Trust Board Papers

Isle of Wight NHS Trust

Board Meeting held in Public

to be held on

Thursday 11 November 2021

at

10.00am

The meeting will be held virtually via Microsoft Teams

See our website for details on how to join the meeting via the Live Event link:

www.iow.nhs.uk/TrustBoard2021

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Trust Board held in Public

Thu 11 November 2021, 10:00 - 12:30

Held via MS Teams

Isle of Wight NHS Trust

Agenda

10:00 - 10:05
5 min

1. Opening Matters

1.1. Chair's Welcome and Apologies

Receive *Chair*

1.2. Declarations of Interest relating to agenda Items

Receive *Chair*

Declarations of interest for Board Members are recorded on the Register of Declarations and do not need to be restated unless there is a specific item on the agenda and which is pertinent to the declared interest.

1.3. Minutes of previous meeting

Approve *Chair*

Meeting held on 14 October 2021

Item 1.3 - 2021-10-14 - Draft Minutes - Board in Public v2 251021.pdf (10 pages)

1.4. Matters Arising and Schedule of Actions

Receive *Chair*

Item 1.4 - Schedule of Actions - Board held in Public as at 041121.pdf (1 pages)

Business of the meeting

10:05 - 10:20
15 min

2. Staff Story

Presentation *Juliet Pearce*

Item 2 - Presentation - Staff Story.pdf (1 pages)

10:20 - 10:25
5 min

3. Chair's Update

Verbal-Receive *Chair*

Item 3 - Verbal - Chair Update.pdf (1 pages)

10:25 - 10:40
15 min

4. Chief Executive's Update

Receive *Maggie Oldham*

Item 4 - Chief Executive's Update 111121_FINAL.pdf (5 pages)

10:40 - 10:50
10 min

5. Update on Transformation Programme

Assurance *Nikki Turner & Lesley Stevens*

Item 5 - Transformation report November 2021 Final Version.pdf (4 pages)

10:50 - 11:00
10 min

6. System Winter Plan 2021/22

Approve *Joe Smyth*

Item 6 - System Winter Plan 2021-22 v1.pdf (41 pages)

11:00 - 11:02
2 min

2 minute silence for Armistice Day

11:02 - 11:22
20 min

7. Quality & Performance

7.1. Quality & Performance Committee Feedback

Assurance *Tim Peachey*

Meeting held on 29 October 2021

Including:

Item 7.1 - Quality Performance Committee Feedback to Board final.pdf (6 pages)

7.2. Update on Quality & Performance section of the Integrated Performance Report

Verbal *Lois Howell, Juliet Pearce, Steve Parker, Joe Smyth and Lesley Stevens*

Item 7.2 - Verbal - Quality &Performance IPR analysis.pdf (1 pages)

7.3. Maternity Report

Assurance *Amanda Pearson/Juliet Pearce*

Item 7.3 - Maternity Report.pdf (20 pages)

11:22 - 11:30
8 min

Comfort Break

11:30 - 11:45
15 min

8. Finance & Infrastructure

8.1. Finance & Infrastructure Committee Feedback

Assurance *Caroline Spicer*

Meeting held on 28 October 2021

Item 8.1 - Finance Infrastructure Committee Feedback Nov Board final.pdf (3 pages)

8.2. Update on Finance section of the Integrated Performance Report

Verbal *Darren Cattell*

Item 8.2 - Verbal - Finance IPR analysis.pdf (1 pages)

11:45 - 11:55
10 min

9. People & Organisational Development

9.1. Update on People section of the Integrated Performance Report

Verbal *Julie Pennycook*

Item 9.1 - Verbal - People IPR analysis.pdf (1 pages)

11:55 - 12:05
10 min

10. Digital Transformation

10.1. Digital Transformation Committee Feedback

Assurance *Kemi Adenubi*

Meeting held on 27 October 2021

Item 10.1 - Digital Transformation Committee Feedback Nov Board - final.pdf (3 pages)

12:05 - 12:25
20 min

11. Governance

11.1. Audit Committee Feedback

Assurance *Phil Berrington*

Meeting held on 3 November 2021

Item 11.1 - Audit Committee Feedback Nov Board Final.pdf (3 pages)

11.2. Board Risk Register

Assurance & Adopt *Lois Howell*

Item 11.2 - Board Risk Register.pdf (31 pages)

12:25 - 12:30
5 min

12. Closing Matters

12.1. Questions from the public on issues raised and covered on this agenda

Receive *Chair*

12.2. Additions to the Board Assurance Framework (BAF) and/or Board Risk Register (BRR) and Board Visits

Review *Chair*

12.3. Any Other Business

Receive *Chair*

12.4. Date of Next Meeting

13 January 2022

12:30 - 12:30
0 min

13. Supporting Documents for Information

Information

Integrated Performance Report

Item 13 - Integrated Performance Report - 11 Nov 21 v1.1 041121.pdf (105 pages)

Minutes of the meeting of the Isle of Wight NHS Trust Board held in public on Thursday 9 September 2021 via Microsoft Teams

PRESENT		
	Melloney Poole	Chair
	Phil Berrington	Non- Executive Director
	Paul Evans	Non-Executive Director
	Tim Peachey	Non-Executive Director
	Julia Ross	Non-Executive Director
	Caroline Spicer	Non-Executive Director
	Anne Stoneham	Non-Executive Director
	Sara Weech	Non-Executive Director
	Maggie Oldham	Chief Executive (CEO)
	Mary Aubrey	Interim Chief Nurse (ICN)
	Darren Cattell	Director of Finance and Estates/Deputy CEO (DoF&E)
	Lois Howell	Director of Governance & Risk (DoGR)
	Steve Parker	Medical Director (MD)
In Attendance	Kirk Millis-Ward	Director of Communication & Engagement (DoC&E)
	Julie Pennycook	Director of People & Organisational Development (DoP&OD)
	Joe Smyth	Chief Operating Officer – Acute & Ambulance (COO)
	Lesley Stevens	Director of Community, Mental Health & Learning Disabilities (DoCMHLD)
	Nikki Turner	Director of Strategy & Partnerships (DoS&P)
Attendees		
	Eloise Shavelar	Head of Communications & Engagement
	Isobel Wroe	Director of Partnerships & Strategic Development – South Central Ambulance Service NHS Foundation Trust (SCAS)
For item 21/T/165	Pieter Joubert	Trust Allied Health Professions Lead (AHPL)
For item 21/T/165	Stephanie Stanley	Consultant Podiatrist
For item 21/T/165	Rebecca Todd	Podiatry Apprentice
Observers		
Up to item 21/T/171	Helen Blanchard	4OC Consultancy
	Jay Chappell	Staffside Representative
	Vincent Grant	Patient Council Representative
	Chris Orchin	Chair of Healthwatch
Minuted by	Lynn Cave	Board Governance Officer

Members of Staff and Public in attendance: No members of the public observed the Microsoft Live Event link.

These minutes reflect the order items were discussed at the meeting and it should be noted that this may differ from the set agenda.

The meeting commenced at 10.00am and closed at 11.20am

Minute No.	
PROCEDURAL	
21/T/161	**APOLOGIES FOR ABSENCE, CONFIRMATION THAT THE MEETING IS QUORATE AND CHAIR'S OPENING REMARKS**

The Chair welcomed everyone to the meeting including those members of the public attending via the Live Event, and expressed her regret that this meeting needs to be virtual due to the ongoing covid prevention measures. She welcomed Helen Blanchard from 4OC who is observing the meeting as part of the review of the integrated performance reporting model.

Apologies for absence were accepted from:

- Kemi Adenubi, Non-Executive Director
- Sarah Anderson, Associate Director of Corporate Affairs
- Pam Fenna, Patient Council

The Chair confirmed that the meeting was quorate.

21/T/162 DECLARATIONS OF INTEREST

The Register of Declarations of Interests holds details of the Board members' various interests and is available on the Trust website. No additional declarations of interest relevant to the agenda were made.

21/T/163 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Isle of Wight NHS Trust Board held on 9 September 2021 were approved subject to minor typographical amendments.

Resolution

The Isle of Wight NHS Trust Board **Approved** the minutes of the meeting held on 9 September 2021.

21/T/164 Matters Arising and Schedule of Actions

a) **Matters Arising:**
None

b) **Schedule of Actions:**
i) **TB/401:** Helen Blanchard from 4OC was observing the Board meeting as part of the ongoing review of the IPR.

Resolution

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

21/T/165 STAFF STORY

The Director of People & Organisational Development advised that the Board meeting coincided with Allied Health Professional (AHP) Day and that therefore some of the Trust's AHPs had been invited to share their stories with the Board. She introduced Pieter Joubert, AHP Lead for the Trust, and Stephanie Stanley and Rebecca Todd from the Podiatry team.

Pieter Joubert gave an overview of the wide range of disciplines included amongst the AHPs in the Trust, including paramedics, dietitians, speech and language therapists, physiotherapists, occupational therapists, and podiatrists to name a few. He advised that this is an important and essential workforce which supports and

enables patients to retain their independence both in hospital and in the community. Nationally there are shortages in trained staff across the AHP field, due in part to the perception that the NHS is about nurses and doctors, but also to a lack new entrants to these areas. Mr Joubert explained how the Trust is expanding its clinical placement capacity using new staffing models.

Stephanie Stanley outlined how the Podiatry team is addressing these challenges and the additional risks associated with an aging workforce by the introduction of podiatry apprenticeships. She advised that as a result of being unable to recruit to Band 5 positions, a decision was made to convert these to apprentice posts. Rebecca Todd described how she joined the team and how her apprenticeship is developing her skills, and the opportunities this will create for her in the future.

An example of the innovative ways in which the AHP teams is the WHZAN[1] telepod system, through which it was possible to link the satellite clinic at Ryde with the onsite Podiatry team at St Mary's to assess and deliver urgent treatment for a patient, which had resulted in limb saving surgery.

The Members of the Board expressed their thanks to the team for presenting an excellent example of transformation and redesign in response to recruitment challenges. They also encouraged further presentations about the innovative ways in which digital solutions are being used for the benefit of patient pathways.

The question of whether there are opportunities to review international qualifications for AHPs, with a view to mapping them across to UK equivalents, thus enabling international recruitment to hard-to-fill posts was asked. It was confirmed that this is being explored and an update could be provided to the People & Organisational Committee.

Action

An update on the outcome of the review of international AHP qualifications to be brought to the People & Organisational Committee.

Action by: DoP&OD & AHPL

Resolution

The Isle of Wight NHS Trust Board received the Staff Story.

21/T/166 CHAIR'S UPDATE

The Chair wished to remind the Board that this was Black History Month. The Board was happy to reaffirmed its commitment to ensuring that ethnicity and diversity are respected and valued across all areas of the organisation, and to the continued development of opportunities to support black and ethnic minority staff.

The Chair also reminded colleagues that there are continued huge pressures across the NHS, including in respect of access to GPs and the increasing prevalence of covid within the island population. It was noted that in the face of these challenges it is important for the Board to continue to ensure the health and wellbeing of staff as far as possible so that they can continue to support patients, especially in the context of the coming winter pressures.

Resolution

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

[1] Whzan Digital Health an integrated suite of health and activity monitoring services.

21/T/167 CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented the report, highlighting the following points:

a) **CQC Report:** She confirmed that the report had been published on 23 September following the inspections of a number of acute, community and mental health services that occurred earlier in the year. She noted that the ambulance service had been disappointed not to have been included within the inspection so that they could also demonstrate the improvements across their service, but confirmed the Trust's commitment to pursuing a further inspection. The CEO expressed thanks to all staff who have endured significant personal and professional challenges above and beyond that which could possibly be expected over the last few years. She reaffirmed that she and the Executive Team are immensely proud of all of the Trust's teams and how they responded to the pandemic by pulling together to support the island community.

b) **Quality Special Measures:** The CEO advised that Ted Baker, Chief Inspector of Hospitals, has recommended to NHSE/I that the Trust is removed from the Quality Special Measures designation. The formal process for this will be undertaken over the coming months, cumulating in a meeting with NHSE/I.

c) Quality Improvements: The CEO thanked the Director of Governance & Risk for her work in guiding the improvement journey and ensuring that the 'must-do' actions had been delivered and the eight core services rated as inadequate for safety were now compliant. She thanked all the staff involved for their enthusiasm in achieving this outcome and highlighted that the commitment to improvement was also reflected in the national Staff Survey results. She highlighted that this is not the end of the journey and that the aim is now to be designated as 'Outstanding'.

d) **Staff Survey 2021:** The CEO reminded all present that this year's staff survey questionnaire is available for staff to complete and encouraged everyone to complete it.

e) **Thank You:** The CEO also thanked the Trust volunteers for all their work across the organisation, and also the Trust's partner organisations across the island and on the mainland for their continued support.

Vincent Grant, on behalf of the Patient Council, extended thanks and congratulations to all at the Trust for all the hard work involved in achieving a 'Good' rating, and for the outstanding leadership demonstrated by the CEO and her team.

Resolution

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

21/T/168 CARE QUALITY COMMISSION (CQC) INSPECTION JUNE/JULY 2021

The Director of Governance & Risk provided an overview of the Trust's progression since 2016 from an 'Inadequate' rating to the current report published in September 2021 and the associated 'Good' rating.

She advised that within the report there are three 'must do' requirements related to the mental health division, but noted that these are all items which are fixable and which are already being actioned. Progress against compliance with these requirements will be included within the quality improvement plan which is reported to the Quality & Performance Committee on a regular basis.

She noted that it is essential now that the improvements noted by the CQC are sustained and that progression toward an 'Outstanding' rating is commenced. It was confirmed that an improvement framework has been introduced with a multi-disciplinary team visiting all areas on a twice-yearly basis to monitor quality and implement support where appropriate.

Resolution

The Isle of Wight NHS Trust Board received the update on the Care Quality Commission Inspection

STRATEGY

21/T/169 TRANSFORMATION REPORT

The Director of Strategy & Partnerships presented the report and highlighted the following:

a) **Acute & Ambulance:** Significant operational pressures are impacting on the opportunities for the transformation programmes to be advanced at present, and this is affecting partner organisations as well. Despite this there has been some good and positive progress and a number of improvements.

The Director of Community, Mental Health & Learning Disabilities highlighted the following:

b) **Community & Mental Health & Learning Disabilities (MHLD):** Similar pressures are being seen across the MHLD services but whilst this is a risk, partnership working plans are being revised to ensure that there is resilience and improved quality across the divisions.

The Members of the Board reviewed the report and queried whether there was anything the Board could do to support the process, and also what could be done to ensure staff are supported during the upcoming winter pressures. The Director of Strategy & Partnerships advised that at present no additional support was needed, and that staff support/health and wellbeing measures introduced during covid pandemic would be maintained during the winter.

The Chair agreed, highlighting the national focus on staff health and wellbeing and the importance of listening to staff as part of the supportive framework.

Resolution

The Isle of Wight NHS Trust Board received the update on the transformation programme.

QUALITY & PERFORMANCE

21/T/170 QUALITY & PERFORMANCE COMMITTEE FEEDBACK

Tim Peachey, Chair of the Quality & Performance Committee (Q&PC), presented the report of the September meeting (held on 1 October 2021), and confirmed that there were no significant areas of concern or issues to escalate to the Board. It was a very good meeting with a busy agenda and all assurance levels were either substantial or reasonable. He highlighted the following:

a) **Duty of Candour:** He advised that the meeting addressed a technical governance point relating to the April meeting at which duty of candour had been discussed. The report to the May board contained a significant error in that it stated that the letter that goes out in fulfilment of the duty of candour is

not necessarily an apology that the report should have said is that the letter is an apology but is not necessarily an admission of liability.

b) **Learning from Deaths/Mortality Report Quarter 1:** The report which was seen at the Q&PC meeting on 1 October was received for information and commended to the Board.

Resolution

The Isle of Wight NHS Trust Board received the Quality & Performance Committee feedback, noting the correction to the Committee's April feedback report and accepting the Learning from deaths / mortality report.

21/T/171 UPDATE ON QUALITY & PERFORMANCE SECTION OF THE INTEGRATED PERFORMANCE REPORT (IPR)

Overviews of the top risks from each of the areas were presented.

a) The Medical Director advised that his top risks are:

i. **Medical Vacancies:** The overall vacancy rate has reduced but remains at 14%. There are impending recruitment interviews in emergency medicine and care of the elderly, but there remain challenges within urology and acute medicine.
ii. **Covid:** There is particular pressure on critical care capacity. The planned closure of additional critical care beds cannot go ahead due to continuing demand.
iii. **National Blood Tube Shortage:** Since the last Board meeting the situation has improved, but the short-term measures to manage demand which were implemented will remain in place at present. This will drive improved utilisation in future, even when the supply issue is resolved.

b) The Interim Chief Nurse advised that her top risks are:

i. **Infection Prevention and Control (IPC):** Best practice measures in line with national guidance remain in place within the hospital. The importance of the effective use and fit of FFP3 masks was noted.
ii. **Covid:** There have been no covid outbreaks amongst staff, and twice weekly lateral flow testing continues. The Covid & Flu vaccine hub is now operational and to date 1420 flu vaccines and 1750 covid boosters have been administered.
iii. **Nursing fill rates**: An overview of the fill rates across the 18 reporting wards was provided included the overall care hours per day average. Ensuring effective fulfilment of all shifts remains a challenge

c) The Chief Operating Officer – Acute & Ambulance advised that his top risks are:

i. **Capacity:** The key risk has been for some time been harm associated with lack of capacity in the community to enable the discharge of in-patients into community care in the form of short-term placements or into packages of care. The hospital continues to have an average of 50 patients per day (the equivalent of two wards) who should have been discharged into the community, but who cannot be found suitable support in a timely way. This is having a significant impact on flow through and beyond the Trust. The emergency department is also being affected due to the necessity for admitted patients to remain in the department until an

in-patient bed can be found for them.

ii. **Covid:** This continues to have an impact on bed occupancy and capacity generally, with 20 beds currently being used by covid positive patients. As this is a small hospital this equates to just under 10% of the bed capacity. As indicated above by the Medical Director, there are currently two intensive care units in operation which also adds to the congestion within the acute hospital.

d) The Director of Community, Mental Health & Learning Disabilities advised that her top risks are:

Community:

i. **Capacity:** The pressures being felt within the acute services are also affecting community services. Discussions are taking place with system partners in adult social care to review what can be done to increase capacity, including the development of the neighbourhood hub, a day unit which provides a step-down facility. The team is also recruiting to extend the care home support service, across both community and mental health services

ii. **Waiting Lists:** The increase in demand is having a negative impact on waiting lists across community services.

Mental Health and Learning Disabilities:

i. **Staff Vacancies:** There continues to be a risk associated with both medical and nursing vacancies, but four international nurses will be joining the team shortly to help mitigate this problem.

ii. **CQC Must do actions:** The CQC identified three must-do actions, of which reducing the psychological therapies waiting list is the most challenging to resolve. It was noted that capacity in such services is a national issue. The Director of Community, Mental Health & Learning Disabilities outlined the measures which are being implemented to address these actions.

iii. **Estate:** One of the CQC must-do items relates to the health-based place of safety. Work is progressing with the support of Solent NHS FT to address the issues. Work is also progressing to develop an estates masterplan with the community division to look at how to improve the estate general in support of these services.

Resolution

The Isle of Wight NHS Trust Board received the update on the quality and performance section of the Integrated Performance Report

FINANCE & INFRASTRUCTURE

21/T/172 FINANCE & INFRASTRUCTURE COMMITTEE FEEDBACK

Caroline Spicer, Chair of the Finance & Infrastructure Committee (F&IC), presented the report of the meeting held on 30 September 2021 and highlighted the following areas:

i. **H2 budget:** The budget for H2 (Oct – March) will not be submitted until mid-November, in line with national requirements.

ii. **Financial Risk:** There is a £1m risk to delivery of the H1 (Apr-Sept) financial plan. The Trust has reviewed the challenge and has mitigation in place for

£200k locally and £800k within the ICS. The gap has arisen as a result of changes in national recovery funding calculations.

iii. **Procurement:** Following an internal audit review, this has been identified as an area of concern with links to cultural behaviours. The F&IC will continue to monitor closely.

Resolution

The Isle of Wight NHS Trust Board received the Finance & Infrastructure Committee feedback.

21/T/173 UPDATE ON THE FINANCE SECTION OF THE INTEGRATED PERFORMANCE REPORT (IPR)

The Director of Finance and Estates highlighted the following areas of risk or concern:

a) **Budget:** As mentioned in the F&IC report, there is significant risk relating to income for H1 although the team expects to be able to mitigate this position. Planning is underway for H2 now that the national planning guidance has been issued, and the draft will be brought to F&IC for review prior to Board approval.
b) **Operational Risks:** There will need to be increased focus on demand and capacity during H2.
c) **Capital Programme:** This is currently behind plan, but it is expected that the position will be recovered. There is mitigation in place with other schemes ready to come online at short notice should the need arise.
d) **Investing in our future:** The Director of Finance and Estates confirmed that progress is going well and that funding has started to be committed to specific projects.

Resolution

The Isle of Wight NHS Trust Board received the update on the financial section of the Integrated Performance Report

PEOPLE & ORGANISATIONAL DEVELOPMENT

21/T/174 PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE FEEDBACK

Anne Stoneham, Chair of the People & Organisational Development Committee (P&ODC), presented the report of the meeting held on 30 September 2021 and confirmed that there were no significant areas of concern or issues to escalate to Board. It was also a very good meeting with all assurance levels were either substantial or reasonable. She highlighted the following:

a) **Medical Recruitment:** This is an ongoing issue which has already been mentioned at this meeting.
b) **Health Care Assistants:** The shortage of HCAs within the Trust and the wider island system is having a direct impact on patient flow within and beyond the hospital.
c) **Diversity:** There has been some deterioration in some of the metrics such as race and career progression opportunities, and work is being undertaken to understand the causes and improve the position.
d) **Internal Audit Reviews:** The three reviews undertaken by Internal Audit which were rated as limited were reviewed and actions to address areas of concern will be closely monitored to ensure that the recommendations are implemented.
e) **Staff fatigue:** Over the covid pandemic period there has been significant and sustained pressure on staff which has resulted in fatigue. There is a wide

range of health and wellbeing initiatives in place to support staff in the best possible way.

21/T/175 UPDATE ON PEOPLE SECTION OF THE INTEGRATED PERFORMANCE REPORT

The Director of People & Organisational Development advised that the key risks had already been raised by the Chair of the People & Organisational Development Committee.

She confirmed that in relation to the shortage in Health Care Assistants, that this is not just a Trust issue but that there are shortages of domiciliary care across the island, and that a systemwide response is being implemented.

Resolution

The Isle of Wight NHS Trust Board received the update on the people section of the Integrated Performance Report

DIGITAL TRANSFORMATION

21/T/176 DIGITAL TRANSFORMATION COMMITTEE FEEDBACK

The report of the Digital Transformation Committee (DTC) meeting held 29 September 2021 was taken as read in the absence of the Chair of the Committee. There were no specific areas of concern raised.

Resolution

The Isle of Wight NHS Trust Board received the Digital Transformation Committee Feedback.

GOVERNANCE & RISK

21/T/177 BOARD ASSURANCE FRAMEWORK (BAF)

The Director of Governance & Risk provided an overview of the key areas:

a) **BAF 8:** The risk rating has increasing to 16 as this is a significant issue
b) **BAF 1:** The wording will be revised to include reference to flow through the hospital as this could impact on the ability to deliver the strategies.
c) **BAF 9/10/11:** It was asked that the these are not adopted as drafted and rated at this time.
   i) **BAF 9:** This related to training and the Internal Audit report reviewed at P&ODC shows some negative assurance.
   ii) **BAF10:** The Audit Committee felt that not enough progress was being achieved as planned and that the risk rating should be increased due to the delay.
   iii) **BAF 11**: This is included within the human resources governance systems and processes.

The Director of Governance & Risk recommended that with the exception of BAF 9,10 and 11, the remaining risks be adopted, whilst noting that this is a live document which is updated regularly.

Resolution

The Isle of Wight NHS Trust Board received and adopted the Board Assurance Framework as recommended by the Director of Governance & Risk.

CLOSING MATTERS

21/T/178 QUESTIONS FROM THE PUBLIC

A number of questions raised in connection with this agenda have been received and a response to the originator will be provided after the meeting. A pdf transcript of the Trust responses will be added to the Trust Board 2021 website page.

