



# **Trust Board Papers**

**Isle of Wight NHS Trust**

**Board Meeting in Public (Part 1)**

**to be held on**

**Wednesday 6th July 2016**

**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.**



The next meeting in public of the Isle of Wight NHS Trust Board will be held on **Wednesday 6<sup>th</sup> July 2016** commencing at **9.30am** in the Conference Room – School of Health Science, St Mary's Hospital, Newport, IW 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](mailto: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
<b>This meeting will be recorded for the purposes of assisting in preparing the minutes and actions from the meeting.</b>					
09:30	<b>1</b>	<b>Apologies for Absence, Declarations of Interest and Confirmation that meeting is Quorate</b>			
	1.1	Apologies for Absence: Nina Moorman, Non-Executive Director Chris Palmer (Gary Edgson Deputising) Lizzie Peers, Non-Executive Director, Financial Advisor	Chair	Receive	Verbal
	1.2	Confirmation that meeting is Quorate <i>No business shall be transacted at a meeting of the Board of Directors unless one-third of the whole number is present including: The Chairman; one Executive Director; and two Non-Executive Directors.</i>	Chair	Receive	Verbal
	1.3	Declarations of Interest	Chair	Receive	Verbal
09:35	<b>2</b>	<b>Minutes of Previous Meetings</b>			
	2.1	To approve the minutes from the meeting of the Isle of Wight NHS Trust Board held on 8 <sup>th</sup> June 2016	Chair	Approve	Enc A
	2.2	Chairman to sign minutes as true and accurate record			
	2.3	Review Schedule of Actions	Chair	Receive	Enc B
09:45	<b>3</b>	<b>Chairman's Update</b>			
	3.1	The Chairman will make a statement about recent activity	Chair	Receive	Verbal
09:50	<b>4</b>	<b>Chief Executive's Update</b>			
	4.1	The Chief Executive will make a statement on recent local, regional and national activity.	CEO	Receive	Enc C
	<b>5</b>	<b>WORKFORCE</b>			
	5.1	Employee Recognition of Achievement Awards	CEO	Receive	Pres
	5.2	Staff Story – Ward Accreditation Programme	EDN	Receive	Pres
10:00	<b>6</b>	<b>QUALITY (PATIENT SAFETY, EXPERIENCE &amp; CLINICAL EFFECTIVENESS)</b>			
	6.1	Patient Story	CEO	Receive	Pres
	6.2	Quality Governance Committee Chair Report	QGC Chair	Receive	Enc D
	6.4	Reports from Serious Incidents Requiring Investigation (SIRIs)	EDN	Receive	Enc E
	6.5	Safer Staffing report monthly report	EDN	Receive	Enc F
	6.7	Mortality Update	EMD	Receive	Pres
	6.8	Annual Report - Complaints & Patient Advice & Liaison Services (PALS) 2015/16	EDN	Receive	Enc G
	<b>7</b>	<b>STRATEGY &amp; PLANNING</b>			
	7.1	My Life a Full Life Health and Care System Redesign Pre-Consultation Business Case Authorisation	CEO	Approve	Enc H
	7.2	Principal Risk Register (Board Assurance Framework)	CS	Receive	Enc I
	7.3	Reference Costs	EDFHR	Approve	Enc J

	<b>8</b>	<b>PERFORMANCE</b>			
	8.1	Finance, Investment, Information & Workforce Committee Chair Report	FIIWC Chair	Receive	Enc K
	8.2	Performance Report	EMD	Receive	Enc L
	8.3	Chief Operating Officers Report	COO	Receive	Enc M
	<b>9</b>	<b>GOVERNANCE</b>			
	9.1	Board Assurance Visits	CS	Approve	Enc N
	9.2	Board Sub-Committee Terms of Reference	CS	Approve	Enc O
	9.3	Top Key Issues & Risks arising from Sub Committees for raising at Trust Board. Minutes Included: <ul style="list-style-type: none"> <li>Minutes of the Quality Governance Committee held on 28th June 2016</li> <li>Minutes of the Finance, Investment, Information &amp; Workforce Committee held on 25th May &amp; 28<sup>th</sup> June 2016</li> <li>Minutes of the Audit and Corporate Risk Committee 10<sup>th</sup> May 2016 &amp; 1<sup>st</sup> June 2016</li> </ul>	CS	Receive	Enc P
	<b>10</b>	<b>Any Other Business</b>	Chair		
	<b>11</b>	<b>Questions from the Public</b>	Chair		
	<b>12</b>	<b>Issues to be covered in private.</b>			
		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: <i>'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.</i>			
		The items which will be discussed and considered for approval in private due to their confidential nature are:			
		<ul style="list-style-type: none"> <li>Sustainability Transformation Plan</li> <li>Financial Control Total</li> <li>Chief Executive's Update on Hot Topics</li> <li>Safeguarding Children Assurance Report</li> <li>Current Consultation on Bed Plan</li> <li>Employee Relations Issues</li> </ul>			
<b>12:00</b>	<b>13</b>	<b>Date of Next Meeting:</b>			
		The next meeting of the Isle of Wight NHS Trust Board to be held in public is on <b>Wednesday 7<sup>th</sup> September 2016</b> in the Conference Room - School of Health Science Building, St Mary's Hospital, Newport, IW PO30 5TG  The Annual General Meeting will be held on Friday 15 <sup>th</sup> July 2016 in the Education Centre, St Mary's Hospital, Newport, IW PO30 5TG			
Following the conclusion of the agenda items in Part 1 of the Trust Board, the Board will now convene as Corporate Trustee					
	<b>1</b>	<b>Board Convened as Corporate Trustee</b>			
	1.1	Minutes of the Charitable Funds Committee Meeting held on 21 <sup>st</sup> June 2016	EDFHR	Approve	Enc Q
	1.2	Revised Terms of Reference – Charitable Funds Committee	EDFHR	Approve	Enc R





**Minutes of the meeting in Public of the Isle of Wight NHS Trust Board  
held on Wednesday 8<sup>th</sup> June 2016 at the  
Conference Room – School of Health Science, St Mary's Hospital,  
Newport, IW PO30 5TG**

<b>PRESENT:</b>	Eve Richardson Jessamy Baird David King Charles Rogers Karen Baker Chris Palmer Mark Pugh Alan Sheward	Trust Chair Non-Executive Director Non-Executive Director Non-Executive Director (SID <sup>1</sup> ) Chief Executive Executive Director of Financial & Human Resources Executive Medical Director Executive Director of Nursing (Deputising for Chief Executive) Chief Operating Officer Deputy Medical Director (Deputising for Executive Medical Director)
<b>In Attendance:</b>	Mark Price Jon Burwell  Andy Hollebon <i>For Item 16/T/105</i> Jean Witney <i>For Item 16/T/105</i> Sharon Brackley <i>For Item 16/T/105</i> Jackie Young <i>For Item 16/T/105</i> Helen Maddox <i>For Item 16/T/106</i> Steph Stanley	Company Secretary Interim Executive Director for Strategy, Planning, ICT & Estates (IED) Head of Communications Cleanliness Assistant Cleanliness Assistant Mental Health Practitioner Occupational Therapy Lead – Community Rehab Deputy Head of Podiatry
<b>Observers:</b>	Linda Fair Jeanine Johnson Andy Newman	Patient Council Lead Nurse/Lead Clinician Stroke Services Communications and Engagement Manager
<b>Minuted by:</b>	Julie Benson	Executive Personal Assistant
<b>Members of the Public in attendance:</b>	There were no members of the public present. A representative from the IW County Press also attended.	

**Minute No.****16/T/101****APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE**

The Chair welcomed everyone to the meeting.  
Apologies received from Mark Pugh, Executive Medical Director, Nina Moorman, Non-Executive Director, Jane Tabor, Non-Executive Director and Lizzie Peers Non-Executive Financial Advisor

The Chairman announced that the meeting was quorate and welcomed Jon Burwell to his first meeting. Jeanine Johnson, Lead Nurse/Lead Clinical Stroke Services was welcomed as she was observing the meeting. Andy Newman, Communications and Engagement Manager was also welcomed as a new appointee to the Trust.

Declarations of Interest were received from Charles Rogers and the Executive Director of Financial & Human Resources in their role as Directors of Wightlife Partnership.

---

<sup>1</sup>Senior Independent Director

**16/T/102 MINUTES OF PREVIOUS MEETING**

Minutes of the meetings of the Isle of Wight NHS Trust Board held on 4<sup>th</sup> May 2016 were reviewed and approved.

**16/T/103 REVIEW OF SCHEDULE OF ACTIONS**

The Board received the schedule of actions and the following updates were provided:

- a) **TB/193 – ICT Update – Actions for Task & Finish Group:** The Chief Executive confirmed that a structure had now been set up for the delivery of ICT. The work is progressing and Minutes of meetings will be presented to the future Board Meetings. The Chair confirmed that David King will link in with IED.
- b) **TB/203 – Oncology Service Review:** The Executive Director of Nursing confirmed that the item did go to the QGC in May and there was assurance around the tripartite work that has been done between Portsmouth, Southampton and Isle of Wight NHS Trust and will report back to QGC in 3 months' time. It was agreed that this action be closed and an action to progress the Oncology Implementation Plan be opened with a 3 month forecast date.

*Action: This action to be closed and Company Secretary to open a new action to progress the Oncology Implementation Plan.*

- c) **TB/206 – Ambulance Targets:** The Chief Executive reported that it would come back to the next Board meeting.
- d) **TB/207 – Care of Elderly:** The Executive Director of Nursing confirmed that he and Jane Tabor had had a discussion but as Jane was not available at the meeting it would remain open as an action.
- e) **TB/212 – Operating Plan 2016:** The Executive Director of Nursing confirmed that this was closed.

**16/T/103 CHAIR'S UPDATE**

The Chair reported that she had attended the Mental Health Summit on 7<sup>th</sup> June which was opened by Karen Baker. Sgt Paul Jennings gave an excellent presentation on Operation Serenity.

She had attended a Kings Fund event with Lord Carter presenting on productivity and his recent report in discussion with Roy Lilley. There is interest on what we are doing on the Island around integration and they will be visiting the Island later on in the year.

There had been a recent Board to Board with the CCG which was a positive meeting. The Chair had also met with the Chair of the League of Friends who was very keen to work closely with us.

**16/T/104 CHIEF EXECUTIVE'S UPDATE**

The Chief Executive presented the report and highlighted the following:

**National**

- i. **Junior Doctors' Industrial Action:** A ballot of BMA members is to take place. The Chief Executive reported that our junior doctors have handled the strike very well, and spent strike time going out to schools to teach about life support and other important issues. She also reported that our junior doctors do feel supported by the Trust.
- ii. **National Performance and Financial Position:** There has been a national acknowledgement that the NHS will not be able to balance the books in 2016/17; however we do need to do all we can to achieve our local financial targets.

**Regional**

- iii. **Hampshire & Isle of Wight Sustainability and Transformation Plan (STP):** We have to submit our plan on 30<sup>th</sup> June. At the Board Seminar on 21<sup>st</sup> June 2016 more detail will be able to be given on the development of the plan.

#### Local

- iv. **My Life a Full Life Programme:** We are entering a period of focused engagement with Island residents, staff and volunteers to ensure that services are of a very high quality and sustainable. Our urgent care hub continues to attract visits.
- v. **System Director:** It has been agreed with the CCG and Local Authority that a System Director will be appointed to focus on how, as a whole health and care system, we can push forward with our transformational change.
- vi. **Urology:** We have given notice to the CCG on our Urology service. We are working closely with the CCG to ensure that a sustainable service can be put in place.
- vii. **Partnership Working:** Time has been spent with senior colleagues in the CCG and Local Authority to discuss what our joint strategic direction is. It is very much about integration.
- viii. **Fight for the Wight:** We have agreed to support the Local Authority in trying to achieve an acknowledgement that the Island is unique and needs extra financial support.
- ix. **International Nurses Day and Admiral Nurses:** A very successful International Nurses Day was held on 12<sup>th</sup> May. It was great to see the commitment and care shown to deliver care. Admiral Nurses are appointed in conjunction with Dementia UK.
- x. **Accreditation – Hospital Sterile Devices Unit (HSDU), Cellular Pathology and the Mortuary:** A four day inspection has recently been carried out on our HSDU and accreditation received. The Cellular pathology and the mortuary team have also been granted accreditation.

Charles Rogers congratulated the Trust on receiving the ISO accreditation.

He questioned whether emergency out of hours cover for Urology will be continuing after June. The Chief Operating Officer confirmed that patients would still be seen, assessed and appropriately managed.

## WORKFORCE

16/T/105

### EMPLOYEE RECOGNITION OF ACHIEVEMENT AWARDS

The Chief Executive presented the Employee Recognition of Achievement Awards. This month the nominations were as follows:

#### Going the Extra Mile:

- Whippingham Ward Staff Team
- Jean Witney – Cleanliness Assistant
- Sharon Brackley – Cleanliness Assistant
- Jackie Young – Mental Health Practitioner

#### **Quality Care & Innovation**

Helen Maddox – Occupational Therapy Lead – Community Rehab

The Chief Executive congratulated all the recipients on their achievements.

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

#### **16/T/106 EMPLOYEE OF THE MONTH**

The Chief Executive presented the Employee of the Month Award:

**Employee of the Month – June 2016:** Steph Stanley, Deputy Head of Podiatry

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

### **QUALITY (PATIENT SAFETY, EXPERIENCE AND CLINICAL EFFECTIVENESS)**

#### **16/T/107 PATIENT STORY**

The Chief Executive introduced the patient story with an explanation that it is focuses on what patients had said and what the Trust had done to achieve improvements following all of the patient stories over the last year.

The Executive Director of Nursing reported that safer staffing reviews had been completed since the making of the film and the nursing establishment had been increased by 29. He also reiterated that complaints were valued as it allowed the Trust to make changes necessary.

#### **The Isle of Wight NHS Trust Board received the Patient Story**

#### **16/T/108 QUALITY GOVERNANCE COMMITTEE CHAIR REPORT**

The Executive Director of Nursing reported that Nina Moorman, Chair of Quality Governance Committee had requested that he reported back that with full Clinical Director representation at the meeting it was now much more effective. The Executive Director of Nursing highlighted aspects of this report to the Board.

The Deputy Medical Director clarified that one of the Consultant Microbiologists is going on Maternity Leave and will return to work. Jessamy Baird asked if there was a mitigation plan with the lack of Microbiologists. The Executive Director of Nursing responded that the Microbiologist who was working her notice has given a commitment to cover the service in the interim and we are actively recruiting to the post.

Charles Rogers confirmed that there is now much closer working between Quality Governance Committee and Financial Investment Information and Workforce Committee.

#### **The Isle of Wight NHS Trust Board received the Quality Governance Committee Chair Report**

#### **16/T/107 QUALITY IMPROVEMENT PLAN/Framework MONTHLY UPDATE**

The Executive Director of Nursing outlined the development of the Quality Improvement Plan and the engagement that has occurred with the Clinical Business

Units. It was also outlined how the quality priorities were monitored and would be managed going forward.

Another Quality Summit is due to be held on 24<sup>th</sup> June and will continue to be quarterly. By September all CBUs will self-assess against the Framework. Each of the Clinical Directors will be asked to lead on a quality improvement project of their choice and they will then feedback on this. The development of the Quality Improvement Plan will continue to be reported back to the Board.

### **The Isle of Wight NHS Trust Board received the Quality Improvement Plan/Framework Monthly Update**

**16/T/108****REPORTS FROM SERIOUS INCIDENT REQUIRING INVESTIGATION (SIRIS)**

The Executive Director of Nursing reported that four Serious Incidents Requiring Investigations (SIRIs) had been carried out during April 2016.

- An Unexpected Event – Surgical
- Allegation against healthcare staff – Surgical
- Failure to escalate – Critical Care Services
- Retained Foreign Object – Day Surgery.

The Executive Director of Nursing reported that the SIRI process has been amended as follows.

1. All Serious Incidents must be reviewed within 48 hours and a report produced to the Executive Director of Nursing and the Executive Medical Director. This must take part as a table top review.
2. The introduction of an Integrated Panel Review (IPR) and that all SIRIs will be reviewed by either the Executive Director of Nursing, Executive Medical Director, Deputy Director of Nursing or Deputy Medical Director. These have been very successful and good feedback has been received from the Clinical Commissioning Group and a number of SIRIs have been closed.

The Chief Executive commended the team working on the SIRIs as there has been a fantastic improvement in the process.

### **The Isle of Wight NHS Trust Board received the Serious Incident Requiring Investigation (SIRIs) Report.**

**16/T/109****SAFER STAFFING MONTHLY REPORT**

The Executive Director of Nursing reported that for the first time the Trust has met its locally set target of 90% average fill rate for all 4 nursing measures for April. The national standard is 80%. Bank fill rate also remains positive and there has been a successful round of Health Care Assistant recruitment. Both national and local recruitment campaigns for registered nurses are continuing. Sickness rates are above 3% in 9 areas.

Charles Rogers and Jessamy Baird both commented that it was a good report.

Charles Rogers questioned what were the risks that the Board need to be informed about. The Executive Director of Nursing responded that the quality and cost of agency staff. It was also confirmed that there was a proactive recruitment plan in place at the moment. The Executive Director of Financial and Human Resources did confirm that there are times where we are in breach of the national cap for agency staff due to travel and accommodation.

### **The Isle of Wight NHS Trust Board received the Safer Staffing Monthly Report**

**16/T/110 DATA QUALITY UNDERPINNING KPIs REPORT**

The Executive Director of Financial and Human Resources reported that this was the annual report to give assurance around the data quality underpinning the Key Performance Indicators. Overall there is a degree of confidence as all ratings are good or fair. An 89% target has been achieved for indicators with a good rating. It was also reported that progress had been made with ensuring electronic data capture as opposed to manual.

**The Isle of Wight NHS Trust Board received the Data Quality Underpinning KPIs Report**

**16/T/111 DATA QUALITY REPORT**

The Executive Director of Financial and Human Resources reported that we do still have 3 red rated indicators in the Secondary Uses Service (SUS) data sets.

Outstanding discharges are the biggest concern at the moment. There are still 463 discharges outstanding. There is a concern that if the discharges are not done we may not get paid for the work that has been done.

The Deputy Medical Director confirmed that from August no patient will be discharged without a summary being completed. Work will be done with primary care colleagues to improve the current status of discharge summaries.

Charles Rogers commented that the FIWC concern is that there does not appear to be any great improvement which was disappointing.

**The Isle of Wight NHS Trust Board received the Data Quality Report**

## **STRATEGY & PLANNING**

**16/T/112 STRATEGY UPDATE**

The Chief Executive provided the Board with a Strategy Update. We have been linking the Strategy to the My Life a Full Life programme and the developing Sustainability Transformation Plan. Monitoring delivery against priorities will be through Trust Executive Committee from July onwards.

**The Isle of Wight NHS Trust Board received the Strategy Update**

**16/T/113 PRINCIPAL RISK REGISTER (BOARD ASSURANCE FRAMEWORK)**

The Company Secretary presented the Principal Risk Register (Board Assurance Framework) Report. It shows the latest position on the 8 Principal Risks. The Board was asked to approve the risk 672 for closure and to approve the opening on a new financial risk for 2016/17.

Jessamy Baird commented that it was a good concise report but there is nothing relating to key partnership risks. The Company Secretary said that this was within Risk 677.

**The Isle of Wight NHS Trust Board received Principal Risk Register (Board Assurance Framework) and approved the closure of Risk 672 and the opening of a new financial risk for 2016/17.**

**16/T/114 BUDGET 2016/17 (FULL BUDGET APPROVAL)**

The Executive Director of Financial and Human Resources presented to the Board the financial budget for 2016/17 for approval. An interim budget was approved by the Trust Board on 30<sup>th</sup> March 2016.

The final financial plan was submitted to NHS Improvement on 18<sup>th</sup> April 2016 following review by Board members on 15<sup>th</sup> April 2016.

The plan formally sets out the 2016/17 plan for:



- Statement of Comprehensive Income (SOCl) Income and Expenditure account
- Statement of Financial Position (SOFP) Balance Sheet
- Statement of Cash Flows.

The financial plan for 2016/17 is a deficit position of £9.844m.

Some of the risks have been mitigated and there will be a continued effort to identify schemes to cover the current unidentified savings gap. The Executive Director of Financial and Human Resources stressed that the paper includes an indicative capital programme and that each prioritised capital scheme will be approved during the year.

Charles Rogers confirmed that the budget had been approved at Finance, Investment, Information and Workforce Committee.

**The Isle of Wight NHS Trust Board approved the 2016-17 Budget**

## **PERFORMANCE**

### **16/T/115 FINANCE, INVESTMENT, INFORMATION AND WORKFORCE COMMITTEE CHAIR REPORT**

Charles Rogers, Chair of the Finance, Investment, Information and Workforce Committee reported on the meetings of 25<sup>th</sup> May, which he had chaired, and 26<sup>th</sup> April 2016 which was chaired by Jane Tabor.

He highlighted a number of issues from 25<sup>th</sup> May 2016 meeting including:

Safer staffing rostering: There are concerns that although there has been an improvement more needs to be done to ensure that this continues.

Cost Improvement Plan: Acknowledged that work is going on but still very challenging and felt that there is still a risk as far as the Committee is concerned. Concerns were expressed that the Trust will have to borrow again to maintain an acceptable cash position due to our financial position.

Information Governance: There were concerns with the current lack of compliance and limited engagement across the Trust. Jessamy Baird said that the SIRO needs to drive this. The Company Secretary confirmed that there was a clear set of actions to ensure compliance and these will be monitored by the Trust Executive Committee.

**The Isle of Wight NHS Trust Board received Finance, Investment, Information and Workforce Committee Chair Report**

### **16/T/116 PERFORMANCE REPORT**

The Executive Director of Nursing presented the Performance Report.

#### **Highlights:**

- High Risk TIA fully investigated and treated within 24 hour above the target
- No falls resulting in significant injury
- Symptomatic Breast Referrals Seen <2 weeks. Cancer patients seen <14 days after urgent GP referral, Cancer patients receiving subsequent Chemo/Drug <31 days and Cancer diagnosis to treatment <31 days above target.
- No mixed sex accommodation breaches in April
- No new cases of MRSA or C.Diff
- % of Care Programme Approach patients receiving follow up contact within 7 days of discharge and % of Care Programme Approach patients having formal review within last 12 months above target.
- Summary Hospital level Mortality Indicator.

- No Clinical Incidents (Major) result in harm

**Lowlights:**

- % patients waiting <6 weeks for diagnostics failing the target for the month
- Referral to Treatment Time - % incomplete pathways below 92% target
- 1 Never Event in April
- Staff sickness remains above plan
- Emergency Care 4 hour standard remains below target
- Theatres utilisation below target
- All 3 ambulance indicators below target
- Cancer patients receiving subsequent surgery <31 days, Cancer patients treated after screening referral <62 days and Cancer urgent referral to treatment <62 days below target
- Governance Risk Rating of 11 for April 2016
- 9 cancelled operations on/after day of admission (not rebooked within 28 days)
- 22 formal complaints in month
- 2 patients who have waited over 12 hours in A&E from decision to admit to admission in April
- 2 patients developed a grade 4 pressure ulcer
- Stroke patients (90% of stay on Stroke Unit) below target.

David King commented that the Ambulance service performance was of concern and sought assurance that the Trust had a clear implementation plan. The Executive Director of Nursing responded that a number of First Responders were across the Island in training at the moment.

The Chief Operating Officer also reported that work was being carried out to ensure that there was adequate ambulance cover in each part of the island. He confirmed that the situation would improve in the coming months. It was agreed that the Board would focus more on the performance against key access targets at the next Board Seminar. It was also reported that the Air Ambulance would be here a lot more in the future. It had also been agreed to share our data with the Air Ambulance.

*Action: The Chief Operating Officer to present on performance against key access targets at the next Board Seminar*

**The Isle of Wight NHS Trust Board received the Performance Report**

**GOVERNANCE**

16/T/117

**CORPORATE GOVERNANCE FRAMEWORK**

The Company Secretary presented the Corporate Governance Framework. It was confirmed that the Standing Orders and Standing Financial Instructions had been approved by the relevant sub-committee.

The Scheme of Delegation is proposed to be approved for a six month extension in order to address recommendations made by Capsticks Governance Consultancy.

Jessamy Baird commented that the Standing Financial Instructions were showing an inaccurate title in that the Executive Director of Transformation and Integration was still included. The Company Secretary confirmed that this would be amended together with changes to the names of the Board Sub-Committees.

*Action: The Company Secretary to amend the Standing Financial Instructions*



The Isle of Wight NHS Trust Board approved the Corporate Governance Framework with the minor agreed amendments.

**16/T/118 TOP KEY ISSUES AND RISKS ARISING FROM SUB-COMMITTEES**

The Company Secretary presented the Top Key Issues and Risks arising Sub-Committees.

Jessamy Baird reported that at the Mental Health Act Scrutiny Committee there was a lack of Executive Director and Clinical Director representation. The Chief Operating Officer has confirmed that with immediate effect the Clinical Director will be in attendance and the Chief Operating Officer will be able to attend 3 of the 4 meetings in the year. This would be added to the Terms of Reference.

*Action: The Company Secretary to amend the Terms of Reference to reflect the changes to membership*

**The Isle of Wight NHS Trust Board received the Top Key issues and risks arising from Sub-Committees**

**16/T/119 REVISED TERMS OF REFERENCE FOR TRUST BOARD**

The Company Secretary presented the revised Terms of Reference for the Trust Board following a review of the Trust Governance arrangements.

**The Isle of Wight NHS Trust Board approved the revised Trust Board Terms of Reference**

**16/T/120 ANY OTHER BUSINESS**

**16/T/121 DATE OF NEXT MEETING**

The Chair confirmed that the next meeting of the Isle of Wight NHS Trust Board to be held in public is:

Wednesday 6<sup>th</sup> July 2016 – Full Board meeting in public to be held in the Conference Room – School of Health Science, St Mary's Hospital, Newport, IOW, PO30 5TG

**The meeting closed at 12:20**

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

# Enc B

## ISLE OF WIGHT TRUST BOARD Pt 1 (Public) - April 16 - March 17

### ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

Key to LEAD: Chief Executive (CE) Executive Director of Financial & Human Resources (EDFHR) Interim Executive Director of Strategy, Planning, ICT and Estates (IED) Executive Medical Director (EMD)

Executive Director of Nursing (EDN) Deputy Director of Nursing (DDN) Chief Operating Officer (COO)

Company Secretary (CS) Board Governance Officer (BGO) Head of Communications (HOC)

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

Deputy Director of Informatics (DDI)

Non Executive Directors: Eve Richardson (Chair) Charles Rogers (CR) Nina Moorman (NM) David King (DK) Jane Tabor (JT) Jessamy Baird (JB)

Non Executive Financial Advisor: Lizzie Peers (LP)

Date of Meeting	Minute No.	Action No.	Item	Action	Exec Lead	Update	Report Author	Further Action by Other Committee	Due Date	Forecast Date	Progress RAG	Date Closed
04-Nov-15	15/T/228	TB/188	Older Persons Nurse Fellowship Update	Company Secretary to arrange for Di Goring to present an update at Seminar in approximately 6 months.	CS	On Seminar Forward Plan for May 16 <b>04/05/16</b> - This would be presented at the 17th May Board Seminar. <b>16/05/16</b> - Due to sickness leave this item has been deferred to a future Seminar		Seminar	17-May-16	09-Aug-16	Progressing	
15-Dec-15	15/T/255	TB/193	ICT Update - Actions for Task & Finish Group	It was agreed to include cost savings as efficiencies as key goals and the Chair asked that the expertise of primary care and what was emerging in the My Life work be included in the Task & Finish Group	CEO (IED)	<b>22/02/16</b> - The Chief Executive to give an update on the ICT Task & Finish Group at the March Board meeting <b>02/03/16</b> - ICT Task & Finish Group: The Chief Executive would be updating the Board within Part 2 of the meeting. <b>29/03/16</b> - First meeting took place on 15 March 2016 <b>06/04/16</b> - The Chief Executive reported that the ICT Programme Board had met on 15th March to set the governance structure and agree the terms of reference for the Users Group. She confirmed that they would be reporting to the ICT Programme Board. David King is the NED lead, with the other NEDs deputising as required. She also confirmed that the Isle of Wight Council had gone live with the PARIS system this week. <b>08/06/16</b> - The Chief Executive confirmed that a structure had now been set up for the delivery of ICT. The work is progressing and Minutes of meetings will be presented to the future Board. The Chair confirmed that David King will link in with IED.		Task & Finish Group	15-Mar-16	06-Jul-16	Progressing	
02-Mar-16	16/T/040	TB/202	Patient Flow & Key Access Targets	The Company Secretary to arrange a session on patient flow and key access targets at a future Board Seminar	CS	<b>29/03/16</b> - To be scheduled at a future seminar with agreement of the Chair <b>21/06/16</b> - Completed at Board Seminar		Seminar	21-Jun-16	21-Jun-16	Completed	21-Jun-16
06-Apr-16	16/T/052	TB/203	Oncology Service Review	The Executive Director of Nursing to update the Board on the progress of the Oncology Service review and implementation of the new service model.	EDN	<b>27/04/16</b> - This item is going to QGC in May <b>08/06/16</b> - Agreed to close at Board Meeting			08-Jun-16	08-Jun-16	Completed	08-Jun-16

# Enc B

Date of Meeting	Minute No.	Action No.	Item	Action	Exec Lead	Update	Report Author	Further Action by Other Committee	Due Date	Forecast Date	Progress RAG	Date Closed
06-Apr-16	16/T/053d)	TB/204	Terms of Reference alignment to Principal Risks	Company Secretary to arrange alignment of the Board and its Sub Committee's terms of reference to the 8 principal risks.	CS	<b>25/04/16</b> - Terms of Reference to be circulated and discussed at Board Seminar 17th May. Final Approval will be sought at 6th July Board meeting <b>29/06/16</b> - All Terms of Reference in Board papers for 6 July meeting for approval.			06-Jul-16	06-Jul-16	Completed	
06-Apr-16	16/T/053d)	TB/205	Principal Risk 8 - Capacity & Capability of the Board	The Chief Executive to update the FIIWC on the progress of the capacity and capability principal risk.	CEO HCG	<b>25/04/16</b> - This action relates to Board Statement 13 which sat under FIIWC and therefore has been requested that FIIWC undertake a 'deep dive' to provide assurance to the Board that this is being managed effectively.		FIIWC	10-May-16	30-Aug-16	Progressing	
06-Apr-16	16/T/053e)	TB/206	Ambulance Targets	The Chief Operating Officer to include more detail on ambulance target performance in his monthly Board report.	COO	<b>26/04/16</b> - Enhanced information on Ambulance targets will be included in June's report. <b>08/06/16</b> - The Chief Executive reported that it would come back to the next Board meeting.			06-Jul-16	06-Jul-16	Progressing	
06-Apr-16	16/T/060	TB/207	Care of Elderly	The Executive Director of Nursing to discuss with Jane Tabor the good practice in the care of elderly frail patients at University Hospital Southampton NHS FT.	EDN	<b>27/04/16</b> - A conference call is being arranged to discuss this issue. <b>04/05/16</b> - The Executive Medical Director confirmed that discussions had taken place. Jane Tabor would be providing further details.			08-Jun-16	06-Jul-16	Progressing	
06-Apr-16	16/T/064	TB/208	Nursing recruitment & retention	The Executive Director of Nursing to report to FIIWC on nursing staff recruitment and retention.	EDN	<b>25/04/16</b> - FIIWC agenda for June. <b>29/06/16</b> - Now on FIIWC Agenda for July		FIIWC	28-Jun-16	26-Jul-16	Progressing	
06-Apr-16	16/T/070	TB/210	Mottistone Suite	The Chief Operating Officer to present report on the review of Mottistone to FIIWC.	COO	<b>26/04/16</b> - This report will be presented to FIIWC in July		FIIWC	06-Jul-16	30-Jul-16	Progressing	
04-May-16	16/T/086i)	TB/213	National Bed Day data	The Executive Director of Nursing to include benchmarked data against the national 1000 bed day criteria within the QGC deep dive into clostridium difficile cases.	EDN	<b>28/06/16</b> - Moved to July QGC		QGC	28-Jun-16	26-Jul-16	Progressing	
04-May-16	16/T/088	TB/214	Addition to the Statutory & Formal Roles	The Company Secretary to investigate the need for a formal Guardian Board lead and seek approval if required.	CS	<b>27/05/16</b> - The Board will need to approve an individual to act as the Freedom to Speak up Guardian. A proposal will be made following further advice and guidance being sought on the role.			07-Sep-16	07-Sep-16	Progressing	

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> July 2016

<b>Title</b>	Chief Executive Officer's Report		
<b>Sponsoring Executive Director</b>	Karen Baker, Chief Executive Officer		
<b>Author(s)</b>	Andy Newman, Communications and Engagement Manager		
<b>Purpose</b>	For information		
<b>Action required by the Board:</b>	Receive	X	Approve
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Trust Executive Committee			
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee			
Mental Health Act Scrutiny Committee			
Remuneration & Nominations Committee			
Quality Governance Committee			
<b>Please add any other committees below as needed</b>			
Board Seminar			
Other (please state)			
<b>Staff, stakeholder, patient and public engagement:</b>			
<p>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 28 May to 24 June 2016. Information which relates to the five Clinical Business Units will appear in a separate Chief Operating Officers report. My report will cover issues of national and regional importance and local issues which come within the remit of the Trust's corporate services.</p>			
<b>Executive Summary &amp; Analysis:</b>			
<p>This report provides a summary of key successes and issues which have come to the attention of the Chief Executive over the last month. The report covers the following issues:</p> <p><b>National</b></p> <ul style="list-style-type: none"> <li>• European Union Referendum Result</li> <li>• Commissioning for Quality and Innovation (CQUIN)</li> <li>• 'What Matters To You? Day 2016'</li> </ul> <p><b>Regional.</b></p> <ul style="list-style-type: none"> <li>• Mental Health Summit</li> <li>• Sustainability and Transformation Plan (STP)</li> </ul>			

<b>Local</b> <ul style="list-style-type: none"> <li>• Inquest</li> <li>• Healthy and contented staff equals better patient care</li> <li>• Clinical Directorate Restructure</li> <li>• Return of Thank You Postcards</li> <li>• 'Greener Care' booklet</li> <li>• Staffing</li> <li>• The Ambulance Clinical Support Officers</li> <li>• Discharge summaries</li> <li>• Key Points Arising from the Trust Executive Committee</li> </ul>	
<b>Recommendation to the Board:</b> The Board is recommended to note the contents and receive the report.	
<b>Attached Appendices &amp; Background papers</b>	
<b>For following sections – please indicate as appropriate:</b>	
<b>Trust Goals &amp; Priorities</b>	All
<b>Principal Risks (BAF)</b>	None
<b>Legal implications, regulatory and consultation requirements</b>	None
<b>Date:</b> 31 <sup>st</sup> May 2016	<b>Completed by:</b> Andy Newman, Communications and Engagement Manager

## **Chief Executive's Report covering the period 28<sup>th</sup> May to 24th June 2016**

My report will cover issues of national and regional importance, and local issues which come within the remit of the Trust's corporate services.

### **National**

#### **European Union Referendum Result**

As you all will be aware, the Isle of Wight along with the United Kingdom as a whole, voted to leave the European Union. Many things have since been said in the national press and on social media. What is clear, the timetable for exit, along with the process and outcomes, at the time of writing has still yet to be fully decided, creating a time for great uncertainty for people within and outside the United Kingdom.

Many things have been said during the past weeks about workers from abroad. Within our own organisation we have a number of staff from outside the United Kingdom, who make an important and vital contribution to the successful running of the IOW NHS Trust and most important, the care of our patients, which we cannot provide without them. Regarding the exit, nothing will happen quickly, time scales are unclear and could take some considerable time, so in the meantime, I have asked our staff to stay focused on the work and care in hand, and thanked them for their great work.

#### **Commissioning for Quality and Innovation (CQUIN)**

In 2009, the Commissioning for Quality and Innovation (CQUIN) payment framework was introduced to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals. Each year, the Trust is given a number of national, local and NHS England CQUINs to achieve. For 2016/17, there are four national and two local CQUINs. The Contracts Team were involved in negotiations with the Executive Director of Nursing, Quality Governance Team and Clinical Commissioning Group to agree these CQUINs which are:

1. NHS Staff Health and Wellbeing
  - a. Introduction of health and wellbeing
  - b. Healthy food for NHS staff, visitors and patients
  - c. Improving the uptake of flu vaccinations for front line staff
2. Timely identification and treatment of sepsis in Emergency Departments and acute inpatient settings
3. Mental Health – Improving physical healthcare to reduce premature mortality in people with severe mental illness
4. Antimicrobial resistance and antimicrobial stewardship
5. Holistic Health Care in Community Settings - Safer Staffing, Innovation and Technology, Risk Assessment and Care Planning
6. Falls - Prevention of Slips, Trips and Falls in In-patient Settings

#### **'What Matters To You? Day 2016'**

The day, Monday 6th June, which started in Norway in 2014, aims to encourage and support more meaningful conversations in order to improve health and social care through gaining an understanding of the things that are really important in people's lives. The deeper purpose of this work is to promote a culture focused on listening and understanding; a system of support and care that is better at meeting people's needs and supporting them to live well on their terms. All too often we don't invest a little time to truly listen, to understand people's personal preferences, their fears and concerns, and this in turn leads to a failure to deliver high quality compassionate care tailored to their needs.

Our hope is that once people have a go at asking 'what matters to you?' and experience the benefits for both themselves and the people they serve, that they will continue to use this approach. The 'What matters to you?' question can be asked in many different ways. For example:

- “What are the things that are important to you at the moment?”
- “What are some of the things you would like to achieve as a result of this support?”
- “When you have a good day, what are the things that make it good?”

This type of approach can help in a number of ways. First and foremost it helps to establish a relationship, but it also helps you to understand the person in the context of their own life and the things that are most important to them. With this crucial insight you are in a much better position to work with the person to find the best way forward for them. As a Trust we fully supported and joined in with this initiative, with many staff and members of our patient council writing on cards, what mattered to them, and then photographed with their statement, which was subsequently shared on social media.

## **Regional.**

### **Mental Health Summit**

I had the privilege of opening the Mental Health Summit on the 7th June, which had been arranged for practitioners and others involved in service provision from Hampshire and the IOW. This is the first time that there has been a whole day regional summit looking specifically at how we should be providing care to people from the community right the way up to tertiary mental health care. It was a fantastic day and met colleagues from other areas and discussed how we can improve services right across our region. The Island's own Sgt Paul Jennings gave an excellent talk about Operation Serenity and how he has developed the programme with the police and mental health staff to triage mental health patients on the street. This helps to ensure patients get the right treatment without the need for admission Sevenacres or spend a night in the cells. There were some great discussions about how services can work more closely with partners and each other.

### **Sustainability and Transformation Plan (STP)**

The mental health summit was followed by the second of the Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Plan (STP) workshops for service providers and commissioners. STPs are all about working at scale to achieve the best quality efficient services for the population covered by the STP. The challenges faced across the region are immense. People are finding it harder to keep healthy. Tactical and fragmented investment in prevention fails to capitalise on our opportunities, and the care system needs to be further adapted to address multiple morbidities. In the next five years there will be a minimum estimated additional 41,000 long term conditions in Hampshire and the Isle of Wight. Co-morbid mental health problems raise total health care costs by at least 45%, when interacting with physical illness.

Clinical, operational and financial sustainability issues exist across HIOW and are contributing to the care and quality gap. Three out of the six acute hospital sites in HIOW will be unsustainable in the next 5 years. There is unwarranted variation in quality and performance across the region, and challenges in workforce availability necessitate a different approach, as our vacancy rates are higher than the national average, leaving the system with high agency costs.

Considering the scale, across 21 providers, 8 CCGs, as chair of the Hampshire & IoW STP I think we are making good progress, particularly in the areas of Mental Health, Acute Care (integration) and Urgent and Emergency Care towards the submission of our plan at the end of June, and as an Island we were fortunate in that we had already got the My Life a Full Life programme underway which has helped to shape our thinking on the best way to provide services for the Island.

## **Local**

### **Inquest**

An inquest was held on 14 and 15 June, and I attended alongside a number of our staff. The inquest was into the death of 96 year old Mr Thomas Higgins a patient on the District Nursing caseload, who was found to have passed away at home by his carer. On behalf of The Isle of

Wight NHS Trust I offer our deepest sympathy to the family of Mr Higgins for the anguish and distress caused by his unexpected death.

During the two days, the coroner questioned colleagues and myself, as we presented evidence. Human error resulted in a significant failing and the failure of Trust systems contributed to the Trust's ability to fulfil our commitment to provide quality care to all our patients. For this we sincerely apologise to Mr Higgins' family.

Having joined my colleagues in giving evidence, I have experienced first-hand how important and vital it is that we have stringent and robust systems in place that we all follow when the care and lives of our patients are concerned. I have already had discussions with staff and am personally working with colleagues, and the teams involved in events prior to Mr Higgins death, to help and support the work in ensuring that we deliver care in a planned and timely way to our patients.

**Healthy and contented staff equals better patient care** and the Trust wants to support staff to be the best that they can be. Working in the NHS is challenging, busy and it can be very stressful at times juggling the different demands. We have personal lives that are also challenging sometimes and it so important to look after ourselves and each other as best we can so that we have the capacity for our patients and clients. There are many avenues of support for all Trust staff to help build and maintain optimum health and wellbeing. Whether it be some counselling, want some advice about diet, weight or exercise, information about childcare or managing your finances.

The Staff Health and Wellbeing group and the Staff Experience group are working hard together to develop more and better avenues of support, different activities for individuals or groups and a variety of ways to keep you informed and up to date about what is available.

Although work place health week was in May, the work is ongoing, as it aims to promote a healthier way of life by introducing staff to a wealth of different sport and physical activities, with an array of exciting events and activities taking place throughout the working week across the country. A recent survey received 432 responses from staff; by far the largest interest was in fitness classes. The trust will now look at how it can respond to this by utilising its own facilities or with local providers.

Chamber Health MOT checks for staff are available on allocated days in June, July, August and September. Staff can chose a 20 minute MOT that includes height, weight, BMI, blood pressure, Diabetes and Cardiovascular risk score, lifestyle advice that includes physical activity, smoking, diet and nutrition, sign posting and referrals if required – e.g. weight management programmes or exercise. Additionally a 30 minute MOT, includes all of the above plus cholesterol and blood glucose tests at an additional cost. The health checks will be provided by Chamber Health and can be accessed by the Occupational Health team.

**Clinical Directorate Restructure:** The Operations Division and its five Clinical Business Units (CBUs) have been running operationally since 1<sup>st</sup> November 2015. As planned, each of the CBUs is led by a Clinical Director (CD) supported by a Head of Operations (HOO) and Head of Nursing and Quality (HONQ). 18.64 whole time equivalents were removed from clinical directorates through this organisational change with 11.8 of those moving to corporate departments. Final office moves took place early May 2016 and the Operations Division, with its five CBUs; divisional support services and leadership are now co-located on the first and second floors of the General Management Offices in the main hospital. 62 individuals were directed affected by this organisational change and numerous others affected by line management changes and team changes. Despite 12 staff being formally displaced only 1 redundancy has taken place as a result of this organisational change. The restructure has improved the focus, productivity and efficiency of the operational delivery of services. The first report by the Chief Operating Officer will appear in another paper submitted to the Board, and will be ongoing for the future.



### **Return of Thank You Postcards**

Following from the success of the pilot scheme of the Thank You postcards, this initiative has been approved to continue to be rolled out throughout the Trust. Feedback received from the pilot scheme was very positive; staff appreciate the personal touch and felt valued of the recognition of work.

### **'Greener Care' booklet**

I congratulate everyone who contributed to the joint Trust and CCG 'Greener Care' booklet which set out how the Island NHS is working to ensure that services are more sustainable. Recently this has made it as a case study on a United Nations Agency website. It's listed among other global projects for improving environmental sustainability in the healthcare sector!

### **Staffing**

We have been able to bring the Business Planning and Programme Governance organisational change to a close and made two important appointments. Andrew Shorkey has been appointed Head of Strategy & Planning and Jo Case, Head of Service Improvement. The team, which reports into Jon Burwell, will continue to be based on the ground floor of the South Block and will now be known as the Intelligence, Planning and Delivery Unit (IPDU) incorporating strategy, planning and service improvement. The Unit will be focused on supporting the organisation to achieve improvements in the care we provide. Additionally, Andy Newman from the Isle of Wight Council has joined our Communications, Engagement & Membership team on secondment till the autumn.

**The Ambulance Clinical Support Officers hosted a Continuing Professional Development (CPD) workshop** for Health Care Professions Council (HCPC) registrants on Monday 6th June 2016. We invited over two lecturers from Portsmouth University who are HCPC auditors (Mick Harper and Penny Joyce) and hosted a workshop in the education centre. It was attended by approximately 25 professionals including Paramedics, Physiotherapy, Occupational Therapy and Microbiology. All attendees engaged in the session and the feedback from the auditors was positive all round.

**The subject of discharge summaries was raised the Isle of Wight Council's Health and Adult Social Care Scrutiny** meeting on Monday 20 June. A joint discharge policy has been developed across the Health and Social care System on the Isle of Wight. Arrangements are being made to ensure that by the end of August, all Patients leaving the care of the IOW NHS Trust will have a completed discharge summary. Staff involved in discharging patients, are being given the opportunity to view this draft policy, and to feedback thoughts and comments.

## **Key Points Arising from the Trust Executive Committee**

The Trust Executive Committee (TEC) – comprising Executive Directors, and Clinical Business Unit representatives meet every Thursday. The following key issues have been discussed at recent meetings:

### **26 May 2016**

- Emergency Preparedness, Resilience and Response (EPRR) approved
- CQUINs update received

### **2 June 2016**

- Study/Professional Leave Policy for Consultants, Associate Specialist and Specialty Doctors – TEC approved
- Maverick TV filming at Isle of Wight NHS Trust – TEC approved

### **9 June 2016**

- Update on the Implementation of the Clinical Directorate Restructure – TEC received

**Karen Baker**  
**Chief Executive Officer**  
**24 June 2016**

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6 July 2016

<b>Title</b>	Report from Chair of Quality Governance Committee		
<b>Sponsoring Executive Director</b>	Nina Moorman, Chair of Quality Governance Committee		
<b>Author(s)</b>	Nina Moorman, Chair of Quality Governance Committee		
<b>Purpose</b>	To receive the report from the Chair of the Quality Governance Committee		
<b>Action required by the Board:</b>	Receive	X	Approve
<b>Previously considered by (state date and outcome):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee			
Mental Health Act Scrutiny Committee			
Quality Governance Committee	24/05/2016		
Remuneration & Nominations Committee			
Turnaround Board			
<b>Please add any other committees below as needed</b>			
<b>Staff, stakeholder, patient and public engagement:</b>			
Not applicable			
<b>Executive Summary:</b>			
The Chair of the Quality Governance Committee will report on the following areas as discussed at the meeting held on 28 June 2016			
<b>Cancelled Operations</b>			
<b>Complaints</b>			
<b>Discharges</b>			
<b>Emergency readmissions</b>			
<b>Quality Impact Assessment Report</b>			
<b>Patient Safety – Final Report on deaths in Mental Health and Learning Disability Service (MHL D)</b>			

**Patient Experience – *I Want Great Care***

**Clinical Effectiveness**

- Clinical Audit
- External Agencies Visits

**Recommendation to the Trust Board:**

The Board is recommended to receive the assurance report by the Chair of the Quality Governance Committee

**Attached Appendices & Background papers Report**

For following sections – please indicate as appropriate:

**Trust Goals & Priorities**

**Principal Risks (BAF)**

**Legal implications, regulatory and consultation requirements**

**Date: 30<sup>th</sup> June 2016**

**Completed by:** Chair of the Quality Governance Committee

## **Quality Governance Committee**

### **Assurance Report for Board**

**29<sup>th</sup> June 2016**

This month's assurance report from the Quality Governance Team for the rolling programme of the Quality Improvement Plan covered the following:

**Cancelled operations:** the Trust has an overall 2% cancellation rate for non-clinical reasons. This mainly affects the Surgical CBU which is reviewing cancellation reports daily with actions given to the appropriate manager. An improvement collaborative led by the CBU working with PIDS to agree service level data which can then be used to address specific departments is underway. Assurance negative, review 3 months.

**Complaints:** The process for managing complaints aims to ensure that staff closest to the patient address concerns at the earliest opportunity. There is a 20 day timescale to respond which is currently achieved in less than half of cases. Patients who complain are routinely asked about their experience in line with the Ombudsman recommendations, and learning from complaints needs improvement. Assurance limited, review 3 months.

**Discharges:** there is a system-wide Facilitated Discharge Policy monitored by the Operational Management Group. Any discharge issues are reported on Datix and monitored by the Clinical Capacity and Pathway Manager, and followed up by the Patient Pathway Collaborative and Intervention Group. Assurance Limited, review 3 months.

**Emergency readmissions:** numbers are consistently less than 5% which is our target and this compares favourably with National figures. There are plans to introduce telephone follow up calls within 24 hours of discharge in line with NICE Guidance N27. Assurance positive.

Items not covered but on the agenda for next month – the deep dive into C Diff infections delayed by the absence of the Microbiology Consultants, and cancelled appointments, where there are ongoing concerns about governance processes together with an investigation into endoscopy appointments. Review July.

#### **Quality Impact Assessment report.**

All projects overseen by the Programme Governance Office are routinely assessed for potential impact on the quality of clinical services affected. QGC received an overview of the process, a report on projects signed off in 15/16 and a first report of schemes for 16/17. These are mostly cost improvement projects but in future will include proposed changes introduced under the Whole Integrated System Redesign (WISR) and New Models of Care. A twice yearly report will come to QGC. Assurance positive.

#### **Patient Safety – Final report on deaths in Mental Health and Learning Disability Service (MHLDS).**

The Mazars Report into deaths at Southern Health prompted an initial review of deaths amongst patients in contact with our own MHLDS services. That review found 43 unexpected deaths between April 2012 and December 2015, of which 12 were investigated as SIRIs and

31 were subject to local review: of these 20 were natural causes and 11 un-natural and this final report concerns the latter. All the cases were appropriately reviewed but action will now be taken to strengthen the governance processes around this, so that investigation reports will be scrutinised by a newly established MHL D Mortality and Morbidity meeting and shared with the Trust-wide Mortality Review Group. Lessons learnt will be acted upon to change systems and processes where necessary. Assurance positive.

### **Patient experience – *I Want Great Care***

*I want great care* is a programme that captures the Friends and Family Test (FFT) required by the NHS but also includes a facility for patients to comment on the care of individual doctors, nurses and departments along the lines of “Tripadvisor”. The Trust will introduce this in July and it will run for an initial 12 months. The expectation is that this will enrich the feedback that we routinely receive from patients in an easy and acceptable way, and will be service specific and timely. QGC will be receiving outcome reports on a quarterly basis.

### **Clinical Effectiveness**

**Clinical audit:** We were concerned to hear that some of the Nationally mandated clinical audits are not being submitted this year due to lack of manpower to input data. Incomplete or inaccurate data means the Trust appears to be underperforming when results are made public. These will be reviewed together with an estimate of resources required for each one, so that a corporate decision can be taken on which to get involved in. Assurance negative, review one month.

**External agencies visits:** agreement has still not been reached on how these visits will be managed within the CBUs. 75% of external visits relate to the quality of our clinical services and these are therefore an important source of assurance. Review 3 months.

Nina Moorman  
Chair Quality Governance Committee  
29 June 2016



## REPORT TO THE TRUST BOARD (Part 1 - Public)

6<sup>th</sup> July 2016

<b>Title</b>	Serious Incidents Requiring Investigation (SIRI Report )		
<b>Sponsoring Executive Director</b>	Alan Sheward, Executive Director of Nursing		
<b>Author(s)</b>	Karen Kitcher , Quality Assurance Lead		
<b>Purpose</b>	To provide the Trust Board with an update report on SIRIs		
<b>Action required by the Board:</b>	<b>Receive</b>	✓	Approve
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	Key Issues, Concerns and Recommendations from Sub Committee	
Trust Executive Committee			
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee			
Mental Health Act Scrutiny Committee			
Remuneration & Nominations Committee			
Quality Governance Committee	28/6/2016		
Foundation Trust Programme Board			
<b>Please add any other committees below as needed</b>			
Board Seminar			
Patient Safety, Experience & Clinical Effectiveness (SEE) Group	22/6/2016		
<b>Staff, stakeholder, patient and public engagement:</b>			
Patient Representative in attendance at SEE & QGC			
<b>Executive Summary &amp; Analysis:</b>			
<p>This report provides an overview of Serious Incidents Requiring Investigation (SIRI) activity during May 2016. 2 serious incidents were reported to the Isle of Wight Clinical Commissioning Group (CCG) during May</p> <ul style="list-style-type: none"> <li>• Delayed Treatment – pathway/waiting list</li> <li>• Clinical Incident – complication following procedure</li> </ul> <p>The report explains our arrangements under NHS England's SIRI Framework (March 2015) for "cluster" reviewing pressure ulcers that have occurred detailing some of the contributing care and service delivery problems that have been identified.</p> <p>At the time of writing this report there were:</p> <ul style="list-style-type: none"> <li>• 26 Open SIRI's <ul style="list-style-type: none"> <li>- 7 of which are with the CCG awaiting consideration for closure</li> <li>- of the remaining 19 - 3 were overdue and 16 were progressing in-time</li> </ul> </li> </ul> <p>The case numbers by CBU are summarized within the report.</p> <p>During May, and at the time of reporting the IW CCG had <u>closed</u> 6 SIRI cases</p> <p>The details of these and the lessons learnt for those closed SIRI cases are detailed within the report.</p>			



<b>Recommendation to the Board:</b>	
The Board is asked to receive this report.	
<b>Attached Appendices &amp; Background papers</b>	
<b>For following sections – please indicate as appropriate:</b>	
<b>Trust Goals &amp; Priorities</b>	Excellent Patient Care; Working with others to keep improving our services; A positive experience for patients, service users and staff; Skilled and capable staff.
<b>Principal Risks (BAF)</b>	2.6
<b>Legal implications, regulatory and consultation requirements</b>	
<b>Date: 29 June 2016</b>	<b>Completed by: Karen Kitcher &amp; Deborah Matthews</b>

Serious Incident Requiring Investigation (SIRI) Activity Report  
For Trust Board – July 2016  
**May 2016 data**

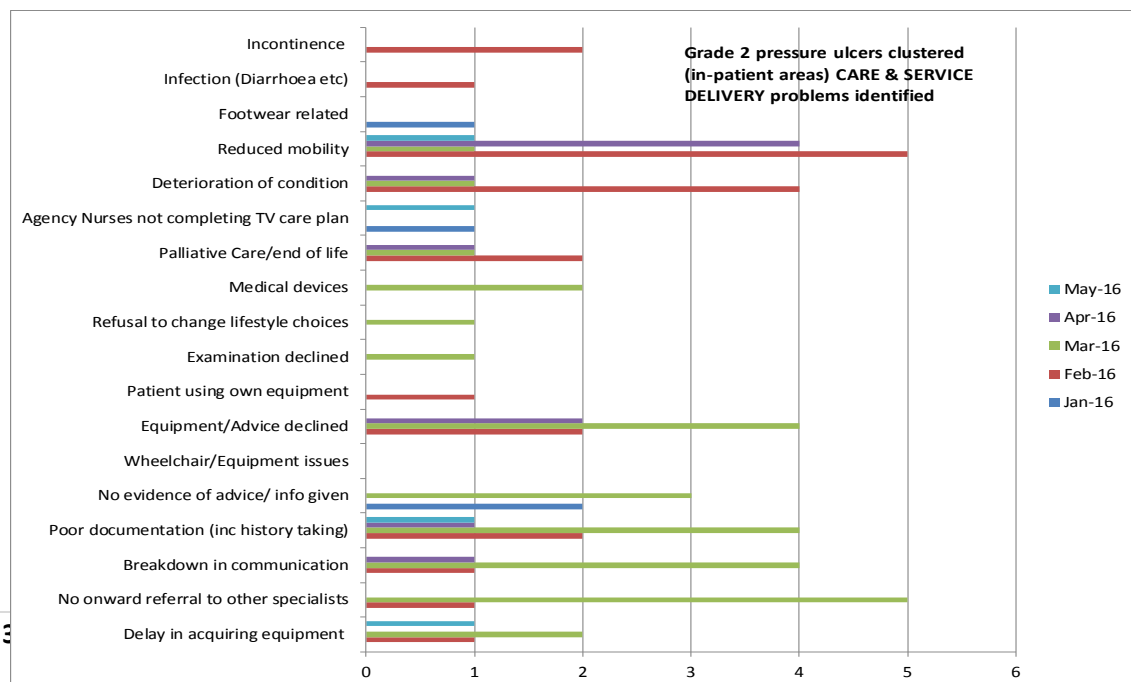
- (1) **NEW INCIDENTS REPORTED AS SIRIs:** During May 2016 the Trust reported 2 Serious Incident to the Isle of Wight Clinical Commissioning Group (CCG). Below is a summary of those incidents:

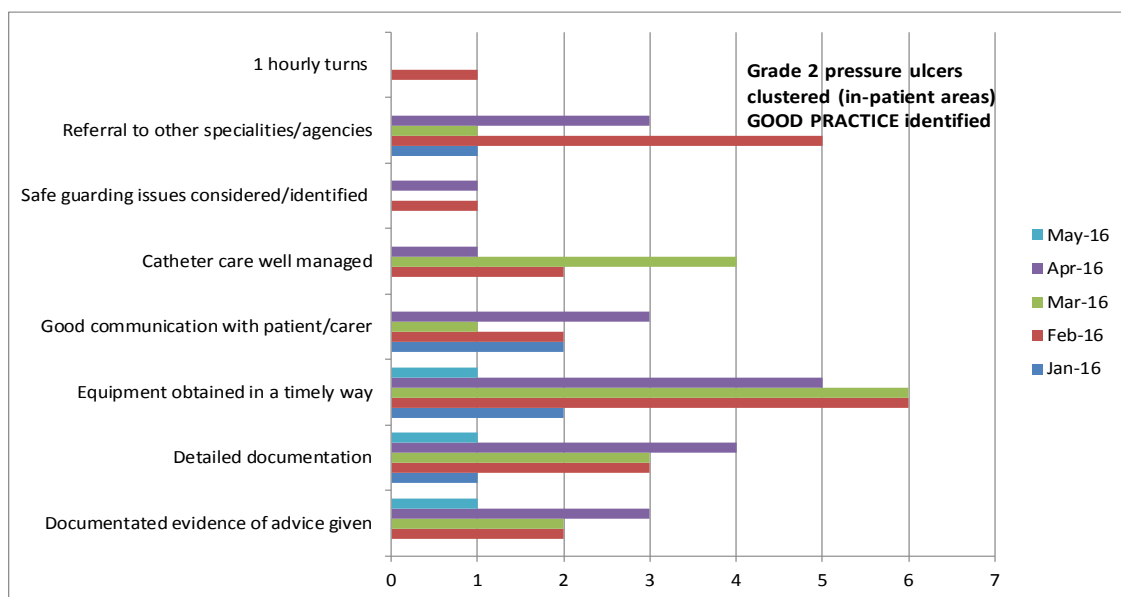
Category/ subject	Under whose care	Summary
Delayed treatment	Surgery	Pathway/waiting list
Clinical event	Community	Complication following procedure

IPR = Integrated Panel Review (meeting)

(1a) **PRESSURE ULCERS – COMMUNITY:** grade 3 and 4 pressure ulcer cases continue to be clustered and peer reviewed. Individual teams are now reviewing grade 2 pressure ulcers locally, with feedback monthly. The learning is captured on cluster sheets with categories for good practice/care and service delivery problems/contributory factors.

(1b) **PRESSURE ULCERS – ACUTE TRUST:** the same procedure for clustering grade 2 pressure ulcers has also being rolled out across all ward areas. In addition, collaborative working groups meet regularly to review the learning around hospital acquired pressure ulcers. Below is a snapshot of the findings so far.





(1c) **SLIPS/TRIPS/FALLS – COMMUNITY**: falls in community continue to be clustered and the learning shared.

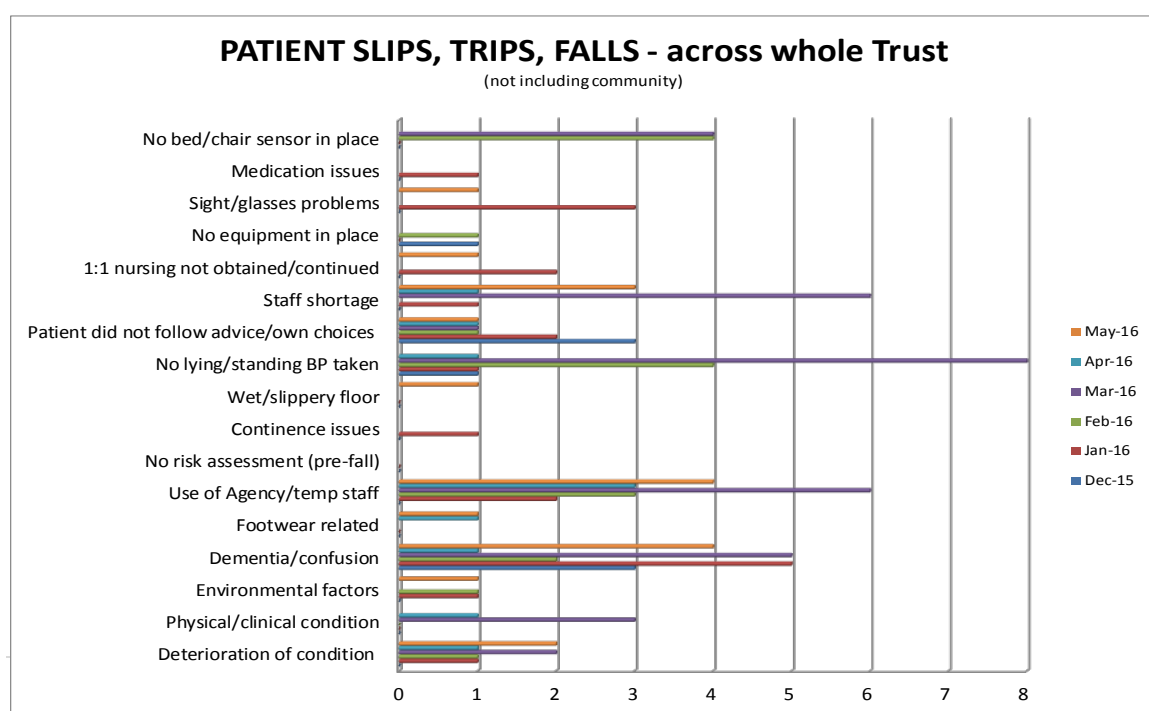
Issues/actions arising:

- Patients mobilising unsupervised, contrary to advice

(1d) **SLIPS/TRIPS/FALLS – ACUTE**: regular falls cluster review meetings and collaborative working group continue to review incidents of falls in acute settings.

Issues/actions arising:

- Difficulty in obtaining 1-2-1 care for patient
- Consideration to purchasing dementia friendly soft furnishings
- Confused patient
- Second fall in 24 hours; no assurance that risk was mitigated – SIRS reportable



(2) **CURRENT POSITION:** This table provides the current status of open SIRIs as of 13 June 2016.

Isle of Wight <b>NHS</b>									
NHS Trust									
SIRIs	COMMUNITY & MENTAL HEALTH	HOSPITAL & AMBULANCE	OTHER CORPORATE AREAS	CBU 1 Surgery, Women's & Children's	CBU 2 Medicine	CBU 3 Clinical Support, Cancer & Diagnostics	CBU 4 Ambulance, Urgent Care, Community	CBU 5 Mental Health & Learning Disabilities	
<b>OVERDUE CASES</b>									
• With Coroner	0	0	0	0	0	0	0	0	
• With Directorate	0	1	0	0	2	0	0	0	
• With Quality team	0	0	0	0	0	0	0	0	
• With Execs	0	0	0	0	0	0	0	0	
• With Commissioner	0	2	0	2	0	2	1	0	
• Returned from Commissioner - further work	0	0	0	0	0	0	0	0	
<b>TOTAL OVERDUE</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>0</b>	
<b>CURRENT CASES</b>									
• With Coroner	0	0	0	0	0	0	0	0	
• With Directorate	0	0	0	6	3	3	1	1	
• With Quality team	0	0	0	0	0	0	0	0	
• With Execs	0	0	0	0	0	0	0	0	
• With Commissioner	0	0	0	0	0	0	0	0	
• Returned from Commissioner - further work	0	0	0	0	0	0	2	0	
<b>TOTAL CURRENT</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>1</b>	
<b>TOTAL NUMBER OF OPEN CASES</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>8</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>1</b>	<b>26</b>
how many <u>ongoing</u> SIRIs (auto)		<b>19</b>							

(2a) At the time of producing this report (13 June 2016) there were 10 overdue cases, however 7 of these cases have now been submitted to the Commissioners for closure; of the 3 cases still being reviewed 1 is due for finalising within the next two days; 1 is imminently to be forwarded to the IW Clinical Commissioning Group for closure and 1 case was reviewed and has since been sent back to the Clinical Business Unit as further information was required to conclude.

In line with the Trust's new arrangements, the process of arranging IPRs (Integrated Panel Review) meetings for every SIRI case continues; as each SIRI is reported an IPR date is allocated and sent to staff at an early stage together with the notification of the SIRI. This is helping to map out the process at an early stage allowing the clinical business units to pre-plan.

(3) **CLOSED SIRI CASES:** During May 2016, and at the time of reporting, the IW Clinical Commissioning Group had advised on the closure of 6 SIRI cases.

(3a) **LESSONS LEARNT:** Following closure of SIRI cases, the outcome and learning is shared across the Trust via the Clinical Business Unit's own governance arrangements, with some cases forwarded for inclusion in the Trust's Learning Lessons Newsletter. Outcomes are also captured via quarterly collation of outcomes by subject, e.g. communication, clinical care, education etc., and is available for staff to access via the SIRI page of the Trust's intranet site.

In addition to the sharing of information indicated above, of the 6 closed this month, below is an indication of how the learning was further disseminated:

Case 1:

- E-mail communication to all Medical teams and staff with expanded practice roles
- Attendance at education sessions
- Highlighted at Cancer forum, HMSC (Hospital Medical Staffing Committee), Trust Executive Committee, Patient Safety, Experience & Clinical Effectiveness Committee (soon to be known as Quality Governance Committee)
- Teaching arranged from the Royal Marsden hospital (feedback very positive following teaching)

Case 2:

- Cascaded by the department manager and Consultant responsible for the medical team

Case 3:

- Incident and learning shared with services involved
- E-mail communication to all service staff to share recommendation
- Reminder communication sent to dispatch staff regarding escalation when there are handover delays
- New standard operating procedure shared with staff
- Discussion ongoing between Isle of Wight and South Central to allow real-time access computer assisted dispatch data
- Learning shared at quality and effectiveness meeting

Case 4:

- Outcome and lessons learned shared at directorate meeting, monthly Quality meeting and Director of Nursing Team meeting

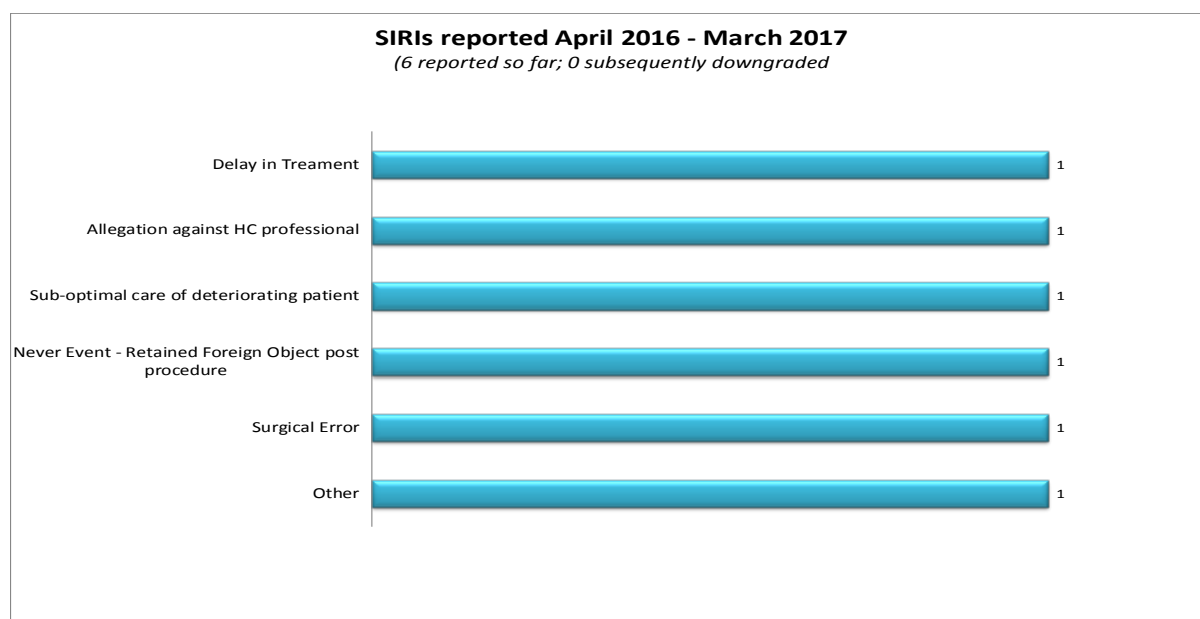
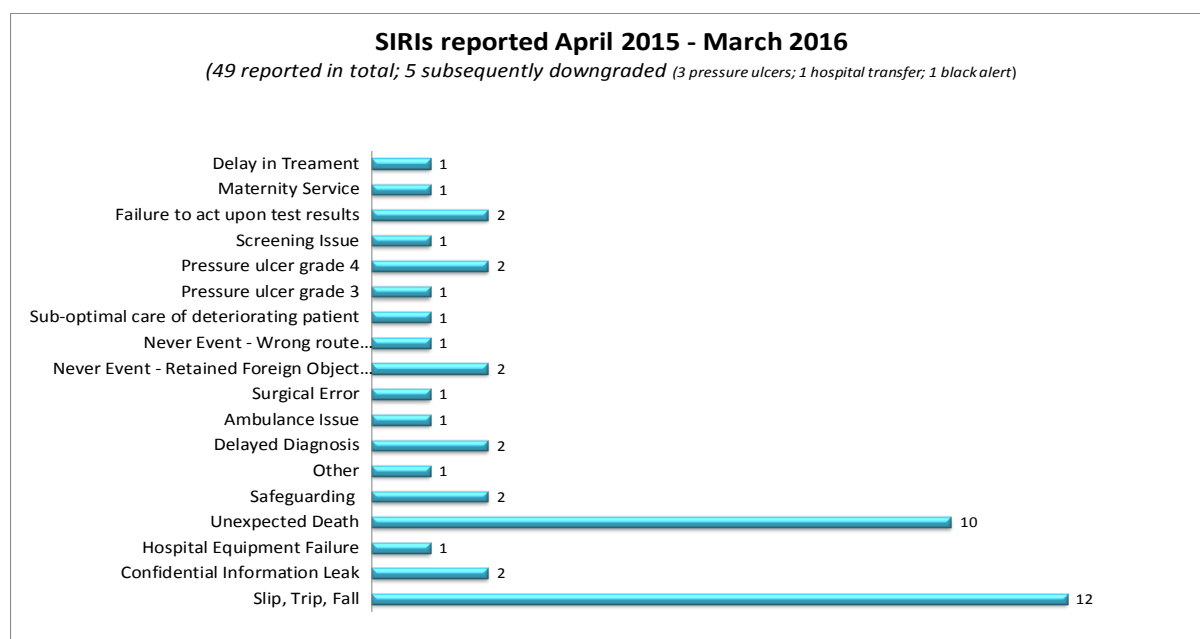
Case 5:

- Learning shared at the joint DNT (Director of Nursing Team) & MAGS (Matrons Action Group) and at Operational Management Group.

Case 6:

- Outcome shared at Clinical Nurse Leaders, Nutrition link nurse group, Dietetics team meeting, Ward Team meeting and junior doctor's training.
- Individual team members made aware of outcome; also shared at ward meeting
- A poster has been distributed to all inpatient wards and placed on e-bulletin to define role of Clinical nutrition nurse specialist
- Discussed at junior doctors training and with consultant relating to further training

(4) **OVERVIEW OF SIRI SUBJECTS:** April 2015 – March 2016, followed by current year



(5) **ACTION PLANS:** The Patient Safety, Experience and Clinical Effectiveness team, together with the Clinical Business Units, continue to monitor and update all actions plans arising from previous/current SIRI cases. Completed action plans are then forwarded to Patient Safety, Experience and Clinical Effectiveness Committee for review and final sign off.

**Alan Sheward**  
Executive Director of Nursing & Quality  
June 2016

Paper produced and prepared by: Karen Kitcher, Quality Assurance Lead

Enc F

REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> July 2016

<b>Title</b>	Safer Staffing Report for Nursing and Midwifery for May 2016		
<b>Sponsoring Executive Director</b>	Alan Sheward, Executive Director of Nursing		
<b>Author(s)</b>	Sarah Johnston, Deputy Director of Nursing		
<b>Purpose</b>	For assurance		
<b>Action required by the Board:</b>	Receive	X	Approve
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Trust Executive Committee			
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee			
Mental Health Act Scrutiny Committee			
Remuneration & Nominations Committee			
Quality Governance Committee			
Foundation Trust Programme Board			
<b>Please add any other committees below as needed</b>			
Board Seminar			
Other (please state)			
<b>Staff, stakeholder, patient and public engagement:</b>			
None			
<b>Executive Summary &amp; Analysis:</b>			
<ul style="list-style-type: none"> <li>The Trust did not meet its locally set target of 90% average fill rate for all 4 nursing measures for April: HCA fill rates overall were 88.4%.</li> <li>Our bank fill rate was RN 83% which is excellent, and HCA's 70% which is reduced from last month. Agency nursing requests were also up to 88% fill rate. Improved fill rate may be down to improved planning for managing vacancies and gaps, which the teams are now achieving with new processes for booking bank and agency.</li> <li>For individual areas day shifts for RN's still remain the main area where we do not achieve our planned hours. The number of red rated wards was 11 the same as last month however only 1 area was below 80% and has raised a concern about staffing. This area was NICU and mitigation plans are in place to ensure safety. The teams need to plan for July and August to also ensure low staffing due to sickness and vacancy continues to be managed well. Actions are in place to address this.</li> <li>Sickness rates remain above 3% in 12 areas which is an increase on last month when 9 were identified. This measure can fluctuate however overall we are not making significant improvement in this area.</li> <li>Training on MAPS and management of staff resources has taken place with Workforce Information Team and CBU Nursing leads. Further training is taking place on 30<sup>th</sup> July. There are still issues and challenges with moving forward to assure the Board that we have robust processes in this area. We are aware that Wards are not robustly following rostering policy (i.e. approval of rosters in a timely manner) and this is being addressed through training. This</li> </ul>			

item is being reported through to FIWC.

**Recommendation to the Board:**

The Board is recommended to receive this report and identify whether any further actions are required.

**Attached Appendices & Background papers: Appendices are provided (referenced in paper)**

For following sections – please indicate as appropriate:

**Trust Goals & Priorities**

Excellent patient care  
Skilled and capable staff

**Principal Risks (BAF)**

Risk of inadequate staffing whilst recruitment plans come to fruition. DNT will discuss issues raised on a weekly basis and HoN&Q will ensure good forward planning for bank and agency requests to ensure maximum planning success.

Risk of not recruiting adequately to RN and Midwife positions to adequately increase workforce. As staff are leaving the current recruitment plan is inadequate to achieve full establishments. A full workforce plan for nursing, including where new planned for staff, and assumption around leavers, is still required.

