Isle of Wight NHS Trust Board
Meeting in Public

Date: 7 June 2018
Time: 1.30pm – 4.00pm
Venue: Conference Room – Level B Main Hospital
(opposite Full Circle Restaurant), St. Mary's Hospital, Newport,
Isle of Wight PO30 5TG

AGENDA

No.	Item	Lead	Purpose	Enc/Verbal
	PROCEDURAL			
1	Apologies	Chair	Receive	Verbal
2	Confirmation that meeting is Quorate	Chair	Receive	Verbal
3	Declarations of Interest	Chair	Receive	Verbal
4	Minutes of previous meeting	Chair	Approve	A
5	Matters Arising and Schedule of Actions	Chair	Receive	B
6	Chair's Update	Chair	Receive	C
7	Chief Executive's Update	Maggie Oldham	Receive	D
	STRATEGY			
8	Diversity and Inclusion Workforce Report 2017/8 – incorporating the Public Sector Equality Duty	Julie Pennycook	Approve	E
9	Local Care Board Update	Darren Cattell	Assurance	F
	PERFORMANCE			
10.1	Quality Performance Report	Suzanne Rostron Barbara Stuttle Steve Parker	Assurance	G
10.2	CQC Feedback	Suzanne Rostron	Assurance	Pres
10.3	Safe Staffing Report	Barbara Stuttle	Assurance	H
11	Workforce & Organisational Development Performance Report	Julie Pennycook	Assurance	I
12	Financial Performance Report	Darren Cattell	Assurance	J
	Integrated Performance Reports:			
13.1	• Acute Services	Nikki Turner	Assurance	K
13.2	• Ambulance Services & Patient Transport Services	Bob Williams	Assurance	L
13.3	• Community Services	Barbara Stuttle	Assurance	M
13.4	• Mental Health & Learning Disabilities Services	Lesley Stevens	Assurance	N
	COMMITTEE ASSURANCE AND GOVERNANCE			
14	Terms of Reference and Membership for Board and Committees	Suzanne Rostron	Approve	O
15	Freedom to Speak Up Guardian Quarterly Report	Maggie Oldham	Assurance	P
16	Committee Reports from the meetings held on 6 June 2018: • Quality Committee • Performance Committee • Assurance, Risk & Compliance Committee • Mental Health Act Committee	Chairs: Tim Peachey Charles Rogers Anne Stoneham Charles Godden	Assurance	Verbal
	CLOSING MATTERS			
17	Issues to be covered in Private	Chair	Receive	Verbal

18	Questions from the Public	Chair	Receive	Verbal
19	The next meeting in Public of the IW NHS Trust Board will be on: Date: Thursday 5 July 2018 Venue: Conference Room - Level B, St Mary's Hospital, Newport, IW PO30 5TG	Chair	Receive	Verbal

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 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 l960.

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

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Enc A

Minutes of the meeting of the Isle of Wight NHS Trust Board held in public at 1.30pm on Thursday 3 May 2018 in the Conference Room, St Mary's Hospital, Newport, IW PO30 5TG

PRESENT:		
Voting Members:	Vaughan Thomas	Chair
	Darren Cattell	Interim Turnaround Chief Financial Officer (ITCFO)
	David King,	Non-Executive Director
	Maggie Oldham	Chief Executive (CEO)
	Steve Parker	Interim Medical Director (IMD)
	Dr Tim Peachey	Non-Executive Director
	Charles Rogers	Non-Executive Director
	Caroline Spicer	Non-Executive Director
	Barbara Stuttle CBE	Director of Nursing (DN)
	Nikki Turner	Director of Acute Services (deputising for Chief Operating Officer) (DAS)
Non-Voting Members:	Dr Charles Godden	Associate Non-Executive Director
	Julie Pennycook	Director of Human Resources & Organisational Development
	Suzanne Rostron	Director of Quality Governance
	Frank Sims	Deputy Chief Executive Officer
	Sara Weech	Associate Non-Executive Director
Attendees	David Haycox	Governance Advisor
	Andy Hollebon	Head of Communications & Engagement
For item 18/T/079& 080	Emily Mullan	Clinical Lead for eRostering and SafeCare
	Daniel Robinson	Corporate Business and Development Manager
For item 18/T/086	Dr. Sreeshyla Basavaraj	Junior Doctor's Guardian of Safe Working
Observers:	Doreen Britton	Chair of Patient Council
	Alistair Flowerdew	Medical Director & Acting CEO of The Royal Berkshire NHS FT
	Caryl Morrison	Healthwatch
	Cllr John Nicholson	Councillor – IW Council
	Dr Lesley Stevens	Associate Medical Director for Mental Health
Minuted by:	Lynn Cave	Board Governance Officer

Members of Staff and Public in attendance: There were no members of staff or members of the public present. A representative from the IW County Press attended

Minute No.

Chair's Opening Remarks

The Chair welcomed everyone to the meeting and especially the representatives from the Patient Council, Healthwatch, IW Council and IW County Press.

PROCEDURAL

18/T/070 APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST AND CONFIRMATION THAT THE MEETING IS QUORATE

Apologies for absence were received from:

- Dr Robert Ghosh, Director of Clinical Improvement
- Anne Stoneham, Non-Executive Director
- Shaun Stacey, Chief Operating Officer
- Alan Thorne, Improvement Director
- Bob Williams, Board Advisor – Ambulance Services

The Chair confirmed that the meeting was quorate.

Declarations of interest were received from:

- Darren Cattell as Director of Wight Life Partnership
- Charles Rogers as Director of Wight Life Partnership
- Barbara Stuttle as Non-Executive Director of Basildon and Thurrock University Hospitals NHS Foundation Trust
- Sara Weech as Chair of the Earl Mountbatten Hospice
- Tim Peachey as Deputy Chief Executive of Barts Health NHS Trust

18/T/071 MINUTES OF PREVIOUS MEETING

Minutes of the meetings of the Isle of Wight NHS Trust Board held on 5 April 2018 were reviewed and approved.

Resolution

The Chair requested that the minutes of the meeting held on 5April 2018 be **Approved**. Motion Proposed by Darren Cattell and Seconded by David King. The motion was carried unanimously.

18/T/072 MATTERS ARISING AND SCHEDULE OF ACTIONS

a) **Matters Arising:**

The Interim Medical Director read a statement regarding the Breast Screening national announcement:

"On 2 May 2018, the Secretary of State for Health and Social Care made an announcement that since 2009, that nationally up to 450,000 may have not been called for their final round of breast screening as a result of an error in the algorithm in the computer system that generated appointments. The error has now been resolved.

As a result, there is national need to either recall or offer self-referral to some women between the ages of 70 and 79 years who would not have been offered a mammogram at the appropriate time. Breast screening units will be informed of the identities of the women affected within the next 2 weeks. Invitations for screening will be sent out to the affected women between May and October 2018.

"Here on the Island, like elsewhere in England, we rely on the national system to issue the invitations for screening. It is estimated that there are

*352 women on the Island who may be affected. Of these 138 are in the age range who in the coming weeks will be sent a letter inviting them in for a mammogram. The other 214 women are individuals who will be invited to self-refer into the service and the advice to them and anyone else who is concerned is that they should telephone the **national help line on 0800 169 2692**. The Isle of Wight Breast Screening Unit screens 9,000 women per year. Despite this being a national issue, the Isle of Wight Breast Screening Unit is committed to resolving the issue locally as quickly as possible in order to reduce the anxiety for the women involved.*

"It is important that individuals who have questions ring the Helpline number rather than St. Mary's Hospital, the Breast Screening Service or their GP because the records are held nationally. Further information can be found on the Public Health England website at https://www.gov.uk/government/news/women-offered-nhs-breast-screening-after-missed-invitations."

The Chair requested that the Patient Council, Healthwatch and the IW County Press also publicise this approach so that the message is shared across the widest possible Island audience.

b) **Schedule of Actions:**
The Governance Advisor confirmed that a number of actions had been completed since the previous meeting and that the remaining 3 actions were due in June and July.

i. **TB/298 – Committee Terms of Reference:** The Governance Advisor advised that this paper would be presented to the Board meeting on 7 June 2018 to enable changes to the Executive Team to be included. The action is therefore reopened with a due date of June.

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

18/T/073 CHAIR'S UPDATE

The Chair presented his report which outlined his activities over the last month.

He advised that together with the Chief Executive, he had been undertaking meetings with other Trusts and had received strong support for collaboration with the Island. He outlined that any agreements would be based on the Trust Board's decision-making rather than legislation and would include the delivery of a programme of excellence. He confirmed that a series of meetings were being arranged which would include presentations from Maria Gabriel, Chair of East London NHS FT, Wessex Academy Health Science Network and Keith Dewar, Interim CEO of an island based Canadian healthcare organisation.

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

18/T/074 CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented the report and in addition gave an update on the appointment of the new Directors. She confirmed that offers had been made to all posts except the Director of Ambulance Services, and that confirmation was now awaited from NHSI before any announcements could be made.

She confirmed that Bob Williams had joined the Trust for a 6 month period to

support the Ambulance Services whilst a further recruitment process was undertaken to identify a suitable candidate.

She advised that Shaun Stacey, Chief Operating Officer was now leaving the Trust and would be moving to Lincolnshire. She expressed the Board's thanks for all the tireless work he had given over the 3 years he had been with the Trust.

Dr Nikki Turner would be joining the Board as Director of Acute Services.

The Chief Executive also gave thanks to Kevin Bond, Interim Director of Mental Health & Learning Disabilities; Dr Paul Evans, Board Advisor – Medical Leadership and Rick Strang, Emergency Care Improvement Lead, who had all recently left, for all their work during their time with the Trust.

The Chief Executive stated that she acknowledged that the Staff Survey and some of the verbal feedback she had received following the CQC visit indicate that there are pockets of areas within the Trust where people feel that it is not the best place to work in part due to the environment and culture within the teams. She confirmed that this was being taken very seriously and announced that a range of support had been implemented including Anti-bullying Advisors, Freedom to Speak Up Champions, and a very active Freedom to Speak Up Guardian. She stated that all the Executive Directors had made a commitment to eradicate bullying in whatever form it takes.

The Chief Executive gave the Boards congratulations to Nicola Longson, Programme Director for My Life a Full Life, on her contribution to the King's Fund publication *Developing new models of care in the PACS vanguards: A new national approach to large-scale change?*. The report features two local Vanguard programmes – the Trust and the Frimley system and collated a series of first-hand accounts from those, like ourselves, who have led the development of the primary, acute and community services (PACS) model, to reflect on the process of being part of the programme, and of trying to bring about complex change in local systems.

Resolution

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

STRATEGY

18/T/075 INTEGRATED IMPROVEMENT FRAMEWORK (IIF) REPORT

The Deputy Chief Executive advised that the final meeting of the IIF Programme Board had taken place and that the work is being taken forward by the Financial & Services Improvement Sub-Committee which reports to the Performance Committee, with weekly Executive oversight meetings for mental health and workforce. He also confirmed that the Getting to Good dashboard was being reviewed to include Corporate divisions.

He confirmed that the IIF Programme Board had agreed for the IIF Programme Board be discontinued and closed, with alternative governance arrangements.

Resolution

The Isle of Wight NHS Trust Board received the Integrated Improvement Framework (IIF) Report and noted the closure of the IIF Programme Board

18/T/076 BOARD ASSURANCE FRAMEWORK (BAF)

The Director of Quality Governance presented the report and advised that it provides a summary of all of the strategic objectives and associated strategic risk scores at Quarter 4 for 2017/18 for overall context and the detail in relation to all

strategic risks. She confirmed that both the Quality Committee and the Performance Committee had reviewed their specific risks at their meetings on 2 May.

The Director of Quality Governance advised that the risks to be included within the BAF for 2018/19 would be discussed at Board Seminar in June and consideration would be had at the Assurance, Risk & Compliance Committee also in June before being presented to Board at the July meeting for approval. She advised that as part of the preparation for the new BAF a review of the controls and actions would be undertaken to align with the strategic objectives as well as a review of the risk ratings.

The Chairs of the Quality Committee and Performance Committee confirmed that the Committees were happy with the new layout and that it provided significant assurance.

Resolution

The Isle of Wight NHS Trust Board received the Board Assurance Framework

18/T/077 ANNUAL BUSINESS OPERATING PLAN 2018/19 & ANNUAL FINANCIAL PLAN 2018/19

The Chair advised that due to the submission deadline of 30 April a special Board meeting had been convened on 26 April to discuss and approve the reports. He confirmed that following discussion the reports had both been approved and were being presented to the Board to receive in public.

Resolution

The Isle of Wight NHS Trust Board received the Annual Business Operating Plan 2018/19 and the Annual Financial Plan 2018/19 which had previously been approved by the Board on 26 April 2018

PERFORMANCE

18/T/078 QUALITY PERFORMANCE REPORT

The Director of Quality Governance presented the report which included updates on:

- Serious Incidents
- Claims and Inquests
- Complaints, Compliments and Concerns
- Draft Quality Account

The Board discussed the report with the Director of Quality Governance providing additional details as requested.

She confirmed that the draft CQC reports had been received but were currently subject to an embargo and therefore could not be included in her report at this time.

Resolution

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

18/T/079 SAFE STAFFING MONTHLY REPORT

The Director of Nursing presented the report which provides an overview of staffing levels, agency and bank fill rates and the work being undertaken for improved rostering practice using the Carter KPI s for rostering. She advised that the acute wards continued to use agency and bank staff to cover vacancies and sickness.

She also provided an update on the SafeCare project which is now live with acuity and dependency data being entered three times a day on Appley, Colwell, Luccombe, CCU, Afton, The Stoke Unit, Compton and Children's Ward, St Helen's, Alverstone, Mottistone and Whippingham. There are plans to go live with ITU and NICU once appropriate acuity and dependency tools have been identified. It was advised that further education and support is being put in place to ensure full utilisation of this system is achieved in delivering safe staffing levels based on patient need.

The Board discussed the report and Sara Weech, Associate Non-Executive requested a timescale for when Community, Mental Health and Ambulance would be included within the safe staffing data. The Director of Nursing advised that currently all the tools were acute focussed and that specific matrix for these areas was not currently available and therefore could not provide a timescale at this time. She did however, confirm that work was being undertaken to provide suitable data for the outstanding areas.

Doreen Britton, Chair of Patient Council, highlighted that causes of sickness had seen a decrease in musculoskeletal cases but that stress continued to be a high factor and queried what was being done to support staff. The Director of Human Resources & Organisational Development advised that through Occupational Health fast access to physiotherapy had been put into place and that similar provision for counselling was also being enhanced.

The Chief Executive queried why there were incidences of over establishment shown within the report and what was the reason behind the data. The Director of Nursing explained that some wards have requested additional staff to accommodate the acuity of patients on particular days and sometimes this would be additional health care assistants rather than additional nurses. She confirmed that the template was being adjusted to better reflect these cases.

Resolution

The Isle of Wight NHS Trust Board received the Safe Staffing Monthly Report

18/T/080 NURSING & MIDWIFERY SIX MONTHLY STAFFING REVIEW

The Director of Nursing advised that the Trust is required to undertake an annual comprehensive nursing and midwifery skills mix review to ensure that there are safe staffing levels to provide assurance to the board and our stakeholders that the organisation is safe and providing high quality care. She confirmed that she had met with all the ward sisters to discuss their needs to ensure that they have the appropriate balance of registered nurses and health care assistants and that their establishment levels are correct. She also advised that the team were working with the education facilitators to ensure that competency levels across the wards are maintained.

Tim Peachey, Chair of Quality Committee confirmed that the report had been discussed and that the Committee had been assured.

The Board discussed the report with Charles Rogers, Non-Executive Director querying why recruitment and training are being spread over a two year period. The Director of Nursing advised that there will be a year on year plan which will be agreed with the ward sisters and which has identified a potential financial opportunity. The Interim Turnaround Chief Financial Officer advised that there was still more work to be undertaken to ensure that any plan are linked to the recruitment plan, that it results in a reduction in agency use and the financial implications are fully explored and validated.

The Chief Executive stated that as there were a number of outstanding questions

relating to the report, that it be received at this point. She requested that it be brought to the Executive Management team for discussion and then returned to Board for approval.

Action

Outstanding queries relating to the Nursing & Midwifery Six Monthly Staffing Review to be addressed and presented to the Executive Management team for discussion prior to returning to the Board for approval.

Action by: DN

Resolution

The Isle of Wight NHS Trust Board received the Nursing & Midwifery Six Monthly Staffing Review

18/T/081 LEARNING FROM DEATHS & MORTALITY REPORT

The Interim Medical Director presented the report which had been reviewed at the Quality Committee. He provided updates on the following:

- Learning from Deaths process
- Latest Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) data
- CUSUM[1] alerts
- Coroner Inquests concluded in month
- Latest Bereavement Data
- Latest Dr Foster Data
- LeDer- Learning Disabilities Mortality Review- LeDer Programme

The Board discussed the report and agreed that it was very transparent but cautioned that it was important to have good and clear information included within the report and that this is communicated effectively so as not to alarm the public unnecessarily.

The Chief Executive stressed that the Board could endorse the approach being taken but it was for the Committee to progress and monitor for assurance.

Resolution

The Isle of Wight NHS Trust Board received the Learning From Deaths & Mortality Report

18/T/082 WORKFORCE & ORGANISATIONAL DEVELOPMENT PERFORMANCE REPORT

The Director of Human Resources & Organisational Development report which have been reviewed at the Performance Committee. She provided updates on the following:

- Agency & Bank Staff Usage
- Overseas Recruitment
- Workforce Summit
- Sickness Absence
- Mandatory Training

The Board discussed the report and Charles Rogers, Chair of Performance Committee, confirmed that the Committee had been pleased to hear the progress being made in recruitment but remained concerned over the level of agency staff

[1] The **CUSUM** chart method as a tool for continuous monitoring of clinical outcomes using routinely collected data

being used. He also advised that training and appraisals also remained areas of concern.

Sara Weech, Associate Non-Executive Director, highlighted that the report presented to the Performance Committee had additional information concerning leavers and queried if this could be included within the Board report. The Director of Human Resources & Organisational Development confirmed that this would in included within future reports and that any relevant sensitive details could be reported at the Private Board meeting where necessary.

Caroline Spicer, Non-Executive Director stressed that appraisals were not just a HR responsibility and that more needed to be done to ensure that they are undertaken. The Chief Executive confirmed that the Executive Director appraisals were scheduled which would provide their objectives which would then cascade down through their reporting lines.

Resolution

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

18/T/083 OPERATIONAL PERFORMANCE REPORT

The Director of Acute Services presented the report and in addition to the areas mentioned within the report she updated on the following:

Highlights:

- Cancer 62 Day target: Confirmed that the February and March targets had been achieved.
- Ambulance: Confirmed that at present there are a mixture of old and new targets being reported due to the national change in reporting. Category 2, 3 and 4 were performing well. She explained that the Red Category 1 show related to very low numbers. 111 Service was sustaining its improved position.

Lowlights:

- Medical care standard for bed pressures: this had reduced with April showing an improved position
- RTT: Maintaining position
- Diagnostic Imaging: now showing 99% due to extra clinics being provided.

The Board discussed the report with the Director of Acute Services providing additional information as required.

Charles Rogers, Chair of Performance Committee advised that a review of the ambulance targets would be presented to the Committee.

Resolution

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

18/T/084 FINANCIAL PERFORMANCE REPORT

The Interim Turnaround Chief Financial Officer presented the report which had been discussed at the Trust Leadership Committee, Performance Committee and the Board session on 26 April. He confirmed that the Trust's year-end financial position is a deficit of £23.25m with a performance against plan to date of £4.4m adverse variance. He reminded the Board that the achievement of the year end Board approved deficit of £22.2m was dependent on receiving additional CCG income to improve on the predicted £23.8m deficit.

He advised that Capital Expenditure was underspent at £8.3m against the Capital allocation for the year which was £9.1m. He confirmed that the balance had been approved by NHSI to be carried forward to 2018/19.

The Interim Turnaround Chief Financial Officer highlighted that although agency cost had reduced in Month 12, the actual agency spend for the year was £10.9m against an Agency control total ceiling for 2017/18 of £4.990m which is an adverse cost to date of £5.9m.

He confirmed that measures to control spend were starting to show benefits with a saving of £3k per day reported in Month 12. However, he stressed that it was early days and these measures would remain in place.

The Board discussed the report and Charles Godden, Associate Non-Executive Director, expressed concern that once the new financial year commences that expenditure will start to rise again. The Interim Turnaround Chief Financial Officer confirmed that non-recurring elements had been factored into the Financial Plan 2018/19 which had been approved on 26 April.

The Chair highlighted that it was important to note that the grip and control measures had been in place since November and included the winter pressures and improvements required by the CQC.

Resolution

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

COMMITTEE ASSURANCE AND GOVERNANCE

18/T/085 EQUALITY & DIVERSITY STRATEGY & DELIVERY PLAN

The Director of Human Resources & Organisational Developed confirmed that the strategy had been discussed at the Quality Committee. She advised that the strategy was designed to provide a sustainable delivery model for equality and diversity and help the Trust to respond positively to its legal, regulatory and commissioner requirements, including the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES).

She stressed the importance of culturally embedding equality and diversity throughout the organisation and that it was equally important for staff to realise that it is not just a HR function. She outlined the delivery plan which showed how the strategy would be implemented and that the Equality Steering Group would be set up to monitor progress. It would have a cross section of staff included within it and there will be an Equality & Diversity Lead Non-Executive Director.

Resolution

The Chair requested that the Board **Approve** the Equality & Diversity Strategy and the delivery plan. Motion Proposed by Maggie Oldham and Seconded by David King. The motion was carried unanimously.

18/T/086 JUNIOR DOCTORS GUARDIAN OF SAFE WORKING QUARTERLY REPORT

Dr. Sreeshyla Basavaraj, Junior Doctor's Guardian of Safe Working presented the report which covered the period from 1 December 2017 to 31 March 2018.

He advised that there had been a significant improvement in exception reporting and that the main causes were the additional hours that trainees are working, over and above their rostered hours, due to unfilled vacancies; the vacancies rise from unfilled Health Education England (HEE) trainee doctor posts. He confirmed that attempts have been made to fill the vacancies with little success due the short and fixed term nature of the roles.

He reported that the attendance by members of the Executive Team at the Junior Doctors Forum has been welcomed and had a positive impact.

The Board discussed the report with Dr Basavaraj providing additional insight into the areas of concern.

The Chief Executive thanked him for the work he is undertaking with the junior doctors.

Resolution

The Isle of Wight NHS Trust Board received the Junior Doctors Guardian of Safe Working Quarterly Report

18/T/087 GENERAL DATA PROTECTION REGULATION (GDPR) TRUST'S READINESS FOR IMPLEMENTATION ON 26 MAY 2018

The Deputy Chief Executive advised that the paper had been discussed at the Performance Committee. He advised that the new GDPR replaces the Data Protection Act 1998 (DPA) and comes into effect from 25 May 2018. It applies to all businesses operating within the EU and It brings changes to how organisations address modern data practices and risks and relates to the collection, use and sharing of personal data. He advised that an action plan has been developed to address the immediate changes, but will be further developed as required.

The Board discussed the implications for the Trust and the affects it would have on patient care and patient information. The Deputy Chief Executive advised that clear guidance would be provided to staff and that the DPA was already embedded within the organisation.

The Chair queried if the Trusts would be compliant by 25 May. The Chief Executive advised that there was no definitive answer but a clear plan of what was required was in place and this would be monitored regularly throughout the year by the Executive Directors.

Charles Rogers, Chair of Performance Committee confirmed that they would be monitoring compliance on a regular basis also.

Resolution

The Isle of Wight NHS Trust Board received the General Data Protection Regulation (GDPR) Trust's readiness for implementation on 26 May 2018

18/T/088 COMMITTEE REPORTS: QUALITY COMMITTEE

Tim Peachey, Chair of the Committee which covered the key points raised at the last meeting held on 2 May 2018:

PATIENT SAFETY

- **Patient Safety Sub Committee Report:** The Committee received updates on progress across the remit of the Sub-Committee and noted that there was evidence of good work in progress but still requiring significant development.

  Limited Assurance

- **Safe Staffing Levels:** The Committee were assured that the Director of Nursing is maintaining staffing to safe levels and recruitment under current establishments and within the staffing recruitment limitations

  Reasonable Assurance

- **Nursing & Midwifery 6 Monthly Staffing Review:** The Committee noted that the key purpose of the report relates to acute inpatients. Other work on staffing in A&E, MAU and community is in progress. A timeline for delivery is required. It also recommended that the Board discuss investment in the development of new models of nursing. The Committee recommend that the Board approve the report.

  Reasonable Assurance
- **Serious Incident Activity Report:** The Committee received the revised report and was assured that effective progress is being made.

  Significant Assurance
- **Quality Impact Assessments:** The Committee were assured that there is a process in place, but had not seen evidence of implementation and therefore received limited assurance.

  Limited Assurance
- **IPC Compliance & KPIs Update:** The Committee received the revised report and was assured that effective progress is being made.

  Significant Assurance
- **Monthly Update on progress of the implementation of the Mental Health Business Cases:** The Committee received a verbal update which did not give any assurance on progress.

  No Assurance

PATIENT EXPERIENCE

- **Patient Experience Sub-Committee Report:** The Committee received updates on progress across the remit of the Sub-Committee and noted that there was evidence of good work in progress

  Reasonable Assurance

ORGANISATIONAL DEVELOPMENT

- **Equality & Diversity Strategy 2018/22:** The Committee recommend that the Board approve the report.

  Significant Assurance

GOVERNANCE

- **Quality Account (Draft):** The Committee noted the report which is currently out for stakeholder consultation
- **BAF risks and risk appetite statement Quarterly Report (for quality risks only):** The Committee received the risk appetite statements for 2017-18 on Quality Risks.

  Significant Assurance
- **Isle of Wight Care System Quality Approach:** The Committee noted that the paper had been approved by the Local Care Board and the CCG and that it agreed to the adoption of the care system quality approach set out in the paper.

Resolution

The Isle of Wight NHS Trust Board received the Chair's Report from the Quality Committee

18/T/089 PERFORMANCE COMMITTEE

Charles Rogers, Chair of the Performance Committee presented the report on the key points raised at the last meeting held on 2 May 2018

- **Procurement:** The Committee was updated on the development of

potential savings and the introduction of a new process to facilitate savings.

- **GDPR:** The Committee supported the proposed action plan and confirmed regular monitoring against compliance would be undertaken.
- **ICT:** The Committee was concerned about capacity issues for the delivery of ongoing projects including the connectivity between systems and staff training.
- **ICT Strategy:** The Committee heard that the strategy is to be developed and that it would include the prioritisation of capital required to implement systems.
- **Cyber Security:** The Committee received the Internal Audit report which gave limited assurance. It highlighted the weakness of skills and capacity to carry out work within the new GDPR. Regular progress reports will be provided by the Executive Director
- **Medical Job Planning:** The Committee received an update on progress of the Internal Audit report but was not assured that significant progress was being made. Internal Audit had been requested to re-audit within their 2018/19 workplan. The Committee also was concerned about the achievement of the job planning cycle and that it needed to include other productivity work undertaken.

The Interim Medical Director provided an update on the two internal audit reports into Private Practice and Job Planning. He highlighted that there were issues with the electronic systems and capacity to undertake the reviews. He outlined measures that were being put into place to address these issues.

Resolution

The Isle of Wight NHS Trust Board received the Chair's Report from the Performance Committee

18/T/090 AUDIT COMMITTEE

David King, Chair of the Performance Committee presented the report on the key points raised at the last meeting held on 2 May 2018.

- **Quality Account:** The Committee reviewed the draft document and were assured that it was on track for completion.
- **Annual Accounts:** The Committee reviewed the draft accounts which were currently being audited by the external auditors.
- **Statement of Going Concern:** The Committee reviewed the proposed statement which would be submitted to the Secretary of State.
- **Internal Audit & Counter Fraud:** The Committee was concerned that outstanding actions from 2016/17 and 201/18 were not completed. Update would be provided to the next meeting.
- **Audit Committee Development:** The Committee received training from the Internal Auditors, External Auditors and Counter Fraud Specialists.

Resolution

The Isle of Wight NHS Trust Board received the Chair's Report from the Audit Committee

CLOSING MATTERS

18/T/091 ISSUES TO BE COVERED IN PRIVATE

The Chair advised that the following items would be covered in private:

- Replacement Computer Aided Despatch (CAD) System Options Appraisal
- Employee Relations
- Infection Prevention & Control Update
- Quality Report - Supplementary Appendices

18/T/092 QUESTIONS FROM THE PUBLIC

None received

18/T/093 ANY OTHER BUSINESS

- Cllr John Nicholson expressed his thanks for positive way in which the issues he had raised at the last meeting had been dealt with

DATE OF NEXT MEETINGS

The Chair confirmed that the next meeting of the Isle of Wight NHS Trust Board to be held in public is on **Thursday 7 June 2018.** 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 3.45pm

Signed……..Chair - Vaughan Thomas

Date:……

Enc B

ISLE OF WIGHT TRUST BOARD January 2018 - December 2018
ROLLING SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

KEY TO RAG STATUS
Action overdue
Action Progressing
Action complete

Name of Meeting	Date of Meeting	Minute No.	Action No.	Item	Action	Exec Lead	Update & Evidence of Completion	Due Date	Forecast Date	Progress RAG	Date Closed
Board in Public	06-Dec-17	17/T/203	TB/298	Committee Terms of Reference	Quoracy within the Terms of Reference to be amended and ratification to go to Board	David Haycox	25/01/18 - This has been included within the revised Board Committee Pack and will be brought to Board following the meetings of the Committees in January and February where any additional changes to the terms of reference will be agreed. 27/03/18 - final terms of reference will be reviewed by the Committees in April with the amendments going to Board in May for approval. 24/04/18 - Revised pack will be presented to Board. Action Closed 03/05/18 - The Governance Advisor advised that this paper would now be going to the June meeting to enable changes to the Executive Team to be included. The action is therefore reopened with a due date of June. 30/05/18 - Board & Committee revised Terms of Reference are being presented for approval at the June meeting. Action closed	03-May-18	07-Jun-18	Action complete	30-May-18
Board in Public	01-Mar-18	18/T/036	TB/323	All Staffing Levels in Safe Staffing report	The Director of Nursing & Interim Medical Director to review the report to show all staffing levels across all business units and to include nursing, clinical and allied health professionals.	Barbara Stuttle Steve Parker	24/04/18 - Information to be obtained from HR and incorporated within future reports from Quarter 2. Nursing Review done and the Medicine and Allied Health Professionals will be undertaken over next 2 months.	05-Jul-18	05-Jul-18	Action Progressing	
Board in Public	01-Mar-18	18/T/041	TB/327	Promoting equality and fairness for all – meeting the public sector equality duty	Revised report to be submitted for approval at Board	Julie Pennycook	24/04/18 - Report drafted. Final version submission to Quality Committee and Board in June 30/05/18 - Report is being submitted for approval. Action closed	06-Jun-17	06-Jun-17	Action complete	30-May-18
Board in Public	05-Apr-18	18/T/069	TB/337	Access to Specialist Treatment by Island Residents	A review of the data covering referrals for off island treatment to be undertaken in conjunction with the Local Care Board and the CCG	Steve Parker		05-Jul-18	05-Jul-18	Action Progressing	
Board in Public	03-May-18	18/T/080	TB/338	Nursing & Midwifery Six Monthly Staffing Review	Outstanding queries relating to the Nursing & Midwifery Six Monthly Staffing Review to be addressed and presented to the Executive Management team for discussion prior to returning to the Board for approval.	Barbara Stuttle	30/05/18 - Review is taking place and the revised paper will be submitted through the governance process.	05-Jul-18	05-Jul-18	Action Progressing	

Enc C

Agenda Item No	6	**Meeting**	Trust Board in Public	**Meeting Date**	7 June 2018
Title	Chair Report				
Sponsoring Executive Director	Vaughan Thomas, Chair				
Author(s)	Vaughan Thomas, Chair				
Committees previously considered by including date	N/a				

Purpose of the report			
Information only		Assurance	
Receive	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 Well Led Domains			
Effective	X	Responsive	X
Caring	X	Well-led	X
Safe	X		

Executive Summary

Last Board meeting on 3 May 2018.

During the month, I have conducted and participated in meetings with, advisors, stakeholders, staff, and partners of the Trust. These have included:

- Meetings/calls with NHSI including:
  - Fortnightly calls with Transactions and Sustainable Solutions Director
  - Discussion with NHSI re future NED appointment programme
  - University Hospitals NHS Trust Morecambe Bay

- Meetings with partner organisations including:
  - Local Care Board 10 May 2018 and Joint Seminar LCB & ODG 17 May 2018
  - Peter Cruttenden, Chair of Hampshire & Isle of Wight CCG Partnership Board
  - Visit to 'Our Place' – Wight Sports & Community Centre – followed by further meeting with Gill Kennett regarding funding
  - Solent Acute Alliance Steering Group
  - Wessex Academic Health Science Network presentation to Executive Team to showcase the work they have undertaken with the Trust

- Meetings with Individuals including trust executives and
  - Margarita Kitova-John, Federation Chair and GP Partner
  - Meeting with Anne Lancey, Librarian to review Trust Library

Key outcomes from these activities are:

- Arrangement finalized for Wessex Health Innovation Forum with Keith Dewar CEO of Prince Edward Island as part of an innovation seminar to be held at St Mary's
- Joint Audit Committee & Board Meeting to sign off Annual Accounts

During the course of the month ahead I shall continue the programme of meetings and visits.

Key Recommendation

The Board is recommended to receive the report.

Enc D

Agenda Item No	7	**Meeting**	Trust Board in Public	**Meeting Date**	7 June 2018
Title	Chief Executive Officer's Report - 24th April to 29th May 2018				
Sponsoring Executive Director	Maggie Oldham, Chief Executive Officer				
Author(s)	Andy Hollebon, Head of Communications and Engagement				
Report previously considered by inc date	N/A				

Purpose of the report			
Information only	X	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 Well Led Domains			
Effective	X	Responsive	X
Caring	X	Well-led	X
Safe	X		

Executive Summary

This report has been prepared by the Head of Communications & Engagement on my behalf. The report covers the period 24th April to 29th May 2018. The report is intended to provide information on activities and events and usually cover issues of national, regional and local importance that would not normally be covered by the other reports and agenda items. Detailed information about the business of the Trust appears in the performance reports. This report provides a summary of key successes and issues which have come to the attention of the Chief Executive. The report covers the following issues:

- Audrey Gunnell and Susan Pedder – sad news
- CQC Inspection and forthcoming reports
- Summer Sun and recruitment
- Executive Director posts
- Culture and Leadership Programme
- Policy and Scrutiny Committee for Adult Social Care and Health visit
- International Nurses Day
- Remembering the Fallen and the Armed Forces Covenant
- General Data Protection Regulations (GDPR)
- Smoke Free NHS
- Volunteers
- Building hospital services fit for the future
- Wessex Health Innovation Forum – 4th July on the Isle of Wight
- NHS Provider briefings and reports
- Governance - Trust Leadership Committee

Key Recommendation

The Board is asked to consider the following recommendations:

- The Board is recommended to note the contents and receive the report.
- The Board is asked to agree that the Trust should sign the Smoke Free NHS pledge.

Chief Executive's Report for the period to 24th April to 29th May 2018

My report this month covers a range of issues between 24th April to 29th May 2018 including items of national and regional importance, and local issues. More detailed information about the business of the Trust appears in the performance reports.

