Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 27th August 2014

at

09.30am - Conference Room—Level B

St. Mary's Hospital, Parkhurst Road,

NEWPORT, Isle of Wight, PO30 5TG

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

Key Trust Strategic Objectives & Critical Success Factors 2014/15

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

Isle of Wight NHS Trust

The next meeting in public of the Isle of Wight NHS Trust Board will be held on **Wednesday 27th August 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:		Chair	Receive	Verbal
	1.2	Confirmation that meeting is Quorate ***No business shall be transacted at a meeting of the Board of Directors unless one-third of the whole number is present including:*** *The Chairman; one Executive Director; and two Non-Executive Directors.*		Chair	Receive	Verbal
	1.3	Declarations of Interest		Chair	Receive	Verbal
	2	**Chairman's Update**				
	2.1	The Chairman will make a statement about recent activity		Chair	Receive	Verbal
	3	**Chief Executive's Update**				
	3.1	The Chief Executive will make a statement on recent local, regional and national activity.		CEO	Receive	Enc A
	3.2	Local Update from Hospital & Ambulance		EDNW	Receive	Enc B
	3.3	Local Update from Community & Mental Health		EMD	Receive	Enc C
	4	**Patients & Staff**				
	4.1	Presentation of this month's Patient Story	Quality and Performance Management	CEO	Receive	Pres
	4.2	Employee Recognition of Achievement Awards	Culture & Workforce	CEO	Receive	Pres
	4.3	Employee of the Month July 2014 August 2014	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 30th July 2014 and the Schedule of Actions.		Chair	Approve	Enc D
	5.2	Chairman to sign minutes as true and accurate record				
	5.3	Review Schedule of Actions		Chair	Receive	Enc E
10:30	**6**	**Items for the Board**				
	6.1	Performance Report	Quality and Performance Management	EMD	Receive	Enc F
	6.2	Minutes of the Quality & Clinical Performance Committee held on 20th August 2014	Quality and Performance Management	QCPC Chair	Receive	Enc G
	6.3	Minutes of the Finance, Investment & Workforce Committee held on 20th August 2014	Quality and Performance Management	FIWC Chair	Receive	Enc H
	6.4	Minutes of the Mental Health Act Scrutiny Committee held on 6th August 2014	Quality and Performance Management	MHASC Chair	Receive	Enc I

	6.5	Reports from Serious Incidents Requiring Investigation (SIRIs)	Quality and Performance Management	EDNW	Receive	Enc J
	6.6	Quarterly Board Walkabouts Action Tracker	Quality and Performance Management	EDNW	Receive	Enc K
	6.7	Quarterly Patient Story Action Tracker	Quality and Performance Management	EDNW	Receive	Enc L
	6.8	Annual Report from Director of Infection Prevention & Control 2013/14	Quality and Performance Management	EDNW	Receive	Enc M
	6.9	Monthly Safer Staffing Update	Culture & Workforce	EDNW	Approve	Enc N
	6.10	Stakeholder Engagement Strategy	Strategy and Business Planning	EDTI	Approve	Enc O
	6.11	Notes of the FT Programme Board held on 22nd July 2014	Strategy and Business Planning	CEO	Receive	Enc P
	6.12	Board Self Certification	Strategy and Business Planning	FTPD	Approve	Enc Q
	6.13	Minutes of the Audit & Corporate Risk Committee held on 19th August 2014	Governance and Administration	ACRC Chair	Receive	Enc R
	6.14	Recommendations of the Audit & Corporate Risk Committee held on 19th August 2014	Governance and Administration	ACRC Chair	Approve	Enc S
12:20	**7**	**Matters to be reported to the Board**		Chair		
	8	**Any Other Business**		Chair		
	9	**Questions from the Public**		Chair		
		To be notified in advance				
	10	**Issues to be covered in private**.		Chair		

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

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

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

Business Case - Strategic Estates Partner
Business Case - Carbon Energy Fund
Tenders - Update
Employee Relations Issues
Business Case – Cost Improvement Projects – Remedial Steps to Ensure Delivery
Minutes of FIWC Part 2 meeting held on 20th August 2014

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

12:30	**11**	**Date of Next Meeting:**

The next meeting of the Isle of Wight NHS Trust Board to be held in public is on Wednesday 1st October 2014 in the Conference Room at St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG.

Enc A

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 27th AUGUST 2014

Title	Chief Executive's Report					
Sponsoring Executive Director	Chief Executive Officer					
Author(s)	Head of Communications and Engagement					
Purpose	For information					
Action required by the Board:	**Receive**		**P**	**Approve**		
Previously considered by (state date):						
Trust Executive Committee			Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee			Remuneration & Nominations Committee			
Charitable Funds Committee			Quality & Clinical Performance Committee			
Finance, Investment & Workforce Committee						
Foundation Trust Programme Board						
Please add any other committees below as needed						
Board Seminar						
Other (please state)						
Staff, stakeholder, patient and public engagement:						
This report is intended to provide information on activities and events that would not normally be covered by the other reports and agenda items.						
Executive Summary:						
This report provides a summary of key successes and issues which have come to the attention of the Chief Executive over the last month.						
For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	All Trust goals					
Critical Success Factors *(see key)*	All Trust Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None					
Date: 18th August 2014	**Completed by:** Andy Hollebon Head of Communications and Engagement & Sarah Morrison – Exec Assistant to Chief Executive					

NATIONAL

CQC Inspections – the national perspective

With the imminent publication of the Care Quality Commission's (CQC) report on their inspection of Isle of Wight NHS Trust it is worth reflecting on the national position. The CQC published the first reports from their new regime of inspections in November 2013. Under the new inspection regime no Trusts have achieved 'outstanding', only four have achieved 'good', and 23 have been rated as 'requiring improvement'. Another four have been rated as 'inadequate'.

Regional

Health Education England

The number of local education and training boards (LETBs) is reducing. Currently there are 13 and in the new structure, there will be 4. The management teams will be streamlined in order to save money. We will be in the South Geography, which consists of Thames Valley, Wessex and the South West. The 4 teams will each be run by a National Director, a Director of Education and Quality and a Finance Director. The current LETBs will have one locality director and they will be accountable to the National Director. Interviews for the senior positions will take place on 3rd September and the other appointments will be made in the following 2 weeks.

Academic Health Science Network

I have been elected as a Board Director of the AHSN and am also the sponsoring CEO for the respiratory workstream.

LOCAL

Annual General Meeting

Around 90 people attended the Trust's Annual General Meeting also on Wednesday at the Riverside Centre. My thanks to all the staff who helped organise the event particularly those who put on some great stands for our Members, patients and public to look at and talk about. You can find the Annual Report and Quality Account which were published at the meeting on our website at www.iow.nhs.uk/publications.

It was great to hear from the Emma Woodfield and Jane Oliver from the Children's Respite Care Service about their progress since winning the Chairman's Diamond Award at last year's Trust awards and from Martin Keightley about the Helipad and how that has improved patient care. Heather Cooper helped us recognise your achievements in education and training with the unveiling of the Scroll of Honour. This will be on display in the Full Circle Restaurant soon. And we had the fabulous NHS Nightingales sing for us.

Executive Salaries

In the County Press on Friday 8th August it was reported that both Mark Pugh and I had received a pay rise in the last year. This is not the case and has been reported incorrectly by the County Press following publication of the Trust's Annual Report and Accounts.

The pay of senior Executives is determined by the Trust's Remuneration Committee in accordance with guidance from the Department of Health and benchmarking information about Executive pay in the health service. No Executive Director role has received a pay rise since 2010 and, only the Executive Director of Finance Chris Palmer and I are contractually entitled to performance bonuses but we have both declined payment of this element of our remuneration since 2010.

Cost Improvement Programme (CIP) Savings

The whole NHS is facing a period of financial constraint. We are required to deliver four percent efficiency savings per year. The scale of the challenge is unprecedented. We have sought external help from two individuals with expertise in delivering savings. They will then help us understand where best to put our precious resources to devise, plan and deliver the 2014/15 and 2015/16 savings targets. We are clear that any proposals will be assessed in the light of clinical validation.

Business Planning

The annual planning cycle starts earlier every year. Teams are now planning for 2015/16 and beyond. Staff have been encouraged to contribute to the planning process through meetings, the Trust's intranet and 'Staff News', our monthly staff magazine.

Listening to our staff

Over 1,000 members of staff responded to the Listening into Action (LiA) Pulse Check. It's given us a good insight into the current feeling among staff. We'll be carrying out another 'Pulse Check' in 6 months and 12 months time to see whether the actions we are all taking are the right ones. During September and October I am hosting a number of 'Listening Sessions' which a wide range of staff have been invited to. We have also placed new suggestion boxes in the Trust's buildings across the Island to encourage staff to feedback on issues. Over the last couple of weeks I have visited a number of teams located across the Island to hear their comments and my diary is being published so that staff know where they can find me for a chat.

The annual Staff Survey for 2014 will be carried out during between early September and November. Staff across the Trust will receive a questionnaire and are encouraged to complete and return it as soon as they can. The answers are treated in complete confidence, and no-one in your organisation will be able to identify individual responses. Results will be used to improve local working conditions, and to provide public accountability of levels of quality and safety.

Last year's Staff Survey highlighted three areas of concern to staff:

- Work-related stress update
- Communications and engagement
- Quality of appraisal update

which have all been the subject of targeted action.

2014 Isle of Wight NHS Trust Awards

Applications are now open for the 2014 Isle of Wight NHS Trust Awards. More details www.iow.nhs.uk/awards. There are nine categories in the Isle of Wight NHS Trust Awards and seven individual and team awards open to nomination.

The 2014 main awards are:

A. Improving services for children and young people (under 25s)
B. Improving services for older patients (60+)
C. Innovation in healthcare
D. Integrating care – working with partners to implement the My Life A Full Life programme
E. Improving patient safety
F. Improving staff health and wellbeing
G. Supporting excellence in Healthcare (Behind the scenes) – for the most improved support service
H. Excellence in Research and Development
I. Recognising voluntary organisation support for healthcare (open to external organisations) – this is a new category for 2014.

The closing date for entries which should reference the organisations objectives and the Trust's 'Vision Values and Behaviours' is 5:00p.m. on Friday 12th September 2014.

The 2014 Individual and Team Awards are:

- Vectis Award for excellence by a Doctor or Doctors
- Osborne Award for excellence by a non clinical Band 5 and above
- Carisbrooke Award for excellence by a non clinical band 4 and below
- Solent Award presented to the most outstanding team (non-clinical or mixture of both)
- Medina Award for allied healthcare professionals for excellence & innovation in practice
- Island Award for outstanding achievement by a nurse or midwife
- Wight Award for outstanding achievement by a volunteer or group of volunteers

Completed nomination forms which should refererence the organisation's 'Vision Values and Behaviours' should be returned by Tuesday 23rd September 2014.

The entry / nomination forms for both sets of award categories can be found at www.iow.nhs.uk/awards.

Isle of Wight NHS Trust

Key Points Arising from the Trust Executive Committee

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

21st July

- Medical Workforce Resource Business Case approved
- Safer Staffing Business Case approved

28th July

- Outstanding CIP savings discussed
- Maternity Action Plan approved
- Service Plan Templates and Guidance approved

4th August

- The 'Yet to Be Planned' CIP Savings: A Dual Work-stream Approach approved
- Eye Screening Memorandum of Understanding approved

11th August

- No meeting

Karen Baker
Chief Executive Officer
18th August 2014

Enc B

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 27th AUGUST 2014

Title	Hospital & Ambulance Directorate update			
Sponsoring Executive Director	Executive Director of Nursing and Workforce			
Author(s)	Associate Director – Hospital and Ambulance Directorate			
Purpose	For information			
Action required by the Board:	**Receive**	P	**Approve**	
Previously considered by (state date):				
Trust Executive Committee		Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee		Remuneration & Nominations Committee		
Charitable Funds Committee		Quality & Clinical Performance Committee		
Finance, Investment & Workforce Committee				
Foundation Trust Programme Board				
Please add any other committees below as needed				
Board Seminar				
Other (please state)				
Staff, stakeholder, patient and public engagement:				
This report is provided as a regular update to the Trust Board from the Hospital & Ambulance Directorate.				
Executive Summary:				
This report gives an update on quality, finance, performance and key issues, successes for the Hospital & Ambulance Directorate.				
For following sections – please indicate as appropriate:				
Trust Goal *(see key)*	All Trust goals			
Critical Success Factors *(see key)*	All Trust Critical Success Factors			
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None			
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None			
Date: 19th August 2014	**Completed by:** Donna Collins, Associate Director – Hospital and Ambulance Directorate			

Directorate wide update

Interim structure

The Acute and Planned Clinical Directorates have become the Hospital and Ambulance Directorate (H&AD) on an interim basis until the 31st March 2015. The interim arrangements were agreed as part of an organisational change process, which will allow for formal feedback on the CQC inspection to be received and for clarification on the Foundation Trust journey timeline to be confirmed, informing the organisational structure required to move forward. The interim structure has been developed to ensure senior clinical and managerial accountability across all services is maintained, whilst we embark on a programme of development to clearly define keys roles for the future.

Governance structure development

In parallel to the introduction of the interim structure, the H&AD has moved forward to ensure governance is in place for clear lines of accountability for quality, finance and performance. This includes key assurance mechanisms and responsibilities, such as the 'shop floor to executive level' monitoring of Referral to Treatment Time standards and the introduction of an interim Head of Performance post for the directorate. These mechanisms are designed to use key metrics, available on a daily basis, to monitor and where necessary realign resources to ensure the services deliver quality and effective care for our patients.

Performance

In the first quarter of the 2014/15, the impact of bed pressures has been a concern across both elective and non elective pathways. The consequence for the directorate has been an increased pressure on the Emergency Care Standard and Referral to Treatment Times. In response to these pressures the H&AD have worked very closely across all pathways and all service areas to implement proactive recovery plans to ensure performance is back on track for October

Sickness in the directorate has increased against the Trust target of 3%. This has been escalated with individual managers and ongoing monitoring is being undertaken to improve this position. Also medical workforce vacancies remain a challenge, with proactive management of cover being undertaken with the most cost effective resource available, such as NHS locum's instead of more expensive locum agency staff. There is also further emphasis in this area with the recruitment of a Medical Workforce post for 6 months, based in the HR department.

Finance

Inline with the interim structure arrangements, the Acute and Planned budgets are being reported together as at Quarter 1.

Year to date overspend combined was £1.188m at month 3, but it must be noted that budgetary control has improved since last year for pay, however the challenge remains with achievement of Cost Improvement Programme (CIP) savings, with the target last year of £5,197,000 being increased to £5,888,000 this year. The underachievement of the CIP target (£836,000) is a significant pressure on the budgets at present.

As previously mentioned mechanisms are in place to monitor budgetary spend, including finance deep dives undertaken with executive input, through to individual budget surgeries with budget holders. The service areas are actively engaged with the transformation programme and are starting to work with the external support experts to improve the CIP position.

Quality

The H&AD has now combined the quality assurance meetings previously undertaken in Acute and Planned, into one multidisciplinary meeting, ensuring consistent practice across all service areas. The combined approach has been seen as a real benefit whilst preparing for and responding to the recent CQC inspection, helping to reduce the barriers to service improvement.

From the first of April until July, data shows that the cumulative combined total of concerns and complaints for the whole joint directorate remains at the lower trajectory achieved in 2013/14

For complaints, the local goal within the directorate is to increase timeliness of responses to within 20 days rather than a further reduction in numbers – this is improving and will continue to be a an area of key focus.

Trends across the whole directorate for complaints year to date

- 22 of the 45 complaints across the whole directorate (year.to.date). relate to clinical care. These relate to a variety of issues and there are no clear themes emerging as yet. This continues to be closely monitored.

It is encouraging to note that whilst there are high levels of concerns with regards to communication (41) and delays in appointments (47), these are being resolved quickly as concerns with only 1 formal complaint in each of those categories year to date

Service specific -update

The Hospital and Ambulance Directorate is currently engaged on 7 key transformational change projects, covering many areas of service delivery including, integrated care hub, improvement, outpatient redesign, hospital patient flow, urgent care pathway, access to diagnostics / pharmacy services, review of maternity and paediatric services and critical care service provision. These are major transformation projects and teams are actively involved in working toward significant change as we help secure the future sustainability of the Trust.

Hospital

The estates work being undertaken across the Trust has seen significant investment in the past couple of years, and this continues with improvement to the medical wards, the Level C template and the start of refurbishment to the Medical Assessment Unit. The introduction of shared drugs cupboards and treatment rooms has also brought about efficiencies, which will be implemented across more areas as works complete. This all helps to move forward the goal of improving the environment and care for our patients.

OPARU (Outpatient Appointments and Records Unit)

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

The Chief Executive recently joined Barbara Sullivan to help celebrate her 80th birthday. Barbara is our oldest employee and started working for the Trust 20 years ago. She keeps the surgical team in OPARU cheerful, helping the surgical secretaries. She has also worked in the Medical Records department and as a receptionist in the ENT department. During her working life Barbara has only ever had one day off sick. Well done Barbara!

Pharmacy

Our Pharmacy was recently visited by a Foundation Trust who reported back that they were "totally bowled over by the slick integration of Electronic Prescribing and Medicine Administration (EPMA) and other IT solutions on the Isle of Wight. One of the highlights was the fact that everybody in the pharmacy department was excited and 'bought in' to the system, its development and future opportunities – a position we are slightly envious of and hope to achieve". This is great feedback – well done to all involved

Pathology Staff Qualify

Congratulations to Melanie Armstrong (Medical Laboratory Assistant, Blood science), David Byers (Medical Laboratory Assistant, Microbiology), Rob Harris (Medical Laboratory Assistant, Blood science), Daisy McDonagh (Medical Laboratory Assistant, Cellular Pathology), Rachelle Wheeler (Phlebotomist), and Vicky Lloyd (phlebotomist) who were all awarded Diplomas in their respective disciplines marking qualifications in Clinical Pathology Support and Phlebotomy. Also congratulations to Blood sciences senior Biomedical scientist and lead Pathology coordinator, Pete Stockman who was also awarded a Level 4 diploma in Assessors qualification enabling him to take a more prominent role in future assessments. This is a fantastic example of how we work in partnership with mainland Trusts, in this case Portsmouth Hospitals who are the accredited education provider.

Ambulance

The formation of the interim directorate gives a clear message around the importance of the Ambulance Service as part of our organisation. Managerial links established will help to remove any barriers to change across the interface between admissions areas and the pathways of care commenced by the Ambulance service in the pre hospital care setting, such as the early administration of antibiotics for the most at risk patients (those receiving chemotherapy) and pre-alerts for trauma care and suspected stroke patients

Nursing Times Awards

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

Donna Collins
Associate Director Hospital & Ambulance Directorate

Alan Sheward
Executive Director of Nursing and Workforce
19th August 2014

Enc C

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 27th AUGUST 2014

Title	Community & Mental Health Directorate update						
Sponsoring Executive Director	Executive Medical Director						
Author(s)	Acting Associate Director – Community & Mental Health Directorate						
Purpose	For information						
Action required by the Board:	**Receive**		P	**Approve**			
Previously considered by (state date):							
Trust Executive Committee			Mental Health Act Scrutiny Committee				
Audit and Corporate Risk Committee			Remuneration & Nominations Committee				
Charitable Funds Committee			Quality & Clinical Performance Committee				
Finance, Investment & Workforce Committee							
Foundation Trust Programme Board							
Please add any other committees below as needed							
Board Seminar							
Other (please state)							
Staff, stakeholder, patient and public engagement:							
This report is provided as a regular update to the Trust Board from the Community & Mental Health Directorate.							
Executive Summary:							
This report gives an update on quality, finance, performance and key issues, successes for the Community & Mental Health Directorate.							
For following sections – please indicate as appropriate:							
Trust Goal *(see key)*	All Trust goals						
Critical Success Factors *(see key)*	All Trust Critical Success Factors						
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None						
Assurance Level ***(shown on BAF)***	Red		Amber		Green		
Legal implications, regulatory and consultation requirements	None						
Date: 20th August 2014	**Completed by:** Nikki Turner, Acting Associate Director – Community & Mental Health Directorate						

Community and Mental Health Services Directorate Update

Work on acuity and dependency in community nursing

Building on from the visit by the CEO of the Queen's Nursing Institute, 2 Team leaders Louise Windle and Jenni Edgington have been invited to present to National District Nursing Forum in September. The Community Service Lead, Jeannine Johnston, has also been invited to present at the Westminster Briefing in London on 1st October. The team will be submitting an article to the British Journal of Community Nursing.

Award for cervical screening

An Isle of Wight sexual health clinic was the winner of the national Cervical Screening Awards run by Jo's Cervical Cancer Trust. The clinic's health promotion initiative, led by a team of a nurses, won the top accolade for successfully targeting hard to reach groups to increase screening uptake and general awareness about cervical cancer prevention.

Robert Music, Chief Executive of Jo's Cervical Cancer Trust, said: "The UK's cervical screening programme save around 5,000 lives every year yet 1 in 5 women do not take up their screening invitation. This is why we started the awards; to recognise outstanding campaigns targeted at educating women around the importance of cervical screening.

Julietta Patnick, Director of the NHS Cervical Screening Programme and one of the judges said 'I was very impressed with the work undertaken by the winner. The programme reached and encouraged a key group of women and the results were very positive. It was good to see such excellent partnership work to achieve the campaign goals including with hard to reach groups and moving beyond the health service."

The Cervical Screening Awards aim to recognise innovative local campaigns that have worked hard to increase awareness, drive uptake and ultimately save women from a disease that claims three lives every day

Nursing Home Liaison – Trusted Assessment pilot

During the last 5 months, Karen Byrne, Transfer of Care Co-ordinator, has been working with a selected group of nursing homes to provide daily liaison between ward areas, multi-professionals and care home provider. This includes assessment of all patients on admission to ascertain individualised needs; progressing discharge plans and updating care home providers on the patient's progress. This pilot has resulted in supporting earlier discharge back to care home provider where appropriate (same day the patient is declared multidisciplinary fit for discharge) as the Care Home Matrons are confident to accept the "Trusted Assessment" that the patient is ready and safe to return to their Care Home and do not need to complete that assessment themselves. Evaluation and further work to streamline documentation between care homes and the hospital is underway.

Rehabilitation and Reablement

CCG and Local Authority are undertaking a review of Rehabilitation and Reablement service on the Island. Representatives from the Community Services are working with Commissioners within the CCG and Local Authority to support their review of the Island's Rehabilitation and Reablement services. The aim is to develop more integrated pathways of care in line with the My Life a Full Life Programme. The initial Stakeholder Engagement Event took place on 30th July 2014 with representatives from IOW NHS Trust Rehabilitation teams (Inpatient and Community), Therapy Services, Adult Social Care, Reablement Service, Nursing and Residential Home providers, Voluntary sector and IW Council.

Rehabilitation Ward Summer Fayre

The Rehabilitation Ward under the leadership of Sister Natalie Mew have organised their second summer fayre to be held on Saturday 30th August between 1:00p.m. and 4:00p.m. There will be face painting, a raffle, bouncy castle, live music from 'All Washed Up', Irish dancing from 'Bailey Academy' and many more activities. Do please support them if you can.

Mental Health Accreditation Programme

The services continue to progress with the Royal College of Psychiatrist's Accreditation Programme**.** Inpatient Mental Health Services (AIMS) accreditation has been achieved by Home Treatment, Electroconvulsive Therapy and Osborne Ward and our Memory Service has also achieved Memory Services National Accreditation Programme (MSNAP) accreditation for the second year running.

Mental Health Collaboration

In line with local Strategies our MH Services continue to explore opportunities to work collaboratively with other agencies to improve patient experience and enhance positive clinical outcomes.

Two examples of this work are short term funding from the CCG to support Serenity Project run jointly with the IOW NHS Trust and Hampshire constabulary and the joint commissioning (CCG and LA) of a Reablement Pathway to provide additional support to individuals living with serious MH problems to access housing , employment and community participation.

Mark Pugh
Executive Medical Director
20th August 2014

Enc D

Isle of Wight NHS Trust

Minutes of the meeting in Public of the Isle of Wight NHS Trust Board held on Wednesday 30th July 2014
Conference Room, St Mary's Hospital, Newport, Isle of Wight

PRESENT:	Danny Fisher	Chairman
	Karen Baker	Chief Executive (CEO)
	Chris Palmer	Executive Director of Finance (EDF)
	Alan Sheward	Executive Director of Nursing & Workforce (EDNW)
	Mark Pugh	Executive Medical Director (EMD)
	Katie Gray	Executive Director for Transformation & Integration (EDTI)
	Nina Moorman	Non Executive Director
	Charles Rogers	Non-Executive Director (Senior Independent Director)
	Jane Tabor	Non-Executive Director
	David King	Non-Executive Director
	Sue Wadsworth	Non-Executive Director
In Attendance:	Mark Price	FT Programme Director & Company Secretary
	Andy Heyes	Head of Commercial Development
	Andy Hollebon	Head of Communications
	Kevin Bolan	Associate Director for Estates
For item 14/210	Iain Hendey	Assistant Director - Performance Information & Decision Support
	Lawrence Cooper	System Development Manager
	Brogaen Maynard	Information Clerk - PIDS
	Helen Baughan	Information Clerk - PIDS
	Marion Reed	PA to Head of Governance & Risk Management
	Richard Deavall	Governance & Risk Management Facilitator
	Pauline Woodford	Risk Administrator
	Hilary Male	HSDU Manager
	Lisa Potts	HSDU Supervisor
	Simon Gustar	HSDU Production Manager
	David Fishburn	HSDU Driver
For item 14/212	Marina Amos	Clinical Lead for inpatient Occupational Therapy (Acute & Rehabilitation)
For item 14/225 & 226	Brian Johnston	Head of Corporate Governance & Risk Management
Observers:		
	Chris Orchin	Health Watch
	Cllr Lora Peacey Wilcox	Isle of Wight Council
	Charles Joly	Environmental, Waste and Sustainability Manager
Minuted by:	Lynn Cave	Trust Board Administrator
Members of the Public in attendance:	There were 6 members of the public present	

Minute No.	
14/206	**APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE**

Apologies for absence were received from Jessamy Baird, Designate Non-Executive Director and Lizzie Peers, Non-Executive Financial Advisor.

There were no declarations of interest.

The Chairman announced that the meeting was quorate.

14/207 CHAIRMAN'S UPDATE

a) **Summer Pressures:** The Chairman gave thanks to all staff for their considerable efforts during the summer pressures. He commented that hot weather caused as many problems as cold.

b) **CQC[1] Report:** He reported that the report from the CQC would not be available until September.

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

14/208 CHIEF EXECUTIVE'S UPDATE

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

National

- National Transplant Week
- NICE Guidance on Staffing

Local

- Friends and Family Test for Staff
- Listening into Action (LiA)
- Patient Safety, Experience and Clinical Effectiveness Triumvirate
- CQC Inspection

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

14/209 PATIENT STORY

The Chief Executive advised the meeting that this month's story related to the Botox Clinic and the work it carries out to as part of the treatment provided to patients with neurological conditions. It showed a patient receiving treatment and allowed them to give feedback how this benefited their condition.

The Isle of Wight NHS Trust Board received the Patient Story

14/210 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

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

Category 3 – Going the Extra Mile

Performance Information & Decision Support (PIDS) Team:
Brogaen Maynard - Information Clerk - PIDS
Lawrence Cooper - Systems Development Manager - PIDS
Helen Baughan - Information Clerk - PIDS

Governance & Risk Management Team:
Pauline Woodford - Risk Administrator
Richard Deavall - Risk Management Facilitator
Marion Reed - PA to Head of Corporate Governance

[1] Care Quality Commission

Hospital Sterilisation and Decontamination Unit (HSDU) Team:

The whole team has been nominated but today the following will received their awards:

Hilary Male - Sterile Services Operational Manager
Simon Gustar - Production Manager
Lisa Potts - Supervisor
David Fishburn - Support Worker/Driver

Post Meeting Note: The Chief Executive presented the rest of the HSDU team with their certificates on Friday 8th August.

- Jennifer Mitchell - Team Leader
- Sarah Atkinson - Senior Tutor Technician
- Christine Rogers - Office Manager
- Perry Hill - Team Leader
- Patricia Evans - Team Leader
- Matthew Lister - Supervisor
- Simon Telfer - Technician
- Nicola Vaughan - Technician
- Nichola Lawrence - Supervisor
- Sue Potts - Technician
- Christopher Miles - Support Worker/Driver
- Debbie Bird - Technician
- Kalena Orchard - Technician
- Mark Gayle - Support Worker/Driver
- Lisa Scambell - Trainee Technician

The Chief Executive congratulated all recipients on their achievements.

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

14/211 EMPLOYEE OF THE MONTH

The Chief Executive advised that the recipient of the Employee of the Month Award for July could not be present and this award would be presented on 27th August.

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

14/212 BI MONTHLY STAFF STORY

The Executive Director of Nursing & Workforce explained that the staff story would now be seen at Board on a bi monthly basis and this month's story was being presented by Marina Amos - Occupational Therapist.

She presented an overview of her experience and involvement in Acute OT at St Marys Hospital and outlined the scope of her new role of Clinical Lead for inpatient Occupational Therapy (Acute & Rehabilitation). She explained to the Board her vision for how the inpatient occupational therapy service could be development to include a range of benefits including:

- Seamless patient pathway
- Breaking down boundaries
- Creating efficiencies
- Eliminating unnecessary duplication
- Enabling & facilitating a flexible workforce

The Executive Director of Nursing & Workforce stated that this story was a perfect example of how therapy services can benefit patients. Jane Tabor echoed this sentiment and stated the importance of working with patients from discharge to their homes and how was this being achieved. Marina Amos advised that the community occupational therapists were involved in discussions to provide integrated cover and were on applicable occasions, invited to attend case conferences for specific patients.

The Isle of Wight NHS Trust Board received the Staff Story

14/213 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 2nd July 2014 were approved.

Proposed by Sue Wadsworth and seconded by Charles Rogers

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

14/214 REVIEW OF SCHEDULE OF ACTIONS

The following updates to the schedule of actions were noted:

a) TB/091 – Benchmarking of Key National Performance Indicators: The Executive Director of Finance advised that these were being incorporated into the performance report. This action is now closed.

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

14/215 QUARTERLY MORTALITY REPORT

The Executive Medical Director presented the provisional data for the Summary Hospital-level Mortality Indicator (SHMI) which was 1.10. He reminded the Board that this data was 6 months in arrears and shown a stabilised position.

Hospital Standardised Mortality Ratio data showed that the Isle of Wight was showing a below average which was good. He advised that the data collected did not factor in the type of Trust and that a request to have community data removed from the matrix had been declined by the government.

He confirmed that the CQC had no issues and that the Trust had been rated "as expected".

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

14/216 CAPITAL PROGRAMME 2014/15 INCLUDING BUSINESS CASE – ENDOSCOPY (REVISED)

The Executive Director of Nursing & Workforce presented the report and outlined the changes to the capital programme. These included the pause in the ICU/CCU[2] project which had affected the original approved business case for Endoscopy.

He outlined the revised plan for the Endoscopy unit and confirmed that all options had been discussed. The revised plan showed the Endoscopy unit moving into the footprint of St Helens Ward which in turn would relocate to an alternative location.

It was also confirmed that the ICU/CCU project would be paused and a revised business case submitted at the appropriate time.

A discussion took place on the detail of the business case for Endoscopy with Charles Rogers reporting that the FIWC[3] were comfortable with the proposed project. However, it was noted that written confirmation should be received from both the Clinicians and JAG[4] to confirm their approval of the business case.

It was agreed that written confirmation should be received from both the Clinicians and JAG prior to formal approval being given. Deferred authorisation for this would be given to Charles Rogers as Chair of the FIWC

[2] Intensive Care Unit/Coronary Care Unit
[3] Finance, Investment & Workforce Committee
[4] Joint Advisory Group on GI Endoscopy

Proposed by Sue Wadsworth and seconded by Charles Rogers

The Isle of Wight NHS Trust Board approved the Capital Programme 2014/14. It also approved the revised Business Case for Endoscopy subject to written confirmation of acceptance by Clinicians and JAG.

14/217 BUSINESS CASE – DISPOSAL OF SWANMORE ROAD PROPERTIES

The Executive Director for Transformation & Integration presented the business case and advised that currently clinical services are provided from the premises of 68-71 Swanmore Road, Ryde which will relocate to the Ryde Community clinic early in 2015.

When the properties are vacated it is the intention that these should be disposed of to generate a capital receipt and ongoing-revenue savings as part of the trust's planned estate rationalisation programme as identified in the Trust's Estates Strategy.

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

The Chairman asked if the Secretary of State would receive any funds from the disposal of these properties. The Associate Director for Estates confirmed that they had first refusal on the property but that approaches would be made to other interested parties such as My Life a Full Life or local General Practioners to gauge their interest in taking over the properties.

Charles Rogers confirmed that the business case had been to FIWC and had received approval.

Jane Tabor asked for an update on the Ryde Community Clinic project. The Associate Director for Estates confirmed that work as slightly behind schedule but that any sale on the properties in Swanmore road would be linked to the completion of this project.

Proposed by Charles Rogers and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Business Case for the Disposal of Swanmore Road Properties

14/218 PERFORMANCE REPORT

The following areas were raised in discussion:

Highlights:

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

Lowlights:

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

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

Safe:

- **Pressure ulcers:** We continue to under achieve our planned local reduction across all grades of pressure ulcers, both in the hospital setting and the wider community although we have achieved the national 25% reduction target in the

hospital setting. A range of actions are in place to support improvements in this priority indicator in all areas.

Responsive:

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

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

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

Caring:

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

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

- **Friends & Family Test** - response rate for June is encouraging but maintaining the increase continues to be challenging and work is ongoing to improve access.

Well Led:

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

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

- **Financial Surplus** - At the end of June the Trust is reporting a retained surplus of £341k against the actual plan of £343k. The adjusted retained surplus shows £343k against a plan of £349k - £6k below plan. The Continuity of Service Risk Rating is 4.

- **Cost Improvement Programme (CIP)** - shows a year to date overachievement of £657k against the target of £1,605k. Included within this performance is the recognition of full year savings amounting to £1,280k. Of the total £2,261k achieved, £1,647k was achieved recurrently with £614k achieved non recurrently against a non-recurrent target Year to date of £412k.

Effective:

- **Theatre Utilisation** – This has improved but is again below plan for both Main Theatres and Day surgery giving a joint rate of 81% in June.

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

The following areas were raised in discussion:

i. **Symptomatic Breast referrals:** Sue Wadsworth reported that the QCPC had seen details of the work carried out to enhance the service and confirmed that these will make a difference. The Executive Director of Nursing & Workforce confirmed that additional consultants had arrived and were completing their competency supervision process. This was great news.

ii. **Community Mental Health Scorecard:** Jane Tabor asked what the best practice was for this area and whether the Root Cause of Issues were being recorded. The Executive Director of Nursing & Workforce advised that there were variable reasons which could affect the data shown on these scorecards. In addition weekly meetings had been introduced to review and understand the reasons and review lessons learnt.

iii. **Benchmarking:** Nina Moorman commented that it was nice to see benchmarked data and would these be further developed. The Executive Director of Finance confirmed that these would continue to be developed.

iv. **Cost Improvement Programme:** Nina Moorman queried whether the CIPs were being viewed across services/pathways and could this be broken down into directorates. The Executive Director for Transformation & Integration advised that as part of the hospital redesign there would be a review of how the data is presented and it was planned to show a breakdown of the data to show how the programme was working. She also advised that the TDA[5] had requested this information and had provided a format which would show a confidence indicator.

Action Note: *The Executive Director of Transformation & Integration to provide a report to the Board on 27th August on the progress of the TDA report format.*
Action by: EDTI

The Isle of Wight NHS Trust Board received the Performance Report

14/219 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Sue Wadsworth reported on the key points raised at the last meeting held on 23RD July 2014.

a) **Min No. 14/274 - SEE Committee Terms of Reference:** The Committee discussed and agreed that further work was required on how the SEE committee reports into the QCPC.
b) **Min No. 14/254 – Planned Directorate Area of Concern:** The Committee were updated on reviews and deep dive meetings taking place.
c) **Min No.14/269 – Nutrition Review:** The Committee will receive a further report at their September meeting.
d) **Min No. 14/246 – Quality Report:** The Committee noted that there had been zero Grade 3 and Grade 4 pressure ulcers reported in June 2014 for patients within the Hospital setting
e) **Min No. 14/256 Breast Screening Arrangements:** the Committee received an update on the new arrangements in place

[5] Trust Development Authority

Nina Moorman stated that she was not aware that the Breast Screening service had been suspended. The Executive Medical Director reassured her that the service had not been suspended and that all patients had been seen.

The Company Secretary advised that no items of reference should be proposed to go to the IT Committee and that any which had been would require reassigning.

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

14/220 MINUTES OF THE FINANCE, INVESTMENT & WORKFORCE COMMITTEE

Charles Rogers reported on the key points raised at the last meeting held on 23rd July 2014.

a) **Min No 14/110 – CIPs:** The Trust is reporting £2.261m against a target of £1.605m. This is circa £600k ahead of plan. However, this is after £1.2m of future banking. This is the common practise of recognising the full budget removal of achieving CIP plans in advance of the original schemes phasing. The Trust must now ensure that the schemes that have slipped to date are recovered in the coming period and deliver the equivalent full year effect so as not to impact on next year's financial plans.

b) **Min No. 14/114 - Investments/Disinvestments:**
- Disposal of Swanmore Road Properties. The Committee agreed to support the business case for the disposal of these properties.
- Dental Services Contract. The business case for bidding for the new contract was still being developed at the time of the meeting and the Committee were able to offer advice on the progress of the work, but not enough information was available to provide recommendation for approval.
- Endoscopy Business Case. As there was no one available to present the business case, it was not discussed.

c) **Min No. 14/116 - Self Certification:** Sufficient assurance had been provided for the Committee to recommend that Trust Board approve the self-certification returns as proposed.

The Executive Director of Transformation & Integration confirmed that the CIP schemes were currently under review due to Amber rating for CIPs as shown in the Performance Report which reflects the level of non-recurrent plans.

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

14/221 REPORTS FROM SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs)

The Executive Director of Nursing & Workforce advised that this was the first instance of this report coming to the Public Board. He presented an overview of the report and advised that during June 2014 the Trust reported 9 Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG) and are all currently under investigation using Root Cause Analysis (RCA) methodology.

He explained the process by which the cases are reviewed by the Quality & Clinical Performance Committee (QCPC) on a monthly basis. Sue Wadsworth confirmed that the QCPC were now seeing less cases coming for review which enabled them to be discussed extensively and in some cases to refuse to sign off. This required the cases to have further action taken before being resubmitted to the committee.

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

14/222 MONTHLY UPDATE ON SAFER STAFFING

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

He confirmed that 17 areas were currently included within the Safer Staffing programme which included areas outside the Acute areas. The guidance only specified Acute areas and the Trust had decided to expand the programme to other areas.

The Executive Director of Nursing & Workforce brought the Board's attention to the appendices which had been included which showed the analysis of the data collected for the period.

He requested the Trust Board:

1. Note the Trust's monthly staffing figures for planned and actual for Inpatient areas.
2. Note the identification of shortfalls in staff and mitigating actions.
3. Note the Trust's status of compliance in relation to the National Quality Board's requirements.
4. Note the urgent requirement for automation in the data collection, and reporting process to improve the quality assurance required.
5. Note the on-going progression towards reporting of quality, HR metrics with safe staffing indicators for benchmarking as these become available.

Proposed by Sue Wadsworth and seconded by David King

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

14/223 FT PROGRAMME UPDATE

The FT Programme Director presented the monthly update

- CQC visit had taken place and the report was due. Arrangements have been put in place to ensure that the report is fully reviewed and any issues of accuracy are identified and responded to within the allotted timeframe

- Public membership was now 4,440 with staff members at 2,915.

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

14/224 FT SELF CERTIFICATION

The FT Programme Director presented the monthly update stating that the current status was green across all categories with the exception of Statement 10 as agreed at the last Trust Board.

He confirmed that the report had been approved by both QCPC and FIWC.

Proposed by Charles Rogers and seconded by Sue Wadsworth

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

14/225 BOARD ASSURANCE FRAMEWORK (BAF) DASHBOARD & SUMMARY REPORT

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

There are no Principal Risks now rated as Red; 2 new Risks have been added since the June 2014 report. The exception report details four recommended changes to the Board Assurance RAG ratings of Principal Risks, all from Amber to Green. He outlined the background of the new risks.

A number of amendments were requested by the Board:

- CSF5 – Change Exec Lead from EDTI to EDNW/EMD
- CSF10.22 – Consider the wording of the Risk Description as currently lacks clarity.

Action Note: *The Head of Corporate Governance & Risk Management to arrange for amendments to be made.*

Action by: HCGRM

Proposed by Sue Wadsworth and seconded by Charles Rogers

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

14/226 STATUTORY & FORMAL ROLES 2014-15 - REVISED

he Head of Corporate Governance & Risk Management presented the revised report and highlighted the changes:

- Care of the Dying – line added
- End of Life Care – line added
- Deputy DIPC changed to Deborah Matthews
- Emergency Preparedness added
- Change to Review Annually for Decontamination & Medicines Management
- Senior Independent Director (SID) changed to Charles Rogers

It was requested that 2 more additional be made to the list:

- Lead for Medical Devices – Patient Safety Alert – Lead EDNW Deputy EMD
- NED Lead for Procurement – Lead Charles Rogers Deputy David King

Proposed by David King and seconded by Sue Wadsworth

The Isle of Wight NHS Trust Board approved the revised Statutory & Formal Roles 2014-15 with the 2 additional changes included.

14/227 MATTERS TO BE REPORTED TO THE BOARD

None

14/228 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

14/229 ANY OTHER BUSINESS

a) **Personal Alarms**: David King raised the topic of personal alarms for staff in potential high risk areas and asked if these were provided. The Chief Executive confirmed that these were in place and had been viewed in action during a Board walkabout to the mental health department. The Executive Medical Director confirmed that training was in place for areas of high risk and suggested that this could be brought to a future seminar where the process could be demonstrated.

Action Note: *The Company Secretary to add a topic of working in high risk areas and lone working to the seminar forward programme.*

Action by: CS

b) **Diabetic Pathway:** David King queried if diabetic care indicators were monitored. Nina Moorman advised that these were discussed regularly at QCPC. The Executive Medical Director advised that there was integrated care for all diabetic patients across the island and they were well monitored.