**Legal implications, regulatory and consultation requirements**

The National Quality Board guidance sets out requirements of the Board in relation to safe staffing - the Board should receive nurse staffing data on a monthly basis.

**Date 20<sup>th</sup> June 2016**

**Completed by: Sarah Johnston, Deputy Director of Nursing**



MONTHLY SAFE STAFFING REPORT  
June 2016 Report  
MAY 2016 POSITION

**1. New measure introduced - Care Hours Per Patient Per Day (CHPPPD)**

- This month a new measure – Care Hours Per Patient Per Day (CHPPPD) is introduced. This is an automatic calculation provided by the input of our data. The measure indicates, for each ward area, and by registered and non-registered staff, the number of care hours available for each person in a 24 hour period.
- The measure will be utilised to benchmark against other organisations and ward types. The summary measure provides only an average and this is not adequate assurance for the Board as areas differ greatly in levels of care needed. Intensive Care, for example, would be expected to be significantly higher CHPPPD than a rehab ward which relies on a more diverse group of professionals to provide care to patients, not just nurses. The Board should consider the more detailed ward measures as a better indicator of the provision of care for each ward or patient group.
- For May, CHPPPD indicates our organisation provides an average of 8.3 hours of care for each patient: 5 hours of Registered Nurse care, and 3.3 hours of Nursing Assistant care. The ratio is an appropriate ratio at 60:40 which is what we aim to provide for all areas as a minimum (where relevant to the area, i.e. not for high acuity areas such as ITU or NICU where higher ratios are expected). See Appendix 1, Table 1
- Overall, for our usual percentage achievements of actual staffing versus planned staffing the Trust dropped below the locally set target of 90% for non-registered staff in the day, achieving only 88.4%. Other measures were achieved. A recruitment drive to recruit non-registered staff resulted in approx. 30 new staff being hired it is expected to improve this going forward.
- In the individual areas (See Table 2) there were still 12 areas with below 90% staffing for Registered Nurses, but only 2 areas below 80% compared with 4 last month (excluding Poppy). Whippingham Ward is measured against its establishment which is for 16 beds however is staffed for 27 through the winter pressures planning, and shows a 170% average fill rate because of this. Changes will be made to the MAPS system to enable the measures to identify correctly. Measurement issues should be rectified as the rotas are changed to reflect bed changes.
- For short term staffing bank staff are utilised where possible. RN bank has achieved an 83% fill rate which is excellent, and HCA's a 70% fill rate.
- Agency staff are being utilised on a planned basis, to cover vacancy gaps. We are striving to reduce agency to days in the week and utilise our substantive staff at the weekends which is higher risk and higher cost. Agency has achieved an 88% fill rate.
- See Appendix 1 Table 1 - Unify average fill rate data for each ward and quality and safety indicators.
- See Appendix 1 Graph 1, - Safe Staffing average fill rates over time against our locally set target of 90% fill rate.
- Staff sickness is above 3% in 12 out of the 21 Safe staffing areas. Two areas are over 10%.
- See Appendix 1 Table 3. Red rated areas improving and areas that are below 80% fill rate on shift by shift process. Information and analysis is provided to support review of this for the Board.

## **2. Assessment of monthly position**

- See Appendix 1 Table 2
- In January all acute areas were below the 90% target for planned hours for registered staff in the day. For the May data period this is now 11 areas (excluding Poppy) which is the same as the previous month. For areas below 80% this would present a challenge to deliver high quality care particular if HCA are also low which for the May period this is the case. In addition new staff will need induction and a period of adjustment to the ward.
- Mottistone, NICU and Luccombe, have improvement this month in their sickness ratings. Other areas have shown little or no improvement. Twelve areas remain red rated over 4% sickness and 3 other areas rated amber for 4% sickness. Covering sickness, either long or short term is a challenge for all the ward managers. Linking into the health and wellbeing agenda to consider preventative strategies is required as well as good staff management. There is extremely low sickness on MAAU, which should be commended. MAAU is high pressured and can be fast turnover, and staff have to manage additional beds in 'A' bay on a regular basis.
- Paediatric Ward (children) still has 3 staffing indicators below target. Following on from the careers day 4 potential paediatric nurses were identified as being interested in working in the Trust. This is being followed up. Paediatric Ward have no clinical KPI's as red rated although these currently do not relate well to paediatric care and are being reviewed. Appley Ward and CCU have been highlighted this month as having red and amber staffing indicators and 2 red rated clinical indicators. CCU has high sickness also. These issues are being discussed with ward manager through the Nurse staffing operational meeting.
- Areas with red rag rated safety indicators (falls and pressure ulcers) are not necessarily areas that are poorly staffed. ICU has had 6 pressure ulcers during May and had 7 during April. These are still related to devices and the Ward Manager is aware of this and looking at actions to address this. A deep dive has taken place with ITU during June to address issues raised around agency availability and resource management and an action plan is being planned in relation to this.
- NICU is very challenged currently. The Ward Manager has reported high sickness in this small team. The Ward Manager has provided assurance that all staff are in appropriate processes to manage sickness however there have been shifts where cover is low. A mitigation plan to call staff in as required when staffing is below the 80% of planned. Recruitment is in progress. A rotational post is being considered to manage resources across paediatric areas. The Ward Manager has been asked to discuss potential agency due to high risk of unacceptable staffing for July/Aug due to prolonged sickness and annual leave.
- Luccombe Ward is over utilising HCA and has under provision of RN cover. This is being reviewed and needs to be shifted to the correct provision.
- There remain no concerns for night fill rates. Night duties are filled first as this is a more risky time with limited other clinical staff available and in most cases this is achieved. See Table 3 for more detailed information.

## **3. Actions in place**

- The Nurse staffing management operational group is in place to support staff with a forum for discussing issues and identifying gaps and actions to mitigate.
- Proactive temporary staffing is in place, with teams reviewing establishment vacancies and planning relevant temporary cover within budget. This is a much more controlled approach and appears to be working well as feedback from teams

- Data has been reviewed and significant issues discussed with Ward Managers. Of note this month is NICU and actions are in place as above to ensure safe staffing for July and August.
- Sickness is being managed through CBU's utilising relevant processes however sickness rates do not appear to be improving greatly. Safe Staffing Cafés are now focussing on community areas, theatres and day surgery so it is expected that CBU's keep good oversight over their sickness. The Director of Nursing's Team (DNT) meeting will continue to review the monthly report and action or support as required.
- The fourth cohort of staff from the Philippines is now in place. The third cohort, that did not do well overall, will be retaking their OSCI's shortly. This will boost the RN numbers significantly for areas these staff are placed in.
- Improved management and use of MAPS system is in place; a training session was run with clinical leaders from CBU's, following which action plans were drawn up by teams to ensure improvements in management of the MAPS rota system. A further session is planned for end of July to progress this.

# Appendix 1

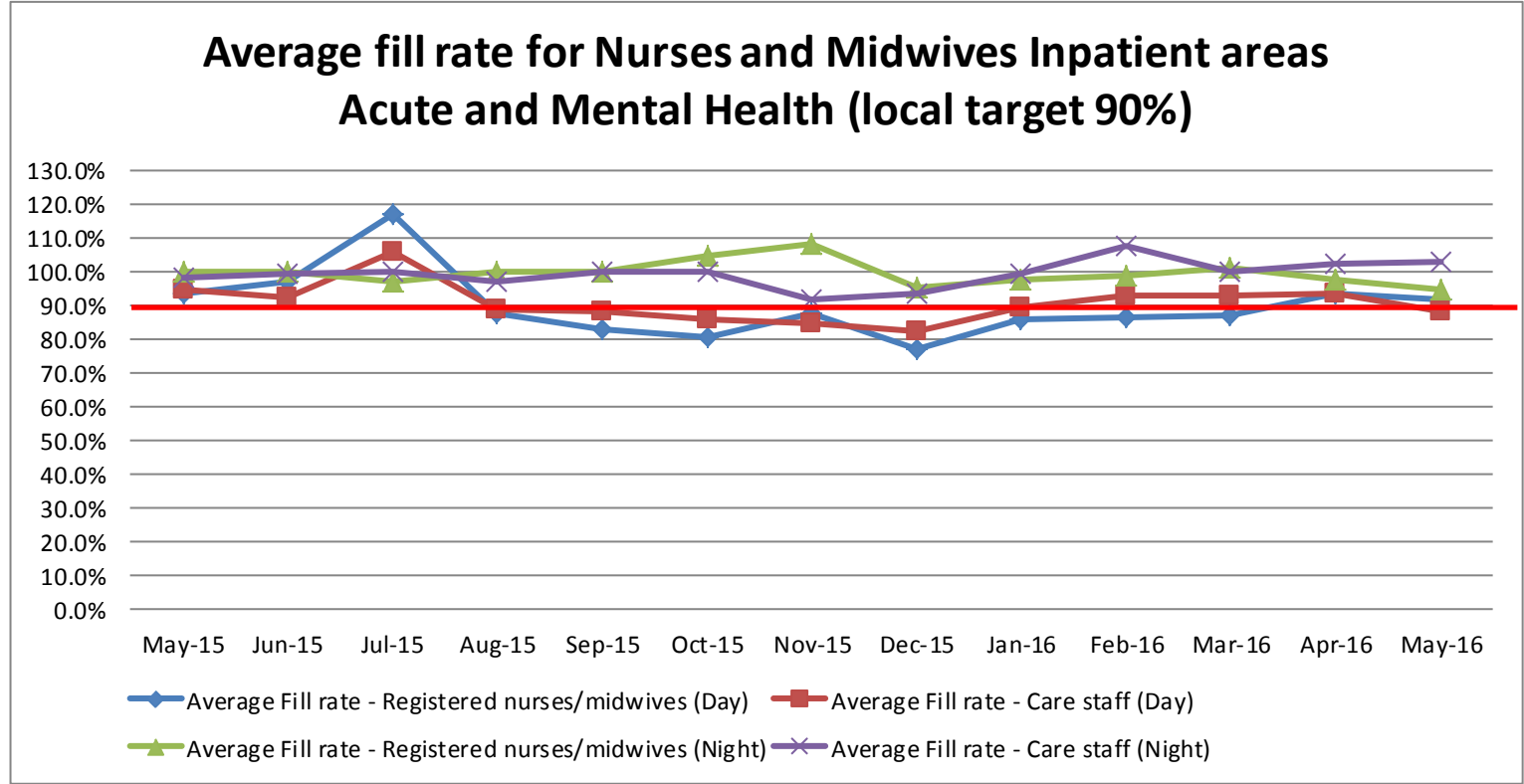
Table 1. Site Summary of Nurse staffing Data as per Unify report – Note new Care Hours Per Patient Per Day (CHPPPD) Measure

Day				Night											
Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night		Care Hours Per Patient Day (CHPPD)			
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 (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/nurses	Care Staff	Overall
33871.25	31030.2	22398.7	19807.92	16249.05	15346.05	10206.5	10518.25	91.6%	88.4%	94.4%	103.1%	9233	5.0	3.3	8.3

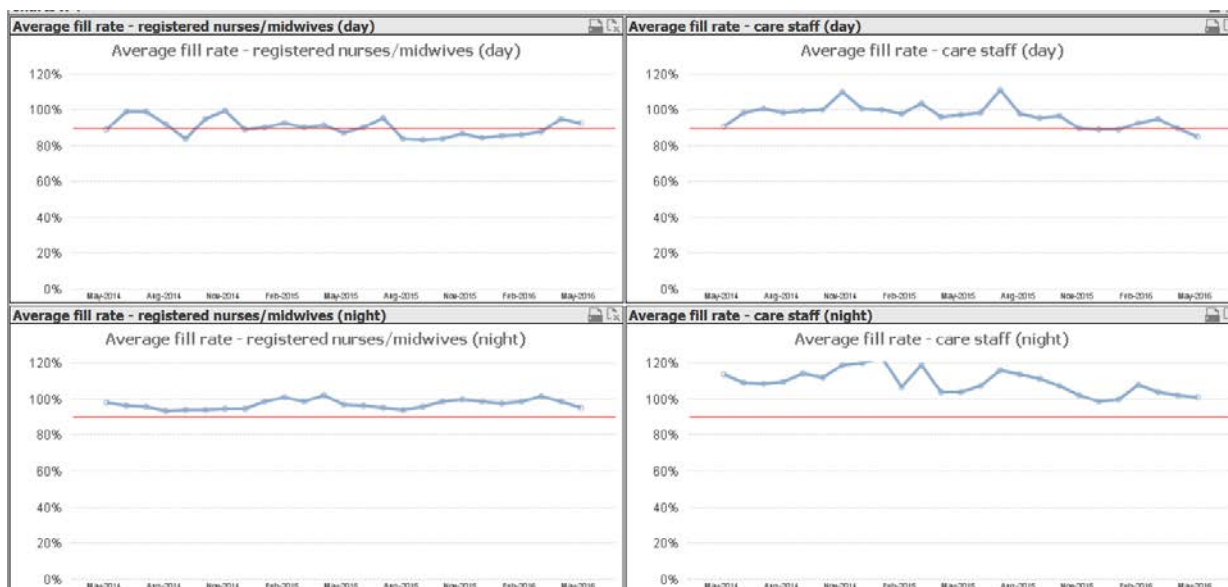
Table 2. May 2016 percentage rate and KPI's for each area, RAG rated

May-16	Day		Night		Care Hours Per Patient Day (CHPPD)							
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Sickness	Mandatory Training	Falls	Pressure Ulcers
SHACKLETON	81.1%	72.9%	102.9%	103.4%	187	5.4	9.6	14.9	5.0%	93%	2	0
ALVERSTONE WARD	92.9%	86.2%	99.6%	100.5%	326	4.7	2.4	7.1	9.0%	84%	0	2
SEAGROVE	93.7%	98.0%	100.0%	99.4%	157	11.6	10.7	22.4	8.0%	82%	0	0
OSBORNE	100.5%	84.4%	98.8%	96.5%	347	6.2	4.5	10.6	5.0%	88%	0	0
MOTTISTONE	90.4%	100.3%	100.0%	-	234	6.9	1.7	8.6	3.2%	88%	1	0
ST HELENS	82.3%	94.3%	98.4%	100.0%	416	3.8	2.7	6.5	4.0%	83%	0	0
STROKE	85.5%	106.0%	75.2%	158.2%	763	3.4	3.5	6.9	9.0%	84%	2	3
REHAB	113.3%	104.0%	112.9%	116.1%	937	2.9	2.5	5.4	4.0%	84%	0	0
WHIPPINGHAM*	196.5%	138.8%	103.2%	185.5%	756	3.6	2.2	5.8	9.0%	64%	0	0
COLWELL	99.3%	85.4%	100.0%	114.5%	863	2.8	2.6	5.3	10.0%	87%	0	0
INTENSIVE CARE UNIT	87.7%	154.7%	101.3%	130.4%	173	29.1	3.1	32.2	5.0%	87%	0	6
CORONARY CARE UNIT	88.0%	92.3%	95.7%	100.0%	524	7.0	1.8	8.8	7.0%	87%	5	5
NEONATAL INTENSIVE CARE UNIT	78.6%	67.3%	105.0%	91.0%	139	11.6	4.1	15.6	7.0%	85%	0	0
MEDICAL ASSESSMENT UNIT	87.1%	91.8%	102.2%	68.1%	668	4.7	2.8	7.5	1.0%	86%	3	1
AFTON	93.7%	90.8%	101.6%	99.4%	286	5.2	5.8	11.1	2.0%	96%	4	0
PAEDIATRIC WARD	86.3%	79.8%	74.2%	100.0%	163	13.3	4.2	17.5	3.0%	79%	0	0
MATERNITY	96.0%	92.7%	101.1%	98.5%	258	11.8	6.5	18.3	9.0%	85%	0	0
WOODLANDS	84.0%	47.2%	103.2%	96.8%	249	4.2	2.5	6.7	16.0%	81%	0	0
LUCCOMBE WARD	77.3%	138.0%	88.7%	130.6%	678	2.4	3.4	5.8	3.0%	73%	3	0
POPPY UNIT	45.8%	26.6%	45.2%	52.7%	249	3.1	4.2	7.3	1.0%	72%	0	3
APPLEY WARD	82.4%	95.1%	83.9%	108.1%	860	3.0	2.5	5.6	0.0%	80%	4	3
*Ward template set to 16 beds only and 27 beds utilised												
	95% - 100% fill rate								<=3%	>75%	0	0
	90% - 94.9% fill rate								4%	70 - 75%	2	2
	<90% fill rate								<4%	<70%	>2	>2

Graph 1. Safer staffing levels overall since May 2014

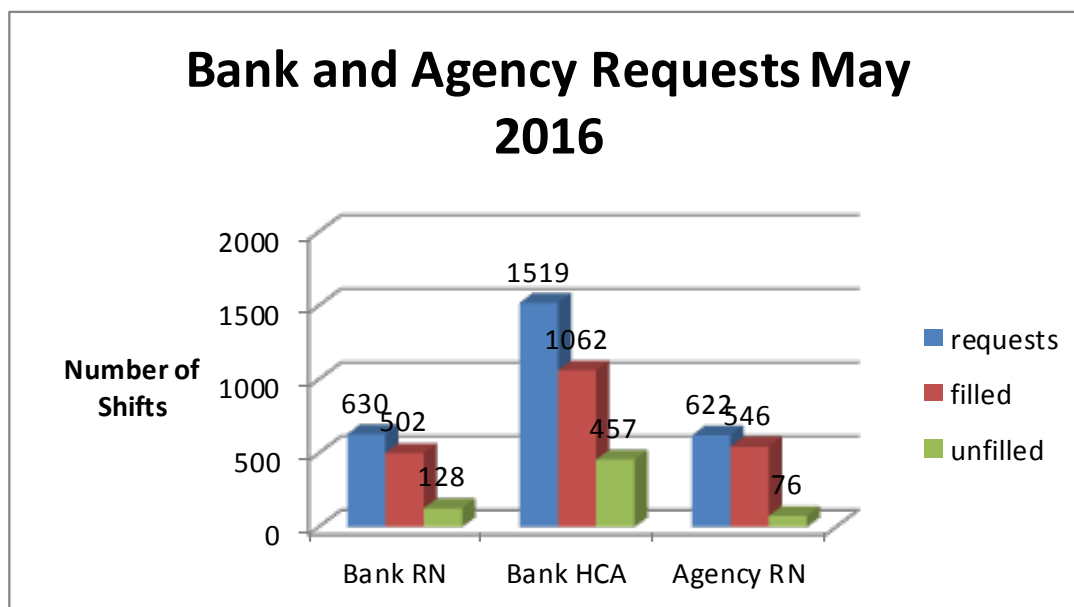


Graphs 2a, b, c and d safer staffing levels by day/night and staff category since May 2014



Graph 3 Bank and Agency Fill rates for Apr 2016

Tables 3a and



## Tables 3a and 3b Shift by Shift Data

- The National Quality Board Guidance – ‘How to ensure the right people with the right skills, are in the right place at the right time’ (2014) sets out expectations in relation to managing and obtaining assurance around nurse staffing. Expectation 1 (Accountability and Responsibility) states ‘Boards monitor staffing capacity and capability through regular and frequent reports on actual staff on duty on a shift by shift basis, versus planned staff staffing levels.’ (p5, p 12).
- The purpose of this data is to highlight those wards where staffing capacity (i.e. numbers) and capability (RN and HCA is a guide to this) frequently falls short of what is required to provide quality care for patients.
- Where areas fall below 80% of expected staffing this would be flagged red. This report highlights where areas are either frequently red or consistently red over a period of time.
- The organisation should understand the gap and take actions to address this.

## Summary and analysis of data

- Poppy Ward has been removed from this data as it has been in a transition to close
- It is expected that Night shifts are covered first as these are higher risk shifts.
  - For HCA shifts this is achieved with exception of MAAU which has consistently lower than planned HCA. MAAU actually plan for 2 HCA's at night rather than 3 so this data is misleading and will be rectified for August.
  - For RN shifts at night the Stroke Unit is at 67% for many shifts. This is because the 3<sup>rd</sup> RN for nights is in the new establishment however not yet available. The additional RN post will be covered by the overseas RN once registration is achieved but there is a short lead in time to achieve this. Bank is sought if required.
  - Paediatric Ward is short of RN's for night shift currently and paediatric bank nurses are not available. The Charge Nurse is satisfied that the paediatric ward was safe however the risk is that, although not required during May, there would be difficulties in administration of the one front door approach. An on call system has been put into place to mitigate this risk and a meeting to discuss deployment of newly qualified staff is planned to consider how best to manage resources.
- For Day shifts
  - Luccombe Ward is consistently below 80% and a review into their rota and application of MAPS is planned for July. There is no identified risk for this are currently
  - Overall there are red areas spread across all areas which are reflective of the overall picture of high sickness, the ability to fill bank and agency which although good is not always 100% and current vacancy as we seek to fill our new establishment. It is anticipated that as our overseas nurses obtain registration this picture will improve however overall this is a satisfactory position.



### Table 3a Registered Nurses Shift by Shift data

[illegible]

Table 3b Health Care Assistants Shift by Shift Data

[illegible]



## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> July 2016

<b>Title</b>	Annual Complaints, Concerns & Compliments Report 2015/16		
<b>Sponsoring Executive Director</b>	Alan Sheward, Executive Director of Nursing and Quality (EDONQ)		
<b>Author(s)</b>	Vanessa Flower, Patient Experience Lead		
<b>Purpose</b>	To provide information to Board in relation to the Trusts complaints handling.		
<b>Action required by the Board:</b>	Receive	X	Approve
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Trust Executive Committee			
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee			
Mental Health Act Scrutiny Committee			
Remuneration & Nominations Committee			
Quality Governance Committee	28 June 2016	Reported up to QGC via Patient Safety, Experience & Clinical Effectiveness Committee as part of EDONQ report to QGC	
<b>Please add any other committees below as needed</b>			
Patient Safety, Experience and Clinical Effectiveness Committee	18 May 2016		
Other (please state)			
<b>Staff, stakeholder, patient and public engagement:</b>			
This report is based on the feedback provided by patients and relatives using the complaints, concerns and good news processes.			
All staff are asked to support the response / management of complaints and have been fully involved in the process during the year.			
<b>Executive Summary &amp; Analysis:</b>			
During the year the Trust saw an increase of 17% in formal complaints receiving 253 compared to 216 in the previous year.			
Concerns also increased by 3% from 920 in 2014/15 to 950 in 2015/16. The Trust received a total of 3816 compliments which equates to 15 compliments to each formal complaint received.			
The Patient Advice and Liaison Service saw an increase of 19.6% in direct contacts during the year. 109 of these contacts were enquiries requiring general advice or signposting.			
The top subjects for both complaints and concerns during the year were communication and clinical treatment; with Outpatients, Appointments and Records Unit and Emergency Department receiving the highest numbers.			

The Trust saw a decrease in the numbers of complaints being reviewed by the Parliamentary Health Service Ombudsman with 8 requests made for information, compared to 12 last year.

The numbers of returners has decreased this year, and it is possible this is due to the increase in local resolution meetings, and ensuring robust answers to the complaints.

There remains a concern about the lack of achievement of response times, and the Trust needs to ensure that action is taken to respond within the negotiated time frame.

The Trust has reviewed the complaints handling process this year, and is working in line with the PHSO user led vision for complaints, and is undertaking a survey of all complainants to assess their experience of using the Trusts complaint's process.

#### **Recommendation to the Board:**

The Board is asked to accept this report, and note the actions being taken to improve the experience for our complainants to ensure that the Trust is acting on and learning from this valuable patient experience feedback.

#### **Attached Appendices & Background papers**

Annual Complaints, Concerns and Compliments Report 2015/16

For following sections – please indicate as appropriate:

<b>Trust Goals &amp; Priorities</b>	A positive experience for patients, service users and staff.
<b>Principal Risks (BAF)</b>	674 Quality and Harm.
<b>Legal implications, regulatory and consultation requirements</b>	The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009,

**Date:** 19 May 2016

**Completed by:** Vanessa Flower Patient Experience Lead

# **Annual Complaints, Concerns and Compliments Report**

## **2015 / 2016**

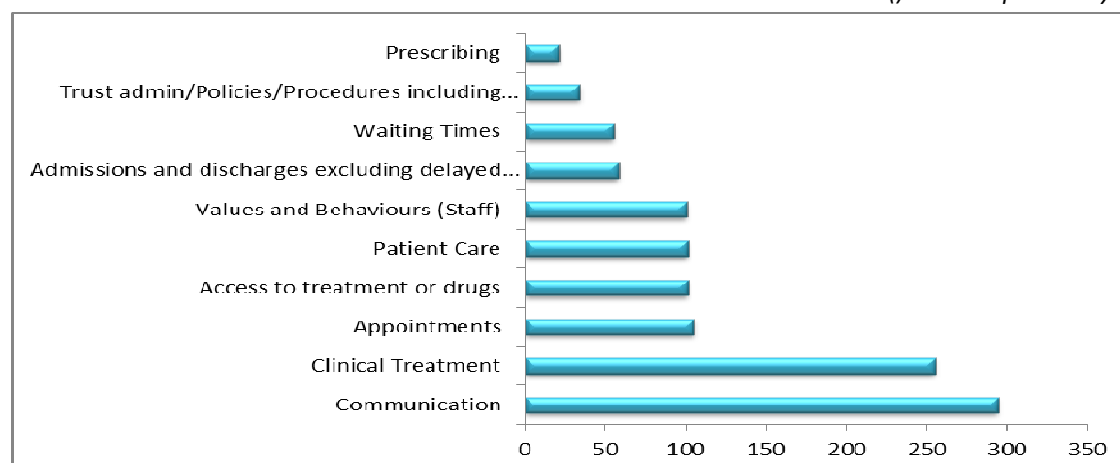
Author: Vanessa Flower  
Patient Experience Lead  
13 May 2016

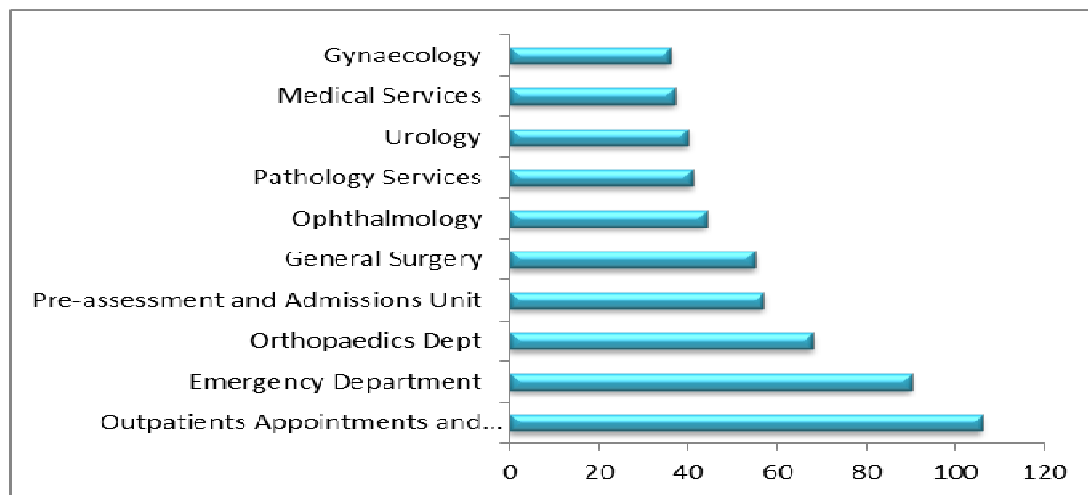
Endorsed by Patient Safety, Experience and Clinical Effectiveness Committee 18 May 2016

## 1 Executive Summary:

- 1.1 This report provides a summary of the complaints, concerns and PALS contacts received during the financial year 2015/16. This is produced in line with the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009. A copy of this report will be available publically via the Trusts website.
- 1.2 It is recognised that this report does not included any national benchmarking data as this is not yet available; but it is hoped with the introduction of the new national KO41a reporting this will be available soon.
- 1.3 The Trust has received a total of 253 (216) formal complaints during 2015/16, which is an increase on last year of 17%.
- 1.4 During the year as part of KO41a reporting the Trust upheld 163 complaints, partially upheld 17 and did not uphold 22 complaints. 51 Complaints still remained under investigation by the Trust on 1 April 2016.
- 1.5 The highest primary subject areas for the complaints for the year related to clinical treatment (106). The service receiving the highest number of complaints during the year was the Emergency Department (32).
- 1.6 In relation to concerns the Trust received 950 compared to 920 during 2014/15, an increase of 3%. The highest primary subject for the concerns was communication (260) and the service receiving the most concerns was outpatients, appointments and records unit (106).
- 1.7 During the year the Trust received a total of 3816 compliments, and this equates to 15 compliments for each formal complaint received.
- 1.8 The Parliamentary and Health Service Ombudsman (PHSO) made 8 requests for information during the year, and closed a total of 5 cases, 1 from the previous year. Of these 2 were partly upheld and 2 were not upheld.
- 1.9 The graphs below show the top 10 subjects and specialty (admitted) across both complaints and concerns for the year.

*\*( ) denotes previous years data*



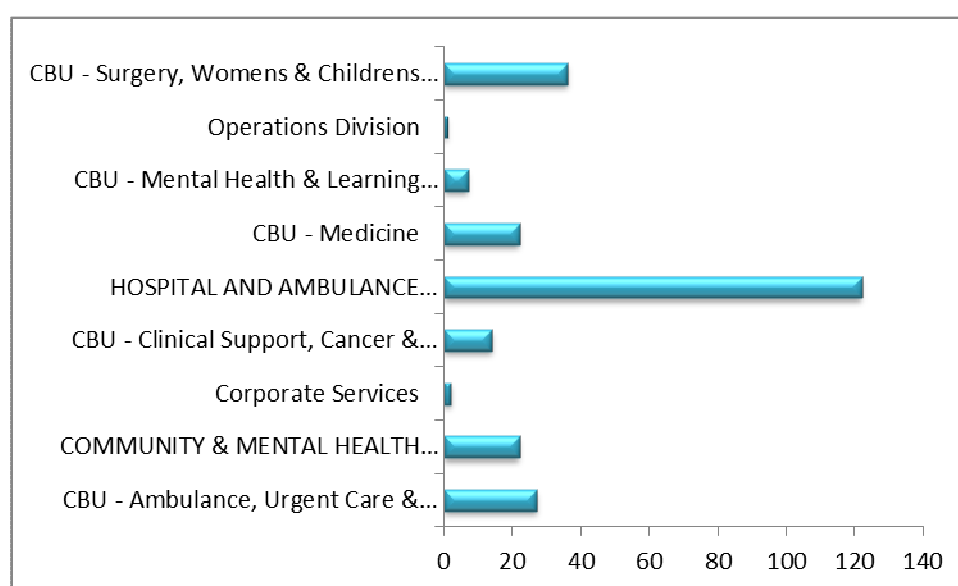




## 2. Formal Complaints:

During the year the Trust received a total of 253 formal complaints, an increase of 17% on 2014/15. The Trust has continued to review its process for managing complaints, and has responded to the Healthwatch Isle of Wight recommendations following their review of the complaints handling process. It is possible that the changes in the process that have been implemented in line with the NHS Complaints Regulations may have contributed to the increase in formal complaints logged, however, other factors may have also contributed to this increase.

The chart below shows the complaints broken down for 2015/16 by clinical directorate / business unit. During the latter part of the year the Trust went through a period of organisational change and the clinical directorates were restructured to create Clinical Business Units (CBU); this is illustrated in the chart below:



### 2.1 Complaints by Specialty (admitted):

The table below shows the formal complaints by specialty (admitted) for the year 2015/16:

<b>MH - Acute &amp; Recovery Team</b>	<b>1</b>
<b>Alverstone Ward</b>	<b>2</b>
<b>Ambulance Service</b>	<b>4</b>
<b>Anaesthetics</b>	<b>4</b>
<b>Beacon Healthcare Centre (St Mary's)</b>	<b>6</b>
<b>Bed Management</b>	<b>2</b>
<b>Breast Care Centre</b>	<b>1</b>
<b>Cardiology</b>	<b>3</b>
<b>Colwell Ward</b>	<b>3</b>

<b>MH - Crisis Resolution &amp; Home Treatment</b>	1
<b>Day Surgery Unit</b>	2
<b>Diabetes Centre &amp; Endocrinology</b>	2
<b>Diagnostic Services</b>	6
<b>Ear Nose and Throat</b>	5
<b>Emergency Department</b>	32
<b>Endoscopy</b>	6
<b>Gastroenterology</b>	1
<b>General Medicine</b>	7
<b>General Surgery</b>	21
<b>Corporate Governance Department</b>	1
<b>Gynaecology</b>	14
<b>Health Centres &amp; Clinics</b>	1
<b>Health Visitors</b>	1
<b>Luccombe Ward</b>	2
<b>Maternity Services</b>	2
<b>Maxillofacial Unit</b>	1
<b>Medical Assessment Unit</b>	8
<b>Medical Services</b>	11
<b>MH - Access / Acute Services</b>	1
<b>MH - Community Services</b>	11
<b>MH - Inpatient Services (Sevenacres, Shackleton, Woodlands)</b>	3
<b>MH - Memory Service</b>	1
<b>MH - Rehabilitation &amp; Recovery Team</b>	3
<b>Medical Wards</b>	8
<b>Ophthalmology</b>	5
<b>Orthopaedics Dept</b>	21
<b>Orthotics and Prosthetics</b>	1
<b>Occupational Therapy Services</b>	3
<b>Paediatric Services</b>	4
<b>Pathology Services</b>	5
<b>Pharmacy</b>	1
<b>Podiatry Service</b>	1
<b>Pre-assessment and Admissions Unit</b>	3
<b>Rehab Unit</b>	1
<b>Respiratory Services</b>	3
<b>Rheumatology</b>	1
<b>Security and Car Parking</b>	1
<b>St Helen's Ward</b>	2
<b>SPARRCS Team</b>	1
<b>Stroke Unit</b>	1

<b>Stroke Services</b>	1
<b>Orthopaedics / Surgical Wards</b>	5
<b>Urology</b>	5
<b>OT – Wheelchair</b>	2
<b>Whippingham Ward</b>	8
<b>Winter Ward</b>	1
<b>Totals:</b>	253

As can be seen from the table above the top 10 areas receiving the highest numbers of complaints were:

<b>Emergency Department</b>	<b>32</b>
<b>General Surgery</b>	21
<b>Orthopaedics Dept</b>	21
<b>Gynaecology</b>	14
<b>MH - Community Services</b>	11
<b>Medical Services</b>	11
<b>Medical Wards</b>	8
<b>Medical Assessment Unit</b>	8
<b>Whippingham Ward</b>	8
<b>General Medicine</b>	7

#### **2.1.1 Top 10 Speciality (admitted)**

Looking at the top 10 specialties receiving the highest number of complaints, some areas can be broken down further into location exact as can be seen below:

##### **Orthopaedics (21):**

Alverstone Ward	7
Day Surgical Unit	2
Emergency Department	1
Fracture Clinic	2
Luccombe Ward	3
Orthopaedics	4
Out-patients Department	1
Pre-admission & assessment	1

##### **Mental Health – Community Services (11):**

Chantry House	8
Patients Home	3

### Medical Wards (8):

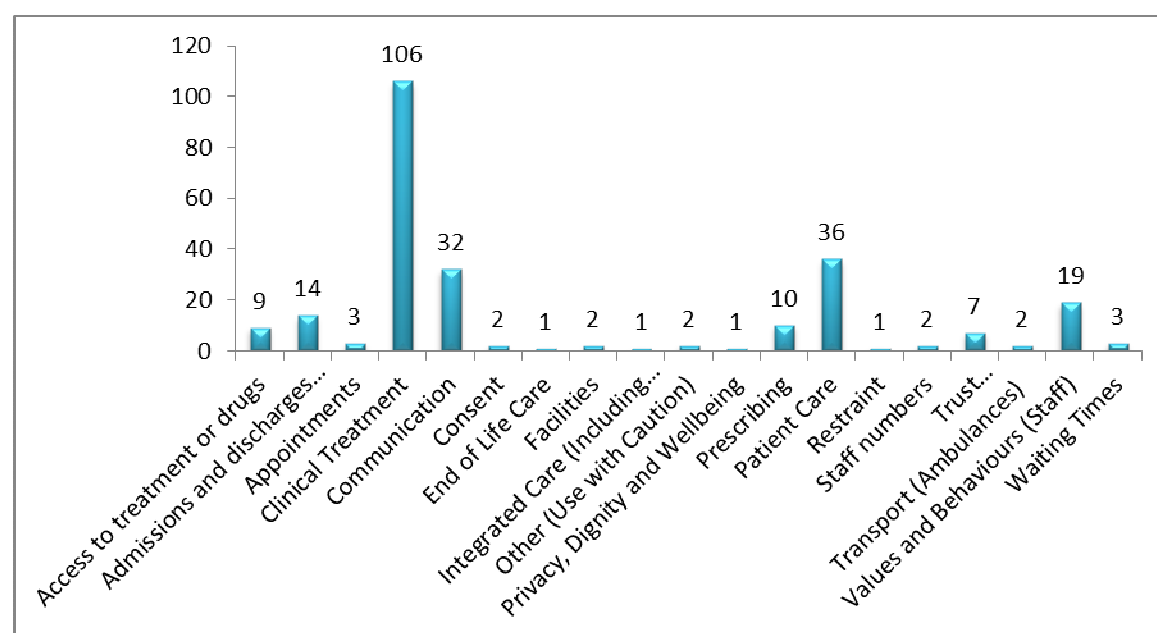
Appley Ward	1
Colwell Ward	2
Poppy Unit	1
Rehabilitation Unit	1
Stroke Unit	2

## 2.2 Subjects of complaints:

The information obtained from the KO41a collection monitors Hospital & Community Health Services formal complaints received each year. This supports the NHS Plan commitment to improve the Patient Experience and will contribute to delivering the Improving the Patients Experience PPF/2004 PSA (objective 4) targets.

Following the changes in the national reporting of the KO41a we are now able to drill down further with the subjects and sub-subjects to identify the issues that are being raised.

The graph below shows the subject (primary) recorded for the complaints during 2015/16



As can be seen in the graph above, the primary subject of complaints is clinical treatment (106), followed by patient care (36) and communication (32) followed by values and behaviours of staff (19).

### 2.2.1 Clinical Treatment (n=106):

Further analysis for the year in relation to the clinical treatment complaints follows, for the purpose of this report the data has been aligned to specialty admitted, then by sub-subject.

<b>Specialty admitted</b>	<b>Sub-subject (primary)</b>
<b>Ambulance (2)</b>	Delay or failure in treatment for infection / sepsis; failure to diagnose (incl. missed fracture) / misdiagnosis
<b>Anaesthetics (3)</b>	Injury / complication sustained during treatment or operation /procedure; Delay or failure in clinical follow-up; lack of clinical assessment
<b>Beacon Health Centre (2)</b>	Lack of clinical assessment; delay or difficulty in obtaining clinical assistance / escalating concerns
<b>Breast Care Centre (1)</b>	Delay or difficulty in obtaining clinical assistance/escalating concerns
<b>Cardiology (2)</b>	Delay or failure in treatment / procedure (2)
<b>Diabetes Centre &amp; Endocrinology (1)</b>	Dispute of diagnosis
<b>Diagnostic Services (3)</b>	Delay or failure to undertake scan/x-ray; delay or failure in ordering/undertaking tests x-ray/scan; failure to diagnose (incl. missed fracture) / misdiagnosis
<b>Ear, Nose &amp; Throat (3)</b>	Injury / complication sustained during treatment / operation / procedure; Post-Treatment complication; Failure to diagnose (incl. missed fracture) / misdiagnosis
<b>Emergency Department (16)</b>	Awareness under anaesthetic / sedation; catheter related UTI/Catheter issues; critical of decision to discharge; delay or difficulty in obtaining clinical assistance/escalating concerns; delay or failure in treatment or procedure; delay or failure in ordering/undertaking tests/x-ray/scans (2); Delay or failure to undertake scan/x-ray etc; Dispute over diagnosis (1); Failure to diagnose (incl. e.g. missed fracture)/misdiagnosis (5); Inadequate pain management ; Lack of clinical assessment
<b>Endoscopy (1)</b>	Injury/complication sustained during treatment or operation / procedure
<b>Gastroenterology (1)</b>	Dispute over diagnosis

<b>General Medicine (3)</b>	Lack of clinical assessment; Failure to recognise deteriorating patient; Failure to diagnose (incl. missed fracture)/ misdiagnosis
<b>General Surgery (15)</b>	Catheter accidentally pulled out; critical of decision to discharge; delay or failure in acting on test results/reports; delay or failure in treatment or procedure (2); delay or failure in ordering / undertaking tests / x-rays/ scans; failure to diagnose (incl. missed fractures) / misdiagnosis (3); failure to recognise deteriorating patient; inappropriate procedure / treatment; injury / complication sustained during treatment or operation / procedure (2); post-treatment complications (2)
<b>Gynaecology (7)</b>	Complications relating to birth /labour; delay or failure in treatment or procedure; unplanned return to theatre; injury/complication sustained during treatment or operation/procedure; failure to diagnose (incl. missed fracture)/misdiagnosis; dispute over diagnosis; post treatment complications.
<b>Maternity Services (2)</b>	Lack of clinical assessment; complications relating to birth / labour
<b>Maxillofacial Unit (1)</b>	Post-treatment complications
<b>Medical Assessment Unit (1)</b>	Delay or failure in clinical follow-up
<b>Medical Services (8)</b>	Delay or difficulty in obtaining clinical assistance/escalating concerns (Colwell Ward); delay or failure in treatment or procedure (MAU); delay or failure to undertake scan /x-ray (Winter ward); delay / failure / inadequate observations incl. monitoring (MAU); Dispute over diagnosis (2) (Colwell Ward (1), Stroke Unit (1); Failure to diagnose (incl. missed fracture) / misdiagnosis (MAU); inappropriate procedure / treatment (MAU).
<b>Mental Health – Acute &amp; Recovery Team (1)</b>	Inappropriate procedure / treatment (Chantry House)

<b>Mental Health – Community Services (5)</b>	Delay or failure in clinical follow-up (3); dispute over diagnosis (2)
<b>Mental Health – Inpatient Services (1)</b>	Dispute over diagnosis
<b>Mental Health – Memory Service (1)</b>	Failure to recognise deteriorating patient
<b>Mental Health – Rehabilitation &amp; recovery team (1)</b>	Lack of clinical assessment
<b>Ophthalmology (2)</b>	Injury / complication sustained during treatment or operation/procedure (1); Failure to diagnose (incl. missed fracture)/misdiagnosis (1)
<b>Orthopaedic Department (13)</b>	Critical of decision to discharge (1); (Failure to diagnose (incl. missed fracture)/misdiagnosis (4); incorrect procedure / treatment (1); injury / complication sustained during treatment or operation/procedure (1); lack of clinical assessment (1); post-treatment complications (5)
<b>Paediatric Services (1)</b>	Lack of clinical assessment
<b>Pathology Services (1)</b>	Injury / complication sustained during treatment or operation / procedure
<b>Respiratory Services (2)</b>	Failure to diagnose (incl. e.g. missed fracture) / misdiagnosis; Delay or failure in treatment for infection / sepsis
<b>St Helens (1)</b>	Delay or difficulty in obtaining clinical assistance / escalating concerns
<b>Stroke (1)</b>	Lack of clinical assessment
<b>Urology (4)</b>	Injury / complication sustained during treatment or operation / procedure (2); inappropriate procedure / treatment (1)  delay or failure ordering / undertaking tests/xrays/scans

### 2.2.2 Patient Care (n = 36)

Specialty Admitted	Sub-subject (primary)
Alverstone Ward (1)	Care needs not identified (incl. therapy needs)/ inadequately met
Colwell Ward (2)	Slip, trip, fall (1); failure to provide adequate care (incl. overall level of care provided) (1)
Day Surgery Unit (1)	Inappropriate care setting
Ear, nose and Throat (1)	Acquired infection (i.e. not present on admission)
Endoscopy (2)	Failure to provide adequate care (incl. overall level of care provided) (1); Painful/rough treatment or procedure (1)
Health Centres & Clinics (1)	Inappropriate care setting
Health Visitors (1)	Care pathway issues
Luccombe Ward (1)	Failure to comply with hand-hygiene requirement (incl. bare below the elbows, hand washing/sanitising)
Medical Assessment Unit (3)	Food and Hydration – failure to provide appropriate foods linked to clinical need/personal (e.g. diabetes, coeliac, texture modified/dysphagic) (2); Inadequate support provided (1)
Medical Wards (6)	Care needs not identified (incl. therapy needs)/ inadequately met (2); failure to provide adequate care (incl. overall level of care provided)(1); inappropriate care setting (1); neglect in hospital (1); slips, trips and falls (1)
Mental Health – Community Services (2)	Care needs not identified (incl. therapy needs) / inadequately met (2)
Orthopaedics / surgical wards (4)	Inadequate support provided (1); failure to adopt infection control measures (1); cannula management / left insitu on discharge (1); Food hydration – failure to provide monitor food/fluid/intake during period of admission (1).



<b>Respiratory Services (1)</b>	Failure to provide adequate care (incl. overall level of care provided)
<b>St Helen's Ward (1)</b>	Inadequate support provided
<b>Urology (1)</b>	Catheter care
<b>Whippingham Ward (7)</b>	Failure to provide adequate care (incl. overall level of care provided) (4); slips trips and falls (3).
<b>Winter Ward (1)</b>	Failure to provide adequate care (incl. overall level of care provided)

### 2.2.3 Communication (n = 32)

<b>Specialty Admitted</b>	<b>Sub-subject (primary)</b>
<b>Beacon Healthcare Centre (1)</b>	<b>Telephone not answered/calls not returned /cannot contact service.</b>
<b>Colwell Ward (1)</b>	Critical of communication with relatives
<b>Corporate Governance Department (1)</b>	Communication between external agencies i.e. GP
<b>Diagnostic Services (1)</b>	Delay or failure to received / communicate scans/x-rays/reports
<b>Emergency Department (4)</b>	Critical of communication with patient (1); Breaking bad news (1); Critical of communication with relatives / carers (2)
<b>Endoscopy (1)</b>	Breakdown in communication re appointments
<b>General Medicine (2)</b>	Critical of communication with relatives /carers (2)
<b>General Surgery (3)</b>	Breakdown in communication re appointments (1); critical of communication with patient (2)
<b>Gynaecology (1)</b>	Critical of communication with patient
<b>Medical Assessment Unit (1)</b>	Communication between external agencies i.e. GP
<b>Medical Services (1)</b>	Critical of communication with patient

Medical Wards (1)	Critical of communication with relatives / carers
Mental Health Community Services (2)	Critical of communication with patient (1); Patient not listened too (1)
Mental Health – Crisis Resolution & Home Treatment (1)	Critical of communication with patient
Mental Health – Inpatient Services (1)	Critical of communication with relatives / carers
Orthopaedics / surgical wards (1)	Access to interpreting services
Orthopaedics Department (3)	Communication between external agencies i.e. GP (1); Incorrect/no information given / insufficient client information (1); critical of communication with patient (1)
OT – Wheelchair Service (1)	Critical of communication with patient
Paediatric Services (1)	Critical of communication with relatives / carers
Pathology Services (2)	Communication between external agencies (1); Delay or failure to receive/communicate scans/x-rays/reports (1)
Pharmacy (1)	Incorrect/no information given/insufficient information (1)
Pre-assessment & admissions unit (1)	Communication between external agencies i.e. GP

#### 2.2.4 Values and behaviours (staff) (n=19):

Specialty Admitted	Sub-subject (primary)
Anaesthetics (1)	Emotional / psychological / verbal abuse by staff
Diagnostic Services (1)	Allegation of physical abuse/assault by staff incl. sexual (incl. alleged)
Emergency Department(4)	Attitude of nursing staff / midwives (3); attitude of medical staff (1)
General Medicine (1)	Breach of confidentiality by staff / staff discussing patient in public area
General Surgery (1)	Attitude of medical Staff

<b>Gynaecology (3)</b>	Allegation of physical abuse / assault by staff incl. sexual (incl. alleged) (1); Attitude of Consultant (2)
<b>Medical Assessment Unit (1)</b>	Attitude of nursing staff / midwives
<b>Mental Health – Access / acute services (1)</b>	Failure to act in a professional manner
<b>Mental Health – Community Services (1)</b>	Failure to act in a professional manner
<b>Ophthalmology (1)</b>	Attitude of Consultant
<b>Orthopaedics (2)</b>	Attitude of Consultant (1); Failure to act in a professional manner (1)
<b>Podiatry Service (1)</b>	Attitude of admin and clerical staff
<b>Rheumatology (1)</b>	Failure to act in a professional manner

### 2.2.5 Other subjects of complaints (n=20):

Below is a summary of all other subjects / sub-subjects of complaints and the location the complaint relates to:

**Access to treatment or drugs (n=9):** Access to services (4) Mental Health – Rehabilitation and Recovery Team (1), mental Health - Community Services (1), OT-Wheelchair (1), Paediatric services (1); Cancellation of operation /procedure (1) – Orthopaedics (include #); Length of waiting list (3) Occupational Therapy (2), Ophthalmology (1), service not available (1).

**Admissions & discharges (n=14):** cancelled / rescheduled surgery / procedure (2) – Day Surgery Unit, Orthopaedics (incl. #); Delay in discharge awaiting medication (1) – Emergency Department; Delay in treatment (1) – General surgery; Discharged at an appropriate hour (2) – Emergency Department; Failure to admit (1) – Emergency Department; internal transfer (incl. to x-ray/test) (1) – Colwell Ward; Patient not expected (1) – Luccombe Ward (1); poor transfer discharge arrangements (4) – Emergency Department, Alverstone ward, Medical Assessment Unit, Rehabilitation Unit; Transport Issues (1) – Bed Management.

**Appointments (n=3)** Appointment availability (incl. urgent) (2) – Cardiology, Ear, nose & throat); Appointment cancellations/delay/error (1) – Diabetes centre/endocrinology.

<b>Consent (n=2)</b>	Insufficient information provided prior to consent (2) – Gynaecology, General Surgery.
<b>End of Life Care (n=1)</b>	DNA/CPR Check – General medicine.
<b>Facilities (n=2)</b>	Equipment – availability/condition (2) – Orthopaedic Department, occupational therapy services
<b>Integrated Care (including delayed Discharge due to absence of care Package) (n=1)</b>	Delayed discharge - absence of a care package (1)
<b>Other (n=2)</b>	Loss of /damage to personal property incl. compensation issues (1) – Mental Health Inpatient Services; Generic injury sustained (non-clinical) – Diagnostic services.
<b>Prescribing (n=10)</b>	Adverse Drug reaction (1) – orthopaedic department; Prescribing Issues (n=9) – Alverstoke Ward, Beacon Health Centre, , Emergency Department, Endoscopy, Medical Services (2), Medical Wards (1), Mental Health - rehabilitation and Recovery, Whippingham Ward.
<b>Privacy, Dignity and Well-being (n=1)</b>	Lack of privacy – Emergency Department
<b>Restraint (n=1)</b>	All aspects of restraint issues – Security and Car parking
<b>Staff Numbers (n=2)</b>	Impact on patient care because of lack of suitably trained staff (2) – Pathology services (2)
<b>Transport (ambulances) (n=2)</b>	Delay in ambulance / paramedic arriving on scene (1); inappropriate mode of transport arranged (1)
<b>Trust admin /policies/procedures incl. Patient record management (n=7)</b>	Accuracy of health records (e.g. errors / omissions, other patient records in file) (1) – Medical Assessment Unit; child protection policy / process (2) – Paediatric services (1), Beacon Healthcare (1); Complaint handling – all aspects (1) – Orthotics and prosthetics; patient incorrectly identified (1) – Emergency Department; Travelling expenses (1) – Gynaecology; visiting times/arrangements (1) – Endoscopy.
<b>Waiting Times (n=3)</b>	Waiting at an appointment (in clinic) (1) – Beacon Healthcare; Waiting list time inpatient (2) – Ophthalmology (1), Orthopaedics (include #) (1)

## 2.3 Response Times:

Overall for the year the Trust achieved 98.8% against the three day acknowledgement of complaints.

This can be seen broken down by quarters below

Quarter 1 Apr - June	Quarter 2 July - Sept	Quarter 3 Oct – Dec	Quarter 4 Dec – Mar
100%	100%	99%	96%

Below shows the achievement against the target by Clinical Directorate (quarters 1 and 2) and Clinical Business Unit (quarters 3 & 4)

	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT
<b>HOSP &amp; AMB</b>	100%	100%	100%	100%	100%	100%	100%
<b>COMMUNITY</b>	100%	100%	100%	100%		100%	100%
<b>OTHER</b>							
<b>AVERAGE per quarter</b>			<b>100%</b>			<b>100%</b>	

		NOV	DEC	JAN	FEB	MAR
CBU 1 (surgery, women, children)		100%	90%	100%	100%	100%
CBU 2 (medicine)		100%	100%	100%	100%	83%
CBU 3 (clinical, support, diagnostics)		100%	100%	100%	50%	100%
CBU 4 (ambulance, urgent, community)		100%	100%	100%	100%	100%
CBU 5 (mental health, learning disabilities)		100%	100%	100%	100%	
AVERAGE per quarter			99%			96%

In relation to formal complaints managed within timescale, at the time of reporting the Trust managed 39% of complaints within agreed timescales at year end. This needs to be used with caution as not all complaint responses were due at the time of reporting, and this figure is subject to change.

The tables below show this as a quarterly breakdown by clinical directorate / clinical business unit.

	April	May	June	July	Aug	Sept	Oct
<b>Hospital</b>	<b>47%</b>	<b>55%</b>	<b>71%</b>	<b>38%</b>	<b>19%</b>	<b>18%</b>	<b>14%</b>
<b>Community</b>	<b>50%</b>	<b>50%</b>	<b>50%</b>	<b>100%</b>		<b>63%</b>	<b>25%</b>
<b>Other Areas</b>							
<b>Total</b>	<b>47%</b>	<b>54%</b>	<b>69%</b>	<b>40%</b>	<b>19%</b>	<b>37%</b>	<b>16%</b>

*Quarterly*

**56%**

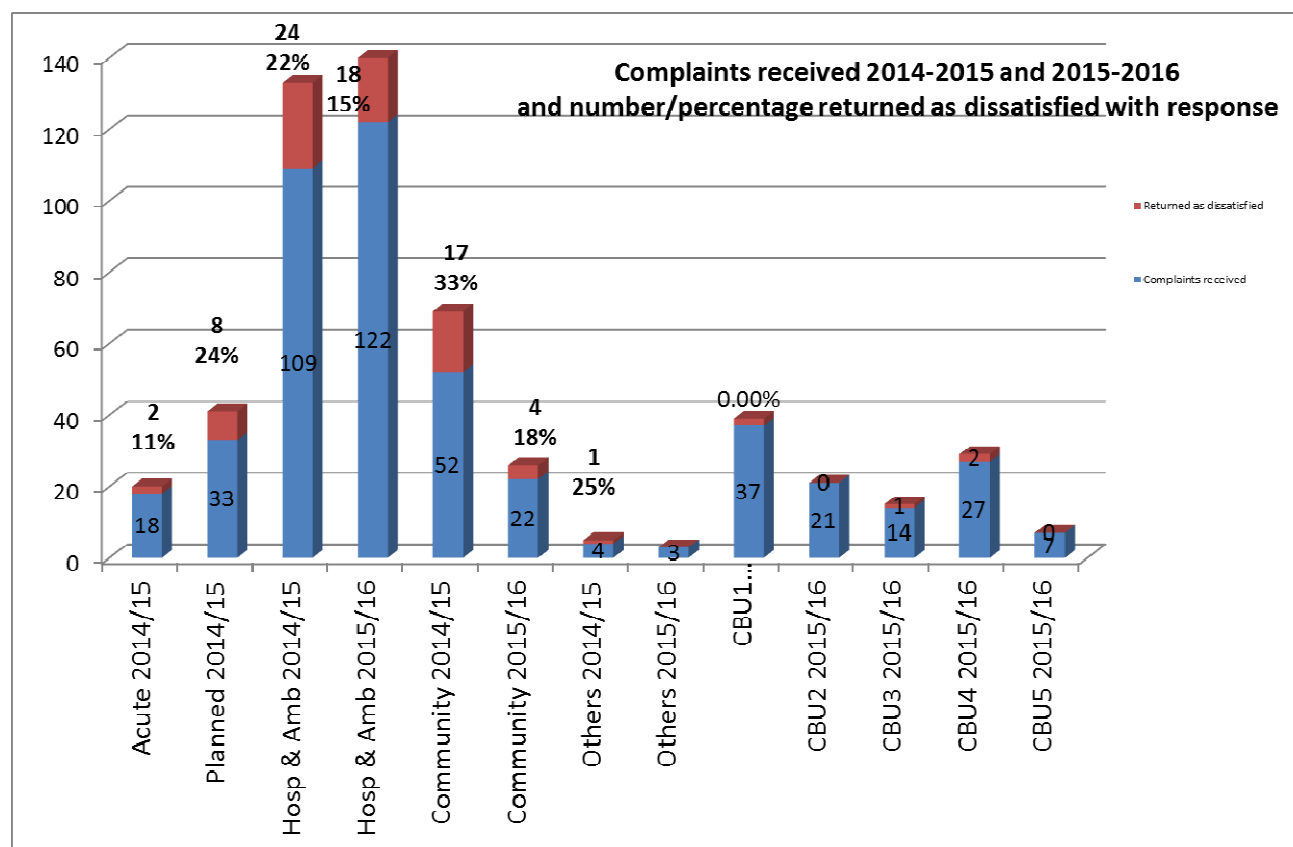
**33%**

			Nov	Dec	Jan	Feb	March
<b>CBU 1</b> (surgery, women, children)			<b>38%</b>	<b>10%</b>	<b>43%</b>	<b>50%</b>	<b>100%</b>
<b>CBU 2</b> (medicine)			<b>25%</b>	<b>50%</b>	<b>0%</b>	<b>50%</b>	<b>100%</b>
<b>CBU 3</b> (clinical, support, diagnostics)			<b>0%</b>	<b>33%</b>	<b>0%</b>	<b>100%</b>	<b>100%</b>
<b>CBU 4</b> (ambulance, urgent, community)			<b>40%</b>	<b>67%</b>	<b>0%</b>		<b>100%</b>
<b>CBU 5</b> (mental health, learning disabilities)			<b>0%</b>	<b>0%</b>	<b>50%</b>	<b>100%</b>	
<b>Total</b>			<b>27%</b>	<b>26%</b>	<b>29%</b>	<b>71%</b>	<b>100%</b>
<i>Quarterly</i>				<b>16%</b>			<b>52%</b>

Red text so far: some complaints not due yet

### 3. Returners:

The graph below shows the returning complaints



**\*Please see chart above for CBU explanation.**

What can be seen from the chart above is that the numbers of returning complains during 2015/16 has decreased. This is a very positive position against this time last year, and we hope to continue to maintain this improvement going forward. This improvement may be down to offering increased local resolution meetings. The Trust will be monitoring the offer of meetings to complainants as part of the complaints key performance indicators going forward into 2016/17.

#### 3.1 Parliamentary and Health Service Ombudsman (PHSO):

During the year the PHSO opened 8 new cases, these are cases where the complainant was not happy with the final outcome they received from the Trust. A breakdown of service these related to can be seen below:

- |   |  |
|---|--|
| <b>3.1.1 Community (3)</b>              | Physiotherapy; Mental Health – Child & Adolescent Services; Orthotics and Prosthetics. |
| <b>3.1.2 Hospital and Ambulance (4)</b> | General Surgery; OPARU; St Helen's Ward; urology                                       |
| <b>3.1.3 Planned (1)</b>                | Gynaecology  |

3.1.4 During the year 5 cases were closed by the PHSO, one of which was from the previous year (2014/15)

Below are the areas that those cases closed for 2015/16 related to and the outcome by the PHSO:

**3.15 Planned (2)** General Surgery – Not upheld; Urology – Partly upheld

**3.16 Acute (1)** Emergency Department – Partly upheld

**3.17 Community (1)** Mental Health – Child and Adolescent Services – Not upheld

At the time of reporting there are 3 that the PHSO have made a decision on, but remain open awaiting assurance from the Trust the all action has been taken.

Below are the areas that those cases closed for 2015/16 related to and the outcome by the PHSO:

**3.18 Planned (2)** General Surgery (2) – Partly upheld

**3.19 Hospital & Ambulance (1)** OPARU - Upheld.

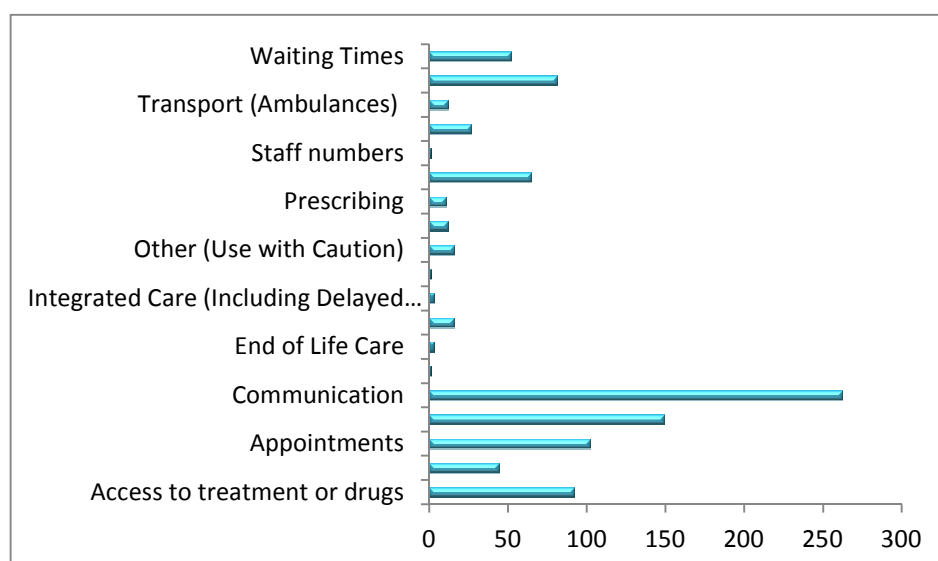
The Clinical Business Units will continue to ensure that the action plans are progressed and regular updates are provided to the complainants in line with the recommendations of the PHSO.

#### 4. Concerns:

During the year the Trust received a total of 950 concerns, the table below shows the number received per month by clinical business units.

##### 4.1 Concerns by primary subject:

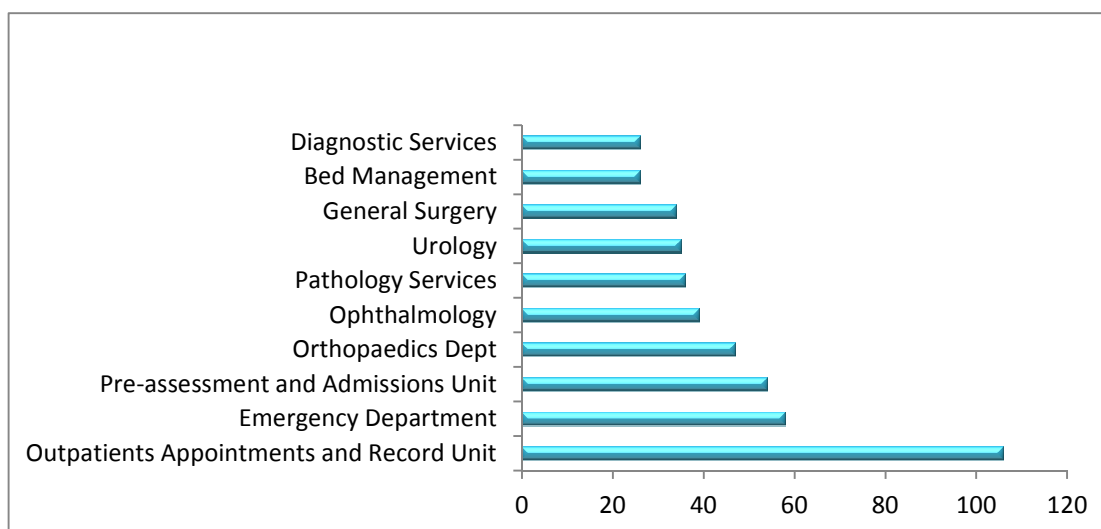
The graph below shows the concerns logged by primary subject for the year:





## 4.2 Concerns by specialty (admitted):

The table below provides the specialty the concern was logged to:



## 4.3 Further analysis of concerns:

Concerns are managed jointly between Patient Experience Officers (PALS) and the relevant services, and centrally recorded on Datix. Concerns can be received either in writing, including email or verbally via the PALS Team.

This year we have seen an increase of 3% in concerns against 2014/15. Outpatients Appointments and Records Unit (OPARU) (106), Emergency Department (58) and Pre-assessment and Admissions Unit (PAAU) (54) were the top 3 areas receiving concerns during the year.

Both OPARU and the Emergency Department were in the top 3 areas for 2014 / 15; however the number of concerns logged against them has reduced OPARU has seen a decrease in 37% and ED 8%. PAAU have seen an increase of 59% this year.

Further analysis of the concerns for the top 3 areas can be seen below, using the subjects and sub-subjects.

### 4.3.1 OPARU (n=106)

Access to treatment or drugs (2) - Length of waiting list (1); access to services (1)

Appointments (22) Appointment letter not issued /not received (2); Appointment availability (including urgent) (4); Appointment booking system (1); Appointment cancellation / delay / error (15).

Clinical Treatment (1) Critical of decision to discharge (1)

Communication (71) Access to interpreting service (1); breakdown in communication re appointment (14); critical of

	communication with patient (3); inadequate / poor record keeping/medical records (1); telephone not answered/calls not returned /cannot contact service (52)
Trust admin policies / procedures (1)	Policy decision/service configuration incl closure /relocation
Values and behaviours (staff) (6)	Attitude of admin and clerical staff (6)
Waiting times (3)	Waiting list time outpatient / clinic (2); waiting for appointment /length of waiting list (1)

#### **4.3.2 Emergency Department (n=58)**

Access to treatment / drugs (1)	Treatment delayed / cancelled
Admissions and discharged excluding delayed discharges (5)	Discharged at an inappropriate hour (2); failure to admit (1); internal transfer (incl. to xray / test) (1); waiting on trolley (1).
Clinical Treatment (24)	Catheter related UTI's (1); critical of decision to discharge (5); delay or difficulty in obtaining clinical assistance / escalating concerns (2); delay or failure in treatment or procedure (2); dispute over diagnosis (1); Failure to diagnose (incl. e.g missed fracture) / misdiagnosis (9); Inadequate pain management (2); lack of clinical assessment (2)
Communication (9)	Breakdown in communication between staff / departments (1); breaking bad news (1); communication between external agencies i.e. GP's (2); critical of communication with relatives/carers (2); inadequate information provided (1); incorrect /no information / insufficient information (2)
Facilities (1)	Laundry / linen / cleanliness / availability / condition
Other (1)	Loss of /damage to personal property incl. compensation issues
Patient Care (5)	Cannula management / left insitu on discharge (2); failure to adopt infection control measures (1); failure to provide adequate care (incl. overall level of care provided) (1); painful / rough treatment or procedure
Privacy, dignity, wellbeing (4)	Lack of privacy (2); Discrimination /equality (1) patient left in dirty soiled clothing / bedding (1)
Trust admin/policy/procedures (1)	Access to health records (incl. availability/non-availability)

Values and behaviours (staff) (6)	Attitude of medical staff (2); attitude of nursing staff / midwives (1); attitude of other staff (1); Failure to react in a professional manner (2)
-----------------------------------	---

Waiting Times (1)	Waiting at an appointment (in clinic)
-------------------	---------------------------------------

#### **4.3.3 Pre-assessment and admissions unit (n=54)**

Access to treatment or drugs(15)	Access to services (1); cancellation of operation / procedure (7); length of waiting list (1); service not available (2); treatment / delayed cancelled (4)
----------------------------------	---

Admissions & discharges (excl. delayed discharges due to absence of care package) (8)	Admission arrangements (3); cancelled / rescheduled surgery/ procedure (5)
---	--

Appointments (9)	Appointments cancellation /delay / error (7); appointment not kept by staff (1); referral delay / refusal / failure / not received (1)
------------------	--

Communication (13)	Breakdown in communication between staff / departments (1); breakdown in communication re appointments (3); communication between external agencies i.e. GP's (1); critical of communication with patient (1); inadequate information provided (3); incorrect / inaccurate interpretation of information (1); incorrect / no information given / insufficient information (1); telephone answered / calls not returned / cannot contact service (1)
--------------------	---

Values & behaviours (staff) (3)	Attitude of admin and clerical staff (2); values and behaviours of staff (1)
---------------------------------	--

Waiting times (6)	Waiting list time (inpatient) (5); waiting for appointment / length of waiting list (1)
-------------------	---

## **5. Compliments (Good News):**

Good News is recorded by Clinical Business Units, and is recorded only where significant thanks are received, i.e cards or letters.

During the year the Trust reported receiving 3816 (3713) compliments, an increase of 3% on the previous year. This equates to 15 (17) compliments for each formal complaint received.

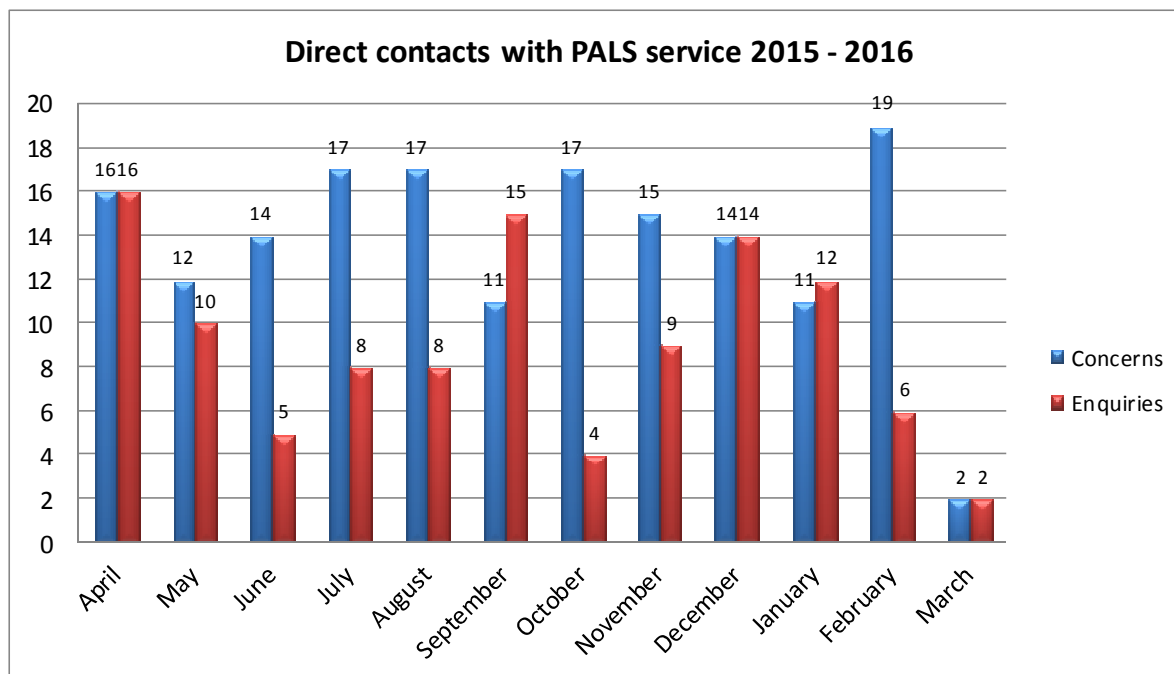
The annual numbers are broken down by clinical directorate / clinical business unit, as can be seen on the chart overleaf.

	LETTERS AND CARDS OF THANKS April 2015 - March 2016												Yearly Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Community	18	131	85	76	25	66	99	80					580
Mental Health	5	20	14	12	6	7	6	19					89
Hospital	191	210	186	243	266	215	101	279					1691
Ambulance	11	11	6	7	5	5	5	5					55
OTHER	0	0	0	0	1	2	0	0				1	4
Executive Director of Nursing & Workforce	9	10	9	13	12	8	11	10	10	11			103
CBU 1 (surgery, women, children)									137	106	111	99	
CBU 2 (medicine)									156	41	91	37	
CBU 3 (clinical, support, diagnostics)									121	40	62	74	
CBU 4 (ambulance, urgent, community)									88	26	23	19	
CBU 5 (mental health, learning disabilities)									17	15	21	10	
TOTAL	234	382	300	351	315	303	222	393	529	239	308	240	3816
			916			969			1144			787	

## 6. PALS Contacts:

During the year the Patient Experience Officers dealt with a total of 274 (229) direct contacts through the office which is an increase of 19.6% on 2014/15. Of these contacts, 109 were enquiries where signposting to external agencies or general advice was given, and 165 were managed as a concern or formal complaint

The graph below shows the number of contacts the number of direct contacts per month for the year.



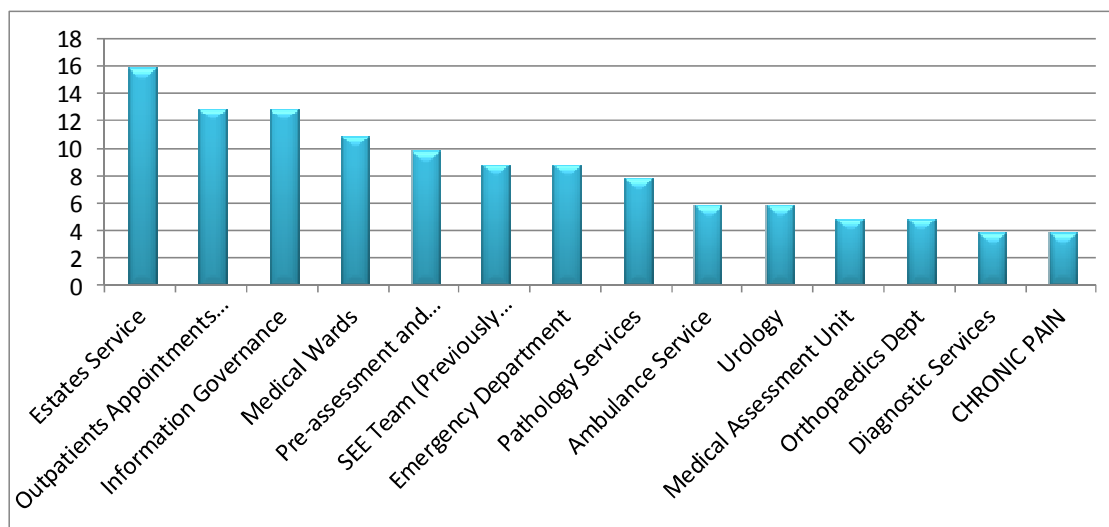
There was a significant decrease in contacts during March, as due to staffing issues within the team. Whilst the PALS service has been available, and continued to support patients and relatives, the office in main reception has been closed.

In addition to concerns raised with the PALS service, the Patient Experience Officers also received and managed 233 telephone or written enquires where advice or signposting was offered

The table below shows the PALS enquiry contact by Type. As enquiries are more about signpost and answering questions the subject matter is not always recorded and they are categorised by type, therefore it is not possible to identify the reason for the contact if the subject did not relate to this Trust.

<b>PALS Enquiries by Type</b>	<b>Total</b>
Issues in relation to CCG/commissioning	5
Charity services	5
Comment	1
CQC information	1
GP issues	21
Issues relating to hospice an macmillan team	1
NHS England issues	2
Other Mainland Hospital issues	7
Other issues not related to St Mary's	22
Issues in relation to private practice (not mottistone ward issues)	8
Portsmouth hospital issues	16
SEAP	3
Southampton hospital issues	28
Social Services/council Issues	14
Somerset NHS Trust (Dentist)	4
Issues relating to St Mary's	195
Expression of gratitude or thankyou	3
Issues relating to travelling to the mainland	6
<b>Totals:</b>	<b>342</b>

The graph below shows the top 15 PALS contacts for issues relating to St Mary's issues by speciality:



As can be seen from the above, enquiries regarding Estates services was the largest specialty enquired about; closely followed by enquiries regarding appointments and access to medical records (Information Governance).