Audrey Gunnell and Susan Pedder – sad news

Sadly I start this report with the passing on 9th May of Audrey Gunnell and over the late May Bank Holiday weekend of Susan Pedder. Audrey was a Ward Clerk on Whippingham and she had worked with us for 21 years. Susan was employed as a Telephone/Switchboard Operator and had worked for us for 13 years. Our thoughts are with Audrey and Susan's family, friends and colleagues.

CQC Inspection and forthcoming reports

As you will be aware, in April 2017 the Isle of Wight NHS Trust was rated as 'inadequate' by the Care Quality Commission (CQC) following an inspection of our services, and was subsequently placed in 'special measures'. Since then, the Trust has been looking at all the ways it can improve the care and services it provides, working through a detailed plan to address the root causes of the issues identified by the CQC.

On 25-28 January 2018 the CQC revisited the Trust to conduct its first full and comprehensive inspection of our services since we were placed in 'special measures'. The CQC also conducted a further inspection on 22-25 February 2018 to determine how "well-led" the Trust is.

We have always said that our improvement journey would not be an easy or a short one; that turning things around would take time and a lot of hard work. However, the findings of these inspections will provide us with a firm basis, along with recommendations, that will help us on our improvement journey as we aim to get to 'good' by 2020.

I understand that the CQC will be publishing the results of these inspections imminently and until then I am unable to comment further. If the reports are published before the Board meeting, I will update this section of my report at the meeting.

Summer Sun and recruitment

We've had some fantastic weather on the Island in recent weeks (some stormy as well!) and it's made me really appreciate what a great place the Island is to live and work. I've been really pleased to move to a lovely village on the Island now that we've bought a home. However whilst I and my husband have started turning the home into a place we can call our own and enjoying the warm weather I always remember that there are those continuing to work 24/7 to ensure that as Islanders we are safe and cared for.

We cannot though rely on summer sun to solve our recruitment problem. Health Education England (HEE) Wessex have been very supportive to our Trust recently and they recognise that our approach to *'Getting to Good'* has to be built upon our existing and future workforce. It goes without saying how important our emerging recruitment and retention strategy is to the island, and it was impressive to hear Dr Peter Hockey, Postgraduate Dean of Wessex HEE recently talk about how a Trust with similar problems to ours had been able to dramatically reduce its medical vacancies by some very focused work around medical recruitment. We all came away from the meeting with some good ideas for what we could do here.

It was good to be able to share with HEE Wessex the work we are doing in workforce development, and equally to hear from them about some of the developments they have worked on and are introducing. It was also really good to hear about our 74 apprentices who have been working with us, and hear about their progress. We beat our target number of 70 so that's really pleasing to hear as well.

Executive Director posts

I would like to formally record my thanks to former Chief Operating Officer Shaun Stacey. Shaun left us during May, to take up a new post in Northern Lincolnshire and Goole NHS Foundation Trust, where he will be Chief Operating Officer and Deputy CEO. I have appreciated all the help and support Shaun has given me and I'm sure, like me, you will all wish him well in the next chapter of his career.

Culture and Leadership Programme

Our Culture and Leadership Programme is now underway. This is working with all levels of the Trust to discover how as part of our journey of '*Getting to Good*' we can have a culture which lives the values of the Trust and provides the kind of supportive culture which we know is good for patients and good for staff. This means a place where staff treat each other with compassion and understanding, individuals feel valued and fulfilled, where poor behaviour is tackled and people are aligned around improving quality and delivering high quality care as a core value. We want to be a community where we develop and support our staff to be the best they can be.

The programme will take place over two years and has started with a 'discovery' phase. This will be followed by the creation of a Leadership Strategy to define the leadership and organisation development and where in the organisation activity is needed in order to create a sustainable compassionate working environment. To understand the current culture the team are also holding focus groups, doing desk research and surveys. Led by Leisa Gardiner and Jacqui Skeel, and supported by Pamela Ainslie, the programme is fully supported by the Board and has my total backing.

Policy and Scrutiny Committee for Adult Social Care and Health visit

On 9th May I was pleased to host a visit for Members of the Island's Policy and Scrutiny Committee for Adult Social Care and Health who visited St. Mary's Hospital. The visit was the first of a series of opportunities for Committee Members to find out more about the day to day running of health services and the improvements that are being made in many areas of the Trust as we move forward on our '*Getting to Good'* journey.

They had a tour of the Emergency Department which is currently being partly reconfigured and upgraded to improve patient flow. Members toured the newly opened Minors Treatment Unit which will offer a dedicated area for patients with minor illness or injury to be treated without the need to enter the main Emergency Department. Colleagues were also shown the new Ambulatory Emergency Care Unit which is still under construction. Patients requiring further investigations and tests will be transferred to this area with a view to them going home the same day and without the need to be admitted to hospital overnight.

The visit also included a tour of our Operations Centre which coordinates the flow of emergency and elective patients coming into hospital and supports their discharge home, ensuring that patients are in the right place for the right care at the right time.

I was delighted that the visit took place, in the spirit of open and transparent relationships and this is one of a number of planned visits. I look forward to introducing colleagues to our Ambulance, Community and Mental Health services.

International Nurses Day

We celebrated International Nurses Day on 11th May and I was so pleased to be able to meet so many nurses current and past taking part in the activities at St. Mary's.



Remembering the Fallen and the Armed Forces Covenant

Some readers of this report will be aware that our Ambulance Service has a Colour Party who parade with the Ambulance Service flag at ceremonial occasions. On 17th May I was privileged and humbled to watch as Ambulance service colleagues stood guard of honour at the Menin Gate Memorial in Ypres, Belgium. I also laid a wreath on behalf of the Trust. Often referred to simply as the Menin Gate, it bears the names of more than 54,000 soldiers who died and have no known grave. Between October 1914 and September 1918 hundreds of thousands of servicemen of the British Empire marched through the town of Ypres's Menin Gate on their way to the battlefields. The memorial now stands as a reminder of those who died that have no known grave and is perhaps one of the most well-known war memorials in the world.




The Armed Forces Covenant is enshrined in the NHS Constitution to ensure equal access to services for serving military personnel and their families who may have to move around the country a lot. It also aims to ensure that we prioritise the treatment of veterans where their condition is a result of their service. Director of Nursing Barbara Stuttle is keen that we look more closely at the service we provide for serving forces personnel and veterans. We have asked the Communications and Engagement team to undertake an engagement exercise with interested parties including service associations and representative bodies on the Island to see how we can improve services for them as part of our programme of '*Getting to Good*'.

General Data Protection Regulations (GDPR)

The General Data Protection Regulations (GDPR) came into effect on Friday 25th May to strengthen and update the way that personal information/data is used (processed) and builds on the existing Data Protection Act 1998 (DPA). A lot of what GDPR brings is already in place within the Trust as part of the existing Information Governance Toolkit and other local action plans – so it's not all new. There is a large programme of work underway which will continue throughout 2018 and I am confident that we are well on the way to ensuring that the Trust is compliant with the requirements.

Smoke Free NHS

Thursday 31st May was World No Tobacco Day. In January 2018 the Smokefree Action Coalition launched the NHS Smokefree Pledge. The Pledge is designed to be a clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smokefree environments which support them. The Pledge has been endorsed by the Public Health Minister Steve

Brine MP, and the Chief Executives of NHS England and Public Health England. It is an update to the NHS Statement of Support for Tobacco Control.

While smoking rates are at an all-time low, it is still our country's biggest preventable killer—so we are absolutely committed to helping people quit for life. In 2016 the rate of smoking amongst adults aged 18 and over on the Island was 15.3%, only just below the national average and much worse than the best rated area at 4.9%. In 2015/16 around 160 women were smoking during pregnancy – a rate of 13% compared to the best area in England with just 1.8%. And in the period 2013-2015 there were 875 smoking related deaths.[1]

I want to be clear to all visitors, patients and members of staff that the Trust's NHS buildings and grounds are smoke free. Our policy on this issue is clear also that this includes 'vaping'. I am concerned that all too often I see individuals smoking or vaping at the front entrance to St. Mary's and this along with smoking or vaping anywhere on NHS property is unacceptable. With Trust Board's agreement I am proposing that the Chair, Medical Director and I all sign the NHS Smoke Free Pledge (attached) on behalf of the Trust.

Volunteers Week – 1st to 7th June

We are fortunate to have over 300 dedicated volunteers supporting our clinical and non-clinical staff in the delivery of high quality patient care. Our volunteers are able to support patients, visitors and staff by offering extra time and small acts of kindness which can really make a positive impact on the services that we provide. With our Board meeting falling during this week I wanted to express my heartfelt thanks to all our volunteers, whatever their role and however much time they are able to spend with us. We really do appreciate their support.

Building hospital services fit for the future

In February, the Isle of Wight Clinical Commissioning Group endorsed the Local Care Board recommended option; an outline approach that that would see the majority of services remain on the Island, with around 11 per cent of the most complex, specialist acute care procedures (**not** whole services) being potentially delivered by hospitals on the mainland in the next three to five years. Conversations about this redesign of services are being held across the Island during June and the first of these opportunities will be a 'Question Time' style panel event with both Trust and CCG representatives on Wednesday 6th June from 4.30pm-6.30pm in the Lecture Theatre at the Education Centre for NHS staff. We hope this will provide staff with the opportunity to hear more about this work and to ask any questions they might have and to share views with the Acute Services Redesign team to help further shape their thinking. Events for the public include:

- Monday 11th June – a Question Time style event at Cowes Enterprise College from 6.00pm-8.00pm which will also be broadcast live on Isle of Wight Radio and on social media.
- Four further public drop-in events across the Island where people can also share their views with clinicians and other experts:
    - Tuesday 19 June, 4pm-7pm, The Heights (Café area), The Broadway, Sandown PO36 9ET
    - Tuesday 26th June, 4pm-7pm, West Wight Sports & Community Centre (Café area) Moa Place, Freshwater, PO40 9XH
    - Wednesday 27th June, 4pm-7pm, Ryde Library, George Street, Ryde, PO33 2JE
    - Thursday 28th June 10.30am-1.30pm, Riverside Centre, Hunnyhill room, The Quay, Newport PO30 2QR

1 Public Health England Isle of Wight Area Health Profile (http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000046.pdf).

More about this issue can be found on the Isle of Wight Clinical Commissioning Group (CCG) website.

Wessex Health Innovation Forum – 4th July on the Isle of Wight

I am really excited about a partnership we have established with Wessex Academic Health Sciences Network (AHSN) to organise an 'innovation forum' on 4th July – the eve of the 70th Anniversary of the NHS. The main aim of this Forum is to bring together the island's primary and secondary care professionals; to network, share ideas, connect and explore ways to help improve services for the island's population.

The key speaker will be Keith Dewar – who has spent his working life transforming healthcare services on an island with strikingly similar challenges to the Isle of Wight. Keith is the Chief Executive Officer of Health PEI - Prince Edward Island, Canada. Keith will share his hindsight of what worked and what didn't over the past 15 years.

We will also hear from healthcare innovators who have developed new ways to tackle current (and future) problems. The Innovation Forum will showcase some exciting innovations which are already impacting other areas of the NHS, as examples of how technology might help some of the island's challenges.

NHS Provider Briefings and reports

Over the last month NHS Providers, who represent almost all NHS Trusts and Foundation Trusts including Isle of Wight NHS Trust, provided briefings and reports on a range of topics as follows:

26-04-18 House of Lords debate on the long-term sustainability of the NHS
09-05-18 On the day briefing: Recent reports on mental health and learning disabilities provision
11-05-18 Public attitudes to health and care: New NHS Providers polling
17-05-18 Brexit briefing: Lords stages of the EU (Withdrawal) Bill
21-05-18 The state of the provider sector - Community services: taking centre stage
24-05-18 No trust is an island - Working collaboratively in health and care systems
24-05-18 Summary of statutory board meetings: May 2018
24-05-18 On the day briefing: Next steps on aligning the work of NHS England and NHS Improvement
24-05-18 On the day briefing: Operational productivity in mental health and community health services

These briefings are available on the NHS Providers website at http://nhsproviders.org/resource-library/briefings

Governance - Trust Leadership Committee

The Trust Leadership Committee (TLC) comprises Executive Directors and Clinical Business Unit representatives and meets monthly. There are no items from the meeting held on 18th April 2018 to be reported to the Trust Board that are not already covered by agenda items.

Maggie Oldham
Chief Executive Officer
29th May 2018

APPENDIX

The NHS Smokefree Pledge

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- 1 in 4 patients in acute settings are smokers and that staff working for the NHS also smoke;
- Smoking places a significant additional burden on health and social care services and is impacting on the future sustainability of the NHS;
- Reducing smoking in our communities increases disposable household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and

We welcome:

- The Government's commitment to achieve a smokefree future and reduce smoking rates to less than 5 per cent;
- NICE public health guidance on tackling smoking particularly PH48, PH45 and PH26;
- Endorsement of this declaration by central government, Public Health England and others.

In support of a smokefree future we commit from this date ……to

- Treat tobacco dependency among patients and staff who smoke as set out in the Tobacco Control Plan for England;
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care;
- Create environments that support quitting through implementing smokefree policies as recommended by NICE;
- Deliver consistent messages to smokers about harms from smoking and the opportunities to quit in line with NICE guidance on brief advice;
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities;
- Protect tobacco control work from the commercial and vested interests of the tobacco industry;
- Support Government action at national level;
- Join the Smokefree Action Coalition (SFAC).

The NHS Smokefree Pledge is endorsed by

Department of Health

Public Health England

NHS England

Royal College of Physicians

RCPCH Royal College of Paediatrics and Child Health

Association of Directors of Public Health

Faculty of Public Health

BMA

RCGP Royal College of General Practitioners

Enc E

Agenda Item No	8	**Meeting**	Trust Board in Public	**Meeting Date**	7 June 2018
Title	Diversity and Inclusion Workforce Report 2017/8 – incorporating the Public Sector Equality Duty				
Sponsoring Executive Director	Julie Pennycook – Director of Human Resources and Organisational Development				
Author(s)	Liz Nials – Senior HR Manager, Sam Greatrex – Equalities Lead				
Report previously considered by inc date	Quality Committee (6th June 2018)				

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

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	X
Lead strategic change on the Isle of Wight	X

Link to CQC Well Led Domains			
Effective		Responsive	
Caring	X	Well-led	X
Safe			

Executive Summary

Equality, diversity and inclusion is important for the Trust to achieving our vision and embedding our values into everything we do.

The Equality and Diversity Report measures our progress to becoming an inclusive employer and outstanding service provider. The report provides an outline of our performance against our Equality Standard, before providing a demographic profile of our workforce and information to drive a more focused approach to identifying and tackling inequalities – Public Sector Equality Duty.

Key Recommendation

The Trust Board is asked to consider the following recommendations

Approve the actions set out in the Equality and Diversity Report 2017/18

EQUALITY AND DIVERSITY REPORT

2017/18

Incorporating the Public Sector Equality Duty

Contents

1. Introduction

The Isle of Wight NHS Trust's vision is "Patients come first in everything we do. We fully involve patients, staff and volunteers, carers and communities" this is underpinned by our values *"We care….We are a team…..We innovate and improve.*

The Trust Board understands that equality, diversity and inclusion are important in achieving our vision and embedding our organisational values in everything we do.

The Trust's Equality Objective is "*The Isle of Wight NHS Trust strives to demonstrate excellence against all goals set out in the NHS Equality Delivery System (EDS 2), by everyone recognising equality and integrating it into everything we do".* By end of March 2019 the Trust intends to review and re-define its Equality Objectives.

Protected Characteristic	Diversity Scorecard Analysis[1]
Age	• 100% workforce reporting to Age • The largest age group employed at Isle of Wight NHS Trust is 46-55 yrs. • The number of staff employed between the ages of 16-25 is 6.76% • Leavers are over-represented in the 16-25 age range
Disability	• 75% of our workforce data reporting to Disability • 2.68% of the workforce have declared 'yes' when asked if they had a disability. • Of our future workforce, 4.70% of applications received and 5.50% of those appointed declared to having a disability
Marriage and Civil Partnership	• 97.65% workforce reporting to Marital and Civil Partnership Status
Race	• 95.05% workforce reporting to Race • 85.98% of the workforce is White British • 9.7% of the workforce is BAME • BAME staff fare less favourably to White British staff in recruitment and selection; employee relations (excluding sickness absence) and are under-represented from Band 6 and above.
Religion or Belief	• 69.32% of our workforce reporting to Religion or Belief
Sex	• 95.54% of our workforce reporting to Sex • 74.14% of the total workforce is female • 25.40% of the total workforce is male • Employment banding shows under-representation of women from Band 7 and above. • Employment banding shows under-representation of males in

[1] Data source Electronic Staff Record and NHS Jobs as at 31st December 2017

	Band 1, 3, 4, 5 and 6.
Sexual Orientation	• 71.05% workforce reporting to Sexual Orientation • 59.98% of the workforce identify their sexual orientation as Heterosexual • 1.04% of the workforce identify as Lesbian, Gay or Bisexual (LGB)

With our commitment to quality improvement, we have identified the following actions for further investigation and response.

1.1. Workforce Race Equality Standard (WRES)

85.98% of our workforce is White British and 9.7% Black, Asian and Minority Ethnic backgrounds (BAME).

Actions for further investigation:

Recruitment and Selection:
- The proportion of applications received from people who identify as White is 79.60%, and the proportion of successful applicants is 88.20%.
- The proportion of applications received from people who identify as Asian is 6.60%, and the proportion of successful applicants is 2.30%.
- The proportion of applications received from people who identify as Black is 3.50%, and the proportion of successful applicants is 1.50%.

Employee Relations:
- BAME staff are over-represented in being subject to Grievance; Bullying and Harassment and Disciplinary compared to White British staff.
- BAME staff are under-represented in sickness absence.

Employment Banding:
- BAME staff are under-represented at band 6 and above.

WRES
- The Trust will continue to publish WRES data and review our WRES action plan ready for delivery in July 2018. We aim to demonstrate year on year improvements across all WRES metrics.

1.2. Sex

74.14% of our workforce is Female and 25.40% is Male.

Actions for further investigation:

Employee Relations
- We will seek to establish any trends between men and women who have been subject to Grievance, Bullying and Harassment and Disciplinary procedure.

Employment Banding
- The Trust will report on the Gender Pay Gap on 31 March 2018
- Female staff are under-represented from Band 7 and above

1.3. EDS2

Completion of EDS2 summary reports across each Clinical Business Unit will be launched during 2018, pilot grading panels will be undertaken after the reports are generated.

- EDS2 Grading Panels demonstrate our commitment to the public sector equality duty (PSED) we will deliver a strong engagement programme with our patients, families, carers, communities and staff. More specifically, we will engage and involve our patients and people and invite them to have the opportunity to scrutinise our equality performance. This will be based on the completed EDS2 summary reports. Involvement of the voluntary and community sector is crucial to our engagement.

1.4. Equality and Diversity Programmes, Frameworks and Initiatives

- The Trust will closely monitor its response to the Accessible Information Standard; Disability Equality Standard and Time for Change. We will also respond positively to Equality, Diversity and Human Rights Week and key equality and human rights events.

2. Diversity and Inclusion Report 2017/18

We are delighted to introduce our Equality and Diversity Annual Report 2017/18. It gives us the baseline from which we will measure our progress to become an outstanding service provider and an inclusive employer of choice.

This report aims to demonstrate due regard to promote equality of opportunity, foster good relations and eliminate unlawful discrimination. The report provides a demographic profile of our current workforce and information to drive a more focussed approach to identifying and tackling inequality.

The Isle of Wight NHS Trust monitors its workforce against the following protected characteristics:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religious and/or Belief
- Sex
- Sexual Orientation

This report will be presented in three sections.

Section 1
Will introduce our Equality Standard, a nationally awarded framework to integrate equality, diversity and inclusion in everything we do. This includes a rapid assessment of key actions to enable the Trust to respond positively to our legal, regulatory and commissioner requirements to equality and diversity.

Section 2

Presents our response to the Public Sector Equality Duty (PSED) which contains our workforce diversity information.

Section 3
Will present our ‘Next Steps’

Section 1: Equality Standard

The Trust has adopted the Equality Delivery System (EDS2), a national framework developed by NHS England. In response to the requirements of the EDS2, the Trust's new equality and diversity strategic 'Equality Standard' and this report outlines the progress we have made as at 31st May 2018.

The aim of our Equality Standard is to:

- respond positively to the legal, regulatory and commissioner requirements for equality, diversity and human rights;
- meet the requirements of the EDS2, Gender Pay Reporting and WRES (NHS England);
- embed an evidence based equality and diversity strategy with clear governance and reporting structures;
- to embed equality and diversity into everything we do.

These aims have been identified from an appraisal of local and national policies and legislative drivers including the requirements on Trusts to meet the regulatory framework of the CQC well-led domain and other inspection systems that encompass equality and diversity functions.

The summary report below outlines our response in meeting our obligations for equality, diversity and inclusion.

Section 1. Equality Standard Performance Report	
Organisational Values	**Equality Objectives**
We Care.. **We are part of a team..** **We innovate and improve..**	The Equality Standard will champion the values of the organisation at every opportunity and in everything we do. The values are an integral part of defining our culture and being recognised as an inclusive employer of choice. Our equality objectives include: • Excellent Patient Care • Work with others to keep improving our services • A positive experience for patients, service users and staff • Skilled and capable staff • Cost effective, sustainable services
Equality Standard Actions	
Idenfity Executive Lead/s for equality and diversity	The Trust has identified an executive lead for equality and diversity and has responsibility to champion and be accountable for the Equality Standard. The identified executive leads are: • The Director of Workforce, Organisational Development and Communication is the nominated executive lead for equality and diversity. • Diversity and Inclusion is being championed by our Associate Directors of Nursing; one of whom is the clinical lead for the HR and OD "Getting to Good" work stream. • The Deputy Director Medical Director will also champion diversity and inclusion focussing on the medical workforce.
Co-design and launch an equality and diversity strategy	This 2018 strategy embraces the national requirements of the EDS2, Gender Pay and WRES. • Equality Impact Leads (EIL) will be identified across our Clinical Business Units to oversee the implementation of the

	Equality Standard. VOX POP Diversity Champions will be identified to drive the standard at a local level. • A review will take place in September 2018 to prepare actions in response to the findings of the Equal Pay Gap Reporting; Accessible Information Standard and Disability Equality Standard.
Establish governance and reporting arrangements for equality and diversity	HR data is collated across all protected characteristics of the workforce and is reported against employee relations including recruitment and selection and retention throughout the staff journey (employee life cycle). This data is an integral part of our diversity performance and is published annually in response to the Public Sector Equality Duty (PSED). The Trust will complete the EDS2 across each clinical area of the organisation and report annually against the WRES. The Trust positively supports the completion of Equality Analysis on all new policies and those that are being reviewed. The Trust has identified the following committees to monitor and report the performance of equality and diversity: • Equality Impact Group • HR and OD Sub-Committee • Performance Committee • Quality Governance Committee • Trust Board • Patient Experience Group
Delivery of equality and diversity training	The Trust is establishing a multi methods approach to delivering equality and diversity. This includes: • Organisational Induction • E-Learning • VOX POP staff engagement events • Diversity Moments is a series of 10 equality and diversity learning topics that are aimed to be presented at a mainstream business meeting at each clinical division and corporate function. The benefit of Diversity Moments is that it (i) raises operational understanding of equality and diversity; and (ii) demonstrates evidence of mainstreaming equality and diversity across the organisation.
Workforce engagement for equality and diversity	The Trust will establish staff network groups with equality and diversity an integral part of their function. A number of engagement events are delivered throughout the year which focuses upon the key objectives and outcomes of the EDS2, WRES and NHS Staff Survey • Diversity calendar of events to celebrate diversity and inclusion and embed equality for all. • VOX POP – Diversity Champions • Health and Wellbeing Champions • Patient Experience Champions
Identify risk and assurance	Active management of the Trusts statutory obligations through the delivery of the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES). The Trust Board has recognized that its diversity and inclusion is an area of high risk for the organisation. An action plan has been developed to address the Board's concerns. The Risk Register will be

	used to monitor progress to ensure the risk to the organisation is significantly reduced by March 2019.
Legal implications	The Trust has quality, safety and operational obligations related to Equality and Diversity, both for patients and staff. • Equality Act 2010 • Human Rights Act 1998
Regulatory and commissioner requirements	• CQC Domains • NHSI • SC13 – NHS Standard Contract

Section 2: Introduction of a Workforce Diversity Scorecard

2.1. Introduction

Supporting individual differences helps every member of staff reach their own potential and contributes to the delivery of the Trust's vision and values. To do this we need to have an in-depth understanding of the effect of our workplace cultures, policies, practices and procedures on our workforce and people who use our services.

Collating and analysing data on our staff by protected characteristics (Workforce Diversity Scorecard) provides a good starting point to develop this understanding. It provides us with an evidence base to identify any differences in outcomes for groups protected by the Equality Act 2010.

We have published this report because, under the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees." [2]

We also have a duty to "publish information relating to persons who share a relevant protected characteristic who are other persons affected by its policies and practices."[3]

The public sector equality duty, which came into force on 5 April 2011, was created by the Equality Act 2010 in order to harmonise the race, disability and gender equality duties and extend protection to the new protected characteristics of age, sex, gender re-assignment, pregnancy and maternity, religion or belief and sexual orientation. There is now a requirement for public bodies to publish:

- equality objectives, at least every four years
- equality information to demonstrate their compliance with the equality duty at least annually.

[2] Equality Act 2010 (Specific Duties) Regulations [2011] para 2(4)a.

[3] Equality Act 2010 (Specific Duties) Regulations [2011] para 2(4)b.

2.2. Workforce Diversity Scorecard

This data is based on staff employed at Isle of Wight NHS Trust as at 31 December 2017.

Staff In Post as at 31.12.17	Sum of Headcount	Sum of FTE
Total	3579	2713

The Equality Standard was launched in 2014 as a positive response to meet the requirements of the EDS2. A work programme was designed and implemented to improve workforce equality monitoring across all protected characteristics of the workforce.

2.3. Age

- Isle of Wight NHS Trust has 100% workforce reporting to Age
- The largest age group employed at Isle of Wight NHS Trust is 46-55 (30.32%)
- The number of staff employed between the ages of 16-25 is 6.76%

Table 1. Workforce by Age

Age Group	Sum of Headcount	Percentage of Total
16-25	242	6.76%
26-35	657	18.36%
36-45	773	21.06%
46-55	1085	30.32%
56-65	719	20.09%
66 and above	103	2.88%
Grand Total	3579	100.00%

Table 2. Recruitment and Selection by Age

Age Band (NHS JOBS)	Total Applicants	%	Total Shortlisted	%	Total Appointed	%
Under 20	137	**1.70%**	59	**1.80%**	7	**1.50**
20-24	1004	**12.60%**	349	**10.90%**	48	**10.10**
25-29	1337	**16.70%**	461	**14.30%**	72	**15.20**
30-34	892	**11.20%**	344	**10.70%**	64	**13.50**
35-39	755	**9.40%**	286	**8.90%**	41	**8.70%**
40-44	873	**10.90%**	397	**12.40%**	56	**11.80%**
45-49	1007	**12.60%**	446	**13.90**	60	**12.70%**
50-54	976	**12.20%**	419	**13%**	58	**12.30%**
55-59	669	**8.40%**	307	**9.60%**	49	**10.40%**
60-64	298	**3.70%**	126	**3.90%**	16	**3.40%**
65-69	28	**0.40%**	9	**0.30**	2	**0.40%**
70+	16	**0.20**	10	**0.30**	0	**0%**
Undisclosed	1	**0%**	0	**0%**	0	**0%**
Total		**100%**		**100%**		

Table 3. Leavers by Age

Age Group	Total Sum of Headcount	Percentage of Total	Leavers as a % of total workforce
16-25	242	6.76%	1.8%(65)
26-35	657	18.36%	3.8%(139)
36-45	773	21.06%	2.5%(90)
46-55	1085	30.32%	3.0%(109)
56-65	719	20.09%	4.3%(156)
66 and above	103	2.88%	1.0%(36)
Grand Total	3579	100.00%	

2.3.1. Actions for further analysis and response (2018/19)

Our workforce information by age tells us:

- we have an ageing workforce
- The impact of age on recruitment and selection show a slight under-representation in appointments from 16-39 and a slight over-representation from 40-70+. However, this does require further analysis including a statistical significance test.
- Leavers are over-represented in the 16-25 age range
- A key action is to undertake further analysis to identify the involvement of age groups in employee relations and employment banding.

Key issues to consider about the ageing workforce (NHS Employers)

- Research has shown that many older workers report feeling undervalued and not respected by managers and their co-workers.
- Managing a multi-generational team where more staff are older will require managers and organisations to adopt a more flexible approach to work organisation, task management and rotas/shifts.
- Organisations need to be prepared for the fact that, just like the communities they serve, their workforce will experience ill health, impairment and disabilities. Retaining staff with these lived experiences can be beneficial to organisations as their understanding can enhance patient care.
- Flexible working, including different or set work patterns, has been proven in recruitment and retention strategies.
- Attracting, retaining and developing a millennial workforce is a priority action for our equality and diversity plan. We have already started to ‘re-brand’ the Trust as an a “great place to work”. Recruitment and Retention Ideas generated at a Workforce Summit in April 2018 will feed to the revised HR and OD strategy.

2.4. Disability

- Isle of Wight NHS has 75% workforce reporting to Disability
- 2.68% of the workforce have declared 'yes' to disability.
- Recruitment and Selection for people who have declared 'Yes' to disability is positive in regard to application received and appointed.

Table 1. Workforce by Disability

Disability	Sum of Headcount	Percentage of Total
No	1728	48.30%
Not Declared	1039	29%
Prefer Not To Answer	3	0.1%
Undefined	715	20%
Yes	94	2.68%
Grand Total	3579	100%

Table 2. Recruitment and Selection by Disability

Disabled	Total Applicants	%	Total Shortlisted	%	Total Appointed	%
No Not Declared	7476	**93.50%**	2986	**92.90%**	442	**93.40%**
Undefined	141	**1.80%**	54	**1.70%**	5	**1.10%**
Yes	375	**4.70%**	173	**5.40%**	26	**5.50%**
Total		**100%**		**100%**		**100%**

Table 3. Employee Relations by Disability

Diversity Scorecard	Employees who have reported they have a disability	Employees who have not reported a disability
Workforce (3579)		
Grievance	2	35
Bullying and Harassment	0	4
Disciplinary	2	52
Sickness Absence	3	146
Leavers	1	598

Table 4. Employment Banding by Disability

Diversity Scorecard	Headcount with a disability
Workforce (3579)	
Band 1 and 2	22
Band 3	13
Band 4	9
Band 5	28
Band 6	30
Band 7	6
Band 8a to 8d	3
Band 9	0
Medical workforce from FY1 to Consultant	2

2.4.1. Actions for further analysis and response (2018/19)

- The Trust will raise the importance of workforce and patient equality monitoring.
- Further analysis will be undertaken to identify the involvement of staff declaring 'yes' to disability and being subject to a grievance.
- Staff who declare 'yes' to disability are under-represented at Band 8a and above.
- The Trust anticipates the proposed Disability Equality Standard (DES) will be a challenge; we have a good foundation to work from. We have been recognised as a Mindful Employer, supporting staff with mental health problems. The Trust has recently been recognised as a champion for patients and staff with a disability by achieving the Disability Confident Leader accreditation and shows people with a disability, we are committed to improving the experiences of patients and staff.

2.5. Marriage and Civil Partnership

The Isle of Wight NHS Trust has 97.65% workforce reporting to Marital and Civil Partnership Status

Table 1. Workforce by Marriage and Civil Partnership

Marital Status	Sum of Headcount	Percentage of Total
Civil Partnership	41	1.13%
Divorced	308	8.46%
Legally Separated	72	1.98%
Married	1983	54.45%
NULL	25	0.69%
Single	1114	30.59%
Unknown	61	1.67%
Widowed	38	1.04%
Grand Total	3246	97.65%

2.4.1. Actions for further analysis and response (2018/19)

- The Trust will investigate the impact of marital and civil partnership status on recruitment and selection; employee relations and employment banding.

- The Equality Act 2010 says an employer must not discriminate against you because you're married or in a civil partnership. Further work will be undertaken to identify how services are responding to the needs of people who are married or in a civil partnership in the design, delivery and evaluation of services..

2.5. Race

- Isle of Wight NHS Trust has 95.05% workforce reporting to Race
- 85.98% of the workforce is White British
- 9.7% of the workforce is BAME

Table 1. Workforce by Race

Race	Sum of Headcount	Percentage of Total Workforce
A White - British	2924	81.70%
B White - Irish	27	0.80%
C White - Any other White background	126	3.50%
D Mixed - White & Black Caribbean	7	0.20%
E Mixed - White & Black African	4	0.10%
F Mixed - White & Asian	8	0.20%
G Mixed - Any other mixed background	21	0.60%
H Asian or Asian British - Indian	41	1.10%
J Asian or Asian British - Pakistani	8	0.20%
K Asian or Asian British - Bangladeshi	2	0.10%

L Asian or Asian British - Any other Asian background	125	3.50%
M Black or Black British - Caribbean	5	0.10%
N Black or Black British - African	20	0.60%
P Black or Black British - Any other Black background	5	0.10%
R Chinese	6	0.20%
S Any Other Ethnic Group	51	1.40%
Undefined	15	0.40%
Z Not Stated	182	5.10%
Grand Total	3579	100.00%

Table 2. Recruitment and Selection by Race

Ethnic Origin	Total Applicants	%	Total Shortlisted	%	Total Appointed	%
Asian	530	**6.60%**	145	**4.50%**	11	**2.30%**
Black	282	**3.50%**	94	**2.90%**	7	**1.50%**
Mixed	109	**1.50%**	20	**1.10%**	3	**0.60%**
Other	137	**1.70%**	37	**1.20%**	1	**0.20**
Unknown/ Not Stated	147	**1.80%**	79	**2.50%**	22	**4.70%**
White	6362	**79.60%**	2680	**83.40%**	417	**88.20%**
Total	7567	**100.00%**	3055	**100.00%**	461	**100.00%**

Table 3. Employee Relations by Race

Diversity Scorecard	White British	BAME (including White Irish and White Other Background)	BAME (excluding White Irish and White Other Background)
Workforce (3579)			
Grievance	33		5
Bullying and Harassment	0		4
Disciplinary	2		52
Sickness Absence	3		146
Leavers	462	137	109

Table 4. Employment Banding by Race

Diversity Scorecard	White British		BAME (excluding White Irish and White Other Background)	
Workforce (3579)	Clinical %	Non-Clinical %	Clinical %	Non-Clinical %
Band 1	0			
Band 2	86.8	84.7	6.9	7.3
Band 3	92.1	93.7		0.8
Band 4	93.3	96.1	2.6	1.2
Band 5	73.1	97.5	20.7	0
Band 6	92.3	100	4.1	0
Band 7	90	91.5	5	4.3
Band 8a	98.4	100	0	0
Band 8b	94.1	93.3	0	0
Band 8c	100	100	0	0
Band 8d	50	87.5	0	0
Band 9	0	0	0	0
Medical Workforce	117	0	85	0

N.B variances are attributed to staff who do not wish to disclose their ethnicity

2.5.1. Actions for further analysis and response (2018/19)

- Our workforce race equality performance must improve. We will identify key actions contained within a WRES action plan that will be underpinned by engagement at all levels of the organisation.

- We will design and deliver a strong staff engagement programme that aims to (i) understand the experience of BAME people within our organisation; and (ii) undertake a review of BAME recruitment and selection, involvement of BAME in employee relations and identifying any potential barriers to career development and progression.

- The Trust has identified that BAME are significantly under-represented at Band 6 and above with the exception of non-clinical band 8d.

