Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 1st July 2015

at

9.30am - Conference Room, School of Health Sciences (South Hospital)

St. Mary's Hospital, Parkhurst Road,

NEWPORT, Isle of Wight, PO30 5TG

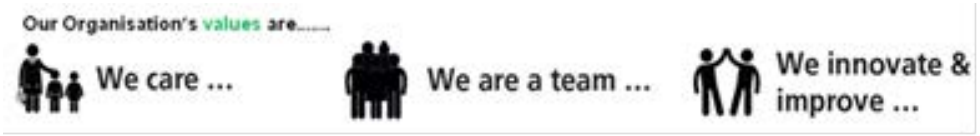
Staff and members of the public are welcome to attend the meeting.

Please Note: Later start time this month

Isle of Wight NHS
NHS Trust

Quality care for everyone, every time

Goals	Excellent patient care	Work with others to keep improving our services	A positive experience for patients, service users and staff	Skilled and capable staff	Cost effective, sustainable services
Priorities	▪ Improve mortality rate ▪ Prevent avoidable harm **QI** Reduce Incidence of Patient Harm	▪ Create and maintain partnerships with other organisations so that we can deliver excellent care ▪ Make every service the best it can be **QI** Improve End of Life Care	▪ Improve what people think of their care ▪ Improve how staff feel about work **QI** Improve the Discharging Planning Process	▪ All staff continue to develop ▪ All staff understand how their contribution helps to achieve our Vision	▪ Design services to deliver best practice within our resources ▪ Ensure value for money for each service



Our Values

Our vision and goals guide us; our values underpin everything we do

Isle of Wight NHS
NHS Trust

Annual General Meeting

Wednesday 1st July 2015

5.00pm – 7.00pm

Meeting starts 5.30pm

Riverside Centre
Newport Quay
Newport, Isle of Wight

Showcasing

- Celebrating ten years of the Patient Council
- Hear the NHS Nightingales
- Award Winning Wave Project

RSVP

email: board@iow.nhs.uk or
telephone: 01983 822099 ext. 5741

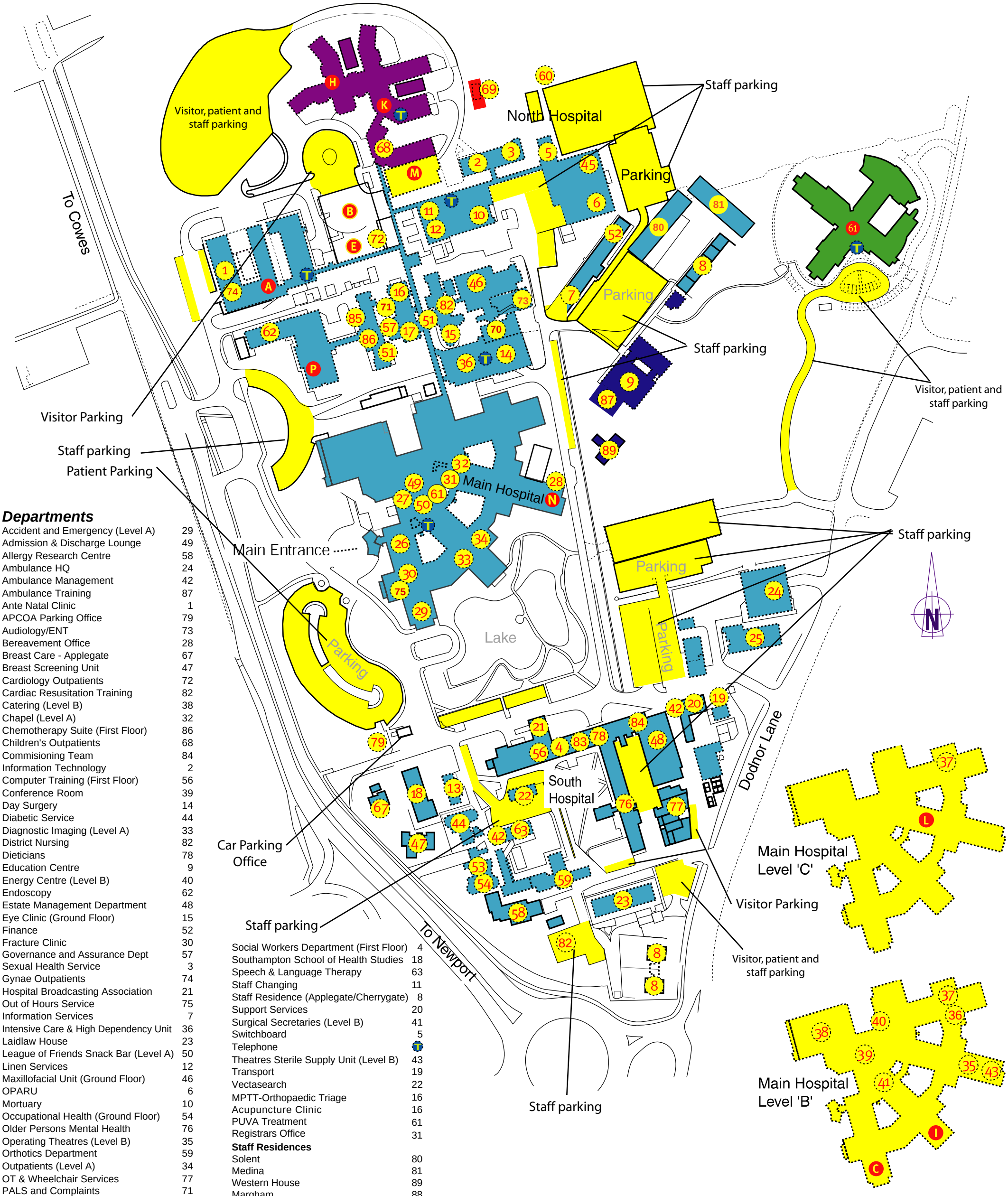
Questions from the public:

If you have a question which you would like raised at the meeting, these must be received in writing no later than 48 hours prior to the meeting.

Please either email: board@iow.nhs.uk or
post to: Trust Board c/o St. Mary's Hospital, Newport, Isle of Wight, PO30 5TG

Hospital Services • Community Services • Mental Health Services • Ambulance Services • Quality Care NHS everyone everytime

St Mary's Hospital



Departments

Accident and Emergency (Level A)	29
Admission & Discharge Lounge	49
Allergy Research Centre	58
Ambulance HQ	24
Ambulance Management	42
Ambulance Training	87
Ante Natal Clinic	1
APCOA Parking Office	79
Audiology/ENT	73
Bereavement Office	28
Breast Care - Applegate	67
Breast Screening Unit	47
Cardiology Outpatients	72
Cardiac Resusitation Training	82
Catering (Level B)	38
Chapel (Level A)	32
Chemotherapy Suite (First Floor)	86
Children's Outpatients	68
Commisioning Team	84
Information Technology	2
Computer Training (First Floor)	56
Conference Room	39
Day Surgery	14
Diabetic Service	44
Diagnostic Imaging (Level A)	33
District Nursing	82
Dieticians	78
Education Centre	9
Energy Centre (Level B)	40
Endoscopy	62
Estate Management Department	48
Eye Clinic (Ground Floor)	15
Finance	52
Fracture Clinic	30
Governance and Assurance Dept	57
Sexual Health Service	3
Gynae Outpatients	74
Hospital Broadcasting Association	21
Out of Hours Service	75
Information Services	7
Intensive Care & High Dependency Unit	36
Laidlaw House	23
League of Friends Snack Bar (Level A)	50
Linen Services	12
Maxillofacial Unit (Ground Floor)	46
OPARU	6
Mortuary	10
Occupational Health (Ground Floor)	54
Older Persons Mental Health	76
Operating Theatres (Level B)	35
Orthotics Department	59
Outpatients (Level A)	34
OT & Wheelchair Services	77
PALS and Complaints	71
Pathology Laboratories (Level B&C)	37
PCT Headquarters (First Floor)	83
Personnel (First Floor)	53
Pharmacy (Level A)	27
Physiotherapy (Ground Floor)	16
Porters	51
Post Room	6
Pre Assessment Unit	70
Printing Department	45
Main Reception (Level A)	26
Renal Dialysis	60
YMCA Creche	69
Social Club	25
Chapel of Rest	10
Healing Arts	13
Respiratory Physio	85
Social Workers Department (First Floor)	4
Southampton School of Health Studies	18
Speech & Language Therapy	63
Staff Changing	11
Staff Residence (Applegate/Cherrygate)	8
Support Services	20
Surgical Secretaries (Level B)	41
Switchboard	5
Telephone	T
Theatres Sterile Supply Unit (Level B)	43
Transport	19
Vectasearch	22
MPTT-Orthopaedic Triage	16
Acupuncture Clinic	16
PUVA Treatment	61
Registrars Office	31
Staff Residences	
Solent	80
Medina	81
Western House	89
Margham	88

Wards

Newchurch Ward	E
Children's	M
Coronary Care Unit	B
Rehabilitation	H
Luccombe & Alverstone (Level C)	L
Maternity	A
Medical Assessment (Level A)	N
Mottistone Suite	P
Neonatal Intensive Care Unit (Ground Floor)	A
Colwell & Appley Wards (Level B)	C
Sevenacres	61
Stroke Unit	K
St Helens & Whippingham Ward (Level B)	I

Isle of Wight NHS
NHS Trust

Please note the School of Health Science Building is shown as No. 18 on map

Isle of Wight NHS Trust

The next meeting in public of the Isle of Wight NHS Trust Board will be held on **Wednesday 1st July 2015** commencing at 9.30am in the Conference Room – School of Health Science Building (South Hospital), St. Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG. Staff and members of the public are welcome to attend the meeting. Staff and members of the public are asked to send their questions in advance to board@iow.nhs.uk to ensure that as comprehensive a reply as possible can be given.

AGENDA

Indicative Timing	No.	Item	Who	Purpose	Enc, Pres or Verbal
09:30	**1**	**Apologies for Absence, Declarations of Interest and Confirmation that meeting is Quorate**			
	1.1	Apologies for Absence: Jessamy Baird, NED & Lizzie Peers Non Executive Financial Advisor	Chair	Receive	Verbal
	1.2	Confirmation that meeting is Quorate	Chair	Receive	Verbal
		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.			
	1.3	Declarations of Interest	Chair	Receive	Verbal
09:35	**2**	**Minutes of Previous Meetings**			
	2.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 3rd June 2015 and the Schedule of Actions.	Chair	Approve	Enc A
	2.2	Chairman to sign minutes as true and accurate record			
	2.3	Review Schedule of Actions	Chair	Receive	Enc B
09:40	**3**	**Chairman's Update**			
	3.1	The Chairman will make a statement about recent activity	Chair	Receive	Verbal
09:50	**4**	**Chief Executive's Update**			
	4.1	The Chief Executive will make a statement on recent local, regional and national activity.	CEO	Receive	Enc C
10:00	**5**	**Patient & Staff Recognition**			
	5.1	Presentation of this month's Patient Story	CEO	Receive	Pres
	5.2	Employee Recognition of Achievement Awards	CEO	Receive	Pres
	5.3	Employee of the Month	CEO	Receive	Pres
	5.4	Staff Story	CEO	Receive	Pres
10:30	**6**	**Operational**			
	6.1	Performance Report	EMD	Receive	Enc D
	6.2	Local Update from Hospital & Ambulance	ICOO	Receive	Enc E
	6.3	Local Update from Community & Mental Health	EMD	Receive	Enc F
	6.4	Nursing Revalidation	EDN	Receive	Enc G
11:15	**7**	**Quality**			
	7.1	Quality Improvement Plan	EDN	Approve	Enc H
	7.2	Self-assessment against Lampard Review	EDN	Approve	Enc I
	7.3	Histopathology Review	EMD	Receive	Enc J
	7.4	Reports from Serious Incidents Requiring Investigation (SIRIs)	EDN	Receive	Enc K
	7.5	Director of Infection Prevention & Control 2014/15 Annual Report	EDN	Receive	Enc L
	8	**Governance**			
	8.1	Board Self Certification	CS	Approve	Enc M
	8.2	Board Assurance Framework (BAF) Monthly update	CS	Approve	Enc N
	8.3	Statutory & Formal Roles 2015-16	CS	Approve	Enc O
	8.4	Terms of Reference for Turnaround Board	EDF	Approve	Enc P

12:15		**Minutes of Board Sub Committees for noting**			
	8.5	Minutes of the Quality & Clinical Performance Committee held on 24th June 2015	QCPC Chair	Receive	Enc Q
	8.6	Minutes of the Finance, Investment, Information & Workforce Committee held on 23rd June 2015	FIWC Chair	Receive	Enc R
	8.7	Minutes of the Audit & Corporate Risk Committee held on 3rd June 2015	ACRC Chair	Receive	Enc S
	9	**Any Other Business**	Chair		
	10	**Questions from the Public**	Chair		
		To be notified in advance			
	11	**Issues to be covered in private**.			
		The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to issues concerning individual people (staff or patients). On this occasion the Chairman will ask the Board to resolve:			
		'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act I960.			
		The items which will be discussed and considered for approval in private due to their confidential nature are:			
		Carbon Energy Fund Contract Update			
		Disposal of The Gables			
		Disposal of Swanmore Road Property			
		Chief Executive's Update on Hot Topics:			
		Turnaround & CIPs Update			
		Approval for the the Public Consultation of the End of Life Care Strategy			
		Employee Relations Issues			
		Medical Staffing Update by NED lead.			
		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	**12**	**Date of Next Meeting:**			
		The next meeting of the Isle of Wight NHS Trust Board to be held in public is on **Wednesday 2nd Sept 2015** in the Conference Room, St Mary's Hospital, Newport, IW PO30 5TG			

Enc A

Isle of Wight NHS Trust

Minutes of the meeting in Public of the Isle of Wight NHS Trust Board held on Wednesday 3rd June 2015
Conference Room – School of Health Sciences, St Mary's Hospital, Newport, Isle of Wight

PRESENT:	Charles Rogers	Non-Executive Director (SID) (Chair of Meeting)
	Karen Baker	Chief Executive
	Chris Palmer	Executive Director of Finance
	Mark Pugh	Executive Medical Director
	Alan Sheward	Executive Director of Nursing
	Jessamy Baird	Non-Executive Director
	David King	Non-Executive Director
	Nina Moorman	Non-Executive Director
	Jane Tabor	Non-Executive Director
In Attendance:	Mark Price	FT Programme Director & Company Secretary
	Lizzie Peers	Non-Executive Financial Advisor
	Shaun Stacey	Interim Chief Operating Officer
	Jane Pound	Interim Director of Workforce
For item 15/T/113	Charles Joly	Environmental, Waste and Sustainability Manager
For item 15/T/115	Fiona Brothers	Risk & Litigation Officer
For item 15/T/122	Andrew Hill	Bank Porter
For item 15/T/122	Tom Moriarty	Porter
For item 15/T/122	Kevin Harvey	Porter
For item 15/T/122	David Hopkins	Porter
For item 15/T/122	Simon Laughton	Senior Supervisor – Hotel Services
For item 15/T/122	Dolores Candaza	Cleanliness Assistant
Observers:	Linda Fair	Patient Council
	Mike Carr	Patient Council
	Chris Orchin	Health Watch
Minuted by:	Lynn Cave	Trust Board Administrator (TB)
Members of the Public in attendance:	There were 3 members of the public present and 1 member of the media	

Minute No.

15/T/087 APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE

Apologies for absence were received from Danny Fisher - Chairman, and Katie Gray - Executive Director of Transformation & Integration

Apologies were also received from Cllr Lora Peacey-Wilcox, Dennis Ford & Roy Murphy

The Chairman announced that the meeting was quorate.

There were no declarations of interest from the Board members.

Formal Board Sign off of Year End Reports

15/T/088 ANNUAL ACCOUNTS 2014/15

The Executive Director of Finance advised the meeting that the Annual Accounts 2014/15 had been discussed and approved at the Audit & Corporate Risk Committee.

She confirmed that there were minor adjustments which had been discussed with the external auditors and had been approved at the Audit & Corporate Risk Committee.

The Executive Director of Finance asked that the Board approve the Annual Accounts 2014/15.

Proposed by David King and seconded by Mark Pugh

The Isle of Wight NHS Trust Board approved the Annual Accounts 2014/15

15/T/089 EXTERNAL AUDITORS REPORT ON ANNUAL ACCOUNTS 2014/15

The Executive Director of Finance advised the meeting that the External Auditors had conducted an in depth review and no significant issues had been raised from economy, efficiency and effectiveness for 2015 and the accounts were received subject to a qualification clause as a true & accurate accounts.

The Isle of Wight NHS Trust Board received the External Auditors Report on the Annual Accounts 2014/15

15/T/090 DIRECTORS CERTIFICATES

The Executive Director of Finance confirmed that these were of a standard format and wording. She confirmed that she and the Chief Executive would be signing these as well as the notes on the Annual report.

Proposed by David King and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Directors Certificates

15/T/091 ANNUAL GOVERNANCE STATEMENT 2014/15

The Company Secretary confirmed that this report had been approved by the Audit & Corporate Risk Committee which was happy with the content and stated that it was well presented. The Annual Governance Statement 2014/15 was here for approval.

Proposed by David King and seconded by Nina Moorman

The Isle of Wight NHS Trust Board approved the Annual Governance Statement 2014/15

15/T/092 HEAD OF INTERNAL AUDIT OPINION

The Executive Director of Finance reported that the report had been received by the Audit & Corporate Risk Committee and that it provided significant assurance that the Trust had an adequate and effective system of internal control to manage the significant risks identified by the Trust. The Assurance Framework is sufficient to meet the requirements of the 2014/15 Annual Governance Statement.

The Isle of Wight NHS Trust Board received the Head of Internal Audit Opinion

15/T/093 NHS SHARED BUSINESS SERVICES (SBS) AUDIT REPORTS 2014/15

The Executive Director of Finance advised that the outcome of the NHS Shared Business Services Audit for 2014/15 was being presented for information and that there were no issues to report.

he Isle of Wight NHS Trust Board received the NHS Shared Business Services Audit Report 2014/15

15/T/094 STATEMENT OF TRUST AS GOING CONCERN

The Executive Director of Finance confirmed that the statement on the Trust as a Going Concern included the statement of financial position which indicated that the organisation would continue for the foreseeable future and for a minimum of 12 months after this was signed.

Proposed by David King and seconded by Jessamy Baird

The Isle of Wight NHS Trust Board approved the Statement of Trust as Going Concern

15/T/095 ANNUAL REPORT 2014/15

The Chief Executive presented the Annual Report and stated that extensive discussion had taken place outside the Board meetings and the report was the result of lots of

work with thanks to the Finance Team and the Communications Team for compiling the report. It was requested that the report be approved.

The Chair advised that an additional table was to be inserted into the report on 2014/15 performance which was tabled for approval

Proposed by David King and seconded by Nina Moorman

The Isle of Wight NHS Trust Board approved the Annual Report 2014/15

15/T/096 QUALITY ACCOUNT 2014/15

The Executive Director of Nursing advised that the Quality Account 2014/15 had been discussed and approved at the Audit & Corporate Risk Committee.

He confirmed that all stakeholder feedback had now been received and included within the report.

Proposed by Jessamy Baird and seconded by Nina Moorman

The Isle of Wight NHS Trust Board approved the Quality Account 2014/15

The Year End Reports were duly signed and the Board continued with the regular business of the meeting

15/T/097 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 4th March 2015 were approved with the following amendments:

Proposed by Mark Pugh and Seconded by Jane Tabor

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

15/T/098 REVIEW OF SCHEDULE OF ACTIONS

The Board received the schedule of actions and noted the following updates:

a) **TB/141 – Safer Staffing Funding for Option 4:** The Executive Director of Nursing confirmed that work continues to progress this.
b) **TB/142 – Patient Story Structure:** The Executive Director of Nursing confirmed that the format had now been completed. This action is now closed.
c) **TB/143 – Monitoring Staff Viewing of Patient Story:** The Executive Director of Nursing advised that a review of 'hits' on the intranet had been undertaken and work would continue to monitor activity which would be provided to QCPC. This action is now closed.
d) **TB/144 – Cancelled Appointments:** The Executive Director of Finance advised that a report would be seen at FIIWC and Board from July.
e) **TB/145 – Sickness Benchmarking Exercise:** The Interim Director of Workforce confirmed that this would be included within the Turnaround process.
f) **TB/146 – Friends & Family Test – Mental Health:** The Executive Medical Director reported that national data was similar and that the Trust is shown as a low percentile response but our actual numbers mean we are within the top areas. He confirmed that benchmark data was being collated to further expand this exercise.
g) **TB/150 – SIRI Reports:** The Executive Director of Nursing confirmed that new guidance had been received in April and the reports would be updated in accordance with these and the outcome would be shown in the next reports submitted to QCPC and Board.
h) **TB/0153 – Community Treatment Orders Audit**:The Executive Medical Director confirmed that the outcome of the Audit had been presented to SEE

and QCPC. Jessamy Baird confirmed that all cases should be reviewed by both QCPC and MHASC to ensure the right issues are addressed. Nina Moorman confirmed that Mental Health audits would follow the same process. This action is now closed.

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

15/T/099 CHAIRMAN'S UPDATE

Charles Rogers requested that the Company Secretary reported on the following:

a) **Recruitment for Chairman:** This was now in progress and Danny Fisher had his tenure extended to 30th September. The post is advertised and the closing date is 22nd June. A local stakeholder event would be held to meet the shortlisted candidates and it was anticipated that an appointment would be made by the end of July. This would allow a period of handover before the new Chair takes up their post by 1st October 2015.

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

15/T/100 CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented the report and highlighted the following:

National:

- **New Models of Care (NMOC) – My Life a Full Life, powered by Vanguard:** A successful stakeholder event had taken place and the team were encouraged by the pace at which the project is progressing. A presentation was given on the Isle of Wight Programme to the NHS England Board last week and it was well received. They recognised the fact that the Island was not a traditional NHS Trust. The Chief Executive confirmed that regular updates would be provided.

Local:

- **Trust Financial Position:** There is a £4.6m CIP deficit in the budget set for 2015/16. She stressed that whilst this was not an unknown situation for other Trusts the Island was not used to being in this position. The Executive Director of Finance would be leading the Turnaround team to develop a breakeven plan for 2016/17 and a surplus position for the following year. She invited staff to submit any suggestions to the team over the next 4 weeks, after which time a review of progress would be taken and a decision on whether to bring in external consultants to assist with turnaround would be made.
- **Interim Chief Operating Officer**: Shaun Stacey would be undertaking this role during the period when a substantive recruitment is made.
- **Wight Life Partnership:** Robert Graham had been appointed General Manager of Wight Life Partnership and he was working closely with the Turnaround team.
- **Overseas Recruitment:** 30 nurses would be arriving in June/July and plans were in place to support their integration into the Trust.
- **Nurse Recruitment Fair:** There was a fantastic response to the event and work would continue to encourage people to join the nursing profession.
- **Ryde Health & Wellbeing Centre:** Opens this week. This is a multipurpose centre which will deliver a range of Health & Wellbeing programmes for the community.
- **Extension to Poppy Ward:** The unit has now closed. The outcome has shown that this was a successful pilot scheme and there is a potential to use the format in the future.

Nina Moorman asked how the NMOC would change the way the Trust operates and how would services be included. The Chief Executive advised that currently the Acute section of the organisation was not engaged as fully as the Community, Mental Health and Ambulance service but lead clinicans were engaged and would be promoting the programme. The Executive Medical Director confirmed that there was clinical support and a number of areas were exploring new ways of working with patients, such as using telephone consultations where appropriate. He confirmed that this is a very exciting period for the Trust.

Jane Tabor asked that TEC agenda and minutes be circulated to Board members so that the NEDs would have a full picture of what is being discussed at TEC.

Action Note: *The Company Secretary to ensure that the Agenda and Minutes from the TEC meetings would be circulated to all Board members for information.*

Action by: CS

Jessamy Baird asked that discussions at TEC and QCPC and the other Sub Committees is triangulated and that actions are linked appropriately.

Action Note: *The Company Secretary to arrange for a standard agenda item to be included on the TEC agenda to reflect feedback and actions required of TEC from the Sub Committees.*

Action by: CS

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

OPERATIONAL

15/T/101 PERFORMANCE REPORT

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

Quality:

- Pressure Ulcers
  - Hospital - Increase of concern
  - Community - Small reduction on April
  - Deep dive review of all April and May Cases.
  - Non compliance of patient common theme
- Clostridium Difficile (C.Diff) – 2 Cases
  - Local threshold (7) for 2015/16
- Mixed Sex Accommodation
  - 1 Case in April (affecting 6 patients)

Performance & Activity:

- Ambulance 8 minute response – validation has shown that we have failed the target in April 74.4% (Target - 75%)
  - Action plan in place from mid April on trajectory for June
  - Increased actions taken at scene, less unnecessary transfers to ED
- ED 4 hour waiting time 92.1% (Target - 95%)
  - Action plan revised to focus on process and internal referral unnecessary delays
  - Bed capacity plan with actions completed, awaiting outcome of discussion
  - On trajectory for June
- 62 Day Standard Cancer target failed in April 74.3% (Target - 85%)
  - RCA being undertaken on all breaches with lessons learnt to be shared
  - On trajectory for June
- RTT Admitted 68.1% (Target - 90%) Non admitted 94.2% (Target - 95%)
  - Demand and Capacity plan completed awaiting outcome of discussion

- Bed capacity plan, awaiting outcome of discussion
- Admitted list size reduced with activity commenced in April
- Action plan in place focus on improved scheduling and theatre utilisation. On trajectory for October

Finance:

- April planned deficit £0.745m
- Reported position - £1.484m. Causative factors:
  - Overspend of pay budget in month by £914K
  - Underachievement of CIP £406K
  - Overspend against budget including use of temporary staffing £508K
- 2014/15 Year-end £15k surplus (original plan £1.7m)
- Shortfall on 14/15 Cost Improvement Plan delivery – carry forward £4.4m
- Shortfall on CIP plans for 15/16 and beyond
- Winter Pressures impact on staffing and activity
- Attraction and recruitment issues, driving up temporary staffing costs
- Month 1 deficit significantly in excess of plan

Turnaround & Aims

- Commenced 18th May
- Planned and co-ordinated approach driving out inefficiencies and savings
- Focus is on pay, non-pay and budgetary control
- Reinforcing financial and workforce controls

A discussion followed and the following points were raised:

i. **Staff Resources:** David King queried if there were sufficient staff resources in place to effectively manage the Nutrition and Tissue Viability requirements within the Trust. Jessamy Baird stated that the QCPC felt that too much reliance was being put on one person and that they did not feel assured at present. The Executive Director of Nursing advised that currently these areas were covered by a single member of staff but that plans were being developed to submit to the CCG for more resources. David King suggested reviewing how other Trusts in the area covered these services. The Executive Director of Nursing confirmed that this would be looked into as part of the review.

Action Note: *The Executive Director of Nursing to review other Trusts provision and staffing levels for Nutrition and Tissue Viability services.*

Action by: EDN

ii. **Ambulance Data:** David King asked for clarity on the timings related to the Ambulance data. The Executive Director of Nursing advised that due to system issues it was necessary to manually verify the timings on the system, and confirmed that following completion of the system update this would no longer be necessary. He confirmed that the Ambulance data was reviewed hourly. The Chief Executive advised that discussions were ongoing with NHS England to review the targets for the Island and that the NMOC would allow for this and a range of other areas to be reviewed.

iii. **Agency Staff:** Jessamy Baird queried what level of agency staff should be used outside the agreed framework. The Executive Director of Finance advised that no agency work should be used outside the framework. The Executive Director of Nursing advised that all locum doctor work was via the agreed single vendor.

iv. **CIPs –** Lizzie Peers asked when the Long Term Financial Model would be revised to show the CIPs and planned surplus. The Executive Director of Finance advised that the PGO were providing a visual report for FIIWC which

included all CIP projects and would be working with the Turnaround team in the coming weeks. The Integrated Business Plan would also be reviewed in the coming weeks but this needed to be undertaken first so that the financial aspects could be ratified.

The Isle of Wight NHS Trust Board received the Performance Report

15/T/102 LOCAL UPDATE FROM HOSPITAL & AMBULANCE

The Interim Chief Operating Officer presented the update from the Hospital and Ambulance Directorate.

Jessamy Baird asked that more quantative data and a more expansive executive summary be included for future reports.

Action Note: *The Interim Chief Operating Officer to review the report and amend for future Board meetings to include more quantative data and an expanded executive summary.*

Action by: ICOO

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

15/T/103 LOCAL UPDATE FROM COMMUNITY & MENTAL HEALTH

The Executive Medical Director presented the update from the Community and Mental Health Directorate.

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

QUALITY

15/T/104 PATIENT STORY

The Chief Executive advised that the Patient Story this month featured a retired nurse. Due to technical difficulties this was unable to be shown and she advised that this story was available electronically for all to view.

The Isle of Wight NHS Trust Board received the Patient Story

15/T/105 QUALITY IMPROVEMENT FRAMEWORK

The Executive Director of Nursing presented the Quality Improvement Framework and advised that it would be going out for stakeholder consultation over the coming 4 weeks. He advised that the purpose of the paper was to set out at a high level what is to be achieved and how the Trust will get there. He advised that the paper was coming to Board for information at this stage.

Nina Moorman advised that the paper had been reviewed by QCPC and the Committee would continue to monitor. She suggested that a 'test area' be used to check the robustness of the framework. The Executive Director of Nursing agreed that it was important to ensure that the framework was appropriate and this would be fully discussed during the consultation period. He invited members to feedback any observations on the paper.

The Isle of Wight NHS Trust Board received the Quality Improvement Framework

15/T/106 QUALITY IMPROVEMENT PLAN

The Executive Director of Nursing advised that the Quality Improvement Plan had been reviewed at the May Quality & Clinical Performance Committee (QCPC). He brought attention to Section 3.5 of the plan in which are outlined the current quality improvement themes.

He re-confirmed all enforcement actions are complete; 8 outstanding compliance actions which the Trust Board take very seriously, 7 of which will be completed by 30

September 2015 (1 action has an element relating to safer staffing – completion by 31 March 2016).

He highlighted the areas of key risk and updated Board on the 4 areas which included 2 areas of staff recruitment in Emergency Department (ED) and Community In patient wards, 1 with regard to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Although progress had been made with respect to MCA & DoLS this was not at the pace required to ensure patients were receiving timely access to appropriate assessment. He described work that was being undertaken to address this issue including direct training with the Trust Consultant body. There is also 1 compliance action relating to Paediatric nurses being available 24 hours a day in the Emergency department. This followed on from an enforcement action related to the single paediatric front door , although the overarching action is compliant there is a risk to the sustainability of the action given that the Trust is finding it increasingly difficult to recruit sufficient paediatric nurses to operate a 24/7 service. The risk is being mitigated by using ward staff to cover the very small numbers of children who are admitted out of hours. However, this does not happen consistently. The Executive Director of Nursing suggested a more pragmatic view to this risk given the very small numbers of Children who enter the ED after 01:00am.

There are also 4 outstanding 'must do' actions – 3 to be completed by 30 September 2015 and 1 by 31 March 2016. The 18 outstanding 'should do' actions will be completed by March 2016.

The Quality Improvement Plan (QIP) will continue to be monitored by the Executive Director of Nursing and Executive Team reporting to QCPC which will look at the detail behind the actions and provide assurance to the Board.

The Chief Executive stated that reasonable progress had been made on the actions with 30 outstanding with the remaining actions quite difficult to turn green. She asked how the Board could be assured that these actions were being progressed at pace on the compliance actions. The Executive Director of Nursing stated that the detailed assurance would be received by the QCPC and he confirmed that the Chair of the QCPC had agreed that the agenda would be structured to ensure that this would occur. He also advised that each outstanding action now had 3 KPIs against them which were presented to the weekly assurance meeting, Trust Executive Committee (TEC) and QCPC on a monthly basis where the committees can challenge that evidence is available. Nina Moorman also commented that QCPC had requested sight of the minutes from the monthly challenge meetings with external stakeholders which would provide additional insight into how other areas were dealing with actions.

Jessamy Baird stated that it was good to see the risks highlighted in the paper and stressed that these should be triangulated with the main risk register.

Jane Tabor stated that she did not feel assurance in relation to the detail provided on the action relating to paediatric nurses given that the due date was shown as 31st March 2015. The EDON outlined the procedures currently in place to provide short term cover and thus mitigate any risks and confirmed that the action was being monitored by QCPC. The date reflects the fact that the action was linked to an enforcement action which related to establishing a single front door for children. This action is now complete.

The Chief Executive asked that this action be followed up at the Board Seminar on 9th June. Jessamy Baird stressed that this had been identified as a risk, the actions in place are not sufficient to mitigate it completely and we may need a contingency plan and communicate it to Commissioners or CQC. She confirmed that she would also raise this at QCPC.

Action Note: The Executive Director of Nursing to discuss with colleagues and provide a follow up at Board Seminar on 9th June.

Action by: EDN

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

15/T/107 FUTURE OF BOARD ASSURANCE VISITS

The Executive Director of Nursing presented the plan to take the Board Assurance visits forward. He outlined that the Board members had been aligned with specific areas within the organisation and that it was agreed that visits would be undertaken outside of Board meeting days. He confirmed that all areas would be visited during a 12 month period with areas of greatest risk being reviewed first. Feedback on these visits would be received and reviewed.

Nina Moorman stressed that the areas were not set in stone and should allow for a patient pathway to be reviewed across a number of areas.

Jessamy Baird mentioned that out of hours visits would potentially be an issue for non-Island resident members which could affect the frequency of visits. She also stated that administrative support should be provided.

The Executive Director of Nursing requested that the Board agree which areas they would cover by the end of June and asked if the Board were happy to go ahead with the visits. This was agreed.

Linda Fair mentioned that the Patients Council also undertook visits around the organisation. Jane Tabor suggested that members could link up with the Patient Council members for some visits.

Action Note: *Company Secretary to confirm which Patient Council members do visits to which areas.*

Action by: CS

Proposed by Nina Moorman and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Future of Board Assurance Visits

15/T/108 REPORT FROM SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs)

The Executive Director of Nursing presented the SIRI report and stated that 5 SIRIs had been reported in the month including 2 Pressure Ulcers, 2 falls and 1 confidential information breach.

He advised that a revised Serious Incident Framework has recently been published by NHS England, to be implemented from 1st April 2015. NHS England has also published a revised Never Events Policy. The most significant changes are the removal of the grading of SIRI, and the time scale for working with Commissioners on the process to instruct an investigation, carry it out and conclude it with agreement with the Commissioner within 60 days, which is a change to our current time frame. The report therefore will be changing and a focus on those cases which are out of date will be made and those cases which result in multiple incidents these will be grouped within the report.

He reported that 18 cases had been closed with the Commissioner during the period.

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

15/T/109 ANNUAL REPORT – COMPLAINTS & PATIENTS ADVICE AND LIAISON SERVICE (PALS) 2014/15

The Executive Director of Nursing presented the annual report and detailed some of the highlights from the report. He also highlighted that the increase in PALS[1] service

[1] Patient Advice and Liaison Service

was a direct result of the relocation of the team to the main foyer area. He drew attention to the key priorities for 2015/16.

The Isle of Wight NHS Trust Board received the Annual Report of the Complaints & Patients Advice and Liaison Service (PALS) 2014/15

STRATEGIC

15/T/110 TRUST VISION, VALUES, GOALS & PRIORITIES

The Chief Executive presented the report and highlighted that during a series of iterations, dating back to November 2014, the Executive team have tried to articulate our Trust Goals and Priorities in a form that is easy to understand and is accessible to all staff. "The House" has been in various forms of draft and re-draft and is now at the stage where its edits and reviews are concluded. Trust Board is asked to approve this final form as the visual representation we will use to engage with staff on our Vision, Goals, Priorities and Values.

She also advised that they were ready to be shared with the organisation and every member of staff will be facilitated to learn, discuss and understand what these are and what they mean to each person, team, service, directorate and to The Trust as a whole.

Proposed by Jessamy Baird and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Trust Vision, Values, Goals & Priorities

15/T/111 NURSING , MIDWIFERY & ALLIED HEALTH PROFESSIONAL STRATEGY 2015-2020

The Executive Director of Nursing presented the strategy. He outlined that the Trust had over 880 nursing staff and 12 allied health professional groups represented at present. He stressed the need for a clear vision on how to bring these groups together. He advised that the strategy was the result of 12 months work and would be produced in booklet form and distributed to all staff.

He reported that the nursing recruitment day had been very successful and a total of 150 potential recruits had attended.

A discussion took place during which the Executive Director of Nursing assured members that the strategy had been developed with staff collaboration and stressed that this strategy would be active for a number of years and would be amended to allow for developments within the organisation.

Proposed by Nina Moorman and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Nursing, Midwifery & Allied Health Professional Strategy 2015-2020

15/T/112 MEMORANDUM OF UNDERSTANDING WITH HERTFORDSHIRE NHS MENTAL HEALTH SERVICES FOUNDATION TRUST

The Executive Medical Director presented the Memorandum of Understanding between the Trust and Hertfordshire NHS Mental Health Services Foundation Trust and advised that following consultation and review it was now being presented for formal approval and signing by the Chief Executive.

He confirmed that at present there was no formal end date, but that further discussions with Hertfordshire NHS Mental Health Services Foundation Trust would be undertaken at which a review in 3 to 5 years would be suggested with an annual review during the interim period. He confirmed that an annual report would be presented to the Board.

Proposed by Jane Tabor and seconded by Nina Moorman

The Isle of Wight NHS Trust Board approved the Memorandum of Understanding between the Isle of Wight NHS Trust Mental Health services and Hertfordshire NHS Mental Health Services Foundation Trust and confirmed that the Chief Executive would formally sign the Memorandum of Understanding.

15/T/113 SUSTAINABLE DEVELOPMENT MANAGEMENT PLAN 2015-2020

The Chief Executive presented the Sustainable Development Management Plan 2015-2020. She advised that this is a joint plan with the CCG and addresses a performance indicator under the national Public Health Outcomes Framework.

Proposed by Jessamy Baird and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Sustainable Development Management Plan 2015-2020

GOVERNANCE

15/T/114 BOARD SELF CERTIFICATION

The Company Secretary presented the monthly update. He confirmed that the Finance, Investment, Information & Workforce Committee (FIIWC) had considered the self-certification return and requested Board Statement 7 be amended to "at risk" as it considered that the Board have not fully considered all potential future risks associated with national drivers and resultant changes in healthcare delivery.

The Quality & Clinical Performance Committee (QCPC) considered and agreed the self-certification return including the amendment requested by FIIWC

Including the amendment outlined above the Company Secretary recommended that the Board approved the Board Self Certification.

Proposed by Jessamy Baird and seconded by David King

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

15/T/115 BOARD ASSURANCE FRAMEWORK (BAF) MONTHLY UPDATE

The Company Secretary presented the BAF. He advised that there were 8 Principal Risks on the BAF with increased scores, 2 with reduced scores and 4 new risks added to the Risk Register.

Proposed by David King and seconded by Chris Palmer

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

15/T/116 CORPORATE GOVERNANCE FRAMEWORK: SCHEME OF DELEGATION, STANDING FINANCIAL INSTRUCTIONS & STANDING ORDERS

The Company Secretary presented the revised Scheme of Delegation, Standing Financial Instructions and Standing Orders for approval. He confirmed that these had been discussed at FIIWC and ACRC and been approved.

Proposed by David King and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the Corporate Governance Framework: Scheme of Delegation, Standing Financial Instructions and Standing Orders

Minutes of Board Sub Committees

15/T/117 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Nina Moorman reported on the key points raised at the meeting held on 29th April 2015:

a) **Min No. 15/Q/068 – End of Life Care:** Assurance received regarding progress with the implementation of End of Life Care throughout the Trust.
b) **Min No. 15/Q/067 – QIP:** Assurance received regarding progress with the QIP.
c) **Min No. 15/Q/072 – Orthogeriatrician Consultant:** Concern about suboptimal care provided to patients with hip fracture due to lack of a Consultant Orthogeriatrician.

The Executive Medical Director explained that the issue with the Orthogeriatrician Consultant was a national KPI and assured the Board that patients were receiving appropriate care and confirmed that he had reviewed the hip fracture data and that all outcome data was good as was the mortality data. He advised that older patients tended to require more preoperative care and the Trust had appropriate arrangements in place to ensure that this was provided. The Executive Director of Nursing confirmed that this item would be discussed again at the June QCPC meeting.

Nina Moorman reported on the key points raised at the meeting held on 27th May 2015:

d) **Min No. 15/Q/085 – Infection Prevention and Control**: The Committee is concerned regarding the number of C.diff cases and poor attendance at the Infection Prevention & Control Committee Meeting.
e) **Min No's15/Q/087 and 15/Q/091 – Physician recruitment Issues:** The Committee is concerned regarding the number of difficult to recruit to posts.

The Executive Medical Director advised that in relation to physican recruitment issues that many of the posts were in specialities which have national shortages and therefore, there may be occasions were agency staff are used to cover these vacant posts. The Executive Director of Nursing also confirmed that QCPC would continue to monitor issues relating to recruitment shortages

f) **Min No. 15/Q/092 – OPARU review:** The Committee received an update following the OPARU review. The Committee noted that progress has been made but further work is required.
g) **Min No. 15/Q/094 – QIP–CQC Compliance Actions:** – The Committee noted that there are 8 compliance actions to be completed.

The Executive Medical Director advised that he was working closely with the HR Recruitment team as part of the OPARU review and that areas including a review of working practice by medics and the effects of short notice cancellation of clinics would be included.

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

15/T/118 MINUTES OF THE FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE

Jane Tabor reported on the key points raised at the meeting held on 28th April 2015:

a) 1**5/F/088 - Annual Financial Plan 2015/16:** Committee agreed that assurance had been provided with the caveat that a full CIPs programme would be available by June 2015, and this would be reported to the Audit & Corporate Risk Committee on 12th May.
b) **15/F/095 - 2015/16 CIPs programme risk:** The Committee continues to have no sight of CIP plans for 2015/16.
c) **15/F/096 - Financial Position:** The Trust is reporting an unaudited £15k

surplus for the financial year 2014/15. Additionally, the Trust has also met its Capital Resource Limit.

d) **15/F/116 - Board Certification:** Sufficient assurance has been provided for the Committee to recommend that the Trust Board approve the Self Certification return as proposed

She also reported on the key points raised at the meeting held on 26th May 2015:

e) **15/F/128 -Annual Financial Plan 2015/16:** The Committee is advised that the plan has been submitted to the TDA on schedule and is now awaiting feedback.

f) **15/F/135 - Financial Position:** The Trust is reporting a deficit position of £1.484m against a planned position of a £0.745m deficit in M1. This is an adverse variance of £0.739m.

g) **15/F/141 - Risk Register:** The Committee is concerned over the level of overdue risks identified and has requested a full review.

h) 1**5/F/142 - Standing Financial Instructions (SFIs) 2015/16:** The Committee gave retrospective approval and recommend to Board for formal approval.

Jane Tabor also reported that the Committee was concerned over compliance with the Standing Financial Instructions (SFIs) in relation to the current financial deficit. She stated that the Committee would refer this the ACRC for monitoring and would bring to the attention of TEC. The Executive Director of Finance supported this concern and highlighted that this would be reviewed in addition by the Turnaround team, and she suggested that in the case of non-compliance the responsible officer for the relevant budget would be asked to come to FIIWC to discuss the case. She stressed the need for full compliance with the SFIs.

Action Note: *The FIIWC concern over the compliance with the SFIs would be monitored by ACRC and flagged to TEC as a major concern for action.*

Action by: EDF

i) **15/F/147 - Board Certification:** The Committee requested that Statement 7 be amended to At Risk. With this amendment the Committee confirmed that Sufficient assurance has been provided for the Committee to recommend that the Trust Board approve the Self Certification return as proposed

Jane Tabor also stated that the Committee was concerned that the Internal Audit outstanding recommendations were significantly overdue and this also would be flagged to TEC as an issue.

Action Note: *The FIIWC concern over the overdue Internal Audit Recommendations to be raised as a major concern to TEC for action.*

Action by: EDF

Jane Tabor also reported that the Committee had requested the following items to be presented to future meetings:

- 7 Day Hospital Working
- Standing Financial Instructions (SFIs) compliance levels
- Budgetary Process
- Turnaround Group reports on a monthly basis

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

15/T/119 MINUTES OF THE MENTAL HEALTH ACT SCRUTINY COMMITTEE

Nina Moorman reported on the key points raised at the last meeting held on 14th April 2015:

a) **Min No. 15/012 - Revised Code of Practice:** The Code of Practice has been updated. An area of concern is within Chapter 39 recommending that it is good practice for one of the doctors who make the medical recommendations during a MHAA[2] not to be employed by the admitting hospital trust. The Clinical Commissioning Group (CCG) are trying to recruit more General Practitioners (GPs) for S12 training and has also written to the Department of Health to highlight the issue.

b) **Min No. 15/014 - Mental Health Act Scrutiny Committee Annual Report** The draft report was discussed and it was agreed to include in Paragraph 7 'The Year Ahead' to review the effectiveness of Hospital Managers and to monitor the use of risk assessment proformas to be completed by Doctors during MHAAs.

c) **Min No. 15/015 - Operation Serenity**: A business case is to be written to request further funding beyond March 2016.

Jessamy Baird also advised that the quorum required for the Committee had been reviewed and it was deemed appropriate for Associate Hospital Managers to be included to strengthen the link between the Committee and those Hospital Managers undertaking the mental health hearings.

Jessamy Baird also highlighted the small pool of doctors who were available to act at MHAA and advised that this issue was included on the Mental Health Risk Register.

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

15/T/120 MINUTES OF THE AUDIT & CORPORATE RISK COMMITTEE

David King reported on the key points raised at the last meeting held on 12TH May 2015:

a) **Min No. 15/A/037 - Annual Governance Statement:** The Committee proposed amendments to the draft Statement and agreed to approve an amended version following circulation.

b) **Min No. 15/A/038 - Corporate Governance Framework:** Amendments agreed to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

c) **Min No. 15/A/041 - Review of Achievement of Corporate Objectives:** The Committee received and debated the review of achievement of Corporate Objectives.

d) **Min No. 15/A/043 - Annual Review of the Seal:** The Committee received the annual report on the use of the Trust Seal.

e) **Min No. 15/A048 - Extension to Internal Audit Contract:** The Committee noted the 3 month extension to 30th June 2015 to the Internal Audit Contract with Mazars.

f) **Min No. 15/A/050 - Internal Audit:** Patient Records – limited assurance regarding management of patient records and accuracy of discharge letters. David King also confirmed that the Committee would continue to monitor progress on the Internal Audit.

g) **Min No. 15/A/054 - External Audit:** It is more probable that there will be a Qualification of the value for money conclusion on an 'except for' basis against

[2] Mental Health Act Assessment

the resilience criteria, which is also a position reflected nationally. This is subject to final confirmation of processes and risk review. David King confirmed that the Committee would continue to monitor progress on the External Auditors comments in line with the action plan.

h) **Min No. 15/A/056 - QCPC Quarterly Report:** Pressure Ulcers – QCPC agreed that as this was a major SIRI topic and that it was not assured on the management of pressure ulcers, the Executive Director of Nursing be invited to attend the next meeting of the Committee in August to outline how the management of pressure ulcers is being taken forward.

i) **Min No. 15/A/047 - FIIWC Quarterly Report:** The Committee was extremely concerned at the lack of progress on Plans for both CIPs and the Staff Survey, agreeing that if there was no progress on the development of the Plans by the next meeting, the Chief Executive to be invited to attend the August meeting to outline the action being taken to resolve the situation.

David King confirmed that the Committee would continue to monitor and review the Risk Register to ensure that it reflected how the Trust was operating.

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

15/T/121 SUMMARY OF THE MINUTES OF THE REMUNERATION & NOMINATIONS COMMITTEE

The Company Secretary presented the 6 monthly summary of the minutes of the committee.

The Isle of Wight NHS Trust Board received the summary of the minutes of the Remuneration & Nominations Committee

CULTURE & WORKFORCE

15/T/122 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

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

Category 2 - Employee Role Model:

- Dolores Candaza
  Cleanliness Assistant

Category – Excellence in Team Working

- Porters Team:
  Kevin Harvey, Peter Crombie, Gary Sharp, Alan Chapman, David Hopkins, Tom Moriarty, Tom Johnson, David Humber, Gary Collins. Andy Hill, David Webb, Graham Mew

The Chief Executive congratulated all recipients on their achievements.

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

15/T/123 ANY OTHER BUSINESS

a) **Post Meeting Feedback:** The Chief Executive asked Board members to provide her with feedback on how the meeting went, level of challenge etc.

b) **Items for Board:** Jessamy Baird requested that the Board had more discussion on Corporate and Clinical Risk. The Company Secretary confirmed that this was a key theme of the current Governance Review.

c) **Patient Council:** Linda Fair advised the Board that the Patient Council shared their concern over Pressure Ulcers and OPARU and would be reviewing this at

their meetings.

d) **Formal Sign off of Accounts:** The Executive Medical Director queried if the formal sign off of the annual accounts and annual report should be undertaken in detail at future meetings. The Company Secretary advised that the reports were reviewed in depth at ACRC and that they were formally adopted at the AGM at which time the public were able to ask questions. He confirmed that these would be requested in advance to ensure that full answers could be provided on the night.

15/T/124 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

15/T/125 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 1st July 2015** in the Conference Room, School of Health Sciences, South Hospital, St Mary's Hospital, Newport, Isle of Wight.

The Chairman also confirmed that the Annual General Meeting would be held on **Wednesday 1st July 2015** at the Riverside Centre, Newport, Isle of Wight

The meeting closed at 1.40pm

Signed……Chair Date:……

Enc B

ISLE OF WIGHT TRUST BOARD Pt 1 (Public) - April 15 - March 16
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 (EDN) Deputy Director of Nursing (DDN) Interim Director of Workforce (IDW) Interim Chief Operating Officer (ICOO)
Foundation Trust Programme Director/Company Secretary (FTPD/CS) Trust Board Administrator (BA) Head of Communication (HOC)

Head of Corporate Governance (HCG)Business Manager for Patient Safety, Experience & Clinical Effectiveness (BMSEE)
Action Associate Director for Community & Mental Health Directorate (AAD-C&MH) Deputy Director of Informatics (DDI)

Non Executive Directors: Danny Fisher (DF) Charles Rogers (CR) Nina Moorman (NM) David King (DK) Jane Tabor (JT) 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
03-Dec-14	14/329c)	TB/135	**Sub Committee's responsibilities:** The Committee expressed concern as to where within the sub-committee structure Information Technology, Estates, Board Assurance Framework and Corporate Risk were reviewed. The Committee felt that it was not appropriate for these areas only to be covered at the Audit & Corporate Risk Committee without prior discussion at sub-committee level.	CS	The Company Secretary to arrange for a Board discussion on where Information Technology, Estates, Board Assurance Framework and Corporate Risk were reviewed. **16/01/15** - To be scheduled on Board Seminar Forward Plan by 31st March 2015. **04/03/15** - Will be discussed as part of Governance Review.	31-Jul-15	31-Jul-15	Progressing		Open
28-Jan-15	15/T/016	TB/141	**Safer Staffing Funding for Option 4: T**he Executive Team would draw up plans and a timeline to identify funding for Option 4.	CEO/EDF	A progress update will be given in the private part of the 4th March Board meeting. **20/03/15** - 2015/16 cost estimate to be incorporated into budget proposal for 1st April Board meeting. **01/04/15** - The Executive Director of Finance advised that work was underway to finalise the cost for 2015/16 but acuity and dependency reviews were not yet concluded. **03/06/15** - The Executive Director of Nursing confirmed that work continues to progress this.	01-Apr-15	02-Sep-15	Progressing		Open
04-Mar-15	15/T/037ii)	TB/144	**Cancelled Appointments:** The Executive Medical Director requested that the report be expanded to include all cancellations and also numbers for cases of multiple cancellations.	EDF DDI	The Executive Director of Finance to arrange for the operational matrix to be amended to include multiple cancellation data **03/06/15** - The Executive Director of Finance advised that a report would be seen at FIIWC and Board from July.	03-Jun-15	01-Jul-15	Progressing		Open
04-Mar-15	15/T/037iii)	TB/145	**Sickness Benchmarking Exercise:** The Executive Director of Nursing & Workforce advised that it was important to strive for the best target and that changes in absence reasons will give greater clarity. Jane Tabor asked if a benchmarking exercise against the Trusts perceived to be 'well led' could be undertaken to show how the Trust compared.	EDN IDW	Executive Director of Nursing & Workforce to arrange for benchmarking exercise. **03/06/15** - The Interim Director of Workforce confirmed that this would be included within the Turnaround process.	03-Jun-15	01-Jul-15	Progressing		Open
04-Mar-15	15/T/037iv)	TB/146	**Friends & Family Test - Mental Health**: Jessamy Baird stated that Mental Health areas benchmark lower in many reporting areas and asked whether the targets should be adjusted in line with other Mental Health Trusts.	EMD	Executive Medical Director to consider whether targets should be adjusted in line with other Mental Health Trusts. **25/03/15** - Head of Mental Health has discussed with colleagues is awaiting feedback. **03/06/15** - The Executive Medical Director reported that national data was similar and that the Trust is shown as a low percentile response but our actual numbers mean we are within the top areas. He confirmed that benchmark data was being collated to further expand this exercise.	03-Jun-15	02-Sep-15	Progressing		Open
04-Mar-15	15/T/037v)	TB/147	**Winter Pressures:** Charles Rogers requested a robust plan be developed (Long Term Capacity Plan covering beds and staffing) and a full review be undertaken for Board discussion in 4-6 months	EDN / EMD	Executive Director of Nursing & Workforce and Executive Medical Director to develop a long term capacity plan covering beds and staffing. To be presented to Board by September 2015.	02-Sep-15	02-Sep-15	Progressing		Open

Enc B

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
04-Mar-15	15/T/037vii)	TB/148	**Provision of Care in Community:** Jessamy Baird asked if a matrix for community and mental health could be developed with clear links to provision of services and outcomes. David King agreed that this would provide an holistic approach.	JB/EMD	Jessamy Baird and Executive Medical Director to develop a matrix for community and mental health. **25/03/15** - Jessamy and David understandably want to raise the profile for Mental Health and Community services by seeing more performance information on the services. This would be based on what are the services, and what are they achieving for patients in terms of outcome. There was a view that we do not "see" all the services and what we looked at did not necessarily tell us whether they are any good. Discussed issue and agreed timeline of 3 months for delivery.	01-Jul-15	01-Jul-15	Progressing		Open
04-Mar-15	15/T/140	TB/150	**SIRI Reports:** Jane Tabor asked that future reports indicate a 'due date' for completion of cases and indicate those which were overdue and by how much.	EDN	The Executive Director of Nursing & Workforce to arrange for an amendment to the SIRI report to include a due date for completion of investigation and details of any overdue investigations with timescale. **25/03/15** - Revised report will be presented at June Board. **03/06/15** - The Executive Director of Nursing confirmed that new guidance had been received in April and the reports would be updated in accordance with these and the outcome would be shown in the next reports submitted to QCPC and Board.	03-Jun-15	01-Jul-15	Completed	18-Jun-15	Closed
04-Mar-15	15/T/155	TB/155	**Standard of Business Cases** – Jane Tabor stated that the presentation and papers submitted for the Business Case – MRI Upgrade was an example of the standard which should be set for all such cases and asked that guidance be prepared to enable this.	CS	Company Secretary to prepare guidance on business cases required to be approved at the Board. **13/05/15** - This will be part of the Governance Review.	31-Jul-15	31-Jul-15	Progressing		Open
01-Apr-15	15/T/064	TB/156	**Patient Flow Project:** Jessamy Baird asked for an update on the Patient Flow Project.	CS	The Company Secretary to arrange for an information session on the Patient Flow Project at a Board Seminar.	02-Sep-15	02-Sep-15	Progressing		Open
01-Apr-15	15/T/068i	TB/157	**Community Nurses Case Load vs Levels of Pressure Ulcers:** Jessamy Baird asked if the level of pressure ulcers in the community was reflective of the level of caseloads undertaken by the community nurses. She stated that this was not reflected in the data provided and asked for an analysis of the number of district nurses/time with patient. The Executive Medical Director confirmed that this data was available and he was currently in discussions with the PIDs team to present it. He also confirmed that the increase in pressure ulcers in the community was a result of better recording of incidents. The Deputy Director of Nursing confirmed that Safer Staffing within the Community was not currently part of the NICE guidance but the Trust was undertaking work which would be reported in the 6 monthly Safer Staffing report in September.	DDN	Community Nursing to be included within the 6 monthly Safer Staffing Report due in September.	02-Sep-15	02-Sep-15	Progressing		Open
03-Jun-15	15/T/100	TB/158	**TEC Minutes & Agendas:** Jane Tabor asked that TEC agenda and minutes be circulated to Board members so that the NEDs would have a full picture of what is being discussed at TEC.	CS TEC	The Company Secretary to ensure that the Agenda and Minutes from the TEC meetings would be circulated to all Board members for information. **18/06/15** - Discussed with TEC Administrator and confirmed process in place. This action is now closed	01-Jul-15	01-Jul-15	Completed	18-Jun-15	Closed
03-Jun-15	15/T/100	TB/159	**Sub Committee/TEC triangulation:** Jessamy Baird asked that discussions at TEC and QCPC and the other Sub Committees is triangulated and that actions are linked appropriately.	CS TEC	The Company Secretary to arrange for a standard agenda item to be included on the TEC agenda to reflect feedback and actions required of TEC from the Sub Committees. **18/06/15** - Discussed with TEC Administrator and confirmed process in place. This action is now closed	01-Jul-15	01-Jul-15	Completed	18-Jun-15	Closed

Enc B

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
03-Jun-15	15/T/101i	TB/160	**Staff Resources:** David King queried if there were sufficient staff resources in place to effectively manage the Nutrition and Tissue Viability requirements within the Trust. Jessamy Baird stated that the QCPC felt that too much reliance was being put on one person and that they did not feel assured at present. The Executive Director of Nursing advised that currently these areas were covered by a single member of staff but that plans were being developed to submit to the CCG for more resources. David King suggested reviewing how other Trusts in the area covered these services. The Executive Director of Nursing confirmed that this would be looked into as part of the review.	EDN	The Executive Director of Nursing to review other Trusts provision and staffing levels for Nutrition and Tissue Viability services. **18/06/15** - Southampton & Portsmouth Trusts have teams of staff working on nutrition and tissue viability departments. We are working with dieticians to support the nutrition role. This action is now closed.	02-Sep-15	02-Sep-15	Completed	18-Jun-15	Closed
03-Jun-15	15/T/102	TB/161	**Directorate Reports to Board:** Jessamy Baird asked that the more quantative data and a more expansive executive summary be included for future reports.	ICOO	The Interim Chief Operating Officer to review the report and amend for future Board meetings to include more quantative data and an expanded executive summary.	01-Jul-15	01-Jul-15	Progressing		Open
03-Jun-15	15/T/106	TB/162	**Paediatric Nurse Provision:** Jane Tabor stated that she did not feel assurance in relation to the detail provided on the action relating to paediatric nurses given that the due date was shown as 31st March 2015. The Executive Director of Nursing outlined the procedures currently in place. Detailed discussion on these actions were undertaken at QCPC. The Chief Executive asked that this action be followed up at the Board Seminar on 9th June. Jessamy Baird stressed that this had been identified as a risk, the actions in place are not sufficient to mitigate it completely or assurance that it will be managed, then we need a Plan B, and if it needs to be communicated to Commissioners or CQC it needs to be explicit with an date around Plan B and it needs to be specific. She confirmed that she would also raise this at QCPC.	EDN QCPC	Action Note: The Executive Director of Nursing to discuss with colleagues and provide discussion at Board Seminar on 9th June. **18/06/15** - Due to time constraints this item was not covered on 9th June at Seminar and the Executive Director of Nursing will provide an update. **22/06/15** - Consideration is being given to recruitment outside of the UK if possible, Maternity leave and sickness compounding issue of staffing Emergency Department.	01-Jul-15	02-Sep-15	Progressing		Open
04-Jun-15	15/T/107	TB/163	**Assurance Visits:** Linda Fair mentioned that the Patients Council also undertook visits around the organisation. Jane Tabor suggested that members could link up with the Patient Council members for some visits.	CS	Company Secretary to confirm which Patient Council members do visits to which areas.	01-Jul-15	01-Jul-15	Progressing		Open
04-Jun-15	15/T/118h	TB/164	**Standing Financial Instructions (SFIs) 2015/16:** Jane Tabor also reported that the Committee was concerned over compliance in the use of the SFI's in relation to the current financial deficit. She stated that the Committee would refer this the ACRC for monitoring and would bring to the attention of TEC. The Executive Director of Finance supported this concern and highlighted that this would be reviewed in addition by the Turnaround team, and she suggested that in the case of non-compliance the responsible officer for the relevant budget would be asked to come to FIIWC to discuss the case. She stressed the need for full compliance with the SFIs.	EDF ACRC TEC	The FIIWC concern over the compliance with the SFIs would be monitored by ACRC and flagged to TEC as a major concern for action.	02-Sep-15	02-Sep-15	Progressing		Open
04-Jun-15	15/T/118h	TB/165	**Internal Audit Recommendations:** Jane Tabor also stated that the Committee was concerned that the Internal Audit outstanding recommendations were now overdue and this also would be flagged to TEC as an issue.	EDF DDF TEC	The FIIWC concern over the overdue Internal Audit Recommendations to be raised as a major concern to TEC for action. **22/06/15** - This has been included twice on TEC agenda during June. An update on actions can be given at the Board meeting.	01-Jul-15	01-Jul-15	Progressing		Open

Enc C

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public) ON 1st JULY 2015

Title	Chief Executive's Report				
Sponsoring Executive Director	Chief Executive Officer				
Author(s)	Head of Communications and Engagement				
Purpose	For information				
Action required by the Board:	**Receive**	✓	**Approve**		
Previously considered by (state date):					
Trust Executive Committee		Mental Health Act Scrutiny Committee			
Audit and Corporate Risk Committee		Remuneration & Nominations Committee			
Charitable Funds Committee		Quality & Clinical Performance Committee			
Finance, Investment, Information & 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. This report covers the period 22nd May to 22nd June 2015.

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. The report covers the following issues:

National:

- New Models of Care (NMOC) – My Life a Full Life, powered by Vanguard
- Empire Windrush – Celebrating BME involvement in the NHS

Local:

- Our organisations challenges around Quality, Performance and Finance.
- LiA – what a result!
- Farewell and thank you, Poppy Unit
- Chair appointment process underway
- Lead Clinician for Surgery
- Ryde Health and Wellbeing Centre
- Recruitment
- Four Seasons Garden
- Isle of Wight Festival
- Key points arising from the Trust Executive Committee

For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	All Trust goals					
Critical Success Factors *(see key)*	All Trust Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	None					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None					

Date: 23rd June 2015 **Completed by:** Andy Hollebon, Head of Communications and Engagement

Isle of Wight NHS
NHS Trust

Chief Executive's Report
covering the period 22nd May 2015 to 22nd June

National

The NHS Five Year Forward View, the My Life A Full Life programme

National NHS Chief Executive Simon Stevens spoke recently at the NHS Confederation Conference about the challenges facing the NHS and social care, the importance of the Five Year Forward View and how the issues are being addressed. The film shown at the start of his speech which can be viewed on You Tube (https://youtu.be/cfCxgraKtrM) shows that some key organisations across the health and care spectrum are very positive about the ability to address the significant challenges. Simon went on to talk about the Vanguard sites and mentions the Isle of Wight as one of the areas leading the work on vertical integration between primary, community and hospital services.