All Board papers are available by entering the following into a search bar - www.iow.nhs.uk/about-us/our-trust-board/2021-board-papers.htm. (Please note this is not a hyperlink.)

21/T/179 ADDITIONS TO THE BOARD ASSURANCE FRAMEWORK (BAF) AND/OR BOARD RISK REGISTER (BRR)

It was advised that the risks and issues highlighted within the meeting are included already within the Board Risk Register

21/T/180 ANY OTHER BUSINESS

a) **Mary Aubrey:** The Chair advised that this was Mary Aubrey's last Board as Interim Chief Nurse. She has been instrumental in supporting the Trust through its CQC inspection, its IPC measures in response to the pandemic and her lasting legacy within the development of the nursing teams. The Chair wished her well in her future endeavours and extended the Trust grateful thanks for the rigour, charm and dedication which she has brought to the role.

21/T/181 Supporting Documents for Information

The Board received the following documents for information:

- Integrated Performance Report

21/T/182 DATE OF NEXT MEETING

The Chair confirmed that the next meeting of the Isle of Wight NHS Trust Board to be held in public is on Thursday 11 November 2021 and will be held via MS Teams.

Signed: Melloney Poole, Chair Date: 11 November 2021

SCHEDULE OF ACTIONS TAKEN FROM THE MINUTES

Trust Board held in Public

Action not yet due	
Action Overdue	
Propose action is closed	
Action Closed	

Date of Meeting	Minute No	Action No.	Action	Exec Lead	Update & Evidence of Completion	Due Date	Progress RAG
13-May-21	21/T/070b)	TB/401	Integrated Performance Report review will now be undertaken holistically and in line with the 'Making Data Count' methodology and by section.	Darren Cattell Lois Howell	**30/06/21** - Not yet due **02/09/21** – Specialist external support for this project has been secured and the project is underway – Committee Chairs will be consulted as part of the work. A deadline of the end of October has been given, and it is hoped that the revised IPR will be available for the November Board meeting. Extend to 11 Nov **09/09/21** - It was confirmed that work continues to be undertaken to develop the integrated performance report. **06/10/21** – 4OC have been commissioned to review our IPR process. They have observed meetings in September to inform this. **14/10/21** - Helen Blanchard from 4OC attended the Board meeting as part of the ongoing review of the IPR. **04/11/21** – a draft report has been presented to the Trust. The headline recommendations will be reported verbally to the Board and an opportunity for full Board consideration will be found. Extend to January	~~09-Sep-21~~ ~~11-Nov-21~~ 13-Jan-22	Not due yet
14-Oct-21	21/T/165	TB/402	An update on the outcome of the review of international AHP qualifications to be brought to the People & Organisational Committee.	Julie Pennycook Pieter Joubert	**04/11/21** - This action has been added to the workplan of the P&ODC. Propose action is closed	27-Nov-21	Propose action is closed

Presentation

Item 2

Staff Story

Verbal

Item 3

CHAIR UPDATE

great people great place

NHS Isle of Wight NHS Trust

Agenda Item No	4	Meeting	Trust Board held in Public	Meeting Date	11 November 2021
Title	Chief Executive's Update				
Sponsoring Executive Director	Maggie Oldham, Chief Executive				
Author(s)	Kirk Millis-Ward, Director of Communications and Engagement				
Report previously considered by including date	n/a				

Purpose of the Report		Reason for submission to Trust Board in Private only (please indicate below)		Link to CQC Domain		Link to Trust Strategic Objectives 2020-2025	
Trust Board Approval		Commercial Confidentiality		Effective	X	SO 01: Make our Trust a great place to work and receive care	X
Committee Agreement		Patient Confidentiality		Caring	X	SO 02: Work with our partners and our community to improve services	X
Assurance		Staff Confidentiality		Safe	X	SO 03: Deliver high quality compassionate care	X
Information Only	X	Other Exceptional Circumstance		Responsive	X	SO 04: Make sure our services are clinically and financially sustainable	X
				Well-led	X	SO 05: Join up health and care services by working more closely with our partners	X
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	X

Key Recommendations to be considered:
The Board is asked to receive the Chief Executive's Update.

1. Introduction

Earlier this month I announced that I have accepted a role on secondment with the NHS England and Improvement National Intensive Support Team.

I am sad to be leaving the Trust and the many wonderful people I have been lucky enough to work with in the last four years.

It has been an honour to lead this organisation and to serve the people of the Isle of Wight and I am proud of everything this Board, our Trust, and our teams have achieved for our community.

I am delighted that our Deputy Chief Executive, Darren Cattell, will be seconded into the role of Chief Executive – he will do a fantastic job and I know you will all join me in wishing him the very best of luck.

To support Darren as he takes on the role of Chief Executive, we will also soon welcome Jo Gooch to the Trust as our new Director of Finance.

Joining on secondment from Portsmouth Hospitals University NHS Trust, she will lead our finance department and play a pivotal role in developing our partnerships and delivering financially sustainable services.

I am also pleased to welcome Juliet Pearce to the Trust as our new Chief Nurse, she brings with her a wealth of experience and a strong track record as a highly effective nurse leader.

As this will be my last Board meeting before taking up my new role on December 1, I wanted to take a moment to thank members, colleagues, and our partners for all your support.

I have every confidence in Darren and the wider Executive Team and am excited to see what they can achieve on behalf of our staff and the people who use our services.

2. Strategy

With the passage of the Health and Care Bill through Parliament and the expectation that it will become law by April 2022, the NHS is busy preparing for a major change to how it is organised at a local and regional level.

The creation of Integrated Care Systems and the place-based leadership arrangements (Integrated Care Partnerships) create a real opportunity for the Island to be proactive and ambitious about how its Integrated Care Partnership will evolve in the coming months.

All this change is happening as the Trust explores what the next steps for its strategic partnerships might mean for the delivery of NHS services on the Isle of Wight and how it will ensure services are clinically and financially sustainable.

To inform our response to the changes in the wider NHS and the next steps for our partnership working we will be holding Health and Care Conversations with staff starting this month.

We want to hear from our colleagues about the challenges they face, the successes they have delivered and what they would like to see change or improved over the coming years.

This work will also feed into the refresh of the Isle of Wight Health and Care Plan, which we

hope will set clear and ambitious priorities for the health and care sector on the Island.

3. Three key risks

3.1 Winter

Winter has very much arrived, with increasing demand for urgent and emergency care accompanying the colder weather.

This is likely to be a winter like no other as the NHS seeks to manage the triple threat of COVID-19, flu, and the increase in demand for our services.

The rate of transmission of COVID-19 in the community is still relatively high and there is a risk that people who have been vaccinated or contracted the virus earlier in the year may start to see their immunity wane in the coming months.

It is crucial that as many people as possible, staff and members of the public, take up the offer of the vaccine and booster injections as soon as they can.

Last year, because of the social distancing measures in place, there was very little influenza recorded across the country. We expect the see increasing rates of flu this winter as more people are mixing and there is a risk that people will become more unwell because they have little built up immunity.

We are working hard to increase the uptake of the flu vaccine among NHS staff and my thanks go to all those colleagues working in our staff vaccination hub at St Mary's Hospital. But I would also encourage the public to take up the flu vaccine when it is offered.

Maintaining patient flow through our acute hospital is going to take a great deal of hard work during the winter, especially as it continues to be so difficult to maintain the level of discharges in to adult social, nursing, and residential care settings.

All the above issues mean that there is a risk to the ongoing elective programme and the wider recovery of our services.

3.2 Recruitment

Staffing is already a challenge, especially as we try to expand our bed base to deal with increased demand for urgent and emergency care.

A key issue for us during winter, but also beyond, will be our ability to recruit new colleagues to work with us to provide high quality services.

Recruitment is also an issue in the wider health and care system with pressure being felt in primary care and adult social care.

We will need to work together to build the capacity we need so that our community can receive the quality of services they rightly expect.

3.3 System capacity

The capacity of the Island's health and care system is a key risk for our organisation. The pressures in adult social care, nursing, and residential care, are longstanding but have become a significant problem in recent months.

The Trust regularly has more than 50 people in hospital who do not meet the criteria to reside, which means that they should be discharged home with support or into another community setting.

This is a large proportion of the beds available to us and when you factor in COVID-19 it means that it can be a real challenge to admit people into hospital in a timely way, leading to delays and congestion in our Emergency Department.

If we are not able to secure, with our partners, additional capacity in social care it is going to become more and more difficult to maintain patient flow.

It may also mean that we need to take the extremely difficult decision to pause our elective recovery programme to free up staff and beds to care for people admitted to hospital through the urgent and emergency care pathway safely.

4. Celebrating success and staff engagement

4.1 Nursing Times Award winners

Congratulations to our Community Service and to the Community Rapid Response Team who won a Nursing Times Award in the category of Care of Older People at this year's ceremony in London.

The well-deserved recognition underlines the team's commitment to providing high quality crisis care for older people during what was a very challenging time for everyone on the Island.

My thanks also to Jen Edgington, Associate Director of Nursing and Allied Health Professionals for Community Services, who was a finalist in the Nurse Leader of the Year category.

She will always be a winner in our eyes because it her leadership has been vital in the transformation of community services on the Isle of Wight and she has been instrumental in the collaboration between staff, patients, families, carers, and our partners which has driven much of our improvement in recent years.

4.2 Chief Nursing Officer and Regional Chief Nurse visit

It was with great pride that we welcomed Ruth May, Chief Nursing Officer for NHS England and Improvement and Regional Chief Nurse Acosia Nyanin to the Trust at the end of October.

Ruth and Acosia met with nurses from across the Trust and visited several services, before meeting colleagues for a feedback session. Ruth then surprised colleagues by presenting three Chief Nursing Officer Silver Awards for Nursing Excellence.

The winners were:

- Karen Caramat, Sister on Appley Ward
- Christian Gregory Grageda, Acute Oncology, Clinical Nurse Specialist
- Sam Whitewood, Trainee Consultant Nurse in the Recovery Service

My sincere thanks to Ruth and Acosia for visiting the Island and to everyone who helped to make their time with us so informative and useful.

And of course, huge congratulations to Karen, Sam and Christian on receiving their prestigious awards.

Agenda Item No	5	Meeting	Trust Board held in Public	Meeting Date	11th November 2021
Title	Transformation Report				
Sponsoring Executive Director	Dr Nikki Turner, Director of Strategy & Partnerships and Dr Lesley Stevens, Director of MHLD and Community Services				
Author(s)	Dr Nikki Turner, Director of Strategy & Partnerships and Dr Lesley Stevens, Director of MHLD and Community Services				
Report previously considered by:(including dates)	Quality and Performance Committee, 29th October 2021				

Purpose of the Report		Reason for submission to Trust Board in Private only (please indicate below)		Link to CQC Domain		Link to Trust Strategic Objectives 2020-2025	
Trust Board Approval		Commercial Confidentiality		Effective		SO 01: Make our Trust a great place to work and receive care	
Committee Agreement		Patient Confidentiality		Caring		SO 02: Work with our partners and our community to improve services	
Assurance	x	Staff Confidentiality		Safe		SO 03: Deliver high quality compassionate care	
Information Only		Other Exceptional Circumstance		Responsive	x	SO 04: Make sure our services are clinically and financially sustainable	x
				Well-led	x	SO 05: Join up health and care services by working more closely with our partners	x
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	

Key Recommendations to be considered:

Trust Board is asked to receive a report on behalf of the Acute, Ambulance and the Community and Mental Health Partnerships and note the progress made.

Executive Summary

The report below covers an update on the partnership work that has been undertaken in September 2021.

Ambulance Partnership

Both SCAS and IWAS have still under extreme operational pressure in September and October due to high levels of demand in both 999 and 111 services.

The partnership working remains strong. There is agreement for transformation schemes within the 111 service that link with other services such as community division and primary care to support reduction in admission and use of alternate pathways of care. Discussions have been held with Mental Health Commissioners for provision of a MH rapid response vehicle on the Island staffed by paramedic and MH practitioner to support patients in crisis The ambulance service is on track tor deliver year 1 of the ambulance strategy.

Acute Partnership

Stroke, Urology and Emergency Surgery continue to show progress in service transformation. There is continuing focus on recruitment and development of staff into consultant roles; as is evident in ED and Acute & General Medicine. As part of a Gateway review at the start of November the partnership will review what has been achieved so far and begin developing the work plan for 2022/23. It was agreed that there needs to be a continuation to support clinically vulnerable services, particularly single-handed services as well as an opportunity to build on or leverage national networks in pathology and radiology where we can add pace locally together.

MHLD & Community Partnership:

A Partnership Management Group for MH&LD & Community is in place. The group is exploring a range of options for joint working between the two trusts in order to improve the resilience and quality of care across mental health, learning disability and community services. Opportunities have been identified to work in partnership with Solent around workforce including, hard to recruit to posts and Service User Engagement Co-ordinators.

Joint working with Solent around development of an estates master plan and delivery of the hub and spoke model is underway. A short term (October – March 22) plan is being articulated in conjunction with medium- and long-term plans for mental health, learning disabilities and community services in the Isle of Wight. In addition, Solent partners are supporting the forward estates development of the 136 suite in Sevenacres in response to the CQC inspection report, and work is underway to provide improved physical access to PICU.

Solent are supporting our digital transformation work. Electronic Patient Record business cases were submitted to the Digital Transformation Committee at the end of October and were supported.

Our overarching Programme risks remain the same. Whilst the target risk rating was expected to be achieved within 12 months, it must be recognised the impact that Covid has had on their delivery. All areas are showing a reduction in their risks, but there is further work to be done.

Status of each partnership

Ambulance Services Partnership

- Implementation of new Telephony system complete and risk removed from register
- Implementation Plan delivering Ambulance Strategy on target for year 1.
- Prehospital Urgent Care transformation initiation document drafted and agreed. Schemes include but not limited too;
  - Care homes
  - Falls Pathway
  - Telehealth Pathways
- Ambulance HR Task and Finish Group established, and key schemes of work agreed to include;
  - Recruitment and Retention
  - Long Term workforce plan
  - Efficient use of agency / temporary staffing
- Good Sam Video conferencing application installed with CAD, part of a national roll out.
- 2hr Urgent Care Response Team clinical coordinator located within the hub.
- Discussions held with Mental Health Commissioners in relation to funding of MH rapid response vehicle on the Island.

Acute Services Partnership

- **The Stroke Service** are delivering their strategic objectives as required by October 2021, with the exception of consultant recruitment.
- **Emergency Surgery and Urology services** –an experienced locum urologist and associate specialist have been secured on an interim basis to provide support and facilitate the out-of-hours cover in the partnership urology service.
- **Emergency Department – i**nterviews to recruit into substantive positions were undertaken in October with positive outcome with job offers being made
- **Future partnership priorities** - A workshop to determine the service priorities for the acute partnership in 2021/22. was held on the 7th September. This will build on the priorities set out in the acute strategy.
- **Operational and clinical leaders** from both PHU and IWT unplanned care was held on the 14th October to develop stronger joint working relationships and to plan which specialities would benefit most from this closer partnership moving forward.
- **A Gateway review** is scheduled for the 4th November for the Acute Partnership Board to look at achievements for 21/22, lessons learnt and to decide focus of Partnership for next 12 months.

Mental Health & Learning Disability Services and Community Services Partnership

Joint Developments across MH&LD and Community Services

- The IOW & Solent Partnership Management Group has been established and met twice.
- An Executive Oversight Group will also be established to oversee this work, and will meet for the first time in November An
- Electronic Patient Records business cases for both Divisions with Solent support, have been supported by the Digital Transformation Committee and Finance and Infrastructure Committee.
- Community & MH&LD estates master plan, with Support from Solent, with short term objectives were agreed for H2 and longer term plans in development.

Community

- Reviewing sub-scale services that lack resilience in both trusts, to explore opportunities for joint working
- Integrated community strategy development progressing with creation of draft collaborative agreement.
- Community clinical forum established with Solent CMO, Solent Community Clinical Directors, IOW Primary Care Network Clinical Directors and IOW Trust Director of Community, MH&LD

MH&LD

- Exploring digital inclusion developments across both organisations, including roll out of the SHaRON platform in Psychological therapies and the MAST platform in Community Mental Health services
- Solent LD team supporting LD progress to integrated working with Adult Social Care
- Psychological therapies work stream progressing with shared learning across partnership

Top Partnership Risks

Title	Key risk	Initial Risk Rating	Mitigation / controlling action (*Completed actions in italic*)	Target Risk Rating	Current Risk Rating
Performance	Current partnerships aren't able to demonstrate clinical and financial sustainable solutions	Very High	• *ICS Oversight Committee established to support this delivery* • Exploring how to evolve the partnerships with respective Trusts inline with White Paper • Discussions with commissioner/regulators on 'island premium' • Analysis of financial performance, cost drivers and savings opportunities • Case for change to provide long term financial plan for services	**Moderate**	High
People	Partnerships are not able to address all of the workforce gaps	Very High	• *SLA with SCAS for specialist advice where we don't have staff in place e.g. EPRR* • Rotation of staff underway across IWT & PHU • Joint recruitment of posts as identified with PHU • Joint training and development [on-going], Acute, MHLD • Use of agency to recruit to consultant and middle grade posts • Workshops to review MHLD workforce model • Review Acute clinical models / strategy {Sept 2021} • Innovative role design (QI / Education /Strategy / Leadership)	**Moderate**	High
Performance / People	Managing future surge of Covid and/or winter demand impacts on our ability to deliver service delivery plans	Very High	• *Additional programme resources for each partnership programme have been secured* • Futher resource requirement as programmes develop • Recovery Plan and associated modelling to assess any future risk to delivery • Programme design must account for teams facing winter pressure across all partnerships • Operational and clinical capacity will need to be monitored across all partnerships	**Moderate**	High

Agenda Item No	6	**Meeting**	Trust Board held in Public	**Meeting Date**	11th November 2021
Title	Isle of Wight Winter Planning 2021/22				
Sponsoring Executive Director	Joe Smyth, Chief Operating Officer, Acute and Ambulance				
Author(s)	Claire Gowland, Director of Operations – Unplanned Care				
Report previously considered by including date	Integrated Care Partnership Board Quality and Performance Committee October 2021				

Purpose of the Report		**Reason for submission to Trust Board in Private only (please indicate below)**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2020-2025**	
Trust Board Approval	x	Commercial Confidentiality		Effective	x	SO 01: Make our Trust a great place to work and receive care	x
Committee Agreement		Patient Confidentiality		Caring	x	SO 02: Work with our partners and our community to improve services	x
Assurance		Staff Confidentiality		Safe	x	SO 03: Deliver high quality compassionate care	x
Information Only		Other Exceptional Circumstance		Responsive	x	SO 04: Make sure our services are clinically and financially sustainable	x
				Well-led	x	SO 05: Join up health and care services by working more closely with our partners	x
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	

Key Recommendations to be considered:

The System Wide Winter resilience plan can be seen at Appendix 2.
The report below summarises the high-level plans and principles for managing the Isle of Wight Care System through the expected and varying demands of Winter 2021/22.
This plan will be a live working document and will continue to be developed throughout the early winter periods, in conjunction with system wide partners to ensure alignment.
The Trust Board are asked to approve the Trust's winter plan response for 2021/22.

Winter Planning 2021/2022

1. Introduction

This document outlines the high-level plans and principles for managing the Isle of Wight Care System through the demands of Winter 21/22 drawing on activity and demand from previous years and using system knowledge and experience. The plan considers the impact of COVID, seasonal activity, workforce and the relationship of Health and Care agencies on the island.

Throughout September local plans will continue to be collated and reviewed to ensure system-wide alignment and take in to account local and national quality and performance standards.

The plan is a live document which will continue to be developed throughout the autumn and early winter period. The winter plan is part of a suite of contingency plans, which supports and is linked closely to Major Incident Planning, COVID Recovery and Response Plans and workforce plans.

Monitoring will be through the System Resilience Group to ensure the plan remains effective. Quantitative and qualitative information will be reviewed through this group to measure the efficacy of the plan and adjust as necessary.

1.1 Aims and Objectives

- Ensure continued responsiveness to the threat of COVID-19
- Protect Elective Recovery
- Maintain safe and effective delivery of services
- Maximise whole system capacity
- Work within footprint of existing bed resources
- Deliver additional schemes to manage surges in demand
- Support agile and flexible working across the system

1.2 Measurement of Success

- National Key Performance Triggers
- Emergency Access Standard
- Local and National Waiting Times Targets
- 18 Weeks Referral to Treatment
- 31 and 62 Day Cancer Waiting Times
- No. of patients who remain in an Acute bed for ≥ 3 days after not meeting the criteria to reside
- Bed Occupancy compared to local target of 90%

2. Lessons Learnt from Winter 2020/21

2.1 Capacity

Ambitious assumptions had been made regarding continued reduction of length of Stay following good progress made during the summer. The system relied upon additional capacity (Community Unit) and community step-down beds to maintain flow. There are also increased complexities owing to the need to separate COVID and non-COVID flows.

The system has been impacted by COVID-19, whilst the system was able to adequately recover from the winter period in terms of being able to close winter capacity; it has been unable to

recover the elective position due to COVID19 restrictions implemented during March 2020.

2.2 Collaboration

Effective development and introduction of an Integrated Discharge Team to improve partnership working has continued and this approach will support a collegial, no-blame culture to support patient-centred pathways.

2.3 Data

Improvements have been made from last winter, but the system has multiple data sources which provide a variation in information, data and interpretation. A common data set for reporting is being agreed across the system for this year.

2.4 Escalation

Inconsistent escalation and response at multiple levels often led to delays in system response times. A review of local escalation plans will be undertaken to ensure alignment and training to support compliance and reinvigoration of SHREWD.

2.5 Processes

A number of Best Practice and pathway processes were highlighted as not having been fully implemented or fully embedded. There has been a reinvigoration of the SAFER bundle and a greater emphasis on correcting/supporting non-compliance through engagement and education.

2.6 Workforce

Existing staffing constraints have been exacerbated by COVID-19 reducing the number of clinical and non-clinical staff able to work in Acute and Community settings across Health and Social Care.

High dependency on bank and agency staff in NHS, Local Authority and independent sectors resulting in inconsistent application of policy and process and increased staffing gaps during holiday periods.

3. Risks

The following risks have been identified; this list is not exhaustive and other risks will be added to the plan as and when identified.

Area	Risk	Mitigation
Leadership	Reduction in collaborative working between partners during periods of intense pressure	- Weekly Executive meetings to agree and execute system wide plans.
Process	Failure to deliver constitutional standards	- Predictive planning completed - System response plan to manage surges in demands and maintain operational performance - Interventions identified that will provide additional capacity and support demand management

	Less effective process and communications through patient pathways causing slow patient flow.	- Embed recognised best practice - Robust governance and escalation triggers, both within organisations and assurance at system level system groups
Operational	Workforce shortages across key staff groups, specifically at holiday periods	- Early recruitment of staffing - Plan to improve temporary workforce fill rates and reduce cancellations - Active Flu Vaccinations for key staff group including LA, NHS and Voluntary sector - Early agreement of staff rotas including Christmas/New Year and February Half-Term
	Patient Flow – Managing surges in demand	- Escalation plans in place and system-wide actions defined for response during escalation - Predictive planning in place
	Reduced patient flow consequently impacting on Inpatient Elective Activity	- Ring-fenced elective beds - Escalation process to include risk-assessed flexibility of elective beds to increase non-elective capacity and support flow
	Increasing capacity gap of elective programme	- 7-day elective plans in place with ring fenced orthopaedics beds ensuring the maintaining of clearing the longest waiters
	Delaying or provision of sub-optimal effective care by managing patients in the wrong locations due to not having the right capacity in the right areas to meet expected levels of demand	- Implementing the IW Health and Care plan to increase community capacity to support the management outside of the hospital setting when this is appropriate.
	Infection Control and outbreak impact (COVID and non-COVID)	- On site testing of patients on admission for COVID and influenza. - Prioritisation of side rooms - COVID ward escalation plan supported incorporating IPC/Microbiology guidance
	The private Domiciliary Care market is unable to meet demand to support system flow	- Work with the market to share demand modelling - Understand periods when market capacity will be constrained - Assess appropriate mechanisms to secure capacity at risk periods

4. Components of Plan for 21/22

The following will all be incorporated into this year's plan which will be complete and signed off by the system by end of November 2021.

