Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public (Part 1)

to be held on

Wednesday 4th March 2015

at

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

St. Mary's Hospital, Parkhurst Road,

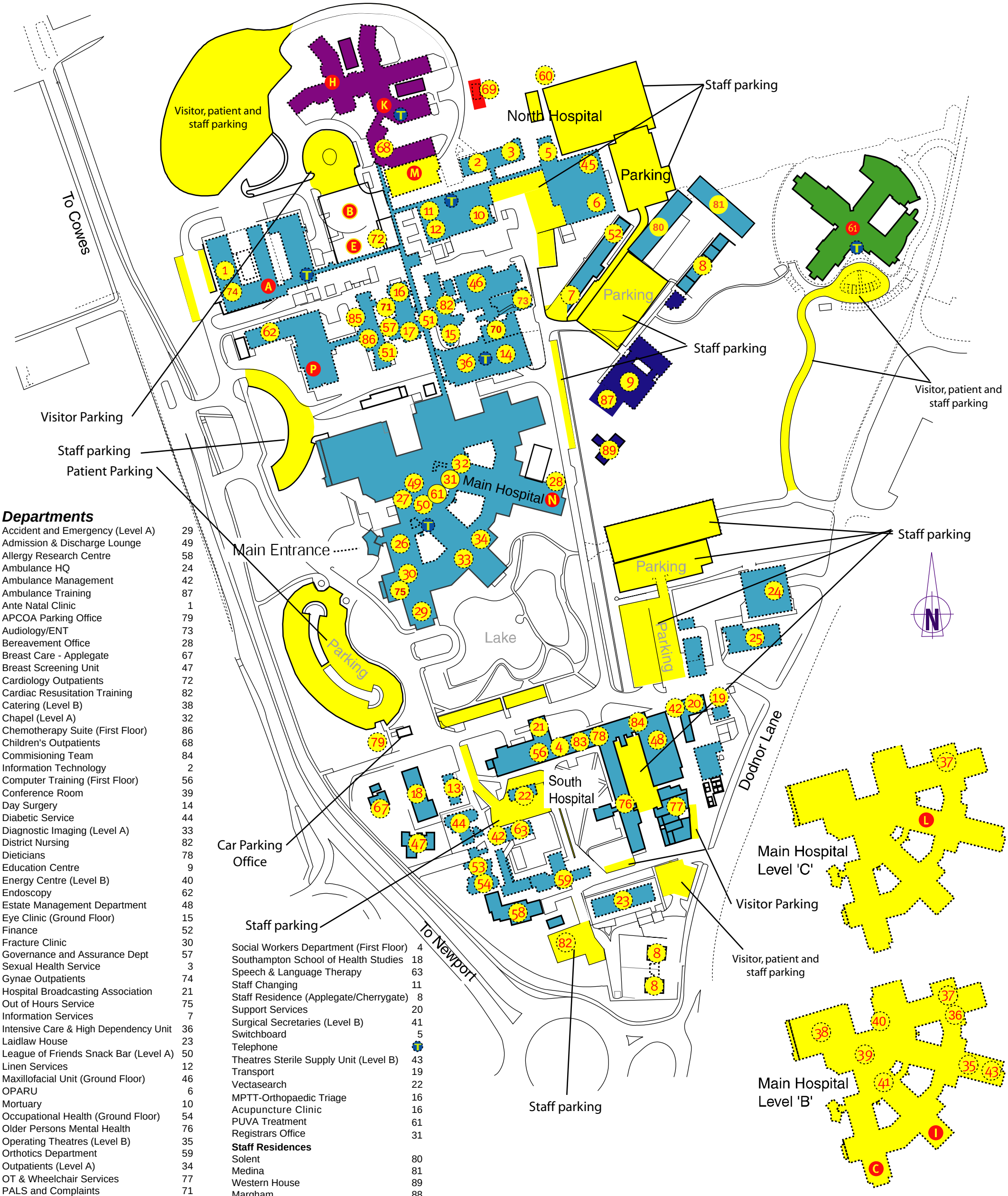
NEWPORT, Isle of Wight, PO30 5TG

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

Key Trust Strategic Objectives & Critical Success Factors 2014/15

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

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 4th March 2015** commencing at 09:30hrs.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
	1	**Apologies for Absence, Declarations of Interest and Confirmation that meeting is Quorate**			
09:30	1.1	Apologies for Absence: Lizzie Peers, David King, Karen Baker	Chair	Receive	Verbal
	1.2	Confirmation that meeting is Quorate ***No business shall be transacted at a meeting of the Board of Directors unless one-third of the whole number is present including:*** *The Chairman; one Executive Director; and two Non-Executive Directors.*	Chair	Receive	Verbal
	1.3	Declarations of Interest	Chair	Receive	Verbal
	2	**Minutes of Previous Meetings**			
	2.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 28th January 2015	Chair	Approve	Enc A
	2.2	Chairman to sign minutes as true and accurate record			
	2.3	Review of Schedule of Actions	Chair	Receive	Enc B
	3	**Chairman's Update**			
	3.1	The Chairman will make a statement about recent activity	Chair	Receive	Verbal
	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
	5	**Culture & Workforce**			
	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
	6	**Operational**			
	6.1	Financial Year-end Out-Turn Position 2014/15	EDF	Receive	Pres
	6.2	Performance Report	EDTI	Receive	Enc D
	6.3	Local Update from Hospital & Ambulance	EDNW	Receive	Enc E
	6.4	Local Update from Community & Mental Health	EMD	Receive	Enc F
	6.5	Reports from Serious Incidents Requiring Investigation (SIRIs)	EDNW	Receive	Enc G
	6.6	Quality Improvement Plan update	EDNW	Receive	Enc H
	6.7	Board Walkabout & Patient Story Action Tracker	EDNW	Receive	Enc I
	7	**Strategic**			
	7.1	Research & Development - 6 Monthly Report	EMD	Receive	Enc J
	7.2	Reference Costs 2013/14	EDF	Receive	Enc K
	7.3	Business Case - MRI Upgrade	EDF	Approve	Enc L
	7.4	Strategic Partnership with IW Council update	CEO	Receive	Enc M
	8	**Governance**			
	8.1	Board Self Certification	FTPD	Approve	Enc N
	8.2	Board Assurance Framework (BAF) Monthly update	Comp Sec	Approve	Enc O
	8.3	Terms of Reference of Mental Health Act Scrutiny Committee	Comp Sec	Approve	Enc P

	8.4	Terms of Reference of Audit & Corporate Risk Committee	Comp Sec	Approve	Enc Q
		Minutes of Board Sub Committees for noting			
	8.5	Minutes of the Quality & Clinical Performance Committee held on 25th February 2015	QCPC Chair	Receive	Enc R
	8.6	Minutes of the Finance, Investment, Information & Workforce Committee held on 24th February 2015	FIWC Chair	Receive	Enc S
	8.7	Minutes of the Mental Health Act Scrutiny Committee held on 13th January 2015	MHASC Chair	Receive	Enc T
	8.8	Minutes of the Audit & Corporate Risk Committee held on 10th February 2015	ACRC Chair	Receive	Enc U
	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: *Tenders Update* *Financial Year End Out-turn Position 2014/15* *Operating Plan 2015/16 and Contracts Update* *IW NHS Trust 2015/16 Contracts* *Carbon Energy Fund Update* *Wightlife Partnership/ Informed Client Update* *Transformation Programme Update* *Chief Executive's Update on Hot Topics* 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.			
13:00	**12**	**Date of Next Meeting:**			
		The next meeting of the Isle of Wight NHS Trust Board to be held in public is on **Wednesday 1st April 2015** and will be held at St Mary's Hospital, Newport, IW PO30 5TG (Room venue to be confirmed)			

Enc A

Isle of Wight NHS Trust

Minutes of the meeting in Public of the Isle of Wight NHS Trust Board held on Wednesday 28th January 2015 Conference Room – School of Health Sciences, St Mary's Hospital, Newport, Isle of Wight

PRESENT:	Danny Fisher	Chairman
	Karen Baker	Chief Executive (CEO)
	Katie Gray	Executive Director for Transformation & Integration (EDTI)
	Chris Palmer	Executive Director of Finance (EDF)
	Mark Pugh	Executive Medical Director
	Alan Sheward	Executive Director of Nursing & Workforce (EDNW)
	David King	Non-Executive Director
	Charles Rogers	Non-Executive Director (SID)
	Jane Tabor	Non-Executive Director
	Sue Wadsworth	Non-Executive Director
In Attendance:	Mark Price	FT Programme Director & Company Secretary
	Andy Hollebon	Head of Communications and Engagement
For item 15/005	Nikki Turner	Acting Associate Director for the Community & Mental Health Directorate
For item 15/007	Gary Thornton	Dental Lab Technician - Maxillofacial Unit
For item 15/007	Janet Warwick	Senior Dental Nurse Specialist
For item 15/007	Kathryn Taylor	Assistant General Manager
For item 15/007	Lorna Collingwood	Paediatric Occupational Therapist
For item 15/007	Clare Wallace	Team Lead, Paediatric Occupational Therapy
For item 15/007	Linda Fishburn,	Matron – Accident & Emergency
For item 15/007	Andy Carroll,	Staff Nurse – Accident & Emergency
For item 15/007	Marina Rogers,	Emergency Department Assistant – Accident & Emergency
For item 15/008	Pam Pragnell,	Nursery Nurse – Children's Ward
For item 15/008	Matt Powell	Paediatric Charge Nurse
For item 15/008	Samantha Stevens	Receptionist – Main Reception
For item 15/008	Theresa Gallard	Business Manager - SEE[1]
For item 15/009	Lynsey McAlpine	FY2 Junior Doctor
For item 15/009	Husay Janebdar	FY2 Junior Doctor
For item 15/013	Neil Fradgley	Head of Performance Information & Decision Support
For item 15/014	Deborah Matthews	Lead for SEE and Deputy Director of IPC[2]
For item 15/015 & 016	Sarah Johnston	Deputy Director of Nursing
Observers:	Chris Orchin	Health Watch
	Mike Carr	Patient Council
	Penny Emerit	Portfolio Director – Trust Development Authority
	Sarah Hughes	Deputy Clinical Quality Director – Trust Development Authority
	Frederick Psyk	Vice Chair – Isle of Wight Clinical Commissioning Group
	Cllr Lora Peacey-Wilcox	IW Council
Minuted by:	Lynn Cave	Trust Board Administrator (TB)
Members of the Public in attendance:	There were 4 members of the public present	

[1] Patient Safety, Experience & Clinical Effectiveness
[2] Infection Prevention & Control

Minute No.	
15/T/001	**APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE**

The Chairman welcomed the representatives from the Trust Development Authority who were observing the meeting as well as representatives from the Clinical Commissioning Group, Local Authority, staff and members of the public.

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

The Chairman announced that the meeting was quorate.

There were no declarations of interest from the Board members.

15/T/002 CHAIRMAN'S UPDATE

The Chairman reported that he had visited the Trust over the Christmas and New Year period and that his impression was that morale was good. He congratulated all staff who worked over this period for their efforts to ensure that the patient experience over this period was positive.

He stated that with the forthcoming general election in May there was likely to be greater focus on the NHS. He had also met with the MP, Andrew Turner, but was keen to stress that the Trust was a non-political organisation.

He attended the HFMA[3] Chairman's Conference which had focused on integrated care, working with social care providers, recruitment and safer staffing.

A joint seminar meeting between the Trust and the CCG had been agreed by the Chair of each Board. He advised that both organisations had the same aims for real integrated care for the benefit of the local population.
He was looking forward to the Awards ceremony on 30th January which was a sell out with Trust members attending as well as staff.

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

15/T/003 CHIEF EXECUTIVE'S UPDATE

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

- **Winter Pressures –** Continue to be a challenge. Recent report on Channel 4 News featured the Island.
- **Scheduled Operations** – Due to operational pressures the waiting lists have grown. Every measure is being taken to treat patients by the 18 week target and one option being offered to patients is the option of having treatment on the mainland.
- **Patient Council Chairman** – New Chair of the Patient Council is Linda Fair who will be supported by Vice Chair's Mike Carr and Nick Wingrave. She paid tribute to Mike Carr for his period as Chairman. She also advised that Nancy Ellacott had resigned from the Patient Council due to ill health and expressed the Trust's thanks and appreciation for all her work with the organisation.
- **Summary Hospital Mortality Indicator (SHMI)** – lowest ever rating at 1.04 which is good news for patients.
- **Reprovision of Services from Ventnor Clinic** – these have been approved and a letter of support from the Isle of Wight Council's Health & Wellbeing Scrutiny Panel has been received by the Trust.
- **"Hello my name is**…" - This is a new national programme to improve communication between staff and patients. Dr Kate Granger, a 31-year-old hospital consultant, started the "Hello my name is..." campaign while she was being treated for cancer. She felt frustrated by staff who failed to introduce themselves to her. Her campaign reminds staff to go back to basics, build trust

[3] Healthcare Financial Management Association (**HFMA**)

and make a vital human connection with patients by - at the very least - giving their names. The Chief Executive advised that the Trust is 100% behind this campaign and is introducing it across the organisation.

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

15/T/004 LOCAL UPDATE FROM HOSPITAL & AMBULANCE

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

- **System Resilience Schemes** - There are currently 15 active schemes which are proving beneficial to patients.
- **St Helens Ward** – Bespoke elective surgical ward has now opened which will provide a better experience for patients.
- **Senior Nurse in Hospital & Ambulance** – The post of Senior Nurse is currently vacant and recruitment is a priority to support the Clinical Director and Associate Director.
- **Ambulance Update** – The outstanding concern raised by CQC has now been resolved. He reported that the 111 services is working really well providing access to patients and is one of the strengths of the service.

Questions were invited:

Sue Wadsworth asked when it was expect to fill the vacant Senior Nurse role. The Executive Director of Nursing and Workforce advised that an expression of interest had been sent to the whole of the south coast and an interim arrangement was in place at present.

Charles Rogers asked if the financial forecast for the directorate could be improved. The Executive Director of Nursing and Workforce advised that savings from some CIP[4] schemes had not been realised but these were being reviewed weekly. The Executive Director of Transformation & Integration stressed that in order to deliver a 24 month programme of CIP projects it would require organisational change, and at present the forecast to deliver by end of the financial year was unlikely to be achieved. Executive Director of Nursing and Workforce assured the Board that all efforts were being made to improve the financial position with weekly reviews on activity, funding and spending. The Executive Director of Finance confirmed that the finance team were having weekly budget meetings to ensure accurate forecasting together with a review of discretionary spending. The Executive Director of Transformation & Integration highlighted the exemplary position of the Ambulance division with was on target to achieve their CIP targets.

The Chairman expressed his concern that for the first time since the Trust formation the organisation was facing not achieving its financial targets but he recognised that there was no quick fix.

Jane Tabor asked if sufficient time had been allocated to planning and implementing the process for the next financial year. The Chief Executive advised that this would be covered in Part 2 of the Board meeting but assured her that the issues were well recognised.

David King asked how the internal transfer of patients was monitored within the hospital. The Executive Medical Director advised that this was recorded by the PID[5]s team as part of the process. The Executive Director of Nursing and Workforce gave an overview of the process and examples were provided.

[4] Cost improvement programme
[5] Performance Information & Decision Support

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

15/T/005 LOCAL UPDATE FROM COMMUNITY & MENTAL HEALTH

The Executive Medical Director presented the update from the Community and Mental Health Directorate which included:

- **Named Nurse for Safeguarding** - The Executive Medical Director advised that Named Nurse for Safeguarding Children and Service Lead for School Nurses and Health Visitors had retired. He confirmed that this post had now been filled and had increased clinical support by 1.6wte[6] to 2.6wte and 2wte administrative support. He confirmed that the Safeguarding Children team have moved to the Nursing Directorate.

- **Shackleton Ward** - Following a visit by a Trust Board member to Shackleton ward it was suggested that soft furnishings would enhance the area. The Executive Medical Director advised that as the unit was subject to the same infection prevention and control (IPC) standards it was not possible to provide soft furnishings which did not comply with IPC standards. It was also reported that following the CQC visit it was confirmed that locks had been fitted to bedroom doors on Shackleton ward but these could be overridden from the inside to of the door to prevent the patient locking themselves in. These changes have had a positive effect on patient experience, privacy and dignity.

- **SIRIs** - The directorate had reduced to 4 live cases which showed a year on year improvement.

- **Safety of Lone Workers** - The use of Safety 'Skyguard Badges' have been implemented as part of the review of the Standing Operating Procedures for Lone Working and this has been further enhanced by the provision of senior nurse provision to ensure community nurses have clinical support out of hours.

Questions were invited:

Sue Wadsworth asked for an update on the current situation with the secure doors and windows at Sevenacres to be provided to both herself and Jessamy Baird.

Action Note: *The Acting Associate Director to provide a progress report on security features at Sevenacres to Sue Wadsworth and Jessamy Baird.*

Action by: AAD

David King asked for more information on night cover and out of hours services for Community areas. The Acting Associate Director advised that system resilience funding had enabled additional resources to be made available. She outlined the Hub procedures to support calls from the community. The Chairman asked if data was available for this area of activity. It was confirmed that the PIDs team collect data as part of their process. The Executive Director of Nursing & Workforce also confirmed that it was included within the Quality Improvement Plan as a key performance indicator (KPI).

David King asked if the directorate was on track to reduce their overspend. The Executive Medical Director advised that the team were optimistic that they will reach their targets but this is reliant on a number of income receipts. The Executive Director of Finance confirmed that weekly meetings are taking place to monitor progress of schemes.

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

[6] Whole time equivalent

15/T/006 PATIENT STORY

The Chief Executive advised the meeting that this month there would be two stories shown both of which had been reviewed at the QCPC[7] meetings in December and January. These were from patients on the Stroke Unit and Winter Ward.

The Executive Director of Nursing & Workforce advised that since the Interim Sister on the Stroke Unit had been in post, morale and team working had improved. He also highlighted the new style of filming shown in the Winter Ward presentation which showed the questions on screen followed by the patient's response.

The Executive Director of Nursing & Workforce stressed the importance of showing both good and bad feedback from patients. He stated that having feedback from patients was important for the teams who deliver frontline care and he confirmed that both teams involved had viewed the films. He also confirmed that these films were available on the intranet for all staff to view.

Sue Wadsworth requested a Patient Story film be undertaken at the new Poppy Ward[8] and also Community cases. The Executive Medical Director confirmed that the first patients had been placed on Poppy Ward and initial patient feedback was very positive.

Action Note: *The Executive Director of Nursing & Workforce to arrange for appropriate filming to be undertaken in the Community areas and also in Poppy Ward.*

Action by: EDNW

The Isle of Wight NHS Trust Board received the Patient Story

15/T/007 EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

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

Category 2 - Employee Role Model:

- Gary Thornton, Dental Lab Technician - Maxillofacial Unit

Category 3 - Going the Extra Mile:

- Lorna Collingwood, Specialist Paediatric Occupational Therapist – OT & Wheelchair Services
- Linda Fishburn, Matron – Accident & Emergency
- Andy Carroll, Staff Nurse – Accident & Emergency
- Marina Rogers, Emergency Department Assistant – Accident & Emergency

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/008 EMPLOYEE OF THE MONTH

The Chief Executive presented the Employee of the Month Award.

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Employee of the Month – December 14

- Pam Pragnell, Nursery Nurse – Children's Ward

[7] Quality & Clinical Performance Committee
[8] New Community Capacity Ward (see Min 15/017)

Employee of the Month - January 15

- Samantha Stevens, Receptionist – Main Reception

The Chief Executive congratulated the recipients on their achievements.

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

15/T/009 STAFF STORY

The Staff Story was presented by FY2[9] Dr's Husay Janebdar and Linsey McAlpine on their Medical Careers Day which they organised. This was a fun and interactive event to inspire/encourage/support Isle of Wight school students interested in a career in medicine covering a range of topics including:

- ★ 'The Qualities of a Doctor'
- ★ 'A Day in the Life of…'
- ★ 'Life as a Medical Student'
- ★ 'How to Get Into Medical School'
- ★ Hands-on clinical skills sessions
- ★ Signposting to local opportunities

The doctors created this event to give to the next generation of possible medical students an overview of what they could expect life to be as a medical student. A number of students who attended have now signed up as hospital volunteers and the feedback received was extremely positive.

Charles Rogers congratulated Dr Janebdar and Dr McAlpine on their work which had shown such a positive side to being a medical student and junior doctor to local school students. The Company Secretary echoed this praise as he is Chairman of a local school trust and he confirmed that the feedback had been extremely positive. He confirmed that Dr Oliver Cramer, Consultant/Associate Director of Medical Education and Dr Maria Lynch were keen for this to be repeated in the future for Year 11, 12 and 13 school students and that this event was an extremely good legacy for the two doctors to leave behind them when they move on with their careers.

The Isle of Wight NHS Trust Board received the Staff Story

15/T/010 MINUTES OF PREVIOUS MEETING

Minutes of the meeting of the Isle of Wight NHS Trust Board held on 3rd December 2014 were approved.

Proposed by Sue Wadsworth and Seconded by David King

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

15/T/011 REVIEW OF SCHEDULE OF ACTIONS

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

a) **TB/129 – Consultant Workforce Report:** The Executive Director of Nursing & Workforce confirmed that this report is presented to TEC[10] on a weekly basis. This action is now closed.

b) **TB/130 – PARIS System:** The Executive Director of Transformation & Integration confirmed that a report on the progress of this system is presented to QCPC on a monthly basis. This action is now closed.

c) **TB/131 – Assaults in Mental Health Services:** The Executive Medical Director advised that following a review he could confirm that there had been 58 assaults in the last 2 years; a high percentile of which were on Shackleton Ward and the

[9] Foundation Year 2 Doctors
[10] Trust Executive Committee

open ward at Sevenacres. He confirmed that no patient had come to significant harm. These incidents are recorded within the Performance Summary of the Performance Report on a monthly basis. Chris Orchin, Representative for Healthwatch who raised the original query confirmed he was satisfied with this information. This action is now closed.

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

ITEMS FOR THE BOARD

15/T/012 PERFORMANCE REPORT

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

Highlights:

- Ambulance Red 1 and Red 2 calls response time <8 minutes above target
- 90% of stay on Stroke Unit and High risk TIA[11] fully investigated & treated within 24 hours above target
- Referral To Treatment Time for Incompletes above target
- All Cancer Targets achieved in December

Lowlights:

- Clostridium Difficile (C.Diff) - now exceeded the national threshold (6) for the whole year
- Referral To Treatment Time for Admitted and Non-Admitted remain below target
- Staff sickness remains above plan
- Theatre Utilisation below target
- Emergency care 4 hour standard below target
- Financial position £174k below plan

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.
- **Clostridium Difficile (C.Diff):** We had 1 additional case during December and have now exceeded our full year target of 6.

Responsive:

- **Admitted and Non-Admitted Targets:** We continue to underperform beyond the expected period due to further validation identifying a number of patients waiting longer than originally calculated; treating these patients in turn impacts on performance against these targets for December onwards. However, the admitted performance for December increased from 81.42% in November to 86.67% this month and the non-admitted performance has increased from 91.68% last month to 94.44% in December.
- **Ambulance**: Red 1 and Red 2 calls response time <8 minutes - achieving all targets during December. Additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall. The Winter resilience monies are also being utilised to boost performance and support services where necessary.

- **Emergency Care 4 hour Standard:** The 95% target for December was again not achieved unfortunately due to the increased pressure on community bed availability. Despite action plans being followed the increase in attendances at the Emergency department contributed to the target being failed.

11 Transient Ischaemic Attack (also known as 'mini-stroke')

Caring:

- **Complaints**: The number of complaints has increased slightly since November and it is lower than in April 2014.
- **Compliments**: Compliments in the form of letters and cards of thanks, were higher during December than in November.
- **The Friends & Family Test**: The response rate for A&E improved during December and now exceeding the target for the month.
- **Mixed Sex Accommodation**: No breaches during December.

Well Led:

- **Paybill:** Total paybill exceeds budgeted expenditure £2.6m year to date excluding release of reserves; an improvement of £141k in month. The number of FTEs in post including variable FTEs (2,730) is currently below plan by 34 FTE.
- **Sickness Absence:** This has decreased from 5.29% to 4.93% during December but remains above the 3% plan.
- **Financial:** The Trust planned for a deficit of £85k in December, after adjustments made for normalising items (these include the net costs associated with donated assets and impairments). The reported position is a deficit of £79k in the month, a favourable variance of £7k.

Effective:

- **Theatre Utilisation**: This has improved for Day Surgery Unit (81%) but decreased for Main Theatres (77.1%) - both below 83% target - giving a joint rate of 78.9% in December.
- **Bed Pressures:** Continue despite opening of St Helens ward. Increased emergency admissions prevented access to elective beds again impacting on ability to ensure high theatre utilisation.

The Executive Director of Finance advised the Board that although there was currently a monthly surplus showing there were a number of underlying issues which meant that the Trust would need to revise its year-end financial position to the TDA[12]. She outlined the assumptions and mitigating actions taken by the Finance team during their review process and advised the Board that the following action was requested to be approved for the Financial Forecast 2014/15:

- M9 Recommending a Revised Year End Forecast Position £3k surplus (deterioration of £1.697m)
- Must maintain strict cost control and delivery of required improvements
- System Resilience Funding fully deployed
- Repercussions – Cash impact 2015/16, Recurrent CIP Gap circa £3m, Risk to Reputation, Longer Term Sustainability, Robust Recovery Process
- Board Action: Consider and Approve the Proposal to reduce the surplus to £3k for 2014/15

There followed a detailed discussion on this proposal. The Chief Executive stated that this was the first time in many years that the Trust had been in this position and whilst it is possible to amend the year-end target care must be given to how this is reflected to the staff, to ensure focus is maintained to ensure the position does not deteriorate further. It was, therefore, agreed that in light of the nature of the points raised by members, more detailed financial information would be presented to the Board in the private section of the meeting which follows after this public meeting, at which point a decision on the year-end financial forecast position would be made.

The Isle of Wight NHS Trust Board received the Performance Report and agreed to continue the discussion in Part 2 – Private Board – 28th January 2015

[12] Trust Development Authority

15/T/013 DATA QUALITY REPORT

The Executive Director of Finance advised that this report was being presented following a request by the Board. She confirmed that accurate data quality was important to gain assurance and that work continued to be done to further improve the processes. An annual report would be presented to the Board at the beginning of each financial year which will include an assessment of any new measures included in the Performance Report.

Proposed by Sue Wadsworth and seconded by Charles Rogers and unanimously agreed

The Isle of Wight NHS Trust Board approved the Data Quality Report

15/T/014 REPORT FROM SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs)

The Lead for SEE[13] and Deputy Director of IPC[14] provided an overview of the 10 Serious Incidents reported during December 2014

Of the 10 incidents reported 5 related to pressure ulcers, 2 to patient falls and the remaining 3 to various other issues. There were also 13 SIRI cases closed during December.

The Lead for SEE and Deputy Director of IPC advised that additional training courses had been arranged to enable further Investigating Officers to be available and she confirmed that a number of consultants had expressed interest in becoming Investigating Officers. She also advised that regular meetings to review SIRI cases had been arranged with the pool of Investigating Officers.

Jane Tabor asked if there was any connection between the falls and levels of staffing. The Lead for SEE and Deputy Director of IPC advised that this would be included as part of the investigation with the outcomes being reported to the SEE Committee and QCPC. The Executive Medical Director advised that historically there was no evidence to show that staffing levels had any effect on level of falls. The Executive Director of Nursing & Workforce referred the Board to the Safer Staffing 6 Monthly report which was coming up later in the meeting.

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

15/T/015 SAFER STAFFING – 6 MONTHLY UPDATE

The Deputy Director of Nursing presented the Safer Staffing 6 Monthly update and advised that the report had been submitted in December in accordance with NHS England requirements.

She confirmed that work continued on the acuity and dependency reporting and this was in progress during January Reviews would take place with the ward sisters on the results and actions to take forward.

Charles Rogers stated that excellent work was being done. He queried if the figures correlated to patient occupancy as this was not obvious. The Deputy Director of Nursing advised that in some cases occupancy was less than 100% e.g. Intensive Care and Acuity and Dependency would reflect a lower occupancy as it measures patient requirements every day, but it should be noted that these are not the sole measure utilised. For example, Intensive Care requirements would also take into considerations the national recommendations on nurse to bed ratio, together with local requirements as set out in the nurse staffing principles.

Proposed by Sue Wadsworth and seconded by Jane Tabor

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

[13] Patient Safety, Experience & Clinical Effectiveness
[14] Infection Prevention & Control

15/T/016 SAFER STAFFING BUSINESS CASE

The Deputy Director of Nursing presented the business case for Safer Staffing. She outlined the process which had taken place together with the extensive consultation process and advised that following the Safer Staffing review which included the Acuity and Dependency review of all areas it had identified the need for 76 nurses (including Mental Health). The cost of this was circa £2.5m in total.

She reminded that the Board had previously approved the development of a business case to enable funding to be sought via the Clinical Commissioning Group (CCG). Funding has not been secured and the business case was therefore resubmitted to Trust Board for review of recommendation of Option 4, which indicates a phased approach to increasing nursing establishment.

The Deputy Director of Nursing outlined the key changes made and why Option 4 is recommended:

- The previous version of the business case recommended Option 2, still a phased approach but in two cohorts rather than 3.
- There is still work to do to ensure robust reporting against key safety indicators.
- Recruiting over a 3 year cohort gives time to provide an uplift to nursing to ensure high risk areas are brought into line with an amber or green risk rating (see paper), and also allows time to continue the work to implement the recommendations from NICE.
- The Board had requested further information in relation to key indicators and return on investment. Under the Economic case (section 7) information is provided to articulate how poor safety outcomes can be financially adverse, or result in additional hours utilised ineffectively such as in complaint reviews or investigations. This results in more effective working and better outcomes for patients but is difficult to quantify. There is however, evidence to suggest having more nursing staff does reduce mortality and that 1 additional nurse can save 5 lives in medicine per 1000 patients, and 6 in surgery per 1000 patients (Keogh review 2013).

A detailed discussion took place on the revised Business case and the recommendation of Option 4:

Sue Wadsworth expressed concern as to how this would affect the CIPs for future years. The Executive Director of Finance advised that no additional funding on the block contract tariffs had been received and there was no certainty that additional funding would be available as there was only a limited pool of funding for the Island.

David King asked how this proposal affected the Trust's legal obligations and would nursing budgets be ring fenced against future CIPs. The Deputy Director of Nursing advised that the nursing budgets would not be ring fenced but nursing levels would be based on the ongoing acuity and dependency reviews together with discussions with the senior team. David King was not happy with the wording within the paper regarding this issue. The Executive Director of Transformation & Integration agreed that the paper gives the impression of the budget being ring fenced but it also showed that flexibility was allowed and the removal of that particular sentence would have ensured greater clarity.

David King also asked how the organisation currently was positioned as far as Safer Staffing levels. The Deputy Director of Nursing informed him that the organisation was operating within safe levels within current establishment with any gaps in substantive posts being filled with bank staff. She confirmed that staffing levels were monitored on a daily basis by the matrons and staff were assigned as appropriate. David King asked

for assurance that if the Trust does not approve the Safer Staffing case whether the hospital would still be safe. The Executive Director of Nursing & Workforce reassured him that the hospital was staffed at safe levels in that the wards are working within their current parameters of current establishment and bank was utilised to ensure establishments were met. Chairman questioned that if this was the case was there a need for Safer Staffing as there was no additional funding available. The Chief Executive stated that the hospitals reputation was at risk if it does not approve the Safer Staffing measures proposed. She felt that it should approve them and it was then for the Executive team to ensure that it creates a plan to ensure this is affordable.

Jane Tabor stated that assuming the additional staff were recruited and the CIP agreed it would still require transformational change across the organisation and she was concerned how the Board would get assurance that it was effective. The Executive Director of Finance advised that continued CIP would be needed as costs were increasing. She stated that to achieve this, tough decisions would need to be taken.

The Executive Medical Director wanted to highlight the need to stress that we are currently working within SAFE staffing levels but that moving to SAFER levels should be seen as stage 2 of the process. He therefore queried why option 3 was not recommended. The Deputy Director of Nursing advised that once the existing vacancies were filled we would be in a better position to review requirements; softer elements are likely to have an impact including improving staff morale and confidence. And with time freed up for competency training, supervision, we will be developing a more robust workforce. She stressed that even when the 41 staff arrive there would be a period of supervision and orientation, and therefore, the effect of their arrival would be phased over a 6 month period.

The Company Secretary confirmed that Safer Staffing had been discussed extensively at the Board and its sub-committees over more than a year and the Board had previously approved the methodology on which the recommended Option 4 is based. He suggested that if the Board approved the business case if could request the Executive Directors present a plan for its affordability as part of the 2015/16 budget. The Executive Director of Finance expressed concern at the additional cost pressure this would create for the 2015/16 budget.

Charles Rogers stated that as there was already a predicted loss next year, the cost of this would only add to it. However, he did agree that it was important for the Trust to be compliant with safety as well as to balance its budget.

The Executive Director of Nursing & Workforce asked the Board to bear in mind that the level of safer staffing was taken at a specific point in time, and that this was an ever changing variable. He asked that the Board approve the initial recruitment to fill the existing vacancies. He argued that the recruitment of 55 posts would address the most urgent staffing shortfalls and enable more than the current vacancies to be recruited via the current overseas recruitment initiative in the Philippines. He confirmed that following organisation change with the existing Band 6 nurses additional monies will be available from June 2016 when the pay protection period ends. Jane Tabor asked for information on the cost of bank and agency staff being used to back fill the vacant posts. The Executive Director of Nursing & Workforce confirmed that they were largely the same as if the posts were filled as the Trust hardly ever used agency staff.

The Chief Executive stated that she agreed that the Trust should work to Safer Staffing but in an affordable way and the challenge now was to make it affordable. Jane Tabor asked for a timeline for this to be achieved.

The Executive Director of Nursing & Workforce asked the Board to agree the proposal today and that specific areas would continue to be reviewed as the process rolls out. This was supported by the Executive Medical Director.

Following this discussion it was agreed by the Board that the following resolution would be put forward:

1. The business case was supported in principle

2. The Executive Team would draw up plans and a timeline to identify funding for Option 4
3. 55 Registered Nurses would be appointed in the meantime which includes 26 wte vacancies.

The Chairman put the resolution to a formal vote:

For	**Against**
Danny Fisher	David King
Charles Rogers	
Jane Tabor	
Sue Wadsworth	
Karen Baker	
Alan Sheward	
Mark Pugh	
Chris Palmer	
Katie Gray	

For the Resolution = 9 **Against** the Resolution = 1 There were no abstentions

Resolution was carried

The Isle of Wight NHS Trust Board supported the Safer Staffing Business Case in principle and approved the appointment of 55 Registered Nurses in the interim.

Action Note: Safer Staffing Funding for Option 4 *- the Executive Team would draw up plans and a timeline to identify funding for Option 4.*

Action by: CEO

15/T/017 CREATING COMMUNITY CAPACITY DURING THE WINTER PERIOD

The Company Secretary advised that following the decision made at the Board Seminar on 13th January 2015, it was required that the Board formally ratify this decision. The decision made on 13th January is as follows:

Min No 15/003 - **WINTER RESILIENCE – SOLENT GRANGE PROPOSAL**

Proposed by Sue Wadsworth and Seconded by Jane Tabor. Unanimously agreed

The Isle of Wight Trust Board approved the pilot Community Capacity scheme and agreed that this be ratified at the Board meeting on 28th January.

The Board agreed to ratify this decision.

Proposed by Jane Tabor and Seconded by Alan Sheward

The Isle of Wight NHS Trust Board ratified the approval given at the Board Seminar on 13th January 2015 for the *pilot Community Capacity scheme.*

15/T/018 RESEARCH & DEVELOPMENT – 6 MONTHLY REPORT

The Chairman deferred this item until the meeting on 4th March 2015

15/T/019 FT PROGRAMME UPDATE

The FT Programme Director presented the update and advised that membership was still increasing and the next Medicine for Members event was already full. Further updates would be made at future meetings.

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

15/T/020 BOARD SELF CERTIFICATION

The Company Secretary presented the monthly update. He confirmed that both the FIIWC and QCPC had approved the recommendations. He highlighted the change to Statement 10 where the compliance date had been slipped to 28th February 2015.

Proposed by Sue Wadsworth and seconded by Charles Rogers

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

15/T/021 BOARD ASSURANCE FRAMEWORK (BAF) MONTHLY UPDATE

The Company Secretary presented the BAF. He advised that there were 2 changes to BAF assurance ratings from Amber to Green and 5 new risks. He confirmed that since going to print risk 634 – Dental Compressor had been resolved with the equipment replaced.

The Executive Director of Nursing & Workforce requested that Exec Lead be amended on CSF2-632-1 to the Executive Medical Director.

Proposed by Sue Wadsworth and seconded by Jane Tabor

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

15/T/022 TERMS OF REFERENCE – REMUNERATION & NOMINATIONS COMMITTEE

The Company Secretary presented the revised Remuneration & Nominations Committee's terms of reference which were approved by the committee on 3rd December 2014. He highlighted a small number of amendments.

Proposed by Sue Wadsworth and seconded by Jane Tabor

The Isle of Wight NHS Trust Board approved the revised Terms of Reference for the Remuneration & Nominations Committee

15/T/023 MINUTES OF THE QUALITY & CLINICAL PERFORMANCE COMMITTEE

Sue Wadsworth reported on the key points raised at the last meeting held on 17th December 2014:

a) **Min No. 14/394** – The Committee was updated on the ISIS[15] upgrade
b) **Min No. 14/399** – The Committee discussed the Quality Report
c) **Min No. 14/399** – The Committee discussed Patient Surveys and asked for an update for the February 2015 meeting
d) **Min No. 14/400** – The Committee was updated on mortality rates.
e) **Min No. 14/404** – The Committee received **positive assurance** regarding the Quality Improvement Plan
f) **Min No. 14/405** – The Committee discussed SIRIs relating to pressure ulcers in the Community Directorate
g) **Min No. 14/415** – The Committee approved the Board Self-Certification

Sue Wadsworth reported on the key points raised at the last meeting held on 21st January 2015:

h) **Min No. 15/008** – The Committee discussed the Quality Report - cancelled appointments were highlighted as an issue. The Committee gained **limited assurance.**

[15] Integrated Services Information System

i) **Min No. 15/008** - The Committee discussed the Quality Report and highlighted issues around the assurance process. The Committee gained **limited assurance.**
j) **Min No. 15/006** - The Committee was updated on Infection, Prevention and Control issues. The Committee gained **limited assurance.**
k) **Min No. 15/025** - The Committee discussed governance processes and were informed of a Quality Framework meeting to be held on 23 February 2015.
l) **Min No. 15/020** - The Committee discussed the Visual Impairment Inspection Report. The Committee gained **positive assurance** on the process but **limited assurance** regarding the outcomes.

Sue Wadsworth also reported that the January meeting had been observed by the TDA and she looked forward to receiving the feedback report in due course.

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

15/T/024 MINUTES OF THE FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE

Charles Rogers reported on the key points raised at the last meeting held on 18th December 2014:

a) **Min No. 14/221 - CIPS –** The Committee discussed the remaining recurrent CIP gap of £4.2m and had discussions about the cost improvement process and the current levels achieved in year. In addition to the challenges faced this financial year it was noted that a carry over into 2015/16 of this size would be very difficult to manage successfully.
b) **Min No. 14/222 - Financial Position -** The Committee discussed the forecast out-turn position of the organisation if the current predicted spend pattern, prior to recovery actions, continued. The Committee noted the potential risk & both further risks & opportunities available to ensure the Trust meets its £1.7m surplus position.
c) **Min No. 14/225 - Carbon Energy Fund Update –** The Committee agreed to recommend the full business case to the Trust Board.
d) **Min No. 14/226 - Self Certification -** The Committee agreed to recommend the review subject to the recommended points.

Charles Rogers reported on the key points raised at the last meeting held on 21st January 2015:

e) **Min No. 15/018 - CIPS –** The Executive Director of Transformation & Integration reported the gap to savings targeted in year as £2.0m and the likely carry forward of CIPs into 2015/16 of £4.2m. The Committee raised concern at the gap and requested sight of 2015/16 schemes at the February FIIWC meeting.
f) **Min No. 15/019 - Financial Position –** The Executive Director of Finance reported year to date position of £1.58m surplus, a variance of £174k to plan. She highlighted the worsening position at year end and that revised forecasts required the Board to consider requesting a change from the planned surplus of £1.7m to just over breakeven. This position would still require achievement of stretched targets for directorates and especially the Hospital and Ambulance directorate who are forecasting a projected deficit of £6.3m.
g) **Min No. 15/013 - Safer Staffing -** It was agreed that the Safer Staffing business case should be presented to the Trust Board subject to the modifications and additions proposed by the Committee. The Committee notes that in considering the paper the Trust Board will need to balance the corporate and safety requirements to recruit the extra staff against the

additional unbudgeted costs.

h) **Min No. 15/029 - NHS Creative –** The Committee received a paper reviewing the work of NHS Creative. The paper included a business case and strategy for growth. The Committee agreed that the Trust should continue to host NHS Creative and will continue to monitor quarterly updates.

i) **Min No. 15/030 - Self Certification -** Sufficient assurance had been provided for the Committee to recommend that Trust Board approve the self-certification returns as proposed.

Charles Rogers also confirmed that the January meeting had been observed by the TDA.

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

15/T/025 NOTES OF THE FT PROGRAMME BOARD

The Chief Executive reported on the key points raised at the last meeting held on 25th November 2014.

a) **Note No. 109/14** - The timeline would be amended to reflect the Trust's projected delivery of CQC compliance requirements.
b) **Note No. 111/14** - £86K would be released from the 2014/15 FT budget as a non-recurrent cost improvement contribution.
c) **Note No. 115/14** - Monitor's Well Led Framework would replace the Quality Governance and Board Governance Assurance Frameworks.

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

15/T/026 MATTERS TO BE REPORTED TO THE BOARD

There were no matters to be reported.

15/T/027 ANY OTHER BUSINESS

a) **CQC Warning Letter:** The Executive Director of Nursing & Workforce confirmed that following declaration of compliance against all except 3 enforcement actions, the CQC has now lifted its warning notice.

b) **New Board and Sub-Committee meeting schedule:** The Company Secretary highlighted that the new meeting schedule for Board and Sub-Committees would commence from 1st February.

15/T/028 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

15/T/029 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 4th March 2015** in the Conference Room, School of Health Sciences, South Hospital, St Mary's Hospital, Newport, Isle of Wight.

The meeting closed at 2pm

Signed……Chair Date:……

Following the conclusion of the agenda items in Part 1 of the Trust Board, the Board continued to sit to discuss Charitable Funds.

BOARD CONVENED AS CORPORATE TRUSTEE:

15/CT/001 APPROVAL & SIGN OFF OF THE CHARITABLE FUNDS ANNUAL REPORT & ACCOUNTS 2013/14

The Executive Director of Finance advised that an extraordinary Charitable Funds Committee meeting had been held immediately prior to this Board meeting and

confirmed that the Annual Report and Accounts for 2013/14 had been approved. She requested that formal approval be given by the Corporate Trustee for these to be signed.

Proposed by Sue Wadsworth and seconded by Jane Tabor

The Corporate Trustee of the Isle of Wight NHS Trust approved the Charitable Funds Annual Report and Accounts 2013/14

15/CT/002 LETTER OF REPRESENTATION

The Executive Director of Finance confirmed that the Letter of Representation had been approved by the Charitable Funds Committee. This was a standard document.

Proposed by Sue Wadsworth and seconded by David King

The Corporate Trustee of the Isle of Wight NHS Trust approved the Letter of Representation

15/CT/003 NON CONSOLIDATION OF 2014/15 CHARITABLE FUNDS ACCOUNTS

The Executive Director of Finance confirmed that it was necessary to formally agree to the non-consolidation of the 2014/15 Charitable Funds Accounts.

She explained that materiality was assessed annually and will vary depending on the NHS organisation's accounts as well as the NHS Charity's accounts. She confirmed that following discussion with External Audit, this had been agreed by the Charitable Funds Committee.

Proposed by Charles Rogers and seconded by Sue Wadsworth

The Corporate Trustee of the Isle of Wight NHS Trust approved the Non Consolidation of 2014/15 Charitable Funds Accounts

15/CT/004 MINUTES OF THE CHARITABLE FUNDS COMMITTEE

Sue Wadsworth reported on the key points raised at the last meeting held on 9th December 2014.

a) **Min No. 14/067 - Terms of Reference:** Updated TOR to be approved by Corporate Trustee
b) **Min No. 14/068 - Draft Annual Report & Accounts 2013/14:** As the Independent Examination Report was not available, a CFC meeting will be held prior to the Trust Board meeting on the 28th January 2015 to agree and recommend the Annual Report and Accounts to the Corporate Trustee for approval and sign off.
c) **Min No. 14/070 - Charity Independence:** Now possible to register as a charity independent to the related NHS organisation. Agreed that this option would not benefit the IOW NHS Trust Charitable Funds as only really viable for larger organisations.
d) **Min No. 14/071 - Friends of St. Mary's Hospital Charity Lottery:** Agreed to recommend to the Corporate Trustee to enter into an 'arrangement' with Friends for staff to join the Unity Lottery. A proposal will be presented to a future meeting of the Corporate Trustee outlining Unity's proposal.
e) **Min No. – 14/073 - Approval of items over £15k:** Friends of St. Mary's (Agreed purchases) - £56,229.58

The Corporate Trustee of the Isle of Wight NHS Trust received the minutes of the Charitable Funds Committee

15/CT/006 TERMS OF REFERENCE – CHARITABLE FUNDS COMMITTEE

The Executive Director of Finance presented the revised Terms of Reference for the Charitable Funds Committee which had been approved by the committee on 9th December 2014

Proposed by Jane Tabor and seconded by Sue Wadsworth

The Corporate Trustee of the Isle of Wight NHS Trust approved the Terms of Reference for the Charitable Funds Committee

15/CT/007 CHARITABLE FUNDS INVESTMENT & RESERVES POLICY

The Executive Director of Finance presented the Charitable Funds Investment & Reserve Policy which had been approved by the committee on 9th December2014. It was requested that these be approved and adopted by the Corporate Trustee.

Proposed by Sue Wadsworth and seconded by Charles Rogers

The Corporate Trustee of the Isle of Wight NHS Trust approved the Charitable Funds Investment & Reserves Policy

Enc B

ISLE OF WIGHT TRUST BOARD Pt 1 (Public) - April 14 - March 15

ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

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

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

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

Head of Corporate Governance & Risk Management (HCGRM)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) Sue Wadsworth (SW) Charles Rogers (CR) Nina Moorman (NM) David King (DK) Jane Tabor (JT)

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

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
30-Apr-14	14/125	TB/093	**Board Walkabout Timings:** The Chairman stated that he had undertaken walkabouts on Sundays and he encouraged members to vary the times they make their visits to include out of hours times including weekends and late evenings to get a wider picture of how the organisation functions during these times. There was a discussion surrounding the timings of the Board day walkabouts and it was requested that these be reviewed.	EDNW	Company Secretary to review timings and adjust Board day programme accordingly. **16/05/14** - Scheduled at lunchtime for May Board meeting. Timings to be adjusted following feedback. **28/05/14** - The Company Secretary advised that this item had been left open to allow for feedback on the new timings of these walkabouts within the Board programme. **01/10/14** - The Company Secretary report that a new format for these was being trailed and that the action would be left open with a discussion due to be held at Board Seminar. **24/11/14** - Principles for new process and timings for Walkabouts agreed at October Board Seminar including not scheduling them on Board days. New process to be proposed by EDNW. **03/12/14** - The Executive Director of Nursing & Workforce confirmed that the revised process was currently in development. **18/02/15** - Discussion paper has gone out to consultation and Patient Experience Lead is awaiting feedback.	14-Oct-14	01-Apr-15	Progressing		Open
03-Dec-14	14/320	TB/128	**Safeguarding:** Sue Wadsworth asked that succession planning for the Safeguarding team be presented to the next QCPC meeting. This was agreed.	AAD-C&MH	The Acting Associate Director to present details of the succession planning for the Safeguarding team to QCPC in January. **19/01/15** - Confirmed this will be on the agenda for 25th February meeting. **20/02/15** - Acting Associate Director presenting update at QCPC on 25th February. This action is now closed.	21-Jan-15	25-Feb-15	Completed	20-Feb-15	Closed
03-Dec-14	14/326c)	TB/129	**Consultant Workforce Report:** Develop the Consultant Workforce Report which currently goes to TEC, to include locum usage and any gaps in Consultant cover.	EDNW	The Executive Director of Nursing & Workforce to arrange for this report to be developed. **28/01/15** - The Executive Director of Nursing & Workforce confirmed that this report is presented to TEC on a weekly basis. This action is now closed.	28-Jan-15	28-Jan-15	Completed	28-Jan-15	Closed
03-Dec-14	14/326e)	TB/130	**PARIS System**: Executive Director of Transformation & Integration to report back to QCPC on PARIS system roll out.	EDTI	The Executive Director of Transformation & Integration to report to the QCPC on the PARIS system roll out. **28/01/15** - The Executive Director of Transformation & Integration confirmed that a report on the progress of this system is presented to QCPC on a monthly basis. This action is now closed.	21-Jan-15	21-Jan-15	Completed	28-Jan-15	Closed

Enc B

Date of Meeting	Minute No.	Action No.	Action	Lead	Update	Due Date	Forecast Date	Progress RAG	Date Closed	Status
03-Dec-14	14/327i)	TB/131	**Assaults against Staff in Mental Health Services p6** – Chris Orchin, with permission from the Chair, asked if the cases shown were recorded as to whether they were connected to SIRIs or were patient to patient incidents. The Executive Medical Director advised that all cases were recorded and exact details could be provided. He agreed he would look into the details and report back.	EMD	The Executive Medical Director to get details of all assaults on staff in mental health services and report back to Board. **19/01/15** - Executive Medical Director will give a verbal update at the meeting. **28/01/15** - The Executive Medical Director advised that following a review he could confirm that there had been 58 assaults in the last 2 years; a high percentile of which were on Shackleton Ward and the open ward at Sevenacres. He confirmed that no patient had come to significant harm. These incidents are recorded within the Performance Summary of the Performance Report on a monthly basis. Chris Orchin, Representative for Healthwatch who raised the original query confirmed he was satisfied with this information. This action is now closed.	28-Jan-15	28-Jan-15	Completed	28-Jan-15	Closed
03-Dec-14	14/327v)	TB/133	**Directorate Reports p's4 – 7** – Nina Moorman stated that she felt that there was repetition within the Trust Performance report and the Directorate reports received earlier in the meeting and queried if this was deliberate. The Chief Executive advised that work had been done to ensure consistency between the reports but that the Directorate reports were still being developed and this point would be taken into consideration for future reports.	CS	The Company Secretary to review the respective information provided in the directorate reports and Trust Performance report. **23/02/15** - Directorate reports reviewed to address duplication with Trust Performance Report. Revised reports for 4th March Board meeting. This action is now closed.	04-Mar-15	04-Mar-15	Completed	23-Feb-15	Closed
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.	31-Mar-15	31-Mar-15	Progressing		Open
03-Dec-14	14/334	TB/137	**Capital Scheme Approval Process**: Lizzie Peers queried why approval had not been granted prior to this and was there an issue with the approval process. The Chief Executive advised that the processes in place were being reviewed to ensure compliance with governance requirements by the Company Secretary and Executive Director of Transformation & Integration. As part of this process the documentation was being standardised. The Deputy Director of Informatics also confirmed that the annual review of the standing financial instructions was under way.	CS/EDTI	Processes to be reviewed to ensure compliance with governance requirements. **24/02/15** - Review of Standing Financial Instructions and Standing Orders completed by 1st April 2015	01-Apr-15	01-Apr-15	Progressing		Open
28-Jan-15	15/T/005	TB/139	**Mental Health Security Doors & Windows:** Sue Wadsworth asked for an update on the current situation with the secure doors and windows at Sevenacres to be provided to both herself and Jessamy Baird.	AAD-C&MH	The Acting Associate Director to provide a progress report on security features at Sevenacres to Sue Wadsworth and Jessamy Baird. **16/02/15** - Confirmed that progress report has been sent to Non Executives as requested. A tour of the facility to view changes has also been offered. This action is now closed.	04-Mar-15	04-Mar-15	Completed	16-Feb-15	Closed
28-Jan-15	15/T/006	TB/140	**Future Patient Stories:** Sue Wadsworth requested a Patient Story film be undertaken at the new Poppy Ward and also Community cases.	EDNW	The Executive Director of Nursing & Workforce to arrange for appropriate filming to be undertaken in the Community areas and also in Poppy Ward. **18/02/15** - Filming will commence at the end of this month for viewing at Trust Board at the end of March 2015. This action is now closed.	04-Mar-15	04-Mar-15	Completed	18-Feb-15	Closed
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	A progress update will be given in the private part of the 4th March Board meeting	01-Apr-15	01-Apr-15	Progressing		Open

Enc C

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 4th MARCH 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 21st January to 24th February 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.							
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: 24th February 2015	**Completed by:** Andy Hollebon Head of Communications and Engagement & Sarah Morrison – Exec Assistant to Chief Executive						

Health System Pressures

We have continued to face significant pressures across the whole of the health care system. Many of our staff are working above and beyond the call of duty to ensure that patients are provided with the best possible service. The pressures are principally caused by a greater number of elderly patients who are more poorly for a longer period of time than has previously been the case. It is not clear whether this has been exacerbated by the lack of an effective flu vaccine this year.

We recognise that in some instances patients have had to wait longer for an ambulance, wait longer for a healthcare professional and wait longer for a bed in hospital than we would have wanted. We have taken measures, including the cancellation of some non-urgent inpatient surgery, requesting some patients to attend mainland hospitals for their operations and the opening of Poppy Unit, to ease the pressures on the Island. Our aim is provide quality care for everyone every time and even during these pressured times we are confident that with the fantastic support of our staff the majority of patients do have a good experience of our services.

BME Network

The inaugural meeting of the Black and Minority Ethnic (BME) Staff Network has been held. The network will be run by and for staff whose ancestral origins are African, Asian, Caribbean, Chinese, Irish, Japanese, Middle Eastern, North African, Romany, the indigenous peoples of the South Pacific Islands, the American continent, Australia and New Zealand as well as staff from mainland Europe and any European island. At its first meeting Patience Kapuya, Biomedical Scientist and Max Ferrer, Cleanliness Assistant agreed to co-chair the Network. This is a new venture for the Trust. It is clear to me that BME staff have a lot to contribute and I hope the network will create a forum for BME staff to be able to share their ideas and views.

General Election

With the election fast approaching there is no doubt that the NHS will be a central point of discussion. I would however make a plea to all those taking an active part in the election. Please get your facts about the Island's NHS correct and please, no distribution or display of party political material on NHS premises. On 30th March, with the dissolution of Parliament, the NHS will enter a period of pre-election 'purdah' which may place restrictions on some activities until a new Government is formed.

CQC Enforcement Notice

During the last month we have met with representatives from the Care Quality Commission (CQC) to discuss our submission in response to the enforcement notice we were issued in July. I have shared with staff the feedback from the CQC representatives who acknowledged and appreciated how much effort we as an organisation have put into making the required improvements. The CQC felt we had made significant progress on the required actions and have lifted the Warning Notice. Our work continues on the Quality Improvement Plan.

Trust Awards evening

Congratulations to everyone who was shortlisted for the Trust Awards on Friday 30th January. This glittering ceremony held this year at Cowes Yacht Haven was sponsored by KM&T and a number of other sponsors without whom the whole event would not have been possible. A list of the award recipients at Appendix 1.

Roy Lilley

Influential health and social care commentator Roy Lilley visited the Island on 4th February. In his recent 'blog' on www.nhsmanagers.net he spoke in glowing terms about what the Trust and partners are doing. The blog is attached as Appendix 2.

Executive Director portfolios

As an organisation with a turnover of £170m per annum, a workforce of around 3,000 people and providing care to 140,000 people on the Island it is important that the Trust has the capacity to provide leadership across all its functions. It has become increasingly apparent with the current pressures and the demands for increased quality of care in the NHS following the Francis report that the portfolio assigned to the Executive Director of Nursing and Workforce post is too wide ranging.

Following an extensive period of discussion with Board colleagues and a Trust wide engagement process I have decided, with the support of the Trust Development Authority, to make changes to the Executive Director portfolios. Therefore, with a lot of support from Trust staff, the following actions have been agreed:

- Appointment of a substantive Chief Operating Officer (COO). This will separate this role from the Director of Nursing and Executive Medical Director posts enabling the new COO to focus on operational issues and the Director of Nursing and Medical Director posts to focus on improving the quality of care we provide to patients. The COO and Director of Nursing posts will be advertised nationally to ensure that the best possible appointment is made to both of the posts.

- Transfer of the Hotel Services functions (e.g. catering, portering, cleaning, post, etc.) from the Executive Director of Nursing and Workforce portfolio to the Executive Director of Transformation and Integration.

- Appointment of an interim Workforce Director pending a review of which portfolio the workforce function should sit under.

Nancy Ellacott MBE

I reported at the last meeting that Nancy Ellacott, a long standing member and vice chair of the Trust's Patient Council was standing down due to ill health. I regret to now have to report that Nancy passed away on Monday 16th February after bravely battling leukaemia. Nancy had a distinguished career rising to be the Chief Civilian Nursing Officer for the Ministry of Defence. She had championed and represented patients for many years amongst her many activities and interests. She will be greatly missed by all who knew her.

NHS Staff survey

The results of the national NHS staff survey have been published and can be found at http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results/. We are reviewing the results of the survey and undertaking a review of the culture of the organisation with over 100 face to face confidential interviews, peer focus groups and an organisation-wide survey with staff. This work will help us to strengthen the organisation by ensuring that staff are better engaged in the direction and management of the Trust.

Major incident

A fire in Albany prison, part of HMP Isle of Wight, on 18th February resulted in the declaration of a major incident by the Trust spanning ambulance and hospital services. Additional staff were drafted in to enable the ambulance service to respond and for the hospital to be prepared for an influx of patients. Thankfully the majority of patients could be treated within the prison with just a handful brought to St. Mary's. We are working with the other agencies involved to learn lessons from this incident. I would like to thank all the staff who responded to the incident call out.

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:

19th January 2015

- Endoscopy Project Timeline slippage by 2 weeks approved
- Proposal for Solent Grange approved

26th January 2015

- Business Case – Safer Staffing discussed
- Clinical Coding Audit approved

2nd February 2015

- Solent Grange Update provided
- Wight Life Partnership proposal approved

Key points from meetings held on 9th and 16th February 2015 will be reported to the Trust Board on 1st April 2015.

Karen Baker
Chief Executive Officer
24th February 2015

Appendix 1

KM&T Isle of Wight NHS Trust Awards 2015

The awards were held on 30th January 2015 at Cowes Yacht Haven. In front of an audience of 360, awards were made to the following:

Chairman's Diamond Award suported by KM&T	
Winner	Wave Project - improving health through surfing
Innovation in Healthcare – Supported by Ryhurst	
Finalist	Omnicell drug storage cabinets and connecting robot
Winner	A Level Students Careers Programme
Finalist	Quality Champions Project
Improving services for children and young people (under 25)	
Finalist	Improving access to Children's Ward for known critical/chronic paediatric patients
Finalist	Lights, CCAMHS, Action'
Winner	Canadian Occupational Performance Measure (COPM) to detect change in a client's self perception of occupational performance
Improving staff health and wellbeing supported by 3663	
Winner	NHS Nightingales Choir
Finalist	Establishment of the LGBT Network
Finalist	Staff News
Integrating care - working with partners to implement the My Life A Full Life Programme	
Winner	Setting up and expansion of the Crisis Response Team
Finalist	Singing for Breathing
Finalist	Winning of Island Drug and Alcohol Service Contract
Improving patient safety supported by Clarkes Mechanical	
Winner	Sepsis 6 care bundle
Finalist	Safe Staffing levels in the District Nursing Service
Finalist	Development of Band 4 Assistant role in regards to management of non complex dysphagia
Excellence in voluntary organisation support for Healthcare	
Finalist	Eye Clinic Liaison Officers (RNIB Volunteers)
Winner	Wave Project - improving health through surfing
Finalist	Health Trainer Buddies scheme
Supporting excellence in Healthcare supported by Allocate Software	
Finalist	MRI Department for whole body diffusion weighted (DWIBs) scanning

Finalist	Electro Convulsive Therapy Service at Sevenacres
Winner	Integrated Community Equipment Service (ICES)
Improving services for older patients (60+) – Supported by INPS	
Finalist	Action for Rehabilitation of Neurological Injury approach for stroke survivors
Finalist	Prioritisation and Caseload weighting for acute and palliative occupational therapy service
Winner	Dementia Friendly Environments
Excellence in research and development supported by University of Portsmouth	
Finalist	Research into Restless Leg syndrome/Excessive daytime sleepiness
Finalist	Gene-testing for suspected cholesterol plaque in blood vessel linings
Winner	Preventing house dust mite allergy

Team and Individual Awards
The **Carisbrooke Award** for excellence by a Non-Clinical Band 4 and below **sponsored by Bevan Brittan** was awarded to **Danny (Garry) Driscoll**.
The **Wight Award** for the most outstanding volunteer **sponsored by Needles Landmark Attractions** was awarded to **Isle of Wight Health Walk Volunteers**.
The **Osborne Award** for excellence by a Non-Clinical Band 5 and above **sponsored by Spectrum Housing** was awarded to **Brian Johnston**.
The **Sandy Reed Rosebowl Award** – awarded to healthcare assistants or nursing auxiliaries who have demonstrated significant success as part of an NVQ programme, **sponsored by Artesian** was awarded to **Hannah Bridges.**
The **Solent Award** for the most outstanding team (non clinical or a mixture of both) **sponsored by Studio Four Architects** was awarded to the **IAPT/Primary Care Mental Health Team.**
Island Award for outstanding achievement by a nurse or midwife **sponsored by SB Electrical** was awarded to **Georgia Tuckey.**
The **Vectis Award** for excellence by a Doctor **sponsored by Kier Construction** was awarded to **Dr John Pike.**
The **Leadership Award** for outstanding leadership by a non-clinical individual was awarded to **Kevin Bolan**.
Presentation of certificates for the **Walsh Best Clinical Audit** programme undertaken by Junior Doctors was awarded to **Dr Neena Singh**.
The **Medina Award** for allied healthcare professionals for excellence & innovation in practice sponsored by **Henderson Green Ltd** was awarded to the **Community Stroke Rehabilitation Team**.
The **Leadership Award** for outstanding leadership by an individual in a clinical role was awarded to **Jenni Edgington**.

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13th February 2015 3

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News and Comment from Roy Lilley

Excellence. Management guru Tom Peters was 'In Search of Excellence' when, in 1985, he wrote his seminal book. It is still valid today.