2.6. Religion and Belief

- Isle of Wight NHS Trust has 69.35 % workforce reporting to Religion or Belief
- 41.83% of the workforce identifies their religion/belief with Christianity

Table 1. Workforce by Religion or Belief

Religion and/or Belief	Sum of Headcount	Percentage of Total
Atheism	330	9.22%
Buddhism	12	034%
Christianity	1497	41.83%
Hinduism	19	0.53%
I do not wish to disclose	1097	30.65%
Islam	22	0.61%
Jainism	1	0.03%
Judaism	1	0.03%
Other	271	7.57%
Sikhism	1	0.03%
Undefined	328	9.16%
Grand Total	3579	100%

Table 2. Recruitment and Selection by Religion or Belief

Religious Belief	Total Applicants	%	Total Shortlisted	%	Total Appointed	%
Atheism	1347	**16.90%**	561	**17.50%**	91	**19.20**
Buddhism	51	**0.60%**	15	**0.50%**	0	**0%**
Christianity	4036	**50.50%**	1689	**52.60%**	261	**55.20%**
Hinduism	131	**1.60%**	36	**1.10%**	5	**1.10%**
I do not with to disclose religion/ belief	947	**11.80%**	407	**12.70%**	60	**12.70%**
Islam	285	**3.60%**	60	**1.90%**	1	**0.20%**
Jainism	1	**0%**	1	**0%**	0	**0%**
Judaism	2	**0.10%**	2	**0.10%**	0	**0%**
Other	1184	**14.80%**	439	**13.70%**	55	**11.60**
Sikhism	8	**0.10%**	3	**0.10%**	0	**0%**
Total	7992	**100.00%**	3213	**100.00%**	473	**100.00%**

2.6.1. Actions for further analysis and response (2018/19)

- The Trust will investigate the impact of religion or belief status on employee relations and employment banding. This will be incorporated and analysed for statistical significance within the WRES action plan.

- Initial analysis of recruitment and selection data does show a negative impact in applications received to appointments for the following categories: Hinduism; Islam; Jainism; Sikhism and Other.

2.7. Sex

- Isle of Wight NHS Trust has 100% workforce reporting to Sex
- 74.30% of the total workforce is female
- 25.70% of the total workforce is male
- Isle of Wight NHS Trust monitors the representation of Women on Board and will respond positively to the requirements contained with Equal Pay Gap Reporting (31 March 2018)

Table 1. Workforce by Sex

Gender	Sum of Headcount	Percentage of Total
Female	2658	74.30%
Male	921	25.70%
Grand Total	3579	100%

Table 2. Recruitment and Selection by Sex

Gender	Total Applicants	%	Total Shortlisted	%	Total Appointed	%
Male	1954	24.40%	735	22.90%	99	20.90%
Female	6004	75.10%	2456	76.40%	367	77.60%
Undisclosed	34	0.40	22	0.70%	7	1.50%
Total	7992	100%	3213	100	473	100%

Table 3. Employee Relations by Sex

Diversity Scorecard	Female	Male
Leavers	427	169

2.7.2. Actions for further analysis and response (2018/19)

- We will investigate the involvement of males subject to a disciplinary. We will triangulate with Race to identify any trends in data sets.

- We are unable to provide a breakdown of employee relation cases by pay band/grade. This report will be developed during 2018.

2.8. Sexual Orientation

- Isle of Wight NHS Trust has 62.23% workforce reporting to Sexual Orientation
- 61.62% of the workforce identify their sexual orientation as Heterosexual
- 1.01% of the workforce identify as Lesbian, Gay or Bisexual (LGB)

Table1. Workforce by Sexual Orientation

Sexual Orientation	Sum of Headcount	Percentage of Total
Bisexual	6	0.17%
Gay	19	0.53%
Heterosexual	2191	61.61%
I do not wish to disclose my sexual orientation	1023	28.58%
Lesbian	11	0.31%
Undefined	329	9.19%
Transgender	0	0
Grand Total	3579	100%

Table 2. Recruitment and Selection by Sexual Orientation

Sexual Orientation	Total Applicants	%	Total Shortlisted	%	Total Appointed	%
Bisexual	80	**1%**	18	**0.60%**	1	**0.20%**
Gay	77	**1%**	31	**1%**	5	**1.10%**
Heterosexual	7294	**91.30%**	2932	**91.30%**	428	**90.50%**
I do not wish to disclose sexual orientation	497	**6.20%**	208	**6.50%**	37	**7.80%**
Lesbian	44	**0.60%**	24	**0.70%**	2	**0.40%**
Total	7992	**100.00%**	3213	**100.00%**	473	**100.00%**

2.8.1. Actions for further analysis and response (2018/19)

1. The Trust will investigate the impact of sexual orientation status on recruitment and selection; employee relations and employment banding.

Section 3 Next steps 2018-19

1. The Trust will undertake a full analysis of workforce data by protected characteristics and address gaps in reporting as specified in the report.

2. The Trust will respond positively to workforce equality requirements such as Gender Pay Gap reporting; Disability Equality Standard; Accessible Information Standard; Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2).

3. The Trust will publish EDS2 Summary reports completed by our clinical divisions

4. The Trust will pilot a programme of EDS2 Grading Panels (April- August 2018) with a full launch (September 2018-March 2019).

Enc F

Agenda Item No	9	**Meeting**	Trust Board in Public	**Meeting Date**	7 June 2018
Title	Local Care Plan Report				
Sponsoring Executive Director	Darren Cattell, Director of Finance				
Author(s)	Nicola Longson – Programme Director, Isle of Wight Local Care System Rachael Knight – Programme Governance Manager				
Report previously considered by inc date	Operational Delivery Group – 26 April 2018 Local Care Board – 10 May 2018 Trust Leadership Committee – 16 May 2018				

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 Well Led Domains			
Effective	X	Responsive	X
Caring	X	Well-led	X
Safe	X		

Executive Summary

The Local Care Plan Programme Summary Report provides an overview of key progress and risks/issues against the six initiatives within the Local Care Plan.

The overall Programme status is currently Red, indicating that key milestones are behind schedule and there are significant issues to delivering agreed outcomes. The Red/Amber/Green rating of each initiative is broken down within the report. Further development of programme reporting is underway to ensure delivery of impact is reported alongside delivery of key milestones.

The key messages from Local Care Board meeting on 12 April are detailed as Appendix A.

The report was considered by the Trust Leadership Committee on 16 May 2018 and areas of concern will be communicated back to the Local Care Board.

Key Recommendation

The Trust Board is asked to consider the following recommendation:

- To receive the update on the Local Care Plan Programme and to receive limited assurance on the status of the Programme.

Programme Overall Status

Red

✓ Key progress in reporting period

Local Care Plan Governance Review
An independent assessment of progress made with the set up and delivery of the six LCP initiatives and the six System Enabling Groups and a brief analysis has been carried out.

Acute Service Redesign:

- Trust Board Seminar 1st March 2018 – NICU papers were presented in the private section. A recommended start date for the Neonates project will be made in May 2018 during the next neonatal network meeting.
- STP PMO meeting was held to discuss shared working possibilities with the Solent Acute Alliance, resources from the IW & SAA are limited, and a resource and funding allocation plan has been drafted by Sarah Turner.
- IW Specialty meetings started in March, project documentation has been started to be built in Paediatrics, Neonates and Maternity. Other specialties are still in the scoping process.
- Overall ownership of programme governance was agreed to be led by the IW System-wide Transformation Team allocated resource. These projects are being supported by an overall Solent Acute Alliance Workforce and Resilience Clinical Leadership Group, chaired by Tim Cotton, Medical Director, Hampshire and IOW STP. Reporting into the ASR Programme are these 4 projects;
  - IW Digital Maturity Project
  - Communications & Stakeholder Engagement

! Risks/issues for escalation

Local Care Plan Governance Review

- CSR & Mental Health Core management documentation not yet in place due to programme scope changes – will be in place by end of April 2018
- Communication Plans not signed-off, due to limited support provided through the System Comms & Engagement function
- Completion of all Logic models and reporting of Tier 3 indicators not yet complete
- Work is underway to review Hospital to Home to ensure embedded in Trust Transformation work
- Enabling group charters and delivery plans are behind schedule. Urgent action required

Acute Service Redesign:

- **ISSUE: Media handling and communications** –A more sustainable approach and capacity for handling of the overall staff and public communications and engagement plan from 1st March is urgently required. **Mitigation** – Current external communications consultant to be extended until June ’18. Request further escalation with system to ensure prioritised and issue mitigate.
- **ISSUE: Digital Maturity** project needs to progress at a quicker pace to enable the IT changes that will be identified in clinical pathways as part of the Workforce and Resilience 14 workstreams. **Mitigation -** The Digital (IT) group

- Modelling workstream project
- Cross Solent Travel Improvement Project

Co-ordinated Access:

Implementation of New Integrated Urgent Care Pathway:

- PID's work completed to enable inclusion of data for KPI's
- Meetings, for GP appointment booking pilot for both in hours and out of hours held around System One technical interoperability

Redesigned Urgent Care Floor (Urgent Care Treatment Centre, Ambulatory Care etc.):

- Meeting completed with providers, commissioner and project team to confirm joined up vision of programme and identify potential challenges
- AEC sub project group commenced, estate works slightly delayed

Community Service Re-design:

- Community rehab ward decommissioning plan agreed
- Recruitment of Community Rehab staff progressing
- Frailty screening has been rolled out in the Ambulance Service
- Referral process in place for localities case review meetings
- 2 out of 3 GP Practices agreed contract for Primary Care engagement into Localities model of care
- Mental health representative linked to Integrated Localities
- Further TEC rollout in the community – 15 care/nursing homes across island in total now
- West and Central Locality base identified and work began to make fit for purpose
- 1/3 GP Practices implementing agreed processes for referral to Integrated Locality Case Review Meetings

have been asked to prioritise in line with the workstream project timelines.

- **ISSUE: Resourcing issue** –There is a need for a Business Intelligence role to analyse McKinsey's data and map the activity figures to the number of transfers for Emergency & Elective Surgery & Urology. Until this activity data is ready the SAA will not go forward with these projects. **Mitigation** ODG informed due to risk of local programme if this resource no available. A resource funding paper has been written and shared with the SAA to request a bid for extra resource to allow the progression of the projects.

Co-ordinated Access:

- **ISSUE:** Trust restructure - Internal restructure in Trust impacting on leadership and delivery. **Mitigation:** ODG asked for confirmation of Exec lead for this initiative

ODG DECISION 40:

The group agreed NT to be Executive Sponsor for Coordinated Access Programme

Community Service Re-design:

- **ISSUE:** Recruitment delays for Community Rehabilitation staff due to lengthy recruitment processes. **Mitigation**: Requested support from Trust HR to streamline recruitment process (I.e. submit in bulk and fast track recruitment – 04/01/18 and 15/02/18 ODG meetings). Original escalation route through System Workforce enabling group has not helped to progress this. Direct request to Director of HR (Trust) via ODG to enable rapid recruitment.

- Alliance Agreement communication drafted

Hospital from Home:

- Hospital to Home Gap Analysis completed on 20/03/18 in preparation of next steps/phase 2 of programme.
- Trust Assessors meeting held on 16/03/18 with CCG Nursing Home Lead. Agreed to work collaboratively in the development of Trusted Assessor roles within the acute setting.
- Inpatient Clinical Pathway Workshop held on 07/03/18 focusing on Gold ward rounds and discharge processes. Hosted by Clinical Improvement Director.
- H2H Roadshow Comms Plan in place for 19/04/18 event - publicity has started via Trust E-Bulletin & Team Brief.
- ECIP PDSA & SAFER Training booked and - Key stakeholders attended for 11/04/18 training workshop.
- Discharges to Assess pathways discussions have been held with the CCG Team to support the implementation of D2A Pathways across the Trust.
- iBCF Funding for year two of the programme has been agreed.

Mental Health Transformation:

- MH Blueprint wider stakeholder engagement at Community Mental Health Service workshops, through Service User T&F Group
- Mood and Anxiety Pathway workshop held with positive outcomes
- The final workshop (red) for Community Mental Health Services took place on 21st March 2018. The outputs are being collated and this will be reported next month.
- Steering group held and governance agreed for Transforming

ODG ACTION 174:

Community Service Redesign - Recruitment of Rehabilitation staff delayed. NL to discuss with EP.

ACTION UPDATE:

03/05/18 - NL - discussion took place. Some delays with regard to budget availability to support requirement. EP discussing with Finance and will escalate if still a problem on 11/5/2018 to B Stuttle.

Hospital to Home:

- **ISSUE:** Culture & behaviours - no ward level nursing, medical and therapy engagement and accountability, impacting roll out of SAFER and associated Length of Stay indicators. **Mitigation:** Trust taking ownership of scheme to ensure leadership and accountability is in place. Support being received from ECIP
- **ISSUE:** Capacity of Trust Information Systems Team to build and support roll out of electronic Patient Admission form on E care Logic. **Mitigation:** Currently liaising with Information Systems Manager to understand resource requirements.

ODG ACTION 173:

Hospital to Home - NT to provide update/more detail regarding capacity of Trust Information Systems Team to build and support roll out of electronic Patient Admission form on E care Logic.

ACTION UPDATE:

27/04/18 - NT - significant capacity issues in IM at present causing delays. However team speaking to Trust H2H link and are in a position to start working up the form - estimated completion is July 18.

Dementia and Older Persons Mental Health

- Dementia strategy refresh commenced
- Proposal paper for future contracting model for Re-provision of MH Rehabilitation and Reablement Services under development.

Transforming Learning Disabilities:

- Draft Action plan completed with stakeholders to support delivery of the Commissioning Strategy
- Launch of PA Market place held on the 22/3/2018 100+ individuals attended the launch
- PA Notice Board linking accredited PA's with potential went live 26/03/2018
- Project plan completed and reporting to the Task & Finish Group
- First (HOLD) Home Ownership for people with Long Term disability, Property identified and decision to purchase taken.
- Draft plan completed for development and delivery of an integrated health and social care team, bringing together Learning disability team in health and social care.
- Project team expanded to include additional MDT health staff.

- **ISSUE:** Medworxx Implementation delayed due to review of existing internal IT system opportunities, delay negatively impacting the monitoring of flow within Trust. **Mitigation:** Funding with Trust and Trust required to confirm by 1st July if progressing with this.

Mental Health Transformation:

- **RISK:** Resourcing of Housing Officer not confirmed. Without funding there will be no progression of review and development of Housing Market project within programme. **Mitigation:** ODG considering funding allocations at 26/04/18 meeting.

Transforming Learning Disabilities:

- No risks or issues identified for escalation to ODG.

Programme Overall Status – initiative status (delivery of key milestones)	Red

Initiative	RAG
Acute Service Redesign	Amber
Community Service Redesign	Red
Mental Health Transformation	Green

Initiative	RAG
Co-ordinated Access	Amber
Hospital to Home	Red
Transforming Learning Disabilities Care	Amber

RAG status criteria:

B Multiple key milestones are significantly behind schedule. Sponsor identified significant risk to outcomes being achieved

R Key milestones behind schedule (30+ days) /significant issues to delivering agreed outcomes

A Key milestones within 30 days of schedule/ work underway to address delays

G Key milestones completed/project on schedule

APPENDIX A

Local Care Board – 12 April 2018

Stakeholder Engagement

The Board considered a comprehensive report from Eve Richardson (Stakeholder Group Chair) on the Island's approach to health and care stakeholder engagement. The feedback highlighted poor engagement on the development of the Local Care Plan with some pockets of good engagement identified around the Acute Service Re-design programme.

The group discussed the ongoing misunderstandings around 'My Life a Full Life' with some stakeholders on the Island. The Group recognized 'My Life a Full Life' as a model of care developed by public sector staff, voluntary sector and the public to shape future Island service provision. Examples of service changes over recent 3 years to support the shift to the 'My Life' model of care are varied for example Care Navigation and Local Area Co-ordination.

The Board agreed that the existing Stakeholder Group should cease and further consideration on the best way to engage stakeholders would be carried out. This work is fundamentally linked to the role and function of the system Communications & Engagement Group which will be led by the Council going forward. The Board also discussed some of the existing channels of communication e.g. website and social media and how these need to be linked with the Health and Wellbeing Board.

A&E Delivery

The LCB continued to receive their regular update as the A&E Delivery Board. A&E performance remains inconsistent with sustained good performance unlikely whilst Acute Bed Occupancy levels remain above 95%. The Board recognised that all partner organisations have worked more effectively together throughout this Winter to ensure a speedy recovery from any escalation in pressures. However, increased levels of pressure continue to cause 1-2 days of significantly poor performance followed by 2-3 days of recovery.

The Board agreed key actions are required to manage the high levels of stranded and super stranded patients with over 50% of acute beds filled with patients with a Length of Stay over 7 days, and over 20% of hospital beds filled with patients who have been in hospital over 21 days. The Board recognised the need for system leaders to review the challenges around super stranded patients and this will be a focus of discussion at the next meeting on 10/05/18. The Board also received their regular update on performance with Delayed Transfers of Care (DTOC) highlighted as performing well.

Alliance Working

The group received a brief update on the progress made with alliance contracting, specifically, the final Alliance Working Group meeting (29/03/18), where discussions too place on the governance arrangements for the operational management of the alliance contract moving forwards. The group wished to feedback the following points to Local Care Board:

- Need to make the alliance work part of day job and create capacity by stopping doing things that are no longer important or a priority.
- Celebrate the progress made on delivery, joint working and behaviors through this work and to learn from this to help drive change.
- Essential to ensure we use the alliance engine to drive future transformation and not continue to manage services in alliance through existing and more traditional routes (both contract management and operational management of services)

It is envisaged that the Alliance Contracting 'Heads of Agreement' will be signed off by all parties next week.

Logic Modeling

The Local Care Plan initiatives have been working through a 'logic modeling' process to help the system Finance Group to quantify the benefits of the transformational changes underway. The Board received an update on progress and committed to continue with this work to help quantify future quality, performance and financial impact of the local care plan initiatives.

Future meetings

As from April, the cycle of Local Care Board meetings has changed. The Board now meets once a month in its usual format; the second meeting is a wider seminar with the members of the Operational Delivery Group to discuss issues in more depth. The topics for the next three seminars are:

- 19th April - Part 1: Integrated Care Systems; Part 2: Digital.
- 17th May – Part 1: Early Help & Well Being; Part 2: Winter Plan Wash-up.
- 21st June – Part 1: Workforce; Part 2: CQC Local System Reviews.

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Agenda Item No	10.1	**Meeting**	Trust Board in Public	**Meeting Date**	7 June 2018
Title	Quality Report				
Sponsoring Executive Director	Barbara Stuttle CBE, Interim Director of Nursing Suzanne Rostron, Director of Quality Governance Steve Parker, Interim Medical Director				
Author(s)	Suzanne Rostron, Director of Quality Governance Judy Dyos, Interim Deputy Director of Nursing Quality Governance Team PIDS team				
Report previously considered by inc date	This paper has not been considered at any other Committee but provides highlights from reports received at the Quality Committee and its Sub-Committees.				

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 Well Led Domains			
Effective	X	Responsive	
Caring	X	Well-led	X
Safe	X		

Executive Summary

Key areas of activity to note this month include:

- Quality Strategy Indicator Dashboard has now been developed.
- There are 39 Serious Incidents overdue for submission to the CCG
- There have been 34 inquests involving the Trust since the last Board report
- The National Inpatient Survey is scheduled to be published on the 18 June 2018
- Work has commenced on linking the CQC inspection report findings to the key priorities within the Quality Strategy.
- CQC reports were expected to be published on the 6 June 2018.
- Nursing teams across Acute, Community and Mental Health services have been working on a clinical standards

Key Recommendation

The Committee is asked to consider the following recommendations:

- Decide if sufficient assurance has been received in relation to the issues raised in the Quality Report

Quality Report
Trust Board
June 2018

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' has started evolving to reflect the appropriate amount of information at each level of the Quality Committee structure. The Sub-Committees receive more detailed information and interrogate thematic and trend analysis. The extent of this will improve as new processes become 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 Report

The Quality Strategy Indicator Dashboard has now been developed to support the more generic Quality Dashboard. The Quality Committee reviewed both sets of dashboards as 'works in progress'. The data for April had not yet been included or the targets for 2018/19. Areas within the Strategy that would not have baseline data (due to not being collected in the past) were acknowledged.

The cycle for Quality Reporting to the Board and the Quality Committee is detailed in the table below. This allows for the need for a shorter Quality Committee in the month that Assurance, Risk and Compliance Committee also meets.

Report	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Trust Quality Dashboard	✓			✓		
Trust Quality Strategy Dashboard		✓			✓	
Division Quality Dashboard		✓			✓	
Division Quality Strategy Dashboard			✓			✓

4. Serious Incidents

4.1 New incidents reported

23 serious incidents were declared to the Isle of Wight Clinical Commissioning Group (CCG) during April 2018.

In May, up to 23 May 2018, 9 incidents had been declared.

A detailed summary of the incidents reported and 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 Immediate actions taken

The 23 incidents reported in April all had an initial review via 72-hour report; immediate actions were identified to mitigate risk. These included:

- ☐ Regular safety huddles introduced to support staff in clinical area
- ☐ Clinical supervision need identified and implemented
- ☐ Plan to check daily on patient's whereabouts when outlier on different ward
- ☐ Calls audited following incident
- ☐ Safety checks of work carried out
- ☐ Adoption of BMJ best practice guidelines
- ☐ Erroneous code on system removed
- ☐ Immediate validation of patient list to ensure no-one at risk
- ☐ Escalation of incident to Trust Board
- ☐ Links with mainland colleagues to share findings/learning
- ☐ Immediate feedback to Agency when agency staff involved in incident
- ☐ Review of escalation issues reviewed by senior medical leads

4.3 New incidents reported in May (up to 23.05.18)

Division	Clinical Business Unit	Number reported	SI type/subject
Acute	Surgery, Women's & Children's Health	**1**	• Delay in treatment
	Medicine (including ED & MAU)	**6**	• Patient fall (Appley) • Patient fall (Compton) • Delay in treatment (General Medicine) • Medication issue (Appley) • Issues with naso-gastric tube (Emergency Dept) • Care of deteriorating patient (MAU)

	Clinical Support, Cancer & Diagnostics	**1**	• Issues with intubation (Theatres)
	Mental Health & Learning Disabilities	**1**	• Patient self-harm (community mental health)

4.4 Ongoing Serious Incident Management

Of the 12 cases submitted to the IW CCG for closure in April, 50% were submitted 'in-time', which is an improvement on last month.

For year 2018/19 so far, the following is a list, by clinical business unit, of those cases that were submitted for closure in-time, out of time or subsequently downgraded by the CCG following submission of evidence that they no longer meet with SI framework criteria for reporting.

CLINICAL BUSINESS UNIT	Number out of time	Number in-time	Numbers downgraded ⇩
Surgery, Women's, Children's	**1**	**2**	1
Medicine	**5**	**2**	2
Clinical, Cancer & Diagnostics	**3**	**2**	1
Ambulance, Urgent Care, Community	**7**	**5**	4
Mental Health & Learning Disabilities	**3**	**1**	0

4.3 Serious Incident Performance

Key Performance Indicators (KPI) against the SI process were agreed when the new process was implemented in October 2017.

The chart below demonstrates the KPI status across all CBUs, and May is subject to adjustment.

Criteria being measured	Apr-18	May-18
New SIs reported in month	23	9
SI **reported** in 2 working days (of awareness)	14	5
% in 2 working days	61%	56%
72-hour report **completed** in 3 working days	10	7
% in 3 working days	43%	78%
How many reports included immediate actions	19	5

The stats below demonstrate the KPI of reporting an SI within 2 working days, by area

	Apr-18	May-18
Trajectory %	80%	80%
Acute	60%	44%
Ambulance	0%	-
Mental Health	100%	100%
Community	100%	-

KPI – how many final reports submitted for closure within 60 working days (individual areas)

	Apr-18	May-18
Trajectory %	60%	60%
Acute	40%	78%
Ambulance	100%	-
Mental Health	0%	0%
Community	100%	-

KPI – 72-hour report completed within 3 working days (individual areas)

There are a total of 85 current cases being managed through the SI process; 39 are overdue for submission to the CCG. Of those overdue, 3 were subject to non-closure by the CCG and further information was requested.

Those overdue cases are listed below, by clinical business unit.

CLINICAL BUSINESS UNIT	Number OVERDUE
Surgery, Women's, Children's	9
Medicine	8
Clinical, Cancer & Diagnostics	2
Ambulance, Urgent Care, Community	12
Mental Health & Learning Disabilities	6
Corporate services	0

The oldest case should have been completed in November 2017 but is overdue because it is being investigated by an external investigator. This case remains incomplete.

As reported last month, it was identified that there was an element of over-reporting. This has been discussed at the twice weekly incident review meetings; it was acknowledged that incidents still needed reviewing, where appropriate, to gain assurance in relation to patient safety, but that if they don't meet the SI criteria they could be done under the heading of "local reviews"; escalation and sharing of learning would still need to be evidenced and this

will be done either via the incident review meetings (for escalation) or submission to the patient safety sub-committee for shared learning.

5. Inquests

The Trust has been liaising with the Coroner and her team to streamline the inquest process. The historic poor performance with Serious Incidents has had an impact on the timeliness of inquests. New processes have been introduced to bring together the functioning of the whole of the Patient Safety Team to prioritise investigations that involve an unexpected death. Links to the mortality review process are also being established.

Since the last report to the Board, there have been 34 inquests involving the Trust. A summary of these is provided in the private board papers.

6. National Inpatient Survey

The National Inpatient Survey is scheduled to be published on the 13th June 2018. The next Quality Report to the Board will contain the benchmarking information that this provides. Quality Health, who co-ordinate the survey on behalf of the Trust, presented to a group of senior nurses and the Quality Team on the 15th May 2018 to enable improvements required to be linked to the Quality Strategy and for work to commence in time to impact for the next survey.

The key areas identified included:

- Discharge (this links with the Right Patient work stream in the Quality Strategy)
- Patient Information throughout the patient pathway
- Medication information on discharge and knowing who to contact with any concerns
- Confidence in clinical staff, particularly doctors
- Communication

Quality Health is able to analyse the data at different levels of Acute services; this option is being explored. The areas where the Trust was in the bottom 20% of trusts will be used in local surveys to help the Patient Experience Sub-Committee track progress.

7. Quality Strategy

Work has commenced on linking the CQC inspection report findings to the key priorities within the Quality Strategy. Updates will be provided on all priorities following the end of Quarter 1. These will be published on the 'getting to good' website following receipt at the Board, Quality Committee and appropriate Sub-Committee.

One of the main focuses during Quarter 1 has been developing quality strategies, which are aligned to the Trust strategy, for each of the 4 services (Acute, Ambulance, Community and Mental Health). These strategies will be presented to the Division Quality Committees during June and July 2018 and included in the Quarter 1 update report to the Quality Committee. Once finalised, the quality strategy dashboard will be amended for each Division. This data, along with the Trust-wide dashboard, will be made available via the 'getting to good' website.

8. CQC Reports

At the time of writing, the CQC reports were expected to be published on the 6 June 2018. Assuming that this has taken place, there will be a presentation to the Board summarising the CQC's findings and detailing the Trust's response to date.

A Quality Summit will be held on the 27th June 2018 to showcase some of the excellent work and improvements that have taken place since the inspection in January 2018. Whilst the Trust faces many challenges to make the required improvements at pace, it is important to celebrate the success and hard work of our dedicated staff.

9. Clinical Standards

Nursing teams across Acute, Community and Mental Health services have been working on a clinical standards setting project looking at service specific core domains of care. Three workshops have run, with a further two booked for June. There are also plans to undertake a patient engagement event to seek patient views on what standards of care to expect within the core domains. Through consultation with the nurses, it has been agreed that these standards should be presented as "always events" with a patient facing booklet describing what this means for their care. A launch of the "Always care " is planned for July 2018. A full report will be presented to the July Quality Committee.

10. 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.

Suzanne Rostron	**Barbara Stuttle CBE**	**Mr Steve Parker**
Director of Quality Governance	**Interim Director of Nursing**	**Interim Medical Director**
May 2018	**May 2018**	**May 2018**

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Agenda Item No	10.3	Meeting	Board in Public	Meeting Date	7 June 2018
Title	Safe Staffing Report for the Period April 2018				
Sponsoring Executive Director	Barbara Stuttle Director of Nursing, Midwifery, AHPs and Out of Hospital Services				
Author(s)	Emily Mullan Clinical Lead for eRostering and SafeCare				
Report previously considered by inc date	Quality Committee 6 June 2018				

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	
Achieve excellence in employment, education and development	X
Lead strategic change on the Isle of Wight	

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

Executive Summary

This report provides an overview of staffing levels and gives details of issues that have arisen and points of note.

Due to necessary building work within the mental health units, additional staff are currently deployed on every shift to maintain patient safety, which has increased the establishment fill rate.

Recording of daily acuity and dependency has commenced via the implementation of the SafeCare tool. Twelve wards are currently live recording the current inpatients acuity and dependency three times a day, to generate a 'Care Hours per Patient per Day' score. This score is measured against staffing available hours to ensure safe staffing levels are attained.

The monthly average fill rates for day shifts (Registered Nurses) in April showed four wards rated as red (less than 90% fill rate); two amber (90-94.9% fill rate), six green (95-100% fill rate) and eight purple (above 100%). For night shifts, two wards were red, none amber, eight green and ten purple. Further details (including Healthcare Assistant fill rates) are contained within the body of this report.

Sickness across almost all areas has increased, and there are only two wards with less than 3% sickness in April; compared with eleven wards in March. There has also been a slight decrease in mandatory training attendance.

Vacancies currently remain high but there have been positive responses to current recruitment.

A three year strategy for managing workforce is being developed and establishment meetings have been held to review current staffing and identify opportunities to realign Registered Nurse care hours to Healthcare Assistant care hours in line with staffing recommendations.

The SafeCare project is now live, with acuity and dependency data being entered three times a day on 12 wards. The current challenge with this is in embedding it into everyday practice.
NHSI commenced phase 2 of supporting effective rostering and this work is ongoing. A senior nurse has been working with Human Resources and Nursing to support effective use of temporary staffing and reduce agency usage across inpatient areas.

A decision has been made to reduce agency float by 9.3 WTE (350 hours per week) due to reduced patient acuity and dependency post winter pressures.

Key Recommendation

The Board is asked to receive this report

Safe Staffing Levels Report
April 2018

1. Overview

Nurse staffing levels are monitored daily at the 08:30 operational meeting by Managers of the Day, Matrons, Ward Sisters and the Clinical lead for e-Rostering using SafeCare. Staffing is risk assessed and agency and substantive staff are redeployed as required to ensure staffing levels are as safe as possible across the wards. A daily staffing report is emailed out to all Ward Sisters, Matron's, Heads of Nursing and Temporary Staffing outlining the daily staffing position, including any areas for concern and actions for the next 24hrs. Any emergency staffing issues occurring are managed by Ward Managers, Matrons and Temporary Staffing using SafeCare to review staffing levels and redeploy staff as appropriate.

See Appendix A - Unify average fill rate data for each ward and quality and safety indicators.

1.1 Total hours planned is our planned staffing levels to deliver care for each area. This is based on our current establishment and rota templates.

1.2 **Enhanced Care (1 to 1 care)**
A number of patients require specialist nursing care, i.e. for those patients with dementia. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over 100% fill rate as additional shifts will have been added to the template. 1 to 1 requirement is managed in this way as it is challenging to predict when enhanced care will be required.

1.3 **Security Shifts due to building work**
Due to necessary building work within the mental health units additional staff are currently employed on every shift to safeguard patient safety this has increased the establishment fill rate.

1.4 **Acuity and Dependency Monitoring (SafeCare)**
Recording daily acuity and dependency has commenced via the implementation of the SafeCare tool. Twelve wards are currently live recording the current inpatients acuity and dependency three times a day to generate a Care Hours per Patient per Day score. This score is measured against available staffing hours to ensure safe staffing levels

1.5 **CHPPD**
(Care Hours Per Patient Day) is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period - this will vary across wards and departments based on the specialty and type of care required. Both Registered Nurses and HCA staff care hours are include in the calculation. This data is included in the safe staffing report and is benchmarked online via The Model Hospital allowing comparison to Trust of similar makeup to Isle of Wight NHS Trust

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2 Monthly Data

2.1 The monthly average day shift fill rate of registered staff for April shows four ward areas had red ratings (less than 90% fill rate), two had amber (90-94.9% fill rate), six achieved green (95-100%) and eight achieved purple (above 100%) . The four areas that were rated red: ITU due to unfilled vacancies and above average sickness and maternity leave. The Stroke Unit due to above average sick leave, Colwell due to unfilled vacancies and Coronary Care Unit due to unfilled vacancies and sickness.

2.2 The monthly average night shift fill rate of registered staff for April shows two ward areas had red ratings (less than 90% fill rate), none had amber (90-94.9% fill rate), eight achieved green (95-100%) and 10 achieved purple (above 100%). The two areas that were rated red: Paediatric Ward additional registered staff not required due to low acuity and dependency and ability for staff to flex between NICU and Paediatric Ward. Appley rated red due to unfilled vacancies and high level of sickness.

2.3 The monthly average day shift fill rate of HCA staff for April shows five ward areas had red ratings (less than 90% fill rate), two had amber (90-94.9% fill rate), four achieved green (95-100%) and nine achieved purple (above 100%). The five areas that were rated red: Shackleton, Maternity, NICU, Medical Assessment Unit, and Compton due to unfilled vacancies and sickness.

2.4 The monthly average night shift fill rate of HCA staff for April shows two ward areas had red ratings (less than 90% fill rate), two had amber (90-94.9% fill rate), seven achieved green (greater than 94.9%) and nine achieved purple (above 100%). The two areas that were rated red: Appley due to unfilled vacancies and ITU due to roster template and establishment differences which will be rectified in June with the revised establishments.

2.5 Long lines of agency nurses continue to be booked for Mental Health Wards, Medical Wards, Surgical Wards and Medical Assessment Unit during April. This has enabled vacancies to be filled in a planned way, so that whilst vacancy rate is high, wards are not depleted to an unsafe position. Agency nurse requests are scrutinised at Executive level and are also reviewed on a daily and weekly basis to ensure that wards maintain safe staffing levels without being overstaffed.

2.6 Sickness across almost all areas has increased. There are only two wards rated green for sickness in April (less than 3%) in March there were eleven wards rated green.

2.7 There has been a slight decrease of Mandatory Training attendance with seven wards rated green (above 80%) in April compared to eight in March. Ward Managers continue to be challenged in being able to ensure staff can achieve not only mandatory training but also additional training for competencies and improving practice, or for quality improvement initiatives.

2.8 Vacancy rates at the time of reporting remain high however there have been positive responses to current recruitment. With applications from student nurses gaining their registered nurse qualification in September.

See Appendix B- Current Vacancy Rates

2.9 In April our CHPPD indicates we have provided over 5 care hours per patient per day across all areas this may be a result of patient acuity and dependency. Some areas showed extremely high CHPPD levels, these are predominantly specialist areas where higher staffing levels are mandated.

3 Summary of actions in progress

3.1 The three year strategy for managing nursing workforce is in progress; this details the recommendations for the organisation to take forward which include utilsing new roles and apprenticeship models. We are also looking to provide additional HCA staff to support 1 to 1 care.

3.2 Establishment meetings have been held with with the Director of Nursing, Interim Deputy Director of Nursing, Finance Lead, Head of Nursing, Matron and Ward Sister. These meetings reviewed current establishments and identify the opportunity to realign RN care hours to HCA hours in line with staffing recommendations. The new acute wards and paediatric ward establishments were approved at Trust Leadership Committee on 16/05/18 these will go live in June 2018.