Earlier in June I spoke at the at the Healthcare Finance Managers Association's Forum for CEOs about our integrated model of care. I talked about how our status as a Vanguard site for the New Models of Care Programme will enable us to expand the My Life a Full Life programme much faster and at greater scale. Along with the other Vanguard sites we will be the benchmark for integration and we can expect visits from those interested in our services. By the time the Trust Board meets we will have hosted a visit (25th June) from Airedale Foundation NHS Trust. As a Vanguard site they are focusing on telemedicine and already have links into prisons (including HMP Isle of Wight), nursing and residential care homes. You can see their latest development on their website (http://www.airedale-trust.nhs.uk/blog/30-april-2015-patients-get-round-the-clock-on-screen-care-when-they-leave-hospital-thanks-to-new-technology/). Independent research shows that for the nursing and residential homes using technology over the past two years hospital admissions dropped by 37% and use of A&E dropped by 45%. Airedale are coming to look at our Integrated Care Hub but I'm pretty sure that we can learn lots from them about their innovative approach to supporting care in nursing and residential care homes.

To keep up to date with developments about MLAFL and the new models of care programme visit the MLAFL website at www.mylifeafulllife.com and look for the updates under the Vanguard tab.

Celebrating the contribution of BME staff

The NHS held a celebration on Wednesday evening to recognise those who arrived on Empire Windrush from Jamaica in 1948, their contribution to the NHS and the legacy of diversity they have given our workforce. The arrival of the Windrush helped to mark a new chapter in both the birth of our NHS and the growth of multicultural Britain. However seven decades later there is still under-representation at senior levels in the NHS workforce. You can find out more about IoW NHS Trust's commitment to Equality, Diversity and Inclusion at www.iow.nhs.uk Look for 'About Us' and then 'Equality and Diversity'.

Local

Our organisations challenges around Quality, Performance and Finance.

Whilst we will discuss this in more detail in the Performance Report, I think it is important that I acknowledge the challenges we have across the acute hospital sector of our organisation. We have more C diff infections than we should have. In common with many other Acute Trusts, we are not hitting our Emergency Care 4 hour standard. We will not meet our 18 week referral to treatment (RTT) target until October 2015. Our work to reach financial stability continues, with the internal Turnaround Team meeting for daily updates to drive the delivery of safe cost savings, increase efficient working and improve productivity. Together, we need to achieve Cost Improvement Plans of £8.5m this year, to reach our agreed planned deficit of £4.6m. Whilst we do this, we must at least maintain, and where possible, improve the quality of patient care. We are supporting staff with Innovation Workshops and Coaching Conversation sessions.

Recognising the challenges we face and following interviews, I have recommended to the Remuneration Committee that we appoint Shaun Stacey to the role of Chief Operating Officer (COO) subject to Board approval. Shaun will formally take up post in mid-August. He is a welcome addition to the senior management team and his role will stretch across all areas of our business – ambulance, community, hospital and mental health – with a view to better co-ordinating the interaction and integration between the four areas. An important part of the COO role will be to ensure that all parts of the organisation are fully represented and involved in developments, responding to issues and reporting arrangements.

LiA – what a result!

When we began our Listening into Action (LiA) journey nearly a year ago, I was very clear about our mission – to fundamentally shift how we work and lead, putting staff who know the most at the centre of change. I am really proud of the work that has been achieved by those involved over the last few months, and really pleased that the journey is clearly beginning to have an impact on our organisation. Earlier this month, we carried out a second Pulse Check to measure the impact of LiA. I am delighted to report that the majority of responses - 11 of the 15 questions asked - have improved. The largest improvement was the response to the question 'Managers and leaders seek my views about how we can improve our services', which has improved by over 10%. This is a significant achievement and proves that listening to our clinicians and frontline staff to make positive changes to patient care is absolutely the right thing to do.

Farewell and thank you, Poppy Unit

Poppy Unit at Solent Grange Nursing home, has closed after 5 months of great development and learning from having this unit open. I would like to thank everyone that has been involved from the concept through to the delivery and those who masterminded the closure so carefully. This unit provided those patients that occupied it with a modern and innovative way of accessing care, at a time when capacity is limited.
We must now move forward without this additional capacity, working within a smaller footprint until our new MAU opens later this year (building work is due to be completed on 7 August). We have seen yet again this week the excellent work of clinical teams, managing peaks in our emergency activity. We must focus on how we can do this better whilst sustaining our planned activity and improving access to services for Island people.

Chair appointment process underway

The recruitment process to find our next Chair is underway. It follows Danny Fisher's announcement that he would be standing down. This is a pivotal role for our organisation and we will need strong and clear leadership from the right candidate. Interviews are scheduled to take place on Monday 27th July 2015.

Lead Clinician for Surgery

Steve Parker has taken on the role of Lead Clinician for Surgery. We look forward to working with him and would like to thank Steve Elsmore for his previous contributions in this role.

Ryde Health and Wellbeing Centre

The move of the whole community clinic from Swanmore Road to the new Ryde Health and Wellbeing Centre has taken place and the Centre opened its doors to patients on 1st June. I'm sure that patients will appreciate the welcoming environment on Pellhurst Road. We've had a great reaction from the public and stakeholders who visited. Well done, too, to Phlebotomy staff at St Mary's who coped really well with the additional workload from Ryde during the move.

Recruitment
There has been a lot in the national media about the cost of agency and locum staff and there is no doubt that increasing demand and the setting of minimum staffing levels across the NHS has led to a shortage of qualified nurses. It takes three years to train a nurse and whilst the number of training places available has been increased it's going to take some time for the effects of this to reach our wards and services. It's for that reason that we've been to the Philippines to recruit more Filipino colleagues to work with us over the next couple of years.
The first group of Filipino colleagues will now join us in mid August and a second cohort will follow later in the year. We were one of the first Trusts to recruit from the Filipinos and our colleagues from the Philippines are a much valued part of our Island NHS team. Of course they come from a set of much warmer Islands but nevertheless they are Islanders like us and that may be one of the reasons why they fit in so well with us.

Four Seasons Garden
It was great to see the Four Seasons Garden formally opened by John Curtis from Ventnor Botanic Garden CIC. John made the important comparison between the founding principles of the hospital in Ventnor – design of the building and the beautiful garden environment – and the increasing body of evidence which supports the delivery of healthcare in surroundings which patients want to be in. The Four Seasons Garden is a lovely environment in which service users with dementia with their carers – whether they are patients in

Shackleton – or just visiting St. Mary's for the day – can use in the knowledge that the garden has been created especially with their needs in mind. Well done to everyone involved in this excellent garden which was a true community effort.

Isle of Wight Festival

Last weekend's Festival appears to have gone off without too many hitches. Whilst our involvement is now much less than it used to be we still play a key role in helping to ensure that the event is safe. The Emergency Department saw a few cases over the weekend which were Festival related but the vast majority of care is provided on the Festival site by a combination of Festimed (www.festimed.org/) and clinics run for them by Robin Beal. Our Pharmacy Department, who run the Wight Pharmacy on site, provided services to around 600 people. We also had a volunteer team on site assisting with the Welfare provision and recruiting Members – around 280 people signed up.

Key Points Arising from the Trust Executive Committee

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

18th May 2015

- TEC Terms of Reference – Approved for 6 months (pending governance review)
- Safeguarding Paper - Part approved
- Corporate Governance Framework – Approved
- Safer Staffing Mental Health – Approved with caveat

1st June

- Clinical Operational Performance - Discussed
- Quality Improvement Framework - Discussed
- Quality Improvement Plan - Approved
- Vision, Values, Goals and priorities – Approved
- Serenity Business Case - Approved

8th June

- Strategic Bed Plan – Approved
- Workforce Race Equality Standards - Approved
- Telehealth Business Case – Approved
- TDA – Trust Consultancy Business – Approved and to go to Board
- Recruitment & Retention – Approved
- Short Term Medical Cover Arrangements of Stroke Services - Approved
- Emergency Locum Cover – Approved
- End of Life Policy - Approved

15th June

- Turnaround Board Terms of Reference - Approved
- Sale of Swanmore – Approved for Board
- 18 Week RTT Training Strategy – Approved
- Scrutiny Obstetrics & Gynaecology staffing - Approved

22nd June

- Hospital Social Work Admin Business Case – Approved
- CQC Registration – Supported by TEC
- CIP Update Report – Received by TEC
- Paris 5.1 Upgrade – Approved by TEC

Karen Baker
Chief Executive Officer
23rd June 2015

Enc D

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Isle of Wight NHS Trust

Title	**Isle of Wight NHS Trust Board Performance Report 2015/16**			
Sponsoring Executive Director	Chris Palmer (Executive Director of Finance) Tel: 534462 email: Chris.Palmer@iow.nhs.uk			
Author(s)	Iain Hendey (Deputy Director of Information) 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	24/06/2015	
Finance, Information, Investment & Workforce Committee	23/06/2015	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 2015/16. A more detailed executive summary of this report is set out on page 3.				
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: Tuesday 23rd June 2015	**Completed by: Iain Hendey, Deputy Director of Information**			

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

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

Isle of Wight NHS Trust

Safe

GRR ref		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
	Patients that develop a grade 4 pressure ulcer	TW	12	5	May-15	14	↗	
	Reduction across all grades of pressure ulcers (25% on 2014/15 Acute baseline, 50% Community)	TW	245	53	May-15	100	↔	
	VTE (Assessment for risk of)	AC	>95%	99.1%	May-15	99.1%	↘	
	MRSA (confirmed MRSA bacteraemia)	AC	0	0	May-15	0	↔	
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)	AC	7	4	May-15	6	↘	
	Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	TW	48	3	May-15	6	↔	
	Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	TW	9	0	May-15	1	↗	
	Falls - resulting in significant injury	TW	7	1	May-15	1	↘	

Effective

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Summary Hospital-level Mortality Indicator (SHMI) Oct-13 - Sep-14	TW	1	1.0557	Published Apr 2015	N/A	↗	
Stroke patients (90% of stay on Stroke Unit)	CM	80%	100%	May-15	100%	↔	
High risk TIA fully investigated & treated within 24 hours (National 60%)	CM	60%	67%	May-15	70%	↘	
Cancelled Operations on/after day of admission	AC		5	May-15	12	↗	
Cancelled operations on/after day of admission (not rebooked within 28 days)	AC	0	2	May-15	5	↗	
Delayed Transfer of Care (lost bed days)	TW	N/A	143	May-15	338	↗	
Number of Ambulance Handover Delays between 1-2 hours	AM	N/A	6	May-15	10	↘	
Theatre utilisation	AC	83%	80%	May-15	76%	↗	
New Cases of Psychosis by Early Intervention Team	CM	18	3	May-15	5	↗	

Caring

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Patient Satisfaction (Friends & Family test - Total Inpatient response rate)	AC	30%	8%	May-15	8%	↗	
Patient Satisfaction (Friends & Family test - A&E response rate)	AC	20%	10%	May-15	12%	↘	
Mixed Sex Accommodation Breaches	TW	0	6	May-15	12	↔	
Formal Complaints	TW	<175	24	May-15	41	↘	
Compliments received	TW	N/A	382	May-15	616	↗	

Responsive

		Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
1	RTT:% of admitted patients who waited 18 weeks or less - IoW CCG	AC	90%	65%	May-15	65%	↘	
2	RTT: % of non-admitted patients who waited 18 weeks or less - IoW CCG	AC	95%	97%	May-15	96%	↗	
3	RTT % of incomplete pathways within 18 weeks - IoW CCG	AC	92%	94%	May-15	94%	↗	
	RTT:% of admitted patients who waited 18 weeks or less - NHS England	AC	90%	82%	May-15	83%	↘	
	RTT: % of non-admitted patients who waited 18 weeks or less - NHS England	AC	95%	84%	May-15	81%	↗	
	RTT % of incomplete pathways within 18 weeks - NHS England	AC	92%	93%	May-15	92%	↗	
8b	Symptomatic Breast Referrals Seen <2 weeks*	AC	93%	98.8%	May-15	98.6%	↗	
6b	Cancer patients seen <14 days after urgent GP referral*	AC	93%	95.8%	May-15	96.5%	↘	
6a	Cancer Patients receiving subsequent Chemo/Drug <31 days*	AC	98%	100%	May-15	100%	↔	
5a	Cancer Patients receiving subsequent surgery <31 days*	AC	94%	100%	May-15	100%	↔	
	Cancer diagnosis to treatment <31 days*	AC	96%	98.3%	May-15	97.6%	↗	
7	Cancer Patients treated after screening referral <62 days*	AC	90%	100%	May-15	96.7%	↗	
5b	Cancer Patients treated after consultant upgrade <62 days*	AC	No measured operational standard	0%	May-15	0%	↘	
8a	Cancer urgent referral to treatment <62 days*	AC	85%	85.3%	May-15	79.6%	↗	
	No. Patients waiting > 6 weeks for diagnostics	AC	<100	2	May-15	3	↘	
	%. Patients waiting > 6 weeks for diagnostics	AC	<1%	0.2%	May-15	0.1%	↘	
4	Emergency Care 4 hour Standards	AC	95%	93%	May-15	92%	↗	
12	Ambulance Category A Calls % < 8 minutes	AM	75%	76%	May-15	75%	↗	
13	Ambulance Category A Calls % < 19 minutes	AM	95%	95%	May-15	96%	↘	
9a	% of CPA patients receiving FU contact within 7 days of discharge	MH	95%	100%	May-15	95%	↗	
9b	% of CPA patients having formal review within last 12 months	MH	95%	96.0%	May-15	N/A	↘	
10	% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	MH	95%	96%	May-15	95%	↗	

**Cancer figures for May are provisional.*

Well-Led

	Area	In Month Target	Actual Performance		YTD Target	YTD Actual	Month Trend
Total workforce SIP (FTEs)	TW	2684.6	2,620.4	May-15	N/A	N/A	
Total pay costs (inc flexible working) (£000)	TW	£9,398	£10,174	May-15	£18,979	£20,669	↗
Variable Hours (FTE)	TW	146.6	159.4	May-15	148.0	156.0	↘
Variable Hours (£000)	TW	£597	£958	May-15	£1,164	£2,249	↘
Staff sickness absences	TW	3%	3.93%	May-15	3%	3.98%	↗
Staff Turnover	TW	5%	0.39%	May-15	5%	1.24%	↗
Achievement of financial plan	TW	N/A	N/A	May-15	(£4.6m)	(£1.4m)	↘
Underlying performance	TW	N/A	N/A	May-15	(£8.3m)	(£8.3m)	↔
Liquidity ratio days	TW	N/A	N/A	May-15	3	2	↔
Capital Servicing Capacity (times)	TW	N/A	N/A	May-15	3	1	↔
Overall Continuity of Services Risk Rating	TW	N/A	N/A	May-15	3	2	↔
Capital Expenditure as a % of YTD plan	TW	N/A	N/A	May-15	=>75%	61%	↗
Quarter end cash balance (days of operating expenses)	TW	N/A	N/A	May-15	=>10	13	↘
Debtors over 90 days as a % of total debtor balance	TW	N/A	N/A	May-15	=<5%	4.0%	↘
Creditors over 90 days as a % of total creditor balance	TW	N/A	N/A	May-15	=<5%	1.2%	↘
Recurring CIP savings achieved	TW	N/A	N/A	May-15	100%	18.3%	↘
Total CIP savings achieved	TW	N/A	N/A	May-15	100%	28.0%	↗

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 2015/16

May 15

Executive Summary

Safe:

Pressure ulcers: We continue to under achieve our planned local reduction across all grades of pressure ulcers, both in the hospital setting and the wider community. A public awareness campaign is continuing to highlight prevention within the wider community and encourage regular mobilisation for those at risk.

C.diff: We had a further 4 cases during May and have exceeded our year to date target, we have now had 6 cases year to date. Our annual target is 7 cases.

Responsive:

Performance against the admitted target remained low at 67.57% as we continue to treat in turn. This figure is also indicative of the increase in the waiting list, particularly patients waiting for longer periods, and the previously cancelled operations (due to recent high levels of activity in A&E and the associated bed pressures).

The Ambulance Service has achieved all three categories required in May; Red 1 (75%) achieved 77.1%, Red 2 (75%) achieved 75.7% and 19 Min (95%) achieved 95.4%. This has been due to additional focus on demand vs. resource and adding additional resources where applicable using qualified paramedic managers to fill shortfall. However the additional focus on resources has produced a cost pressure to the service. We are currently examining data to ensure we have the correct model of operational format going forward to ensure we maintain the targets required.

Emergency care 4 hour standard - The 95% target for May was again not achieved largely due to the increased pressure on community bed availability preventing patients flowing through the system. Despite action plans being followed further closures of community places made the target beyond our reach.

Well Led:

The trust as a whole has overspent its pay budget in month by £777k and £1.7m year to date.
Under achievement of CIP equates to £566k in month and £972k year to date.
Overspends against budget including temporary staffing equate to £719k. Spending on temporary staffing equated to £1m in month and represents a total cost in year of £2.2m.
Sickness levels have reduced marginally though remain above plan. In month cost of sickness absence equates to £260k with a year to date total of £520k

The Trust planned for a deficit of £391k in May, after adjustments made for normalising items (these include the net costs associated with donated assets).
The reported position is a deficit of £1.1m in the month, an adverse variance of £704km against plan.

The cumulative Trust plan was a deficit of £1.1m, after normalising items. The actual position is a cumulative deficit of £2.6m, an adverse variance of £1.4m.

The Trusts planned forecast out-turn deficit remains at £4.6m but the current directorate performances increases the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.

Caring:

The number of complaints increased in May.

Compliments, in the form of letters and cards of thanks, were higher during May than in April.

Mixed Sex Accommodation - Further 6 breaches during May following 6 in April. One single event impacting upon patients in a 6 bedded bay occurred; privacy and dignity was maintained during this period.

Effective:

The percentage utilisation of theatre facilities has increased since last month from 77% to 82.8% however remains just below the 83% target. Day Surgery Unit utilisation has increased during May 2015 (76.2%). Overall we have achieved 79.5%. Bed pressures eased supporting improved utilisation.

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Performance Summary - Hospital

Isle of Wight NHS Trust

Balanced Scorecard - Hospital

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Grade 1&2 Pressure Ulcers developing in hospital	May-15		22		36	
No. of Grade 3&4 Pressure Ulcers developing in hospital	May-15		4		6	
VTE	May-15	95%	99.1%	95%	99.1%	
MRSA	May-15	0	0	0	0	
C.Diff	May-15		2	4	4	
No. of Reported SIRI's	May-15		4		6	
Physical Assaults against staff	May-15		1		2	
Verbal abuse/threats against staff	May-15		3		8	

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Delayed Transfers of Care (lost bed days)	May-15	N/A	143	N/A	338	
Cancelled operations on/after day of admission (not rebooked within 28 days)	May-15	0	2	0	5	

Responsive*	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Care 4 hour Standards	May-15	95%	92.8%	95%	92.5%	
RTT Admitted - % within 18 Weeks (NHS England included)	May-15	90%	67.6%	90%	67.8%	
RTT Non Admitted - % within 18 Weeks (NHS England included)	May-15	95%	95.3%	95%	94.7%	
RTT Incomplete - % within 18 Weeks (NHS England included)	May-15	92%	93.9%	92%	93.2%	
No. Patients waiting > 6 weeks for diagnostics	May-15	< 8	2	100	3	
%. Patients waiting > 6 weeks for diagnostics	May-15	1%	0.19%	1%	0.13%	
Cancer 2 wk GP referral to 1st OP	May-15	93%	95.8%	93%	96.5%	
Breast Symptoms 2 wk GP referral to 1st OP	May-15	93%	98.8%	93%	98.6%	
31 day second or subsequent (surgery)	May-15	94%	100%	94%	100%	
31 day second or subsequent (drug)	May-15	98%	100%	98%	100%	
31 day diagnosis to treatment for all cancers	May-15	96%	98%	96%	98%	
62 day referral to treatment from screening	May-15	90%	100%	90%	97%	
62 days urgent referral to treatment of all cancers	May-15	85%	85.3%	85%	79.6%	
Emergency 30 day Readmissions	May-15		5.1%		5.2%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	May-15	3%	3.88%	3%	3.78%	
Appraisals	May-15		2.7%		5.1%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
FFT Hospital - % Response Rate	May-15		51.4%		47.5%	
FFT Hospital - % Recommending	May-15	90%	98.0%	90%	97.4%	
FFT A&E - % Response Rate	May-15		9.9%		11.9%	
FFT A&E - % Recommending	May-15	90%	90.8%	90%	92.3%	
Mixed Sex Accommodation Breaches	May-15	0	6	0	12	
No. of Complaints	May-15		20		35	
No. of Concerns	May-15		65		140	
No. of Compliments	May-15	N/A	210	N/A	401	

Contracted Activity**	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Spells	Apr-15	987	1,067	987	1,067	
Elective Spells	Apr-15	682	477	682	477	
Outpatients Attendances	Apr-15	8,998	9,056	8,998	9,056	

**Cancer figures for May 2015 are provisional*

***The Acute Service Level Agreement performance reports a month behind, therefore figures are from April 15.*

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

RTT performance – The admitted target underperformed into May; action plans and revised forecasts are in place to address this.

Cancelled operations – There were 2 cancellations on or after the day of admission; all cancellations are audited and lesson learnt implemented on a regular basis.

Sickness absenteeism - This has worsened from the previous month (which was 3.59%); those areas with high sickness levels continue to be actively monitored by the individual managers with HR colleagues, with specific sickness management actions being undertaken as required on an individual basis.

Friends and Family Test – Departmental pressures have impacted upon the response rate this month, however, of those responding, those recommending has increased from 93.6% last month to 98% this month.

Mixed Sex Accommodation Breaches - One single event impacting upon patients in a 6 bedded bay occurred to avoid a 12hr breach in ED when the Hospital was on Black Alert; privacy and dignity was maintained during this period.

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Performance Summary - Community

Isle of Wight NHS Trust

Balanced Scorecard - Community

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Grade 1&2 Pressure Ulcers developing in the community	May-15		19		43	
No. of Grade 3&4 Pressure Ulcers developing in the community	May-15		8		15	
MRSA	May-15	0	0	0	0	
C.Diff	May-15		2	2	2	
No. of Reported SIRI's	May-15		0		3	
Physical Assaults against staff	May-15		0		0	
Verbal abuse/threats against staff	May-15		4		5	

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Stroke patients (90% of stay on Stroke Unit)	May-15	80%	100.0%	80%	100.0%	
High risk TIA fully investigated & treated within 24 hours (National 60%)	May-15	60%	66.7%	60%	70.0%	

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Routine Waiting times	May-15		95.3%		96%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism - C Directorate	May-15	3%	3.82%	3%	4.09%	
Appraisals	May-15		1.9%		4.4%	

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Community Contacts	May-15	17,048	16,969	34,096	35,269	
Health Visitors	May-15	-	823	-	1,573	
School Nurses	Apr-15	799	1,038	799	1,038	
Sexual Health	Apr-15	518	697	518	697	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
FFT - % Response Rate	May-15		6.8%		6.6%	
FFT - % Recommending	May-15	90%	94.5%	90%	94.2%	
No. of Complaints	May-15		3		4	
No. of Concerns	May-15		6		15	
No. of Compliments	May-15	N/A	131	N/A	149	

Safe - No new MRSA cases in May 2015. 2 C.Diff cases reported in May 2015. No SIRIs reported in May 2015

Responsive - As the Directorate has many diverse services we have given a percentage of patients waiting less than their service maximum waiting time - 95.3%. Those services regularly breaching targets are monitored with our Commissioners on a monthly basis.

Contracted Activity - Community Services are based on a block contract and are overperforming. Demand and capacity is closely monitored particularly around community nursing and therapy services.

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

Well Led - Community May sickness rate is 3.82% which is over the Trust's 3% target, however it is showing a reduction from April. Reduction in short term sickness remains a key focus for the Directorate. This is being closely managed via Occupational Health and HR processes.

Caring - The Friends and Family Test response rate is 6.8% for May 2015. Please note that FFT figures are now split between Community and Mental Health. The Directorate's Friends and Family recommending percentage for May is 94.5% against a target of 90%. Complaints, concerns and compliments are monitored closely and lessons learned shared through the Directorate Board, Community Quality Group and with the wider Directorate.

Isle of Wight NHS Trust Board Performance Report 2015/16

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Performance Summary - Mental Health

Isle of Wight NHS Trust

Balanced Scorecard - Mental Health

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Physical Assaults against staff	May-15		5		12	
Verbal abuse/threats against staff	May-15		8		20	

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
IAPT – Proportion of people who have completed treatment and moving to recovery	May-15	50%	45%	50%	46%	
New Cases of Psychosis by Early Intervention Team	May-15	2	3	11	5	

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% of CPA patients receiving FU contact within 7 days of discharge	May-15	95%	100%	95%	95%	
% of CPA patients having formal review within 12 months	May-15	95%	96%	95%	97%	
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	May-15	95%	96%	95%	95%	
RTT Non Admitted - % within 18 Weeks	May-15	95%	99%	95%	99%	
RTT Incomplete - % within 18 Weeks	May-15	92%	99%	92%	99%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	May-15	3%	5.75%	3%	5.56%	
Appraisals	May-15		5.3%		6.9%	

Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Mental Health Inpatient Activity	May-15	N/A	56	N/A	104	
Mental Health Outpatient Activity	May-15	N/A	456	N/A	997	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Complaints	May-15		1		2	
No. of Concerns	May-15		1		4	
No. of Compliments	May-15	N/A	20	N/A	25	
FFT - % Response Rate	May-15		0%		0%	
FFT - % Recommending	May-15	90%	92%	90%	94%	

Mental Health RTT

Learning Disabilities – Learning Disability Consultant Led activity – all referrals into service are screened by Multi-Disciplinary Team and if identified as appropriate will be passed to consultant for initial assessment. 18 weeks module has recently been undertaken to implement 18 week pathways for this service and will enable seperate RTT reporting for this patient group.

Adult Mental Health –All referrals into service are screened by Multi-Disciplinary Team and some patients are identified as requiring initial assessment at consultant led out-patient clinic. 18 weeks pathways are implemented for all patients identified as appropriate for Consultant-led Psychiatrist assessment.

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

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

Safe - Incidences of physical/verbal assault are monitored on a monthly basis through the Mental Health Quality Group. Any identified trends are investigated and lessons learned shared with the service and the wider directorate.

Responsive - Mental Health and Learning Disabilities achieved against KPIs in May 2015.

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

Well Led - The Mental Health April 2015 sickness absence rate is 5.75% and is above the Trust's target of 3%. Sickness absence rates are due to increased short term sickness together with long term sickness and vacancies within the Community Mental Health Service. Reduction in short term sickness remains a key focus for the Directorate. All sickness absence is being closely managed via Occupational Health and HR processes.

Effective - IAPT - Target for the proportion of people who have completed treatment and moving to recovery was not reached for May 2015. This is being closely monitored. New Cases of Psychosis by Early Intervention Team is out performing target.

Caring - Complaints, concerns and compliments are monitored closely and lessons learned shared through the Directorate Board, MH Quality Group and with the wider Directorate. The Directorate's Friends and Family recommending percentage for May is 92% against a target of 90%.

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Performance Summary - Ambulance and 111

Isle of Wight NHS Trust

Balanced Scorecard - Ambulance & 111

Safe	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Physical Assaults against staff	May-15		0		0	
Verbal abuse/threats against staff	May-15		0		1	

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Number of Ambulance Handover Delays between 1-2 hours	May-15		6		10	

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Category A 8 Minute Response Time (Red 1)	May-15	75%	77.1%	75%	76.3%	
Category A 8 Minute Response Time (Red 2)	May-15	75%	75.7%	75%	75.0%	
Category A 19 Minute Response Time	May-15	95%	95.4%	95%	95.7%	
Ambulance re-contact rate following discharge from care by telephone	May-15	3%	5.5%	3%	5.6%	
Ambulance re-contact rate following discharge from care at scene	May-15	2%	3.1%	2%	3.3%	
Ambulance time to answer call (in seconds) - median	May-15	1	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 95th percentile	May-15	5	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 99th percentile	May-15	14	11	N/A	N/A	
NHS 111 Call abandoned rate	May-15	5%	0.9%	5%	1.4%	
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	May-15	95%	97.6%	95%	97.2%	
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	May-15	95%	98.0%	95%	97.8%	
NHS 111 Where the above is not achieved callers should be called back within 10 mins	May-15	100%	61.1%	100%	50.0%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	May-15	3%	3.30%	3%	4.65%	
Appraisals	May-15		9.0%		9.0%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Complaints	May-15		0		0	
No. of Concerns	May-15		1		4	
No. of Compliments	May-15	N/A	11	N/A	22	

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Calls Answered	Apr-15	2,215	2,264	2,215	2,264	
Hear & Treat / Refer	Apr-15	339	384	339	384	
See & Treat / Refer	Apr-15	487	475	487	475	
See, Treat and Convey	Apr-15	1,104	1,208	1,104	1,208	
111 Service	Apr-15	4,701	4,715	4,701	4,715	

The Ambulance Service has achieved all three categories required in May; Red 1 (75%) achieved 77.1%, Red 2 (75%) achieved 75.7% and 19 Min (95%) achieved 95.4%. This has been due to additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall. The additional focus on resources has produced a cost pressure to the service. We are currently examining data to ensure we have the correct model of operational format going forward to ensure we maintain the targets required.

Our NHS 111 service continues to achieve its targets; 95% on call answering and 97% on warm transfers to a clinician. This has been again consistently high when benchmarking national service providers.

Highlights

- **Ambulance Category A Red 1 and Red 2 calls response time <8 minutes above target**
- **90% of stay on Stroke Unit and High Risk TIA fully investigated & treated within 24 hours above target both in month and year to date**
- **Referral To Treatment Time for Non-Admitted and Incompletes above target in May**
- **Mental Health CPA patients targets achieved**
- **Mental Health admissions access to Crisis Resolution and Home Treatment Teams**
- **All Cancer Targets achieved in May**

Lowlights

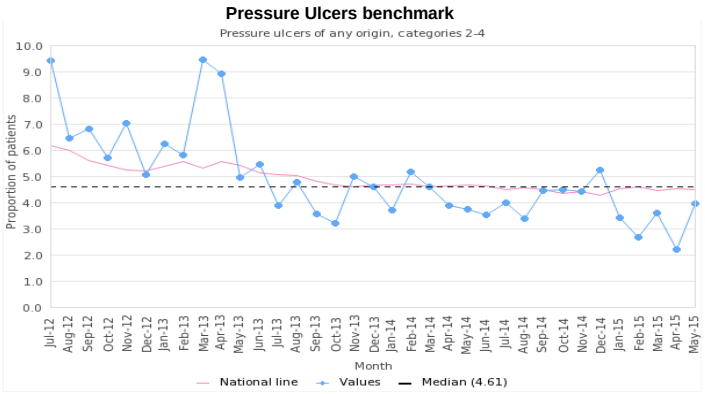
- **Clostridium Difficile (C.Diff) - above the year to date target of 2**
- **Referral ToTreatment Time for Admitted remains below target**
- **Staff sickness remains above plan**
- **Emergency care 4 hour standard below target**
- **Mixed Sex Accommodation breach affecting 6 patients**

Commentary:

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

Hospital acquired: During May there was a slight decrease in reported pressure ulcers in the hospital setting from the previous month across all grades. The Tissue Viability Nurse continues to support ward staff with recognition and management of patients at risk but higher numbers of patients staying longer is challenging. Validation of avoidable pressure injury continues and deterioration of existing pressure injury is now being reported separately so that reduction can be monitored but this is not currently split.

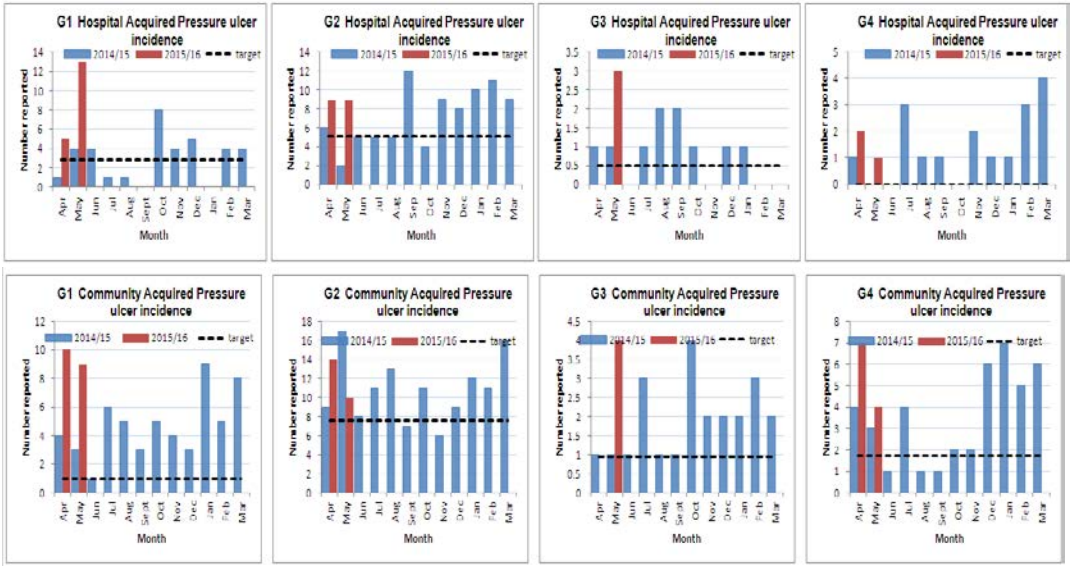
Community acquired: Incidence of pressure ulcer development continues to cause concern and remain challenging with District Nurses continuing to experience increasing caseloads within the community. The numbers remain similar to last month and this may be due to the effectiveness of the recent awareness campaign activity, particularly over the lower grades. Overall incidence as a percentage of the number of contacts over the month remains low. The public awareness campaign across local press and venues has resulted in increased referrals as awareness of pressure injury is raised.



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

Analysis:

Quality Account Priority 2 & National Safety Thermometer CQUIN schemes
Prevention & Management of Pressure Ulcers



Action Plan:	Person Responsible:	Date:	Status:
• Trust wide Pressure Ulcer Prevention Group meets monthly. • Deep dives for each directorate going ahead to look at why expected reductions were not achieved last year. • Action plans for pressure ulcer reduction have been reviewed and are being amalgamated into a single master plan for coming year. • Local monthly Tissue Viability and MUST audits will be established by Tissue Viability Service. • Pressure Ulcer Reporting has been handed to Matrons and Locality leads to supervise to develop local ownership of reporting and understanding the scale of the issue.	Tissue Viability Specialist Nurse	Jun-15	Ongoing
The Tissue Viability Nurse Specialist continues to work with the Communications team on a public awareness campaign to encourage prevention and self help in the community. (Further awareness week scheduled in March 15 with ongoing training and support for care homes available)	Tissue Viability Specialist Nurse / Communications Team	Jun-15	Ongoing
The public awareness event 'I feel good' was taken to locations across that island and was well attended by patients/carers and non-trust staff involved in patient care as well as a delegation from Southampton CCG who are looking to hold a similar campaign in their area	Tissue Viability Specialist Nurse / Communications Team	Jun-15	Completed

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Patient Safety

Commentary:

Clostridium difficile

There have been 4 cases of Healthcare acquired Clostridium Difficile identified in the Trust during May. These have occurred in both Hospital and Ambulance Directorate & Community and Mental Health directorate and are under investigation.

Microbiological investigation has identified that previous cases over the past few months show no links in the bacterial strains and are therefore unconnected. There are also appeals against the attribution where the infection could not be attributable to a lapse in care, but these will take time to be considered and figures will be adjusted retrospectively if appropriate.

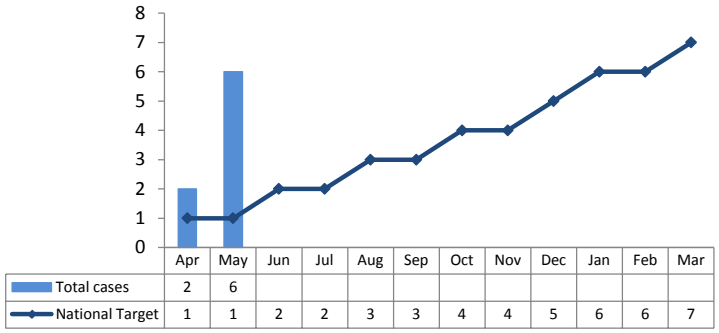
Work continues to raise awareness and highlight actions, including intranet and poster campaigns regarding bowel management with action plans for rapid isolation of suspected cases. Reconfiguration of ward to facilitate further isolation facilities is ongoing although bed pressures continue to present challenges.

Methicillin-resistant Staphylococcus Aureus (MRSA)

There have been no further cases of Healthcare acquired MRSA identified in the Trust since November 2014.

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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total cases	2	6										
National Target	1	1	2	2	3	3	4	4	5	6	6	7

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

Action Plan:	Person Responsible:	Date:	Status:
Increasing education regarding timely sampling of loose stool events and isolation	Infection Control Team	Jun-15	Continuing
Highlighted awareness campaign including intranet, posters & pocket cards and screensavers	Infection control team & Communications team	Jun-15	Continuing
Increased auditing of commode cleaning on individual wards	Ward managers	Jun-15	Continuing

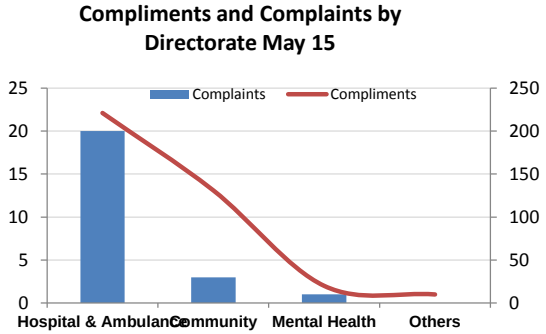
Commentary:

There were 24 formal Trust complaints received in May 2015 (17 in the previous month) against approximately 55,730 patient contacts (Inpatient episodes, all outpatient, A&E attendances and community and Mental Health contacts), with 382 compliments received by letters and cards of thanks across the same period.

Across all complaints and concerns in May 2015:
Top 3 subjects complained about were:
- Clinical treatment (21)
- Appointments (11)
- Communication (24)

Top areas complained about were:
- OPARU (15)
- Orthopaedics (8)
- Emergency Department (7)
- Ophthalmology (7)

Analysis: Complaints only



Primary Subject	Apr-15	May-15	CHANGE	RAG rating
Access to treatment or drugs	0	1	1	↑
Admissions and discharges	4	4	0	→
Appointments	0	0	0	✓
Clinical Treatment	9	8	-1	↓
Commissioning	0	0	0	✓
Communication	2	2	0	→
Consent	0	1	1	↑
End of Life Care	0	0	0	✓
Facilities	0	0	0	✓
Integrated Care	0	0	0	✓
Mortuary	0	0	0	✓
Other (Use with Caution)	0	0	0	✓
Privacy, Dignity and Wellbeing	0	0	0	✓
Prescribing	1	0	-1	✓
Patient Care	1	5	4	↑
Restraint	0	0	0	✓
Staff numbers	0	0	0	✓
Trust admin/Policies/Procedures	0	2	2	↑
Transport (Ambulances)	0	0	0	✓
Values and Behaviours (Staff)	0	1	1	↑
Waiting Times	0	0	0	✓

Action Plan:	Person Responsible:	Date:	Status:
Complaints response times continue to be monitored against the locally agreed 20 day timescale on a weekly basis at TEC.	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Sep-15	In progress

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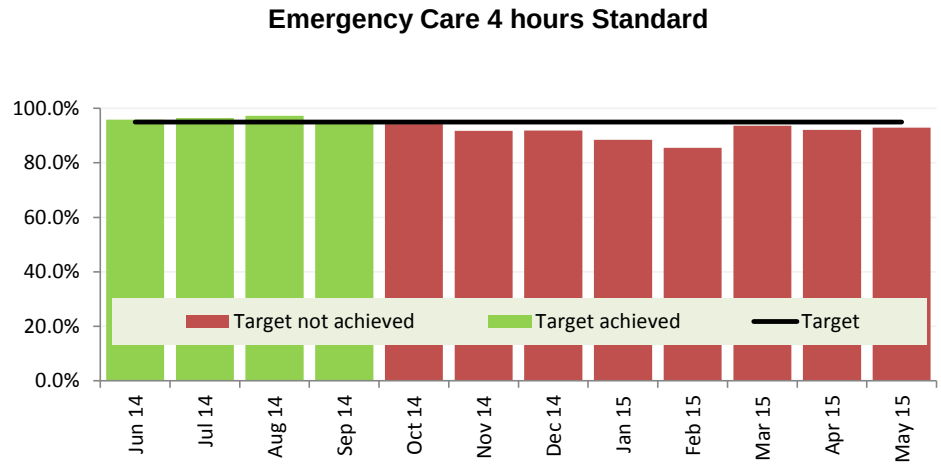
A&E Performance - Emergency Care 4 hours Standard

Isle of Wight NHS Trust

Commentary:	Analysis:
The 95% target for May was again not achieved due to the increased pressure on community bed availability preventing patients flowing through the system. Despite action plans being followed further closures of community places made the target beyond our reach. Increased efforts and focus throughout May continued including continuing with Poppy Unit until it closed at the end of May 15. Internal processes and practices have been revised including the Trust's operational hub to manage patient flow through the Trust and into the community.	

Action Plan:	Person Responsible:	Date:	Status:
Increase focus on local authority bed situation	System Resilience Group / Exec on call	Jun-15	Ongoing
Daily focus on bed states	Matrons	Jun-15	Ongoing

Isle of Wight NHS Trust Board Performance Report 2015/16

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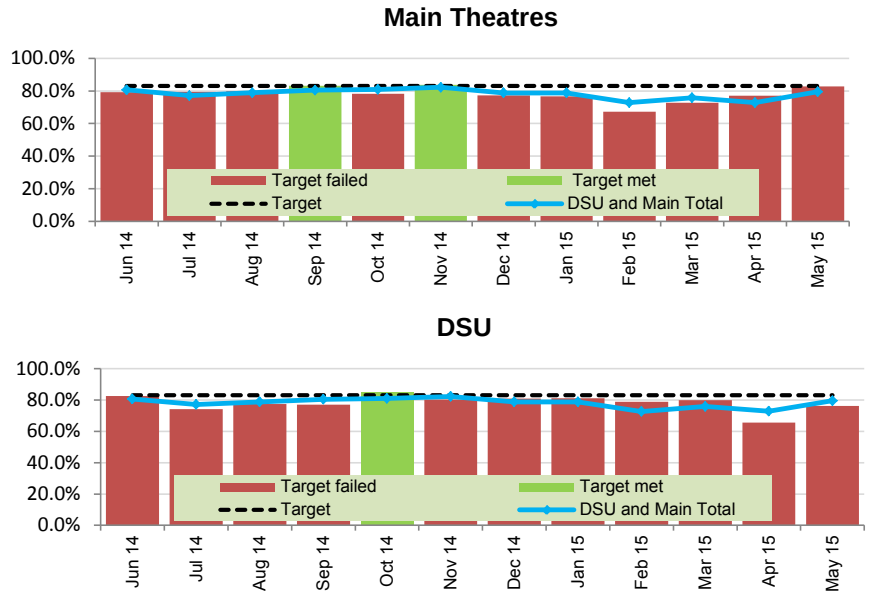
Theatre Utilisation

Commentary	Analysis:
The percentage utilisation of theatre facilities has increased since last month from 77% to 82.8% however remains just below the 83% target. Day Surgery Unit utilisation has increased during May 2015 (76.2%). Overall we have achieved 79.5%. Bed pressures eased supporting improved utilisation.	

Action plan	Person Responsible:	Date:	Status:
Forecast being reviewed with managers to determine trajectory for managing 18 weeks admitted target following impact of previous cancellations. Weekly assurance meeting to monitor RTT	General manager- Hospital and Ambulance Directorate	Jun-15	Ongoing
Incident room set up for regular 4 daily bed meetings to ensure all patients in hospital are being managed for appropriate discharge. Additional bed capacity plan being developed by exec lead.	HAD Directorate Lead	Jun-15	Ongoing
Review of application of annual leave criteria being undertaken, alongside monitoring of absence management in PAAU, and review of nurse led pre assessment capacity.	General manager- Hospital and Ambulance Directorate	Jun-15	Ongoing

Commentary:

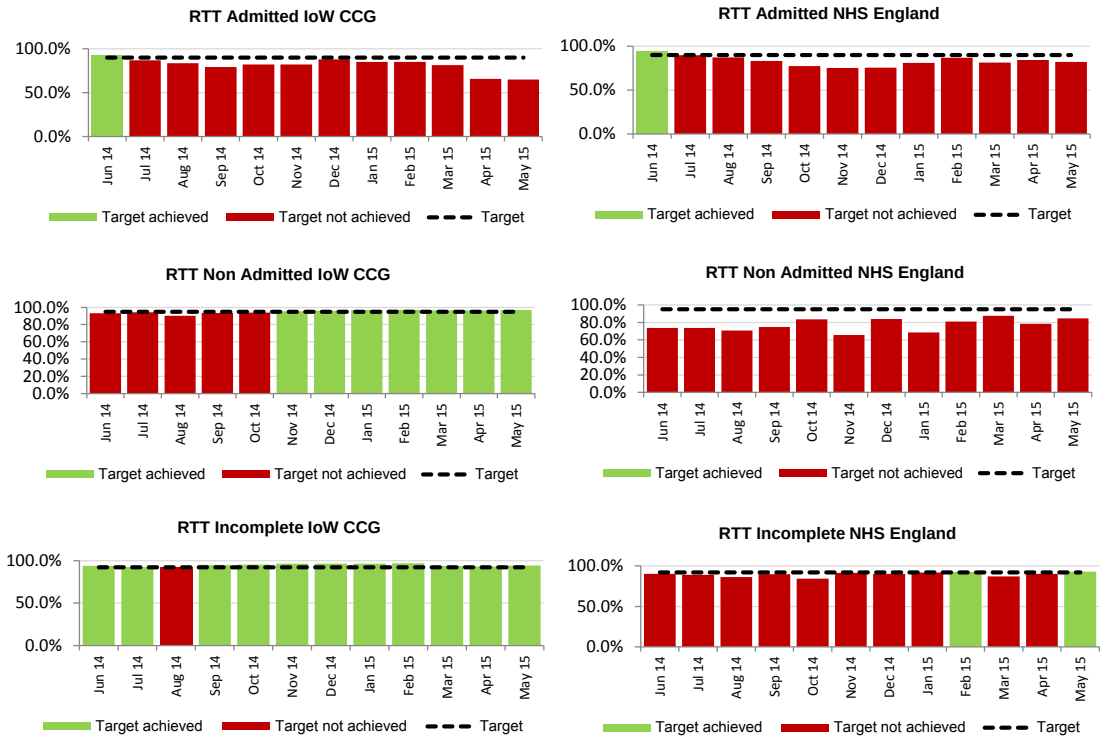
Performance against the admitted target remained low at 67.57% as we continue to treat in turn. This figure is also indicative of the increase in the waiting list, particularly patients waiting for longer periods, and the previously cancelled operations (due to recent high levels of activity in A&E and the associated bed pressures).

The non-admitted performance achieved target this month, achieving 95.66%.

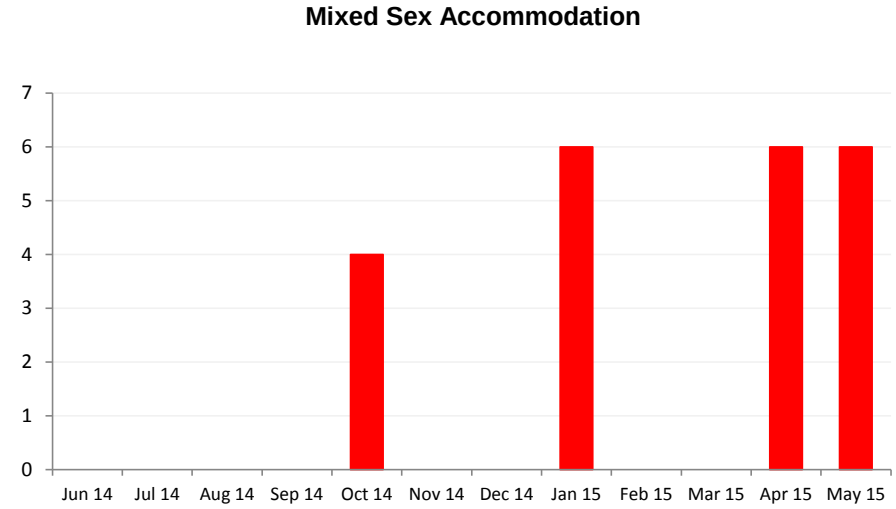
The incomplete target is continuing to achieve and has improved from 92.81% to 94.19% due to higher levels of validation throughout the month. This validation needs to be continued if this standard is to be maintained.

Modelling of demand and capacity for this year is nearly complete. Weekly modelling and validation of the assumptions is being undertaken in order to provide GMs with robust activity and performance information to enable them to deliver their services.

Analysis:



	Person Responsible:	Date:	Status:
Demand and capacity modelling, revised forecast and weekly plan for General Managers to deliver services	Head of PIDS	May-15	In progress
Rebooking of cancelled operations alongside booking of waiting list backlog	PAAU Lead/ Clinical Leads	May-15	In progress
Development of robust processes and documentation to enable training and awareness of 18 week procedures.	Patient Access Lead	Jun-15	Planned

Commentary:	**Analysis:**
During May there was a further event of mixed sex accommodation involving 6 patients. The staff continued to support the principles of single sex accommodation which is to ensure privacy and dignity for all patients affected with use of curtains and support to use toilets in single sex areas. Actions were put in place to ensure privacy and dignity was maintained and the patients were moved as soon as possible. There is a continued risk of recurrence whilst we maintain our current bed occupancy levels until such time as the MAAU rebuild is completed (August 2015), reconfiguration work is completed and more single rooms are available for use, particularly since the closure of the temporary wards, Winter & Poppy Unit.	

Action Plan:	**Person Responsible:**	**Date:**	**Status:**
Root cause analysis and review has been completed	Director of Nursing & Workforce	Jun-15	Completed
Reconfiguration and upgrade to MAAU area on ground floor is continuing as planned	Director of Nursing & Workforce	Jun-15	In progress

Isle of Wight NHS Trust Board Performance Report 2015/16

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Benchmarking of Key National Performance Indicators: Summary Report

Isle of Wight NHS Trust

	National Target	National Performance			IW Performance	IW Rank	IW Status	Data Period
		Best	Worst	Eng				
Emergency Care 4 hour Standards	95%	100%	74%	90.8%	89.4%	115 / 171	Amber Red	Qtr 4 14/15
RTT:% of admitted patients who waited 18 weeks or less	90%	100%	0%	86.1%	68.1%	155 / 160	Red	Apr-15
RTT: % of non-admitted patients who waited 18 weeks or less	95%	100%	60%	95.0%	94.6%	142 / 185	Amber Red	Apr-15
RTT % of incomplete pathways within 18 weeks	92%	100%	45%	93.1%	92.8%	132 / 185	Top Quartile	Apr-15
%. Patients waiting > 6 weeks for diagnostic	1%	0%	31%	2.0%	0.1%	41 / 180	Better than national average	Apr-15
Ambulance Category A Calls % < 8 minutes - Red 1	75%	81%	69%	75.6%	75.0%	7 / 11	Better than national average	Apr-15
Ambulance Category A Calls % < 8 minutes - Red 2	75%	77%	65%	72.4%	74.4%	6 / 11	Amber Red	Apr-15
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	77%	65%	72.5%	74.4%	6 / 11	Amber Red	Apr-15
Ambulance Category A Calls % < 19 minutes	95%	98%	93%	95.0%	96.0%	4 / 11	Better than national average	Apr-15
Cancer patients seen <14 days after urgent GP referral	93%	100%	85%	94.7%	96.9%	41 / 155	Better than national average	Qtr 4 14/15
Cancer diagnosis to treatment <31 days	96%	100%	88%	97.5%	99.5%	44 / 159	Better than national average	Qtr 4 14/15
Cancer urgent referral to treatment <62 days	85%	100%	0%	82.2%	88.6%	36 / 160	Top Quartile	Qtr 4 14/15
Symptomatic Breast Referrals Seen <2 weeks	93%	100%	54%	94.7%	97.3%	38 / 135	Top Quartile	Qtr 4 14/15
Cancer Patients receiving subsequent surgery <31 days	94%	100%	50%	94.9%	100.0%	1 / 156	Top Quartile	Qtr 4 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	100%	95%	99.5%	100.0%	1 / 145	Top Quartile	Qtr 4 14/15
Cancer Patients treated after consultant upgrade <62 days	85%	100%	0%	89.3%	100.0%	1 / 148	Top Quartile	Qtr 4 14/15
Cancer Patients treated after screening referral <62 days	90%	100%	40%	91.3%	95.6%	54 / 141	Top Quartile	Qtr 4 14/15

Key:

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

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

Isle of Wight NHS Trust Board Performance Report 2015/16

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

Isle of Wight NHS Trust

Other Small Acute Trusts	National Target	IW	RA3	RA4	RBD	RBT	RBZ	RC1	RC3	RCD	RCF	RCX	RD8	RE9	RFF	RFW	RGR	RJC	RJD	RJF	RJN	RLQ	RLT	RMP	RN7	RNQ	RNZ	RQQ	RQX	Data Period
Emergency Care 4 hour Standards	95%	89.4% 17	90.0% 16	94.1% 9	90.9% 12	86.6% 23	94.8% 7	96.0% 2	N/A	96.5% 1	95.4% 5	87.5% 21	88.5% 19	84.2% 25	95.7% 4	93.5% 10	90.0% 15	87.6% 20	N/A	94.3% 8	86.7% 22	85.2% 24	90.0% 14	88.6% 18	92.8% 11	82.4% 26	95.7% 3	90.8% 13	95.3% 6	Qtr 4 14/15
RTT:% of admitted patients who waited 18 weeks or less	92%	68.1% 24	95.2% 3	74.3% 23	92.1% 11	92.9% 6	95.1% 4	86.7% 19	N/A	94.3% 5	91.3% 13	90.5% 16	87.9% 18	92.7% 7	96.9% 1	95.5% 2	84.1% 21	85.7% 20	N/A	91.2% 14	63.3% 25	62.2% 26	90.6% 15	89.3% 17	92.1% 10	79.3% 22	91.7% 12	92.6% 8	92.2% 9	Apr-15
RTT: % of non-admitted patients who waited 18 weeks or less	95%	94.6% 21	97.8% 9	92.7% 23	97.7% 11	92.7% 24	98.6% 3	97.9% 8	N/A	97.3% 13	96.5% 15	98.3% 6	95.6% 19	99.1% 1	97.7% 10	97.2% 14	96.3% 16	95.0% 20	N/A	98.1% 7	96.2% 18	N/A N/A	96.2% 17	86.4% 25	97.4% 12	92.8% 22	98.4% 5	98.7% 2	98.5% 4	Apr-15
RTT % of incomplete pathways within 18 weeks	92%	92.8% 18	97.4% 3	89.6% 23	90.1% 22	94.5% 14	96.2% 10	95.7% 13	N/A	96.5% 9	92.1% 20	96.8% 8	93.3% 16	98.5% 1	91.3% 21	95.9% 12	96.0% 11	92.7% 19	N/A	97.1% 6	93.2% 17	64.2% 25	94.3% 15	N/A	96.9% 7	85.4% 24	97.2% 4	97.2% 5	97.9% 2	Apr-15
%. Patients waiting > 6 weeks for diagnostic	1%	0.1% 5	0.4% 10	0.5% 11	1.4% 18	0.6% 13	1.0% 16	0.3% 9	N/A	0.1% 7	0.1% 2	1.7% 20	1.0% 15	0.0% 1	0.1% 3	0.8% 14	12.4% 26	1.8% 21	N/A	0.1% 4	1.3% 17	6.7% 24	10.7% 25	0.59% 12	0.2% 8	2.3% 22	4.9% 23	1.6% 19	0.1% 6	Apr-15
Cancer patients seen <14 days after urgent GP referral*	93%	96.9% 11	97.7% 7	92.4% 24	91.4% 25	96.7% 12	87.1% 26	94.5% 21	N/A	96.4% 14	98.4% 5	98.6% 4	95.3% 19	96.9% 10	99.1% 1	93.2% 23	99.0% 2	96.1% 16	N/A	97.5% 8	98.7% 3	96.2% 15	95.9% 18	96.6% 13	93.3% 22	96.1% 17	94.8% 20	98.0% 6	96.9% 9	Qtr 4 14/15
Cancer diagnosis to treatment <31 days*	96%	99.5% 10	100.0% 1	97.8% 24	99.6% 9	100.0% 1	93.2% 26	100.0% 1	N/A	100.0% 1	100.0% 1	99.4% 13	98.3% 21	100.0% 1	99.4% 11	99.2% 14	100.0% 1	96.4% 25	N/A	99.0% 18	98.9% 20	99.1% 15	97.8% 23	99.0% 19	100.0% 1	99.1% 16	99.4% 12	98.1% 22	99.0% 17	Qtr 4 14/15
Cancer urgent referral to treatment <62 days*	85%	88.6% 9	83.0% 24	87.5% 15	87.9% 12	91.1% 1	72.8% 27	89.7% 6	87.5% 15	90.2% 5	87.2% 17	80.5% 26	87.6% 13	85.4% 20	85.6% 19	90.5% 3	88.7% 8	88.4% 10	33.3% 28	85.1% 22	87.6% 14	83.8% 23	85.1% 21	90.7% 2	88.4% 11	81.9% 25	86.9% 18	90.5% 4	89.6% 7	Qtr 4 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	97.3% 5	87.7% 23	93.0% 21	73.5% 25	96.5% 10	76.4% 24	94.4% 17	N/A	96.6% 9	98.5% 3	97.1% 8	98.3% 4	N/A	96.3% 12	95.6% 14	100.0% 1	93.6% 20	N/A	95.5% 15	97.3% 7	91.9% 22	93.8% 19	96.0% 13	95.0% 16	99.5% 2	94.2% 18	96.4% 11	97.3% 6	Qtr 4 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	100.0% 1	100.0% 1	94.4% 22	98.0% 19	97.6% 20	78.4% 26	100.0% 1	N/A	96.7% 21	100.0% 1	98.3% 18	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	87.0% 24	N/A	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	91.9% 23	100.0% 1	83.3% 25	100.0% 1	Qtr 4 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% 1	97.6% 25	100.0% 1	100.0% 1	100.0% 1	96.4% 26	100.0% 1	N/A	100.0% 1	100.0% 1	99.4% 22	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	N/A	98.0% 24	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	98.6% 23	100.0% 1	Qtr 4 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	100.0% 1	61.5% 25	91.2% 16	100.0% 1	90.9% 17	87.2% 20	95.2% 11	N/A	100.0% 1	68.2% 24	70.0% 23	100.0% 1	100.0% 1	93.8% 14	93.2% 15	87.8% 19	95.1% 12	N/A	83.3% 21	88.9% 18	82.4% 22	100.0% 1	96.6% 10	100.0% 1	60.7% 26	100.0% 1	100.0% 1	93.8% 13	Qtr 4 14/15
Cancer Patients treated after screening referral <62 days*	90%	95.6% 17	100.0% 1	100.0% 1	95.5% 18	93.0% 20	80.0% 24	93.3% 19	N/A	100.0% 1	88.9% 22	97.6% 13	100.0% 1	N/A	100.0% 1	100.0% 1	88.7% 23	96.9% 15	N/A	100.0% 1	98.8% 12	91.7% 21	100.0% 1	100.0% 1	97.1% 14	95.9% 16	100.0% 1	100.0% 1	N/A	Qtr 4 14/15

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

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

R1F	ISLE OF WIGHT NHS TRUST
RA3	WESTON AREA HEALTH NHS TRUST
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST
RC1	BEDFORD HOSPITAL NHS TRUST

RC3	EALING HOSPITAL NHS TRUST
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST
RCF	AIREDALE NHS FOUNDATION TRUST
RCX	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS TRUST
RD8	MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST

RFW	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
RGR	WEST SUFFOLK NHS FOUNDATION TRUST
RJC	SOUTH WARWICKSHIRE GENERAL HOSPITALS NHS TRUST
RJD	MID STAFFORDSHIRE NHS FOUNDATION TRUST
RJF	BURTON HOSPITALS NHS FOUNDATION TRUST
RJN	EAST CHESHIRE NHS TRUST
RLQ	WYE VALLEY NHS TRUST

RLT	GEORGE ELIOT HOSPITAL NHS TRUST
RMP	TAMESIDE HOSPITAL NHS FOUNDATION TRUST
RN7	DARTFORD AND GRAVESHAM NHS TRUST
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
RNZ	SALISBURY NHS FOUNDATION TRUST
RQQ	HINCHINGBROOKE HEALTH CARE NHS TRUST
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Isle of Wight NHS Trust Board Performance Report 2015/16

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Isle of Wight NHS Trust

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

	National Target	IW	R1C	RBD	RD3	RDY	RDZ	RHM	RHU	RN5	RW1	Data Period
Emergency Care 4 hour Standards	95%	89.4% 7	100.0% 1	90.9% 6	91.5% 5	100.0% 2	92.6% 4	86.1% 9	80.6% 10	88.8% 8	99.4% 3	Qtr 4 14/15
RTT:% of admitted patients who waited 18 weeks or less	90%	68.1% 10	100.0% 1	92.1% 3	90.9% 6	90.9% 5	90.1% 7	90.0% 9	91.2% 4	90.1% 8	96.4% 2	Apr-15
RTT: % of non-admitted patients who waited 18 weeks or less	95%	94.6% 8	98.6% 2	97.7% 4	95.8% 5	99.4% 1	93.0% 10	95.5% 7	95.6% 6	93.2% 9	98.3% 3	Apr-15
RTT % of incomplete pathways within 18 weeks	92%	92.8% 8	99.7% 1	90.1% 10	96.4% 4	98.1% 3	92.7% 9	95.0% 5	94.2% 6	93.1% 7	98.4% 2	Apr-15
%. Patients waiting > 6 weeks for diagnostic	1%	0.1% 3	0.0% 1	1.4% 8	1.2% 7	3.2% 9	5.2% 10	0.4% 4	0.9% 6	0.7% 5	0.0% 1	Apr-15
Cancer patients seen <14 days after urgent GP referral*	93%	96.9% 2	N/A	91.4% 7	98.8% 1	N/A	91.6% 6	96.3% 5	96.5% 4	96.7% 3	N/A	Qtr 4 14/15
Cancer diagnosis to treatment <31 days*	96%	99.5% 2	N/A	99.6% 1	99.0% 3	N/A	96.2% 7	97.0% 6	97.3% 5	98.9% 4	N/A	Qtr 4 14/15
Cancer urgent referral to treatment <62 days*	85%	88.6% 2	N/A	87.9% 3	89.0% 1	N/A	82.0% 5	81.0% 7	82.0% 6	87.5% 4	N/A	Qtr 4 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	97.3% 4	N/A	73.5% 7	100.0% 1	N/A	98.1% 2	97.4% 3	96.0% 6	96.8% 5	N/A	Qtr 4 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	100.0% 1	N/A	98.0% 5	99.0% 3	N/A	86.1% 7	98.2% 4	97.8% 6	99.1% 2	N/A	Qtr 4 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% 1	N/A	100.0% 1	100.0% 1	N/A	100.0% 1	99.4% 7	100.0% 1	100.0% 1	N/A	Qtr 4 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	100.0% 1	N/A	100.0% 1	100.0% 1	N/A	83.3% 7	93.8% 4	84.2% 6	90.0% 5	N/A	Qtr 4 14/15
Cancer Patients treated after screening referral <62 days*	90%	95.6% 2	N/A	95.5% 3	93.0% 6	N/A	89.6% 7	93.8% 5	94.6% 4	97.9% 1	N/A	Qtr 4 14/15

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

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

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

Isle of Wight NHS Trust Board Performance Report 2015/16

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Benchmarking of Key National Performance Indicators: Ambulance Performance

	National Target	IW Performance	RX9	RYC	RRU	RX6	RX7	RYE	RYD	RYF	RYA	RX8	Data Period
Ambulance Category A Calls % < 8 minutes - Red 1	75%	75.0% 7	75.0% 6	79.9% 2	69.5% 11	73.2% 9	71.2% 10	76.7% 4	75.9% 5	78.9% 3	81.2% 1	74.9% 8	Apr-15
Ambulance Category A Calls % < 8 minutes - Red 2	75%	74.4% 6	74.6% 5	71.5% 9	64.7% 11	77.2% 2	72.1% 8	76.5% 4	77.3% 1	68.2% 10	76.8% 3	72.7% 7	Apr-15
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	74.4% 6	74.6% 5	72.0% 9	64.8% 11	76.9% 3	72.1% 8	76.5% 4	77.3% 1	68.8% 10	77.1% 2	72.8% 7	Apr-15
Ambulance Category A Calls % < 19 minutes	95%	96.0% 4	94.0% 9	95.5% 7	94.2% 8	95.8% 5	93.3% 10	95.7% 6	96.4% 2	92.7% 11	97.6% 1	96.2% 3	Apr-15

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

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

Commentary:

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

The latest information is up to March 2015. Overall we now 5 red rated indicators 4 of which are in the Admitted Patient Care (APC) Dataset and the other in the A&E Attendances Dataset. The Outpatient dataset indicators are all green. The 4 red indicators in the APC dataset are the NHS Number, Postcode, Primary Diagnosis and the HRG4 (Healthcare Resource Grouping). The last 2 issues are linked as you need the diagnosis to generate the HRG and we believe the issues has been resolved and has been improving month on month within the data but will take time to appear as amber or green.

