Trust Board Papers

Isle of Wight NHS Trust

Board Meeting in Public
to be held on
Thursday 2 May 2019
at
1.30pm - Conference Room
Level B Main Hospital
(opposite Full Circle Restaurant)
St. Mary’s Hospital, Parkhurst Road,
NEWPORT, Isle of Wight, PO30 5TG
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The next meeting in Public of the IW NHS Trust Board will be on:
Date: Thursday 6 June 2019
Venue: Conference Room - Level B, St Mary's Hospital, Newport, IW PO30 5TG

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

Questions for the Board
Staff and members of the public are asked to send their questions in advance at least 48 hours prior to the meeting to board@iow.nhs.uk to ensure that as comprehensive a reply as possible can be given.

Issues to be Covered in Private
The meeting may need to move into private session to discuss issues which are considered to be ‘commercial in confidence’ or business relating to issues concerning individual people (staff or patients). On this occasion the Chairman will ask the Board to resolve: 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.

Recording of Meeting
This meeting will be recorded for the purposes of assisting in transcribing the minutes and actions from the meeting.

Confirmation of Quoracy
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.

Apologies Received from
- Paul Evans, Non-Executive Director
- Alan Thorne, Quality Improvement Director
Minutes of the meeting of the Isle of Wight NHS Trust Board
held in public at 1.30pm on Thursday 4 April 2019 in the Conference Room, St Mary’s Hospital, Newport, IW PO30 5TG

Non-Executive Directors
- Vaughan Thomas Chair
- Phil Berrington Non-Executive Director
- Dr Paul Evans Non-Executive Director
- Dr Tim Peachey Vice Chair & Non-Executive Director
- Caroline Spicer Non-Executive Director
- Anne Stoneham Non-Executive Director
- Sara Weech Non-Executive Director

Executive Directors:
- Maggie Oldham Chief Executive
- Darren Cattell Director of Finance, Estates and IM&T & Deputy Chief Executive
- Mr Alistair Medical Director
- Flowerdew
- Tim Lynch Director of Integrated Urgent & Emergency Care
- Julie Pennycook Director of Human Resources & Organisational Development
- Suzanne Rostron Director of Quality Governance
- Dr Lesley Stevens Director of Mental Health & Learning Disabilities Services
- Dr Nikki Turner Director of Acute Services
- Alice Webster Director of Nursing, Midwifery, AHPs & Community Services

Attendees:
- Claire Budden Board Secretary
- Lyn Cromley Patient Carer
- Leisa Gardiner Freedom to Speak Up Guardian
- Martyn Davies IW CCG
- Chris Orchin Healthwatch
- Cllr John Nicholson Chair of Policy and Scrutiny Committee for Adult Social Care and Health, IW Council
- Dennis Ford Patient Council
- Alan Thorne NHSI Improvement Director
- Nick Gerrard NHSI Financial Improvement Director
- Prof Ann Jacklin NHSI
- Jay Chappell Staff side representative

Minuted by:
- Lynn Cave Board Governance Officer

Members of Staff and Public in attendance:
There were members of staff, public and the media present.
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<td>19/T/057</td>
<td>APOLOGIES FOR ABSENCE, CONFIRMATION THAT THE MEETING IS QUORATE AND CHAIR’S OPENING REMARKS</td>
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<td>Apologies for absence were received from:</td>
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<td>• Kemi Adenubi, Non-Executive Director</td>
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<td>• Dr Paul Evans, Non-Executive Director</td>
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<td>• Dr Charles Godden, Non-Executive Director</td>
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<td>• Dudley Delannoy, Healthwatch</td>
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<td>The Chair advised that Dr Godden had tendered his resignation from the Board, and thanked him for his support to the Trust.</td>
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<td>The Chair confirmed that the meeting was quorate, and welcomed Dennis Ford representing the Patient Council; Chris Orchin for Healthwatch and Cllr John Nicholson for the IW Council. He also welcomed Nick Gerrard who is the NHSI Financial Improvement Director who will be supporting the Trust following the introduction special measures for financial reasons. He also welcomed Martyn Davies from IW CCG and members of the public and staff who were observing the meeting.</td>
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<td>19/T/058</td>
<td>PATIENT STORY</td>
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<td>The Chair welcomed Lyn Cromley and thanked her for agreeing to come and share her story as a carer of a patient living with dementia.</td>
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<td>Lyn introduced herself and provided her story about her life with Mark who is 70 and was an electrical shop fitter; they have two grown children both of whom live abroad. Mark has always been an active individual and a problem solver, he was diagnosed with dementia in 2011 and Lyn attended a number of courses locally to understand the disease.</td>
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<td>They both joined the Ventnor dementia café and things had run well for some years. In 2017 Mark's health started to decline further and Lyn read a number of emails from the last few years that summarised the challenges they had been through and the impact on their lives.</td>
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<td>The barriers in accessing attendance allowance and blue badge parking, and the practicalities of help were identified as well as the changes in Mark's personality. In November 2018 the couple found that they were not eligible for a blue badge as Mark did not suffer from a physical impairment and had also been declined additional financial support.</td>
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<td>Talking about the highlights of support received Lyn noted the memory pathway which had been highly positive, a number of staff were identified as providing fantastic care, and the Alzheimer's Cafe has been highly supportive. She spoke about the effects his illness has had on her as the main carer and the challenges she has faced when seeking support to assist her. In addition, she explained that due to her husband’s dependence on her that her quality of life has diminished and she gave examples of how this manifests.</td>
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<td>Lyn Cromley highlighted the need for practical help such as a day centre and the example of the dedicated centre run in Chichester was noted, the lack of respite care availability, and the lack of support available after diagnosis. In conclusion after diagnosis of early onset Alzheimer’s she felt they had been left with no cure, no help and no life</td>
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The Chair thanked her for story which had covered a wide range of issues including links with a variety of agencies.

Cllr Nicholson stated that he would like to take up the issues raised through the Health & Scrutiny Committee and requested that Lyn Cromley discuss this with him. She agreed that she would be happy to help others in similar situations for the future.

Sara Weech thanked Lyn Cromley for sharing her experiences which had acted as a reminder of why we are here and the need to be person centred when developing our services. This was echoed by the Director of Mental Health & Learning Disabilities who noted that it underlined all of the areas we are focussing on a Board; including the need to join up services across the Trust and more widely over the system.

Caroline Spicer noted the comment about the bedside manner of one of the staff and Lyn fed-back on what she had considered to be the unsupportive approach of some individuals. The Medical Director thanked Lyn Cromley for the comments and commented that information like this can be used to support develop our teams and help them to improve.

Chris Orchin advised that dementia was one of Healthwatch’s key issues and requested that Lyn Cromley link with Healthwatch to share her story.

The Chair in summary thanked Lyn Cromley again and noted the need to improve to join services up across the Island. He offered to connect her with the Chair of Age UK on the island. Lyn Cromley accepted the offers from the Chair, Cllr Nicholson and Chris Orchin.

### DECLARATIONS OF INTEREST

**19/T/059**

Declarations of interest were received from:
- Darren Cattell as Director of Wight Life Partnership
- Phil Berrington as an employee of IBM
- Sara Weech as Chair of Mountbatten

### MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Isle of Wight NHS Trust Board held on 07 March 2019 were reviewed and the following amendments agreed:

a) **19/T/036 – Islandwide Plan – p 6 para 9**: Caroline Spicer request that the minutes be amended to read: ‘Caroline Spicer said it was helpful to hear feedback formally from the Local Care Board, ……’

**Resolution**

Following the amendments above the Chair requested that the minutes of the meeting held on 7 March 2019 be **Approved**. The motion was carried unanimously, with no abstentions.

### MATTERS ARISING AND SCHEDULE OF ACTIONS

a) **Matters Arising:**

   There were no matters arising.

b) **Schedule of Actions:**

   a) TB/352 – Freedom to Speak Up: Action closed
   b) TB/357 – Recovery Workshop: Action closed
   c) TB/359 – Mortality & Learning from Deaths: This action is due in
d) TB/360 – Culture Dashboard: Action closed

e) TB/361 – Non Active Recruitment: Action closed

Resolution
The Isle of Wight NHS Trust Board received the Matters Arising and Schedule of Actions Update

19/T/062 CHAIRS UPDATE

The Chair presented his report and advised that since the last meeting he had attended a wide range of meetings which were outlined within the paper. He also highlighted the following:

a) Acute Service Redesign: He advised that this was reported at Board 18 months ago, and confirmed that work is continuing in the background with the Trust working with partners on the mainland to progress to a sustainable service.

b) Isle of Wight Improvements: He reported that the Trust is continuing to work with the Local Authority and the IW Clinical Commissioning Group to ensure that there are sustainable services across the island.

c) Leadership Conference: The Chair confirmed that on 29 March a one day leadership conference focused on compassionate leadership within healthcare had taken place, which attracted attendance by 280 people. This included 170 Trust staff as well as staff from both the Local Authority, HM Prison and a range of partner organisations. It had included updates from key speakers about the development of compassionate leadership within service delivery in the public sector and he thanked all of those involved for organising such a worthwhile event

Resolution
The Isle of Wight NHS Trust Board received the Chair’s Update.

19/T/063 CHIEF EXECUTIVE’S UPDATE

The Chief Executive presented her report, and highlighted that although the Board receives many reports, there is nothing to compare with having someone come and recount their experiences in person as has been seen at the meeting through the Patient Story.

She confirmed that the ledgers for the year end are now closing for both operational and financial areas, and with a new financial year commencing she stressed that the programmes of improvement would continue to be implemented.

She advised that the Board are reviewing the impact of the application of Financial Special Measures to ensure that there would be no adverse effect on services. The Board had received an update at the Seminar session earlier in the day on the ‘Getting it right first time - GIRFT’ process, and how the benefits of ensuring the Trust is consistent with best practice can be realised.

The Chief Executive updated that quality improvement measures are being implemented which will result in the betterment of Trust services for our community and which are anticipated to also result in an improved rating from our regulators. She confirmed that the CQC will be visiting in the near future; the Trust has been clear that its improvement journey will take time and that the goal of Getting to Good is set for 2020 with an expectation that we would hope to move to a rating of Requires Improvement in this year given the considerable work undertaken. She advised that there is the anticipation that many areas with be turning from red to
amber, and from amber to green. There are no formal dates for the visit as yet but it is likely to be at the end of May/beginning of June. She confirmed that the CQC will be undertaking their planning meeting in April and therefore is it not likely to be before this period. She advised that Prof. Ann Jacklin was supporting the Board and ensuring that progress is highlighted.

**Resolution**
The Isle of Wight NHS Trust Board received the Chief Executive’s Update.

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<td>The Chief Executive confirmed that as previously discussed at Board the Trust is working on a sustainability plan for the Island jointly with the IW CCG and Local Authority. She advised that an update had been planned for this meeting to share publicly the additional work undertaken with our community but unfortunately there is an element of the work which is dependent on our partners on the mainland that is not due to conclude until the end of April. As a result a full update will be provided at the meeting of the Board in May.</td>
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She advised that the progress had been discussed at Board Seminar earlier in the day, and that year one of the sustainability plan is the Trust operating plan 2019/20 which will be discussed later in the meeting. It focuses on three areas – one is productivity, including what is within the Trust’s gift to deliver; secondly what models of care could look like on the Island, and the third area is what partnerships can be developed with our neighbouring Trusts. An example of this is the work which has taken place in the last twelve months with South Central Ambulance Service to procure and implement the computer aided dispatch system.

She confirmed that the sustainability plan builds on all three areas and she looks forward to being able to bring a report to the May Board which will allow a more in depth discussion.

**Resolution**
The Isle of Wight NHS Trust Board received the report and expressed their ongoing support to the Island wide plan.

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<td>The Chair introduced the item and stated that there was considerable activity in Westminster around the EU Exit. The NHS has been planning a range of measures both national and regionally to address any issues.</td>
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The Medical Director confirmed that a monthly update has been provided to the Board, and that given the uncertainty at the moment contact across the network is continuing on a daily basis. He advised that the Trust was in a very similar position to other NHS organisations and that the team will continue to monitor the situation closely.

The Chair noted that the planned call today with NHS partners is one of a series of regular reporting and information sharing sessions which take place.

The Chief Executive advised that when there is a confirmed exit date the escalation of calls will diminish or escalate as appropriate, and that this information will be shared with the Board.

The Chair confirmed that the Trust was as well prepared as can be at this stage and would continue to follow all guidance on the matter to ensure compliance.
Resolution
The Isle of Wight NHS Trust Board received the EU Exit Update.

19/T/066 OPERATING PLAN 2019/20
The Director of Finance, Estates and IM&T/Deputy CEO apologised for the lateness of the papers and ensured that all members were in receipt of a copy of the report.

He advised that he is the sponsoring director but noted that it is important to note that this is the Trust’s plan for 2019/20 and relates to all areas of its business; the Chief Executive had already set the context earlier in the meeting which confirmed that this is year one of the three year sustainability plan. It sets out what will be done, and what the potential risks are to achieving the plan. He confirmed that this report had been discussed in depth at the Board Seminar earlier in the day, and that he would be highlighting key issues.

The Chair noted that the development of the operating plan had seen considerable progress against previous years’ work, and had been undertaken based on divisional plans, consultations and a series of conference calls with the Board. He also advised that it had been prepared in collaboration with the IW CCG joint financial plan.

The Director of Finance, Estates and IM&T/Deputy CEO advised that there was a high level of regulatory content within the plan which has to be submitted on an annual basis. The report is the result of considerable detailed work undertaken both within the Trust and externally. The focus is on the level of activity the Trust is commissioned to provide. The CCG and Trust are still working to agree the level of activity and the final value; the plan includes a number of initiatives which are included within the quality improvement programme. Within the workforce plan there is the expectation that more staff will be recruited than leave, and he confirmed that with every permanent appointment the reliance on agency staff reduces. The current model of care needs to be reviewed and this will include workforce skill mix requirements to ensure the right posts are in place to provide the services within the care model. He advised that the variance within the proposed control total of £24.2m and the proposed level of £30.1m was circa £6m which would need to be found through cost improvement plans. It is therefore necessary to change the care models toward treatment in the community rather than the current inpatient model.

In relation to the constitutional standards, he confirmed that the targets across accident and emergency services, cancer, and diagnostic waiting times would be achieved under the plan. However, ambulance performance standards will not be achieved across the whole range of indicators although these continue to improve there is still more work to be done. Referral to Treatment Times will also be a challenge to achieve through 2019/20. He confirmed that the Executive team continue to review risks and to ensure that grip and control measures are being implemented.

The Director of Human Resources & Organisational Development advised that the key workforce remodel and productivity workstream was reliant on attracting and retaining staff to enable agency use to be reduced. She confirmed that there are plans to mitigate the risk and confirmed that this included a second campaign to recruit circa 76 overseas nurses.

The Chief Executive noted that from the details of finance in 2018/19 that agency costs have been significant. She stressed that the key factors is safety and that there are nationally 33,000 vacancies the largest number of which are for band 5
staff which also has the highest shortages. The Trust is actively seeking to address this challenge, including through the use of associate nurses and other models.

The Director of Nursing, Midwifery, AHPs & Community Services confirmed that overseas recruitment has had a large impact on vacancies. In addition it is important to ensure that those doing the job are supported to focus on the right tasks for their skills, and this is supported through a twice daily staffing review. She advised that through talking to other organisations, feedback shows that they are all experiencing similar problems and therefore it is important to look at how the Trust can do things differently. By aiming to keep patients in their home environment through looking at different models of care and different staffing models it is anticipated that this will have the required outcome. She also confirmed that discussions are taking place with University Hospital Southampton NHS Foundation Trust to look at staff rotation programme to ensure staff maintain up to date skills by working in a variety of areas.

The Medical Director confirmed that there was good recruitment for doctors, with encouraging consultant levels being seen. He confirmed that there would continue to be locum consultant cover in place but there needed to be a clear level of mid-grade fixed term specialist doctors. He confirmed that the Deanery was supporting us with this process and that in addition alternative sources of recruitment are being explored.

The Chief Executive also advised that there is a national shortage of allied health professionals and that work needs to continue to focus recruitment in this area. She advised that not all countries providing training in these disciplines and therefore overseas recruitment was less of an option for these roles.

In relation to the performance standards and activity levels the Director of Acute Services advised that there were some contract risks but that there were several transformation projects in place to mitigate the risks. These would enable validation of the waiting list and help avoid ‘did not attend’ incidents, including steps to ensure patients were fit for surgery ahead of planned dates to minimise cancellations. She advised that there was a need to ensure that the efforts are made to ensure that specialists are able to have effective use of their time.

The Chief Executive stated that she was keen that patients are not waiting longer than necessary from a patient experience perspective. She advised that there may be changes to the constitutional targets in the coming year which would need to be taken into consideration, and the Director of Acute Services confirmed that the Trust operates a clinical harm review process to ensure that patients can be escalated for treatment where appropriate and that this is an area the teams monitor closely.

Concerning the Trust’s financial position the Director of Finance, Estates and IM&T/Deputy CEO advised that there was an improved CIP position but that the planned CIP of £9m does carry risks but that there is divisional director commitment to achieving the target.

The Director of Mental Health & Learning Disabilities confirmed that within Mental Health & Learning Disabilities there was more engagement across the division than before regarding the financial plan. There are some stretch targets and the teams are working to establish how to achieve these. She also confirmed that transformation support was in place to develop a sustainable plan. This will include sustainable ways of delivering services and workforce roles.
The Chief Executive advised that communication will go via the service leads who will be checking budgets, and owning CIP and stretch targets to ensure that these are achieved. It is important that they feel empowered to do this rather than to have it imposed on them. She also stressed the need to ensure that if there is an increase in activities within the community that there is clear sight of where the money is goes.

The Director of Acute Services advised that there are transformation projects in place to look at digital solutions, theatre productivity, pre-assessments to ensure effective use of resources, alternative roles within nursing, associate roles and alternative ways to deliver services. She confirmed that there is clinical engagement with operational leads owning and articulating their plans.

The Director of Integrated Urgent & Emergency Care advised that the biggest risks within his division are within the emergency department and medical assessment unit where there is a gap in Band 5 staff. He confirmed that a review will take place to look at new roles which will enable the reduction of agency costs. He confirmed that this work is also being linked with primary care to ensure alignment. He advised that there is the potential to offer unique employment opportunities on the island which will be highlighted during recruitment campaigns, and that the team are owning and controlling their budgets and are tracking all lines to ensure effective and efficient services.

The Director of Finance, Estates and IM&T/Deputy CEO confirmed that considerable discussion has taken place outside the Board meetings over the previous few weeks and that this plan is the outcome.

Caroline Spicer, Chair of the Performance Committee, advised that the Committee was assured by the detailed work undertaken at divisional level on plans and that there is evidence that they are owning the risks. The key risk identified was within workforce and it was noted that there was more work to be done to review the workforce skills mix and that this needs to be undertaken at pace. The Committee also noted that there were some changes as to how risks are managed, and identifying the trigger points to ensure better risk management.

The Director of Finance, Estates and IM&T/Deputy CEO summarised that the Trust had worked hard to get to this point which represents significant progress for the organisation; there is ownership of the plans with risk mitigations in place, the governance process to monitor the plan is in development which the Financial Improvement Director will be providing support on.

The Chair congratulated the team on the plan and noted that there had been considerable progress from the previous year.

**Resolution**

The Chair requested that the Operating Plan 2019/20 be Approved. The motion was carried unanimously, with no abstentions. It was confirmed that the Operating Plan 2019/20 would be submitted.

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The Chair advised that this is a summary report of the report which had been presented to the Quality Committee the day before.

The Director of Quality Governance presented the report which was taken as read. She highlighted the following:

a) **Duty of Candour**: She explained that this is a statutory requirement which is
applied to all incidents reported as having caused moderate harm or above. She confirmed that staff are currently reporting on the potential for harm as opposed to acknowledging when incidents had actually been near misses or caused no harm. This is affecting the report data. Data validation has taken place to ensure that these are correct and this is being shared with staff to improve future reporting.

b) **Weekly Safety Summit:** This has been introduced and will be reviewing all reported incidents and any inappropriate ratings will be challenged to ensure the Trust is consistent with its approach.

c) **Serious Incident Oversight Group:** The remit of this group is to review the serious incident investigations at the mid-point to ensure they remain on track and reduce the potential for matters being referred back which can result in a delay in closing the investigation. Additional training and support is being provided to educate staff.

d) **Never Event:** She advised that an incident has occurred which was required to be reported as a never event. She confirmed that incident related to the unintentional connection of a patient requiring oxygen to an airflow meter. Whilst the patient did not come to any harm, it is still essential that the Trust reports and learns from events such as these. A full review of all safety alerts has been commissioned with the aim of preventing any further never events and providing assurance to the Board that the Trust has appropriate mechanisms in place to enact lessons learnt from national safety alerts. She further advised that this particular case related to a national issue which was proving difficult to resolve, and that this was an opportunity to ensure all safety reports are compliant. This will be included in future reporting.

e) **Patient Survey:** A survey of in-patient areas has taken place and an action plan is being developed which will be included in the report for the next Board.

f) **Quality Account:** This is in development and will be reviewed on 24 May. She confirmed that stakeholder feedback would be included prior to release. The proposed priorities are:

- Safe: Using information to support delivery of clinical quality priorities
- Effective: Right person, right place, right time
- Experience: Dementia Pathway

She confirmed that these had been taken to the Islandwide quality meeting where it was agreed that this is an Islandwide issue which should be promoted in the same way as end of life care has been.

Tim Peachey, Chair of the Quality Committee, advised that there were no further issues to be raised from the Quality Committee.

**Resolution**

The Isle of Wight NHS Trust Board received the Quality Performance Report.
The Director of Acute Services presented the report which was taken as read. She highlighted the following:

a) **62 Day Cancer:** All cancer targets had been achieved with the exception of the 62 Day target. She advised that the January reported positioning of 76% had been validated at 80.1%. February is reporting as ahead of forecast but the key element of the backlog is the number of patients waiting over 52 days. This has reduced from over 100 to 64 which demonstrates that the recovery plan is working.

b) **52 week breach:** There was one incident which occurred within urology and this was due to patient choice. She confirmed that no harm had occurred as a result of the delay.

c) **Diagnostics:** Performance has dropped but a recovery plan is in place. The plan has been implemented which has seen an improved position in March and is forecast to be compliant by May.

d) **System Factors:** She advised that for super stranded patients (over 21 days in-patient) and stranded patients (over 7 days in-patient) have reduced.

e) **Appraisals:** The forecast for the end of year is 80% which is a much improved position.

f) **Mandatory Training:** This currently is at 86%.

The Chief Executive noted that the summary diagnostic for theatre efficiencies was showing a positive trend. The Director of Acute Services confirmed that the team are developing a business case to ensure the greatest opportunities for the existing resources are realised.

**Resolution**

The Isle of Wight NHS Trust Board received the Acute Performance Report.

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INTEGRATED URGENT & EMERGENCY CARE

The Director of Integrated Urgent & Emergency Care (IUEC) presented the report and highlighted the following:

**Emergency Department & Medical Assessment Unit:**

a) **CQC Section 29A:** The action plan is in place to address the issues raised by the CQC and there is evidence of progress which is good for patients. Daily staffing levels are now clear and displayed within the areas, which enable staff to be able to identity lines of escalation/treatment. Any shortfall in staffing levels is escalated at the safety round to be addressed as required.

b) **Same Day Emergency Care Unit:** Ambulance teams are able to review, treat and return patients to their home environment without the need to be admitted which supports patients to be cared for in the best possible location.

c) **Serious Incident:** He identified that during a recent upgrade to the software used in the department there had been an issue with data access and reporting which had been raised as a serious incident for review, however he confirmed that no patient harm has occurred as a result of this.
Ambulance:

d) **National Ambulance Resilience Unit (NARU):** Confirmation of the agreed contract variations is still awaited.

e) **Computer Aided Dispatch System (CAD):** A power outage has occurred within the South Central Ambulance Services (SCAS) CAD system which has resulted in some of the local data being corrupted. He confirmed that there are no indications that performance has been affected in terms of patient care, and that the issue had been identified and corrected within the month.

The Chief Executive asked for an update on the plans for the emergency department. The Director of Integrated Urgent & Emergency Care outlined that a dedicated paediatric area with its own reception and waiting area was planned which would allow separation from the adult areas. He also advised that an area dedicated to patients with frailty was planned to ensure that they have a full wrap around treatment to enable them to return to their home environment rather than admitting them.

Sara Weech queried when this work would be completed. The Director of Integrated Urgent & Emergency Care advised that it would by maximum of 18 months which included provision for slippage.

Phil Berrington queried given that there were 500 incidents within the CAD corruption, has a root cause analysis been undertaken. The Director of Integrated Urgent & Emergency Care confirmed that this had been completed but that the resulting report was of a highly technical nature.

Caroline Spicer, Chair of the Performance Committee, confirmed that this report had been discussed at the meeting yesterday. She queried what assurance was there that the recent incident within CAD would not reoccur. The Director of Integrated Urgent & Emergency Care advised that the software company had altered the system and separated the geo-zones for patients from 111. SCAS have been requested to provide a final report with all testing details.

Tim Peachey requested that a full suite of data be provided with this report. The Director of Integrated Urgent & Emergency Care confirmed that a data pack for ambulance is seen at the Performance Committee and that a similar data pack for the emergency department and medical assessment units is being prepared.

**Action**

Data pack to be included in future IU&EC reports for both ED/MAU & Ambulance.

**Resolution**

The Isle of Wight NHS Trust Board received the Integrated Urgent & Emergency Care Performance Report.

**19/T/070 COMMUNITY SERVICES**

The Director of Nursing, Midwifery, AHPs & Community Services introduced the report and highlighted the following:

a) **IT Interface within Community:** She advised that the Systm One programme remains a challenge.
b) **Community Nurses/Therapists:** The leadership team are working with the individual service teams to challenge the thoughts and processes to enable a more effective service to be provided for both staff and patients.

c) **Mandatory Training:** Levels of compliance continue to rise across the division with NEWS2 (Early Warning System) being compliant.

d) **10 Week Improvement Plans:** These are in progress with an additional two week reflective period to assess effectiveness. The teams are very positive and enthusiastic about these programmes and are owning the process.

e) **Celebration:** The Division celebrated the nomination of Andrea Bevan from the 0-19 team to the Health Services Journal ‘Health Visitor of the Year’ awards. Andrea was shortlisted and was recognised as receiving second place in this National Awards.

f) **Medical cover for community beds:** The CCG have now commissioned this service from the Trust and cover is now in place.

Anne Stoneham queried if there was any progress against the community caseloads. The Director of Nursing, Midwifery, AHPs & Community Services confirmed that a review of the district nurse caseloads and referrals to the service is being undertaken with primary care to ensure that these are appropriate. She stressed that there is a difference between the caseload total and active caseloads and this needed to be clarified also.

Sara Weech noted that there was a KPI for recruitment and queried who this related to. The Director of Human Resources & Organisational Development confirmed that this is an indicator for HR staff.

Sara Weech also noted that there was good news regarding the waiting times and that through the well led programme working with other teams has been a positive development. The Director of Integrated Urgent & Emergency Care highlighted that an example of working across divisions was shown with telemedicine.

The Chief Executive noted the positive improvements.

The Chair highlighted that Andrea Bevan had been nominated for a national award and this reflected the wide range of initiatives she has been instrumental in supporting. The Board extended its congratulations.

**Resolution**

The Isle of Wight NHS Trust Board received the Community Performance Report.

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<th>19/T/071</th>
<th>MENTAL HEALTH &amp; LEARNING DISABILITIES SERVICES</th>
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<td></td>
<td>The Director of Mental Health &amp; Learning Disabilities (MHLD) presented the report and highlighted the following:</td>
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<tr>
<td>a)</td>
<td><strong>Community Child &amp; Adolescent Mental Health Services:</strong> She advised that the CCG had provided additional funds to allow the service to run from 8am to 8pm Monday to Friday and Saturday morning.</td>
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<td>b)</td>
<td><strong>Volunteer Mental Health Team:</strong> She reported that the team are very active and undertaking lots of work with the division. It has been agreed at the Mental Health &amp; Learning Disabilities Divisional Board to develop a peer</td>
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worker strategy which will include the recruitment of substantive peer workers.

c) **Shackleton Ward:** She advised that the refurbishment of the area was due to commence on 8 April and confirmed that the remaining patient will be transferred prior to this. The ward is due to reopen in June and during the refurbishment staff will be supporting their colleagues and gaining experience in other wards delivering dementia care. They will also be undertaking training and team development.

d) **Community Mental Health:** The Well Being service now is helping 70 individuals through the programme. The procurement process for a third party partner will commence in May.

e) **Workforce:** She reported that there remain some challenges and the team are continuing to work towards recruitment of mental health staff.

f) **Sickness:** This remains high at 7%. However, support is being provided by both HR and Occupational Health who are working with the team managers to support their staff and manage sickness.

**Resolution**

The Isle of Wight NHS Trust Board received the Mental Health & Learning Disabilities Services Performance Report.

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19/T/072  WORKFORCE PERFORMANCE REPORT

The Director of Human Resources and Organisational Development presented the report and highlighted the following:

a) **Leadership Conference:** She confirmed that this had been a successful day at which the focus was on leadership and culture.

b) **Culture & Development:** The annual staff survey has been completed and there are indications of progress in some areas. She advised that the scores are disappointing but this was anticipated given the point in the journey to good that the Trust is on. She confirmed that the action plan is in development but stressed that the survey is a ‘point in time’ reflection which was undertaken between October and December 2018. The more current measures are seen through the monthly pulse check surveys which are showing positive improvements.

c) **Vacancies:** The current gap is at 11.5% which has meant that the Trust is heavily reliant on temporary staff. There has been an increase in usage in month but costs have reduced.

d) **Sickness Absence:** Trust wide this has increase in month although stress/anxiety/depression cases have reduced. The team are working hard to reduce these levels by supporting staff to return to work and through preventative measures across the organisation.

e) **Appraisals:** Compliance was at 75.8% at the end of February. Good progress has been made with some areas achieving their targets and a plan is in place to improve this further for 2019/20.
f) **Mandatory Training:** Compliance with the annual target of 85% was achieved at the end of February. A number of services have achieved 90%, and those who remain below this level are being actively monitored.

The Chief Executive advised that at the Leadership Conference the March data for the pulse checks had showing an overall improvement. She confirmed that it was beneficial to have real time data and the pulse checks would continue.

Caroline Spicer queried what the response rate was for the pulse checks. The Director of Human Resources and Organisational Development advised that it was currently around 10%. The Chief Executive confirmed that the team are working with the Communications team to improve this level. Work is also underway with the volunteers to promote the checks and the divisional boards will be reviewing the returns.

Anne Stoneham noted that the trend was improving but noted that there was a weakness in the way this is communicated with staff and challenge should be made to assess how information is shared and how staff are encouraged to engage. The Chief Executive confirmed that an Associate Director of Communications would be joining the Trust in May.

The Chair advised that he had spoken with the new Deputy Chief Inspector of Hospitals who had commented that when he reviews self-assessments from Trusts who go on to be rated as outstanding their people shine through the narrative of how they operate, and the emphasis they place on people being at the core of their business is clear for all to see.

Phil Berrington queried if the outcome of the survey is fed back to the divisional boards given the low percentile of returns to certain questions. The Director of Human Resources and Organisational Development confirmed that the detail will go to the divisional boards who would work with staff thought workshops to gain fuller details on the responses. She advised that the national survey was only undertaken on an annual basis.

The Chief Executive advised that given the position the Trust is in within its journey out of special measures, that this is a predictable position. She stressed that it takes time to see changes and that the journey is on average 1-4 years. Much of the work undertaken in years 1 and 2 will not result in an impact on the metrics until years 3 and 4, however it is important to maintain progress and continue with the plans. The pulse checks provide feedback on what staff are saying on a monthly basis. She confirmed that the Trust is aspiring to reach ‘requires improvement’ for the year ahead as part of our journey to good and that she is keen for staff to speak up and have faith.

**Resolution**

The Isle of Wight NHS Trust Board received the Workforce & Organisational Development Performance Report.

### 19/T/073 FINANCIAL PERFORMANCE REPORT

The Director of Finance, Estates and IM&T & Deputy CEO presented the report and advised that there is assurance on the delivery of the year-end target.

a) **Year End Target:** He advised that month 11 – February was on target and it is expected that month 12 will hit the revised target. There are some risks which are predicated on aspects of low achievement in clinical areas and over achievement in corporate areas. He confirmed that all the Directors are committed to delivering the plan. In relation to the control totals, Acute and Emergency
Department are under performing which is down to pressures but these are being managed. Internal and external measures to reach target have been discussed with the CCG and NHSI. He confirmed that support was being provided by NHSI.

b) **CIP:** The Trust is on track to deliver £7m against its plan.

c) **Capital Investment:** It is expected that all monies will be spent with a programme of work including estates, equipment and IT.

d) **Cash:** He confirmed that borrowing has been enabled and he confirmed that the approach of prioritising payments to local suppliers is in place.

Caroline Spicer, Chair of the Performance Committee, confirmed that the Committee were reasonably assured that the Trust would reach its year end targets and that there are detailed line by line financial reviews taking place. The Director of Finance, Estates and IM&T & Deputy CEO has provided assurance that the variables are manageable.

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

**COMMITTEE ASSURANCE & GOVERNANCE**

**19/T/074 FREEDOM TO SPEAK UP GUARDIAN REPORT & BOARD ASSESSMENT**
The Freedom to Speak Up Guardian presented the report which included a summary of activity for Quarters 2 and 3.

She outlined the concerns which had been received over the period and confirmed that this largest number of concerns had been raised by administrative staff. A range of measures were launched during National Anti-Bullying week to support staff.

She advised that benchmarking against similar sized trusts show that the Trust has seen a significant rise in concerns. She advised that benchmarking is difficult given that the Trust is the only combined organisation and the benchmarking cohort lacks ambulance and mental health data. This issue is also reflected in the staff survey data where community is difficult to benchmark against.

She confirmed that staff are able to report their concerns through a range of forums and this is shown in the results.

The Freedom to Speak Up Guardian advised that the behaviours framework is being rolled out and additional advocates are being recruited. Her dedicated hours for freedom to speak up have increased which will be of benefit. The Raising Concerns/Whistle Blowing Policy was refreshed in January and she confirmed that she is the joint lead for culture and leadership. Next steps include working to increase staff confidence to speak up, an information card detailing how to raise concerns, the branding of the grievance policy, human factors training. She will also be going out and about to experience staff working in areas to better understand the issues which concern them.

Dennis Ford, Patient Council, noted that there was no reference to the action being taken against the perpetrators. The Freedom to Speak Up Guardian advised that it depended on the wishes of the individual raising the concern, the level of support they wish to have, and the issues being raised, but that there are a range of options which can be implemented if required.
Caroline Spicer noted that within the concerns there is a significant difference in the levels of concerns raised across the three criteria with low levels in patient safety. She queried is this due to the mix of staff raising the concerns and if there is enough support in place. The Freedom to Speak Up Guardian advised that similar data is being seen in other regions. Some staff are reporting via DATIX or to their matrons and this needs to be reviewed.

Sara Weech queried if there has been an increase in reporting and what will be done to address this. The Freedom to Speak Up Guardian confirmed that this was being considered and would be included in the next report.

Sara Weech queried how the Board would be sighted on the issues raised by the FY2 Doctors to the General Medical Council. The Freedom to Speak Up Guardian advised that there is a junior doctors forum which meets monthly which she attends and there is also an advocate who is a junior doctor, therefore the Trust can receive increased assurance that there is a clear route for issues to be identified and addressed.

The Chief Executive confirmed that there is evidence of listening to junior doctors. By enabling them to meet and review patients in place with their support system provides powerful evidence that they are taken seriously. She highlighted that there is no other Trust in the UK which has all four services, and that the Trust needs to submit all services for benchmarking. When reviewed separately by division and then brought together the data shows that there is similarity across the benchmarking. Consideration is being given to reviewing the current approach in the Grievance Policy to ensure that the approach is constructive for all those involved. She confirmed that both the Freedom to Speak Up Guardian and her team are involved in dealing with sensitive issues in addition to their day jobs and she thanked her for all the work and support she provides.

The Chair stressed the need for staff to be able to access the Freedom to Speak Up team and to ensure that this is part of the approach to supporting staff to return to work. He recognised that although there is a desire from the Board to know further details regarding the issues that have been identified and incidents of poor behaviour, we must respect the need for privacy at times of those involved. There is a challenge for the Board in balancing the confidentiality of those who raise concerns and the desire to see details of how the Trust is addressing these challenges – we can be assured that the Freedom to Speak Up process is operating well and staff can feel confident the Trust will address concerns appropriately.

The Board Secretary confirmed that the Board assessment which is included in the papers for information and that this would be taken forward.

19/T/075 QUALITY COMMITTEE

Dr Tim Peachey, Chair of the Quality Committee, advised that following the meeting on 3 April 2019, and in addition to the items mentioned elsewhere in the meeting, the following areas were of note:

a) Patient Safety Sub Committee: The Committee were advised that there has been a refresh of the sub-committee to ensure that it focuses on clinical issues. The revised terms of reference were approved and the Committee is looking forward to seeing progress.

b) Clinical Audit Plan: The Committee were advised that as a small organisation it is difficult to achieve all the national surveys where they are
required to be undertaken by nurse specialists. The Committee were advised that the Trust had completed 77 out of 79 national surveys. The outstanding ones relate to the Heart Failure Audit and IBD Registry.

c) **GMC Report:** The Committee received an update on the last GMC visit which was extremely encouraging. No cases of bullying were reported, and the feedback on the Hospital @ Night programme is very positive. In addition it was confirmed that supervision of F2 doctors by a medical registrar when surgical team are no longer on site has been implemented.

d) **Stroke Sentinel National Audit Programme (SSNAP):** A very good presentation on the audit was given which provided details of where improvements can be made as well as areas of good practice. The key quality indicators were highlighted and the work which is in place to address any areas of concern.

e) **Quality Dashboard:** This issue of access to timely data was raised and has been discussed at Board Seminar earlier in the day.

f) **Quality Account 2018/19:** The Committee were advised that preparation of the report was in hand and on track. Submission to stakeholders for their feedback will be undertaken.

**Resolution**
The Isle of Wight NHS Trust Board received the Chair’s Report from the Quality Committee.

19/T/076 **ASSURANCE RISK & COMPLIANCE COMMITTEE**

Anne Stoneham, Chair of the Assurance Risk & Compliance Committee, advised that following the meeting on 3 April 2019, and in addition to the items mentioned elsewhere in the meeting, the following areas were of note:

a) **Information Management:** The Committee expressed their disappointment that the position across Information Services had not moved at the desired pace but were pleased to hear that interim support is now in place. It is keen to recommend work to support the digitisation funding bids prioritised and for the development of a Chief Information Officer (CIO) role to be progressed as soon as possible, and supported the proposed scope of work. They recommended that this be monitored through Performance Committee and discuss at the next ARCC.

b) **Regulatory Actions:** The Committee considered the level of progress achieved against each area of the regulatory actions in place for the Trust and heard detailed updates around the mechanisms that are used to support progress to move at pace. A number of regulatory actions that remain overdue will be escalated to the Board in April; this includes the actions relating to information management which will be addressed through the plan detailed above. It was recommended that this be considered further by the Board.

c) **Undertakings:** It was confirmed that the Committee supported the position that the Trust had made sufficient progress on the undertakings and that
discussions will be undertaken with our regulators about this following the CQC inspection which is anticipated for summer this year.

d) **Board Assurance Framework (BAF):** The Committee supported the revised risk score for the risk of failing to achieve and maintain regulatory compliance and supported the work undertaken on the BAF which will come to Board for approval in May. The Committee proposed a half year in-depth review for 2019/20.

e) **Corporate Risk Register:** An update on the Trusts corporate risk register showed progress in evidencing that the organisation is owning and addressing the risks it faces in a more robust way, with some issues on consistency of scoring noted for further development.

f) **Risk Strategy:** The progress the Trust has made in delivering its Risk Management Strategy was noted and milestones for 2019/20 were agreed.

g) **Emergency Preparedness, Resilience & Response (EPRR):** The Committee heard that there had been progress in many areas but was not able to take full assurance on the current position due to the challenges with training engagement at this stage.

h) **Information Governance:** The Committee were disappointed to hear that insufficient progress had been achieved on information governance compliance.

The Chair of the Committee expressed concern that the Trust would not reach compliance within Information Management and that recruitment to the post of Chief Information Officer be escalated. The Chief Executive advised that this post is not within the current plan, and that a range of options are being explored as this is a necessary post. The Executive Directors will be discussing how to progress recruitment.

Anne Stoneham gave an overview of the current position with regard to regulatory compliance and stressed that progress was being made with a number of actions only just missing the required compliance level.

**Resolution**
The Isle of Wight NHS Trust Board received the Chair’s Report from the Assurance Risk & Compliance Committee.

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<td>Caroline Spicer, Chair of the Performance Committee, advised that following the meeting on 3 April 2019, and in addition to the items mentioned elsewhere in the meeting, the following areas were of note:</td>
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a) **Information Governance:** The Committee was disappointed that the Trust had not meet the IG toolkit target and that it was awaiting a plan for addressing these issues with an updated expected for the next meeting.

b) **Information Services:** The Committee reviewed an interim report on work currently being undertaken and an outcome report will be provided in June.
c) **Operating Plan:** The Committee reviewed the report and recommended that the capital plan be reviewed to ensure that the Trust is getting the best value for each plan in terms of what benefits the plan will deliver and if not that the capital plan is amended. The Committee requested a review to take place in April to look at alternative ways in which funding could be spent.

**Resolution**
The Isle of Wight NHS Trust Board received the Chair’s Report from the Performance Committee.

**CLOSING MATTERS**

**19/T/078 CHAIRS CLOSING COMMENTS AND ISSUES TO BE COVERED IN PRIVATE**
The Chair advised that the following items would be covered in a private meeting of the Board:
- Employee relations
- Quality report – additional information
- Confidential commercial and operational matters

**19/T/079 QUESTIONS FROM THE PUBLIC**
The following questions were received for the Board to consider:

**Question 1:** The IW NHS Trust CEO in her report acknowledges the hospital is seeing an ‘increasing number of patients’, this is set to rise significantly if the planned expansion of housing on the IW goes ahead, which could result in up to a 10% increase in the island’s population. How is the Trust and NHSI preparing to meet this imminent reality with adequate hospital provision here on the island?

*Response:* The Island wide Sustainability Plan, under development between the Trust, CCG and Council, provides a clear assessment of the expected levels of demand over the coming years and proposes a way forward for the public sector locally to address the collective challenges that we face. An overview has been provided through previous Board meetings with details available on our website and a comprehensive approach will be shared at each of the partners meetings in public in May with an engagement plan to seek feedback from our community. We are also working closely with NHSI in developing our operating plan for the coming 12 months and further ahead.

**Question 2:** Given the IW NHS Trust Board has now been placed into Financial Special Measures, with the remit of NHSI to bring the Trust’s deficit under sustainable control, how will the Trust’s NHSI team ensure a further squeeze on funding will not detrimentally impact on services and embroil the Trust and NHS in significantly increased levels of costly patient litigation as the quality of patient care declines?

*Response:* The Trust has a comprehensive approach to Quality Impact Assessments which ensures that a team of senior individuals review all schemes that involve service changes ahead of their implementation to review the potential impacts. The Chief Executive, supported by the Board, have publicly stated our commitment to delivering safe services above all else. The Board receive details of claims and litigations on a regular basis along with overviews of information on complaints, incidents and patient feedback to ensure we can triangulate the experiences of those we are here to support.

**Question 3:** Given the increasing number of events where the IW NHS Trust has had to regretfully publicly declare, ‘lessons have been learned’, will the Trust be seeking to introduce a ‘Get it right first time’ culture? If the answer to the first
question is affirmative, then how does the Trust Board propose introducing a GRIFT culture?

Response: The Trust is working closely with the national Getting it Right First Time (GIRFT) programme and received a comprehensive update earlier today from our staff working with them to embed the approach we can take.

The reporting culture within the Trust has improved considerably over the last eighteen months with increases in staff raising details of incidents and near misses, and our Pulse staff surveys show an increased awareness of how to report matters – both of which we see as positive steps to ensure that we can continue to learn. Other industries – in particular the airline and nuclear industries – have learned the importance of developing a learning culture and not a blame culture if safety is to be improved and that is the approach we are committed to delivering.