I met Tom after I had published my first management book FutureProofing (I think now out of print, so not so proof!) we compared notes. What was the one enduring message in our books? Tom said straight away '*management by wandering about*'... so right.

I said I thought my bit was; *'If you can imagine it, it can happen'.*

I've always followed Tom's advice; get out and about. Success and failure is held in the balance, every day, at the front-line. Whether it's a factory, a shop, a hospital or community service, you can't run it until you've smelt it. You have to go and get involved. If I had my way no Trust chief executive would have an office. I'd burn their desks.

The NHS is in pursuit of excellence. For as long as I have been involved, the mantra; *do what we do better, quicker, safer and for less*. There are some things we still struggle with.

Joint working is one. The obvious 'no-brainer' is crash health and social care together and sort the bits as we go along. There is an urgent need to do it. Right now the NHS is selling cars... but you have to go down the road to buy the wheels.

Are there examples of really good integrated services? I mean unified not just joined up. Working seamlessly. There is a place, I know where it is, I've been there, seen it.

Getting GPs to syndicate their practice, not just their practices... a lot of pressure could be taken off the services if GPs federated, confederated, affiliated, worked in synchronisation, whatever, with each other. This is very tricky to do as it means joining up independent traders and there's money, processes and egos to sort out.

It can be done. I know a place that is taking the first steps but they will deliver because they know it is vital.

Lean; I also know a place where, for a brave investment, the Trust has installed a robot to receive, stack, retrieve, triple-check and despatch prescription drugs. It has cut errors to almost none, saved time-to-discharge, cut costs and never goes home.

All the palaver about NHS111 and 999; I've seen a place where highly skilled call handlers do both types of call. The centre also handles out-of-hours doctors and (wait for it) crisis teams for mental health and social care.

I've met outreach teams that not only include occupational therapists and district nurses but social workers. They sit, side by side, in the same office.

I have spoken with a chief executive of a local authority, at the same table as the CCG who said; 'It doesn't matter who runs social services, as long as they are well run and deliver for people'. At the same meeting the deputy leader of the Council agreed.

I have spoken with an impressively good ex-soldier who runs voluntary services; debt counselling, Relate, CAB and goodness knows how many more. He has put a wrapper around them, takes care of the back-office, runs the whole thing like a business and provides 150 seamless consultations a week out of modern customer friendly offices.

I travel miles around England seeing fabulous stuff but I didn't have to go far to see all these examples. They are all in the Isle of Wight. The IoW healthcare economy is one of most forward thinking, well run and organised I have seen, anywhere and I bet you didn't know!

There's loadsa good stuff, all over. Bristol and Surrey have invested in mobile working for community staff; stunning stuff. The problem is; we don't know about it. Imagine there was a way to share good ideas.

Like I wrote, all those years ago, in FutrureProofing; I imagined it and it is going to happen. This Saturday we launch The Academy of Fabulous NHS Stuff. Yes, Valentines Day; coz we love the NHS.

It's simple and free; upload 500 words and three pictures of your fabulous stuff, plus contact details. It will be tagged, indexed and there for others to find, download and share.

Big stuff, little stuff, stuff that made a difference. Stuff that solves problems; bright ideas, stuff that makes you proud and stuff that makes you smile. Stuff that will save someone else inventing the wheel.

Will the idea get traction, work and deliver? Dunno; It's up to you. Good stuff is going on everywhere. I see it all the time. I want you to see it, too.

Have a good weekend.

'What is the point of a select committee' come and join me in conversation with Dr Sarah Wollaston MP, chair of the Health Select Committee.

Kings Fund 11th March - details here.

Contact Roy - please use this e-address

roy.lilley@nhsmanagers.net

Know something I don't - email me in confidence.

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Enc D

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

Isle of Wight NHS Trust

Title	**Isle of Wight NHS Trust Board Performance Report 2014/15**			
Sponsoring Executive Director	Chris Palmer (Executive Director of Finance) Tel: 534462 email: Chris.Palmer@iow.nhs.uk			
Author(s)	Iain Hendey (Assistant Director of Performance Information and Decision Support) Tel: 822099 ext 5352 email: Iain.Hendey@iow.nhs.uk			
Purpose	To update the Trust Board regarding progress against key performance measures and highlight risks and the management of these risks.			
Action required by the Board:	**Receive**	**X**	**Approve**	
Previously considered by (state date):				
Trust Executive Committee		Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee		Nominations Committee (Shadow)		
Charitable Funds Committee		Quality & Clinical Performance Committee	25/02/2015	
Finance, Information, Investment & Workforce Committee	24/02/2015	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 2014/15. 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: Wednesday 25th February 2015 **Completed by: Iain Hendey, Deputy Director of Information**

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

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Isle of Wight NHS Trust Board Performance Report 2014/15

January 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	12	Jan-15	46	↘	
	Reduction across all grades of pressure ulcers (25% on 2013/14 Acute baseline, 50% Community)	TW	203	45	Jan-15	316	↘	
	VTE (Assessment for risk of)	AC	>95%	95.1%	Jan-15	98.6%	↘	
	MRSA (confirmed MRSA bacteraemia)	AC	0	0	Jan-15	1	↔	
14	C.Diff (confirmed Clostridium Difficile infection - stretched target)	AC	6	2	Jan-15	9	↘	
	Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	TW	48	9	Jan-15	49	↘	
	Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	TW	9	0	Jan-15	3	↗	
	Falls - resulting in significant injury	TW	7	1	Jan-15	4	↘	

Effective

	Area	Annual Target	Actual Performance			YTD	Month Trend	Sparkline / Forecast
Summary Hospital-level Mortality Indicator (SHMI) Jul-13 - Jun-14	TW	1	1.043	Published Jan 2015		N/A	↗	
Hospital Standardised Mortality Ratio (HSMR) Oct-12 - Sep-13	TW	100	96	Published Apr 2014		N/A	↗	
Stroke patients (90% of stay on Stroke Unit)	CM	80%	94%	Jan-15		92%	↘	
High risk TIA fully investigated & treated within 24 hours (National 60%)	CM	60%	100%	Jan-15		68%	↗	
Cancelled operations on/after day of admission (not rebooked within 28 days)	AC	0	5	Jan-15		17	↘	
Delayed Transfer of Care (lost bed days)	TW	N/A	376	Jan-15		2,105	↘	
Number of Ambulance Handover Delays between 1-2 hours	AM	N/A	18	Jan-15		97	↘	
Theatre utilisation	AC	83%	82%	Jan-15		80%	↗	

Caring

	Area	Annual Target	Actual Performance		YTD	Month Trend	Sparkline / Forecast
Patient Satisfaction (Friends & Family test - Total Inpatient response rate)	AC	30%	56%	Jan-15	39%	↗	
Patient Satisfaction (Friends & Family test - A&E response rate)	AC	20%	19%	Jan-15	18%	↘	
Mixed Sex Accommodation Breaches	TW	0	6	Jan-15	10	↘	
Formal Complaints	TW	<175	15	Jan-15	159	↗	
Compliments received	TW	N/A	272	Jan-15	3,023	↘	

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%	85%	Jan-15	87%	↘	
2	RTT: % of non-admitted patients who waited 18 weeks or less - IoW CCG	AC	95%	97%	Jan-15	94%	↗	
3	RTT % of incomplete pathways within 18 weeks - IoW CCG	AC	92%	96%	Jan-15	94%	↘	
	RTT:% of admitted patients who waited 18 weeks or less - NHS England	AC	90%	81%	Jan-15	84%	↗	
	RTT: % of non-admitted patients who waited 18 weeks or less - NHS England	AC	95%	68%	Jan-15	75%	↘	
	RTT % of incomplete pathways within 18 weeks - NHS England	AC	92%	92%	Jan-15	90%	↗	
8b	Symptomatic Breast Referrals Seen <2 weeks*	AC	93%	95.5%	Jan-15	91.2%	↘	
6b	Cancer patients seen <14 days after urgent GP referral*	AC	93%	94.0%	Jan-15	95.5%	↘	
6a	Cancer Patients receiving subsequent Chemo/Drug <31 days*	AC	98%	100%	Jan-15	100%	↔	
5a	Cancer Patients receiving subsequent surgery <31 days*	AC	94%	100%	Jan-15	98%	↗	
	Cancer diagnosis to treatment <31 days*	AC	96%	100.0%	Jan-15	99.1%	↔	
7	Cancer Patients treated after screening referral <62 days*	AC	90%	94%	Jan-15	94.4%	↘	
5b	Cancer Patients treated after consultant upgrade <62 days*	AC	85%	No patients	Jan-15	100%	↔	
8a	Cancer urgent referral to treatment <62 days*	AC	85%	87.5%	Jan-15	86.6%	↘	
	No. Patients waiting > 6 weeks for diagnostics	AC	<100	3	Jan-15	17	↔	
	%. Patients waiting > 6 weeks for diagnostics	AC	<1%	0.2%	Jan-15	0.1%	↘	
4	Emergency Care 4 hour Standards	AC	95%	88%	Jan-15	94%	↘	
12	Ambulance Category A Calls % < 8 minutes	AM	75%	76%	Jan-15	76%	↗	
13	Ambulance Category A Calls % < 19 minutes	AM	95%	97%	Jan-15	96%	↗	
9a	% of CPA patients receiving FU contact within 7 days of discharge	MH	95%	98%	Jan-15	97%	↗	
9b	% of CPA patients having formal review within last 12 months	MH	95%	98.0%	Jan-15	N/A	↔	
10	% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	MH	95%	95%	Jan-15	99%	↘	

**Cancer figures for January are provisional.*

Well-Led

	Area	In Month Target	Actual Performance		YTD Target	YTD Actual	Month Trend
Total workforce SIP (FTEs)	TW	2627.43	2,656.7	Jan-15	N/A	N/A	↘
Total pay costs (inc flexible working) (£000)	TW	£9,960	£9,977	Jan-15	£97,858	£98,017	↗
Variable Hours (FTE)	TW	136.7	90.9	Jan-15	1371.6	1328.5	↘
Variable Hours (£000)	TW	£394	£650	Jan-15	£987	£6,404	↗
Staff sickness absences	TW	3%	4.82%	Jan-15	3%	4.24%	↗
Staff Turnover	TW	5%	0.74%	Jan-15	5%	6.67%	↗
Achievement of financial plan	TW	N/A	N/A	Jan-15	£1.7m	£682	↘
Underlying performance	TW	N/A	N/A	Jan-15	-£0.23m	(£4,612)	↔
Net return after financing	TW	N/A	N/A	Jan-15	0.50%	0.55%	↘
I&E surplus margin net of dividend	TW	N/A	N/A	Jan-15	=>1%	0.61%	↘
Liquidity ratio days	TW	N/A	N/A	Jan-15	=>0	4	↔
Continuity of Service Risk Rating	TW	N/A	N/A	Jan-15	3	4	↔
Capital Expenditure as a % of YTD plan	TW	N/A	N/A	Jan-15	=>75%	54%	↗
Quarter end cash balance (days of operating expenses)	TW	N/A	N/A	Jan-15	=>10	19	↗
Debtors over 90 days as a % of total debtor balance	TW	N/A	N/A	Jan-15	=<5%	3.92%	↗
Creditors over 90 days as a % of total creditor balance	TW	N/A	N/A	Jan-15	=<5%	0.9%	↗
Recurring CIP savings achieved	TW	N/A	N/A	Jan-15	100%	50.3%	↘
Total CIP savings achieved	TW	N/A	N/A	Jan-15	100%	87%	↘

Notes

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

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

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

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

Executive Summary

Isle of Wight NHS Trust

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 2 additional cases during January and have now exceeded our full year target of 6.

Responsive:

The Admitted target continues to underperform largely due to the bed pressures experienced locally; this is consistent with the national position. Waiting list cancellations due to unfitness for surgery, especially in T&O have also affected this target. The non-admitted performance is improving however we narrowly missed the 95% target with performance of 94.5% in January. Underperformance is largely caused by significant failure in Maxillofacial Surgery.

Ambulance Red 1 and Red 2 calls response time <8 minutes - achieving all targets during January; Additional focus on demand vs. resource and putting additional resources on where applicable using qualified paramedic managers to fill shortfall. The Winter resilience monies are also being utilised to boost performance and support services where necessary.

Emergency care 4 hour standard - The 95% target for January was again not achieved unfortunately due to the increased pressure on community bed availability. Despite action plans being followed the increase in attendances at the Emergency department created a situation whereby towards the end of the month the target was lost.

Well Led:

The trust continues to experience considerable pressure on its pay budgets. In month expenditure exceeds plan by £185k resulting in a year to date overspend of £2.7m.
The main contributor is the significant under achievement of pay related CIP schemes, amounting to c£2m of adverse variance to plan.
Temporary staffing costs also continue to contribute to budget overspends and as a total equates to £6.7m year to date, 6.9% of the total pay spend.
Sickness levels remain significantly above plan and continues to cost the organisation in excess of £300k in monthly sick pay and backfill requirements.

The Trust planned for a surplus of £0.341m in January, after adjustments made for normalising items (these include the net costs associated with donated assets and impairments). The reported position is a deficit of £0.895m in the month, an adverse variance of £1.236m against plan.
The cumulative Trust plan was to deliver a surplus of £2.092m, after normalising items. The actual position is a cumulative surplus of £0.682m, an adverse variance of £1.410m. This position has £0.7m of forward banking recognised to the end of month 10.

This position is consistent with the revised forecast to achieve a £3k surplus position at year end.

Caring:

Complaints number has decreased slightly since December and it is lower than in April 2014.

Compliments, in the form of letters and cards of thanks, were lower during January than in December.

The Friends and Family Test criteria has changed and we have now two new returns - Community and Mental health. This is the first month of reporting which explains the very low response rate.

Mixed Sex Accommodation - 6 breaches during January following the 4 in October.

Effective:

The percentage utilisation of theatre facilities has decreased below the 83% target for Main Theatres (77.7%). Day Surgery Unit utilisation has increased during January 2015 (84.8%) - giving a joint rate of 81.6% in January. Bed pressures have continued with high levels of emergency admissions impacting on ability to accommodate elective patients; lists therefore have had cancellations. Delays in elective patients on arrival being admitted has also contributed to late starts further impacting on utilisation percentage.

Isle of Wight NHS Trust Board Performance Report 2014/15

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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	Jan-15		13		100	
No. of Grade 3&4 Pressure Ulcers developing in hospital	Jan-15		4		22	
VTE	Jan-15	95%	95.1%	95%	98.6%	
MRSA	Jan-15	0	0	0	1	
C.Diff	Jan-15		2	4	6	
No. of Reported SIRI's	Jan-15		7		40	
Physical Assaults against staff	Jan-15		4			
Verbal abuse/threats against staff	Jan-15		18			

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Delayed Transfers of Care (lost bed days)	Jan-15	N/A	376	N/A	2,105	
Cancelled operations on/after day of admission (not rebooked within 28 days)	Jan-15	0	5	0	17	

Responsive*	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Care 4 hour Standards	Jan-15	95%	88.5%	95%	94.2%	
RTT Admitted - % within 18 Weeks (NHS England included)	Jan-15	90%	84.6%	90%	85.7%	
RTT Non Admitted - % within 18 Weeks (NHS England included)	Jan-15	95%	93.9%	95%	91.9%	
RTT Incomplete - % within 18 Weeks (NHS England included)	Jan-15	92%	95.7%	92%	93.6%	
No. Patients waiting > 6 weeks for diagnostics	Jan-15	< 8	3	100	17	
%. Patients waiting > 6 weeks for diagnostics	Jan-15	1%	0.23%	1%	0.15%	
Cancer 2 wk GP referral to 1st OP	Jan-15	93%	94.0%	93%	95.5%	
Breast Symptoms 2 wk GP referral to 1st OP	Jan-15	93%	95.5%	93%	91.2%	
31 day second or subsequent (surgery)	Jan-15	94%	100%	94%	98%	
31 day second or subsequent (drug)	Jan-15	98%	100%	98%	100%	
31 day diagnosis to treatment for all cancers	Jan-15	96%	100%	96%	99%	
62 day referral to treatment from screening	Jan-15	90%	94%	90%	94%	
62 days urgent referral to treatment of all cancers	Jan-15	85%	87.5%	85%	86.6%	
Emergency 30 day Readmissions	Jan-15		4.3%		4.8%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Jan-15	3%	4.89%	3%	4.07%	
Appraisals	Jan-15		2.1%		50.9%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
FFT Hospital - % Response Rate	Jan-15	30%	56.4%	30%	39.5%	
FFT Hospital - % Recommending	Jan-15	95%	95.1%	95%	96.4%	
FFT A&E - % Response Rate	Jan-15	20%	18.6%	20%	18.0%	
FFT A&E - % Recommending	Jan-15	90%	91.2%	90%	91.5%	
Mixed Sex Accommodation Breaches	Jan-15	0	6	0	10	
No. of Complaints	Jan-15		11		118	
No. of Concerns	Jan-15		56		598	
No. of Compliments	Jan-15	N/A	149	N/A	1794	

Contracted Activity**	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Emergency Spells	Dec-14	1,119	1,167	10,211	9,900	
Elective Spells	Dec-14	666	613	6,025	5,883	
Outpatients Attendances	Dec-14	9,686	9,680	87,630	89,114	

**Cancer figures for January 2014 are provisional*

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

Emergency Care 4hr standard - the 95% target for January 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 – Admitted and non-admitted targets continued to under perform into January; action plans and revised forecasts are in place to address this.

Cancelled operations – There were 5 cancellations on or after the day of admission; all cancellations are audited and lesson learnt implemented on a regular basis.

Sickness absenteeism - Whilst this is still high, it has reduced since December; 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 – The response rate performance remains a focus for the Department; tablets continue to be a benefit.

MIxed Sex Accommodation breaches - Incurring this breach prevented a 12hr patient breach and maintained adequate patient care for other patients at the time.

Isle of Wight NHS Trust Board Performance Report 2014/15

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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	Jan-15		18		144	
No. of Grade 3&4 Pressure Ulcers developing in the community	Jan-15		10		50	
MRSA	Jan-15	0	0	0	0	
C.Diff	Jan-15		0	2	3	
No. of Reported SIRI's	Jan-15		12		68	
Physical Assaults against staff	Jan-15		0			
Verbal abuse/threats against staff	Jan-15		4			

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Stroke patients (90% of stay on Stroke Unit)	Jan-15	80%	93.5%	80%	92.3%	
High risk TIA fully investigated & treated within 24 hours (National 60%)	Jan-15	60%	100.0%	60%	67.7%	

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Routine Waiting times	Dec-14		95.2%		95%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism - C Directorate	Jan-15	3%	4.63%	3%	4.79%	
Appraisals	Jan-15		0.2%		85.8%	

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Community Contacts	Dec-14	16,515	16,950	147,660	165,710	
Health Visitors	Dec-14	2,899	3,188	26,091	28,685	
School Nurses	Dec-14	-	854	-	9,534	
Sexual Health	Dec-14	855	1,007	7,695	8,555	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
FFT - % Response Rate	Jan-15		2.3%		2.3%	
FFT - % Recommending	Jan-15	95%	98.6%	95%	98.6%	
No. of Complaints	Jan-15		1		18	
No. of Concerns	Jan-15		3		73	
No. of Compliments	Jan-15	N/A	103	N/A	971	

Safe - No new MRSA or Cdiff cases in January 2015. Number of reported SIRIs reduces once review has taken place. SIRIs reported may not be attributable to the Directorate. Early detection of Grade 1&2 Pressure Ulcers has resulted in these increasing whilst numbers of Grade 3&4 Pressure Ulcers are falling.

Responsive - As the Directorate has many diverse services we have given a percentage of patients waiting less than their service maximum waiting time. Those services regularly breaching targets are monitored with our Commissioners on a monthly basis. 95% of new routine patients have been seen within the service target time.

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

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

Well Led - Community January 2015 sickness rate is 4.79% year to date against a 3% trust target. Percentages are due to increased short term sickness absence together with long term sickness absence within the Stroke Unit and Community Nursing. This is being closely managed via Occupational Health and HR processes.

Caring - The Friends and Family Test criteria has changed from wards areas only to include all community contacts. This is the first month of reporting which explains the very low response rate of 2.3% for January 2015. Please note that FFT figures are now split between Community and Mental Health. The Directorate is above target on its recommending percentage. Complaints, concerns and compliments are monitored closely and lessons learned shared through the Directorate Board, Community Quality Group and with the wider Directorate.

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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	Jan-15		2			
Verbal abuse/threats against staff	Jan-15		6			

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	Jan-15	50%	51%	50%	46%	
New Cases of Psychosis by Early Intervention Team	Jan-15	2	5	11	39	

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	Jan-15	95%	98%	95%	97%	
% of CPA patients having formal review within 12 months	Jan-15	95%	98%	95%	N/A	
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	Jan-15	95%	95%	95%	99%	
RTT Non Admitted - % within 18 Weeks	Jan-15	95%	100%	95%	98%	
RTT Incomplete - % within 18 Weeks	Jan-15	92%	100%	92%	99%	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Jan-15	3%	4.52%	3%	4.15%	
Appraisals	Jan-15		0.5%		64.6%	

Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Mental Health Inpatient Activity	Jan-15	N/A	60	N/A	467	
Mental Health Outpatient Activity	Jan-15	N/A	571	N/A	5,407	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Complaints	Jan-15		2		18	
No. of Concerns	Jan-15		3		33	
No. of Compliments	Jan-15	N/A	7	N/A	181	
FFT - % Response Rate	Jan-15		1%		1%	
FFT - % Recommending	Jan-15	95%	93%	95%	93%	

Mental Health RTT

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

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

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

Unfortunately due to difficulties earlier in the year with securing consistent locum Consultant cover service capacity was reduced and waiting times increased. A number of patients cancelled their first appointments and it was not possible to rebook these within the 18 week period. The Memory Service now has permanent consultant cover and is working to address long waiting times and avoid future breaches.

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

Safe -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 continues to overachieve against its KPIs.

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

Well Led --The Mental Health January 2015 sickness absence rate has decreased from 5.19% in December 2014 to 4.52% in January 2015. Sickness absence YTD is 4.15% against a 3% trust target. Sickness absence rates are due to increased short term sickness together with long term sickness and vacancies within the Community Mental Health Service which is being closely managed via Occupational Health and HR processes.

Effective - IAPT - The proportion of people who have completed treatment and moving to recovery is currently under target however contingency plans are in place to ensure that the target is achieved by year end. Progress is being monitored closely. 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.

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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						
Verbal abuse/threats against staff	Jan-15		1			

Responsive	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Category A 8 Minute Response Time (Red 1)	Jan-15	75%	77.8%	75%	80.8%	
Category A 8 Minute Response Time (Red 2)	Jan-15	75%	75.7%	75%	75.4%	
Category A 19 Minute Response Time	Jan-15	95%	96.8%	95%	96.4%	
Ambulance re-contact rate following discharge from care by telephone	Jan-15	3%	0.0%	3%	4.4%	
Ambulance re-contact rate following discharge from care at scene	Jan-15	2%	0.0%	2%	3.4%	
Ambulance time to answer call (in seconds) - median	Jan-15	1	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 95th percentile	Jan-15	5	1	N/A	N/A	
Ambulance time to answer call (in seconds) - 99th percentile	Jan-15	14	8	N/A	N/A	
NHS 111 Call abandoned rate	Jan-15	5%	1.6%	5%	2.0%	
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	Jan-15	95%	96.4%	95%	96.4%	
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	Jan-15	95%	97.8%	95%	97.7%	
NHS 111 Where the above is not achieved callers should be called back within 10 mins	Jan-15	100%	72.2%	100%	48.0%	

Contracted Activity	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Calls Answered	Dec-14	2,102	2,290	19,321	21,184	
Hear & Treat / Refer	Dec-14	337	270	3,098	3,164	
See & Treat / Refer	Dec-14	494	557	4,541	4,714	
See, Treat and Convey	Dec-14	1,148	1,201	10,552	10,612	
111 Service	Dec-14	4,867	4,913	37,135	39,066	

Effective	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
Number of Ambulance Handover Delays between 1-2 hours	Jan-15		18		97	

Well-Led	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
% Sickness Absenteeism	Jan-15	3%	8.08%	3%	6.34%	
Appraisals	Jan-15		0.0%		58.9%	

Caring	Latest data	In month Target	In month Actual	YTD Target	YTD Actual	Sparkline / Forecast
No. of Complaints	Jan-15		0		3	
No. of Concerns	Jan-15		3		23	
No. of Compliments	Jan-15	N/A	4	N/A	64	

The Ambulance Service has achieved all three categories required in January; Red 1 (75%) achieved 77.8%, Red 2 (75%) achieved 75.7% and 19 Min (95%) achieved 96.8%. 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 Winter resilience monies are also being utilised to boost performance and support services where necessary.

Our NHS 111 service continues to achieve its targets 96% on call answering and 98% on warm transfers to a clinician.

Highlights

- **Ambulance Red 1 and Red 2 calls response time <8 minutes above target**
- **90% of stay on Stroke Unit and High Risk TIA fully investigated & treated within 24 hours above target**
- **Referral To Treatment Time for Incompletes above target**
- **All Cancer Targets achieved in January**

Lowlights

- **Clostridium Difficile (C.Diff) - now exceeded the national threshold (6) for the whole year**
- **Referral ToTreatment Time for Admitted and Non-Admitted remain below target**
- **Staff sickness remains above plan**
- **Theatre Utilisation below target**
- **Emergency care 4 hour standard below target**
- **Total Pay Costs over budget**
- **CIP delivery below target**

Commentary:

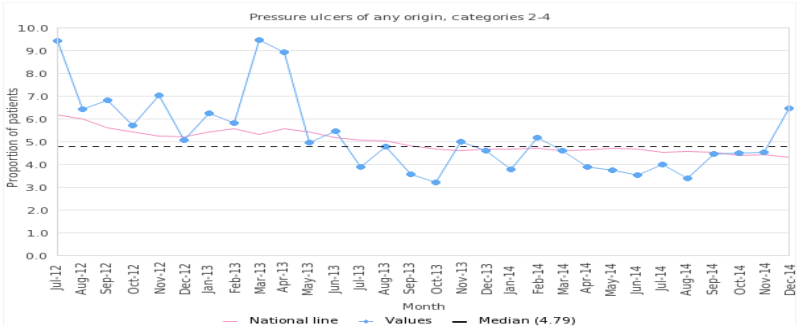
General: Numbers are reviewed for both the current and previous month and there may be changes to previous figures once validated. Pressure ulcer figures also contribute to the Safety Thermometer and are included within the clinical incident reporting, where any change is also reflected.

Hospital acquired: During January there was a slight reduction in reported pressure ulcers in the hospital setting from the previous month with both grades 1 & 3 show improvement this month. However, neither the individual or aggregated targets are being achieved and we are at a similiar YTD position as last year. The Tissue Viability Nurse continues to support ward staff with recognition and management of patients at risk but the current higher numbers of patients staying longer is continuing.

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. Although the numbers are increased this month this may be due to the effectiveness of the recent awareness campaign activity. Overall incidence as a percentage of the number of contacts over the month remains low.

The public awareness campaign across local press and venues continues to highlight prevention within the wider community and encourage regular mobilisation for those at risk.

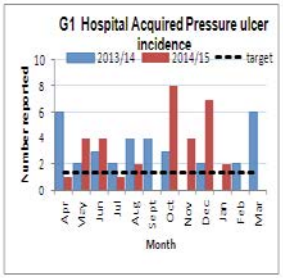
Pressure Ulcers benchmark

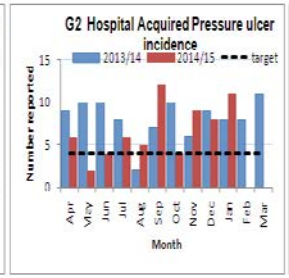


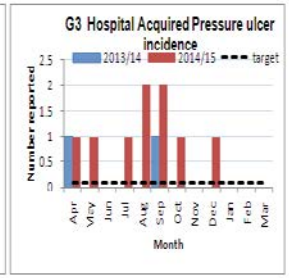
The graph shows improving trend. In December the Trust has been above the national average.

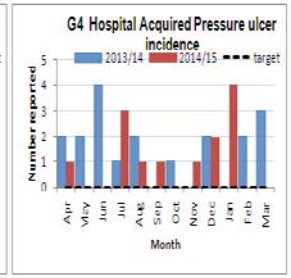
Analysis:

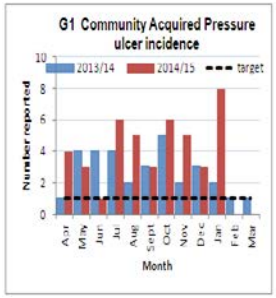
Quality Account Priority 2 & National Safety Thermometer CQUIN schemes
Prevention & Management of Pressure Ulcers

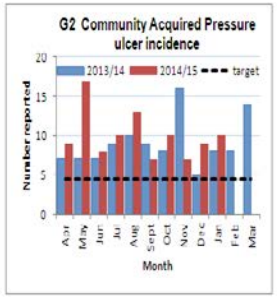


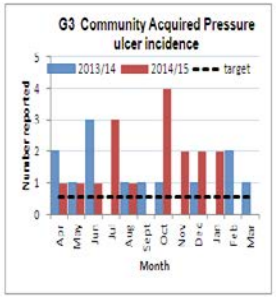


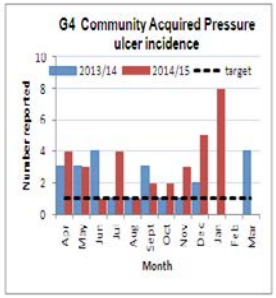












Action Plan:	Person Responsible:	Date:	Status:
The Tissue Viability Nurse Specialist continues to work with the Communications team on a public awareness campaign to encourage prevention and self help in the community. (Further awareness week scheduled in March 15 with ongoing training and support for care homes available)	Tissue Viability Specialist Nurse / Communications Team	Jan-15	Ongoing
The public awareness event 'Isle feel good' (part of My Life Full Life campaign) 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	Jan-15	Completed
The Tissue Viability Nurse continues to support ward staff with recognition and management of patients at risk.	Tissue Viability Nurse Specialist	Jan-15	Ongoing

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Patient Safety

Commentary:

Clostridium difficile

There have been 2 further cases of Healthcare Acquired Clostridium Difficile identified in the Trust during January. We have exceeded both our local stretched target and the nationally set threshold for the whole year.

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.

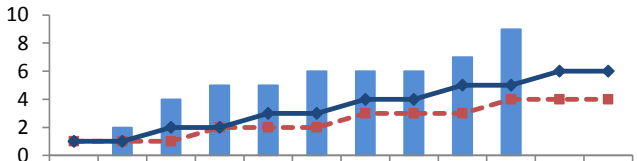
Methicillin-resistant Staphylococcus Aureus (MRSA)

MRSA incident occurred on 20 November on St Helens ward, however, this is only just being reflected in the data as the incident was originally linked to the CCG. As the patient was discharged the previous day this has now been re-attributed to the Trust. RCA meeting took place 2nd December 2014.

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

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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total cases	0	2	4	5	5	6	6	6	7	9		
Local Target	1	1	1	2	2	2	3	3	3	4	4	4
National Target	1	1	2	2	3	3	4	4	5	5	6	6

Isle of Wight NHS Trust

MRSA	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Acute Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Actual	0	0	0	0	0	0	0	1	0	0			1

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

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Formal Complaints

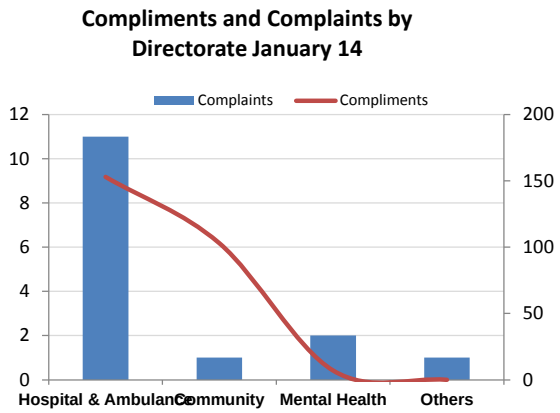
Commentary:

There were 15 formal Trust complaints received in January 2015 (16 in the previous month) against approximately 42,290 patient contacts (Inpatient episodes, all outpatient, A&E attendances and community and Mental Health contacts), with 272 compliments received by letters and cards of thanks across the same period.

Across all complaints and concerns in January 2015:
Top areas complained about were:
- Outpatient appointments/records unit (17)
- Emergency Department (6)
- Medical Services (6)

Across all complaints and concerns in January 2015:
Top 3 subjects complained about were:
- Clinical care (23)
- Out-patient appointment delay/cancellation (14)
- Communication (19)

Analysis: Complaints only



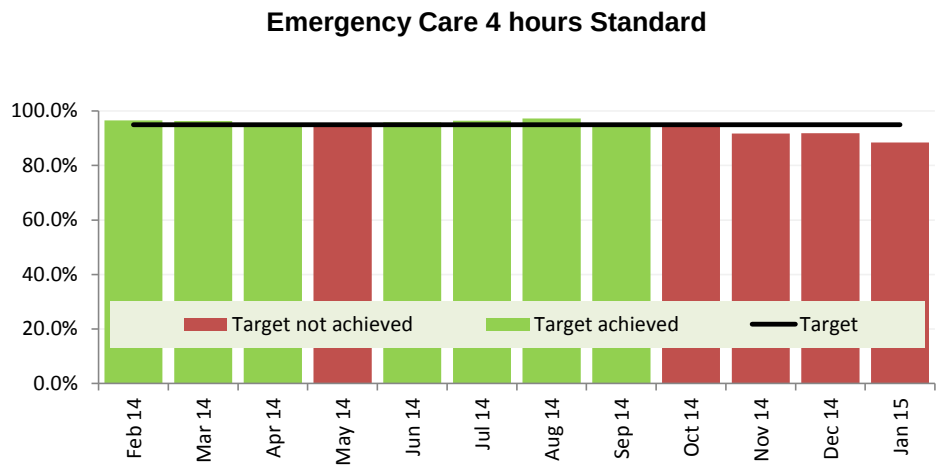
Primary Subject	Dec-14	Jan-15	CHANGE	RAG rating
Clinical Care	8	8	0	→
Nursing Care	1	1	0	→
Staff Attitude	1	0	-1	✓
Communication	2	3	1	↑
Outpatient Appointment Delay/ Cancellation	0	2	2	↑
Inpatient Appointment Delay / Cancellation	1	0	-1	✓
Admission / Discharge / Transfer Arrangements	1	0	-1	✓
Aids and appliances, equipment and premises	0	0	0	✓
Transport	1	0	-1	✓
Consent to treatment	0	0	0	✓
Failure to follow agreed procedure	0	0	0	✓
Hotel services (including food)	0	0	0	✓
Patients status/discrimination (e.g. racial, sex)	0	0	0	✓
Privacy & Dignity	0	0	0	✓
Other	1	1	0	→

Action Plan:	Person Responsible:	Date:	Status:
Monitor the performance of complaint response times against the locally agreed 20 day timescale.	Executive Director of Nursing & Workforce / Business Manager - Patient Safety; Experience & Clinical Effectiveness	Mar-15	In progress

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

A&E Performance - Emergency Care 4 hours Standard

Commentary:	**Analysis:**
The 95% target for January was again not achieved due to the increased pressure on community bed availability preventing patients flowing through the system. 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 became unachievable. Increased efforts and focus throughout January continued including the commencement of system resilience schemes, ongoing till March, providing additional bed capacity within the Trust and additional medical staffing to support the increased activity. Internal processes and practices have been revised including the Trust's operational hub to manage patient flow through the Trust and into the community.	

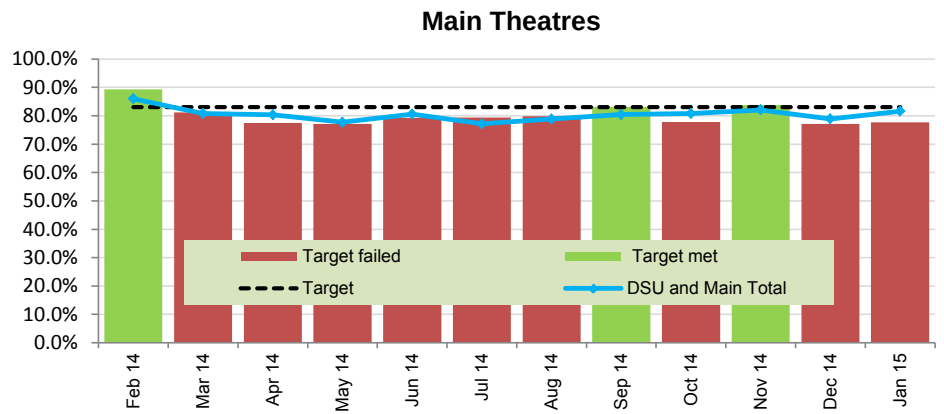
Action Plan:	**Person Responsible:**	**Date:**	**Status:**
Increase focus on local authority bed situation	Exec on call	Jan-15	Ongoing
Daily focus on bed states	Matrons	Jan-15	Ongoing

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

Theatre Utilisation

Isle of Wight NHS Trust

Commentary	Analysis:
The percentage utilisation of theatre facilities has decreased below the 83% target for Main Theatres (77.7%). Day Surgery Unit utilisation has increased during January 2015 (84.8%). Overall we have achieved 81.6%. Bed pressures have continued with high levels of emergency admissions impacting on ability to accommodate elective patients; main impacts have been urology, general surgery and orthopaedic inpatients. Lists therefore have had cancellations. Due to clinical priority and following of cancellation policy operating lists could not be cohorted to be able to demonstrate complete list utilisation. Delays in elective patients on arrival being admitted has also contributed to late starts further impacting on utilisation percentage.	

Action plan	Person Responsible:	Date:	Status:
1) Review of Pre-Assessment Unit staffing levels - increased senior support to area continuing with a view to extending till June 2015. Two additional locums for administration support. 2) Speciality based action plans developed by each general manager to review 18 weeks activity - with weekly assurance meeting to monitor RTT and impact of bed pressures	General manager- Planned Directorate	Jan-15	Ongoing
Incident room set up for regular 4 daily bed meetings to ensure all patients in hospital and being managed for appropriate discharge. Winter ward has remained opened during January, however, high levels of emergency activity have still not enabled elective admissions. Poppy Ward opened to enable additional transfers from acute beds.	HAD Directorate Lead	Jan-15	Ongoing

Isle of Wight NHS Trust Board Performance Report 2014/15

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Referral to Treatment Times

Commentary:

Admitted performance for January decreased from 86.67% in December to 84.60% in January as we continue to treat in turn, and the non-admitted performance has remained constant from 94.44% last month to 94.46% in January.

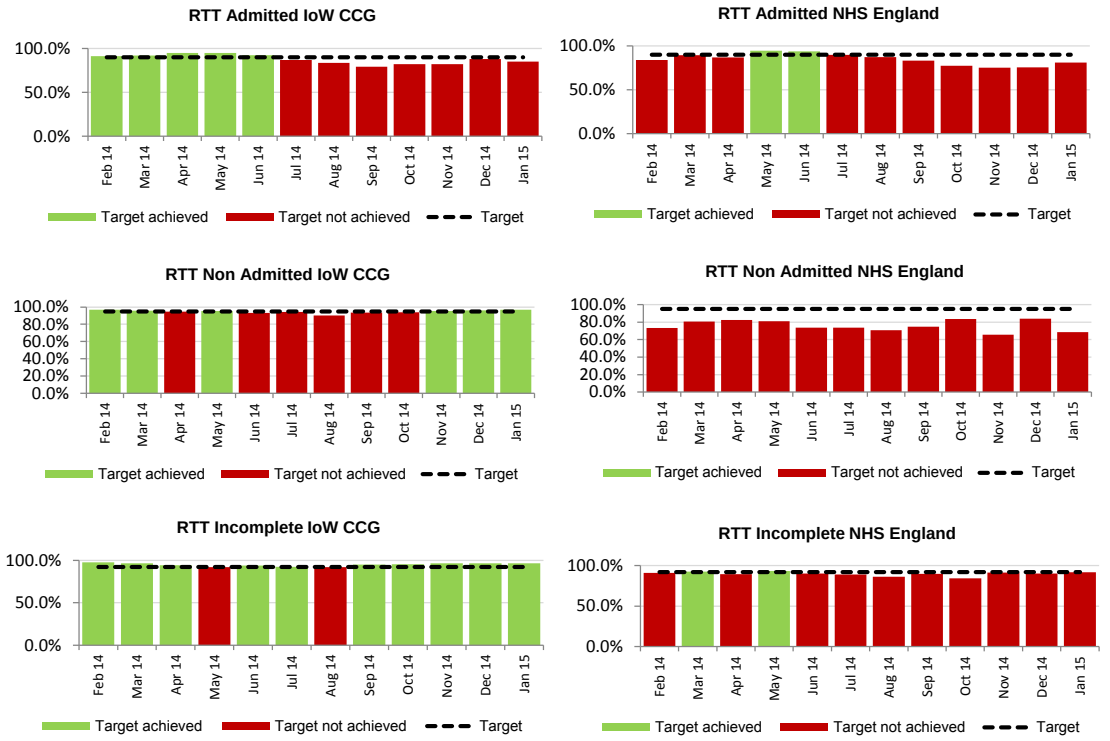
The Admitted target continues to underperform due to the bed pressures experienced locally, as per the national position. Waiting list cancellations due to unfitness for surgery, especially in T&O have also affected this target.

The non-admitted performance is improving and as a CCG achieved target. NHS England performance pulled the percentage down to just over half a percent below target.

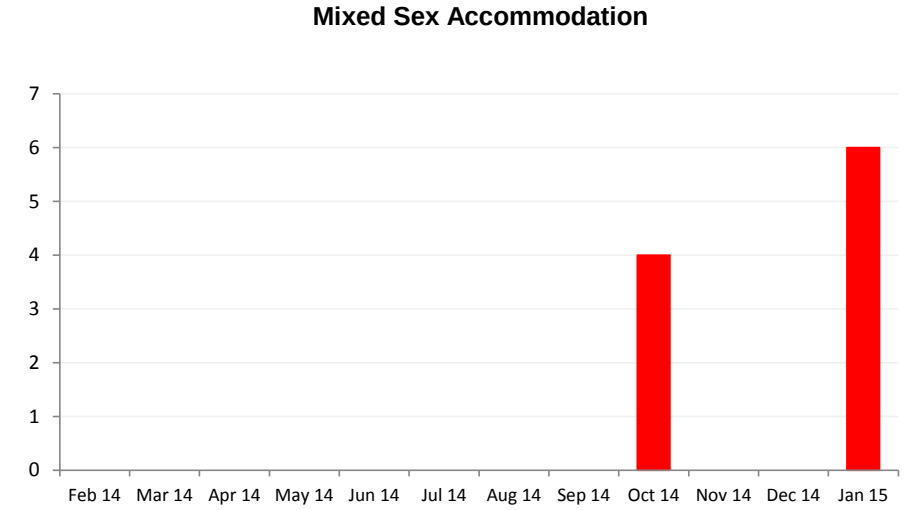
The plan for delivering baseline activity plus additional in January continued to contribute towards the planned reduction of our waiting lists to 18wks, although, February is also forecast to fail the admitted performance targets due to the pressures described above.

Activity and capacity modelling on a weekly level is continually being developed enabling General Managers to plan and monitor weekly outpatient and inpatient activity against targets, alongside managing the impact of emergency and medical activity upon elective activity during this winter period.

Analysis:



	Person Responsible:	Date:	Status:
Ongoing development of forecasting tools to match demand and capacity and highlight further data quality issues.	Senior Information Analyst (PIDS)	Jan-15	In progress
Engagement with clinicians to ensure that accurate data is communicated to administrators for data capture through revision of Referral to Treatment coding forms. Implemented and in trial period. Certain areas have been identified as needing support in this area.	OPARU Lead/ Clinical Leads	Jan-15	In progress
Development of robust processes and documentation to enable training and awareness of 18 week procedures.	Information Systems Manager & Access Lead	Feb-15	Planned

Commentary:	**Analysis:**
During January we experienced significant pressures on patient flow. On 19th January a planned single sex breach was allowed to occur in order to maintain adequate care for all patients. In particular the current pressures included preventing a patient waiting over 12 hours in Emergency Department, and ensuring urgent patient was able to have a bed for surgery. This was a controlled decision made by the bed management team and on call team, agreed by the Executive Director on Call. 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 patient was moved as soon as possible. The resulting outcome was that the patients were in a mixed area overnight but not for a period longer than 24 hours. There is a continued risk of recurrence whilst we maintain our current bed management practices until such time as the MAAU rebuild is completed (August 2015) , reconfiguration work is completed and more single rooms are available for use.	

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

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

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%	75%	91.7%	92.8%	93 / 172	Amber Red	Qtr 3 14/15
RTT:% of admitted patients who waited 18 weeks or less	90%	100%	0%	89.3%	86.7%	131 / 161	Bottom Quartile	Dec-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	100%	84%	95.4%	94.4%	153 / 188	Bottom Quartile	Dec-14
RTT % of incomplete pathways within 18 weeks	92%	100%	74%	92.6%	95.7%	66 / 187	Top Quartile	Dec-14
%. Patients waiting > 6 weeks for diagnostic	1%	0%	24%	2.1%	0.2%	57 / 181	Better than national average	Dec-14
Ambulance Category A Calls % < 8 minutes - Red 1	75%	80%	59%	66.0%	80.4%	1 / 11	Top Quartile	Dec-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	75%	48%	61.1%	75.0%	1 / 11	Top Quartile	Dec-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	75%	48%	61.4%	75.4%	1 / 11	Top Quartile	Dec-14
Ambulance Category A Calls % < 19 minutes	95%	96%	85%	90.1%	96.3%	1 / 11	Top Quartile	Dec-14
Cancer patients seen <14 days after urgent GP referral	93%	100%	83%	94.7%	97.0%	40 / 153	Better than national average	Qtr 3 14/15
Cancer diagnosis to treatment <31 days	96%	100%	71%	97.8%	100.0%	1 / 162	Top Quartile	Qtr 3 14/15
Cancer urgent referral to treatment <62 days	85%	100%	0%	83.8%	86.6%	69 / 156	Better than national average	Qtr 3 14/15
Symptomatic Breast Referrals Seen <2 weeks	93%	100%	58%	94.9%	97.4%	32 / 137	Top Quartile	Qtr 3 14/15
Cancer Patients receiving subsequent surgery <31 days	94%	100%	50%	95.8%	98.0%	82 / 158	Better than national average	Qtr 3 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	100%	95%	99.6%	100.0%	1 / 146	Top Quartile	Qtr 3 14/15
Cancer Patients treated after consultant upgrade <62 days	85%	100%	0%	90.0%	#N/A	#N/A / 149	No patients	Qtr 3 14/15
Cancer Patients treated after screening referral <62 days	90%	100%	50%	93.5%	100.0%	1 / 146	Top Quartile	Qtr 3 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 2014/15

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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%	92.8% 18	91.2% 20	94.4% 10	96.4% 1	91.2% 21	96.3% 3	95.8% 4	N/A	96.3% 2	94.5% 9	89.9% 26	90.7% 23	90.5% 24	94.6% 7	93.4% 14	93.5% 13	92.8% 17	91.0% 22	93.8% 12	94.6% 8	86.1% 27	92.9% 16	93.4% 15	94.7% 6	91.3% 19	94.0% 11	90.3% 25	95.4% 5	Qtr 3 14/15
RTT:% of admitted patients who waited 18 weeks or less	92%	86.7% 24	96.1% 2	92.7% 16	93.4% 13	95.7% 3	94.6% 7	91.7% 20	N/A	95.0% 4	93.8% 10	93.6% 12	92.5% 17	99.1% 1	94.2% 8	94.6% 6	91.8% 18	90.0% 23	N/A	92.8% 15	93.0% 14	70.2% 26	90.2% 22	82.6% 25	94.0% 9	90.4% 21	94.9% 5	93.7% 11	91.8% 19	Dec-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	94.4% 24	98.0% 7	95.1% 23	95.8% 19	95.2% 21	99.0% 2	97.7% 9	N/A	97.4% 11	95.9% 18	97.1% 14	98.1% 6	98.7% 4	97.2% 12	96.9% 15	96.8% 17	95.2% 22	N/A	98.5% 5	96.8% 16	95.4% 20	97.1% 13	91.2% 25	97.6% 10	90.9% 26	99.1% 1	98.8% 3	97.9% 8	Dec-14
RTT % of incomplete pathways within 18 weeks	92%	95.7% 10	98.3% 1	93.7% 19	93.2% 20	94.4% 17	96.7% 6	94.6% 14	N/A	96.9% 5	92.2% 23	92.5% 21	95.3% 13	94.4% 16	94.4% 15	95.7% 11	96.4% 7	94.4% 18	N/A	97.6% 3	96.2% 9	81.8% 25	92.3% 22	N/A	97.2% 4	91.3% 24	95.5% 12	96.2% 8	97.7% 2	Dec-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.2% 9	0.2% 8	2.1% 20	0.5% 11	0.5% 12	0.8% 15	0.2% 7	N/A	0.0% 5	0.0% 1	2.6% 22	0.8% 14	0.5% 10	2.2% 21	0.0% 1	1.5% 19	1.1% 17	N/A N/A	0.1% 6	0.6% 13	7.9% 26	4.3% 23	1.41% 18	1.1% 16	6.9% 25	0.0% 1	5.9% 24	0.0% 1	Dec-14
Cancer patients seen <14 days after urgent GP referral*	93%	97.0% 10	98.3% 3	91.6% 28	94.1% 23	96.5% 14	92.0% 27	94.8% 19	94.7% 20	97.6% 8	98.1% 5	98.0% 6	96.1% 17	94.6% 21	97.7% 7	94.5% 22	99.2% 2	96.7% 12	96.9% 11	96.4% 16	99.2% 1	96.5% 15	93.8% 26	96.0% 18	93.9% 25	96.6% 13	94.1% 24	98.2% 4	97.1% 9	Qtr 3 14/15
Cancer diagnosis to treatment <31 days*	96%	100.0% 1	100.0% 1	98.7% 24	99.7% 13	99.3% 16	98.8% 22	100.0% 1	100.0% 1	100.0% 1	99.0% 19	99.7% 12	100.0% 1	100.0% 1	100.0% 1	98.6% 25	100.0% 1	97.8% 27	100.0% 1	98.0% 26	100.0% 1	99.1% 18	99.0% 20	97.6% 28	99.6% 14	99.1% 17	98.7% 23	99.4% 15	99.0% 21	Qtr 3 14/15
Cancer urgent referral to treatment <62 days*	85%	86.6% 17	89.2% 10	84.2% 22	89.1% 11	94.8% 2	78.6% 27	89.9% 6	81.0% 26	89.8% 8	88.3% 14	86.8% 16	89.9% 7	95.8% 1	89.0% 12	88.8% 13	85.4% 21	85.4% 20	82.2% 25	83.6% 23	88.1% 15	83.2% 24	75.6% 28	92.6% 5	89.3% 9	85.5% 19	94.5% 3	86.3% 18	93.5% 4	Qtr 3 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	97.4% 9	95.5% 19	93.5% 22	82.7% 27	94.8% 20	93.8% 21	96.4% 15	93.5% 23	96.1% 17	98.5% 5	97.1% 10	96.7% 13	N/A	97.0% 12	98.9% 2	97.0% 11	93.3% 24	98.8% 4	96.1% 18	99.0% 1	89.9% 26	93.1% 25	97.5% 8	96.5% 14	98.3% 6	97.6% 7	96.2% 16	98.8% 3	Qtr 3 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	98.0% 18	100.0% 1	94.3% 24	100.0% 1	97.5% 19	87.5% 27	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	91.7% 25	100.0% 1	95.0% 22	100.0% 1	94.4% 23	100.0% 1	100.0% 1	90.9% 26	100.0% 1	100.0% 1	97.4% 20	100.0% 1	96.7% 21	87.5% 27	Qtr 3 14/15
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	94.7% 28	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	100.0% 1	98.4% 27	100.0% 1	100.0% 1	100.0% 1	100.0% 1	98.7% 26	100.0% 1	Qtr 3 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	N/A	85.7% 18	87.9% 17	66.7% 22	92.6% 10	91.7% 13	91.8% 12	95.0% 8	N/A	75.0% 20	61.5% 25	N/A	66.7% 22	75.0% 20	88.0% 16	94.4% 9	97.1% 6	100.0% 1	100.0% 1	66.7% 22	88.2% 15	88.9% 14	92.3% 11	100.0% 1	76.0% 19	100.0% 1	100.0% 1	95.6% 7	Qtr 3 14/15
Cancer Patients treated after screening referral <62 days*	90%	100.0% 1	100.0% 1	100.0% 1	100.0% 1	98.1% 16	83.3% 28	100.0% 1	100.0% 1	88.9% 26	100.0% 1	95.4% 19	94.9% 21	100.0% 1	100.0% 1	100.0% 1	96.3% 17	95.7% 18	92.7% 23	100.0% 1	99.1% 15	100.0% 1	93.2% 22	100.0% 1	95.0% 20	92.0% 24	85.7% 27	89.5% 25	100.0% 1	Qtr 3 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 2014/15

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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%	92.8% 6	100.0% 1	96.4% 4	92.0% 8	99.9% 2	92.3% 7	84.0% 9	81.7% 10	93.5% 5	99.3% 3	Qtr 3 14/15
RTT:% of admitted patients who waited 18 weeks or less	90%	86.7% 9	100.0% 1	93.4% 5	93.6% 4	96.2% 2	87.7% 8	90.0% 7	92.5% 6	84.2% 10	94.4% 3	Dec-14
RTT: % of non-admitted patients who waited 18 weeks or less	95%	94.4% 9	99.2% 1	95.8% 6	96.2% 5	98.9% 2	95.0% 8	95.1% 7	97.4% 4	94.3% 10	98.9% 3	Dec-14
RTT % of incomplete pathways within 18 weeks	92%	95.7% 5	99.3% 1	93.2% 10	96.5% 4	98.9% 2	94.0% 9	94.4% 8	95.0% 7	95.3% 6	98.7% 3	Dec-14
%. Patients waiting > 6 weeks for diagnostic	1%	0.2% 3	0.0% 1	0.5% 4	0.5% 5	5.6% 10	3.1% 9	0.5% 6	0.9% 7	1.9% 8	0.0% 1	Dec-14
Cancer patients seen <14 days after urgent GP referral*	93%	97.0% 2	N/A	94.1% 6	98.8% 1	N/A	86.1% 7	94.9% 4	94.3% 5	96.1% 3	N/A	Qtr 3 14/15
Cancer diagnosis to treatment <31 days*	96%	100.0% 1	N/A	99.7% 3	99.8% 2	N/A	93.0% 7	96.0% 6	97.7% 5	98.8% 4	N/A	Qtr 3 14/15
Cancer urgent referral to treatment <62 days*	85%	86.6% 4	N/A	89.1% 2	87.0% 3	N/A	82.4% 6	81.2% 7	85.2% 5	89.6% 1	N/A	Qtr 3 14/15
Breast Cancer Referrals Seen <2 weeks*	93%	97.4% 2	N/A	82.7% 7	99.4% 1	N/A	91.5% 6	94.6% 4	94.3% 5	96.3% 3	N/A	Qtr 3 14/15
Cancer Patients receiving subsequent surgery <31 days*	94%	98.0% 3	N/A	100.0% 1	100.0% 1	N/A	94.2% 6	96.2% 4	94.0% 7	96.2% 4	N/A	Qtr 3 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	99.6% 7	100.0% 1	100.0% 1	N/A	Qtr 3 14/15
Cancer Patients treated after consultant upgrade <62 days*	85%	N/A	N/A	N/A	100.0% 1	N/A	86.7% 4	92.5% 2	89.8% 3	85.2% 5	N/A	Qtr 3 14/15
Cancer Patients treated after screening referral <62 days*	90%	100.0% 1	N/A	100.0% 1	95.2% 5	N/A	90.7% 6	95.4% 4	90.6% 7	100.0% 1	N/A	Qtr 3 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

Isle of Wight NHS Trust Board Performance Report 2014/15

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Benchmarking of Key National Performance Indicators: Ambulance Performance

Isle of Wight NHS Trust

	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%	80.4% 1	63.0% 8	71.7% 4	59.3% 10	62.4% 9	58.9% 11	69.9% 5	72.5% 3	69.6% 6	72.8% 2	63.4% 7	Dec-14
Ambulance Category A Calls % < 8 minutes - Red 2	75%	75.0% 1	58.2% 10	61.1% 7	47.7% 11	66.4% 5	58.5% 9	70.1% 3	71.4% 2	63.3% 6	68.5% 4	60.4% 8	Dec-14
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	75.4% 1	58.5% 10	61.6% 7	48.0% 11	66.2% 5	58.5% 9	70.1% 3	71.4% 2	63.7% 6	68.8% 4	60.6% 8	Dec-14
Ambulance Category A Calls % < 19 minutes	95%	96.3% 1	85.8% 10	90.3% 7	84.8% 11	91.3% 6	87.7% 9	93.8% 4	94.5% 3	89.7% 8	95.7% 2	92.5% 5	Dec-14

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

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

Isle of Wight NHS Trust Board Performance Report 2014/15

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Data Quality

Isle of Wight NHS Trust

Commentary:

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

The latest information is up to November 2014. Overall we have 3 red rated indicators 2 of which are in the Admitted Patient Care Dataset with the third in the A&E dataset. The Outpatient dataset indicators are all green. The 2 indicators in the APC dataset are the Primary Diagnosis and the HRG4 (Healthcare Resource Grouping) these are linked as you need the diagnosis to generate the HRG. Investigation has shown that the issue relates to duplicate records being created in SUS when a record is updated, we are still working with Portsmouth Hospitals to identifiy the cause of this error but are confident that the codes are applied on our system and in the CDS file we generate suggesting the problem is either with the translator process or SUS itself.

In the A&E dataset we are red for the number of invalid or missing commissioner codes, this was due to an invalid default code generated by the system. This issue has been corrected and should see improvements in the coming months.

Analysis:

Total APC General Episodes: 17,204

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	244	98.6%	99.1%
Patient Pathway	317	94.5%	60.7%
Treatment Function	0	100.0%	99.9%
Main Specialty	0	100.0%	100.0%
Reg GP Practice	3	100.0%	99.9%
Postcode	113	99.3%	99.8%
Org of Residence	9	99.9%	98.7%
Commissioner	17	99.9%	99.4%
Primary Diagnosis	1,384	92.0%	98.4%
Primary Procedure	0	100.0%	99.5%
Ethnic Category	25	99.9%	97.5%
Site of Treatment	0	100.0%	95.3%
HRG4	1,402	91.9%	98.4%

Total Outpatient General Episodes: 114,045

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	608	99.5%	99.3%
Patient Pathway	50,930	51.8%	49.7%
Treatment Function	0	100.0%	99.9%
Main Specialty	0	100.0%	99.8%
Reg GP Practice	4	100.0%	99.9%
Postcode	8	100.0%	99.8%
Org of Residence	18	100.0%	69.9%
Commissioner	43	100.0%	99.4%
First Attendance	0	100.0%	99.5%
Attendance Indicator	1	100.0%	99.6%
Referral Source	532	99.5%	98.8%
Referral Rec'd Date	532	99.5%	95.9%
Attendance Outcome	87	99.9%	98.3%
Priority Type	532	99.5%	97.5%
OP Primary Procedure	0	100.0%	99.6%
Ethnic Category	61	99.9%	93.6%
Site of Treatment	1	100.0%	96.1%
HRG4	0	100.0%	98.9%

Total A&E Attendances 43,564

Data Item	Invalid Records	Provider % Valid	National % Valid
NHS Number	935	97.9%	95.1%
Registered GP Practice	15	100.0%	99.2%
Postcode	22	99.9%	98.9%
Org of Residence	433	99.0%	96.0%
Commissioner	670	98.5%	99.1%
Attendance Disposal	438	99.0%	97.2%
Patient Group	25	99.9%	96.1%
First Investigation	440	99.0%	94.5%
First Treatment	1,196	97.3%	93.8%
Conclusion Time	428	99.0%	97.9%
Ethnic Category	0	100.0%	94.0%
Departure Time	271	99.4%	99.9%
Department Type	0	100.0%	99.7%
HRG4	607	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:
Determine cause of records not updating	Head of Information / Asst. Director - PIDS	Dec-14	Ongoing
Review missing commissioner codes in A&E dataset		Sep-14	Ongoing

Data Quality - November 2014

Dataset	Measure	IW Performance	National	Threshold G	Threshold A	Threshold R	Status	Weighting	Score	Notes
APC	Total Invalid Data Items	2	n/a	=<2	>2 =<4	>4	A	2	1.0	Performance relates to the no. of Red rated data items
APC	Valid NHS Number	98.6%	99.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	A	1	0.5	
APC	Valid Ethnic Category	99.9%	97.5%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Invalid Data Items	0	n/a	=<2	>2 =<5	>5	G	2	0.0	Performance relates to the no. of Red rated data items
OP	Valid NHS Number	99.5%	99.3%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Valid Ethnic Category	99.9%	93.6%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Total Invalid Data Items	1	n/a	=<2	>2 =<4	>4	G	2	0.0	Performance relates to the no. of Red rated data items
A&E	Valid NHS Number	97.9%	95.1%	> = national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Valid Ethnic Category	100.0%	94.0%	> = 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

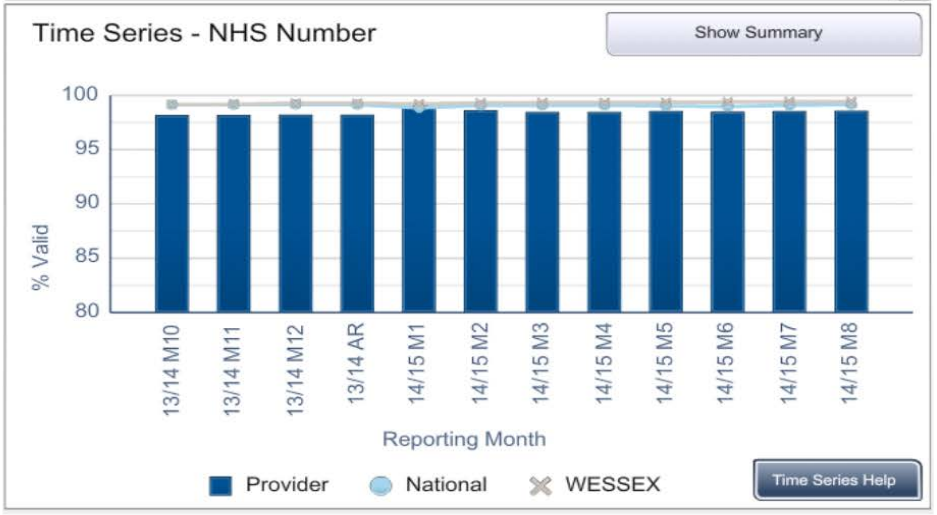
Time Series Analysis for Red Rated Indicators:

Data item information:

NHS Number

The NHS Number is the unique identifier and is mandatory to record for each patient.