The NHS Number in the APC dataset is also red, we know this issue relates mostly to two issues: 1) Prisoners, this is because we have difficulty in confirming a certain match throught the patient tracing system. This issue will be raised through the Information Steering Group for an approriate action to be sought. 2) Anonymised patients - These are often patients receiving sensitive treatments such as termination of pregnancy and as such their details are fully anonymised.

2 Further indicators have flagged as red this month the postcode in the APC dataset and the departure time in the A&E dataset both will be investigated in order to identify the cause.

Analysis:

Total APC General Episodes: 25,809

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	372	98.6%	99.2%
Patient Pathway	487	94.2%	61.4%
Treatment Function	0	100.0%	99.9%
Main Specialty	0	100.0%	99.9%
Reg GP Practice	3	100.0%	99.9%
Postcode	214	99.2%	99.8%
Org of Residence	9	100.0%	99.3%
Commissioner	18	99.9%	99.5%
Primary Diagnosis	1,254	94.5%	98.8%
Primary Procedure	0	100.0%	99.5%
Ethnic Category	20	99.9%	97.3%
Site of Treatment	0	100.0%	96.5%
HRG4	1,279	95.0%	98.7%

Total Outpatient General Episodes: 172,071

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	913	99.5%	99.3%
Patient Pathway	77,208	51.6%	50.5%
Treatment Function	0	100.0%	99.9%
Main Specialty	0	100.0%	99.6%
Reg GP Practice	5	100.0%	99.9%
Postcode	12	100.0%	99.7%
Org of Residence	19	100.0%	97.8%
Commissioner	45	100.0%	99.4%
First Attendance	0	100.0%	99.3%
Attendance Indicator	5	100.0%	99.6%
Referral Source	831	99.5%	98.6%
Referral Rec'd Date	831	99.5%	95.8%
Attendance Outcome	24	100.0%	98.5%
Priority Type	831	99.5%	97.4%
OP Primary Procedure	0	100.0%	99.6%
Ethnic Category	69	100.0%	93.7%
Site of Treatment	2	100.0%	96.7%
HRG4	0	100.0%	98.2%

Total A&E Attendances 63,230

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	1,140	98.2%	95.2%
Registered GP Practice	17	100.0%	99.2%
Postcode	33	99.9%	98.8%
Org of Residence	524	99.2%	96.2%
Commissioner	769	98.8%	99.1%
Attendance Disposal	753	98.8%	97.6%
Patient Group	26	100.0%	96.5%
First Investigation	662	99.0%	94.6%
First Treatment	1,931	96.9%	93.8%
Conclusion Time	741	98.8%	97.8%
Ethnic Category	0	100.0%	94.5%
Departure Time	483	99.2%	99.9%
Department Type	0	100.0%	99.8%
HRG4	906	98.6%	96.1%

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:
Develop an action plan to improve NHS Number completeness for prisoners	Head of Information / Asst. Director - PIDS	Jul-15	Ongoing
Review missing postcodes in APC and Departure Time in A&E datasets to identify cause		Jul-15	Ongoing

Data Quality - Mar 2015

Dataset	Measure	IW Performance	National	Threshold G	Threshold A	Threshold R	Status	Weighting	Score	Notes
APC	Total Invalid Data Items	4	n/a	=<2	>2 =<4	>4	A	2	1.0	Performance relates to the no. of Red rated data items
APC	Valid NHS Number	98.6%	99.2%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	A	1	0.5	
APC	Valid Ethnic Category	99.9%	97.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Invalid Data Items	0	n/a	=<2	>2 =<5	>5	G	2	0.0	Performance relates to the no. of Red rated data items
OP	Valid NHS Number	99.5%	99.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Valid Ethnic Category	100.0%	93.7%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Total Invalid Data Items	1	n/a	=<2	>2 =<4	>4	G	2	0.0	Performance relates to the no. of Red rated data items
A&E	Valid NHS Number	98.2%	95.2%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Valid Ethnic Category	100.0%	94.5%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
	Total			= < 2	2 > = < 4	= > 4	G	12	1.5	

Source: Information Centre, SUS Data Quality Dashboard

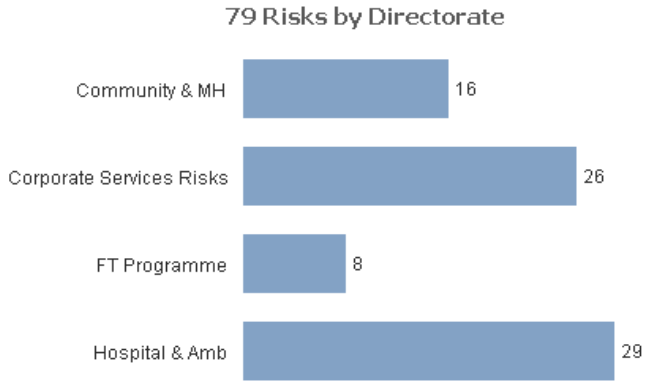
Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Risk Register - Situation current as at 17/06/2015

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	%
Community & MH	07/12/2009	Increased Demand On Orthotics	8	6	75%
Hospital & Amb	23/02/2011	Insufficient And Inadequate Endoscopy Facilities To Meet Service Requirements	9	8	89%
Hospital & Amb	20/10/2011	Insufficient And Inadequate Ophthalmology Facilities To Meet Service Requirements	6	4	67%
Hospital & Amb	16/08/2012	Blood Sciences Out-Of-Hours Staffing Inadequate	5	4	80%
Hospital & Amb	22/08/2012	Risk Due To Bed Capacity Problems	5	3	60%
Community & MH	22/11/2012	Low Staffing Levels Within Occupational Therapy Acute Team	9	6	67%
Hospital & Amb	05/12/2012	Vacant Consultant Physician Posts	3	1	33%
Hospital & Amb	22/01/2013	Excessive Nhs Use Of Private Patient Ward Impacting Upon Business Profitability	4	3	75%
Corporate Services Ris	26/03/2013	Pressure Ulcer Incidences Need Reducing	7	5	71%
Hospital & Amb	23/09/2013	Ophthalmic Casenotes - Poor Condition, Misfiling And Duplication Leading To Potential Clinical Error	6	2	33%
Hospital & Amb	21/01/2014	Acquisition Of Mechanical Device For Chest Compressions	5	4	80%
Corporate Services Ris	24/07/2014	Mandatory Resuscitation Training - Lack Of Capacity	6	5	83%
Hospital & Amb	28/08/2014	Computer Aided Dispatch (CAD) Server And Software Update Required Urgently	6	2	33%
Corporate Services Ris	28/08/2014	Unsupported Desktop Environment	6	0	0%
Corporate Services Ris	31/12/2014	Trust Archive Records Storage - Lack Of Capacity	6	1	17%
Hospital & Amb	19/03/2015	18 Weeks Referral To Treatment - Patient Access Performance Targets Not Achieved	6	0	0%
Community & MH	19/03/2015	Iris Staffing Issues	5	0	0%
Community & MH	21/05/2015	No Stroke Consultant Specialist	7	0	0%
Corporate Services Ris	21/05/2015	Unsupported And Outdated Edge Infrastructure - Risk Loss Of Access To Network And Clinical Systems	5	0	0%

Data as at 17/06/2015 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. Some risk action plans (above) are out of date and the Directorates have been asked to update with immediate effect.

Since the last report No new risks have been added to the register. 3 risks have been signed off the risk register - **RR346** Potential loss of Emergency Telephone Services and Fire Alarm System Control Centre by Fire - The phone system has been upgraded to provide resilience in diverse locations, A backup switchboard solution has been implemented and tested successfully, The multitone bleep solution is being upgraded to the latest technology, with resilient location planned for later this year. Equipment has been re-sited to other areas, which has negated the need for the additional fire suppression solution to be installed, **RR641** Access to Sevenacres Roof - Eaves to Sevenacres roof have been fully replaced to prevent patients from accessing the roof. This risk is now fully mitigated. RR644 Failure to Achieve Financial Plan - End of financial year has passed with the unaudited position being a £15K surplus compared to a planned £1.7m surplus. New risk to be added for 2015/16 Financial Year.

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Workforce - Summary - RAG Rating based on Out-turn position

Isle of Wight NHS Trust

Paybill				R
	Plan	Actual	Overspend	
Year to date £k	- 18,979	- 20,669	1,691	

Establishment				R
	Plan	Actual / Forecast	Variance	
Year to date	2,831	2,620	211	

Vacancies			R
	Under-Establishment Gap	Recruitment Activity	
Vacancy FTE	211	155	

Summary

The trust as a whole has overspent its pay budget in month by £777k and £1.7m year to date.
Under achievement of CIP equates to £566k in month and £972k year to date.
Overspends against budget including temporary staffing equate to £719k. Spending on temporary staffing equated to £1m in month and represents a total cost in year of £2.2m.
Sickness levels have reduced marginally though remain above plan. In month cost of sickness absence equates to £260 with a year to date total of £520k

Summary

Under establishment has risen from 7% in April to 7.4% and is in line with staff turnover expectations.
Usage of temporary/variable staffing in month equates to 76% of vacant WTE, down significantly from 97% in March, but slightly higher than April's 73%.
Nursing establishments are most significantly under plan, but are line with turnover expectations. Particular pressures are experienced in the medical and dental, scientific & technical, & additional clinical services staffing groups where under establishment is greater than planned turnover rates. This is resulting in significant temporary staffing costs in these areas and contributing to the trusts overspend. Of the current under establishment, 42.32 wte posts are currently in the recruitment process.

Summary

The trust is currently under established against approved budgets by 208 wte. The recruitment to 155 WTE are currently at different stages in the recruitment process.

Highlights	Lowlights
	Hospital & Ambulance overspent

Highlights	Lowlights

Highlights	Lowlights

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Workforce - Summary - RAG Rating based on Out-turn position

Isle of Wight NHS Trust

Sickness			R	Overpayment			G	Rostering	
	Plan	Actual / Forecast	Variance		Plan	Actual		Adherence to forward rostering policy requirement	36%
Year to date	3%	3.98%	0.98%	Year to date £ 000	0	94		Units finalising to payroll deadline	91%
In Month	3%	3.93%	0.93%					Safe staffing units > 80% staffed (overall)	100%
Summary Sickness absence has decreased from 3.93% in Apr 15 to 3.88% in May 15. Trust wide highest reason remains sickness absence is Anxiety, Stress & Depression. Cost of Sickness Absence: HAD £128,99 Community £102,413 Non-Clinical £29,639				Summary: New overpayments have resulted in a slight increase in overpayment figure in month. This figure includes Legacy overpayments not included in Directorate summaries of £5851. The significant majority of overpayments remain due to incorrect or late forms. Underlying factors will include: 1. Competing Priorities in units. 2. Lack of understanding regarding potential impacts. 3. Duration of process from completing forms to updating ESR.				At time of lockdown, multiple costs centres were not locked down. Substantial effort was made to contact areas to get this done as outlined in the rostering policy. This month 25 units were removed from the batch list. There is still some considerable progress required to achieve compliance with the recently approved rostering policy., though progress has been made. 86% of safe staffing areas are now rostered 12 weeks in advance from 65% of units in April. 8 units has fully approved 8 weeks of future rosters representing 36%, up from 13% in April. 7 units have not 1st or 2nd approved 8 weeks future rosters. The only unit to fall below 80% of planned RN's was CCU. Five of the 20 units monitored and included on the Unify staffing return for safe staffing recorded a position with either day or night shifts across the month with less than 80% of duty's filled. These were: Stroke 79.8% RN's Day CCU 74.1% RN's Day MAU 74.8% RN's Day Paediatric Ward 75.3% RN's Night Luccombe Ward 77.7 RM & 78.9% HCA Day			

Underlying Causes	Underlying Causes	Underlying Causes
	The significant majority of overpayments are due to incorrect or late forms. Underlying factors will include: 1. Competing Priorities in units. 2. Lack of understanding regarding potential impacts. 3. Duration of process from completing forms to submission.	1. Competing Priorities in units. 2. Lack of understanding regarding potential impacts. 3. Unit managers timesheets not being finalised by their manager preventing unit lockdown. 4. Inadequate cover arrangements for finalising during manager absence. 5. System flaw allowing locked units to be unlocked by staff entering web timesheets
Remedies & Actions	**Remedies & Actions**	**Remedies & Actions**
1. Monthly sickness absence meeting with HR/OH/ H&S to review LTS sickness cases to ensure compliance to policy and triangulate OH and Back care referrals and provide follow up advice to managers. 2. OH monitor weekly list of sickness absence of two weeks or more duration and review trends and liaise with HR and H&S on cases that may require additional support. 3. Employee relations reporting is provided on a monthly basis which includes attendance management cases to Trust Exec's and AD's 4. Monitoring within directorates occurs at monthly directorate boards and performance reviews 5. Review of Attendance mgt policy is in progress working across HR and OH. 6. Targeted support provided to on ad hoc basis as requested by departments ie, HSDU session, sickness absence toolkit distribution to pathology.	Overpayment information sent to directorates on a monthly basis for review and action. Furthermore, ESR self service is currently in the initial phases of a rollout that will empower staff and managers to review and update employment records. A pilot phase for employee self service (ESS) is in action, and will be reviewed for trust wide rollout from Autumn 2015. Manager self service will be implemented following the successful deployment of ESS and review.	1. Importance of finalising and impacts of not doing so to be re-iterated. This will be reinforced by staff who will have had pay implications contacting unit managers. 2. System resolution to be implemented by Allocate. Resolution found in other trusts to be applied here but requires multiple criteria to be adjusted. Allocate are currently investigating the adjustments required for IOW NHS Trust.

Trust

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Pay	(18,979)	(20,669)	(1,691)
			-8.91%

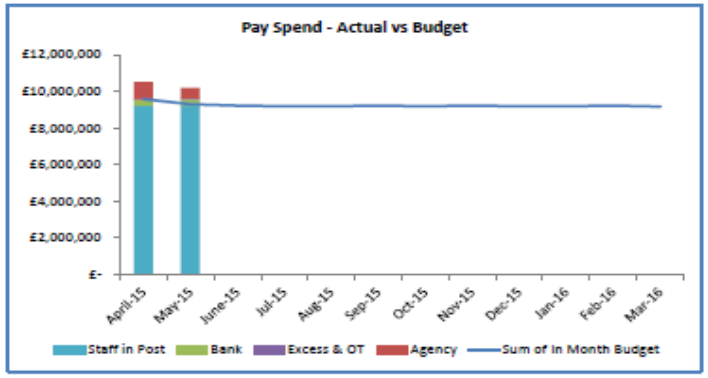
Summary

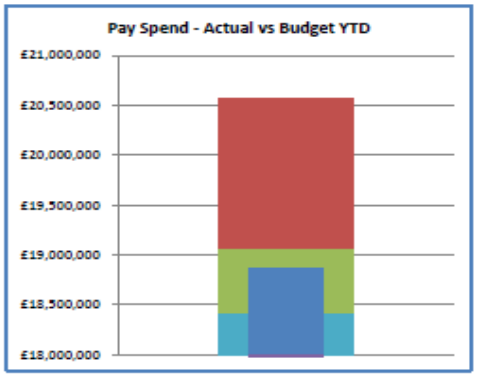
The trust as a whole has overspent its pay budget in month by £777k and £1.7m year to date.

Under achievement of CIP equates to £566k in month and £972k year to date.

Overspends against budget including temporary staffing equate to £719k. Spending on temporary staffing equated to £1m in month and represents a total cost in year of £2.2m.

Sickness levels have reduced marginally though remain above plan. In month cost of sickness absence equates to £260 with a year to date total of £520k





Trust

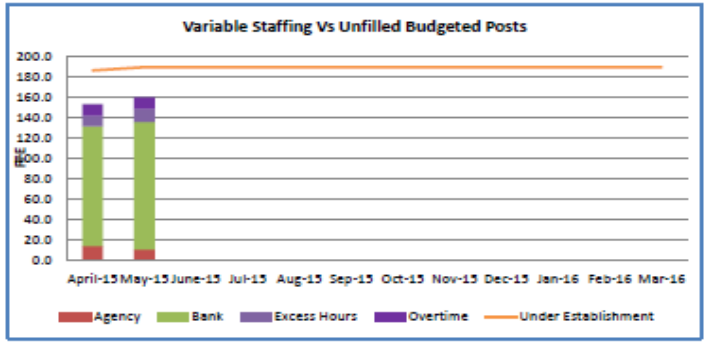
	In Month			
	Plan	Actual	Variance	
Substantive WTE	2,831	2,620	(211)	7%
Temporary Staffing		159	159	76%
Total	**2,831**	**2,780**	(51)	**2%**

Summary

Under establishment has risen from 7% in April to 7.4% and is in line with staff turnover expectations.

Usage of temporary/variable staffing in month equates to 76% of vacant WTE, down significantly from 97% in March, but slightly higher than April's 73%.

Nursing establishments are most significantly under plan, but are line with turnover expectations. Particular pressures are experienced in the medical and dental, scientific & technical, & additional clinical services staffing groups where under establishment is greater than planned turnover rates. This is resulting in significant temporary staffing costs in these areas and contributing to the trusts overspend. Of the current under establishment, 42.32 wte posts are currently in the recruitment process.



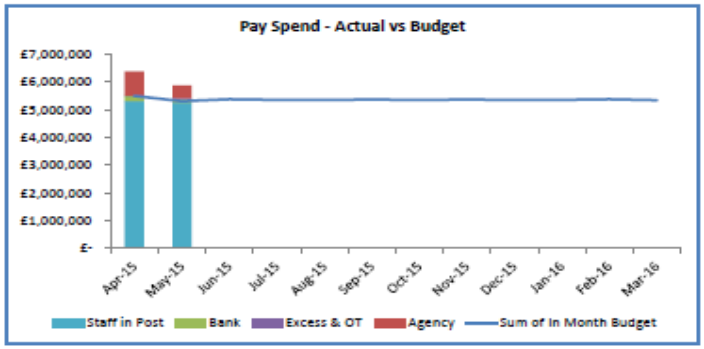
Active Recruitment by Stage in Process	Trustwide
Awaiting Interview	2.96
Being Shortlisted	1.00
Out to Advert	14.00
Paperwork in HR/ Awaiting Instruction	10.74
Appointed Awaiting Clearances	13.62
Total	**42.32**

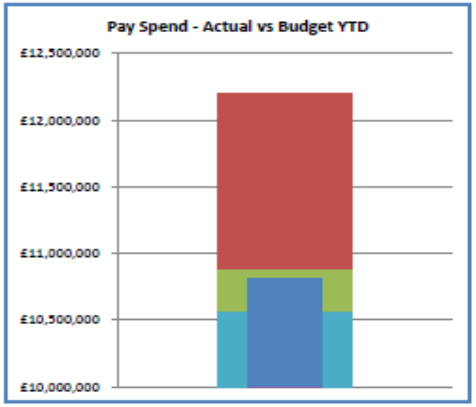
Hospital & Ambulance

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Pay	(10,811)	(12,261)	(1,450)
			-13.41%

Summary

Overspends in the paybill for the Hospital & Ambulance directorate are the biggest contributors to the trusts overall adverse position. The directorate has ended month 2 with an overspend of £1.45m up from £885k in April, equating to 86% of the trusts total overspend.
Unachieved CIP accounts for £896k of the directorates overspend. Spending on temporary staffing amounts to £627k in month £1.1m year to date, representing 114% of the directorates total pay bill. Higher than planned sickness absence is also contributing to the cost pressures.



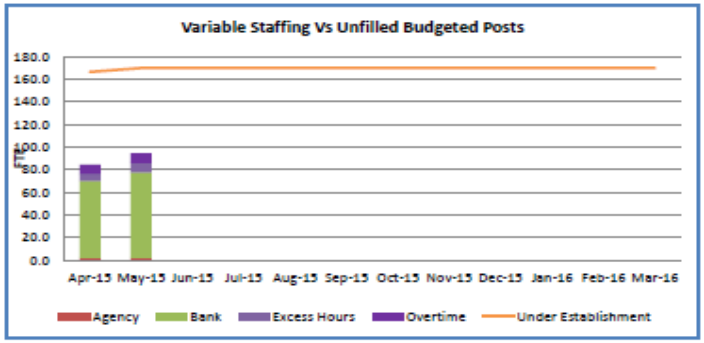


Hospital & Ambulance

	In Month			
	Plan	Actual	Variance	
Substantive WTE	1,548	1,370	(178)	11%
Temporary Staffing		94	94	53%
Total	**1,548**	**1,465**	(84)	5%

Summary

Under established posts have increased marginally in month, with 178 WTE posts currently vacant from 174 in April. (Up from 124 in March) These are resulting in the need for temporary staffing in the form of bank and agency which are adding to the cost pressures above. Temporary staffing numbers represent 53% of under establishment being covered. Of the 178 under establishment within the directorate, 14 WTE posts are currently in the recruitment process.



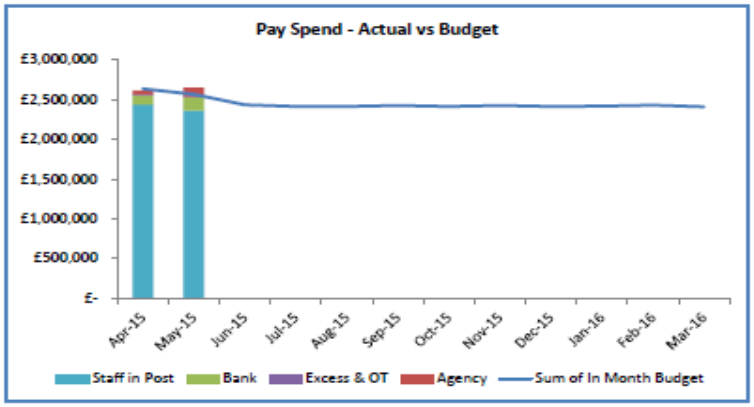
Active Recruitment by Stage in Process	Hospital & Ambulance
Awaiting Interview	1.96
Being Shortlisted	1.00
Out to Advert	2.00
Paperwork in HR/ Awaiting Instruction	1.64
Appointed Awaiting Clearances	7.40
Total	**14.00**

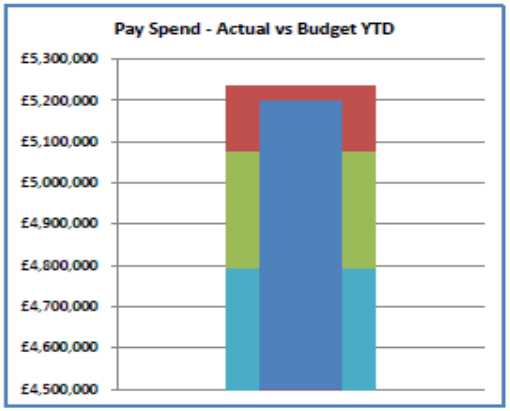
Community Health

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Pay	(5,197)	(5,260)	(62)
			-1.20%

Summary

The community health directorate is overspent by £62k year to date, from under spend in month 1 of £18k. This is primarily due to an increase in spending on temporary staffing in month, representing an increase of £100k month on month.



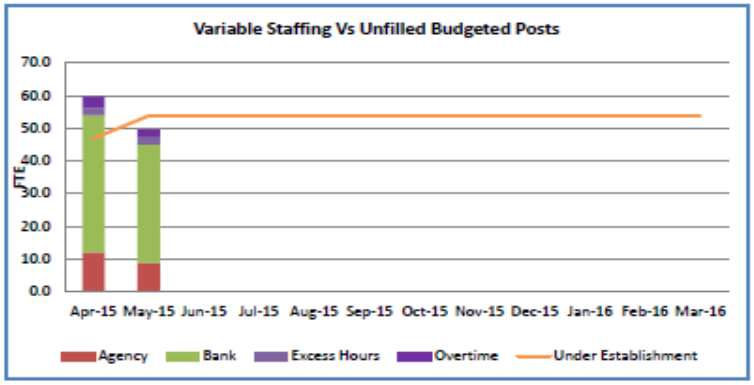


Community Health

	In Month			
	Plan	Actual	Variance	
Substantive WTE	821	767	(54)	7%
Temporary Staffing		50	50	93%
Total	**821**	**817**	**(4)**	**0%**

Summary

The Community Heath directorate is currently under established by 54 WTE an increase of 11 WTE from April Understablishment now equates to 7% of budgeted establishment and is in line with staff turnover expectations. These posts are being backfilled by a combination of bank, agency & excess hours. Temporary staffing equates to 93% of Understablishment rom 137%.There are currently 24.52 WTE posts in the process of recruitment.

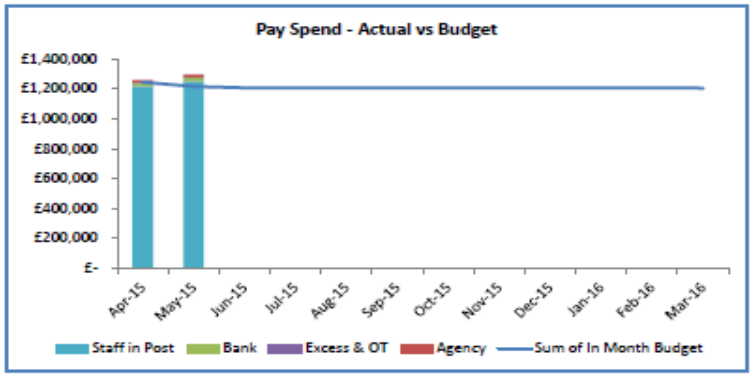


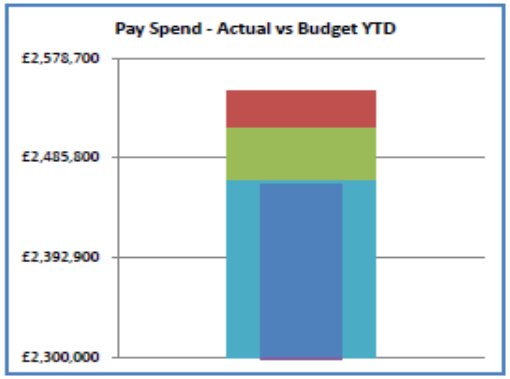
Active Recruitment by Stage in Process	Community & Mental Health
Awaiting Interview	1.00
Being Shortlisted	-
Out to Advert	11.00
Paperwork in HR/ Awaiting Instruction	8.10
Appointed Awaiting Clearances	4.42
Total	**24.52**

Corporate	Year to date		
	Plan	Actual	Variance
	£000s	£000s	£000s
Pay	(2,461)	(2,556)	(95)
			-3.85%

Summary

The paybill in corporate areas as a whole continues to exceed budget. This has been due to a combination of increased spend on establishment and temporary staffing, and under achievement of CIP. CIP under-achievement equates to £129k year to date.

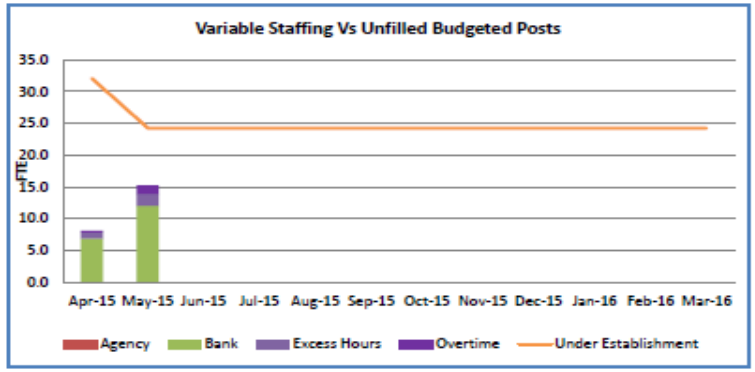




Corporate	In Month			
	Plan	Actual	Variance	
Substantive WTE	451	423	(28)	6%
Temporary Staffing		15	15	54%
Total	**451**	**438**	(13)	3%

Summary

Corporate areas remain under established against budgeted WTE. Vacant posts have reduced to 28 WTE from 49 in April. 54% of underestablishment has been covered through the use of variable staffing. Of the 28 WTE under establishment within corporate area's, 3.8 wte are currently in the recruitment process from 3.8 in April, 5 in March & 4.8 in February. An evaluation of the balance should be undertaken to establish why these are not currently being recruited to and the future need for these roles.



Active Recruitment by Stage in Process	Corporate
Awaiting Interview	-
Being Shortlisted	-
Out to Advert	1.00
Paperwork in HR/ Awaiting Instruction	1.00
Appointed Awaiting Clearances	1.80
Total	3.80

Decrease in Sickness absence in month from 4.03% to 3.93% - above the 3% target. Minimal reduction on Anxiety Stress - still remains highest reason across the Trust

Trust

The Trust's sickness target is 3%

Currently Sickness Absence rate is 3.93% for May 2015
YTD Sickness Absence is 3.98%.
10 Highest areas within Trust

Organisation	Total FTE Days Available	Sickness FTE Days Lost	Sickness %
Child & Adolescent MH Medics J61830	55.80	24.80	44.44%
Transfer of Care J61300	59.52	19.84	33.33%
Chlamydia Screening J61432	51.67	17.00	32.90%
Allergy - Funded By Income J61350	34.10	7.20	21.11%
Community Paediatrics J61371	215.76	34.00	15.76%
Paediatric Diabetic Nurse J61373	49.60	7.40	14.92%
Acute & Recovery CMHS J61933	799.80	108.60	13.58%
Infection Control J61077	73.99	10.00	13.52%
Pathology General J61071	86.80	11.40	13.13%
Mottistone Suite J61090	580.32	72.00	12.41%

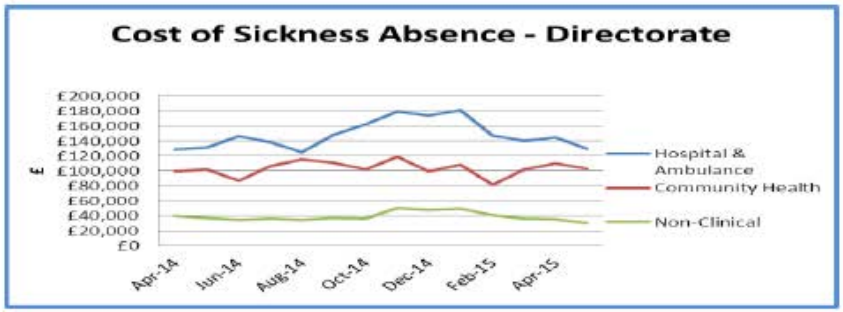
Hospital & Ambulance

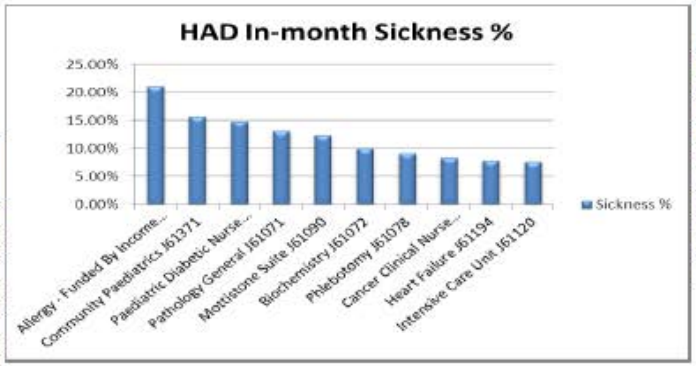
Sickness Absence: 3.82% - Down from 3.97%
YTD Sickness Absence is 3.90%

10 Highest areas within Directorate

Area	Total FTE	Sickness FTE Days Lost	Sickness %
Allergy - Funded By Income J61350	34.10	7.20	21.11%
Community Paediatrics J61371	215.76	34.00	15.76%
Paediatric Diabetic Nurse J61373	49.60	7.40	14.92%
Pathology General J61071	86.80	11.40	13.13%
Mottistone Suite J61090	580.32	72.00	12.41%
Biochemistry J61072	624.13	63.40	10.16%
Phlebotomy J61078	337.28	31.28	9.27%
Cancer Clinical Nurse Specialist J61032	370.76	31.00	8.36%
Heart Failure J61194	93.00	7.40	7.96%
Intensive Care Unit J61120	1262.32	97.20	7.70%

	Sum of FTE Days Lost		
Absence Reason	Apr-15	May-15	Variance
S10 Anxiety/stress/depression/other psychiatric illnesses	732.85	841.24	14.79%
S11 Back Problems	337.59	284.48	-15.73%
S12 Other musculoskeletal problems	302.80	279.37	-7.74%
S13 Cold, Cough, Flu - Influenza	313.49	251.47	-19.79%
S19 Heart, cardiac & circulatory problems	171.20	170.40	-0.47%





10 Highest Sickness Reasons - HAD	FTE Days Lost	Sickness %
S10 Anxiety/stress/depression/other psychiatric illnesses	404.79	1.65%
S25 Gastrointestinal problems	180.79	0.74%
S11 Back Problems	161.20	0.66%
S28 Injury, fracture	111.41	0.45%
S12 Other musculoskeletal problems	109.45	0.45%
S13 Cold, Cough, Flu - Influenza	105.26	0.43%
S19 Heart, cardiac & circulatory problems	103.60	0.42%
S17 Benign and malignant tumours, cancers	73.40	0.30%
S21 Ear, nose, throat (ENT)	73.35	0.30%
S26 Genitourinary & gynaecological disorders	62.60	0.26%

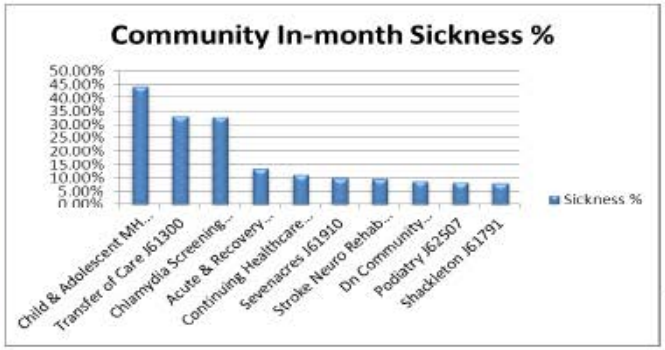
Decrease in Sickness absence in month from 4.03% to 3.93% - above the 3% target. Minimal reduction on Anxiety Stress - still remains highest reason across the Trust

Community Health

Sickness Absence: 4.63% down from 4.78%
YTD Sickness Absence is **4.70%**

10 Highest areas within Directorate

Area	Total FTE	Sickness FTE Days Lost	Sickness %
Child & Adolescent MH Medics J61830	55.80	24.80	44.44%
Transfer of Care J61300	59.52	19.84	33.33%
Chlamydia Screening J61432	51.67	17.00	32.90%
Acute & Recovery CMHS J61933	799.80	108.60	13.58%
Continuing Healthcare J61241	62.00	7.00	11.29%
Sevenacres J61910	299.67	30.40	10.14%
Stroke Neuro Rehab J61221	1036.64	104.25	10.06%
Dn Community Matrons J62543	199.23	18.00	9.03%
Podiatry J62507	523.69	44.41	8.48%
Shackleton J61791	850.64	70.89	8.33%



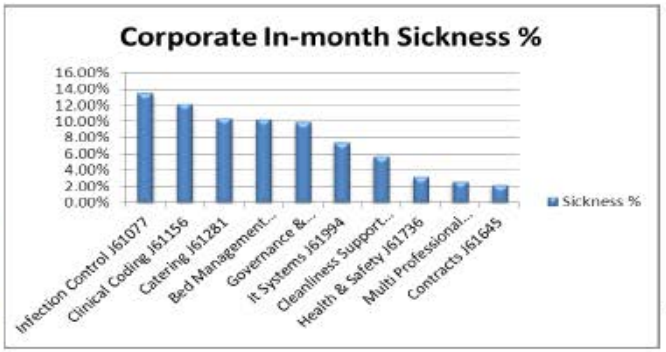
10 Highest Sickness Reasons - Community	FTE Days Lost	Sickness %
S10 Anxiety/stress/depression/other psychiatric illnesses	336.65	1.31%
S25 Gastrointestinal problems	120.11	0.47%
S11 Back Problems	106.35	0.42%
S12 Other musculoskeletal problems	106.19	0.41%
S13 Cold, Cough, Flu - Influenza	105.27	0.41%
S16 Headache / migraine	59.60	0.23%
S28 Injury, fracture	55.40	0.22%
S30 Pregnancy related disorders	52.49	0.21%
S19 Heart, cardiac & circulatory problems	48.00	0.19%
S26 Genitourinary & gynaecological disorders	45.61	0.18%

Corporate

Sickness Absence: 1.85% Up From 1.60%
YTD Sickness Absence is 1.73%

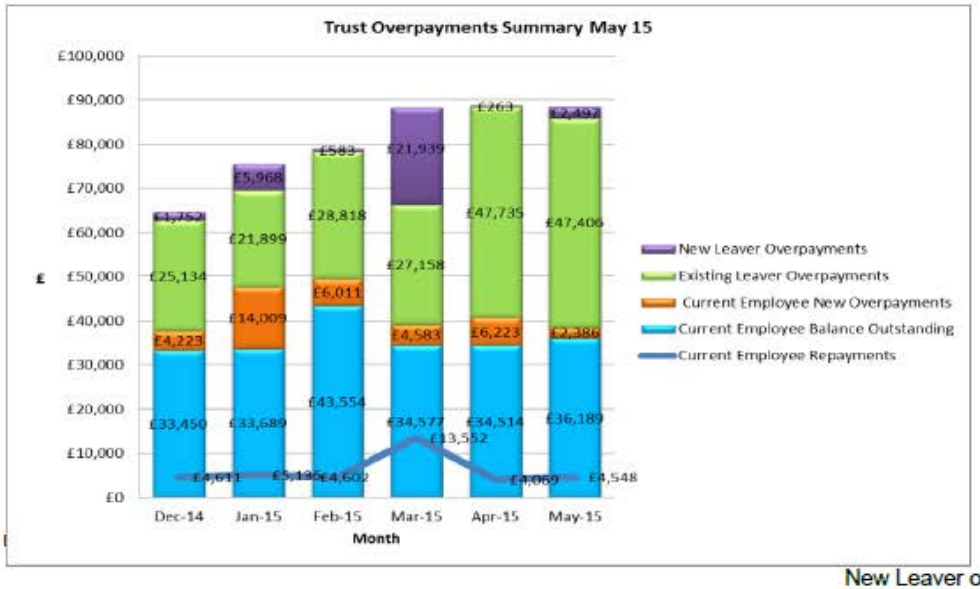
10 Highest areas within Directorate

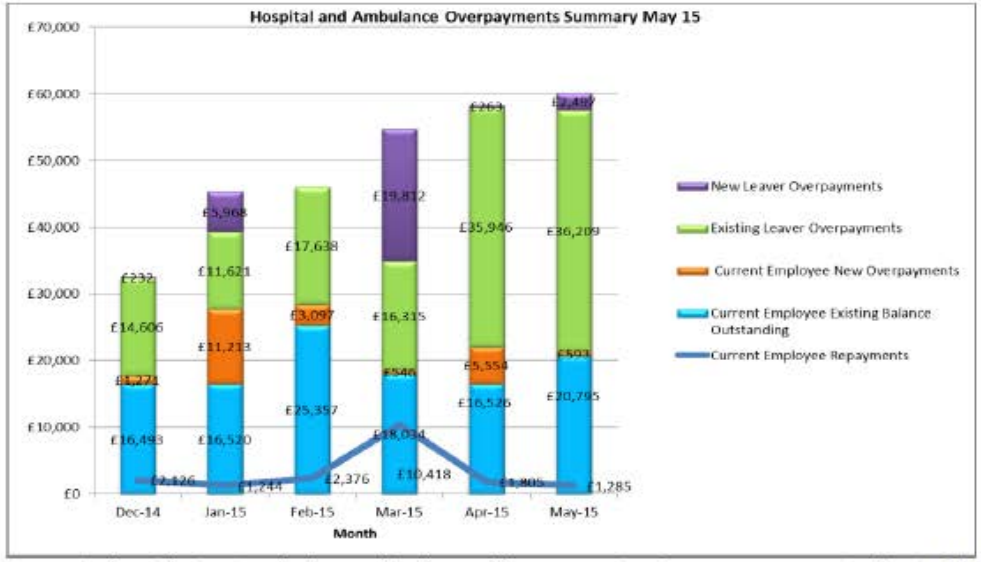
Area	Total FTE	Sickness FTE Days Lost	Sickness %
Infection Control J61077	73.99	10.00	13.52%
Clinical Coding J61156	308.35	37.40	12.13%
Catering J61281	782.03	81.16	10.38%
Bed Management J61010	155.00	16.00	10.32%
Governance & Assurance J61685	268.25	26.51	9.88%
It Systems J61994	434.00	32.00	7.37%
Cleanliness Support Team J61282	2288.42	130.60	5.71%
Health & Safety J61736	41.33	1.33	3.23%
Multi Professional Library J62010	96.31	2.52	2.62%
Contracts J61645	93.00	2.00	2.15%



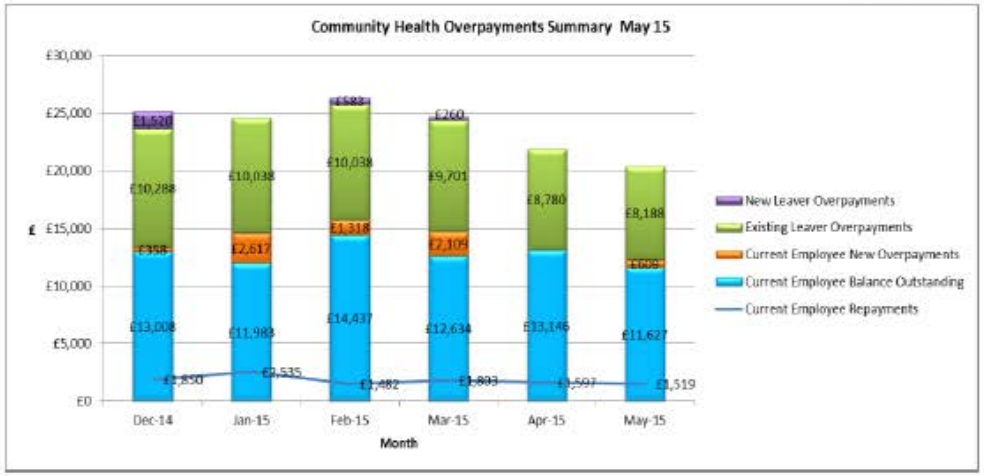
10 Highest Sickness Reasons - Corporate	FTE Days Lost	Sickness %
S10 Anxiety/stress/depression/other psychiatric illnesses	87.80	0.68%
S12 Other musculoskeletal problems	63.73	0.50%
S99 Unknown causes / Not specified	40.23	0.31%
S13 Cold, Cough, Flu - Influenza	29.67	0.23%
S16 Headache / migraine	25.44	0.20%
S25 Gastrointestinal problems	24.23	0.19%
S28 Injury, fracture	24.15	0.19%
S14 Asthma	19.00	0.15%
S19 Heart, cardiac & circulatory problems	18.80	0.15%
S21 Ear, nose, throat (ENT)	14.00	0.11%

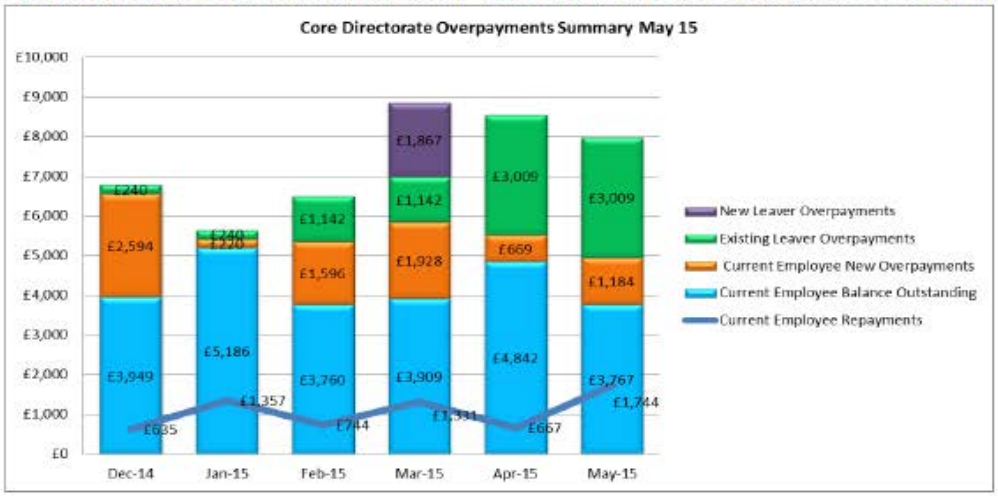
Summary:





New Leaver overpayments due to late e-termination notifications. New current employee overpayments due to SBS error.





Reduction in total amount owed by over £1500, new overpayments in month due to sickness absence recording. Overall reduction in total amount owed of over £500.

Achievement of planned versus actual staffing hours

• The Trust did not achieve an average of above 90% fill rate on all measures for May 2015. The Trust achieved 87.7% of planned Registered Nurses in the day. This percentage slips below our own RAG ratings which indicates red below 90%.and requires monitoring and managing of risk.
• External monitoring from TDA usually raises concerns at <80% for consistent months
• There is also delay in the arrival of the Filipino staff expected on 27th June. This is due to delays in paperwork processes outside of our control. The anticipated date is August but there is no confirmed date. This means the current vacancies to be filled by the Filipino staff will be on hold until August, which will require bank fill.
• The new staff will initially fill posts at band 2, and complete processes for registration within 8 weeks. We therefore anticipate our additional 32 Registered nurses to be fully working by November 2015.
• Given the 70% fill rate of registered nurses for bank shifts we will be carefully monitoring the staffing gaps whilst we wait for the new staff.
• There are no additional plans to fill gaps with agency at present; we will continue to monitor bank fill rates and other staffing and quality indicators going forward
• Registered Nurses and night, and Heath Care Assistants in the day and night achieved over 95% overall: a green RAG rating under Trust ratings.
• Individual ward areas are facing pressures and this is highlighted at Table 3. Red areas are mainly for registered nurse day cover as discussed and we continue to move staff around as required.
• Agency staff are not currently being utilised unless for contingency areas.
• Sickness continues to be higher than the target of 3% in a number of areas.

Risks
• The delay in the start date of the Filipino nurses means it could be up to 2 months before our additional permanent staff arrive and 4 months to when we can see a substantial increase in numbers. The organisation is planning to open Appley Ward however this will need careful review given the staffing position. This is currently been undertaken.
• In addition the safer staffing establishments come on line in July. Reporting in August will therefore evidence a significant gap on Unify data which will be seem externally on the NHS choices website, as it is unlikely this will be filled by Bank staff given the current fill rate

Day				Night				Day		Night	
Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
29837.65	26179.53	19006.55	18525.21	14560	14077.9	9445.25	9797	87.7%	97.5%	96.7%	103.7%

Bank Fill rate for May 2015

Grade:	Total shifts:	Filled:	Unfilled:	% Fill rate:
RN	673	471	202	70.28%
HCA	1098	961	137	87.5%
Agency (RN)	229	213	16	93.01%

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Monthly actual figures by ward as uploaded on the Unify return

Isle of Wight NHS Trust

Ward name	Day				Night				Day		Night	
	Registered		Care Staff		Registered		Care Staff		Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
SHACKLETON	622.5	552.01	1385.8	1234	294.5	299	589	535.5	88.7%	89.0%	101.5%	90.9%
ALVERSTONE WARD	994.8	901	649	627	620	512.5	220	210	90.6%	96.6%	82.7%	95.5%
SEAGROVE	1235.3	1021.6	929.75	998.06	620	516	620	633.5	82.7%	107.3%	83.2%	102.2%
OSBORNE	1245	1327.5	929	1083	620	717.5	589	761.5	106.6%	116.6%	115.7%	129.3%
MOTTISTONE	1084	966.17	384.5	363	620	611			89.1%	94.4%	98.5%	
ST HELENS	998	925	891.5	838.5	620	610	310	310	92.7%	94.1%	98.4%	100.0%
STROKE	1617.5	1455	1364	1361.3	620	610	620	630	90.0%	99.8%	98.4%	101.6%
REHAB	1763	1760.8	1616.5	1299.5	620	860	620	630	99.9%	80.4%	138.7%	101.6%
WHIPPINGHAM	1820	1801.3	1489.5	1378.5	620	620	620	600	99.0%	92.5%	100.0%	96.8%
COLWELL	1543	1443.5	1716.5	1626.3	620	620	620	610	93.6%	94.7%	100.0%	98.4%
INTENSIVE CARE UNIT	3405	2683.6	232.5	263.5	2018.5	1804.8	157.25	149	78.8%	113.3%	89.4%	94.8%
CORONARY CARE UNIT	2442.5	1810.5	685.5	666	1550	1321.8	310	440	74.1%	97.2%	85.3%	141.9%
NEONATAL INTENSIVE CARE UNIT	1196.5	987	418.5	388.5	620	610	310	290	82.5%	92.8%	98.4%	93.5%
MEDICAL ASSESSMENT UNIT	2476	1853	1423.5	1157.5	930	920	860	730	74.8%	81.3%	98.9%	84.9%
AFTON	1085.3	1134.5	930	993	310	330	620	727.5	104.5%	106.8%	106.5%	117.3%
PAEDIATRIC WARD	1696.5	1403	465	412.5	930	700	310	310	82.7%	88.7%	75.3%	100.0%
MATERNITY	2092.5	1954.3	1240	1284.8	1147	1209.8	620	620	93.4%	103.6%	105.5%	100.0%
WOODLANDS	622.75	706.25	474	374	310	310	310	310	113.4%	78.9%	100.0%	100.0%
LUCCOMBE WARD	1409.5	1095.5	1057.5	1398	620	645.5	620	790	77.7%	132.2%	104.1%	127.4%
POPPY	488	398	724	778.25	250	250	520	510	81.6%	107.5%	100.0%	98.1%

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

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

Isle of Wight NHS Trust

Ward	Day		Night		Key Nursing indictors				
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	mandatory training %	falls with harm	PU	Complaints	COMMENTS
Shackleton	88.7%	89.0%	101.5%	90.9%	93%	0	0	0	
Ortho Unit/ Alverstone	90.6%	96.6%	82.7%	95.5%	71%	2	1	2	
Seagrove	82.7%	107.3%	83.2%	102.2%	88%	0	0	0	
Osborne	106.6%	116.6%	115.7%	129.3%	88%	0	0	0	
Mottistone	89.1%	94.4%	98.5%		85%	1	0	0	
St Helens	92.7%	94.1%	98.4%	100.0%	85%	2	2	0	
Stroke	90.0%	99.8%	98.4%	101.6%	90%	1	0	0	
Rehab	99.9%	80.4%	138.7%	101.6%	92%	1	0	1	
Whippingham	99.0%	92.5%	100.0%	96.8%	70%	1	3	0	
Colwell	93.6%	94.7%	100.0%	98.4%	80%	2	3	1	
Intensive Care Unit	78.8%	113.3%	89.4%	94.8%	91%	0	2	0	Vacancies difficult to fill from bank - agency requested for 1 month via workforce control process
Coronary Care Unit	74.1%	97.2%	85.3%	141.9%	84%	0	0	0	Vacancies, dificult to fill form bank
Neonatal Intensive Care Unit	82.5%	92.8%	98.4%	93.5%	88%	0	0	0	low occupancy
Medical Assessment Unit	74.8%	81.3%	98.9%	84.9%	89%	1	2	1	High vacancies, recruitment in progress
Afton	104.5%	106.8%	106.5%	117.3%	91%	0	0	0	
Paediatric Ward	82.7%	88.7%	75.3%	100.0%	79%	0	0	0	2 maternity leave, 1 long term sickness. Unable to cover ED as required as less than 2 RN's at night, looking at other options to support
Maternity	93.4%	103.6%	105.5%	100.0%	83%	0	0	0	
Woodlands	113.4%	78.9%	100.0%	100.0%	83%	0	0	0	
Luccombe	77.7%	132.2%	104.1%	127.4%					
Poppy	81.6%	107.5%	100.0%	98.1%		0	0	0	

95-100% hours achieved	>75%	0	0	0
90- 94.9% hours achieved	70 - 75%	2	2	1
<90% of planned hours achieved	<70%	>2	>2	2
over achieved planned hours				

Previous data indicating where wards dropped below <80% for total day or night hours for that month.

The current risk rating for each area is identified which indicates the percentage gap against safer staffing requirements that areas are also currently managing whilst recruitment is underway.

Less than 80% fill rate identified for any shift or staff group over a consistent period

• Intensive Care Unit has been registering less than 80% non registered staff consistently. This has been attributed to an additional shift on MAPS which has not been rectified. This month there has also been less than 80% for registered nurses in the day (78.8%).

• Luccombe, CCU and MAAU are all below 80% for third month running. CCU and MAAU have vacancies, however these are in the process f being filled, and bank fill has been inconsistent. CCU have recruited to their posts, MAAU have recruited 1 post only with further advertisements in place.

	<80% fill rate identified for any shift or staff group							
WARD	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	additional % gap on Safer staffing Risk Rating
Shackleton								
Ortho Unit/ Alverstone								22.90%
Seagrove								16.60%
Osborne								17.70%
Mottistone								2.60%
St Helens								18.10%
Stroke								18%
Rehab								33.20%
Whippingham								23.10%
Colwell								40%
Intensive Care Unit								8.90%
Coronary Care Unit								
Neonatal Intensive Care Unit								11.80%
Medical Assessment Unit								14.20%
Afton								22.40%
Paediatric Ward								20.70%
Maternity								
Winter Ward								
Woodlands								
Luccombe								20.90%

• ITU, MAAU, CCU and paediatric areas all have vacancies which are currently held for Filipino staff but we are unable to consistently fill with bank, or do not have adequate specialist staff available on the bank.

Mitigating actions
• ITU have had to request agency via the scrutiny process to support for 1 month
• Daily reporting tool in place and the Matron for staffing has oversight daily of ward requirements and is able to work with other Matrons to move staff to enable best safe option
• June Acuity and Dependency has starting on 1st June with annual review taking place during July and August. The review will challenge the use of the roster policy and seek assurance of good rota management in line with requirements.
• The Deputy Director of Nursing and the Nurse Bank Manager are still in process of developing strategies to improve bank nurse availability and numbers.