The Chair invited the member of the public who had submitted the questions above to clarify any aspects of the response which remained unclear. A member of the public asked for clarity on the outcome of the CQC visit to the emergency department. The Executive Directors responded detailing that the visit was undertaken over a short 8 hour period and provided clarity on the outcome and measures taken at the time.

The Chair advised that the department had received four inspections in four days from NHSI both national and regional, paediatrics and the CQC. The Trust had received three very complementary report where no concerns were raised. He acknowledged that the CQC were right to raise the concerns and the Board taken them very seriously. However, it should be noted that the general trend does demonstrate improvements and the Trust is keen to address issues as they are identified.

19/T/080 ISSUES RAISE BY OBSERVERS

a) Patient Council: Dennis Ford noted that within Mental Health & Learning Disability he believed there was an increase in referrals for young people and advised that he had, through his position on education panels, noted that young people are not being assessed. The Chair suggested that this issued be taken up by the Director of Mental Health & Learning Disabilities after the meeting.

b) IW Council: Cllr Nicholson highlighted the measurement and monitoring of equality and diversity issues within the reporting could be demonstrated. The Director of Human Resources & Organisational Development confirmed that the team are focusing on greater visibility in this area and that it would be included within the workforce report.

c) Healthwatch: No Issues

d) Staffside: No Issues

19/T/081 ANY OTHER BUSINESS

There was no other business.

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 on Thursday 2 May 2019. The venue for this meeting will be the Conference Room – Level B Main Hospital – opposite Full Circle Restaurant, St Mary’s Hospital, Newport, IW PO30 5TG
The meeting closed at 4.30pm

Signed………………………………….Chair   Vaughan Thomas
Date:
### Board & Board Committee

**ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES**

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<th>Name of Meeting</th>
<th>Date of Meeting</th>
<th>Minute No.</th>
<th>Action No.</th>
<th>Item</th>
<th>Action</th>
<th>Exec Lead</th>
<th>Update &amp; Evidence of Completion</th>
<th>Due Date</th>
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<tr>
<td>Board in Public</td>
<td>06-Mar-19</td>
<td>19/T/047</td>
<td>TB/359</td>
<td>Mortality &amp; Learning from Deaths</td>
<td>A further update on mortality and learning from deaths to be scheduled as a Board seminar topic.</td>
<td>Claire Budden</td>
<td>28/03/19 - To be undertaken ahead of the September report</td>
<td>05-Sep-19</td>
<td>05-Sep-19</td>
<td>Action Progressing</td>
<td>24-Apr-19</td>
</tr>
<tr>
<td>Board in Public</td>
<td>04-Apr-19</td>
<td>19/T/069</td>
<td>TB/362</td>
<td>IUEC Reports</td>
<td>Data pack to be included in future IUEC reports for both ED/MAU &amp; Ambulance</td>
<td>Tim Lynch</td>
<td>24/04/19 - Data packs now included in reports. Action close</td>
<td>02-May-19</td>
<td>02-May-19</td>
<td>Action complete</td>
<td>24-Apr-19</td>
</tr>
</tbody>
</table>
Agenda Item No | 7 | Meeting | Trust Board In Public | Meeting Date | 2 May 2019
Title | Chair Report
Sponsoring Executive Director | Vaughan Thomas, Chair
Author(s) | Vaughan Thomas, Chair
Report previously considered by inc date | N/A
Purpose of the report
Information only | | Assurance |
Review and discuss | X | Agreement |
Trust Board Approval is required
Reason for submission to Trust Board in Private only (please indicate below)
Commercial Confidentiality | | Staff Confidentiality |
Patient Confidentiality | | Other Exceptional Circumstance |
Link to Trust Strategic Objectives
Provide safe, effective, caring and responsive services – ‘Good’ by 2020 | X |
Ensure efficient use of resources | X |
Achieve NHS constitutional patient access standards | X |
Achieve excellence in employment, education and development | X |
Lead strategic change on the Isle of Wight | X |
Link to CQC Domains
Effective | X | Responsive |
Caring | X | Well-led |
Safe | X |
Executive Summary
During the month, I have conducted and participated in meetings with, advisors, stakeholders, staff, and partners of the Trust. These have included:

- Meetings with partner organisations including:
  - Call with Lena Samuels, South Central Ambulance NHS Trust, 2 April 2019
  - Care in the Garden Project, 24 April 2019
  - IW Leadership Forum, 30 April 2019

- Meetings with Individuals including trust executives and
  - Non-Executive Directors Private Meeting, 4 April 2019
  - Alice Webster, Director of Nursing 3 April 2019
  - Medicine for Members Meeting, 23 April 2019
  - Mental Health Act Review Meeting, 26 April 2019

Key Recommendation
The Board is recommended to receive the report.
<table>
<thead>
<tr>
<th>Agenda Item No</th>
<th>Meeting</th>
<th>Trust Board in Public</th>
<th>Meeting Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td></td>
<td>Trust Board in Public</td>
<td>2 May 2019</td>
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</tbody>
</table>

**Title**
Chief Executive Report

**Sponsoring Executive Director**
Maggie Oldham, Chief Executive

**Author(s)**
Maggie Oldham, Chief Executive

**Report previously considered by inc date**
n/a

**Purpose of the report**
Information only | Assurance  
Review and discuss | x | Agreement  
Trust Board Approval is required

**Reason for submission to Trust Board in Private only (please indicate below)**
Commercial Confidentiality | Staff Confidentiality  
Patient Confidentiality | Other Exceptional Circumstance

**Link to Trust Strategic Objectives**
Provide safe, effective, caring and responsive services – ‘Good’ by 2020 | x  
Ensure efficient use of resources | x  
Achieve NHS constitutional patient access standards | x  
Achieve excellence in employment, education and development | x  
Lead strategic change on the Isle of Wight | x

**Link to CQC Domains**
Effective | x | Responsive | x  
Caring | x | Well-led | x  
Safe | x

**Executive Summary**
Key highlights for the Board’s consideration

**Key Recommendation**
The Trust Board is asked to consider the report

**Level of Assurance**
This report is intended to provide the Committee with the following level of assurance:

<table>
<thead>
<tr>
<th>Substantial Assurance</th>
<th>Limited Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Assurance</td>
<td>Negative Assurance</td>
</tr>
</tbody>
</table>
May Trust Board Meeting, Chief Executive’s Report

Major Incident

The Trust declared a Major Incident this month following tragic road traffic accident involving a bus and two cars resulting in a large number of casualties, one of whom was Eve Copland, a member of Trust staff who very sadly died. We can take huge pride in how the Trust responded alongside emergency service partners. The Trust, police, fire service, air ambulances, council and mainland trauma centres were all involved and staff from across the organisation were involved and many who were off duty came in to help. Our Major Incident Plan whilst focused on ensuring our Ambulance and Emergency Department teams can effectively deploy to manage the incident actually involves a whole organisation response that worked very well.

We are a learning organisation we follow best practice in learning from our experience. Every major incident is significant and unique and we have put in place follow up reviews to ensure staff have the opportunity to share their experiences, and we can identify new learning to incorporate into our response to future incidents. I have spoken with Eve Copland’s family and colleagues to express our immense sadness and condolences for her death. Staff have been advised of the support available to them. On behalf of the Board I would like to express my thanks and admiration for everyone involved in responding brilliantly to this tragic and traumatic incident.

CQC Inspection

The CQC have informed us of the date of their next inspection, which will be in May and June 2019 looking at all aspects of the Trust and assessing improvements against their last inspection’s findings. The dates are as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Inspection Focus</th>
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<tbody>
<tr>
<td>13th May</td>
<td>Mental Health &amp; Learning Disabilities</td>
</tr>
<tr>
<td>14th – 16th May</td>
<td>Community Adults &amp; Children Ambulance (All areas)</td>
</tr>
<tr>
<td>21st – 23rd May</td>
<td>Acute Services</td>
</tr>
<tr>
<td>18th – 20th June</td>
<td>Well Led</td>
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</table>

For the Trust, the inspection will provide an important opportunity to demonstrate the improvements we have made, the high standards we keep, and our unrelenting focus safety, quality and patient experience. I am also clear that it is important that we also demonstrate we understand where we need to improve further and our Getting to Good journey to deliver outstanding care and services which are effective, sustainable and compassionate.

CARE – our new Trust vision and values

We launched our new vision and values CARE last month which marks an important milestone on our Getting to Good programme of improvement. The vision and values represent the ideas, experience, knowledge and contributions of our staff and patients who were involved in many different ways in developing them. We will be equally relentless in both promoting our values and living and working by them. They will only mean something and be effective if they are part of everyone’s behavior and
Isle of Wight Health and Care Sustainability Plan – a partnership between the Isle of Wight NHS Trust, Council and NHS Clinical Commissioning Group

The publication of the NHS Long Term Plan earlier this year highlights the increasing nationwide drive to improve the integration of all aspects of care – health, social care, primary care and the voluntary sector - for the benefit of local people.

As part of this national drive the Isle of Wight Sustainability Plan has been developed by the Isle of Wight NHS Trust, Council and NHS Clinical Commissioning Group and sets-out the challenges in delivering health and care on the Isle of Wight over the next 3 years and identifies the priorities for meeting these challenges. The three organisations have come together as the Isle of Wight Local Care Board to work and plan together to ensure the integrated development and delivery of health and care services on the Isle of Wight. We will set out the changes needed to deliver this programme, in terms of how services can best be organised and provided, so that the overall intention, to deliver high quality care in a sustainable way, ensures that our population needs are met.

We are pleased to see that the NHS Long Term Plan reinforces and develops many of the priorities already identified locally, including developing strategies to deliver more care out of hospital, closer to home and with an emphasis on prevention.

Aims of System
The system is working together to improve services to support people to lead healthier
lives and to be able to access the right care at the right time and in the right place. We are undertaking a number of larger scale programmes of work focusing on the key elements of the Long-Term Plan and the Sustainability Plan such as prevention, social care, care closer to home, mental health, digital improvements and workforce recruitment and retention.

**The system’s vision**
People will live healthy and independent lives.

**Isle of Wight Sustainability Plan**
As part of the development of the Sustainability Plan, a review completed by the Local Care Board recognises the valuable feedback already received from our local community over the past few years. This includes the work undertaken on the new model of care for the Island, the strategy for primary care, the work undertaken on the redesign of both acute and community services and the vision for social care. We have greatly appreciated the involvement of Island residents during that time and we recognise it is important to continue the dialogue as things move forward – a commitment all organisations share.

We have also been gathering the views of current leaders and senior staff across the system on the current position and operational environment. This was supported by care strategy experts Carnall Farrar who are funded by NHS England.

The Isle of Wight Sustainability Plan sets-out the challenges in delivering health and care on the Isle of Wight over the next 3 years and identifies the priorities for meeting these challenges. This will set out the changes needed to deliver this programme, in terms of how services can best be organised and provided, so that the overall intention, to deliver high quality care in a sustainable way, so we are able to ensure that our population needs are met.

Our priorities and timescales for change include:

**Phase One 2019**
- Supporting return to home
- Onwards care and independent living
- Trust productivity
- IW Council social care productivity

**Phase Two 2019 to 2020**
- Mental health
- IW System efficiency
- Trust productivity
- CCG Productivity
- IW Council social care productivity

**Phase Three 2020/21 to 2021/22**
- Community supported care
- Acute services
- Networked ambulance
- Trust productivity
One Island – One Public Service

One Public Services (OPS) Mission is to organise services to the public to meet the continuing needs of our island residents so that people are empowered to realise their life opportunities. Through greater collaborative working OPS will continually develop more efficient and effective joined up public services applying a ‘same front door’ approach (whether virtual or real) serviced by all public service organisations; sharing facilities, skills, knowledge and aligned system approaches that are seen as a success and champion of public service delivery for everyone, everywhere.
### Agenda Item No 9

**Meeting** Trust Board in Public  
**Meeting Date** 2 May 2019

**Title** Isle of Wight Health and Care Sustainability Plan

**Sponsoring Executive Director** Maggie Oldham, Chief Executive

**Author(s)** Martin Wakeley – Senior Responsible Officer (SRO) for the plan

**Report previously considered by inc date** n/a

**Purpose of the report**

| Information only | Assurance | X |
| Review and discuss | Agreement | |

**Trust Board Approval is required**

**Reason for submission to Trust Board in Private only (please indicate below)**

| Commercial Confidentiality | Staff Confidentiality |
| Patient Confidentiality | Other Exceptional Circumstance |

**Link to Trust Strategic Objectives**

| Provide safe, effective, caring and responsive services – ‘Good’ by 2020 | X |
| Ensure efficient use of resources | X |
| Achieve NHS constitutional patient access standards | X |
| Achieve excellence in employment, education and development | |
| Lead strategic change on the Isle of Wight | X |

**Link to CQC Domains**

| Effective | X | Responsive | X |
| Caring | X | Well-led | X |
| Safe | X |

**Executive Summary**

The health and social care partners on the IOW have been working collectively since October 2018 to create an overarching plan to ensure that services reflect newly published national guidance in addition to being clinically and financially sustainable. The plan has been created iteratively by all partners and shared with key stakeholders during its development. As the plan moves into implementation it is both desirable and necessary to share the plan with the public and all other stakeholders. The attached document starts the process of communication and engagement by providing a brief overview of the plan and how the system will look to engage and communicate with patients, the public, staff and other stakeholders over the next few years.

The detailed plans for implementation will be created via dialogue with staff and other affected parties over the next few years and therefore it is appropriate that rather than providing prescriptive detail about how change will take place there is more emphasis at this stage about the intended outcomes of the changes and the timescales required.

**Key Recommendation**

The Trust Board is asked to note the attached document and take assurance that there will be a comprehensive communication and engagement process in support of delivering the sustainability plan.
Isle of Wight health and care sustainability plan

2 May 2019
We have a simple vision for the way health and care services on the Island should evolve

- ‘People will live healthy and independent lives’
- To achieve that vision will take time, and it is something we need to do together
- We have a plan to make it happen – it is based on national guidance and local priorities
- Critically, it has also been shaped by the views of local people over the past few years
We are all aware that the current state of health services on the Island is not what we would want them to be

- People tell us that it is difficult to get an appointment with their local GP
- CQC inspectors have revealed their concerns about a number of health services on the Island
- We know that 5% of our local population use one third of our available resources because they have complex needs
- 43% of people who were fit to leave hospital had to wait more than a week to do so
- Mental health services are admitting more people into short-term care than anywhere else in the country
- We face even greater strain during the summer months
There are also a number of organisational issues that we need to address

- The financial challenge is significant - we face a major struggle every year to manage our budgets, increasing our collective deficit
- Recruitment to clinical roles is increasingly a challenge, not just confined to the Island
- Local NHS organisations have faced substantial leadership changes
- Previous plans to redesign services have been slow to implement – lacking a coordinated, consistent case for change
Solving the issues is best done together so we have been reviewing our approach

- Over the past few months we have collectively been reviewing the transformation process we had originally embarked on to take stock
- We recognised that the existing case for change was not comprehensive enough and partially out of date
- We also wanted to take account of new influences, such as the NHS Long Term Plan, which will have an impact on our overall approach
Our review has highlighted some interesting statistics which have also influenced our thinking

• Around 7000 individuals (5% of the Island population) with the most complex needs use 36% of our total resource, which is about £106m
• Compared to peers, less money is spent on community care on the Island in terms of value and a proportion of total spend
• The Trust spends more money on mental health hospital-based services than any other mental health trust in the country – pointing to underprovided community services
• Alongside this, the Trust has the highest rate of mental health admissions for adults and the lowest length of stay in the country
Feedback received during the previous public engagements informed us that:

- Patients wanted better coordinated care
- That we needed to improve mental healthcare services
- That services needed to be retained on island
- That support was required for patients needing to access healthcare off island
- That access to GP services was a concern
The plan we have all signed up to focuses on clinical and financial sustainability for the Island

- It is based on making continuous improvements for our population
- It has ‘one public service’ at its core – the CCG, Trust and Council all working as one
- It will mean we have to make some tough choices, but this will be done in the context of our overall vision
- We will innovate and learn as we improve services so that we can all share the benefit
Our plan will focus on providing care out of hospital in new and innovative ways, with a focus on individual need.

- We want to make care out of hospital more effective, more joined up, more focused on individual need.
- We want to bring primary care and community services together in extended teams, to create the right environment and network of care for each individual patient.
- This supports people to manage the condition(s) they have in a way that prevents crisis and costly hospital admission.
There are also a number of organisational issues that we need to address

- The financial challenge is significant - we face a major struggle every year to manage our budgets, increasing our collective deficit
- Recruitment to clinical roles is increasingly a challenge, not just confined to the Island
- Local NHS organisations have faced substantial leadership changes
- Previous plans to redesign services have been slow to implement – lacking a coordinated, consistent case for change
Length of stay in hospital will be significantly reduced with a far greater emphasis on care out of hospital

- The network teams will look to help prevent hospital admission, or be able to facilitate faster discharge and coordinate the support people need when they leave hospital
- This helps to reduce the resource we need to commit to inpatient hospital care, which is often more expensive
- We’re already working on an intervention programme in the community using extended teams to support people with complex needs
To achieve our ambitions we have created a plan

- Our plan is a whole system plan, supported by the IOW Council, IOW Trust and the IOW CCG
- All decisions will be taken collectively and will be scrutinised independently by the Health and Social Care Overview and Scrutiny Committee
- There is a focus on reducing costs, improving quality and addressing concerns raised previously
- The workplan is ambitious and challenging but phased over a 3-year period
New primary care networks will be at the forefront of delivering change

• The development of primary care networks (where GP practices work together to provide more coordinated care for people across an area) will help forge change, with the intention of wrapping care around the needs of each individual so that hospital stays are only required when absolutely necessary
• Networks will coordinate all aspects of people’s day to day care, including same day/urgent appointments when needed
What can you expect to see change

• We will reduce the reliance on inpatient services for mental health provision
• We will increase the number of permanent clinical staff in the NHS and reduce reliance on temporary staff
• We will invest in community services and keeping patients out of hospital
• There will be even closer integration of health ad social care services and personnel
• We will look to reduce expenditure on non-clinical services
More detail

- We intend to share more detail of our plans and their impact via a series of workshops with staff, interviews with media and drop in sessions with other stakeholders whom have an interest in our plans
- We have already committed to explaining our plans to local people via a series of clinics with local councillors who wish for us to meet with them
- We will be transparent and open in sharing our plans for change
**Agenda Item No** | 10  
---|---
**Meeting** | Trust Board in Public  
---|---
**Meeting Date** | 2 May 2019  
---|---
**Title** | CQC Core Services Self-Assessment - Summary  
---|---
**Sponsoring Executive Director** | Suzanne Rostron, Director of Quality Governance  
---|---
**Author(s)** | Jo Case, Head of Service Improvement  
---|---
**David Haycox, Governance Advisor**  
---|---
**Report previously considered by inc date** | n/a  
---|---
**Purpose of the report** |  
---|---
Information only | X Assurance  
---|---
Review and discuss | Agreement  
---|---
Trust Board Approval is required |  
---|---
**Reason for submission to Trust Board in Private only (please indicate below)** |  
---|---
Commercial Confidentiality | Staff Confidentiality  
---|---
Patient Confidentiality | Other Exceptional Circumstance  
---|---
**Link to Trust Strategic Objectives** |  
---|---
Provide safe, effective, caring and responsive services – ‘Good’ by 2020 | X  
---|---
Ensure efficient use of resources |  
---|---
Achieve NHS constitutional patient access standards |  
---|---
Achieve excellence in employment, education and development |  
---|---
Lead strategic change on the Isle of Wight |  
---|---
**Link to CQC Domains** |  
---|---
Effective | X Responsive | X  
---|---
Caring | X Well-led | X  
---|---
Safe |  
---|---
**Executive Summary** |  
---|---

The Trust underwent a full comprehensive inspection across Acute, Ambulance, Community and Mental Health Services from the 23-25 January 2018, with the ‘Well-led’ element inspected in detail from the 20-22 February 2018. The findings of the inspection were published in June 2018. With improvements only being made at Trust-level in the ‘Responsive’ domain, the Trust continues to be in special measures.

The findings were presented in detail to the Trust Board on the 7 June 2018. At this meeting, it was agreed that to have ratings of ‘inadequate’ in the Safe domain was not acceptable. The 10-week Safe programme was launched in response to this and met its initial aims after 2 10-week cycles.
In readiness for the 2019 Inspection the Trust was asked to submit a Provider Information Request (PIR) to the CQC in March 2019. Part of this data submission was to include a Self-Assessment on where the Trust believes they would rate by in this inspection.

There have been significant improvements across all services within the Trust and the Trust self-assessed as below give the Trust an overall status of Requires Improvement:

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires Improvement*</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement*</td>
<td>Requires Improvement*</td>
</tr>
</tbody>
</table>

The Trust was notified on 17 April of the dates of the anticipated CQC inspection. They are:

<table>
<thead>
<tr>
<th>Dates</th>
<th>Core Services Inspection</th>
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</thead>
<tbody>
<tr>
<td>w/c 13 May</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>14 to 16 May</td>
<td>Community Services, including children, young person and families and adults</td>
</tr>
<tr>
<td>14 to 16 May</td>
<td>Emergency and urgent care, emergency operations centre, NHS 111 and patient transport services</td>
</tr>
<tr>
<td>21 to 23 May</td>
<td>Acute services</td>
</tr>
</tbody>
</table>

Additionally, the Trust has been advised of the dates of the CQC “well led” inspection and these are 18 to 20 June. As part of this inspection, CQC will interview, as a minimum, the following (or the equivalent title holders):

- Trust Chair
- Chief Executive
- Medical Director
- Nursing Director / Chief Nurse
- Chief Operating Officer
- Director of Finance / Chief Financial Officer
- Director of Human Resources
- A sample of Non-Executive Directors (the NED for safety and risk being a priority)
- Director of Infection, Prevention and Control
- Freedom to Speak Up Guardian
- Chair of Audit Committee
- Chair of Finance Committee
- Guardian(s) of safe working hours

The "well led" inspection will commence with a presentation by the Trust to the inspection team and create an opportunity for us to share our vision and strategy for the organisation, as well as outlining our performance and plans, including our self-assessment of leadership capacity and capability.
The areas that are likely to be inspected are:

- Urgent & Emergency Care
- Medical Care
- Surgery
- End of Life
- Community Services - Adults
- Community Services - Children
- Mental Health Older People Wards
- Community Mental Health
- Mental Health Crisis services
- Ambulance Services

**Key Recommendation**

The Trust Board is asked to receive the report for information.
Executive Summary

This report provides the Board with details of the end of year position for the Board Assurance Framework (BAF) for 2018/19. It builds upon the reports taken to each of the Assurance Committees throughout the year and seeks to provide details of the work in hand to continue to develop risk maturity within the organisation.

The BAF brings together in one place all of the relevant information on the risks to the Board’s strategic objectives. Having robust and proportionate assurance arrangements in place is critical for the Board to receive assurance that resource can be directed at the most significant areas for managing and mitigating strategic risks.

Within Quarter Four it has been proposed that five risks have seen an improved position:

- Inability to achieve and maintain regulatory compliance is proposed to have reduced in likelihood to a score of 3, achieving its target score of 12
- attract and recruit the right staff is proposed to have reduced in likelihood to a score of 3, achieving a reduced score of 15 against a target of 12
- develop and retain the right staff is proposed to have reduced in impact to a score of 4, achieving a reduced score of 16 against a target of 12
- driving cultural change is proposed to have reduced in likelihood to a score of 3, achieving its target score of 12
- future strategy for the provision of health services on the Isle of Wight is not sufficiently led by the
Trust is proposed to have reduced in likelihood to a score of 2, achieving its target score of 8.

Of the eleven strategic risks identified by the Board in June 2018 seven areas (64%) have seen an improved risk position within the year, three areas (27%) have remained static, and one area (9%) has seen a deterioration.

Following a review by the Trust's Internal Auditors who have noted the intelligent approach to the BAF and risk management it is proposed that the Board can receive an improved level of reasonable assurance on the extent to which systems underpinning risk management are effective and can be relied upon to provide assurance that key objectives are being achieved, and that the main risks to their achievement are being effectively managed.

**Key Recommendation**

The Board is recommended to receive assurance on the progress of the Board Assurance Framework, and to approve the end of year assessment for 2018/19.
BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

The role of the BAF is to provide evidence and structure to support effective management of risk within the organisation. The BAF provides evidence to support the Annual Governance Statement.

The BAF provides this totality of assurance and identifies which of the Trust’s strategic objectives are at risk of not being delivered. At the same time, it provides positive assurance where risks are being managed effectively and objectives are being delivered. This allows the Board to determine where to make most efficient use of their resources and address the issues identified in order to improve the quality and safety of care.

The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are derived from independent reviewers; these are supplemented by internal sources such as clinical audit, internal management representations, performance management and self-assessment reports.

2. BACKGROUND

In June 2018 the Board held a workshop that considered the strategic objectives for 2018/19 and the strategic risks for each of those strategic objectives. It also gave consideration to the risk appetite and inherent, current and target, risk scores for each of those strategic risks.

The Board Secretary and Governance Advisor worked with each of the Executive Directors to build upon the outputs of the workshop, with the development of the Board Assurance Framework for 2018/19 and a current position for the end of Quarter one. This built on the Board Assurance Framework for 2017/18 and was approved by the Trust Board at its meeting on 5th July 2018, following discussion and input through the assurance committees.

Quarter Four and end of year updates of the BAF were shared with each of the Performance Committee, Quality Committee and Assurance, Risk & Compliance Committee in April 2019. Feedback throughout the year has identified suggestions for additional developments in reporting that will be factored in for 2019/20.

3. PROGRESS

Overview
The BAF brings together in one place all of the relevant information on the risks to the Board’s strategic objectives. Having robust and proportionate assurance arrangements in place is critical for the Board to receive assurance that resource can be directed at the most significant areas for managing and mitigating strategic risks.

At the end of the financial year, a further five areas are proposed to receive an improved risk rating – bringing the total number that have seen positive change in their score to seven of the eleven areas covered, with one area deteriorating over the course of the year, and three areas not moving across the year.

Three of the eleven risks are proposed to have achieved their target score at the end of the financial year, and the Committees have discussed that in relation to those strategic risks which have not achieved their target scores many actions have taken place to lay the foundations for improving and mitigating the risk position for the Trust over the year ahead.

Appendix 1 provides an overview of the strategic risks and scoring, with a full breakdown detailed in Appendix 2 to the report.
Previously approved risk adjustments (Q1-Q3 without further revision in Q4)

The Board has previously supported adjustments in the scores of the risk positions for the following strategic risks which have not seen further change in Quarter Four:

- Non delivery of the outcomes of the Quality Strategy to an improved score of 12 (possible x major) against an end of year target score of 8 (unlikely x major)
- Failure to deliver safe care to an improved score of 12 (possible x major) against an end of year target score of 8 (unlikely x major)
- Expenditure incurred exceeds income by greater than agreed control total to a deteriorated score of 25 (certain x catastrophic) against a target score of 15 (possible x catastrophic)

Static strategic risks

At the end of the financial year no adjustments in the risk scores have been proposed across the twelve month period for the following strategic risks:

- Failure to deliver patient standards of care including constitutional and contractual levels from a score of 16 (likely x major)
- Failure to set out and implement an analytics and digital technology strategy/plan from a score of 16 (likely x major)
- Failure to set out and implement an estates and facilities strategy/plan from a score of 16 (likely x major)

In relation to the risk relating to the failure to deliver patient standards of care including constitutional and contractual levels, the Performance Committee noted that significant progress had been made in some areas of the Trust but that given the organisations failure to achieve a number of constitutional targets the risk score was not proposed to have been achieved. Feedback and challenge was received through the Committee meetings on the lack of progress in relation to both the failure to set out and implement an analytics and digital technology strategy/plan, and the failure to set out and implement an estates and facilities strategy/plan and additional support has been brought in to progress these areas moving in to 2019/20.

Quarter Four adjustments

In relation to the strategic risks proposed to receive a revised risk score at the end of the fourth Quarter:

The risk score in relation to ‘Inability to achieve and maintain regulatory compliance’ has seen an improved position with the revised scoring based on a number of factors shared with the Committees and Board including:

- Provider Information Request submitted
- The implementation of the Quality Improvement Board to deliver Trustwide oversight
- Governance within divisions has continued to embed and is evidenced though the self-assessments and performance reviews
- Increase in take up of mandatory training (target achieved February 2019) and appraisal levels
- Assurance visits undertaken with external parties to demonstrate progress and identify areas for continued development
- Action plan implemented to address areas of concern within the Emergency Department including improvements to the layout of the department, and increased visibility/escalation of staffing levels

On this basis it is proposed that the risk has achieved its target score for the financial year of 12 with a likelihood of 3 (possible) and an impact of 4 (major). While there remains more work to do to ensure that the changes made are sustained over time and continued improvements are rolled out the Trust has implemented material changes over the course of the year to ensure that the likelihood of failing to achieve regulatory compliance has been reduced. In the absence of an inspection across the Trust at this point in time assurances have been pulled from a number of sources including external and independent views.
The risk score in relation to ‘*attract and recruit the right staff*’ has seen an improved position with the revised scoring based on a number of factors shared with the Committees and Board including:

- A full recruitment programme in accordance with the Recruitment & Retention strategy is now in place leading to a number of actions across the year including registered nurse (Acute and MH) recruitment events, and onsite Recruitment Welcome days.
- Divisions are all developing individual workforce strategies and ensuring that this feeds into the future service models to address the impact of certain types of roles being particularly challenging to recruit to, exploring new models of care and different ways of delivering services.
- Following work with NHSI to process map our recruitment approach and create a more effective system the team have developed metrics to identify and track the effect of the improvements being implemented.
- International Recruitment commenced with a visit to the Philippines in Quarter Four and a further visit planned for early in 2019/20, alongside the implementation of the master vendor arrangement to support long lining of temporary staff and steps to further develop the Trust Bank.

The proposed revised score, which does not meet the target score for the year, is reflective of the actions that have been undertaken but is still rated as a ‘red’ risk as further work is required through 2019/20. While the risk has not achieved its target level for the end of the financial year of ‘12’ (possible x major) it is recommended that a risk score is appropriate given the impact and outcomes of the actions noted above. The original risk rating was 4 (likely) x 5 (catastrophic) = 20. With the actions taken it is proposed that the likelihood of the risk arising has been reduced to 3 (possible) with a continued impact of 5 (catastrophic) giving an overall risk rating of 15.

The Performance Committee considered a proposed reduction from officers to a risk score of 4 (likely) x 4 (major) but considered that greater evidence of reduced likelihood of the risk arising had been demonstrated to support a further reduction in this area, while the impact of the risk remained unchanged.

The risk score in relation to ‘*develop and retain the right staff*’ has seen an improved position with the revised scoring based on a number of factors shared with the Committees and Board including:

- Development programmes for each of the Executive Team, Medical leaders, sisters, senior managers and middle managers have all progressed at pace.
- Workforce information is provided to managers on a regular basis to increase their visibility on areas for targeting appraisals and training development.
- Workforce information for the Performance Committee is starting to develop with greater visibility of the balance between leavers and starters, and a trajectory is in place to demonstrate progress on our objectives throughout the current year and in to 2019/2020.
- Mandatory Training compliance has improved to 85%, the planned target before the end of the financial year.
- Appraisal compliance failed to achieve its target of 80% and finished the year at 76% with plans in place to reset and revise the approach from Quarter One.

The proposed revised score, which does not meet the target score for the year, is reflective of the actions that have been undertaken but is still rated as a ‘red’ risk as further work is required through 2019/20. While the risk has not achieved its target level for the end of the financial year of 12 (possible x major) it is recommended that a reduced risk score is appropriate given the impact and outcomes of the actions noted above. The original risk rating was 4 (likely) x 5 (catastrophic) = 20. With the actions taken it is proposed that the impact of the risk is reduced to 4 (major) giving an overall risk rating of 16.

The Performance Committee considered a proposed reduction from officers to a risk score of 3 (possible) x 4 (major) but considered that while progress had been made insufficient evidence had been provided to demonstrate achievement of the target score.

The risk score in relation to ‘*driving cultural change*’ has seen an improved position with the revised scoring based on a number of factors shared with the Committees and Board including:

- Workforce strategies agreed through the Trust Board in the first part of 18/19 supported by the approval of a Leadership Strategy and Leadership Conference at the end of the financial year.
- Diagnostic phase of its Culture and Leadership programme; working with over 600 staff and service
users to develop the revised vision and values for the Trust

- a Culture Dashboard has been designed to capture measurable indicators aligned to the areas of improvement
- a range of staff development programmes have been implemented across many levels of the organisation

The proposed revised score, which meets the target score for the year, is reflective of the actions that have been undertaken but is still rated as an ‘amber’ risk as further work is required through 2019/20. The original risk rating was 5 (certain) x 4 (major) = 20. With the actions taken it is proposed that the likelihood of the risk is reduced to a score of 3 (possible) with the impact of the risk remaining as 4 (major) giving an overall risk rating of 12.

The risk score in relation to the risk that the ‘future strategy for the provision of health services on the Isle of Wight is not sufficiently led by the Trust’ has seen an improved position with the revised scoring based on a number of factors shared with the Committees and Board including;

- The work undertaken with both the CCG and Council to jointly develop an approach to planning service development and direction for the future, supported by Carnall Farrar leading to the publication of the sustainability plan and development of an implementation plan
- Ongoing close role within the Local Care Board and more widely the STP
- Positive development of relationships and networking support from neighbouring Trusts
- Underpinning work on vision and values to drive cultural change

On this basis it is proposed that the risk has achieved its target score for the financial year of 8 with a likelihood of 2 (unlikely) and an impact of 4 (major). As part of the discussions for the development of the BAF in 2019/20 the Board will be invited to consider the development of the strategic risk to move to a question of implementation of the strategic plans that have been developed over the previous twelve months.

The risk scoring model for likelihood and impact are set out below with the full breakdown of scoring detailed in the Trust Risk Management Strategy:

<table>
<thead>
<tr>
<th>Likelihood Score</th>
<th>Impact Score</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
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<td>8</td>
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<tr>
<td></td>
<td>5</td>
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</tr>
</tbody>
</table>

A breakdown of the actions undertaken, sources of assurance, and future actions has been shared with the relevant committee’s and additional clarity has been provided by the committees on the areas that they would like to see an improved level of depth of assurance and evidence.
4. **RISK APPETITE**

The Trust recognises it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Indeed, only by taking risks can the Trust realise its aims. It must, however, take risks in a controlled manner, thus reducing its exposure to a level deemed acceptable from time to time by the Board and, by extension, external inspectors/regulators and relevant legislation.

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. In other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.

Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation’s risk appetite.

The risk appetite for the strategic risks captured within the Board Assurance Framework has not changed and remains as follows:

<table>
<thead>
<tr>
<th>STRATEGIC OBJECTIVES AND STRATEGIC RISKS</th>
<th>PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020</th>
<th>RISK APPETITE LEVELS</th>
<th>ENSURE EFFICIENT USE OF RESOURCES</th>
<th>PATIENT STANDARDS</th>
<th>EXCELLENCE IN EMPLOYMENT</th>
<th>LEAD STRATEGIC CHANGE ON ISLE OF WIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability to achieve and maintain regulatory compliance</td>
<td>Non-delivery of the outcomes of the Quality Strategy</td>
<td>Failure to deliver patient standards of care including constitutional and contractual levels</td>
<td>Expenditure incurred exceeds income by greater than agreed control total</td>
<td>Failure to deliver patient standards of care including constitutional and contractual levels</td>
<td>Attract and recruit the right staff</td>
<td>The future strategy for the provision of health services on Isle of Wight is not sufficiently being led by the Trust</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>Develop and retain the right staff</td>
<td>Failure to set out and implement an analytics and digital technology strategy/plan</td>
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<td></td>
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<td></td>
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<td></td>
<td>Driving cultural change</td>
<td>Failure to set out and implement an estates and facilities strategy/plan</td>
</tr>
</tbody>
</table>
5. **EXTERNAL ASSURANCE**

Each year the Trust’s Internal Auditors carry out a review of the Board Assurance Framework and have provided an assessment in relation to the work in 2018/19 of ‘reasonable assurance’ progressing from the rating of ‘limited assurance’ in 2017/18.

Feedback has been provided that “The Trust has developed an intelligent approach to the BAF and risk management, with progress being made to effectively link strategic and operational risk. Work continues to rationalise risk registers, and to embed risk management throughout the Trust through the promulgation of the new Risk Management Strategy.”

No urgent action points have been identified with seven matters proposed for important/routine or operational progression which will be taken forward through the Quality Governance team with oversight at the Operational Risk Sub-Committee.

The Board can therefore receive an improved level of reasonable assurance on the extent to which systems underpinning risk management are effective and can be relied upon to provide assurance that key objectives are being achieved, and that the main risks to their achievement are being effectively managed.

6. **END OF YEAR SUMMARY & NEXT STEPS**

Of the eleven strategic risks identified by the Board in June 2018 seven areas (64%) have seen an improved risk position within the year, three areas (27%) have remained static, and one area (9%) has seen a deterioration.

The Committees have discussed the proposed revisions to the risk assessments, challenging and scrutinising the proposals from officers, and their revised recommendations have been included in this report to the Board.

The Trust objective of Getting to Good by 2020 has been supported by a range of strategies and plans that reach across multiple years; reflecting the feedback from the CQC and others that the organisation was starting from a low position and change of this level takes time. The proposal is therefore to build and develop on the content of the Board Assurance Framework which will enable us to monitor and develop greater levels of assurance on the programmes seen to date, and incorporate new initiatives as they are launched and this will be discussed with the Board through its seminar sessions. Feedback received from the Committees over the year regarding ways in which clearer links between gaps in controls, actions to be undertaken, and progress reporting, will be built into future iterations.

Regarding the BAF overall, in hindsight the Board may have been overly optimistic concerning the level of change that could realistically be achieved within the space of twelve months bearing in mind the baseline from which the change was starting, however it is important to continue to be amitious and aim for an increased pace of change moving forward capitalising on the work to date.

Many of the supporting strategies which enable the development of mitigations and actions for these risks are set to run over a two or three year period and these have been developed, reviewed and assessed to establish clear milestones for 2019/20.

7. **RECOMMENDATIONS**

The Board is recommended to receive assurance on the progress of the Board Assurance Framework, and to approve the end of year assessment for 2018/19.
### Appendix 1

<table>
<thead>
<tr>
<th>RISK APPETITE</th>
<th>STRATEGIC OBJECTIVES AND STRATEGIC RISKS</th>
<th>INHERENT RISK</th>
<th>RISK AT Q4</th>
<th>PROPOSED RISK SCORE AT Q4</th>
<th>TARGET RISK SCORE</th>
<th>LEAD COMMITTEE</th>
<th>EXECUTIVE LEAD</th>
<th>POSITION</th>
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<tr>
<td></td>
<td><strong>STRATEGIC OBJECTIVE 01: PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020</strong></td>
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<tr>
<td>Cautious</td>
<td>Inability to achieve and maintain regulatory compliance</td>
<td>5 5 25</td>
<td>3 4 12</td>
<td>3 4 12</td>
<td>PROPOSED ACHIEVED</td>
<td>Assurance, Risk &amp; Compliance</td>
<td>Director of Quality Governance</td>
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<tr>
<td>Minimal</td>
<td>Non-delivery of the outcomes of the Quality Strategy</td>
<td>4 4 16</td>
<td>3 4 12</td>
<td>2 4 8</td>
<td>Quality</td>
<td>Medical Director / Director of Nursing / Director of Quality Governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid</td>
<td>Failure to deliver safe care</td>
<td>5 5 25</td>
<td>3 4 12</td>
<td>2 4 8</td>
<td>Quality</td>
<td>Medical Director / Director of Nursing / Director of Quality Governance</td>
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<tr>
<td></td>
<td><strong>STRATEGIC OBJECTIVE 02: ENSURE EFFICIENT USE OF RESOURCES</strong></td>
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<tr>
<td>Cautious</td>
<td>Expenditure incurred exceeds income by greater than agreed control total</td>
<td>4 5 20</td>
<td>5 5 25</td>
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<td>Performance</td>
<td>Director of FEIMT &amp; Deputy CEO</td>
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<td><strong>STRATEGIC OBJECTIVE 03: PATIENT STANDARDS</strong></td>
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<tr>
<td>Cautious</td>
<td>Failure to deliver patient standards of care including constitutional and contractual levels</td>
<td>4 4 16</td>
<td>4 4 16</td>
<td>3 4 12</td>
<td>Performance</td>
<td>Divisional Directors</td>
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<td></td>
<td><strong>STRATEGIC OBJECTIVE 04: EXCELLENCE IN EMPLOYMENT</strong></td>
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<tr>
<td>Cautious</td>
<td>Attract and recruit the right staff</td>
<td>4 5 20</td>
<td>3 5 15</td>
<td>3 4 12</td>
<td>Performance</td>
<td>Director of Human Resources &amp; OD</td>
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</tr>
<tr>
<td>Cautious</td>
<td>Develop and retain the right staff</td>
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<td>4 4 16</td>
<td>3 4 12</td>
<td>Performance</td>
<td>Director of Human Resources &amp; OD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cautious</td>
<td>Driving cultural change</td>
<td>5 4 20</td>
<td>3 4 12</td>
<td>3 4 12</td>
<td>PROPOSED ACHIEVED</td>
<td>Performance</td>
<td>Director of Human Resources &amp; OD</td>
<td></td>
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### STRATEGIC OBJECTIVE 05: LEAD STRATEGIC CHANGE ON ISLE OF WIGHT

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<thead>
<tr>
<th>Status</th>
<th>Description</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Scoring</th>
<th>Responsible</th>
<th>Initiative</th>
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<td>The future strategy for the provision of health services on Isle of Wight is not sufficiently led by the Trust</td>
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<td>16</td>
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<td>4</td>
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<tr>
<td>Open</td>
<td>Failure to set out and implement an analytics and digital technology strategy/plan</td>
<td>4</td>
<td>4</td>
<td>16</td>
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<td>4</td>
</tr>
<tr>
<td>Open</td>
<td>Failure to set out and implement an estates and facilities strategy/plan</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

**L = Likelihood**

**I = Impact**

Scoring matrix as detailed in the Trust Risk Management Policy
Appendix 2 BOARD ASSURANCE FRAMEWORK 2018/19 Proposed scoring subject to approval

**SOI: Objective:** PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020

**Assurance Committee:** ASSURANCE RISK AND COMPLIANCE COMMITTEE

**Executive Lead:** DIRECTOR OF QUALITY GOVERNANCE

**CQC Domain:** ALL

### Enabling Strategy: QUALITY STRATEGY/ RISK MANAGEMENT STRATEGY

#### Risks to objective

**Controls**

1. Governance structures
2. Clinical standards programme
3. 10 week ‘Safe’ programme
4. Executive walk rounds
5. Quality Impact Assessments for all service changes and CIPs that are considered
6. Professional standards
7. Trust policies and procedures
8. Quality Strategy and Risk Management Strategy
9. Board governance functioning effectively
10. Clinical audits/outcomes
11. Strengthened Divisional governance processes
12. Quality Committee and supporting arrangements in place
13. Registers for external agency visits and accreditations in place with mechanisms to identify and deliver regulatory requirements
14. IG Toolkit level 2/ Data Security & Protection Toolkit achieved for majority of requirements

**Gaps in controls**

1. Clinical Standards programme in early stages
2. Lack of consistency or co-ordination of Executive walk-rounds.
3. Inconsistent challenge/accountability for maintaining professional standards.
4. Implementation of Quality Strategy – approved April 18
5. Embedding new Divisional governance structures (commenced Q1 18/19)
6. Reporting of external agency visits and accreditation requirements to be embedded at Divisional level

**Sources of Assurance**

1. Assurance, Risk and Compliance Committee
2. Performance Committee
3. Quality Committee
4. Safety Recovery Sub-Committee
5. Information Governance Sub-Committee
6. Operational Risk Sub-Committee
7. Divisional Boards
8. QIB
9. Well led reviews
10. Action tracker for regulatory actions
11. Safety recovery and associated reports

**Assurance outcomes / gaps**

1. To implement mock inspections and reviews across the Trust
2. Maintain Provider information return with a quarterly review of data to identify any risks
3. Embed new governance structures at all levels of the organisation
4. Provide training to further develop functional risk registers
5. Implement a process for formal recording of Executive walk rounds and any subsequent actions.
6. Continue to develop the regulatory support from the Quality Governance Directorate
7. Ongoing refinements of the PMO processes
8. Actions as detailed within the Quality Strategy
9. 10 week programme for key areas

**Management assurance:**

- 1. Safety Recovery Sub-Committee to be established - addressed
- 2. Embedding Divisional Boards and supporting committees – addressed

**Action plan**

- 1. Assurance, Risk and Compliance Committee
- 2. Performance Committee
- 3. Quality Committee
- 4. Safety Recovery Sub-Committee
- 5. Information Governance Sub-Committee
- 6. Operational Risk Sub-Committee
- 7. Divisional Boards
- 8. QIB
- 9. Well led reviews
- 10. Action tracker for regulatory actions

**Progress / Timescales**

- 1. To implement mock inspections and reviews across the Trust
- 2. Maintain Provider information return with a quarterly review of data to identify any risks
- 3. Embed new governance structures at all levels of the organisation
- 9. Safety Recovery Board in place and embedded
- 9 - 10 week programmes have developed and achieved significant progress as evidenced through the Improvement Director updates
- 9 - Mandatory training levels have improved considerably across the organisation, alongside use of human factors and QI training
- 9 - High level of compliance with environmental risk audits
- 8 - Quality Strategy actions detailed under separate strategic risk and show good progress in many areas.