## 7. Complainants Survey:

During the year the team implemented a survey to assess the satisfaction of complainants, which is sent to them with their final response. This was implemented following the recommendations by Healthwatch review into the Trusts complaints process.

Following initial feedback it was agreed to further amend the survey to align it to the 'I' statements contained with the PHSO service user led vision on complaints, and this new survey is now being distributed.

The change in the survey used, has meant that there was a reduction on complainants receiving this but below is the summary of results from the feedback received from complainants during 2015/16 using the original survey forms. Going forward into 2016/17, quarterly results will be published from the new survey.

Only 21 respondents have completed this questionnaire, which is a very poor response rate, and at this time we are unable to calculate a true response rate, as the sample will have included complainants from the latter part of 2014/15.

The full results can be seen in Appendix A, however overall 65% felt that they found it very / reasonably easy to make a complaint; 65% felt that the communication /correspondence received from the hospital was easy to understand; 62% felt that their complaint was not fully addressed with only 43% getting the response within the agreed timescale. Overall 37% were either very happy or happy with the way the complaints process worked.

## 8. Learning from complaints and concerns: contributing to improving the patient experience

All complaints received by the Isle of Wight NHS Trust are investigated and reviewed directly with the staff involved, with lessons learnt developed and shared with the wider clinical area. The following positive outcomes and actions have been identified from a sample of complaints received in order to prevent similar situations occurring:

**Below are a few examples of actions taken / lessons learnt from complaints and concerns during 2014/15:**

Speciality	Complaint	Root Cause	Action taken
<b>St Helens</b>	Critical of care on ward due to short staffing. Poor food. Lack of continuity. Issue of breach of confidentiality	Patient did not understand reason for decisions made regarding care and eating.	New information system put in place to keep patients informed of discharge process  Electronic tracking system put in place in discharge lounge to keep patients informed of process
<b>Wheelchair Service</b>	Critical of delay in being assessed by Team	Delay in referrals being answered and acted on	Updated Standard Operating Procedure implemented on 1 May 2015 to ensure all referrals receive written communication or direct contact with a member of the Housing and Adaptations Occupational Therapy Team within 2 weeks of the referral being received by the team.
<b>Whippingham</b>	Critical of nursing care, attitude of male nurse and delay in diagnosis.	Poor Nursing Care	Intentional Rounding is now in place
<b>ENT</b>	Failure to recognise serious complication of	Complication of Surgery	Patients receive oral antibiotics after this type of surgery.

	surgery.		Reviewed all post op advice for all ENT patients
<b>Medical Assessment Unit</b>	Lack of medication or pain relief/ poor communication	Poor pain management due to long wait, and staff performance	<p>Complaint shared with team and individuals concerned, top enable reflection.</p> <p>Mechanism put in place by ward sister to ensure that management of patients is regularly supervised and monitored so that staff are working at the level expected at the Trust.</p>

## 9. Reflection on the last year & priorities for coming year:

There have been a number of factors that have impacted on the complaints and concerns process, and this includes changes to the national reporting processes (KO41a); change from clinical directorate to clinical business units; implementation of the new datix web module for complaints, and the reduced staffing in the corporate teams.

Despite this the Trust has continued to implement the recommendations from the Healthwatch report from Pillar to Post that was published in September 2015. At the time of reporting from the 13 actions identified the Trust has fully completed 7 actions; is nearing completion of 3; has 2 still in progress and 1 that was never actioned as it was felt that this was not applicable but would be continued to be monitored. The updated action plan has been shared with Healthwatch, and will be monitored to completion.

It was disappointing to have to make the decision to close the PALS office temporarily during the last quarter of the year due to staff sickness, and this did impact on the number of face to face contacts that the PALS service managed during the year. However, it is important to reiterate that the service was available and still managing concerns and enquiries. I am pleased to report that the office has now re-opened but we do still have a reduced staffing at present, which we hope to fully resolve during June 2016.

The following actions have been taken to improve the complaints handling process:

- The PALS and complaints functions have commenced separation.



- The complaints literature has been updated; new posters are on display and the leaflets are to be printed during May.
- The complaints policy has been updated, and the new process agreed with the Clinical Business Units.
- The Trust has moved onto Datixweb, and will be working on this fully in Quarter 1 2016/17
- The patient experience steering group has been set up and will be reviewing all patient feedback including complaints, concerns, comments and compliments
- Two complaints handling training courses will be delivered by an external company for Trust staff during 2015/16

The Trust continues to work closely with Healthwatch, and the independent health advocacy service seAp, to ensure that all patients / relatives are supported when they want to raise a concern.

***The key priorities for the next year are:-***

- Full Implementation of Datixweb Complaints Module
- Ratification of the Complaints, Concerns and Compliments Policy
- Recruitment of Complaints Co-ordinator
- Distribution of complaints leaflets.
- Improve reporting to service level / individual clinician
- Improve the lessons learnt / action planning in response to complaints.
- Ensure we are publishing anonymous complaints on the Trust website
- Delivery of the complaints handling training.

## Complaints Handling Feedback Form Survey Results



Complaints Handling  
Feedback Form - Sur

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> JULY 2016

<b>Title</b>	My Life a Full Life Health & Care System Redesign Pre-Consultation Business Case Authorisation			
<b>Sponsoring Executive Director</b>	Karen Baker, Chief Executive			
<b>Author(s)</b>	James Seward, WISR Programme Director, MLAFL			
<b>Purpose</b>	Agree in principle the first-draft of the MLAFL Health & Care System redesign ('WISR') Pre-Consultation Business Case and give delegated authority to the Chief Executive of the IW NHS Trust to agree the final draft at an extraordinary meeting of the My Life a Full Life Board on the 14 <sup>th</sup> July in order that the proposals may begin the process of external Programme Assurance and iterative development towards likely Public Consultation in late 2016.			
<b>Action required by the Board:</b>	<b>Receive</b>		<b>Approve</b>	<b>x</b>
<b>Previously considered by (state date):</b>				
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>		
Trust Executive Committee				
Audit and Corporate Risk Committee				
Charitable Funds Committee				
Finance, Investment, Information & Workforce Committee				
Mental Health Act Scrutiny Committee				
Remuneration & Nominations Committee				
Quality Governance Committee				
<b>Please add any other committees below as needed</b>				
Board Seminar	15 <sup>th</sup> March, 19 <sup>th</sup> April, 17 <sup>th</sup> May, 21 <sup>st</sup> June	Progress noted and discussed on four occasions		
Hospital Medical Specialists Committee (HMSC)	4 <sup>th</sup> July (& previous monthly updates)	Progress and overall proposals discussed		
External Systems Committees	7 <sup>th</sup> July (CCG Governing Body), 14 <sup>th</sup> July MLAFL Board, 14 <sup>th</sup> July IW Council Executive	This paper is also being considered at the CCG Governing Body and the IW Council Executive Committee.		
Health and Adult Social Care Scrutiny	Progress reported to Scrutiny Committee on 18 <sup>th</sup> April and			

Sub Committee	20 <sup>th</sup> June
Other (please state)	<p>WISR Professional Reference Group (PRG) – 18<sup>th</sup> May, 7<sup>th</sup> June &amp; 30<sup>th</sup> June</p> <p>IOW Health &amp; Wellbeing Board – 30<sup>th</sup> June</p> <p>IOW Adult Safeguarding Board – 15<sup>th</sup> July</p> <p>IOW Children's Safeguarding Board – 20<sup>th</sup> July</p> <p>CCG Clinical Executive – 21<sup>st</sup> July</p>
<b>Staff, stakeholder, patient and public engagement:</b>	
<p><i>Caring for Our Island – Time to Change</i> case for change and public engagement leaflet launched in March and sent to every address on the Island. 613 responses were received by end of May, which have been thematically analysed and fed into the redesign process. The Case for Change was developed into a more detailed technical case for change <i>Our Island, Our Future: Rethinking health and care services on the Isle of Wight</i> published in June 2016.</p> <p>Engagement events:</p> <ul style="list-style-type: none"> <li>• 18 locality events, one for each working group in each locality – 189 attendees</li> <li>• 2 public engagement events – 97 attendees</li> <li>• 317 people reached through direct community conversations including: <ul style="list-style-type: none"> <li>○ 65 people at a Carers event</li> <li>○ 52 people at the Beacon Centre</li> <li>○ 32 people at Active Living</li> <li>○ 20 people at IW college</li> <li>○ 20 people at Older Voices</li> </ul> </li> <li>• Contacted 230 community groups, including 'hard to reach' groups</li> <li>• Case for Change leaflet mailed out island-wide – 723 responses</li> <li>• Thematic analysis of public responses feeding in to redesign process</li> </ul> <p>Redesign Working Groups:</p> <p>Over 160 people from the Trust, CCG, IWC, Voluntary &amp; Independent Sectors as well as members of the public have been actively participating in the redesign working groups over the last three months. Additionally, more than 20 national health and social care experts have inspired and challenged the ambition of the groups.</p>	
<b>Executive Summary &amp; Analysis:</b>	
<ul style="list-style-type: none"> <li>• The My Life A Full Life Whole Integrated System Redesign (WISR) programme has developed an overall vision for how health and social care services should be redesigned across the Island to deliver safe, sustainable and high quality services and better meet the challenges in meeting the future needs of local people</li> <li>• The vision is set-out in a draft Pre-Consultation Business Case (PCBC) which will provide an overall set of goals for how the MLAFL partners can come together to deliver integrated services and enable the Island to deliver on the MLAFL vision of moving to person-centred services which support people in communities to better manage their health and wellbeing and to get access to high quality community based and hospital services when they need them</li> <li>• The purpose of the PCBC is to bring together for the first time a clear description of the shared vision of what these services may look like at an overarching strategic level for System Partners' endorsement</li> <li>• The last working group meetings are on the 28<sup>th</sup> July followed by a final public engagement event the following day. As such, the first complete draft of the PCBC will not be available until 6<sup>th</sup> July and will therefore be tabled at the Board meeting. The attachments here provide the key content covering: the Case for Change, the Redesign Methodology (including public and staff co-production) and the overall new model of care proposal under separate cover</li> <li>• The Trust Board, CCG Governing Body, and IWC Executive Committee are being asked to approve the Case for Change and the Redesign Methodology and the resulting strategic direction; and authorise the appropriate senior officer to approve the final draft of the PCBC at an extraordinary meeting of the MLFL Board on the 14<sup>th</sup> July</li> <li>• Once the draft PCBC is agreed through the Trust, CCG and IWC governance processes the</li> </ul>	

PCBC will be shared externally with NHS England and other national bodies to begin the Programme Assurance process which will be an iterative process over the next few months of testing, developing and refining the proposals (nationally and with local stakeholders) with a view to moving to a formal Public Consultation on the proposals at the end of 2016	
<b>Recommendation to the Board:</b> The Board is asked to: <ul style="list-style-type: none"> <li>• <b>Note</b> the process through which the MLAFL redesign proposals have been developed (including the Case for Change and the Redesign Methodology);</li> <li>• <b>Agree</b> the process and evidence base as being sound;</li> <li>• <b>Agree</b> in principle the proposed new care models recognising that they provide a robust overall strategic vision for health and care services should be redesign across the Island over the next few years; and</li> <li>• <b>Agree</b> to delegate authority to the Chief Executive, IOW NHS Trust to agree the final draft at an extraordinary meeting of the My Life a Full Life Board on the 14<sup>th</sup> July and authorise its presentation to NHS England for assurance.</li> </ul>	
<b>Attached Appendices &amp; Background papers</b> <ul style="list-style-type: none"> <li>• MLAFL Health &amp; Care System Redesign Pre-Consultation Business Case Authorisation report</li> <li>• Draft MLAFL Health &amp; Care System Redesign Pre-Consultation Business Case</li> <li>• Vision for the Island's New Models of Care Slide Deck</li> </ul>	
For following sections – please indicate as appropriate:	
<b>Trust Goals &amp; Priorities</b>	The Trust is a founding MLAFL partner and has through its Executive, clinical and managerial staff played a crucial role in developing the MLAFL redesign proposals. The proposals are intended to enable the Trust and other system partners to deliver on their corporate and shared values and priorities for delivering high quality, safe and sustainable services which provide excellent public/user experience and choice.
<b>Principal Risks (BAF)</b>	<ol style="list-style-type: none"> <li>1. <b>Human Resources</b> – in order to deliver the new model of care, the future workforce will need new skills and capabilities and may be expected to work in different settings. However, these proposals are likely to need more staff overall across the system than are currently in posts so as to be able to manage future demand.</li> <li>2. <b>Financial Resources</b> – the overall aim of the new model of care is to redesign services to make them more affordable to the Island by developing prevention and early intervention services in community settings to reduce pressure on acute and residential extra care services.</li> <li>3. <b>Culture</b> – these proposals will require all partners to commit to period of concerted change over the next few years. Considerable work will be required to ensure that the culture across organisations and staffing groups can be engaged in driving this process.</li> <li>4. <b>Local Health and Social Care Economy Resilience</b> Some the redesign proposals will enable system savings in 2016/17 and will be taken forward as part of the System Resilience programme and will be essential enablers for the subsequent stages of the redesign implementation process.</li> <li>5. <b>ICT</b> – realising the benefits of the redesign proposals will be contingent on developing the ICT infrastructure and</li> </ol>

	<p>digital supports to facilitate their implementation.</p> <p><b>6. Investment</b> – While all partners will be working to ensure a smooth transition from existing activity to new models of care it is probable that investment will be required to make the necessary step-change in some areas. Due to the constrained financial situation of all partners this may require additional external funding</p>
<b>Legal implications, regulatory and consultation requirements</b>	<p>The subsequent development of the MLAFL redesign PCBC will be subject to thorough external Programme Assurance led by NHS England in accordance with the national requirements set-out in <i>Planning, assuring and delivering service change for patients</i> (NHS England, November 2015). Ultimately, through this iterative process, the overall vision and any specific service changes that in law must be agreed with the public will be subject to Public Consultation at the end of 2016</p>
<b>Date:</b> 30 <sup>th</sup> June 2016	<b>Completed by:</b> James Seward

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> JULY 2016

## MLAFL Health &amp; Care System Redesign Pre-Consultation Business Case Authorisation

## Issue:

1. This paper and attachments set out the health and care system redesign proposals which have been developed as outputs of the MLAFL Whole Integrated System Redesign (WISR) workstream comprising:
  - a. Draft MLAFL Health & Care System Redesign Pre-Consultation Business Case (PCBC) covering:
    - i. The Case for Change
    - ii. The Redesign Methodology
  - b. The vision for the Island's New Models of Care
2. The purpose is to seek the Board's agreement in principle that it supports the vision for the Island's New Models of Care and is therefore content to give delegated authority to the Trust Chief Executive to agree the final draft MLAFL Health & Care System Redesign PCBC at an extraordinary meeting of the My Life a Full Life Board on the 14<sup>th</sup> July.
3. This action will enable the PCBC to be submitted as an agreed draft across the MLAFL System Partners to NHS England to begin the process of external Programme Assurance commencing on 10<sup>th</sup> August with a Stage 1 Strategic Sense Check meeting which will initiate a process of iterative development of the proposals towards likely Public Consultation in late 2016.

## Recommendation to the Board:

4. The Board is asked to:
  - **Note** the process through which the MLAFL redesign proposals have been developed (including the Case for Change and the Redesign Methodology)
  - **Agree** in principle the proposed new care models recognising that they provide a robust overall strategic vision for health and care services should be redesigned across the Island over the next few years
  - **Agree** to delegate authority to the Chairman and Chief Executive, IOW NHS Trust to agree the final draft at an extraordinary meeting of the My Life a Full Life Board on the 14<sup>th</sup> July

## Timing:

5. **Urgent:** there is a high level of time-sensitivity in gaining the Board's approval in principle to proceed within the existing timelines in order to avoid a 1-2 month delay in the process which will delay the move to Programme Assurance and will almost certainly mean that the Public Consultation phase will not be completed before 23<sup>rd</sup> March 2017 (which is when the local elections pre-election period begins). More importantly, the proposals from the Redesign Working Groups are being discussed widely across staff groups, so it is important that the work can move to the next stage which will include sharing the agreed vision with the staff and public and engaging them in co-producing the development of these plans.

### The Case for Change:

6. The draft PCBC attachment provides the detailed Case for Change. These principles have been the subject of a public engagement exercise launched in March with the publication of the *Caring for Our Island: Time to Act* leaflet which was subsequently posted as hard copy to every address on the Island. The key aims of *Caring for Our Island* were to:
  - a. Set-out to Island residents the key challenges facing health and social care services now and into the future, including:
    - Increased demand
    - Increasing complexity of patient/service users' needs
    - A workforce that needs to grow and change
    - Current and projected system pressures
  - b. Confirm that it was the intention of the health and social care system partners to face these challenges by changing the way in which services are designed and delivered in order to:
    - Provide better access to high quality integrated services as close to people's homes as possible
    - Meet growing demand more appropriately and safely
    - Adapt to people's health care needs changing as people live longer with various and often multiple issues
    - Tackle the growing financial challenges in delivering current services with a new more cost-effective and financially sustainable approach
  - c. Ask the public for their views and comments on how health and social care services on the Island should change to address the issues presented
7. A more detailed technical case for change *Our Island, Our Future: Rethinking health and care services on the Isle of Wight* published in June 2016 setting-out the Island's:
  - a. Changing health needs – considering demographic changes, the local profile of disease prevalence and incidence, patterns of public demand and changing public expectations of services
  - b. Quality of care
  - c. Workforce challenges, particularly recruitment and retention
  - d. Financial challenges in providing services in an Island setting
  - e. Redesign approach

### Redesign methodology and approach:

8. The draft PCBC attachment provides the detailed redesign methodology. In summary, the redesign approach has been based on a robust methodology comprising:
  - a. **Co-production of solutions with the local public, users of services and staff:** the redesign process has brought together the views, concerns and ideas of the public, users of services and staff to co-design solutions.
  - b. **Testing and assessing redesign proposals against an 'Individual Needs Framework':** each new care model proposal has been assessed for suitability within the MLAFL programme and with local system partners before they have been developed for inclusion in the PCBC. This has been done in a transparent and fair way by using an assessment framework based on the individual needs of the people on the Island ('**Individual Needs Framework**').

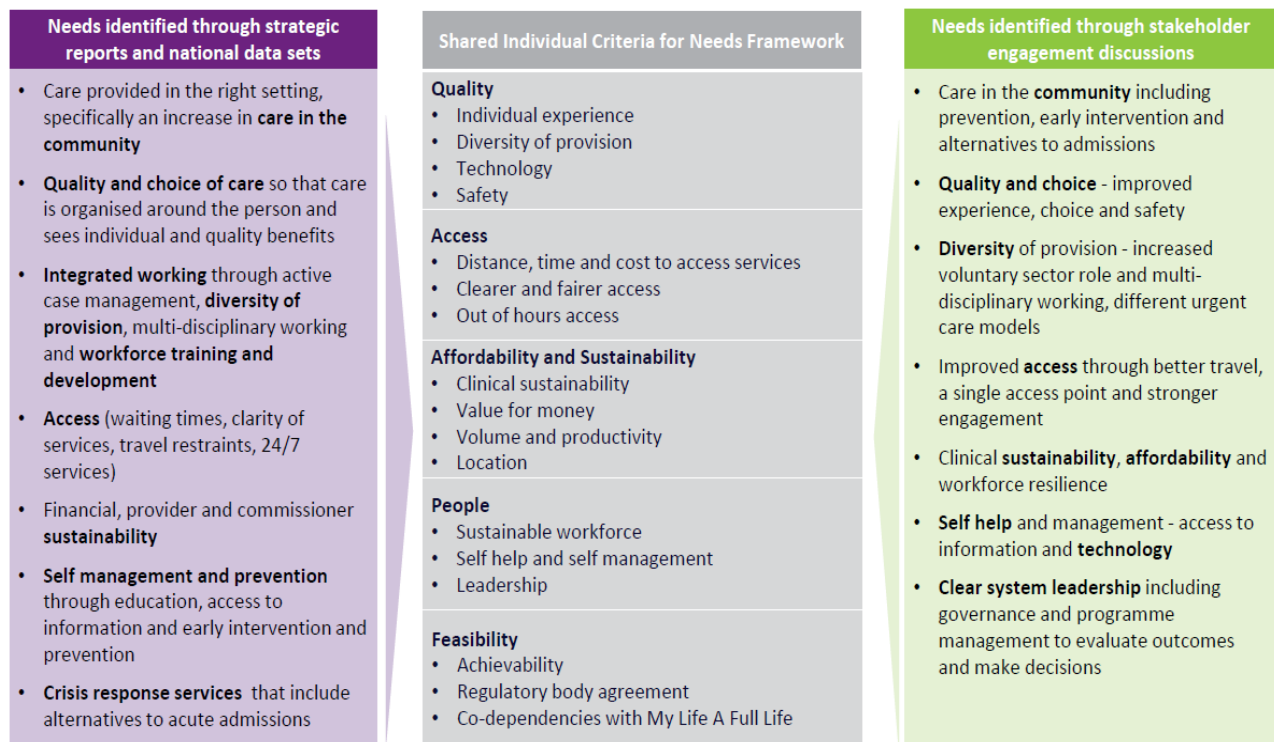


### **Co-production:**

9. The following principles of co-production have been applied throughout the redesign process:
  - The purpose of this review is to make sure health and care services on the Isle of Wight make best use of available resources and continue to deliver excellence for years to come
  - The changes to the Island's health and care services will be shaped by people on the Isle of Wight through engagement, co-design, consultation, and co-production.
  - The redesign programme has worked with key stakeholders including Island residents in general to shape the future of services through:
    - Engagement – *Time to Act – Caring for our Island*, and a series of public meetings across each locality area resulted in 723 formal responses and public representatives actively engaged in every redesign working group
    - Co-production – providing opportunities for different groups and individuals to help shape the redesign of specific services
    - Consultation – asking the Island for their views on existing health and care services on the Island and the options for the future design of services.
10. These principles have been informed by a number of best practice examples, such as the *National Principles for Public Engagement in Wales; NHS Engagement Cycle* and examples from recent health and care redesign programmes including from Dorset and Eastern Cheshire.
11. The full details of evidence from this process are being collated and will be shortly published in the MLAFL Health and Care System Redesign Public Engagement Report (expected early July 2016).

### **Individual Needs Framework:**

12. The Framework criteria is based on the national Programme Assurance criteria (*Planning, assuring and delivering service change for patients* (NHS England, November 2015), the MLAFL 'I' and 'We statements' (which have been based on extensive public engagement) and the principles of *Making Safeguarding Personal*. The Framework has been used by the Redesign Working Groups to test emerging thinking, by the Professional Reference Group and the MLAFL/WISR Programme Board to assure the overall acceptability and coherence of the change proposals.
13. The Framework was produced by KPMG by analysing 27 existing local strategic reviews and reports from across health and social care, including national benchmarking and local Health Watch priorities. The key themes from these sources have been summarised and grouped into potential characteristics in the Framework.
14. This information has been triangulated with the outputs from 43 stakeholder engagement interviews where participants were asked to present their own views on care needs for the Island population, both professionally and as residents. The key themes from these discussions have also been summarised and grouped into potential characteristics in the Framework.
15. The key findings from this process and how they have informed the final content of the Framework are set out in the graphic below:



**Figure 1: Individual Needs Framework characteristics**

**Redesign process:**

16. Six focus areas for redesign were created based on analysis performance data, predictive demographics and public and professional stakeholder views. This data was combined with the local Joint Strategic Needs Assessment, Health and Wellbeing Strategy, Right Care “Where to Look” 2016 packs and existing local strategies to determine the most appropriate focus areas for redesign. These were:
  - Urgent and Emergency Care
  - Children, Young Persons and Families
  - Planned Care
  - Mental Health
  - Frailty
  - Long-term Conditions
17. Initiatives for service redesign were determined within the six focus areas. Each focus area had an associated working group that created initiatives based on input from the public, professionals and analytical modelling insights. To oversee the outputs of the Working Groups and ensure overall coherence of the proposals, a Professional Reference Group (PRG) was set up consisting of clinical and non-clinical professionals from across the spectrum of wellbeing, health and care services.
18. Public input (as described in the engagement section above) was gathered from a series of engagement events and each working group session included the latest views from these

activities to test and challenge working group thinking. This was in addition to the public membership on the working groups.

### ***Equalities, Safeguarding and Evaluation:***

19. The overall redesign proposals will be validated by an evaluation and assessment of the execution and outputs of the redesign process to be led by the MLAFL Evaluation workstream in conjunction with NHS England's New Models of Care Evaluation programme. A full Equality Impact Assessment (EqIA) will be undertaken and the proposals will be considered by both the Adult and Children's Safeguarding Boards as part of the Programme Assurance phase of the work.

### **The Vision for the Island's New Models of Care:**

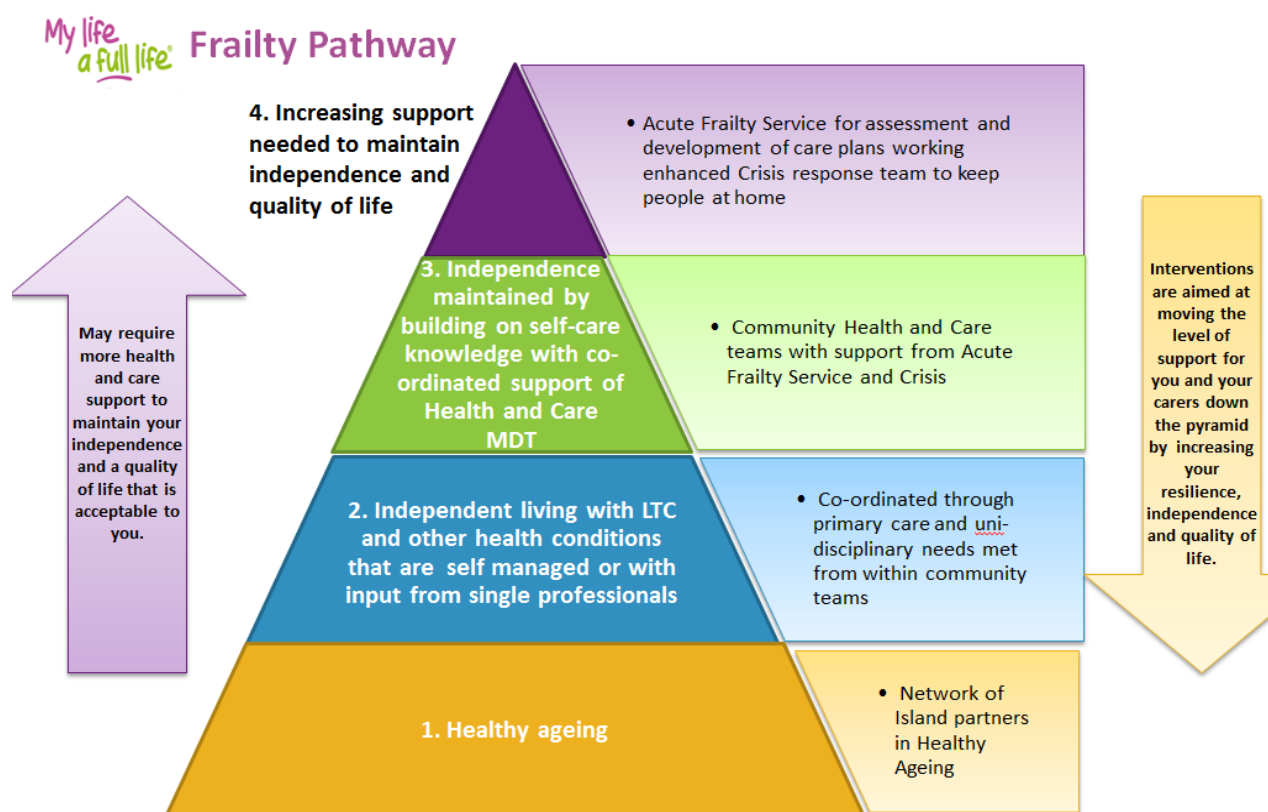
20. The new model of health and social care will transform our services from being reactive and orientated around organisations, to being proactive and orientated around the needs of the public. Care will be delivered as early as possible, through a variety of places and methods. It will be delivered by staff and volunteers who are empowered and supported to maximise the use of their own skills.
21. Building on the work of the My Life A Full Life programme, and aligned with the ongoing work of the Sustainability and Transformation Programme, this new model of care will help ensure the Island can sustain high quality services, secure best value for the Island pound, and position itself to tackle the challenges of an ageing population.
22. The foundations to the success of our care services in the future will be built upon enabling the Isle of Wight public to **proactively care for themselves and each other**. This approach will support 'activated' members of the public to take greater responsibility for keeping healthy and well while the care system will be designed to place prevention at its heart.
23. Greater availability of **community based support and education** will help the public identify and access low-level guidance quickly and effectively. Single points of access for services will help the public navigate support.
24. The **unparalleled contribution of carers** on the Island will be supported with a recognition and provision in services to help maintain their own health and well-being as a vital aspect to the care system.
25. The **voluntary and community sectors**, embedded within our communities, will among a diverse range of services provide peer support programmes, education and signposting to care options and importantly proactively identify and help intervene early for those that require care, particularly for the elderly and those with long term conditions.
26. Better and coordinated **use of technology** will help ensure information is readily available, those that seek help will find it easily, and that new options for care and self-help are publicised.
27. In addition to enabling the public to better care for themselves and each other, the ongoing role of patients and social care service users in the **design of future services** will be enshrined in how we transform services. The Isle of Wight public will be the driving force behind the development and maintenance of services on the Island, with the public voice central to shaping what is provided, how and where.

28. With the residents of the Isle of Wight supported to look after themselves as much as possible, care services will be **integrated and community based** to keep the public healthy and well, at home, for as long as possible. This includes full integration of health and social care services – the public will no longer see barriers and uncoordinated care due to organisational boundaries.
29. **Locality based teams** comprised of a diverse range of care professionals will coordinate, plan and proactively offer support. These teams will be both physical – providing face to face care across our three localities, and also virtual – working behind the scenes to share information and knowledge, ensure care is based upon individual need and delivered in the most convenient manner for the person.
30. Across our care system **staff will be empowered** to work at the top of their skills. They will make confident decisions, have access to rapid professional support where needed, and do everything they can to proactively prevent the exacerbation of conditions or cause unnecessary delays in the delivery of care.
31. A dynamic and diverse array of care services will be provided across the Isle of Wight – a model unique to our Island. With our strong and enviable community infrastructure the skills, reach and capacity of our **voluntary and community sector partners** will see innovative approaches emerge to support our population. This will be particularly focused upon peer-centred support and the deep insight third sector partners can bring to the management of long term conditions and enduring needs.
32. **Mental health services will be integrated** with physical health and social care services with the same preventative and proactive approach taken. Low and higher level mental health services based in the community will encourage anyone with mental health needs or concerns to seek early support without stigma or unnecessary barriers.
33. **Primary care will remain at the heart** of each community's health services, working in conjunction with locality based teams to provide advice, guidance and treatment. Support will be signposted to community based alternatives where available and appropriate. More complex needs will be coordinated working in conjunction with the patient, to ensure they are in the best possible position to benefit from specialist input.
34. Where specialist, more complex support is required **hospital services will be delivered in new ways**. Utilising technology and supported, empowered staff, more complex care services will come out from behind the hospital walls with specialist staff working along-side community based professionals.
35. With hospital staff and services reaching out via locality teams to support the population staying healthy and well at home for as long as possible, a visit to the hospital will only be for when the care required can't be delivered safely elsewhere. This will help ensure **hospital services are focused on those that need it most** is accessed rapidly and is of the highest quality.
36. **Urgent care services will be supported primarily via locality teams and associated community services**. However when specialist input is required immediately, A&E triage will direct the public to the most appropriate care professional and service, and pre-defined ambulatory care pathways will ensure rapid assessment, diagnosis, treatment and discharge back to the most appropriate setting – in most instances this being the normal place of residence.
37. Where needed to bolster capacity and capabilities, **formalised networks of professionals will provide more complex care**. This will see in some cases care delivered on the Island by external professional staff (both physically and virtually), as well as Isle of Wight patients and staff travelling to the mainland where specific services cannot be safely or sustainably delivered on the Island.

38. **Partnerships between the hospital and other complex care providers** will help underpin the future of these services on the Island. They will bring access to new technologies and help us develop a dynamic environment to attract and retain staff. Working in conjunction with a revitalised community-orientated care system these partnerships will help ensure the Island can provide access to the best care possible.

#### **The New Models by thematic area:**

39. **Frailty:** The Frailty redesign proposals have been developed by considering a stepped care approach and are set-out in figure 1. The MLAFL principles have been applied to develop an approach to services which spans:
- a. **Healthy ageing:** promoting healthy ageing in supportive communities through a network of Island partners providing access to community-based resources and a directory of service.
  - b. **Independent Living:** an open community based living environment for frail individuals and those living with dementia providing the ability for step-up and step-down of care within one environment.
  - c. **Community Health and Care Teams:** integrated teams of professional and non-professional community staff able to identify functional deterioration, perform timely, relevant assessment of need with the aim of developing plans with the person to promote self-care, plans for escalation of care, for appropriate onward referral for specialist advice (housing, legal) and for referral to specific speciality diagnostic pathways and anticipatory care plans for end of life care (EOLC) as appropriate.
  - d. **Acute Frailty Service:** specialist frailty services that will support community services to provide assessment, diagnostic and treatment of people who are deteriorating and at risk of admission and permanent reduction in function and quality of life. A centrally located service will provide outreach to support locality community and crisis services with complex, frail people who have had a sudden change in function or who are presenting with a slow decline of unknown cause that is putting them at risk of sudden change and hospital admission. The Acute Frailty Service would provide a “one-stop-shop” for developing single care plans and the appropriate location and mode of care across the spectrum of need. The service will comprise: Ambulatory Care; Rapid Outpatient review and Day assessment (in MAU or frailty unit) and inpatient beds.



**Figure 2: Frailty Pathway**

40. **Urgent and Emergency Care:** The vision (see Figure 3) is to fundamentally reduce reliance on acute hospital admissions by focusing on: targeted individual care planning for people who are frail and/or have complex care needs; developing a robust Urgent Care triage and signposting 'Front Door'; and rapid access to a 'one stop shop' same-day investigations and treatments. The future service will comprise:
- Future-proof primary care provision:** Envisages new structures across GP practices (e.g. federated/ super-practices/ smaller practices supported by community teams/ shared GMS) and new incentives systems based on outcomes and shared responsibility to sustain primary care.
  - Primary and Community Care Capacity:** Integrated Multi-Disciplinary Teams (MDTs) will share information on the most complex patients with case management to allow people to get home as soon as they are able to. It will be delivered using a virtual "Hub" approach.
  - Urgent Care Service:** Each entry point will include triage with a disposition to signpost patients to appropriate services .GPs will triage via 111, this will reduce attendances and improve GP capacity and provide alternatives to the Beacon Centre.
  - Default Ambulatory Care in the Emergency Department:** For all conditions in the ambulatory care handbook, providing a "same day service" to reduce admissions from urgent/emergency attendances.





**Figure 3: Vision to reduce dependence on hospital services**

41. **Mental Health:** The Mental Health proposals should be considered in conjunction with those in Children, Young People and Families where the priority areas relating to preventing mental ill-health (emotional wellbeing and resilience) and early intervention for young people's mental health and wellbeing feature. The commitment is to support and use those in recovery and with lived experience to help support and deliver services in both community and inpatient settings where there is demand. The role of those in recovery and with lived experience could also be to encourage people and service users to get access to the right services, to get the most out of current services and to build resilience. The overall ambition is to increase prevention, access and early intervention including support in times of crisis. The key proposals are:
- Integrated Health and Social Care Single Point of Access (SPOA):** Bringing together these separate systems will provide system efficiencies and ensure a more appropriate and targeted response for service users. It will provide quick and easy access to treatment for people when they first become unwell and reduce the likelihood of a more chronic and debilitating illness.
  - Serenity Safe Haven:** This will provide alternative places of support and safety during times of crisis for those with mental health needs out of hours. It will offer police and ambulance staff a 'first port of call' for any person in crisis as an alternative to the use of Section 136 powers and use of Sevenacres and the Emergency Department as a place of safety.

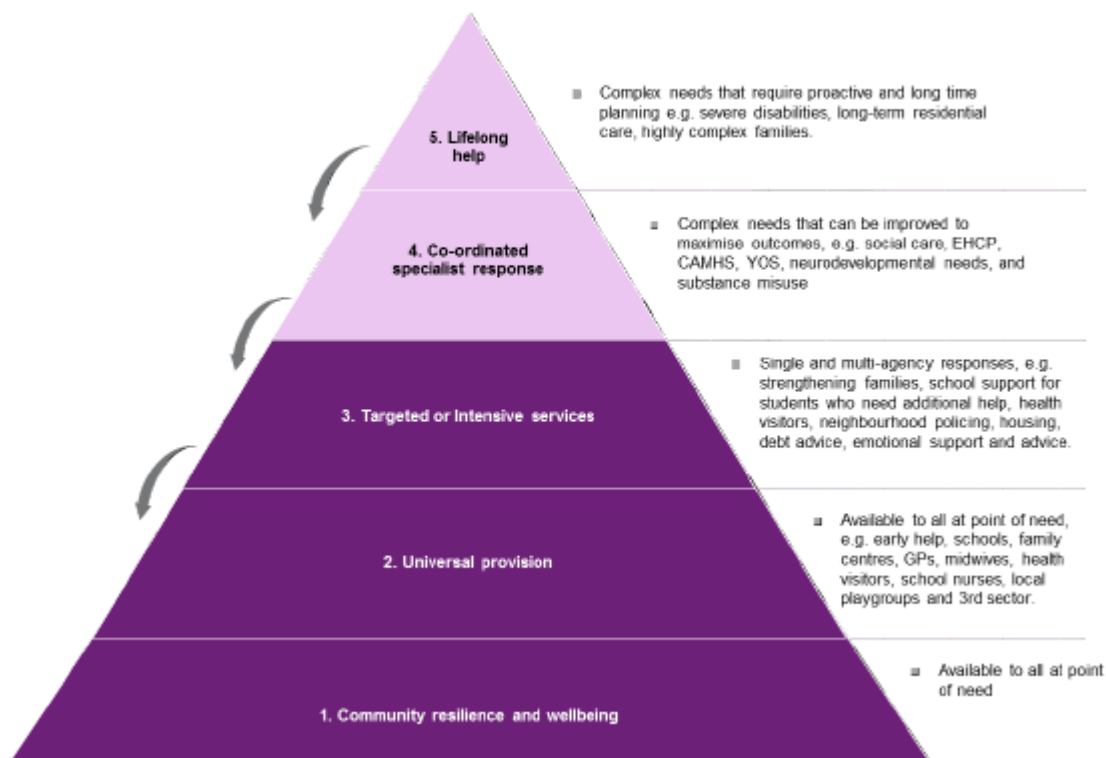
- c. **IAPT Plus:** Increased Access to Psychological Therapy for people with a Severe Mental Illness (IAPT for SMI) by moving to a stepped care model will reduce the current waiting times by addressing the more complex needs of people waiting to access the service. This will reduce emergency attendances and crises.
  - d. **Complex Needs Service:** Develop a Complex Needs (Personality Disorder) Service, including a long term vision to support the repatriation of mainland placements.
42. **Planned Care:** The vision (Figure 4) for Planned Care is to ensure that people are receiving the right care at the right time in the right setting by ensuring that everyone providing these services is working at the optimum of their skills and competencies ('working at the top of their license'). The core elements of the proposals are:
- a. **Enhanced roles for practitioners:** Developing enhanced roles for some practitioners, such as physiotherapists will enable them to take on more responsibility such as providing musculoskeletal assessments and care
  - b. **Transforming Outpatient Services:** Developing a one stop clinic by carrying out assessment and treatment on the same day will reduce the need for people to come back for unnecessary follow up appointments after an operation or procedure.
  - c. **Strategic decisions about the sustainability of acute services:** A clear set of options and recommendations are being developed considering the range of acute services which should remain on the Island cohesively linked through a network of complex care provided off-Island. As happens now, if some specialist care is provided off the Island, people's ongoing care needs should be provided here. This will entail expanding the use of video link and telehealth to maximise the use of digital supports to provide access to off-Island expertise as appropriate.
  - d. **Leading edge elective care:** The aim is that the Island will continue to provide leading edge elective care in the areas where there is the greatest needs, for example



in orthopaedics and to treat people as a day cases avoiding overnight stays where possible.

**Figure 4: Planned Care Pathway**



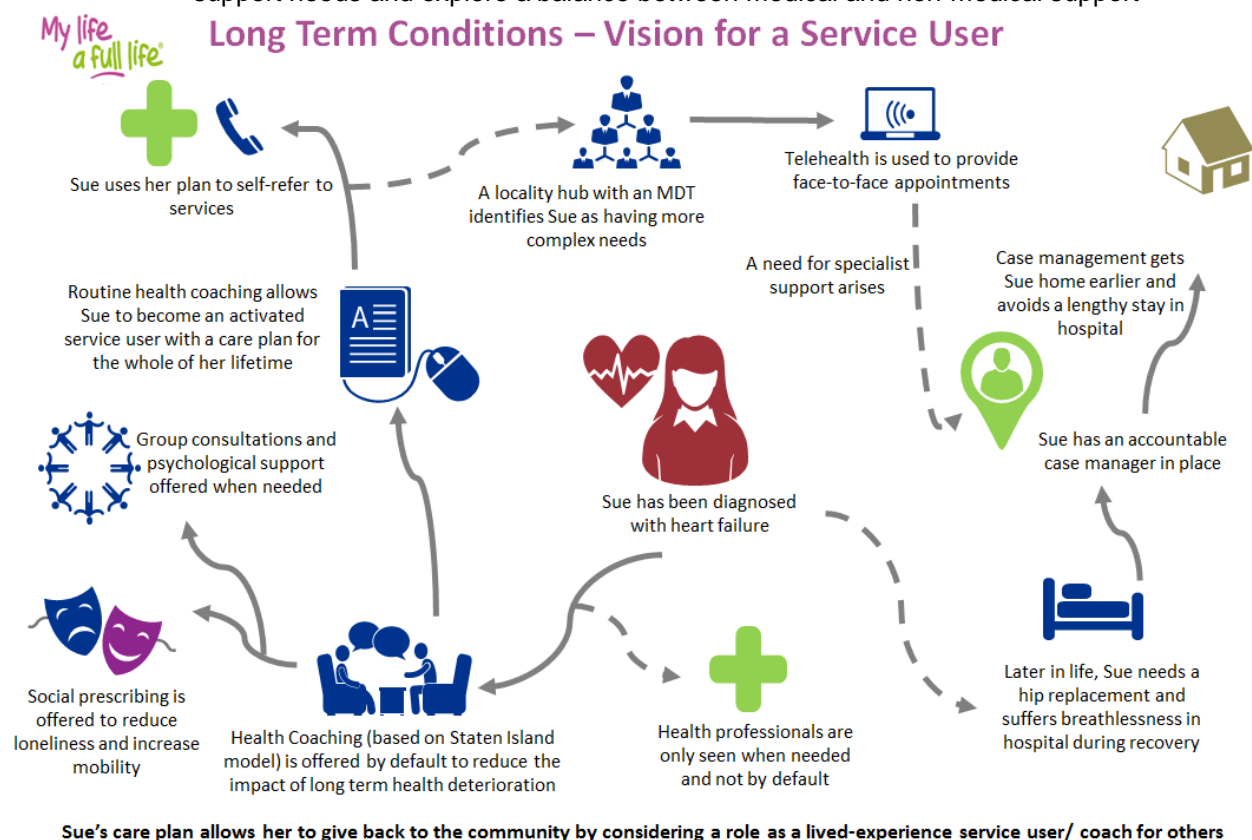


**Figure 5: Children, Young People and Families stepped care model**

43. **Children, Young People and Families:** The vision for children and young people is that they should have access to the right care at the right time in the right setting (see Figure 5). The key elements of these proposals are:
- Emotional wellbeing and resilience (Earlier access and intervention for young people's mental health needs):** The vision is to improve mental health and wellbeing and increased resilience by encouraging a culture shift towards prevention and self-care, informed choices and access to technology.
  - Integrated service for Autism and Attention Deficit Hyperactivity Disorder (ADHD):** The vision is to provide an integrated assessment, treatment and support service in the community for children, young people and adults with autism (ASD) and attention deficit hyperactivity disorder (ADHD).
  - Paediatric Assessment Unit (PAU):** The vision is to develop a unit to alleviate the need for avoidable paediatric admissions, as a result of children presenting with urgent or emergency care needs at A&E. The aim will be to develop the locality Community Service to increasingly provide the capability to meet the ongoing needs of children and young people via the PAU.
44. **Long-Term Conditions (LTC):** The vision for the future service user journey through the long term conditions (LTC) service is set-out at Figure 6. The key components of the proposal are:
- Local Wellbeing Planning Model:** will provide a single approach to care planning across for medical and social care. It includes advanced personalised care planning (including end of life care), self-assessment and monitoring and the provision of a comprehensive directory of services and is linked to the development of support

groups and networks and behavioural approaches to supporting people to cope with long term chronic illnesses.

- ii. **Social and Psychological Support:** Use of telehealth, focus on social prescribing, encourage self-management and provide co-ordinated care that allows people to remain in their communities.
- iii. **Health coaching:** to support people with LTCs and their carers to choose their support needs and explore a balance between medical and non-medical support



- iv. **Locality Hubs:** Community teams to support the most vulnerable with help to get back home after a visit to hospital

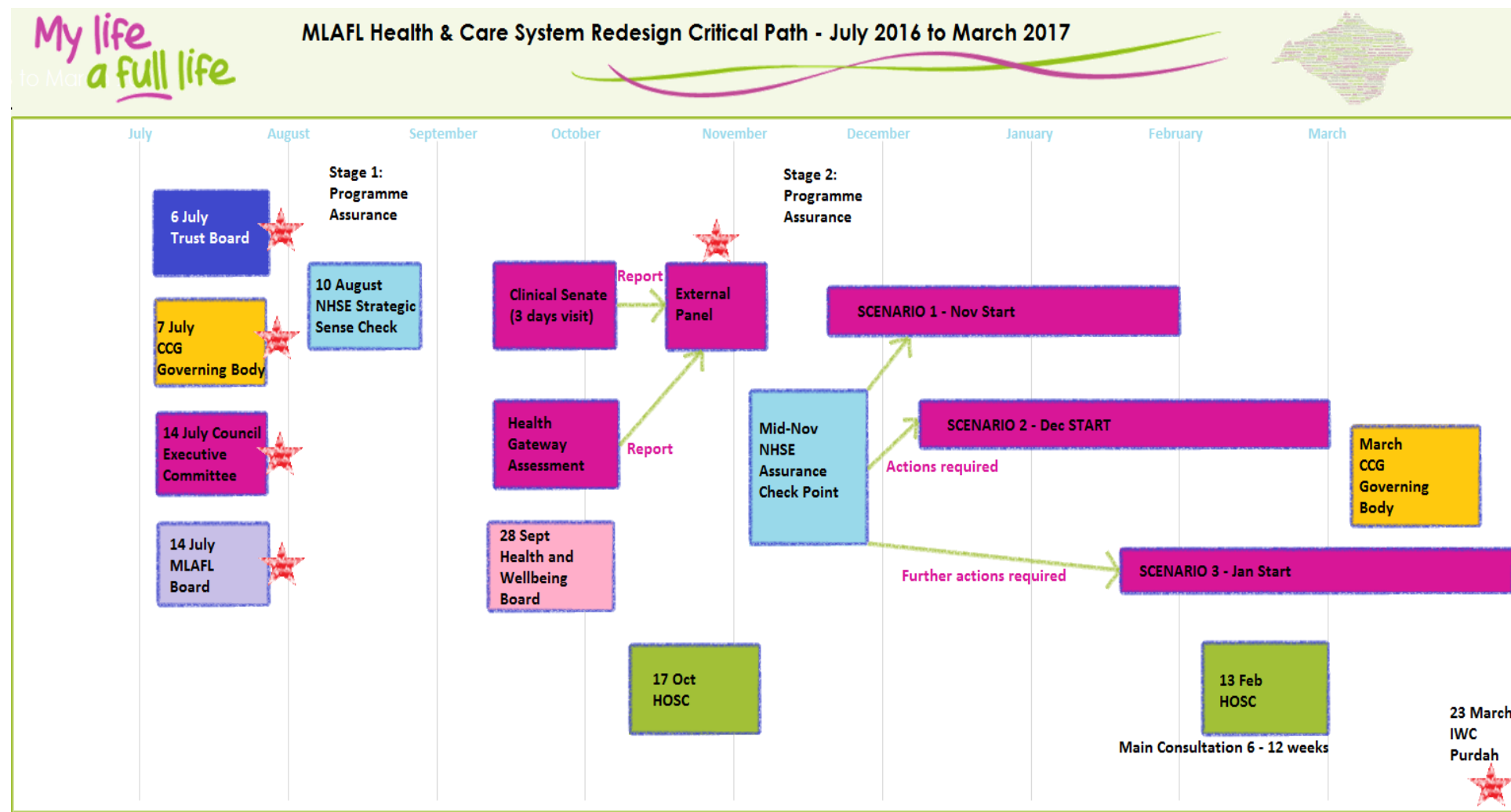
**Figure 6: Long Term Conditions – vision for service user journey**

#### Next steps:

43. The final draft PCBC will be submitted to NHS England on 22<sup>nd</sup> July when it has received the necessary local governance approvals. The proposals will be tested against four key Programme Assurance tests to ensure that they have been developed with:
  - Strong public and patient engagement
  - Consistency with current and prospective need for patient choice
  - Clear clinical evidence base
  - Support for proposals from Commissioners
44. The PCBC will be formally reviewed by NHS England at the Stage 1: Strategic Sense Check meeting on 10<sup>th</sup> August. The purpose of this meeting is to consider the overall strategic direction, to consider the level of change proposed and to agree the steps that will be needed and the support offered in developing the proposals.

45. As the PCBC includes redesign proposals which will require significant service change, it is likely that a formal Public Consultation process will be required towards the end of 2016. In order to move to Public Consultation, the PCBC will need to be worked up over a series of iterative steps during the summer and autumn months to develop more detailed proposals. Locally, these final proposals will need to be approved by the Trust Board, the CCG Governing Body, IW Council Executive, the IWC Health and Adult Social Care Scrutiny Sub Committee and the Health and Wellbeing Board before being submitted to NHS England for the consideration at the Stage 2 Programme Assurance Checkpoint (October/November) which is the final gateway that needs to be cleared in order to proceed to Public Consultation.
46. The milestone plan for managing the Programme Assurance process is set out at appendix 1.

## Appendix 1:



**IMPORTANT COVER NOTE: This is a first draft of the pre-consultation business case.**

The below text, emailed to the WISR Chair and Programme Director, provides context and important caveats regarding this document.

"Please find attached a first draft of the pre-consultation business case. As mentioned in our conversations over the past week, this is an incomplete draft and has some significant caveats around it.

- Overall:
  - We haven't finalised formatting and there remain some consistency issues we have not yet addressed.
  - We have not included any appendices, for example the Strategic Outline Business Cases. These have been labelled as 'Appendix x' in the attached document and will be added in at a later draft stage.
  - There are a few figures / diagrams that are incomplete, for example the 'future' and 'current' state case studies in Section 7.
- Financial impact:
  - A number of proposed initiatives have not been modelled as key impact assumptions are still not fully determined. These are:
    - Complex needs service
    - Social support
    - Supporting primary care
    - Service line reconfiguration
    - Dementia care
  - While the financial baseline has been signed-off by the Finance Directors at the CCG, Trust and Council, the assumptions have not yet been signed-off. We are in the process of doing this in the latter part of this week and early next week.
  - Not all social care financial impacts have yet been modelled due to either missing data and / or lack of impact assumptions.

In terms of next steps, we will have a revised draft pre-consultation business case next Thursday, 7<sup>th</sup> July."

# Isle of Wight

## Whole Integrated System Redesign

### Pre-Consultation Business Case

<b>Version Number</b>	Draft – v1.00
<b>Programme Phase</b>	Pre-consultation
<b>Contact for Information</b>	James Seward (Programme Director)
<b>Date of version publication</b>	30 <sup>th</sup> June 2016



## Table of contents

1.	Foreword .....	1
2.	Introduction.....	3
2.1	About My Life A Full Life	3
2.2	About the Whole Integrated System Redesign programme	5
2.3	Purpose of the pre-consultation business case	5
2.4	Approach to developing the pre-consultation business case	5
3.	An overview of the Isle of Wight.....	7
3.1	Demographics overview	7
3.2	Population health needs	8
3.3	Public expectations of health and social care	8
3.4	The current provider landscape and quality of care	10
3.4.1	Primary care	11
3.4.2	Community and Mental Health services	11
3.4.3	Acute care	12
3.4.4	Social care	15
4.	Case for change .....	17
4.1	The demand for health and social care services in the future	17
4.2	The challenges around workforce	<b>Error! Bookmark not defined.</b>
4.3	The growing financial challenge	19
5.	Approach to public engagement and involvement.....	22
5.1	Communication and public engagement	22
5.2	Engagement with groups with protected characteristics	23
5.3	Rate of response to public engagement	24
5.4	Outcomes of public engagement	24
5.5	Co-production	25
6.	Redesign approach and timeline.....	27
6.1	Working groups	27
6.2	Professional and public input	28
7.	Our new model of care.....	30
7.1	An overview of the new model of care	30
7.2	Principles of the model of care	31
7.3	Patients, public and carers – opportunities and responsibilities	32
7.4	Community based services – prevention and proactivity	33
7.5	Specialist and more complex care – high quality, sustainable and affordable	34
7.6	New models of care: Mental Health	35

7.6.1	Improved single point of access	37
7.6.2	Alternative places of support and safety during times of crisis for those with Mental Health needs	37
7.6.3	Increased Access to Psychological Therapy for people with a Severe Mental Illness (IAPT for SMI)	38
7.7	New models of care: Long Term Conditions	39
7.7.1	Health Coaching and Service User Activation	41
7.7.2	Co-produced Wellbeing Planning	42
7.7.3	Locality Hubs	42
7.8	New models of care: Children, Young People and Families	43
7.8.1	Reduced admissions through community working and Paediatric Assessment Unit (PAU)	45
7.8.2	Emotional Wellbeing and Resilience (Earlier access and intervention for young people's mental health needs)	46
7.8.3	Integrated service for Autism and ADHD	47
7.9	New models of care: Frailty	48
7.9.1	Islands Partners in Healthy Ageing	50
7.9.2	Community Health and Care Teams	50
7.9.3	Acute Frailty Service	52
7.9.4	Inpatient dementia solution	53
7.10	New models of care: Planned Care	54
7.10.1	Enhanced Role for Practitioners	55
7.10.2	Transforming Outpatient Services	56
7.10.3	Strategic Decisions about Sustainability of Acute Services	57
7.10.4	Leading Edge Elective Care	58
7.11	New models of care: Urgent and Emergency Care	59
7.11.1	Co-ordinated Urgent Care Service	60
7.11.2	Default Ambulatory Care in the Emergency Department	61
7.11.3	Community and MDT Case Management	62
7.11.4	Primary care support	62
7.12	Summary of WISR initiative benefits	63
8.	Future service financial model .....	65
8.1	Our approach to quantifying the challenge	65
8.2	Our approach to analysing the redesign initiatives	65
8.3	Summary of overall financial impacts	66
8.4	Impact on the 'wicked issues'	68
8.5	Contribution to addressing the overall system gap	70
9.	Governance and assessment against the four tests.....	73
9.1	Governance arrangements	73
9.2	The 'four test' review	74



9.3	Equality impact assessment	76
10.	Next steps: public consultation.....	77
10.1	The consultation process	77
10.2	Results analysis and feedback	79
10.3	Decision-making process	80

DRAFT



## 1. Foreword

The importance of this document should not be underestimated. It is the outcome of six months of intensive work that has the potential to change the Island's health and social care services for years to come. It has been produced through the My Life A Full Life programme by an alliance of NHS and Local Authority service providers and commissioners along with voluntary sector and private sector partners. It is an important step in addressing the significant challenges the Isle of Wight currently faces in order to secure high quality, sustainable services long into the future.

The Isle of Wight has a problem: the ways in which we deliver our health and social care services were designed for a different era. Our outdated approach is struggling to meet current demand and cannot be sustained for much longer. This is not unique to the Island – it is a national issue – but there are aspects of Island life that amplify these pressures and make our challenges greater than many places in the UK.

In order to address these pressures on health and social care, key organisations on the Island have secured government funding to undertake a Whole Integrated System Redesign (WISR) as a part of the My Life A Full Life programme. This document is the central outcome of the WISR process. It is the first draft of a 'blueprint' for how we will care for people in the future.

This 'blueprint' has been developed through the hard work and ongoing engagement of more than 160 health and social care professionals and comments and involvement from over 700 members of the public. The details around these stakeholders' ideas will evolve over time as the My Life A Full Life team undertake an external assurance process and further engagement with key stakeholders while working towards a formal public consultation in the New Year. However, the core principles are now clear and need to be shared to ensure that this work has correctly captured and refined the ideas and issues of all those that have been involved in the work so far.

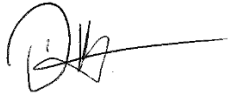
At the heart of this work is the belief that when Islanders and our visitors need help they should get the right care, in the right place, at the right time. At those times, the people being cared for, and those who care about them, should feel supported in each step of their care journey and respected as people and individuals at all times. But more than that, we want everyone – even the most vulnerable people in our communities – to enjoy fulfilling lives with good health and a positive sense of wellbeing. That is the aim of My Life A Full Life.

Achieving this will not be easy as we face many challenges. While much good work goes on here and many areas are working well, the system is struggling to cope under new pressures. These pressures and the ways in which the Island can tackle them are explained in this document.

The suggested solutions found in this document reflect a central vision formed through work with people across the Island. It is a vision of a person-centred approach looking at the whole person with an emphasis on prevention. It requires that when additional care is needed it will be seamlessly co-ordinated and flexibly delivered to enable self-help and support people to spend as much time as possible in their homes and communities with their loved ones.

This vision holds the answers to many of the issues we face and will improve the quality of care for many people across the Island. It also unlocks existing potential so that we can make the most of current resources to deal with the growing needs of our population. This is both a challenging and exciting time for health and social care on the Isle of Wight and I would like to thank all those who have contributed to developing this vision for the future. I look forward to continuing to work with you to see these ideas and our services evolve to meet its high aspirations months and years to follow.

**Signed**



Dave Newton

**Chair, the WISR Programme**

DRAFT

## 2. Introduction

The Isle of Wight is the largest island in England. It is situated around six kilometres off the coast of Hampshire, separated from the mainland by the Solent. The Island has a population of approximately 140,000 that is expected to grow to 146,000 within the next ten years, with significant growth in the population aged 65 or over. This will place additional pressure on the ability of the existing health and social care system – which is already under significant strain – to deliver sustainable services.

Specifically, the Island's health and social care system faces existential challenges to maintain financial balance across the care system, to sustain a workforce that can deliver services required by the population and to effectively manage forecast demand for existing services.

This pre-consultation business case proposes a set of future of health and care services for the island. These proposals have been created through a Whole Integrated System Redesign (WISR) programme that sits within a wider NHS Primary and Acute Care System vanguard on the Island known as My Life A Full Life (MLAFL).

The initiatives developed through the WISR programme to tackle the key issues for health and social care services have been developed with input from across the NHS (including acute, community and voluntary services), social care, the voluntary sector and the local GP Federation. They have also been co-produced with the public.

This report outlines all the initiatives that have been developed for service redesign. It is not expected that all of these initiatives will require formal public consultation. The decision on those that do require formal public consultation will be determined in July 2016.

### 2.1 About My Life A Full Life

The My Life A Full Life (MLAFL) programme was established in 2012 and is a collaboration of health, care and voluntary sector organisations looking at new ways to deliver health and social care services on the Isle of Wight. It aims to improve the lives of people needing care and support, and help them take control of their own health, wellbeing and care.

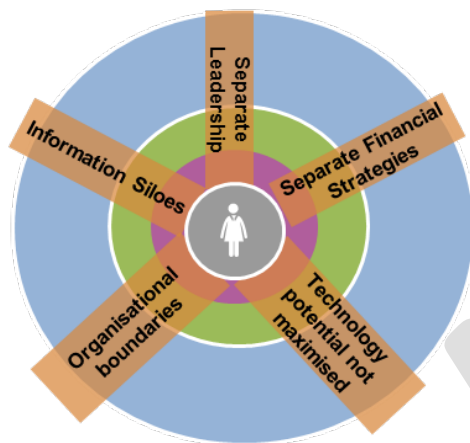
MLAFL is working with the Island community to develop initiatives with people at the centre of their health, wellbeing and care. Greater integration will enable the team to work more effectively, deliver a more coordinated approach to health and social care services and plan for increasing demands in the future.

The new care model development of MLAFL aims to improve the health and wellbeing of the island population, improve care and quality outcomes, deliver appropriate care at home and in the community and make health and wellbeing clinically and financially sustainable. This process provides an opportunity for a radical paradigm shift in thinking and approach to delivering effective health and social care interventions to residents.

### Current care service delivery model

Currently, there is a larger reliance on statutory services (outer rings). Our model has been:

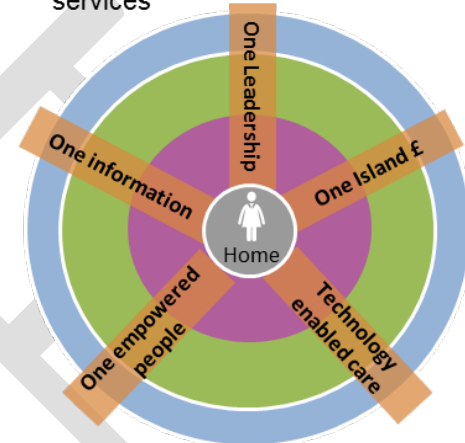
- Episode based
- Unintegrated and disjointed
- Expert led
- Does not give flexibility for where people are treated
- Financially & clinically unsustainable



### Future care service delivery model

People will have greater involvement with their associate life and family/friends (inner rings). Our co-produced new care model:

- Builds on assets & mobilises social capital within communities
- Integrates services
- Is based in the community / at home
- Is a significant shift to prevention
- Reduces reliance on statutory services



**Figure 1: The MLAFL Vision for the future of health and care on the Island**

MLAFL has embarked on an ambitious programme of systemic transformation where residents will have much greater support from their community, family and friends, as it seeks to:

- Build on assets and mobilises social capital to help reshape care delivery to meet people's changing needs
- Integrate services to improve quality and increase system efficiencies using technology as the key enabler
- Be based in the community / at home
- Promote a significant shift towards prevention and early intervention, self-help/care, with the aim of reducing health inequalities and the health and wellbeing gap
- Reduce reliance on statutory health and care services

MLAFL consists of ten main areas of focus, or workstreams, of which the WISR programme is one. The workstreams are:

1. Prevention and Early Intervention
2. Whole Integrated System Redesign (WISR)
3. Integrated Locality Teams

4. Integrated Access
5. Workforce Development
6. Communications, Engagement and PMO
7. Strategic Commissioning
8. Information Technology and Estates
9. Organisational Integration and Form
10. Performance Monitoring and Evaluation

## **2.2 About the Whole Integrated System Redesign programme**

The WISR programme was initiated as a MLAFL workstream to build on and support work to achieve a redesigned care system that is sustainable and delivers care excellence for the Island over the next ten years and beyond.

The WISR programme aims to make changes to the Island's health and care services, and these are being shaped by people on the Isle of Wight through consultation, engagement and co-production:

- Consultation – asking Island residents for their views on existing health and care services both on and off the Island, and the options for the future design of services.
- Engagement – establishing a dialogue with Island residents and staff on how best to shape services around their needs.
- Co-production – providing opportunities for different groups and individuals to proactively help shape the re-design of specific services, through participation in working groups and focus sessions.

The scope of the redesign includes health, social care services, commissioned public health services and related voluntary sector services across the whole integrated system. This takes into account the whole patient pathway including prevention, community healthcare, social care, primary and secondary care.

The WISR programme also supports and is supported by the other nine MLAFL workstreams and includes activities beyond the scope of this document relating to future commissioning strategy and provider market engagement.

## **2.3 Purpose of the pre-consultation business case**

The purpose of this pre-consultation business case is to support preparation for the NHS England assurance process required prior to public consultation on the proposed model of care delivery covered by the initiatives in this report. This pre-consultation business case includes potential options for service change that are feasible, affordable and likely to bring about enhanced value for money to the local health economy, including providers and commissioners.

## **2.4 Approach to developing the pre-consultation business case**

This document is the pre-consultation business case for the MLAFL approach to service redesign on the Isle of Wight. It outlines the approach that has been taken and is continuing for decision making and governance arrangements relating to service redesign.

The MLAFL programme took the decision for the WISR programme to involve and engage local stakeholders and residents from the very beginning of the redesign process. This resulted in a local engagement exercise that began in March 2016 and is still ongoing as at the time of pre-consultation business case publication (August 2016).

The WISR Programme has planned for continued engagement with stakeholders, including the public, beyond the date of this report. During the NHS England assurance process, the views of the public and staff will continue to be gathered until the start of the formal public consultation at the end of 2016.

This pre-consultation business case will be discussed formally by the IoW Council Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee (HOSC), the Isle of Wight NHS Trust Board, the Isle of Wight CCG Board and the MLAFL Board. Discussions will culminate in a decision – to be made on 21<sup>st</sup> July 2016 – as to which service redesign initiatives from this report require formal public consultation against relevant statutory definitions of major service change.

DRAFT



### 3. An overview of the Isle of Wight

#### 3.1 Demographics overview

The population of the Isle of Wight, which is around 140,000 at the moment, is expected to grow to around 146,000 by the year 2024/25. The age profile of the Isle of Wight is significantly higher than the England average: 26% of the population are over 65, compared with 18% nationally. By 2025, almost one in three of the Island's residents will be over 65, compared to under one in five nationally.

Over the same period, the Island's working age population is expected to decline marginally by 0.11%, while the child population will stay almost the same, growing by 0.7%.

Generally, the Isle of Wight experiences better than average social and economic conditions when compared to England as a whole (in 2014 there was a 14.7% deprivation rate compared to 20.2% for England). Having said that, there are several areas on the Island, like Newport, Ryde and Ventnor, where deprivation is much more prevalent and is among the worst in the country. When compared to the rest of south-east England, the Island as a whole is relatively more deprived.

Life expectancy on the Island is broadly in line with the rest of England for men (79.8 years compared to 79.5 nationally) and women (81.5 years compared to 83.2 nationally). Child mortality is significantly below the national average at two per 1,000 a year, compared to four per 1,000 nationally.

The population of the Isle of Wight is presented in the table below.

Group	2014 population ('000)	2024 population ('000)	Annual growth %	England annual growth %
Children (0–19)	28.6	28.8	0.07%	0.70%
Adults (20–64)	74.6	73.8	-0.11%	0.28%
Elderly (65+)	36.3	43.3	1.78%	1.94%
<b>Total</b>	<b>139.5</b>	<b>145.9</b>	<b>0.45%</b>	<b>0.69%</b>

**Table 1: Isle of Wight population – 10-year forecast (source: ONS)**

A breakdown of population by age-group is presented below.

Group	Island age split 2014 (%)	England age split 2014 (%)	Island age split 2024 (%)	England age split 2024 (%)
Children (0–19)	21%	24%	20%	24%
Adults (20–64)	53%	58%	50%	56%
Elderly (65+)	26%	18%	30%	20%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

**Table 2: Isle of Wight demographics (source: ONS)**



## 3.2 Population health needs

In a lot of areas the Isle of Wight has greater health challenges than other parts of the country. Many of these are linked to the above-average older population, and others are linked to lifestyle factors.

With old age comes the increased likelihood of long-term conditions and frailty. These lead to an increased prevalence of conditions like chronic heart disease, stroke and dementia, all of which are above the national average on the Island (and in the case of dementia, almost twice the national average). Given the forecast increase in the elderly population, the prevalence of these and similar diseases is likely to increase.

Diabetes prevalence is also marginally higher than the national average, along with cancer and childhood obesity. Although smoking rates on the Island are noticeably lower than the English average, the prevalence of smoking while pregnant is considerably higher.

In terms of Mental Health, there is a higher than average proportion of individuals with a diagnosed condition on the Island. This in turn translates to higher rates of both suicide and self-harm.

	Year of Measurement	National prevalence	Isle of Wight Prevalence
STIs	2014/15	0.83%	0.51%
Cancer (all types)	2014/15	2.30%	2.90%
Chronic heart disease	2013/14	3.30%	4.00%
Diabetes	2013/14	6.20%	6.40%
Chronic Obstructive Pulmonary Disease	2014/15	1.80%	1.90%
Self-harm	2014/15	0.19%	0.20%
Stroke	2013/14	1.70%	2.40%
Smoking	2014	18.00%	16.20%
Childhood obesity (year 6)	2014/15	19.50%	20.50%
Alcohol related admissions (all)	2013/14	0.37%	0.29%
Alcohol related admissions (under 18)	2013/14	0.04%	0.09%
Individuals with a Mental Health condition	2014/15	0.88%	1.10%
Adults with a learning disability	2013/14	0.41%	0.65%
Adults with a physical disability	2013/14	0.46%	0.45%
Dementia	2014/15	0.74%	1.37%

**Table 3: Isle of Wight disease prevalence (Public Health England , n.d.)**

## 3.3 Public expectations of health and social care

Since its inception, the MLAFL programme has spoken with the public to understand the service changes they'd like to see. At a series of workshops in 2013<sup>1</sup>, people told the

<sup>1</sup> National Development Team for Inclusion, MLAFL: An overview of the early stages of the programme.

programme where they wanted to see visible change and improvements in care. These have formed the founding principles of what the MLAFL programme aims to deliver for the people on the Island.

**“We should be empowered and responsible”**

- Health should be taken more seriously. There needs to be the right local information available to make healthy choices, and find help and advice when it is needed.
- For long-term conditions the public should be able to manage them themselves with support from peers (or expert patients) so they know when to get professional help. And should value the role of carers and help them carry out their roles with information and practical support.
- The public should be able to express their views knowing they are at the centre of local service planning and delivery. There should be joint health and social care personal budgets which give greater choice and control. There should also be investment in integrated, digital healthcare records to allow information to be shared across certain providers.
- Communities should be supportive places for older people and people with long-term conditions – neighbours and local businesses should notice and step in if people are in danger of becoming isolated.

**“Healthcare should be within the community”**

- There must be simple and clear access to services, 24/7. And all services should promote wellbeing and independent living, working to avoid crises. If there is a crisis, health and social care staff should respond quickly to resolve it, then make sure the person involved is able to return to independence as soon as possible.
- Integrated services should be based in community hubs that bring together the whole range of health and social care staff. And these staff should work in equal partnerships with voluntary organisations, with primary care at the centre.
- Multidisciplinary team meetings can help make sure departments share information, and build knowledge and understanding of what integration really means in practice. And multidisciplinary local teams know their local population and the services that exist in each community. So they can provide a genuinely people-centred service.
- Pathways through services must be clear and go beyond health and social care services to involve both traditional and non-traditional services. This could include (for example) voluntary organisations, housing and the fire service. And while the hubs are the focus of many services, staff should spend time in the community, giving care both in people's homes and also in places like parish halls, sheltered housing or local pubs.
- Ways of working must be streamlined to make them more efficient and minimise duplication and bureaucracy. For example, a single assessment process is already in place, which can be used by any professional and will be trusted by others.

**“Infrastructure must support integration”**

- Commissioning should be completely integrated, based on a shared vision and priorities across organisations. And budgets should be pooled, which means no more disputes about who's responsible for funding.

- It should be easy to share data across organisations, so IT systems must interact with each other. These systems should also be designed around the needs of people who use them. And performance metrics should be shared.
- There must be good quality training on My Life a Full Life values and principles right across the system. It's an important way of strengthening the team approach, especially for multidisciplinary teams.
- My Life A Full Life must have the support of leaders across the partner organisations, including a strong political commitment.

**“There is a need for a culture that drives change”**

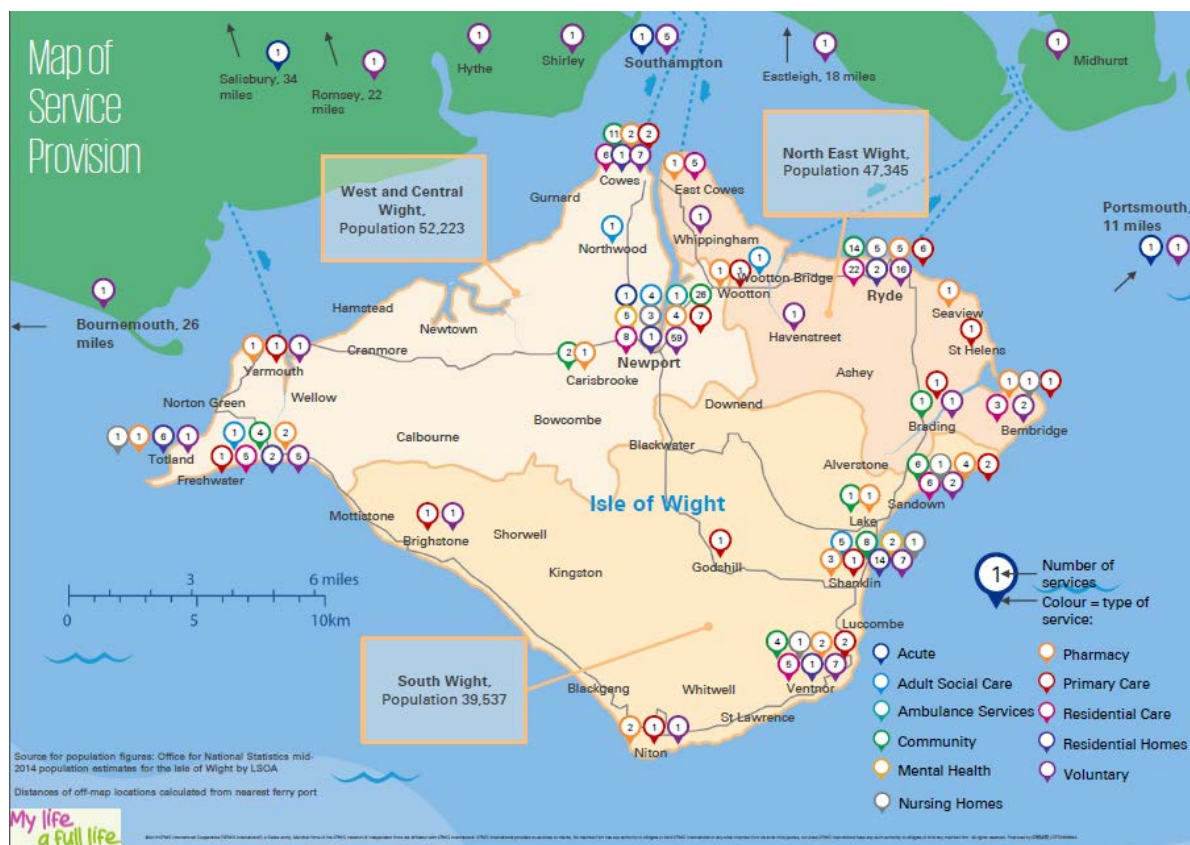
- Different professional groups must trust each other and value all contributions. To do this, relationships between groups must be based on equality. And they should all show this trust, value and equality when working with people.
- Communication between professional groups and different parts of the system (for example between primary and secondary care) should be open. All staff, service users and the wider community should understand the reasons for the change and have been given the chance to help make it happen.
- Staff should be keen to embrace new ways of working and be more flexible in their approach. So they need to be shown the difference this will make to people.