4.1 Capacity and Demand Modelling

Modelling is being undertaken (delayed due to responding to COVID modelling) with specific consideration to the potential impact of COVID-19 and include best- and worst-case scenarios. The modelling will take account of the following:

- COVID 19 (Emergency Response and Elective Recovery)
- Influenza
- Ambulance
- 111
- Urgent and Emergency Care attendances
- Conversion to non-elective demand
- Elective demand
- Length of stay
- Bed capacity and demand by Medical, Surgical and T&O

Acute Daily Bed Demand and Capacity is the common denominator being used as the currency for measuring System resilience as this is where the pressure will be felt and is more measurable. **Further details can be seen at Appendix 1**.

4.2 Managing Flow

The plan will contain specific actions to be undertaken across the Emergency Floor (ED, UTC, AAU and SSU) and to support flow within the hospital:

4.2.1 Emergency Department

- Senior streaming at the point of arrival (ambulance or walk-in) to ensure patients are directed to most appropriate setting
- Suitably trained and experience staff to enable early commencement of investigations and diagnostics as clinically appropriate
- In-reach from IDT through designated Patient Navigator
- Enhanced therapy support
- Point of Care COVID and Influenza testing
- Designated Hospital Social Worker in ED

4.2.2 Urgent Treatment Centre

- Outreach 'flu vaccination to homeless and out of hours service
- Limited point of care testing
- Extra clinician for advice calls (to support reduction of on-site attendances)

4.2.3 Same Day Emergency Care

- Extended hours to control Urgent and Emergency Care presentations, reduce admissions and support early discharge

4.2.4 Acute Medicine/Surgery

- Continuous Rounding on Acute Assessment Unit
- Twice daily Board Rounds on Short Stay Unit
- YOULA – early supported discharge

4.2.5 Managing Capacity and Flow

- Review of bed configuration to support COVID and non-COVID flows
- Contingency beds to be included in escalation plan

4.2.6 Decision Making

- Additional Consultant to support outlying patients
- Seven-day consultant cover to support safe and effective discharges
- Criteria-Led Discharge to improve discharge profile across 7/7
- Senior clinical support through effective Senior Manager and Executive Director on Call rota

4.2.7 Processes

- Senior overview of patients with ≥ 14-day LoS through Long Stay Wednesday (Acute, Community, Adult Social Care and CCG)

4.2.8 Flow

- Continued focus on embedding SAFER bundle including criteria-led discharge and meaningful EDD
- Senior oversight of patients with ≥ 14-day LoS through Long Stay Wednesday (Acute, Community, Adult Social Care and CCG)

4.2.9 Discharge Processes

- Integrated Discharge Team now co-located with Clinical Site Team
- Discharge on same day of not meeting criteria to reside (pathway 0). Ambition for pathways 1 – 3 remain the same, but reliant on market
- New COVID-19 testing on site within 8 weeks which will provide greater capacity for testing on admission and discharge

4.2.10 Transfer of Care

- Continue work with ASC/CCG to align hospital discharge criteria with community admission criteria (Community Unit, Reablement etc.)

4.3 Escalation Processes in place

- Operational Pressures Escalation Level framework
- SHREWD
- Twice daily reporting through Site Meetings
- Visual live performance Dashboard and measures in the Operations Room
- Good experienced relationships built by system partners
- Agreed data sets to inform effective decision making

The wider system will review trigger points with all partners as part of a wider system escalation review. Review action cards for all partners to ensure effective management of COVID activity and avoidance of 12-hour trolley breaches

4.4 Flu Planning

As with every year the planning for flu will form a major component on planning for winter. Planning for potential flu outbreak is undertaken by a separate working group and is led by the Chief Nurse.

4.5 Workforce

The continued impact of COVID-19, limited availability of accommodation, heavy reliance on contingency staff and a fatigued workforce remain significant challenges to maintaining safe and effective staffing levels. Actions include:

- Supported return to work of shielding staff as appropriate
- Workforce group to review access to accommodation
- Role clarity for staff working at home linked to escalation policies
- Standardised enhanced payments related to escalation plans to promote parity

In addition to the COVID response the plan will also incorporate a response to the normal staffing pressures during this period of the year. These include;

- Specific Christmas and New Year staffing plan
- Staff sickness
- Use of bank and agency
- Staff wellbeing
- Advanced preparation and signed off rotas.

4.6 Adverse Weather Plan

The plan will also identify special arrangements that will be put in place during periods of disruption owing to severe weather and outlines an approach to dealing with situations where travelling to or attending work and patient discharges may be disrupted.

Staff will be expected to have a knowledge and understanding of their business continuity arrangements and their role in the event of unexpected incidents or adverse weather

4.7 Inclusion of all services

The following divisions and sectors are working on individual plans that will be finalised and incorporated into the Isle of Wight System Wide Winter Resilience Plan:

- Ambulance
- Community
- Mental Health
- Local Authority
- Voluntary Sector
- CCG

5. Brexit

The impact of Brexit is out of scope of the Winter Resilience Plan although the potential operational impact is acknowledged. The winter plans will however link closely with this and other business continuity plans.

Staff will be expected to have a knowledge and understanding of their local and organisational plans and procedures.

6. Summary Conclusion

The Trust has made good progress in developing a comprehensive response to winter 2021/2022 and seeks to address the key risks:

1) Infection Prevention and Control Issues (COVID and Influenza);
2) workforce deficits;
3) reduced flow owing to increased activity and decreased capacity in the care market.

Additionally, specific consideration is being given to maintaining an effective Elective Care Programme and ensuring a sufficient workforce in terms of resource and capability to maintain levels of safe and effective patient care.

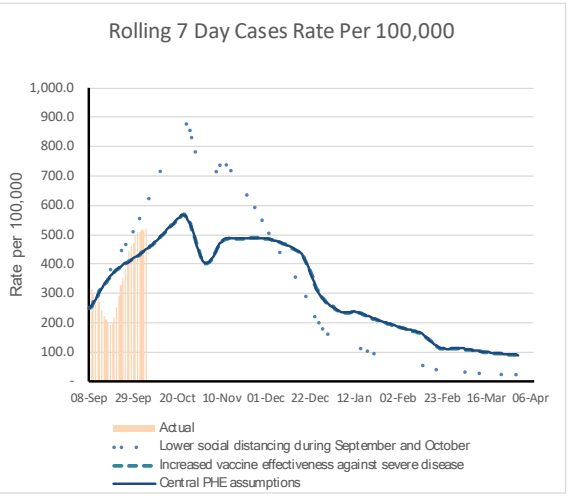
Attached as an Appendix for information to this summary are;

- **Appendix 1 – Performance Information Bed Modelling and Demand and Capacity forecasts for Winter Planning**
- **Appendix 2 – System wide resilience plan for winter**
- **Appendix 3 - SOP for Winter Ward**
- **Appendix 4 – Covid Escalation plan**

Appendix 1

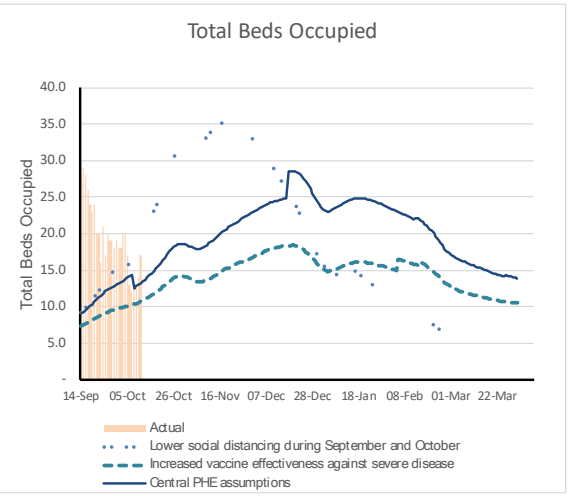
Inc	Bed Allocation			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
1	Alverstone		T&O	16	16	16	16	16	16	16	16	16	16	16	16
1	Alverstone D Bay		T&O	5	5	5	5	5	5	5	5	5	5	5	5
1	Appley		Medical	28	28	28	28	28	28	28	28	28	28	28	28
1	ITU 2		Medical	6	6	6	6	6	6	6	6	6	6	6	6
1	CCU SD		Medical	12	12	12	12	12	12	12	12	12	12	12	12
1	Colwell		Medical	28	28	28	28	28	28	28	28	28	28	28	28
0	ICU		Medical	6	6	6	6	6	6	6	6	6	6	6	6
1	MAAU		Medical	18	18	18	18	18	18	18	18	18	18	18	18
1	MAAU (SDEC)		Medical	6	6	6	6	6	6	6	6	6	6	6	6
1	Luccombe		T&O	24	24	24	24	24	24	24	24	24	24	24	24
1	Luccombe (O Bay)		T&O	4	4	4	4	4	4	4	4	4	4	4	4
1	Mottistone		Surgical	10	10	10	10	10	10	10	10	10	10	10	10
1	Isolation Ward 1		Surgical	25	25	25	25	25	25	25	25	25	25	25	25
1	St Helens / Stroke		Medical	14	14	14	14	14	14	14	14	14	14	14	14
1	St Helens / Stroke HASU		Medical	4	4	4	4	4	4	4	4	4	4	4	4
1	Whippingham		Medical	27	27	27	27	27	27	27	27	27	27	27	27
0	Childrens		Childrens	10	10	10	10	10	10	10	10	10	10	10	10
0	Wellow		Medical	3	3	3	3	3	3	3	3	3	3	3	3
0	Other		Other	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL		TOTAL	246	246	246	246	246	246	246	246	246	246	246	246
	Total	Medical	Non Elective	149	149	149	149	149	149	149	149	149	149	149	149
	Total	Medical	Elective	3	3	3	3	3	3	3	3	3	3	3	3
	Total	Surgical	Non Elective	25	25	25	25	25	25	25	25	25	25	25	25
	Total	Surgical	Elective	10	10	10	10	10	10	10	10	10	10	10	10
	Total	T&O	Non Elective	33	33	33	33	33	33	33	33	33	33	33	33
	Total	T&O	Elective	16	16	16	16	16	16	16	16	16	16	16	16
	Sub totlal (Excl Childrens and other)			236	236	236	236	236	236	236	236	236	236	236	236

COVID Forecasts



Rolling 7 Day Cases Rate Per 100,000

	Forecast			Actual
	Lower social distancing during September and October	Increased vaccine effectiveness against severe disease	Central PHE assumptions	
05-Oct	605.2	448.8	449.7	522.2
06-Oct	621.4	454.3	455.1	-
07-Oct	637.8	460.0	460.9	-
08-Oct	654.4	466.1	467.0	-
09-Oct	671.2	472.6	473.5	-
10-Oct	688.1	479.4	480.3	-
11-Oct	705.0	486.4	487.4	-
12-Oct	722.0	493.7	494.6	-
13-Oct	738.9	501.0	501.9	-
14-Oct	755.8	508.3	509.3	-
15-Oct	772.4	515.7	516.7	-
16-Oct	788.9	523.1	524.1	-
17-Oct	805.0	530.5	531.5	-
18-Oct	820.9	537.8	538.8	-
19-Oct	836.3	545.0	546.0	-



Total Beds Occupied

	Forecast			Actual
	Lower social distancing during September and October	Increased vaccine effectiveness against severe disease	Central PHE assumptions	
11-Oct	18.8	10.7	13.2	17.0
12-Oct	19.5	10.8	13.5	
13-Oct	20.1	11.0	13.7	
14-Oct	20.8	11.2	14.0	
15-Oct	21.5	11.3	14.3	
16-Oct	22.3	11.5	14.6	
17-Oct	23.0	11.7	14.9	
18-Oct	23.8	12.0	15.2	
19-Oct	24.6	12.2	15.6	
20-Oct	25.4	12.4	15.9	
21-Oct	26.2	12.7	16.3	
22-Oct	27.1	12.9	16.7	
23-Oct	27.9	13.2	17.1	
24-Oct	28.8	13.5	17.5	
25-Oct	29.7	13.7	17.9	

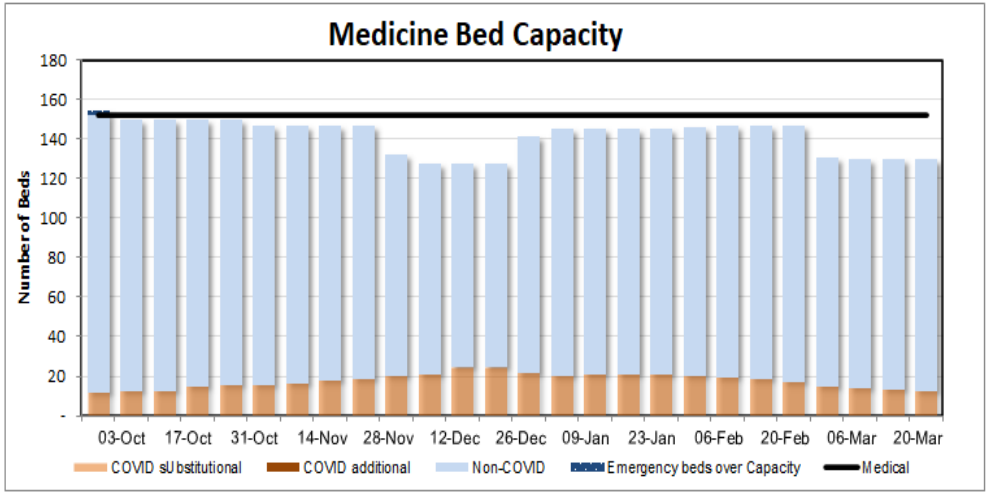
Projections for future COVID cases and admissions are being provided by an external consultancy supporting multiple Trusts. A large amount on uncertainty still exists and when considering the impact of COVID on bed capacity a number of factors need to be considered, including but not exclusively:-

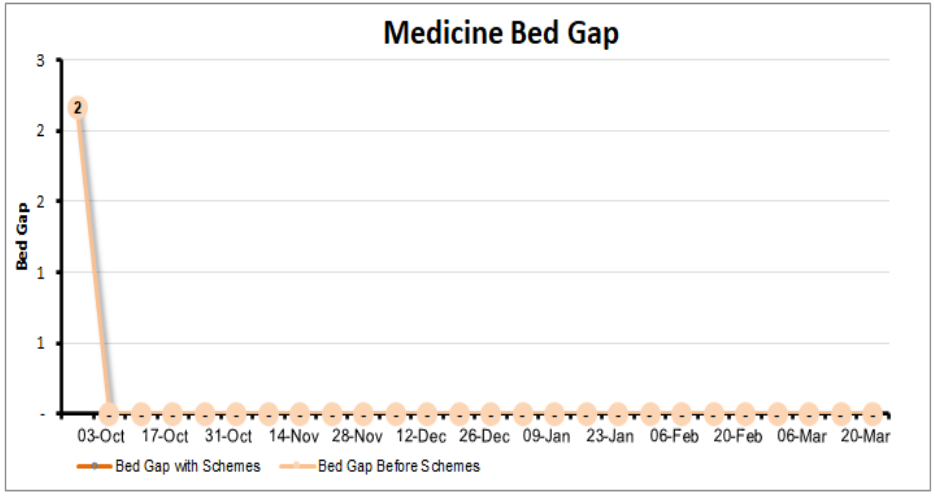
- Implementation and compliance with Social distancing measures
- Impact of Vaccine, take up % and future booster programmes.
- Are COVID admissions additional activity or substitutional for other emergency admissions
- Length of stay and system healthcare support for patient discharges
- Social migration to the Island
- Island special events (Festival)

Emergency Bed Demand & Capacity (ICS Forecast)

W/E	03-Oct	10-Oct	17-Oct	24-Oct	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	27-Mar
Emergency Activity	313	301	301	301	301	325	325	325	325	304	295	295	295	298	306	306	306	306	316	318	318	318	303	300	300	300
Medicine	03-Oct	10-Oct	17-Oct	24-Oct	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	27-Mar
Beds Available																										
Medical	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152
Beds Required																										
Medical	154	150	150	150	150	147	147	147	147	132	128	128	128	141	145	145	145	145	146	147	147	147	131	130	130	130
COVID sUbstitutional	12	12	13	15	16	15	16	18	19	20	21	24	24	22	20	21	21	20	20	19	18	17	14	13	13	12
COVID additional	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-COVID	142	138	137	135	134	132	131	129	128	112	107	103	103	119	125	124	124	125	126	128	128	130	116	116	117	117
Excess Bed Demand	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Assumes 7,999 Emergency Admissions during period and COVID activity to be 100.0% Substitutional

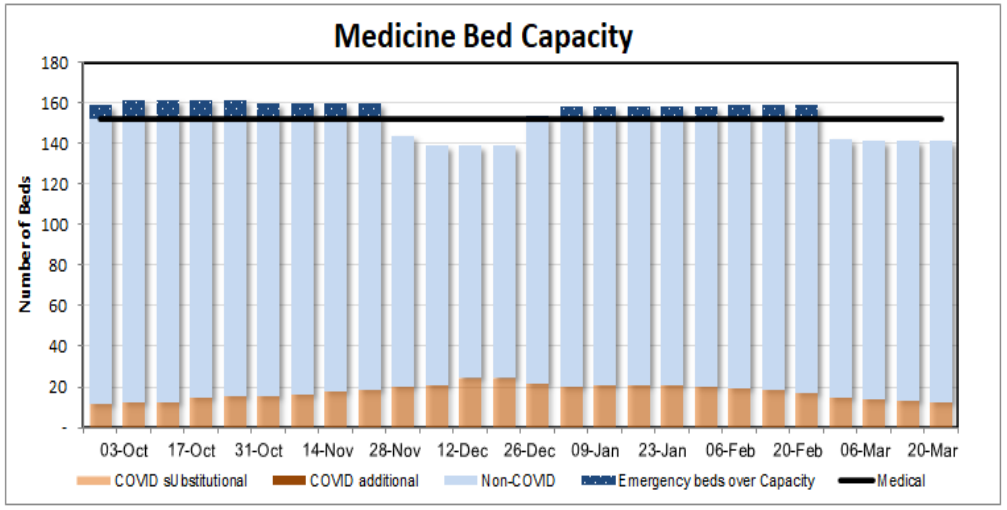


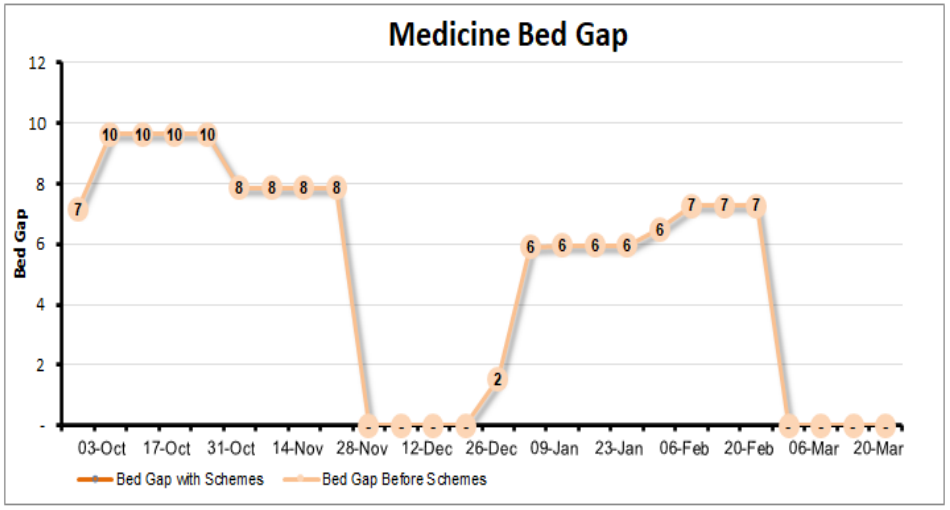


Emergency Bed Demand & Capacity (Trust Forecast)

W/E	03-Oct	10-Oct	17-Oct	24-Oct	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	27-Mar
Emergency Activity	324	327	327	327	327	353	353	353	353	330	321	321	321	324	333	333	333	333	343	345	345	345	329	326	326	326
Medicine	03-Oct	10-Oct	17-Oct	24-Oct	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	27-Mar
Beds Available																										
Medical	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152
Beds Required																										
Medical	159	162	162	162	162	160	160	160	160	143	139	139	139	154	158	158	158	158	158	159	159	159	142	141	141	141
COVID sUbstitutional	12	12	13	15	16	15	16	18	19	20	21	24	24	22	20	21	21	20	20	19	18	17	14	13	13	12
COVID additional	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-COVID	147	149	149	147	146	145	144	142	141	124	119	115	115	132	138	137	137	137	139	140	141	143	128	128	128	129
Excess Bed Demand	7	10	10	10	10	8	8	8	8	-	-	-	-	2	6	6	6	6	6	7	7	7	-	-	-	-

Assumes 8,676 Emergency Admissions during period and COVID activity to be 100.0% Substitutional





Appendix 2


NHS
Isle of Wight
NHS Trust
NHS
Hampshire, Southampton and
Isle of Wight
Clinical Commissioning Group
ISLE of WIGHT
COUNCIL
Seasonal (Winter) Plan
2021/22

Seasonal Planning Development Content

1. National / Regional Framework
2. Hampshire and Isle of Wight ICC Health And Social Care - Concept of Operations (CONOPS)
3. Local System Framework
4. Local Planning Document Structure
5. Identified Risks (to mitigate)
6. Recommendations

1. Frameworks - Guidance

- NHS England Winter Frameworks – *Confirmation awaited*

Planning Timeframes
Daily reporting requirements and any exception thresholds

- ICS Frameworks – *Confirmation awaited but based on Draft 'ICC Concept of Operations'*

Current assumption that an overarching plan will be at ICS level, with local operational plans beneath
ICS may suggest that planning templates, structures and approaches are consistent across Hampshire and IW
Mutual Aid Opportunities
Meeting and reporting requirements
Hampshire and Isle of Wight ICC Health And Social Care Concept of Operations framework will be in place to fully retain incident co-ordination functions

- National/local Incident Control Management

COVID measures in place – "Planning in the context of COVID"
Vaccination programmes
Oxygen Supplies
Local capacity management – agile capacity planning - need for hot and Cold capacity
ICC Concept of Operations in place

1a. Adult Social Care Winter Plan – National Planning Requirements

There was an expectation that the Government would publish Guidance on a Winter Plan for Adult Social Care in May 2021 – As yet this has not arrived but as previously reported this is likely to focus on:

- **preventing and controlling the spread of infection in care settings (development of an IPC strategy for all social care settings – aligned to the NHS; continuation of IPC funding; ramping up to daily testing; compulsory vaccination for all staff working in care homes for the over 65s; assured access to PPE (including making PPE VAT exempt in line with NHS)**
- **collaboration across health and care (continuation of EHCH model for all care homes**
- **remote monitoring and digital support (e.g., provision of iPad to care homes)**
- **supporting the workforce (especially ensuring that there is no COVID positive working this winter; national recruitment campaign; support to the ASC nurse workforce; and dedicated occupational health service to all ASC staff working in independent sector)**
- **supporting people who receive social care, and their carers (maintain visiting in care homes, extend direct payments, access to testing for volunteers and staff of services such as day centres, free PPE to carers, access to respite services, reopening of day services**

Additional local focus will be on;

- Ensuring Business Continuity Plans are updated and providers are 'Winter prepared'
- Assessing Financial Care packages and review the need to maintain schemes and initiatives
- Further enhance the provider engagement network

1 - National and Regional Framework (awaiting national detail)

Statutory Responsibilities

- NHS Constitutional Standards and national delivery requirements
- NHSE/I Statutory Assurance
- Continuing Health Care
- Individual Placements
- Medicines Optimisation

Local System Lead

- HIOW STP Programme Board
- Integrated Care Community
- Wessex Cancer Alliance
- HIOW SCG
- Regional CHC Leads
- HIOW Partnership Leads
- A&E Delivery Board

Local System Partner

- ICP Board
- Solent Acute Alliance Board
- Mental Health Alliance
- IW Tactical Control Group
- IW Affected Residents Cell
- ICP Island Quality Committee
- Island Infection Prevention Control Committee
- IOW Outbreak Control Board
- IOWC Health Protection Board
- Violence Against Women Group
- Suicide Prevention Group
- Emotional Health and Wellbeing Group

Policy Implementation

- NHS Long Term Plan
- Isle of Wight Health and Care Plan
- Mental Health Five Year Forward View
- MH Blueprint
- Better Care Fund
- Primary Care Networks Directed Enhanced Service
- Transformation Delivery Group
- Planned Care Recovery
- System Recovery Plan
- Care Close to Home strategy

2 - Hampshire and Isle of Wight ICC Health And Social Care Concept of Operations (CONOPS)

The aim of this framework is to set out the future structures and system working that describes Hampshire and the Isle of Wight (HIOW) system response to:

- Future COVID-19 surge (wave 3 and beyond)
- Whole system response requirements (future Major Incidents)
- Whole system collaboration – specific performance/delivery requirements (eg CAMHS)
- **Operational system pressures inevitably experienced during times of pressure (eg Winter).**
- **Provision of a single point of contact into HIOW**

This framework sets out the triggers that will be used to support escalation of the NHS system response and the proposed actions and system intervention in the event of escalation. It includes the operating principles for managing system pressure throughout the remainder of 2021/22, key system partners required, the method of operation and an overview of the enabling work to support this framework.