---

**Strategic Theme:** QUALITY

**Risk Appetite:** CAUTIOUS

**Risk: Inability to achieve and maintain regulatory compliance**

- Principal risks:
  - Condition: Inability to achieve and maintain regulatory compliance
  - Cause: Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies, poor understanding of minimum standards, ineffective governance, poor leadership.
  - Consequence: Enforcement action, special measures, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services

<table>
<thead>
<tr>
<th>Risk from Risk Register:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1394 inability to achieve regulatory compliance</td>
</tr>
<tr>
<td>1458 Non Compliance with National Guidance for Falls (NAIF and NICE)</td>
</tr>
<tr>
<td>1291 Non Compliance against Standards for Children and Young People in Emergency Care Settings</td>
</tr>
<tr>
<td>1274 - Risk that the inadequate estate for Shackleton impacts patient standards</td>
</tr>
</tbody>
</table>

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**Inherent risk**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
<th>Likelihood</th>
<th>Impact</th>
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<td>16</td>
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<td>12</td>
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</tbody>
</table>

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**Risk as at 1st April**

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<th>Score</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td>25</td>
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**Current risk level Q4**

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<th>Likelihood</th>
<th>Impact</th>
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<th>Likelihood</th>
<th>Impact</th>
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</thead>
<tbody>
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<td>16</td>
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<td></td>
<td>12</td>
<td>3</td>
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**Target risk position by 31/3/19**

<table>
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<tr>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
<th>Likelihood</th>
<th>Impact</th>
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<tbody>
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<td>25</td>
<td>4</td>
<td></td>
<td>16</td>
<td>3</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>
Strategic Theme: QUALITY
Risk Appetite: MINIMAL
Risk: Non-delivery of the outcomes of the Quality Strategy

SO1: Objective: PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020
Assurance Committee: QUALITY COMMITTEE
Executive Lead: MEDICAL DIRECTOR/ DIRECTOR OF NURSING/ DIRECTOR OF QUALITY
CQC Domain: ALL
Enabling Strategy: QUALITY STRATEGY

### Risks to objective

<table>
<thead>
<tr>
<th>Principal risks:</th>
<th>Controls</th>
<th>Gaps in controls</th>
<th>Sources of Assurance</th>
<th>Assurance outcomes / gaps</th>
<th>Action plan</th>
<th>Progress / Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition: Non-delivery of the outcomes of the Quality Strategy.</td>
<td>1. Implementation plan for the Quality Strategy – provider level</td>
<td>1. Further development of the implementation plan for the eight strands detailed in the Quality Strategy (Effective Domain and Dementia)</td>
<td>Management assurance: 1. Quality Committee 2. Safety Recovery Sub-Committee 3. Divisional Quality Committees 4. Patient Safety Sub-Committee 5. Patient Experience Sub-Committee 6. Clinical Effectiveness Sub-Committee 7. Divisional Boards</td>
<td>Gaps: 1. Safety Recovery Sub-Committee to be established (27/6/18) Embedding Divisional Boards and supporting committees</td>
<td>1. Quality Strategy work plan 2. Divisional level Quality Strategies &amp; implementation plans 3. Continue to develop the support from the Quality Governance Directorate 4. Develop and implement engagement plan 5. Hold stakeholder events (2-3) throughout the year</td>
<td>Cross cutting/ outcomes: Safety Recovery Board in place and embedded 2. Divisional strategies in place but gaps remain in relation to clarity of implementation plans and QIB is now addressing this 4 &amp; 5: Engagement plan: a number of events have taken place throughout the year including Quality Summit x 2, Alzheimer’s Day, Dementia Café, Medicine for Members, End of Life sessions, and attendance at a number of local forums 3- Team structure developed within Quality Governance to support teams in delivering the strategy – includes through SI, complaints, learning lessons, governance developments etc. Outcomes: Improved clinical outcomes evidenced by e.g. NELA audit 4- Greatix system developed to celebrate good practice 4- Pulse surveys show more than half of staff completely or strongly agree that quality is the Trusts top priority 1- Development of new integrated palliative and end of life care team to cover the hospital led by Clinical Director for EoLC 1 -Work with external consultancy input to support and improve patient flow – supporting the right care in the right place agenda</td>
</tr>
<tr>
<td>Cause: New strategy collating quality matters from across the Trust for consistent application and roll out</td>
<td>2. Divisional level Quality strategies and plans</td>
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<tr>
<td>Consequence: Failure to provide safe, effective, caring and responsive services.</td>
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</tbody>
</table>

### Risks from Risk Register:

- 1291 Non Compliance against Standards for Children and Young People in Emergency Care Settings
- 1458 Non Compliance with National Guidance for Falls (NAIF and NICE)

### Metrics

- As detailed in each of the eight Quality Strategy strands
- Complaints & compliments data
- National Inpatient Survey

### Independent / semi-independent:

- QIPOG
- NHSI Oversight Meetings
- CCG
- Healthwatch

### Outcomes:

- Progress on “Getting to Good”
- Improved patient experience
- Improved clinical outcomes (national audits, benchmarking)

### Inherent risk

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<thead>
<tr>
<th>Likelihood</th>
<th>Impact</th>
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</tbody>
</table>
Likelihood Impact Score Likelihood Impact Score Likelihood Impact Score Likelihood Impact Score

Strategic Theme: QUALITY

5 5

Risk Appetite: AVOID

5 4

Risks to objective Controls Gaps in controls Sources of Assurance Assurance outcomes / gaps Action plan Progress / Timescales

Principal risks: Condition: Failure to deliver safe care

1. Clinical standards clearly stated across the Trust’s services
2. Governance structures
3. Training programme (mandatory and non-mandatory)
4. Supervision and education of clinical staff across all professions.
5. Clinical revalidation
6. Clinical Audit Programme including participation in relevant National Audit Programmes and reviews.
7. Mortality review process
9. R&D programme
10. Human factors training
11. 10 week safe programme
12. SI and Inquest processes and learning
13. Quality Strategy

1. Main themes identified include:
   - Mandatory training
   - Standard of record keeping
   - WHO checklist
   - Staffing
   - Incident reporting and learning
   - Environmental risk assessments
   - Patient risk assessment and escalation
   - Systems and connectivity
   - Safeguarding
2. Delivery of 10 week programmes across the Trust

Management assurance:

1. Quality Committee
2. Safety Recovery Sub-Committee
3. Operational Risk Sub-Committee
4. Patient Safety Sub-Committee
5. Patient Experience Sub-Committee
6. Clinical Effectiveness Sub-Committee
7. Divisional Boards

Gaps:

1. Application of 10 week programmes to address the main themes identified as gaps in control
2. Embedding Divisional Boards and supporting committees
3. 10 week programme to be embedded

SO1: Objective: PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020

Assurance Committee: QUALITY COMMITTEE

Executive Lead: MEDICAL DIRECTOR COMMITTEE OF NURSING/ DIRECTOR OF QUALITY

Operational Lead: 

CQC Domain: SAFE / WELL LED

Enabling Strategy: QUALITY STRATEGY

Risks from Risk Register: Includes:

1396 Risk of insufficient Medical Cover for Community Rehab Beds impacting patient care
1427 - Insufficient capacity across MHLD
1458 Non compliance with National Guidance for Falls (NAIF and NICE)
1187/88 anaesthetist resource challenges
1277 Unreviewed Ophthalmology follow-up outpatient backlog
1344 Off Island transfers
1359 labour suite ventilation fails to meet recommended standards
1288 Non compliance with EPRR Standards - ED Lock down

1428 - Insufficient capacity across Mental Health and Learning Disability services and requires improvement within Ambulance services.

Consequence: Increased complication rate, poor clinical outcomes for patients, loss of commissioner and patient confidence in provision of services, reputational damage, continued regulatory intervention (special measures)

Consequence:

1. National Audits
2. Complication Rates
3. Outlier alerts
4. HSMR/SHMI
5. NICE compliance
6. Internal peer review/ mock inspection

Independent / semi-independent:

DFOG & Oversight (NHSI)
CQC
Healthwatch
NHRI regional visits
NHSI national visits
Improvement Director report

1. Application of 10 week programmes to address the main themes identified as gaps in control
2. Embedding Divisional Boards and supporting committees
3. 10 week programme to be embedded

Outcomes:

1. Progress on “Getting to Good”
2. Improved patient outcomes

Inherent risk Risk as at 1st April Current risk level Q4 Target risk position by 31/3/19

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<tr>
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SO2: Objective: ENSURE EFFICIENT USE OF RESOURCES  
Executive Lead: DIRECTOR OF FINANCE  
COC Domain: WELL LED

<table>
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<tr>
<th>Risks to objective</th>
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<th>Gaps in controls</th>
<th>Sources of Assurance</th>
<th>Assurance outcomes / gaps</th>
<th>Action plan</th>
<th>Progress / Timescales</th>
</tr>
</thead>
</table>
| Principal risks:   | 1. Devolved and delegated budgets based on 2017/18 outturn in place with amendments for recurrent/non recurrent schemes  
| Condition:         | 2. Improved financial controls and governance in place  
| Expenditure incurred exceeds income by greater than agreed control total | 3. Some CIP schemes agreed and further work ongoing  
| Cause:             | 4. CIP process in place through Service Improvement and Finance Sub committee  
| Divisions and Corporate Departments do not deliver services within agreed budgets and do not achieve CIPs | 5. Financial Performance Review meetings in place with Divisions  
| Additionality delivered may not result in increased income, due to levels of activity or coding issues | 6. Continuation of process for expenditure reduction throughout the Trust  
| Consequence:       | 7. Substantive Director of Finance in place  
| Impact on investment in quality | 8. External resource (KPMG and Moorhouse) consultancy arrangements in place to (a) support CIP plans (b) review of income maximisation and (c) develop contracting arrangements  
| Inability to meet regulatory requirements | 9. Mechanisms for joint working with other partners established and operating effectively with CCG and local authority |

| Management assurance: Key assurance mechanisms are: | 1. Divisional financial awareness of spend within new structures as budget centres have shifted  
| Key assurance mechanisms are: | 2. Clarity of ownership of schemes  
| Finance Performance Reviews on a fortnightly basis | 3. Pace of delivery |

| Gaps: | 1. Increase accountability via monthly financial performance review meetings  
| | 2. Use scrutiny from commercial partners and internal auditors to identify additional savings  
| | 3. Challenge CBU's on the monthly finance reporting upwards from CBUs to Executive Directors  
| | 4. Identify real cost reduction and expenditure controls with agreed timescales for delivery  
| | 5. Work with a commercial partner to progress CIP schemes and identify other cost saving options |

| Measures | 1. Run rate  
| Sources of Assurance | 2. I&E position  
| Assurance outcomes / gaps | 3. CIPs position  
| | 4. Activity performance  
| | 5. Cash flow |

| Independent / semi-independent: | 1. NHSI  
| | 2. CQC  
| | 3. Internal Audit  
| | 4. External Audit  
| | 5. Local Counter Fraud Specialist |

| Outcomes: | 1. Reduced NSHI regulation  
| | 2. Achieve Board approved financial plan  
| | 3. Achieve NSHI financial control total |

| Risk from Risk Register: | 1403 Insufficient Cash Resource  
| | 1402 Inadequate identification and implementation of CIP  
| | 1400 Failure to secure SLA contractual income  
| | 1405 Failure to plan effectively for future financial sustainability  
| | 1401 Failure to deliver the current year agreed Financial Plan  
| | 1404 Inadequate Capital Resource Limit  
| | 1421 Inability to deliver financial plan due to need to use agency |

| Metrics | 1. NHG  
| | 2. CQC  
| | 3. Internal Audit  
| | 4. External Audit  
| | 5. Local Counter Fraud Specialist |

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<tr>
<th>Progress / Timescales</th>
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| 1Divisional finance arrangements are still evolving with incremental improvements month on month and a stronger connections to divisional board meetings.  
| 3 Finance Recovery Checkpoint meetings in place: Focussed sessions in place in overspent areas  
| 1 Improved consistency of application of controls within divisional areas but work required within some corporate teams  
| 5- CIP schemes fully identified and delivering however on a delayed trajectory. CIP buffer was insufficiently developed and lessons have been learnt for 19/20 planning  
| Overarching: Review of demand control measures, and the impact on the wider deficit, underway to be factored into 19/20 |

<p>| Overarching: Review of demand control measures, and the impact on the wider deficit, underway to be factored into 19/20 |
| 3 Monthly performance reviews in place and developed into FRC where needed |
| 2 5- KPMG support to identify CIP schemes and reactive responses to IA reports/ findings |
| 3&amp;4 -Divisional Board reporting on finance ensures improved Exec Director visibility and through to TLC |</p>
<table>
<thead>
<tr>
<th>Principal risks: Failure to deliver patient standards of care including constitutional and contractual levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditions: Flow, demand and capacity across Acute, MHLD Ambulance, Community Healthcare, including social care, 111, primary care etc. Lack of appropriately trained medical, nursing and allied healthcare staffing. Instances of inappropriate use of system resources. Service restrictions due to funding challenges.</td>
</tr>
<tr>
<td>Consequence: Medically fit for discharge (MFFD) patients not progressing through the health &amp; social care system. ED breaching 4 hour targets. Ambulance, Community Healthcare. Does not place on diagnostics and best place of treatment for patients.</td>
</tr>
<tr>
<td>Causes: Failure to achieve cancer 62 day target for achievement of RTT for oncology outpatient pathway including greater self-care pathways and flow support effective early recovery in ambulance services and ED and social care. Introduction of CAD for ambulance services and development of service in light of improved data.</td>
</tr>
</tbody>
</table>

**Strategic Theme:** OPERATIONAL STRATEGY  
**Strategic Appetite:** CAUTIOUS  
**Risk: Failure to deliver patient standards of care**

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<td></td>
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<td></td>
</tr>
<tr>
<td>1. Opportunities to maximise benefits of unified Trust not capitalised on. 2. Acute Service Redesign (ASR) model to be consulted, progressed and subsequently implemented. 3. Consistent approach to promoting and educating users on self-management and collaboration to be developed. 4. An Urgent Care Centres model. 5. Winter Plan has not been fully developed, costed and approved. 6. Workforce &amp; Organisational development (OD) and Recruitment &amp; Retention strategies to be finalised and approved. 7. Inconsistency in standards as a result of the utilisation of locum and agency staff. 8. Plan for achievement of Cancer targets requires further development. 9. Plan for achievement of RTT targets requires further development. 10. Plan for achievement of Emergency Department targets requires further development. 11. Relationships with primary care services require development.</td>
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</table>

**Metrics:**
1. Ambulance R1, R2, 19min. 2. A&E 4 hour target. 3. Cancer 62 day target. 4. DTC system performance. 5. DTC system performance.

**Outcomes:**
1. Right place right time for care. 2. Timely access to services with consistent flow through the health and social care system.

**Independent / semi-independent:**
NHSI, CQC, Internal Audit, External agency visits.

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<table>
<thead>
<tr>
<th>Inherent risk</th>
<th>Risk as at 1st April</th>
<th>Current risk level Q4</th>
<th>Target risk position by 31/3/19</th>
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</table>
### Risks to objective

#### Controls

<table>
<thead>
<tr>
<th>Principal risks: Attract and recruit the right staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition: Attract and recruit the right staff</td>
</tr>
<tr>
<td>Cause: Challenging recruitment picture across the NHS exacerbated by the Trust’s geographical location alongside a range of other issues</td>
</tr>
<tr>
<td>Consequence: Failure to deliver high quality, safe patient care,</td>
</tr>
</tbody>
</table>

#### Controls

<table>
<thead>
<tr>
<th>Risks from Risk Register:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inability to recruit and retain sufficient staff to deliver safe, effective services</td>
</tr>
<tr>
<td>2. Failure to attract and recruit the right staff</td>
</tr>
</tbody>
</table>

#### Sources of Assurance

<table>
<thead>
<tr>
<th>Management assurance</th>
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</thead>
<tbody>
<tr>
<td>1. Lack of finalised Recruitment and retention strategy</td>
</tr>
<tr>
<td>2. Lack of finalised Workforce and OD strategy</td>
</tr>
<tr>
<td>3. Development programme not fully in place</td>
</tr>
<tr>
<td>4. Not all new starters attending induction</td>
</tr>
<tr>
<td>5. Low compliance of Mandatory training</td>
</tr>
<tr>
<td>6. Releasing staff for training</td>
</tr>
<tr>
<td>7. Not talent spotting / succession planning</td>
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</table>

#### Risks to objective

<table>
<thead>
<tr>
<th>Controls</th>
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</thead>
<tbody>
<tr>
<td>1. Produce weekly workforce information data and respond to trends</td>
</tr>
<tr>
<td>2. Effective and efficient recruitment processes rolled out</td>
</tr>
<tr>
<td>3. Appraisal policy, paperwork in place for all staff</td>
</tr>
<tr>
<td>4. Leadership Programme in place</td>
</tr>
<tr>
<td>5. Mandatory Training programme in place</td>
</tr>
<tr>
<td>6. Induction process for all new employees</td>
</tr>
<tr>
<td>7. Staff Recognition Programme in place</td>
</tr>
<tr>
<td>8. Visions &amp; Values</td>
</tr>
<tr>
<td>9. Recruitment campaigns</td>
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#### Gaps in controls

<table>
<thead>
<tr>
<th>Gaps:</th>
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<tbody>
<tr>
<td>1. Trajectory reporting for workforce plan</td>
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</table>

#### Enabling Strategy: RECRUITMENT & RETENTION STRATEGY

<table>
<thead>
<tr>
<th>Action plan</th>
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</thead>
<tbody>
<tr>
<td>1. Finalise the Recruitment and Retention strategy</td>
</tr>
<tr>
<td>2. Finalise the Workforce and OD strategy</td>
</tr>
<tr>
<td>3. Development programme to include:</td>
</tr>
<tr>
<td>• Kings Fund culture programme</td>
</tr>
<tr>
<td>• Published organisational standards</td>
</tr>
<tr>
<td>4 Leadership development programme for all managers underway</td>
</tr>
<tr>
<td>5 All staff attend induction on first day of employment</td>
</tr>
<tr>
<td>6 New policies reflecting the needs of staff developed and rolled out</td>
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#### Outcomes:

<table>
<thead>
<tr>
<th>Outcomes:</th>
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<tbody>
<tr>
<td>1. Improved Staff Survey results</td>
</tr>
<tr>
<td>2. Sickness absence above target</td>
</tr>
<tr>
<td>3. Mandatory Training above Target</td>
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#### Metrics

<table>
<thead>
<tr>
<th>Metrics</th>
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<tbody>
<tr>
<td>1. Time to fill</td>
</tr>
<tr>
<td>2. Mandatory Training Compliance Appraisal Monitoring</td>
</tr>
<tr>
<td>3. Sickness Data</td>
</tr>
<tr>
<td>4. Survey Results</td>
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<tr>
<td>5. Operating Plan</td>
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#### Independent / semi-independent

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<tbody>
<tr>
<td>1. NHSI</td>
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<tr>
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<td>3. CCG</td>
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<tr>
<td>4. National award</td>
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### Inherent risk

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### Progress / Timescales

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>1 Recruitment and Retention Strategy in place and milestones mapped through HR&amp;OD Sub-Committee</td>
</tr>
<tr>
<td>1 Recruitment brand ‘Great place to live, great place to work’ was launched in 2018</td>
</tr>
<tr>
<td>1 Programme to improve automation of technology and systems to ensure our recruitment processes are agile, safe and secure new staff in the shortest time</td>
</tr>
<tr>
<td>1 NHSI supported programme to support a reduction in time to hire</td>
</tr>
<tr>
<td>1 Careers Facebook page went live in June 2018 with active followers of currently up to 600 to date</td>
</tr>
<tr>
<td>1 Travel to the Philippines Q4 to recruit acute nurses</td>
</tr>
<tr>
<td>1 Recruited 14 Registered Nurse Apprentices Sept 2018 and 12 Trainee Nursing Associate Apprentices Feb 2019. Further cohorts planned for Sept 2019</td>
</tr>
<tr>
<td>2 Examining the case for financial incentives to attract new employees</td>
</tr>
<tr>
<td>1 Recruitment Team shortlisted as a finalist for the ‘Best Recruitment Experience’ by Nursing Times workforce summit awards in October 2018</td>
</tr>
</tbody>
</table>
SO4: Objective: EXCELLENCE IN EMPLOYMENT

Committee: PERFORMANCE COMMITTEE

Executive Lead: DIRECTOR OF HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT

CQC Domain: WELL LED

STRATEGY

Risks to objective

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<td>1. Poor quality of appraisals</td>
<td>Management assurance</td>
<td>1. Lack of clarity on trajectory for addressing staffing gaps</td>
<td>1. Finalise the Recruitment and retention strategy</td>
<td>5 Ensuring all staff receive a comprehensive induction on the day they join the Trust and receive additional support in their first few months</td>
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<tr>
<td>2. Appraisal policy, paperwork in place for all staff</td>
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<tr>
<td>6. Whistleblowing Policy</td>
<td>6. Freedom to speak up guardian reporting</td>
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<tr>
<td>7. Anti-Bullying Advisors in place</td>
<td>7. Poor staff morale</td>
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<tr>
<td>8. Freedom to speak up guardian process operating effectively with clear oversight</td>
<td>8. Vision &amp; values</td>
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<tr>
<td>9. Staff Engagement Group in place</td>
<td>9. Lack of consistent communication at all levels</td>
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<tr>
<td>10. Staff Recognition Programme in place</td>
<td>10. Lack of formal internal communications strategy</td>
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<tr>
<td>11. OD &amp; Workforce Policy strategy not in place</td>
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<tr>
<td>12. Clinical Supervision policy</td>
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<td>13. Draft HR&amp;OD Strategy</td>
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<td>14. Recruitment and Retention strategy not in place</td>
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<tr>
<td>15. Communications Strategy - meet your chief executive</td>
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</table>

Risks from Risk Register:

1221 If unable to attract, recruit & retain sufficient staff of right quality/ skillset then the Trust will be unable to meet demand

1421 Inability to deliver financial plan due to need to use agency / locum staff

Principals risks:

Condition: Develop and retain the right staff

Staff are not motivated, engaged or effective in delivery of the Trust’s vision, values and aims

Cause: Poor staff morale, lack of clarity re objectives, lack of ability to influence, insufficient numbers of staff with appropriate skill mix. Stability of leadership team. Quality of appraisals. Poor communication.

Consequence: Failure to deliver high quality, safe patient care.

Risks to objective

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<td>4. Mandatory Training programme in place</td>
<td>4. Releasing staff for training</td>
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<tr>
<td>5. Induction process for all new employees</td>
<td>5. Not talent spotting / succession planning</td>
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<tr>
<td>6. Whistleblowing Policy</td>
<td>6. Freedom to speak up guardian reporting</td>
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<tr>
<td>7. Anti-Bullying Advisors in place</td>
<td>7. Poor staff morale</td>
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<tr>
<td>8. Freedom to speak up guardian process operating effectively with clear oversight</td>
<td>8. Vision &amp; values</td>
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<tr>
<td>9. Staff Engagement Group in place</td>
<td>9. Lack of consistent communication at all levels</td>
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<tr>
<td>10. Staff Recognition Programme in place</td>
<td>10. Lack of formal internal communications strategy</td>
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<td>11. OD &amp; Workforce Policy strategy not in place</td>
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<td>12. Clinical Supervision policy</td>
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<td>13. Draft HR&amp;OD Strategy</td>
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<td>14. Recruitment and Retention strategy not in place</td>
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<td>15. Communications Strategy - meet your chief executive</td>
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Risk Appetite: CAUTIOUS

(aspiring to be open)

Risks to objective

<table>
<thead>
<tr>
<th>Controls</th>
<th>Gaps in controls</th>
<th>Sources of Assurance</th>
<th>Assurance outcomes / gaps</th>
<th>Action plan</th>
<th>Progress / Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Produce weekly workforce information data and respond to trends</td>
<td>1. Poor quality of appraisals</td>
<td>Management assurance</td>
<td>1. Lack of clarity on trajectory for addressing staffing gaps</td>
<td>1. Finalise the Recruitment and retention strategy</td>
<td>5 Ensuring all staff receive a comprehensive induction on the day they join the Trust and receive additional support in their first few months</td>
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<tr>
<td>2. Appraisal policy, paperwork in place for all staff</td>
<td>2. No clinical supervision</td>
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<td>2. Lack of clarity on impact and timeframes at divisional level of workforce right sizing</td>
<td>2. Finalise the Workforce and OD strategy</td>
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<tr>
<td>3. Leadership Programme in place</td>
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Inherent risk

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Risk as at 1st April

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Current risk level Q4

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Target risk position by 31/3/19

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</table>
### Risks to Objective Controls Gaps in Controls Sources of Assurance Assurance Outcomes / Gaps Action Plan Progress / Timescales

<table>
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<th>Risks to objective</th>
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<th>Gaps in controls</th>
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<th>Assurance outcomes / gaps</th>
<th>Action plan</th>
<th>Progress / Timescales</th>
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</thead>
<tbody>
<tr>
<td><strong>Principal risks:</strong></td>
<td>1. Vision and values development</td>
<td>As detailed in the draft Leadership Strategy including: - Launch of new vision and values - Behaviours framework - Development programmes leading to on the ground change - Development of culture dashboard</td>
<td>Management assurance</td>
<td>Gaps: - As detailed in the draft Leadership Strategy including: - Need for greater staff feedback and increase in use of surveys</td>
<td>Full project plan included in draft Leadership strategy to be approved in Q4 including projects relating to: - Leadership Development Framework - Culture Change Programmes - Communication and Engagement - Creating a broader compassionate community which is outward looking - HR Policies and Processes to support a compassionate culture</td>
<td>Roll out of new vision and values and Leadership Strategy – approved Q4</td>
</tr>
<tr>
<td><strong>Condition:</strong></td>
<td>2. Leadership programmes throughout the organisation</td>
<td></td>
<td>1. HR &amp; OD Sub Committee</td>
<td></td>
<td></td>
<td>Commenced use of culture dashboard to improve visibility of information and improve reporting</td>
</tr>
<tr>
<td><strong>Cause:</strong></td>
<td>3. Visible leadership</td>
<td></td>
<td>2. Cultural Leadership Steering Group</td>
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<td>Ensuring all staff receive a comprehensive induction on the day they join the Trust and receive additional support in their first few months</td>
</tr>
<tr>
<td><strong>Consequence:</strong></td>
<td>4. Equality &amp; Diversity programme</td>
<td></td>
<td>3. Quality Committee</td>
<td></td>
<td></td>
<td>Consulting staff on new workforce policies and practices that create a positive and supportive working environment</td>
</tr>
<tr>
<td><strong>Risks from Risk Register:</strong></td>
<td>5. Trust strategy development</td>
<td></td>
<td>4. Performance Committee</td>
<td></td>
<td></td>
<td>New Communications &amp; Engagement lead jointly appointed with the Council for partnership approach to driving change</td>
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<tr>
<td>Not succeeding to embed cultural change within the organisation</td>
<td>6. Board development</td>
<td></td>
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<td></td>
<td>10 core behaviours mapped to our Organisation’s values</td>
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<tr>
<td>Failure to deliver high quality, safe patient care,</td>
<td>7. Freedom to speak up and Anti- Bullying campaigns</td>
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<tr>
<td>Condition:</td>
<td>Culture within the Trust</td>
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<tr>
<td>Cause:</td>
<td>Poor staff morale, historic embedded behaviours and expectations</td>
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<tr>
<td>Consequence:</td>
<td>Failure to deliver high quality, safe patient care,</td>
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<tr>
<td>Inherent risk</td>
<td>Risk as at 1st April</td>
<td>Current risk level Q4</td>
<td>Target risk position by 31/3/19</td>
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<td>Likelihood</td>
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<tr>
<td>Risks to objective</td>
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<td>Gaps in controls</td>
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<tr>
<td><strong>Principal risks:</strong></td>
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<tr>
<td><strong>Condition:</strong> Lack of a Trust enabling strategy and supporting clinical and other strategies</td>
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<tr>
<td><strong>Consequence:</strong> Failure to deliver a vision of effective, efficient, affordable high quality health services for the population of the Isle of Wight</td>
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<tr>
<td><strong>Cause:</strong> Isle of Wight Health System Strategy in place that has been led by the Trust and supported by all stakeholder organisations</td>
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<tr>
<td><strong>Risks from Risk Register:</strong> Risks have been mitigated and will be reset to new 19/20 position</td>
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<tr>
<td>1. Five new strategic objectives initially proposed and agreed by the Board in November 2017 as part of Board Assurance Framework (BAF) and subsequently agreed by the Board as appropriate for 2018/19</td>
<td>1. No Isle of Wight Health System Strategy in place that has been led by the Trust and supported by all stakeholder organisations</td>
<td>1. Consideration of strategy at recent Board and Board Seminars</td>
<td>1. Specific gaps of assurance to be outlined following the identification of specific assurance reports</td>
<td>The plan remains for the Trust to have a developed overall strategy between September 2018 and December 2018.</td>
<td>Islandwide plan developed across Trust, CCG and Council and seen at Board with implementation plan to be brought forward for agreement</td>
<td></td>
</tr>
<tr>
<td>2. Business Planning 2018/19 proposals considered by the Board leading to Business Plan and supporting Financial Plan Board approval</td>
<td>2. Current Trust strategy does not adequately meet the current and future needs of the organisation and does not fully or overly address strategies for community, ambulance and mental health</td>
<td>2. Plan agreed for the development of an overall strategy and underpinning supporting strategies</td>
<td>2. Entry to special measures highlighted a lack of progress and drive to deliver – leadership</td>
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<tr>
<td>3. Development of the acute services redesign – option 4 recommended by CCG 1/2/18 and supported by the Trust’s Board</td>
<td>3. Trust Strategy does not fully derive options based on population need, prevalence and impact on pathways</td>
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<td>3. Financial position seriously deteriorated, highlighting the fragility of sub-scale services</td>
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<tr>
<td>4. Local Care Board established with stated priorities</td>
<td>4. Trust Strategy lacks clear delivery plan and staff and stakeholder engagement was limited</td>
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<tr>
<td>5. Creation of a community services redesign programme</td>
<td>5. Trust Strategy does not address the benefits of being an integrated Trust or whether these were currently being achieved</td>
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<tr>
<td>6. Development of a blueprint for mental health &amp; learning disabilities as new model for MH and progressing some tactical actions i.e.; relocation of early intervention in psychosis and community mental health</td>
<td>6. Supporting strategies not all in place approved by the Board</td>
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<tr>
<td>7. Solent Acute Alliance (SAA) to review how a range of services (pharmacy, spinal surgery, renal, vascular &amp; back office) can be better coordinated between Southampton, Portsmouth and IoW</td>
<td>7. Lack of Trust underpinning strategies including Estates &amp; Facilities, IM&amp;T, Workforce and Recruitment and Retention approved by the Board</td>
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<tr>
<td>8. Creation of a pathology network across SAA and Hampshire and Dorset</td>
<td>8. System context is complex and needs to take into account: the system-wide developments (listed under controls)</td>
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<tr>
<td><strong>Enabling Strategy:</strong> TRUST OVERALL STRATEGY</td>
<td><strong>Sources of Assurance</strong></td>
<td><strong>Assurance outcomes / gaps</strong></td>
<td><strong>Action plan</strong></td>
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<tr>
<td></td>
<td>Metrics</td>
<td>Outcomes: Isle of Wight Health System Strategy led by the Trust and supported by all stakeholder organisations</td>
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<tr>
<td></td>
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<td>1. To be a clinically, operationally and financially sustainable Trust</td>
<td>1.</td>
<td>The plan remains for the Trust to have a developed overall strategy between September 2018 and December 2018.</td>
<td>Islandwide plan developed across Trust, CCG and Council and seen at Board with implementation plan to be brought forward for agreement</td>
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<tr>
<td></td>
<td></td>
<td>Independent / semi-independent</td>
<td>2. Trust Strategy approved by the Board</td>
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<tr>
<td></td>
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<td>1. Local Care Board</td>
<td>3. Trust supporting strategies including Clinical, Operational and Financial approved by the Board</td>
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<td>2. NHSI</td>
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<td>5. Internal Auditors</td>
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<td>6. Other external advisors to the Trust</td>
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- Does the strategy move the Trust to operational, clinical and financial sustainability?
- To have answered a series of high-level questions that will shape the future, strategic position of service provided by the Trust (and partners), including:
- What is the Trust's sustainability?
- How will we exit special measures and get to good by 2020?
- What are the invest and disinvest criteria?
- Do we make, share or buy services and do we expand into new areas of health & social care, such as primary care, or withdraw from some aspects of current provision?
- What is the Trust's vision and values to drive cultural change
To clearly describe the benefits of being an integrated Trust with supporting and enabling strategies.

<table>
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<tr>
<th>Inherent risk</th>
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<th>Current risk level Q4</th>
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### Principal risks:

**Condition:**
- Failure to set out and implement an analytics and digital technology strategy/plan

**Cause:**
- Lack of a Trust ICT Strategy

**Consequence:**
- Failure to deliver a vision of effective, efficient, affordable high quality health services for the population of the Isle of Wight

### Gaps in controls

1. No Trust ICT Strategy developed and approved by the Board
2. No Trust underpinning funded ICT plan developed and approved
3. No Trust Information Strategy developed and approved by the Board
4. No Trust underpinning funded Information Plan developed and approved
5. Failure to articulate workplan
6. Lack of fully developed user group to support prioritisation and engagement

### Sources of Assurance

**Management assurance**
- 1. Performance Committee
- 2. ICT Sub Committee

### Assurance outcomes / gaps

**Gaps:**
- 1. Supporting internal groups and forums reporting to ICT Sub Committee and attended by representatives from each Division and Corporate Function
- 2. ICT underpinning funded plan to be developed
- 3. Information Strategy to be developed
- 4. Information underpinning plan to be developed
- 5. User group to be developed

### Action plan

1. ICT Strategy to be developed
2. ICT underpinning funded plan to be developed
3. Information Strategy to be developed
4. Information underpinning plan to be developed
5. User group to be developed

### Progress / Timescales

Management of the strategic risks has not progressed at the desired pace. Overarching actions include:
- 4 Internal Audit report showed reasonable assurance on data quality and cyber security maturity audit completed
- 5 Digital User Group is in place with representation from Trust, Council and CCG to ensure Islandwide approach and ensure effective links to wider STP developments

### Metrics

**Independent / semi-independent**
- 1. NHSE/I
- 2. CCG
- 3. STP
- 4. Local Care Board
- 5. Internal Auditors

**Outcomes:**
- 1. ICT Strategy approved by Board
- 2. ICT underpinning funded plan with agreed timescales
- 3. No clinical risks associated with ICT infrastructure / systems / information

### Inherent risk

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### Current risk level Q4

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<tbody>
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### Target risk position by 31/3/19

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**SO5: Objective:** LEAD STRATEGIC CHANGE ON ISLE OF WIGHT

**Executive Lead:** DIRECTOR FEIMT

**CQC Domain:** WELL LED

**Enabling Strategy:** TRUST OVERALL

### Strategic Theme: STRATEGY / ENGAGEMENT

**Risks to objective**

<table>
<thead>
<tr>
<th>Controls</th>
<th>Gaps in controls</th>
<th>Sources of Assurance</th>
<th>Assurance outcomes / gaps</th>
<th>Action plan</th>
<th>Progress / Timescales</th>
</tr>
</thead>
</table>

**Management assurance**

- 1. Supporting internal groups and forums reporting to Estates and Facilities Sub Committee and attended by representatives from each Division and Corporate Function
- 2. Estates and Facilities Strategy approved by Board

**Gaps:**

- 1. Estates and Facilities Sub Committee to be established
- 2. Estates Strategy to be developed
- 3. Estates underpinning funded plan to be developed
- 4. Facilities Strategy to be developed
- 5. Facilities underpinning plan to be developed

**Metrics**

- 1. No clinical risks associated with Estates and Facilities

**Outcomes:**

- 1. Estates and Facilities Strategy approved by Board
- 2. Estates and Facilities underpinning funded plans with agreed timescales

**Independent / semi-independent**

- 1. NHSE/I
- 2. CCG
- 3. STP
- 4. Local Care Board
- 5. Internal Auditors

### Inherent risk

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<th>Impact</th>
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</table>

**Progress / Timescales**

- 3&4 - Overarching strategy work with the Council and CCG finalising an Island-wide plan which will inform estates strategy development.
- 3 - Engagement with STP estates groups continues but development of ASR implications has not been at anticipated pace.
- 3 - Ongoing service reviews across SAA to explore partnership working.
- 3 & 4 - Strategy review commenced with Trustwide meeting to prioritise initial focus – high level schemes identified.
- 3 - Wight Life Partnership review of North Site completed and wider review of options for use under development.
- 1 - Estates and Facilities sub-group established.
Board members were invited to complete a self-assessment of the organisation against each of the CQC well led key lines of enquiry (KLOE) by making an assessment of each of the 46 CQC prompts (statements) and the outputs were considered at Trust Board seminar on 7 March.

At the seminar, Board members concurred with the views that emanated from the self-assessment, in particular that there were 13 of the 46 statements where a third or more Board members were not sufficiently assured that the Trust met the requirements. It was agreed that a progress would be provided to Trust Board seminar on 4 April and this outlined the process for providing the Board will a report providing Trust Board with an Executive view and position regarding those 13 statements.

This report provides that response with a one-page summary for each of the 13 statements where a third or more Board members considered that they were not sufficiently assured of the Trust’s position. These responses show that significant progress has been made during the past 18 months and refers, where relevant, to the further plans for continually improving those aspects of well led.

Key Recommendation

The Trust Board is recommended to receive this report as assurance of the progress made and further plans in relation to the 13 statements where a third or more of Board members considered that they were not assured when completing the self-assessment.
Well Led Framework
Self Assessment

Update to Trust Board

Suzanne Rostron
Director of Quality Governance

2 May 2019
Board Self Assessment – Recap

- Undertaken and considered at Trust Board Seminar in March
- Update report provided to Board Seminar in April
- 8 Key Lines of Enquiry (KLOE) with 46 statements (CQC prompts)
- 13 statements for specific focus across 5 KLOE where a third or more Board members had concern
### Rating Assessment of each Key Line of Enquiry and overall for Well-Led

<table>
<thead>
<tr>
<th>Key Line of Enquiry</th>
<th>Inadequate</th>
<th>Requires Improvement</th>
<th>Good</th>
<th>Outstanding</th>
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</thead>
<tbody>
<tr>
<td>1. IS THERE THE LEADERSHIP CAPACITY AND CAPABILITY TO DELIVER HIGH QUALITY, SUSTAINABLE CARE?</td>
<td></td>
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<tr>
<td>2. IS THERE A CLEAR VISION AND CREDIBLE STRATEGY TO DELIVER HIGH QUALITY SUSTAINABLE CARE TO PEOPLE WHO USE SERVICES, AND ROBUST PLANS TO DELIVER?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. IS THERE A CULTURE OF HIGH QUALITY, SUSTAINABLE CARE?</td>
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<tr>
<td>4. ARE THERE CLEAR RESPONSIBILITIES, ROLES AND SYSTEMS OF ACCOUNTABILITY TO SUPPORT GOOD GOVERNANCE AND MANAGEMENT?</td>
<td>Org</td>
<td>Board</td>
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<tr>
<td>5. ARE THERE CLEAR AND EFFECTIVE PROCESSES FOR MANAGING RISKS, ISSUES AND PERFORMANCE?</td>
<td>Org</td>
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<tr>
<td>6. IS ROBUST AND APPROPRIATE INFORMATION BEING EFFECTIVELY PROCESSED AND CHALLENGED?</td>
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<tr>
<td>7. ARE THE PEOPLE WHO USE SERVICES, THE PUBLIC, STAFF AND EXTERNAL PARTNERS ENGAGED AND INVOLVED TO SUPPORT HIGH QUALITY SUSTAINABLE SERVICES?</td>
<td></td>
<td></td>
<td>Acute</td>
<td>MH/Comm/Amb</td>
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<tr>
<td>8. ARE THERE ROBUST SYSTEMS AND PROCESSES FOR LEARNING, CONTINUOUS IMPROVEMENT AND INNOVATION?</td>
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</tbody>
</table>

**OVERALL**
## Executive Director Lead for each Key Line of Enquiry

<table>
<thead>
<tr>
<th>Key Line of Enquiry</th>
<th>Executive Director Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. IS THERE THE LEADERSHIP CAPACITY AND CAPABILITY TO DELIVER HIGH QUALITY, SUSTAINABLE CARE?</td>
<td>Director of Human Resources &amp; OD</td>
</tr>
<tr>
<td>2. IS THERE A CLEAR VISION AND CREDIBLE STRATEGY TO DELIVER HIGH QUALITY SUSTAINABLE CARE TO PEOPLE WHO USE SERVICES, AND ROBUST PLANS TO DELIVER?</td>
<td>Deputy Chief Executive / Director of Finance, Estates &amp; IM&amp;T</td>
</tr>
<tr>
<td>3. IS THERE A CULTURE OF HIGH QUALITY, SUSTAINABLE CARE?</td>
<td>Director of Human Resources &amp; OD</td>
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<tr>
<td>4. ARE THERE CLEAR RESPONSIBILITIES, ROLES AND SYSTEMS OF ACCOUNTABILITY TO SUPPORT GOOD GOVERNANCE AND MANAGEMENT?</td>
<td>Director of Quality Governance</td>
</tr>
<tr>
<td>5. ARE THERE CLEAR AND EFFECTIVE PROCESSES FOR MANAGING RISKS, ISSUES AND PERFORMANCE?</td>
<td>Director of Quality Governance</td>
</tr>
<tr>
<td>6. IS ROBUST AND APPROPRIATE INFORMATION BEING EFFECTIVELY PROCESSED AND CHALLENGED?</td>
<td>Deputy Chief Executive / Director of Finance, Estates &amp; IM&amp;T</td>
</tr>
<tr>
<td>7. ARE THE PEOPLE WHO USE SERVICES, THE PUBLIC, STAFF AND EXTERNAL PARTNERS ENGAGED AND INVOLVED TO SUPPORT HIGH QUALITY SUSTAINABLE SERVICES?</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>8. ARE THERE ROBUST SYSTEMS AND PROCESSES FOR LEARNING, CONTINUOUS IMPROVEMENT AND INNOVATION?</td>
<td>Director of Quality Governance</td>
</tr>
</tbody>
</table>
Responses for the 13 specific statements for which a third or more Board members had concerns
Response – KLOE 1.4

‘Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?’