14/230 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 27th August 2014** in the Conference Room, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 11.35pm

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)

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

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

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

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
26-Mar-14	14/091 i)	TB/085	**Pressure Ulcers:** Charles Rogers commented how helpful it was to show the rolling averages and how the revised charts demonstrated areas of resistance. He asked what was being done to rectify these. The Executive Director of Nursing & Workforce advised that the education campaign to show patients in the community what to look for and how to prevent pressure ulcers was going well. Public Health were involved to promote preventative measures. The initial training had reached 50% of registered nurses, and when complete would be rolled out to cover Health Care Workers and other community staff. Charles Rogers asked if feedback from Public Health could be provided on their programme.	EDNW	The Executive Director of Nursing & Workforce to request update from Public Health on their pressure ulcer prevention initiative. **23/04/14** - The Tissue Viability Specialist Nurse is in discussions with Public Health. **28/05/14** - The Executive Director of Nursing & Workforce confirmed that the Tissue Viability Nurse Specialist had met with Public Health and work was going ahead to roll out a programme of training by the end of this financial year. There would be a stakeholder event with both health care representatives and members of the public involved. He stated that it was important to get the message on how to prevent pressure ulcers forming across as many people as possible. **02/07/14** - Sue Wadsworth requested more information on the external review. The Executive Director of Nursing & Workforce to report back to Board on the progress of the external review on pressure ulcers. **18/07/14** - Full report and actions reviewed at QCPC in June 2014 **18/07/14** - Glenn Smith (Nutrition & Tissue Viability Nurse Specialist is currently finalising the action plan, so will be preparing an update for the August QCPC; where he will present an update and the associated action plan. **19/08/14** - This topic has been added to the Board Seminar forward plan.	28-May-14	01-Oct-14	Progressing		Open
30-Apr-14	14/124	TB/092	**Mortality & Morbidity Reviews:** Nina Moorman asked if the Mortality & Morbidity reviews could go to QCPC. Dr Sandya stated that this would be encouraged and suggested that it be added to the June QCPC agenda. The Executive Director of Nursing & Workforce suggested that due to the volume of items which go to QCPC it would be more appropriate for this to be discussed at a separate forum with Dr Sandya and the summary report which results from this to be presented to QCPC. This was agreed.	EMD	Executive Director of Nursing & Workforce to identify a separate forum to discuss the Mortality & Morbidity report and to arrange for summary report to go to QCPC. **28/05/14** - The Executive Director of Nursing & Workforce confirmed that a standard mortality template had been put into place and that these would be reviewed by the Quality & Clinical Performance Committee on a regular basis. This action is now closed. **02/07/14** - This action is reopended - Nina Moorman advised that this item had not yet come to QCPC. The Executive Medical Director confirmed that the Quarterly Mortality report would be coming to Board on 30th July and would also be presented to QCPC. Nina Moorman queried if the morbidity review in hospital was part of the clinical audit process. The Executive Medical Director advised that he would discuss this with the Clinical Lead for SEE which would report to QCPC. The Executive Medical Director to discuss Morbidity Review with the Clinical Lead for SEE. **20/08/14** – Meeting set up with Clinical Lead for SEE and Medical Director to discuss Mortality on Friday 22nd August, verbal update to be given at the Trust Board meeting.	28-May-14	27-Aug-14	Progressing		Open

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.	28-May-14	01-Oct-14	Progressing		Open
30-Apr-14	14/140	TB/096	**NED Involvment in Mental Health Hearings:** Charles Rogers queried whether the substantive NEDs should be more involved. The Company Secretary agreed to seek advice on the legal position from the Mental Health Act/Mental Capacity Act Lead.	CS	The Company Secretary to seek advice on the legal position from the Mental Health Act/Mental Capacity Act Lead. **20/05/14** - Company Secretary to arrange a meeting with the MHS/MCA Lead and new Chair of the Mental Health Act Scrutiny Committee. **28/05/14** - The Company Secretary advised that a meeting to facilitate this had been arranged for 5th June. This action is now closed. **02/07/14** - This action is reopened - Charles Rogers requested that this action be reopened as a date for a suitable meeting was not yet set and he would like feedback on the outcome. This was agreed. It was also agreed for a seminar item to be arranged for the autumn on Mental Health Hearings and the role of hospital managers under the Mental Health Act. The Company Secretary to arrange a seminar item on the role of NEDs at Mental Health Hearings. **19/08/14** - This session is arranged for November 2014. This action is now closed.	28-May-14	01-Oct-14	Completed	19-Aug-14	Closed
02-Jul-14	14/181	TB/100	**Interviewing Scripts:** A discussion took place in which the Non-Executive Directors stressed the need for a more flexible way of interviewing patients and in particular those with learning disabilities and mental health issues, so that their views could be clearly given.	EDNW	The Executive Director of Nursing & Workforce to progress the revision of the interview scripts with the Patient Experience team. **18/07/14** - Patient Experience lead working with Sunshine Radio and Volunteer Service to agree format of questions.	01-Oct-14	01-Oct-14	Progressing		Open
02-Jul-14	14/185a)	TB/101	**Flu Campaign:** Charles Rogers asked that details of the Flu Campaign, including Staff incentives, for autumn 2015 be brought to Board.	EDNW	The Executive Director of Nursing & Workforce to arrange for details on the plans for the Flu campaign 2015 together with details of how the staff incentives would apply to be brought to the Board. **18/07/14** - This will come to the Board in August 2014. **19/08/14** - this item has been deferred to 1st October Board.	27-Aug-14	01-Oct-14	Progressing		Open
02-Jul-14	14/188	TB/103	**PALs Office** - Business Manager for Patient Safety, Experience & Clinical Effectiveness advised that some work was still ongoing as there was a gap between the walls and the ceiling which was allowing in noise from the café area.	EDNW BMSEE	The Executive Director of Nursing & Workforce to provide updates on progress of work to address this to the Board. **07/07/14 -** Scheme to address this approved at Trust Executive Committee on 7th July. **18/07/14** - Estates to confirm timeline for work to be complete. Updated Business Case to go back to the Charitable Funds Committee. **19/08/14** - Funding to be confirmed as business case will now not be going to Charitable Funds Committee.	01-Oct-14	01-Oct-14	Progressing		Open
30-Jul-14	14/218iv	TB/104	**Cost Improvement Programme:** Nina Moorman queried whether the CIPs were being viewed across services/pathways and could this be broken down into directorates. The Executive Director for Transformation & Integration advised that as part of the hospital redesign there would be a review of how the data is presented and it was planned to show a breakdown of the data to show how the programme was working. She also advised that the TDA had requested this information and had provided a format which would show a confidence indicator.	EDTI	The Executive Director of Transformation & Integration to provide a report to the Board on 27th August on the progress of the TDA report format. **19/08/14** - This item would be covered in the 1st October Board.	27-Aug-14	01-Oct-14	Progressing		Open
30-Jul-14	14/225	TB/105	**BAF** - A number of amendments were requested by the Board: · CSF5 – Change Exec Lead from EDTI to EDNW/EMD · CSF10.22 – Consider the wording of the Risk Description as currently lacks clarity.	GCGRM	The Head of Corporate Governance & Risk Management to arrange for amendments to be made.	27-Aug-14	27-Aug-14	Completed	19-Aug-14	Closed

Enc C

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
30-Jul-14	14/229	TB/106	**Personal Alarms**: David King raised the topic of personal alarms for staff in potential high risk areas and asked if these were provided. The Chief Executive confirmed that these were in place and had been viewed in action during a Board walkabout to the mental health department. The Executive Medical Director confirmed that training was in place for areas of high risk and suggested that this could be brought to a future seminar where the process could be demonstrated.	CS	The Company Secretary to add a topic of working in high risk areas and lone working to the seminar forward programme. **19/08/14** - This item has been added to the Board Seminar forward plan. This item is now closed.	27-Aug-14	27-Aug-14	Completed	19-Aug-14	Closed

Enc F

Isle of Wight NHS Trust Board Performance Report 2014/15

July 14

Isle of Wight NHS Trust

Title	**Isle of Wight NHS Trust Board Performance Report 2014/15**			
Sponsoring Executive Director	Chris Palmer (Executive Director of Finance) Tel: 534462 email: Chris.Palmer@iow.nhs.uk			
Author(s)	Iain Hendey (Assistant Director of Performance Information and Decision Support) Tel: 822099 ext 5352 email: Iain.Hendey@iow.nhs.uk			
Purpose	To update the Trust Board regarding progress against key performance measures and highlight risks and the management of these risks.			
Action required by the Board:	**Receive**	**X**	**Approve**	
Previously considered by (state date):				
Trust Executive Committee		Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee		Nominations Committee (Shadow)		
Charitable Funds Committee		Quality & Clinical Performance Committee	20/08/2014	
Finance, Investment & Workforce Committee	20/08/2014	Remuneration Committee		
Foundation Trust Programme Board				
Please add any other committees below as needed				
Other (please state)				
Staff, stakeholder, patient and public engagement:				
Executive Summary:				
This paper sets out the key performance indicators by which the Trust is measuring its performance in 2014/15. A more detailed executive summary of this report is set out on page 2.				
For following sections – please indicate as appropriate:				
Trust Goal *(see key)*	Quality, Resilience,Productivity & Workforce			
Critical Success Factors *(see key)*	CSF1, CSF2, CSF6, CSF7, CSF9			
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***				
Assurance Level ***(shown on BAF)***	☐ Red	☐ Amber	☐ Green	
Legal implications, regulatory and consultation requirements	None			

Date: Wednesday 27th August 2014 **Completed by: Iain Hendey, Assistant Director of Performance Information and Decision Support**

Isle of Wight NHS Trust Board Performance Report 2014/15

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

Isle of Wight NHS Trust

Safe

GRR ref		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline
	Patients that develop a grade 4 pressure ulcer	TW	12	3	Jul-14	4	↗	
	Reduction across all grades of pressure ulcers (25% on 2013/14 Acute baseline, 50% Community)	TW	203	47	Jul-14	129	↘	
	VTE (Assessment for risk of)	AC	>95%	100%	Jul-14	99.8%	↘	
	MRSA (confirmed MRSA bacteraemia)	AC	0	0	Jul-14	0	↔	
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)	AC	6	0	Jul-14	4	↘	
	Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	TW	48	8	Jul-14	27	↗	
	Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	TW	9	0	Jul-14	0	↔	
	Falls - resulting in significant injury	TW	7	1	Jul-14	3	↘	

Effective

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline
Summary Hospital-level Mortality Indicator (SHMI)* Oct-12 - Sep-13	TW	1	1.1026	Published Apr 2014	N/A	↗	
Hospital Standardised Mortality Ratio (HSMR) Oct-12 - Sep-13	TW	100	96	Published Apr 2014	N/A	↗	
Stroke patients (90% of stay on Stroke Unit)	CM	80%	94%	Jun-14	91%	↗	
High risk TIA fully investigated & treated within 24 hours (National 60%)	CM	60%	71%	Jun-14	91%	↗	
Cancelled operations on/after day of admission (not rebooked within 28 days)	AC	0	9	Jul-14	13	↗	
Delayed Transfer of Care (lost bed days)	TW	N/A	138	Jul-14	547	↗	
Number of Ambulance Handover Delays between 1-2 hours	AM	N/A	1	Jul-14	18	↘	
Theatre utilisation	AC	83%	78%	Jul-14	79%	↘	

Caring

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline
Patient Satisfaction (Friends & Family test - Total Inpatient response rate)	AC	30%	37%	Jul-14	35%	↘	
Patient Satisfaction (Friends & Family test - A&E response rate)	AC	20%	12%	Jul-14	16%	↘	
Mixed Sex Accommodation Breaches	TW	0	0	Jul-14	0	↔	
Formal Complaints	TW	<175	17	Jul-14	66	↗	
Compliments received	TW	N/A	368	Jul-14	1,213	↗	

Responsive

		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline
1	RTT:% of admitted patients who waited 18 weeks or less	AC	90%	87%	Jul-14	92%	↘	
2	RTT: % of non-admitted patients who waited 18 weeks or less	AC	95%	92%	Jul-14	92%	↗	
3	RTT % of incomplete pathways within 18 weeks	AC	92%	92%	Jul-14	93%	↘	
8b	Symptomatic Breast Referrals Seen <2 weeks*	AC	93%	86.6%	Jul-14	84.3%	↗	
6b	Cancer patients seen <14 days after urgent GP referral*	AC	93%	95.4%	Jul-14	94.5%	↗	
6a	Cancer Patients receiving subsequent Chemo/Drug <31 days*	AC	98%	100%	Jul-14	100%	↔	
5a	Cancer Patients receiving subsequent surgery <31 days*	AC	94%	100%	Jul-14	100%	↔	
	Cancer diagnosis to treatment <31 days*	AC	96%	95.7%	Jul-14	97.5%	↘	
7	Cancer Patients treated after screening referral <62 days*	AC	90%	100%	Jul-14	87.5%	↔	
5b	Cancer Patients treated after consultant upgrade <62 days*	AC	85%	No patients	Jul-14	100%	↘	
8a	Cancer urgent referral to treatment <62 days*	AC	85%	89.1%	Jul-14	86.5%	↗	
	No. Patients waiting > 6 weeks for diagnostics	AC	<100	0	Jul-14	7	↘	
	%. Patients waiting > 6 weeks for diagnostics	AC	<1%	0.0%	Jul-14	0.1%	↘	
4	Emergency Care 4 hour Standards	AC	95%	96%	Jul-14	96%	↗	
12	Ambulance Category A Calls % < 8 minutes	AM	75%	76%	Jul-14	76%	↘	
13	Ambulance Category A Calls % < 19 minutes	AM	95%	96%	Jul-14	96%	↗	
9a	% of CPA patients receiving FU contact within 7 days of discharge	MH	95%	100%	Jul-14	97%	↗	
9b	% of CPA patients having formal review within last 12 months	MH	95%	100%	Jul-14	N/A	↗	
10	% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	MH	95%	100%	Jul-14	99%	↔	

**Cancer figures for July are provisional.*

Well-Led

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline
Total workforce SIP (FTEs)	TW	2616.6	2622.6	Jul-14	N/A	↗	
Total pay costs (inc flexible working) (£000)	TW	£9,578	£9,574	Jul-14	£38,735	↗	
Variable Hours (FTE)	TW	136.7	143.65	Jul-14	559.41	↘	
Variable Hours (£000)	TW	£78	£587	Jul-14	£2,462	↘	
Staff sickness absences	TW	3%	3.72%	Jul-14	3.68%	↘	
Staff Turnover	TW	5%	0.79%	Jul-14	2.62%	↗	
Achievement of financial plan	TW	£1.7m	£759k	Jul-14	£759k	↗	
Underlying performance	TW	-£0.8m	(£869k)	Jul-14	(£869k)	↘	
Net return after financing	TW	0.50%	24.80%	Jul-14	24.80%	↗	
I&E surplus margin net of dividend	TW	=>1%	5.05%	Jul-14	5.05%	↗	
Liquidity ratio days	TW	=>15	26	Jul-14	26	↗	
Continuity of Service Risk Rating	TW	3	4	Jul-14	4	↔	
Capital Expenditure as a % of YTD plan	TW	=>75%	29%	Jul-14	29%	↗	
Quarter end cash balance (days of operating expenses)	TW	=>10	28	Jul-14	28	↔	
Debtors over 90 days as a % of total debtor balance	TW	=<5%	16.52%	Jul-14	16.52%	↘	
Creditors over 90 days as a % of total creditor balance	TW	=<5%	3.5%	Jul-14	3.5%	↘	
Recurring CIP savings achieved	TW	100%	72.4%	Jul-14	72.4%	↘	
Total CIP savings achieved	TW	100%	142%	Jul-14	142%	↗	

Notes

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

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

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

Isle of Wight NHS Trust Board Performance Report 2014/15

July 14

Executive Summary

Isle of Wight NHS Trust

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

Safe:

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

Responsive:

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

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

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

Well Led:

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

Sickness absence has icreased from 3.49% to 3.72% during July and remains above the 3% plan. Detailed analysis of all long-term Sickness Absence is sent to Occupational Health, Health and Safety, Back Care and also to the Associate Directors, Quality and Finance. Actions are followed up at Performance Review and Directorate meetings.

Short-term absence is being monitored using the Bradford Score. The capability policy has been streamlined and review periods are being scrutinised. Education sessions for Bradford Score are being cascaded.

At the end of July the Trust is reporting a surplus of £772k against the actual planned financial position of £759k. The adjusted retained surplus shows £783k against a plan of £766k - £17k ahead of plan. The Continuity of Service Risk Rating is 4.The Cost Improvement Programme showed a year to date overachievement of £951k against the target of £2,260k. Included within this performance is the recognition of forward banked savings amounting to £1,683k. Of the total £3,211k achieved, £2,324k was achieved recurrently and therefore the focus still remains on the delivery of recurrent savings.

Caring:

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

Effective:

Theatre Utilisation has improved for Main Theatres, but declined for Day Surgery Unit from 82.7% to 75.8% giving a joint rate of 77.9% in July. Bed pressures continue to effect performance with a reduction in elective admissions due to the high risk of cancellation as well as delays in admission processing.

Isle of Wight NHS Trust Board Performance Report 2014/15

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Performance Summary - Hospital

Isle of Wight NHS Trust

Balance Scorecard - Hospital

Safe	Latest data	In month		YTD	
		Target	Actual	Target	Actual
No. of Grade 1&2 Pressure Ulcers	Jul-14		13		29
No. of Grade 3&4 Pressure Ulcers	Jul-14		5		10
VTE	Jul-14	95%	99.9%	95%	99.8%
MRSA	Jul-14	0	0	0	0
C.Diff	Jul-14		0	4	2
No. of Reported SIRI's	Jul-14		4		12

Responsive*	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Emergency Care 4 hour Standards	Jul-14	95%	96.5%	95%	95.5%
RTT Admitted - % within 18 Weeks	Jul-14	90%	86.9%	90%	92.3%
RTT Non Admitted - % within 18 Weeks	Jul-14	95%	93.9%	95%	93.9%
RTT Incomplete - % within 18 Weeks	Jul-14	92%	91.8%	92%	92.8%
No. Patients waiting > 6 weeks for diagnostics	Jul-14	8	0	100	7
%. Patients waiting > 6 weeks for diagnostics	Jul-14	1%	0.00%	1%	0.14%
Cancer 2 wk GP referral to 1st OP	Jul-14	93%	95.4%	93%	94.5%
Breast Symptoms 2 wk GP referral to 1st OP	Jul-14	93%	86.6%	93%	84.3%
31 day second or subsequent (surgery)	Jul-14	94%	100%	94%	100%
31 day second or subsequent (drug)	Jul-14	98%	100%	98%	100%
31 day diagnosis to treatment for all cancers	Jul-14	96%	96%	96%	97%
62 day referral to treatment from screening	Jul-14	90%	100%	90%	88%
62 days urgent referral to treatment of all cancers	Jul-14	85%	89.1%	85%	86.5%
Emergency 30 day Readmissions	Jul-14		6.0%		5.1%

Contracted Activity**	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Emergency Spells	Jun-14	1,129	1,023	3,386	3,130
Elective Spells	Jun-14	667	611	1,936	1,823
Outpatients Attendances	Jun-14	9,686	9,794	28,143	28,577

Effective	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Delayed Transfers of Care (lost bed days)	Jul-14	N/A	138	N/A	547
Cancelled operations on/after day of admission (not rebooked within 28 days)	Jul-14	0	9	0	13

Well-Led	Latest data	In month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism					
FTE vs Budget					
Appraisals	Jul-14		7.5%		30.5%
Actual vs Budget (in £'000's)					
CIP (in £'000's)					

Caring	Latest data	In month		YTD	
		Target	Actual	Target	Actual
FFT Acute - % Response Rate	Jul-14	30%	38.0%	30%	35.3%
FFT Acute - % Recommending	Jul-14	95%	95.3%	95%	96.0%
FFT A&E - % Response Rate	Jul-14	20%	11.7%	20%	15.8%
FFT A&E - % Recommending	Jul-14	95%	93.0%	95%	93.0%
Mixed Sex Accommodation Breaches	Jul-14	0	0	0	0
No. of Complaints	Jul-14		10		49
No. of Concerns	Jul-14		58		192
No. of Compliments	Jul-14	N/A	217	N/A	837

**Cancer figures for July 2014 are provisional*

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

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

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

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

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

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

Isle of Wight NHS Trust Board Performance Report 2014/15

July 14

Performance Summary - Community

Balance Scorecard - Community

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
No. of Grade 1&2 Pressure Ulcers	Jul-14		21		70
No. of Grade 3&4 Pressure Ulcers	Jul-14		9		26
MRSA	Jul-14	0	0	0	0
C.Diff	Jul-14		0	2	2
No. of Reported SIRI's	Jul-14		4		21

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
Stroke patients (90% of stay on Stroke Unit)	Jun-14	80%	94.1%	80%	91.4%
High risk TIA fully investigated & treated within 24 hours (National 60%)	Jun-14	60%	70.8%	60%	91.4%

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
% Sickness Absenteeism - C Directorate	Jul-14	3%	4.35%	3%	3.99%
FTE vs Budget - Community Directorate					
Appraisals	Jul-14		3.8%		71.9%
Actual vs Budget (in £'000's)					
CIP (in £'000's)					

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
Community Contacts	Jun-14	16,514	17,951	49,542	53,581
Health Visitors	Jun-14	2,899	3,010	8,697	10,916
Sexual Health	Jun-14	847	943	2,541	2,628

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
FFT - % Response Rate	Jul-14	30%	31.3%	30%	31.4%
FFT - % Recommending	Jul-14	95%	92.3%	95%	92.9%
No. of Complaints	Jul-14		5		15
No. of Concerns	Jul-14		14		50
No. of Compliments	Jul-14	N/A	151	N/A	376

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

Isle of Wight NHS Trust Board Performance Report 2014/15

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Performance Summary - Mental Health

Isle of Wight NHS Trust

Balance Scorecard - Mental Health

Safe	Latest data	In month		YTD	
		Target	Actual	Target	Actual

Effective	Latest data	In month		YTD	
		Target	Actual	Target	Actual

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

Well-Led	Latest data	In month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism (included in Community Directorate)	Jul-14	3%	4.35%	3%	3.99%
FTE vs Budget (included in Community Directorate)					
Appraisals (included in Community Directorate)	Jul-14		3.8%		71.9%

Activity	Latest data	In month		YTD	
		Target	Actual	Target	Actual
Mental Health Inpatient Activity	Jul-14	N/A	54	N/A	191
Mental Health Outpatient Activity	Jul-14	N/A	561	N/A	2,140

Caring	Latest data	In month		YTD	
		Target	Actual	Target	Actual

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

Isle of Wight NHS Trust Board Performance Report 2014/15

July 14

Performance Summary - Ambulance and 111

Isle of Wight NHS Trust

Balance Scorecard - Ambulance & 111

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
Category A 8 Minute Response Time (Red 1)	Jul-14	75%	85.3%	75%	85.1%
Category A 8 Minute Response Time (Red 2)	Jul-14	75%	75.6%	75%	75.3%
Category A 19 Minute Response Time	Jul-14	95%	96.2%	95%	96.0%
Ambulance re-contact rate following discharge from care by telephone	Jul-14	3%	4.6%	3%	5.0%
Ambulance re-contact rate following discharge from care at scene	Jul-14	2%	4.0%	2%	3.4%
Ambulance time to answer call (in seconds) - median	Jul-14	1	1		N/A
Ambulance time to answer call (in seconds) - 95th percentile	Jul-14	5	1		N/A
Ambulance time to answer call (in seconds) - 99th percentile	Jul-14	14	8		N/A
NHS 111 Call abandoned rate	Jul-14	5%	2.4%	5%	1.9%
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	Jul-14	95%	96.0%	95%	96.7%
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	Jul-14	95%	97.9%	95%	97.3%
NHS 111 Where the above is not achieved callers should be called back within 10 mins	Jul-14	100%	35.7%	100%	45.3%

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
Number of Ambulance Handover Delays between 1-2 hours	Jul-14		1		18

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual
% Sickness Absenteeism	Jul-14	3%	5.38%	3%	4.85%
Appraisals	Jul-14		9.0%		35.0%

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual

The ambulance service continues to achieve its nationally set targets despite increased pressure upon resources. The areas of note in the report reflect that currently we are unable to meet the targets set by local commissioners around the number of call backs received from patients we have left at home. We believed that these targets were incorrectly set at the start of the year, and this has been discussed with the commissioners. It has been agreed that this is not impairing the quality of service given. The national benchmark for this target is around 10-15% therefore the target originally set was too low.

The NHS 111 target of call backs within 10 mins is under national debate due to measurement methods used by different providers. Therefore this is not a reflection of the service provided by the Isle of Wight Ambulance Service which is again supported by our commissioners here on the Island.

The sickness target noted is above the target set by the Trust at 3%, however the figures published for this month are unusually high, due to a small number of staff going on sick leave for the majority of their notice periods. It should also be noted that the national benchmarking for emergency Ambulance services is around 5.4%, due to the nature of front line emergency work the risks associated with minor ailments and injuries is higher in the work environment than other departments.

Highlights

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

Lowlights

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

Commentary:

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

Hospital acquired: No reductions were achieved for any grade of pressure ulcer during the month of July. There was an increase on baseline incidence of newly acquired pressure ulcers in patients that were admitted during July.

Incidence reporting for moisture lesions is in development and training is starting to be rolled out for this important development in the identification and reporting of preventable skin damage.

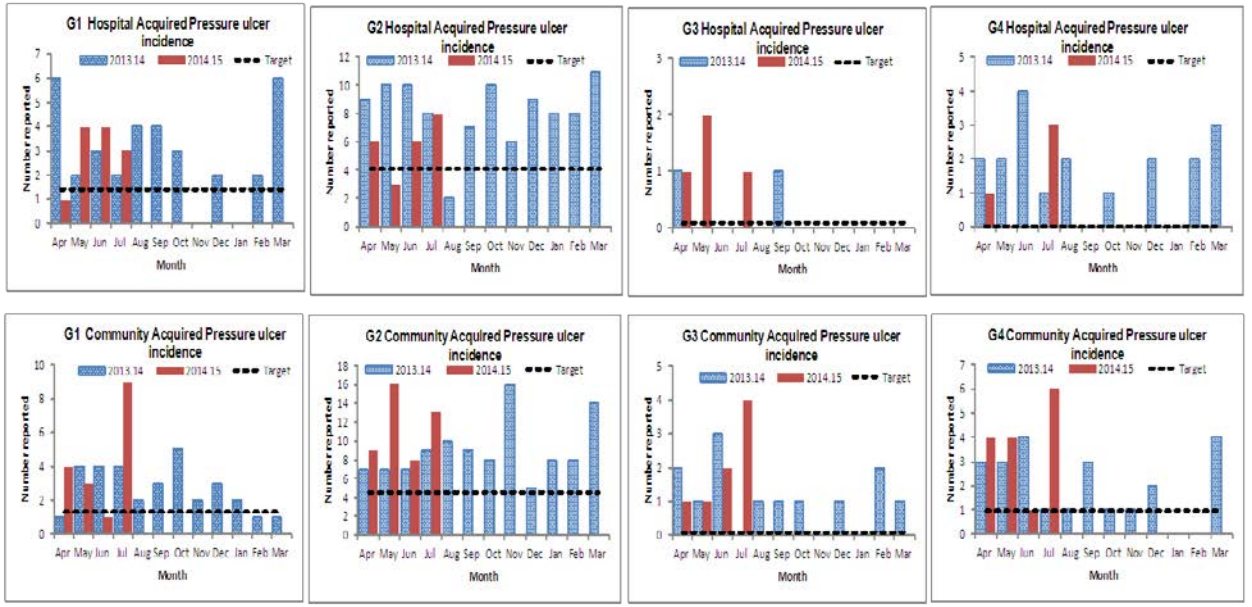
Community acquired: No improvement on baseline in any grade of pressure ulcer were achieved during July 2014.
The Nutrition and Tissue Viability service are working on developing incidence reporting to provide a context for the pressure ulcer numbers, in the same way as incidence is reported for the hospital setting.
The island wide pressure ulcer campaign has started, with advertisement space taken up in local publications promoting awareness of simple steps to avoid tissue damage, such as regular movement and changing of position.

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

Analysis:

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

Prevention & Management of Pressure Ulcers



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

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Patient Safety

Commentary:

Clostridium difficile

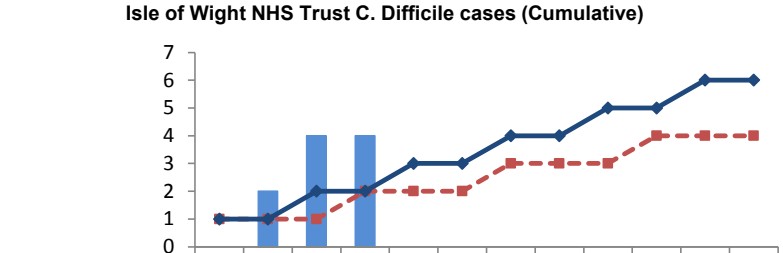
There were no cases of Healthcare Acquired Clostridium Difficile (C. Diff) in the hospital during July 2014, giving a YTD of 4. This exceeds the planned trajectories for both our nationally set year threshold (6) and our local stretched target (4). Maintaining zero tolerance for the rest of year to remain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

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

Methicillin-resistant Staphylococcus Aureus (MRSA)

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

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



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

Isle of Wight NHS Trust

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

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

Commentary:

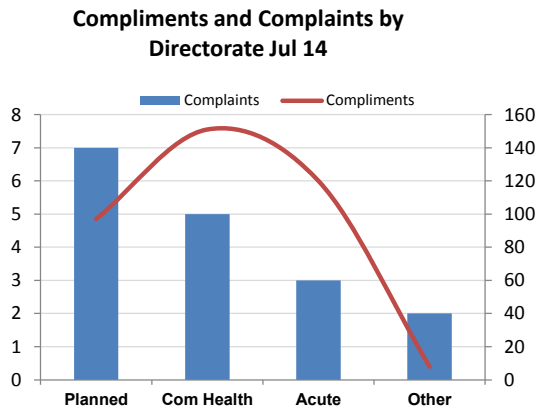
There were 17 formal Trust complaints received in July 2014 (15 in the previous month) against approximately 40,400 patient contacts (Inpatient episodes, all outpatient, A&E attendances and community contacts), with 376 compliments received by letters and cards of thanks across the same period.

Across all complaints and concerns in July 2014:
Top areas complained about were:
- Emergency Department (10)
- Occupational Therapy/Wheelchair (5)
- General Surgery (5) / Urology (5)

Across all complaints and concerns in July 2014:
Top subjects complained about were:
- Clinical care (32)
- Out-patient appointment delay/cancellation (15)
- Communication (16)

These are the same top subjects as last month.

Analysis: Complaints



Primary Subject	Jun-14	Jul-14	CHANGE	RAG rating
Clinical Care	8	7	-1	↓
Nursing Care	1	1	0	→
Staff Attitude	1	1	0	→
Communication	2	3	1	↑
Outpatient Appointment Delay/ Cancellation	0	1	1	↑
Inpatient Appointment Delay / Cancellation	1	0	-1	✓
Admission / Discharge / Transfer Arrangements	0	1	1	↑
Aids and appliances, equipment and premises	0	1	1	↑
Transport	0	0	0	✓
Consent to treatment	0	0	0	✓
Failure to follow agreed procedure	0	0	0	✓
Hotel services (including food)	0	0	0	✓
Patients status/discrimination (e.g. racial, sex)	0	0	0	✓
Privacy & Dignity	0	0	0	✓
Other	0	1	1	↑

Action Plan:	Person Responsible:	Date:	Status:
Patient Experience Officers have now relocated to the main reception area of the hospital to improve accessability. Scoping has been undertaken on Estates Works required (including sound proofing) and quotes received. Works will take 6 weeks from instruction of contractors.	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Oct-14	In progress

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Cancer - Symptomatic Breast referrals Seen< 2 weeks/Diagnosis to treatment <31 days

Isle of Wight NHS Trust

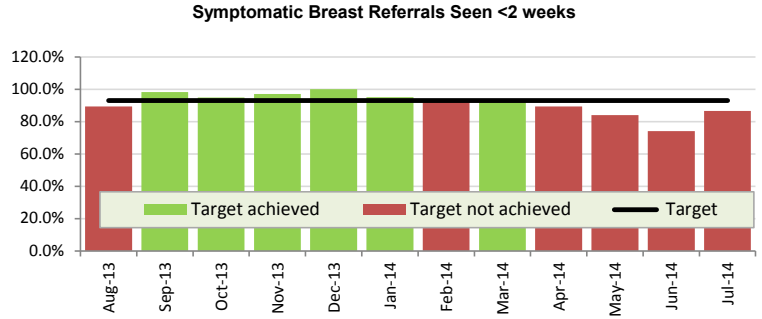
Commentary:

All July figures are still provisional. 15 of the total 39 breaches (38%) during July were patient led with a further 16 hospital led.

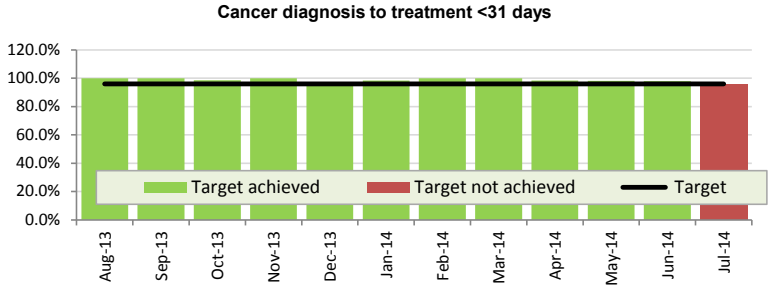
Symptomatic Breast Referrals seen within 2 weeks (93% target)
In July 2014 the provisional report is showing that 82 patients were seen for 2 weeks wait breast symptomatic . This is higher than in the last 4 months since the National Awareness and Early Diagnosis Initiative (NAEDI) campaign. Despite this, there is a reduction in the number of breaches (11 breaches in total - 4 patient led and 7 due to capacity issues) and an improved position with 86.6% compliance. The work to provide additional capacity is starting to pay off as an additional 25 patients have been accommodated in July than last year's average and 10 more than in June. This has delivered an improved performance of 86.6% with 2ww in July as opposed to 74.1% in June

Cancer diagnosis to treatment < 31 days (96% target):
1 x Gynaecology and 2 x Urology breaches. Urology due to lack of clinic capacity. The gynae patient is an unconfirmed breach due to the complexity of treatments and still under review.

Analysis:



Analysis:



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

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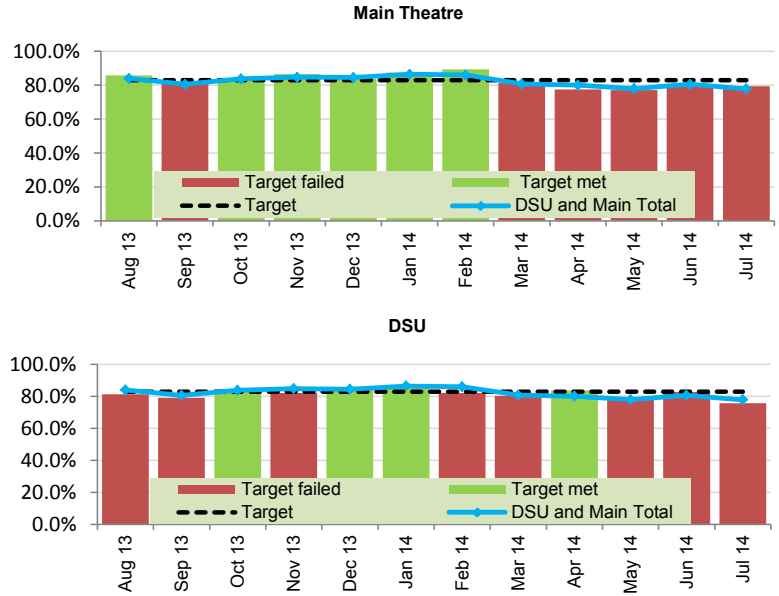
Theatre Utilisation

Isle of Wight NHS Trust

Commentary	Analysis:
The percentage utilisation of theatre facilities remains below the 83% target for both Main (79.4%) and Day theatres (75.8%) during July 2014 (77.9% total). The main contributory factor to this has been bed capacity. Delays are continuing to be experienced with patients being admitted in timely fashion into beds, as elective admissions have been reliant on discharges occuring on the day of admission. Orthopaedic elective ward has been limited to one bay of 6, and up to 4 side rooms if available to manage single sex throughput, limiting orthopaedic activity. Cancellations on day have also occured due to bed capacity. In addition Pre-Assessment Unit admission booking staff have experienced low staffing levels, impacting on utilisation being booked due to sickness, leave and unfilled vacancy.	

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

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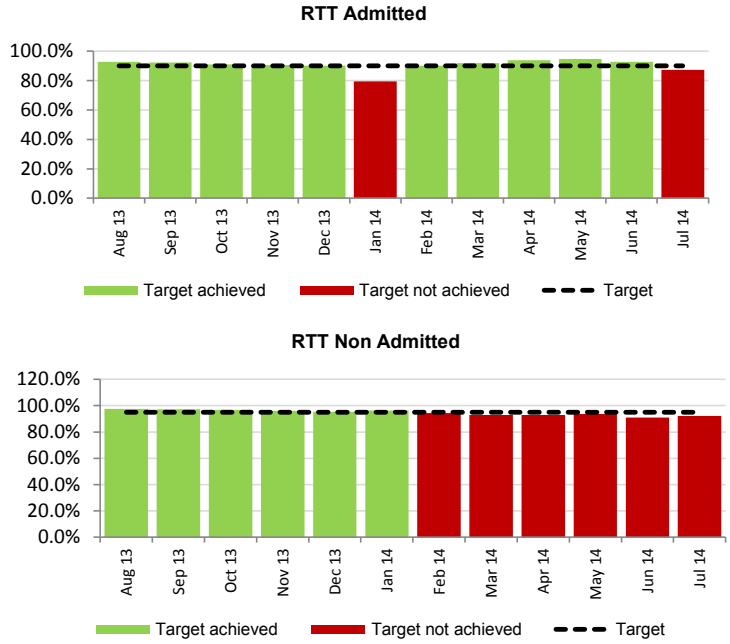
Referral to Treatment Times

Isle of Wight NHS Trust

Commentary:	Analysis:
The National Funding described in recent reports to reduce waiting times over 16 weeks has been extended and now covers July, August and September. We are predicting recovery by October. Clinicial leave over this period has been taken into account and is having a corresponding impact on capacity at this time. The forecasting tools developed by Performance Information & Decision Support (PIDS) have highlighted that data quality is an issue. PIDS are currently undertaking partial manual validation but due to volume it is not possible to check all pathways, this work highlights that there are a number of pathways that should be closed or the reporting times reduced. Therefore the figures being produced are not necessarily representative of our true performance. We are confident of our underperformance at In Patient level, but capacity in Outpatient we believe is currently matching demand. Work continues to validate existing pathways and has resulted in significantly less issues with the incomplete return. The Non-Admitted remains a data quality concern. The Admitted return has failed due to a build up of over 18 week waits in Urology and Trauma & Orthopaedics especially during bed pressures 2 months ago. The continued pressures in the Orthopaedic wards has meant that the additional Referral To Treatment Times funding cannot be used to 'catch up' and this present time.	

	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)	Aug-14	In progress
Engagement with clincians to ensure that accurate data is communicated to administrators for data capture through revision of Referral to Treatment coding forms. Still to be implemented.	OPARU Lead/ Clinical Leads	Aug-14	In progress
Additional capacity for Non admitted & Admitted patients will be put in place to reduced patients waiting over 16 weeks funded via additional CCG Referral To Treatment monies which has been made available nationally. Ongoing.	General Access Lead & General Managers	Aug-14	Planned
Referral To Treatment times awareness session with Portsmouth Hospital Trust and General Managers. Completed.	Access Lead / General Managers	Jul-14	Completed
Development of robust processes and documentation to enable training and awareness of 18 week procedures. Still to be implemented.	Information Systems	Aug-14	In progress

Source: Unify2 data collection - RTT
Published: 7th August 2014
Contact: RTTdata@dh.gsi.gov.uk

Patients waiting to start treatment	All Specialties			General Surgery		Urology		T&O		ENT		Ophthalmology		Oral Surgery		Gastroenterology		Cardiology		Dermatology		Thoracic Medicine		Rheumatology		Geriatirc Medicine		Gyanecology		Other	
At the end of June 2014…	**IW NHS Trust**	**England**		IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng	IW	Eng
What proportion of patients were waiting within 18 weeks?	93.4%	93.8%	(The NHS operational standard is 92%)	95.6%	92.1%	93.5%	91.6%	92.5%	91.7%	94.6%	94.2%	91.8%	94.7%	91.3%	93.6%	77.9%	93.6%	90.6%	94.4%	95.7%	96.7%	91.4%	95.5%	98.0%	96.6%	100.0%	97.4%	92.7%	95.4%	97.4%	94.4%
Half of patients were waiting less than	7	6	weeks	7	6	6	6	7	6	7	6	8	6	8	6	9	6	7	6	5	5	7	6	5	5	6	4	8	5	5	6
19 out of 20 patients were waiting less than	19	19	weeks	18	21	19	22	20	22	18	19	20	18	20	19	23	19	20	19	16	16	21	18	15	17	15	16	21	18	16	19
How many patients were waiting to start treatment?	8,590	3,062,335	patients	1,151	261,118	460	153,703	1,173	406,891	878	218,774	1,226	321,789	831	132,901	145	132,360	372	141,016	376	170,356	162	61,727	153	57,696	56	20,086	628	179,773	931	584,359
Patients who completed their pathway and started treatment																															
During June 2014…																															
For treatment that involved admission to hospital, e.g. inpatient appointments																															
How many patients started admitted treatment?	633	314,412	patients	123	38,915	62	19,477	115	58,150	39	17,006	149	44,487	75	16,371	0	14,165	0	9,869	0	6,959	0	1,858	0	2,092	0	168	44	23,784	26	40,595
Half of these patients started treatment within	12	9	weeks	9	9	8	8	12	12	–	11	13	12	14	12	N/A	4	N/A	7	N/A	7	N/A	3	N/A	4	N/A	1	–	8	–	7
19 out of 20 patients started treatment within	20	24	weeks	18	27	24	24	21	27	–	25	19	22	18	25	N/A	15	N/A	20	N/A	19	N/A	14	N/A	14	N/A	10	–	21	–	22
What proportion started admitted treatment within 18 weeks?[3]	92.7%	89.7%	(The NHS operational standard is 90%)	95.9%	87.9%	85.5%	89.5%	87.8%	85.9%	92.3%	87.6%	94.0%	89.4%	97.3%	87.5%	N/A	98.2%	N/A	93.3%	N/A	94.3%	N/A	99.6%	N/A	98.6%	N/A	99.4%	93.2%	92.2%	96.2%	91.0%
Without adjustments[4], what proportion started admitted treatment within 18 weeks?	85.2%	87.3%		91.1%	85.7%	82.3%	87.9%	79.1%	81.4%	92.3%	83.7%	88.6%	87.1%	77.3%	84.3%	N/A	98.1%	N/A	92.5%	N/A	93.3%	N/A	99.6%	N/A	98.5%	N/A	99.4%	81.8%	89.5%	88.5%	90.0%
For treatment that did not involve admission to hospital, e.g. outpatient appointments																															
How many patients started non-admitted treatment?	1,759	900,136	patients	209	64,634	71	31,877	141	92,221	95	66,877	136	88,034	161	30,976	95	27,571	103	40,915	162	65,358	71	20,851	65	22,684	14	10,714	114	65,597	314	212,415
Half of these patients started treatment within	7	5	weeks	3	3	5	6	9	5	8	6	9	6	12	8	5	7	10	6	5	6	14	6	7	7	–	4	5	4	9	5
19 out of 20 patients started treatment within	21	17	weeks	19	17	23	18	20	18	22	17	19	17	27	19	22	19	19	17	15	16	26	17	11	16	–	14	19	15	17	17
What proportion started non-admitted treatment within 18 weeks?	91.1%	96.3%	(The NHS operational standard is 95%)	94.7%	95.9%	87.3%	95.1%	87.9%	95.5%	82.1%	96.4%	93.4%	96.3%	73.3%	93.6%	91.6%	93.8%	93.2%	96.4%	96.3%	97.3%	88.7%	96.7%	100.0%	97.2%	–	98.9%	93.0%	97.9%	97.8%	96.8%

Notes:

1. **N/A** = Data not available. Either this trust does not provide services under this treatment area or they have not submitted RTT data for this month.

2. **"–"** = Percentage figure not displayed for less than 20 patients. Measures in weeks (median and 95th percentile waiting time) cannot be accurately estimated for less than 50 patients.

3. This figure may include adjustments made by the trust for patients that declined reasonable offers of admission and chose to wait longer. For more information about these patient clock pauses please see the RTT guidance.

4. Adjustments can be applied by trusts for patients that declined reasonable offers of admission and chose to wait longer. The unadjusted figure is the full wait excluding any patient clock pause adjustments.

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Data Quality

Isle of Wight NHS Trust

Commentary:

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

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

Analysis:

Total APC General Episodes: 4,213

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

Total Outpatient General Episodes: 26,889

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

Total A&E Attendances 10,634

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

Key:

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

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

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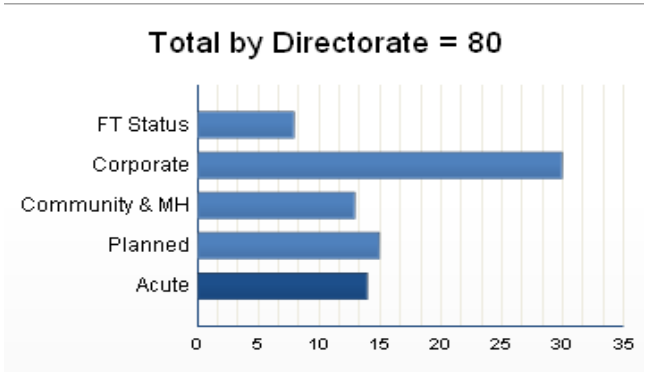
Risk Register -Situation current as at 18/08/2014

Isle of Wight NHS Trust

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



Directorate	Added	Title	Actions	Done	%
PLANND	23/02/2011	Insufficient And Inadequate Endoscopy Facilities To Meet Service Requirements	9	7	78%
PLANND	20/10/2011	Insufficient And Inadequate Ophthalmology Facilities To Meet Service Requirements	6	4	67%
CORPRI	22/11/2011	Mandatory Training	6	5	83%
ACUTE	16/08/2012	Blood Sciences Out-Of-Hours Staffing	4	3	75%
ACUTE	22/08/2012	Risk Due To Bed Capacity Problems	4	3	75%
PLANND	24/10/2012	Failing Heating/Cooling System Impacting On Service Delivery	2	2	100%
COMMH	22/11/2012	Low Staffing Levels Within Occupational Therapy Acute Team	6	2	33%
ACUTE	05/12/2012	Vacant Consultant Physician Posts	3	1	33%
CORPRI	26/03/2013	Pressure Ulcers	4	2	50%
PLANND	23/09/2013	Ophthalmic Casenotes - Poor Condition, Misfiling And Duplication Leading To Potential Clinical Error	4	2	50%
ACUTE	21/01/2014	Acquisition Of Mechanical Device For Chest Compressions	4	3	75%
PLANND	30/04/2014	Maternity Theatre Inadequate Airflow Leading To Potential Infection Control Risk	3	1	33%
CORPRI	24/07/2014	Mandatory Resuscitation Training	6	0	0%
CORPRI	24/07/2014	Air Conditioning Unit In Network Core Room	5	1	20%

Data as at 18/08/2014 Risk Register Dashboard

Commentary

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

Since the last report three new risks have been added to the register, although the table above shows only those with the highest level rating. These are (1) RR618 OHPiT Increase of activity, RR619 Air Conditioning Unit in Network Core Room, RR620 Mandatory Resuscitation Training,. One risk has been signed off the register - RR598 Vision Telephone Recorder Server as all actions were completed. RR540 Failing Heating/Cooling System Impacting on Service Delivery - will be going to the Hospital and Ambulance Quality and Risk meeting in August for their agreement to sign off.