### **3.4 The current provider landscape and quality of care**

NHS primary care health services on the Isle of Wight are provided by 16 GP practices plus other service providers like dentists, pharmacies and opticians. Acute hospital services (acute care is where a patient gets short-term treatment for a severe injury or illness, an urgent medical condition, or during recovery from surgery), community services, Mental Health services and ambulance services all come from the Isle of Wight NHS Trust – in fact, this combination of services being provided by a single trust is unique in England. The Island's healthcare services also work closely with adult and Children social services provided by the Isle of Wight Council.

Informal carers and voluntary and support organisations contribute a lot to health and care services. Data suggests that both voluntary activity and informal, unpaid care on the Island are higher than the national average and are a vital part of the health and care infrastructure.

Residents also use healthcare services in nearby mainland areas, especially Portsmouth and Southampton. These are mainly for more specialised hospital services like neurology and vascular surgery.



**Figure 2: Provision of health and social care on the Isle of Wight**

### 3.4.1 Primary care

There are approximately 79 whole time equivalent (WTE) GPs on the Island, and the number would be 89 WTE if all practices were fully staffed. At the moment, there are difficulties in recruiting GPs to the Island, which means there are already 10 too few GPs. The GPs work across 16 practices, the Beacon Centre and the prison system. The Beacon Centre also provides the only out-of-hours GP service on the Island.

These primary care services are under significant pressure. Compared to the national average, the Island has the second highest proportion of registered patients aged 75 or over (11.48% compared to 7.63%). The Island's GP practices also have around 12% more patients per practice than the national average. Despite this high demand, a higher than average proportion of residents says they're happy with their access to GP services and that they'd recommend their practice to others.

### 3.4.2 Community and Mental Health services

The Isle of Wight NHS Trust provides community inpatient, community-based children's and families' services, community-based adult services, mental health inpatient and community mental health services on the Island.

In September 2014, the Care Quality Commission (CQC), the independent regulator of health and social care in England, reported that the community services on the Island

'require improvement'. This is their second-lowest rating of quality. Areas they said needed improvement included:

- **safety:** nursing staff didn't feel safe, and improvements were needed to arrangements to lower risks to patients and staff working alone in the community, particularly out of hours
- **rehabilitation patients:** staff weren't able to be as responsive to the needs of rehabilitation patients as they wanted, because patients who were medical outlier admissions took priority, reducing time available to treat this cohort of patients as a whole
- **staffing levels:** these varied across locations and weren't matching demand in some localities. This could compromise safe and effective patient care.

In terms of Mental Health services the Isle of Wight has fewer people per 100,000 in contact with Mental Health services than the English average (1,206 on the Isle of Wight vs 2,160 nationally).

As well as this, historically a slightly lower proportion of Mental Health patients have a comprehensive care plan (or a CPA, which is a plan for care that a patient agrees with their healthcare professionals and that includes both medical and lifestyle issues) than nationally, and lower numbers of patients with CPAs are in paid employment. This could contribute towards the Island having twice the national average number of admissions to A&E due to psychiatric disorders in 2012/13.

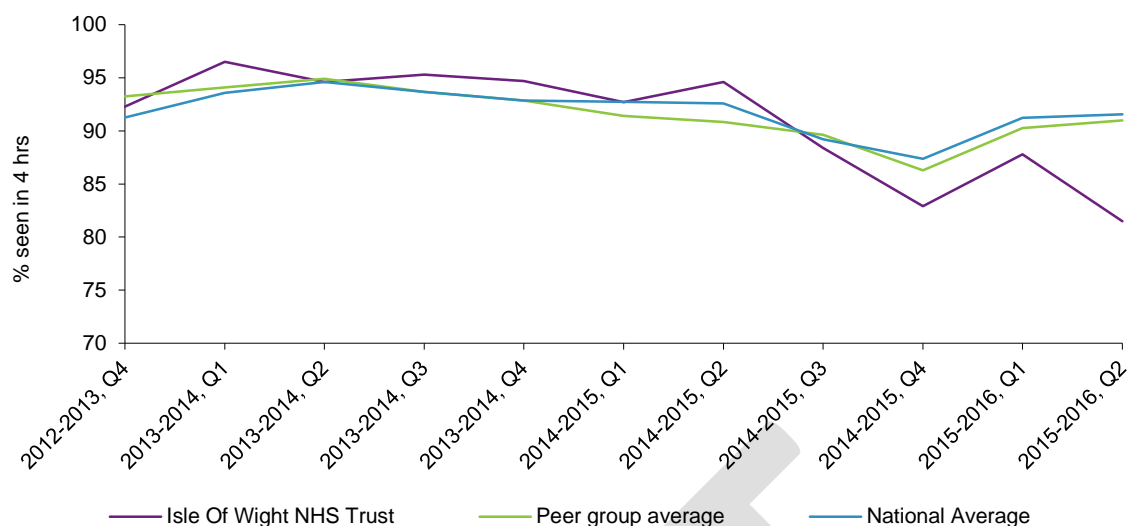
In September 2014, the CQC found that most Mental Health related services were 'good', except for community Mental Health teams, which the CQC said had excessively high caseloads and a lack of proper incident reporting. More recently, the proportion of care spells where patients are discharged without recorded crisis plans is shown as an elevated risk in the CQC latest monitoring report (February 2016).

### 3.4.3 Acute care

Acute care is also provided by the Isle of Wight NHS Trust at St Mary's Hospital in Newport. Several specialised services are provided by mainland hospitals in Southampton and Portsmouth.

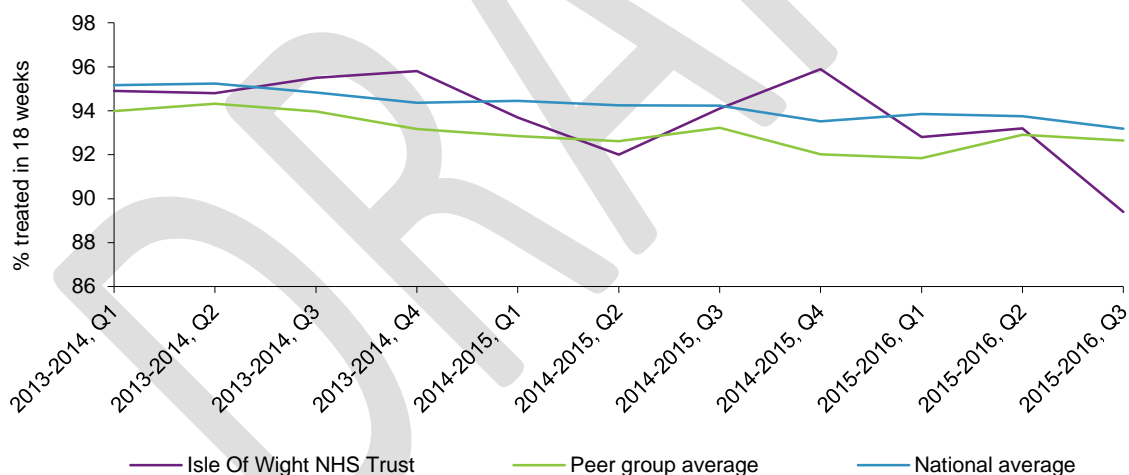
Recent performance against the four-hour A&E target (i.e. that at least 95% of patients going to A&E must be seen, treated, admitted or discharged in under four hours) has been getting significantly worse, and the Trust has announced several 'black alerts' in recent months as the A&E department struggles to cope with admissions and delays in getting patients admitted. This deterioration began in mid-2014; before then, the Trust was performing in line with national and peer group averages.





**Figure 3: Performance against the four-hour target**

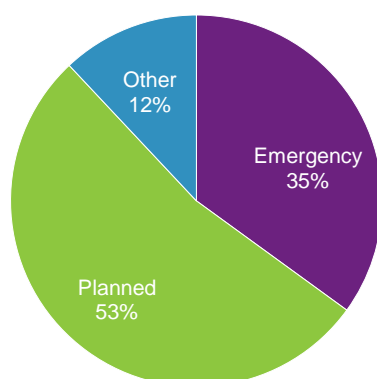
In terms of planned care, the Trust's performance against the 18-week referral to treatment target is similarly erratic, showing a fluctuating level of operational pressures throughout the year. There was also particularly pronounced deterioration in quarter three of 2015/16.



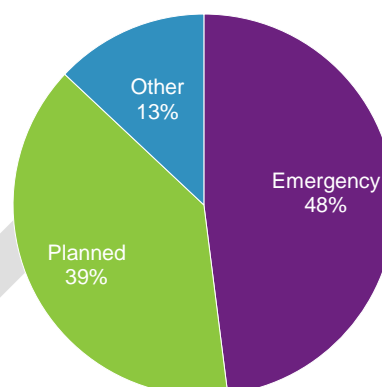
**Figure 4: Performance against the 18-weeks referral time to treatment**

A major driver of these pressures on both A&E and waiting times is that the Trust has a much higher proportion of non-elective (emergency) activity than the national average. This is shown in the pie charts below.

*England admissions episodes*



*Isle of Wight admissions episodes*



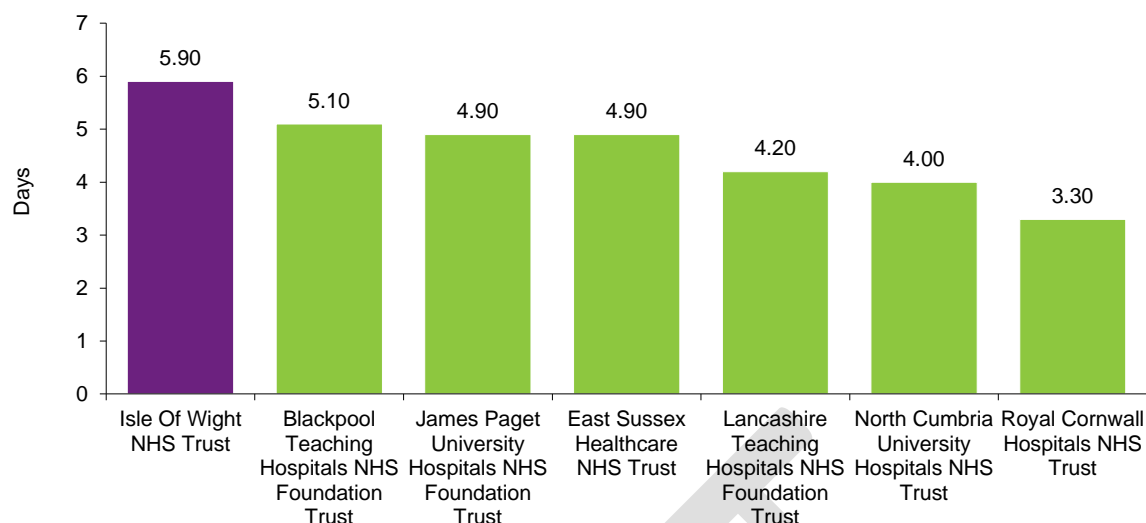
**Figure 5: Proportion of emergency activity compared to the national average**

Because of recent significant bed constraints and estates works, bed occupancy rates for acute medical beds at the Isle of Wight NHS Trust are regularly more than 95%. This could partly be alleviated, for example, by managing admissions better and using ambulatory care. At the moment there are large and growing numbers of medical outliers using surgical and other beds due to increasing difficulties in managing patient flow.

The higher proportion of unplanned care can be a major cause of operational difficulties, in particular in terms of managing the flow of inpatients through the hospital and out into the community. There is a need to reduce the number of emergency admissions on the Island through a combination of:

- better treatment of long-term conditions to prevent crises which need an emergency inpatient stay
- better use of out-of-hospital services, or the development of local hubs across the Island where earlier treatment can again reduce the likelihood of a crisis.

As the chart below shows, compared to a group of peers (ONS Coastal and Countryside), the Isle of Wight has a much higher average length of stay per patient. This compounds the pressures in terms of patient flow and admitting patients from A&E quickly.



**Figure 6: Average length of stay 2014/15**

By virtue of being delivered on an island, several of the acute inpatient services don't have the levels of activity a typical mainland service would expect. Services like maternity, urology and others struggle to generate the income they need to run a full service and need extra subsidisation to stay open. This requirement for subsidisation isn't recognised in national allocations of health funding.

Most elective care on the Island falls into a few specialties: general surgery, urology, trauma and orthopaedics, and gynaecology. Large volumes of elective activity relating to other specialties are carried out on the mainland by larger and more specialised services. For example, all neurosurgery inpatient services are provided on the mainland.

In terms of maternity services, the Trust provides a consultant-led service for high-risk pregnancies and a midwife-led service for low-risk births. The service has six beds and delivers around 1,250 babies per year. Steps are being taken to implement recommendations from the National Maternity Review, but more could be more done to increase work in the community, including the number of home births. The Maternity Review by Healthwatch in late 2015 highlighted improvements relating to the current rotation of midwives and a lack of continuity of care in the community. Other issues were also flagged, including the postnatal ward being understaffed.

Paediatric inpatient services are provided by the Trust and have around 3,300 unplanned admissions each year. They have one ward with 13 beds, a children's day ward with six beds, and a children's outpatient centre. The Trust works closely with Southampton, with a large proportion of surgical care being delivered on the mainland.

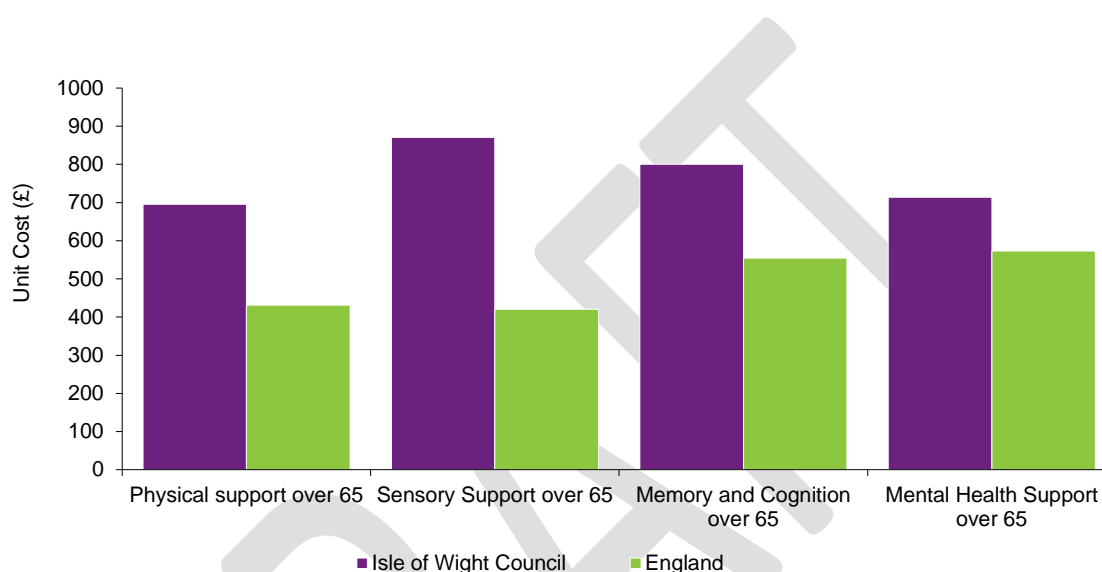
### 3.4.4 Social care

In a 2013/14 survey of users of adult social care services on the Island, 68% of respondents said they were satisfied with their care, compared to 65% in England. In 2012/13 survey, 49% of carers on the Island said they were satisfied with the support they'd received, compared to 43% nationally. A significantly higher proportion of service users on the Island reported that they felt safe, and over 65s were 31% less likely to suffer an injury from a fall



than the national average. This is in spite of the fact that demand for social care services on the Island is comparatively high – for instance the number of permanent admissions to residential care over 65 years old is 26% higher than the national average.

Because of this, expenditure on adult social services on the Island is comparatively high, with social care spending per 100,000 of population being 19% higher than the national average in 2013/14. The number of adults getting direct payments to fund their care was also twice as high as the national average. This is partly due to the population of the Island being elderly and so having greater care needs, but is also driven by higher unit costs for certain care packages, most notably short-term packages. This is shown in the graphic below.



**Figure 7: Unit cost of short-term support for over 65s, 2014/15**

Social services on the Island have reasonably good outcomes, but they cost more than the national average. This is likely due to a combination of the historic legacy of a network of small-scale residential homes which don't benefit from economies of scale as well as the difficulties in attracting larger independent sector providers because of problems with getting to the Island.

## 4. Case for change

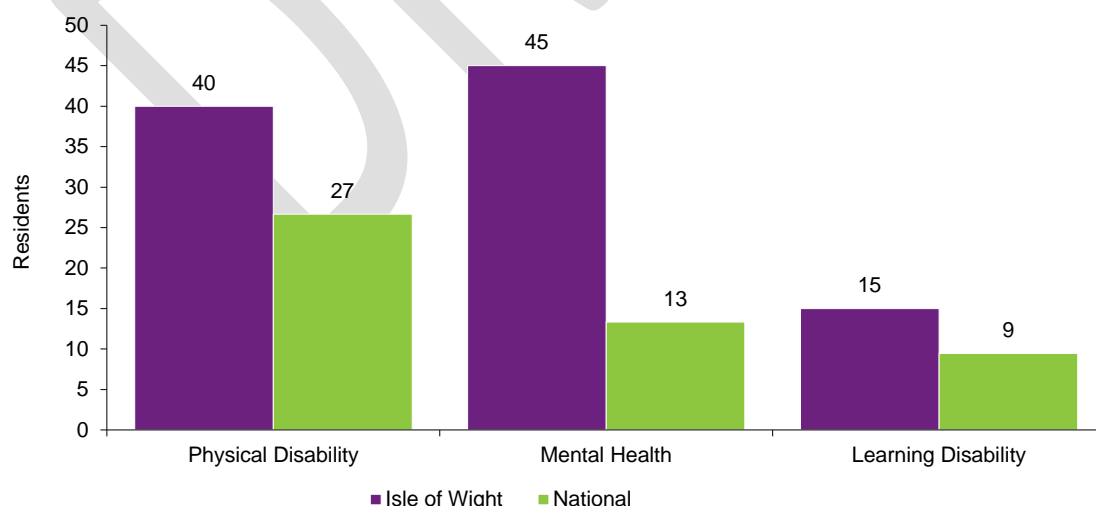
There is high ambition for improved health and social care on the Island across the entire system and the public. The overarching case for change is evident, as Section 3.1 demonstrates. The demand for health and social care services is increasing with an ageing population, which means the cost for these services is also increasing. This is occurring at a time when the economic context means funding is limited and recruiting a skilled workforce is increasingly difficult. If the Island's health and social care system is unable to significantly change the way services are delivered, it will be unable to provide the same (or improved) services in the future.

### 4.1 The demand for health and social care services in the future

The ageing population and increasing numbers of people with long-term conditions means there will be increased demand for healthcare services. In terms of hospital care, in the next 10 years the Island is expecting to see a 19% increase in A&E admissions, a 14% increase in inpatient spells and 13% more outpatient attendances. For services outside the hospital, the system faces a 10% increase in demand for GP appointments and a 20% increase in the need for community care.

Mental Health activity is forecast to increase at a slower pace, but this is mainly due to the fact that there is already have a heightened incidence of Mental Health conditions. So it will simply continue to remain high.

In terms of social care, there is an expected 25% increase in demand for services in the next 10 years. These will mostly be for residents with needs around memory and cognition, and physical support. The need for children's services is forecast to remain stable in terms of absolute numbers (due to the Island's low birth rate and stable child population), but it's likely the complexity of children's cases will increase.



**Figure 8: Residents supported in residential care, nursing care and adult placements per 10,000 population – 2013 Adult Social Care – Combined Activity Return**

It's also important to recognise that as well as growth in demand for services, the complexity of residents' needs will also increase over time. People are living longer and with more conditions, with developments in medicine allowing this trend to increase. This doesn't just impact health services but also social care, as residents need extra help with day-to-day living and managing their conditions.

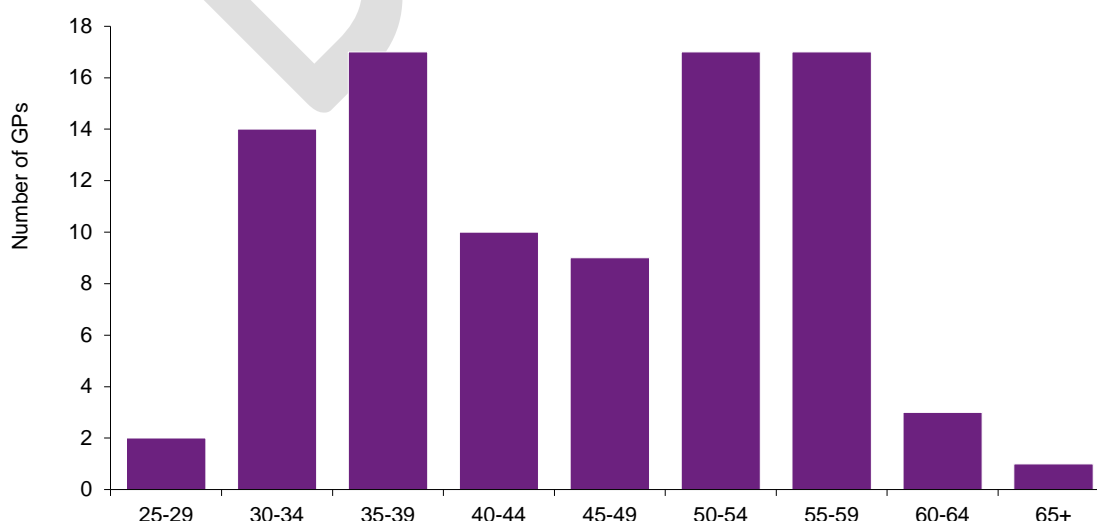
## 4.2 Workforce challenges

Both nationally and on the Isle of Wight, there's a shortage of key workforce groups like emergency medicine trainees and consultants. Across the country, many hospitals are struggling to recruit for substantive consultant posts in emergency medicine, paediatrics and other specialties like urology. This leads to an over-reliance on short term 'locum' or agency staff (who are much more expensive because they're paid day rates rather than a salary) and also creates extra training and administration costs. The Isle of Wight NHS Trust is planning for £3.2m in extra staff costs in 2016/17 to use agency or locum staff – nearly 2% of their planned overall expenditure that year.

The fact that services must be delivered on an island also creates issues. Travel problems mean that recruiting clinical staff is difficult, and it costs more for staff who aren't resident to travel here. There are 19 consultants who are likely to retire in the next five to ten years, and there is likely to be a need for a further nine consultants to cover rising demand. This means a future requirement of up to 30 consultants by 2024/25.

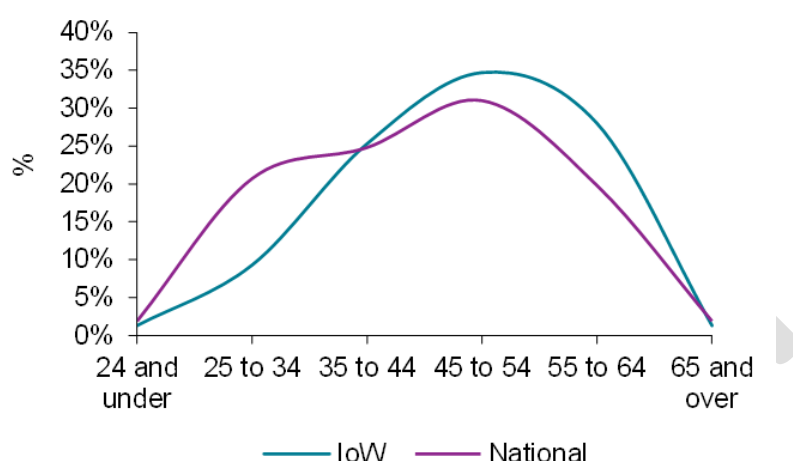
The GP workforce is also under pressure across the Isle of Wight, with many practices failing to fill posts. In fact, the overall number of GP WTEs is at least 10 WTE below the current requirement.

As well as this, several of the current GPs are approaching retirement. There are 34 in the 50–60 age bracket, with a much smaller number in the 40–50 age bracket. This suggests that when the older ones begin to retire (which is possible from age 55) there's likely to be huge pressure on the workforce in the medium term. But this isn't simply a case of needing to train and employ more GPs. National and international research suggests that multidisciplinary teams, often led by a doctor but including a range of professional staff, can get better results than GPs working by themselves.



**Figure 9: Age profile of Isle of Wight GPs**

The social care workforce also faces similar pressures. At present the average age of social workers is above the national average, and in some case social workers continue working well into retirement. The number of social workers and other frontline social care staff needed on the Island is likely to increase significantly over the next 10 years, as demand for social care services rises with the growth in the elderly population. Current forecasts show that the Council itself is likely to need to recruit an extra 107 frontline social care staff (both assessment staff and carers) by 2024/25, and the independent sector will need considerably more than that still.



**Figure 10: Age profile of Social Workers – adult social care**

Recruitment and retention of social workers is also a major challenge on the Island, with adult social care experiencing a turnover rate of 39.8%. This is compared to the national average of 24.7%.

### 4.3 The growing financial challenge

Across England, the need for more effective ways of delivering health and social care has been well publicised. The NHS Five Year Forward View highlights a forecast £30bn financial gap in health sector funding by 2020/21, £22bn of which needs to be found through efficiency. Similarly the Better Care Fund was put together to recognise the financial pressures on social care. It attempts to create alignment and pooled budgets across health and social care so that those services make better use of resources that are already available.

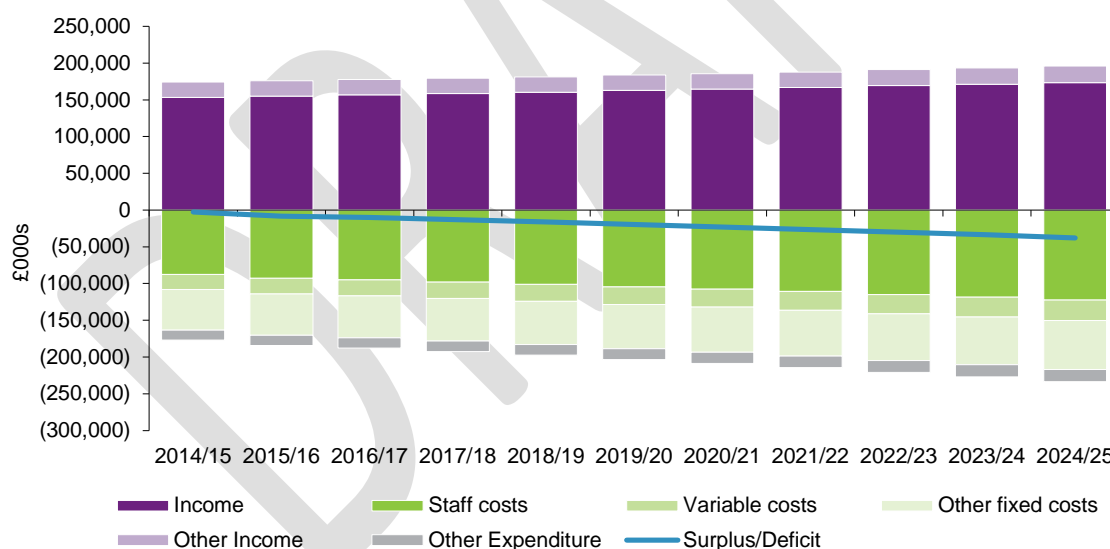
In this context, individual health and care providers are facing increased demand for activity together with only marginally growing, or even decreasing, income. Traditional improvements to productivity (e.g. cutting costs of procurement, estates and clinical supplies) won't be enough to meet rising financial pressures in the same way they did in the past. More transformational changes are needed in order to maintain patient care in the face of these financial pressures.

If the current models of care delivery continue on the Island, the health sector is facing a forecast financial gap of around £52m a year by 2024/25. That will be one fifth of the total

health spend by that time. Healthcare services on the Isle of Wight are subject to national requirements, and there are a number of improvements that will have a role to play in keeping health spending manageable and improving value for money, including:

- making access to high-quality primary and community care easier
- reducing stays in all hospitals
- keeping the salary bill manageable by spending wisely on locum and agency staff
- reducing duplication across the system
- better performance management
- improving information management
- better procurement practices.

The Isle of Wight NHS Trust (including the ambulance service) in the area is facing increased financial pressure. Because of the need for more activity and expenditure to maintain quality in the face of that increasing demand, it's moved to an underlying deficit position. In the future, this deficit is going to increase. Cost inflation and the need to meet clinical service standards will drive up the cost of services. On top of this, the 140,000 residents of the Island generate one third of the activity needed to fund normal services (e.g. trauma, maternity), creating a unique challenge due to diseconomies of scale in an environment where services are expected to be provided to an island population at national prices.



**Figure 11: The Trust's overall financial position**

Like healthcare providers, local authorities are also under intense financial pressure, with allocations falling behind the level of demand for social care services, meaning they're unprotected by ring fencing. The Isle of Wight Council is likely to experience an increase in demand for social care services of around 25% by 2024/25, as the increasingly elderly population lives longer with more complex needs. In turn, this growth in demand will require growth in the social care budget of around £46m per year by 2024/25. The £46m increase is from a net budget adult social care and children's services budget of £70.5m in 2014/15.

In the current public sector finance environment, increases in funding to match this demand can't be assumed; this compounds the requirement to significantly redesign services to meet residents' needs. Local authorities have to decide how much to spend on local need, which is competing with essential services like street lighting, bin collection and housing. Because of this, financially challenged councils have (in some locations) have had to reduce their spending on social care.

The current average hourly rate for carers on the Island is £7.40 an hour, compared to £7.78 in the South East. This means that as pay increases over the coming years to meet the new national living wage, bigger spending increases on staff will be needed here than across the rest of the region. This will create more pressure on the Island's resources than it does elsewhere.

Reducing social care funding at a time when demand is increasing will have a significant knock-on effect on health services. It will also drive cost growth. As the boundary between health and social care becomes increasingly blurred, decisions need to be made now that will enable resources from both health and care to work as a single workforce, so it will not matter which organisation is providing the service.

It's important to examine how to better invest resources in prevention and primary/community care. If this is done well, it is likely to lead to benefits in the medium to long term in improved health outcomes and reduced spending on avoidable conditions. Giving people the tools to help themselves will also be critical. For example, technology can allow residents to take greater roles in keeping themselves healthy or in treating chronic conditions. The importance of the role of the voluntary sector and informal care sector, while already very significant, is likely to grow in future also. There will be a need to use the Island's social resources as much as possible to care and support residents closer to home and outside hospital and other medical settings.



## 5. Approach to public engagement and involvement

The WISR programme has undertaken a significant mobilisation exercise to involve island residents in the redesign process and had 160 participants who are actively engaged in co-production of the initiatives presented in this report.

Initiatives for redesign of care services on the Island have been made as a result of communications, engagement and co-production with the public as detailed below.

### 5.1 Communication and public engagement

The core purpose of the WISR programmes approach to communication and public engagement was to involve as many people as possible in the redesign of health and care services on the Isle of Wight. This work commenced in March 2016 and built on previous public engagement carried out by the MLAFL programme.

The objectives created for the WISR programmes public engagement activities were to ensure that:

- any future changes to services were developed with the awareness and involvement of the public
- the voice of service users was directly considered in any redesign
- future services would reflect the particular health and care needs of those who live on the Island

The engagement process was designed in conjunction with the communications and engagement teams from the Council, CCG and the Trust supported with volunteers from Community Action. Approval of the approach to engagement with the public during the redesign process was provided by the WISR programmes Operational Monitoring Group (OMG).

From March 2016 to June 2016, a number of methods were employed to engage with the public, including:

- Case for change mail-out leaflet “*Caring for our Island: Time to Act*” sent to 69,000 households to raise awareness of the challenges facing the Island’s health and care system
- Locality events covering the three locality areas on the Island for each of the six focus areas for redesign detailed in section 6
- Weekly staff updates via an existing news alert channel
- Weekly website updates on the progress of redesign, challenges being addressed and wider public feedback
- General practice events for GPs, practice managers and others who work in primary and community care to provide feedback
- Professional Reference Group meetings to challenge emerging ideas, increase overall ambition of service change and provide guidance and examples of best practice approaches to change
- Direct public membership on all redesign Working Groups (defined below in 6.1)

- Community conversations with carers, college students, walk-in centre attendees, and older persons groups

## **5.2 Engagement with groups with protected characteristics**

It was critical that the WISR programme engaged with hard-to-reach groups to ensure that service changes suggested included the views of as many people living on the Island as possible. This was important not only to follow the guidance in the 2010 Equality Act but also because it was the right thing to do. The starting point for the identification of these groups was based on the following:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership
- Race
- Religion or belief
- Sex
- Sexual orientation

This list was broadened to include characteristics of specific groups on the Island that are known to be more difficult to engage with or those that have not been engaged prior to the work of the WISR programme:

- Young adults
- Carers
- Homeless people
- People with drug and alcohol issues
- Offenders
- Unemployed people
- People with disabilities and/or long term conditions
- People with learning disabilities including ASD
- People with English as a second language
- Mainland workers
- Children
- Residents of residential homes

These characteristics were used to decide which groups, organisations and communities to engage with during the WISR programme process.



### 5.3 Rate of response to public engagement

During the redesign process from March to June 2016, the following numbers of people were reached:

- 723 formal responses were received from the case for change leaflet sent to Island residents.
- 18 locality events to gather feedback on ideas for service change were attended by 189 individuals.
- 160 people regularly working as part of the working groups including; clinicians, professionals, service users, voluntary services, and members of the public.
- General Practice events were attended by 145 individuals.
- 18 Professional Reference Group members were recruited to provide perspective and insights on the emerging models of care.
- Over 230 community groups were contacted, including 'seldom heard' groups (as per national and local characteristics detailed above) and 317 people involved in community discussions.
- 24 providers who expressed interest to provide services under the WISR programme and attended a specific provider engagement event.
- 315 people engaged through the staff events with more staff and volunteer engagement sessions continuing post WISR programme.
- Two public engagement events attracted 97 individuals to provide feedback on emerging ideas.

A range of other local, regional and national stakeholders from political, community, business and health-related groups were also kept informed and engaged throughout the process.

The feedback from these events has been fed into the redesign process (detailed in section 6.1) directly, with each redesign Working Group discussing public feedback to inform further work on redesign proposals. Members of the public in the Working Groups themselves were also invited to share their views to shape redesign proposals.

### 5.4 Outcomes of public engagement

Key themes aggregated from engagement with the public during March to June 2016 from all events, discussions and information responses were:

- Accessibility of GPs has been criticised due to the difficulty to make appointments that leads, in some cases, to individuals attending emergency care settings such as A&E. Alternatives to GPs and GP practices with clear signposting to other services (including to weekend alternatives) were discussed.
- Transport was an issue across all services and was seen to have a particularly acute impact on the elderly, those with mobility difficulties and those with financial issues. Transport to and from the hospital and the mainland were seen as important areas for improvement, and many suggested that a better transport service would reduce elderly isolation.

- The 111 service was thought to be too risk averse, with respondents suggesting that it sent too many people – especially young children – to the Beacon Centre. It was recommended that awareness of what the service is for could be improved, with suggestions that it could be promoted via social media or be accessed via an app.
- “Bed-blocking” (i.e. the availability of beds in care settings being reduced by those who are ready to go home but have not been discharged) was raised regularly across all engagement activity, with respondents seeing it as caused by a lack of appropriate care for the elderly
- Cottage hospitals and more residential care homes were frequently suggested solutions to the problem of “bed blocking” described above.
- Information about service users is not acted on in the most appropriate way due to a lack of continuity of staff. In Mental Health, for example, a named social worker was suggested as a way to improve information sharing on patients when different staff are needed to provide support at different times.
- Mental Health services for children were flagged as an area in need of significant improvement. Respondents provided various recommendations for change, with teenage students at the Isle of Wight College for example, suggesting a lived-experience Mental Health volunteer to provide an on-call telephone service.
- Health education was seen as an area for potential in order to develop a “culture of responsibility” and drive greater awareness of appropriate care. It was suggested that this education could take place through more health education in schools, more creative campaigns for the public to sustain awareness and improved access to knowledge on managing conditions.
- Better communication and co-ordination between departments and services was a recommendation that came across in all areas of public engagement. A more functional IT system was seen as a good way to facilitate this. More practical ideas were also raised such as the use of admission forms that patients can use whilst moving between areas of the hospital to avoid having repeated information requests.
- Greater awareness of resources for carers was seen as a particularly important area for the redesign. Respondents recommended a hub, or roadshow, that could provide information on access to respite care, practical support about access to benefits and knowledge sharing of relevant volunteer services on the Island
- Technology frequently highlighted as a service solution with many individuals seeing it as a way of improving access to GPs and reducing travel to the mainland. This opinion included caveats that technology should not be the only option available to access services.

## 5.5 Co-production

The focus on working directly with individuals who live on the Isle of Wight was a core aspect of the health and care redesign process. The aim was to first raise awareness of the challenges facing the Island and then to encourage the population to participate in developing solutions to these challenges.

The ambition of the WISR programme was to involve as much of the Island as possible in helping to reshape health and care services. For each focus area, a Working Group was established to understand key service challenges and propose changes to service design.

Each Working Group had a requirement to include public membership (see section 5 for determination of working group focus areas).

Members of the public were invited to join the redesign process following an advert in the local County Press and online. Responders to the adverts were interviewed by phone and asked about their ability to contribute in a group setting on ideas for service redesign, their confidence to challenge others and listen to differing views and their willingness to attend relevant Working Group sessions that they considered to be an area of interest or expertise.

Health Watch Isle of Wight provided a cohort of six candidates for membership on the working groups as public members and each of these was accepted following successful interview.

Engagement events with the public (detailed in section 5.3) produced views from Island residents and staff that were collated and fed into the redesign process to ensure that public input was used throughout and played a meaningful role in shaping the specifics of service redesign.

A wide range of service professionals and managers covering all disciplines from across healthcare (both mental and physical), social care, voluntary sector and off-island care providers were directly involved in the development of redesign initiatives. These individuals joined the public as members of the redesign working groups.

Over 20 clinical and professional specialist experts were used to inform, challenge and stretch the ambition of the redesign process by attending working group meetings and supporting business case development. This included subject matter expertise provided by the NHS England New Care Models Team.

## 6. Redesign approach and timeline

Six focus areas for redesign were agreed based on benchmarked data of service quality against other care systems (e.g. Right Care Commissioning for Value data), predicted demographic change and public and professional stakeholder views. This data was combined with the local Joint Strategic Needs Assessment, Health and Wellbeing Strategy, Right Care “Where to Look” 2016 packs and existing local strategies to determine the most appropriate focus areas for redesign. The focus areas were approved by the WISR programme Board and named as:

- Urgent and Emergency Care
- Children, Young Persons and Families
- Planned Care
- Mental Health
- Frailty
- Long Term Conditions

Initiatives for service redesign were determined within the six focus areas. Each focus area had an associated working group that created initiatives based on input from the public, professionals and analytical modelling insights (see section 6.2).

### 6.1 Working groups

Working Groups met four times to create the ideas for how to change services on the Island. The membership role of each group is shown below and was approved by the WISR programme OMG.

- A senior appropriate and accountable Chair
- Isle of Wight subject matter experts (SMEs). One to two representatives from each sector i.e., Trust, Community, Primary Care, Voluntary Sector, Social Care
- Isle of Wight members of the public (at least two)
- External professional expert / subject matter expert
- External consulting project facilitation

Commitment from Working Group members required attendance at four workshops, some work in between meetings and attendance for some members at public events. During meetings, Working Group members were empowered to make any suggestions for change, however radical they might be, before these were tested with members of the public and the WISR OMG.

Each Working Group was supported by a Project Team consisting of external consultancy support and one day per week support from a commissioning lead and service professional lead.

The agreed scope for each working group meeting was as follows:

**Meeting One** – Kick-off for each individual Working Group to suggest ideas for service change

Key Inputs – information pack describing the overall the WISR programme process and what type of work has been done outside the Island to fix similar challenges; overview of the evidence need for service change; current public views

Key Outputs – high-level views of service change initiatives suggested; agreed roles for future meetings

**Meeting Two** – Determine ideas that will have the most impact on service challenges

Key Inputs – initial draft ideas from Meeting One produced by the Project Team; summary of views from Professional Reference Group Members and from Public Engagement events

Key Outputs – refined ideas for service change of suggested pathways; test of initial ideas against the Individual Needs Framework; merge ideas into wider programmes of work

**Meeting Three** – Agree the preferred options for pathway redesign

Key Inputs – process map of current versus proposed pathways; summary of second set of views from Professional Reference Group; summary of views from second set of Public Engagement events; overview of how draft ideas affect finance, workforce and demand pressures for the next ten years

Key Outputs – key gaps in ideas understood with draft solutions created

**Meeting Four** – Understand modelling input and sign-off plans

Key Inputs – final activity, workforce and finance implications of proposed pathway redesign; draft strategic outline business cases for service redesign; summary of further views from relevant Public Groups

Key Outputs – internal Working Group sign-off of proposed redesign; final brief to Project Team to include any changes ready for last Professional Reference Group and sign-off via the WISR programme OMG and Board as required

## 6.2 Professional and public input

A Professional Reference Group (PRG) was set up consisting of clinical and non-clinical professionals from across the spectrum of wellbeing, health and care services. The purpose of the PRG was to ensure all the workstreams are cohesive and fit within the broader context of MLAFL. Senior front-line leaders were chosen over system executive leaders to provide operational and strategic views.

Public input, as described in section 5, was gathered from a series of engagement events and each working group session included the latest views from these activities to test and challenge working group thinking. This was in addition to the public membership on the working groups.

The process diagram below (Fig. 12) shows how the four meetings of each Working Group were supported by information and challenge from public engagement events, professional engagement and the WISR programme analytical model (that forecasts the impact of ideas created in Working Groups on finance, workforce and service demand over the next ten years).



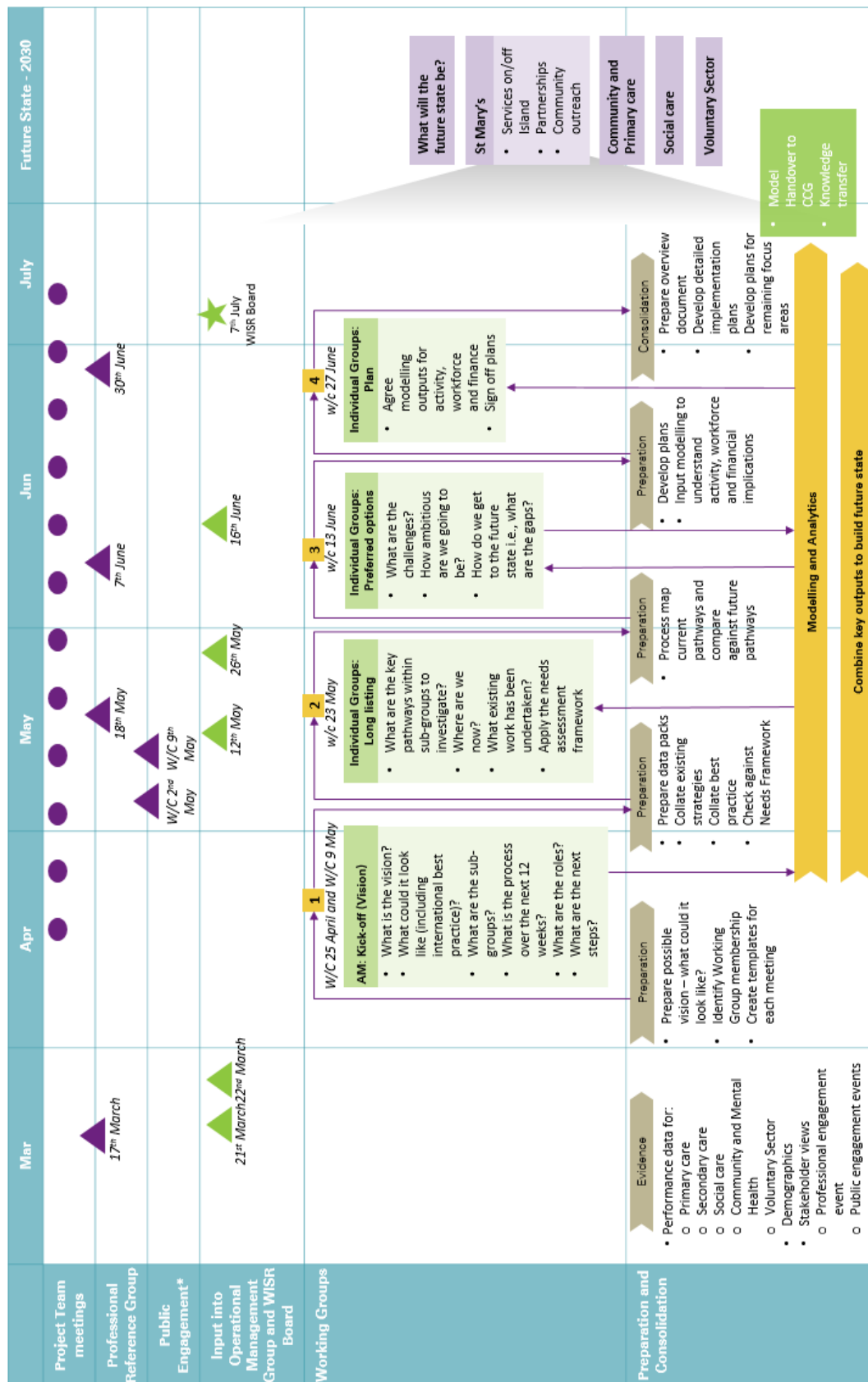


Figure 12: Timeline and dependencies between the WISR programme Working Groups and wider engagement activities with the public and professionals on the Island

## 7. Our new model of care

As outlined in Section 2.2, the WISR programme has brought together a diverse range of professional and commissioning expertise, as well as public input, to develop a new model of care that addresses some of the key financial and workforce issues outlined in the Case for Change.

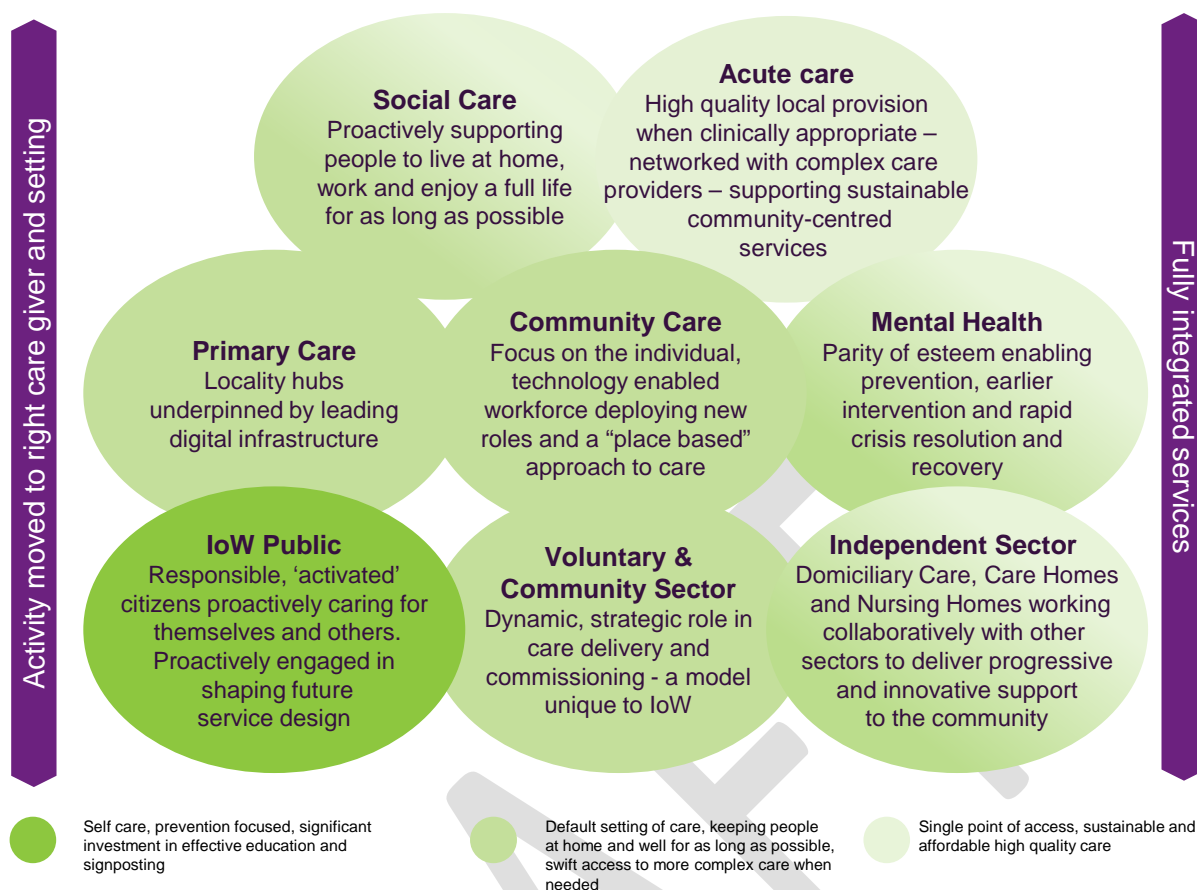
This section sets out the overall vision for future redesign of health and care services on the Island. It describes:

- The overall model of care, including the principles that underpin it
- The difference that the new model of care will make for:
  - Patients, public and carers
  - Community-based services
  - Specialist and more complex care

### 7.1 An overview of the new model of care

The new model of health and social care will transform our services from being reactive and orientated around organisations to being proactive and orientated around the needs of the public. Care will be delivered as early as possible, through a variety of places and methods. It will be delivered by staff and volunteers who are empowered and supported to maximise the use of their own skills and through greater self-management of care needs.

Building on the work of the My Life A Full Life programme, and aligned with the ongoing work of the Hampshire and the Isle of Wight Sustainability and Transformation Programme, this new model of care will help ensure the Island can sustain high quality services, secure best value for the Island pound, and prepare itself to tackle the challenges of an ageing population.



**Figure 13: Overview of the new Model of Care**

## 7.2 Principles of the model of care

The principles that underpin this model are detailed in the Individual Needs Framework (see [Appendix X](#)), which was used to assess potential redesign initiatives. The principles that underpinned the redesign process were used to test the appropriateness of redesign proposals were:

- **Quality:** The initiatives provide sufficient information to empower individuals to be active participants in the design, choice and delivery of their care. They promote a diversity of provision and maintains or improves safety of care delivery. They also makes appropriate use of technology for both individuals and staff.
- **Access:** The initiatives provide an appropriate balance between quality of care and distance to access services, with better signposting and particularly addressing the needs of those who have traditionally been ‘often overlooked or seldom heard’. Given the difficulties with out-of-hours provision, a particular focus has been placed on ensuring services are provided safely and appropriately out of hours.
- **Affordability and sustainability:** The initiatives are clinically sustainable and financially and operationally sustainable. They consider the minimum volumes requires to safely and effectively deliver new and current services and, if they cannot be provided safely, consider whether they must be provided on Island.



- People: The initiatives promote early prevention and wellbeing and effectively recognise and prevent abuse and neglect. They also empower the workforce and provide support to carers.
- Feasibility: The initiatives are co-produced with members of the public, are acceptable to all regulatory and oversight bodies (including the voluntary sector) and are consistent with the strategy and work being done in the broader My Life A Full Life programme.

### 7.3 Patients, public and carers – opportunities and responsibilities



The foundations to the success of our care services in the future will be built upon enabling the Isle of Wight public to **proactively care for themselves and each other**. This approach will support 'activated' members of the public to take greater responsibility for keeping as healthy as they can be while the care system will be designed to place prevention at its heart. People will be supported to make the most of their personal and community assets.

To support Isle of Wight residents with **complex and multiple conditions**, care professionals will treat the person, not the condition – and health and social care staff will be able to access professional networks to provide a seamless response. Information will be shared to reduce duplication and support the best care decisions with residents.

Greater availability of **community based support and education** will help the public identify and access low-level advice quickly and effectively. Single points of access for services will help the public navigate support.

The **unparalleled contribution of carers** on the Island will be supported with a recognition and provision in services to help maintain their own health and well-being as a vital aspect to the care system.

The **voluntary and third sector**, within our Island community, will contribute to a diverse range of services providing peer support programmes, education and signposting to care. These organisations will also support proactive identification and early intervention for those that require care, particularly for the elderly and those with long term conditions.

Better and coordinated **use of technology** will help ensure information is readily available, those that seek help will find it easily, and that new options for care and self-help will be publicised.

The role of patients and service users in the **design of future services** will continue to be based on a co-production approach. The Isle of Wight public will be the driving force behind the development and maintenance of services on the Island, with their voice being central to shaping what is provided, how and where.

## 7.4 Community based services – prevention and proactivity



With the residents of the Isle of Wight supported to look after themselves as much as possible, care services will be **integrated and community based** to keep the public healthy and well at home for as long as possible. This includes full integration of health and social care services; the public will no longer see barriers and uncoordinated care due to organisational boundaries.

**Locality-based teams** comprised of a diverse range of care professionals will coordinate, plan and proactively offer support. These teams will be both physical (providing face-to-face care across our three localities) and virtual (working behind the scenes to share information and knowledge, ensure care is based upon individual need and delivered in the most convenient manner for the person).

Across our health and care system, **staff will be empowered** to work at the top of their skills. They will make confident decisions, have access to rapid professional support where needed and do everything they can to proactively prevent the exacerbation of conditions or cause unnecessary delays in the delivery of care.

A dynamic and diverse array of care services will be provided across the Isle of Wight – a model unique to our Island. With our strong and enviable community infrastructure the skills, reach and capacity of our **voluntary and third sector partners** will see innovative approaches emerge to support our population. This will be particularly focused upon peer-centred support and the deep insight third sector partners can bring to the management of long term conditions and enduring needs.

**Mental health services will be integrated** with physical health and social care services with the same preventative and proactive approach taken. Low- and higher-level mental health services based in the community will encourage anyone with mental health needs or concerns to seek early support without stigma or unnecessary barriers.

People will be supported to live in their own home and to be as independent as possible. Residents will have access to the best **social care** when this is appropriate, and health and social care staff promote services in the community. Information will be accessible for residents, carers, professionals, voluntary sector organisations and providers.

**Primary care will remain at the heart** of each community's health services, working in conjunction with locality based teams to provide advice, guidance and treatment. Support will be signposted to community based alternatives where available and appropriate. More complex needs will be coordinated working in conjunction with the patient, to ensure they are in the best possible position to benefit from specialist input, and recognising the impact of multiple conditions on the outcomes for the patient and carers.

Where specialist, more complex support is required **hospital services will be delivered in new ways**. Utilising technology and supported, empowered staff, more complex care services will come out from behind the hospital walls with specialist staff working along-side community based professionals.

## 7.5 Specialist and more complex care – high quality, sustainable and affordable



With hospital staff and services reaching out via locality teams to support the population staying healthy and well at home for as long as possible, a visit to the hospital will only be required for care that can't be delivered safely elsewhere. This will help ensure **hospital services are focused on those that need it most**, are accessed rapidly and are of the highest quality.

If hospital admission is required, **multi-disciplinary teams will also commence discharge planning at the point of admission**. This will reduce the number of people unable to be discharged due to insufficient support in the community or at home.

**Urgent care services will be supported primarily via locality teams and associated community services**. However when specialist input is required immediately, A&E triage will direct the public to the most appropriate care professional and service. Pre-defined ambulatory care pathways will ensure rapid assessment, diagnosis, treatment and discharge back to the most appropriate setting – in most instances this being the normal place of residence.

Where needed to bolster capacity and capabilities, **formalised networks of professionals will provide more complex care**. This will see in some cases care delivered on the Island by external professional staff (both physically and virtually), as well as Isle of Wight patients and staff travelling to the mainland where specific services cannot be safely or sustainably delivered on the Island.

**Partnerships between complex care providers** will help underpin the future of these services on the Island. They will bring access to new technologies and help us develop a dynamic environment to attract and retain staff. Health and care organisations will work together to support a revitalised community-orientated care system to ensure the Island can provide access to the best care possible.

The overall model of care described above has been used to inform and has been informed by specific initiatives for care service change on the Island. These initiatives are outlined below for each of the six Working Groups (described in section 6) including the challenges that they aim to address.

## 7.6 New models of care: Mental Health

The definition of Mental Health that informed the scope of work is that it is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community<sup>2</sup>. In the context of the WISR programme, the Mental Health working group has focused on those aged 18-65. Children's Mental Health is addressed in the Children, Young People and Families Working Group (see Section 7.4).

### *Key issues*

The key mental health issues identified by the WISR programme board members, through data analysis such as Right Care "Commissioning for Value 2016" and from engagement with the public during the redesign programme included:

- Prevention and help are not being provided early enough to reduce demand for care services in the future. This is exacerbated by a higher percentage of people reporting a long-term Mental Health problem compared with the average across England.
- Waiting lists in Improving Access to Psychological Therapies (IAPT) and Community Mental Health Services (CMHS) services are increasing due to workforce constraints, in addition to growing vacancies at the Trust.
- Quicker access was needed to Mental Health services. The Isle of Wight has fewer people per 100,000 population in contact with Mental Health services than the English average (1206 vs. 2160 nationally), suggesting that access was an issue.
- Individuals admitted with Mental Health needs were experiencing delays in being discharged and the proportion of care spells where patients were discharged without a recorded crisis plan was an elevated risk by CQC.
- Individuals in crisis only had two main options, to be picked up as part of the police triage, Operation Serenity, or to visit A&E.
- Costs associated with supporting patients in mainland placements were placing a strain on budgets.
- High intensity patients were accounting for approximately 40% of work across services, highlighting a service gap for patients with more complex needs. The percentage of patients (crude prevalence rate) with a serious Mental Health diagnosis of schizophrenia, bipolar affective disorder, other psychoses and patients on lithium therapy was significantly higher (worse) at 1.1% compared to the English average of 0.88%.

### *Overall vision*

The initiatives in Mental Health have specifically focused on early intervention, access and recovery. These support a vision to increase access to Mental Health services, provide quicker and better treatment for those with complex needs, provide alternatives to inpatient admissions in times of crisis, and to increase and sustain recovery rates.

The initiatives support a philosophy to avoid unnecessary admissions to Sevenacres Mental Health Inpatient Wards for all but the most high risk/complex needs. These initiatives

---

<sup>2</sup> [http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/)

collectively work towards reducing the number of inpatient admissions and to support help people return to their place of residence when possible.

All of the ideas include the commitment to co-produce support offers with existing service users, allowing people with lived experience to help support and deliver care to others suffering mental illness.

The table below outlines an overall vision for Mental Health services and it indicates which aspects have been specifically covered in redesign initiatives. Primary and Secondary Prevention has been covered through the Children, Young People and Families working group.

Primary Prevention: Place based and person centred life course approach improving outcomes, population health and initiatives such as health and work	Secondary Prevention: Systematically detecting the early stages of and intervening before full symptoms develop	Early Intervention and Access: Responsive and clear access arrangements connecting people to the support they need at the right time	Recovery: Ongoing care, treatment and support for service users, friends, family and supporters	Integration: Parity of mental health and physical illness through collaborative and mature cross-sector working across public sector bodies & voluntary organisations	Transformation: Improved financial and clinical sustainability by changing contracts, incentives, integrating and improving IT & investing in new workforce roles
Emotional Wellbeing and Resilience (Education and Parenting)	Maximise use of technology: IAPT, Big White Wall, MindEd etc.	Psychological Services of Consistent High Quality through IAPT+	Increase in Recovery Care in the community	Integrated monitoring, standards and KPIs	Real commitment across system leadership
Wellbeing including reduction in stigma and discrimination	Improving access to info for self-management	Single Point of Access integrated with social care	Employment support	Whole person integrated vertical care pathway across a horizontal integration of care	Understanding of population health
A clear shift to self care and self-help through family centres	Quick referrals into appropriate services e.g. counselling	Alternative options in times of crisis (Safe Havens)	Signposting to life support e.g. Relationship guidance, financial advice	Increased use of digital tools, technology and telehealth	Working practices: Workforce is trained in a range of disciplines and knowledge of relevant services for referral
Targeted public health campaigns		Improved primary care including signposting to alternative services and improved use of voluntary sector e.g. MyTime and Samaritans	Reconfiguration of Out of Area Transfers and Sevenacres	A strong partnership with the community, voluntary and independent sector	Co-production with users
Improved wellbeing in the workforce				Integrated approach to housing and support services	Recognise the value in alternative sources of investment e.g. Social Impact Bonds
Improved Support for Carers, parents and families		Earlier access and intervention for young people's mental health		Life course support including perinatal care	Better training for primary care workers in early intervention
				Integrated data sharing and using data already gathered	Development of skills of non-Mental Health professionals
				Integration of social care	

■ Specifically covered within ideas in Mental Health Working Group  
■ Specifically covered within ideas in Children's, Young People and Families Working Group

**Figure 14: Vision for Mental Health**

### Initiatives summary

Three final ideas have been proposed in this Working Group. These are:

1. Improved single point of access
2. Alternative places of support and safety during times of crisis for those with Mental Health needs
3. Increased Access to Psychological Therapy for people with a Severe Mental Illness (IAPT for SMI)



### **7.6.1 Improved single point of access**

#### *Vision*

The vision for the Single Point of Access (SPOA) is to maximise opportunities for crisis and suicide prevention, productivity and access through digital (e.g. digital dictation) for all individuals with a Mental Health need. This initiative is an enabler to facilitating the rest of the Mental Health redesign.

#### *Challenge*

The current demand for Mental Health services is not being met in a manner that is as productive as it could be, this is highlighted through the fact that there is no routine report of the level of need and the outcomes for new/known patients. Patients often need to tell their story several times and referral forms are duplicated or contain variable information quality. This means that triage and referrals take longer than required under the current system. For example, it is not uncommon for referrals to go by email to the Mental Health Social Work Manager, even though there is already a functioning PARIS system in place between the local authority and the Trust.

#### *Initiative outline*

The Single Point of Access already exists for those aged 18-65 with a Mental Health need and is based at Sevenacres. However, this needs to be integrated with other public services, notably social care to increase productivity, efficiency and greater multidisciplinary working.

The services that will be integrated within the SPOA include Adult Mental Health Social Workers, a housing worker, Tele-triage and tele health and an up to date Directory of Services (e.g. Employability advisors, voluntary counselling services)

#### *Benefits and financial impact*

Benefits include productivity and efficiency gains, including a reduced response time to meet service users (from point of referral through to assessment) and a reduction in the number of home visits through increased use of telephone consultations. The individual will only have to tell their story once and will be more likely to experience better outcomes such as employment, reduced stress, stable housing etc.

For more information, see business case in [Appendix x](#)

### **7.6.2 Alternative places of support and safety during times of crisis for those with Mental Health needs**

#### *Vision*

A Safe Haven offers the opportunity to walk in, promote self-care and receive earlier access to services. A longer term vision is around co-locating the Single Point of Access with the Safe Haven and to provide 'Serenity' Families for those with more urgent housing needs.

### *Challenge*

Individuals in Mental Health crisis have little support other than to attend A&E, come into contact with Operation Serenity or go through Single Point of Access. Many of these individuals in crisis are 'frequent flyers' to the system, presenting frequently to the same services, generating significant costs and not achieving high quality outcomes.

### *Initiative outline*

A Safe Haven (Crisis Café) will be set up to provide an out of hour's service during the week, and an extended service during the weekend. The service will be marketed through community groups/media and will be located in non-institutional community-owned locations. On arrival, the person will be met and informally assessed by the Supervisor who will be tasked with either making an onward call to the Single Point of Access (SPOA) if they are concerned about the person's condition and/or provide them with a person to talk to, cup of tea and place of safety via the team.

### *Benefits and financial impact*

After the set-up of one Safe Haven, the savings profile is in the range of £232k - £385k, based on reduced A&E attendances and reduced non-elective admissions. Although the impact of attendances and admissions will be significant, Sevenacres is already at a minimum staffing level so a reduction in admissions doesn't result in a reduction in staffing levels and the related costs.

Other benefits include a reduction in number of section 136s, a reduction in the number of crises by at least 30%, a reduction in self-harm numbers and a reduction in caseloads of care coordinators.

For more information, see business case in [Appendix x](#)

## **7.6.3 Increased Access to Psychological Therapy for people with a Severe Mental Illness (IAPT for SMI)**

### *Vision*

Individuals with a Severe Mental Health Illness will be seen quicker through the introduction of IAPT Plus. They will be less likely to see their GP, attend A&E or be supported through Operation Serenity. Individuals will have improved health, wellbeing and quality of life. It will improve the patient experience as it gives patients access to evidence based psychological treatments in a timely manner, enabling patients to become experts at managing their own condition and any future relapses.

### *Challenge*

The waiting times for psychological therapy within Community Mental Health Service (CMHS) are growing. The current waiting time for therapy is 1 year, but it will increase if the volume of referrals is continued. The waiting time increases a patient's risk of relapsing further into their illness, increases risk to patient safety as well as lengthening the time the patient is within the service. It would also impact on the national focus themes of improving prevention, quality of treatment and parity of esteem to treatment.

In addition there would be severe impact on the primary care IAPT team as referrers will, and already do, send patients through to IAPT due to the long wait for therapy within CMHS. That team has seen an increase of 6% in inappropriate referrals which impacts on that team meeting its constitutional targets of 22% access to treatment rate, waiting time for treatment of 6 weeks and the recovery rate set at 50%.

#### *Initiative outline*

This initiative will introduce Increased Access to Psychological Therapy for people with a Severe Mental Illness (IAPT for SMI) by moving to a stepped care model. In order for this to happen, appropriately trained staff need to be employed to carry out NICE recommended interventions at both low intensity, high intensity and at specialist level. The introduction of IAPT Plus will also include a Personality Disorder Service.

#### *Benefits and financial impact*

The benefits for introducing IAPT Plus include reduced waiting lists for Psychological Therapy for people with SMI, reduced admissions to Sevenacres (especially for those with Personality Disorder), improved patient flow in the whole of community Mental Health services, reduction in relapse through improved relapse management and reduction in GP appointments for those with Personality Disorder.

After the set-up of one IAPT Plus (which includes £400k investment in additional workforce), the savings profile is in the range of £37k - £40k based on reduced admissions to the inpatient Mental Health wards and keeping activity on-island instead of more expensive off-island placements.

For more information, see business case in [Appendix x](#)

## **7.7 New models of care: Long Term Conditions**

The initiatives proposed in this section are based on the definition of Long Term Conditions (LTCs) that are conditions that last for more than one year and can be classed as sudden onset, stable with changing needs, intermittent or progressive. In the context of the WISR programme, the LTCs Working Group has focused on creating approaches to LTC management, support and intervention with an emphasis on neurology, respiratory and heart failure. The initiatives could also be applied holistically to all relevant conditions.

#### *Key issues*

The key issues identified by system leadership, data analysis and the public during the redesign programme included:

- Poor quality and access to services for those with neurological conditions
- A need to increase capacity within the community, including greater emphasis on self-management to care for those with LTCs
- A disconnect between the increasing complexity of need for those with LTCs and the ability of the workforce to cope with increased demand
- A lack of housing support for those living with one or more LTCs
- The rate of increase in LTCs for people 85+ is projected to double by 2030 but without a plan to create capacity to deal with this increase



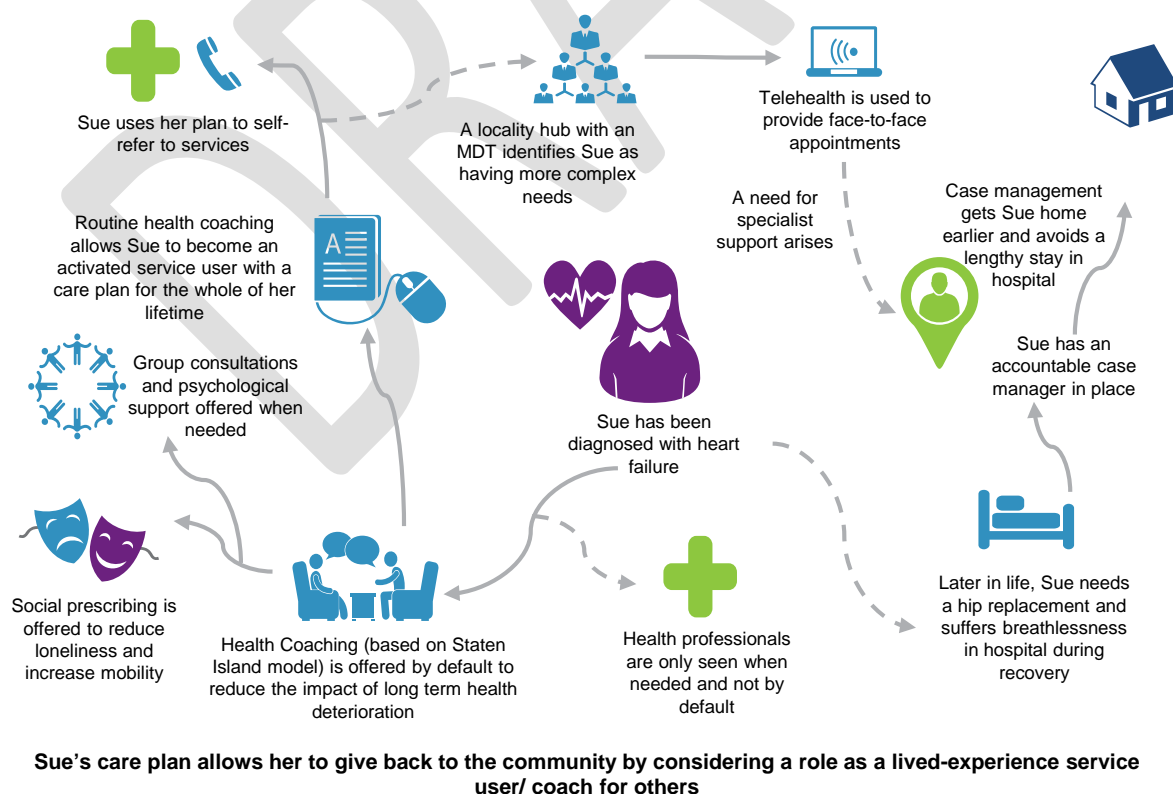
- Benchmarking against “coastal” CCGs shows COPD prevalence being higher than peers by 20%
- On the Island, 20.1% of the population is estimated to live with at least one LTC, compared with a national average of 16.9%
- 47.4% of the 65+ age group have a reported LTC and this demographic is expected to increase in complexity of need over the next ten years

### Overall vision

The Island vision for LTCs agreed in the first Working Group session with service professionals and members of the public was to use cost-effective interventions such as telehealth, focus on social prescribing, encourage self-management and provide co-ordinated care that allows people to remain in their communities whilst not creating demand for primary care services that could not be met using current service models.

This has been translated into a visual journey for a service user (Figure 15) in this journey, LTC diagnosis results in a default to health coaching rather than a medical intervention. This coaching forms the basis of patient/ service user activation and signposting to services such as group coaching, social activities and medical support where required. The coaching also forms the basis of co-produced wellbeing/ care planning that allows the individual to take control of their own LTC(s) management, including self-referral.

As LTCs progress or worsen, plans will be in place for risk stratification to identify those individuals with accountable case management to help people return to their place of residence, for example, following a planned operation at hospital.



**Figure 15: The overall vision for LTCs shown from the perspective of a service user**

### *Initiatives summary*

Three final ideas have been proposed in this Working Group. These are:

1. Health Coaching and Service User Activation
2. Co-Produced Wellbeing Planning
3. Locality Hubs<sup>3</sup>

#### **7.7.1 Health Coaching and Service User Activation**

##### *Vision*

This initiative aims to create activated service users, via health coaching, living with one or more LTC who are more aware of services available to them, including those that are not medical. The vision includes the goal to support these individuals to take more control of their own care and to participate in more activities that are important to the goals of the individual (such as social groups and group consultations).

##### *Challenge*

The current model of care for LTCs is to default to medical support on diagnosis or not to provide practical support at all, particularly for those diagnosed with neurological conditions. The above average prevalence of those living with LTCs on the Island (see above) and continuing pressure in primary care and acute care to provide support means that a new approach is needed. Signposting to services available to those with a LTC is also mixed and public feedback received to date has highlighted that many individuals do not know the type of support that they can receive (including non-medical and social activities).

##### *Initiative outline*

A health coach/ support “buddy” will be assigned on diagnosis to those with a LTC who may be another member of the public rather than a service professional.

Discussions with the individual will result in understanding of how to access a variety of support including how to come to terms with their own condition, cognitive behavioural therapy, action therapy, support groups, group consultations and self-management.

This initiative links closely to wellbeing planning that will be carried out in parallel.

##### *Benefits and financial impact*

Qualitative benefits include reduced loneliness, ability to take control in a crisis, equality in discussions between health and social care professionals with service users and social inclusion. The patient activation measure will measure improvements an individual’s ability to manage their own health.

If the coaching programme is rolled out in full and covers all people at the point of diagnosis, there is a hypothesised reduction of 5% of activity in primary care.

---

<sup>3</sup> Being combined with Specialty Teams form the Frailty working group and Community Teams/ Case Management from the Urgent and Emergency Care working group

It is expected that unplanned hospital admissions as a result of improved escalation management would be achieved, with the specific impact dependent on how many individuals would be activated by health coaches.

For more information, see business case in [Appendix x](#)

### **7.7.2 Co-produced Wellbeing Planning**

#### *Vision*

This initiative aims to create a single approach to establishing wellbeing/ care plans for individuals with LTCs that allow self-management and self-referral for services, linked to life goals rather than only medical outcomes.

#### *Challenge*

The draft 2016-19 early intervention and prevention strategy for the Island calls for a proactive approach to care planning to “To empower and enable self-care, recovery and self-management for people with Long Term Conditions and self-management”. For several LTCs, no care planning exists that allows individuals to meet this statement, especially for those with neurological conditions.

#### *Initiative outline*

Wellbeing plans will be created with individuals based on their personal goals and will include all aspects of lifestyle needs, care needs, end of life planning and escalation needs for crisis situations. These will be linked to a service directory and supported following conversations with a health coach (see initiative above). Plans may be virtual or physical and allow individuals to self-refer to relevant services.

#### *Benefits and financial impact*

Qualitative benefits include reduced loneliness, better individual decision making in a crisis and improved quality of life.

This scheme will reduce contacts with primary care for those with LTCs of between 5-15% and reduce non-elective hospital admissions by 5-15%. Planning of medicines management will allow for an estimated saving of 4% of the primary care budget.

In isolation the total net savings for this initiative amount to between £2.0m – £3.5m per annum. However it is an enabler of other initiatives which also affect the same cohort of patients, therefore in order to avoid double counting the calculated savings are excluded at an aggregate level.

For more information, see business case in [Appendix x](#)

### **7.7.3 Locality Hubs**

#### *Vision*

Sustainability in primary care and in community care provision in the future will be achieved using a locality hub model a co-ordinated approach to using virtual multidisciplinary teams

(MDTs) that is not fragmented. These teams would have accountability for risk stratified individuals in their communities with associated local QOF payments.

### *Challenge*

The 16 GP practices on the Island are under significant pressure with a number of GPs expected to retire in the next 5-10 years. Particularly in Newport, practices are under pressure and require a new model of care delivery.

### *Initiative outline*

This initiative suggests a single physical location for services in the Central-West locality and virtual working for the other areas on the island for MDTs (including GPs). Risk stratification will be used to identify those individuals with LTCs who need the most support with virtual appointments and telephone advice offered to help reduce attendances at GP practices and hospital admissions. If admitted to hospital for Planned Care, the MDT team will take responsibility to help the individual get back home with support from acute care professionals.