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

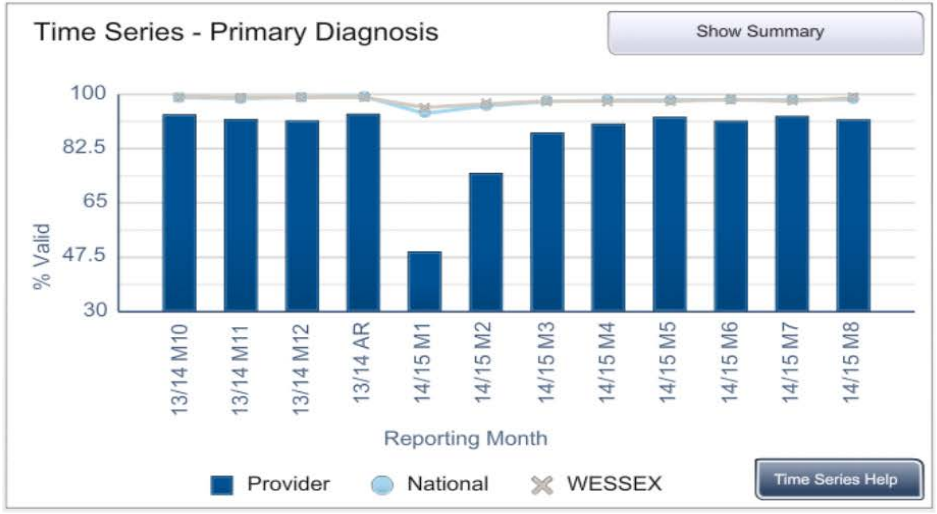


Data item information:

Primary Diagnosis (ICD-10)

This is a clinical classification associated with the patient diagnosis.

The patient diagnosis is:
i. the main condition treated or investigated during the relevant episode of healthcare, and
ii. where there is no definitive diagnosis, the main symptom,



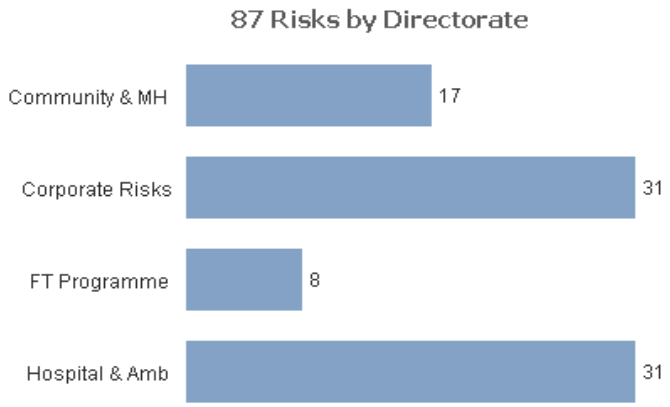
Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

Risk Register - Situation current as at 24/02/2015

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	4	50%
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	5	4	80%
Hospital & Amb	22/08/2012	Risk Due To Bed Capacity Problems	4	3	75%
Community & MH	22/11/2012	Low Staffing Levels Within Occupational Therapy Acute Team	9	5	56%
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 Risks	26/03/2013	Pressure Ulcers	4	2	50%
Hospital & Amb	23/09/2013	Ophthalmic Casenotes - Poor Condition, Misfiling And Duplication Leading To Potential Clinical Error	4	2	50%
Hospital & Amb	21/01/2014	Acquisition Of Mechanical Device For Chest Compressions	5	4	80%
Corporate Risks	24/07/2014	Air Conditioning Unit In Network Core Room	7	2	29%
Corporate Risks	24/07/2014	Mandatory Resuscitation Training	6	3	50%
Hospital & Amb	28/08/2014	Computer Aided Dispatch (Cad) Server And Software Update	5	2	40%
Hospital & Amb	28/08/2014	Maxfax Dental Carts And Compressor No Longer Fit For Purpose	8	6	75%
Corporate Risks	28/08/2014	Unsupported Desktop Environment	6	0	0%
Corporate Risks	31/12/2014	Trust Archive Records Storage	6	0	0%
Corporate Risks	19/02/2015	Failure To Achieve Financial Plan	1	0	0%
Community & MH	19/02/2015	Integrated Community Equipment Demand	11	1	9%

Data as at 24/02/2015 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 7 new risks have been added to the register - RR639 Working with potential VHF or Similar infectious diseases of high consequences in samples, RR640 Go live of care identity service (CIS), RR641 Access to Sevenacres Roof, RR642 Integrated Community Equipment Demand, RR643 MHLD Outpatient community Data set (CDS) on PARIS, RR644 Failure to achieve Financial Plan, RR645 Replacement of Ultrasound Machine in Breast Screening unit . 3 risks have been signed off the risk register - RR506 Intensive Care Unit Capacity - 7th bed funding / RR543 Failing medical casenote label printers / RR634 No Dental Compressor.

Isle of Wight NHS Trust Board Performance Report 2014/15

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

Isle of Wight NHS Trust

Paybill				R
		Plan	Actual	Overspend
Year to date £k	-	95,167	- 97,951	2,784

Su mmary

The trust continues to experience considerable pressure on its pay budgets. In month expenditure exceeds plan by £185k resulting in a year to date overspend of £2.7m.
The main contributor is the significant under achievement of pay related CIP schemes, amounting to c£2m of adverse variance to plan.
Temporary staffing costs also continue to contribute to budget overspends and as a total equates to £6.7m year to date, 6.9% of the total pay spend.
Sickness levels remain significantly above plan and continues to cost the organisation in excess of £300k in monthly sick pay and backfill requirements.

Highlights	Lowlights
Community Health directorate overspend reduced due to reduced in month spend and funding received from the CCG Corporate paybill remains within plan	Hospital & Ambulance overspend increased in month

Establishment				R
		Plan	Actual / Forecast	Variance
Year to date		2,878	2,674	204

Summary

Under establishment remains at around 7% and is in line with the annual turnover rates.
Temporary/Variable staffing is used to file 62% of vacant posts, though this rate has fallen from in recent months from an average of 69% ytd.
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. A review of vacancy posts not filled with temporary staffing should be reviewed to asses impacts on safety, and to review the need for the post.

Highlights	Lowlights

Vacancies			126
		Establishment	Recruitment Activity
Vacancy FTE		204	126

Summary

The trust currently has 204 vacant posts, with 126 posts currently in the recruitment process.

Trustwide action required: review all current vacancies and establishment to reconcile the gap between what is an actual required vacancy and under establishment.

Highlights	Lowlights
Recruitment to 32 Nursing positions following Philippines recruitment.	

Sickness				R
		Plan	Actual / Forecast	Variance
Year to date		3%	4.24%	1.24%
In Month		3%	4.82%	1.82%

Summary: Sickness absence has been reduced from 4.93% in Dec 14 to 4.82% in Jan 15. Trustwide there are still instances of Gastrointestinal Problems, but the majority of sickness absence reasons are Cold, Cough Flu and Stress, Anxiety Depression. Ear, Nose and Throat absences have seen the sharpest increase in month. LTS figures have remained static.

Highlights	Lowlights
Decrease in Sickness absence %	Still well over 3% target

Overpayment			G
		Plan	Actual
Year to date £		0	84,128

Summary: Category A overpayments (those which are repaid in month) January £2202.16 - due to incorrect information received. The increase in current employee in leaver overpayments was due to late receipt of e-termination forms.overpayments was mainly due to late change forms and the increase in leaver overpayments was due to late receipt of e-termination forms.

Highlights	Lowlights
Overall outstanding Overpayment amount reduced to £84,128 (ongoing recoveries)	Within HAD almost £6000 added to leaver overpayments due to late e-terminations & the increase of over £10,000 to current employee overpayments due to incorrect and late change forms.

Rostering	G

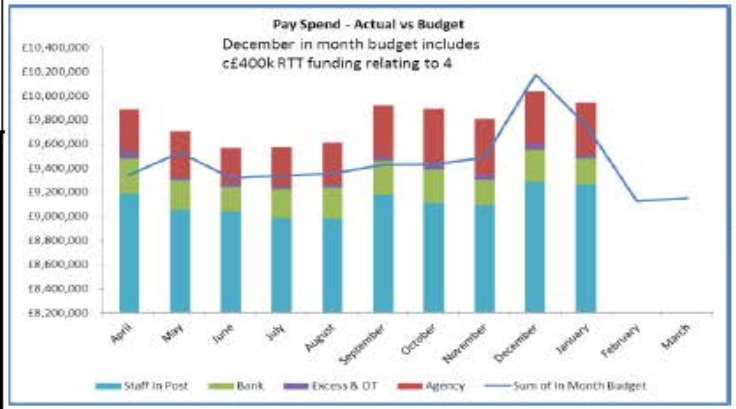
At time of lockdown, multiple costs centres were not locked down. Substantial effort was made to contact areas to get this done as outlined in the rostering policy. Lockdown for February is Tuesday 3rd March @ 13:00. Daily Staffing report is in infancy but developments are planned. Shows a projected view of staffing a week ahead of time to identify where is the shortfall.

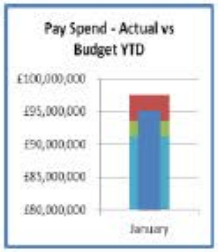
Highlights	Lowlights
	Payroll was run with five units removed from the batch list. This means that for the month of January these units will not receive any enhancements or overtime payments that are due: A&E Medics, Paediatric Secretaries, Poppy Unit, Project Management Office (PMO), Specialist Nurses

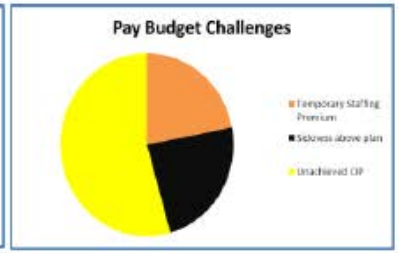
Trust	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Pay	(95,167)	(97,951)	(2,784)
			-2.93%

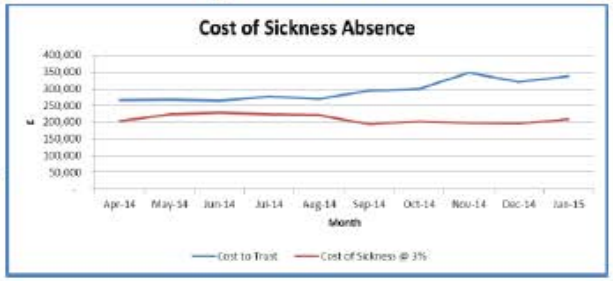
Summary

The trust continues to experience considerable pressure on its pay budgets. In month expenditure exceeds plan by £185k resulting in a year to date overspend of £2.7m.
The main contributor is the significant under achievement of pay related CIP schemes, amounting to c£2m of adverse variance to plan.
Temporary staffing costs also continue to contribute to budget overspends and as a total equates to £6.7m year to date, 6.9% of the total pay spend.
Sickness levels remain significantly above plan and continues to cost the organisation in excess of £300k in monthly sick pay and backfill requirements.





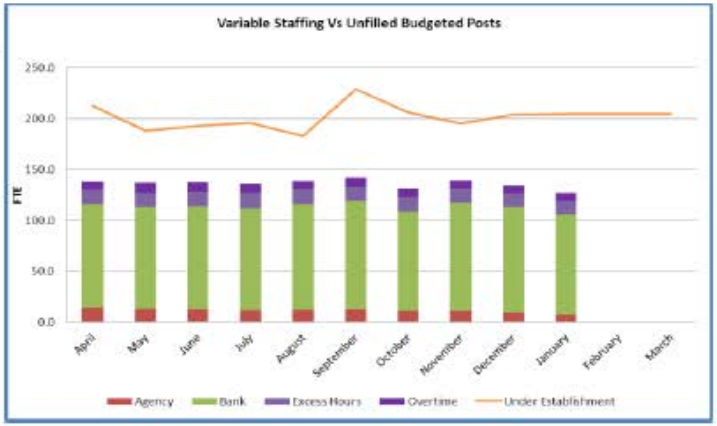




Trust	In Month		
	Plan	Actual	Variance
WTE	2,878	2,674	(204)
			7.10%

Summary

Under establishment remains at around 7% and is in line with the annual turnover rates.
Temporary/Variable staffing is used to file 62% of vacant posts, though this rate has fallen from in recent months from an average of 69% ytd.
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. A review of vacancy posts not filled with temporary staffing should be reviewed to asses impacts on safety, and to review the need for the post.



Staff Group	Under Establishment	% of Funded WTE	Temporary Staffing % (Cost)	Overspend
Additional Clinical Services	45.47	8.19%	11.73%	8.23%
Administrative and Clerical	26.53	4.51%	3.65%	-1.19%
Allied Health Professional	9.79	4.77%	0.22%	-8.85%
Estates and Ancillary	10.36	4.44%	1.25%	-3.31%
Medical and Dental	34.79	13.91%	14.44%	4.72%
Nursing & Midwifery	60.69	6.93%	3.07%	0.94%
Scientific & Technical	16.82	10.09%	10.08%	3.93%
	204.44	7.10%	6.99%	2.90%

Live Vacancies with Recruitment	
Hospital & Ambulance	70.58
Cummunity Health	53.95
Corporate	1.60
Total	126.13

Hospital & Ambulance

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Pay	(52,690)	(55,517)	(2,827)
			-5.36%

Summary

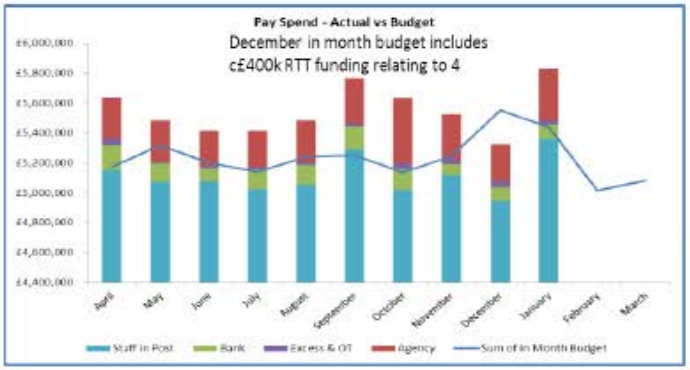
Overspends in the paybill for the Hospital & Ambulance directorate are the biggest contributors to the trusts overall adverse position. The directorate is £2.8m overspent year to date and the position is likely to worsen in the remaining months of the year due to the phasing of CIP targets and lack of schemes to deliver required savings. Unachieved CIP accounts for £2.3m of the directorates overspend. Spending on temporary staffing exceeds budgeted establishment by £538k. Higher than planned sickness absence is also contributing to the cost pressures.

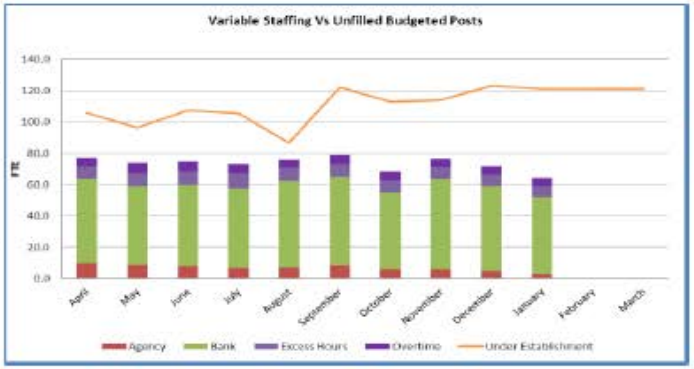
Hospital & Ambulance

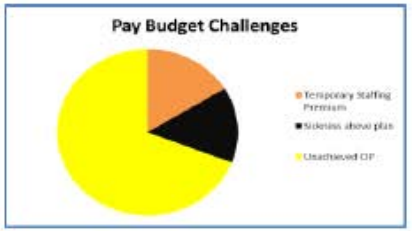
	In Month		
	Plan	Actual	Variance
WTE	1,463	1,341	(121)
			8.29%

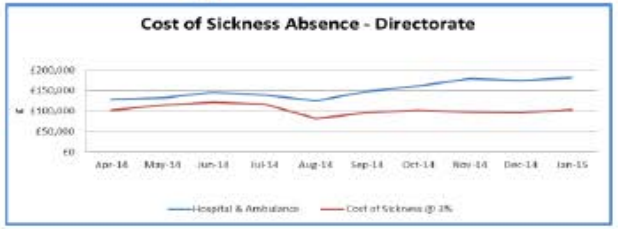
Summary

Under established posts have increased to 8.3% in month, with 121.18 WTE posts currently vacant. These are resulting in the need for temporary staffing in the form of bank and agency which are adding to the cost pressures above. Reliance on temporary staffing to backfill vacant posts has fallen in December & January to a greater extent than recruitment. Impact to clinical care needs to be assessed. Almost half of vacant WTE positions were not backfilled by temporary staffig arrangements.









Staff Group	Under Establishment	% of Funded WTE	Temporary Staffing % (Cost)	Overspend
Additional Clinical Services	28.41	8.05%	8.46%	3.15%
Administrative and Clerical	11.82	6.12%	4.15%	1.62%
Allied Health Professional	4.15	9.38%	0.10%	-1.84%
Estates and Ancillary	1.41	-2.63%	0.77%	-3.69%
Medical and Dental	29.41	14.04%	14.69%	2.92%
Nursing & Midwifery	28.49	6.14%	3.50%	-0.44%
Scientific & Technical	20.31	14.00%	5.07%	-4.11%
	121.18	8.29%	8.36%	5.36%

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January 15

Workforce - Directorate Performance

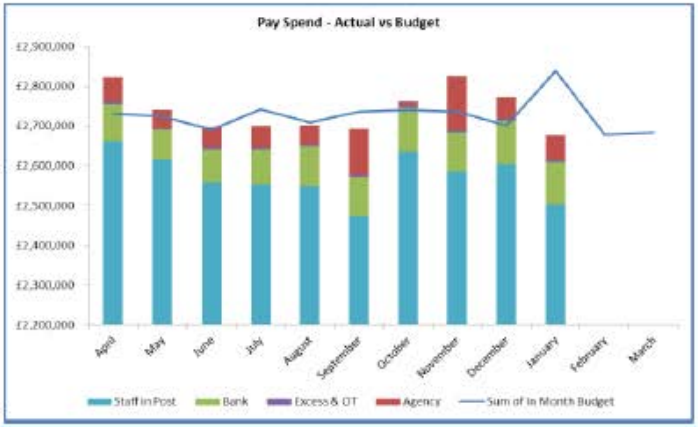
Isle of Wight NHS Trust

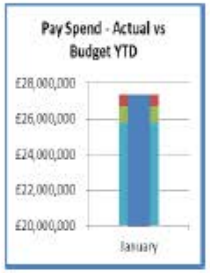
Community Health

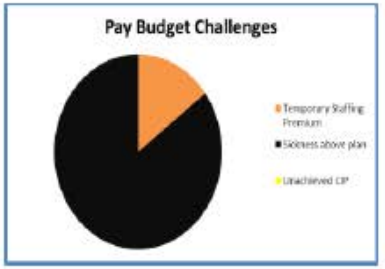
	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Pay	(27,357)	(27,396)	(39)
			-0.14%

Summary

The community health directorate has reduced its overspend in month and is within 0.14% of plan. This is due to a combination of a reduction of spend in month, and the funding forthcoming from the CCG for investment in areas such as healthvisitor recruitment, Solent Grange staffing, and agreed business cases. The cost of sickness absence continues to be a cost pressure and is an area for focus.





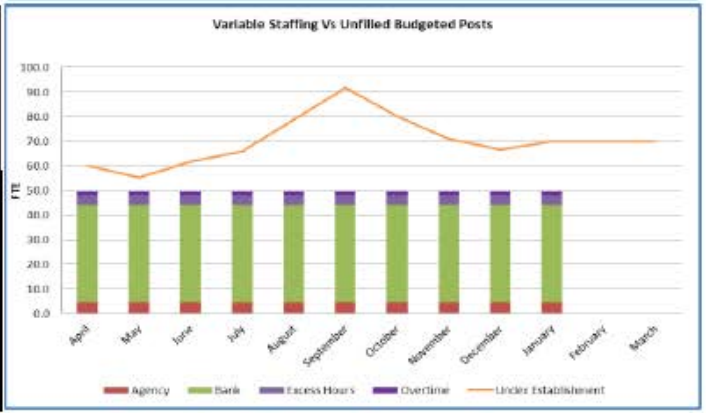


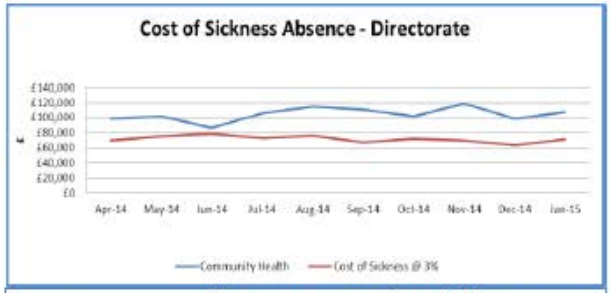
Community Health

	In Month		
	Plan	Actual	Variance
WTE	918	848	(70)
			7.61%

Summary

The Community Heath directorate is currently under established by 70 WTE, equating to 7.61% of its budgeted establishment. These posts are being backfilled by a combination of bank, agency & excess hours. There are approximately 20 WTE posts not backfilled by temporary staffing in recent months.





Staff Group	Under Establishment	% of Funded WTE	Temporary Staffing % (Cost)	Overspend
Additional Clinical Services	19.41	10.26%	15.85%	7.80%
Administrative and Clerical	10.52	7.32%	3.77%	-3.28%
Allied Health Professional	6.64	4.18%	0.26%	-12.30%
Estates and Ancillary	0.18	1.78%	0.36%	-6.06%
Medical and Dental	3.33	10.77%	11.36%	2.83%
Nursing & Midwifery	32.84	8.99%	2.20%	-6.70%
Scientific & Technical	2.99	14.74%	37.23%	37.26%
	69.93	7.61%	6.04%	0.14%

Corporate	Year to date Plan £000s	Actual £000s	Variance £000s
Pay	(13,032)	(12,620)	412
			3.16%

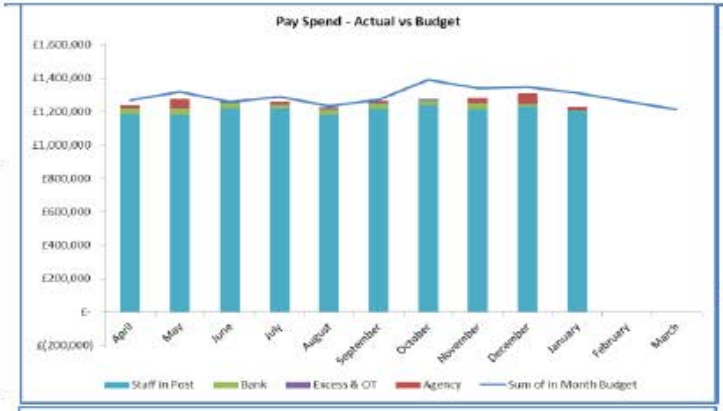
Summary

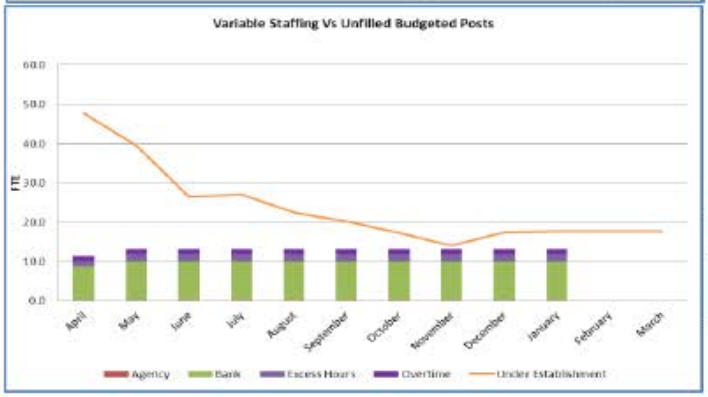
The paybill in corporate areas as a whole remains within plan by £412k. The cost of bank and agency usage has fallen, but the cost of sick pay continues to be above plan.

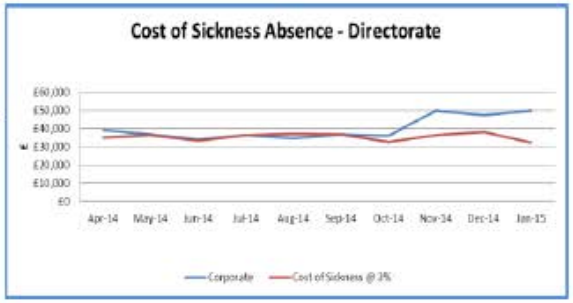
Corporate	In Month Plan	Actual	Variance
WTE	448	431	(18)
			3.94%

Summary

Corporate areas remain under established against budgeted WTE in the region of 18 WTE in December & January. 10 WTE bank staff and approximately 3 WTE of excess hours and overtime have been utilised to backfill for these vacanct posts.







Staff Group	Under Establishment	% of Funded WTE	Temporary Staffing % (Cost)	Overspend
Administrative and Clerical	4.19	1.67%	3.32%	-1.83%
Estates and Ancillary	11.59	6.82%	0.72%	-3.03%
	17.68	3.94%	0.00%	-3.16%

Drop in Sickness absence in month from 4.93% to 4.82% - still well above the 3% target. Highest increase in Ear, Nose, Throat absence reasons. Cold, Cough, Flu - Influenza is the main reason for sickness absence.

Trust

The Trust's sickness target is 3%

Currently Sickness Absence rate is 4.82% for January 2015.

YTD Sickness Absence is 4.24%.

10 Highest areas within Directorate

Area	FTE Days available	Sickness Days	Sickness %
Contracts J61645	93.00	32.00	34.41%
Laidlaw House J61223	198.81	37.72	18.97%
Surgical General Office J61100	179.80	33.40	18.58%
Maxillo/Dental Unit J61057	170.71	31.00	18.16%
Stroke & Rehab Comm Team J61227	499.31	85.47	17.12%
Cancer Admin J61020	203.36	31.00	15.24%
Telephones J61991	223.20	33.92	15.20%
Orthopaedic Unit J61111	1517.35	210.88	13.90%
Clinical Coding J61156	308.35	42.60	13.82%
HSDU J61271	702.67	96.95	13.80%

	Sum of FTE Days Lost					
Absence Reason	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Variance
S10 Anxiety/stress/depression/other psychiatric illnesses	896.13	729.56	1214.15	1034.72	793.68	-23.29%
S25 Gastrointestinal problems	475.63	482.65	471.50	266.27	331.83	24.62%
S11 Back Problems	373.34	419.21	420.88	432.14	361.50	-16.35%
S13 Cold, Cough, Flu - Influenza	233.13	415.14	407.52	619.71	826.06	33.30%
S12 Other musculoskeletal problems	235.50	303.83	319.60	505.89	401.31	-20.67%
S28 Injury, fracture	312.64	202.52	154.48	152.61	205.69	34.78%
S15 Chest & respiratory problems	114.78	198.97	205.92	176.40	222.81	26.31%
S21 Ear, nose, throat (ENT)	111.43	139.67	140.00	91.89	131.44	43.05%
S26 Genitourinary & gynaecological disorders	214.73	137.87	185.65	196.03	189.70	-3.23%
S17 Benign and malignant tumours, cancers	147.20	126.13	114.60	133.39	112.79	-15.44%
Grand Total	**3114.52**	**3155.56**	**3634.30**	**3609.05**	**3576.81**	**-0.69%**

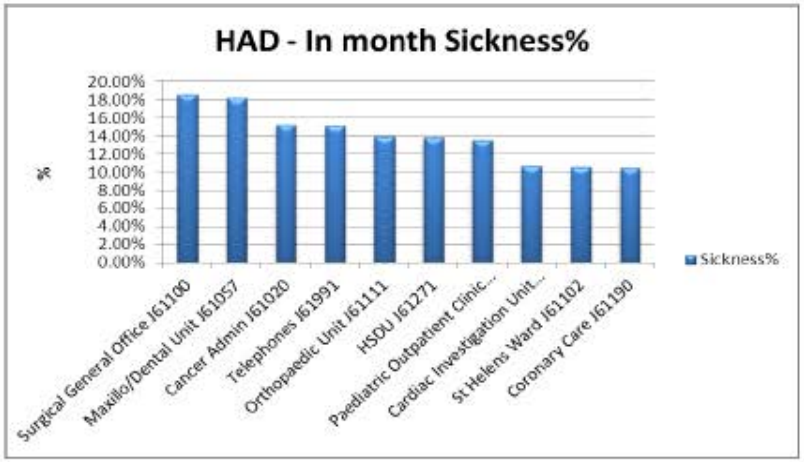
Hospital & Ambulance

Sickness Absence: 5.25%

YTD Sickness Absence is 4.34%.

10 Highest areas within Directorate

Area	FTE Days available	Sickness days	Sickness %
Surgical General Office J61100	179.80	33.40	18.58%
Maxillo/Dental Unit J61057	170.71	31.00	18.16%
Cancer Admin J61020	203.36	31.00	15.24%
Telephones J61991	223.20	33.92	15.20%
Orthopaedic Unit J61111	1517.35	210.88	13.90%
HSDU J61271	702.67	96.95	13.80%
Paediatric Outpatient Clinic J61374	82.67	11.20	13.55%
Cardiac Investigation Unit J61192	252.96	27.00	10.67%
St Helens Ward J61102	797.32	84.13	10.55%
Coronary Care J61190	1014.11	106.17	10.47%



Drop in Sickness absence in month from 4.93% to 4.82% - still well above the 3% target. Highest increase in Ear, Nose, Throat absence reasons. Cold, Cough, Flu - Influenza is the main reason for sickness absence.

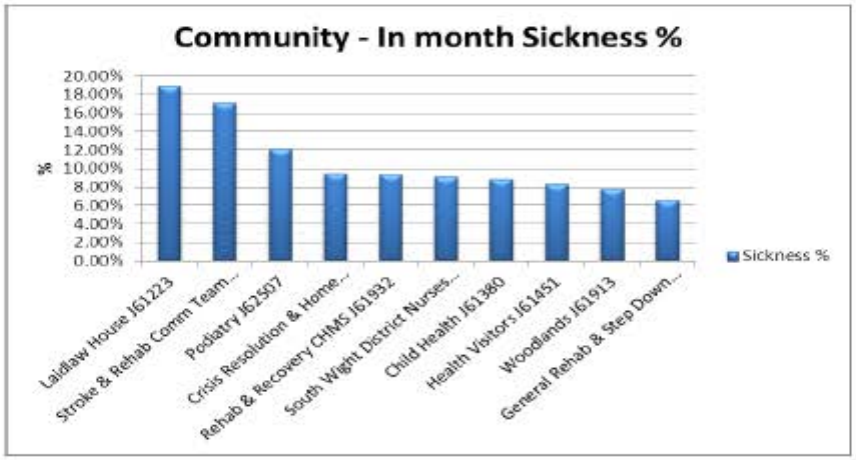
Community Health

Sickness Absence: 4.58%

YTD Sickness Absence is 4.40%.

10 Highest areas within Directorate

Area	FTE Days available	Sickness days	Sickness %
Laidlaw House J61223	198.81	37.72	18.97%
Stroke & Rehab Comm Team J61227	499.31	85.47	17.12%
Podiatry J62507	492.69	59.47	12.07%
Crisis Resolution & Home Treatment Team J61850	775.00	73.40	9.47%
Rehab & Recovery CHMS J61932	478.64	44.60	9.32%
South Wight District Nurses J62527	707.63	64.03	9.05%
Child Health J61380	150.87	13.33	8.84%
Health Visitors J61451	1119.72	93.09	8.31%
Woodlands J61913	442.27	34.53	7.81%
General Rehab & Step Down Unit J61226	1095.75	72.09	6.58%



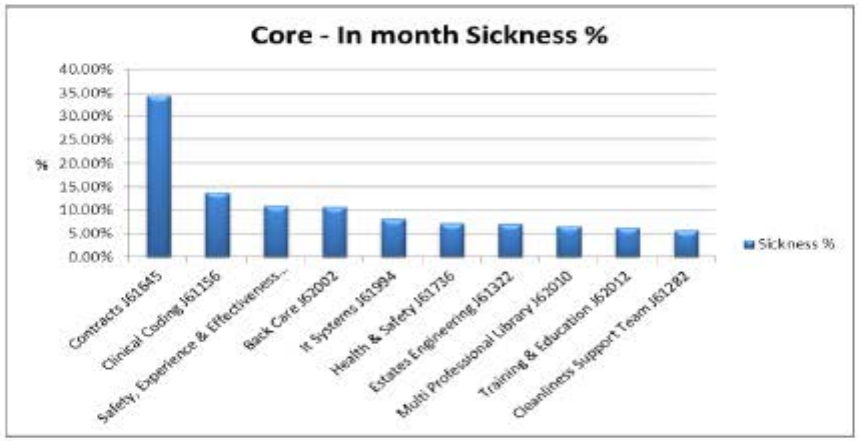
Corporate

Sickness Absence: 3.48%

YTD Sickness Absence is 3.00%.

10 Highest areas within Directorate

Area	FTE Days available	Sickness days	Sickness %
470 4Contracts J61645	93.00	32.00	34.41%
470 4Clinical Coding J61156	308.35	42.60	13.82%
470 4Safety, Experience & Effectiveness (SEE) Business Team J61340	256.68	27.88	10.86%
470 4Back Care J62002	140.53	15.13	10.77%
470 4It Systems J61994	434.00	35.00	8.06%
470 4Health & Safety J61736	37.20	2.67	7.17%
470 4Estates Engineering J61322	496.00	35.00	7.06%
470 4Multi Professional Library J62010	96.31	6.37	6.62%
470 4Training & Education J62012	320.33	20.17	6.30%
470 4Cleanliness Support Team J61282	2418.21	137.40	5.68%



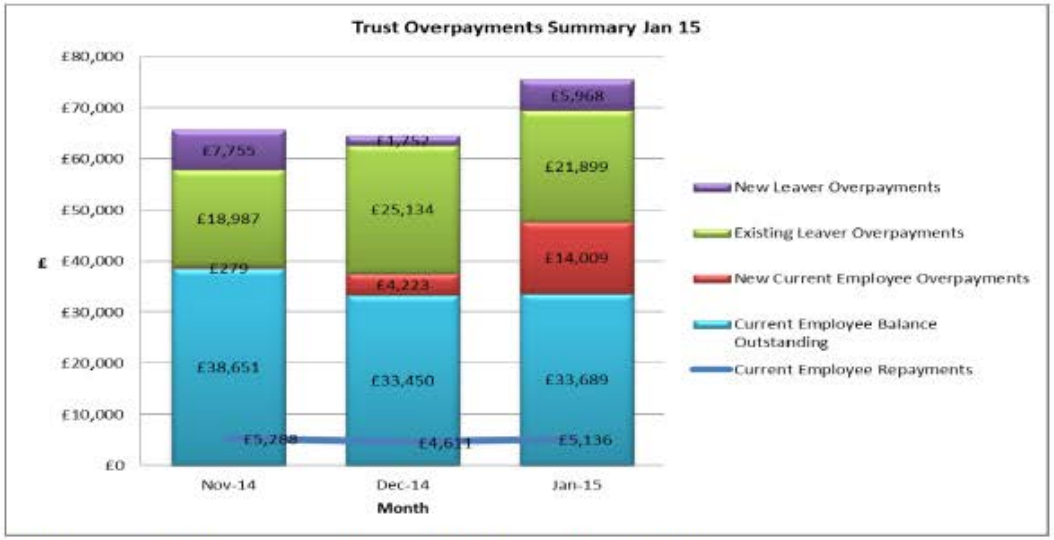
Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

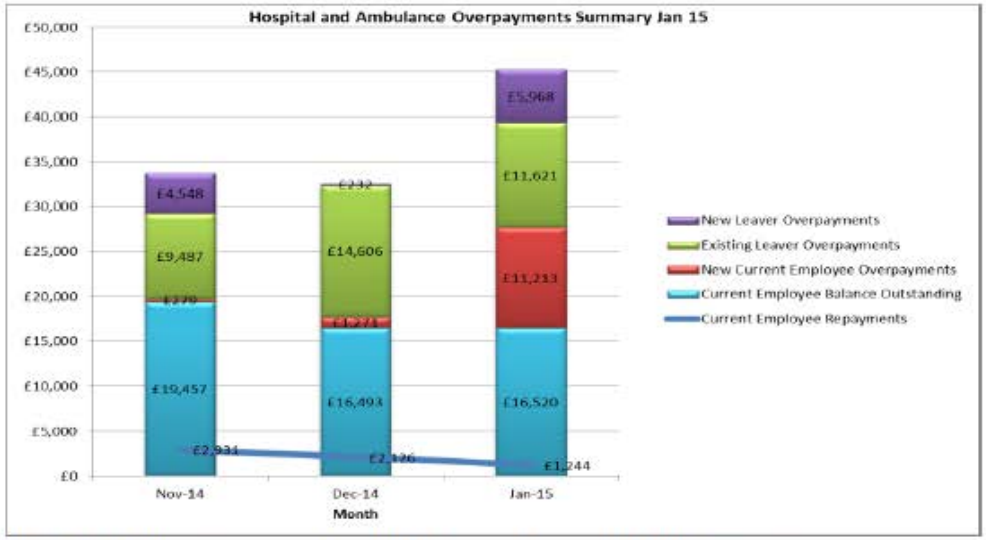
Workforce - Overpayments Summary

Isle of Wight NHS Trust

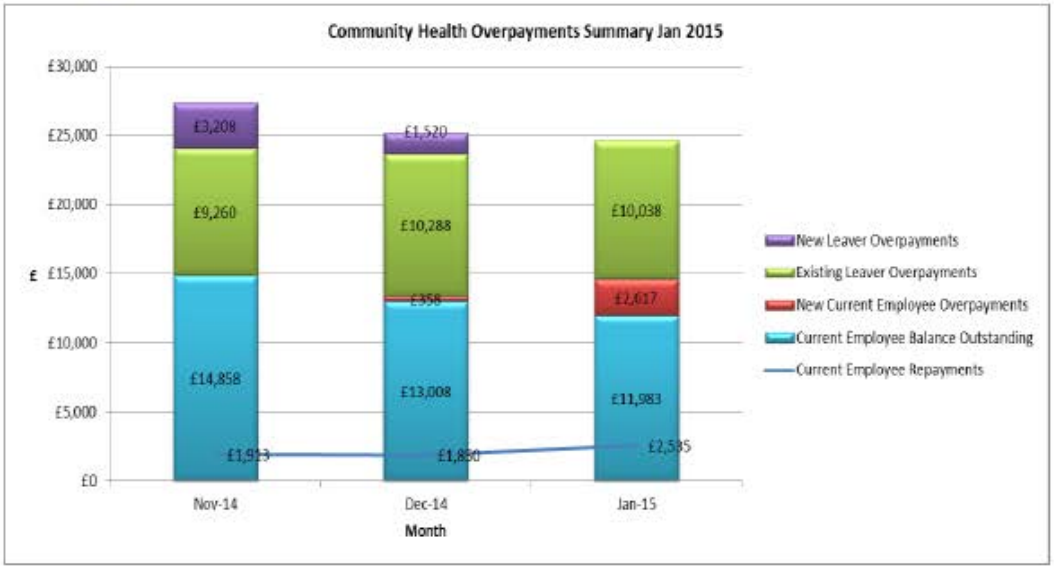
Summary: Category A overpayments (those which are repaid in month) January £2202.16 - due to incorrect information received.



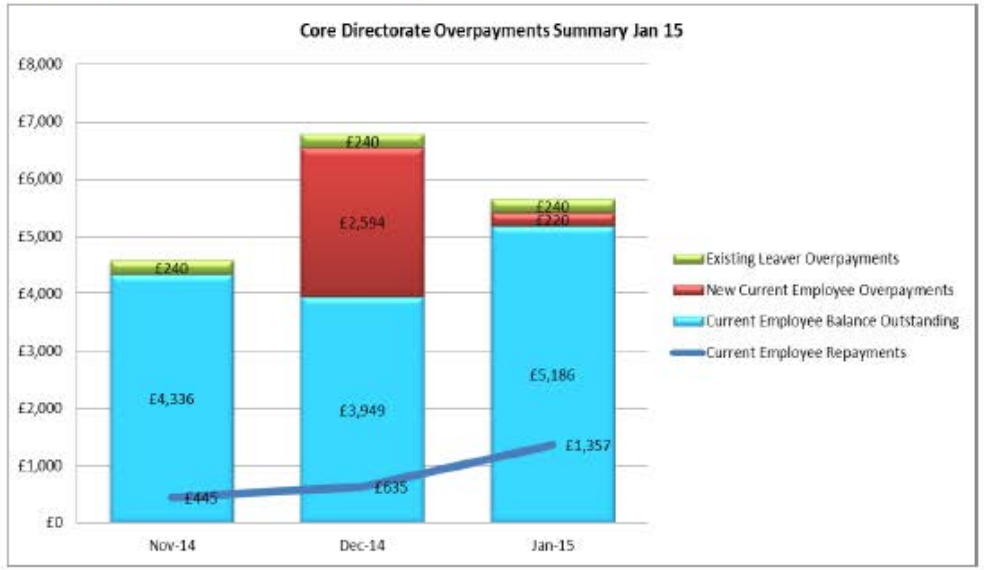
The increase in current employee overpayments was mainly due to late change forms and the increase in leaver overpayments was due to late receipt of e-termination forms.



Nearly £6000 added to leaver overpayments due to late e-terminations. The increase of over £10,000 to current employee overpayments due to incorrect and late change forms.



Although the overall figure has decreased, there was an increase of overpayments for current employees which was due to



The December increase in current employee overpayments was due to late and incorrect change forms.

Actions now completed from the timetable of actions in relation to National Quality Board Requirements

C The Trust receives an update detailing planned versus actual staffing on a shift by shift basis Information is provided on a shared drive and via email to senior nurses which details planned versus actual staffing on a shift by shift basis for each ward, by Registered and non registered staff. This enables staff to see where 'hot spots may have appeared on the day and adjust staff accordingly across the whole organisation. This enables senior nurses to view the week forward and previous week to consider additional planning requirements.	
E The planned staffing should be reviewed on a daily basis The planned staffing is reviewed on a daily basis. Assurance is provided from senior nurse team that operational teams are reviewing staffing daily. The Matron assigned to daily staffing has oversight of the organisational staffing and reviews this at the 9.00am operational hub meeting and actions are put in accordingly.	

Achievement of planned versus actual staffing hours

- The Trust achieved an average of 89.8% fill rate on RN's in the day for January 2015
- This is below the organisations target of 90% for an amber rating

Day				Night							
Registered midwives/nurses		Care Staff		Registered midwives/ nurses		Care Staff		Day		Night	
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 (%)
27637.25	24810.07	18737.25	18722.78	14717	14445.55	8865.25	10658.25	89.8%	99.9%	98.2%	120.2%

Bank Fill rate for January 2015

Grade:	Total shifts:	Filled:	Unfilled:	% Fill rate:
RN	1515	1181	334	77.9%
HCA	955	747	208	78.2%
Agency (RN)	166	154	12	92.7%

Unify Date for January 2015

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	465	523	1393.75	1114.5	294.5	299.75	589	606.5	112.5%	80.0%	101.8%	103.0%
ORTHOPAEDIC UNIT	1280.25	1137	1084	1065.59	820	771.5	540	490	88.8%	98.3%	94.1%	90.7%
SEAGROVE	926.5	967.07	926	1335.61	620	662.5	620	899.5	104.4%	144.2%	106.9%	145.1%
OSBORNE	1048.5	1108.5	765	1104.25	720	723.25	294.5	668.5	105.7%	144.3%	100.5%	227.0%
MOTTISTONE	930	865	395.5	435.75	620	622			93.0%	110.2%	100.3%	
ST HELENS	870	817	840.5	726	629	589.5	310	350	93.9%	86.4%	93.7%	112.9%
STROKE	1775	1452.25	1463.5	1798.75	620	600	620	940	81.8%	122.9%	96.8%	151.6%
REHAB	1601	1411.17	1616	1936.75	620	741	620	1136	88.1%	119.8%	119.5%	183.2%
WHIPPINGHAM	1729.5	1489.25	1473.5	1260	620	650	620	620	86.1%	85.5%	104.8%	100.0%
COLWELL	1389.5	1461.5	1736	1375.5	620	640	619.25	600	105.2%	79.2%	103.2%	96.9%
INTENSIVE CARE UNIT	3255	2604.5	330	245.5	2015.5	1738.75	203.5	189	80.0%	74.4%	86.3%	92.9%
CORONARY CARE UNIT	2280.5	1868.75	681	700.5	1541	1343.25	310	380	81.9%	102.9%	87.2%	122.6%
NEONATAL INTENSIVE CARE UNIT	1057.5	937.52	418.5	357.33	620	640	310	300	88.7%	85.4%	103.2%	96.8%
MEDICAL ASSESSMENT UNIT	2288.5	1870	982	1071.5	930	960	620	877.25	81.7%	109.1%	103.2%	141.5%
AFTON	930	1091	930	813.25	310	310	620	682.5	117.3%	87.4%	100.0%	110.1%
PAEDIATRIC WARD	1552.5	1403	465	411	930	898.25	310	310	90.4%	88.4%	96.6%	100.0%
MATERNITY	2092.5	1983.3	1240	1240	1147	1243.8	620	620	94.8%	100.0%	108.4%	100.0%
WINTER BED WARD	1322.5	1089.76	1121.5	1039	620	612	620	590	82.4%	92.6%	98.7%	95.2%
LUCCOMBE WARD	843	730.5	875.5	692	420	400	419	399	86.7%	79.0%	95.2%	95.2%

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	112.5%	80.0%	101.8%	103.0%	92.3%	1	0	0	Day - staff moved to support patient care requirements and to enable mandatory training. Nights - staff moved to evening shift to assist with patient care requirements
Ortho Unit/ Alverstone	88.8%	98.3%	94.1%	90.7%	72.4%	0	0	2	
Seagrove	104.4%	144.2%	106.9%	145.1%	89.1%	0	0	0	Additional 1:1's requried and booked via comissioners as per protocol, (1215 hours)
Osborne	105.7%	144.3%	100.5%	227.0%	84.0%	0	0	0	Additional 1:1's requried and booked via comissioners as per protocol, (435 hours), OOH cover required to support ED, based on ward (80 hours)
Mottistone	93.0%	110.2%	100.3%		82.3%	1	0	0	Additional HCA put in place to enable day case work to continue whilst elective work under pressure
StHelens	93.9%	86.4%	93.7%	112.9%	62.0%	0	0	1	Additional 1:1 support for patient at night
Stroke	81.8%	122.9%	96.8%	151.6%	84.3%	1	0	0	Additional 1:1 support for patients
Rehab	88.1%	119.8%	119.5%	183.2%	85.2%	4	0	0	1:1's requried for patient care throughout January. Additional hours for 4 Winter Pressure beds
Whippingham	86.1%	85.5%	104.8%	100.0%	69.6%	0	2	1	Poor safety indicators noted
Colwell	105.2%	79.2%	103.2%	96.9%	70.7%	3	2	0	reduced HCA cover noted
Intensive Care Unit	80.0%	74.4%	86.3%	92.9%	90.9%	1	0	0	safety
Coronary Care Unit	81.9%	102.9%	87.2%	122.6%	79.0%	1	0	0	7 Vacancies currently being managed. HCA fill for non fill of RN bank shifts
Neonatal Intensive Care Unit	88.7%	85.4%	103.2%	96.8%	86.2%	0	0	0	Movement of staff to cover sickness
Medical Assessment Unit	81.7%	109.1%	103.2%	141.5%	90.9%	1	3	0	Additional hours for Winter pressures
Afton	117.3%	87.4%	100.0%	110.1%	89.1%	2	0	0	Additional 1:1's requried and booked via comissioners as per protocol, (495 hours)
Paediatric Ward	90.4%	88.4%	96.8%	100.0%	80.2%	0	0	0	
Maternity	94.8%	100.0%	108.4%	100.0%	81.4%	0	0	0	Movement of staff to cover patient need
Winter Ward	82.4%	92.6%	98.7%	95.2%					
Lucoombe	88.7%	79.0%	95.2%	95.2%	72.40%				Data anomaly for reporting HCA - corrected for Feb. No issues with HCA actual hours
		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 3 months data indicating where wards dropped below <80% for total day or night hours for that month. This is based n current ward establishment only. 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.

<80% fill rate identified for any shift or staff group

WARD	Oct-14	Nov-14	Dec-14	Jan-14	Additional percentage gap identified through Safer Staffing review (as per business case) 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					
Luccombe					20.90%

Comment on January 2015 data

- CCU/Step down currently have vacancies due to retirement and staff leaving. Staff are being moved around to cover shifts to ensure safety and KPI's indicate this is satisfactory for this month.
- Winter Ward area has been flexed from 0 beds to 27 beds during January and agency staff have been utilised to support this. Where possible permanent staff are moved from permanent wards to the temporary wards and agency staff are utilised to backfill permeate ward staffing.
- Whippingham, Colwell and MAU are noted as 3 red or amber indicators and this is raised with relevant teams for action
- Bank fill rate is below 80% which means a 20% gap on requirement based on current establishment. In addition there is the percentage gap identified form Acuity and dependency review and Safe Staffing requirements identified.

Mitigating actions

- Daily reporting tool is now 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
- The international recruitment yielded 32 staff which are being planned for now, and being allocated to ward areas.
- Winter Ward will now be open to 27 beds until April and planning for staff to be available to cover this rota is in progress
- Monthly staffing reviews are being set up to review areas current position
- Bank user group are working on solutions to improve nursing bank staff numbers
- Agency usage is authorised for staffing for Winter Ward and additional bed capacity currently required.

Recommendations on reporting

- Following review with the TDA it was recommended that the Safer Staffing report is a stand alone report, rather than incorporated into the performance report. The EDoN&W and DDoN are reviewing other organisations to consider which option to recommend .

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

Summary - RAG Rating based on Out-turn position

Isle of Wight NHS Trust

Summary

The Trust is reporting a £0.682m surplus in the year to January 2015, which is £1.410m less than the plan. The position includes forward banking of £0.7m, expected recovery of Referral To Treatment (RTT) costs of £0.405m, and £0.470m in respect of additional transition funding support.
This position is consistent with the revised forecast to achieve a £0.003m surplus position at year end.

Continuity of Service Rating — G

	Plan	Actual
Year to date	4	4

The Trust is currently reporting a Continuity of Service Rating (CoSR) of '4' which is consistent with the operational plan. Due to the pressures expected on the working capital balance at the end of the year the out-turn rating has reduced to 3 for the first time.

Surplus — R

	Plan	Actual / Forecast	Variance
Year to date £k	2,092	682	(1,410)
Year end forecast £k	1,702	3	(1,699)

The Trust planned for a surplus of £0.341m in January, after adjustments made for normalising items (these include the net costs associated with donated assets and impairments). The reported position is a deficit of £0.895m in the month, an adverse variance of £1.236m against plan.
The cumulative Trust plan was to deliver a surplus of £2.092m, after normalising items. The actual position is a cumulative surplus of £0.682m, an adverse variance of £1.410m. This position has £0.7m of forward banking recognised to the end of month 10.

This position is consistent with the revised forecast to achieve a £3k surplus at year end.

Income — G

	Plan	Actual / Forecast	Variance
Year to date £k	142,680	143,215	535
Year end forecast £k	170,682	171,774	1,091

The Trust planned income in January was £14.460m. The actual reported income is £14.279m in month, a negative variance of £0.181m.

The cumulative income plan is £142.680m. The actual position is a cumulative income of £143.215m, a positive variance of £0.535m.
This position includes an estimated reduction in income of £0.643m relating to CCG contract penalties and NHSE contract under performance, but does include expected additional transitional support from the CCG of £0.470m.

Operating Costs (including directorate income) — R

	Plan	Actual / Forecast	Variance
Year to date £k	(115,823)	(116,779)	(955)
Year end forecast £k	(139,320)	(138,711)	609

The Trust is reporting an overspend against an expenditure budget ytd of £955k. The forecast year end position is an overspend of £1.894m. Including additional forecast costs relating to the Public Dividend Capital Charge the adjusted overspend expenditure variance is £1.870m.
The year end net operating costs include £22.3m of directorate income (netting off risk share adjustment of £0.776m) excluding this income source the total costs amount to £162.6m. In addition to the operating costs, capital charges & finance costs amount to c.£9m.

CIP — R

The year end position for CIP is predicted to be an achievement of £7.2m against a target of £8.998m, ie a shortfall of £1.8m. Of this £3.0m has been achieved non recurrently. Including the full year effect of in year recurrent schemes of £0.6m, the carry forward CIP gap into 2015/16 is £4.2m.

Cash — G

	Plan	Actual / Forecast	Variance
Year to date £k	6,376	7,595	1,219
Year end forecast £k	5,407	5,990	583

The cash balance held at the end of January is considerably more than was planned and is due to:
i) the actual spend on capital being less than the planned spend in the first six months of the year
ii) the movement in working balances

Capital — G

	Plan	Actual / Forecast	Variance
Year to date £k	7,161	3,861	3,300
Year end forecast £k	8,318	7,816	502

The total Capital Resource for this year was originally approved at £8.3M. This included property sales of £0.648m, but these properties are now expected to be sold during 2015/16 which brings the forecast expenditure to £7.8M for 2014/15.

Indicators of Forward Financial Risk — G

	Plan	Forecast
Number of indicators breach	2	0
Number of indicators	11	11

Indicators breached are:
i) Unplanned decrease in EBITDA margin in two consecutive quarters
ii) Capital expenditure <75% of plan for the year

Month 10 - Risk Rating:

The Trust is currently reporting a Continuity of Service Rating (CoSR) of '4' which is consistent with the operational plan. Due to the pressures expected on the working capital balance at the end of the year the out-turn rating has reduced to 3 for the first time.

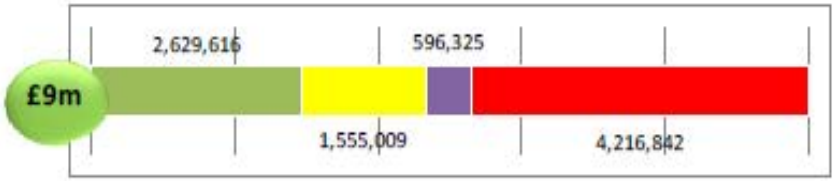
The reason for the reduction in the COSRR at year end relates to the worsening liquid position of the Trust. The predicted spend in forecast operating expenditure is predicted to be c.£5m higher than originally planned. This, in conjunction with working cash balances being less than planned because of increased creditors balances reduces the rating to 2.

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

Financial Criteria	Weight %		Metric to be scored	Definition	Rating categories 4	3	2	1
Liquidity Ratio	1	50%	Liquid Ratio (days)	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

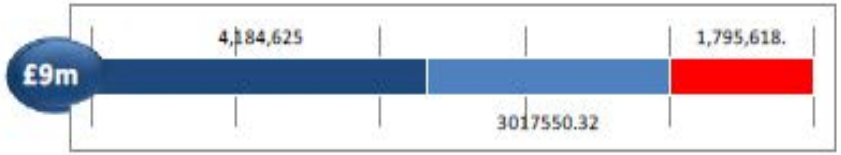
The year end position for CIP is predicted to be an achievement of £7.2m against a target of £8.998m, ie a shortfall of £1.8m. Of this £3.0m has been achieved non recurrently. Including the full year effect of in year recurrent schemes of £0.6m, the carry forward CIP gap into 2015/16 is £4.2m.

Recurring Forecast Outturn



	Current Position	Month 9 Close
Complies with all Audit Criteria and Finance Validated	2,629,616	2,646,616
Complies with some Audit Criteria and Finance Validated	1,555,009	1,540,062
Part year effect of Recurring Savings	596,325	583,550
Does not comply with any Audit Criteria and / or Finance not Validated	4,216,843	4,227,566

In Year Delivery



	Current Position	Month 9 Close
Recurring forecast outturn	4,184,626	4,186,679
Non Recurring forecast outturn	3,017,550	2,451,186
Gap remaining	1,795,618	2,359,929

Reconciliation of in-year gap to carry forward

	£
In year shortfall	1,795,618
Less Part Year Effect	-596,325
Add back non recurring	3,017,550
Carry Forward Gap	4,216,843

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Surplus

Isle of Wight NHS Trust

The Trust planned for a surplus of £0.341m in January, after adjustments made for normalising items (these include the net costs associated with donated assets and impairments). The reported position is a deficit of £0.895m in the month, an adverse variance of £1.236m against plan.
The cumulative Trust plan was to deliver a surplus of £2.092m, after normalising items. The actual position is a cumulative surplus of £0.682m, an adverse variance of £1.410m. This position has £0.7m of forward banking recognised to the end of month 10.

This position is consistent with the revised forecast to achieve a £3k surplus at year end.

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Surplus / (Deficit)	**2,092**	**682**	**(1,410)**

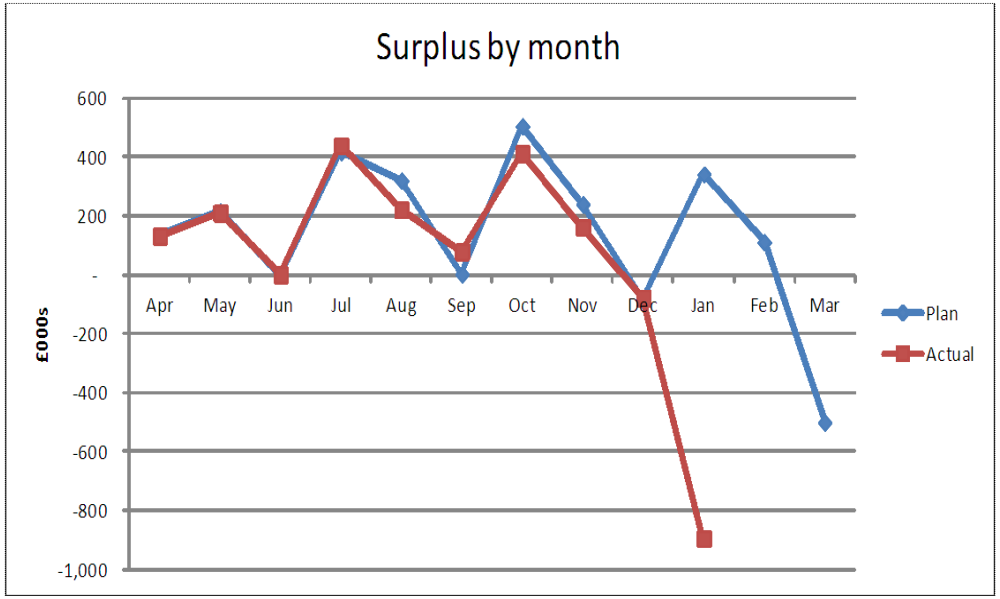
	Full Year		
	Plan £000s	Forecast £000s	Variance £000s
Surplus / (Deficit)	**1,702**	**3**	**(1,699)**

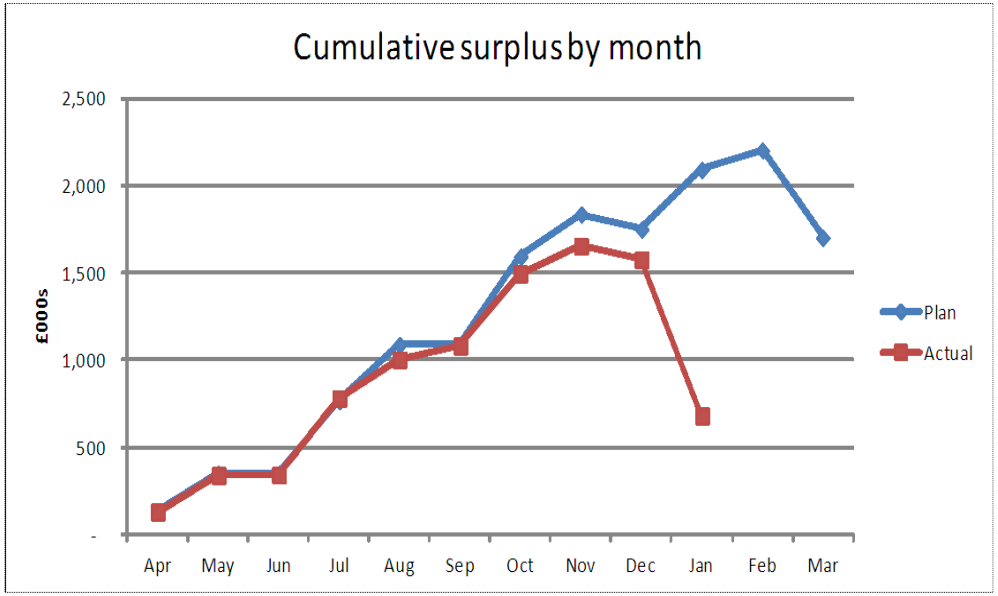
The Category A income position includes contract penalties and contractual under performance. The balance relates to contract variations that have yet to be agreed, but are offset by a corresponding balance in revenue reserves.

Operating costs include considerable over spends in Hospital & Ambulance directorate. These are offset by under utilised reserves and over achievement of CIP (including forward banking) in the corporate directorate.
During September an impairment was realised of c.£1.3m on assets subject to the District Valuers (DV) revaluation. A further £1.3m impairment has been recognised in January after some initial work by the DV prior to year end, bringing the total impairment year to date to £2.6m. These impairments have resulted in the planned retained surplus position having a negative variance of £2.6m. This is due to the impairment being recognised in advance of the planned budgeted impairment which was in March 2015. As reported last month the forecast position at the year end corrects this position & in fact the recent work by the DV indicates that impairments overall will be significantly less than anticipated due to the current upward trend in land & property values.
The adjusted reported performance for NHS monitoring purposes is not affected by this impairment charge as it is an adjusted item in that metric.