3.3 Weekly Roster meetings have been established by the Assoiciate Director of Nursing, Matrons, Sisters and eRostering Team in order to monitor and review adherence to the policy and process for rostering. This includes reviewing a series of Key Performance Indicators (KPIs) as recommended in The Carter Review (2016) these KPI's include;

- **KPI 1** Headroom and usage of annual leave, study leave, sickness, maternity leave and other leave

- **KPI 2** 6 week roster approval rates

See Appendix C - KPI 2 6 week roster approval rates

- **KPI 3** Lost contracted hours not used per month (unused hours)

Unused hours are currently under review with the plan out to consultation, a decision will be made on existing unused hours by the next board meeting

- **KPI 4** Additional shifts and reasons for booking

- **KPI 5** Working restrictions

- **KPI 6** Auto-roster percentage enabled

Actions going forward will be to ensure shift patterns are EU working time directive compliant in order healthroster system to safely auto- roster.

- **KPI 7** Number of bank requests to the total bank hours worked

- **KPI 8** Number of bank requests on weekend and night duties

3.4 The SafeCare project is now live with acuity and dependency data being entered three times a day on Appley, Colwell, Luccombe, CCU, Afton, The Stoke Unit, Compton and Children's Ward, St Helen's, Alverstone, Mottistone and Whippingham. With plans to go live with ITU and NICU once appropriate acuity and dependency tools have been identified. There remain multiple gaps on SafeCare data entry therefore the data is not currently operational.

Current Challenges – embedding the three times a day acuity and dependence data gathering (census periods) into everyday working practice. Progress has already been seen in May.

Current Actions – education, weekly roster meetings, one to one support for ward managers and ward walks

See Appendix D – SafeCare report

3.5 NHSi commenced Phase 2 of supporting effective eRostering this work is ongoing with further meetings in June 2018

3.6 A senior Nurse has been working with Human Resources and Nursing to support effective use of temporary staffing and reduce agency use across inpatient services.

3.7 Decision made to reduce agency float by 9.3wte (350 hours) a week commencing 28/05/18. This is a Safe Staffing decision due to reduced patent acuity and dependency post winter pressures.

Barbara Stuttle
Director of Nursing, Midwifery, AHP's and Out of Hospital Services

Prepared by:
Emily Mullan
Clinical Lead for eRostering and SafeCare

Appendix A - Unify average fill rate data for each ward and quality and safety indicators

Apr-18	Day		Night		Care Hours Per Patient Day (CHPPD)								
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative count over the month of patients at 23:59 each day**	**Registered midwives/ nurses**	**Care Staff**	**Overall**	**Sickness**	**Mandatory Training**	**Falls with any harm**	**Pressure Ulcers (new reported)**	**Medication Errors**
SHACKLETON	107.9%	74.3%	103.1%	101.8%	196	6.2	8.9	15.1	5.1%	74%	0		**0**
SEAGROVE	119.9%	106.4%	103.3%	131.7%	174	12.1	11.0	23.1	5.0%	79%	0		**0**
OSBOURNE	92.5%	100.4%	95.6%	103.5%	476	4.1	3.6	7.7	5.2%	81%	0		**0**
AFTON	95.1%	104.6%	97.9%	100.7%	244	7.1	6.0	13.1	3.7%	95%	0		**0**
WOODLANDS	95.2%	90.5%	100.4%	96.8%	213	7.5	3.3	10.8	8.9%	79%	0		**0**
ALVERSTONE	128.3%	96.0%	120.4%	185.7%	406	4.8	2.5	7.3	11.3%	72%	1	0	**2**
LUCCOMBE	110.9%	161.2%	100.0%	145.5%	670	3.4	4.1	7.5	4.7%	62%	2	4	**0**
MOTTISTONE	107.3%	101.8%	100.3%		259	6.3	1.8	8.2	9.5%	85%	3	0	**0**
ST HELENS	108.8%	100.3%	100.0%	103.3%	387	4.3	2.9	7.2	0.3%	86%	2	0	**0**
WHIPPINGHAM	98.0%	104.1%	100.0%	97.8%	770	3.5	2.7	6.2	7.3%	78%	6	1	**0**
PAEDIATRIC WARD	96.0%	113.7%	82.2%	93.3%	167	13.8	4.4	18.2	5.9%	75%			
MATERNITY	93.4%	88.1%	104.7%	101.0%	157	18.7	11.2	29.9	2.4%	73%			**1**
NEONATAL INTENSIVE CARE UNIT	119.4%	77.7%	98.9%	90.0%	50	40.9	12.4	53.3	9.5%	78%			**0**
MEDICAL ASSESSMENT UNIT	112.0%	77.3%	120.8%	96.7%	310	11.5	6.1	17.6	4.0%	82%	4	3	**0**
STROKE	84.8%	98.8%	96.7%	121.7%	656	4.1	3.2	7.3	7.7%	81%	3	1	**1**
COMPTON	96.8%	87.5%	147.0%	100.0%	918	2.9	2.5	5.5	9.7%	76%	0	0	**1**
COLWELL	80.7%	109.0%	107.8%	100.0%	798	3.3	2.7	6.0	6.7%	76%	2	1	**0**
APPLEY	94.0%	90.1%	81.1%	88.0%	833	3.1	2.5	5.6	10.7%	82%	4	1	**3**
INTENSIVE CARE UNIT	84.0%	95.2%	101.7%	65.2%	129	36.9	3.2	40.1	5.5%	88%	0	4	**0**
CORONARY CARE UNIT	80.7%	99.9%	97.1%	93.1%	463	7.3	2.0	9.4	7%	78%	1	4	**6**
	95% - 100% fill rate	90% - 94.9% fill rate							as per	as per	0	0	
	<90% fill rate	>100% fill rate							quality	quality	2	2	
									dashboard	dashbaord	>2	>2	

Appendix B- Current Vacancy Rates

Row Labels	Sum of YTD Funded WTE	Sum of In Month Contract WTE	Sum of Variance
Additional Clinical Services	**228.38**	**207.36**	**21.02**
Afton Ward (clusters 8, 10-17)	11.6	10.6	1
Alverstone Ward	7.46	5.56	1.9
Appley Ward (Newchurch)	14.34	11.96	2.38
Colwell Ward	18.01	14.91	3.1
Compton Ward	18.63	16.71	1.92
General Theatre	14.63	14.5	0.13
Luccombe Ward	14.14	13	1.14
MAAU	12.08	13.11	-1.03
Maternity Services	18.59	18.26	0.33
Mottistone Suite	2.8	2.8	0
Neonatal	5.59	5.6	-0.01
Osborne Ward (clusters 8, 10-17)	11.95	11.6	0.35
Paediatric Ward	4.98	6.98	-2
Seagrove Ward (clusters 8, 10-17)	15.13	12.93	2.2
Shackleton (clusters 19-21)	11.75	10.93	0.82
St Helens Ward	14.74	8.33	6.41
The Stroke Unit	13.56	12.79	0.77
Whippingham Ward	12.67	11.66	1.01
Woodlands (clusters 12-13)	5.73	5.13	0.6
Nursing and Midwifery Registered	**389.94**	**308.55**	**81.39**
Afton Ward (clusters 8, 10-17)	15	13.99	1.01
Alverstone Ward	13	11.2	1.8
Appley Ward (Newchurch)	23.12	11.4	11.72
Colwell Ward	22.71	15.27	7.44
Compton Ward	21.4	13.67	7.73
General Theatre	35.64	32.87	2.77
Luccombe Ward	19.3	10.8	8.5
MAAU	28.3	21.8	6.5
Maternity Services	41.91	40.68	1.23
Mottistone Suite	12.95	9.62	3.33
Neonatal	13.22	17.14	-3.92
Osborne Ward (clusters 8, 10-17)	17.4	14.8	2.6
Paediatric Ward	22.5	19.43	3.07
Seagrove Ward (clusters 8, 10-17)	14.07	11.66	2.41
Shackleton (clusters 19-21)	11.6	9.4	2.2
St Helens Ward	18.37	11.76	6.61
The Stroke Unit	23.22	17.73	5.49
Whippingham Ward	22.83	16.8	6.03
Woodlands (clusters 12-13)	13.4	8.53	4.87
Grand Total	**618.32**	**515.91**	**102.41**

Appendix C - **KPI 2** 6 week roster approval rates

Row Labels	Cost Centres to approve	Cost Centres Approved	% of CBU Approved
470 2Ambulance, Urgent Care & Community Services Business Unit	5	2	40.00%
470 2Clinical Support, Cancer & Diagnostic Services Business Unit	4	3	75.00%
470 2General Medicines Business Unit	4	1	25.00%
470 2Mental Health & Learning Disability Business Unit	5	1	20.00%
470 2Surgical & Women & Child Health Services Business Unit	8	8	100.00%
Grand Total	**26**	**15**	57.69%

Report ran on 21/5/2018

This includes roster bars;
27/5/2018 - 23/6/2018 and
24/6/2018 - 21/7/2018

On Sunday 13/5/2018 the roster's should be available (fully approved) for the whole period upto 21st July 2018.

There are **15 Rosters** fully approved.

Row Labels	Cost Centres to approve	Cost Centres Approved
470 2Ambulance, Urgent Care & Community Services Business Uni	**5**	**2**
Accident & Emergency J61230	1	0
MAAU J61231	1	1
North East Wight District Nurses J62549	1	1
South Wight District Nurses J62527	1	0
West & Central Wight District Nurses J62548	1	0
470 2Clinical Support, Cancer & Diagnostic Services Business Unit	**4**	**3**
Coronary Care J61190	1	1
Intensive Care Unit J61120	1	1
Endoscopy Unit J61127	1	0
Day Surgery Ward J61124	1	1
470 2General Medicines Business Unit	**4**	**1**
Appley Ward J61250	1	0
Colwell Ward J61254	1	0
The Stroke Unit J61221	1	0
Compton Ward J61226	1	1
470 2Mental Health & Learning Disability Business Unit	**5**	**1**
Afton Ward J61794	1	0
Seagrove Ward J61916	1	1
Shackleton J61791	1	0
Woodlands J61913	1	0
Osborne Ward J61915	1	0
470 2Surgical & Women & Child Health Services Business Unit	**8**	**8**
Alverstone Ward J61111	1	1
Luccombe Ward J61112	1	1
Maternity Services J61500	1	1
Mottistone Suite J61090	1	1
Neonatal Intensive Care Unit J61520	1	1
Paediatric Ward J61372	1	1
St Helens Ward J61102	1	1
Whippingham Ward J61101	1	1
Grand Total	**26**	**15**

Creating Roster	Approving Roster	
Roster Name (First day of 4 week roster)	Date Partially Approved (8 weeks prior)	Date Fully Approved (6 weeks prior)
04 March 2018	07-Jan-18	21-Jan-18
01 April 2018	04-Feb-18	18-Feb-18
29 April 2018	04-Mar-18	18-Mar-18
27 May 2018	01-Apr-18	15-Apr-18
24 June 2018	29-Apr-18	13-May-18
22 July 2018	27-May-18	10-Jun-18
19 August 2018	24-Jun-18	08-Jul-18

Appendix D – SafeCare report

Ward name	SafeCare Live	Data collection three times a day	Pier scoreing supervsion
SHACKLETON	no	no	no
SEAGROVE	no	no	no
OSBORNE	no	no	no
AFTON	yes	yes	no
WOODLANDS	no	no	no
ALVERSTONE	yes	no	no
LUCCOMBE	yes	no	no
MOTTISTONE	yes	no	no
ST HELENS	yes	no	no
WHIPPINGHAM	yes	no	no
PAEDIATRIC WARD	yes	no	no
MATERNITY	no	no	no
NEONATAL INTENSIVE CARE UNIT	no	no	no
MEDICAL ASSESSMENT UNIT	no	no	no
STROKE	yes	no	no
COMPTON	yes	no	no
COLWELL	yes	no	no
APPLEY	yes	no	no
INTENSIVE CARE UNIT	no	no	no
CORONARY CARE UNIT	yes	no	no

Enc I

Agenda Item No	11	**Meeting**	Trust Board in Public	**Meeting Date**	07 June 2018
Title	Workforce Performance Report May 2018				
Sponsoring Executive Director	Julie Pennycook, Director of HR & OD				
Author(s)	Mark Elmore – Deputy Director HR				
Report previously considered by inc date	Performance Committee May 2018				

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	
Achieve excellence in employment, education and development	X
Lead strategic change on the Isle of Wight	X

Link to CQC Well Led Domains			
Effective	X	Responsive	X
Caring		Well-led	X
Safe			

Executive Summary

Headlines from this report are:

- Total fte staffing level is under budgeted establishment by 76 FTE, although costs are higher than budget due to use of agency.
- Workforce profile and recruitment planning is underway to address workforce deficits
- Good progress in recruitment activity to reduce vacancies and corresponding use of Bank & Agency staffing
- We are making solid progress on filling our medical vacancies. The number of vacancies has fallen since April from 35 to currently 28 vacancies and we are confident that further appointments will be made in the coming months. Notable successes have been the appointment to consultant posts in Emergency Medicine, Paediatrics, Radiology, Respiratory Medicine.
- Agency usage has exceeded the NHSI ceiling due in the main to medical and nursing resources required to cover for vacancies and higher acuity and additional activity.
- Trust sickness absence rate: 4.64% in month (increase from March sickness of 4.48%). Top reasons for absence: Anxiety, Stress & Depression was the highest % reason for sickness absence Trustwide in April, even with a decrease of 7.28%. Back Problems and Other Musculoskeletal Problems both showed a reduction in month of 20% and 13% respectively.Staff Turnover has decreased to 9.49% (rolling 12 months)
- Following the introduction of a Physiotherapy referral service for staff by Occupational Health, we

have seen a decrease in staff absent from work with MSK related issues.

- Mandatory Training compliance has remained at 80% against a target of 85%.
- Data Security Awareness (Information Governance) compliance has maintained at 86%
- Physical Assaults information is provided to PIDS and is available to the Board through their reports, supplied from Corporate Governance Department.

Appendix A: Recruitment & Retention Update attached

Key Recommendation

The Board is asked to receive the report.

WORKFORCE PERFORMANCE REPORT

1. Workforce Information

Month 1 Summary

	Actual	Funded Establishment	Vacancies
Staff In Post (FTE)	2722 ↓	3024	302 ↑
Temporary staff (FTE)	226 ↓		
Total	2948 ↓		76 ↑

The Trust employs 3143 substantive full and part time staff, some 400 bank workers with additional support provided by 300 volunteers. The increase in headcount from 3129 last month reflects a number of part–time workers starting to work within the Trust.

Tables 1 & 2 show that whilst staffing levels are under budgeted establishment, costs are in excess due to the high cost of agency and in particular medical staffing. Action is underway to recruit more substantive staff and offer long term agency doctors employment with the Trust.

2. Recruitment and Retention

The interim workforce strategy describes the challenging environment that we, as a health care employer, operates and sets out our overarching aims to improve the recruitment and retention of staff. The attached table (appendix 1) summarises the action we have taken since the beginning of the year to actively improve the recruitment and retention of permanent staff and also improve the cost-effective supply of temporary workers from local specialist staffing agencies and our own internal staff bank.

Temporary staff, many of whom have worked in health care for many years, are a vital addition to our permanent workforce. They help meet staffing needs, often at short notice, as well as respond to peaks in patient workload. Temporary staff are subject to the same employment checks as permanent staff and will always be an essential part of our workforce.

Our staffing priorities have been, understandably, medical and nursing staff although many of the initiatives have wider application.

We are making solid progress on filling our medical vacancies. The number of vacancies has fallen since April from 35 to currently 28 vacancies and we are confident that further appointments will be made in the coming months. Notable successes have been the appointment to consultant posts in Emergency Medicine, Paediatrics, Radiology, Respiratory Medicine.

The nursing workforce has remained largely stable during the last 12 months but we know we must do more to retain staff and promote the Isle of Wight as a great place to work and live. We have seen some modest success with a recent recruitment initiative with some 15 prospective nurse candidates attending for a follow up visit to the Trust on 02 June 2018 for an open day/interviews. We plan to follow up this with other initiatives later in the year. We are currently launching dedicated IOW job sites through Facebook, LinkedIn and Instagram to promote and advertise jobs and are also actively looking at international recruitment. This has been a successful source of nursing staff previously and we will decide in June whether to pursue another overseas initiative. Table 1 shows current inpost FTE figures for Medics and Nursing Staff against the submitted Workforce plan. Table 2 shows Starters and Leavers for Medics & Nursing throughout 17/18. There is a spike of leavers in March 18, which is expected from the end of Fixed Term contracts. Changes have been made to the format of the e-termination form which will give us greater level of detail for the leaving reason, enabling us to focus our efforts in encouraging individuals to stay in the appropriate areas.

Table 1

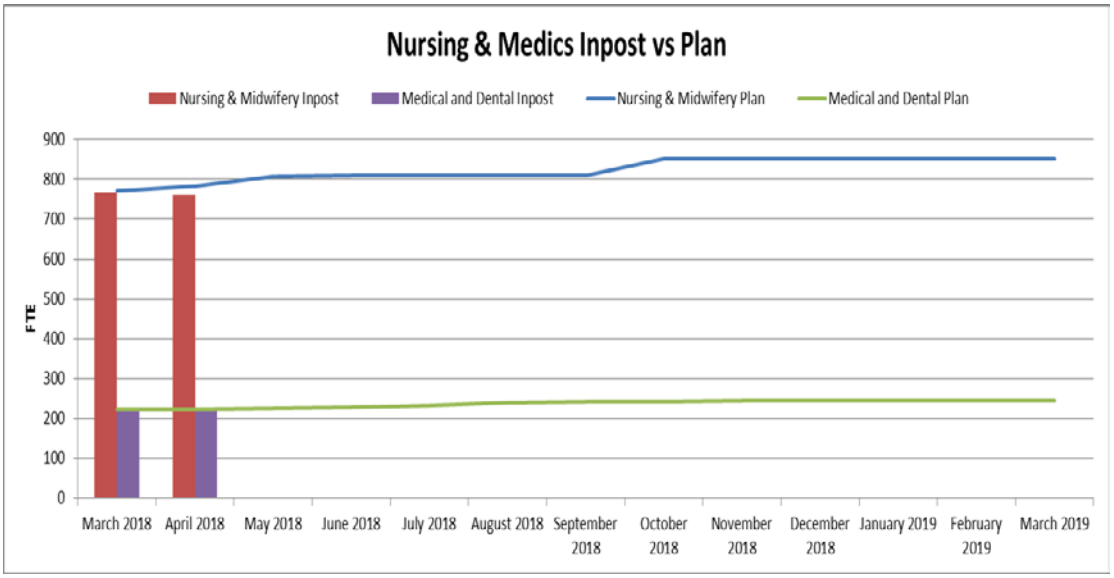
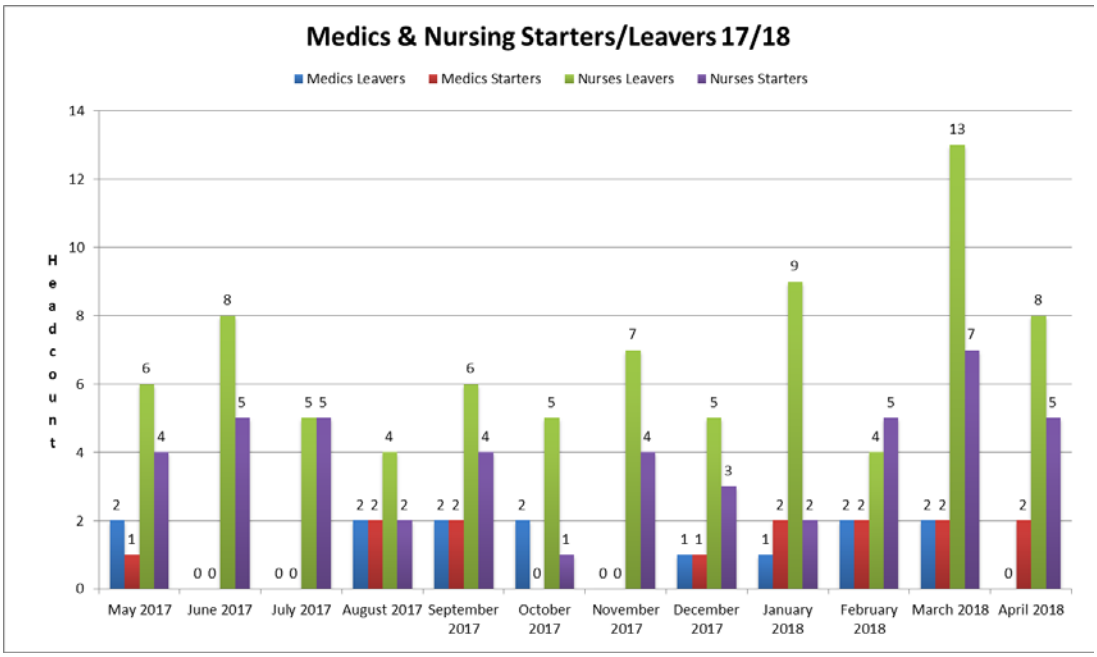


Table 2



We also recognise the need to improve how we manage recruitment and temporary supply and we recently employed a former Matron of the Trust, to work with HR and the wards to review every aspect of our management of nurse staffing rosters, vacancies and temporary workers.

These initiatives and our success must be seen within the wider context of cultural change and improvement. In addition to improving our systems we must provide a positive working environment and great career opportunities for staff and build a public reputation, as both a place to work and to live, that makes the Isle of Wight a compelling career option.

As part of our culture work we hosted a workforce summit where staff from all levels and across all services within the Trust were invited to contribute their ideas about what more we can do to improve our reputation, job opportunities and ability to attract and retain staff. The summit was a great afternoon and many great ideas came forward. The outputs are currently being worked into the Workforce Strategy.

The recent staff survey results underlined the work that is needed to improve our reputation and eliminate the causes of staff dissatisfaction. 'Getting to Good' is our best chance of recruiting and retaining staff.

Table 3 shows the changes in funded establishment, substantive staffing and temporary staffing over the past 18 months. Table 4 shows monthly budget vs pay costs for the past 18 months.

Table 3

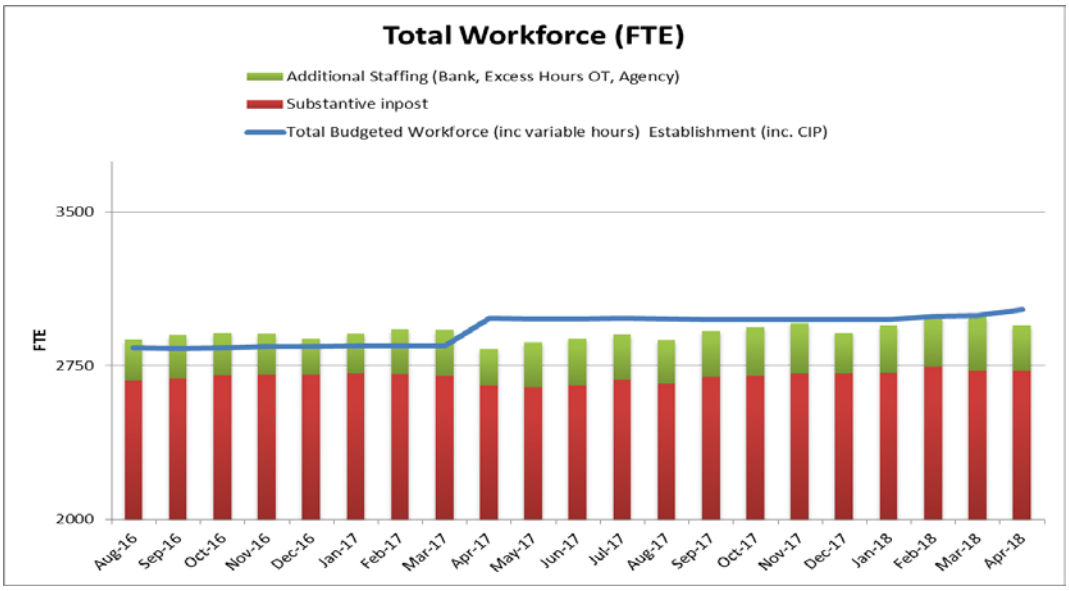
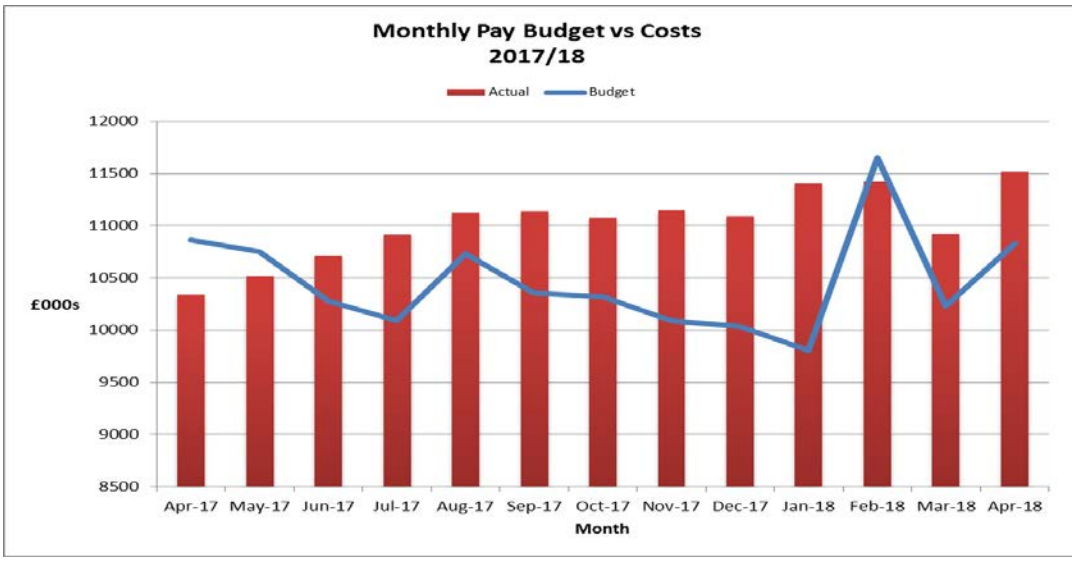


Table 4



3. Agency Information

Continued Agency usage in month was predominantly to cover medical posts and continued cover for nursing vacancies. Medical and nursing usage in month remains high in MH/LD. Outcomes of revised Workforce Controls has resulted in changing the skill mix of agency floats in nursing and will result in a saving of c£1m to the Trust in the current financial year – 2018/19. The outcomes of the establishment reviews will be uploaded onto the rostering system and take effect from the 1st June 2018. We are currently in the process of tendering for a Master Vendor for the provision of nurses. Once a supplier has been awarded the contract will go live from 02 July 2018.

Agency Use: Breakdown of agency staff groups actual spend:

Table 5

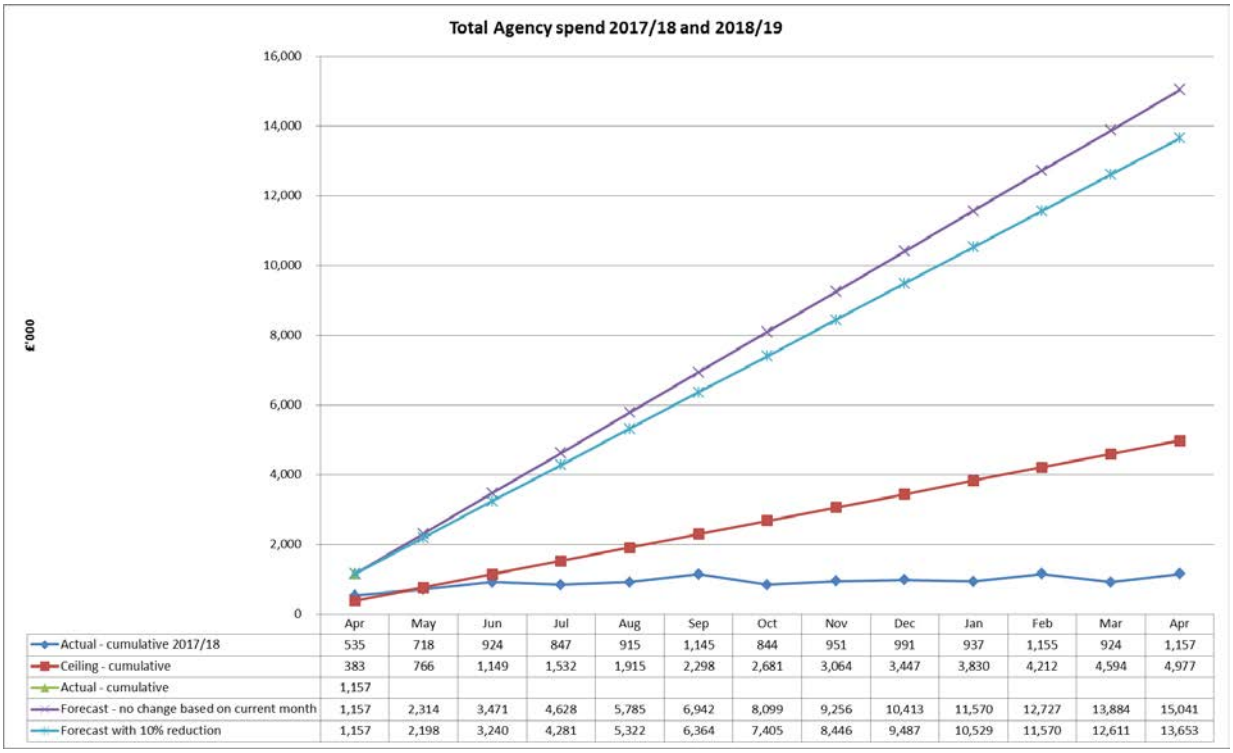
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical	475												475
Nursing	633												633
Clinical	(0)												(0)
Administration	27												27
Other	22												22
Total spend - month	1,157												1,157
Total spend - cumulative	1,157	1,157	1,157	1,157	1,157	1,157	1,157	1,157	1,157	1,157	1,157	1,157	
Ceiling - month	383	383	383	383	383	383	383	383	383	383	382	382	
Ceiling - cumulative	383	766	1,149	1,532	1,915	2,298	2,681	3,064	3,447	3,830	4,212	4,594	
Variance to ceiling	774												774

Highest users of Medical Agency staff continue to be General Medicine and Psychiatry Adult. Highest users of non-Medical Agency staff continue to be Mental Health & Acute Nursing.

Agency Use: Breakdown of agency staff groups FTE and cost:

Staff Group	Monthly Hours	Monthly Cost £000	Weekly FTE
Consultant	1144	£132k	7.15
Specialist Registrar	345	£26k	2.16
Core Trainee/ST1&2 (formally SHO)	536	£33k	3.35
Nursing	11,639	£633k	77.59
TOTAL	**13,664**	£824k	90.25

4. Compliance with NHSi Agency Ceiling



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Actual - cumulative 2017/18	535	718	924	847	915	1,145	844	951	991	937	1,155	924	1,157
Ceiling - cumulative	383	766	1,149	1,532	1,915	2,298	2,681	3,064	3,447	3,830	4,212	4,594	4,977
Actual - cumulative	1,157												
Forecast - no change based on current month	1,157	2,314	3,471	4,628	5,785	6,942	8,099	9,256	10,413	11,570	12,727	13,884	15,041
Forecast with 10% reduction	1,157	2,198	3,240	4,281	5,322	6,364	7,405	8,446	9,487	10,529	11,570	12,611	13,653

We recognise the importance and urgency of managing downwards our use and costs of agency staffing. We have introduced a range of measures but the focus must be to strengthen substantive and in-house Bank staffing. Our priority remains maintaining safe staffing levels.

5. Sickness

Trust sickness absence rate: 4.64% in month (increase from March sickness of 4.48%). Top reasons for absence: Anxiety, Stress & Depression was the highest % reason for sickness absence Trustwide in April, even with a decrease of 7.28%. Back Problems and Other Musculoskeletal Problems both showed a reduction in month of 20% and 13% respectively.

Following the introduction of a Physiotherapy referral service for staff by Occupational Health, we have seen a decrease in staff absent from work with MSK related issues. This is highlighted in Table 8.