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Safer Staffing - Full staffing fill rate by shift

Isle of Wight NHS Trust

Vlook: Early

Sum of RN%	Column Labels																															
Row Labels	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May	13-May	14-May	15-May	16-May	17-May	18-May	19-May	20-May	21-May	22-May	23-May	24-May	25-May	26-May	27-May	28-May	29-May	30-May	31-May	Grand Total
Afton Ward J61794	100%	100%	150%	150%	100%	100%	100%	150%	100%	150%	100%	100%	150%	150%	100%	50%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	110%
Alverstone Ward J61111	200%	150%	200%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	50%	50%	100%	100%	50%	100%	100%	50%	100%	100%	100%
Colwell Ward J61254	167%	100%	100%	133%	167%	133%	167%	100%	100%	100%	100%	167%	167%	133%	133%	100%	100%	133%	133%	133%	133%	100%	100%	133%	100%	100%	133%	133%	133%	133%	100%	125%
Coronary Care J61190	100%	100%	100%	100%	60%	80%	100%	80%	100%	100%	100%	80%	100%	80%	100%	60%	80%	80%	80%	100%	80%	100%	80%	100%	100%	80%	80%	80%	100%	100%	80%	89%
General Rehab & Step Down Unit J6122	125%	150%	150%	150%	125%	150%	125%	125%	100%	125%	100%	100%	100%	125%	100%	125%	125%	125%	125%	100%	150%	100%	50%	75%	100%	100%	100%	100%	75%	100%	100%	113%
Intensive Care Unit J61120	86%	86%	86%	86%	86%	86%	100%	86%	86%	100%	100%	86%	86%	100%	86%	71%	86%	100%	86%	100%	86%	100%	86%	86%	100%	86%	86%	86%	86%	86%	86%	89%
Luccombe Ward	100%	133%	100%	133%	133%	133%	67%	100%	100%	100%	100%	100%	67%	67%	100%	67%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	67%	100%	98%
MAAU J61231	80%	100%	100%	100%	120%	80%	80%	80%	80%	100%	100%	100%	100%	100%	100%	60%	80%	80%	100%	80%	80%	80%	80%	80%	100%	80%	100%	80%	80%	60%	80%	87%
Mat Clinic	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Maternity Services J61500	125%	125%	100%	100%	100%	100%	125%	125%	125%	125%	125%	125%	125%	150%	150%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	150%	100%	125%	100%	125%	123%
Mottistone Suite J61090	100%	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	102%
Neonatal Intensive Care Unit J61520	100%	67%	100%	100%	100%	100%	100%	133%	100%	67%	67%	67%	67%	67%	67%	67%	67%	133%	100%	100%	100%	67%	67%	100%	67%	67%	100%	100%	100%	100%	150%	89%
Osborne Ward J61915	100%	100%	100%	150%	150%	150%	100%	150%	100%	100%	150%	50%	150%	100%	150%	100%	100%	100%	200%	100%	200%	150%	150%	100%	200%	100%	100%	150%	150%	100%	100%	126%
Paediatric Ward J61372	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	75%	100%	100%	100%	96%
Poppy Unit J61235	50%	100%	100%	50%	50%	50%	50%	100%	100%	100%	100%	50%	50%	100%	50%	100%	100%	50%	50%	50%	100%	50%	100%	100%	50%	50%	50%	50%	50%	0%	100%	65%
Seagrove Ward J61916	100%	100%	150%	100%	100%	150%	100%	100%	100%	100%	50%	100%	100%	100%	100%	150%	100%	100%	50%	50%	100%	50%	100%	100%	100%	150%	100%	100%	100%	150%	102%	
Shackleton J61791	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	200%	100%	200%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	106%
St Helens Ward J61102	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Stroke & Neuro Rehab Unit J61221	100%	125%	100%	100%	75%	75%	100%	100%	100%	100%	100%	75%	75%	75%	25%	75%	50%	75%	125%	75%	75%	100%	100%	75%	100%	75%	100%	75%	75%	100%	100%	87%
Whippingham Ward J61101	125%	125%	125%	125%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	125%	100%	100%	100%	100%	125%	100%	100%	125%	125%	100%	100%	100%	75%	75%	104%
Winter Bed Plan Ward J61107	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%
Woodlands J61913	200%	100%	100%	100%	200%	100%	100%	100%	100%	100%	100%	100%	100%	200%	100%	200%	100%	100%	100%	100%	100%	200%	100%	100%	100%	100%	100%	200%	100%	100%	100%	119%
Appley Ward J61250	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%
Grand Total	**102%**	**102%**	**108%**	**108%**	**103%**	**102%**	**102%**	**105%**	**98%**	**103%**	**98%**	**95%**	**98%**	**102%**	**95%**	**90%**	**95%**	**102%**	**105%**	**98%**	**103%**	**98%**	**90%**	**98%**	**100%**	**95%**	**98%**	**95%**	**94%**	**93%**	**90%**	**99%**

Vlook: Late

Sum of RN%	Column Labels																															
Row Labels	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May	13-May	14-May	15-May	16-May	17-May	18-May	19-May	20-May	21-May	22-May	23-May	24-May	25-May	26-May	27-May	28-May	29-May	30-May	31-May	Grand Total
Afton Ward J61794	150%	150%	100%	100%	150%	150%	100%	100%	150%	100%	150%	100%	100%	100%	150%	150%	50%	150%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	115%
Alverstone Ward J61111	150%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Colwell Ward J61254	100%	133%	100%	67%	100%	100%	100%	67%	100%	100%	67%	67%	133%	100%	100%	100%	100%	100%	100%	133%	67%	100%	133%	100%	100%	100%	100%	100%	100%	100%	100%	99%
Coronary Care J61190	80%	100%	80%	80%	100%	80%	100%	100%	100%	80%	100%	80%	80%	80%	80%	80%	100%	80%	80%	100%	80%	100%	100%	100%	80%	80%	60%	80%	80%	80%	80%	86%
General Rehab & Step Down Unit J6122	133%	100%	167%	167%	100%	200%	167%	133%	133%	133%	133%	67%	133%	133%	100%	133%	133%	133%	133%	100%	133%	100%	100%	67%	100%	100%	100%	100%	100%	67%	100%	119%
Intensive Care Unit J61120	86%	86%	86%	86%	100%	100%	86%	86%	71%	71%	86%	100%	86%	100%	86%	100%	86%	86%	100%	86%	71%	86%	86%	86%	71%	86%	86%	86%	71%	86%	86%	86%
Luccombe Ward	100%	100%	67%	133%	133%	133%	67%	67%	100%	67%	67%	67%	67%	33%	100%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	76%
MAAU J61231	100%	100%	120%	100%	100%	100%	100%	80%	100%	100%	80%	100%	100%	100%	100%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	60%	88%
Mat Clinic	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Maternity Services J61500	125%	125%	100%	100%	100%	100%	100%	125%	125%	125%	125%	125%	125%	150%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	122%
Mottistone Suite J61090	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	97%
Neonatal Intensive Care Unit J61520	100%	100%	100%	100%	50%	100%	150%	100%	100%	150%	100%	100%	100%	150%	100%	100%	100%	100%	100%	100%	150%	50%	50%	100%	100%	150%	100%	50%	100%	50%	100%	100%
Osborne Ward J61915	100%	100%	100%	100%	100%	100%	150%	100%	50%	150%	100%	100%	100%	150%	100%	100%	150%	150%	150%	100%	150%	150%	100%	150%	150%	100%	100%	100%	100%	100%	100%	115%
Paediatric Ward J61372	100%	100%	67%	100%	100%	100%	100%	75%	67%	100%	100%	100%	75%	75%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	75%	75%	75%	75%	75%	100%	33%	89%
Poppy Unit J61235	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	0%	0%	100%	83%	
Seagrove Ward J61916	100%	100%	100%	150%	150%	150%	100%	100%	100%	100%	150%	50%	100%	100%	100%	100%	50%	50%	100%	50%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Shackleton J61791	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
St Helens Ward J61102	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	95%
Stroke & Neuro Rehab Unit J61221	75%	75%	75%	125%	100%	75%	100%	100%	100%	75%	75%	75%	75%	75%	25%	75%	50%	75%	75%	75%	75%	75%	100%	75%	50%	50%	75%	75%	75%	75%	75%	77%
Whippingham Ward J61101	100%	125%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	125%	100%	100%	100%	100%	125%	100%	125%	100%	100%	125%	100%	100%	100%	75%	102%
Winter Bed Plan Ward J61107	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%
Woodlands J61913	100%	100%	100%	200%	100%	200%	200%	100%	100%	100%	200%	200%	100%	100%	200%	100%	100%	200%	100%	100%	200%	200%	100%	100%	100%	100%	200%	100%	100%	100%	100%	132%
Appley Ward J61250	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%
Grand Total	**95%**	**97%**	**97%**	**105%**	**102%**	**108%**	**103%**	**97%**	**100%**	**95%**	**98%**	**92%**	**97%**	**98%**	**98%**	**98%**	**95%**	**98%**	**100%**	**95%**	**95%**	**97%**	**95%**	**97%**	**90%**	**90%**	**92%**	**88%**	**88%**	**86%**	**80%**	**96%**

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Safer Staffing - Full staffing fill rate by shift

Isle of Wight NHS Trust

Vlook: Night

Sum of RN% — Column Labels

Row Labels	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May	13-May	14-May	15-May	16-May	17-May	18-May	19-May	20-May	21-May	22-May	23-May	24-May	25-May	26-May	27-May	28-May	29-May	30-May	31-May	Grand Total
Afton Ward J61794	100%	100%	100%	100%	100%	100%	100%	200%	100%	100%	100%	100%	100%	100%	100%	200%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	106%
Alverstone Ward J61111	100%	100%	50%	100%	100%	50%	100%	100%	100%	100%	100%	50%	100%	100%	0%	50%	100%	100%	100%	50%	100%	50%	100%	100%	100%	100%	50%	50%	100%	100%	100%	84%
Colwell Ward J61254	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Coronary Care J61190	100%	100%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	100%	80%	80%	80%	80%	100%	60%	60%	80%	80%	100%	80%	80%	100%	100%	100%	100%	100%	80%	85%
General Rehab & Step Down Unit J6122	200%	100%	150%	150%	200%	200%	150%	150%	100%	150%	150%	150%	150%	100%	150%	100%	150%	150%	150%	100%	150%	150%	100%	100%	100%	150%	200%	150%	100%	100%	100%	139%
Intensive Care Unit J61120	86%	86%	86%	86%	86%	86%	86%	86%	71%	86%	100%	86%	86%	86%	86%	86%	86%	71%	86%	86%	86%	86%	86%	100%	100%	100%	100%	86%	86%	71%	86%	87%
Luccombe Ward	150%	150%	150%	150%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	50%	100%	105%
MAAU J61231	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
Maternity Services J61500	125%	100%	100%	100%	100%	100%	100%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	100%	125%	125%	125%	125%	125%	119%
Mottistone Suite J61090	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Neonatal Intensive Care Unit J61520	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	98%
Osborne Ward J61915	100%	150%	150%	150%	50%	150%	100%	150%	150%	100%	50%	50%	150%	100%	100%	100%	100%	100%	150%	200%	100%	100%	100%	150%	150%	200%	100%	100%	100%	150%	100%	119%
Paediatric Ward J61372	67%	100%	67%	67%	67%	100%	100%	100%	67%	67%	67%	67%	67%	67%	67%	33%	67%	67%	67%	67%	100%	67%	67%	67%	100%	100%	100%	67%	67%	67%	100%	75%
Poppy Unit J61235	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	0%	0%	0%	100%	83%
Seagrove Ward J61916	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	150%	100%	100%	50%	50%	50%	50%	50%	50%	50%	50%	50%	100%	100%	100%	50%	100%	100%	50%	50%	100%	85%
Shackleton J61791	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
St Helens Ward J61102	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Stroke & Neuro Rehab Unit J61221	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Whippingham Ward J61101	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Winter Bed Plan Ward J61107	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%
Woodlands J61913	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Appley Ward J61250	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%
Grand Total	**100%**	**98%**	**98%**	**98%**	**96%**	**100%**	**100%**	**104%**	**96%**	**98%**	**98%**	**94%**	**102%**	**94%**	**92%**	**90%**	**96%**	**96%**	**96%**	**94%**	**100%**	**96%**	**96%**	**100%**	**102%**	**100%**	**102%**	**96%**	**92%**	**92%**	**92%**	**97%**

Vlook: Early

Sum of HCA% — Column Labels

Row Labels	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May	13-May	14-May	15-May	16-May	17-May	18-May	19-May	20-May	21-May	22-May	23-May	24-May	25-May	26-May	27-May	28-May	29-May	30-May	31-May	Grand Total
Afton Ward J61794	100%	100%	100%	100%	100%	150%	100%	100%	150%	100%	100%	100%	100%	100%	150%	150%	100%	100%	100%	100%	150%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	110%
Alverstone Ward J61111	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	103%
Colwell Ward J61254	120%	120%	100%	100%	80%	80%	80%	100%	100%	100%	100%	80%	80%	100%	80%	100%	80%	80%	100%	100%	100%	100%	100%	80%	100%	120%	80%	100%	100%	80%	80%	94%
Coronary Care J61190	100%	100%	100%	100%	100%	150%	100%	150%	50%	100%	50%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	150%	100%	150%	103%
General Rehab & Step Down Unit J6122	75%	100%	100%	100%	100%	75%	100%	75%	75%	75%	75%	75%	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	125%	75%	100%	100%	100%	100%	100%	100%	75%	93%
Intensive Care Unit J61120	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	141%
Luccombe Ward	67%	100%	100%	100%	100%	100%	167%	133%	133%	100%	133%	133%	133%	167%	100%	133%	133%	133%	133%	167%	133%	133%	167%	133%	100%	133%	133%	133%	100%	133%	133%	126%
MAAU J61231	100%	100%	100%	100%	100%	100%	100%	75%	133%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	99%
Mat Clinic	50%	0%	0%	0%	50%	0%	100%	100%	0%	0%	50%	50%	0%	100%	50%	0%	0%	50%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	19%
Maternity Services J61500	50%	100%	100%	100%	150%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	105%
Mottistone Suite J61090	100%	100%	100%	100%	100%	100%	100%	0%	100%	200%	200%	100%	100%	100%	100%	200%	100%	100%	100%	0%	100%	100%	0%	100%	100%	0%	100%	0%	100%	100%	100%	94%
Neonatal Intensive Care Unit J61520	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Osborne Ward J61915	200%	100%	150%	50%	150%	100%	100%	100%	150%	150%	100%	100%	50%	150%	150%	150%	150%	150%	100%	100%	50%	150%	100%	150%	100%	150%	100%	100%	150%	100%	100%	118%
Paediatric Ward J61372	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Poppy Unit J61235	200%	100%	100%	200%	100%	150%	150%	150%	100%	100%	150%	100%	100%	100%	100%	50%	100%	150%	150%	150%	100%	200%	100%	100%	150%	100%	50%	0%	100%	0%	100%	113%
Seagrove Ward J61916	100%	100%	50%	100%	100%	50%	100%	150%	100%	100%	150%	100%	100%	150%	100%	150%	150%	100%	100%	100%	150%	100%	100%	100%	100%	50%	100%	100%	150%	100%	100%	106%
Shackleton J61791	67%	100%	100%	100%	67%	67%	100%	100%	100%	67%	100%	133%	100%	100%	100%	67%	100%	67%	100%	100%	100%	67%	100%	67%	100%	67%	100%	100%	100%	100%	100%	91%
St Helens Ward J61102	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	150%	50%	100%	100%	100%	100%	100%	98%
Stroke & Neuro Rehab Unit J61221	100%	75%	100%	75%	100%	100%	100%	125%	100%	100%	75%	125%	125%	100%	125%	125%	125%	100%	75%	125%	125%	100%	75%	125%	100%	100%	100%	100%	125%	75%	100%	103%
Whippingham Ward J61101	75%	100%	100%	100%	100%	100%	75%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	125%	100%	125%	100%	100%	75%	75%	125%	100%	100%	100%	75%	97%
Winter Bed Plan Ward J61107	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%
Woodlands J61913	0%	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	0%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	0%	100%	100%	100%	81%
Appley Ward J61250	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%
Grand Total	**88%**	**92%**	**98%**	**96%**	**96%**	**94%**	**102%**	**102%**	**100%**	**96%**	**102%**	**100%**	**96%**	**104%**	**100%**	**104%**	**102%**	**98%**	**98%**	**104%**	**102%**	**104%**	**104%**	**98%**	**98%**	**92%**	**96%**	**89%**	**104%**	**89%**	**88%**	**98%**

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Safer Staffing - Full staffing fill rate by shift

Isle of Wight NHS Trust

Vlook	Late

Sum of HCA %	Column Labels																															
Row Labels	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May	13-May	14-May	15-May	16-May	17-May	18-May	19-May	20-May	21-May	22-May	23-May	24-May	25-May	26-May	27-May	28-May	29-May	30-May	31-May	Grand Total
Afton Ward J61794	100%	100%	150%	150%	100%	100%	150%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	50%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	106%
Alverstone Ward J61111	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	200%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	200%	100%	100%	100%	100%	100%	100%	100%	100%	106%
Colwell Ward J61254	100%	150%	150%	133%	133%	100%	100%	100%	200%	150%	133%	133%	67%	100%	100%	150%	150%	100%	100%	67%	100%	100%	100%	150%	100%	100%	100%	100%	100%	150%	150%	114%
Coronary Care J61190	100%	100%	200%	200%	100%	100%	100%	100%	100%	200%	100%	100%	100%	100%	100%	100%	0%	100%	200%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	200%	100%	113%
General Rehab & Step Down Unit J6122	100%	100%	67%	100%	100%	67%	67%	100%	100%	100%	100%	133%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	133%	100%	100%	100%	100%	133%	100%	100%
Intensive Care Unit J61120	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	107%
Luccombe Ward	100%	100%	150%	100%	100%	100%	100%	150%	150%	150%	150%	200%	150%	250%	150%	200%	200%	150%	150%	200%	200%	200%	200%	200%	150%	200%	150%	150%	150%	150%	150%	158%
MAAU J61231	100%	100%	100%	133%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Mat Clinic	50%	0%	0%	0%	50%	50%	0%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	100%	50%	100%	100%	0%	0%	0%	100%	50%	100%	50%	0%	0%	31%
Maternity Services J61500	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	67%	67%	96%
Mottistone Suite J61090	100%	100%	100%	100%	100%	0%	0%	100%	100%	100%	0%	100%	100%	100%	0%	100%	100%	100%	200%	0%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	105%
Neonatal Intensive Care Unit J61520	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Osborne Ward J61915	150%	150%	150%	150%	150%	150%	150%	50%	100%	150%	100%	100%	100%	150%	150%	100%	100%	50%	100%	100%	100%	100%	150%	100%	100%	150%	100%	50%	100%	100%	100%	115%
Paediatric Ward J61372	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Poppy Unit J61235	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	150%	0%	0%	0%	0%	0%	100%	83%
Seagrove Ward J61916	150%	100%	100%	50%	50%	100%	100%	100%	100%	100%	100%	200%	100%	150%	100%	100%	200%	150%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	110%
Shackleton J61791	67%	100%	100%	100%	100%	100%	67%	67%	100%	100%	100%	67%	67%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	67%	91%
St Helens Ward J61102	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	98%
Stroke & Neuro Rehab Unit J61221	150%	150%	150%	100%	100%	100%	150%	150%	100%	150%	150%	150%	150%	150%	100%	100%	150%	150%	150%	150%	150%	150%	100%	150%	100%	200%	150%	100%	100%	150%	150%	135%
Whippingham Ward J61101	67%	100%	100%	100%	100%	67%	100%	100%	100%	100%	133%	100%	100%	100%	100%	100%	100%	100%	100%	133%	100%	133%	100%	100%	100%	100%	133%	67%	100%	67%	100%	100%
Winter Bed Plan Ward J61107	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%
Woodlands J61913	0%	100%	100%	0%	100%	0%	0%	100%	100%	100%	0%	200%	100%	100%	100%	100%	100%	0%	100%	100%	0%	0%	100%	100%	100%	100%	0%	100%	100%	100%	100%	74%
Appley Ward J61250	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%
Grand Total	**88%**	**100%**	**111%**	**103%**	**100%**	**90%**	**92%**	**95%**	**106%**	**114%**	**97%**	**118%**	**97%**	**110%**	**95%**	**103%**	**111%**	**97%**	**111%**	**103%**	**108%**	**105%**	**106%**	**103%**	**100%**	**108%**	**92%**	**92%**	**95%**	**94%**	**92%**	**101%**

Vlook	Night

Sum of HCA %	Column Labels																															
Row Labels	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May	13-May	14-May	15-May	16-May	17-May	18-May	19-May	20-May	21-May	22-May	23-May	24-May	25-May	26-May	27-May	28-May	29-May	30-May	31-May	Grand Total
Afton Ward J61794	100%	150%	100%	100%	100%	200%	150%	100%	100%	100%	150%	150%	150%	150%	100%	100%	100%	150%	150%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	118%
Alverstone Ward J61111	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	95%
Colwell Ward J61254	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Coronary Care J61190	100%	100%	200%	200%	200%	100%	100%	200%	200%	200%	200%	100%	100%	100%	200%	200%	200%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	200%	200%	200%	200%	142%
General Rehab & Step Down Unit J6122	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	100%	102%
Intensive Care Unit J61120	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%	100%	100%	100%	100%	0%	0%	0%	100%	100%	88%
Luccombe Ward	50%	100%	100%	100%	100%	150%	100%	150%	150%	150%	150%	150%	150%	100%	150%	150%	150%	150%	150%	150%	150%	100%	150%	100%	150%	150%	150%	100%	100%	100%	100%	127%
MAAU J61231	100%	100%	100%	75%	100%	67%	100%	100%	100%	100%	100%	100%	50%	67%	100%	67%	67%	67%	100%	100%	67%	100%	25%	100%	100%	100%	100%	100%	100%	100%	67%	85%
Maternity Services J61500	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mottistone Suite J61090	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neonatal Intensive Care Unit J61520	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Osborne Ward J61915	100%	150%	150%	150%	100%	150%	150%	150%	150%	150%	100%	150%	150%	100%	150%	100%	150%	150%	100%	150%	100%	150%	100%	150%	150%	150%	100%	100%	100%	100%	100%	129%
Paediatric Ward J61372	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Poppy Unit J61235	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	50%	50%	0%	0%	0%	100%	85%
Seagrove Ward J61916	100%	100%	100%	100%	100%	100%	100%	100%	150%	150%	100%	100%	100%	100%	150%	100%	100%	150%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	105%
Shackleton J61791	100%	100%	50%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	50%	50%	50%	50%	100%	100%	50%	50%	100%	100%	100%	100%	100%	100%	100%	87%
St Helens Ward J61102	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Stroke & Neuro Rehab Unit J61221	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	102%
Whippingham Ward J61101	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%
Winter Bed Plan Ward J61107	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%
Woodlands J61913	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Appley Ward J61250	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%
Grand Total	**91%**	**110%**	**114%**	**100%**	**103%**	**110%**	**110%**	**110%**	**114%**	**111%**	**110%**	**107%**	**100%**	**100%**	**113%**	**104%**	**104%**	**107%**	**103%**	**100%**	**93%**	**97%**	**90%**	**100%**	**110%**	**104%**	**97%**	**93%**	**93%**	**100%**	**93%**	**103%**

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Summary - RAG Rating based on Out-turn position

Isle of Wight NHS Trust

Summary
The Trust is reporting a £1.095m deficit for May 2015, which is an adverse variance of £0.704m against plan.
Cumulatively, there is a deficit of £2.579m as at May 2015, an adverse variance of £1.443m against plan.

The main area of overspend is Hospital & Ambulance Directorate CIP unachievement and the impact of operational pressures.

Continuity of Service Rating — G

	Plan	Actual
Year to date	2	2

The planned Continuity of Service Rating (CoSR) for the first quarter of 2015/16 is '1'. To the end of May, the Trust is currently reporting an overall Continuity of Service Rating '2' and is as per plan.

Surplus — R

	Plan	Actual / Forecast	Variance
Year to date £k	(1,136)	(2,579)	(1,443)
Year end forecast £k	(4,600)	(4,600)	0

The Trust planned for a deficit of £0.391m in May, after adjustments made for normalising items (these include the net costs associated with donated assets). The reported position is a deficit of £1.095m in the month, an adverse variance of £0.704m against plan.

The cumulative Trust plan was a deficit of £1.136m, after normalising items. The actual position is a cumulative deficit of £2.579m, an adverse variance of £1.443m.

The Trusts planned forecast out-turn deficit remains at £4.6m but the current directorate performances increases the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.

Income — A

	Plan	Actual / Forecast	Variance
Year to date £k	28,012	27,526	(486)
Year end forecast £k	166,911	166,911	0

The Trust planned income in May was £14.167m. The actual reported income is £13.885m in month, an adverse variance of £0.282m.
The cumulative income plan is £28.012m. The actual position is a cumulative income of £27.526m, an adverse variance of £0.486m.

This position is due to contract services that have yet to commence, and estimated contract underperformance.

Operating Costs (including directorate income) — R

	Plan	Actual / Forecast	Variance
Year to date £k	(24,109)	(25,140)	(1,031)
Year end forecast £k	(142,020)	(142,020)	0

The Trust is reporting a current year overspend against expenditure budget of £1.031m. Including additional costs relating to the Public Dividend Capital Charge the adjusted overspend expenditure variance is £1.019m.

The current year net operating costs include £3.328m of directorate income. Excluding this income source the total costs amount to £28.468m. In addition to the operating costs, capital charges & finance costs amount to £1.637m.

CIP — R

	Plan	Actual / Forecast	Variance
Year to date £k	1,192	334	(858)
Year end forecast £k	8,500	3,415	(5,085)

The in month position for CIP is an achievement of £0.202m against a target of £0.599m, a shortfall of £0.397m.
Cumulatively there is an achievement of £0.334m with a target of £1.192m. This is an adverse variance of £0.858m.

The current year forecast is an achievement of £3.415m against a target of £8.500m, a shortfall of £5.085m. Plans are being developed through the turnaround programme of work to ensure that this gap is bridged.

There are currently plans for £5.132m with full project documentation completed, and £3.368m of CIP schemes still to be identified and developed by Directorates.

Cash — G

	Plan	Actual / Forecast	Variance
Year to date £k	6,251	6,180	(71)
Year end forecast £k	1,890	1,890	0

The cash balance held at the end of May is £6.18m. This is a similar level to that planned with the increase in the operating deficit offset by a movement in working balances.

Capital — G

	Plan	Actual / Forecast	Variance
Year to date £k	(580)	(356)	(224)
Year end forecast £k	(8,180)	(8,180)	0

Strategic Capital schemes includes the larger capital projects. All schemes are progressing well and expected to complete within approved timescales. The ICU/CCU project from 2014/15 remains on hold and in Assets Under Construction in 2015/16, no further expenditure on this project has been agreed as yet.

Indicators of Forward Financial Risk — G

	Actual	Forecast for quarter
Number of indicators breach	3	3
Number of indicators	12	12

Indicators breached are:
i) Trust financial performance is on plan
ii) Capital expenditure <75% of plan for the year
iii) Trusts CIP schemes on plan

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Continuity of Service Risk Rating

Isle of Wight NHS Trust

The planned Continuity of Service Rating (CoSR) for the first quarter of 2015/16 is '1'. To the end of May, the Trust is currently reporting an overall Continuity of Service Rating '2' and is as per plan.

Year To Date	Plan Rating	Actual Rating
Liquidity Ratio	2	2
Capital Servicing Capacity (Times)	1	1
Continuity of Services Risk Rating for Trust	**2**	**2**

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

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Surplus

Isle of Wight NHS Trust

The Trust planned for a deficit of £0.391m in May, after adjustments made for normalising items (these include the net costs associated with donated assets).
The reported position is a deficit of £1.095m in the month, an adverse variance of £0.704m against plan.

The cumulative Trust plan was a deficit of £1.136m, after normalising items. The actual position is a cumulative deficit of £2.579m, an adverse variance of £1.443m.

The Trusts planned forecast out-turn deficit remains at £4.6m but the current directorate performances increases the risk of this delivery. This position is actively being managed through performance reviews & where necessary more frequent finance assessments.

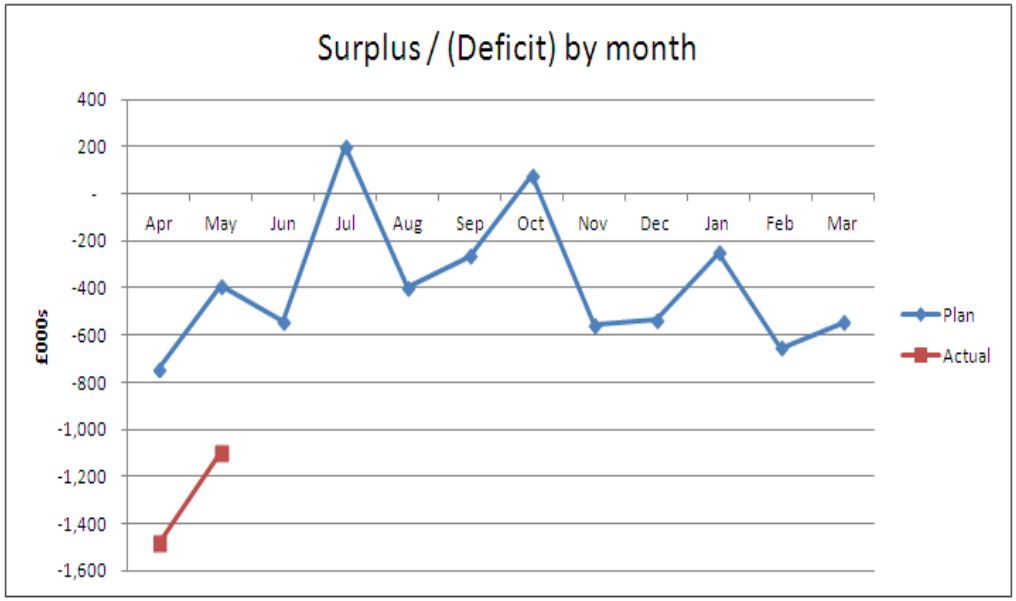
	Base Budget Plan £000s	In month Plan £000s	In month Actual £000s	In month Variance £000s	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Full Year Plan £000s	Full Year Forecast £000s	Full Year Variance £000s
Surplus / (Deficit)	(4,600)	(391)	(1,095)	(704)	(1,136)	(2,579)	(1,443)	(4,600)	(4,600)	0

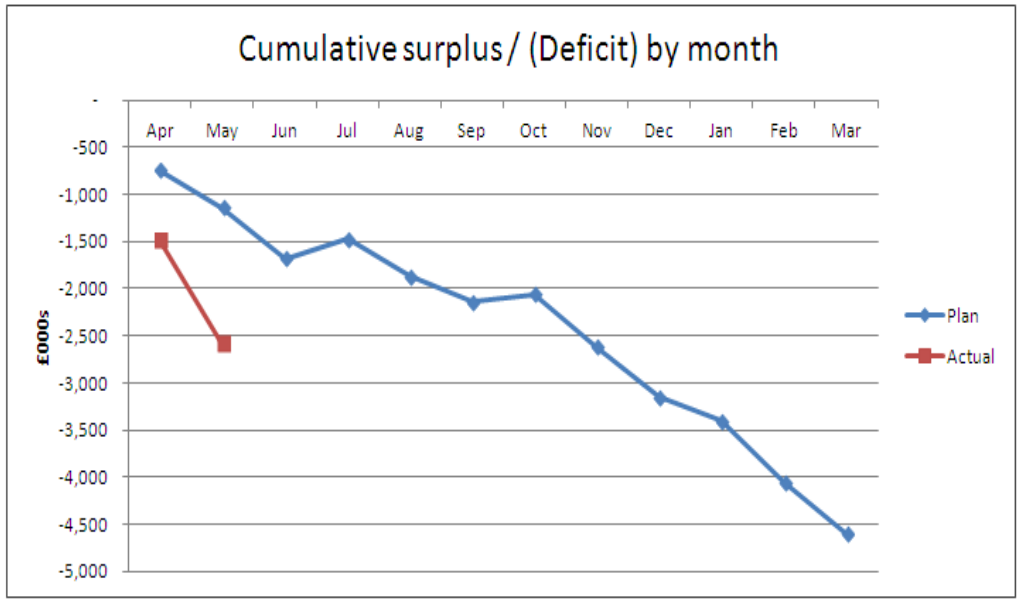
The Category A income under recovery relates to contract services that have yet to commence, but is offset by a corresponding balance in revenue reserves. It also includes an estimate for underperformance against the Acute SLA PbR contract.

Operating costs include considerable over spends in Hospital & Ambulance directorate. These relate to unachievement of CIP requirements, and additional costs in respect of operational pressures.

The current Full Year Plan budgets differ from the Base Budget Plan due to directorates movement of CIP targets between Pay, Non Pay and Income as savings plans are developed.

	Base Budget Plan £000s	In month Plan £000s	In month Actual £000s	In month Variance £000s	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Full Year Plan £000s	Full Year Forecast £000s	Full Year Variance £000s
Income	166,836	14,167	13,885	(282)	28,012	27,526	(486)	166,911	166,911	0
Pay	(114,151)	(9,584)	(10,174)	(590)	(19,387)	(20,669)	(1,282)	(113,692)	(113,692)	0
Non Pay	(47,147)	(4,149)	(3,970)	179	(8,112)	(7,799)	313	(47,681)	(47,681)	0
EBITDA	5,538	434	(259)	(693)	512	(942)	(1,455)	5,538	5,538	0
Depreciation & Amortisation	(6,531)	(530)	(511)	19	(1,059)	(1,022)	37	(6,531)	(6,531)	0
PDC	(3,625)	(302)	(302)	(0)	(604)	(604)	(0)	(3,625)	(3,625)	0
Impairment	0	0	0	0	0	0	0	0	0	0
Profit/(Loss) on Asset Disposal	0	0	(30)	(30)	0	(30)	(30)	0	0	0
Interest Receivable/(Payable)	0	0	(1)	(1)	0	2	2	0	0	0
Bank Charges	(8)	(1)	(0)	0	(1)	(1)	0	(8)	(8)	0
RETAINED SURPLUS / (DEFICIT)	(4,626)	(399)	(1,104)	(705)	(1,152)	(2,598)	(1,446)	(4,626)	(4,626)	0
Receipt of Charitable Donations for Asset Acquisition	(70)	0	0	0	0	0	0	(70)	(70)	0
Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation - Donated Assets	96	8	10	2	16	19	3	96	96	0
REVISED RETAINED SURPLUS / (DEFICIT)	(4,600)	(391)	(1,095)	(704)	(1,136)	(2,579)	(1,443)	(4,600)	(4,600)	0


Surplus / (Deficit) by month
400
200
-
-200
-400
-600
-800
-1,000
-1,200
-1,400
-1,600
£000s
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan
Actual


Cumulative surplus / (Deficit) by month
-
-500
-1,000
-1,500
-2,000
-2,500
-3,000
-3,500
-4,000
-4,500
-5,000
£000s
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan
Actual

The Trust planned income in May was £14.167m. The actual reported income is £13.885m in month, an adverse variance of £0.282m.
The cumulative income plan is £28.012m. The actual position is a cumulative income of £27.526m, an adverse variance of £0.486m.

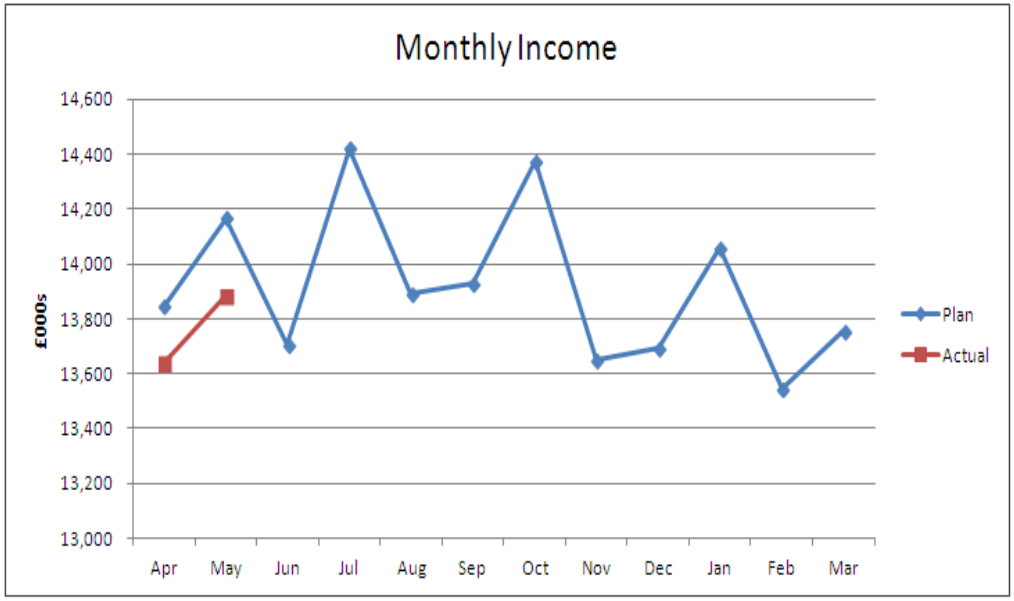
This position is due to contract services that have yet to commence, and estimated contract underperformance.

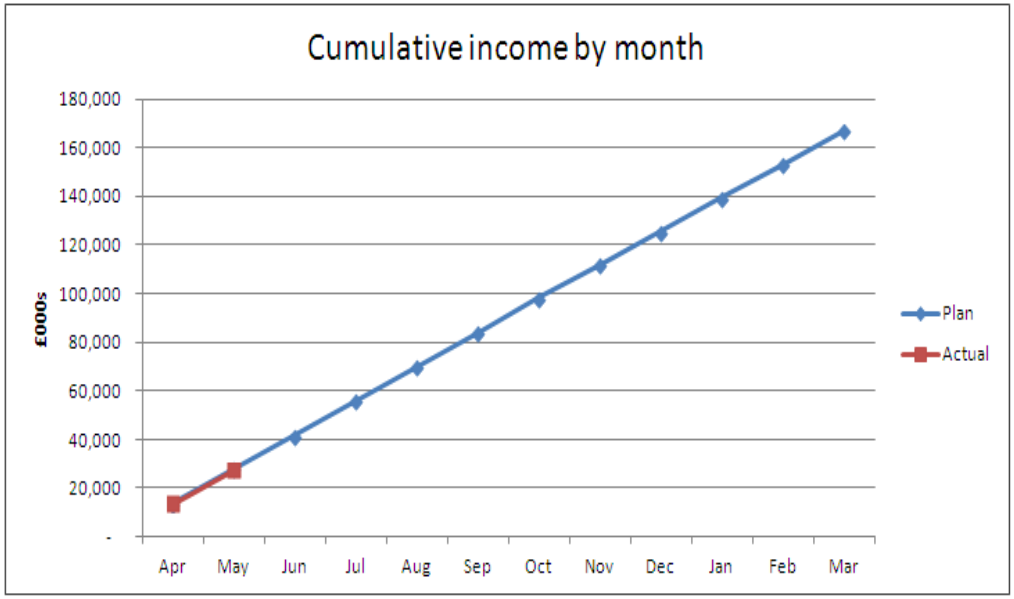
	Base Budget	In month			Year to date			Full Year		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Surplus / (Deficit)	**166,836**	**14,167**	**13,885**	**(282)**	**28,012**	**27,526**	**(486)**	**166,911**	**166,911**	**0**

The NHS Isle of Wight CCG position relates to contract services that have yet to commence, but is offset by a corresponding balance in revenue reserves. It also includes an estimate for underperformance against the Acute SLA PbR contract of £305k. Of this, £114k relates to Non Elective activity, with the balance on Elective and Outpatient activity performance. This is being reviewed and challenged through weekly operational performance meetings with Directorates.

NHS England variance relates to under performance against Non PbR excluded drugs. This is offset by a reduction in costs within Hospital & Ambulance Directorate.

	Base Budget	In month			Year to date			Full Year		
Income	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
NHS Isle of Wight CCG	132,668	11,155	10,842	(314)	22,100	21,593	(507)	132,668	132,668	0
NHS England	11,142	933	907	(26)	1,857	1,804	(53)	11,142	11,142	0
Isle of Wight Council	1,748	146	168	22	291	313	22	1,748	1,748	0
Commissioning Support Unit	320	27	27	1	53	54	1	320	320	0
Non Contractual Activity	1,575	180	296	116	302	419	117	1,575	1,575	0
Southampton University Hospitals FT	105	9	15	6	18	13	(4)	105	105	0
Other directorate income - Patient Care Activities	8,686	834	805	(29)	1,624	1,659	35	8,683	8,683	0
Income from Patient Care Activities	**156,244**	**13,283**	**13,059**	**(224)**	**26,245**	**25,857**	**(388)**	**156,241**	**156,241**	**0**
Other directorate income - Other Operating Revenue	10,592	883	825	(58)	1,767	1,669	(98)	10,670	10,670	0
TOTAL INCOME	**166,836**	**14,167**	**13,885**	**(282)**	**28,012**	**27,526**	**(486)**	**166,911**	**166,911**	**0**


Monthly Income
£000s
14,600
14,400
14,200
14,000
13,800
13,600
13,400
13,200
13,000
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan
Actual


Cumulative income by month
£000s
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan
Actual

Isle of Wight NHS Trust Board Performance Report 2015/16

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Directorate Performance

Isle of Wight NHS Trust

Hospital & Ambulance

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	863	727	(137)	1,590	1,406	(184)	0
Pay	(5,309)	(5,875)	(565)	(10,811)	(12,261)	(1,450)	0
Non Pay	(2,232)	(2,314)	(81)	(4,401)	(4,452)	(52)	0
TOTAL	**(6,678)**	**(7,462)**	**(783)**	**(13,621)**	**(15,307)**	**(1,686)**	**0**

The Directorate overspent in month by £783k.
£600k was due to unachieved CIP and vacancy factor. £252k was charged to Winter Ward against no budgeted funding for agency nurses and medical staff covering the additional contingency beds and managing the red alert.
Agency medical staff covering vacancies accounted for another £409k of the overspend which has been offset by underspends in other areas including Day Surgery Unit (£72k)

Community Health

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	237	271	34	536	632	96	0
Pay	(2,578)	(2,662)	(84)	(5,236)	(5,295)	(59)	0
Non Pay	(361)	(383)	(22)	(726)	(788)	(62)	0
TOTAL	**(2,702)**	**(2,774)**	**(72)**	**(5,426)**	**(5,451)**	**(25)**	**0**

The main reason for the movement in the month, is due to allocation of the remaining CIP target for the allocation. The year to date expenditure includes £64k for the provision for cost relating to the rebanding of junior doctors.

Research & Development

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	37	59	22	74	109	35	0
Pay	(37)	(49)	(13)	(73)	(91)	(18)	0
Non Pay	(0)	(10)	(9)	(0)	(18)	(17)	0
TOTAL	**0**	**(0)**	**(0)**	**0**	**(0)**	**(0)**	**0**

This budget will report a break even position as all costs are offset by income.

Earl Mountbatten Hospice

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	168	237	69	337	458	122	0
Pay	(168)	(214)	(46)	(337)	(423)	(87)	0
Non Pay	(1)	(24)	(23)	(3)	(38)	(35)	0
TOTAL	**(1)**	**(1)**	**0**	**(3)**	**(3)**	**(0)**	**0**

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

Corporate - Finance & Performance Management

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	8	12	4	16	19	3	0
Pay	(198)	(198)	(1)	(399)	(401)	(2)	0
Non Pay	(177)	(162)	15	(345)	(307)	37	0
TOTAL	**(367)**	**(349)**	**18**	**(728)**	**(690)**	**38**	**0**

Finance & Performance Management reported a year to date underspend of £38k, relating to various minor underspends against non pay budgets, with the largest of this being £8k from NHS Supply chain discounts and £6k due to a reduction in the use of external consultancy.

Corporate - Nursing & Workforce

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	9	11	2	19	16	(2)	0
Pay	(229)	(235)	(6)	(459)	(466)	(7)	0
Non Pay	(58)	(50)	8	(115)	(121)	(6)	0
TOTAL	**(278)**	**(274)**	**4**	**(555)**	**(571)**	**(15)**	**0**

Nursing and Workforce directorate's overspend is mainly due to a year to date £28k under achievement of CIP, (Nursing £13k, Workforce £15k). Plans to address this are underway. This issue is being offset by numerous underspends elsewhere.

Corporate - Strategic & Commercial

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	390	284	(106)	779	630	(149)	0
Pay	(585)	(624)	(39)	(1,187)	(1,230)	(43)	0
Non Pay	(727)	(596)	131	(1,465)	(1,301)	164	0
TOTAL	**(923)**	**(937)**	**(14)**	**(1,873)**	**(1,902)**	**(29)**	**0**

Strategic and Commercial planning directorate reported an overspend against budget of £14k. This is mainly due to an under achievement against income budgets, including Residences (offset by underspend in non pay), NHS Creative (again reduced by an underspend in non pay, with a recovery plan, following the election, in place forecasting an overall profit of £55k by yearend).

Corporate - Trust Administration

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	17	30	13	34	58	25	0
Pay	(177)	(199)	(22)	(361)	(384)	(24)	0
Non Pay	(339)	(345)	(6)	(683)	(687)	(4)	0
TOTAL	**(499)**	**(514)**	**(15)**	**(1,010)**	**(1,013)**	**(3)**	**0**

Trust Administration reported an overall overspend of £15k. Pay has impacted in month by 2 mths recharge of an End Of Life Care post (£8k), which is currently being resolved, plus year to date £18k of unachieved CIP. Non pay has year to overspends relating to staff travel, External Consultancy fees and an increase in legal fee's. The impact of these issues in being offset by overachievement against income budgets relating to My Life a full Life

Reserves

	In month			Year to date			Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Income	(12)	0	12	7	0	(7)	0
Pay	(302)	(117)	186	(525)	(117)	409	0
Non Pay	(253)	(87)	166	(375)	(87)	288	0
TOTAL	**(568)**	**(204)**	**364**	**(893)**	**(204)**	**690**	**0**

The main variance relates to commissioners contract variations that have yet to commence, but is offset by a corresponding balance in income (£202k).
The balance is from slippage on reserves for which funding has been committed.

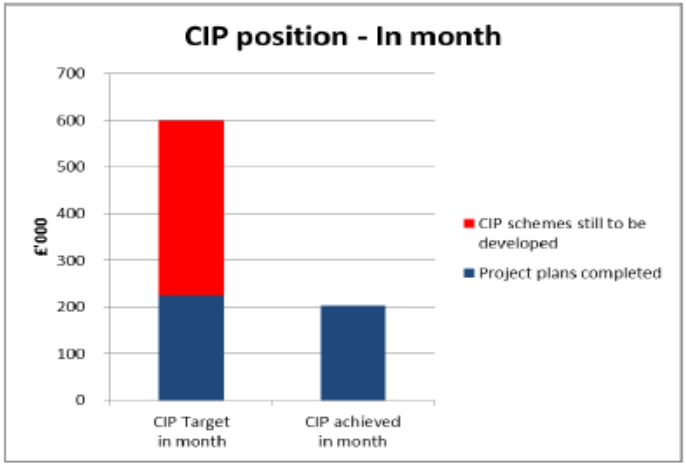
The Trust is reporting a current year overspend against expenditure budget of £1.031m. Including additional costs relating to the Public Dividend Capital Charge the adjusted overspend expenditure variance is £1.019m.

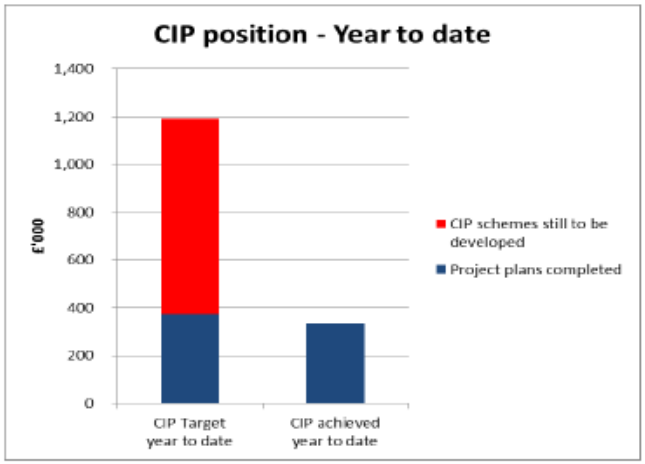
The current year net operating costs include £3.328m of directorate income. Excluding this income source the total costs amount to £28.468m. In addition to the operating costs, capital charges & finance costs amount to £1.637m.

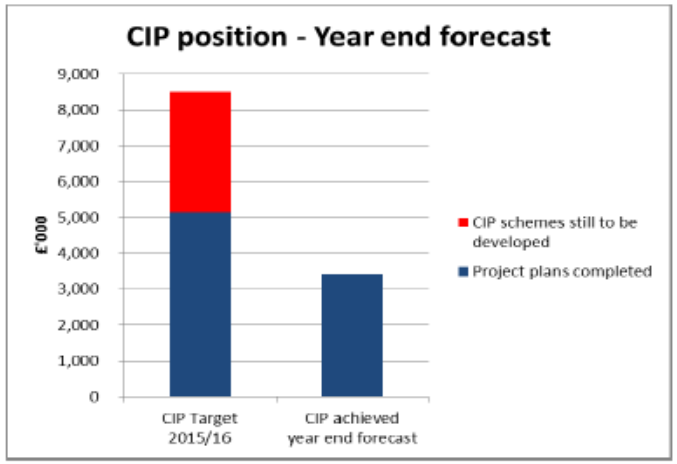
The in month position for CIP is an achievement of £0.202m against a target of £0.599m, a shortfall of £0.397m.
Cumulatively there is an achievement of £0.334m with a target of £1.192m. This is an adverse variance of £0.858m.

The current year forecast is an achievement of £3.415m against a target of £8.500m, a shortfall of £5.085m. Plans are being developed through the turnaround programme of work to ensure that this gap is bridged.

There are currently plans for £5.132m with full project documentation completed, and £3.368m of CIP schemes still to be identified and developed by Directorates.







	IN MONTH				
Directorate	CIP Schemes with project plans completed	CIP Schemes still to be developed	Total CIP Target in month £'000	CIP achieved in month £'000	Over / (Under) Target in month £'000
Hospital and Ambulance	88	329	417	11	(406)
Community and Mental Health	83	2	86	139	53
Finance and Performance	17	1	18	17	(1)
Nursing and Workforce	1	14	15	1	(14)
Strategic and Commercial	19	31	50	19	(31)
Trust Administration	16	(2)	14	16	2
Grand Total	**225**	**375**	**599**	**202**	**(397)**

	YEAR TO DATE				
	CIP Schemes with project plans completed	CIP Schemes still to be developed	CIP Target year to date £'000	CIP achieved year to date £'000	Over / (Under) Target year to date £'000
Hospital and Ambulance	113	717	830	24	(806)
Community and Mental Health	167	4	170	216	46
Finance and Performance	34	1	35	34	(1)
Nursing and Workforce	2	28	31	2	(29)
Strategic and Commercial	32	67	99	32	(67)
Trust Administration	26	1	27	26	(1)
Grand Total	**374**	**818**	**1,192**	**334**	**(858)**

	YEAR END FORECAST				
	CIP Schemes with project plans completed	CIP Schemes still to be developed	CIP Target 2015/16 £'000	CIP achieved year end forecast	Over / (Under) Target forecast £'000
Hospital and Ambulance	3,530	2,387	5,917	1,815	(4,102)
Community and Mental Health	1,000	216	1,216	1,000	(216)
Finance and Performance	204	46	250	204	(46)
Nursing and Workforce	15	204	219	13	(206)
Strategic and Commercial	260	446	706	260	(446)
Trust Administration	123	69	192	123	(69)
Grand Total	**5,132**	**3,368**	**8,500**	**3,415**	**(5,085)**

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Cash

Isle of Wight NHS Trust

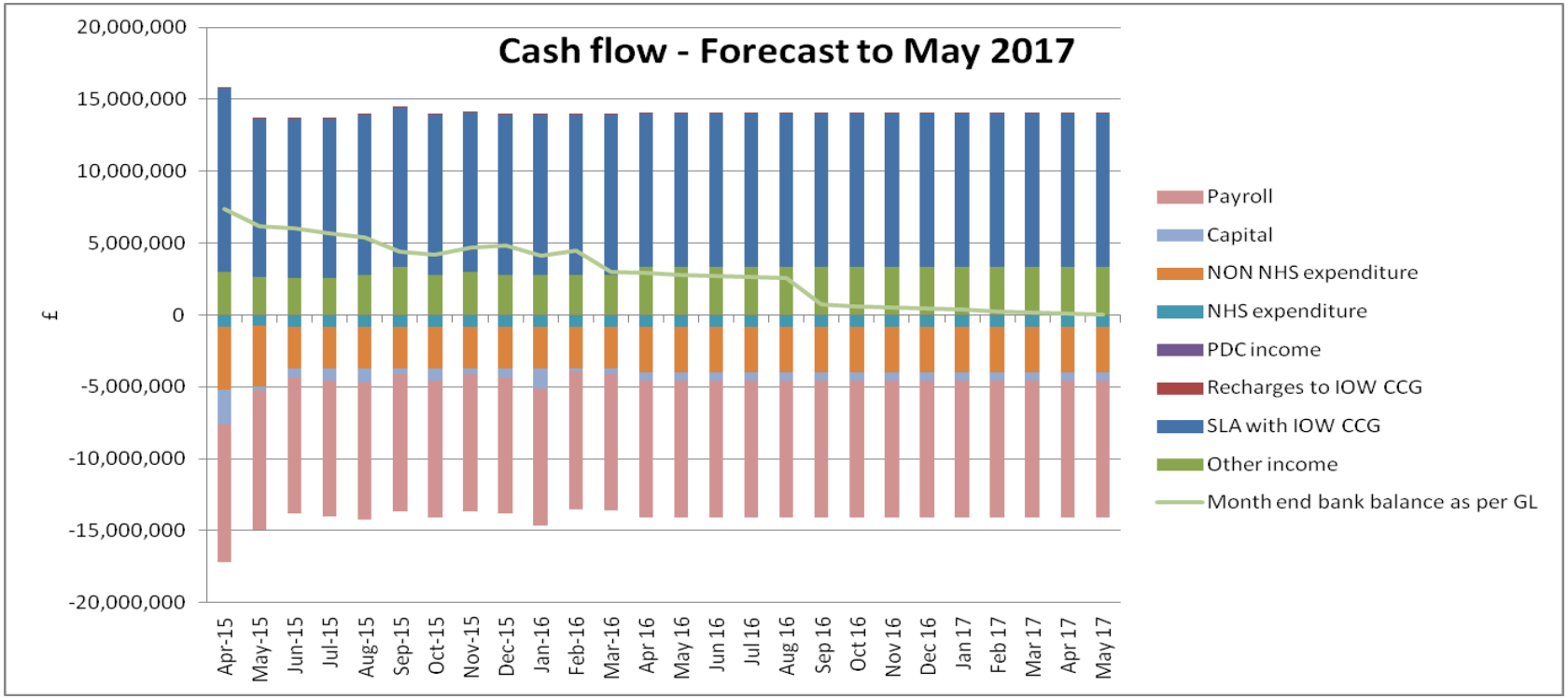
The cash balance held at the end of May is £6.18m. This is a similar level to that planned with the increase in the operating deficit offset by a movement in working balances.

	Year to date			Full Year Forecast		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Cash Balance	**6,251**	**6,180**	**(71)**	**1,890**	**1,890**	**0**

	Year to date			Full Year Forecast		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Operating Surplus/(Deficit)	(548)	(1,964)	(1,416)	(1,001)	(993)	8
Depreciation and Amortisation	1,059	1,022	(37)	6,531	6,134	(397)
Impairments and Reversals	0	0	0	0	0	0
Gains /(Losses) on foreign exchange	0	0	0	0	0	0
Donated Assets - non-cash	0	0	0	(70)	(70)	0
Interest Paid	0	(4)	(4)	(27)	(27)	0
Dividend (Paid)/Refunded	0	0	0	(3,625)	(3,625)	0
Movement in Inventories	0	(5)	(5)	(228)	(228)	0
Movement in Receivables	0	(355)	(355)	1,000	1,000	0
Movement in Trade and Other Payables	417	1,684	1,267	2,997	921	(2,076)
Provisions Utilised	0	0	0	(330)	(330)	0
Movement in Non Cash Provisions	0	(167)	(167)	0	0	0
Cashflow from Operating Activities	**928**	**211**	**(717)**	**5,247**	**2,782**	**(2,465)**
Cashflow from Investing Activities	**0**	**0**	**0**	**0**	**0**	**0**
Interest Received	4	6	(2)	24	24	0
Capital Expenditure - PPE	(3,480)	(2,721)	(759)			
Capital Expenditure				(11,244)	(9,308)	(1,936)
Capital Expenditure - Intangibles	0	(115)	115	(837)	(308)	(529)
Cashflow from Investing Activities	**(3,476)**	**(2,830)**	**(646)**	**(12,057)**	**(9,592)**	**(2,465)**
Cash Flows from Financing Activities	**(2,548)**	**(2,619)**	**71**	**(6,810)**	**(6,810)**	**0**
Capital Element of Finance Leases	0	0	0	(99)	(99)	0
Cashflow from Financing Activities	**0**	**0**	**0**	**(99)**	**(99)**	**0**
Net increase/decrease in cash	**(2,548)**	**(2,619)**	**71**	**(6,909)**	**(6,909)**	**0**
Opening Cash Balance	8,799	8,799	0	8,799	8,799	0
Opening Balance Adjustment	0	0	0	0	0	0
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	8,799	8,799	0	8,799	8,799	0
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0	0	0	0	0
Closing Cash Balance	**6,251**	**6,180**	**(71)**	**1,890**	**1,890**	**0**

The cash balance of c£6.2m held at the end of May is on plan. However, as the table indicates, the increase of c£1.4m in the planned operating deficit has been offset by the movement in working balance, primarily the increase in creditors.

The forecast cash balance held at 31st March 2016 is reliant of the full achievement of the CIP Programme. The expectation is that organisations will hold a minimum of balances equivalent to 2 days operating costs which, in theTrust's case would equate to c£1m. The c£1.9m is therefore ahead of the requirement but will provide a small buffer for unmitigated risks in the financial position if these were to materialise.


Cash flow - Forecast to May 2017
£
20,000,000
15,000,000
10,000,000
5,000,000
0
-5,000,000
-10,000,000
-15,000,000
-20,000,000
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16
Jan 17
Feb 17
Mar 17
Apr 17
May 17
Payroll
Capital
NON NHS expenditure
NHS expenditure
PDC income
Recharges to IOW CCG
SLA with IOW CCG
Other income
Month end bank balance as per GL

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Statement of Financial Position

Isle of Wight NHS Trust

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

	1st April 2015	Year to Date				Full Year			
		Plan	Actual	Variance	Notes	Plan	Actual	Variance	Notes
	£k	£k	£k	£k		£k	£k	£k	
Property, Plant and Equipment	107,504	107,310	107,013	(297)		114,042	114,042	0	
Intangible Assets	3,495	3,269	3,275	6		2,451	2,451	0	
Investment Property	0	0	0	0		0	0	0	
Other Financial Assets	0	0	0	0		0	0	0	
Trade and Other Receivables	340	299	321	22		150	150	0	
Non Current Assets	**111,339**	**110,878**	**110,609**	**(269)**		**116,643**	**116,643**	**0**	
Inventories	2,303	1,728	2,309	581		1,500	1,500	0	
Trade and Other Receivables	7,604	7,487	7,992	505		6,930	6,930	0	
Other Financial Assets	0	0	0	0		0	0	0	
Other Current Assets	0	0	0	0		0	0	0	
Cash and Cash Equivalents	8,799	6,251	6,180	(71)		1,890	1,890	0	
Sub Total Current Assets	**18,706**	**15,466**	**16,481**	**1,015**		**10,320**	**10,320**	**0**	
Non-Current Assets Held For Sale	0	0	0	0		0	0	0	
Current Assets	**18,706**	**15,466**	**16,481**	**1,015**		**10,320**	**10,320**	**0**	
Trade and Other Payables	(18,694)	(18,798)	(18,503)	295		(17,993)	(17,993)	0	
Other Liabilities	0	0	0	0		0	0	0	
Provisions	(643)	(334)	(477)	(143)		(448)	(448)	0	
Borrowings	0	0	0	0		0	0	0	
Other Financial Liabilities	0	0	0	0		0	0	0	
Liabilities arising from PFIs / Finance Leas	0	0	0	0		0	0	0	
DH Working Capital Loan - FT Liquidity	0	0	0	0		0	0	0	
DH Working Capital Loan - Revenue Supp	0	0	0	0		0	0	0	
DH Capital Loan	0	0	0	0		0	0	0	
Current Liabilities	**(19,337)**	**(19,132)**	**(18,980)**	**152**		**(18,441)**	**(18,441)**	**0**	
Trade and Other Payables	0	0	0	0		0	0	0	
Other Liabilities	0	0	0	0		0	0	0	
Provisions	0	0	0	0		0	0	0	
Borrowings	0	0	0	0		0	0	0	
Other Financial Liabilities	0	0	0	0		0	0	0	
Liabilities arising from PFIs/Finance Lease	0	0	0	0		(933)	(933)	0	
DH Working Capital Loan - FT Liquidity	0	0	0	0		0	0	0	
DH Working Capital Loan - Revenue Supp	0	0	0	0		0	0	0	
DH Capital Loan	0	0	0	0		0	0	0	
Non-Current Liabilities	**0**	**0**	**0**	**0**		**(933)**	**(933)**	**0**	
TOTAL ASSETS EMPLOYED	**110,708**	**107,212**	**108,110**	**898**		**107,589**	**107,589**	**0**	
FINANCED BY:									
Public Dividend Capital	6,762	6,762	6,762	0		6,762	6,762	0	
Retained Earnings Reserve	69,520	66,024	67,014	990		62,406	62,406	0	
Revaluation Reserve	34,426	34,426	34,334	(92)		38,421	38,421	0	
Other Reserves	0	0	0	0		0	0	0	
TOTAL TAXPAYERS EQUITY	**110,708**	**107,212**	**108,110**	**898**		**107,589**	**107,589**	**0**	

The movement in working capital, specifically inventories, receivables and payables, are c£1m more than the planned level at month 2. This is mainly because the plan was based on figures before the final outturn for 2014/15 was confirmed with the balances held at the year end being greater than expected.

The balance sheet is currently forecast to be as planned at year end.

Isle of Wight NHS Trust Board Performance Report 2015/16

May 15

Capital

Isle of Wight NHS Trust

The initial source of funds for 2015/16 is £8.18M. This includes expected property sales of £750k which were delayed from 2014/15.

Year to Date

	Plan £k	Actual £k	Variance £k
Strategic Capital	350	283	67
Operational Capital	230	73	157
Total	**580**	**356**	**224**

Year End Forecast

	Plan £k	Forecast £k	Variance £k
Strategic Capital	4,233	4,233	0
Operational Capital	3,947	3,947	0
Total	**8,180**	**8,180**	0

Strategic Capital schemes includes the larger capital projects. All schemes are progressing well and expected to complete within approved timescales. The ICU/CCU project from 2014/15 remains on hold and in Assets Under Construction in 2015/16, no further expenditure on this project has been agreed as yet.

Operational Capital - Projects from 2014/15 carried forward into 2015/16 are the Ambulance CAD Upgrade (Equipment RRP) and the Sevencares AntiClimb Roofing Installation (Estates Scheme). The Upgrade to the MRI (Equipment RRP) is underway and the mobile scanner is in place. Further bids for 2015/16 were presented to the Capital Investment Group on 5th June and are in the process of being prioritised by the Directorates. As this process is still ongoing, the prioritisation on IM & T projects has still to be determined and therefore the forecast spend is included in spend against the contingency funding.

Strategic Capital	Year to Date			Full Year			Risk
	Plan	Actual	Variance	Plan	Forecast	Variance	Rating
Source of Funds	£k	£k	£k	£k	£k	£k	
Strategic Funds C/F			0			0	
External Funding			0			0	
Capital Investment Loans			0			0	
Operational Capital	350	350	0	4,233	4,233	0	
Donated Capital			0			0	
	350	**350**	**0**	**4,233**	**4,233**	**0**	
Application of Funds							
Strategic Capital Schemes							
MAU Extension	100	280	(180)	588	588	0	G
Ward Reconfiguration Level C	0	0	0	103	103	0	G
Endoscopy Relocation	250	3	247	2,774	2,774	0	G
Carbon Energy Fund	0	0	0	769	769	0	G
ICU/CCU	0	0	0	0	0	0	G
	350	**283**	**67**	**4,233**	**4,233**	**0**	

Operational Capital	Full Year	Year to Date			Full Year		Risk
	Plan	Plan	Actual	Variance	Plan	Forecast	Variance	Rating
Source of Funds	£k	£k	£k	£k	£k	£k	£k	
Depreciation	6,134	529	511	18	6,134	6,134	0	
Property Sales	750	0	0	0	750	750	0	
Donated Funds	70	0	0	0	70	70	0	
Other	1,226	0	0	0	1,226	1,226	0	
Transfer to Strategic Capital	(4,233)	(350)	(350)	0	(4,233)	(4,233)	0	
	3,947	**179**	**161**	**18**	**3,947**	**3,947**	0	
Application of Funds								
Operational Schemes								
Estates Schemes	534	116	45	71	534	489	45	G
IM&T RRP	500	0	0	0	500	0	500	G
MRI Upgrade - Finance Lease	1,057	0	0	0	1,057	1,057	0	
Equipment RRP	882	84	0	84	882	518	364	G
Estates Staff Capitalisation	180	30	28	2	180	180	0	G
Contingency/Unallocated	555	0	0	0	555	1,464	(909)	G
Donated Assets	70	0	0	0	70	70	0	G
PARIS Implementation	169	0	0	0	169	169	0	G
Other (Non RRP, Equipment)	0	0	0	0	0	0	0	G
	3,947	**230**	**73**	**157**	**3,947**	**3,947**	0	

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

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 Q2 2014/15	Historic Data Q3 2014/15	Historic Data Q4 2014/15	Current Data Apr	Current Data May	Current Data Jun	Current Data Q1 2015/16	Notes
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	No	No	No	No	No		No	
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		95%	1.0	No	No	No	No	Yes		No	
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		92%	1.0	No	Yes	Yes	Yes	Yes		Yes	
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	Yes	No	No	No	No		No	
	5	All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	1.0	No	No	Yes	No	Yes		No	
			NHS Cancer Screening Service referral	90%									
	6	All cancers: 31-day wait for second or subsequent treatment, comprising:	surgery	94%	1.0	No	Yes	Yes	Yes	No		No	
			anti-cancer drug treatments	98%									
			radiotherapy	94%									
	7	All cancers: 31-day wait from diagnosis to first treatment		96%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93%	1.0	No	No	Yes	Yes	Yes		Yes	
			For symptomatic breast patients (cancer not initially suspected)	93%									
	9	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within seven days of discharge	95%	1.0	Yes	Yes	No	No	Yes		No	
			Having formal review within 12 months	95%									
	10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	Yes	Yes	Yes	No	Yes		No	
	11	Meeting commitment to serve new psychosis cases by early intervention teams		95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	12	Category A call – emergency response within 8 minutes, comprising:	Red 1 calls	75%	1.0	No	Yes	Yes	Yes	Yes		Yes	
			Red 2 calls	75%	1.0	No	Yes	Yes	No	Yes		No	
	13	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	14	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral		50%	1.0	-	-	-	-	-		-	
	15	Improving access to psychological therapies (IAPT)	People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	1.0	-	-	-	No	No		No	
			People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	1.0	-	-	-	Yes	Yes		Yes	
Outcomes	16	Clostridium difficile – meeting the C. difficile objective	Is the Trust below the de minimus	12	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
			Is the Trust below the YTD ceiling	1		No	No	No	No	No		No	
	17	Minimising mental health delayed transfers of care		≤7.5%	1.0	No	No	No	No	Yes		No	
	18	Mental health data completeness: identifiers		97%	1.0	Yes	Yes	Yes	Yes	No		No	
	19	Mental health data completeness: outcomes for patients on CPA		50%	1.0	Yes	Yes	No	Yes	Yes		Yes	
	20	Certification against compliance with requirements regarding access to health care for people with a learning disability		N/A	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	21	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
			Referral information	50%									
			Treatment activity information	50%									
		TOTAL				**9.0** R	**6.0** R	**6.0** R	**9.0** R	**5.0** R	**0.0** G	**11.0** R	

Terms and abbreviations used in this performance report

Quality & Performance and General terms

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

Workforce and Finance terms

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

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 3 JUNE 2015

Title	Hospital and Ambulance Directorate Update			
Sponsoring Executive Director	Interim Chief Operating Officer, Shaun Stacey			
Author(s)	Associate Director– Donna Collins Sabeena Allahdin - Interim Clinical Director Hospital and Ambulance Directorate & Consultant Obstetrician and Gynaecologist			
Purpose	For information			
Action required by the Board:	**Receive**	**X**	**Approve**	
Previously considered by (state date):				
Trust Executive Committee		Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee		Remuneration & Nominations Committee		
Charitable Funds Committee		Quality & Clinical Performance Committee		
Finance, Investment, Information & 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 monthly report is provided as a regular update to the Trust Board from the Hospital and Ambulance Directorate.				
Executive Summary:				

This monthly report is provided as a regular update to the Trust Board on:

Service Delivery Updates

- **18 week recovery** – recovery plan being discussed with TDA and CCG
    - **Consideration to outsource**
    - **Managing chronologically therefore worse position initially until September/October**
- **Text message reminder service** – being rolled out across the Trust
- **Women and Child Health new post** – Maternity Services Coordinator enabling working across community and acute midwifery
- **Bank holiday birth bonanza** – Late May bank holiday had nearly three times the number of normally expected births
- **New Clinical Lead in post in General Surgery** – Mr Steve Parker has commenced in the role, bringing many years of clinical and management experience from his time in Coventry.
- **Achievement of key targets –** by Ambulance service in May

Key Issues

- **Changes to national targets** – only the incomplete 18 week target to remain nationally

Successes

- **New 18 weeks training strategy** – agreed and being rolled out across the Trust.