### *Benefits and financial impact*

This will allow improved patient satisfaction with services, a reduced need for travel, increased communication between professional groups and better links to care planning.

Initial financial modelling for COPD, asthma, angina and heart failure alone show annual net savings of between £9 – 22k. This is being expanded to include neurology, diabetes, depression, rheumatology, gastro and pain management. The initiative is also an enabler of other initiatives which also affect the same cohort of patients, therefore in order to avoid double counting the calculated savings are excluded at an aggregate level.

*The financial impact for this initiative will be merged with similar MDT approaches from the Frailty and Urgent and Emergency Care Working Groups.*

For more information, see business case in [Appendix x](#)

## **7.8 New models of care: Children, Young People and Families**

This working group has identified initiatives for Children, Young People and Families. This refers to all children and young people aged 18 and under, as well as their respective families and carers. It should be noted that this Working Group has also put forward ideas on other population groups (for ASD and ADHD) in line with national guidance around whole-life pathways.

### *Key issues*

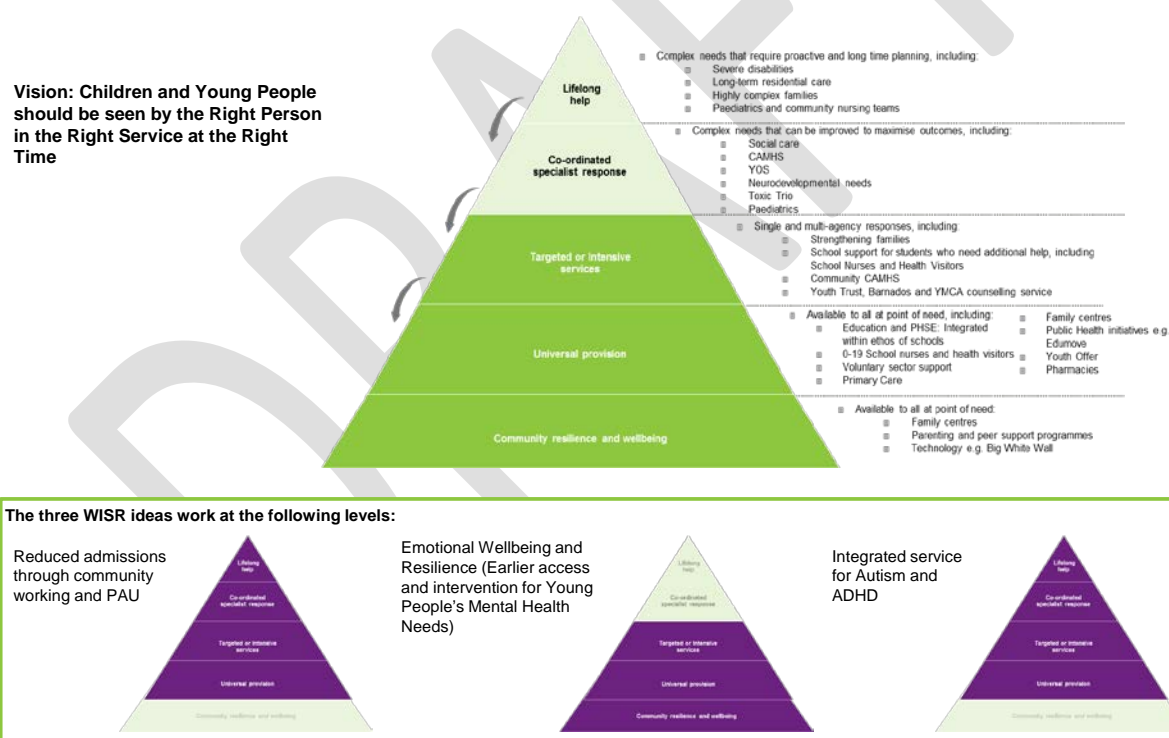
The key issues facing Children, Young People and Families, include growing demand in both A&E and the Children ward, increasing complexity and caseloads of young people's Mental Health needs and fragmented services across acute and community settings.

The detail contributing to these pressures is below. These issues were identified by system leadership, data analysis and the public during the redesign programme.

- A&E attendances were rising for children under 18. In 2014/15, there were 5,402 A&E attendances by children aged four years and under. This was higher than the England average and 80% worse than CCG peers.
- The risk-averse appetite of 111 responders and GPs was resulting in a higher influx of patients to the Walk-in Centre and/or A&E
- The admission rates to the Children ward were higher than the rest of Wessex
- There were calls from the public and teachers for improvements to Mental Health work in schools, and greater education on emotional resilience
- There was demand for more Children care in the community, including the balance of community and specialist provision
- There was a gap in care for those without a diagnosis but whom still require support

### Overall vision

The triangle below outlines an overall vision for Children, Young People and Families and it indicates at which care setting each of the three ideas is working at. The vision is for Children and Young People to be seen by the right person in the right service at the right time.



**Figure 16: The overall vision for Children Young People and Families**

When children and young people's needs are escalated to a targeted, intensive or specialist response, the aim should be to ensure that this is a short intervention and that the child or young people are moved back to a more appropriate care setting where feasible and appropriate.



### *Initiatives Summary*

Three ideas have been proposed in this Working Group. These are:

1. Reduced admissions through community working and Paediatric Assessment Unit (PAU)
2. Emotional Wellbeing and Resilience (Earlier access and intervention for Young people's Mental Health needs)
3. Integrated service for Autism and ADHD

#### **7.8.1 Reduced admissions through community working and Paediatric Assessment Unit (PAU)**

##### *Vision*

The vision for the Paediatric Assessment Unit is to alleviate the need for avoidable paediatric admissions, as a result of children presenting with urgent or emergency care needs at A&E.

##### *Challenge*

According to figures from South West Commissioning Support Unit 2013-14, the Isle of Wight has the highest admission rate per 1,000 by CCG - Ages zero to four – within the Wessex GP registered patients. There is no paediatric emergency trained consultant in the Emergency Department (ED), resulting in a high referral rate to paediatrics with little communication between Paediatrics and ED around common pathways, shared protocols and transfer of knowledge via structured education programmes.

Further to this, high pressure on GP surgeries has resulted in a higher influx of patients to the Walk in centre and/or A&E. Gaps in Paediatric training for GPs on the island (only an estimated 30% of GPs have Paediatric training) has resulted in GPs being more risk-averse. When children and young people do present at A&E, it is not an appropriate place for a child to be seen in a child friendly environment.

##### *Initiative outline*

A Paediatric Assessment Unit (PAU) would enable children to be assessed and observed over a short period of time to try to avoid admission to the Children ward. In paediatrics, observation is an intervention and allowing a period of time for therapy to take effect of presenting problems such as a fever to resolve can mean that children return home earlier.

The addition of a robust community paediatrics nursing service, who will 'scoop up' these children if required, will improve safety, reduce re-attendances and provide families with a much improved service in their own homes. Primary care will also work more closely with the acute service with increased communication, shared pathways and an ability to refer children for periods of observation.

##### *Benefits and financial impact*

After the set-up of the PAU, the benefits include savings of up to £121k based on a decrease in non-elective admissions of up to 40%. Other benefits include earlier discharge for patients

seen in PAU to their home environment, a reduction in readmissions to the Paediatric ward, improved overall 4 hour target for A&E and an increase in community care provided.

### **7.8.2 Emotional Wellbeing and Resilience (Earlier access and intervention for young people's mental health needs)**

#### *Vision*

The vision is to improve mental wellbeing and increased resilience by encouraging a culture shift towards prevention and self-care, informed choices and access to technology.

#### *Challenge*

Support for children and young people's mental wellbeing is fragmented; there are a range of initiatives across the island but little awareness exists within the system, and are often only considered when more intensive support is required. This means that children and young people are often referred into specialist services unnecessarily or too early, when other community based support would have been more appropriate. The emphasis for support children and young people's Mental Health has been on specialist services, and acting within a deficit model, rather than promoting assets and mental wellbeing in mainstream settings.

#### *Initiative outline*

This initiative would develop a systematic framework to emotional wellbeing and resilience, to improve multidisciplinary working and share learning across the island. This systematic approach would look at three projects.

Firstly, the support for education, based on Ofsted-promoted best practice, would be mapped and developed, linking with national schemes to support across age profiles – from nursery through to sixth form colleges.

Information and locality knowledge provided in Family Centres and across the Island would be improved through a Directory of Services. This would be hosted by MLAFL and supported by a Standard Operating Procedure for clarity of ownership and updates. Referral processes will be included in the directory, it will incorporate IsleHelp and build on best practice models (e.g. MyDoS, ASAP Gloucester, I-links)

Finally, the Strengthening Families approach will be reviewed to develop and maximise impact on emotional wellbeing and resilience through localities and family centres.

#### *Benefits*

The financial modelling shows annual net savings of between £30 – 62k. This scheme will reduce A&E admissions for children by 5-15% and reduce non-elective hospital admissions by 5-10%. Other benefits include encouraging parity of esteem for Mental Health and physical health from the start, enabling less flow through to specialist services, opening up capacity to support those with more complex needs and facilitating a coordinated and multidisciplinary approach with less duplication of services.

### **7.8.3 Integrated service for Autism and ADHD**

#### *Vision*

The Island vision is to provide an integrated assessment, treatment and support service in the community for children, young people and adults with autism (ASD) and attention deficit hyperactivity disorder (ADHD). The service will include a seamless pathway from child to adulthood with person centred planning and support during transition.

#### *Challenge*

Children and young people were assessed and diagnosed by the Autism Diagnostic Research Centre (ADRC), with access via a multidisciplinary filtering panel. The Local Authority who manage the ASD filtering panel are making changes to their SEN service and as from August/September the ASD filtering panel function will no longer be supported both administratively or financially. It is anticipated with withdrawal of this, all referrals will go directly to ADRC, and therefore, costs are likely to increase.

Further to this, parents and carers expectations are increasing with many challenging clinical decisions for those who aren't put through for diagnosis, or for those who are assessed and not diagnosed. This is likely due to the gap in services for those with challenging behaviour who are under the thresholds. There is also a gap in post diagnostic support for both children and adults.

The Adult ADHD and ASD service is receiving increasing numbers of referrals year on year due to a better understanding and recognition of both ADHD and ASD in recent years. When the Autism clinic was first established the demand was estimated at approximately 25 new assessments per year. In 2015-16 the service received 80 plus referrals for diagnostic assessment. In addition to this, the waiting time for the Autism clinic was breaching NICE guidelines of 12 weeks and the ADHD adults service is at risk of providing notice.

#### *Initiative outline*

Development of a full ASD and ADHD service for children and young people, integrated with the current and future provision for adults to achieve a whole life pathway. The Island would no longer commission the ASD service provided by ADRC.

This service will include multidisciplinary working, a single point of access, post-diagnostic and ongoing support and an improved technology offer.

#### *Benefits and financial impact*

The financial model shows that savings are expected to be approximately £33k and in addition there are several benefits to this initiative. Firstly, there will be a reduction in initial referrals in children and young people by around a third (over the next ten years) once improved school and family support is in place. There will also be a reduction in the number of children going into adult services as their conditions are managed earlier and more effectively.

Paediatric consultants will have increased capacity which could be used to support general paediatric clinics, reducing Paediatric waiting lists. Better value of money could further be

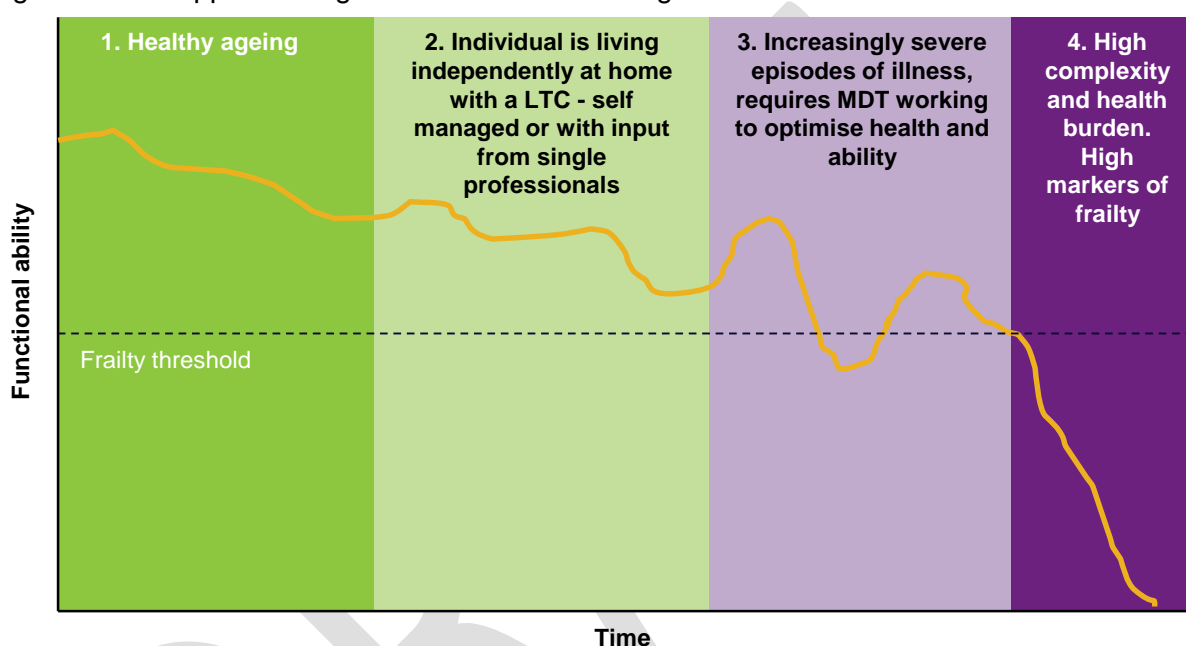


achieved in the current financial envelope, as well as improving the quality of life for both children and adults with ASD and ADHD.

There are also wider societal benefits as schools are likely to notice an improvement in behaviour and attainment.

## 7.9 New models of care: Frailty

As people get older, their functional ability will decrease over time. It is not a linear decline, people's functional ability can decrease and then get better again. The below figure shows the different stages in the Frailty pathway. The initiatives proposed here aim to provide the right level of support throughout all the different stages.



**Figure 17: Rate of functional decrease**

### Key Issues

The key issues identified by system leadership, data analysis and the public during the redesign programme include a need for:

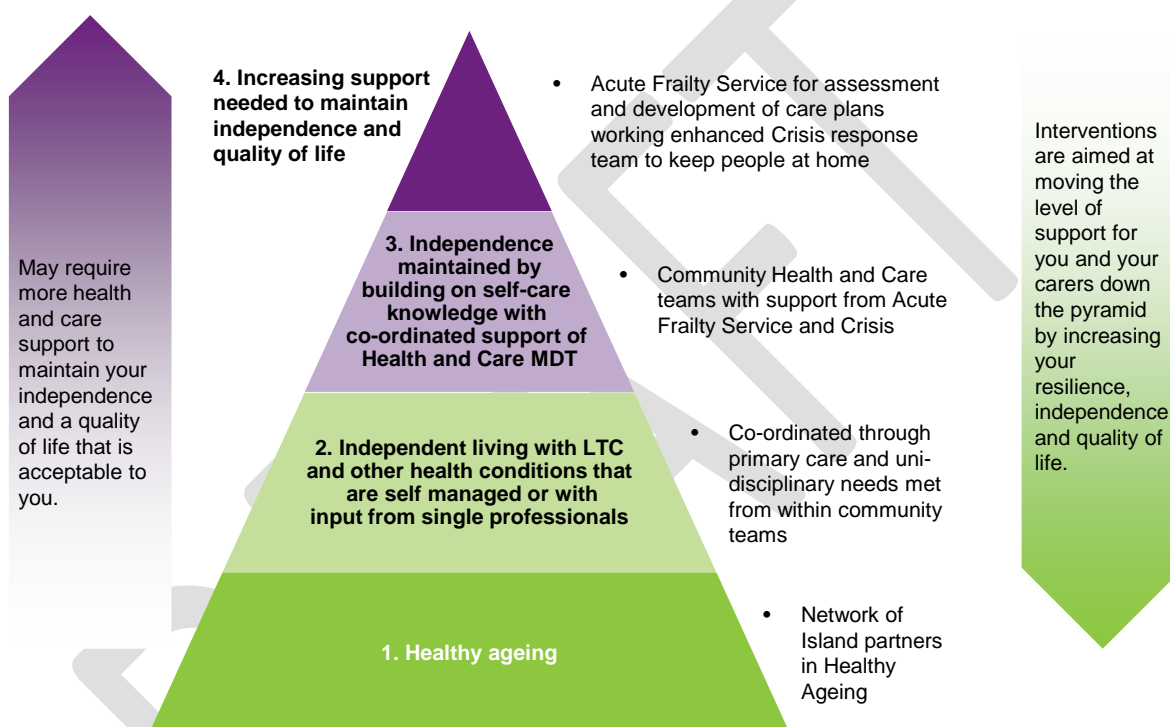
- Effective multi-disciplinary care management for frail elderly
- Capacity in the community for patients to ensure they do not get admitted to acute care if it is not necessary.
- Stretched Care Home bed capacity for people with challenging behaviours
- Balance between front end community based care and support, rehabilitation and reablement and long term care
- Increasing complexity of need requires upskilling of the workforce to support it with a more proactive approach

## Overall Vision

The Island ambition for Frailty Services is to:

- support people in healthy ageing;
- improve self-management of long-term conditions with input from single professionals
- optimise health and wellbeing for people with increasingly severe episodes of illness
- support patients with highly complex needs to stay at home as long as possible.

The below figure illustrates this ambition in a single vision. The pyramid represents the different stages frail elderly go through. On the right of the pyramid the services that are needed to properly support the frail elderly is shown.



**Figure 18: The overall vision for Frailty**

## Initiatives Summary

The following initiatives have been proposed in the Frailty Working Group:

1. Islands Partners in Healthy Ageing
2. Community Health and Care Teams
3. Acute Frailty Service
4. Inpatient Dementia Solution

The initiatives combined aim to enable frail elderly to live at home as long as possible, with the right amount of support in place. People will feel safe and confident in managing their conditions by themselves. Where possible their health and care needs have moved down the pyramid. Additionally the initiatives aims to reduce the number of admissions of patients with Frailty syndrome.

### **7.9.1 Islands Partners in Healthy Ageing**

#### *Vision*

The visions for the Islands Partners in Healthy Ageing is to prevent frail older people from reaching crisis point through access to information, promotion of self-help strategy and prevention. Isle of Wight residents are given the support they want close to their home. People are accepting of healthy ageing and recognise their own and others Frailty – therefore feel comfortable seeking support from community based services.

#### *Challenge*

Community based networks vary and in some cases are disjointed across the island. Community based networks vary and in some cases are disjointed across the island. Various organisations and community services do not always collaboratively leading to pockets of information that aren't necessarily consistent across the island for the general public or professionals.

In particular, the general public, through public engagement have highlighted their uncertainty over whether services on the island to reduce loneliness and support frail individuals were working well, with some noting that knowledge and awareness of services was a particular issue.

There is a recognised need for community activation to empower the population of the Isle of Wight to become more resilient. The island must work together towards a unified vision of early intervention and prevention for those who are beginning to show markers of Frailty.

#### *Initiative Outline*

Networking organisations and community based services through an expansion of existing platforms i.e. IsleHelp, formalised joint working and promotion of a unified vision to support the frail population living in the community.

#### *Benefits and financial impact*

By implementing the Islands Partners in Healthy Ageing initiative, the following benefits can be achieved:

- Reduction in GP referrals and contacts from older population
- Increased IsleHelp activity
- Increased numbers of people reached through community based support
- Improved quality of life - measured with EQ5D-5L
- Improved ability to manage own health – measured with Patient Activation Measure

### **7.9.2 Community Health and Care Teams**

#### *Vision*

Frail elderly people in particular are identified as early as possible and get the best support and care they need in order to prevent unnecessary admissions to the hospital through proper case management and care planning.

### *Challenge*

Daily average emergency admissions to English acute hospitals for the >65 age group doubled between 2005 and 2012 and could do the same again by 2020 if there are no viable alternatives. For every 10 days of bed rest in a person >75, there is 10% loss of aerobic capacity and 14% loss of muscle strength the equivalent of ageing 10 years in 10 days. This is nearly impossible to fully recover from, thus, the less time they are in hospital the less likely it is that frail older people will come to harm.

The current care model has few processes in place to identify and assess those individual with most complex needs and/or are frail before they reach a crisis point. The current community setup is unsustainable due to upcoming workforce challenges, giving rise to the need for a different community model.

### *Initiative Outline*

Integrated teams of professional and non-professional community staff who are able to identify functional deterioration, perform timely, relevant assessment of need with the aim of developing plans with the person to promote self-care, plans for escalation of care, for appropriate onward referral for specialist advice (housing, legal) and for referral to specific speciality diagnostic pathways and anticipatory care plans for EOLC.

The scheme will provide intensive case management of the top 10% of complex patients in each locality to reduce dependence on GP capacity and avoid hospital admissions. The scheme will see the transfer of generalist nursing into the community with access to specialist and therapist services from a central pool. This scheme provides an opportunity to develop the workforce and provide a higher quality of service to the Islands most vulnerable and complex patients.

A multi-skilled integrated workforce will be able to identify and provide holistic assessments of vulnerable individuals and put in place future care planning in the community working closely with locality teams, community rehabilitation and other services to help prevent frail individuals reaching a crisis point.

### *Benefits and financial impact*

This initiative will lead to reduced A&E attendances and unplanned admissions for frail elderly. In addition emergency bed-days and re-admissions within 30 days will be reduced as well. A likely increase in patient/carer satisfaction will be seen through better system planning.

The financial impact for this initiative will be merged with similar MDT approaches from the Long Term Conditions and Urgent and Emergency Care Working Groups.

### 7.9.3 Acute Frailty Service

#### *Vision*

The vision of the Acute Frailty Service initiative is that:

- The People with significant markers of Frailty are able to access the appropriate level of investigation and intervention at the right time, right place and by adequately skilled people, particularly when they are rapidly deteriorating.
- The response and management to peoples' need is proportionate, safe, sustainable and takes place as close to home as is possible under the circumstances.
- The assessment and management allows the escalation and de-escalation of care and support to be timely and proportionate to the assessed risk and need.

#### *Challenge*

Older people with complex medical conditions and markers of Frailty are the people who are getting 'stuck' in the system – particularly the inpatient system. There are few options available to primary care as alternatives to admission and very limited support to help with the risk management of keeping unwell, frail and vulnerable people out of hospital.

#### *Initiative Outline*

An integrated specialist frailty service will be developed that will support community services to provide assessment, diagnostic, specialist advice and treatment of people who are deteriorating and at risk of admission and permanent reduction in function and quality of life. A centrally located service will support people who have had a sudden change in function or who are presenting with a slow decline of unknown cause that is putting them at risk of sudden change and hospital admission.

#### *Benefits and financial impact*

The Acute Frailty Service will lead to timely identification, assessment and diagnostics of frail elderly. Interventions will occur in a variety of setting appropriate to each person's need resulting in increased knowledge for the individual about the opportunities to manage their conditions by themselves. Where possible their health and care needs have been moved down the 'pyramid of need' and they are confident and feel safe. Other markers of success will include the coalition of the different acute service teams that provide care for older people into a larger service that addresses the specific roles of the original teams but can share generic roles and administration. This will provide efficiencies of staff time and increase the resilience of these services.

The financial modelling shows annual net savings between £92 – 276k. This scheme will reduce A&E admissions for 85+ yrs age group by 5-15% and a corresponding reduction will be seen in Non-Elective and Outpatient Follow up activity. If successful it will among others result in improved QoL, shorter LoS, a decrease in the number of re-admissions to the hospital and reduced admission rates to the hospital.

#### **7.9.4 Inpatient dementia solution**

##### *Challenge*

The Isle of Wight has a high proportion of older people, and with this comes an increased prevalence of dementia. As with other conditions, most people are supported in their own homes, some with support, and as needs increase are supported in residential, nursing or acute settings. Provision (in either the NHS or in private care) has in some cases not kept up with the capacity required to meet changing needs of the population or maintenance of physical environments to best support this client group. Current provision was not purpose built, and is not designed to meet the needs of people with dementia. Discharge delays can impact on appropriate use of existing facilities, and other settings are not appropriate for when the current provision is full. Recent work by public health has established that between 25% and 33% of beds in the hospital are occupied by people with dementia

##### *Vision*

People with dementia and their carers are supported in the community and their needs addressed in other settings, taking the implementation of the Dementia Strategy to the next level. This will also support the longer term vision for the Trust's acute provision and longer term accommodation solutions, whilst reducing demand for specialist acute care for people with dementia.

##### *Outline of the initiative*

To improve the outcomes for people with dementia and their carers, releasing capacity and supporting people to be as independent as possible. This initiative is not to duplicate the work already underway through the dementia strategy or in the individual organisations, but to maximise the opportunities of the WISR programme for people with dementia.

- Training needs assessment for health and social care staff and with voluntary, community and private sector providers, and review of existing training programmes.
- Review pathways for people with dementia in acute settings – both to avoid unnecessary admissions or delays to discharge, based on the existing community pathways
- Establish baselines for outcomes for people with dementia across the pathway
- Work with other WISR programmes to ensure that health, social care and VCS providers “Think dementia” in the development of new programmes

##### *Benefits and financial impact*

The aim of the initiative is to quantify and release existing “bottle necks” in the system on the Isle of Wight, which is having a negative impact on the outcomes for people with dementia, their carers and on the availability of care on the island. Impacts are expected to be:

- 1/5/10% reduction in bed days for people with dementia, including saving x% from excess days
- Increase in the providers in the community that are able to support people with dementia



- In / out reach of dementia specialists to release capacity and ease blocks in the system, including in the provision of crisis care, discharge planning and in access to prevention and lower level services
- 10% reduction in admissions to Shackleton
- 5/10% reduction in admissions to residential and nursing care for people with dementia

## 7.10 New models of care: Planned Care

Planned Care comprises of all care that is scheduled in advance, both at general practices and in outpatient settings at the hospital.

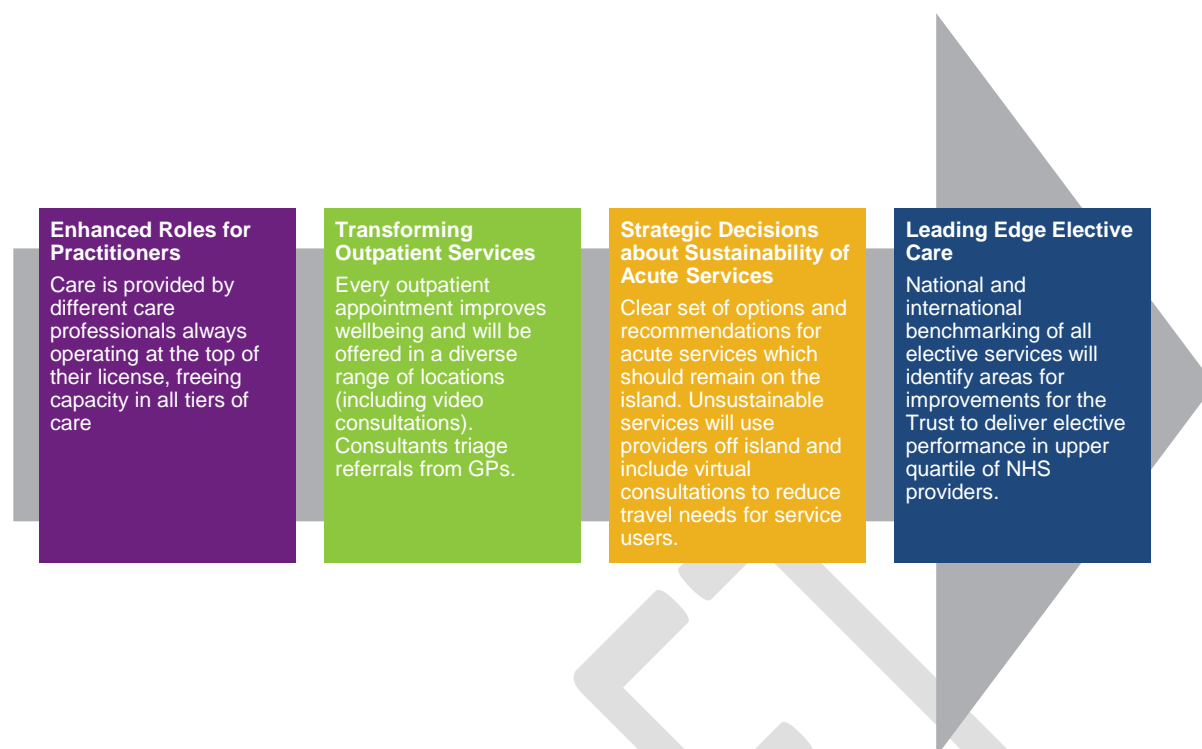
### *Key Issues*

The key issues identified by system leadership, data analysis and the public during the redesign programme include:

- Tackling all specialties or services where clinical sustainability/quality is an issue
- Solving the under capacity of care providers throughout the entire system
- Creating sustainable acute services
- Cope with changing demographics

### *Overall Vision*

The below figure represents the overall vision of the Planned Care working group. The overall vision for Planned Care is to ensure every patient's elective care is provided by the right person, at the right time and in the right setting. Care is provided by professionals operating at the top of their license, with every appointment adding value for the patient. A high level assessment of the sustainability of current acute services alongside recommendations for provision of these services will allow for the Trust to focus on providing leading edge elective care. Recommendations will include where appropriate networks with providers off island for those services considered to be unsustainable now or in the near future.



**Figure 19: The overall vision for Planned Care services on the Island**

#### *Initiatives summary*

The following initiatives have been proposed in the Planned Care Working Group:

1. Enhanced Role for Practitioners
2. Transforming Outpatient Services
3. Strategic Decisions about Sustainability of Acute Services
4. Leading Edge Elective Care

The initiatives are described in more detail below.

#### **7.10.1 Enhanced Role for Practitioners**

##### *Vision*

The ambition of this initiative is to empower and enable staff throughout planned care to work at the top of their licence, creating much needed capacity across the system's workforce. By giving patients direct and timely access to care, worsening of symptoms and conditions due to long access times will be minimised.

##### *Challenge*

The whole care system faces great capacity issues. The CCG, GP Federation and the Trust have experienced challenges in recruiting and retaining staff. The under capacity has resulted in waiting times in primary care of approximately 3-4 weeks and some outpatient care waiting times exceeding 18 weeks. Due to the older than national average demographic of the island the pressure on the system is expected to further increase.



### *Initiative Outline*

This initiative aims at expanding the role of practitioners, with an initial focus on a greater role for physiotherapy in triaging musculoskeletal patients who would normally have required a GP appointment. This initial project will allow specialist physiotherapists to work alongside primary and secondary care as a first point of contact to triage patients, hereby preventing a GP appointment. In this initial project patients with musculoskeletal (MSK) disorder will be given a choice to be seen by a GP or a physiotherapist.

### *Benefits and financial impact*

If we do nothing pressures on the current capacity throughout the system will only increase further, leading to even longer access times to the right care. The value in the scheme is derived from both its clinical and cost effectiveness. Increased value through clinical effectiveness will be seen through shortened patient pathways, more appropriate secondary care referrals, broadening patient access, encouragement of self-management and increased patient safety. Whilst the cost benefits will be derived from saved GP time, decreased prescription costs, fewer referrals to secondary care and unnecessary diagnostics and shortened patient pathways. The financial modelling shows annual net savings of £30 – 152k, with the scheme reducing Trauma & Orthopaedics NEL admissions by 1-5%.

## **7.10.2 Transforming Outpatient Services**

### *Vision*

Every appointment in outpatient care improves the wellbeing of the service user and is only offered if other types of appointment are not suitable e.g. via technology such as Skype or other care providers. Care providers will thus need to work at the top of their licence; technology will be used if possible and the number of outpatient appointments will be limited as much as possible.

### *Challenge*

The traditional outpatient model will thus not be a sustainable model for the future.

The hospital is operating a traditional outpatient model whereby GP's are the gatekeepers referring patients in to a physical appointment (first appointment, diagnostics, follow ups). Thirty percent of the outpatient appointments have a waiting time of over 10 weeks. Waiting times are particularly long for procedures in Ophthalmology (47% >6 weeks) and Gastroenterology appointments (68% > 10 weeks and 44% >18 weeks). In addition to the current demand an expected increase of 4,019 additional outpatient first appointments, 7,529 additional follow up appointments and 5,968 additional outpatient procedures is expected by 2024/25. The increase in activity is driven primarily by the increase in demographics.

### *Initiative Outline*

This initiative aims to deliver care at St Mary's in a way that is sustainable now and in the future, given the anticipated changes in demographics, patient expectation and workforce. It

consists of a number of initiatives to transform outpatient pathways – both focussed on efficiency and shifting activity into the community. There are four key ways of reducing the number of outpatient appointments and procedures:

- Ceasing or reducing the default outpatient follow ups for certain specialties where evidence demonstrates that the follow up appointment does not improve wellbeing
- Providing services virtually
- Delivering care by other care providers (GPs, nurses, practitioners, AHP)
- Preventing unnecessary referrals from primary care

#### *Benefits and financial impact*

The financial modelling shows annual net savings between £88 – 175k, with a reduction in General Surgery outpatient follow-ups by 10-20%. Similarly 10-20% Ophthalmology, Gastroenterology, ENT and Pain Management outpatient follow-up attendances can be shifted to the community with nurse led appointments. Transforming outpatient pathways will decrease the pressure on the system by:

- Reducing the number of default follow-up appointments
- Reducing the number of referrals from primary care
- Increasing the number of virtual appointments
- Reducing the waiting times for outpatient appointments
- Reducing the waiting times for outpatient procedures
- Improving new to follow-up ratios

### **7.10.3 Strategic Decisions about Sustainability of Acute Services**

#### *Vision*

To provide leading acute services which are sustainable in terms of quality, safety, cost, volumes and workforce.

#### *Challenge*

The Service Sustainability review has identified services which are not sustainable in terms of:

- Meeting national and Royal College standards
- Workforce availability now and in the future
- Volume levels for quality governance purposes

The Trust will need to consider what options are available for these services and which elements can continue to be provided on the island, and which elements will need to move to a mainland provider.

The Trust is experiencing problems in recruitment particularly medical staffing in some key specialties and plans need to be developed for alternative models. The Trust has developed linkages in some services with mainland Trusts which may support future partnership working.

### *Initiative Outline*

To develop strategic options for services that are no longer sustainable in their current form as identified by the Sustainable Services review. Clear options need to be developed with recommendations for those acute services which are not sustainable, identifying which services should remain on the island as part of cohesive networks with mainland providers. The aim is to develop sustainable services for the Isle of Wight, which are clinically safe and affordable, and fit the emerging Sustainability and Transformation Plan (STP) vision.

### *Benefits and financial impact*

The work around the financial impact of the Strategic Decisions about Sustainability of Acute Services is in progress. It will result in a clear set of options and recommendations for those acute services which should remain on the island cohesively networked with complex care providers off island.

## **7.10.4 Leading Edge Elective Care**

### *Vision*

Delivering Planned Care to a level that improves access for patients and delivers performance in the upper quartile of NHS providers. A leading edge Planned Care facility at St Marys will be delivering the highest quality care for patients. This will be accomplished by a stepped change in the delivery of elective care.

### *Challenge*

Acute services are facing challenges around service delivery, including financial pressures, income constraints, recruitment and retention of key staff, and issues of volume and scale. The trust is failing to meet access standards (RTT) and needs to improve its focus on elective delivery.

Elective capacity is extremely limited at times due to emergency pressures, leading to cancellations in surgery. The Trust has a recovery trajectory for waiting times in surgery where it fails to meet national standards. The delivery of this plan is constrained by non-elective activity pressures. Some services may not be sustainable in the future and emerging new care models present real opportunity to introduce a stepped change in care delivery through a Planned Care facility.

### *Outline of Initiative*

To deliver a stepped change in the delivery of planned and elective care to a level that improves access for patients and delivers performance in the upper quartile of NHS providers. This will focus on adopting the principles of NHS Enhanced Recovery for all surgical in patients, undertaking surgery as day cases where possible, and transferring some activity currently undertaken as day cases to an out-patient setting or alternative provision. This will be developed in two phases: an initial phase to focus on joint injections, day case surgery, and enhanced recovery in orthopaedics areas for quick wins, and a second wider roll out phase.

### *Benefits and financial impact*

NHS England Commissioning for Value identified opportunities for £777k savings in elective care delivery on the island and the new care models provide opportunity to deliver cost savings.

## **7.11 New models of care: Urgent and Emergency Care**

For the purposes of the WISR programme, the existing Urgent and Emergency Care (UEC) Strategy definition of UEC has been adopted, being “Urgent Care is typically non-life threatening but may be time sensitive in that delays in delivering it may result in a deterioration in the persons health and wellbeing. Emergency Care is delivered for an unexpected illness or injury which is life threatening and without which the patient would suffer serious harm or death.” This creates scope for redesign that includes the emergency department in the hospital, primary and community care and self-management at home.

### *Key issues*

The key issues identified by system leadership, data analysis and the public during the redesign programme included:

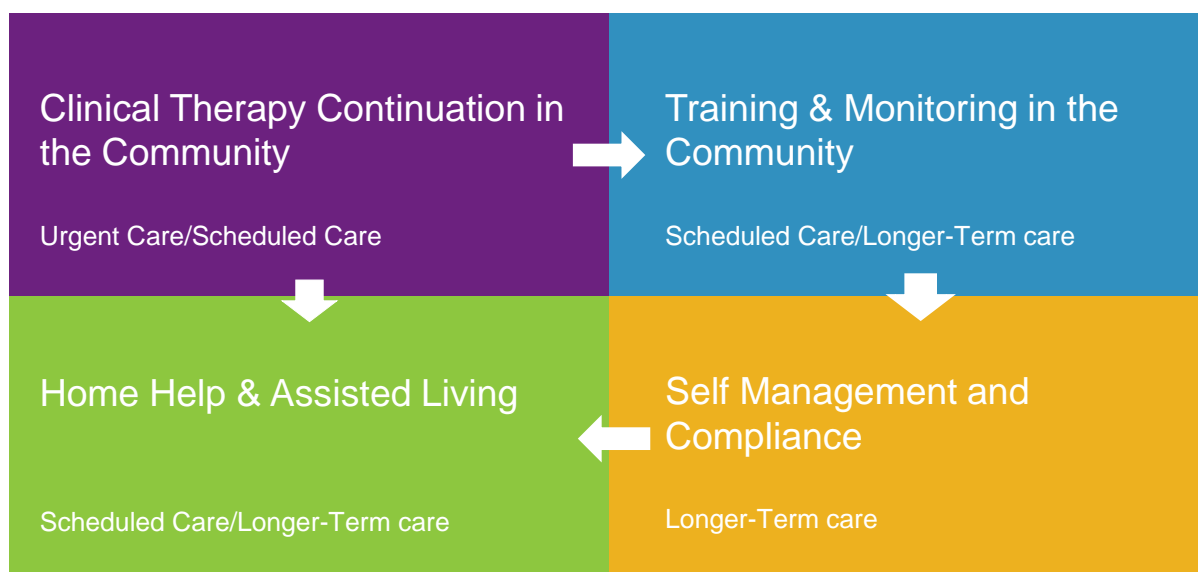
- GP out-of-hours services need to be offered in a sustainable and localised way
- The current walk-in centre contract will expire before March 2017
- Workforce vacancies, across primary care and at the hospital are difficult to recruit to, giving rise to a need for different ways of working
- People with non-emergency conditions need to be provided with clearer options to attend non-Emergency Department (ED) type settings
- Primary care and community support has to take a proactive role with colleagues from acute care to avoid reactive approaches to dealing with Urgent Care needs
- Information sharing across care disciplines is not in place, preventing co-ordinated and rapid decision making

### *Overall vision*

The Island vision for UEC is for the people on the Isle of Wight to have access to the right urgent and emergency care support, advice and information when it is needed, that is of a consistently high quality and which is also available when needed.

To meet this, the vision also includes a need to focus on self-management of Urgent Care needs by individuals before they determine a need to access care services and appropriate responses beyond a traditional triage approach into virtual assessment and advice to reduce attendance at settings such as A&E.

This vision is represented below (Fig. x) that outlines components that have been aimed for in this Working Group to alleviate demand pressure on emergency care services and the overall workload of GPs in the community.



**Figure 20: The overall vision for UEC whereby people support themselves and are supported to avoid unnecessary diversion to “traditional” medical settings such as A&E and 999 for Urgent Care needs**

#### *Initiatives summary*

Three final ideas have been proposed in this Working Group. These are:

1. Co-ordinated Urgent Care Service
2. Default Ambulatory Care in the Emergency Department
3. Community and MDT Case Management<sup>4</sup>
4. Future Proof Primary Care Provision<sup>5</sup>

#### **7.11.1 Co-ordinated Urgent Care Service**

##### *Vision*

To provide an integrated emergency care system for the Island which means that patients are seen by the correct professional for their needs at an appropriate time for the condition. This system will reduce duplication by maximising the number of times the patient sees the correct person first time. It will also ensure that people are only admitted to hospital if that is the only means by which their care can be undertaken.

##### *Challenge*

At present, patients with urgent primary care needs may present to a variety of sources of care including their own GP in hours, the GP out of hours service, the Beacon Centre, A&E department and the ambulance service. The complexity often means they do not see the best clinician for their needs or see multiple care professionals

<sup>4</sup> Being combined with Specialty Teams form the Frailty working group and Community Teams/ Case Management from the Urgent and Emergency Care working group.

<sup>5</sup> Initiative raised for further development prior to 6th July with a high level current view in this report.

### *Initiative outline*

Patients will only need to know three phone numbers – 999 for life threatening emergencies, their own GP during office hours, 111 for other urgent needs. The services will be coordinated to ensure a uniform approach and designed to maximise the chances of seeing the best person for their needs first time. Those attending for a face to face consultation will also have a simplified approach. Access to their own GP surgery for urgent consultations will be improved. When this service is not available, a unified Urgent Care centre using existing space at the NHS Trust will be available and will also be the route of public access to the A&E.

### *Benefits and financial impact*

The number of patients referred by 111 to the ED will decrease by 40%. Emergency bed days will reduce by 10% and emergency re-admissions within 30 days will reduce to below the national average. Patient experience outcomes will be improved.

Financial modelling of this initiative forecasts potential annual savings of between £1.3 – 1.8m.

For more information, see business case in [Appendix x](#)

## **7.11.2 Default Ambulatory Care in the Emergency Department**

### *Vision*

The vision for this initiative matches the initiative above as it is a sub-component of it.

### *Challenge*

The Acute Trust is facing a potential forecast increase of A&E activity of 9% over the next decade with the potential for admitted patients to rise by 19%. This will place additional unsustainable pressure on the ability of the Trust to manage demand for A&E activity with negative impacts on capacity to perform elective inpatient care.

### *Initiative outline*

This initiative aims to introduce default ambulatory care for all people who attend the Emergency Department using a nurse-led protocol approach for all ambulatory care sensitive conditions. It also focuses on changing the role of the Acute Trust to reach out more into the community, including care homes to support discharge. Changes in staff behaviour to allow risk-based decisions to be reached jointly with patients are needed to avoid unnecessary admissions.

### *Benefits and financial impact*

Patients will be able to return to their place of residence on the same day as attendance at the Emergency Department. Patient experience outcomes will be improved. 40% of all same day referrals from GPs and A&E that traditionally become admissions will be avoided.



Financial modelling of this initiative forecasts potential annual savings of between approximately £79k.

For more information, see business case in [Appendix x](#)

### **7.11.3 Community and MDT Case Management**

#### *Vision*

This initiative aims to provide proactive case management for the most complex patients and support people to remain at home where possible and get home efficiently following emergency admissions.

#### *Challenge*

The main “wicked issue” that this scheme aims to help alleviate is the need to avoid unnecessary admissions as a result of individuals presenting with urgent or emergency care needs at A&E and improve capacity within the community to manage a cohort of complex and vulnerable patients, including discharge.

#### *Initiative outline*

The scheme will provide intensive care management of top 10% of complex patients in each locality that will reduce dependence on GP capacity and avoid hospital admissions. The scheme will see the transfer of generalist nursing into the community with access to specialist and therapist services from a central pool. This scheme provides an opportunity to develop the workforce and provide a higher quality of service to our most vulnerable and complex patients.

#### *Benefits and financial impact*

Non-elective admissions will reduce by 2%, patient experience outcomes will be improved, emergency re-admissions within 30 days will reduce.

Financial modelling of this initiative forecasts potential annual savings of between £2 – 2.5m per annum.

*The financial impact for this initiative will be merged with similar MDT approaches from the Frailty and LTCs Working Groups.*

For more information, see business case in [Appendix x](#)

### **7.11.4 Primary care support**

*This initiative is currently under development and will require agreement from GP Practices and the One Wight Health GP Federation prior to any decision to implement.*

#### *Vision*

This initiative has a vision to support primary care to be reconfigured in the way which is most appropriate for future delivery of services and flexibility needed by GP Practices on the

Island. It includes having a primary care system that offers as much support as possible to increase capacity of GPs.

### *Challenge*

The Hampshire and Isle of Wight STP indicates that 30% of GP appointments are not needed, indicating that work is needed to change behaviours for access to primary care. Several GP practices on the island are already at capacity for appointments and retiring GPs expected over the next 5-10 years will exacerbate this delivery model challenge.

### *Initiative outline*

Support for some GP practices may take the form of telephone triage and telephone appointments that is dependent on the complexity and continuity of the needs of the patient (including whether a named GP is required or not). Support to reduce home visits may involve skype appointments, an expanded hospital car service and/or asking residential homes to carry out basic observations such as urine test strips prior to appointment requests. Data sharing across the system by linking care professionals to SystMOne will aid decision making and reduce GP appointment requests. A paid for subscription by practices to an enhanced 111 with senior clinical support could be offered when practices have reached capacity but can't support (or can't recruit) an additional GP partner.

The CCG, individual GP Practices and One Wight Health will work towards flexible and appropriate contracting and organisational form(s). This explicitly means allowing practices (and/or One Wight Health) to determine how best to configure themselves to meet the needs of future pressures in primary care. This will differ on a practice and locality basis and align to the ongoing concerns of individual practices.

### *Benefits and financial impact*

Quantitative benefits will be determined on agreement of the initiative outline and will be aligned to the challenge and outline described above. Qualitative benefits include an increase in capacity for GPs to manage workload over the next ten years, a greater proportion of non-GP staff in primary care working at the top of their licence and cultural change with staff and the public to encourage self-management of urgent care needs when appropriate.

For more information, see business case in [Appendix x](#)

## **7.12 Summary of WISR initiative benefits**

The initiatives outlined above in section 7.7 are aligned to the overall vision for the Island to offer a sustainable set of health and care services with professionals working at the top of their licence. Patients and service users will be supported to make the right decisions about their own care and self-manage their care needs to the fullest extent possible during a crisis before turning to care services for support.

Capacity challenges in acute care, community care, mental health and primary care will all be relieved as a result of initiatives that provide better signposting to existing alternatives



and changes to increase the efficiency of care delivery without compromising care quality (such as increased ambulatory emergency care).

Care staff will be able to make better, more informed judgments about care decisions for all service users thanks to proposed improvements in data sharing and use of digital technology that will also remove the need for travel away from home in some cases. Carers will feel more supported within the care system as they become more connected to a wider service user and carer support network available on the Island.

Health conditions that have been difficult to support in the past (such as neurological conditions) will be provided for in a more holistic way through wellbeing planning, social support and accountable case management.

A summary of the overall benefits in terms of finance, demand and workforce within the care model and initiatives described above is detailed in section 8.

DRAFT

## 8. Future service financial model

### 8.1 Our approach to quantifying the challenge

The Isle of Wight Health and Care economy has worked collaboratively to develop a robust and common view of the financial baseline for a 10-year period, beginning from the base year of 2014/15 going through to 2024/25. This baseline covers the Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust, and social care provision by Isle of Wight Council, Primary Care and Voluntary Care.

The purpose of this baseline is to identify and quantify the likely financial position of the island's health and care economy if the current models of service delivery are continued into the future without any redesign occurring or achievement of business-as-usual productivity and efficiency or commissioner QIPP. This 'do-nothing scenario' provides the conceptual yardstick against which the likely impact of any proposed service changes can be measured.

The key features of the baseline development approach are that it:

- Captures all NHS and social care activity on the island and projects demand forward by marrying activity data to ONS subnational population projections for the island
- Applies a forecasting approach consistent with that being undertaken in health economies across the country and recommended in the Strategy Toolkit published by NHS Improvement
- Uses standard financial forecasting assumptions and inflation percentages
- Is developed collaboratively with the CCG and providers on the island, through workshops, regular meetings and one-to-one discussions
- Follows standard planning assumptions and guidelines
- Is confirmed by finance directors at the CCG, Trust and Council

The purpose of creating the 'do-nothing' baseline was to develop one version of the truth (robustly evidence based and follows NHSE and NHSI recommend planning and forecasting assumptions) regarding the future challenges facing the Health and care economy of the Isle of Wight.

### 8.2 Our approach to analysing the redesign initiatives

For each redesign initiative developed by the working groups, a consistent set of variables was quantified and analysed to ensure that the analysis was performed in a consistent and comparable way. In particular, each initiative was analysed in terms of the following:

- The level of care setting in which activity currently takes place, and where it will take place following redesign (i.e. acute, community, primary etc.)
- The point of delivery of care (i.e. non-elective, elective, outpatient etc.)
- Which service line/division/specialty currently delivers care, and which will do so in the future service model
- The cohorts of patients which each initiative is targeted at – for instance over 65s with one or more long term condition

- The volumes of patient activity which are impacted, as measured in terms of spells, contacts, weeks of care etc.

The following process was undertaken in order to generate and agree assumptions underpinning the analysis for each initiative:

- Discussions with working groups to agree an initial set of assumptions on the possible impact (i.e. a 5-10% reduction in non-elective spells). These were supported by review of academic literature, input from clinicians' professional judgement and examples from other health economies
- The presentation of initial analysis to working groups and further refinements made to the planning assumptions
- Sign off by working groups of the final assumptions underpinning the modelling of each initiative

The activity and financial modelling of the initiatives enabled:

- An illustration of the impact of each initiative on activity at point of delivery and the financial impact on individual service lines, providers and the commissioner
- Clear articulation of the knock-on impact of each initiative on the different settings of care.
- An illustration of the individual impact of each initiative as well as the overall aggregated impact on the system as a whole

### 8.3 Summary of overall financial impacts

The below table sets out the impact of each of the initiatives modelled in terms of the financial savings each would generate when compared to the 'do-nothing' scenario. These represent the whole system saving, which is equal to the provider cost savings of each initiative.

The Workings Groups determined a potential range for the impacts that each initiative would have (for instance a 1% to 5% reduction in inpatient spells). Therefore, the overall savings range presented in the table below shows the overall savings if the lowest impacts are assumed for all schemes and the overall savings if the highest impact is assumed.

			17/18		24/25	
			Impact (Low - High)		Impact (Low - High)	
<b>Children and Young People</b>	PAU	(£000's)	(100)	121	(116)	143
	Autism & ADHD	(£000's)	33	33	38	38
	Emotional Wellbeing & Intervention	(£000's)	30	89	74	154
<b>Total</b>			<b>(38)</b>	<b>242</b>	<b>(4)</b>	<b>335</b>
<b>Urgent and Emergency</b>	Ambulatory care	(£000's)	79	79	94	94
	UCC Front Door	(£000's)	453	604	532	709
	Primary Care (WISR)	(£000's)	437	1,093	512	1,280
<b>Total</b>			<b>969</b>	<b>1,776</b>	<b>1,138</b>	<b>2,083</b>
<b>Planned Care</b>	Digital Solutions	(£000's)	710	1,230	830	1,439
	Extended Physio role	(£000's)	30	152	36	178
	Transforming Outpatient Pathways	(£000's)	88	175	103	205
<b>Total</b>			<b>828</b>	<b>1,557</b>	<b>969</b>	<b>1,822</b>
<b>Frailty</b>	Acute Frailty Service	(£000's)	92	276	108	324
	Community health and care	(£000's)	2,047	2,482	2,397	2,906
<b>Total</b>			<b>2,140</b>	<b>2,758</b>	<b>2,505</b>	<b>3,230</b>
<b>LTCs</b>	LTC Locality Hubs	(£000's)	9	22	10	26
	LTC Local Wellbeing	(£000's)	2,000	3,530	2,753	4,542
<b>Total</b>			<b>2,009</b>	<b>3,553</b>	<b>2,763</b>	<b>4,568</b>
<b>Mental Health</b>	Safe Havens	(£000's)	232	385	277	458
	IAPT+	(£000's)	37	40	23	21
<b>Total</b>			<b>270</b>	<b>424</b>	<b>253</b>	<b>438</b>
<b>Grand total</b>			<b>6,177</b>	<b>10,310</b>	<b>7,624</b>	<b>12,476</b>

<b>Less: potential double counted impacts</b>						
	UCC Front Door	(£000's)	-	453	-	709
	Primary Care (WISR)	(£000's)	-	437	-	1,280
	LTC Locality Hubs	(£000's)	-	9	-	26

<b>Net Savings</b>	<b>(£000's)</b>	<b>5,278</b>	<b>8,591</b>	<b>6,570</b>	<b>10,461</b>
--------------------	-----------------	--------------	--------------	--------------	---------------

In order to quantify the overall savings for each scheme they have initially been modelled independently. However, a number of the different schemes are predicted to impact the same cohort of patients in the same way – for instance more than one scheme may intend to prevent A&E admissions of over 65s with a long term condition. Therefore were it has been identified that schemes are having an overlapping impact then this has been excluded – it is not possible to avoid a single A&E admission twice.

At this stage a number of proposed initiatives have not been modelled as they are still in very early stages of development or certain key impact assumptions are still not fully determined. These are:

- Complex needs service
- Social support
- Supporting Primary care
- Service line reconfiguration
- Dementia care

The analysis of the impact of each option was performed on the following basis:

- The data used to create the 'do-nothing' baseline was based on 2014/15 datasets from across the health and care economy. As a result, the ten-year view is forecast to 2024/25.
- The Working Groups were responsible for defining and/or validating the assumptions which underpin each option (such as for instance the percentage reduction in inpatient spells, the change in average length of stay etc.)
- The analysis was performed at the level of average costs per unit of activity
- Each option was analysed as being in a steady state position and therefore the analysis has not included any costs associated with double running or enabling investment
- Unless an alternative assumption was available, it was assumed that where activity has been transferred from an acute to a community setting the unit costs in the community will be 50% of those in the acute

#### 8.4 Impact on the 'wicked issues'

In the case for change section of this document a number of wicked issues were identified, which comprise the central drivers of the growing challenges in the island's health and care economy. The below table demonstrates how the proposed initiatives will address these wicked issues:

Wicked Issue	Initiatives addressing the wicked issue	How the initiatives will impact the wicked issue
<b>Unplanned (emergency) care</b> On the island the amount of unplanned care episodes are high when compared to the rest of the country. Many of these episodes would be fully avoidable through earlier intervention. Emergency episodes are very often not the most effective or efficient means of treatment for patients, and represent a very significant cost driver for the acute trust	<ul style="list-style-type: none"> <li>• Default ambulatory care</li> <li>• Urgent Care Centre Front Door</li> <li>• Increased Primary Care Capacity</li> <li>• Safe Havens</li> <li>• LTC locality Hubs</li> <li>• LTC Local Wellbeing</li> <li>• Community Health and Care Teams</li> </ul>	<ul style="list-style-type: none"> <li>• All the initiatives will result in fewer emergency attendances and admissions through a combination of better signposting within urgent care, earlier intervention to prevent crises before they arise, early triage for less acute conditions and</li> </ul>
<b>Productivity and Efficiency</b> The island faces a combination of productivity challenges. Some of which are common throughout the country and are outlined in the recent Carter Review. Others are particular to the island such as dealing with low activity volumes and travel costs for certain types of staff	<ul style="list-style-type: none"> <li>• Transforming outpatient pathways</li> </ul>	<ul style="list-style-type: none"> <li>• The primary vehicle for achievement of efficiency savings are the Cost Improvement Plans for the Trust, which must aim to achieve 'business as usual' cost reductions in addition to the savings achieved by the redesign initiatives.</li> </ul>

		<ul style="list-style-type: none"> <li>• However a number of the initiatives will result in more efficient use of resources on the island, most notably Transforming outpatient pathways, which aims to significantly reduce the number of clinically unnecessary outpatient appointments, freeing up capacity for both medical consultants and administration staff</li> </ul>
<b>Primary and Community Capacity</b> GPs on the island face a significant and challenging workload and currently deal with many appointments that could be avoided through earlier triage and signposting of services. Community services	<ul style="list-style-type: none"> <li>• LTC Local Wellbeing</li> <li>• Extended Physio Role</li> <li>• Community Health and Care Teams</li> <li>• Digital Solutions</li> </ul>	<ul style="list-style-type: none"> <li>• The Extended Physio Role initiative would free up a significant number of musculoskeletal primary care appointments, due to effective triage by a targeted team of physiotherapists</li> <li>• Implementation of MDT-led care plans will result in less avoidable GP appointments</li> <li>• Earlier identification of needs for frail and elderly patients to ensure better planned and efficient care</li> </ul>
<b>Mental Health</b> There is a need for a comprehensive evidence based, recovery focused service on the island, with a simplified pathway and a reduction in the growth of inpatient activity, particularly for less severe patients	<ul style="list-style-type: none"> <li>• Safe Havens</li> <li>• IAPT+</li> <li>• Autism and ADHD</li> <li>• Emotional Wellbeing and Intervention</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced inpatient mental health activity through treatment of less severe patients in a community setting</li> <li>• Earlier identification and engagement of young people with mental health issues</li> <li>• A single point of access to Mental Health care, creating a simpler patient pathway</li> </ul>
<b>Workforce</b> With demand for health and care activity forecast to increase significantly over the next five to 10 years, the need to recruit additional staff will be great. Over the same period,	<ul style="list-style-type: none"> <li>• All</li> </ul>	<ul style="list-style-type: none"> <li>• Transferring of low acuity care to community or primary settings will ease recruitment pressure for highly skilled consultants and other</li> </ul>



the working age population of the island is forecast to marginally decline, meaning that there will be no readily available pool of workforce from which to recruit		senior clinical staff, most notably in the acute setting <ul style="list-style-type: none"> <li>• More efficient pathways, effective triage and signposting will lead to less unnecessary or avoidable activity, again reducing the pressure on staffing</li> </ul>
---	--	---

## 8.5 Contribution to addressing the overall system gap

The forecast financial gap for the entire health and care economy reaches £126m per year by 2024/25. Closing this gap will require progress across three areas:

- Service redesign – implementing the initiatives required to achieve the total of the combined savings identified above
- Ongoing recurrent efficiency savings – taking action to achieve the 2% standard efficiency target per the current Sustainability and Transformation Plans being developed
- Prevention and demand mitigation – reducing demand growth by 1% per year through a combination of commissioner QIPP, Public Health Initiatives and a reduction in procedures with limited clinical value.

When the service redesign initiatives are viewed in aggregate, and after removing double counting, they provide recurrent annual revenue savings of £10.5m per year by 2024/25. The total savings for each year in the forecast period are set out in the table below.

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Total gross saving	10,283	10,575	10,887	11,208	11,509	11,821	12,143	12,476
Less double counted impacts	(1,719)	(1,756)	(1,797)	(1,839)	(1,881)	(1,925)	(1,969)	(2,015)
<b>Net saving</b>	<b>8,564</b>	<b>8,819</b>	<b>9,089</b>	<b>9,369</b>	<b>9,628</b>	<b>9,896</b>	<b>10,174</b>	<b>10,461</b>

As a sensitivity the potential knock on impact to social care services has been calculated, for which an assumption has been made that 5% of all avoided inpatient spells will also result in the avoidance of a long-term residential support package. This is combined with a reduction

of 10% of people with dementia living in care homes. This analysis requires further development at this stage and is only included below for illustrative purposes.

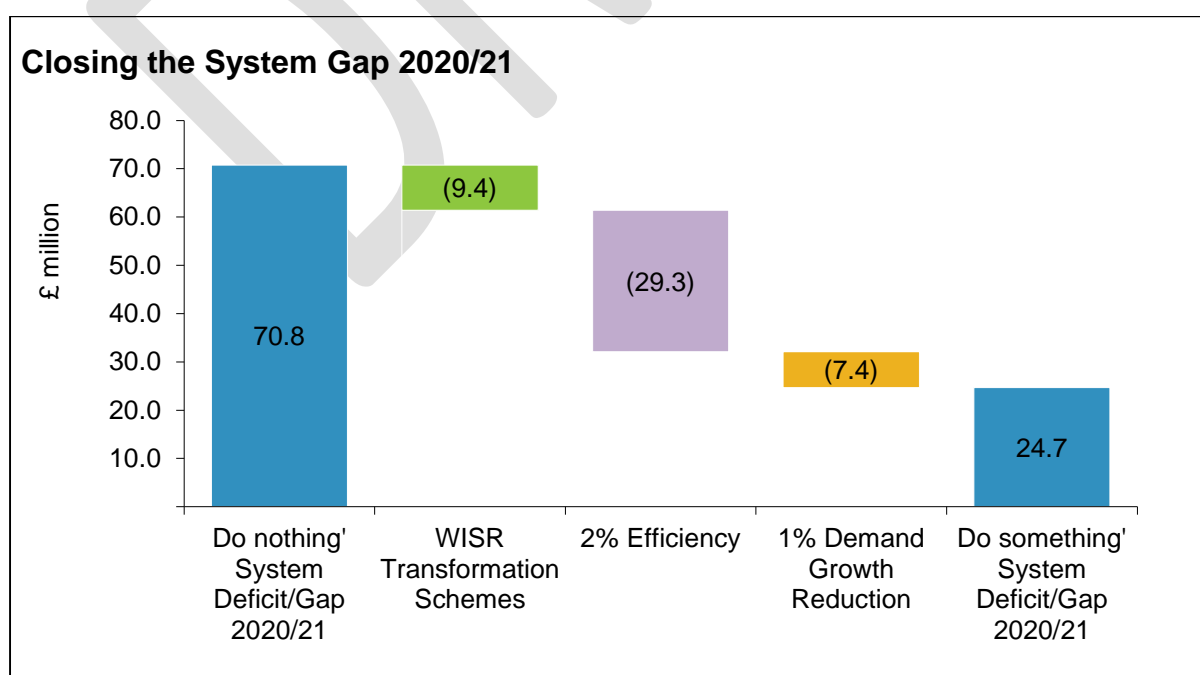
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
<i>Social care savings sensitivity</i>	4,491	4,587	4,687	4,790	4,890	4,992	5,097	5,205

It is important to note that these are recurrent revenue savings arising due to either avoidance of future activity or through transferring future activity into a lower cost setting of care. The capital costs associated with implementing the initiatives are not included at this stage, and the calculations also do not currently assume any double running will be required as the initiatives are set up.

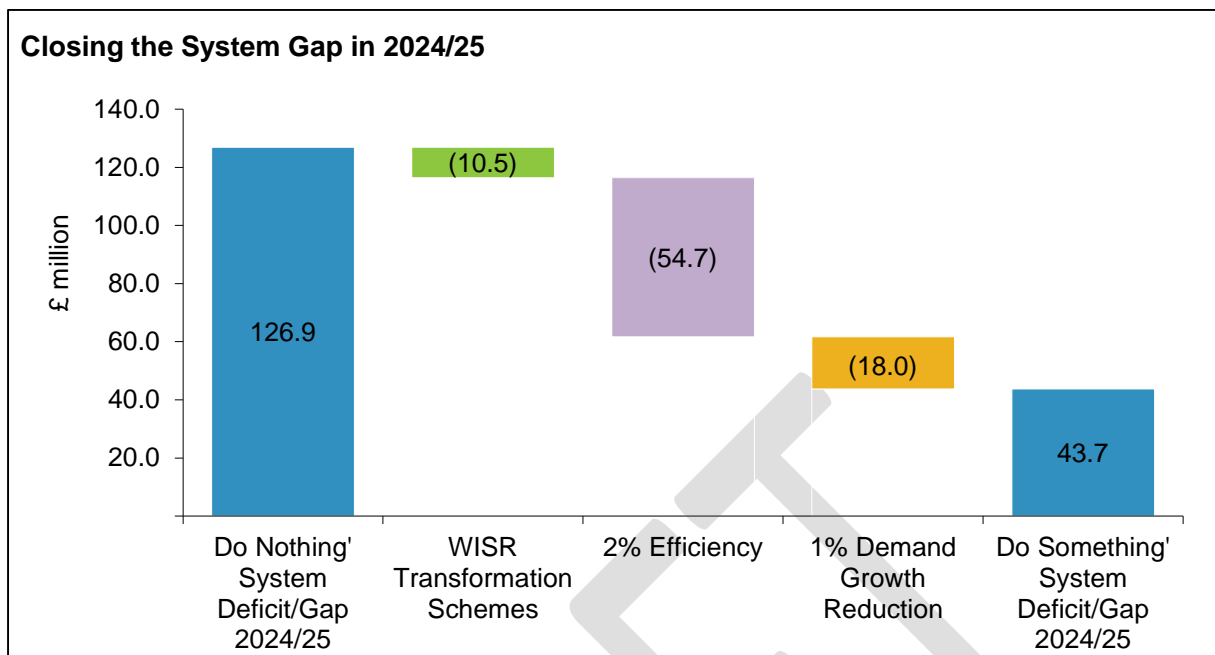
A number of the initiatives are also designed such that they will impact similar cohorts of patients; for example, more than one initiatives aims to reduce non-elective admissions for over 65s. An exercise has been undertaken to ensure that there is not double counting of the impact of the initiatives overall ensuring that any future activity which will be avoided is only counted once, and is not included in the savings of more than one initiative.

Two of the initiatives are phased in their impact (IAPT+, Emotional Wellbeing), whereas the remainder have been assumed to take effect from FY2017/18.

As the bridge diagrams below show, when service redesign, ongoing efficiencies of 2% per year and demand mitigation of 1% per year are factored in, the overall system gap is forecast to be reduced from £70.8m to £24.7m by 2020/21, and from £126.9m to £43.7m by 2024/25.







As can be seen, after redesign, ongoing efficiency and demand mitigation are factored in this leaves a residual funding challenge of £24.7m by 2020/21 and of £43.7m by 2024/25.

## 9. Governance and assessment against the four tests

### 9.1 Governance arrangements

As outlined in Section 2.2, the WISR programme is a core workstream within the Isle of Wight *My Life A Full Life* (MLAFL) programme. MLAFL is an NHS England Integrated Primary and Acute Care System Vanguard site.

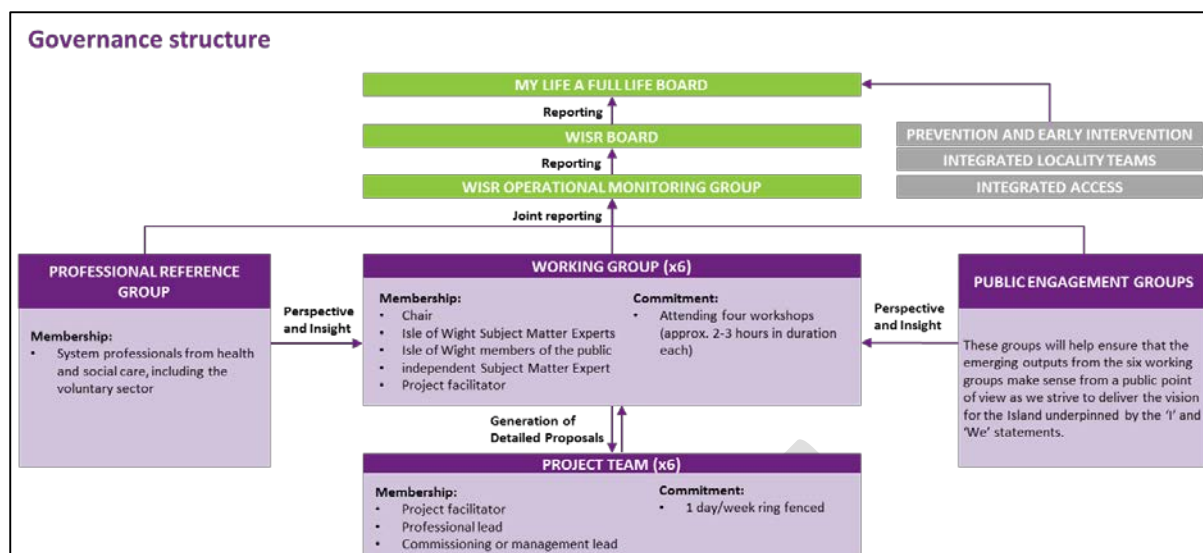
The current governance arrangements are as follows:

*MLAFL Programme Board:* The MLAFL Programme Board was established in 2013. It is governed by Programme Board convened jointly by the statutory and non-statutory programme partners, including the Isle of Wight Council, the Isle of Wight NHS Trust and the Isle of Wight Clinical Commissioning Group (CCG). Within this partnership, the CCG are responsible and accountable for development of the WISR programme and for the subsequent consultation and implementation process. The MLAFL Programme Board is establishing clear terms of accountability to the Isle of Wight Health and Wellbeing Board and establishing its authority to act to deliver the programme across the programme partners as part of a system-wide Governance Review supported by the Local Government Association (LGA).

*The WISR Programme Board:* The MLAFL Board established the WISR Programme Board in early 2015. The Programme Board is accountable to the MLAFL Board, and is chaired by a Lay Member. Membership of the Programme Board includes the Accountable Officer of the CCG, the Chief Executive of the Trust, the Director of Adult Services at the Council, Director of Public Health, CEO of Community Action, and the Head of One Wight Health. The membership of the WISR Programme Board also has clinical leadership from a GP lead, consultant, and Medical Director.

*The WISR programme Operational Management Group (OMG):* The OMG was established by the MLAFL Board in February 2016. The OMG meets on a weekly basis and is chaired by the Lay Chair of the WISR programme Board. Membership of the OMG includes the representation from the CCG, Trust, Council, Voluntary Sector, primary care, and clinicians.

The WISR Programme is led by a full time Programme Director. The WISR Programme Board and Programme Director are responsible for the process outlined in this pre-consultation business case, the consultation later in the year, and any implementation of the business case once approved.



**Figure 21: MLAFL Governance structure**

## 9.2 The 'four test' review

In 2010, the Secretary of State introduced the 'four key tests' that need to be applied to assure NHS significant service change proposals before they are put forward for local Public Consultation. These requirements have been further developed in *Planning, assuring and delivering service change for patients* (NHS England, November 2015). The WISR programme has satisfied itself against these tests to date as summarised below. Further consideration against these four tests will be given when developing the proposed service model and options for implementation prior to the consultation phase of the project.

### *Test One: The changes have support from GP Commissioners*

GP clinical commissioners and the whole GP community on the Isle of Wight have been actively engaged and involved and have led key aspects of the WISR programme. The CCG Clinical Executive has played an active part in leading the development of the redesign priority focus areas and the individual GP Clinical Executive members (and other CCG Clinical Leads) have taken an active role in chairing and leading the various redesign groups. The CCG Clinical Executive has enabled access to existing and the creation of additional GP half-day Learning Events, which on three occasions (13th January, 17th March and 18th May) during the redesign phase have been held as joint sessions with the medical Consultant body and senior social care colleagues. The proposals in this paper will be formally presented to the CCG Clinical Executive on 21st June 2016.

The GP Federation, One Wight Health has also been actively involved in the programme. The One Wight Health Chair is a member of the MLAFL and the WISR Programme Boards and has provided clinical leadership in the development of the Frailty redesign proposals. GP Federation members have contributed to each of the redesign groups and have taken a lead role in the development of the Long Term Conditions strategy where they are informing and being informed by the emerging redesign proposals which in turn are shaping wider thinking around the development of a primary care services on the Island.

In addition to having involvement in the Working Groups, the Professional Reference Group, and the MLAFL Board, the WISR Programme has held three commissioning workshops for both CCG and Council commissioners. The purpose of these workshops was to discuss the impact of the initiatives and what this may mean for transitioning towards a One Island Pound and value based commissioning. The output of these sessions is a Joint Commissioning Strategy, which will be produced towards the end of 2016.

The consultation process has been design so that throughout this period the WISR programme will continue to engage CCG members.

*Test Two: The public, patients and local authorities have been genuinely engaged in the process*

The WISR Programme has undertaken an extensive communications, co-production and engagement process over the past six months (see section 5). A comprehensive communications and engagement strategy was implemented with the support of health, local authority, voluntary and independent sector partners. This involved the production and island-wide mail out of the Case for Change leaflet; over 160 people mobilised in six Working Groups, including the Local Authority and members of the public; 20 public events (one for each Working Group in each locality and two initial public engagement events); more than 230 community groups contacted; and over 300 people reached through direct community conversations working closely with voluntary sector partners and service user groups. Particular care has also been taken to alert and seek to involve groups within the Island community that are seldom heard and those with protected characteristics under the Equality Act 2010. An easy read version of the leaflet was co-produced with community groups to assist in this process. An Island-wide survey contained within the leaflet, and made available online, also attracted over 600 responses.

In addition, staff and volunteers were actively involved across the NHS Trust, CCG, Local Authority and voluntary sector in briefing and engagement sessions, with a mix of formal and informal drop-in sessions. This has included separate sessions with each of the Clinical Business Units, the Voluntary Sector Forum and wider sessions for professional and non-professional staff across the health and care system. These have developed during the process from briefing sessions; to raise awareness of the programme, to interactive engagement sessions where staff and volunteers were able to contribute their views and ideas to the process. This included joint meetings for adult social care and NHS Trust staff working in an integrated way to review the emerging redesign initiatives. This work is continuing over the summer period.

The process has also sought to engage the local MP, town and parish councils and Isle of Wight (County) Councillors with a series of briefing and engagement sessions both within, and in addition to, the formal democratic processes of the local authority. The portfolio holder for Adult Social Care and Integration has also been a significant part of the programme throughout the process and a lead sponsor for key workstreams within the programme.

Throughout summer and prior to public consultation, the WISR programme will continue engaging with the public and key stakeholders to gauge their views.

The WISR programme proposes to have a 13-week consultation and to maintain engagement activities in the lead-up to this and thereafter.

*Test Three: Proposal and recommendations are underpinned by a clear evidence base*

The development of initiatives for the proposed care model have been based upon the input of local and external clinical and social care expertise.

- Local expertise: The WISR Programme has led a process of co-production with as wide a range of clinicians and social care professionals from every sector and discipline. Each Working Group had representation from across the system, including from the Voluntary Sector, Policing, Housing and members of the public. In addition, the Professional Reference Group, which provided recommendations on the initiatives, had representation from across the system.
- External expertise: The WISR Programme brought in approximately 20 external experts to assist with the development and assessment of initiatives. For example, Professor Matthew Cooke assisted with the Urgent and Emergency Care Working Group; Dr Geraldine Strathdee worked with the Mental Health Working Group; and Clare Evans worked with the Planned Care Working Group.

In addition to the local and external expertise, the development of the focus areas and their initiatives has been informed by the JSNA, CCG and Local Authority Atlas Opportunity Tools, Health and Wellbeing Strategy for the Isle of Wight 2013-16, and the Isle of Wight Clinical Strategy.

The majority of initiatives proposed for the assurance process are based on national and / or international best practice. To reflect this, each strategic outline business case answers the questions 'Why was this change chosen above others?' with a reference to where this initiative has been successfully implemented. For example, the initiative to introduce an Ambulatory Care model in St Mary's A&E is based on the Southern Manchester model, supported by recommendations from the NHS Institute for innovation and Improvement.

*Test four: The changes give patients a choice of good quality providers*

Providing patient choice has been a key consideration throughout the redesign process to date. In developing the framework to assess any redesign ideas against, called the 'Individual Needs Framework', patient choice part of several criterion.