Response

• Leadership Strategy approved by Board in March 2019
• “Getting to Good” Leadership and Culture Programme – Leadership Development Framework in place
• Board Leadership Development commenced September 2018
• Executive Team Leadership commenced June 2018
• Leadership Conference held in March 2019
• Appropriate governance in place with Culture and Leadership Steering Group
• Organisation, Division and Directorate culture dashboards operational
• Senior Leaders Development Programme in progress for 37 of the top leaders
• Medical leadership Development Programme in progress
• Middle Leaders Development Programme in progress, with cohort 1 for 24 leaders and cohort 2 for 43 leaders
• Team Leaders and Supervisors Development Programme to commence
• Fundamentals for personal growth at work programme to commence
• Annual training Needs Analysis in place
• Further improvement for succession planning through specific talent management plans identified including engagement with Leadership Academy for support and establishing a framework to effectively spot and manage talent
Response – KLOE 2.2

"Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care?"

Response

• The Trust has a clear vision and a strap line of “Getting to Good….. aiming for outstanding” and clear values of compassionate, team working, improving and valued.
• System-wide approach to the development of a system-wide health and care strategy which subsequently morphed in to the development of a three-year system-wide health and care sustainability plan, which has now been produced and agreed by system partners, with NHSI and NHSE support, and presented to Board on 2 May 2019.
• The Trust’s operational plan for 2019/20 sets out the priorities for the year which identify what the Trust is specifically focusing on achieving in 2019/20 and aligns to the sustainability plan.
• The strategic objectives, underpinning the priorities, are being agreed with Board as part of the assessment of the strategic risks for 2019/20 on 2 May 2019.
• Each of the four Divisions within the Trust have developed operational plans for 2019/20 which identify priorities and objectives and align to the overall Trust operational plan, which includes financial plans.
• The operational plan is delivered through the Trust’s performance management approach providing a framework for staff at all levels to be clear about priorities, progress against them and how they can contribute, in addition to steering the development of improvement initiatives to support these aims.
• The Trust has a fully refreshed Quality Strategy aligned to the Darzi quality pillars: Patient safety, Clinical outcomes, Patient experience, Staff engagement and experience.
• Clinical strategies and models are being developed in conjunction with system-partners now that a system-wide sustainability plan has been agreed and these will build on the existing Acute Services Redesign, Community Services Transformation and Mental Health Blueprint.
• The Trust has a workforce and organisational development strategy, a recruitment and retention strategy and a leadership strategy.
• The Trust is in the process of refreshing and developing underpinning supporting strategies including estates and IT.
"Do staff know and understand what the vision, values and strategy are, and their role in achieving them?"

Response

• To support the roll-out of our strategies, communication plans have been developed and tailored to different audiences to best reach staff in different parts of the organisation.

• The refreshed vision and values developed in the Trust during 2018 were communicated extensively throughout the organisation and emphasised in the widely available booklet “Getting to Good – our culture and leadership improvement journey”.

• The appraisal process for 2019/20 is a key mechanism to support the communication of the vision, values, sustainability plan and operational plan, through defining how each member of staff’s role will support delivery and setting appropriate objectives.

• The Divisional operational plans for 2019/20 were developed in conjunction with the respective senior clinical and non-clinical teams, who will use the plans to underpin the agreement of objectives at service and departmental levels.

• Now that a system-wide sustainability plan has been agreed by system-partners, the Trust are developing a communications plan for ensuring all staff are aware of it and how their respective services or departments will support delivery, including roadshows delivered by the Chair and Chief Executive.
"Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?"

Response

• The Trust reports regularly through its governance arrangements on progress against delivery to the Board and Committees, providing assurance and identifying key risks and mitigations to delivery.
• Performance against the Trust’s priorities and objectives is focused and reinforced through the Trust’s Integrated Performance Review (IPR) process.
• Divisional Boards and the supporting Divisional Committees monitor the progress of delivery against operational, quality, workforce and financial plans against targets and KPIs on a monthly basis, identifying risks to delivery and escalating where necessary to Executive Directors through the IPR process.
• Progress is reviewed regularly with external partners and regulators through various forums including Local Care Board, Health Oversight and Scrutiny Committee, Integrated Assurance Meeting with NHSI and Quality Improvement Programme Oversight Group with NHSI, CCG, Healthwatch and CQC.
• The annual business planning process includes a comprehensive timeline incorporating the ongoing monitoring and review of plans and provides a logical cyclical approach taking account of regulatory requirements.
‘Do staff feel supported, respected and valued?’

Response

• Improving the experience and engagement of our staff is fundamental to delivering a culture of high sustainable care and our strategic objectives.
• Our staff are at the heart of our values which are compassionate, teamworking, improving and valued, which are encapsulated within the “Getting to Good – our culture and leadership improvement journey” booklet, made available to all staff.
• We aim to empower staff to make improvements and to be listened to and respected.
• We have listened to what our staff said in the 2018 NHS National Staff Survey and in response we have developed plans to improve staff experience and engagement.
• To ensure we can measure the improvements we are making, we have developed a monthly ‘pulse survey’ to monitor improvements and provide feedback to divisions and departments.
• We recognise the importance of leadership behaviours and this is key within the Leadership Strategy 2019-2021.
• Improvements are being made in appraisals, both rates and quality and this should help staff feeling valued.
• We monitor and gain insights from our staff family and friends test.
• Senior leaders act as role models re inclusive behaviour and not tolerating poor behaviours.
• We have a freedom to speak up policy and process.
• We aim to continually improve holding those to account those leaders that are not valuing staff.
Response – KLOE 3.3

‘Do staff feel positive and proud to work in the organisation?’

Response

• Many of our staff do feel positive to work in the organisation; however, the potential of redeployment and other uncertainties for staff create added challenges for the organisation.

• Our Staff Awards and the number of and quality of the applications clearly demonstrated the amazing contributions our staff make to improving care for patients and how positive they feel about their service.

• Only about 40% of our staff are proud to work within the organisation and this is being addressed through developing our leaders to communicate positive messages.
Response – KLOE 3.6

‘Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations?’

Response

• Over the last 12 months we have significantly improved our appraisal rates.
• We have now commenced reviewing the effectiveness and quality of the appraisal conversations through surveying staff.
• The Trust’s Education Department supports the learning needs of all staff and has Practice Educators working clinically across the organisation.
• The Trust’s HR and OD Improvement Delivery Plan and the Leadership Strategy both include a focus on improving appraisals with a focus on values based appraisals.
‘Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?’

Response

• There has been a significant cultural shift with the changes in leadership, the new divisional structures and introduction of safety huddles has fostered the corporation and collaboration of staff.
• As a result the motivation and morale of staff has improved and this has seen a significant reduction in conflict.
• In a small number of areas where we have had concerns we continually work directly with these teams to improve.
• Our continued plans underpinning our “Getting to Good” Leadership and Culture Programme will help to improve collaborative working.
• Enhancements in mechanisms for holding our leaders to account for addressing deficiencies in relationships amongst staff are expected to result in improvements.
"Is there a holistic understanding of performance, which sufficiently covers and integrates people’s views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?"

Response

• The Trust’s strategic objectives set the context for the understanding of performance across the key strategic themes.
• The Trust undertakes monthly integrated performance review meetings with Divisions to consider a rounded view of performance, this comprises of a balanced scorecard of quality (patient safety, outcomes and experience including patient and staff survey experience metrics and complaints), operational performance, financial and workforce metrics.
• Using standard working approaches with defined triggers for review, Divisions present outlying performance metrics and project updates, describing the challenge, stratifying reasons and describing actions with timescales to drive improvement, which allows executive level visibility, risk assessment, formal escalation, ratification and challenge as part of a routine monthly performance and improvement cycle.
• From an efficiency perspective, the Trust utilises the Model Hospital tool.
• The Trust also makes great use of benchmarking for improvement through the ‘Getting it right first time’ programme.
• Inter-relationships between KPIs between quality, operational, workforce and financial needs to be improved regarding the correlation between the variables to ensure the right balance between quality and productivity.
• KPIs are in the process of being redeveloped so that they not only meet the contractual and statutory obligations but also align to the recently developed sustainability plan.
• Whilst there is general recognition that there is good information to support assurance, information to measure improvement is being developed with reporting at divisional and executive levels, for example, re urgent care flow, a weekly dashboard has been developed that measures various aspects of flow with the aim of determining that the changes made are effective.
• Accountability reporting is robust with a recognition that between the PIDS team and PMO team there is a need to further improve mechanisms for exception reporting, especially in the correlation of the impact between the four Divisions.
"Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?"

Response

- The Trust has developed a comprehensive data quality policy and has introduced a framework tool for the assessment of data quality within the Trust reported quarterly to Performance Committee.
- This framework seeks to identify by exception, departments and staff groups where poor quality processes or outputs may affect patient safety risks (for example, duplicate registration, misidentification, delay in recording clinical events, etc) or inaccurate reporting due to inadequate data quality (for example, the closing down of outpatient clinics and outcome of the appointments on the system).
- Within specific systems there are a range of data quality measures that highlight potential issues which are aimed at operational staff (for example, the weekly access meeting reviews the relevant data quality measures to ensure that the waiting list remains valid and correct).
- Internal Audit has undertaken an audit during each of the last three years with no significant findings.
- The Trust has recently been subject to an external waiting list validation review initiated by NHSI, whilst the formal report has not yet been received, the informal feedback suggests that there are no significant findings.
- Plans are in place to develop the architecture with a single data warehouse which would include a range of data quality algorithms focussing on the data that is most at risk of being inaccurate; this will be a long process to fully implement given the resource available for data validation and for architecture development.
- The Trust currently monitors, investigates and corrects the following data issues as part of routine process in relation to external data submission including timeliness of data entry, duplicate registrations, patient misidentifications and GP practice completeness.
- Web forms have been increasingly utilised to support data capture especially related to quality measures and indicators; however, further use of such mechanisms is required to enhance robustness of data capture.
"Are there standardised improvement tools and methods, and do staff have the skills to use them?"

Response

- Quality improvement approach is aligned to the Quality Strategy with a methodology for continuous improvement within the Trust developed and adopted.
- Training has been provided to over 400 of the Trust’s staff utilising the Plan Do Study Act (PDSA) approach.
- A target of continuing the roll-out of this training has been agreed of 100 staff per month.
- Two members of the Quality Improvement Team are currently undertaking QSIR (Quality Service Improvement and Redesign) Programme with the aim of graduating in December 2019; and this approach is being undertaken on a system-wide approach in conjunction with the CCG who also has a member of staff undertaking the same course.
- By early 2020, a plan and approach will be formed to roll-out the QSIR approach across the Trust.
- Other forms of improvement training and tools are being utilised by the Trust’s specialty doctors.
- An approach used during 2018/19 which continues in 2019/20 has been the “10-week Improvement Cycle” with the Community Division utilising it significantly and linked to the PDSA training.
"Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?"

Response

- Staff regularly take time out to resolve problems through huddles at local ward and departmental levels where improvements are raised to support the achievement of objectives.
- There remain pockets of the organisation where consistency in understanding objectives by all members of teams needs to improve and with this in place, will help to facilitate the working together to resolve problems.
- Further improvements will be achieved through objective setting for 2019/20 and the business planning at division and department levels, with clear objectives and KPIs, known and understood by all.
- There are some excellent examples of where working together has worked well, these include within the Community Division (0-19 services, Community Nursing Improvements), the transformation work within Mental Health Division, the consideration of the WHO checklist by Theatres Team and the approach the Ambulance have taken to improve staff morale as well as deliver against key actions that were required.
"Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?"

Response

- Objectives for 2018/19 were clear from the Trust, executive and divisional perspective and are planned to be updated for 2019/20 on 2 May 2019.
- The Quality Strategy priorities have been adopted by each Division to ensure implementation and delivery are led at service level.
- Improvements are being shared through newsletters and use of social media; however, it is planned for communications to be enhanced during the coming months, including the need to strengthen the celebration of good practice and successes.
- An approach called GREATRIX has been adopted which is a way of recognising good work and successes so that the learning can be shared with others.
- The sharing of results of quality improvement training is being undertaken including to Quality Improvement Board; however, this is largely in terms of numbers training rather than details of the outcomes of the training and as the impact of the training materialises with tangible outcomes then these will also be reported.
<table>
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<th>Meeting</th>
<th>Trust Board in Public</th>
<th>Meeting Date</th>
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</tr>
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<td><strong>Title</strong></td>
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<tr>
<td><strong>Sponsoring Executive Director</strong></td>
<td>Suzanne Rostron, Director of Quality Governance</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
| **Author(s)**  | Vanessa Flower, Head of Quality Governance  
Karen Kitcher, Incident Lead  
Jo Case, Head of Service Improvement |
| **Report previously considered by inc date** | |
| **Purpose of the report** | Information only | Assurance | X |
|                          | Review and discuss | Agreement | |
| **Reason for submission to Trust Board in Private only (please indicate below)** | Commercial Confidentiality | Staff Confidentiality |
|                          | Patient Confidentiality | Other Exceptional Circumstance |
| **Link to Trust Strategic Objectives** | Provide safe, effective, caring and responsive services – ‘Good’ by 2020 | X |
|                          | Ensure efficient use of resources | |
|                          | Achieve NHS constitutional patient access standards | |
|                          | Achieve excellence in employment, education and development | |
|                          | Lead strategic change on the Isle of Wight | |
| **Link to CQC Domains** | Effective | Responsive | |
|                          | Caring | Well-led | |
|                          | Safe | X | |
| **Executive Summary** | This report informs the Board of the Quality Improvements, concerns or risks and actions being taken to address them. | |
| The key issues to inform the Board of are: | |
| • Quality Account stakeholder consultation commenced on 23 April 2019, the draft will be provided to the Board on 24 May for review and scrutiny prior to final submission on 30 June 2019. | |
| • 16 Serious Incidents reported during March. | |
| • 8 Serious Incidents were submitted for closure, 75% of these were outside of timescale. Whilst the position of backlog SI cases is improving cases from late 2018 are still being managed. | |
| • The implementation of the Weekly Patient Safety Summit is providing improved scrutiny of incidents and leading to a reduction in the number of serious incidents being reported in line with NHS England SI Framework (2015) ensures appropriate reporting. | |
| • Interim Head of Legal now in post and reviewing Trust processes, working closely with Trust Solicitors. | |
| • Notification of 17 Inquests received during March. | |
• 8 Clinical claims in March.
• 32 Complaints in March; 4 were returning complaints.
• Acute only achieving 46% of complaints managed in time against target of 75% this year, 95% in 2019/20.
• Improved proactive PALS service has seen increase in number of concerns managed at 73 this month.
• 1 case closed by PHSO in March which was Partly upheld. Action to be taken by Medical Director to ensure Trust is acting in line with National Guidance for use of local anaesthetic in Arterial Blood gas testing.
• Trust continues to participate in the National Patient Survey Programme – Results of the Adult Inpatient Survey have been shared with Trust but are under embargo until May / June.
• Quality Improvement Board for fifth time on 10 April. Areas highlighted as a risk are to be monitored weekly through Executive Team meeting.
• Significant improvements have been made across the majority of the Quality Improvement plan.
• Trust has been notified of CQC inspection dates. Well Led inspection to be held 18 to 20 June.

**Key Recommendation**

The Trust Board is asked to consider the following recommendations:

- Decide if sufficient assurance has been received in relation to the issues raised in this report
- Receive the dates of the anticipated CQC inspections.
1. Purpose of the paper
To inform the Board of any quality improvements, concerns or risks and advise of actions being taken.

2. Background
The ‘Quality Report’ summarises key information that has been presented to Quality Committee that the Board needs to be sighted on. The Quality Committee Sub-Committees receive more detailed information and interrogate thematic and trend analysis. The extent of this continues to improve as the processes are further embedded.

The Quality Committee receives escalation and assurance reports and will investigate issues to seek assurance on behalf of the Trust Board. This report provides an overview of key issues or achievements and seeks approval when necessary.

3. Quality Account
A draft of the Quality Account was sent to our stakeholders on 23rd April 2019 and the Trust expects to hear back by the 3rd June 2019 giving them adequate time to review the draft and provide their statements.

The Trust has been advised that our limited assurance from Ernst and Young LLP will be completed towards the end of May 2019; however we have challenged this timescale, to give us sufficient time to complete any amendments and improve the documents aesthetics. Within this timeframe the report will also be converted into an easy read version.

The final version will be provided to board for scrutiny on the 24th May 2019 for review and possible amendments ready for final submission by 30th June 2019.

4. Serious Incidents

4.1 New incidents reported
16 serious incidents were declared to the Isle of Wight Clinical Commissioning Group (CCG) during March 2019.

In April, up to 10.04.19, 2 serious incidents have been declared.

A detailed summary of the incidents reported in March, including any immediate actions taken is included in the private board papers. The final number of incidents each month is subject to change due to the change in our policy of declaring serious incidents at the earliest opportunity and requesting de-escalation should the investigation indicate this is appropriate.
4.2 Ongoing Serious Incident Management

In March 2019, 8 cases were submitted to the IW CCG for closure; 2 were submitted within timescale; 6 were submitted out of timescale. There were no requests for “downgrade” this month.

Below is a summary of closure by Division for year 2018/19 (up to 22.03.19). The number out of time is reflective of the backlog of SI cases that were open over the last two years. This situation has improved and we are currently managing cases from the latter part of 2018 to current date.

<table>
<thead>
<tr>
<th>DIVISION</th>
<th>Area</th>
<th>Number out of time</th>
<th>Number in-time</th>
<th>Downgrades requested (of totals on left)</th>
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<tbody>
<tr>
<td>Acute</td>
<td>Acute - Surgery, Women’s, Children’s</td>
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<td>Acute – Medicine</td>
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<tr>
<td></td>
<td>Acute - Clinical, Cancer &amp; Diagnostics</td>
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<tr>
<td>Ambulance*</td>
<td>Ambulance</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Mental Health &amp; Learning Disabilities</td>
<td>22</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Community</td>
<td>Community services</td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

* next month’s report (April 2019) will align to the Trust’s new Divisions

4.3 Serious Incident Performance

Key Performance Indicators (KPI) against the SI process; chart below demonstrates the KPI status across all Divisions up to end March 2019.

4.4 Weekly Patient Safety Summit

The new Exec-led Weekly Patient Safety Summit, where leads from across the Divisions meet to discuss ongoing incidents, including new incidents risk scored moderate and above, is proving influential in improving the timeliness of incident reviews and also the timeliness of downgrading incidents where applicable. Early intervention by the heads of service is proving valuable in sharing the knowledge and requirements of effective incident reporting. This in turn is leading to a reduction in the number of SIs being reported, as earlier review of the circumstances indicates whether an incident meets the current NHS England SI Framework (2015).
5. Inquests

During April the Trust appointed an Interim Head of Legal to support the Trust with the inquest process and liaising with the Coroner’s office.

During March the Trust received 17 Schedule 5 requests for information in relation to Coroners Inquests.

At the time of reporting the Trust continues to await the outcome of all inquests held in March, details of those that we have received are provided in the Private Board Papers.

During April at the time of reporting 15 Inquests have been or are being held.

6. Claims

There were 8 clinical claims in March (1 additional to those reported previously) an actual claim in relation to urology (TURP procedure). With 5 clinical cases closed, further information on these can be found in Part 2 (Private) Board Paper.

One non clinical case was closed as the Claimant discontinued the case against the Trust.

7. Complaints

During March 32 complaints were received compared to 38 in February 2019; and as of the 11 April 2019 a total of 8 complaints have been received. Of the complaints received 28 were new complaints and 4 were returning complaints. The returning complaints related to:

- An almost identical complaint previously raised and the same situation arose.
- Disagreed with content of final response (disagreed with timings of ambulance).
- Given assurances that posters would be displayed in previous response, they are not.
- Further reassurances requested following receipt of final letter (medications and follow-up appointments).

Two of the cases above identify the importance of ensuring that actions are taken following patient feedback, and these have been shared with the relevant Divisions.

The number of concerns received in March was higher with 73 compared to 64 in February 2019. This is a positive position as it supports the positive improvement in how PALS are managing issues more proactively.

The Chart below shows the number of concerns and complaints received per month between April 2018 to March 2019:
Due to reduced capacity in the Patient Experience Team unfortunately only 84% of complaints were acknowledged in time, compared to 97.5% achieved in February; of the 34 complaints closed across the Trust in March 47% were managed within the agreed timescale, which is an improvement on the 35% managed in February 2019.

Some of the delays in the process are due to a decrease in the quality of the responses, presented for signature, requiring further work to be undertaken. The Executive Director for each Division is required to sign off the responses before being submitted to the Chief Executive for final review and sign off.

The delays in the Acute Division are causing the Trusts overall compliance against the target response rate of 75% to not be achieved; as can be seen in the breakdown below.

The Trust's aim was to achieve 75% compliance with the 30 day timescale by the end of the financial year 2018/19. This has been exceeded in 2 of the 4 Divisions but not met in Acute and Community Divisions. The drop within Community against the target this month is due to the small numbers of overall complaints in the Division. Performance up to the end of March in relation to the 30 day timescale was as below:

- Acute: 46%
- Ambulance: 100%
- Community: 71.4%
- Mental Health: 76%

Performance against response rates is reported at the Trust Leadership Committee (TLC); as well as being monitored at the Patient Experience Sub-Committee and Divisional Quality Committees. A weekly flash report is sent out by the Patient Experience Team to the Executive Team and Care Group Leadership Teams to ensure they are aware of the position of complaints in their areas. The Director of Acute Services, who has the largest proportion of both complaints and overdue complaints, has introduced a weekly meeting to focus on complaints, incidents, inquests and CQC regulatory actions.

At the time of reporting, the Trust has 7 open requests for information from the PHSO; these include the following:
<table>
<thead>
<tr>
<th>Case</th>
<th>Date request received</th>
<th>Service</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11997</td>
<td>11/07/2017</td>
<td>Emergency Department</td>
<td>Under investigation (Provisional report received from PHSO advising may not uphold)</td>
</tr>
<tr>
<td>14085</td>
<td>07/03/2018</td>
<td>Rheumatology</td>
<td>Under investigation</td>
</tr>
<tr>
<td>13760</td>
<td>18/09/2018</td>
<td>Alverstone Ward (was also an SI)</td>
<td>Under investigation</td>
</tr>
<tr>
<td>13612</td>
<td>22/10/2018</td>
<td>Appley Ward</td>
<td>Under investigation.</td>
</tr>
<tr>
<td>14580</td>
<td>8/3/19</td>
<td>Colwell Ward</td>
<td>Under investigation.</td>
</tr>
<tr>
<td>13565</td>
<td>31/1/19</td>
<td>MHLD</td>
<td>Under investigation.</td>
</tr>
<tr>
<td>15275</td>
<td>26/2/19</td>
<td>Respiratory</td>
<td>Under investigation.</td>
</tr>
</tbody>
</table>

1 case was closed in March 2019 by the PHSO who partly upheld the complaint.

**Case 13696**

The complaint was first received by the Trust on 10/7/17 and relates to Colwell Ward/ED/MAU. The Trust’s response was sent 20/12/17. The PHSO requested information on 6/6/18 and have since advised they have closed the case as they were satisfied that the Trust complied with their recommendations; they partly upheld the complaint due to the failings in the way the patient was transferred to different wards, not taking into account the patients need, and a failure to acknowledge the relatives expertise in managing the patients care. It was also acknowledged that for this patient the use of local anaesthetic prior to taking arterial blood could have avoided discomfort.

**Actions taken:**

The Medical Director is reviewing the British Thoracic Society Guidelines issued for the use of local anaesthetic for Arterial Blood Gas to ensure the Trust adopts best practice.

Full capacity Protocol has been introduced which ensures patients are appropriately transferred with a suitable escort to a ward that is able to support their care needs.

Hospital has adopted ‘Call 4 Concern’ initiative to enable patients, relatives and carers to call for immediate help / advice from the Critical Care outreach team, when they are concerned about a patient’s condition and feel their concern is not being addressed by the ward team.
8. Patient Surveys

The Trust received a presentation from Quality Health on the results of the National Adult Inpatient Survey 2018. The results are currently under embargo until May / June 2019 when they will be published by the Care Quality Commission (CQC).

A workshop was held with key staff following the presentation to ensure action is taken in response to the feedback and an improvement plan was developed that will be monitored via the Patient Experience Sub-Committee to ensure implementation.

The Trust is currently participating in a number of National Patient Surveys including:
- Cancer Patient Experience Survey 2019
- Community Mental Health Survey 2019
- Maternity Survey 2019
- Children’s and Young Persons Survey 2018
- Urgent and Emergency Care Survey 2018

Some of these are in the early stages of preparation, and questionnaires have not yet been distributed by our survey provider, Quality Health.

The Membership Engagement Services (MES) implementation has continued to improve with more ownership being taken at a local level, but there is still a need to ensure that services are displaying and acting on their results. MES are updating the Trust to the Version 5 roll out which provides improved survey development tools, including the ability to include more pictures for children and easy read formats, as well as now having the ability to provide divisional level reporting.

9. Quality Improvement Programme

The Quality Improvement Board met for the fifth time on the 10th April 2019 and presented its full report to the Quality Committee. This Board, chaired by the Chief Executive, is to provide Executive oversight and challenge on the progress of the whole Quality Improvement Plan.

The challenge at this Board is to recognise any areas of risk and implement focussed remedial actions to ensure improvements are on track. The ratings at the last Board are detailed below:

<table>
<thead>
<tr>
<th>Quality Improvement Plan</th>
<th>Status (14/03)</th>
<th>Status (10/04)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC regulatory actions – provider level</td>
<td>R</td>
<td>R</td>
<td>3/18 action overdue – known risk areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Information management/governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data quality</td>
</tr>
</tbody>
</table>
### Mental Health Section 31
- **Actions all undertaken.** Outstanding risk is caseload of >1700 (increase since last inspection).

### Mental Health CQC Actions
- **31/88 action overdue.**

### Acute CQC Actions
- **20/96 actions overdue.** Insignificant progress made in Medicine (17/50 actions).

### Community CQC Actions
- **5/24 actions overdue.** Significant progress made.

### Ambulance CQC Actions
- **3/41 actions overdue.** Significant progress made.

### 10 week safe Programme
- Initial outcomes achieved – mandatory training, resuscitation checklists, deteriorating patient, infection prevention & control. Incorporated into Patient Safety Sub-Committee.

### Quality Improvement

#### Trust Quality Strategy
- Progress regularly reported in learning from experience, learning from events, Deteriorating patients, AKI/Sepsis, Dementia, End of Life, Patient Flow, GIRFT.

#### Mental Health Quality Strategy

#### Acute Quality Strategy
- Engagement on Strategy with staff implemented.

#### Community Quality Strategy
- Engagement on Strategy with staff implemented.

#### Ambulance Quality Strategy
- In place and has been embedded within the Division for six months

#### Cultural Programme
- Vision & values approved. Engagement week 25/2 to validate behavioural framework.

#### Leadership Programme
- Leadership development programme in place.
<table>
<thead>
<tr>
<th>Transformation Programmes</th>
<th>Status</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Flow</td>
<td>R</td>
<td>Not yet achieving sustained outcome measures (ECS, discharges before 2pm, super stranded patients).</td>
</tr>
<tr>
<td>Theatres</td>
<td>R</td>
<td>Agreed to move to Financial Recovery Board for monitoring as forms part of the Cost Improvement Plan</td>
</tr>
<tr>
<td>Outpatients</td>
<td>LA</td>
<td>Agreed to move to Financial Recovery Board for monitoring as forms part of the Cost Improvement Plan</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>LA</td>
<td>Plan is on track with outcomes measures yet to be changed or sustained</td>
</tr>
<tr>
<td>Older Peoples Mental Health</td>
<td>R</td>
<td>Not yet achieving sustained outcome measures (environment on Shackleton, 2 year programme to new model of care).</td>
</tr>
<tr>
<td>Mental Health Rehabilitation</td>
<td>LA</td>
<td>Plan is on track with outcomes measures yet to be changed or sustained</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>LA</td>
<td>Plan is on track with outcomes measures yet to be changed or sustained</td>
</tr>
<tr>
<td>Community Service Redesign</td>
<td>LA</td>
<td>Plan is on track with outcomes measures yet to be changed or sustained</td>
</tr>
<tr>
<td>Acute Service Redesign</td>
<td>R</td>
<td>Awaiting alignment with system sustainability plan.</td>
</tr>
</tbody>
</table>

**Status Key:**

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>A lack of pace and/or outcomes. The plan is off track and not meeting agreed milestones.</td>
</tr>
<tr>
<td>Limited Assurance</td>
<td>The plan is on track with outcome measures yet to change or be sustained.</td>
</tr>
<tr>
<td>Assured</td>
<td>Plan and outcomes achieved.</td>
</tr>
</tbody>
</table>

An action was taken that all areas highlighted as a Risk would be monitored weekly through the Executive Team meeting to manage the mitigations and drive the pace. It was also
agreed that the Quality Improvement Plan would be updated to remove theatres and outpatients from Quality Improvement Board to Financial Recovery Board and to include the sustainability plan for each area as opposed to previous transformation programmes.

Significant improvements have been made across the majority of the quality improvement plan. The challenge is for outcome measures to change and be sustained, which is where we would expect to be less than a year following the introduction of this plan.

Increased support and focus is being provided in relation to the regulatory actions, particularly in relation to the Acute Division. There is also close scrutiny of the Warning Notice issued last month in relation to the Emergency Department to ensure that these risks are mitigated in line with the 29 April 2019 timeframe.

10. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

During 2018/19 9 RIDDOR incidents were reported, 8 related to a member of staff and one (case noted below) to a patient.

For the incidents relating to staff:
- 3 related to a slip / trip
- 2 related to moving / handling of patient
- 2 related to moving of patient locker
- 1 related to kneeling on small sharp stone.

Lessons learnt captured from the review of all cases include:
- Staff to ensure suitable footwear is worn
- Estates have cleared out drain in bathroom which contributed to wet floor.

A recent incident relates to a patient who slipped on a wet floor due to a faulty shower leaking that had been reported but not fixed as such this was RIDDOR reportable but was not initially reported as such. Despite the legal requirement being extended to patients in March 2015, staff are still not overly familiar with this.

The Health and Safety Team is reviewing all Datix occurrences that might constitute as RIDDOR reportable in addition to writing an explanatory instruction of what constitutes a RIDDOR. This update is also going to be included in the e-bulletin to support learning for staff. There is potential for this to result in further reportable RIDDOR incidents or to simply provide assurance that no other cases have been missed. The Health and Safety Team will undertake this process on a quarterly basis going forward.

11. Recommendations

The Board is asked to consider the following recommendations:
- Decide if sufficient assurance has been received in relation to the issues raised in this report.
- Receive the dates of the anticipated CQC Inspection
Agenda Item No | 14 | Meeting | Trust Board in Public | Meeting Date | 2 May 2019
--- | --- | --- | --- | --- | ---
Title | Acute Operational Performance Report – M11
Sponsoring Executive | Nikki Turner – Director of Acute Services
Author(s) | Steve Young – Head of Operational Performance
Report previously considered by inc date | Acute Performance Committee – 1 May 2019
 | Trust Performance Committee - 1 May 2019

Purpose of the report

| Information only | Assurance |
| Review and discuss | Agreement | X |
| Trust Board Approval is required | |

Reason for submission to Trust Board in Private only (please indicate below)

| Commercial Confidentiality | Staff Confidentiality |
| Patient Confidentiality | Other Exceptional Circumstance |

Link to Trust Strategic Objectives

| Provide safe, effective, caring and responsive services – ‘Good’ by 2020 | X |
| Ensure efficient use of resources | X |
| Achieve NHS constitutional patient access standards | X |
| Achieve excellence in employment, education and development | X |
| Lead strategic change on the Isle of Wight | X |

Link to CQC Domains

| Effective | Responsive | X |
| Caring | Well-led | X |
| Safe | | X |

Executive Summary

Key Points:

**RESPONSIVE**

**Referral to Treatment ‘Incomplete’**

The Trust under-performed against March's Referral to Treatment Incomplete trajectory of 89.3% at 77.2% due to the continued impact of increased non-elective activity levels, reducing the elective activity being able to be undertaken and increased non-admitted referrals.

**Actions**

The actions previously reported to improve the elective activity levels continue to be implemented, in particular:

- Bed Capacity is now ring fenced on Mottistone allowing Orthopaedic surgery to begin again
- 6:4:2 theatre scheduling meetings have been formalised to focus on appropriate usage of available theatre sessions
- DSU future floorplan has been signed off. Transitional plans are being developed by nursing
teams in each area and overseen by the matron.

- Outsourcing work continues although Care-UK have not booked as many cases as originally agreed, nor within the specified time frames. No further patients will be identified for transfer.
- The Trust continues to work closely with its partners to expedite discharges of medically fit patients. The extension of Compton capacity into April permits urgent elective surgery to continue.
- The plan for long waiting patients is reviewed at patient level on a weekly basis to monitor any variation to plan
- Service level weekly meetings will be introduced to focus on booking patients requiring admitted care in order. While this will not improve the overall list size, it should assist in the management of the backlog
- Detailed scenario planning for 19/20 has been undertaken with PIDS to inform the actions the CCG will need to take to manage elective demand over the next 12 months.
- Job planning has commenced to align the 19/20 demand with capacity

Impact
These actions will:

- Increase capacity for elective activity both locally and on the mainland
- Improve tracking of both non elective and elective activity at patient level
- Maximise the theatre utilisation for the delivery of elective activity

Cancer
The Trust continues to achieve all cancer targets with the exception of 62 day.

The Trust provisionally (as at 17/04/19) under-performed against March’s 62 day Cancer trajectory of 85.0% at 65.5%; treatments remain at around the average 40 per month. Issues continue regarding diagnostic capacity, at tertiary centres, and delays in Inter Trust referrals for both diagnostics and treatment. Local performance (excluding those shared treatments with tertiary centres) is provisionally at 73.2%. Total performance excluding all urology treatments is provisionally at 71.7%.

The backlog which was reported in February of over 100 patients has reduced to 61 patients waiting over 62 days. These patients are on complex pathways which might require multiple diagnostics and more support from more than one specialty. Tertiary referrals can also lengthen waits due to capacity issues at mainland providers.

Actions

- Continue Twice weekly huddles per tumour site and ‘live’ tracking of long waits
- New Urology Pathway including
  - Booking of MRI/TRUS prior to first Appointment
  - Discharging of 2 DNA
  - Monitoring of patients on treatment for raised PSA
  - Monitoring of Referral Thresholds from Primary Care
- Increased Diagnostic capacity, especially in Endoscopy
- Monthly Cancer Steering Group meetings to improve performance of the 62 day cancer target

Impact
Implementation of actions above has had the initial effect of reducing the 62 Day backlog from over 100 to 61 (as at 17/4/2019), and reducing the list size from over 600 to 500. 104 day waits are currently 24, a 25% reduction from one month ago.

**Diagnostics**

The Trust under-performed in March against the Diagnostics Standard of 99% at 93.8%. The impact of the misreporting issues in Endoscopy means that the diagnostic percentage is below target, however the recovery plan has had an impact in the last month, rising 1.8%. The plan remains on track for recovery by end of May.

Capacity in Endoscopy is a continuing issue with Nurse Endoscopist training adding to backlog in the short term. Urodynamics has seen the loss of some consultant lists and Cystoscopy waiting list has been validated and performance will improve through in house capacity.

**Actions**

- Stabilise endoscopy capacity with new nurse Endoscopist and weekend lists provided by Medinet.
- Going forward, with a newly recruited nurse Endoscopist in post, in-house additional sessions are being undertaken at a much lower additional cost then contracting Medinet.
- Longer term capacity will be created once Endoscopist nurse in training is completed.
- Additional Endoscopy lists have been scoped to deal with the backlog and began in mid March.
- A new Patient Pathways Dashboard has been developed to provide additional oversight and early warning of backlog build up.

**Impact**

- Further additional weekend sessions to meet the demand and loss of activity due to lists and training were scheduled in February. This ensured the backlog position continues to recover and provides increased capacity going forward to address 2ww, 6ww and 62 day delay in colorectal cancer pathway.
- Cancer backlog has already been reduced by over 50%.

**Super Stranded Patients**

The target for reducing super-stranded patients, i.e. Those patients who have a stay of 21 days or more, has been set nationally to help reduce bed occupancy to increase safe flow through the system. The Trust is required to have reduced the number of patients by 26% compared to 2017/18 from 53 (as at June 2018) to 39 (by December 2018) to enable released bed capacity.

At the end of March the trust had 44 super-stranded patients. The current position (23.4.19) is 54 super stranded patients. This position aligns with a decline in the delayed transfers of care (DTOC). In order to continue work on this challenging target, the continued embedding of the below actions is vital to support this.

- Ongoing operational review of discharge pathways and implementation of discharge to assess.
- Bi weekly Executive led community capacity review in place.
- Twice weekly operational level Hard to Place Patient Meeting enabling unblocking of any constraints.
- Weekly strategic Executive led DTOC meeting.
- Daily review and monitoring of all stranded patients by Clinical Navigators.
- Daily escalation of performance issues through system calls as required.

**Patient Waits 40+ Weeks** - There are a total of 319 patients waiting over 40wks and the majority are within the orthopedic specialty. All patients are monitored weekly and if over 46 weeks receive a clinical harm review. Actions to address long waiting patients are detailed above in the ‘Incomplete’ target section.

One 52 week wait was reported as an incomplete Urology Non-Admitted Pathway in March.
SAFE:
Quality Strategy for the Acute Division Leads have been identified against each of the 8 quality priorities with KPI’s agreed and a monthly dashboard will be provided to the Acute Quality committee for monitoring purposes. This strategy has now been launched on the intranet with drop in awareness sessions planned for staff during April, along with posters and leaflets and a planned newsletter to update staff on progress.

Serious Incidents: For the division as at the 1 March 2019 there were a total of 44 open SI’s. The Care Groups remain focused on completing these within required deadlines.
CQC regulatory actions total 96 for the Acute Division, of which 65 have been completed and 31 remain overdue. It is forecast that by the end of May 2019 the division plan to have reduced this 31 down to 11. Some of the key themes of these are around staffing i.e. adequate nursing medical and AHP levels reducing use of agency - OOH at weekends to achieve equity of working for medical and surgical doctors. These are trust-wide and not just specific to Acute only and some will be addressed by 7 day working. Other areas are discharging and training (e.g. safeguarding). Identifying dates to complete for these 11 is more complex due to external factors impacting on these (e.g. bed capacity, availability of training). Weekly monitoring of this position is undertaken with the DAS.

CARING:
Staff Surveys (monthly pulse check, FFT for staff quarterly, annual national survey)
- Feedback on all surveys being provided to departments/divisions. Leadership team working on effective way to report across all 3 surveys (monthly, quarterly and annual).
- Annual staff surveys now published. Our organisation has 4 surveys; acute (including corporate), community, mental health and ambulance. Acute review of results and action plan development at workshop on 28th March 2018.
- Communications to staff over the coming weeks to include ‘you said, we did’.

There was 1 new Grade 3 or 4 pressure ulcers reported in month.

EFFECTIVE
Local Audits - There have been seven local audits registered in month. The division are on track with these with none outstanding. No National Audits have been received in month.

WELL-LED
Finance
The Division is currently showing a significant overspend year to date which will not be recovered by the year end, however the division has been focussed on tight control totals from M10 to M12.

Areas of focus as contributing to the overspend are;
- Year-end forecast replaced with Divisional Control Totals in order to achieve the FOT £30.1m
- Financial performance for M10, M11 & M12 monitored against control total
- Budget setting for 2019/20 to be agreed for final submission of plan
- Development of robust CIP plans for 2019/20

Planned adjustments to the control total includes:-
- Reduction of income for pharmacy gainshare agreement
• Winter expenditure
• Assumes reduction in costs

**HR/Workforce**

The Division achieved 81.31% appraisal compliance as at 31.03.19. This percentage is the Division's validated position. The ESR compliance position was recorded as 77.49%.

**International Recruitment (Acute Nursing)**

Cohort 1 (11 nurses) to arrive on 19 July, allocation to be confirmed. The nurses will complete a 2 week ‘OSCE boot camp’ to support them gaining their registration and then they will be supernumerary for 6 weeks. This results in an 8 week lead time before they will be working as registered nurse.

**Sickness**

Sickness remains above target although there has been a decrease absence in all care groups in March.

HR Business Partner is undertaking deep dives to support areas where this is a concern.

Deep dive Key activity delivered in month:

Follow up support within Blood Sciences (4 April); 1 LTS planned RTW in April, 1 LTS planned RTW May. Case conferences scheduled for 1 LTS.

Deep Dive into Back/MSK absence; triangulation of sickness absence for this reason within General Medicine and Ambulance Division undertaken between HRBP, OH and Back Care. General Medicine; absences on 3 wards areas, no correlation between cases.

Colwell Ward (03.04.19) – deep dive; 2 cases to be assigned to HR officer team for ongoing support.