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Income	142,680	143,215	535
Pay	(97,806)	(97,999)	(193)
Non Pay	(35,180)	(36,949)	(1,769)
EBITDA	**9,694**	**8,267**	**(1,427)**
Depreciation & Amortisation	(4,824)	(4,818)	6
PDC	(2,749)	(2,749)	(0)
Impairment	0	(2,574)	(2,574)
Profit/Loss on Asset Disp	0	(15)	(15)
Interest Receivable	45	40	(5)
Interest Payable	(48)	(23)	25
Bank Charges	(14)	(6)	8
Foreign Currency Adjustments	(1)	(3)	(3)
RETAINED SURPLUS / (DEFICIT)	**2,103**	**(1,881)**	**(3,984)**
Receipt of Charitable Donations for Asset Acquisition	(83)	(83)	0
Impairment	0	2,574	2,574
Depreciation - Donated Assets	72	72	0
ADJUSTED RETAINED SURPLUS / (DEFICIT)	**2,092**	**682**	**(1,410)**

	Full Year		
	Plan £000s	Forecast £000s	Variance £000s
Income	170,682	171,774	1,091
Pay	(116,904)	(118,017)	(1,113)
Non Pay	(42,835)	(44,536)	(1,701)
EBITDA	**10,944**	**9,221**	**(1,723)**
Depreciation & Amortisation	(5,800)	(5,775)	25
PDC	(3,299)	(3,399)	(100)
Impairment	(5,347)	(2,953)	2,394
Profit/Loss on Asset Disp	(125)	(30)	95
Interest Receivable	54	49	(5)
Interest Payable	(48)	(26)	22
Bank Charges	(17)	(9)	8
Foreign Currency Adjustments	(1)	(3)	(3)
RETAINED SURPLUS / (DEFICIT)	**(3,639)**	**(2,925)**	**714**
Receipt of Charitable Donations for Asset Acquisition	(100)	(100)	0
Impairment	5,347	2,953	(2,394)
Depreciation - Donated Assets	94	75	(19)
ADJUSTED RETAINED SURPLUS / (DEFICIT)	**1,702**	**3**	**(1,699)**


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


Cumulative surplus by month
2,500
2,000
1,500
1,000
500
-
£000s
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan
Actual

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Income

The Trust planned income in January was £14.460m. The actual reported income is £14.279m in month, a negative variance of £0.181m.

The cumulative income plan is £142.680m. The actual position is a cumulative income of £143.215m, a positive variance of £0.535m.
This position includes an estimated reduction in income of £0.643m relating to CCG contract penalties and NHSE contract under performance, but does include expected additional transitional support from the CCG of £0.470m.

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Surplus / (Deficit)	**142,680**	**143,215**	**535**

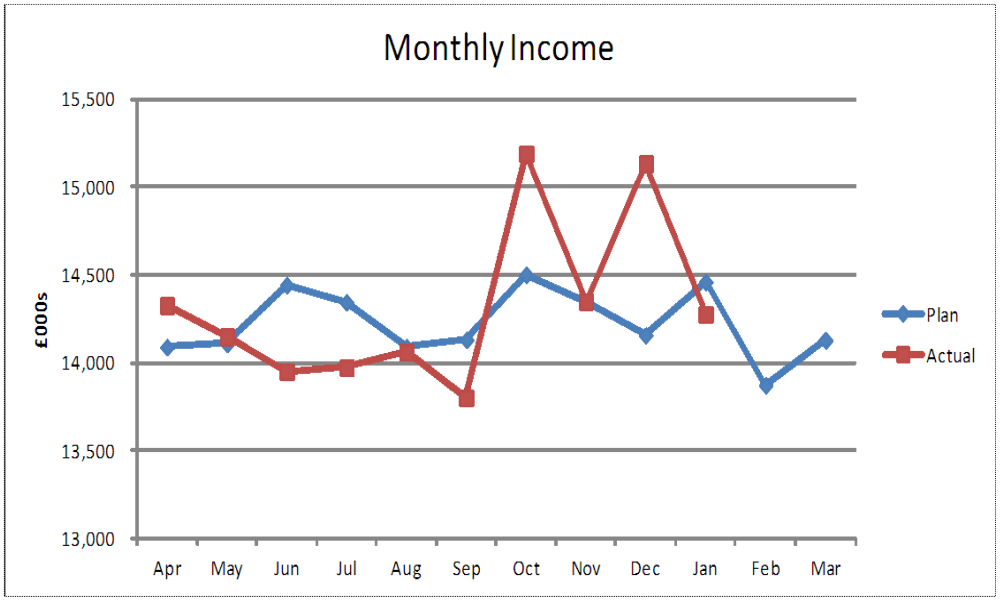
	Full Year		
	Plan £000s	Forecast £000s	Variance £000s
Surplus / (Deficit)	**170,682**	**171,774**	**1,091**

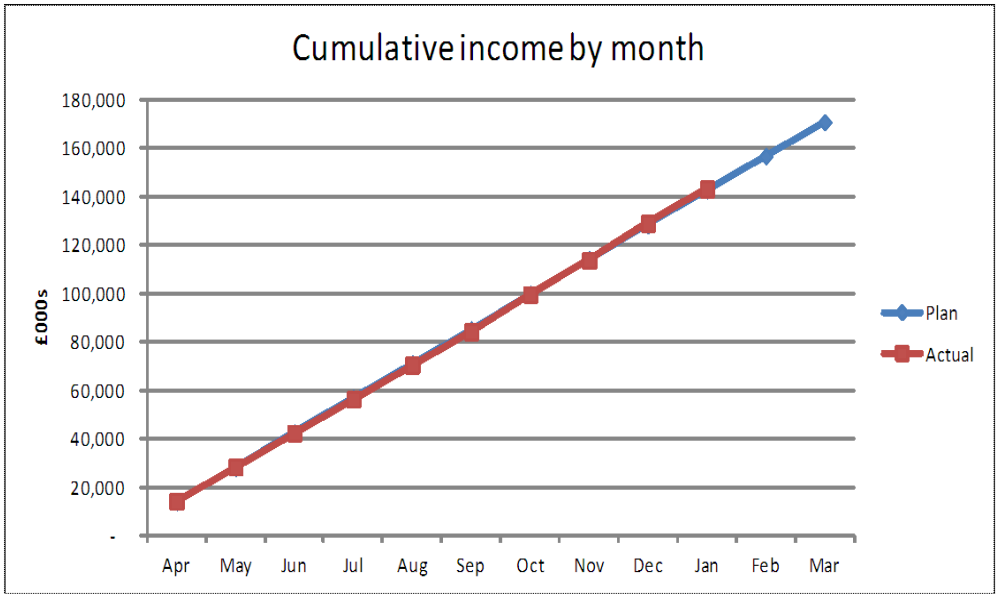
The NHS Isle of Wight CCG position to date includes £0.136m of contract penalties. The balance relates to contract variations that have yet to be agreed, but are offset by a corresponding balance in revenue reserves. CCG income has also been assumed for delivery of RTT targets (£0.405m), costs of redundancies already incurred (£0.155m), the cost of CQC QIP incurred to date (£0.177m) and a further £0.470m in respect of additional transition funding support.

NHS England variance relates to under performance against contract on breast screening services and neonatal critical care, and non-tariff drugs.

	Year to date		
Income	**Plan £000s**	**Actual £000s**	**Variance £000s**
NHS Isle of Wight CCG	112,759	113,164	405
NHS England	9,681	8,627	(1,054)
Isle of Wight Council	1,457	1,472	16
Commissioning Support Unit	296	296	(0)
Non Contractual Activity	1,250	1,398	148
Southampton University Hospitals FT	75	88	13
Income from Patient Care Activities	**125,517**	**125,046**	**(471)**
Other directorate income	17,163	18,169	1,006
TOTAL INCOME	**142,680**	**143,215**	**535**

	Full Year		
Income	**Plan £000s**	**Forecast £000s**	**Variance £000s**
NHS Isle of Wight CCG	134,985	135,705	720
NHS England	11,594	10,341	(1,252)
Isle of Wight Council	1,748	1,764	16
Commissioning Support Unit	355	355	0
Non Contractual Activity	1,500	1,523	23
Southampton University Hospitals FT	90	105	15
Income from Patient Care Activities	**150,272**	**149,794**	**(478)**
Other directorate income	20,410	21,980	1,570
TOTAL INCOME	**170,682**	**171,774**	**1,091**


Monthly Income
15,500
15,000
14,500
14,000
13,500
13,000
£000s
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan
Actual


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

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Directorate Performance

Isle of Wight NHS Trust

Hospital & Ambulance

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	7,489	7,473	(16)	380
Pay	(53,354)	(56,163)	(2,809)	(3,455)
Non Pay	(19,448)	(21,656)	(2,208)	(2,276)
TOTAL	**(65,313)**	**(70,346)**	**(5,033)**	**(5,351)**

The Hospital and Ambulance Directorate continues to report an overspend as at M10. The main pressures the Directorate faces include unachieved CIP and Vacancy Factor of £3.4m ytd plus Agency Staff covering Medical Vacancies (£1.2m adverse variance ytd). The Directorate has also incurred additional expenditure for RTT to reduce the >18 week waiting list.
The directorate is predicting a year end overspend of £6m, although this is reduced to £5.3m with additional spend reduction challenges and funding support.

Community Health

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	3,571	3,536	(35)	(143)
Pay	(27,079)	(27,110)	(31)	135
Non Pay	(3,616)	(4,085)	(469)	(448)
TOTAL	**(27,124)**	**(27,658)**	**(534)**	**(456)**

Community are cumulatively overspent by £534k, the directorate is carrying a vacancy factor of £320k to date. There are areas of concern due to high levels of expenditure - these are Orthotics & Prosthetics, Continence and Wheelchair. The Directorate is developing business cases to resolve the on-going pressure in these areas. The Directorate has recognised £120k due to the under-performance of the PDS contract (£75k in month).
The directorate is predicting a year end overspend of £679k although this has been reduced to £456k to recognise the directorates contribution to Trusts additional financial challenge.

Corporate - Research & Development

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	351	488	138	156
Pay	(345)	(429)	(84)	(100)
Non Pay	(9)	(61)	(52)	(55)
TOTAL	**(2)**	**(1)**	**1**	**0**

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

Corporate - Earl Mountbatten Hospice

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	1,683	2,146	463	462
Pay	(1,683)	(1,979)	(296)	(295)
Non Pay	(1)	(168)	(167)	(167)
TOTAL	**(1)**	**(1)**	**(0)**	**(0)**

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

Corporate - Finance & Performance Management

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	187	544	357	352
Pay	(2,187)	(1,958)	229	339
Non Pay	(2,853)	(614)	2,239	2,638
TOTAL	**(4,853)**	**(2,028)**	**2,825**	**3,329**

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

Corporate - Nursing & Workforce

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	501	477	(24)	(37)
Pay	(4,934)	(5,037)	(102)	(110)
Non Pay	(1,557)	(1,592)	(35)	(190)
TOTAL	**(5,990)**	**(6,152)**	**(162)**	**(337)**

The in month position for Nursing and workforce has been improved by £20k overall, mainly with the directorate delivering a balanced position whilst absorbing £27k CIP (non recurently). This has been achieved by transfer of costs to Winter Resiliance (18k) and Bank Nursing costs (£21k) to the appropriate cost centres, mainly in HAD. The yearend forecast overspend of £337k is mainly due to unachieved CIP of £227k (original N&W target), £101k (original COO target) and early overspends on Hotel services pay.

Corporate - Strategic & Commercial

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	3,247	4,136	889	669
Pay	(4,164)	(3,917)	247	221
Non Pay	(6,041)	(6,964)	(923)	(878)
TOTAL	**(6,959)**	**(6,745)**	**214**	**12**

The ytd variance of £214k relates partially to the £128k 'profit' element (income exceeding expenditure) of NHS Creative, who are forecasting to increase this to £185k by year end. The overall year end forecast has been reduced to £12k surplus due to the forecast cost of the KM&T project work.

Corporate - Trust Administration

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	135	146	12	12
Pay	(1,446)	(1,408)	39	32
Non Pay	(2,831)	(2,745)	87	73
TOTAL	**(4,143)**	**(4,006)**	**137**	**117**

Trust Administration is reporting a fairly balanced position both in month and year to date. As CIP was achieved earlier in the year and there is a slow trend to underspend, currently an overall surplus of £117k is being forecast for year end.

Reserves

	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s
Income	0	(776)	(776)	(931)
Pay	(2,613)	0	2,613	2,121
Non Pay	1,176	936	(240)	(398)
TOTAL	**(1,438)**	**160**	**1,598**	**791**

The variance to date on reserves includes £0.7m of forward banked CIP. The balance relates to commissioners contract variations and are offset by a corresponding balance in income.

The Trust is reporting an overspend against an expenditure budget ytd of £955k.
The forecast year end position is an overspend of £1.894m. Including additional forecast costs relating to the Public Dividend Capital Charge the adjusted overspend expenditure variance is £1.870m.
The year end net operating costs include £22.3m of directorate income (netting off risk share adjustment of £0.776m) excluding this income source the total costs amount to £162.6m. In addition to the operating costs, capital charges & finance costs amount to c.£9m.

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Cash

The cash balance held at the end of January is considerably more than was planned and is due to:
i) the actual spend on capital being less than the planned spend in the first six months of the year
ii) the movement in working balances

	Year to date		
	Plan £000s	Actual £000s	Variance £000s
Cash Balance	**6,376**	**7,595**	**1,219**

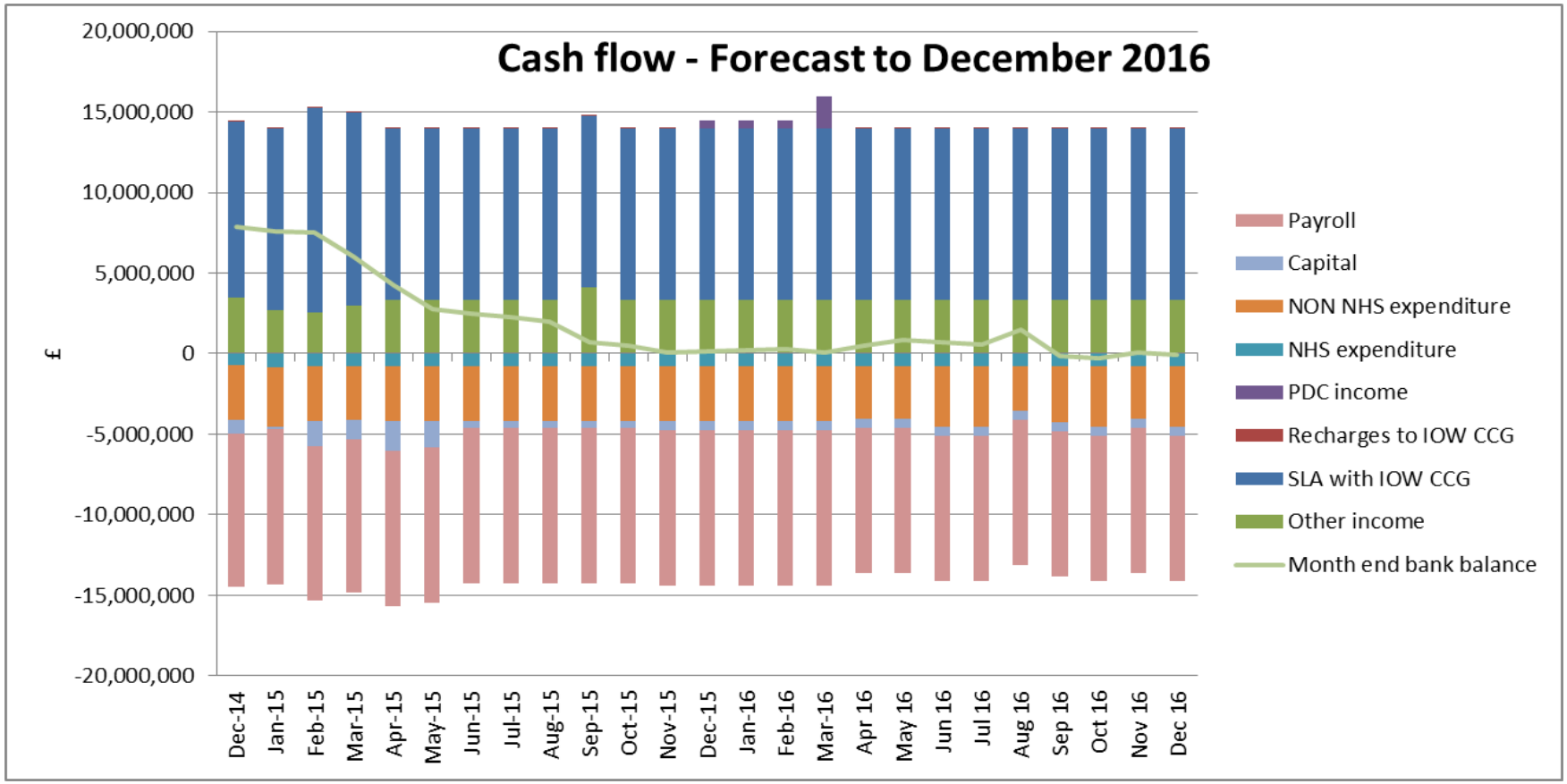
	Full Year		
	Plan £000s	Forecast Actual £000s	Variance £000s
Cash Balance	**5,407**	**5,990**	**583**

	Plan £000s	Year to date £000s	Variance £000s
Operating Surplus/(Deficit)	4,848	869	(3,979)
Depreciation and Amortisation	6,222	4,817	(1,405)
Impairments and Reversals	0	2,574	2,574
Gains /(Losses) on foreign exchange	0	(3)	(3)
Donated Assets - non-cash	(100)	(83)	17
Interest Paid	(6)	(23)	(17)
Dividend (Paid)/Refunded	(1,650)	(2,749)	(1,099)
Movement in Inventories	150	127	(23)
Movement in Receivables	0	(4,003)	(4,003)
Movement in Trade and Other Payables	(9,103)	(3,022)	6,081
Provisions Utilised	(250)	(226)	24
Movement in Non Cash Provisions	0	(182)	(182)
Cashflow from Operating Activities	**111**	**(1,904)**	**(2,015)**
Interest Received	20	40	(20)
Capital Expenditure - PPE	(6,772)	(3,534)	(3,238)
Capital Expenditure - Intangibles	(345)	(330)	(15)
Cashflow from Investing Activities	**(7,097)**	**(3,824)**	**(3,273)**
Cash Flows from Financing Activities	**(6,986)**	**(5,728)**	**(1,258)**
Capital Element of Finance Leases	(42)	(35)	(7)
Cashflow from Financing Activities	**(42)**	**(35)**	**(7)**
Net increase/decrease in cash	**(7,028)**	**(5,763)**	**(1,265)**
Opening Cash Balance	13,404	13,358	46
Restated Cash and Cash Equivalents (and Bank Overdra	13,404	13,358	46
Closing Cash Balance	**6,376**	**7,595**	**1,219**

	Plan £000s	Full Year £000s	Variance £000s
Operating Surplus/(Deficit)	(223)	484	707
Depreciation and Amortisation	7,460	5,776	(1,684)
Impairments and Reversals	5,347	2,953	(2,394)
Gains /(Losses) on foreign exchange	0	(3)	(3)
Donated Assets - non-cash	(100)	(100)	0
Interest Paid	(6)	(26)	(20)
Dividend (Paid)/Refunded	(3,299)	(3,399)	(100)
Movement in Inventories	250	472	222
Movement in Receivables	733	(1,022)	(1,755)
Movement in Trade and Other Payables	(9,387)	(2,351)	7,036
Provisions Utilised	(466)	(341)	125
Movement in Non Cash Provisions	30	(36)	(66)
Cashflow from Operating Activities	**339**	**2,407**	**2,068**
Interest Received	24	49	(25)
Capital Expenditure	(7,973)	(9,444)	1,471
Capital Expenditure - Intangibles	(345)	(345)	0
Cashflow from Investing Activities	**(8,294)**	**(9,740)**	**1,446**
Cash Flows from Financing Activities	**(7,955)**	**(7,333)**	**(622)**
Capital Element of Finance Leases	(42)	(35)	(6)
Cashflow from Financing Activities	**(42)**	**(35)**	**(6)**
Net increase/decrease in cash	**(7,997)**	**(7,368)**	**4,959**
Opening Cash Balance	13,404	13,358	(46)
Restated Cash and Cash Equivalents (and Bank Over	13,404	13,358	(46)
Closing Cash Balance	**5,407**	**5,990**	**583**

The cash balance held at the end of January amounted to £7.595m. This is £1.2m more than was planned and is largely attributable to actual spend on capital being less than the planned spend in the first six months of the year.

The forecast cash position is a favourable variance to plan of £0.6m. This takes into account the more likely movement in creditors and shows a forecast cash balance of c£6.0m.


Cash flow - Forecast to December 2016
£
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
Dec-14
Jan-15
Feb-15
Mar-15
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
Payroll
Capital
NON NHS expenditure
NHS expenditure
PDC income
Recharges to IOW CCG
SLA with IOW CCG
Other income
Month end bank balance

Isle of Wight NHS Trust Board Performance Report 2014/15

January 15

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 2014	Year to Date			
		Plan	Actual	Variance	Notes
	£k	£k	£k	£k	
Property, Plant and Equipment	97,613	93,967	96,052	2,085	
Intangible Assets	4,150	3,360	3,487	127	
Trade and Other Receivables	277	200	153	(47)	
Non Current Assets	**102,040**	**97,527**	**99,692**	**2,165**	
Inventories	2,200	1,828	2,073	245	
Trade and Other Receivables	6,930	8,177	11,057	2,880	
Cash and Cash Equivalents	13,358	6,376	7,595	1,219	
Sub Total Current Assets	22,488	16,381	20,725	4,344	
Current Assets	**22,488**	**16,381**	**20,725**	**4,344**	
Trade and Other Payables	(20,395)	(10,179)	(17,373)	(7,194)	
Provisions	(711)	(50)	(303)	(253)	
Liabilities arising from PFIs / Finance Leases	(48)	0	0	0	
Current Liabilities	**(21,154)**	**(10,229)**	**(17,676)**	**(7,447)**	
Provisions	0	0	0	0	
Non-Current Liabilities	**0**	**0**	**0**	**0**	
TOTAL ASSETS EMPLOYED	**103,374**	**103,679**	**102,741**	**(938)**	
FINANCED BY:					
Public Dividend Capital	6,762	6,762	6,762	0	
Retained Earnings Reserve	72,124	75,666	70,344	(5,322)	
Revaluation Reserve	24,488	21,251	25,635	4,384	
Other Reserves	0	0	0	0	
TOTAL TAXPAYERS EQUITY	**103,374**	**103,679**	**102,741**	**(938)**	

	Full Year			
	Plan	Actual	Variance	Notes
	£k	£k	£k	
Property, Plant and Equipment	88,794	99,296	10,502	
Intangible Assets	3,143	3,637	494	
Trade and Other Receivables	200	299	99	
Non Current Assets	**92,137**	**103,232**	**11,095**	
Inventories	1,728	1,728	0	
Trade and Other Receivables	8,177	7,930	(247)	
Cash and Cash Equivalents	5,407	5,990	583	
Sub Total Current Assets	15,312	15,648	336	
Current Assets	**15,312**	**15,648**	**336**	
Trade and Other Payables	(10,179)	(18,044)	(7,865)	
Provisions	(50)	(334)	(284)	
Liabilities arising from PFIs / Finance Leases	0	0	0	
Current Liabilities	**(10,229)**	**(18,378)**	**(8,149)**	
Provisions	0	0	0	
Non-Current Liabilities	0	0	0	
TOTAL ASSETS EMPLOYED	**97,220**	**100,502**	**3,282**	
FINANCED BY:				
Public Dividend Capital	6,762	6,762	0	
Retained Earnings Reserve	69,590	67,789	(1,801)	
Revaluation Reserve	20,868	25,951	5,083	
Other Reserves	0	0	0	
TOTAL TAXPAYERS EQUITY	**97,220**	**100,502**	**3,282**	

There has been little overall movement in working balances since last month with debtors, creditors and cash showing similar values to December.

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

Isle of Wight NHS Trust Board Performance Report 2014/15

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Capital

Isle of Wight NHS Trust

The total Capital Resource for this year was originally approved at £8.3M. This included property sales of £0.648m, but these properties are now expected to be sold during 2015/16 which brings the forecast expenditure to £7.8M for 2014/15.

Year to Date	Plan	Actual	Variance
	£k	£k	£k
Strategic Capital	5,902	3,147	2,755
Operational Capital	1,259	714	545
Total	7,161	3,861	3,300

Year End Forecast	Plan	Forecast	Variance
	£k	£k	£k
Strategic Capital	6,854	6,412	442
Operational Capital	1,464	1,404	60
Total	8,318	7,816	502

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

Operational Capital - Bids for IM&T RRP and Equipment RRP were brought to the Capital Investment Group in November. Bids for the replacement of the Ambulance CAD System and Telephony System Upgrade were approved.

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	3,782	3,782	0	6,854	6,854	0	
Donated Capital			0			0	
	3,782	3,782	0	6,854	6,854	0	
Application of Funds							
Strategic Capital Schemes							
MAU Extension	1,920	1,032	888	2,378	1,840	538	G
Ward Reconfiguration Level C	100	79	21	100	42	58	G
Ryde Community Clinic	1,203	737	466	1,203	1,280	(77)	G
Dementia Friendly		267	(267)		192	(192)	G
ISIS Further Faster	344	273	71	344	344	0	G
ICU/CCU	2,040	125	1,915	2,204	126	2,078	A
Endoscopy Relocation	295	340	(45)	625	2,197	(1,572)	G
St Helens Relocation		286	(286)		369	(369)	G
Carbon Energy Fund		8	(8)		22	(22)	G
	5,902	3,147	2,755	6,854	6,412	442	

Operational Capital	Full Year	Year to Date			Full Year			Risk
	Plan	Approved	Actual	Variance	Approved	Forecast	Variance	Rating
Source of Funds	£k	£k	£k	£k	£k	£k	£k	
Depreciation	7,460	6,217	6,217	0	7,460	7,460	0	
Property Sales	648	0	0	0	648	0	648	
Donated Funds	100	83	83	0	100	100	0	
Other	110	55	0	55	110	258	(148)	
Transfer to Strategic Capital	(6,854)	(3,782)	(3,782)	0	(6,854)	(6,854)	0	
	1,464	2,573	2,518	55	1,464	964	500	
Application of Funds								
Operational Schemes								
Estates Schemes	320	320	244	76	320	351	(31)	G
IM&T RRP	156	156	40	116	156	156	(0)	G
Equipment RRP	500	500	228	272	500	469	31	G
Staff Capitalisation	200	168	173	(5)	200	200	0	G
Contingency/Unallocated	188	115	0	115	188	0	188	G
Donated Assets	100	0	0	0	100	100	0	G
PARIS Implementation	0	0	30	(30)	0	128	(128)	G
	1,464	1,259	714	545	1,464	1,404	60	

NB - Please note the Year to Date and Full Year Plan figures are as per FIMS Return and not the revised 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 Q1 2014/15	Historic Data Q2 2014/15	Historic Data Q3 2014/15	Current Data Jan	Current Data Feb	Current Data Mar	Current Data Q4	Notes
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	Yes	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			No	
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		92%	1.0	Yes	No	Yes	Yes			Yes	
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	No	Yes	No	No			No	
	5	All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	1.0	No	No	No	Yes			Yes	
			NHS Cancer Screening Service referral	90%									
	6	All cancers: 31-day wait for second or subsequent treatment, comprising:	surgery	94%	1.0	Yes	No	Yes	Yes			Yes	
			anti-cancer drug treatments	98%									
			radiotherapy	94%									
	7	All cancers: 31-day wait from diagnosis to first treatment		96%	1.0	Yes	Yes	Yes	Yes			Yes	
	8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93%	1.0	No	No	No	Yes			Yes	
			For symptomatic breast patients (cancer not initially suspected)	93%									
	9	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within seven days of discharge	95%	1.0	no	Yes	Yes	Yes			Yes	
			Having formal review within 12 months	95%									
	10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	Yes	Yes	Yes	Yes			Yes	
	11	Meeting commitment to serve new psychosis cases by early intervention teams		95%	1.0	Yes	Yes	Yes	Yes			Yes	
	12	Category A call – emergency response within 8 minutes, comprising:	Red 1 calls	75%	1.0	Yes	No	Yes	Yes			Yes	
			Red 2 calls	75%	1.0	Yes	No	Yes	Yes			Yes	
	13	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	Yes	Yes	Yes	Yes			Yes	
Outcomes	14	Clostridium difficile – meeting the C. difficile objective	Is the Trust below the de minimus	12	1.0	Yes	Yes	Yes	Yes			Yes	
			Is the Trust below the YTD ceiling	3		No	No	No	No			No	
	16	Minimising mental health delayed transfers of care		≤7.5%	1.0	No	No	No	Yes			Yes	
	17	Mental health data completeness: identifiers		97%	1.0	Yes	Yes	Yes	Yes			Yes	
	18	Mental health data completeness: outcomes for patients on CPA		50%	1.0	Yes	Yes	Yes	No			No	
	19	Certification against compliance with requirements regarding access to health care for people with a learning disability		N/A	1.0	Yes	Yes	Yes	Yes			Yes	
	20	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes			Yes	
			Referral information	50%									
			Treatment activity information	50%									
		TOTAL				**6.0** R	**9.0** R	**6.0** R	**4.0** R	**0.0** G	**0.0** G	**4.0** 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

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th March 2015

Title	Hospital & Ambulance Directorate Update			
Sponsoring Executive Director	Alan Sheward - Executive Director of Nursing and Workforce			
Author(s)	Sabeena Allahdin - Interim Clinical Director Hospital and Ambulance Directorate & Consultant Obstetrician and Gynaecologist Donna Collins - Associate Director Hospital & Ambulance Directorate			
Purpose				
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:

Executive Summary:

The Hospital and Ambulance Directorate is currently experiencing a sustained period of high demand and consequent capacity constraints. Major issues and challenges outside of this pertain mainly to managing the impact of staff vacancies in hard to fill posts. The Directorate was pleased that Roy Lilley noted many examples of innovation and promoted the Island's model through his blog.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	All Trust goals					
Critical Success Factors *(see key)*	All success factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	Endoscopy facilities ref 428 Risk of not achieving the 4 hour target ref 513 Risk due to bed capacity problems ref 514					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements						

Date: 23rd February 2015 **Completed by:** Victoria Lauchlan Interim Project/Business Manager – Hospital and Ambulance Directorate

Hospital:

Service Delivery Update:

The Hospital Directorate has been operating in a period of sustained demand pressure for a number of months. These pressures became acute on Monday 16 February 2015 when a significant incident was declared due to the potential for six 12 hour DTA breaches, bed pressures, ambulance delays and community constraints. The incident was intensively managed with two hourly meetings led by the Senior Manager on Call/Executive Director on Call and a capital project was delayed so additional escalation beds could be opened. The impacts included eight cancelled operations and the use of agency nurses and medical locums.

Within Women and Child Health, the Health Visitor Team and School Nurses are now line managed by Sarah Butler with support from Annie Hunter. These should allow strong clinical alignment with the other paediatric services.

Also within Women and Child Health services, the antenatal clinic project review has been completed with changes to strengthen leadership and Maternity has established a new birth choice clinic and a vaginal birth after C-section (VBAC) clinic. Maternity are also reviewing the model for midwifery rotation with the staff leading on the next step in the initiative and peer supporters for breastfeeding mums have been identified and are going through the volunteer process.

Key Issues:

The bed pressures have been the most significant issue within the Directorate. This has impacted all areas and, as well as the obvious effects on wards and medics, support services are also working harder to manage the pressures. For example, the rapid movement of patients across wards is causing operational challenges for Pharmacy, including the transfer of medicines with patients, as well as the overall high level of activity.

Seasonal pressures are not the only driver of increased demand. The maternity scanning requirement requires review as a result of the increase in demand from the NICE guidance Gestation Related Optimal Weight (GROW) programme.

Successes:

Despite the heavy demand on Hospital Directorate services, the Directorate has celebrated a number of successes. The Trust Development Authority (TDA) have visited to review our cancer services and share advice and best practice for implementation. An internal waiting list management audit draft report has been received giving opinion of ‘substantial assurance’ provided.

Pharmacy continues to innovate and drive improvements in the patient pathway. They have succeeded in reducing some outpatient prescribing and moving the advice service back to GPs. They are supporting changes to the admission pathway by providing support to pre-assessment through provision of the admission prescription and the emergency admission pharmacist is also completing the admissions prescription, both changes releasing medical time. Finally, the dispensing cupboard (Omnicell) project is nearing completion and patients’ own drugs are being trialled in Poppy Unit.

In Women and Child Health, the new paediatric urgent care pathway through ED (ambulance admissions) has been implemented and there is now collaborative working between departments to ensure there is a paediatric appropriate environment and staff available 24/7. The Maternity Services Liaison Committee restarted on 23rd January with excellent user involvement.

In Pathology, we have received confirmation of Clinical Pathology Association (CPA) accreditation for Haematology and Chemistry, a significant success given the challenges in recruiting to the vacant consultant positions.

Challenges:

The primary challenge facing the Directorate, in addition to the operational pressures, is the TDA request of 27th Jan 2015, as part of a national initiative, to reduce the18wks backlog by end of February 2015. This necessitates additional activity in all areas including admitted, non admitted, and diagnostic patient care, as well as waiting list validation being undertaken.

In the media spotlight:

The Directorate was delighted that, following the Roy Lilley visit, he used his blog to highlight a number of aspects of the Hospital and Ambulance Directorate where we work innovatively (see Appendix 2 of the CEO report at Enc C). As well as a mention on the blog, Pharmacy now features on videos on the Omnicell and JAC websites illustrating our whole systems approach.

Ambulance:

Service Delivery Update:

The Ambulance service on the island continues to perform despite the unique challenges it faces on a daily, monthly, and yearly basis. As we are on an island, we have to innovate and improve our efficiencies to ensure we maximise our resources and staff on a regular basis. This requires significant planning to ensure the resources match demand.

It is also key to engage with our staff to ensure our workforce are trained and motivated to carry out the tasks of patient care. The service continues to work alongside stakeholders from within and outside the Trust and maintain links with our strategic blue light agencies. The Ambulance Service also delivers the 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 are extremely high

Key Issues:

The key issues facing the service is its ability to provide a high quality of care against a back drop of financial pressures upon the whole system and when the Trust experiences bed capacity issues which result in ambulance delays in the ED. The ambulance service continues to provide support across the directorate; it also leads the way through innovative workforce developments with its generic worker concept.

Successes:

The service continues to be one of the best performing services in the UK against its key performance indicators for both 111 and 999 delivery.

Another success this year has been the staff survey results which demonstrate the service on the island is the best in the country when benchmarked against its larger ambulance trusts on the mainland.

The service successfully led the development of the crisis response service through its integrated care hub and provided care at the point of delivery. This enables patients to stay in their home surroundings whilst being cared for by a multi disciplinary team for up to 72hrs.

Challenges:

The challenges this year have been centred around the financial efficiencies required to deliver the necessary cost improvements whilst maintaining a quality of service. A further challenge is the continued pressure from the whole system of ensuring the patient flow is maintained to enable the service to deliver the key performance indicators. This has bought about greater integrated working and the flexing of the workforce to enable all areas to perform using ambulance staff in key area to assist with patient safety.

In the media spotlight:

The service has continued to receive media attention through positive press and broadcast reports. The service continues to attract accolades from visitors to the UK and abroad and most recently saw the visit from Roy Lilley, the acclaimed commentator, who described the Hub to us as a "pot of Gold" that actually truly demonstrates integration across health and social care and works. We also hosted Channel Four who, again, visited us on the backdrop of negativity across the UK for NHS111 service but portrayed the Island as a success within the system that others could learn from.

Sabeena Allahdin - Interim Clinical Director Hospital and Ambulance Directorate & Consultant Obstetrician and Gynaecologist

Donna Collins - Associate Director Hospital & Ambulance Directorate

26th February 2015

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)
ON 4 MARCH 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**	P	**Approve**	
Previously considered by (state date):				
Trust Executive Committee		Mental Health Act Scrutiny Committee		
Audit and Corporate Risk Committee		Remuneration & Nominations Committee		
Charitable Funds Committee		Quality & Clinical Performance Committee		
Finance, Investment, 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 Community & Mental Health Directorate.				
Executive Summary:				
This monthly report is provided as a regular update to the Trust Board on: **Service Delivery Updates** – CMHS, Poppy Unit, ICES Demand & Capacity and SIRIs **Key Issues** – ICES Demand and Capacity, Psychology/Psychiatry Waiting List **Successes** – Poppy Unit, Sexual Health Service shortlisted for an award, Trust Awards **Challenges** – On going bed pressures, Pressure Injuries, Sickness Levels **In the media spotlight** – Directorate awards received at Trust Awards				
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: 20 February 2015	**Completed by:** Nikki Turner, Acting Associate Director Community & Mental Health Directorate			

Service Delivery Updates

The Community and Mental Health Directorate is made up of 50 diverse services spanning mental health, learning disability and community areas. Services are delivered via block, tariff and section 75 contracts. The Directorate delivers services that are broader than traditional Community and Mental Health Services.

The Community and Mental Health Directorate's vision is to provide health care at the heart of the community taking the Isle of Wight NHS Trust from a good health care system to a great integrated care provider. In five years this directorate will be a comprehensive community based integrated service, identifying individual's needs and supporting them as appropriate to optimise their health and wellbeing. This will be supported by maximising efficient use of available technology.

Community Mental Health Services (CMHS)

There continues to be an increase in referrals to the assessment and filtering team of the community mental health service. This continues to be supported by the use of agency staff with full time Band 6 Nursing posts due to commence in April 2015. A review of community mental health services is currently underway which is being funded by the CCG. Workshops for all stakeholders are currently taking place with a full report and recommendations to be presented at the end of April 2015.

Psychological Therapy waiting lists within CMHS have increased and a Business Case to increase the team's capacity was submitted to the Clinical Commissioning Group (CCG) they have requested further data in relation to this case prior to making any decisions.

Island Drug and Alcohol Service - IRIS

The Isle of Wight NHS Trust were recently successful in the tender for adult and young peoples' integrated and recovery services across the island. The new service commenced on 1st October 2015 bringing together the services Cranstoun, Isle of Wight Council and the Trust. The service will continue to offer assessment and recovery focussed treatment for people who misuse drugs and alcohol in addition to providing support for their families and carers. The official launch date for the service will be Tuesday 17th March 2015.

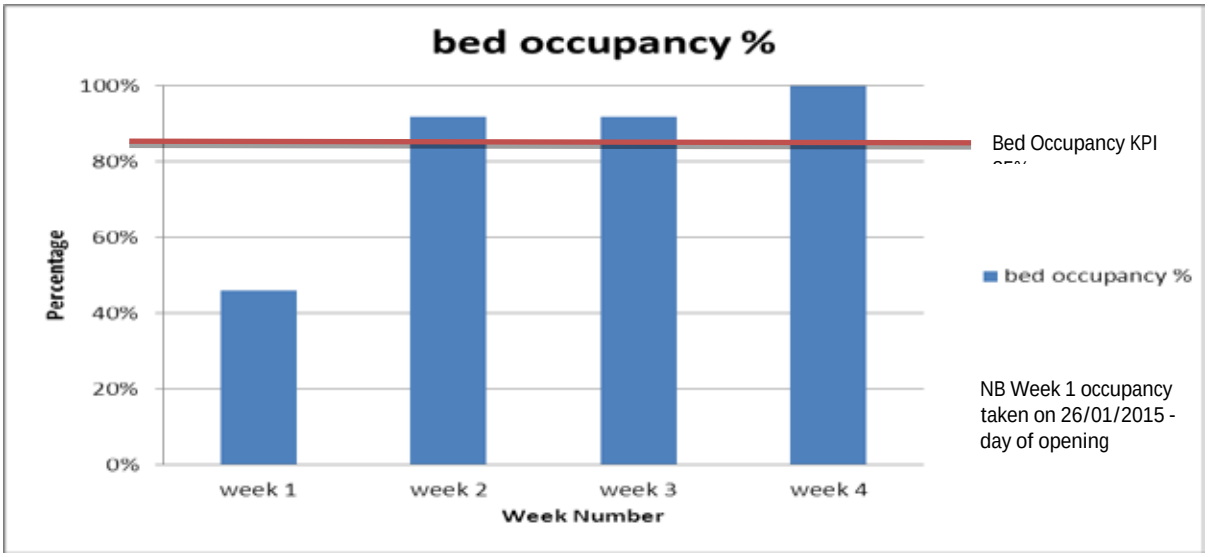
Poppy Unit

Poppy Unit, a 13 bed community unit, opened week commencing 26 January 2015 and is located at Solent Grange, a nursing home just outside Newport. The Unit, housed on one floor of Solent Grange, is managed and staffed by the NHS Trust and has a separate Care Quality Commission (CQC) registration from Solent Grange.

Poppy Unit is intended for patients who no longer need to be in an acute hospital bed and could be cared for in a more appropriate environment, moving to alternative accommodation to complete their inpatient stay. Whilst at the Unit the final co-ordination of their discharge

arrangements are made. For some the discharge may be to a nursing or residential care home.

To date bed occupancy at Poppy Unit has remained above its 85% key performance indicator. The chart below demonstrates the bed occupancy taken on the Monday of each week – therefore week 1 depicts the opening day of Poppy Unit. During week 1 bed occupancy rose from 46% to 85% with patients that met the criteria for transfer to Poppy Unit.



Of the 16 friends and family tests completed for Poppy Unit 94% of patients are likely or extremely likely to recommend Poppy Unit to friends and family.

To date free text comments include:

> 'I just hope the nursing home mum is going to will look after her as well as you all have.' - Relative
>
> 'Very impressed by the unit' - Patient
>
> 'Beautiful place would like to stay' - Patient
>
> 'Made to feel welcome and looked after' - Patient

<u>Demand and Capacity within the Integrated Community Equipment Service (ICES)</u>

ICES has grown from a small store for aids to daily living equipment to a service that provides all round assistive technology co-ordination and support. The service enables professionals like District Nurses, Physiotherapists and Occupational Therapists to help people to live as independently as possible and in some cases monitor their own health through tele-health technology. Demand has increased significantly year on year reaching unsustainable levels throughout 2014-2015 and forecasted to continue to increase. This increased demand is in line with national trends as ICES services are supporting more people with complex needs in the community and facilitating a faster turnover of patients through the hospital setting for discharge. The service supports around 1000 people with profiling beds at any one time and has a turnover of up to 10 beds a day. Additional staff have been put into place as a plan with the CCG and Local Authority is established in order to manage these pressures and ensure that equipment cleaning, statutory equipment testing

and deliveries are maintained. A Business case will be submitted to the Local Authority & Clinical Commissioning Group (CCG) partnership for long term investment. It is hoped that this would support the findings of the ICES review undertaken by the Local Authority.

Serious Incidents Requiring Investigation (SIRI's)

The Directorate has further streamlined its SIRI process to ensure that all incidents are reviewed with 48 hours. If deemed to be SIRI reportable, a Review Meeting is scheduled immediately and a Root Cause Analysis report completed. The Directorate continues to work very hard to improve its response to SIRI's within expected timescales. The backlog of overdue SIRIs is being prioritised. At the time of writing this report, the Directorate has 13 overdue SIRI's. 4 have been transferred to the CCG for final signoff, leaving 9 with the directorate.

Key Issues

- ICES Demand and Capacity – as above.
- Psychology/Psychiatry Waiting List – as above.
- Sexual Health Contract negotiations with Public Health England

Successes

- Opening of Poppy Unit – Solent Grange – as above.
- Integrated Sexual Health Service Shortlisted for the Annual National Sexual Health Awards for the In Reach Prison Service.
- Services recognised at Trust Awards – see media spotlight below.

Challenges

On-going Bed Pressures

Bed pressures within the Acute Wards are having an impact on all the services involved in supporting safe discharge and on-going rehabilitation. The Community Services have responded to support with ICES delivering 700 more pieces of equipment in January 2015 than in January 2014. Community Nursing continues to deploy all nursing staff to cover extra visits each day. Acute Allied Health Professionals (AHPs) Teams which include Occupational Therapy, Physiotherapy, Speech and Language Therapy and Dietetics are also working above capacity to support more discharges. They prioritise critical assessments daily to ensure the most urgent patients are seen.

Pressure Injuries

Pressure injuries within the Community, Residential Home and Nursing Home settings continue to be reported at a consistent level. Review meetings and Root Cause Analysis meetings in place as per the SIRI process. Residential/Nursing Home Managers/Matrons are invited to participate in these meetings to share lessons learned and best practice.

Sickness Levels

Sickness levels continue to be above the Trust's target of 3%. The Directorate Management Team is monitoring its sickness levels on a monthly basis and identifying those staff with high Bradford scores in order to manage and reduce sickness absence. Senior Management continues to set clear and high expectations to impact positively on this target.

In the media Spotlight

The Community and Mental Health Directorate was well represented at the KM&T Isle of Wight NHS Trust Awards. A full list of the awards made can be found in the Chief Executive Officers report at Enc C.

The opening of Poppy Unit drew considerable coverage both on it's opening and when the CQC announced it's inspection report for Solent Grange.

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

Mark Pugh, Executive Medical Director

20 February 2015

Enc G

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th March 2015

Title	Serious Incidents Requiring Investigation (SIRI) Report			
Sponsoring Executive Director	Alan Sheward, Executive Director of Nursing & Workforce			
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	
Finance, Investment & Workforce Committee		Foundation Trust Programme Board	
ICT & Integration Committee			
Please add any other committees below as needed			
Board Seminar			
Patient Safety, Experience & Clinical Effectiveness Committee (SEE)	18 February 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 19 Serious Incidents reported during January 2015, as well as identifying the lessons learnt from 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: 24 January 2015 **Completed by:** Deborah Matthews, Interim Lead for SEE

Isle of Wight NHS Trust

Serious Incident Requiring Investigation (SIRI) Activity Report
For The Patient Safety, Experience and Clinical Effectiveness Committee
(January 2015 data)

1. BACKGROUND:

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

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

2. NEW INCIDENTS REPORTED AS SIRIs:

During January 2015 the Trust reported **19** Serious Incidents to the Isle of Wight Clinical Commissioning Group (CCG). Below is a summary of these incidents:

- Grade 3 and 4 pressure ulcers (12):

Grade 4	**Grade 3**
Sandown District Nursing x 3	Alverstone ward x 1
Freshwater District Nursing x 2	Whippingham ward x 1
East Cowes District Nursing x 1	Medical Assessment & Admission Unit x 1
Colwell ward x 1	East Cowes District Nursing x 1
	Newport District Nursing x 1

- (Over) 52 week wait (2)

Responsible speciality	**Summary**
Administration (Hosp & Amb)	(x 3 patients) wait of over 52 weeks for procedure
Urology	(x 1 patient) waited over 52 weeks for procedure

- Slip, Trip, Fall (2)

Under whose care	**Summary**
Mental Health (Shackleton)	Un-witnessed patient fall resulting in fracture neck of femur
Stroke/Neuro Unit	Patient fall; subsequent x-ray revealed fractured neck of femur (patient already discharged home)

Continued ... 2/ SIRI activity report (January 2015 data)

· Safeguarding Children (1)

Under whose care	**Summary**
Mental Health	Multi-agency Serious Case Review

· Unexpected (Hospital) death (2)

Under whose care	**Summary**
Mental Health in-patient (Osborne)	Unexpected death of patient
	Unexpected death of patient
St Helens ward	

3. **CURRENT POSITION:**

This table provides the current status of open SIRIs as of 10.02.15

SIRIs	COMMUNITY & MENTAL HEALTH	HOSPITAL & AMBULANCE	OTHER CORPORATE AREAS	
OVERDUE CASES				
· *With Coroner*	0	0	0	
· *With Directorate*	7	8	0	
· *With Quality team*	0	0	0	
· *With Commissioner*	6	3	0	
· *Returned from Commissioner with further questions*	4	0	0	
TOTAL OVERDUE	**17**	**11**	**0**	
CURRENT CASES				
· *With Coroner*	0	0	0	
· *With Directorate*	15	11	0	
· *With Quality team*	1	0	0	
· *With Commissioner*	1	0	0	
· *Returned from Commissioner with further questions*	0	2	0	
TOTAL CURRENT	**17**	**13**	**0**	
TOTAL NUMBER OF OPEN CASES	**34**	**24**	**0**	**58**

4. CLOSED SIRI CASES

During January 2015, and at the time of reporting, the IW Clinical Commissioning Group had closed **9** SIRI cases. Listed below are the lessons learned from those closed SIRI cases**:**

Subject/Learning:
HEALTH ACQUIRED INFECTION - C diff infection
LESSONS LEARNED/including any remedial action:
Use of appropriate multiple antibiotics due to infection during admission. To have an early multidisciplinary review of patients when C diff identified; Ward sister and consultant to call a review with matron, infection control and microbiologist when infection identified
GRADE 3 PRESSURE ULCERS (x 5)
LESSONS LEARNED
1. Patient high risk on transfer; had known pressure ulcer and known to be nutritionally compromised. Based upon rapid deterioration of wound, possible further deterioration had already begun and continued whilst patient being transferred/discharged. In future, high risk patients will not be transferred to Discharge Lounge to await transport; high risk patients to be put on a positional regime to minimise risk of pressure injury and deterioration of same.
2. Patients should be given information about need to reposition as soon as risk was identified as this may have led to better patient involvement in care; staff have been reminded of this
3. All nurses are being competency trained/updated to ensure that nurses are aware of difference between a pressure ulcer and a moisture lesion and provide consistency in reporting.
4. To ensure pressure care leaflet is given to patients/carers and recorded appropriately, and ensure clear communication is relayed to patient/carer around risks; to be monitored via documentation audit.
5. Improve care planning through education /supported practice/clinical supervision. A caseload audit being undertaken to identify high risk patients and action senior nurse review
GRADE 4 PRESSURE ULCER (x 1)
LESSONS LEARNED
1. No documentary evidence to show that, on identifying a change in patient's pressure areas, the plan of care changed, therefore assumed that original plan of care was in place; changes being made to documentation - ward to trial paperwork for 1/12 and then to be taken to development day to share learning throughout organisation. Feedback on RCA meeting to also be shared at development day with colleagues. Outcome of SIRI and lessons learnt to be shared with ward staff.
UNEXPECTED DEATH of Community Patient
LESSONS LEARNED/including any remedial action:
Discharge planning and communication to include information on non NHS services available to support patients in the community; this action will form part of the CMHS (community mental health service) transformation project, supported by CCG.
DEATH IN CUSTODY (previous reporting)
SUMMARY: Serious Incident Investigation is routinely undertaken by the Prison and Probation Ombudsman (PPO); for all deaths in custody; a clinical review is also undertaken. (*At the time of this SIRI, IoW NHS Trust was commissioned by Isle of Wight PCT to provide prison healthcare. At this time Isle of Wight PCT was part of the Southampton, Hampshire, Isle of Wight and Portsmouth PCT Cluster, which was abolished 31 March 2013.*) LESSONS LEARNED/including any remedial action: No recommendations for the Trust (Thames Valley Area Team to share learning through the Health and Justice Quality Assurance Seminar Group).

Prepared by:
Deborah Matthews
Interim Lead for Patient Safety, Experience & Clinical Effectiveness (LSEE)
24 Feb 2015

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th MARCH 2015

Title	Quality Improvement Plan Update			
Sponsoring Executive Director	Alan Sheward Executive Director of Nursing and Workforce			
Author(s)	Alan Sheward – Executive Director of Nursing & Workforce			
Purpose	To give assurance to the Board of the developments and implementation of the Quality Improvement Plan			
Action required by the QCPC:	**Receive**	P	**Approve**	

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Nominations Committee (Shadow)	
Charitable Funds Committee		Remuneration Committee	
Finance, Investment, Information & Workforce Committee		Quality & Clinical Performance Committee	25/02/15
Foundation Trust Programme Board			
Please add any other committees below as needed			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

The attached report gives a high level summary of publication / events occurring JuneJuly / August 2014 in relation to the Quality Agenda; the report also identifies some forthcoming key events.

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	P Green
Legal implications, regulatory and consultation requirements			

Date 25 February 2015 **Completed by:** Alan Sheward – Executive Director of Nursing & Workforce

Quality Improvement Plan
Update to Board
Executive Director of Nursing & Workforce
February 2015

EXECUTIVE SUMMARY

The Isle of Wight NHS Trust has made good 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.

All actions termed enforcement are either complete or have moved to compliance actions. The Warning letter issues to the Trust following the CQC visit in June 2014 has now been lifted.

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.

There is a clear programme of delivery to ensure the remaining actions are completed. However, the Trust board recognised that sustained improvement is the true goal. The sustainable delivery of the actions will require a greater focus on Quality Improvement (QI) and the link to culture. The Executive Director of Nursing & Workforce has described an overarching approach to Quality Improvement, Quality Assurance and the Management of Risk, emphasising the need for a framework to deliver such improvements.

SITUATION

This paper is intended to update the Quality & Clinical Performance Committee (QCPC) and then the Trust Board on the progress of the Trusts Quality Improvement Plan (QIP).

BACKGROUND

The Quality Improvement Plan has been developed by clinical and corporate services following the Care Quality Commission (CQC) Chief Inspector of Hospitals (CIH) visit to the Trust in June 2014. The inspection lasted 5 days covering all areas of the Trust resulting in an overall rating of "Requires Improvement".

Following a detailed analysis of the 3 CQC reports covering Hospital & Ambulance, Mental Health and Community Services the Isle of Wight NHS Trust developed a Quality Improvement Plan consisting of action focused responses to the concerns raised. The original number of actions was approx 218 taking all of the actions from all three CQC reports. The actions were captured under the following headings that replicate the CQC hierarchy of actions.

1. Enforcement
2. Compliance
3. Must do's
4. Should do's

Duplications existed in the three reports resulting in the same actions being counted 3 times. Themes of duplication included Governance, Clinical Leadership, Staffing, Culture and Patient flow. Duplicate actions have been aggregated into a single action taking the overall actions to 102 broken down as follows;

1. Enforcement	13
2. Compliance	38 (13 are also Enforcement)
3. Must do's	10
4. Should do's	41
Total	**102**

The Quality Improvement Plan 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.

ENFORCEMENT ACTIONS (Warning Letter)

Included in the actions, outlined above, the Trust was issued with a Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the Quality of Service Provision. The notice detailed 26 actions that required immediate improvement (Enforcement). Compliance against the warning notice, required by 12th December 2014, was submitted on time. The Trust declared compliance against 23 of the 26 actions. Three actions where it felt further action was required have due dates in 2015 with a single action related to safer staffing due in March 2016. The CQC have subsequently removed the warning notice reassigning the 3 outstanding actions to compliance actions.

ASSESSMENT

The Trust has a Board approved Quality Improvement Plan. The 102 actions within the QIP are aligned to one of the Key Themes and Executive leads outlined in Table 1.

Theme	Lead
1. Clinical leadership, staff engagement and culture	Katie Gray
2. Governance	Mark Price
3. End of life care	Mark Pugh
4. Recruitment and retention	Alan Sheward
5. Patient caseload and flow	Alan Sheward

Table 1

Each action within the QIP has an outcome or success factor. There are also Key Performance Indicators associated to the aggregate themes outlined in **Appendix 1.**

There has been clear progress on the actions taken to respond to the immediate concerns and subsequent compliance actions which has supported the removal of the warning notice. However, the Trust is mindful that all actions are not complete in this respect with 3 key actions outstanding from the warning letter that has since been reassigned as compliance actions outlined in Table 2.

Action Number	Local Tracking Number	Area of action	Date when compliance is expected
4	EA1.3 (2)	Sepsis Six Implementation	28 February 2015
5	EA1.4	Number of bed moves & named consultant	Moved to compliance Due date March 2015
20	CA7.2	Insufficient numbers of nursing staff – leading to issues of inconsistent care.	31 March 2016

Table 2

QIP PRIORITIES

When deciding on the priorities associated with the QIP the Trust (with Partners and Stakeholders) has taken a risk approach recognising the improvements required for the quality of services for patients. The Trust also recognises the warning letter contains those actions that will have the biggest impact on the Quality of care for patients and staff whilst reducing overall risk.

The immediate focus of the plan includes;

- Identify and mitigate against immediate risks.
- Identify areas that have the largest impact on the quality of care delivered to patients.
- Recognise those actions that benefit staff in the delivery of care
- Identify areas of good practice and ensure shared learning

The Trust Priority 1 Focus has been on the Warning Notice (received 30th July 2014) following receipt of the overall CQC reports in September 2014 resulted in the Warning notice being removed in February 2015. The Trust has adopted a risk based approach to prioritising the actions required.

Update on Progress

	Actions	Total Number	Date for completion	Residual Actions to complete at 16th February 2015	% of Actions complete	Actual Date for Completion	Progress
Priority 1	Enforcement Actions	26(13 included in compliance)	12th December 2014	2	93%	11th February 2015	Complete
Priority 2	Compliance Actions	38	31 March 2015	6		31 March 2015	On target
Priority 3	Must Do Actions	10	26th June 2015	8		26th June 2015	On target

Priority 4	Should Do Actions	41	30th September 2015	14		30th September 2015	On target

GOVERNANCE & BOARD OVERSIGHT

The oversight and governance of arrangements to ensure improvements are being made are through the weekly Quality Improvement Plan assurance meeting. This is chaired by either the Lead Nurse or Associate Medical Director from the Patient Safety, Experience & Clinical Effectiveness team (SEE). The 4th meeting in each month preceding the Trust Development Authority (Integrated Delivery Meeting) is held with all stakeholders including;

1. Local Authority - Local Overview and Scrutiny Committee (Scrutiny Officer)
2. Head of Quality - Isle of Wight Clinical Commissioning Group
3. Local Education and Training Board member
4. Healthwatch

The 4th meeting is established as a "confirm and challenge" meeting. Partners and Stakeholders can confirm and challenge each other over progress being made against the individual stakeholder actions as outlined in the Quality Improvement Plan (QIP).

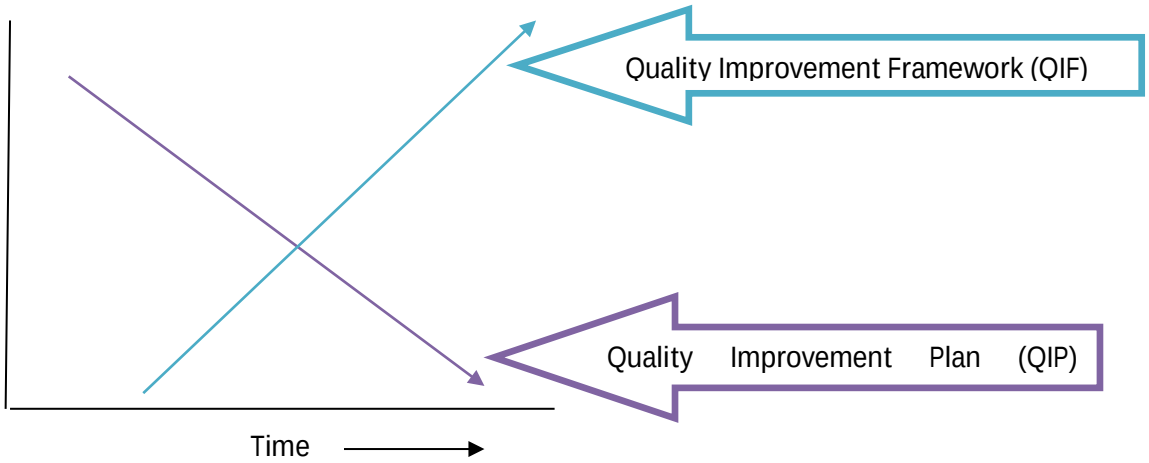
The QIP assurance meeting reports directly to the Trust Executive Committee (TEC) weekly. Assurance on the progress of the QIP is through the Quality & Clinical Performance Committee. Although the QCPC has received monthly updates since October 2014 on the QIP, there was not a detailed update at the Board meeting held on 28th Jan 2014. Given the focus on improvement required, it is right the QCPC receives a monthly update with an exception report going to the Monthly Trust Board. The structure for oversight and governance of the QIP is outlined with greater detail in the full QIP.

TIME SCALES

The timescales for the mitigating of the Quality Improvement Plan extend into September 2015. However, there are a number of longer term actions (Safer Staffing) that will extend into 2017. The Trust recognises the need for pace in the delivery of the actions whilst also recognising the change in culture to ensure the plans are sustainable and any future changes and risks are identified at the earliest opportunity.

SUSTAINABILITY & CULTURAL CHANGE

In February 2015 the Executive Director of Nursing & Workforce presented to the Trust Board seminar a presentation on sustainability, built on a Quality Improvement Model. This recognises the short term actions identified in the QIP. For true sustainability to be realised a longer term Quality Improvement is required. It is therefore suggested that the Trust adopts a Quality Improvement Framework (QIF) that builds on the Trusts Organisational Vision, Values and Goals.



The Quality Improvement Framework is based on the Institute for Health Improvement (IHI) principles of creating a High Reliability Culture across the Organisation. The Trust recognises the need to confirm its Strategic Direction and the need for a programme of sustained improvement which will focus on Quality Improvement, Quality Assurance, and the management of risk.

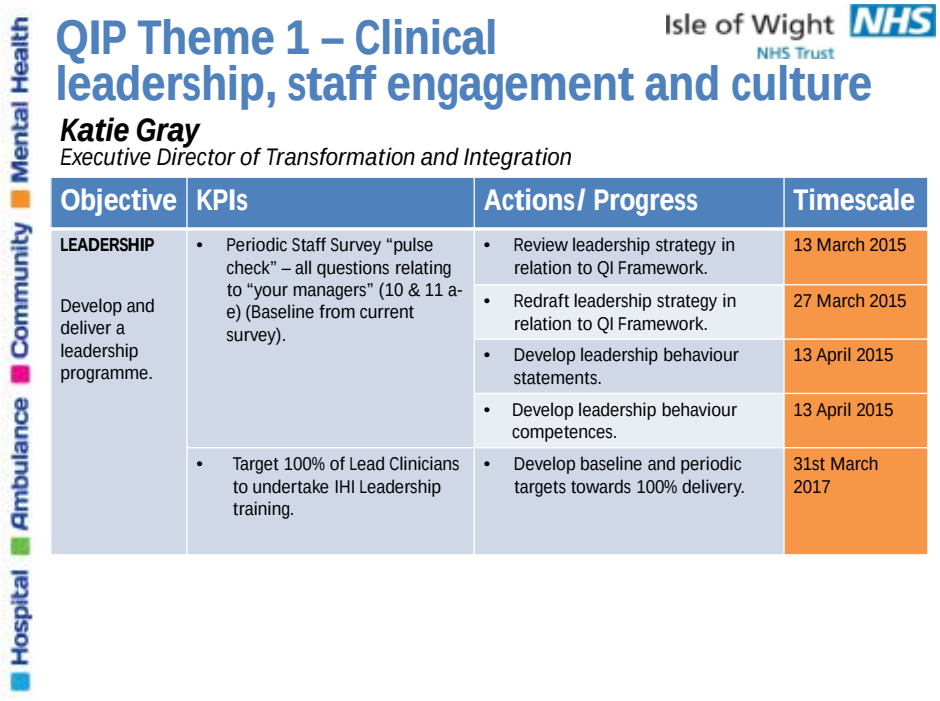
We are developing this framework (QIF) which is underpinned by organisational development. Early discussion is taking place with the Clinical Commissioning Group on making this a key feature of the 2015 – 2017 CQUINS programmes.