At this stage of the WISR programme, we believe that the care model and initiatives proposed will not result in a reduction of choice of existing commissioned providers and will enhance choice for local residents to receive care in their communities. The proposed initiatives increase access in terms of service provider location and the ability to choose the timing of their care. The level of choice provided by any model will be reviewed at each stage of the WISR programme going forward.

### **9.3 Equality impact assessment**

In addition to addressing the four tests as outlined above, the MLAFL evaluation workstream will undertake an Equality Impact Assessment as part of the project.



## 10. Next steps: public consultation

### 10.1 The consultation process

Given the WISR programme is considering changes to the whole health and care system, it is important to continue to involve the public in the redesign process and formally consult with people on the proposed clinical model and the potential options for its delivery.

The WISR programme is very mindful of relevant legislation including Section 242 of the NHS Act 2006 and the 2010 Equality Act. Due consideration will also be given to wider learning including the Independent Reconfiguration Panel's *Learning from Reviews*, which highlights reasons why programmes are referred to the Secretary of State for Health as well as relevant sections in the NHS England guidance, *Planning, assuring and delivering service change*, and *Reconfigure it out*, produced by the NHS Confederation.

It is proposed that the consultation run from the 1 November 2016 to 31 January 2017. This is a period of thirteen weeks rather than twelve because the Christmas holidays falls during the period.

#### *Preparation over the summer 2016 period*

Prior to consultation, the WISR Programme will continue to involve the public as the consultation options are developed during the NHSE Assurance process. This will include:

- Continuing to invite people to submit ideas, comments and suggestions
- Working with key community representatives to check the way the review team has scored options and to ensure their views are considered as the final shortlist of options is developed
- Liaising with key councillors particularly those on the Health Overview Scrutiny Committee
- Testing the impact of the potential options with equality/protected groups. This will help the programme team be aware of the likely impact of any changes on some of the most vulnerable people on the Island.

A full consultation plan and consultation document based on the options presented in this pre-consultation business case will be developed. Independent engagement experts with experience of running engagement and consultation programmes before have been enlisted to assist with this. The approach to consultation is to involve people and staff throughout such as:

- Using the lessons learnt from the case for change phase, for instance, focussing more on using existing channels (e.g. community groups' meetings) rather than too much reliance on asking people to come to set events.
- Asking the public what the best way to reach all groups on the Island is, including those who are hard to reach.
- Testing the approach to engaging staff in the consultation – and consider their feedback

### *Developing and testing materials*

The core materials will include:

- A consultation document setting out the current situation, the options for change and how people can have their say. The document will include information to spell out the advantages and disadvantages for the various options. The document will be designed to help people on the Island make an informed decision
- A summary document will be posted to all households on the Island with a free post card to request a full consultation document
- People on the Island will be invited to complete a consultation response form which will be available from the MLAFL website and on paper
- Easy read materials will also be produced and cascaded via community organisations. Additional materials such as large print and alternative languages will be available on request

Additional materials will include:

- Advertising materials
- Updates to the MLAFL website, including video and details of how to get involved in the consultation
- Posters/flyers for distribution to community facilities, surgeries, the hospital, care homes and so on
- FAQs

In September and October 2016 the WISR programme will work with key community groups on the Island to ensure the type of materials we develop for consultation are appropriate, including for people with learning disabilities. The intention is to test the language and some of the descriptions of options in the consultation document with key community representatives before the document is published. The feedback will be considered carefully and amend materials to ensure they are fit for purpose.

### *Consultation activity*

Face-to-face discussions are an important part of the consultation process. The WISR programme will work with the voluntary sector to use existing channels wherever possible so that we can meet people in their communities.

In addition, three public exhibitions (one in each geographical locality) will be held during the consultation period. Public exhibitions are a very useful way for people to understand more about the consultation options and their potential impact. The exhibitions will be held at a range of times during the day and evenings. Key components include:

- An exhibition with display boards bringing to life the pros and cons of each option
- An opportunity to speak to a clinician or member of the WISR programme, ask questions and raise points of challenge and new ideas
- Materials about the consultation including the consultation document, summary and consultation response form
- iPads with internet connection enabling people to complete the consultation response form on site. Paper copies and assistance will also be available as required

To ensure adequate reach to the target populations, and will use multiple channels of communication. This will include:

- Direct mail to every household with the consultation summary or flyer
- Direct mail to community organisations
- Content about the consultation for inclusion in community organisations' newsletters and on websites
- Coverage across print, online and broadcast channels aimed at encouraging people to have their say
- Online, radio and newspaper advertising, subject to costs
- Regular updates on the MLAFL website and email updates

Particular attention will be paid to ensuring that those identified as protected characteristics groups (Equalities Act 2010) are reached. The WISR programme will develop a clear plan alongside the consultation strategy that sets out how to engage with both hard to reach and protected groups. Working collaboratively with voluntary sector organisations, the programme team will:

- Seek their advice and feedback on the best ways to reach and engage people
- Test materials to ensure they meet the needs of these communities
- Use a variety of existing channels (e.g. community organisations' forums, newsletters, face to face meetings and social media) to invite people to get involved in the consultation
- Work with Community Action Isle of Wight and provide a facilitator to attend community group meetings to discuss the consultation and enable people to complete the consultation response form. The number of these meetings is to be decided but anticipate a minimum of ten

## **10.2 Results analysis and feedback**

The WISR programme team have appointed an external communications firm to evaluate the consultation process and analyse the results. This partner will develop a process and infrastructure that reassures stakeholders of the independent nature of the evaluation responses.

People will be able to respond to the consultation in a variety of ways including:

- Online using the consultation response form
- Completing paper copies of the response form
- Correspondence via letter and email
- In person at facilitated events
- By telephone as required

Following the process, the WISR programme team will analyse and assess the consultation responses in the form of a final report and a statistical analysis. All responses will be carefully considered. The report will be used to inform the decision-making of the WISR Programme Board.



### 10.3 Decision-making process

After the completion of the report, the MLAFL programme will consider the implications of the findings and make final recommendations to the MLAFL Programme Board.

The expected timelines are:

What	Who	When
Programme assurance	MLAFL programme team	22 July to 31 October
Public Consultation	MLAFL programme team	1 November to 31 January
Analysis of responses and preparation of DMBC	MLAFL programme team	February 2017
Consideration of all material by the WISR Programme Board	MLAFL Programme Board	March 2017
Board to Board session (all partners)	IOW Council, CCG, IOW NHS Trust, Community Action IOW	March 2017
Summary of feedback provided to consultees and wider public and stakeholders	MLAFL programme team	March 2017
MLAFL Programme Board meets in public to make final decisions. CCG governing body to make final decision in collaboration with other system partners corporate governance	IOW Council, CCG, IOW NHS Trust, Community Action IOW	March 2017

**Table 4: Decision making time frames**

It is anticipated that the MLAFL Programme Board will meet in public to make its final decisions. A detailed communications plan will be developed to ensure people with an interest in attending the meeting have an opportunity to do so.

Following the decision making meeting, further updates will be provided to all those who took part in the consultation as well as wider stakeholders with an interest. Ongoing involvement and engagement with communities, staff and other stakeholders will need planning to run alongside the implementation process.

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> JULY 2016

<b>Title</b>	Principal Risk Register (Board Assurance Framework) Report		
<b>Sponsoring Executive Director</b>	Mark Price, Company Secretary		
<b>Author(s)</b>	Lucie Johnson, Head of Corporate Governance		
<b>Purpose</b>	1) To provide an update to the Trust Board in relation to the current Principal risks identified by the Trust, and the broader risk landscape of the Trust.		
<b>Action required by the Board:</b>	Receive	✓	Approve
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Not applicable			
<b>Please add any other committees below as needed</b>			
Not applicable.			
<b>Staff, stakeholder, patient and public engagement:</b>			
Not applicable.			
<b>Executive Summary &amp; Analysis:</b>			
<p><b><u>Principal Risks</u></b></p> <p>The Trust has currently 8 Principal Risks associated with the themes identified below:-</p> <ol style="list-style-type: none"> <li>1. 705 Executive Team Capacity and Capability = Likely x Major</li> <li>2. 677 Local Health and Social Care Economy Resilience = Certain x Major</li> <li>3. 676 ICT = Likely x Catastrophic</li> <li>4. 675 Culture = Likely x Major</li> <li>5. 674 Quality Governance = Possible x Major</li> <li>6. 673 Strategy and Planning = Possible x Major</li> <li>7. 712 Financial Resources = Likely x Major</li> <li>8. 671 Human Resources = Likely x Moderate</li> </ol> <p>The risk score in relation to Strategy and Planning has reduced from Likely x Major (16) to Possible x Major (12), all other risks retain the same risk score as when the risk was first identified.</p> <p>Board members will note two additional fields in the attached report, namely gaps in controls and gaps in assurances. These two fields have been added to the template in order to satisfy the recommendations made by our internal auditors TIAA following their review of our Board Assurance Framework in April. Unfortunately as these are new fields they have not as yet been populated by the risk owners, however, this will be achieved by the next Trust Board meeting.</p>			

It is useful for Board members to consider the above 7 Principal risks in light of the information provided below.

### **Corporate Risks**

The Trust currently has 29 Corporate risks identified. These risks are multi faceted, and span the following thematic areas outlined below. It is prudent to note that this represents no change from the previous months report. Indeed the same risks are present and the scores have not changed in the past month since the last meeting.

17 = Quality

13 = Reputational

10 = Workforce

8 = Finance

4 = ICT

4 related to Corporate Governance matters

2 relate to estates

1 = Mental Health Act

Corporate Risks are overseen by the relevant Board Assurance Committee and the newly formed Executive Led Sub Committees.

### **Corporate Issues log**

Following on from the update made to the last Trust Board meeting in June, a number of risks had been transferred from the Corporate Risk Register to a Corporate Issues Log, as above these are multi faceted and span the following thematic areas:-

27 = Quality

25 = Reputational

20 = Finance

18 = Workforce

11 = Estates

6 = ICT

2 related to Corporate Governance matters

0 = Mental Health Act

### **Recommendation to the Board:**

- 1) Review the 8 risks currently identified on the Principal Risk Register, and seek further assurance from risk owners as deemed appropriate.
- 2) Identify further risks and ensure they are flagged for inclusion on the risk register.
- 3) Consider the landscape in relation to Corporate Risks and Issues and determine appropriate steps as necessary.

### **Attached Appendices & Background papers**

- 1) Principal Risk Register report

**ENC I**

For following sections – please indicate as appropriate:

**Trust Goals & Priorities**

All

**Principal Risks (BAF)**

All

**Legal implications, regulatory and  
consultation requirements**

**Date:** 22-6-16

**Completed by:** Lucie Johnson

ID	Risk Owner	Risk Description	Date Opened	Rating (current)	Rating (Target)	Review date	Progress notes	Action Planning	Action due date	Action completed date	Principal objectives	Gaps in assurance	Gaps in controls
							[Clark, Michelle 08/01/16 12:48:43] A Quality Improvement Framework report, will be presented to the Board on the 15th December 2015 to update Board members more fully in relation to this risk. The QGAF score is currently 5.5.	Revise Clinical Governance arrangements	31/03/2016	31/03/2016			
							[Sheward, Alan 08/02/16 10:58:47] QGAF Assessment to be completed by SEE team. Appointments in place to support work of SEE.	Complete actions identified through QGAF self assessment	30/06/2016				
							[Sheward, Alan 14/03/16 09:51:52] 14.03.2016 - SEE leads to review current governance arrangements to ensure quality improvement and quality assurance from Clinical Business Units to Board. -Supportive discussions with NHSI (TDA) to ensure best processes are in place to provide board and committee assurance. -Appointment to Deputy Director of Allied Health Professionals to be completed. - Newly appointed Nutritional Nurse Specialist. - Needs assessment on Falls and Dementia workforce requirements to be completed.	Role out of QIF through Trust Busines Planning process	31/03/2016	16/05/2016			
	Sheward,	If the Trusts quality governance processes are not robut and embedded then the Trust will									A positive experience for Patients, Service		

674	Alan - Executive Director of Nursing	embedded then the Trust may not be able to maintain adequate patient safety, patient experience and clinical effectiveness.	07/10/2015	12	2	30/06/2016	[Sheward, Alan 29/03/16 13:26:52] Attendance at Quality Governance/Assurance meetings has been poor. Clarity on expectation to be shared with the CBU leads. - Recruitment to Deputy Director of AHP pending outcome of Organisational Change. - Good QI progress with the appointment of Nutritional Nurse Specialist. - 2016/17 CQUINS to be agreed	Refresh and Revise Actions to demonstrate compliance with the Trust Quality Improvement Plan	31/05/2016	21/06/2016	for Patients, Service Users and Staff, Cost effective sustainable services, Excellent Patient Care
							[Sheward, Alan 08/04/16 10:53:36] - The Board have approved an approach to QI that will also satisfy the needs of the CQC's fundamental standards. Reporting schedule agreed. First 1/4 reporting agreed with CBU's				
							[Sheward, Alan 16/05/16 09:26:48] Quality Priorities and Quality Reporting Schedule agreed at QGC and Trust Board. Clinical Business Units supporting monthly reporting against the Trusts Top 20 Key Quality Priorities. Subject matter experts completed self assessment and recommendations.				
							[Blackler, Mandy 21/06/16 13:08:20] New QIP in development. Survey Monkey QGAF self assessment being put together by Jo Winch and will be				

676	Burwell, Jon - Interim Executive Director of Strategy, Planning, ICT and Estates	If the Trust is unable to deliver against the ICT Strategy, then there will be a negative impact on quality, Income, Performance, Information Governance Compliance and Staff morale	10/11/2015	20	12	18/07/2016	[Deavall, Richard 08/01/16 12:57:08] A paper is being presented at the Trust Board meeting on the 15th December 2015 regarding ICT, and will provide further information in relation to this risk.	Executive Led ICT Committee to be setup	29/01/2016	29/03/2016	Cost effective sustainable services	All gaps in assurance are addressed in actions	All gaps in controls are addressed in actions
							[Johnson, Lucie 29/03/16 13:38:37] Updated on behalf of Karen Baker:- The Executive Led ICT Committee (action below) has now been set up, and is being chaired by the Chief Executive in the absence of the Executive Director of Integration and Transformation. This group will review this and other ICT related risks (Corporate Risks) and determine, further actions and assurance mechanisms required. Once determined these action will be added to this risk register entry.	ICT Strategy to be refreshed	07/09/2016				
							[Johnson, Lucie 18/05/16 17:04:24] Risk reviewed during the Executive Governance Review Meeting on the 16th May 2016. It was noted that a Executive Director of Strategy, Information Communication Technology and Estates was due to be seconded to the Trust imminently, whilst the post was advertised. This will enhance capacity and support progression with this risk.	Review ICT risk on risk register	24/06/2016				
							[Burwell, Jon 10/06/16 13:33:38] Interim Executive						

							15.05.16] interim Executive Director of Strategy, Planning, ICT and Estates has now started. ICT Strategy to be revised into a Trust Informatics Strategy covering information also, aim to go to September Board. Engagement with staff will happen as part of this. Wider island alignment of ICT is being considered to ensure a sustainable and high quality service.	Align ICT capital plans with risk register	24/06/2016				
							[Clark, Michelle 08/01/16 12:54:31] 1) Refreshed and revised Terms of Reference in place for both the System Resilience Strategic Group and the System Resilience Operational Group. 2) Work on-going with the Local Government to describe and finalise governance arrangements across the breadth of services on the Island	Internal review of processes	30/11/2015	25/02/2016			
								Closer and more regular work with Commissioners and system lead and system review of priorities including funding.	31/03/2016				
							[Baker, Karen 22/02/16 11:13:11] Whole Island System Redesign started in January 2016						
								System Resilience Action plan to be developed	30/11/2015	16/05/2016			
							[Johnson, Lucie 25/02/16 11:22:39] Update 25-2-16 KB:- Action plan updated						
								Whole Island System Review being undertaken as part of My Life a Full Life	31/03/2017				



677	Baker, Karen Chief Executive	If there is insufficient resilience in the local health and social care economy then we will be unable to deliver safe effective and financially viable care.	07/10/2015	20	28/07/2016	[Johnson, Lucie 29/03/16 13:26:56] Updated on behalf of Karen Baker:- 2 new actions determined as below (MLaFL governance arrangements and Hampshire and IOW Sustainability Transformation Plan). In terms of 1st new action, the Head of Corporate Governance has met with the MLaFL Director for an initial scoping meeting, and has shared the proposed Executive Governance Meeting Structure. MLaFL Director intends to map existing arrangements across key organisations to determine where structures can be merged to provide enhanced efficiencies.	System discussion facilitated by the LGA to define governance structures for the MLaFL and HWBB	30/11/2015		Work with others to keep improving our Services		
						[Johnson, Lucie 16/05/16 15:14:28] Update from LJ action owner. Half day governance workshop scheduled my MLaFL Programme Director to take place on the 26th May 2016. A number of Trust employees have been invited to attend. Action owner, HOCG confirmed to attend, alongside others. Risk reviewed on the 16th May 2016 during the Executive Governance Review Meeting.	Hampshire and IOW Sustainability Transformation plan to be developed	30/06/2016				
						[Ferguson, Joanne 23/05/16 13:32:56] Update 23.05.16 JF. Systems resilience Group - QIPP plans and SRG report for FIIWC uploaded and attached for	My Life a Full Life Governance	30/06/2016				



705	Baker, Karen Chief Executive	and capability within the Executive and Non Executive Team, then the Trust will not be able to achieve its strategic ambitions, particularly in relation to my life a full life. The organisational improvements in quality, operational targets and the financial position will not be delivered.	22/02/2016	12	8	20/07/2016	<p>Programme Director 16-5-16 re staffing requirements for MLFL (including staff seconded from the Trust. CEO has undertaken a number of appraisals with Executive Directors in order to satisfy the action below re ascertaining pinch points.</p> <p>Risk reviewed on the 16th May 2016 as part of the Executive Governance Review meeting.</p>	Director of ICT, Strategy and Planning and Estates (Secondment) 6-6-16	06/06/2016	20/06/2016	A positive experience for Patients, Service Users and Staff, Cost effective sustainable services, Excellent Patient Care, Skilled and capable staff, Work with others to keep improving our Services		
							[Johnson, Lucie 20/06/16 09:06:53] Interim Executive Director commenced 6th June. Recruitment commenced for substantive employee. Also currently recruiting for a joint post with the CCG for a System Director.	Recruit to substantive appointment to replace secondees	05/09/2016				
								Recruit to System Director post	29/07/2016				

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6 JULY 2016

<b>Title</b>	Reference Costs 2015/16		
<b>Sponsoring Executive Director</b>	Chris Palmer – Executive Director of Financial & Human Resources		
<b>Author(s)</b>	Gary Edgson – Deputy Director of Finance		
<b>Purpose</b>	To delegate authority to approve the costing process and submission of the final return for 2015/16 Reference Costs		
<b>Action required by the Board:</b>	<b>Receive</b>		<b>Approve</b> ✓
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Trust Executive Committee			
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee			
Mental Health Act Scrutiny Committee			
Remuneration & Nominations Committee			
Quality Governance Committee			
<b>Please add any other committees below as needed</b>			
Board Seminar			
Other (please state)			
<b>Staff, stakeholder, patient and public engagement:</b>			
<b>Executive Summary &amp; Analysis:</b>			
<p>Reference costs is a national mandated annual submission for all NHS Trusts and Foundation Trusts. Department of Health guidance states that the Board or appropriate sub-committee is required to confirm the following in relation to the reference cost return:</p> <p>(a) The Board or its appropriate sub-committee has approved the costing process ahead of the collection;</p> <p>(b) The Director of Finance has, on behalf of the board, approved the final reference cost return prior to submission;</p> <p>(c) The reference cost return has been prepared in accordance with Monitor's Approved Costing Guidance, which includes the reference cost guidance</p> <p>(d) Information, data and systems underpinning the reference cost return are reliable and accurate;</p> <p>(e) There are proper internal controls over the collection and reporting of the information included in the reference costs, and these controls are subject to review to confirm that they are working</p>			

effectively in practice; and

(f) Costing teams are appropriately resourced to complete the reference costs return, including the self-assessment quality checklist and validations accurately within the timescales set out in the reference costs guidance.

The 2015/16 submission is due on 26 July 2016.

**Recommendation to the Board:**

This paper recommends that the Board delegate authority to the Finance, Investment, Information and Workforce Committee for assurance that the Trust will submit its Reference Cost Return in accordance with Department of Health guidance.

**Attached Appendices & Background papers**

For following sections – please indicate as appropriate:

<b>Trust Goals &amp; Priorities</b>	Cost effective, sustainable services
<b>Principal Risks (BAF)</b>	
<b>Legal implications, regulatory and consultation requirements</b>	

**Date:** 28 June 2016

**Completed by:** Gary Edgson, Deputy Director of Finance

**REPORT TO THE TRUST BOARD (Part 1 - Public)**  
**ON 6<sup>th</sup> July 2016**

<b>Title</b>	Report from Chair of Finance, Investment, Information & Workforce Committee		
<b>Sponsoring Executive Director</b>	Charles Rogers, Chair of Finance, Investment, Information & Workforce Committee		
<b>Author(s)</b>	Charles Rogers, Chair of Finance, Investment, Information & Workforce Committee		
<b>Purpose</b>	To receive the report on the Finance, Investment, Information & Workforce Committee		
<b>Action required by the Board:</b>	Receive	X	Approve
<b>Previously considered by (state date and outcome):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee	28 <sup>th</sup> June 2016		
Mental Health Act Scrutiny Committee			
Quality Governance Committee			
Remuneration & Nominations Committee			
Foundation Trust Programme Board			
Turnaround Board			
<i>Please add any other committees below as needed</i>			
<b>Staff, stakeholder, patient and public engagement:</b>			
Not applicable			
<b>Executive Summary:</b>			
<p>The Chair of Finance, Investment, Information &amp; Workforce Committee will report on the following areas as discussed at the meeting held on 28<sup>th</sup> June 2016:</p> <p><b>Human Resources</b></p> <ul style="list-style-type: none"> <li>• Safer Staffing Management</li> <li>• Staff Experience Group Update</li> <li>• Agency Staff</li> <li>• Organisational Development</li> </ul> <p><b>Capital Investment</b></p> <p><b>Financial</b></p> <ul style="list-style-type: none"> <li>• Cost Improvement Plan</li> <li>• Cash</li> </ul> <p><b>Other Items</b></p> <ul style="list-style-type: none"> <li>• NHS Creative</li> </ul>			
<b>Recommendation to the Trust Board:</b>			

The Board is recommended to receive the report by the Chair of Finance, Investment, Information & Workforce Committee

**Attached Appendices & Background papers**

None

For following sections – please indicate as appropriate:

**Trust Goals & Priorities**

Cost Effective, Sustainable Services; Skilled and Capable Staff

**Principal Risks (BAF)**

Finance, Workforce, Strategy & Planning

**Legal implications, regulatory and consultation requirements**

**Date:** 30<sup>th</sup> June 2016

**Completed by:** Chair of Finance, Investment, Information & Workforce Committee

## **FINANCE, INVESTMENT, INFORMATION AND WORKFORCE COMMITTEE**

### **MONTHLY ASSURANCE REPORT TO ISLE OF WIGHT TRUST BOARD: JULY 2016**

This report to the Trust Board follows from the June meeting of the Finance, Investment, Information and Workforce Committee (FIWIC) held on 28th June 2016.

The Committee welcomed Jon Burwell, Interim Executive Director of Strategy, Planning, ICT and Estates to the meeting.

#### **Human Resources**

**Safer Staffing Management:** The Deputy Director of Nursing updated the Committee on Safer Staffing compliance and in particular the need to improve rostering arrangements. Rostering compliance at the end of May was 24% which is an improvement from the 5% compliance reported at the end of April. The Committee were advised of the actions being taken to provide sustained improvement in this area. The Committee support the pro-active arrangements in place to improve rostering given the fundamental importance of this work to improve productivity and reduce costs. Limited Assurance.

**Staff Experience Group Update:** The group are continuing to meet regularly and are following through on a number of actions to improve staff experience. A primary action is the completion of all appraisals by 30<sup>th</sup> June. The Committee questioned how the Trust intends to react to parts of the organisation that will not have been compliant at this point. Positive Assurance.

**Agency Staff:** There remains a heavy reliance on agency staff to fill positions and at month 2 the Trust is overspent. The Committee consider that current reporting arrangements require development so that there is a clearer understanding of where and why we are exceeding trajectory as well as the actions, ownership and timeframes for improvement. This should be for the full agency complement and not just nursing. Limited Assurance.

**Organisational Development:** Mandatory training is at 79%, an increase of 1% on the previous month despite new courses being added.

The new role of Guardian has been scoped and is ready to be advertised. This post is intended to support safe working.

A response to the Government Consultation on the removal of student bursaries has been provided by the Trust. There is a concern that the Trust will be significantly disadvantaged if this reform proceeds. Many of the students we have on placement join the Trust directly after leaving full time education. If the changes proceed the Trust could potentially see a reduction in the number of students because the bursary includes costs for travel and accommodation. This also has a direct impact on Education income. The Trust needs to consider the best approach to mitigate this risk over the next couple of months. Positive Assurance.



## **Capital Investment**

Total available funds to be spent on capital during the year is £6.533m. This money has now been allocated to projects with ratification at the next Capital Investment Committee and presentation at the next FWIIC Committee. Positive Assurance.

## **Financial**

Cost Improvement Plan (CIP): The Trust's revised CIP requirement for 2016/17 is £10.25m. At Month 2 the Trust has achieved £1.097m of savings. This has primarily been through storing underspends rather than delivery of specific programmes of work and is therefore non-recurrent. The Committee note the importance of achieving this year's target and the considerable gap that remains in identifying plans to achieve this. A revised summary report will be brought monthly to the Committee from July. Limited assurance.

Cash: In June the Trust requisitioned a further £1.031m cash on top of the £1.735m drawn in February and this enabled the Trust to maintain the £1m minimum balance statutory requirement. It is expected that a further draw of £1.8m will be required in July which will bring the Trust to its maximum Board approved level. A re-modelling of cash requirements is taking place and will take into account any allocation of Sustainability and Transformation Fund. Limited Assurance.

## **Other Items**

NHS Creative: The Company Secretary (CS) has provided an overview of the work being undertaken by NHS Creative. In 2015/16 they produced a gross profit of £52,533. It is expected that a restrained market will continue in 2016/17 and a forecast gross profit of £15,074. A savings target of £100k has been set by the Trust of which £75k has so far been identified. The CS has agreed to provide an options paper to consider the future strategy in relation to NHS Creative. Limited Assurance.

Chair

Finance, Investment, Information and Workforce Committee

June 2016

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

<b>Title</b>	Isle of Wight NHS Trust Board Performance Report 2016/17		
<b>Sponsoring Executive Director</b>	Chris Palmer - Executive Director of Financial & Human Resources		
<b>Author(s)</b>	Iain Hendey - Deputy Director of Information		
<b>Purpose</b>	To update the Trust Board regarding progress against key performance measures and highlight risks and the management of these risks.		
<b>Action required by the Board:</b>	<b>Receive</b>	<b>X</b>	<b>Approve</b>
<b>Previously considered by (state date):</b>			
Trust Executive Committee		Mental Health Act Scrutiny Committee	
Audit and Corporate Risk Committee		Remuneration and Nominations Committee	
Charitable Funds Committee		Quality Governance Committee	27/06/2016
Finance, Information, Investment & Workforce Committee	28/06/2016		
<i>Please add any other committees below as needed</i>			
<i>Other (please state)</i>			
<b>Staff, stakeholder, patient and public engagement:</b>			
<b>Executive Summary:</b>			
This paper sets out the key performance indicators by which the Trust is measuring its performance in 2016/17. A more detailed executive summary of this report is set out on page 4.			
<i>For following sections – please indicate as appropriate:</i>			
<b>Trust Vision:</b>	Quality care for everyone, everytime		
<b>Trust Goals:</b>	Excellent patient care; Working with others to keep improving our services; A positive experience for patients, service users and staff; Skilled and capable staff; Cost effective, sustainable services		
<b>Principal Risks</b> <i>(please enter applicable BAF references – eg 1.1; 1.6)</i>			
<b>Assurance Level</b> <i>(shown on BAF)</i>	<input type="checkbox"/> Red	<input type="checkbox"/> Amber	<input type="checkbox"/> Green
<b>Legal implications, regulatory and consultation requirements</b>	None		
<b>Date: Tuesday 28th June 2016      Completed by: Iain Hendey, Deputy Director of Information</b>			

Balanced Scorecard - Aligned to 'Key Line of Enquiry' (KLOEs).....	3
Executive Summary.....	4
Performance Summary Pages.....	5-9
<i>Surgery, Women's and Children's Health</i> .....	5
<i>Medicine</i> .....	6
<i>Clinical Support, Cancer and Diagnostics</i> .....	7
<i>Ambulance, Urgent Care and Community</i> .....	8
<i>Mental Health and Learning Disabilities</i> .....	9
Highlights.....	10
Lowlights.....	11
Exception Reports.....	12-19
<i>Pressure Ulcers</i> .....	12
<i>Patient Safety</i> .....	13
<i>Formal Complaints</i> .....	14
<i>A&amp;E Performance - Emergency Care 4 hours Standard</i> .....	15
<i>Cancer</i> .....	16
<i>Ambulance</i> .....	17
<i>Theatre Utilisation</i> .....	18
<i>Referral To Treatment Times</i> .....	19
Benchmarking of Key National Performance Indicators.....	20-23
<i>Summary Report</i> .....	20
<i>IW Performance Compared To Other 'Small Acute Trusts'</i> .....	21
<i>IW Performance Compared To Other Trusts in the 'Wessex Area'</i> .....	22
<i>Ambulance Performance</i> .....	23
Data Quality.....	24
Workforce Report.....	25-27
<i>Summary - RAG rated based on Out-Turn position</i> .....	25
<i>Sickness</i> .....	26
<i>Overpayments Summary</i> .....	27
Finance Report.....	28-38
<i>Summary - RAG Rating based on Out-turn position &amp; CIP graph</i> .....	28
<i>Continuity of Service Risk Rating</i> .....	29
<i>Surplus</i> .....	30-31
<i>Income</i> .....	32-33
<i>Cost Improvement Programme</i> .....	34
<i>Cash</i> .....	35-36
<i>Statement of Financial Position</i> .....	37
<i>Capital</i> .....	38
Governance Risk Rating.....	39
Glossary of Terms.....	40

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

Balanced Scorecard - Aligned to Our Goals

Excellent Patient Care	Area	Annual Target	Actual Performance	YTD	Month Trend
Patients that develop a grade 4 pressure ulcer	TW	3 (80% reduction on 15/16)	1	May-16	1
Patients that develop an ungraded pressure ulcer	TW	4	May-16	9	↓
VTE (Assessment for risk of)	TW	>95%	99.0%	May-16	99.2%
MRSA (confirmed MRSA bacteraemia)	TW	0	0	May-16	0
C.Diff (confirmed Clostridium Difficile infection - stretched target)	TW	7	1	May-16	1
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	TW	17	2	May-16	3
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	TW	2	May-16	2	↓
Falls - resulting in significant injury	TW	5	0	May-16	0
Symptomatic Breast Referrals Seen <2 weeks*	CCD	93%	96.6%	May-16	97.5%
Cancer patients seen <14 days after urgent GP referral*	CCD	93%	95.1%	May-16	96.0%
Cancer Patients receiving subsequent Chemo/Drug <31 days*	CCD	98%	100.0%	May-16	100.0%
Cancer Patients receiving subsequent surgery <31 days*	CCD	94%	100.0%	May-16	96.7%
Cancer diagnosis to treatment <31 days*	CCD	96%	100.0%	May-16	100.0%
Cancer Patients treated after screening referral <62 days*	CCD	90%	90.9%	May-16	80.0%
Cancer Patients treated after consultant upgrade <62 days*	CCD	No measured operational standard	No Pts	May-16	100%
Cancer urgent referral to treatment <62 days*	CCD	85%	79.4%	May-16	78.2%
Summary Hospital-level Mortality Indicator (SHMI) Apr-14 - Mar-15	TW	1	0.986	Published Jan 2016	N/A
Never events	TW	0	1	Apr-16	1
Stroke patients (90% of stay on Stroke Unit)	M	80%	91%	May-16	83%
High risk TIA fully investigated & treated within 24 hours (National 60%)	M	60%	100%	May-16	90%

\*Cancer figures for May are provisional.

Working with others to keep improving our services	Area	Annual Target	Actual Performance	YTD	Month Trend
Delayed Transfer of Care (lost bed days) - (MH)	TW	N/A	161	May-16	383
Delayed Transfer of Care (lost bed days) - (Acute)	TW	N/A	103	May-16	260
Delayed Transfer of Care (lost bed days) - (Community)	TW	N/A	180	May-16	267

## Notes

Delivering or exceeding Target	Green	Improvement on previous month	↑
Underachieving Target	Yellow	No change to previous month	↔
Falling Target	Red	Deterioration on previous month	↓

## Key to Area Code

TW = Trust Wide

SWC = Surgery, Women's and Children's Health

M = Medicine

CCD = Clinical Support, Cancer and Diagnostics

AUC = Ambulance, Urgent Care and Community

MH = Mental Health and Learning Disabilities

## A positive experience for patients, service users and staff

Emergency Care 4 hour Standards	AUC	95%	92%	May-16	89%	🔻
Number of patients who have waited over 12 hours in A&E from decision to admit to admission	AUC	0	0	May-16	2	🔻
Ambulance Category A Calls % < 8 minutes	AUC	75%	75%	May-16	73.7%	🔻
Ambulance Category A Calls % < 19 minutes	AUC	95%	96%	May-16	94%	🔻
Number of Ambulance Handover Delays between 1-2 hours	AUC	N/A	5	May-16	35	🔻
% of CPA patients receiving FU contact within 7 days of discharge	MH	95%	95.3%	May-16	96.5%	🔻
% of CPA patients having formal review within last 12 months	MH	95%	94.6%	May-16	94.8%	🔻
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	MH	95%	97.4%	May-16	98.6%	🔻
All Cancelled Operations on/after day of admission	SWC / CCD		10	May-16	34	🔻
Cancelled operations on/after day of admission (not rebooked within 28 days) - including those not rebooked at the time of reporting	SWC / CCD	0	2	May-16	7	🔻
Patient Satisfaction (Friends & Family test - Total response rate)	TW		52%	May-16	28%	🔻
Patient Satisfaction (Friends & Family test - A&E response rate)	TW		3%	May-16	4%	🔻
Mixed Sex Accommodation Breaches	TW	0	0	May-16	0	↔
Formal Complaints	TW		6	May-16	28	🔻
Compliments received	TW	N/A	247	May-16	511	🔻

## Skilled and capable staff

Total Workforce (inc flexible working) (FTEs)	TW	2827.16	2,831.1	May-16	N/A	N/A
Total workforce SP (FTEs)	TW	2675.47	2,630.3	May-16	N/A	N/A
Variable Hours (FTE)	TW	151.7	200.8	May-16	303.4	406

## QIs under development:

- Patient Safety:
  - Implementation and monitoring the effectiveness of the sepsis care bundle
  - Reduce incidents of patient harm
- Clinical effectiveness
  - Improve the discharge planning process
  - Improve communication with patients and carers
- Patient Experience
  - Improve the culture of the organisation to improve patient experience

## Cost effective, sustainable services

Area	In month plan	Actual Performance	Annual Target	YTD	Month Trend
RTT % of incomplete pathways within 18 weeks - low CCG	TW	92%	90%	May-16	92%
RTT % of incomplete pathways within 18 weeks - NHS England	TW	92%	93%	May-16	92%
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	TW	0	0	May-16	0
No. Patients waiting > 6 weeks for diagnostics	TW	<8	2	May-16	<100
% Patients waiting > 6 weeks for diagnostics	TW	<1%	0.2%	May-16	<1%
New Cases of Psychosis by Early Intervention Team	MH	2	0	May-16	18
Theatre utilisation	CWC / CCD	83%	83%	May-16	83%
Total pay costs (inc flexible working) (£000)	TW	£10,297	£10,487	May-16	£20,412
Staff in Post (£000)	TW	£10,065	£9,240	May-16	£19,976
Variable Hours (£000)	TW	£232	£1,247	May-16	£436
Staff sickness absences	TW	3%	4.21%	May-16	3%
Staff Turnover	TW	5%	0.43%	May-16	5%
Achievement of financial plan	TW		(£1,031k)	May-16	(£9.8m)
Variance against adjusted financial performance	TW			May-16	£0
Liquidity ratio days	TW			May-16	1
Capital Servicing Capacity (times)	TW			May-16	1
Overall Continuity of Services Risk Rating	TW			May-16	1
Capital Expenditure as a % of YTD plan	TW			May-16	=>75%
I&E Margin Rating	TW			May-16	1
I&E Margin Variance from Plan	TW			May-16	1
Overall Continuity of Services Risk Rating	TW			May-16	1
Debtors over 90 days as a % of total debtor balance	TW			May-16	=<5%
Creditors over 90 days as a % of total creditor balance	TW			May-16	=<5%
Total CIP savings achieved	TW			May-16	100%
Recurring CIP savings achieved	TW			May-16	100%

As reported last month the balanced scorecard has been reviewed and a few slight changes have been made to reflect metrics which are reported monthly to NHS Improvement.

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

## Executive Summary

The Performance Report has been re-aligned to our Goals and the Clinical Business Unit Structure. Further alignment and refinement will be undertaken in future reports. QIs are currently under development and will be added to the report as soon as they are agreed.

### Excellent Patient Care:

Pressure ulcers: 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.

C.diff: There has been one case of Healthcare acquired Clostridium Difficile identified in the Trust during May.

No new cases of MRSA within the Trust during May.

### A positive experience for patients, service users and staff:

Ambulance - The Service met 2 out of the 3 targets in May 2016, the Service failed Category A 8 Minute Response Time (Red 1) target. This is an improvement from the performance seen in April 2016. Data reporting issues are resolving with an improvement in A&E handovers processes and technical data capture. The key issues facing the service is its ability to provide a high quality of care against a back drop of system wide pressures and flow of patients through the hospital setting leading to delays in response times. This is a similar picture with ambulance services across the country. Recruitment to paramedic posts is also a challenge but we are currently recruiting to vacancies with plans to secure qualified staff or students due to qualify in the summer.

Emergency Care Standard - The trajectory for May was 88% and the Trust achieved 92.87% (target standard is 95%). This good performance against the trajectory was due to emergency activity levels as forecast (whereas the previous month there was a 10% increase in emergency activity than expected), and the continued focus on the benefits of Safer Start Week held at the end of April. Progression of the trajectory improvement plan and the embedding of weekly urgent care performance management group has also contributed. However, sustaining performance at this level is subject to system wide pressures and the System Resilience Group is implementing schemes to also support performance in the delivery of emergency care.

Mixed Sex Accommodation - There were no mixed sex accommodation breaches during May.

We have received 6 formal complaints during May (22 in April).

### Skilled and capable staff:

SIP decreased in May by 16 FTE - from 2646 (April 16). The temporary staffing figure, decreased from 204 FTE in April 16 to 201 FTE in May 16.

Trust Headcount at the end of May 16: 3084 (Decrease of 15)

Turnover remains low - decrease in month from 0.92% in April to 0.43% in May - the majority of which are voluntary resignations.

Executive Brief update detailed the new appraisal process, and set the end of June 2016 as the target for completion of appraisals. The updated paperwork makes it clear how to record appraisals carried out, and ensure quality of appraisal. Communication has also been sent via 10 Minute Team Brief. Business Unit leads and Execs have been given updates on completion rates in their respective areas.

### Cost effective, sustainable services:

The RTT Incomplete trajectory for May was 89.8% and the Trust achieved 90.47% (target standard is 92%). This good performance against the trajectory was due to lesser number of long waiting patients (over 18wks) on the waiting list than forecast, against a higher number of patients waiting overall than forecast. Progression of the trajectory improvement plan and the embedding of the dialy activity performance huddle and weekly patient access performance management group has also contributed.

The percentage utilisation of Main Theatre facilities has increased to 84.5% during May 2016, and is above the 83% target. Day Surgery Unit utilisation has decreased to 81.1% and remains below target; this small level of under performance is due to the combination of cancellations, short notice booking and case mix, however, emergency activity, urgent operations and cancer operations continue to be prioritised. The overall theatre utilisation achieved at 83.1%.

The Trust planned for a deficit of £1.096m in May, after adjustments made for normalising items (these include the net costs associated with donated assets). The reported position is a deficit of £1.022m in the month, a favourable variance of £0.074m against plan. The cumulative Trust plan was a deficit of £2.384m, after normalising items. The actual position is a cumulative deficit of £2.178m, a favourable variance of £0.206m. The favourable variance relates to the phasing of income and expenditure in the operating plan, with the position expected to return to plan next month. CCG activity was £0.365m behind plan mainly due to changes in activity casemix. There has also been a benefit year to date of £0.399m in respect of uncommitted investments.

The reported position includes a planned and achieved CIP saving year to date of £1.097m. Almost all of this has been achieved non recurrently. The Trusts planned forecast out-turn deficit is £9.844m.


Scrutiny and challenge of financial performance to improve on this forecast position is underway. This includes weekly Executive Panel scrutiny review of all recruitment requests, weekly finance reviews with Operational Management Group, detailed integrated finance and CIP challenge meetings with Business Units each month, and Executive led performance reviews.


# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16


Performance Summary - Surgery, Women's and Children's Health

## Balanced Scorecard - Surgery, Women's and Children's Health


Excellent Patient Care 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	May-16	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)	May-16		1		1
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	May-16		0		0
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	May-16		0		0
Falls - resulting in significant injury	May-16		0		0
Emergency 30 day Readmissions	May-16		3.7%		2.9%
Never Events	Apr-16	0	0	0	0
Pressure Ulcers - Grade 1	May-16		0		0
Pressure Ulcers - Grade 2	May-16		1		2
Pressure Ulcers - Grade 3	May-16		0		0
Pressure Ulcers - Grade 4	May-16		0		1
Pressure Ulcers - Ungradable	May-16		1		1

A positive experience for patients, service users and staff 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	May-16	0	0	0	0
No. of Complaints	May-16		2		9
No. of Concerns	May-16		16		42
No. of Compliments	May-16		97		211
Cancelled operations on/after day of admission (not rebooked within 28 days) - including those not rebooked at the time of reporting	May-16	0	2	0	7
All Cancelled Operations on/after day of admission	May-16		10		34
Theatre utilisation	May-16	83%	83.1%	83%	82.0%
No. of Reported SIRIs	May-16		0		2
Physical Assaults against staff	May-16		1		2
Verbal abuse/threats against staff	May-16		1		5

Working with others to keep improving our services 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual

Skilled and capable staff 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	May-16				10.20%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Apr-16	£ 3,430,301	£ 3,175,922	£ 3,430,301	£ 3,175,922

Cost effective, sustainable services 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (IoW CCG + NHS England)	May-16	92%	92.1%	92%	91.9%
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	May-16	0	0	0	1
% Sickness Absenteeism	May-16	3%	4.36%	3%	4.21%

\*\*The Acute Service Level Agreement performance reports a month behind, therefore figures are from April 2016.


The CBU has been focusing on sickness hotspots and has seen targeted reductions in place where this relates to short term absence.  
Theatre cancellations and the underperformance against the SLA relate to the continued impact of medical outliers on Whippingham (~80% medical occupancy).


# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

Performance Summary - Medicine

## Balanced Scorecard - Medicine

Excellent Patient Care 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	May-16	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)	May-16		0		0
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	May-16		1		1
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	May-16		0		0
Falls - resulting in significant injury	May-16		0		0
Emergency 30 day Readmissions	May-16		9.5%		9.3%
Stroke patients (90% of stay on Stroke Unit)	May-16	80%	91.3%	80%	82.7%
High risk TIA fully investigated & treated within 24 hours (National 60%)	May-16	60%	100.0%	60%	90.0%
Never Events	Apr-16	0	0	0	0
Pressure Ulcers - Grade 1	May-16		1		2
Pressure Ulcers - Grade 2	May-16		2		7
Pressure Ulcers - Grade 3	May-16		0		0
Pressure Ulcers - Grade 4	May-16		1		1
Pressure Ulcers - Ungradable	May-16		1		4

A positive experience for patients, service users and staff 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	May-16	0	0	0	0
No. of Complaints	May-16		0		2
No. of Concerns	May-16		9		25
No. of Compliments	May-16		29		88
No. of Reported SIRIs	May-16		0		0
Physical Assaults against staff	May-16		3		4
Verbal abuse/threats against staff	May-16		4		6

Working with others to keep improving our services 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual

Skilled and capable staff 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	May-16				6.20%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Apr-16	£ 1,559,542	£ 1,723,072	£ 1,559,542	£ 1,723,072

Cost effective, sustainable services 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (IoW CCG + NHS England)	May-16	92%	82.1%	92%	82.7%
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	May-16	0	0	0	0
% Sickness Absenteeism	May-16	3%	6.15%	3%	5.57%

\*\*The Acute Service Level Agreement performance reports a month behind, therefore figures are from April 2016.


The RTT incomplete pathways for 18 weeks relates largely to Gastroenterology. Alternative ways are currently being explored for delivering the RTT targets in Gastroenterology and a paper has been presented to Trust Executive Committee (TEC) with options and recommendations. An additional weekly evening clinic is taking place for Gastroenterology and 2 new inflammatory bowel nurses have now been recruited. Sickness absenteeism is being actively managed.

# Isle of Wight NHS Trust Board Performance Report 2015/16


April 16

Performance Summary - Clinical Support, Cancer and Diagnostics


## Balanced Scorecard - Clinical Support, Cancer and Diagnostics

Excellent Patient Care 					
	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	May-16	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)	May-16		0		0
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	May-16		0		0
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	May-16		1		1
Falls - resulting in significant injury	May-16		0		0
Emergency 30 day Readmissions	May-16		0.0%		0.0%
Symptomatic Breast Referrals Seen <2 weeks*	May-16	93%	96.6%	93%	97.5%
Cancer patients seen <14 days after urgent GP referral*	May-16	93%	95.1%	93%	96.0%
Cancer Patients receiving subsequent Chemo/Drug <31 days*	May-16	98%	100.0%	98%	100.0%
Cancer Patients receiving subsequent surgery <31 days*	May-16	94%	100.0%	94%	96.7%
Cancer diagnosis to treatment <31 days*	May-16	96%	100.0%	96%	100.0%
Cancer Patients treated after screening referral <62 days*	May-16	90%	90.9%	90%	80.0%
Cancer Patients treated after consultant upgrade <62 days*	May-16	No measured operational standard	No Pts	No measured operational standard	100.0%
Cancer urgent referral to treatment <62 days*	May-16	85%	79.4%	85%	78.2%
Never Events	Apr-16	0	1	0	1
Pressure Ulcers - Grade 1	May-16		2		9
Pressure Ulcers - Grade 2	May-16		1		4
Pressure Ulcers - Grade 3	May-16		0		0
Pressure Ulcers - Grade 4	May-16		0		0
Pressure Ulcers - Ungradable	May-16		2		3


  

A positive experience for patients, service users and staff 					
	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	May-16	0	0	0	0
No. of Complaints	May-16		0		2
No. of Concerns	May-16		12		28
No. of Compliments	May-16		86		140
Cancelled operations on/after day of admission (not rebooked within 28 days) - including those not rebooked at the time of reporting	May-16	0	2	0	7
All Cancelled Operations on/after day of admission	May-16		10		34
Theatre utilisation	May-16	83%	83.1%	83%	82.0%
No. of Reported SIRIs	May-16		1		3
Physical Assaults against staff	May-16		1		1
Verbal abuse/threats against staff	May-16		0		3


  

Working with others to keep our services 					
	Latest data	In Month		YTD	
		Target	Actual	Target	Actual


  

Income** 					
	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Apr-16	£ 972,746	£ 950,876	£ 972,746	£ 950,876

Skilled and capable staff 					
	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	May-16				11.60%

Cost effective, sustainable services 					
	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (loW CCG + NHS England)	May-16	92%	93.6%	92%	94.8%
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	May-16	0	0	0	0
No. Patients waiting > 6 weeks for diagnostics	May-16	<8	2	<100	11
% Patients waiting > 6 weeks for diagnostics	May-16	<1%	0.2%	<1%	0.6%
% Sickness Absenteeism	May-16	3%	4.03%	3%	4.07%

\*Cancer figures for April are provisional.

\*\*The Acute Service Level Agreement performance reports a month behind, therefore figures are from April 2016.

### Cancer Breach Analysis

31 day subsequent surgery standard not achieved with one patient choice breach (Breast). 62 day standard not achieved with 8 breaches (1 x UGI, 5 x Urology, 1 x Colorectal and 1 x CUP - various reasons). 62 day screening standard not achieved with 2 local breaches (Breast) and one shared breach with PHT (Bowel). Full breach analysis and root cause analysis performed for every breach. Performance data and issues reviewed twice weekly by Performance Lead and Operational Managers. As at 28/06/16 - The Cancer urgent referral to treatment <62 days figure for the month is at 80.60%, still not achieving for YTD.

### Cancellation Analysis

Cancelled operations on/after day of admission (not rebooked within 28 days)- targets may not be missed, as the 28 day pathway is ongoing at present so these may be rebooked in time. - Currently there are 9 confirmed patients who have had surgery cancelled on/day after admission who have been booked passed 28 days. Those patients booked outside of the 28 days are due to patient choice.

### Theatre Utilisation Analysis

The theatre utilisation targets were not achieved due to bed capacity both the theatre underutilisation and cancelled appointments were as a result of ongoing bed pressures. The CSCD Management team is fully engaged with improving patient flow and attend daily bed meeting to expedite actions.

### Appraisal and Sickness Absence Monitoring Analysis

New management are addressing long term absences and supporting their return to work.

### Never event

Investigation was carried out. SIRI report has been received and is with Interim Head of Quality for review.





# Isle of Wight NHS Trust Board Performance Report 2016/17


May 16


Performance Summary - Ambulance, Urgent Care and Community

## Balanced Scorecard - Ambulance, Urgent Care and Community


Excellent Patient Care 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	May-16	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection - stretched target)	May-16		0		0
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	May-16		1		2
Clinical Incidents (Catastrophic) resulting in harm(actual only - as confirmed by investigation)	May-16		1		1
Falls - resulting in significant injury	May-16		0		0
Never Events	Apr-16	0	0	0	0
Pressure Ulcers - Grade 1	May-16		0		2
Pressure Ulcers - Grade 2	May-16		2		3
Pressure Ulcers - Grade 3	May-16		0		0
Pressure Ulcers - Grade 4	May-16		0		0
Pressure Ulcers - Ungradable	May-16		0		1

A positive experience for patients, service users and staff 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	May-16	0	0	0	0
No. of Complaints	May-16		4		13
No. of Concerns	May-16		16		34
No. of Compliments	May-16		30		60
Emergency Care 4 hour Standards	May-16	95%	92.5%	95%	88.8%
Number of patients who have waited over 12 hours in A&E from decision to admit to admission	May-16	0	0	0	2
Category A 8 Minute Response Time (Red 1)	May-16	75%	66.7%	75%	59.3%
Category A 8 Minute Response Time (Red 2)	May-16	75%	75.3%	75%	74.4%
Category A 19 Minute Response Time	May-16	95%	95.7%	95%	94.4%
Number of Ambulance Handover Delays between 1-2 hours	May-16		5		35
No. of Reported SIRIs	May-16		1		1
Physical Assaults against staff	May-16		1		2
Verbal abuse/threats against staff	May-16		4		6

Working with others to keep improving our services 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual

Skilled and capable staff 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	May-16				7.20%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Apr-16	£ 2,950,141	£ 3,038,760	£ 2,950,141	£ 3,038,760

Cost effective, sustainable services 	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism	May-16	3%	4.14%	3%	4.34%
Ambulance re-contact rate following discharge from care by telephone	May-16	3%	4.3%	3%	2.6%
Ambulance re-contact rate following discharge from care at scene	May-16	2%	2.8%	2%	3.3%
Ambulance time to answer call (in seconds) - median	May-16	1	1	N/A	N/A
Ambulance time to answer call (in seconds) - 95th percentile	May-16	5	1	N/A	N/A
Ambulance time to answer call (in seconds) - 99th percentile	May-16	14	10	N/A	N/A
NHS 111 Call abandoned rate	May-16	5%	1.8%	5%	1.9%
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	May-16	95%	95.8%	95%	95.5%
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	May-16	95%	95.5%	95%	94.9%
NHS 111 Where the above is not achieved callers should be called back within 10 mins	May-16	100%	34.0%	100%	30.0%

\*\*The Acute Service Level Agreement performance reports a month behind, therefore figures are from April 2016.

Emergency Care Standard - The 95% target was not achieved in May due to ongoing system wide pressures impacting upon patient flow and appropriate bed capacity. However the recovery trajectory of 88% was achieved. The System Resilience Winter Action Plan and ED improvement plans continue to be monitored weekly and monthly with the Clinical Commissioning Group. Revised trajectories for the year have been set based on capacity and demand planning for 16/17; this has been informed by historical activity and performance, as well as the intended impact of the above actions currently being implemented now and throughout quarter 1. In addition, the impact of our system partners' actions are incorporated and, once agreed, will be monitored by the System Resilience Group.

Ambulance - The Service met 2 out of the 3 targets in May. Data reporting issues are resolving with an improvement in A&E handovers processes and technical data capture. The key issues facing the service is its ability to provide a high quality of care against a back drop of system wide pressures and flow of patients through the hospital setting leading to delays in responding at times. This is a similar picture across ambulance services across the country. Recruitment to paramedic posts is also a challenge but we are currently recruiting for 3 vacancies with plans to secure qualified staff or students due to qualify in the summer.


The 111 service achieved the calls answered in 60 secs target. It has been recognised that a change in practice following recommendations from a SIRI has reduced additional ad hoc call handling support from the Hub Performance Support Officers affecting performance. Also at times shortages of GP capacity means 111 receives a higher level of activity at times. We continue to mitigate this by arranging for an additional call handler to be on duty whenever available. We are monitoring the success and costs of this closely.

# Isle of Wight NHS Trust Board Performance Report 2016/17


May 16

## Performance Summary - Mental Health and Learning Disabilities


### Balanced Scorecard - Mental Health and Learning Disabilities

<b>Excellent Patient Care</b> 		Latest data	In Month		YTD	
			Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)		May-16	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)		May-16		0		0
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)		May-16		0		0
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)		May-16		0		0
Falls - resulting in significant injury		May-16		0		0
Never Events		Apr-16	0	0	0	0

<b>A positive experience for patients, service users and staff</b> 		Latest data	In Month		YTD	
			Target	Actual	Target	Actual
FFT - % Response Rate		May-16		1.4%		1.3%
FFT - % Recommending		May-16	90%	94%	90%	96%
Mixed Sex Accommodation Breaches		May-16	0	0	0	0
No. of Complaints		May-16		0		1
No. of Concerns		May-16		7		12
No. of Compliments		May-16		5		12
No. of Reported SIRIs		May-16		0		0
Physical Assaults against staff		May-16		4		8
Verbal abuse/threats against staff		May-16		15		34
% of CPA patients receiving FU contact within 7 days of discharge		May-16	95%	95.3%	95%	96.5%
% of CPA patients having formal review within last 12 months		May-16	95%	94.6%	95%	94.8%
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)		May-16	95%	97.4%	95%	98.6%


  

<b>Working with others to keep improving our services</b> 		Latest data	In Month		YTD	
			Target	Actual	Target	Actual
Delayed Transfer of Care (lost bed days) - (MH)		May-16		161		383


  

<b>Income**</b>		Latest data	In Month		YTD	
			Plan	Actual	Plan	Actual
Total SLA Value		Mar-16	£ 1,706,506	£ 1,706,506	£ 20,478,074	£ 20,478,074

<b>Skilled and capable staff</b> 		Latest data	In Month		YTD	
			Target	Actual	Target	Actual
Appraisals		May-16				6.10%

<b>Cost effective, sustainable services</b> 		Latest data	In Month		YTD	
			Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (IoW CCG + NHS England)		May-16	92%	100.0%	92%	96.9%
Zero tolerance RTT waits over 52 weeks (Incomplete Return)		May-16	0	0	0	0
% Sickness Absenteeism		May-16	3%	4.62%	3%	4.51%
New Cases of Psychosis by Early Intervention Team		May-16	2	0	4	1
IAPT - Proportion of people who have completed treatment and moving to recovery		May-16	50%	50.7%	50%	49.2%

\*\*The Acute Service Level Agreement performance reports a month behind, therefore figures are from March 2016.

- Improved performance against the CR/HT indicator in May was sustained and remained above the required 95%
- The percentage of patients on CPA having formal review fell below target in May. This has been raised at the CBU Operational Management meeting and work will be undertaken to enable improved performance during June.
- Improved RTT Performance for MH out-patients was maintained in May. Validation of pathways continues to enable early identification and management of potential breaches.
- Sickness absence remains above the target with a slight increase in absenteeism compared to the previous month. Mechanisms are in place to support operational managers in relation to management of short term sickness.
- Performance against the IAPT Recovery indicator has been based on local performance information. We are awaiting publication of HSCIC to confirm the final position. The YTD position has fallen below requirements due to two factors:-
  1. Vacancies within the IAPT service - we now have authorisation to recruit to agency PWP to support improvement against target.
  2. Cluster 4 patients on the caseload take longer to move to recovery due to the nature of their illness continue and continue to impact on performance.

## Highlights

- High risk TIA fully investigated & treated within 24 hour and Stroke patients (90% of stay on Stroke Unit) above the target
- No falls resulting in significant injury
- Symptomatic Breast Referrals Seen <2 weeks, Cancer patients seen <14 days after urgent GP referral, Cancer Patients receiving subsequent Chemo/Drug <31 days and Cancer diagnosis to treatment <31 days, Cancer Patients receiving subsequent surgery <31 days, Cancer Patients treated after screening referral <62 days above target
- No Mixed Sex Accommodation Breaches in May
- No new cases of MRSA
- % of Care Programme Approach patients receiving FU contact within 7 days of discharge above target
- Summary Hospital level Mortality Indicator
- Category A 8 Minute Response Time (Red 2) and Category A 19 Minute Response Time both above target

## Lowlights

- Referral ToTreatment Time - % Incomplete pathways below 92% target
- Staff sickness remains above plan
- Emergency care 4 hour standard remains below target
- Theatres utilisation below target
- Category A 8 Minute Response Time (Red 1) below target
- Cancer urgent referral to treatment <62 days below target
- Governance Risk Rating of 9 for May 2016
- 2 cancelled operations on/after day of admission (not rebooked within 28 days)
- 6 formal complaints in month
- % of Care Programme Approach patients having formal review within last 12 months below target
- 1 Patient developed a grade 4 pressure ulcer
- One case of C.Diff during May
- 2 Clinical Incidents (Major) resulting in harm

## 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:** The Pressure Ulcer Collaborative has been operating over the past few months to review of all pressure ulcers that occur in the IW NHS care on a weekly basis. This has focussed further attention on this issue and raised awareness in the directorates. Whilst there has been a rise in the overall reporting, this has been mainly in the area of grade 1 and 2 pressure ulcers. There are a number of ungradable pressure ulcers that are still under review.

**Community:** Pressure ulcer development contributes to clinical incident numbers and the higher grades contribute to the numbers of Serious Incidents Requiring Investigation. (SIRIs).

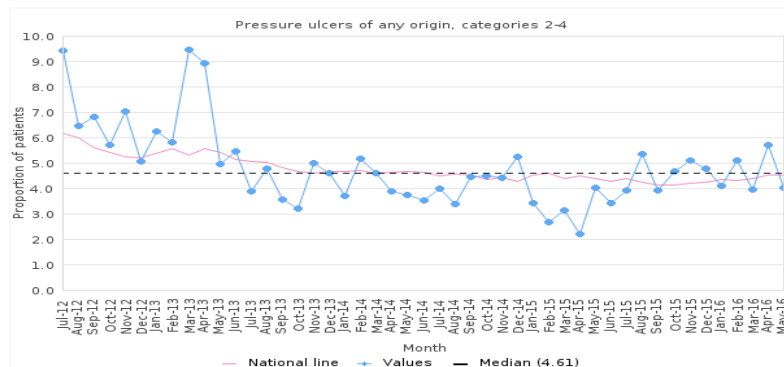
The Clinical Directorates took full responsibility for the management of pressure ulcer incidents in June including approval status and checking for duplicates. This is a move away from overall final responsibility for pressure ulcers incidents sitting with the Nutrition and Tissue Viability Service. Increased awareness is continuing to lead to increased numbers being reported.

The Pressure Ulcer collaborative is also looking at the community and in this setting only two grade 3 pressure ulcers and 1 grade 4 pressure ulcer have been reported during the review period. The trend overall is encouraging, and the reviews are now focussing on the root cause analysis and cluster review of grade 2 pressure ulcers as the Trust has set itself the target of reducing the occurrence of this grade of pressure ulcers by 50% in the next year. The overall trend across 2015/16 is decreasing incidence across all grades.

The report now separates out Ungradable pressure ulcers as a distinct reporting line so that it is clear that these ulcers (which were previously counted as grade 4s) have not yet been assigned a grade and do not automatically mean that this is an incident that has resulted in patient harm.

Level 3/4 pressure ulcers are likely to reduce on validation.

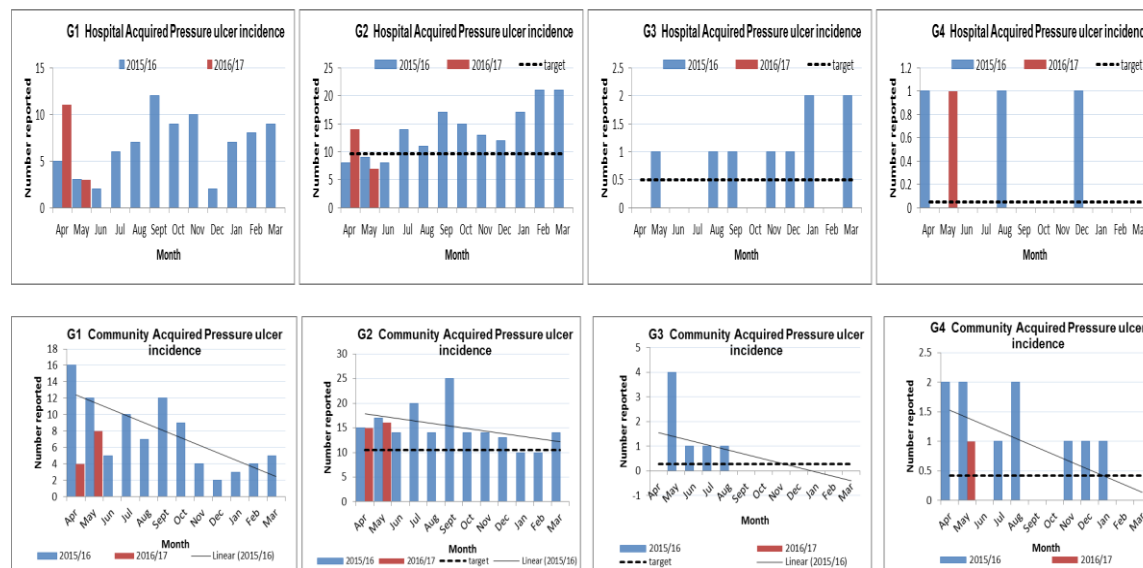
## Pressure Ulcers benchmark



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

## Analysis:

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



## Action Plan:

- The pressure ulcer collaborative continues to meet. The overall trends are encouraging and the recent increases in numbers are more indicative of increased awareness and reporting of lower grades than of increasing incidence. The trend continues to decrease.
- Deep dives for each directorate going ahead to look at why expected reductions were not achieved last year.
- Action plans for pressure ulcer reduction have been reviewed and are being amalgamated into a single master plan for coming year.
- Local monthly Tissue Viability and MUST audits are being established by Tissue Viability Service.
- Pressure Ulcer Reporting has been handed to Matrons and Locality leads to supervise to develop local ownership of reporting and understanding the scale of the issue.
- Work is also ongoing to identify where patients are admitted from their home address who have been receiving non NHS care assistance.

## Person Responsible:

Clinical directorate leads and Tissue Viability Nurse Specialist

## Date:

Jun-16

## Status:

Ongoing

## Commentary:

### Clostridium difficile

There was 1 case of C Diff in May. The root cause analysis has now been completed and found that there was a lapse in care and this may have been avoidable. Actions have been put in place in the relevant ward and details have been shared across the other wards so that lessons can be learned. It is acknowledged nationally that some cases are effectively unavoidable and no alternative action could have been taken. There is a new move toward offering a probiotic to patients at risk that can be taken during and for a short while after specific antibiotics are prescribed and this will be offered where appropriate. There are a number of people within the wider community who are known to be MRSA or C Diff positive although the infection may be neither active nor causing symptoms at the time and these people may require admission for other conditions.

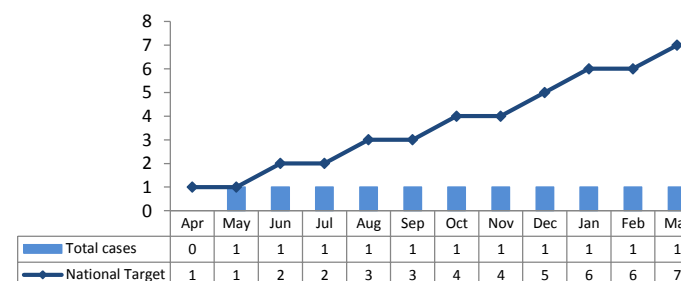
### Methicillin-resistant Staphylococcus Aureus (MRSA)

There have been no cases identified as Healthcare acquired infections during May.

## Analysis:

### Clostridium Difficile infections against national and local targets

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



Isle of Wight NHS Trust

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

## Action Plan:

Action Plan:	Person Responsible:	Date:	Status:
Participation in National 90 day improvement programme with results discussed at national meeting	Infection Prevention & Control team/ Business Unit Head of Nursing & Quality/ Ward Managers	Sep-16	Continuing
Improved stool sampling, with ward staff to complete e-learning and sign off on education poster	Ward sister	End of June 2016	Continuing
Daily checks on commode cleanliness, Infection Control Link Nurse to observe cleaning practice and advise.	Ward sister	Ongoing until consistent compliance achieved.	Continuing
Use of BioQuell gas fogging intensive cleaning following surface cleaning between patients where isolation has been in place.	Infection Prevention & Control team / Hotel services	Jun-16	Continuing

## Commentary:

There were 6 formal Trust complaints received in May 2016 (22 in the previous month) with 247 compliments received by letters and cards of thanks for the same period. In addition to the 6 formal complaints, a further 68 concerns were raised.

Across all complaints and concerns in May 2016:

Top subjects were:

- Clinical treatment (17)
- Communication (19)
- Appointments (10)

Top areas of complaints and concerns were:

- Podiatry (6)
- Orthopaedics (4)
- Beacon Healthcare (5)
- OPARU (4)
- Cardiology (4)
- Emergency Dept (4)

## Analysis: Complaints only

Primary Subject	Apr-16	May-16	CHANGE	RAG rating
Access to treatment or drugs	2	0	-2	✓
Admissions and discharges	0	0	0	✓
Appointments	0	1	1	↑
Clinical Treatment	7	3	-4	↓
Commissioning	0	0	0	✓
Communication	3	1	-2	↓
Consent	0	0	0	✓
End of Life Care	0	0	0	✓
Facilities	2	1	-1	↓
Integrated Care	0	0	0	✓
Mortuary	0	0	0	✓
Other (Use with Caution)	1	0	-1	✓
Privacy, Dignity and Wellbeing	0	0	0	✓
Prescribing	0	0	0	✓
Patient Care	1	0	-1	✓
Restraint	0	0	0	✓
Staff numbers	0	0	0	✓
Trust admin/Policies/Procedures	0	0	0	✓
Transport (Ambulances)	0	0	0	✓
Values and Behaviours (Staff)	3	0	-3	✓
Waiting Times	3	0	-3	✓

## Action Plan:

Complaints process is currently being reviewed to ensure complainants are responded to in line with negotiated timescales, and that they receive a high quality response that fully addresses their concerns.

## Person Responsible:

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

## Date:

Jun-16

## Status:

In progress

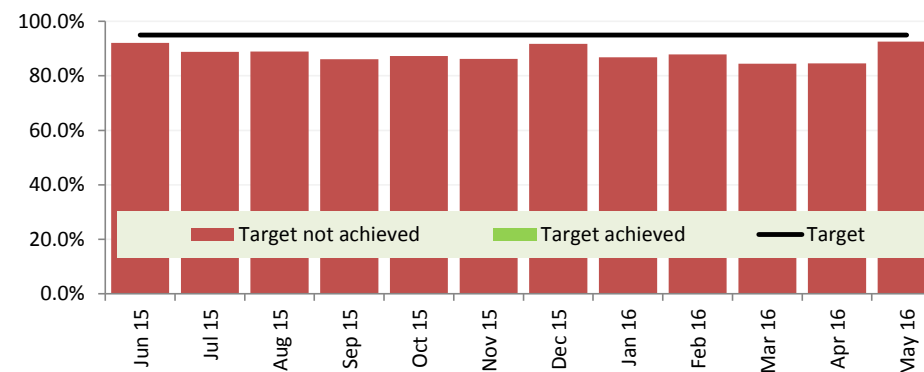
## Commentary:

For 2016/17, the Trust has set trajectories for some key national performance standards that we are currently under performing against. This is to enable an informed, manageable and sustainable improvement in performance during the year until the target is achieved.

The trajectory for May was 88% and the Trust achieved 92.87% (target standard is 95%). This good performance against the trajectory was due to emergency activity levels as forecast (whereas the previous month there was a 10% increase in emergency activity than expected), and the continued focus on the benefits of Safer Start Week held at the end of April. Progression of the trajectory improvement plan and the embedding of weekly urgent care performance management group has also contributed. However, sustaining performance at this level is subject to system wide pressures and the System Resilience Group is implementing schemes to also support performance in the delivery of emergency care.

## Analysis:

### Emergency Care 4 hours Standard



## Action Plan:

## Person Responsible:

## Date:

## Status:

Ensure robust data information

Head of Operations

Jun-16

In progress

Review of nursing resources across including vacancies, skill mix, management and processes

Head of Nursing & Quality

Jun-16

In progress



# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

## Cancer Urgent referral to treatment <62 days

### Commentary:

Cancer urgent referral to treatment <62 days - Standard 85% - Performance - 76.5%

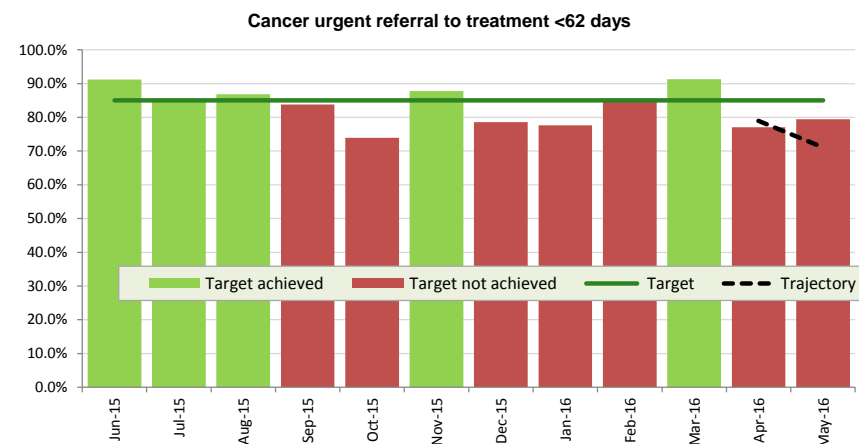
#### Breaches:

- 1 x Breast - Delay to initial diagnostic tests
- 1 x Breast - Patient requested thinking time regarding treatment options
- 1 x Breast - Complex diagnostic pathway
- 1 x Colorectal - Patient required other tumour site MDT opinion and investigation
- 1 x Colorectal - Patient required specialist imaging and referral to other tumour site for MDT opinion
- 1 x Lung - Cytological diagnosis only - multiple oncology reviews before treatment plan agreed
- 1 x Urology - Patient required Tertiary Centre investigation

All other Cancer Waiting Times standards have been achieving for May.

For 2016/17, the Trust has set trajectories for some key national performance standards that we are currently under performing against. This is to enable an informed, manageable and sustainable improvement in performance during the year until the target is achieved.