**Mandatory Training** - Continues to remain on target and as at the end of March reported an 88% achievement.

**Acute Risks**

The Division has 10 risks which score over 15 now on the Risk Register with mitigating actions identified. These are discussed at monthly Care Group and Acute Quality meetings to provide progress on actions and for escalation where further support is required.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>Risk Score</th>
<th>Risk Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSCD</td>
<td>High Risk</td>
<td>Poor environment within Cellular Pathology</td>
</tr>
<tr>
<td>CSCD</td>
<td>High Risk</td>
<td>Lack of accreditation for Haematology</td>
</tr>
<tr>
<td>SWCH</td>
<td>High Risk</td>
<td>Inadequate capacity within paediatrics ADHD service</td>
</tr>
<tr>
<td>Medicine</td>
<td>High Risk</td>
<td>Hepatology patients not receiving routine reviews</td>
</tr>
<tr>
<td>Medicine</td>
<td>High Risk</td>
<td>Stroke services impacted by workforce issues</td>
</tr>
<tr>
<td>Medicine</td>
<td>High Risk</td>
<td>Capacity in Gastroenterology service</td>
</tr>
<tr>
<td>Medicine</td>
<td>High Risk</td>
<td>Misreporting of Echocardiograms</td>
</tr>
<tr>
<td>Medicine</td>
<td>High Risk</td>
<td>OHPiT staffing levels</td>
</tr>
</tbody>
</table>
## Key Recommendation

The Trust Board are asked to consider the following recommendation:

To receive this information as assurance against the Acute Division’s current operational performance
Isle of Wight NHS Trust
18–19 M12
Operational Performance

Acute Services

Apr’ 19
## Acute Dashboard

### Excellent Patient Care

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Data to</th>
<th>Target 18/19</th>
<th>Actual YTD</th>
<th>Actual Month</th>
<th>4 Month Trend</th>
<th>Exception Report Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients that develop a grade 4 pressure ulcer</td>
<td>Mar-19</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Patients that develop an ungraded pressure ulcer</td>
<td>Mar-19</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>VTE (Assessment for risk of)</td>
<td>Mar-19</td>
<td>&gt;95%</td>
<td>98.8%</td>
<td>98.4%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>MRSA (confirmed MRSA bacteraemia)</td>
<td>Mar-19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>C. Diff (confirmed Clostridium Difficile infection - stretched target)</td>
<td>Mar-19</td>
<td>7</td>
<td>12</td>
<td>2</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Clinical Incidents (Major) resulting in harm (all reported, actual &amp; potential, includes falls &amp; PU G4)</td>
<td>Mar-19</td>
<td>–</td>
<td>11</td>
<td>1</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)</td>
<td>Mar-19</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Falls - resulting in significant injury</td>
<td>Mar-19</td>
<td>93.0%</td>
<td>93.2%</td>
<td>88.6%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Symptomatic Breast Referrals Seen &lt;2 weeks*</td>
<td>Mar-19</td>
<td>98.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Cancer patients seen &lt;14 days after urgent GP referral*</td>
<td>Mar-19</td>
<td>98.0%</td>
<td>96.2%</td>
<td>95.6%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent Chemo/Drug &lt;31 days*</td>
<td>Mar-19</td>
<td>96.0%</td>
<td>99.2%</td>
<td>100.0%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent surgery &lt;31 days*</td>
<td>Mar-19</td>
<td>94.0%</td>
<td>98.6%</td>
<td>100.0%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Cancer diagnosis to treatment &lt;31 days*</td>
<td>Mar-19</td>
<td>90.0%</td>
<td>92.9%</td>
<td>100.0%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Cancer Patients treated after screening referral &lt;62 days*</td>
<td>Mar-19</td>
<td>71.4%</td>
<td>No Pts</td>
<td>No measured operational standard</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Cancer Patients treated after consultant upgrade &lt;62 days*</td>
<td>Mar-19</td>
<td>85.0%</td>
<td>74.1%</td>
<td>65.5%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Cancer urgent referral to treatment &lt;62 days* (target)</td>
<td>Mar-19</td>
<td>79.3%</td>
<td>74.1%</td>
<td>65.5%</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

### Excellent Patient Care

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Data to</th>
<th>Target 18/19</th>
<th>Actual YTD</th>
<th>Actual Month</th>
<th>4 Month Trend</th>
<th>Exception Report Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care 4 hour Standards</td>
<td>Mar-19</td>
<td>96%</td>
<td>82%</td>
<td>85%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Number of patients who have waited over 12 hours in A&amp;E from decision to admit to admission</td>
<td>Mar-19</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>All Cancelled Operations on/after day of admission</td>
<td>Mar-19</td>
<td>–</td>
<td>326</td>
<td>29</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Cancelled operations on/after day of admission (not rebooked within 28 days) - including those not rebooked at the time of reporting</td>
<td>Mar-19</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Patient Satisfaction (Friends &amp; Family test - Total response rate)</td>
<td>Mar-19</td>
<td>30.0%</td>
<td>1.9%</td>
<td>3.4%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Patient Satisfaction (Friends &amp; Family test - A&amp;E response rate)</td>
<td>Mar-19</td>
<td>95.0%</td>
<td>1.6%</td>
<td>1.9%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Mixed Sex Accommodation Breaches</td>
<td>Mar-19</td>
<td>0</td>
<td>148</td>
<td>16</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Formal Complaints</td>
<td>Mar-19</td>
<td>–</td>
<td>326</td>
<td>23</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>RTT % of incomplete pathways within 18 weeks - IoW CCG</td>
<td>Mar-19</td>
<td>92.0%</td>
<td>–</td>
<td>76.5%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>RTT % of incomplete pathways within 18 weeks - NHS England</td>
<td>Mar-19</td>
<td>92.0%</td>
<td>–</td>
<td>96.8%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Zero tolerance RTT waits over 52 weeks (Incomplete Return)</td>
<td>Mar-19</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>RTT Incomplete Trust Combined</td>
<td>Mar-19</td>
<td>92.0%</td>
<td>–</td>
<td>77.2%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>RTT Incomplete Trust Combined</td>
<td>Mar-19</td>
<td>Trajectory 84.5%</td>
<td>–</td>
<td>77.2%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>No. Patients waiting &gt; 6 weeks for diagnostics</td>
<td>Mar-19</td>
<td>17</td>
<td>1112</td>
<td>124</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>% Patients waiting &gt; 6 weeks for diagnostics</td>
<td>Mar-19</td>
<td>99%</td>
<td>95.0%</td>
<td>93.8%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Theatre Utilisation - Audit Commission (NEW)</td>
<td>Mar-19</td>
<td>–</td>
<td>73.8%</td>
<td>75.9%</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
## Acute Dashboard

### Summary Hospital-level Mortality Indicator (SHMI)
**July-16 - June-17**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Published</th>
<th>Jan 2018</th>
<th>Variable Hours (£000) (Trust Wide)</th>
<th>Mar-19</th>
<th>1,097</th>
<th>1,664</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never events</td>
<td>Mar-19</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>NO</td>
<td>854</td>
<td>19,057</td>
</tr>
<tr>
<td>Stroke patients (90% of stay on Stroke Unit)</td>
<td>Mar-19</td>
<td>80.0%</td>
<td>84.3%</td>
<td>85.7%</td>
<td>NO</td>
<td>3%</td>
<td>6.23%</td>
</tr>
<tr>
<td>High risk TIA fully investigated &amp; treated within 24 hours (National 60%)</td>
<td>Mar-19</td>
<td>60.0%</td>
<td>94.1%</td>
<td>66.7%</td>
<td>YES</td>
<td>3%</td>
<td>4.62%</td>
</tr>
<tr>
<td>Total Workforce (inc flexible working) (FTE’s)</td>
<td>Mar-19</td>
<td>2,970.7</td>
<td>3,065.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total workforce SIP (FTEs)</td>
<td>Mar-19</td>
<td>2,775.3</td>
<td>2,777.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable Hours (FTE)</td>
<td>Mar-19</td>
<td>195.4</td>
<td>2,907</td>
<td>288</td>
<td>NO</td>
<td>3%</td>
<td>5.08%</td>
</tr>
<tr>
<td>Delayed Transfer of Care (lost bed days) - (Acute)</td>
<td>Mar-19</td>
<td>115</td>
<td>1635</td>
<td>214</td>
<td>NO</td>
<td>3%</td>
<td>6.23%</td>
</tr>
<tr>
<td>Stranded Patients</td>
<td>Mar-19</td>
<td>127</td>
<td>1502</td>
<td>122</td>
<td>NO</td>
<td>3%</td>
<td>4.62%</td>
</tr>
<tr>
<td>Super Stranded Patients</td>
<td>Mar-19</td>
<td>46</td>
<td>582</td>
<td>44</td>
<td>YES</td>
<td>3%</td>
<td>5.08%</td>
</tr>
</tbody>
</table>

* Rolling year
*Cancer figures for March are provisional.

### Staff absences
- Acute: 3% - 5.10%
- CSCD: 3% - 6.23%
- GEN MED: 3% - 4.62%
- SWCH: 3% - 5.08%

### Appraisal Monitoring
- Acute: 100% - 77.49%
- CSCD: 100% - 77.07%
- GEN MED: 100% - 86.08%
- SWCH: 100% - 82.06%

### Mandatory Training*
- Acute: 85% - 86%
- CSCD: 86% - 86%

### Staff Turnover
- Acute: 5% - 10.19%

### Employee Relations Cases
- Acute: 0 - 118

### Delayed Transfer of Care (lost bed days) - (Acute)
- Mar-19: 115 - 1635 - 214

### Stranded Patients
- Mar-19: 127 - 1502 - 122

### Super Stranded Patients
- Mar-19: 46 - 582 - 44

* Rolling year

### Employee Relations Cases
- Feb-19: 0 - 118 - 27

### Mandatory Training*
- Acute: 85% - 86%

### Staff Turnover
- Acute: 5% - 10.19%

### Employee Relations Cases
- Feb-19: 0 - 118 - 27
 Commentary:

**Issue**
The Trust under-performed against March's Referral to Treatment Incomplete trajectory of 89.3% at 77.2% due to the continued impact of increased non-elective activity levels, reducing the elective activity being able to be undertaken and increased non-admitted referrals.

**Actions**
- Bed Capacity is now ring fenced on Mottistone allowing Orthopaedic surgery to begin again
- 6:4:2 theatre scheduling meetings have been formalised to focus on appropriate usage of available theatre sessions
- DSU future floorplan has been signed off. Transitional plans are being developed by nursing teams in each area and overseen by the matron.
- Outsourcing work continues although Care-UK have not booked as many cases as originally agreed, nor within the specified time frames. No further patients will be identified for transfer.
- The Trust continues to work closely with its partners to expedite discharges of medically fit patients. The extension of Compton capacity into April permits urgent elective surgery to continue.
- The plan for long waiting patients is reviewed at patient level on a weekly basis to monitor any variation to plan
- Service level weekly meetings will be introduced to focus on booking patients requiring admitted care in order. While this will not improve the overall list size, it should assist in the management of the backlog
- Detailed scenario planning for 19/20 has been undertaken with PIDS to inform the actions the CCG will need to take to manage elective demand over the next 12 months.
- Job planning has commenced to align the 19/20 demand with capacity.

**Additional actions include:**
- Theatre productivity is ongoing, delivery via 3 workstreams (scheduling, pre-assessment and processes and controls in theatre)
- Theatre productivity opportunity identified by Four Eyes being incorporated into Theatre Project
- The PTL validation being undertaken by 'Clear PTL' to identify any possibilities for further waiting list reduction is complete from the trust side and results are expected in the last week of March

**Impact**
- Maximise capacity for elective activity both locally and on the mainland
- Improve tracking of both non elective and elective activity at patient level
- Maximise the theatre utilisation for the delivery of elective activity and improve booking efficiency.

---

**Referral to Treatment Times**

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>17/18</td>
<td>88.7%</td>
<td>91.2%</td>
<td>91.9%</td>
<td>92.3%</td>
<td>92.3%</td>
<td>92.2%</td>
<td>91.7%</td>
<td>90.9%</td>
<td>86.0%</td>
<td>85.7%</td>
<td>84.9%</td>
<td>84.0%</td>
</tr>
<tr>
<td>18/19</td>
<td>84.1%</td>
<td>85.2%</td>
<td>85.1%</td>
<td>84.5%</td>
<td>82.0%</td>
<td>81.1%</td>
<td>80.8%</td>
<td>81.0%</td>
<td>81.6%</td>
<td>80.6%</td>
<td>79.3%</td>
<td>77.2%</td>
</tr>
<tr>
<td>Target</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Trajectory</td>
<td>84.1%</td>
<td>85.5%</td>
<td>85.2%</td>
<td>85.2%</td>
<td>84.5%</td>
<td>87.7%</td>
<td>88.0%</td>
<td>79.5%</td>
<td>86.8%</td>
<td>88.8%</td>
<td>89.1%</td>
<td>89.3%</td>
</tr>
</tbody>
</table>

**Target - Within normal variation so may be achieved but not consistently**

**Trajectory - Within normal variation so may be achieved but not consistently**
Cancer Targets

Commentary:

Issue

The Trust provisionally (as at 17/04/19) under-performed against March’s 62 day Cancer trajectory of 85.0% at 65.5%; treatments remain at around the average 40 per month. Issues continue regarding diagnostic capacity, at tertiary centres, and delays in Inter Trust referrals for both diagnostics and treatment. Local performance (excluding those shared treatments with tertiary centres) is provisionally at 73.2%. Total performance excluding all urology treatments is provisionally at 71.7%.

Performance at tumour site level (17/04/2019):

NB. 0.5 treatment/breach can be incurred as per new ‘breach allocation’ guidance

The attached chart shows how the actual backlog is dropping much more quickly than trajectory. It is anticipated that as the backlog drops performance will begin to improve, whilst emphasising, and echoing NHSI opinion that performance is likely to drop as backlog issues are addressed.

Currently performance is slightly higher than that projected by the trajectory.

Actions

- Continue Twice weekly huddles per tumour site and ‘live’ tracking of long waits
- New Urology Pathway including
  - Booking of MRI/TRUS prior to first Appointment
  - Discharging of 2 DNA
  - Monitoring of patients on treatment for raised PSA
  - Monitoring of Referral Thresholds from Primary Care
- Increased Diagnostic capacity, especially in Endoscopy
- Monthly Cancer Steering Group meetings to improve performance of the 62 day cancer target

Impact

Implementation of actions above has had the initial effect of reducing the 62 Day backlog from over 100 to 61 (as at 17/4/2019), and reducing the list size from over 600 to 500. 104 day waits are currently 24, a 25% reduction from one month ago.
Commentary:

Issue
The Trust under-performed in March against the Diagnostics Standard of 99% at 93.8%. The impact of the misreporting issues in Endoscopy means that the diagnostic percentage is below target, however the recovery plan has had an impact in the last month, rising 1.8%. The plan remains on track for recovery by end of May.

Capacity in Endoscopy is a continuing issue with Nurse Endoscopist training adding to backlog in the short term. Urodynamics has seen the loss of some consultant lists and Cystoscopy waiting list has been validated and performance will improve through in house capacity.

Actions
• Stabilise endoscopy capacity with new nurse Endoscopist and weekend lists provided by Medinet
• Going forward, with a newly recruited nurse Endoscopist in post, in-house additional sessions are being undertaken at a much lower additional cost then contracting Medinet
• Longer term capacity will be created once Endoscopist nurse in training is completed.
• Additional Endoscopy lists have been scoped to deal with the backlog and began in mid March.
• A new Patient Pathways Dashboard has been developed to provide additional oversight and early warning of backlog build up

Impact
• Further additional weekend sessions to meet the demand and loss of activity due to lists and training were scheduled in February. This ensured the backlog position continues to recover and provides increased capacity going forward to address 2ww, 6w2 and 62 day delay in colorectal cancer pathway.
• Cancer backlog has already been reduced by over 50%

---

### Table: Patients waiting > 6 weeks for diagnostics

<table>
<thead>
<tr>
<th>Area</th>
<th>Service</th>
<th>Mar-19 WL</th>
<th>Mar-19 64 Wks</th>
<th>Mar-19 %&lt;6 Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Imaging</strong></td>
<td>Magnetic Resonance Imaging</td>
<td>275</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Computed Tomography</td>
<td>241</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Non-Obstetric Ultrasound</td>
<td>800</td>
<td>1</td>
<td>99.9%</td>
</tr>
<tr>
<td></td>
<td>Barium Enema</td>
<td>0</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>DEVA Scan</td>
<td>0</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Physiological Measurement</strong></td>
<td>Cardiology - echocardiography</td>
<td>67</td>
<td>5</td>
<td>92.6%</td>
</tr>
<tr>
<td></td>
<td>Neurophysiology - Nerve conduction studies</td>
<td>33</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Respiratory physiology - sleep studies</td>
<td>31</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Urodynamics - pressures &amp; flows - Urology</td>
<td>17</td>
<td>2</td>
<td>88.2%</td>
</tr>
<tr>
<td></td>
<td>Urodynamics - pressures &amp; flows - Gynae</td>
<td>11</td>
<td>1</td>
<td>90.9%</td>
</tr>
<tr>
<td><strong>Endoscopy</strong></td>
<td>Colonoscopy</td>
<td>160</td>
<td>26</td>
<td>85.8%</td>
</tr>
<tr>
<td></td>
<td>Flex sigmoidoscopy</td>
<td>57</td>
<td>2</td>
<td>96.6%</td>
</tr>
<tr>
<td></td>
<td>Cystoscopy</td>
<td>32</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Gastroscopy</td>
<td>261</td>
<td>87</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>1685</td>
<td>124</td>
<td></td>
</tr>
</tbody>
</table>
Commentary:
The Division achieved 81.31% compliance for appraisals as at 31.03.19. This percentage is the Division’s validated position.

International Recruitment (Acute Nursing)
Cohort 1 (11 nurses) to arrive on 19 July, allocation to be confirmed. The nurses will complete a 2 week ‘OSCE boot camp’ to support them gaining their registration and then they will be supernumerary for 6 weeks. This results in an 8 week lead time before they will be working as registered nurse.

Sickness
• Sickness remains above target although there has been a decrease absence in all care groups in March.
• HR Business Partner is undertaking deep dives to support areas where this is a concern.
• Business Partner deep dive key activity delivered in month include:
  • Follow up support within Blood Sciences (4 April);
  • Deep Dive into Back/MSK absence; triangulation of sickness absence for this reason within General Medicine.

Mandatory Training
Continues to remain on target at 88% as at 31.3.19.

<table>
<thead>
<tr>
<th>KPI</th>
<th>Budget</th>
<th>In-post</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>In post v Budgeted FTE</td>
<td>1592.52</td>
<td>1396.92</td>
<td>-195.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In month</th>
<th>YTD</th>
<th>Trust In Month</th>
<th>Trust YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnover</td>
<td>1.18%</td>
<td>10.19%</td>
<td>1.20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KPI</th>
<th>In month</th>
<th>YTD</th>
<th>KPI Target</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness*</td>
<td>5.10%</td>
<td>5.18%</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>Appraisal**</td>
<td>77.49%</td>
<td>77.49%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Mandatory Training***</td>
<td>88%</td>
<td>88%</td>
<td>85%</td>
<td></td>
</tr>
</tbody>
</table>

• Sickness data – March 2019
• **Appraisal data includes Medics – March 2019
• ***Mandatory Training – March 2019

SICKNESS ABSENCE by Care Group

<table>
<thead>
<tr>
<th>Care Group</th>
<th>March 2019</th>
<th>February 2019</th>
<th>January 2019</th>
<th>Hot Spots</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSCD</td>
<td>6.23%</td>
<td>6.55%</td>
<td>5.91%</td>
<td>Blood Sciences, ITU, Pathology General, HSDU, CCU Stress, anxiety, depression highest reason for absence</td>
</tr>
<tr>
<td>Gen Medicine</td>
<td>4.62%</td>
<td>7.29%</td>
<td>7.69%</td>
<td>Appley, Stroke and Colwell Stress, anxiety, depression highest reason for absence</td>
</tr>
<tr>
<td>SWCH</td>
<td>5.08%</td>
<td>5.59%</td>
<td>5.34%</td>
<td>Day surgery ward, PAAU, Luccombe, General Theatre Stress, anxiety, depression highest reason for absence</td>
</tr>
</tbody>
</table>
## Benchmarking Report (1)

<table>
<thead>
<tr>
<th>National Target</th>
<th>National Performance</th>
<th>IW Performance</th>
<th>IW Rank</th>
<th>IW Status</th>
<th>Data Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Best</td>
<td>Worst</td>
<td>Eng</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care 4 hour Standards</td>
<td>95%</td>
<td>100%</td>
<td>63%</td>
<td>85.1%</td>
<td>81.0%</td>
</tr>
<tr>
<td>RTT: % of admitted patients who waited 18 weeks or less</td>
<td>90%</td>
<td>100%</td>
<td>0%</td>
<td>70.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>RTT: % of non-admitted patients who waited 18 weeks or less</td>
<td>95%</td>
<td>100%</td>
<td>61%</td>
<td>100.0%</td>
<td>80.7%</td>
</tr>
<tr>
<td>RTT % of incomplete pathways within 18 weeks</td>
<td>92%</td>
<td>100%</td>
<td>74%</td>
<td>86.5%</td>
<td>79.3%</td>
</tr>
<tr>
<td>%. Patients waiting &gt; 6 weeks for diagnostic</td>
<td>1%</td>
<td>0%</td>
<td>20%</td>
<td>2.3%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Cancer patients seen &lt;14 days after urgent GP referral</td>
<td>93%</td>
<td>100%</td>
<td>69%</td>
<td>92.8%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Cancer diagnosis to treatment &lt;31 days</td>
<td>96%</td>
<td>100%</td>
<td>78%</td>
<td>95.0%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Cancer urgent referral to treatment &lt;62 days</td>
<td>85%</td>
<td>100%</td>
<td>47%</td>
<td>78.2%</td>
<td>67.8%</td>
</tr>
<tr>
<td>Symptomatic Breast Referrals Seen &lt;2 weeks</td>
<td>93%</td>
<td>100%</td>
<td>26%</td>
<td>88.7%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent surgery &lt;31 days</td>
<td>94%</td>
<td>100%</td>
<td>67%</td>
<td>92.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent Chemo/Drug &lt;31 days</td>
<td>98%</td>
<td>100%</td>
<td>81%</td>
<td>99.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer Patients treated after screening referral &lt;62 days</td>
<td>90%</td>
<td>100%</td>
<td>0%</td>
<td>88.6%</td>
<td>94.4%</td>
</tr>
</tbody>
</table>

**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
## Benchmarking Report (2)

### Table: Small Acute Trusts

<table>
<thead>
<tr>
<th>National Target</th>
<th>NU</th>
<th>RAB</th>
<th>HAA</th>
<th>MIO</th>
<th>WIP</th>
<th>KIRK</th>
<th>KHE</th>
<th>SCS</th>
<th>COO</th>
<th>SPD</th>
<th>ROC</th>
<th>BFR</th>
<th>YTB</th>
<th>BSF</th>
<th>BSX</th>
<th>DHH</th>
<th>ADA</th>
<th>JTT</th>
<th>SHL</th>
<th>PTJ</th>
<th>NTP</th>
<th>DTR</th>
<th>GDA</th>
<th>NTP</th>
<th>HTR</th>
<th>Date/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>15% of patients waiting 4+ weeks for elective surgery</td>
<td>13%</td>
<td>10%</td>
<td>12%</td>
<td>15%</td>
<td>18%</td>
<td>20%</td>
<td>16%</td>
<td>14%</td>
<td>12%</td>
<td>10%</td>
<td>8%</td>
<td>6%</td>
<td>4%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Q1 2018</td>
</tr>
<tr>
<td>% of patients waiting 16+ weeks for diagnostic tests</td>
<td>10%</td>
<td>8%</td>
<td>6%</td>
<td>4%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cancer patients seen within 42 days of urgent GP referral</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Q4 2017</td>
</tr>
<tr>
<td>Cancer diagnosis to treatment &lt; 32 days</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Q4 2018</td>
</tr>
<tr>
<td>Cancer urgent referrals to treatment &lt; 48 days</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Q1 2018</td>
</tr>
<tr>
<td>Breast Cancer Referrals seen in 30 weeks</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Q2 2018</td>
</tr>
<tr>
<td>Cancer patients receiving subsequent surgery &lt; 42 days</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Q3 2018</td>
</tr>
<tr>
<td>Cancer patients receiving subsequent chemotherapy &lt; 42 days</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Q4 2018</td>
</tr>
</tbody>
</table>

**Key:**
- Better than National Target = ✔
- Worse than National Target = ☐
- Target Not Applicable for Trust = —

Note: Bold font represents the trust's performance, and the small font figure represents the trust ranking out of the 28 other small acute trusts.
# Benchmarking Report (3)

<table>
<thead>
<tr>
<th>National Target</th>
<th>IV</th>
<th>R1C</th>
<th>RBD</th>
<th>RD3</th>
<th>RDY</th>
<th>RDZ</th>
<th>RHU</th>
<th>RNS</th>
<th>RW1</th>
<th>Data Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care 4 hour Standards</td>
<td>95%</td>
<td>81.0%</td>
<td>N/A</td>
<td>92.1%</td>
<td>86.9%</td>
<td>N/A</td>
<td>91.3%</td>
<td>81.3%</td>
<td>67.7%</td>
<td>85.1%</td>
</tr>
<tr>
<td>RTT % of incomplete pathways within 18 weeks</td>
<td>92%</td>
<td>79.3%</td>
<td>100.0%</td>
<td>77.5%</td>
<td>82.5%</td>
<td>95.1%</td>
<td>85.3%</td>
<td>86.7%</td>
<td>81.6%</td>
<td>88.4%</td>
</tr>
<tr>
<td>% Patients waiting &gt; 6 weeks for diagnostic</td>
<td>1%</td>
<td>8.0%</td>
<td>0.6%</td>
<td>12.7%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>3.3%</td>
<td>0.7%</td>
<td>2.4%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Cancer patients seen &lt;14 days after urgent GP referral*</td>
<td>93%</td>
<td>96.4%</td>
<td>NA</td>
<td>93.2%</td>
<td>98.6%</td>
<td>NA</td>
<td>96.1%</td>
<td>83.0%</td>
<td>97.4%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Cancer diagnosis to treatment &lt;31 days*</td>
<td>96%</td>
<td>98.0%</td>
<td>NA</td>
<td>97.2%</td>
<td>98.7%</td>
<td>NA</td>
<td>95.6%</td>
<td>84.0%</td>
<td>97.4%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Cancer urgent referral to treatment &lt;62 days*</td>
<td>85%</td>
<td>67.8%</td>
<td>NA</td>
<td>78.4%</td>
<td>79.6%</td>
<td>NA</td>
<td>84.4%</td>
<td>67.5%</td>
<td>80.6%</td>
<td>84.5%</td>
</tr>
<tr>
<td>Breast Cancer Referrals Seen &lt;2 weeks*</td>
<td>93%</td>
<td>94.9%</td>
<td>NA</td>
<td>81.5%</td>
<td>100.0%</td>
<td>NA</td>
<td>97.7%</td>
<td>37.3%</td>
<td>96.6%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent surgery &lt;31 days*</td>
<td>94%</td>
<td>100.0%</td>
<td>NA</td>
<td>100.0%</td>
<td>96.1%</td>
<td>NA</td>
<td>94.7%</td>
<td>83.8%</td>
<td>95.4%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Cancer Patients receiving subsequent Chemo/Drug &lt;31 days*</td>
<td>98%</td>
<td>100.0%</td>
<td>NA</td>
<td>100.0%</td>
<td>100.0%</td>
<td>NA</td>
<td>100.0%</td>
<td>96.7%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer Patients treated after screening referral &lt;62 days*</td>
<td>90%</td>
<td>94.4%</td>
<td>NA</td>
<td>100.0%</td>
<td>95.6%</td>
<td>NA</td>
<td>94.1%</td>
<td>78.2%</td>
<td>93.4%</td>
<td>94.3%</td>
</tr>
</tbody>
</table>

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
- RHU: University Hospital Southampton NHS Foundation Trust
- RNS: Portsmouth Hospitals NHS Trust
- RW1: Hampshire Hospitals NHS Foundation Trust
- RW2: Southern Health NHS Foundation Trust
Acute Division YTD Financial Performance

Plan YTD: £84.7m
Actual YTD: £94.2m
Variance: £9.5m

- Winter Costs: £1m
- ED Cost Pressures: £3m
- Escalation capacity: £0.7m
- Agency Costs and other including acute skill mix: £2.3m
- Cross Cutting CIP schemes: £3.1m
- CIP: +£0.6m
Complaints, Concerns, Compliments, SI’s & Risks (March)

**Complaints**
- 27 new complaints received for March
- **Common Themes**: Access to treatment or drugs, and communication
- 60 open complaints across the division
- Longest overdue complaint is 56 days (due to internal report to be completed)

**Concerns & Compliments**
- 37 concerns received for March
- 20 compliments received for March

**Serious Incidents**
- 44 SI’s currently open
- 7 overdue SI’s
- Longest outstanding SI is 160 days overdue

**Risks**
- 3 news risks added to the register for March
- 1 risk was closed in March
### Getting to Good: CQC Regulatory Actions

#### Service Total Overdue Completed

<table>
<thead>
<tr>
<th>Service</th>
<th>Total</th>
<th>Overdue</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>43</td>
<td>12</td>
<td>31</td>
</tr>
<tr>
<td>Critical Care</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Maternity</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Children &amp; Young People</td>
<td>8</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Surgery</td>
<td>7</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>End of Life</td>
<td>14</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Totals</td>
<td>89</td>
<td>15</td>
<td>74</td>
</tr>
</tbody>
</table>

Areas that have completed/will have by end May all Must Do Actions are:
- Maternity
- Diagnostics
- Outpatients
- End of Life Care

#### Overdue Actions Summary

<table>
<thead>
<tr>
<th>Area</th>
<th>Overdue Actions</th>
<th>Anticipated completion</th>
<th>Ongoing after May</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWCH</td>
<td>2</td>
<td>DSU is dependant on capital works progressing (Q3 anticipated completion)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C&amp;YP Strategy progressing through Children’s Board</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>6</td>
<td>x4 Amber due to complete April/May with 1 ongoing regarding discharging process</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>x2 red x1 due to complete September and x1 ongoing both relate to staffing</td>
<td></td>
</tr>
<tr>
<td>CSCD</td>
<td>1</td>
<td>X1 related to ACP on ICU- ongoing</td>
<td>1</td>
</tr>
<tr>
<td>EOLC</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>
The purpose of this report is to provide an overview of the key current service opportunities, issues, challenges, or risks affecting the performance of the division.

**Issue:**
The Trust over-performed against the Emergency Care Standard (ECS) trajectory of 70% at 84.55%; Which resulted in a year end position of 81.59%. Attendances were in line with the previous month, but breaches continued to rise.

**Actions:**
The actions previously reported continue be implemented and embedded to enable intense focus on flow and escalation within the Emergency Department (ED) and in particular:
- Launch and opening of Ambulatory Emergency Care/Same Day Emergency Care (AEC/SDEC) with Surgical Assessment Provision become operational from the 8th April 2019.
- 20% minimum specialty activity shift from ED to Specialty Assessment Services (SAU) in line with the recommendations of ‘Getting it Right First Time’ and the Acute Services Redesign
- Development of workforce plan to deliver Urgent Treatment Centers (integrated Minors & Urgent Care Service).
- Front door streaming established and included in ED metrics
• Implementation of CQC section 29A action plan
• Executive sign off for reviewed ED floor plan to deliver separate Adult and Paediatric ED.

Impact
• SAU function within AEC/SDEC will further improve risk of crowding and reduce the risk of surgical breaches within the ED:
• Compliance with Children and Young Persons requirements in Emergency care settings
• Paediatric ED development will release space to be re-designated as a Clinical Decisions Unit this will help reduce risk of breaches and improve episode of care
• Improved business continuity planning within the ED
• These actions will enable the service to align with the ECS trajectory

Key Recommendation

The Board is recommended to note the challenges within the Emergency Department and the mitigation actions being taken to ensure a safe service is delivered.
Appendix 1
Integrate Urgent & Emergency Care Performance Dashboard
March 2019
Early improvement seen in non-admitted performance with ongoing focus on discharges needed to support admitted flow

**WEEKLY AVERAGE ED PERFORMANCE IMPROVEMENT TRAJECTORY**

Source: QlikView data. *Symphony outage on 13/02 may affect data quality and reported figures for w/c.**

*Occupancy calculated as a percentage of Core G&A beds. Core beds defined as MAU, Appley, Colwell, CCU, Stroke, Alverstone, St Helens, Lucombe, Wippingham, Mottistone & Compton (Dec-March only), and excludes ITU, HSU, Shackleton, ED, Paeds and maternity and any escalation beds in use in AEC, Discharge Lounge or Endoscopy.

**WEEKLY AVERAGE BED OCCUPANCY**

**WEEKLY AVERAGE NO. OF STRANDED PATIENTS (LOS > 6 DAYS)**

Trust Target: 124 Pts

Ambulance, Community, Corporate, Hospital, Learning Disability & Mental Health Services - [www.iow.nhs.uk](http://www.iow.nhs.uk)
## Key metrics: Front Door Projects

07– 13/04/2019

<table>
<thead>
<tr>
<th>Metric</th>
<th>Project</th>
<th>w/e 13/4/2019</th>
<th>Week target</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 hour emergency care standard (%)</td>
<td>All</td>
<td>73.4%</td>
<td>85%</td>
</tr>
<tr>
<td>% attendances streamed away from ED</td>
<td>Streaming</td>
<td>5.7%</td>
<td>20%*</td>
</tr>
<tr>
<td>Average time to triage</td>
<td>Triaging</td>
<td>22</td>
<td>15 mins</td>
</tr>
<tr>
<td>Average time to initial assessment</td>
<td>IAT</td>
<td>49</td>
<td>15 mins</td>
</tr>
<tr>
<td>Average time from exam to referral (admitted)</td>
<td>Nurse in Charge role</td>
<td>105</td>
<td>90 mins</td>
</tr>
<tr>
<td>Average time from referral to response</td>
<td>Specialty referral</td>
<td>No Data</td>
<td>30 mins</td>
</tr>
<tr>
<td>Average time from specialty response to DTA</td>
<td>Specialty referral</td>
<td>No Data</td>
<td>30 mins</td>
</tr>
<tr>
<td>Average time from exam to discharge (non-admitted)</td>
<td>Nurse in Charge role</td>
<td>122</td>
<td>3 hours</td>
</tr>
<tr>
<td>Average time from DTA to admission</td>
<td>Bed moves and turnover</td>
<td>392</td>
<td>30 mins</td>
</tr>
<tr>
<td>% safety round conducted</td>
<td>Safety</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Number of hours &gt; 30 patients in ED / day</td>
<td>Escalation policy</td>
<td>12</td>
<td>5 hours / day</td>
</tr>
<tr>
<td>Number of days of suboptimal ED nurse staff (no NiC or gap of &gt;1 RN)</td>
<td>ED nurse staffing</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Data provided by PIDS on 04/03/2019, for period running 24/02 - 02/03. *Target % of patients streamed to be reviewed in 6 months to reflect progress from other workstreams aiming to reduce inappropriate ED attendances overall.
## Significant Improvement

### Same Day Emergency Care (AEC)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Reported Figure</th>
<th>Target Rationale</th>
<th>Target</th>
<th>02/03/2019</th>
<th>09/03/2019</th>
<th>16/03/2019</th>
<th>23/03/2019</th>
<th>30/03/2019</th>
<th>06/04/2019</th>
<th>13/04/2019</th>
<th>SPARK</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Admissions to AEC</td>
<td>7 Day Total</td>
<td>Locally Defined</td>
<td>TBC</td>
<td>15</td>
<td>10</td>
<td>19</td>
<td>14</td>
<td>32</td>
<td>39</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

**Week Ending**

- 02/03/2019
- 09/03/2019
- 16/03/2019
- 23/03/2019
- 30/03/2019
- 06/04/2019
- 13/04/2019
Estate solution agreed for SAU/AEC; ongoing work focuses on development of service model and staffing

**SAU/AEC AND RECRUITMENT : 07/04/19**

**Exec. sponsor:** Tim Lynch

**Area lead:** Tim Petterson / Steve Parker

**PMO lead:** NA

### Key metrics w/e 13/04/19

<table>
<thead>
<tr>
<th>Metric</th>
<th>w/e 13/04/19</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP direct referrals to MAU</td>
<td>18</td>
<td>TBC</td>
</tr>
<tr>
<td>Admissions to SDEC</td>
<td>40</td>
<td>Minimum 12 per day</td>
</tr>
<tr>
<td>% MAU pts with LOS &lt;48 hours</td>
<td>89.2%</td>
<td>95%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project</th>
<th>Lead</th>
<th>Status</th>
<th>Actions completed</th>
<th>Next steps</th>
<th>Issues for escalation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Surgical Day</td>
<td>Steve Parker</td>
<td>A</td>
<td>• Surgical access to SDEC has launched</td>
<td>• Compliance with response times to patients referred within ED – specialty response not being recorded</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• SOP still to be shared directly with the SDEC team (currently not visible)</td>
<td>• Advice via the CGDs to their teams as to the processes for communicating specialty pick-up and interventions thereafter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Surgical patients through SDEC from 8 April</td>
<td>• Agree KPI’s with project team &amp; resource required to support monitoring of KPI’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• CEPOD list from 8 April</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same-Day Emergency Care Service (prev. AEC)</td>
<td>Tim Petterson</td>
<td>A</td>
<td>• SDEC Mon-Fri in place</td>
<td>• ED/MAU joint staffing meetings to cascade the reviewed SOP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Nurse Practitioner coverage with dedicated Consultant support</td>
<td>• Embed process for pulling patients from ED to SDEC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review of SOP – Dr Nakash re-drafted the SOP</td>
<td>• Formalise performance dashboard and activity tracker process with PIDS</td>
<td></td>
</tr>
<tr>
<td>ED Recruitment</td>
<td>Tim Petterson</td>
<td>A</td>
<td>• Initial review of staffing gaps mapped with HR and weekly tracker system agreed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Medical &amp; Nursing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Revised ED rota for medical staffing (Dr Nakash) – draft rota by 15/04/19 for consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Refresh of Consultant ED vacancies and recruitment campaign</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Focus of ward huddle and discharge lounge support will be on encouraging and embedding use of Golden Patients

INPATIENT WARD SUMMARY: 07-APR

**Exec. sponsor:** Alistair Flowerdew

**Area lead:** Mark Connaughton / Ian Osborne

**PMO lead:** Samantha Nicholls

<table>
<thead>
<tr>
<th>Project</th>
<th>Lead</th>
<th>Status</th>
<th>Actions completed</th>
<th>Next steps</th>
<th>Issues for escalation</th>
</tr>
</thead>
</table>
| Discharge lounge         | Sam Nicholls              | G      | • Handed over to Discharge Lounge staff as BAU  
• Ward usage of DL and numbers through DL will continue to be reported into Delivery Group                                                                                                                   | • Continued review of Discharge Lounge performance to be reviewed in Delivery Group and Senior Clinical Nurse & Midwifery forum                                                                                                                                                  |                                                                                                                                                                                                                 |
| Effective ward huddles   | Annie Hunter / Marcia Meaning | A      | • Huddle SOP’s displayed on wards, with exception of St Helens, Alverstone & Mottistone  
• BAU process agreed in Delivery Group  
• Project resource agreed for 2 days per week to support facilitation of Delivery group meetings and audit collation  
• Handover to new project resource  
• Carnall Farrar observing current status of project                                                                                                    | • Further collaboration with Carnall Farrar to support next steps of project  
• Huddle audit report to be shared with Delivery Group                                                                                                                                                                                                                     |                                                                                                                                                                                                                 |
| Live ward dashboard      | Lawrence Cooper           | A      | • Collaborative working within PIDS identified going forwards regards data display to ensure alignment                                                                                                           | • Regular validation of dashboard data  
• Roll out dashboard on wards  
• Feedback and adjustment to content dashboard once displayed                                                                                                                                                                                                                     |                                                                                                                                                                                                                 |
Discharge Lounge use has dropped from its peak of > 60 pts; challenge at huddles is needed to embed use as standard

WEEKLY DISCHARGE LOUNGE USE (OCT – MAR 2019)
Agenda Item No | 15  
---|---
**Meeting** | Trust Board in Public  
**Meeting Date** | 2 May 2019  
**Title** | Ambulance Service Trust Board Report  
**Sponsoring Executive** | Tim Lynch – Director of Integrated Urgent and Emergency Care  
**Author(s)** | Victoria White – Head of Ambulance  
**Report previously considered by inc date** | Ambulance Divisional Board – 25.1.2019  
Performance Committee – 1 May 2019  
**Purpose of the report** |  
Information only | Assurance X  
Review and discuss | Agreement  
Trust Board Approval is required  
**Reason for submission to Trust Board in Private only (please indicate below)** |  
Commercial Confidentiality | Staff Confidentiality  
Patient Confidentiality | Other Exceptional Circumstance  
**Link to Trust Strategic Objectives** |  
Provide safe, effective, caring and responsive services – “Good” by 2020 | x  
Ensure efficient use of resources | x  
Achieve NHS constitutional patient access standards | x  
Achieve excellence in employment, education and development | x  
Lead strategic change on the Isle of Wight | x  
**Link to CQC Domains** |  
Effective | x  
Responsive |  
Caring | x  
Well-led | x  
Safe | x  
**Executive Summary** |  
The division’s Quality, Performance and Divisional Board Meetings took place w/c 18th February. The purpose of this report is to provide an overview of the key current opportunities, issues, challenges or risks affecting the division. A full summary is provided in the attached appendix  
**Key Items of Information for Trust Board:**  
- Quality and Safety:  
  - 1 new SI in March  
  - The service remains non-compliant with NICE NG94 and QS174, advanced paramedic practitioners; there are no current plans for implementing this post so service will remain non-compliant however the service has progressed over the last 2 years to introduce specialist paramedics to support the urgent and emergency agenda.  
  - Trust Emergency Preparedness, Resilience and Response (EPRR) NHSE/CCG assurance visit was held on 16th April to review the Trust improvement plan against the EPRR core standards. Improvements were acknowledged by both NHSE and CCG and consideration to be made for reinstating Chemical/Biological/Radiological/Nuclear Explosive (CBRNe) capabilities within the Trust  
  - The service remains non-compliant with National Ambulance Resilience Unit (NARU) cores standards. The National Ambulance Resilience Unit has redrafted 167 interoperable
capability standards to specifically align them to the IoW. These have now been reviewed by the trust and South Central Ambulance Service (SCAS) in order to agree service line agreement (SLA) required in order to reach compliance. A meeting will be planned by NHSE and NARU to agree and sign off the contract variation and the service is currently awaiting to hear from NHSE regarding this.