2. Hampshire and Isle of Wight ICC Health And Social Care Concept of Operations (CONOPS)

There are four key objectives of the HIOW operating framework and associated management processes.

- **Identify problems that cannot be resolved locally which would benefit from a wider focus and additional support and take action**
- **Ensure resilience coordination across the whole system by responding to surge needs due to specific factors (e.g. COVID, Winter)**
- **Respond to known drivers of high demand and capacity need in a whole system coordinated manner.**

An overarching whole system resilience plan will cover the period May 21 to Apr 22. The winter period will be further considered to ensure the overarching plan can be adjusted to meet future anticipated need as indicated by the analysis. By taking a 6 – 8 week prospective view of demand and supply, the system will be able to identify any areas of concern in enough time to be able to take action. Keeping a short lens and planning for phases as defended by the need has proven very successful during the COVID-19 response period. This approach allows the HSC Hub to refrain from straying into key areas of future design and strategy – which this work can influence through outputs of lessons learned, trends identified and areas of evasive action which cannot be taken – therefore needing a more longer term redesign and strategic focus. The phases are as follows:

Phase W1: 1st Jun to end Aug. This phase covers the next stage in the government roadmap as well as the summer period;
Phase W2: Sep to Mid Nov 21. This phase covers the return to school period as well as October half term holiday. Planned in Aug.
Phase W3: mid Nov to Mid Dec 21. Planned in Sep.
Phase W4: Mid Dec to End Jan 22. Cover the Xmas period and traditional elective start up in early Jan 22. Planned in Oct/Nov.
Phase W5: End Jan to 19 Apr 22. This phase covers Feb half term; Easter and Easter School holidays. Planned in Early Dec 21

**Sensitivity analysis will need to be completed to model the national UEC escalation triggers against the historic profile thereby providing an additional layer of intelligence to refine the activities in each of the phases outlined above

2. Hampshire and Isle of Wight ICC Health And Social Care Key roles and responsibilities

Operational Delivery Hub

- Acts as a point of escalation for issues from local health systems/areas of concern that we are unable to resolve locally
- Acts as single point of contact for any issues from NHSE/I Region for the HIOW health system

Maintaining Hospital Capacity Group

- Sustain the maximum possible hospital capacity to meet the treatment requirements for all patients.
- Ensure consistent and appropriate clinical decision making and thresholds for treatment are in place across HIOW
- Ensure resilience of capacity for emergency admissions, cancer treatment and elective demand.

Mental Health Capacity Group

- Ensure care is delivered locally where ever possible, supported by mutual aid via shared use of resources (staff, beds etc)
- Protection of Acute care (avoid OAPS) best use of local resources and assets for HIOW and troubleshooting/advice
- MDT and/or cross organisational decision making to specific challenging situations – brought forward by exec leads from organisational and local system BRONZE groups.

Local Systems

- Maintain place-based health and social care services inc primary care model of healthcare provision including an urgent response
- Manage pressure within systems. This includes patient flow and interaction with other agencies and providers such as local authorities, OOH etc. Support the delivery of UTLA winter plans including discharge guidance. Local communications with public and stakeholders. Warn and report as required through NHSEI mandated systems and processes

SCAS & IW Ambulance Service

- Sustain the maximum possible capacity (111; 999; PTS) to meet the requirement for patients
- Support Hospital capacity task group and local systems task groups as required.

Logistics

- Co-ordinating the supply of scarce/mission-critical resources at a HIOW ICS level, drawing together colleagues from across all provision components to support.

Workforce

- Ensure a system wide workforce capacity weekly sit-rep (inc private providers, local authority, primary care & NHS orgs.)
- Manage a collaborative ‘capacity bureau’ through the Bring Back Staff/ returners programme

3 - Isle of Wight 'Local System' Operational Framework – Governance and any Local Authority Mutual Aid or escalation will be directed to the appropriate director of Adult Social Care

Operational level (BRONZE)

Demand and capacity will be managed through local systems as per business as usual arrangements. Day to day liaison between hospitals and system partners remains key to managing pressure and is the responsibility of local systems / A&E Delivery Boards to arrange/manage in accordance with local system set up. It is vital that local systems remain empowered to deal with local issues themselves. Actions that impact on other systems should be scarce, but clear routes of discussion and communication exist between systems when needed. Within the Local system there are;

key operational leads - Isle of Wight system BRONZE,

Service leads & Execs – Isle of Wight System SILVER

IW system Executive group / A&E Delivery Board – Isle of Wight System GOLD

(names can change to avoid confusion with wider group)

Tactical level (SILVER)

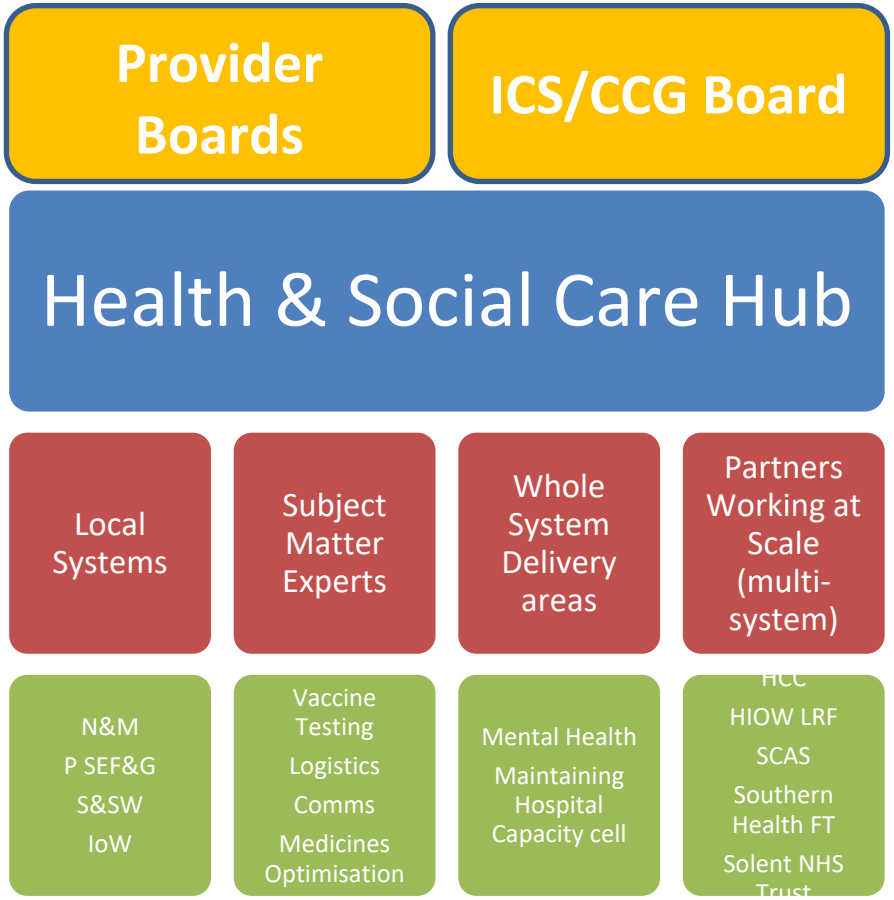
The Ops Hub will on a weekly basis 'look forward' 10 days to ensure future short-range issues are anticipated and managed with System Leads. As and when the requirement to escalate occurs, the Operational Hub will employ the Escalation Framework. In the event of multiple systems in HIOW becoming 'gridlocked', then there is a requirement for certain components of capacity to be coordinated at a HIOW level through the Ops Hub, under the agreed principles of mutual aid and support.

Maintaining Hospital Capacity. Where operational issues threaten to compromise the overall delivery of the HIOW Acute EL and NEL plan, the Maintain Hospital Capacity cell will coordinate actions to manage escalated situations between hospitals.

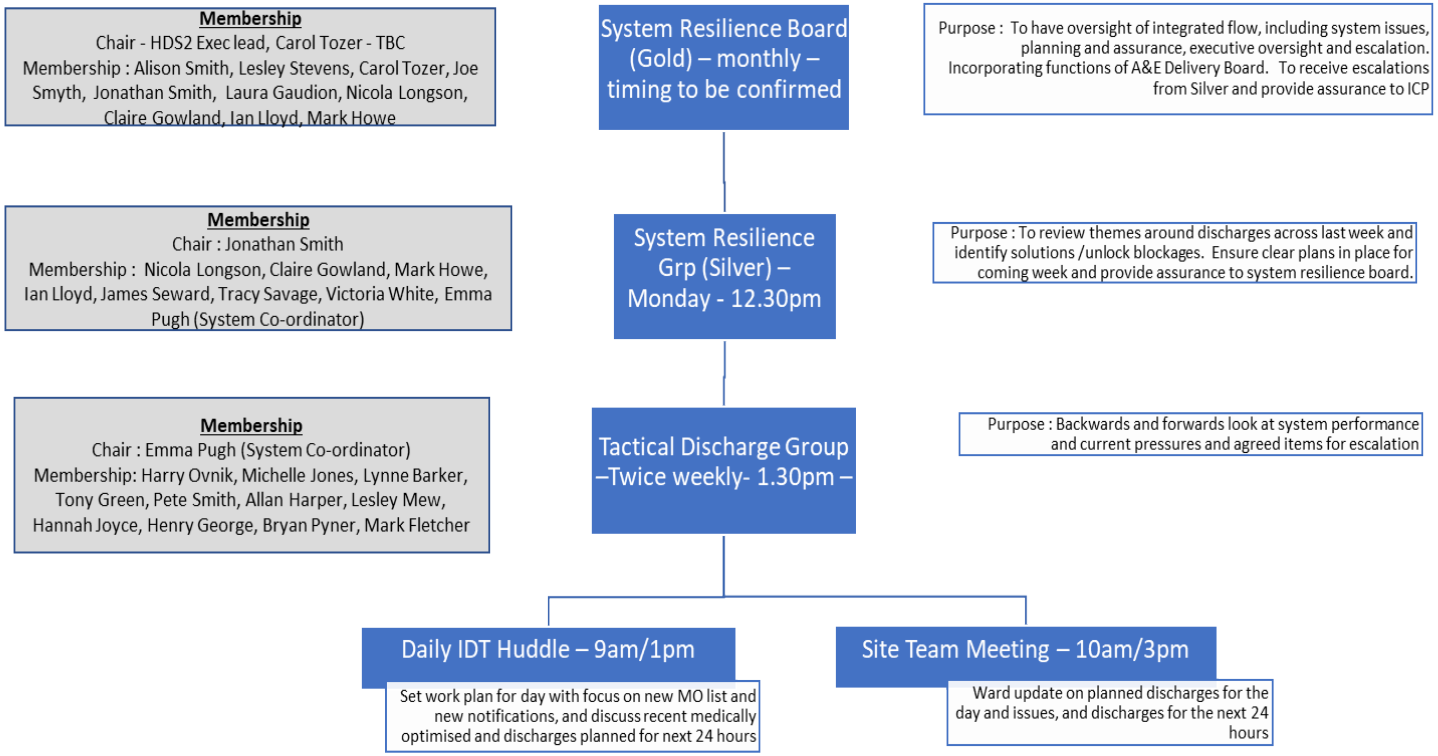
Concurrently, local systems will continue to focus on their Place Based services to maintain patient flow.

Strategic Level (GOLD)

Whole system escalations will go to the HIOW ICS Board for visibility of risks and issues, following agreement to this approach from the Health and Social Care Hub. This allows Operational and ICS boards to be connected to the pressure points in the system and the possible threat to the design and deliver of wider strategic objectives.



3 - Isle of Wight 'Local System' Operational Framework - Governance – System Resilience Board – Business as Usual



Groups to be enhanced in representation and frequency when the IW System is in Escalation

3 - Isle of Wight 'Local System' Operational Framework - Winter Team roles, reviews and escalation triggers

System Level	Operational Group (IW System Bronze)	Senior Operational leads (IW System Silver)	A&E Delivery Board Exec (IW System Gold)
Routine	Twice weekly Tactical Discharge Group meetings 10am Daily Site meetings and Operational focus discussions	Weekly meetings arranged	Weekly meetings arranged
OPEL/REAP** 1	BRONZE	-	-
OPEL 2	BRONZE	-	-
OPEL 3	BRONZE	SILVER CALL	-
OPEL 3 – With Acute escalating towards, or at OPEL 4	BRONZE	SILVER CALL	GOLD CALL
OPEL 4	BRONZE	SILVER CALL	GOLD CALL
Participants	As per previous slide	As per previous slide	As per previous slide

Bronze - An Operational leads Winter Team including Trust EPRR and CCG and ASC resilience leads meet daily for 15 minutes throughout the Winter period. Additionally, Trust site meetings were attended by system representative in order to maintain oversight and track escalation. This is as well as the twice weekly Tactical Discharge Group. This enables sharing of status position, risks and actions within organisations.

Silver Group is scheduled to meet weekly but with enhance frequency of discussion if the system approaches OPEL 3-4.

Gold Group is the highest Escalation point and will begin to meet regularly if the system is at OPEL 3 and at risk of escalating to OPEL 4

3 - Isle of Wight 'Local System' Operational Framework - Operational Rhythm

Daily System oversight by Winter Team (Resilience and EPRR leads)

- Daily system meetings / SITE meetings at Trust
- Operational resilience review process
- Isle of Wight System Silver and Gold escalation groups
- Monitoring of daily COVID and Flu impacts and coordinated actions

The **Winter Standard Operating Procedure** establishes how the system manages itself in order to provide the appropriate and timely response,
In line with the Winter Resilience plan and System Escalation plan

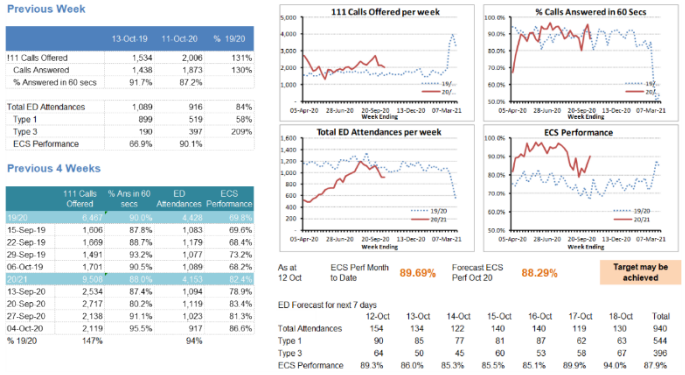
The document outlines;

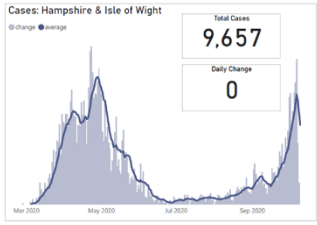
- The key locations (virtual and physical) where key operational discussion will take place
- The period of time that this process will be in place
- NHS England expectations in line with the South East regional Operating Model

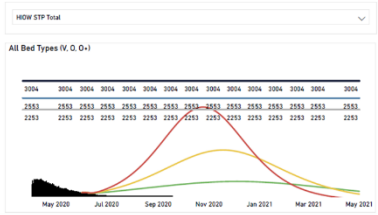
Performance Triggers
Daily Sitrep Reporting
Regional System call arrangements and who leads these
Exception reporting criteria / process

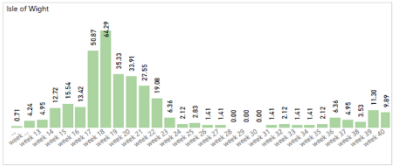
- Roles and responsibilities
- Expected daily activities
- System information

Emergency Care Modelling and Activity









3 - Isle of Wight 'Local System' Operational Framework - Key indicators and Alerts

Escalation framework and Triggers

- Existing System Resilience and COVID-19 related Triggers embedded to supplement existing OPEL Framework.
- Additional national and local measure and triggers may be development through the summer/autumn 2021

Escalation Process in place

- OPEL Escalation plans in place
- Daily operational measures in place

A&E Delivery Board Dashboard / Executive Summary Reports

Silver Group Highlight Report – pictured to the right

SHREWD, (Resilience & Alert Functions) – System Re-launch in progress

ED Breach reporting

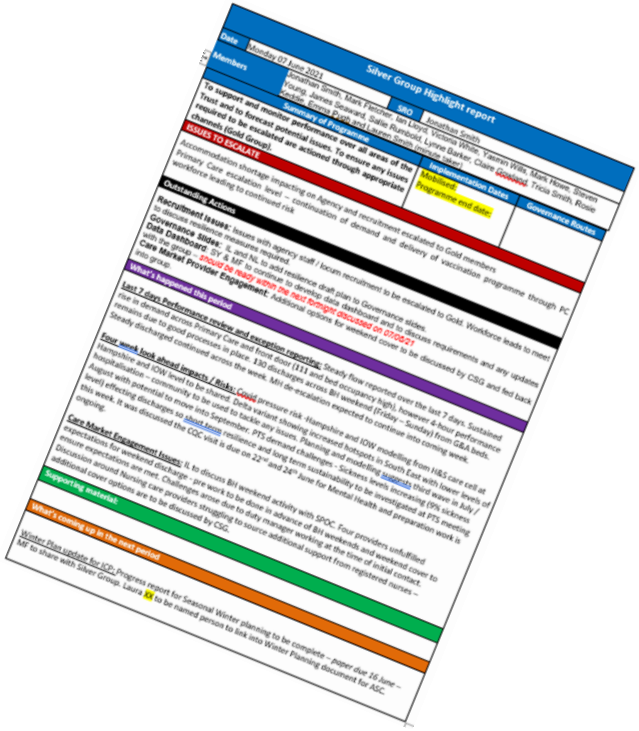
Discharge Tactical Group Dashboard

Core and Discharge SITREP reporting

Primary Care Reporting

Test, Trace and Isolate reporting

- Visual live performance Dashboard and measures in the Operations/Site Room


Silver Group Highlight report

5 - Identified Risk Log - Draft

Risk	Description	Score	Risk Mitigation	Revised Score
001	**Increase of staff absence**	TBC	Individual trusts BC Plans Individual organisational Wellbeing workforce plans Dissemination of national Health and Wellbeing offer for staff	TBC
002	**Increase in patients requiring critical care capacity/oxygen** CoVID-19 is a respiratory illness which requires some patients to require additional medical interventions including oxygen	TBC	Managed through hospital capacity cell Hospital capacity rehearsal/escalation plan SE Region ACC Surge Escalation plan	TBC
003	**Scarcity of essential PPE** Supply chain for FFP3 masks and gloves can be difficult. Additional disruption to the global supply chain due to increased demand in other countries, and due to changes, such as Brexit.	TBC	Managed through Supply Chain cell National management process Online supply chain management LRF warehouse with additional supply	TBC
004	**Mental health capacity** Expecting significant surge in mental health Presentation and demand on MH beds – Reliance on 'leave' beds as contingency	TBC	Managed through Mental health cell Escalation plan National support for NHS staff Work force cell reviewing additional support	TBC
005	**Social care capacity including care home and domiciliary care market** Care facility failure – care home (or similar) meets capacity, does not have enough staff or closes for any other reason i.e. financial sustainability Competition for staffing	TBC	Managed by Local Authorities with support from local systems Provider failure plans Mutual aid arrangements through the work force cell	TBC

5 - Identified Risk Log - Draft

Risk	Description	Score	Risk Mitigation	Revised Score
006	**Patient Transport Service capacity** There is increasing levels of conflicting demand on PTS with increasing levels of discharges requiring support as well as the recovery phase of the elective programme. Additionally there are mainland transfers which are very consuming on resource. There will be potential periods of time when transport capacity will be less than demand resulting in failed discharge	TBC	Ensure applicable use and criteria of the service is applied and all other options of transport are assessed.	TBC
007	**Increase in demand for both UEC and Elective health services** There is a clear and sustained increase in non-elective activity both in ED, Non Elective admissions and demand across ambulance services including patient transport, as well as throughout primary care and community care services. Current data analysis shows that activity levels within our system can be compared with what we would expect to see in a normal 'winter' period	TBC	Local systems working across each area to manage demand as would be expected with any seasonal demand (admission avoidance programmes, in-hospital process improvements, escalation capacity mobilised, discharge criteria relaxed, additional workforce deployed etc)	TBC
008	**Increase in new variants** Local cases of variants of concern (while small in numbers) are increasing. Whilst case rates remain extremely low, have identified positive cases locally of the highly transmissible B.1.617.2 variant of concern.	TBC	DpH Colleagues continue with the surveillance of new variants of COVID Vaccine programme continues rollout to high risk cohorts to ensure maximum protection against future variants Government restrictions remain (Next step no earlier than 21st June)	TBC
009	**Workforce** A high reliance on Agency and Bank staffing causes challenges covering holiday periods. Additionally, due to lockdown and the significant increase is 'staycations' the demand for staff across all tourism sectors is high and could impact of certain health and social Care roles. Additionally, significant demand on accommodation is minimising available accommodation for agency staff and hindering short term recruitment.	TBC	In development	TBC
010	**Conflict of Priorities** A number of services and organisation will be impacted by conflicting priorities that will impact on system flow. EG Primary cares capacity and ability to meet increasing urgent care demand whilst also focusing on delivery of the vaccination programme	TBC	Regular monitoring and increased use of live information and alerting systems such as SHREWD for early warning of pressure	TBC

6. Key Recommendations -

#	Recommendation	Owner
1	The Integrated Care Partnership to delegate to the IW System Gold Group the responsibility for planning and delivery of local seasonal planning. This will Include local self-assurance of the seasonal plans as well as ownership and mitigation of identified risks.	IW System Gold Group
2	The Integrated Care Partnership will be provided with assurance and escalation alerts by the IW Gold Group as and when necessary.	IW System Gold Group
3	The main strategic focus of the seasonal planning will be delivery of the Response, Recovery and Restoration plan, as well as Hospital Discharge Service (HDS2) implementation. COVID and Flu Infection, Prevention and Control Measures will continue to require monitoring and agile management in alignment with Health Protection Board guidance.	IW System Gold Group
4	The CCG leads will continue to lead development and collation of the whole system planning documentation in alignment to national and regional health and social care frameworks and working with IW system Bronze, Silver and Gold leads.	Jonathan Smith / Mark Fletcher
5	Seasonal Planning will be based on a rolling 3 month template rather than individual plans for fixed specific periods of time. As set out in the ICC Concept of Operations (slide 6).	Jonathan Smith / Mark Fletcher

Appendix 3 SOP Winter Ward

STANDARD OPERATING PROCEDURE
OPENING ADDITIONAL BEDS

Document Type	Clinical
Directorate	Corporate
Document Owner	Chief Nurse
Document Authors	Karen Grant (ADN – Unplanned care) Lynda Handley (ADN Planned care) Eliza Mathew (HoN Medicine) Samara Lamb (HoN UEC) Jo Pennell (Matron, unplanned care) Mandy Blackler (Business & Operations Manager, Corporate Nursing)
Next Author Review Date	May 2022
Approving Body	Head of Nursing meeting / Chief Nurse Planned care board for noting. Unplanned care board for noting
Version No.	1.0
Document Valid from date	June 2021
Document Valid to date:	31st May 2022

'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date	Director Responsible for Change	Nature of Change	Ratification / Approval
24.06.21	1	24.06.21	Karen Grant	Competed document	

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1. Executive Summary

This Standard Operating Procedure (SOP) contains guidance on the actions required to open an extra ward facility in response to seasonal pressures or Covid pressures. Whilst it is possible to predict patterns of activity to an extent, it is also important to have access to additional contingency capacity should this be required due to unpredictable or unforeseen circumstances.