Challenges

- **Financial performance** – and recovery of month 1 and 2 position.
- **Medical Staffing** – particularly at the Consultant level.

In the media spotlight

- **National Breastfeeding Week**
- **Omnicell Project**

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 references*	Out of hours blood sciences cover (BAF 4.4) Risk due to bed capacity problems (BAF 2.22 & 6.12) Vacant Consultant Physician posts (BAF: 10.73)					
Assurance Level *(shown on BAF)*	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None					

Date: 17 June 2015 **Completed by** Victoria Lauchlan Interim Project/Business Manager –Hospital and Ambulance Directorate

Hospital:

Service Delivery Update:

In May and June, the Hospital Directorate has continued to focus on recovery actions as it emerges from the peak pressures experienced over the extended winter period. It is also exploring alternative models of service provision to meet the finance challenge and deliver cost effective, quality services.

The Directorate has made progress on treating those patients who have been waiting long periods following previous periods of 'black alert' and subsequent cancelled operations. Action plans are in place to improve upon this ensuring that activity meets the demand plan requirements; these plans are being shared with the Clinical Commissioning Group (CCG) and Trust Development Authority (TDA), and include ring fencing elective beds and daily monitoring of clinic and theatre utilisation.

The roll out of the text message reminder system commenced this month across the Trust. This sends automated text alerts to patients reminding them of upcoming appointments. Patients are able to opt out of this service if they wish but the large majority appreciate the additional 'heads up' and know that missed appointments is a major cause of waste in the NHS.

Within Women and Child Health, a new Coordinator post has been put in place in Maternity Services to oversee both acute and community midwifery. This should drive efficiencies and allow midwifes to work flexibly wherever they are normally based. The Family and Friends test responses rate improved for May and we're pleased to say the feedback was excellent.

The Labour Ward was extremely busy over the late bank holiday weekend with an astonishing 35 births in four days. As we would normally expect to see 12 births over that period, this really was out of the ordinary. Unlike mainland Maternity Units, we do not turn women in labour away when capacity is reached. All the Maternity Services staff should be commended for their flexibility and dedication to ensure all the women were looked after safely and efficiently.

Within General Surgery, we are delighted to announce the appointment of a new Clinical Lead, Mr Steve Parker. Steve brings a wealth of experience to the role. He joined the Isle of Wight NHS Trust as a Consultant Breast and General Paediatric Surgeon in early January 2015, having previously been a consultant in Coventry for 12 years. In Coventry, he held several senior leadership and management roles including the Breast Multi-Disciplinary Team (MDT) Lead Clinician, Clinical Director for Theatres and Associate Medical Director for Cancer Services.

He has already had a major impact on his own services, moving the breast theatre list from a Tuesday to a Monday to improve the flow of patients, protecting wards from high inpatient demand on busy Mondays resulting in fewer patient cancellations due to bed pressures. The Trust is also sustaining its Breast Symptomatic performance year to date, a target that has also been a local challenge.

Finally, Wessex Deanery has received a suitable level of assurance from the General Surgery action plan to improve training opportunities and this has resulted in successfully retaining our trainee numbers for the coming year

Key Issues:

Emergency and non elective activity has reduced its impact slightly on elective activity in recent weeks, and this is evident through a reduction in undated patients waiting more than 18 weeks (from 239 at the end of April to 89 in mid June). Booking efficiency has also improved for day case and inpatient activity from 36% and 39% in May respectively to 63% and 76% in June respectively. A national announcement was made in June that both the national performance standards re admitted and non admitted performance would be removed; further announcements and implementation guidance on this is still awaited. The incomplete target will remain, which measures the Trust's management of all our patients on our waiting list, i.e. At least 92% of patients should be waiting less than 18 weeks for their treatment.

There are a number of specialties facing particular challenges relating to the level of ongoing demand, these include Urology and General Surgery. In addition, a small number of supporting diagnostics also have a reporting backlog which is resulting in some pathway delays.

Successes:

A Trustwide 18 weeks Referral to Treatment (RTT) training strategy has recently been approved which focuses on the importance of all staff receiving training tailored to their role regarding RTT. The programme of modules will begin to be rolled out in September; in the meantime, training on the RTT Access Policy continues for clinical and non clinical staff involved in managing patient pathways with 92 members of staff have been trained as at mid-June. GP briefings on the key policy points will be cascaded in July, along with a patient leaflet around the responsibilities of both the Trust and patients when accessing treatment at the hospital.

Challenges:

The Directorate was significantly overspent against budget in months 1 and 2. This was driven primarily by the extra costs incurred by the winter period mitigation actions and also through the premium paid on temporary staffing to cover vacancies. There a number of measures in place, focused on recovering the early financial position.

However, a number of areas continue to have hard to fill vacancies. The Directorate will continue working with the Human Resources (HR) team to look at ways of raising the profile of the Island and reaching potential staff outside of NHS jobs.

The Directorate's key challenges continue to relate to medical staffing and the difficulty in attracting suitable candidates to fill the vacancies. The Clinical Leads continue to work with

General Managers and Medical Staffing to find effective ways to cover these roles and to recruit substantively.

In the media spotlight:

The successes of the Omnicell project continue to receive national and international interest. There has been presentations at 4 national conferences and is a showcase in the AHSN review next week in London. The Isle of Wight implementation will be the keynote at the Omnicell world conference in October in US. An application has been made to the HSJ awards for the Reablement / Motive project which is about Medicines optimisation in vulnerable people on discharge to home, with three conferences accepting abstracts, posters and presentations.

National Breastfeeding Celebration Week will run from 20th – 28th June 2015 and Maternity Services and Paediatrics will be wholeheartedly supporting this. This year aims to raise awareness of the health and wellbeing benefits of breastfeeding for mothers, their infants and the long term public health for everyone.

On the island we are concentrating on breastfeeding out and about and returning to work. An event is to be held at Bebe'ccino café 15 High St Newport on 23rd June 10.00 to 12.00.

Women will be encouraged to drop in to meet other mums and breastfeeding supporters, get top tips on feeding out and about from other mums and to receive information on returning to work and continuing breastfeeding.

Ambulance:

Service Delivery updates

The Ambulance service on the island has reversed the negative performance in April to a positive one in May, achieving all the national targets and KPIs. The service continues to work alongside stakeholders from within and outside the Trust and maintain links with our strategic blue light agencies. This is moving forward and some positive signs are emerging on joint working. The Ambulance Service also delivers a high quality of care through its innovative Integrated Care Hub. This continues to create efficiencies in delivery of service, and patient satisfaction through 999 and 111 is extremely high. In relation to the recent CQC visit to the Hub we are in receipt of the draft report with some very positive indicators and we eagerly await the final report. The last month has seen Paramedics carrying out GP visits and although this trial has now ended we are looking at ways of extending the trial through close working with the commissioning teams.

Key Issues

The key issue facing the service is its ability to provide a high quality of care against a back drop of financial pressures upon the whole system. The Ambulance service continues to provide support across the Directorate; it also leads the way through innovative workforce developments with its generic worker concept. This month we have also been utilising paramedics working in the ED area to enhance our alignment between the services as part of the new concept of the business unit.

Successes

The key success within the Ambulance Service for the month is the return to achievement of the targets.

The pilot for paramedics carrying out GPs visits proved successful with each paramedic, on average, visiting 12 patients per day and releasing GP time.

Challenges

The level of financial challenge is having an impact on the availability of staff cover.

In the Media spotlight

The Island hosted a special visit from a number of royal dignitaries from around the world and the Ambulance service provided both strategic input into the planning of the visit and a constant present in the joint emergency interoperability control room, ensuring the safety and welfare of our visitors were catered for in any eventuality.

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 1 JULY 2015

Title	Community & Mental Health Directorate Update			
Sponsoring Executive Director	Executive Medical Director, Dr Mark Pugh			
Author(s)	Acting Associate Director– Nikki Turner			
Purpose	For information			
Action required by the Board:	**Receive**	✓	**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 monthly report is provided as a regular update to the Trust Board from the Community & Mental Health Directorate.

Executive Summary:

This monthly report is provided as a regular update to the Trust Board on:

Service Delivery Updates

- **Memorandum of Understanding** - On 3 June 2015, the Trust Board approved a Memorandum of Understanding between the Isle of Wight NHS Trust Mental Health Services and Hertfordshire NHS Mental Health Services Foundation Trust.
- **Therapy capacity and demand on the acute wards at St Mary's Hospital** - Two business cases for increased Occupational Therapy and Physiotherapy have been discussed at the Community and Mental Health Directorate Board and TEC. The Executive Team have agreed to support the directorate when discussing these business cases with the CCG.
- **Stroke Services Medical Cover** - Medical cover for acute stroke patients is currently covered with agency locums. Whilst recruitment efforts continue, we are exploring alternative long term solutions for the medical cover from the Stroke service.
- **Poppy Unit** – Poppy Unit has won the NHS Fab Stuff Hartly Larkin Award. This award qualifies for the NHS Fab Stuff Annual Awards ceremony in November 2015. The learning from this unit is being considered within the new model of care work.
- **SIRI's** - The Directorate continues to investigate in a timely fashion and this has resulted in reducing the number of overdue SIRIs considerably in the last few months.
- **Complaints and Concerns** – Continue to show a downward trajectory.

Key Issues/Risk

- **Medical Staffing** - The Directorate's current medical staffing recruitment challenges within Stroke and Psychiatry have been added to the Corporate Risk Register. This

remains a key focus for the Directorate as it works to attract suitable applicants in a timely manner to its vacancies which have become available due to retirement and resignation.

Successes

- **The opening of the "Four Seasons Garden"** - John Curtis, Director of Ventnor Botanic Gardens, formally opened the new "Four Seasons Garden" on 11 June 2015.
- **IRIS provides support at the Isle of Wight Festival** - The Island Recovery Integrated Service (IRIS) Team attended the Isle of Wight Festival to promote the new local service and to give advice and support on the use of drugs and alcohol and raise awareness of the side effects.
- **The Memory Service featured twice in the Isle of Wight County Press** - There have been two articles in the Isle of Wight County Press featuring the Memory Service.

Challenges

- Medical Staffing as per Key Issues above.

In the media spotlight

- The opening of the "Four Seasons Garden
- IRIS provides support at the Isle of Wight Festival
- The Memory Service featured twice in the Isle of Wight County Press

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)***	**Ref 550**- CSF9 - OT – Corporate Risk Register **Ref 654** - CSF2 - Stroke Consultant – Corporate Risk Register **Ref 650** – CSF9/CSF2 – IRIS Staffing Issues – Corporate Risk Register					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	None					

Date: 19 June 2015 **Completed by:** Nikki Turner, Acting Associate Director Community & Mental Health Directorate

Service Delivery Updates

Memorandum of Understanding

On 3 June 2015, the Trust Board approved a Memorandum of Understanding between the Isle of Wight NHS Trust Mental Health Services and Hertfordshire NHS Mental Health Services Foundation Trust. The two Trusts will collaborate around service models where it is clearly in the patient's and both organisations' interest to do so. This will look at services in the Adult Acute Mental Health pathway incorporating community and inpatient settings. There will also be collaboration around service models that support integrated pathways across Acute and Community Mental Health and Primary Care (GPs) together with clinical supervision of specialist staff.

Therapy capacity and demand on the acute wards at St Mary's Hospital

Occupational Therapy and Physiotherapy enable better patient flow as demonstrated through pilots run during winter pressures and Easter. With additional resourcing, the teams were able to reduce length of stay, improve bed occupancy rates, and facilitate additional discharges.

Current Occupational Therapy establishment is significantly out of kilter with demand that has risen by 35% over the last two years. This risk is on the Corporate Risk Register.

Two business cases for increased Occupational Therapy and Physiotherapy have been discussed at the Community and Mental Health Directorate Board and TEC. The Executive Team have agreed to support the directorate when discussing these business cases with the CCG.

Stroke Services Medical Cover

Inpatient care for individuals who have had a stroke is currently provided on the Stroke Unit, which is a mixture of acute and rehabilitation beds. Thrombolysis and the required 24 hour aftercare are currently provided on the Coronary Care Unit. In addition there is a 24 hour Thrombolysis service and a 7 day a week TIA service.

All of these services require Stroke Specialist medical input.

There is a national shortage of Stroke Specialist Physicians and, due to a continued inability to recruit to the acute stroke consultant, medical cover for acute stroke patients is currently covered with agency locums.

Whilst recruitment efforts continue, we are exploring alternative long term solutions for the medical cover from the Stroke service.

Poppy Unit

Poppy Unit opened on Monday 26th January 2015, since that date patients regularly sat together in the lounge to eat and socialise. The Unit was visited multiple times by the Project Team to ensure smooth running of the Unit and also to pick up soft feedback from patients and staff. The licence to occupy Poppy Unit and the systems resilience funding ended on 31 May 2015 and as such a planned exit strategy was followed.

A write up of the good work carried out at Poppy Unit was submitted to 'The Academy of NHS Fabulous Stuff', http://www.fabnhsstuff.net/, which was subsequently published on the website. Following the publication of the article, site users voted and the article was awarded the NHS Fab Stuff Hartly Larkin

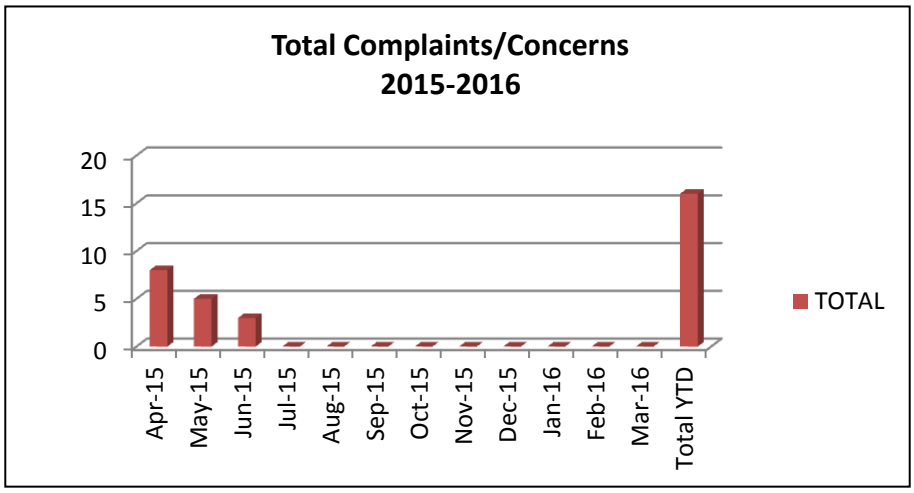
Award – this award qualifies for the NHS Fab Stuff Annual Awards ceremony in November 2015. The learning from this unit is being considered within the new model of care work.

Serious Incidents Requiring Investigation (SIRI's)

Following new guidance from NHS England, the Trust has further reviewed its SIRI process. The Directorate has implemented this process. All incidents rated moderate and above now require a 48 hour report. The 48 hour report will determine whether or not the incident is deemed SIRI reportable. Incidents are now clustered into categories e.g. communication, pressure injuries, etc. and reviewed holistically to highlight important learning to be shared Trust-wide. NHS England recognised that time was being spent on SIRI Reports unnecessarily when the emphasis on SIRIs is the learning. The new process still identifies issues and concerns if outside of existing identified themes. The Directorate continues to investigate in a timely fashion and this has resulted in reducing the number of overdue SIRIs considerably in the last few months.

Lessons learnt from SIRIs are discussed at a number of forums, monitored daily and reported weekly, shared directorate wide and also across the organisation.

Complaints and Concerns



Key Issues

- Medical Staffing
  The Directorate's current medical staffing recruitment challenges within Stroke and Psychiatry have been added to the Corporate Risk Register. This remains a key focus for the Directorate as it works to attract suitable applicants in a timely manner to its vacancies which have become available due to retirement and resignation.

Successes

- The opening of the "Four Seasons Garden" (see Media Spotlight section)
- IRIS provides support at the Isle of Wight Festival (see Media Spotlight section)

Challenges

- Medical Staffing – see Key Issues above

In the media Spotlight

Opening of the "Four Seasons Garden"

John Curtis, Director of Ventnor Botanic Gardens, formally opened the new "Four Seasons Garden" on 11 June 2015. The garden has been created specifically for any person with dementia to use and visit together with their family, friends or carer when they are receiving any form of healthcare treatment at St. Mary's as an in-patient, out-patient or as a visitor.

It is a quiet outdoor sunny secluded site, with raised flowerbeds, full disabled access, special handmade outdoor furniture and beautiful artworks. It is the ideal place for persons to have quiet conversations and escape from the stress of a hospital visit. It is located in the North Hospital opposite Shackleton Ward.

Shackleton Ward Sister, Paula Smith, said: "The garden is a fantastic resource and patients are already benefiting from it. It is a safe environment in which we can get patients involved in weeding and watering the plants. The central raised bed makes it easy for those with mobility difficulties to participate and enjoy the garden. On days when the weather is fine we bring patients into the garden for afternoon tea. It will also be great for other patients with dementia and their carers to use when visiting the hospital for outpatient appointments."

John Curtis, Director, Ventnor Botanic Garden CIC said: "Congratulations to everyone involved with this project. Dementia is a difficult and challenging disease. This new garden is a much needed resource for patients and staff. There is a growing body of evidence that great environments, like the new Four Seasons Garden, the other gardens at St. Mary's and places like Ventnor Botanic Garden, have an important impact on patients and help with their ongoing treatment and wellbeing."

The Garden construction cost was funded by the King's Fund, London in partnership with the Department of Health and the artworks commissioned with a grant from the Arts Council's 'Grants for All' National Lottery funded scheme.

IRIS provides support at the Isle of Wight Festival

The Island Recovery Integrated Service (IRIS) Team was on site promoting the new local service and giving advice and support on the use of drugs and alcohol and raising awareness of the side effects. The IRIS Team was situated in the Welfare tent in Electric Lady Land along with the IW NHS Trust Membership team who were recruiting members to the Trust.

The Memory Service

There have been two articles in the Isle of Wight County Press featuring the Memory Service. Bev Malone and Lynsey Burden demonstrated the use of an age simulation suit which has been a real success in sharing what it is like to have limited/restricted mobility and Kathy St John highlighted our evidence based Cognitive Stimulation Therapy.

Nikki Turner, Acting Associate Director, Community and Mental Health Directorate

Mark Pugh, Executive Medical Director

19 June 2015

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1st July 2015

Title	Revalidation for Nurses and Midwives			
Sponsoring Executive Director	Executive Director of Nursing			
Author(s)	Deputy Director of Nursing			
Purpose	To advise the Trust Board of the Trust plans to ensure Registered Nurses and Midwives are prepared for the implementation of Revalidation in early 2016 and the potential risks to implementation.			
Action required by the Board:	**Receive**	**X**	**Approve**	

Previously considered by (state date):			
Trust Executive Committee	22nd June 2015	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	
Director of Nursing Team Meeting	13th June 2015		
Please add any other committees below as needed			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Links with the Nursing & Midwifery Council are well established. NHS England and the Trust Development Authority are also key players In the preparation.
Communication with Ward Managers has occurred via Band 7 Clinical Leaders Development Day and a session on revalidation has been run on Nurses Day to engage staff.
Links are made with CCG to ensure whole island approach is in place.
Work with Nursing Homes is also underway which will be supported by CCG and Trust as required

Executive Summary:

From 1st April 2016 The Nursing and Midwifery Council (NMC) are changing the requirements that nurses and midwives must meet when they renew their registration every three years. This will replace the current post-registration education and practice (PREP) standards.
All registrants are required to meet a number of minimum standards the three years preceding the date of their application for renewal. Individuals who fail to meet revalidation standards are not legally able work in the United Kingdom within the profession. The Trust has submitted an organisational readiness self assessment to NHS England in May to identify any risks and challenges to the process and develop an implementation plan to address any gaps and mitigate risk that may impact on implementation of revalidation and service delivery.

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

consultation requirements	

Date: 21st June 2015 **Completed by: Deputy Director of Nursing**

Isle of Wight NHS Trust
Executive Director of Nursing & Workforce
Nursing and Midwifery Council (NMC) Revalidation
June 2015

SITUATION

This paper outlines how Nurses and Midwives will maintain their registration through the revalidation at the point of renewal of registration. Revalidation is applicable to all Nurse and Midwives irrespective of their role be that staff in frontline clinical care, education, research, policy, advisory, management and leadership roles. It applies to substantive, temporary and short term contract staff including bank staff.

BACKGROUND

From 1st April 2016 The Nursing and Midwifery Council (NMC) are changing the requirements that nurses and midwives must meet when they renew their registration every three years. This will replace the current post registration education and practice (PREP) standards.

Revalidation supports professionalism through a close alignment with the NMC Code for Nurses and Midwives which has been revised in March 2015.

The four themes of the code are

- Prioritise people
- Practice effectively
- Preserve safety
- Promote professionalism**.**

Revalidation is already common practice for Medical staff so is not a new concept for the Trust. However the number of nurses and Midwives in the Trust is 1689 compared to 341 career grade substantive medical/dental staff therefore the scale of the exercise is considerably more extensive and the potential impact of nurses failing to meet revalidation could have significant consequences for service delivery.

NHS England has established a Regional Programme Board which has good stakeholder representation to ensure an efficient and structured implementation programme is progressed. Each sub region has also established an implementation group with SATH being a member of the North Midlands group.

Revalidation requirements. (Provisional arrangements)

The provisional revalidation standards are currently being piloted in a number of organisations. The final revalidation process and standards will be confirmed in the autumn before implementation on the 1st April 2016.

All registrants are required to meet the following minimum standards for the three year period preceding the date of their application for renewal. Individuals who fail to meet revalidation standards are not legally able work in the UK in their profession

1. A minimum of 450 practice hours within their scope of practice. This scope of practice can be direct patient care, management, education, policy or research in a wide range of health, social care and independent care settings.
2. To undertake 40 hours of continuous professional development (CPD) relevant to the scope of practice – this is an increased requirement with a specified amount of 20 hours relating to participatory practice i.e. working with others, reflection, challenge and discussion, being part of that approach.
3. To obtain at least five pieces of practice related feedback , which can be from patients, carers, service users, students, colleagues and annual appraisals
4. Reflection and discussion through a minimum of 5 written reflections on the code, practice and CPD
5. Declaration of health and character
6. Confirmation of professional indemnity arrangements
7. Confirmation from a third party, usually the manager for the purpose of verifying the declarations

Individual staff have a responsibility for meeting their revalidation requirements and the Trust will need to support staff by having robust systems, and processes, capacity and resources to comply with revalidation, in particular:

- A designated lead to oversee the implementation of revalidation.
- Staff are facilitated to meet their appropriate CPD requirements.
- Staff receive yearly appraisals which can deliver the NMC requirements for revalidation.
- Sufficient management capacity to support staff with revalidation and third party verification and confirmation.
- Information systems that can record and identify nurses and midwives current registration status and know when validation dates are due.

ASSESSMENT

The project steering group is set up to work with current staff in post as much as possible however the administration requirements, the co-ordination of the project, and the costs associated with potential systems to enable the process to be delivered have been costed.

July 2015 – Jan 2016	1 x band 5 project support	£19,394
July 2015 – Jan 2016	1 x band 3 HR support	£14,342
Oct 2015 – Dec 2015	Bank costs for backfill of staff needing to receive training	Minimal expected as new staff in post in August, aim for training in staff own time
July 2015 – Mar 2016	Non pay costs for communications, letters to registrants, training materials, travel to regional groups	Estimated £10 – 20K in submission to KPMG
Potential costs related to IT systems to support revalidation – to be explored through steering	Group access to continuous professional development CPD system with Nursing Times – provides on line	Potential to provide group access to staff which makes it cheaper for them, (if they chose to use it) and

group	modules for training, access to extensive journal library, provides dashboards for linking relevant CPD to areas requiring improvement i.e. Pressure ulcer care, falls medicines management, infection control.	enables the organisation to direct learning, have better oversight of CPD, and to be able to provide an enhancer for staff who work in this organisation.
	Systems to facilitate management of appraisal, CPD record, reflective practice, linked to organisational objectives	Approximate £30,000 quoted in initial discussion for one system, potential for negotiation and joining with wider island partners. Costings for other systems not yet considered

Risks identified

1. Risk of staff not being ready and dropping off register unintentionally – mitigation includes good awareness communication to all staff, additional support as each wave revalidates, project steering group monitoring the staff members and providing oversight to first wave to ensure process is set up and runs smoothly
2. Risk of not being able to deliver project in a timely manner – mitigation includes putting in reporting mechanism to Exec Director of Nursing and an assurance committee to enable escalation of project slippage.
3. Risk of poor delivery as whole process not yet fully understood. Mitigation includes linking with local groups and regional group to share learning.
4. Risk of poor delivery due to lack of capacity to deliver actions. Mitigation includes proposal for part time/WTE project lead to be established

NEXT STEPS

An implementation plan has been developed and a steering group is meeting to identify leads for elements of the process, and to continually assess any risks that may impact on implementation of revalidation and service delivery. These will be placed on risk register.

The plan includes the setting up and delivery of briefings and training sessions for all nurses, midwifes to make them fully aware of the scheme, the implications and their role in delivery.
The steering group will be ensuring staff have access to advice and support to help them meet revalidation particularly for those due to renewal in the early stages of implementation.

A business case will be developed to consider support for this project and potential funding streams are being sought

Engagement with the regional group will continue.

ALAN SHEWARD
EXECUTIVE DIRECTOR OF NURSING
JUNE 2015

Enc H

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 01 July 2015

Title	Quality Improvement Plan Update			
Sponsoring Executive Director	Alan Sheward – Executive Director of Nursing			
Author(s)	Patient Safety, Experience & Clinical Effectiveness Triumvirate			
Purpose	This paper is intended to update the Trust Board on the progress of the Trusts Quality Improvement Plan (QIP).			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	24 June 2015
Finance, Investment, Information & Workforce Committee		Foundation Trust Programme Board	
Please add any other committees below as needed			
Board Seminar			
Patient Safety, Experience & Clinical Effectiveness Committee	17 June 2015		
Other (please state)			

Staff, stakeholder, patient and public engagement:

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

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

Executive Summary:

This paper is to provide an update to the Trust Board on delivery of the Quality Improvement Plan (QIP), including the 102 actions required to be achieved, which was developed following the Care Quality Commission (CQC) Chief Inspector of Hospitals (CIH) Quality Summit in September 2014.

The Trust has agreed the new organisational Goals and priorities, along with the new quality priorities and these have now been linked to the 5 themes within the Quality Improvement Plan.

All enforcement actions are complete; 8 outstanding compliance actions, 7 of which will be completed by 30 September 2015 (1 action has an element relating to safer staffing – completion by 31 March 2016). There are also 4 outstanding 'must do' actions – 3 to be completed by 30 September 2015 and 1 by 31 March 2016. The 18 outstanding 'should do' actions will be completed by March 2016.

The report also highlights key risks and provides summary information within Appendix 1 providing further information against individual actions.

A new reporting matrix has been developed to provide an overview of performance against action specific key performance indicators (KPIs).

Monitoring by the Trust, Care Quality Commission and other external stakeholders is underway. Actions are managed through the weekly Quality Improvement Plan (QIP) meetings, Directorate Performance Reviews and also through the monthly Confirm and Challenge and Integrated Delivery Meetings (TDA) with key stakeholders. Reporting occurs weekly to the Trust Executive Committee (TEC) and to the Trust Board on a monthly basis, through the Quality & Clinical Performance Committee.

In addition, it is also discussed at the six weekly Patient Council meeting and the monthly staff Partnership Forum.

The Trust Board should confirm that the report provides sufficient assurance on progress or provide feedback on further requirements.

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

Date: 22 June 2015 **Completed by:** Theresa Gallard - Business Manager Patient Safety, Experience & Clinical Effectiveness

Isle of Wight NHS Trust

Nursing & Workforce Directorate
Patient Safety Experience & Clinical Effectiveness Team
Quality Improvement Plan Update
22 June 2015

1.0 EXECUTIVE SUMMARY

This paper is to provide an update to the Trust Board on delivery of the Quality Improvement Plan (QIP), including the 102 actions required to be achieved, which was developed following the Care Quality Commission (CQC) Chief Inspector of Hospitals (CIH) Quality Summit in September 2014.

The Trust has agreed the new organisational Goals and priorities, along with the new quality priorities and these have now been linked to the 5 themes within the Quality Improvement Plan.

All enforcement actions are complete; 8 outstanding compliance actions, 7 of which will be completed by 30 September 2015 (1 action has an element relating to safer staffing – completion by 31 March 2016). There are also 4 outstanding 'must do' actions – 3 to be completed by 30 September 2015 and 1 by 31 March 2016. The 18 outstanding 'should do' actions will be completed by March 2016.

Monitoring by the Trust, Care Quality Commission and other external stakeholders continues. Actions are managed through the weekly Quality Improvement Plan (QIP) meetings, Directorate Performance Reviews and also through the monthly Confirm and Challenge and Integrated Delivery Meetings (TDA) with key stakeholders. Reporting occurs weekly to the Trust Executive Committee (TEC) and to the Trust Board on a monthly basis, through the Quality & Clinical Performance Committee.

A new reporting matrix has been developed to provide an overview of performance against action specific key performance indicators (KPIs).

In addition, it is also discussed at the six weekly Patient Council meeting and the monthly staff Partnership Forum.

2.0 BACKGROUND

The Quality Improvement Plan was developed by clinical and corporate services following the Care Quality Commission (CQC) Chief Inspector of Hospitals (CIH) Quality Summit in September 2014. The inspection resulted in an overall rating of "Requires Improvement."

Following a detailed analysis of the 3 CQC reports covering Hospital & Ambulance, Mental Health and Community Services and the 4th overarching report, the Isle of Wight NHS Trust developed the QIP as a response to the concerns identified.

Duplication of actions across all the reports, were combined to form 102 overarching areas of concern, as follows:-

Action Type	Number of Actions
1. Enforcement	13
2. Compliance	38
3. Must do's	10
4. Should do's	41
Total	**102**

The QIP was approved at the Trust Board on 29th October 2014 following a more detailed discussion at the Trust board seminar on the 14th October 2014.

3.0 UPDATE ON PROGRESS

3.1 General

The Isle of Wight NHS Trust has made progress in responding to the Care Quality Reports (September 2014) and subsequent action plans. The development of a Quality Improvement Plan (QIP) describes the actions linked to themes and priorities for delivery.

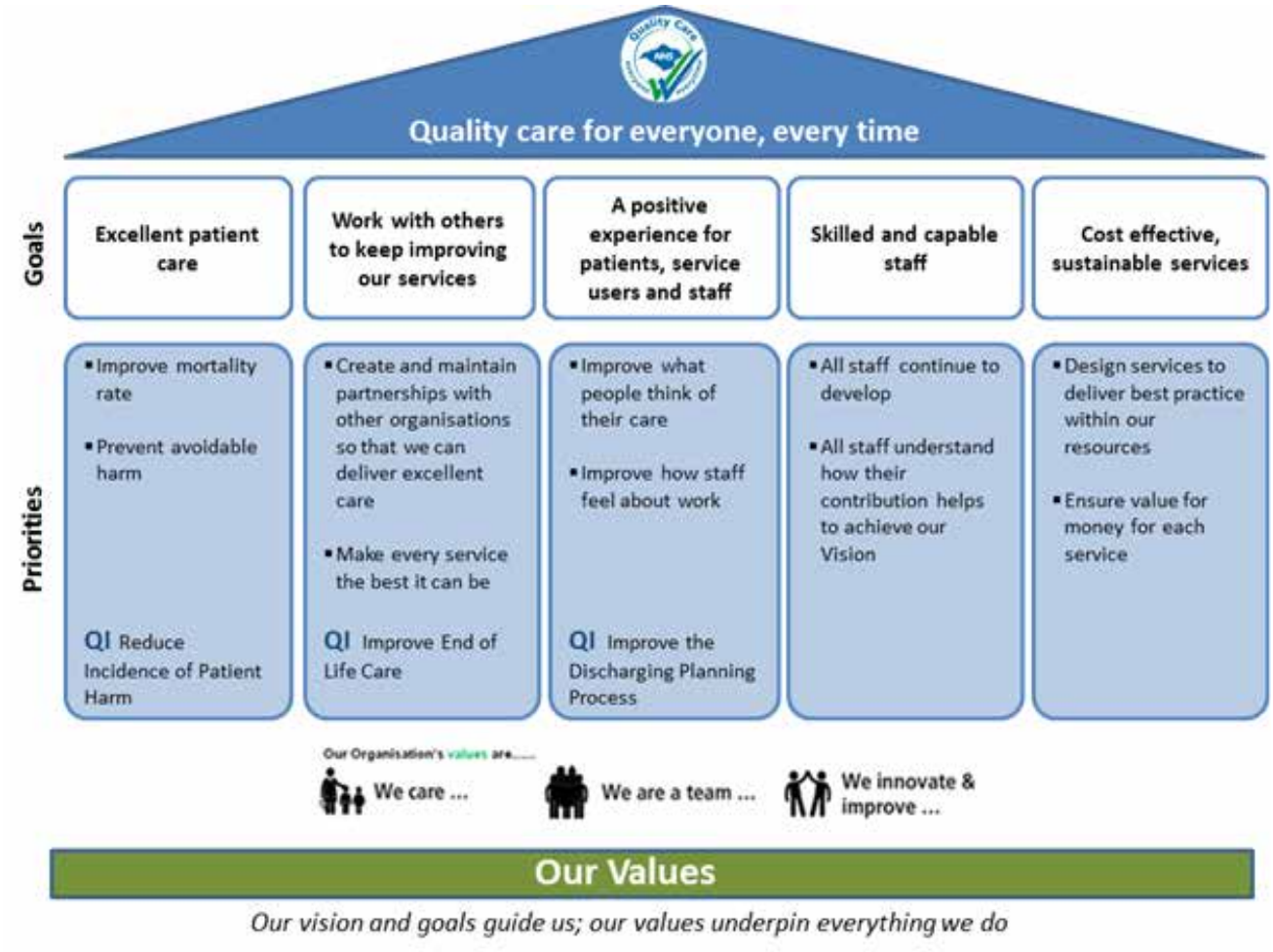
There is a clear programme of delivery to ensure the remaining actions are completed. The governance of monitoring and managing improvements against the QIP is clearly articulated in the QIP and this paper. These structures and committees will be used to provide assurance to the Trust Board.

3.2 Warning Notice

There remains 1 outstanding issue, which is a compliance action, relating to staffing on the Stroke and Rehabilitation Wards. Although this remains a key focus, the CQC were pleased with the progress made by the Trust and removed the warning notice in February 2015.

3.3 Quality Improvement Plan linked to Organisational Goals & Priorities

The Trust has developed new organisational goals and priorities that link to its overarching vision and the Trust Board has approved the new quality priorities on 1 April 2015. The relationship between them is demonstrated by the diagram below.



Key: QI = *Annual Quality Improvement Priorities agreed as part of the Trust's Quality Account*

Five clear themes emerged from the CQC report and they are linked to the organisational goals. The themes are set out below, with the assigned Executive Director leads:-

Theme	Relevant Trust Goals	Lead
1. Clinical leadership, staff engagement and culture	• A positive experience for patients, service users & staff. • Skilled & capable staff	Katie Gray
2. Governance	• Excellent patient care • Work with others to keep improving services • A positive experience for patients, service users & staff. • Skilled & capable staff • Cost effective, sustainable services	Mark Price
3. End of life care	• Excellent patient care • A positive experience for patients, service users & staff.	Mark Pugh
4. Recruitment and retention	• Skilled & capable staff	Jane Pound
5. Patient caseload and flow	• Excellent patient care • Work with others to keep improving services • A positive experience for patients, service users & staff.	Alan Sheward

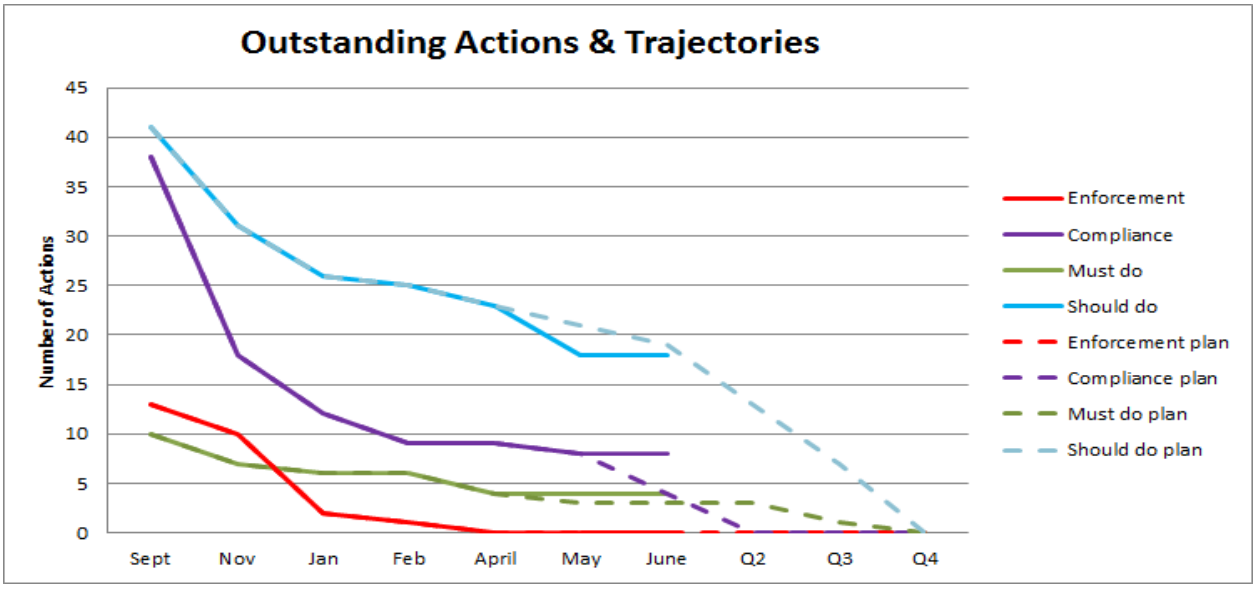
3.4 Delivery of Specific Actions in the QIP

The 102 specific actions from the CQC are set out below and the table outlines current performance of actions by priority order:-

Action Type	Number of Actions	Completed	Actions Outstanding
Enforcement	13	13	0
Compliance	38	30	8 (*1 outstanding from WN)
Must do's	10	6	4
Should do's	41	23	18
Total	**102**	**72**	**30**

*WN = Warning Notice (staffing on Community in-patient wards)

The chart below highlights the number of outstanding actions, by priority and also includes the Trust's timescale trajectory for full completion.



The chart above highlights that all enforcement actions are achieved and the should do actions are ahead of target. The 1 must do action that is behind plan relates to the requirement to ensure there is a lead nurse qualified in the care of children & sufficient registered (Children) nurses are employed to provide 1 per shift in Accident & Emergency (A&E), which was due for completion on 31 March 2015. To mitigate the risk of not having this role in place, Children's Ward continues to provide cover and there is now a designated Lead Paediatric Nurse in A&E.

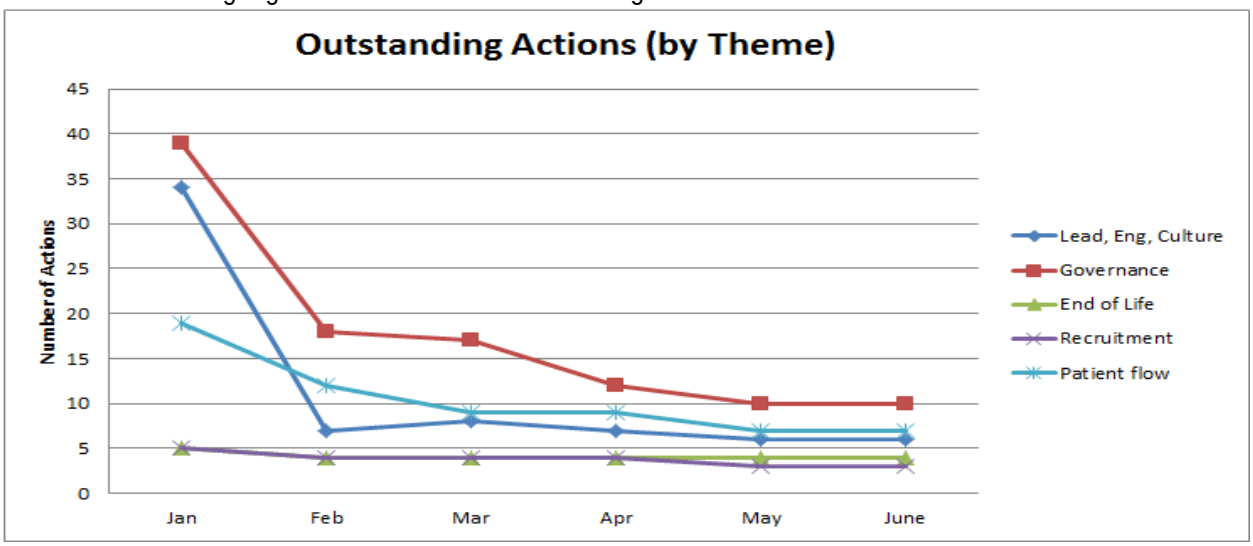
The compliance actions have now fallen behind trajectory due to the newly implemented monitoring of specific KPIs against each action. It has been agreed at the weekly Quality Improvement Plan (QIP) meetings that no further actions will be signed off as complete until there is ongoing evidence of progress made, demonstrated through the new reporting matrix – to allow time for the new reporting framework to become embedded. It is anticipated that this will be back on track by the next Trust Board report.

The table below outlines current performance of actions by theme:-

Theme	Number of Actions	Completed	Actions Outstanding
Clinical Leadership, Staff Engagement & Culture	34	28	6
Governance	39	29	10
End of Life	5	1	4
Recruitment & Retention	5	2	3 (*1 outstanding from WN)
Patient Caseload & flow	19	12	7
Total	**102**	**72**	**30**

*WN = Warning Notice (staffing on Community in-patient wards)

The chart below highlights the number of outstanding actions under the 5 themes.



3.5 Monitoring

Monitoring and challenge around progress continues via the weekly Quality Improvement Plan (QIP) meetings with Directorates and the monthly Confirm and Challenge meetings with key stakeholders.

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

A new reporting matrix has been developed to provide an overview of performance against action specific key performance indicators (KPIs); the latest data is outlined below:-

Compliance Actions Dashboard

As at 17/06/2015		Target	Previous Performance	Current Performance	Period
CA1.1	**Risk assessments not consistently completed**		R	A	
CA1.1a	90% compliance with Matrons weekly ward audit	90%	87%	90%	W/E 12/06/15
CA1.1b	100% of wards are compliant	100%	33%	45%	W/E 12/06/15
CA1.4	**Planning and delivery of End of Life Care**		N/A	G	
CA1.4a	Month on month increase for the use of the Priorities of Care Patient Pathway in cases where a patient death was expected	Increasing Trend	N/A	N/A	
CA1.4b	80% of appropriate clinical staff have completed End of Life Care training by 31 March 2016	80%	N/A	39%	May-15
CA1.4c	A quarterly improvement in the relative survey results for the questions relating to communication	Increasing Trend	N/A	N/A	
CA1.9	**Planning and delivery of care in order to meet individuals needs (Community inpatient)**		R	A	
CA1.9a	90% of patients have documented MFFR prior to transfer to the Rehab Unit	90%	60%	80%	W/E 12/06/15
CA1.9b	90% of patients reviewed had documented that they had received information about service offered to individual and family at or before start of programme	90%	40%	80%	W/E 12/06/15
CA1.9c	90% of patients reviewed had evidence of one standardised outcome measure applied in their care	90%	100%	80%	W/E 12/06/15
CA5.1	**Obtaining consent to display patients details (HAD)**		N/A	R	
CA5.1b	100% of patients have consent documented	100%	N/A	61%	W/E 05/06/15
CA5.1c	100% of patients have received information leaflet	100%	N/A	N/A	
CA6.1	**Treatment and decision to resuscitate not accurately recorded**		R	A	
CA6.1a	DNACPR & Escalation Status Form training to be included in all Adult Resus Mandatory Training Sessions	100%	100%	100%	W/E 12/06/15
CA6.1b	Weekly audit of 10 DNACPR forms - Valid Forms 100% required	100%	90%	80%	W/E 12/06/15
CA6.1c	Weekly audit of 10 DNACPR forms - Clear documentation of decision on DNACPR form	100%	100%	100%	W/E 12/06/15
CA6.1d	Weekly audit of 10 DNACPR forms - DNACPR decision documented in notes	100%	70%	80%	W/E 12/06/15
CA6.1e	Weekly audit of 10 Escalation Status Forms on MAU and CCU, 90% compliance required	90%	50%	40%	W/E 12/06/15
CA7.2	**Sufficient numbers and skill mix of medical and nursing staff (Community inpatient)**		G	G	
CA7.2a	90% of expected staffing level is achieved	90%	98%	98%	W/E 05/06/15
CA7.2b	At least one Junior Doctor available Monday to Friday 0900-1700 with on call cover out of hours	100%	100%	100%	W/E 29/05/15
CA7.2c	Skill mix is no lower than 50:50 (RN:HCA)	50:50	N/A	N/A	
CA7.2d	Supervisory Ward Manager is achieved 80% of the time (Monday - Friday)	80%	N/A	N/A	
CA7.2e	100% of all staffing incidents that are escalated have resulted in appropriate resolution/mitigation	100%	N/A	N/A	
CA7.2f	100% of all required Consultant ward rounds are undertaken	100%	N/A	N/A	
CA8.1	**Informed staff around MCA and DoLs**		N/A	A	
CA8.1a	100% of Band 7 & Band 6 Registered Nurses and Consultants trained in MCA/DoLs	100%	N/A	66%	W/E 12/06/15
CA8.1b	100% of inpatient occupational therapists trained in MCA/DoLs		100%	100%	W/E 12/06/15
CA8.1c	Increasing number of patients referred to DoLS co-ordinator	Increasing Trend	7	5	May-15
CA8.1e	100% of eligible staff undertaken End of Life Care online training.	80%	N/A	39%	May-15
CA8.1f	100% of eligble staff have undertaken Level 2 Adult Safeguarding	100%	N/A	N/A	

3.6 Assurance

Assurance on delivery of the required improvement is gained through the rigorous monitoring and testing programmes and provided to the Trust Board via the Quality & Clinical Performance Committee.

As part of the reporting against actions, completed actions are coded green by the Directorate. However, until appropriate evidence has been provided and testing has been undertaken, they are not deemed as finalised. Actions are coded blue once testing has taken place and endorses that the actions have been completed appropriately, at which point ongoing testing will be undertaken and actions revisited to provide continued assurance that actions are embedded and sustainable. Testing of all actions will now be further supported by monitoring the newly developed specific KPIs and reported via the new matrix. Should testing identify that an action has not been embedded or the evidence does not provide sufficient assurance, it will be re-coded red and the lead asked to revisit and provide additional evidence.

Directorate level monitoring is also undertaken through their Quality Risk & Patient Safety Committees.

The Patient Safety, Experience & Clinical Effectiveness Triumvirate continues to oversee the delivery of the QIP and undertake focused testing of completed actions; with the Patient Safety, Experience & Clinical Effectiveness (SEE) Committee monitoring delivery of the Quality Improvement Plan; providing regular updates to the Quality & Clinical Performance Committee (QCPC); who in turn continue to review detailed KPI progress provide assurance to the Trust Board so that they provide appropriate challenge around progress of delivery. The Trust Board is ultimately accountable for delivery.

Theme	Number of Actions	Tested to Date	Latest actions for completion	Plan
Enforcement Actions	13	4	All actions completed	All actions tested by 31 May 2015
Compliance Actions	38	13	30 September 2015	All actions tested by 31 October 2015
Must Do Actions	10	3	31 March 2016	9 actions tested by 31 December 2015 / 1 remaining action by 30 April 2016
Should do Actions	41	9	31 March 2016	All actions tested by 30 April 2016
Total	**102**	**29**		

The Trust continues to work closely with key stakeholders, for example Patients Council and Healthwatch, who undertake support visits to clinical areas to evidence appropriate outcomes achieved against relevant actions. It also continues to utilise support services, e.g. Performance Information Department, for the provision of quality performance data and utilises existing quality assurance and quality monitoring mechanisms; (e.g. through the local quality contract reporting processes. Quality Champions continue to play a key role in supporting our Quality Improvement Plan.

3.7 Key Risks

Of all the 8 outstanding compliance and 4 outstanding 'must do' actions, there are 4 that currently remain at risk:-

Action	Action Type	Theme
2 relating to staffing (one relating to Accident & Emergency (A&E) and one relating to the Community in-patient wards)	Compliance	Recruitment & Retention
Staff responsibilities under Mental Capacity Act (MCA) & Deprivation of Liberty Standards (DoLs)	Compliance	End of Life Care
Lead Nurse qualified in the care of children & 1 registered children nurse per shift in A&E	Must Do	Clinical Leadership, Staff Engagement & Culture

Further information relating to outstanding compliance and must do actions can be found in Appendix 1.

The CQC are aware of our concerns relating to the outstanding warning notice action and all of the above key risks will form part of the discussion at our next routine quarterly governance meeting with CQC representatives on 7 July 2015.

3.8 Next Steps

Delivery of the Quality Improvement Plan continues to be taken forward utilising the Programme Governance (PG) Framework, with a workstream linked to each theme. The new monitoring form outlining specific KPIs for each of the outstanding individual actions within the QIP has been completed for each of the compliance actions. These are now being completed for the remaining must do and should do actions. KPIs are also being developed in this format for the already completed enforcement actions, to enable continued testing in order to evidence sustainability and embeddedness. Monitoring of all the specific KPIs will be incorporated into the new matrix.

4.0 RECOMMENDATIONS

1. The Board is asked to receive the report and supporting evidence
2. The Board confirms the report provides the required assurance
3. The Board identifies areas where assurance has not been achieved, requesting Executive and Non Executive Leads to undertake additional work
4. The Board seeks assurance from the Chair of the Quality and Clinical Performance Committee (QCPC) that detailed assessment of progress is achieving the required assurance.

ALAN SHEWARD
EXECUTIVE DIRECTOR OF NURSING

Dr Sandya Theminimulle
Lead for Patient Safety, Experience & Clinical Effectiveness

Deborah Matthews
Lead for Patient Safety, Experience & Clinical Effectiveness

Theresa Gallard
Business Manager for Patient Safety, Experience & Clinical Effectiveness

22 June 2015

APPENDIX 1: Outstanding Compliance & Must Do Actions

KEY: Actions = key risks

Outstanding Compliance Actions (22 June 2015)								
Action & Report	**Directorate**	**Linked to Theme**	**Area of Concern**	**Actions Required**	**To be completed by:**	**Exec Lead**	**Lead**	**Supporting Evidence**
CA1.1 CA1.7 MD7 (AcS)	Hospital	CL	Risk assessments were not consistently completed in their entirety to inform the plan of care. (This related to nursing assessments however , going forward we need to also include risk assessments within Medical clerking)	- Appropriate risk assessments must be completed on every patient (at the required frequency on admission and then at least weekly – but more frequently where clinically indicated). - Example: Use of bed rails are consistently risk assessed and patient consent obtained for their use	30/06/15	Exec Director of Nursing & Workforce	Matron (TC)	**Evidence** Overall compliance rate of 90% as at 18 June achieved, although only 6 out of 11 wards either failed to reach the target or failed to submit an audit.
CA1.4 (AcS)	Hospital	EoL	The planning and delivery of End of Life Care (EoLC) did not meet national standards	- Aim to implement key recommendations from the National Care of the Dying Audit for Hospitals (May 14) - Complete review of commissioning in relation to EoLC - Agree (Hospital) End of Life Care Strategy which reflects seamless transition from and to primary & secondary care - Provide Education on National Guidance and Best Practice - roll out necessary supporting education & training through Trust	30/06/15	Exec Medical Director	EoLC Lead Nurse JH	**Comments** Update provided to QCPC who were positively assured on progress being made in relation to improving End of Life care. The End of Life Policy was approved at Policy Management Group 19.5.15. **Evidence** Education & training attendance records for the End of Life Champions show staff from all wards have Champions that have attended, with the exception of 4 wards, and 1 locality. Further dates are being offered so the remaining wards can attend. Education & training report relating to End of Life Care e-learning training module identifies 547 members of staff have now completed the training.
CA1.9 (CS)	Community	GOV	Planning & delivery of care & treatment in order to meet service user's individual needs,	- Undertake review and gap analysis of current care/service - Develop plans for service redesign and	30/06/15	Exec Medical Director	Consultant Physician - Care of the	**Evidence** Significant improvement noted in month with an 80% performance

			ensure their welfare and safety & reflect published evidence & guidance	implement			Elderly	across all KPIs related to this action.
CA5.1 MD28 (TW)	Trust Wide	GOV	Suitable arrangements were not in place for obtaining the consent of service users to display their details on a computerised screen in reception area of the wards.	- Review of Patient Status at a Glance Boards (PSAG) - Incorporate obtaining consent as part of admission process (documented verbal or written consent in the nursing assessment) - Ensure the protocol for dealing with patients who decline to have information displayed is being followed - Information Leaflet for Patients to be implemented - The use of Ward Boards to display why this information is important	30/06/15	Exec Director of Nursing & Workforce	Head of Clinical Services HAD	**Comments** Evidence is in patient notes, checked as part of the documentation audit. PSAG consent is part of the Stroke Care Pathway. Stickers to include PSAG consent will be on the stickers to be placed in the diary and updated daily. Stickers have been requested from print room **Evidence** It has been identified that this consent question is not being asked through the elective pathway and is being addressed immediately with the use of the sticker in the notes. It remains an issue in not being able to remove a patients name from the PSAG board if they decline to consent to its display. This is also being addressed.
CA6.1 MD6 (TW)	Trust Wide	EoL	Decisions relating to resuscitation were not being accurately recorded & reviewed to ensure they were kept current (DNACPR)	- Training on areas of non-compliance with policy will be put in place - Develop escalation plan to improve communication and documentation - Monthly audit of compliance	30/06/15	Exec Medical Director	Senior Resuscitation Officer	**Evidence** Excellent progress against the majority of the KPIs linked to this action. Further work is progressing to achieve compliance with the use of the Escalation Forms in MAU and CCU
CA7.1 MD13 MD18 (AcS)	Hospital	R&R	Patients cannot be assured that at all times there are sufficient numbers of suitably qualified, skilled & experienced staff employed to carry on the regulated activity in A & E & on the Stroke Unit	- Daily safer staffing report template to be developed - Rota management policy to be revised - Review of Band 6 requirements - Recruitment underway for existing vacancies	30/06/15	Exec Director of Nursing & Workforce	Deputy Director of Nursing	**Comments** Have achieved compliance with 90% for RN staffing requirements for 2 consecutive weeks, recruitment challenges remain and issue. ***This is a key risk***
CA7.2 MD18 **WN** (CS)	Community	R&R	There was insufficient medical & nursing staffing for the community inpatient wards, both numbers and skill mix	- Monitor and display daily staffing levels - Report and escalated when actual levels do not meet planned. - Mitigate risk through the re-deployment of staff for other areas (negotiated through	31/03/15 *(Safer Staffing*	Exec Medical Director	Matron – Community Wards	**Comments** Currently sustaining the greater than 90% expected medical and nurse staffing levels, despite the intermittent requirement to open the

			Declared Non Compliance to CQC 12.12.14 – to be resolved by 31.3.15	Matron of the Day responsible for Staffing in the Operational Hub) - Recruit to current vacancies, manage sickness absence, etc. to get to establishment (Safe Staffing) - Plan to recruit to Safer Staffing levels - Review of medical workforce requirements with high level recommendations - Monitor, manage and mitigate the risks associated with medical staff shortages as above.	*31/03/16)*			addition 4 beds. ***This is a key risk – outstanding from the warning notice***
CA8.1 MD4 MD5 SD35 (AcS)	Hospital	EoL	MCA & DoL Staff were not fully informed of their responsibilities under the Mental Capacity Act (MCA) 2005 – ensure staff trained in Deprivation of Liberty Safeguards (DoL's) & MCA EoL Staff were not fully informed of their responsibilities in the recognition of people at the start of the end of life journey, or how to support people through the use of tools designed to support EoLC)	MCA & DoL - Ensure MCA training delivered to relevant staff - Ensure DoL referrals where required are being made - Report monthly completion of MCA/DoL's assessment (to be added to performance report) EoL - Introduce Amber Care Bundle to MAU - Hospital Palliative Care Team to review admissions to MAU for support	30/06/15	Executive Director of Nursing	Head of Clinical Services – HAD	**Evidence** This remains a challenge. DoLs referral levels are still low and to aid the monitoring and managing of this, the weekly data is now to be provided by ward submission. ***This is a key risk***

Outstanding Must do Actions (22 June 2015)								
Action & Report	**Directorate**	**Linked to Theme**	**Area of Concern**	**Actions Required**	**To be completed by:**	**Exec Lead**	**Lead**	**Supporting Evidence / Comments**
MD1 (TW)	Trust Wide	CL	The clinical leadership of services must improve & there must be operational support & coordination to cope with service demands & to manage effective integration	- Engagement with Aston OD/Kings Fund for development of collective leadership strategy and involvement in implementation of Michael West research - Development of Leadership competency profiles in collaboration with the MLAFL workforce development team and 'Talent Works' - Development & Training to provide Clinical	31/03/15	Exec Director of Trans-formation & Integration	Associate Director of Medical Education	**Comments** Board Development session focussing on 'collaborative leadership' on 10 March Work starting with TalentWorks with interviews and focus groups discussing behaviours around leadership, building on our existing vision, values and behaviours. This work will focus on 4 levels of

				Leadership Sessions				leadership, and will feed into the development of leadership behaviour competency profiles and leadership and management skills profiles.
MD2 (TW)	Trust Wide	CL	Staff engagement should be effective, so that service changes & developments are owned & effectively implemented, to reduce risks to patients & people that use services	- Continue roll out of Listening into Action - Quality Champions – induct new champions to increase the team - Implementation of the Communications and Engagement Strategy - Undertake development events for 'Managing the effects of change' and 'successfully implementing change - Roll out a series of Innovation café sessions -	31/03/15	Exec Director of Trans-formation & Integration	Deputy Director of Organisational Development	2nd LiA Pulse check results (Early indications show an improvement in 9 out of the 15 questions asked) Yearly Staff survey collaborative groups project documentation on shared K drive - Monthly updates Staff feedback - uploaded onto Intranet - Monthly updates Quality Champions feedback sessions - monthly Family & Friends Test - Quarterly NHS staff survey - Annual
MD11 (AcS)	Hospital	CL	Ensure there is a lead nurse qualified in the care of children & sufficient registered (Children) nurses are employed to provide 1 per shift in A&E	- Ward Manager to review template on MAPS & create rule for skill on each shift (liaising with roster team) - Create rota to allow for department training needs & maintenance of general paediatric nursing competencies - Recruitment of Paediatric Nurse	31/03/15	Exec Director of Nursing & Workforce	Matron – MAAU / A&E	30/4/15 Advised that ED have recently interviewed but no update with regards to outcome yet. Paediatric dept have also interviewed and recruited 2.6 WTE (one due to start beginning of June 15 and the rest by September 15) but that still leaves 1.8 wte vacancy and staff due to be on maternity leave shortly. Supported ED every night will not be possible until recruitment completed. ***This is a key risk***
MD30	Trust Wide	EoL	The trust must update the DNA CPR policy & ensure wards audit their adherence to this policy	- Policy to be reviewed & updated - Develop Audit tool to audit adherence to DNA CPR policy	31/05/15	Exec Medical Director	Senior Resus Officer	Audit tool developed and in use. DNACPR policy current until December this year, work has now commenced on reviewing this policy and development of a Trust policy as the current policy was regional implemented by the now non-existent SHA.

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1st July 2015

Title	Trust response to Kate Lampard's Assurance Report into matters relating to Jimmy Savile			
Sponsoring Executive Director	Executive Director of Nursing			
Author(s)	Alan Sheward – Executive Director of Nursing			
Purpose	The publication of the report from barrister Kate Lampard in February 2015 entitled; Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile, has highlighted **14** recommendations. This report clarifies the Isle of Wight NHS Trust response to the recommendations.			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee	1st June 2015	Mental Health Act Scrutiny Committee	N/A
Audit and Corporate Risk Committee	N/A	Remuneration & Nominations Committee	N/A
Charitable Funds Committee	Emailed approval 23rd June 2015 ratifcation on 8th Sept 15	Quality & Clinical Performance Committee	27th May 2015
Finance, Investment, Information & Workforce Committee	23rd June 2015	Foundation Trust Programme Board	N/A
Please add any other committees below as needed			
Joint Safeguarding Steering Group	May 2015		
Trust Board Part 2	3rd June 15		
Other (please state)			

Staff, stakeholder, patient and public engagement:

Local Safeguarding Children's Board (LSCB) – July 2015

Local Safeguarding Adults Board (LSAB) June - 2015

Executive Summary:

This paper gives a position statement at IOW NHS Trust in response to the recommendations from the recently published "lessons learnt" report by Kate Lampard associated with Jimmy Savile.

The report shows that the level of access, coupled with a scant regard to the processes designed to protect patients led to an opportunity for him to commit sustained and

widespread abuse of some of the most vulnerable people whilst in a care setting. The recommendations will apply throughout the NHS and also include recommendations for the Department of Health, NHS England, Monitor and the Trust Development Authority as well as individual organisations. These will ensure that systems are robust within organisations in terms of safeguarding patients and further recommend that any voluntary services or fund raising has strict governance processes in place.

The Board is invited to agree the action plan following a meeting with the Director of Nursing and the Head of HR to provide assurance following these recommendations.

