2016. Risks are also identified.

DDN advised the Committee that this paper had been presented to TEC on 17th November at which time a number of adjustments to Option 1 were requested. These were being developed and would be submitted to the CCG for discussion.

A discussion took place surrounding the preferred option 3 and the

implications of the various funding scenarios and the effects this could potentially have on service provision.

The Committee agreed to recommend that following the adjustments requested by TEC that the business case be presented to the CCG, and also to Board on 3rd December for discussion. Following receipt of the outcome from the CCG, the Board will need to consider and make a formal decision on whether to proceed with the preferred option.

The FIWVC supports the submission of the Business Case for Safer Staffing to the CCG via the Contracts team for consideration of current funding and then to Trust Board.

Action by: DDN

14/186 SAFER STAFFING - INTERNATIONAL RECRUITMENT

The DDN briefed the Committee on the plans for international recruitment to support the Business Case for Safer Staffing. She advised that funding for additional staff recurrent costs are not yet identified but this was included within the business case. It was noted that the CCG has agreed to fund the non-recurrent costs of the recruitment process.

International recruitment is planned with the recruitment company Drake Medox, to enable successful initial recruitment of nurses from the Philippines. Staff travel out to the Philippines on 23rd January 2015 to start the process and we anticipate staff will be in post by April 2015.

JT asked if the recruitment staff costs would be lower due to the offset of bank staff costs. The DDN advised that this was likely not the case as bank staff are paid at a flat rate whereas staff are on a variable scale. She advised that the 30 current vacancies are for registered nurses and this was in addition to the planned 2 stage cohort of international recruits (41 1st cohort of which 30 will fill the vacancies leaving 11 extra staff).

JT queried if there were likely to be any immigration issues. The EDNW advised that the Deputy Director of Workforce explored potential staff markets in the EU and confirmed that most Trusts were having to look abroad for staff due to lack of available nurses within the UK. He outlined the reasons for looking outside the EU and confirmed that the Philippines training for nurses was of a comparable standard to the UK. The recruitment process was managed by the recruitment company who would gain any necessary visas, registration and qualification assessments prior to staff starting with the organisation.

The Committee agreed to support this recruitment process in conjunction with the Business Case for Safer Staffing

14/187 DRUG & ALCOHOL POLICY STATUS

The EDNW presented the Drug & Alcohol Policy which he confirmed had been approved by the Policy Management Group on 18th November 2014.

As an organisation directly concerned with health care and health promotion, the Isle of Wight NHS Trust is eager to promote sensible practices in relation to the use of alcohol and drugs. This policy gives guidance to ensure that employees carry out their jobs safely and effectively in an environment which is free from alcohol and drug misuse. The Trust

recognises that alcohol and drug dependency is a health issue which it will seek where appropriate to address in a supportive and positive way.

A discussion took place surrounding the use of alcohol within the staff residential areas of the site and in particular section 6.3 which states:

The Trust is an alcohol free site. Occasionally alcohol may be consumed at social events such as a retirement or other celebration in appropriate areas of Trust premises by off duty staff. A range of non-alcoholic beverages must be available particularly for staff who will be commencing or returning to duty or driving after the event. Alcohol is permitted when used for the Sacrament of Holy Communion.

The EDoF also queried if random breath testing should be included within the policy. The Committee agreed to recommended 2 changes and additions to the policy:

- Random breath tests should be permitted
- Staff should be excluded if they test positive

The Committee felt that a revision should be made to clarify the use of alcohol within the onsite medical staff residences and it was agreed that the EDNW would discuss these with the Culture, Health & Wellbeing lead. These reviews would then be required to be ratified by the Policy Management Group but would not need to be seen at FIWC before approval at TEC.

Action Note: EDNW to discuss amendments to Section 6.3 with the Culture, Health & Wellbeing lead and for the amended policy to be ratified by the Policy Management Group and approved by TEC.

Action by: EDNW

14/188 WORKFORCE VACANCIES REPORT

The EDNW presented the Workforce Vacancies report highlighting the following:

- 102.53 FTE's being recruited to by the workforce recruitment team, against a budgeted under establishment of 211.26 FTE's.
- Area's where budgets are over established or where recruitment will result in an over-establishment.

He advised that in some cases levels of over establishment were showing and this was due to the recruitment process being activated during the notice period of the outgoing staff member. These levels would balance once the new staff member was in post.

JT asked how the Trust benchmarked against other Trusts. The EDNW advised that the KPIs were linked to turnover of staff and at present had not been benchmarked against national data. The EDoF confirmed that this data would be of value when reviewing CIP work within the organisation.

Action Note: EDNW to arrange for investigation into benchmarking staff vacancies against other Trusts.

Action by: EDNW

14/189 **ELECTRONIC STAFF RECORD SYSTEM**

The EDNW advised that due to Electronic Staff Record System data validation process currently being taken this report would be carried forward to next month at which point the revised report would be presented.

Action by: EDNW

TRANSFORMATION MANAGEMENT OFFICE

14/190 **PERFORMANCE OF DIRECTORATE SAVINGS SCHEMES**

The EDTI presented the report to the Committee and advised currently the Trust's Gap to Savings Target stood at £3,312m in year with £4,492m recurring.

She advised that the Project Management Office had now reviewed the majority of the proposed plans but that more work needed to be done within the Directorates to increase potential for recurring savings. This was being undertaken in conjunction with the Finance and Estates teams with the Executive Directors being allocated specific areas to challenge progress.

The EDTI reported on the progress of the PMO Idea Generation forum which had been launched at the Executive Briefing in November. Unfortunately, to date response had not been favourable but it was felt that this could be down to a lack of understanding that all staff members can contribute ideas and that it is everyone's responsibility to help the organisation work more effectively on behalf of patients.

The Committee had a full and wide ranging discussion surrounding the cost improvement process and the current levels within the directorates which included how the teams would be supported. Clinicians support was also flagged as an important factor in the success of any potential initiative.

14/191 **CAPITAL PLANNING UPDATE**

The DDoF presented the report and highlighted the following:

- **Capital Resource:** The total Capital Resource for this year was originally approved at £8.3M. This included property sales of £648k, but these are expected to be sold during 2015/16 bringing the forecast expenditure to £7.7M for 2014/15.
- **Strategic Capital Schemes:** All schemes are progressing well and expected to complete within planned timescales, apart from Ryde Community Clinic. Additional funding has been approved and the completion date of this project will be the end of March. The ICU/CCU project has been paused, and the funding reallocated to bring the completion date of MAU Extension and Endoscopy Relocation projects forward.
- **Operational Capital:** Bids for IM&T RRP and Equipment RRP were brought to the Capital Investment Group in November. Two bids are currently being re-worked to bring them into line with the available funding.

The Chairman asked if there was a backup plan in place should the Endoscopy Relocation be delayed. The EDoF confirmed that concerns have been raised with a potential £2.5m underspend at year end which would result in a loss of the funds. She also advised that any delays were subject to penalty charges which had the potential to increase the project costs over the approval threshold and which would result in the project requiring TDA approval. DK asked if there were any other factors. The EDNW confirmed that the Winter Resilience measures were a factor but options were to be presented to TEC on 24th November which could reduce the risks. The Chairman was keen for alternative plans to be developed and the EDNW assured the Committee that discussions were in progress and further developments would be reported to TEC.

FINANCIAL PERFORMANCE

14/192 FINANCIAL PERFORMANCE REPORT

The DDoF presented the financial performance report to the Committee and highlighted the following:

- The Trust is reporting a £1.495m surplus in the year to October 2014, which is £99k less than the Plan submitted to the Trust Development Authority. The position is based on the contracts agreed and signed with commissioners and also reflects activity levels to October however these variances are largely mitigated by the Risk Share Agreement with the local Clinical Commissioning Group (CCG).
- £1.7m of forward banking of CIP recognised to the end of month 7.
- The Trusts planned forecast out-turn surplus remains at £1.7m but the current clinical directorates performance continues to increase the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.

The Committee agreed that the format of the report was good but asked that 'best case/ worst case/most likely' scenarios be added for future reports.

Action Note: *DDoF to review the financial performance report to incorporate best case/worst case/most likely scenarios.*

Action by: DDoF

JT asked for further clarity on the Ambulance Fines reported. The DDoF advised that these were discussed at the monthly meeting with the CCG. The EDNW also confirmed that an audit was in progress to validate times.

14/193 PROCUREMENT UPDATE TENDER

The DDoF reported that as part of the review of the procurement provision to the Trust and to ensure a new procurement service model / contract is effectively established it is likely a recommendation will be made to FIWC to extend the current contract with South of England Procurement Services for 6 months taking us to September 2015.

He confirmed that an audit of the service is being undertaken with a view to going out to formal tender for procurement provision to the organisation.

AUDIT AND GOVERNANCE

14/194 STANDING FINANCIAL INSTRUCTIONS (SFIS) SCHEDULE OF PROPOSED AMENDMENTS

The DDoF confirmed that the SFIs are currently under review and will be presented to Committee in January.

Action by: DDoF

14/195 AUDIT OUTSTANDING ACTIONS TO BE TAKEN FORWARD

The DDoF advised that these actions went to the Audit & Corporate Risk Committee on 13th November.

The EDoF requested that in future that they are presented to FIWIC prior to any submission to Audit & Corporate Risk Committee. The Committee agreed that this was appropriate.

Action by: DDoF

The DDoF confirmed that there were no outstanding actions.

The Committee expressed concern as to where within the sub-committee structure Information Technology, Estates, Board Assurance Framework and Corporate Risk was reviewed and assurance gained. The Committee felt that it was not appropriate for these areas to go directly to the Audit & Corporate Risk Committee without prior discussion at sub-committee level.

The Committee recommended that the Board discuss where these activities would best be reviewed within the sub-committee framework to provide appropriate assurance to the Audit & Corporate Risk Committee and the Trust Board.

Action by: EDNW

14/196 STATUS OF FINANCIAL AUDITS INCLUDING FORWARD PLAN

The DDoF confirmed that 6 audits had taken place year to date with 2 receiving full assurance, which was very positive, and 4 substantial assurance. All audits were on track for completion by the end of the financial year. The EDoF confirmed that during the last financial year all audits had been completed.

INFORMATION

14/197 DATA QUALITY

The DDofI presented the report and noted that our data is good compared to national figures.

The information centre carry out an analysis of the quality of provider data submitted to Secondary Uses Service (SUS). They review 3 main data sets - Admitted Patient Care (APC), Outpatients (OP) and Accident & Emergency (A&E). The latest information is up to August 2014.

Overall we have 3 red rated indicators 2 of which are in the Admitted Patient Care Dataset with the third in the A&E dataset. The Outpatient dataset indicators are all green. The 2 indicators in the APC dataset are the Primary Diagnosis and the HRG4 (Healthcare Resource Grouping) these are linked as you need the diagnosis to generate the HRG. The position has improved

month on month and relates to an issue with records not updating in SUS despite appearing in our CDS file, we are still trying to determine if the problem is with a translator service that converts the file to the required format or with SUS processes.

The EDoF advised that it was good that the NHS Numbers had upgraded to amber but this was not a cause for concern as it included HMP inmates which prove difficult to trace their NHS numbers.

The Committee requested that an update on the audit for Waiting Lists be brought to FIWC at the December meeting and that Reference Costs be brought to the January meeting.

***Action Note:** DDol to arrange for the results of the Waiting List Audit to be scheduled for the December Meeting and Reference Costs scheduled for the January meeting.*

Action by: DDol

INVESTMENT / DISINVESTMENTS

14/198 STRATEGIC ESTATES PARTNER (SEP) UPDATE

The EDTI reported that TDA approval to proceed to contract sign was given on the 12th November 2014. Offer made to the TDA of our strategic estates partner being a reference site for other aspirant Trusts. The contract was signed on the 13th November 2014 between Isle of Wight NHS Trust and Ryhurst to form *Wight Life Partnership LLP*.

She confirmed that the next steps to operational transition are the Wight Life Partnership launch event on 4th December 2014 and the Inaugural Wight Life Partnership Board also on 4th December 2014.

14/199 CARBON ENERGY FUND UPDATE

The EDTI reported that the application had now proceeded to the TDA in accordance with the timeline. She reported that the team were confident that although there were some risks showing as red within the top 5 risks there were strict governance procedures in place to mitigate any potential risk.

The Chairman queried if the oil price decreases were factored into the costings and asked for assurance that the Trust would get value for money on its energy costs. The DDoF advised that the tariff costs showed as a long term benefit and the DDoF also confirmed that the costing model used ensured that this would occur. The Committee requested that more information on energy tariff provision be provided.

***Action Note:** EDTI to provide further information on energy tariff provision to ensure that value for money was achieved.*

Action by: EDTI

14/200 BUSINESS CASE – AMBULANCE CAD (COMPUTER AIDED DISPATCH)

The EDNW presented the Business Case for Ambulance Computer Aided Despatch. He outlined the benefits of the system and confirmed that the paper had been seen and recommended by the Capital Investment Group and TEC.

He advised that TEC had requested that the wording be changed from Isle of Wight Ambulance Service to Isle of Wight NHS Trust Ambulance Service to reflect the integrated service.

The EDoF confirmed that the bid was within the capital budget balance.

JT expressed concern over the potential risk of unsupported IT controls and questioned if the IT department had capacity to maintain this system. The Committee agreed that the EDNW and EDTI would review this risk.

Action Note: EDNW & EDTI to ensure that IT controls were in place to mitigate any potential IT risk through unsupported IT provision.

Action by: EDNW/EDTI

The Committee recommended the Business Case for Ambulance Computer Aided Despatch for formal approval.

14/201

NURSING TECH FUND BID

The HCD presented an overview of the Nursing Technology Fund to support nurses, midwives and health visitors to make better use of digital technology in all care settings, in order to deliver safer, more effective and more efficient care. He confirmed that the second round of funding, for £350M, was for funding to be spent in FY14/15 or 15/16 (separate bids) and that the funding award will not require matched funding.

He advised that the Trust was proposing to place 2 bids for funding and that work to prepare these was currently ongoing. An interim update would be provided to TEC on November 24th, with an executive summary of the proposed bids. The final authority panel will be agreed. It is proposed that TEC delegate authority to a select panel to oversee the submission of a robust and assured bid.

The EDoF stressed the need for the bids to follow the baseline business case format and Trust approval process if successful to ensure that they were robust and governance could be assured.

Action by: HCD

The EDNW confirmed that all bids would be reviewed at the Directorate Nursing Team meeting.

The HCD also confirmed that the bids would be reviewed for IT impact by the IT Delivery Group.

The Committee asked that if the bid was successful the HCD return to present the project scope to the committee for assurance.

Action by: HCD

14/202

CAPITAL SCHEMES BENEFITS REALISATION

The EDoF outlined the criteria for capital scheme benefits realisation and reported on the following schemes:

Ominicell Medicine Cabinets

The medicine cabinets are automated, there are fifteen areas, with twelve currently using the system, in line with hospital works being carried out. The following is based on 1-3 month data:

- One off saving on installation, forecast £10k saving across fifteen areas, to date £15k has been achieved across five areas.
- Monthly drug expenditure, forecast saving of £20k per annum across fifteen areas, achieved £10k across five areas to date.
- Staff time is saved, not having to look for keys, searching for the correct drug, prevents missing stock, missed doses.
- The Trust is the first to link up to the system in the country, interfaced completed with JAC and Omnicell.
- Monthly reports are conveyed to NHS England.
- The Trust has received visits by six other Trusts to view the system, with excellent feedback.
- Revenue had been a surprise as other Trusts had savings of 10%, we currently are saving 30%. Maintenance costs will balance the drug savings.
- Good evidence that the capital invested had delivered the expected benefits.

Endoscopy camera guide and Insufflators

The objective of this equipment was to improve patient safety and experience for our endoscopy patients through procurement of minimum national bowel screening equipment requirements.

The benefits of this equipment has been:

- Patient more comfortable, less sedation required, improving recovery
- Improved quality of procedure
- Reduction in discomfort for patients and a faster recovery period.

The Committee welcomed the receipt of the benefits realisation assurance and looked forward to receiving further reports.

14/203

BOARD SELF CERTIFICATION REVIEW

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

- **Board Statements 1, 2, 6 and 14** remain 'at risk' as a consequence of the CQC inspection undertaken in June 2014. At the Board Meeting in October 2014 the Board also determined to certify Board Statement 13 as at risk due to its close association with Board Statement 14. The target date for compliance set by the CQC is 12th December 2014 and these statements will remain at risk until the CQC has confirmed compliance. At the point of writing there are risks to delivery of the quality improvement action plan emerging which may result in compliance with these Board Statements not being achievable by 31st December 2014.
- **Board Statement 10**, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, also remains 'at risk' and the decline in the governance risk rating score (GRR) in August 2014 has pushed the forecast compliance date into quarter 3 to allow for a positive trend towards recovery to be established. Although the quarterly GRR for Quarter 2 was at 9.0, the worst position since the self-certification process was initiated in 2012, the monthly score moved favourably from the August position moving towards a positive trend. At the point of writing it is too early to obtain an indication of the GRR performance

for October 2014.

- **Licence Conditions.** All Licence Conditions remain marked as compliant. Condition G7 (Registration with the Care Quality Commission) could be put at risk if the CQC action plan is not delivered sufficiently to the satisfaction of the CQC. It is not presently recommended that this condition be put at risk.

Statement 6: A discussion took place surrounding the wording of Statement 6 in which JT expressed concern that the risks were far broader than shown in the CQC report. She asked that the Committee recommend to the Board that a review of the risk management process be undertaken as part of this assurance process. JT stated that gaps in the Trust's risk management arrangements are broader than that exposed as a consequence of the CQC inspection. JT felt that the Board needs to have a more detailed discussion around how it is assured about risk management arrangements.

Statement 7: The EDoF noted that threats to compliance were not identified and asked that review be undertaken.

Statement 4: The EDoF commented that the GRR was not relevant as evidence against this statement. BP&FT advised that validation of the statements was in some cases delayed.

The EDoF queried where monitoring of compliance to the NHS Constitution occurred.

The Committee requested that the assurance documents be re-validated and updated as appropriate by their owners.

14/204 COMMITTEES PROVIDING ASSURANCE

(a) Minutes from the Capital Investment Group

The Committee received the minutes of the Capital Investment Group held on 7th November.

(b) Quality and Clinical Performance Minutes from Meeting 17/09/14

The Committee received the minutes of the Quality & Clinical Performance Committee held on 22nd October 2014.

The EDNW draw the Committee's attention to the investment in the Meditrac which was being piloted on Whippingham ward with 10 beds. Patient's vital statistics were logged onto the tablet which displayed on a screen above the bed. Doctors could be messaged with updates on their patients via the system. The confirmed that the results were very positive.

The EDTI updated the Committee on the roll out of the ISIS project and advised that there was still working being undertaken to match with the care pathways. Work was in progress within this area.

14/205 ANY OTHER BUSINESS

a) External Agencies Report

The EDoF asked that this item be deferred to the December meeting.

14/206 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Finance, Investment & Workforce committee to be held is on Wednesday 17th December 2014 from 1.00pm – 4.00pm in the Large Meeting Room.

The meeting closed at 4pm.

14/207 MEETING SCHEDULE FOR 2015/16

Finance, Investment, Information & Workforce Committee

Meetings will be held monthly on the last Tuesday of the month unless otherwise stated.