Table 6

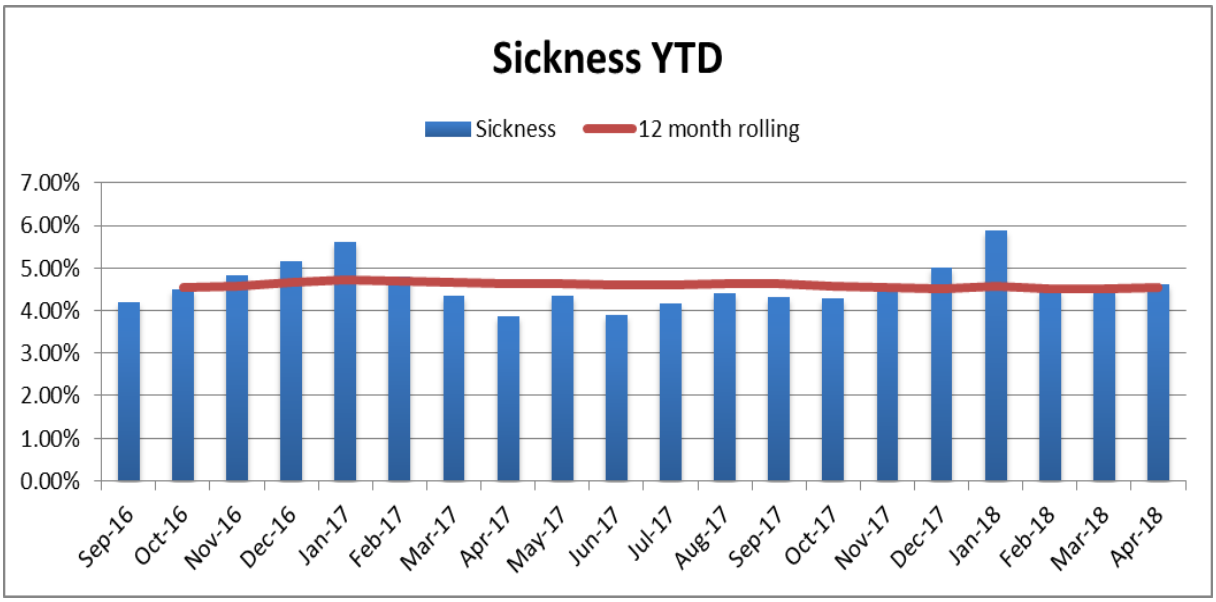
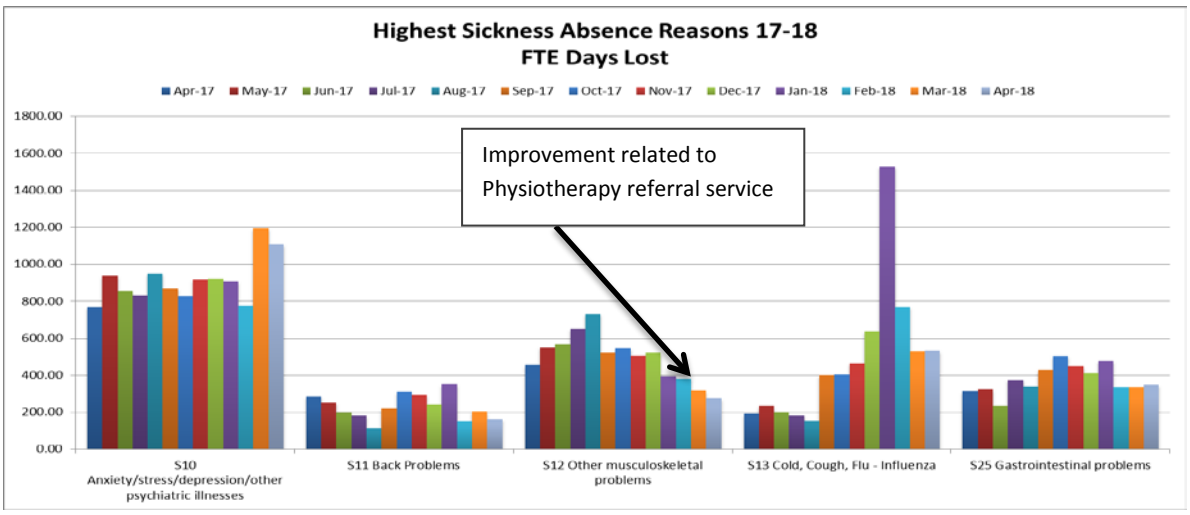


Table 7

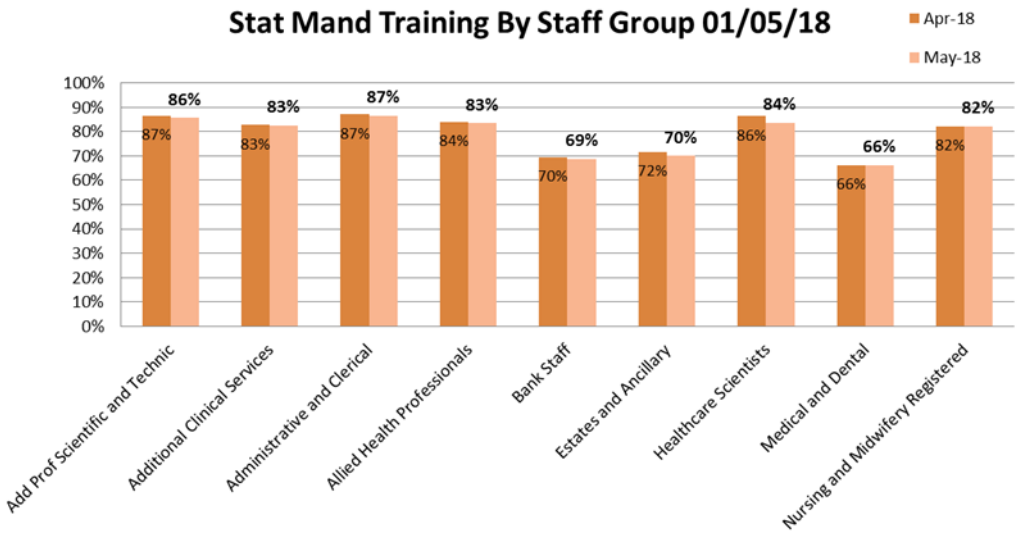


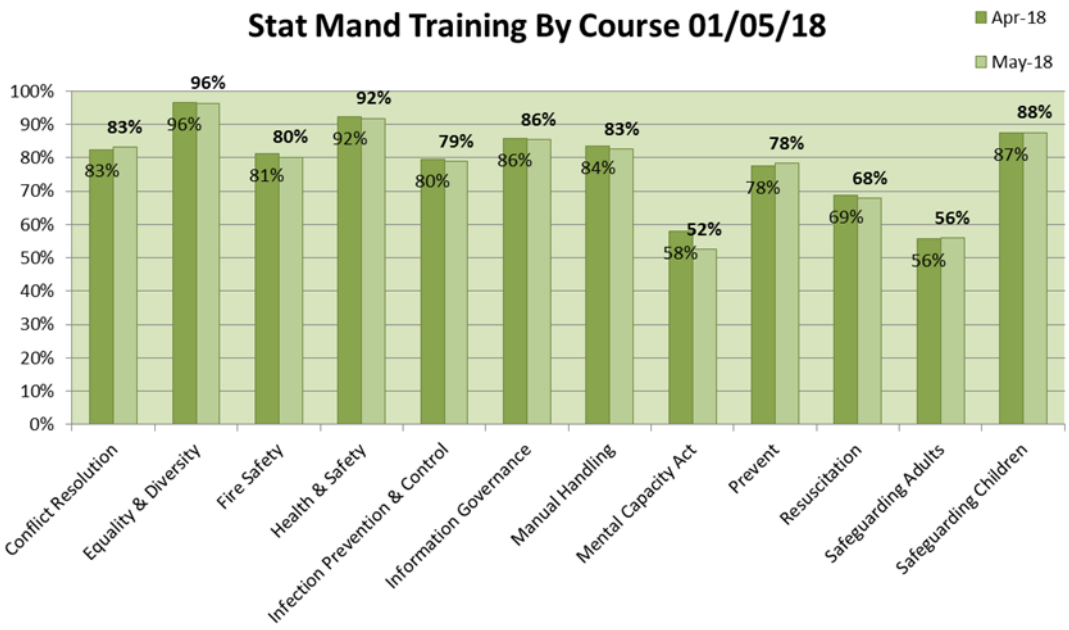
6. Staff turnover

Staff turnover has increased in month 1, rolling 12 month % is 9.70%, an increase from 9.55% in March.

7. Statutory Mandatory Training Compliance

Statutory Mandatory Training Compliance – Substantive and Bank Staff





- Current Trust position (01/05/18) is 80%.
- There has been an increase in Bank Staff activity this month of 15%

Action:

- A programme charter for MT will be created and will be monitored at the HR/OD Subcommittee.
- The next Mandatory Training Group (16/05/18) will be set aside as a workshop for the group to focus on actions to improve DNA's and MT compliance.
- An additional Mandatory Training Group date has been added for June to review existing mandatory training requirements.
- Review criteria for mandatory training.
- A MT benchmarking exercise against national standards and other organisations MT provision is due to commence week beginning 27th June 2018.

- Bank Staff below 85% compliant will be removed from the Bank until compliance has improved.

8. Apprenticeships

- Update: As of the 1st April 2018 we have a total of 44 staff in learning on apprenticeship programmes.
- 24 staff have accessed course fees through our Levy, 30 staff from the 74 in learning from the last financial year 17/18 have now completed and achieved their Apprenticeship framework.
- Registered Nurse-Degree Apprenticeships (RNDA). 2nd stage shortlisting has been completed with support from the Open University, 17 Applicants will be interviewed for 11 Adult Nursing positions and 8 Applicants interviewed for 4 Mental Health, interviews June 18, with our 1st cohort starting in September 2018.
- Nursing Associate Test Site partnerships Application form submission deadline 19/06/2018, advised of outcome two weeks post the panel meeting date of 26/06/2018. 2 x Information sessions on Wednesday 18th July 2018 booked in the Education centre-Open University will be present.
- Apprenticeship Project Charter now complete and has been signed off by all parties. Our weekly update meeting for this takes place every Wednesday at 11:30am in the Education Centre-all welcome.
- Our first member of staff will start his Chartered Manager Degree Apprenticeship in September 18 supported through Portsmouth University.
- With the support of Local training provider HTP Apprenticeship College-Rosie Oliver-Business Officer in GMO/Medicine CBU has been nominated to submit her application in the category " Apprentice of the Year" award for higher or degree Level Apprenticeship in this year's National Apprenticeship Awards 2018. The winners will be announced at an awards ceremony on 28.11.2018.

9. Leadership and OD

Team development continues to be in demand as 3 new teams have commenced a team development programme with the Leadership team this month. Feedback regarding the experience and how it helps team members to work well together to improve patient care and outcomes is positive.

10. Staff Surveys:

Leadership lead has met with all attending Business unit leads to discuss both Quarter 2 friends and family for staff results and Annual staff survey results. All leads are to be asked for an action plan detailing actions planned to address staff concerns raised.

Culture & Leadership Project staff survey currently being planned to take place in June. This is planned to be across the Organisation and will give all staff the opportunity to make comment on the leadership capability and effect upon the Organisation. This work will inform the design phase of the NHSi project.

11. Appraisals

A project to improve the capability of all managers to deliver a quality appraisal for the staff is currently being planned. Documentation and training content have already been reviewed and altered according to an initial feedback exercise undertaken by the Leadership team in January 2018. This is a work in progress and will also be informed by the NHSi project outcomes and feedback.

Organisation compliance remains poor at approximately 59%

'Getting to Good' Leadership and Culture Programme (NHSi toolkit):

Change team have had first meeting and workshop that was attended by Chief Executive Maggie Oldham and Project Consultant Katie Steward. Feedback from group was very positive and all are focussed and committed to creating change.

Focus groups and workshops continue, covering Mental Health, Bands 1-4 and across Organisation groups.

Action:

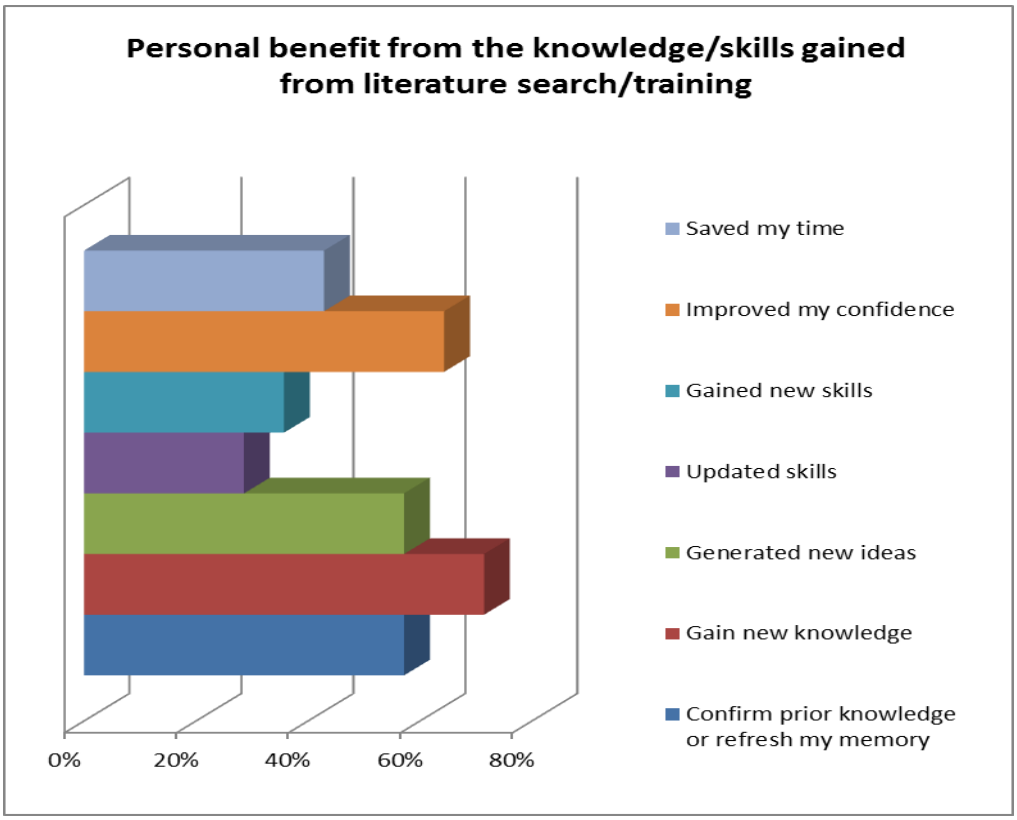
Focus Groups continue and all results and feedback to be collated with Change team when completed following initial phase of the project which will last until approximately July 2018.

The HR&OD sub-committee has asked us to look at the content of appraisals & to review the experience for the appraise.

12. Library & Knowledge Services

We seek to understand from library users the value of their experiences. This is shown in tables 7,8 & 9. Whilst a low return rate (12% for 17/18) the data shows similar patterns to previous years.

Table 8



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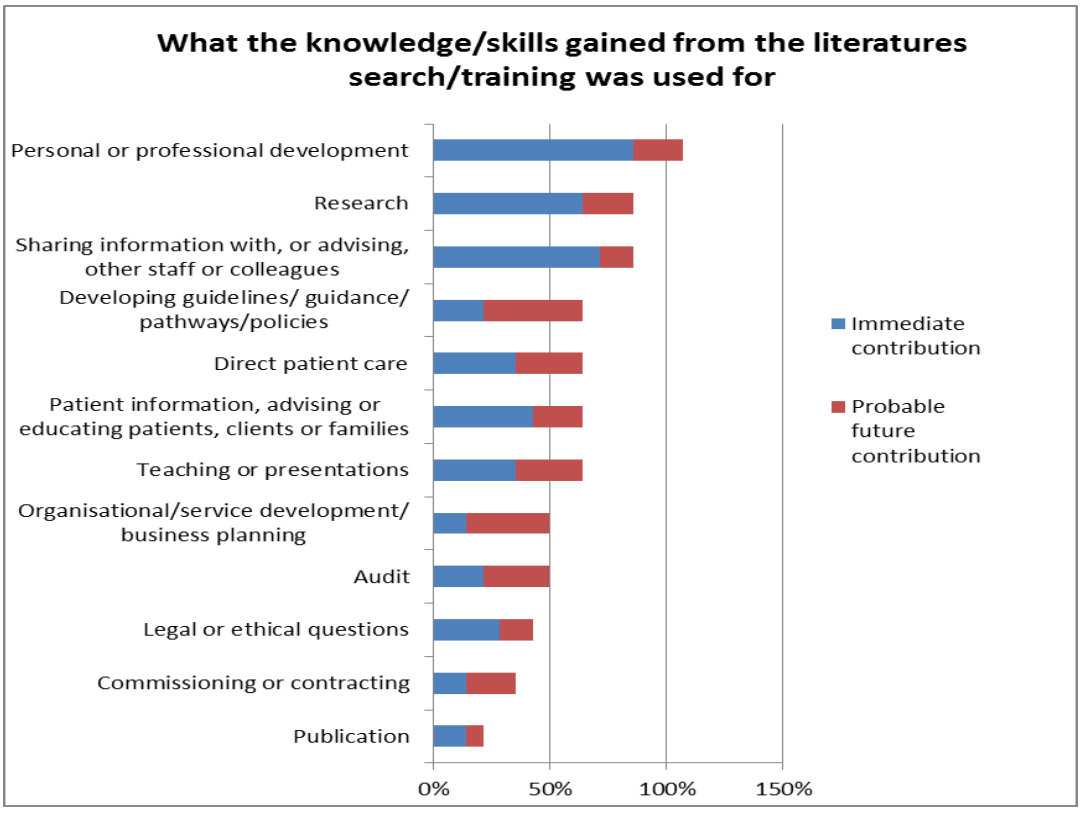

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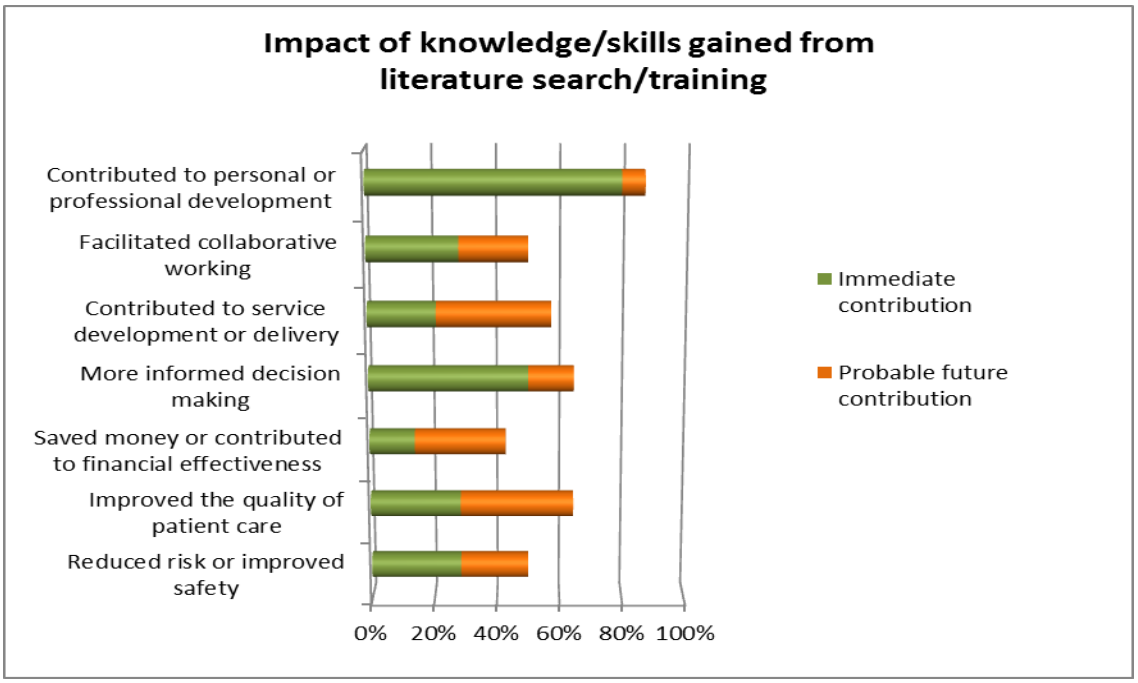
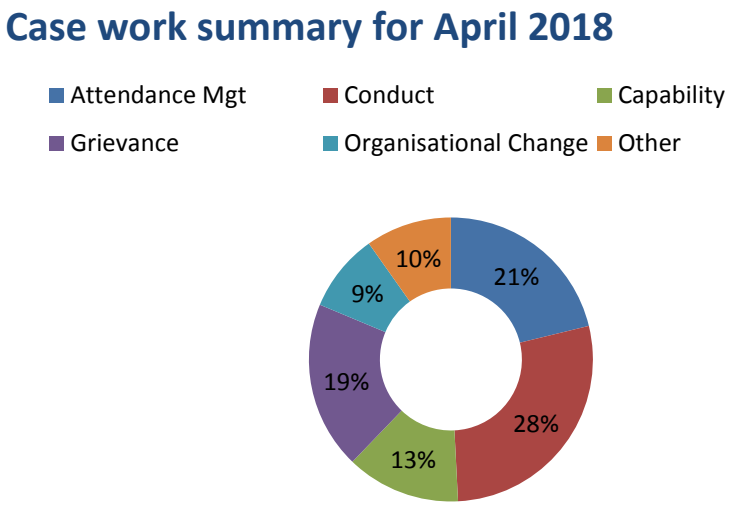


13. Employee Relations

The employee relations activity remains static year on year, a total of 370 cases were managed in accordance with policy frameworks during .

In month (April 2018) 146 employee relations cases are currently being supported. The breakdown of cases by type is shown below.



Attendance Management, Capability, Conduct and Grievance cases

All cases are managed in accordance with the Trusts Policy Frameworks to ensure that fair procedures are followed to ensure compliance to statutory frameworks.

Exclusions/Suspensions

There are 41 cases which are being managed in accordance with the relevant Conduct Policy and Procedure. Of those cases, there was 1 member of staff suspended from duty during April with a further 6 employees remained either suspended or excluded from their usual duties. Formal hearings have been set up in relation to 2 members of staff currently excluded and the remaining 5 cases are at the investigation stage of the relevant policy.

Organisational change cases

The Trust recognises that the NHS needs to continually improve organisational effectiveness and therefore organisational change may be a necessary part of the process to improve service delivery.

The organisation is committed to ensuring that staff are made aware of, and understand, the nature of the change and how it might affect them and to provide them with support and guidance, recognising the uncertainty that such change can cause.

There is currently one consultation process in progress in relation to a proposed organisational change which relates to a change in team structure. There are 3 cases which are at the implementation phase with a further 8 cases where initial advice and guidance has been sought in accordance with the policy frameworks.

Other cases

The definition of cases which fall into these categories relate to other aspects of terms and conditions of employment and referrals to professional bodies in accordance with the Fitness to Practice procedures.

Appendix A

IOW NHS TRUST

Workforce Recruitment, Retention and Supply

Action Plan April - September

ACTION	PURPOSE	BENEFIT	TIME/ SCALE	SUCCESS MEASURES
Management and Organisation				
Master Vendor (Agency supply)	• To appoint a single preferred supplier to act for the Trust on the supply of agency staff	• Single point of contact • Maximise supply • Strengthen authorisation and governance • Strengthen quality control • Strengthen cost control	June	• Reduction in costs and improvement in fill rates
Nurse lead – workforce (15 hrs per week – six months)	• To coordinate HR and nursing in the recruitment and supply of nurse staffing • To set/reiterate standards in the use of e-rostering, staffing requests and deployment of temporary workers	• Better management of vacancies • Better management of requests and deployment • Requests matching establishments and patient need • Reduce demand and prevent avoidable expenditure	May	• Vacancies advertised promptly • Improved supply • Better organisation between HR and nursing • Reduction in expenditure
Recruitment - Processes and systems	• To review internal processes to ensure processes are efficient and meet NHS standards	• Time to fill period reduced • Clarity of recruitment timetable • Pre-employment checks completed	May - June	• Time to fill reduced • No staff employed without appropriate checks
Medical staffing	• To review of internal processes • To make better use of	• Speedier progression of vacancies to advert • Improved ACC process		• Weekly reporting on vacancies • Shorter time to fill

	information • To improve relationships with Divisions	• Improved appointments process • Better understanding of vacancies and progress		• Reduction in no. of vacancies
Promotion				
Branding	• To purchase of materials to help promote IOW as an attractive, modern and exciting proposition	• Part of modernising image Level par with other NHS Trusts •	July	• Modern and fresh look • More applicants for jobs
Social Media	• To make use of modern media platforms to engage with professional people	• Level par with other NHS Trusts and recruiters • Engages better with NHS workers especially younger generation • Instant • Part of modernising image	May	• Presence on Instagram, Facebook and LinkedIn • More applicants for jobs
Recruitment campaigns	• To coordinate campaign to attract UK based nurses; o Events on mainland & Island o On the day interviews and conditional offers o Other partners involved e.g. house builders • To support through radio advertising and other promotional activities	• Tapping into potential supply of nurses	2018	• More applicants for jobs
HCA campaign	• To increase the number of pool HCAs • To fill vacancies	• Pol of trained HCAs • Vacancies reduced	March	• 20 HCAs recruited
Apprentices	• To train 15 apprentices (4 year training programme)	• Longer term supply of locally trained registered nurses	2018-22	• Supply of trained nurses
International				

International recruitment	• To inject trained nurses • To explore possible continuous small supply if needed	• 40-100 nurses • Supply in 2019 • Established processes	June	• 100 nurses to have commenced in 2019
Economic				
Weekly pay for bank staff	• To make the bank more attractive	• To accelerate payment for work done	April	• To increase number of staff on bank
Financial incentives	• To establish if incentives are justified and affordable	• Mirror benefits offered by competitors • Improve recruitment and retention	July	• More applicants for jobs • Reduced turnover
Accommodation	• To review need for accommodation (as an incentive)	• Trust able to attract staff from the mainland	July	• More applicants for jobs
Bank rates	• To establish if comparable with competitors	• Less reliance on agency staff • Offers attractive proposition to existing staff	July	• Reduction in agency usage and expenditure
Reducing high cost long term staff	• To explore alternatives	• Reduction in high cost temporary workers	May - June	• Fewer high cost workers
Workforce Information				
Workforce reporting – nursing and medical staff	• To introduce weekly reporting for the Executive	• Up-to-date picture on vacancies • Identify and respond to trends • Assist planning	April	• Weekly report
Leaver form	• To increase the categories for 'reason from leaving' to NHS standard	• Provide better information on why staff leave	April	• Monthly reviews and reporting (from July)
Workforce Policy				
Flexible working	• To modernise and promote approach to flexible working	• Reduce turnover • Offer attractive employment options	June	• Reduction in turnover • Improved staff survey feedback
Sickness Absence - Management	• To reduce absence	• Consistent and earlier management intervention • Reduced absence and more substantive hours in clinical areas	Aug	• Reduction in sickness absence

E-rostering	• To review current policy and approach	• Ensure rules are fair, appropriate and being adhered to • Help staff plan work/life balance • Assist with planning and staffing levels	May - July	• Consistent application of e-rostering rules and policy • Reduction on temporary usage and costs
Engaging with staff	• To engage with staff to understand what makes IOW a great place to work	• Staff involved • Initiatives based on staff views	May	• Reduced turnover • Improved staff survey results

Enc J

Agenda Item No	12	**Meeting**	Trust Board in Public	**Meeting Date**	6 June 2018
Title	Financial Performance Report – Month 1 (2018 19)				
Sponsoring Executive Director	Darren Cattell – Interim Chief Financial Officer				
Author(s)	Gary Edgson – Deputy Director of Finance				
Committees previously considered by including date	Performance Committee – 6 June 2018				

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	
Achieve excellence in employment, education and development	
Lead strategic change on the Isle of Wight	

Link to CQC Well Led Domains			
Effective	X	Responsive	X
Caring		Well-led	
Safe			

Executive Summary

The key points from the Month 1 financial performance against plan are:

Income & Expenditure

- The Trust's in month financial position is a deficit of £2.1m
- £0.5m adverse variance against deficit plan
- Run rate position off plan due to a). under delivery against the phased CIP plan (£300K) and b). the cost of Winter bed capacity remaining open without an agreed funding source (NB this also includes the impact of community rehab income reduction from CCG)

Agency

- Agency control total ceiling for 2018/19 £4.594m
- Actual agency spend to date £1.2m. Adverse against phased ceiling to date by £0.8m
- Agency costs higher than our planned level

Year-end forecast and financial recovery plan

- A planned deficit of £18.526m was submitted to NHSI on 30 April as agreed by the Board
- CCG Contract income is not finalised and income remains a risk for Acute and Community services

Progress to date against financial recovery plan

- Budgets have been signed off at a CBU control total level
- Plans are being finalised to deliver a cost improvement programme of £8m with enhanced support from KPMG and Moorhouse continuing

Month 1 Trust budgetary performance is relatively strong as you would expect, the key variances are CIP and Bed capacity remaining open without an agreed funding source.

The Executive has agreed a number of further financial control actions through the Financial Recovery Board

Specific Actions

1. Finance to concentrate on forecasting full year outturn and longer term planning
2. ALL additional Quality investments require TLC approval where outside of budget
3. Actively encourage the use of Bank and in all but the most exceptional circumstances ban non clinical overtime
4. ALL posts and changes to pay require approval by the Exceptional Pay Panel
5. Continue Grip and Control non pay controls supported by Procurement
6. Continue negotiations with CCG to resolve income levels and specific funding issues
7. Utilise contract database to enhance both income and expenditure controls
8. Agency reduction plans being developed as part of the Temporary spend work stream in the Workforce CIP

Further assurance for the Board

1. 2018/19 CBU detailed Budget sign-off to take place in early June 2018
2. Financial Recovery Board meeting every two weeks with Finance Performance Reviews meeting (PRM) every two weeks to drive CIP planning and delivery and accountability for corrective actions (there is a presentation to the Board seminar/on this agenda on our CIP status)
3. As part of the finance PRMs, CBU leads have agreed non recurrent underspends to count towards non recurrent CIP delivery in mitigation of current CIP shortfall from M2
4. Focused corrective action plans for overspending services are also being produced at CBU level as part of the finance PRMs
5. The Director of Acute Services has produced a urgent Winter Bed capacity closure plan which has been supported by the Executive

Capital Planning Update

- Initial CRL for 2018/19 based on Depreciation is £6,611k
- Request to be made to NHSI to spend the underspend from 2017/18 of £788k
- Major Projects expected for 2018/19 include:-
- Back Up Generators £1.2m
- Ambulance CAD £1.6m
- Ophthalmology Satellite Unit £0.6m
- Paediatric Assessment Unit £0.6m
- EIP Team Relocation £0.3m
- Education Extension £0.3m
- A&E Streaming Project £0.2m
- Equipment RRP £0.5m
- IM&T RRP £1.2m
- Backlog Maintenance £0.6m

A risk based prioritisation process is underway across all CBUs and Corporate departments to finalise the capital investment plan for 2018-19

Cash update

- The cash position for the Trust remains a significant risk in terms of working capital to pay our suppliers on time
- Loan funding for 2018/19 is being requested in line with the deficit plan
- Loans of £1.6m for April and £1.762m for May have been secured
- Request for £1.845m for June has been made

Use of Resources Rating
The Trust's Use of Resources Rating is still a score of 4 (1 being best and 4 being worst) due to our financial performance.

Key Recommendation

The Board is asked to consider the following recommendations:

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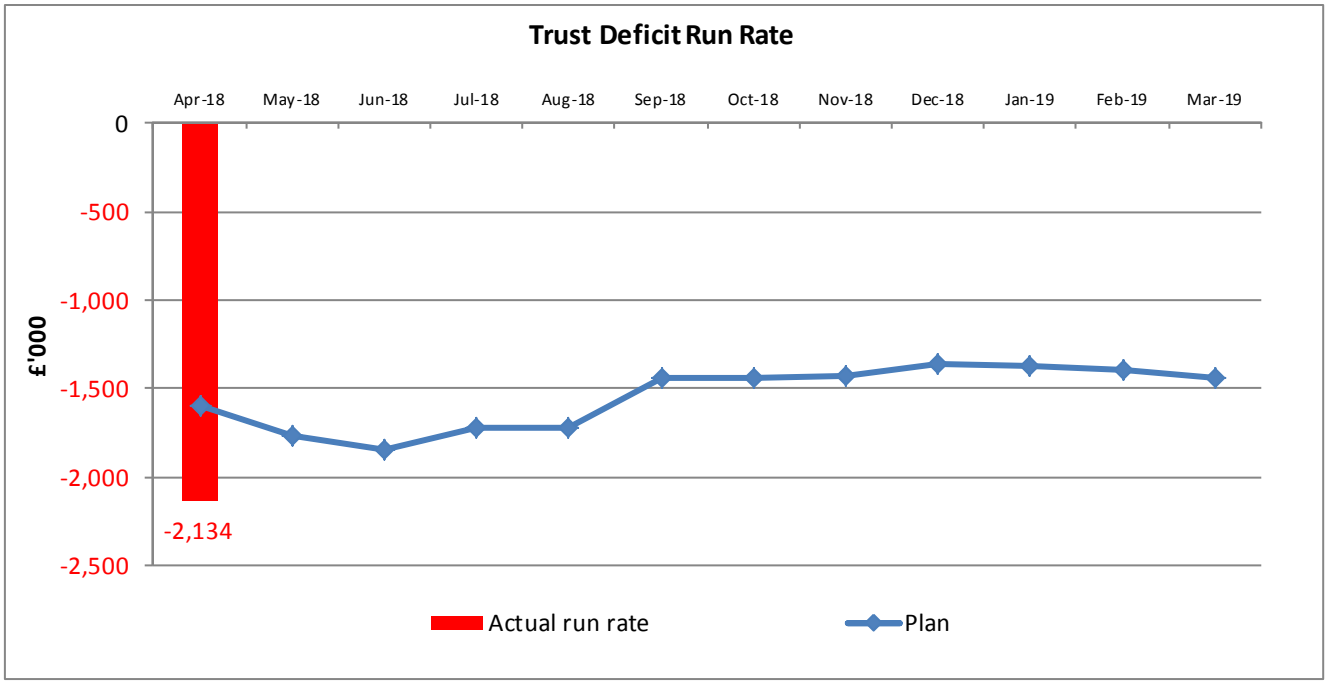
1. To receive the Month 1 Trust performance against the 2018-19 financial plan.

INCOME & EXPENDITURE - SUMMARY

	IN MONTH				YEAR TO DATE				YEAR
	Plan £000s	Actual £000s	Variance £000s		Plan £000s	Actual £000s	Variance £000s		Plan £000s
Income	13,923	14,054	130		13,923	14,054	130		167,456
Pay	(10,824)	(11,503)	(680)		(10,824)	(11,503)	(680)		(127,675)
Non Pay	(3,873)	(3,865)	9		(3,873)	(3,865)	9		(48,392)
EBITDA	**(774)**	**(1,314)**	**(541)**		**(774)**	**(1,314)**	**(541)**		**(8,611)**
Capital Charges	(556)	(552)	3		(556)	(552)	3		(6,677)
PDC	(199)	(199)	0		(199)	(199)	0		(2,389)
Interest Receivable/(Payable)	(81)	(79)	2		(81)	(79)	2		(976)
Bank Charges	(0)	0	0		(0)	0	0		(4)
RETAINED SURPLUS / (DEFICIT)	**(1,610)**	**(2,145)**	**(535)**		**(1,610)**	**(2,145)**	**(535)**		**(18,657)**
Receipt of Charitable Donations for Asset	0	0	0		0	0	0		(50)
Depreciation - Donated Assets	11	11	0		11	11	0		131
CQUIN Risk reserve adjustment	0	0	0		0	0	0		0
REVISED RETAINED SURPLUS / (DEFICIT)	**(1,599)**	**(2,134)**	**(535)**		**(1,599)**	**(2,134)**	**(535)**		**(18,576)**



To date the Trust is reporting a deficit of £2.1m against a deficit plan to date of £1.6m, a negative variance of £0.5m.

The in-month position is a deficit of £2.1m.

To achieve a year end deficit of £18.6m will require an average in month run rate of £1.5m deficit each month.

Achievement of the year end Board approved deficit of £18.6m, **is dependent on agreeing the 2018/19 contract with the CCG at the value of £134.2m and delivery of £8m CIP.**

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2018/19 FINANCIAL PERFORMANCE

	18/19 Plan	Current month		
		Plan	Actual	Variance
	£m	£m	£m	£m
Underlying deficit	**26.4**	2.2	2.2	**0.0**
Cost pressures expected	5.3	0.2	0.4	**0.2**
Gross deficit	**31.7**	**2.4**	**2.6**	**0.2**
Funded by:-				
CNST reduction	(1.0)	(0.1)	(0.1)	**0.0**
Income increased	(4.2)	(0.4)	(0.4)	**0.0**
CIP plan	(8.0)	(0.3)		**0.3**
Sub Total	**(13.2)**	**(0.8)**	**(0.4)**	**0.3**
Net Deficit	**18.5**	**1.6**	**2.1**	**0.5**

Underperformance in month 1 relates to non-achievement of Cost Improvement Plans (CIP) and costs pressures.

CIP schemes have now been finalised to the equivalent of £8m, the majority of the schemes will be delivered in the second half of the financial year with effect from month 6. Project work is underway to ensure these are delivered and milestones are monitored through both the Financial Performance Board and divisions separate Financial Performance Reviews.

Cost Pressure of £0.20m has resulted in the continuous use of Compton Ward. The CCG decommissioned rehab beds with effect from 1st April 2018, the exit strategy for removing beds on Compton Ward has been developed with the aim to close 30 beds by the end of June 2018.

FINANCIAL CONTROL

- **Run rate and CIP**:

Financial Recovery Board has been refocused into the Service and Financial Improvement Sub-Committee to holistically oversee all aspects transformational change and financial recovery.
Internal resources are being realigned to improve planning and delivery.

KPMG continue to support the Trust and their work is focused on the crosscutting scheme – workforce.