The Charitable Funds Committee has reviewed their protocols and strategies and inserted an additional section on Procedures for Major Donors, VIPs and/or Celebraties which are to be made available on the Charitiable Funds website page which is available via the Trust's website. The deadline of the 1st July 2015 has been met.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	1. Excellent Patient Care 2. A positive experience for patients, service users and staff.					
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	CQC Fundamental Standard - *You must not suffer any form of abuse or improper treatment while receiving care.* *The provider of your care must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.*					

Date: 21st June 2015 Completed by: A W Sheward, Executive Director of Nursing

Isle of Wight NHS Trust

Isle of Wight NHS Trust
Director of Nursing
Trust response to Kate Lampard's Assurance Report into matters relating to Jimmy Savile
May 2015

TRUST BOARD MEETING 3rd June 2015

A paper prepared by Alan Sheward, Executive Director of Nursing and presented by Alan Sheward – Executive Director of Nursing

EXECUTIVE SUMMARY

The publication of the report from barrister Kate Lampard in February 2015 entitled; Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile, has highlighted **14** recommendations in an attempt to prevent a reoccurrence of the criminal activities of Jimmy Savile over a period of over 40 years.

The report states, `*Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissistic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and relevance for the NHS today.'*

The report shows that the level of access, coupled with a scant regard to the processes designed to protect patients led to an opportunity for him to commit sustained and widespread abuse of some of the most vulnerable people whilst in a care setting. The recommendations will apply throughout the NHS and also include recommendations for the Department of Health, NHS England, Monitor and the Trust Development Authority as well as individual organisations. These will ensure that systems are robust within organisations in terms of safeguarding patients and further recommend that any voluntary services or fund raising has strict governance processes in place.
The Board are invited to agree the action plan following a meeting with the Director of Nursing and the Head of HR to provide assurance following these recommendations.

This paper gives a position statement at IOW NHS Trust in response to the recommendations from the recently published "lessons learnt" report by Kate Lampard associated with Jimmy Savile.

BACKGROUND

Following the death of Jimmy Savile and the subsequent allegations of his wrong doing at NHS organisations, the Department of Health launched an inquiry into his activities across the NHS. This resulted in the publication of a total of 44 reports being published following investigations triggered by this exercise.

The Savile case covers the time periods from 1954 to 2011 and has involved allegations and proven incidences of abuse by Savile at 41 acute hospitals, five mental health trusts, two children's hospitals, and other care settings.

In October 2012, the Secretary of State for Health asked former barrister Kate Lampard to produce an independent report on 'lessons learned', drawing on the findings from all published investigations and emerging themes. This report was published in March 2015 and included 14 recommendations for the NHS, the Department of Health (DH) and wider government.

The Secretary of State for Health has accepted 13 of the recommendations, 10 of which apply to NHS Trust and Foundation Trusts. The Secretary of State did not accept recommendation 6 on Disclosure and Barring checks.

The Trust Development Authority have written to all Chief Executives of NHS Trusts and instructed that by Monday 15th June 2015 the recommendations have been reviewed and implemented within their organisations.

ASSESSMENT

This paper gives the Trust Board a first status of IOW NHS Trust compliance against the recommendations (Table 1). The table below gives a summarised RAG rating against each recommendation with a detailed action plan as required by the Trust Development Authority (TDA) cited within Appendix 1, to move IOW NHS Trust to a position of compliance.

Table 1

Recommendation	Compliance Status against recommendation.
R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.	
R2 All NHS trusts should review their voluntary services arrangements and ensure that: • they are fit for purpose; • volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and • all voluntary services managers have development opportunities and are properly supported.	
R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice.	External Action
R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.	
R5 All NHS hospital trusts should undertake regular reviews of: • their safeguarding resources, structures and processes (including their training programmes); and	

• the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.	
R6 The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.	**NOTE** - **Cost, value and legality of such an arrangement, which is not currently supported by NHS Employers in any event. The Secretary of State has not accepted this as a recommendation.**
R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	
R8 The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service.	External Action
R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	
R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	
R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	
R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.	
R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.	External Action

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.	External Action

RECOMMENDATIONS

The Trust Board are asked to;

1. Note the position of IOW NHS Trust at this time and review the completed recommendations at a future date reporting back to the Trust board via the Quality and Clinical Performance Sub Committee (QCPC).
2. Agree the actions being taken to move to positive assurance against the whole of the recommendations (except Recommendation 6 & 7)
3. Acknowledge those recommendations where only limited assurance has been provided.
4. Note - the implications around non-compliance to these recommendations are associated with our duty to safeguard the patients that we serve from such occurrences as described within the report.
5. Note the deadlines for completion exist beyond the required deadline outlined in the letter from NHS TDA dated 11th March 2015 with the latest action due 31st August 2015

Alan Sheward
Executive Director of Nursing
20th may 2015

Appendix 1: REPORT ON TRUST PROGRESS IN RESPONSE TO KATE LAMPARD'S LESSONS LEARNT REPORT

Name of Trust – Isle of Wight NHS Trust

Recommendation	IOW NHS Trust Lead	Assurance of Evidence	Issue identified	Planned Action	Progress to date	Due for completion
1. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.	Executive Medical Director / Associate Director of Health & Safety	**Positive Assurance -** Guidance on Visits by VIP's and Celebrities ratified October 2014	None			
2. All NHS trusts should review their voluntary services arrangements and ensure that: • They are fit for purpose	Interim Director of Workforce					
		Positive Assurance - Volunteer Policy Approved June 2013. It details a clear process for the recruitment, selection and training of volunteers. -Training of volunteers is also addressed in the Trust	No Issues Identified			
• Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and,			No issues Identified			

Recommendation	IOW NHS Trust Lead	Assurance of Evidence	Issue identified	Planned Action	Progress to date	Due for completion
• All voluntary services managers have development opportunities and are properly supported.		mandatory training policy. -Volunteer Coordinator has support through line management structure and has access to peer networks for support and development.	Peer support mechanism to be confirmed	Confirm local support networks	Communication to be developed by HR lead.	01 June 2015
I. All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.	Interim Director of Workforce / Executive Director of Nursing	**Limited Assurance -** Substantive staff Safeguarding Training captured on trust Training Tracker. There is **NO** system in place for Volunteers to confirm safeguarding training.	Volunteers are currently unable to access the e-learning modules for safeguarding and there is no mechanism currently for refresher training.	Need to create the ability for volunteers to access safeguarding training	Senior HR Manager to progress in conjunction with AD OD	1st June 2015

Recommendation	IOW NHS Trust Lead	Assurance of Evidence	Issue identified	Planned Action	Progress to date	Due for completion
II. All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes (including their training programmes); and,	Executive Director of Nursing	**Positive Assurance -** Review of Paediatric Safeguarding Team undertaken 2014 with outcomes reviewed. Adult Safeguarding Team reviewed in 2015 with planned investment.	No Issue Identified	No Action planned	N/A	N/A
• The behaviours and responsiveness of management and staff in relation to safeguarding issues.		**Positive Assurance -** Audit & Scrutiny of all safeguarding cases via the Trust Safeguarding Steering Group. -Evidence of additional investigations where concerns raised on Safeguarding outcomes.	No Issue Identified	No Action planned	N/A	N/A

Recommendation	IOW NHS Trust Lead	Assurance of Evidence	Issue identified	Planned Action	Progress to date	Due for completion
• to ensure that their arrangements are robust and operate as effectively as possible.		**Positive Assurance -** See above	No Issue Identified	No Action planned	N/A	N/A
III. All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	Interim Director of Workforce **(Recommendation not upheld – Local agreement required)**	**Limited Assurance -** Assurance via recruitment audit that DBS checks performed on appointment. DBS repeated for changes in role but not location. Further risk assessment required.	We do not currently carry out re-checks every 3 years. There will be considerable cost implications to the organisation of rechecking. Need to consider how we might recheck Bank Workers.	Determine number of posts which require checks and estimate cost of rechecks every 3 years.	Senior HR Manager to cost in conjunction with Finance and present to TEC for consideration and decision	1/7/15
IV. All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and	Executive Director of Transformation & Integration	**Positive Assurance –** Policy is currently moving through Trust Governance processes.	No policy in place. The practicalities of the Trust being able to restrict or manage patient and visitor access to the internet and social media are questionable without the Trust completely banning access to personal mobile phones when patients enter Trust premises.	Policy to be drafted by Communications Team, consulted on and agreed	Draft policy being reviewed and progressing through consultative groups	27/07/2015

Recommendation	IOW NHS Trust Lead	Assurance of Evidence	Issue identified	Planned Action	Progress to date	Due for completion
Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.						
V. All NHS hospital trusts should ensure that arrangements and processed for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	Interim Director of Workforce	**Positive Assurance –** Recent audit of Recruitment processes for Substantive and Volunteer staff identified positive assurance.	Use of contractors – this should be addressed through the contracting/procurement teams . Agency staff are procured through approved framework agencies who are all required to comply with NHS Employment Check standards. Where agency staff are procured from non-framework agencies, procurement secure an SLA to ensure that all requirements are met.	1. Confirmation from SOE Procurement services that Frameworks that are in place are explicit. 2. SOP to be in place where off framework organisations engaged	Senior HR Manager to confirm (1) and (2)	1/6/15

Recommendation	IOW NHS Trust Lead	Assurance of Evidence	Issue identified	Planned Action	Progress to date	Due for completion
VI. NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	Jane Pound	**Positive Assurance –** Workforce sits with Director Lead reporting to Trust Board via Board Sub Committee. Recent Internal Audit report identified positive assurance.	All pre-employment checking is carried out by HR in a centralised process. The Executive Director with responsibility for HR takes overall responsibility for these matters.	Executive Director / Director with HR in portfolio to be assured	Deputy Director of Workforce to assure as required	1/6/15
VII. NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers	Chair of the Charitable Trustees Committee Non _Executive Director.	**Limited Assurance -** The Trusts Charity works under the 2006 NHS Act.	Confirmation required on Governance surrounding local charities that sit under the Umbrella of the Trusts Charitable Funds Committee (CFC).	Confirm MOU with “Friends of St Marys -Confirm governance for individual charities that report into Trust Charitable Funds Committee (CFC)	Agenda item on next CFC meeting.	01 July 2015

Recommendation	IOW NHS Trust Lead	Assurance of Evidence	Issue identified	Planned Action	Progress to date	Due for completion
adequately reflect this.						
I confirm that this Trust Board has reviewed the full recommendations in Kate Lampard's lessons learnt report: SIGNED: DATE: 20th May 2015 CE NAME: Karen Baker – Chief Executive Officer						

Return to Natalie Dixon, Senior Policy Advisor, NHS TDA – Natalie.Dixon7@nhs.net

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1st JULY 2015

Title	Histopathology Review			
Sponsoring Executive Director	Dr Mark Pugh, Executive Medical Director			
Author(s)	Dr Mark Pugh, Executive Medical Director			
Purpose	For Assurance			
Action required by the Board:	**Receive**	X	**Approve**	

Previously considered by (state date):			
Trust Executive Committee	various	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment, Information & Workforce Committee		Foundation Trust Programme Board	
Please add any other committees below as needed			
Board Part 2	03/06/15		
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

This high level report, describes the background, investigation and clinical outcome for patients of an incident of a missed diagnosis of melanoma.

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

Date: 22 June 15 **Completed by:** Dr Mark Pugh, Executive Medical Director

Conclusion of a review into the reporting of specimen slides of skin conditions

The Trust has concluded an investigation into the reporting of skin specimen slides by a temporary member of staff who worked at St. Mary's between 10th December 2012 and 4th June 2014. In November 2014 an alert was raised following the treatment of a case where early skin cancer had been missed on an initial skin biopsy.

The Trust immediately commissioned an external review of all 260 similar skin biopsy cases reported by the individual and in 4 similar cases the doctor had missed the earliest signs of cancer in a specific form of skin cancer. This required us to recall the patients to have further surgery to remove a small extra piece of skin to complete treatment. All these patients have been treated under fast track arrangements and are currently being followed up.

The matter was discussed with The Royal College of Pathologists (www.rcpath.org/) whose opinion was that there was no evidence of a global problem with this doctor's reporting but that they had an issue with one type of skin cancer.

The Trust has been in touch with the doctor concerned and they are working through this matter with their current employer. The Trusts the doctor works for now and previously have undertaken their own reviews of their work and have not found any issue of concern. We have also undertaken a wider review of all the doctor's work and have not found any other matters of concern.

Since this incident the Pathology Laboratory have employed another full time member of staff which means we do not need to employ temporary doctors and there are plans to further expand the number of pathologists.

The laboratory is fully accredited under a national quality process Clinical Pathology Accreditation (CPA) (www.ukas.com/services/CPA/Clinical_Pathology_Accreditation_CPA.asp).

I want to apologise on behalf of the Trust to the patients who rightly were concerned about this change in their diagnosis and treatment. We have provided them with support and they will be subject to further review to ensure that no further signs of cancer develop.

Arrangements are in place for the handling of calls from those who may have concerns following this incident. A copy of the press statement issued to Isle of Wight County Press on 18th June and other media is attached.

Dr Mark Pugh
Executive Medical Director

Isle of Wight NHS Trust

Press Statement

18th June 2015

Trust has reviewed diagnosis for some patients

Isle of Wight NHS Trust has reviewed the diagnosis and treatment of a small number of patients with skin lesions who were treated by the Trust between 10th December 2012 and 4th June 2014.

During the on-going treatment of a patient with a skin growth it became apparent that a report that described the growth as non-cancerous skin growth was wrong. The patient involved has had further treatment and is currently under on-going review.

Isle of Wight Trust was first alerted to a problem on 13/11/14. The error occurred because the original locum pathologist's report, following a biopsy of a small sample of the growth, reported incorrectly that the biopsy showed no sign of cancer. On further review this biopsy did show signs of cancer. The Trust arranged for an external review to be undertaken.

The external review of all 260 similar cases reported by the doctor when they worked for us between 10th December 2012 and 4th June 2014 was completed on 9th February 2015. In total the external review identified another 3 patients in whom the original diagnosis was reported as benign but on review they are now reported as showing signs of early cancer. These patients have been contacted and further treatment undertaken. All four patients involved will be subject to further reviews to check that there are no signs of any further developments. All four have received an apology from the Trust.

The full report from the external review has been discussed with The Royal College of Pathologists who have advised that no further action is required. Past and subsequent UK employers of the locum Pathologist were contacted and the Trust understands that following review by those organisations no other concerns have been raised. However the pathologist concerned, who no longer works for Isle of Wight NHS Trust, has been provided with a package of training and support by their current employer to ensure that their reporting of this specific type of biopsy is up to the standard required by the Royal College of Pathologists. A report on the review is being made to the Trust's Board meeting on 1st July 2015.

Isle of Wight NHS Trust Executive Medical Director, Dr Mark Pugh, comments: "I want to reassure patients and the public that we take patient safety very seriously. We sought immediate advice when this issue was brought to our attention and have taken swift action to ensure that as soon as this small group of patients were identified we spoke to them and arranged for their treatment to be reviewed. I want to apologise on behalf of the Trust to the patients who rightly were concerned about this change in their diagnosis and treatment. We have provided them with support and fast tracked their treatment. They will be subject to

further review to ensure that no further signs of cancer develop."

The majority of services provided by Isle of Wight NHS Trust are commissioned and funded by Isle of Wight Clinical Commissioning Group (CCG), NHS England and Isle of Wight Council.

Notes for Editors

For further information contact the Isle of Wight NHS Trust Corporate Communications & Engagement Team on 01983-552003. Further information about health services can be found at www.iow.nhs.uk or www.nhs.uk.

What is a skin cancer?

Skin cancer is the most common cancer in the UK. Around 100,000 cases are diagnosed each year. Skin cancers are divided into:

- **Melanoma (malignant melanoma)**. This type of skin cancer develops from melanocytes.
- **Non-melanoma.** These are about 20 times more common than melanomas. These are divided into:
- **Basal cell carcinoma (BCC)** - skin cancer which develops from basal cells.
- **Squamous cell carcinoma (SCC)** - skin cancer which develops from keratinocytes.
- **Other** - other types of skin cancer, which are rare.

A malignant tumour is a growth of tissue made up from cancer cells which continue to multiply. Malignant tumours can invade into nearby tissues and cause damage. Most types of malignant tumour also tend to spread (metastasise) to other parts of the body. Melanoma skin cancer has a high risk of spread. However, it is very rare for a BCC to spread, and uncommon with an SCC.

The best way to prevent all types of skin cancer is to avoid overexposure to the sun.

A few minutes in the sun can help maintain healthy levels of vitamin D, which is essential for healthy bones, but it's important to avoid getting sunburn.

Once you are burnt, the damage has already been done to your skin, as it has received a dangerous level of radiation. Every time the skin is exposed to radiation, this increases the chance of a cancer occurring, possibly many years in the future.

For more information visit www.nhs.uk or www.patient.co.uk.

[ENDS]

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

July 2015

Title	Serious Incidents Requiring Investigation (SIRI) Report				
Sponsoring Executive Director	Alan Sheward, Executive Director of Nursing				
Author(s)	Deborah Matthews, Interim Lead for Patient Safety, Experience & Clinical effectiveness (SEE)				
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	24 June 2015
Finance, Investment, Information & Workforce Committee		Foundation Trust Programme Board	
Please add any other committees below as needed			
Board Seminar			
Patient Safety, Experience & Clinical Effectiveness Committee (SEE)	17 June 2015		
Other (please state)			

Staff, stakeholder, patient and public engagement:

Lessons learned are shared with teams after analysis is completed

Executive Summary:

This report provides an overview of the 54Serious Incidents reported during April 2015, as well as identifying the lessons learnt from 12 SIRIs recently closed by the CCG.

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 – e.g. 1.1; 1.6)***	2.6					
Assurance Level ***(shown on BAF)***	Red		Amber	P	Green	
Legal implications, regulatory and consultation requirements						

Date: 19 June 2015 **Completed by:** Deborah Matthews, Interim Lead for SEE

Isle of Wight NHS Trust

Serious Incident Requiring Investigation (SIRI) Activity Report
(May 2015 data)

What is a Serious Incident?

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. *(ref: Serious incident Framework April 2015)*

Serious Incident Framework

A revised Serious Incident Framework has recently been published by NHS England, to be implemented from 01 April 2015. NHS England has also published a revised Never Events Policy; both these documents can be found using the following link:
http://intranet/index.asp?record=1675

This revised framework explains the responsibilities and actions for dealing with Serious Incidents and the tools available. It outlines the process and procedures to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

Two key operational changes have been made:

1. Removal of grading – it was found that incidents were often graded without clear rationale. This causes debate and disagreement and can ultimately lead to incidents being managed and reviewed in an inconsistent and disproportionate manner. Under the new framework serious incidents are not defined by grade - all incidents meeting the threshold of a serious incident must be investigated and reviewed according to principles set out in the Framework.
2. Timescale –a single timeframe (60 working days) has been agreed for the completion of investigation reports. This will allow providers and commissioners to monitor progress in a more consistent way. This also provides clarity for patients and families in relation to completion dates for investigations.

(1) **NEW INCIDENTS REPORTED AS SIRIs**: During May 2015 the Trust reported **4** Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG). Below is a summary of these incidents:

· UNEXPECTED DEATH

Under whose care	Summary	Date reported as SIRI:	Date to finalise with Commissioners:
General Surgery	Unexpected death	21.05.15	14.08.15

· SLIP, TRIP, FALL

Under whose care	Summary	Date reported as SIRI:	Date to finalise with Commissioners:
Colwell ward	Patient fall; fractured neck of femur	12.05.15	05.08.15
Whippingham ward	Patient fall; fractured neck of femur	20.05.15	13.08.15

· EQUIPMENT FAILURE

Under whose care	Summary	Date reported as SIRI:	Date to finalise with Commissioners:
Main Theatre	Equipment broke during procedure	18.05.15	11.08.15

(2) **CURRENT POSITION:** This table provides the current status of open SIRIs as of 10 June 2015

SIRIs	COMMUNITY & MENTAL HEALTH	HOSPITAL & AMBULANCE	OTHER CORPORATE AREAS	
OVERDUE CASES				
· *With Coroner*	0	0	0	
· *With Directorate*	2	5	1	
· *With Quality team*	0	0	0	
· *With Commissioner*	3	7	0	
· *Returned from Commissioner with further questions*	3	1	0	
TOTAL OVERDUE	**8**	**13**	**1**	
CURRENT CASES				
· *With Coroner*	0	0	0	
· *With Directorate*	1	6	0	
· *With Quality team*	0	0	0	
· *With Commissioner*	0	1	0	
· *Returned from Commissioner with further questions*	0	0	0	
TOTAL CURRENT	**1**	**7**	**0**	
TOTAL NUMBER OF OPEN CASES	**9**	**20**	**1**	**30**
how many ongoing SIRIs (auto)				**19**

(3) **CLOSED SIRI CASES:** During May 2015, and at the time of reporting, the IW Clinical Commissioning Group had closed **12** SIRI cases. Listed below are the key lessons learned from those closed SIRI cases**:**

Subject/Learning:
PRESSURE ULCERS (x 6)
LESSONS LEARNED (1) Case subsequently downgraded as the review identified that the patient did not meet the criteria for District Nursing care – patient to be referred back to GP
(2) The Pre-admission pressure ulcer risk assessment did not fully reflect past medical history. Ward and theatres to produce draft pathway and risk assessment documentation to trial. There was a lack of documentation regarding pressure ulcer prevention equipment utilized in theatres – issues being addressed by Matron.
(3) The patient was chair bound and although their pressure areas remained intact for some time a rapidly deterioration in health led to the rapid development of a pressure ulcer. The review indicated there had been good care from the care agency and appropriate equipment from District Nurses.
(4) Delay between equipment being authorised as urgent and being delivered, which is outside agreed standard times. There was a peak in demand for equipment at that time from the equipment store. Chronology obtained from records demonstrated this was not clinically detrimental, as it was noted that the pressures areas had improved, indicating treatment plans, relative's input, together with patient participation, was working.
(5) Patient's clinical condition deteriorated significantly and rapidly; patient being nursed in bed; patient on end of life care - all appropriate actions were taken at the time.
(6) Bank staff had been involved with the patients care and had not undertaken pressure ulcer competency assessment; action forwarded to Human Resources (Resourcing Manager) for action.
BLACK ALERT STATUS
SUMMARY Trust on Black Alert Status; multiple 4 hour breaches experienced LESSONS LEARNED (what went well) Staff response Process for bringing operational leads together well established Escalation policy followed leading to decision Access to community beds Internal communications Cancellation of study and non essential meetings Deployment of staff from Theatres Response from local authority in the following days LESSONS LEARNED (what didn't go so well) Decision taken late Uncertainty if this was IOWNHST or system wide; All other Trusts on Black, Red, Silver, Gold….. Inability to open beds with short notice Absence of a "single truth" Coordination of all services Reliance on individuals Poor environment to discuss individual patients Delays in feedback

UNEXPECTED DEATH
SUMMARY Potential delay in the delivery of antibiotics LESSONS LEARNED Decision made by treating consultant - weighing risks and benefits which did not mean the patient received sub-standard care. ACTIONS Ensure continuity of care and appropriate Senior review of patient - this is being implemented as part of CQC actions, and will ensure a single senior named lead for each patient. Whilst it is not believed this would have altered the outcome in this case, it would have ensured continuity of senior review.
SLIP, TRIP, FALL x 3
(1) SUMMARY Patient fell 1.5 hours after arriving on ward; sustained fracture LESSONS LEARNED Risks were not appropriately handed-over on transfer. *Matron/ Sister discussed with staff the importance of accurate information on handover to other areas and reiterated importance of utilising all information available to inform the handover and subsequent risk assessment. Medical Director circulated communication raising profile of Falls Awareness and Training. Executive Medical Director requested that Director of Medical Education ensures falls are being investigated throughout the organisation. This will feature in the May edition of report that goes to Hospital Medical Staff Committee.* (2) SUMMARY Un-witnessed patient fall resulting in fracture LESSONS LEARNED Poorly supporting footwear may have contributed to the patients fall. All patients admitted with a diagnosis of dementia or history of delirium must have a falls care plan in place, completed on admission. A care plan would include an assessment and assurance that footwear is safe and appropriate for the patient. (3) SUMMARY Patient fall; suspected head injury LESSONS LEARNED Patient left unobserved for a short while (reported to be for a matter of seconds) patient was perceived to have been 'standing steadily'. A need to identify if any further improvements can be made to reduce the incident of falls in this area is to be undertaken. Review of Unit criteria to ensure the right patients are transferred; *this action has already been completed.*

CONFIDENTIAL INFORMATION BREACH
SUMMARY Doctor's hand-over sheet containing patient details sent anonymously to Risk Office, with a post-it-note attached saying 'found in the canteen'. It arrived in a plain brown envelope with no indication of where/from whom it had been sent. LESSONS LEARNED Some wards use Integrated Services Information System to create hand-over sheets which includes the name of the person who printed it, making traceability simpler (ISIS to develop work stream for the roll out of handover sheets to be generated through ISIS).

Prepared by:
Karen Kitcher/Deborah Matthews
SEE Team
10 June 2015

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1st JULY 2015

Title	Infection Prevention and Control Annual Report 2014-15			
Sponsoring Executive Director	Director of Infection Prevention & Control (Executive Director of Nursing)			
Author(s)	Infection Control Team			
Purpose	Assurance and information on infection control measures and performance 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	
Finance, Investment, Information & Workforce Committee		Foundation Trust Programme Board	
Please add any other committees below as needed			
Board Seminar			
Infection Control Committee	11/6/15		
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 2014/2015 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 2015/2016 HCAI prevention strategies and annual plan.

For following sections – please indicate as appropriate:

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

Date: 18-06/15 Completed by: Infection Control Team

Infection Prevention and Control Annual Report 2014-15

For the period
1st April 2014 – 31st March 2015

Dr Emily Macnaughton, Infection Control Doctor

Michelle Ould and Derek Bampton, Infection Control Nurses

Debbie Cumming, Antimicrobial Pharmacist

REVIEW INDEX & CONTENT

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 2014/2015 and gives a summary of performance, including:

- Performance against key objectives to reduce HCAI (using indicators such as MRSA bacteraemia and *Clostridium difficile*).
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- 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 2015/2016 HCAI prevention strategies and annual plan.

What we did well

Extensive Norovirus outbreak procedures produced for different staff groups to assist in management of future outbreaks of viral gastroenteritis.

Guidance for Ebola/Viral Haemorrhagic Fever management in the Trust produced and updated in line with national and global guidance in response to the West African Ebola outbreak. Enhanced PPE (personal protective equipment) obtained to enable safe initial management of patients with suspected VHF in the Trust.

The Trust Water Safety Group met 3 monthly to progress necessary procedures to prevent Legionella and Pseudomonas infections from water within the Trust.

Infection Control Policy suite maintained up to date.

Screening carried out for Carbapenemase Producing Enterobacteriaceae (CPE) for patients transferred from high risk locations.

Maintained improved joint working between the Estates team and IPC team and IPC risk assessments to ensure appropriate precautions implemented for estate projects.

The Decontamination Implementation Group was reformed in 2014. Meetings are now held 3 monthly to provide assurance around decontamination related issues in the organisation.

Compilation of a complete norovirus pack to be accessed and used by clinical staff in the event of an outbreak.

Introduced the DISCO campaign to promote better management of adult inpatients with loose stools. The focus has been on prompt identification, isolation, specimen sending and accurate recording.

New stool chart developed and introduced for adult inpatient assessment books.

Maintenance of the monthly IPC newsletter.

Secured funding for IPCN specialist training course to commence April 2015.

What we did less well

There has been little progress with securing support for the IPCT regarding data collection, collation, analysis and display.

Failure to secure funding for ICNet infection control surveillance software.

C. difficile infection trajectory exceeded. Achieving the low trajectory of only 6 cases for the year was always going to be a challenge, and unfortunately this year we have had 12 cases in total attributed to the Trust.

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)

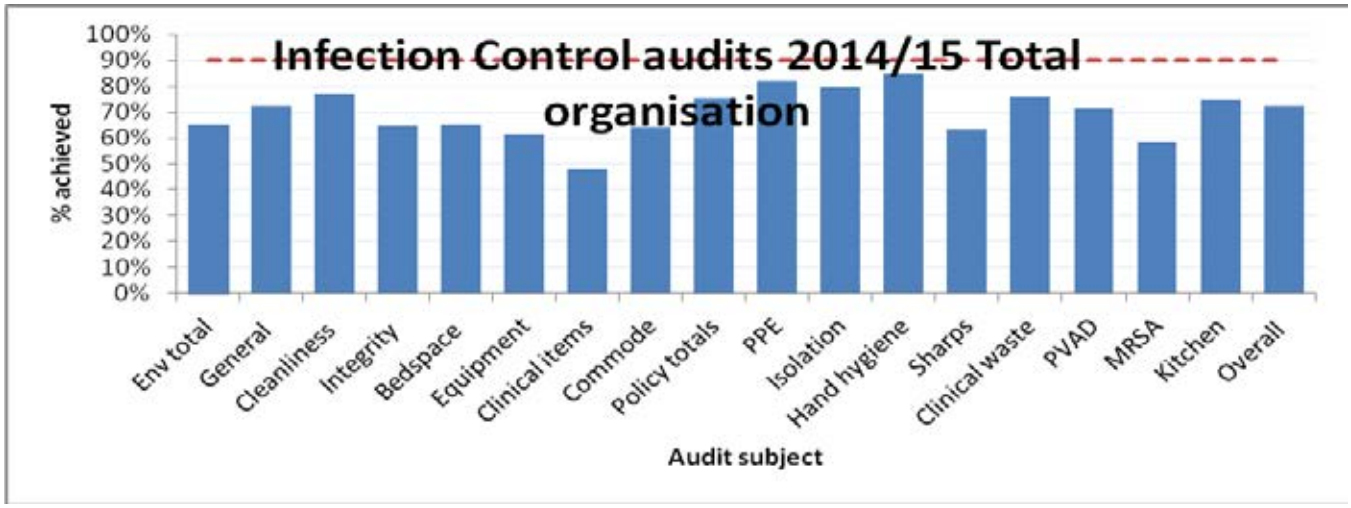
Urinary catheter care has been identified as an underlying cause in several of our hospital acquired bacteraemia cases, especially *E. coli* bacteraemia, requiring development and implementation of training and a care pathway, which was to be a focus for the year 2014/2015. The care pathway originally devised did not meet the needs of inpatient areas. This is currently under review with a completion date of June 2015.

2. IPC AUDITS

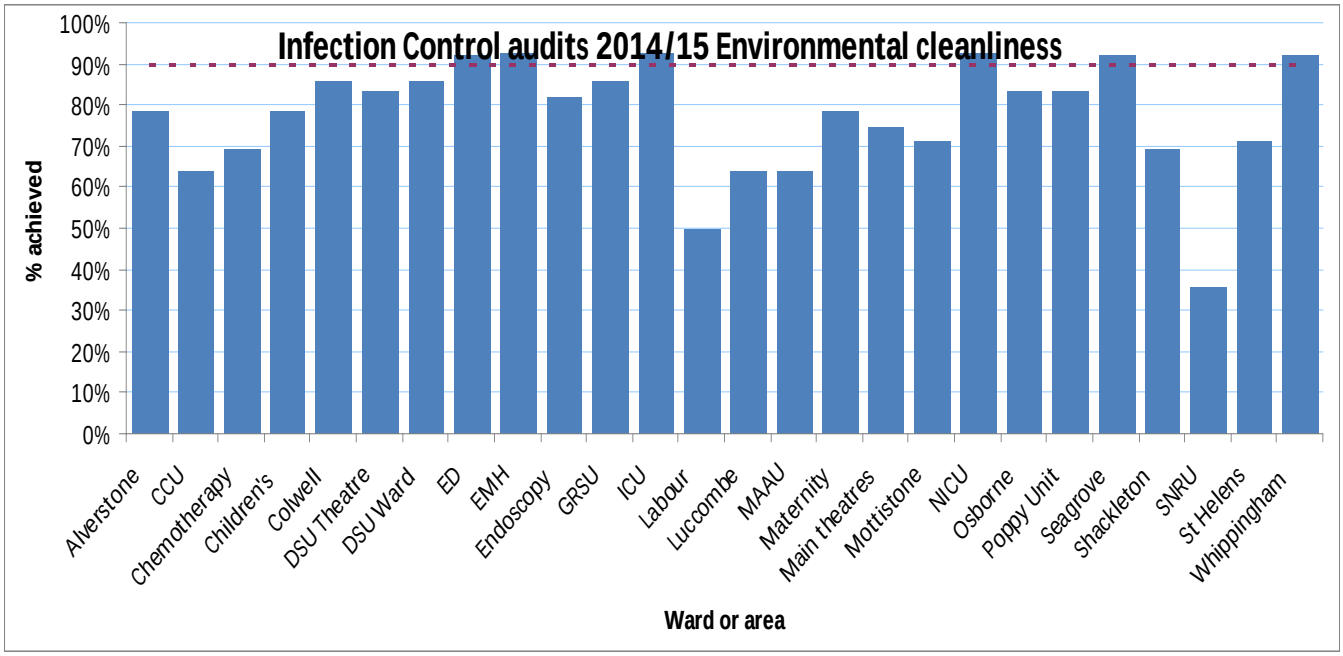
2.1 Inpatient areas: IPCT validation audits

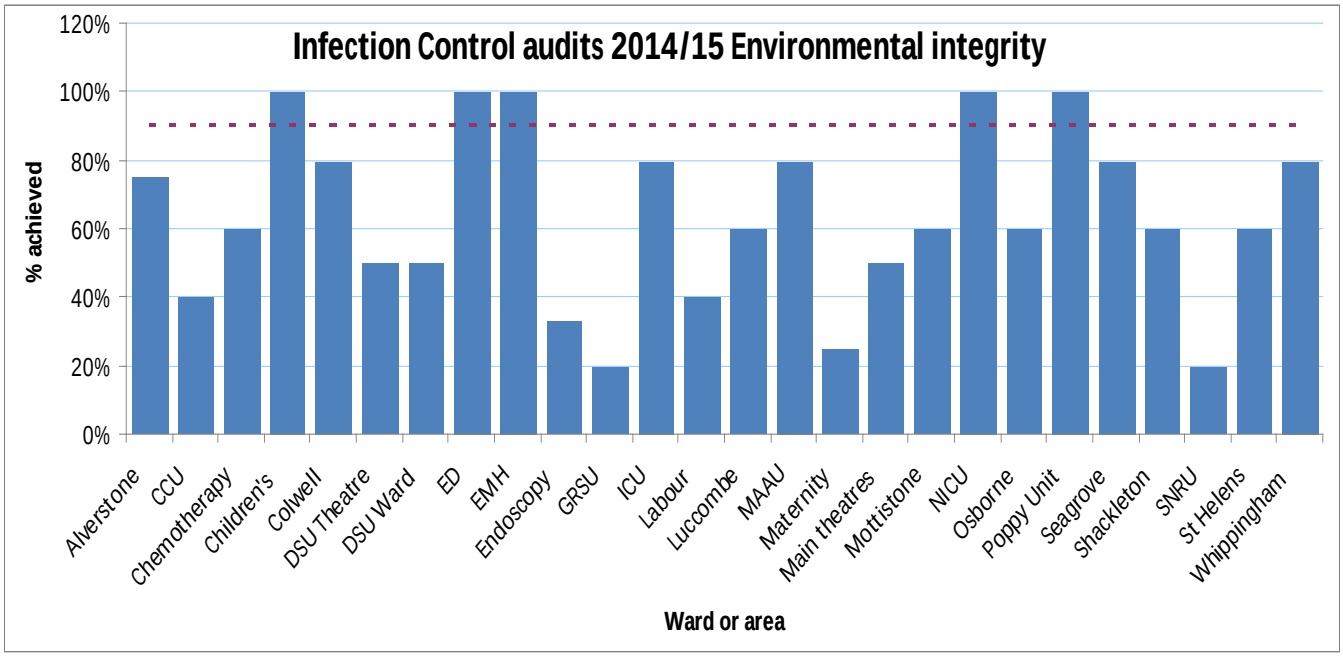
A validation environmental audit (incorporating equipment cleanliness, sharps practice, hand hygiene, personal protective equipment, peripheral venous cannulation, MRSA, isolation practice, clinical waste) was undertaken by the Infection Prevention & Control Nursing Team in all inpatient areas during 2014-15. This year all audits were unannounced. A list of dates was given to the cleanliness manager and estates team of planned audits but not the area to be visited. A representative of the cleanliness team accompanied the IPCN on all inpatient audits but unfortunately there was no representation from the estates team at the audits.

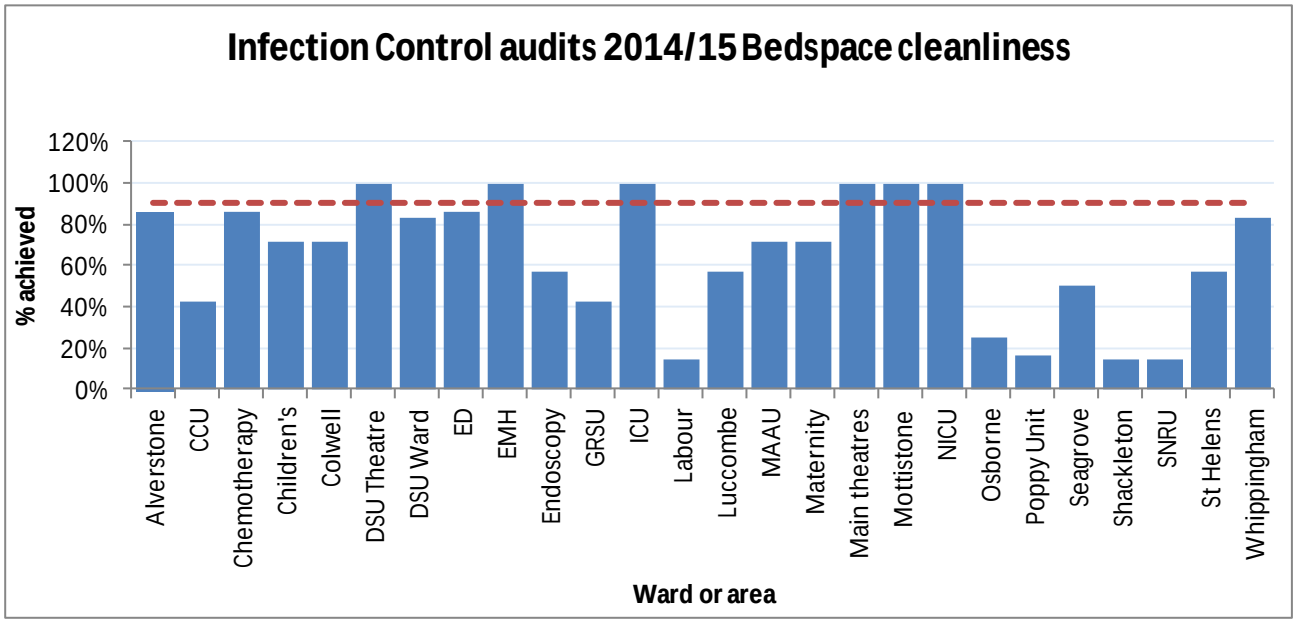
All areas are required to produce an action plan where results were below 90% which must be driven through the relevant directorate.
Audit scores were presented at directorate quality meetings and IPC Operational Group. Outstanding action plans were brought to the attention of the directorates through these forums.
The graph below shows ward scores for the **environmental** and **policy** audits (combined score).

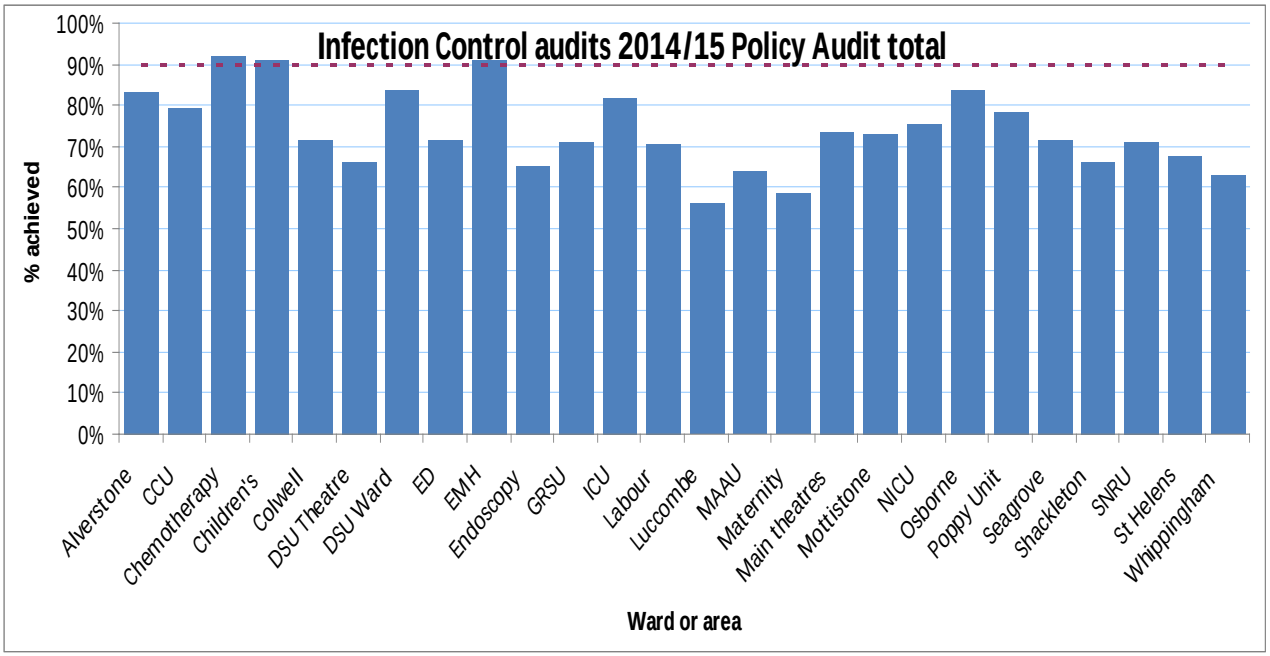


The graphs below show individual scores for environmental cleanliness, integrity and bedspace furniture and equipment cleanliness.




Infection Control audits 2014/15 Environmental integrity
% achieved
120%
100%
80%
60%
40%
20%
0%
Alverstone
CCU
Chemotherapy
Children's
Colwell
DSU Theatre
DSU Ward
ED
EMH
Endoscopy
GRSU
ICU
Labour
Luccombe
MAAU
Maternity
Main theatres
Mottistone
NICU
Osborne
Poppy Unit
Seagrove
Shackleton
SNRU
St Helens
Whippingham
Ward or area

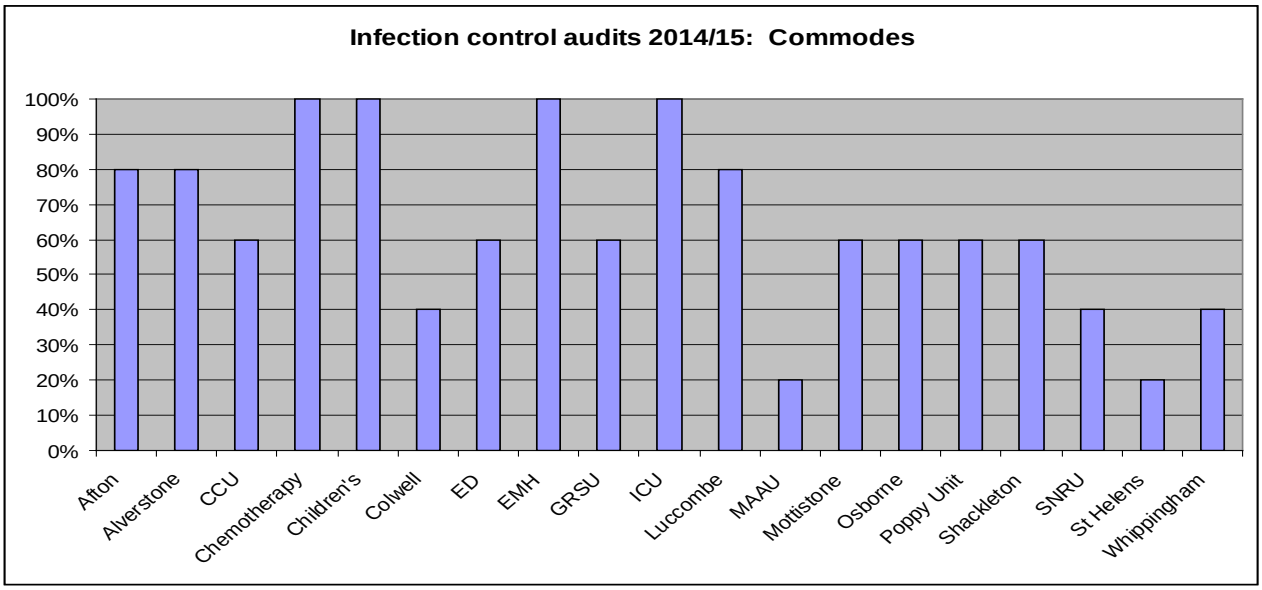

Infection Control audits 2014/15 Bedspace cleanliness
% achieved
120%
100%
80%
60%
40%
20%
0%
Alverstone
CCU
Chemotherapy
Children's
Colwell
DSU Theatre
DSU Ward
ED
EMH
Endoscopy
GRSU
ICU
Labour
Luccombe
MAAU
Maternity
Main theatres
Mottistone
NICU
Osborne
Poppy Unit
Seagrove
Shackleton
SNRU
St Helens
Whippingham
Ward or area



The graph above shows the overall Organisational scores for policy audit, including isolation care, personal protective equipment, sharps, hand hygiene, MRSA, cannula care, clinical waste,

GoJo, the company who supply the Organisation hand hygiene products carried out an observational audit of hand hygiene during 2014-15. Over 4 visits, 20 inpatient areas were audited. There were 235 opportunities for hand hygiene observed. Of these, 191 opportunities taken and 44 missed opportunities were reported – 81% overall compliance. Results were shared with all inpatient areas. This external programme will continue during 2015/16.

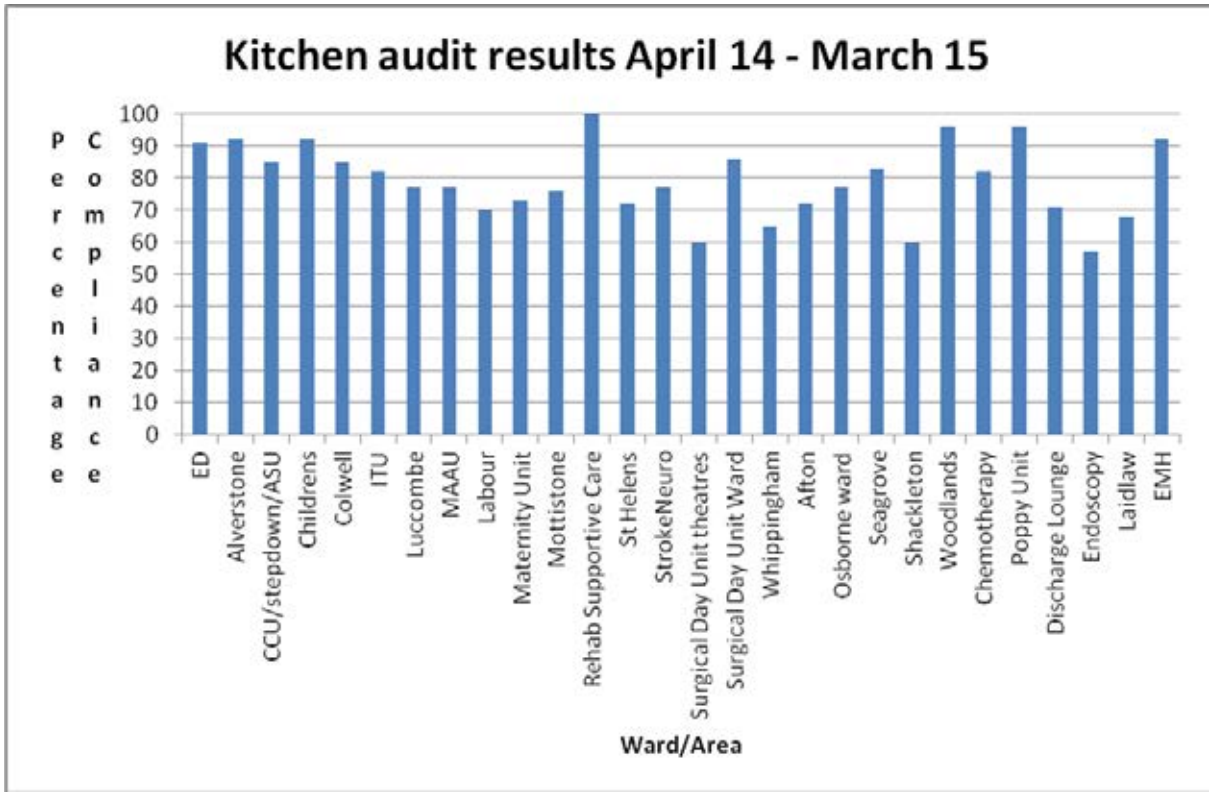
Commode Audits



Poor results were identified in a number of areas for commode cleanliness. Monthly commode audit continues to be included in the inpatient area self-audit programme for the

forthcoming year. One of the link practitioner forthcoming sessions in April will be dedicated to commode audit.

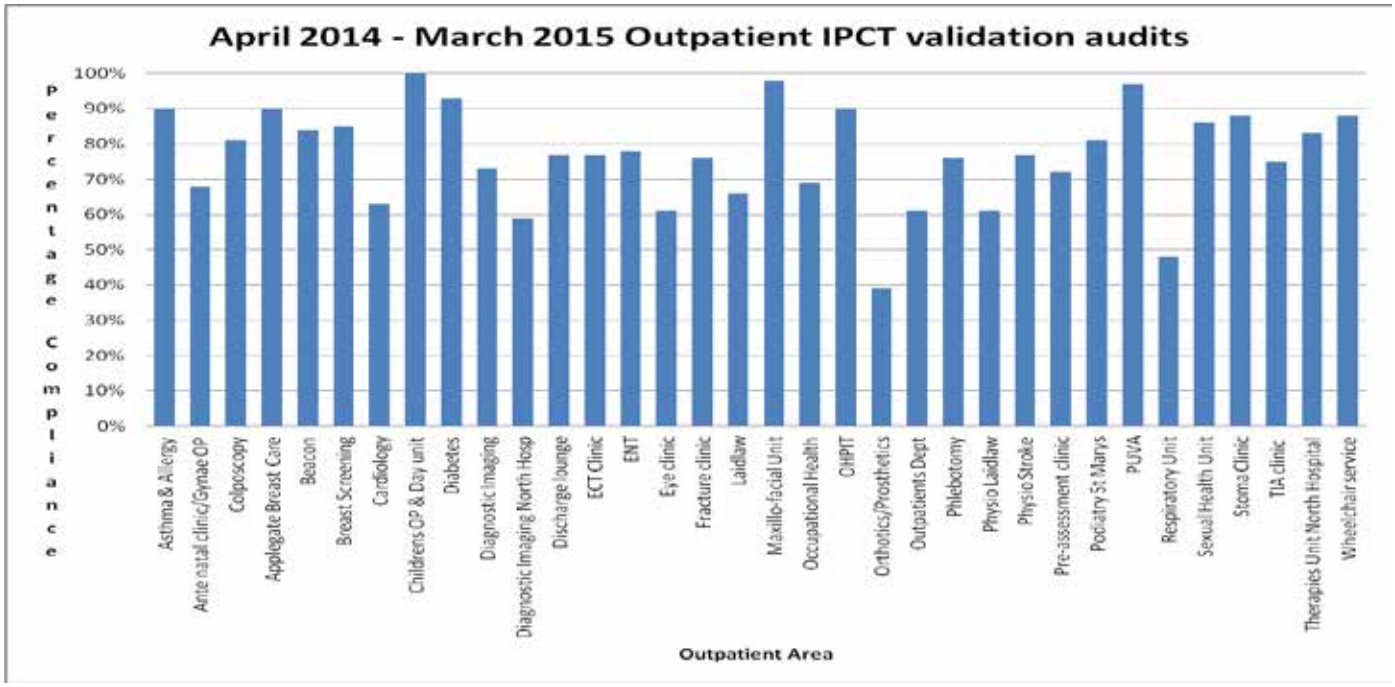
Kitchen Audits
Audit of ward/dept kitchens that serve patients was undertaken by the Infection Prevention and Control Team in 2014-15.



Joint audit with the Infection Prevention & Control Nurses and Health and Safety lead was undertaken for main and Occupational Therapy kitchens.

Sharps Audit
There was no external audit of sharps practice undertaken on behalf of the Organisation by Daniels this year as the long standing rep who previously facilitated this has retired. This will be undertaken in the year 2015/16.

2.2 Outpatient Audit



Environmental audit was undertaken in the majority of on-site outpatient areas. The graph above shows scores for the **environmental** and **policy** audits (combined score).

2.3 Infection Prevention and Control Self-Audit for Inpatient Areas

In 2015, 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:

Environmental Audit (Quarter 1 & 3) Environmental score: Kitchen score: Overall total: Action taken if below 90%	**Catheter Audit (insertion)** (replaces saving lives – High Impact Interventions) Score: Actions taken if below 90% **Catheter Audit (management)** Score: Actions taken if below 90%
Hand Hygiene Observational Audit Score: Actions taken if below 90%	**PPE** (to be undertaken in May/August/November/February) Score: Actions taken if below 90%
PVAD Audit (replaces saving lives – High Impact Interventions) Score: Actions taken if below 90%	**Isolation** (to be undertaken in April/July/October/January) Score: Actions taken if below 90%

MRSA Audit Score: Actions taken if below 90%	**Patients with Diarrhoea** (to be undertaken in May/August/Nov/Feb) Score: Actions taken if below 90%
Central Venous Catheter (replaces saving lives – High Impact Interventions) Score: Actions taken if below 90%	**Sharps** (to be undertaken in June/September/December/March) Score: Actions taken if below 90%
Commode score: (submit N/A if no commode in your area) Score: Actions taken if below 90%	**C difficile Toxin Positive** (replaces saving lives – High Impact Interventions) submit nil return if N/A Score: Actions taken if below 90%
Ventilator Associated Pneumonia (High impact interventions) **2 monthly ITU only** Score: Actions taken	

Results were returned to the IPCN team for collation so that evidence was stored in one central place. This is shared with the directorates through quality meetings.
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:

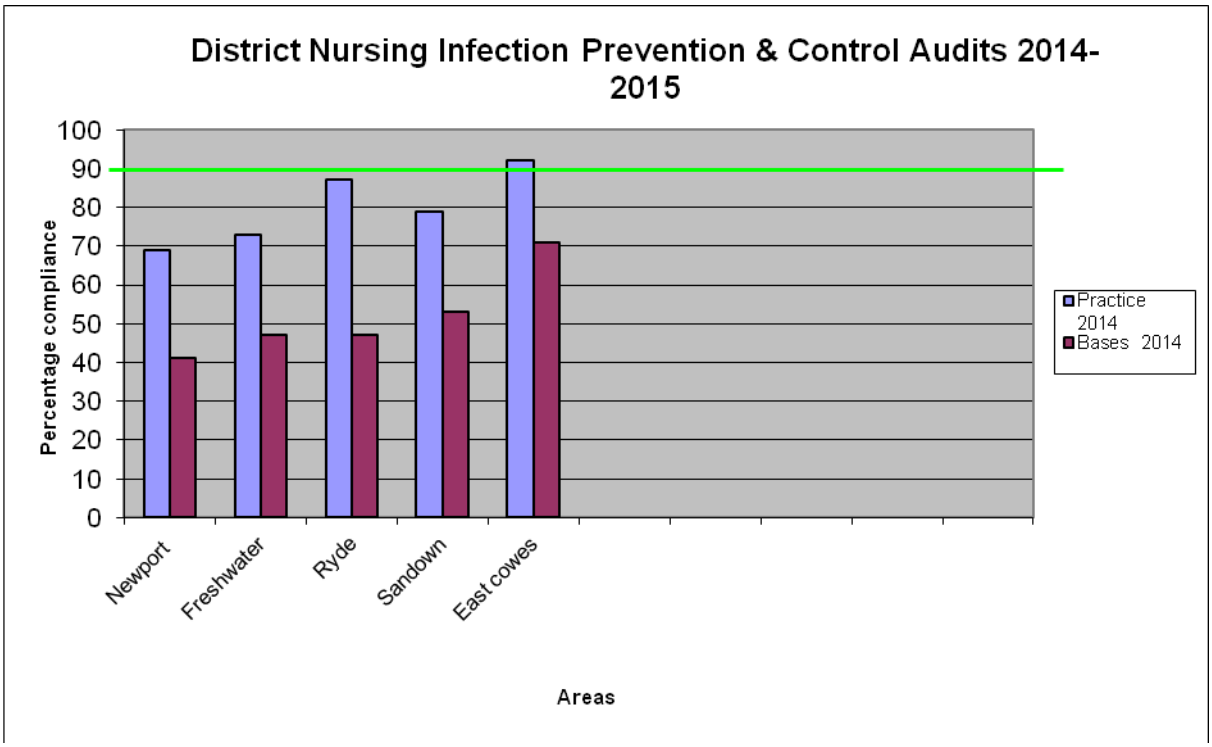
- Improvements in the audit tool functionality (including individualisation of the tool for specific areas), data entry, collation and display arrangements, for which PIDS support is required.
- Peer auditing to limit bias which could be present in the current self-auditing arrangements. This has proved challenging to implement in practice due to severe pressures experienced within the hospital over the last few months.
- A more robust system of follow up of non-returned results.

2.4 Community IPCT Audit

The Infection Prevention and Control Nursing Team have undertaken Infection Prevention and Control audits with District Nursing and the Ambulance station.

District Nursing

Time was spent with most of the District Nursing Teams observing day to day practice by accompanying on home visits and audit of the nursing bases. The service compiled a plan of issues requiring action and is to take this forward.



Ambulance Service
Audit of practice in the ambulance service and Patient Transport Services (PTS) has been deferred to 2015-16 due to constraints within the IPCT.

The ambulance station was previously non compliant but improved to achieve a compliant rating (91%) in 2014-15.

Off site Clinics
Environmental audit has been deferred to 2015-16 due to constraints within the IPCT.

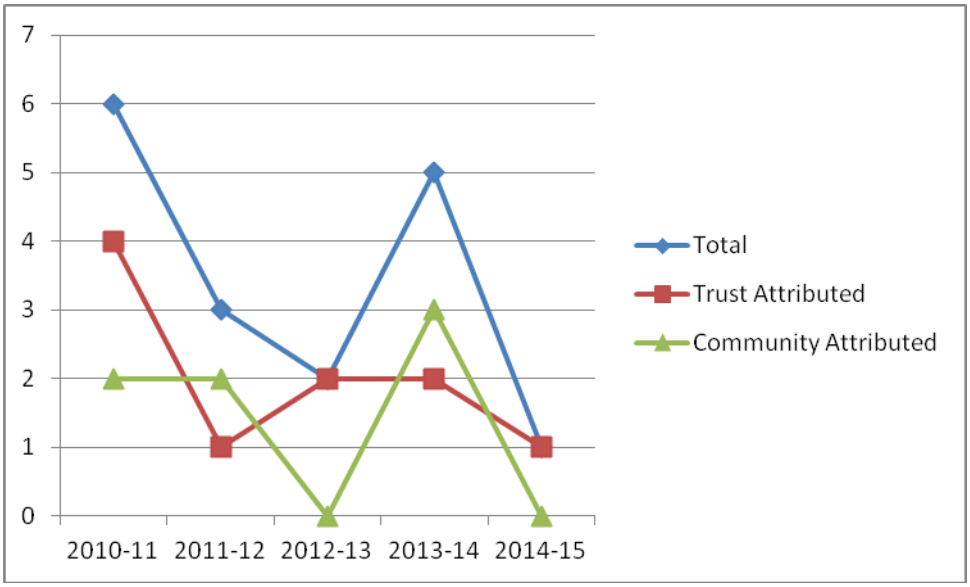
3. HCAI SURVEILLANCE – MANDATORY REPORTING

3.1 MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemia (blood stream infection) data 2014/15

Summary of Trust attributed cases

2010/2011 4 cases
2011/2012 1 case
2012/2013 2 cases
2013/2014 2 cases
2014/2015 1 case

MRSA bacteraemias April 2010 – March 2015



The Department of Health zero tolerance policy on MRSA bacteraemia was not met this year, with 1 case on the Island, which was attributed to the Trust.
A Post Infection Review process was undertaken for the Trust attributed MRSA bacteraemia and was linked to bladder surgery and post surgery catheterisation in a previously MRSA colonised patient. Actions implemented included promoting the use of relevant patient information re catheter care in both the hospital and community setting and continuing the Aseptic Non Touch Technique competency drive in the Organisation.

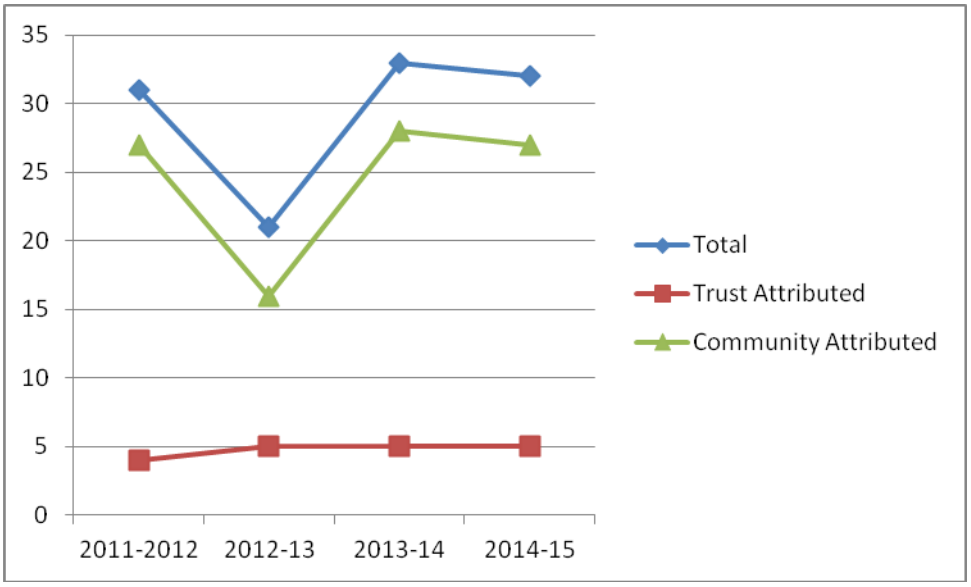
3.2
In summer 2014 the Department of Health issued new guidance around MRSA screening protocols. This was implemented in the Organisation at the beginning of 2015. The changes represent a move away from screening all emergency and elective admissions. Patients will now be screened if they are being admitted or transferred to intensive care units, orthopaedic units (including orthopaedic patients in Mottistone) and acute coronary care OR if they are being admitted to any ward and are known to have been MRSA positive in the past. Day cases are no longer routinely screened. The Organisation MRSA risk assessment was revised in line with the changes. The laboratory continues to provide a 7 day screening service for all emergency patient admissions meeting the criteria for screening.
The PIDS team are currently working on compliance data for screening in line with the new policy.