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Workforce - Key Performance Indicators

Measure	Period	Month Target/Plan	Month Actual	In Month Variance	RAG rating	In Month Final RAG Rating	Trend from last month
Workforce FTE	Jul-14	2616.64	2622.60	5.96			
Workforce Variable FTE	Jul-14	136.70	143.65	6.95			
Workforce Total FTE	Jul-14	2753.34	2766.25	12.91			

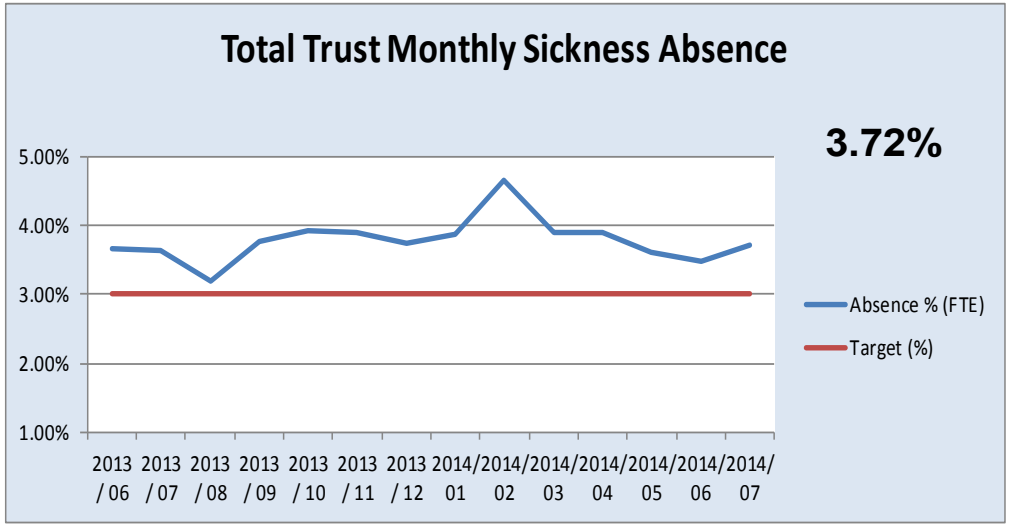
Finance	Period	Month Target/Plan (£000's)	Month Actual (£000's)	In Month Variance (£000's)	RAG rating	Year-to Date Final RAG Rating	
Total In Month Staff In Post Paybill	Jul-14	£9,500	£8,987	-£513			
In Month Variable Hours	Jul-14	£78	£587	£509			
In Month Total Paybill	Jul-14	£9,578	£9,574	-£4			
Year-to Date Paybill	Jul-14	£38,722	£38,735	£13			

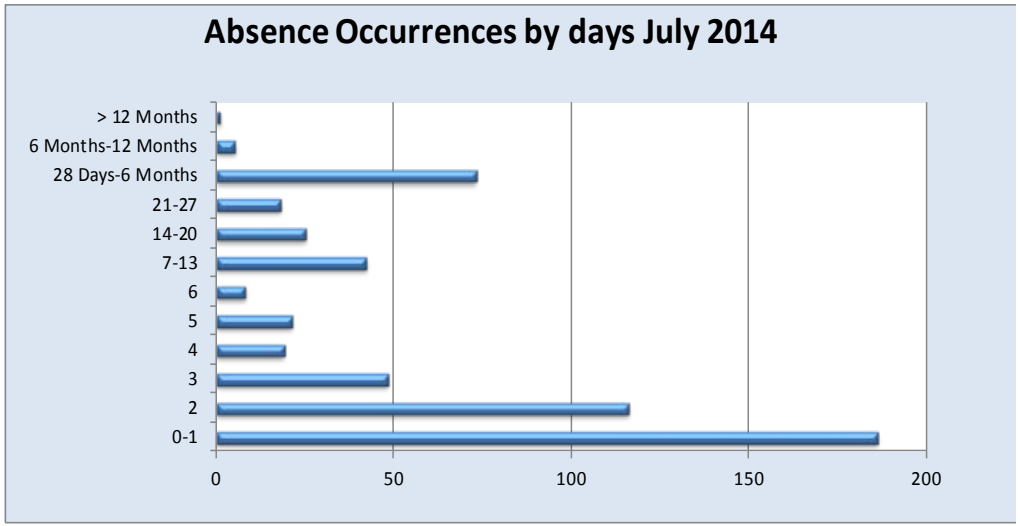
Sickness Absence	Period	Month Target/Plan	Month Actual		RAG Rating		
In Month Absence Rate	Jul-14	3%	3.72%				

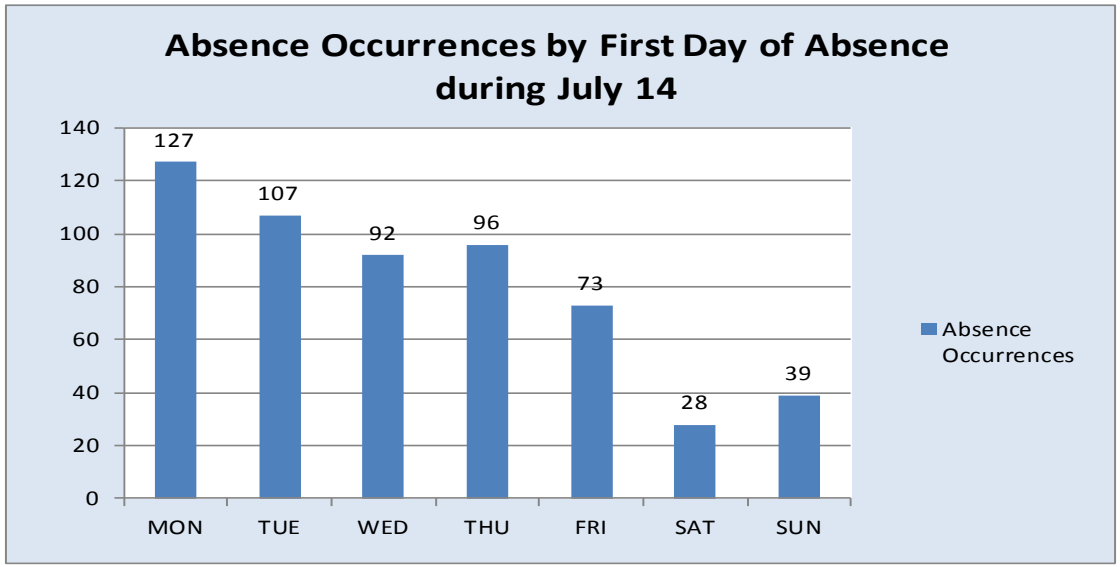
Key	
	Green - On Target
	Amber - Mitigating/corrective action believed to be achievable
	Red - Significant challenge to delivery of target

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

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







Top 10 Absence reasons by FTE Year To Date

Absence Reason
S10 Anxiety/stress/depression/other psychiatric illnesses
S12 Other musculoskeletal problems
S25 Gastrointestinal problems
S26 Genitourinary & gynaecological disorders
S11 Back Problems
S28 Injury, fracture
S15 Chest & respiratory problems
S17 Benign and malignant tumours, cancers
S13 Cold, Cough, Flu - Influenza
S16 Headache / migraine

Data Source: ESR Business Intelligence

Performance Area	Commentary	RAG Rating	RAG Rating	RAG Rating
Continuity of Service Risk Rating (CoSRR)	• Overall Rating of 4 after normalisation adjustments. This maintains the Trust at the highest score achievable in the TDA ratings	Green	Green	Green
Income & Expenditure	• The YTD position is an adjusted surplus of £783k which is a £17k overachievement against a plan of £766k. The Trust is expecting to achieve its forecast adjusted surplus of £1.7m	Green	Green	Green
Cost Improvement Programme (CIP)	• YTD CIPs achieved £3,211k against a plan of £2,260k. The RAG rating is Amber due to the level of non recurrent plans, however the FY15/16 full year effect of current year schemes is greater than the value of non recurrent savings in FY14/15.	Amber	Amber	Amber
Working Capital & Treasury	• Cash 'in-hand' and 'at-bank' at Month 4 was £10,140k.	Green	Green	Green
Capital	• Total year-to-date capital spend amounted to £857k against a planned spend of £2,962k.	Amber	Amber	Green

Isle of Wight NHS Trust Board Performance Report 2014/15

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Income & Expenditure - Key Highlights - Trust

Isle of Wight NHS Trust

Statement of Comprehensive Income	2014/15 Full Year BUDGET	Jul Budget	Jul Actual	Jul Variance	YTD Budget	YTD Actual	YTD Variance	Forecast
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Gross Employee Benefits	(115,265)	(9,578)	(9,574)	4	(38,723)	(38,735)	(12)	(114,525)
Other Operating Costs	(54,862)	(4,077)	(3,706)	372	(16,371)	(15,804)	567	(55,340)
Revenue from Patient Care Activities	160,335	13,460	13,110	(349)	53,440	52,316	(1,124)	156,955
Other Operating Revenue	9,569	882	867	(15)	3,560	4,085	524	12,623
OPERATING SURPLUS/(DEFICIT)	(223)	686	698	11	1,906	1,862	(44)	(287)
Investment Revenue	22	4	5	0	14	16	1	40
Other Gains and Losses	(125)	(1)	(1)	1	(6)	(3)	3	(117)
Finance Costs (including interest on PFIs and Finance Leases)	(48)	0	0	0	(62)	(6)	56	(16)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	(374)	689	702	13	1,853	1,869	16	(380)
Dividends Payable on Public Dividend Capital (PDC)	(3,299)	(275)	(275)	(0)	(1,100)	(1,100)	(0)	(3,299)
Net gains/ (loss) on transfers by absorption (Roundings)	0	1	4	3	6	2	(5)	0
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	(3,673)	416	431	16	759	771	12	(3,679)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR PER ACCOUNTS	(3,673)	416	431	16	759	771	12	(3,679)

Reported NHS Financial Performance	2014/15 Full Year	Jul Budget	Jul Actual	Jul Variance	YTD Budget	YTD Actual	YTD Variance	YTD Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Retained surplus/(deficit) for the year	(3,673)	416	431	16	759	771	12	(3,679)
IFRIC 12 adjustment including impairments	0	0	0	0	0	0	0	0
Impairments excluding IFRIC12 impairments	5,347	0	0	0	0	0	0	5,347
Donated/Government grant assets adjustment (include donation/grant receipts and depreciation of donated/grant funded assets)	28	2	9	7	6	8	1	34
Adjusted Financial Performance Retained Surplus/(Deficit)	1,702	418	440	22	766	783	17	1,702

Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA)	2014/15 Full Year	Jul Budget	Jul Actual	Jul Variance	YTD Budget	YTD Actual	YTD Variance	YTD Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Retained Surplus / (Deficit) for the Year per Accounts	(3,673)	416	431	16	759	771	12	(3,679)
Depreciation	6,158	386	368	(18)	1,886	1,900	15	6,158
Amortisation	1,302	109	104	(5)	436	416	(20)	1,302
Impairments (including IFRIC 12 impairments)	5,347	0	0	0	0	0	0	5,347
Interest Receivable	(22)	(4)	(5)	(0)	(14)	(10)	5	40
Finance Costs (including interest on PFIs and Finance Leases)	48	0	0	0	62	6	(56)	(16)
Dividends	3,299	275	275	0	1,100	1,100	0	3,299
Donated/Government grant assets adjustment (donation income element of SC 380)	(100)	8	3	(6)	33	33	0	(100)
(Gains) / Losses on disposal of assets	125	1	1	(1)	6	3	(3)	117
Net gains/ (loss) on transfers by absorption (Roundings)		1	4	3	6	10	4	4
EBITDA Sub Total	12,484	1,192	1,180	(12)	4,273	4,229	(44)	12,472
Restructuring costs	1,500	0	0	0	0	0	0	1,500
Normalised EBITDA	13,984	1,192	1,180	(12)	4,273	4,229	(44)	13,972

Commentary:

Income

£544k underplan YTD.

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

The total year end forecast variance compared with the plan for patient revenue & other operating revenue is c.£326k. However, there is a greater of variance between these individual streams. This is due to the original patient related plan including some items which are now classified as other operating revenue. To maintain a consistent budget plan to that submitted to the Trust Development Authority the budget has not been amended.

£5k overachieved Cost Improvement Plans.

£1,132k relates to phasing of investment schemes not yet being accessed from contracting authorities. The offset of some of these can be seen in reserves slippage above.

£555k overachievement of income targets from Corporate areas. The majority of this relates to two services, Earl Mountbatten Hospice (EMH) £114k & NHS Creative £311k. The spend related to these variances can be seen in the pay & non pay budgets.

Pay

£12k overspend YTD.

£140k unachieved Cost Improvement Plans.

£1,066k budget overspends - The majority of this relates to the premium costs of agency medical cover in excess of budget.

£1,194k reserves slippage - The Trusts reserved have not been committed to help offset cost pressures within the directorates & is slippage in planned investments not commencing.

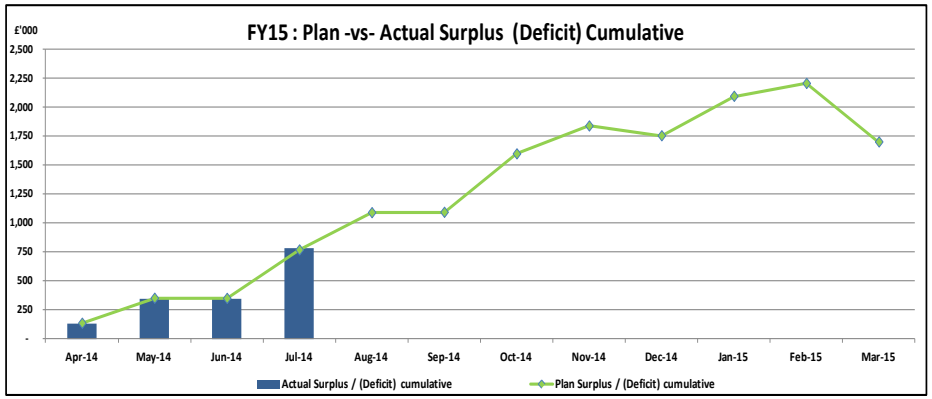
Non Pay

£567k underspend YTD.

£597k unachieved Cost Improvement Plans.

£1,325k budget overspends - £181k of this overspend relates to drug spend across numerous services. The Pharmacy lead is scoping how to better manage this spend/cost pressure. Additionally costs relating to the EMH service & NHS Creative explain the pressure on these budgets.

£1,355k reserves slippage - The Trusts reserved have not been committed to help offset cost pressures within the directorates & is slippage in planned investments not commencing.



Isle of Wight NHS Trust Board Performance Report 2014/15

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Cost Improvement Programme - CIP by Directorates

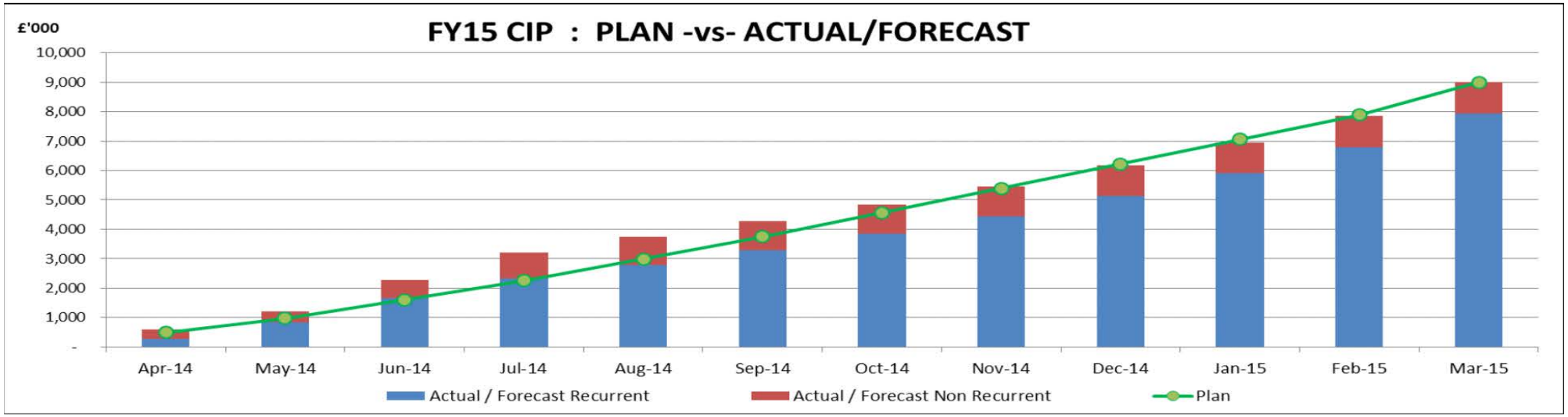
Isle of Wight NHS Trust

	Month			YTD			FULL YEAR		
Directorates	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
ACUTE	245	138	(107)	935	719	(216)	2,992	2,992	0
CHIEF OPERATING OFFICER	2	0	(2)	8	24	16	24	24	0
COMMUNITY	96	108	13	371	494	123	1,399	1,399	(0)
FINANCE & PERFORMANCE MANAGEMENT	15	399	383	61	584	523	183	183	(0)
NURSING & WORKFORCE	53	6	(47)	109	286	176	631	631	0
PLANNED	183	4	(179)	533	297	(236)	2,891	2,891	0
STRATEGIC & COMMERCIAL	36	295	259	144	512	368	582	582	(0)
TRUST ADMINISTRATION	25	0	(25)	99	297	198	297	297	(0)
Total	655	950	294	2,260	3,211	951	8,998	8,998	0

CIP Position Prior to forward banking of CIP	2,260	1,528	(732)

Commentary:

The YTD CIP plan is **£2,260k**. The actual savings total **£3,211k**, a YTD overachievement of **£950k**. The year end position is showing achievement of **£8,998k** which is on plan including **£820k** of non recurrent savings which is delivered in 2015/16 by the full year effect of the schemes (**£1,521k** in FY15/16). This also includes **£1,683k** of forward banked schemes which will unwind over the year.



Isle of Wight NHS Trust Board Performance Report 2014/15

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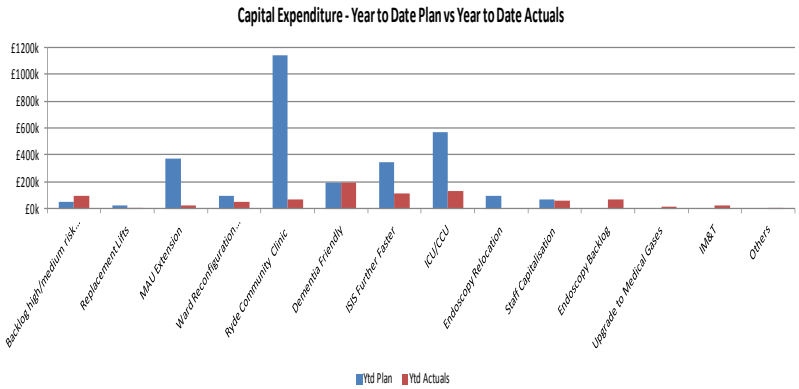
Capital Programme - Capital Schemes

Isle of Wight NHS Trust

Source & Application of Capital Funding	Original Plan £'000	Revised Plan / Budget £'000	YTD Plan	YTD Spend £'000	F'cast to Year End £'000	Full Year £'000
Source of Funds						
Initial CRL	7,460	7,460	0			7,460
Dementia Friendly		0				0
Pharmacy Matched Funding - NHS Technology for Safer Wards (provisional)		0				0
CCG Income (Hand Held Devices)		0				0
Property Sales	648	648	0			648
Proceeds from Disposals - Draeger Monitors		20				20
Cash Surplus						
Anticipated Capital Resource Limit (CRL)	**8,108**	**8,128**	**0**	**0**	**0**	**8,128**
Other charitable donations	100	100				100
Charitable Funds - Dementia	9	9				9
Donated Helipad Income	0	0				0
VAT Recovery	100	100				100
Total Anticipated Funds Available	**8,317**	**8,337**	**0**	**0**	**0**	**8,337**
Application of Funds						
13/14 Schemes Carried Forward						
Backlog high/medium risk & fire safety 13.14	93	93	50	92	0	93
Replacement of two Main Hospital Passenger Lifts	44	44	28	8	36	44
Personal Alarm System for Sevenacres	0	0		0	-0	0
MAU Extension	2,428	1,840	370	25	1,815	1,840
Ward Reconfiguration Level C	142	142	100	50	92	142
Ryde Community Clinic	1,225	1,225	1,140	70	1,155	1,225
Dementia Friendly	192	192	192	192	0	192
ISIS Further Faster	344	344	344	115	229	344
ICU/CCU	2,262	126	570	133	-7	126
Endoscopy Relocation	625	2,465	100	0	2,465	2,465
Sub-total	**7,356**	**6,470**	**2,894**	**685**	**5,785**	**6,470**
14/15 Approved Schemes						
Endoscopy Backlog Maintenance	0	74		67	7	74
Call Vision Call Recording Server	0	27		27	-0	27
Replacement Outpatient Desk	0	5		4	1	5
Medicine Cabinet Installation	0	73		0	73	73
Bratt Pans	0	14		0	14	14
Internal Porters Tug	0	6		0	6	6
Air Conditioning for IT Network Room	0	25		0	25	25
Upgrade to Medical Gases System	12	12	0	12	-0	12
St Helens Ward Relocation	0	357		0	357	357
Sub-total	**12**	**592**	**0**	**110**	**482**	**592**
14/15 Schemes - Requiring TEC/Board Approval						
Backlog Maintenance	0	0		0	0	0
IM&T (balance)	156	129		0	129	129
RRP (Annual Plan adjusted by £45k to offset Endoscopy Backlog)	460	404		0	404	404
Carbon Energy Fund	0	421		0	421	421
Carbon Energy Fund Contingency	0	0			0	0
Contingency (Annual Plan adjusted by £28k to offset Endoscopy Backlog)	33	0		0	0	0
Infrastructure (e.g. underground services)	0	0		0	0	0
Theatre Racking	0	21		0	21	21
Staff Capitalisation	200	200	68	61	139	200
Sub-total	**849**	**1,175**	**68**	**61**	**1,114**	**1,175**
New/Adjustments to Projects - Requiring TEC Approval						
Unallocated	0	0		0	0	0
Sub-total	**0**	**0**	**0**	**0**	**0**	**0**
Other charitable donations	100	100		0	100	100
Gross Outline Capital Plan	**8,317**	**8,337**	**2,962**	**857**	**7,480**	**8,337**



Commentary : The initial Capital Resource Limit, plus expected proceeds from property sales and charitable donations, give the Trust a Source of Capital Funds of £8.3M.Capital Investments already approved in 2013/14 total £7.4M, but the project to relocate ICU to CCU has been delayed, and the approved £2.2M for this project will now be re-allocated to other projects. St Helens Ward will now be relocated to an area previously occupied by Newchurch Ward, which in turn will allow the relocation of the Endoscopy Unit to the space vacated by St Helens Ward, rather than into the area currently occupied by ICU. These changes also mean that there will be a shorter timescale for these two projects, bringing costs forward from 2015/16. These projects were approved at the July Trust Board meeting. There is also a project to invest in energy efficiency and emissions reduction with the Carbon Energy Fund, and approval will be requested to the Board to proceed. This project can be delayed until 2015/16,and is dependant on having capital resources available from the proposed property sales.

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

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

Isle of Wight NHS Trust Board Performance Report 2014/15

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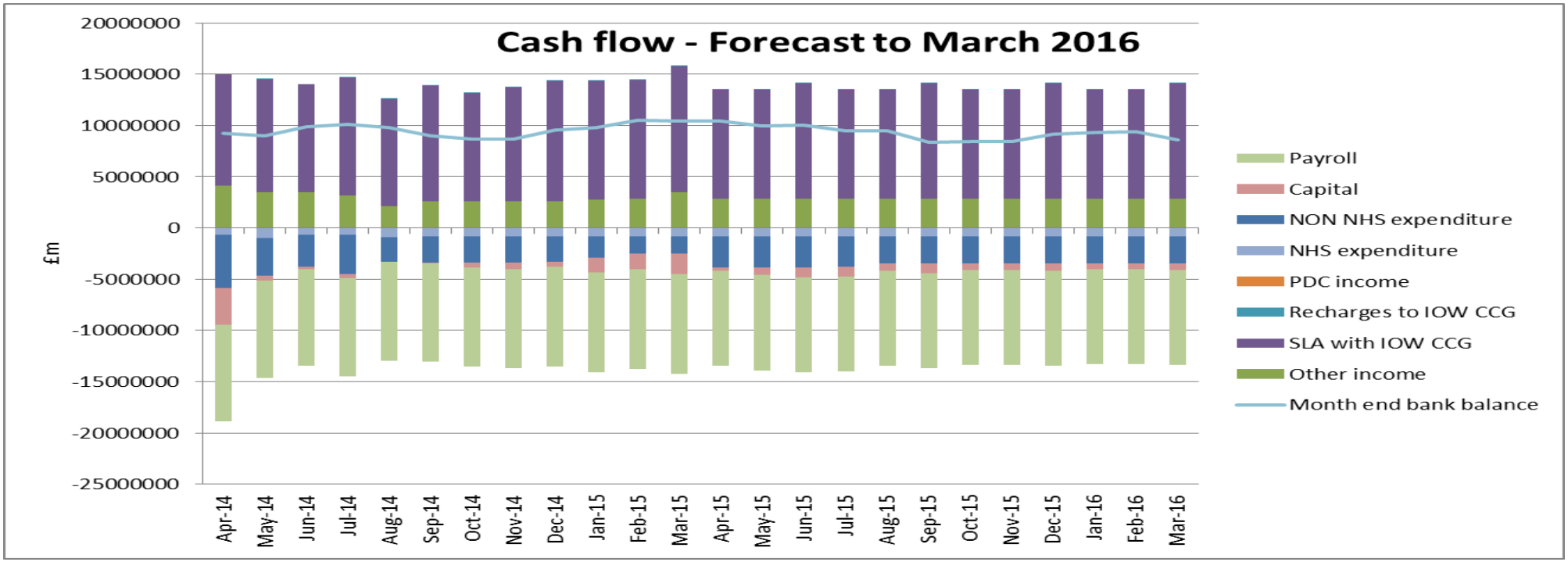
Monthly statement of Financial Position - July 2014

Isle of Wight NHS Trust

	July-14	June-14	Month-on-month Movement
PPE	116,681	116,327	354
Accumulated Depreciation	20,307	19,929	378
Net PPE	**96,374**	**96,398**	**(24)**
Intangible Assets	7,854	7,821	33
Intangible Assets Depreciation	3,979	3,875	104
Net Intangible Assets	**3,875**	**3,946**	**(71)**
Investment Property	0	0	0
Non-Current Assets Held for Sale	0	0	0
Non-Current Financial Assets	0	0	0
Other Receivables Non-Current	227	242	(15)
Total Other Non-Current Assets	**227**	**242**	**(15)**
Total Non-Current Assets	**100,476**	**100,586**	**(110)**
Cash	10,140	9,917	223
Accounts Receivable	10,084	9,683	401
Inventory	2,309	2,514	(205)
Investments	0	0	0
Other Current Assets			0
Current Assets	**22,533**	**22,114**	**419**
Total Assets	**123,009**	**122,700**	**309**
Accounts Payable	18,470	18,364	106
Accrued Liabilities	0	0	0
Short Term Borrowing	27	27	0
Current Liabilities	**18,497**	**18,391**	**106**
Non-Current Payables	0	0	0
Non-Current Borrowing	0	0	0
Other Liabilities	368	596	(228)
Long Term Liabilities	**368**	**596**	**(228)**
Total Net Assets/Liabilities	**104,144**	**103,713**	**431**
Taxpayers Equity:			
Revaluation Reserve	24,489	24,488	1
Other Reserves	76,537	76,539	(2)
Retained Earnings incl. In Year	3,118	2,686	432
Total Taxpayers Equity	**104,144**	**103,713**	**431**

Commentary:
Overall there is a slight reduction in asset values as in-month depreciation charges are greater than in-month additions. Little movement has occurred elsewhere in the balance sheet although Other Liabilities, which relate to Provisions, have been reduced by £228k. This is a combination of introducing new employer liability related provisions (£73k) offset by the reversal of the provisions brought forward from 2013/14 which are no longer required (c.£300k).



Commentary:

The table above shows the forecast cash flow to March 2016. It shows both the in-flow and out-flow of cash broken down to the constituent elements.

Cash held at the end of July amounted to c£10m. During the month the Trust was able to invest an average of £10m in the short term deposit of the National Loans Fund.

Isle of Wight NHS Trust Board Performance Report 2014/15

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Continuity of Service Risk Rating

Isle of Wight NHS Trust

Month 04 - Risk Rating:

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

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

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

Isle of Wight NHS Trust

GOVERNANCE RISK RATINGS

Isle of Wight NHS Trust

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

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

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

	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data Q3 2013/14	Historic Data Q4 2013/14	Historic Data Q1 2014/15	Current Data Jul	Current Data Aug	Current Data Sep	Current Data Q2 2014/15	Notes
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	Yes	No	Yes	No			No	See exception report
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		95%	1.0	Yes	Yes	No	No			No	See exception report
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		92%	1.0	Yes	Yes	Yes	Yes			Yes	
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	Yes	Yes	No	Yes			Yes	
	5	All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	No	Yes			Yes	
			NHS Cancer Screening Service referral	90%									
	6	All cancers: 31-day wait for second or subsequent treatment, comprising:	surgery	94%	1.0	Yes	No	Yes	Yes			Yes	
			anti-cancer drug treatments	98%									
			radiotherapy	94%									
	7	All cancers: 31-day wait from diagnosis to first treatment		96%	1.0	Yes	Yes	Yes	No			No	31 days wait from diagnosis to first treatment - 95.7%. See exception report
	8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93%	1.0	Yes	Yes	No	No			No	Symptomatic Breast referrals 86.6%. See exception report
			For symptomatic breast patients (cancer not initially suspected)	93%									
	9	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within seven days of discharge	95%	1.0	No	No	No	Yes			Yes	
			Having formal review within 12 months	95%									
	10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	Yes	No	Yes	Yes			Yes	
	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	Yes	Yes			Yes	
			Red 2 calls	75%	1.0	Yes	Yes	Yes	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	See exception report
			Is the Trust below the YTD ceiling	2		Yes	Yes	No	No			No	
	16	Minimising mental health delayed transfers of care		≤7.5%	1.0	Yes	No	No	Yes			Yes	
	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	tbc
	20	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes			Yes	tbc
			Referral information	50%									
			Treatment activity information	50%									
		TOTAL				**1.0**	**5.0**	**6.0**	**4.0**	**0.0**	**0.0**	**4.0**	
						AG	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-Assesment Unit
PAS	Patient Administration System - the main computer recording system used
PALS	Patient Advice & Liaison Service now renamed but still dealing with complaints/concerns
PATEXP	Patient Experience
PATSAF	Patient Safety
PEO	Patient Experience Officer - updated name for PALS officer
PPIs	Proton Pump Inhibitors (Pharmacy term)
PIDS	Performance Information Decision Support (team)
Provisional	Raw data not yet validated to remove permitted exclusions (such as patient choice to delay)
QCE	Quality Clinical Excellence
RCA	Route Cause Analysis
RTT	Referral to Treatment Time
SUS	Secondary Uses Service
TIA	Transient Ischaemic Attack (also known as 'mini-stroke')
TDA	Trust Development Authority
VTE	Venous Thrombo-Embolism
YTD	Year To Date - the cumulative total for the financial year so far

Workforce and Finance terms

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

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Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 27 AUGUST 2014

QUALITY & CLINICAL PERFORMANCE COMMITTEE
Wednesday 20 August 2014

Present:	Sue Wadsworth	Non Executive Director and Chair (Chair)
	Nina Moorman	Non Executive Director and Deputy Chair (DC)
	Jessamy Baird	Designate Non Executive Director (NED)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Mark Pugh	Executive Medical Director (EMD)
In Attendance:	Brian Johnston	Head of Corporate Governance & Risk Management (HOCG)
	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM)
	Vanessa Flower	Patient Experience Lead (PEL)
	Deborah Matthews	Lead for Patient Safety, Experience and Clinical Effectiveness (LSEE)
	Kay Marriott	Acting Head of Clinical Services – Community Clinical Directorate (AHOCC)
	Chris Orchin	Non-Executive Director (Governance and Compliance) Healthwatch IW (HIW)
	Sue Biggs	Modern Matron (MM), deputising for Shane Moody, Interim Head of Clinical Services – Planned Clinical Directorate (IHOCP)
	Alexis Bowers	Consultant Psychiatrist (CP), deputising for Sarah Gladdish, Clinical Director, Community & Mental Health Directorate.
	Annie Hunter	Head of Midwifery (HOM), *for item 14/293*
	Mo Smith	Lead Nurse for Mental Health and Learning Disabilities (LN), *for item 14/297*
	Emily Macnaughton	Infection Prevention & Control Dr (IPC Dr) - *for item 14/302 and 14/303*
	Mandy Webb	Ward Sister (WM) – *for item 14/305*
Minuted by:	Amanda Garner	Personal Assistant to EDNW (PA)

Key Points from Minutes to be reported to the Trust Board

Item 14/283 – The Committee discussed the need for a Mental Health Service Users Involvement Policy. This requires submission in September.

Item 14/287 – The Committee received an update from the EMD regarding the CQC report.

Items 14/302 and 14/303 – The Committee reviewed the Infection and Prevention and Control Annual Report and the TDA External Report Action Plan

Item 14/311 – The Committee approved the SEE Committee terms of reference.

Item 14/312 – The Committee did not discuss TDA Self Certification due to lack of time.

Minute No.	
14/279	**APOLOGIES FOR ABSENCE FROM MEMBERS AND ATTENDEES**
	Apologies were received from Sabeena Allahdin, Clinical Director, Hospital and Ambulance (CDHA), Sarah Gladdish, Clinical Director, Community & Mental Health (CDCMH), Sarah Johnston, Deputy Director of Nursing (DDN), Shane Moody, Interim Head of Clinical Services – Planned Clinical Directorate (IHOCP), Ian Bast, Patient Representative (PR), Gill Honeywell, Chief Pharmacist (CP).

14/280	**CONFIRMATION OF QUORACY**
	The Chair confirmed the meeting was quorate.
14/281	**DECLARATIONS OF INTEREST**
	There were no declarations of Interest.
14/282	**MINUTES OF THE LAST MEETING – 23 July 2014**
	The minutes of the meeting held on 23 July 2014 were agreed. The EDNW advised that the Patient Safety, Experience and Clinical Effectiveness (SEE) Triumvirate will provide assurance to this Committee and report operationally to the Trust Executive Committee (TEC). The HOCG will confirm this with the Executive Director of Finance (EDF) ***Action Note**: HOCG will confirm the SEE reporting arrangements with the EDF.* **Action by HOCG**
14/283	**REVIEW OF ACTION TRACKER**
	The Committee reviewed the Action Tracker. The Chair thanked the Committee for their efforts in closing off some actions and added that where actions have not been completed an update and a revised completion date should be provided. ***Action Note**: Members and attendees to provide an update and a revised completion date on any actions not completed by the due date.* **Action by All** The EDNW asked that the LSEE and SEEBM review the open and progressing actions and close off as many as possible. ***Action Note**: LSEE and SEEBM to review open and progressing actions* **Action by SEE Triumvirate** The EDNW advised that action QCPC0277 was now complete. He advised that the Chief Executive Officer had met with HSDU staff and presented them with letters of achievement. The NED highlighted action QCPC0211 regarding the Mental Health Service Users Involvement Policy and noted that this was still not completed. The NED advised that she was concerned that this policy had been in development for two years and that service users do need to get involved. The designate NED advised that she was concerned that the Policy was being delayed as it was becoming part of a corporate policy. The HOCG advised that to have a separate Service Users Policy for Mental Health would mean a conflict and it would have to apply to the whole of the organisation to ensure fairness. The NED advised that it would be better to approve the Policy for now and review later and asked that the Policy be presented to the Committee at the September 2014 meeting. She added that the Service User Involvement Forum had made suggested changes to the Policy and asked that their changes were not amended without consulting them. The HOCG advised that Mark Price, FT Programme Director/Company Secretary (FTPD/CS), is leading on this. The EMD agreed that there should not be a different Policy for Mental Health. The Committee agreed that the Service Users Involvement Policy should be presented to the September 2014 meeting. ***Action Note**: Service Users Involvement Policy to be presented to the September 2014 Meeting.* **Action by FTPD/CS**
UPDATE OF LOCAL / NATIONAL ISSUES	
14/284	**UPDATE FROM NATIONAL QUALITY AGENDA**
	The PEL advised that this was an overview of what had been published during July 2014

	and that she had included benchmarking data and also upcoming events and conferences. The NED highlighted the 7 day follow up information in section 2.5 and advised that she was concerned with the figure of 0%. The CP agreed and advised that this should at least be 90% and ideally should be 100%. The PEL advised that she would review this data. ***Action Note**: PEL to review data on 7 day follow up information.* **Action by PEL**
QUALITY	
14/285	**CIPS: QUALITY IMPACT ASSESSMENT – QUARTERLY UPDATE**
	The EDNW updated the Committee on the current Cost Improvement Plans (CIPs) Quality, advising that 17 schemes did not require quality impact assessments (QIA), 33 had been signed off and 15 were awaiting signature. The EDNW advised that he and the EMD would be involved in a quarterly review of impact on quality Key Performance Indicators (KPI's). He added that key performance indicators (KPIs) would monitor patient experience and the review would be to see if there had been any adverse effect on those KPIs. The EMD advised that some CIPs had been returned to reconsider the potential quality impacts and he added that rejected CIP's were not monitored. The DC advised that CIPs affect how staff and the organisation work and added that there had been a negative impact on one group of staff with the problem being thought to being related to a CIP. The DC added that the Non Executive Directors do not always hear about cross directorate CIPs also. The NED agreed adding that the uniqueness of the Trust would benefit from this. The LSEE advised that the directorates look at overarching schemes; however, they would be presented by one directorate. The MM confirmed that she is linking with the Community Directorate as part of the patient flow and length of stay projects that she is leading on. The EDNW advised that Quarter 2 CIPs will be discussed in September 2014 and that he would update the Committee at the October 2014 meeting. ***Action Note**: EDNW to update Committee on Q2 QIA's at October 2014 meeting.* **Action by EDNW**
14/286	**EXTERNAL AGENCIES REPORT – QUARTERLY UPDATE**
	The HOCG updated the Committee on the external inspection programme highlighting the CQC inspection and the JAG inspection due in September 2014. The DC advised that this was a valuable report but it was difficult to read and asked if the report could be grouped by service. ***Action Note**: The HOCG to revise the report to group visits by service.* **Action by HOCG**
14/287	**CQC DRAFT REPORT**
	The EMD updated the Committee on the CQC draft report. The EMD advised that the Trust had been given the opportunity to check the report for factual accuracy which had been completed and submitted to the CQC last week. The EMD advised that the CQC will get the report back to the Trust by the end of next week. He advised that the Quality Summit is scheduled for 2 September 2014 and within 48 hours after the summit the report will be made public. The EMD added that if there are any delays by the CQC regarding getting the report back to the Trust then the Quality Summit will be held on 22 September 2014. The EMD advised that although some areas of the report have been challenged there are action plans being put in place and that there is an internal CQC meeting scheduled for Thursday 21 August 2014. The EMD advised the Committee that once robust action plans are in place they will be presented to the Committee. The CP enquired regarding the timeline to share the content with staff so improvements can start to be made. The EMD advised that individual reports have been shared and that staff are working on these. The NED advised that there are so many services in the Trust and if services have performed well is it important that they are aware of this. The Chair agreed that when reports like this are received the focus will be on the negative and it is essential that all the good work is highlighted. She added that there was assurance that there was a huge amount of work being done to improve. The EDNW added that the areas of care and

compassion were very good and on the whole patients get a good experience. Many of the concerns highlighted by the CQC were related to the Trust's processes.

14/289 ISIS ROLL OUT PLAN

The EDNW advised that this plan outlined the forecast for rolling out ISIS. The MM advised that she had recently met with the Projects Manager regarding some concerns she had with MedeTrax system and advised the Committee that this has now been put back to September 2014. The MM added that there had been some delays with the PSAG Boards. It was agreed that the Consultants need to be engaged with the implementation of these systems as their use will have implications on clinical care. The Committee agreed that Katie Gray, Executive Director of Transformation and Integration, be invited to the October Committee meeting to give an update on this. The CP advised that the systems are only as good as the information that is put into them and some systems have not been set out very well however with tweaking and clinical engagement the systems could be good with good reporting. The CP added that clinicians are involved with Paris however his concern is that social workers are using a different system. The NED advised that the plan is to roll out the Paris system to social workers. The EMD advised that a more sophisticated timeline is required which gives more detailed information and added that the Trust has not been good at rolling out new systems successfully and ironing out any glitches.

Action: *K Gray to be invited to October 2014 Committee Meeting*

Action by PA

14/290 QUALITY REPORT

The EDNW presented the Quality Report for July 2014 (month 4) to the Committee and highlighted the following:

1. Clinical incidents resulting in harm and those resulting in major harm. The EDNW advised that all major incidents are being reviewed to agree if they are a major and what investigations have been undertaken.
2. MRSA screening – some progress is being made and there will be an audit for every patient who had not been screened who should have been.
3. Readmission rates – slightly higher year to date
4. Pharmacy data
5. Complaints
6. Concerns
7. Friends and Family Test – there has been some improvement in Maternity. The PEL advised that there are some anomalies with the data which is being reviewed and a tablet will be utilised on the ward from this week and this should improve data collection. The PEL advised that tablets will be in use in other areas and that the MedeTrax system will also have the Friends and Family software installed. The PEL added that there will be targeted work done in maternity and that the text back service will be explored. The NED advised that the Friends and Family test did not provide helpful feedback. She added that there are other surveys completed and that data could be reported on which would give better information. The PEL agreed that there is a need to drill down into the data. The LSEE advised that the Quality Service Matrix will allow this. The EDNW advised that this matrix has been developed for inpatients and can be broken down by service including the community services. The PEL advised that volunteers will be trained to collect data. The PEL advised that she will present an action plan to the Committee at the next meeting.

Action Note*: The PEL to present an action plan by service to the Committee at the September 2014 meeting.*

Action by PEL

8. Pressure ulcers
9. Reduction in hospital lead consultant outpatient cancellations – the figure is being reviewed. The EDNW added that this is one of the Trust's Quality Goals.
10. Ward Summary Dashboard – The EDNW advised that this will be ranked. The Committee reviewed the data and the Chair and the DC asked what the directorates were doing to address the "reds" month by month. They were also concerned that some of the data was incorrect ie Whippingham Ward's staff levels data. The MM advised that as matron her job would be to work with and support the ward sister to

improve and escalate to the Head of Clinical Services (HOCS). The EDNW added that the HOCS would hold the area to account and that a framework for a process for escalating is currently being worked on. The NED advised that the data is slowly improving and weighting would be useful. The LSEE advised that the Directorates have added this to the agenda for their Quality, Risk and Patient Safety meetings and that the SEE Group will review. The AHOCC agreed that the Directorates are reviewing and challenging the information.

HIW asked how the view of paediatric patients are collected. The PEL advised that their data is collected but in a different report than the Friends and Family Test.

The Chair advised that she would like to move towards a situation where there were fewer papers and greater assurance provided with the directorates commenting on the dashboard information.

REPORTS FROM DIRECTORATES

HOSPITAL AND AMBULANCE DIRECTORATE

14/291 QUALITY, RISK AND PATIENT SAFETY COMMITTEE

The MM advised that the first Joint meeting of the directorates had taken place on 17 July 2014 and highlighted the following:

Ward Dashboard – accessibility and data reliability
Lessons learnt - central log kept
MRSA – disappointed with figures and a deep dive will be taking place and work will be done to cleanse the data.