Moorhouse are providing support to both cross cutting schemes and the systemwide transformation team to ensure structures are in place to deliver the CIP schemes

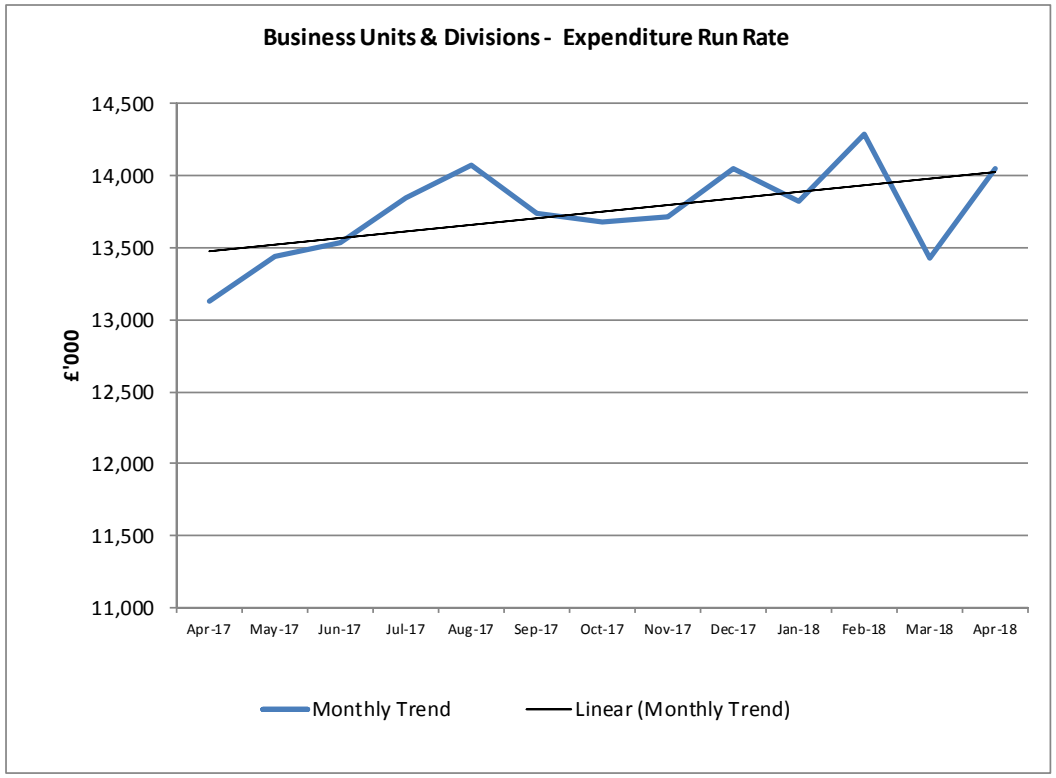
- **Capital**:

Capital investment group are reviewing and prioritising investment proposals.

Schemes	£000's
Workforce - Corporate Support	800
Workforce - Temporary Pay	792
Workforce - Rightsizing	1,700
Medicines Optimisation	50
Outpatients	259
Theatres	163
Procurement	340
Procurement Value Chain	1,844
Total crosscutting schemes	**5,948**

The Trust's total CIP plan is £8m, of which £5.948m is cross cutting schemes

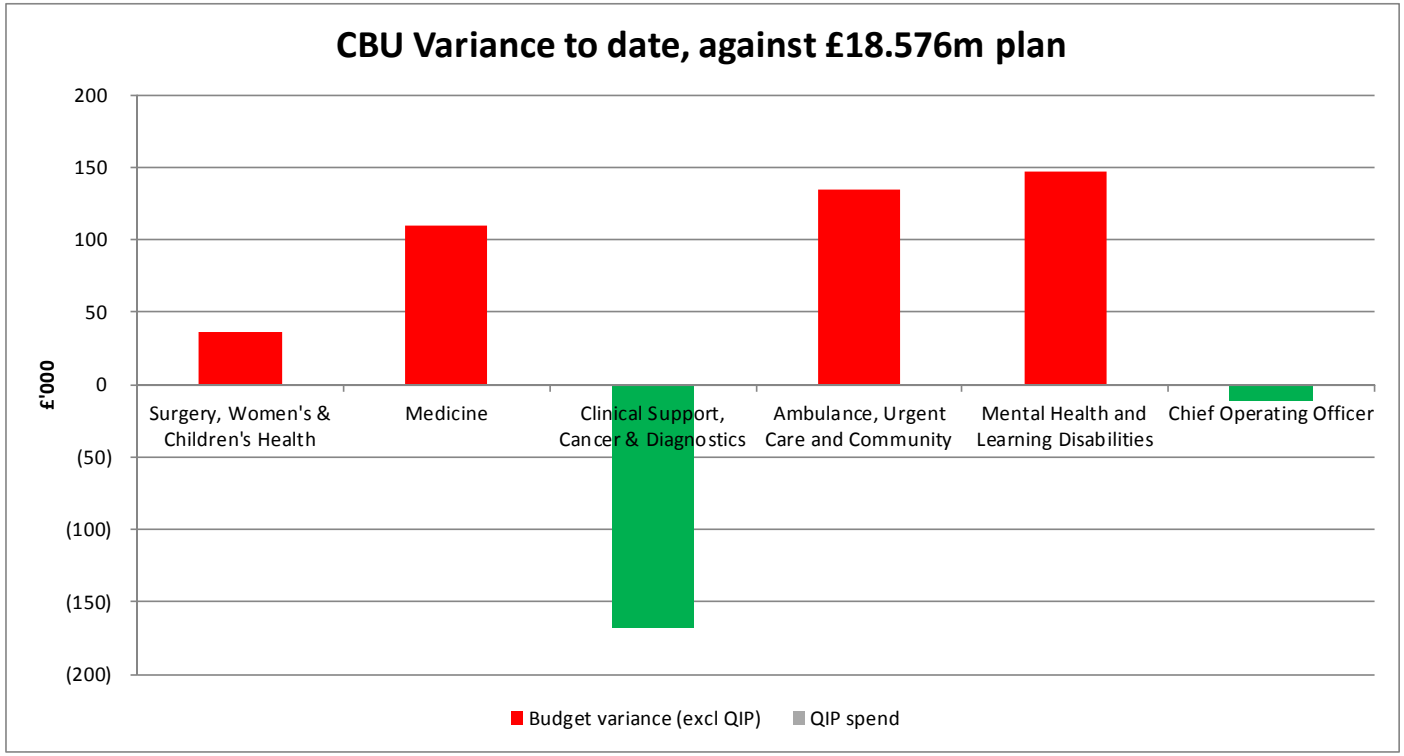
EXPENDITURE RUN RATE



Expenditure run rates are on an increase linear line, however expenditure in April 2018 includes £0.1m of inflationary increases, of which is supported by patient related income.

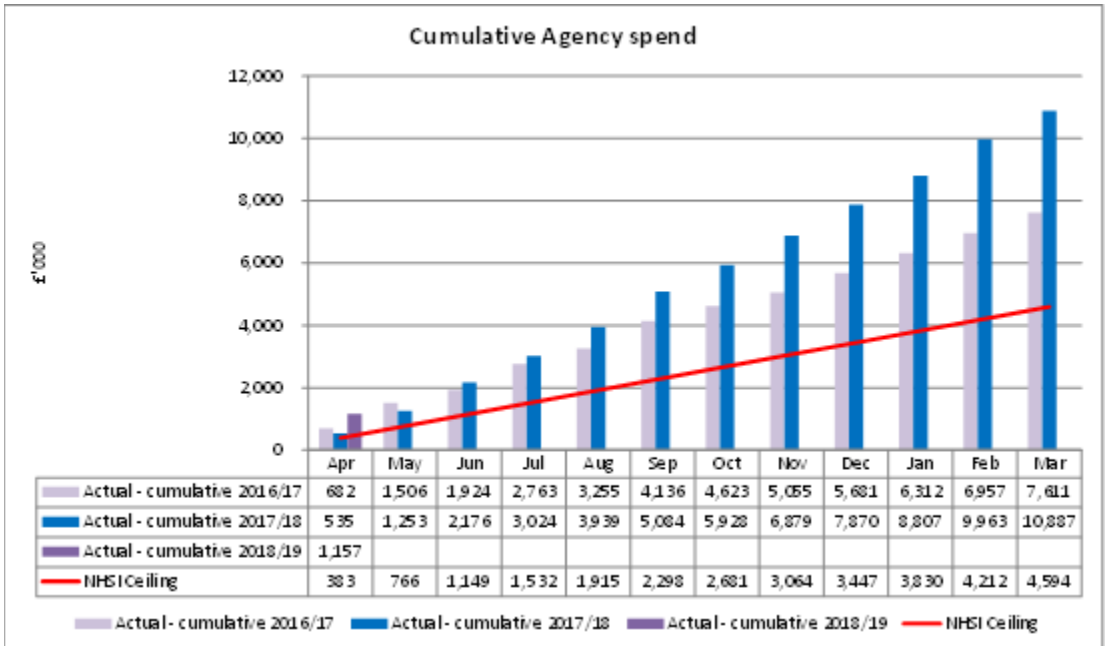
	2017/18												2018/19
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	April
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	(10,332)	(10,516)	(10,724)	(10,913)	(11,122)	(11,134)	(11,066)	(11,141)	(11,090)	(11,398)	(11,414)	(11,020)	(11,503)
Non Pay	(3,975)	(4,302)	(4,342)	(4,185)	(4,476)	(4,223)	(4,603)	(4,480)	(4,337)	(4,319)	(4,315)	(4,159)	(3,865)
Misc Income	1,177	1,373	1,526	1,246	1,521	1,624	1,986	1,905	1,382	1,895	1,447	2,310	1,316
Business Units & Directorates	**(13,130)**	**(13,445)**	**(13,540)**	**(13,852)**	**(14,077)**	**(13,733)**	**(13,684)**	**(13,716)**	**(14,046)**	**(13,822)**	**(14,283)**	**(12,869)**	**(14,052)**
Patient Related Income	12,190	12,311	12,182	12,347	12,416	12,355	12,390	12,458	12,846	12,902	13,557	13,568	12,738
STF												484	
EBITDA	**(940)**	**(1,134)**	**(1,358)**	**(1,505)**	**(1,662)**	**(1,378)**	**(1,294)**	**(1,258)**	**(1,200)**	**(921)**	**(725)**	**1,183**	**(1,314)**
Capital Charges	(781)	(781)	(781)	(781)	(781)	(700)	(781)	(781)	(781)	(781)	(780)	(839)	(740)
Finance Costs	(40)	(40)	(41)	(43)	(41)	(98)	(24)	(58)	(58)	(84)	(61)	(54)	(79)
CQUIN risk reserve												(583)	
Actual Surplus / (Deficit)	**(1,762)**	**(1,955)**	**(2,179)**	**(2,329)**	**(2,484)**	**(2,176)**	**(2,098)**	**(2,097)**	**(2,040)**	**(1,785)**	**(1,566)**	**(293)**	**(2,134)**
Actual Surplus / (Deficit) Excluding STF	**(1,762)**	**(1,955)**	**(2,179)**	**(2,329)**	**(2,484)**	**(2,176)**	**(2,098)**	**(2,097)**	**(2,040)**	**(1,785)**	**(1,566)**	**(777)**	**(2,134)**

CBU FINANCIAL PERFORMANCE



Overall the performance of CBU's is £0.248m overspent in month. This is a reflection of continuous reliance on agency usage to support vacant posts and addressing quality.

AGENCY EXPENDITURE



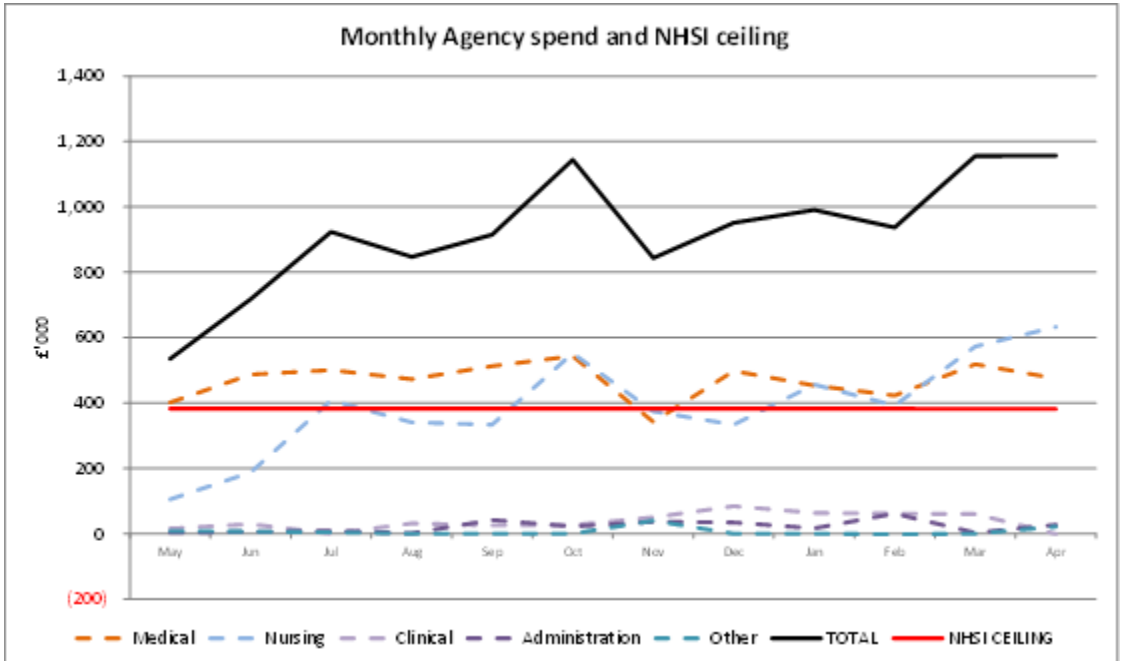
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual - cumulative 2016/17	682	1,506	1,924	2,763	3,255	4,136	4,623	5,055	5,681	6,312	6,957	7,611
Actual - cumulative 2017/18	535	1,253	2,176	3,024	3,939	5,084	5,928	6,879	7,870	8,807	9,963	10,887
Actual - cumulative 2018/19	1,157											
NHSI Ceiling	383	766	1,149	1,532	1,915	2,298	2,681	3,064	3,447	3,830	4,212	4,594

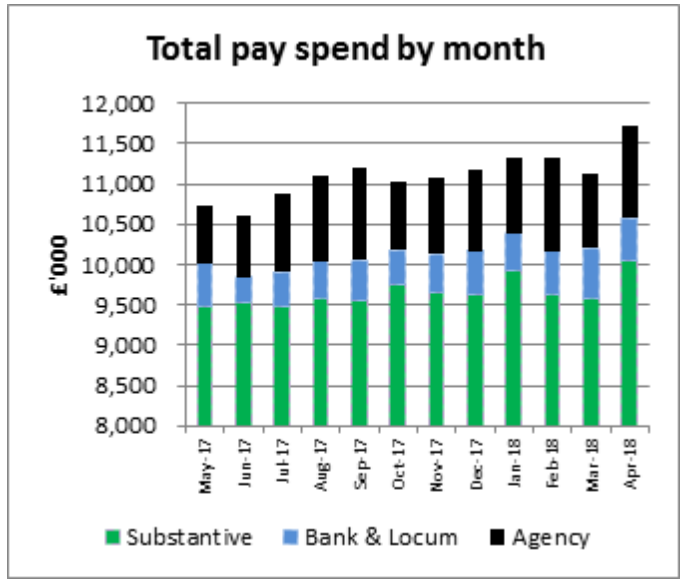
Agency expenditure in month is £1.2m.

The year to date expenditure represents 10% of the total Trust expenditure on pay.
For comparison, agency expenditure in 2017/18 was 8.3% of total pay.

As part of the FRP enhanced pay controls are already in place which will reduce agency expenditure:

- Exceptional Pay Panel – at least weekly
- Finance and HR sign off on change forms
- Interims & consultancies reviewed
- E Rostering “Safe Care” reporting system training held
- Unused hours data review
- E Rostering Clinical Lead now in place
- Recruiting bank HCAs weekly
- Reduction in agency rates





CASH

The cash balance held at the end of April is £5.0m which is a £1m negative movement on last month.

Cash Analysis 2018/19 - Movement in Month

	Actual Month 12 £m	Actual YTD £m	Actual YTD VAR £m
Cash Balance 01.04.18	**7.3**	**6.0**	**-1.3**
Income and Expenditure Surplus / (Deficit)	-22.8	-2.1	20.6
Depreciation	6.5	0.6	-5.9
Interest Payable	0.7	0.1	-0.6
PDC Dividend	2.9	0.2	-2.7
Other non-cash items	0.0	0.0	0.0
Operating Surplus / (Deficit)	**-12.7**	**-1.3**	**11.4**
Change in Stock	0.0	0.0	0.0
Change in Debtors	-3.8	-1.3	2.5
Change in Creditors & Other Liabilities	2.0	3.1	1.1
Change in Provisions	-0.1	0.0	0.1
Net Change in Working Capital	**-2.0**	**1.8**	**3.8**
Capital Spend	-7.7	-3.0	4.7
Interest Paid	-0.6	0.0	0.6
PDC Dividend Paid	-2.9	0.0	2.9
Other	1.0	-0.1	-1.0
Investing Activities	**-10.2**	**-3.1**	**7.2**
Working Capital Loans	23.8	1.6	-22.2
Loan/Finance Lease Repayments	-0.1	0.0	0.1
Cash Balance 30.4.18	**6.0**	**5.0**	**-1.0**

Month 1 YTD Cash Movements

- The Month 1 I&E Cumulative Deficit is £2.1m which £0.5m worse than plan

- Within the I&E deficit, Depreciation (£0.6m) does not impact cash. The charges for Interest Payable (£0.1m) and PDC Dividend (£0.2m) 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 £1.3m

- The movement in working capital movements in month is due to an decrease in Debtors (Accrued Income) but an increase in Creditors

- The Trust has borrowed £1.6m of Uncommitted Loans in month. These borrowings are subject to interest at 1.5% and with interest at 3.5% on previous year borrowings will represent costs in 2017/18 of £1.0m

CAPITAL

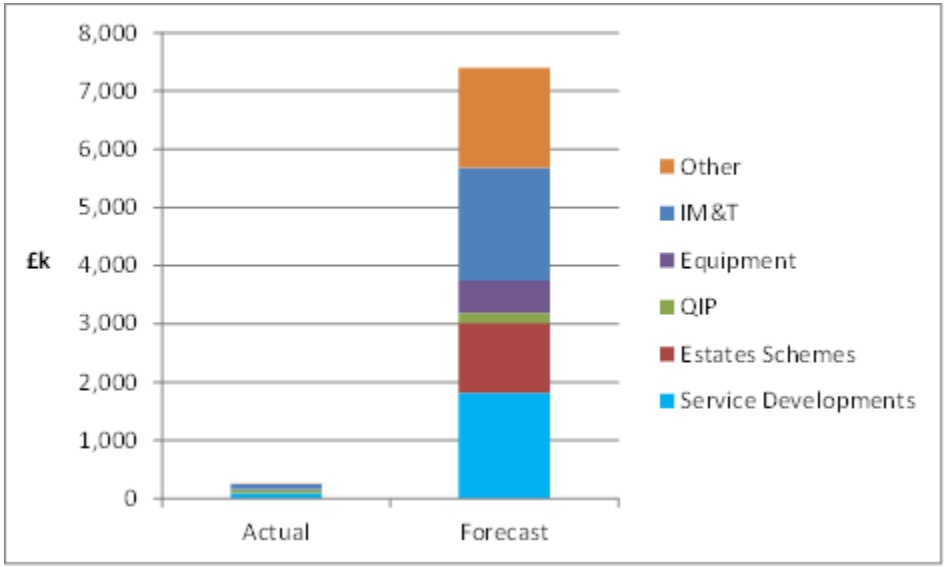
Our initial CRL is based on forecast depreciation of £6.561m and £50k Expected Charitable Donations. We are also going to apply to NHS Improvement to use the £788k underspend from 2017/18.
Therefore capital funds of £7.4m are anticipated for 2019/20.

As at Month 1 we have spent £247k

Major Projects planned for 2018/19 are as follows:-

- Back Up Generators £1.2m
- Ambulance CAD £1.6m
- Ophthalmology Satellite Unit £0.6m
- Paediatric Assessment Unit £0.6m
- EIP Team Relocation £0.3m
- Education Extension £0.3m
- A&E Streaming Project £0.2m
- Equipment RRP £0.5m
- IM&T RRP £1.2m
- Backlog Maintenance £0.6m

2018/19 Capital programme plan and expenditure



USE OF RESOURCES RATING

The Trusts Use of Resources Rating as at 30 April is a score of 4, as set out below.

This is against a score of 1 being best and 4 being worst.

Use of resource risk rating summary	Plan Rating	Actual Rating	Variance
Capital Service Capacity	4	4	0
Liquidity (days)	3	3	0
I&E Margin	4	4	0
Distance from financial plan	4	4	0
Agency spend	4	4	0
Overall Use of Resources Rating	**4**	**4**	0

Basis of scoring mechanism

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

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Agenda Item No	13.1	**Meeting**	Trust Board in Public	**Meeting Date**	07/06/2018
Title	Performance Report - Acute Services				
Sponsoring Executive Director	Nikki Turner, Director of Acute Services				
Author(s)	Sarah Hayward, Head of Operational Performance				
Report previously considered by inc date	Performance Committee, 6 June 2018				

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 Well Led Domains			
Effective	X	Responsive	X
Caring	X	Well-led	X
Safe	X		

Executive Summary

The Trust has set new performance trajectories for 2018/19 for each of its key national targets based on the 2017/18 outturn position and in alignment with the national operational planning guidance; these are currently subject to further review and any revisions will be reported to Board accordingly.

Emergency Care Standard: The Trust performed at 82.4% against the Emergency Care Standard trajectory of 80% for April 2018 (national target is 95%). The requirement entering quarter 1 is to sustain this performance against the trajectory as it increases during the year with the aim of achieving 90% in September 2018 and the national target in March 2019.

Referral to Treatment: The Trust performed at 84.1% against the Referral to Treatment (RTT) 82.1% trajectory for April 2018 (the national target is 92%), sustaining the previous month's performance of around the same level. The requirement entering quarter one is to deliver the 2018/19 planned activity levels.

62 Day Cancer Standard: The Trust has provisionally under-performed in April 2018 at 72.7% against the 62 Day Cancer 85% trajectory (as per the national target) for April 2018; the final performance is subject to actual tertiary provider treatments / breaches for upload in early June. For April, there are currently 38.5 treatments identified with 10.5 breaches; the tumour site level performance and breach detail is provided in the table alongside. This is a worsening of performance compared to the previous two months when the national target was achieved, therefore, the focus is to reduce the number of long waiting patients and ensure treatment is timely both locally and at tertiary providers.
Actions include:
• Finalise the cancer and diagnostics project plan including delivery of the deep dive report recommendations, in particular:
• Increase the number of cancer pathway trackers in the cancer pathways team;
• Increase local diagnostic imaging capacity;
• Increase local endoscopy capacity; and,
• Increase cancer nurse specialist capacity to manage increased referrals and increased activity per patient.

Diagnostics: The Trust slightly under-performed in April 2018 at 97.9% against the diagnostic trajectory of 98% (national target is 99%) requiring patients receive their diagnostic test within 6 weeks of being referred; this under-performance is due to capacity issues leading to longer waits for some tests.

Delivery will be monitored by the Clinical Business Unit, Trustwide Patient Access Group, and Executive Performance Review, leading into the new Acute Services Directorate Board.

Key Recommendation

The Board is asked to consider the following recommendations:
- To note the current performance position of the Acute Services.

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Acute Balanced Scorecard - Aligned to Our Goals

Excellent Patient Care	Area	Annual Target	Actual Performance		YTD	Month Trend
Patients that develop a grade 4 pressure ulcer	AS	3 (80% reduction on 15/16)	0	Apr-18	0	↘
Patients that develop an ungraded pressure ulcer	AS		1	Apr-18	1	↘
VTE (Assessment for risk of)	AS	>95%	96.2%	Apr-18	96.2%	↘
MRSA (confirmed MRSA bacteraemia)	AS	0	0	Apr-18	0	↔
C.Diff (confirmed Clostridium Difficile infection - stretched target)	AS	7	3	Apr-18	3	↘
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	AS	10	0	Apr-18	0	↗
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	AS		2	Apr-18	2	↔
Falls - resulting in significant injury	AS	5	0	Apr-18	0	↔
Symptomatic Breast Referrals Seen <2 weeks*	CCD	93%	87.2%	Apr-18	87.2%	↘
Cancer patients seen <14 days after urgent GP referral*	CCD	93%	96.7%	Apr-18	96.7%	↗
Cancer Patients receiving subsequent Chemo/Drug <31 days*	CCD	98%	100.0%	Apr-18	100.0%	↔
Cancer Patients receiving subsequent surgery <31 days*	CCD	94%	100.0%	Apr-18	100.0%	↔
Cancer diagnosis to treatment <31 days*	CCD	96%	100.0%	Apr-18	100.0%	↗
Cancer Patients treated after screening referral <62 days*	CCD	90%	100.0%	Apr-18	100.0%	↔
Cancer Patients treated after consultant upgrade <62 days*	CCD	No measured operational standard	No Pts	Apr-18	No Pts	↔
Cancer urgent referral to treatment <62 days*	CCD	85%	74.7%	Apr-18	74.7%	↘
Summary Hospital-level Mortality Indicator (SHMI) July-16 - June-17	AS	1	1.097	Published Jan 2018	N/A	↗
Never events	AS	0	0	Apr-18	0	↔
Stroke patients (90% of stay on Stroke Unit)	M	80%	87%	Apr-18	87%	↗
High risk TIA fully investigated & treated within 24 hours (National 60%)	M	60%	100%	Apr-18	100%	↔

**Cancer figures for April are provisional.*

A positive experience for patients, service users and staff	Area	Annual Target	Actual Performance		YTD	Month Trend
Emergency Care 4 hour Standards	AUC	95%	82%	Apr-18	82%	↗
Number of patients who have waited over 12 hours in A&E from decision to admit to admission	AUC	0	0	Apr-18	0	↗
All Cancelled Operations on/after day of admission	SWC / CCD		13	Apr-18	13	↗
Cancelled operations on/after day of admission (not rebooked within 28 days) - including those not rebooked at the time of reporting	SWC / CCD	0	0	Apr-18	0	↔
Patient Satisfaction (Friends & Family test - Total response rate)	AS		0%	Apr-18	0%	↘
Patient Satisfaction (Friends & Family test - A&E response rate)	AS		0%	Apr-18	0%	↘
Mixed Sex Accommodation Breaches	AS	0	14	Apr-18	14	↗
Formal Complaints	AS		16	Apr-18	16	↗
Compliments received	AS	N/A	162	Apr-18	162	↘

Skilled and capable staff	Area	In month plan	Actual Performance		Year to date plan	YTD
Total Workforce (inc flexible working) (FTE's)	AS		1,301.6	Apr-18	N/A	N/A
Total workforce SIP (FTEs)	AS		1,198.8	Apr-18	N/A	N/A
Variable Hours (FTE)	AS		102.8	Apr-18		102.8

Working with others to keep improving our services	Area	Annual Target	Actual Performance		YTD	Month Trend
Delayed Transfer of Care (lost bed days) - (Acute)	AS	N/A	140	Apr-18	140	↘

Cost effective, sustainable services	Area	In month plan	Actual Performance		Annual Target	YTD	Month Trend
RTT % of incomplete pathways within 18 weeks - IoW CCG	AS	89.6%	85%	Apr-18			↘
RTT % of incomplete pathways within 18 weeks - NHS England	AS	92%	76%	Apr-18			↗
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	AS	0	0	Apr-18	0	0	↔
No. Patients waiting > 6 weeks for diagnostics	AS	<8	39	Apr-18	<100	39	↘
% Patients waiting > 6 weeks for diagnostics	AS	<1%	97.9%	Apr-18	<1%	97.9%	↗
Theatre utilisation	SWC / CCD	83%	77%	Apr-18	83%	77%	↗
Variable Hours (£000) (Trust Wide)	TW	£198	£1,567	Apr-18	£198	£1,567	
Staff absences - Acute	AS	3.5%	4.28%	Apr-18			
Appraisal Monitoring	CCD	100.0%	75.28%	Apr-18		75.28%	
Appraisal Monitoring	SWC	100.0%	74.16%	Apr-18		74.16%	
Appraisal Monitoring	M	100.0%	41.04%	Apr-18		41.04%	
Mandatory Training*	AS	85%	80.3%	Apr-18		80.3%	
Staff Turnover	AS	5%	0.7%	Apr-18	5%	0.7%	
Employee Relations Cases	AS	0	70	Apr-18		70	

* Rolling year

Notes

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

Key to Area Code
AS = Acute Services
SWC = Surgery, Women's and Children's Health
M = Medicine

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Performance Summary - Surgery, Women's and Children's Health

Women's and Children's Health

Excellent Patient Care	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	Apr-18	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)	Apr-18		1		1
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	Apr-18	1	0	3	0
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	Apr-18		2		2
Falls - resulting in significant injury	Apr-18		0		0
Emergency 30 day Readmissions	Apr-18		2.6%		2.6%
Never Events	Apr-18	0	0	0	0
Pressure Ulcers - Grade 1	Apr-18		2		2
Pressure Ulcers - Grade 2	Apr-18		3		3
Pressure Ulcers - Grade 3	Apr-18		0		0
Pressure Ulcers - Grade 4	Apr-18		0		0
Pressure Ulcers - Ungradable	Apr-18		0		0

A positive experience for patients, service users and staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	Apr-18	0	0	0	0
No. of Complaints	Apr-18		6		71
No. of Concerns	Apr-18		15		15
No. of Compliments	Apr-18		107		107
Cancelled operations on/after day of admission (not rebooked within 28 days) - including those not rebooked at the time of reporting	Apr-18	0	0	0	0
All Cancelled Operations on/after day of admission	Apr-18		13		13
No. of Reported SIRIs *	Apr-18		5		5
Physical Assaults against staff	Apr-18		2		2
Verbal abuse/threats against staff	Apr-18		3		3

Working with others to keep improving our services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual

Skilled and capable staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	Mar-18				74.16%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Mar-18	£ 3,430,547	£ 3,382,797	£ 41,001,932	£ 40,860,542

Cost effective, sustainable services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (IoW CCG + NHS England)	Apr-18	92%	82.3%		
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	Apr-18	0	0	0	0
% Sickness Absenteeism	Apr-18	3.5%	4.14%		4.14%

**12 hour breaches are now included in Siri figures*

***The Acute Service Level Agreement performance reports a month behind, therefore figures are from March 2018.*

Key Headlines:

- Following the transition out of the winter plan, the RTT position is now improving and plans are in place to accelerate this improvement over the next few months. Sickness absenteeism continues to impact by multiple long term episodes of sickness relating to stress. All are being managed in accordance with Trust policy and with OH input.

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Performance Summary - Medicine

Balanced Scorecard - Medicine

Excellent Patient Care	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	Apr-18	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)	Apr-18		2		2
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	Apr-18	1	0	3	0
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	Apr-18		0		0
Falls - resulting in significant injury	Apr-18		0		0
Emergency 30 day Readmissions	Apr-18		6.3%		6.3%
Stroke patients (90% of stay on Stroke Unit)	Apr-18	80%	86.7%	80%	86.7%
High risk TIA fully investigated & treated within 24 hours (National 60%)	Apr-18	60%	100.0%	60%	100.0%
Never Events	Apr-18	0	0	0	0
Pressure Ulcers - Grade 1	Apr-18		1		1
Pressure Ulcers - Grade 2	Apr-18		1		1
Pressure Ulcers - Grade 3	Apr-18		1		1
Pressure Ulcers - Grade 4	Apr-18		0		0
Pressure Ulcers - Ungradable	Apr-18		0		0

A positive experience for patients, service users and staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	Apr-18	0	0	0	0
No. of Complaints	Apr-18		6		42
No. of Concerns	Apr-18		5		5
No. of Compliments	Apr-18		19		19
No. of Reported SIRIs *	Apr-18		10		10
Physical Assaults against staff	Apr-18		2		2
Verbal abuse/threats against staff	Apr-18		4		4

Working with others to keep improving our services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual

Skilled and capable staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	Mar-18				41.04%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Mar-18	£ 2,371,489	£ 2,360,295	£ 28,122,734	£ 28,266,913

Cost effective, sustainable services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (IoW CCG + NHS England)	Apr-18	92%	98.6%		
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	Apr-18	0	0	0	0
% Sickness Absenteeism	Apr-18	3.5%	5.70%		5.70%

**12 hour breaches are now included in Siri figures*

***The Acute Service Level Agreement performance reports a month behind, therefore figures are from March 2018.*

- **Key Headlines:**
- Sickness absenteeism has increased to 5.7% from 3.56%; sickness absence largely relates to the inpatient medical wards and is being managed against the Attendance Management Policy.
- The 10 SIRIs in April are across the wards and specialities with no common theme. These are all currently being reviewed by the HONQ and it is likely some will be downgraded.
- The 19 compliments received in April are (in general) for excellent patient care across the wards and specialities.

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Performance Summary - Clinical Support, Cancer and Diagnostics

Balanced Scorecard - Clinical Support, Cancer and Diagnostics

Excellent Patient Care	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	Apr-18	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)	Apr-18		0		0
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	Apr-18	1	0	3	0
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	Apr-18		0		0
Falls - resulting in significant injury	Apr-18		0		0
Emergency 30 day Readmissions	Apr-18		0.0%		0.0%
Symptomatic Breast Referrals Seen <2 weeks*	Apr-18	93%	87.2%	93%	87.2%
Cancer patients seen <14 days after urgent GP referral*	Apr-18	93%	96.7%	93%	96.7%
Cancer Patients receiving subsequent Chemo/Drug <31 days*	Apr-18	98%	100.0%	98%	100.0%
Cancer Patients receiving subsequent surgery <31 days*	Apr-18	94%	100.0%	94%	100.0%
Cancer diagnosis to treatment <31 days*	Apr-18	96%	100.0%	96%	100.0%
Cancer Patients treated after screening referral <62 days*	Apr-18	90%	100.0%	90%	100.0%
Cancer urgent referral to treatment <62 days*	Apr-18	85%	74.7%	85%	74.7%
Never Events	Apr-18	0	0	0	0
Pressure Ulcers - Grade 1	Apr-18		2		2
Pressure Ulcers - Grade 2	Apr-18		5		5
Pressure Ulcers - Grade 3	Apr-18		0		0
Pressure Ulcers - Grade 4	Apr-18		0		0
Pressure Ulcers - Ungradable	Apr-18		1		1

A positive experience for patients, service users and staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	Apr-18	0	14	0	14
No. of Complaints	Apr-18		4		30
No. of Concerns	Apr-18		12		12
No. of Compliments	Apr-18		36		36
Cancelled operations on/after day of admission (not rebooked within 28 days) - including those not rebooked at the time of reporting *	Apr-18	0	0	0	0
All Cancelled Operations on/after day of admission	Apr-18		13		13
Theatre utilisation	Apr-18	83%	76.7%	83%	76.7%
No. of Reported SIRIs ***	Apr-18		4		4
Physical Assaults against staff	Apr-18		0		0
Verbal abuse/threats against staff	Apr-18		4		4

Working with others to keep our services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual

Skilled and capable staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	Mar-18				75.3%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Mar-18	£ 1,220,038	£ 1,369,887	£ 14,652,984	£ 15,164,302

Cost effective, sustainable services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (IoW CCG + NHS England)	Apr-18	92%	79.9%		
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	Apr-18	0	0	0	0
No. Patients waiting > 6 weeks for diagnostics	Apr-18	<8	39	<100	39
% Patients waiting > 6 weeks for diagnostics	Apr-18	<1%	97.9%	<1%	97.9%
% Sickness Absenteeism	Apr-18	3.5%	4.51%		4.51%

**These are subject to further validation and may change.* ****12 hour breaches are now included in Siri figures* ***The Acute Service Level Agreement performance reports a month behind, therefore figures are from March 2018.*

Key Headlines:

- Cancer Performance – Provisional performance figures show that the Trust failed to achieve the 2ww Breast Symptomatic and 62 Day standards for April. Performance against 2ww Breast Symptomatic was 87.2% with 6 patient-led breaches. Performance against the 62 Day standard was 74.7% including potential tertiary centre treatments/breaches (new Breach Allocation Guidance). 37.5 treatments were identified with 9 local breaches (3 x Colorectal, 1 x Upper GI, 5 x Urology) and 1 x 0.5 potential shared tertiary centre breach (H&N – UHS). This represents the worst case scenario as actual tertiary centre treatments/breaches are not confirmed until upload in early June. Breach reports have been prepared and root cause analysis is undertaken for each of these by operational management to identify the lessons learned and implement actions to mitigate such further delays; these are shared with the Head of Performance. Tertiary centre delays for diagnostics and treatment are escalated to PHT/UHS management via the Lead Cancer Nurse. The tertiary referral system is continuously monitored and issues highlighted as above. Weekly PTL and Patient Access meetings continue to focus on reducing the number of patients passed the 62 day target. Site specific huddles are now taking place twice weekly for all tumour sites. Colorectal pathway review meetings have commenced. Successful recruitment to vacant CNS posts has taken place to minimise impact on local performance. One temporary band 4 MDT Co-ordinator is now in post for nine months until end of July to assist with patient pathway tracking and provide prospective cover for absence. NHSI Workload Tool has been used to identify necessary resource for the Cancer Pathways Team and will support a Business Case. Support is being received from NHSI Intensive Support Team focussing on demand & capacity, performance management and pathway best practice. Pathway Analysis Tool is being developed by PIDS to demonstrate pathway delays. The PTL dashboard is being further developed to highlight non-compliance with milestones. Improved performance against revised trajectory as per Deep Dive Cancer Report (Dec17) and continued reduction of patients waiting over 62days and 104days. Deep Dive Report recommendations are being incorporated into revised Integrated Improvement Framework cancer work stream for delivery and management by the CBU and monitoring by the Trust.
- Theatre utilisation has improved from 70.8% in March to 78.2% in April (this does not include all emergency and private patient theatre activity). Under performance against the 83% target is due to a combination of factors including an increased amount of cancellations on the day and the day before due to winter pressures planned light lists as part of the winter plan continued into April, and late starts caused by late availability of inpatient beds.. Individual surgeon utilisation to be shared with the lead clinicians for the speciality and to include reasons for late starts. Reduction in the number of late starts due to surgeon not arriving on time to start the list will improve utilisation against the local target. Daily huddles to review theatre lists and escalate any under-utilised lists, alongside regular review of day surgery capacity to ensure maximisation of cases on lists. Escalation of under utilised lists to operational managers for addressing.
- The Trust continues to under-perform against the national diagnostic target requiring 99% of patients waiting to receive their diagnostic test within 6 weeks of being referred. This is in part due to difficult to recruit into Endoscopy Nurse and Consultant vacancies. Due to consultant annual leave, study leave, on-call etc there has been a reduction of lists during the month of March which continues to lead to breaches in all specialities in the month of April - colonoscopy, gastroscopy, flexible sigmoidoscopy, cystoscopy. An additional three weekend lists have been put in place through Medinet to clear the outstanding backlog. Delivery of the planned sub-contracting will enable a manageable waiting list size to be achieved, which, in turn will enable the diagnostics target for the endoscopy procedures to be achieved. Delivery will be monitored by the Clinical Business Unit and Patient Access Group
- Mixed Sex Breaches - Options paper drafted to refurbish DSU and address mixed sex accommodation going forward. Work will not commence until 2018. Risk being mitigated in interim.