3.3 MSSA bacteraemia data 2014/15

As well as MRSA bloodstream infections, the national mandatory 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 2014/2015 (attributable to acute care settings) from a total of 32 cases during the period reported by the laboratory. This is fairly static from the last year.

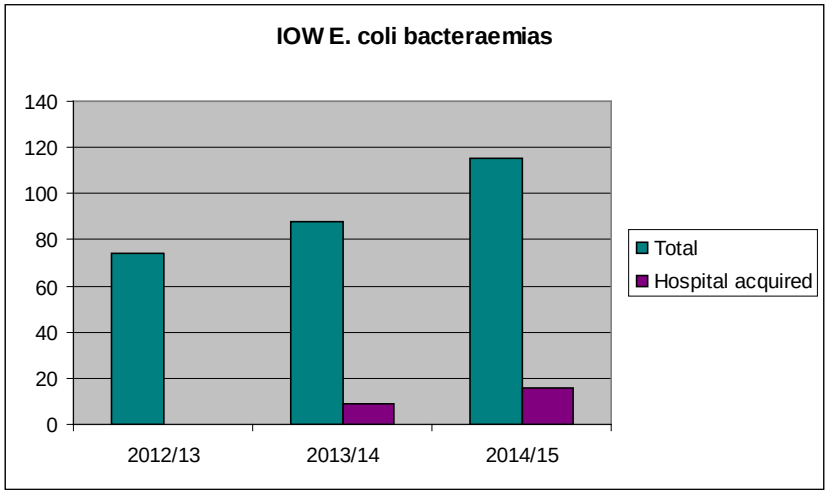
MSSA bacteraemias April 2011 – March 2015



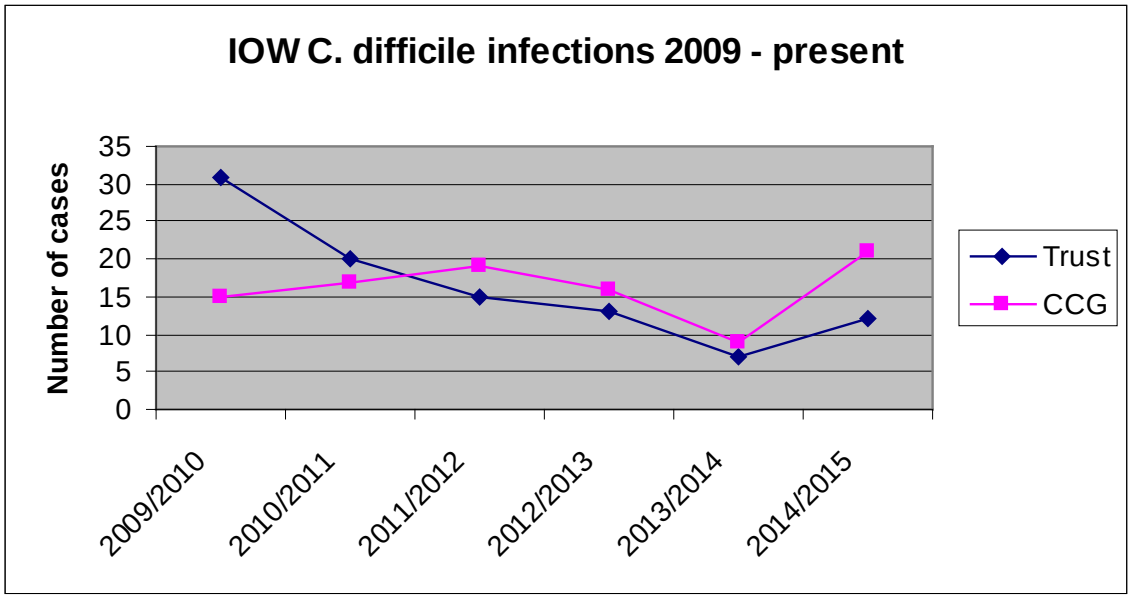
3.4 *E. coli* bacteraemia surveillance

Mandatory surveillance of *E.coli* bacteraemia 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. A catheter care pathway was devised and trialled but did not meet the needs of inpatient areas. This is currently under review with a completion date of June 2015.

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. Fifteen of this year's 115 cases were detected in a time frame suggestive of hospital acquired infection.



3.5 *Clostridium difficile* infection (CDI)



Achieving the low trajectory of only 6 cases for the year was always going to be a challenge, and unfortunately this year we have had 12 cases in total attributed to the Trust. Although we have not managed to meet last years excellent performance, this years' CDI rate is comparable with both regional and national averages. Community acquired CDI has also increased this year. The latest 2 Trust attributed cases are awaiting review, therefore financial penalties may be appealed against for these, as no lapses in care have been initially identified for these patients.

Ribotyping (determining the strain of C. difficile) of CDI cases 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.

Root cause analyses for all hospital acquired CDI cases are performed and the following issues have been identified as potential contributory factors to the infection or risks for further infections:

- Sampling and isolating patients with loose stools in a timely manner with accurate documentation including escalation when no side room is available
- Timely prescription and administration of treatment for CDI
- The need for thorough investigation of patients treated for infection of unknown source to enable narrower spectrum antibiotic use
- Sample sent and tested inappropriately (formed stool)
- Development of a cannula site infection and cannula not removed appropriately leading to further antibiotic prescriptions

C. difficile testing in the laboratory has undergone a change in March 2015, moving from a test that could only be carried out in batches once a day to one that can be carried out throughout the working day. It is anticipated that this will decrease turnaround times and assist in appropriate side room allocation.

Future challenges in CDI

- Targets continue to decrease with the Trust target of only 7 for the year ahead.

- Bed occupancies show no sign of decreasing after the extremely busy winter period which makes it harder to isolate patients with diarrhoea and increases the number of patients at risk.

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).
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).

We are continuing to screen patients who have a risk factor for acquiring these bacteria, this currently includes patients

- Who have been a inpatient in a hospital abroad in the last 12 months
  OR
- Been an inpatient in a UK hospital known to have problems with spread of carbapenemase-producing Enterobacteriaceae
  OR
- Previously been colonised or had an infection with carbapenemase-producing Enterobacteriaceae or close contact with a person who has

There have still been no Trust acquired cases identified so far on the island. If we identify spread of these isolates within the Trust then outbreak control measures will be implemented.
We identified several patients transferred back to St Mary's Hospital from hospitals abroad and carried out screening as per the toolkit guidance.

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 2014 to December 2014 the orthopaedic department undertook:

- 204 total knee replacements with 2 reported infections < 1%
- 204 Total hip replacements with 0 reported infections
- 147 Repair of fractures to neck of femur with 1 reported infections < 1%

Quarter 4 (Jan- March) figures will not be finalised until June 2015 so have not been included. National data from April 2014 has not yet been published so comparison cannot currently be made.

Surveillance for other surgical specialities SSI (Surgical Site Infection) is not currently routinely performed (and there is currently no other national mandatory reporting process). An audit for winter/spring 2015 planned to look at the pre-operative advice compliance for

patients with SSI post elective surgery has been put on hold as of April 2015 due to lack of patients meeting the criteria. This will be reviewed later in the year dependent on patient numbers (this is likely impacted by bed pressures which have resulted in elective surgery cancellation).

Caesarean section wound infections are currently informally monitored by the medical microbiologists flagging wound swabs sent to the laboratory post caesarean section which are then highlighted to the Maternity quality manager. However, determining the proportion of those patients who actually had an infection is still a challenge; a trial of giving stamped addressed envelopes to women to self report infections after discharge was unsuccessful with no returns. There is still no formal national caesarean section SSSI module available.

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

- The large outbreak running from March-April 2014 lasted for over 4 weeks, involving over 100 patients and 323 staff members reported in sick with gastrointestinal symptoms and was detailed in the 2013-14 annual report.
- During 2014-15 there were two outbreaks of gastroenteritis in St Mary's Hospital. One of these was the latter part of the large outbreak that commenced in March 2014 as detailed above.
- The second occurred in November 2014 and affected the medical admissions unit and an orthopaedic and a surgical ward. This was promptly identified by the Trust laboratory as due to norovirus and confirmed on further testing by the reference laboratory. 1 bay of patients was primarily affected on the orthopaedic ward and the outbreak was well contained on the unit. The outbreak on the surgical unit spread across the ward resulting in patients affected in all bays. In total, 30 patients were affected.
  Staff reported sick with D&V symptoms during the outbreak but at fairly low levels.
- Review of the organisational outbreak policy and norovirus guidance information has been undertaken following the 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 2014/15. Group A Streptococcal

infections acquired in hospital need root cause analysis investigation to identify and remedy preventable factors.

- During 2014/15, 2 patients were found to have a Group A Strep. infection acquired in the Trust. The first case was related to a peripheral cannula site infection occurring on the ward and the second was related to a surgical site infection and was detected when the patient was re-admitted. The cases are not linked. Actions have been implemented following investigations to identify the source of the infections.

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.
There are established on-line MRSA, influenza and *Clostridium difficile* training courses available. These are not mandatory at the present time.

In 2014/15: 1664 staff undertook the clinical on-line training session
681 staff undertook the non-clinical on-line training session
592 staff undertook the clinical face to face training session

Infection prevention and control training % compliance rating for directorates is reviewed monthly within the directorate. PIDS are still working on a training dashboard so that compliance is readily visible within the Organisation.

All IPC on-line and the taught session content was reviewed by the team.

Bespoke training sessions were delivered on request in the workplace. This was again less successful than hoped in clinical areas due to difficulties in releasing staff to attend.
A short induction training session is delivered to medical students attending for short placements each month.
The IPCNs support the Infection Prevention & Control Doctor in delivering training annually to the junior doctor intake and to senior clinicians.
A regular infection prevention and control induction training session is delivered to volunteers.
A bespoke training course was delivered to cleanliness support staff.
IPCNs delivered a session on the catheterisation study days.

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.
The IPCNs receive % compliance rating for directorates monthly and take this to directorate quality meetings to drive. PIDS are working on a training dashboard so that compliance is readily visible within the Organisation.
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.
In 2014/15 2189 staff completed practical hand hygiene training.

Respirator Mask Fit Testing
In conjunction with the Occupational Health Team, the Infection Prevention and control Nursing Team delivered 5 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 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 2014 and topics including Managing patients with diarrhoea, waste guidelines, multi-resistant organisms, pseudomonas and legionella. The day was well attended.

Patient Information Leaflets
Current infection prevention and control leaflets are to be reviewed in 2015. MRSA leaflets were revised in Dec 2014 to fit with the new MRSA policy.

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 is well embedded. Closer working between estates and the IPCT has continued with 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. Staff are expected to check patient status on admission. It is recognised by the IPCT that the known status of some patients was not always identified and that an electronic alert system is needed. Application to the Nursing Technology Fund for such a system was unsuccessful.

- **Norovirus information pack**

A norovirus pack was compiled and rolled out for use by inpatient areas. This was further developed during 2014-15 following issues identified during outbreak.

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

The IPCT developed an Organisational ANTT policy that was approved in Nov 2014. A train the trainer and competency assessment programme is currently being undertaken across the Organisation by the clinical training team.

- **The DISCO campaign**

The IPCT worked with colleagues in the communications and quality teams to develop and drive a programme to improve management of adult inpatients with loose stools. The focus was on prompt recognition of patients with loose stools, specimen sending and isolation are and accurate recording.
The following initiatives were designed and launched

- A new adult inpatient stool chart to sit within the adult risk assessment booklet
- Signage for inpatient toilets to encourage reporting of loose stools
- Floor stickers for dirty utility floors
- Cards for staff to carry with the key messages around managing patients with loose stools
- Ward areas were visited by the IPCNs to share the loose stool message
- Screen saver messages
- Newsletters

7. IPC GOVERNANCE

The Infection Prevention & Control Operational Group has continued to meet, reporting into the Infection Prevention & Control Committee, to enable that committee to focus on IPC strategic matters. Consistent representation from some areas of the organisation has not been achieved which is a barrier to the effective cascade of infection control related information and feedback on action plans. Changing responsibilities of the matrons has also hindered the process as continuity of responsibility has been disrupted. 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

The Infection Prevention & Control Committee now reports to the SEE (Safety, Effectiveness and Experience) Triumvirate Committee instead of the Quality and Clinical Performance Committee as previous.

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
- Infection Prevention & Control Operational Group
- Food Hygiene Working Group
- Health and Safety
- Space Utilisation
- Risk Management
- DNT
- 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:

- Code of Practice for Prevention and Control of HCAI
- MRSA policy
- Outbreak Policy - inc Bed Closure policy
- Viral Haemorrhagic Fevers (updated in light of current outbreak and new national guidance)
- Aseptic Non Touch Technique (new policy)

The IPCT were also involved in updating the following policies:

- Clean Patient Environment
- Care and Decontamination and Maintenance of Endoscopes

7.3 TDA (Trust Development Authority) Review

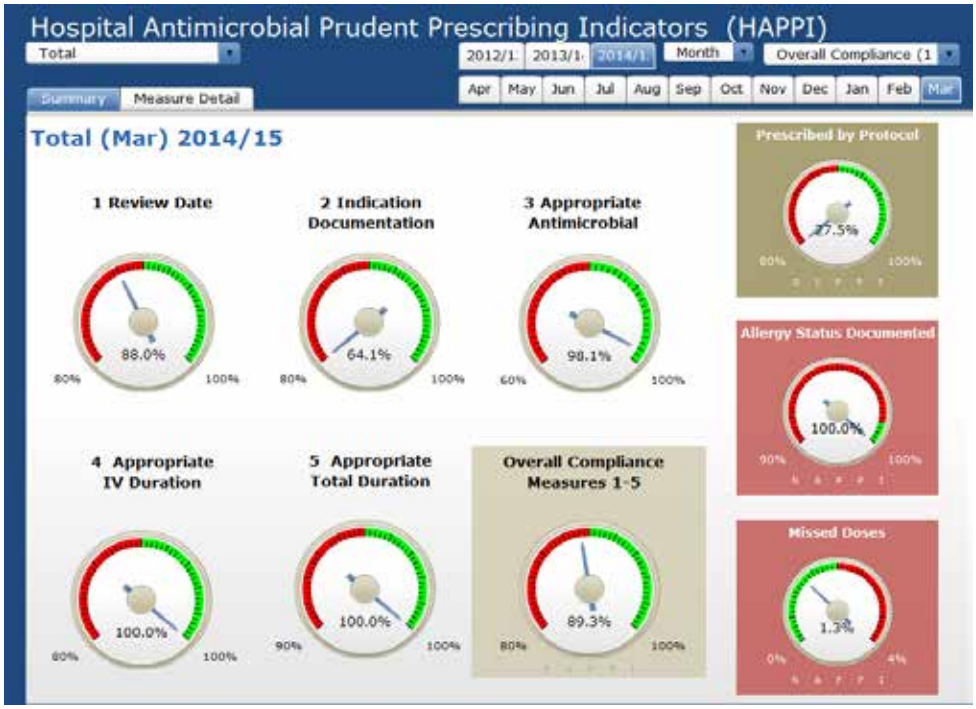
Further liaison with the TDA and the IPCT has been undertaken during this year, particularly with regard to the areas of non-compliance in the Health and Social Care Act Code of Practice:

- Aseptic Non- Touch Technique training and competency assessment (clinical educators rolling out training programme)
- Laundry policy (draft version compiled and undergoing further review)
- Decontamination lead

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 its expected duration. This enables the Consultant Medical Microbiologists and Antimicrobial Pharmacist to advise on optimal antimicrobial prescription in the Trust.
- The HAPPI, DIPPI and NAPPI monthly snapshot audits to monitor antimicrobial stewardship across the Organisation have continued. The results have recently been altered to reflect the new Directorate Structure of the Hospital, namely Hospital and Ambulance Directorate and the Community and Mental Health Directorate. Data can be drilled down to ward level using the dashboards. The result of each monthly audit is included in the Quality Report summary pages.

Example of HAPPI dashboard:



- The **HAPPI (Hospital Prudent Prescribing Indicators) audit** results for 2014/15 have overall been relatively good, but not always reaching the 90% target for each directorate.
- However the **DIPPI (Doctor inputting by prescribing protocol indicator) audit**, which assesses whether the doctors have used the electronic prescribing system to "prescribe by protocol", and therefore used to assess whether they have prescribed in accordance with empiric guidelines, has been less successful. The scores seen in DIPPI do not mean that antimicrobial stewardship is not being achieved, it means that the system used to prescribe by protocol is not fit for the current computer needs of the junior doctors; monitoring of the appropriateness of the antimicrobial agent will continue via the HAPPI audit. We are also exploring ways to improve the ease of achieving excellent antimicrobial stewardship more readily by discussion with the makers of the electronic prescribing systems used throughout the UK.
- The **NAPPI (Nurse administration prudent practice indicator)audit** looks at missed / delayed doses, which we have set a standard of below 2%. This standard is challenging on a busy ward as a missed / delayed dose can be defined as being outside of:

  one hour before or one hour after the prescribed dose.

  This is challenging if a patient is going to theatre, X ray, or has only just been written up and requires the full cooperation of the multidisciplinary team to achieve as near possible to the prescribed time. Some missed doses documented as such in this audit could be considered as delayed doses. It may be better to audit "*avoidable delayed doses"* as an alternative indicator. We have fed back to the wards concerned re their missed / delayed doses. The reason sometimes given of "no stock available" should be removed, as now that we have implemented a roll out programme of electronic storage of medicines, more stock

should be available to be accessed across the hospital, but still with an appropriate audit trail of who has accessed what and for which patient.

9. WATER SAFETY

- The Trust Water safety group has continued to meet in 2014
- Initial *Pseudomonas aeruginosa* testing has been undertaken for high risk areas, although the 6 monthly testing of these areas with consistent reporting of tests undertaken, results and actions still needs implementation.
- Actions from the 2013/2014 Water Hygiene Risk assessment audit carried out by external contractors of Trust Estate have been progressed. The final report of the repeat audit from March 2015 is awaited but the initial draft indicates much improved compliance over the past year.

10. DECONTAMINATION

The Decontamination Implementation Group was fully reconvened in 2014 to provide assurance around decontamination related issues in the organisation.

During the year 2014-15, the following decontamination issues were highlighted:

- Inadequate, outdated and unreliable dental water carts in use in the Maxillo-facial department which had not previously undergone the appropriate microbiological water testing. When this was undertaken, results were unsatisfactory; a new disinfectant protocol was implemented as a temporary measure but the urgent need for new carts was recognised. These have now been purchased for installation as soon as possible (May 2015).
- 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. The new endoscopy unit building project is now underway.
- Need for increased assurance provision of CJD (Creutzfeuld Jacob Disease) risk assessment processes in ENT and ophthalmology. An audit of ENT patient notes in Feb 2015 identified that not all patients were assessed for CJD risk. The endoscopy unit commenced monthly monitoring of compliance with undertaking CJD risk assessment in March 2015. This will be drive by the Decontamination Implementation Group.
- Lack of endoscope decontamination facilities in the ENT department, for which facilities are unlikely to be available until the completion of the new endoscopy unit

11. RECOMMENDATIONS AND PRIORITIES FOR 2014/2015

- Development of electronic data collection tool for infection control audit and electronic dashboard display of these results. Greater ownership of infection control data and actions at a directorate and department level is unlikely to happen until the data can be easily accessed and understood.
- Review of community antibiotic prescribing to minimise Island wide CDI.
- Further roll out of Aseptic Non- Touch Technique training and competency assessment to progress compliance with the Health and Social Care Act Code of Practice.
- Roll out of updated 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 M

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

1st July 2015

Title	Self-certification			
Sponsoring Executive Director	FT Programme Director / Company Secretary			
Author(s)	Head of Corporate Governance & Risk Management			
Purpose	To Approve			
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	24.6.15
Finance, Investment, Information & Workforce Committee	23.6.15	Remuneration Committee	
Foundation Trust Programme Board			
Please add any other committees below as needed			
Board Seminar			
Other (please state)			

Staff, stakeholder, patient and public engagement:

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

Executive Summary:

This paper presents the Trust Development Authority (TDA) self-certification return covering the May 2015 performance period for approval by Trust Board.
The key points covered include:

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

The Finance, Investment, Information & Workforce Committee and the Quality & Clinical Performance Committee considered the self-certification return and have not recommended any amendments.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	3					
Critical Success Factors *(see key)*	6 - Develop our quality governance and financial management systems and processes to deliver performance that exceeds the standards set down for Foundation Trusts.					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***						
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	The Trust Board is required to self-certify against selected Board Statements and Monitor Licence Conditions as part of the Trust Development Authority's oversight arrangements specified in the *Accountability Framework for NHS Trust Boards 2014/15.*					

Date: 22.6.15 Completed by: Lucie Johnson, Head of Corporate Governance & Risk Management

ISLE OF WIGHT NHS TRUST
SELF-CERTIFICATION

1. Purpose

To seek approval of the proposed self-certification return for the May 2015 reporting period, prior to submission to the Trust Development Authority (TDA).

2. Background

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

In March 2014 the TDA published a revised *Accountability Framework* for 2014/15. There are no fundamental changes with respect to the self-certification requirements.

The Trust must continue to make monthly self-certified declarations against prescribed Board Statements and Monitor Licence Conditions.

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

3. Assurance

Lead professionals across the Trust have been engaged to ensure the provision of supporting information and the identification of gaps, issues and actions required to provide a sufficient degree of assurance to the Trust Board to enable approval of the self-certification return as an accurate representation of the Trust's current status.

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

All May assurance updates are showing in red on Self Certification Board Statement and Licence Conditions powerpoint slides.

4. Performance Summary and Key Issues

Board Statements

Board Statements **1, 2, 6, 13** and **14** remain 'at risk' as a consequence of the CQC inspection undertaken in June 2014. Progress continues against the Quality Improvement Plan (QIP) and the Trust remains on trajectory towards declaring full CQC compliance.
Board statements **5** (further assurance needed and challenge by Commissioners) and **8** (Performance against plan this year and the risk to underlying assumptions for 2015/16) have been declared "at risk" following discussion at FIIWC and QCPC and agreed at Board on 1.4.15
Following FIIWC meeting on 26.5.15 Board Statement **7** was proposed "at risk" as it was

identified that the Board have not fully considered all potential future risks associated with national drivers and resultant changes in healthcare delivery. At 3rd June Board meeting this was approved.

As a positive trajectory towards improvement had still not been demonstrated with respect to the governance risk rating (GRR), it was previously recommended that Board Statement **10** remains 'at risk', and that the target compliance date be slipped to 31st March 2015. However, this date was still not achieved and has now been moved forward to 31st May 2015. Urgent consideration needs to be given to setting a realistic date for achievement. This position is reflected within the draft return document (Appendix 1a).

Licence Conditions

All Licence Conditions remain marked as compliant. A watching brief should be maintained with respect to condition G7 (Registration with the Care Quality Commission) as it could be put at risk if the QIP is not delivered sufficiently to the satisfaction of the CQC. This position is reflected within the draft return document (Appendix 1b) and the Licence Condition Assurance Documents (Appendix 3).

5. Recommendations

It is recommended that the Trust Board:

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

Lucie Johnson
Head of Corporate Governance & Risk Management

6. Appendices

1a – Board Statements
1b – Licence Conditions

7. Supporting Information

- *Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards,* 31 March 2014
- *Risk Assessment Framework,* Monitor, 27 August 2013

BB - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

	For CLINICAL QUALITY, that:	Response	Comment where non-compliant or at risk of non-compliance	Timescale for Compliance	Executive Lead	
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's Oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	30-Sep-15	Alan Sheward Mark Pugh	QCPC
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	30-Sep-15	Alan Sheward	QCPC
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	FIIWC
	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	FIIWC
	For GOVERNANCE, that:	**Response**				
5	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	At risk	Further assurance needed and challenge by commissioners	31-Oct-15	Karen Baker Mark Price	FIIWC QCPC
6	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	30-Sep-15	Mark Price	FIIWC QCPC
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.	At risk	The Finance, Investment, Information & Workforce Committee considered the self-certification return and requested Board Statement 7 be amended to "at risk" as it was identified that the Board have not fully considered all potential future risks associated with national drivers and resultant changes in healthcare delivery.	30-Jun-15	Mark Price	FIIWC QCPC
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.	At risk	Performance against plan this year and the risk to underlying assumptions for 2015/16	31-May-15	Karen Baker	FIIWC QCPC
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	FIIWC
10	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR [Governance Risk Rating]; and a commitment to comply with all commissioned targets going forward.	At risk	The Trust's Governance Risk Rating (Monitor access and outcome measures) score declined significantly across quarters 1 & 2 2014/15. Indicator recovery plans are being implemented.	31-May-15	Alan Sheward Mark Pugh	FIIWC QCPC

BB - 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	FIIWC
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	ACRC
13	The board is satisfied all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Aug-15	Karen Baker	FIIWC
14	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Aug-15	Karen Baker Alan Sheward	FIIWC

BB - 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	RemCom
2	Condition G7 – Registration with the Care Quality Commission	Yes	*This indicator could be but at risk if the CQC action plan is not implemented as required by the CQC.*		Alan Sheward	QCPC
3	Condition G8 – Patient eligibility and selection criteria	Yes			Alan Sheward	QCPC
4	Condition P1 – Recording of information	Yes			Chris Palmer	FIIWC
5	Condition P2 – Provision of information	Yes			Chris Palmer	FIIWC
6	Condition P3 – Assurance report on submissions to Monitor	Yes			Chris Palmer	FIIWC
7	Condition P4 – Compliance with the National Tariff	Yes			Chris Palmer	FIIWC
8	Condition P5 – Constructive engagement concerning local tariff modifications	Yes			Chris Palmer	FIIWC
9	Condition C1 – The right of patients to make choices	Yes			Alan Sheward	QCPC
10	Condition C2 – Competition oversight	Yes			Karen Baker	FIIWC
11	Condition IC1 – Provision of integrated care	Yes			Alan Sheward Mark Pugh	QCPC

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 JULY 2015

Title	Board Assurance Framework			
Sponsoring Executive Director	Company Secretary			
Author	Risk & Litigation Officer			
Purpose	To note the Summary Report, the risks and assurances rated as Red, and approve the June 2015 recommended changes to Assurance RAG ratings.			
Action required by the Board:	**Receive**		**Approve**	**X**

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

None

Executive Summary:

The full 2014/15 BAF document was approved by Board in June 2014, including the high scoring local risks from the Corporate Risk Register, together with associated controls and action plans. It was agreed that the Board would receive dashboard summaries and exception reports only for the remainder of that year.

The dashboard summary includes summary details of the key changes in ratings, with 8 Principal Risks now rated Red in Assurance Level and 7 in Risk Scores, unchanged from the previous report.

The exception report details 4 recommended changes to the Board Assurance RAG ratings of Principal Risks, all from Green to Amber (1.11; 2.9; 2.39 and 6.45) and two Principal Risks have been updated in content: 2.15 with a change to include End of Life Care in title; and 3.61 with addition of Executive Director of Transformation & Integration to Lead status

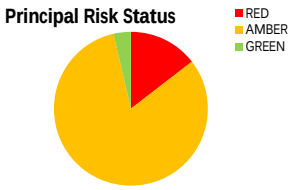
For following sections – please indicate as appropriate:

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

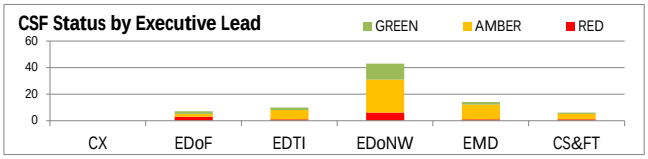
Date: 22 June 2015 **Completed by:** Fiona Brothers, Risk & Litigation Officer

BAF Status Report

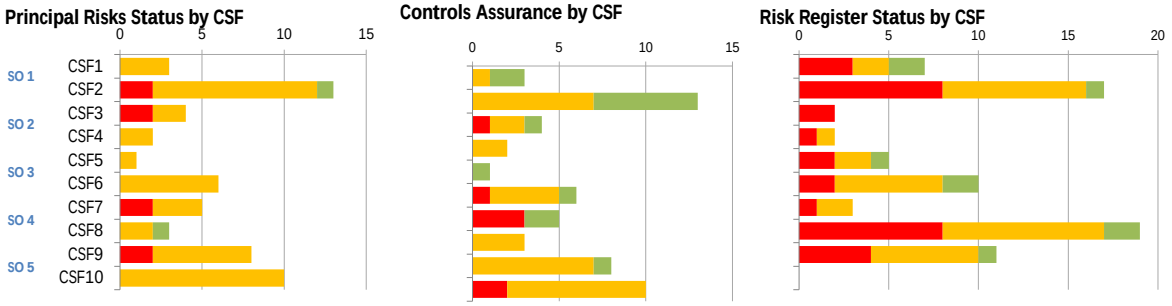
Isle of Wight NHS Trust



Principal Risks:	55	Aligned Risk Register Risks:	79



Strategic Objective & Critical Success Factor Status Overview



BAF
Increased Scores

4

Reduced Scores

0

Commentary

Please note that the period for updates covers 4 weeks whereas the previous report covered a 9 week period.

Principal Risks:
4 Principal Risks are recommended for changes to Amber from Green (1.11, 2.9, 2.39 & 6.45)
1 Principal Risk is recommended for changes to core statement (2.15)
1 Principal Risk is recommended an additional Exec Lead (3.61)

No New Risks have been added to the Risk Register since 21.05.2015

No changes have been made to previously notified Risk scores since the last report

Recommended changes to BAF assurance ratings, NEW BAF entries, Risk Scores and identification of NEW risks

Ref.	Exec Lead	Title/Description	Assurance Rating Current	Assurance Rating Change to
CHANGES TO PRINCIPAL RISKS since last report				
CSF1.11	EDoNW	1.11 The CQC have issued sanctions on registration (Q61) Executive Director of Nursing / Company Secretary	GREEN	Amber
CSF2.9	EDoNW	2.9 (2.14) There are no service level scorecards or dashboards which detail performance against articulated goals (Q35) Executive Director of Nursing / Executive Director of Finance	GREEN	Amber
CSF2.39	EDoNW	2.39 (10.74) There are significant unresolved quality issues (B35) Executive Director of Nursing	GREEN	Amber
CSF6.45	CS&FT	6.45 (10.10 (10.14)) There is little or no evidence of a cohesive quality assurance and escalation framework which is understood by all members of the Board (Q26) Executive Director of Nursing	GREEN	Amber

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
Strategic Objective 1: QUALITY - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience **Exec Sponsor: Executive Director of Nursing**										
<u>Priority 1</u> **Lead: Executive Director of Nursing** **<u>Improve the experience and satisfaction of our patients, their carers, our partners and staff</u>** **Links to CQC Regulations: 9, 12, 17, 19, 21, 22, 23**						*MEASURES:* *Improved patient and staff survey results* *Complaints/concerns from patients/carers and staff* *Compliments from patients/carers and staff* *CQC inspection/Trust inspection outcomes* *Culture, Health and Wellbeing strategy objectives achieved* *No service disruption occurs if Major incident or Business Continuity Plans are invoked* *Friends and Family test results* *Staff Friends and Family test results*			*TARGETS:* *Patient and staff survey results for 14/15 show better outcomes than results for 13/14* *Patient care complaints reduced by 10% on 2013/14* *All CQC key domains / essential standards met* *All services provided 365 days per year* *Increased patient involvement evidenced* *Achieve 30% response rate in patients friends and family test results by March 2015* *Achieve 20% response rate in staff friends and family test results by March 2015* *Greater alignment between patient and staff satisfaction*	
1.11 The CQC have issued sanctions on registration (Q61) Executive Director of Nursing / Company Secretary	**5**			The Board have ensured that all mandated CQC measures have been met and exceeded over time. The CQC have had no concerns about registration. The Trust undertakes its own mock inspections which are fed into the Board. CQC reports to 2013 demonstrate compliance with essential standards but in some areas actions are needed to maintain compliance. Action plans are in place and monitored via Quality and Clinical Performance Committee Review at Trust Board No sanctions issued by CQC during 2012/13 CQC complaince report with no conditions or recommendations	CQC inspection reports are reported to Quality and Clinical Performance Committee All CQC reviewers	QCPC minutes	**Amber**	Contractural issues. Compliance assessement		Embed HealthAssure system across the Trust Sarah Johnston/Brian Johnston Update October 2012: Initial cascade training completed. System continues to be rolled out to wards and departments. Aiming to complete roll-out by March 2013 Update January 2013: Roll-out plans on target and expected to be achieved. Unannounced visit by CQC in January 13 - no significant concerns or sanctions issued . Change of assurance rating to Green approved February 2013 Update June 2015: AWSFollowing discussion with the CQC sufficient mitigation was presented against eenforcement actions. Closer working with TDA and CCG to understand contractual issues. Further compliance assessment undertaken in June 2015. Recommend change of assurance rating from Green to Amber
<u>Priority 2</u> **Lead: Executive Director of Nursing** **<u>Improve clinical effectiveness, safety and outcomes for our patients</u>** **Links to CQC Regulations: 9, 10, 12, 13, 14, 17, 18, 20, 21, 22, 23**					*MEASURES:* *~~VTE compliance~~* *HAPPI audit results* *~~HMSR stats.~~ SHMI* *Pressure Ulcer indicators* *CQUIN outcomes* *MRSA and Cdiff stats.* *Approved departmental clinical governance plans:* *- National performance targets* *- Participation in screening programmes* *- Participation in Health improvement programmes for children and young people*			*TARGETS:* *Board approved quality account within DH deadline* *90% compliance against all HAPPI indicators* *Zero MRSA cases in 2014/15* *Achieve rebased HMSR and SHMI of <108 by end March 2015* *Zero Grade 4 pressure ulcers in a hospital setting* *50% reduction in grades 1,2 and 3 pressure ulcers in hospital setting, from a 2013/14 baseline* *25% reduction in overall incidence of patients developing pressure ulcers in hospital* *50% reduction in grades 1 to 4 pressure ulcers in a community setting, from a 2013/14 baseline* *Centralise PALS service by 31st May 2014* *Trust-wide action plan (from national patient/staff surveys) developed by 31st May 2014* *Ward Boards in place in all identified areas by 31st December 2014* *10% reduction in hospital led outpatient cancellations from a 2013/14 baseline* *100% achievement of CQUINS* *>95% VTE assessments throughout 2014/15*	
2.9 *(2.14)* There are no service level scorecards or dashboards which detail performance against articulated goals (Q35) Executive Director of Nursing / Executive Director of Finance	**5**	**10**		There are service level mechanisms for monitoring quality: There are developed and aligned service level risk register; There are developed and aligned service level dashboards or scorecards; There is an emphasis on real-time reporting and alerting; There is evidence of quality dashboards being used as a key mechanism for monitoring quality; Staff know how performance against local goals relates to the performance against trust wide goals; Local goals are visible in ward areas along with clear improvement plans. Nursing Dashboard in place for Wards, include performance against articulated goals including key quality indicators Service level risk registers are in place which feed up into directorate level risk registers which feeds up into the corporate risk register Directorate level dashboards are in place and a number of these go down to service level Ward Sisters attend a monthly meeting with Executive Director of Nursing and Workforce to review performance against the Nursing Dashboard Incident reporting and alerting takes place in real time Ward - score card then monitored	QCPC QCGC - minutes	Monthly report to Board by Executive Director of Nursing and Workforce Board Performance Reports	**Amber**	No service level dashboard that captures Quality, Finance and Activity/ Performance.		Develop consultants dashboard **Mark Pugh** Update April 2014: Department level dashboards now in development - roll-out expected May 2014 **Update June 2014:** Balanced scorecard for department teams now in development **Review date: August 2015** Develop community teams dashboard **Alan Sheward** Update May 2014: Dashboard development ongoing Update July 2014: Dashboard development complete and now embedding utilisation. **Action complete** **Change of assurance rating to Green approved July 2014.** **Update June 2015: AS** We require service level information on Quality, Finance and Performance (activity). First service (Anaesthetics) currently being approached to generate Quality Dashboard. Work in progress **Recommend change of assurance rating from Green to Amber** **Update: August 2015**

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
2.15 (2.23) Delivering improved mortality ~~patient~~ outcomes and End of Life care Executive Medical Director	**12**			Monthly quality monitoring via performance report Monthly HSMR data into performance report from December 2011 onwards Surgeons outcome data produced and available for review Monthly bereavement review questionnaire commenced 05/15	Monthly performance report to Board Quality and Clinical Performance Committee Quality Account reporting via performance report	Mortality information Improvements in cardiac arrest rates All reported to board regularly as part of monthly performance report Mortality presentation to Board - quarterly reports EOL to be included in monthly Mortality Performace report	Red	Control systems not dealt with 2014-15 winter pressures		**Mark Pugh/Dr Sandya** Update June 2014: Balanced scorecard for department teams now in development Update August 2014: PIDs are now developing dashboards at Departmental level Update October 2014: When dashboards complete agree whether Board are fully assured as this is potentially 'green' now Update December 2014: no change to above Update March 2015: Cancelled surgery because of seasonal pressures, alongside slipped targets. **Change of assurance rating from Amber to Red approved April 2015** **Update May 2015:** Risk title extended to include EOL care. Monthly bereavement review commenced. HMSI 1.06 is within acceptable limit. Policies in review with update to Trust Board 07/15. **Review date: August 2015**
2.39 *(10.74)* There are significant unresolved quality issues (B35) Executive Director of Nursing	**5**	**10**		The Board has communicated a clear set of values/ behaviours and how staff that do not behave consistent with these values will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the Trust's stated values/ behaviours. There are processes in place to ensure that staff are informed about major risks that might impact on patients, staff and the Trust's reputation and understand their personal responsibilities in relation to minimising and managing these key risks. Quality report Quality Account	QPSC QCGC	Performance reports monthly Quality Account	**Amber**	**There Is a lack of assurance specific Nursing Quality Indicators are improving.**	**Insufficent improvments in some of the key quality improvement requirements.**	**Update June 2015: AWS** The Quality report identifies signifianct quality challenges that have been unresolved. Pressure Ulcers being the primary concern raised by board. Sufficient improvement has not been realised. **Recommend change of assurance rating from Green to Amber** **Review date: August 2015**
Principal Objective 2: CLINICAL STRATEGY - To deliver the Trust's clinical strategy, integrating service delivery within our organisation and with our partners, and providing services locally wherever clinically appropriate and cost effective **Exec Sponsor: Executive Medical Director**										
Priority 3 **Lead: Executive Director of Transformation and Integration/ Executive Medical Director/ Executive Director of Nursing** **Continuously develop and successfully implement our Business Plan** **Links to CQC Regulations: 10, 22**						*MEASURES:* *Integrated Trust Business plan* *Directorate business plans* *National key performance targets*				*TARGETS:* *Integrated Business Plan approved by June 2014* *Directorate Business Plans agreed by* *Meeting NHS outcomes framework plans by the year end* *Achievement of CIP schemes*
3.61 (5.7 (8.5)) There is a history of insufficient planning, or plans causing performance exceptions. (Q37) Chief Operating Officer/Executive Director of Transformation & Integration	**4**			Plans take into account some element of target re-basing, assumptions are robust enough to withstand externally prompted change. The Board ensures that key information is assimilated into key aspects of strategy. The Board is assured of the organisation's performance via the Performance Report and high-level RAG rating of performance. Demand Plans are set with commissioners and matched to capacity plans to identify potential areas to be addressed. There is a systematic system for undertaking Market Analysis Board ensures that key information is assimilated into key aspects of strategy Annual business planning signed off via IBP steering group. Directorate Business plans presented to Board March 2014	Performance Reviews, Board COO reports, Demand & Capacity Plan and SLA contract monitoring	Board Performance Report, Performance Dashboards, Monthly SLA reviews Directorate Business plans presented to Board March 2014	**Amber**	The organisation has not demonstrated a consistently good level of performance in the past 12 months across most of its key indicators and targets		**Karen Baker/**Mark Pugh/Alan Sheward/**Shaun Stacey/Katie** **Update April 2015:** Levels of performance have decreased, identified need to be proactive. **Change of assurance rating from Green to Amber approved June 2015** Update May 2015: Developing demand and capacity plan with action plans for all specialities trajectories that are failing RTT. Action plans are to support current intensive work through ED. In final preparation of bed capacity planb to improve scheduling. **Update June 2015: KB** Business planning for 16/17 started 06/15. **EDTI added as Lead Director** **Review date: July 2015** (Monthly) by EDTI

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
Principal Objective 3: RESILIENCE - To build the resilience of our services and organisation, through partnerships within the NHS, with social care and with the private sector **Exec Sponsor: Chief Executive**										
<u>Priority 6</u> **Lead: FT Programme Director** **<u>Develop our Foundation Trust application in line with the timetable set out in our agreement with the TDA</u>** Links to CQC Regulations: 10, 15, 16							*MEASURES:* *FT Milestones* *CQC Inspection outcomes* *CIPs/savings plans* *LTFM* *Board Governance*		*TARGETS:* *Integrated Business Plan and LTFM refresh to be submitted by end June 2014* *CQC inspection outcome of either outstanding or good rating* *Satisfactory 'Board to Board'*	
6.45 *(10.10 (10.14))* There is little or no evidence of a cohesive quality assurance and escalation framework which is understood by all members of the Board (Q26) Executive Director of Nursing	**5**	**10**		There is a clear assurance and escalation framework for the Trust (AEF): The framework describes assurances on controls for most aspects of running the 'system' (e.g. data quality, cost improvements, audit effectiveness, HR and training etc.). The AEF describes a range of both internal and external sources of assurance. The Board are all conversant with the details of the AEF. The AEF contains innovative ways of seeking assurance (back to the floor, quality walks etc). The AEF is brought to life through a robust service line management and reporting framework.. There is an emphasis on real-time performance management for real-time assurance. Nursing dashboard QA and escalation framework in place to meet all the requirements and good practice as listed above	QCPC	Performance Reports	**Amber**	**The current board Quality Improvement Plan has not been approved by the board.**		Quality assurance and escalation framework needs to be developed Alan Sheward Change of assurance rating to Green approved June 2013 Update June 2015: AS As the requirements of the Quality improvment plan reduce the Quality Improvement Framework will need to support sustainable Quality Improvment, clearly articulating the process for Quality Improvement and Quality Assurance. There is a clear need to articulate the process for monitoring and managing. QIF not approved to date Recommend change of assurance from Green to Amber Review date: August 2015

<u>Board Assurance Framework column headings: Guidance for completion and ongoing review</u> (N.B. Refer to DoH publication 'Building an Assurance Framework' for further details)

<u>Principal Risks:</u> All risks which have the potential to threaten the achievement of the organisations principal objectives. Boards need to manage these principal risks rather than reacting to the consequences of risk exposure.
<u>RISK LEVEL</u> = S (Severity where 1 = insignificant; 2 = minor; 3=moderate; 4=major; 5=catastrophic) X L (Likelihood where 1=rare; =unlikely; 3=possible; 4=likely; 5=certain)= RS(Risk Score). Code score: 1-9 GREEN; 10-15 AMBER; 16+ RED

<u>Controls in Place:</u> To include all controls/systems in place to assist in the management of the principal risks and to secure the delivery of the objectives.

<u>Assurances on Controls:</u> Details of where the Board can find evidence that our controls/systems on which we are placing reliance, are effective. Assurances can be derived from independent sources/review e.g. CQC, NHSLA, internal and external audit; or non-independent sources e.g. clinical audit, internal management reports, performance reports, self assessment reports etc.
NB 1: All assurances to the board must be annotated to show whether they are POSITIVE (where the assurance evidences that we are reasonably managing our principal risks and the objectives are being delivered) or NEGATIVE (where the assurance suggests there are gaps in our controls and/or our assurances about our ability to achieve our principal objectives)
NB 2: Care should be taken about references to committee minutes as sources of assurance available to the board. In most cases it is the reports provided to those committees that should be cited as sources of assurance, together with the dates the reports were produced/ reviewed, rather than the minutes of the committee itself.

<u>Assurance Level RAG ratings:</u>
Effective controls in place and Board satisfied that appropriate positive assurances are available <u>OR Effective controls in place with positive assurance available to Board and action plans in place which the Executive Lead is confident will be delivered on time</u> = GREEN (+ add review date)
Effective controls mostly in place and some positive assurance available to the board . Action plans are in place to address any remaining controls/assurance gaps = AMBER
Effective controls may not be in place or may not be sufficient. Appropriate assurances are either not available to Board or the Exec Lead has ongoing concerns about the organisations ability to address the principal risks and/or achieve the objective = RED
(NB - Board will need to periodically review the GREEN controls/assurances to check that these remain current/satisfactory)

<u>Gaps in Control:</u> details of where we are failing to put controls/systems in place to manage the principal risks or where one or more of the key controls is proving to be ineffective.

<u>Gaps in Assurance:</u> details of where there is a lack of board assurance, either positive or negative, about the effectiveness of one or more of the controls in place. This may be as a result of lack of relevant reviews, concerns about the scope or depth of any reviews that have taken place or lack of appropriate information available to the board.

<u>Action Plans:</u> To include details of all plans in place, or being put in place, to manage/control the principal risks and/or to provide suitable assurances to the board. NB: All action plans to include review dates (to enable ongoing monitoring by the board or designated sub-committee) and expected completion dates (to ensure controls/assurances will be put in place and made available in a timely manner)

<u>Assurance Framework 2013/14 working document - August 2013. Guidance last updated December 2009.</u>

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 1 July 2015

Title	Statutory and Formal Roles			
Sponsoring Executive Director	FT Programme Director/Company Secretary			
Author	Lucie Johnson, Head of Corporate Governance			
Purpose	Annual review of the Statutory and Formal Roles to be Approved			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee	08.06.15	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment, Information & 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:

None

Executive Summary:

1. Theresa Gallard is now the deputy for Nominated Officer to the Care Quality Commission.
2. Sarah Johnston is now the Named deputy as Executive lead for Safeguarding Children
3. Similarly Vicky Kalaker, is now the deputy for Named nurse/midwife for Safeguarding Children.
4. Nigel Acheson is the deputy responsible officer for revalidation
5. Mark Pugh has become the responsible Director for Clinical Information Systems with Sabeena Allahdin acting as deputy.
6. Mark Pugh has become the Director with responsibility for End of Life Care, with Sarah Gladdish as his deputy.
7. The formal role for the Care of the Dying has been removed.
8. The lead for Medical Devices Alerts and Patient Safety Alerts is Alan Sheward, with Mark Pugh as deputy.
9. The role of Designated Adult Safeguarding Manager, has been assigned to Sarah Johnston, with Vanessa Flower operating as deputy.
10. Security Management Director – line added
11. Local Security Management Specialist – line added

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Excellent Patient Care Work with others to keep improving our services A positive experience for patients, service users and staff Skilled and capable staff Cost effective sustainable services
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	x
Legal implications, regulatory and consultation requirements						
Date: 18th June 2015 **Completed by:** Lucie Johnson, Head of Corporate Governance						

Isle of Wight NHS Trust – Statutory and Formal Roles - 2015/2016

Directorate	Statutory (*)/ Formal Role	Name	Job Title	Deputy/cover	Job Title	Review date (if applicable)
Corporate	Director of Infection Prevention & Control (DIPC)	**Alan Sheward**	Executive Director of Nursing	Deborah Matthews	Lead for Patient Safety, Experience and Clinical Effectiveness	*Review annually
Corporate	Information Governance Registration Authorities	**Alan Sheward**	Executive Director of Nursing	Mark Elmore	Deputy Director of Workforce	*Review annually
Corporate	Nominated Officer to Care Quality Commission (as registered provider of Services)	**Alan Sheward**	Executive Director of Nursing	Theresa Gallard	Business and Projects Manager	*Review annually
Corporate	Safeguarding Adults	**Alan Sheward**	Executive Director of Nursing	Sarah Johnston	Deputy Director of Nursing	*Review annually
Corporate	Safeguarding Children	Executive Lead **- Alan Sheward** **Sarah Johnston** **Dr Arun Gulati** **Dr Andrew Watson** **Ann Stuart**	Executive Director of Nursing Deputy Director of Nursing Named Doctor for Safeguarding Children Named Doctor for Safeguarding Children Named Nurse / Midwife for Safeguarding children	Sarah Johnston Ann Stuart Dr Watson Dr Gulati Vicky Kalaker	Deputy Director of Nursing Named Nurse / Midwife Named Doctor for Safeguarding Children Named Doctor for Safeguarding Children Specialist Nurse for Safeguarding Children	*Review annually
Corporate	Counter Fraud Board Lead	**Chris Palmer**	Executive Director of Finance	Kevin Curnow	Deputy Director of Finance	*On change of post holder
Corporate	Director responsible for Information	**Chris Palmer**	Executive Director of Finance	Iain Hendey	Deputy Director of PIDS	*On change of post holder
Corporate	Decontamination Lead	**Alan Sheward**	Executive Director of Nursing	Hilary Male	Operational Manager, HSDU	*Review annually
Corporate	Senior Information Risk Officer (SIRO)	**Mark Price**	Foundation Trust Programme Director/ Company Secretary	Chris Palmer	Executive Director of Finance	*Review annually
Corporate	Caldicott Guardian	**Mark Pugh**	Executive Medical Director	Alan Sheward	Executive Director of Nursing and Workforce.	*Review annually
Corporate	Human Tissue Act Licence Holder	**Mark Pugh**	Executive Medical Director	Dr Kamarul Jamil	Consultant Histopathologist	*On change of post holder
Corporate	Responsible Officer for Revalidation (RO)	**Mark Pugh**	Executive Medical Director	Nigel Acheson	NHSE Medical Director (South)	*On change of post holder
Corporate	Senior Independent Director (SID)	**Charles Rogers**	Non Executive Director	N/A	N/A	*Review annually
Corporate	Mental Health Act Managers Lead (Chairman of Mental Health Act Scrutiny Committee)	**Jessamy Baird**	Non Executive Director	Nina Moorman	Non Executive Director	*On change of Post holder

Directorate	Statutory (*)/ Formal Role	Name	Job Title	Deputy/cover	Job Title	Review date (if applicable)
Corporate	Health & Safety Manager	**Connie Wendes**	Assistant Director Health & Safety and Security	Martin Keightley	Deputy Health, Safety & Security Manager	*On change of post holder
Corporate	Accountable Officer for the Distruction of Controlled Drugs	**Connie Wendes**	Assistant Director Health & Safety and Security	Rob Jubb	(Accountable destruction officer) Local Security Management Specialist	*On change of post holder
Corporate	Medicines Management	**Alan Sheward**	Executive Director of Nursing	Gill Honeywell	Chief Pharmacist	*Review annually
Corporate	Local Counter Fraud Specialist	**Barry Eadle**	Local Counter Fraud Specialist	As notified during absence	Designated Member of TIAA Ltd	*Review annually and as part of contract award
Corporate	Director responsible for Clinical Information Systems	**Mark Pugh**	Executive Medical Director	Sabeena Allahdin	Clinical Director	*On change of post holder
Corporate	Lead for Emergency Preparedness	**Alan Sheward**	Executive Director of Nursing and Workforce	Sarah Johnston	Deputy Director of Nursing	Reviewed annually.
Corporate	End of Life Care	**Mark Pugh**	Executive Medical Director	Sarah Gladdish	Consultant Physician - Care of the Elderly	*On change of post holder
Corporate	Executive Lead for Medical Devices	**Alan Sheward**	Executive Director of Nursing	Mark Pugh	Executive Medical Director	*Review Annually
Corporate	Lead for Medical Devices Alerts and Patient Safety Alerts	**Alan Sheward**	Executive Director of Nursing	Mark Pugh	Executive Medical Director	*Review Annually
Corporate	Lead Non-Executive Director for Procurement	**Charles Rogers**	Non Executive Director	David King	Non Executive Director	*On change of post holder
Corporate	Security Management Director	**Mark Pugh**	Executive Medical Director	Connie Wendes	Assistant Director Health & Safety and Security	*On change of post holder
Corporate	Local Security Management Specialist	**Connie Wendes**	Assistant Director Health & Safety and Security	Rob Jubb	Local Security Management Specialist	*On change of post holder
Corporate	Local Security Management Specialist Mental Health	**Rob Jubb**	Local Security Management Specialist	Connie Wendes	Assistant Director Health & Safety and Security	*On change of post holder
Corporate	Designated Adult Safeguarding Manager	**Sarah Johnston**	Deputy Director of Nursing	Vanessa Flower	Interim Lead for Adult Safeguarding	*Review Annually

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 23rd June 2015

Title	Turnaround Board – Terms of Reference			
Sponsoring Executive Director	Chief Executive			
Author(s)	Executive Director of Finance			
Purpose	To approve			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee	15/06/15	Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment, Information & 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:

Executive Summary:

Following the creation of the Turnaround Board, the Trust Board is asked to approve the Terms of Reference for the creation of a new Board Sub Committee.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*						
Critical Success Factors *(see key)*	CSF 1-10					
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: 23/06/15 Completed by: Angelo Cascarini, Compliance Officer

Turnaround Board

TERMS OF REFERENCE

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1. MAIN PURPOSE

1.1 The Turnaround Board will have direct responsibility, delegated by the Trust Board, for overseeing financial turnaround. The Turnaround Board will ensure robust workforce and financial controls are embedded and an accelerated approach to the design and implementation of safe cost savings and new ways of working to achieve productivity improvements. The Board is required to ensure a sustainable financial basis for our long term future, while continuing to improve services for our patients and the wider Island community.

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2. MEMBERSHIP & QUORUM

2.1 Membership

2.1.1 The Committee will consist of 9 members

2.1.2 Members

- Chief Executive (Chair)
- Executive Director of Finance/Turnaround Director (Deputy Chair)
- Executive Director of Nursing(or designated Deputy)
- Executive Medical Director (or designated Deputy)
- Deputy Director of Finance
- Deputy Director of Workforce
- Chief Operating Officer (or designated Deputy)
- Executive Director of Integration and Transformation
- Designate Non-Executive Director

2.1.3 The following will be in attendance:

- Interim Director of Workforce
- Turnaround Board Administrator

2.1.4 Where Turnaround Board members are unable to attend a scheduled meeting it is expected that they will send a deputy with the authority to make decisions and commit resources on their behalf.

2.2 Quorum

2.2.1 A quorum shall be no less than 3 members or their designated deputies (in the case of Executive Directors).

2.2.2 The Designate NED can also be included as part of the quorum.

2.2.3 In line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting.

3. ATTENDANCE OF MEETINGS

3.1 It is agreed that all members should endeavour to attend a minimum of 3 out of the 4 meetings per month.

3.2 When the Committee is discussing areas of risk or operation, any other director, manager or employee may also be required to attend in order to present papers or to provide additional information in support of discussions.

4. FREQUENCY OF MEETINGS

4.1 Meetings will be held on a weekly basis initially but may be varied according to the need of the Board.

5. DELEGATED AUTHORITY

5.1 The Turnaround Board is constituted as a sub-committee of and directly accountable to, the Trust Board.

6. ROLES AND RESPONSIBILITIES

6.1 To oversee the achievement of Financial Turnaround
6.2 To approve proposals and plans to be actioned
6.3 To approve resources needed to deliver turnaround expectations
6.4 To authorise the cessation of services/activities/implementation of new controls
6.5 To monitors progress against targets, CIP and others such as workforce measures
6.6 To ensures that quality and performance objectives are sustainable alongside financial outturn
6.7 To oversee communication regarding Turnaround within the organisation
6.8 To hold individual responsible managers to account for their delivery on their programmes for CIP and Non CIP improvement programmes
6.9 To ensure that service performance is not negatively impacted by Turnaround activity
6.10 To seek assurance of progress of work through the PGO process

7. REPORTING

7.1 The Turnaround Board is constituted as a subcommittee of the Trust Board and reports to the Trust Board through minutes of meeting.

7.2 Its terms of reference will be subject to amendment by the Trust Board as necessary.

7.3 The Turnaround Board will report progress through Trust Executive Committee, Finance, Investment, Information & Workforce Committee, and Quality & Clinical Performance Committee.

8. DUTIES AND ADMINISTRATION

8.1 It is the duty of the Turnaround Board to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour.

8.2 The Turnaround Board will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.

8.3 The Turnaround Board shall be supported administratively by the Turnaround Administrator, whose duties in this respect will include:

a) Agreement of agenda with Chairman and collation of papers
b) Circulate agenda papers a minimum of 2 working days in advance of the meeting
c) Take the minutes
d) In Line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting
e) Keeping a record of matters arising and issues to be carried forward
f) Maintaining an Action Tracking System for agreed actions
g) In conjunction with the Chairman and Lead Executive Director, prepare an annual report on the effectiveness of the Turnaround Board for submission to the Audit & Corporate Risk Committee
h) Maintain an Attendance Register. The completed Register to be attached to the Turnaround Board's annual report
i) To maintain agendas and minutes in line with the policy on retention of records

8.4 An annual review will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Turnaround Board meetings.

9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

9.1 These Terms of Reference will be reviewed annually to ensure that the Turnaround Board is carrying out its functions effectively.

9.2 Attendance and frequency of meetings will be monitored by the Turnaround Administrator and reported back to the Turnaround Board on a monthly basis.

9.3 Concerns highlighted when monitoring compliance with the above will be discussed at Turnaround Board and referred to the Board immediately.

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Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 1 JULY 2015

QUALITY & CLINICAL PERFORMANCE COMMITTEE
Wednesday 24 June 2015

Present:	Nina Moorman	Non-Executive Director - Chair
	Jessamy Baird	Non-Executive Director (Vice-Chair)
	David King	Non-Executive Director
	Alan Sheward	Executive Director of Nursing (EDN)
	Kay Marriott	Clinical Director, Community Directorate (CD-C)
	Alexis Bowers	Clinical Director, Mental Health Directorate (CD-MH)
	Chris Orchin	Chair, Healthwatch IW (HIW)
In Attendance:	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM)
	Lucie Johnson	Head of Corporate Governance (HOCG)
	Vanessa Flower	Patient Experience Lead (PEL)
	Laura Bail	Quality Manager, Community Directorate (QM-C)
	Cath Love	Quality and Clinical Performance Manager, HAD (QMHAD)
	Sarah Butler	Matron/Manager for Paediatrics (MMP) *(for item 15/Q/123)*
	Annie Hunter	Head of Midwifery (HOM) *(for item 15/Q/124)*
Minuted by:	Anna Daish-Miller	Sub Committee Administrator (PA)

Key Points from Minutes to be reported to the Trust Board

0430 (from Action tracker) – Assurance regarding hip fracture post op assessment now provided by Consultant Geriatrician. Further work being done on delay to admission – theatre time.

15/Q/117 – Concern about low levels of Mandatory Training achieved in many wards as training and quality are linked.

15/Q/123 – Assurance provided by action taken by Paediatric unit following review by Royal College of Paediatrics and Child Health: however recruitment of specialist staff remains an issue.

15/Q/124 – Assurance provided by action taken within Maternity Services following Morecombe Bay Report.

15/Q/126 – Quality Improvement Plan. Assured by robust process for monitoring progress although unchanged position from last month on compliance actions.

Minute No.

15/Q/112 APOLOGIES FOR ABSENCE

Apologies were received from Mark Pugh, Executive Medical Director (EMD), Deborah Matthews, Lead for Patient Safety, Experience & Clinical Effectiveness and Deputy DIPC (LSEE) and Sabeena Allahdin, Clinical Director for the Hospital and Ambulance Directorate (CD-HAD)

15/Q/113 CONFIRMATION OF QUORACY

The Chair confirmed the meeting was quorate.

15/Q/114 DECLARATIONS OF INTEREST

There were no declarations of interest.

15/Q/115 MINUTES OF THE MEETING HELD ON 27 MAY 2015

The minutes of the meeting held on 27 May 2015 were agreed with the following amendments:

15/Q/102 – Minutes to reflect that the Clinical Audit Programme was reviewed and agreed alongside the Strategy

15/Q/116 REVIEW OF ACTION TRACKER

The Committee reviewed the Action Tracker:

QCPC0291 – Mortality Presentation is to be presented at the July meeting.

QCPC0316 – Paper discussing 7 day services is to be presented at the July meeting.

QCPC0351 – Report confirming process for Clinical Governance due at the July meeting.

QCPC0364 – It was confirmed the issue of Information Governance around system failure has been added to the risk register, but noted that the focus needs to be around the clinical implications, how to access/retrieve records if the system fails. It was confirmed business continuity plans are in place. Action closed.

QCPC0373 – Update on Nutrition Lead Business Case due at the July meeting.

QCPC0401 – SOP has not yet been finalised, awaiting a piece of work on the documentation process currently underway. Due to be completed end of August. September date to be added to the Action tracker.

QCPC0416 – OPARU Report – Action Closed.

QCPC0448 and QCPC0449 – RCA completed around OPARU and solution developed for support, but not agreed at TEC due to lack of funding. Chair to write and raise with the COO.
***Action Note**: Chair to write to the COO and raise the issue of OPARU.*

Action by Chair

QCPC0425 – Falls to be discussed later in the meeting. Action to remain open.

QCPC0426 – NICE guidance – Results of asthma reaudit to be presented at the next SEE Committee.

QCPC0440 – SEEBM confirmed Trust is now part of networking group, but issue around implementation of NICE Guidance remains. Action to remain open.

QCPC0429 – SIRIs – New SIRI report to be presented later in the meeting. Action Closed.

QCPC0430 – Results of HIP audit suggested the Trust is an outlier, raised at the Trust Board who would like further assurances. There are 2 issues, delay in getting to theatre and post op assessment of bone fragility and falls. Chair has contacted Matron who confirmed that post op assessments are now carried out by Geriatrician. QM-HAD confirmed further breakdown has been added to the report giving more information around the delays going to theatre. . Updated report to be presented at the July meeting.
***Action Note**: Post op assessments and focus on time from admission to theatre to be reported to Trust Board by Chair*
Updated report on HIP audit to be presented at the July meeting.

Action by QC-HAD

QCPC0442 – Complaints Report – Paper to be presented at the July meeting.

QCPC0433 and QCPC0434 – Catheter audit – Formal update to be presented at the next meeting.

QPCP0435 – Sickness rates – Jessamy Baird reported following a visit to Shackleton, sickness levels remain high and as a consequence there are insufficient staff to accompany patients to the garden. The environment is still not fit for purpose and there are no volunteers on the ward. CD-C stated as it is a challenging area, it is difficult to recruit volunteers, CD-MH also confirmed the environment is not suitable for dementia patients. A paper has been commissioned by the CCG to seek alternative solutions, involving key stakeholders. Action Closed.

QCPC0436 and QCPC0425 – Incidents trips falls – Data for the previous year has been RAG rated and included within the Quality Report. Action closed.

QCPC0437 – Mental Health Act Assessments and DoLs – Although training of staff remains an issue process, Stroke and Rehab use to review DoLs at handover has been shared with the Hospital and Ambulance Directorate. Action Closed.

QCPC0438 – Emergency readmission – It was confirmed this has been reviewed by PIDS, and realigned with the Quality Contract. Action Closed.