### Analysis:



### Action Plan:

- All individual breaches continue to be reviewed. Root Cause Analysis is carried out. Analysis of reasons for breaches identified no specific trend. Complex pathways and patient choice were noted.
- Relevant CNSs to be informed by Booking Clerks in OPARU when delay in appointing occurs. This process has been reinforced by the Operational Manager
- Close scrutiny of patient pathway with notification by Cancer Pathways Admin Team to Cancer CNS, OPARU, Secretaries and Operational Managers when delays are noted.
- Multi Disciplinary Team to continue to facilitate timely discussions and actions recommended to be followed
- Continue escalation process to highlight potential breaches for actions to be taken for Operational Managers via twice weekly performance update
- Potential shared breaches to be identified and reported to Operational Managers via twice weekly information submitted for Access Meeting.
- Outstanding histopathology reports highlighted to Technical Head. Pathology request forms to be marked CaFT (Cancer Fast Track) – This process to be reinforced by the Operational Managers. Future version of request form to include CaFT box.
- Outstanding imaging reports highlighted to Diagnostic Imaging twice weekly and ad hoc for MDT meetings
- Breach reports produced for 'near misses' and shared breaches
- Breach reports now include tracking against milestones for comparison with timed pathways

### Person Responsible:

Lead Cancer Nurse/CNSs/Cancer Pathways Manager  
Operational Managers/MDT Clinicians

### Date:

Jun-16

### Status:

Continuing

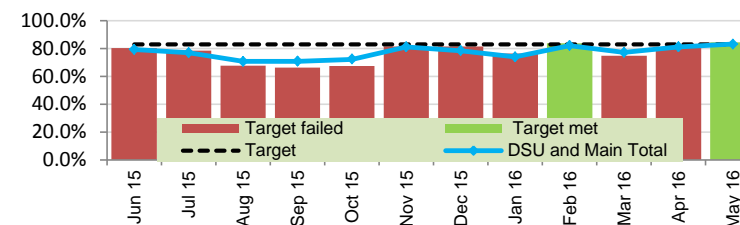
<p><b>Commentary:</b></p> <p>Ambulance - The Service met 2 out of the 3 targets in May 2016, the Service failed Category A 8 Minute Response Time (Red 1) target. This is an improvement from the performance seen in April 2016. Data reporting issues are resolving with an improvement in A&amp;E handovers processes and technical data capture. The key issues facing the service is its ability to provide a high quality of care against a back drop of system wide pressures and flow of patients through the hospital setting leading to delays in response times. This is a similar picture with ambulance services across the country. Recruitment to paramedic posts is also a challenge but we are currently recruiting to vacancies with plans to secure qualified staff or students due to qualify in the summer.</p> <p>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.</p> <p>The Integrated Care Hub continues to attract media and national attention due to the joint working approach being promoted through this approach and the many benefits to patients through this system. The service also continues to work alongside stakeholders from within and outside the Trust and maintaining links with our strategic blue light agencies is moving forward and some positive signs are emerging on joint working.</p> <p>For 2016/17, the Trust has set trajectories for some key national performance standards that we are currently under performing against. This is to enable an informed, manageable and sustainable improvement in performance during the year until the target is achieved.</p>	<p><b>Analysis:</b></p> <div><p><b>Cat A 8 minutes response time (Red 1)</b></p><table border="1"><thead><tr><th>Month</th><th>Target achieved</th><th>Target not achieved</th><th>Target</th></tr></thead><tbody><tr><td>Jun-15</td><td>65%</td><td>35%</td><td>75%</td></tr><tr><td>Jul-15</td><td>70%</td><td>30%</td><td>75%</td></tr><tr><td>Aug-15</td><td>68%</td><td>32%</td><td>75%</td></tr><tr><td>Sep-15</td><td>78%</td><td>22%</td><td>75%</td></tr><tr><td>Oct-15</td><td>80%</td><td>20%</td><td>75%</td></tr><tr><td>Nov-15</td><td>78%</td><td>22%</td><td>75%</td></tr><tr><td>Dec-15</td><td>70%</td><td>30%</td><td>75%</td></tr><tr><td>Jan-16</td><td>60%</td><td>40%</td><td>75%</td></tr><tr><td>Feb-16</td><td>70%</td><td>30%</td><td>75%</td></tr><tr><td>Mar-16</td><td>58%</td><td>42%</td><td>75%</td></tr><tr><td>Apr-16</td><td>52%</td><td>48%</td><td>75%</td></tr><tr><td>May-16</td><td>68%</td><td>32%</td><td>75%</td></tr></tbody></table></div> <div><p><b>Cat A 19 minutes response time</b></p><table border="1"><thead><tr><th>Month</th><th>Target achieved</th><th>Target not achieved</th><th>Target</th></tr></thead><tbody><tr><td>Jun-15</td><td>90%</td><td>10%</td><td>95%</td></tr><tr><td>Jul-15</td><td>92%</td><td>8%</td><td>95%</td></tr><tr><td>Aug-15</td><td>95%</td><td>5%</td><td>95%</td></tr><tr><td>Sep-15</td><td>95%</td><td>5%</td><td>95%</td></tr><tr><td>Oct-15</td><td>95%</td><td>5%</td><td>95%</td></tr><tr><td>Nov-15</td><td>95%</td><td>5%</td><td>95%</td></tr><tr><td>Dec-15</td><td>95%</td><td>5%</td><td>95%</td></tr><tr><td>Jan-16</td><td>95%</td><td>5%</td><td>95%</td></tr><tr><td>Feb-16</td><td>92%</td><td>8%</td><td>95%</td></tr><tr><td>Mar-16</td><td>95%</td><td>5%</td><td>95%</td></tr><tr><td>Apr-16</td><td>90%</td><td>10%</td><td>95%</td></tr><tr><td>May-16</td><td>95%</td><td>5%</td><td>95%</td></tr></tbody></table></div> <div><p><b>Cat A 8 minutes response time (Red 2)</b></p><table border="1"><thead><tr><th>Month</th><th>Target achieved</th><th>Target not achieved</th><th>Target</th><th>Trajectory</th></tr></thead><tbody><tr><td>Jun-15</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr><tr><td>Jul-15</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr><tr><td>Aug-15</td><td>70%</td><td>30%</td><td>75%</td><td>90%</td></tr><tr><td>Sep-15</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr><tr><td>Oct-15</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr><tr><td>Nov-15</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr><tr><td>Dec-15</td><td>78%</td><td>22%</td><td>75%</td><td>90%</td></tr><tr><td>Jan-16</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr><tr><td>Feb-16</td><td>70%</td><td>30%</td><td>75%</td><td>90%</td></tr><tr><td>Mar-16</td><td>70%</td><td>30%</td><td>75%</td><td>90%</td></tr><tr><td>Apr-16</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr><tr><td>May-16</td><td>75%</td><td>25%</td><td>75%</td><td>90%</td></tr></tbody></table></div>	Month	Target achieved	Target not achieved	Target	Jun-15	65%	35%	75%	Jul-15	70%	30%	75%	Aug-15	68%	32%	75%	Sep-15	78%	22%	75%	Oct-15	80%	20%	75%	Nov-15	78%	22%	75%	Dec-15	70%	30%	75%	Jan-16	60%	40%	75%	Feb-16	70%	30%	75%	Mar-16	58%	42%	75%	Apr-16	52%	48%	75%	May-16	68%	32%	75%	Month	Target achieved	Target not achieved	Target	Jun-15	90%	10%	95%	Jul-15	92%	8%	95%	Aug-15	95%	5%	95%	Sep-15	95%	5%	95%	Oct-15	95%	5%	95%	Nov-15	95%	5%	95%	Dec-15	95%	5%	95%	Jan-16	95%	5%	95%	Feb-16	92%	8%	95%	Mar-16	95%	5%	95%	Apr-16	90%	10%	95%	May-16	95%	5%	95%	Month	Target achieved	Target not achieved	Target	Trajectory	Jun-15	75%	25%	75%	90%	Jul-15	75%	25%	75%	90%	Aug-15	70%	30%	75%	90%	Sep-15	75%	25%	75%	90%	Oct-15	75%	25%	75%	90%	Nov-15	75%	25%	75%	90%	Dec-15	78%	22%	75%	90%	Jan-16	75%	25%	75%	90%	Feb-16	70%	30%	75%	90%	Mar-16	70%	30%	75%	90%	Apr-16	75%	25%	75%	90%	May-16	75%	25%	75%	90%
Month	Target achieved	Target not achieved	Target																																																																																																																																																																							
Jun-15	65%	35%	75%																																																																																																																																																																							
Jul-15	70%	30%	75%																																																																																																																																																																							
Aug-15	68%	32%	75%																																																																																																																																																																							
Sep-15	78%	22%	75%																																																																																																																																																																							
Oct-15	80%	20%	75%																																																																																																																																																																							
Nov-15	78%	22%	75%																																																																																																																																																																							
Dec-15	70%	30%	75%																																																																																																																																																																							
Jan-16	60%	40%	75%																																																																																																																																																																							
Feb-16	70%	30%	75%																																																																																																																																																																							
Mar-16	58%	42%	75%																																																																																																																																																																							
Apr-16	52%	48%	75%																																																																																																																																																																							
May-16	68%	32%	75%																																																																																																																																																																							
Month	Target achieved	Target not achieved	Target																																																																																																																																																																							
Jun-15	90%	10%	95%																																																																																																																																																																							
Jul-15	92%	8%	95%																																																																																																																																																																							
Aug-15	95%	5%	95%																																																																																																																																																																							
Sep-15	95%	5%	95%																																																																																																																																																																							
Oct-15	95%	5%	95%																																																																																																																																																																							
Nov-15	95%	5%	95%																																																																																																																																																																							
Dec-15	95%	5%	95%																																																																																																																																																																							
Jan-16	95%	5%	95%																																																																																																																																																																							
Feb-16	92%	8%	95%																																																																																																																																																																							
Mar-16	95%	5%	95%																																																																																																																																																																							
Apr-16	90%	10%	95%																																																																																																																																																																							
May-16	95%	5%	95%																																																																																																																																																																							
Month	Target achieved	Target not achieved	Target	Trajectory																																																																																																																																																																						
Jun-15	75%	25%	75%	90%																																																																																																																																																																						
Jul-15	75%	25%	75%	90%																																																																																																																																																																						
Aug-15	70%	30%	75%	90%																																																																																																																																																																						
Sep-15	75%	25%	75%	90%																																																																																																																																																																						
Oct-15	75%	25%	75%	90%																																																																																																																																																																						
Nov-15	75%	25%	75%	90%																																																																																																																																																																						
Dec-15	78%	22%	75%	90%																																																																																																																																																																						
Jan-16	75%	25%	75%	90%																																																																																																																																																																						
Feb-16	70%	30%	75%	90%																																																																																																																																																																						
Mar-16	70%	30%	75%	90%																																																																																																																																																																						
Apr-16	75%	25%	75%	90%																																																																																																																																																																						
May-16	75%	25%	75%	90%																																																																																																																																																																						
<b>Action Plan:</b>	<b>Person Responsible:</b>	<b>Date:</b>	<b>Status:</b>																																																																																																																																																																							
Continuous monitoring of performance targets, amending REAP (Resourcing Escalatory Action Plans) level as appropriate and sharing status with fellow Senior Managers and increase staffing levels	Service Delivery Manager, Performance Support Officers, Clinical Support Officers	Jun-16	Ongoing																																																																																																																																																																							
Introduction of the new CAD has led to identifying further causes of data anomalies. Prior to the new CAD it was thought that the data errors were singularly down to technical issues and the new CAD has, together with improved wifi, significantly improved the automation of arrival and leaving times. This has highlighted that data manually input from crews does at times not enable accurate data. Data validation process to extend beyond the current measure of 120min. This will require an increase in data verification hours. This will be achieved by increasing hours worked from part time to full time. In addition the corporate performance team will be trained in the verification process to ensure cover is maintained when absences occur	Lead Clinical Support Officer and Pathway Lead	Jun-16	Ongoing																																																																																																																																																																							
Documented Performance Review Meetings (PRM) increased from once daily to three times daily	Service Delivery Manager, Performance Support Officers (Operational) & Performance Support Officers (Hub)	Jun-16	Ongoing																																																																																																																																																																							
Guidance to be developed for ambulance staff to identify recording process, reiterate importance of recording accurate data and confirm clock starts/stops	Service Delivery Manager, Performance Support Officers, Clinical Support Officers	Jun-16	Ongoing																																																																																																																																																																							
All paramedics to have one-to-one session to discuss performance targets and reiterate importance of accurate data recording	Service Delivery Manager, Performance Support Officers, Clinical Support Officers	Jun-16	Ongoing																																																																																																																																																																							
Performance reports to be developed to extract handover time data from CAD system. Data validation process to be put in place	Service Delivery Manager, Performance Support Officers (Operational) & Performance Support Officers (Hub)	Jun-16	Ongoing																																																																																																																																																																							
Using accurate and validated data monitor performance against national handover standards. If shown to be underperforming develop action plan and trajectory to achieve.	Head of Ambulance, HOO	Jun-16	Ongoing																																																																																																																																																																							

## Commentary

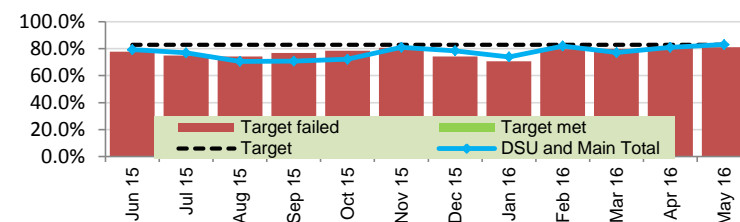
The percentage utilisation of Main Theatre facilities has increased to 84.5% during May 2016, and is above the 83% target. Day Surgery Unit utilisation has decreased to 81.1% and remains below target; this small level of under performance is due to the combination of cancellations, short notice booking and case mix, however, emergency activity, urgent operations and cancer operations continue to be prioritised. The overall theatre utilisation achieved at 83.1%.

## Analysis:

### Main Theatres



### DSU



## Action plan

Daily performance activity huddle in place to monitor elective activity and manage operational issues.

## Person Responsible:

Head of Performance

## Date:

Jun-16

## Status:

Ongoing

## Commentary:

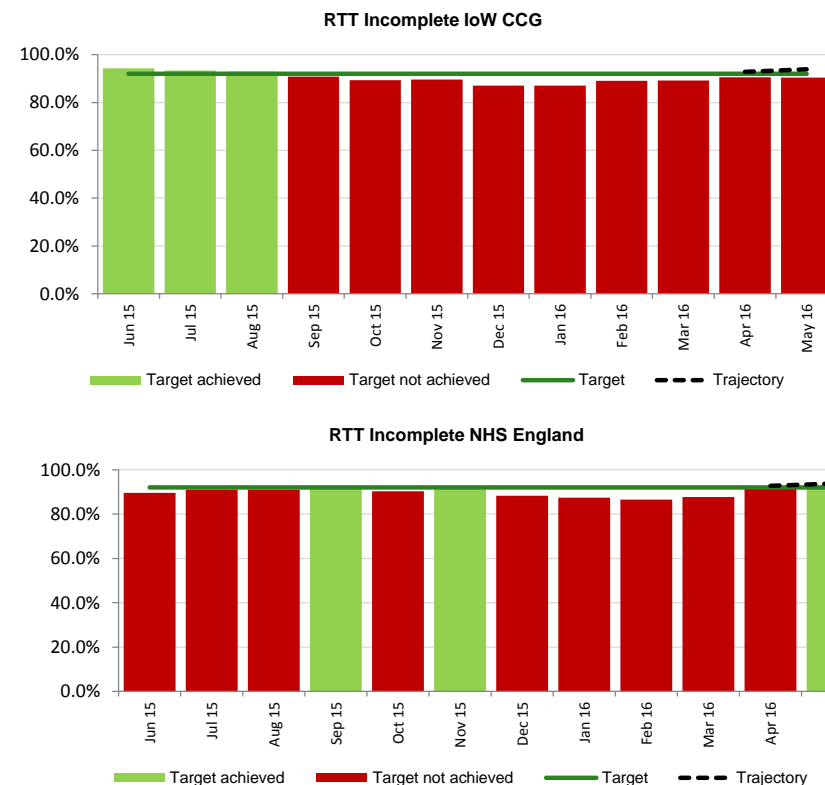
For 2016/17, the Trust has set trajectories for some key national performance standards that we are currently under performing against. This is to enable an informed, manageable and sustainable improvement in performance during the year until the target is achieved.

The trajectory for May was 89.8% and the Trust achieved 90.47% (target standard is 92%). This good performance against the trajectory was due to lesser number of long waiting patients (over 18wks) on the waiting list than forecast, against a higher number of patients waiting overall than forecast. Progression of the trajectory improvement plan and the embedding of the dialy activity performance huddle and weekly patient access performance management group has also contributed.

Delivering admitted (daycase and inpatient) activity continues to be impacted upon by levels of emergency activity and patient flow, both within the hospital and in the community. The System Resilience Group is implementing system wide schemes to also support performance in the elective care environment.

For 2016/17, the Trust has set trajectories for some key national performance standards that we are currently under performing against. This is to enable an informed, manageable and sustainable improvement in performance during the year until the target is achieved.

## Analysis:



	Person Responsible:	Date:	Status:
Daily performance activity huddle in place to monitor elective activity and manage operational issues.	Head of Performance	Jun-16	Ongoing
Transfer proportion of elective capacity currently being used for non elective activity back to elective enabling delivery of planned elective activity	Head of Operations	Jul-16	In planning

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

## Benchmarking of Key National Performance Indicators: Summary Report

	National Target	National Performance			IW Performance	IW Rank	IW Status	Data Period
		Best	Worst	Eng				
Emergency Care 4 hour Standards	95%	100%	67%	86.6%	86.3%	93 / 165	Red	Qtr 4 15/16
RTT % of incomplete pathways within 18 weeks	92%	100%	74%	91.3%	90.6%	144 / 183	Red	Apr-16
% Patients waiting > 6 weeks for diagnostic	1%	0%	35%	1.8%	1.0%	114 / 177	Amber Green	Apr-16
Ambulance Category A Calls % < 8 minutes - Red 1	75%	77%	53%	71.3%	53.1%	11 / 11	Red	Apr-16
Ambulance Category A Calls % < 8 minutes - Red 2	75%	75%	55%	65.2%	73.6%	4 / 11	Amber Red	Apr-16
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	75%	55%	65.5%	72.5%	4 / 11	Amber Red	Apr-16
Ambulance Category A Calls % < 19 minutes	95%	97%	86%	92.2%	93.2%	5 / 11	Amber Red	Apr-16
Cancer patients seen <14 days after urgent GP referral	93%	100%	77%	94.7%	94.8%	98 / 153	Amber Green	Qtr 4 15/16
Cancer diagnosis to treatment <31 days	96%	100%	83%	97.5%	99.0%	60 / 158	Amber Green	Qtr 4 15/16
Cancer urgent referral to treatment <62 days	85%	100%	0%	82.1%	83.8%	87 / 156	Amber Red	Qtr 4 15/16
Symptomatic Breast Referrals Seen <2 weeks	93%	100%	24%	93.6%	96.3%	59 / 131	Amber Green	Qtr 4 15/16
Cancer Patients receiving subsequent surgery <31 days	94%	100%	78%	95.3%	98.0%	74 / 152	Amber Green	Qtr 4 15/16
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	100%	91%	99.2%	99.2%	118 / 142	Amber Green	Qtr 4 15/16
Cancer Patients treated after screening referral <62 days	90%	100%	0%	91.8%	100.0%	1 / 141	Green	Qtr 4 15/16

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 2016/17

May 16

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

Other Small Acute Trusts	National Target	IW	RA3	RA4	RBD	RBT	RBZ	RC1	RC3	RCD	RCF	RCX	RD8	RE9	RFF	RFW	RGR	RJC	RJD	RJF	RJN	RLQ	RLT	RMP	RN7	RNQ	RN2	RQO	RQX	Data Period
Emergency Care 4 hour Standards	95%	86.3% <sup>17</sup>	76.9% <sup>25</sup>	89.9% <sup>12</sup>	90.0% <sup>11</sup>	89.2% <sup>13</sup>	94.4% <sup>4</sup>	90.9% <sup>9</sup>	N/A	94.7% <sup>3</sup>	95.6% <sup>1</sup>	81.0% <sup>23</sup>	90.0% <sup>10</sup>	91.4% <sup>8</sup>	87.6% <sup>14</sup>	N/A	91.5% <sup>7</sup>	95.2% <sup>2</sup>	N/A	85.9% <sup>19</sup>	86.2% <sup>18</sup>	86.8% <sup>16</sup>	84.3% <sup>20</sup>	81.3% <sup>22</sup>	82.4% <sup>21</sup>	78.9% <sup>24</sup>	92.4% <sup>6</sup>	87.1% <sup>15</sup>	94.3% <sup>5</sup>	Qtr 4 15/16
RTT % of incomplete pathways within 18 weeks	92%	90.6% <sup>21</sup>	92.0% <sup>14</sup>	90.7% <sup>20</sup>	90.8% <sup>19</sup>	94.8% <sup>6</sup>	94.2% <sup>9</sup>	94.7% <sup>7</sup>	N/A	95.9% <sup>2</sup>	92.0% <sup>15</sup>	92.0% <sup>16</sup>	88.0% <sup>22</sup>	96.0% <sup>1</sup>	95.1% <sup>4</sup>	N/A	95.6% <sup>3</sup>	93.4% <sup>11</sup>	N/A	N/A	91.8% <sup>17</sup>	N/A	92.9% <sup>13</sup>	92.9% <sup>12</sup>	94.9% <sup>5</sup>	N/A	91.1% <sup>18</sup>	94.2% <sup>10</sup>	94.3% <sup>8</sup>	Apr-16
% Patients waiting > 6 weeks for diagnostic	1%	1.0% <sup>15</sup>	0.9% <sup>14</sup>	2.5% <sup>20</sup>	3.8% <sup>22</sup>	1.2% <sup>18</sup>	0.8% <sup>11</sup>	0.9% <sup>13</sup>	N/A	0.0% <sup>4</sup>	0.0% <sup>1</sup>	0.7% <sup>9</sup>	2.9% <sup>21</sup>	0.0% <sup>1</sup>	4.2% <sup>23</sup>	N/A	1.0% <sup>16</sup>	1.3% <sup>19</sup>	N/A	N/A	0.8% <sup>10</sup>	0.3% <sup>6</sup>	0.1% <sup>5</sup>	0.99% <sup>17</sup>	0.4% <sup>7</sup>	N/A	0.6% <sup>8</sup>	0.9% <sup>12</sup>	0.0% <sup>1</sup>	Apr-16
Cancer patients seen <14 days after urgent GP referral	93%	94.8% <sup>18</sup>	95.8% <sup>13</sup>	95.9% <sup>12</sup>	95.5% <sup>14</sup>	97.0% <sup>9</sup>	96.5% <sup>10</sup>	92.3% <sup>25</sup>	N/A	97.3% <sup>6</sup>	98.5% <sup>3</sup>	98.1% <sup>4</sup>	94.7% <sup>19</sup>	97.1% <sup>7</sup>	92.6% <sup>24</sup>	100.0% <sup>1</sup>	99.1% <sup>2</sup>	97.5% <sup>5</sup>	N/A	94.4% <sup>20</sup>	95.0% <sup>16</sup>	92.8% <sup>23</sup>	94.2% <sup>21</sup>	97.1% <sup>8</sup>	93.6% <sup>22</sup>	96.3% <sup>11</sup>	94.8% <sup>17</sup>	91.6% <sup>26</sup>	95.4% <sup>15</sup>	Qtr 4 15/16
Cancer diagnosis to treatment <31 days	96%	99.0% <sup>19</sup>	97.9% <sup>22</sup>	97.2% <sup>24</sup>	99.7% <sup>10</sup>	99.2% <sup>14</sup>	100.0% <sup>1</sup>	97.4% <sup>23</sup>	N/A	99.6% <sup>12</sup>	100.0% <sup>1</sup>	99.7% <sup>9</sup>	99.6% <sup>11</sup>	100.0% <sup>1</sup>	98.6% <sup>20</sup>	N/A	100.0% <sup>1</sup>	99.0% <sup>17</sup>	N/A	99.1% <sup>16</sup>	100.0% <sup>1</sup>	96.2% <sup>25</sup>	99.4% <sup>13</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	98.0% <sup>21</sup>	99.1% <sup>15</sup>	100.0% <sup>1</sup>	99.0% <sup>18</sup>	Qtr 4 15/16
Cancer urgent referral to treatment <62 days	85%	83.8% <sup>15</sup>	68.5% <sup>25</sup>	85.2% <sup>13</sup>	74.8% <sup>23</sup>	94.1% <sup>2</sup>	85.9% <sup>12</sup>	78.3% <sup>22</sup>	N/A	88.3% <sup>6</sup>	90.9% <sup>4</sup>	86.5% <sup>9</sup>	81.7% <sup>20</sup>	82.1% <sup>19</sup>	89.7% <sup>5</sup>	0.0% <sup>26</sup>	87.5% <sup>7</sup>	82.4% <sup>18</sup>	N/A	79.7% <sup>21</sup>	91.8% <sup>3</sup>	83.4% <sup>17</sup>	74.3% <sup>24</sup>	96.8% <sup>1</sup>	86.1% <sup>11</sup>	83.6% <sup>16</sup>	86.5% <sup>10</sup>	87.0% <sup>8</sup>	84.7% <sup>14</sup>	Qtr 4 15/16
Breast Cancer Referrals Seen <2 weeks	93%	96.3% <sup>12</sup>	86.4% <sup>23</sup>	99.1% <sup>1</sup>	98.7% <sup>2</sup>	97.4% <sup>5</sup>	91.5% <sup>18</sup>	90.8% <sup>19</sup>	N/A	95.5% <sup>14</sup>	96.7% <sup>11</sup>	98.3% <sup>4</sup>	96.8% <sup>10</sup>	N/A	88.5% <sup>21</sup>	N/A	98.6% <sup>3</sup>	96.9% <sup>9</sup>	N/A	43.3% <sup>24</sup>	90.8% <sup>20</sup>	88.3% <sup>22</sup>	95.2% <sup>15</sup>	97.0% <sup>7</sup>	96.9% <sup>8</sup>	97.2% <sup>6</sup>	95.1% <sup>16</sup>	96.0% <sup>13</sup>	94.9% <sup>17</sup>	Qtr 4 15/16
Cancer Patients receiving subsequent surgery <31 days	94%	98.0% <sup>17</sup>	100.0% <sup>1</sup>	89.3% <sup>25</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	93.5% <sup>22</sup>	100.0% <sup>1</sup>	N/A	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	96.7% <sup>20</sup>	100.0% <sup>1</sup>	95.5% <sup>21</sup>	N/A	100.0% <sup>1</sup>	100.0% <sup>1</sup>	N/A	100.0% <sup>1</sup>	100.0% <sup>1</sup>	93.3% <sup>23</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	96.9% <sup>19</sup>	100.0% <sup>1</sup>	97.0% <sup>18</sup>	93.3% <sup>23</sup>	Qtr 4 15/16
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	99.2% <sup>22</sup>	100.0% <sup>1</sup>	98.4% <sup>23</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	N/A	100.0% <sup>1</sup>	100.0% <sup>1</sup>	98.2% <sup>24</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	N/A	99.4% <sup>21</sup>	100.0% <sup>1</sup>	N/A	97.5% <sup>25</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	Qtr 4 15/16
Cancer Patients treated after screening referral <62 days	90%	100.0% <sup>1</sup>	88.9% <sup>20</sup>	100.0% <sup>1</sup>	100.0% <sup>1</sup>	98.0% <sup>13</sup>	100.0% <sup>1</sup>	78.0% <sup>23</sup>	N/A	93.3% <sup>18</sup>	83.3% <sup>21</sup>	100.0% <sup>1</sup>	94.7% <sup>16</sup>	66.7% <sup>25</sup>	100.0% <sup>1</sup>	N/A	93.9% <sup>17</sup>	81.8% <sup>22</sup>	N/A	100.0% <sup>1</sup>	100.0% <sup>1</sup>	90.0% <sup>19</sup>	95.0% <sup>15</sup>	100.0% <sup>1</sup>	98.1% <sup>12</sup>	95.4% <sup>14</sup>	100.0% <sup>1</sup>	71.4% <sup>24</sup>	100.0% <sup>1</sup>	Qtr 4 15/16

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

R1F	ISLE OF WIGHT NHS TRUST	RC3	EALING HOSPITAL NHS TRUST	RFW	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	RLT	GEORGE ELIOT HOSPITAL NHS TRUST
RA3	WESTON AREA HEALTH NHS TRUST	RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	RGR	WEST SUFFOLK NHS FOUNDATION TRUST	RMP	TAMESIDE HOSPITAL NHS FOUNDATION TRUST
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	RCF	AIREDALE NHS FOUNDATION TRUST	RJC	SOUTH WARWICKSHIRE GENERAL HOSPITALS NHS TRUST	RN7	DARTFORD AND GRAVESHAM NHS TRUST
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	RCX	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS TRUST	RJD	MID STAFFORDSHIRE NHS FOUNDATION TRUST	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	RD8	MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST	RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	RN2	SALISBURY NHS FOUNDATION TRUST
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	RJN	EAST CHESHIRE NHS TRUST	RQO	HINCHINGBROOKE HEALTH CARE NHS TRUST
RC1	BEDFORD HOSPITAL NHS TRUST	RFF	BARNESLEY HOSPITAL NHS FOUNDATION TRUST	RLQ	WYE VALLEY NHS TRUST	RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

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

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

## 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%	86.3% <sub>5</sub>	N/A	90.0% <sub>4</sub>	84.7% <sub>6</sub>	100.0% <sub>1</sub>	91.2% <sub>3</sub>	84.3% <sub>7</sub>	74.7% <sub>9</sub>	79.4% <sub>8</sub>	99.3% <sub>2</sub>	Qtr 4 15/16
RTT % of incomplete pathways within 18 weeks	92%	90.6% <sub>10</sub>	99.7% <sub>1</sub>	90.8% <sub>9</sub>	93.0% <sub>4</sub>	99.0% <sub>2</sub>	92.3% <sub>6</sub>	92.6% <sub>5</sub>	92.2% <sub>8</sub>	92.2% <sub>7</sub>	93.8% <sub>3</sub>	Apr-16
%. Patients waiting > 6 weeks for diagnostic	1%	1.0% <sub>4</sub>	N/A	3.8% <sub>9</sub>	1.2% <sub>6</sub>	0.0% <sub>1</sub>	0.0% <sub>2</sub>	1.0% <sub>5</sub>	2.5% <sub>8</sub>	1.7% <sub>7</sub>	0.1% <sub>3</sub>	Apr-16
Cancer patients seen <14 days after urgent GP referral*	93%	94.8% <sub>7</sub>	N/A	95.5% <sub>6</sub>	99.3% <sub>1</sub>	N/A	95.7% <sub>5</sub>	97.1% <sub>2</sub>	95.8% <sub>4</sub>	96.4% <sub>3</sub>	N/A	Qtr 4 15/16
Cancer diagnosis to treatment <31 days*	96%	99.0% <sub>3</sub>	N/A	99.7% <sub>1</sub>	99.0% <sub>2</sub>	N/A	95.3% <sub>7</sub>	97.7% <sub>5</sub>	97.6% <sub>6</sub>	98.7% <sub>4</sub>	N/A	Qtr 4 15/16
Cancer urgent referral to treatment <62 days*	85%	83.8% <sub>5</sub>	N/A	74.8% <sub>7</sub>	87.9% <sub>1</sub>	N/A	87.2% <sub>3</sub>	85.7% <sub>4</sub>	79.5% <sub>6</sub>	87.7% <sub>2</sub>	N/A	Qtr 4 15/16
Breast Cancer Referrals Seen <2 weeks*	93%	96.3% <sub>4</sub>	N/A	98.7% <sub>3</sub>	100.0% <sub>1</sub>	N/A	98.7% <sub>2</sub>	96.3% <sub>5</sub>	95.0% <sub>7</sub>	95.6% <sub>6</sub>	N/A	Qtr 4 15/16
Cancer Patients receiving subsequent surgery <31 days*	94%	98.0% <sub>3</sub>	N/A	100.0% <sub>1</sub>	97.9% <sub>4</sub>	N/A	94.6% <sub>6</sub>	95.8% <sub>5</sub>	91.4% <sub>7</sub>	98.9% <sub>2</sub>	N/A	Qtr 4 15/16
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	99.2% <sub>7</sub>	N/A	100.0% <sub>1</sub>	100.0% <sub>1</sub>	N/A	100.0% <sub>1</sub>	99.2% <sub>6</sub>	100.0% <sub>1</sub>	100.0% <sub>1</sub>	N/A	Qtr 4 15/16
Cancer Patients treated after screening referral <62 days*	90%	100.0% <sub>1</sub>	N/A	100.0% <sub>1</sub>	95.8% <sub>4</sub>	N/A	84.4% <sub>7</sub>	97.2% <sub>3</sub>	93.3% <sub>6</sub>	95.6% <sub>5</sub>	N/A	Qtr 4 15/16

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

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

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

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

## Benchmarking of Key National Performance Indicators: Ambulance Performance

	National Target	IW Performance	RX9	RYC	RRU	RX6	RX7	RYE	RYD	RYF	RYA	RX8	Data Period
Ambulance Category A Calls % < 8 minutes - Red 1	75%	53.1% <sub>11</sub>	66.3% <sub>9</sub>	60.8% <sub>10</sub>	70.0% <sub>6</sub>	69.1% <sub>8</sub>	76.5% <sub>2</sub>	75.1% <sub>3</sub>	70.1% <sub>5</sub>	72.7% <sub>4</sub>	76.8% <sub>1</sub>	69.7% <sub>7</sub>	Apr-16
Ambulance Category A Calls % < 8 minutes - Red 2	75%	73.6% <sub>4</sub>	57.3% <sub>9</sub>	54.8% <sub>11</sub>	64.6% <sub>7</sub>	70.1% <sub>5</sub>	67.5% <sub>6</sub>	74.6% <sub>2</sub>	60.0% <sub>8</sub>	56.9% <sub>10</sub>	75.1% <sub>1</sub>	74.2% <sub>3</sub>	Apr-16
Ambulance Category A Calls % < 8 minutes - Red 1 & Red 2	75%	72.5% <sub>4</sub>	57.7% <sub>10</sub>	55.1% <sub>11</sub>	64.8% <sub>7</sub>	70.0% <sub>5</sub>	68.0% <sub>6</sub>	74.6% <sub>2</sub>	60.5% <sub>8</sub>	57.7% <sub>9</sub>	75.2% <sub>1</sub>	73.9% <sub>3</sub>	Apr-16
Ambulance Category A Calls % < 19 minutes	95%	93.2% <sub>5</sub>	86.7% <sub>10</sub>	87.7% <sub>9</sub>	94.2% <sub>4</sub>	92.9% <sub>6</sub>	92.0% <sub>7</sub>	95.6% <sub>3</sub>	92.0% <sub>8</sub>	86.1% <sub>11</sub>	97.2% <sub>1</sub>	95.7% <sub>2</sub>	Apr-16

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 2016/17

May 16

## Data Quality

### Commentary:

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

The latest information is up to MArch 2016. Overall we now have just 3 red rated indicators reducing from 5 in recent months. Two of the red indicators are in the Admitted Patient Care (APC) Dataset and one in the Outpatient Dataset. The two red indicators in the APC dataset are Primary Diagnosis and the HRG4 (Healthcare Resource Grouping). These are linked as you need the diagnosis to generate the HRG and we believe the issues has been resolved and has been improving month on month and showed a significant improvement once again in M12.

In the Outpatient dataset there are a larger than average number of records with an invalid or missing Patient Patway this is due to the number of patients that have an open episode but are have a closed RTT patient pathway and is not considered a data quality issue.

### Analysis:

Total APC General Episodes: 28,100				Total Outpatient General Episodes: 206,755				Total A&E Attendances: 62,907			
Data Item	Invalid Records	Provider % Valid	National % Valid	Data Item	Invalid Records	Provider % Valid	National % Valid	Data Item	Invalid Records	Provider % Valid	National % Valid
Commissioner	30	99.9%	98.9%	Attendance Indicator	2	100.0%	99.6%	Attendance Disposal	953	98.5%	97.8%
Ethnic Category	20	99.9%	97.1%	Attendance Outcome	84	100.0%	97.1%	Commissioner	640	99.0%	99.1%
HRG4	669	97.6%	98.8%	Commissioner	178	99.9%	99.0%	Conduction Time	914	98.5%	98.4%
Main Specialty	0	100.0%	99.9%	Ethnic Category	79	100.0%	94.5%	Department Type	0	100.0%	99.3%
NHS Number	368	98.7%	99.2%	First Attendance	0	100.0%	99.4%	Departure Time	634	99.0%	99.5%
Org of Residence	14	100.0%	99.6%	HRG4	1	100.0%	97.6%	Ethnic Category	0	100.0%	94.3%
Patient Pathway	1,611	83.5%	63.8%	Main Specialty	0	100.0%	99.1%	First Investigation	1,510	97.6%	94.2%
Postcode	210	99.3%	99.7%	NHS Number	789	99.6%	99.4%	First Treatment	3,116	95.0%	93.3%
Primary Diagnosis	664	97.6%	98.9%	OP Primary Procedure	0	100.0%	99.5%	HRG4	1,735	97.2%	96.6%
Primary Procedure	0	100.0%	99.6%	Org of Residence	14	100.0%	98.6%	NHS Number	892	98.6%	95.6%
Reg GP Practice	9	100.0%	99.9%	Patient Pathway	112,990	42.1%	54.2%	Org of Residence	523	99.2%	97.8%
Site of Treatment	0	100.0%	95.8%	Postcode	185	99.9%	99.7%	Patient Group	1	100.0%	97.8%
Treatment Function	0	100.0%	99.9%	Priority Type	628	99.7%	97.1%	Postcode	73	99.9%	98.6%
				Referral Rec'd Date	628	99.7%	95.8%	Registered GP Practice	31	100.0%	99.0%
				Referral Source	628	99.7%	98.6%				
				Reg GP Practice	9	100.0%	99.8%				
				Site of Treatment	0	100.0%	96.1%				
				Treatment Function	0	100.0%	99.2%				

#### Key:

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

Action Plan:	Person Responsible:	Date:	Status:

### Data Quality - March 2016

Dataset	Measure	IW Performance	National	Threshold			Status	Weighting	Score	Notes
				G	A	R				
APC	Total Invalid Data Items	2	n/a	≤2	>2 ≤4	>4	G	2	0.0	Performance relates to the no. of Red rated data items
APC	Valid NHS Number	98.7%	99.2%	>= national rate	< 0.5% below national rate	> 0.5% below national rate	A	1	0.5	
APC	Valid Ethnic Category	99.9%	97.1%	>= national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Total Invalid Data Items	1	n/a	≤2	>2 ≤5	>5	G	2	0.0	Performance relates to the no. of Red rated data items
OP	Valid NHS Number	99.6%	99.4%	>= national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
OP	Valid Ethnic Category	100.0%	94.5%	>= national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Total Invalid Data Items	0	n/a	≤2	>2 ≤4	>4	G	2	0.0	Performance relates to the no. of Red rated data items
A&E	Valid NHS Number	98.6%	95.6%	>= national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
A&E	Valid Ethnic Category	100.0%	94.3%	>= national rate	< 0.5% below national rate	> 0.5% below national rate	G	1	0.0	
Total				≤ 2	2 > ≤ 4	Page 24 > 4	G	12	0.5	

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

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

Establishment				A	Sickness				R	Turnover & Appraisal		A
	Plan	Actual / Forecast	Variance			Plan	Actual / Forecast	Variance		Turnover	0.43%	
Substantive FTE	2,675	2,630	45		Year to date	3%	4.34%	1.34%		Turnover YTD	1.36%	
Temporary Staffing	152	201	(49)		In Month	3%	4.21%	1.21%		Rolling Appraisal %	41.00%	
Total Funded FTE	2,827	2,831	(4)							Appraisal % (from 1st April)	8.70%	
Summary					Summary					Summary		
SIP decreased in month by 16 FTE - from 2646 (April 16) in May 16. The temporary staffing figure, decreased from 204 FTE in April 16 to 201 FTE in May 16.					Sickness absence has decreased from 4.47% in Apr 16 to 4.21% in May 16. Trust wide highest reason for sickness absence remains Anxiety, Stress, Depression - showing a slight decrease in month by 3.69%.					Turnover remains low - decrease in month from 0.92% in April to 0.43% in May - the majority of which are voluntary resignations.		
Trust Headcount at the end of May 16: 3084 (Decrease of 15)					Estimated Cost of Sickness Absence: Trustwide £264,160					Executive Brief update detailed the new appraisal process, and set the end of June 2016 as the target for completion of appraisals. The updated paperwork makes it clear how to record appraisals carried out, and ensure quality of appraisal.		
					Ambulance, Urgent Care & Community Services (£62,652) Clinical Support Cancer & Diagnostic Services (£55,965) Corporate Services (£47,048) General Medicines (£20,421) Mental Health & Learning Disabilities Services (£40,163) Surgery, Women's & Children's Health Services (£37,910)					Communication has also been sent via 10 Minute Team Brief. Business Unit leads and Execs have been given updates on completion rates in their respective areas.		

Vacancies		R	Overpayment		A	Rostering		R																
Recruitment Activity			Plan			Actual																		
Vacancy FTE	348		Current Position £ 000	0		104																		
						Adherence to forward rostering policy requirement																		
						Units finalising to payroll deadline																		
						Safe staffing units > 80% staffed (overall)																		
Summary			Summary																					
348.13 FTE currently in the recruitment process May 16.			Increase in overpayments to £104k £20k in new overpayments, £10k due to late or incorrect forms,£2.6 due to relocation expense errors (Payroll now include this in the figures).			Calculated live cost centres after organisation restructure at 236.																		
Slight decrease in month from 350.44 FTE in April 16. Recruitment drives in May for Nurses and HCA's have resulted in increased recruitment activity on normal levels, resulting in static recruitment data figures. Further International recruitment is planned for June approximately 40 FTE registered nurses, which will show an increase on numbers for the coming months.			Underlying factors include:			At time of lockdown, multiple costs centres were not locked down (see table below). Substantial effort was made to contact areas to get this done as outlined in the rostering policy.																		
The reasons for recruitment table (below) shows 348.04 FTE in May 16 - this now almost exactly matches the 348.13 FTE recruitment activity table. This has been a result of increased effort to report more accurately from within the Recruitment team. Majority of recruitment remains like for like replacement.			1. Competing Priorities in units. 2. Lack of understanding regarding potential impacts. 3. Duration of process from completing forms to updating ESR.			This month 2 units were removed from the batch list.																		
						<table><tr><th>Business Unit</th><th>Units not locked down</th></tr><tr><td>Corporate</td><td>37</td></tr><tr><td>Ambulance, Urgent Care &amp; Community Services Business Unit</td><td>11</td></tr><tr><td>Surgical &amp; Women &amp; Child Health Services Business Unit</td><td>11</td></tr><tr><td>Clinical Support, Cancer &amp; Diagnostic Services Business Unit</td><td>6</td></tr><tr><td>Mental Health &amp; Learning Disability Business Unit</td><td>3</td></tr><tr><td>General Medicines Business Unit</td><td>3</td></tr><tr><td>Grand Total</td><td>71</td></tr></table>			Business Unit	Units not locked down	Corporate	37	Ambulance, Urgent Care & Community Services Business Unit	11	Surgical & Women & Child Health Services Business Unit	11	Clinical Support, Cancer & Diagnostic Services Business Unit	6	Mental Health & Learning Disability Business Unit	3	General Medicines Business Unit	3	Grand Total	71
Business Unit	Units not locked down																							
Corporate	37																							
Ambulance, Urgent Care & Community Services Business Unit	11																							
Surgical & Women & Child Health Services Business Unit	11																							
Clinical Support, Cancer & Diagnostic Services Business Unit	6																							
Mental Health & Learning Disability Business Unit	3																							
General Medicines Business Unit	3																							
Grand Total	71																							

Underlying Causes								Underlying Causes		Underlying Causes																			
Active Recruitment by Stage in Process	Ambulance, Urgent Care & Community Services	Clinical Support, Cancer & Diagnostic Services	Mental Health & Learning Disabilities Services	Corporate	General Medicines	Surgery, Women's & Children's Health Services	Trustwide	The significant majority of overpayments are due to incorrect or late forms. Underlying factors will include:  1. Competing Priorities in units. 2. Lack of understanding regarding potential impacts. 3. Unit managers timesheets not being finalised by their manager preventing unit lockdown. 4. Inadequate cover arrangements for finalising during manager absence. 5. System flaw allowing locked units to be unlocked by staff entering web timesheets		1. Competing Priorities in units. 2. Lack of understanding regarding potential impacts. 3. Unit managers timesheets not being finalised by their manager preventing unit lockdown. 4. Inadequate cover arrangements for finalising during manager absence. 5. System flaw allowing locked units to be unlocked by staff entering web timesheets																			
Out to Advert	16.80	11.00	7.60	2.80	20.00	3.80	62.00																						
LIVE	31.89	29.77	26.82	24.75	23.59	13.65	150.47																						
Appointed Awaiting Clearances	24.73	17.93	17.73	18.63	38.47	18.17	135.66																						
Total	73.42	58.70	52.15	46.18	82.06	35.62	348.13																						
Remedies & Actions								Remedies & Actions		Remedies & Actions																			
<table><tr><th>Reasons for Recruitment</th><th>FTE</th></tr><tr><td>(blank)</td><td>5.00</td></tr><tr><td>Extension of Fixed Term</td><td>12.98</td></tr><tr><td>Like for Like Replacement</td><td>272.25</td></tr><tr><td>Maternity Cover</td><td>1.00</td></tr><tr><td>New Post</td><td>37.74</td></tr><tr><td>Organisational Change</td><td>13.07</td></tr><tr><td>Vacancy</td><td>6.00</td></tr><tr><td>Grand Total</td><td>348.04</td></tr></table>								Reasons for Recruitment	FTE	(blank)	5.00	Extension of Fixed Term	12.98	Like for Like Replacement	272.25	Maternity Cover	1.00	New Post	37.74	Organisational Change	13.07	Vacancy	6.00	Grand Total	348.04	Overpayment information sent to directorates on a monthly basis for review and action.		1. Importance of finalising and impacts of not doing so to be re-iterated. This will be reinforced by staff who will have had pay implications contacting unit managers. 2. System resolution to be implemented by Allocate. Resolution found in other trusts to be applied here but requires multiple criteria to be adjusted. Allocate are currently investigating the adjustments required for IOW NHS Trust.	
Reasons for Recruitment	FTE																												
(blank)	5.00																												
Extension of Fixed Term	12.98																												
Like for Like Replacement	272.25																												
Maternity Cover	1.00																												
New Post	37.74																												
Organisational Change	13.07																												
Vacancy	6.00																												
Grand Total	348.04																												
ESR Employee self service up and running, empowering staff and managers to review and update their employment records. This will reduce the number of change forms to be completed by managers for employee personal changes.																													

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

## Workforce - Sickness

Decrease in Sickness absence from April 16, 4.47% to 4.21% - above the 3% target. Trust wide highest reason for sickness absence is Anxiety, Stress, Depression although showing a decrease in month by 3.69%. Cold Cough Flu showed the largest reduction in month again of 29.18%

### Trust

The Trust's sickness target is 3%

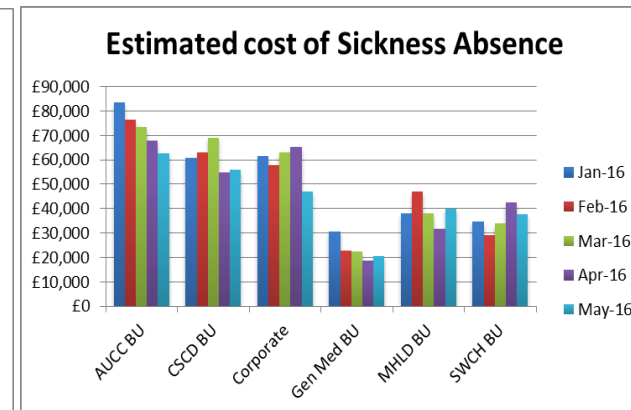
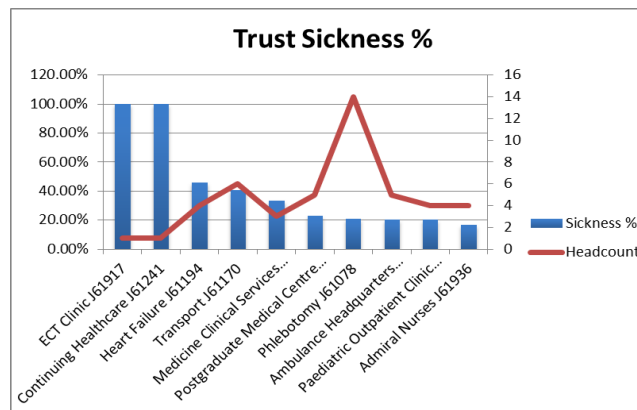
Currently Sickness Absence rate is **4.21%** for May 2016

YTD Sickness Absence is **4.34%**.

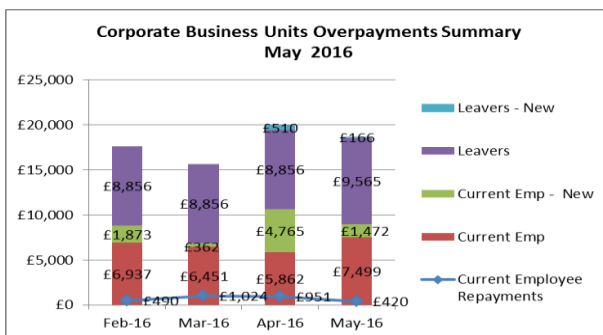
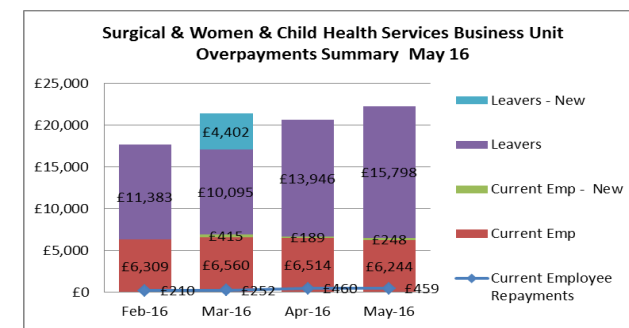
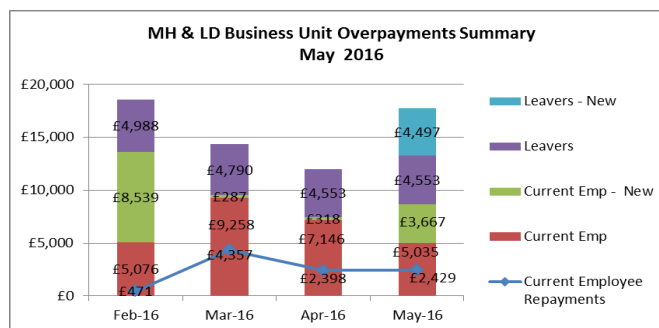
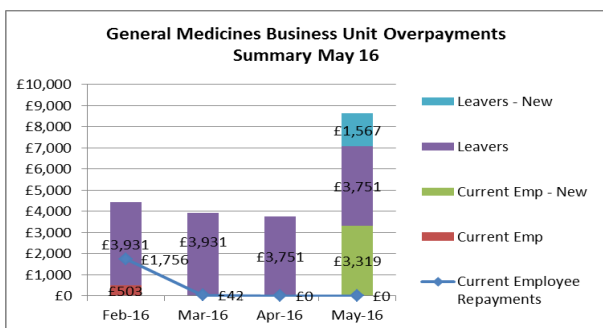
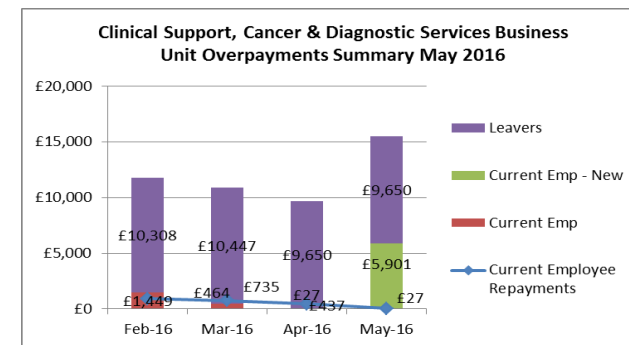
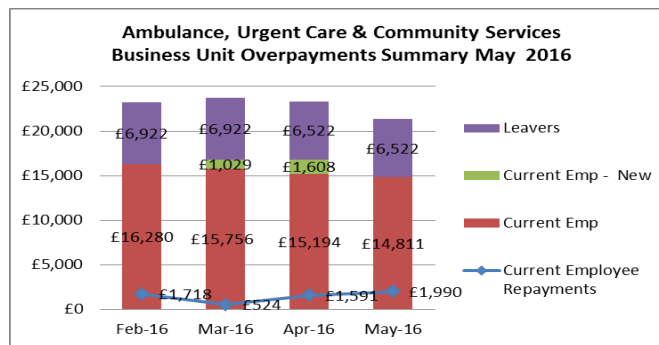
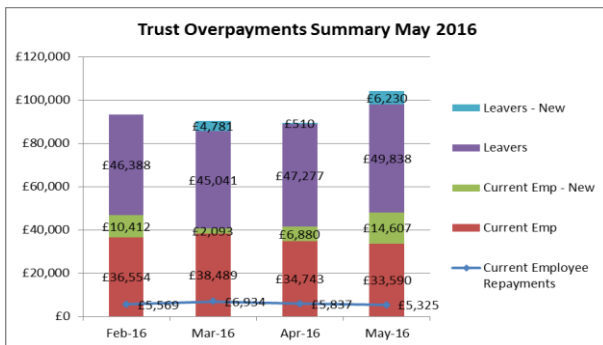
10 Highest areas within Trust

Top 5 Absence Reasons	Sum of FTE Days Lost			
	Mar-16	Apr-16	May-16	Variance
S10 Anxiety/stress/depression/other psychiatric illnesses	816.86	804.98	776.32	-3.69%
S11 Back Problems	196.25	187.53	208.52	10.06%
S12 Other musculoskeletal problems	375.05	539.47	592.41	8.94%
S13 Cold, Cough, Flu - Influenza	739.81	430.33	333.13	-29.18%
S25 Gastrointestinal problems	580.66	476.21	414.93	-14.77%

Organisation	FTE Days Available	Sickness FTE Days Lost	Sickness %	Headcount
ECT Clinic J61917	18.60	18.60	100.00%	1
Continuing Healthcare J61241	31.00	31.00	100.00%	1
Heart Failure J61194	86.80	39.60	45.62%	4
Transport J61170	177.73	72.00	40.51%	6
Medicine Clinical Services J61253	93.00	31.00	33.33%	3
Postgraduate Medical Centre J61700	134.76	31.00	23.00%	5
Phlebotomy J61078	259.16	53.09	20.49%	14
Ambulance Headquarters J61176	155.00	31.00	20.00%	5
Paediatric Outpatient Clinic J61374	82.67	16.53	20.00%	4
Admiral Nurses J61936	108.71	18.00	16.56%	4



Summary: Overall overpayments figure increased to £104k. There was £20K in new overpayments in month, £10k of this due to late or incorrect forms and £2.6k due to relocation expense errors (Payroll now include this in the figures).



May-16 Corporate Directorates Overpayments Summary					
Corporate Directorates	Current Employee Repayments	Current Emp	Current Emp - New	Leavers	Leavers - New
Chief Operating Officer	£330	£3,586		£7,505	
Finance & Performance Mgt	£90	£501	£912	£1,967	
Strategic & Commercial Directorate		£3,412	£560	£93	£166
<b>Total</b>	<b>£420</b>	<b>£7,499</b>	<b>£1,472</b>	<b>£9,565</b>	<b>£166</b>

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

Summary - RAG Rating based on Out-turn position

## Summary

The Trust is reporting a £1.022m deficit for May 2016, which is a favourable variance of £0.074m against plan. Cumulatively, there is a deficit of £2.178m as at May 2016, a favourable variance of £0.206m against plan.

Although a deficit in month, this is an improvement against plan. It is forecast that due to phasing this will return to plan in June.

Overall Financial Sustainability Risk Rating			G		Surplus		G		Income		G	
Plan			Actual		Plan		Actual / Forecast		Plan		Actual / Forecast	
1			2									
Year to date					Year to date £k		(2,384)		28,578		28,334	
					Year end forecast £k		(9,844)		171,308		170,958	
							206				(244)	
							0				(350)	
The planned Continuity of Service Rating (CoSR) in May is '1' which has been achieved. As the I&E Margin Variance is better than plan, the Overall Financial Sustainability Risk Rating is '2' and therefore ahead of plan.			The Trust planned for a deficit of £1.096m in May, after adjustments made for normalising items (these include the net costs associated with donated assets). The reported position is a deficit of £1.022m in the month, a favourable variance of £0.074m against plan.					The Trust planned income in May was £14.434m. The actual reported income is £14.095m in month, an adverse variance of £0.339m.				
			The cumulative Trust plan was a deficit of £2.384m, after normalising items. The actual position is a cumulative deficit of £2.178m, a favourable variance of £0.206m.					The cumulative income plan is £28.578m. The actual position is cumulative income of £28.334m, an adverse variance of £0.244m.				
			The favourable variance relates to the phasing of income and expenditure in the operating plan, with the position expected to return to plan next month.					CCG activity was £0.365m behind plan mainly due to changes in activity casemix. Income reported through the Business Units and Reserves is £0.302m ahead of plan.				
			CCG activity was £0.365m behind plan mainly due to changes in activity casemix. There has also been a benefit year to date of £0.399m in respect of uncommitted investments.									
			The reported position includes a planned and achieved CIP saving year to date of £1.097m. Almost all of this has been achieved non recurrently.									
			The Trusts planned forecast out-turn deficit is £9.844m.									
			Scrutiny and challenge of financial performance to improve on this forecast position is underway. This includes weekly Executive Panel scrutiny review of all recruitment requests, weekly finance reviews with Operational Management Group, detailed integrated finance and CIP challenge meetings with Business Units each month, and Executive led performance reviews.									

Business Unit Performance				CIP				Cash			
G				G				A			
	Plan	Actual / Forecast	Variance		Plan	Actual / Forecast	Variance		Plan	Actual / Forecast	Variance
Year to date £k	(25,816)	(25,568)	249	Year to date £k	1,097	1,097	0	Year to date £k	2,083	1,833	(250)
Year end forecast £k	(152,741)	(152,079)	662	Year end forecast £k	8,500	8,500	(0)	Year end forecast £k	1,014	1,015	1
Business Units and reserves are reporting a current year underspend against expenditure budget of £0.249m.				The in month position for CIP is an achievement of £0.548m against a target of £0.548m. Cumulatively there is an achievement of £1.097m with a target of £1.097m. Of this, currently £1.079m has been achieved non recurrently.				The cash balance held at the end of May is £1.833m which is £0.250m less than planned.			
Including additional costs relating to the Public Dividend Capital Charge the adjusted expenditure variance is £0.234m.											
				There are currently plans for £4.152m, with £4.348m of CIP schemes still to be identified. This is being addressed with a target date of 8 July.							

Capital				Indicators of Forward Financial Risk		
G				A		
	Plan	Actual / Forecast	Variance		Actual	Forecast for quarter
Year to date £k	(50)	(263)	(213)	Number of indicators breach	4	4
Year end forecast £k	(6,773)	(6,533)	240	Number of indicators	12	12
The initial source of funds for 2016/17 was £6.773m, this included a receipt of £250k for Property Sales expected within year. The property sales are now not expected to materialise and so the forecast total funds available have been reduced by the £250k. An amount of £10k was slipped from 2015/16 in relation to the Veterans Prosthetic Equipment funded by NHS England, this amount has therefore been included as a source of funds for this year. These changes mean the total available funds to be spent on capital has decreased to £6.533m.				Indicators breached are: i) Trust financial performance is on plan ii) Capital expenditure <75% of plan for the year iii) Trusts CIP schemes on plan iv) Continuity of service rating on plan		

Page 28

## Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

### Continuity of Service Risk Rating

The planned Continuity of Service Rating (CoSR) in May is '1' which has been achieved.  
As the I&E Margin Variance is better than plan, the Overall Financial Sustainability Risk Rating is '2' and therefore ahead of plan.

Year To Date	Plan Rating	Actual Rating	Variance
<b>Continuity of Service Risk Ratinas</b>			
Liquidity Ratio	1	1	0
Capital Servicing Capacity (Times)	1	1	0
I&E Margin Rating	1	1	0
I&E Margin Variance from Plan	1	4	3
<b>Overall Financial Sustainability Risk Rating</b>	<b>1</b>	<b>2</b>	<b>1</b>

Financial Criteria	Weight %		Metric to be scored	Definition	Rating categories			
					4	3	2	1
<b>Liquidity Ratio</b>	1	50%	Liquid Ratio (days)	$\frac{\text{Working capital balance} \times 360}{\text{Annual operating expenses}}$	0.0	-7.0	-14.0	<-14
<b>Capital Servicing Capacity Ratio</b>	1	50%	Capital servicing capacity (times)	$\frac{\text{Revenue available for capital service}}{\text{Annual debt service}}$	2.5x	1.75x	1.25x	<1.25x
<b>Additional Monitor Risk Ratings</b>								
<b>Underlying Performance</b>	1	25%	I&E Margin (%)	Adjusted $\frac{\text{Financial Performance Retained Surplus}}{\text{Income}}$	>1%	0% to 1%	0% to -1%	<-1%
<b>Variance from Plan</b>	1	25%	Variance in I&E Margin as % of	$\frac{\text{Variance in I\&E Margin}}{\text{Income}}$	>0%	0% to -1%	-1% to -2%	<-2%

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

Surplus

The Trust planned for a deficit of £1.096m in May, after adjustments made for normalising items (these include the net costs associated with donated assets). The reported position is a deficit of £1.022m in the month, a favourable variance of £0.074m against plan.

The cumulative Trust plan was a deficit of £2.384m, after normalising items. The actual position is a cumulative deficit of £2.178m, a favourable variance of £0.206m. The favourable variance relates to the phasing of income and expenditure in the operating plan, with the position expected to return to plan next month.

CCG activity was £0.365m behind plan mainly due to changes in activity casemix. There has also been a benefit year to date of £0.399m in respect of uncommitted investments.

The reported position includes a planned and achieved CIP saving year to date of £1.097m. Almost all of this has been achieved non recurrently.

The Trusts planned forecast out-turn deficit is £9.844m.

Scrutiny and challenge of financial performance to improve on this forecast position is underway. This includes weekly Executive Panel scrutiny review of all recruitment requests, weekly finance reviews with Operational Management Group, detailed integrated finance and CIP challenge meetings with Business Units each month, and Executive led performance reviews.

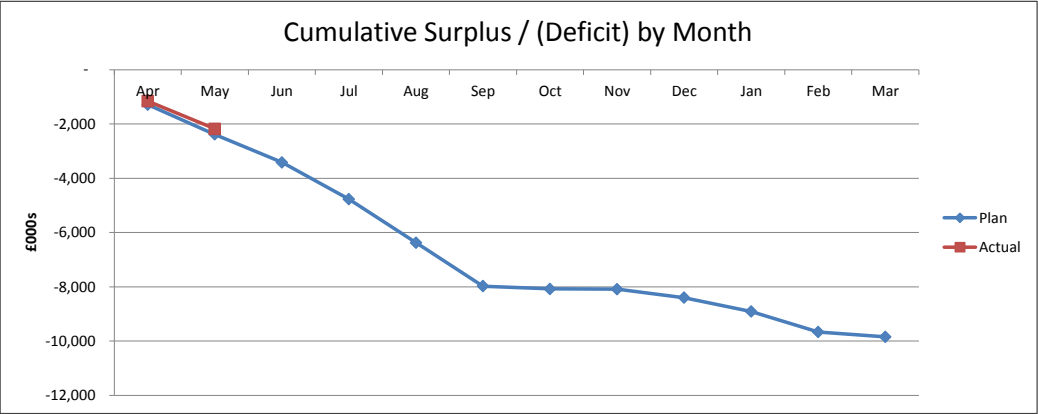
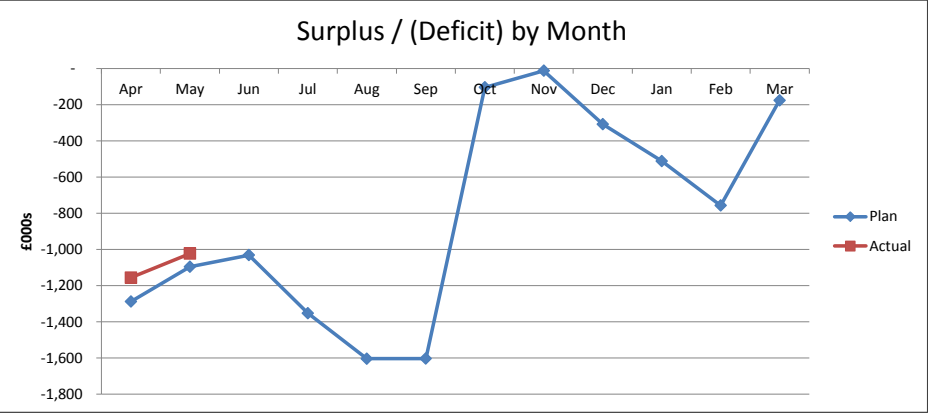
	Base Budget Plan £000s	Plan £000s	In month Actual £000s	Variance £000s	Plan £000s	Year to date Actual £000s	Variance £000s	Plan £000s	Full Year Forecast £000s	Variance £000s
Surplus / (Deficit)	(9,844)	(1,096)	(1,022)	74	(2,384)	(2,178)	206	(9,844)	(9,844)	0

The Category A income position includes under performance against CCG PbR contracted activity of £0.365m plus cost per case services that are under plan. These cost per case services are offset by a corresponding balance in reserves of £0.122m (£58k IoW CCG, £64k NHSE).

Operating costs include over spends in the Clinical Business Units. Although much of these relate to unachievement of CIP requirements, the CIP position is achieved from uncommitted investments to date.

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

	Base Budget Plan £000s	Plan £000s	In month Actual £000s	Variance £000s	Plan £000s	Year to date Actual £000s	Variance £000s	Plan £000s	Full Year Forecast £000s	Variance £000s
Income	170,958	14,434	14,095	(339)	28,578	28,334	(244)	171,308	170,958	(350)
Pay	(123,118)	(10,297)	(10,487)	(190)	(20,412)	(20,828)	(416)	(122,739)	(123,118)	(379)
Non Pay	(47,784)	(4,422)	(3,808)	614	(8,928)	(8,050)	877	(48,513)	(47,772)	741
EBITDA	56	(285)	(200)	85	(762)	(544)	218	56	69	13
Depreciation & Amortisation	(6,346)	(528)	(537)	(8)	(1,056)	(1,069)	(13)	(6,346)	(6,359)	(13)
PDC	(3,419)	(285)	(285)	0	(570)	(570)	0	(3,419)	(3,419)	0
Impairment	0	0	0	0	0	0	0	0	0	0
Profit/(Loss) on Asset Disposal	0	0	0	0	0	0	0	0	0	0
Interest Receivable/(Payable)	(168)	(5)	(8)	(4)	(9)	(10)	(1)	(168)	(169)	(1)
Bank Charges	(6)	(0)	(1)	(0)	(1)	(1)	(0)	(6)	(6)	(0)
RETAINED SURPLUS / (DEFICIT)	(9,883)	(1,103)	(1,031)	73	(2,398)	(2,194)	204	(9,883)	(9,885)	(1)
Receipt of Charitable Donations for Asset Acquisition	(50)	0	0	0	0	0	0	(50)	(50)	0
Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation - Donated Assets	89	7	8	1	14	16	2	89	91	2
REVISED RETAINED SURPLUS / (DEFICIT)	(9,844)	(1,096)	(1,022)	74	(2,384)	(2,178)	206	(9,844)	(9,844)	0





# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

Income

The Trust planned income in May was £14.434m. The actual reported income is £14.095m in month, an adverse variance of £0.339m. The cumulative income plan is £28.578m. The actual position is cumulative income of £28.334m, an adverse variance of £0.244m.

CCG activity was £0.365m behind plan mainly due to changes in activity casemix.  
Income reported through the Business Units and Reserves is £0.302m ahead of plan.

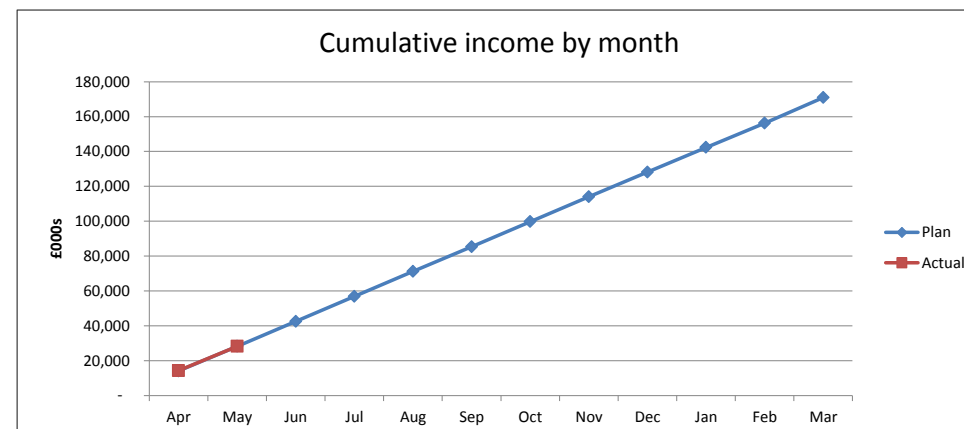
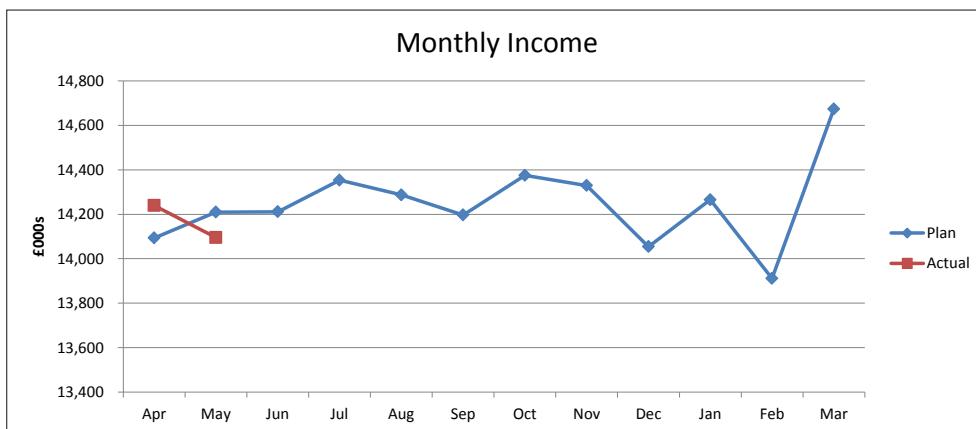
	Base Budget Plan £000s	Plan £000s	In month Actual £000s	Variance £000s	Plan £000s	Year to date Actual £000s	Variance £000s	Plan £000s	Full Year Forecast £000s	Variance £000s
Surplus / (Deficit)	170,958	14,434	14,095	(339)	28,578	28,334	(244)	171,308	170,958	(350)

The NHS Isle of Wight CCG position year to date has an estimate of £0.365m for cumulative under performance against the PbR contract. This is sub divided as £0.300m under performance on Elective and Outpatient activity, and £0.065m on Non Elective activity mainly due to changes in activity casemix.  
There are also cost per case services under plan (£0.058m), but are offset by a corresponding balance in revenue reserves.

NHS England variance relates to under performance against Non PbR excluded drugs (£0.064m), which is offset by a corresponding balance in revenue reserves.

Several Isle of Wight Council contracts have not been renewed giving a forecast deficit of £125k.

Income	Base Budget Plan £000s	Plan £000s	In month Actual £000s	Variance £000s	Plan £000s	Year to date Actual £000s	Variance £000s	Plan £000s	Full Year Forecast £000s	Variance £000s
NHS Isle of Wight CCG	136,499	11,554	11,102	(451)	22,789	22,367	(423)	136,499	136,499	0
NHS England	8,739	741	731	(10)	1,481	1,421	(60)	8,739	8,739	0
Isle of Wight Council	5,558	463	442	(22)	926	904	(23)	5,558	5,433	(125)
Commissioning Support Unit	320	27	27	0	53	54	1	320	321	1
Non Contractual Activity	1,575	180	208	28	302	266	(36)	1,575	1,539	(36)
Southampton University Hospitals FT	105	9	6	(3)	18	12	(6)	105	99	(6)
Other income	18,161	1,461	1,580	119	3,009	3,311	302	18,511	18,328	(184)
<b>TOTAL INCOME</b>	<b>170,958</b>	<b>14,434</b>	<b>14,095</b>	<b>(339)</b>	<b>28,578</b>	<b>28,334</b>	<b>(244)</b>	<b>171,308</b>	<b>170,958</b>	<b>(350)</b>



# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

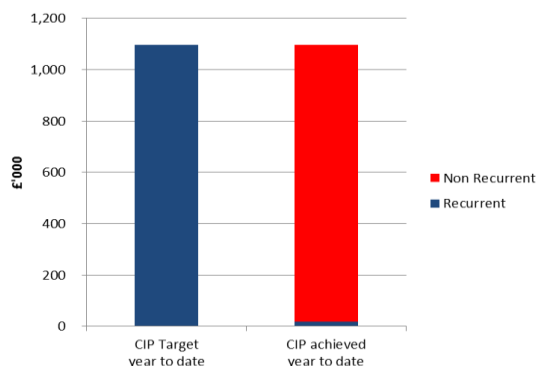
Cost Improvement Programme

The in month position for CIP is an achievement of £0.548m against a target of £0.548m.

Cumulatively there is an achievement of £1.097m with a target of £1.097m. Of this, currently £1.079m has been achieved non recurrently.

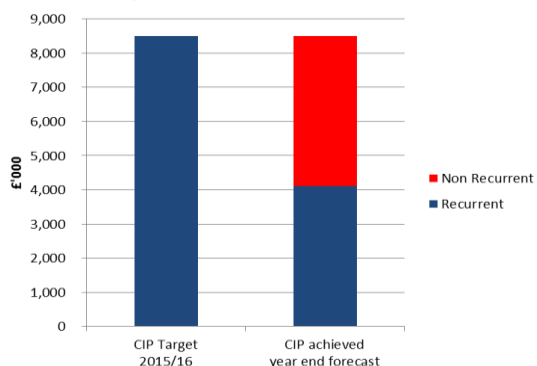
There are currently plans for £4.152m, with £4.348m of CIP schemes still to be identified. This is being addressed with a target date of 8 July.

**CIP position - Year to date**



Business Unit	CIP Target year to date £'000	Recurrent achieved year to date	Non Recurrent achieved year to date	CIP achieved year to date £'000	Over / (Under) Target year to date £'000
Medicine	93	0	15	15	(78)
Surgery, Women's & Children's Health	178	0	137	137	(41)
Ambulance, Urgent Care and Community	240	15	191	206	(34)
Mental Health and Learning Disabilities	133	0	63	63	(70)
Clinical Support, Cancer & Diagnostics	281	0	40	40	(241)
Chief Operating Officer	35	0	1	1	(34)
Financial & Human Resources	15	0	49	49	34
Nursing	23	0	58	58	35
Transformation & Integration	73	3	120	123	50
Trust Administration	27	0	7	7	(20)
Trust Reserves	0	0	399	399	399
<b>Grand Total</b>	<b>1,097</b>	<b>18</b>	<b>1,079</b>	<b>1,097</b>	<b>0</b>

**CIP position - Year end forecast**



Business Unit	CIP Target 2015/16 £'000	Recurrent achieved forecast year end	Non Recurrent achieved forecast year end	CIP achieved year end forecast £'000	Over / (Under) Target forecast £'000
Medicine	723	717	5	722	(1)
Surgery, Women's & Children's Health	1,376	853	443	1,296	(80)
Ambulance, Urgent Care and Community	1,859	795	884	1,679	(180)
Mental Health and Learning Disabilities	1,032	287	618	906	(126)
Clinical Support, Cancer & Diagnostics	2,177	524	1,373	1,897	(280)
Chief Operating Officer	271	50	184	233	(38)
Financial & Human Resources	116	34	68	102	(14)
Nursing	175	8	139	147	(28)
Transformation & Integration	562	827	120	947	385
Trust Administration	210	9	163	172	(38)
Trust Reserves	0	0	399	399	399
<b>Grand Total</b>	<b>8,500</b>	<b>4,104</b>	<b>4,396</b>	<b>8,500</b>	<b>(0)</b>

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16

Cash

The cash balance held at the end of May is £1.833m which is £0.250m less than planned.