Tuesday 21 st January 15	Tuesday 24 th February 15
Tuesday 24 th March 15	Tuesday 28 th April 15
Tuesday 26 th May 15	Tuesday 23 rd June 15
Tuesday 28 th July 15	Tuesday 25 th August 15
Tuesday 29 th September 15	Tuesday 27 th October 15
Tuesday 24 th November 15	Tuesday 22 nd December 15
Tuesday 26 th January 16	Tuesday 23 rd February 16
Tuesday 29 th March 16	

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 3rd December 2014

Title	Serious Incidents Requiring Investigation (SIRIs) Report					
Sponsoring Executive Director	Alan Sheward Executive Director of Nursing and Workforce					
Author(s)	Prepared by: Sarah Johnston, Deputy Director of Nursing					
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		20 August 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 information on Serious Incidents reported during October 2014, as well as identifying the lessons learnt from SIRIs closed by the commissioner during October 2014.						
<i>For following sections – please indicate as appropriate:</i>						
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: 26 th November 2014			Completed by: Sarah Johnston, Deputy Director of Nursing			

Isle of Wight NHS Trust
Serious Incident Requiring Investigation (SIRI) Report
Isle of Wight NHS Trust Board – 3rd December 2014
Reports of SIRIs for October 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 October 2014 the Trust reported 21 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:
- 2.3.

Category 3 and 4 Pressure Ulcers	11 Pressure ulcers were reported: 8 Grade 4 (most severe) and 3 Grade 3
Patient Fall	3 patient falls occurred with significant injury; 1 fractured hip, 1 fractured femur, and 1 fractured rib and head injury
Clostridium Difficile Infections	1
Confidential Information Breach	1
Delayed Diagnosis	1
Multiple 4 hour breaches	1
Safeguarding Vulnerable Adult	1
Unexpected death	1 Patient deceased whilst under Community Mental Health Team
Venous Thromboembolism	1

3. **Closed SRI's**

During October 2014, and at the time of reporting, the IW Clinical Commissioning Group had closed **10** SRI cases. Any confidential adult safeguarding cases are reported as part of the Safeguarding report which is received by the Part 2 of the Trust Board (private).

4. **Lessons Learned**

In some cases there are additional lessons learned from review of e case that are taken forward in addition to any case specific items.

GRADE 4 PRESSURE ULCER (1)
SUMMARY OF ROOT CAUSE Patient at risk but declined to have pressure relieving equipment. There was a delay in obtaining carers due to patient declining care. RECOMMENDATIONS Document all advice given to patients, family and carers Check on the timeliness of carers accessing the patient
GRADE 4 PRESSURE ULCER (2)
ROOT CAUSES Poor communication between Residential Home and Community Rehab Nurse raising concerns relating to bruise to patients toe (pressure injury), leading to a 3 day delay in addressing cause of pressure injury and taking appropriate action LESSONS LEARNED The need for better communication between Residential Home and Community Rehab Staff. Importance of maintaining skin integrity in the compromised patient
GRADE 3 PRESSURE ULCER
ROOT CAUSES This was unavoidable case. LESSONS LEARNED Amended Intentional Rounding form; Naso gastric dressings to be changed daily and skin inspected closely
C DIFF & HEALTH ACQUIRED INFECTION
SUMMARY C diff death RECOMMENDATIONS Education for all clinical staff regarding the importance of taking specimens in a timely manner Catheter care task/finish group established to develop improved standards in catheter care Education for all staff re importance of recording fluid balance records Prescribing practice to be reviewed for assurance
CONFIDENTIAL INFORMATION LEAK (1)
SUMMARY Record keeping breach ROOT CAUSES Failure of staff member to follow policy. LESSONS LEARNED Although it is clear that wider team is aware of best practice with regards to clinical data protection and transportation, it is indicated that formalisation of these processes are required. This would allow for the inclusion of clear expectations in the induction of new staff to the service.

CONFIDENTIAL INFORMATION LEAK (2)
<p>SUMMARY</p> <p>Record keeping breach</p> <p>ROOT CAUSES</p> <p>A non consistent approach to managing loose leaf documents</p> <p>LESSONS LEARNED</p> <p>System of safe keeping of documentation not robust enough; need to establish new ways of working</p>
NEVER EVENT - INAPPROPRIATE ADMINISTRATION OF A DAILY ORAL MEDICINE
<p>SUMMARY</p> <p>Medication given incorrectly</p> <p>LESSONS LEARNED</p> <p>Competencies regarding the administration of medicines. The annual assessment in place at the time of the incident was not fit for purpose as it still had a focus on paper medication charts rather than electronic systems now in place. At time of writing this report the new version of this assessment is not yet on the Trust system for completion by nursing staff. Pharmacy have confirmed that the JAC system has been changed so that when prescribing this medication the 'free form' is not available so this error cannot be repeated with this medication. There have been delays in information being passed to Consultants particularly if incidents have occurred out of hours and been dealt with by on-call cover.</p>
SLIP/TRIP/FALL
<p>SUMMARY</p> <p>Patient fall resulting in fractured neck of femur.</p> <p>ROOT CAUSE</p> <p>Slip / fall would not have been predictable.</p>
UNEXPECTED DEATH
<p>SUMMARY</p> <p>Patient deceased at home following recent hospital admission</p> <p>ROOT CAUSE</p> <p>Unrelated cardiac anomaly</p> <p>LESSONS LEARNED</p> <p>Effective communication and documentation between transferring ward areas; transferring ward and admitting ward to have robust handover discussing all documentation that needs completing</p> <p>Observations not carried out and actioned as per policy; ward audit to ensure that observation charts are being completed and actions taken and documented where appropriate.</p>

Alan Sheward

Executive Director of Nursing & Workforce

26th November 2014

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 3rd December 2014

Title	Emergency Preparedness Core Standards 2014					
Sponsoring Executive Director	Alan Sheward, Executive Director of Nursing & Workforce					
Author(s)	Keith Morey, Civil Contingencies Manager					
Purpose	To gain board approval for the Statement of Compliance to submit via CCG to NHS England.					
Action required by the Board:	Receive		Approve	P		
Previously considered by (state date):						
Trust Executive Committee	22 Sep 14	Mental Health Act Scrutiny Committee				
Audit and Corporate Risk Committee		Remuneration & Nominations Committee				
Charitable Funds Committee		Quality & Clinical Performance Committee				
Finance, Investment & Workforce Committee		Foundation Trust Programme Board				
ICT & Integration Committee						
Please add any other committees below as needed						
Board Seminar						
Other (please state)	Emergency Planning & Business Continuity Group 18 Sep 14					
Staff, stakeholder, patient and public engagement:						
Executive Summary:						
Self assessment, along with discussion with the CCG, has shown the compliance of the Isle of Wight NHS against the core standards is 45 (72%) of the 63 standards. An action plan has been developed to achieve compliance against all applicable standards by the end of May 2015.						
For following sections – please indicate as appropriate:						
Trust Goal (see key)	3 Resilience					
Critical Success Factors (see key)	CSF 2, CSF 5					
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: 10 November 2014 Completed by: Keith Morey, Civil Contingencies Manager						

Emergency Preparedness Report

Clinical Commissioning Group Emergency Preparedness Resilience and Response (EPRR) Assurance Report

Situation

This report with the supporting core standards compliance and action plan spreadsheet will provide an overview of the compliance of the Isle of Wight NHS against its duties as detailed within the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

Background

As part of the assurance process each Clinical Commissioning Group is expected to undertake a review of the current compliance of its provider organisations against the core standards. The CCG will then meet with NHS England Local Area Team and present the compliance statement and action plan for their provider organisations.

Assessment

Self assessment, along with informal discussion with the CCG, has shown the compliance of the Isle of Wight NHS against the core standards is 45 (72%) of the 63 standards. An action plan has been developed to achieve compliance against all applicable standards by the end of May 2015.

The provider organisation's Emergency Preparedness and Business Continuity (EP&BC) group will monitor the compliance against the standards, at each of the quarterly meetings. Any failure to achieve actions or timescales within the action plan will be escalated to the Trust Executive Committee via the EP&BC Top issue updates.

A full copy of the assessment and action plan is attached.

Recommendation

It is recommended that all those in attendance at the review meeting agree the content compliance statement and the action plan.

It is proposed that the CCG and provider organisations review the action plan at regular intervals in a format suitable to each organisation.

EPRR Core Standards 2014 Action Plan

Core Standard No.	Core Standard	Clarifying Information	Action Required	Lead	Timescale
8	Corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Service level (Departmental) BC plans updated to align with new ISO standard	All departments to update their plans using the supplied trust template. Training and guidance has been offered and is available. Currently at 90% for Hospital & 10% for Community (Oct 14)	Carol Foley. This is part of the BC project plan for 2014/15	Plans due by March 2015
8	Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Mass countermeasures to be included within Major Incident Plans	Review current guidance against plan and update if required	Keith Morey	Mar 2015 (Plan review due)
8	Lockdown	Current Lockdown Plan ineffective.	Electronic locking system currently being costed and planned into Estates programme	Connie Wendes/Estates	May 2015
12	Arrangements explain how VIP and/or high profile patients will be managed	VIP Plan written and to go through approval process	Approval at relevant committees	Connie Wendes	Dec 2015

15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary	SMOC/EDOC rota's in place. Effectiveness of these questioned by CCG.	Review of on call to be completed. Ownership, management and role of SMOC/EDOC to be confirmed.	HR for review HR/Alan Sheward for staffing Keith Morey for Operational Document	Feb 2015
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England published competencies are based on National occupational Standards	A combination of local training and nationally recognised courses to be attended by those that will undertake incident command roles	Keith Morey for local training SMOC & EDOC staff to attend courses as available LHRP to coordinate regional training	Apr 2015 for local training to start Ongoing

20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Due to size of service, limited capability to have 24 hour cover. SCAS will be contacted to assess possibility of using their on call support, with a possible charge for this service.	Keith Morey Finance if additional funds are required.	Dec 14
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	As above	Due to size of service, limited capability to have 24 hour cover. SCAS will be contacted to assess possibility of using their on call support, with a possible charge for this service.	Keith Morey Finance if additional funds are required.	Dec 14
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	CCG have raised concerns that there are no formal on-call arrangements for Communications	Executive decision on whether to fund an on call communications function or accept the risk of informal on call arrangements.	Trust execs	Mar 2015
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Training needs analysis completed, training programme to be planned and delivered	BC training taking place across this year, incident training to be planned for next year.	Keith Morey	Jan 2015

36	Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises	Limited opportunity for participation in exercises for Acute Trust staff	Ensure participation of on call staff where available exercises allow.	Execs and senior managers	Ongoing
37	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		CPD template to be devised and supplied to on call staff	Keith Morey for Commanders CPD template Execs and senior managers	Ongoing
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.		Inventory to be compiled from Core Standards Additional equipment required to complete list	Keith Morey for inventory and costs of additional equipment. Finance for funding.	Dec 2014 Dec 2014 Apr 2015
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Suits are revalidated to 2015, two years additional funding required to maintain compliance. Reduction in Ambulance suits requires risk assessment	Keith Morey for costs & risk assessment. Finance for funding.	Dec 2014 Apr 2015

46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Costs of a PPM to be obtained and funding found	Keith Morey for costs. Finance for funding.	Dec 2014 Apr 2015
47	There are effective disposal arrangements in place for PPE no longer required.		Costs of a disposal programme to be obtained and funding found.	Keith Morey for costs. Finance for funding.	Dec 2014 Apr 2015
48	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		ED & Ambulance have CBRN training leads. Both require updating. Training courses currently unavailable but are due shortly.	Keith Morey	Mar 2015

49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	<ul style="list-style-type: none"> • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other 	<p>FFP3 training required in both Ambulance and Emergency Department. Ambulance has masks on order, fit testing programme required.</p>	Keith Morey	Dec 2014
			<p>IOR training required in both Ambulance and Emergency Department. Ambulance preparing for IOR delivery, ED to include it in annual update.</p>	Keith Morey	Apr 2014

Isle of Wight NHS Trust EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements¹. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The accountable emergency officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for 2014/15, the Isle of Wight NHS Trust has been required to assess itself against these core standards by 1st October 2014. The outcome of this self-assessment shows that against 63 of the core standards which are applicable to the organisation, the Isle of Wight NHS Trust

- is fully compliant with 45 of these core standards; and
- will become fully compliant with the other 18 of these core standards by May 2015.

The attached improvement plan sets out actions against all core standards where full compliance has yet to be achieved.

Alan Sheward
Accountable Emergency Officer
Isle of Wight NHS Trust
3rd December 2014

¹ NHS England Core Standards for Emergency Preparedness, Resilience and Response were revised in July 2014. The core standards are available on the NHS England site:
<http://www.england.nhs.uk/ourwork/epr/gf/#core>

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 3rd DECEMBER 2014

Title	Strategic Partnership with the IW NHS Trust by IW Council				
Sponsoring Executive Director	Karen Baker, Chief Executive				
Author(s)	Isle of Wight Council David Burbage, Managing Director, IW Council Martin Elliott, Interim Head of Adult Social Care, IW Council Cllr Steve Stubbings, Deputy Leader and Executive Member for Adult Social Care and Community Wellbeing, IW Council				
Purpose	To endorse recommendations in the enclosed paper to the IoW Council Executive				
Action required by the Board:	Receive		Approve	P	
Previously considered by (state date):					
Trust Executive Committee		Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee		Remuneration & Nominations Committee			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee		Foundation Trust Programme Board			
ICT & Integration Committee					
Please add any other committees below as needed					
Board Seminar					
Trust Board (Part 2)	29 October 2014				
Other (please state)					
Staff, stakeholder, patient and public engagement:					
Executive Summary:					
The enclosed paper is to be considered by the IOW Council Executive on Tuesday 9 th December 2014. The creation of a Strategic Partnership for integrated provision for community services with Isle of Wight Council has already been discussed with the Board and has emerged from the joint working between Trust/CCG/Council. The Board is recommended to endorse the recommendations outlined in this paper.					
<i>For following sections – please indicate as appropriate:</i>					
Trust Goal (see key)	Principal Objective 2				
Critical Success Factors (see key)	CSF 1, 4, 5				
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)					
Assurance Level (shown on BAF)	Red		Amber	ü	Green
Legal implications, regulatory and consultation requirements	Legal advice will be sought on formal agreements.				
Date:	26-11-14		Completed by: Mark Price , Company Secretary		

Committee report

Committee	EXECUTIVE 9 DECEMBER 2014
Title	STRATEGIC PARTNERSHIP WITH THE IOW NHS TRUST
Report of	DEPUTY LEADER AND EXECUTIVE MEMBER FOR ADULT SOCIAL CARE AND COMMUNITY WELLBEING

EXECUTIVE SUMMARY

1. The Council has been working closely with the Isle of Wight NHS Trust and the Isle of Wight Clinical Commissioning Group in moving towards integration of Health and Social Care in line with the 5 year vision agreed and signed by all three organisations in April 2014.
2. This report sets out the progress made to date and the next steps in the journey to integration including entering into a Strategic Partnership with the Isle of Wight NHS Trust in respect of locality working.

OUTCOMES

3. To agree the next steps in the implementation of integrated working through a Strategic Partnership with the Isle of Wight NHS Trust.

BACKGROUND

4. The Council as part of its Corporate Plan agreed at Full Council on 19 March 2014 set out one of its seven priorities - delivering person centred, coordinated Social Care and Health Services. A 5 year vision was developed and agreed and signed by the Isle of Wight NHS Trust, the Isle of Wight Clinical Commissioning Group and the Council (Appendix A).
5. Nationally the Government are encouraging local authorities and health organisations to work closely together (Care Act) and move towards integration of health and adult social care services. To support this, since the 2010 comprehensive spending review, an amount of health funding has been allocated to adult social care to support preventative measures with health outcomes. As part of the local government Finance Settlement for 2014/15 the transfer for Isle of Wight Council services is £3.513m.
6. To encourage even greater partnership at the local level the Local Government Finance Settlement for 2014/15 also set out the creation of a Better Care Fund (BCF). The BCF is a single pooled budget for health and social care services that is used to fund schemes that support the delivery of joint outcomes through an integrated approach. For 2015/16 the BCF will amount to £20.607m. A report on the BCF was made to the Executive on 11 March 2014 and 7 October 2014. The BCF itself is not new funding and brings together a number of existing funding streams. The expectation is that overall savings will be made as part of the integrated approach and that there will be more investment in preventative solutions and supporting people in the community and less in hospital, residential and nursing care.

STRATEGIC CONTEXT

7. The vision and priorities as set out in the current corporate plan are being reviewed as part of the overall consideration of the financial challenge facing the Council and the development of the budget strategy. The overall priorities will still include protecting the most vulnerable with Health and Social Care investing in support, prevention and continuing care. To enable this to be delivered effectively an integrated approach to commissioning and provision of services is needed.
8. This report sets out the proposed next steps in delivering an integrated provision by moving to a locality based approach with integrated health and adult social care provision. To enable this to happen there needs to be a lead organisation and it is proposed that the Council enter into a Strategic Partnership with the IOW NHS Trust to enable effective arrangements to be put in place.

WORKING TOWARDS INTEGRATION

9. The My Life Full Life (MLFL) programme was established in 2013 as a programme that is jointly led and funded by the Isle of Wight Clinical Commissioning Group (CCG), Isle of Wight Council and IWNHS Trust. It is part of the wider partnership and integration approach with the purpose of creating a fundamental change in the way people experience living healthily and well on the Island. The Vision of the programme is to work together promoting innovation and introducing proactive integrated care and support on the Island.
10. As part of this programme a number of projects have been developed in order to develop
 - self-management of long term conditions
 - integrated locality working
 - an integrated crisis response and reablement service
11. The crisis response team includes a multi-disciplinary team of OT/Social Workers/Community Nurses who can respond and assess needs. There is also a carer responder service managed alongside reablement services.
12. In addition the Council has entered into a number of specific joint delivery arrangements with the CCG and IOW NHS Trust in relation to joint commissioning and provisions including the approach to the Pathway for People with complex mental health needs agreed at Cabinet on 10 December 2013; Integrated community equipment services agreed at Cabinet on 9 January 2014 ;and Joint commissioning with the CCG through S 75 agreements in relation to funded nursing care and quality assurance monitoring for nursing homes, residential care and home care agreed at the Executive on 18 April 2014.
13. A Health and Social Care integration Group was set up to develop and progress the integration agenda and to oversee the delivery of the 5 year joint vision. The Group includes the Chief Officers of the CCG, IOW NHS Trust and the Council, the Chairman of the CCG, the Deputy Leader and Executive Member for Adult Social Care and Community Wellbeing, the Interim Director of Public Health as well as a number of key officers from the three organisations.
14. Over the last year significant progress has been made in developing a whole system approach to health and social care on the island and how integration can be achieved to support it.

15. All parties agree that to deliver an effective whole system approach for health and social care on the Island integrated commissioning (between the Council and the CCG) and integrated provision (between the Council, IOW NHS Trust and other providers) is essential.
16. Building on the MLFL programme the next steps to deliver integration is the establishment of locality working

PROPOSED NEXT STEPS

17. Integrated health and social care teams who will work in three localities across the Island. The three localities are

- West and Central Wight
- North East Wight
- South Wight

The Integrated Teams will be working closely with GPs, the voluntary sector and independent providers in the localities and the intention will be that the integrated teams will deliver coordinated care and support.