During the winter period, a number of pressures will be prevalent which may have an impact on our ability to manage demand and capacity, although these pressures can also be experienced at other times of the year. This SOP will be triggered when the decision is made at executive level to open additional capacity which is not part of existing bed base.

2. Introduction

Pressure within the system leading to the need for additional bed capacity, can be encountered for multiple reasons; seasonal variations like norovirus and influenza have traditionally, with the recent addition of the covid pathways changes may make it necessary to open additional capacity at short notice. Learning from the coronavirus pandemic response has informed has aided the development of this SOP in managing an escalation ward staffing. It is also recognised that in additional to variations in bed capacity requirements for outbreak reasons, the fluctuating population on the island, peaking during the summer months may also lead to the requirement to open additional beds over and above the baseline requirements.

The case mix of patients will be determined at the time of escalation, as this will change according to clinical pressures being responded to (COVID or non Covid). If in a non covid pathway, it is anticipated that those patients nearing end of their pathway be moved to the area. This would maintain the high acuity of new admissions being in the core medical ward facilities.

Any new area opened must not have the name changed. This is to maintain safety with the fire panels, patient information systems and emergency calls made to clinical teams.

3 Definitions

SOP – Standard Operating Procedure
ADN – Associate Director of Nursing
HoN – Head of Nursing
IPC – Infection, Prevention and Control
AHP – Allied Health Professionals

4 Scope

This SOP provides guidance on the actions required to staff an extra ward area, once Gold command made to increase capacity in the organisation. This SOP excludes the decision making of increasing capacity. It is to be used by operational staff, clinical staff, site management teams and senior managers on call when opening a clinical area.

5 Purpose

To provide guidance on setting up an escalation winter pressure ward, once a decision has been made that extra beds are required to respond to inpatient pressures.

6 Roles and Responsibilities

Once a decision has been made to increase capacity, the location, the required beds, required and time scale the identification of location and bed requirement, and time scale. The following people must be informed. An Associate Director of Nursing will take a lead in coordinating the team in delivering:

Immediate:

Service / role	Contact name (may change)	Actions required	Signature & time confirmed contact made
Chief Nurse	Mary Aubrey		
Deputy Directors of Nursing	Pippa Street		
Associate Directors of Nursing	Karen Grant (unplanned) Lynda Handley (planned) Jen Edgington (community)	Coordination of responses within care group	
Site Management Team	Lynne Barker	Support ADNs and inform critical services of extra capacity ward opening	
Heads of Nursing	Samara Lamb, Eliza Mathew, Bev Fryer, Natalie Mew, Kathryn Taylor, Marcia Meaning	Inform matrons and support them in releasing the identified RN and HCAs from services. Ensure temporary workers are booked/ filled on the bank.	
Matrons	Rosie Goulding, Carey McShane, Richard Young, Tara Smith, Jo Pennell, Rachel Clarke, Julie Hailes	Release identified RN and HCA from roster Provide oversight of local area and supporting teams	
Infection Control Team	Karen Robinson	Inform team and complete an IPC review of the area	
Pharmacy	Tom Cox	Prepare teams to set up medication requirements	
Stores	Bob Cave	Prepare to set up core stock items	
Catering	Jane Glen	Prepare to set up for extra for extra ward meals requirements	
Cleanliness team	Gayle Perryman	To clean area prior to opening, t provides core cleaning schedule once open	
Porters / caretakers	Simon Laughton	Inform team for opening new area	
Information Systems	Zoe Elliott	Update all IT systems	

Critical services to be informed:

Service / role	Contact name (may change)	Actions required	Signature & time confirming contact made
Critical Care Outreach Service	Vikki Crickmore	Inform team	
Resus Team	Alex Paul	Inform team	
End of Life care team	Shane Moody	Inform team	
Switchboard	Dial 0	Update systems and inform team	
Pathology		Update systems and inform team	
Diagnostic imaging	Liz Hillier	Update systems and inform team	
Medical devices	Nat Ford	To assess medical device requirement in the ward area opening	
E-rostering	Stuart Austin	Provide support to matrons in setting up temporary ward template	
CUPAC	Jay Chappell	For information	
PIDs	Iain Hendey	Update systems and inform team	
Medical devices	Nat Ford	Update systems and inform team	
PIDS	Iain Hendey	Update systems and inform team	

7 Policy detail/ cause of action

The winter pressure ward will be the responsibility of unplanned care nursing leadership. A Head of Nursing and Matron will be allocated by the Associate Director of Nursing of Unplanned care. An experienced band 7 ward leader from AAU/SSU has already been identified to move for the escalation winter pressure ward for 2021. This role will be backfilled, by recruiting interim band 6. This individual will be identified annually.

A minimum of 50 % of the escalation ward will be substantive staff. A list will be updated 6 monthly. The remaining will be pool staff. The substantive staff will be backfilled by pool staff. This will maintain organisational knowledge on safety and practices. The aim is an allocation of one member of staff from each ward, which will reduce the impact. should be sought by the Head of Nursing (Unplanned and Planned) from anyone that would be interested in being redeployed to a new area temporarily. This needs to have agreement from Sister/Matron of the area and the list should be kept by the Associate Directors of Nursing.

Once a decision made by Gold command, that increased bed capacity is required there are options for 15 or 28 beds to be opened. This SOP gives guidance for staffing of both; however, the identified members of staff is for planning of 15 beds.

Area	Capacity opened:	Nursing workforce requirements:	Shift allocations

Compton	15 beds	15.71 WTE RNs 12.0 WTE HCAs Sister/Charge Nurse, Ward Clerk Housekeeper	Early shift: 1 Ward Sister, 1 Ward Clerk, 3 RNs, 2 HCA, 1 Housekeeper, Late shift: 3 RNs 2 HCAs Night: 3 RNs, 2 HCAs
Compton	28 beds	22 WTE RN 19 WTE HCA	Early shift: 4 RN 3 HCA 1 Housekeeper 1 Ward Clerk Late Shift: 4 RN 3 HCA Night shift: 4 RN 3 HCA

8 Consultation

This document has been developed in consultation with the Chief Nurse, Deputy Director of Nursing, Associate Directors of Nursing, Heads of Nursing and Matrons. This document will be approved by Chief Nurse at the head of Nursing meeting. It will be taken for note to the planned and unplanned care boards.

9 Training

Prior to opening, identified team member will be invited to attend regular virtual ward meetings. To commence in September 2021. This will allow for the team to develop working relationships and develop a structure for the ward and prepare governance and quality frameworks.

10 Monitoring Compliance and Effectiveness

Upon closure of any additional beds and returning to business as usual, a post-project evaluation should take place to ensure that any lessons learned, from the implementation of actions within this SOP, can be shared and this document updated accordingly. A quality impact assessment will be completed.

The new ward will be expected to adhere to the same clinical and audit compliances as any other area within the acute Trust.

11 Links to other Organisational Documents

Discharge Lounge SOP

12 References

13 Appendices

Appendix A: Opening escalation ward checklists

Appendix A

Opening escalation ward checklists		
	Action	Completed by
1	Ensure risk assessment is completed	
2	Complete Quality Impact Assessment	
3	Establish staffing ratio and skill mix, ensure staffing plan in place for minimum of 28 days	
4	Ensure Medical or surgical cover agreed by the relevant Division	
5	Ensure physical bed stock available	
6	Ensure bed space provision chair, locker	
7	Ensure all monitoring equipment is available and in working order	
8	Provisions of medication Pod locker	
9	Ensure O2 and suction tubing is set up ready to use	
10	Resuscitation Trolley	
11	Ensure manual handling equipment available	
12	Health and safety team and patient's safety lead made aware and risk assessment completed	
13	Request pharmacy stock provision	
14	Request regular ward stock from Stores (based on 50% Colwell ward if acute patients or Community Unit stock levels if medically optimised patients)	
15	Ensure provision of meals and fluids planned with catering team	
16	Ensure relevant documents are available for patients ongoing management	
17	Ensure JAC transfers are activated for patients transferred to the ward	
18	Arrange laundry provision	
19	Ensure agency staff complete induction form	
20	Induct all agency or bank staff ensuring they have information about how to get assistance and contact the site team	
21	Allocate a Deputy HoN/ Senior sister to undertake a daily review of the areas, provide liaison with socials services and bed managers for discharge activity.	
22	Inform Information systems to set up ward template	
23	Set up for daily check lists books	

Bedside check

Task	Number of items	Date	Signature	Number of items on reopening	Date	Signature
Bedside locker						
Bedside tables						
Beds						
Oxygen working and set up						
Suction working and set up						
Emergency call bells present and working						
Patient call bell present and working						

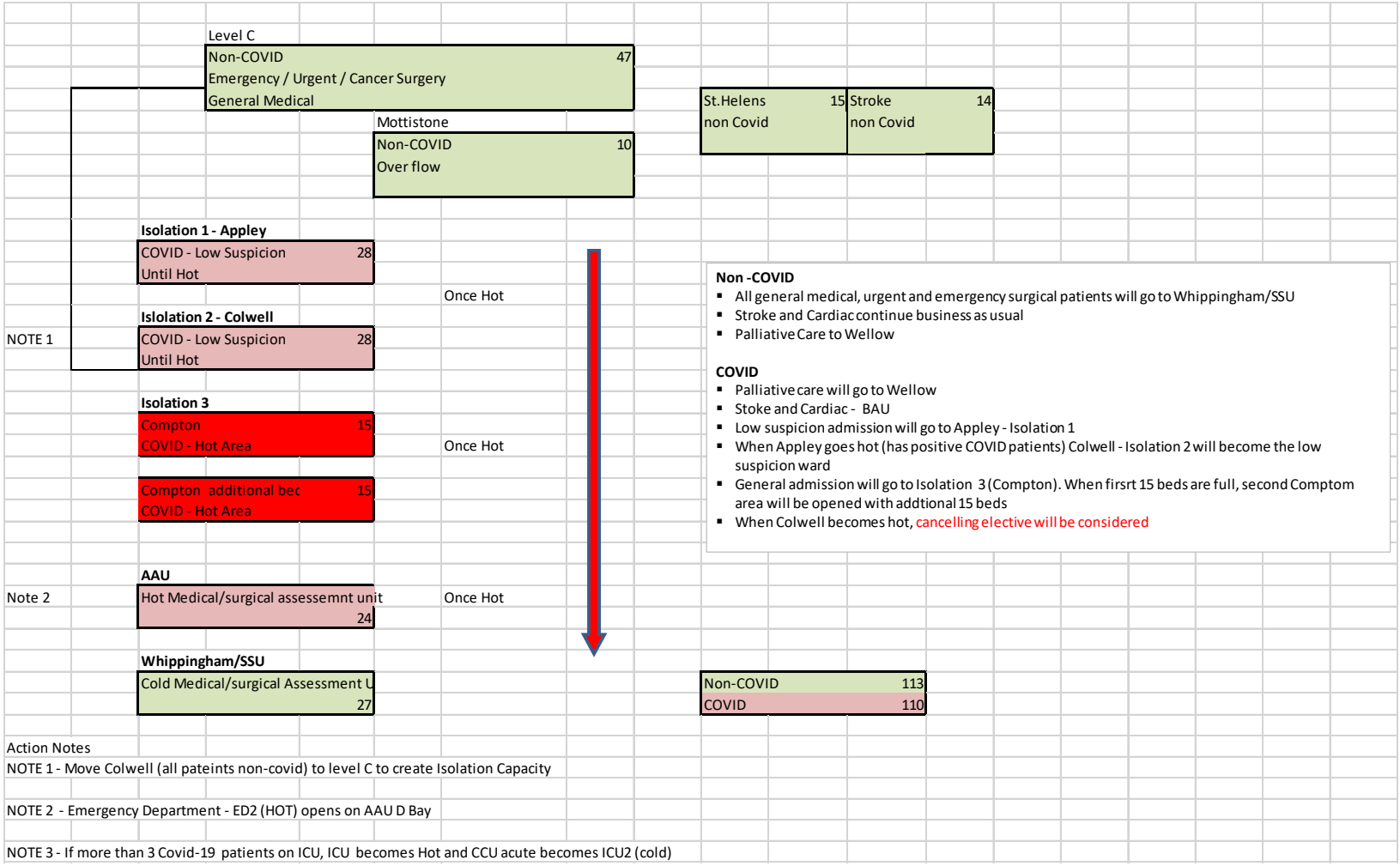
Medicines safety

Task	Date completed	Signature	Date reactivated	Signature
Discussion with Pharmacist				
Removal of CDs by pharmacy on ward closure.				
Delivery of CD's pre re-opening of a ward in liaison with leadership team/ward pharmacist.				
Ensure patient own medication goes with a patient or is disposed of through normal processes.				
Drug cupboard entry code changed by the team closing the ward and kept with the drug keys in an envelope in the Site office.				
Medication computers locked and stored securely in clinical room				
Fridge items removed				
Fridge turned off				
CD keys and Ward Keys labelled and handed to site office.				

Ward Equipment

Task	Date	Signature	Date received equipment after reopened	Signature
Label ECG machine– store in secure place				
Label weighing scales and store in a secure place				
Check crash trolley and lock. Use a security tag to ensure closure				
Label computer on Wheels				

Appendix 4 Covid Escalation Plan



great people great place

NHS Isle of Wight NHS Trust

Agenda Item No	7.1	**Meeting**	Trust Board held in Public	**Meeting Date**	11 November 2021
Title	Committee Report from Quality & Performance Committee				
Sponsoring Executive Director	Tim Peachey, Chair of Quality & Performance Committee				
Author(s)	Lois Howell, Director of Governance & Risk				
Report previously considered by including date	Quality & Performance Committee – 29 October 2021				

Purpose of the Report		**Reason for submission to Trust Board in Private only (please indicate below)**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2020-2025**	
Trust Board Approval		Commercial Confidentiality		Effective	X	SO 01: Make our Trust a great place to work and receive care	
Committee Agreement		Patient Confidentiality		Caring	X	SO 02: Work with our partners and our community to improve services	X
Assurance	X	Staff Confidentiality		Safe	X	SO 03: Deliver high quality compassionate care	X
Information Only		Other Exceptional Circumstance		Responsive	X	SO 04: Make sure our services are clinically and financially sustainable	
				Well-led		SO 05: Join up health and care services by working more closely with our partners	X
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	X

Key Recommendations to be considered:

The Trust Board is asked to note the feedback provide by the Committee following consideration of all agenda items.

Quality & Performance Committee Feedback – 30 April 2021

Report to the Board in Public

Item 2: Patient Story	Level of assurance gained: N/A
• The Committee welcomed the new Patient Story initiative, that will help members contextualise their discussions. • The importance of including patients effectively and appropriately in communication between the Trust and GPs was noted in this case.	
Item 3: Quality elements of the integrated performance report	Level of assurance gained: reasonable

• The Committee noted
  ○ an increase in the number of falls recorded, but with a reduced level of harm
  ○ on-going failure to meet the Trust's own standards in respect of the timeliness of responding to complaints (this was discussed further later in the agenda)
  ○ particular risks to patient experience and operational efficiency arising from a number of breakdowns to the lifts near St Helens Ward
  ○ continuing challenges in ensuring that staffing numbers and skill mix are appropriate, particularly in the context of increasing sickness absence rates and the opening of significant numbers of escalation beds
• The impact on many aspects of quality and safety of the operational pressures in the hospital was discussed
  ○ The Trust is already using winter contingency beds, which are not normally deployed until much later in the season
  ○ At any given time, there are approximately two wards-worth of patients whose discharge from hospital care has been delayed by a lack of suitable community capacity
  ○ The Trust is continuing to liaise with system partners to seek a solution to these problems
  ▪ The Committee also heard about the Ambulance Service's contribution to a project seeking to reduce admissions by collaboration with the Urgent Community Services team
• Focus in the Ambulance Division on managing the risks to patient safety, reduced outcomes and poor patient experience arising from long waits for ambulance support was welcomed and commended
  ○ The Committee also welcomed news that a long-standing risk associated with the Ambulance telephony system has been addressed by the installation of new equipment
  ○ It was noted that the Trust is not experiencing the significant ambulance handover delays seen in many other areas, and will be sharing its practice with others to seek to help address the problem in other trusts
• The Mental Health and Learning Disabilities service highlighted transformation projects key to its quality improvement work, including further expansion of the peer support programme
  ○ The appointment of a peer support worker for those using electro-convulsive therapy was commended as a particularly innovative approach	

Item 6.1: Acute Performance Report	Level of assurance gained: reasonable

- The Committee noted the challenges to delivery of a number of access standards, including particularly the ED access standard, arising from the inhibited flow through the Trust and beyond, discussed earlier in the meeting
  - There is a particular focus on those people who have been waiting for treatment for 52 weeks or more
    - Harm reviews are being used to help prioritise care, and there is frequent communication with patients on the waiting list, along with regular support from the community teams in patients' homes to help ensure that those waiting are in the best possible position to receive their treatment as soon as it becomes available – this innovation is a beacon of good practice in the region, and helps inform the harm reviews and additional referrals as appropriate
    - The Trust is alone in the region in having no patients who have waited 104 weeks for treatment
- Anticipated surges in demand for cancer services are being managed, and the Trust is meeting all standards apart from the 62 days to treatment for urgent GP referrals. This position is unlikely to change materially before the end of 21/22
- Diagnostics performance is improving, although still below the required standard. The key reason for failure of the access standard is the endoscopy service, and the Trust has recently secured additional private capacity to help address this

Item 6.2: Ambulance Performance Report	Level of assurance gained: reasonable

- The Committee heard that call handling capacity in the context of very high levels of demand is the key concern in the division, with call abandonment a particular risk
- Use of agency paramedic staff and private ambulance crews continues, but some recent permanent recruitment and ongoing development of existing staff is contributing to long term resolution of staffing issues

Item 6.3: Mental Health & Learning Disabilities Services performance report	Level of assurance gained: reasonable

- The Committee noted concerns about capacity to meet the national expectation that post-discharge follow-up times will reduce from seven days to three, but welcomed ongoing focus on development of plans to achieve this
- Dementia service waiting lists remain long, and pathways are under review to ensure a more efficient, multi-disciplinary approach is taken to help address these long waits
- There is significant transformational work in hand to reduce waiting lists for psychological therapies, and to engage effectively with patients while they wait
- Estates and IT developments underway will bring significant improvements to a range of services, including closer collaboration between Mental Health and Community Services

Item 6.4: Community Services performance report	Level of assurance gained: reasonable

- The Division is working very closely with Acute and Ambulance colleagues to help improve flow through the Trust and beyond, including increased support and technological intervention in care homes

Item 7: Reception facilities	Level of assurance gained: substantial

- The Committee welcomed news that the reception desk at the main hospital will soon benefit from dedicated managerial oversight and rostered staff, in additional to the valued support provided by Trust volunteers.

Item 8: Deep dive into communication complaints	Level of assurance gained: limited

- The committee welcomed the detailed review of the underlying causes of the significant proportion of complaints received which are based on poor communication
- The ongoing significant challenges associated with restrictions on visiting required as a result of the pandemic were acknowledged, and confirmation that the need for those restrictions is under fortnightly review was welcomed
- The Committee noted the various measures introduced in recent weeks and months to help mitigate the impact of operational pressures on clinical teams' ability to communicate effectively with patients and their families, and subsequently to respond appropriately when communication is sub-optimal
- Performance in this area will continue to be monitored in light of coming developments associated with the Trust's participation in the Parliamentary and Health Service Ombudsman's current pilot of improvements

Item 9: Quarter 2 patient experience report	Level of assurance gained: limited

- The Committee noted that the patient experience report for Q2 reflected broadly the operational and other challenges discussed under other items on the agenda
- It was noted that the proportion of complaints and concerns received was relatively small against the volume of activity delivered, but acknowledged that the Trust cannot be complacent about patient experience
- The timeliness of responses remains very much below the required standard, as outlined in other items above

Item 10: National inpatient survey results	Level of assurance gained: reasonable

- The Committee noted the results of the national inpatient survey for 2020/21, specifically that the Trust performed
  - 'About the same' as most trusts in respect of 39 questions
  - 'Worse' than most trusts in respect of one question
  - 'Somewhat worse' than most trusts in respect of five questions
- Although noting that the Trust had not excelled in any area, the Committee was assured to note that each of the areas identified as worse or somewhat worse is already covered by improvement plans associated with the Trust's Quality Account Priorities for 2021/22
- Delivery of the required improvements will be monitored via the Quality Improvement Plan

Item 11: Maternity update	Level of assurance gained: substantial

- The Committee welcomed a comprehensive update on quality and safety performance in all key areas of maternity practice
- The good practice revealed by the update provided was commended
- It was acknowledged that meeting the aspirations of the Continuity of Carer initiative when it re-starts post-pandemic will be a challenge in the context of the island's relatively small service, and that alternative and innovative approaches may be required
- The Committee noted ongoing challenges with midwifery and medical staffing, but received assurance that the associate risks are managed effectively on a day to day basis.
- The Committee thanked the outgoing Interim Chief Nurse for her support to the maternity service during her tenure in the post.

Item 12: Quality Improvement Plan update	Level of assurance gained: reasonable

- The Committee welcomed the revised format with its increased emphasis on metrics, and noted the progress made in the delivery of the Quality Improvement Objectives
- No areas of concern were identified for escalation

Item 14.2: Maternity and Neo-natal Safety Committee feedback	Level of assurance gained: substantial

- As indicated above, performance in all key areas of quality is good
- The sub-committee continues its focus on supporting staff under pressure and recruiting to vacancies, including through a range of innovative approaches
- The work of the local Maternity Voices Partnership had been discussed and was particularly commended

Item 15: Board Assurance Framework	Level of assurance gained: reasonable

- The Committee noted that the BAF as adopted by the Trust Board at its previous meeting reflected the relevant issues and risks of concerns, as discussed at the meeting

Item 15: Board Risk Register	Level of assurance gained: reasonable

- The Committee requested explicit reference to the issue of defective lifts near St Helen's ward in BRR 15, but otherwise commended the Board Risk Register as drafted to the Trust Board.
-

Recommendations to the Trust Board

None on this occasion

3 = Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
2 = Reasonable Assurance	There is a series of controls in place, however there are potential risks that they may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
1 = Limited Assurance	Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.
0 = No Assurance	There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.

Verbal

Item 7.2

UPDATE ON QUALITY & PERFORMANCE SECTION OF THE INTEGRATED PERFORMATANCE REPORT

Agenda Item No	7.3	Meeting	Trust Board held in Public	Meeting Date	11 November 2021
Title	Maternity Q1 Report				
Sponsoring Executive Director	Juliet Pearce, Director of Nursing, Midwifery & AHPs				
Author(s)	Amanda Pearson, Director of Midwifery				
Report previously considered by including date	People & Organisational Development Committee – 30 September 2021 Quality & Performance Committee – 29 October 2021				

Purpose of the Report		Reason for submission to Trust Board in Private only (please indicate below)		Link to CQC Domain		Link to Trust Strategic Objectives 2020-2025	
Trust Board Approval		Commercial Confidentiality		Effective		SO 01: Make our Trust a great place to work and receive care	
Committee Agreement		Patient Confidentiality		Caring		SO 02: Work with our partners and our community to improve services	
Assurance	X	Staff Confidentiality		Safe		SO 03: Deliver high quality compassionate care	
Information Only		Other Exceptional Circumstance		Responsive		SO 04: Make sure our services are clinically and financially sustainable	
				Well-led		SO 05: Join up health and care services by working more closely with our partners	
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	

Key Recommendations to be considered:

The Trust Board is asked to consider the following recommendations:

- Note the contents of the report

Report to the Trust Board				
Title:	Maternity Safety 2021/22 Quarter 1 Report			
Agenda item:				
Sponsor:	Mary Aubrey Chief Nurse			
Author:	Amanda Pearson Director of Midwifery Claire Carbonell Risk Management Midwife			
Date:	30th September 2021			
Purpose	**Assurance or reassurance** ✓	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report constitutes the agreed Maternity Services Safety report to Trust Board in support of the national focus on improving the safety of maternity services. The timeframe period for this report is Quarter 2 2021/2022. This report provides assurance to Trust Board members that the appropriate reporting is in place to provide assurance on the following, **1.** Update on the Dec 2020 Ockenden Report Immediate and Essential Actions **2.** Provider Board Level Measures - Minimum data set **3.** Healthcare Safety Investigation Branch (HSIB) cases, Serious Incidents (SI) and Moderate Incidents. **4.** Perinatal Mortality Report Tool **5.** Avoiding Term Admissions to the Neonatal unit **6.** Safety Champions **7.** Saving Babies Lives **8.** Continuity of Carer **9.** Maternity and Neonatal Staffing Workforce **10.** Early Notification Scheme Reporting **11.** Listening to women and their families			
Response to the issue:	**1. Update Ockenden Report** All data submissions are currently being reviewed by NHSEI, and a report is anticipated to be submitted to Trusts by the end of October. NHSEI have requested a meeting with the executive team to discuss maternity safety and highlight key maternity safety messages. Date to be confirmed. The refreshed national Maternity Self-Assessment Tool has been completed and is submitted as an agenda item **2. Provider Board Level Measures - Minimum Data Set**			

The Provider Board Level Measures Minimum data set for Qtr. 2 can be seen in Appendix 1. The Service has identified areas that will require additional monitoring through the maternity safety structure and includes,

1. The continual review of cases of perinatal mortality which will require a shorter timeframe for recording and reviewing. This will form part of the year 4 NHS R process and the Maternity Governance team is reviewing the process to ensure compliance.
2. Friends and Family or 'Gather' patient experience feedback has been a focus for the Service and there are quality improvements in place to ensure feedback is used to change the service. Once normal services are restored a process of review 'maternity 15 Steps' will be used to ensure there is co-design and co-production. The Maternity Voices Partnership (MVP) continues to work closely with the service to ensure feedback is addressed.
3. The Service has a process the concerns raised by staff and is actioned and monitored by the Maternity & Neonatal Safety Champions. The concerns are highlighted in the bi monthly safety Champions meetings.
4. Badger net digital

3. Over view of Maternity Serious Incident (SI), including Healthcare Safety Investigation Branch (HSIB) cases and Moderate incidents

Regarding Moderate Incidents and Serious Incidents (SI) Appendix 2 identifies all of the maternity and neonatal cases for the reporting period. The Service's SI reports are outlined in Appendix 4 with the link to the full report.