The EDNW highlighted item 5 of the minutes, Dashboard Summary, and queried who "AS" was. The MM advised that she would clarify this.
***Action Note**: The MM to clarify who "AS" is in the minutes of the meeting.*

Action by MM

The EDNW also highlighted the increase in the number of falls being attributed to medical patients and advised that this read as though it was the fault of the patients.

14/292 ACTIONS BEING TAKEN IN REVIEWING OR ACTION PLANNING AROUND CLINICAL AREAS OF CONCERN

The Committee reviewed the Action Plan that had been put in place. The MM advised that a lot of work is being done in relation to this which includes infection control, staffing, rotas and training. She added that an efficiency project is also underway. The EMD advised that it was not clear from the action plan what success would look like, how it would be monitored and what the targets are. The MM advised that she would feed this back. The Chair advised that the Clinical Director had asked that the deep dive take place. The Chair added that she had chaired the meeting and that the DC had also attended the meeting. The Chair advised the monitoring needs to be tight and the area cannot be allowed to slip backwards. The LSEE advised that the findings of the deep dive need to be fed back to the directorate for factual accuracy checking first and then a review of what support will be available for the area will be carried out. The DC added that the report showed that there had been no patient safety concerns. The EDNW advised that he would meet with the EMD and the LSEE to discuss this further. The Chair asked that an Executive Summary be presented at the next Committee meeting.

The NED advised that a summary would have been helpful and asked that every single paper have a summary sheet going forward.
***Action Note**: All papers to have a summary sheet.*

Action by PA

14/293	**MATERNITY – UPDATE REPORT**

The HOM attended the meeting and updated the Committee on the Quality Report, Healthwatch and the Friends and Family Test.

Quality Report – The HOM advised that the small numbers make a big difference to the figures and although month by month they give a trend, the quarterly figure should be noted. The HOM added that the Trust compares very favourably with other Trusts in the region. The HOM advised that breast feeding continues to be a challenge however a lot of work is being done and she is confident that there will be an increase. She noted that the Trust's breastfeeding figure for July 2014 was 80% which compared to 72% for NHS England. The HOM advised that staff are being recruited to be breast feeding champions, and that there is more infrastructure in the community with more clinics and staff to help and advise women on breast feeding. The HOM advised that the Head of Maternity from Southampton had recently visited the Maternity Unit and was impressed by the Trust's figures. The HOM acknowledged that improvements are required and that the team are striving to achieve this.

Healthwatch – The HOM presented the Committee with some background information regarding he Healthwatch surveys. The HOM advised that the report had overall been favourable with five recommendations and presented the response plan for those recommendations.

The Healthwatch report can be accessed via the following link:

http://www.healthwatchisleofwight.co.uk/sites/default/files/maternity_report_amended_final.pdf

HIW advised that the plan had been received and confirmed that there will be a further visit. HIW advised that Healthwatch England has asked to be able to quote this report in their annual report.

Friends and Family Test – The HOM explained to the Committee the number of surveys that women have to complete advising that they are asked to complete 6 or 7 evaluation tools and think that completing one is all they need to do. The HOM advised that she had benchmarked the unit with other Trust's who were concentrating on their hospital sites however it was noted that work still needed to be done in the Community. The HOM advised the Committee that the cards are given to women, that they are in newsletters, the doctors give them out and that volunteers, housekeepers and HCAs will be asked to help. The HOM added that the possibility of the cards being colour coded was being looked into. The EDNW advised that it was important that administration staff also supported this and ensured that the number of cards given out by them matches the number of women that they book in.

14/294	**HEALTHWATCH VISITS ACTION PLANS**

The MM updated the Committee on the action plans following the Healthwatch visits to MAU, St Helens and Colwell. She advised that the MAU action plan was complete and that some of the actions for Colwell were ongoing ie relating to safer staffing. The MM added that the visit to St Helens had resulted in two actions which had been addressed at the time of the report in April 2014.

The NED highlighted nutrition and hydration and advised that separate initiatives should be linked and owned across the wards. The EDNW confirmed that the intentional rounding tool is in place and the completing criteria is being reviewed. The EDNW advised that the Business Case for the Nutritional Post is being drafted and asked the LSEE to chase this.

***Action Note**: LSEE to chase Business Case for Nutritional Post.*

Action by LSEE

The Chair advised that she had visited MAU yesterday and reported that the ward was very busy but things appeared to be running smoothly and that the move had gone well. The MM advised that the move was temporary until August 2015.

14/295	**UPDATE REPORT – APPLEY WARD**
	The MM advised that the directorate would provide an operational update at the September 2014 meeting. The LSEE advised that monitoring is continuing. ***Action Note**: Update to be provided at September 2014 meeting* **Action by MM**
COMMUNITY AND MENTAL HEALTH DIRECTORATE	
14/296	**QUALITY, RISK AND PATIENT SAFETY COMMITTEE**
	The AHOCC apologised for the lateness of the papers. The Chair reinforced the importance of papers being received in time. The AHOCC presented the minutes of the MHLD and Community Clinical Quality, Risk and Patient Safety Committees held in July and highlighted the following: <u>Mental Health</u> 1. Critical staff levels in CMHS – plan in place and sickness being managed. 2. Seclusion room door – waiting for repair, each case being risk assessed. <u>Community</u> 1. Pressure ulcers – monitoring continuing at weekly meetings and working with nursing and residential homes including them as part of RCA meetings. The AHOCC confirmed that OT are involved. 2. Safeguarding – recruiting to vacant position and a business plan is being drafted for more support.
14/297	**STRENGTHENING THE COMMITMENT REPORT – UPDATE ON PROGRESS**
	The LN updated the Committee on the Strengthening the Commitment Report giving a background and highlighting the recommendations. The LN highlighted the challenges with recruitment of Learning Disabilities (LD) Nurses and explained how the Trust's LD Liaison Nurse shares skills with the Dementia Nurse.
PATIENT SAFETY	
14/298	**SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – ON LINE AND IN PROGRESS**
	The PEL advised that there had been 8 SIRIs during July 2014, six of which were pressure ulcers, one unexpected death and one patient fall. The PEL advised that three SIRIs were open from 2013 and in total there were 37 open cases. The PEL advised that she had included benchmarking data however because of the uniqueness of the Trust it was difficult to compare data. The Committee agreed that the Trust is a good reporter and that the report was very helpful. The EDNW advised that the Chief Nursing Officers in the region had agreed to share such information directly and this should be included. The NED noted that grade one pressure ulcers were increasing with grades 3 and 4 decreasing. The Committee agreed that this was evidence of preventative work.
14/299	**SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – TO BE SIGNED OFF**
	The PEL reported that there were five SIRIs to be presented to the Committee for sign off. <u>Hospital and Ambulance Directorate</u> 2012/25470 – the Committee discussed the need for spirometry in this case and the EDNW advised that it was not realistic for all staff to be trained in this and that the action should reflect this. Sign off was approved.

	2013/10412 – the Committee discussed the pain management and advised that they were not clear on how the patient's pain was managed. The MM advised that she would feed this back. Sign off was approved. 2012/18540 – the Committee reviewed the Risk Summit Meeting notes. The EDNW asked the LSEE to ask the Clinical Lead for SEE to review SIRIs where it had been identified that there had been a failure to identify a deteriorating patient. He added that wider work was required around this with Education and Training. 2012/24507 – the Committee reviewed the Risk Summit Meeting notes. The Committee approved SIRIs 2012/18540 and 2012/24507 on the proviso that this was an ongoing piece of work and an update would be provided to the Committee at the October 2014 meeting. The EMD advised that it was not clear regarding the pathway of level 2 care patients after surgery and asked if there was a Policy. The EMD asked that evidence for assurance be provided for the September 2014 meeting. ***Action Note**: The MM to provide assurance to the Committee at the September 2014 meeting.* **Action by MM** <u>Community and Mental Health Directorate</u> 2013/31971 – KM updated the Committee and advised that a lot of the lessons learned were around education. Sign off was approved. The EDNW advised that he could sense a change in pace for the reduction of pressure ulcers. The EDNW advised that the first Pressure Ulcer Open Day would be held on 29 August 2014 and that he would share the details of this with the Committee. He asked that a "well done" message be fed back to the team.
14/300	**RCA INVESTIGATION REPORT**
	To be discussed at a future meeting.
14/301	**PRESSURE ULCER EXTERNAL REVIEW – ACTION PLAN**
	The LSEE advised that this action plan had been devised following the external review by Dr L McGuiness. The LSEE advised that there were a number of recommendations with five key themes. The LSEE advised that the recommendations link in with the campaign.
14/302	**INFECTION, PREVENTION & CONTROL – ANNUAL REPORT**
	The IPC Dr presented the Annual Report to the Committee. She advised that this provided a review of infection prevention and control and Healthcare Associated Infection (HCAI) for the period of 1 April 2014 to 31 March 2014. The CM added that the report included what had been done well, what needed further work, a summary of IPC audits and HCAI rates. The CM advised that there were policies and procedures in place however there was still work to be done. The DC advised that this was a very interesting report that read well. The Committee discussed ward quality summits and infection control action plan elements and link nurses. The CM advised that there is an intention to have link nurses but there were problems with attendance at training. The LSEE advised that with safer staffing levels this will improve. The Committee discussed IT support and the CM advised that she is due to meet with the Executive Director of Transformation and Integration and a business case is being written at the moment. The Chair advised that it had been helpful to have members of the Infection Prevention and Control Team at the risk summit meeting and asked that her thanks be fed back to them.
14/303	**INFECTION PREVENTION AND CONTROL – EXTERNAL REPORT – ACTION PLAN**
	The CM presented the action plan to the Committee and advised that this action plan had been drafted following the TDA infection Prevention and Control Review in February 2014.

PATIENT EXPERIENCE	
14/304	**PATIENT STORY – UPDATE ON PATIENT STORY FROM JULY 2014 MEETING**
	The WS attended the meeting in response to the relative's story viewed at the July 2014. She advised that the team had met and that they were working hard as a team and a huge amount of work had been done. The EDNW thanked the WS for attending the meeting and advised that he had also met with the team. The EDNW advised that he had met with the patient's relative who had been very complimentary about some of the good care that the patient had received and that she wanted to help fix some of the issues. The Committee agreed that seeing the patient or relative before they left the ward would have helped and discussed options including an appointment system for the Ward Sister. It was agreed the relative in this case would continue to support the PEL and lessons in this case would be shared. It was also agreed only Patient Stories and not relative stories would be provided to the committee and board.
14/305	**PATIENT STORY**
	This item was not discussed due to time constraints.
14/306	**PATIENT EXPERIENCE – QUARTER 1 REPORT**
	This item was not discussed due to time constraints.
14/307	**COMPLAINTS – QUARTER 1 REPORT**
	This item was not discussed due to time constraints.
CLINICAL AUDIT AND GOVERNANCE	
14/308	**GOVERNANCE AND ASSURANCE REPORT**
	This item was not discussed due to time constraints.
14/309	**FINAL INTERNAL AUDIT REPORT – WARD VISITS 2014/15**
	This item was not discussed due to time constraints.
SUB COMMITTEE GROUPS	
14/310	**JOINT SAFEGUARDING STEERING GROUP – MINUTES OF JULY 2014 MEETING**
	This item was not discussed due to time constraints.
14/311	**SEE COMMITTEE AND QCPC TERMS OF REFERENCE**
	The Committee reviewed the SEE and QCPC Terms of Reference and they were agreed. The HCOG pointed out that Clinical Audit remained with QCPC and that Clinical Directors would be deputised by Associate Directors.
CLINICAL PERFORMANCE AND RISK	
14/312	**TDA SELF CERTIFICATION**
	This item was not discussed due to time constraints.
14/313	**ANY OTHER BUSINESS**
	The NED highlighted information governance as documentation is a regular theme in action plans. The Chair advised that this is being reviewed by the Audit Committee to look at streamlining the process.

	The Committee discussed the evaluation sheets received at the end of the July 2014 meeting. The comments received have been collated and will be circulated. **Action: PA** The Committee discussed the possibility of not having a meeting in August due to annual leave or having the meeting bi-monthly. The AHOCC advised that the HOCC is returning to her role and will be attending the September 2014 meeting. The Chair thanked the AHOCC for her input into the meetings.
14/314	**DATE OF NEXT MEETING**
	Wednesday 17 September 2014 9 am to 12 Noon Conference Room
	Signed: _____ Chair Date: _____

Isle of Wight NHS Trust

For Presentation to Trust Board on 27th August 2014

FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE MEETING

Minutes of the Isle of Wight NHS Trust Finance, Investment, Information & Workforce Committee (FIWC) meeting held on Wednesday 20th August 2014 in the Large Meeting Room.

PRESENT:	Charles Rogers	Non-Executive Director (Chair) (CR)
	David King	Non-Executive Director (DK).
	Chris Palmer	Executive Director of Finance (EDOF)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Kevin Curnow	Deputy Director of Finance (DDOF)
	Mark Elmore	Deputy Director of Workforce (DDW)
	Andrew Heyes	Head of Commercial Development (HoCD) *deputising for (Katie Gray, EDTI)*
In Attendance:	Neil Fradgley	Commissioning Manager and Controller (CM&C) *(Items 14/126 & 14/131)*
	Jackie Skeel	Assistant Director for Organisational Development (ADOD) *(Item 14/127)*
Minuted by:	Sarah Booker	PA to Executive Director of Finance (PA-EDOF)

To be Received at the Trust Board meeting on Wednesday 27th August 2014
Key Points from Minutes to be reported to the Trust Board

14/129 **CIPs.** **The Trust is reporting CIP achievement of £3.211m against a target of £2.260m. This is c.£951k ahead of plan. Although, this is after £1.683m of future banking. This recognises the full budget removal of achieving CIP plans in advance of the original schemes phasing. The work of the Transformation Management Office (TMO) and supporting resource is tasked with providing the Board with assurance of the achievable savings this financial year.**

14/127(c) **Drug and Alcohol Policy**

The Committee has learnt and is very concerned that the Trust does not have a Drug and Alcohol Policy.

14/133 **Self Certification.**

The Committee did not have sufficient understanding of the reasons for the change to Board statements and therefore were unable to agree the Self Certification return or recommend these to the Trust Board.

Business Cases

The Committee has made recommendations for two business cases that are to be presented to Part 2 of the Board.

14/120 APOLOGIES

Apologies for absence were received from Jane Tabor, Non-Executive Director (JT) and Katie Gray, Executive Director of Transformation and Integration (EDTI).

14/121 CONFIRMATION OF QUORACY

The Chairman confirmed that the meeting was quorate.

14/122 DECLARATIONS OF INTEREST

There were no declarations.

14/123 APPROVAL OF MINUTES

The minutes of the meeting held on the 23rd July 2014 were agreed by the Committee and signed by the Chairman.

14/124 SCHEDULE OF ACTIONS

The Committee received the schedule of actions taken from the previous meeting on 23rd July and noted the following:

14/081 NHS Creative Performance and Budget Update - The Internal Audit report was reviewed during the Audit and Corporate Risk Committee meeting which took place on 19/08/14 and is included on the FIIWC agenda today. Action closed.

14/092 Workforce Performance Report – The DDW has passed on JT's recommendation of the managers of the areas with 100% training compliance to be praised to the ADOD to action. Action closed.

14/092 Safer Staffing Update – The EDNW confirmed the figures regarding bed numbers are now accurate in the paper. Action closed.

14/125 LONG TERM STRATEGY AND PLANNING

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

The DDOF and the EDOF recently met with Sue Eggleton (SE), Business Director for the Trust Development Authority (TDA) and Daniel Stephens, Business Consultant for the TDA who recommended the Board have further understanding and engagement on the LTFM downsides. This will take place during a future Board Seminar meeting which will be attended by SE who will present to the Board and provide coaching to the members on the downside scenarios.

Action: DDOF to liaise with the Company Secretary to agree a suitable date for SE to present at a Board Seminar and the DDOF will liaise with the EDTI and HoCD to link this in with the Strategy Day.

14/126 CONTRACTS AND ACTIVITY

(a) Contract Status Report Summary:

The Committee commended the revised layout of the report which provides sufficient information in an easy to read format. There were no further comments on this report from the Committee members.

(b) Operational Performance including SLA Activity:

The CM&C attended to brief the Committee on the SLA activity as detailed in the report. CR questioned whether the Trust re-forecasts the income during the year. The EDOF explained the funding provided by the CCG is protected income (included in the Risk Share agreement) apart from any fines. The CM&C explained the CCG contract year-to-date (YTD) penalties of £14k in Planned primarily relates to missed cancer targets and the £52k in Unscheduled is primarily regarding ambulance handover delays. The EDOF recommended the Committee is aware of NHS England contractual variance including Neonatal, Intensive Care Unit activity and other areas which are not covered by a Risk Share Agreement and could potentially lose income.

CR questioned what the impact of the Breast Screening service shutdown meant. The EDNW explained the service was repatriated from Southampton back to the Island and although there is a commitment to see patients within a certain period for a follow up appointment we could still meet this requirement and enable the service shutdown from April – June. This resulted in a £150k underperformance YTD as no income was generated during the shutdown period.

The Committee had no further queries regarding the report and noted their approval of the report format.

14/127 WORKFORCE PERFORMANCE REPORT

(a) Workforce Performance Report including SBS Payroll Report:

The DDW briefed the Committee on the Workforce report and highlighted the following:

- Sickness absence has increased from 3.49% to 3.72%.
- The paybill in month is below target and further work will be carried out next month to look into medical vacancies and locum costs which will be reported to the Committee in the near future.
- **The DDW is in discussions with Sam Lambert, Payroll Manager for Shared Business Services to gain further narrative on the payroll dashboard. The DDW will bring the revised dashboard to the next Committee meeting. Action DDW.**

The EDNW raised his concern at the level of overtime usage and noted this will need to be investigated to find out which areas are using overtime and the reasons why. Action: DDW/EDNW.

(b) Safer Staffing Business Case:

The EDNW updated the Committee on the paper and explained the initial project objective is to secure (after quantifying the actual amount) funding from the Isle of Wight Clinical Commissioning Group (CCG) to implement the first phase of recruitment to take place up to the end of March 2015. The 4 options were discussed by the Committee and the EDNW drew the Committee's attention towards the benefits and impact of each option. The EDNW discussed the recruitment requirements detailed in option 4 which focuses on the establishment of a recruitment team and will access overseas agencies to support recruitment.

The EDOF questioned the addition of accommodation costs and the DDW confirmed these could be removed from the costings as there is no requirement to fund these costs. The placement costs are the costs to the agency when the candidate arrives in the UK which is approximately £4k per person.

The EDOF asked whether we would be required to pay relocation costs but the DDW confirmed 30 nurses will come to the UK as a cohort from overseas and therefore it will not be applicable.

The EDNW explained the nurses would need to have a period of adaptation if they are from overseas with a 12 week supervised practise with a reduced salary and will need to spend time in the classroom during their first year which will be paid for by the candidate.

The EDNW clarified that we are seeking Board approval to submit the business case to the CCG to receive the funding as outlined in the Financial Framework Agreement to support the additional costs of Safer Staffing. Once we have the agreement from the CCG the Board will be asked to consider the approach to be taken to seek the staffing required.

DK questioned the process on non-performance. The DDW explained there will be a probationary period of 3 months and if there are any issues staff can be dismissed and returned home.

The DDOF suggested the plan is linked to the Trust Strategy Day in September to discuss the impact of not being able to source the nurses or the funding.

CR requested the paper is simplified.

The EDNW confirmed the paper will be discussed at the TEC meeting on the 8th September and will return to FIIWC for discussion in September. It will then be sent to the Trust Board at the end of September to formally seek approval for the funding and recruitment.

(c) Staff Survey Action Plan:

The ADOD noted the terms of reference for the Culture, Health and Wellbeing Committee are currently being revised as the structure is not yet robust. The ADOD highlighted the key areas of work that are being

undertaken and discussed the number of staff surveys that had been completed over quarter 1 and 2.

CR questioned whether there is an opportunity to identify any trends in areas where staff are approaching the HR, Occupational Health and Education Teams in distress for support. The EDOF asked where this is reported and shared and whether the Board should be made aware of any areas in particular. The EDNW noted the current policy protects staff who should be using the correct route. **The ADOD will discuss the process of the Trust Board being made aware of this further outside of this meeting. Action: ADOD.**

The EDOF asked whether there is now a drug and alcohol policy in place whereby staff can be randomly tested. The EDNW confirmed there is not yet a policy in place and CR will report the lack of this policy to the Trust Board at their meeting next week. Action: CR. The EDNW will ensure this policy is completed and forwarded to the Policy Management Group as soon as possible. Action: EDNW.

The ADOD will return to the FIWC every 3 months to report on the action plan to seek approval on a regular basis.

14/128 TRANSFORMATION MANAGEMENT OFFICE

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

No report was received by the Committee and the HoCD briefly explained the current status of the Transformation Management Office. The EDTI has procured Consultants from KM & T Healthcare to work with the TMO office in reviewing CIPs. This will give confidence, understand the risks, identify any gaps and look at new schemes. **The EDTI will report back to this Committee next month. Action: EDTI to establish robust process and documentation.**

(b) <u>Capital Planning:</u>

The HoCD noted the Capital Plan is on track. A timing risk has been identified regarding Level C. The reconfiguration is being looked into by EDNW and the Associate Director for Hospital and Ambulance Clinical Directorate and the EDNW will report back to this Committee next month. Action: EDNW.

The DDOF queried whether the plan is revised during the year and whether we report against the original plan or a new plan. EDOF confirmed the plan will remain as per the original so that variances are shown against that. CR noted the Committee would be looking for assurance that the plan in place is manageable.

DK asked whether we receive better business cases now. CR and the EDOF noted they are getting better but there is still further work to do on them.

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

The HoCD presented the CIP report for Month 4. There was a discussion around the summary spreadsheet included in the papers as the figures do not match the detailed report. The EDOF recommended this report is validated by the Finance team and that the Transformation Team should own the process around the reporting of risk and achievement of schemes with validation of figures from the Finance team prior to these reports being shared.

The Committee were in agreement that there is further work required to provide sufficient information to the Committee each month. Action: EDTI.

No papers were received for Enclosures H and I.

14/129 FINANCIAL PERFORMANCE

(a) **Financial Performance Report**

The DDOF briefed the Committee on the Finance Performance Report for Month 4 and highlighted the current position which indicates a surplus of £783k which is £17k ahead of plan. This includes the forward banking of CIP amounting to £1,683k. The non-recurrent element of the CIP position is causing an underlying deficit.

The cash-in-bank is good at £10m and this healthy position should be retained at least for the next 3-4 months.

The deep dive meetings are responsible for looking into budget overspends and CIP delivery to ensure directorates are not overspending on their budgets after delivering their CIPs.

The Committee agreed, subject to finance validation, the TMO should provide the Capital Plan in their report to the Committee and it will therefore not be required in the Finance report to avoid duplication. Action: HoCD/EDTI.

(b) 90 Day Debtors List

The DDOF explained the Trust Development Authority set a target of 5% for outstanding debts and we are currently at 6%. The figures have been reduced considerably over the past few months and the Committee agreed this report should only be received at the FIIWC meeting by exception including an explanation of why we are over target.

The HoCD asked whether Mottistone has improved on the outstanding debts owed by insurance companies. The DDOF confirmed this has improved but there is more work to do on this. There is a policy in place whereby Mottistone take a deposit prior to treatment and this policy will be received by this Committee in September. Action: HoCD.

(c) Cash Flow and Investment Proposals

The Committee did not require any further information on this report.

14/130 AUDIT AND GOVERNANCE

(a) Audit Committee Handbook Assurances:

The Committee discussed the Audit Committee assurances and agreed the FIIWC will incorporate the relevant requirements in the Committee schedule.

The EDOF suggested the FIIWC should review the Asset Register policy and process for assurance rather than the actual register.

The Committee noted the timing issue as the Audit and Corporate Risk Committee was held the day before this meeting as usually the FIIWC should take place prior to the Audit meeting. **Action: Company Secretary to amend.**

(b) NHS Creative Audit Report:

The Committee agreed there were no further comments to be made on the report as it was discussed in detail during the Audit and Corporate Risk Committee meeting which took place yesterday.

14/131 INFORMATION

(a) Data Quality:

The CM&C briefed the Committee on the data quality report which details the analysis of provider data submitted to the Secondary Uses Service (SUS). They review 3 main data sets which are Admitted Patient Care (APC), Outpatients (OP) and Accident and Emergency (A&E). Overall the data quality reporting to SUS has improved slightly compared to 2013/14. The CM&C explained the areas which require attention and the action plan to address the backlog in Clinical Coding and to review the missing Commissioner codes in the A&E dataset.

DK queried how the backlog will be addressed. The CM&C said there should be zero backlog but there is an issue in getting discharge papers completed. Delayed discharge summary reports are sent out to Consultants on a daily basis to keep them informed.

The Committee requested a summary of these reports is brought to this meeting in September. Action: CM&C.

14/132 INVESTMENT / DISINVESTMENTS

(a) Procurement Status Report:

No comments were noted from the Committee members on this paper but the Committee approved the revised format of this report.

14/133 SELF CERTIFICATION REVIEW

The Committee received and discussed the Self Certification report. **Action: After a discussion the Committee did not have sufficient understanding on the self-certification review and were therefore unable to approve the self-certification return or recommend this to the Trust Board.**

Action: The PA-EDoF to inform the Programme Manager and request a clearer explanation by summary of the reasons why certain Board statements have been changed to being 'at risk' and to invite the Programme Manager to each meeting to explain any changes to ensure clarity for the Committee.

14/134 COMMITTEES PROVIDING ASSURANCE

(a) Minutes from the Capital Investment Group

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

14/135 ANY OTHER BUSINESS

Nothing to report.

14/136 DATE OF NEXT MEETING

The Chairman confirmed that next meeting of the Finance, Investment & Workforce committee to be held is on Wednesday 17th September 2014 from 12.30pm – 3.30pm in the Large Meeting Room.

The meeting closed at 5.00pm.

Isle of Wight NHS
NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 27 AUGUST 2014

Minutes of the Isle of Wight NHS Trust **Mental Health Act Scrutiny Committee** held on Wednesday 6th August 2014 in the Family Therapy Room, Sevenacres

PRESENT:	**Jessamy Baird**	**Chair, Designate Non Executive Director (JB)**
	Stephen Ward	**Mental Capacity Act & Mental Health Act Lead (MML)**
	Tracey Hart	**Approved Mental Health Professional (AMHP)**
	Simon Dixey	**Consultant Psychiatrist, Memory Service (CP)**
	David Sellers	**Modern Matron, Sevenacres (MMa)**
	Jan Gavin	**Independent Mental Health Advocate (IMHA)**
Minuted by:	**Alison Hounslow**	**Administrator**

Key points from Minutes to be reported to the Trust Board

14/018 **Terms of Reference** - This meeting was not quorate. The requirements are that two Non Executive Directors should attend in addition to the Chair and the MML. Due to NEDs other commitments this is unachievable.
Recommendation: review TOR at Audit Committee in November and suggest Quorum is Chair, one NED, MHA/MCA Lead, plus one clinical member of staff, and one service user/carer/advocate member.

14/020 b) MH/005 - **Lack of Section 12 qualified doctors**
One General Practitioner (GP) has completed Section 12 training and applied for approval. Approved Mental Health Professionals (AMHPs) often experience difficulty obtaining the services of a GP for a Mental Health Act Assessment (MHAA). A representative of the Clinical Commissioning Group (CCG) is to attend the next AMHP meeting on 18th August.

d) MH/012 - **Service User Involvement Policy**
Service User and Carer Link Co-ordinator (SUCLC) is to meet with Communications Department for re-drafting of this policy. It will then go to the Quality and Clinical Performance Committee for signing off. The Committee agreed that it is essential to support this policy to ensure genuine involvement of service users in our mental health services and the use of the MHA. The policy will be reviewed after 6 months.

14/021 **Operation Serenity** - Funding has been made available by Commissioning from mid-June onwards for another year. This will maintain the existing level of Operation Serenity which is for Wednesday, Friday and Saturday nights to be covered by the Crisis team. The Operation Serenity benefits are not realised the remaining days of the week, but Crisis Team members work to support the partnership on those nights through other mechanisms as best as they can. An ongoing evaluation of the impact of this is underway.

14/022 **The implications of the Mental Capacity Act** were discussed regarding the usage and level of knowledge that is apparent in areas of the hospital outside the Mental Health Services. Staff are not sufficiently trained in the Mental Capacity Act and the implications it has on day to day care of

patients. An action has been raised to ensure linkage of the MH team to the dementia liaison and safeguarding team, placing mental capacity within mandatory training for all staff.

14/023 **Care Planning and Paris** - Care plan and risk assessments are currently unavailable on Paris thereby hampering recording and subsequent review. Any change requirements to enhance the ability of staff to make the best use of the system for service users, should be identified and included in capital plans for PARIS and its ongoing implementation.

14/018 Apologies for Absence, Declarations of Interest and Confirmation that Meeting is Quorate

Apologies for absence were received from:

Mark Pugh, Tim Higginbotham, Su Morris, Nina Moorman, Christine Gardner, Julia Coles.

A Declaration of Interest was received from Jessamy Baird, who has full time involvement within the pharmaceutical industry.

The meeting was declared not quorate as two Non Executive Directors were not present. The requirements are that two Non Executive Directors should attend in addition to the Chair. Due to other commitments this is unachievable. Due to the meeting declared not quorate, these minutes will need to be ratified by the Trust Board.
Action Note: JB to take Terms of Reference to Audit Committee for review.
Action by JB

14/019 Minutes of the previous meeting - 16th April 2014

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

14/020 Review Schedule of Actions

a) MH/002 - Audit of Section 17 leave

This audit of Section 17 leave and associated risk assessments is still outstanding. A change to the Section 17 leave process has recently been introduced and it was suggested that data a month prior to policy change is audited to compare with data collected after the policy change.
Action Note: CP to discuss with Dr Yoganathan. To be raised at October meeting.
Action by CP

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

One General Practitioner (GP) has completed Section 12 training and applied for approval. Approved Mental Health Professionals (AMHPs) often experience difficulty obtaining the services of a GP for a Mental Health Act Assessment (MHAA). A representative of the Clinical Commissioning Group (CCG) is to attend the next AMHP meeting on 18th August.

The payment of Doctors can cause difficulty. Currently if a patient is open to Mental Health Services the first Doctor is not paid. Some Doctors, when covering a ward on behalf of a colleague, refuse to participate in a MHAA unless they are to be paid. It was suggested that a log is kept when these incidents occur and should be on the Trust Risk Register.

Action Note: MML to forward this matter to the Trust Risk Register.

Action by MML

c) MH/006 - Community Treatment Order Audit

This audit is currently being undertaken by Dr Yoganathan.

Action Note: The results to be shared with the October meeting if available.

Action by MML

d) MH/012 - Service User Involvement Policy

Service User and Carer Link Co-ordinator (SUCLC) is to meet with Communications Department for re-drafting of this policy. It will then go to the Quality and Clinical Performance Committee for signing off. The Committee agreed that it is essential to support this policy to ensure genuine involvement of service users in our mental health services and the use of the MHA. The policy will be reviewed after 6 months.

Action by SUCLC

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

Action Note: To be discussed in October meeting.

Action by SUCLC

f) MH/021 - Audit of risk assessments

The data is now available and the audit is to be completed.

Action by MML

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

Anonymous reports were to be selected and presented to Doctors during training. There is now going to be an audit of medical recommendations which will be undertaken by Dr Sharif. Copies of medical recommendations are being kept by the Mental Health Act Office and these will be compared to a gold standard ensuring that criteria are complied with. Guidance has been distributed to doctors and it was suggested that samples of medical recommendations are made available to Doctors for discussion and review.

Action by MML

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

There will be a two hour training session at the Board Seminar on 11th November to which Associate Hospital Managers and Non Executive Directors will be invited.

Action by MML

14/021 Operation Serenity

Funding has been made available by Commissioning from mid-June onwards for another year. This will maintain the existing level of Operation

Serenity which is for Wednesday, Friday and Saturday nights to be covered by the Crisis team. For the remaining nights of the week, Crisis team members can be called upon by Police if needed. Problems raised by the multi-disciplinary approach to Operation Serenity are brought to the monthly Operation Serenity Delivery meeting.

14/022 Deprivation of Liberty Safeguards

The implications of the Mental Capacity Act were discussed regarding the usage and level of knowledge that is apparent in areas of the hospital outside the Mental Health Services. Staff are not sufficiently trained in the Mental Capacity Act and the implications it has on day to day care of patients.

MML is undertaking a considerable amount of training; this needs to be disseminated by senior staff. Involvement of Dementia Liaison Team and Safeguarding are also required.

Action by MML

ANY OTHER BUSINESS

14/023 Care Planning and Paris

Care plan and risk assessments are currently unavailable on Paris thereby hampering recording and subsequent review. Any change requirements to enhance the ability of staff to make the best use of the system for service users, should be identified and included in capital plans for PARIS and its ongoing implementation.
Action Note: To be discussed in October meeting.

Action by JB

14/024 Care Planning and Confidentiality

It was suggested the module of training regarding information sharing for staff is shared with carers. There is currently a 'Triangle of Care' project underway.
Action Note: To be discussed in October meeting.

Action by MML

DATES OF NEXT MEETING

The next meeting of the Mental Health Act Scrutiny Committee is to be held on Wednesday 22nd October 2014 in the Family Therapy Room, Sevenacres.

Meeting closed at 11.20

Glossary:

MHA A	Mental Health Act Assessment
CCG	Clinical Commissioning Group

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 27 August 2014

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

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	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 an overview of the 8 Serious Incidents reported during July 2014, as well as identifying the lessons learnt from SIRIs closed by the commissioner during July 2014.

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

Date: 14 August 2014 **Completed by:** Vanessa Flower Quality Manager

Isle of Wight NHS Trust

Isle of Wight NHS Trust
Serious Incident Requiring Investigation (SIRI) Report
Isle of Wight NHS Trust Board – 27 August 2014
Reports of SIRIs for July 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 July 2014 the Trust reported **8** Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG) and are all currently under investigation using Root Cause Analysis (RCA) methodology.

2.2. The incidents reported by category were:

2.2.1.	**Category 3 and 4 Pressure Ulcers:**	
2.2.2.	6 Pressure ulcer incidents were reported, five were a grade 4 (most severe) with 1 being a grade 1.	Grade 4 Pressure Ulcer to Sacrum developed whilst under care of the IOW NHS Trust. Grade 3 pressure ulcer to sacrum developed whilst under care of the IOW NHS Trust.
2.2.3.	**Unexpected Death:**	Patient known to have a hospital acquired infection; subsequently fund deceased at home. In line with the national SIRI reporting guidance states these must be reported to commissioners and investigated.
2.2.4.	**Patient Fall:**	Patient fell out of bed resulting in fracture neck of femur. In line with the national SIRI reporting guidance states that these must be reported to commissioners and investigated.

3. SIRIs to be signed off:

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

4. At their meeting on 18 July 2014, the Quality and Clinical Performance Committee approved the completed action plans related to 2 incidents.

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

Theme	Learning
Safeguarding Vulnerable Adult	
Communication	· Improve interaction and communication between multidisciplinary teams to ensure that agreed plans are enacted and opinions recognised. .
Patient pathway	· Improve Spinal Tertiary Referral Pathway. Development of a Standard Operating Procedures (SOPs) with patient pathways, transfer criteria and procedures for joint care for patients remaining in the referral centre. · Improve Consultant continuity of care · Use of inter-consultant referral forms for URGENT referrals
Outbreak of Norovirus	
Extensive action plan being monitored in relation to following key issues: · Outbreak Recognition · Isolation · PPE use · Cohort Nursing · Visitor restrictions · Impact on patients · Impact on staff · Hand washing · Cleaning · Supplies/Equipment · Communications · IPCT specific issues · Outbreak meetings · Case recognition	
Pressure ulcers	
Documentation	· Community Nursing Health Assessment documentation to be completed by the second visit as standard operating process. · Pressure Injury information leaflet to be given to Care Home/carers. · To work with care homes when completing the timeline to ensure that all relevant information is collated and lessons learnt can be disseminated across care agency too · Ensure position changes are recorded appropriately
Education	· Improve accuracy of grading pressure ulcers across the Trust · Regular weekly review of Waterlow Scores · Case management of patient by a Community Matron to track patients' journey (No overall case management which may have reduced medical input)
Slip, Trip, Fall	
Equipment	· The hoverjack should be used to transfer patients from the floor
Documentation	· Staff need to ensure falls risk assessments are revised when an incident has occurred that may affect a patient's mobility

Clinical care	· Nurses need to feel empowered to raise concerns around clinical care of a patient (divergence in clinical opinion in appropriate levels of analgesia). · The emergency transfer of patients**,** and the processes that need to be followed**,** need clarification for all ward staff.
Unexpected death	
Training	· Individual training identified; 1:1 updates in Adult Life Support and Deteriorating Patient Competency · Ward commenced undertaking the Deteriorating Patient Competency for all staff. As of 28.04.14 - 78% of staff had passed this competency assessment (Update: 27/5/14 - 95% completed) · Further education given to Communication Centre staff that cover switchboard operators breaks in how to correctly put out a Cardiac Arrest bleep
Clinical care	· MEWS Red Card System instigated. For all patients with MEWS of 3 or above the person completing the observations was required to complete a few brief notes on a magnetised Red Care that was placed prominently over patient's details on Patient Status at a Glance (PSAG) Boards within the Unit, so all staff could see easily which patients had a MEWS of 3 or above. However, since introduced PSAG Boards have been replaced by electronic ISIS PSAG Screen and currently there is no way of flagging a patient in red with a high MEWS. The new MedePad system is being trialled and it is intended to forge a link between the electronic recording of observations and an instant MEWS message alert on ISIS screen. Meanwhile an urgent alternative electronic flagging system on ISIS is being investigated.

Alan Sheward
Executive Director of Nursing & Workforce
14 August 2014
Prepared by: Vanessa Flower, Quality Manager

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 27 AUGUST 2014

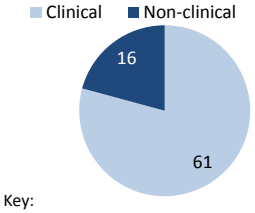
Title	Trust Board Walkabouts – Patient Safety Assurance Visits				
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing and Workforce				
Author(s)	Vanessa Flower, Patient Experience Lead				
Purpose	To provide assurance of progress of actions identified as part of the Patient Safety Assurance Visits Programme				
Action required by the Board:	**Receive**	P	**Approve**		
Previously considered by (state date):					
Trust Executive Committee			Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee			Remuneration & Nominations Committee		
Charitable Funds Committee			Quality & Clinical Performance Committee		
Finance, Investment & Workforce Committee			Foundation Trust Programme Board		
ICT & Integration Committee					
Please add any other committees below as needed					
Board Seminar					
Other (please state)					
Staff, stakeholder, patient and public engagement:					
Staff and patients where appropriate are engaged during the walkabout undertaken					
Executive Summary:					
The attached summary report identifies the number of visits undertaken since the process was implemented in February 2013, and includes the overdue actions that continue to be progressed following the visits undertaken. Of the 77 visits to date the majority have been to clinical settings with only 16 to non clinical areas, from the visits a total of 202 actions have been identified. At the time of reporting 9 actions remain overdue, 7 of which are green against the directorates revised timescale. Currently there are 10 feedback sheets outstanding on walkrounds that have taken place since the beginning of April 2014.					
For following sections – please indicate as appropriate:					
Trust Goal *(see key)*	Quality Goal				
Critical Success Factors *(see key)*	CSF1, CSF2 and CSF10				
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	10.75				
Assurance Level ***(shown on BAF)***	Red		Amber		Green P
Legal implications, regulatory and consultation requirements					

Date: 14 August 2014 **Completed by:** Vanessa Flower, Patient Experience Lead

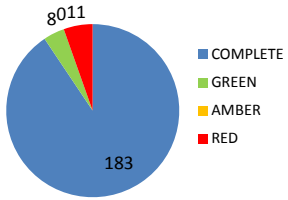
Board Walk Rounds Action Plan Status Report

Trust Overview

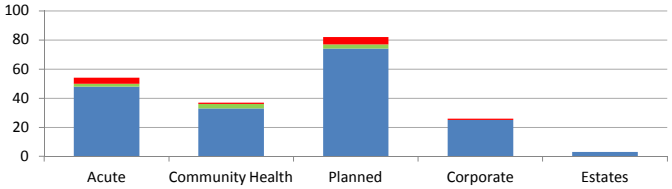
Areas visited



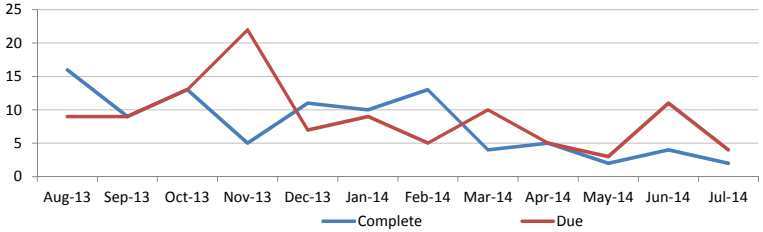
Status of actions



Directorate Profiles



12 month profile from: Aug-13 to Jul-14



Key:
Blue = Complete; Green = action not due; Amber = overdue against due date by < 14 days; Red = Overdue against due date by >14 days

Exception Report

No.	Action Reference	Walk Round	Area Visited	Action	Date for completion set by board	Directorate revised date	Status against date set by board	Progress against directorate revised date	Status Comments	Directorate	Responsible
1	AT/037/2013/007	13-Sep-13	Pathology	Concerns on reliability and cost of current courier service. Seek improvements with supplier liaising with solent supplies.	15-Nov-13	30-Sep-14	RED	GREEN	Update 29.07.14 - Advised that meeting has not yet taken place - will set date for meeting asap. Update 07.08.14 Discussions taken place with company - meeting scheduled for September 2014	Acute	Pathology General Manager
2	AT/037/2013/006	13-Sep-13	Pathology	Strong support for pathology paperless reporting. Develop plan for the implementation	15-Nov-13	31-Mar-15	RED	GREEN	Update: 20.05.14 As a result of extensive discussions and an understanding of hospital processes, the turning off of paper results is now scheduled to tie in with the roll out of Electronic requesting (Order Communications) which is expected by the the end of this financial year.	Acute	Deputy Director for IM&T
3	AT/05/2014/003	03-Mar-14	Endoscopy	Establish Estates support to decontamination facilities in view of regularity of breakdowns.	30-Apr-14	30-Sep-14	RED	GREEN	Update 07.08.14 GM has made assessment for requisition of scopes and made contact with procurement to chase rental options for machines and scopes. Awaiting answer from procurement. GM is assessing the number of scopes required for 2 days along with the rolling requirement and replacement of old scopes. Business case to be developed depending on outcome from procurement.	Planned	Endoscopy Unit Sister
4	AT/05/2014/002	03-Mar-14	Endoscopy	In view of period before transferring to new accommodation (approximately 2 years) develop a plan for short term improvements within current site and seek funding from backlog maintenance funding.	30-Apr-14	30-Sep-14	RED	GREEN	Update 30.07.14 Advised that a business case is being put together for the endoscope replacement. Update 07.08.14 GM advised that new build completion date is October 2015 and is currently exploring options for next year to take them to new build.	Planned	Associate Director - Medical, Emergency & Diagnostic Services
5	AT/02/2014/002	07-Feb-14	Early intervention in psychosis	Review issue of timely access to psychological therapist in view of the work going on with Capita	20-Jun-14	31-Jul-14	RED	RED	update 28.07.14 - Capita Meeting went ahead on 16th July. Psychology and Psychological Therapy is being reviewed internally to establish a new model for all cluster pathways, including Cluster 10 (EIP). Discussions still underway with commissions re provision of senior clinical lead within MH&LD as identified in Contract Query but no immediate funding stream identified.	Community Health	Acting Head of MH, LD and Community Patnerships

No.	Action Reference	Walk Round	Area Visited	Action	Date for completion set by board	Directorate revised date	Status against date set by board	Progress against directorate revised date	Status Comments	Directorate	Responsible
6	AT/07/2014/005	25-Apr-14	DSU	Pursue improved patient information leaflets	30-Jun-14	31-Oct-14	RED	GREEN	Update 28.07.14 Ward sister is currently in the process of ordering some up to date leaflets for patients for the reception area however many of the patient information leaflets/ guidelines on the intranet flag up as requiring updating. Ward Sister is going to delegate the design of a day surgery leaflet to senior members of staff.	Planned	Sarah Nolan - Ward Sister
7	AT/07/2014/004	25-Apr-14	DSU	Check requirements for kitchen area to improve IPC environmental audit	30-Jun-14	30-Sep-14	RED	GREEN	Update 28.07.14 The kitchen is currently meeting nearly all criteria for IC apart from some redecoration areas which have been reported to estates.	Planned	Sarah Nolan - Ward Sister
8	AT/07/2014/001	25-Apr-14	DSU	Stagger admissions to avoid patients waiting all day for planned procedure which is sometimes cancelled at last minute impacting on patients nutritional needs.	30-Jun-14	30-Sep-14	RED	GREEN	Update 29.07.14 Discussed in the theatre redesign meeting on the 1st of July. Discussions are ongoing and we are currently discussing bleeps/ mobile phone for patients on all day lists so that they all come in in the morning but can then leave after having all their paperwork complete. We can then phone/ bleep them when they need to begin making their way back in for surgery. Miss Allahdin is pushing this forward.	Planned	Sarah Nolan - Ward Sister
9	AT/09/2014/002	06-Jun-14	Transport	Review capacity v demand and the potential impact on discharges and patient care	31-Jul-14		RED			Acute	Chris Smith
10	AT/09/2014/001	06-Jun-14	Transport	Check delayed TTO with pharmacy	31-Jul-14		RED			Acute	Gill Honeywell
11	AT/06/2014/001	26-Mar-14	Human Resources	Clean carpets	31-Jul-14		RED	#VALUE!		Corporate	Deputy Director - Human Resources

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 27 AUGUST 2014

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

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

Staff, stakeholder, patient and public engagement:

Staff and patients are engaged in the process of patient stories allowing us capture patients experience. Volunteers and Patient Council Members have been trained to undertake the interviews.