It is proposed that Phase 1 of integrated working will commence on the 1st April 2015.

Phase 1 of the Locality Teams will include the following health and social care teams

- Community Nursing (IW NHS Trust Community and Mental Health Directorate)
- Long Term Care Team (IW Council Adult Social Care)
- Continence Team (IW NHS Trust, Community and Mental Health Directorate)
- Community Matrons (IW NHS Trust, Community and Mental Health Directorate)

These will be managed by three Locality Management Groups. The Locality Management Group will be from Primary Care, Adult Social Care, the voluntary sector, Nursing (both community and practice nursing) and feedback will be sought from a range of key stakeholders, including representatives of people who use services and their carers. These groups will drive a culture of continuous improvement that is inclusive and supportive, creating opportunities for partners and staff to work across traditional boundaries.

18. It is felt essential that if a truly integrated approach is to be achieved then these services will need to be led and managed under single line management with a pooled budget and agreed joint outcomes.
19. At this stage it is not proposed that staff be the subject of TUPE transfer and would remain with their existing employer. To achieve the necessary integration, however, it is proposed that the Council enter into a Strategic Partnership with the Isle of Wight NHS Trust similar to (but not the same) as the one the Council has entered into with Hampshire County Council for Children's Services.
20. Once the partnership agreement has been developed it will be reported back to the Executive for final agreement.

CONSULTATION

21. The proposals in this report have been developed in conjunction with the CCG and IOW NHS Trust. More broadly, the BCF plan encompasses other existing programmes of work which have had, and continue to have, full stakeholder engagement.
22. The vision of integration has been developed through involving local people and listening to what they say is important to them. We have engaged directly with individuals, user groups and user representative organisations, including those people that are experts by experience, to ensure that we are fully able to capture and respond effectively to what they tell us.
23. Health and social care providers have been fully participating partners in shaping, developing and now delivering our overarching vision and the programmes, strategies and plans which are in place to deliver that vision.
24. To gain key stakeholder engagement, a number of locality workshops were held and a launch event for the My Life a Full Life1 (MLAFL) programme which were used to develop the vision for integrated care on the Island, how to deliver that vision and how to measure success. In addition, there has been wide consultation with both carers organisations and carers themselves to develop the Carers Strategy, as well as workshops in which provider organisations, professionals and residents were fully engaged in developing the Island's Mental Health Strategy and Suicide Prevention Strategy, with individuals fully supported to have a voice as expert by experience.
25. Additionally, in order to reach as many people as possible, and in addition to speaking to individuals directly, we have fully engaged People Matter, the Island's user led organisation, and our local Healthwatch. Both of these organisations have a large membership consisting of people with many different perspectives and experiences and are, therefore, able to give views from a broad range of perspectives and experiences.
26. The proposals affecting staff will be the subject of specific consultation.

FINANCIAL / BUDGET IMPLICATIONS

27. The Council faces a significant financial challenge with a projected revenue budget gap of £13.5m in 2015/16 with a further revenue budget gap of £8.5m in 2016/17. A major budget pressure relates to the cost of Adult Social Care and having to meet increasing need. The budget strategy includes making savings through managing demand for services down and in implementing preventative strategies and integrated care models that deliver better outcomes for people at reduced costs.
28. The only realistic chance of achieving effective adult social care services in the future that are affordable is to organise and deliver care in a radically different way. The development and implementation of integrated commissioning and integrated provision by the Council health partners, voluntary sector and others is the only way forward that offers some chance of success.
29. Any costs arising from the proposed next steps in this report will be met from existing budgets. There will also be opportunities to achieve savings through reducing duplication, cost avoidance and greater efficiencies. These are currently being worked up.

LEGAL IMPLICATIONS

Broadly, the council has duties to carry out various health-related functions including providing support, carrying out needs assessments and devising packages of care for both adults and children, including those with mental health problems, learning difficulties, older people, offenders, drug and alcohol misusers, vulnerable children and families and looked-after children. The NHS deliver health functions.

Partnership Arrangements under the National Health Service Act 2006

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) local authorities and NHS bodies can enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised.

The powers permit local authorities and NHS bodies to pool budgets (section 75(2)(a)(ii)), carry out prescribed health-related functions of the other bodies in conjunction with the exercise of its own prescribed health-related functions (known as lead commissioning) (section 75(2)(b)-(c)) and to provide staff, goods or services between the partners (section 75(2)(d)-(f)). These agreements are made under section 75 of the National Health Service Act 2006 ("section 75 agreements").

Duty to consider partnership arrangements under Health and Social Care Act 2012

Local authorities and clinical commissioning groups have a duty, in conjunction with the primary care trust to produce a Joint Strategic Needs Assessment (section 192, Health and Social Care Act 2012; section 116, Local Government and Public Involvement in Health Act 2007), and a further duty requires the local authority and the clinical commissioning group to prepare a joint health and wellbeing strategy (a strategy for meeting the needs included in the Joint Strategic Needs Assessment).

There is a duty on both local authorities and clinical commissioning groups to consider, when forming their Joint Health and Wellbeing Strategy, how the needs identified in their Joint Strategic Needs Assessment could be met more effectively through section 75 arrangements rather than in any other way.

Care Act 2014

In addition to the powers and duties set out above there will be duties imposed by the Care Act 2014, which will reform the law relating to care and support for adults and support for carers (the relevant provisions of which are not yet in force) which require the council to promote the integration of care and support with health provision and health-related provision (section 3), to promote diversity and quality in provision of services (section 5), to cooperate with relevant partners and vice-versa in the exercise of its respective functions relating to adults and carers (section 6) and to cooperate with relevant partners in the exercise of a function in the case of an individual with needs for care and support or in the case of a carer, a carer of a child or a young carer, when requested to do so (section 7).

A partnership agreement would assist the council to meet these duties under the Care Act 2014.

EQUALITY AND DIVERSITY

30. The Council has to comply with Section 149 of the Equality Act 2010. This provides that decision makers must have due regard to the elimination of discrimination, victimisation and harassment, advancing equalities, and fostering good relations between different groups

(race, disability, gender, age, sexual orientation, gender reassignment, religion/belief and marriage/civil partnership).

31. The proposed way forward does not directly affect who receives health and adult social care services but relates to how services are organised and managed and working differently to deliver care more effectively. There are no proposed changes in eligibility.

OPTIONS

32. There are a number of options in relation to the next steps in moving towards integrated health and social care. The Council is progressing with the Clinical Commissioning Group moving towards integrated commissioning and this will be the subject of further reports.
33. With regard to integrated provision there are a number of different organisational models that could achieve this. The final organisational model will need to be developed and will also be the subject of further reports.
34. This report sets out proposed next steps on the journey to integrated provision through a locality based approach that can be implemented regardless of the final organisational model chosen. In moving to these next steps there are three main options:-
- (a) To continue towards integration through joint working but with no formal integration of staffing through single line management and with no partnership put in place.
 - (b) To set up a formal staffing structure within a single organisation with staff formally transferring under TUPE.
 - (c) To move to a phased approach to locality working with staff working under a single line management under a formal Strategic Partnership Agreement with the IOW NHS Trust

EVALUATION

35. The financial challenges facing the Council and the health sector as a whole are significant and unless radical changes are made there is a significant risk that the health system on the island becomes unaffordable and undeliverable.
36. Changes need to be made at pace and therefore option (a) is not recommended as it does not deliver what is required early enough.
37. The terms and conditions of staff in adult social care and the NHS are different and the process of TUPE transfers and harmonisation would be a complex and difficult one. Within the timescales involved and the likely difficulties option (b) is not recommended.
38. Option (c) gives the best option as it enables us to move at pace but in a managed phased way that should be more deliverable and effective. This also allows time to consider the longer term integration model we should be implementing.

RISK MANAGEMENT

39. There are a number of risks in relation to implementing a strategic partnership and these need to be managed and mitigated against where practicable. The risks relate to implementation, service delivery, budget control and management. The partnership agreement will cover these aspects and how they are to be managed. Appropriate frameworks will be put in place to ensure that the necessary controls are in place and effective monitoring is in place.

40. There are also a number of risks related to integration itself. These relate to financial risks if the proposed preventative strategies and integration is ineffective in delivering care that is affordable and failure to manage costs ; partnership risks in relation to trust and commitment to deliver radical change; lack of current capacity and capability to deliver the change required: recruitment and retention of staff; ability to integrate IT systems effectively.
41. The Better Care Fund submission included a risk log and the risks have been highlighted and will be managed.

1. RECOMMENDATIONS

That the EXECUTIVE considers the report and agrees that

- (a) The overall direction for the Council in relation to Adult Social care is to develop and implement integrated commissioning and integrated provision of services.
- (b) That the move to a locality based model from 1 April 2015 is endorsed.
- (c) That a strategic partnership between the Council and the IOW NHS Trust be developed in respect of services to be integrated on a locality basis and to receive a further report in March 2015 to agree the final partnership arrangements.

1. APPENDICES.

APPENDIX A – 5 Year health and social care vision

2. BACKGROUND PAPERS

None

Contact Point: David Burbage Managing Director
(823606 e-mail *David Burbage @iow.gov.uk*

DAVID BURBAGE
Managing Director
MARTIN ELLIOTT
Interim Head of Adult Social Care

CLLR STEVE STUBBINGS
*Deputy Leader and Executive Member for Adult
Social Care and Community wellbeing*

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON Wednesday 3rd December. 2014

Title	Capital Projects Requiring Retrospective Approval					
Sponsoring Executive Director	Executive Director of Finance - Chris Palmer					
Author(s)	Capital and Treasury Accountant - Sarah Gorbutt					
Purpose	To seek retrospective Trust Board Approval for current Capital Projects.					
Action required by the Board:	Receive		Approve		X	
Previously considered by (state date):						
Trust Executive Committee	24/11/2014		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:						
Paper to outline the Capital Projects requiring approval.						
For following sections – please indicate as appropriate:						
Trust Goal (see key)	4					
Critical Success Factors (see key)	CFS 1 & 2 CSF 3 CSF 7 & 8					
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)	Mitigation of Health & Safety, Infection Control & Information Governance issues					
Assurance Level (shown on BAF)	Red		Amber		Green	
Legal implications, regulatory and consultation requirements						
Date: 26/11/2014 Completed by: SARAH GORBUTT						

Retrospective Approval requested for Capital Projects 1415

Situation







It has emerged that a handful of current Capital projects were not initially approved in line with the Trust's Standing Financial instructions (SFI's, excerpt included for reference) and will therefore require retrospective approval.

Schemes Using Procure 21+ with Guranteed Maximum Price		
Financial Value of the Capital Investment or Property Transaction	Approving Person or Group	Documentation Required
Value up to £0.25m with maximum fluctuation of $\pm 2\%$ for an approved scheme	Capital Investment Group	NHS Trust internal governance process
Value up to £1m with a maximum fluctuation of $\pm 2\%$ for an approved scheme	Trust Executive Committee	NHS Trust internal governance process
Up to £5 million or 3% of turnover whichever is the lower	NHS Trust Board	NHS Trust internal governance process
Between £5 million, or 3% of turnover whichever is the lower, and £10 million	NHS TDA Director of Finance	OBC and FBC
£10 million to £25 million	NHS TDA Capital Investment Group	SOC, OBC and FBC
£25 million to £50 million	NHS TDA Capital Investment Group and NHS TDA Board	SOC, OBC and FBC
Over £50 million	NHS TDA Capital Investment Group and NHS TDA Board and the Department of Health	SOC, OBC and FBC

All Other Capital Schemes		
Financial Value of the Capital Investment or Property Transaction	Approving Person or Group	Documentation Required
Value up to £0.25m with maximum fluctuation of $\pm 2\%$ for an approved scheme	Trust Executive Committee	NHS Trust internal governance process
Up to £5 million or 3% of turnover whichever is the lower	NHS Trust Board	NHS Trust internal governance process
Between £5 million, or 3% of turnover whichever is the lower, and £10 million	NHS TDA Director of Finance	OBC and FBC
£10 million to £25 million	NHS TDA Capital Investment Group	SOC, OBC and FBC
£25 million to £50 million	NHS TDA Capital Investment Group and NHS TDA Board	SOC, OBC and FBC
Over £50 million	NHS TDA Capital Investment Group and NHS TDA Board and the Department of Health	SOC, OBC and FBC

The table below details where in the approval process the correct path was not adhered to.

Schedule of Approvals for 1415 Capital projects in excess of £250k.

Project Name	APPROVED SUM	APPROVED AT:						Was the Project P21+?	Comments
		CAPITAL INVESTMENT GROUP		TRUST EXECUTIVE COMMITTEE		TRUST BOARD			
ISIS Full Implementation	986,269	06/12/2013 and 10/01/2014		13/01/2014		-		X	Should have gone to Board as not P21+
Dementia Friendly	399,000	06/12/2013		-		-		✓	Should have gone to TEC for approval



Correct Approval Path followed at this point

Correct Approval path not followed at this point

Please see below an overview of the two projects seeking approval.

Project One - ISIS Full Implementation

Capital Funding Requirement: 2013/14 £642,269

2014/15 £344,000

Project Outline: The IM&T programme for the Isle of Wight NHS Trust is unique in the NHS in England. It aims to integrate information across all care settings – ambulance, primary care, acute, community, mental health and ultimately social care.

The aim of this project is to build a truly integrated electronic patient record (EPR) that will provide healthcare professionals with a rich source of information about their patients via a single point of access. The Integrated Services Information System (ISIS) will enable clinicians to see results from diagnostics (pathology and radiology), order tests online, view documents, assessments and operational notes, produce discharge summaries and view and prescribe medicines. The benefits are direct improvements to quality of service delivered to our patients. This is enabled through improved efficiencies for clinicians by reducing the time they spend looking for information, improving the quality of the information available and therefore helping to reduce the risks associated with poor quality information.

Managers will have access to dashboards and reports that will show the current status of capacity and performance across the Trust as well as supporting patient level costing and accurate clinical coding data ensuring accurate and appropriate income for the work we do.

Patients will have access to their own health record helping to enable them to be more involved in their care and to see other information like outpatient appointments and test results.

Project Two – Dementia Friendly

Capital Funding: £399,000

Project Outline: Funding was received from the Department of Health in 2013/14 to aid the provision of a Dementia Friendly Environment on the Acute Medical Wards. Due to the external nature of this funding the usual governance routes were not correctly followed at the project's inception. The work took place across two financial years (1314 and 1415) and has enabled significant improvements to Appley Ward and Colwell Ward and the provision of a Dementia Friendly Garden for use by patients.

Recommendation

The Trust Board is requested to approve the above projects retrospectively.

For Information: The current SFI's are under review and if amendments are deemed necessary these will be brought forward for discussion/approval through the relevant processes in January/February 2015.

Sarah Gorbutt
Capital and Treasury Accountant
17/11/14

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 3rd December 2014

Title	Ambulance CAD Upgrade and Technology Refresh Business Case (Executive Summary)				
Sponsoring Executive Director	Katie Gray Executive Director of Transformation and Integration				
Author(s)	Chris Smith Head of Ambulance Service, Paul Cassford Integrated Care Technologies Manager, Claire Cox Ambulance Business Coordinator, Sarah Gorbett Capital and Treasury Accountant.				
Purpose	Approve the Business Case (Executive Summary)				
Action required by the Board:	Receive		Approve	Ü	
Previously considered by (state date):					
Trust Executive Committee	17 th November 2014	Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee	20 th August 2014	Remuneration & Nominations Committee			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee	19 th November 2014	Foundation Trust Programme Board			
ICT & Integration Committee					
Please add any other committees below as needed					
Board Seminar					
Capital Investment Group	7 th November 2014				
Other (please state)					
Staff, stakeholder, patient and public engagement:					
Executive Summary:					
To upgrade the software and hardware solution used within the Isle of Wight NHS Trust Ambulance Service to coordinate the received 999 calls and dispatch appropriate Ambulance resources in the most effective way, to ensure all 999 emergency calls are prioritised appropriately and the correct resources are deployed to meet the needs of the public. The detailed business case was approved at the Trust Executive Committee on 17 November and the Finance, Investment, Information and Workforce Committee on 19 th November. The Executive Summary of the case is presented to the Trust Board for approval.					
For following sections – please indicate as appropriate:					
Trust Goal (see key)	QUALITY - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and positive experience of care				
Critical Success Factors (see key)	CSF 8				
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)	62.1				
Assurance Level (shown on BAF)	Red	Ü	Amber		Green
Legal implications, regulatory and consultation requirements					
Date: 11th November 2014 Completed by: Paul Cassford Integrated Care Technologies Manager					

CAD Upgrade and Technology Refresh Executive Summary

The current Computer Aided Dispatch (CAD) system was procured and installed in 2009 / 2010. The aim was to provide a fully integrated solution to provide mobilisation of Ambulance vehicles, tracking of vehicles, provision of an Electronic Patient Clinical Record and a reliable data connection to Ambulance vehicles. The CareMonX CAD was an innovation at that time, and as technologies have advanced significantly in both hardware and the software, it is necessary to review our current solution and carry out a significant update at this time.

An update to the system, will allow the migration to the Windows Seven operating system, which is required following the cessation of support for windows XP. Remaining on an unsupported operating system exposes the trust to security risks, and failure of systems due to incompatibility and unresolved bugs in the software.

It will also facilitate improved reporting, and avoidance of costs from Post Code software, as the system will utilise the Public Services Mapping Agreement (PSMA) for which the trust is licensed at no cost, this would facilitate a saving on the cost of licences. This is noted in the option 2 section within the table of the business case

There is also a requirement to provide a national interoperability solution to other Ambulance Services (directive from Association of Ambulance Chief Executives (AACE) in line with the NHS111 service, currently, the Isle of Wight Ambulance Service who led this work, are the only service not undertaking this development at this time.

The current solution resides on 10 individual servers which are near end of life, will require the replacement with six blade servers which will provide a faster more reliable & resilient solution. The upgrade to Windows Seven will require an update of the server software as well, which would be carried out at the same time as the change to blade servers. The support from Microsoft for the existing SQL server software expires in 2015, and as such will require updating, it is anticipated that the current servers would not support updated operating software. This has been confirmed by the IT department.

Additionally the current solution resides on 20 client machines located in the Integrated Care HUB which are between four and six years old, the machines are bespoke high specification computers with multi-screen capability to facilitate the use of multiple solutions to manage calls. The upgrade to Windows Seven will require an update of the Valentiatech CaremonX software as well, which will place an increase in demand on these machines.

This business case includes all proposed developments of the system to allow the service to exploit the advances in technology for the benefit of the Patient, Trust and staff, including the upgrade of the client machines that are used within the HUB to manage the call taking, clinical assessment and resource deployment. Whilst it could be viewed that the software and servers could be updated without replacing the client machines, it is important to remember that the client machines are in excess of four years old and are outside of their support period.

Additionally it will be necessary to rebuild 20 machines with the new software, during which time the CAD solution will be offline until sufficient machines can be rebuilt. The easiest and safest solution is to replace the client machines at the same time as the servers and software are updated. This will allow for a new and thoroughly tested solution to be implemented whilst still maintaining an option to revert back to the original solution in the event of a failure of the updated solution.