RECOMMENDATIONS

1. The Quality & Clinical Performance Committee receives this update on the progress of the Quality Improvement Plan
2. QCPC holds as a standing agenda the QIP and progress
3. QCPC supports the approach to prioritisation
4. QCPC Supports the development of a framework approach to Quality Improvement (QIF)

Alan Sheward
Executive Director of Nursing & Workforce.

Appendix 1. Themes of the QIP



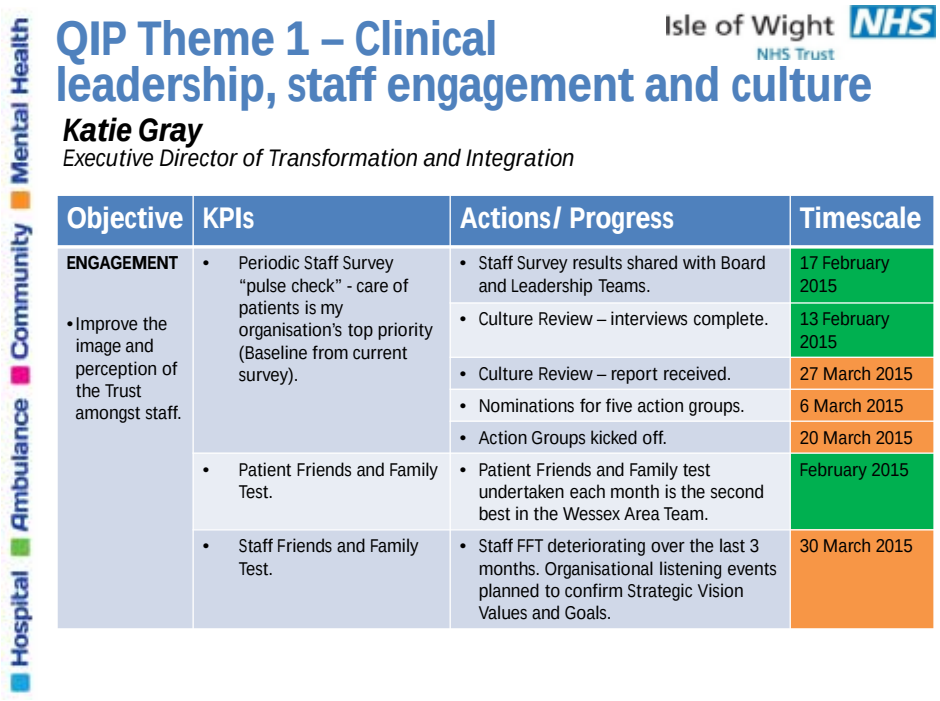
QIP Theme 1 – Clinical leadership, staff engagement and culture

Isle of Wight NHS Trust

Katie Gray

Executive Director of Transformation and Integration

Objective	KPIs	Actions/ Progress	Timescale
LEADERSHIP Develop and deliver a leadership programme.	• Periodic Staff Survey "pulse check" – all questions relating to "your managers" (10 & 11 a-e) (Baseline from current survey).	• Review leadership strategy in relation to QI Framework.	13 March 2015
		• Redraft leadership strategy in relation to QI Framework.	27 March 2015
		• Develop leadership behaviour statements.	13 April 2015
		• Develop leadership behaviour competences.	13 April 2015
	• Target 100% of Lead Clinicians to undertake IHI Leadership training.	• Develop baseline and periodic targets towards 100% delivery.	31st March 2017



QIP Theme 1 – Clinical leadership, staff engagement and culture

Isle of Wight NHS Trust

Katie Gray

Executive Director of Transformation and Integration

Objective	KPIs	Actions/ Progress	Timescale
ENGAGEMENT • Improve the image and perception of the Trust amongst staff.	• Periodic Staff Survey "pulse check" - care of patients is my organisation's top priority (Baseline from current survey).	• Staff Survey results shared with Board and Leadership Teams.	17 February 2015
		• Culture Review – interviews complete.	13 February 2015
		• Culture Review – report received.	27 March 2015
		• Nominations for five action groups.	6 March 2015
		• Action Groups kicked off.	20 March 2015
	• Patient Friends and Family Test.	• Patient Friends and Family test undertaken each month is the second best in the Wessex Area Team.	February 2015
	• Staff Friends and Family Test.	• Staff FFT deteriorating over the last 3 months. Organisational listening events planned to confirm Strategic Vision Values and Goals.	30 March 2015

QIP Theme 1 – Clinical leadership, staff engagement and culture

Isle of Wight NHS Trust

Katie Gray

Executive Director of Transformation and Integration

Objective	KPIs	Actions/ Progress	Timescale
CULTURE • Ensure staff understand their role and contribution to patient experience and outcomes.	• Periodic Staff Survey "pulse check" - I am able to do my job to a standard I am personally pleased with (Baseline from current survey).	• QIF – Incorporates 'People Development' element.	10 Feb 2015
	• Number of complaints moved to informal face to face meetings.	• Risk and Safety Table top reviews commenced.	September 2015
	• 100% staff undertake patient engagement training.	• Board approved patient engagement strategy.	April 2015
	• 100 % of Safety Reviews and Complaint meeting with Medical Lead (Consultant) presence.	• Risk policy being updated to include Responsible consultant presence.	September 2015

QIP Theme 2 – Governance

Isle of Wight NHS Trust

Mark Price

Company Secretary and FT Programme Director

Objective	KPIs	Actions/ Progress	Timescale
• Ensure there are clear/ robust governance processes within our wards, services, directorates and Boards. • Develop comprehensive governance around the Trust's performance against targets and goals. • Staff are being appropriately held to account around poor performance.	• Implement agreed recommendations from external governance review (October 2014).	• Implementation in progress. • Awaiting final copy of review. • Additional staff transferred to SEE team December 2014.	March 2015
	• Identify list of core services with governance related KPIs.	• Testing database.	September 2015
	• Assurance levels at Ward – Board Governance meetings through 3rd party assessment.	• TDA team visiting Trust and attending SEE Committee.	18 March 2015
	• New structures to be implemented.	• New Executive Structure approved. • Consulting on Directorate Structure.	31 March 2015
• Make sure that all our staff understand the term 'governance'.	• All staff to receive Governance training.	• Redefine all committees with governance through Corporate meeting structure.	March 2016

QIP Theme 3 – End of Life Care

Isle of Wight NHS Trust

Mark Pugh

Executive Medical Director

Objective	KPIs	Actions/ Progress	Timescale
• There is a clear, comprehensive strategy in place to support the delivery of end of life care. • Work with partners to ensure an island Wide approach to delivering end of life care. • Patients identified as being in the last days of life / on the AMBER Care Bundle are not moved between wards for non clinical reasons.	• Deliver 98% of patients requiring consideration for inclusion in the AMBER Care Bundle (ACB) within 24 hours of admission.	• ACB is in use on MAU, nurses to take ACB forward have been identified.	March 2015
	• Reduce beds moves of EOLC patients for non clinical reasons.	• Escalation Form now indicates ACB.	October 2014
	• Ensure the leadership of end of life care services is supported to improve service across the trust.	• Article placed in Staff News. • Hold Band 7 development.	November 2014
	• Develop and implement an End of Life Policy.	• Policy is being developed.	March 2015
	• Work with the CCG to develop an End of Life Strategy.	• Strategy Workshop held.	March 2015
	• Ensure that discussion with patients and relatives happens and is appropriately documented.	• Audit Tool developed • Care Plan developed and has been shared for feedback.	November 2014

Hospital Ambulance Community Mental Health

QIP Theme 3 – End of Life Care

Isle of Wight NHS Trust

Mark Pugh

Executive Medical Director

Objective	KPIs	Actions/ Progress	Timescale
• Reduce the number of deaths that occur in the hospital and work with local Primary Care Leads to improve the patient experience & decision making around their end of life care. • Increase the number of deaths that occur in patients own home, where this is appropriate.	• Staff are competent in how to recognise a patient is on an end of life journey, so that decisions are made and their care managed appropriately.	• End of Life Care education programme has been put in place to include a mandatory EOL Care module.	October 2014
	• Appropriate training is provided to ensure staff understand the tools available to them.	• End of Life Care education programme has been put in place and includes Syringe Driver training and Therapeutic Interventions training.	October 2014
	• DNA CPR orders are completed in their entirety, in a timely manner, and include clear documentation as to how this decision was reached.	• Audit undertaken on MAAU and Colwell Ward. • Re-audit planned for March.	March 2015
	• Use EOLC audit to confirm priority of care plan completion.	• Audit to be carried out in April 2015.	April 2015
	• Relative satisfaction survey.	• Survey to be undertaken in March 2015.	March 2015

Hospital Ambulance Community Mental Health

Mental Health Community Ambulance Hospital

QIP Theme 4 – Recruitment and Retention

Isle of Wight NHS Trust

Alan Sheward

Executive Director of Nursing & Workforce

Objective	KPIs	Actions/ Progress	Timescale
• Safer Nurse staffing principles will be fully implemented into inpatient wards by 31 March 2016	• Wards working to revised safer staffing numbers.	• Review of staffing levels, skill mix and caseloads has been undertaken. • Trust Board approved (in principle) Safer Staffing Business Case February 2015.	March 2016
• The % of vacancies in any clinical area will not be greater than 5%. • The use of locum medical staff will be significantly reduced.	• % of medical staff covered by locums will reduce.		
	• Overall bank and agency usage will be reduced.		
	• All clinical areas will report a vacancy factor of <5%		
• There is an overall increase in the number of Consultant Medical, Nursing, Midwifery & AHP posts.	• Overall substantive staff numbers will increase.		
	• Reduction in the turnover of senior clinicians.		
	• LiA temperature checks • Staff Friends and Family Test	• 2 LiA temperature checks have been completed.	March 2016

Mental Health Community Ambulance Hospital

QIP Theme 5 – Patient caseload and flow

Isle of Wight NHS Trust

Alan Sheward

Executive Director of Nursing & Workforce

Objective	KPIs	Actions/ Progress	Timescale
• Reduce timed delays to discharge for those requiring social care funded home packages of care or residential home placement.	• Reduce the run rate of patients who are subject to a delayed transfer.	• Dedicate an operational room for the central coordination of patient flow.	November 2014
	• The reasons for discharge delays for older adults with complex needs should be identified & procedures improved.	• Linking with the CCG and Local Authority commissioners discharge delays.	March 2015
• Clear referral & acceptance criteria in place for moves relating to clinical reasons.	• Audit the number of patients who are moved from non clinical reasons.	• Monthly audit of patient moves are carried out.	January 2015
	• Implement clear referral criteria.	• Transfer of care document.	December 2014
• Implementation of an escalation process when patients are changed to a 3rd consultant during a single admission.	• Establish a baseline and reduce by % the number of patients who are moved more than 3 times.	• PIDs running data on the number of patients who undergo more than 2 moves. This will be used by bed management team to prioritise the best patient to move.	March 2015

Enc H3

CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171
www.cqc.org.uk

Karen Baker
Chief Executive Officer
Isle of Wight NHS Trust
St Mary's Hospital
Parkhurst Road
Newport, Isle of Wight
PO305TG

6 February 2015

Your account number: R1F
Inspection ID SPL1-1303004550

Care Quality Commission
Health and Social Care Act 2008

Trust name: Isle of Wight NHS Trust
Provider ID: R1F

Dear Karen,

Please find detailed below our formal response to the specific elements of your submission of compliance relating to the warning notice that was served under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 201) specifically regulation **10 (1)(a)(b) (2 (b)(iv) (c) (i) (ii) (d) (i) and (e).**

We have reviewed documentation you have submitted in response to the warning notice and met with your senior governance team on 16 January 2015, to discuss this submission. We have noted your declaration of compliance with the regulation, with the two exceptions of actions EA 1.3(2) Sepsis Six Implementation, and CA7.2 Insufficient numbers of nursing staff-leading to issues of inconsistent care.

I enclose a table outlining our review of the evidence you have submitted in terms of compliance with the regulation.

The outcome of our review is to confirm that you have demonstrated compliance with the warning notice and this notice is now lifted. Our website will be changed accordingly and reference to the warning notice will be removed. There will, however, be a compliance action under Regulation 10 for the two areas where you have declared non-compliance. Your staff clearly demonstrated where the work has

begun on these areas and we will use the dates of compliance that you have identified in your current action plan.

Mr Alan Sheward shared with us the disappointment and dismay felt by many staff in response to the trust inspection report. He eloquently made the point that it is not just their hospital, but also the community in which they live. May I take this opportunity to thank you and your team for the positive and productive meeting we had. As a trust, your staff have demonstrated commitment and hard work to improve patient care and patient's experiences of care.

We will continue to liaise through quarterly engagement meetings. Your inspector is Yasin Rahim (Yasin.Rahim@cqc.org.uk) and he and I will attend these meetings. Many trusts also provide us with a regular email update (weekly or monthly) in between these meetings to keep us abreast of issues, such as hospital successes as well as matters of regulation and governance. This ongoing dialogue and liaison is helpful.

Please contact me if you any queries or if I can assist you further.

Kind Regards

Moira Black
Inspection Manager (Hampshire)
Moira.Black@cqc.org.uk
Mobile: 07789 875 243

Cc :

Edward Baker: Deputy Chief Inspector, CQC
Joyce Frederick, Head of Hospital Inspection, CQC
John.Scott@cqc.org.uk
Alan.Sheward@iow.nhs.uk
Deborah Matthews@iow.nhs.uk
TDA: Penny.Emerit@nhs.net
TDA: Julie.Blumgart@nhs.net
Sarah.Hughes15@nhs.net

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4 MARCH 2015

Title	Board Walkabouts & Patient Story Action Trackers			
Sponsoring Executive Director	Alan Sheward, Executive Director of Nursing and Workforce			
Author(s)	Vanessa Flower – Patient Experience Lead			
Purpose	To provide assurance to the board that actions are taken following feedback received from patient stories, and ward / department visits undertaken by the Board.			
Action required by the Board:	**Receive**	**P**	**Approve**	

Previously considered by (state date):			
Trust Executive Committee	19.1.14	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			

Staff, stakeholder, patient and public engagement:

Staff are involved in the visits undertaken by the Board members, and patient and staff participate in the patient stories, both in supporting the recording, and by ensuring action is taken from this valuable feedback.

Executive Summary:

Patient Stories:

Since the commencement of the programme we have recorded a total of 34 stories, of these 12 videos have been shown at the Quality and Clinical Performance Committee, the Committee have also had stories verbally using formal complaints received in the Trust.

All of the stories captured to date have resulted in 46 actions which have been monitored and reviewed by Trust Board through to completion. At the time of reporting there is one outstanding action that remains in progress.

The outstanding action relates to a story of 29 October 2014 from patient in Sevenacres, who identified that it was perceived that reduced staffing was not allowing for appropriate time to provide access to outdoor spaces when on Seagrove Ward, this action is being reviewed with the Matron for the service, in conjunction with the Deputy Director of Nursing.

Board Assurance Visits:

Attached is the current summary exception report following board visits undertaken and reported back to the corporate team.

Of the 77 visits to date the majority have been to clinical setting with 16 to non-clinical areas, to date a total of 215 actions have been identified

At the time of writing 10 remain overdue against original timescale set, all of which are green against the directorate's revised timescale.

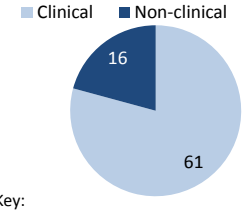
There are currently 11 feedback sheets yet to be received by the corporate team that have taken place since the beginning of April 2014.

.						
For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	Quality Goal					
Critical Success Factors *(see key)*	CSF1, CSF2, and CSF10					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	10.75					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	P
Legal implications, regulatory and consultation requirements						
Date: 25.02.15	**Completed by:** Vanessa Flower – Patient Experience Lead					

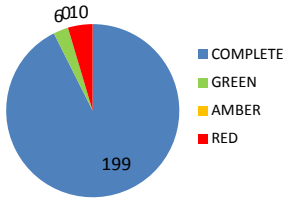
Board Walk Rounds Action Plan Status Report

Trust Overview

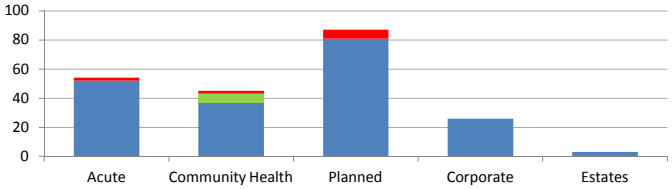
Areas visited



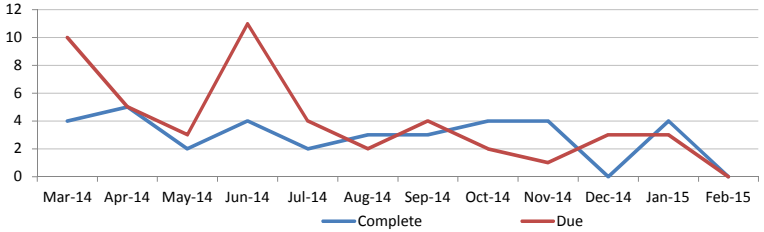
Status of actions



Directorate Profiles



12 month profile from: Mar-14 to Feb-15



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

Exception Report

No.	Action Reference	Walk Round	Area Visited	Action	Date for completion set by board	Directorate revised date	Status against date set by board	Progress against directorate revised date	Status Comments	Directorate	Responsible
1	AT/037/2013/006	13-Sep-13	Pathology	Strong support for pathology paperless reporting. Develop plan for the implementation	15-Nov-13	31-Oct-15	RED	GREEN	19.01.15 - There is a schedule for roll out of functionality, but not the turning off of paper as yet. There have been some issues with the confidence of the data coming from the Telepath system consistently into ISIS and Barabara has been seeking a cost from the supplier to put in a validation report that someone can run on a daily basis to make sure everything that is leaving TPath arrives in ISIS. Once we are happy with this, we can progress with the plan to turn paper off in areas as a phased approach as agreed by Mark Pugh. 18.02.15 - Updates requested. No response from team Update 24/2/15 Lack of system manager within Pathology has led to a lack of assurance that all data is correct, therefore can't turn off paper until validation reports have been established. This will be completed as soon as possible but financial constraints mean it may not be in this financial year. Survey conducted amongst clinical areas as to whether paper could be turned off in advance. Although there is a desire to move this forward, until there is a system manager in place it is not likely that this will be achieved.	Acute	Liz Thorne
2	AT/07/2014/005	25-Apr-14	DSU	Pursue improved patient information leaflets	30-Jun-14	30-Mar-15	RED	GREEN	Update 03/02/15 Paul will follow this up, should still be on Track but will need to check current status. 24.02.15 - this has been delayed due to other work priorities but does remain in progress and is hoped to be completed soon. In the mean time directorate quality manager has been linking with Patient Experience Lead to develop and agree a new leaflet approval process which will speed up the process once leaflets have been finalised.	Planned	Paul Sanders , Theatres
3	AT/07/2014/004	25-Apr-14	DSU	Check requirements for kitchen area to improve IPC environmental audit	30-Jun-14	30-Mar-15	RED	GREEN	Update 03/02/15 Work has not yet started yet - unable to pin point a weekend when work can be done. 18.02.15 - Updates requested. PS away. General Managers unable to answer 24.02.15 - outstanding Estates issues have been combined and sent as a directorate to Estates for an update on time scales.	Planned	Paul Sanders , Theatres

No.	Action Reference	Walk Round	Area Visited	Action	Date for completion set by board	Directorate revised date	Status against date set by board	Progress against directorate revised date	Status Comments	Directorate	Responsible
4	AT/10/2014/003	20-Jun-14	Maxillofacial unit	Review admin processes using LEAN/Productive model as highlighted in last walkabout	30-Sep-14	31-Mar-15	RED	GREEN	19.01.15 - owing to operational pressures this has not progressed as far as we would have liked as yet. It remains a focus that Kathryn will be taking forward with PGO support as soon as possible, and still aim to be completed by the end of February 2015 18.02.15 - Updates received via Alison Price. Advised that the Lean process has started with regards to treatment cards but further changes will still need to be made. Due to continuing operational pressures these have not been started yet. Stephen Wheeler has agreed to support but doesn't have capacity at the moment	Planned	Kathryn Taylor, AGM
5	AT/10/2014/002	20-Jun-14	Maxillofacial unit	Explore potential for income generation around technical production (linked with above)	30-Sep-14	31-Mar-15	RED	GREEN	19.01.15 - The situation remains the same, that we are still awaiting the decision around the contract that is expected 15/02/15 before we can progress this action 18.02.15 - Updates received from Alison Price. Contract meeting is due to take place with NHS England week beginning 23 February. Once that has taken place further decisions can be made.	Planned	Kathryn Taylor, AGM
6	AT/10/2014/001	20-Jun-14	Maxillofacial unit	Areas to be reviewed – succession planning around the technician role	30-Sep-14	31-Mar-15	RED	GREEN	19.01.15 - The situation remains the same, that we are still awaiting the decision around the contract that is expected 15/02/15 before we can progress this action 18.02.15 - Update received from Alison Price. Contract meeting is due to take place with NHS England week beginning 23 February. Once that has taken place further decisions can be made.	Planned	Kathryn Taylor, AGM
7	AT/49/2013/001	27-Nov-13	Osborne Ward	Discuss Paris – utility needs reviewing and sorting	31-Oct-14	30-Apr-15	RED	GREEN	Update 11.02.15 - Meeting has been held with Consultant Psychiatrists to review the quality of the Core Assessments on Paris and how to improve them. Currently awaiting the implementation of Version 5.1 of Paris. Service Leads are considering moving the Care Plan and Risk Management Plan back to paper versions to manage the risks until the upgrade of Paris.	Community Health	Acting Head of MH, LD and Community Patnerships
8	AT/15/2014/002	22-Oct-14	St Helens	No photos in place in the boards in the corridor leading to the ward	31-Dec-14	30-Apr-15	RED	GREEN	Update 13/02/2015 - Board will be moved when Winter Ward closes. Photos have been taken and are currently with Print Room being printed 24.02.15 - Winter ward now staying open until 13th April 2015 which will delay the removal of the board	Planned	Patient Experience Lead

No.	Action Reference	Walk Round	Area Visited	Action	Date for completion set by board	Directorate revised date	Status against date set by board	Progress against directorate revised date	Status Comments	Directorate	Responsible
9	AT/12/2014/001	05-Sep-14	North Block therapies	Review how IT systems can improve productivity of the function of the North Block Therapies service	31-Dec-14	30-Apr-15	RED	GREEN	Update 12.02.2015: IT systems have been reviewed by this team and utilised innovations led by SLT and Katie Grey. Duplication has be reduced within the teams own reviews and future work from other services (eg; ICES new electronic ordering system, further ISIS utilisation) will impact and further increase efficiencies by reducing duplications.	Community Health	Clinical Lead for Inpatient Occupational Therapy
10	AT/11/2014/003	25-Jul-14	MAAU	Explore items which could be purchased to take advantage of Charitable Funds	31-Dec-14	30-Sep-15	RED	GREEN	19.01.15 - As previous update this will be further investigated once MAU return to the original template 18.02.15 - Updates requested. No response from team about use of Charitable Funds 23/2/15 Linda Fishburn advised that as per previous update, further investigations will be made once MAU returns to its original template which is in August 2015.	Acute	Ward Sister/ Modern Matron

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th March 2015

Title	Research & Development 6 Monthly report			
Sponsoring Executive Director	Executive Medical Director			
Author(s)	Lead Research & Development Officer			
Purpose	To inform the Board on research activities within 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			
Other (please state)			

Staff, stakeholder, patient and public engagement:

Executive Summary:

The report gives an overview of research activity during the year to January 2015, including the number and range of new studies approved, the number of staff who participated in portfolio research and the number of patients recruited during the year.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Quality					
Critical Success Factors *(see key)*	**CSF2** - Improve clinical effectiveness, safety and outcomes for our patients **CSF5** - Demonstrate robust linkages with our NHS partners, the local authority, the third sector and commercial entities for the clear benefit of our patients					
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: 19th January 2015 **Completed by:** Alex Punter, Lead Research & Development Officer

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD – JANUARY 2015

MID-YEAR RESEARCH REPORT – 2014/15

Our participation in clinical research projects continues, with **17 new** studies approved year to date (*Appendix A refers*) and our annual funding allocation from the Local Clinical Research Network: Wessex has been utilised to maintain our infrastructure to support clinical research *(Appendix B refers)*.

As at 12 January 2015, **740** participants have been recruited to twenty-six portfolio studies, against an annual target of 840, across the clinical specialties of dementias and neuro-degeneration, cancer, metabolic and endocrine disorders, mental health, diabetes, musculoskeletal, children, stroke, respiratory, health services research, anaesthesia/critical care, ophthalmology, haematology and cardiovascular.

The initial investment from the **Dementia & Neurodegenerative Diseases Research** Network (DeNDRoN) in a part-time research nurse at the end of 2013/14 and our own investment in Dr Sharif with continuing support for the Research Nurse has materialised in the opening of 2 studies (Londowns Cohort and IDEAL[1]) with recruitment into both.

The capital investments at Residential Care Homes, Nursing Homes, Hospital General Medical Wards and Specialist Dementia Inpatient Unit across the Island received as part of the **DOH Dementia Friendly Environments Funding** Award in July 2013, has led to 7 Care Homes signing up to the ENRICH ((Enabling Research in Care Homes) project developed by the National Institute of Health Research (NIHR).

Mr Basavaraj, one of our **ENT[2] Surgeons** is about to open the first ENT study (OSTRICH[3]) and **Dr Debreceni, Consultant Anaesthetist**, was Local Collaborator for the SNAP survey looking at patient reported outcomes after anaesthesia and will be for the POPULAR[4] study, looking at post-anaesthesia pulmonary complications after use of muscle relaxants, due to take place in February.

Sanjay Ramdany has been awarded a **NIHR fully funded scholarship** to study an MSc in Research - the first nurse on the island to be awarded this highly competitive scholarship and Gary Whitwam, Nurse Specialist for OHPiT[5] Infusion Clinic, is being supported to undertake a PhD under the **Wessex Clinical Academic Scheme.**

The David Hide Asthma & Allergy Research Centre has continued recruitment into the 3rd Generation Study and also recruited MAPS/ITEC children at 3 years for follow-up and to the Asthma UK adolescent asthma study. Their collaboration with the University of Manchester continues with the provision of data from our IOW cohort for a 4 year project entitled "STELAR" (Asthma e-lab and identification of novel endotypes of childhood asthma).

Finance

Local Clinical Research Network, Wessex 2014/15 Funding
A central annual allocation of **£371,781** (a reduction of 8% on last year's actual spend and the second successive annual reduction for our organization), together with **£10,000** Contingency Funding was made available to the Trust to provide NHS infrastructure support to studies within the National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio. This funding covers clinician sessions, research nurses and associated staff, NHS service support (pathology, radiology & pharmacy)

[1] **I**mproving the experience of **d**ementia and **e**nhancing **a**ctive **l**ife
[2] Ears, Nose & Throat
[3] Oral Steroids for the Resolution of Oitis Media with effusion in Children
[4] **PO**stanaesthesia **PUL**monary complications **A**fter use of muscle **R**elaxants
[5] Out-Patient and Home Parenteral Infusion Service

and research management and governance. The contingency funding was allocated to meet the shortfall in funding clinician sessions in the David Hide Asthma & Allergy Research Centre.

NIHR Research Capacity Funding (RCF) 2014/15
Standard RCF is allocated to research-active NHS bodies or NHS health care providers, if they either received sufficient NIHR income to reach a threshold to trigger an RCF allocation of at least £20k or recruited at least 500 individuals to non-commercial studies, conducted through the NIHR-Clinical Research Network, during the previous financial year reporting period. The Trust received **£20,000** in 2014/15 and this funding has been used part to fund Gary Whitwam's scholarship and also to contribute towards the cost of a research management and governance service.

Our achievements against key performance indicators are detailed in *Appendix C:*

- Recruitment against annual target achieved
- Recruiting first patient within 30 days of NHS Permission
- Local studies reviewed within 15 days of valid research application
- 70 day or less benchmark from receipt of a valid research application to the time the first patient is recruited for that study

This year, the Trust's contract with the DH for NIHR funding contains conditions on data requirements on Performance in Initiating and Delivering Clinical Research. From Quarter 3, the Trust is now required to submit and publish information in two areas:

a) Initiating clinical research: whereby providers must submit to the National Institute for Health Research Central Commissioning Facility (CCF), within 30 days of each quarter, information on the days elapsing between obtaining a Valid Research Application and recruitment of first patient to a clinical trial for every clinical trial for which it gave NHS permission in the previous three quarters

b) Delivering clinical research: whereby providers must submit to CCF, within 30 days of each quarter, information on recruitment to time and target for every commercial contract clinical trial hosted by the NHS provider in the previous three quarters

c) Providers must publish the information as required in the attached guidelines within 30 days of the end of each quarter in a publicly accessible part of their website.

Alexandra Punter, Research Management and Governance Manager
18 January 2015

APPENDIX A:

Research Projects approved – April 2014 to October 2014

Non-Commercial

- CSP 141805 : The IDEAL Study - Improving the experience of dementia and enhancing active like; living well with dementia (Dr Sharif)

- CSP 137716 : Knowledge leadership and Early AHSNs - NHS top managers, knowledge exchange and leadership: The Early development of academic Health Science Networks

- CSP 130663 Feeding and Autoimmunity in Down's syndrome Evaluation Study (FADES) (Dr G Williams, University Hospitals Bristol - Nutrition BRU)

- CSP 151153 : Adoloscent Asthma Study - Improving the engagement of teenagers with asthma with their healthcare (Prof G Roberts, DHAARC)

- CSP: 150697) 3rd Generation Study Three Year Follow UP (Prof Arshad, DHAARC)

- CSP: 95005: Genetic and biochemical investigations of children with symptoms suspicious for an inherited metabolic disease (*minor amendment still pending)*

- CSP: 97743: OCS-Care: A pilot study for developing and evaluating a care pathway for cognitive problems after stroke (*SSI submission still pending)*

- CSP 119358 OSTRICH – Oral steroids for otitis media with effusion in children study (Dr N Francis, Cariff Univ/SBasavaraj, ENT Surgeon)

- CSP 155270 POPULAR - POstanaesthesia PULmonary complications After use of muscle Relaxants in Europe (Dr V Murthy-Burra, Royal Liverpool University Hospitals/Dr Debreceni, Consultant Anaesthetist)

Commercial:

- CSP 160472 : FOURIER Cognitive Sub-Study - A Double-Blind, Placebo Controlled, Multicenter Study to Assess the Effect of Evolocumab on Cognitive Function in Patients with Clinically Evident Cardiovascular Disease and Receiving Statin Background Lipid Lowering Therapy: A Study for Subjects Enrolled in the FOURIER (Study 20110118) Trial (Vectasearch/Dr Al-Bahrani & Amgen Inc)

- CSP: 156081: DRN2832 Linagliptin and Insulin in elderly Type 2 Diabetes patients (Dr Baksi/Vectasearch & Boehringer Ingelheim Limited)

Non-Portfolio (Student):

- Study of the relationship between electronic prescribing and medicines safety culture (Angela Carrington, Masters in Public Administration at the University of Ulster)

- Case Series Study into the prevalence of Restless Leg Syndrome with periodic Leg Movement in Patients Referred to Secondary Care for Suspected Obstructive Sleep Apnoea (Tracey Jones, MSC Advance Clinical Practice, University of Southampton)

- Pharmacy Emergency Admissions Service: A service development evaluation (Nicola Wright, Pharmacy – MSc, UoPortsmouth)

- Determining universal processes related to best outcome in emergency abdominal surgery (PChaichanavichkij, CT2 in General Surgery)

- Stakeholder perceptions of a 'Street Triage' Service (KHorspool, Msc Uni Sheffield)

- Patients' experiences of self-managing COPD exacerbations with rescue medication packs: An Exploratory Study (SRamdany, Masters in Research)

APPENDIX B:

Allocation of Resources to deliver our planned portfolio of activity in 2014/15 (£371,781 + £10,000)

Division 1: Cancer
- Research Nurse (1.2 WTE) – Alison Brown and Debbie Fraser

Division 2: Diabetes/Stroke/Metaboic & Endocrine
- Clinical Lead Diabetes (0.5PA) – Arun Baksi
- Research Nurse, Diabetes (0.5WTE) – Liz Nicol
- Research Nurse, Diabetes (0.2 WTE – Apr-Aug) – Pat Wilson
- Clinical Lead Stroke (1PA) – Eluzai Hakim
- Research Nurse, Stroke (0.5 WTE) - Jane Herman
- Research Physio, Stroke (0.2 WTE) – Brian Nobles
- Assistant Practitioner, Stroke (0.16 WTE) – William Hayles

Division 3: Blood/Medicines for Children
- Clinical Lead, Children -Asthma & Allergy (1PA – Oct-Mar) – Prof Hasan Arshad
- Clinical Lead, Children -Asthma & Allergy (1PA – Oct-Mar) – Dr Ramesh Kurukulaaratchy
- Registrar, Children (0.4 PA) – Ewa Szynaka
- Research Nurse, Children (0.2 WTE) – Charlene Middleton
- Study Co-Ordinator, Children (0.3 WTE) – Chloe Fox

Division 4: DeNDRoN/Mental Health
- Clinical Lead, Dementia (1PA) – Saif Sharif
- Research Nurse (0.4 WTE) – Joy Wilkins

Division 5: Primary Care/Health Services Research
- Research Nurse (0.3 WTE) – Jane Grundy
- Study Co-Ordinator (0.5 WTE) – Gill Glaseby

Division 6: Eye/Gastro/Injuries & Emergencies/Respiratory
- Clinical Lead, Ophthalmology (0.5PA) – Javeed Khan
- Research Nurse, Ophthalmology (0.43 WTE) – Becky Massey
- Clinical Lead, Gastroenterology (0.5 PA) – Leonie Grellier
- Research Nurse, Gastroenterology (0.4 WTE) – Joy Wilkins
- Research Paramedic (0.04 WTE) – Joanna Barry (OHCAO)
- Senior Research Nurse, Asthma/Allergy (0.4 WTE) – Sharon Matthews
- Research Nurse, Asthma/Allergy (0.6 WTE) – Maria Larsson
- Clinical Lead, Asthma/Allergy (2PA) – Graham Roberts
- Clinical Lead, ENT (0.5 PA) – Mr Basavaraj
- Clinical Lead, Anaesthesia/Critical Care (0.03 PA) – Gabor Debreceni

Other:
- Lead Nurse (0.7 WTE) – to be appointed
- Research Management & Governance (0.64 WTE) – Tracey Tidbury

Supporting Clinical Services:
- Research Pharmacist (0.2 WTE) – Liz Harrison
- Research Technician (0.4 WTE) – Nick Culshaw
- Radiographer (0.2 WTE) – John Pettit
- MLSO (0.1 WTE) – Roger Twistleton

APPENDIX C:

Performance Metrics:

- % of CRN: Wessex led, non-commercial studies recruiting first patient within 30 days of NHS Permission
- % of local studies reviewed within 15 days (Site-Specific Information Form (SSI) to NHS Permission)
- benchmark of 70 days or less from the time a provider receives a valid research application to the time that the provider recruits the first patient for that study

CSP CLRN ID	Study Title	SSI Submission	Permissions Granted OR PIC Approval	Days SSI Received to NHS Permission	Reasons for >15 days	First Patient First Visit (FPFV)	Reasons for >30 days	70 day benchmark
115956 (14175)	Personalized Anti-TNF Therapy in Crohn's Disease (PANTS)	20/03/2014	15/04/2014	**26**	SSI pre 1/4	0	Initial IT problems connecting to study site - fixed 11/8	N
140148 (16399)	In-patient suicide whilst under non-routine observation	11/02/2014	09/04/2014	**58**	SSI pre 1/4 - Global Review was suspended for long time and got put to one side	0	No local investigator	N
149651 (16565)	3rd Generation Study Two Year Follow-up	14/03/2014	22/04/2014	**39**	SSI pre 1/4 - we achieved in 30 days but Global Review was suspended	24/04/2014		Y
138384 (16249)	A national survey of patient reported outcome after anaesthesia	18/03/2014	22/04/2014	**35**	SSI pre 1/4 - 4 day Easter BH weekend delay in hearing back from our anaesthetists pushed us over 30 days	13/05/2014		N outside our control - 2 day survey with fixed date
120344 (14796)	LonDowns Cohort	26/03/2014	25/04/2014	**30**	SSI pre 1/4	06/08/2014	Signed Contract recvd 4/6, signed LOAs recd 16/6	N
137716 (15922)	Knowledge Leadership & early AHSNs	13/05/2014	29/05/2014	**16**	No reason	0	No local investigator	N
101849 (15404)	ELFIN	17/04/2014	09/05/2014	**22**	Data retention query as babies which wasn't answered by Sponsor til 7/5, after the 15 day deadline	0	continuing care site - no recruitment whole study as yet	N
130663 (16735)	Feeding and Autoimmunity in Down's syndrome Evaluation Study (FADES)	20/05/2014	04/06/2014	**15**		0	No local investigator	N

CSP CLRN ID	Study Title	SSI Submission	Permissions Granted OR PIC Approval	Days SSI Received to NHS Permission	Reasons for >15 days	First Patient First Visit (FPFV)	Reasons for >30 days	70 day benchmark
149426 (16454)	SHOES	09/06/2014	04/07/2014	**25**	Outside our control - problem identified with REC approval letter for Amdmt 1 – re-sent to us 30/6 (6 days after 15 day deadline)	14/10/2014 *(date first complete Q returned)*	Phase 1 stage - Q only Phase 2 will involve lab assessments	N
151153 (16918)	Adolescent Asthma	09/07/2014	28/07/2014	**19**	Could have achieved 15 but gave priority to staff appraisals that week	17/08/2014		Y
141805 (16593)	IDEAL Study	17/07/2014	07/08/2014	**21**	Contract queries raised 30/7 and finalised 7/8	16/09/2014	Site Initiation Visit 20/8 – first patient recruited within 30 days of SIV	Y
150697 (17415)	3rd Generation Study Three Year Follow-up	10/09/2014	26/09/2014	**16**	No reason	29/10/2014		Y
95005	Inherited metabolic diseases	21/08/2014	*Target 5/9*		Local review complete - awaiting minor amendment needed by Sponsor to change PIS so useable for non GOSH sites	0		*target 30/10*
152611	TULIP (Commercial - Eye)	03/10/2014	*Target 18/10*		Contract queries outstanding with Sponsor – same unresolved concerns raised by Portsmouth Hospitals	0		*target 12/12*
119358	OSTRICH	28/10/2014	20/11/2014	**23**	Contract queries	0	Site Initiation Visit 15/12 Research Nurse needs Local Safeguarding Training before recruit ment can commence – scheduled 20/1	*target 7/1*
156081	DRN2832 – Basal Insulin	07/11/2014	24/11/2014	**17**	Waiting on pharmacy for confirmation that arrangements in place to comply with Clinical Trial Regs	0		*target 16/1*

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4 March 2015

Title	Reference Costs 2013-14			
Sponsoring Executive Director	Chris Palmer – Executive Director of Finance			
Author(s)	Iain Hendey – Deputy Director of Information			
Purpose	To provide an overview for the Board of the outcome of our 2013/14 Reference Cost Submission.			
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	21/01/2015	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:

This paper presents the output of the IW NHS Trust 2013/14 Reference Cost submission showing key variances to the previous year and to the national average. The paper also outlines the main drivers behind these variances.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	Productivity					
Critical Success Factors *(see key)*	CSF 7					
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: 24 February 15 **Completed by:** Iain Hendey – Deputy Director of Information

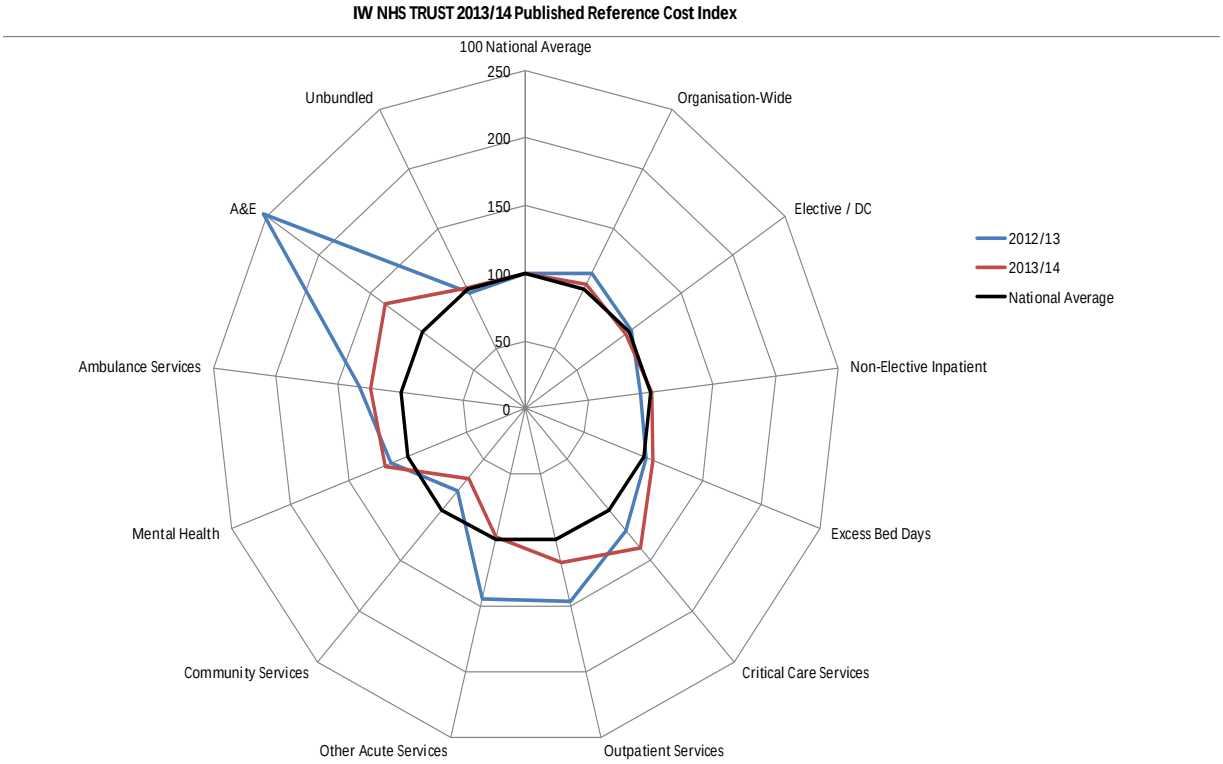
ISLE OF WIGHT NHS TRUST
REFERENCE COSTS 2013-2014

Introduction:

The 2013-14 Reference Cost Index (RCI), released by the Department of Health reported that the Isle of Wight NHS Trust had an index score of 103.87 (Market Forces Factor (MFF) adjusted, including Excess Bed Days). The adjusted RCI for 2012-13 was 112.59, indicating a year on year decrease of 8.72.

Following submission in 12-13 an inaccuracy was discovered within the A&E data handling – below you can see the improvement in the13-14 submission and the overall positive impact on the Organisation Wide RCI score.

The graph below shows the RCI for each of the services provided, with the overall index.



As in previous years, changes in submission criteria have resulted in a number of movements between categories, details of these changes are covered in the explanations below. These changes mean that it is not safe to consider that any comparison is a direct like for like issue.

Issues and Areas of Note:-

Overall RCI movement

The total movement from the 2012-13 to the 2013-14 submission is a reduction of 8.72 points. This indicates that as a Trust we are now moving closer to National Average prices compared to other organisations across the country but remain slightly more expensive overall. The 8.72 RCI reduction represents an improvement to the costing practices, reflecting better cost allocations across many services. The shift towards an RCI of 100 also indicates the Trust has moved more in line with the rest of the NHS.

Inpatient & Day Case

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
Elective/DC	9,151	9,463	312	£ 13,575	£ 15,572	£ 1,998	£ 13,321	£ 16,041	£ 2,721	101.91	97.08	-4.83	£ 1,483.41	£1,645.61	£ 1,455.63	£ 1,695.14
Non-Elective	18,409	16,817	- 1,592	£ 23,795	£ 27,915	£ 4,120	£ 25,809	£ 27,618	£ 1,809	92.20	101.08	8.88	£ 1,292.58	£1,659.92	£ 1,401.96	£ 1,642.26
Inpatient/DC Total	27,560	26,280	- 1,280	£ 37,370	£ 43,487	£ 6,118	£ 39,129	£ 43,659	£ 4,530	95.50	99.61	4.10	£ 1,355.94	£1,654.77	£ 1,419.79	£ 1,661.30

*PPU - Price Per Unit of Activity

The Inpatient and Day Case RCI for 2013-14 shows an increase in comparison to 2012-13 of 4 points. The overall RCI for Inpatient and Day Case services now stands at 99.61, slightly cheaper than the NHS as a whole. This change follows a significant increase in overall costs of £6.1m against and expected increase of £4.5m (MFF Adjusted).

The increase in costs year on year are due to the improvements in cost allocations at patient level for Radiology and Pathology, with work planned to continuously improve this area in the near future. Identified improvements to A&E data and costing from lessons learned from the previous year have had a big impact as shown in the chart above. A reduction to RCI 135 shows a much improved costing; however we remain 35% more expensive than the NHS average. As an island this is expected and covered by the Island Premium.

Outpatients

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
Outpatient Services	190,629	210,459	19,830	£ 28,895	£ 29,449	£ 554	£ 19,660	£ 25,143	£ 5,483	146.98	117.12	-29.85	£ 151.58	£ 139.93	£ 103.13	£ 119.47

*PPU - Price Per Unit of Activity

Outpatient activity has increased in 2013-14 compared with 2012-13 this was mainly due to the increase in Outpatient procedures carried out. The outpatient RCI index has decreased by 30 giving an RCI 117, the actual costs in 2012-13 were 9m more than expected for the activity in that year. In 2013-14 the actual costs were 4m higher than the actual costs for the activity taken place.

Other Acute Services

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
Other Acute Services	619,178	677,804	28,626	£ 2,551	£ 1,783	-£ 768	£ 1,759	£ 1,828	£ 69	145.02	97.54	-47.48	£ 3.93	£ 2.63	£ 2.71	£ 2.70

*PPU - Price Per Unit of Activity

Other acute services mostly relates to Direct Access pathology. The RCI has decreased by 47 giving an RCI of 98 down from 145. The reduction of costs allocated to DA Pathology is largely because of better Pathology matching to inpatients: This meant more pathology costs were identified as part of inpatient care and as a result drew more costs away from Direct Access patients.

Mental Health

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
Mental Health	681,563	614,859	66,704	£ 18,306	£ 19,129	£ 823	£ 16,012	£ 15,968	£ 44	114.32	119.79	5.47	£ 26.86	£ 31.11	£ 23.49	£ 25.97

*PPU - Price Per Unit of Activity

Last year the RCI recorded for Mental Health was 114 in 13/14 there has been an increase to 119. However, it should be noted that 2012/13 was the first year of reference costs that reflected a complete change of activity currency making comparisons with previous years meaningless. Activity has decreased and costs have increased thus the higher RCI score for this service.

Unbundled Services

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
Unbundled	36,518	39,334	2,816	£ 9,517	£ 12,947	£ 3,430	£ 9,910	£ 12,928	£ 3,018	96.03	100.15	4.12	£ 260.61	£ 329.16	£ 271.38	£ 328.68

*PPU - Price Per Unit of Activity

Unbundled services include High Cost Drugs, Rehab, Chemotherapy and Diagnostic Services. Activity is on the increase in 13/14 and higher costs but in line with the national average bringing the trusts RCI in line with the NHS average now 100 from 96.

Accident & Emergency

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
A&E	42,490	40,705	- 1,785	£ 8,131	£ 7,632	-£ 499	£ 3,215	£ 5,622	£ 2,407	252.87	135.74	-117.13	£ 191.36	£ 187.49	£ 75.68	£ 138.12

*PPU - Price Per Unit of Activity

The Trust's published RCI for A&E was 253 points in 2012-13 significantly higher than average. However as stated above an error was identified post submission of the 2012/13 reference costs. As a result the A&E activity was incorrectly distributed across HRGs, with a significantly higher proportion being assigned to a lower cost HRG. Now this has been rectified you can see above the increase in the expected cost for 13-14 has risen to 2.4m. Also there has been an improved cost allocation for staffing and medics costs the RCI has decreased by 117 points to a new RCI for A&E of 135. This has had a significant impact on the overall RCI of the Trust.

Community

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
Community Services	262,057	296,910	34,853	£12,427	£ 14,423	£ 1,996	£15,302	£ 21,007	£ 5,705	81.22	68.66	-12.55	£ 47.42	£ 48.58	£ 58.39	£ 70.75

*PPU - Price Per Unit of Activity

Community has decreased by 12.5 points down to 69 from 81. Activity and costs have increased in 2013-14 from 2012-13 but there were so many changes to the Community Guidance that like for like comparison will be difficult. In addition the collection of Community activity continues to improve year on year, but it is not reported at patient level and therefore there are a number of assumptions that have been made. Also in Reference Costs a lot of services are excluded from the submission following guidance.

Ambulance

	Activity			Actual Costs			Expected Costs			RCI			Actual PPU*		Expected PPU*	
	12/13	13/14	Change	12/13 £000s	13/14 £000s	Change £000s	12/13 £000s	13/14 £000s	Change £000s	12/13 RCI	13/14 RCI	Change	12/13	13/14	12/13	13/14
Ambulance Service	49,654	44,022	- 5,632	£ 5,564	£ 5,501	-£ 63	£ 4,188	£ 4,418	£ 230	132.87	124.51	-8.35	£ 112.05	£ 124.95	£ 84.34	£ 100.35

*PPU - Price Per Unit of Activity

Ambulance RCI has decreased by 8 down to 124 from 132 in 2012-13. Even though the activity has dropped by 5.5k the improved costs and activity across the categories has meant a reduction in the RCI score as we have come more in line with National average.

Changes to the national submission

Monitor and HfMA continue to develop costing in the NHS – responding to changes in practices and casemix, and increasing the level of detail collected, in order to better understand what drives healthcare costs.
The previous approach to fully absorbed costing was a 'top down' approach. This would start with the total organisation's costs apportioned between services, and then again within the service to point of delivery, ultimately grouping costs to HRGs.

Nationally and locally we are moving towards a new costing model that allocates costs by staff and activities and is ultimately driven to patients via detailed patient data sets. This leads to greater accuracy in costing but it is complex and requires a far greater level of detail in the source data and time and technical resources in order to allocate cost fairly. For example actual nurse costs by time spent on wards, theatre costs by time spent in operating room, consultant ward rounds to patients on wards.

As well as this general change of approach there were a number of very specific changes in 2013-14 as follows:

- In addition to the traditional FCE level submission, a spell based submission was also mandatory in 13-14 where FCE costs exist.

- Trusts were informed to exclude costs rather than net off income (and bad debts) from private patients and other categories of non-NHS patients.

- No longer required to report the total number of unique service users under Mental Health Care Clusters but added a requirement to report the average length of completed cluster review periods. A project has been set up to review the MH Cluster costing.

- To raise the profile of costing, there is now an additional sign off process in place in addition to Finance Director. Executive Boards are now also required to approve the costing process supporting the reference costs submission.

Annual update to mandatory and non-mandatory validations required, including mandatory minimum unit costs for some services.

All Mandatory validations were cleared prior to the submission and Non Mandatory validations were reduced from 1900 to 32.

New non-mandatory validations include
(a) Checking required where different HRGs are costed at same price
(b) Cost relativities that are inconsistent with HRG design – for example HRG with Complications and Co-morbidities calculated cheaper than equivalent HRG without Complications and Co-morbidities

Cost Base Review

The SLR team is currently undertaking a piece of work with support from the IOW CCG, to fully review services.

Iain Hendey
Deputy Director Finance PIDS
16th January 2015

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th March 2015

Title	Upgrade to the existing MRI Scanner – approval for Capital Funding			
Sponsoring Executive Director	Chris Palmer, Executive Director of Finance			
Author(s)	Diane Adams - Diagnostic Imaging & Lead Cancer Manager Sarah Gorbutt - Capital & Treasury Accountant			
Purpose	To seek approval for the Capital Funding of an Upgrade to the MRI Scanner			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
H&A Directorate Board	27 October 2014	Associate Directors Authorisation	30 January 2015
Estates Delivery Board	06 November 2014	Capital Investment Group	06 February 2015
Capital Investment Group	07 November 2014	Trust Executive Committee	23 February 2015
H&A Directorate Board	24 November 2014	Finance, Investment, Information & Workforce Committee	24 February 2015
Please add any other committees below as needed			
Trust Board	04 March 2015	Capital Investment Group	09 January 2015

Staff, stakeholder, patient and public engagement: Directorate staff and CCG Leads

Executive Summary:

The MRI scanner is due for replacement to maintain high levels of performance and diagnostic capability. The proposal is to rebuild digital technology around the existing core magnet and achieve modern technology without the associated high costs for a full replacement. The original scanner was replaced in 2007 through a 7-year lease agreement with Shawbrook Asset Finance. The lease was due to expire in November 2014, however due to limited capital funds in 2014/15 a 6-month extension was agreed to move the project forward to 2015/16 Capital Rolling Replacement allocation. However, to ensure the replacement project starts promptly in April 2015, the business case and authorisation has been sought during the second half of 2014/15. With approval in March an order can be placed and allow the 6 weeks lead in time required by the builders and manufacturers to deliver the project within the agreed timeframe

The MRI upgrade has been considered and supported at the above stated Boards and agreed by both Associate Directors within the Trust as the priority for 2015/16 Capital Rolling Replacement allocation.

The purpose of this paper is to seek approval for the capital funds required to support the building costs associated with the MRI project. It will also fund the hire of a mobile scanner and ensure continuity of service throughout the 10 week project.

In accordance with the Isle of Wight NHS Trust's standing financial instructions this project, which is requesting funding in excess of £250k and is not a P21+ approved scheme, requires Trust Board approval.

The Strategic Outline Case for the project was received at Trust Executive Committee on Monday 23 February 2015 and approved. The full business case was presented at the Finance, Investment, Information and Workforce Committee on 24th February and recommended for approval to the Trust Board.

For following sections – please indicate as appropriate:						
Trust Goal *(see key)*	4					
Critical Success Factors *(see key)*	CFS 1 & 2, CSF 3, CSF 7 & 8					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	Mitigation of Health & Safety, Infection Control & Information Governance issues					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements						

Date: 24/02/2015 Completed by: SARAH GORBUTT/DIANE ADAMS

Project Name: **UPGRADE EXISTING MRI SCANNER**

QuinCE Reference: **346**

FULL BUSINESS CASE

Revised business case

24/02/2015

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

Project Sponsor Name:

Diane Adams

_____ / /

Signature date

Authorisation to Proceed:

Donna Collins

_____ / /

Signature or Meeting Reference date

Configuration Management:

Number	**Narrative**	**Issue Date**	**Author/Editor**
Version 1.0	New business case	01/10/2014	Diane Adams/Liz Hillier
Version 2.0	Revised business case	24/02/2015	Diane Adams/Liz Hillier
Meeting/Group	**Comments**	**Date**	**Approved**

Contents

1. EXECUTIVE SUMMARY

The MRI scanner is due for replacement to maintain high levels of performance and diagnostic capability. The original scanner was replaced in 2007 through a 7-year lease agreement with Shawbrook Asset Finance. The lease was due to expire in November 2014, however due to limited capital funds in 2014/15 a 6-month extension was agreed to move the project forward to 2015/16 Capital Rolling Replacement allocation.

To ensure the replacement project starts promptly in April 2015, the business case and authorisation has been sought during the second half of 2014/15.

The MRI business case received conditional approval at November 2014 Capital Investment Group (CIG) subject to the Directorate assurance that it was their priority investment for the next financial year. The Directorate gave this assurance at December 2014 Directorate Board. A further request was made for the Associate Directors to prioritise the Capital Rolling Replacement allocation for 2015/16 across the Trust. A subsequent meeting followed and both Associate Directors supported the MRI replacement as the priority. The business case was endorsed at February 2015 Capital Investment Group and submitted to the Trust Executive Committee on 23 February where it gained approval. The Finance, Investment, Information and Workforce Committee received the business case on 24 February and recommended it to the Trust Board for approval.

The existing MRI scanner is manufactured by Philips Healthcare who has offered an alternative solution to a full scanner replacement. The proposal is to rebuild digital technology around the existing core magnet (d-stream) and achieve modern technology without the associated high costs for a full replacement. The lease company have given approval to modify their asset and are prepared to consider the arrangement as an upgrade with revised financial agreement. Solent Supplies team has been made aware of the proposal and advise they would have minimal involvement.

D-streaming the MR scanner will deliver all the benefits of digital broadband architecture without the cost and upheaval of installing a completely new system. This solution offers faster installation with minimal disruption to service and no costly magnet removal. The result is a system that is like new with all the associated warranties in place but at a substantially lower cost.

During the system upgrade and associated building works, the MRI service will be delivered from a mobile scanner. There is an identified area on the St Mary's site which was used previously for the same function and has the required utilities in place to support the mobile solution.

The purpose of this paper is to provide information for the Board on the full options available allowing the Trust to make a balanced and objective decision around the future of the MRI service provision on the Isle of Wight. With approval in March an order can be placed and allow the 6 weeks lead in time required by the builders and manufacturers to deliver the project within the agreed timeframe.

OPTION 1 **Removal of MR Equipment and Service from Isle of Wight**	**OPTION 2** **New Scanner and New Magnet**	**OPTION 3** **New Scanner Utilising Existing Magnet**
No local MRI service	Maintain local MRI service with a requirement of both capital and revenue investment	Maintain local MRI service with capital investment only

Option 3 is the preferred option requiring capital investment only to support the enabling works needed to upgrade the existing scanner. The revenue requirement can be met within the existing budget.

There are both long term and short-term risks associated with all options which will be detailed further later in this paper.

1.1 Timescale for implementation

Milestone	Target Date
Project Mandate Issued / SOC Completed	Oct 2014
Case Approval – Hospital & Ambulance Directorate Board	Oct 2014
Case Approval – Estates Programme Delivery Board	Nov 2014
Case Approval – Capital Investment Group	Nov 2014
H&A Directorate Board	Nov 2014
Capital Investment Group	Jan 2015
Capital Investment Group	Feb 2015
TEC Approval	Feb 2015
Finance Investment Information and Workforce Committee	Feb 2015
Authorisation of revised lease agreement	Mar 2015
Mobile Scanner Installed	Apr 2015
Enabling Works for New Scanner	Apr 2015
D-streaming new scanner	Jun 2015
Acceptance and physics check	Jun 2015
Application training	Jul 2015
New MRI Service	Jul 2015

2. INTRODUCTION

2.1 Project Objective

The aim of this business case is to outline the options open to the Trust that will ensure a highly efficient MRI service, capable of producing high resolution images. A modern variant will support the Trust in meeting its performance targets and improve the diagnostic capability of the service.

2.2 Purpose of the Business Case

The MR world is constantly evolving towards higher levels of performance in terms of better image quality and consistency, faster imaging and processing.

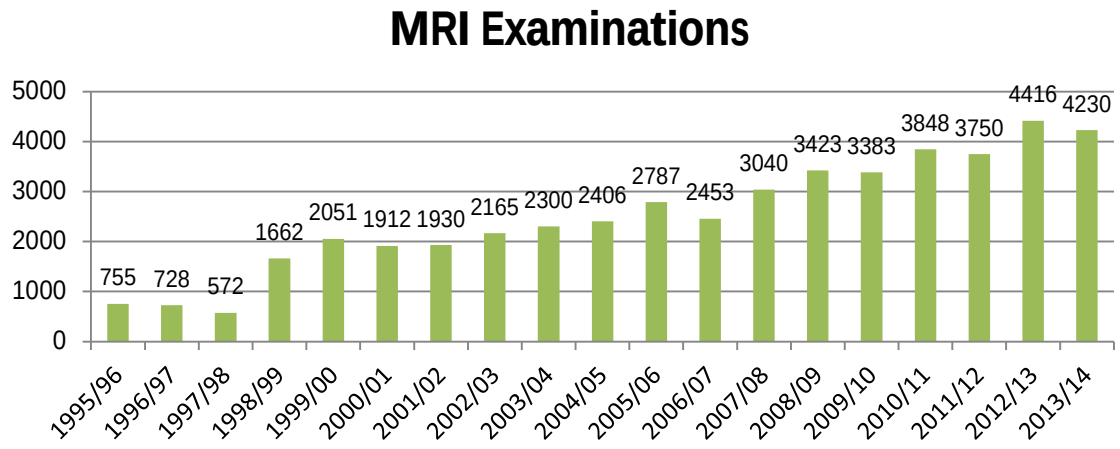
Demand for MRI is increasing and is no longer seen as the 'Gold Standard', but more as an expected part of the diagnostic workup for patients treatment planning. It provides a level of information not visible on conventional x-ray or CT imaging.

The need for local MRI facilities resulted in the Island population fundraising for the first fixed scanner on the Island. Prior to that patients were either transferred to the mainland or there was an intermittent mobile scanner. It should be noted at that time, the demand for MRI was less than a thousand patients per year. The complexity of accurate diagnosis and staging of cancer has seen the demand for MRI rise exponentially in the last decade. Failure to replace the MRI scanner could result in poor reputation for the Trust.

The original scanner was replaced in 2007 with a modern variant through a lease agreement with a national finance company. The 7-year lease is due to expire. This paper will present a case to upgrade the existing scanner within the available budget. It will identify the capital required to upgrade the existing scanning room to a digital environment plus the cost of a mobile scanner during the upgrade project.

This paper will also demonstrate the high costs associated with removing the facility from the Island or to replace the scanner as opposed to upgrading it.

It is the intention of this document to highlight the reasons for upgrading the MR Scanner and the benefits to service delivery.



3. STRATEGIC CASE

The Isle of Wight NHS Trust aspires to achieve excellence in patient safety, clinical standards and patient experience with a duty to maintain a comprehensive health service on the Isle of Wight.

An inability to provide MRI scans to meet the requirements of the National Cancer Standards will result in the MRI service being commissioned elsewhere.

The Diagnostic Imaging Department is a significant resource within the Trust and is pivotal to achieving its activity and performance targets, thus improving patient care. It will support the Trust to meet all key access targets including 18-week referral to treatment.

There is a need to meet competition in the future and to exploit the benefits of new technology, in particular to provide services in a faster, more responsive and more convenient way. It is essential to demonstrate patient choice whilst meeting overall key financial duties. Improving efficiency in order to produce services at the national tariff will fit in with the Reference Costs as well as patient choice.

In the interests of efficiency, patient experience and meeting the demands of the service continual improvement inpatient flows will result in improved access to diagnostics, thus reducing length of stay.