- Improvements have been made across the ambulance service with regards to infection and prevention. 4 of the 8 domains were showing 100% compliance and the remaining 4 all showed significant improvement compared to last year.
- A National Staff Survey Feedback poster has been sent to all ambulance staff – see appendix 1
- Ambulance Appraisal at 73.23%, Mandatory training at 85% and IG at 92.23%

**Operational Performance:**

The March performance for the 999 Ambulance Response Programme (ARP) standards and NHS111 standards are attached as appendix 1 and were discussed in detail at the Ambulance Divisional Performance subcommittee and Ambulance Divisional Board

- The national reporting position for the ambulance performance for March is attached as appendix 1. Performance for 999 has continued to improve in the month across all standards compared to March although they are not all being met consistently. The standard was met for Cat 2 and the month on month trend is also improving and shown in appendix 1.
- The service has commissioned a capacity modelling report through SCAS which demonstrates that the service is under capacity in relation to fleet/crews in order to meet the national standards consistently. Discussions are ongoing with commissioners regarding the funding gap within the contract for both operations and EPRR
- The missing CAD incidents have now been uploaded. Overall impact has seen a slight reduction in performance for Cat1, improvement in overall performance in Cat 2 and Cat 3 and a slight deterioration in performance for Cat 4 compared to previously nationally/externally reported data. See appendix 1. Commissioners and NHSE central ARP team have been kept up to date of the position and all data since implementation of the CAD in October has now been resubmitted to the national data centre. A paper describing the causality is included as appendix 2
- The NHS111 performance standards are also attached in appendix 1 and demonstrate the continued position of good call handling standards, with improving clinical standards. The overall performance of the NHS111 service on the island continues to be excellent with consistently less 111 calls resulting in an ambulance disposition better than the national average.
- The Patient Transport Service (PTS) continues to not be in a position to report against KPI’s due to the manual workaround currently in place since CAD implementation

**Programme items:**

- The PTS Computer Aided Dispatch (CAD) Programme continues in order to support integration between the CAD and the electronic booking system
- Integration of Electronic Patient Care Record (EPCR) to the CAD continues
- Staff Engagement – see appendix 1 for ambulance staff survey feedback poster
- The Quality Improvement Programme in on track and incorporates the CQC Must Do / Should Do tasks into a separate work stream which is monitored through this Programme and the Divisional Board – appendix 1

**Key Items of Risk:**
• CCG lack of funding of 999 ambulance service and EPRR
• 999 performance
• PTS CAD integration to the electronic booking system – lack of PTS reporting

Key Recommendation

The Trust Board is asked to consider the following recommendations:

To receive this report
Appendix 1
Ambulance Service
Performance Dashboard
March 2019
# Performance report March 2019

## 999 Performance

<table>
<thead>
<tr>
<th>Performance</th>
<th>Mean standard</th>
<th>Mean</th>
<th>90% standard</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Answer</td>
<td>N/A</td>
<td>10.04s</td>
<td>N/A</td>
<td>54.55 (95%)</td>
</tr>
<tr>
<td>Category 1</td>
<td>7 minutes</td>
<td>9:54</td>
<td>15 minutes</td>
<td>19.14</td>
</tr>
<tr>
<td>Category 2</td>
<td>18 minutes</td>
<td>19:11</td>
<td>40 minutes</td>
<td>39:16</td>
</tr>
<tr>
<td>Category 3</td>
<td>N/A</td>
<td>53:00</td>
<td>120 minutes</td>
<td>122:58</td>
</tr>
<tr>
<td>Category 4</td>
<td>N/A</td>
<td>89.51</td>
<td>180 minutes</td>
<td>217:19</td>
</tr>
</tbody>
</table>

## 111 / IUC Performance

<table>
<thead>
<tr>
<th>Performance</th>
<th>Standard</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Answer</td>
<td>95% &lt; 60 seconds</td>
<td>92.75%</td>
</tr>
<tr>
<td>Calls abandoned</td>
<td>&lt;5% after 30 seconds</td>
<td>3.50%</td>
</tr>
<tr>
<td>111 clinician input</td>
<td>&gt;20%</td>
<td>23.56%</td>
</tr>
<tr>
<td>IUC (CAS) clinician – calls triaged</td>
<td>&gt;50%</td>
<td>54.14%</td>
</tr>
</tbody>
</table>

## Call Volumes

### 999 Call Volumes

<table>
<thead>
<tr>
<th>Month</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>999 Call Volumes</td>
<td>2572</td>
<td>2783</td>
<td>2715</td>
<td>2501</td>
<td>2547</td>
</tr>
</tbody>
</table>

### 111 Call Volumes

<table>
<thead>
<tr>
<th>Month</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>111 Call Volumes</td>
<td>7040</td>
<td>7807</td>
<td>7146</td>
<td>6739</td>
<td>6459</td>
</tr>
</tbody>
</table>

### Total Ambulance Responses

<table>
<thead>
<tr>
<th>Month</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Ambulance Responses</td>
<td>1974</td>
<td>2046</td>
<td>2015</td>
<td>1894</td>
<td>1933</td>
</tr>
</tbody>
</table>
## 999 Ambulance performance

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 4</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidents</td>
<td>85</td>
<td>Incidents</td>
<td>831</td>
</tr>
<tr>
<td>Mean Response</td>
<td>09:54</td>
<td>Mean Response</td>
<td>19:11</td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>Response @ 90th</td>
<td>19:14</td>
<td>Response @ 90th</td>
<td>1:29:51</td>
</tr>
<tr>
<td>Percentile</td>
<td></td>
<td>Percentile</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Category 1T</td>
<td>Category 3</td>
<td></td>
</tr>
<tr>
<td>Incidents</td>
<td>53</td>
<td>Incidents</td>
<td>684</td>
</tr>
<tr>
<td>Mean Response</td>
<td>13:10</td>
<td>Mean Response</td>
<td>0:53:00</td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>Response @ 90th</td>
<td>22:48</td>
<td>Response @ 90th</td>
<td>2:02:58</td>
</tr>
<tr>
<td>Percentile</td>
<td></td>
<td>Percentile</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HT &amp; ST &amp; STC %</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# CAD Missing Incidents – Performance before and after

<table>
<thead>
<tr>
<th></th>
<th>October</th>
<th></th>
<th>November</th>
<th></th>
<th>December</th>
<th></th>
<th>January</th>
<th></th>
<th>February</th>
<th></th>
<th>March</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
<td>Before</td>
<td>After</td>
<td>Before</td>
<td>After</td>
<td>Before</td>
<td>After</td>
<td>Before</td>
<td>After</td>
<td>Before</td>
<td>After</td>
</tr>
<tr>
<td>Cat 1</td>
<td>55</td>
<td>59</td>
<td>71</td>
<td>101</td>
<td>71</td>
<td>98</td>
<td>82</td>
<td>111</td>
<td>68</td>
<td>78</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Cat 1 Mean</td>
<td>00:16:37</td>
<td>00:16:43</td>
<td>00:11:23</td>
<td>00:11:49</td>
<td>00:09:40</td>
<td>00:10:28</td>
<td>00:10:13</td>
<td>00:10:10</td>
<td>00:10:11</td>
<td>00:10:24</td>
<td>00:09:54</td>
<td>00:09:54</td>
</tr>
<tr>
<td>Cat 1 90th</td>
<td>00:26:20</td>
<td>00:27:14</td>
<td>00:20:40</td>
<td>00:20:54</td>
<td>00:18:34</td>
<td>00:19:19</td>
<td>00:19:58</td>
<td>00:19:41</td>
<td>00:17:25</td>
<td>00:17:25</td>
<td>00:19:14</td>
<td>00:19:14</td>
</tr>
<tr>
<td>Cat 1 T</td>
<td>33</td>
<td>34</td>
<td>51</td>
<td>68</td>
<td>44</td>
<td>64</td>
<td>62</td>
<td>85</td>
<td>47</td>
<td>53</td>
<td>53</td>
<td>53</td>
</tr>
<tr>
<td>Cat 1T mean</td>
<td>00:22:06</td>
<td>00:21:58</td>
<td>00:14:24</td>
<td>00:14:54</td>
<td>00:10:42</td>
<td>00:12:12</td>
<td>00:13:55</td>
<td>00:13:30</td>
<td>00:12:10</td>
<td>00:12:33</td>
<td>00:13:10</td>
<td>00:13:10</td>
</tr>
<tr>
<td>Cat 1 T 90th</td>
<td>00:38:41</td>
<td>00:38:14</td>
<td>00:23:13</td>
<td>00:25:07</td>
<td>00:20:34</td>
<td>00:21:15</td>
<td>00:24:59</td>
<td>00:24:12</td>
<td>00:23:58</td>
<td>00:24:35</td>
<td>00:22:48</td>
<td>00:22:48</td>
</tr>
<tr>
<td>Cat 2</td>
<td>587</td>
<td>610</td>
<td>771</td>
<td>886</td>
<td>716</td>
<td>833</td>
<td>772</td>
<td>889</td>
<td>791</td>
<td>840</td>
<td>831</td>
<td>831</td>
</tr>
<tr>
<td>Cat 2 Mean</td>
<td>00:20:59</td>
<td>00:21:05</td>
<td>00:19:07</td>
<td>00:18:36</td>
<td>00:18:22</td>
<td>00:18:01</td>
<td>00:21:18</td>
<td>00:20:56</td>
<td>00:21:19</td>
<td>00:21:09</td>
<td>00:19:11</td>
<td>00:19:11</td>
</tr>
<tr>
<td>Cat 2 90th</td>
<td>00:42:51</td>
<td>00:44:42</td>
<td>00:38:37</td>
<td>00:36:50</td>
<td>00:36:37</td>
<td>00:35:08</td>
<td>00:38:25</td>
<td>00:39:10</td>
<td>00:44:46</td>
<td>00:43:52</td>
<td>00:39:16</td>
<td>00:39:16</td>
</tr>
<tr>
<td>Cat 3</td>
<td>481</td>
<td>515</td>
<td>548</td>
<td>683</td>
<td>705</td>
<td>818</td>
<td>609</td>
<td>707</td>
<td>638</td>
<td>672</td>
<td>684</td>
<td>684</td>
</tr>
<tr>
<td>Cat 3 Mean</td>
<td>01:18:38</td>
<td>01:16:47</td>
<td>01:01:03</td>
<td>00:58:01</td>
<td>01:02:05</td>
<td>01:01:25</td>
<td>01:06:56</td>
<td>01:04:58</td>
<td>01:02:39</td>
<td>01:01:49</td>
<td>00:53:00</td>
<td>00:53:00</td>
</tr>
<tr>
<td>Cat 3 90th</td>
<td>02:59:04</td>
<td>02:58:00</td>
<td>02:28:27</td>
<td>02:24:22</td>
<td>02:22:50</td>
<td>02:22:13</td>
<td>02:35:43</td>
<td>02:33:16</td>
<td>02:26:52</td>
<td>02:26:23</td>
<td>02:02:58</td>
<td>02:02:58</td>
</tr>
<tr>
<td>Cat 4</td>
<td>35</td>
<td>37</td>
<td>80</td>
<td>83</td>
<td>79</td>
<td>84</td>
<td>79</td>
<td>83</td>
<td>75</td>
<td>76</td>
<td>80</td>
<td>80</td>
</tr>
</tbody>
</table>

Volumes: 1191, 1255, 63, 1521, 1821, 283, 1615, 1897, 262, 1604, 1875, 248, 1619, 1719, 94, 1733, 1733
# Workforce Scorecard

<table>
<thead>
<tr>
<th>KPI</th>
<th>Budget</th>
<th>In-post</th>
<th>Variance</th>
</tr>
</thead>
</table>
| In post v
Budgeted FTE   | 190.77 | 185.74  | -5.03    |

<table>
<thead>
<tr>
<th>KPI</th>
<th>In month</th>
<th>YTD</th>
<th>Trust In Month</th>
<th>Trust YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnover</td>
<td>0.00%</td>
<td>5.47%</td>
<td>0.71%</td>
<td>10.31%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KPI</th>
<th>In month</th>
<th>YTD</th>
<th>KPI Target</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness</td>
<td>6.88%</td>
<td>6.31%</td>
<td>5.5%</td>
<td></td>
</tr>
<tr>
<td>Appraisal*</td>
<td>73.23%</td>
<td>73.23%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Mandatory Training</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td></td>
</tr>
</tbody>
</table>
### M12 Finance

Month 12 position - £106k overspent with a YTD position of £334k overspent.

<table>
<thead>
<tr>
<th></th>
<th>Budget £'000's</th>
<th>Actual £'000's</th>
<th>Variance £'000's</th>
<th>Budget £'000's</th>
<th>Actual £'000's</th>
<th>Variance £'000's</th>
<th>Forecast £'000's</th>
<th>Variance £'000's</th>
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</thead>
<tbody>
<tr>
<td><strong>PAY</strong></td>
<td>549</td>
<td>626</td>
<td>76</td>
<td>7,117</td>
<td>7,582</td>
<td>465</td>
<td>7,117</td>
<td>7,510</td>
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<tr>
<td><strong>NON-PAY</strong></td>
<td>183</td>
<td>217</td>
<td>34</td>
<td>2,139</td>
<td>2,112</td>
<td>27</td>
<td>2,131</td>
<td>2,010</td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
<td>(20)</td>
<td>(25)</td>
<td>(5)</td>
<td>(245)</td>
<td>(349)</td>
<td>(104)</td>
<td>(245)</td>
<td>(299)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>712</td>
<td>817</td>
<td>106</td>
<td>9,012</td>
<td>9,345</td>
<td>334</td>
<td>9,003</td>
<td>9,222</td>
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</table>

**Plan YTD** £9.01m  
**Actual YTD** £9.34m  
**Variance YTD** £0.33m
National Survey Results – Ambulance Service Feedback

Staff Attitude Survey Results 2018/19
Ambulance and PTS Service

Areas for improvement
Areas as a service where we have scored the same or worsened compared to last year (i.e., satisfaction has declined) and are below the national average.
- Look forward to coming to work
- Feeling unwell due to stress
- Feeling pressurised by manager to come to work
- Experience of physical violence from other staff.
- Team does not share same objectives
- Manager asking for opinion, valuing work, taking an interest in health and wellbeing, providing support
- Training needs being identified at appraisal
- Come to work despite feeling unwell

Areas we have improved
Areas as a service where we have scored better than last year and are above the national average for ambulance trusts.
- Being able to make suggestions
- Being involved in making improvements
- Being recognised for work done
- Open communication with managers
- Treating staff fairly involved in an error
- Encourage reporting of errors
- Appraisal leaves staff feeling valued
- Harassment from colleagues
- Patient/user feedback is collated in service
- Updates are given on patient and user feedback
- Feedback from patient and users is used to inform change

Sickness management training for all managers
All managers to undertake compassionate leadership training
Implementation of staff engagement strategy
What are we going to do as a result of this feedback?
Increase feedback to staff from incidents reported
Encourage incident reporting
Zero tolerance approach to any physical violence
Ensure all appraisals include team development

Do you have ideas on how we can make positive improvements and how best to share these with staff across our services?
E-mail adminHQ@iow.nhs.uk, contact any of the Senior Manager Team direct or speak to your line manager

SAS Feedback results Victoria White April 2019

67 staff across all our services completed the national survey. This represented 35% of the workforce.
Agenda Item No | 16  
---|---
Meeting | Trust Board in Public
Meeting Date | 2 May 2019

Title | Community Division Report

Sponsoring Executive Director | Alice Webster, Director of Nursing, Midwifery, AHPs & Community Services

Author(s) | Nicola Longson, Deputy Director of Out of Hospital Services

Report previously considered by inc date | Community Divisional Board (16 April 2019)
| Community Quality & Performance Meeting (16 April 2019)
| Performance Committee 1 May 2019

Purpose of the report
- Information only
- Assurance
- Review and discuss
- Agreement

Trust Board Approval is required

Reason for submission to Trust Board in Private only (please indicate below)
- Commercial Confidentiality
- Staff Confidentiality
- Patient Confidentiality
- Other Exceptional Circumstance

Link to Trust Strategic Objectives
- Provide safe, effective, caring and responsive services – ‘Good’ by 2020 x
- Ensure efficient use of resources x
- Achieve NHS constitutional patient access standards x
- Achieve excellence in employment, education and development x
- Lead strategic change on the Isle of Wight x

Link to CQC Domains
- Effective x
- Responsive x
- Caring x
- Well-led x
- Safe x

Executive Summary
SAFE
- Temporary medical cover for rehabilitation beds now in place across the community. The related risk score will be reduced to moderate as a result.

- Ongoing positive progress made with CQC Regulatory Actions – ‘Achieved’ or ‘Sustained’ 20 out of 24 actions; ‘Should do’ Actions – all actions ‘Achieved’ or ‘Sustained’ (see slides 2 & 3). Regulatory actions reviewed robustly through Divisional governance and process put in place to drive implementation of outstanding actions.

- Duty of Candour compliance sits at 100% for the Division

- Continuing to demonstrate good progress on mandatory training compliance, see table below:

<table>
<thead>
<tr>
<th>Competency Name</th>
<th>Total Required</th>
<th>Total Achieved</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>352</td>
<td>301</td>
<td>86%</td>
</tr>
<tr>
<td>Preventing Radicalisation Level 1 &amp; 2</td>
<td>389</td>
<td>362</td>
<td>93%</td>
</tr>
<tr>
<td>Preventing Radicalisation Level 3</td>
<td>321</td>
<td>237</td>
<td>74%</td>
</tr>
<tr>
<td>Safeguarding Adults Lev 1</td>
<td>388</td>
<td>377</td>
<td>97%</td>
</tr>
</tbody>
</table>
Safeguarding Adults Lev 2 Part 1 351 326 93%
Safeguarding Adults Lev 2 Part 2 350 337 96%
Safeguarding Children Lev 1 388 380 98%
Safeguarding Children Lev 2 303 261 86%
Safeguarding Children Lev 3 74 73 99%

EFFECTIVE
- Podiatry audit – The NHS Wessex Peer Review took place on 31st October 2018. It was a very positive experience and good practice and significant achievements were noted, including:
  - Podiatry service and clinical facilities.
  - Diabetologist leadership and commitment.
  - Vascular input
  - Orthotics in-house and on site
  - Annual review from podiatry
  - Team working
  - Cover for diabetologist from colleague
  - Excellent admin team
  - Low major amputation rate
  - Podiatry retention and recruitment rates are good
There were eight resulting recommendations, an action plan has been formulated and presented to the Clinical Effectiveness Committee in April 2019.

- Public Health amputation figures for 2015-2018 have been released and the IW figures have remained the same at 5.8 DSR (direct standardised rate), per 10,000 of population. This is an excellent result for the Island and our Podiatry service given the increasing burden of diabetes on our population. As a comparison, Southampton figures are 11.9 and Portsmouth at 16 (one of the highest in the country).

- Early data is showing the new implementation of the Falls pathway has been successful in preventing admissions (refer to slides 4-7). The ‘RAG’ pathway for non-conveyed fallers was established in April 2018 to improve KPIs for the Ambulance service and to improve the care provided to older people at risk of falls. At the point that an ambulance is called out to a person who has had a fall and who meets the inclusion criteria, a judgement is made by the crew alongside the clinical support desk staff as to the response required. The response provided is determined by level of urgency but will ultimately result in the person being assessed for falls risk and evidence based interventions being provided on an individual basis. The data slides show us considerable reductions across 999/111 conveyances and non-conveyances since the introduction of the RAG referral. The current data set excludes the data from the Crisis Response Team but we will be working to be able to include this going forwards. The associated Falls Prevention & Bone Health Strategy has been approved across statutory bodies, now awaiting approval from Local Care Board.

- Community Nursing - Referral in SystmOne – agreement reached with GP’s engaged around electronic system of referral.

- Children's SLT - Evidence of good outcomes following the introduction of TOMS & Isle Attend.

CARING
- 0-19 Services are changing the way they deliver services to enable more personalised care, tailoring provision to meet the needs of parents. The team has received a letter from a new mother who has recently received enhanced antenatal services from health visitors and an excellent package of care. The words in the letter are certainly ones that cause reflection: *During my pregnancy the health visitors came into see me and talked me through and demonstrate how to do things like hold the baby and how to do things. As a young 15 year old, about to become a mum, I found their help and support really helpful, and I know you don’t*
normally do things like this but I feel like this would be a great help for other young mums in need of the help and support and to reassure them about the birth and what to expect when the time comes and how to prepare for when the time comes. Thank you for all your help and support’. The relationship that was formed antenatal has allowed for a very positive start and a period of reflection on what programmes are available to ensure that this is offered as a standard and that it supports during the first 1000 days.

- Harm Free Care – a Pressure Ulcers deep dive (see slide 8) shows an overall steep decline in all areas since November 2018. This positive performance, particularly the reducing numbers ‘deteriorating under IW care’ is reflective of the improving competencies around pressure ulcer and wound management within Community Nursing. This performance can also be linked to lessons learnt from Serious Incidents over the last 12 months.

RESPONSIVE
- The Orthotics service have worked hard to maximise efficiency in the time it takes to start and finish an episode of care, using “productive community” methodologies. They have reduced their overall activity by 7% whilst maintaining the same episode of care rate. They have reduced their new to follow up rate (to 1:0.52), helping them to maintain productivity despite a vacancy.
- Children’s Speech & Language Therapy are demonstrating good governance of caseload - all patients seen within 12 weeks of referral and average wait is 6 weeks.
- Division has identified risk that immature systems are in place in some services for monitoring caseload and capacity/demand. Work is underway to identify actions required to mitigate this risk.

WELL-LED
- The Division achieved its year-end financial target with very constructive engagement of Service Leads in achieving both the 2018/19 control total and ideas for 2019/20 Cost Improvement Plan.
- Slide 9 shows the latest position within the division regarding recruitment. The new set of recruitment KPIs enable the senior management team to understand where breaches are occurring and actions are in place to improve, this is coupled with further internal checks on both the job matching process and preparation of recruitment information to present to the weekly Employment Panel (pre recruitment activities).
- Divisional sickness for March was 5.5% against a target of 3.3% - work continuing with Physiotherapy & Community Nursing to address stress-related absence.
- Ongoing support to Outpatients Redesign project – moving 60+ staff to new locations over the next few weeks.
- A Staff Engagement Strategy was agreed at Divisional Board in April with an action plan in place to implement improved engagement across all services. The monthly Pulse Survey response rates have been poor for the Division to date, support and encouragement from the Director of Out-of-Hospital Services and Community Service Leads this month should deliver improved participation rates.
COMMUNITY RISK
The Division has recently reviewed its high scoring risks and has just one 'red' risk to escalate to the Committee.

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Risk Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Risk of patient harm and reduced levels of care as a result of demand of Diabetes/insulin administration on Community Nursing</td>
</tr>
</tbody>
</table>

**Key Recommendation**

The Trust Board is asked to:

- Note the update provided
- Receive assurance on performance in relation to CQC key lines of enquiry
## Community Division – Regulatory Actions

<table>
<thead>
<tr>
<th>Service</th>
<th>Total</th>
<th>Overdue</th>
<th>Planned for next month</th>
<th>Achieved</th>
<th>Achieved &amp; Sustained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services - Adult</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Community Health Services – Children</td>
<td>15</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>24</strong></td>
<td><strong>1</strong></td>
<td><strong>3</strong></td>
<td><strong>11</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

### Areas of concern (overdue actions/planned for next month)

**Community Health Services Adult**
- There is a workload and dependency tool in use to ensure safe and appropriate care for patients. Regulation 12 (2) (b)
- Undertake impact assessments for service changes, identify and implement actions to lessen risks. Regulation 17 (2) (b)

**Community Health Services Children**
- There is a robust governance structure in place and there is oversight of all services within the children, young people’s and families service. Regulation 17 (1)
- There is a vision and strategy for the service and this is communicated to all staff. Regulation 17 (1)(2)(f)

### Mitigation in Place/Actions taken

**Community Health Services Adult**
- Local demand and capacity tool in place for Community Nursing - review currently part of 10 week improvement plan with further work being undertaken with IM&T to ensure changes are embedded and sustained and to develop reporting mechanism to support robust monitoring.
- Demand and Capacity to be extended to other Community Services.
- Quality Impact Assessments being built in to Phase 3 of Quality Improvement plans in areas where there are service changes

**Community Health Services Children**
- 0-19, acute paediatric services and safeguarding children's team are developing a governance process and children's board
- 0-19, acute paediatric services and safeguarding children's team have scoped their vision and strategy and have developed a draft strategy

### Sustaining

Monitoring is undertaken by Teams in their own service meetings, with regular reporting and oversight by Quality and Performance Committee reporting to Community Divisional Board

### Outcomes for next month

- Confirmation that Quality Impact Assessments built in to improvement plans
- Output of Children's services scoping workshop and implementation plan for vision and strategy

---

*Actions not expected to be addressed by June 2019*

Demand and Capacity – Community Nursing underway but there is a risk around ability to implement and embed IT system changes in all services across the Division to June timescale.
## Community Division – Progress
### CQC ‘Should do’ Actions Update

<table>
<thead>
<tr>
<th>Service</th>
<th>Total</th>
<th>Overdue</th>
<th>Planned for next month</th>
<th>Achieved</th>
<th>Achieved &amp; Sustained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services - Adult</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Community Health Services – Children</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>13</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>2</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

### Areas of concern (overdue actions)

**Community Health Services Children**
- Services use feedback from children, young people and their families to improve services.

### Mitigation in Place/Actions taken

**Community Health Services Children**
- Attending school assembly's for reception and year 6 for NCMP
- Assembly for Year 8/9 for immunisations.
- Clinic consultation, Feeding survey consultation with parents.
- Consultation work with Children to develop transition pathway
- Ongoing consultation with children scheduled for each school Term.
- Working with all school heads to build on the school readiness work already undertaken

### Monitoring/Sustaining

Monitoring is undertaken by Teams in their own service meetings, with regular reporting and oversight by Quality and Performance Committee reporting to Community Divisional Board

### Outcomes for next month

- Output of 0-19 consultation progress
Falls Prevention work (see page 2 of main report)
111 Non-Conveyances for RAG Cohort
Falls Prevention work (see page 2 of main report)
999 Non-Conveyances for RAG Cohort

999 Non-Conveyance SPC

Before RAG Referral
- Lower Limit (0.0)
- Average (5.3)
- Upper Limit (19.1)

After RAG Referral
- Lower Limit (0.0)
- Average (0.7)
- Upper Limit (3.4)
Falls Prevention work (see page 2 of main report)

111 Conveyances for RAG Cohort

111 Conveyances SPC

Before RAG Referral
Lower Limit (0.0)
Average (1.2)
Upper Limit (4.9)

After RAG Referral
Lower Limit (0.0)
Average (0.3)
Upper Limit (1.6)
Falls Prevention work (see page 2 of main report)

999 Conveyances for RAG Cohort
Harm Free Care – Pressure Ulcers

Pressure Ulcers – Deep dive

Community Pressure areas month on month per category

- Pressure Ulcer / Moisture Lesion present on admission to IW NHS care
- Pressure Ulcer / Moisture Lesion deteriorated under IW NHS care
- Pressure Ulcer / Moisture Lesion developed under IW NHS care

Falls
- 15 (12% of 130 reported incidents) Falls recorded in January 2019
- 6 (40%) of these falls were in The Elms
- No theme in particular surrounding these falls
Recruitment KPI’s – Community

<table>
<thead>
<tr>
<th>JANUARY DATA 2019</th>
<th>KPI TARGET (average days)</th>
<th>KPI ACHIEVED (average days)</th>
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<tbody>
<tr>
<td>1a) Time between vacancy received &amp; RO assigned/HM notified</td>
<td>1</td>
<td>0.61</td>
</tr>
<tr>
<td>1b) Time between Vacancy received &amp; Publish advert onto NHS Jobs</td>
<td>2</td>
<td>0.83</td>
</tr>
<tr>
<td>2a) Time between application close date &amp; applications sent to Recruiting Manager for shortlisting</td>
<td>1</td>
<td>0.78</td>
</tr>
<tr>
<td>2b) Time between Shortlisting sent and shortlisting outcome received</td>
<td>3* RM KPI</td>
<td>*2.61</td>
</tr>
<tr>
<td>3A) Time between shortlisted applicants confirmed &amp; Invite to interviews sent</td>
<td>2</td>
<td>3.28</td>
</tr>
<tr>
<td>3B) Panel packs received prior to interview date</td>
<td>2</td>
<td>6.44</td>
</tr>
<tr>
<td>4a) Appointment Information Form sent to Resourcing Officer by the Recruiting Manager</td>
<td>1* RM KPI</td>
<td>*5.39</td>
</tr>
<tr>
<td>4b) Conditional Offer letter issued to successful candidate following notification of successful appointment</td>
<td>2</td>
<td>1.94</td>
</tr>
<tr>
<td>5a) Pre-employment screening to commence following confirmation of appointment</td>
<td>2</td>
<td>1.94</td>
</tr>
<tr>
<td>5b) Unconditional offer to confirm start date letter issued following start date confirmation</td>
<td>2</td>
<td>1.94</td>
</tr>
<tr>
<td>6a) Contract of employment issued to recruiting manager following start date</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>6b) Time between Signed contract being issued and returned to HR for file</td>
<td>5* RM KPI</td>
<td>***19</td>
</tr>
</tbody>
</table>

** TIME TO RECRUIT - Band 1-4 (Avg days) **
- 49
- 47

** TIME TO RECRUIT - Band 5-6 (Avg days) **
- 70

** TIME TO RECRUIT - Band 7 and above (Avg days) **
- 91
- No data yet available

**Key**
- Green – KPI achieved
- Amber – Breach within 1 working day
- Red – KPI breached

*Recruiting Manager KPI

Data compiled from vacancy approvals received in HR in December 18
- excludes medical vacancy data
- Time to hire is based on actual confirmed start dates in December

*RM KPI - Recruiting Manager KPI

**Hiring Managers to ensure appointment information form is completed within 3 days of vacancy close date. This will become automated with new roles wef 1st April which should reduce the wait time, prompting automated chase for outstanding information

*** Contracts wef 1st April will be issued via NHS Jobs – Candidates will be required to read and accept T&C’s electronically (tick box) – Reduction in days to be expected.

Note: Time to recruit KPI targets based on NHS Improvement
<table>
<thead>
<tr>
<th>Agenda Item No</th>
<th>Meeting</th>
<th>Trust Board in Public</th>
<th>Meeting Date</th>
<th>2 May 2019</th>
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<tr>
<td>Title</td>
<td>Performance Report - Mental Health &amp; Learning Disabilities Services</td>
<td></td>
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<td></td>
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<tr>
<td>Sponsoring Executive Director</td>
<td>Dr. Lesley Stevens, Director of Mental Health and Learning Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>John Doherty, Head of Mental Health and Learning Disabilities</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Report previously considered by inc date</td>
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<tr>
<td>Purpose of the report</td>
<td>Information only</td>
<td>Assurance</td>
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<tr>
<td></td>
<td>Review and discuss</td>
<td>Agreement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Board Approval is required</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Reason for submission to Trust Board in Private only (please indicate below)</td>
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<td>Staff Confidentiality</td>
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<tr>
<td></td>
<td>Patient Confidentiality</td>
<td>Other Exceptional Circumstance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to Trust Strategic Objectives</td>
<td>Provide safe, effective, caring and responsive services – ‘Good’ by 2020</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure efficient use of resources</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieve NHS constitutional patient access standards</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieve excellence in employment, education and development</td>
<td>x</td>
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<td></td>
<td>Lead strategic change on the Isle of Wight</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>Link to CQC Domains</td>
<td>Effective</td>
<td>x</td>
<td>Responsive</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Caring</td>
<td>x</td>
<td>Well-led</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Safe</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td>The report outlines performance, risks and financial position for the Mental Health and Learning Disabilities Division.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>The Board is asked to take assurance from the current performance position of the Mental Health &amp; Learning Disabilities Service.</td>
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</tbody>
</table>
Mental Health and Learning Disabilities Performance Report

1. Good News:

- The procurement process for the new Wellbeing Service has been completed. The Safe Haven contract has been awarded to Two Saints. The Wellbeing Service has been awarded to Issoropia. New contracts will be in place by May 2019.

2. Performance Summary:

   Effective:

   - The planned temporary closure of Shackleton ward (mental health dementia service) for refurbishment took place as planned in April. There is agreement with Southern Health to provide two beds for patients requiring in-patient care during the closure. Shackleton staff are out-reaching to nursing and residential homes to prevent mainland admissions during the closure period. A development programme for Shackleton staff has been planned for the temporary closure of the ward, and will include training, team development and experience in other wards delivering dementia care.

   - Achievement of the Gatekeeping indicator continues to be challenging due to the small number of admissions. Just one breach in February meant the target was not achieved. Work is ongoing with local authority Approved Mental Health Practitioners (AMHPs) to ensure Home Treatment staff are involved in the Mental Health Act assessment and decision to admit.

   Well Led

   - MH&LD Divisional Board discussed publication of the Independent Report into the homicide of a six year old girl by her father in 2016, and his subsequent suicide. The report makes a series of recommendation captured in an action plan which is publically accessible. The Board reviewed the action plan and agreed that it will be monitored in the Quality Committee, and report through to the Island-wide Quality Committee chaired by the CCG. The Executive Director of Mental Health and Learning Disabilities and Head of Nursing and Quality have met with the mother who has agreed to work with us to share learning from this tragic event and particularly with regards to the Think Family Programme.

   - The Divisional Board Seminar programme, with extended membership to include team leaders and consultants, continues with seminars on preparation for the CQC visit and Finances planned for May.

   - Appraisal performance continued to improve in February at 77%. However, from April appraisal will be reset to zero. This was discussed at the Divisional Performance Committee and plans agreed to take forward completion of appraisal during the first quarter of 19/20.

   - Levels of sickness continue to remain high across the Division, but show a slight decrease from the previous month. Deep dives have identified the sickness “hotspot” areas and work will be undertaken with our HR Business Partner and Team Leaders to ensure robust but supportive sickness management going forward.
5 Team Leader posts across the Division currently out to advert – the division has recognised this as a risk due to ongoing difficulties in recruitment to qualified posts.

Caring

It has been agreed through EPP for a new post to lead care planning improvement work on Osborne Ward.

Safe

Performance in relation to patients on Care Programme Approach (CPA) with a current risk assessment in the Community Mental Health Service (CMHS) has deteriorated. The Care Programme Approach (CPA) is a national framework for multidisciplinary and multiagency care planning in mental health services. It applies to people with more complex needs or higher risk. There are a number of contributory factors to the deterioration in performance, including reallocation of caseloads due to workforce changes, incorrect application of the CPA policy resulting in people being recorded as being on CPA when this is not required from a clinical perspective, and data quality issues. Considerable work is being undertaken during April and we are already seeing an improvement in performance as a consequence, with an expectation that it will reach 80% by May 2019. In addition work is in progress to improve our reporting of risk assessment for people who are not subject to CPA, and to improve the quality of risk assessments.

Responsive

The total CMHS caseload continues to be above the Transitions Project trajectory. The predicted rate of discharge is being achieved, but we have seen an increase in referrals into the service, resulting in the caseload remaining broadly unchanged. As the procurement process for the new Wellbeing Service is now complete and contracts awarded it is expected that reductions in CMHS caseload will be achieved from May 2019, as the full wellbeing programme is delivered, and there is flow through the service. In addition, the Wellbeing service is starting to support the Single Point of Access in diverting referrals from CMHS.

The Division is currently validating RTT waiting lists to ensure waiting lists and waiting times are accurate. The waiting times for Older People’s Mental Health service (OPMH) increased during the year due to long-term Consultant Psychiatrist vacancy and lack of consistent locum cover, however there is now agency Consultant cover in place until end May 2019. Work is ongoing with the OPMH team to review the waiting list and ensure robust booking processes are in place.

Bed occupancy in February was above 100% in both adult and older adult wards. It has been recognised that there is a higher proportion of patients detained under the Mental Health Act and this will be monitored through the weekly Medics and Managers meeting.

The year end position re the IAPT access target is predicted to be below the local stretch target of 22%, however we are expecting to achieve the national target. Performance against the recovery target continues to improve and it is anticipated that the year-end recovery target will be achieved. We are currently waiting for
confirmation from CCG for additional High Intensity Therapists and Psychological Wellbeing Practitioners to commence training in September 2019. This could potentially have a negative impact on the constitutional targets for 2019/20.

- The Early Intervention in Psychosis (EIP) waiting times target was not achieved in February 2019. Only one of six reported pathways was completed within the required two weeks. This was due to some delays in referrals from the Single Point of Access and CMHS to EIP. There were also a number of difficult to engage patients. The EIP Team Lead is working with colleagues across the Division to ensure onwards referral to the EIP team is made immediately psychosis is suspected.

3. Operational Risks:

As of 1st April 2019 the MH&LD Division had 35 risks recorded on the risk register, 9 of which fall within the remit of the MH&LD Divisional. Eight of the risks are rated as high at this time. All high risks are reviewed on a monthly basis as the Divisional Board. It was agreed in the MH&LD Board to add a risk regarding risk assessment in CMHS.

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Owner</th>
<th>Title</th>
<th>Opened</th>
<th>Risk level (Inherent)</th>
<th>Risk level (current)</th>
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<tbody>
<tr>
<td>1521</td>
<td>James Dawson</td>
<td>Extensive waiting list for Care Coordinators within CMHS</td>
<td>13/02/2019</td>
<td>High risk</td>
<td>High risk</td>
</tr>
<tr>
<td>1421</td>
<td>John Doherty</td>
<td>Inability to deliver financial plan due to need to use agency / locum staff</td>
<td>25/09/2018</td>
<td>High risk</td>
<td>High risk</td>
</tr>
<tr>
<td>1274</td>
<td>Lesley Stevens</td>
<td>Risk that the Inadequate estate for Shackleton impacts patient standards</td>
<td>23/11/2017</td>
<td>High risk</td>
<td>High risk</td>
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<tr>
<td>1427</td>
<td>John Doherty</td>
<td>Risk to the delivery of safe and effective services due to inability to recruit and retain sufficient staff</td>
<td>02/10/2018</td>
<td>High risk</td>
<td>High risk</td>
</tr>
<tr>
<td>1424</td>
<td>Lucie Johnson</td>
<td>Lack of staff engagement / poor staff morale across MH&amp;LD division</td>
<td>25/09/2018</td>
<td>High risk</td>
<td>High risk</td>
</tr>
<tr>
<td>1423</td>
<td>Lucie Johnson</td>
<td>Risk of insufficient admin capacity across MHLD</td>
<td>25/09/2018</td>
<td>High risk</td>
<td>High risk</td>
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<tr>
<td>1480</td>
<td>David Sellers</td>
<td>Insufficient resources allocated to the Adult ADHD service</td>
<td>31/12/2018</td>
<td>High risk</td>
<td>High risk</td>
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<tr>
<td>1479</td>
<td>David Sellers</td>
<td>Insufficient resources allocated to Adult ASD resulting in excessive waiting times and limited post diagnostic support</td>
<td>31/12/2018</td>
<td>High risk</td>
<td>High risk</td>
</tr>
</tbody>
</table>
4. Finance

**Mental Health & LD Control Total v Forecast**

Whilst there has been significant reduction in the use of agency staff within CMHS an increase in the use of agency in in-patients services due to recruitment difficulties of registered nurses has meant the overall expected reduction in spend has not been achieved.

The Division is undertaking a full review of our staffing establishment with a view to implementing a sustainable staffing model to help prevent the reliance on agency staff across all services.

---

**Key Recommendation**

The Board is asked to take assurance from the current performance position of the Mental Health & Learning Disabilities Service.
### Mental Health and Learning Disabilities Division

#### Safe

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Data to</th>
<th>Target 18/19</th>
<th>Actual YTD</th>
<th>Actual Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIRF's</td>
<td>Feb-19</td>
<td>28</td>
<td>4</td>
<td></td>
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<tr>
<td>CMHS Caseload</td>
<td>Feb-19</td>
<td>1650 Q4 18/19</td>
<td>1715</td>
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<tr>
<td>% of people on CPA with an updated risk assessment completed within the last 12 months</td>
<td>Feb-19</td>
<td>100%</td>
<td>53.4%</td>
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<td></td>
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<tr>
<td>Mandatory Training Compliance</td>
<td>Feb-19</td>
<td>85%</td>
<td>85.0%</td>
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</table>

#### Well Led

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Data to</th>
<th>Target 18/19</th>
<th>Actual YTD</th>
<th>Actual Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal %</td>
<td>Feb-19</td>
<td>85.0%</td>
<td>76.7%</td>
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<td></td>
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<tr>
<td>Sickness Levels</td>
<td>Feb-19</td>
<td>4.5%</td>
<td>6.6%</td>
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<tr>
<td>Retention - Staff Turnover</td>
<td>Jan-19</td>
<td>11.3%</td>
<td>0.0%</td>
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</table>

#### Responsive

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<tr>
<th>Key Performance Indicator</th>
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<th>Actual YTD</th>
<th>Actual Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people experiencing a first episode of psychosis taken onto the pathway within 2 weeks</td>
<td>Feb-19</td>
<td>53%</td>
<td>57.8%</td>
<td>16.7%</td>
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<tr>
<td>CAMHS: Proportion of CYP with Eating Disorder (routine) that wait 4 weeks or less from referral to NICE approved pathway (Quarterly Reporting)</td>
<td>Dec-18</td>
<td>95% (from 2020)</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>RTT Incomplete MH % within 18 Weeks - All</td>
<td>Feb-19</td>
<td>92%</td>
<td>81.9%</td>
<td>80.3%</td>
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<tr>
<td>RTT Incomplete MH % within 18 Weeks - Adult Mental Illness</td>
<td>Feb-19</td>
<td>92%</td>
<td>71.2%</td>
<td>85.0%</td>
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<tr>
<td>RTT Incomplete MH % within 18 Weeks - Old Age Psychiatry</td>
<td>Feb-19</td>
<td>92%</td>
<td>83.2%</td>
<td>79.2%</td>
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<tr>
<td>RTT Incomplete MH % within 18 Weeks - CAMHS</td>
<td>Feb-19</td>
<td>92%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>IAPT Access Rate</td>
<td>Feb-19</td>
<td>22% Local Target - 19% National</td>
<td>19.4%</td>
<td>18.4%</td>
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</table>

#### Effective

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Data to</th>
<th>Target 18/19</th>
<th>Actual YTD</th>
<th>Actual Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Acute Bed Occupancy</td>
<td>Feb-19</td>
<td>85%</td>
<td>107.4%</td>
<td>103.4%</td>
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<tr>
<td>Older Person's Bed Occupancy</td>
<td>Feb-19</td>
<td>85%</td>
<td>111.0%</td>
<td>104.0%</td>
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</tr>
<tr>
<td>Readmission Rates within 90 Days</td>
<td>Feb-19</td>
<td>19.8%</td>
<td>26.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IAPT Recovery</td>
<td>Feb-19</td>
<td>50%</td>
<td>53.3%</td>
<td>64.1%</td>
<td></td>
</tr>
<tr>
<td>Number of people followed up within 7 days of inpatient care</td>
<td>Feb-19</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)</td>
<td>Feb-19</td>
<td>95%</td>
<td>88%</td>
<td>92%</td>
<td></td>
</tr>
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</table>
### Agenda Item No 18

<table>
<thead>
<tr>
<th>Title</th>
<th>Workforce Performance Report April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsoring Executive Director</td>
<td>Julie Pennycook, Director of HR &amp; OD</td>
</tr>
</tbody>
</table>
| Author(s)                 | Calum Robertson, Operational Lead, Workforce Information  
                        | Jacqui Skeel, Associate Director of OD |
| Report previously considered by inc date | HR & OD Sub Committee; Culture & Leadership Steering Group  
                        | Performance Committee – 1 May 2019 |

#### Purpose of the report

- Information only
- Review and discuss
- Trust Board Approval is required

#### Reason for submission to Trust Board in Private only (please indicate below)

- Commercial Confidentiality
- Patient Confidentiality
- Other Exceptional Circumstance

#### Link to Trust Strategic Objectives

- Provide safe, effective, caring and responsive services – ‘Good’ by 2020
- Ensure efficient use of resources
- Achieve NHS constitutional patient access standards
- Achieve excellence in employment, education and development
- Lead strategic change on the Isle of Wight

#### Link to CQC Well Led Domains

<table>
<thead>
<tr>
<th>Effective</th>
<th>Responsive</th>
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<table>
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<tr>
<th>Caring</th>
<th>Well-led</th>
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<table>
<thead>
<tr>
<th>Safe</th>
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</table>

#### Executive Summary

- Successful Leadership Event 29 March 2019
- Culture dashboard/staff surveys show some encouraging signs of improvement, albeit there are many areas of development to follow up on
- Mandatory Training compliance - 86% compliance achieved against target of 85%
- Appraisal rate 77%, increase on M11. Improvement plan in progress to improve position and experience for staff 2019-20.
- Master Vendor for Nursing has resulted in further cost avoidance of £108k in month
- Overseas Nurse Recruitment - first cohort of nurses arrive in July 19 – 11 Acute nurses
- Overseas Recruitment Steering Group progressing on-boarding and engagement programme
- Trust sickness absence rate: 5.10% in month (decrease from 5.93% M11). Highest reasons for absence: Anxiety, Stress & Depression – action to address in place
- Staff Turnover 10.48% (rolling 12 months) against local benchmark avg 14%

#### Key Recommendation

The Trust Board is asked to receive the report
Workforce Performance Report

April 2019
Workforce – Trust level metrics

- Workforce FTE
  - Establishment: 3097
  - In-post: 2777
  - Bank Usage: 169
  - Agency Usage: 119
  - TOTAL: 3065
  - Variance: -32

- Sickness Absence: 5.10%
- Turnover: 10.48% (Rolling 12 months)
- Appraisal Compliance: 77%
- Vacancy Factor: 12%

March 2019 data (Finance data includes CIP within establishment)

- The Trust employs 3236 (headcount) substantive full and part time staff, 400 bank workers with additional support provided by 300 volunteers.
- Sickness decreased in M12 from 5.93% M11. Stress Anxiety & Depression remains the highest cause of absence, with 26% of total Trust sickness (increased level of 25% from M11)
- Mandatory training has achieved its highest level this year, exceeding the target of 85%
- Bank/Agency usage shows an increase in M11, due to increased sickness in Acute.
- Master Vendor for Nursing, has delivered further cost avoidance of £108k in month
- Overseas Recruitment Steering Group working to on-board and engagement programme for 1st cohort of nurses due to arrive 19 July 2019
- Turnover remains low and is below other Trusts within the region average of 14%
- Vacancy Factor increased to 12% from 11.5% in M11

RAG Ratings Key –
- Appraisal – over 80%: Amber
- 95%+: Green
- Mandatory Training - 85+ Green
- 75-84 Amber

Bank/Agency against workforce plan target: 191 FTE
Leadership and Culture

• Continued excellent feedback from Corporate Induction.
• More work to do to with team leaders to improve quality and completion of local induction.
• An increase in the number of staff attending corporate induction in the first few weeks of their employment. Work in progress to further improve to ensure as many new starters as possible attend corporate induction during their first week with the Trust.
• Encouraging feedback being received from new clinical induction (held in the 2 weeks following the corporate induction day). This enables more timely completion of mandatory training. Staff are also reporting that this induction process is enabling them to have the time to build relationships with others, very important to working in a new Organisation and for many also new to the Island.

“A very good day and excellent induction... interesting and good to meet lots of other new starters.”
“Much better than I expected...”
“It was great to meet and get to know the Executive team and their individual job roles.”
“Overall a welcoming and interesting day.”
“Excellent presentations and lots of useful information given.”
Leadership and Culture

Culture & Leadership Update

• Leadership development programme on track.
• Currently 113 staff across 4 cohorts are participating in the Middle Leaders Programme. Discussions underway for further cohorts to commence later in 2019.
• Leadership Strategy Action Plan in revision
• Leadership Conference held 29 March 2019 just under 300 attendees (c200 from the Trust) – excellent feedback with evidence of learning and inspiration being put into practice. Full evaluation underway.
• Work in progress to engage staff on revised Vision, Values and Behaviours framework. Toolkit being developed for implementation in April.
• ‘You said, we did’ planned in response to staff feedback in the annual survey and further work with divisions to collate action plans.

‘Wonderful warm welcome, real sense of your journey to good and outstanding .... best of luck. Your honesty about your challenges have been refreshing and has resonated with me; I have seen and heard of your compassion, tenacity and resilience. Well done IOW, keeping going. Thank you for a great day.’

‘Thank you for an inspiring well organised learning day. I have felt welcomed from registering to attending then being here today. I have felt empowered by the speakers and the work you are doing on the IOW and will be taking the learning back to my teams. Thank you.’

‘I feel as if I am coming out of a dark tunnel towards the light. I feel inspired, motivated and energised to look for positive ways of making a difference.’

‘Fantastic day. Lots to go away and reflect. Very inspirational speakers which have left me feeling motivated and re-energised. Well done to the team for organising such a fab event.’

‘Very inspiring day, great to hear the speakers and take some of the thoughts, tools and learning back to share with colleagues. Great to celebrate the work we do on the IOW.’

‘Thoroughly enjoyed the guest speakers. They were motivating and I feel I have gained some great ideas which I feel very enthusiastic about putting forward within my team.’

‘One of the best conferences I have attended. Totally inspirational as is our CEO Maggie.’
Leadership and Culture – Organisation Dashboard

This month’s dashboard is in a new format to display monthly trends. The annual measures (WRES and Annual Staff Survey) have been separated from scores so will not impact adversely on overall outcomes on a monthly basis. This data is still displayed below for information purposes only.