3.1 Healthcare Safety Investigation Branch (HSIB)

There have been no reportable cases to HSIB during quarter 1.

Cases to date	
Total referrals	6
Referrals rejected (excludes duplicates)	3
Total investigations to date	3
Total investigations completed	3
Current active cases	0
Exception reporting to DHSC	Nil

Safety recommendations and findings from previous reports have been reviewed and appropriate actions are put in place to learn from the incident. These action plans are reviewed within the Trust following the PSII process and approved at the Patient safety incident framework (PSIRF). All reports are shared with the family where possible through tripartite meetings which are held between HSIB, the Trust and the family. They are also shared with the Clinical Commissioning Groups (CCGs).

4. Perinatal Mortality Review Tool (PMRT) Reporting

The Service can confirm that all perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards will be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death. For Quarter 1 2021/2022 assurance can be given that,

1. A review using the Perinatal Mortality Review Tool (PMRT) shows that 100% (must be at least 95%) of all deaths of babies, suitable for review using the PMRT, from 1 April until 30 June 2021 have been started.
2. That 100% (must be at least 50%) of all deaths of babies (suitable for review using the PMRT) who were born and died at UHS, including home births, 1 April until 30 June 2021 have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool.
3. That 100% (must be at least 95%) of all deaths of babies who were born and died at UHS from 1 April until 30 June 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought.

5. Avoiding Term Admissions to the Neonatal Unit

The service re4mains with an admission rate <5% for quarter 1, our current action plan remains for review and benchmarking and is monitored through the perinatal meeting

6. Maternity Safety Champions

The Service can confirm that there are in place both Maternity and Neonatal Safety Champions in place including an Executive and Non-Executive lead, who provide oversight of safety with the service. Bi-monthly meetings are well established and are held on a basis although escalations of key concerns can be made outside of the planned meetings. Information is available to all staff on the Trust intranet pages

As part of the remit of this group is to ensure concerns raised by staff are reviewed and highlighted on a regular basis and outcomes shared by YOU said we did on the Maternity Intranet pages as well as locally within the Maternity Newsletters.

7. Saving Babies Lives Care Bundle

The Service can confirm that the Saving Babies Lives (SBL) audits where undertaken and demonstrated the Table 1 below. Any variances to pathways have been agreed with the CCG's and Maternal Networks groups.

Table 1

Element 1 Reducing Smoking in Pregnancy	Target 80% compliance	**B.** Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. **IOW compliance is 100%** **C**. Percentage of women where CO

		measurement at 36 weeks is recorded. **IOW compliance is 80%**
Element 2 Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction	Target 80% compliance	**A**. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. **IOW compliance is 100%**
Element 3 Raising awareness of reduced fetal movement	Target 80% compliance	**IOW compliance is 100%**
Element 4 Effective fetal monitoring during labour	Target 90% compliance	The compliance target of 90% has been removed fortnightly CTG sessions take place with fetal wellbeing leads
Element 5 Reducing preterm birth	Target 85% compliance	**A.** Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. **IOW compliance is 85%.** **B.** Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. **IOW compliance is 90%** **C.** Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). **IOW compliance is 80% Exception reports completed for women who attended in advanced labour and unable to transfer**

8. Update on Continuity of Carer (CoC)

The Service has an action plan to ensure that continuity of carer is the default model of care offered to all women by March 2023. The challenge on the IOW is the population we serve and the small numbers of our BAME women currently 4 within the service. The ongoing action plan for the IOW is to have 3 teams of 8 that cover the geographical locations. This would provide 100% continuity to all women. Recruitment is underway for us to be able to expand the teams.

Table 2 shows the current compliance for Qtr 1.

Qtr 1	Booked onto' % (Total)	Harbour team	Received % (Total)	Received % (BAME women)
April 21	39%	39%		N/A
May	40%	40%		N/A
June	50%	50%		N/A

9. Midwifery and Neonatal Workforce

9.1 Midwifery Workforce

Staffing levels across maternity services have remained challenging during Quarter 1 with the reasons for absence being varied and complex. High activity and acuity levels against persistently high levels of short-term staff sickness, has been forced the Service to temporarily suspend continuity of care teams to ensure that staff are in the unit. We have had a significant high number of maternity leave 5 WTE and this has required a flexible workforce with non-clinical staff working clinically to ensure safety for women and babies

We have supported our partnership Trust with inductions of labour.

Maternity staffing overview can be seen in Appendix 5. Current actions for the maternity workforce include,

1. Recruitment of 5 WTE preceptorship midwives to cover existing vacancies and commence in October with another 5 WTE out to advert as part of the national maternity workforce bid.
2. Further specialist Midwives roles to be supported via Business case as per the Ockenden recommendations

9.2 Neonatal Nursing

The Neonatal unit meets the required British Association of Perinatal Medicine (BAPM) standards. With 5% of nurses Qualified in speciality (QIS)

1. 2 members of staff will commence the Qualified in Specialty (QIS) course in September 2021

10. Early Notification Scheme (ENS) Reporting

The Early Notification Scheme (ENS) is a process in which all maternity incidents of potentially severe brain injury, following labour that had a potentially severe brain injury diagnosed in the first seven days of life are reported within 30 days. From 1 April 2021, Trusts will no longer need to report EN incidents separately to NHSR. Reports should continue to be made to HSIB which will in turn continue to inform NHSR of relevant incidents. The Service is currently reviewing the normal Governance processes to ensure that there is correct identification of cases and these are continued to be reviewed within the Service to identify immediate learning.

11. Listening to Women and their Families

Quarter 1 Trust 'FFT response can be seen in Table 3 below. The total response rate for the Trust remains under the target of 20% however; there improvement actions in place to increase the feedback from women and these actions are being supported by

	the Maternity Voices Partnership (MVP) chair. The feedback responses have reflected the difficult changes made by the Service during COVID there has only been one complaint of a major level within the service which did not highlight any concerns about recommending the Trust. Listening to women and families features in both NHS Resolution and the Ockenden report and the Service can confirm that it has actions and improvements in place to ensure co-design and production with service users. The MVP focus groups have been • Early pregnancy • Postnatal care **Table 3** Current actions for the addressing feedback include, **1.** Availability of food for women out of hours, has been addressed with catering we will be able to provide individual hot meals from the maternity ward **2.** Breastfeeding support increased.
Implications: (Clinical, Organisational, Governance, Legal?)	The national safety focus on all maternity services at all levels continues to drive significant safety improvements. Consequences for not meeting safety recommendations and actions clearly have cultural and leadership implications and less positive impact on outcomes for women and babies. There are well established Governance frameworks within the maternity service, Trust and the LMS however, gaps in systems and processes may lead to significant financial ramifications and reputational implications if patient safety recommendations are not a high focus within the Trust and across the LMS.
Risks: (Top 3) of carrying out the change / or not:	The risk implications for the IOW Trust and Maternity sit within several frameworks including:

Division	Service Area	Ward/ Clinic/ Service	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Acute	Maternity	Antenatal Services	94.74%	0.00%	57	45	9	3	0	0	0
	Maternity	Postnatal Ward	96.30%	0.00%	54	42	10	2	0	0	0
	Maternity	Labour Ward	96.23%	1.89%	53	48	3	1	1	0	0
		Total	95.73%	0.61%	164	135	22	6	1	0	0

	• **Reputational** – Safety concerns ca be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns. • **Financial** – Compliance with Trusts meet all ten NHS Resolution maternity Safety Actions is an expectation for many maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration, and to NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and DHSC for information. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women, families leading to increased poor outcomes and staff wellbeing.
Summary: Conclusion and/or recommendation	The Service can confirm that the information provided in this maternity safety report provides the required information that is required for oversight of the maternity service. The Service feels confident about the successful submission of information for all external assurance. The Service is making impactful improvements with all avenues of maternity safety and will continue to undertake Quality Improvement to continue to improve the service. Further ongoing reports made to Trust Board will be adjusted as information changes but will continue to provide the required level of information to provide assurance on the IOW Maternity Service.

Appendix 1 - Provider Board Level Measures (Quarter 1 2021/2022)

RAG rated using the below method:			
Complete/action resolved/no risk	On track to achieve actions by completion date/low risk	Off track/plan in place/medium risk	Off track/no plan in place/high risk

		2021		
		Apr	**May**	**Jun**
1	Maternity safety support programme?	No	No	No
2a	The number of incidents logged graded as moderate or above	1 X Moderate	1 x Moderate	1 x moderate
2b	Themes of incidents graded moderate & above What actions are being taken?	Delay in administering Anti > 72 hours	1 x PPH and delay in recognition	1 x missed opportunity to treat asymptomatic E Coli
3	Themes from reviews of perinatal deaths *Findings of review of all perinatal deaths using the real time data monitoring tool*	No PMRT reviews completed	No PMRT reviews completed	No PMRT reviews completed
4	Did 100% of perinatal mortality reviews include an external reviewer?	No PMRT reviews completed	No PMRT reviews completed	No PMRT reviews completed.
5a	HSIB referrals made in month	No HSIB referrals this month	No HSIB referrals this month	N/A - no referrals made
5b	HSIB referral criteria met *Findings of review of all cases eligible for referral to HSIB*	N/A - no referrals made	N/A - no referrals made	N/A - no referrals made

6	Audit findings relating to safety/quality	Full review of the maternity services Audit programme has been undertaken as part of the IOW Clinical Effectiveness and Outcomes Meeting. This is inclusive of any themes or trends identified by incidents and national agendas	• Full audit programme in place to support compliance with Saving Babies Lives requirements. • Audits commenced where required to evidence compliance with the Ockenden requirements. • Audits in place to provide compliance with requirements for NHS Resolution.	• Audits completed for compliance with the Ockenden IEAs. Good levels of compliance. • Audits completed to provide compliance with requirements for NHS Resolution including PMRT and ENS/ HSIB. Good levels of compliance actions in place where required.
7a	Safeguarding allegations against providers *Any Section 42 investigations reported to LADO*	No allegations have been received.	No allegations have been received.	No allegations have been received.
7b	Issues affecting wider safeguarding which could affect maternity	Domestic abuse – staff aware of increase of Domestic abuse situations within the pandemic. Training refreshed	No changes within the last month.	No allegations within the last month.

8	Feedback from safety champions & walkabouts	Staffing remains the theme from staff and safety champions walk abouts	Staffing remains a continuous theme, feedback from staff	
9a	Service user voice feedback *Patient experience outliers*	• MVP in place and meetings being held. • MVP are looking currently at perinatal Mental Health and BAME • Requirements for NHS Resolution on plan to meet.	MVP focus groups • Early pregnancy • Postnatal care	MVP patient story
9b	Complaints *Number*	1 concern	2 complaints 3 concerns	2 concerns Communication
9c	Complaints *Themes & key actions*	Communication	Management of 3rd degree tear and onward referral Management of GBS	Complaints
9d	Friends & Family Test *Response rate* *Score – % likely to recommend overall*			Qtr 1 2021 FFT information Total Response Rate = 164 to improve uptake of the survey
10a	External reviews or actions requested from CQC, RCOG, HSIB, HEE, NHSR,	None	The maternity services have undertaken presentation to the CQC in preparation for inspection	The Maternity services were not assessed during the recent inspection
10b	Coroner Reg 28	None	None	None
11a	Workforce- concerns regarding staffing levels or skill mix *Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.*	Workforce concerns regarding skill mix Midwives sickness 5% MSW 9.7% Labour ward coordinator has maintained supernumerary status	**Workforce- concerns regarding staffing levels or skill mix** **Midwives 12%** **MSW 9.2%** **Non patient facing staff due to covid 3%** **LW coordinator has maintained supernumerary status**	**Workforce-** concerns regarding staffing levels or skill mix Midwives' sickness 7% MSW 8% Staffing levels across maternity services have remained challenging for the month of June, the reasons for which are both varied and complex. With high activity and acuity levels against persistently high levels of short term staff sickness,

	BR+ levels recommended/actual Obs cover recommended/actual % shielding % sick % maternity leave Quarterly issues # posts out to recruitment Recruitment success level			LW coordinator has been compromised on occasions and mitigated by the on call service
11b	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (Target 90%)	**PROMPT Maternity Emergency Training:** Obstetric registrars 80% Consultant Obstetricians 80% Consultant Anaesthetists 80% IOW Midwives 80% MSW & Nursery nurses 90% Theatre Staff 78%	**PROMPT Maternity Emergency Training**: Obstetric registrars 90% Consultant Obstetricians 80% Consultant Anaesthetists 80% IOW Midwives 92% MSW & Nursery nurses 90% Theatre Staff 86%	**PROMPT Maternity Emergency Training:** Obstetric registrars 90% Consultant Obstetricians 100% Consultant Anaesthetists 90% IOW Midwives 93% MSW & Nursery nurses 94% Theatre Staff 90%
12	**Progress / challenges in meeting CNST safety actions**			
1: Are you using the PMRT to review perinatal deaths?		Complete	Complete	Complete
2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		Complete	Complete	Complete
3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		Complete	Complete	Complete
4: Can you demonstrate an effective system of medical workforce planning to the required standard?		Complete	Complete	Complete

5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	On track	Birth-rate Plus acuity tool being purchase to support evidencing safe staffing	Complete
6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	On track, audits in progress	• Survey 5 completed and sent to NHSE&I • Audits in place to provide assurance •CCG and Clinical Network aware of any variance	Complete
7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Complete with action plan to monitor	Template for NHS R safety action 7 completed and processes in place	Complete
8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	IOW on track to have actions in place to reach 90% compliance.	IOW on track to have actions in place to reach 90% compliance.	Complete
9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Yes	Yes	Complete
10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	Yes	Yes	Complete
13 Outstanding Ockenden Recommendations Red ockenden actions only	Safety report in place. Available to Trust Board, Safety Champions and LMS for oversight as required. Includes SI reporting. Report to be presented in May 2021	Safety report in place. Available to Trust Board, Safety Champions and LMS for oversight as required. Includes SI reporting. Report to be presented in May 2021	Complete Report to be presented in October 21
14 Significant gaps in NHSI maternity self-assessment tool	Complete	Complete	New template to be distributed by NHSEI

15 Concerns raised in Annual Surveys & progress on actions to address: Staff Maternity		None	Staff survey complete and information has been reviewed. Action plan in place to address key concerns raised.	Staff survey complete and information has been reviewed. Action plan in place to address key concerns raised.
16	**Saving Babies Lives Care Bundles**			
16a	Reducing smoking in pregnancy *RAG rating* *% compliance*	Of all case notes audited, 100% women were asked whether they smoked at booking and 67.5% of women were asked whether they smoked at 36 weeks.	Further auditing in place for 36 weeks	B. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. IOW compliance is 100% C. Percentage of women where CO measurement at 36 weeks is recorded. UHS compliance is 82%
16b	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction *RAG rating* *% compliance*	Of all case notes audited, 100% of women had a risk status for FGR identified and recorded at booking.	Of all case notes audited, 100% of women had a risk status for FGR identified and recorded at booking.	A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. IOW compliance is 100%
16c	Raising awareness of reduced fetal movement *RAG rating* *% compliance*	Of all case notes audited, 95% of women booked for antenatal care had received leaflet/information by 28+0 weeks of pregnancy. Moreover, 100% of women who attended with RFM had a computerised CTG.	Of all case notes audited, 100% of women booked for antenatal care had received leaflet/information by 28+0 weeks of pregnancy. Moreover, 100% of women who attended with RFM had a computerised CTG.	IOW compliance is 100%
16d	Effective fetal monitoring during labour *RAG rating* *% compliance*	As of April 2021, 92% of midwives and 80% of obstetric registrars and 90% of consultants had received training on fetal monitoring in labour (including intermittent auscultation, electronic fetal monitoring, human factors, situational awareness, and have successfully completed mandatory annual competency assessment.	May 88% of midwives, 80% obstetric registrars and 90% of consultants had Completed fetal monitoring training	The compliance target of 90% has been removed, the training forms part of the mandatory training day with a competency assessment tool . Fortnightly sessions take place with fetal monitoring leads for all staff.
16e	Reducing preterm birth *RAG rating* *% compliance*	Of all case notes audited, 45% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids within seven days of birth; 80% of singleton live births (less than 30+0 weeks) received magnesium sulphate within 24 hours prior birth; 100% of women gave birth in an appropriate care setting for gestation.	All audits completed and actions in place to achieve compliance	A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. IOW compliance is 85%. B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. UHS compliance is 90% C. Percentage of women who give birth in an

				appropriate care setting for gestation (in accordance with local ODN guidance). IOW compliance is 80% as we had 2 women who were unable to be transferred due to established labour. Exception reports have beem completed

Appendix 2 – Moderate incidents or above (Quarter 1 2021/2022) (including updates of previously reported incidents)

Date	Type of incident	Summary of incident	Outcome of incident	Key Learning and Recommendations	What actions have been identified?	Action Completion Date
April 21	Moderate clinical	An RhD negative mother delivered a predicted RhD positive baby on 29Apr2021 at 18:14. Samples for blood group antibody screen and Kleihauer test were received in the laboratory later that day at 23:20 along with a request for 500IU anti-D. The issued anti-D was found to be still in the laboratory pharmacy fridge at 12:00 on 04 May2021 which is beyond the 72 hour deadline for administering anti-D post sensitising event.	No harm to the mother as the Kleihauer did not show any fetal cells present. However due to the incident being a near miss incident the grading of the incident remained as moderate. A Hot Debrief/Immediate Safety actions was undertaken with the Lead transfusion Nurse And it was ascertained that there were process issues within Maternity and the Transfusion Lab that could be improved. This case was clustered with another similar incident and the learning and actions were identified. Identified gaps in process.	**Maternity** Improvements with regard to clear communication and documentation (advised the use of SBAR). To check results on E-Carelogic at each contact. Ensure a process for checking Anti D is available. **Transfusion laboratory** Fridge checking & communication with the Ward and Day Assessment Unit (DAU)	**Maternity** • SBAR handover • Clear processes for follow up of results and planning Anti D administration. **Transfusion laboratory** • Daily check of transfusion fridge to identify if blood products have not been collected. • Ward and the Day Assessment Unit (DAU) when Anti D available. Note with staff members name to be added onto TPATH. **Through joint working the Transfusion Lab has agreed to issue Anti D within 1 hour of the request being sent to the lab, this in turn will ensure our women receive Anti D in a timely manner and will not be required to return to the department for its administration.**	June 21

May 21	Moderate clinical	Delay in the recognition of treatment of a Post-partum Haemorrhage (ppH) 2009 mls. Mother taken back to theatre and surgical incision reopened.	The mother required a Bakri Balloon and a further 12 hours stay in a High Dependency area (HDU) but went on to make a full recovery and was discharged two days later. The mother dropped her Hb from 130 – 69 suggestive of excessive blood loss. The mother had a 3 unit blood transfusion. A Hot Debrief/Immediate Safety action was undertaken and this incident was clustered with other ppH incidents that contribute into a service improvement plan.	When abnormal blood loss is identified to ensure the blood loss is weighed (safety Message of the week). Use of SBAR for handover. Expectation that the Registrar will examine the mother. Clear pathways for escalation when workload is unmanageable between Registrar and Consultant. Ensuring support for junior Midwifery staff in emergency situations.	• Expectation to weigh abnormal blood loss • To incorporate SBAR into the handover and for escalation to ensure the urgency of the situation is conveyed. • Ensure processes are in place to support escalation for Obstetric Doctors. The findings to be added to the Mandatory training for ppH.	June 21
June 21	Moderate clinical	Missed opportunity to treat asymptomatic E.coli in pregnancy as per NICE guidance [NICE CG62] mother went on to develop an E.coli bacteraemia in labour and was treated to prevent sepsis. The mother and baby's observations became	Mother and baby required ongoing treatment for the prevention of sepsis in the immediate post-natal period. Mother and baby were discharged home on day 4 following delivery.	Reminder to all staff especially community midwives (CMW) to ensure that they are mindful to check the results on E Carelogic especially if they have requested the test (sent as a Safety Message). Exploration of processes individual and departmental to ensure robust processes for the	• Clear expectation for the checking of results – each CMW is supplied with a laptop for this purpose. • Ensure that midwives are clear as to as to the management of sepsis. Case to feed into Mandatory training.	August 21

		abnormal and the mother required a Category 1 CS under a General anaesthetist	Mother and her partner suffered a degree of psychological trauma from their experience and had a number of questions about their care and whether the untreated E.coli in the urine contributed to the outcome of labour and the E.coli bacteraemia	follow up of test results including DAU processes		
June 21	Moderate clinical	Woman had E.coli detected in her urine at booking through routine testing. Antibiotics were given but repeat screening tests at monthly intervals the results were not checked and the woman did not receive further antibiotics until later on in her pregnancy.	No direct harm came to this mother or her baby. She did not develop pyelonephritis. A Hot Debrief/Immediate Safety action was undertaken with a Microbiologist and Infection prevention Control lead Nurse. Learning clustered with the case above.	Reminder to all staff especially community midwives (CMW) to ensure that they are mindful to check the results on E Carelogic especially if they have requested the test (sent as a Safety Message). Exploration of processes individual and departmental to ensure robust processes for the follow up of test results including DAU processes	• Clear expectation for the checking of results – each CMW is supplied with a laptop for this purpose. • Ensure that midwives are clear as to as to the management of sepsis. Case to feed into Mandatory training	August 21

Appendix 3 – HSIB reported incidents – Summary of incidents reported to HSIB for Q1 2021/22

Date	HSIB criteria	Summary of Incident	Summary of immediate actions learning	Accepted / Rejected
April 21	Therapeutic cooling	Mother transferred via Ambulance from Homebirth with decelerations of the Fetal Heart. On arrival on the LW Fetal Heart Bradycardic. Category 1 CS under GA Cord gases: Arterial pH 6.85 BE -20, Venous pH 7.0 BE -15. Baby required therapeutic cooling in Portsmouth	Expectations for LW staff receiving an Obstetric emergency Review of homebirth equipment Embedding a safe huddle within an emergency situation – to ensure all risk was addressed. Clarity around expectation of auscultating the FH in an emergency transfer. Ensure systems and processes are in place to support junior staff attending a homebirth/obstetric emergency.	Rejected due to MRI, PSII completed and awaiting sign off by CTG
May 21	Therapeutic cooling	Baby bought through to SCBU from maternity by a midwife. Baby was unresponsive possible smothering event. It was believed that the baby had been accidentally smothered under the mother's breast following a breast feed.	• Staff reminded as to the importance of giving women information about positioning of baby. Posters to put up in all rooms incorporating the principles of the postnatal risk Assessment (PRAM).	Rejected due to MRI, PSII completed

Appendix 3 – Maternity Staffing Overview

Period	WTE of Contracted Staff		Changes (Between Snapshot Dates)			Unavailabilities outside of Trust Headroom		Unavailabilities within Trust Headroom		Trust Headroom			COVID - 19	
	Overall Budget	Total WTE	Starters	Leavers	Vacancy = (-) Overspent = (+)	Total in WTE	Total in a %	Total WTE	Total of as a %	Actual Trust Headroom	Difference of Trust Headroom used (-) = Over (+) = Under	Difference of Trust and Non Trust Headroom used (-) = Over (+) = Under	Isolation in WTE	Isolation As a %
July 1st														

Agenda Item No	8.1	**Meeting**	Trust Board held in Public	**Meeting Date**	11 November 2021
Title	Finance & Infrastructure Committee feedback				
Sponsoring Executive Director	Caroline Spicer, Chair of Finance & Infrastructure Committee				
Author(s)	Sarah Anderson, Associate Director of Corporate Affairs				
Report previously considered by including date	Finance & Infrastructure Committee – 28 October 2021				

Purpose of the Report		**Reason for submission to Trust Board in Private only (please indicate below)**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2020-2025**	
Trust Board Approval		Commercial Confidentiality		Effective	X	SO 01: Make our Trust a great place to work and receive care	
Committee Agreement		Patient Confidentiality		Caring		SO 02: Work with our partners and our community to improve services	
Assurance	X	Staff Confidentiality		Safe		SO 03: Deliver high quality compassionate care	
Information Only		Other Exceptional Circumstance		Responsive	X	SO 04: Make sure our services are clinically and financially sustainable	
				Well-led		SO 05: Join up health and care services by working more closely with our partners	
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	X

Key Recommendations to be considered:
The Trust Board is asked to consider the following recommendations: Receive report and recommendations from the Finance and Infrastructure Committee meeting on 28 October 2021 for assurance

Committee Report – Finance and Infrastructure Committee – 28 October 2021

Board in Public

The Finance and Infrastructure Committee held its monthly meeting and covered a number of key issues.