Note:

The requirement for 3000 'R18-04301 WinSvrCAL 2012 SNGL MVL DvcCAL' licences is as a result of the upgrade to windows server 2012, which then requires every PC within the organisation to have a licence for this server operating system. Importantly, this cost would be incurred by any project requiring windows server 2012 for the first time within the organisation, with the purchase of these licences for this project, all future projects requiring windows server 2012 will be covered by these licences, to this end, it is suggested that these costs should be viewed as corporate costs as opposed to project costs.

The £49,500-00 could be offset from the total cost of this solution as a benefit to future IT based projects. This would in effect, then reflect a cost of £353,131.84 for the upgrade of the Valentia system, as opposed to the full £402K for the business case.

The additional cost for electrical work within the server room, is to facilitate the required electrical supply and connections to support the new blade servers, this work upgrades the existing infrastructure with the server room, which will benefit future projects requiring the use of the enclosures for these blade servers.

There is also a cost for the increase in 2 years for the warranty and support for the hardware to cover the 5 year life of the equipment, rather than 3 years for the proposed contract duration. This would potentially allow a new solution to be installed on the blade servers, or an extension of the contract

Description	Cost (£)
CAD & EPRF Upgrade (Windows 7)	134,337.50
CAD Interoperability for 999	31,167.50
Pathways Data Transfer Interface	12,707.50
(HP) Blade Server Replacement (x8)	24,790.85
(HP) Server Enclosure (x1)	28,357.41
Server and Enclosure Delivery	588.59
Server Connection Peripherals Fibre Optic cables etc.	823.60
WinSvrStd 2012R2 SNGL MVL 2Proc (x8)	3,321.92
WinSvrCAL 2012 SNGL MVL DvcCAL (x3000)	41,250.00
SQLSvrStdCore 2014 SNGL MVL 2Lic CoreLic (x8)	13,333.52
SQLSvrBsnssIntelligence 2014 SNGL MVL (x1)	3,993.79
SQLCAL 2014 SNGL MVL DvcCAL (x20)	1,945.00
Server Warranty Upgrade to 5 years (x8)	9,600.00
Server Enclosure Warranty Upgrade (x1)	1,600.00
Server Room Electrical Work	6,000.00
Expert User Secondment	6,836.34 (not subject to VAT)
HP Elite Desk Business PC (x 20)	15,012.40
Environmental Recharge (x 20)	1,000.00
Total	336,665.92
VAT @ 20% (on 329,829.58)	65,965.92
Total Including VAT	402,631.84

Annual Support & Maintenance costs would be set at £42,500 (ex VAT) inclusive any additional support & maintenance that would arise from the new work packages. The charge is based on the provision remote Level 3 support as per the terms of the original contract. The charge would be fixed for the next three years (excluding incremental further support, if any, which might arise from future additional work, if any, during this period).

The duration of the new contract would be three years (or longer, if the Trust so wishes).”

Since the introduction of the ValentiaTech CAD in 2010, the software company have further developed their product, to refine its operating processes and have supplied it to South Africa, Qatar and New Zealand Ambulance Services. As a result of this process, the unique demands of each service have allowed them to further enhance the CAD capabilities, which have the potential to allow us to enhance our service with this upgrade.

Recommendation

The Trust Board is recommended to approve the business case (executive summary)

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 3rd DECEMBER 2014

Title	Board Self-certification				
Sponsoring Executive Director	FT Programme Director / Company Secretary				
Author(s)	Programme Manager – Business Planning and Foundation Trust Application				
Purpose	To Approve				
Action required by the Board:	Receive		Approve	✓	
Previously considered by (state date):					
Trust Executive Committee		Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee		Nominations Committee (Shadow)			
Charitable Funds Committee		Quality & Clinical Performance Committee	19-Nov-14		
Finance, Investment & Workforce Committee	19-Nov-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 Trust Development Authority (TDA) self-certification return covering the October 2014 performance period for approval by Trust Board. The key points covered include: <ul style="list-style-type: none"> • Background to the requirement • Assurance • Performance summary and key issues • Recommendations 					
<i>For following sections – please indicate as appropriate:</i>					
Trust Goal (see key)	3				
Critical Success Factors (see key)	6 - Develop our organisational culture, processes and capabilities to be a thriving FT				
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)					
Assurance Level (shown on BAF)	Red		Amber		Green
Legal implications, regulatory and consultation requirements	Develop our quality governance and financial management systems and processes to deliver performance that exceeds the standards set down for Foundation Trusts.				
Date: 25 November 2014					
Completed by: Andrew Shorkey					

ISLE OF WIGHT NHS TRUST

SELF-CERTIFICATION

1. Purpose

To seek approval of the proposed self-certification return for the October 2014 reporting period, prior to submission to the Trust Development Authority (TDA) in December 2014.

2. Background

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

In March 2014 the TDA published a revised *Accountability Framework* for 2014/15. There are no fundamental changes with respect to the self-certification requirements.

The Trust must continue to make monthly self-certified declarations against prescribed Board Statements and Monitor Licence Conditions.

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

3. Assurance

Lead professionals across the Trust have been engaged to ensure the provision of supporting information and the identification of gaps, issues and actions required to provide a sufficient degree of assurance to the Trust Board to enable approval of the self-certification return as an accurate representation of the Trust's current status.

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

4. Performance Summary and Key Issues

Board Statements

Board Statements 1, 2, 6 and 14 remain 'at risk' as a consequence of the CQC inspection undertaken in June 2014. At the Board Meeting in October 2014 the Board also determined to certify Board Statement 13 as 'at risk' due to its close association with Board Statement 14. The target date for compliance set by the CQC is 12 December 2014 and these statements will remain at risk until the CQC has confirmed compliance. At the point of writing there are risks to delivery of the quality improvement action plan emerging which may result in compliance with these Board Statements not being achievable by 31 December 2014.

Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, also remains 'at risk'. Although the quarterly Governance Risk Rating, comprised of 'Access and Outcome' indicators, for Quarter 2 was at 9.0, the monthly score moved favourably from 6.0 to 4.0 in September and this has been

maintained for October. The October position includes planned breaches in relation to the 18 weeks targets. This position is reflected within the draft return document (Appendix 1a).

Licence Conditions

All Licence Conditions remain marked as compliant. Condition G7 (Registration with the Care Quality Commission) could be put at risk if the CQC action plan (Quality Improvement Plan) is not delivered sufficiently to the satisfaction of the CQC. It is not presently recommended that this condition be put at risk, but a watching brief should be maintained with respect to the status of the Quality Improvement Plan. This position is reflected within the draft return document (Appendix 1b).

5. Recommendations

It is recommended that the Trust Board:

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

Andrew Shorkey

Programme Manager – Business Planning and Foundation Trust Application
25 November 2014

6. Appendices

1a – Board Statements
1b – Licence Conditions

7. Supporting Information

- *Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards*, 31 March 2014
- *Risk Assessment Framework*, Monitor, 27 August 2013

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

	For CLINICAL QUALITY, that:	Response	Comment where non-compliant or at risk of non-compliance	Timescale for Compliance	Executive Lead
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's Oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-14	Alan Sheward Mark Pugh
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-14	Mark Price
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes			Mark Pugh
	For FINANCE, that:	Response			
4	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes			Chris Palmer
	For GOVERNANCE, that:	Response			
5	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes			Karen Baker Mark Price
6	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-14	Mark Price
7	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes			Mark Price
8	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes			Karen Baker
9	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes			Mark Price
10	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR [Governance Risk Rating]; and a commitment to comply with all commissioned targets going forward.	At risk	The Trust's Governance Risk Rating (Monitor access and outcome measures) score declined significantly across quarters 1 & 2 2014/15. Indicator recovery plans are being implemented.	30-Nov-14	Alan Sheward Mark Pugh
11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes			Mark Price

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

12	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies	Yes			Mark Price
13	The board is satisfied all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.		Karen Baker
14	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Dec-14	Karen Baker Alan Sheward

Z2 - TDA Accountability Framework - Licence Conditions

Appendix - 1(b)

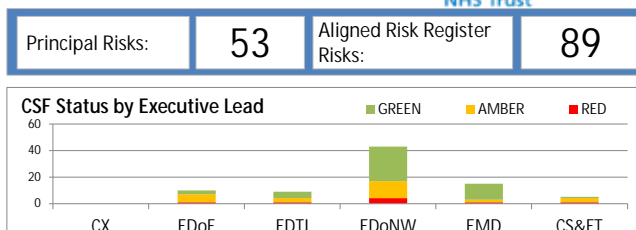
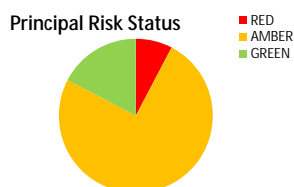
	Licence condition Compliance	Compliance (Yes / No)	Comment where non-compliant or at risk of non-compliance	Timescale for compliance	Accountable
1	Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	Yes			Mark Price
2	Condition G7 – Registration with the Care Quality Commission	Yes	This indicator could be but at risk if the CQC action plan is not implemented as required by the CQC.		Mark Price
3	Condition G8 – Patient eligibility and selection criteria	Yes			Alan Sheward
4	Condition P1 – Recording of information	Yes			Chris Palmer
5	Condition P2 – Provision of information	Yes			Chris Palmer
6	Condition P3 – Assurance report on submissions to Monitor	Yes			Chris Palmer
7	Condition P4 – Compliance with the National Tariff	Yes			Chris Palmer
8	Condition P5 – Constructive engagement concerning local tariff modifications	Yes			Chris Palmer
9	Condition C1 – The right of patients to make choices	Yes			Alan Sheward
10	Condition C2 – Competition oversight	Yes			Karen Baker
11	Condition IC1 – Provision of integrated care	Yes			Alan Sheward Mark Pugh

REPORT TO THE TRUST BOARD (Part 1 - Public)

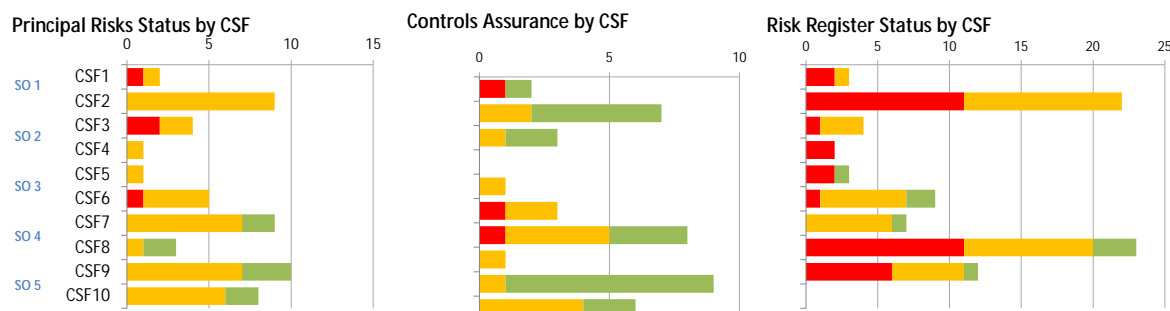
ON 3 DECEMBER 2014

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 November 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:						
<p>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.</p> <p>It was agreed that the Board would receive dashboard summaries and exception reports only for the remainder of the year.</p> <p>The dashboard summary includes summary details of the key changes in ratings: there are 4 Principal Risks now rated as Red; 5 new Risks have been added since the September 2014 report.</p> <p>The exception report details 10 recommended changes to the Board Assurance RAG ratings of Principal Risks: 4 changes from Green to Red for 1.12, 3.44, 3.45 and 6.24; 2 changes from Green to Amber for 9.5 and 9.74; 3 changes from Amber to Green for 9.7, 9.14 and 9.15; and a change in responsibility for 3.56 to Executive Director of Finance.</p>						
<i>For following sections – please indicate as appropriate:</i>						
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: 25 November 2014						
Completed by: Brian Johnston						

BAF Status Report



Strategic Objective & Critical Success Factor Status Overview



Commentary

Principal Risks:

- 4 Principal Risks are recommended for changes from Green to Red
- 2 Principal Risks are recommended for changes from Green to Amber
- 3 Principal Risks are recommended for changes from Amber to Green
- 1 Principal Risk is recommended for change in Executive Lead

5 New Risks were added to the Risk Register this month:

Ref. Directorate Title

- 629 Hosp/Amb Consortium PACS systems restrictions
- 630 Comm Health SPARCCS database Security and appropriate governance
- 631 Comm Health Inadequate staffing levels in Community Health Services
- 632 Comm Health Seclusion Room and doors out of action on Seagrove Ward, Sevenacres
- 633 Corporate Appointment of Catering Manager

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	Change to
CSF9.7	EDoNW; EMD	9.7 (4.16) No recent review of Finance function or finance skills required in future to support delivery of business strategy (F32) Executive Director of Finance	Amber	Green
CSF9.14	EDoNW; EMD	9.14 (4.20) No mention of the importance of financial awareness and staff individual/collective roles made at induction (F33) Executive Director of Finance	Amber	Green
CSF9.15	EDoNW; EMD	9.15 (5.39) No mention of the importance of financial awareness and staff individual/collective roles made at induction (F27) Executive Director of Finance	Amber	Green
CSF1.12	EDoNW	1.12 The CQC have expressed concerns as the result of unannounced visits (Q61) Executive Director of Nursing and Workforce/ Company Secretary	GREEN	Red
CSF3.44	EDTI; EMD; EDoNW	3.44 (9.48) Historic and current CIPs are stated. However, no future plans are provided/ established (O39) Executive Medical Director / Executive Director of Nursing and Workforce / Executive Director of Finance	GREEN	Red

CSF3.45	EDTI; EMD; EDoNW	3.45 (9.49) CIPs cannot demonstrate that they support the Trust's strategy, system-wide CIPs or are linked to commissioning intentions. (O39) Executive Medical Director/ Executive Director of Nursing and Workforce/ Executive Director of Finance	GREEN	Red
CSF6.24	CS&FT	6.24 (10.54) Performance failures were brought to the Board's attention by an external party and/or not in a timely manner (B28) Chief Executive	GREEN	Red
CSF9.5	EDoNW; EMD	9.5 (4.12) No NEDs possess a recognised financial qualification and/or recent relevant experience (F31) Chief Executive Officer	GREEN	Amber
CSF9.74	EDoNW; EMD	9.74 (10.17 (10.34)) There are no NEDs with a recent and relevant financial background (B18) Chief Executive	GREEN	Amber
CSF8 630 - 1	EDONW	SPARRCS DATABASE SECURITY AND APPROPRIATE GOVERNANCE	20	20
CSF9 631 - 1	EDONW	INADEQUATE STAFFING LEVELS COMMUNITY MENTAL HEALTH SERVICES	16	16
CSF2 632 - 1	EDONW	SECLUSION ROOM AND DOORS OUT OF ACTION ON SEAGROVE WARD	20	20
CSF8 629 - 1	EDONW	CONSORTIUM PACS- IW	12	12
CSF9 633 - 1	EDONW	APPOINTMENT OF CATERING MANAGER	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		
1.12 The CQC have expressed concerns as the result of unannounced visits (Q61) Executive Director of Nursing and Workforce/ Company Secretary	5	20		1. The CQC have had no concerns about registration 2. The Trust undertakes its own mock inspections which are fed into the Board 3. The Board monitors CQC compliance	CQC inspection reports are reported to Quality and Clinical Performance Committee	QCPC minutes	Red	Concerns identified by CQC following unannounced visit in June 2014		Mark Pugh/Alan Sheward Update October 2013: CQC inspection to Sevenacres in September 13 raised 3 concerns but nothing major. Action plan under development Change of assurance rating from Green to Amber approved October 2013 Update January 2014: Action plans from MH visits not fully completed as yet. Plans in place for all completed CQC visit action plans to come to QCPC in future for assurance. Update February 2014: CQC re-visit w/c 10th Feb and confirmed all 3 issues satisfactorily resolved. CQC will be confirming this in writing. Feedback from the CQC was excellent. Action complete Change of assurance rating to Green approved February 2014 Update November 2014: Recommend return to Amber/Red schedule following CQC inspection in June 14 - and until associated action plan completed and signed off. Recommend change of assurance rating to Red Review date: January 2015
Principal Objective 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 Exec Sponsor: Executive Medical Director										
<u>Critical success factor CSF3</u> Lead: Executive Director of Transformation and Integration/ Executive Medical Director/ Executive Director of Nursing and Workforce <u>Continuously develop and successfully implement our Business Plan</u> Links to CQC Regulations: 10, 22					MEASURES: Integrated Trust Business plan Directorate business plans National key performance targets			TARGETS: Integrated Business Plan approved by June 2014 Directorate Business Plans agreed by Meeting NHS outcomes framework plans by the year end Achievement of CIP schemes		
3.44 (9.48) Historic and current CIPs are stated. However, no future plans are provided/ established (O39) Executive Medical Director / Executive Director of Nursing and Workforce / Executive Director of Finance		8			CIP Programme and supporting plans managed through TMO & monthly performance reviews	Monthly monitoring of schemes through FIUWC & performance reviews and finance reports to Board.	Red	Cost Improvement Plans (CIPS) are established and integral to the delivery of the Trust's Strategy: 1. Full CIPs are stated, outlining the range of initiatives, the services that they will potentially impact upon, the timing of these, the financial saving target to be achieved and whether recurrent / non-recurrent. 2. CIPs are detailed by project area outlining what is going to be achieved, the timeline, the resource impact, key responsible officer/(s), any key risks / challenges and the reporting mechanism for monitoring purposes.	CIP Programme and supporting plans managed through TMO & monthly performance reviews. Further reporting needs to be developed by PMO re progress of schemes/milestones/de liverables.	Chris Palmer Recommend change to Red - full year plans for 2014/15 no longer evidence based, plans for 2015/16 and future years require evidence. Recommend also addition of executive Director of Transformation & Integration as responsible lead