4. ECONOMIC CASE - OPTIONS APPRAISAL (value for Money)

4.1 Non-Financial Option Appraisal

Option 1	**Removal of MR Equipment and Service from Isle of Wight**
Benefits	No benefits
Risks	· No local MRI service in the future resulting in poor patient experience and potential clinical risk with mainland transfer · Loss of income
Spend profile	· Cost of removing existing scanner including:- - Ferry and accommodation costs - Crane hire - Building works to remove/rebuild back wall of Diagnostic Imaging

Option 2	**New Scanner and New Magnet**
Benefits	**Technical Benefits** · Optimum use of the scanning room with improved image processing · Improved image quality to facilitate accurate diagnosis by offering a more complete examination · Improved image capture and processing time · Reduced sequence time, decreased artefacts and increased resolution · Enhanced functionality to allow whole body scans in 10 minutes · Superior noise reduction to improve patient experience and deliver high gradient performance · Inherent patient monitoring system to allow safe imaging for anaesthetised patients in conjunction with a compatible MR ventilator **Clinical Benefits** · Fulfil the minimum requirements of diagnostic investigations needed to run a Stroke and Cardiac Unit · More accurate diagnosis from perfusion/diffusion scans to predict the outcome more effectively · Provide a more extensive vascular imaging service that is non-invasive · Bring the orthopaedic imaging up-to-date with higher resolution scans, as it would increase data capture · Improved throughput will reduce waiting times for cancer patients specifically · Reduce radiation exposure to patients (e.g. children) by selecting and offering the most appropriate, non-invasive procedure
Risks	· Lack of available revenue to support lease cost of new scanner · Potential limited service initially on mobile scanner during project- scanner dependent · Potential cost implication to maintain compliance with 18 week target. · Potential to fail diagnostic 6 week element of 18 week target
Spend profile	· Cost of removing existing scanner including:- - Ferry and accommodation costs - Crane hire - Building works to remove back wall of Diagnostic Imaging · Capital cost of new scanner, enabling works and mobile scanner or · Increased revenue required to support lease cost of new scanner plus capital for enabling works and mobile scanner
Option 3	**New Scanner Utilising Existing Magnet**
Benefits	Same risks as Option 2 except revenue is available to support new lease
Risks	Same risks as Option 2 except no revenue shortfall
Spend profile	· Cost of D-streamed scanner through lease agreement · Capital cost for enabling works and mobile scanner

4.2 Preferred Option – Option 3

Benefits to the Organisation
· Having a modern scanner at reduced cost · Maintaining a local MRI service securing positive reputation for the Trust
Benefits to Patient and Carer Groups
· Improved facilities and access to services · Improved experience and perception of the service
Benefits to Staff
· Reduce musculoskeletal strain or injury · Minimise load handling · Maintain staffing level through investment of modern technology · Professional development through software upgrades and associated training
Impact on Quality
· Delivery on national performance targets · Improved diagnostic capability
Impact on Productivity
· Improved image quality reduces requirement for repeat scan
Links to Strategic Goals / Critical Success Factors
Trust Goal CSF1,2 / Critical Success Factors 2

Benefits of this project include (Critical Success Factors):-

CSF 1: Improve our clinical effectiveness and the safety and outcomes for our patients
CSF 2: Improve the experience and satisfaction of our patients, carers, partners and staff.

Quality: Achieving excellence in patient safety and clinical effectiveness
Performance: Developing capacity, creating long term sustainability. Contributing towards FT status

Our Strategic Objectives

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

5. RISKS

There are both long term and short-term risks associated with the proposed options and equipment replacement.

OPTION 1: REMOVAL OF MR EQUIPMENT AND SERVICE FROM ISLE OF WIGHT

- 7 year lease agreement expired end of 2014. Scanner is Finance Company's asset
- No local MRI service in the future
- Reduction of income to Trust as service commissioned elsewhere
- Poor reputation as patients required to travel to mainland
- Cost and poor patient experience in travelling to mainland provider
- Considerable building and removal costs required as the rear wall of the scanner would need to be removed
- Crane hire cost and transport cost to move scanner off island
- Cost to rebuild rear wall of scanner and make the room good for future use.

OPTION 2: NEW SCANNER AND NEW MAGNET

No long term risks as the replacement scanner would deliver cutting edge digital technology with all the benefits to produce greater diagnostic capability.

The risk is financial in both capital and revenue costs. Greater capital is required as the old scanner will have to be removed which results in the rear wall of the scanning room being affected. The scanner would be removed by a crane and also require transport cost. This is in addition to the costs given for Option 3 which include room enabling costs and mobile scanner hire

In terms of revenue, a greater investment will be required as a completely new scanner costs considerably more than D-streaming the existing scanner. This revenue is not available in the current diagnostic imaging budget.

Short-Term Risks

Downtime

In the short term this option is the same as Option 3 plus an increased disruption to service due to more extensive building works. The project timescale would be 14 weeks and result in increased hire costs associated with mobile scanner

OPTION 3: NEW SCANNER UTILISING EXISTING MAGNET (PREFERRED OPTION)

This is the preferred option, for both the patient experience and the continuance of service during the period of building works and installation. It can be delivered over a shorter timescale at reduced cost compared with Option 2a and 2. Revenue required to support this option is available within the diagnostic imaging budget to cover both the lease costs as well as the service and maintenance cost

No long term risks as the D-streamed scanner would also deliver cutting edge digital technology with all the benefits to produce greater diagnostic capability.

Short-Term Risks

Downtime

It is estimated that there will be 10 weeks when the MR Scanner will be out of action. During this time period, the existing scanner will be upgraded and enabling works completed. This will be followed by acceptance test by the Physicists and then applications training for the MRI staff. The costs for this are included in the tender price.

The majority of scan types will be available from the mobile facility although inpatients will be required to be transferred outside of the main building.

Initially the throughput of patients may be reduced whilst staff gain experience on the mobile scanner this will be dependent on the type of scanner selected and available at the time of placing an order. In preparation for this delay, MR staff will work some additional hours prior to the project commencing and effectively reduce the current 5 week waiting time. This will give a greater flexibility and responsiveness to the service and avoid any delay in patient pathway. This will ultimately support the Trust in compliance with national performance targets. There will be a cost implication to the additional hours worked but will be kept to a minimum through flexible working.

Inherent within current practice, close monitoring of the diagnostic element of the 18 week target is in place. The staff offer flexible working to minimise any cost implication whilst ensuring the service remain below the 6 week measure given for imaging. This will continue.

The project will deliver improved imaging and diagnostic capability. Capacity is being addressed within the Hospital Redesign Project looking at 7 day service and effectively increasing capacity.

Lease Mobile MR Scanner

During the downtime, the MRI service will be delivered from a mobile scanner sited at St Mary's. There is a hard stand adjacent to the Emergency Department that is currently used as a parking facility but has previously been used to site a mobile scanner. The Estates Department has checked the area and confirm the utilities remain in place to support the mobile scanner without the requirement for further investment. There will be no increase in utility costs as the existing provision for the fixed scanner will be out of use during the install.

Previous IT set up was in place to ensure connectivity of mobile scanner to Trust IT systems and support safe image transfer to the PACS system. The Estates Department has passed the testing of the data supply to the IT Department and await a response.

Solent Supplies has provided indicative costs for a mobile scanner during the 10 week project. There is a cost of £10,000 per week plus initial transport and ferry costs to deliver the scanner on island plus it removal at the end of the project. An initial delivery/return cost of £2000 per journey. Maintenance is included in the hire costs.

The IOW MRI staff will man the scanner and training would be included in the mobile hire costs. A mobile scanner will be selected that staff are familiar with to deliver the level of service we currently provide and minimise disruption. There are some scans currently not provided on the Island and patients are transferred to the mainland with costs supported. We should see no change in our service delivery.

The costs for a mobile scanner service have been included with the enabling works of the scanning room and are the bid being presented for capital investment.

Inpatient Transfer

Full risk assessments will be completed prior to using the mobile scanner to include not only patient care and transfer, but also fire and security aspect to ensure patient safety at all times. In 2007 the project was carried out in the middle of winter during adverse weather conditions, the forward planning this time allows the mobile unit to be in place during Spring and hopefully better weather. There were no previous costs associated with transferring inpatients to the mobile scanner.

6. FINANCIAL CASE (Affordability)

Option 1: Removal of MR Equipment and Service from Isle of Wight

Cost of Equipment	
VAT	
Total Cost of Machine	

	YEAR										
All Costs include VAT	**1 15/16**	**2 16/17**	**3 17/18**	**4 18/19**	**5 19/20**	**6 20/21**	**7 21/22**	**8 22/23**	**9 23/24**	**10 25/25**	**TOTAL**
CAPITAL INVESTMENT											
Enabling Works:											
Building Costs	**123,720**										
Crane Hire	**6,000**										
Lorry Hire	**1,440**										
Machine purchase:											
Purchase cost including VAT	**0**										
Total Capital	**131,160**										**131,160**
Total against Radiology Budget p/a	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Revenue	**131,160**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**131,160**

Capital Charges:											
Depreciation (write off in one year)	131,160	0	0	0	0	0	0	0	0	0	131,160
Interest 3.5% Capital Charge											0
Total Capital Charges	**131,160**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**131,160**

Option 2a: New Scanner and New Magnet - Capital

Cost of Equipment	913,838
VAT	182,768
Total Cost of Machine	**1,096,606**

All Costs include VAT	YEAR 1 15/16	2 16/17	3 17/18	4 18/19	5 19/20	6 20/21	7 21/22	8 22/23	9 23/24	10 25/25	TOTAL
CAPITAL INVESTMENT											
Enabling Works:											
Crane Hire	6,000										
Lorry Hire	1,440										
Building Works	123,720										
RF Cage	50,000										
Chiller	48,000										
Enabling Works	171,186										
14 week rental mobile and associated costs	168,000										
Cost of Equipment	1,096,606										
Total Capital	**1,664,952**										**1,664,952**

Capital Charges:											
Depreciation	166,495	166,495	166,495	166,495	166,495	166,495	166,495	166,495	166,495	166,495	**1,664,952**
Interest 3.5% Capital Charge	55,360	45,932	43,705	37,878	32,050	26,223	20,396	14,568	8,741	2,914	291,367
Total Capital Charges	**221,855**	**216,027**	**210,200**	**204,373**	**198,545**	**192,718**	**186,891**	**181,063**	**175,236**	**169,409**	**1,956,318**

Option 2b: New Scanner and New Magnet - Lease

Cost of Equipment	913,838
Plus Residual Value of Machine	108,749
Total Cost of Machine	**1,096,606**

	YEAR										
All Costs include VAT	**1 15/16**	**2 16/17**	**3 17/18**	**4 18/19**	**5 19/20**	**6 20/21**	**7 21/22**	**8 22/23**	**9 23/24**	**10 25/25**	**TOTAL**
CAPITAL INVESTMENT											
Enabling Works:											
Crane Hire	6,000										
Lorry Hire	1,440										
Building Works	123,720										
RF Cage	50,000										
Chiller	48,000										
Enabling Works	171,186										
14 week rental mobile	168,000										
Total Capital	**568,346**										**568,346**
Revenue/Budget Costs: (company to send definitive)											
Lease Costs	184,185	184,185	184,185	184,185	184,185	184,185	184,185	184,185	184,185	184,185	1,841,849
Service and Maintenance	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	660,000
Total against Radiology Budget p/a	**250,185**	**250,185**	**250,185**	**250,185**	**250,185**	**250,185**	**250,185**	**250,185**	**250,185**	**250,185**	**2,501,849**
Cost Pressure to Budget	**66,824**	**66,824**	**66,824**	**66,824**	**66,824**	**66,824**	**66,824**	**66,824**	**66,824**	**66,824**	**668,236**
Capital Charges:											
Depreciation	56,835	56,835	56,835	56,835	56,835	56,835	56,835	56,835	56,835	56,835	568,346
Interest 3.5% Capital Charge	18,898	16,908	14,919	12,930	10,941	8,951	6,962	4,973	2,984	995	**99,461**
Total Capital Charges	**75,732**	**73,743**	**71,754**	**69,764**	**67,775**	**65,786**	**63,797**	**61,808**	**59,818**	**57,829**	**667,807**

Option 3: New Scanner Utilising Existing Magnet

Cost of Equipment	590,000
Plus Residual Value of Machine	108,749
Total Cost of Machine	**698,749**

All Costs include VAT	YEAR 1 15/16	2 16/17	3 17/18	4 18/19	5 19/20	6 20/21	7 21/22	8 22/23	9 23/24	10 25/25	TOTAL
CAPITAL INVESTMENT											
Enabling Works	175,800										
Chiller	48,000										
10 week rental mobile and associated costs	127,000										
Total Capital	**350,800**										
Revenue/Budget Costs:											
Lease Costs	117,361	117,361	117,361	117,361	117,361	117,361	117,361	117,361	117,361	117,361	**1,173,612**
Service and Maintenance	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	**660,000**
Total against Radiology Budget p/a	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**1,833,612**

Capital Charges – currently paying Capital Charges for existing scanner

Depreciation	35,080	35,080	35,080	35,080	35,080	35,080	35,080	35,080	35,080	35,080	350,800
Interest 3.5% Capital Charge	11,664	10,436	9,209	7,981	6,753	5,525	4,297	3,070	1,842	614	61,390
Total Capital Charges	**46,744**	**45,516**	**44,289**	**43,061**	**41,833**	**40,605**	**39,377**	**38,150**	**36,922**	**35,694**	**412,190**

Option 3: New Scanner Utilising Existing Magnet
Capitalise Lesser of Fair Value or NPV of Minimum Lease Payments

Cost of Equipment	590,000
Plus Residual Value of Machine	108,749
Total Cost of Machine	**698,749**

	YEAR										
All Costs include VAT	**1 15/16**	**2 16/17**	**3 17/18**	**4 18/19**	**5 19/20**	**6 20/21**	**7 21/22**	**8 22/23**	**9 23/24**	**10 25/25**	**TOTAL**
CAPITAL INVESTMENT											
Enabling Works	175,800										
Chiller	48,000										
10 week rental mobile and associated costs	127,000										
Fair Value of Asset	698,749										
Total Capital	**1,049,549**										
Revenue/Budget Costs:											
Lease Costs	117,361	117,361	117,361	117,361	117,361	117,361	117,361	117,361	117,361	117,361	**1,173,612**
Service and Maintenance	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	66,000	**660,000**
Total against Radiology Budget p/a	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**183,361**	**1,833,612**

Capital Charges – currently paying Capital Charges for existing scanner

Depreciation	104,955	104,955	104,955	104,955	104,955	104,955	104,955	104,955	104,955	104,955	1,049,549
Credit to Accumulated Depreciation	-69,875	-69,875	-69,875	-69,875	-69,875	-69,875	-69,875	-69,875	-69,875	-69,875	-698,749
Interest 3.5% Capital Charge	11,664	10,436	9,209	7,981	6,753	5,525	4,297	3,070	1,842	614	61,390
Total Capital Charges	**46,744**	**45,516**	**44,289**	**43,061**	**41,833**	**40,605**	**39,377**	**38,150**	**36,922**	**35,694**	**412,190**

6.1 Extension to Existing Lease Contract

If the new contract proves to be a finance lease then there will be capital financial implications, please see chart above.

The existing 7 year lease expired on 09 November 2014. Due to the financial constraints of the capital provision this project has been moved back by 6 months and sits on the Directorate's priority for next year's spend. In the interim the Trust has requested an extension of 6 months to the current agreement and repayment schedule, which the Finance Company is happy to accept. Revised paperwork has been authorised to support this extension. This will however result in the following capital investment in 2014/15. There is a residual value associated with the Finance Company's asset and this will be added to the replacement cost of the scanner and reflected in the repayment schedule.

Revenue Charge (budget)	
Lease Payments and Interest	54,057
Capital	30,589
Depreciation	30,589

7. MANAGEMENT CASE

7.1 Project Governance

Project Manager:	Alistair Day, Superintendent Radiographer - MRI
Project Sponsor:	Diane Adams, Diagnostic Imaging Manager
Project Board members:	Donna Collins, AD / Alan Sheward, Executive Director of Nursing

7.2 Project Schedule

Milestone	Target Date
Project Mandate Issued / SOC Completed	Oct 2014
Case Approval – Hospital & Ambulance Directorate Board	Oct 2014
Case Approval – Estates Programme Delivery Board	Nov 2014
Case Approval – Capital Investment Group	Nov 2014
H&A Directorate Board	Nov 2014
Capital Investment Group	Jan 2015
Capital Investment Group	Feb 2015
TEC Approval	Feb 2015
Finance Investment, Information and Workforce Committee	Feb 2015
Authorisation of revised lease agreement	Mar 2015
Mobile Scanner Installed	Apr 2015
Enabling Works for New Scanner	Apr 2015
D-streaming new scanner	Jun 2015
Acceptance and physics check	Jun 2015
Application training	Jul 2015
New MRI Service	Jul 2015

8. BENEFITS REALISATION

The options considered under this business case will, to varying degrees, address the following:

Benefits will be realised by the wider health economy and include:

Benefits to the Organisation
· Having a modern scanner at reduced cost · Maintaining a local MRI service securing positive reputation for the Trust
Benefits to Patient and Carer Groups
· Improved facilities and access to services · Improved experience and perception of the service
Benefits to Staff
· Reduce musculoskeletal strain or injury · Minimise load handling · Maintain staffing level through investment of modern technology · Professional development through software upgrades and associated training
Impact on Quality
· Delivery on national performance targets · Improved diagnostic capability
Impact on Productivity
· Improved image quality reduces requirement for repeat scan

Benefits including Improvements in Quality and Intellectual Property (IP)

Benefit Owner	Benefit Description	Measurement			Target	Baseline
		How	When	Where		
Diane Adams	Improved image quality Improved diagnostic capability	Stakeholder survey Patient Experience Survey Discrepancy Meeting	Annual Annual Bi-monthly	Report into Directorate Board Annual Report Annual Report		

9. RISK MANAGEMENT

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

						Prior to Mitigation			Post Mitigation					
Ref	Author	Date Identified	Date Last Updated	Description	Proximity	Likelihood	Severity / Consequence	Mitigating actions	Likelihood	Severity / Consequence	Owner	Current Status	Current Risk Score	Future Risk Score
	D Adams	Oct-14	Oct-14	7 year lease agreement expires end of 2014. Scanner is Finance Company's asset.	Dec-14	Certain	Major	Exploring options to modernise new scanner or purchase new one	Certain	Insignificant			20	5
	D Adams	Oct-14	Oct-14	No local MRI service in the future	Dec-14	Certain	Major	Exploring options to modernise new scanner or purchase new one	Certain	Insignificant	D Adams		20	5
	D Adams	Oct-14	Oct-14	No local MRI service in the future resulting in poor reputation as first scanner supplied through public fundraising	Dec-14	Certain	Major	Exploring options to modernise new scanner or purchase new one	Certain	Insignificant	D Adams		20	5

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

						Prior to Mitigation			Post Mitigation					
Ref	Author	Date Identified	Date Last Updated	Description	Proximity	Likelihood	Severity / Consequence	Mitigating actions	Likelihood	Severity / Consequence	Owner	Current Status	Current Risk Score	Future Risk Score
	D Adams	Oct-14	Oct-14	No local MRI service in the future would result in poor patient experience and potential clinical risk with mainland transfer	Dec-14	Certain	Major	Exploring options to modernise new scanner or purchase new one	Certain	Insignificant	D Adams		20	5
	D Adams	Oct-14	Oct-14	Initial limited service on mobile scanner during project period, potential cost implication to maintain compliance with 18 week target.	Apr-15	Certain	Major	Staff to work additional hours prior to project to minimise waiting list and allow for slight backlog during initial use of mobile scanner	Certain	Moderate	D Adams		20	15
	D Adams	Oct-14	Oct-14	Potential to fail diagnostic 6 week element of 18 week target	Apr-15	Certain	Major	Staff to work additional hours during early stages of project	Certain	Moderate	D Adams		20	15

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

						Prior to Mitigation			Post Mitigation					
Ref	Author	Date Identified	Date Last Updated	Description	Proximity	Likelihood	Severity / Consequence	Mitigating actions	Likelihood	Severity / Consequence	Owner	Current Status	Current Risk Score	Future Risk Score
	D Adams	Oct-14	Oct-14	The MRI staff will be required work extended hours there is a limited work pool to deliver this	Apr-15	Certain	Moderate	Pay existing staff additional monies	Certain	Minor	D Adams		15	10
	D Adams	Oct-14	Oct-14	Limited workforce therefore potential to fail in delivering additional hours due to sickness	Apr-15	Possible	Major	Encourage staff to have flu jabs and regular breaks during working day	Possible	Major	D Adams		12	12
	D Adams	Oct-14	Oct-14	Potential for breaches on both urgent and routine waiting targets	Apr-15	Certain	Moderate	Address backlog prior to project commencing	Certain	Minor	D Adams		15	10
	D Adams	Oct-14	Oct-14	Limited routine scans during 10 week project plan if winter pressures impact on current demand	Apr-15	Certain	Moderate	Staff to work additional hours as required to maintain compliance with performance targets	Certain	Minor	D Adams		15	10
	D Adams	Oct-14	Oct-14	Backlog of routine cases to be addressed post installation with financial implication	Mar-15	Certain	Moderate	Staff will work additional hours to reduce backlog as soon possible	Certain	Major	D Adams		15	20
	D Adams	Oct-14	Oct-14	Suitability of inpatient to transfer to mainland or being scanned on mobile scanner	Apr-15	Possible	Major	Referrals assessed for clinical suitability on a case by case basis	Possible	Major	D Adams		12	12

Summary

	Organisational Risk	
	Current	**Future**
Total Green	0	3
Total Amber	0	0
	3	0
Max Score	20	5

	Quality Impact	
	Current	**Future**
Green	0	1
Amber	0	0
Red	3	2
	20	15

	Project Delivery	
	Current	**Future**
Green	0	0
Amber	2	5
Red	4	1
	15	20

10. EQUALITY CONSIDERATIONS

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

11. STAKEHOLDER ENGAGEMENT AND COMMUNICATIONS PLAN

Stakeholder Engagement				Communications Plan		
Stakeholder	What is expected of Stakeholder	Stakeholder Management strategy	Perceived attitudes and/or risks	Means of Communication	Frequency of Communication	Responsibility for Communication
Associate Director	Provide strategic overview Assist in the breakdown of barriers as needed	Involve as necessary throughout the life of the project	Engaged	Face to Face E-Mail or telephone as and when needed	Monthly or as required - to be reviewed as needed	Project Manager /Project Support
Financial Accountant	Provide financial knowledge of budgets	Regular meeting from the start of the project	Engaged	Face to Face E-Mail or telephone as and when needed	As required	Project Manager /Project Support
Diagnostic Imaging staff	To be kept informed/updated and included in the plans	Involve as necessary throughout the life of the project	Engaged	Face to Face E-Mail	Monthly or as required - to be reviewed as needed	Project Manager / Project Support
Capital Planning Development Manager	Knowledge and expertise advice from specialty area	Regular meeting from the start of the project	Engaged	Face to Face E-Mail or telephone as and when needed	As required	Project Manager /Project Support
IT	Knowledge and expertise advice from specialty area	Regular meeting from the start of the project	Engaged	Face to Face E-Mail or telephone as and when needed	As required	Project Manager/ Project Support
Mobile Scanner company	Knowledge and expertise advice from specialty area	Involve as necessary throughout the life of the project	Engaged	E-Mail or telephone as and when needed	As required	Project Manager/ Project Support
Lease company	Knowledge and expertise advice from specialty area	Regular meeting from the start of the project	Engaged	E-Mail or telephone as and when needed	As required	Project Manager/ Project Support
CCG	To be kept informed/updated and included in the plans	Involve as necessary throughout the life of the project	To be engaged, no risk perceived	Face to Face E-Mail or telephone as and when needed	Monthly or as required - to be reviewed as needed	Project Manager/ Project Support
GPs	To be kept informed/updated and included in the plans	Involve as necessary throughout the life of the project	To be engaged, no risk perceived	E-Mail or telephone as and when needed	As required	Project Manager/ Project Support

Stakeholder Engagement				Communications Plan		
Stakeholder	What is expected of Stakeholder	Stakeholder Management strategy	Perceived attitudes and/or risks	Means of Communication	Frequency of Communication	Responsibility for Communication
Solent Supplies	Knowledge and expertise advice from specialty area	Involve as necessary throughout the life of the project	Engaged	E-Mail or telephone as and when needed	As required	Project Manager/ Project Support
Trust Clinicians	To be kept informed/updated and included in the plans	Involve as necessary throughout the life of the project	To be engaged, no risk perceived	E-Mail or telephone as and when needed	As required	Project Manager/ Project Support
MDTs	To be kept informed/updated and included in the plans	Involve as necessary throughout the life of the project	To be engaged, no risk perceived	E-Mail or telephone as and when needed	As required	Project Manager/ Project Support

RECORD OF STAKEHOLDER ASSURANCES

Area	Name	Approved	Date	Evidence of Approval	Comments
Finance	Isla Gubbins	Yes	04/11/14	E-mail	None
HR	Amy Rolf	Yes	27/10/14	Directorate Board minutes	None
Health & Safety / Security	Connie Wendes	Yes	05/11/14	E-mail	None
Fire	Martin Keightley	Yes	04/11/14	E-mail	None
IT	Jake Gully	Yes	04/11/14	E-mail	None
Information Governance	Tony Martin	Yes	06/11/14	E-mail	None
PIDS	Iain Hendey	Yes	07/11/14	E-mail	None
Contracts	Abdi Abolfazi	Yes	06/11/14	E-mail	None
Hospital & Ambulance Business Manager	Russell Ball	Yes	27/10/14	Directorate Board minutes	None
Community Business Manager	Jo Blackley	N/A			
Risk & Assurance	Brian Johnston	Yes	04/11/14	E-mail	None
Quality	Deborah Matthews	Yes	04/11/14	E-mail	None
Estates	Kevin Bolan	Yes	07/11/14	Capital Investment Group	None
Infection Control	Michelle Ould	Yes	10/11/14	E-mail	Would want to be included in carrying out risk assessment for any works involved that are carried out in dept.
Medical Electronics	Nathaniel Ford	Yes	06/11/14	E-mail	None
Solent Supplies	Sara White	Yes	07/11/14	Capital Investment Group	None

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

13. APPENDICES

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

PIA Screening Questions

Will person identifiable data be collected as part of the project and considering the technology used, have potential for substantial intrusion to the individual's privacy?
No

What data will be collected? Who is the owner of the data? Why is this information being collected?
Patient demographics. Diagnostic Imaging Department. Recorded on Radiology Information System.

Will patients be asked for consent for collection or sharing?
Yes

Does the project involve new or significantly changed handling of personal data that is sensitive, or of particular concern to individuals?
No

Might the project have the effect of allowing staff not directly involved in the care of the patient access to information.
Yes. Audits and national data submissions

Does the project involve new or significantly changed handling of a considerable number of personal data about each individual in the database?
No

Does the project involve reporting requirements? If so, who will be able to run reports? Will data in the reports be anonymised or identifiable?
Yes. National data submissions which include NHS Numbers

Does the project involve new or significantly changed consideration, inter-linking, cross-referencing or matching of personal data from multiple sources?
No

Will the information be transferred outside of the organisation? Are sharing agreements in place?
Yes. Yes.

Does the project involve systematic disclosure of personal data to, or access by, third parties that are not subject to comparable privacy regulation?
No

Does the project relate to data processing which is in anyway exempt from legislative privacy protections?
No

Does the project's justification include significant contributions to public security measures?
No

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th March 2015

Title	Development of a Strategic Partnership Agreement between the Isle of Wight NHS Trust and Isle of Wight Council in respect of provider services			
Sponsoring Executive Director	Karen Baker, Chief Executive, IW NHS Trust			
Author(s)	Gill Kennett, Integrated Locality Lead, My Life a Full Life Programme Mark Price, Company Secretary			
Purpose	For the Trust Board to note the progress since December 2014 and approve the development of a Strategic Partnership Agreement between the Isle of Wight NHS Trust and the Isle of Wight Council to deliver integrated health and social care services within the 3 identified localities.			
Action required by the Board:	**Receive**		**Approve**	**P**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration & Nominations Committee	
Charitable Funds Committee		Quality & Clinical Performance Committee	
Finance, Investment, Information & Workforce Committee		Foundation Trust Programme Board	
Please add any other committees below as needed			
Board Seminar			
Integrated Locality Workshop 19th February 2015	A workshop for all stakeholders who will be involved in integrated locality working.		

Staff, stakeholder, patient and public engagement:

Engagement has been ongoing through the My Life a Full Life Board, the IW NHS Trust, IW Council, IW CCG, Primary Care, Community Action Isle of Wight and the independent sector. Significant public engagement was undertaken in 2013 and this has shaped the My Life a Full Life Programme. Integrated Locality Working is a key element of the programme and has been supported by all of the organisations listed above.

Executive Summary:

Phase 1 of Integrated Locality Working will become operational from the 1st April 2015. The first roll-out of services into the integrated teams will be relatively small; three trust services and one council service. Phase 11 which is scheduled to start 1st April 2016 will be a much wider integration, involving greater numbers of staff and for this reason it will be necessary to have a formal Strategic Partnership Agreement which incorporates single line management of the integrated teams within a pooled budget.

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	This initiative fits with the 5 Year Health and Social Care Vision agreed between the three principal organisations
Critical Success Factors *(see key)*	CSF 1 Improve the experience and satisfaction of our patients their carers, our partners and staff CSF4 Develop our relationships with key stakeholders to continually build on our integration across health and between health, social care and the voluntary/third sector, collectively delivering a sustainable local system

	CSF5 Demonstrate robust linkages with our NHS partners, the local authority, the third sector and commercial entities for the clear benefit of our patients					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	1. No agreement to the Strategic Partnership Agreement 2. Legal implications around procurement particularly around social care packages					
Assurance Level ***(shown on BAF)***	Red		Amber		Green	
Legal implications, regulatory and consultation requirements	The Strategic Partnership Agreement will need to be a legal entity between the 2 organisations. Due to the requirement for single line management of the Integrated Locality Service there will need to consultation with staff affected within any organizational change.					
Date: 24th February 2015 **Completed by:** Gill Kennett, Integrated Locality Lead, My Life a Full Life Programme						

Development of a Strategic Partnership Agreement

1. Purpose

1.1 The purpose of the Strategic Partnership Agreement is to establish a long term partnership between the provider services of the Isle of Wight Council (the Council) and the Isle of Wight NHS Trust (the Trust).

1.2 The named partners within the strategic partnership agree to act together to address the opportunities and challenges in managing the care and support of adults. The direction of the work will be set by the Island's Health and Wellbeing Board and the partnership will work to deliver on joint health and social care outcomes for people on the Isle of Wight.

1.3 A transitional integration group (the Health and Social Care Integration Group {HSCIG}) has been established to oversee the move to integrated provider services between the council and the trust. The HSCIG will during 2015/16.

- Oversee the management and delivery of services delegated to the Partnership.
- Work with the parent bodies in development of the legal agreement (Strategic Partnership) that will set out the detail of integration including what resources are delegated to the partnership and the outcomes that are required.
- Make arrangements for full legal integration

1.4 There are essentially three elements which the HSCIG will need to consider and take forward for the successful creation of an integrated service:

- Leadership and Management of the Service
- Professional and clinical governance of the service
- Planning, Development and Business/Resource Support

1.5 The objectives of the partnership have been stated and agreed within the Five Year Health and Social Care Vision[1] which has been signed up to by the Isle of Wight Clinical Commissioning Group, the Council and the Trust.

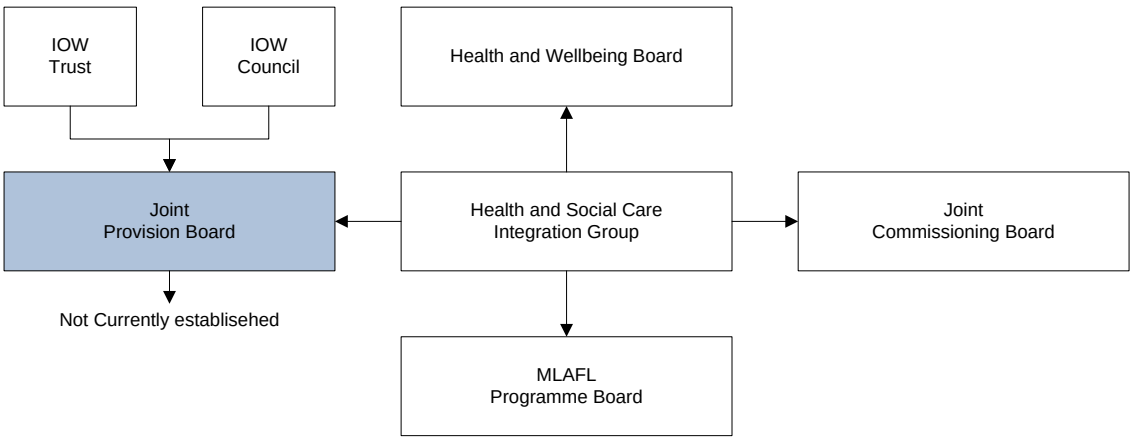
- § Person centred provision
- § Improved health and social care outcomes
- § People have a positive experience of care
- § Service provision and commissioning is delivered in the most efficient and cost effect way across the whole system, leading to system sustainability
- § Our staff will be proud of the work they do, the services they provide and the organisations they work for and we will be employers of choice

2. Governance

2.1 The Governance of the partnership will be provided through the creation of a Joint Provider Board which will be accountable to the HSCIG and ultimately accountable to the Health and Wellbeing Board for the Isle of Wight. The My Life a Full Life (MLAFL) Programme Board currently reports into the Health and Social Care Integration Group.

2.2 The MLAFL Programme Board meet monthly as do the Health and Social Care Integration Group, the Health and Well-being Board meet bi-monthly. Representation on these Boards can be seen in Appendix A.

2.3 The proposed governance structure is outlined below. It is proposed that the Joint Provision Board would have a rotating chair.



[1] IW NHS Trust; IW CCG; IW Council (April 2014) Five Year Health and Social Care Vision

3. Scope

3.1 The services which are in scope for Phase 1 of the Integrated Locality Teams commencing on the 1st April 2015 will be:

- § Community Nursing Services (the Trust)
- § Adult Long Term Care Team (the Council)
- § Continence Team (the Trust)
- § Community Matrons (the Trust)

Voluntary Services and the independent sector will be key stakeholders within the localities but are not included within this strategic partnership.

3.2 By April 2016 it is proposed that a fuller integration of the health and social care services will be achieved providing a wider range of services and incorporating the full range of Adult Social Care Services. The services which have been considered for inclusion are

- § Rehabilitation and Reablement services and associated Community Beds
- § Adult Short and Long Term Adult Social Care Teams
- § Health Trainers
- § Consideration for the Adelaide and Gouldings as an element of Adult Social Care directly provided services

3.3 **Budget** - The two provider bodies will work together towards a single pooled budget which based on current budgets would be in the region of circa £9-£15m. A cost benefit analysis will be commenced as the programme develops to better understand the financial impact of the programme.

3.4 Workstreams will now be established with representatives from both the Trust and the Council to progress the work required to implement Phase II.

4. Service Principles and Aims[2]

4.1 The principles and aims of the partnership are stated within the Five Year Health and Social Care Vision and have been agreed between the Trust and the Council.

4.2 It is felt essential that if a truly integrated approach is to be achieved then these services will ideally be led and managed under a single line management with a pooled budget and agreed outcomes[3] Consideration will need to be given to the statutory roles that are required within both organisations.

4.3 The principles and aims are detailed below.

- To work towards better integration and coordination of care across all sectors of health and social care provision within statutory deadlines.
- To reduce bureaucracy, improve efficiency and increase capacity to meet future demands for services.
- To work towards one Island budget for health and social care which makes the best use of resources.
- To ensure all care will be person centred, evidence based and delivered by the right person in the right place and at the right time.
- To jointly ensure that that our resources are focused on prevention, recovery and continuing care in the community.
- To jointly ensure that people are supported to take more responsibility for their care and to be independent at home for as long as possible reducing the need for hospital admission and long term residential care.
- To continually improve the quality of our care and improve the experience of people in contact with our services within available resources.
- To ensure partnership working across all sectors, including the third Sector and independent Sector.
- To develop our workforce to enable our staff to have to have the right knowledge, skills and expertise that is appropriate to their role.
- To encourage staff to work beyond existing boundaries to support system wide innovative delivery of care.
- To work towards a fully integrated IT system across primary, secondary and social care with appropriate access for staff.

[2] 5 year Health and Social Care Vision
[3] Committee Report Paper – Strategic Partnership with the IOW NHS Trust – 9th December 2014

- § To jointly commission services with outcome focused contracts, which incentivise positive change in providers of services.
- § To recognise the importance of communities and act to ensure we listen to Island people in the planning of services and responding to their concerns.
- § To share information in an open and transparent way to enable decision making across the organisations.

5. Operational Service Delivery

5.1 The operational service delivery will initially focus on Phase 1 of the Integrated Locality Teams. Work is also progressing on the Integrated Contact Centre (Council and Trust). Day to day line management will be provided by the Locality Lead Nurse. Professional leadership for the Adult Social Care team will remain, at this point, with social care.

5.2 A structure will need to be developed by September 2015 to support Phase 2 of the Integrated Locality Teams which will provide single-line management of health and social care. The premise is that single-line management responsibility and authority over NHS and Trust resource will be provided by a joint health and social care post

5.3 An integrated performance framework for health, social care and public health will be developed to ensure the joint priorities are achieved.

5.4 A workforce development programme is in place to underpin the learning needed to work in a different and integrated way and this programme will be available to all staff working within the statutory services, voluntary services and independent sector.

5.5 A formative evaluation of Phase 1 of the programme will be undertaken by Public Health to inform a service improvement policy based on the needs of people using the service.

6. Delegated Authority

In Phase 1 of the integrated locality team roll-out due to the small number of services involved there would not necessarily be a need to have full delegated authority. With increased numbers of services coming in in Phase 11 it will be necessary that formal delegated powers should be given to the joint provider board within a single pooled budget.

Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4 MARCH 2015

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

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Nominations Committee (Shadow)	
Charitable Funds Committee		Quality & Clinical Performance Committee	25-Feb-15
Finance, Investment, Information & Workforce Committee	24-Feb-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 January 2015 performance period for approval by Trust Board.

The key points covered include:

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

For following sections – please indicate as appropriate:

Trust Goal *(see key)*	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: **Completed by:** Andrew Shorkey, Programme Manager – Business Planning and Foundation Trust Application

ISLE OF WIGHT NHS TRUST
SELF-CERTIFICATION

1. Purpose

To seek approval of the proposed self-certification return for the January 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.

4. Performance Summary and Key Issues

Board Statements

Board Statements 1, 2, 6, 13 and 14 remain 'at risk' as a consequence of the Care Quality Commission (CQC) inspection undertaken in June 2014. Confirmation has been received from the CQC that the warning notice has been lifted and the Trust remains on trajectory towards declaring full CQC compliance.

Board Statement 10, relating to assurance that 'plans in place are sufficient to ensure ongoing compliance' with performance targets, also remains 'at risk'. It was agreed by Trust Board that the target date for compliance would be amended to 28 February 2015 to provide sufficient time for a positive trajectory towards improvement to be established. The Governance Risk Rating score (access and outcomes performance measures) for January 2015 has improved from 4.0 to 3.0 demonstrating progress towards compliance. This position is reflected within the draft return document (Appendix 1a).

Licence Conditions

All Licence Conditions remain marked as compliant. Condition G7 (Registration with the Care Quality Commission) could be put at risk if the CQC action plan is not delivered sufficiently to the satisfaction of the CQC, the lifting of the warning notice by the CQC indicates that sufficient progress is being made to ensure this condition remains compliant. This position is reflected within the draft return document (Appendix 1b).

5. Recommendations

It is recommended that the Trust Board:

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

Andrew Shorkey
Programme Manager – Business Planning and Foundation Trust Application
24 February 2015

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-Apr-15	Alan Sheward Mark Pugh
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	30-Apr-15	Mark Price
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes			Mark Pugh
	For FINANCE, that:	**Response**			
4	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes			Chris Palmer
	For GOVERNANCE, that:	**Response**			
5	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes			Karen Baker Mark Price
6	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	30-Apr-15	Mark Price
7	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes			Mark Price
8	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes			Karen Baker
9	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes			Mark Price
10	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR [Governance Risk Rating]; and a commitment to comply with all commissioned targets going forward.	At risk	The Trust's Governance Risk Rating (Monitor access and outcome measures) score declined significantly across quarters 1 & 2 2014/15. Indicator recovery plans are being implemented.	28-Feb-15	Alan Sheward Mark Pugh
11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes			Mark Price

BB - TDA Accountability Framework - Board Statements

Appendix - 1(a)

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

12	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies	Yes			Mark Price
13	The board is satisfied all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Mar-15	Karen Baker
14	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	At risk	The CQC Chief Inspector of Hospitals report identified gaps in assurance. An action plan has been developed and work to clarify gaps in assurance and test systems and processes is underway.	31-Mar-15	Karen Baker Alan Sheward

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
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
3	Condition G8 – Patient eligibility and selection criteria	Yes			Alan Sheward
4	Condition P1 – Recording of information	Yes			Chris Palmer
5	Condition P2 – Provision of information	Yes			Chris Palmer
6	Condition P3 – Assurance report on submissions to Monitor	Yes			Chris Palmer
7	Condition P4 – Compliance with the National Tariff	Yes			Chris Palmer
8	Condition P5 – Constructive engagement concerning local tariff modifications	Yes			Chris Palmer
9	Condition C1 – The right of patients to make choices	Yes			Alan Sheward
10	Condition C2 – Competition oversight	Yes			Karen Baker
11	Condition IC1 – Provision of integrated care	Yes			Alan Sheward Mark Pugh

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Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4 MARCH 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 February 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 the year.

The dashboard summary includes summary details of the key changes in ratings, with 7 Principal Risks now rated Red.

The exception report details 10 recommended changes to the Board Assurance RAG ratings of Principal Risks: two changes from Amber to Red (2.8 & 7.3); one change from Green to Red (7.22); three changes from Green to Amber (8.5, 9.1 & 10.23); one change from Red to Green (1.15); and three changes from Amber to Green (2.10, 2.17 & 9.10)

For following sections – please indicate as appropriate:

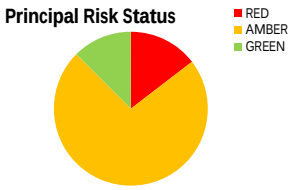
Trust Goal *(see key)*	All five goals					
Critical Success Factors *(see key)*	All Critical Success Factors					
Principal Risks ***(please enter applicable BAF references – eg 1.1; 1.6)***	All Principal Risks					
Assurance Level ***(shown on BAF)***	Red	X	Amber	X	Green	X
Legal implications, regulatory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

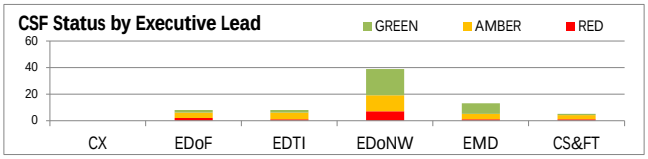
Date: 24 February 2015 **Completed by:** Fiona Brothers, Risk & Litigation Officer

BAF Status Report

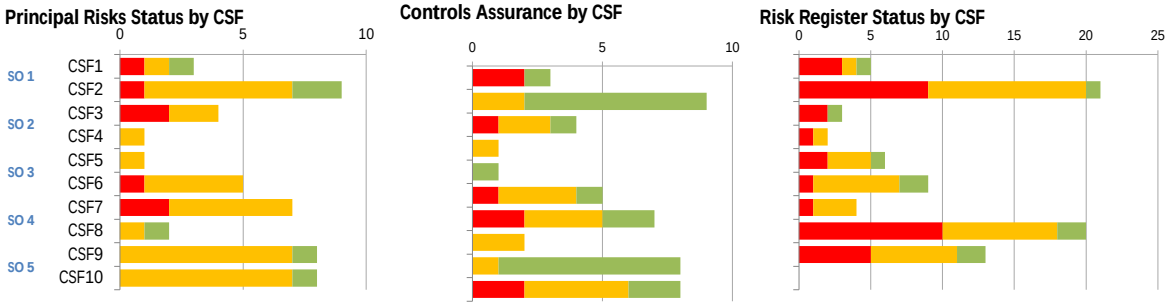
Isle of Wight NHS Trust

Principal Risks:	48	Aligned Risk Register Risks:	87





Strategic Objective & Critical Success Factor Status Overview



BAF
Increased Scores

6

Reduced Scores

4

Commentary

Principal Risks:

3 Principal Risks are recommended for changes to Red (2.8 & 7.3 from Amber, 7.22 from Green)
3 Principal Risks are recommended for changes from Green to Amber (8.5, 9.1, 10.23)
4 Principal Risks are recommended for changes to Green (1.15 from Red and 2.10, 2.17 & 9.10 from Amber)

7 New Risks were added to the Risk Register since 15.01.2015:

Ref.	Directorate	Title
639	Hosp/Amb	Working with potential Viral Haemorrhagic Fever (VHF) or similar infectious diseases
640	Corporate	Go Live of Care Identity Service
641	Comm.Health	Access to Sevenacres roof
642	Comm.Health	Integrated Community Equipment demand
643	Comm.Health	MHLD Outpatient Community Data Set (CDS) on PARIS
644	Corporate	Failure to achieve Financial Plan
645	Hosp/Amb	Replacement of Ultrasound machine in Breast Screening Unit

6 Changes to previously notified Risk scores since the last report:

557	Hosp/Amb	Cancellations of private surgery (increase to Red rating)
607	Hosp/Amb	Maternity Theatre inadequate airflow (change from Red to Amber)
630	Comm Health	SPARRCS database reslience (change from Red to Amber)
635	Comm Health	Provision of Minor Oral Surgery Service after 31.03.15 (change from Red to Green)
445	Hosp/Amb	Shared maternity bidets' potential infection control risk (change from Amber to Green)
602	Hosp/Amb	Ambulance Service vehicles 'Stockers and Washers' (change from Amber to Green)

Recommended changes to BAF assurance ratings, NEW BAF entries, Risk Scores and identification of NEW risks

Ref.	Exec Lead	Title/Description	Assurance Rating Current	Assurance Rating Change to
CSF1.15	EDoNW	1.15 Care Quality Commission Inspection - If we fail to provide a satisfactory and acceptable response to the CQC Warning letter and achieve compliance with the relevant requirements within the given timescale then we will become subject to further civil enforcement and/or criminal law action by the CQC (Ref - CQC Enforcement Policy - June 2013) Chief Executive/ Executive Medical Director/ Executive Director of Nursing and Workforce	Red	Green
CSF2.8	EDoNW	2.8 (2.13) There are many repeated incidents by type/area and individual (Q34) Company Secretary/ Executive Director of Nursing and Workforce/ Executive Medical Director	Amber	Red
CSF2.10	EDoNW	2.10 (2.15) External information on quality does not automatically feed in through the governance framework (Q40) Executive Director of Nursing and Workforce	Amber	Green
CSF2.17	EDoNW	2.17 (2.25) Meeting NICE guidelines and technology appraisals Executive Director of Nursing and Workforce	Amber	Green
CSF7.3	EDoF; EDoNW	7.3 (5.7) The Trust fails to achieve against its CIP plan by > 15% of the initial plan in the last financial year (F13) Executive Director of Finance/ Executive Medical Director/ Executive Director of Nursing and Workforce/ Executive Director of Transformation and Integration	Amber	Red

CSF7.22	EDoF; EDoNW	7.22 (9.67) Achieving the financial performance required for Foundation Trust status Executive Medical Director/ Executive Director of Nursing and Workforce/ Executive Director of Finance	Green	Red
CSF8.5	EDTI	8.5 (6.8) Implementing ICT strategy/ISIS Executive Director of Transformation and Integration	Green	Amber
CSF9.10	EDoNW; EMD	9.10 (4.21) No mention of financial awareness and responsibility in job descriptions (F33) Executive Director of Nursing and Workforce	Amber	Green
CSF10.23	EDoNW	10.23 (10.72) The Trust's latest staff survey results are poor (B35) Executive Director of Nursing and Workforce/ Executive Director of Transformation and Integration	Green	Amber
CSF9.1	EDoNW; EMD	9.1 (4.2) There is a weak recruitment process and the HR function is overstretched (Q47) Executive Director of Nursing and Workforce	GREEN	Amber
CSF2 607 - 1	EDONW	Maternity Theatre inadequate airflow leading to potential infection control risk	20	12
CSF8 630 - 1	EDONW	SPARRCS DATABASE RESILIENCE	20	12
CSF9 635 - 1	EDONW	FUTURE PROVISION FOR MINOR ORAL SURGERY SERVICE AFTER 31.03.2015	16	3
CSF2 445 - 1	EDONW	Shared maternity bidets causing potential infection control risk (BAF 2.21)	12	9
CSF3 602 - 1	EDONW	AMBULANCE SERVICE - VEHICLE "STOCKERS & WASHERS"	12	4
CSF7 557 - 1	EDONW	Excessive NHS use of private patient ward impacting upon business profitability (BAF 2.26)	12	20
CSF1 642 - 1	EDONW	INTEGRATED COMMUNITY EQUIPMENT DEMAND	20	20
CSF8 644 - 1	EDOF	FAILURE TO ACHIEVE FINANCIAL PLAN	20	20
CSF1 645 - 1	EDONW	REPLACEMENT OF ULTRASOUND MACHINE IN BREAST SCREENING UNIT	9	9
CSF5 639 - 1	EDONW	WORKING WITH POTENTIAL VHF OR SIMILAR INFECTIOUS DISEASES OF HIGH CONSEQUENCES IN SAMPLES	15	15
CSF5 640 - 1	EDONW	GO LIVE OF CARE IDENTITY SERVICE (CIS)	12	12
CSF2 641 - 1	EDONW	ACCESS TO THE ROOF - SEVENACRES	12	12
CSF4 643 - 1	EDONW	MHLD OUTPATIENT COMMUNITY DATA SET (CDS) ON PARIS	12	12

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
Strategic Objective 1: QUALITY - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and experience **Exec Sponsor: Executive Director of Nursing and Workforce**										
<u>Critical Success Factor CSF1</u> **Lead: Executive Director of Nursing and Workforce** **<u>Improve the experience and satisfaction of our patients, their carers, our partners and staff</u>** **Links to CQC Regulations: 9, 12, 17, 19, 21, 22, 23**						MEASURES: **Improved patient and staff survey results** **Complaints/concerns from patients/carers and staff** **Compliments from patients/carers and staff** **CQC inspection/Trust inspection outcomes** **Culture, Health and Wellbeing strategy objectives achieved** **No service disruption occurs if Major incident or Business Continuity Plans are invoked** **Friends and Family test results** **Staff Friends and Family test results**			TARGETS: **Patient and staff survey results for 14/15 show better outcomes than results for 13/14** **Patient care complaints reduced by 10% on 2013/14** **All CQC key domains / essential standards met** **All services provided 365 days per year** **Increased patient involvement evidenced** **Achieve 30% response rate in patients friends and family test results by March 2015** **Achieve 20% response rate in staff friends and family test results by March 2015** **Greater alignment between patient and staff satisfaction**	
1.15 Care Quality Commission Inspection - If we fail to provide a satisfactory and acceptable response to the CQC Warning letter and achieve compliance with the relevant requirements within the given timescale then we will become subject to further civil enforcement and/or criminal law action by the CQC (Ref - CQC Enforcement Policy - June 2013) Chief Executive/ Executive Medical Director/ Executive Director of Nursing and Workforce		**20**		Executive and Senior Management leads identified for all aspects of the Quality Improvement plan CQC Project team in place meeting weekly Patient Safety, Experience and Clinical Effectiveness Committee (SEE Committee) given responsibility for ongoing review of the improvement plan to track delivery and highlight any potential failings TEC reviewing actions taken and ongoing progress reports weekly Links established with TDA to oversee and advise on the development of our improvement plans	Trust Executive Committee Quaility and Clinical Performance Committee SEE Committee Improvement Plan in respect of warning notice and inspection report approved by CQC. Resistance to some of the changes required to meet CQC requirements addressed. CQC accepted that delivery of some of the actions/ improvements required was not possible within original timescales.	Monthly updates from QCPC Monitoring and assurance reports - to be agreed	**Green**			Fully complete the action/improvement plan for TEC review and agreement **Alan Sheward/Deborah Matthews/Dr. Sandya** Update November 2014: Quality Improvement Plan completed and approved by Trust Board October 2014 Update January 2015: Submitted statement re compliance re Enforcement Notice to CQC in Dec 2014, with 3 declared non compliant. **Update February 2015:** CQC confirmed Compliance Action accepted. Warning notice Lifted 13.02.2015. **Action complete** Agree Executive Director/Clinical Director level responsibility for resolving any outstanding difficulties regarding the action we must take to deliver the warning notice requirements and agree an approved assurance process for monitoring and managing change and the actions required **Alan Sheward** Update November 2014: Executive and Clinical Leads agreed. Action plan reflects these leads. Weekly assurance reviews taking place against the action plan. Assurance reports provided to this weekly meeting. **Update February 2015:** CQC confirmed Compliance Action accepted. Warning notice Lifted 13.02.2015. **Action complete** Continue to link with the TDA and CQC to ensure their agreement to the actions we are putting in place to meet CQC requirements for compliance actions where we are unable to meet the deadlines requested by the Commission. **Alan Sheward** **Update November 2014:** Monthly IDMs in place with the TDA. Clarity required from CQC on local Lead. **Update February 2015:** CQC Confirmed Compliance Action accepoted. Warning notice Lifted 13.02.2015. **Action complete** **Recommend change of assurance rating from Red to Green**
<u>Critical Success Factor CSF2</u> **Lead: Executive Director of Nursing and Workforce** **<u>Improve clinical effectiveness, safety and outcomes for our patients</u>** **Links to CQC Regulations: 9, 10, 12, 13, 14, 17, 18, 20, 21, 22, 23**					MEASURES: **VTE compliance** **HAPPI audit results** **HMSR stats.** **Pressure Ulcer indicators** **CQUIN outcomes** **MRSA and Cdiff stats.** **Approved departmental clinical governance plans:** **- National performance targets** **- Participation in screening programmes** **- Participation in Health improvement programmes for children and young people**			TARGETS: **Board approved quality account within DH deadline** **90% compliance against all HAPPI indicators** **Zero MRSA cases in 2014/15** **Achieve rebased HMSR and SHMI of <108 by end March 2015** **Zero Grade 4 pressure ulcers in a hospital setting** **50% reduction in grades 1,2 and 3 pressure ulcers in hospital setting, from a 2013/14 baseline** **25% reduction in overall incidence of patients developing pressure ulcers in hospital** **50% reduction in grades 1 to 4 pressure ulcers in a community setting, from a 2013/14 baseline** **Centralise PALS service by 31st May 2014** **Trust-wide action plan (from national patient/staff surveys) developed by 31st May 2014** **Ward Boards in place in all identified areas by 31st December 2014** **10% reduction in hospital led outpatient cancellations from a 2013/14 baseline** **100% achievement of CQUINS** **>95% VTE assessments throughout 2014/15**	
2.8 *(2.13)* There are many repeated incidents by type/area and individual (Q34) Company Secretary/ Executive Director of Nursing and Workforce/ Executive Medical Director	**8**	**8**		There is a campaign to support harm reduction which includes on the job training. The Trust undertakes additional innovative measures to reduce harm for example, global trigger tool, aseptic non-touch technique (ANTT) etc. There is a shared learning framework/ forum across the organisation.	Quarterly Learning Lessons newsletters Directorate Board reports montly Risk Management Committee minutes QCPC minutes Regular monitoring and reporting of incident trends RMC/QCPC promotes shared learning across the organisation Safety Thermometer, Island wide Pressure Ulcer Reduction campaign	NHSLA level 1 accreditation	**Red**	No local 'campaign' in place to support harm reduction -Policies related to risk need urgent review.		Review at Quality and Clinical Performance Committee and agree current initiatives and future plans Sarah Johnston/**Deborah Matthews** Update May 2014: Unable to recruit to new SEE lead nurse post. Six month secondment opportunity to be explored and then post readvertised. Update July 2014: Now appointed to SEE lead nurse role on 6 month secondment. SEE committee will oversee patient safety incident trends as part of their TOR. Update September 2014: 6 weeks Secondee to oversee specific SIRI work Update October 2014: Secondee report to be presented to TEC 20.10.14 Update November 2014: SEE overseeing a number of safety related initiatives aimed at monitoring, managing and reducing avoidable harm. Developing competencies to reduce avoidable harm. Update December 2014: MP **-** Await introduction of Quality Improvement workstream to complete campaign for harm reduction; AWS - Clinical Risk steering group to be developed by SEE triumvirate providing assurance on lessons learned, monitoring and management of risk. **Update February 2015: AS** Assurance and process for assurance requires urgent review. Lines of Accountability, Responsability and Lessons learned are still unclear. Structure to undertake this work reporting to Board need to be clarified and agreed. Negative level of assurance at QCPC at current time. **Recommend change of assurance rating from Amber to Red.** **Review date: March 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
2.10 *(2.15)* External information on quality does not automatically feed in through the governance framework (Q40) Executive Director of Nursing and Workforce	**6**	**6**		There is assimilation of NICE guidance, external reviews and enquiries, rule 43 etc.: This Board ensures that key regulatory and outcome information feeds systematically into Trust-wide and divisional governance systems; External sources of assurance are largely covered in the Assurance and Escalation Framework; There is a timetable of the production of external reports or there is advanced warning to the Board that external reports are due for publication (i.e. Ombudsman reports) this will assist with NED challenge; External reports are summarised and communicated throughout the Trust where relevant. CQC QRP reports are shared when published NCEPOD and CQC reports are shared via Quality and Patient Safety Committee QCPC - Exec - Trust Board	SEE QCGC Care Quality Commission Intelligent Monitoring reports Systems for monitoring NICE and NCPOD now robust	Board Performance report monthly SEE report to QCPC, whose minutes inform Trust Board	**Green**			Systems for monitoring NICE guidance, external reviews and enquiries to be strengthened during 2013/14 Timetable of external reports to be established and early warning mechanism of external reports for publication to be strengthened. Sarah Johnston/Vanessa Flower/**Deborah Matthews** Update April 2014: (VF) Awaiting staff appointments following March 2014 interviews. SEE interviews postponed until April 2014. Update June 2014: (VF) Gap still remains for a robust system for monitoring and gaining assurance in the management of NICE/ NCEPOD. Work currently underway to ensure that new SEE committee, due to commence by end June 2014, picks this up. No lead for SEE appointed as yet, but committee is to commence and oversee the work of the Quality Governance Framework. Assurance will then be fed up to Q&CPC and TEC. Update September 2014: HealthAssure package reviewed as a driver to improve monitoring, now looking to source funding. Update October 2014: (BJ) Business case awaiting approval by Capital Investment Group. Update November 2014: CIG approved bid but no funding available. Developed an interim measure of NICE dissemination monitoring and escalation tool, potentially permanent. Same system to be developed for Audit **Update February 2015:(DM)** System tool now operating for NICE on permanent basis, monitoring through SEE. **Action complete** **Recommend change of assurance rating to Green**
2.17 *(2.25)* Meeting NICE guidelines and technology appraisals Executive Director of Nursing and Workforce	**9**	**12**		Monitoring via Quality and Clinical Performance Committee	QCPC review monthly all newly issued guidelines etc SEE Committee Directorate Quality Meetings Pharmacy monitoring system Systems for monitoring NICE and NCPOD now robust	Quality reports to Board monthly SEE report to QCPC, whose minutes inform Trust Board	**Green**			Review and agree system for reporting on NICE guidelines and TAs and put in place. **Sarah Johnston/**Vanessa Flower/**Deborah Matthews** Update May 2014: New SEE Committee terms of reference currently being drafted and finalised. Management and monitoring of NICE guidelines will be part of the responsibilities of this group. Update July 2014: Awaiting SEE committee to commence. TOR have been drafted and provisionally agreed. Also looking at possibility of purchasing NICEAssure software system which would be a great help towards mitigating this risk. Update September 2014: Still no evidence to date, currently dependent on HealthAssure package implementation. Update November 2014: CIG approved bid for HA funding, albeit not available at present. Developed an interim measure of NICE dissemination monitoring and escalation tool, potentially permanent. Technology appraisal continue to be well monitored and managed through the Chief Pharmacist. **Update February 2015:(DM)** System tool now operating for NICE on permanent basis, monitoring through SEE. **Action complete** **Recommend change of assurance rating to Green**
Principal Objective 4: PRODUCTIVITY - To improve the productivity and efficiency of the Trust, building greater financial sustainability **Exec Sponsor: Executive Director of Finance**										
<u>Critical success factor CSF7</u> **Leads: Executive Director of Finance, Executive Director of Nursing and Workforce** **<u>Improve value for money and generate our planned surplus whilst maintaining or improving quality</u>** Links to CQC Regulations: 24						MEASURES: **Achievement of revenue financial plan** **Achievement of capital financial plan** **Achievement of cash plan** **Achievement of surplus position** **Achievement of recurrent CIP plan** **Satisfactory Internal & External Audit Reports**			TARGETS: **£170m income 31/03/15** **£7.460m capital Resource Limit** **£5.407m 31/03/15** **Surplus of £1.7m 31/03//15** **Target of £8.998m 31/03/15** **Positive annual reports from Internal & External audit**	
7.3 *(5.7)* The Trust fails to achieve against its CIP plan by > 15% of the initial plan in the last financial year (F13) Executive Director of Finance/ Executive Medical Director/ Executive Director of Nursing and Workforce/ Executive Director of Transformation and Integration	**15**	**15**		There is a track record of delivering against financial plans on a comparative scale without compromising the Trust's overall objectives. The Board has taken action to address key financial issues in previous years and is monitoring progress against these. The Trust can demonstrate that key financial targets have been met and there are no significant variances between outturn and the annual financial plan. There are no significant variances in the performance reported to the Board in the current year against plan. The Trust has a good track record of delivering >90% of CIP plans and can demonstrate that this has predominantly been met through recurrent schemes	Trust's Financial/LTFM and CIP plans. Variance analysis. Trust Board Financial Papers/Presentations/Dashboards and Sub-Committee papers Detailed reporting of CIPS to Board Best practice templates developedCIP process	Monthly performance review, weekly financial review, Trust Executive Committee, Trust Board, Directorate Board, Finance Investment Workforce Committee. All forums monitor performance & require action if targets are not being met.	**Red**	Gaps in CIP schemes identified at business planning stage, requirement for 2 years rolling CIP programme.		Ensure Financial Procedures updated in relation to CIPs **Katie Gray/Kevin Curnow/**Dave Arnold (04/13-03/14) Update April 2014: (KC) Figures for M11 indicated the Trust would deliver its CIP programme for 2013/14 of which 65% is expected to be recurrent. Update June 2014: (KC) CIP monitoring by TMO on a monthly basis to drive achievement. Update August 2014: (KC) CIP monitoring on going & appraised at monthly performance reviews & deep dives Update October 2014: (KC) CIP assurance process undertaken with assistance from External resource to establish current baseline. Subsequent to outcome actions to be determined. Update December 2014: (KC) Achievement of CIP in the last financial year, although 35% was non recurrent. Executive Director of Transformation and Integration added to Lead Execs. **Update February 2015: (KC)** Current in year CIP achievement expected to be circa 50%. **Recommend change of assurance rating from Amber to Red** **Review date: March 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
7.22 *(9.67)* Achieving the financial performance required for Foundation Trust status Executive Medical Director/ Executive Director of Nursing and Workforce/ Executive Director of Finance	**10**	**10**	**16**	Introduction of QUINCE monitoring system Transformation Management Office relaunch embedding programme management of schemes Regular Clinical Directorate Group meetings Weekly/Monthly finance meetings with clinical directorates including CIP monitoring Monthly performance monitoring Directorate 'focus' days on CIPs	Financial performance reviewed monthly at FIWC and Trust Board as part of self-certification submisison to TDA	Trust Board Reports; Audit Committee; Finance Investment and Workforce Committee and FT Programme Board Achieving a Continuity of Service Risk Rating of 4.	**Red**	Revised planned surplus position as of January 2015		**Chris Palmer/Kevin Curnow** **Change of assurance rating to Green approved September 2013** Update April 2014: (KC) Financial measures currently being achieved, however a £9.2m CIP programme in 2014/15 will need to be delivered. Update July 2014: (KC) Financial performance currently on plan. Performance reviews & CIP monitoring are held with directorates on at least a monthly basis to maintain focus on financial achievement. Update November 2014: (KC) no change to above **Update January 2015: (KC)** As at M9 the Trust is reporting the planned surplus position of £1.7m. **Recommend change of assurance rating from Green to Red**
Critical success factor CSF8 **Lead: Executive Director of Transformation and Integration** **Develop our support infrastructure, including driving our integrated information system (ISIS) forwards to improve the quality and value of the services we provide** **Links to CQC Regulations: 9, 11, 17, 21, 23, 24**							MEASURES: **Delivery of IM&T Strategy** **Delivery of Estates Strategy** **Delivery of Backlog Maintenance Plan**		TARGETS: **Capital estate business cases approved by October 2014** **IT business cases approved by October 2014** **Capital programme 80% complete by December 2014**	
8.5 *(6.8)* Implementing ICT strategy/ISIS Executive Director of Transformation and Integration	**12**	**12**		PRINCE2 project structure with Project Board & exec sponsor Programme Director, Transformational Change in place Oct 2012 to support change elements. IM&T Strategy	Board reporting IM&T Delivery Group Executive briefings Capital Investment Group Funding for the IM&T programme approved for 2013/14 & 2014/15	Project highlight reports	**Amber**	Resource & operational ownership. Requires organisational programme support - not just IT.		Ensure business case for provider options clearly states and encompasses IM&T strategy capital and revenue requirements. IM&T incorporated into IBP & strategy refresh Nov 2013. Katie Gray/Paul Dubery Update November 2014: IT strategy refreshed June 2014 Update February 2015: Wider organisational support is suboptimal. Recommend change of assurance rating from Green to Amber Review date: April 2015
Principal Objective 5: WORKFORCE - To develop our people, culture and workforce competencies to implement our vision and clinical strategy **Executive Sponsors: Executive Director of Nursing and Workforce, Executive Medical Director**										
Critical success factor CSF9 **Leads: Executive Director of Nursing and Workforce, Executive Medical Director** **Redesign our workforce so people of the right attitude, skills and capabilities are in the right places at the right time to deliver high quality patient care** Links to CQC Regulations: 15, 22, 24						MEASURES: **Workforce productivity measures including:** **Staff Turnover** **Safe staffing levels** **Bank and agency usage** **Mandatory Training compliance**			TARGETS: **Meet workforce strategy KPIs** **- Long term sickness rates under 1.2% by 31/3/15** **- Short term sickness rates under 1.6% by 31/3/15** **- 98% staff appraisals undertaken period 1/4/14 - 31/3/15** **- reduction in bank/agency costs to <£250K by 31/3/14** **-100% staff fully compliant with mandatory training at some point within the year 1/4/14 -31/3/15** **- staff turnover under 4.5% by 31/3/15** **- achieve 80% actual against plan for safe staffing levels by March 2015**	
9.1 *(4.2)* There is a weak recruitment process and the HR function is overstretched (Q47) Executive Director of Nursing and Workforce	6	6	6	The Board ensures that all staff are positively recruited, trained and developed: Staff are recruited not only for competency but also for values. There is a robust induction process with a focus on visions and values. Clear process supported by legal best practice and Policy. Clear timescales set and monitored as part of the recruitment process. Recruitment & Selection procedure, Workforce Strategy, using National Tool NHS Jobs.	Regular review of policy	Board Performance Report	**Amber**	Recruitment strategy not meeting requirements of organisation		Alan Sheward/Mark Elmore Recruitment strategy to confirm recruitment processes meet demand Change of assurance rating to Green approved September 2013 Update February 2014: Introducing medical workforce role in next financial year Update April 2014: business case being developed Update February 2015: HR Recruitment remains under pressure. Additional resource required via bid to CCG as part of CQC Action Plan. Recommend change of assurance rating from Green to Amber Red
9.10 *(4.21)* No mention of financial awareness and responsibility in job descriptions (F33) Executive Director of Nursing and Workforce	**8**	**8**		Job descriptions specify competency required	Job descriptions/profiles Job evaluations Appraisals **Job description template includes reference to financial aspects for new appointments** **Formal review of current job descriptions undertaken**	Audit report Evaluation report	**Green**			HR Director to undertake review of job descriptions for all senior staff **Alan Sheward**/Jackie Skeel/**Mark Elmore** Update October 2014: Liz Nials actioning 'Clean-up' required for current staff JDs as part of ongoing work Update December 2014: **AWS** Confirmation requested from LN & ME Update January 2015: LN confirmed that Managing Financial Resources is now Item 6 in the JD template that is available on the HR Portal. **Update February 2015: Action complete** **Recommend change of assurance rating to Green**