Executive Summary:

The Board is asked to note that 2 actions remain overdue against timescales as per attached exception report.

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

To date10 stories have been shown at board with 17 actions being monitored. Work is underway to review the Patient Story Process and monitoring to provide greater assurance to the board on lessons learnt and actions taken.

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

Date 19.08.14 (revised 21.08.14) **Completed by:** Vanessa Flower, Quality Manager

Log No.	Date of Video	Area	Key Issue (s) raised	Date Reviewed at QPSC	Date Reviewed at Trust Board	Theme	Action to be taken following Board /QCPC review	Nominated Lead for Action	Target Date	Date action complete	Current Status	Comments / Status	Lessons learned/action taken
14	17-07-13	Chemotherapy	The Oncology Nurse only working one long day and 2 half days a week. When she was off on leave and then sick for a week there was a delay in getting back to the patient. There may have been an answering machine message added now but this may not be sufficient.		31-07-13	Workforce	Stop lone working of CNS posts.	Lead Cancer Nurse	30-01-14		Behind	Update 04.07.14 - CNS structure unchanged, cross-cover occurs as able within current establishment. Second Urology Nurse business case approved by Directorate Board and reviewed by TEC. Agreed for quality, but awaiting financial review	
13	17-07-13	Chemotherapy	The patient complained there were not private rooms available in the Obs and Gynae Department when discussing their case. They complained the consulting rooms were poor.		31-07-13	Estates	Refurbishment for maternity clinic was at number 3 in capital plan for this year. This has been changed now due to other priority issues and is now not planned for this year.	Head of Midwifery	27-01-14		Behind	9.4.14 Update HoM has advised that the bid to DoH was not successful, bid to be resubmitted to Capital Plan 2014/15. 15.07.14 Update: No further progress with the refurbishment bid. Plan still to resubmit at future date. 18.08.14 Update: Still awaiting bid to move forward with refurbishment.	Refurbishment of Maternity Clinics required.

Patient Story Action Tracker Status as updated 21 08 14

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 27th August 2014

Title	Annual Infection & Prevention Control Report April 2013 – March 2014			
Sponsoring Executive Director	Alan Sheward, Executive Director of Nursing and Workforce			
Author(s)	Dr Emily Macnaughton, Infection Control Doctor, Michelle Ould and Derek Bampton, Infection Control Nurses, Debbie Cumming, Antimicrobial Pharmacist			
Purpose	Provide an annual update on the status of infection control procedures and measures in the Trust			
Action required by the Board:	**Receive**	x	**Approve**	

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	On agenda for 20/8/2014
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:

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

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

The report is a resume of the key successes and events during the report period and progress in implementing the infection prevention and control annual plan. It also reports on future challenges and priorities, which will inform the 2014/2015 HCAI prevention strategies and annual plan.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Quality					
Critical Success Factors *(see key)*	1,2, 6					
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: 15th August 2014 **Completed by:** ***Dr Emily Macnaughton, Infection Control Doctor***

Infection Prevention and Control Annual Report 2013-14

For the period
1st April 2013 – 31st March 2014

Dr Emily Macnaughton, Infection Prevention and Control Doctor

Michelle Ould and Derek Bampton, Infection Control Nurses

Debbie Cumming, Antimicrobial Pharmacist

1. INTRODUCTION AND SUMMARY

Introduction

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

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

The report is a resume of the key successes and events during the report period and progress in implementing the infection prevention and control annual plan. It also reports on future challenges and priorities, which will inform the 2014/2015 HCAI prevention strategies and annual plan.

What we did well

C. difficile rates fell to their lowest rate yet since the current mandatory surveillance scheme introduced in 2007. The Trust had only 7 attributed cases of *C. difficile* for the whole year, nearly half that of the preceding year's 13 cases, and putting us in the top 20 lowest *C. difficile* infection rates in the country.

Antibiotic stewardship has been developed further by the introduction of the "prescribing by protocol" function on the electronic prescribing system, as well as the expansion of the audit process.

The Trust is pioneering a new strategy to improve the management of sepsis by enabling pre-hospital diagnosis and treatment initiation.

The Trust Water Safety Group has now been set up and the Water Safety Policy and plan has been written and approved with implementation of the necessary procedures to prevent Legionella and Pseudomonas infections from water within the Trust now progressing.

Introduction of screening for Carbapenemase Producing Enterobacteriaceae (CPE) for patients transferred from high risk locations, therefore enabling us to detect and implement prompt precautions for a patient carrying CPE transferred from abroad.

Improved joint working between the Estates team and IPC team has developed IPC risk assessments and enhanced the implementation of appropriate precautions for estate projects.

Work has commenced on a training programme for Aseptic Non Touch Technique, an essential element of any invasive procedure to minimise infection risks. The first "train the

trainer" session via an external trainer was carried out and work on the training package is well underway.

What we did less well

An extensive norovirus outbreak in March 2014 highlighted deficiencies to be addressed in infection control practices and capacity of the IPC team and resources to manage the outbreak, particularly around the ability to collect and analyse data.

Review of Infection prevention and control processes in the Trust by a TDA (Trust Development Authority) representative in September 2013 and February 2014 identified multiple issues that could be improved, particularly regarding the governance arrangements for infection prevention and control and the lack of consequences for non-compliance with infection control practices and monitoring. Changes in governance arrangements to develop an "Infection Prevention & Control Operational Group" have had a lack of engagement from some areas of the organisation limiting the functionality of this group.

The Decontamination Implementation Group was briefly resurrected in September 2013 to provide assurance around decontamination related issues in the organisation. However, following a change in roles of the then Decontamination Lead for the organisation, the group has not yet been re-convened and decontamination issues have been dealt with on an ad hoc basis. Further work is therefore required to re-set up the group to provide systematic assurance of the Trust decontamination processes.

Compliance with certain aspects of IPC policy has been an organisation wide issue, including: -

- Timely isolation of patients with diarrhoea to prevent the spread of gut pathogens such as *C. difficile* and norovirus.
- MRSA risk assessment and detection of infection flags on admission
- Commode cleanliness
- Documentation and monitoring of peripheral vascular access devices (PVADs)

Urinary catheter care has been identified as an underlying cause in several of our hospital acquired bacteraemia cases, especially *E. coli* bacteraemia, requiring development and implementation of training and a care pathway, which will be a focus for the year 2014/2015.

2. IPC AUDITS

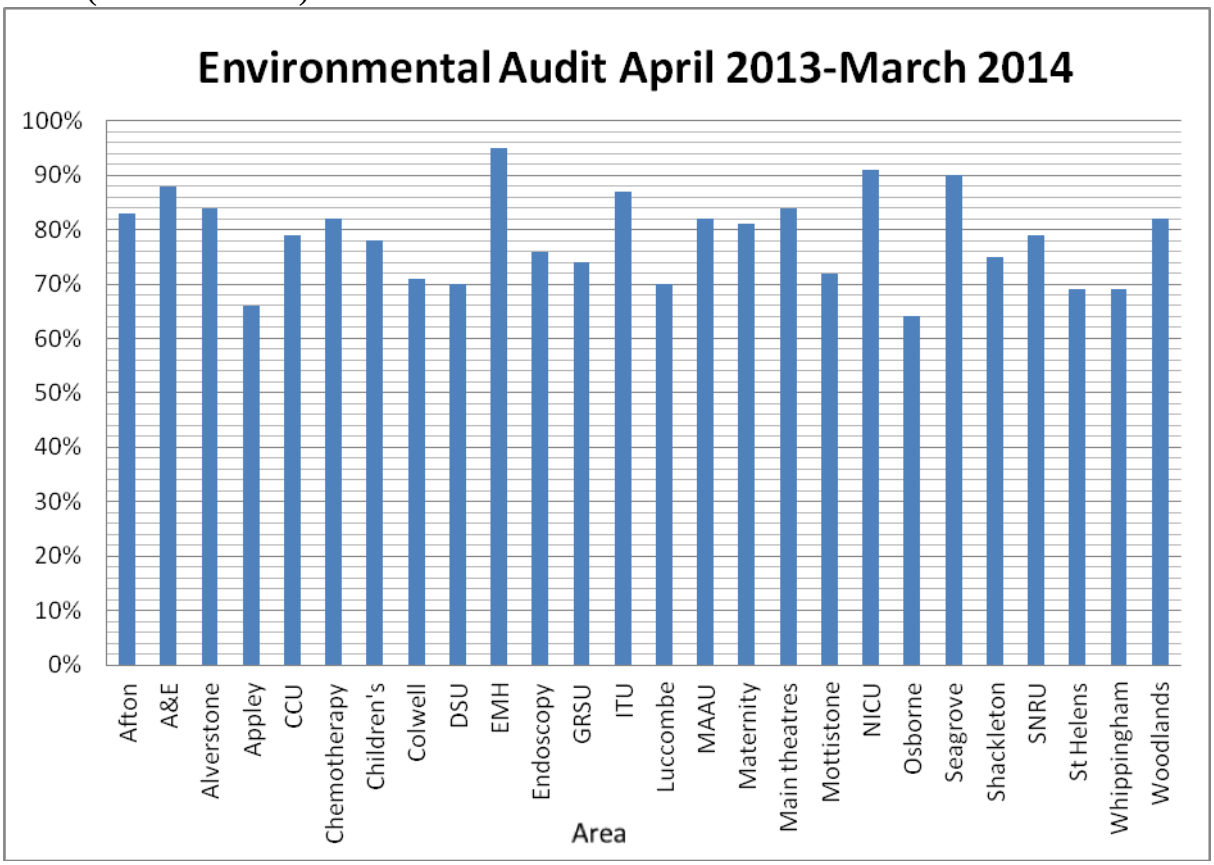
2.1 Inpatient areas: IPCT validation audits

An environmental audit (incorporating equipment cleanliness, sharps practice, hand hygiene, personal protective equipment, peripheral venous cannulation, MRSA, isolation practice, clinical waste) was undertaken by the Infection Prevention & Control Nursing Team in all inpatient areas during 2013/14. This year all audits were totally unannounced so neither matrons, sisters, estates team or cleanliness team were specifically invited.

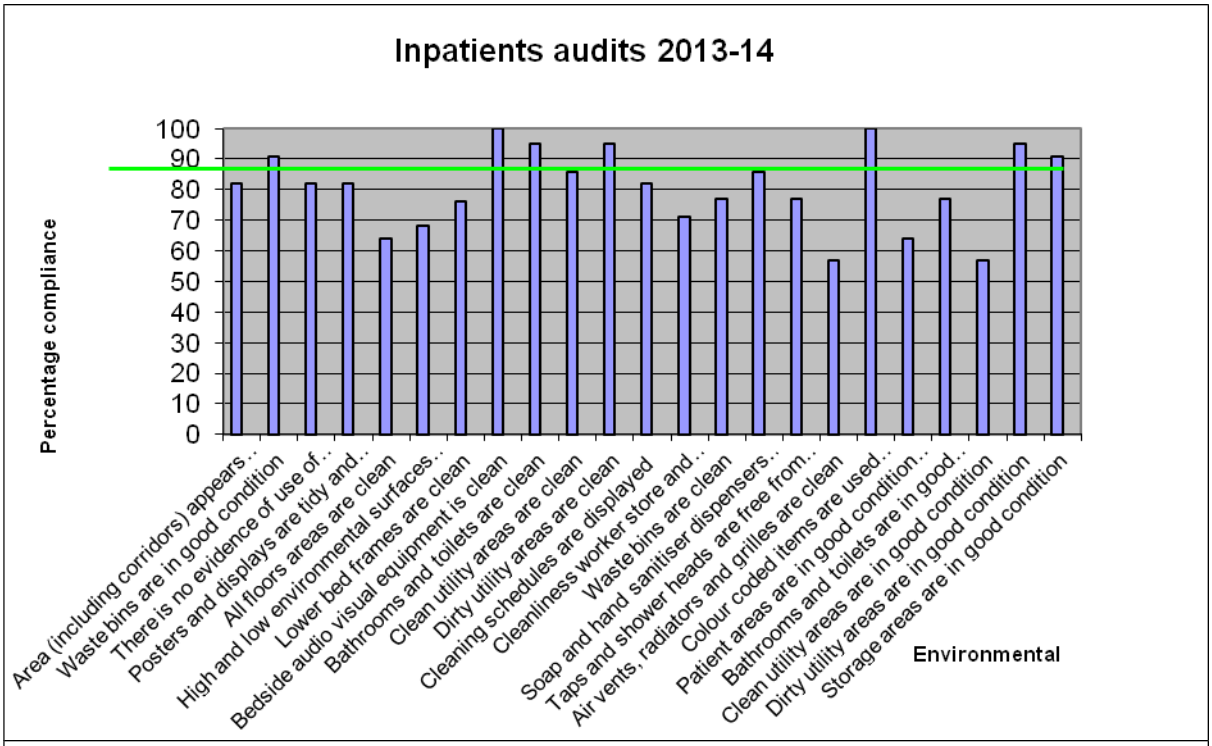
Some of the key themes emerging related to equipment cleanliness (particularly commodes) and environmental integrity (particularly clean and dirty utility areas). In some areas, not all equipment was fully clean when checked (bedspace furniture, diagnostic equipment).
All areas are required to produce an action plan where results were below 90%. This must be driven through the relevant directorate.

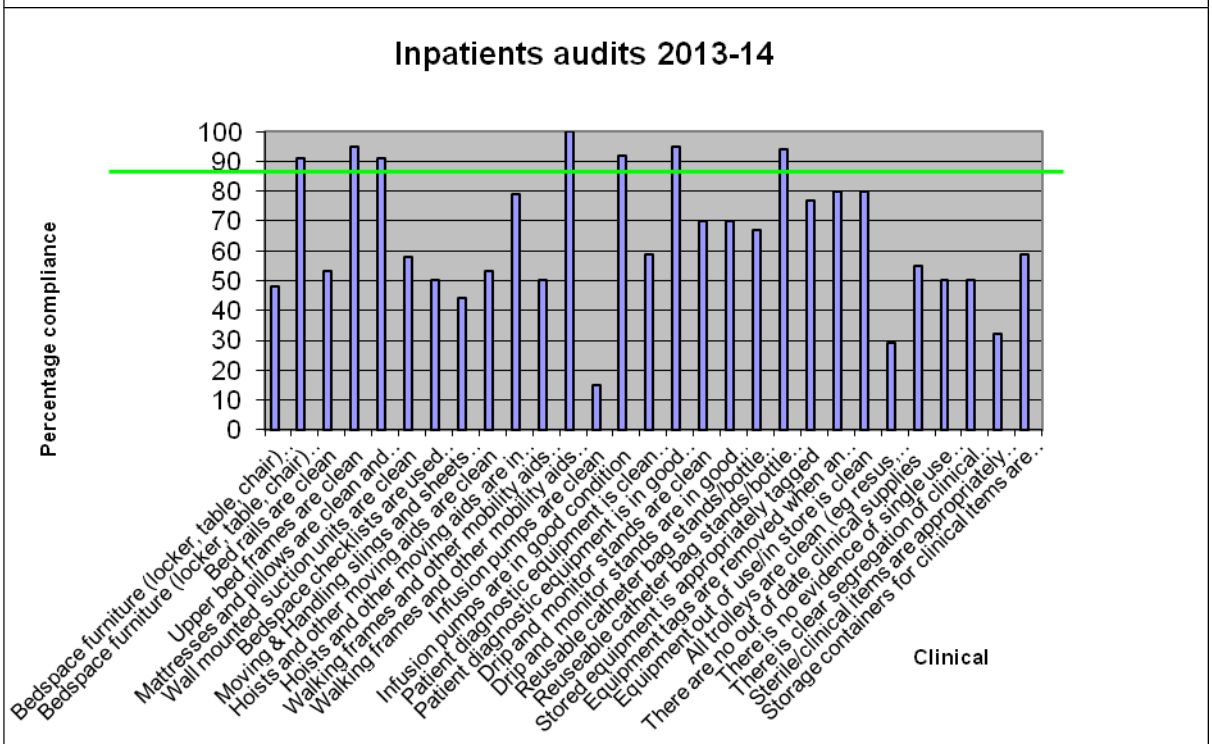
There was a particular focus on Day Surgery Unit and Appley Ward due to concerns highlighted in audit.

The graph below shows the overall individual ward scores for the **environmental** and **policy** audits (combined score).

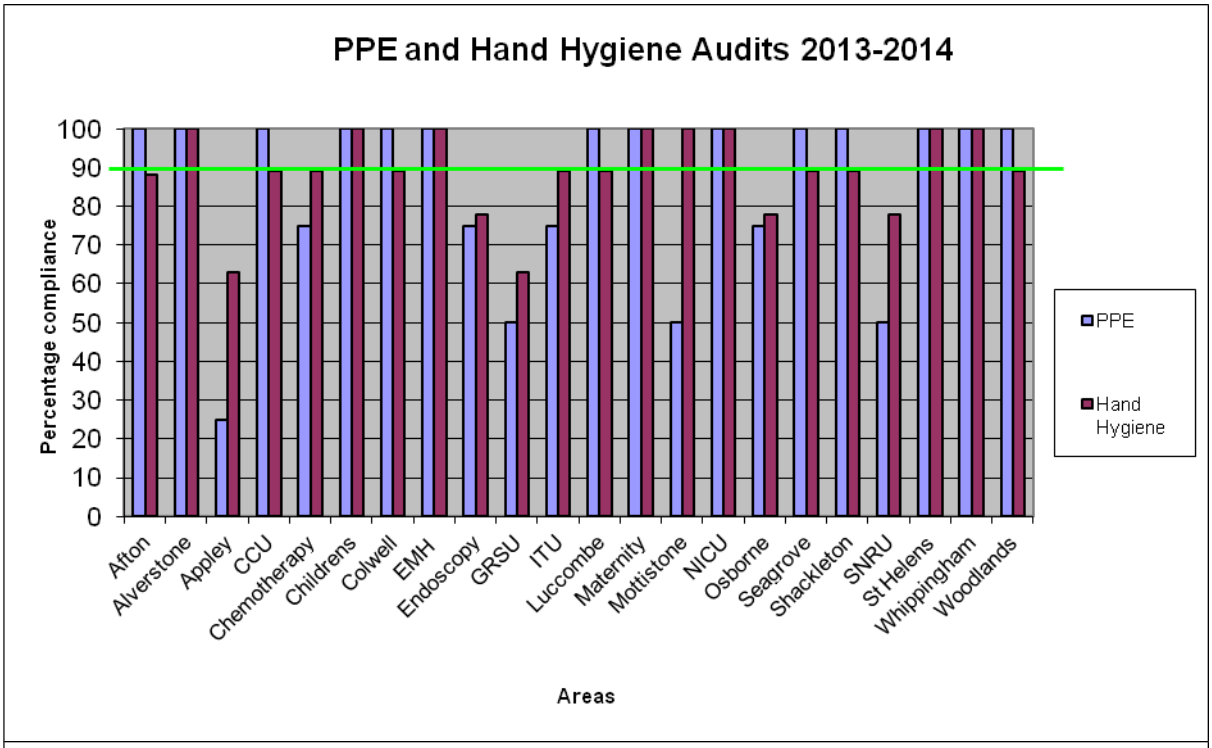


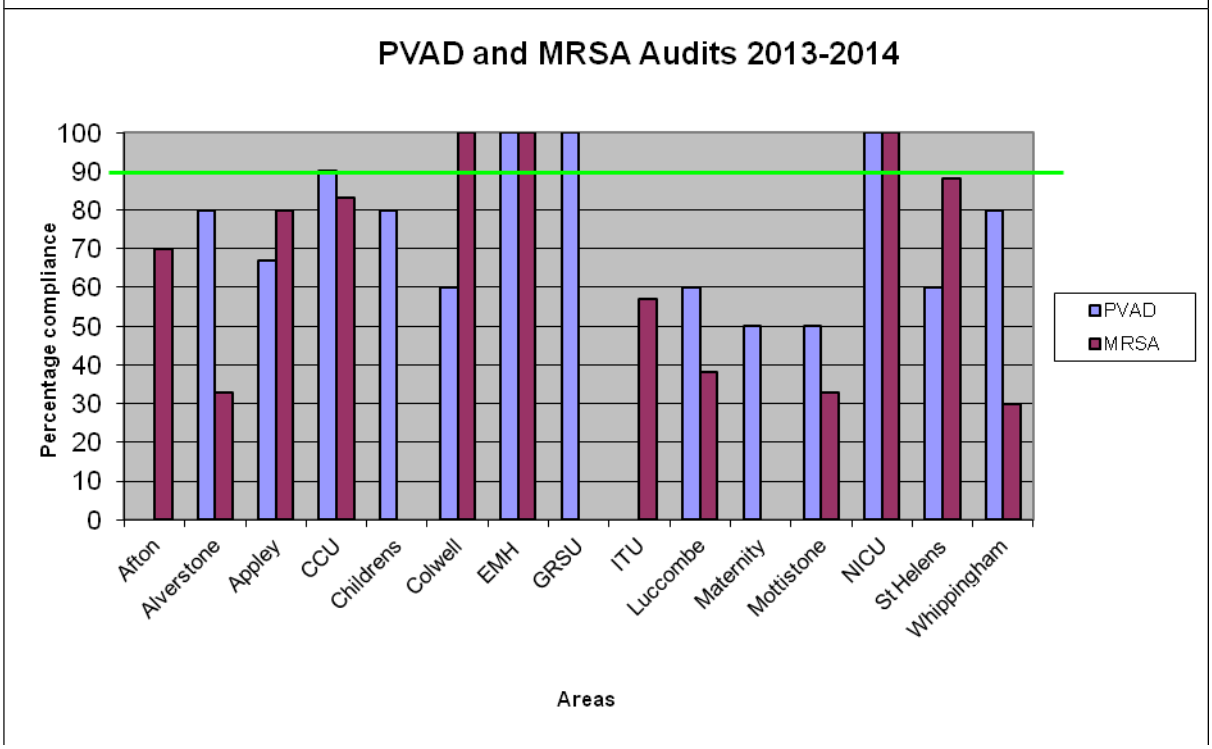
The graphs below show the overall Organisational scores for each element of the **environmental** audit

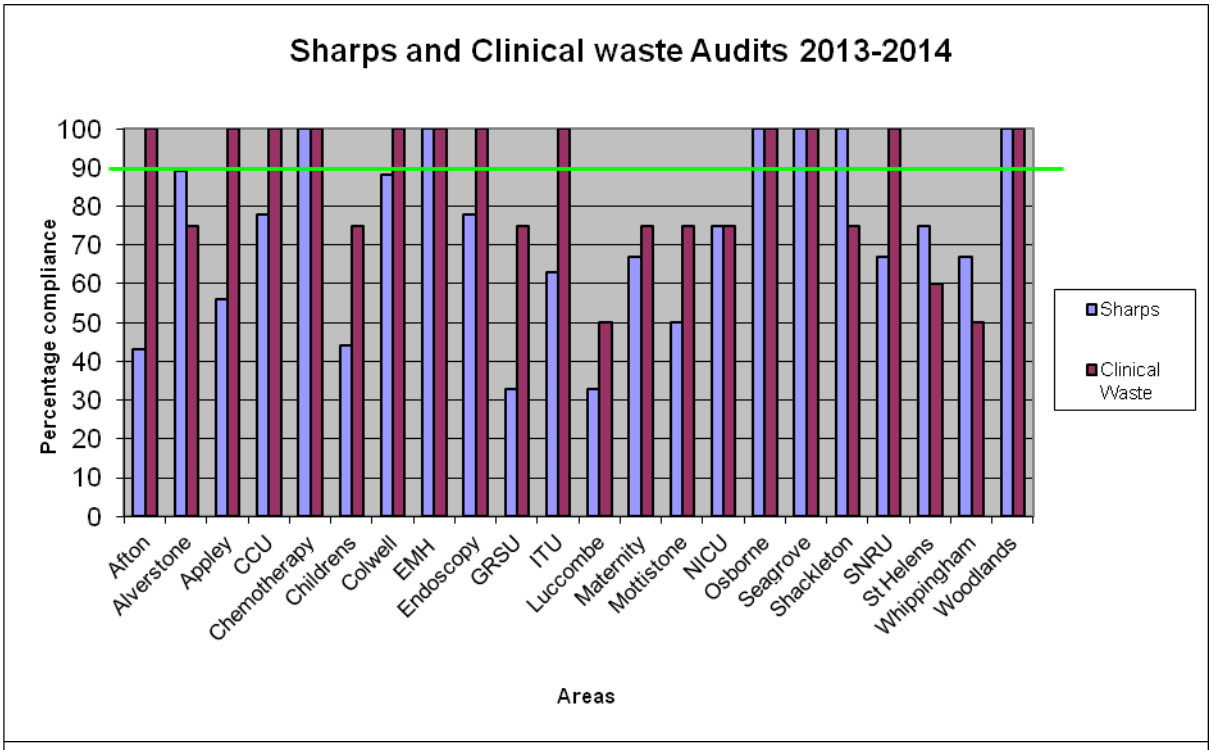


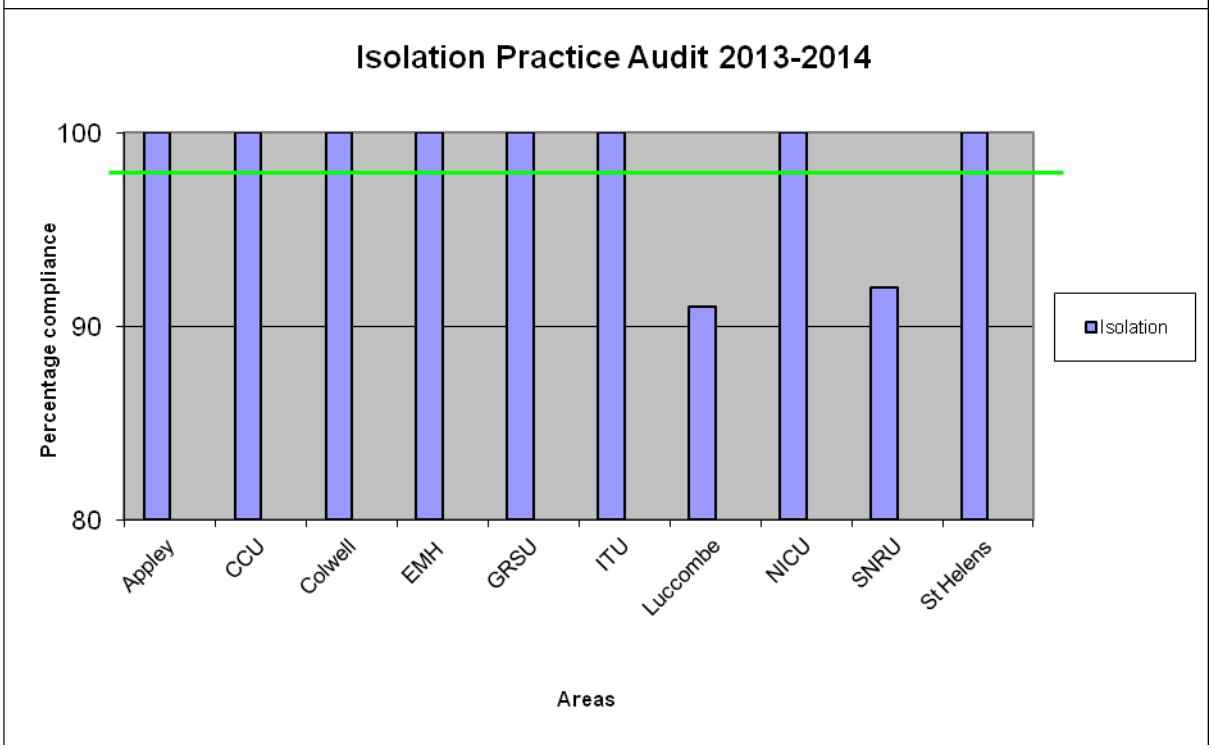


The graphs below show the overall Organisational scores for each element of the **policy** audit

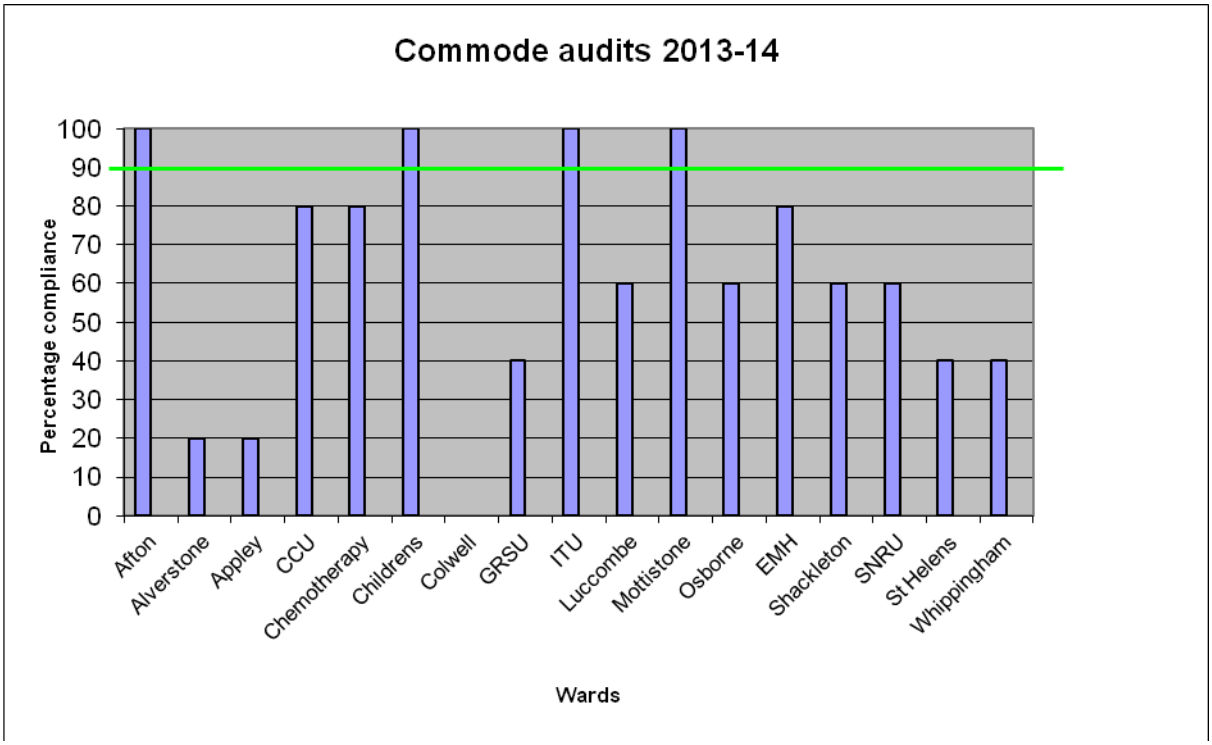

PPE and Hand Hygiene Audits 2013-2014
Percentage compliance
100
90
80
70
60
50
40
30
20
10
0
Afton
Alverstone
Appley
CCU
Chemotherapy
Childrens
Colwell
EMH
Endoscopy
GRSU
ITU
Luccombe
Maternity
Mottistone
NICU
Osborne
Seagrove
Shackleton
SNRU
St Helens
Whippingham
Woodlands
PPE
Hand Hygiene
Areas


PVAD and MRSA Audits 2013-2014
Percentage compliance
100
90
80
70
60
50
40
30
20
10
0
Afton
Alverstone
Appley
CCU
Childrens
Colwell
EMH
GRSU
ITU
Luccombe
Maternity
Mottistone
NICU
St Helens
Whippingham
PVAD
MRSA
Areas


Sharps and Clinical waste Audits 2013-2014
Percentage compliance
100
90
80
70
60
50
40
30
20
10
0
Afton
Alverstone
Appley
CCU
Chemotherapy
Childrens
Colwell
EMH
Endoscopy
GRSU
ITU
Luccombe
Maternity
Mottistone
NICU
Osborne
Seagrove
Shackleton
SNRU
St Helens
Whippingham
Woodlands
Areas
Sharps
Clinical Waste


Isolation Practice Audit 2013-2014
Percentage compliance
100
90
80
Appley
CCU
Colwell
EMH
GRSU
ITU
Luccombe
NICU
SNRU
St Helens
Areas
Isolation

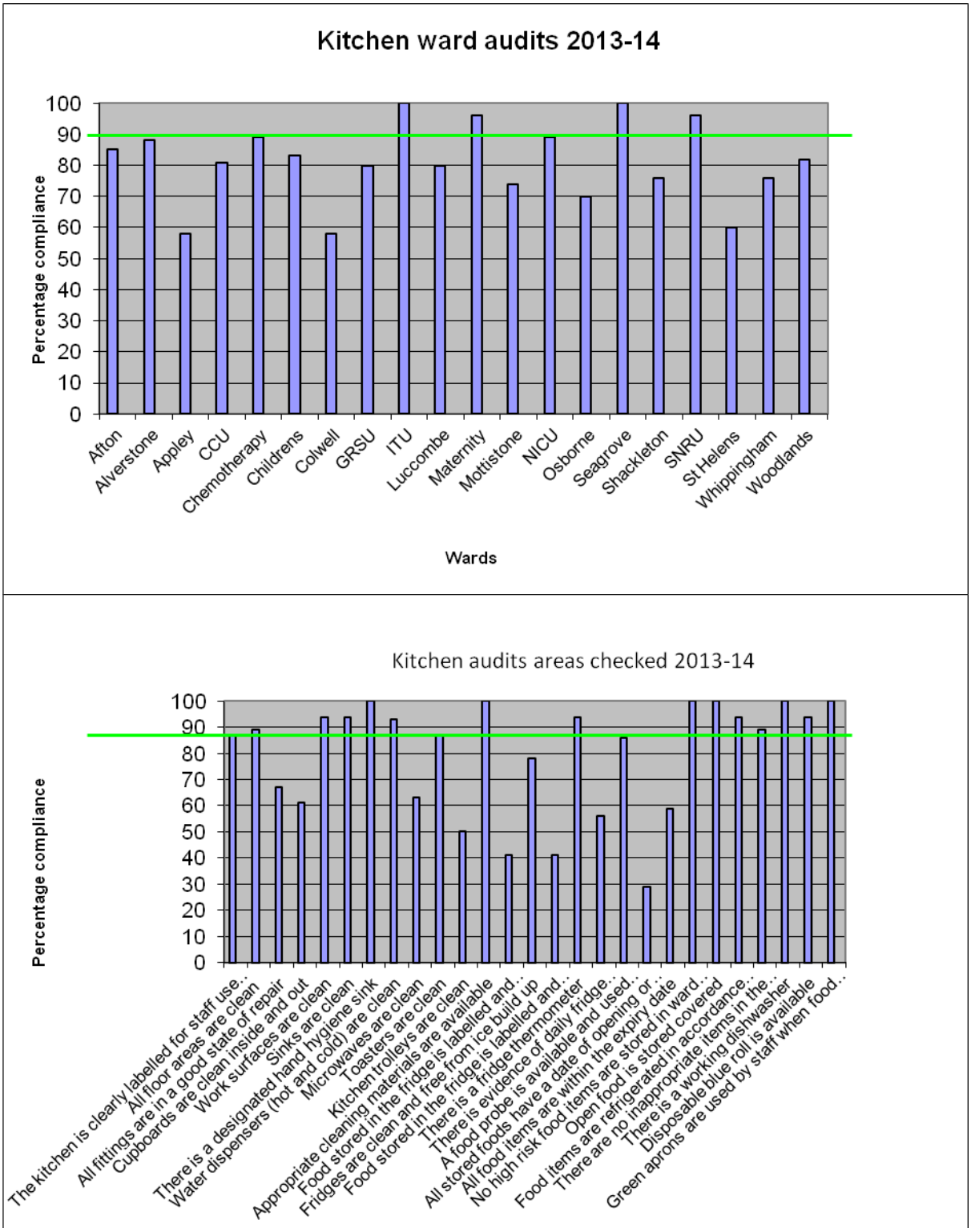
Commode Audits



Poor results were identified in a number of areas for commode cleanliness. To help drive commode cleanliness as a priority, monthly commode audit has been included in the inpatient area self-audit programme for the forthcoming year.

Kitchen Audits

Audit of ward/dept kitchens that serve patients was undertaken by the Infection Prevention and Control Team in 2013. Joint audit with the Infection Prevention & Control Nurses and Health and Safety lead was undertaken for main and Occupational Therapy kitchens. Results were taken to the Food Hygiene Working Group (FHWG) and recommendations proposed, including inviting non-compliant areas to attend and present action plans to the group. This did not work particularly well due to non-attendance of ward reps to present action plans and the issue requires further driving through FHWG.



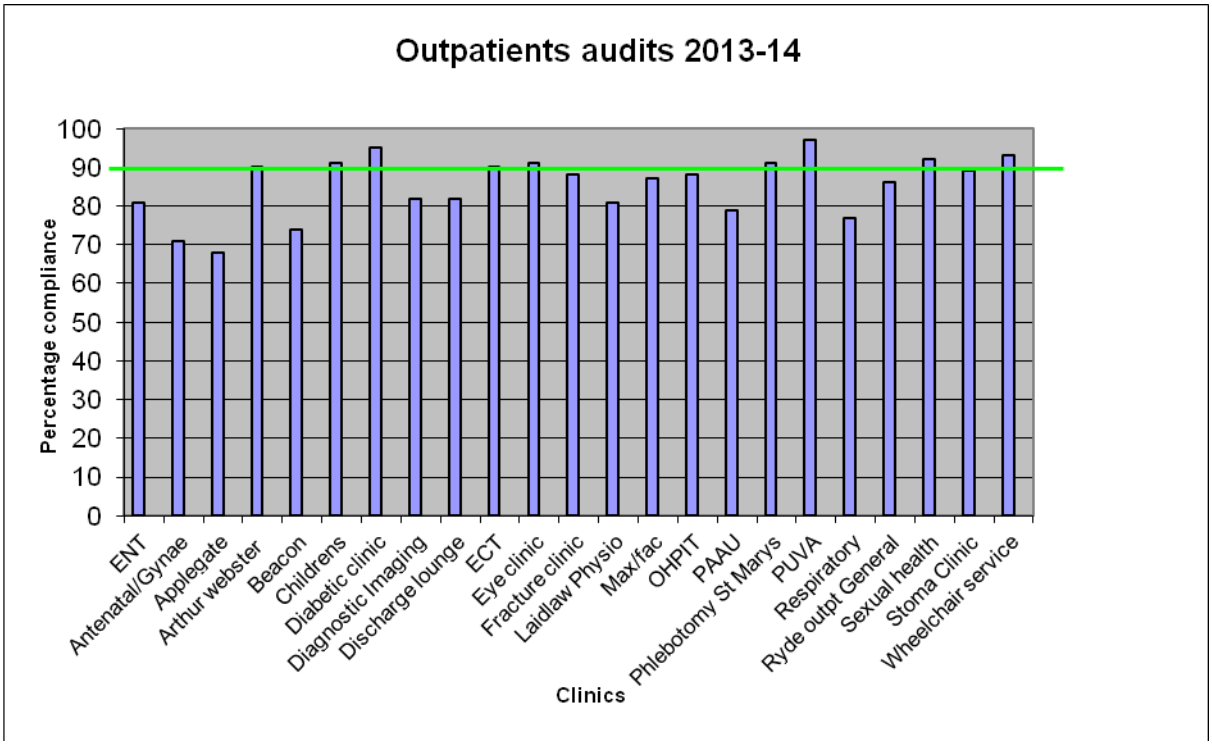
Sharps Audit

Annual audit of sharps practice was undertaken on behalf of the Organisation by Daniels in Winter 2014. The results were fed back to all departments and recommendations made. 42 of 54 areas audited were compliant. The main issues leading to non-compliance related to some bins that were not labelled, some not assembled correctly and some without the temporary

closure mechanism in use.
Recommendations included continuing education with emphasis on assembly, use of temporary closure mechanisms and labelling of bins.

2.2 Outpatient Audit

Environmental audit was undertaken in the majority of outpatient areas.
Work is needed to further develop the Outpatient area audit tool and implement an Organisational programme of self audit for these areas.



2.3 Infection Prevention and Control Self-Audit for Inpatient Areas

In the second half of 2013, the Infection Prevention & Control Nursing Team gave direction to the inpatient areas regarding undertaking their own IPC self-audit programme. The programme aims to improve ownership of infection control practices within the clinical areas, in conjunction with the annual IPCT environmental and practice audit, which should be used to validate the clinical areas' own findings. All areas with audit compliance below 90% are asked to produce an action plan to address those deficiencies. The programme is detailed below:

Audit Focus	Audit carried out by:	Time scale
Environmental	Inpatient area	Complete once before end March 14

Environmental	Infection Prevention & Control Team	Annually
MRSA risk assessment (section in main environmental tool)	Inpatient area	Monthly
PVAD monitoring (section in main environmental tool)	Inpatient area	Monthly
Hand Hygiene audit	Inpatient area	Monthly
High Impact Interventions *Clostridium difficile*	Inpatient area	Every toxin positive inpatient
High Impact Interventions Ventilator associated pneumonia	ITU only	Monthly
High Impact Interventions Central Venous Catheter (CVC) Care	Inpatient area	Every inpatient with a CVC (ITU monthly)

Results were returned to the IPCN team for collation so that evidence was stored in one central place. Work with PIDS is ongoing to develop this to enable data entry by staff in each area and an automated feed into an easily viewed dashboard of audit results. This would reduce the time spent on data collation, develop local ownership of the data and enable easy access by management and quality team to the data.

Completion of these monthly audits has been improving since the introduction of these expectations although some areas have not provided information consistently. Where audit compliance is below 90% the area should develop an action plan to improve practice.
Issues identified for further work over the next year for this audit programme include:

- Improvements in the audit tool functionality (including individualisation of the tool for specific areas), data entry, collation and display arrangements, for which PIDS support is required.
- Peer auditing to limit bias which could be present in the current self-auditing arrangements
- The need for more comprehensive follow up of audit action plans and increased awareness of IPC problems identified in the audit within the directorates by developing the distribution of lessons learned.