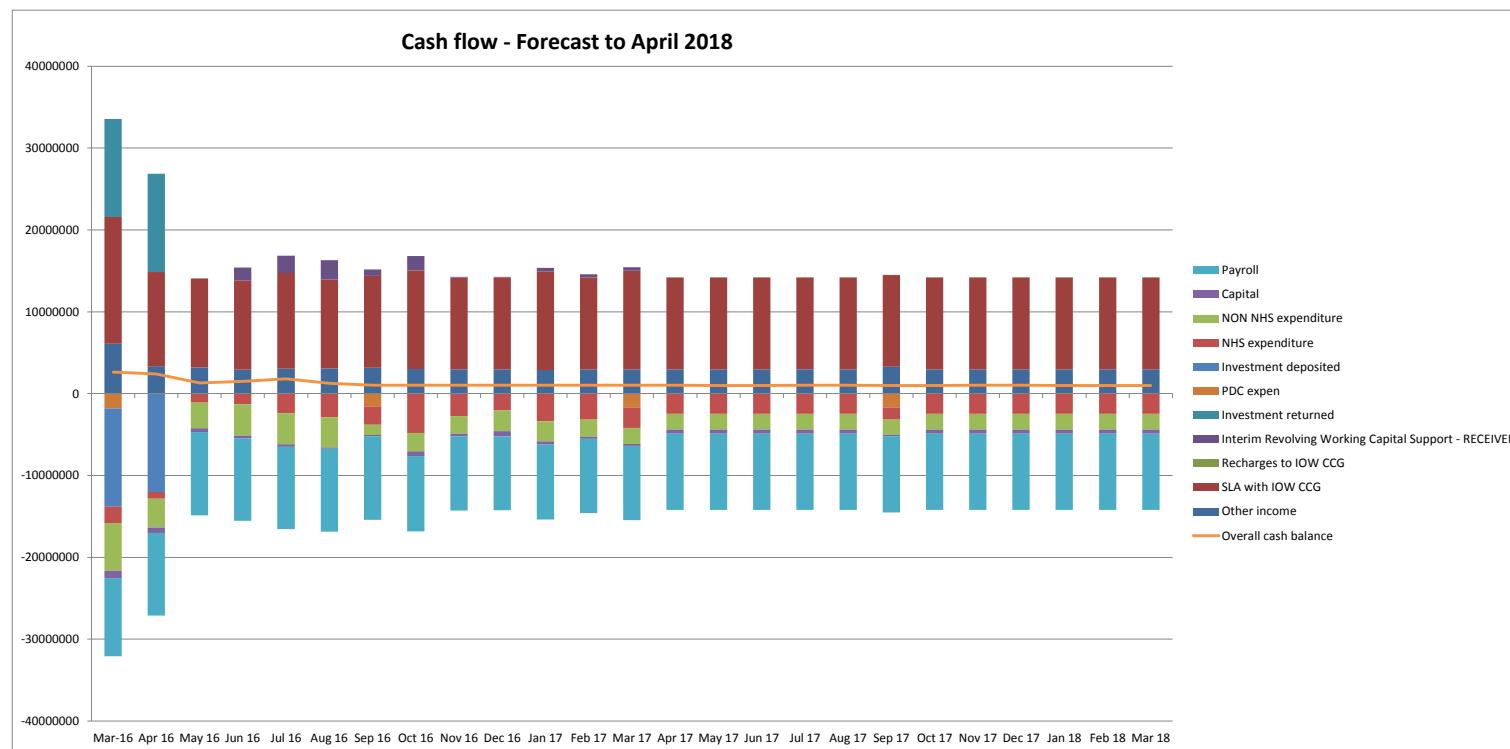
	Plan £000s	Year to date Actual £000s	Variance £000s
<b>Cash Balance</b>	<b>2,083</b>	<b>1,833</b>	<b>(250)</b>
Operating Surplus/(Deficit)	(1,818)	(1,616)	202
Depreciation and Amortisation	1,056	1,069	13
Donated Assets - non-cash	0	0	0
Interest Paid	(6)	(5)	1
Dividend (Paid)/Refunded	0	0	0
Movement in Inventories	37	(48)	(85)
Movement in Receivables	(1,779)	(3,360)	(1,581)
Movement in Other Current Assets	0	0	0
Movement in Trade and Other Payables	2,854	4,064	1,210
Provisions Utilised	0	0	0
<b>Cashflow from Operating Activities</b>	<b>344</b>	<b>104</b>	<b>(240)</b>
<b>Cashflow from Investing Activities</b>	<b>0</b>	<b>0</b>	<b>0</b>
Interest Received	2	5	3
Capital Expenditure - PPE	(764)	(670)	94
Capital Expenditure - Intangibles	(120)	(218)	(98)
<b>Cashflow from Investing Activities</b>	<b>(882)</b>	<b>(883)</b>	<b>(1)</b>
<b>Cash Flows from Financing Activities</b>	<b>(538)</b>	<b>(779)</b>	<b>241</b>
Revolving Working Capital Support Facility Accessed	0	0	0
Capital Element of Finance Leases	(17)	(26)	(9)
Other Loans Repaid	0	0	0
Other Capital Receipts	0	0	0
Cash transferred to NHS Foundation Trusts	0	0	0
Capital grants and other capital receipts (excluding donated/government granted cash receipts)	0	0	0
<b>Cashflow from Financing Activities</b>	<b>(17)</b>	<b>(26)</b>	<b>(9)</b>
<b>Net increase/decrease in cash</b>	<b>(555)</b>	<b>(805)</b>	<b>232</b>
Opening Cash Balance	2,638	2,638	0
Opening Balance Adjustment	0	0	0
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	2,638	2,638	0
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0	0
<b>Closing Cash Balance</b>	<b>2,083</b>	<b>1,833</b>	<b>(250)</b>

The cash balance of £1.833m held at the end of May is £0.250m less than planned. The movement in both receivables and payables are, in the main, the reason for this slight variance.

	Plan £000s	Full Year Forecast £000s	Variance £000s
<b>Cash Balance</b>	<b>1,014</b>	<b>1,015</b>	<b>1</b>
Operating Surplus/(Deficit)	(6,290)	(6,290)	0
Depreciation and Amortisation	6,346	6,346	0
Donated Assets - non-cash	(50)	(50)	0
Interest Paid	(169)	(169)	0
Dividend (Paid)/Refunded	(3,323)	(3,323)	0
Movement in Inventories	137	137	0
Movement in Receivables	(779)	(779)	0
Movement in Other Current Assets	0	0	0
Movement in Trade and Other Payables	(1)	0	1
Provisions Utilised	(265)	(265)	0
<b>Cashflow from Operating Activities</b>	<b>(4,394)</b>	<b>(4,393)</b>	<b>1</b>
<b>Cashflow from Investing Activities</b>	<b>0</b>	<b>0</b>	<b>0</b>
Interest Received	12	12	0
Capital Expenditure	(6,253)	(6,253)	0
Capital Expenditure - Intangibles	(831)	(831)	0
<b>Cashflow from Investing Activities</b>	<b>(7,072)</b>	<b>(7,072)</b>	<b>0</b>
<b>Cash Flows from Financing Activities</b>	<b>(11,466)</b>	<b>(11,465)</b>	<b>1</b>
Revolving Working Capital Support Facility Accessed	9,944	9,944	0
Capital Element of Finance Leases	(102)	(102)	0
Other Loans Repaid	0	0	0
Other Capital Receipts	0	0	0
Cash transferred to NHS Foundation Trusts	0	0	0
Capital grants and other capital receipts (excluding donated/government granted cash receipts)	0	0	0
<b>Cashflow from Financing Activities</b>	<b>9,842</b>	<b>9,842</b>	<b>0</b>
<b>Net increase/decrease in cash</b>	<b>(1,624)</b>	<b>(1,623)</b>	<b>1</b>
Opening Cash Balance	2,638	2,638	0
Opening Balance Adjustment	0	0	0
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	2,638	2,638	0
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0	0
<b>Closing Cash Balance</b>	<b>1,014</b>	<b>1,015</b>	<b>1</b>

The table above shows the forecast outturn cash balance at 31st March 2017.

The updated plan submitted on 18th April, includes a cash forecast that incorporates a need to borrow cash to an equivalent sum of the planned Income and Expenditure deficit i.e. £9.9m in 2016/17. The graph below therefore includes the assumption that the Interim Revolving Working Capital facility is available for the 2 year period shown. This will enable the Trust to show a minimum daily balance of £1m held at any time.



# Isle of Wight NHS Trust Board Performance Report 2016/17

May 15

## Statement of Financial Position

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

	Previous Month Apr-16 £k	YTD Actual £k	Variance £k
Property, Plant and Equipment	112,934	112,597	337
Intangible Assets	2,446	2,356	90
Trade and Other Receivables	242	235	7
<b>Non Current Assets</b>	<b>115,622</b>	<b>115,188</b>	<b>434</b>
Inventories	2,139	2,286	(147)
Trade and Other Receivables	8,586	9,711	(1,125)
Cash and Cash Equivalents	3,073	1,833	1,240
<b>Sub Total Current Assets</b>	<b>13,798</b>	<b>13,830</b>	<b>(32)</b>
Non-Current Assets Held For Sale	0	0	0
<b>Current Assets</b>	<b>13,798</b>	<b>13,830</b>	<b>(32)</b>
Trade and Other Payables	(21,396)	(22,032)	636
Provisions	(407)	(337)	(70)
Liabilities arising from PFIs / Finance Leases	(94)	(86)	(8)
DH Revenue Support Loan (Including RWCSF)	(1,735)	(1,735)	0
<b>Current Liabilities</b>	<b>(23,632)</b>	<b>(24,190)</b>	<b>558</b>
Provisions	0	(70)	70
Liabilities arising from PFIs/Finance Leases	(637)	(637)	0
<b>Non-Current Liabilities</b>	<b>(637)</b>	<b>(707)</b>	<b>70</b>
<b>TOTAL ASSETS EMPLOYED</b>	<b>105,151</b>	<b>104,121</b>	<b>1,030</b>
<b>FINANCED BY:</b>			
Public Dividend Capital	6,155	6,155	0
Retained Earnings Reserve	60,213	59,183	1,030
Revaluation Reserve	38,783	38,783	0
Other Reserves	0	0	0
<b>TOTAL TAXPAYERS EQUITY</b>	<b>105,151</b>	<b>104,121</b>	<b>1,030</b>

There have been minimal movements since month 1 in the statement of financial performance. Fixed Assets values have been adjusted to reflect the net effect of in-month purchases and depreciation. The net movement in working capital balances has been offset by the reduction in cash. The movement in Retained Earnings represents the Month 2 deficit position.

	Plan £k	Full Year Forecast £k	Variance £k
Property, Plant and Equipment	118,635	118,635	0
Intangible Assets	1,550	1,550	0
Trade and Other Receivables	190	190	0
<b>Non Current Assets</b>	<b>120,375</b>	<b>120,375</b>	<b>0</b>
Inventories	2,100	2,100	0
Trade and Other Receivables	8,000	8,000	0
Cash and Cash Equivalents	1,015	1,015	0
<b>Sub Total Current Assets</b>	<b>11,115</b>	<b>11,115</b>	<b>0</b>
Non-Current Assets Held For Sale	0	0	0
<b>Current Assets</b>	<b>11,115</b>	<b>11,115</b>	<b>0</b>
Trade and Other Payables	(18,318)	(18,318)	0
Provisions	(357)	(337)	20
Liabilities arising from PFIs / Finance Leases	0	(106)	(106)
DH Revenue Support Loan (Including RWCSF)	(11,679)	(11,679)	0
<b>Current Liabilities</b>	<b>(30,354)</b>	<b>(30,440)</b>	<b>(86)</b>
Provisions	(70)	(90)	(20)
Liabilities arising from PFIs/Finance Leases	(637)	(531)	106
<b>Non-Current Liabilities</b>	<b>(707)</b>	<b>(621)</b>	<b>86</b>
<b>TOTAL ASSETS EMPLOYED</b>	<b>100,429</b>	<b>100,429</b>	<b>0</b>
<b>FINANCED BY:</b>			
Public Dividend Capital	6,155	6,155	0
Retained Earnings Reserve	51,493	51,493	0
Revaluation Reserve	42,781	42,781	0
Other Reserves	0	0	0
<b>TOTAL TAXPAYERS EQUITY</b>	<b>100,429</b>	<b>100,429</b>	<b>0</b>

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

# Isle of Wight NHS Trust Board Performance Report 2016/17

May 16  
Capital

The initial source of funds for 2016/17 was £6.773m, this included a receipt of £250k for Property Sales expected within year. The property sales are now not expected to materialise and so the forecast total funds available have been reduced by the £250k. An amount of £10k was slipped from 2015/16 in relation to the Veterans Prosthetic Equipment funded by NHS England, this amount has therefore been included as a source of funds for this year. These changes mean the total available funds to be spent on capital has decreased to £6.533m.

	Year to Date			Full Year			Risk
	Plan £k	Actual £k	Variance £k	Plan £k	Forecast £k	Variance £k	
<b>SOURCE OF FUNDS</b>							
Initial Capital Resource Limit	50	50	0	6,346	6,346	0	
Current Capital Resource Limit	<b>50</b>	<b>50</b>	<b>0</b>	<b>6,346</b>	<b>6,346</b>	<b>0</b>	
Property Sales	0	0	0	250	0	(250)	
Donated Funds	0	0	0	50	50	0	
Other	0	0	0	127	137	10	
<b>Total Funds Available 2016/17</b>	<b>50</b>	<b>50</b>	<b>0</b>	<b>6,773</b>	<b>6,533</b>	<b>(240)</b>	
<b>APPLICATION OF FUNDS</b>							
	Plan £k	Actual £k	Variance £k	Plan £k	Forecast £k	Variance £k	
<b>Strategic Schemes</b>							
Ward Reconfiguration Level C	0	0	0	103	0	103	G
Carbon Energy Fund	20	0	20	1,213	1,213	0	G
	<b>20</b>	<b>0</b>	<b>20</b>	<b>1,316</b>	<b>1,213</b>	<b>103</b>	
<b>Operational Schemes</b>							
Estates Schemes	0	3	(3)	1,500	1,500	0	G
GS1	0	0	0	1,500	1,500	0	G
IM&T RRP	0	0	0	500	500	0	G
Equipment RRP	0	80	(80)	500	500	0	G
Estates Staff Capitalisation	30	0	30	180	180	0	G
Contingency/Unallocated	0	0	0	766	0	766	G
Donated Assets	0	0	0	50	50	0	G
PARIS Implementation	0	127	(127)	0	127	(127)	G
Veterans Funding Orthotic Equipment	0	12	(12)	0	10	(10)	G
Other (Non RRP, Equipment)	0	40	(40)	461	953	(492)	G
	<b>30</b>	<b>263</b>	<b>(233)</b>	<b>5,457</b>	<b>5,320</b>	<b>137</b>	
<b>Total Expenditure 2016/17</b>	<b>50</b>	<b>263</b>	<b>(213)</b>	<b>6,773</b>	<b>6,533</b>	<b>240</b>	
<b>NB - Please note the Year to Date and Full Year Plan figures are as per FIMS Return and not Capital Plan</b>							

Year to Date Plan vs Actual			
	Plan £k	Actual £k	Variance £k
Strategic Capital	20	0	20
Operational Capital	30	263	(233)
<b>Total</b>	<b>50</b>	<b>263</b>	<b>(213)</b>

Year End Plan vs Forecast			
	Plan £k	Forecast £k	Variance £k
Strategic Capital	1,316	1,213	103
Operational Capital	5,457	5,320	137
<b>Total</b>	<b>6,773</b>	<b>6,533</b>	<b>240</b>

**Strategic Capital Schemes** - Strategic Capital Schemes included in the initial Capital Plan for this financial year are the Ward Reconfiguration of Level C and the Carbon Energy Fund Project. The Carbon Energy Fund Project is currently expected to complete this year however following discussions at June's Capital Investment Group it was decided to return the funding set aside in the plan for Level C Ward Reconfiguration to the unallocated funding whilst the need for this project is reviewed and resubmitted.

**Operational Schemes** - Operational schemes carried forward from 2015/16 include the following; Frontline Ambulance (£115k RRP), Upgrade of patient showers Osborne Ward Sevenacres (£30k Estates Schemes), the remainder of the Veteran's Fund Prosthetic Equipment (£10k Veterans Funding Orthotic Equipment) and the Relocation of Operations Division (£3k Estates Schemes). Also carried forward to this financial year is the final part of the IW Council funded Paris Civica Implementation Project (£127k Paris Implementation).

The variance between the Plan and Actual is primarily as a result of the projects detailed above which were slipped late on in 2015/16 to this financial year and so not included at the time the plan was submitted. A paper due at Capital Investment Group in June for approval of the Staff Capitalisation figure was not submitted, this is now expected for the July meeting, costs will then be moved to capital which will eliminate the variance on this particular project.

At the planning stage funding was agreed for the broad headings shown in the table. However, allocations have yet to be agreed against specific detailed schemes and there is an ongoing exercise within the business units to prioritise the requirements for this financial year as soon as possible.

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

See Notes for further detail of each of the below indicators						Historic Data			Current Data			Notes	
Ref	Indicator	Sub Sections	Thresh- old	Weight- ing	Q1 2015/16	Q2 2015/16	Q4 2015/16	Apr	May	Jun	Q1 2016/17		
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		90%	1.0	No	No	No	No	No		No	
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		95%	1.0	No	No	No	No	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	No	No	No		No	
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		95%	1.0	No	No	No	No	No		No	
	5	All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	1.0	No	No	No	No	No		No	
			NHS Cancer Screening Service referral	90%									
	6	All cancers: 31-day wait for second or subsequent treatment, comprising:	surgery	94%	1.0	Yes	Yes	No	No	Yes		No	
			anti-cancer drug treatments	98%									
			radiotherapy	94%									
	7	All cancers: 31-day wait from diagnosis to first treatment		96%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93%	1.0	Yes	Yes	No	Yes	Yes		Yes	
			For symptomatic breast patients (cancer not initially suspected)	93%									
	9	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within seven days of discharge	95%	1.0	No	Yes	Yes	Yes	No		No	
			Having formal review within 12 months	95%									
	10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	No	No	No	Yes	Yes		Yes	
	11	Meeting commitment to serve new psychosis cases by early intervention teams		95%	1.0	Yes	Yes	Yes	No	No		No	
	12	Category A call – emergency response within 8 minutes, comprising:	Red 1 calls	75%	1.0	No	No	No	No	No		No	
Red 2 calls			75%	1.0	No	No	No	No	Yes		No		
13	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	No	No	No	No	Yes		No		
14	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral		50%	1.0	-	-	-	-	-		-		
15	Improving access to psychological therapies (IAPT)	People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	1.0	No	No	No	Yes	Yes		Yes		
		People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes		
Outcomes	16	Is the Trust below the de minimus	12	1.0	Yes	No	No	Yes	Yes		Yes		
		Is the Trust below the YTD ceiling	1		No	No	No	Yes	Yes		Yes		
	17	Minimising mental health delayed transfers of care		≤7.5%	1.0	No	No	No	No	No		No	
	18	Mental health data completeness: identifiers		97%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	19	Mental health data completeness: outcomes for patients on CPA		50%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	20	Certification against compliance with requirements regarding access to health care for people with a learning disability		N/A	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	21	Data completeness: community services, comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
Referral information			50%										
Treatment activity information			50%										
TOTAL					11.0	12.0	14.0	11.0	9.0	0.0	12.0		
					R	R	R	R	R	R	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
CBU	Clinical Business Unit
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

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> July 2016

<b>Title</b>	Chief Operating Officer's Report		
<b>Sponsoring Executive Director</b>	Shaun Stacey, Chief Operating Officer		
<b>Author(s)</b>	Jo Blackley, Head of Divisional Business Planning and Sustainability		
<b>Purpose</b>	To inform Trust Board of current service issues and challenges, good news, risks, opportunities and commissioning issues or changes affecting the five clinical business units.		
<b>Action required by the Board:</b>	<b>Receive</b>	X	<b>Approve</b>
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations</b>	
Trust Executive Committee	n/a		
Audit and Corporate Risk Committee	n/a		
Charitable Funds Committee	n/a		
Finance, Investment, Information & Workforce Committee	n/a		
Mental Health Act Scrutiny Committee	n/a		
Remuneration & Nominations Committee	n/a		
Quality Governance Committee	n/a		
<b>Please add any other committees below as needed</b>			
Board Seminar			
<b>Staff, stakeholder, patient and public engagement:</b>			
n/a			
<b>Executive Summary &amp; Analysis:</b>			
<p>The report provides a brief overview of current service issues and challenges, good news, risks, opportunities and commissioning issues or changes affecting the five clinical business units.</p> <ul style="list-style-type: none"> <li>• Surgery, Women's and Children's Health Clinical Business Unit</li> <li>• Ambulance, Urgent Care and Community Clinical Business Unit</li> <li>• Clinical Support, Cancer and Diagnostic Service Clinical Business Unit</li> <li>• Medicine, Clinical Business Unit</li> <li>• Mental Health and Learning Disabilities Clinical Business Unit</li> </ul> <p>This is the first Chief Operating Officer's report since the creation of the division and the five clinical business units. This report will cover the period 1<sup>st</sup> May to 24<sup>th</sup> June 2016.</p>			
<b>Recommendation to the Board:</b> Trust Board is asked to receive the report and provide feedback as to the content and level of detail within the report to enable future reports to meet the needs of the board.			
<b>Attached Appendices &amp; Background papers</b>			
For following sections – please indicate as appropriate:			
<b>Trust Goals &amp; Priorities</b>	All Trust Goals and Priorities		
<b>Principal Risks (BAF)</b>	671 through to 676		
<b>Legal implications, regulatory and consultation requirements</b>	n/a		
<b>Date: 24<sup>th</sup> June 2016</b>			
<b>Completed by: Jo Blackley</b>			

**CHIEF OPERATING OFFICER'S REPORT  
TO TRUST BOARD  
6<sup>th</sup> JULY 2016**

This is the first Chief Operating Officer's report since the creation of the Operations Division and the five clinical business units. The purpose of this report is to provide a brief overview on a monthly basis of current service issues, challenges, or risks affecting the five clinical business units balanced with good news, and opportunities. This initial report covers the period 1<sup>st</sup> May to 24th June 2016.

The Trust Board is asked to receive the report and provide feedback as to the content, style, frequency and level of detail within the document to enable future reports to meet the needs of the Trust Board.

**1. Current Service Updates, Issues and Challenges**

**Mental Health & Learning Disabilities**

- 1.1. Recruitment of consultants (40% vacant consultant posts) and qualified nurses remains an issue within the Mental Health and Learning Disabilities (MHL) Clinical Business Unit. This causes a cost pressure due to agency staffing costs and has a potential impact on quality and patient experience, demonstrated through the recent change seen in the Improving Access to Psychological Therapies (IAPT) performance.
- 1.2. All MHL vacant posts are in the recruitment process. One old age psychiatrist is due to start 1<sup>st</sup> September 2016. A working group has been established involving the Human Resources team looking at different strategies to enable recruitment into nursing posts. Work is now underway with Mark Elmore in relation to recruiting into vacant nursing posts from the Republic of Ireland and conversations have now taken place.
- 1.3. Ongoing issues with information systems and lack of IT hardware are causing inefficiencies in teams across the MHL Clinical Business Unit. The hardware has been ordered but we are experiencing long waiting times for equipment from IT. This has been raised at the Operational Management Group (OMG) and Trust Executive Committee (TEC).
- 1.4. IAPT performance has dipped currently due to an increase in cluster 4 patients coming through the system and the team's vacancy levels. Agency support will be required as an interim measure whilst recruitment takes place.

**Medicine**

- 1.5. Gastroenterology continues to experience capacity issues and negotiations continue with the CCG to agree plans to manage the demand in the immediate and medium term. The CCG are reviewing funding options and have initially agreed the use of an external contractor to support the increasing demand in gastroenterology. This will have a positive impact on our waiting lists from Quarter 2.

- 1.6. Poppy Unit was vacated at the end of May and is now closed. Thanks to all those who have been involved in Poppy which this time was led by Acting Sister Debbie Johnson with the support of our Local Authority and SPARRCS (single point of access referral, review and co-ordination service) colleagues who worked so proactively to achieve the discharges including supporting one relative in assisting them to liaise with residential homes to identify a placement destination. This was a really great example of the value of the Support at Home team multi-agency working for the benefit of a patient.
- 1.7. Medical Recruitment issues and nursing are 50% below required staff levels impacting across the service.

### **Ambulance Urgent Care and Community**

- 1.8. The Ambulance Urgent Care and Community (AUCC) Clinical Business Unit has experienced pressure in the 111 service in the mornings when GP surgeries have had reduced capacity due to staffing gaps or introduction of new system software.
- 1.9. Reduced capacity in senior posts has impacted on the responsiveness of the CBU and focus will be recruiting to these posts particularly in the Emergency Department and Ambulance as a matter of urgency. The team's ambition is to focus on delivering the business unit plan.

### **Clinical Support, Cancer & Diagnostic Services**

- 1.10. Increasing high demand and staffing vacancies in diagnostics is affecting turnaround times for reporting. The services are actively recruiting to all vacancies.
- 1.11. A consultant haematologist was appointed from Greece in July but has now withdrawn, however 3 candidates have applied for the permanent position and all radiography vacancies have now been appointed to.

### **Surgery, Women's and Children's Health**

- 1.12. The number of patients waiting over 40 weeks for operations has dramatically reduced down to just 5 and the overall management and booking of patients over 20 weeks has improved significantly. This has included the fact that these patients either have a 'to come in' (TCI) date confirmed or clear plans on how their pathway is being managed. Patients benefit significantly by having sight of their treatment date and to know their care is being closely managed. There's been some tremendous work by PAAU and I hope they take great pride in how they have improved the patient experience.
- 1.13. More recently there has been seen an impact on 18 week performance from clinical staff who have been released to support the Whole Integrated System Review (WISR) work without backfill provision.
- 1.14. A Mottistone Organisational Change consultation process of 30 days is currently underway. Listening Into Action (LIA) feedback style sessions have been held with staff. All feedback is currently being collated with a summary paper due to be presented to Partnership Forum on 5<sup>th</sup> July 2016.

## **General/Chief Operating Officer**

- 1.15. Bed state reports have been revised and now include full bed stock (increased by 27 contingency beds). June has seen sustained pressure, but we only had 2 days of black alert.



- 1.16. The teams are focussed on reducing length of stay and managing the complex discharges, some of which have been impacted on care agency capacity.
- 1.17. The Division is planning a 3<sup>rd</sup> Safer Start week (w.c. 4<sup>th</sup> July) to take steps to improve our position.

## **2. Good News**

### **Mental Health & Learning Disabilities**

- 2.1. The Mental Health Fete was held on Friday 20<sup>th</sup> May 2016 for Mental Health Awareness Week. This was a very successful event and work has already begun to make this bigger and better for next year.
- 2.2. Helen Figgins commenced as Operations Manager for specialist services in MHL D CBU.
- 2.3. Sue Nelson has also started as Assistant Operational Manager.
- 2.4. Now fully appointed into all Admiral Nurses posts and the service is now fully operational.
- 2.5. Implementation of the 72 hrs assessment beds are showing to have a positive impact within inpatient services. Figures now report a 70% discharge rate within the 72 hour window with service users being signposted to appropriate services i.e. Crisis Resolution and Home Treatment Team (CRHT), Community Mental Health, and the voluntary sector.
- 2.6. A carers forum has now commenced in Sevenacres every Monday between 6pm and 8pm to support carers of service users who have been admitted to Sevenacres. The intention is to expand this group into the community in the near future.

### **Medicine**

- 2.7. Diane Kettell commenced as specialist nurse for cardiac rehab in the Medicine Clinical Business Unit.
- 2.8. All Health Care Assistant vacancies in the Medicine CBU were appointed to after a series of interviews in the last week of May 2016.
- 2.9. Dr Chibwana specialty Dr for Medicine has recently started on Appley Ward.

### **Ambulance, Urgent Care and Community**

- 2.10. Community practitioners at night started on Sunday 26<sup>th</sup> June 2016, with some district nursing support in the transition period.
- 2.11. Appointed new locality lead for community nursing. Will take up post within the next 2 months, end of August 2016.
- 2.12. Emma Pugh returned from maternity leave to a new role in June 2016 as Operational Manager for specialist services.

### **Clinical Support, Cancer & Diagnostic Services**

- 2.13. The recruitment for the Head of Nursing and Quality post for the Clinical Support, Cancer and Diagnostic Services CBU received a very positive response. Interviews were held Monday 20<sup>th</sup> June and an offer made to the successful candidate subject to references. Further announcements will follow.

### **Surgery, Women's and Children's Health**

- 2.14. The Children's Ward 'It's a Knockout' competition took place for a second time this year on 26<sup>th</sup> June.
- 2.15. Improvements have been seen in sickness absence levels within the CBU hot spots. Sara Henderson, Sister of Mottistone should be commended for reducing sickness levels from 11% to 3%.

### **General**

- 2.16. A successful School of Medicine visit was held on 18<sup>th</sup> May 2016. The visiting team reported that there was clear evidence of excellent senior leadership at consultant and executive level.
- 2.17. The integrated working with the Red Cross and Care UK (The Homecare Team) has proved itself again in the last month by enabling the support of an increasing number of patients to their home and ensuring their relatives are supported during the initial period following discharge. This team are supported by funding from the CCG through the system resilience fund but are based in the Trust working closely with the bed management team.
- 2.18. Jo Blackley has been appointed to the role of Head of Divisional Business Development and Sustainability. This role supports the five Clinical Business Units in the development of their service plans.
- 2.19. We are also pleased to announce that Abolfazl Abdi, better known as Ab, was successfully appointed into the Interim Head of Operations role for the Medicine Clinical Business Unit and started in post with effect from 3<sup>rd</sup> May. He also continues to be the Assistant Director of Contracting on a part time basis.

### **3. Risks**

#### **Mental Health and Learning Disabilities**

- 3.1. We continue to run with high nursing vacancies (Band 5's) across the Mental Health CBU work is underway to look at alternative solutions to staffing these posts.

#### **Medicine**

- 3.2. Qualified nursing vacancies within the Medicine CBU are running at over 30%. An action plan is currently being worked up.
- 3.3. The CCG /System Resilience Group have submitted intentions to integrate rehabilitation and re-ablement services which may include a decision in July to go out to tender for services.

#### **Ambulance Urgent Care and Community**

- 3.4. Emergency Department nursing staff remains a challenge with 3 posts currently out to recruitment.
- 3.5. Speech and Language Therapy is experiencing a rise in referrals to the adult team. The team are working with Portsmouth Hospital Trust around the head and neck pathway and discussing working collaboratively together.

#### **Clinical Support, Cancer & Diagnostic Services**

- 3.6. The IT system in pathology is causing two significant issues. The system does not connect to the chemotherapy prescribing system therefore manual dual entry is required causing a risk of prescribing errors. Whilst only 2 prescribing errors have been reported in the last four years the visiting oncologist has raised concerns about the risk posed by this system limitation. Whilst the CCG have not stated any intent to impose a penalty, the potential is 2% of the cancer income. The replacement of the pathology system is the number one capital priority for the Clinical Support, Cancer and Diagnostic Services (CSCDS) CBU.

#### **Surgery Women's and Children's Health**

- 3.7. Surgical bed capacity continues to be a problem due to medical patients on surgical wards. Bed reconfiguration plans are included as part of the current proposed Bed Changes and Impact on Private Patient Facilities paper, currently out for consultation.
- 3.8. Notice on Urology added to risk register as CCG have not yet confirmed arrangements from February 2016 onwards.
- 3.9. Staffing for the middle grade and SHO rotas in Obs & Gynae remains a risk and currently depending on agency support.
- 3.10. All vacant ophthalmology posts recruited to with the exception of 1 consultant post. All new starters not available until August so there will be a period of reliance on locums in the interim.

## 4. Opportunities

### **Mental Health & Learning Disabilities**

- 4.1. Ongoing work with the Whole Integrated System Review (WISR) is starting look at opportunities for Mental Health which in the longer term could become cost efficiencies to the Trust.

### **Ambulance Urgent Care and Community**

- 4.2. A contract valued at £50K for 'Continuing Health Care physiotherapy plus' is out to tender. The Ambulance, Urgent Care and Community CBU is reviewing the detail to decide if a bid will be submitted.

### **Surgery, Women's and Children's Health**

- 4.3. Whole Integrated System Review (WISR) work streams looking at planned care and paediatrics.

## 5. Commissioning Issues or Changes

### **Medicine**

- 5.1. Gastroenterology continues to experience capacity issues and negotiations continue with the CCG to agree plans to manage the demand in the immediate and medium term.

### **Ambulance, Urgent Care and Community**

- 5.2. Public Health commissioners are indicating a potential funding gap in year for 0-19 year old services (Health Visiting and School Nurses). The Ambulance Urgent Care and Community CBU are working with them and the contracting team to identify necessary in year restrictions to the service specification.

### **Clinical Support, Cancer & Diagnostic Services**

- 5.3. Improved Direct Access for GPs to diagnostics has been stated as a commissioning intention for 2016/17. The impact of this is still in the early stages of modelling.

### **Surgery, Women's and Children's Health**

- 5.4. With regard to the **Urology service** we want to provide high quality consistent care and treatment for people and following four attempts to recruit 'staff grade' doctors and our concerns about the resilience of out of hours emergency cover we raised the issue with the Clinical Commissioning Group (CCG). Since December 2015, we have been undertaking a joint review of the resilience and longer term future of the urology service with a focus on the adult elective (scheduled), non-elective (emergency), and cancer pathways. A review of the report to the Trust and CCG will take place later this month. In the meantime and until decisions are taken about the future service model Isle of Wight NHS Trust continues to provide a Urology Service but we have given notice to the CCG on the basis that the service needs to change



## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6 JULY 2016

<b>Title</b>	Board Assurance Visits		
<b>Sponsoring Executive Director</b>	Karen Baker, Chief Executive		
<b>Author(s)</b>	Mark Price, Company Secretary		
<b>Purpose</b>			
<b>Action required by the Board:</b>	Receive		Approve x
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Trust Executive Committee			
Audit and Corporate Risk Committee			
Charitable Funds Committee			
Finance, Investment, Information & Workforce Committee			
Mental Health Act Scrutiny Committee			
Remuneration & Nominations Committee			
Quality Governance Committee			
<b>Please add any other committees below as needed</b>			
Board Seminar	15/03/2016		
Other (please state)			
<b>Staff, stakeholder, patient and public engagement:</b>			
There has been engagement with Board members and CBU leaders in the development of this paper.			
<b>Executive Summary &amp; Analysis:</b>			
<b>Recommendation to the Board:</b>			
The Board is recommended to:			
(i) Approve this paper; and			
(ii) Approve a review of the process after 6 months			
<b>Attached Appendices &amp; Background papers</b>			
For following sections – please indicate as appropriate:			

<b>Trust Goals &amp; Priorities</b>	All goals and priorities
<b>Principal Risks (BAF)</b>	All Principal Risks
<b>Legal implications, regulatory and consultation requirements</b>	
<b>Date:</b> 27 <sup>th</sup> June 2016	<b>Completed by:</b> Mark Price, Company Secretary

# **ISLE OF WIGHT NHS TRUST**

## **BOARD ASSURANCE VISITS**

### **1. Introduction**

Board assurance visits to wards and departments have been taking place since the formation of the Trust in 2012/13 but there has been an ongoing dialogue within the Board on the degree of formality, frequency and structure for them. One of the recommendations of the Capsticks External Governance Review was “restart the Board walkabout programme”. In response to this a paper was approved by the Board last summer which outlines the current system.

### **2. March 2016 Board Seminar**

At the March 2016 Board Seminar the Executive Director of Nursing (EDN) presented a paper entitled ‘In Your Shoes’ (attached as Appendix A). Board members debated this and supported the approach. It was agreed that a proposal would be developed. This paper presents the formal proposal for future Board Assurance Visits.

### **3. Proposal**

The Chair has encouraged NEDs to align to the new Clinical Business Units which has already been taking place to some extent. There are 5 CBUs and 1 Corporate Business Unit. There are 6 NEDs including the Chair (this is not part of the agreement the Trust has with Lizzie Peers) and 7 Execs, including the Chief Executive. Appendix B outlines the list of main departments in each of the 6 CBUs and which Board members are proposed to cover which areas. Members have previously been given the opportunity to express a preference on which CBU to cover.

The EDN has proposed that a standard letter is sent in advance to the area requesting any relevant pre-reading in advance, what training/instruction may be required on arrival, and the appropriate dress code. This would be compiled within the SEE team and the Feedback Sheet (Appendix One of Appendix A) would be sent by Exec/NED after the visit back to the SEE team.

There are many areas/departments in some CBUs and it could take a considerable time to visit all of them. Hence it is envisaged that the Exec/NED would prioritise the areas to be visited based upon current issues, performance, professional advice from Executive Director of Nursing/Executive Medical Director, CBU recommendation etc. In the meantime short informal ‘drop ins’ could be undertaken and more could be covered if the Exec/NED pair undertake some of these separately. This would certainly help to cover the numerous small corporate departments.

In the Seminar discussion it was also emphasised that the Exec/NED should develop a relationship with the CBU leaders and maintain regular dialogue and feedback from these visits.

A regular agenda slot under the Governance part of Seminars would provide an opportunity to feedback to Board colleagues on these visits. It is also proposed that the process is reviewed 6 months after its introduction.

#### **4. Recommendation**

The Board is recommended to:

- (i) Approve this paper; and
- (ii) Approve a review of the process after 6 months

Mark Price  
Company Secretary

## Appendix A

### Paper to Trust Executive Committee re: In Your Shoes

#### Introduction

'In Your Shoes' is a concept that is widely embraced in hospitals throughout the country. It typically involves meeting patients and spending time with them to understand what it is to be like in their shoes and see the NHS from a patient's perspective. It is a chance for patients to tell us their experiences and help us understand what we do well and what we need to improve upon. The idea behind this is to listen to our patients and use what they tell us to improve the quality of care that we provide. Staff will be trained to facilitate "In your shoes" workshops with service users, their carers and staff, to build a shared ambition and gain an understanding of the impact of their interactions.

The Isle of Wight NHS Trust is keen to embrace this concept but want to go beyond the familiar boundaries; we not only want to *walk in the shoes* of patients but also those of our staff. We recognise that staff are under pressure and need to take this opportunity to work with them hand in hand and understand what they are dealing with on a daily basis.

Patients are trusted in our care and we have a duty to look after them to the best of our ability. To do this we need happy and fulfilled staff. We acknowledge the need to work more closely with our staff and value their considerable contribution to the organisation in order to change culture for the future.

This paper sets out the proposal for taking this forward.

#### Proposal

There is a well known saying that suggests that a good Manager should spend:

- 30% of their time **with** their team;
- 30% of their time **on** their team (i.e. sickness management, rotas etc), and
- 40% of their time doing their day job.

It is important to acknowledge that to suddenly be asked to find 30% of your working week to spend with your staff would be almost impossible for most, however in this proposal we suggest that 10% of Manager's time is spent working with their staff which equates to one half day per week (2 days per month) for all Managers from Executive Directors and Non-Executive Directors down.

In the first instance, it is envisaged that Managers should spend a minimum of 10% of their time 'in the shoes' of the people they work with and their service users. This could include working in Theatres, on Switchboard, with a Porter etc.

Executive Directors , leaders of Clinical Business Units and Senior Managers should all spend a minimum of two days per month (3.75 hours per week) 'in their shoes'

Non-Executive Directors should spend one day per month 'in the shoes' of members of staff/patients.

Clinical Leads from the Clinical Business Units (CBU) should spend two days per month working with Senior Managers of their CBU.

This will help us understand from the staff's perspective the challenges they face on a daily basis, and afford us the opportunity to understand what we do well in the services.

## **Guidance**

Managers are advised to arrange a half-day session with their staff once a week. They will need to spend time with different members of staff covering all aspects of their service with the aim of understanding exactly what their work involves on a day to day basis, including:

<b>What went well</b>
-----------------------

- What works well
- Areas for improvement
- Innovative suggestions for new ways of working that improve quality or financial outcomes

At the end of the session the Manager will need to complete the attached feedback sheet and return it to the PA to the Executive Director of Nursing for collation.

## **Rollout and communication**

The programme of activity from Managers should start at the earliest opportunity. A copy of this paper will be circulated to all senior leads for onward cascade through their teams as appropriate once this proposal has been approved by TEC. It is envisaged that in the first instance the 'in your shoes' sessions should be with staff. Once this has been completed, patient sessions can be arranged.

We will work closely with the Communications Team to ensure that the message goes out via E-Bulletin and through 10 minute team briefing sessions.

## **Monitoring and measuring success**

The feedback sheets (Appendix One) will be collated and monitored to ensure that these events are taking place, and that any actions arising from these are undertaken. These will help us identify any areas for improvement and also provide evidence of who is undertaking these visits.

Key Performance Indicators will be developed and a briefing paper submitted to TEC on a monthly basis detailing progress against KPIs and highlighting key achievements or areas of concern.

## **Recommendation**

It is recommended that TEC approve this process.

**Alan Sheward**  
**Executive Director of Nursing**

## Appendix One

### In Your Shoes Feedback Sheet

<b>Name of Manager</b>	
<b>Area worked and date</b>	
<b>Name and role of person worked with</b>	

<b>Areas for improvement or concerns raised by staff member</b>
<b>Actions required</b>
<b>Overall comments</b>

## Appendix B

Board Members	Clinical Business Unit	Areas included.
Jane Tabor Alan Sheward Jon Burwell	Ambulance, Urgent care and community services	Ambulance services, Hub/111, Emergency Department, MAAU, Crisis response SPARRCS (Single Point of Access Referral, Review and Co-ordination Service for Adult rehab), Sexual health, MPTT, Continence Service, dietetics, occupational therapy, orthotics & prosthetics, physiotherapy, podiatry, Speech & Language Therapy, Community Matrons, District Nursing, Integrated Community Equipment Services (ICES), Assistive Technology, Health Visitors/Schools Nursing, Community Clinics (Arthur Webster, Ryde Wellbeing Centre, Beacon (managed by COO))
Nina Moorman Karen Baker	Surgery, women's and children's health	<b>Wards:</b> St Helen's, Whippingham, Luccombe, Alverstone, Children's ward, Maternity including Labour ward, outpatients and post/antenatal ward. Neonatal, NICU, Stoma care, Surgical Specialist Nurses, Community Midwives, Allergy unit, Health visitors, school nurses, Urology, orthopaedics, Maxillofacial Unit, ENT, Ophthalmology, Mottistone (managed by COO)
David King Mark Pugh	Medicine	<b>Wards:</b> Appley, Colwell, Stroke Unit, Rehab Unit, Poppy Ward  Cardiology, Rheumatology, Diabetes, Gastro, Respiratory, Care of the Elderly, General Medicine, stroke services, community stroke rehab team (CRST), respiratory services, Bed Management (managed by COO)
Eve Richardson Chris Palmer	Clinical Support, cancer and diagnostic services	<b>Wards:</b> ICU, CCU, Chemotherapy, Main Theatres, Day Surgery Unit (DSU), Endoscopy, pain clinic & pain management, OPARU, PAAU clinical and Admin, Pharmacy, OHPiT, HSDU, Cancer Clinical Specialists, Chemotherapy, , Breast Screening, Pathology, Phlebotomy, Mortuary, Outpatients (including Laidlaw),



		critical care services, cancer nurse specialists, breast care unit, Anaesthetics / Pain Services, Bio-Chemistry, Histopathology, Diagnostic Imaging - Radiology/ PACS, CT, MRI, Ultra-sound, Microbiology, Oncology, Palliative Care
Jessamy Baird Mark Price	<b>Mental Health and learning Disabilities</b>	Community Mental Health – x3 localities  Early intervention in psychosis (EIP) (formerly AESOP), Afton Ward, Community CAHMS (Pyle Street Clinic), Crisis Resolution Home Treatment Team, Memory Service, PCMHT (The Gables), Seagrove Ward, Osborne Ward, Shackleton, Woodlands.
Charles Rogers Shaun Stacey	<b>Corporate Services</b>	Finance, Clinical Coding, Communications, Development & Training / Education Centre, Estates, Human Resources, IT Helpdesk, PIDS, Print Room, Programme Governance Office, Patient Safety, Experience and Clinical Effectiveness Team (Incl PALS), Research & Development, Corporate Governance & Risk Management, Bereavement Service, Chaplains, Catering / Kitchens, portering cleanliness, post room, transport Offices, Infection Control, Medical Electronics, Tissue Viability & Nutrition, NHS Creative

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> JULY 2016

<b>Title</b>	Board Committee Terms of Reference		
<b>Sponsoring Executive Director</b>	Mark Price, Company Secretary		
<b>Author(s)</b>	Lucie Johnson, Head of Corporate Governance		
<b>Purpose</b>	The Trust Board is asked to formally approve the Suite of Board Committee Terms of Reference (TOR), which have been amended to reflect the new meeting structure and recommendations made by Capsticks Governance Consultancy following their review of the Trust governance arrangements during the summer of 2015.		
<b>Action required by the Board:</b>	<b>Receive</b>		<b>Approve</b> ✓
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Audit and Corporate Risk Committee	Circulated remotely 17-5-16 and approved	ACRC TOR = Minor changes suggested and undertaken	
Finance, Investment, Information & Workforce Committee	Circulated remotely 17-5-16 and discussed during FIIWC 28-6-16 & 25-5-16	FIIWC TOR = Minor changes suggested and undertaken	
Remuneration & Nominations Committee	Circulated remotely 17-5-6 and discussed during Committee meeting 8-6-16	R&N TOR = Minor changes suggested and undertaken	
Quality Governance Committee	QGC Planning meeting held 26-4-16, TOR amends agreed. Circulated remotely 17-5-16, and discussed further at QGC meeting on the 24-5-16	QGC TOR = Changes suggested and undertaken	
<b>Please add any other committees below as needed</b>			
Board Seminar			

Other (please state)	
<b>Staff, stakeholder, patient and public engagement:</b>	
<p>The suite of Board Committee TOR was circulated to all Executive and Non-Executive Directors on the 17-5-16 for their consideration. Further to this an email was sent on the 24-5-16, requesting that the revised TOR be considered during the next available committee or where appropriate remotely.</p> <p>A number of comments were received and incorporated, into the suite of documents attached to this front sheet.</p>	
<b>Executive Summary &amp; Analysis:</b>	
Each revised ToR includes a summary of the initial changes made on the front page.	
<b>Recommendation to the Board:</b>	
Approves the suite of attached TOR for immediate use.	
<b>Attached Appendices &amp; Background papers</b>	
<p>Attached are the suite of Board Committee Terms of Reference, excluding the Mental Health Act Scrutiny Committee and Information Communication Technology (ICT) Committee (which at their next meetings will consider their revised TOR), as follows:-</p> <ol style="list-style-type: none"> <li>1. Audit and Corporate Risk</li> <li>2. Quality Governance Committee</li> <li>3. Finance, Investment, Information and Workforce Committee</li> <li>4. Remunerations and Nominations Committee</li> </ol> <p>Please note the Charitable Funds Terms of Reference will be circulated to the Trust Board via a separate front cover</p>	
<b>For following sections – please indicate as appropriate:</b>	
<b>Trust Goals &amp; Priorities</b>	All
<b>Principal Risks (BAF)</b>	All
<b>Legal implications, regulatory and consultation requirements</b>	
<b>Date: 28-6-16</b>	<b>Completed by: Lucie Johnson</b>

FOR PRESENTATION TO TRUST BOARD ON 6<sup>th</sup> July 2016

## Top Key Issues and Risks arising from Sub Committees for raising at Trust Board

**Quality Governance Committee meeting held on 28<sup>th</sup> June 2016 (see Enc P1)**

---

**These Minutes will be circulated separately to Board members ahead of the meeting.**

**Finance, Investment, Information & Workforce Committee meeting held on 28<sup>th</sup> June 2016 (see Enc P2 )**

---

**These Minutes will be circulated separately to Board members ahead of the meeting.**

**Finance, Investment, Information & Workforce Committee meeting held on 25<sup>th</sup> May 2016 (see Enc P3 )**

---

Min. No.	Top Key Issues & Risks for Raising at TEC & Trust Board
16/F/202	<b>Human Resources:</b> Rostering in safe staffing areas has increased in compliance (8 weeks in advance improved rosters) to 36% in April from a low of 5% in March. The Committee notes the improvement and understands that there are focused efforts being made for this to continue. Nevertheless, based on the figures provided covering the last few months, the Committee remain concerned that continuing improvement can be sustained and operational productivity realised.
16/F/203	<b>Staff Survey:</b> The Staff Experience Group and Quality Champions are joining together to support key initiatives to improve staff experience and, in turn, positively influence the staff survey results for the coming year. Bringing these 2 groups together, along with work being undertaken by Health and Wellbeing, has enabled a detailed plan of work to be developed. One of the initiatives is to improve the appraisal process with a target for all staff to have had an appraisal by June 2016.
16/F/208	<b>Data Quality Report:</b> The report notes that there is only one metric existing within 'Working with others to keep providing our services' which relates to lost bed days due to delayed transfer of care (DTC). The data is considered to be fair but is currently captured manually by the Bed Management Team. Meetings have been held to discuss the exact meaning of DTC and the Performance Information & Decision Support Team are working with Bed Management to improve the process for data capture and presentation. Therefore, whilst the data is a good indicative view, it is not currently considered to be robust.
16/F/208	<b>Data Quality Report – Discharge Summaries:</b> The Committee is aware that a plan to reduce outstanding summaries is to be provided in August but is disappointed that there have been no effective interim arrangements in place to start reducing the high monthly volume of outstanding summaries.
16/F/209	<b>Data Quality Annual Report:</b> The Committee reviewed and agreed the Annual Data Quality Report summarising the integrity (data quality) of the information contained in the Board Performance Reports. Through the completion of the data quality audit, the Trust is able to ensure compliance with the regulations underpinning the criminal offence or supplying or publishing False or Misleading Information (FOMI).

<b>16/F/220-223</b>	<b>Financial Reports:</b> The Committee reviewed and agreed the following: <ul style="list-style-type: none"> <li>• Financial Plan 2016/17</li> <li>• Budget 2016/17</li> <li>• Treasury and Cash Management Policy</li> </ul>
<b>16/F/225</b>	<b>CIPS Programme Report 2016/17:</b> The Committee noted the CIP requirement of £8.5m (5.3% of turnover) is required for 2016/17. In month 1 the target of £0.549 was achieved. There are currently plans identified worth £4.152m with £4.348m of schemes still to be identified. The Committee was concerned at the high outstanding requirement and note that where plans have been identified, many still require validation.
<b>16/F/228</b>	<b>Information Governance Report:</b> The Committee received the end of year governance report and was concerned with the current lack of compliance and the limited engagement across the Trust. The Committee was not assured that there is a plan in place to gain the necessary engagement to provide the improvement required.

#### Audit and Corporate Risk Committee meeting held on 10<sup>th</sup> May 2016 (see Enc P4)

<b>Min. No.</b>	<b>Top Key Issues/Risk</b>
<b>16/A/033</b>	<b>Principal Risk – Excellent Patient Care:</b> The Committee gained positive assurance from the update provided by the EDN.
<b>16/A/034</b>	<b>Review of Achievement of Corporate Goals &amp; Priorities 2015/16:</b> The Committee did not feel that it was assured on the process for capturing achievement and asked that a Gant chart should be developed to capture achievement, with TEC reviewing the proposed governance and performance management arrangements.
<b>16/A/038</b>	<b>Review of Corporate Governance Framework:</b> The Committee agreed the amendments to the Standing Financial Instructions and Standing Orders.
<b>16/A/041</b>	<b>.Annual Use of Trust Seal:</b> The Committee received the report outlining the 26 instances of the Seal being used in accordance with Standing Order 9.2
<b>16/A/050</b>	<b>External Audit – Annual Audit Fee 2016/17:</b> The Committee agreed the fee for 2016/17
<b>16/A/053</b>	<b>Extension to Counter Fraud Contract 2015/16:</b> The Committee agreed the 2 year extension to 31 <sup>st</sup> March 2018.

#### Audit and Corporate Risk Committee meeting held on 1<sup>st</sup> June 2016 (see Enc P5 )

<b>Min. No.</b>	<b>Top Key Issues/Risk</b>
<b>16/A/062</b>	<b>Audit Results Report:</b> Section 30 referral to the Secretary of State regarding breach of the 3 year breakeven duty.
<b>16/A/068</b>	<b>Annual Accounts 2015/16:</b> The draft Annual Accounts for 2015/16 were recommended for approval and adoption by the Trust Board
<b>16/A/069</b>	<b>Directors' Certificates:</b> The Certificates were recommended for approval by the Trust Board

<b>16/A/070</b>	<b>Annual Governance Statement:</b> The AGS was recommended for approval by the Trust Board
<b>16/A/071</b>	<b>Annual Report 2015/16:</b> The Annual Report for 2015/16 was recommended for approval by the Trust Board
<b>16/A/072</b>	<b>Quality Account 2016:</b> The Quality Account for 2015 was recommended for approval by the Trust Board

## ENC Q

FOR PRESENTATION TO CORPORATE TRUSTEE ON 6 JULY 2016

### CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee held on the 21 June 2016 at 3.00 p.m. in the School of Health Sciences, St. Mary's Hospital, Newport.

<b>PRESENT</b>	Nina Moorman	Non Executive Director (Chair)
	Gary Edgson	Deputy Director of Finance (DDF) Deputising for the Executive Director of Financial & HR
	David King	Non Executive Director
	Sarah Johnston	Deputy Director of Nursing (DDN)
<b>In Attendance</b>	Mark Price	Company Secretary (CS)
	Katie Parrott	Senior Financial Accountant (SFA)
	Alison Toney	Communications & Engagement Team (CET)
<i>Item 16/C025&amp;033(c)</i>	Bisi Lawal-Riele	Staff Activities Co-ordinator (SAC)
<i>Item 16/C025</i>	Leisa Gardiner	Lead for Listening into Action
<i>Item 16/C032( c)</i>	Jackie Humphries	Resourcing Manager (RM)
<i>Item 16/C33(a)</i>	Brenda Fishwick	Lifelong Learning Manager
<i>Item 16/C33(b)</i>	Guy Eades	Healing Arts Director
<b>Observer</b>	Deborah Downer	Clerk to Friends of St. Mary's Trustees
<b>Minuted by</b>	Linda Mowle	Corporate Governance Officer

Min. No.	Top Key Issues
<b>16/C020</b>	<b>Quoracy:</b> Meeting was not quorate. The Corporate Trustee to ratify all actions and recommendations.
<b>16/C021</b>	<b>Draft Terms of Reference:</b> The Committee agreed the draft terms of reference for approval by the Corporate Trustee.
<b>16/C021</b>	<b>Membership:</b> There are now 3 vacancies on the Committee. Plan in place for each of them
<b>16/C026</b>	<b>CFC Annual Report 2015/16:</b> The Committee agreed the annual report for submission to the Audit & Corporate Risk Committee.
<b>16/C027</b>	<b>Guidance for Staff on Charitable and Fundraising Activities on IOW NHS Trust Premises:</b> Agreed the guidance for presentation to the Policy Management Group

<b>16/C019</b>	<b>APOLOGIES</b> Received from Jane Tabor (Non Executive Director), Chris Palmer (Executive Director for Financial & Human Resources), Lesley Myland (Friends of St. Mary's), Dennis Ford (Patient Representative) and Andy Hollebon (Head of Communications)
<b>16/C020</b>	<b>QUORACY</b> The Chair confirmed that the meeting was not quorate. The Corporate Trustee to ratify all actions and recommendations. The minutes to be circulated to members for agreement.

16/C021	<p><b>DRAFT TERMS OF REFERENCE</b> The Committee received and agreed the draft Terms of Reference for approval by the Corporate Trustee.</p> <p><b>MEMBERSHIP</b> The Committee, noted the following vacancies:</p> <ul style="list-style-type: none"> <li>• Katie Gray, Executive Director of Transformation &amp; Integration, with effect from the 30<sup>th</sup> April 2016 (proposed to be replaced by Mark Price, Company Secretary)</li> <li>• Jane Tabor, Non Executive Director &amp; Vice Chair, with effect from 6<sup>th</sup> August 2016 (proposed to be replaced by the new NED replacing Jane Tabor)</li> <li>• Staff Representative (Fund Manager) The SFA to follow up the staff representative with the Deputy Chief Operating Officer in time for the replacement to attend the September 2016 meeting. <b>Action: SFA</b></li> </ul> <p>The Chair, on behalf of the Committee, thanked both Jane and Katie for their input into the work of the Committee which was very much appreciated and wished them well for the future.</p>
16/C022	<p><b>DECLARATIONS OF INTEREST</b> Mark Price declared an interest in the bid for funding for Apprenticeships and Work Experience (Future Careers Development Facilitator) as Chairman of the Island Innovation Trust which runs Medina College, Carisbrooke College and the joint Sixth Form.</p>
16/C023	<p><b>MINUTES</b> The minutes of the meeting held on the 15<sup>th</sup> March 2016 were agreed. The minutes to be signed at the September 2016 meeting following formal approval by the Corporate Trustee.</p>
16/C024	<p><b>MATTERS ARISING FROM PREVIOUS MEETINGS</b> The Committee received the schedule of actions as follows:</p> <p><b>Min. No. 14/053 Alignment of NICU and Barely Born Funds:</b> The Committee agreed to combine the Funds. Status – closed.</p> <p><b>Min. No. 15/C041 Southampton Hospital Charity Leaflet:</b> The SAC advised that she would like to try and create an emailable newsletter on staff activities which provided all the information on activities and also the accessible websites. The Committee noted that the Staff Newsletter is currently on hold whilst it is reviewed.</p> <p><b>Min. No. 16/C016 Car Parking – Cash Incentive:</b> The Committee agreed that this was not feasible. Status – closed.</p>
16/C025	<p><b>STAFF ACTIVITIES</b> The Committee received the update report outlining the activities the SAC has been undertaking for the past 6 months including the Staff Awards Ceremony.</p> <p><b>(a) Awards Ceremony 2016:</b> The SAC tabled the updated budgets for expenditure and sponsorship together with the 2017 proposed income increases. The Committee noted the deficit in funding of £5,558.</p> <p>The CS advised that this figure may be revised once all the final bills have been received. In addition, there may be scope within the Celebrations Budget to fund some of the shortfall. The DDF to take forward and provide an</p>



	<p>update.</p> <p style="text-align: right;"><b>Action: DDF</b></p> <p>The Committee agreed to re-assess the funding at the December 2016 meeting.</p> <p style="text-align: right;"><b>Action: CS/SAC</b></p> <p>Overall, the Committee acknowledged the very successful Awards evening and thanked the SAC for her commitment and hard work to ensure such a successful outcome for the evening.</p> <p>The Committee noted that for next year, the SAC hoped that the event would be self-funded through sponsorship alone.</p> <p><b>(b) Staff Activities:</b> The Staff Activities Survey results were tabled. The SAC advised that the winner of the survey was to be announced in the 22<sup>nd</sup> June 2016 issue of e-Bulletin.</p> <p>The Committee noted the various events and activities currently being organised by the SAC and, in particular, the 10,000 steps a day Walking Challenge which will commence on the 18<sup>th</sup> July 2016 for which a CQUIN bid has been secured which will purchase pedometers and provide a limited number of health checks both at the start of the Challenge and after the 3 month completion.</p> <p>The Chair suggested that the health checks could be provided by the Trust and to check that CQUIN funding was definitely available.</p> <p><i>(Post meeting note: SAC advised on 22 June 2016 that she has checked with Cloe Rebourgeard who is in charge of the CQUIN money and it is available for use now for the Walking Challenge.)</i></p> <p>The DDN asked whether there were any groups of staff not engaging, in particular nurses and doctors, and how to achieve engagement. The DDN and SAC to discuss and take forward outside of the meeting.</p> <p>The Committee noted that the Charitable Funds leaflet was now being printed and will be distributed in the near future.</p> <p>The Committee requested that a further update be presented to the September 2016 meeting.</p> <p style="text-align: right;"><b>Action: SAC</b></p>
<b>16/C026</b>	<p><b>CFC ANNUAL REPORT 2015/16</b></p> <p>The Committee received and agreed the Annual Report for presentation to the Audit &amp; Corporate Risk Committee.</p>
<b>16/C027</b>	<p><b>GUIDANCE FOR STAFF ON CHARITABLE AND FUNDRAISING ACTIVITIES ON IOW NHS TRUST PREMISES</b></p> <p>The Committee received the draft guidance which is designed to provide a guide for both the CEM Team and Trust staff on what is possible and the limited support the CEM Team can provide.</p> <p>The Committee agreed the guidance subject to the following amendment:</p> <ul style="list-style-type: none"> <li>• Section 3 – Ethical Code: delete the second sentence and sub sections a to f</li> <li>• Insert: All activity should be in line with the IOW NHS Trust Charitable Funds Policy</li> </ul>

	<p>The amended guidance to be circulated to members for agreement before presentation to the Corporate Trustee. <b>Action: CS/HOCE</b></p>
<b>16/C028</b>	<p><b>FUND MANAGERS' EXPENDITURE PLANS 2016/17</b> The SFA tabled the expenditure plans for 2016/17 advising that 23 plans were still outstanding.</p> <p>The Committee agreed that, where funds fit the criteria stated in the Charitable Funds Static Funds Policy, the balances, these should be combined within the General Fund. <b>Action: SFA</b></p> <p>The Committee requested that a reminder to Fund Managers of the need to submit their Expenditure Plans for 2016/17 by the end of the month be included within the next e-Bulletin. <b>Action: CET</b></p> <p>The SFA to provide the Deputy Director of Finance with the Fund balances in order that the available funds can be highlighted to the CBUs and the Operational Management Group. <b>Action: SFA</b></p> <p>The Committee hoped that, by these initiatives, there would be movement within the funds by the next meeting in September.</p> <p>The SFA to provide an updated Fund Managers Plans schedule for the September 2016 meeting. <b>Action: SFA</b></p>
<b>16/C029</b>	<p><b>BALANCES, INCOME AND EXPENDITURE</b> The SFA tabled the current income, balances and expenditure for the period February to March 2016.</p> <p>The Committee noted that at the end of March 2016 the committed balance for the General Fund was approximately £1,600.</p> <p>The Chair requested that queries be emailed to the SFA with a copy to her.</p>
<b>16/C030</b>	<p><b>ACKNOWLEDGEMENT LETTERS TO MAJOR DONORS</b> The SFA advised there had been no major donors since the last meeting. The Chair to continue signing acknowledgement letters.</p>
<b>16/C031</b>	<p><b>LEGACIES UPDATE</b> The SFA presented the update on the status of unspent legacies as at 31<sup>st</sup> March 2016.</p>
<b>16/C032</b>	<p><b>REQUESTS FOR CONSIDERATION</b> The following bids from the General Fund were considered in accordance with the Charity Commission Guidelines and agreed that approved items were an enhancement for patients and staff:</p> <p><b>a) Friends of St. Mary's Hospital Bids:</b> The application form and information leaflet for the 2016 bids was received. The Committee noted that the closing date for bids is the 30<sup>th</sup> June 2016. The DDN and SFA to liaise to promote further access to the Friends application for funds. <b>Action: DDN/SFA</b></p> <p><b>b) Healing Arts – 'Incest &amp; Child Abuse Survivors' Commemorative Garden: £1,750 – approved pending re-allocation of static funds into the General Fund</b> Guy Eades presented the revised costing of £1,750 explaining that the Garden was first created in 2000 and where it was originally located.</p> <p><b>c) Funding for Apprenticeships and Work Experience: Funding for 1</b></p>

	<p><b>year Future Careers Development Facilitator: £25,541 - approved</b></p> <p>The HR Resourcing Manager confirmed that the DDHR had pursued whether funding from My Life A Full Life and the CCG would be available, as the work of the post could be beneficial to primary/social care and the health sector as a whole. Hilary Salisbury, in her role as HR support for MLAFL, confirmed that this post was not part of the bid submitted for MLAFL funding and that MLAFL will not be able to fund the post in the coming financial year.</p> <p>In approving the bid, the Committee had taken note of the emails dated 10<sup>th</sup> and 13<sup>th</sup> June 2016 respectively from Dennis Ford and the Executive Director of Financial &amp; Human Resources.</p> <p>The Committee requested that an update report together with the project plan for the post be presented to the September 2016 meeting. The Committee wish to see a clear list of what is expected of the post together with KPIs.</p> <p style="text-align: right;"><b>Action: RM</b></p>
16/C033	<p><b>FEEDBACK ON FUNDING:</b></p> <p><b>a) Careers Fair – 16 April 2016:</b> The Lifelong Learning Manager presented the feedback on the event which was very successful with around 400 visitors, and thanked the CFC for its generosity in funding the event.</p> <p><b>b) 5-6 Club:</b> The CS confirmed that the Trust Chair is proposing to invite Roy Lilley and Lord Carter to the Island in September 2016 which will incur costs for travel and refreshments, etc.</p> <p>The Committee agreed to review funding in 6 months' time at the meeting on the 20<sup>th</sup> December 2016.</p> <p style="text-align: right;"><b>Action: CS</b></p> <p><b>c) Long Service Awards:</b> The SAC advised that the award, in the form of a gift, for 40+ years' NHS service will be presented to staff at the AGM on the 15<sup>th</sup> July 2016.</p> <p>Going forward, the Committee requested that following review another paper be submitted to the September 2016 meeting on the future intention for the scheme.</p> <p style="text-align: right;"><b>Action: SAC</b></p>
16/C034	<p><b>E-BULLETIN ITEMS</b></p> <p>The following items to be included in E-Bulletin in order to promote the work of Charitable Funds, funding for</p> <ul style="list-style-type: none"> <li>• Future Careers Development Facilitator</li> <li>• Reinstatement of Commemorative Garden</li> <li>• Fund Managers' Expenditure Plans for 2016/17</li> <li>• Friends of St. Mary's bids for funding.</li> </ul> <p style="text-align: right;"><b>Action: CET</b></p> <p><i>(Post meeting note: included within the 22<sup>nd</sup> June 2016 e-Bulletin)</i></p>
16/C035	<p><b>DATES OF 2016 MEETINGS</b></p> <p>Meetings to be held at 3.00 – 5.00 p.m.</p> <p>20 September</p> <p>20 December</p>

**Signed:** .....

**Dated:**

**CHAIR**

## REPORT TO THE TRUST BOARD (Part 1 - Public)

ON 6<sup>th</sup> JULY 2016

<b>Title</b>	Charitable Funds Committee Terms of Reference		
<b>Sponsoring Executive Director</b>	Mark Price, Company Secretary		
<b>Author(s)</b>	Lucie Johnson, Head of Corporate Governance		
<b>Purpose</b>	The Trust Board is asked to formally approve the Charitable Funds Committee Terms of Reference, which have been amended to reflect the new meeting structure and recommendations made by Capsticks Governance Consultancy following their review of the Trust governance arrangements during the summer of 2015.		
<b>Action required by the Board:</b>	<b>Receive</b>		<b>Approve</b> <b>X</b>
<b>Previously considered by (state date):</b>			
<b>Sub-Committee</b>	<b>Dates Discussed</b>	<b>Key Issues, Concerns and Recommendations from Sub Committee</b>	
Charitable Funds Committee	21/06/16	Approved	
<b>Please add any other committees below as needed</b>			
Board Seminar			
Other (please state)			
<b>Staff, stakeholder, patient and public engagement:</b>			
<p>The suite of Board Committee TOR was circulated to all Executive and Non-Executive Directors on the 17-5-16 for their consideration. Further to this an email was sent on the 24-5-16, requesting that the revised TOR be considered during the next available committee or where appropriate remotely.</p> <p>The Charitable Funds Committee took the Terms of Reference at its last meeting on 21<sup>st</sup> June 2016 and they were approved.</p>			
<b>Executive Summary &amp; Analysis:</b>			
A summary of the initial changes is made on the front page.			
<b>Recommendation to the Board:</b>			
Approve the attached TOR for immediate use.			
<b>Attached Appendices &amp; Background papers</b>			
Attached are the Terms of Reference for the Charitable Funds Committee			
For following sections – please indicate as appropriate:			

<b>Trust Goals &amp; Priorities</b>	All
<b>Principal Risks (BAF)</b>	All
<b>Legal implications, regulatory and consultation requirements</b>	
<b>Date: 28-6-16                      Completed by: Lucie Johnson</b>	

## Charitable Funds Committee Terms of Reference

<b>Document Type:</b>	Charitable Funds Committee Terms of Reference
<b>Date document valid from:</b>	TBC
<b>Document review due date:</b>	1 year from valid date

### AUDIT TRAIL:

<b>Date(s) reviewed:</b>	May 2016		
<b>Date(s) agreed:</b>		<b>Version number:</b>	V8
<b>Details of most recent review:</b> <i>(Outline main changes made to document)</i>		<ul style="list-style-type: none"> <li>Slightly revised format.</li> <li>Introduced a main purpose section to bring the template in line with other committees.</li> <li>Removed delegated powers of the EDOF&amp;HR as this should not form part of the TOR, but part of the SFI's.</li> <li>Revised the reporting requirements section, so it is clear who the committee reports to and who reports to the committee.</li> <li>Included that the CEO and the Chair will use attendance at meetings to inform their annual appraisals with Directors.</li> <li>Executive Director of Transformation and Integration to be replaced as a member by Company Secretary.</li> </ul>	

<b>Trust Board Approval</b>	
<b>Approved at:</b>	Trust Board
<b>Date Approved by Trust Board:</b>	

# **1 Main Purpose**

The Isle of Wight NHS Trust has a vision to deliver quality care for everyone, everytime.

The Isle of Wight NHS Trust was appointed as Corporate Trustee of the Charitable Funds by virtue of SI 2012 No. 786 and its Board serves as its agent in the administration of the charitable funds held by the Trust.

The Corporate Trustee (i.e. Trust Board) has established an independent Committee to be known as the Charitable Funds Committee.

The Charitable Funds Committee has been formally constituted by the Corporate Trustee in accordance with the Trust's Standing Orders, delegated responsibility to make and monitor arrangements for the control and management of the Trust's charitable funds and will report through to the Corporate Trustee.

For a body to be a Charity, it must be Independent:

“It must exist in order to carry out its charitable purposes and not for the purpose of implementing the policies of a governmental authority or carrying out the directions of a governmental authority”.

(Paragraph 5, RR7. The Independence of Charities from the State)

The main purpose of the committee is to support the Trust to achieve its vision by making the most effective use of all available charitable funds, ensuring that the funds are spent appropriately as a financially sustainable organisation.

The Charitable Funds Committee's strategic intent is to oversee the proactive raising of funds and to monitor the development and maintenance of effective partnerships. This will be achieved by working with Trustees and supporters of the charitable funds to ensure that the requirements of the Charities Acts are upheld and maintained at all times.

## **Membership and Quorum**

### **1.1 Membership**

The Committee will consist of 9 members

The following membership has been approved by the Corporate Trustee

- a) Non-Executive Director - Chair
- b) Non-Executive Director – Vice Chair
- c) Non-Executive Director
- d) Non-Executive Financial Advisor to Trust Board
- e) Executive Director of Financial and Human Resources
- f) Deputy Director of Nursing
- g) Company Secretary
- h) Staff Representative (Fund Manager)
- i) Patient Representative/Patient Council



Co-Opted Members (non-voting):

The following have been Co-opted to the Committee:

- j) Friends of St. Mary's Representative

## **1.2 Quorum**

A quorum shall be 5 members including as a minimum, 2 x Non-Executive Directors, 1 x Executive Director and if the Executive Director of Financial and Human Resources is unable to attend their nominated deputy will deputise with full voting rights and be accepted as part of the quorum.

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.

## **2 Attendance at Meetings**

The following will attend as and when requested

- a)
- b) Deputy Director of Finance
- c) Senior Financial Accountant
- d) Head of Communications/Communications representative
- e)

It is expected that all members will endeavour to attend every meeting.

The Chair of the Committee may require attendance of other personnel in support of specific applications for funds or to provide advice, support and information.

The Committee has the right to invite external representatives for specific advice, or representatives of the Trust's internal or external auditors, if it considers this necessary.

## **3 Frequency of Meetings**

No less than 4 meetings will be held each year, however, the frequency may be varied in order to ensure that the Committee discharges all of its responsibilities.

## **4 Delegated Authority**

The Committee is authorised to approve expenditure of Charitable Funds in accordance with delegated limits as set out in the Standing Financial Instructions.

The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if they consider this necessary.

The Committee is empowered with the responsibility for day to day management of the investments of the charitable funds in accordance with the approved Investment Strategy ensuring that:

- a) The scope of the investments is clearly set out in writing and communicated to the Executive Director of Finance and Human Resources
- b) That there are adequate internal controls and procedures in place which will ensure that the investments are being exercised properly and prudently
- c) That they review regularly the performance of the investments
- d) That acquisitions or disposal of a material nature must always have written authority of the Charitable Funds Committee, or the Chair of the Committee in conjunction with the Executive Director of Finance and Human Resources.

The Committee must ensure that the banking arrangements for the charitable funds should be kept entirely distinct from the Trust's NHS fund.

Separate current and deposit accounts should be minimised consistent with meeting expenditure obligations

The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

The Committee will operate an investment pool when this is considered appropriate to the charity in accordance with the charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commissioner Guidance.

The Committee will obtain appropriate professional advice to support its investment activities.

The Committee shall regularly review investments to see if other opportunities or investment managers offer a better return

## **5 Roles and Responsibilities**

The responsibilities of the Committee shall be:

- a) to apply the charitable funds in accordance with their respective governing documents consistent with the requirements of the Charities Act 1993,

Charities Act 2006 or any modification to these Acts (as summarised in Appendix 2).

- b) to ensure that the Trust's policies and procedures for charitable funds investments are robust and are followed.
- c) to make decisions involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
  - i. Trustee Act 2000
  - ii. The Charities Act 1993
  - iii. The Charities Act 2006
  - iv. Terms of the funds governing documents.
- d) to receive at least twice a year reports for ratification from the Executive Director of Financial and Human Resources for investment decisions and action taken through delegated powers upon the advice of the Trust's investment advisor.
- e) to oversee and monitor the functions performed by the Executive Director of Finance and Human Resources as defined in the Standing Financial Instructions.
- f) to appoint and review Auditors for statutory audit/independent examination of annual accounts as per guidance from the Charity Commission.
- g) to monitor progress of any Trust's charitable appeal funds and to receive reports from the Appeal Fundraising Groups.
- h) to monitor the Trust's scheme of delegation for expenditure for the levels:
  - i. Up to £1,000 – Fund Manager
  - ii. Between £1,000 and £5,000 – Associate Director
  - iii. Between £5,000 and £15,000 – Charitable Fund Committee
  - iv. Expenditure over £15,000 must have Corporate Trustee approval
- i) to oversee the development of the Charitable Funds Strategy and recommend to the Corporate Trustee for approval and consider the approach to fundraising, the investment of funds, the approach to expenditure and the approval of procedures associated with the use of charitable funds within the regulations provided by the Charitable Funds Commission and to ensure compliance with the laws governing charitable funds.
- j) to administer the Isle of Wight NHS Trust Charitable Fund in pursuance of its objects as stated in its Declaration of Trust and in accordance with the Charitable Funds Strategy.
- k) to ensure the Trust complies with all legal, Charity Commissioners and Department of Health guidelines as they relate to the administration of Charities.
- l) to advise, where appropriate, on raising funds for the Isle of Wight NHS Trust Charitable Fund.
- m) to ensure proper books of account are kept and to review and approve the annual return and annual accounts in line with the requirements of the Charities Commission and laws governing charitable funds.
- n) to review all income and expenditure transactions for all funds.
- o) to review legacies received and ensure that the Trust complies with the terms of the legacy.
- p) to authorise the establishment of new funds and new charities.

- q) to authorise donations when an individual item has a value of more than £5,000 in line with the Trust's SFIs and Scheme of Delegation.
- r) to consider the use of professional fundraisers and links with other organisations for major fundraising projects.
- s) to oversee and monitor the effectiveness of the Healing Arts Management Committee in order to advise the Corporate Trustee on the robustness and management of the Healing Arts programme and insurance of the artworks.

## **6 Reporting Requirements**

### **6.1 Reporting to**

The Committee is accountable to the Corporate Trustee. Minutes of meetings will be submitted and presented to the Corporate Trustee by the Chair, who shall draw to the attention of the Corporate Trustee issues that require disclosure or approval to the full Board as the Corporate Trustee, or require executive action.

Minutes of the Committee meetings shall be submitted to and received by the Trust Executive Committee and the Audit & Corporate Risk Committee.

### **6.2 Receive reports from**

The Charitable Funds Committee will receive regular reports and the minutes from the Healing Arts Management Committee.

In addition, the Charitable Funds Committee will review and agree the terms of reference of the Healing Arts Management Committee.

## **7 Duties and Administration**

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. The Committee will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.

The Committee shall be supported administratively by the governance officer, whose duties in this respect will include:

- a) Agreement of agendas with the Chair and attendees
- b) Maintaining a Forward Planner for the Committee to ensure that agendas retain greater strategic focus.
- b) Preparation, collation and circulation of papers a minimum of 5 days in advance of the meetings.
- c) Taking the minutes and helping the Chair to prepare reports to the Trust Board, and the Audit and Corporate Risk Committee.
- 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) Maintaining an Action Tracking System for agreed Committee actions 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.
- k)
- l) To maintain agendas, minutes, and other papers in line with the policy on retention of records

## **8 Monitoring Compliance with Terms of Reference**

Attendance and frequency of meetings will be monitored by the Chief Executive Officer and the Chair in order to inform the annual appraisal process. Indeed, attendance and frequency of meetings will be reported to the Audit and Corporate Risk Committee and the Trust Board on an annual basis, as part of the Committee annual report. Concerns highlighted when monitoring compliance will be discussed at the Audit and Corporate Risk Committee and escalated to the Trust Board as appropriate. Remedial action will be taken as appropriate to effect corrective measures.

The Audit and Corporate Risk Committee and the Trust Board will review these Terms of Reference, and the Committee's review of its effectiveness on an annual basis.

The Audit and Corporate Risk Committee will also monitor the work of the Committee to ensure it is discharging its duties effectively and efficiently