Principal Risks (What could prevent this objective being achieved?)	Initial RS	Mid year RS	End of Year RS	Controls in Place (What controls/systems do we have in place to assist in securing delivery of the objective?)	Assurances on Controls (Where can the board gain evidence that our controls/ systems on which we are placing reliance, are effective)	Positive Assurance to Board (Actual evidence that our controls/systems are effective and the objective is being achieved)	Assurance Level	Gaps in Control (Where we are failing to put controls/ systems in place)	Gaps in Assurance (Where we are failing to provide evidence that our controls/ systems are effective)	Action Plan to Address Gaps in Controls/Assurances Performance management and monitoring committees: Objective 1 - QUALITY - Quality & Clinical Performance Committee Objective 2 - CLINICAL STRATEGY - Quality & Clinical Performance Committee Objective 3 - RESILIENCE - Trust Executive Committee Objective 4 - PRODUCTIVITY - Finance, Investment & Workforce Committee Objective 5 - WORKFORCE - Finance, Investment & Workforce Committee
Critical success factor CSF10 **Lead: Executive Director of Nursing and Workforce** **Develop our organisational culture, processes and capabilities to be a thriving FT** Links to CQC Regulations: 9, 10 , 17						MEASURES: **Monitor ratings for governance, including quality and finance** **Board Development** **Stakeholder engagement** **Organisational Thermometer** **Staff survey results** **Staff raising concerns** **Staff friends and family test**			TARGETS: **Achieve top Monitor ratings for governance by March 2015** **Achieve 25% response rate in staff friends and family test results by March 2015** **Percentage of vacancies to be under 11.7% by 31/3/15** **Staff survey results for 14/15 show better outcomes than results for 13/14:** **- survey response rate over 60% in 2014/15** **- Over 60% of staff would recommend the Trust as a place to work** **- Over 93% of staff feel satisfied with the quality of patient care they deliver** **- Over 60% of staff would be happy for us to provide care to a relative or friend**	
10.23 *(10.72)* The Trust's latest staff survey results are poor (B35) Executive Director of Nursing and Workforce/ Executive Director of Transformation and Integration	**12**	**12**	**20**	A variety of methods are used by the Trust to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. The Board can evidence how staff have been engaged in the development of their 5 year strategy for the Trust and provide examples of where their views have been included and not included in the IBP. The Board ensures that staff understand the Trust's key priorities and how they contribute as individual staff members to delivering these priorities. The Trust uses various ways to celebrate services that have an excellent reputation and acknowledge staff who have made an outstanding contribution to patient care and the running of the Trust. Staff attitude survey annual report Individual Reports SAS Champions Group and Action Plan	Board Performance Report	Board performance Report	**Amber**	**Action Plan from 2013 Survey not monitored or managed effectively**		**Alan Sheward/Katie Gray** Update January 2015: Recommendation to change Lead Director to Katie Gray approved **Update Febuary 2015:** Results of 2014 survey highlighted major areas of concern. 5 key themes identified and working groups are to be developed 03/15, led bottom up with Exec sponsorship. **Recommend change of assurance rating from Green to Amber** **Review date: April 2015**

Board Assurance Framework column headings: Guidance for completion and ongoing review (N.B. Refer to DoH publication 'Building an Assurance Framework' for further details)

Principal Risks: All risks which have the potential to threaten the achievement of the organisations principal objectives. Boards need to manage these principal risks rather than reacting to the consequences of risk exposure.
RISK LEVEL = S (Severity where 1 = insignificant; 2 = minor; 3=moderate; 4=major; 5=catastrophic) X L (Likelihood where 1=rare; =unlikely; 3=possible; 4=likely; 5=certain)= RS(Risk Score). Code score: 1-9 GREEN; 10-15 AMBER; 16+ RED

Controls in Place: To include all controls/systems in place to assist in the management of the principal risks and to secure the delivery of the objectives.

Assurances on Controls: Details of where the Board can find evidence that our controls/systems on which we are placing reliance, are effective. Assurances can be derived from independent sources/review e.g. CQC, NHSLA, internal and external audit; or non-independent sources e.g. clinical audit, internal management reports, performance reports, self assessment reports etc.
NB 1: All assurances to the board must be annotated to show whether they are POSITIVE (where the assurance evidences that we are reasonably managing our principal risks and the objectives are being delivered) or NEGATIVE (where the assurance suggests there are gaps in our controls and/or our assurances about our ability to achieve our principal objectives)
NB 2: Care should be taken about references to committee minutes as sources of assurance available to the board. In most cases it is the reports provided to those committees that should be cited as sources of assurance, together with the dates the reports were produced/ reviewed, rather than the minutes of the committee itself.

Assurance Level RAG ratings:
Effective controls in place and Board satisfied that appropriate positive assurances are available OR Effective controls in place with positive assurance available to Board and action plans in place which the Executive Lead is confident will be delivered on time = GREEN (+ add review date)
Effective controls mostly in place and some positive assurance available to the board . Action plans are in place to address any remaining controls/assurance gaps = AMBER
Effective controls may not be in place or may not be sufficient. Appropriate assurances are either not available to Board or the Exec Lead has ongoing concerns about the organisations ability to address the principal risks and/or achieve the objective = RED
(NB - Board will need to periodically review the GREEN controls/assurances to check that these remain current/satisfactory)

Gaps in Control: details of where we are failing to put controls/systems in place to manage the principal risks or where one or more of the key controls is proving to be ineffective.

Gaps in Assurance: details of where there is a lack of board assurance, either positive or negative, about the effectiveness of one or more of the controls in place. This may be as a result of lack of relevant reviews, concerns about the scope or depth of any reviews that have taken place or lack of appropriate information available to the board.

Action Plans: To include details of all plans in place, or being put in place, to manage/control the principal risks and/or to provide suitable assurances to the board. NB: All action plans to include review dates (to enable ongoing monitoring by the board or designated sub-committee) and expected completion dates (to ensure controls/assurances will be put in place and made available in a timely manner)

Assurance Framework 2013/14 working document - August 2013. Guidance last updated December 2009.

ID	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
639	HOSAMB	GOVCOM	28/01/15	31/01/16	WORKING WITH POTENTIAL VHF OR SIMILAR INFECTIOUSE DISEASES OF HIGH CONSEQUENCES IN SAMPLES	ET	* Incidental exposure to staff□ * Processing, storage and disposal of potentially VHF or similar samples□ * Samples received within Pathology without prior warning or referral through a Consultant Microbiologist□ * Cross discipline involvement - Performing Malaria testing, full blood count, INR and APTT on fully enclosed analysers□ * Dealing with spills or breakages within centrifuge sealed buckets.□ * Referral of sample to RIPL Porton Down to establish if VHF case or not. This includes packaging of sample, Trust non patient transport drivers, Red funnel ferry or MOD police launch, PDP courier.□	15	15	MOD	* All samples/cultures would be handled under Containment Level 3 conditions□ * Risk assessments in place. These are revised on a yearly basis or if a process has changed.□ * Full PPE. 'Buddy' system and documented checklist for donning and doffing. Competency and training records.□ * Main physical involvement carried out by Microbiology BMS staff only.□ * Referral of samples to RIPL Porton Down - Trust non patient transport checklists, Red Funnel Dangerous Goods Declaration note, Shippers Declaration for Dangerous Goods form, Maritime and Coastguard Agency letter of approval, UN specification packaging, labelling and documentation requirements for infectious substances in Category A, ADR registration and PHE recommendation for PDP couriers.□ * VHF status of patient will be known within 6-7hours of receipt of sample at RIPL Porton Down. No other work will be carried out until status is known.□	A	28.01.15 Approved at RMC on 21.01.15.	6 items listed to date, with latest completion date of 8.01.2016	EDONW
640	CORPRI	PATSAF	11/02/15	25/02/15	GO LIVE OF CARE IDENTITY SERVICE (CIS)	ME	* Care Identity Service is the replacement system for managing smartcards and smartcard users.□ * The switch over from the current systems to CIS will take place from Thursday 19th February to Monday 23rd February. CIS will be available from Tuesday 24th February 2015.□ * The Trust uses smartcards to access some national systems, namely:□ Choose and Book, 111, Adastra, Electronic Staff Record, NHS Baby Registration, SUS data (for reporting by PID's).□ * During the transition, there may be a brief outage, which may disconnect a user from the spine for up to 5 minutes.□ * This outage may have an impact on the 111 service	12	12	MOD	* Notified managers in both Community and Mental Health and HAD directorates on 3rd and 10th February 2015.□ * Screen saver to promote smartcard vigilance to be displayed 16th February 2015.□ * Raised awareness through e-bulletin.				EDONW
641	COMMH	PATSAF	19/02/15	30/04/15	ACCESS TO THE ROOF - SEVENACRES	JDO	* Patient can climb onto the roof of the building with relative ease with consequent risk to life.	12	12	MOD	All patients are risk assessed and place on the appropriate level of nursing observations.□ Garden furniture fixed to the floor to prevent moving under the eaves for access. □ Anti-climb paint will be applied on exterior of building with the next 2/52□	I	19.02.15 Approved at RMC on 18.02.15	3 items listed to date, with latest completion date of 16.02.2015	EDONW
642	COMMH	PATSAF	19/02/15	31/03/15	INTEGRATED COMMUNITY EQUIPMENT DEMAND	NT	* Failure to meet organisational commitments□ * Failure to meet Government initiative targets□ * Increased admissions□ * Delayed discharges, bed blocking□ * Staffing (numbers, stress, absence)□ * Bed blocking in nursing homes due to inability to collect equipment (beds)□ * Essential equipment safety maintenance□ * Decontamination□ * Not supporting patients on Telehealth in the community	20	20	HIGH	Current staff adapting working practice i.e. loan workers where the task requires 2 persons (risk). Service managers undertaking operational duties (essential strategic work delayed). Postponed collections in favour of deliveries, (available equipment shortage, distress to bereaved relatives)	I	19.02.15 Approved at RMC on 18.02.15.	11 items listed to date, with latest completion date of 31.03.2015	EDONW
643	COMMH	PATSAF	19/02/15	31/03/15	MHLD OUTPATIENT COMMUNITY DATA SET (CDS) ON PARIS	NT	* MHLD out-patient data has to be included in a Trust wide statutory CDS submission □ * Currently Information Management are not able to include Paris data in the Trust submission □ * MHLD Outpatient clinics remain within PAS to enable the CDS statutory submission .□ * Staff are currently required to duplicate patient information into Paris and PAS □ * This issue has been highlighted for 18 months and still has not been resolved□ * Cost implication of £7k to submit data set from Isle of Wight NHS Trust□ * Information Management to decide on how this can be progressed.	12	12	MOD	* Double entry from PAS to Paris to ensure that information is accessible	I	19.02.15 Approved at RMC on 18.02.15.	4 items listed to date, with latest completion date of 31.03.2015	EDONW

ID	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
644	CORPRI	GOVCOM	19/02/15	31/03/15	FAILURE TO ACHIEVE FINANCIAL PLAN	CP	* Key financial governance target missed * Lack of cash available within organisation * In ability to re-invest in service	20	20	HIGH	Monthly performance reviews held & further escalation meetings as required. Monthly report to Finance, Investment, Information & Workforce Committee as well as board	A	19.02.15 Approved at RMC on 18.02.15.	Continual monitoring & review of directorate recovery plans	EDOF
645	HOSAMB	QCE	19/02/15	31/03/15	REPLACEMENT OF ULTRASOUND MACHINE IN BREAST SCREENING UNIT	DCOLL	* Quality of imaging is poor for small lesions especially micro calcifications * Risk of missing small cancers - confidence levels of operator * Current machine in BSU cumbersome making workflows difficult * Risk of MSK injury to staff due to room ergonomics and size of the unit * Consistency of imaging quality across the departments * No ability to transfer services between imaging services to aid workload pressures * Risk of breakdowns affecting service delivery and achieving targets * At recommended age for consideration of replacement (5 years).	9	9	LOW	* Equipment on rolling replacement programme * Service contract * Routine quality assurance programme * Suggest repeat examination if uncertainty prevails		19.02.15 Approved at RMC on 21.01.15 and Q&R on 19.02.15.	Early replacement of US unit ahead of anticipated equipment replacement programme	EDONW

Key for Assurance Level for Risk Register Entries: GREEN - A adequate controls; AMBER - I inadequate controls; RED - U uncontrolled risks

ID	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
445	HOSAMB	PATSAF	21/03/11	31/03/16	Shared maternity bidets causing potential infection control risk (BAF 2.21)	AHU	* shared bidet facilities. Patient Safety risk e.g. colonisation of Group Strep A infection	25	9	LOW	* bidets to remain out of action until they can be removed. * Running of water twice a week in place to reduce risk of legionnaire's.	A	05/09/14 Update following CIG - Work to remove Bidets to be undertaken as part of backlog maintenance work by estates - plans in place to achieve this by end of the financial year. RB Jan 2015 - Work to commence 16/02/15 and to complete by year end. VL	4 items listed to date, with latest completion date of 31.03.2015	EDONW
557	HOSAMB	PATEXP	22/01/13	01/04/15	Excessive NHS use of private patient ward impacting upon business profitability (BAF 2.26)	CBU	* Risk of reduced income and damage to long term business though excessive use of Mottistone beds by the NHS.	16	20	HIGH	* Highlighting risk in bed decisions to senior management. * Planning with Bed Management private admissions. * Trust wide work to reduce bed LOS (and thus freeing up beds).	I	Update (18/08/14): Use of private beds for NHS patients being monitored - looking to ring fence beds once estates work in the the Trust has been completed, easing impact. 19.1.15 update from MR. Following 8 cancellations of private work/amenity in three weeks, significant loss of revenue and reputational damage is being experienced e.g. source patient complaints/cancellation records.	4 items listed to date, with latest completion date of 1.04.2015	EDONW
602	HOSAMB	PATSAF	27/03/14	30/03/15	AMBULANCE SERVICE - VEHICLE "STOCKERS & WASHERS"	DCOLL	Hotel Services employs 5 (five) staff as Ambulance Service Vehicle "Stockers & Washers" * Those five staff operate a rota system, but if one is on annual leave or sick they are often not replaced with a suitably trained substitute * If a substitute is sent: 1. They are not assessed as able to drive our vehicles - essential for the role 2. They are not trained in the stocking process - critical for safe service delivery * We are not aware of when staff will or will not be working, as we do not line manage them	12	4	LOW	* Only control method in place is to report absence of staff to their Line Manager, and submit a Datix form. * We have no control of substitute staff that are sent * Action plan implemented and so risk reduced but unfunded cost pressure for 2015/16 so risk will increase again if controls removed.	A	27.03.14 Approved by RMC members via voting button circulated on 20.03.14. Reviewed RB (21.05.14) Staff to transfer line management responsibility to Ambulance during June - Budget transfer to be reviewed after this managerial transfer. RB update (01/10/14) New rota to be implemented - to review impact after 1 month RB. 19.01.15 This plan was not able to be progressed when the hrs associated with this service (those they were going to transfer to our management) were not enough to cover the service. We subsequently met with the hotel services team to agree a different rota within the hrs/ personnel available. This rota has been agreed with Hotel services although there is still some work to be done on assurance that holiday/sickness cover will be there. The current plan would require a month's notice on the relocation of staff so the expected implementation date is the 1st of March 2015. If the new rota is able to deliver the service and cover is maintained we will again look at taking over the management of the service.	4 items listed to date, with latest completion date of 31.03.2015	EDONW
607	HOSAMB	PATSAF	30/04/14	31/03/15	Maternity Theatre inadequate airflow leading to potential infection control risk	DCOLL	* Prep room inadequate air flow for laying up of instruments or storage of equipment * Dirty utility has inadequate air flow that could lead to contamination through the clean corridor to the delivery rooms * The pressure differentials did not create the correct cascade through delivery suite to maintain a hierarchy of cleanliness	20	12	MOD	* Currently laying up instruments in theatre. This has to be done in front of the woman which is not good for patient experience. * Labour ward theatre is small and numerous people are required to attend laying up in theatre would mean an increased risk of de sterilisation of equipment * Cat 1 caesarean sections are required to be performed in under 30 minutes again laying up in theatre in a rushed environment a higher risk of de sterilisation of instruments is higher	I	30.04.14 Approved at RMC on 16th April. Update 08/12/14 RB - Action plan in place with mitigation to ensure laying up of instruments in theatre as temporary measure and working closely with microbiologist to improve practice and monitor infection rates - working with estates to move forward on a capital bid for theatre upgrade for next financial year, subject to prioritisation. Update 05/02/15 VL - The lay out has been altered to make sure the setting up in done in main theatre directly under maximum air flow. Microbiology still have major concerns. Laying up cabinets not endorsed by clinicians. Same issue in main theatres in two rooms so parallel risk to be raised. SEE to take Trustwide line on the issue. Department keen to explore managing the risk until the theatre upgrade. Likelihood altered to 'likely' from certain as infection rates have been monitored since risk raised and no detectable effect.	5 items listed to date, with latest completion date of 30.06.2015	EDONW

ID	DIR	Risk Subtype	Opened	Anticipated Target/ Completion date	Title	Resp	Description	Rating (initial)	Rating (current)	RAG	Status of Controls in Place	Adequacy of controls	Action summary	Description (Action Plan)	Exec Director
630	COMMH	GOVCOM	24/10/14	30/06/15	SPARRCS DATABASE RESILIENCE	NT	* One database for all referrals and data for Community Rehab and SPARRC's service. * Database unstable and lost data (for example: informed lost 55 SLT referrals added in month of August). Data lost internally but no information governance breach. * Data lost and has required resubmitting. However reliant on human eye/memory to note if data accurate. * Informed unable to draw data from the database as database has become too large to filter. * Multiple users of one key system increases risk of corruption. * System which contains PID is not secure * This data is required for managing waiting lists, caseload, response times, key involvements. * This system is both the working database for the service and also the data collection for the SLA reporting (too wide for current set up) * Database is 2 years old (set up by service for service as pilot). No investment/support from IT in place	20	12	MOD	Reviewed structure and needs of database Modified database to reduce data loss Back up copy of database taken each day Daily monitoring and working with PIDS and Paris to find a solution Recognised need for IT support	A	24.10.14 Approved at RMC on 15.10.14. Discussions with PIDS/IT/PARIS to determine long term solution. 31.10.14 Ongoing implementation of controls to minimise risk and liaison with PIDS and Paris to formalise a solution. IT involvement pending. EP. 30.11.14 Awaiting agreement from IT to support new PIDS solution. LA. 31.12.14 Work progressing alongside Paris and PIDS however IT involvement limited due to current capacity. EP. 17.02.15 No further update. LA.	7 items listed to date, with latest completion date of 30.06.2015	EDONW
635	COMMH	QCE	26/11/14	31/03/15	FUTURE PROVISION FOR MINOR ORAL SURGERY SERVICE AFTER 31.03.2015	NT	* Dental service is transferring to new mainland provider from 1st April. * MOSS is not part of the contract that went out to tender and won by the new provider. * Staff that work for the dental service support the MOSS for the Isle of Wight Trust and staff will transfer to the new provider.	16	3	LOW	The IOW dental service will continue to support the Moss service until the end of the dental service contract. NHS Somerset to take Minor Oral Surgery Contract from 01.04.15.	A	26.11.14 Approved by RMC members via voting buttons on e-mail 17.11.14. 31.12.14 Discussions ongoing with Commissioners. DC. 19.02.15 NHS Somerset to take Minor Oral Surgery (MOS) Contract on 01.04.15 when this risk will close. NT.	3 items listed to date, with latest completion date of 31.03.2015	EDONW

Key for Assurance Level for Risk Register Entries: GREEN - A adequate controls; AMBER - I inadequate controls; RED - U uncontrolled risks

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Isle of Wight NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th MARCH 2015

Title	Mental Health Act Scrutiny Committee			
Sponsoring Executive Director	Mark Price, Company Secretary			
Author(s)	Stephen Ward, Mental Health Act & Mental Capacity Lead			
Purpose	To approve the MHASC's updated terms of reference			
Action required by the Board:	**Receive**		**Approve**	**X**

Previously considered by (state date):			
Trust Executive Committee		Mental Health Act Scrutiny Committee	13/01/15
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:

The attached updated terms of reference were agreed by the Mental Health Act Scrutiny Committee on the 13th January 2015. They now reflect 2 Non-Executive members with a quorum including 1 Non-Executive Member.

For following sections – please indicate as appropriate:

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

Date: 11th February2015 **Completed by:** Company Secretary

Mental Health Act Scrutiny Committee

Terms of Reference

Document Type:	**Committee Terms of Reference**
Date document valid from:	**4th March 2015**
Document review due date:	**15th January 2015**

AUDIT TRAIL:

Dates reviewed:	15th January 2015	**Version number:**	V7 2014
Dates agreed:	15th January 2015	**Version number:**	V8
Details of most recent review: (*Outline main changes made to document*)	· Updated members list · Updated quorum requirement		

Signature of Chairman of Committee:

Print Name: Jessamy Baird Post Held: Designate Non Executive Director
Date: 15th January 2015

Trust Board Approval Authorised Signature	
Authorised by:	**Danny Fisher**
Job Title:	**Chairman of Trust**
Approved at:	**Trust Board**
Date Approved by Trust Board:	**4th March 2015**

Isle of Wight NHS
NHS Trust

MENTAL HEALTH ACT SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. MAIN PURPOSE

1.1 To ensure the Mental Health Act 1983 is implemented in accordance with the law and the associated Code of Practice.

1.2 To ensure guidance and case law relating to the Act is disseminated and implemented.

2. MEMBERSHIP & QUORUM

2.1 The Committee will consist of 16 members

2.2 Members:

Designate Non Executive Director (Chairman)
Non Executive Director (Vice Chairman)
Consultant Psychiatrist – Adult Psychiatry
Consultant Psychiatrist – Psychiatry of Old Age
Mental Health Administrator
Mental Health Act Lead
Approved Mental Health Professional
Service User Representative
Carer Representative
IMHA Representative
Hospital Manager x 2
Departmental Representatives for:

- Community Mental Health Services
- Inpatient Services
- Learning Disabilities Services
- Child and Adolescent Mental Health Services
- Dementia Services

2.3 Members are required to send a deputy if they are unable to attend a meeting. Members' deputies will be included as part of the quorum with full voting rights. Apologies for non-attendance should be sent one week in advance whenever possible.

2.4 The following will be in attendance:

- Committee Administrator

2.5 Quorum:

2.5.1 A quorum shall be no less than six members including:

- 1 Non Executive Director orDesignate Non Executive Director
- 1 Mental Health specialist

- 1 Hospital Manager
- 3 other representatives

2.5.2 In line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting.

3. ATTENDANCE AT MEETINGS

3.1 Members are expected to attend quarterly meetings a minimum of 3 out of the 4 meetings per year, and to advise the Committee Administrator if unable to attend

3.2 When the Committee is discussing areas of risk or operation that are the responsibility of an Executive or Clinical Director, any other director, manager or employee may also be required to attend in order to present papers or to provide additional information in support of discussions.

4. FREQUENCY OF MEETINGS

4.1 Meetings are to be held Quarterly.

5. DELEGATED AUTHORITY

5.1 The Mental Health Act Scrutiny Committee is a formal sub - committee of, and directly accountable to, the Trust Board.

6. ROLE & RESPONSIBILITES

6.1 To monitor and report quarterly on Mental Health Act activity within the Trust and provide an annual review. To monitor utilisation of S12 qualified doctors.

6.2 To monitor and report quarterly on the use of the Deprivation of Liberty Safeguards within the Trust and provide an annual review.

6.3 To commission the drafting of policies, protocols and procedures relating to the Mental Health Act.

6.4 To identify and monitor clinical audit priorities and reporting in relation to the use of the Mental Health Act.

6.5 To ensure that Mental Health Act responsibilities and training needs are identified and met.

6.6 To share good practice in relation to the Mental Health Act.

6.7 The business discussed at MHASC meetings does not normally identify individuals. However, in some instances members of the committee may identify individuals from their circumstances and are then expected to maintain confidentiality.

7. REPORTING

7.1 The Mental Health Act Scrutiny Committee will report directly to the Trust Board. Copies of meeting minutes will be submitted to the Trust Board

7.2 The Committee will report to the Community Health Directorate Board and Executive Medical Director through minutes.

7.3 The minutes of the Committee meetings also to be submitted to:
a) Trust Executive Committee
b) Mental Health Quality Group Meeting

8. DUTIES & ADMINISTRATION

8.1 It is the duty of the Committee to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour.

8.2 The Committee will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.

8.3 The Committee shall be supported administratively by the Committee Administrator, whose duties in this respect will include:

a) Agreement of agenda with Chairman and collation of papers
b) Circulate agenda papers a minimum of 5 working days in advance of the meeting
c) Take the minutes
d) In Line with Standing Orders 4.12.5 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting
e) Keeping a record of matters arising and issues to be carried forward
f) Maintaining an Action Tracking System for agreed Committee actions
g) In conjunction with the Chairman and Lead Executive Director, prepare an annual report on the effectiveness of the Committee for submission to the Audit & Corporate Risk Committee
h) Maintain an Attendance Register. The completed Register to be submitted to the Trust Chairman and attached to the Committee's annual report
i) Advising the Committee on pertinent areas.
j) To maintain agendas and minutes in line with the policy on retention of records

8.4 An Annual report will be submitted to the Audit & Corporate Risk Committee which will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Committee meetings**.**

9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

9.1 These Terms of Reference will be reviewed annually to ensure that the committee is carrying out its functions effectively.

9.2 Attendance and frequency of meetings will be monitored by the Committee Administrator and reported back to the Committee on a 6 monthly basis.

9.3 Concerns highlighted when monitoring compliance with the above will be discussed at Mental Health Act Scrutiny Committee and referred to the Board immediately.

Isle of Wight NHS
NHS Trust

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 4th MARCH 2015

Title	Audit & Corporate Risk Committee			
Sponsoring Executive Director	Chris Palmer, Executive Director of Finance Mark Price, Company Secretary			
Author(s)	Corporate Governance Officer			
Purpose	To approve the ACRC's updated terms of reference			
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	10/02/15	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:

The attached updated terms of reference were agreed by the Audit & Corporate Risk Committee on the 10th February 2015. The terms of reference are replicated from the NHS Audit Committee Handbook 2014 Appendix A.

For following sections – please indicate as appropriate:

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

Date: 11th February2015 **Completed by:** **Corporate Governance Officer**

AUDIT & CORPORATE RISK COMMITTEE
Terms of Reference

Document Type:	Committee Terms of Reference
Date document valid from:	4th March 2015
Document review due date:	1st January 2016

AUDIT TRAIL:

Date(s) reviewed:	December 2014		
Date(s) agreed:	February 2014	**Version number:**	V6
Details of most recent review: (*Outline main changes made to document*)		The terms of reference are replicated from the NHS Audit Committee Handbook 2014 Appendix A. The Audit & Corporate Risk Committee is asked to agree the terms of reference for presentation to the Trust Board for approval.	

Signature of Chair of Committee:

Print Name: David King **Post Held:** Non Executive Director **Date: 10th February 2015**

Trust Board Approval Authorised Signature	
Authorised by:	**Danny Fisher**
Job Title:	**Chairman of Trust**
Approved at:	**Trust Board**
Date Approved by Trust Board:	**4th March 2015**

Isle of Wight NHS
NHS Trust

AUDIT AND CORPORATE RISK COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Trust Board hereby resolves to establish a committee of the Trust Board to be known as the Audit & Corporate Risk Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. MEMBERSHIP AND QUORUM

2.1 Membership

2.1.1 The Committee shall be appointed by the Trust Board from amongst its independent, non-executive directors and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board. The Chair of the organisation itself shall not be a member of the Committee.

2.2 Quorum

2.2.1 A quorum shall be two of the three independent members.

3 ATTENDANCE AT MEETINGS

3.1 The Executive Director of Finance and appropriate internal and external audit representatives shall normally attend meetings.

3.2 The counter fraud specialist will attend a minimum of two committee meetings a year.

3.3 The Accountable Officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. He or she should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

3.4 Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

3.5 Representatives from other organisations (for example, NHS Protect) and other individuals may be invited to attend on occasion.

3.6 The organisation's company secretary (or governance lead) shall be secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

3.7 At least once a year the Committee should meet privately with the external and internal auditors.

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4. ACCESS

4.1 The Head of Internal Audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the Committee.

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5. FREQUENCY OF MEETINGS

5.1 The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting and audit cycle is suggested. The Trust Board, Accountable Officer, external auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

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6 AUTHORITY

6.1 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

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7 RESPONSIBILITIES

7.1 The Committee's duties/responsibilities can be categorised as follows:

7.2 Integrated governance, risk management and internal control

7.2.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's objectives.

7.2.2 In particular, the Committee will review the adequacy and effectiveness of:

a) all risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independence assurances, prior to submission to the Trust Board

b) the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

c) the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications

d) the policies and procedures for all work related to counter fraud and security as required by NHS Protect

e) receive an annual report on the use of the Board Seal in line with Standing Orders clause 9.4

7.2.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.2.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

7.2.5 As part of its integrated approach, the Committee will have effective relationships with other key committees (for example the quality committee) so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

7.3 Internal Audit

7.3.1 The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2013* and provides appropriate independent assurance to the Committee, Accountable Officer and Trust Board. This will be achieved by:

a) considering the provision of the internal audit service and the costs involved

b) reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework

c) considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources

d) ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

e) monitoring the effectiveness of internal audit and carrying out an annual review.

7.4 External Audit

7.4.1 The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee

will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

a) considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Trust Board when appropriate)

b) discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan

c) discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee

d) reviewing all external audit reports, including the report to those charges with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

e) ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services

7.5 Other assurance functions

7.5.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

7.5.2 These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges, accreditation bodies, etc.)

7.5.3 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.

7.5.4 In reviewing the work of a clinical governance committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

7.6 Counter Fraud and Security

7.6.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

7.7 Management

7.7.1 The Committee shall request and review reports, evidence and assurance from directors and managers on the overall arrangements for governance, risk management and internal control.

7.7.2 The Committee may also request specific reports from individual functions within the organisation (for example clinical audit).

7.8 Financial Reporting

7.8.1 The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

7.8.2 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

7.8.3 The Committee shall review the annual report and financial statements before submission to the Trust Board, focusing particularly on:

a) the wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee

b) changes in, and compliance with, accounting policies, practices and estimation techniques

c) unadjusted mis-statements in the financial statements

d) significant judgements in preparation of the financial statements

e) significant adjustments resulting from the audit

f) Letters of representation

g) Explanations for significant variances.

7.9 Whistle Blowing

7.9.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

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8 REPORTING

8.1 The Committee shall report to the Trust Board on how it discharges its responsibilities.

8.2 The minutes of the Committee's meetings shall be formally recorded by the secretary and submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full governing body, or require executive action.

8.3 The Committee will report to the Trust Board at least annually on its work in support of the annual governance statement, specifically commenting on:

a) the fitness for purpose of the assurance framework

b) the completeness and 'embeddedness' of risk management in the organisation

c) the integration of governance arrangements

d) the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business

e) The robustness of the processes behind the quality accounts.

8.4 This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

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9 ADMINISTRATIVE SUPPORT

9.1 It is the duty of the Committee to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Committee), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour.

9.2 The Committee will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.

9.3 The Committee shall be supported administratively by its secretary (the organisation's company secretary or governance lead), whose duties in this respect will include:

a) Agreement of agendas with the Chair and attendees
b) Preparation, collation and circulation of papers in good time
c) Taking the minutes and helping the Chair to prepare reports to the Trust Board
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 and ensuring that action points are taken forward between meetings
f) Arranging meetings for the Chair, for example with the internal/external auditors or local counter fraud specialist
g) Maintaining records of members' appointments and renewal dates etc.
h) Maintain an Attendance Register. The completed Register to be attached to the Committee's annual report
i) Advising the Committee on pertinent issues/areas of interest/policy developments
j) Ensuring that Committee members receive the development and training they need

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Isle of Wight NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 4 MARCH 2015

QUALITY & CLINICAL PERFORMANCE COMMITTEE
Wednesday 25 February 2015

Present:	Sue Wadsworth	Non-Executive Director (Chair)
	Nina Moorman	Non-Executive Director and Deputy Chair (DC)
	Alan Sheward	Executive Director of Nursing and Workforce (EDNW)
	Mark Pugh	Executive Medical Director (EMD)
	Deborah Matthews	Lead for Patient Safety, Experience and Clinical Effectiveness (LSEE)
	Donna Collins	Associate Director, Hospital and Ambulance Directorate (AD-HAD) on behalf of Sabeena Allahdin, Clinical Director, Hospital and Ambulance Directorate (CD-HAD)
	Lisa Reed	Head of Clinical Services, Community and Mental Health Directorate (HOCS-CMHD) on behalf of Clinical Director, Community and Mental Health Directorate (CD-CMHD)
	Chris Orchin	Non-Executive Director (Governance and Compliance) Healthwatch IW (HIW)
In Attendance:	Theresa Gallard	Safety, Experience & Effectiveness Business Manager (SEEBM)
	Stephen Wheeler	Programme Manager, Patient Flow & Length of Stay Programme (PM)
	Vanessa Flower	Patient Experience Lead (PEL) *(for item 15/Q/043)*
	Diane Adams	Manager, Diagnostic Imaging (MDI) *(for item 15/Q/047)*
	Andy Shorkey	Business Planning and Foundation Trust Programme Management Officer (BPFTMO) *(for item 15/Q/049)*
Minuted by:	Amanda Garner	Sub Committee Administrator (SCA)

Key Points from Minutes to be reported to the Trust Board

- **Issues raised regarding breadth of TOR of QCPC**: Should be concentrating on Clinical Quality; concern re level of assurance that can be given by SEE to QCPC - to be discussed at Seminar session to replace QCPC meeting in March
- **15/Q/032 - Risks flagged by SEE Committee:** Quality of data; increase in pressure ulcers in the community; C Diff 3 cases over target; SIRI process being monitored by TDA – to be discussed at Seminar
- **15/Q/033 - Key risks from Hospital and Ambulance Directorate:** RTT and the bed situation – all elective surgery is cancelled for next 2 weeks except for urgent cancer cases; OPARU work progressing. Discharge planning – positive assurance re the project on Colwell Ward to reduce Length of stay – benefits for patients and for the financial position. Will take until April 2017 to roll the programme out to all wards.
- **15/Q/034 - Key risks from Community and Mental Health Directorate:** Sharply increasing demand on Integrated Community Equipment Stores (ICES) which is crucial to support patients in the community and reduce hospital stays; Access to the roof at Sevenacres.
- **15/Q/036 – Quality Improvement Plan (QIP):** Positive assurance given by Director of Nursing. Report will be provided monthly together with minutes of challenge meeting.
- **15/A/038 - Quality Governance Assurance Framework:** Re-score – increased to 5.5 to reflect concerns of CQC.
- **15/Q/047 - Oncology Action Plan:** Negative assurance received as we are failing to comply with national Standards due to lack of appropriate commissioning by NHS England of the service required for the island from Southampton. We need at least daily presence of oncologist to provide urgent clinic slots. Appears to be a money issue compounded by lack of oncologists nationally and changes in clinical practice. CCG are being supportive. Agreed to escalate to Board to facilitate the local review that has been proposed but for which there is no date set.

Minute No.	
15/Q/027	**APOLOGIES FOR ABSENCE**
	Apologies were received from Jessamy Baird, Designate Non-Executive Director (JB), Ian Bast, Patient Representative (PR), and Sabeena Allahdin, Clinical Director, Hospital & Ambulance Directorate (CD-HAD). The Chair advised the Committee that this would be her last meeting and Nina Moorman, current Deputy Chair (DC), will be taking over as Chair from next month. The DC advised that she would like the meeting on 25 March 2015 to take the form of a seminar to enable the Committee to move the meeting forward. The DC added that she thought that the Committee does not always review things that it should and needs to get assurance on quality across the Trust.. She advised that she will be attending the Quality Meetings at University of Southampton NHS FT and Portsmouth Hospitals NHS Trust and will be attending other Quality Meetings within the Trust as preparation for the seminar.. The Committee agreed and the HOCS-CMHD added that the Terms of Reference also need to be reviewed. The Committee discussed the title of the Committee. The EDNW advised that this had been part of the feedback from the Trust Development Authority (TDA) and added that the recent review of Governance carried out by Fiona Hoskins had suggested that the Committee be known as the Clinical Governance Committee. The EDNW added that Mark Price, Company Secretary, is looking at the Corporate Governance process and he will be reviewing the Clinical Governance process as it is currently not clear. The Committee discussed setting principles for gaining assurance. The Committee were asked to send the DC their thoughts on this. ***Action Note**: The Committee to send the DC their thoughts on the Committee going forward.* **Action by All** The EMD reflected on the TDA feedback of the meeting that they observed. The AD-HAD advised that some of the assurance was limited as the person in attendance at the meeting did not know the answer to the queries raised. The Committee agreed that the subject matter expert should be invited to the meeting. The DC added that the Committee should be looking at clinical services. The EMD advised that at Frimley Park the Lead Consultant attended the meeting to update the Committee and answer any queries and advised that we should do this too. The DC agreed and added that over 12 months the Committee could hear from most clinical areas. The HOCS-CMHD agreed adding that this would give clinicians the opportunity to give assurance and highlight any issues.
15/Q/028	**CONFIRMATION OF QUORACY**
	The Chair confirmed the meeting was quorate.
15/Q/029	**DECLARATIONS OF INTEREST**
	There were no declarations of interest.
15/Q/030	**MINUTES OF THE MEETING HELD ON 21 JANUARY 2015**
	The minutes of the meeting held on 21 January 2015 were approved by the Committee.
15/Q/031	**REVIEW OF ACTION TRACKER AND ASSURANCE TRACKER**
	The Committee reviewed the action tracker: **Action QCPC0360** – The SEEBM advised that Fiona Brothers, Risk and Litigations Officer, had met with the Company Secretary recently and that the External Agencies Report is

	being reviewed with more of a forward view. The EMD advised that it would be of value to see this report and see who has visited and the resulting action plan. The SEEBM advised that part of the review will include a responsible committee and an assurance committee on this report. The DC advised that this is an item that can be discussed at the Seminar Meeting on 25 March 2015. **Action QCPC0369** – The AD-HAD advised that this action was closed and updated the Committee including how a system is in place to audit readmissions The EDNW advised that this had come up as part of contract negotiations. He added that the audit was clearly happening but that the results need to be seen by this Committee. The AD-HAD advised that crisis response is part of the system resilience schemes and the team had been put into ED and tasked with preventing 10 admissions per month but had achieved 13. She added that they had prevented up to 42 admissions in some months. The Chair advised that it would be good to hear a brief composite report in April 2015 of the audit results. **Action QCPC0379** – The Chair advised that she was not happy with the current arrangements regarding Trust Board Visits in that they had stopped and asked that this be fed back to the Company Secretary. The EDNW agreed that they need to restart and advised that he will get a small task and finish group together to redraft the Terms of Reference and report to Trust Board. ***Action Note:*** *The EDNW to establish a 'Task and Finish' group.* *Action by: EDNW* The Chair advised that it would take a long time to review the actions and asked that all Committee members update the Sub-Committee Administrator on their actions. ***Action Note****: Committee members to update their actions and update the Sub Committee Administrator.* **Action by All**
QUALITY	
15/Q/032	**REPORT FROM PATIENT SAFETY, EXPERIENCE AND EFFECTIVENESS (SEE) COMMITTEE**
	The LSEE advised that was an update report from the Patient Safety, Experience and Clinical Effectiveness (SEE) Committee following their meeting on 18 February 2015. The LSEE highlighted the following: • Quality Report – the data had been disaggregated and there were some concerns around the validity of the data. PIDS are working on this. The Chair advised that she had received some anecdotal feedback concerning inaccurate data. The LSEE advised that there was some data missing but there was no gaming involved. • Quality Improvement Plan – two outstanding enforcement actions and these are making good progress. The Chair advised that she agreed with the negative TDA feedback comment that the Committee are not giving enough time to this. • CQUINS – All CQUINS achieved their Quarter 3 milestones. The DC advised that this Committee should be aware of the CQUINS i.e. what they are and how they are being monitored. The LSEE advised that there is concern regarding the Patient Safety Thermometer for Quarter 4. The Committee discussed benchmarking data. The EDNW advised that these were useful guides and part of the national audit. He advised that the Trust is an outlier and grade 4 pressure ulcers may want to be considered as never events. He added that there was much work to do on this. The LSEE added that clarity is required on the strategy and what is being done to drive this forward. The HOCS-CMHD advised that demand in the Community had increased. The DC advised that Audit Committee would like feedback on this. The Chair asked for feedback at the April 2015 meeting. ***Action Note****: Feedback to be given at April 2015 meeting.* **Action by LSEE**

- Quality Goals Consultation – Feedback has been requested.
- Care Quality Commission (CQC) Inspection Report for Shackleton – an unannounced visit took place on 15 December 2014 and there were 3 recommended actions. The action plan is being monitored at the Mental Health Quality Meeting.
- Clinical Leads Update – no updates provided
- Serious Incidents Requiring Investigation (SIRI) Report – 58 open SIRI cases.
- Safeguarding Vulnerable Adults Monthly Review – During January 2015 there were 9 safeguarding cases reported, three of which were regarding one ward which is of concern. Increase in referrals is positive showing increased level of awareness amongst staff. Higher number of cases of absconders from mental health wards reports and this is being taken forward as one issue. No pressure ulcers reported under safeguarding during January 2015. Assurance given that the IW Council are ensuring that health take the appropriate action in relation to cases that relate to conduct and capability. Safeguarding Team are working closely with the Directorate Quality Managers to ensure that lessons learned are shared across the whole Trust. Concern regarding a level 3 case has gone forward for consideration for a Serious Case Review.
- A number of policies have been updated and approved.
- Infection Prevention and Control Quarterly Report – C difficile – 3 cases over target of 6 for year 2014/15. Key issues – failure to take specimens early enough. The LSEE highlighted the DISCO campaign and changes made to the stool chart. Environmental Audit Scores appear to be worse than last year. Estates are being regularly chased regarding this. Peer review audit will be undertaken.

The EMD highlighted the number of abbreviations in the report and asked for these to be explained in the report.

***Action Note**: Abbreviations to be explained.*

Action by LSEE

- Safety Alerts Report – MDA alert regarding infusion pumps – a trial for new pumps is underway. The LSEE is taking this to the Trust Executive Committee (TEC).
- Report on Correlation between Bed Moves and Pressure Ulcers – will be discussed at the next SEE meeting due to staff sickness.
- Patient Experience Quarterly Report – positive assurance of Friends and Family Test (FFT). Slight rise in complaints, concerns and PALS contacts. The timeliness in responding to complaints needs to improve.
- Laundry Audit – very assured. The Committee could not understand why this had been referred to this meeting by the Audit Committee and asked the SCA to send this extract from the SEE Report to the Audit Committee.

***Action Note**: Extract of SEE report regarding Laundry Audit to be sent to Audit Committee.*

Action by SCA

- Management Plan for Appointment Cancellations – limited assurance regarding impact on patient care from cancelled appointments. The AD-HAD updated the Committee regarding some changes to one of the Breast Clinics which improved the service to patients however because the clinic was split it looked like some appointments had been cancelled when they had not, they had been moved.
- Clinical Audit – national audits – Asthma in Children Audit results were poor and there was concern that this was potentially due to methodology of the data collected and the picture was not as bad as depicted and an audit had been requested. The EMD advised that it was our data and the results need to be accepted at face value and for the teams to prove this it is wrong. The LSEE advised that an action plan is in development. The Chair highlighted that four national audits were delayed. The LSEE advised that these were being undertaken by a staff member who was new in post and there was a backlog. The AD-HAD advised that she is ensuring that the manager puts support in place.
- Coroners Inquests – increasing number

The EDNW commended the Team on their report advising that is was showing quality assurance as a process with a non-biased view and recognising the shortfalls. He added

	that there was more assurance given to the SEE Committee than was being received by this Committee. The DC advised that this Committee cannot be assured simply by the SEE Committee being assured The Committee discussed infection control issues and the AD-HAD advised that a theme had been recognised concerning night staff and this is being addressed. The EDNW advised that the Trust Action Plan is monitored by the Infection Prevention and Control Committee (IPCC). The AD-HAD advised that representatives from the directorate attend IPCC feedback at the team meeting.
15/Q/033	**HOSPITAL AND AMBULANCE DIRECTORATE**
	The AD-HAD updated the Committee regarding the risk and governance processes and advised that local risks are monitored monthly and there is a lot of work ongoing. She advised that there is a new Business Manager and a process in place for managing risks within the directorate. The AD-HAD updated the Committee on the Hospital and Ambulance Directorate Governance Structure highlighting when the various meetings take place. She added that performance reviews are being put in place and each service unit will have a performance review. The AD-HAD updated the Committee regarding Morbidity and Mortality (M&M) and advised that the Terms of Reference are being updated to include lessons learnt and action plans. She added that the directorate does not have full assurance however work is ongoing on this. The DC asked if the outcomes of the M&M meetings should be presented to this Committee. The Committee discussed this and agreed that something overarching would be helpful. The EMD advised that the information would be presented to the SEE Committee who would update this Committee. The EMD advised that the Community and Mental Health Directorate are undertaking a weekly review and it is important to think about the quality of care, i.e. end of life care given to patients rather than their numbers. He added that the PEL will be sending out a questionnaire to families after 6 months for their feedback regarding this. The AD-HAD advised that the End of Life Strategy will be crucial and that it is currently out for comment. The EMD advised that work is ongoing regarding End of Life care in the hospital. The Committee asked for an update for the April 2015 meeting. ***Action Note**: End of Life update to be presented at April 2015 meeting* **Action by AD-HAD and EMD** The AD-HAD updated the Committee on the standard agenda used at the Directorate Service Board meetings including top issues, what is reported and minutes from sub-committees. The AD-HAD advised the Committee that the key risks facing the Directorate are Referral to Treatment (RTT) and the bed situation. She advised that for the next two weeks all elective surgery is being paused with the exception of urgent cancer patients. The AD-HAD advised that there has been an increase in pressure ulcers, complaints, the use of locum and agency nurses and this was a concern. She added that whilst staff are dealing with these issues SIRIs and monitoring are becoming a second priority. The AD-HAD added that she had identified additional resource to support the matrons. The EMD highlighted the new risk added to the Corporate Risk Register (RR639) and asked that this be re-worded for clarity. ***Action Note**: Risk RR639 to be reworded for clarity.* **Action by AD-HAD** The EDNW advised that this was very useful and helped the Committee to understand where the gaps are. The Committee discussed the standardisation of Terms of Reference, agenda and minute presentation for both Directorates. ***Action Note**: SEE to complete Standardisation of Terms of Reference, Meeting Agenda and Minutes presentation* **Action by SEE**

	The EDNW highlighted the update report from the Outpatient Appointment and Records Unit (OPARU) and advised that a lot of work was being done to improve the service. The SEEBM advised that the SEE Committee had asked for this update for the Committee for assurance. The AD-HAD advised that the Quality Performance KPIs are already in the project and the Committee needs to have oversight of the project. The Chair asked for an update at the April or May 2015 meeting. The Committee agreed that it would be nice to see Mr Steve Elsmore's response to the work as he had raised the issue to the Board as chair of HMSC. ***Action Note**: Steve Elsmore to be invited to the next QCPC* **Action by PA** The AD-HAD advised that Beacon follows the same process as the other Committees and reporting to the Directorate Board. She advised that there had been concern regarding the recording of incidents however the Trust systems are used. The AD-HAD advised that Beacon uses hospital clinical protocols plus GP ones. The EDNW advised that incidents do not show on the Quality Report. ***Action Note**: EDNW to meet with AD-HAD and CD for Beacon* **Action by EDNW**
15/Q/034	**COMMUNITY AND MENTAL HEALTH DIRECTORATE**
	The HOCS-CMHD updated the Committee on how the Directorate monitors and manages the risk process. She advised that this is reviewed at the Quality Meetings and Directorate Board meetings and reviewed at the beginning and end of each year. She added that the directorate is doing work on sitreps. The Committee noted that the Integrated Community Equipment Store (ICES) demand had been added to the Corporate Risk Register. The HOCS-CMHD advised that the Service currently has between 20,000 and 25,000 pieces of equipment in use including 1200 beds in the community which is a huge increase but there has not been an increase in staff. The HOCS-CMHD advised that demand had increased and the team had put in a better system for getting equipment back. She added that the risk was in terms of meeting demand hence putting it on the Risk Register. The DC advised that she had spent some time with ICES and was impressed with the service they provided. Another risk added was the roof of Sevenacres for which a business case was put forward:the new Head of Mental Health and Learning Disabilities had identified this as much more of a risk than previously thought, . The HOCS-CMHD advised that risks are discussed at the Directorate Board and the two Quality meetings.
15/Q/035	**QUALITY REPORT - EXCEPTIONS**
	The LSEE presented the Quality Report to the Committee and highlighted that the report had been disaggregated. The LSEE highlighted the follows: • Friends and Family Test – wards doing well with returns.. The monthly target will be increased to 40% but the Trust will still achieve. • Clinical Incidents Resulting in Harm • Slips, Trips and Falls • Complaints – not concentrating on numbers but on how to deal with in a timely way. The EMD highlighted the number of E.coli bacteraemia cases. The LSEE advised that there had been a post infection review relating to cannula and catheters and there was concern but work is being done on this. She added that the Commissioners want to more closely monitor patient discharges with catheters in place.

The EDNW highlighted the number of "reds" on the report and referred to the Berwick and other reports. He added that these should be ringing alarm bells. The EDNW referred to clinical incidents resulting in harm and noted that this was worsening and something needs to be done about this. He suggested a table top review be carried out to include evidence of actions in place and the process for monitoring and managing. The EDNW added that he would be uncomfortable if the risks were not acknowledged. The DC added that the report referred to catastrophic and serious harm incidents but the Committee are not aware of the detail of these. The EDNW advised that it was not clear if falls related to the same patient or a number of patients. The Committee agreed that the three particular areas of Slips, Trips and Falls, Pressure Ulcers and Clinical Incidents that it did not feel that there was a plan in place to resolve and this needs to be addressed including a line of reporting. The Committee agreed to discuss how to manage this at the Seminar Meeting to be held on 25 March 2015.

***Action Note**: Table top review of Risks to be undertaken*

Action by SEE

The EMD asked if the Sepsis Care Bundle Roll out can be included with the information on Slide 13 on a ward by ward basis.

15/Q/036 QUALITY IMPROVEMENT PLAN (QIP)

The EDNW shared the Trusts Quality Improvement Plan (QIP) paper with the Committee and advised that he had provided Board Seminar with a presentation on the Quality Governance Framework in February 2015. He updated the Committee on the following:

- Background – 102 actions and 5 themes
- Enforcement Actions – 26 actions – compliance against 23. Warning notice removed and 3 outstanding actions reassigned to compliance actions.
- Priorities – 4 priorities – updated on progress. Priority 1 (Enforcement) complete.
- Quality Improvement Plan (QIP) – themes and leads
- Summary of progress – blue actions have been tested.
- Progress against partner actions
- Governance and Board Oversight
- QIP Themes – Objectives and KPIs, actions/progress and timescales. Longest action 2017 – related to staffing
- Sustainability – Plan will not address all issues – 5 year strategy to ensure actions remain.
- Case Study – Intentional rounding - Stroke and Rehabilitation Wards. Evidence that actions are complete.

The Committee agreed that this update had been really helpful. The DC advised that it would be helpful to see the outcome of the challenge meetings and an update paper and minutes of the meetings on a monthly basis. The DC added that there is a need to assure the Audit & Corporate Risk Committee and Trust Board.

The EMD recognised the amount of work that had gone into this and asked if the "should do's" need to be achieved by September 2017 as he was concerned about losing sight of other quality issues that may come to light. The DC agreed that this should be reviewed. The Committee were supportive of this approach to enable a transition from the QIP to Quality Improvement Framework.

15/Q/037 QUALITY GOALS SURVEY 2015

The SEEBM advised that this had been requested by the Chair last year as it was not felt that the Committee had an input. The SEEBM advised that the Quality Goals were currently out for consultation and asked the Committee to feedback to her within the next couple of days.

***Action Note**: Committee members to feedback to SEEBM regarding Quality Goals.*

	Action by All
15/Q/038	**QUALITY GOVERNANCE ASSURANCE FRAMEWORK RE-SCORE**
	The SEEBM updated the Committee regarding the Quality Governance Framework Self-Assessment Score advising this this was rescored periodically. She advised that the Framework consists of 10 questions and a scoring matrix. The SEEBM advised that the panel met on 16 January 2015 to agree the scores and upon review agreed to a score of 5.5 which is an increase on the previous score of 2 in April 2014. The SEEBM advised that this score was reflective of the CQC inspection and the ongoing work. She added that it was an open and honest assessment and that the Trust needs to be at a score of 3.5 or below for Foundation Trust (FT) authorisation. The SEEBM added that the TDA are visiting the Trust on 16, 17 and 18 March to provide informal support. The Committee agreed that this was a fair score.
15/Q/039	**GOVERNANCE AND ASSURANCE REPORT**
	The Committee agreed to discuss this at the Seminar Meeting to be held on 25 March 2015 as it contains a lot of information which comes to the Committee via other reports,
PATIENT SAFETY	
15/Q/040	**SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) – TO BE SIGNED OFF**
	HIW highlighted to the Committee that he was not clear on the process for SIRI's. LSEE and SEEBM will meet with HIW regarding this. ***Action Note**: LSEE and SEEBM to meet with HIW regarding SIRI processes.* **Action by LSEE/SEEBM** The EDNW advised that the policy needs to be reviewed. He advised that there were two policies – Incident Reporting and Management Policy and SIRI Policy and that these two need to be mergedmerged and expectations clearly articulated. He suggested that the way QCPC gains assurance regarding the management of SIRIs should be discussed at the Seminar Meeting to be held on 25 March 2015. The Committee reviewed the following SIRIs: <u>Community Directorate</u> 2014/11847 - The EDNW identified a lack of information providing assurance on whether there had been a failure to assess the patient properly and asked for further clarification. ***Action Note**: The HOCS-CMHD to update at the next meeting.* **Action by HOCS-CMHD** 2014/35501 - The Committee approved sign off 2014/34803 - The Committee approved sign off 2014/34130 - The EDNW highlighted professional issues and requested assurance that this was being dealt with. ***Action Note**: The HOCS-CMHD to update at the next meeting.* **Action by HOCS-CMHD** <u>Acute (old directorate cases)</u> 2013/6695 - The Committee approved sign off 2014/6459 - The Committee approved sign off The DC suggested that the Trust use independent Investigating Officers (IO). The AD-HAD

	advised that she was looking at putting a full time IO in place. The LSEE advised that there are two 2-day training sessions being held in March and May 2015.
15/Q/041	**PROPOSED CHANGES TO SAFEGUARDING CHILDREN**
	This item was not discussed due to time constraints. The SCA to add to agenda for the meeting in April 2015. ***Action Note**: SCA to update rolling programme* **Action by SCA**
15/Q/042	**DISCHARGE PLANNING PROJECT – UPDATE REPORT**
	The PM attended the meeting and updated the Committee on the Patient Flow and Length of Stay Programme and the Home for Lunch and Weekend Discharges Projects. He advised that the team are working with Colwell Ward on these. Home for Lunch – There were 944 discharges from Colwell Ward between November 2014 and November 2014 and of these 12% were discharged before 12 Noon and 43% after 5pm. There are now ward discharge meetings in place and these take place at 9 am 12.30 pm and 3 pm for 10 minutes incorporating the Patient Status at a Glance boards. He advised that there has been training in all aspect of discharge planning. The PM advised that the figure of discharges before 12 Noon is now at 19%. Weekend Discharges – 11% of patients were discharged at the weekend and highlighted that Nursing Homes do not admit at the weekend. The PM advised that there is now criteria-led discharging process in place and a Standard Operating Procedure is in circulation and added that staff training had started. The PM advised that with regards to sustainability that a culture of ownership is being embedded. The PM advised that although the 11% has been maintained there is room for improvement on this and added that length of stay has decreased. The PM updated the Committee on the ICD-10 codes highlighting where the Trust is doing better than the national target. He advised that this information was a couple of weeks out of date but the February data should show an improvement. The PM praised the staff who he said were very enthusiastic and the next steps would be to roll this out to the ten other wards. The PM advised that he had set up a mock project plan and estimated that each ward would take three months which would take the project up to April 2017. The AD-HAD advised that this was a good example of using the same resources in a different way and a multidisciplinary way of working and the results were very pleasing.
PATIENT EXPERIENCE	
15/Q/043	**PATIENT STORY**
	The Committee listened to an audio recording of a patient giving her feedback when they had C-Difficile and how ill they had been. The PEL advised that this will be shared via the e-Bulletin and used by Infection Control to help to train staff.
15/Q/044	**PATIENT STORY ACTION TRACKER – QUARTERLY REPORT**
	This item was not discussed due to time constraints. The SCA to add to agenda for the meeting in April 2015. ***Action Note**: SCA to update rolling programme* **Action by SCA**
15/Q/045	**PATIENT EXPERIENCE – QUARTERLY REPORT**
	This item was not discussed due to time constraints however the content had been discussed at the SEE Committee Meeting

15/Q/046	**COMPLAINTS – QUARTERLY REPORT**
	This item was not discussed due to time constraints however the content had been discussed at the SEE Committee Meeting
15/Q/047	**ACUTE ONCOLOGY ACTION PLAN**
	The MDI updated the Committee on the Acute Oncology Action Plan following the Peer Review. She advised that the Trust needs to comply with national measures regarding delivering a full Acute Oncology Service however it is failing to do so. She advised that the external peer review took place in February 2014 and a business case will be presented to the Trust Executive Committee. The MDI advised that the Trust currently provides a 4 day service and there is no cover when the consultant is on leave or sick and over the Christmas period there was no cover for 2½ weeks. The MDI advised that the service is commissioned by NHS England and they engaged with the process in September 2014, setting up a meeting with Southampton and the CCG in December 2014 for an options appraisal. She added that there had been a meeting with the CCG in January 2015 to identify a way forward and an independent review into oncology services on the Island is to be commissioned. The MDI advised that the service now has a 24/7 helpline for clinicians and patients but there are no fast track clinics. She added that there is no set date for the review yet. The DC asked if there was anything that the Committee can do via the Trust Board. The EMD advised that there is an issue with finance and a shortage of consultants. He added that travel time to the Island counts as a PA. The DC advised that she was not aware that this was a problem and needs to be raised elsewhere. The MDI advised that the providers had been tasked with improving this service. The DC advised that this should be escalated to Trust Board.
CLINICAL EFFECTIVENESS	
15/Q/048	**NATIONAL HIP AUDIT**
	The Report was not available. The SCA to add to agenda for a future meeting . ***Action Note**: SCA to update rolling programme* **Action by SCA**
	The Chair left the meeting at this point. The EDNW noted that it was the Chair's last Committee Meeting and took the opportunity to thank her for her work and wish her well. The Committee agreed. The Deputy Chair chaired the remaining part of the meeting.
CLINICAL PERFORMANCE AND RISK	
15/Q/049	**BOARD SELF CERTIFICATION**
	The BPFTMO attended the meeting and updated the Committee advising that there were no contra indicators. He advised that the lifting of the Warning Notice meant that the Trust remained on trajectory towards declaring full CQC compliance. The BPFTMO advised that the Governance Risk Rating score for January 2015 had improved. The Committee approved the Board Self Certification.
MINUTES OF COMMITTEES AND WORKING GROUPS	
15/Q/050	**INFECTION PREVENTION AND CONTROL COMMITTEE**
	This item was not discussed due to time constraints. The SCA to add to agenda for the meeting in April 2015. ***Action Note**: SCA to update rolling programme* **Action by SCA**

15/Q/051	**JOINT SAFEGUARDING STEERING GROUP**
	This item was not discussed due to time constraints. The SCA to add to agenda for the meeting in April 2015. ***Action Note**: SCA to update rolling programme* **Action by SCA**
15/Q/052	**ANY OTHER BUSINESS**
	CQC Visits – The SEEBM advised that there is a pending CQC visit in March 2015 and the Trust is awaiting a confirmation of the date. This will cover the Beacon Service.
15/Q/053	**DATE OF NEXT MEETING – SEMINAR MEETING**
	Wednesday 25 March 2015 Time: 9 am to 12 Noon Venue: Lecture Theatre 1, Education Centre
	Signed: _____ Chair Date: _____

Isle of Wight NHS Trust

For Presentation to Trust Board on 4th March 2015

FINANCE, INVESTMENT, INFORMATION & WORKFORCE COMMITTEE MEETING

Minutes of the Isle of Wight NHS Trust Finance, Investment, Information & Workforce Committee (FIIWC) meeting held on Tuesday 24th February 2015 in the Large Meeting Room.