2.4 Community IPCT Audit

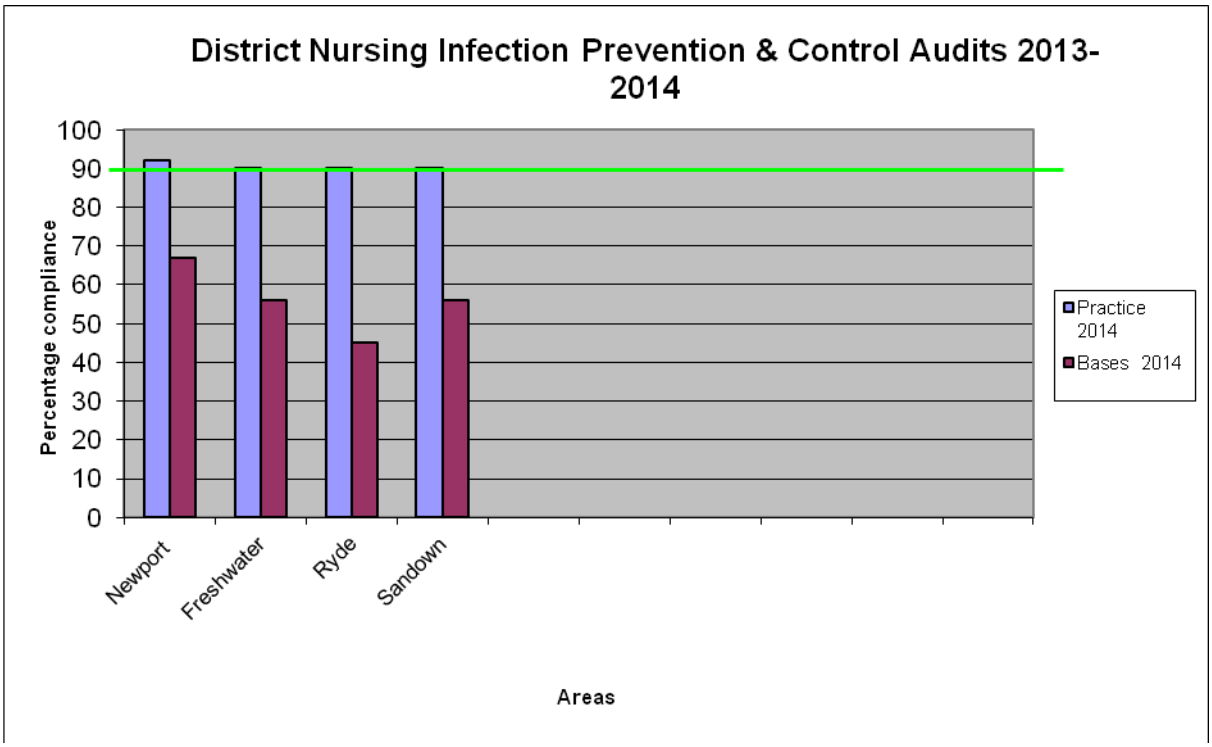
The Infection Prevention and Control Nursing Team have undertaken Infection Prevention and Control audits with District nursing and Ambulance service including Patient Transport Service. Significant improvements have been noted in all the areas with the practice audits, but the bases are still falling short of being compliant.

District Nursing

Time was spent with most of the District Nursing Teams observing day to day practice by accompanying on home visits. Practice audits for district nurses are compliant at an average of 90%

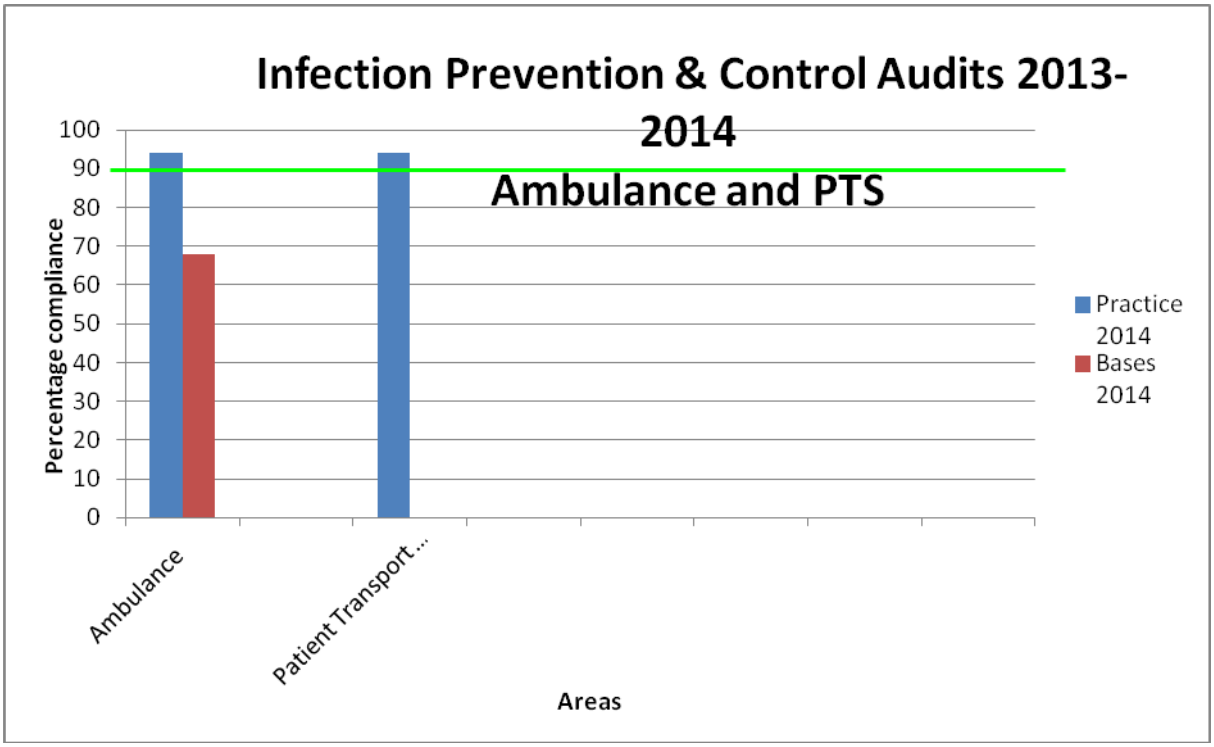
The bases are non-compliant with a range from the lowest at 45% up to the highest at 67%. Some of the issues relate to storage of items. The service is to take this forward. Other issues

relate to environmental integrity.



Ambulance Service
Time was spent accompanying the service in their day to day work.
Both the Ambulance service and the Patient Transport Services (PTS) practice audits scored a compliant 94%
The ambulance station was non compliant with a score of 68%. An action plan has been devised and is to be driven by the service.

Clinics
Environmental audit was undertaken at Ryde outpatients and Arthur Webster Clinic. The audit planned for East Cowes clinic were postponed due to time constraints related to the norovirus outbreak.

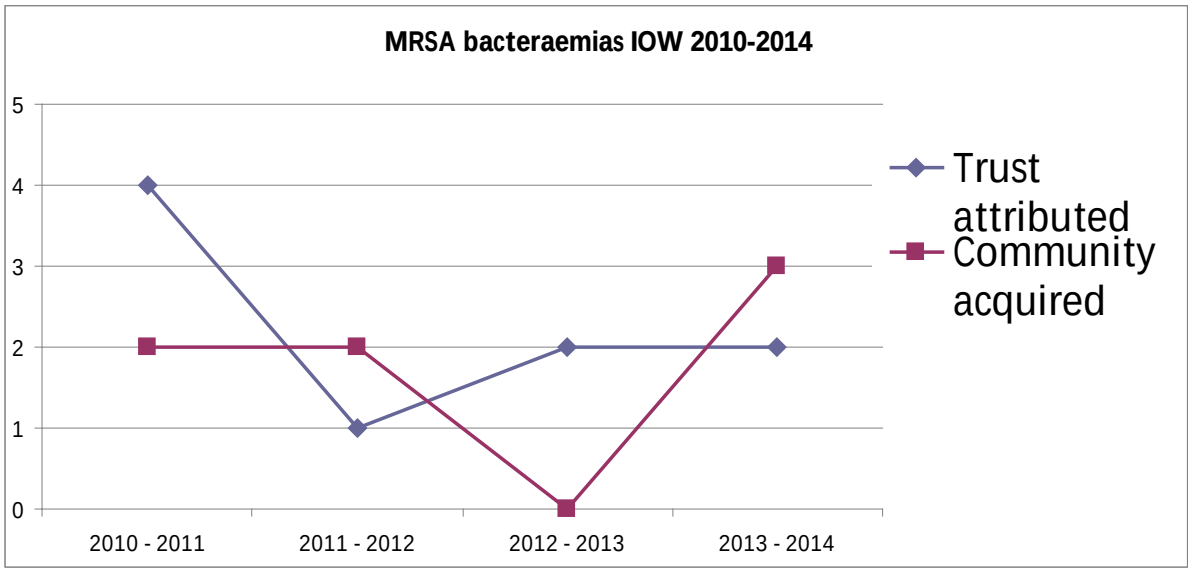


3. HCAI SURVEILLANCE – MANDATORY REPORTING

3.1 MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemia (blood stream infection) data 2013/14

Summary of Trust attributed cases

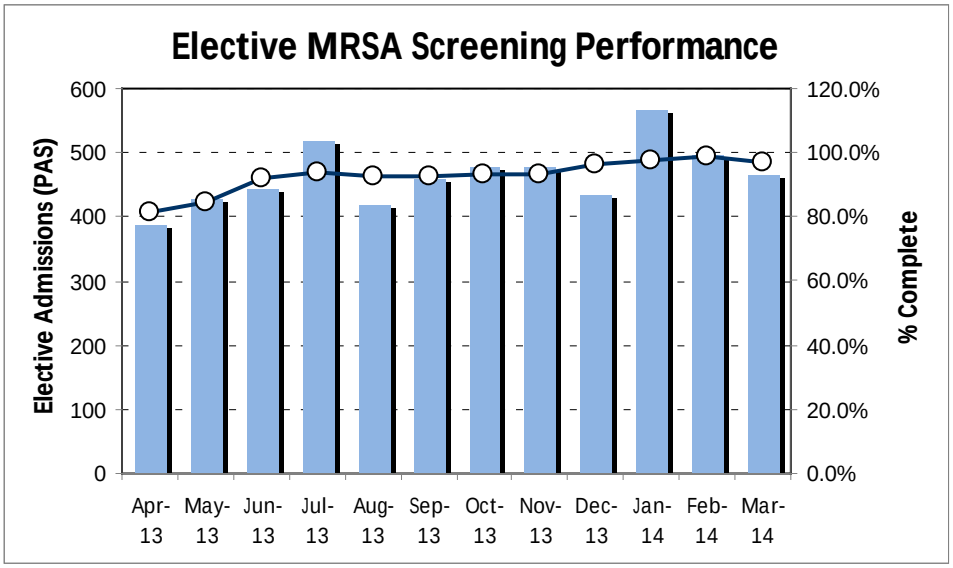
2010/2011 4 cases
2011/2012 1 case
2012/2013 2 cases
2013/2014 2 cases

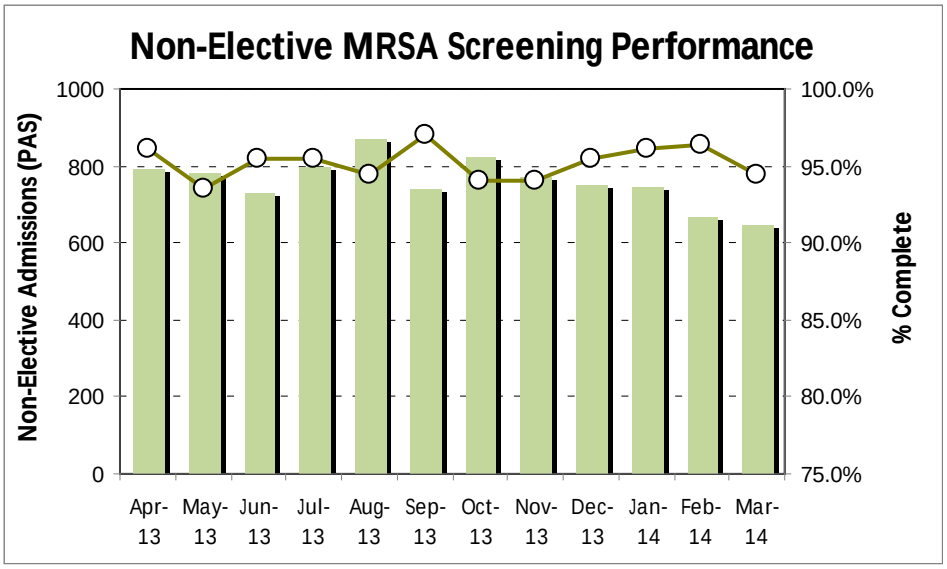


The Department of Health zero tolerance policy on MRSA bacteraemias was not met this year, with 5 cases on the island, 2 of which were attributed the Trust.
Action plans have been implemented based on the root cause analyses and the mandatory Post Infection Review process for MRSA bacteraemia which was introduced in 2013. Of the 2 Trust attributed MRSA bacteraemias, one was linked to urinary catheterisation in a previously MRSA colonised patient; delays in recognition of the patient's previous MRSA positive status are also a probable factor. The other case was linked to a vascular device infection

3.2 MRSA screening performance

- The laboratory provides a 7 day screening service for all emergency patient admissions meeting the criteria for screening. This is in addition to MRSA screening of planned admissions.
- An admission proforma for MRSA risk assessment was introduced in 2013, to improve the management of patients at higher risk of carrying MRSA by pre-emptively initiating precautions.
- Screening figures for planned (elective) and emergency admissions are monitored on a monthly basis by IPC operational Group. Overall screening compliance is good, including over 95% compliance for the last 4 months of the year, but areas with poor compliance are challenged. Overall, 94.3% compliance was achieved for the year; 92.9% for elective admissions and 95.2% for non-elective admissions. The charts below show screening rates with admission figures for both elective and non-elective admissions in 2013/14.
- Monitoring of re-screening compliance for patients remaining in hospital over a week (which is required for specific patient groups in line with the policy) has not yet been implemented as further development of data analysis is required.



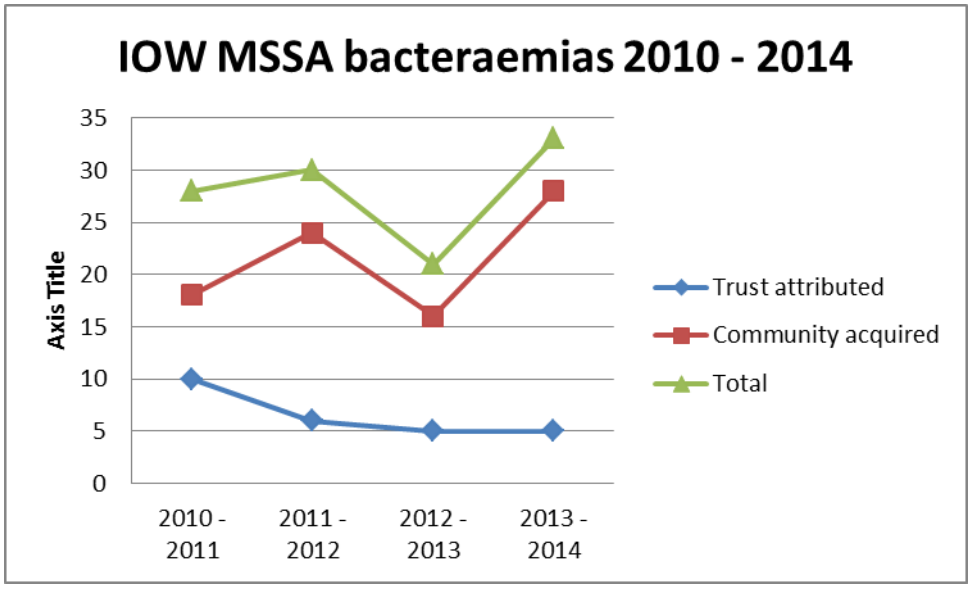


(Charts produced by PIDS department)

3.3 MSSA bacteraemia data 2013/14

As well as MRSA bloodstream infections, the surveillance programme also monitors bloodstream infections caused by MSSA (Meticillin Sensitive *Staphylococcus aureus*). Nationally, the MSSA burden is much larger than the MRSA burden and is consistently increasing particularly due to skin and soft tissue infections, although most cases of MSSA bacteraemia are acquired before admission to hospital. There are currently no national or local targets set for these infections but RCAs are performed for hospital acquired cases.

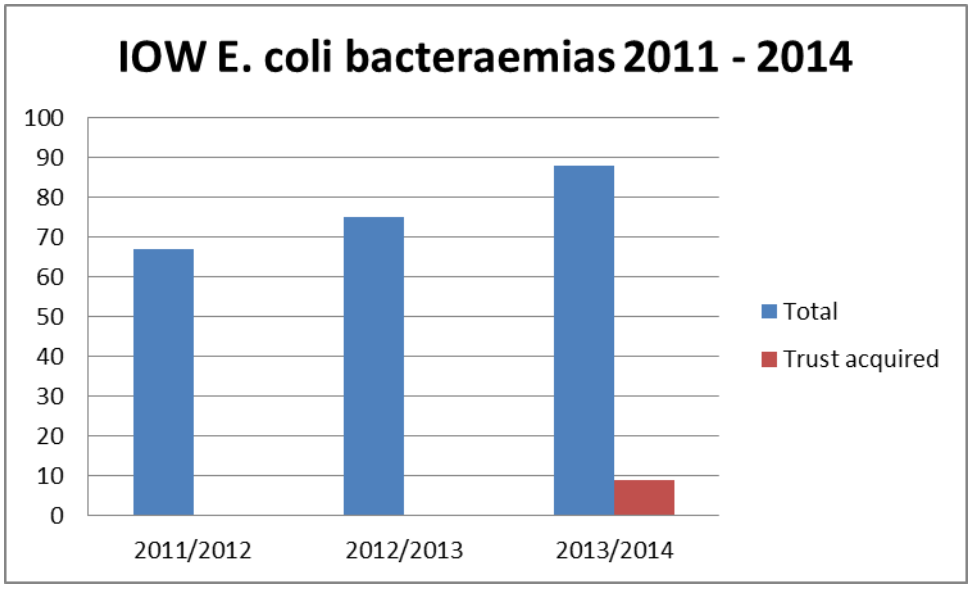
- There were a total of 5 cases of MSSA bacteraemia during the year 2013/2014 (attributable to acute care settings) from a total of 33 cases during the period reported by the laboratory. This is a reduction in the proportion of hospital acquired cases of MSSA bacteraemia compared with the previous reporting period although the absolute number of hospital acquired cases is static.
- As with MRSA, MSSA rates are calculated as cases per 100,000 bed days (within confidence limits). Data to date shows the annual MSSA rate for Isle of Wight is below the national average annual MSSA rate for hospital acquired infection, although higher than the national average for community acquired MSSA bacteraemia.



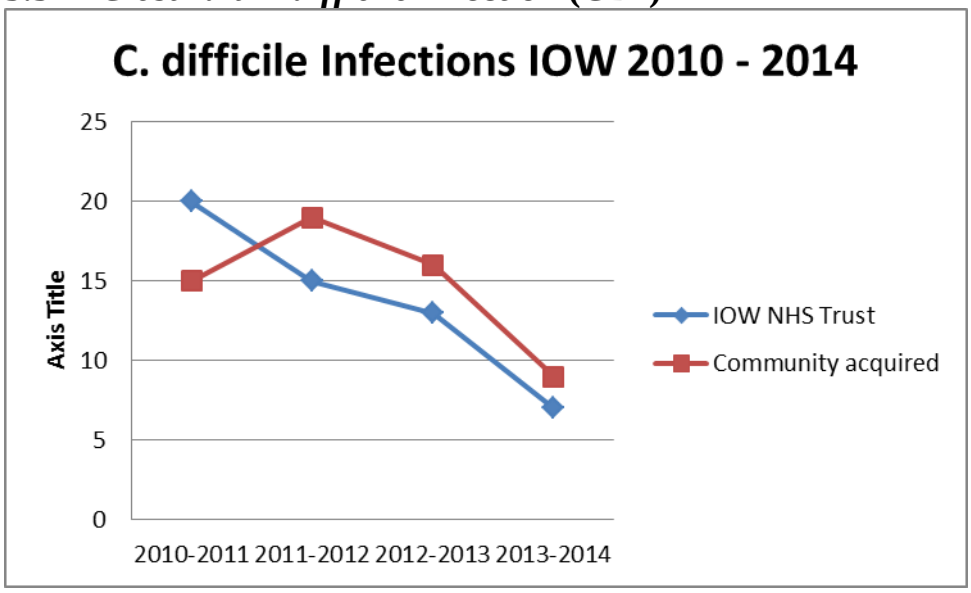
3.4 *E. coli* bacteraemia surveillance

Mandatory surveillance of *E.coli* bacteraemias by laboratories continues although as yet no reduction targets have been set. However, in anticipation of future targets and to look at how these infection rates may be improved, root cause analysis investigation is now being undertaken for hospital acquired cases of these infections (since the start of 2014). A common theme arising from these investigations is the need for improvements in urinary catheter care as a result of which the catheter care task group has been set up to address the issue.

Overall the number of cases of *E. coli* bacteraemia continues to increase, although the vast majority are community acquired infections (mostly linked to urinary tract infections and other intra-abdominal infections). This is a trend being seen across the country. Nine of this year's 88 cases were detected in a time frame suggestive of hospital acquired infection.



3.5 *Clostridium difficile* infection (CDI)



- Reductions in CDI rates have continued in 2013/14, with only 7 hospital acquired cases in the year, well under the Trust target of 13 cases, although just over the Trust's self-set "stretch target" of 6 cases. The lasts year's rate of CDI is 7.34 cases per 100,000 bed days which compares very favourably with the national rate of 14.7 cases per 100,00 bed days and puts the trust in the top 20 lowest rates in the country for non-specialist hospitals
- Root cause analyses for all hospital acquired CDI cases are performed. Ribotyping (determining the strain of C. difficile) of CDI cases and patients identified as carrying *C. difficile*, who have been inpatients on the same wards, has not identified any outbreak of a specific strain; a variety of strains of the bacteria were found, which may suggest that patients are already be carrying *C. difficile* on admission. .

Future challenges in CDI

- Targets continue to decrease with the Trust target of only 6 for the year ahead.

3.6 Carbapenemase Producing Enterobacteriaceae

These are highly antibiotic resistant organisms (resistant to carbapenem antibiotics, one of our "last line" antibiotic classes, as well as resistant to many other, if not all, antibiotic classes) which can cause untreatable infections, and pose a significant threat to our ability to treat even simple infections like UTI (urinary tract infection). Many areas of the world are known to have significant problems with these organisms and outbreaks are increasingly being recognized in the UK, including a cluster of hospital acquired cases in Southampton General ITU at the start of 2014.

People can carry these bacteria in their gut without symptoms but are a risk of spreading the organisms without effective infection control precautions (there is no eradication therapy available).

To control the spread of these organisms, the following measures were introduced:

- We are now screening patients who have a risk factor for acquiring these bacteria, this currently includes patients with recent admission to Southampton General (to be reviewed September 2014).
- We are isolating the highest risk patients currently and will review this if we identify further cases.
- We have a protocol for the precautions required for positive patients, although are expanding this in light of further guidance published by Public Health England

No Trust acquired cases have been identified so far on the island, however we have 1 positive patient who was detected on transfer from abroad, and another who was identified as a carrier on screens at a London hospital (where they had a local outbreak on that unit). If we identify spread of these isolates within the Trust then outbreak control measures will be implemented

3.7 Surveillance of Surgical Site Infection (SSSI)

Surveillance of Surgical Site Infection (SSSI) for orthopaedic patients has been undertaken at St Mary's Hospital since 2004. This surveillance is undertaken on all orthopaedic patients undergoing elective or emergency knee and hip surgery and information gathered is recorded on the Public Health England database, as part of the mandatory surveillance programme.
From April 2013 to March 2014 the orthopaedic department undertook:

- 332 total knee replacements with 4 reported infections (1.2%)
- 329 Total hip replacements with 4 reported infections (1.2%)
- 236 Repair of fractures to neck of femur with 0 reported infections (0%)

Surveillance for other surgical specialities SSI (Surgical Site Infection) is not currently routinely performed (and there is currently no other national mandatory reporting process). However, development of our organisation wide SSSI programme will be a focus for the following year to enable assurance to be provided that SSI risks are minimised.

4. OTHER SURVEILLANCE – OUTBREAKS AND SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRI)

4.1 Viral gastro-enteritis

Norovirus or 'winter vomiting' disease is the most common cause of acute gastro-enteritis and vomiting. It is easily transmissible and may rapidly spread in closed communities, including hospitals. Gastro-enteritis outbreak incidents affecting hospitals and institutions are reported to Public Health England

- During 2013-14 there were two outbreaks of gastroenteritis in St Mary's Hospital. In October 2013 a small outbreak affected the 2 acute medical wards, the cause was not definitively confirmed although one patient tested positive for sapovirus, a virus which has been associated with gastroenteritis. In March 2014 a large outbreak occurred, affecting most of the inpatient wards. This was promptly identified by the Trust

laboratory as due to norovirus and confirmed on further testing by the reference laboratory.

- The later outbreak lasted for over 4 weeks, involving over 100 patients and 323 staff members reported in sick with gastrointestinal symptoms. Challenges to control included high levels of norovirus activity in the community (likely reflected in the high staff sickness rates) which resulted in multiple points of introduction and the lack of beds and staff to enable effective cohort isolation nursing. The business continuity framework was invoked as a result of the extent of the outbreak which impacted on most organisation functions, including cancellation of elective surgery as a result of the bed capacity issues.

- Reviews of this outbreak and the use of the business continuity framework have been undertaken which have identified multiple areas for improvement including review of the organisational outbreak policy and norovirus guidance information. This will therefore be a major focus for the subsequent year to improve preparedness for future outbreaks.

4.2 Group A streptococcal infection (GAS)

Group A Streptococci (GAS) most commonly cause sore throats. The organism is the cause of Scarlet Fever and can cause cellulitis and rarely may cause serious infection such as bloodstream infection (invasive GAS or iGAS) and Toxic Shock Syndrome. Cases of iGAS and Scarlet Fever are notified to Public Health England. Nationally and on the IOW, rates of Scarlet Fever have been above average for the year 2013/14. Group A Strep infections acquired in hospital need root cause analysis investigation to identify and remedy preventable factors.

- 8 patients were treated for an invasive Group A Strep infection during the year 2013/2014 and were reported to Public Health England as required
- 1 patient with a Group A Strep. infection acquired it whilst an in-patient in the Trust. This case was an iGAS infection; a root cause analysis identified concerns in the monitoring and documentation of the patient's peripheral intravenous cannula for which an action plan has been produced.

5. IPC TRAINING AND EDUCATION

Infection Prevention & Control delivered the following taught sessions:
1 hour training session for all clinical staff as part of the Organisational Compulsory Basic Training programme
15 minute induction session for new staff as part of the Organisational induction programme
All staff who work with patients or in patient areas are required to undertake the clinical mandatory infection prevention and control annually. This is available as an on-line course as

well as a taught session. Non-clinical staff are required to undertake the non-clinical on-line training course 3 yearly.
An on-line MRSA and *Clostridium difficile* training course was developed in 2013 and is available alongside the established influenza on-line training course. These are not mandatory at the present time.
In 2013/14: 1834 staff undertook the clinical on-line training session
608 staff undertook the non-clinical on-line training session

All on-line session content was reviewed by the team.
Bespoke training sessions were delivered on request in the workplace. This was less successful than hoped in clinical areas due to difficulties in releasing staff to attend.
A short induction training session is delivered to junior doctors attending for short placements each month.
The Nurses support the Infection Prevention & Control Doctor in delivering training annually to the junior doctor intake.
A regular infection prevention and control induction training session is delivered to volunteers.

Hand Hygiene
It is a mandatory requirement that all clinical staff undertake practical hand hygiene training yearly. This is delivered by both the infection prevention and control nursing team and workplace trainers using the 'glitterbox' as a training aid.
There is an ongoing programme of training trainers to deliver hand hygiene training in the workplace. This is provided on request. The team supported the organisational delivery of hand hygiene training by delivering hand hygiene training to smaller departments on request, training for consultants and provided 'drop in' sessions for staff to undertake mandatory hand hygiene training.
The team co-ordinated the loaning of the 'glitterboxes' to clinical areas.

Respirator Mask Fit Testing
In conjunction with the Occupational Health Team, the Infection Prevention and control Nursing Team delivered 2 training sessions to train trainers in the workplace to safely use respirator masks. The PPE policy gives guidance on use of and training for respirator masks.

IPC Link Practitioners
Link practitioner meetings are held 3-4 times annually. This continues to be important for dissemination of information to ward/dept level. Link practitioners are provided with updates of national and local initiatives and presentations are delivered by external speakers or the Infection Prevention and Control Nursing Team.
Attendance at the meetings has been poor at times due to reported problems in releasing staff from the workplace. A full study day was provided in July 2013 and topics including Aseptic Non-touch Technique, Long and mid-line care and skin preparation.

Patient Information Leaflets
All current infection prevention and control leaflets were reviewed in March 2013 and became available for use end of spring 2013.

6. IPCT INITIATIVES

- **IPCT and Estates liaison**

A risk assessment tool was developed for use with Estates, cleanliness and the IPCT. This assessment is jointly undertaken before any building or refurbishment work is agreed. Weekly 'walkarounds' instigated during works to monitor adherence to agreed standards (estates team, cleanliness team & IPCN). Processes for 'signing off' works as compliant from IPC perspective before being brought back into use strengthened. Closer working between estates and the IPCT has also been developed further by the use of regular structured meetings to ensure regular follow up of the relevant issues.

- **Alert organism flagging**

The 'flagging' of all patients known to be carry alert organisms continued to be an issue. Patients are flagged on Patient Centre and JAC and now ISIS. This is in response to findings from previous RCAs where the known status of some patients was not always identified.

- **Norovirus information pack**

A norovirus pack was compiled and rolled out for use by inpatient areas. This is to be further developed during the forthcoming year following issues identified during the outbreak.

- **Cleaning of isolation areas**

A barrier/specialist cleaning checklist was devised and introduced to inpatient areas to provide assurance (by visually checking) that the cleaning of areas used for isolation is undertaken to a satisfactory standard. This has not yet been successfully implemented in practice and requires further work.

- **Aseptic No Touch Technique (ANTT)**

The Infection prevention and control nursing team worked with the education lead and OHPIT (outpatient and home parenteral infusion therapy) team lead to undertake preliminary work on developing an Organisational training package. A study day was delivered to a core group of 18 staff by the National lead for ANTT. These staff have been themselves assessed as competent in the skill and will be instrumental in supporting roll out of the programme. This will be a main focus for the forthcoming year.

7. IPC GOVERNANCE

Changes in governance arrangements have occurred during the past year, to develop an "Infection Prevention & Control Operational Group" to monitor the Infection Prevention and Control Operational issues. The group reports to Infection Prevention & Control Committee, to enable that committee to focus on IPC strategic matters. The functionality of this group requires development as consistent representation from some areas of the organisation has not been achieved. Objectives for the following year include:

- working with the quality department to improve the follow up of IPC audit and HCAI RCA action plans
- facilitate data entry, collation and analysis for IPC audit by working with PIDS to improve the audit tools and create a dashboard for this information

7.1 Attendance at meetings/groups

The Infection prevention and control nursing team attend and contribute to the following groups/forums;

- Waste policy group
- Estates projects
- Infection Prevention & Control Committee
- Food Hygiene Working Group
- Health and Safety
- Space Utilisation
- Risk Management
- Matrons Action Group
- Medical Devices
- Total bed management
- Product Standardisation
- Policy Review Group
- Water Safety Group
- Directorate quality meetings
- Decontamination Implementation Group

7.2 IPC Policies

Infection prevention and control policies were revised and updated on expiry, including the following:

- Antibiotic Resistant Bacteria
- CJD Policy
- *Clostridium Difficile* policy
- Diarrhoeal Infections (Including norovirus) policy
- Healthcare Associated Infection (HCAI) - Policy for Reporting
- Isolation Policy
- Outbreak Policy - inc Bed Closure policy
- Respiratory Viruses Policy (inc Swine Flu)
- Safe Handling and Disposal of Sharps and Prevention of Occupational Exposure to BBV Policy
- Viral Haemorrhagic Fevers Policy
- Use of Personal Protective Equipment - Standard (Universal) Precautions

The IPCT were also involved in updating the following policies:

- Decontamination of Reusable Medical Devices Policy
- Tuberculosis (TB) Diagnosis and Management Policy
- Food Hygiene Policy
- Medical Devices Management Policy

- Water Systems (Legionella, *Pseudomonas Aeruginosa*) policy
- Waste Management Policy

7.3 TDA (Trust Development Authority) Review

Review of Infection prevention and control processes in the Trust by a TDA (Trust Development Authority) representative was carried out in September 2013 and February 2014. This review recognised that the IPCT was committed to delivering a high standard of IP&C but also identified several areas that could be improved, particularly regarding the governance arrangements for infection prevention and control and the lack of consequences for non-compliance with infection control practices and monitoring.

An action plan is being formulated to address these issues.

8. ANTIMICROBIAL STEWARDSHIP

- The **daily antimicrobial ward rounds** (M-F) have continued - using the reports created from our electronic prescribing system. This system allows us to know which patients are currently on an antimicrobial, who prescribed it, when it was started and also it's expected duration. Such information allows the daily ward round to target those patients most in need of input from the Consultant Medical Microbiologist, but also allows consistent education and training for both junior doctors and other members of the multi-disciplinary team. These ward rounds allow the Trust to meet most of the *"Start Smart then Focus"* objectives.

- Electronic prescribing has been developed to allow the introduction of **prescribing by protocol** – i.e. the protocol outlined in the Trust Antimicrobial Guidelines (for Hospital use) can be chosen from a drop down list that is divided by body area (Cardiac, ENT, Respiratory, Skin and Soft Tissue etc). When prescribed using protocol for a particular indication it ensures that the correct empiric antibiotics are chosen. This was introduced sometime after the annual intake of junior doctors, and they had already become accustomed to prescribing free text. Therefore it has not been as well adhered to as expected. With the next intake of junior doctors, their induction training will emphasise that this is the mandatory approach to prescribing - for those specific indications included in the protocols, to ensure adherence to guidelines.

- **The HAPPI audit** (Hospital Antimicrobial Prudent Prescribing Indicator) has been re-launched in an expanded format and continues to be carried out one day each month, with a newsletter then circulated with the results to all the wards. It now incorporates a DIPPI audit (Doctors inputting prescribing by protocol indicator) and a NAPPI audit (Nursing administration prudent practice indicator) - regarding adherence to documentation of allergy status and number of missed doses in previous 24 hours.

- **Sepsis** - the Trust has embarked on a innovative service development for the diagnosis and initiation of treatment of sepsis pre hospital (using a patient group direction for trained paramedics) for two specific groups of patients, namely patients on (or recently taken) chemotherapy, and those patients at risk of sepsis with a urinary catheter in situ. This has received favourable feedback and is being worked up for a

grant application with East of England Ambulance Trust and South Coast Ambulance Trust.

- **Other Audits:** Other antimicrobial audits have been carried out and presented including those surrounding Sepsis, Community Acquired Pneumonia and Urinary Tract Infections.

9. WATER SAFETY

Water safety has been an area of focus during the year 2013/2014, developing the Trust's strategy to prevent Legionella and *Pseudomonas aeruginosa* infections, in line with national requirements and guidelines. The following actions were undertaken:

- Water safety group set up to monitor and advise on required actions, reporting to Infection Prevention and Control Committee
- Water Safety Plan and Policy developed and approved by Trust Board
- Legionella testing undertaken throughout Trust buildings with actions implemented as required.
- Water Hygiene Risk assessment audit carried out by external contractors of Trust Estate. An action plan has been formulated on the basis of these findings which is being progressed, including an updating of the processes within the department.
- Pseudomonas aeruginosa testing commenced for high risk areas

10. DECONTAMINATION

The Decontamination Implementation Group was briefly resurrected in September 2013 to provide assurance around decontamination related issues in the organisation. However, following a change in roles of the then Decontamination Lead for the organisation, the group has not yet been re-convened and decontamination issues have been dealt with on an ad hoc basis. Further work is therefore required to re-set up the group to provide systematic assurance of the Trust decontamination processes. The Trust Policy for Decontamination of Reusable Medical Devices was updated by the members of the previous Decontamination Implementation Group, including IPCT.

During the year 2013/2014, the following decontamination issues were highlighted:

- Need for significant improvements in the endoscopy unit facilities, including replacement unreliable endoscope washer disinfectors. Risks are mitigated by restricted use of washer disinfectors with unsatisfactory results but this is unsustainable in the long term
- Need for updating and assurance provision of CJD (Creutzfeuld Jacob Disease) risk assessment processes (the CJD policy has been updated during this year)
- Lack of endoscope decontamination facilities in the ENT department, for which facilities are unlikely to be available until the development of the new endoscopy unit

11. RECOMMENDATIONS AND PRIORITIES FOR 2014/2015

- Expansion of surgical site infection surveillance within the Trust and development of a consistent approach to periods of increased incidence
- Development of a formal policy for Control of Carbapenem Resistant Enterobacteriaceae
- *Pseudomonas aeruginosa* testing on a 6 monthly basis to be routine for ITU/NICU/Dialysis unit, with appropriate actions where positive results identified
- Greater ownership of infection control data and actions at a directorate and department level needs further development with the quality team and directorates
- Re-instigation of the decontamination implementation group to provide consistent and structured monitoring of decontamination issues within the Trust
- Updating of norovirus advice pack and outbreak management policy
- Roll out of Aseptic Non- Touch Technique training and competency assessment
- Roll out of urinary catheter care plan, training and competency assessment
- Development of the use of information technology to enable effective infection control practices, including recognition of patients carrying alert organisms, facilitating IPC audit processes and health care acquired infection surveillance

12. GLOSSARY OF TERMS

ANTT Aseptic Non-Touch Technique
CDI *Clostridium difficile* infection
CJD Creutzfeuld Jacob Disease
CPE Carbapenemase Producing Enterobacteriaceae
CVC Central Venous Catheter
DIPC Director of Infection Prevention and Control
HCAI Healthcare Associated Infection
ICD Infection Control Doctor
IPCC Infection Prevention and Control Committee
IPCN Infection Prevention and Control Nurse
IPCT Infection Prevention and Control Team
MRSA Meticillin Resistant *Staphylococcus aureus*
MSSA Meticillin Susceptible *Staphylococcus aureus*
OHPIT Outpatient and Home Parenteral Infusion Therapy
PHE Public Health England
PPE Personal Protective Equipment
PVAD Peripheral Vascular Access Device
RCA Root Cause Analysis
SIRI Serious Incident requiring reporting
TDA Trust Development Authority

Enc N

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

August 2014

Title	Safer Staffing Monthly Report			
Sponsoring Executive Director	Executive Director of Nursing & Workforce			
Author(s)	Executive Director of Nursing & Workforce			
Purpose	To provide the Trust Board with the new Safer Staffing monthly report as required by NHS England, with requirements identified by the National Quality Board (NQB) To provide the Trust Board with detailed information of planned nurse staffing and actual nurse staffing for July 2014, to ensure safer staffing is considered by the Board and actions taken as required			
Action required by the Board:	**Receive**		**Approve**	**X**

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

Staff, stakeholder, patient and public engagement:

Executive Summary:

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

This report details actual staffing against planned levels on shifts during July 2014. A local RAG rating has been developed and applied to the data to flag percentages of concern with a subsequent overall RAG rating taking note of mitigating actions to highlight potential areas where staffing levels could impact on the quality of patient care.

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

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

Date: 22nd August 2014 **Completed by: Executive Director of Nursing & Workforce**

Isle of Wight NHS Trust
Nursing & Workforce Directorate
Safer Staffing
July 2014

SITUATION

This paper is to provide Trust Board with the Safer Staffing monthly report for July 2014. The Trust Board are asked to acknowledge the July 2014 position.

BACKGROUND

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

The current method of collecting actual staffing data against planned establishment is undertaken through ward staff inputting into the MAPS© database.

This compliance report details "actual against planned" staffing levels on shifts throughout the month. The wards where staffing levels were below planned have been identified and are highlighted, (Appendix 1) and the potential impact on patient care was assessed using the quality indicators and professional judgement (Appendix 2).

ASSESSMENT

In July 2014, there were shortfalls identified in the UNIFY report. Shortfalls in the staffing levels were due to a number of factors i.e. unfilled vacancies, last minute sickness, maternity leave, etc. Senior nurses have made decisions with colleagues to mitigate the risks through strategies such as moving staff from one area to another or making a judgement that additional staff are not required, or a non-registered member of staff may be utilised instead. Professional judgement was also used to determine whether the actual staff numbers available were safe or of concern.

During July 2014, it was not always possible to fill all vacant shifts. On these occasions various steps were taken to ensure patient safety. These actions included: adjusting planned workload; admitting emergencies to other wards; adding the ward sister to the rostered numbers on the wards; moving staff from wards with lower occupancy rates to those where the workload demand was higher. By adopting such measures a safe clinical environment for patients was maintained in all cases.

There remains a data quality for rotas that were approved in July 2014. This will be addressed with the approval of the Trust Rostering procedure. The procedure will be used by all staff who construct and approve rotas.

RECOMMENDATIONS

The Trust Board are asked to receive and acknowledge the following actions.

- The Director of Nursing team (DNT) are currently in the process of approving a rostering procedure which clearly articulates the expectation not only in safe roster production, but also the expected actions to be taken when rosters fall short. We are currently working with the MAPS provider “Allocate software” on the development of functionality to support the rapid deployment of staff to cover such shortfalls.

- The current process for documenting shortfalls in inconsistent and we need to develop a rating system to define the thresholds for whether the staffing level is ‘**agreed’**, ‘**minimum safe**, or requires ‘**escalation’**, moderated through Professional Judgement dependent upon the activity and dependency in the ward or department at the time.

- Minimum staffing and escalation levels must continue to be addressed locally then escalated as required through Matrons, Heads of Clinical Service, Deputy Director of Nursing, Executive Director of Nursing and (Duty Managers out of hours).

- Ward Boards are updated daily and reviewed by the Matron. Rapid deployment should be utilised at the discretion of the Matron or Head of Clinical Service. This will need to be captured in the MAPS system for future reporting.

- The emphasis continues on seeking safe staffing reporting and thus assurance. The Community nursing teams will be added to Hospital Inpatient and Mental Health reposting.

- Continue our recruitment drive to support the addition of staff to vacancies, staff to new posts and additions to the bank.