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
3.45 (9.49) CIPs cannot demonstrate that they support the Trust's strategy, system-wide CIPs or are linked to commissioning intentions. (O39) Executive Medical Director/ Executive Director of Nursing and Workforce/ Executive Director of Finance		8			CIP Programme and supporting plans managed through TMO & monthly performance reviews	Monthly monitoring of schemes through FIWC & performance reviews.	Red	Cost Improvement Plans (CIPS) are established and integral to the delivery of the Trust's Strategy: 1. The CIPs contribute to system-wide CIPs and can demonstrate that they are linked to commissioning intentions. 2. The CIPs demonstrate how the Trust is going to achieve greater efficiency and productivity. Plans are formed with Commissioning intentions taken into consideration. CCG review schemes for appropriateness	CIP Programme and supporting plans managed through TMO & monthly performance reviewsLiaising with local CCG to ensure plans are in line with commissioning intentions.	Chris Palmer Recommend change to Red - full year plans for 2014/15 no longer evidence based, plans for 2015/16 and future years require evidence. Recommend also addition of executive Director of Transformation & Integration as responsible lead
3.56 (10.68) The development of the IBP and LTFM has only involved the Board and a limited number of Trust staff (B34) FT Programme Director/ Executive Director of Finance	8	8	8	The Board has an External Stakeholder Engagement Plan that clearly describes the Trust's key existing and emerging external stakeholders, their relative priority and the tailored methods used to involve each stakeholder group (stakeholders include PCT Cluster, Clinical Commissioning Groups, Local Authorities and Wellbeing Boards).	External Stakeholder Engagement Plan Organisational/ management structure Clinical Commissioning Group Strategy Description of disputes with Commissioners and how they have been resolved	Refer to DoH reference B34	Green			Update November 2014: Mark Price suggested responsibility needs to also include Exec Director of Finance Change of Lead recommended to Trust Board
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 CSF6 Lead: FT Programme Director <u>Develop our Foundation Trust application in line with the timetable set out in our agreement with the TDA</u> Links to CQC Regulations: 10, 15, 16							MEASURES: FT Milestones CQC Inspection outcomes CIPs/savings plans LTFM Board Governance	TARGETS: Integrated Business Plan and LTFM refresh to be submitted by end June 2014 CQC inspection outcome of either outstanding or good rating Satisfactory 'Board to Board'		
6.24 (10.54) Performance failures were brought to the Board's attention by an external party and/or not in a timely manner (B28) Chief Executive	5	20		The Board has debated and agreed a set of quality and financial metrics outside the national and regionally agreed metrics that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Improved quality and performance reports to Board Ward dashboards QRP monitoring HealthAssure system Executive walkrounds	Trust Executive Committee	Monthly Board performance reports	Red	Failings identified by CQC following unannounced inspection in June 2014		Mark Pugh/Alan Sheward Update November 2014: Recommend return to Amber/Red schedule until CQC inspection action plan is completed and signed off Recommend change of assurance rating to Red Review date: January 2015
Principal Objective 5: WORKFORCE - To develop our people, culture and workforce competencies to implement our vision and clinical strategy Executive Sponsors: Executive Director of Nursing and Workforce, Executive Medical Director										
Critical success factor CSF9 Leads: Executive Director of Nursing and Workforce, Executive Medical Director <u>Redesign our workforce so people of the right attitude, skills and capabilities are in the right places at the right time to deliver high quality patient care</u> Links to CQC Regulations: 15, 22, 24						MEASURES: Workforce productivity measures including: Staff Turnover Safe staffing levels Bank and agency usage Mandatory Training compliance	TARGETS: Meet workforce strategy KPI's - Long term sickness rates under 1.2% by 31/3/15 - Short term sickness rates under 1.6% by 31/3/15 - 98% staff appraisals undertaken period 1/4/14 - 31/3/15 - reduction in bank/agency costs to <£250K by 31/3/14 -100% staff fully compliant with mandatory training at some point within the year 1/4/14 -31/3/15 - staff turnover under 4.5% by 31/3/15 - achieve 80% actual against plan for safe staffing levels by March 2015			
9.5 (4.12) No NEDs possess a recognised financial qualification and/or recent relevant experience (F31) Chief Executive Officer	5	5		Financial advisor to the Board appointed and in place	Presentation of financial papers to Board: appraisal of Board Directors; introduction of finance committee	Board Performance Report	Amber	At least two NEDs have a professional financial qualification and numerical literacy and experience in areas relevant to the delivery of the business strategy		KPMG producing Report Karen Baker Update December 2012: Risk reduced following recent NED appointments Update April 2013: Newly appointed Company Secretary creating plan for recruitment Update August 2013: Now two NEDs with appropriate qualifications and experience. Action complete Change of assurance rating to Green approved August 2013 Update November 2014: Board to consider return to Amber /Red schedule as we have a financial advisor to the Board in place but not a Non-Executive Director with a financial qualification Recommend change of assurance rating to Amber Review date: January 2015

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
9.7 (4.16) No recent review of Finance function or finance skills required in future to support delivery of business strategy (F32) Executive Director of Finance	6	6		The Trust has assessed the adequacy of the finance function and broader financial skills requirements across the organisation, and keeps this under regular review: The Trust has undertaken a recent capacity and capability assessment of its present finance function, and a programme is in place to address any key gaps identified from recruitment to training/ development and succession planning. The finance function meets the organisation's transaction processing and information production requirements effectively and provides effective support to financial governance processes – and this is supported by independent assessment (e.g. Internal and External Audit). Board Development Programme in place Finance skills programme in place	Percentage of fully qualified staff is benchmarked against HFMA survey results; Relevant and up to date training supported by Director of Finance; periodic review of skill mix; mix of private and public sector experience within the recruitment process FIIWC	Appraisals; support for CPD; membership of HFMA supported by DoF; training records for staff. Board seminars to assist the board with more technical aspects of finance ie LTFM.	Green			Chris Palmer/Kevin Curnow A review of the finance structure has been made but needs review after the change in Executive change in portfolios and roles. Unipart review is in progress and will impact on any potential changes in the team. EDoF is leading a meeting to consider interaction of teams within her portfolio. A timetable for consultation for a new structure will be produced by mid-June ready for the new DDoF to take forward as part of the finance team's preparation for FT status. Update March 2014: Finance restructure approved at Staff Partnership Forum and now being implemented. Update June 2014: (KC) Restructure complete, KPMG benchmarking completed & awaiting feedback. Appraisals all booked to be completed prior to the end of June, identifying training & development requirements. Update August 2014: (KC) All key posts now appointed. External benchmarking undertaken to be presented to FIIWC in September 14 to provide assurance on aspects of the department with regards VFM. Finance team attending board seminars to inform Trust Board of financial strategy. Update October 2014: (KC) <i>Potential to turn Green</i> Update November 2014: Board Development Programme in place and Finance skills programme in place. Action complete Recommend change of assurance rating to Green
9.14 (4.20) No mention of the importance of financial awareness and staff individual/collective roles made at induction (F33) Executive Director of Finance	12	6		Organisational culture: All staff members are introduced to financial awareness through the induction process and regularly informed of progress through cascade briefings and financial awareness training sessions. Training sessions provided to staff in financial awareness as a new slot within the corporate induction programme . This is in place and working.	Induction programme, Management Development Programme, Clinical Leadership Programme, Board and Committee Reports, Executive briefings Finance Investment Information and Workforce Committee	Appraisals Completion of HFMA certificate in finance FIIWC reports	Green			Pursue a structured finance awareness training programme for non-finance staff Kevin Curnow Change of assurance rating from Green to Amber approved October 2013 Update April 2014: (KC) No further update to plans re introduction of finance awareness at induction but finance dept in conjunction with Training Dept to roll out awareness drop in sessions for all staff in 2014-15. Update June 2014: No further update to plans re introduction of finance awareness at induction but finance dept in conjunction with Training Dept to roll out awareness drop in sessions for all staff in 2014-15. Update August 2014: Now aiming to commence financial awareness session at corporate induction in October 14 Update September 2014: (KC) Finance awareness importance recognised & from 1 October reintroduced to Corporate Induction. Action complete Update November 2014: Finance session now a regular slot within the monthly corporate induction programme for new staff. Recommend change of assurance rating to Green
9.15 (5.39) No mention of the importance of financial awareness and staff individual/collective roles made at induction (F27) Executive Director of Finance	12	6		CIP reporting - KPIs: All staff members are introduced to financial awareness through the induction process and regularly informed of progress through cascade briefings All staff members are introduced to financial awareness through the induction process	Induction programme coverage.	HR performance reports to Board	Green			Consideration of reinstatement of financial awareness within corporate induction Change of assurance rating from Green to Amber approved January 2014 Alan Sheward/Jackie Skeel Update April 2014: JS and Kevin Curnow to meet 29/4 to consider options Update May 2014: Financial awareness to be reinstated into the corporate induction programme, hopefully commencing July 2014. Review and possibly change to Green next month. Update July 2014: Now aiming to commence financial awareness session at corporate induction in October 14 Update September 2014: Deputy Director of Finance (Kevin Curnow) will begin delivery of a short session on Financial Awareness as part of the Corporate Induction programme in October 2014. <i>Potential to turn Green</i> Update November 2014: Financial awareness now a regular session on the induction programme. Action complete Recommend change of assurance rating to Green
9.74 (10.17 (10.34)) There are no NEDs with a recent and relevant financial background (B18) Chief Executive	8	8		At least one member of the Audit Committee has recent and relevant financial experience. One current NED is a chartered accountant and the chair of the Audit Committee. Another NED has significant financial experience and is the Chair of the Finance Investment & Workforce Committee. At least two NEDs have numerical literacy and experience in areas relevant to the delivery of the business strategy and one has a professional financial qualification	Biographies of NEDS Board and Committee Terms of Office for NEDs Legal advice from Bevan Brittan Nominations Committee	Board review as required Nominations Committee minutes - 13th August 2013	Amber			Consider whether we need to address the issue of having a second NED with a professional financial qualification Karen Baker/Danny Fisher/Mark Price Update April 2013: Action plan being developed Update June 2013: Newly appointed company secretary creating plan for recruitment Update August 2013: Action complete Change of assurance rating to Green approved August 2013 Update November 2014: Board to consider return to Red/Amber schedule as we have a financial advisor to the Board in place but not a Non-Executive Director with a recent and relevant financial background Recommend change of assurance rating to Amber Review date: January 2015

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
<p><u>Board Assurance Framework column headings: Guidance for completion and ongoing review</u> (N.B. Refer to DoH publication 'Building an Assurance Framework' for further details)</p> <p><u>Principal Risks:</u> All risks which have the potential to threaten the achievement of the organisations principal objectives. Boards need to manage these principal risks rather than reacting to the consequences of risk exposure.</p> <p><u>RISK LEVEL</u> = S (Severity where 1 = insignificant; 2 = minor; 3=moderate; 4=major; 5=catastrophic) X L (Likelihood where 1=rare; =unlikely; 3=possible; 4=likely; 5=certain)= RS(Risk Score). Code score: 1-9 GREEN; 10-15 AMBER; 16+ RED</p> <p><u>Controls in Place:</u> To include all controls/systems in place to assist in the management of the principal risks and to secure the delivery of the objectives.</p> <p><u>Assurances on Controls:</u> Details of where the Board can find evidence that our controls/systems on which we are placing reliance, are effective. Assurances can be derived from independent sources/review e.g. CQC, NHSLA, internal and external audit; or non-independent sources e.g. clinical audit, internal management reports, performance reports, self assessment reports etc.</p> <p>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)</p> <p>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.</p> <p><u>Assurance Level RAG ratings:</u></p> <p>Effective controls in place and Board satisfied that appropriate positive assurances are available <u>OR Effective controls in place with positive assurance available to Board and action plans in place which the Executive Lead is confident will be delivered on time</u> = GREEN (+ add review date)</p> <p>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</p> <p>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</p> <p>(NB - Board will need to periodically review the GREEN controls/assurances to check that these remain current/satisfactory)</p> <p><u>Gaps in Control:</u> details of where we are failing to put controls/systems in place to manage the principal risks or where one or more of the key controls is proving to be ineffective.</p> <p><u>Gaps in Assurance:</u> details of where there is a lack of board assurance, either positive or negative, about the effectiveness of one or more of the controls in place. This may be as a result of lack of relevant reviews, concerns about the scope or depth of any reviews that have taken place or lack of appropriate information available to the board.</p> <p><u>Action Plans:</u> To include details of all plans in place, or being put in place, to manage/control the principal risks and/or to provide suitable assurances to the board. NB: All action plans to include review dates (to enable ongoing monitoring by the board or designated sub-committee) and expected completion dates (to ensure controls/assurances will be put in place and made available in a timely manner)</p> <p>Assurance Framework 2013/14 working document - August 2013. Guidance last updated December 2009.</p>										

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
629		HOSAMB	QCE	24/10/14	31/03/16	CONSORTIUM PACS- IW	DCOLL	* Increased local requirements in dealing with multiple issues / meetings associated with the PACS both in Radiology and IT without increased resources. * Ongoing problems preventing radiologist being able to report in a timely manner * Increasing financial costs * Delays in XDS impacting on image retrieval impacting on clinical time * Non accreditation of NBSS integration	12	12	MOD	Radiologists / Radiographers manually pulling images back from data centre to allow image comparison - very time consuming but helping to mitigate risk but not a long term solution. Inform GP's to indicate that Radiologist may not have previous images for comparison. if images are not available this will be indicated in the report. Logged clinical risk with Consortium Ongoing development of XDS to be able to easily retrieve images currently unavailable Service management team driving PACS issues forward with 4 vendors IW review of benefits of being part of consortium	A	24.10.14 Approved at RMC on 17.09.14.	3 items listed to date, with latest completion 31.03.2016: Accreditation of NBSS integration Removal of duplicates Ongoing development of XDA	EDONW
630		COMMH	GOVCOM	24/10/14	31/03/15	SPARRCS DATABASE SECURITY AND APPROPRIATE GOVERNANCE	NT	* One database for all referrals and data for Community Rehab and SPARRC's service. * Database unstable and lost data captured (for example: informed lost 55 SLT referrals added in month of August). * Data lost and has required resubmitting. However reliant on human eye/memory to note if data accurate. * Informed unable to draw data from the database as database has become too large to filter. * Multiple users of one key system increases risk of corruption. * System which contains PID is not secure * This data is required for managing waiting lists, caseload, response times, key involvements. * This system is both the working database for the service and also the data collection for the SLA reporting (too wide for current set up) * Database is 2 years old (set up by service for service as pilot). No investment/support from IT in place	20	20	HIGH	Reviewed structure and needs of database Modified database to reduce data loss Back up copy of database taken each day Daily monitoring and working with PIDS and Paris to find a solution Recognised need for IT support	A	24.10.14 Approved at RMC on 15.10.14. Discussions with PIDS/IT/PARIS to determine long term solution. 31.10.14 Ongoing implementation of controls to minimise risk and liaison with PIDS and Paris to formalise a solution. IT involvement pending. EP.	7 items listed to date, with latest completion date of 31.01.2015	EDONW
631		COMMH	PATSAF	24/10/14	31/03/15	INADEQUATE STAFFING LEVELS COMMUNITY MENTAL HEALTH SERVICES	NT	* Increased demand for Mental Health Service * Reduced resource over last 3 years * Requirement to redesign services	16	16	HIGH	Recruitment is ongoing Agency nurses have been drafted in Sickness being managed within policy	U	24.10.14 Approved at RMC on 15.10.14 Business case to be submitted to CCG for mainland placements and staffing. Continue redesign of CMHS.	4 items listed to date, with latest completion 31.03.2015	EDONW
632		COMMH	PATSAF	24/10/14	31/12/14	SECLUSION ROOM AND DOORS OUT OF ACTION ON SEAGROVE WARD	DSE	* Inadequate locking mechanisms for the Ward's seclusion room * Duration of time to get appropriate fixtures/replacements is taking much longer than necessary (currently taking three months plus to resolve) * Seclusion room now out of action, bedroom 4 is being used as a temporary but inadequate solution until this is resolved.	20	20	HIGH	Bedroom 4 has been utilised as a temporary seclusion area, although is not designed for this purpose at all.	I	24.10.14 Approved at RMC on 15.10.14. Ongoing discussions with Estates regarding plans for conversion of S136 room so it can be used as a second back up seclusion room along with electronic gates for S136 admissions.	6 items listed to date, with latest completion date of 31.12.2014	EDONW
633		CORPRI	PATSAF	24/10/14	30/11/14	APPOINTMENT OF CATERING MANAGER	ASW	* Lack of professional leadership in catering due to absence of post holder. * Lack of liaison with departments due to absence of post holder	12	12	MOD	Interim manager in place, no catering experience. Daily hygiene check. Monthly hygiene audit. Action plan for place	I	24.10.14 Approved at RMC on 15.10.14 . Awaiting confirmation to appoint temporary professional catering manager.	3 items in action plan. One action - interim arrangements in place with support from Hotel Services manager - already completed	EDONW

ID	Source	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
Key for Assurance Level for Risk Register Entries: GREEN - A adequate controls; AMBER - I inadequate controls; RED - U uncontrolled risks																

FOR PRESENTATION TO TRUST BOARD ON 3 DECEMBER 2014

AUDIT AND CORPORATE RISK COMMITTEE

Minutes of the meeting of the Audit & Corporate Risk Committee held on Thursday, 13th November 2014 at 9.30 a.m. in the Large Meetings Room, St. Mary's Hospital, Newport.

PRESENT	David King	Chairman
	Nina Moorman	Non Executive Director
	Jane Tabor	Non Executive Director
	Charles Rogers	Non Executive Director
In Attendance	Nina Moorman	Deputy Chair of Quality & Clinical Performance Committee
	Chris Palmer	Executive Director of Finance
	Mark Price	Company Secretary
	Kevin Suter	External Audit Manager
	Andy Jefford	Chief Internal Auditor
	Kevin Curnow	Deputy Director of Finance
	Brian Johnston	Head of Corporate Governance & Risk Management
	Karen Baker	Chief Executive (Item 14/119)
	Katie Gray	Executive Director of Transformation & Integration (Item 14/128)
	Andy Hollebon	Head of Communications & Engagement (Item 14/128)
	Iain Hendey	Assistant Director of Informatics (Item 14/127)
Minuted by	Linda Mowle	Corporate Governance Officer

Min. No.	Top Key Issues/Risks
14/119	Care Quality Commission Report – Action Plan: The Chief Executive outlined actions being taken through the Quality Improvement Plan.
14/120	FIWIC Quarterly Assurance Report: New assurance report developed providing in depth knowledge of the assurances being provided. CIP Plans for 2015/16 – Assurance Level: Negative: Further assurance to be sought as part of the Business Planning process and LTFP
14/124	Procurement Services Contract: The current SLA Agreement with South of England Procurement Services extended for 12 months to allow exploration of options and the assessment of benefits in order to prepare a business case.
14/125	ACRC Terms of Reference: Agreed subject to further amendments for approval by Trust Board.
14/126	Legal Services Contract Tender: Contract has been awarded to Bevan Brittan LLP for a period of 3 years with the option to extend for a further 2 x 12 months commencing on the 1 st October 2014 to 30 th September 2017.
14/128(118)	ANNUAL REPORT 2014/15: Monitoring of operational and executive management of the Annual Report to meet the deadlines will be through the Trust Executive Committee.

- 14/110 APOLOGIES**
 For absence were received from Sue Wadsworth, Non Executive Director, and John Micklewright, Internal Audit Manager
- 14/111 QUORACY**
 The Chairman confirmed that the meeting was quorate.