Mandatory training compliance is increasing, 86% against Trust target of 85%. Introduction of a clinical induction programme will support improved compliance.

Monthly staff pulse survey has been amalgamated with the quarterly FFT for staff, hence one measure displayed below. There has been a month on month increase in staff recommending the Trust as a place to work.

Staff who make contact with Freedom to Speak Up and Anti Bullying Advisors are all reporting that they would feel confident to raise concerns again, this is a positive message to share with staff across the Trust and indicates that the support, advice and guidance provided by F2SUG and ABA’s is beneficial.

Junior Doctor staff survey results to be included when available Q1

<table>
<thead>
<tr>
<th>Area of Improvement</th>
<th>Theme</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>MoM Change</th>
</tr>
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<tbody>
<tr>
<td>Supportive &amp; Compassionate Leadership</td>
<td>Appraisal Compliance</td>
<td>M</td>
<td>100%</td>
<td>58.6%</td>
<td>76%</td>
<td>69%</td>
<td>72%</td>
<td>74.9%</td>
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<tr>
<td></td>
<td>Mandatory Training Compliance</td>
<td>M</td>
<td>85%</td>
<td>80.4%</td>
<td>83%</td>
<td>83%</td>
<td>84%</td>
<td>84.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F2SUG/People Feel Confident To Raise Concerns Again %</td>
<td>Q4</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Teamworking (vs Last Fin Year/NHS AVG)</td>
<td>Absence Related to Stress Anxiety &amp; Depression (FT2) %</td>
<td>M</td>
<td>1.3%</td>
<td>1.1%</td>
<td>1.7%</td>
<td>1.5%</td>
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<tr>
<td></td>
<td>Complaints (Communication Concerns)</td>
<td>M</td>
<td>18</td>
<td>36</td>
<td>46</td>
<td>26</td>
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<td>Complaints (Attitude Concerns)</td>
<td>M</td>
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<td>14</td>
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<td>13</td>
<td>12</td>
<td>9</td>
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<td></td>
<td>Compliments</td>
<td>M</td>
<td>50</td>
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<td>133</td>
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<tr>
<td>Staff Feeling Valued</td>
<td>Junior Doctor Survey (Data To Follow)</td>
<td>TBD</td>
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<tr>
<td></td>
<td>Monthly Staff Survey (Recommend IOW Trust As A Place To Work) %</td>
<td>M</td>
<td>59.2%</td>
<td>N/A</td>
<td>28.0%</td>
<td>28.0%</td>
<td>40.0%</td>
<td>43.0%</td>
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<table>
<thead>
<tr>
<th>Area of Improvement</th>
<th>Theme</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>YoY Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive &amp; Compassionate Leadership</td>
<td>Annual WRES (% of from Shortlisting to Appointment, BME compare to W Group)</td>
<td>Y</td>
<td>0.26</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.5</td>
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<td>Staff Feeling Valued</td>
<td>Annual Staff Survey (Recommend IOW Trust As A Place To Work) %</td>
<td>Y</td>
<td>59.2%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>44.2%</td>
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</table>

Against Bench Mark

- Above Target
- On Target
- Below Target
Staff Surveys

Pulse check - Whole Organisation Positive responses

From April 2019 we will be running 2 surveys;
1. A monthly staff survey (pulse check) on the 3rd week of each month.
2. The national annual staff survey during October-December.
The national requirement to report on a quarterly basis through the ‘Friends and Family Test for Staff’ will be achieved with data collected through a monthly survey. This will streamline our processes and analysis and avoid confusion for staff.

Monthly Survey
- Slight increase in response rates. It is anticipated that, through our engagement and communication with staff in relation to our vision, values and behaviours during April and May, we will see an increased awareness of this survey and month on month increase in completions. December was low due to the Christmas period and February was due to it being half term holidays.
- March outcomes have seen a significant decline in staff feeling able to make suggestions to improve the work of their team or department. Service level reports are sent to departments to review this data for appropriate action to take place.
- All other responses remain the same or are slightly increased from the previous month.

Annual Survey
- Following a workshop held in February with service leads to share the national staff survey results, the Leadership Development Team will be proactively working with clinical divisions and corporate directorates to implement their action plans. Each of the team will attend the division staff engagement groups.
- A further action planning workshop has been scheduled for 24 April 2019.

<table>
<thead>
<tr>
<th>Response rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
</tr>
<tr>
<td>162</td>
</tr>
</tbody>
</table>
Division/directorate and staff group outliers:

- **Bank staff (74%)** – Temporary staffing team are sending out communications and a newsletter to staff.
- **Finance & Performance Management (76%)** – This figure is affected by low compliance within support services teams.
- **Trust Administration (76%)**
- **Junior Doctors (73%)** – Marginal increase in month, Medical Education team continue to follow up at an individual level.
- **Estates & Ancillary (72%)** – This staff group have the lowest compliance across the Organisation – actions in place to improve
Organisation compliance is above target for the first time since reporting began.

Course outliers:
- **Information Governance** – final compliance submission at 31.3.19 was 76% against target of 100%. (11% lower than last year). Actions in place to improve.
- **Mental Capacity Act** (78%) – increasing month on month. Completed through e-learning or classroom and increased capacity for arranged for 2019.
- **Resuscitation** (71%) – Bookings for Adult Resus and AED and Paediatric Resus for Clinical staff are encouraging, with capacity available Adult Resus sessions. Low bookings currently for Senior Medical Staff for Adult Resus sessions with late cancellations attributed to work pressures. Action to follow up in place.
Appraisals

- Reporting for Appraisals will begin from 1 April 2019 at 0%.
- Revised paperwork published to incorporate refreshed values and behaviours.
- Updated Appraisal Policy in consultation. Revision for 2019 to reflect the new NHS Agenda for Change pay deal.
- Additional training and support for appraisers scheduled, targeted to the leads of departments with lowest compliance.

Trust overall (all staff)
As at 31.3.19 – this is the final year figure.

Non-medical staff: 75.11%
Medical & Dental staff: 98.01%
Trust overall (all staff): 77.11%
Learning, Development and Apprenticeships

- Visit by the National Lead for Nursing Associates from HEE who was highly complementary in relation to our Trainee Nurse Associate apprenticeship programme with a recommendation to showcase this work nationally.
- 196 applications received for Registered Nurse Degree Apprenticeship programme (Sept 19 cohort). 15 places currently available.
  - 55 shortlisted from 127 Adult Nursing applications
  - 29 shortlisted from 67 Mental Health pathway applications.
- Recruitment for 2nd cohort of Trainee Nursing Associate apprenticeship underway. 61 applications received, 20 places currently available.
- Discussions underway with Island Healthcare to support two Registered Nurse Degree Apprentices through levy transfer.
- 71 staff currently in learning on apprenticeship programmes. 27 of which studying degree and Foundation Degree level apprenticeships through Portsmouth University, Open University and University of the West of England, Bristol.
- DNACPR Policy (Do not attempt cardio pulmonary resuscitation) under review for nurse signatures to be recognised as responsible clinician.
- Resuscitation Policy under review, consultation to commence in April.
- Advanced Life Support course delivered with internal and external candidates. All 17 candidates successfully passed the course.
- Training needs analysis completed for clinical band 6 development programme to be designed and implemented.
- 29 delegates completed Preceptorship programmes for 18/19.
- 67 staff completed the Care Certificate programme for 18/19.
Health & Wellbeing Update

• **FLU 2018/19** – national uptake total 68.6% - IW NHS Trust uptake 56%
• Decrease of 13.5% compared to last year (69.5%).
• CQUIN target of 80% for 2019/20 although NHSE may set 100%
• Early planning and MH Practitioner continues to support average of 24 new referrals each month
• Deep dive into MSK data due to a rise in SA
• Mini MOT health checks booked May 2019 for Estates teams (these will then be offered to other areas/teams as part of health & wellbeing support)
• Health & Wellbeing Open day booked for Wednesday 24th April Conference Room
• Inclusion of health & wellbeing question within monthly pulse survey – “My manager takes positive action in my health and wellbeing”
Equality and Diversity Progress

<table>
<thead>
<tr>
<th>Strategic Aim</th>
<th>Progress to 31 03 2019</th>
<th>Plan to 31 07 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strengthening our legal, regulatory and</td>
<td>• PSED and Gender Pay Gap Reports completed.</td>
<td>• Publish PSED and GDP</td>
</tr>
<tr>
<td>commissioner requirements</td>
<td></td>
<td>• Generate Workforce Disability and Race Standard Reports</td>
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<td></td>
<td></td>
<td>• Establish sustainable reporting mechanism</td>
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<td></td>
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<td>• Establish monthly reporting via Workforce Report</td>
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<tr>
<td>2. Transforming the delivery of equality and</td>
<td>• E&amp;D Lead recruited</td>
<td>• VOX POP (Voice of the People) events booked from April 2019</td>
</tr>
<tr>
<td>diversity</td>
<td>• Published our E&amp;D Strategy in June 18</td>
<td>• Health and Wellbeing event booked April 2019</td>
</tr>
<tr>
<td></td>
<td>• New Trust vision and values in place</td>
<td>• Launch new E-learning module</td>
</tr>
<tr>
<td></td>
<td>• Leadership Development Programme in place incorporating E&amp;D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Established Equality Impact Group</td>
<td></td>
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<td></td>
<td>• E&amp;D promotional materials in draft</td>
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<td></td>
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<tr>
<td>3. Embed and evidenced framework to monitor</td>
<td>• Launched EDS Goal 1 to members of EIG</td>
<td>• Publish Diversity Scorecard</td>
</tr>
<tr>
<td>equality performance</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>4. Empower, engage and support people</td>
<td>• Delivered Trust divisional engagement events</td>
<td>• Attend Corporate Induction Marketplace</td>
</tr>
<tr>
<td></td>
<td>• Anti-bullying advisors and Freedom Speak Up Guardian in place</td>
<td>• Launch Equality Champions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Publish calendar of diversity events</td>
</tr>
</tbody>
</table>
Workforce Metrics – M12 Plan

FTE £ (000’s)

- Agency and Bank utilisation has increased in month, this is mainly due to high sickness levels in the Acute areas.

- Improved spend on agency through improved control on shift requests and the continued benefits of the Master Vend for nursing. In month cost avoidance of £108k.

- The planned reduction in substantive staff has not been achieved due to the slippage in workforce rightsizing schemes (36.26 wte delivered to date against a plan of 92wte), together with unplanned investments. Additional opportunities are being investigated as part of staff control processes for 2019-20.

- Month 12 sickness rate of 5.10%. The Mental Health division has the highest sickness rate of 6.49% in month against a 5.00% baseline. Actions are in place across all divisions to reduce absence.

- Overall WTE usage across substantive, bank and agency has increased by 89 WTE since M1.
Summary

- Month 12 sickness rate of 5.10%. This is a reduction of 0.83% compared to M11 (5.93%).
- The highest reason for absence continues to be Stress, Anxiety and Depression (26.3%) for the organisation, this is an increase of 1.8% from M11 (24.5%)
- Back problems and Musculoskeletal problems accounted for 28.9% of absences in Ambulance and 23.1% in GM. In Community Division the highest reason was coughs, cold, flu (25.2%) this is a reduction from M11 (35.3%).

Key activity undertaken;

Deep Dive into Back/MSK absence; triangulation of sickness absence for this reason within General Medicine and Ambulance Division undertaken between HR, OH and Back Care. General Medicine; absences on 3 wards areas, no correlation between cases.
Next steps – long term sickness monthly review in April to continue to focus on review of absence for the reason of Back/MSK. Proactive contact from back care team to line managers/individuals to be piloted in April/May. Rapid Access to Physio under review to support continuation of service,

Acute Division;
- Deep dive undertaken. Actions taken; return to work interviews & management training, long term absence case referrals to HR to support ongoing management in line with policy framework..

Ambulance;
- HR support to management teams to ensure robust management of sickness absence continues.

Mental Health;
- Two further short term sickness absence management training sessions held with team leaders. Deep dives within hotspot areas planned for April.

Community Services;
- Two short term sickness absence sessions were held for District Nursing Teams.
Overview:
- There has been a slight increase in agency usage due to Compton remaining open and high sickness absence. Impacting on late agency requests. Targeted project work is being undertaken to improve rostering.

Benefits realisation of Nursing Master Vendor:
- 18% reduction in average hourly charge rate = in month price reduction of £108k
- Registered Agency Nurses fill rate - 95% March 19.

Medics:
- Medic agency hours has reduced by 655 in month and spend has reduced by £66k in month
- Increase spend on the graph is reflective of an increase in booking agency Consultants.

Bank Activity:
- 9 HCA new bank starters
- 1 RN new bank starter
- 1 RMN new bank starter
- 1 Consultant Ophthalmologist
- 1 SPR
- 8 HCA interviews/offers in February
- Bank Nursing & Midwifery % fill rate: 82.3%
Workforce – Bank & Agency Nurse Utilisation

- 78.7% of temporary staff utilisation (bank & agency) is within the Nursing staff group in March 2019, compared to 78.5% in February 2019.
- Collectively, registered nurse vacancy rates has increased, but sickness levels have decreased. Centralised recruitment to HCA posts across acute will support service demands. Also, the footprint of some wards being utilised to support emergency admissions is still ongoing.
- Acuity data has been extracted from Health Roster and the variances from staffing requires further investigation. Work is being undertaken to improve processes around compliance of Safe Care.

Mental Health
- Shackleton = Sickness 13.33%
- Seagrove = Sickness 3.61%
- Osborne = Sickness 13.06%

Medicine
- Appley = Sickness 15.38% and service demand 1:1 care
- Colwell = Sickness 8.09% and service demand 1:1 care

CSCD
- CCU = Sickness 7.29% and service demand 1:1 care

SWCH
- St Helens = Sickness 10.27%, establishment set for Elective care and continue to have high levels of Emergency causing an increase in service demand, Acuity and Dependency
- Alverstone = Sickness 3.86%, establishment set for Elective care and continue to have high levels of Emergency causing an increase in service demand, Acuity and Dependency
- Maternity = Already over establishment, Sickness 6.81%

Urgent care
- MAAU = Increased service demand and staffing ambulatory care
Workforce – Vacancy/Recruitment

Successes
- Recruitment Welcome Day 6 April 2019 – 14 attendees - 4 Final Year students nurses, 6 Registered Nurses, 3 Registered MH Nurses and 1 GP
- 6 Registered Nurses appointed
- 2 Emergency Department Assistants appointed
- Head of Psychology appointed
- 39 HCA Interviews took place in Mar and all posts successfully appointed to and pre-employment checks are being undertaken
- x2 doctors offered posts to start in April.
- Interviews for L.Cons Resp, L.Cons CAMHS, LAS ST3+ Resp.

Process Improvement
- Training workshops for revised NHS Jobs process booked monthly
- Intranet pages have been revised and re-launched to reflect NHS Jobs project implementation
- Go live of revised Automated Recruitment Process – 1 Apr 19 achieved

Planned activity
- Recruitment Welcome Day 6 April 2019
- Monthly Recruitment Drop Ins/Cafes to continue
- Planned attendance at Nursing Times and RCN recruitment events – dates to be confirmed
- 1st cohort of overseas nurses from February 2019 recruitment campaign arrive 19 July 2019
- 2nd overseas recruitment campaign booked 3 May 2019 (c76 nurses)

Increase from 11.5% vacancy gap M11

Variance in budgeted establishment & active recruitment allows for temporary staffing headroom and CIPs

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Budgeted Establishment FTE</th>
<th>In post FTE</th>
<th>Variance against budgeted establishment FTE</th>
<th>Active Recruitment FTE M12 (Out to Advert)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; Midwifery Registered</td>
<td>925.30</td>
<td>781.14</td>
<td>144.16</td>
<td>55.19</td>
</tr>
<tr>
<td>Medical &amp; Dental</td>
<td>273.08</td>
<td>237.14</td>
<td>35.94</td>
<td>26.0</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>246.00</td>
<td>216.75</td>
<td>29.25</td>
<td>13.4</td>
</tr>
</tbody>
</table>

*Excludes Administrative, Clerical, Estates and Ancillary staff groups

Gap = 12%
Workforce – Vacancy/Recruitment

Planned Recruitment activity would represent over 10% increase on total Registered Nursing numbers from start of calendar year

- The graph above outlines the anticipated recruitment trajectory for acute nursing. International recruitment is in progress with a second campaign to be undertaken in May 2019 for a further 76 Registered Nurses.
- HR continue to work closely with services to inform recruitment plans to reduce current level of vacancies
- Mapping medical agency usage to current active recruitment to create a trajectory of anticipated substantive appointments
- Resourcing Officers are embedded into the Divisions and are attending Divisional team meetings to ensure they are working in alignment to the needs of the services.
Recruitment KPI’s

<table>
<thead>
<tr>
<th>MARCH DATA 2019</th>
<th>KPI TARGET (average days)</th>
<th>KPI ACHIEVED (average days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a) Time between vacancy received &amp; RO assigned/HM notified</td>
<td>1</td>
<td>0.47 ↓</td>
</tr>
<tr>
<td>1b) Time between Vacancy received &amp; Publish advert onto NHS Jobs</td>
<td>2</td>
<td>0.47 ↓</td>
</tr>
<tr>
<td>2a) Time between application close date &amp; applications sent to Recruiting Manager for shortlisting</td>
<td>1</td>
<td>1.08 ↓</td>
</tr>
<tr>
<td>2b) Time between Shortlisting sent and shortlisting outcome received</td>
<td>3 * RM KPI</td>
<td>6.0 ↓</td>
</tr>
<tr>
<td>3a) Time between shortlisted applicants confirmed &amp; Invite to interviews sent</td>
<td>2</td>
<td>0.88 ↓</td>
</tr>
<tr>
<td>3B) Panel packs received prior to interview date (2 days + to achieve KPI)</td>
<td>2</td>
<td>4.63 ↑</td>
</tr>
<tr>
<td>4a) Appointment Information Form sent to Resourcing Officer by the Recruiting Manager</td>
<td>1 * RM KPI</td>
<td>*5.05 ↑</td>
</tr>
<tr>
<td>4b) Conditional Offer letter issued to successful candidate following notification of successful appointment</td>
<td>2</td>
<td>3.14 ↓</td>
</tr>
<tr>
<td>5a) Pre-employment screening to commence following confirmation of appointment</td>
<td>2</td>
<td>3.14 ↓</td>
</tr>
<tr>
<td>5b) Unconditional offer to confirm start date letter issued following start date confirmation</td>
<td>2</td>
<td>4.45 ↑</td>
</tr>
<tr>
<td>6a) Contract of employment issued to recruiting manager &amp; candidate prior to start date (10 + days to achieve KPI)</td>
<td>10</td>
<td>15.03 ↑</td>
</tr>
<tr>
<td>6b) Time between Signed contract being issued and returned to HR for file</td>
<td>5 * RM KPI</td>
<td>*6.36 ↑</td>
</tr>
</tbody>
</table>

TIME TO RECRUIT - Band 1-4 (Avg days) | 49 | 40 ↑ |
TIME TO RECRUIT - Band 5-6 (Avg days) | 70 | 86 ↓ |
TIME TO RECRUIT - Band 7 and above (Avg days) | 91 | 97.7 ↓ |

*RM KPI - Recruiting Manager KPI
**Delays in receiving OH forms from candidates - New process will issue guidance that OH forms need to be returned within 5 working days and monitor via NHS Jobs

Key
Green – KPI achieved
Amber – Breach within 1 working day
Red – KPI breached

* Recruiting Manager KPI

- Data compiled from vacancy approvals received in HR in from 1 Dec 18 to date excludes medical vacancy data. (extracted from live working document)
- Time to hire is based on actual confirmed start dates
- Areas for review in the Resourcing Team are KPI’s 4b, 5a and 5b – there has been an improvement through targeted work and the KPI’s are reducing

- Project Delivery Plan live to reduce time to hire and increase KPI efficiencies
- Time to recruit KPI targets are from NHS Improvement as complied nationally
<table>
<thead>
<tr>
<th>Agenda Item No</th>
<th>19</th>
<th>Meeting</th>
<th>Trust Board in Public</th>
<th>Meeting Date</th>
<th>2 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Financial Performance Report – Month 12 (2018/19)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sponsoring Executive Director</td>
<td>Darren Cattell – Director of Finance, Estates and IM&amp;T</td>
<td></td>
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</tr>
<tr>
<td>Author(s)</td>
<td>Gary Edgson – Deputy Director of Finance</td>
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<tr>
<td>Report previously considered by inc date</td>
<td>Performance Committee – 1 May 2019</td>
<td></td>
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</tr>
<tr>
<td>Purpose of the report</td>
<td>Information only</td>
<td>Assurance</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review and discuss</td>
<td>Agreement</td>
<td></td>
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<td></td>
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<tr>
<td>Trust Board Approval is required</td>
<td></td>
<td></td>
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<tr>
<td>Reason for submission to Trust Board in Private only (please indicate below)</td>
<td>Commercial Confidentiality</td>
<td>Staff Confidentiality</td>
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<tr>
<td></td>
<td>Patient Confidentiality</td>
<td>Other Exceptional Circumstance</td>
<td></td>
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</tr>
<tr>
<td>Link to Trust Strategic Objectives</td>
<td>Provide safe, effective, caring and responsive services – ‘Good’ by 2020</td>
<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Ensure efficient use of resources</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Achieve NHS constitutional patient access standards</td>
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<tr>
<td></td>
<td>Achieve excellence in employment, education and development</td>
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<td></td>
<td>Lead strategic change on the Isle of Wight</td>
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<tr>
<td>Link to CQC Domains</td>
<td>Effective</td>
<td>Responsive</td>
<td></td>
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<tr>
<td></td>
<td>Caring</td>
<td>Well-led</td>
<td>X</td>
<td></td>
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<tr>
<td></td>
<td>Safe</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td></td>
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<tr>
<td>The key points from the Month 12 financial performance against plan are:</td>
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<tr>
<td>Income &amp; Expenditure - Rating Red</td>
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<tr>
<td>• The required in month position for March, as part of the trajectory to achieve the revised year-end forecast position of £30.1m deficit, was £3.0m.</td>
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<tr>
<td>• The Trust’s in month financial position is a deficit of £3.0m</td>
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<tr>
<td>• £30.1m actual year end deficit (£13.0m off original plan)</td>
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<tr>
<td>• This is consistent with the Board approved revised forecast outturn position</td>
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</tbody>
</table>
The revised forecast outturn of £30.1m was dependent on receiving external support of £0.9m. Actual external support received was £0.4m. The Trust was able to offset this shortfall in external support, and achieve the revised forecast outturn position.

<table>
<thead>
<tr>
<th></th>
<th>Forecast £m</th>
<th>Actual £m</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outturn pre external support</td>
<td>(31.0)</td>
<td>(30.5)</td>
<td>+0.5</td>
</tr>
<tr>
<td>External Support</td>
<td>0.9</td>
<td>0.4</td>
<td>(0.5)</td>
</tr>
<tr>
<td><strong>Reported Outturn</strong></td>
<td><strong>(30.1)</strong></td>
<td><strong>(30.1)</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

**Pay and Agency**
- **Actual agency spend for year** £11.7m
- NHSI agency control total ceiling for 2018/19 £4.6m
- Further pay and agency costs have also been incurred to deliver the winter plan
- Master Vendor contract for agency nurses began in November. Agency nursing spend has been decreasing since this began
- Agency costs have continued a downward trajectory since November

**Progress to date against financial recovery plan - Rating Amber**
- £8m baseline plan
- **£6.8m delivery for year**
  - Non recurrent YTD £3.1m 45%
  - Recurrent YTD £3.7m 55%
- Programmes being carried forward into 2019/20
  - Theatres efficiency
  - Outpatients efficiency
  - Workforce rightsizing
  - Procurement
- Risks impacting on delivery for 2019/20
  - Pace of mobilisation
  - Operational capacity

**Financial recovery actions – Rating Amber**

Actions and governance being taken into 2019/20, and updates since last month:
- CIP allocations aligned to sustainability plan and distributed to Divisions
- Central support provided to develop detailed plans via checkpoint meetings
- Trust productivity programme launched as part of sustainability plan delivery
- Trust productivity programme team established with Programme Director in place
- Divisions CIP plans to be in place by 26 April

**Capital Investment Update – Rating Amber**
- Available capital funding for 2018/19 was £6.9m
- **Actual capital investment was £6.9m**
- 2019/20 investment plans are £9m, against an estimated available funding of £6.5m
- Work is underway to prioritise the 2019/20 investment plans
- This will be progressed at the next Capital Investment Group meeting – w/c 6 May
Cash update – Rating Amber

- Loans of £30.1m for April to March have been secured from DHSC
- April’s cash loan requirement of £2.712m has been approved by NHSI and DHSC
- The Trust in unable to borrow more funds than our agreed financial plan to date

Use of Resources Rating – Rating Red

The Trust’s Use of Resources Rating has remained at a score 4 (1 being best and 4 being worst)

Key Recommendation

The Board is asked to consider the following recommendations:

To receive the Month 12 Trust performance against the 2018/19 financial plan and note the immediate and note the ongoing financial recovery actions required into 2019/20
# Income and Expenditure

For the year-end the Trust is reporting a pre-audited deficit of £30.1m against a deficit plan of £17.1m, an adverse variance of £12.9m. This is consistent with the Board approved revised forecast outturn position.

This position includes the improvement in Public Dividend Capital (PDC) (£0.3m), as a result of site optimisation.

The revised forecast outturn of £30.1m was dependent on receiving external support of £0.9m. Actual external support received was £0.4m. Improvement in PDC enabled the Trust to offset this shortfall in external support, and achieve the revised forecast outturn position.

## Income and Expenditure

<table>
<thead>
<tr>
<th></th>
<th>IN MONTH</th>
<th>YEAR TO DATE</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £000s</td>
<td>Actual £000s</td>
<td>Variance £000s</td>
</tr>
<tr>
<td>Income</td>
<td>13,950</td>
<td>14,531</td>
<td>581</td>
</tr>
<tr>
<td>Pay</td>
<td>(9,881)</td>
<td>(11,765)</td>
<td>(1,884)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>(4,132)</td>
<td>(5,170)</td>
<td>(1,038)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>(63)</td>
<td>(2,404)</td>
<td>(2,341)</td>
</tr>
<tr>
<td>Capital Charges</td>
<td>(566)</td>
<td>(603)</td>
<td>(38)</td>
</tr>
<tr>
<td>Public Dividend Capital</td>
<td>(199)</td>
<td>146</td>
<td>345</td>
</tr>
<tr>
<td>Net Interest Receivable/(Payable)</td>
<td>(81)</td>
<td>(109)</td>
<td>(27)</td>
</tr>
<tr>
<td>Bank Charges</td>
<td>(0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RETAINED SURPLUS / (DEFICIT)</td>
<td>(910)</td>
<td>(2,970)</td>
<td>(2,060)</td>
</tr>
<tr>
<td>Receipt of Charitable Donations for Asset Acquisition</td>
<td>(50)</td>
<td>(48)</td>
<td>3</td>
</tr>
<tr>
<td>Depreciation - Donated Assets</td>
<td>11</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>REVISED RETAINED SURPLUS / (DEFICIT)</td>
<td>(949)</td>
<td>(3,007)</td>
<td>(2,058)</td>
</tr>
</tbody>
</table>

For the year-end the Trust is reporting a pre-audited deficit of £30.1m against a deficit plan of £17.1m, an adverse variance of £12.9m. This is consistent with the Board approved revised forecast outturn position.

This position includes the improvement in Public Dividend Capital (PDC) (£0.3m), as a result of site optimisation.

The revised forecast outturn of £30.1m was dependent on receiving external support of £0.9m. Actual external support received was £0.4m. Improvement in PDC enabled the Trust to offset this shortfall in external support, and achieve the revised forecast outturn position.
The run rate movement from February to March includes the planned deterioration in income (£0.9m)
This was off set by:
• Reduction in PDC costs (£0.3m)
• Receipt of external support in March (£0.1m)
Pay and agency spend

- Non-recurrent pay costs in November related to one-off restructuring costs (£0.5m)
- Weekly pay panel in place to review and scrutinise all applications for recruitment, for both substantive and temporary staffing
- Agency costs have continued a downward trajectory since November
- Agency costs now reconciled on a monthly basis, improving accuracy of reporting
- The 2018/19 agency expenditure represents 8.28% of the total Trust expenditure on pay. For comparison, agency expenditure in 2017/18 was 8.0% of total pay
- Efficiency plans for 2019/20 aimed at improving productivity and reducing reliance on agency staff. Enablers include overseas recruitment
Cost Improvement Plans

**Summary**

- **£6.8m delivered against £8m baseline plan:**
  - Non recurrent - £3.1m (45%)
  - Recurrent YTD - £3.7m (55%)
  - Recurrent PAY savings - £2.6m (38%)
  - WTE reduction – 36.26

- **Issues impacting on delivery:**
  - Conversion of opportunities into deliverable schemes / robustness of planning assumptions
  - Pace of mobilisation
  - Robustness of delivery plans
  - Operational capacity
  - CIP delivery not balanced with quality focus

- **Programmes carried forward:**
  - Theatres efficiency
  - Outpatients efficiency
  - Workforce rightsizing
  - Procurement
Financial Recovery Plan Actions and Governance

- CIP allocations aligned to sustainability plan and distributed to Divisions
- Central support provided to develop detailed plans via checkpoint meetings
- Trust productivity programme launched as part of sustainability plan delivery
- Trust productivity programme team established with Programme Director in place
- Divisions CIP plans to be in place by 26 April
- Monthly Control Totals based on operating plan allocated to Divisions for 2019/20
- Service and Financial Improvement Committee in place to challenge and ensure progress
- Embedding the structure required to deliver the Sustainability Plan
- Focus on actions that have a positive impact on the run rate of the System
- Prioritisation of capital plans for 2019/20
- Improved cash management with CCG to reduce loan interest charges
### Cash Analysis 2018/19 - Movement in Month

<table>
<thead>
<tr>
<th></th>
<th>Actual Month 11 £m</th>
<th>Actual YTD £m</th>
<th>Actual YTD VAR £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Balance 01.04.18</strong></td>
<td>6.0</td>
<td>6.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Income and Expenditure Surplus / (Deficit)</td>
<td>-27.2</td>
<td>-30.2</td>
<td>-3.0</td>
</tr>
<tr>
<td>Depreciation</td>
<td>6.2</td>
<td>6.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Interest Payable/Receivable</td>
<td>1.0</td>
<td>1.2</td>
<td>0.1</td>
</tr>
<tr>
<td>PDC Dividend</td>
<td>2.0</td>
<td>1.8</td>
<td>-0.1</td>
</tr>
<tr>
<td>Other non-cash items</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Operating Surplus / (Deficit)</strong></td>
<td><strong>-18.0</strong></td>
<td><strong>-20.5</strong></td>
<td><strong>-2.4</strong></td>
</tr>
<tr>
<td>Change in Stock</td>
<td>-0.2</td>
<td>0.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Change in Debtors</td>
<td>-2.6</td>
<td>0.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Change in Creditors &amp; Other Liabilities</td>
<td>4.9</td>
<td>0.1</td>
<td>-4.8</td>
</tr>
<tr>
<td>Change in Provisions</td>
<td>-0.3</td>
<td>-0.1</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Net Change in Working Capital</strong></td>
<td><strong>1.8</strong></td>
<td><strong>0.4</strong></td>
<td><strong>-1.4</strong></td>
</tr>
<tr>
<td>Capital Spend</td>
<td>-8.2</td>
<td>-8.5</td>
<td>-0.3</td>
</tr>
<tr>
<td>Interest Paid / Received</td>
<td>-0.8</td>
<td>-1.1</td>
<td>-0.3</td>
</tr>
<tr>
<td>PDC Dividend Paid</td>
<td>-1.2</td>
<td>-2.2</td>
<td>-1.0</td>
</tr>
<tr>
<td>Other</td>
<td>0.1</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Investing Activities</strong></td>
<td><strong>-10.1</strong></td>
<td><strong>-11.7</strong></td>
<td><strong>-1.6</strong></td>
</tr>
<tr>
<td>Working Capital Loans</td>
<td>23.7</td>
<td>30.1</td>
<td>6.4</td>
</tr>
<tr>
<td>Loan/Finance Lease Repayments</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Cash Balance 31.3.19</strong></td>
<td>3.4</td>
<td>4.4</td>
<td>1.0</td>
</tr>
</tbody>
</table>

The cash balance held at the end of March is £4.4m, which is an increase on previous month.

- The Month 12 I&E Cumulative Deficit is £30.2m which is £3m worse than previous month.
- Within the I&E deficit, Depreciation (£6.7m) does not impact cash. The charges for Interest Payable (£1.2m) and PDC Dividend (£1.8m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "Operating Deficit" of £20.5m.
- For Working Capital, creditors have reduced in month with additional payments being possible from the increase in DHSC loan support up to the revised deficit plan. Debtors have also reduced due to year end payments being received.
- Capital Spend is a combination of creditors from 2017/18 and new projects in 2018/19.
- The Trust paid the £1m second instalment of PDC in March 2019.
- The Trust has borrowed £30.1m of Uncommitted Loans to month 12. Together with previous year borrowings, interest costs in 2018/19 are £1.2m.
The original capital investment plan for 2018/19 was £6.6m.

Our final available funding was £6.9m, derived from:
- Original Plan £6.6m
- Central PDC funding £0.1m
- Asset disposals £0.1m
- NHSI approved 17/18 carry fwd £0.1m

For 2018/19 capital investment made was £6.9m. A summary of investments are as follows:

- IM&T Systems £1.3m
- Equipment RRP £1.2m
- Backlog Maintenance £1.1m
- Ophthalmology Unit upgrade £0.8m
- Service Relocations £0.8m
- Paediatric Assessment Unit £0.7m
- Ambulance CAD £0.5m
- A&E Streaming £0.2m
- Other small schemes £0.3m

Plans from Divisions, put forward as part of the Business Planning process, would require c£9m of funding. The estimated investment funding available for 2019/20 is £6.5m. Work is underway to prioritise the 2019/20 investment plans, and will be progressed at the next Capital Investment Group meeting.
Use of resources rating

The Trust’s Use of Resources Rating has remained at a score of 4.

This is against a score of 1 being best and 4 being worst.

Liquidity has improved due to the increase in DHSC loan support up to the revised deficit plan.

### Basis of scoring mechanism

<table>
<thead>
<tr>
<th>Area</th>
<th>Weighting</th>
<th>Metric</th>
<th>Definition</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial sustainability</td>
<td>0.2</td>
<td>Capital service capacity</td>
<td>Degree to which the provider’s generated income covers its financial obligations</td>
<td>&gt;2.5x, 1.75-2.5x, 1.25-1.75x, &lt;1.25x</td>
</tr>
<tr>
<td></td>
<td>0.2</td>
<td>Liquidity (days)</td>
<td>Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown</td>
<td>&gt;0, (7)-0, (14)-(7), &lt;(14)</td>
</tr>
<tr>
<td>Financial efficiency</td>
<td>0.2</td>
<td>I&amp;E margin</td>
<td>I&amp;E surplus or deficit / total revenue</td>
<td>&gt;1%, 1-0%, 0-1%, ≤1%</td>
</tr>
<tr>
<td>Financial controls</td>
<td>0.2</td>
<td>Distance from financial plan</td>
<td>Year-to-date actual I&amp;E surplus/deficit in comparison to Year-to-date plan I&amp;E surplus/deficit</td>
<td>≥0%, (1)-0%, (2)-(1)% ≤(2)%</td>
</tr>
<tr>
<td></td>
<td>0.2</td>
<td>Agency spend</td>
<td>Distance from provider’s cap</td>
<td>≤0%, 0%-25%, 25-50%, &gt;50%</td>
</tr>
</tbody>
</table>
Executive Summary

The Junior Doctors Forum continues to support trainees to improve their working environment. In the quarterly a number of Rota’s have been amended as trainees were working longer than they were contracted to work and trainees reported that they felt patient care was being compromised.

During the quarter there have been no breaches of the Working Time Directive.

At least 50% of exceptional reports (more than 50) cited the lack of support to our juniors at Registrar level. A number of these vacancies have since been filled, with doctors taking up their posts in from April 2019. Medical HR has started to work proactively with clinical managers to anticipate any shortfalls in trainees coming to the Island from the August 2019, and where possible recruitment activity has already commenced.

Key Recommendation

The Trust Board is asked to consider the following recommendations:

Accept the Guardian of Safe Working Report
1. Executive summary
The 2016 Junior Doctor contract requires NHS organisations to appoint a Guardian of Safe Working. The Guardian ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer as appropriate and provides assurance to the Board of the employing organisation that doctors’ working hours are safe.

The Guardian is also required to provide the Trust Board with quarterly reports, but agreed to provide one report after every placement for junior doctors i.e., once every 4 months.

2. Qualitative Analysis
2.1. The Guardian of safe working hours for junior doctors was appointed in July 2016 in view of implementing new contract obligation set by NHS England. During initial months he took opportunity to engage with juniors and make them aware of terms and conditions with regards to new contract working hours.

2.2. Once an exception report has been raised, the trainees Education Supervisor is required to meet with the trainee so the issue/concern can be resolved.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>April - July 2018</th>
<th>August - Dec 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of doctors in training allocated to the Trust</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>Trainees in post</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td>Number of doctors on the 2016 TCS’s including Locum in Appointment for Service (LAS’s) posts</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td>Time available in job plan for the guardian to do the role</td>
<td>1 PA per week / 4 hours</td>
<td></td>
</tr>
<tr>
<td>Admin support to the guardian role</td>
<td>Ad hoc</td>
<td></td>
</tr>
<tr>
<td>Time available in job plan for Educational Supervisors</td>
<td>0.25 PA per trainee</td>
<td></td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Unresolved carried over exceptions</th>
<th>New Exceptions raised</th>
<th>Total Exceptions closed</th>
<th>Cumulative outstanding exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obs and Gynae</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>40</td>
<td>143</td>
<td>14</td>
<td>169</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urology / Surgery</td>
<td>2</td>
<td>49</td>
<td>31</td>
<td>20</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>193</td>
<td>45</td>
<td>148</td>
</tr>
</tbody>
</table>

The following tables detail the number of exception reports raised between August and December 2018; 223 in total.
Table 3 Exception Reports by Rota - August to December 2018

<table>
<thead>
<tr>
<th>Reason</th>
<th>ED FY2</th>
<th>CT/ST Surgery</th>
<th>FY1 Gen Med</th>
<th>FY2 BST</th>
<th>FY2 MAU</th>
<th>FY1 Surgery</th>
<th>FY2/CT/ST Med</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variation in hours of work and/or rest</td>
<td>1</td>
<td>13</td>
<td>81</td>
<td>1</td>
<td>2</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>Missed Educational or learning opportunity</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pattern of Work</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of support available to the doctor</td>
<td>39</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

53 of the exception reports were identified by trainees as “Immediate Safety Concerns”. These were raised by trainees working in mainly in MAU caused by Registrar and Consultant vacancies.

Table 4 Exception Reports with Rota Breaches - August to December 2018

The Guardian of Safe Working is required to review all exception reports to identify whether a breach of the terms and conditions has occurred which incurs a financial penalty.

<table>
<thead>
<tr>
<th>Time period</th>
<th>April to July 2018</th>
<th>Aug to Dec 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breach of 48 hours average working week</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Breach of maximum 72 hours limit in 7 days</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Minimum of 11 hours rest between shifts has been reduced to less than 8 hours</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rest break missed on at least 25% of occasions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Work schedule reviews</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

3. Qualitative Analysis

3.1. The Trust had a significant number of vacant training posts from the Deanery which had to be recruited to locally; the delayed start has resulted in a number of reports to be submitted.

3.2. The surgical Core Trainees and Specialty Registrars have had their work schedule and Rota reviewed as a result of exception reporting, which has seen a reduction in the subsequent number of reports.

3.3. Successful recruitment to the vacant FY2 in T&O has resolved the Rota gap affecting the BST Rota.

3.4. Work is continuing with both Educational Supervisors and Junior Doctors to ensure that submitted reports are resolved within timescales set out in the 2016 contract. Training sessions are being arranged.

3.5. Medical vacancies in General Medicine from Registrars to Consultants continue to be a concern at a time. At least 50% of exceptional reports (more than 50) are due to lack of support to our juniors at Registrar level. A number of these vacancies have since been filled, with doctors taking up their posts in from April 2019.
3.6. Support for trainees working in MAU has improved with the appointment of the senior level of cover on MAU has been addressed with the appointment of good quality locum Consultants and the situation is improving whilst work is ongoing with the doctors to rebalance the weekend cover shift and the expectations of the senior staff.

3.7. In addressing the concerns raised by the GMC an ongoing plan to implement of the Hospital at Night continues. In support this Rota’s in Medicine have been reviewed, and the FY2/CT/ST Rota has been changed. No action has been taken at this time to align the FY1 Rota with the Hospital at Night Team.

3.8. Junior doctor forum has been vital in resolving significant problems faced by the juniors and is well attended by doctors in training. They feel listened to and their concerns are being addressed by their mangers and the Executive Management Team.. Particular thanks go to Vicky Lauchlan, Samara Lamb, Dr. M Connaughton and Dr. A Woolley for their help and support.

Mr. R Basavaraj
Guardian of Safe Working

11 March 2019
At the Trust Board seminar on 7 March, Board members supported a self-assessment of each Board Committee during March and April which would be reported to those Committees meeting on 1 May and to other Committees to the relevant Committee Chair. This would form part of Committee annual reports with a review of the terms of reference, providing any recommendation to the Board.

Whilst the Committees will have only considered these reports on 1 May, in order to expedite changes deemed beneficial to the continual improvement of the functioning of Trust Board and Committees, discussion took place at Board seminar on 7 April regarding some of the key proposals for changes to Committees, thus facilitating the ability for this report to be provided to Board with formal recommendations to be effective in a phased approach, commencing from June 2019.

This report provides details of the proposed key changes to the Committee structure and timing, in addition to a proposed full set of terms of reference for all Committees. The key changes detailed within the report are:

- The dis-establishment of the Assurance, Risk and Compliance Committee with effect from June 2019 with responsibilities and duties transferring to a combination of Quality Committee, Performance Committee and Audit Committee.
- The dis-establishment of the Mental Health Act Committee with effect from June 2019 with responsibilities and duties transferring to Quality Committee and Mental Health and Learning
Disabilities Division Board, supplemented with a bi-annual meeting with the Trust Chair.

- The establishment of Human Resources and Organisational Development Committee with effect from June 2019 which would take on relevant duties from Performance Committee and Quality Committee.

- The change of dates for Trust Board from the existing first Thursday in the month to the second Thursday in the month, with Committees continuing to meet the day prior to Trust Board; this would facilitate improved reporting to Committees and Trust Board and be effective from September 2019.

- Refreshing the informal Board members’ session at the end of the day of Committee meetings, effective from June 2019.

**Key Recommendation**

Trust Board is recommended to approve the proposals outlined within the report.
1. INTRODUCTION

At the Trust Board seminar on 7 March, Board members supported a self-assessment of each Board Committee during March and April which would be reported to those Committees meeting on 1 May and for other Committees to the relevant Committee Chair. This would form part of Committee annual reports with a review of the terms of reference, providing any recommendation to the Board.

Whilst the Committees will have only considered these reports on 1 May, in order to expedite changes deemed beneficial to the continual improvement of the functioning of Trust Board and Committees, discussion took place at Board seminar on 7 April regarding some of the key proposals for changes to Committees, thus facilitating the ability for this report to be provided to Board with formal recommendations to be effective in a phased approach, commencing from June 2019.

2. KEY PROPOSED CHANGES

The following are the key proposed changes.

**Assurance, Risk and Compliance Committee**

This Committee was established in June 2018 to meet quarterly with the intention that it would be a short-term committee with the primary focus of overseeing improvements on risk management within the organisation. Recently a draft report has been received from the Trust’s Internal Auditors that identifies the Trust as having improved from limited to reasonable assurance and with a risk maturity of “risk defined”. This exceeds Executive expectations for year one (up to June 2019) of the Risk Management Strategy.