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Emergency Care 4 hours Standard (ECS)

Commentary:

The Trust has set new performance trajectories for 2018/19 for each of its key national targets based on the 2017/18 outturn position and in alignment with the national operational planning guidance; these are currently subject to further review and any revisions will be reported to Board accordingly.

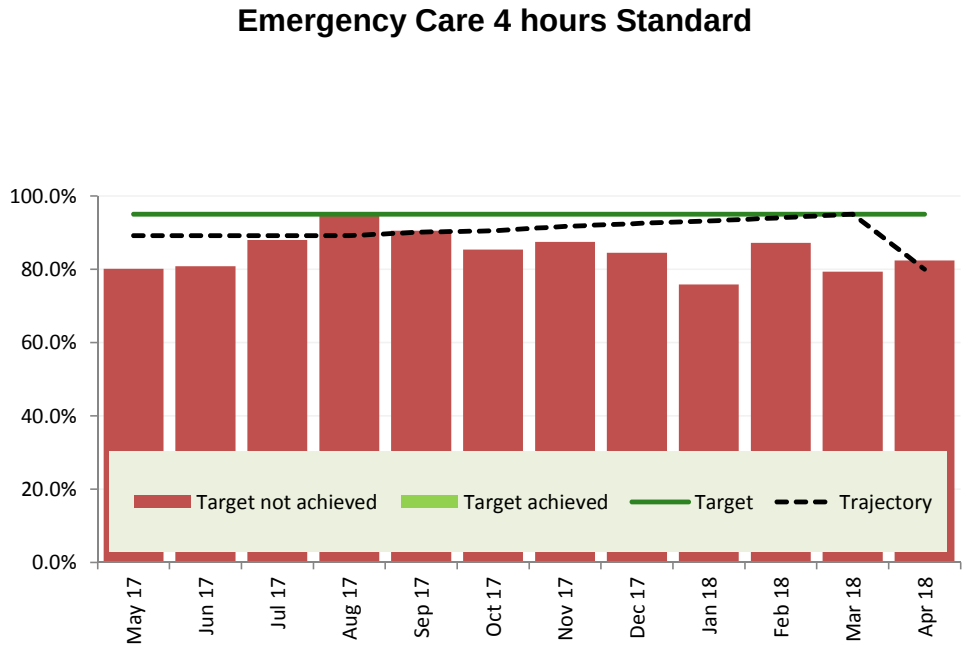
Issue:
The Trust performed at 82.4% against the Emergency Care Standard trajectory of 80% for April 2018 (national target is 95%). The requirement entering quarter 1 is to sustain this performance against the trajectory as it increases during the year with the aim of achieving 90% in September 2018 and the national target in March 2019.

Actions:
• Increase and develop GP streaming;
• Develop ambulatory care through Ambulatory Emergency Care (AEC) Collaborative;
• Reduce length of stay (LOS) of patients staying longer than 7 days (stranded patients) on Wards and reduce the number of bed days occupied by patients with a LOS greater than 21 days, termed super stranded, to less than 10% of current bed stock or less than the benchmarked figure in a comparable Trust;
• Reduce delayed transfers of care (DTOCs);
• Flex medical bed capacity to match seasonal demands; and,
• Complete Emergency Department estates works.

Impact:
The impact of these improvement actions will be quantified as to their contribution towards a sustainable recovery against the current position whilst needing to accommodate the planned reduction of medical bed capacity as we approach the Summer period, thereby, contributing to an improved Referral to Treatment (RTT) performance.

Governance:
As with other urgent care service delivery, hourly and daily monitoring takes place, informing Clinical Business Unit leadership meetings and Executive Performance Reviews, informing the new Acute Services Directorate Board.

Analysis:



Isle of Wight NHS Trust Board Performance Report 2018/19

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Cancer urgent referral to treatment <62 days

Commentary:

The Trust has set new performance trajectories for 2018/19 for each of its key national targets based on the 2017/18 outturn position and in alignment with the national operational planning guidance; these are currently subject to further review and any revisions will be reported to Board accordingly.

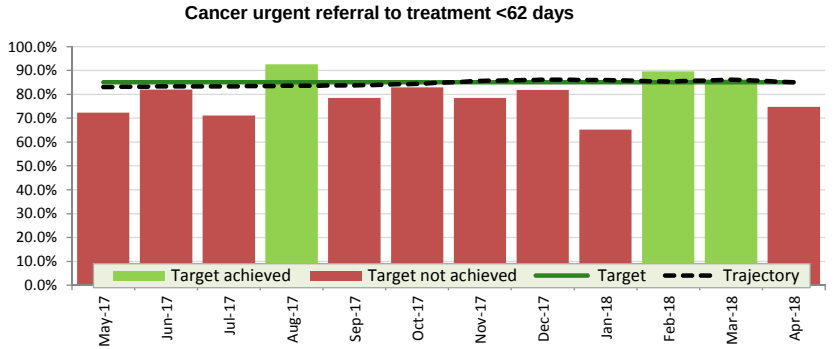
Issue:
The Trust has provisionally under-performed in April 2018 at 72.7% against the 62 Day Cancer 85% trajectory (as per the national target) for April 2018; the final performance is subject to actual tertiary centre treatments / breaches for upload in early June. For April, there are currently 38.5 treatments identified with 10.5 breaches; the tumour site level performance and breach detail is provided in the table alongside. This is a worsening of performance compared to the previous two months when the national target was achieved, therefore, the focus is to reduce the number of long waiting patients and ensure treatment is timely both locally and at tertiary providers.

Actions:
Finalise the cancer and diagnostics project plan including delivery of the deep dive report recommendations, in particular:
• Increase the number of cancer pathway trackers in the cancer pathways team;
• Increase local diagnostic imaging capacity;
• Increase local endoscopy capacity; and,
• Increase cancer nurse specialist capacity to manage increased referrals and increased activity per patient.

Impact:
Recovery of performance against revised trajectory and continued reduction of patients waiting over 62days and 104days, ensuring timely treatment.

Governance:
Deep Dive Report recommendations are being incorporated into revised cancer and diagnostics project plan for delivery and management by the CBU and monitoring by the Trust. Daily oversight of tumour site level waiting lists continues with the Clinical Business Units, feeding into the weekly Trustwide Patient Access Group, alongside the monthly Executive Performance Reviews, into the newly forming Acute Services Directorate Board.

Analysis:



	local treatments	local breaches	tertiary treatment allocated to IOW	tertiary treatment allocated to tertiary	tertiary breach allocated to IOW	tertiary breach allocated to tertiary	total treatments	total breaches	%	breach reasons
62 day cancer	36	9	2.5	4.5	1.5	1.5	38.5	10.5	72.73%	
breast	10						10	0	100.00%	
colorectal	5	3					5	3	40.00%	1 x Colorectal - Patient had high temperature - treatment deferred for one week 1 x Colorectal - Required additional imaging to define liver lesion 1 x Colorectal - Patient required Tertiary Centre MDT discussion and additional imaging
gynaecology	2						2	0	100.00%	
haematology	1		0.5	0.5	1		1.5	1	33.33%	1 x Potential UHS Haem
H&N	1		0.5	1.5	0.5	0.5	1.5	0.5	66.67%	1 x Potential UHS H&N
lung			0.5	1.5			0.5	0	100.00%	
skin	5						5	0	100.00%	
UGI	1	1	0.5	0.5			1.5	1	33.33%	1 x UGI - Referred from other tumour site - required multiple MDT discussions and Tertiary Centre investigation,
urology	11	5	0.5	0.5		1	11.5	5	56.52%	1 x Urology - Required Tertiary Centre investigation after initial treatment plan inappropriate 1 x Urology - Clinically-indicated delay to histological investigation 1 x Urology - Clinically-led delay to follow-up OPA, 1 x Urology - Patient required in-patient cystoscopic investigation prior to treatment 1 x Urology - Oncology out-patient capacity inadequate

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Referral to Treatment Times

Commentary:

The Trust has set new performance trajectories for 2018/19 for each of its key national targets based on the 2017/18 outturn position and in alignment with the national operational planning guidance; these are currently subject to further review and any revisions will be reported to Board accordingly.

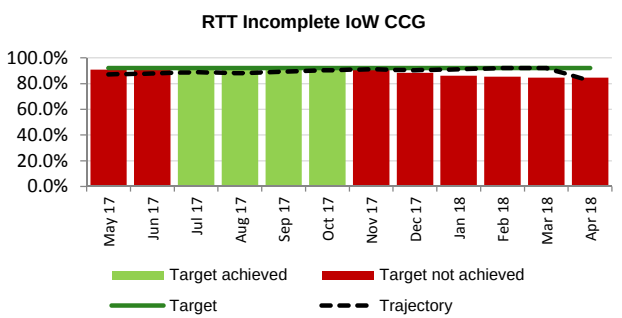
Issue:
The Trust performed at 84.1% against the Referral to Treatment (RTT) 82.1% trajectory for April 2018 (the national target is 92%), sustaining the previous month's performance of around the same level. The requirement entering quarter one is to deliver the 2018/19 planned activity levels, however, this has been affected by the impact of medical patients continuing to occupy surgical wards, as well as the impact of the emergency activity forecast during the Easter period.

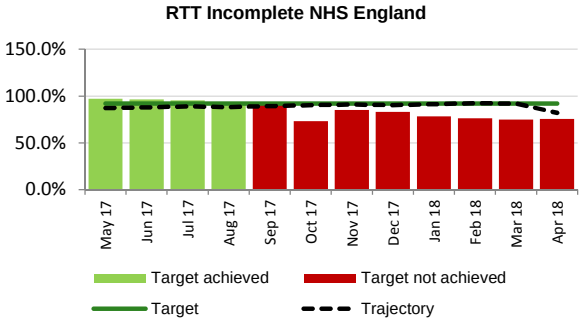
Actions:
- Finalise 18/19 demand and capacity plans including IST non admitted modelling
- Implement robust recovery plan at specialty and 'point of delivery' level
- Deliver diagnostics performance, in particular, improving endoscopy capacity
- Deliver surgical length of stay programme of work
- Deliver KPMG efficiencies from quarter 2, in particular, improving outpatient clinic productivity and improving theatre utilisation

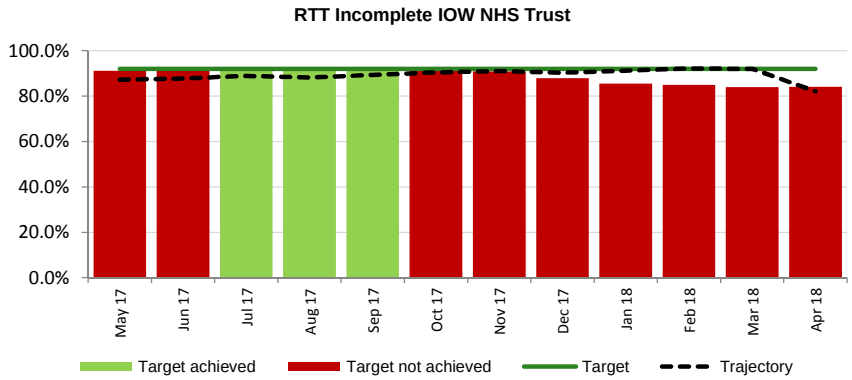
Impact:
Undertaking inpatient activity will improve patient experience, reduce waiting times for elective procedures and recover the current under-performance as we commence 2018/19. Delivery of outpatient efficiencies will improve the non-admitted element of this performance target thereby, offsetting the current under-performance of the admitted element.

Governance:
Daily oversight of the elective activity is undertaken by the Clinical Business Units, feeding into weekly RTT specialty meetings and the Trustwide Patient Access Group, alongside the monthly Executive Performance Reviews, into the newly forming Acute Services Directorate Board.

Analysis:







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Patients waiting > 6 weeks for diagnostics

Commentary:

The Trust has set new performance trajectories for 2018/19 for each of its key national targets based on the 2017/18 outturn position and in alignment with the national operational planning guidance; these are currently subject to further review and any revisions will be reported to Board accordingly.

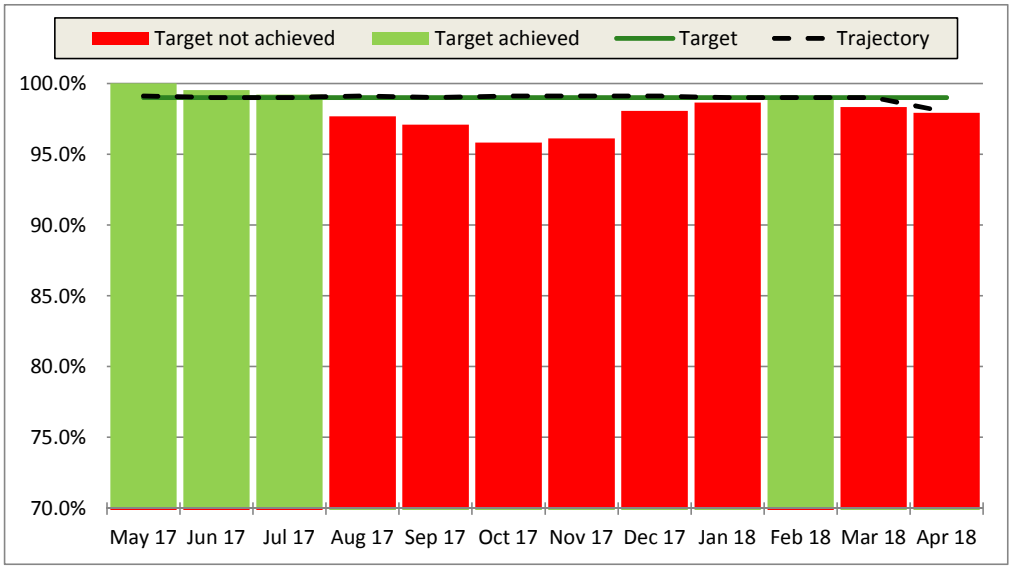
Issue:
The Trust slightly under-performed in April 2018 at 97.9% against the diagnostic trajectory of 98% (national target is 99%) requiring patients receive their diagnostic test within 6 weeks of being referred; this under-performance is due to capacity issues leading to longer waits for some tests.

Actions:
• Identify reasons for late / non-receipt referrals at diagnostic test level and actions to improve the process
• Identify reasons for hospital led cancellations at diagnostic test level and actions to improve capacity to meet the demand
• Identify reasons for lack of capacity and process inefficiency at diagnostic test level and actions to improve the capacity and actions to improve the process
• Gain assurance of robust diagnostic pathway management across the Trust including consistent application of national guidance and standard validation processes

Impact:
Delivery of the recovery actions with realistic actions and timescales will enable a manageable waiting list size to be achieved, which, in turn will enable performance against the diagnostics target for all tests.

Governance:
Delivery will be monitored by the Clinical Business Unit, Trustwide Patient Access Group, and Executive Performance Review, leading into the new Acute Services Directorate Board.

Analysis:



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Benchmarking of Key National Performance Indicators: Summary Report

	National Target	National Performance			IW Performance	IW Rank		IW Status	Data Period
		Best	Worst	Eng					
Emergency Care 4 hour Standards	95%	100%	65%	85.0%	80.5%	**112**	**161**	Amber Red	Qtr 4 17/18
RTT % of incomplete pathways within 18 weeks	92%	100%	66%	86.8%	84.0%	**150**	**183**	Red	Mar-18
%. Patients waiting > 6 weeks for diagnostic	1%	0%	32%	2.1%	1.7%	**124**	**175**	Amber Red	Mar-18
Cancer patients seen <14 days after urgent GP referral	93%	100%	68%	94.5%	96.9%	**29**	**149**	Green	Qtr 4 17/18
Cancer diagnosis to treatment <31 days	96%	100%	85%	96.4%	95.5%	**120**	**153**	Red	Qtr 4 17/18
Cancer urgent referral to treatment <62 days	85%	100%	56%	83.0%	81.1%	**108**	**152**	Amber Red	Qtr 4 17/18
Symptomatic Breast Referrals Seen <2 weeks	93%	100%	51%	92.3%	93.3%	**79**	**129**	Amber Red	Qtr 4 17/18
Cancer Patients receiving subsequent surgery <31 days	94%	100%	77%	94.5%	96.7%	**81**	**148**	Amber Red	Qtr 4 17/18
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	100%	89%	99.0%	100.0%	**1**	**130**	Green	Qtr 4 17/18
Cancer Patients treated after screening referral <62 days	90%	100%	0%	90.7%	88.9%	**79**	**135**	Amber Red	Qtr 4 17/18

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

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

Other Small Acute Trusts	National Target	IW	RA3	RA4	RBD	RBT	RBZ	RC1	RC3	RCD	RCF	RCX	RD8	RE9	RFF	RFW	RGR	RJC	RJD	RJF	RJN	RLQ	RLT	RMP	RN7	RNQ	RNZ	RQQ	RQX	Data Period
Emergency Care 4 hour Standards	95%	80.5% 17	76.0% 21	94.9% 2	96.1% 1	78.1% 18	85.7% 11	84.3% 15	N/A	92.7% 4	92.5% 5	76.8% 20	88.1% 10	90.0% 6	88.9% 7	N/A	84.7% 13	85.1% 12	N/A	88.7% 9	71.2% 23	72.5% 22	77.7% 19	84.7% 14	82.6% 16	68.8% 24	88.8% 8	N/A	93.4% 3	Qtr 4 17/18
RTT % of incomplete pathways within 18 weeks	92%	84.0% 19	90.4% 12	91.0% 11	88.1% 15	92.7% 3	NA	87.5% 16	NA	90.2% 13	92.2% 5	81.1% 21	84.6% 18	95.6% 1	92.2% 7	NA	89.5% 14	91.3% 10	NA	92.1% 8	85.7% 17	N/A	81.9% 20	92.0% 9	92.4% 4	77.1% 22	92.2% 6	NA	95.4% 2	Mar-18
%. Patients waiting > 6 weeks for diagnostic	1%	1.7% 19	0.5% 11	0.5% 10	11.9% 23	0.3% 6	21.1% 24	0.6% 12	NA	0.5% 9	3.8% 22	2.5% 21	1.0% 17	0.0% 1	1.0% 16	NA	0.7% 13	2.3% 20	NA	0.4% 8	1.0% 15	0.0% 5	0.0% 3	0.0% 1	0.4% 7	0.9% 14	1.5% 18	NA	0.0% 4	Mar-18
Cancer patients seen <14 days after urgent GP referral	93%	96.9% 5	94.0% 25	96.1% 14	92.2% 28	95.6% 21	91.7% 30	94.3% 23	NA	96.5% 11	96.5% 12	97.2% 3	95.8% 19	89.4% 31	95.7% 20	NA	96.6% 9	97.0% 4	NA NA	96.9% 7	96.2% 13	92.9% 27	98.3% 1	96.5% 10	96.0% 15	95.9% 18	94.3% 23	NA	95.9% 17	Qtr 4 17/18
Cancer diagnosis to treatment <31 days	96%	95.5% 19	93.7% 21	97.1% 16	96.3% 18	100.0% 1	97.3% 15	93.4% 23	NA	99.2% 9	100.0% 1	97.5% 13	98.0% 10	100.0% 1	97.7% 12	NA	100.0% 1	97.4% 14	NA	95.5% 20	100.0% 1	93.4% 22	97.0% 17	100.0% 1	100.0% 1	97.9% 11	84.8% 24	NA	100.0% 1	Qtr 4 17/18
Cancer urgent referral to treatment <62 days	85%	81.1% 19	73.9% 24	85.3% 15	79.5% 21	92.1% 2	76.4% 23	83.4% 18	NA	90.6% 4	90.4% 6	80.7% 20	89.0% 8	91.4% 3	90.5% 5	NA	84.7% 16	85.7% 14	NA	85.9% 13	88.4% 10	87.9% 11	86.1% 12	92.9% 1	88.8% 9	89.4% 7	83.5% 17	NA NA	79.4% 22	Qtr 4 17/18
Breast Cancer Referrals Seen <2 weeks	93%	93.3% 15	95.1% 12	98.8% 4	90.9% 19	51.2% 23	91.7% 18	92.0% 17	NA	89.4% 21	95.2% 11	97.0% 7	95.9% 8	NA	95.8% 9	NA	92.4% 16	98.8% 6	NA	99.5% 2	90.6% 20	72.0% 22	99.7% 1	94.8% 14	95.0% 13	99.1% 3	97.9% 6	NA	95.3% 10	Qtr 4 17/18
Cancer Patients receiving subsequent surgery <31 days	94%	96.7% 16	92.9% 22	94.1% 19	97.1% 15	100.0% 1	100.0% 1	94.4% 18	NA	96.6% 17	100.0% 1	93.3% 21	100.0% 1	100.0% 1	100.0% 1	NA	100.0% 1	85.2% 24	NA	100.0% 1	100.0% 1	90.9% 23	94.1% 19	100.0% 1	100.0% 1	100.0% 1	100.0% 1	NA	100.0% 1	Qtr 4 17/18
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	100.0% 1	90.9% 20	100.0% 1	98.0% 18	NA	95.7% 19	100.0% 1	NA	98.8% 17	100.0% 1	99.1% 16	100.0% 1	100.0% 1	100.0% 1	NA	100.0% 1	100.0% 1	NA	100.0% 1	100.0% 1	NA	100.0% NA	NA	100.0% 1	100.0% 1	100.0% 1	NA	NA	Qtr 4 17/18
Cancer Patients treated after screening referral <62 days	90%	88.9% 15	81.8% 19	80.0% NA	100.0% 1	100.0% 1	66.7% 23	90.3% 14	NA	100.0% 1	85.0% 17	94.4% 12	81.5% 20	100.0% 1	91.0% 13	NA	95.1% 11	79.2% 22	NA	98.3% 8	100.0% 1	95.7% 10	88.2% 16	50.0% 24	83.7% 18	96.0% 9	100.0% 1	NA	100.0% 1	Qtr 4 17/18

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

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

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

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

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

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

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

	National Target	IW	R1C	RBD	RD3	RDY	RDZ	RHM	RHU	RN5	RW1	Data Period
Emergency Care 4 hour Standards	95%	80.5% 7	NA	96.1% 2	86.7% 4	NA	91.9% 3	83.9% 5	71.1% 8	81.3% 6	100.0% 1	Qtr 4 17/18
RTT % of incomplete pathways within 18 weeks	92%	84.0% 10	99.7% 1	88.1% 6	87.2% 7	95.9% 2	88.9% 5	86.2% 8	86.0% 9	90.4% 4	94.0% 3	Mar-18
%. Patients waiting > 6 weeks for diagnostic	1%	1.7% 6	0.0% 1	11.9% 10	3.0% 9	1.2% 4	0.5% 3	2.9% 8	1.4% 5	1.8% 7	0.0% 1	Mar-18
Cancer patients seen <14 days after urgent GP referral*	93%	96.9% 5	NA	92.2% 28	98.2% 2	NA	96.0% 16	93.9% 26	95.6% 22	96.8% 8	NA	Qtr 4 17/18
Cancer diagnosis to treatment <31 days*	96%	95.5% 6	NA	96.3% 5	97.9% 3	NA	96.8% 4	89.6% 7	99.0% 2	99.2% 1	NA	Qtr 4 17/18
Cancer urgent referral to treatment <62 days*	85%	81.1% 5	NA	79.5% 6	87.6% 2	NA	89.1% 1	78.7% 7	83.9% 4	85.3% 3	NA	Qtr 4 17/18
Breast Cancer Referrals Seen <2 weeks*	93%	93.3% 5	NA	90.9% 6	98.3% 2	NA	100.0% 1	81.4% 7	95.1% 4	95.9% 3	NA	Qtr 4 17/18
Cancer Patients receiving subsequent surgery <31 days*	94%	96.7% 4	NA	97.1% 2	97.1% 2	NA	95.7% 6	86.7% 7	98.0% 1	96.5% 5	NA	Qtr 4 17/18
Cancer Patients receiving subsequent Chemo/Drug <31 days*	98%	100.0% 1	NA	98.0% 7	100.0% 1	NA	100.0% 1	100.0% 1	99.1% 6	100.0% 1	NA	Qtr 4 17/18
Cancer Patients treated after screening referral <62 days*	90%	88.9% 7	NA	100.0% 1	98.6% 3	NA	93.3% 5	89.3% 6	94.0% 4	100.0% 1	NA	Qtr 4 17/18

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

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

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

Terms and abbreviations used in this performance report

Quality & Performance and General terms

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

Workforce and Finance terms

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

Enc L

Agenda Item No	13.2	**Meeting**	Trust Board in Public	**Meeting Date**	07/06/2018
Title	Performance Report - Ambulance Services & Patient Transport Services				
Sponsoring Executive Director	Bob Williams, Advisor to the Trust Board - Ambulance				
Author(s)	Victoria White, Head of Operations - Ambulance				
Report previously considered by inc date	Performance Committee				

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	
Lead strategic change on the Isle of Wight	X

Link to CQC Well Led Domains			
Effective	X	Responsive	X
Caring	X	Well-led	X
Safe	X		

Executive Summary

Proxy reporting of new Ambulance Response Programme national targets commenced and data for the service is now being submitted nationally

NHS 111 (95% target):
- Targets re call answering and calls aborted both met.
- Targets re clinicians were outside the standards; to be addressed over the next few months as part of the further development of a fully integrated call handling hub.

Ambulance performance:
- Category 1 targets have not been met; however, this has been the first month of application of the new targets. The service has averaged 1 x Category 1 incident per day and is yet to fully evaluate what it will take to meet the standards on a daily basis with these dynamics.
- The vast majority of ambulance calls on a daily basis fall into either Category 2 or 3 and all the standards associated with these for April were met.

Priority actions which continue alongside the implementation of reporting against the new Ambulance targets are:
- Review of governance and leadership requirements;
- Review of current transfer and discharge process;
- Further development of a fully integrated call handling hub
- Evaluation of service requirements to determine requirements to meet standards on a daily basis
- Review of Hub and operational processes to deliver the Ambulance Response Programme sustainably
- Implementation of the new Computer Aided Dispatch system.

Key Recommendation

The Board is asked to consider the following recommendations:
- To note the current performance position of the ambulance service

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Performance Summary - Ambulance

Balanced Scorecard - Ambulance

Excellent Patient Care	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	Apr-18	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection - stretched target)	Apr-18		0		0
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	Apr-18	1	0	3	0
Clinical Incidents (Catastrophic) resulting in harm(actual only - as confirmed by investigation)	Apr-18		2		2
Falls - resulting in significant injury	Apr-18		0		0
Never Events	Apr-18	0	0	0	0
Pressure Ulcers - Grade 1	Apr-18		2		2
Pressure Ulcers - Grade 2	Apr-18		1		1
Pressure Ulcers - Grade 3	Apr-18		1		1
Pressure Ulcers - Grade 4	Apr-18		0		0
Pressure Ulcers - Ungradable	Apr-18		0		0

A positive experience for patients, service users and staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Mixed Sex Accommodation Breaches	Apr-18	0	0	0	0
No. of Complaints	Apr-18		13		66
No. of Concerns	Apr-18		8		8
No. of Compliments	Apr-18		0		0
Emergency Care 4 hour Standards	Apr-18	95%	82.4%	95%	82.4%
Number of patients who have waited over 12 hours in A&E from decision to admit to admission	Apr-18	0	0	0	0
Ambulance response on scene by category - Category 1 - Mean	Apr-18		00:07:43	0%	00:07:43
Ambulance response on scene by category - Category 1 - 90th centile	Apr-18		00:16:37	0%	00:16:37
Ambulance response on scene by category - Category 2 - Mean	Apr-18		00:12:20	0%	00:12:20
Number of Ambulance Handover Delays over 1 hours	Apr-18		0		0
No. of Reported SIRIs *	Apr-18		3		3
Physical Assaults against staff	Apr-18		4		4
Verbal abuse/threats against staff	Apr-18		3		3

Working with others to keep improving our services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual

Skilled and capable staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	Mar-18				57.7%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Mar-18	£ 2,402,441	£ 2,396,102	£ 28,894,956	£ 29,109,411

Cost effective, sustainable services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
% Sickness Absenteeism	Apr-18	5.5%	4.70%		4.70%
Ambulance time to answer call (in seconds) - median	Apr-18	1	1	-	-
Ambulance time to answer call (in seconds) - 95th percentile	Apr-18	5	21	-	-
Ambulance time to answer call (in seconds) - 99th percentile	Apr-18	14	87	-	-
NHS 111 Call abandoned rate	Apr-18	5%	1.5%	5%	1.5%
NHS 111 All calls to be answered within 60 seconds of the end of the introductory message	Apr-18	95%	95.9%	95%	95.9%
NHS 111 Where disposition indicates need to pass call to Clinical Advisor this should be achieved by 'Warm Transfer'	Apr-18	95%	92.7%	95%	92.7%
NHS 111 Where the above is not achieved callers should be called back within 10 mins	Apr-18	100%	33.7%	100%	33.7%

**12 hour breaches are now included in Siri figures* ***The Acute Service Level Agreement performance reports a month behind, therefore figures are from March 2018.*

Key Headlines:

Ambulance: Proxy reporting of new Ambulance Response Programme national targets commenced and being submitted nationally
Priority actions continue alongside the implementation of reporting against the new Ambulance targets are:
- review of governance and leadership requirements; review of current transfer and discharge process; further development of a fully integrated call handling hub ; evaluation of service requirements to determine requirements to meet standards on a daily basis ; review of hub and operational processes to deliver ARP sustainably; implementation of new CAD.

Community:
Ongoing development of provision of services through locality model. 0-19 services, Integrated Community Nursing are leading way.
Frailty- initial data from front door frailty initiative demonstrates an impact on LOS and likely readmission/ attendance rate. This is being progressed at speed to generate further quality outcomes for this cohort.
All Adults Orthotics patients are waiting within 18 weeks, excluding those that have DNA. A further improvement of 6% from last month of those patients waiting within time. Children's Orthotics waiting list longest wait is currently at 7 weeks
Acute OT response times continue to improve, extended working hours, closer MDT working with the implementation of priority meetings to allocate patients across the team, the wait for urgent assessment is currently around 17hours, much closer to the NHS Benchmarking standard of 11hours
Increase in referrals for Community Physiotherapy (Specialist Practitioner Referred)
SPARRCS referrals remain high with over 120 referrals received in fortnight cycle .
Community Nursing caseload review underway; 0-19 Caseload review continues and performance against KPIs remains above average
DNA rates across Community services remain stable and in line with national benchmarking
Referrals for the management of diabetic patients has risen in Dietetics, Community Nursing and Podiatry.
Urgent Care
Underperformance against national target; actions being taken forward include introductio of pitstop model in ED and 2 hourly huddles (Nurse in charge, nurse co-ordinating minors and senior doctor) to improve communication and flow; phase 1 estates to remodel minors in ED underway and due to complete May . Plans in place to commence/launch ambulatory care model in June one phase 2 of internal estates works

Isle of Wight NHS Trust Board Performance Report 2018/19

April 18

New Ambulance Response Programme

Commentary:

Position:
Proxy reporting of new Ambulance Response Programme national targets commenced and being submitted nationally; April's position is shown here.

Action:
Priority actions continue alongside the implementation of reporting against the new Ambulance targets are:
- review of governance and leadership requirements;
- review of current transfer and discharge process;
- further development of a fully integrated call handling hub
- evaluation of service requirements to determine requirements to meet standards on a daily basis
- review of hub and operational processes to deliver ARP sustainably; and,
- implementation of new CAD.

Impact:
Performance information, as it develops, will inform the trajectory for delivery against the new ARP standards; it is forecast it will remain at baseline for quarter 1 with an increase upwards to meet the core standards by September.

Governance:
The performance of the Service is being monitored and managed throughout the Trust, however, the Ambulance Service is currently reviewing its governance structures in line with the new Trust Executive stuctures.