Business cases/Contracts for approval	**Level of Assurance Gained: Not applicable**

• The Committee reviewed and approved business cases for:
  ○ Community Electronic Patient Record (Phase 3)
  ○ Mental Health & Learning Disabilities Electronic Patient Record
  The Committee would like to highlight the interdependencies of these business cases and the digital programme to the Board.
• Furthermore the Committee reviewed and commends to the Board two business cases for approval:
  ○ Trust Datacentre and Cloud
  ○ Outline Business Case for Digital Wave 4 Capital
• The Committee noted that some funding bids to support approved business cases are in progress and, if successful, would reduce the cost of the business case to the Trust (and thus free up funding for further projects).	

Long Term Financial Plan (LTFM) Update	**Level of Assurance Gained: Not applicable**
• The Committee received the updated report from the consultants and noted that the finer detail is still being finalised ready for submission to the November Board meeting. The Committee noted the direction and process and the need to align this financial plan with other key plans that are required such as a detailed workforce plan. • This plan is a key step for the Trust to exit financial special measures and the Committee discussed the levels of risk and adjustments which may be required if these materialised. The co-dependencies on other organisations to provide assurance to enable the Trust to achieve financial balance by the end of 2026/27 were noted. • The programme to be agreed by the Board is challenging and will be factored into a delivery programme and linked to improvement plans and the Island Health and Care Plan. The LTFM will need to be reviewed on a regular basis as issues emerge and change. • The Committee assures the Board on the process and approach adopted for the LTFM to be approved at its November meeting.	
Operating Plan Update H2	**Level of Assurance Gained: Not applicable**
• The Committee noted that the H2 envelope has been published to the ICS and that the Trust (along with other organisations) is working to achieve a fair proportion of the funding. The Committee considered the forecast deficit and noted that the Trust is continuing to work through the gap in funding and identifying the cost improvements, and risk mitigations required along with confirming assumptions made on activity, income etc.	

- The Committee noted that the detail in the H2 plan is still being refined and needs to be submitted in the week following Board with a more detailed plan to support this submission later in November.
- The Committee is able to assure the Board on the processes and approach used and noted the challenges to plan for an organisational deficit within the financial envelope currently available to the ICS.

Integrated Performance Report	**Level of Assurance Gained: Not applicable**

- The Integrated Performance Report was taken as read and its contents noted.

Sub-Committee Reports	**Level of Assurance Gained: Reasonable**

- **Investing in our Future (£48m):** The Committee noted the progress being made in each of the workstreams. Work on the outline business case (OBC) for Estates is ongoing and will come to the Committee in November prior to submission in December. The Committee agreed to request that Board delegate approval of the OBC to Chair, Chief Executive and Director of Finance and Estates.
- **Capital Investment Group:** The Committee noted the work of the Group and requested some further assurance that the capital allocation of the Trust will be spent in year as there is a current underspend and a significant proportion is allocated to Q3 and Q4.
- **Estates & Facilities Group:** The Committee noted the overview of activity and associated performance of the Group.
- **Strategic Finance Group/Financial Recovery Board:** The Committee agreed the change of purpose for the Financial Recovery Board and its renaming to the Strategic Finance Group and that the Group would be established from November 2021. The Committee requested the Terms of Reference to approve. In addition, the Committee wondered if the level of oversight of the LTFM and Improvement Plan along with the holistic approach needed would be at the correct level if left to this Group alone.

As outlined above the Committee requests that the Board delegates approval of the Estates Outline Business Case to the Chair, Chief Executive and Director of Finance and Estates prior to submission by mid-December.

3 = Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
2 = Reasonable Assurance	There is a series of controls in place, however there are potential risks that they may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
1 = Limited Assurance	Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.
0 = No Assurance	There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.

Verbal

Item 8.2

UPDATE ON FINANCE SECTION OF THE INTEGRATED PERFORMANCE REPORT

Verbal

Item 9.1

UPDATE ON PEOPLE SECTION OF THE INTEGRATED PERFORMANCE REPORT

Agenda Item No	10.1	**Meeting**	Trust Board held in Public	**Meeting Date**	11 November 2021
Title	Digital Transformation Committee Feedback				
Sponsoring Executive Director	Kemi Adenubi, Chair of Digital Transformation Committee				
Author(s)	Sarah Anderson, Associate Director of Corporate Affairs				
Report previously considered by including date	Digital Transformation Committee 27 October 2021				

Purpose of the Report		**Reason for submission to Trust Board in Private only (please indicate below)**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2020-2025**	
Trust Board Approval		Commercial Confidentiality		Effective	X	SO 01: Make our Trust a great place to work and receive care	
Committee Agreement		Patient Confidentiality		Caring		SO 02: Work with our partners and our community to improve services	
Assurance	X	Staff Confidentiality		Safe		SO 03: Deliver high quality compassionate care	
Information Only		Other Exceptional Circumstance		Responsive	X	SO 04: Make sure our services are clinically and financially sustainable	
				Well-led		SO 05: Join up health and care services by working more closely with our partners	
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	X

Key Recommendations to be considered:

The Trust Board is asked to consider the following recommendations:

- Receive report and recommendations from the Digital Transformation Committee

Committee Report – Digital Transformation Committee – 27 October 2021

Board in Public

The Digital Transformation Committee held its monthly meeting and covered a number of key issues.

Clinical Systems Strategy Update	**Level of Assurance Gained: Not applicable**
• No update on the Clinical Systems Strategy was made to the Committee as further work is dependent on the outcomes of Mental Health & Learning Disabilities Electronic Patient Record (EPR) and Community Electronic Patient Record (EPR) business cases.	
Horizon Scanning – Funding Opportunities	**Level of Assurance Gained: Not applicable**
• The Committee noted that a number of funding opportunities are being pursued as sources of funding are identified and become available. In the past the Trust has been successful in securing funding and is optimistic that this will continue. In the past 3 weeks the Trust has bid for close to £4m additional funding for Digital schemes.	
Business Case Review	**Level of Assurance Gained: Not applicable**
• The Committee reviewed and commended the Community Electronic Patient Record, Mental Health & Learning Disabilities Electronic Patient Record, Trust Datacentre and Cloud and Outline Business Case for Digital Wave 4 Capital to the Finance and Infrastructure Committee. • The Committee also received an update on the Centralised management of clinical letters and patient information leaflets business case.	
Project Update - Strategic Projects and other projects by exception	**Level of Assurance Gained: Reasonable**
• The Committee received a summary status report of the key strategic programmes and projects. The Committee noted that these are now being managed by the Digital Transformation Programme Board and in future key items only will be escalated to this Committee along with assurance.	
Board Assurance Framework (BAF) Q2	**Level of Assurance Gained: Not applicable**
• The Committee received the Board Assurance Framework and noted the need to reflect this into the Committee's work programme along with targeting its work to provide assurance from the Committee into the Board Assurance Framework. • The Committee highlighted the need to reflect the resource implications of digital demands into the BAF on recruitment and retention and also noted the need to address system processes and challenges into the system objectives BAF.	
Sub-Committee Feedback	**Level of Assurance Gained: Limited**
• **Digital Clinical Senate Feedback:** . The Committee noted the working with partners and how this is recognised in the digital programme. • **Data Governance Group Feedback:** The Committee noted the ongoing challenges relating to freedom of information requests and that the team is working towards a digital solution and process. • **Digital Transformation Programme Board Feedback:** The Committee noted the programmes in place and the progress being made in managing these in accordance with the Governance arrangements agreed at the last DTC.	

3 = Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
2 = Reasonable Assurance	There is a series of controls in place, however there are potential risks that they may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
1 = Limited Assurance	Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.
0 = No Assurance	There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.

	11.1	**Meeting**	Trust Board held in Public	**Meeting Date**	11 November 2021
Title	Audit Committee Feedback				
Sponsoring Executive Director	Phil Berrington, Chair of Audit Committee				
Author(s)	Sarah Anderson, Associate Director of Corporate Affairs				
Report previously considered by including date	Audit Committee 3 November 2021				

Purpose of the Report		**Reason for submission to Trust Board in Private only (please indicate below)**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2020-2025**	
Trust Board Approval		Commercial Confidentiality		Effective	X	SO 01: Make our Trust a great place to work and receive care	X
Committee Agreement		Patient Confidentiality		Caring	X	SO 02: Work with our partners and our community to improve services	X
Assurance	X	Staff Confidentiality		Safe	X	SO 03: Deliver high quality compassionate care	X
Information Only		Other Exceptional Circumstance		Responsive	X	SO 04: Make sure our services are clinically and financially sustainable	X
				Well-led	X	SO 05: Join up health and care services by working more closely with our partners	X
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	X

Key Recommendations to be considered:

The Trust Board is asked to consider the following recommendations:

- Receive report from the Audit Committee

Audit Committee Feedback – 3 November 2021 Report to the Board in Public

The Committee held its regular scheduled meeting on 3 November 2021.

Review of Losses and Special Payments	Level of assurance gained: Reasonable
• The Audit Committee reviewed and approved executive recommendations for losses and compensation payments.	
Review Single Tender Waivers to Standing Financial Instructions	Level of assurance gained: Limited
• The Audit Committee reviewed the procurement related Single Tender Waivers raised and noted the exposure of the Trust to unnecessary financial risk and risk of continuity of supply of services. • The Audit Committee noted the actions being taken to reduce the number of retrospective waivers raised, and that progress has been slow but is being made. This remains the subject of focus of ongoing review by the Finance and Infrastructure Committee.	
Board Assurance Framework	Level of assurance gained: Reasonable
• The Audit Committee reviewed the Board Assurance Framework that has been passed to it following adoption by the Board in its October meeting. It was presented to the Audit Committee for comments which will be included in the Q3 update. • The Audit Committee queried whether the strategic objectives should be reviewed due to change in systems around the long term plan and ICS/ICP and other partneship working which have evolved since the Trust Strategy was agreed. Furthermore a conversation was held on the need to be open and transparent on risk and how this is managed.	
Summary Internal Controls Assurance (SICA) Report	Level of assurance gained: Reasonable

• The Audit Committee noted that the results of TIAA's survey of clients to ascertain how organisations are planning to deliver some of their functions going forward generally found that remotely held Audit Committees meetings has been positive with no change in or increased attendance, efficiency and engagement at meetings. The Audit Committee noted that its meetings are likely to continue as virtual meetings.
• The Audit Committee noted the progress on delivering reviews contained within the 2021/22 Internal Audit Plan and the adjustments made to the Plan.
• Three Internal Audit Review reports were brought to the Audit Committee, two of which are substantial assurance and one a reasonable assurance rating:
  ○ Data Quality – Cancer Standards – Substantial Assurance
  ○ Duty of Candour – Substantial Assurance
  ○ Staff Welfare – Reasonable Assurance
• The Audit Committee has referred the reports to the assurance committee relevant to the subject matter for information and follow through on recommendations.	

• The Audit Committee noted that the briefings received from TIAA are followed through and responded to as appropriate. • Overall indicative Head of Internal Audit Opinion remains at Limited Assurance given the ratings obtained on three reviews performed earlier in the year.	
Internal Audit Recommendation Tracker	Level of assurance gained: Reasonable
• The Audit Committee noted the current status of the outstanding recommendations and noted the positive progress being made with their implementation. • The Audit Committee queried that some of the timeframes to implement actions appeared to have been extended to avoid failure to deliver on the actions but was assured by the other assurance committee chairs that traction is maintained and dates have been amended for appropriate reasons.	
External Audit	Level of assurance gained: Not Applicable
• The Audit Committee did not receive an update from the external auditors as there was nothing to report.	
Counter Fraud Progress Report	Level of assurance gained: Limited
• The Audit Committee received the Progress Report which summarises the counter fraud work since the start of the financial year. A request was made by the Audit Committee to TIAA to align the process of engagement with the Trust between Counter Fraud and Internal Audit. • The Audit Committee noted the upcoming Counter Fraud Awareness Week and that TIAA are working with the Trust on a Communications Plan to promote fraud awareness across the organisation.	

Furthermore, the Committee noted the split of responsibilities on Single Tender Waivers between Finance & Infrastructure Committee and the Audit Committee, and reporting on Internal Audit actions in People & Organisational Development Committee to provide assurance to the Audit Committee.

3 = Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
2 = Reasonable Assurance	There is a series of controls in place; however there are potential risks that they may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
1 = Limited Assurance	Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.
0 = No Assurance	There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.

Agenda Item No	11.2	Meeting	Trust Board held in Public	Meeting Date	11th November 2021
Title	Review of Board Risk Register				
Sponsoring Executive Director	Lois Howell, Director of Governance and Risk				
Author(s)	Daniel Robinson, Corporate Governance and Risk Manager				
Report previously considered by including date	Quality and Performance Committee (2nd November 2021)				

Purpose of the Report		Reason for submission to Trust Board in Private only (please indicate below)		Link to CQC Domain		Link to Trust Strategic Objectives 2020-2025	
Trust Board Approval	X	Commercial Confidentiality		Effective	x	SO 01: Make our Trust a great place to work and receive care	x
Committee Agreement		Patient Confidentiality		Caring		SO 02: Work with our partners and our community to improve services	x
Assurance	X	Staff Confidentiality		Safe		SO 03: Deliver high quality compassionate care	
Information Only		Other Exceptional Circumstance		Responsive	x	SO 04: Make sure our services are clinically and financially sustainable	
				Well-led	x	SO 05: Join up health and care services by working more closely with our partners	x
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	

Key Recommendations to be considered:

The Trust Board is asked to consider the following recommendations:

- Adopt the draft Board Risk Register, with or without changes

Executive Summary:

The Board Risk Register is comprised of the most significant of the divisional level operational risks and those risks which affect the organisation as a whole, rather than individual services, care groups or divisions – such risks will require management at an organisational level.

This report is accurate as of **2nd November 2021** following feedback from Quality and Performance Committee. There are currently **15** Operational risks included in this document for the Board's consideration and oversight.

All risk owners review and update their risks regularly to maintain effective oversight and control. The risk escalation process has been implemented and adopted to seek engagement and resolution of any overdue risks to ensure a timely response.

Update:

Appendix A – Full Board Risk Register Summary - *Outlines each of the risk's trends month on month*
Appendix B – Summary of Risks – *Provides detail of all Board Risks including a link to the corporate risks (those risk that score 15 or more) across the organisation*
Appendix C – Summary of Corporate Risks – *Risks that score 15 or more and are managed at Divisional level.*

Since the last report to the Board in July there have been several changes made to improve risk reporting across the organisation. Appendix C has been introduced in line with the Risk Management Policy to provide oversight of Corporate risks that score 15 or more and are managed at Divisional level. These risks are also used to inform the Board Risk Register report through themes and associated risks.

There has been one new addition to the Board Risk Register: **BRR-15** (Risk of harm to staff, patients and/or visitors to Trust premises as a result of a backlog of routine maintenance) has been included following a Trust-commissioned external assessment of maintenance issues. A Service Improvement Plan (SIP) has been developed to address issues raised in the report. Further to the Quality & Performance Committee's consideration of the draft BRR, an associated risk (1901) has also been allocated to BRR-15, relating specifically to the defective lifts near St Helen's ward.

Other key movements include:

- **BRR-04** (Risk of impaired patient outcomes and harm arising from reduced flow through the hospital and beyond) has **increased** its score to highlight the reduction in capacity of community services which is preventing the timely discharge of in-patients.
- **BRR-14** (Risk of patient and staff harm arising from nosocomial infection (Covid) and flu) has **increased** its score to reflect the **increased** focus and delivery of the flu and booster covid jab roll out.

- **BRR-12** (Risk of patient harm / impaired outcomes arising from communication failures within and beyond the Trust) has **increased** its score as friends / families continue to experience frustration as a result of the on-going restrictions on access to the hospital.
- Risk **1755** (Impact of EU Exit Transition on Trust Business as usual activity) has been **closed** as the transition period has ended and the impact on the Trust has been minimal. There are Business continuity Plans in place across the Trust which should help mitigate any residual effects.

The Trust has identified a range of operational risks whose impact could have a direct bearing on national NHS requirements and constitutional targets, CQC registration, operational delivery, the health safety and wellbeing of individuals and the Trust's reputation with its regulators and stakeholders.

All risks, including these material risks, are currently subject to monthly review by the risk owner, and are discussed at regular governance meetings with the Associate Director of Corporate Affairs. All risks are reported through their respective divisions on a monthly basis to consider current and potential operational risks and supported where necessary by the Corporate Governance Team. Overdue risks are escalated directly to the Executive Lead during the governance meeting.

Significant work has been undertaken in recent months to revamp the risk module on Datix and update reporting templates in an effort to develop greater consistency of scoring across the organisation, and while further work is still required, there are early signs that this workflow has yielded improved clarity of risk management and that risks are now accurately reflected and monitored within their divisional areas.

Risks are scored using the following grid – full details and guidance are set out in the Risk Management Policy:

		Impact Score				
		1	2	3	4	5
Likelihood Score	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Risk Score		Monitoring Period
1 – 3	Very Low	6 monthly
4 – 6	Low	6 monthly
8 – 12	Moderate	3 monthly
15 – 16	High	Monthly
20 - 25	Very High	Mitigated within 2 weeks to practicable score (within reason)

Appendix A:

Full Board Risk Register Summary and Trend

ID	Title	Lead	Jul-21 Review (9)	Aug-21 Review (10)	Sep-21 Review (10)	Oct-21 Review (12)	Trend	Target/ by	
BRR-01	Risk of reduced outcomes/ mismanagement of patient care from pressure on urgent care pathway services are outstripping demand in Primary Care	COO	20	20	20	20	⇔	8	31/08/2022
BRR-02	Risk of patient harm arising from inaccessibility of clinical systems	DFEDCE	20	20	20	20	⇔	4	31/03/2022
BRR-05	Risk of patient harm caused by a long delay to treatment as a result of activity suspension in Phases 1 and 2 of Covid response.	COO	20	20	20	20	⇔	8	31/03/2022
BRR-04	Risk of impaired patient outcomes and harm arising from reduced flow through the hospital and beyond.	JS			12	20	↑	5	31/12/2022
BRR-03	Risk of interruption to service delivery and mismanagement of patient care.	MD	12	12	16	16	⇔	8	31/03/2022
BRR-15	Risk of harm to staff, patients and/or visitors to Trust premises as a result of a backlog of routine maintenance	DFEDCE				12	**NEW**	8	31/03/2022
BRR-07	Risk of compromise of the Trust's financial position in relation to Covid phases	DFEDCE	12	12	12	12	⇔	9	31/03/2022
BRR-06	Risk of regulatory action arising from failure to deliver against Constitutional Access Standards as a result of the suspension	COO	12	12	12	12	⇔	8	31/03/2022
BRR-08	Risk of patient harm and poor patient outcomes as a result of high levels of Covid related staff absences.	COO	12	12	12	12	⇔	6	30/12/2021
BRR-09	Risk of patient harm / poor outcomes arising from winter/Covid operational pressures and need to maintain strict IPC practices.	CN	12	12	12	12	⇔	8	31/10/2022
BRR-12	Risk of patient harm / impaired outcomes arising from communication failures within and beyond the Trust	DGR	6	6	6	12	↑	6	31/12/2021
BRR-10	Risk of Patient harm/ poor outcomes arising from failure to deliver against best practice/ regulatory requirements.	DGR	8	8	8	8	⇔	8	31/03/2022
BRR-11	Risk of harm to staff health and well-being as a result of the prolonged operational pressures and/or displacement	DP&OD	8	8	8	8	⇔	8	30/09/2021
BRR-14	Risk of patient and staff harm arising from nosocomial infection (Covid) and flu.	CN	4	4	4	8	↑	4	30/12/2022
BRR-13	Risk of patient harm/poor outcomes arising from high vacancy rates in some specialties / staff groups.	DP&OD	6	6	6	6	⇔	6	31/12/2021

Appendix B: Summary of Board Risks:

ID	Risk Score (Inherent)	Title	Division / Care Group	Executive Lead	Risk Score (Current) Impact x Likelihood	Latest Update	Risk Score (Target)	Anticipated Target/ Completion date
BRR-01	**16 (4x4)**	Risk of reduced outcomes/ mismanagement of patient care from pressure arising from unmet primary care need.	Acute	Joe Smyth - Chief Operating Officer	**20 (5x4)**	15.10.21 This risk is no longer the principal challenge to urgent care services. Demand and attendances in ED have settled to manageable levels. It is proposed that this risk is closed and replaced by BRR-04.	**8 (4x2)**	31-Aug-22
BRR-02	**20 (5x4)**	Risk of patient harm arising from inaccessibility of clinical systems	IM&T	Darren Cattel - Director of Finance, Estates, IM&T	**20 (5x4)**	15.10.21: The age and condition of the trust's single data network system means that it is vulnerable to failure. This would lead to lack of access to certain key clinical systems, compromising the timeliness, accuracy and effectiveness of patient care. The position is compounded by supply chain problems in respect of consumables and other critical components arising from departure from the EU and COVID. Associated risks: (IM&T) 1111 - Failure in the Trust's single data centre (no access to critical patient data) lack of resilience and aging equip (5x4=20) (IM&T) 1750 - Obsolete and Outdated Network Infrastructure (5x3=15) (IM&T) 1729 - Fire and Access Control Risk in Network Distributions Rooms (5x3=15) (IM&T) 1902 - Supply Side Issues Leading to long Delays in IT Procurement (4x4=16)	**4 (4x1)**	31-Mar-22

ID	Risk Score (Inherent)	Title	Division / Care Group	Executive Lead	Risk Score (Current) Impact x Likelihood	Latest Update	Risk Score (Target)	Anticipated Target/ Completion date
BRR-05	**20 (5x4)**	Risk of patient harm caused by a long delay to treatment as a result of activity suspension in Phases 1 and 2 of Covid response.	Planned Care Group	Joe Smyth - Chief Operating Officer	**20 (5x4)**	15.10.21: Performance against agreed recovery plan is on track. The trust is not facing some of the set backs being experienced by other organisations in the region. However patients are still facing long waits for treatment which causes poor patient experience and in some cases reduced outcomes. The trust comtinues to prioritise waiting lists according to clinical need to reduce the impact of long waits wherever possible. Elective Recovery remains on plan, capacity secured through insourcing with 18w and Medefer - Extended to reflect H2 Plan Ongoing review to reflect subsequent waves of Covid and the increasing numbers of patients waiting for treatment whilst the urgent cases were addressed in the pandemic.	**8 (4x2)**	31-Mar-22
BRR-04	**16 (4x4)**	Risk of impaired patient outcomes and harm arising from reduced flow through the hospital and beyond.	Planned Care Group	Joe Smyth - Chief Operating Officer	**20 (4x5)**	15.10.21 The continuing reduction in capacity in community services is preventing the timely discharge of in-patients. The Trust had approximately two-wards' worth of beds occupied by patients who no longer require acute in-patient care. This creates a risk of harm / deconditioning for those patients, and inhibits the timely treatment and admission of other patients, compromising their experience and outcomes, and leading to breach of patients' rights under the NHS Constitution	**8 (4x2)**	31-Dec-22