- Progress ongoing work to drive down sickness in the organisation

Alan Sheward
Executive Director of Nursing & Workforce
August 2014

Prepared by Deborah Matthews – Lead Nurse Safety, Experience & Clinical Effectiveness

Appendix 1

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: R1F Isle Of Wight NHS Trust

Period: July_2014-15

Please provide the URL to the page on your trust website where your staffing information is available

http://www.iow.nhs.uk/about-us/safe-staffing.htm

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	R1F01	St Mary's Hospital - R1F01	Shackleton	715 - OLD AGE PSYCHIATRY	715 - OLD AGE PSYCHIATR	465	535.83	1395	1249.5	294.5	298	589	608	115.2%	89.6%	101.2%	103.2%
	R1F01	St Mary's Hospital - R1F01	Orthopaedic Unit	110 - TRAUMA & ORTHOPAEDICS	110 - TRAUMA & ORTHOPAEDICS	2325	1820.5	1953	1797.8	1240	1182.5	930	792.75	78.3%	92.1%	95.4%	85.2%
	R1F01	St Mary's Hospital - R1F01	Seagrove	996 - PSYCHIATRIC INTENSIVE CARE UNIT	996 - PSYCHIATRIC INTENSIVE CARE UNIT	930	1015.85	930	1091.33	620	625	620	842.5	109.2%	117.3%	100.8%	135.9%
	R1F01	St Mary's Hospital - R1F01	Osborne	710 - ADULT MENTAL ILLNESS	710 - ADULT MENTAL ILLNESS	1650	1528	990	1017.5	930	665	294.5	657.5	92.6%	102.8%	71.5%	223.3%
	R1F01	St Mary's Hospital - R1F01	Mottistone	130 - OPHTHALMOLOGY	502 - GYNAECOLOGY	840	805	390	328.75	582	582	0	10.25	95.8%	84.3%	100.0%	#DIV/0!
	R1F01	St Mary's Hospital - R1F01	St Helens	100 - GENERAL SURGERY	101 - UROLOGY	1626	1730.5	1255.5	1053.5	620	620	620	600	106.4%	83.9%	100.0%	96.8%
	R1F01	St Mary's Hospital - R1F01	Stroke	400 - NEUROLOGY	314 - REHABILITATION	1830	1646	1627.5	1801.01	620	620	620	620	89.9%	110.7%	100.0%	100.0%
	R1F01	St Mary's Hospital - R1F01	Rehab	314 - REHABILITATION	314 - REHABILITATION	1823	1890	1164	1714.5	620	620	620	600.75	103.7%	147.3%	100.0%	96.9%
	R1F01	St Mary's Hospital - R1F01	Whippingham	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1674	1608.08	1488	1431.5	930	770	620	710	96.1%	96.2%	82.8%	114.5%
	R1F01	St Mary's Hospital - R1F01	Colwell	300 - GENERAL MEDICINE	300 - GENERAL MEDICINE	1395	1372	1852.5	2003	620	620	620	620	98.4%	108.1%	100.0%	100.0%
	R1F01	St Mary's Hospital - R1F01	Intensive Care Unit	192 - CRITICAL CARE MEDICINE	192 - CRITICAL CARE MEDICINE	3255	3054	465	260	1776	1837.5	286.75	201.75	93.8%	55.9%	103.5%	70.4%
	R1F01	St Mary's Hospital - R1F01	Coronary Care Unit	320 - CARDIOLOGY	320 - CARDIOLOGY	2325	2269.75	697.5	730.25	1550	1343.5	310	440	97.6%	104.7%	86.7%	141.9%
	R1F01	St Mary's Hospital - R1F01	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE	192 - CRITICAL CARE MEDICINE	1054	1104.26	418.5	413.75	620	665.5	310	260	104.8%	98.9%	107.3%	83.9%
	R1F01	St Mary's Hospital - R1F01	Medical Assessment Unit	326 - ACUTE INTERNAL MEDICINE	326 - ACUTE INTERNAL MEDICINE	2362.5	2329	1093	1121.5	930	930	620	620	98.6%	102.6%	100.0%	100.0%
	R1F01	St Mary's Hospital - R1F01	Afton	715 - OLD AGE PSYCHIATRY	715 - OLD AGE PSYCHIATRY	930	970.5	930	847.5	310	310	620	620	104.4%	91.1%	100.0%	100.0%
	R1F01	St Mary's Hospital - R1F01	Paediatric Ward	171 - PAEDIATRIC SURGERY	171 - PAEDIATRIC SURGERY	1661.5	1307	460	417	620	616.5	310	310	78.7%	90.7%	99.4%	100.0%
	R1F01	St Mary's Hospital - R1F01	Maternity	501 - OBSTETRICS	501 - OBSTETRICS	1860	1836.67	713	593.58	1240	1239.25	620	610	98.7%	83.3%	99.9%	98.4%

Appendix 2

UNIFY Data for July 2014 – Rag rated with locally set RAG rating

	Day		Night		
Ward name	**Average fill rate registered nurses/midwives (%)**	**Average fill rate – non-registered care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate – non-registered care staff (%)**	**Ward self assessment – Professional Judgment** Re-validation required once the Rostering Procedure is in place against which to re-assess staffing levels for August.
Shackleton	115.2%	89.6%	101.2%	103.2%	The non-registered shortfall was off-set by higher Registered staffing levels. Factoring in the availability of staff who are rostered to also cover their community role is difficult
Orthopaedic Unit	97.9%	92.1%	95.4%	85.2%	Lower non-registered staffing levels were satisfactory because occupancy levels on Alverstone were sufficiently low enough (range 5-63%) to enable re-deployment of staff across the areas
Seagrove	109.2%	117.3%	100.8%	135.9%	Higher staffing levels reflect lower occupancy rates – occupancy range 13-63%.
Osborne	92.6%	102.8%	71.5%	223.3%	Although shortfalls these are balanced against occupancy rates – range 5% to 63%. However taking note of acuity and dependency makes calculations problematic
Mottistone	95.8%	84.3%	100.0%	N/A	The area was closed for one full weekend during the month and this has influence the data
St Helens	106.4%	83.9%	100.0%	96.8%	Registered nurses numbers already partially reflect the safer staffing levels on a number of shifts. The combined shift templates made assessments of availability more challenging
Stroke	94.9%	105.0%	100.0%	100.0%	This data and the templates that underpin the return require further analysis - which needs to be in line with the rostering guidance. A significant number of 1:1 close supervision shifts are potentially misrepresenting the actual basic shift fill rates
Rehab	103.7%	147.3%	100.0%	96.9%	Higher non-registered staffing levels reflect the use of 1:1 close supervision care. The significant number of 1:1 close supervision shifts are potentially misrepresenting the actual basic shift fill rates
Whippingham	96.1%	96.2%	82.8%	114.5%	Although some of the shifts currently reflect the safer staffing principles (because of the redeployment of RN's from Appley ward) it makes the interpretation of the overall situation more difficult, and the judgement despite the numbers is that this ward area requires improving. HCA have been substituated for the 3rd RN on nights (although the 3rd RN is a safer staffing aim)
Colwell	98.4%	108.1%	100.0%	100.0%	Although staffing numbers were bolstered by Bank during the month, the staffing levels agaist which this retun was made was based on their current template - not on the safer staffing numbers the ward requires. Recruitment in being progressed.
ICU	93.8%	55.9%	103.5%	70.4%	Substantively there has not been HCA cover for all shifts. Occupancy rates denote this is not an area of concern
CCU	97.6%	104.7%	86.7%	141.9%	Bank usage (to cover vacancies) has maintained reasonable safe staffing levels; reduced RN's at night have been off-set by increased HCA use to cover.
Neonatal ICU	104.8%	98.9%	107.3%	83.9%	
MAU	98.6%	102.6%	100.0%	100.0%	
Afton	104.4%	91.1%	100.0%	100.0%	Lower HCA levels off set by RN level
Paediatric Ward	98.3%	90.7%	99.4%	100.0%	Occupancy rates have varied hugely.
Maternity	98.7%	83.3%	99.9%	98.4%	Although staffing acceptable. Concerns over Quality Indicators requiring further assessment.

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 27th AUGUST 2014

Title	Stakeholder Engagement Strategy			
Sponsoring Executive Director	Mark Price, Company Secretary			
Author(s)	Andy Hollebon, Head of Communications & Engagement			
Purpose	To approve for consultation and delegation of further action to the Trust Executive Committee.			
Action required by the Board:	**Receive**		**Approve**	ü

Previously considered by (state date):			
Trust Executive Committee	14/07/14	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	Feb & May 2013 and 08/07/2014		
Other (please state)			

Staff, stakeholder, patient and public engagement:

This draft strategy will be shared with a wide range of stakeholders when approved for consultation.

Executive Summary:

This strategy sets out how the Trust will engage with stakeholders in the future. It is now submitted for approval for consultation with Island stakeholder groups – both external and internal. It is also proposed that further action on the strategy is delegated to the Trust Executive Committee.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	All Trust Goals					
Critical Success Factors *(see key)*	CSF 1, CSF4, CSF5, CSF8, CSF10					
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	Under the Health and Social Care Act 2012 there are statutory duties placed on NHS organizations to ensure that they consult with and involve local people.					

Date: 19th August 2014 **Completed by:** Andy Hollebon, Head of Communications & Engagement

Isle of Wight NHS Trust

Draft v2014.4

STAKEHOLDER ENGAGEMENT STRATEGY

August 2014

ISLE OF WIGHT NHS TRUST STAKEHOLDER ENGAGEMENT STRATEGY

FOREWORD

Health and health services play a significant part in the life of us all. As the provider of ambulance, community, hospital and mental health services to local people when they require care, the Trust and its activities are naturally of particular interest to service users, a wide range of individuals, groups and organisations, and to our staff. All of these people are our stakeholders.

This Strategy, which is very much a 'living document' represents our renewed commitment to engage more effectively with our local community in the future. We will work to ensure that our stakeholders are more aware of our work, our successes and our challenges in general - on a more regular basis. We will also listen and learn from what local people have to say about our services and in the development and consideration of options - before change is made or decisions are taken.

As a Trust Non-executive Director, working both within and outside the Trust, I particularly recognise the value and importance of effective stakeholder engagement. Effective stakeholder engagement requires strong and enduring relationships between the Trust and local people, which continue even in times of challenge or pressure. It relies on having a good understanding of our various perspectives and our respective areas of interest and concern.

We cannot achieve this Strategy alone. We collaborate closely with representatives of some of the Trust's key stakeholders, including the Health and Community Wellbeing Scrutiny Panel, Isle of Wight Clinical Commissioning Group (CCG), Healthwatch IoW, Community Action Isle of Wight, Isle of Wight Council and our Patient Council. All have an important part to play.

Isle of Wight NHS Trust

ISLE OF WIGHT NHS TRUST STAKEHOLDER ENGAGEMENT STRATEGY

1. INTRODUCTION

Overall aim and audience

The aim of this Strategy is to provide a clear, high level and enduring framework within which the Trust can develop increasingly effective and appropriate means of engaging with its many and varied stakeholders – in ways which meet the needs and expectations of our stakeholders.

This Strategy is designed to set out our philosophy and principles for engaging with our stakeholders. It is intended to provide a checklist against which we can test our actions. It is also intended to set out for our stakeholders the way in which they can expect us to act and engage with them and how we can work together. The Strategy is also a guide for us to use for developing a more detailed delivery plan within the Trust, but is not intended, in itself, to be a detailed delivery plan.

The Strategy, which reflects both our statutory duties and our Trust values and corporate objectives, will be of especial relevance to a number of different groups, including:

- our external stakeholders;
- our internal stakeholders, our Trust Staff;
- our service users.

Amongst our many stakeholders are two significant groups – our service users and our staff. Whilst this Strategy provides the over-arching framework relating to all our stakeholders, details of our approaches to engaging with these particular groups will be set out in two linked, but separate, Trust documents. This Strategy should be considered alongside the Trust's:

- Patient Experience Strategy; and
- Health and Wellbeing Strategy

The format of the document

The remaining sections of this document cover:

- Definitions of stakeholder engagement
- The national and statutory context
- Why stakeholder engagement is important
- Who are our stakeholders?
- Our objectives for engagement
- Our philosophy and guiding principles for engagement
- Stakeholder engagement - principles into practice
- Roles and responsibilities
- Measuring success

2. STAKEHOLDER ENGAGEMENT – WHAT IS IT?

Definitions

- **Stakeholders** can be defined as any person or group of people who have a significant interest in services provided, or will be affected by, any planned changes in an organisation or Local Health Community. They can be internal or external to that Local Health Community, and they can comprise staff, patients, trade unions, MPs and members of the public and community groups.

- **Stakeholder Engagement** is a process by which an organisation or Local Health Community learns about the perceptions, issues and expectations of its stakeholders and uses these views to assist in managing, supporting and influencing any planned changes/improvements in service delivery.

- **Service users** are those who use services or those who may use them. Service user involvement can be directly or through representatives.

3. THE NATIONAL AND STATUTORY CONTEXT

Engagement of people who use health and social services and the wider public has gained an increasing focus in government policy in recent years. Major government policies designed to improve and modernise the NHS reinforce this commitment to involve service users and stakeholders.

The legal duty to involve service users is set out in *the Health and Social Care Act 2012*. This places a duty of care on those providing health services to make arrangements to involve users of services - whether directly or through representatives:

- from the beginning in the planning and the provision of services;
- in the development and consideration of proposals for change in the way the services are provided;
- in decisions to be made by the body affecting the operation of services.

The Act also identifies a requirement to consult Health, Community and Care Overview and Scrutiny Committees (HCCOSC) where there is any proposal for substantial change or development of the health services in the areas of the local authority or for substantial variation in how that service is provided.

The NHS Constitution (DOH 2009, updated 2013) informs people of *"their right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided and in the decisions to be made affecting the operation of these services."*

Further guidance and good practice is set out in a range of national documents including:

- *Real Involvement: Working with people to improve* health service;
- *Guidance when undertaking major changes to NHS services*;
- *Planning and delivering service changes for patients*;
- *Transforming Participation in Healthcare*

4. STAKEHOLDER ENGAGEMENT – WHY IS IT IMPORTANT?

Building relationships based on mutual understanding and trust

Effective stakeholder engagement is about building sustainable relationships with people who are affected by what we do and the services which we provide, and who have a contribution to make with regard to what we do. It relies on a commitment to engage, listen, respond and communicate openly and honestly with stakeholders.

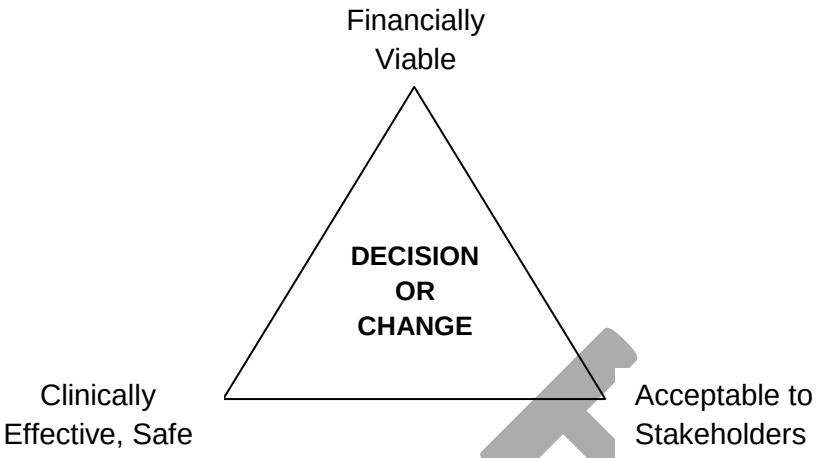
Most people naturally place a high value on their health and the health of their families and friends. As a consequence, services provided to local people by the NHS are of particular importance and interest to both individuals and groups – whether these services are provided in the community or in hospital.

Through working with our stakeholders, we believe that we can achieve improved mutual understanding and trust. By sharing more about the work which we do and how we do it, about our successes and our challenges, we hope that local people will feel that they know us better as the organisation which cares for them when they need our services. Through maintaining regular two-way dialogue we will also be able to listen to, and understand more clearly, the issues, concerns and ideas of local people. This also enables us to make improvements to the ways in which we provide our services.

Enabling and facilitating change

Change, development and innovation are on-going and inevitable in all areas of life. They are an essential part of health services nationally, and locally - within the wider Isle of Wight health community and within the NHS Trust. This is reflected in our commitment to continuous service improvement and in our values.

We believe strongly that change should be associated with improving service quality, or with improving the use of limited resources, and that stakeholder involvement is important in identifying the need for change and the means by which this can be achieved. The aim is to achieve a balance between providing clinically effective and safe services, acceptability to stakeholders, and making the best use of scarce resources.



Adapted from "Real Involvement" DOH 2008

David Nicholson, then Chief Executive of the NHS, reflected some years ago, that: *" …. the NHS needs to be much better at engaging with stakeholders, including the public and their representatives, patients and their carers, clinicians and staff, MPs and a whole range of other stakeholders. The NHS needs to do more to ensure that stakeholders are actively engaged in developing proposals for change and also explaining the reasons behind decisions that are made"*

(David Nicholson CEO letter Feb 2007)

This Strategy represents our commitment to engage more effectively with our local community in the future - to listen and learn from what local people have to say, in the development and consideration of options and before change is made or decisions are taken.

4.3 A reflection of our Trust values and strategic objectives

The Strategy reflects the Trust's mission, vision and values, which were developed in recent years in discussion with staff and patients. The values are also expressed in a shorter format through a number of key words:

listening, helping, excelling, improving, uniting, caring – better for you

The Trust's Mission, Vision and Values

Our vision - Quality care for everyone, every time. For us this means that:

- Our patients and their families will say that we care and will recommend us to others
- We will provide the right service for every individual, every time, delivered locally wherever clinically appropriate and cost effective
- We will be an excellent, trusted provider of health and social care, central to the health and wellbeing of Island residents and visitors

- Our services will provide the best integrated care in the country – services integrated with each other and with those of our partners – and as a result we will be locally and globally admired
- We will fully realise for our patients and our commissioners the potential of our integrated organisational form and deliver the Isle of Wight health system strategy of integrated care.

Our mission

- Redesign patient pathways to ensure patients are being cared for in the right place every time. This will lead to a smaller hospital facility with more care being delivered in the community setting.
- Develop integrated locality teams that work across primary, secondary and Social Care through the use of leading edge technology and innovative ways of working.
- Further develop the Hub and the integrated working supported by this initiative.
- Deliver – 'My Life a Full Life' – integrated working across health and social care.
- Develop new and innovative business opportunities that build on what we do best.
- Develop new initiatives such as a retirement village, an intermediate care facility and a new Welcome Centre through the engagement of strategic partners.
- Enable the integration of systems to further support health care through the ongoing development of the Integrated Service Information System (ISIS).

Our values

Our values are the same as those written within the NHS Constitution, which establishes the principles and values of the NHS in England.

- **Working together for patients** – Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

- **Respect and dignity** – We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

- **Commitment to quality of care** – We earn the trust places in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

- **Compassion** – We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person' pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

- **Improving lives** – We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

- **Everyone counts** – We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

Our set of Vision, Values and Behaviours sets out how as individuals and as an organisation we will act.

The vision, values and behaviours were developed through consultation with a wide range of staff and patient representatives and reflect similar initiatives undertaken by other NHS and non-health related organisations. They support and reflect an organisational culture of empowerment, effective communications and inclusivity. We challenge unacceptable behaviour promptly, but we also recognise and acknowledge good work and behaviour.

Our Trust's Strategic Objectives

- **Quality** - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience.
- **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.
- **Resilience** - To build the resilience of our services and organisation, through partnerships within the NHS, with social care and with the private sector.
- **Productivity** - To improve the productivity and efficiency of the Trust, building greater financial sustainability.
- **Workforce** - To develop our people, culture and workforce competencies to implement our vision and clinical strategy.

The achievement of all of our strategic objectives will depend on our ability as an organisation to interact and work effectively with our stakeholders. Effective stakeholder engagement is a core activity which must run through all of our activities, and at all levels.

5. WHO ARE OUR STAKEHOLDERS?

We recognise that it is important to have a clear understanding of who our stakeholders are. Each stakeholder or stakeholder group will have differing characteristics, roles, needs, expectations and interests and these will vary according to the issue under consideration. Careful stakeholder analysis and the development of a tailored "stakeholder map" and associated communications strategy will be essential to the success of individual engagement projects or activities.

The figure below, for illustrative purposes only, is designed to demonstrate the variety of broad external stakeholder groups who may have a potential interest in what we do.

Our external stakeholders

Regulators	Monitor, CQC, TDA, HSE.
Wider community	Past / future patients, employees, families, businesses, education.
Future of the Isle of Wight	Media, MP, County, Town & Parish Councils, Employers, local partnerships.
Local service providers	Neighbouring NHS Trusts especially those providing services on the Island, GPs, social, residential and nursing care providers, housing providers, Care UK, dentists, opticians, pharmacists, chiropodists, 3rd sector providers.
Commissioners	Isle of Wight Clinical Commissioning Group, NHS England, Isle of Wight Council.
Customer proxies	Governors, Members, Healthwatch, Health Scrutiny Sub-Committee, Councillors, User and voluntary groups.
Service users	Patients and carers.
External influencers	Academic Health Science Network (AHSN), Health Education England (HEE), Foundation Trust Network (FTN), King's Fund.

Our **patients and service users** are at the centre of all that we do – our reason for being. Like the Trust itself, all the other stakeholder groups share this common focus of interest and concern. As the direct recipients of our care, individual service users may be seen as our *"customers",* although not in the sense of having a financial or formal contractual arrangement with us.

Those whom we have described as our **customer proxies** are groups in the community with a particularly close and informed interest in the services which our patients receive. As a consequence, they are often able to provide a further service user perspective or another reflection of the views of patients and carers.

In a business sense, our true *"customers"* are actually our **commissioners** – those organisations and groups with whom we have formal contractual service level agreements. These include Isle of Wight Clinical Commissioning Group (CCG) and other CCGs, NHS England, Isle of Wight Council and others who purchase services from us.

Local service providers are those who also provide services to local people – health care, social care or associated care or services. Often we are all involved in providing elements of a wider continuum of care. Close partnership and dialogue is essential between us – changes in service provision in one area will frequently have an impact in another area of service.

Those whom we have identified as having a particular interest in the **quality of life** of local people and individuals and in the **future of Isle of Wight** may have a formal representative role – for example, Members of Parliament, Local Councillors and other elected representatives.

External influencers include bodies such as Academic Health Science Network (AHSN), Health Education England (HEE), Foundation Trust Network (FTN) and the King's Fund which all produces influential reports and comment on the NHS.

Others, for example, the media or local Strategic Partnerships and other partnerships will have a different relationship, but will still have a strong focus on the interests of local people and communities.

The wider community is likely to have what we have described as a watchful, broad interest in services from a distance – alert to potential issues which might be of interest from time to time, but perhaps not actively involved on a regular or day to day basis.

Our regulators are those external and formal bodies which regulate and monitor us from a distance. When we perform well they are likely to remain at a distance – alert and interested, but with limited involvement on a day to day basis.

Our internal stakeholders – our staff

Our staff, nearly 3,000 in all, and their representatives, are another of our key stakeholder groups. We have identified them amongst our external stakeholders as they, too, are members of the community and the public. In this capacity they will have an informed interest and views on the general provision of health services. However, as our staff, they are our also our *internal"* stakeholders – involved in and close to the day-to -day provision of services in the hospital. Our broad principles and approach to stakeholder engagement extends to all our stakeholders, including our staff. However, the relationship which we have with our staff will differ slightly from that which we have with other stakeholder groups.

6. OUR OBJECTIVES FOR ENGAGEMENT

We have identified three broad strategic objectives for engagement.

- Our processes and mechanisms for engagement are appropriate and effective;
- Our services and use of healthcare resources are enhanced through engagement with our stakeholders;
- Our stakeholders have a closer, on-going relationship with the Trust, they feel involved and that their contribution is considered, valued and can make a difference.

These objectives will form the basis for the development of more detailed delivery plans within the Trust. We would like to work with stakeholders to identify appropriate measures which we can use to assess our achievement of these objectives.

7. OUR PHILOSOPHY OF ENGAGEMENT

Our guiding principles

The Trust's core values lie behind our approach to stakeholder involvement. These values are reflected below in the following more detailed operational principles, which we will use as guiding principles for our future engagement activities. They have been developed by the small group which was established to develop this Strategy. They summarise the expectations and aspirations expressed by participants in the group, who included of members of the Trust and a number of representatives of key stakeholder groups who kindly agreed to work with us on this project:

- we will work towards ensuring wherever possible, there are ***"no surprises"*** – through on going, open communication with our stakeholders, a proactive approach and timely sharing of emerging issues;
- we will work to promote improved **general awareness and understanding** of the day to day role, work and activities of the Trust as a whole;
- we will focus on **improvement** - proposals for change which we bring forward will be associated with improving service quality, or with improving the use of limited resources;
- we will be **clear** about the purpose and scope of our engagement activities - what we are and not engaging on, what can change or not change;

- we will work to develop the concept of different types of **"conversations"** in our approach to stakeholder engagement, and explore opportunities for using **coproduction and experience-based design** methodologies;
- we will **listen,** reflect and explore issues and options *before* we agree a solution – we will take account of what we **learn** in our decision-making, to achieve better outcomes and mutually beneficial solutions;
- we will **value the contribution, expertise and time of our stakeholders** – where possible we will work through existing groups and networks, but continue to build alliances, to involve groups which may be seldom heard and overcome barriers to effective engagement. We will reflect our equality and diversity policies in our engagement activities.
- we will work to **strengthen relationships and build mutual trust** with stakeholders – through openness, honesty and supporting people in feeling "safe" in making their contribution;
- we will **communicate clearly and effectively** by using a variety of methods appropriate and proportionate to the context and circumstances - we will provide background information to the issues under discussion;
- we will **check understanding and provide timely feedback** *"you said, we listened, and this is the outcome"* and we will continue to keep people abreast of progress and to maintain links;
- we will **support and develop our staff** to enable them to contribute as internal stakeholders, and work with external stakeholders with confidence.

We recognise that however effective engagement processes may be, they will not always achieve universal agreement with a particular decision or change, although it might be preferred or supported by the majority of stakeholders. On occasions external and national imperatives may also restrict our freedom to take the option which is preferred. It will be important that on these occasions we acknowledge our differences and that the reasons behind a decision are clearly explained. Where relationships are strong, we believe these differences of view should not impede our ability to continue to work closely together.

Equality and diversity

Engagement activities should offer the widest opportunity for the involvement of stakeholders. Particular attention should be given to involving groups who may be seldom heard. For all engagement activities an equality and diversity impact assessment will be undertaken and activities will comply with the Trust's Single Equality Policy, designed to ensure that groups are not excluded through their disability; race, ethnicity or nationality; gender; sexual orientation; age (younger or older people); religion, belief or faith.

8. STAKEHOLDER ENGAGEMENT

PRINCIPLES INTO PRACTICE – SOME EXAMPLES

As a large and complex organisation we must constantly adapt to the changing needs of health care services and other demands upon us. In common with other large organisations, the majority of issues will lie within the legitimate remit of our internal management decision making processes.

Our expectation is that stakeholders would not generally expect to be involved in operational decisions which are about the day-to-day running of services. However, we wholly acknowledge the importance of keeping people informed and our duty to listen to and involve service users and stakeholders. This is both an on-going basis, and from an early stage in the consideration and planning of potential service development or change.

Through ensuring that our routine and on-going communication is effective, we hope that local stakeholders and organisations will gradually become more familiar generally with their local hospitals - about the range of our activities and what we do, what is happening, successes, general performance and on-going news. We too will become more familiar with our stakeholders' issues and concerns.

In the work which we have done to date, we have identified three different broad approaches, which we might adopt, with the support of stakeholders, in our engagement activities. The common theme is that of a two-way *"conversation"* - a conversation which will take different forms depending on the circumstances.

One to one conversations

Building links and relationships through key individuals

We believe that it would be of significant benefit to identify designated named individuals within the Trust who can establish links with individual stakeholders or with a designated named contact from particular a stakeholder organisation or group. Our expectation is that through continuity and regular contact, relationships can grow to enable better shared understanding of the other's perspective and current issues; to enable informal soundings to be taken where appropriate; to provide a contact to alert when unexpected issues may emerge at short notice. Sometimes the focus for the relationship or *"buddying"* arrangement might be associated with a particular subject or area of interest.

One possible option to explore is whether these designated individuals might also form part of a wider reference panel which the Trust could approach when required, for early advice or comment. Such a panel would be in addition to, and not a substitute for, wider engagement activities.

Regular, organised conversations

These regular, organised, conversations would take a number of different forms depending on the context. They are likely to have some structure around them, and might take place within existing forums or meetings held by stakeholder groups, or as part of a specific event or seminar, or take the form of a *"road show".* Whilst there would be an opportunity for us to raise awareness of current achievements and issues facing the Trust, as *'conversations'* these would also offer the opportunity for two-way discussion, to listen to each other and share views and issues.

These conversations might take place at a set time during the year. For example, as we develop plans for the year ahead in our '*Annual Plan',* and as we reflect and report back on our performance in the year which is ending in *our 'Annual Report'* and associated *'Quality Account'*. We have an obligation to share these reports with key stakeholders, but recognise that there is an opportunity for more active engagement in these areas, and to share and discuss our emerging plans and pressures more fully.

For some of our stakeholder groups it might be more appropriate for us to meet more frequently or for there to be a standing agenda item at appropriate stakeholder meetings or ad hoc events. We recognise the pressures on stakeholder time and resources, and we propose that wherever possible or appropriate, we use existing meetings or networks as the setting for these conversations.

Targeted/in depth conversations, particularly associated with projects relating to service development and change

We would like to continue the concept of *"conversations"* with our stakeholders when the need for specific service change or development is indicated. However, these conversations are likely to take a different form, to be more in depth and vary in scale according to the context. They would be specifically designed and the relevant stakeholders carefully identified for each area of work. They might focus on one element of a specific patient pathway, be associated with the design of a new building or department, or be much wider in scope involving whole services.

Some of these conversations might take place in the context of a wider stakeholder involvement exercise or formal consultation undertaken jointly with the wider health community. They may involve internal or external stakeholders, or in most cases both of these groups.

In relation to these wider projects or discussions around change we believe that there is significant benefit to be gained in developing a consistent approach and philosophy, perhaps in collaboration with the CCG and others for engaging with both internal and external stakeholders groups.

It is characterised by two-way and open communication, a cycle of sharing and drawing out the issues, of listening and considering views, before potential options or solutions are identified.

Another essential feature of the process is to reflect back and check the understanding of those involved. On occasions it may be necessary to go through this cycle several times.
We would also like to explore opportunities, where appropriate, for developing *'co-production' and 'experience-based design'* methodologies in some of the areas in which we work together with stakeholders. Our patients and our staff are best placed to identify the changes which might be made to improve services. We believe that over time these approaches will enable us to explore potential changes or developments in a more collaborative and informed way.

We also believe that by engaging effectively at the level of the patient pathway or service delivery these activities can increasingly inform and influence annual planning activities and opportunities for broader service change.

Engaging with individual service users and patients in the course of their care

This is an important aspect of the services which we provide, but is different in nature from the much broader engagement situations highlighted above. It is reflected in the person to person activity, including relationship building and the quality of engagement and communication, which is established between people/patients, carers and relatives and the clinicians/staff during treatment and care. Feedback through comments, concerns, compliments and complaints from individual service users and members of the public can also influence and change in the ways in which we deliver our services.

Support and advice for engagement activities

We have outlined above, in very broad terms, a number of approaches for engaging with stakeholders. Toolkits to assist Trust staff and advice and support will be available from the Communications, Engagement and Membership Team. Annex 2 identifies a range of means of engaging and communicating with individuals and groups through personal contact or electronic means. Development and training initiatives will be required to further develop capacity and skills amongst our staff in the area of stakeholder engagement. There is a wealth of advice and guidance available including two well recognised and used models for engagement:

- the ladder of engagement and participation
- the engagement cycle

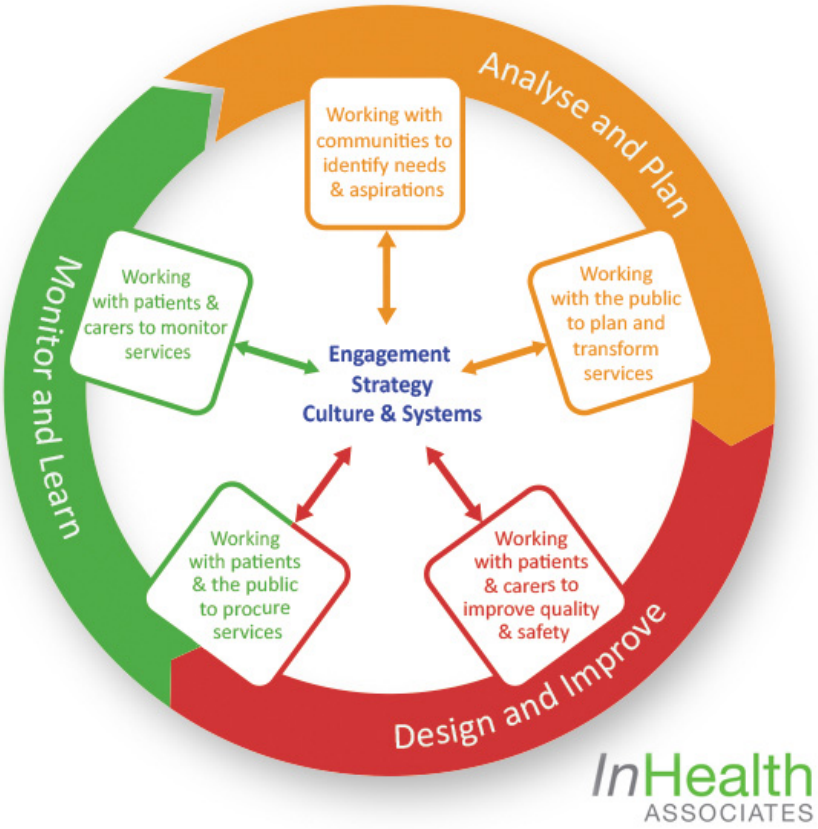
'Ladder of Engagement and Participation'

There are many different ways in which people might participate in health depending upon their personal circumstances and interest. The 'Ladder of Engagement and Participation' is a widely recognised model for understanding different forms and degrees of patient and public involvement, (based on the work of Sherry Arnstein). Patient and public voice activity on every step of the ladder is valuable, although participation becomes more meaningful at the top of the ladder.

Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.

The Engagement Cycle

The Engagement Cycle (pictured right) can help meaningful patient and public engagement for maximum impact. It is a tried and tested, practical resource, used by dozens of Clinical Commissioning Groups (and others) to plan, design and deliver great services for, and with, local people.



9. ROLES AND RESPONSIBILITIES

This is an ambitious Strategy and it important to recognise that it will take time to implement and require the commitment and input of both the Trust and our stakeholders. We need to ensure that we set challenging but achievable milestones along the way but are also realistic about managing expectations and perceptions. Relationships mature over time. As we progress, we need to reflect together regularly on our relationship and above all be willing to learn from our experience to build this learning into future ways of engaging with each other.

Within the Trust

The Strategic leadership and accountability for the Stakeholder Engagement, and associated activities within the Trust, rests ultimately with the Board and the Chief Executive. At present, contact with our stakeholders lies with a relatively small number of staff – particularly our Directors and our Communications and Engagement Team. Over time, we would wish to extend the range of those who are able and confident in working with both internal and external stakeholders, and to involve others including Non-executive Directors, Divisional and Clinical staff more actively in this.

We are making a commitment to establish named links within the Trust for those of our key stakeholder groups who would find this a helpful approach. We would like to work towards developing a directory of key stakeholder contacts and areas of interest, building on the template included in Annex 3. We see this as live document which will be updated on a regular basis in the future.

Our staff are our internal stakeholders and an important and key group. Through cultural change across the organisation, our objective is that staff at all levels recognise the opportunities for active involvement in engagement activities, and have the confidence to contribute and to influence discussions. Patients, carers and the public respect the expertise of our staff and listen to what they say. There are clear opportunities for building on this existing trust and involving appropriate clinical and other staff more directly in external stakeholder engagement activities.

In order to achieve this we will need to incorporate engagement more explicitly into our core leadership programmes and to ensure that stakeholder engagement embedded in our project management and other activities. We will also develop tool kits to support our staff.

External stakeholders

For stakeholder engagement to be effective, it requires the commitment from all those concerned. Through the willingness of key stakeholders to contribute actively to the development of this Strategy, and by listening to their views, we believe that we are setting

down stronger foundations for working together more closely and effectively in the future. In earlier sections of the Strategy, we have highlighted a number of areas in which we would welcome the support of stakeholders and recognise that we need to work together, including, to:

- help us understand their particular areas of interest and expectations;
- identify link individuals within organisations to facilitate the building of on-going relationships;
- identify existing meetings in which on-going '*organised conversations'* can take place and other mechanisms for two-way communication.

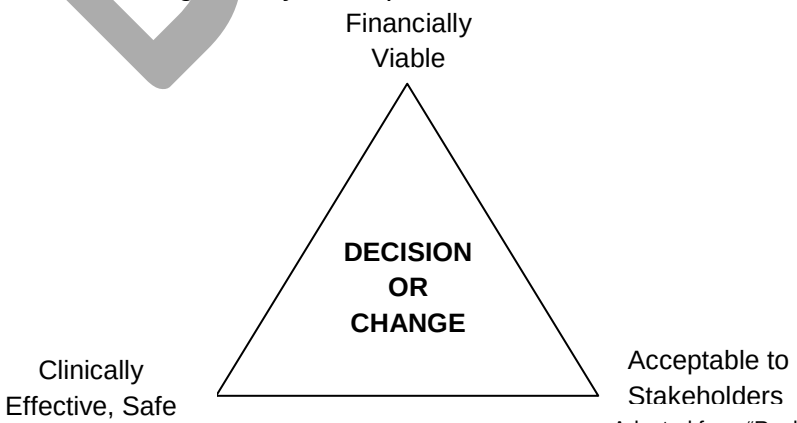
We recognise that early involvement with stakeholders is key and this is an approach to which we are committed. It will be necessary, however, to find means of reaching a mutual understanding of our roles and responsibilities in engaging in discussions in a way which is appropriate to the stage of development of ideas and proposals. On some occasions, for example, early or emerging issues or options may be of a particularly sensitive or confidential nature. A clear understanding of responsibilities and expectations in these cases will be especially important.

We appreciate that many of our service users are also users of other parts of the health and social care community. Each organisation will have its own engagement strategy and policy reflecting its role and responsibilities. We need to make sure that we work closely together and to ensure consistency of approach in circumstances where our engagement activities should or should not overlap.

10. WHAT WILL SUCCESS LOOK LIKE? HOW CAN WE MEASURE IT?

In earlier sections, we identified our guiding principles and the broad objectives which we believe we can achieve over time, by working jointly with our stakeholders.

A range of measures exist for patient and public involvement activities, and in relation to staff - for example, through patient surveys and the annual staff survey, the Friends and Family test, the Listening into Action pulse checks – and we can draw on these. In relation to specific projects linked to service change it may be helpful to reflect on the three dimensions below.



Adapted from "Real Involvement" DOH 2008

We will need to work further to develop the range of measures which we can use to assess our progress and success in engaging with our other stakeholders. We would welcome their help in identifying suitable measures.

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- Transforming Participation in Healthcare, NHS England, 2013
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- Making Experience Count (Department of Health) June 2007
- Our NHS, Our Future: NHS Next Stage Review, Leading Local Change (Department of Health) 2008
- Real Involvement. Working with people to improve health services (Department of Health) 2008
- Guidance when undertaking major changes to NHS services (Department of Health) 2008
- The National Health Service Constitution for England (Department of Health) 2009.
- Better Regulation Executive 2008 Code of Practice on Consultation London BRE. www.bre.berr.gov.uk
- Her Majesty's Government 2006 National Health Services Act (HMSO) 2006

GLOSSARY

Annual Plan	A forward look of the Trust's current future intentions.
Annual Report (and Accounts)	A statutory document produced by the Trust and which is laid before Parliament.
Care Quality Commission (CQC)	The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisation. It also protects the interests of people detained under the Mental Health Act.
Clinical Commissioning Group (CCG)	The NHS body responsible for commissioning and funding the majority of local healthcare services.
Commissioning / Commissioners	Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. Commissioners are those who do this, and who agree service level agreements with service providers for a range of services. Commissioners may include PCTs or increasingly also groups of GP practices.
Co-production and experience-based design methodologies	Ways of working/activities which involve patients and staff or other stakeholders in re-designing services or improving care, and which draw on their experiences.
Customer proxies	In this document this term refers to specific groups with a particularly close and informed interest (from a public/patient perspective) in the service which the Trust patients receive – including, Trust Governors, Foundation Trust Members, Healthwatch, Health Scrutiny Sub Committee (the health overview and scrutiny committee (HOSC) for the Island), voluntary and support groups.
Foundation Trust	NHS providers who achieve Foundation Trust status have greater freedoms and are subject to less central control. Foundation Trusts are part of the NHS and have to meet the same national targets and standards.
Foundation Trust Governors	The Council of Governors are elected by Foundation Trust members. Over half are local people or service users, other membership includes staff members and local partner organisations. Governors advise a Foundation Trust on how it carries out its work so that this is consistent with the needs of members and the wider community.
Health Overview and Scrutiny Committee (HOSC)	Health Overview and Scrutiny Committees (HOSCs) are made up of local government councillors and offer a view on local and social care matters. On the Island it is called the Health Scrutiny Sub Committee. This is responsible for overview and scrutiny of health related issues. It focuses on health issues from a public perspective and works in partnership with other agencies to improve local health services.
Healthwatch	Local organisation in each local authority area, set up to represent the views of local people on health and social care services. This organisation's predecessors include Local Involvement Networks (LINk); Patient and Public

	Involvement Forums (PPIF) and Community Health Councils (CHCs).
Internal stakeholders	Our staff are the Hospital Trust's internal stakeholders.
Local health and social care community	The local health community includes commissioners and providers of healthcare in the local area. The local health and social care community will also include commissioners and providers of social care.
Local Strategic Partnerships (LSPs)	These bring together representatives of all the different sectors (public, private, voluntary and community) and thematic partnerships. They have responsibility for developing and delivering the local sustainable Community Strategy and the Local Area Agreement.
Monitor	Monitor is the independent regulator of NHS foundation trusts, established in January 2004 to authorise and regulate NHS foundation trusts. It is independent of central government and directly accountable to Parliament.
NHS Constitution	A national document which describes the principles and values of the NHS in England, and the rights and responsibilities of patients, the public and staff.
NHS England	The public body which oversees commissioning of NHS services at a regional level.
NHS Trust Development Authority	The public body which oversees NHS Trusts which have not yet achieved Foundation Trust status.
Provider	Organisations which provide services direct to patient, including hospitals, community services, mental health services and ambulances.
Quality Account	A report on the quality of services published annually by providers of NHS care. Quality accounts are intended to enhance accountability to the public. Quality is assessed from a number of perspectives, including: patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.
Reference panel	A group of people who can be approached for advice or guidance.
Regulators	External and formal bodies which regulate and monitor the Trust – these include Monitor, Care Quality Commission (CQC), Health and Safety Executive, the Strategic Health Authority, the Department of Health.
Representatives	People who are in a position to speak on behalf of other service users. People are representatives when the views they share are the opinions of the people they are representing, which may not be the same as their own – these may be from statutory or voluntary or support organisations.
Service users	Those who use services or those who may use them. Service user involvement can be directly or through representatives.
Stakeholder engagement	A process by which an organisation or Local Health Community learns about the perceptions, issues and expectations of its stakeholders and uses these views to

	assist in managing, supporting and influencing any planned changes/improvements in service delivery.
Stakeholders	Any person or group of people who have a significant interest in services provided, or will be affected by, any planned changes in an organisation or Local Health Community. They can be internal or external to that Local Health Community, and they can comprise staff, patients, trade unions, MPs and members of the public and community groups.

ANNEX 1

INVOLVING SERVICES USERS – OUR LEGAL DUTY

Since January 2003, all NHS bodies have had a legal duty to involve and consult the public about the running of local health services. Patients are listened to and actions taken to meet their concerns.

There are many ways in which patients and the public can get involved to influence and improve health and social care services. They include the following:

Healthwatch

Healthwatch is the independent consumer champion that gathers and represents the views of the public about health and social care services in England.

It operates both on a national and local level, and ensures that the views of the public and people who use services are taken into account.

National level - Healthwatch England

Healthwatch England was established in October 2012. As a national body it works closely with local Healthwatch and advises NHS England (the commissioning board), local authorities, the Care Quality Commission (CQC) and the Secretary of State. It was set up as a committee of the CQC.

Healthwatch England also alerts the CQC to concerns about health and social care providers, and recommends actions if necessary. It has its own identity within the CQC, and operates independently of them, but can use the CQC's expertise and infrastructure.

Healthwatch England is funded as part of the Department of Health's grant in aid to the CQC, and is required to make an annual report to Parliament.

Local level - Local Healthwatch

Local Healthwatch organisations were established in April 2013. They took over the work previously done by the Local Involvement Networks (LINks), but with additional functions.

A local Healthwatch is an independent organisation, able to employ its own staff and to involve volunteers, so it can become the influential and effective voice of the public. It will have to keep accounts and make its annual reports available to the public.

The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

- It represents the views of the public, patients, health and care service users and their carers and families on the health and wellbeing boards.
- It reports to Healthwatch England any concerns about a health or social care service – Healthwatch England can then recommend that the CQC takes action, if necessary.

- It helps people find information about local health and care services, including how to access them.
- It provides authoritative, evidence-based feedback to organisations responsible for commissioning or delivering local health and social care services.
- It visits services and provides reports and recommendations about how these could be improved.

Local Healthwatch has to be representative of its local community as laid out in the Health and Social Care Act 2012. This includes ethnic groups, different users of services and carers. Further information about Healthwatch Isle of Wight can be found at www.healthwatchisleofwight.co.uk

Patient Advice and Liaison Service

PALS is a key driver of public and patient involvement in the NHS. Officers from PALS are available in all hospitals. The Trust's PALS service can be found at the Main Entrance to St. Mary's Hospital, Newport . They offer confidential advice, support and information on health-related matters to patients, their families and their carers. Patients who are concerned about their care or treatment, are encouraged to speak to the staff treating them or to speak to a member of the PALS team and they will try to resolve the situation. If they are unable to help, they will explain the formal NHS complaints procedure and put the individual in touch with the right people to speak to.

NHS Foundation Trusts

Isle of Wight NHS Trust aspires to be a NHS Foundation Trust. This allows greater autonomy from central government, and requires that local people, patients and staff have a say in the running of the Trust. In preparaton for Foundation Trust status Isle of Wight NHS Trust has created a free Membership scheme (www.iow.nhs.uk/membership). All local people, patients and NHS staff are eligible to become members and when created take an active part in its management. Members will elect representatives from among themselves to serve on the trust's Council of Governors.

Patient Council

The Trust has had a Patient Council for around 10 years. Membership comprises circa 25 patients who have volunteered to help the Trust develop policy, strategy and plans for healthcare. It has been agreed that the Patient Council will continue in existence until the Council of Governors is elected.

Volunteering

In addition to the options mentioned above, there are lots of other ways to become involved in improving healthcare in the local community.

Source: based on NHS Choices (www.nhs.uk), August 2014

ANNEX 2

METHODS OF ENGAGEMENT

Methods of engagement and communication are many and varied. Different methods will be used depending on circumstances. We believe that wherever possible we should build on and seek to maximise the use of existing channels, networks and recognised geographical communities, to avoid establishing a separate structure of engagement networks. At the same time, where current mechanisms are insufficient or fail to include relevant stakeholders, we recognise that we will need to extend existing links and means of engagement. The table below is designed to capture some of the main methods commonly used in stakeholder engagement activities. A toolkit will be developed to assist staff. They will also be able to draw on the support and expertise of the Communications, Engagement and Membership Team.