- 14/112 DECLARATIONS OF INTEREST**
There were no declarations. The Register of Interests for 2014/15 was available for scrutiny. The Head of Corporate Governance confirmed that all NEDs had completed Declarations of Interest.
- 14/113 MINUTES**
The minutes of the meeting held on the 19th August 2014 were agreed and signed by the Chairman as a true record, subject to the following amendment:
- Min. No. 14/095 External Audit: Last sentence insert 'qualified' before value for money conclusions.
 -
- 14/114 MATTERS ARISING FROM PREVIOUS MINUTES**
The schedule of progress on actions arising was noted with the following comments:
- Min. No. 14/040 Annual Review of Self-Certification Process – Training Session:** The Committee considered that the Seminar training session be expanded to include working examples of strategic risk to align with the Strategy Development work led by the Executive Director of Transformation & Integration and that the training session be scheduled within the next 3 months. **Action: CS**
- Min. No. 14/050 Internal Audit Contract Tender 2015/18:** Noted that the Service Specification had been received and that the new service will commence at the beginning of April 2015.
- Min. No. 14/058 TEC Minutes – Mental Health Service User Involvement Policy:** The Company Secretary advised that the Policy has been approved at TEC. Action status – completed.
- Min. No. 14/090 Counter Fraud Management Arrangements:** The Committee received and noted the letter dated 15th October 2014 from Kish Sidhu, Director of Finance & IM&T at Kettering General Hospital NHS Foundation Trust, confirming the transfer of CEAC to TIAA Ltd which will now deliver the counter fraud service on behalf of Kettering. The Agreement for the provision of Counter Fraud Services to the Isle of Wight NHS Trust was received detailing the one additional clause which provides for Kettering to be able to sub-contract the delivery of the service to TIAA.
- Min. No. 14/101 BAF – Review of Corporate Objective 5 Workforce – Review of Achievement:** The Company Secretary reported that the BAF is to be reviewed at the executive weekly session and following this, any status changes will be reported to the Trust Board. The Committee noted that for 2015/16 the BAF is to be streamlined into a more concise document and process. **Action: CS**
- 14/115 INTERNAL AUDIT**
The Chief Internal Auditor introduced the progress report highlighting the following:
- Progress against the Internal Audit Plan is on track at 44%
 - 8 final reports issued:
 - NHS Contracts & Reporting – Substantial Assurance
 - Sickness Absence Management – Substantial Assurance
 - Hotel Services – Substantial Assurance
 - Debtors – Full Assurance

- Creditors – Full Assurance
- Financial Ledger – Substantial Assurance
- Charitable Funds – Substantial Assurance
- Freedom of Information – Limited Assurance: The Head of Corporate Governance & Risk Management advised that, since the audit, compliance has increased to 94% with the aim of achieving 100%. The action plan has been accepted with half of the actions already completed.

The Executive Director of Finance highlighted the significant tenfold increase in the number of FOIs and the Company Secretary commented on the complexity of the information requested.

The Committee was of the opinion that the number of FOIs should be monitored so that there is more transparency on costs, complexity of requests and the amount of time required to provide information, as well as in some cases seeking legal advice. Kevin Suter stated that that many mainland Trusts take a robust approach in challenging FOI requests and felt that this approach should also be taken within the Trust. **Action: HOG/CS**

(Post meeting note: HOG has organised with the Information Governance Manager for FOI information to be incorporated quarterly within the Board Performance Report.)

14/116

PROGRESS ON AUDIT AND FRAUD RECOMMENDATIONS

The Deputy Director of Finance presented the schedule outlining the follow up actions for audit and fraud recommendations as at 5 November 2014 and advised that since the report was issued the number of actions outstanding had reduced from 44 to 24 (20 Priority 2 recommendations and 4 Priority 3 recommendations). The Committee noted that due to the change in process and staff, the summarising report and chart had not been available but would be available for the next meeting.

The Committee was not satisfied with the backlog of actions that were still open and need the executive to take ownership for attending to the items they are responsible for.

The Executive Director of Finance advised that clinical recommendations were reviewed at the Directorate Performance Reviews but that for corporate recommendations there needed to be an equivalent escalation process. The Committee agreed that the EDF raise with the Trust Executive Committee the internal escalation process to TEC for corporate recommendations.

Action: EDF

14/117

PROCEDURE FOR THE FOLLOW UP OF INTERNAL AUDIT RECOMMENDATIONS

The Committee noted the update on the Procedure for the follow up of recommendations prepared by the Interim Head of Financial Services which sets out the monitoring process to provide assurance that recommendations have been implemented. The amended Procedure to be circulated to Committee members for assurance. **Action: DDF/CA**

14/118

EXTERNAL AUDIT

The External Audit Manager, Kevin Suter, presented the Update Report dated October 2014 advising that the detailed planning procedures to complete the audit plan are being undertaken, including:

- Detailed discussions with senior officers to develop External Audit's understanding of the challenges and risks the Trust is facing
- Discussions with key finance staff to identify and discuss risks and emerging issues around the financial statement preparation process.

Kevin Suter reported that the deadline date for the submission of the Annual Accounts and Annual Report was the 5th June 2015 and in order for EY to sign off the Annual Report:

- a finalised and full copy of the Annual Report needs to be with EY by the 1st May 2015 having already been agreed by the Trust Executive Committee and the Audit & Corporate Risk Committee
- the Annual Accounts, Annual Report and Quality Account timetables all dovetail to meet the deadline

Kevin Suter further advised that EY was not assured of the processes for the Annual Report to be delivered to that timetable from the current plan being presented to the Committee. If further work was required this year, then an additional fee may apply.

With regard to the Quality Account, the Committee noted that guidance was awaited from the DOH.

The Executive Director of Finance confirmed that the date for the sign off of the Accounts and Annual Report, and if available the Quality Account, by the Audit & Corporate Risk Committee and the Trust Board was the 3rd June 2015 and that confirmation and assurance would be sought from the Executive Director of Transformation & Integration that the deadlines for the Annual Report would be met. In addition, the monitoring of operational and executive management of the Annual Report will be through the Trust Executive Committee.

14/119

CARE QUALITY COMMISSION REPORT – ACTION PLAN

The Chief Executive introduced the Quality Improvement Plan which has been developed from information provided by staff from across the organisation. The action plan seeks to address all of the enforcement actions, compliance actions must do and should do actions against the CQC report.

The Committee challenged the Chief Executive to explain why some issues appeared to be surprises to the Trust and, as a follow up, why some issues appeared to be known to the Executive but not sighted to the Board.

The Chief Executive acknowledged that some services were not quite as good as they should have been and discovering that some staff had accepted practices which were not best practice has been of concern. The CEO highlighted the following areas:

- Lessons Learned with clear escalation policies and lines of accountability up to the Accountable Officer
- Trust culture to embrace raising issues of concern – See something, say something campaign.
- Organisational restructure with clear line of sight from ward up to

Board

- Aspiration to provide the best services: Isolation of services on Island requires links with mainland Trusts.
- Listening into Action has been a really good achievement in the highlighting and raising of issues
- Need to challenge managers to find out what the problems are and how they are dealing with them and to encourage staff to raise issues on which they feel uncomfortable
- All services should follow national guidance
- More focus at Board on the prioritisation of operational issues and strategic risk – to be discussed at a Board Seminar
- Assurance on the achievement of the QIP and cultural change will be provided through the FIIWC and QCPC, with the QCPC being the lead sub-committee to provide assurance that the QIP is being implemented and CQC targets and deadlines met

The CEO also explained that in order to gain assurance, testing of 'completed' actions is being undertaken by the SEE Triumvirate which has introduced another RAG rating of 'blue' which confirms that the action has been tested and is signed off as completed.

The CEO added that it should be noted that many of the Trust's services provide high quality care/best practice which has been recognised nationally, e.g. Orthopaedics, Sexual Health, Improving Access to Psychological Therapy (IAPT).

The CEO commented that overall the CQC inspection should be regarded as a positive experience rather than a negative one in order to focus the organisation on achieving high quality standards of care in all of its services.

14/120

FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE QUARTERLY ASSURANCE REPORT

The Chairman of the FIIWC, Charles Rogers, presented the quarterly report covering the period July – October 2014, with the corresponding minutes attached. The Committee noted:

- Actual and forecast revenue – Assurance Level: Positive
- Capital income and expenditure – Assurance Level: Positive
- Cash Flow – Assurance level: Positive
- Review Disclosure Statements – Self-certification – Assurance Level: Positive
- Review schedules of Losses and Compensations – Assurance Level: Limited – Comprehensive review to be undertaken to understand what the trends are and to provide more information to ACRC
- Review schedules of debtors and creditors balances over 3 months with explanations and plans – Assurance Level : Positive
- Monitor Better Payment Practice Code (half yearly/quarterly) – Assurance Level – Positive
- Review Implementation of Reference Costs and SLR (half yearly) – Assurance Level – Positive
- Monitor Contractual Risk – reviewing contract status report and implementation of Strategy – Assurance Level : Positive
- Review and monitor implementation of Cost Improvement Plans (CIPs) – Assurance Level: Limited – Programme Governance Office (PGO) now undertaken work to find further savings to close the gap, which is

improving each month. In order to provide assurance and monitor closure of the gap, comprehensive information is to be received by FIIWC

- CIP Plans for 2015/16 – testing assurance in relation to the 3 phases of CIP achievement – Assurance Level: Negative – Further assurance will be sought monthly as part of the Business Planning process and Long Term Financial Plan
- Staff Survey Action Plan – implementation to be monitored, including effective management of stress levels amongst staff – Assurance Level: Negative – This will remain on each FIIWC agenda until assurance has been obtained. The EDTI is now taking forward implementation. ACRC concerned that no focus has been given to this particularly as the Culture, Health & Wellbeing Committee has not met for several months. Update to next ACRC meeting
- Monitor implementation of Workforce Strategy to include succession planning at operational level – Assurance Level: Limited – KPIs will now be monitored and guidance provided to ACRC when updates have been considered
- Future agenda items:
 - Monitor NHS SBS Performance including Payroll Overpayments
 - Risk Register review ensuring the link between the register and the performance management system
 - Review implementation of Long Term Financial Model (LTFM)

The Chairman, on behalf of the Committee, thanked Charles Rogers for the comprehensive report which provided the Committee with in depth knowledge of the assurances being provided.

14/121

QUALITY & CLINICAL PERFORMANCE COMMITTEE QUARTERLY ASSURANCE REPORT

The Vice Chair of QCPC, Nina Moorman, presented the QCPC minutes for the 17th September and 22nd October 2014 and reported:

- Child Safeguarding: the QCPC was assured on the current state of Child Safeguarding. CQC inspection had identified that procedures were good. Caveat is that the clinical lead is to retire at the end of the year – Assurance Level: Positive
- Clinical Audit: Clinical Audit Programme to have a detailed review carried out. Meeting with the SEE Group to agree the monitoring process for QCPC in order to provide assurance to ACRC – Assurance Level: Limited
- SIRI Process – revised process now in place with the aim to have all SIRIs completed and submitted to the Commissioners within the 45 day target. Future assurance on how documentation will be monitored and managed as part of the lessons learned from SIRIs is to be provided to QCPC in order to assure ACRC – Assurance Level: Limited

14/122

DECISIONS TO SUSPEND STANDING ORDERS

None to date.

- 14/123 WAIVERS TO SIFIs:**
The Committee agreed the following Waivers:
- Nos. 12-17 dated 22/08/14 – 03/11/14
- The DDOF confirmed that the rationale will be expanded for the next meeting.
- The Committee agreed that as there were so few waivers, the controls in place appeared to be working.
- 14/124 PROCUREMENT SERVICES CONTRACT**
The Committee received the update on the Procurement Services Contract prepared by Andy Heyes, Head of Commercial Development, dated November 2014. The Committee noted that the current SLA agreement with South of England Procurement Services ends on 31st March 2015 but that a 12 month extension to the service has been agreed in order to continue exploring options and assessing benefits in order to prepare a business case. The DDF advised that updates will be presented to future meetings of the Committee.
Action: DDF
- 14/125 REVIEW OF TERMS OF REFERENCE – AUDIT & CORPORATE RISK COMMITTEE**
The Committee received the updated terms of reference with the amendments highlighted in bold italics. The amendments take into account the recommendations contained within the NHS Audit Committee Handbook 2014. The Committee agreed the amendments and for the following amendments to be included before presentation to the Trust Board for approval:
- Incorporate how the ACRC draws assurance from the sub-committees and LCFS
 - Whistleblowing – incorporation of FIIWC role
- (Post meeting note: Above amendments and additional amendments received have been included within the terms of reference and agreed by the Chair and Company Secretary for presentation to the Trust Board for approval.)*
- Sub-Committees' Terms of Reference:**
Finance, Investment, Information & Workforce Committee
Quality & Clinical Performance Committee
The Committee received the terms of reference for the FIIWC and QCPC which had been approved at Board on the 1st October 2014. The Committee considered that these terms of reference needed to be reviewed in line with the ACRC's terms of reference and asked that the Company Secretary review these with Jane Tabor.
Action: CS/JT
- 14/126 LEGAL SERVICES CONTRACT TENDER**
The self-explanatory Ratification Report dated 15th September 2014 was received. The Committee noted that the contract has been awarded to Bevan Brittan LLP for a period of 3 years with the option to extend for a further 2 years commencing on the 1st October 2014 to 30th September 2017.
- 14/127 REVIEW OF DIRECTORATE PERFORMANCE MANAGEMENT**
The Assistant Director of Informatics presented the overview of the Directorate Performance Review which form part of the Trust's performance management framework and are conducted on a monthly basis. The purpose of the reviews

is to give those accountable for Trust performance the opportunity to discuss and escalate performance issues.

The EDOF advised that the directorate performance reviews enable an oversight of actions being taken within the directorates and a mechanism for assurance to the Trust Board. The directorate performance reviews also enable assurance to be provided on the Board's Performance Report through the knowledge and understanding of the issues and risks gained through the monthly review meetings.

The Committee was of the opinion that a summary report of the key issues arising from the directorate reviews would be useful information for the NEDs. Nina Moorman agreed to attend a performance review in order to compare and contrast the information/data with the directorate report to QCPC and to report back on what information would be useful for the NEDs.

Action: EDOF/NM

In addition, it was felt that this information would be useful as part of the NEDs' induction process.

Action: CS

14/128

REVIEW OF 2013/14 ANNUAL REPORT AND 2014/15 TIMETABLE

The Executive Director of Transformation & Integration and the Head of Communications & Engagement presented the following reports:

- Review of the 2013/14 Annual Report and Quality Account
- Project Chart for 2014/15 Annual Report
- Master Timetable for 2014/15

The HOC advised that key leads within the Trust are being consulted on the Project Charter and master timetable and these will be expanded as more key dates are included. External stakeholders will be consulted as part of the process of developing both the Annual Report and Quality Account.

The Committee noted that the deadline needs to be brought forward to the 3rd June 2015 for Trust Board sign off with meetings adjusted accordingly, and requested that a comprehensive Annual Report is available at the ACRC February 2015 meeting.

The Committee asked that consideration be given to the inclusion of a baseline for the measurement of success and agreed that a follow up survey with stakeholders could be initiated. The EDTI confirmed that the production of the Annual Report would be given high priority to enable achievement of deadlines.

14/129

HEAD OF CORPORATE GOVERNANCE AND RISK MANAGEMENT

As this was to be Brian Johnston's last ACRC meeting, the Chairman, on behalf of the Committee, thanked Brian for the tremendous and diligent work he has undertaken for the Committee and Trust over the last 40 years of service and wished him well in his retirement and future endeavours.

14/130 ITEMS FOR NOTING (Previously Circulated)

The Committee noted the following items:

- Payment & Tariff Assurance Framework – 2014/15 coding and costing audit by Monitor
- NAO Draft Code of Audit Practice for the Audit of Local Public Bodies
- Financial Reporting Council's consultation document on the regulation of auditors in the new local audit framework

14/131 KEY ISSUE FOR REPORTING/REFERRAL TO TRUST BOARD

Please see Key Issues

14/132 DATES OF 2015 MEETINGS

To be held on Tuesdays at 2.00 pm – 4.30 pm

- 10 February (Year End Planning)
- 12 May
- 03 June (Provisional for sign off of Accounts 9.00 – 10.00 a.m. prior to Trust Board meeting)
- 11 August
- 10 November
- 09 February 2016

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 3 DECEMBER 2014

Title	Audit & Corporate Risk Committee Terms of Reference				
Sponsoring Executive Director	Mark Price, Company Secretary				
Author(s)	Linda Mowle, Corporate Governance Officer				
Purpose	To approve the updated ACRC Terms of Reference				
Action required by the Board:	Receive		Approve	P	
Previously considered by (state date):					
Trust Executive Committee		Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee	13/11/14	Remuneration & Nominations Committee			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee		Foundation Trust Programme Board			
ICT & Integration Committee					
Please add any other committees below as needed					
Board Seminar					
Other (please state)					
Staff, stakeholder, patient and public engagement:					
N/A					
Executive Summary:					
<p>The ACRC's terms of reference have been updated to reflect increased responsibilities as outlined in the NHS Audit Committee Handbook 2014 and to expand on the assurances to be gained from sub-committees and Counter Fraud. Membership is to include the Non Executive Financial Advisor to the Trust Board and 4 Non Executive Directors.</p> <p>The ACRC at its meeting on the 13th November 2014 agreed the amendments.</p>					
For following sections – please indicate as appropriate:					
Trust Goal (see key)	All				
Critical Success Factors (see key)	All				
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)					
Assurance Level (shown on BAF)	Red		Amber		Green
Legal implications, regulatory and consultation requirements	Compliance with NHS Audit Committee Handbook 2014				
Date: 25 November 2014					
Completed by: Corporate Governance Officer					

Audit and Corporate Risk Committee

Terms of Reference

Document Type:	Committee Terms of Reference
Date document valid from:	3rd December 2014
Document review due date:	1st October 2015

AUDIT TRAIL:

Dates reviewed:	October 2014	Version number:	V1/2012
Dates agreed:	November 2014	Version number:	V 4
Details of most recent review: (Outline main changes made to document)		Original terms of reference agreed by the IOW NHS Trust Board on 4 th April 2012 Min. No. 12/009.2 Reviewed: November 2012 (A&CRC) March 2013 (A&CRC) Review Date: March 2014	
Signature of Chairman of Committee:			
Print Name: David King			

Trust Board Approval Authorised Signature

Authorised by:	Danny Fisher
Job Title:	Chairman of Trust
Approved at:	Trust Board
Date Approved by Trust Board:	3 rd December 2014

AUDIT AND CORPORATE RISK COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

- 1.1 The Board hereby resolves to establish a Committee of the Board to be known as the 'Audit and Corporate Risk Committee' (The Committee) to provide the Board with an independent and objective review of its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.
- 1.2 The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. The terms of reference to be approved by the Board.

2 ROLE

- 2.1 The role of the Committee is to effectively support the Board and the Accountable Officer by reviewing the completeness of assurances to satisfy their needs, and by reviewing the reliability and integrity of those assurances.

3 MEMBERSHIP AND QUORUM

3.1 Membership

- 3.1.1 The Committee will consist of **4** members excluding co-opted members.
- 3.1.2 The Committee shall be appointed by the Board and shall comprise:

- **4 Non-Executive Directors.**
- ***Non Executive Financial Advisor to the Trust Board***

- 3.1.3 One of the members will be appointed Chair of the Committee by the Board and one will be nominated as Vice Chair of the Committee.
- 3.1.4 The Chairman of the Trust shall not be a member of the Committee.