PRESENT:	Lizzie Peers	Non-Executive Financial Advisor to the Trust Board (LP)
	Jane Tabor	Non-Executive Director (JT) *via telephone*
	Chris Palmer	Executive Director of Finance (EDoF)
	Katie Gray	Executive Director of Transformation and Integration (EDTI) *(left meeting at 3.30pm)*
	Mark Elmore	Deputy Director of Workforce (DDW) *(deputising for EDNW)*
In Attendance:	Kevin Curnow	Deputy Director of Finance (DDoF)
	Stewart Churchward	Workforce Planning & Information Manager (WPIM) *(For items 15/F/042)*
	Gary Edgson	Head of Management Accounts (HMA)
	Abolfazl Abdi	Assistant Director of Contracting (ADC) *(For item 15/F/040 & 041)*
	Richard Harvey	External Consultant (EC) *(For item 15/F/047)*
	Diane Adams	Manager - Diagnostic Imaging (MDI) *(For item 15/F/051)*
Minuted by:	Sarah Booker	PA to Executive Director of Finance

To be Received at the Trust Board meeting on Wednesday 4th March 2015 Key Points from Minutes to be reported to the Trust Board	
15/F/045 & 046	**CIPS 2014-15** – the forecast year end shortfall for 14/15 is £1.79m. Of the £7.2m forecast to be delivered, £3.017m is non-recurrent. There is a carry forward gap of £4.2m into 15/16.
15/F/045	**CIPS 2015-16 -** 2015/16 CIPS were not presented to the Committee as requested at the January Committee. These schemes are being developed but are in differing stages of maturity. Escalated development of these is key to support successful 15/16 delivery
15/F/046	**Financial Position –** The financial position reported shows a year to date surplus of £0.682m versus a plan of £2.092m, an adverse variance of £1.409m.
15/F/054	**Self Certification -** Sufficient assurance had been provided for the Committee to recommend that Trust Board approve the self-certification return as proposed.

15/F/034 APOLOGIES

Apologies for absence were received from Charles Rogers, Non-Executive Director (CR), Alan Sheward, Executive Director of Nursing and Workforce (EDNW).

15/F/035 CONFIRMATION OF QUORACY

The Chairman confirmed that the meeting was quorate.

Jane Tabor was in attendance via electronic communication and was able to communicate interactively and simultaneously with all parties for the whole duration of the meeting, and all members were able to hear each other throughout the meeting.

15/F/036 DECLARATIONS OF INTEREST

There were no declarations.

15/F/037 APPROVAL OF MINUTES

The minutes of the meeting held on the 21st January 2015 were agreed by the Committee and signed by the Chairman.

15/F/038 SCHEDULE OF ACTIONS

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

a) 14/167c - Reference Costs Draft Report: action completed and closed.
b) 14/168c - Terms of Reference: include as part of wider governance review. Action closed.
c) 14/188 - Workforce Vacancies Report: still progressing; HR directorate are meeting on Friday next week.
d) 14/195 - Audit Outstanding Actions: this also needs to progress through the wider governance review to ensure escalation is going through the correct group. A timeline for each outstanding action is required.
e) 14/197a - Data Quality: due date for the Committee changed to March 2015.
f) 14/201 - Nursing Tech Fund: this bid was not successful which was due to the lack of supporting strategies. A device strategy is now in the process of being devised.
g) 14/225 - Carbon Energy Fund: The DDoF confirmed that the advice we have received from KPMG is that this would be an off balance sheet transaction. This opinion has been shared with the TDA and will be shared with the Trust's external auditors at the appropriate time
h) 15/006 - LTFM Update: the final submission will be presented to the Committee prior to the final submission date which has now moved to May. Due date for the Committee changed to April 2015.
i) 15/010 - Operational Performance: RTT penalties have not been incurred from September to December but they may be applied from January - March. This will be discussed with the CCG during the Service Line Agreement (SLA) reviews. Due date for the Committee changed to March 2015.
j) 15/011b - Workforce Performance Report: the WPIM confirmed this has been sent electronically to JT today. An update will be presented at the next FIIWC meeting.
k) 15/012a - Safer Staffing 6 monthly report: due date for the Committee changed to March 2015.
l) 15/012b - Safer Staffing 6 monthly report: due date for the Committee changed to March 2015.
m) 15/012c - Safer Staffing 6 monthly report: due date for the Committee changed to March 2015.
n) 15/013 - Safer Staffing Business Case: due date for the Committee changed to March 2015.
o) 15/017a – Workforce Strategy including KPIs: action closed as included on this meeting's agenda.
p) 15/018 – Performance of Directorate Savings Schemes: the EDTI noted we are not in a position at this point for the Committee to discuss and scrutinise the plans. The EDTI and the EDoF are focusing on a number of schemes each and will report back on them accordingly. Due date for the Committee changed to March 2015.
q) 15/021a – Procurement Quarterly Update: due date for the Committee changed to March 2015.
r) 15/021b - Procurement Quarterly Update: action closed as included on this meeting's agenda.
s) 15/023 – Cost Base Review Programme: action closed as included on this meeting's agenda.
t) 15/025 – Audit Outstanding Actions: due date for the Committee changed to March 2015 as the report needs to include further information.
u) 15/026 – Data Quality: due date for the Committee changed to March 2015.
v) 15/030 – Self Certification Review: due date for the Committee changed to March 2015.

Action Note: *LP requested an additional column is included on the schedule of actions list to note an agreed revised date for each action to provide a clear audit trail of delivery or slippage'*

Action by: Administrator.

LONG TERM STRATEGY AND PLANNING

15/F/039 LONG TERM FINANCIAL MODEL (LTFM) & 1 YEAR OPERATING PLAN UPDATE

The DDoF gave a verbal update on the status of the Operating Plan. The draft plan should have been submitted on Friday this week however the dates have now changed nationally and it will now be submitted in early April. The final submission date will now be in May. The DDoF discussed the 2 options around the tariff (which was explained in the 2015/16 Contracts item on this agenda) and said a lot of work is being carried out around the demand and capacity plan. A decision on which option the Trust will choose will need to be made at 4th March Board

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LP asked whether there are income risks around the modelling presented to the Committee. The EDoF said there could be if particular volumes are sent to the mainland as not all costs would be reduced.

The DDoF noted the Trust is currently unsure whether the Commissioners will offer a Risk Share Agreement once again.

Action Note: *The EDoF recommended that due to the revised submission timeline an update should be provided on the status of this during next month's meeting.*

Action by: Administrator/DDoF.

CONTRACTS AND ACTIVITY

15/F/040 CONTRACT STATUS REPORT FEBRUARY 2015

LP welcomed the ADC to the meeting. The ADC discussed the slides provided to the Committee and highlighted the following:

- The year-end value of sanctions is estimated at £680k mainly due to 18 week referrals to treatment breaches as a result of capacity pressures.
- The NHS England contract has under-performed in Chemotherapy Delivery, Neonatal Critical Care and Breast Screening.
- The CVs regarding Serenity, Improved Access to Psychological Therapy (IAPT) and Learning Disability Transition have now been signed.
- Public Health Documentation – the specifications have now been completed and shared as required.

The EDoF stated there is still the issue around ambulance handovers but assurance had been given by the Head of Ambulance that this should improve upon completion of the CAD upgrade in March 2015. The DDoF is projecting £130k of the penalties will be reimbursed. LP queried whether this was a prudent assumption around possible penalties to year end, given recent capacity pressures, and the EDoF confirmed this was. The Commissioners are not proposing to raise any more ambulance penalties.

LP asked the ADC if he was comfortable with the activity information due for submission by the end of the week, and the ADC noted the only potential issue is with the timeliness of Trauma and Orthopaedic data.

15/F/041 ISLE OF WIGHT NHS TRUST 2015/16 CONTRACTS – DELEGATION OF AUTHORITY

The EDoF explained the Trust is working very closely with the Commissioners to agree the contract value, inflation and deflation and how this will be applied. The Trust recognises there is a fixed level of funding within the Health Economy but is continuing to challenge the approach of the provider planning for a deficit.

LP asked what the risks are surrounding the Winter Resilience Funding. The EDoF said the Trust Development Authority (TDA) advised Trusts to assume the same funding as this year which we assumed as £1.5m although the Commissioners' allocation is £1m. The Trust is trying to ensure alignment on this.

LP questioned whether the new requirement to have a full cost neutral year where there are coding changes meant there was a more pressing financial incentive for the Trust to review coding quality. The EDoF explained a lot of work has been carried out on this over the past couple of years. She confirmed there was always room for further improvement but did not consider this to represent a major financial risk at this time. The Clinical Coding team are engaged with the clinical community.

Given the requirement for commissioners to demonstrate cost benefits from reinvestment of fines, LP asked whether there was more the Trust could do to support this and help demonstrate cost benefits. The EDoF emphasised that whilst the Trust needed to support reinvestment of fines, it was crucial to achieve the required performance level in the first pace and negate the need for fines.

The ADC presented the detailed report on the 2015/16 Contracts and briefed the Committee on the 2015/16 changes and challenges and highlighted the following:

- The 2015/16 National Tariff has been delayed due to the objection mechanism being triggered by 37% of providers (75% of value). Monitor needs to resolve the issue either through amendment and consultation or referral to the Competition and Markets Authority.
- Monitor and NHS England have provided NHS Trusts with 2 options and asked the Trusts to respond with their choice by 4th March 2015;
    - Option A: Enhanced Tariff Option (ETO)
    - Option B: Default Tariff Rollover (DTR)
- Information Requirements clauses have changed to allow for a shorter period (2 months compared to 6 months) for breach ratification by the providers. The EDTI asked the ADC to clarify this point and the ADC explained that the Commissioners can withhold money if they request information from the provider and this is not actioned within a certain time period. This time period is now 2 months instead of 6 months as it was previously. The EDTI questioned how much of a risk this is to the Trust and the ADC assured that it was negligible.

The ADC explained the differences between Option A and Option B and discussion followed. The ADC also discussed the potential risks and benefits of entering into a Risk Share Agreement.

JT queried the number of penalties on the NHS contract and asked whether the Trust is confident that we can meet the current criteria. The EDoF said the 18 week target is not being met but the Trust is working closely with the Commissioners around the capacity plan. There are clear actions which the Trust needs to take forward and action to ensure the system is managed correctly. The new CAD system should negate the ambulance penalties and the CDIFF and MRSA penalties should be minimised and this will be focused on next year.

The ADC asked the Committee to approve the decision for the Trust's Chief Executive to have delegation of signatory authority. The Committee agreed that the ADC would present a similar paper to the Trust Board in March for formal approval.

The Committee confirmed it was happy to agree the following:

- **To approve delegation of signatory authority to the Trust's Chief Executive Officer (CEO) with regard to 2015/16 CCG Heads of Agreement & contract:**
- **To approve delegation of signatory authority to the Trust's Chief**

Executive Officer (CEO) with regard to 2015/16 NHS England contract; and

- **To approve delegation of signatory authority to the Trust's Chief Executive Officer (CEO) with regard to 2015/16 Local Authority Public Health services contracts**
- **To approve delegation of signatory authority to the Trust's Chief Executive Officer (CEO) with regard to 2015/16 Earl Mountbatten Hospice (EMH) Contract**

WORKFORCE PERFORMANCE

15/F/042 WORKFORCE PERFORMANCE REPORT INCLUDING SBS PAYROLL REPORT

The WPIM presented the Workforce Performance report and highlighted the following:

- The Trust continues to experience considerable pressure on its pay budgets. In month expenditure exceeds plan by £185k resulting in a year to date overspend of £2.7m.
- The main contributor is the significant under achievement of pay related CIP schemes, amounting to around £2m of adverse variance to plan.
- Temporary staffing costs also continue to contribute to budget overspends and as a total equates to £6.7m year to date, 6.9% of the total pay spend.
- Sickness levels remain significantly above plan and continue to cost the organisation in excess of £300k in monthly sick pay and backfill requirements. There has been a significant reduction in stress related problems and the main reason for absence is now coughs, colds and flu symptoms.

The Trust currently has 204 vacancies, with 126 posts currently in the recruitment process. LP asked how sure the Trust is that we have the right number of staff. The EDoF explained there are weekly scrutiny meetings with a representative of Human Resources and the Executive team who are continuing to provide a challenge on every vacancy request. A large number of the vacancy requests are not being approved first time due to a lack of supporting evidence regarding skill mix documentation and costs.

The DDW said since the last FIIWC meeting the recruitment team have returned from the Philippines and there are 32 offers of employment in place with further ones planned.

The EDoF said the Workforce team are clear that they must not lock MAPs down for any areas as was happening in the past. This means managers must lock down their own areas to ensure their staff receive any enhancements due. If any enhancements have not been approved they will need to be approved for the following month's paybill.

The WPIM noted there are still a number of overpayments due to late or incorrect change forms received by Human Resources (HR). The DDW suggested this should be raised during performance management.

Action Note: *The EDoF requested the HR team send an acknowledgement email to managers to confirm termination forms have been received and actioned.*

Action: DDW

15/F/043 WORKFORCE STRATEGY INCLUDING KPIs FROM 2014/15 STRATEGY

LP suggested that some of the detailed SBS payroll operational information could be summarised on an exception basis to reduce the size of the report.

Action Note: *DDW to review report and develop a summarised version based on exception reporting for presentation at March FIIWC meeting.*

Action by: DDW

15/F/044 **WORKFORCE STRATEGY INCLUDING KPIs FROM 2015/16 AND BEYOND**

The DDW presented the revised paper for discussion. The report was considered helpful but it was recognised it would continue to be refined. JT sought confirmation that the key issues arising from the staff survey would be reflected in the metrics and reporting and this was confirmed.

The EDoF requested sight of the deadlines for phased delivery of the KPIs which the DDW will take back to the Workforce team.

JT asked where the biggest concern around quality or spend is and look at other Trusts to benchmark.

Action Note: *The DDW to seek views from the Committee members in advance of the March version for any further comments and submit the final version of this paper to the Committee at the March FIIWC meeting.*

Action by: DDW

PROGRAMME MANAGEMENT

15/F/045 **PERFORMANCE OF DIRECTORATE SAVINGS SCHEMES**

The EDTI updated the Committee on the latest status of the Directorate savings schemes and noted the following:

- Hospital and Ambulance – a great deal of work has been carried out in the last couple of months which should be recognised.
- Nursing and Workforce – is static and has been for many months.
- Anticipated carry forward of £4.2m next year.

LP asked whether there was anything else that could be done to close the gap as the level of non-recurring CIP schemes is very high. The EDoF said everything is being implemented to close the gap as much as possible. The Community and Mental Health directorate has shown the biggest commitment and ability to drive savings forward. Managers need to take ownership of their budgets to ensure they do not overspend.

LP noted the importance of these reports being viewed by the FIIWC to gain assurance around delivery and slippage.

LP commented that there was an action from the last meeting that the 2015/16 CIPS should be presented to the February Committee meeting. She asked how these were progressing. The EDTI and EDOF gave an update on current progress and confirmed 2015/16 CIPs would come to the March Committee.

LP re-iterated the heightened risk of non-delivery that the delay in having a well worked up programme of CIPs for 2015/16 represented to the Trust.

FINANCIAL PERFORMANCE

15/F/046 **FINANCIAL PERFORMANCE REPORT INCLUDING CAPITAL PLANNING UPDATE**

The DDoF presented the Financial Performance Report for Month 9 and highlighted the following:

- The Continuity of Service Rating is still rated at '4' which is consistent with the Operational Plan. Due to the pressures expected on the working capital balance at the end of the year the out-turn has reduced to 3 for the first time. This could be a risk for 2015/16 if the Trust does not deliver to break even position and the Trust might need financial support.

LP asked whether the Trust proposes to seek financial support in 2015/16. The DDoF

confirmed this is anticipated for next year.

Action Note: *LP requested a cash report to be brought to the March FIIWC meeting.*
Action: DDoF.

The EDoF said the Trust Development Authority is clear about the change to our year end plan. The FIIWC should recommend to the Trust Board that the year-end position will change now this has been approved by the Commissioners. LP highlighted that it was important the Board is aware of the risks to the £3k forecast out-turn and suggested this part of the paper be included in the Board papers.

The Committee confirmed it was happy to recommend to Board that the year-end position should be revised to £3k surplus

The financial forecast paper will also be discussed at the Trust Board meeting next week.

Action Note: *DDoF to send Financial Forecast paper to Trust Board Administrator for 4th March Board meeting.*
Action by: DDoF

JT asked how confident the Trust was on delivering the revised forecast outturn by applying mitigating actions. The EDoF highlighted the current RAG rating of each of the mitigating schemes.

- The Capital shows a variance in position but there is confidence that the Capital Resource Limit will be delivered. The Endoscopy build could slip slightly as the Winter Ward is still open.
- There is scrutiny of every vacancy; any spending must be signed off at Assistant Director level; all discretionary spending has stopped and unnecessary travel costs are avoided. LP commented that this sends clear signals to the staff.

15/047 COST BASE REVIEW PROGRAMME

The External Consultant (EC) attended the meeting to brief the Committee on the Cost Base Review report being undertaken with the Finance costing team. He presented the reports for Mental Health and Community Services which will now be presented at TEC for further discussions.

Action Note: *LP requested the dates of completion and the benefits of these projects are brought to the Committee in March.*
Action by: EC/Administrator.

The EDoF asked the EC whether this work could help with reference cost work prior to the Monitor audit..

AUDIT AND GOVERNANCE

15/F/048 AUDIT OUTSTANDING ACTIONS TO BE TAKEN FORWARD

The Committee discussed this paper and requested the following changes to be made prior to the paper returning to the Committee next month:

- An oversight on all outstanding recommendations in relation to Finance, Investment, Information and Workforce.
- A detailed recommendation to ensure each action is delivered for overdue priority 1 and 2 recommendations.
- Include priority status on overdue actions and invite the lead person to attend the FIIWC meeting to explain why the recommendation is still outstanding.
- The Trust Executive Committee will assess which outstanding recommendations are most appropriately discussed at the Quality and Clinical

Performance Committee and the FIIWC.

Action Note: *The DDoF agreed to take these recommendations forward and make the required amendments to the paper.*

Action: DDoF.

15/F/049 INTERNAL CLINICAL CODING AUDIT

The EDoF briefed the Committee on the coding from case notes paper and explained that the Commissioners have agreed with the Performance Information and Decision Support (PIDS) team the approach to carry out an audit around the activity coded from notes. They wanted to understand how many adjustments would need to be made and if the Coders would double code any notes.

The paper shows the findings of the audit and in summary the paper is proposing that the Trust seek to negotiate with the CCG a recurring adjustment to the total baseline value of the 2014/15 contract of £2.1m (Option 1) or £1.3m (Option 2).

It is important to note that this will be funded from transition funding and will not result in additional funding in 2014/15. It will however, benefit the Trust by shifting funds from a non-recurring fund into the recurring baseline.

In addition if this is agreed it is also important to recognise a further adjustment will be required to the value of the actual activity of £374k in order to allow a like for like comparison of actual against plan.

INFORMATION

15/F/050 DATA QUALITY

Due to the late presentation of the paper, the Chair withdrew this item from the agenda and confirmed that it will now be discussed at the March FIIWC Committee meeting.

Action Note: *DDI to submit paper on Data Quality for the March FIIWC meeting.*

Action by: DDI

INVESTMENT / DISINVESTMENTS

15/F/051 MRI CAPITAL BUSINESS CASE

The MDI attended to give an overview on the status of the upgrade to the existing MRI Scanner. The 7 year lease expired in November 2014 however a 6-month extension was agreed to allow the project to move to 2015/16 for capital allocation. The previous MRI replacement incurred significant building costs, the proposal this time is to rebuild digital technology around the existing core. This will effectively provide a new scanner with a 10 year guarantee and minimise building and removal costs. The revised lease costs and service/maintenance costs are all supported in the existing budget. The bid for Capital costs from 2015/16 allocation will support the enabling costs for installation and the hire of a mobile scanner during the upgrade period of 10 weeks from April 2015. The Committee sought and received assurance that this was a capital priority. The EDoF confirmed it had been prioritised by the directorates

Action Note: *JT asked that the MDI includes a summary of recommendations and information on the stakeholders to indicate their input and support for the business case.*

Action: MDI.

The EDoF noted the Trust will need to inform the Commissioners but confirmed that we are not required to seek approval from them.

The EDoF asked where the temporary Scanner will be located and whether that would have an impact on staff parking. The MDI confirmed it will be located in the same

place as before which would have an impact on staff parking and this will be discussed at the next Staff Partnership Forum.

The Committee agreed to recommend this business case to the Trust Board subject to the suggested amendments.

15/F/052 CARBON ENERGY FUND UPDATE

The EDTI briefed the Committee on the status of the of the Carbon Energy Fund. The risk associated with the District Network Operator (DNO) to the project has increased significantly over the last few weeks. As a result of the revised risk profile, and to ensure the Trust is not increasing its exposure level unjustifiably, a number of elements of the CEF programme are temporarily on hold while we gain more clarity on the DNO connection costs.

4 mitigation processes are being worked through and were discussed by the Committee. LP queried whether the Trust should have known about the DNO issue. The EDTI said there are constraints for being on the Island which should have been considered more closely by the Trust as well as the provider. This has been highlighted on the risk register.

The worst case scenario is that the Trust will lose £107k and the DDoF noted there is a real risk if we do not push on with the contract as the cost avoidance is £2m which is not included in the planning assumptions.

Action Note: *The EDTI will provide a further update during the March FIIWC meeting.*
Action: EDTI.

15/F/053 PROCUREMENT SERVICES CONTRACT UPDATE

The DDoF gave a very brief overview on this paper as it had been discussed at the January 2015 FIIWC meeting for approval to extend for 12 months. The paper provided to the Committee formally requests this extension.

After a brief discussion around the TUPE implications the Committee were in agreement to approve this request for the 12 month extension.

15/F/054 BOARD SELF CERTIFICATION REVIEW

The Committee received the Self Certification review and discussed their requirements from these papers and the issue of assurance was discussed.

The EDoF queried where the missing assurance committee is if the papers are not scrutinised at either QCPC or FIIWC meetings. The Committee agreed the papers must be specific to this Committee rather than receiving the entire pack.

Action Note: *The BP&FT to provide an update to the Committee at the March FIIWC to clarify.*

Action by: BP&FT

15/F/055 COMMITTEES PROVIDING ASSURANCE

(a) Quality and Clinical Performance Minutes from Meeting 21/01/15

The Committee received the minutes of the Quality & Clinical Performance Committee held on 21st January 2015.

(b) CEF Programme Board Minutes from Meeting 04/02/15

The Committee received the papers and had no further comments.

15/F/056	**ANY OTHER BUSINESS**
	The EDoF thanked the PA-EDoF on behalf of the Committee for her support and efforts in administering the meeting. The Committee wished her every success in her new job
15/F/057	**DATE OF NEXT MEETING**
	The Chairman confirmed that next meeting of the Finance, Investment, Information & Workforce committee to be held on Tuesday 24th March 2015 from 1.00pm – 4.00pm in the Large Meeting Room. The meeting closed at 4.30pm.

Isle of Wight NHS
NHS Trust

FOR PRESENTATION TO PUBLIC BOARD ON: 4 MARCH 2015

Minutes of the Isle of Wight NHS Trust **Mental Health Act Scrutiny Committee** held on Tuesday 13th January 2015 in the Seminar Room, Sevenacres

PRESENT:	**Jessamy Baird**	**Chair, Designate Non Executive Director (JB)**
	Jane Tabor	**Non Executive Director (JT)**
	Stephen Ward	**Mental Capacity Act & Mental Health Act Lead (MML)**
	Simon Dixey	**Consultant Psychiatrist, Memory Service (CP)**
	Nadarasar Yoganathan	**Consultant Psychiatrist, Rehab & Recovery Services**
	Elisa Stanley	**Mental Health Act Manager (MM)**
	Julia Coles	**Learning Disability Care Co-ordinator (LDC)**
	Christine Gardiner	**Service User (SU)**
Noted by:	**Alison Hounslow**	**Administrator**

Key points from Minutes to be reported to the Trust Board

15/003 f) MH/023 - Implementation of meetings for Hospital Managers

The Board Seminar has occurred and as a result regular meetings are to be arranged.

Action by MML/JB

i) MH/026 – Care Implementation and Paris

These issues will be discussed with members of the Hertfordshire Partnership Trust who will be visiting mental health services during February. They use the same system and have reportedly resolved most issues.

Action by JB

15/004 **Community Treatment Orders Audit** - Recommendations on improved information for patients and simplified paperwork to be carried forward.

Action by MM, MML & CP

15/001 Apologies for Absence, Declarations of Interest and Confirmation that Meeting is Quorate

Apologies for absence were received from:

Su Morris, Nina Moorman, Tim Higginbotham, Tracey Hart.

The meeting was declared quorate.

15/002 Minutes of the previous meeting – 22nd October 2014

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

15/003 Review Schedule of Actions

a) MH/002 – Audit of Section 17 leave

Dr Dixey has agreed to undertake this audit which was commissioned to assess the effectiveness of risk assessment prior to Section 17 Leave. Paris recording system does not have a built in reporting ability, which has made it difficult to pick a specific time (quarter) to audit according to the audit request. Therefore, it needs to be agreed with the CCG that the audit can proceed by choosing a random sample from the paper record list of patients that have had Section 17 Leave. A set of standards for comparison purposes is to be sought by MM, MML is to check with commissioners the change is acceptable, CP is to carry out the audit.

Action by MM, MML and CP

b) MH/006 – Community Treatment Order Audit

Please see Minute 15/004.

This action has now been closed

c) MH/020 – Development of Service User & Carer Forum

The Terms of Reference are still under discussion. Service User & Carer Link Coordinator (SUCLC) to update at the next meeting.

Action by SUCLC

d) MH/021 – Audit of risk assessments

The audit will be presented by the Mental Health Act Manager (MM) at the next meeting.

Action by MM

e) MH/022 – Scrutiny of Mental Health Act Section papers

The audit of medical recommendations will be presented at the next meeting. This information is to be presented to the Medical Staffing Group and a training plan is to be agreed. The information is also to be shared with the doctors at their monthly meeting.

Action by MML

f) MH/023 – Implementation of meetings for Hospital Managers

The Board Seminar has occurred and as a result regular meetings are to be arranged.

Action by MML/JB

g) MH/024 – Terms of Reference

The Terms of Reference are to be amended to reduce the number of Non Executive Directors (NEDs) required for quoracy. It was felt that one NED would be sufficient for quoracy and that priority was given to the attendance of the wider spectrum of members of the Committee, specifically addition of Hospital Managers and ensuring patient representatives/advocates are present.

Action by MML

h) MH/025 – Mental Capacity Act Training

Training dates have now been arranged.

This action has now been closed

i) MH/026 – Care Planning and Paris

A review of Paris has been commissioned by Katie Gray, Executive Director of Transformation and Integration.

Post meeting update – a meeting has been arranged with Hertfordshire Partnership Trust for end of February. JB discussed with John Doherty the issues around care planning and PARIS discussed by MHASC. Action to update the group at next meeting on Hertfordshire visit.

Action by JB

15/004 Community Treatment Orders Audit

Dr Yoganathan presented the meeting with his audit of Community Treatment Orders (CTOs).

CTOs are a means to discharge inpatients subject to Section 3 from hospital detention to a supervised discharge within the community. They are subject to certain conditions and are closely monitored. Non compliance and/or deterioration of mental state can result in recall to hospital and revocation of the CTO to a S3.

A random sample of 19 CTOs were examined. The audit considered the following issues:

- Recording who the Responsible Clinician (RC) consulted with;
- The timeliness of the delivery of the paperwork to the Mental Health Act Office;
- Recording staff involvement in the patients' Care Programme Approach (CPA);
- Recording of a contingency plan and the criteria if a recall is required;
- The numbers of recalls, grounds for recalls and completion of paperwork;
- The timeliness of the revocation paperwork.

The outcomes:

- There are few records of patients' comments regarding their CTO;
- General Practitioners (GPs) are not always consulted;
- Delays in paperwork received by the Mental Health Act Office have been found to be due to recent introduction of Paris;
- Inconsistency in recording GP roles; prescribing responsibility; contingency plans; and S132 information on community notes;
- CTO4 form (detailing date and time of return to hospital) and reasons for recall were fully recorded.

Recommendations:

- To include record of patients' understanding of their condition and the

role of the CTO in their care needs;
- Consultations to be forwarded to GPs, with provision for their response;
- To consider the need to retain complementary paper documentation alongside electronic records;
- Consistent recording on CPAs;
- Greater clarification on S132 community notes;
- Clarify the time taken for RCs to complete treatment certificates;
- To consider colour coding on the CTO checklist;
- Reduce duplication of information on CTO consultation form.

The audit and its recommendations are to be studied further.

Action by MM, MML & CP

15/005 Hospital Managers & Board Seminar

There was discussion surrounding issues raised at the Board Seminar held on 9 December 2014. These included the availability of therapeutic and psychological treatments. Also discussed were Hospital Manager reviews of patients; the experience from the patients' perspective and their advocacy; the care plans provided and resources available.

Further Agenda Items

Due to time constraints it was agreed that remaining agenda items were to be held over until the next meeting on 14th April 2015.

DATES OF NEXT MEETINGS

The next meeting of the Mental Health Act Scrutiny Committee is to be held on Tuesday 14th April 2015 in the Seminar Room, Sevenacres.

Meeting closed at 1715

Glossary:
CCG – Clinical Commissioning Group
CTO – Community Treatment Order
RC – Responsible Clinician
CPA – Care Programme Approach

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Isle of Wight NHS
NHS Trust

FOR PRESENTATION TO TRUST BOARD ON 4 MARCH 2015

AUDIT AND CORPORATE RISK COMMITTEE

Minutes of the meeting of the Audit & Corporate Risk Committee held on Tuesday, 10th February, 2015 at 2.30 p.m. in the School of Health Sciences, St. Mary's Hospital, Newport.

PRESENT	David King	Chairman
	Nina Moorman	Non Executive Director
	Lizzie Peers	Non Executive Financial Advisor to the Trust Board
	Charles Rogers	Non Executive Director
	Jane Tabor	Non Executive Director
In Attendance	Chris Palmer	Executive Director of Finance
	Mark Price	Company Secretary
	Paul King	External Audit Director
	Kevin Suter	External Audit Manager
	Andy Jefford	Chief Internal Auditor
	John Micklewright	Senior Internal Audit Manager
	Barry Eadle	Local Counter Fraud Specialist (Item 15/023)
	Kevin Curnow	Deputy Director of Finance
	Karen Baker	Chief Executive (Item 15/000)
	Deborah Matthews	Lead for SEE
	Katie Gray	Executive Director of Transformation & Integration (Items 15/008)
	Andy Hollebon	Head of communications & Engagement (Item 15/009)
	Andy Shorkey	Programme Manager (Business Planning) (Item 15/010)
	Graham Warren	Fleet Manager (Item 15/017)
	Connie Wendes	Asst Director Health & Safety & Security (Item 15/024)
Minuted by	Linda Mowle	Corporate Governance Officer

Min. No.	Top Key Issues/Risks
15/A/008	**Review of Governance Arrangements for Wight Life Partnership:** initial governance arrangements were considered to be a positive commencement of the working partnership with WLP and will evolve over the next 3 months.
15/A/010	**Annual Business Planning Cycle & Business Plan Development Timetable:** assurance provided that an achievable operating plan would be delivered within the required timescales, but that implementation of the plan would be contingent on robust performance management arrangements.
15/A/020	**Timetable for the Appointment of Auditor Panels:** Noted that the appointment by the Trust Board of the Audit Committee as the Auditor Panel to appoint external auditors is in January – February 2016.
15/A/021	**QCPC Quarterly Report – Pressure Ulcers:** Concern expressed that there was no level of assurance on the implementation of the action plan for pressure

	ulcers. Requested that an in depth report be provided to the Committee in May in order to gain assurance that the action plan is being progressed.
15/A/025	**ACRC Revised Terms of Reference:** Agreed for presentation to Trust Board for approval and adoption.
15/A/026	**Internal Audit Contract Tender 2015/18:** Joint contract with Portsmouth Hospitals on track for the new internal audit services to commence on the 1st April 2015.

15/A/001	**APOLOGIES** No apologies were received.
15/A/002	**QUORACY** The Chairman confirmed that the meeting was quorate.
15/A/003	**DECLARATIONS OF INTEREST** Charles Rogers declared an interest as a Director of Wight Life Partnership
15/A/004	**MINUTES** The minutes of the meeting held on the 13th November 2014 were agreed and signed by the Chairman as a true record.
15/A/005	**MATTERS ARISING FROM PREVIOUS MINUTES** The schedule of progress on actions arising was noted with the following comments: **Min. No. 14/114 Annual Review of Self-Certification Process – Training Session:** Due to time and work constraints on Board Seminar work, the training has been delayed. As the Committee considered that this was an important piece of work to better understand the assurance being provided by the self-certification process, the Company Secretary agreed to incorporate this into the planned Board Seminar session on Board Governance. **Action: CS** **Min. No. 14/089(c) – Organisational Culture, Health and Wellbeing:** The Executive Director of Transformation & Integration has been charged with taking this forward, part of which will be the results of the recent staff survey and which will help define the Strategy. This is to be a standard agenda item on the FIIWC from April 2015. **Min. No. 14/090 – Format of Counter Fraud Report:** To be followed up as it was felt that not all actions had been included in the report. *(Post meeting note: LCFS emailed EDF on 10/02/15 advising that this is a new format of report that TIAA have given to use. The report commented on the number of days used against the planned days. There was a front summary sheet completed. A table included detailing the actions taken to ensure that SRT amber ratings are addressed and that there are no outstanding recommendations arising from investigations.)* **Min. No. 14/116 – Internal Audit Recommendations – Escalation Process to TEC for Corporate Recommendations:** Lizzie Peers requested the outcome of the discussion at TEC. The EDF advised that discussions were taking place on the process for audit recommendations with the DDF in order to achieve the right structure for recommendations to be discussed at TEC. *(Post meeting note: TEC min. no. 15/021(g) EDF requested that TEC members focused on the outstanding recommendations and ensure they were auctioned.)* **Min. No. 14/127 Review of Directorate Performance Reviews:** Members advised that invites had not been received and requested that this be followed up. *(Post meeting note: Angie Squibb emailed NEDs on the 11/02/15 with the 2015*

	dates of the Directorate Performance Reviews and is linking with Anna Daish-Miller on which meetings NEDs will attend.)

15/A/006	**CARE QUALITY COMMISSION REPORT – UPDATE**
	The Chief Executive and the Lead for SEE/Deputy Director of IPC provided an update on the Quality Improvement Plan advising that CQC:
	• had acknowledged the work done to date
	• declared that the warning notice will be removed
	• are aware of the 3 actions where non-compliance has been declared namely:
	  • Sepsis 6 Implementation
	  • Number of bed moves and named consultant
	  • Insufficient numbers of nursing staff leading to issues of inconsistent care.
	
	The CE outlined that of the 26 areas of non compliance, the Trust was now compliant in 23 and as stated, only 3 areas where there is now non compliance, and highlighting the following achievements:
	• Excellent progress with Sepsis
	• End of life care and patient moves – audit undertaken in December showed no bed moves on end of life care pathway. The issue around bed moves generally is being led by the Executive Medical Director and the CD for Hospital & Ambulance Directorate to reduce the number of moves resulting in changes of consultant and on trajectory to complete by 31 March 2015
	• Recruited 32 nurses in the Philippines
	
	Nina Moorman concurred that as a result of the warning notice being removed, this should provide strong assurance that the hospital is moving in the right direction.
	
	Overall, the CEO acknowledged that work still needed to be undertaken particularly around bed moves and Sepsis in order to improve the quality of care.
	
	Nina Moorman advised that the consultant surgeons at the Hospital Medical Staff Committee (HMSC) were not aware that there was a form that required completing in relation to Sepsis.
	
	In response, the Lead for SEE advised that although procedures are in line with NICE guidance, documentation needed to be transparent and in this regard, following discussion with the consultant staff, the tool from the Royal Free Hospital was being used to devise a form which could be used across all geographical areas.
	
	Nina Moorman asked whether, as part of end of life care education, mandatory training should be provided on completing CPR forms. The CEO advised that it was the responsibility of the admitting doctor and not necessarily the doctor who continues the care/treatment. In addition, the decision should be ratified by the consultant within a set timeframe, hence the need for transparent documentation.
	
	The CEO acknowledged the work achieved on the Rehabilitation Unit with the appropriate placement of patients on the Ward and the system for monitoring

	and managing the risk of inappropriate referrals. The Committee also noted the dedicated midwife now in place on the Maternity Ward for triage co-ordination. The CEO expressed her appreciation and thanks to the Triumvirate Team who are driving the changes to keep the Trust on track to meet the CQC's recommendations. The Committee felt that it was assured that the organisation was on track to implementing and achieving the 3 actions where the Trust is still non-compliant.
15/A/007	**FINANCIAL PERFORMANCE** The Chairman invited the CEO to give her observations on the financial pressures now facing the Trust in the context of the impact on financial recovery and the quality agenda in light of the new year end forecast out-turn position from a planned surplus to a breakeven position. The CEO informed the Committee that the only potential risk to the organisation, particularly around quality of patient care, was the additional nursing staff being deployed onto wards to cover temporary patient care arrangements in response to winter pressures. With regard to financial recovery, plans identified to release efficiency savings needed to be delivered. The Committee recognised that assurance processes were in place to effectively forecast the Trust's year end financial position.
15/A/008	**REVIEW OF GOVERNANCE ARRANGEMENTS FOR WIGHT LIFE PARTNERSHIP** The Executive Director of Transformation & Integration presented an overview of best practice adopted in designing the assurance arrangements for the new business venture with Wight Life Partnership which lays the foundation for good governance. The Committee noted that over the coming months the assurance framework, which is in two parts, will be embedded and the effectiveness of the operation of the controls in place will be managed through the Wight Life Partnership Board (WLP Board). A first draft of the principal risks is to be presented to the next WLP Board for agreement. The Trust members on the WLP Board are the Chief Executive Officer and Charles Rogers. The EDTI advised that the first project had been agreed, which was reviewing the Clinical Strategy from an Estates focus in order that capital schemes can be effectively prioritised. The services of Fusion have been procured who have expertise in this field of work. A proposal will be prepared detailing what schemes should be undertaken and in what order. The Chairman considered that as this was a brand new way of working with new arrangements and relationships, roles and responsibilities needed to be clearly defined, particularly in meetings. Charles Rogers briefed the Committee on the meeting of the WLP Board on the 5th February 2015 which considered that there was benefit to be gained from the assurance provided, although there was more to be done to the structure on business aspects and that the meeting agreed that FIIWC should be kept informed from an early stage.

	The Committee noted that a general manager is being recruited who will be located in the Trust and work on behalf of WLP and not on behalf of the Trust or Ryhurst. In response to Lizzie Peers seeking clarity on costs, the EDTI confirmed that each project will have a cap and that approval will be sought from TEC and FIIWC. Lizzie Peers asked how the assurance framework would be monitored. The EDTI confirmed that the content of the framework will evolve over the next 2 to 3 months and will be presented to FIIWC every 3 months with ownership by the General Manager once appointed. Nina Moorman queried whether, as a healthcare provider for clinical provision, there needed to be a quality impact assessment built into the framework. The EDTI to consider the inclusion of this proposal and advise the Committee accordingly. **Action: EDTI** The Committee considered that this was a favourable commencement of the working partnership with WLP and requested that an update on the governance arrangements be provided in 3 months time. **Action: EDTI**
15/A/009	**ANNUAL REPORT 2014/15** The draft Annual Report and Accounts for 2014/15 was received. The EDTI in introducing the update on the Report advised that there were 3 risks to delivering the Annual Report and which are all being managed within the project and not being escalated. The Head of Communications & Engagement explained that this was a first draft with the format based on last year's contents. Various sections required text updating and in particular it will not be possible to insert many of the figures until after the 31st March 2015. A revised draft of the Report will be issued after the 10th March with further drafts being produced. The Annual Report & Accounts will be presented to the Trust AGM on the 1st July 2015. HOC reported that although the Report was currently behind schedule, the project was manageable and that the submission date would be achieved. In reply to Nina Moorman's query on the production of the Quality Account, the HOC advised that this was a separate document being produced by the Quality Team along the same timetable as the Annual Report & Accounts for publication at the AGM. Kevin Suter advised that under the Code of Audit Practice, external audit do not have to provide an opinion on the Quality Account and therefore it is not included in their planned framework. However, NHS England may specify that an auditor or accountant provide assurance on the Quality Account but at the moment guidance has not yet been issued. The Committee noted that an updated draft of the main report will be available for the meeting on the 12th May 2015 along with the draft summary document, both in initial design form. **Action: HOC**
15/A/010	**ANNUAL BUSINESS PLANNING CYCLE & BUSINESS PLAN DEVELOPMENT TIMETABLE** The Committee received the update report on the Business Plan development

	arrangements for operational year 2015/16 prepared by the Programme Manager (Business Planning & FT Application). The Committee noted that the Trust is required by the Trust Development Authority (TDA) to deliver a Board-approved, Commissioner aligned one year Operating Plan which should reflect year 2 of the 2014/15 two year and five year strategic plans. The final Board approved plan is required to be submitted to the TDA on 10th April 2015. In addition, the IBP, which sits behind the plan, will need to be refreshed in line with the Trust's FT trajectory. The PM(BP&FTA) advised that, following the initial submission on the 13th January 2015, feedback had been received from the TDA on 30th January 2015, which identified gaps in the plan and areas to be strengthened. Inputs into the plan are being collated from across the organisation to have updates in time for the next submission on the 27th February 2015. With regard to the planning checklist, the PM(BP&FTA) highlighted that of the 130 areas requiring assurance on compliance, nearly 50 areas were flagged as not compliant in the initial submission. Service leads have been requested to ensure that robust responses and clear explanations with plans to achieve compliance are submitted within the required timeframe. Lizzie Peers raised the risks flagged within the report. The PM(BP&FTA) advised that the key risks related to uncertainties around the finance plan including delivery of cost improvement plans, development of new schemes, containment of expenditure and achievement of the forecast outturn budget position. There was a need to increase the robustness of performance management processes so that planning arrangements and assurance around delivery of plans were embedded alongside operational performance management. The PM(BP&FTA) further advised that work was ongoing to mitigate the risks and improve planning processes to ensure that underlying plans were robust and deliverable within required timeframes. EDF confirmed that by the 10th April deadline the organisation should be much clearer on the estate, clinical strategy and capital requirements, which will underpin the business of the organisation and links with financial performance. A holistic planning process was required. The Committee was of the opinion that the Board could be assured that an achievable operating plan would be delivered within the required timescales, but that implementation of the plan would be contingent on robust performance management arrangements.
15/A/011	**BOARD ASSURANCE FRAMEWORK** The Company Secretary provided a verbal update on the different approach being taken to formulate the BAF for 2015/16. It was envisaged that the next stage would be to take some of the content from the Board Seminar discussion on the Quality Framework and Goals into a discussion around key risks and objectives. Trust Board time needs to be identified to discuss the NEDs' view of the risks and objectives before developing the new BAF. With regard to the 2014/15 BAF, monthly reports continue to be presented to the Trust Board outlining the high level risks and any changes to risks. The Chairman emphasised the need for the BAF and Risk Register to be connected. Jane Tabor suggested that a session on the strategic themes and associated

	risks would be beneficial to articulate the risks for the Risk Register. This would provide an effective method with an open discussion to determine the Trust's strategic risks as she was concerned that the Trust had not identified all external risks. Having a fresh look and process with all the Board members would provide assurance on the capturing of risks. The Chief Internal Auditor advised that they had undertaken this type of facilitated session and would be happy to undertaken a workshop for the Trust. The Company Secretary advised that an annual internal audit of the Trust Assurance Framework is about to commence with NEDs being invited to comment on the ease of use of the Assurance Framework, its design, whether it is a useful tool in the decision making process, etc. Hopefully, this piece of work will inform the BAF for 2015/16. The Committee agreed to await the internal audit report and, following receipt of this, recommendations from the Company Secretary on the formulation of the 2015/16 BAF. **Action: CS**
15/A/012	**ANNUAL GOVERNANCE STATEMENT 2014/15** The Committee received a verbal report from the Company Secretary on the draft Annual Governance Statement for 2014/15 included in the draft Annual Report 2014/15 which had been prepared by the Head of Corporate Governance & Risk Management before his retirement from the Trust. The draft AGS was based on last year's submission. The CS advised that guidance from the DOH on the completion of the AGS had now been received which will result in the draft AGS being updated. In addition, some sections will also require updating, e.g. Review of Effectiveness for the Audit & Corporate Risk Committee (page 39). With regard to the disclosure of Significant Issues (page 41), the CS advised that a judgement was required on the items to be disclosed, examples of which were: • CQC Report • Staff Survey • Financial Performance requesting comments from members on whether these were significant issues which should be disclosed together with any others they felt should be included. **Action: ALL** In relation to limited assurance audits (page 40), the Chief Internal Auditor suggested that the trend in the IA reports be reported. **Action: CS** The Company Secretary to present the updated AGS to the May meeting of the Committee for agreement. **Action: CS**
15/A/013	**RISK REGISTER – REVIEW OF SCORE LEVELS** Lizzie Peers raised the question of how assurance was provided to ACRC on corporate risks, how these risks were managed and monitored, and the risk score level to be reviewed by ACRC. The Company Secretary pointed out that the Trust Executive Committee has overarching responsibility for risk management within the Trust. The Risk Management Committee reviews the Risk Register and provides regular reports along with their minutes to the Trust Executive Committee. The Audit &

	Corporate Risk Committee is to provide assurance to the Trust Board that the process was robust for capturing risks, fit for purpose and embedded within the organisation. Clinical risks are reviewed by QCPC and financial risks by FIIWC and provide assurance through their quarterly reports to ACRC. The EDF advised that the Trust Board reviews scores over 20 and suggested that the ACRC could review scores of over 16. The Committee considered that a score threshold for ACRC to review risks requires to be set and agreed that Lizzie Peers and Nina Moorman meet with the Company Secretary in order to provide a proposal on how corporate/strategic risks are to be dealt with at ACRC. **Action: CS/LP/NM** *(Post meeting note: ACRC's terms of reference state 7.2.1 The Committee shall review the establishment and maintenance of an effective system of ….. risk management and internal control across the whole of the organisation's activities (clinical and non clinical) that supports the achievement of the organisation's objectives. 7.2.2 In particular, the Committee will review the adequacy and effectiveness of (a) all risk and control related disclosure statements (b) …… the effectiveness of the management of principal risks)* Charles Rogers highlighted that there was a gap in assurance covering areas of risk which the two main sub-committees, i.e. FIIWC and QCPC, do not cover and which the ACRC requires assurance upon. This requires to be reviewed in the overall sub-committee governance structure. The Committee asked that this be taken forward in a review of the Trust's governance structure. **Action: CS**
15/A/014	**DECISIONS TO SUSPEND STANDING ORDERS** None to date.
15/A/015	**WAIVERS TO SFIs** The Committee agreed the following waivers: • Nos. 17-34 dates 3/11/13 to 19/01/15 Lizzie Peers sought reassurance that the process for single tender waivers was robust. The EDF advised that reliance is placed on Procurement to ensure that processes are followed as well as value for money and if Procurement do not sign the waiver then it is not taken forward and countersigned for approval.
15/A/016	**FINANCE, INFORMATION, INVESTMENT & WORKFORCE COMMITTEE QUARTERLY ASSURANCE REPORT** The Chairman of FIIWC, Charles Rogers, presented the quarterly report covering the period November 2014 to January 2015. The Committee noted: • Actual and forecast revenue – Limited assurance has been given with regard to the adjusted financial position proposed in recognition of the level of risks still to be addressed. • Capital income and expenditure – Positive assurance • Review Disclosure Statements – Self-certification - Positive assurance • Review schedules of losses and compensations – Assurance limited because there is no comparative information to assess whether the trend is improving or deteriorating • Review schedules of debtors and creditors balances over 3 months with explanations and plans – Assurance positive

	• Monitor Better Payment Practice Code – Assurance positive • Review implementation of reference costs and SLR – Assurance positive • Monitor Contractual Risk – Reviewing contract status report and implementation of Strategy – Assurance positive • Review and monitor implementation of CIPs – Assurance negative. Concern expressed that CIPs will not be achieved by year end. EDOF advised that every effort is being made to cover the slippage. Nina Moorman queried whether, if it was realised that a scheme was not viable, then the scheme should be taken out of the equation. EDOF agreed that if there was no change during the year then the scheme should be taken out. For all CIPs, it is ensuring that plans are robust and strong, particularly at the beginning of the year, and for the Project Management Office to flag at the earliest opportunity when a scheme is not on track in order to enable another scheme/project to be put in place. • CIP Plans for 2015/16 – testing assurance in relation to the 3 phases of CIP achievement – Assurance negative as plans are due to be presented to the February meeting • Staff Survey Action Plan – implementation to be monitored, including effective management of stress levels amongst staff – Assurance negative as no progress to date • Review implementation of Long Term Financial Model (LTFM) – Assurance limited. Nationally required to prepare a one year operating plan (which replaces the LTFM) and to also prepare a two year plan and a 5 year forward strategy in conjunction with the operating plan. The first year plan needs to be locked down and then the following years can be added. • Timetable for Market Testing of Procurement Services – Assurance positive. A formal proposal to extend the contract for a further 6 months to March 2016 is being presented to the February meeting for consideration.
15/A/017	**INTERNAL AUDIT** The Senior Internal Audit Manager introduced the progress report highlighting the following: • Internal Audit Plan on track at 61% • One final report issued: Use of Trust Vehicles – Limited Assurance due to a lack of driving licence verification on staff who drive a vehicle on Trust business. Graham Warren, Fleet Manager, concurred that the Trust does need a safe means of checking staff's driving licences. However, the DVLA from June 2015 (changed from January) will no longer issue a paper counterpart to the photocard driving licence and, as a result, the Trust needs a new system to undertake the checks which could link in to ESR. A meeting has been held with HR and Information Governance to take this forward and, hopefully, something will be in place before June 2015. Currently, driving licence checks are part of appraisals and at commencement of employment. In reply to Nina Moorman's query on whether the same checks apply to ambulance staff, the Fleet Manager advised that ambulance staff are required to meet special licencing criteria.

	Jane Tabor was concerned with the lack of a Transport Strategy that should support staff in the community to provide quality care. The FM confirmed that a Strategy is being developed and will be presented to TEC which will provide a clear policy on the use of pool cars in order to assist in the provision of quality care in the community. Nina Moorman asked whether the Trust had a strategic view on the use of electronic cars, given the small distances travelled on the Island, and whether there was an opportunity for a commercial sponsor. FM advised that in order to be financially viable to save on fuel, a considerable amount of mileage needs to be undertaken for which the cars are not designed. The Committee noted that the audit report will be presented to TEC which will review the issues and provide oversight and support to ensure the service is properly managed. • 8 reports are either in draft or where fieldwork has progressed • The Payroll audit, due to commence early in January, has been placed on hold by HR due to resourcing pressures. The Committee noted that despite frequent calls and emails, no response has been received from HR on a likely start date for the audit. The DDOF has been asked to intervene in this respect and the Senior Internal Audit Manager requested that if there was still no response that the Executive Team progress the request. The Committee requested that this be taken forward as a priority and that the Chairman be advised of the start date. **Action: DDOF** In reply to Jane Tabor's query on the lack of feedback to internal audit, the EDOF advised that feedback was in the format of a survey which staff did not always complete. The Senior Internal Audit Manager stated that feedback was valued in order to know that the process had been well received. With regard to the Safeguarding (Children and Vulnerable Children) audit, Nina Moorman asked that a copy of the report be sent to her and this was agreed by John Micklewright who commented that the report was substantial assurance. **Action: JM**
15/A/018	**PROGRESS ON AUDIT RECOMMENDATIONS** Not discussed.
15/A/019	**EXTERNAL AUDIT** The External Audit Director presented the Audit Plan for 2014/15 highlighting the areas of risk to the Financial Statements and the audit approach which will be taken. The EAD outlined that, as a result of continuing financial pressures and the amendment to the financial forecast position for year end, this has been included as a significant risk to both the financial statements opinion and the value for money conclusion. Work on the financial statements would focus on the completeness and valuation of income and expenditure. For the value for money conclusion a review of the progress on achieving the identified CIPs and the balance of recurrent to non-recurrent plans will be undertaken. In addition, there will also be a review of the reasonableness of assumptions made within the Trust's operating financial model. Other financial statement risks for review

	are: • Position of the Capital Programme • Potential issues with the operational status of Ryde Community Clinic impacting on Swanmore Road properties • New system for theatre stock-taking and arrangements for ongoing and year-end stock counts and valuations With regard to Materiality, the Committee noted that EY's professional judgement will take into account qualitative as well as quantitative considerations and that the overall materiality for the financial statements of the Trust is based on 1% of the estimated gross expenditure. The EAD reported that the indicative scale fee has reduced from £100,000 to £90,000 excluding VAT, due to the assurance work on the Trust's Quality Account no longer being mandated by the Audit Commission. It is anticipated that the audit report including the opinion on the financial statements and the conclusion on economy, efficiency and effectiveness will be available for the first week in June to enable the Accounts to be submitted to the Department of Health by the 5th June 2015.
15/A/020	**TIMETABLE FOR THE APPOINTMENT OF AUDITOR PANELS** The EDOF introduced the paper providing an overview of the Department of Health's documents on the Health Service Bodies' Auditor Panels and their independence. The guidance sets out the regulations to implement new constitutional requirements for audit committees (acting as auditor panels) of NHS Trusts to ensure audit committees are appropriately constituted to advise their governing board on the selection, appointment and maintenance of independent relations with external auditors and their future audit contracts. In addition, the auditor panel will advise on the adoption and content of a policy on awarding additional 'non audit' work to their appointed auditors. The outline expected timetable for NHS Trusts for the preparation of the appointment of auditor panels was received and noted. The External Audit Director informed the Committee that existing contracts could be extended for a period of up to 3 years but that it was unclear at the moment whether this extension would be exercised and governmental guidance was awaited. The Committee noted that guidance on the appointment of Health Service Auditor Panels is due to be issued in March 2015 and that the appointment of auditor panels by the Trust is in January-February 2016. The Company Secretary to include this in the work programme for the Trust Board. **Action:CS** *(Post meeting note: Included in the Trust Board's forward plan for 3 February 2016)*
15/A/021	**QUALITY & CLINICAL PERFORMANCE COMMITTEE** **QUARTERLY ASSURANCE REPORT** The Vice Chair of QCPC, Nina Moorman, presented the QCPC minutes for the 21 January 2015 together with the January 2015 assurance report which outlined: <u>Positive Assurance</u>: Mortality Figures, Quality Improvement Plan Monitoring Process, Consultant Outcomes Publication, Patient Story, OFSTED Safeguarding Inspection, NICE

	Guidance, Raff Raising Concern 6 monthly update. Limited Assurance: ISIS Upgrade, Emergency Re-admissions, Cancelled appointments, Patient Survey, SIR Process, Infection Prevention and Control, Theatres Audit, Laundry Audit Negative Assurance: National Hip Audit. Pressure Ulcer CQUIN With regard to Infection Control, Nina Moorman reported on the successful outcome of the containment of the norovirus outbreak and advised that for future reports, more information on outcomes of national benchmarking as well as clinical audit will be provided in order that the Committee can be assured that clinical audit and governance is moving forward. Jane Tabor expressed concern that there was no level of assurance on implementation of the action plan for pressure ulcers. In reply, Nina Moore reported that there had been some progress with a number of grade ones going down but that overall, the lesser grades going up and that this was disappointing but this was due to increased reporting for nursing home patients. The Committee requested that a more in depth report on pressure ulcers and how the action plan is being monitored and implemented, be provided to the next meeting of the Committee in May so that the Audit Committee can be assured that the process for the reduction of pressure ulcers is robust in order to provide quality care for patients. **Action: NM**
15/A/022	**QUALITY & CLINICAL PERFORMANCE COMMITTEE TERMS OF REFERENCE AND WORK PLAN** Not discussed.
15/A/023	**COUNTER FRAUD** Barry Eadle presented the performance report incorporating the Protocol for interaction between the Local Counter Fraud Specialist and Human Resources dated January 2015. The report outlined: • Summary of Fraud Awareness task undertaken • Summary of survey for 2014/15 • TIAA Benchmarking Report re Mental Health • Update on investigations
15/A/024	**OVERVIEW OF SECURITY MANAGEMENT** The Assistant Director for Health & Safety & Security presented her report to inform the Committee of when and how the LSMS, action plan and yearly report will be available and an overview of Lockdown issues. The ADHSS advised that the work plan and annual report is formed from the previous year's action plan which will be completed at the end of the financial year and will be available for the May meeting. In addition, the new NHS Protect self assessment tool which creates the RAG rating will not be available until May. The ADHSS provided a status report on the Lockdown of the Trust and outlined the way in which the organisation is able to control or limit access to the hospital site, buildings, departments and wards with limited success. Work is ongoing on how an electronic locking system throughout the hospital can be phased in. The EDOF advised that the electronic locking system is a regular item on the

	Capital Investment Group to see how it can be phased in as quickly as possible. Jane Tabor asked whether there was a 3 year security strategy for the Trust. The Company Secretary advised that TEC have agreed a Security Policy and a Lone Worker Policy. The ADHSS stated that the Major Incident Plan contains lockdown of the site. The Committee was of the opinion that a 3 year security strategy would be of operational benefit in providing a safe and secure site for patients and staff alike. The Committee requested the Company Secretary take forward this suggestion with TEC to ascertain the merits of developing an overall Security Strategy. **Action: CS** The Work Plan and Annual Report to be presented to the May meeting of the Committee. **Action: ADHSS**
15/A/025	**REVISED TERMS OF REFERENCE** The Committee agreed the revised terms of reference for presentation to the Trust Board for approval. The Committee noted that the terms of reference are replicated from the NHS Audit Committee Handbook 2014 Appendix A. **Action: CS** Jane Tabor requested that an amendment to all sub-committees' terms of reference was required with regard to quoracy and the uninterrupted involvement of members via electronic means. The Company Secretary to take forward. **Action: CS**
15/A/026	**INTERNAL AUDIT CONTRACT TENDER 2015/18** The DDOF reported that the timetable for the joint contract tender with Portsmouth Hospitals had been received with the invitation to quote for internal audit services going out on the 24th February, and following receipt of tenders, presentation to be held during the week 16th March for commencement of the contract on the 1st April 2015. The Chairman of the Audit Committee to be a member of the interview panel alongside the EDOF and DDOF.
15/A/027	**DATES OF 2015 MEETINGS** Meetings to be held at 2.00 – 4.30 p.m. Venue to be advised. 12 May 2.00 – 4.30 p.m. in the School of Health Sciences 03 June (Provisional for Accounts Sign Off) 11 August 10 November – Lizzie Peers' apologies 09 February 2016