FACE TO FACE PERSONAL CONTACT	DOCUMENTATION ELECTRONIC
Individual focused	**Written/printed**
• designated contact person/representative • informal meeting/conversation • formal meeting • one to one briefing • telephone call • interview – informal/in depth • open door/drop in opportunity • "hotline" facility/access to individual • visits	• letter – targeted/general • formal reports/agenda papers/plans • notes/minutes/summaries of meetings • press releases • consultation packs • leaflets/posters • briefings • newsletters/ articles in publications of others • storyboards • displays/stalls • roadshows • individual "stories" • survey/questionnaire • newspapers • frequently-asked questions
Group focused	**Electronic**
• meeting – other organisation (formal/informal) • meeting – Trust-based (formal/informal) • partners' meeting/reference group • public meeting • Annual General Meeting • briefing – regular/special/team • seminars/presentations • project/task/special interest groups • rapid improvement events • focus groups/forums/panels • open days/visits/tours • citizens juries and related approaches • public hearing	• e mail – targeted/global • website • webcasts/video • blogs/twitter • "Facebook" approaches • E news • web survey • electronic storyboards • SMS text-messaging • film/video • mass media – TV/radio

ANNEX 3

KEY CONTACTS AND CHANNELS FOR ENGAGING WITH KEY STAKEHOLDER GROUPS

We see this as a live and dynamic listing which we will refine and to which we will add over time. We will work to identify the Accountable Officer and key designated points of contact within the Trust. It is not, at this stage a comprehensive list. We would welcome the input of our stakeholders in helping us add to this and complete elements of relevance to them or their organisation or group and to ensure that the information we hold is current.

We recognise that individual stakeholders may fall within different broad stakeholder groups depending upon the area, service or project concerned, or into more than one group. Here we have grouped a range of stakeholders for illustrative purposes into the broad groups identified earlier, in section 5.1 of the draft Strategy. No specific order of importance is implied in the positions within this list.

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
SERVICE USERS/CARERS			
Service Users	Executive Director of Nursing and Workforce	• Individual members of staff responsible for the care of a patient • Communications and Engagement Officers	• comments, concerns, compliments, and complaints ("4Cs") • Members Involvement Forum • special interest groups/ user • groups/project groups • service or condition-specific user / support groups in the county • Healthwatch • community events • general communication / website
Carers	Executive Director of	• Individual members of staff	• attend Carers' Forum

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
	Nursing and Workforce	responsible for the care of a patient • Communications and Engagement Officers	• meetings run by Carers Isle of Wight • reports/briefings • Trust meetings / project groups • carers within condition specific • support groups • general communication / website
CUSTOMER PROXIES			
Members and Member Involvement Forum	Company Secretary	• Head of Communications & Engagement • Membership and Engagement Officer	• annual meeting • forum meetings / seminars • attend Trust meetings / project group / special interest groups • review of Annual Report / Quality Account • general communication / website
Healthwatch Isle of Wight	Executive Director of Nursing and Workforce	• Head of Communications & Engagement • Communications and Engagement Officer • Quality Manager	• attendance Healthwatch meetings • briefings / presentations • Members forum / seminars • Partners Group • Review of Annual Report / Quality • Account • project groups / Trust meetings • open days • general communication / website
Community Action IoW (formerly Isle of Wight Rural Community Council)	Executive Director of Integration and Transformation	• Head of Communications & Engagement • Communications and Engagement Officer	• attendance at meetings • briefings / presentations • project groups / Trust meetings • open days

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
			• general communication / website
Health Scrutiny Sub Committee	Chief Executive	• Executive Directors as appropriate • Head of Communications & Engagement • Communications and Engagement Officer	• attendance at meetings • briefings / presentations • meetings • visits to IoW NHST • general communication / website
Patient Council (will be replaced byTrust Governors)	Executive Director of Nursing and Workforce (will be taken on by Company Secretary when Council of Governors elected)	• Matrons • Chief Executive and Executive Directors as appropriate • Head of Communications & Engagement • Communications and Engagement Officer	• Council meetings • Briefings / presentations / open days • general communication / website
Voluntary Organisations	Chief Executive	• Lead clinical staff for areas where the voluntary organisation is orientated to a specific condition • Executive Directors • Head of Communications & Engagement • Communications and Engagement Officer	• Voluntary Sector Forum • Community Action IoW • Meetings / presentations • general communication / website
COMMISSIONERS			
GP Locality Groups x 3	Executive Medical Director	• Directorate Senior Management Teams (CDs, HOCs, ADs)	• Locality Executive Board meetings • other meetings targeted communications • general communications / website
Isle of Wight Clinical	Chief Executive	• Executive Directors as appropriate	• Strategic Forum meetings

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
Commissioning Group		• Head of Communications & Engagement	• Clinical Priorities Forum meetings • other meeting / groups • general communication / website
Isle of Wight Council	Chief Executive	• Executive Directors as appropriate • Head of Communications & Engagement	• Strategic Forum meetings • Clinical Priorities Forum meetings • other meeting / groups • general communication / website
NHS England and Wessex LAT	Executive Director of Finance	• Contracts Team • Head of Communications and Engagement	• Ad hoc meetings
LOCAL SERVICE PROVIDERS AND PARTNERS			
Care UK (HMP IoW healthcare provider)	Executive Medical Director	• Staff dealing with the treatment of prisoners	• Meetings as required • E-mail • Website
Dentists	Executive Medical Director	• Staff receiving referrals from local dentists • NHS 111 service advisers	• Meetings as required • E-mail • Website
Domiciliary Care Agencies	Executive Director of Nursing & Workforce	• Staff working with staff arranged by Domiciliary Care Agencies	• Meetings as required • E-mail • Website
Earl Mountbatten Hospice	Executive Medical Director	• Staff dealing with the palliative care treatment	• Meetings as required • E-mail • Websit
GPs	Executive Medical Director	• Directorate Senior Management Teams (CDs, HOCs, ADs) • Head of Communications and	• attendance at MSC / LNC meetings • targeted communications • general communications / website

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
		Engagement • NHS 111 service advisers	
Hertfordshire Partnership University NHS Foundation Trust	Executive Medical Director	• Associate Director, Head of Clinical Service and Clinical Director responsible for mental health services	• Meetings as required • E-mail • Website
Independent sector providers	Executive Director of Finance	• Head of Commercial • Contracts Team • Head of Communications and Engagement	• Meetings • general communication / website
Isle of Wight Council	Chief Executive	• Staff making referrals and accessing services provided	• E-mails, telephone calls and ad-hoc meetings
Isle of Wight Youth Trust	Executive Director of Nursing & Workforce	• Staff making referrals and accessing services provided	• E-mails, telephone calls and ad-hoc meetings
NHS Blood & Transplant	Executive Medical Director	• Chair of the Organ Donation Committee • Chief Pharmacist • Head of Intensive Care	• Meetings of the Organ Donation Committee • E-mails, telephone calls and ad-hoc meetings
NHS Business Services Authority	Executive Director of Finance	• Staff accessing services	• E-mails, telephone calls and ad-hoc meetings
NHS Litigation Authority	Executive Director of Finance	• Head of Governance • Risk Management Officers	• E-mails, telephone calls and ad-hoc meetings
NHS Supplies Authority	Executive Director of Finance	• Staff accessing services	• E-mails, telephone calls and ad-hoc meetings
Nursing Homes	Executive Director of Nursing & Workforce	• Executive Medical Director • Staff working with homes on	• E-mails, telephone calls and ad-hoc meetings

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
		admissions and discharges	
Opticians	Executive Medical Director	• Staff receiving referrals from local opticians • NHS 111 service advisers	• E-mails, telephone calls and ad-hoc meetings
Pharmacists	Executive Medical Director	• Chief Phamacist • NHS 111 service advisers	• E-mails, telephone calls and ad-hoc meetings
Portsmouth Hospitals NHST	Executive Director of Finance	• Contracts Team • Head of Communications and Engagement	• meetings • general communication / website • Strategic Forum meetings • Clinical Priorities Forum meetings
Residential Care Homes	Executive Director of Nursing & Workforce	• Executive Medical Director • Staff working with homes on admissions and discharges	• E-mails, telephone calls and ad-hoc meetings
Solent NHS Trust	Chief Executive	• Executive Directors and other staff as appropriate	• E-mails, telephone calls and ad-hoc meetings
Southern Health NHSFT	Chief Executive	• Executive Directors and other staff as appropriate	• E-mails, telephone calls and ad-hoc meetings
University Hospitals Southampton NHSFT	Executive Director of Finance	• Contracts Team • Head of Communications and Engagement	• meetings • general communication / website • Strategic Forum meetings • Clinical Priorities Forum meetings
FUTURE OF ISLE OF WIGHT/LOCAL QUALITY OF LIFE PERSPECTIVE			
County, Town and Parish Councils	Chief Executive	• Executive Directors as appropriate • Directorate Senior Management Teams (CDs, HOCs, ADs) • Head of Communications &	· briefings · attend meetings (specific issue) · Association of Local Councils · open days

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
		Engagement	· general communication / website
Health and Wellbeing Board	Chief Executive	• Executive Directors and other staff as appropriate	• E-mails, telephone calls and meetings
Isle of Wight Chamber of Commerce, Tourism & Industry	Executive Director of Transformation & integration	• Executive Directors and other staff as appropriate · Head of Communications and Engagement	• E-mails, telephone calls and meetings
Member of Parliament	Chairman	• Chief Executive • Company Secretary · Head of Communications and Engagement	· regular meetings · briefings · visits to IoW NHST / open days · general communication / website
Media	Executive Director of Transformation & integration	· Chief Executive · Executive Directors · Head of Communications and Engagement · Communications Manager · Communications and Engagement Officers · Clinical or project leads as appropriate	· briefings/press releases · one-to-one contact · open days/photo-opportunities · general communication / website
REGULATORS			
Care Quality Commission	Executive Director of Nursing and Workforce	• Chief Executive and other Executive Directors as appropriate	reports/clarifications/registration - meetings - visits/inspections
Health and Safety	Executive Medical	• Chief Executive and other Executive	Reports / correspondence / clarification

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
Executive	Director	Directors as appropriate	- meetings - visits/inspections
Health Research Authority	Executive Medical Director	• Research and Development staff	· E-mails, telephone calls and meetings
Human Fertilisation & Embryology Authority (HFEA)	Executive Medical Director	• Consultants	· E-mails, telephone calls and ad-hoc meetings
Human Tissue Authority	Executive Medical Director	• Pathologists	· E-mails, telephone calls and meetings
Medicines and Healthcare Products Regulatory Authority	Executive Medical Director	• Clinical and managerial staff as appropriate	· E-mails, telephone calls and meetings
Monitor	Company Secretary	• Chief Executive and other Executive Directors as appropriate	· Annual reports · Quality Accounts · Meetings
National Institute for Clinical Excellence (NICE)	Executive Medical Director	• Clinical and managerial staff as appropriate	· E-mails, telephone calls and meetings
National Patient Safety Agency (NPSA)	Executive Director of Nursing and Workforce	• Executive Medical Director	· E-mails, telephone calls and meetings
NHS England	Chief Executive	• Executive Directors as appropriate	· regional meetings · other meetings · reports/briefings
NHS Trust Development	Chief Executive	• Executive Directors as appropriate	· regional meetings · other meetings

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
Authority			· reports/briefings
Public Health England	Executive Medical Director	• Executive Director of Nursing and Workforce	· E-mails, telephone calls and ad-hoc meetings
Royal Colleges	Executive Medical Director or Executive Director of Nursing and Workforce	• Chief Executive • Human Resources staff • Clinicians dependent on their registration and specialisms	· E-mails, telephone calls and meetings
INTERNAL STAKEHOLDERS			
Our staff and their representatives	Executive Director of Nursing and Workforce	• Chief Executive and other Executive Directors as appropriate • Head of Communications & Engagement	- Hospital Management Staff Committee - Joint Staff Consultative Committee - Local Negotiating Committee - Staff side/CUPAC - staff briefings - team briefing - team meetings - global e mails - Outline - general communication/website
WIDER COMMUNITY			
IoW Children's Trust	Chief Executive	Executive Director of Nursing and Workforce	· Attendance and participation · general communication / website
Local Safeguarding Children Board	Executive Director of Nursing and Workforce	Executive Director of Nursing and Workforce	· Attendance and participation · general communication / website
Local Safeguarding	Executive Director of	Deputy Director Nursing	· Attendance and participation

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
Adult Board	Nursing and Workforce		· general communication / website
Local Education & Training Board (LETB)	Chief Executive	Executive Director of Nursing and Workforce	· Attendance and participation · general communication / website
EXTERNAL INFLUENCERS			
Academic Health Sciences Network	Chief Executive	Executive Director of Nursing and Workforce	· Attendance and participation · general communication / website
Associaton of Chief Ambulance Officers	Head of Ambulance	Deputy Ambulance Officers	· Attendance and participation · general communication / website
Cancer Research Network	Executive Medical Director	Research and Development staff Staff dealing with cancer	· E-mails, telephone calls and meetings
Carer'sTrust (formerly The Princess Royal Trust for Carers and Crossroads Care)	Executive Director of Nursing and Workforce	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
Foundation Trust Network (FTN)	Chief Executive	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
Department of Health	Chief Executive	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
Health & Social Care Information Centre (HSCIC)	Executive Director of Transformation and Integration	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
Health Education England (HEE)	Executive Director of Nursing and Workforce	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings

STAKEHOLDERS KEY CONTACTS	TRUST ACCOUNTABLE OFFICER	DELEGATED TO, OR INVOLVEMENT OF, OTHERS IN TRUST	MEANS OF ENGAGEMENT (EXAMPLES)
Healthwatch England	Executive Director of Nursing and Workforce	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
King's Fund	Chief Executive	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
Mental Health Research Network	Executive Medical Director	Research and Development staff Staff dealing with mental health	· E-mails, telephone calls and meetings
National Institute for Health Research	Executive Medical Director	Research and Development staff	· E-mails, telephone calls and meetings
NHS Confederation	Chief Executive	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
NHS Employers	Executive Director of Nursing and Workforce	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
Patients Association	Executive Director of Nursing and Workforce	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings
Queen's Nursing Institute	Executive Director of Nursing and Workforce	Other Executive Directors and staff as appropriate	· E-mails, telephone calls and meetings

Annex 4

Equality Analysis and Action Plan

Step 1. Identify who is responsible for the equality analysis.

Name: Andy Hollebon
Role: Head of Communications and Engagement
Other people or agencies who will be involved in undertaking the equality analysis:

Step 2. Establishing relevance to equality

Show how this document or service change meets the aims of the Equality Act 2010?

Equality Act – General Duty	Relevance to Equality Act General Duties
Eliminates unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act.	Engaging in a meaningful way with all strata of society will enhance understanding between individuals and organisations.

	Relevance		
Protected Groups	**Staff**	**Service Users**	**Wider Community**
Age	All	All	All
Gender Reassignment	All	All	All
Race	All	All	All
Sex and Sexual Orientation	All	All	All
Religion or belief	All	All	All
Disability	All	All	All
Marriage and Civil Partnerships	All	All	All
Human Rights	All	All	All
Pregnancy and Maternity	All	All	All
Advance equality of opportunity between people who share a protected characteristic and people who do not share it	Engaging in a meaningful way with all strata of society will enhance understanding between individuals and organisations.		
Foster good relations between people who share a protected characteristic and people who do not share it.	Engaging in a meaningful way with all strata of society will enhance understanding between individuals and organisations.		

Step 3. Scope your equality analysis

	Scope

What is the purpose of this document or service change?	The aim of this Strategy is to provide a clear, high level and enduring framework within which the Trust can develop increasingly effective and appropriate means of engaging with its many and varied stakeholders – in ways which meet the needs and expectations of our stakeholders.
Who will benefit?	Patients, the population of and visitors to the Isle of Wight.
What are the expected outcomes?	Improved health services.
Why do we need this document or do we need to change the service?	This document will assist the development of improved health services.

It is important that appropriate and relevant information is used about the different protected groups that will be affected by this document or service change. Information from your service users is in the majority of cases, the most valuable.

Information sources are likely to vary depending on the nature of the document or service change.

Listed below are some suggested sources of information that could be helpful:

- Results from the most recent service user or staff surveys.
- Regional or national surveys
- Analysis of complaints or enquiries
- Recommendations from an audit or inspection
- Local census data
- Information from protected groups or agencies.
- Information from engagement events.

Step 4. Analyse your information.

As yourself two simple questions:

- What will happen, or not happen, if we do things this way?
- What would happen in relation to equality and good relations?

In identifying whether a proposed document or service changes discriminates unlawfully, consider the scope of discrimination set out in the Equality Act 2010, as well as direct and indirect discrimination, harassment, victimization and failure to make a reasonable adjustment.

Findings of your analysis

	Description	Justification of your analysis
No major change	Your analysis demonstrates that the proposal is robust and the evidence shows no potential for discrimination.	This strategy sets the direction of travel and requirements for the Trust to engage with individuals and organisaitons. It does not exclude anyone. It seeks to encourage those planning changes to health services to consider how to engage with as wide a range of individuals and organisations as appropriate to the issue under consideration.
Adjust your document or service change proposals	This involves taking steps to remove barriers or to better advance equality outcomes. This might include introducing measures to mitigate the potential effect.	
Continue to implement the document or service change	Despite any adverse effect or missed opportunity to advance equality, provided you can satisfy yourself it does not unlawfully discriminate.	
Stop and review	Adverse effects that cannot be justified or mitigated against, you should consider stopping the proposal. You must stop and review if unlawful discrimination is identified	

5. Next steps.

5.1 Monitoring and Review.

Equality analysis is an ongoing process that does not end once the document has been published or the service change has been implemented.

This does not mean repeating the equality analysis, but using the experience gained through implementation to check the findings and to make any necessary adjustments.

Consider:

How will you measure the effectiveness of this change	The Communications and Engagement Officer will produce an annual review of all consultation and engagement activity.
When will the document or service change be reviewed?	The document is a 'living document' especially Annex 3 and will be reviewed on an annual basis.
Who will be responsible for monitoring and review?	Head of Communications and Engagement
What information will you need for monitoring?	Records and plans for engagement and consultation.
How will you engage with stakeholders, staff and service users	See Annex 2.

ISLE OF WIGHT NHS TRUST

FOUNDATION TRUST PROGRAMME BOARD

TUESDAY 22 JULY 2014 BETWEEN 11:00 – 12:30
LARGE MEETINGS ROOM, TRUST HQ, SOUTH BLOCK

NOTES

PRESENT

Karen Baker (Chair)	Sue Wadsworth	Katie Gray	Chris Palmer
Mark Elmore (for Alan Sheward)	David King (by phone)	Alan Sheward	Danny Fisher

1. APOLOGIES

Mark Price	Mark Pugh	Andy Hollebon

IN ATTENDANCE

Andrew Shorkey	Jo Henley (Item 5)	Anna Daish-Miller (Item 4)

Top Key Issues	Subject
089/14	The CQC's draft inspection report was scheduled to be received on 28 Jul 14 and the Trust would have 10 working days to respond.

ACTION

Notes and matters arising from 17 June 2014

082/14 The notes of the meeting were received and accepted as a correct record.

Action Tracker

083/14 The following actions could now be closed: 462, 487, 500, 503. The status and forecast dates would be reviewed for the remaining open actions. **AS**

FT Application Submission to TDA 8 August 2014

084/14 AS presented the latest correspondence to the Trust Development Authority (TDA) identifying our current working assumptions in relation to the 8 August submission. An updated version of the Integrated Business Plan would be submitted including the downside scenario within chapter 7. Minor amendments would also be made to chapters 5 and 6. **CP**

085/14 CP advised that, with respect to the mock Board to Board meeting on 30 July, clarification would be sought around the extent of financial questioning as the Board as a whole would not yet be fully sighted on the downside scenario. Work was being progressed by Katie Gray to ensure quality impact assessments were in place for the two-year cost improvement programme.

Chief Inspector of Hospitals Visit Update

086/14 ADM introduced the item and provided an update against actions with AWS. Key concerns related to staffing levels and outliers on stroke and rehab. AWS advised that the staffing issues were mainly related to doctors and he would be undertaking a review. ADM advised that criteria were in place in relation to medical outliers.

087/14 ADM to receive the senior manager on call (SMOC) report to obtain updates on current numbers of medical outliers. AWS advised that action 2.2.4 would be re-drafted to ensure there was a clear and shared understanding of the requirement. **ADM** **AWS**

088/14 SW raised a query in relation to the single point of entry for emergency paediatric patients in A&E and AWS advised that he was working with A&E and the paediatric ward to address any issues.

089/14 KB advised that the CQC's draft inspection report was scheduled to be received on 28 Jul 14 and that we would have 10 working days to respond. There was a need to ensure confidentiality prior to the publication of the report after the Quality Summit September 2014. **All**

Communications and Engagement

099/14 Membership update

JH advised that the staff database was up to date and that the number of volunteers had dropped slightly to 544. The second edition of the member's magazine had been published and it had been well received. The majority of the production had been handled 'in-house' and this had significantly reduced the cost. Medicine for Member events had been scheduled and notifications would be sent out in due course. There had been some difficulties in attracting staff governor speakers for future governor events. It is thought that this is due to the smaller numbers of staff governors and the limitations on their availability. It was noted that there had been difficulty in securing support for the Chale show and additional support was requested. **MP**

Workstream updates

100/14 AS advised that the templates and process for the 2014/15 round of business planning would be going to TEC for approval on 28 July 2014.

Programme Management

Programme Timeline

101/14 It was noted that the timeline would be affected if the CQC report was not 'good' or 'outstanding'.

Integrated Action Plan

102/14 It was agreed that actions Foresight 13 and 14 and TDA QR 12 could now be marked as complete. **AS**

Updates to be provided against TDA QR 1, 4, 10, 25 and 26. **AS**

Risk Management **AS**

103/14 No changes were recommended with respect to current risk ratings.

Budget update

104/14 AS presented the current budget breakdown and advised that an additional line had been included with respect to the Listening into Action Programme. CP advised that the overall budget had now been reduced to contribute to the cost improvement programme.

Any other Business

105/14 DF advised that he had received a consultation paper relating to tariff. CP advised that the Contracts
106/14 Team were co-ordinating a response.

SW gave apologies for the meetings scheduled for September and October 2014 and advised that if an additional NED was required Charles Rogers could be approached. **MP**

Future Meetings

The next meeting was scheduled for 11:00-12:30hrs, Tuesday 23 September 2014, Large Meetings Room, South Block.

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 27 August 2014

Title	Self-certification			
Sponsoring Executive Director	Mark Price, FT Programme Director / Company Secretary			
Author(s)	Andrew Shorkey, 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	20-Aug-14
Finance, Investment & Workforce Committee	20-Aug-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 August 2014 Trust Development Authority (TDA) self-certification return covering July 2014 performance period for approval by Trust Board.
The key points covered include:

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

For following sections – please indicate as appropriate:

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

Date: 8th August 2014 **Completed by:** Andrew Shorkey, Programme Manager – Business Planning and Foundation Trust Application

ISLE OF WIGHT NHS TRUST
SELF-CERTIFICATION

1. Purpose

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

2. Background

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

According to the TDA:

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

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

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

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

3. Assurance

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

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

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 a holistic view of the complete self-certification return and feedback from Board sub-committee Chairs.

4. Performance Summary and Key Issues

Board Statements

1. In consideration of recent intelligence and performance information it is recommended that Board Statements 1, 2, 6 and 14 are marked as 'at risk' until work to clarify gaps in assurance and test systems and processes is concluded. Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, remains 'at risk' until a positive trend towards recovery is established, as determined by the Board at its 02 July 2014 meeting. This position is reflected within the draft sample return document (Appendix 1a).

Licence Conditions

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

Foundation Trust Milestones

3. The Trust continues to meet agreed milestones. The Trust's trajectory could alter as a consequence of the Care Quality Commission's assessment of the Trust received in draft form and embargoed for publication until after the Quality Summit scheduled for 2 September 2014. As stated above, the trajectory could also be impacted following an assessment of the Trust's IBP by the TDA. The draft return document is attached as Appendix 1c.

5. Recommendations

It is recommended that the Trust Board:

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

Andrew Shorkey
Programme Manager – Business Planning and Foundation Trust Application
8 August 2014

6. Appendices

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

7. Supporting Information

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

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

	For CLINICAL QUALITY, that:	Response	Comment where non-compliant or at risk of non-compliance	Timescale for Compliance	Executive Lead
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's Oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	At risk	Recent intelligence and performance has determined that this statement will be marked at risk until work to clarify gaps in assurance and test systems and processes is concluded.	31-Oct-14	Alan Sheward Mark Pugh
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	At risk	Recent intelligence and performance has determined that this statement will be marked at risk until work to clarify gaps in assurance and test systems and processes is concluded.	31-Oct-14	Mark Price
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes			Mark Pugh
	For FINANCE, that:	**Response**			
4	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes			Chris Palmer
	For GOVERNANCE, that:	**Response**			
5	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes			Karen Baker Mark Price
6	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	At risk	Recent intelligence and performance has determined that this statement will be marked at risk until work to clarify gaps in assurance and test systems and processes is concluded.	31-Oct-14	Mark Price
7	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes			Mark Price
8	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes			Karen Baker
9	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes			Mark Price
10	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR [Governance Risk Rating]; and a commitment to comply with all commissioned targets going forward.	At risk	The Trust's Governance Risk Rating (Monitor access and outcome measures) score has significantly declined. Issues impacting on performance are understood and indicator recovery plans have been reviewed. Early indications suggest that a number of these indicators will be recovered in advance of our next submission.	30-Sep-14	Alan Sheward Mark Pugh

Z2 - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes			Mark Price
12	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies	Yes			Mark Price
13	The board is satisfied all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes			Karen Baker
14	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	At risk	Recent intelligence and performance has determined that this statement will be marked at risk until work to clarify gaps in assurance and test systems and processes is concluded.	31-Oct-14	Karen Baker Alan Sheward

Z2 - TDA Accountability Framework - Licence Conditions

Appendix - 1(b)

	Licence condition Compliance	Compliance (Yes / No)	Comment where non-compliant or at risk of non-compliance	Timescale for compliance	Accountable
1	Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	Yes			Mark Price
2	Condition G7 – Registration with the Care Quality Commission	Yes			Mark Price
3	Condition G8 – Patient eligibility and selection criteria	Yes			Alan Sheward
4	Condition P1 – Recording of information	Yes			Chris Palmer
5	Condition P2 – Provision of information	Yes			Chris Palmer
6	Condition P3 – Assurance report on submissions to Monitor	Yes			Chris Palmer
7	Condition P4 – Compliance with the National Tariff	Yes			Chris Palmer
8	Condition P5 – Constructive engagement concerning local tariff modifications	Yes			Chris Palmer
9	Condition C1 – The right of patients to make choices	Yes			Alan Sheward
10	Condition C2 – Competition oversight	Yes			Karen Baker
11	Condition IC1 – Provision of integrated care	Yes			Alan Sheward Mark Pugh

TDA Accountability Framework - Timeline Towards Sustainability Milestones

Appendix - 1(c)

	Milestone (all including those delivered)	Milestone date	Performance	Comment where milestones are not delivered or where a risk to delivery has been identified
1	Quality Governance Framework score at 2.5	30-Jun-13	Complete	
2	Draft IBP/LTFM Submission	30-Nov-13	Complete	
4	Chief Inspector of Hospitals visit	03-Jun-14	Complete	
5	Final IBP/LTFM Submission	20-Jun-14	Complete	
6	FT Application Submission	08-Aug-14	On target	
7	TDA Quality Summit	02-Sep-14	On target	
8	Board to Board meeting with TDA	03-Sep-14	On target	
9	TDA approval to proceed and application to Monitor	18-Sep-14	On target	

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Isle of Wight NHS Trust

FOR PRESENTATION TO TRUST BOARD ON 27 AUGUST 2014

AUDIT AND CORPORATE RISK COMMITTEE

Minutes of the meeting of the Audit and Corporate Risk Committee held on the 19th August 2014 at 9.30 a.m. in the Small Meetings Room, St. Mary's Hospital, Newport

PRESENT:	David King	Chairman
	Lizzie Peers	NED Financial Advisor to Trust Board
	Charles Rogers	Non Executive Director
	Sue Wadsworth	Non Executive Director
In Attendance:	Chris Palmer	Executive Director of Finance
	Paul King	External Audit Engagement Lead
	Andy Jefford	Chief Internal Auditor
	Barry Eadle	Local Counter Fraud Specialist
	Kevin Curnow	Deputy Director of Finance
	Brian Johnston	Head of Corporate Governance & Risk
	Andy Heyes	Head of Commercial Development (Item 14/096
	Charles Joly	Environmental, Waste & Sustainability Manager (Item 14/092)
	Brian Maszynski	Waste & Recycling Assistant (Item14/092)
	David Sellars	MH Modern Matron (Item 14/102)
	Mandy Tate	Lead for ECT Clinic (Item 14/102)
Minuted by:	Linda Mowle	Corporate Governance Officer

Min. No.	Recommendations to Trust Board
14/093	**REVIEW OF NHS AUDIT COMMITTEE HANDBOOK 2014** **COMMITTEE OBJECTIVES UPDATE** **REVIEW OF INTEGRATION WITH OTHER COMMITTEES WHICH REVIEW RISK** Items deferred for discussion at a future Board Seminar. In order to ensure that the assurances the Committee receives are appropriate, the Committee recommended that a Board Seminar be held in the very near future to discuss: · Timings of sub-committees · Membership of Audit & Corporate Risk Committee · Alignment of sub-committees' terms of reference to ensure they are correctly structured to meet the needs of the organisation · The level of assurance required and how this is provided · Enhancement of Audit Committee's role and effectiveness – section of Action Plan to be discussed

Min. No.	Top Key Issues/Risks
14/090	**Counter Fraud – CEAC new management arrangements:** TIAA Ltd have initially been asked jto provide a managerial role to CEA which hopefully will lead to a fusion between CEA and TIAA in the near future. TIAA has a significant Counter Fraud and Security Management Directorate
14/091	**Environment Agency Clinical Waste Audit Update:** Assurance could be provided to the Trust Board that Clinical Waste practices were now fully compliant with current statutory regulations

14/095	**External Audit –** Annual Audit Letter 2013/14 confirming unqualified opinion and value for money conclusion
14/096	**IA Report – NHS Creative – Limited Assurance:** Committee of the opinion that in future decisions to host a service or department need to be more carefully considered and related to the organisation's Business Strategy
14/104	**Internal Audit Contract Tender 2015/18:** Contract to go out to tender
14/105	**Procurement Services Contract:** A year's extension with a review date and process to be implemented for the future tendering of the service.

14/083	**APOLOGIES** for absence were received from Jane Tabor, Non Executive Director, Mark Price, Company Secretary, Kevin Suter, External Audit Manager, and John Micklewright, Internal Audit Manager
14/084	**QUORACY:** The Chairman confirmed that the meeting was quorate.
14/085	**WELCOME:** The Chairman, on behalf of the Committee, welcomed Lizzie Peers, NED Financial Advisor to the Trust Board, to her first meeting of the Committee.
14/086	**DECLARATIONS OF INTEREST:** There were no declarations. The Register of Gifts & Hospitality, and Register of Interests for 2014/15 were available for scrutiny.
14/087	**MEMBERSHIP:** The Committee noted the revised membership of 4 NEDs agreed at Trust Board on the 28th May, 2014 (Min. No. 14/148) and the addition of Lizzie Peers, NED Financial Advisor to the Trust Board as a co-opted member. The Chairman highlighted the importance of an independent Member with clinical expertise being appointed as an advisor to the Committee in order to enhance its effectiveness, particularly in view on the heightened emphasis on clinical audit and governance.
14/088	**MINUTES:** The minutes of the meetings held on the 21st May and 5th June 2014 were agreed and signed by the Chairman as a true record, subject to the following amendment: · Min. No. 14/048 Committee Objectives A4.2 Monitor achievement of the Integrated Services Information System (ISIS) to improve the quality and value of services: second sentence insert 'organisation' instead of 'hospital'.
14/089	**MATTERS ARISING FROM PREVIOUS MINUTES:** **Min. No. 14/076 – 2013/14 Annual Governance Statement – Action Plan:** The Head of Governance & Risk updated the Committee on the current status of the significant issue on Information Governance contained within the AGS. A full SIRI investigation has been undertaken with a report and action plan developed. The outstanding action is to make sure that information governance training is a priority for new junior doctors and to be undertaken within 2 weeks of employment in the Trust. The Medical Director is writing to the Wessex Deanery to ascertain whether they can provide IG Training for their trainees. The Committee requested that the letter is sent by the MD by the end of August 2014 and that an update is provided to the next meeting in November. **Action: HOG** In addition, Charles Rogers confirmed that FIWC will follow up the action plan at its meeting in September. The Committee received and noted the following schedules:

	a) Schedule of Actions **ACRC/009 Legal Service Agreement:** HOG to circulate to NEDs the date of the presentation on 4th September 2014 in order that a NED can be at the adjudication meeting. **ACRC/021 IA Limited Assurance Report – Private Patients:** The new Executive Director for Transformation & Integration will be reviewing the private patients' service, including the Strategy, its management and development. The Executive Director of Finance highlighted that the contracts with insurance companies have still not been renegotiated and that this is to be followed up by Internal Audit in Q4 as this is a potential area of risk. The Committee requested that an update be provided to the next meeting in November. **Action: IA** Actions to be defined, e.g. high risk, and actions 'completed' to be listed at the end of the schedule. **Action: DDOF/CGO** **b) Schedule of Recommendations to Trust Board:** **ACRC/R006 IA Report – Payroll Workforce Transactions – Limited Assurance:** Noted completed. **c) Annual Review Action Plan 2014/15:** **Organisational Culture, Health and Wellbeing:** The terms of reference for the new Culture, Health & Wellbeing Committee, which reports to TEC, were received for information. The Committee noted that a strategy is still being developed and that this topic will be discussed at FIWC on the 20th August 2014.The Committee agreed that an update be provided to the November meeting of the Committee to gain further insight into how this sub-committee will meet the Committee's assurance requirements. **Action: CS/EDOF** **Enhancement of Audit Committee's role and effectiveness:** This section of the Action Plan to be included in the Board Seminar's discussion on sub-committees in order to ensure that sub-committees are appropriately structured to provide the requisite assurance to ACRC. **Action: CS** The Committee was concerned that Board Seminars were becoming unwieldy and not the most efficient use of NEDs time, and that the NEDs should be involved in the prioritisation of topics to be discussed at Seminars. The Executive Director of Finance agreed to take this feedback to TEC and to the Company Secretary. **Action: EDOF** The Committee was of the opinion that overall there was a lack of pace for the implementation of internal audit recommendations and that a procedure needs to be introduced whereby any change to agreed implementation dates has the agreement of the Audit & Corporate Risk Committee, with the direct lead attending the ACRC meeting to explain the reasoning for the changed implementation date. **Action: DDOF**
14/090	**COUNTER FRAUD:** The Local Counter Fraud Specialist, Barry Eadle, introduced the comprehensive and self-explanatory progress report, highlighting the following: · Self Review Assessment for the work completed in 2013/14 with an overall score of 'Green' · Central England Audit Consortium's new management arrangements: Kettering General Hospital NHS Trust, CEAC's hosts, have been seeking alternative hosting arrangements. Following a period of consultation, TIAA Ltd have initially been asked to provide a managerial

	role to CEAC which hopefully will lead to a fusion between CEAC and TIAA in the near future. It is proposed that the staff of CEAC will be integrated as part of TIAA by the 1st October 2014. This integration will preserve and enhance CEAC's Counter Fraud Service and provide additional resilience. TIAA has a significant Counter Fraud and Security Management directorate with 49 staff delivering high quality services to over 80 NHS organisations. · Closure Report SERT No. 13/00275 · Update on 2 current investigations In order to enhance the assurance provided within the report, the Committee requested that the following be included within the progress report: · A front summary sheet · Column stating days against planned days · Column stating actions/recommendations arising from investigations · Self Review Tool (SRT) process summary of the 3 amber ratings – why an issue, the risk and the action being taken **Action: LCFS** Sue Wadsworth formally thanked Barry Eadle for the excellent 'scam' work he has undertaken with such efficiency and authority.
14/091	**FT STATUS GOVERANCE AND SELF-CERTIFICATIONS:** Deferred to future meeting
14/092	**ENVIRONMENT AGENCY CLINICAL WASTE AUDIT UPDATE:** Charles Joly and Brian Meszynski presented the update report outlining the following progress: · Action tracker showing all due actions implemented and on track for achieving remaining actions · The aggregated Trust risk register entry for waste is now closed · Environment Agency officer has praised the Trust for speed and efficiency of change made · Clinical staff have embraced change and adoption of the new clinical waste segregation procedures at ward level has been very successful · Environment Agency will visit again mid-August for a routine visit of the clinical waste transfer station and again around April 2015 for a follow-up Trust-wide audit of clinical waste segregation and practices · Trust is now regionally recognised as a hub for good practice The Committee congratulated Charles Joly and his team on the excellent work undertaken and considered the quality of the documentation be an example of best practice within the Trust. In order to highlight this important work, the Committee requested that an article is included in the Staff Magazine by Charles Joly and that this is highlighted to TEC by the Executive Director of Finance. **Action: EDOF/CJ** The Audit & Corporate Risk Committee was of the opinion that assurance could be provided to the Trust Board that Clinical Waste practices were fully compliant with current statutory regulations.
14/093	**REVIEW OF NHS AUDIT COMMITTEE HANDBOOK 2014** **COMMITTEE OBJECTIVES UPDATE** **REVIEW OF INTEGRATION WITH OTHER COMMITTEES WHICH REVIEW RISK** Items deferred for discussion at a future Board Seminar.

	In order to ensure that the assurances the Committee receives are appropriate, the Committee recommended that a Board Seminar be held in the very near future to discuss: · Timings of sub-committees · Membership of Audit & Corporate Risk Committee · Alignment of sub-committees' terms of reference to ensure they are correctly structured to meet the needs of the organisation · The level of assurance required and how this is provided · Enhancement of Audit Committee's role and effectiveness – section of action plan to be discussed **Action: CS**
14/094	**PROCEDURE FOR THE FOLLOW UP OF RECOMMENDATIONS PROGRESS ON AUDIT & FRAUD RECOMMENDATIONS** Deferred to a future meeting
14/095	**EXTERNAL AUDIT:** The External Audit Engagement Lead, Paul King, presented the following reports: · Annual Audit Letter 2013/14: unqualified opinion and value for money conclusion and audit completion certificate issued on 6th June 2014 · External Assurance on the Trust's Quality Account: an unqualified report Paul King highlighted the national trend that there was 100% submission of accounts by the deadline including CCGs. However, around 40% of NHS Trusts received some form of 'value for money' conclusion and the picture is one of increasing number of value for money conclusions as Trusts struggle to achieve financial balance.
14/096	**INTERNAL AUDIT:** The Chief Internal Auditor introduced the progress report highlighting the following: · Progress against the internal audit plan is on track at 25%. Plan to be linked to the BAF and Trust Corporate Objectives for future year and track as the risk profiles change. Draft Internal Audit Plan to be included in the February year end planning meeting. · Ward Visits – substantial assurance · Follow up of recommendations in 2013/14 Limited Assurance Reports: separate independent verification of achievements of outstanding recommendations. Procedure to be amended to cover ACRC agreement to changed implementation dates. · NHS Creative – Limited Assurance: Andy Heyes, Head of Commercial Development, attended for this report advising that this will be monitored through FIWC and how it will be aligned to the Strategic Estates Partner. The Executive Director of Transformation & Integration has been tasked to carry out a full review of the department which should be completed by the end of September 2014 when an initial business case will be presented to FIWC. The Committee was of the opinion that in future decisions to host a service or department need to be more carefully considered and related to the organisation's Business Strategy. · Final Internal Audit Plan 2014/15 – final year of the 2 Year Strategic Plan · Internal Audit Quality Plan · Guidance for our Internal Audit Customers
14/097	**DECISIONS TO SUSPEND STANDING ORDERS:**

	None to date
14/098	**WAIVERS TO SFIs:** The Committee agreed the following Waivers: · No. 5 dated 05/06/14 and Nos. 9-11 dated 20/06/14 -13/08/14 The Committee requested that a rationale column be included in the schedule. **Action: DDOF**
14/099	**REVIEW OF STATUTORY AND FORMAL ROLES 2014/15:** The schedule of Statutory and Formal Roles as at 13/08/14 was received. The Committee noted that since approval by the Trust Board on the 2nd July 2014, 2 new roles have been added, namely Executive Lead for Medical Devices and Lead Non Executive Director for Procurement.
14/100	**SCHEME OF RESERVATION AND DELEGATION UNDER THE MENTAL HEALTH ACT:** The Committee agreed the minor amendment, namely Directorate On Call Manager now changed to Mental Health on call Manager, for approval by Trust Board. HOG to forward to the Chair of the Mental Health Act Scrutiny Committee. **Action: HOG**
14/101	**BOARD ASSURANCE FRAMEWORK – REVIEW OF CORPORATE OBJECTIVE 5 WORKFORCE:** The Committee received the schedule outlining Corporate Objective 5 on Workforce and noted that this is reviewed on a monthly basis by Executive Directors and their nominated senior managers. The Executive Director of Finance reported that following an in depth review of the green assurance levels in the BAF, these need to be verified in order to provide the requisite level of assurance required. The Company Secretary has been tasked with the overall review of the BAF in order to detail the exact assurance status. As the schedule did not provide the necessary assurance on the achievement of the Corporate Objective, the Committee requested that the review be undertaken by the end of September 2014. **Action: CS/HOG**
14/102	**REVIEW OF REGISTER OF EXTERNAL VISITS – ROYAL COLLEGE OF PSYCHIATRISTS ACCREDITATION:** David Sellers and Mandy Tate presented the Final Reports for the Isle of Wight Crisis Resolution Home Treatment Team and the Sevenacres ECT Clinic both accredited as excellent, outlining the background to the accreditation and how this was undertaken. The Committee noted that overall this was viewed by staff as a very positive experience and advising on how to improve the standard of services, which improves the patients' journey and the care patients receive. The Committee congratulated the Mental Health Team for this initiative and for achieving such an excellent accreditation. David Sellers highlighted the need within Shackleton Ward as a result of the limited number of beds and the rapidly growing elderly population and people with dementia on the Isle of Wight. Sue Wadsworth requested that an update be provided to QCPC. **Action: DS**
14/103	**BOARD ASSURANCE FRAMEWORK – RED/AMBER RISKS REVIEW OF RISK REGISTER PROCESS** Deferred to a future meeting
14/104	**INTERNAL AUDIT CONTRACT TENDER 2015/18:**

	Andy Jefford declared an interest in this item on behalf of Mazars and withdrew from the meeting. Following an in-depth discussion, the Committee agreed that the contract for the Internal Audit Service should go out to tender. **Action: DDOF** The ACRC Chairman to be a member of the interview panel.
14/105	**PROCUREMENT SERVICES CONTRACT:** The Committee agreed a year's extension to the South of England Procurement Services Contract, hosted by Portsmouth Hospitals. A review date to be agreed and a process to be put in place for the tendering of the service. An update to be presented to the next meeting of the Committee. **Action: DDOF**
14/106	**ITEMS FOR NOTING (Previously Circulated):** The Committee noted the following items: · NHS Audit Committee Handbook 2014 (HFMA) · Annual Clinical Audit Report 2013/14 · PWC Report – Greater risks, wider responsibilities: The evolving role of NHS audit committees · DOH Health Service Bodies' Auditor Panels and Their Independence: Consultation on secondary legislation for NHS Trusts and CCGs under the Local Audit and Accountability Act 2014
14/107	**KEY ISSUES FOR REPORTING/REFERRAL TO TRUST BOARD:** Please see Recommendations and Key Issues
14/108	**DATES OF 2014/15 MEETINGS:** To be held at 9.30 – 11.30 a.m. · Thursday, 13 November 2014 in Large meetings room *Sue Wadsworth tendered her apologies in advance of the meeting* · Wednesday, 11 February 2015 (Year End Planning) in Small meetings room
14/109	**INFORMATION ITEMS (Previously Circulated):** · Healthwatch Annual Report 2013/14 · TIAA Counter Fraud Newsletter – Issue 1 Summer 2014

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 27 AUGUST 2014

Title	Recommendations from the Audit & Corporate Risk Committee to Trust Board			
Sponsoring Executive Director	Executive Director of Finance			
Author(s)	David King, Chair of Audit & Corporate Risk Committee			
Purpose	To make recommendations to the Trust Board on matters required by the Audit & Corporate Risk Committee			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee	19/08/14	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			

Staff, stakeholder, patient and public engagement:

Executive Summary:

The Recommendation from the Audit & Corporate Risk Committee held on 19 August 2014 is:
Min. No. 14/093
REVIEW OF NHS AUDIT COMMITTEE HANDBOOK 2014
COMMITTEE OBJECTIVES UPDATE
REVIEW OF INTEGRATION WITH OTHER COMMITTEES WHICH REVIEW RISK
Items deferred for discussion at a future Board Seminar.

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

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

For following sections – please indicate as appropriate:

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

Date: 26 August 2014 **Completed by: Linda Mowle, Corporate Governance Officer**