3.2 Quorum

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

4 ATTENDANCE AT MEETINGS

- 4.1 All members of the Committee are expected to attend a minimum of two meetings per annum.
- 4.2 The Executive Director of Finance, and appropriate Internal and External Audit representatives, shall normally attend meetings. However, at least once a year the Committee should meet privately with the External and Internal Auditors.
- 4.2 The Company Secretary shall normally attend meetings to provide advice on all legal matters and to provide appropriate support to the Chair and Committee members so that the Committee's influence continues to be felt between meetings. In addition, the Company Secretary shall advise the Committee on assurances to be gained from external agencies and to ensure that the Committee receives the required resources in order to fulfil its role.
- 4.3 The Chief Executive and other executive directors should be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director, in which case any other manager or employee may also be required to attend in order to present papers or to provide additional information in support of discussions.
- 4.4 The Chief Executive will be invited to attend at least annually to discuss with the Audit & Corporate Risk Committee the process for assurance that supports the Annual Governance Statement.
- 4.5 The Committee Administrator shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

5 FREQUENCY OF MEETINGS

- 5.1 Meetings shall be held not less than three times a year.
- 5.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6 DELEGATED AUTHORITY

- 6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- 6.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7 ROLES & RESPONSIBILITIES

The duties of the Committee can be categorised as follows:

7.1 Governance, Risk Management and Internal Control

- 7.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievements of the organisation's objectives.

In particular, the Committee **shall assure itself (either directly or through the work of the Board's sub committees) of the accuracy, adequacy and effectiveness of:**

- a) All risk and control related disclosure statements, together with any accompanying Head of Internal Audit Statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board.
- b) The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal **corporate and clinical** risks and the appropriateness of the above disclosure statements. **These will include, but will not be limited to, the Board Assurance Framework, Risk Management Strategy and Risk Register, along with realistic prioritised action plans and targets to eliminate or minimise risk.**
- c) The effectiveness of the Trust's risk management arrangements, the Trust's risk management strategy, and the organisation's compliance with it.
- d) The Committee will oversee the management of risks and related risk treatments considered by the committees which report to it, as detailed in these terms of reference. Where appropriate, the committee will add issues of concern raised by other committees to the Corporate Risk Register.
- e) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements **and related reporting and self-certification.**
- f) The policies and procedures for all work related to fraud and corruption as set out in the Administration of State Directions and as required by the Counter Fraud NHS Protect Service.
- g) Review Whistle blowing arrangements by which staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting, **clinical practices** or other matters. The objective is to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. **Review the work and assurance on whistle blowing arrangements undertaken by the Finance, Investment, Information & Workforce Committee and Quality & Clinical Performance Committee on behalf of the Audit & Corporate Risk Committee in order to provide the relevant assurance to the Trust Board**
- h) The Committee will oversee work on maintaining an effective system of emergency preparedness, emergency response and contingency planning for the Trust.
- i) In line with Standing Orders 4.13.4 and the Scheme of Delegation, the Audit and Corporate Risk Committee shall review every decision to suspend Standing Orders **and Standing Financial Instructions.**
- j) Review the process for the production of the Quality Account.

k) The Committee shall satisfy itself that the organisation has adequate arrangements and plans in place for security to ensure adequate coverage, and shall review the outcomes of work in this area.

7.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, **Local Counter Fraud Service (LCFS)**, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.1.3 This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.1.4 The Committee will seek assurance from the Quality & Clinical Performance Committee to the extent that this is reasonable and possible, that the quality and clinical risk elements of the Trust's Board Assurance Framework, Risk Register, Risk Management Strategy and underpinning risk management and clinical governance processes are in place, fully effective and in line with best practice.

7.1.5 The Committee will seek assurance from the Finance, Investment, Information & Workforce Committee to the extent that this is reasonable and possible, that the financial, workforce and information risk elements of the Trust's Board Assurance Framework, Risk Register, Risk Management Strategy and underpinning risk management and governance processes are in place, fully effective and in line with best practice.

7.1.6 The Committee will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.2. Internal Audit

7.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Corporate Risk Committee, Chief Executive and Board. This will be achieved by:

7.2.2 Consideration of the appointment and performance of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

7.2.3 Review and approval of the Internal Audit Strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.

7.2.4 Consideration of the major findings of internal audit work and management's response, **ensuring that recommendations are followed-up and any lessons are learned within the Trust.**

7.2.5 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

- 7.2.6 Annual review of the effectiveness of internal audit **and of co-ordination between the Internal and External Auditors to optimise audit resources. (Moved from 7.2.4)**

7.3 External Audit

- 7.3.1 In line with Standing Financial Instructions 2.4, the Audit and Corporate Risk Committee shall ensure a cost-efficient External Audit service. The Committee shall review the work and findings of the External Auditor, and consider the implications and management's responses to their work. This will be achieved by:
- 7.3.2 Consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit
- 7.3.3 Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- 7.3.4 Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- 7.3.5 Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

7.4 Other Assurance Functions

- 7.4.1 The Audit and Corporate Risk Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.
- These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).
- 7.4.2 The Audit and Corporate Risk Committee will ensure compliance with external reporting requirements and regularly review the register of external agency visits, inspections and accreditations.
- 7.4.3 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit and Corporate Risk Committee's own scope of work. This will particularly include the Trust Executive Committee, the Quality & Clinical Performance Committee **and the Finance, Investment, Information & Workforce Committee.**
- 7.4.4 The Audit & Corporate Risk Committee will receive the minutes of the following committees in order to provide greater clarity and understanding of their roles, as well as providing relevant assurance to the Audit & Corporate Risk Committee's own scope of work and scrutineer role:

- a) Trust Executive Committee
- b) Quality & Clinical Performance Committee
- c) Finance, Investment, Information & Workforce Committee
- d) Charitable Funds Committee
- e) Risk Management Committee
- f) Health & Safety Committee
- g) **Mental Health Act Scrutiny Committee**

7.4.5 In reviewing the work of the committees, the Committee will wish to satisfy itself on the assurance that can be provided on how the corporate objectives of the Trust Board are being achieved.

7.5 Clinical Governance/Audit

7.5.1 The Committee shall provide the Trust Board with an independent and objective review of clinical governance **by reviewing and considering** the clinical objectives and risks in the Board Assurance Framework and report to the Trust Board on the controls and assurance in relation to these. The Committee will wish to satisfy itself that the same level of scrutiny and independent audit over controls and assurances is applied to clinical governance and audit.

7.5.2 The Audit & Corporate Risk Committee will wish to satisfy itself on the assurance that can be gained from the Quality & Clinical Performance Committee on the clinical audit function, in particular the policies, procedures and work programme for all work undertaken with regard to clinical audit. **The Committee will also wish to be assured that all clinical audit recommendations are followed-up and implemented, and that any lessons are learned within the Trust.**

7.6 Management

7.6.1 The Committee shall request and review reports and positive assurances from directors and managers **as appropriate, concentrating** on the over-**arching systems of integrated governance (delete arrangements)** for all corporate and clinical governance, risk management and internal control, to ensure that quality, performance and governance are aligned and integrated.

7.6.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to overall arrangements.

7.7 Financial Reporting

7.7.1 The Audit and Corporate Risk Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

7.7.2 The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

- a) Changes in, and compliance with, accounting policies and practices
- b) Unadjusted mis-statements in the financial statements
- c) Major judgemental areas
- d) Significant adjustments resulting from the audit

- 7.7.3 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. ***The Audit & Corporate Risk Committee will wish to satisfy itself on the assurance that can be gained from the Finance, Investment, Information & Workforce Committee on the financial reporting function.***

7.8 Charitable Funds

- 7.8.1 To review and agree the Charitable Funds Annual Report and Accounts before formally recommending sign off and adoption by the Charitable Funds Trustees.

7.9 Counter Fraud

- 7.9.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for Counter Fraud that meet NHS Protect's standards. This will be achieved by regular review of resource allocation to the Local Counter Fraud Service (LCFS), progress against the LCFS work plan and ongoing LCFS investigations, and the outcomes, learning and actions resulting from counter fraud work.***

8 REPORTING

- 8.1 The minutes of the Audit and Corporate Risk Committee meetings shall be formally recorded by the Committee Administrator and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action. The Committee must report all material failures in control to the Board at the earliest opportunity.
- 8.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statements, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission.

9 DUTIES AND ADMINISTRATION

- 9.1 It is the duty of the Committee to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour. Furthermore, the Committee will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.
- 9.2 The Committee shall be supported administratively by the Committee Administrator, whose duties in this respect will include:
- a) Agreement of agenda with Chairman and attendees, and collation of papers
 - b) Circulate agenda papers at least 5 working days in advance of the meeting
 - c) Take the minutes
 - d) In line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via

electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting

- e) Keeping a record of matters arising and issues to be carried forward
- f) Maintaining an Action Tracking System for agreed Committee actions and for Audit Reports agreed actions
- g) In conjunction with the Chairman and Lead Executive Director, prepare an annual report on the effectiveness of the Committee for submission to the Trust Board
- h) Maintain an Attendance Register. The completed Register to be submitted to the Trust Chairman and attached to the Committee's annual report
- i) Advising the Committee on pertinent areas.
- j) To maintain agendas and minutes in line with the policy on retention of records

10. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

- 10.1 These Terms of Reference will be reviewed annually to ensure that the committee is carrying out its functions effectively.
 - 10.2 An annual report to be submitted to the Trust Board which will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Committee meetings.
 - 10.3 Attendance and frequency of meetings will be monitored by the Committee Administrator and reported back to the Chairman on a 6 monthly basis.
 - 10.4 Concerns highlighted when monitoring compliance with the above will be discussed with the Chairman and, if appropriate, referred to the Board immediately.
 - 10.5 Amendments to the Terms of Reference to be approved by the Trust Board.
-

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON Wednesday 3rd December 2014

Title	Terms of Reference - Mental Health Act Scrutiny Committee					
Sponsoring Executive Director	Company Secretary					
Author(s)	Head of Corporate Governance & Risk Management					
Purpose	Revised Board Sub Committee Terms of Reference for Board review and approval					
Action required by the Board:	Receive		Approve	X		
Previously considered by (state date):						
Trust Executive Committee	31/07/2013	Mental Health Act Scrutiny Committee	22/10/2014			
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 attached document sets out the newly agreed Terms of Reference for the Mental Health Act Scrutiny Committee. They have been revised to ensure the Mental Health Act 1983 is implemented in accordance with the law and the associated Code of Practice and to ensure guidance and case law relating to the Act is disseminated and implemented. These Terms of Reference were approved at the Mental Health Act Scrutiny Committee meeting held on 22 nd October 2014.						
For following sections – please indicate as appropriate:						
Trust Goal (see key)	All					
Critical Success Factors (see key)	All					
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)	5.21 – 5.36					
Assurance Level (shown on BAF)	Red		Amber		Green	X
Legal implications, regulatory and consultation requirements						
Date: 22/10/2014 Completed by: Head of Corporate Governance & Risk Management						

Mental Health Act Scrutiny Committee

Terms of Reference

Document Type:	Committee Terms of Reference
Date document valid from:	3 December 2014
Document review due date:	1 October 2015

AUDIT TRAIL:

Dates reviewed:	28 August 2014	Version number:	V5 2014
Dates agreed:	22 October 2014	Version number:	V7
Details of most recent review: (<i>Outline main changes made to document</i>)		<ul style="list-style-type: none">· Updated members list· Updated quorum requirement	
Signature of Chairman of Committee:			
Print Name: Jessamy Baird Post Held: Designate Non Executive Director Date: 22 October 2014			

Trust Board Approval Authorised Signature	
Authorised by:	Danny Fisher
Job Title:	Chairman of Trust
Approved at:	Trust Board
Date Approved by Trust Board:	3rd December 2014

MENTAL HEALTH ACT SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. MAIN PURPOSE

- 1.1 To ensure the Mental Health Act 1983 is implemented in accordance with the law and the associated Code of Practice.
- 1.2 To ensure guidance and case law relating to the Act is disseminated and implemented.
-

2. MEMBERSHIP & QUORUM

- 2.1 The Committee will consist of 16 members

2.2 Members:

Designate Non Executive Director (Chairman)
Non Executive Director (Vice Chairman)
Non Executive Director
Consultant Psychiatrist – Adult Psychiatry
Consultant Psychiatrist – Psychiatry of Old Age
Mental Health Administrator
Mental Health Act Lead
Approved Mental Health Professional
Service User Representative
Carer Representative
IMHA Representative
Departmental Representatives for:

- Community Mental Health Services
- Inpatient Services
- Learning Disabilities Services
- Child and Adolescent Mental Health Services
- Dementia Services

- 2.3 Members are required to send a deputy if they are unable to attend a meeting. Members' deputies will be included as part of the quorum with full voting rights. Apologies for non-attendance should be sent one week in advance whenever possible.

- 2.4 The following will be in attendance:

- Committee Administrator

2.5 Quorum:

- 2.5.1 A quorum shall be no less than six members including:
- 2 Non Executive Directors/Designate Non Executive Director
 - 1 Mental Health specialist

- 3 other representatives

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

3. ATTENDANCE AT MEETINGS

- 3.1 Members are expected to attend quarterly meetings a minimum of 3 out of the 4 meetings per year, and to advise the Committee Administrator if unable to attend
- 3.2 When the Committee is discussing areas of risk or operation that are the responsibility of an Executive or Clinical Director, any other director, manager or employee may also be required to attend in order to present papers or to provide additional information in support of discussions.

4. FREQUENCY OF MEETINGS

- 4.1 Meetings are to be held Quarterly.

5. DELEGATED AUTHORITY

- 5.1 The Mental Health Act Scrutiny Committee is a formal sub - committee of, and directly accountable to, the Trust Board.

6. ROLE & RESPONSIBILITIES

- 6.1 To monitor and report quarterly on Mental Health Act activity within the Trust and provide an annual review. To monitor utilisation of S12 qualified doctors.
- 6.2 To monitor and report quarterly on the use of the Deprivation of Liberty Safeguards within the Trust and provide an annual review.
- 6.3 To commission the drafting of policies, protocols and procedures relating to the Mental Health Act.
- 6.4 To identify and monitor clinical audit priorities and reporting in relation to the use of the Mental Health Act.
- 6.5 To ensure that Mental Health Act training needs are identified and met.
- 6.6 To share good practice in relation to the Mental Health Act.

- 6.7** The business discussed at MHASC meetings does not normally identify individuals. However, in some instances members of the committee may identify individuals from their circumstances and are then expected to maintain confidentiality.
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7. REPORTING

- 7.1** The Mental Health Act Scrutiny Committee will report directly to the Trust Board. Copies of meeting minutes will be submitted to the Trust Board
- 7.2** The Committee will report to the Community Health Directorate Board and Executive Medical Director through minutes.
- 7.3** The minutes of the Committee meetings also to be submitted to:
- a) Trust Executive Committee
 - b) Mental Health Quality Group Meeting

8. DUTIES & ADMINISTRATION

- 8.1** It is the duty of the Committee to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour.
- 8.2** The Committee will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.
- 8.3** The Committee shall be supported administratively by the Committee Administrator, whose duties in this respect will include:
- a) Agreement of agenda with Chairman and collation of papers
 - b) Circulate agenda papers a minimum of 5 working days in advance of the meeting
 - c) Take the minutes
 - d) In Line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting
 - e) Keeping a record of matters arising and issues to be carried forward
 - f) Maintaining an Action Tracking System for agreed Committee actions
 - g) In conjunction with the Chairman and Lead Executive Director, prepare an annual report on the effectiveness of the Committee for submission to the Audit & Corporate Risk Committee
 - h) Maintain an Attendance Register. The completed Register to be submitted to the Trust Chairman and attached to the Committee's annual report
 - i) Advising the Committee on pertinent areas.
 - j) To maintain agendas and minutes in line with the policy on retention of records
- 8.4** An Annual report will be submitted to the Audit & Corporate Risk Committee which will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Committee meetings.
-

9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

- 9.1** These Terms of Reference will be reviewed annually to ensure that the committee is carrying out its functions effectively.
 - 9.2** Attendance and frequency of meetings will be monitored by the Committee Administrator and reported back to the Committee on a 6 monthly basis.
 - 9.3** Concerns highlighted when monitoring compliance with the above will be discussed at Mental Health Act Scrutiny Committee and referred to the Board immediately.
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REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 3 DECEMBER 2014

Title	Trust Board Terms of Reference				
Sponsoring Executive Director	Mark Price, Company Secretary				
Author(s)	Company Secretary				
Purpose	To approve the updated Trust Board Terms of Reference				
Action required by the Board:	Receive		Approve	P	
Previously considered by (state date):					
Trust Executive Committee	17 th November 14	Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee		Remuneration & Nominations Committee			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee		Foundation Trust Programme Board			
ICT & Integration Committee					
Please add any other committees below as needed					
Board Seminar	11 th November 14				
Other (please state)					
Staff, stakeholder, patient and public engagement:					
N/A					
Executive Summary:					
<p>The Trust Board's terms of reference have been updated in the following areas:</p> <p>Updated membership and quorum Amend attendance at meetings Amend frequency of meetings</p>					
For following sections – please indicate as appropriate:					
Trust Goal (see key)	All				
Critical Success Factors (see key)	All				
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)					
Assurance Level (shown on BAF)	Red		Amber		Green
Legal implications, regulatory and consultation requirements	Compliance with NHS Audit Committee Handbook 2014				
Date: 25 November 2014 Completed by: Company Secretary					

Isle of Wight NHS Trust Board Terms of Reference

Document Type:	Trust Board Terms of Reference
Date document valid from:	3 rd December 2014
Document review due date:	1 st November 2015

AUDIT TRAIL:

Dates reviewed:	10 th October 2014	Version number:	V6
Dates agreed:	11 th November 2014	Version number:	V8
Details of most recent review:		Update membership and quorum. Amend attendance at meetings Amend frequency of meetings	
Signature of Chairman of Committee:			
Prepared by: Mark Price Post Held: Company Secretary Date: 11 th November 2014			

Trust Board Approval Authorised Signature	
Authorised by:	Danny Fisher
Job Title:	Chairman of Trust
Approved at:	Trust Board
Date Approved by Trust Board:	3 rd December 2014



Isle of Wight NHS Trust Board

Terms of Reference

1. MAIN PURPOSE

- 1.1 The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health'.
 - 1.2 The Trust has a Board of Directors, known as the Trust Board, which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate powers to a sub-committee of the Board or to one or more executive director(s). This is detailed in the Scheme of Reservation and Delegation.
 - 1.3 The Trust Board leads the Trust by undertaking three key roles:
 - a) Formulating strategy
 - b) Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
 - c) Shaping a positive culture for the Trust Board and the organisation.
 - 1.4 The general duty of the Trust Board, and each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.
 - 1.5 These terms of reference describe the role and workings of the Trust Board and are for the guidance of the Trust Board, for the information of the Trust as a whole and serve as the basis of the terms of reference for the Trust Board's own sub-committees.
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2. MEMBERSHIP AND QUORUM

2.1 Membership

- 2.1.1 The Trust Board will consist of 11 members. The composition of the Trust Board is laid down in the Trust's Standing Orders (Section 3.1.2)
- 2.1.2 The current membership comprises:
 - a) The non-executive Chairman of the Trust
 - b) Five other non-executive directors including a Senior Independent Director & a Vice Chairman
 - c) The following executive directors:
 - Chief Executive Officer
 - Executive Director of Finance
 - Executive Medical Director
 - Executive Director of Nursing & Workforce
 - Executive Director of Transformation & Integration
- 2.1.3 All non-executive directors and executive directors as detailed above are voting members.
- 2.1.4 The Board may also appoint Designate Non-Executive Directors as non-voting attendees of the Board.