QPCP0439 - CQUINS 15/16 – On the agenda for the July meeting.

QCPC0440 – Clinical Audit is on the agenda

QPCP0441 – Committee process has been discussed. Action closed.

QPCP0442 – Safety Alert Bulletins – Issues exits regarding Mandatory Training request declined, due to difficulty in staff attending. Nurse Specialist for Diabetes now to provide on the ward training to make attendance more manageable. Action closed.

QPCP0446 – The PEL confirmed this action has been completed. Action closed.

QPCP0447 - Bed Capacity – Confirmation that numbers are to be included in the HAD Report rather than a general update.

QCPC0450 – Sepsis Review. QM-HAD confirmed Sepsis is CQUIN for 15/16 requiring monthly audits and work has been completed with the roll out of the Sepsis Bundle throughout the organisation. Sepsis Review is an agenda item for the July meeting.

QCPC0452 – SEEBM confirmed waiting for formal letter from auditors regarding the Quality Account. One area flagged within the report concerning Friends and Family test including inpatient as well as Emergency Department. This has been rectified. Action Closed.

QCPC0453 – Deep dive of SIRIs has taken place using new paperwork and SIRIs are to be presented to the SEE Committee for sign off. Action Closed.

QPCP0455 – External Agencies Report. EDN asked to highlight overdue actions to TEC to increase assurance that actions are being taken in accordance with the report.

QUALITY

15/Q/117 QUALITY REPORT – EXCEPTIONS

The Committee reviewed the Quality Report for May 2015 in conjunction with the SEE Committee report. The main issues highlighted as follows:

- Number of C-diff cases increasing
- Number of SIRIs decreasing
- Number of falls increasing – Mandy Webb has been appointed Falls Lead and is keen to drive improvements forward starting with the reimplementation of the Acute

Falls Group linking with the Community Falls Group. It is important that this meeting is multidisciplinary meeting, with representation from Pharmacy, Physiotherapy and medical staff. A brief paper to be presented by Falls Lead on the ongoing work following the reinstatement of the Falls Group.

***Action Note**: to be added to the rolling programme.*

Action by PA

- Number of incidents and incidents causing harm increasing, but numbers post investigation have been downgraded.
- Pressure ulcers remain a concern with no decrease on last years figures. It was reported the new skin bundle is being rolled out in the Community where high patient caseload and pressure ulcers are interrelated. . Practice educator roles are being recruited in each locality to help provide education for Practice Nurses, Carers and Residential and Nursing Homes. Pressure Ulcer deep dive meeting took place this week, unfortunately there was a lack of medical representation. It was felt that more action should be taken and suggestion made to develop a strategic plan in conjunction the CCG, GPs and MLAFL combining all the ongoing work by the different organisations and identifying the gaps. Plan to be presented at the next meeting.

***Action Note**: EDN to set up Pressure Ulcer Risk Summit with key stakeholders and develop a strategy plan.*

Action by EDN

- Ward Dashboard reviewed and Mandatory Training figures noted as low. This could be staff unable to be released from the wards, staff sickness. As training and quality are linked it was felt this should be escalated to the Trust Board.

***Action Note**: Chair to raise low Mandatory Training compliance figures on the ward dashboard to the Trust Board*

Action by Chair

15/Q/118 REPORT FROM PATIENT SAFETY, EXPERIENCE AND EFFECTIVENESS (SEE) COMMITTEE – EXCEPTIONS

The SEEBM gave a verbal update following the SEE Committee meeting on 17 June 2015 highlighting the following:

Jessamy Baird queried why the Trust was rated in the bottom 20% for Mental Health Survey results. The issues raised within the report include CPA, lack of community beds and access to psychological therapies. The CD-MH explained there were lots of interventions ongoing to improve the score including redesigning of Psychological Therapies, reallocating of resources ensuring access within 18 weeks, formal CPA training for all staff.

The Chair requested an action plan be submitted to the Committee for assurance progress is being made as currently there is no assurance.
Action point for CD-MH

15/Q/119 RISK REGISTER REPORT

The HOCG presented the Risk Register Report and explained the papers included all the risks against QCPC regardless of score, and more details for those scoring 16 and above. It is anticipated the report for the next Committee will be more streamlined following a move to the new web based system Datix Webrisk.

It was recognised that there is currently an external governance review underway which will likely change processes etc. however the committee felt we should not delay making our own improvements.

The HOCG raised the issue that there are a number of risks discussed at this Committee, that are not on the risk register; falls, NICE Guidance compliance, increasing use of catheters and lack of clinical attendance at key meetings.

It was requested that strategic and service specific risks are differentiated as currently directorates are producing the actions on the registers and trust wide risks are not always identified. Also a way of highlighting actions that are systemic and are being 'tolerated' by the organisation, and those where changes should be made.

SEEBM raised the issue of staffing on the Stroke and Rehab wards as a key risk but is not on the risk register.

HOCG noted the Finance, Investment Information and Workforce Committee raised 2 risks to be highlighted at this Committee, HOCG to circulate them separately.
***Action Note**: HOCG to circulate the 2 risks raised at FIIWC to QCPC.*

Action by HOCG

DIRECTORATE REPORTS

15/Q/120 COMMUNITY DIRECTORATE

The CD-C presented the Community and Mental Health Service update advising this report will be presented to Trust Board on 1 July 2015. The CD-C highlighted the following:

- Medical Staffing for Stroke remains an issue, alternatives are been sought including meeting with Portsmouth to provide support. Vacancy is being covered with a locum who has been extended for 3 months, providing some consistency. Plan to ask Deanery to reinstate Junior Doctors training on the wards.. . There was a discussion about use of Nurse Consultant for stroke but there would be a knock on effect on on-call rotas.
- Difficulty also exists recruiting to vacancies with Psychiatry: locums and agency doctors are in place but causing financial pressure. It was noted that funding for transport and accommodation is currently being discussed by the financial turn-around team as a cost saving measure.
- Success with the opening of the Four Seasons garden and IRIS providing support at the Isle of Wight Festival

15/Q/121 MENTAL HEALTH DIRECTORATE

This item was covered under item 15/Q/120.

15/Q/122 HOSPITAL DIRECTORATE

The QM-HAD presented the Hospital and Ambulance Directorate update advising this report will be presented to Trust Board on 1 July 2015. The QM-HAD highlighted the following:

- Pressure for elective surgery to get back on plan, this has also affected the finances.
- Success of Omnicell project
- 8 minute metrics improvement on last month

15/Q/123 PAEDIATRIC ACTION PLAN

Sarah Butler presented the action plan following the Royal College of Paediatrics and Child Health Review and raised the following:

- Recruitment of both medical and nursing posts remain an issue. Difficulty exists attracting potential staff to the Island, particularly paediatric nurses. One of the solutions includes two NICU nurses looking to transfer to the Paediatric team and Southampton may reintroduce the shortened course to become a paediatric nurse, which could encourage nurses to dual train. Nursing posts remain more flexible than medical posts, and although currently fully staffed with Consultants, there are retirements in the future,

and plans are already being developed.
- To assist with the staffing issues, rotation with mainland hospitals was investigated, but difficult as St Mary's is not a training hospital for Paediatrics.
- Chief Executive has agreed to chair the Children's Board/ until a more permanent Chair has been agreed.

The Committee were assured by the Action Plan.

15/Q/124 MORECAMBE BAY REVIEW

The HOM presented the recommendations following the Morecambe Bay Review and highlighting the following:

- New co-ordinator post has been developed that will link the acute ward, community midwives, NICU and clinics.
- There will be one phone number that patients can use for advice for early labour that will be manned by the new co-ordinator freeing up the ward staff.
- Joint Mortality & Morbidity meetings with Southampton and Portsmouth are planned, which is a good opportunity to share lessons learnt.
- Invitation received to present a M&M Report at the Trust Mortality Review Committee in the Autumn.

The Committee were assured by the report.

15/Q/125 AMBULANCE DIRECTORATE

Item discussed under 15/Q/122.

15/Q/126 QUALITY IMPROVEMENT PLAN (QIP)

The SEEBM presented the copy of the presentation given to the Trust Development Authority at the most recent Integrated Delivery Meeting. A new quality matrix has been developed with Key Performance Indicators for all of the outstanding Compliance Actions. The matrix is reviewed weekly, with results of audits providing the data for the KPIs.

Further KPIs are being developed for the completed Enforcement Actions to ensure sustainability, measuring how processes are embedded and the remaining Must Dos and should Do Actions. Once finalised, all the KPIs will be included in the matrix.

The committee were assured by the clarity of the system for monitoring progress and look forward to actual progress soon.

15/Q/127 QUALITY GOVERNANCE WORKSHOP FEEDBACK

EDN gave a verbal report on the Quality Governance Workshop held on 29 May, exploring governance with the Directorates who were asked to self-assess their areas against the Quality Governance Assessment Framework. Further workshops have been set up on a quarterly basis.

Difficulty experienced gaining clinical engagement, despite providing 6 weeks notice. It was felt attending a clinical forum to explain the purpose of the events might be beneficial.

The self assessments carried out during the workshop highlighted concerns in some areas around the monitoring of quality governance. The service leads knew of the work ongoing in their areas, but it isn't always going through the correct processes. QM-HAD has requested every service self assess against the QGAF and report back to this Committee. Need to ensure clinicians are engaged, making it relevant to them, asking them to identify their own indicators of the service they provide.

EDN concluded there is lots of work ongoing and with a clearer governance structure some

of our areas would be rated as Outstanding.

PATIENT SAFETY

15/Q/128 SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) REPORT AND LESSONS LEARNT

The PEL presented the new SIRI Report which includes recent incidents and lessons learnt from closed cases, rather than reviewing action plans once they had been signed off by commissioners. This will now be done by SEE Committee. The committee discussed the new report format and requested sight of the flow chart for the new SIRI process.
It was suggested that information gathered in the SIRI 48 hour report could be added, including possible issues raised from the initial investigation. Also lessons learnt to be improved ensuring the content is less 'defensive' and provides actual lessons that can be shared. The PEL explained the new RCA tool will help this process ensuring the right information can be drawn and shared. The QM-HAD confirmed the information around lessons learnt that is shared at this Committee is a summary and more information is shared at Directorate level.

The EMD and EDN review all SIRIs before submission to the CCG and a monthly meeting has been set up with the Commissioner to avoid any SIRI reports being asked for further information.

The new report was welcomed by the Committee and noted the numbers of SIRIs are decreasing. HOCG queried whether it was possible to add into the report trend analysis year on year. PEL to discuss with Karen Kitcher.
***Action Note**: PEL to request trend analysis to be added in SIRI Report monitoring year on year providing assurances that trends can be identified and actions taken.*

Action by PEL

15/Q/129 SAFER STAFFING REPORT – EXCEPTIONS

This item was deferred to the July meeting.
***Action Note**: To be added to the rolling programme.*

Action by PA

PATIENT EXPERIENCE

15/Q/130 PATIENT STORY

The Committee viewed a video of a 2 families who had dealings with the Paediatric Ward and the following was noted:

- Staff took good care of patients
- Welcoming and relaxed atmosphere
- Same nurses on each day shift and night shifts
- Procedures and process was explained to the patient and parents
- Call bells not answered at busy times of day
- Lack of paediatric rooms in the Emergency Department. .
- Long wait for results
- Patient and parent asked by Beacon Centre to find their own way to the Paediatric ward noting that signage could be better and this was out of normal hours

***Action Note**: QM-HAD to investigate if it is normal practice for the Beacon not to accompany patients to the Paediatric ward*

Action by QM-HAD

The two patient stories were felt to be very positive.

15/Q/131 HEALTHWATCH ENTER AND VIEW VISITS – SUMMARY REPORT

The Healthwatch Enter and View Visits report was well received and progress can be seen against issues previously raised, particularly Cowell Ward responding to suggestions.

CLINICAL EFFECTIVENESS

15/Q/132 CLINICAL AUDIT ANNUAL REPORT

The PEL presented the Clinical Audit Annual Report 14/15. The following issues were highlighted:

- A number of National Audits not submitted, these are reported in the Annual Quality Account.
- It is expected that the number of audits submitted will be higher this year with the governance arrangements changing significantly

The committee requested more information on outcomes and action taken to address shortcomes. Chair requested a meeting with the report writer to expand on this

CLINICAL PERFORMANCE AND RISK

15/Q/133 BAF CRITICAL SUCCESS FACTORS

The HOCG presented the paper summarising the targets against BAF Critical Success Factors underpinning the 5 Strategic Objectives for 14/15. The summary of achievement against these targets was 30%.

The NHS Outcomes Framework was included as a supplementary document for information only as it related to one of the measures.

15/Q/134 CQC REGISTRATION LOG

The SEEBM explained the CQC Registration log is for information, and provides the Committee with an overview of any changes to registration.

The SEEBM further explained a paper has been submitted to the Trust Executive Committee (TEC) highlighting anomalies concerning registration of services. A working group is to be set up looking at each individual registration as it is believed they are not correctly registered.

15/Q/135 BOARD SELF CERTIFICATION

The HOCG presented the Board Self Certification and the Committee agreed that no changes are required, and it was confirmed there were no comments from the Finance, Investment, Information and Workforce Committee.

The Committee approved the Board Self Certification as presented.

15/Q/136 ANY OTHER BUSINESS

The Chair explained Patient Representative Ian Bast has resigned from the Committee, the Chair thanked Ian for his time on the Committee and stated he made a valuable contribution. 2 members of the Patients Council have been identified as member and deputy and will be present at the July meeting.

David King raised the issue of what assurances do we have as an organisation for the services we share with Portsmouth following their CQC rating of “Improvement Required”. EDN agreed to discuss with the Commissioners as we don’t directly commission the services and provide feedback at the next meeting.

Action Note: *EDN to discuss what affect Portsmouths CQC rating of Improvement Required will have on the services we share.*

Action by EDN

It was requested Chris Jackson attend the next meeting to provide an update on medical recruitment.
***Action Note**: Item to be added to the rolling agenda.*

Action by PA

The chair requested feedback from the Committee on how the meeting ran, including the papers. The feedback received was positive, feeling the meeting was more organised, understanding what the Committee is trying to address, with the Executive Summaries including relevant information from the paper. It was suggested a representative from a service/ward attend each meeting, could link with a key issue, concern or item on the QCPC. Shane Moody to be invited to the next meeting to discuss Sepsis.
***Action Note**: Sepsis to be added to the next agenda and Shane Moody asked to attend and present a paper.*

Action by PA

15/Q/137 DATE OF NEXT MEETING

Wednesday 29 July 2015
Time: 9 am to 12 Noon
Venue: School of Health Sciences

Signed: _____ Chair

Date: _____

Isle of Wight NHS Trust

FOR PRESENTATION TO TRUST BOARD ON 1st JULY 2015

FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE

Minutes of the meeting of the Finance, Investment, Information & Workforce Committee held on Tuesday, 23rd June 2015 at 1.00 p.m. in the Large Meeting Room, St. Mary's Hospital, Newport.

PRESENT	Charles Rogers	Non-Executive Director (Chairman)
	Jane Tabor	Non-Executive Director (JT)
	Katie Gray	Executive Director of Transformation & Integration (EDTI) Part meeting only
	Jane Pound	Interim Director of Workforce (IDW)
In Attendance	Kevin Curnow	Deputy Director of Finance (DDF) Deputising for EDF
	Gary Edgson	Head of Financial Management
(Items 15/F180/184/185/)	Iain Hendey	Deputy Director of Informatics (DDI)
(Items 15/F/181/182/183)	Lucie Johnson	Head of Corporate Governance (HCG)
(Items 15/F/170)	Jo Case	Programme Governance Manager
(Items 15/F/186/187)	Kevin Bolan	Associate Director of Estates
Minuted by	Linda Mowle	Corporate Governance Officer

Min. No.	Top Key Issues & Risks for Raising at TEC & Trust Board
15/F/158	**Long Term Financial Model/Annual Financial Plan 2015/16:** The Committee is concerned that at this point in the financial year there is no formal Financial Plan to turnaround the deficit forecast for 2015/16. The Committee has requested that, as well as a Long Term Financial Plan, a short term and a medium term plan be developed. In addition, financial planning for 2016/17 and 2017/18 be commenced in order to bring the Trust back into financial sustainability.
15/F/170	**CIPs Programme 2015/16:** The Committee is not assured that the CIPs Programme is on track to deliver the target of £8.5m for 20215/16. A CIPs Programme for 2016/17 has been requested.
15/F/171	**Financial Position:** The Trust is reporting a deficit position of £1.095m against a planned position of a £0.391m deficit in M2. This is an adverse variance of £0.704m. The Committee is not assured at this state that the Trust will meet its forecast financial outturn position for 2015/16.
15//F/180	.**Reference Costs Submission:** The Committee was satisfied with the Trust's costing processes and systems and is assured that the Trust will submit its Reference Cost Return in accordance with guidance.
15/F/186 & 187	**Sale of The Gables and 68-71 Swanmore Road, Ryde:** The Committee has made a recommendation on the proposal to sell the two properties.
15/F/188	**Board Certification:** The Committee confirmed that sufficient assurance has been provided to be able to recommend that the Trust Board approve the Self Certification return as proposed

15/F/152 APOLOGIES

Apologies were received from Lizzie Peers, Non-Executive Financial Advisor, and Chris Palmer, Executive Director of Finance.

Lizzie Peer's had submitted her comments on the reports and these are included within the minutes.

15/F/153 QUORACY

The Chairman confirmed that the meeting was quorate.

15/F/154 DECLARATIONS OF INTEREST

There were no declarations.

15/F/155 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on the 26th May 2015 were agreed and signed by the Chairman as a true record.

15/F/156 SCHEDULE OF ACTIONS

The schedule of progress on actions arising from previous minutes was noted with the following comments:

a) F/009 Carbon Energy Fund: The Committee noted that dialogue is on-going with the Trust's auditors (E&Y) to obtain confirmation of the scheme's balance sheet treatment. The District Network Operator (DNO) has confirmed it should be in a position to provide a connection offer in September. The EW&SM to provide an update report for the July meeting of the Committee.

Action: EW&SM

b) F/050 Completion of Clinical Evaluations for Procurement: The DDN to provide an update for the schedule of actions for the July meeting.

Action: DDN/CA

c) F057 Workforce Programme: The IDW tabled the Programme Overview Document – Organisational Workforce Schemes for information. Status – closed.

d) F/062 Annual Review of Losses & Compensations: Agenda item for June meeting. Status – closed.

e) F/064 Protocol for Non Supported Software: Agenda item for June meeting. Status – closed.

f) F/067 Risks to Software: Agenda item for June meeting. Status – closed.

g) F/070 Sale of Gables: Agenda item for June meeting. Status – closed.

h) F/071 Board Self Certification Report: Agenda item for June meeting. Status – closed.

i) F/072 Cash Flow Trends: Included within Finance Report for June meeting. Status – closed.

j) F/073 Oncology Service: An update to be provided by QCPC to ensure Island residents are receiving appropriate care and to highlight any concerns. To be included in the schedule of actions. **Action: QCPC/CA**
(Post meeting note: 24/06/26 Chairman emailed to request QCPC's update.)

k) F/074 Compliance with SFIs: Jane Tabor was disappointed to note that

no Officer was available for the meeting given the organisation's financial position. The Committee agreed that the Accountable Officer for the Hospital Directorate be formally invited to attend to explain the budgetary breach of SFIs and how this is to be rectified. **Action: CA**
(Post meeting note: The Chief Operating Officer has been invited to attend the meeting on the 28th July 2015 at 1.30 p.m.)

l) F/078 CIP Programme Report: The top 5 projects to be included in the update report for the July meeting. **Action: EDTI/PGM**
(Post meeting note: email sent 24/06/15 to Programme Manager, Jo Case, asking for confirmation that the top 5 projects can be incorporated into the report with regular monitoring.)

m) F/079 Monitor Financial Risk Indicators: Indicators reviewed and included on the June agenda. Status – closed.

n) F/081 Internal Audit Recommendations: Agenda item for June meeting. Status – closed.

o) F/082 Risk Register: Agenda item for June meeting. Status – closed.

LONG TERM STRATEGY AND PLANNING

15/F/157 ANNUAL OPERATING PLAN 2015/16

The DDF advised the meeting that the Annual Operating Plan 2015/16 had been submitted to the TDA on 14th May 2015 and confirmed that a high level feedback letter providing an overall assessment of the Plan had been received which had RAG rated the Plan in 3 areas as 'Red', namely Finance, Performance and Quality.

With regard to the red RAG ratings, Jane Tabor asked what the implications for the Trust were and was advised by the DDF that this would mean that the Trust would be monitored more frequently and that the TDA will be working closely with the Trust over the coming weeks.

15/F/158 LONG TERM FINANCIAL MODEL

The DDF confirmed that the LTFM was being updated with the outturn figures for 2014/15 and advised that the team was working on adding future CIP details, pay inflation and planned activity data for the next 5 years. However, at this point in time there is a limited Financial Plan and work is being undertaken in conjunction with the Turnaround Board where 4 main projects were being proposed that would release a significant amount of money to offset the deficit for the current financial year. The first meeting of the Turnaround Board is tomorrow, Wednesday 25th June 2015.

The Chairman expressed the Committee's concern regarding the External Auditors' qualified value for money conclusion contained within their Audit Results Report for the Annual Accounts 2014/15 in respect of financial resilience. The DDF reported that this had been discussed at the recent Board to Board meeting with the TDA where it was questioned whether the Trust was financially sustainable.

Jane Tabor asked that as well as a Long Term Financial Plan, a short term and a medium term plan be developed as the Turnaround Board was only looking at the short term. In addition, she queried in what form and how the

discussions around the various options will be taken forward in order to make the decisions on the Plans. The Chairman requested that engagement of the clinical teams be included in the development of the Plans. **Action: DDF**

Lizzie Peers had commented that in order to gain assurance going forward financial planning for 2016/17 and 2017/18 should be reviewed. The Committee agreed and requested a paper on the financial planning for 2016/17 and 2017/18 be presented to the July meeting. **Action: DDF**

The Committee agreed that the EDF take forward these proposals and provide a written update report at the next meeting. **Action: EDF**

The Committee was extremely concerned that at this point in the financial year there was only a limited Financial Plan to turnaround the deficit forecast for this financial year.

CONTRACTS AND ACTIVITY

15/F/159 CONTRACT STATUS REPORT

The Committee received the self-explanatory status report prepared by the Assistant Director of Contracting, noting the following:

- The Trust has a signed 3 year contract with the Isle of Wight Clinical Commissioning Group (IoW CCG) which expires on 31/03/17 and therefore is signing the National Variation for 2015/16.
- IoW CCG 2015/16 contract value has been agreed at £122.5m. The contract has been finalised and being signed off. Acute elements will be on Payment by Result basis, with a 2% cap on elective services. Community, Ambulance and Mental Health services will be on a block basis. The CCG has agreed to fund £5.1m Interim Support
- The Trust has received approximately £83k worth of penalties in April 2015 as a result of breaches to A&E 4 hours, ambulance handover, admitted 18 weeks referrals to treatment and waits over 52 weeks. The Trust is working with the CCG through the System Resilience Group to re-invest these penalties into the health economy in line with the national guidelines
- The Trust has incurred 4 C-Diff breaches in April and May 2015 against 2015/16 cumulative target of 7
- NHS England 2015/16 contract value has been agreed at £11.4m. The Trust and NHSE have signed a Heads of Agreement. The contract has been finalised and is going through final touch up
- The value of under-delivery of routine units of dental activity in 2014/15 under the Personal Dental Services (PDS) contract has been estimated at approximately £120k
- IOW CCG has identified 3 services to move into the Locality Contract in 2015/16 as part of the development of My Life A Full Life alliance contracting model.

In reply to a query from Jane Tabor on the CCG contract, the Committee noted that the contract amount is divided equally across the year and as at month 2 the funds had not been drawn down resulting in an income slippage but overall, there will be no adverse financial effect.

WORKFORCE PERFORMANCE

15/F/160 WORKFORCE PERFORMANCE REPORT

The IDW presented the report and highlighted the following:

- Overall paybill exceeds funding (excluding Trust reserves) by £777l in month and £1.7m year to date. The overspend is primarily attributable to overspends with the Hospital & Ambulance Directorate but Community & Mental Health and Corporate areas are overspent also
- Sickness has remained at around 3.9%. Anxiety, stress and depression absences continue to be most common
- Use of temporary staffing increases marginally in month to 76% equating to 159 WTE
- Under-establishment remains around 7% and in line with staff turnover expectations
- Recruitment activity has reduced significantly to 42 wte in month from 155 in April
- Overpayments have remained static in month. Monthly data provided to directorates
- 25 Units were removed from the batch list for payment of enhancements and variable hours due to rosters not being finalized by the deadline
- Rostering in safe staffing areas has improved significantly since April, with compliance to policy up to 36% from 13%.

In relation to compliance in rostering in safe staffing areas, IDW explained that the HR Team has made enormous efforts, going into departments to sit alongside staff to provide training and get lockdown, which has had some impact.

With regard to sickness levels, the IDW advised that in comparison with other NHS organisations, the Trust is marginally higher at 3.9%. but, given the complexity of the Trust, the sickness level was within tolerance levels. However, if the sickness level could be reduced significantly this would help resolve the need to employ agency staff.

15/F/161 SIX MONTHLY COST OF LIVING SUPPLEMENT REPORT

The IDW provided an update on the Cost of Living Supplement currently received by 408 employees, advising that the pay protection will be removed on the 30th November 2015.

Jane Tabor asked whether the recurring savings had been factored into the budgets. The DDF agreed to take this forward as a CIP. **Action: DDF**

15/F/162 WORKFORCE KPIs 2015/16

The Committee received the report on the proposed Workforce KPIs for 2015/16 prepared by the IDW dated 16th June 2015. The Committee noted that the KPIs have been created to incorporate current KPIs deemed to be good/useful metrics, TDA suggested Workforce KPIs and feedback received from interested parties. The indicators fall into 2 main groupings, namely Safe Staffing & Quality and Staff Wellbeing & Development.

The Committee reviewed the KPIs suggesting that the KPIs focus on people's outcomes. It was agreed that Jane Tabor discuss suggestions with the IDW outside Committee.

The Committee agreed that an update KPI paper encompassing the suggestions made be presented to the next meeting in July before being presented to the Trust Board for approval. **Action: IDW**

15/F/163 MEDICAL WORKFORCE UPDATE

The IDW introduced the Medical Workforce Update as at June 2015 prepared by the Medical HR Lead, the purpose of which is to provide an overview of both the on-going recruitment activity for medical posts and how vacancies are being covered.

The IDW highlighted the current difficulty in recruiting consultant posts with the difficulties being perceived as accommodation and travel. Proposals/options are currently being developed on the recruitment to difficult posts.

Jane Tabor requested that the commentary be expanded to include recruitment issues in order to demonstrate understanding of the underlying issues and the remedial actions being taken to overcome any difficulties. In addition, Jane requested comparative costs of substantive posts compared to locum costs. **Action: IDW**

Lizzie Peers had commented that if the Trust is using premia mechanisms in some way to recruit and retain staff (as outlined in the Cost of Living Report), that these are well managed and part of a wider strategic HR cost - benefit plan/package for certain hard to recruit staff.

The Committee requested than an expanded report, detailing the issues and actions being taken on the recruitment of medical staff together with comparative costs of substantive posts compared to locums, be provided for the August meeting. **Action: IDW**

15/F/164 UPDATE ON HR REVIEW

The IDW provided an update on the review of HR which has been delayed due to the commencement of the Turnaround Board. However, recommendations, including different ways of working and potential invest to save options, should be available by the end of June. The Committee noted that the review was carried out during May 2015 with 4 workshops held with various teams as well as visits to other Trusts.

Once the report has been finalised, the Committee requested that this be presented. **Action: IDW**

15/F/165 UPDATE ON INDUCTION/RETENTION OF FILIPINO NURSES AS PART OF SAFE STAFFING RECRUITMENT

The IDW reported that the first group of nurses is due to arrive by the end of August 2015, having been through the LMC process for checking. Support is being provided from the local community and through the organisation to ensure ease of transaction and pastoral care. The induction of the nurses will be in 2 parts, namely an informal planned welcome and billeting followed by a formal induction. Clinical induction is planned as 2 weeks of supervisory support, including completion of mandatory training and information giving, and working on the appropriate ward with mentors provided. For a period of a maximum of a further 6 weeks, the nurses will be working as healthcare assistants, until completion of practical tests as required for registration. The second group of nurses is expected in November/December 2015.

The process is supported by ward sisters, clinical educators and senior nursing teams and is on track to deliver as expected. The nurses arriving is August will fill vacancies rather than contribute to safer staffing numbers.

With regard to the current media reports on overseas workers, the Committee noted that no statement had been issued from NHS Employers. The IDW felt that in order to offer reassurance to the newly arrived nurses, the Trust should issue a statement welcoming the nurses to the organisation.

15/F/166 SAFER STAFFING FUNDING AND OFFSETTING CIPs

The IDW confirmed that assuming all the Filipino nurses recruited commence in post, the Safer Staffing targets will be met and the Trust will be up to complement for nurse recruitment.

The Chairman commented that this should see a reduction in bank and agency staff.

15/F/167 REPORT ON AGENCY USAGE AND RECRUITMENT

The Committee received the report on temporary staffing and recruitment as at June 2015 prepared by the Workforce Planning & Information Manager. The purpose of the report is to provide an overview of both the on-going recruitment activity for all posts and how vacancies are being covered.

The Committee noted that as at the 31st May 2015 the Trust is under established by 210.8 wte. (270 excluding EMH) Temporary staffing (bank, agency and excess hours) amounted to 159.4 wte in May 2015. 42 wte posts are currently at various stages of recruitment. This is down significantly from 155 at the end of April 2015.

Lizzie Peers had queried whether the controls on agency spend were now working, given the temporary staffing overspend against budget. The IDW explained that the controls were now starting to be effective as recruitment activity has reduced, with requests being scrutinised and challenged vigorously. Posts that have been vacant for a long time are being closed.

The Chairman stated that vacancies that have been managed for a while should, if possible, be continued to the end of the financial year and that vacancies that have been vacant for a long time and the service has been well managed without any deterioration in the quality of care should be taken out of the budget and structure. The IDW agreed that these areas need to be reviewed.

The Committee requested that monitoring of agency usage and recruitment continue with a monthly update report to the Committee. **Action: IDW**

15/F/168 STAFF SURVEY LEARNING COLLABORATIVE UPDATE

The EDTI gave an overview of the work being undertaken by the 5 collaborative groups which have been established to take forward the results of the Staff Survey:

- Getting the most from the Appraisals process
- Delivering effective communications in a complex environment
- Improving the health and wellbeing in the workplace

- Recognising and valuing people
- Achieving quality improvement through learning from concerns raised by staff

The Committee asked that bi-monthly reports be presented which contain measurable KPIs. The first report to be presented to the July FIIWC meeting.
Action: EDTI

15/F/169 RAISING CONCERNS (WHISTLEBLOWING) POLICY AND LOG

The Committee received the report for the period 1 January to 11 June 2015, the purpose of which is to provide a summary of those concerns that have been highlighted via the Datix System, the dedicated 'concerns' email address, HR and the Counter Fraud Specialist.

The Committee requested that an update report be provided to the July meeting on the conclusions of the investigations. **Action: IDW**

The Committee confirmed that reports are to be received 6 monthly and annually. **Action: IDW**

The Committee considered that the reporting process was working but felt that staff should be reassured that the organisation was a safe environment in which to raise concerns. **Action: IDW**

PROGRAMME MANAGEMENT

15/F/170 CIPs PROGRAMME 2015/16

The Programme Governance Manager presented the Cost Improvement Programme 2015/16 Dashboard and outlined how each CIP will be monitored through the programme process. She advised that behind the high level report presented to the Committee there was significant detail involving the delivery schedules and phasing of the programmes to deliver the CIP.

She confirmed that the 2015/16 target was £8.5m of which £4.16m schemes currently in place against plan, £3.415m Forecast delivery of schemes, leaving a CIP gap of £5.085m.

PGM confirmed that Scrutiny & Challenge meetings were set up to focus on the delivery of CIPs with the Directorates.

The Committee noted the following key issues:

- Significant variance against planned schemes = £1.709m
- High levels of non-compliance with weekly status reporting
- Major scheme paused at QIA stage = £1.6m

Following review, the Committee requested:

- The CIPs and Finance Reports to be combined
- CIPs to be RAG rated
- Project Managers and Service Leads to provide status reports on their projects
- Demonstration of recurring and non-recurring together with related benefits and costs in order to get an early view of any shortfall going into 2016/17
- CIPs by Directorate
- Top 5 CIPs to be shown separately with additional information

Action: EDTI/PGM

Jane Tabor expressed concern on the high level of non-reporting. PGM advised that this had now improved due to weekly reporting to TEC and Directorates.

Lizzie Peers had commented on the fact that nearly all schemes have not got QIA sign off and that this must be accelerated faster in terms of quality risk, and also the fact that other schemes may be pulled once QIA is done, increasing the CIP gap beyond £5m.

She further commented that given the status on CIPs for 2015/16 (£858 off plan YTD per month 2 Finance Report) and with the £5m gap, an update on Plan B is needed as even with Turnaround pushing things through harder, CIPs need to deliver to hit £4.6m and this report suggests the Trust is at significant risk. Linked to this, some headroom for 2015/16 schemes is needed to give some resilience on the programme.

In this regard, the Chairman requested that the CIPs Programme for 2016/17 be presented to the July meeting. **Action: EDTI/PGM**

Overall, the Committee considered that it was not assured that the CIPs Programme was on track to deliver the target of £8.5m for 2015/16 and that this should be highlighted to the Trust Board. **Action: Chairman**

FINANCIAL PERFORMANCE

15/F/171 FINANCIAL PERFORMANCE REPORT

The DDF presented the financial position of the Trust as at month 2, highlighting:

- The Trust is reporting a deficit position for the month of £1.095m against a planned position of a £0.391m deficit. This is an adverse variance of £0.704m. The year to date position is now a deficit of £2.579m against a planned deficit of £1.136m, an adverse variance of £1.443m.
- In month 2 the income position is £0.282m and £0.486m year to date behind planned. Of this balance, £305k is related to underperformance against the Isle of Wight CCG contract. The majority of the remaining variance can be attributed to slippage on investments from the local CCG and therefore has an equal positive variance in the Trust's reserves position
- As with month 1, the main concern, along with income performance, is the variance in the Hospital & Ambulance Directorate. This Directorate has overspent in month by £0.783m, a cumulative overspend of £1.686m. This overspend is broadly split into 2 categories, one being the failure in delivery of the Directorate's CIP targets, £1.065m and the second relating to operational pressures regarding the black and red alert status across the organisation resulting in the opening of additional beds in April and early May
- The Trust's forecast outturn position remains at £4.6m. The Trust has instigated a turnaround approach to the finances in an attempt to rectify the current position to achieve this outturn.
- The total capital spend planned for the financial year is £8.180m. As at month 2 the actual spend is £0.356m compared to a plan of £0.580m.

The main slippage relating to the rolling replacement programme which was prioritised at the last Capital Investment Group meeting.

- The Trust's CIPs has an adverse variance in the period to month 2 of £0.397m. The total CIP target for the Trust this year is £8.5m.

Jane Tabor requested that for consistency and assurance/insight, the Finance Report should have similar information to that provided in the Workforce Report where appropriate, i.e. performance data, underlying cause, actions and remedies. **Action: DDF**.

The Chairman requested that underlying causes for overspends with mitigating actions be included in the Finance Report. **Action: DDF**

Lizzie Peers had commented on the cash report querying where the 2 days operating costs number had been derived and whether the buffer is sufficient. She asked that the graph show the cashflow based on current CIP performance. In addition, it would be helpful to see the risks to cashflow of CP failures which would serve as an early warning system. **Action: DDF**

The Committee was concerned that costs were running out of control and CIPs not being carried out with no-one being held to account. It was felt that the Executive Committee should take control and hold budget holders to account.

15/F/172 ANNUAL REVIEW OF LOSSES & COMPENSATION

The Committee received the annual Losses & Compensations for the period 1 April 2014 to 31 March 2015 prepared by the Interim Head of Financial Services.

The Committee felt assured that the policies and procedures in place ensures that losses are kept to a minimum and that continual review of these policies and procedures safeguard against financial losses.

15/F/173 MOTTISTONE UPDATE

The EDTI updated the Committee on the financial position of Mottistone in that the profit and loss account showed a small profit for the year although turn over for the 2014/15 year was down 16%.

The Committee noted that a two part paper which features a demand analysis that shows significant potential business opportunities and recommends rationale for seeking an external partner was considered by TEC on the 22nd June 2015. A further paper on Mottistone is to be presented to TEC following consideration by the Wight Life Partnership Client Group.

The EDTI advised that the Mottistone service struggled across the winter period with significant delayed or cancelled operations due to NHS pressures. This significantly reduced private income and amenity income across the period as well as impacting on the service reputation.

Jane Tabor asked that a Business Plan with strategic options and recommendations should be prepared and presented to both TEC and FIIWC. **Action: EDTI**

15/F/174 PROCUREMENT STATUS REPORT

The DDF gave an overview of the procurement report for the period 1st May to 31st May 2015 prepared by NHS South of England Procurement Services.

With regard to the Product Standardisation Group, the DDF advised that a meeting has been arranged for the 3rd July 2015.

Lizzie Peers had commented that the terms of reference for the Product Standardisation Group should be revised and that support from the Trust be provided to deliver the workplan of opportunities.

She also commented that large savings opportunities have been missed due to delays in receiving back the evaluation forms from Theatres and General Packs.

Jane Tabor requested that it would be helpful to the Committee to have signposted anything in particular that the Committee should be aware of.

The Committee requested that the DDF take forward these requests with Procurement in order that the status report can be updated for the next meeting. **Action: DDF**

AUDIT & CORPORATE GOVERNANCE

15/F/175 INTERNAL AUDIT OUTSTANDING RECOMMENDATIONS

The DDF reported that as at 15 June 2015 there were 10 audit recommendations exceeding the proposed implementation date of which 2 have now been closed. A summary of these outstanding recommendations, along with the responsible leads, has been included in the report. All recommendations are chased on a monthly basis and escalated through the TEC agenda as necessary.

The Committee asked that the DDF following up the outstanding actions with the EDTI in an attempt to get resolution by the end of the month. **Action: DDF**

Jane Tabor requested that additional commentary is provided on the actions at TEC to resolve the overdue recommendations. **Action: DDF**

Lizzie Peers had commented that all the amended due dates are now passed, some by a long while and, as such, this gives little assurance She further commented on the need to have a policy on temporary staff and its usage as this is a key financial risk for the Trust. The recommendation was made in December 2013 with an amended due date for completion May 2015. The Committee asked the IDW to follow this up as a matter of urgency.

Action: IDW

Lizzie Peers commented further that there are some recommendations on making sure clinical audits are effective and that these are re-tested where significant issues are found and asked for confirmation that there is a programme in place to retest.

The DDF confirmed that the Internal Auditors have a rolling programme to monitor and follow up implementation of recommendations and that an audit report has been issued.

The Committee requested that the schedule of outstanding recommendations is updated with the results of the audit report in time for the July meeting.

Action: DDF

15/F/176 EXTERNAL AUDIT ANNUAL ACCOUNTS REPORT 2014/15 – ACTION PLAN

The DDF advised that following the unqualified opinion on the annual accounts for 2014/15, a number of issues have been identified which will be incorporated into an action plan to take forward and which will have timescales for completion. The report will be presented to the July meeting.

Action: DDF

15/F/177 IM&T RECOMMENDATIONS: DISASTER RECOVERY INCLUDING UPDATE ON PROTOCOL FOR NON-SUPPORTED SYSTEMS AND RISKS TO SOFTWARE

The EDTI advised that the table top exercise is scheduled for 20th July and following this a report will be submitted to the Committee. **Action: EDTI**

Jane Tabor asked whether the exercise will determine which systems will be integrated going forward and the ones which will not, e.g. integration of the Risk Register systems. The EDTI confirmed that this is something which will be determined as a result of the exercise.

15/F/178 NURSING, MIDWIFERY AND AHP STRATEGY

The Committee received and noted the Caring Beyond Boundaries – Nursing, Midwifery and Allied Health Professional Strategy 2015-2020, the purpose of which is to provide a 5 year approach, rationale and plan to develop Nursing, Midwifery and Allied Health Professionals.

The Committee noted that each group will evaluate their objective on an annual basis and set priorities for the coming year. The plan will be overseen by the Deputy Director of Nursing and monitored by the Director of Nursing's senior nurse team and the Allied Health Professional Forum, the Clinical Professions Advisory Group. This will report to the TEC and Trust Board.

15/F/179 LAMPARD REPORT ON J. SAVILLE – LESSONS LEARNT

The Trust's response to Kate Lampard's Assurance Report into matters relating to J. Saville prepared by the Executive Director of Nursing was received. The Committee noted that the paper gives a position statement in response to the recommendations recently published in the 'lessons 'learnt' report. The recommendation will apply throughout the NHS and will ensure that systems are robust within organisations in terms of safeguarding patients and further recommend that any voluntary services or fund raising has strict governance processes in place.

The Chairman sought assurance on the management of the volunteers within the Trust and whether a register of volunteers and the work/posts allocated to them is maintained. The IDW advised that a new Volunteers Co-ordinator will be starting in post the week commencing 22nd June 2015 whose role will be to manage the volunteers and to ensure that they are subject to the same policies and procedures, as well as mandatory training, as other groups of staff. In addition, the register of volunteers will be reviewed. The IDW also

confirmed that job descriptions for the volunteers will be followed up with the Deputy Director of HR as well as reviewing the job description for the Volunteer Co-ordinator to take account of the expectations of managers and volunteers alike.

Lizzie Peers had commented on how the policy is applied and whether the Trust is at risk on safeguarding. In particular, whether the volunteers were able to access the e-learning on safeguarding by the deadline of 1 June 2015. The Committee requested that the IDW take this forward with the EDN and update the Committee at its next meeting. **Action: EDIW/EDN**

In reply to Jane Tabor's query regarding the on-going assessment, the IDW confirmed that there were a number of parameters which are looked at frequently and which will be taken to a future HR Management Board.

15/F/180 REFERENCE COST SUBMISSION 2014/15

The Committee received the Reference Cost Submission 2014/15 the aim of which is to confirm the Trust's costing processes and systems and that the Trust will submit its Reference Cost Return in accordance with the Reference Costs Guidance 2014/15. The DDI advised that the Company Secretary had confirmed that the FIIWC was the appropriate sub-committee to provide assurance to the Trust Board.

In reply to a query from the Chairman on Data quality re some exceptions have been resolved but not all, the DDI advised that at this stage it was not possible to guarantee there would be no exceptions until the initial Submission has been completed.

Jane Tabor agreed to provide any additional comments direct to the DDI.

The Committee confirmed that it was satisfied with the Trust's costing processes and systems and that the Trust will submit its Reference Cost Return in accordance with guidance.

15/F/181 REVIEW OF RISK REGISTER AND ACTION PLAN

The HOCG presented the report which included all Risks allocated to FIIWC as a Board Assurance Committee. Further information was provided in relation to Risks scoring 16 above (allocated to FIIWC) including the action summaries. She confirmed that the process is that Full Action Plans are reviewed and monitored by Directorates on a regular basis and available on request.

She confirmed that 2 risks have been closed since the last report, i. e. RR567 and RR644 and that 1 new risk has been allocated to FIIWC as the Assurance Committee RR654 No Stroke Consultant Specialist.

The HOCG also confirmed that a fundamental review of the entire process/strategy associated with the Risk Register has been incorporated into the currently on-going external governance review. This is a necessary piece of work as it is acknowledged that a number of the risk register entries do not adequately describe or indeed score the risk. The review of the thematic pathways, Risk Register and Management Strategy will conclude once the Corporate Governance Review has been undertaken and the report issued to Trust Board in September 2015.

The HOG also advised the Committee that the input of data for the Risk Register had been transferred to the DATIX System which would provide easier and more effective updates. The Committee noted that the upgrade of the DATIX System is to take place on the 25th June 2015 following which training will be undertaken initially to and then by the Risk Management Team across the Trust which will lead to improvements.

The Committee agreed that the following 2 Risks should be referred to QCPC to take forward:

RR549: Risk to Patient Safety due to multiple paper and electronic record systems
RR653: Unsupported and outdated edge infrastructure – risk loss of access to network and clinical systems: The Committee was concerned that the quality of care element of the risk had not been accurately identified **Action: HOCG**

In addition, RR415 Space Utilisation including beds and medical equipment to be reassigned to the Chief Operating Officer to take forward. **Action: HOCG**

As the FIIWC was now reviewing the risks allocated to it, Jane Tabor confirmed that support will be provided to HOG to address the Committee's allocated risks.

Jane Tabor requested that the direction of travel to risks in future versions be included in the FIIWC risk report. **Action: HOG**

Lizzie Peers had commented that some of the risk narratives did not describe the risk and that the narratives need to be expanded in order to manage the risk. Examples of this are Shackleton Ward windows and the space utilisation risk. The Committee requested that all risks allocated to FIIWC are reviewed and the narratives expanded where appropriate. An updated report to be presented to a future meeting. **Action: HOCG**

The Committee recognised the risk to patient safety contained within RR549 multiple paper and electronic record systems and RR648 Shackleton Ward Windows and that this should be highlighted to the Trust Board.
Action: Chairman

15/F/182 BOARD ASSURANCE FRAMEWORK (BAF) 2015/16

The Head of Corporate Governance advised the Committee that the 2015/16 objectives have not yet been determined. She advised the Committee that until this piece of work is undertaken, the existing measures will remain in place.

Smart Objectives and the risks to achieving these needed to be identified. Once these have been developed and the Governance Review concluded, then the 2015/16 BAF will be designed around them.

15/F/183 REVIEW OF ACHIEVEMENT OF CORPORATE OBJECTIVES 2014/15

The HOCG presented the update report, together with the NHS Outcomes Framework 2014/15, which the Committee considered was an excellent piece of work. The Committee noted that the Trust was 29.5% compliant against the Objectives set for 2014/15.

The Chairman asked whether the achievement of the Objectives should be monitored through the year, with the Committee agreeing a quarterly review process. However, due to the 2015/16 BAF still being developed, it was agreed that a review be undertaken in 6 months' time at the December FIIWC meeting. However, it was noted that clarity was required in relation to the objectives to be monitored as a number had not yet been defined.

Action: HOCG

The Committee noted that the Goals contained in 'The House – Our Vision, Goals and Priorities' will form the basis of the Corporate Objectives for 2015/16. The Committee requested for the EDTI to confirm this.
(Post meeting note: the EDTI confirmed that the Goals will form the Corporate Objectives for 2015/16.)

Jane Tabor emphasised the need for Smart Objectives that are measurable. With regard to the NHS Outcomes Framework, Jane stated that this was the first time this had been seen and asked whether i) the Framework is reflected with the Trust's Objectives; ii) whether it sits alongside our Objectives; and iii) whether it will be incorporated into the 2015/16 Objectives. The HOCG confirmed that one of the measures for 2014/15 was 100% compliant with the NHS Outcomes Framework for 2014/15. However, she had not been able to establish levels of compliance with this as it was not clear who was the lead for this objective. It was discussed that this should sit with the SEE Committee. HOCG to liaise with the Company Secretary/Executive Director of Nursing with regard to where this should sit. **Action: HOCG**

The Committee requested that the Corporate Objectives and CSFs for 2015/16 and whether the NHS Framework will be encompassed within the Objectives be taken forward .and an update report provided to the July meeting. **Action: EDTI**

INFORMANCE GOVERNANCE

15/F/184 DATA QUALITY REPORT

The DDI presented the report which covers the assessment of the Trust data quality submitted to SUS. Overall, when comparing the proportion of our invalid records with the rest of the country our data quality looks favourable. The Trust does however, have 5 indicators that are currently rated as 'red' - they are NHS Number, Postcode Primary Diagnosis & HRG4 in the admitted patient care CDS and Departure Time in the A&E dataset.

Although there are 5 indicators currently RAG rated 'Red', overall data quality is reasonably good.. However the issue that has led to two of these five has been resolved and they only remain 'Red' due to time lag. Given that there are still 3 red indicators to be resolved the level of assurance is limited.

15/F/185 SLA ACTIVITY & OPERATIONAL PERFORMANCE

The DDI introduced the assessment of the Trust SLA Position and associated operational performance. He reported that overall, as at M1 Flex date, the Trust has underperformed against the Planned Care SLA circa £119k and conversely over performed against the Unscheduled Care SLA circa £335k. Operational performance has been challenging most notably against the ED 4 hour target and the RTT Admitted targets.

Jane Tabor asked in regard to Unscheduled Care, whether enough focus was

being given to Ambulance which was now accruing penalties or was it the system. The EDTI responded that the CAD system which was due to be replaced in April 2015 was not working properly and the contract, which is with an international supplier, is now been reviewed.

Jane Tabor also requested that key actions underway to address key areas of variance, together with an indication of direction of travel, be included for the next report to the Committee in July. **Action: DDI**

INVESTMENT/DISINVESTMENT

15/F/186 SALE OF THE GABLES UPDATE

The Associate Director of Estates presented the full business case dated 15th June 2015 for the disposal of The Gables.

The Committee noted that risks had not been really reviewed and that there was no mention of any current account implications of the forward sale.

Following review, the Committee agreed to proceed to sale, subject to contract..

15/F/187 SALE OF 68-71 SWANMORE ROAD, RYDE

The Associate Director of Estates presented report on the disposal of the Swanmore Road properties and noted that TEC had reviewed this on the 15th June 2015.

Jane Tabor to provide any additional comments direct to the ADE.

Following review, the Committee agreed to proceed to sale subject to contract.

15/F/188 BOARD SELF CERTIFICATION

The Committee received the report and noted the following:

Board Statements
Board Statements 1, 2, 5, 6, 8, 10, 13 and 14 remain 'at risk' as a consequence of the CQC inspection undertaken in June 2014. Statements 5 and 8 were declared 'at risk' by the Board at its meeting on 1st April 2015. Progress continues against the Quality Improvement Plan (QIP) and the Trust remains on trajectory towards declaring full CQC compliance.

Licence Conditions
All Licence Conditions remain marked as compliant.

Statement 5 - The Board will ensure that the Trust remains at all times compliant with/has regard to the NHS Constitution: The Committee requested sight of the review being undertaken on the Trust's compliance with the NHS Constitution due for completion on 31st May 2015. **Action: HOCG**

The Committee confirmed that sufficient assurance has been provided to enable the Committee to recommend that the Trust Board approves the Self Certification return as proposed.

15/F/189 COMMITTEES PROVIDING ASSURANCE

The notes and minutes of the following committees were received and noted

by the Committee:

- Quality & Clinical Performance Committee Minutes held on 27 May 2015
- Carbon Energy Fund Programme Board Minutes held on 29 May 2015
- Capital Investment Group Minutes held 5 June 2015
- Information User Group Notes held on 27 May 2015 and draft Terms of Reference
- Risk Management Committee Minutes held on 20 May 2015

The Committee asked that all minutes and notes submitted to the Committee contain the 'top key issues and risks box' at the beginning of the minutes. In addition, as part of the Governance Review a clear pathway for the top risks and issues identified by the sub committees to be monitored and reviewed.

Action: HOG

15/F/190 ANY OTHER BUSINESS

The Committee reviewed the following items which had been requested to come to future meetings as follows:

- 7 Day Hospital Working to be discussed at the July 2015 Board Seminar
  (Post meeting note: added to the agenda for the July 2015 Board Seminar)
- SFIs compliance levels – budgetary non-compliance to be reported monthly with managers to attend Committee meeting
- Budgetary Process - deferred
- Turnaround Board reports on a monthly basis – first report to July 2015 meeting – added to agenda

15/F/191 INFORMATION ITEMS

The following papers were received for information only and had been previously circulated to members on 11 June 2015:

- Head of Internal Audit Opinion – Final Version
- Internal Audit Report – BAF and Risk Management – Full Assurance

15/F/192 DATE OF NEXT MEETING

- Tuesday, 28 July 2015
- 1.00pm – 4.00 p.m.
- Large Meetings Room – South Block, St Marys

The meeting closed at 4.00pm

Signed: …… Date: ……

Enc S

Isle of Wight NHS Trust

FOR PRESENTATION TO TRUST BOARD ON 1 JULY 2015

AUDIT AND CORPORATE RISK COMMITTEE

Minutes of the meeting of the Audit & Corporate Risk Committee held on the 3rd June 2015 at 9.00 a.m. in the Conference Room, School of Health Science, St. Mary's Hospital, Newport.

PRESENT	David King	Chairman
	Nina Moorman	Non Executive Director
	Charles Rogers	Non Executive Director (Vice Chairman)
In Attendance	Lizzie Peers	Non Executive Financial Advisor to Trust Board
	Karen Baker	Chief Executive
	Chris Palmer	Executive Director of Finance
	Mark Price	Company Secretary
	Alan Sheward	Executive Director of Nursing
	Paul King	External Audit Director
	Kevin Suter	External Audit Manager
	Lucie Johnson	Head of Corporate Governance
	Kevin Curnow	Deputy Director of Finance
	Emma Topping	Communications & Engagement Manager (Item 15/A/078)
	Theresa Gallard	Business Manager, Patient Safety, Experience & Clinical Effectiveness (Item 15/A/079)_
Minuted by	Linda Mowle	Corporate Governance Officer

Min. No.	Top Key Issues/Risk
15/A/069	**Audit Results Report:** The Committee wishes to highlight a significant risk in respect of financial resilience. The External Auditors have issued a qualified value for money conclusion in respect of financial resilience. This is due to the lack of sufficient progress in identifying the savings required to demonstrate the delivery of its 2015/16 plan and forecast outturn, and a lack of clear evidence of how and when it will return to statutory breakeven. The Auditors state it cannot be concluded that proper business and financial planning arrangements are in place to support the Trust's financial resilience.
15/A/072	**Annual Accounts 2014/15:** The draft Annual Accounts for 2014/15 were recommended for approval and adoption by the Trust Board
15/A/073	**Directors' Certificates:** The Certificates were recommended for approval by the Trust Board
15/A/074	**Annual Governance Statement:** The AGS was recommended for approval by the Trust Board
15/A/078	**Annual Report 2014/15:** The Annual Report for 2014/15 was recommended for approval by the Trust Board
15/A/079	**Quality Account 2015:** The Quality Account for 2015 was recommended for approval by the Trust Board

15/A/066	**APOLOGIES** Received from Danny Fisher, Trust Chairman
15/A/067	**QUORACY** The Chairman confirmed that the meeting was quorate.
15/A/068	**DECLARATIONS OF INTEREST**

	There were no declarations.
15/A/069	**AUDIT RESULTS REPORT** Paul King, External Audit Director, presented the Audit Results Report for the year ended 31st March 2015, which summarises the preliminary audit conclusion on the Trust's financial position and results of operations for the year ended 31st March 2015. The audit certificate to demonstrate that the full requirements of the Audit Commission's Code of Audit Practice have been discharged, will be issued at the same time as the audit opinion. In presenting the report, Paul King highlighted: **Economy, efficiency and effectiveness** • A qualified 'except for' Value for Money Conclusion in respect of Financial Resilience. The Trust has not yet made sufficient progress in identifying the savings required to demonstrate the delivery of its 2015/16 plan and forecast outturn. Neither can it demonstrate clearly the basis of how and when it will return to statutory breakeven if the 2015/16 budget is delivered to its forecast £4.6million deficit. Therefore, it cannot be concluded that proper business and financial planning arrangements are in place to support the Trust's financial resilience. • The Trust needs to identify and update sufficient schemes, with an appropriate level of additional headroom, sufficient to achieve its 2015/16 budget • Update the financial model to assess the likely scale of future savings requirements and start to identify sufficient plans to achieve those required savings over the longer term. • There is a likely need for joint working across the Island's health and social care economy. **Financial Statements, summarisation schedules and the remuneration report** • An unqualified audit opinion on the financial statements • No material misstatements but a number of non-material errors which have not been corrected by management and which if corrected would result in a small deficit being reported • Improve processes for the recording and recognition of deferred income and to review procedures around payroll accruals • No evidence of material fraud, or of management override of its controls **Fee** • An additional fee of £8,500 for non-audit work on the Quality Account Kevin Suter highlighted the 3 additional misstatements contained within the Letter of Representation which takes the impact to £314k on income and expenditure but advised that the cumulative effect does not affect materiality either qualitative or quantitative. Lizzie Peers asked what value of unadjusted material misstatements would be needed for the auditors to conclude the accounts were materially misstated and how far away from this value were the current reported misstatements. Paul King advised that the £314k was well below the level of materiality that might lead to a qualified audit opinion, but that the nature of what is being reporting needs to be taken into account as there are a large number of judgemental misstatements. If all the misstatements had been factual, the auditors might have adopted a different approach.

	The Committee requested that an action plan be developed from the recommendations contained within the report for presentation to the August meeting of the Committee. **Action: DDF** **Management's Response:** The Committee received the report on the Annual Accounts for 2014/15. The Executive Director of Finance reported on the successful completion of the audit, formally thanking the Finance Team and Ernst & Young to ensure a positive audit and a good set of accounts. The Committee noted that due to the forecasted outturn of £15k surplus, the level for materiality of misstatements is lowered resulting in small misstatements being highlighted which would not normally be the case if the forecast outturn had remained at £1.7m. The items highlighted are being taken forward in order to strengthen and improve the financial processes for next year's accounts. The Committee noted that: • **Stock:** Theatre/DSU and Pharmacy stock procedures will be reviewed. In reply to Lizzie Peer's query on the Theatre stock extrapolation as to whether management was assured this was a one off error not replicated across stock balances, the DDF responded that this was a judgement call as it was less than 1% and, therefore, it was unreasonable to extrapolate across the whole of the stock. • **Payroll Accrual:** standardisation of estimations carried out in Finance will be undertaken • **Disputed invoices:** will be taken forward to resolution. In response to Lizzie Peer's query on the disputed invoice with Southampton University Hospital and whether it would be payable in 2015/16, the EDF advised that the University Hospital has not provided the service and therefore it was rightly disputed. The Chairman, on behalf of the Committee, also extended congratulations and thanks to both the Finance Team and Ernst & Young for their support which had enabled a positive and smooth audit, resulting in a good set of accounts and excellent partnership/team work.
15/A/070	**LETTER OF REPRESENTATION** The draft Letter of Representation to the External Auditor in connection with the audit of the financial statements for the year ended 31st March 2015 was received. The Committee noted that the Letter takes account of the discussions and reasoning around the financial statements. The Committee approved the draft Letter of Representation for formal signing by the Executive Director of Finance and the Committee Chairman.

15/A/071	**REPORT ON 2014/15 ANNUAL ACCOUNTS**
	The Committee received and noted the contents of the report prepared by the Interim Head of Financial Services which summarised the key features of the 2014/15 annual accounts process and highlighting the positive achievement of the following:
	• The Accounts were submitted on the 23rd April 2015 in compliance with the noon deadline
	• The Trust ended the year with a £15k surplus
	• The regulatory duties were achieved:
	  • Kept within its External Financing Limit (EFL) of £6,083k
	  • Kept within its Capital Resource Limit of £7,460k

	• BPPC (payment of invoices within 30 days) results acceptable
15/A/072	**ANNUAL ACCOUNTS 2014/15** The post-audit Annual Accounts for 2014/15 were received. The Executive Director of Finance advised that the Accounts followed the standard document with reference notes and explanations to support the Accounts position and that no material amendments were identified. The Committee agreed the draft Annual Accounts for 2014/15 for approval and adoption by the Trust Board.
15/A/073	**DIRECTORS' CERTIFICATES** The Committee received and agreed the Directors' Certifications, in the discharge of the responsibilities of the Accountable Officer, for approval by the Trust Board and formal sign off by the Chief Executive and Executive Director of Finance.
15/A/074	**2014/15 ANNUAL GOVERNANCE STATEMENT** The Company Secretary presented the 2014/15 Annual Governance Statement (AGS) which forms part of the Annual Report and Accounts. The Committee noted that the AGS has been drafted in accordance with formal guidance and was submitted to the External Auditors and the Trust Development Authority on the 1st May 2015. The AGS sets out how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control. The Committee agreed the AGS for formal approval by the Trust Board and sign off by the Chief Executive.
15/A/075	**HEAD OF INTERNAL AUDIT OPINION (HIAO)** In presenting the HIAO for the year ended 31st March 2015, the Executive Director of Finance highlighted the Chief Internal Auditor's opinion in that: • Significant assurance given • There is an adequate and effective system of internal control to manage the significant risks identified by the Trust • The Assurance Framework is sufficient to meet the requirements of the 2014/15 AGS
15/A/076	**NHS SHARED BUSINESS SERVICES (SBS) 2014/15** The following audit reports were presented for assurance to the Committee: • Employment Services ISAE3402 Report 2015 • Finance & Accounting ISAE3042 Report 2015 The reports provide the Committee and the Trust's auditors with the audit opinion of Grant Thornton on the controls in place related to the NHS Shared Business Service
15/A/077	**STATEMENT ON GOING CONCERN** The Committee received the review of the Statement on the Trust as a Going Concern and noted, from the evidence presented in the report, that the Trust is a 'Going Concern' and that it was appropriate for the 2014/15 Accounts to be prepared on that basis. The Committee considered that assurance could be provided to the Trust Board that the Going Concern concept had been reviewed and agreed that it was appropriate for the Accounts to be prepared on that basis.
15/A/078	**ANNUAL REPORT 2014/15** The Communications & Engagement Manager introduced the Annual Report for 2014/15 advising that the report is compliant with the Department of Health's

	Manual for Accounts and outlining that the year on year performance table on page 17 was currently awaited. In addition, final versions of the AGS and Final Accounts will be inserted. The Committee noted that the report will be published before the Trust AGM on the 1st July 2015. A limited number of copies of the Report will be printed, which will be available on request, as well as a download being available on the Trust website. The External Audit Manager requested that the year on year activity performance table be available by noon today in order to meet the deadline. **Action: CEM** *(Post meeting note: The CEM provided the activity performance table to the External Audit Manager by 12 noon on the 5th June 2015.)* The Committee agreed the Annual Report, subject to the inclusion of the year on year activity performance table on page 17, for approval by the Trust Board.
15/A/079	**QUALITY ACCOUNT 2015** The Committee received the draft Quality Account for 2015 presented by the Business Manager – Patient Safety, Experience & Clinical Effectiveness, advising that: • Includes all mandatory requirements of the Department of Health Quality Account Toolkit (2010) along with the requirements published in January 2015 • Sets out the 3 priority quality goals for 2015/16 reflecting the 3 domains of quality, i.e. patient experience, patient safety and clinical effectiveness • Formal statements from the 3 key stakeholders have been added • Formatting and pictures will be added prior to publication on 30th June 2015 The Committee noted that the audit of the Quality Account was currently in progress and once finalised, the auditors' opinion will be included in the Quality Account. The Committee agreed the draft Quality Account for 2015, subject to inclusion of the auditors' opinion, for approval by the Trust Board.
15/A/080	**DATE OF NEXT MEETING** The next meeting to be held on Tuesday, 11th August 2015 at 2.00 p.m.