Analysis:

Initial Performance report for week ending 20th April 2018

999 Performance	Mean standard	Mean	90% standard	90%
Call Answer	N/A	04.38	N/A	14.00
Category 1	7 minutes	11:07	15 minutes	18:05
Category 2	18 minutes	15:15	40 minutes	39:30
Category 3	N/A	35:13	120 minutes	01:31:20
Category 4	N/A	01:25:19	180 minutes	02:45:49

111 Performance	Standard	Performance
Call Answer	95% < 60 seconds	95.91%
Calls abandoned	<5% after 30 seconds	1.46%
Calls with clinician	>20%	18.79%
Triaged calls with clinician	>50%	42.50%

Please note there are caveats around the ambulance data with the existing CAD reporting capability

Current programme of works	Due date
Implementation of new EPRR governance	April 2018
Review of ambulance service governance and leadership requirements	May 2018
Review of current ambulance transfer and discharge processes	May 2018
Review of ambulance hub & operational processes to deliver ARP sustainably	September 2018

Key risks	Status
Data quality of ARP performance reporting	
Replacement of existing ambulance CAD	
Completion of NARU audit requirements	

Please note there are caveats around the ambulance data with the existing CAD reporting capability

Enc M

Agenda Item No	13.3	**Meeting**	Trust Board in Public	**Meeting Date**	07/06/2018
Title	Performance Report - Community Services				
Sponsoring Executive Director	Barbara Stuttle, Nursing Advisor to the Board - Community Services				
Author(s)	Emma Pugh / Jen Edgington				
Report previously considered by inc date	Performance Committee				

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

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 Well Led Domains			
Effective	X	Responsive	X
Caring	X	Well-led	X
Safe	X		

Executive Summary

Ongoing development of provision of services through locality model; 0-19 services has started their realignment, Integrated Community Nursing are leading way.

Frailty- initial data from front door frailty initiative demonstrates an impact on LOS and likely readmission/ attendance rate. This is being progressed at speed to generate further quality outcomes for this cohort.

All Adults Orthotics patients are waiting within 18 weeks, excluding those that have DNA. A further improvement of 6% from last month of those patients waiting within time.
Children's Orthotics waiting list longest wait is currently at 7 weeks.

Acute OT response times continue to improve, extended working hours, closer MDT working with the implementation of priority meetings to allocate patients across the team, the wait for urgent assessment is currently around 17 hours, much closer to the NHS Benchmarking standard of 11hours.
Increase in referrals for Community Physiotherapy (Specialist Practitioner Referred)
SPARRCS referrals remain high with over 120 referrals received in fortnight cycle .

Community Nursing caseload review underway.

0-19 Caseload review continues and performance against KPIs remains above average.

DNA rates across Community services remain stable and in line with national benchmarking.

Referrals for the management of patients with Diabetes have risen in Dietetics, Community Nursing and Podiatry.

Key Recommendation

The Board is asked to consider the following recommendations:
- To note the current performance position of the Community Services.

Enc N

Agenda Item No	13.4	**Meeting**	Trust Board in Public	**Meeting Date**	07/06/2018
Title	Performance Report - Mental Health & Learning Disabilities Services				
Sponsoring Executive Director	Lesley Stevens, Associate Medical Director for Mental Health				
Author(s)	Sue Nelson & John Doherty				
Report previously considered by inc date	Performance Committee				

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	
Lead strategic change on the Isle of Wight	X

Link to CQC Well Led Domains			
Effective	X	Responsive	X
Caring	X	Well-led	X
Safe	X		

Executive Summary

7 Day Follow up for inpatients discharged from inpatient services

The CBU has been unable to maintain consistent performance against this indicator over the last year. The responsibility for carrying out the follow-ups will be held by the Crisis Resolution and Home Treatment Team to ensure consistency thereby meeting our constitutional target, ensuring patient safety and appropriate follow-up.

RTT

The CBU is currently validating all of the identified long waits to resolve any data quality issues and ensure patients identified as waiting for appointments are booked as a priority.

KPIs

The CBU is working with PIDs to develop a suit of appropriate MH KPIs which will be monitored by the new MH CBU Board and reported to Trust Board on a monthly basis.

The Board is asked to consider the following recommendations:

- To note the current performance position of the Mental Health & Learning Disabilities Service

Isle of Wight NHS Trust Board Performance Report 2018/19

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Isle of Wight NHS Trust Board Performance Report 2018/19

April 18

Performance Summary - Mental Health and Learning Disabilities

Balanced Scorecard - Mental Health and Learning Disabilities

Excellent Patient Care	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
MRSA (confirmed MRSA bacteraemia)	Apr-18	0	0	0	0
C.Diff (confirmed Clostridium Difficile infection)	Apr-18		0		0
Clinical Incidents (Major) resulting in harm (all reported, actual & potential, includes falls & PU G4)	Apr-18	1	0	3	0
Clinical Incidents (Catastrophic) resulting in harm (actual only - as confirmed by investigation)	Apr-18		1		1
Falls - resulting in significant injury	Apr-18		0		0
Never Events	Apr-18	0	0	0	0
% of EIP pathways completed within two weeks	Apr-18	50%	100.0%	50%	100.0%
IAPT – Proportion of people who have completed treatment and moving to recovery	Apr-18	50%	53.8%	50%	53.8%
% of Users known to CMHS with a risk assessment completed within the last 12 months	Apr-18	100%	87.9%		87.9%

A positive experience for patients, service users and staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
FFT - % Response Rate	Apr-18		1.8%		1.8%
FFT - % Recommending	Apr-18	90%	97%	90%	97%
No. of Complaints	Apr-18		4		29
No. of Concerns	Apr-18		1		1
No. of Compliments	Apr-18		0		0
No. of Reported SIRIs *	Apr-18		1		1
Physical Assaults against staff	Apr-18		6		6
Verbal abuse/threats against staff	Apr-18		19		19
% of CPA patients receiving FU contact within 7 days of discharge	Apr-18	95%	Not Available	95%	Not Available
% of CPA patients having formal review within last 12 months	Apr-18	95%		95%	0.0%
% of MH admissions that had access to Crisis Resolution / Home Treatment Teams (HTTs)	Apr-18	95%	95.5%	95%	95.50%

Working with others to keep improving our services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Delayed Transfer of Care (lost bed days) - (MH)	Apr-18		0		0

Skilled and capable staff	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
Appraisals	Mar-18				59.2%

Income**	Latest data	In Month		YTD	
		Plan	Actual	Plan	Actual
Total SLA Value	Mar-18	£ 2,079.758	£ 2,559.058	£ 37,729.520	£ 59,861.720

Cost effective, sustainable services	Latest data	In Month		YTD	
		Target	Actual	Target	Actual
RTT % of incomplete pathways within 18 weeks (IoW CCG + NHS England)	Apr-18	92%	84.7%		
Zero tolerance RTT waits over 52 weeks (Incomplete Return)	Apr-18	0	0	0	0
% Sickness Absenteeism	Apr-18	4.5%	5.95%		5.95%
Caseload management supervision	Apr-18	90%	Not Available		78%
Bed occupancy	Apr-18		89.6%		89.6%

**12 hour breaches are now included in Siri figures*

***The Acute Service Level Agreement performance reports a month behind, therefore figures are from March 2018.*

Key Headlines:

Sickness levels had been improving but have increased again in April. The service will undertake a piece of work to understand the detail and trends.
The 7-day follow-up target was achieved in March but unfortunately the CBU has been unable to consistenly achieve this target in year resulting a year end position lower than the required target. The CBU will discuss issues and improvement plans for this indicator at the next Leadership Meeting.
The CBU is working with PIDS to develope new reports for reporting against the CPA formal review within 12 months indicator. Data validation is to be undertaken and when complete the report be backdated to October 17.
RTT performance has dipped below target this month due to a number of long waits in the Single Point of Access for Adult MH Services, these waits are currently being validated. The CBU is aware of capacity issues within the Single Point of Access and work is ongoing to review Consultant Job Plans across the community service to create additional capacity for new patient assessments in the longer term. A new In-patient Consultant Psychiatrist has taken up post and will be providing additional capacity in Single Point of Access in the short term whilst completing the qualifications necessary for the in-patient role.

Enc O

Agenda Item No	14	**Meeting**	Trust Board in Public	**Meeting Date**	7 June 2018
Title	Terms of Reference and Membership for Board and Committees				
Sponsoring Executive Director	Suzanne Rostron, Director of Quality Governance				
Author(s)	David Haycox, Governance Advisor Lynn Cave, Board Governance Officer				
Report previously considered by inc date	Review by all Committees and Executive Team				

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

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 Well Led Domains			
Effective		Responsive	
Caring		Well-led	X
Safe			

Executive Summary

The Trust Board Committees' Terms of Reference and Membership were considered and approved by the Board in November 2017. Subsequently, the Executive Director structure has been revised following proposals by the Chief Executive which were approved by the Board.

These Terms of Reference reflect the required changes to membership to take account of the new Executive Director structure. Additionally, the Trust Board Committees Governance Pack (attached) has also been updated to reflect the agreement for Integrated Improvement Framework Board to be closed.

The Terms of Reference for the Trust Board have also been revised to reflect the Executive Director membership.

Key Recommendation

The Board is recommended to approve the Terms of Reference for the Trust Board and the Trust Board Committees Governance Pack.

Isle of Wight NHS Trust Board

Terms of Reference and Membership

Date Valid from: 7 June 2018

1. MAIN PURPOSE

1.1 The Trust exists to 'provide goods and services, namely hospital accommodation and services, community health services and ambulance and associated transport services for the purposes of the health service (from the Trust Establishment Order March 2012).

1.2 The Trust has a Board of Directors, known as the Trust Board, which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate powers to a sub-committee of the Board or to one or more executive director(s). This is detailed in the Scheme of Reservation and Delegation.

1.3 The Trust Board leads the Trust by undertaking the following key roles:

a) Formulating strategy
b) Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
c) Shaping and role-modelling a positive culture for the Trust.

1.4 The general duty of the Trust Board, and each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

2. MEMBERSHIP AND QUORUM

2.1 Membership

2.1.1 The Trust Board will consist of 11 voting members. The composition of the Trust Board is laid down in the Trust's Standing Orders (Section 5.1.1)

2.1.2 The voting membership comprises:

a) The Non-Executive Chairman of the Trust
b) Five other Non-Executive Directors including a Senior Independent Non-Executive Director and a Vice Chairman
c) The following Executive Directors:
   - Chief Executive Officer
   - Director of Finance & Information
   - Medical Director
   - Director of Nursing, Midwifery, Allied Health Professionals & Community Services
   - Deputy Chief Executive *(until August 18 when the post ceases. Voting rights will at this point transfer to the Director of Quality Governance)*

2.1.3 All Non-Executive Directors and Directors as detailed above are voting members.

A Deputy Director or Nominated Officer in attendance for a Director will act as if that Director is present but will have no voting rights nor will be counted as part of the quorum.

2.1.4 The following Directors are non-voting members of the Board:

- Director of Quality Governance *(effective from August 2018 will take over the voting rights of the Deputy Chief Executive when that post ceases)*
- Director of Human Resources and Organisational Development
- Director of Acute Services
- Director of Mental Health & Learning Disabilities
- Director of Ambulance Services & Patient Transport Services

- Director of Clinical Improvement

2.1.5 The Board may also appoint Associate Non-Executive Directors as non-voting members of the Board.

2.1.6 The Board is supported by a Board Secretary, who attends Trust Board meetings in a non-voting capacity.

2.1.7 The Board is supported by a Board Governance Officer, who administers and takes minutes.

2.1.8 Other Trust officers may be asked to attend at the discretion of the Chairman, for example when the Trust Board is discussing areas that an Officer has specialist knowledge.

2.2 Quorum

2.2.1 No business shall be transacted at a meeting of the Trust Board unless five members are present including:

- The Chairman (or Vice-Chairman)
- Two Executive Directors
- Two other Non-Executive Directors

2.2.2 A Deputy Director or Nominated Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum (see Standing Orders Section 6.7)

2.2.3 In line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting.

3. ATTENDANCE AT MEETINGS

3.1. Commitment to Attend

3.1.1 It is expected that all members will endeavour to attend every meeting. Apologies for absence, stating the reason for absence, should be given in advance of the meeting to the Board Governance Officer.

3.1.2 Members are expected to attend the Annual General Meeting

3.2 Attendance of Meetings

3.2.1 Poor attendance will be followed up by the Trust Chairman

3.3 Record of Attendance

3.3.1. A register of attendance will be signed at every meeting.

3.3.2 A record of attendance will be provided to the Chairman and included in the Trust's Annual Report

4. FREQUENCY OF MEETINGS

4.1 Decision Making Meetings

4.1.1 The Trust Board shall meet regularly to approve and receive relevant reports, and instigate appropriate action in response to reports relating to the Trust. Additional meetings can be held to discuss specific items such as approval of Operational and Financial Plans and approval of Annual Report and Accounts, or where specific risks or issues require more expedient resolution.

4.2 Informal Meetings

4.2.1 The Trust Board shall also meet regularly to discuss key strategic issues and for board development. Additional meetings can be held if required to discuss specific items. These meetings will be known as Trust Board Seminars.

5. AUTHORITY

5.1 Delegated Authority to Board Committees

5.1.1 The Trust Board has established the following Board Assurance Committees

a) Audit Committee
b) Assurance, Risk and Compliance Committee
c) Performance Committee
d) Quality Committee
e) Mental Health Act Committee
f) Nominations and Remuneration Committee

5.1.2 The Trust Board may establish additional Board Committees as required and will approve their terms of reference and the designated members.

5.1.3 Each Board Committee should report regularly to the Trust Board in line with their Terms of Reference. The Trust Board remains responsible for the activities of, and powers delegated to, its Committees.

5.2 Other Committees of the Board

5.2.1 The Trust Board acting as the corporate Trustee has established the following Committee:

a) Charitable Funds Committee

5.2. Board Authority

5.2.1 Internal

The Trust Board may investigate any activity within its terms of reference. It may seek and secure the information it requires from any employee and all employees are directed to co-operate with any request made by the Trust Board or any of its sub-committees.

5.2.1 External

The Trust Board can seek external advice from any source if necessary, taking into consideration issues of confidentiality and Standing Financial Instructions.

6. ROLE & RESPONSIBILITIES

6.1 Role of the Chairman

6.1.1 The Chairman is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

6.1.2 The Chairman is responsible for the effective running of the Trust Board ensuring that the Trust Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

6.1.3 The Chairman is the guardian of the Trust Board's decision-making processes and provides general leadership of the Trust Board.

6.2 Role of the Chief Executive Officer

6.2.1 The Chief Executive Officer reports to the Chairman and to the Trust Board directly. All Executive Directors and members of the management structure report either directly or indirectly to the Chief Executive Officer.

6.2.2. The Chief Executive Officer is responsible for implementing the decisions of the Trust Board and its Committees, providing information and support to the Trust Board as necessary.

6.3 Role of the Trust Board

6.3.1 The general role of the Trust Board is as follows.

a) To seek assurance through the Audit Committee that systems of control are robust and reliable, including those relating to personal conduct, and risk management.
b) Ensuring that the statutory duties of the Trust are effectively discharged
c) Approving documents at a commensurate level in line with the Trust Document Control Policy.
d) Ensuring that the Trust has comprehensive governance arrangements in place that guarantee that the resources invested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
e) Ensuring that the Trust complies with its governance and assurance obligation in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
f) Approving and publishing an Annual Report and Accounts
g) Regularly monitoring our performance against objectives, and ensuring that risks to the achievement of strategic goals and objectives are mitigated and monitored
h) Providing financial stewardship through value for money, financial control and financial planning
i) Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
j) Ensuring the delivery of high quality sustainable services
k) Ensuring high standards of corporate governance, and personal conduct.
l) Ensuring that risks to the achievement of strategic goals, namely principal risks as outlined below, are mitigated and monitored.

6.3.2 At all times the Trust Board will conform with the requirements of Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Board and the Scheme of Reservation and Delegation.

7. REPORTING ARRANGEMENTS

7.1 Copies of meeting minutes will be made available to NHS Improvement for information, on request.

7.2 The Trust Board will receive reports from the Board Committees as appropriate.

8. DUTIES AND ADMINISTRATION

8.1 It is the duty of the Board to uphold the Code of Conduct for NHS Managers, which includes the seven principles of public life (The Nolan Principles), namely, selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and to maintain the Duty of Candour.

8.2 The Board will endeavour to uphold the principles and values as set out in the NHS Constitution for England, March 2013.

8.3 The Board shall be supported administratively by the Board Governance Officer, whose duties in this respect will include:

a) Agreement of agenda with Chairman and collation of papers
b) Circulate agenda papers a minimum of 5 working days in advance of the meeting
c) Take the minutes
d) In Line with Standing Orders 6.8 Electronic Communication, the meeting minutes must state whenever a member/director was in attendance via electronic communication. In order for the meeting to be quorate the member/director must have been able to communicate interactively and simultaneously with all parties attending the meeting for the whole duration of the meeting, so that all members/directors were able to hear each other throughout the meeting
e) Keeping a record of matters arising and issues to be carried forward
f) Maintaining an Action Tracking System for agreed Board actions
g) In conjunction with the Chairman and Lead Executive Director, prepare an annual report on the effectiveness of the Board for submission to the Audit Committee
h) Maintain an Attendance Register. The completed Register to be submitted to the Trust Chairman and attached to the Board's annual report
i) Maintain agendas and minutes in line with the policy on retention of records
j) Ensure that meeting papers are circulated at least three working days in advance of the meeting.
k) Ensuring that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.

8.4 An annual review will include a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Board meetings.

9. MONITORING COMPLIANCE WITH TERMS OF REFERENCE

9.1 These Terms of Reference, and the overall effectiveness of the Trust Board, will be reviewed annually via a self-assessment of performance against the specific duties as listed above, together with a review of attendance at Board meetings. The work of Board Committees will be reviewed by the Trust Board, through the production of annual reports.

9.2 Attendance and frequency of meetings will be monitored by the Board Secretary and reported to the Trust Board on an annual basis. Concerns highlighted when monitoring compliance will be discussed at Trust Board and remedial action taken immediately to effect corrective measures.

9.3 The Trust Board will review these Terms of Reference annually in conjunction with its review of the Terms of Reference of those Committees identified in section 5.1.1.

9.4 The Trust Board will produce an Annual Report which shall include details about its effectiveness

TRUST BOARD COMMITTEES

GOVERNANCE PACK

Effective from 7 June 2018

AUDIT TRAIL:

Date document valid from:	7 June 2018
Document review due date:	1 year from valid date

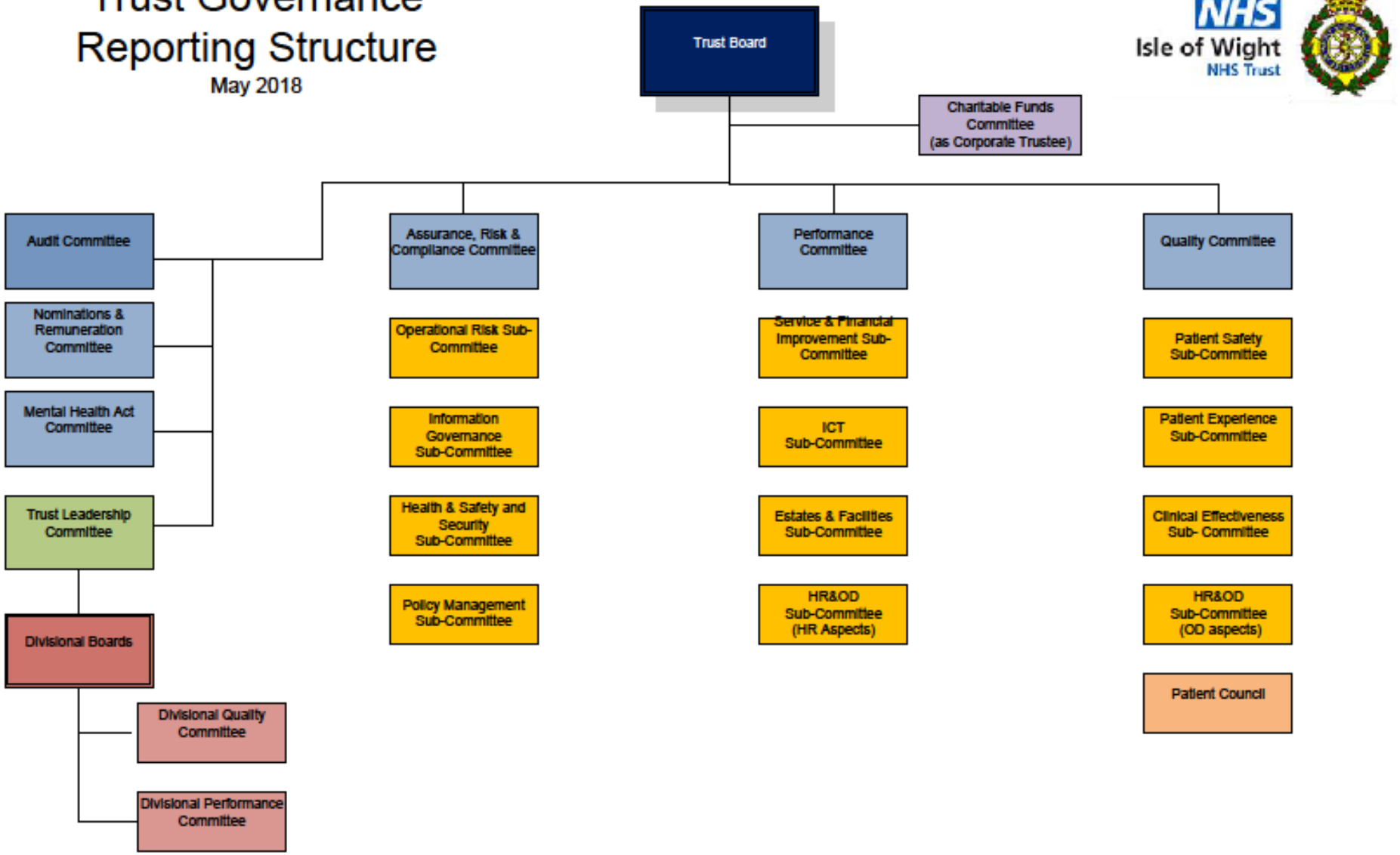
Date(s) reviewed:	May 2018	**Version number:**	V5
Details of most recent review: (*Outline main changes made to document*)		Following Governance review the structure of the Board Committees has been revised following the Executive Reorganisation.	

Trust Board Approval	
Approved at:	Trust Board
Date Approved by Trust Board:	-

Contents

Trust Governance Reporting Structure

May 2018



Board Non-Executive Led Committees

1. Quality Committee
2. Assurance, Risk and Compliance Committee
3. Performance Committee
4. Audit Committee
5. Mental Health Act Committee
6. Nominations and Remuneration Committee
7. Charitable Funds 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 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 members, to include two Non-Executive Directors, four 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

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.

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 Acute Services
- Director of 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.
- Consider strategies relevant to the Committee including financial, operational, workforce, estates 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.

Risk Management

The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic 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 (monthly)
- Human Resources and Organisational Development Sub-Committee – regarding workforce aspects (monthly)
- ICT Sub-Committee (quarterly)
- Estates & Facilities Sub-Committee (quarterly)

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.

Assurance, Risk and Compliance Committee

Terms of Reference and Membership

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Assurance, Risk and Compliance 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)
- Director of Quality Governance
- Deputy Chief Executive
- Medical Director
- Director of Nursing, Midwifery, Allied Health Professionals & Community Services

A deputy assumes full rights of the Director they are deputising for at the meeting.

Attendance

Regular attendees will include:

- Board Secretary
- Deputy Director of Quality Governance

Other Executive Directors and officers may be asked to attend by the Committee Chair.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive Directors 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 quarterly. No less than 4 meetings will be held each year, however, the frequency may be varied in order to ensure that the Committee discharges all of its responsibilities.

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 primary duties and responsibilities of the Committee are to assure the Trust Board of the Trust's management of risk, compliance with legislation and integrated governance.

Risk Management

The Committee shall consider all of the Trust's strategic and key operational risks and 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

Quality Governance 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).

Health and Safety, Security and Estates Compliance

The Committee shall consider health and safety, security and estates related compliance issues and seek assurance.

Information Governance

The Committee shall receive assurance on all Information Governance related matters and approve the Information Governance Toolkit submission and receive assurance regarding compliance with GDPR requirements.

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 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:

- Operational Risk Sub-Committee
- Information Governance Sub-Committee
- Health and Safety & Security Sub-Committee Policy Management 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.

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 Assurance, Risk and Compliance 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.

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 managements response) 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.

Reporting

The Committee shall report to the Board on how it discharges its responsibilities.

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.

MENTAL HEALTH ACT COMMITTEE

TERMS OF REFERENCE AND MEMBERSHIP

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Mental Health Act 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 of:

- Four Non-Executive Directors (may include Associate)
- Medical Director
- Director of Nursing, Midwifery, Allied Health Professionals & Community Services
- Director of Mental Health & Learning Disabilities
- Mental Health Act Review Manager x 2
- Consultant Psychiatrist x 2
- Mental Health Act Manager
- Mental Health Act Lead Approved Mental Health Professional
- Service User Representatives x 2
- Departmental Representatives for:
  - Community Mental Health Services
  - Inpatient Services
  - Learning Disabilities Services
  - Child and Adolescent Mental Health Services
  - Dementia Services

A deputy assumes full rights of the Director they are deputising for at the meeting.

Attendance

The additional officers may be invited to attend by the Committee Chair as required
A Nominated Carer Representative will be invited to attend meetings
A Nominated Independent Mental Health Advocacy Representative will be invited to attend meetings
A Nominated Local Authority Approved Mental Health Professional will be invited to attend meetings

Quorum

A quorum for the Committee shall be six members, to include two Non-Executive Directors and
1 x Mental Health Act Review Manager, 1 x Consultant Psychiatrist; 1 x Executive Director, 1 x Mental Health Act Specialist (MHA lead or MHA Manager)

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 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.

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 primary duties and responsibilities of the Committee are to:

- 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 the utilisation of S12 qualified doctors.
- Monitor and report quarterly on the use of the Deprivation of Liberty Safeguards within the Trust and provide an annual review.
- Commission the drafting of policies, protocols and procedures relating to the Mental Health Act and ensure they are robust and embedded.
- 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.
- Ensure that Mental Health Act responsibilities and training needs are identified and met.
- Identify and share good practice in relation to the Mental Health Act.
- Incorporate feedback from service users and staff into the working of the Committee, with Committee members acting as representatives for those views.

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 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.

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 & 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 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 Delegationfor 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 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 with in 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 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.

Executive Committees

1. Trust Leadership Committee

TRUST LEADERSHIP COMMITTEE

TERMS OF REFERENCE AND MEMBERSHIP

Constitution

The Board hereby resolves to establish an Executive Committee of the Board to be known as Trust Leadership Committee (the Committee).

Membership

Membership of the Committee shall comprise of:

- Chief Executive Officer (Chair)
- All Executive Directors
    - Deputy Chief Executive
    - Director of Nursing, Midwifery, Allied Health Professionals & Community Services
    - Director of Finance & Information
    - Medical Director
    - Director of Quality Governance
    - Director of Mental Health & Learning Disabilities Services
    - Director of Acute Services
    - Director of Ambulance Services & Patient Transport Services
    - Director of Clinical Improvement
    - Director of Human Resources & Organisational Development

A deputy assumes full rights of the Director they are deputising for at the meeting.

Attendance

The following will attend as required and in agreement with the respective Director:

- Board Secretary
- Clinical Directors within Acute Services
- Clinical Director of Ambulance Services & Patient Transport Services
- Clinical Director of Community Services
- Clinical Director of Mental Health and Learning Disabilities Services

Other officers may be asked to attend by the Committee Chair.

Quorum

A quorum for the Committee shall be six members, to include at least three executive members of the Trust 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, however, the frequency may be varied in order to ensure that the Committee discharges all of its responsibilities.

Authority

The Committee has delegated authority from the Trust Board and is authorised to investigate any activity within its terms of reference. It may seek and secure the information it requires from any employee and all employees are directed to co-operate with any request made by the committee.

The Committee can seek external advice from any source if necessary, taking into consideration issues of confidentiality and Standing Financial Instructions.

The Committee is constituted as an Executive Committee of the Trust and as such has a number of specific responsibilities to discharge in order that the Trust can achieve its vision, strategy and objectives.

The Committee has the highest level of executive decision making authority.

Duties

The Committee has a number of specific roles and responsibilities as outlined below:

Strategy and Planning

The Committee is responsible for supporting the Trust Board to develop a robust overarching Trust strategy, by advising on appropriate strategic aims goals and areas of priority for the organisation, and for monitoring delivery of the overarching Trust strategy and its strategic goals and priorities once it has been approved by the Trust Board.

The Committee will formally recommend to the Trust Board all Strategies and the Annual Business Plan.

Further to this the Committee will be instrumental in ensuring that all external drivers and influences are considered as part of strategy development, including all Island-wide, regional and national policies and strategies. It will be reliant on its members to alert it to these pressures and drivers, both internal to the organisation and external.

The Committee, will also receive for consideration partnership strategies, and oversee Trust implementation of these.

Partnerships

The Committee has a fundamental role to play in determining and overseeing the effectiveness of any partnerships, joint ventures, or consortium arrangements entered into by the Trust in order to transform health and social care provision across the Island and wider as appropriate. This includes the My Life a Full Life Programme, Strategic Partnership with IW Council and the Wightlife Partnership.

Contracts

The Committee will oversee delivery of contractual arrangements for the provision of services, ensuring alignment to Trust vision, strategy and objectives.

Performance

The Committee will consider Trust wide performance drawing out key issues requiring action or response by Executive Directors or Divisional Directors. The Committee will also consider integrated performance from each division.

Business Case approval

The Committee will approve business cases, as required in line with the Trust Standing Financial Instructions and in accordance with the Trust's business case methodology.

Any business case over the value of £250,000, in accordance with SFIs and aligned to the limit of the Chief Executive will be submitted to Trust Board for approval.

Risks

The Committee will receive the Board Assurance Framework for consideration prior to presentation to relevant Board Committees and to Trust Board.

Reporting

The Committee, led by the Chief Executive, will undertake an annual effectiveness evaluation against its Terms of Reference and Membership.

Reports will be received from Executive Directors regarding Trust wide strategy, planning and performance.

Reports on each Divisions integrated performance will be presented on a monthly basis including key issues and risks.

- Acute Services
- Community Services
- Ambulance Services & Patient Transport Services
- Mental Health & Learning Disabilities Services

Other reports which require Trust Leadership Committee approval will be presented as required.

Administrative Support

The Committee shall be supported administratively by the Chief Executive's PA, 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.

Enc P

Agenda Item No	15	**Meeting**	Trust Board in Public	**Meeting Date**	7 June 2018
Title	Freedom to Speak Up Guardian Report Q4 2018				
Sponsoring Executive Director	Maggie Oldham, Chief Executive Officer				
Author(s)	Leisa Gardiner, Trust Freedom To Speak Up Guardian				
Committees previously considered by including 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	X
Lead strategic change on the Isle of Wight	X

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

Executive Summary

The Freedom to Speak Up independent review into creating an open and honest culture in the NHS (2015) recommended the widespread introduction of the Freedom to Speak Up Guardian (FTSU) role in each NHS organisation. The Trust has appointed Leisa Gardiner as the Freedom To Speak Up Guardian. The FTSU Guardian has directly received 20 concerns for Quarter 4 and 13 concerns were raised via the FTSU Advocates/Anti Bullying Advisors. Of the 33 concerns raised 7 related to patient safety and Quality and 23 related to behaviours in particular bullying and harassment. The biggest staff group to raise concerns were Allied Health Professionals. The intension of this FTSU report is that it will be submitted quarterly to be in the public domain.

Key Recommendation

The Board is asked to consider the following recommendations:

To receive and have assurance given by the report that there is a robust policy and structure which allows our staff to safely raise concerns, to be supported in doing so and to ensure they are treated according to the principles outlined by Sir Robert Francis.

FREEDOM TO SPEAK UP REPORT

1 Purpose

1.1 This report outlines activity and progress to date of the Freedom To Speak Up Guardian (FTSU) role and provides a summary of concerns raised for Quarter 4 (January – March 2018)

2 Background

2.1 The Freedom to Speak Up independent review into creating an open and honest culture in the NHS (2015) recommended the widespread introduction of the Freedom to Speak Up Guardian (FTSU) role in each NHS organisation.

2.2 The standard NHS contract requires all trusts and foundation trusts to nominate a Freedom to Speak Up Guardian by October 2016.

2.3 Leisa Gardiner, took up this Guardian role in October 2016. Prior to this as part of her role as Lead for LiA (Listening into Action) staff approached her to raise their concerns and she encouraged staff to speak up and well as providing support.

2.4 This report outlines activity and progress to date and provides a summary of concerns raised for Quarter 4.

3 Activity and progress to date

3.1 The FTSU Guardian has attended the national Freedom to Speak Up conference and is part of the regional network of guardians as well as attending FTSU related seminars.

3.2 The FTSU Guardian (or deputy) attends the monthly Trust Induction Programme to promote Freedom to Speak Up.

3.3 The FTSU guardian meets with the CEO and Chair separately on a monthly basis to brief them on FTSU matters, but has access to discuss any issues as and when required.

3.4 The FTSU Guardian attends the weekly CEO Drop in Sessions to support the CEO and staff as required.

3.5 Linked in with the Development and Training department with regards developing a programme to recruit further FTSU Advocates and Anti Bulling Advisors to help promote and raise the profile of raising concerns.

3.6 Along with the CEO the FTSU Guardian has attended drop in sessions off site at outlying clinic areas.

3.7 The FTSU Guardian is jointly leading on the Culture & Leadership Programme for the Trust strongly supported by the CEO.

3.8 The FTSU Guardian is working closely with the CEO to deliver clear messages

to staff about what is considered to be unacceptable behaviour through" A conversation with Maggie".

4 Concerns raised in Quarter 4

4.1 There have been a total of 33 concerns raised to the FTSU Guardian/Advocates and Anti Bullying Advisors during Quarter 4 (January-March) 2018.

4.2 Concerns were raised by the following staff groups

Healthcare Assistants	**Nurse**	**Administrator**	**Corporate**	**Ancillary staff**	**AHP**
2	**8**	**7**	**1**	**2**	**13**

4.3 Concerns were categorised as follows.

Patient Safety and Quality	**Behavioural including Bullying and Harassments**	**Anti-Bullying Advisors contacts**	**Other**
7	10	13	3

4.4 3 cases remains open and 30 have been closed

5 Lessons learnt

5.1 There continues to be the perception by staff of an ongoing bullying culture within the Trust. The CEO and FTSUG are encouraging staff at every possible opportunity to report any incidents of bullying whether observe it or personally experienced it. Discussions are being had around rolling out the Forum Theatre workshops to incorporate all staff.

5.2 Whilst the number of concerns raised have significantly increased in this quarter it is clear that the staff from Band 1-4 are not reporting incidents as commonly as other staff groups. As one of the next steps there will be a focus around recruiting Band 1-4 staff members into the roles of Freedom To Speak Up Advocates and Anti Bullying Advisors in the hope that staff may feel able to raise concerns to someone from a similar job role.

6 Next Steps

6.1 With the support of the FTSU Advocates and Anti Bullying Advisors continue to engage with staff to make Freedom to speak up more visible and encourage staff to raise concerns.

6.2 Creation of a video re Raising Concerns for staff to be able to access and see.

6.3 Share information with staff re number of concerns raised from staff through E Bulletin and staff news on a quarterly basis.

6.4 Develop measures, data sets and indicators to monitor trends and identify linkages between issues raised through people speaking up, and issues raised through other safety and quality routes.

6.5 Review the underlying themes of the annual staff survey and other feedback mechanisms (I want great care/Exit interviews) to ensure that management actions are focussed on addressing themes.

6.6 Update the Intranet page to make it more visible for staff to be able to view information on how to raise a concern and the support available to them.

6.7 Look to recruit additional staff at Band 1-4 to support the FTSU Advocate and Anti Bullying Roles

6.8 Review the option of rolling out “Forum Theatre” training to all staff members.

6.9 Attendance at regional and National meetings

6.10 Review and update the Freedom to speak up: raising concerns (whistleblowing) policy to incorporate the FTSU Advocates and new Executives when recruited..

5.3 Continue to provide reports to the National Office

5.4 Continue to provide quarterly reports for the Trust Board