- 2.1.5 The Board is supported by a Company Secretary, who attends Trust Board meetings in a non-voting capacity, and is also the Foundation Trust Programme Director.
- 2.1.6 The Board is supported by a Trust Board Administrator.
- 2.1.7 When an Executive Director is otherwise unable to attend a meeting they may appoint a deputy to attend on their behalf. The nominated deputy will have no voting rights.
- 2.1.8 Other Trust officers may be asked to attend at the discretion of the Trust Board, for example when the Trust Board is discussing areas that are the responsibility of that individual.

2.2 Quorum

- 2.2.1 No business shall be transacted at a meeting of the Trust Board unless one third in totality of the whole number is present including:
 - The Chairman (or Vice-Chairman)
 - 1 x Executive Director
 - 2 x Non Executive Directors
- 2.2.1 A Deputy Director or Nominated Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum (see Standing Orders Section 4.11.2)
- 2.2.3 In line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting.

3. ATTENDANCE AT MEETINGS

3.1. Commitment to attend

- 3.1.1 It is expected that all members will endeavour to attend every meeting. Apologies for absence, stating the reason for absence, should be given in advance of the meeting to the Trust Board Administrator.
- 3.1.2 Members are expected to attend the Annual General Meeting

3.2 Attendance of Meetings

- 3.2.1 Poor attendance will be followed up by the Trust Chairman

3.3 Record of Attendance

- 3.3.1. A register of attendance will be signed at every meeting.
- 3.3.2 A record of attendance will be provided to the Chairman and included in the annual report

4. FREQUENCY OF MEETINGS

4.1 Decision Making Meetings

- 4.1.1 The Trust Board shall meet on a regular basis to approve and receive the reports relating to the Trust.

4.2 Informal Meetings

- 4.2.1 The Trust Board shall meet once a month to discuss key strategic issues and for board development. These meetings will be known as Trust Board Seminars.
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5. AUTHORITY

5.1 Delegated Authority to Sub Committees

- 5.1.1 The Trust Board has established the following sub-committees:
- a) Audit & Corporate Risk Committee
 - b) Charitable Funds Committee.
 - c) Finance, Investment, Information & Workforce Committee
 - d) Foundation Trust Programme Board
 - e) Mental Health Act Scrutiny Committee
 - f) Quality & Clinical Performance Committee
 - g) Remuneration and Nominations Committee
- 5.1.2 The Trust Board may establish additional sub-committees as required and will specify their terms of reference and the designated members.
- 5.1.3 Each sub-committee should report regularly to the Trust Board. The Trust Board remains responsible for the activities of, and powers delegated to, its sub-committees.

5.2. Board Authority

5.2.1 Internal

The Trust Board may investigate any activity within its terms of reference. It may seek and secure the information it requires from any employee and all employees are directed to co-operate with any request made by the Trust Board or any of its sub-committees.

5.2.1 External

The Trust Board can seek external advice from any source if necessary, taking into consideration issues of confidentiality and Standing Financial Instructions.

6. ROLE & RESPONSIBILITIES

6.1 Role of the Chairman

- 6.1.1 The Chairman is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- 6.1.2 The Chairman is responsible for the effective running of the Trust Board ensuring that the Trust Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.
- 6.1.3 The Chairman is the guardian of the Trust Board's decision-making processes and provides general leadership of the Trust Board.

6.2 Role of the Chief Executive Officer

- 6.2.1 The Chief Executive Officer reports to the Chairman and to the Trust Board directly. All members of the management structure report either directly or indirectly to the Chief Executive Officer.
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- 6.2.2 The Chief Executive Officer is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Trust Board.
 - 6.2.3. The Chief Executive Officer is responsible for implementing the decisions of the Trust Board and its sub-committees, providing information and support to the Trust Board as necessary.
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7. REPORTING ARRANGEMENTS

- 7.1 The Trust Board will support the work of the Chief Executive and Executive Directors in discharging their duties.
 - 7.2 Copies of meeting minutes will be submitted to the Trust Development Authority (TDA) for information.
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8. DUTIES AND ADMINISTRATION

8.1 Duties of Trust Board

- 8.1.1 It is the duty of the Committee to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour. Furthermore, the Board will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013
- 8.1.2 The general duties of the Trust Board are as follows. To achieve this, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors:
 - a) Work in partnership with service users, carers, members, local healthcare organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients. This may include entering into formal partnership arrangements as required.
 - b) Ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity.
 - c) Exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.
- 8.1.3 At all times the Trust Board will conform with the requirements of Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Board and the Scheme of Delegation ensuring:
 - a) the administration of the Trust Board is managed efficiently and effectively.
 - b) the Trust Board undertakes the duties retained by it.
 - c) reports to the Trust Board and actions arising from meetings are completed in a timely manner.
 - d) the Trust Chairman, Chief Executive and Company Secretary meet as required to set agendas and follow-up action points.
 - e) meeting papers are circulated at least three working days in advance of the meeting by the Trust Board Administrator.

8.2 Quality & Performance Management

- 8.2.1 The Trust Board assures the quality of services & ensures the performance management of the organisation by:
 - a) Ensuring there is a clear vision and strategy for the Trust that is communicated and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed.
 - b) Ensuring there is a Long Term Quality Plan which outlines how improvements to patient care will be made.

- c) Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.
- d) Setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.
- e) Monitoring and reviewing management performance to ensure the Trust's objectives are met.
- f) Overseeing both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.
- g) Developing and maintaining an annual business plan and ensuring its delivery as a means of taking forward strategy of the Trust to meet the expectations and requirements of stakeholders.
- h) Ensuring that the Trust operates effectively, efficiently and economically.
- i) Ensuring the continuing financial viability of the organisation.
- j) Ensuring the proper management of resources and that financial and quality of service responsibilities are achieved.
- k) Ensuring that the Trust achieves its targets and requirements of stakeholders within the available resources.
- l) Reviewing performance, identifying opportunities for improvement and ensuring those opportunities are taken.

8.3 Strategy & Business Planning

8.3.1 The Trust Board determines strategy & business planning by:

- a) Setting and maintaining the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives.
- b) Ensuring that national policies and strategies are effectively addressed and implemented within the Trust.
- c) Ensuring effective communication channels exists between the Trust, its patients, staff, commissioners and the local community.
- d) Ensuring the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- e) Ensuring that those Trust Board proceedings and outcomes that are not confidential are communicated publicly, primarily via the Trust's website.
- f) Publishing an annual report and accounts.

8.4 Governance & Administration

8.4.1 The Trust Board determines governance & administration by:

- a) Ensuring that the Trust has comprehensive governance arrangements in place that guarantee that the resources invested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- b) Ensuring that the Trust complies with its governance and assurance obligation in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- c) Ensuring compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness.
- d) Formulating, implementing and reviewing standing orders and standing financial instructions as a means of regulating the conduct and transactions of Trust business.
- e) Ensuring that the statutory duties of the Trust are effectively discharged
- f) Acting as the corporate trustee for the charitable funds held by the Trust.
- g) Ensuring an effective system of integrated governance, risk management and internal control across the whole system of the Trust's clinical and corporate activities.
- h) Ensuring that there are sound processes and mechanisms in place to ensure effective service user involvement with regard to the quality of services provided and the development of new services.
- i) Ensuring there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.
- j) Ensuring that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business.

8.5 Trust Board Terms of Reference

- 8.5.1 Terms of Reference will be reviewed annually and there will also be an annual review which will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Board meetings.
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9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

- 9.1 These Terms of Reference will be reviewed annually to ensure that the Trust Board is carrying out its functions effectively.
- 9.2 Work of Sub-Committees and other related committees will be reviewed via their minutes on a monthly basis. This will be monitored by the Company Secretary and reported back to the Trust Board on an annual basis.
- 9.3 Attendance and frequency of meetings will be monitored by the Company Secretary and reported to the Trust Board on a 6 monthly basis.
- 9.4 Concerns highlighted when monitoring compliance with the above will be discussed at Trust Board and remedial action taken immediately to effect corrective measures.
- 9.5 The Trust Board will review these Terms of Reference annually in conjunction with its review of the Terms of Reference of those Committees identified in section 5.1.1.
- 9.6 The Trust Board will produce an Annual Report in order to monitor its effectiveness, which will be submitted to Trust Development Authority (TDA) for information.
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REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 3rd December 2014

Title	Isle of Wight NHS Trust Board & Sub Committee Meetings January 2015 – March 2016				
Sponsoring Executive Director	Company Secretary				
Author(s)	Company Secretary				
Purpose	To agree Trust Board and Sub Committee meeting dates for 2015				
Action required by the Board:	Receive		Approve	P	
Previously considered by (state date):					
Trust Executive Committee		Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee		Remuneration & Nominations Committee			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee		Foundation Trust Programme Board			
ICT & Integration Committee					
Please add any other committees below as needed					
Board Seminar	14 th October 14				
Other (please state)					
Staff, stakeholder, patient and public engagement:					
Executive Summary:					
<p>The meeting dates have been discussed by the Board and the sub committees and the attached schedule has been approved at the various committees.</p> <p>The period covered is from January 2015 to March 2016. The main changes are:</p> <ul style="list-style-type: none"> Board meeting move to 1st Wednesday of month No Board meetings in the Months of May 15, Aug 15 or Jan 16 RNC will be 1st Wednesday of Month immediately after Board meeting (bi monthly) QCPC will be Wednesday of the week prior to Board (monthly) FIIWC will be Tuesday of the week prior to Board (monthly) CFC will move to the afternoon of the 2nd Tuesday of month (quarterly) ACRC will move to the afternoon of the 2nd Tuesday of month (quarterly) MHASC will move to the afternoon of the 2nd Tuesday of month (quarterly) 					
<i>For following sections – please indicate as appropriate:</i>					
Trust Goal (see key)	ALL				
Critical Success Factors (see key)					
Principal Risks (please enter applicable BAF references – eg 1.1; 1.6)					
Assurance Level (shown on BAF)	Red		Amber		Green
Legal implications, regulatory and consultation requirements					
Date: 24th November 2014 Completed by: Mark Price, Company Secretary					

Isle of Wight NHS Trust Board & Sub Committee Meetings January 2015 – March 2016

This document outlines the dates of the Isle of Wight NHS Trust Board and its sub-committees for the period January 2015 to March 2016.

Trust Board

Meetings will be held on the 1st Wednesday of the month unless specified.

Wednesday 28 th January 15	<i>No Meeting in February 15</i>
Wednesday 4 th March 15	Wednesday 1 st April 15
<i>No Meeting in May 15</i>	Wednesday 3 rd June 15
Wednesday 1 st July 15	<i>No Meeting in August 15</i>
Wednesday 2 nd September 15	Wednesday 7 th October 15
Wednesday 4 th November 15	Wednesday 2 nd December 15
<i>No Meeting in January 16</i>	Wednesday 3 rd February 16
Wednesday 2 nd March 16	

Trust Board Seminar

Meetings will be held on 2nd Tuesday of the Month

Tuesday 13 th January 15	Tuesday 10 th February 15
Tuesday 10 th March 15	Tuesday 14 th April 15
Tuesday 12 th May 15	Tuesday 9 th June 15
Tuesday 14 th July 15	Tuesday 11 th August 15
Tuesday 8 th September 15	Tuesday 13 th October 15
Tuesday 10 th November 15	Tuesday 8 th December 15
Tuesday 12 th January 16	Tuesday 9 th February 16
Tuesday 8 th March 16	

Audit & Corporate Risk Committee

Meetings will be held on 2nd Tuesday of the month on quarterly basis unless stated

Tuesday 10 th February 15	Tuesday 12 th May 15
Wednesday 3 rd June 15*	Tuesday 11 th August 15
Tuesday 10 th November 15	Tuesday 9 th February 16

*Special Meeting for the formal signing off of annual accounts

Charitable Funds Committee

Meetings will be held on 2nd Tuesday of the month on quarterly basis

Tuesday 10 th March 15	Tuesday 9 th June 15
Tuesday 8 th September 15	Tuesday 2 nd December 15
Tuesday 8 th March 16	

Finance, Investment, Information & Workforce Committee

Meetings will be held monthly on the last Tuesday of the month unless otherwise stated.

Tuesday 21 st January 15	Tuesday 24 th February 15
Tuesday 24 th March 15	Tuesday 28 th April 15
Tuesday 26 th May 15	Tuesday 23 rd June 15
Tuesday 28 th July 15	Tuesday 25 th August 15
Tuesday 29 th September 15	Tuesday 27 th October 15
Tuesday 24 th November 15	Tuesday 22 nd December 15
Tuesday 26 th January 16	Tuesday 23 rd February 16
Tuesday 29 th March 16	

Foundation Trust Programme Board

Dated to be determined for 2015.

Mental Health Act Scrutiny Committee

Meetings will be held on 2nd Tuesday of the month on quarterly basis

Tuesday 13 th January 15	Tuesday 14 th April 15
Tuesday 14 th July 15	Tuesday 13 th October 15
Tuesday 12 th January 16	

Quality & Clinical Performance Committee

Meetings will be held monthly on the last Wednesday of the month unless otherwise stated.

Wednesday 21 st January 15	Wednesday 25 th February 15
Wednesday 25 th March 15	Wednesday 29 th April 15
Wednesday 27 th May 15	Wednesday 24 th June 15
Wednesday 29 th July 15	Wednesday 26 th August 15
Wednesday 30 th September 15	Wednesday 28 th October 15
Wednesday 25 th November 15	Wednesday 23 rd December 15
Wednesday 27 th January 16	Wednesday 24 th February 16
Wednesday 30 th March 16	

Remuneration & Nominations Committee

The Committee will plan to meet regularly (planned minimum of 6 times per annum) but the Chairman will cancel meetings if there is no business to transact. Meetings are held immediately after Trust Board.

Wednesday 28 th January 15	Wednesday 4 th March 15
Wednesday 3 rd June 15	Wednesday 2 nd September 15
Wednesday 4 November 15	Wednesday 3 rd February 15

Mark Price
Company Secretary & FT Programme Director
14th November 2014

FOR PRESENTATION TO PUBLIC BOARD ON: 3 rd December 2014
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Summary of Remuneration Committee & Remuneration & Nominations Committee Minutes

January – August 2014

8th January 2014

a) Executive Director of Planning, ICT & Integration Update and Temporary Arrangements

Appointment of the Head of Commercial Development to the interim post of Director of Planning, ICT & Integration approved with effect from 23rd December 2013. Confirmation that the substantive post job description had been updated and the title amended to Executive Director of Transformation & Integration, and that this post had gone out to advertisement with interviews planned for 18th February 2014. These arrangements were approved by the Committee.

b) Senior Managers' Pay Restraint & Chief Executive & Vsm Pay

The Committee noted the return submitted to the Trust Development Authority under the title "Senior Managers Pay Restraint" and approved the recommendations for the future evaluation of Chief Executive & Executive Directors Pay

c) Foundation Trust Network Remuneration Surveys 2013

The Committee received the FTN Remuneration Surveys 2013

d) Revised Terms of Reference for Combined Remuneration & Nominations Committee

The revised terms of reference for a combined Remuneration & Nominations Committee which could come into effect from the end of January 2014 following formal approval by the Trust Board were approved by the Committee.

Following the merger of the Remuneration & Nominations Committee as from 31st January 2014 to a bi monthly meeting, the following meetings have occurred:

26th February 2014

Remuneration:

a) Interim Director of Planning, ICT & Integration Update

The committee was advised that the Head of Commercial Development would be continuing in the post of Interim Director of Planning, ICT & Integration as no formal appointment to the substantive post had been made.

b) Redundancy Update

The Committee was advised that the Trust Executive Committee had approved a redundancy payment below the threshold that required Remuneration & Nominations Committee approval.

Nominations

- c) The Committee received the Board Governance Assessment Framework (BGAF) Board Governance Memorandum Update

- d) The Committee received the Board Development Action Plan
- e) The Committee received the Board Governance Action Plan

f) Board Development Proposal

The Board development proposal which had already been discussed informally by the Board was presented and approved by the Committee.

30th April 2014

Remuneration:

a) Executive Director of Transformation & Integration Update

The advert had been issued for this post with the interviews set for 23rd May.

b) Executive Director Performance Appraisals & Pay Proposal

c) Remuneration & Nominations Committee Annual Report

The annual report which was a requirement of the Audit & Corporate Risk Committee was presented and approved by the Committee.

d) Redundancy Update

The Trust Executive Committee had approved 3 redundancy payments which fell within the criteria of their delegated authority and a summary update report was received.

Nominations

e) Board Development Update

Consultants would be attending the Board Seminar on 13th May to present their feedback on the recent Board Development review.

2nd July 2014

Remuneration:

a) Clinical Excellence Awards 2014

Awards details for 2014 were presented and approved by the Committee.

b) Executive Director Remuneration and Performance Review

The Committee approved the Chief Executive's performance appraisal, and the recommendation that there be no pay increase or bonus awarded to the Executive Directors at this time.

c) Executive Director of Transformation & Integration & Interim Director of Planning, ICT

The Committee was advised that the Executive Director of Transformation & Integration would be taking up her post with effect from Monday 7th July 2014 and the Committee approved the appointment and the remuneration for the post. The Interim Director of Planning, ICT and Integration would end his secondment on Friday 4 July 2014. The Remuneration & Nominations Committee formally expressed their gratitude for the work of the Interim Director of Planning, ICT & Integration for his work during his secondment.

d) Redundancy Update

The Trust Executive Committee had approved 3 redundancy payments which fell within the criteria of the delegated authority. The Committee noted these redundancies.

e) Remuneration & Nominations Committee Forward Plan

The new forward plan for the committee was presented which had been linked to the terms of reference.

Nominations

f) Board Development Update

The Board Development Feedback report gave a range of recommendations for action which would be incorporated within the current Board Development plan. It was agreed that the action plan would be brought back to Board as part of the Seminar on 8th July.

g) Board Appointments

The Trust Development Authority had approved David King and Jane Tabor as Non-Executive Directors. Lizzie Peers would be joining as Non-Executive Financial Advisor to the Trust Board. The Committee approved these changes to the Trust Board.

h) Board Succession Plan

Succession planning to the senior posts was necessary and was a requirement of the Board Governance Assurance Framework. The Committee agreed that the Board could support the development of senior staff by encouraging direct reports to attend as deputies for their respective Executive Director/Clinical Director at meetings. The Board Succession Plan was approved by the Committee.

i) Board Governance Action Plan Update

The exception report showed the areas of the Board Governance Assurance Framework action plan which still required work to bring them into compliance. The Committee was advised of the measures which would be put into place to facilitate Item 2.1 and 4.2 to be brought into compliance.

27th August 2014

Remuneration

a) Letter to TDA from FT Network – Terms of Office & Remuneration, NHS Trust Chairs & NEDS

The letter sent by the FT Network to Sir Peter Carr, Chair and David Flory, Chief Executive of the NHS Trust Development Authority was presented to the Committee.

b) Redundancy Update

The Trust Executive Committee had approved 2 redundancy payments which fell within the criteria of the delegated authority and a summary update was received.

c) Strike Action:

The Committee was advised that as a result of the national pay awards a letter had been received from the trade unions indicating an intention for limited industrial action. The Board would be kept up to date with developments.

Nominations

d) Board Development Update

The Board Development Feedback had been discussed at Board Seminar in July. The actions identified would be viewed in light of the CQC report and the TWWLA Action plan would be brought back to the Committee on 3rd December 2014.

Mark Price, Company Secretary
21st November 2014