Performance Committee and Quality Committee already have the responsibility of reviewing their allocated strategic risks contained within the Board Assurance Framework and relevant risks within the Corporate Risk Register. Audit Committee has responsibility for overseeing the processes of risk management are functioning appropriately.

The following table identifies how each of the duties contained within the terms of reference of Assurance, Risk and Compliance Committee (ARCC) are proposed to transfer, effective from June 2019.

<table>
<thead>
<tr>
<th>Matrix of ARCC Duties: Responsibilities and Reporting</th>
<th>ARCC Responsibilities</th>
<th>Audit Committee</th>
<th>Quality Committee</th>
<th>Performance Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Management – Strategy and Policy (review and approval)</td>
<td>ARCC Responsibilities</td>
<td>Annual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF / strategic risks</td>
<td>Audit Committee</td>
<td>Quarterly</td>
<td>Quarterly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Corporate risks</td>
<td>Quality Committee</td>
<td>Quarterly</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>CQC compliance</td>
<td>Performance Committee</td>
<td>Quarterly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other legislative / regulatory compliance:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHSI undertakings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• External agencies (including accreditation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARCC Sub Committees Reporting</td>
<td></td>
<td>Audit Committee</td>
<td>Quality Committee</td>
<td>Performance Committee</td>
</tr>
<tr>
<td>Operational Risk Sub-Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance Sub-Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Safety, Security &amp; Fire Sub-Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Management Sub-Committee</td>
<td></td>
<td>Audit Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Planning &amp; Business Continuity Sub-Committee</td>
<td></td>
<td>Audit Committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following table identifies how each of the duties contained within the terms of reference of Assurance, Risk and Compliance Committee (ARCC) are proposed to transfer, effective from June 2019.
**Mental Health Act Committee**
This Committee was previously established prior to the major review of the Committee structure in June 2018 and it was agreed appropriate to retain the Committee at that stage. Since then, following the appointment of Lesley Stevens as Director of Mental Health and Learning Disabilities (MH&LD), consideration has been given as to how the quantity of meetings can be reduced in order to make more effective use of the time of Board members and other senior officers, whilst still discharging appropriately the legislative and statutory responsibilities of the Board.

The following table identifies how each of the duties contained within the terms of reference of Mental Health Act Committee (MHAC) are proposed to transfer, effective from June 2019.

<table>
<thead>
<tr>
<th>Matrix of MHAC Duties: Responsibilities and Reporting</th>
<th>Quality Committee</th>
<th>MH&amp;LD Division Board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAHA Responsibilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor and report to Trust Board on activities in relation to Mental Health Act</td>
<td>Receive report quarterly and report by exception</td>
<td>Monitor and report to QC quarterly</td>
</tr>
<tr>
<td>Monitor the utilisation of S12 qualified doctors</td>
<td></td>
<td>Monitor quarterly</td>
</tr>
<tr>
<td>Monitor and report to Trust Board on Deprivation of Liberty Safeguards</td>
<td>Receive report quarterly and report by exception</td>
<td></td>
</tr>
<tr>
<td>Commission the drafting of policies, protocols and procedures relating to Mental Health Act and Mental Capacity Act</td>
<td>As and when necessary</td>
<td></td>
</tr>
<tr>
<td>Identify and monitor clinical audit priorities and reporting in relation to Mental Health Act for inclusion within the clinical audit plan</td>
<td>Agree clinical audit plan annually and monitor quarterly</td>
<td>Identify and provide recommendations to QC annually</td>
</tr>
<tr>
<td>Ensure Mental Health Act training needs are identified and met</td>
<td>Monitor quarterly</td>
<td></td>
</tr>
<tr>
<td>Identify and share good practice in relation to Mental Health Act</td>
<td>Monitor quarterly</td>
<td></td>
</tr>
<tr>
<td>Incorporate feedback from service users and staff in to the functioning of the Committee</td>
<td>Monitor quarterly</td>
<td></td>
</tr>
<tr>
<td><strong>MHAC Sub-Committees Reporting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no sub-committees that report to MHAC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additionally, representatives of the Mental Health Act Review Managers (MHARMs) would be invited to the Divisional Mental Health Act Committee (which already exists and report to MH&LD Division Board) and in order to have a direct line of communication to Trust Board, would meet with Director of MH&LD and Trust Chair on a bi-annual basis, which would also ensure statutory responsibilities are achieved.

**Human Resources and Organisational Development Committee**
When the Board approved the Committee structure and supporting terms of reference in June 2018, it was considered that human resource (HR) workforce metrics and targets, including recruitment, retention and appraisals, could be reasonably monitored by and assurance provided to Performance Committee. Additionally, that the continual improvement of all organisational development (OD) activities, including leadership and culture could be appropriately monitored by and assurance provided to Quality Committee.

Following careful consideration by Executive Directors it is proposed that, given the significant challenges that face the Trust in connection with HR and OD, a separate and dedicated
Committee is established to oversee the monitoring and receipt of assurance. This Committee would meet monthly, similar to both Performance Committee and Quality Committee and would be chaired by a Non-Executive Director and consisting of membership of both Executive and Non-Executive Directors.

The Committee would be established to meet from June 2019 and would replace the existing:
- HR & OD Sub-Committee that currently reports to both Performance Committee and Quality Committee; and
- Culture & Leadership Oversight & Delivery Steering Group that currently reports to Trust Leadership Committee.

The proposed terms of reference and membership are attached at appendix A as part of the full pack of the proposed terms of reference of Board Committees.

**Change of dates of Trust Board and Committees**
The agreement for Trust Board to be held the day following the Committees of Board was introduced early in 2018 and since then adapting to the intricacies of this arrangement, especially regarding reporting, went well and overall Trust Board and the Committees have delivered their duties and performed their responsibilities through appropriate governance mechanisms during 2018/19.

However, upon review, it is considered that continual further improvements can be made within the reporting by Executives to the Board and Committees if changes to the scheduling of meetings is made.

The Executive Directors have held a specific workshop to map out how best reporting could be achieved to Trust Board and Committees with the full confidence that due consideration has been given through Divisional and Sub-Committees prior to the writing of reports for Trust Board and Committees.

The conclusion from this workshop was that for the achievement of further enhanced reporting, Trust Board (and seminar) should be held on the second Thursday in the month, rather than the current arrangement of the first Thursday in the month. Dates of Committee meetings would also be changed in order that they continued to be held on the day prior to Trust Board meeting.

The following is the detailed rationale that supports this approach, much of which impacts upon Executive Directors and their teams. The schedule referred to is included at appendix B and this sets out proposed dates of Trust Board Committees from September 2019 to March 2020.

- Changes to become effective from September for Trust Board and Committees, given that there are no scheduled Trust Board and Committee meetings in August and to commence in July would create diary conflicts with existing commitments.

- The schedule of dates is based on the aim for an electronic solution to be in place with paper copies of Board and Committee and other meeting papers being limited to members of public at the Board meeting.

- Divisional Committees will occur the week prior to Divisional Boards, giving time for Divisional teams to reflect the outcome of Divisional Committees within Divisional Board papers.

- Divisional Boards will occur the week prior to IPR meetings and ETM review of papers, giving time for Divisions to reflect the outcome of Divisional Boards within Trust Board and Committee papers.

- Sub-Committees reporting to Committees of Board will be held during either the week of Divisional Committees or the week of Divisional Boards.

- Quality Improvement Board and Financial Recovery Board meetings will be held on the
Friday morning following Divisional Board meetings, acknowledging that reports from these Boards to respective Committees will not be available for review by Board Secretary.

- Executive Team meetings are held on a Tuesday in the week when Board papers are reviewed, as shown on the schedule, and in the week of Board. ETM on other weeks will be held on a Wednesday or Thursday.

- Integrated Performance Review (IPR) meetings are all held on two consecutive days, with two of the four Clinical Divisions being reviewed on a Tuesday and the other two being reviewed on a Wednesday.

- IPRs will include reviews of quality, operational, workforce and financial performance. KPIs will be agreed for each Division for each quadrant of performance, based upon the Trust's regulatory and contractual commitments, reflected within the Operational Plan.

- Trust Leadership Committee is held on the Tuesday when two of the IPR meetings and ETM are held.

- The schedule for the day of two of the IPRs, ETM and TLC and also for the day of the other two IPRs, would be as follows:
  
<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00</td>
<td>11:30</td>
<td>IPR – Acute Services</td>
</tr>
<tr>
<td>12:00</td>
<td>13:30</td>
<td>IPR – Urgent &amp; Emergency Care Services</td>
</tr>
<tr>
<td>14:00</td>
<td>15:00</td>
<td>ETM – to review draft Board papers</td>
</tr>
<tr>
<td>15:30</td>
<td>17:00</td>
<td>TLC</td>
</tr>
</tbody>
</table>

- No regular meetings shall be scheduled to occur on a Monday.

- Propose to NHSI and regulators that regulatory meetings are schedule one week following Trust Board, thus ensuring that the outputs of Trust Board are incorporated within presentations to Regulators.

- Executive Directors will influence, so far as possible, the timing of other system-wide meetings in order to align with the Trust's meeting structure. A current and future conflict will be that on occasions the Local Care Board meetings conflict with Trust Board and Seminar.

- In order to ensure the day of Committee meetings is clear and each Committee is able to operate efficiently, a revised schedule of the timing of meetings for the day of Board Committees is proposed as follows:
  
  - When there is no Audit Committee (ie two in every three months):
    
    | From  | To   | Meeting                     |
    |-------|------|-----------------------------|
    | 09:00 | 11:45| Quality Committee           |
    | 12:15 | 14:00| HR & OD Committee           |
    | 14:30 | 17:15| Performance Committee       |
    | 17:30 | 18:00| Board Briefing              |

  - When there is an Audit Committee (ie one in every three months):
    
    | From  | To   | Meeting                     |
    |-------|------|-----------------------------|
    | 09:00 | 11:00| Quality Committee           |
    | 11:15 | 13:15| Audit Committee             |
    | 13:30 | 15:00| HR & OD Committee           |
    | 15:15 | 17:15| Performance Committee       |
    | 17:30 | 18:00| Board Briefing              |
• Charitable Funds Committee will be held on a separate day to the other Committees, being a day suitable for those Non-Executive Directors that are members of the Committee.

• The Trust Board briefing evening session following the day of Board Committees will be focussed purely on any key messages from Committees, necessary ahead of Trust Board, and limited to ½ hour; therefore it will not be necessary for food to be provided.

3. RECOMMENDATION

Trust Board is recommended to approve the proposals outlined within the report.

Appendices:
A: Terms of Reference of Committees of Board
B: Schedule of dates of Board, Committees and Executive-led meetings
TRUST BOARD COMMITTEES

GOVERNANCE PACK

Effective from 2 May 2019
AUDIT TRAIL:

Date document valid from: 2 May 2019

Document review due date: 1 year from valid date

<table>
<thead>
<tr>
<th>Date(s) reviewed:</th>
<th>April 2019</th>
<th>Version number:</th>
<th>v/7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of most recent review:</td>
<td>Committee Quorums have been revised Committee Frequency has been updated Membership and role titles have been updated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Trust Board Approval

<table>
<thead>
<tr>
<th>Approved at:</th>
<th>Trust Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Approved by Trust Board:</td>
<td>-</td>
</tr>
</tbody>
</table>

Contents

Board Non-Executive Led Committees:

1. Quality Committee
2. Performance Committee
3. Audit Committee
4. HR & OD Committee
5. Charitable Funds Committee
6. Nominations and Remuneration Committee
# Quality Committee

## Terms of Reference and Membership

### Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Quality Committee (the Committee). The Committee is a non-executive led Committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

### Membership

Membership of the Committee shall comprise:

- Three Non-Executive Directors (may include Associates)
- Chief Executive
- Medical Director
- Director of Nursing, Midwifery, Allied Health Professionals & Community Services
- Director of Quality Governance
- Director of Human Resources and Organisational Development
- Director of Acute Services
- Director of Mental Health & Learning Disabilities
- Director of Integrated Urgent & Emergency Care Ambulance Services & Patient Transport Services
- Director of Clinical Improvement

A deputy assumes full rights of the Director they are deputising for at the meeting.

### Attendance

Other Executive Directors may be asked to attend by the Committee Chair.

A nominated member of the Patients’ Council and Healthwatch will attend the meetings.

A nominated Service User representative will attend the meetings.

The Director of Nursing from IW Clinical Commissioning Group to be invited to attend the meetings.

Other officers such as, but not restricted to, Deputy Director of Nursing, Deputy Director of Quality, representatives of Quality Governance and internal and external audit may be invited to attend all or part of any meeting as and when appropriate and necessary.

### Quorum

A quorum for the Committee shall be six four members, to include two Non-Executive Directors, four and two Executive Directors of the Board.

In line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member was in attendance via electronic communication. In order for the meeting to be quorate the member 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.
Frequency

Meetings will be held monthly and no less than 10 meetings will be held each year, however, the frequency may be varied in order to ensure that the Committee discharges all of its responsibilities.

Authority

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Trust Board in its Scheme of Delegation.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Duties

The primary duties and responsibilities of the Committee are to assure the Trust Board of the Trust's development of strategies and performance against agreed objectives and targets for:

- Quality (safety, effectiveness and experience)
- Research
- Organisational Development
- Regulatory Compliance
- Mental Health Act compliance

Seek assurance regarding quality and research, to be received through quality assurance reports, the Board Assurance Framework, the Corporate Risk Register and Clinical Audit plans, which focus on the quality and research objectives of the Trust.

Ensure the Quality Accounts process meets all legal requirements and monitor the implementation of the Quality Account work streams for safety, effectiveness and experience.

Seek assurance on the learning from complaints, claims, incidents, clinical audits and benchmarking data and monitor the implementation of any mortality reduction action plans.

Ensure implementation plans for meeting CQUIN requirements are robust and all risks identified and mitigating actions taken

Seek assurance regarding Organisational Development to be received through an Organisational Development report and the Board Assurance Framework.

Oversee all aspects of quality related performance, underpinned by the achievement of the Integrated Improvement Framework, to meet Care Quality Commission (CQC) standards and recommendations; and including the quality targets identified by NHS Improvement in the Single Oversight Framework.

Risk Management

The Committee shall consider the Trust’s strategic risks of a quality and organisational development nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
• Impact that the risk has on strategic objectives
• Potential consequences of the risk
• Impact that the risk has on achieving Care Quality Commission standards
• Impact of operational risks on the risk
• Potential or actual origins that have led to the risk
• How the risk is controlled and reported
• The assurance mechanisms for the risk
• Gaps in controls or negative assurances for the risk
• The actions and timescales for mitigating the risk

Patient Safety
The Committee shall:
• Review the risk and adequacy of assurance of patient safety (the avoidance, prevention and improvement of adverse outcomes). Ensure that internal and external assurances of patient safety are regularly reviewed and the strength of assurances evaluated.
• Receive assurance that external reports on patient safety that have an impact on care have been reviewed, considered and any learning adopted. This will include national inquiries, Department of Health reviews, NHS Improvement reviews, guidance from other regulatory bodies, such as NICE and professional bodies with responsibility for the performance of staff, including Royal Colleges.
• Review the risks and adequacy of assurance that statutory and mandatory training requirements are being met.
• Review reports regarding incidents and details of all serious incidents, the investigation of them, ensuring that learning across the organisation is achieved and sustained.

Clinical Effectiveness
The Committee shall:
• Review the risks and adequacy of assurance of regarding all matters of compliance with all clinical standards and outcomes.
• Review the assurance that the Clinical Audit programme and the delivery of it is aligned with the key strategic and operational risks.
• Review the risks and adequacy of assurance of staff engagement in annual objectives improving patient safety, clinical best practice and patient experience.
• Review mortality indicators and seek assurance regarding actions taken to address negative indicators.

Patient Experience
The Committee shall:
• Review risks and the adequacy of assurance of patient experience via review of the action plans to address the outcomes of patient surveys, patient experience tracker results, complaints and comments, patient stories, external reports including CQC; Healthwatch; Local Health Board and associated Committees.

Research
The Committee shall:
• Review the risks and adequacy of assurance that research activity across the Trust is delivered within the national regulatory requirements.
• Review the risks and adequacy of assurance that any new interventions have received the appropriate due diligence and associated activity is driving improvement.

Organisational Development
The Committee shall:
• Review the progress against delivery of all organisational development and cultural strategies and objectives, including equality and diversity matters.
Review the risks and adequacy of assurance of compliance with relevant CQC outcomes, including requirements related to workers, staffing and supporting staffing.

Review the risks and adequacy of assurance of the quality of education and training and that the organisation demonstrates that it is a learning organisation.

Review the risks and adequacy of assurance that systems have been established to deliver good quality clinical training placements for undergraduate and postgraduate trainees.

Mental Health Act

- Monitor and report quarterly and annually to the Trust Board as required in relation to Mental Health Act activity within the Trust. An annual future work plan will be evaluated and reported in the annual report.
- Monitor and report quarterly on the use of the Deprivation of Liberty Safeguards within the Trust and provide an annual review.
- Identify and monitor clinical audit priorities and reporting in relation to the use of the Mental Health Act and ensure these are captured within the audit plan.

Other Assurance Functions

The Committee shall:
- Review the process and methodology for production of the quality account ensuring that it meets legal obligations and duties.
- Review any investigations of activities which are within its terms of reference.
- Review the findings of other significant clinical risk reports, both internal and external to the organisation and consider any implications for the Trust.
- To maintain oversight of the potential impact on quality arising from financial pressures, the Committee will review Quality Impact Assessment reports.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities on a monthly basis through a Chair’s report.

The Committee shall receive reports on a frequency as indicated from each of the Executive Led Sub-Committees reporting to the Committee:
- Patient Safety Sub-Committee (monthly)
- Clinical Effectiveness Sub-Committee (quarterly)
- Patient Experience Sub-Committee (bi-monthly)
- Human Resources and Organisational Development Sub-Committee (regarding organisational development aspects) (quarterly)
- Patient Council

The minutes of the Committee meetings shall be formally recorded and made available to all Trust Board members upon request.

The Board Governance Office will prepare a report following each Committee meeting, in conjunction with the Committee Chair, for presentation by the Committee Chair at the next Trust Board (in public). The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against the Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

Administrative Support
The Committee shall be supported administratively by the Board Governance Office, whose duties in respect of this include:

- Agreement of agendas with Chair and attendees and preparation, collation and circulation of papers.
- Encouraging attendance of those invited to each meeting.
- Taking the minutes and preparing a report to Trust Board in conjunction with the Committee Chair.
- Keeping a record of matters arising and issues to be carried forward and ensuring that action points are taken forward between meetings.
- Maintain an attendance register. The completed register to be attached to the Committee’s annual report.
- Arrange meetings for the Committee.
- Advising the Committee on pertinent issues and areas of interest.
PERFORMANCE COMMITTEE

Terms of Reference and Membership

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Performance Committee (the Committee). The Committee is a non-executive led Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

Membership

Membership of the Committee shall comprise:

- Three Non-Executive Directors (may include Associates)
- Chief Executive
- Deputy Chief Executive
- Director of Finance & Information
- Director of Finance, Estates and IM&T
- Director of Acute Services
- Director of Integrated Urgent & Emergency Care Ambulance Services & Patient Transport Services
- Director of Human Resources and Organisational Development
- Director of Mental Health & Learning Disabilities
- Director of Nursing, Midwifery, AHPs and Community Services

A deputy assumes full rights of the Director they are deputising for at the meeting.

Attendance

Regular attendees will include:
- Board Secretary

Other Executive Directors may be asked to attend by the Committee Chair.

Quorum

A quorum for the Committee shall be four members, to include at least two Non-Executive Directors and two Executive Directors.

In line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member was in attendance via electronic communication. In order for the meeting to be quorate the member 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.

Frequency

Meetings will be held monthly and no less than 10 meetings will be held each year, however, the frequency may be varied in order to ensure that the Committee discharges all of its responsibilities.

Authority
The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Trust Board in its Scheme of Reservation and Delegation.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

**Duties**

On behalf of the Board, the primary duties of the Committee are to consider, scrutinise and challenge performance against all regulatory requirements, including all aspects of finance, contracting, income and activity, operational and workforce. Additionally, the Committee’s duties will include overseeing performance against objectives for the enabling services of estates and IM&T.

The duties of the Committee are as follows:

**Financial Performance**
- To monitor and evaluate progress against delivery of the Trust’s annual financial plan and financial recovery plan, including the cost improvement programme (CIP) to achieve financial objectives and targets
- To review the proposed annual financial plans for revenue and capital, working capital and cash management.
- Review a Medium and Long term Financial Plan
- Consider the financial implications of the Trust clinical strategy and supporting strategies.

**Business Development**
- To consider the Trust’s Annual Business Plan prior to consideration by the Board for approval.
- To agree the Trust’s Capital Strategy for submission to the Trust Board.
- To consider business cases requiring Trust Board approval and capital investments prior to Trust Board consideration other than where reviewed through the Human Resources & Organisational Development Committee in relation to business cases that fall within their remit.
- Consider strategies relevant to the Committee including financial, operational, workforce, estates, information governance, and IM&T, prior to submission to the Board for approval and subsequently will monitor progress in delivery against each strategy.

**Contract and Income Monitoring**
- To scrutinise the development of the Trust’s contractual regime including contract portfolios and contracting processes.
- To identify and scrutinise the systems to provide early warnings of potential risks and opportunities in the implementation of the contractual framework of the Trust.
- To identify, monitor, prioritise and mitigate risks in relation to the implementation of the model contract and the relationship between activity, income and costs.
- To ensure the Board is advised of any significant variation in activity and its impact on income and costs.
- To review the systems in place to ensure compliance with the contract terms.

**Treasury Management**
- To monitor cash, liquidity and working capital.
To approve relevant benchmarks for monitoring investment performance.
To review and monitor investment performance.
To monitor compliance with Treasury Management Policy and procedures in respect of limits, approved counterparties and types of investment.

Operational
To consider, oversee and evaluate the delivery of the Trust’s operational plan to achieve the statutory operational NHS Constitutional, regulatory and commissioner targets.
To consider the efficiency of key services, including bed utilisation, theatre utilisation and use and access to clinical support services and of the estate.

Workforce
To oversee and evaluate the delivery of the Trust’s workforce plan to achieve delivery of the regulatory workforce targets.
To ensure that the workforce implications of financial plans and wider strategies are considered and taken into account.
To oversee the use of agency and locum workers, receiving assurance against compliance with regulatory requirements.
To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts through a robust workforce strategy.

Enabling Services
To oversee delivery of objectives for enabling services including those of estates and IM&T, ensuring nationally mandated areas are taken into account.
To ensure implications from wider plans and strategies on Estates and IM&T are considered and taken into account.
To ensure that current and future estates and IM&T issues and developments are fully reflected in business and financial plans and forecasts through robust Estates and IM&T strategies.
To oversee and ensure that robust arrangements are in place to support effective information governance management.

Risk Management
The Committee shall consider the Trust’s strategic risks of a non-clinical nature and for each strategic risk and corporate risk, on a quarterly basis through the Board Assurance Framework, assess:
The risks of achieving non-clinical strategic objectives.
The risk appetite for those strategic objectives.
Initial, current and target risk scores.
Controls and assurances in place for each risk.
The actions and timescales for closing gaps in controls and assurances and mitigating each risk.
Oversee financial, operational, workforce and enabling services of estates and IM&T related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis.

Reporting
The Committee shall report to Trust Board on how it discharges its responsibilities.
The Committee shall receive reports on a quarterly basis from each of the Sub-Committees reporting to the Committee:
Service & Financial Improvement Sub-Committee Financial Recovery Board (monthly)
Human Resources and Organisational Development Sub-Committee — regarding workforce aspects (monthly)
• ICT Sub-Committee (quarterly)
• Estates & Facilities Sub-Committee (quarterly)
• Information Governance Sub-Committee
• Health and Safety, Security & Fire Sub Committee
• Emergency Planning & Business Continuity Sub Committee

The minutes of the Committee meetings shall be formally recorded and made available to all Trust Board members upon request.

The Board Governance Office will prepare a report following each Committee meeting, in conjunction with the Committee Chair, for presentation by the Committee Chair at the next Trust Board (in public). The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against the Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

**Administrative Support**

The Committee shall be supported administratively by the Board Governance Office, whose duties in respect of this include:

- Agreement of agendas with Chair and attendees and preparation, collation and circulation of papers.
- Encouraging attendance of those invited to each meeting.
- Taking the minutes and preparing a report to Trust Board in conjunction with the Committee Chair.
- Keeping a record of matters arising and issues to be carried forward and ensuring that action points are taken forward between meetings.
- Maintain an attendance register. The completed register to be attached to the Committee's annual report.
- Arrange meetings for the Committee.
- Advising the Committee on pertinent issues and areas of interest.
AUDIT COMMITTEE

Terms of Reference and Membership

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

Membership

Membership of the Committee shall comprise of all Non-Executive Directors.

Attendance

Associate NEDs are invited to attend.

Regular attendees will include:
- Director of Finance,
- Board Secretary
- Internal Audit
- External Audit
- Local Counter Fraud Specialist

The Chief Executive, as Accountable Officer, should be invited to attend and discuss at least annually with the Committee the process for assurance that supports the Annual Governance Statement.

All other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Executive Director.

Representatives from other organisations and other officers may be invited to attend on occasion.

Quorum

A quorum for the Committee shall be two Non-Executive Directors.

At least once a year the Committee should meet privately with the external and internal auditors.

In line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member was in attendance via electronic communication. In order for the meeting to be quorate the member 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.

Access

The Head of Internal Audit, the External Audit and Local Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

Frequency


No less than four meetings per annum shall be held plus one meeting specifically for considering the Annual Report and Accounts.

The External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

**Authority**

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Trust Board in its Scheme of Reservation and Delegation.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

**Duties**

The Committee’s duties and responsibilities can be categorised as follows:

**Integrated Governance, Risk Management and Internal Control**

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives.

In particular the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as required by NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors.

This will be evidenced through the Committee’s use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will liaise with other key committees (in particular, Quality Committee, Performance Committee and HR & OD Committee) so that it receives assurance of processes and linkages and to ensure no duplication of responsibilities. However, these other committees must not usurp the Committee’s role.

The Committee shall consider all of the Trust’s strategic and key operational risks, and operation
of the Risk Management Strategy, and on a quarterly basis through the Board Assurance Framework, shall assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Potential consequences of the risk
- Impact that the risk has on achieving regulatory standards
- Impact of operational risks on the risk
- Potential or actual origins that have led to the risk
- How the risk is controlled and reported
- The assurance mechanisms for the risk
- Gaps in controls or negative assurances for the risk
- The actions and timescales for mitigating the risk

**Internal Audit**

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service and the costs involved
- Review and approval of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consideration of the major findings of internal audit work (and management responses) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

**External Audit**

The Committee shall review and monitor the external auditors' independence and objectivity and effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management’s responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

**Other Assurance Functions**

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health’s arms-length bodies or regulators / inspectors (for example, the Care Quality Commission, NHS
Resolution, NHS Counter Fraud Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.).

The Committee will receive the Board Assurance Framework on a quarterly basis to be assured of the process undertaken by other Committees of the Trust Board regarding risk management.

**Counter Fraud**
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority’s standards and shall review the outcomes of work in these areas.

**Management**
The Committee shall request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

**Financial Reporting**
The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust’s financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The working in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Qualitative aspects of financial reporting.

**Whistle Blowing**
The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

**Use of the Official Seal**
The Committee will receive on an annual basis a report regarding the use of the Board Seal.

**Regulatory Compliance**
The Committee shall consider compliance against quality governance legislative and regulatory standards and good practice, including receipt of reports from external agencies including Care Quality Commission (CQC) registration requirements and National Institute for Clinical Excellence (NICE), and progress against Trust undertakings.

**Policy Management**
The Committee shall consider the effectiveness of policy management within the Trust, receiving reports providing assurance regarding the need for policies to be current and reflective of
regulatory and legal requirements.

**Reporting**

The Committee shall report to the Board on how it discharges its responsibilities.

The Committee shall receive reports on a quarterly basis from each of the Sub-Committees reporting to the Committee:

- Operational Risk Sub-Committee
- Policy Management Sub-Committee

The minutes of the Committee meetings shall be formally recorded and made available to all Trust Board members upon request.

The Board Governance Office will prepare a report following each Committee meeting, in conjunction with the Committee Chair, for presentation by the Committee Chair at the next Trust Board (in public). The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against the Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness of and how embedded risk management is in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows compliance with regulatory requirements
- The robustness of the processes behind the quality accounts.

The annual report will describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

**Administrative Support**

The Committee shall be supported administratively by the Board Governance Office, whose duties in respect of this include:

- Agreement of agendas with Chair and attendees and preparation, collation and circulation of papers.
- Encouraging attendance of those invited to each meeting.
- Taking the minutes and preparing a report to Trust Board in conjunction with the Committee Chair.
- Keeping a record of matters arising and issues to be carried forward and ensuring that action points are taken forward between meetings.
- Maintain an attendance register. The completed register to be attached to the Committee's annual report.
- Arrange meetings for the Committee.
- Advising the Committee on pertinent issues and areas of interest.
Human Resources & Organisational Development Committee

Terms of Reference and Membership

Date Valid from: 1 June 2019

Constitution

It has hereby resolved to establish a Committee of the Trust to be known as the Human Resources & Organisational Development (HR&OD) Committee (the Committee). The Committee is a Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

Membership

Membership of the Committee shall comprise:
- Three Non-Executive Directors (one of whom shall be the Chair and one of whom shall be Deputy Chair)
- Director of Human Resources & Organisational Development
- Director of Acute Services
- Director of Nursing, Midwifery, AHPs & Community Services
- Medical Director
- Director of Finance, Estates & IM&T / Deputy Chief Executive

A deputy assumes full rights of the Director they are deputising for at the meeting.

Attendance

Other Directors or managers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that manager.

Representatives from other organisations and other individuals may be invited to attend, including Staff Side Lead and Chair of Local Negotiating Committee.

Quorum

A quorum for the Committee shall be four members, to include at least two Non-Executive Directors and at least two Executive Directors.

In line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member was in attendance via electronic communication. In order for the meeting to be quorate the member 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/attendees were able to hear each other throughout the meeting.

Frequency

Meetings will be held monthly and no less than 10 meetings will be held each year; however, the frequency may be varied in order to ensure that the Committee discharges all of its responsibilities.

Authority

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Trust Board in its Scheme of Delegation.
The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee has delegated responsibility in line with the Trust Standing Financial Instructions.

In the event that an urgent decision is required the Chair or their nominated deputy can seek the electronic approval of members which must then be noted at the next Committee meeting. This will be exercised only in extreme circumstances.

**Duties**

The primary duties and responsibilities of the Committee are to assure the Trust Board:

1. **Strategies**
   
   To oversee the development and delivery of:
   
   - Workforce Strategy
   - Recruitment and Retention Strategy
   - Diversity and Inclusion Strategy
   - Leadership Strategy

2. **Governance framework**
   
   The Committee will oversee the effectiveness and embeddedness of the Trust arrangements in relation to Human Resources (including Equality and Diversity) and Organisational Development, ensuring that the Trust remains compliant with relevant legislation and best practice, including the following:
   
   - Policies, Procedures and Guidelines
   - Training including availability, compliance with and effectiveness of training
   - Resource allocation including staffing and equipment
   - Systems and processes, include those relating to audits and inspections
   - Compliance monitoring (legislation and best practice)
   - Performance measures
   - Communication and engagement
   - The impact of Cost Improvement Plans – Workforce Impact
   - Review any internal and external audit or inspections and ensure that action planning occurs as appropriate
   - Implementation of Workforce Race Equality Standard and related reporting

3. **Performance Management**
   
   In order to discharge the above duties effectively the Committee will receive exception reports from those Executive Directors reporting to it in relation to areas of over or under performance for Human Resources and Organisational Development performance indicators. The Committee will confirm and challenge performance and request that action plans are drawn up as appropriate. The Committee will oversee the delivery of these action plans and monitor a HR&OD dashboard of performance indicators and instigate action plans to address shortfalls in performance.

4. **Document Control**
   
   The Committee will be responsible for overseeing the production of HR and OD strategies and plans, in accordance with the Document Control Policy.

5. **Risk Management**
   
   The Committee shall consider the Trust's strategic risks and corporate risks relating to HR & OD and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:
   
   - Current and target risk scores
   - Impact that the risk has on strategic objectives
   - Potential consequences of the risk
• Impact that the risk has on achieving Care Quality Commission standards
• Impact of operational risks on the risk
• Potential or actual origins that have led to the risk
• How the risk is controlled and reported
• The assurance mechanisms for the risk
• Gaps in controls or negative assurances for the risk
• The actions and timescales for mitigating the risk

The Committee will oversee the Business Continuity Planning arrangement in relation to Human Resources and Organisational Development.

7. Revenue Business Cases
The Committee will consider business cases that are HR or OD driven for providing a view to Trust Board, where Board approval is required.

Reporting
The Committee shall report to Trust Board on how it discharges its responsibilities on a monthly basis through a Chair’s report.

The Committee will receive and consider the quarterly Guardian of Safe Working Hours report and the quarterly Freedom to Speak-up Guardian report. Additionally, the Committee will receive formal exception reports and minutes from the following groups:
• Health and Wellbeing Group
• Joint Local Negotiating Committee
• Staff Partnership Forum
• Mandatory Training Group
• Equality Impact Group

The minutes of the Committee meetings shall be formally recorded and made available to all Trust Board members upon request.

The Board Governance Office will prepare a report following each Committee meeting, in conjunction with the Committee Chair, for presentation by the Committee Chair at the next Trust Board (in public). The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against the Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

Administrative Support
The Committee shall be supported administratively by the Board Governance Office, whose duties in respect of this include:
• Agreement of agendas with Chair and attendees and preparation, collation and circulation of papers.
• Encouraging attendance of those invited to each meeting.
• Taking the minutes and preparing a report to Trust Board in conjunction with the Committee Chair.
• Keeping a record of matters arising and issues to be carried forward and ensuring that action points are taken forward between meetings.
• Maintain an attendance register. The completed register to be attached to the Committee’s annual report.
• Arrange meetings for the Committee, with a published timetable 12 months forward
• Advising the Committee on pertinent issues and areas of interest.

Approved:  2 May 2019
CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE AND MEMBERSHIP

Constitution

The Board hereby resolves to establish a Committee to be known as the Charitable Funds Committee (the Committee). The Committee is a non-executive led committee whose powers are set out within these terms of reference.

Membership

Membership of the Committee shall comprise of:

- Three Non-Executive Directors (may include Associates)
- Medical Director
- Director of Finance, Estates & IMT Information
- Director of Nursing, Midwifery, Allied Health Professionals & Community Services

Co-Opted Members (non-voting):

- Friends of St. Mary’s Representative
- Staff Representative (Fund Manager)
- Patient Representative/Patient Council

All voting Members of the Trust Board are Trustees of the Charitable Funds Committee and entitled to attend Committee meetings.

A deputy takes full rights of the Director they are deputising for at the meeting.

Attendance

Regular attendees will include:

- Board Secretary

The following may also be invited to attend:

- Officers of the Trust with responsibility for administering the charitable funds
- Representative of the External Auditor (annually)
- Representative of the Internal Auditor (as required)
- Other Executive Directors and officers may be asked to attend by the Committee Chair.

Quorum

The quorum will be four members including two Non-Executive Directors and two Executive Directors.

In line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member was in attendance via electronic communication. In order for the meeting to be quorate the member 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.
Frequency

Meetings will be held quarterly. No less than 3 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.

An Annual General Meeting (AGM) shall be held of the Corporate Trustees.

Authority

The Isle of Wight NHS Trust was appointed as Corporate Trustee of the Charitable Funds by virtue of Standing Instruction 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 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:

- The scope of the investments is clearly set out in writing and communicated to the Director of Finance.
- That there are adequate internal controls and procedures in place which will ensure that the investments are being exercised properly and prudently
- That they review regularly the performance of the investments
- 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 Director of Finance.

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.

**Duties**

The responsibilities of the Committee shall be:

- 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.
- to ensure that the Trust’s policies and procedures for charitable funds investments are robust and are followed.
- 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:
  - Trustee Act 2000
  - The Charities Act 1993
  - The Charities Act 2006
  - Terms of the funds governing documents.
- to receive at least twice a year reports for ratification from the Director of Finance for investment decisions and action taken through delegated powers upon the advice of the Trust’s investment advisor.
- to oversee and monitor the functions performed by the Director of Finance as defined in the Standing Financial Instructions.
- to appoint and review Auditors for statutory audit/independent examination of annual accounts as per guidance from the Charity Commission.
- to monitor progress of any Trust’s charitable appeal funds and to receive reports from the Appeal Fundraising Groups.
- to monitor the Trust’s Scheme of Reservation and Delegation for expenditure for the levels:
  - Up to £1,000 – Fund Manager
  - Between £1,000 and £5,000 – Associate Director
  - Between £5,000 and £15,000 – Charitable Fund Committee
  - Expenditure over £15,000 must have Corporate Trustee approval
- 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.

- 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.
- to ensure the Trust complies with all legal, Charity Commissioners and Department of Health & Social Care guidelines as they relate to the administration of Charities.
- to advise, where appropriate, on raising funds for the Isle of Wight NHS Trust Charitable Fund.
- 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.
- to review all income and expenditure transactions for all funds.
- to review legacies received and ensure that the Trust complies with the terms of the legacy.
- to authorise the establishment of new funds and new charities.
- 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 Reservation and Delegation.
- to consider the use of professional fundraisers and links with other organisations for major fundraising projects.
- 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.

**Reporting**

The Committee shall report to the Board on how it discharges its responsibilities.

The Committee will receive reports from the Healing Arts Management Sub-Committee.

The minutes of the Committee meetings shall be formally recorded and made available to all Trust Board members upon request.

The Board Governance Office will prepare a report following each Committee meeting, in conjunction with the Committee Chair, for presentation by the Committee Chair at the next Trust Board (in public). The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against the Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

**Administrative Support**

The Committee shall be supported administratively by the Board Governance Office, whose duties in respect of this include:

- Agreement of agendas with Chair and attendees and preparation, collation and circulation of papers.
- Encouraging attendance of those invited to each meeting.
- Taking the minutes and preparing a report to Trust Board in conjunction with the Committee Chair.
- Keeping a record of matters arising and issues to be carried forward and ensuring that action points are taken forward between meetings.
• Maintain an attendance register. The completed register to be attached to the Committee’s annual report.
• Arrange meetings for the Committee.
• Advising the Committee on pertinent issues and areas of interest.
NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE AND MEMBERSHIP

Constitution

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference.

Membership

Membership of the Committee shall comprise of:
- Chairman
- All Non-Executive Directors

Attendance

Associate Non-Executive Directors may be invited to attend.

The Chief Executive shall report to the Committee and external advisors may be invited to attend for all or part of any meeting as appropriate and necessary.

Additionally, the following may be invited to attend in an advisory capacity:
- Director of Human Resources and Organisational Development will be invited to attend as required in order to provide advice but will be excluded from meetings when his/her own remuneration is being considered.
- Board Secretary will be invited to attend when required to advise on points of governance.

Quorum

A quorum for the Committee shall be three members, including either the Chair or Vice Chair.

In line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member was in attendance via electronic communication. In order for the meeting to be quorate the member 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.

Frequency

The Committee shall meet biannually or more frequently if required in order to ensure that the Committee discharges all of its responsibilities.

Authority

The Committee is authorised by the Trust Board to take action in respect of any activities within its Terms of Reference.
The Committee is authorised by the Trust Board to obtain, at the Trust’s expense, outside legal or other professional advice on any matters within its terms of reference

**Duties**

**Remuneration:**

The Committee will decide and review the terms and conditions of office of the Trust’s Executive Directors in accordance with all relevant Trust policies, including:

1. Salary, including any performance-related pay or bonus
2. Provisions for other benefits, or allowances
   - Arrangements for termination of employment and other contractual terms

The Committee will:

- monitor and evaluate the performance of individual directors. In part this will be achieved through receiving an annual report following the appraisal of Executive Directors including the Chief Executive.
- adhere to all relevant laws, regulations and policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors whilst remaining cost effective. This includes ‘Managing Public Money’ (HM Treasury), other Treasury, Department of Health and Trust Development Authority guidance.
- advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.
- consider and seek external approval as required for redundancy payments for all staff above the threshold that requires approval external to the Trust e.g. from NHSI/E the Trust Development Authority.
- receive as required a report from the Chief Executive on all redundancy payments.
- consider and seek external approval as required for any extra-contractual redundancy severance payments.
- approve the annual Clinical Excellence Awards.

**Nominations:**

The Committee will:

- regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any improvements.
- give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, paying particular attention to future requirements.
- be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- consider any matter relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- approve and monitor the delivery of the Board Development Programme plan.
- consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the committee's responsibilities for remuneration or nominations.
• consider the implications, and required actions associated with any declaration of interest, or register of gifts, hospitality and sponsorship made by any Executive Director.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded and made available to members of the Committee.

The Director of Human Resources and Organisational Development will submit a report following each Committee meeting, in conjunction with the Committee Chair, for presentation at the next Trust Board (in private). The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee will record its decisions in formal minutes, a summary of which will be received by the Trust Board on an annual basis as a minimum. Minutes of the committee will be circulated to members and, if appropriate, to attendees.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. The outcome will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Director of Human Resources and Organisational Development, whose duties in respect of this include:

• Agreement of agendas with Chair and attendees and preparation, collation and circulation of papers.
• Encouraging attendance of those invited to each meeting.
• Taking the minutes and preparing a report to Trust Board in conjunction with the Committee Chair.
• Keeping a record of matters arising and issues to be carried forward and ensuring that action points are taken forward between meetings.
• Maintain an attendance register. The completed register to be attached to the Committee’s annual report.
• Arrange meetings for the Committee.
• Advising the Committee on pertinent issues and areas of interest.
<table>
<thead>
<tr>
<th>Meetings (in red) / Deliverables (in black)</th>
<th>Proposed Working Day in Workshop</th>
<th>Month of Trust Board and Committees</th>
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<tbody>
<tr>
<td>Data Available</td>
<td>10 10 Wednesday 14/8</td>
<td>Working Day 10 Wednesday 14/8</td>
</tr>
<tr>
<td>Submit Divisional Board and Committee Reports</td>
<td>12 12 Friday 16/8</td>
<td>Working Day 12 Friday 16/8</td>
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<td>Sub-Committees</td>
<td>w/c 19/8 or 26/8</td>
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<td>Working Day 15 Tuesday 20/8</td>
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<td>Divisional Boards</td>
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<td>Working Day 20 Tuesday 27/8</td>
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<tr>
<td>Quality Improvement Board</td>
<td>21 21 Friday 30/8</td>
<td>Working Day 21 Friday 30/8</td>
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<tr>
<td>Financial Recovery Board</td>
<td>21 21 Friday 30/8</td>
<td>Working Day 21 Friday 30/8</td>
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<tr>
<td>Submit Draft Board and Committee Reports</td>
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<td>Working Day 22 Friday 30/8</td>
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<tr>
<td>Board Secretary Review of Reports</td>
<td>22 22 Monday 2/9</td>
<td>Working Day 22 Monday 2/9</td>
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<tr>
<td>Integrated Performance Review (IPR) Meetings</td>
<td>23 23 Tuesday 3/9</td>
<td>Working Day 23 Tuesday 3/9</td>
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<tr>
<td>Executive Team Meeting (ETM) Papers Review</td>
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<td>Working Day 23 Tuesday 3/9</td>
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<td>Trust Leadership Committee (TLC)</td>
<td>23 23 Tuesday 3/9</td>
<td>Working Day 23 Tuesday 3/9</td>
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<tr>
<td>Submit Final Board and Committee Reports</td>
<td>26 26 Friday 6/9</td>
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<td>Board and Committee Reports Published</td>
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<td>Working Day 26 Friday 6/9</td>
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<td>Trust Board Committees</td>
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<td>Working Day 31 Wednesday 11/9</td>
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<td>Trust Board and Seminar</td>
<td>32 32 Thursday 12/9</td>
<td>Working Day 32 Thursday 12/9</td>
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<tr>
<td>Regulatory Meetings (Oversight and QIPOS)</td>
<td>35 35 Thursday 19/9</td>
<td>Working Day 35 Thursday 19/9</td>
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ISLE OF WIGHT NHS TRUST
PROPOSED MEETING STRUCTURE - 2019/2020 (MONTHS 6 TO 12)