ID	Risk Score (Inherent)	Title	Division / Care Group	Executive Lead	Risk Score (Current) Impact x Likelihood	Latest Update	Risk Score (Target)	Anticipated Target/ Completion date
BRR-03	**20 (4x5)**	Risk of interuption to service delivery and mis-management of patient care.	Planned Care Group	Steve Parker - Medical Director	**16 (4x4)**	Changed title, amended current score, response to risk and target score. Consultant and Specialty Doctor vacancy due to retirement and leaver. Agency Consultant locum in place until Sept 2022 and Associate Specialist appointed from overseas who requires a longer period of shadowing and support who commenced in Aug 2021. A further Locum Consultant request for a two month period has gone to agency to help support the service in this stage of reduced capacity as there is also annual leave to cover and a increased build up of overdue follow ups Associated risks: (ACUTE) 1666 - Inability to deliver a sustainable urology service due to consultant cover availability/ ability to recruit - Urology Fragile service. (4X4=16) (ACUTE) 1852 - No Dedicated Cancer/Haematological Ward Base for Cancer and Haematological Patients (3x5=15) (ACUTE) 661 - Oncology Service Contract between providers of specialist commissioning and tertiary centres for IOW Patients (4x4=16) (ACUTE) 1609 - Lack of Ophthalmology trained nurses to effectively manage & deliver safe service (4x4=16) (ACUTE) 1730 - Consultant Radiologist Recruitment Issues (4x5=20)	**8 (4x2)**	31-Mar-22
BRR-15	**25(5x5)**	Risk of harm to staff, patients and/or visitors to Trust premises as a result of a backlog of routine maintenance	Finance, Estates and IM&T Division	Darren Cattel - Director of Finance, Estates, IM&T	**12(4x3)**	A review of the Estates operational management system has revealed that oversight of routine maintenance is not as effective as had been believed. A backlog has been identified in a number of areas, but the full extent of the overdue work is not yet known. A plan to address the known overdue items has been developed and implementation commenced. The plan will be extended as required to include other items as they are identified. Included in this plan are the defective lifts near St Helen's ward. Once the full scale of the problem is understood, the risk rating is likely to change – the likelihood rating is currently at three to reflect current uncertainties. Associated risks: (Estates) 1901 - Operational Estate Service - Performance (4x4=16)	**12(4x3)**	31-Mar-22

ID	Risk Score (Inherent)	Title	Division / Care Group	Executive Lead	Risk Score (Current) Impact x Likelihood	Latest Update	Risk Score (Target)	Anticipated Target/ Completion date
BRR-07	**16 (4x4)**	Risk of compromise of the Trust's financial position in relation to Covid phases	Finance, Estates and IM&T Division	Darren Cattel - Director of Finance, Estates, IM&T	**12 (4x3)**	15.10.21: The position with regard to further waves of COVID is still unknown. The H2 planning guidance has only just been issued and its impact on the Trust is not yet clear. In the light of these two relatively unknown elements it is proposed that the risk rating remains static for this quarter. Movement is expected in the next reporting phase. Associated risks: MHLD (1855) - Risk - Financial position 21/22 - Risk to patient safety, experience, clinical effectiveness, and staff morale	**8 (4x2)**	31-Mar-22
BRR-06	**20 (5x4)**	Risk of regulatory action arising from failure to deliver against Constitutional Access Standards as a result of the suspension of services during the pandemic	Planned Care Group	Joe Smyth - Chief Operating Officer	**12 (4x3)**	The risk of regulatory action is now extremely low, given the national picture. It is proposed that this risk is closed, and focus centred on the impact for individual patients of long waits during the recovery period.	**8 (4x2)**	31-Mar-22
BRR-08	**12 (3x4)**	Risk of patient harm and poor patient outcomes as a result of high levels of Covid related staff absences.	Planned Care Group	Joe Smyth - Chief Operating Officer	**12 (3x4)**	Staffing and skill-mix are reviewed on a shift by shaft basis to ensure staff are allocated appropriately to clinical areas where there are known gaps. Covid staff absence reports are provided regularly to the operational teams There is good vaccine take up amongst staff in the Trust, but the prevailing rate in the local community is the third highest in the country. Although there is no current evidence of harm to patients or outcomes arising from COVID related staff absence, sickness / isolation absence could increase quickly at any point. For this reason, it is proposed that this risk remains at 12 for the coming quarter.	**6 (3x2)**	30-Dec-21

ID	Risk Score (Inherent)	Title	Division / Care Group	Executive Lead	Risk Score (Current) Impact x Likelihood	Latest Update	Risk Score (Target)	Anticipated Target/ Completion date
BRR-09	**16 (4x4)**	Risk of patient harm / poor outcomes arising from winter/Covid operational pressures and need to maintain strict IPC practices.	Corporate Nursing Division	Mary Aubrey - Chief Nurse	**12 (4x3)**	The number of COVID positive in-patients is currently reducing, but remains a challenge to flow through the hospital, particularly coupled with the wider flow issues set out at BRR-04. Infection rates in the wider community are currently the third highest in the UK, but the predominant age group affected is younger than in previous waves, and admissions remain relatively low by comparison with the prevailing community rate. COVID positive occupancy rates in the ICU remain high, and a challenge to meeting thew needs of other patients who require Critical Care. The risk is being managed by careful prioritisation of care / beds on the basis of need / acuity, and the potential for cancellation of some elements of non-urgent activity remains an option, although only used in exceptional circumstances. All existing COVID-19 healthcare guidance restrictions remain in place with particular focus on visiting restrictions, wearing of face coverings and social distancing. Associated risks: (CORPNURSE) 1766 - Patient flow impact on appropriate placement of patients with Infection Prevention and Control risk (3x5=15)	**8 (4x2)**	31-Oct-22
BRR-12	**20(5x4)**	Risk of patient harm / impaired outcomes arising from communication failures within and beyond the Trust	Quality Governance Division	Lois Howell - Director of Risk and Governance	**12(3x4)**	Patients and their friends / families continue to experience frustration as a result of the on-going restrictions on access to the hospital. The Trust seeks to mitigate these by the implementation of new processes to ensure better communication, but operational pressures in the Trust mean that those are not consistently effective.The Trust is reviewing the ongoing need for access restrictions on a fortnightly basis and will vary / lift them as soon as it is safe to do so. In the meantime, leaders and staff are reminded on a regular basis of the impact that poor communication is having on patients, and other options to address the problems are sought.	**6(3x2)**	31-Dec-21

ID	Risk Score (Inherent)	Title	Division / Care Group	Executive Lead	Risk Score (Current) Impact x Likelihood	Latest Update	Risk Score (Target)	Anticipated Target/ Completion date
BRR-10	**16 (4x4)**	Risk of Patient harm/ poor outcomes arising from failure to deliver against best practice/ regulatory requirements.	Quality Governance Division	Lois Howell - Director of Risk and Governance	**8 (4x2)**	The CQC has found the Trust to be 'Good' overall and 'good' in the majority of services. Three must-do requirements were issued with the latest inspection report (September 2021), but these are matters of narrow focus, and action to address them has commenced. Given the scale and extent of improvements identified, it is proposed that this risk is closed.	**8 (4x2)**	31-Mar-22
BRR-11	**12 (3x4)**	Risk of harm to staff health and well-being as a result of the prolonged operational pressures and/or displacement	Human Resources and Organisational Development Division	Julie Pennycook - Director of People & Organisational Development	**8 (4x2)**	Risk is Mitigated by: - Our established Health & Wellbeing Programmes are in place to provide support and guidance to our people. These include; H&W Champions Network, Equality Networks, Wellbeing focused monthly Thrive newsletter, TeamCARE development sessions, MHFA, TRIM, OH Support, Coaching through the leadership academy and listening ear service and the staff recognition programmes. - Regionally, our people have access to the HIOW ICS Enhanced HWB Service - Resilience Based Supervision is being delivered by the education team to clinical colleagues - In order to provide dedicated support in relation to "burnout" we are delivering "Wellbeing Essentials" in Q3 which is a dedicated programme of H&W virtual events focused on improving mental and physical health. - We continue to encourage the completion of the Appraisal/H&W Conversation as this provides a supportive space for staff to engage their line management, its an opportunity to promote the importance of taking annual leave and breaks, and in signposting to support services.	**8 (4x2)**	01-Apr-22
BRR-14	**20 (5x4)**	Risk of patient and staff harm arising from nosocomial infection (Covid) and flu.	Planned Care Group	Mary Aubrey - Chief Nurse	**8 (4x2)**	All identified COVID infections are reviewed by the microbiologist and Head of Infection Prevention and Control to assess whether it is likely that the patient has been admitted with the infection or acquired it in hospital. There have been no cases of hospital acquired COVID infection in the current wave. Staff infection rates remain proportionate with community infection rates, and there is no evidence that staff are being infected in the workplace. The Trust continues to apply all relevant national guidance.	**4 (4x1)**	30-Dec-21

ID	Risk Score (Inherent)	Title	Division / Care Group	Executive Lead	Risk Score (Current) Impact x Likelihood	Latest Update	Risk Score (Target)	Anticipated Target/ Completion date
BRR-13	**9 (3x3)**	Risk of patient harm/poor outcomes arising from high vacancy rates in some specialties / staff groups.	Human Resources and Organisational Development Division	Julie Pennycook - Director of People & Organisational Development	**6 (3x2)**	Risk is Mitigated By: - Monitoring of safe staffing continues on a daily basis, this enables responsive mitigation of staffing gaps. - Recruitment through "Indeed" campaign commences in October with a view to attract 50 HCSWs (of this, 10 shall be apprenticeships) - 5 Registered Mental Health Nurses (RMHN) recruited with plan to deploy in December 21. - International Deployment is ongoing with current trajectory indicating that the Trust is on target to meet its plan of deploying 111 nurses by the end of December 2021. - Employment of 16 Doctors (10 international & 6 UK) to be onboarded between Sept-Dec. - We are engaged in the HCSW programme to increase healthcare support worker recruitment. We have successfully recruited to 50 FTE pots, leaving a variance of 38FTE. - Of these 38FTE, 24 vacancies shall be utilised to create opportunities that enable us to "grow our own": 10 HCSW roles within Acute & MHLD, 10 AHP apprenticeship training positions and 4 FTE hours to be offered to UCAS Nursing & AHP Students. Associated risks: MHLD (1616) - Risk - Lack of Medical Cover across MHLD - patient safety, experience, clinical effectiveness, staff morale and financial risk (ACUTE) 1431 - Gastroenterology capacity impacting service delivery (4x4=16)	**6 (3x2)**	01-Apr-22

Appendix C:

Summary of Corporate Risk Register

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1897	Ambulance Care Group	Pre-hospital enhanced care teams are not available on the island 24/7	Cause: access to enhanced care teams in the pre-hospital setting for the management of major trauma and critically ill patients is limited to where there is availability of an air ambulance. This risk was identified through peer review by the Wessex Trauma Network. Consequence: 1) patients cannot access care at the major trauma centre (Southampton) within the required timescales. 2) Risk to patient care and clinical outcomes for major trauma and serious medical cases on the Isle of Wight 3) Inequalities in access to healthcare. 4) Secondary transfers required. 5) reputational damage.	20/08/2021	5x3=15	5x1=5	[Taylor, Kathryn 23/08/21 13:34:28] 23.08.2021 Risk review meeting, approved for entry to the risk register. KT
1766	Corporate Nursing Division	Patient flow impact on appropriate placement of patients with Infection Prevention and Control risk	1) Failure to recognise and act upon existing known or newly identified Infection Prevention and Control risk 2) Inability to appropriately place patient with Infection Prevention and Control risk, lack of side room availability. 3) Increased number of patients identified as requiring isolation due to Infection Prevention and Control issues 4) Impact of COVID-19 presentations to hospital requiring admission in absence of dedicated isolation ward.	10/11/2020	3x5=15	3x3=9	[Robinson, Karen 24/06/21 15:57:50] 24/06/2021 Potential impact of patient presentation with COVID-19 in absence of dedicated isolation ward added as risk/issue 4. KR Head of Infection Prevention and Control [Robinson, Karen 06/10/21 10:39:20] 06/10/2021 Challenges ongoing in regard to patient flow impact on appropriate placement of patients with Infection Prevention and Control risk further exacerbated by COVID-19 and expected Winter surge pressures. KR Head of Infection Prevention and Control.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
			Consequence 1) Potential of incorrect management of patient with Infection Prevention and Control risk. 2)Potential of exposure to other patients of Infection Prevention and Control risk. 3) Additional multiple moves of patients to facilitate achievement of appropriate placements. Site team bed allocation reliant upon quality of information accessible to inform decision making.				[Kitcher, Karen 12/01/21 14:24:24] 14/12/2020 Recruitment in progress to increase staffing levels in Infection Prevention and Control team, one Band 76 starting from 14/12/2020 and two Band 3 posts interviews being held 17/12/20. Additional staffing will enable and support the delivery of a 7 day a week telephone advice service. KR Head of Infection Prevention and Control 29/12/2020 Band 3 posts successfully recruited to new staff due to start 01/02/2021. KR Head of Infection Prevention and Control
							[Robinson, Karen 09/03/21 16:03:21] 09/03/2021 New staff in process of being inducted into IPC service. Gamma Clinell Rediroom, 'Pop up' isolation option being explored with free trial of system being arranged for March 2021. This system will provide opportunity to isolate a patient in their bed space thereby resolving potential issue of multiple patients moves to accommodate in a side room. KR Head of Infection Prevention and Control

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1750	Finance, Estates and IMT Division	Obsolete and Outdated Network Infrastructure	Cause: 1) Current WLAN Access Points and Access Switching are old, obsolete, and unsupported. Distribution and Core network are EOL and do not provide sufficient resilience or capacity. Consequence: 1) The network will not provide sufficient capacity to support transformation. 2) The network does not meet modern security standards and is not compliant with IS/DSPT requirements. 3) Lack of resilience and multiple single points of failure are significant risk to business continuity and patient safety	11/09/2020	5x3=15	4x1=4	[Gully, Jake 04/03/21 11:35:52] 03/03 - Business case was not submitted to Feb CIG, as still o/w capital charges - updated BC to go for Mar CIG. JDG Ops Mgr.
1729	Finance, Estates and IMT Division	Fire and Access Control Risk in Network Distributions Rooms	Cause: 1. Network distribution rooms do not have adequate/any access controls and are insecure. 2. Rooms are often used as storerooms with filing cabinets, carboard and other flammable materials. Consequence: 1. The rooms are insecure and could be accessed by unauthorised personnel. 2. An electrical fire could quickly escalate and would not be contained.	04/08/2020	5x3=15	4x2=8	[Gully, Jake 11/02/21 09:56:06] 11/02/2021 - clearance still pending at E0 and H0 data rooms - chaser e-mail sent. [Gully, Jake 04/08/20 11:37:41] 04/08/20 - Discussions started with H&S and Estates, mitigations planned as part of Wave 4 Capital Infrastructure programme. JG ICT Ops Mgr.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1901	Finance, Estates and IMT Division	Operational Estate Service - Performance	10/09/2021 - In July 2021 the Trust engaged the services of Opengate, an external consultancy, to undertake an analysis of the of the Operational Estate Team and determine opportunities to improve Operational, Financial and Cultural performance. The analysis is currently underway and Opengate have verbally reported their findings at the end of the first week. To date their findings have suggested that there are a number of concerns around the performance of the team which have resulted in certain maintenance activities, some of which are statutory (safety related), have not be been undertaken and this could result in system failures with potential service disruption / patient harm. The onsite analysis work will continue over the next two weeks following which a full report will be presented back to the Trust and an action plan will be developed. RG DDE&F	10/09/2021	4x4=16	4x3=12	[Graham, Robert 08/10/21 15:05:38] 08/10/2021 - Opengate presented their report to the SLT on 27/09/2021 as planned. The report identified a number of issues that has led our Service Improvement Plan (SIP) being expanded to take account of the issues and address them. A business case has been prepared that will seek additional funding to resource to support the delivery of the SIP and we aim to commence the delivery on 18/10/2021. RG DDE&F

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1904	Finance, Estates and IMT Division	Supply Side Issues Leading to long Delays in IT Procurement	Cause: 1. Global Supply side issues arising from Covid Pandemic have resulted in global disruption to manufacture and distribution. 2. Pandemic recovery has led to surge in demand. 3. Manufacture and distribution expected to take some 18 months to recover. Consequence: 1. Critical shortage of IT Components affecting manufacture of end user devices, servers, and critical network infrastructure. 2. 3-6 Month delays in procurement of laptops, desktops, and servers. 3. >6 Month delays for some network/infrastructure components. 4. Increased costs due to reduced supply and increased demand. 5. Likely to lead to delays in Infrastructure and Transformation projects. 6. Price inflation may lead to cost overruns.	04/10/2021	4x4=16	4x1=4	

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1111	Finance, Estates and IMT Division	Failure in the Trust's single data centre (no access to critical patient data) lack of resilience and aging equip	Cause: 1. Single Data Centre represents a single point of failure. Consequence: 1. Clinical, corporate and IT systems would be unavailable should there be a failure 2. Systems would not be able to be restored from backups 3. Potential closure of clinics and wider hospital 4. Poor patient care due to cancellations 5. Lack of ability to implement new technology 6. In event of catastrophic loss (fire/flood), procurement delays would add weeks into a recovery plan.	14/02/2017	5x4=20	5x1=5	[Gully, Jake 22/07/21 09:51:29] 22/07 New Data set for DC Refresh Case to be presented to CIG in September, pending inputs form PUHT for Opt 6, Collocated/Converged DC at PUHT. Implementation is dependent on W4 LAN/WLAN Refresh, and therefore unlikely before 2nd Quarter 2022. To further mitigate the risk, we are looking to implement DRaaS, which is an approved business case from CIG in Feb 20. Combined with Azure Express Route Connectivity, which was also approved at CIG in Feb 20. This will provide backup of all servers to Azure and the ability to spin up and run from Azure cloud in event of a catastrophic loss of DC. Implementation for this is likely to take 6 months but aims to be in place before W4 Network and DC Refresh start, by Jan 22. JDG, ICT Ops Mgr.
1852	Planned Care Group	No Dedicated Cancer/Haematological Ward Base for Cancer and Haematological Patients	Cause: 1) No dedicated ward area for cancer and haematological patients. 2) No prioritisation and cohorting of patients 3) No decided side wards for Neutropenic Sepsis patients. Consequence: 1) Patients allocated throughout the Trust to various areas 2) No dedicated nursing experience of cancer patients 3) No side room availability with regard to IPC 4) Reduced Quality of Care for patients	23/04/2021	3x5=15	3x2=6	[Baker, Chelsey 15/06/21 11:13:20] Update sought from the risk own to update overdue risk. CB QM [Baker, Chelsey 22/06/21 15:15:58] Update from Risk Lead: Review of Ward and Acute Oncology Service Provision being undertaken by Senior Management and Executive Team. Patient Cohorted to medical and surgical wards as appropriate. [Rabbits, Holly 03/09/21 14:12:21] Update sought from risk owner. HR, Interim QM. [Rabbits, Holly 05/10/21 14:59:34] Update sought from risk owner. HR, Interim QM.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1900	Planned Care Group	Becton Dickinson blood collection tube – National Supply Disruption	Cause: 1) National Supply Disruption Consequences: 1) Unable to maintain a full blood sampling service. 2) Potential for missed diagnosis 3) Risk to patient outcomes without full blood sample monitoring. 4) An issue with storage of ANC booking bloods, as sera needs to be kept for 2 years so reducing number if tubes would be a problem. 5) Potential knock-on effect to other tubes types (such as Blood Transfusion group and save samples) if Trusts switch sample types (discouraged under current guidance) 6) Potential for non-urgent tests to become urgent due to delay 7) Potential increase in rejected samples if alternative bottles supplied. For example tubes that use blank labels instead of form style labels (labels that prompt forename, surname, DOB, hospital number). 8) Potential increase in complaints from patients who are deferred for testing	03/09/2021	4x4=16	3x1=3	[Simkin, Anne 19/10/21 12:21:26] 19.10.2021 Stocks are returning to normal levels. We have been asked to slowly bring levels back to normal but still be mindful of regular stock rotation and no stockpiling. Weekly data submissions are still being made nationally. ASi PQM

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1609	Planned Care Group	Lack of Ophthalmology trained nurses to effectively manage & deliver safe service	Cause: 1) Staffing historically been CIP'd 2) Sickness (short term)/ long term 3) Increased activity 4) Lack of senior departmental lead i.e. sister role 5) Staff retirement leaving gaps within the workforce. Consequence: 1) Training below compliance 2) Appraisals below compliance 3) Lost activity i.e. cancelled clinics / on call 4) Potential increase in complaints resulting in poor patient experience 5) No management time for senior staff 6) Unable to staff new satellite 7) Impact on RTT 8) Impact on HRM processes - attendance management/ competency development / performance management/ rostering compliance 9) Lack of IPC oversight as departmental level 10) Lack of Post-operative clinics 11) Staff morale low in the unit shown through the recent staff survey.	07/08/2019	4x4=16	4x2=8	[Hailes, Julie 01/10/21 14:27:56] 1/10/2021 Band 6 remains on LTS - new recruits now started but training process will take time for them to become skilled in area. Training review needed to see if mandatory training compliance improved (JH Matron)

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
661	Planned Care Group	Oncology Service Contract between providers of specialist commissioning and tertiary centres for IOW Patients	Cause: 1) Lack of Oncology Service Provision from Tertiary Centres - Under Review. 2) Lack of 5-day Oncology Service 52 wks. / yr. 3) Lack of Cover for Oncologist Absence. Consequence: 1) Acute oncology service non-compliant with peer review. 2) Lack of clinical leadership. 3) Lack of clinical review of patients. 4) Lack of 7-day service. 5) Patient care comprised. 6) Cost Implications.	27/08/2015	4x4=16	3x3=9	[Rabbits, Holly 05/10/21 14:55:43] Update sought from risk owner. HR, Interim QM.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1822	Planned Care Group	Lack of Radiologist's for MDT's. Specifically Urology and Lower GI. No Cover in Radiologist Absence for all MDT's.	Cause: 1) Colorectal, Urology, Cancer Unknown Primary (CUP) affected by the reduction of Radiologists (due to resignation). Consequence: 1) Inability to provide Radiologists for safe MDT discussion 2) Provide accurate and timely decision making 3) For patients diagnosis treatment for ongoing care 4) Failure to achieve to NHSE Quality Surveillance measure for MDT quoracy 5) Inability to report DWIBS for prostate patients at specialist MDT 6) Inability to review MRI at Radiology review meeting (linked to MDT) 7) Lack of interventional diagnostic Radiologist 8) For timeliness of diagnostic procedure and cancer pathway	23/02/2021	4x4=16	2x2=4	[Rabbits, Holly 05/10/21 14:58:08] Update sought from risk owner. HR, Interim QM.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1666	Planned Care Group	Inability to deliver a sustainable urology service due to Consultant cover availability/ability to recruit	Cause 1. Demand exceeding capacity 2. Clinical case mix ability 3. Further with NHS fixed term locum due to isolation. Consequence 1. Further 52-week breaches 2. Cancer 2ww breaches 3. Clinical harm to patients	24/12/2019	4x4=16	4x2=8	[Honey, Ally 03/09/21 13:34:43] 03/09/21 - Changed title, amended current score, response to risk and target score. Consultant and Specialty Doctor vacancy due to retirement and leaver. Agency Consultant locum in place until Sept 2022 and Associate Specialist appointed from overseas who requires a longer period of shadowing and support who commenced in Aug 2021. A further Locum Consultant request for a two-month period has gone to agency to help support the service in this stage of reduced capacity as there is also annual leave to cover and an increased build-up of overdue follow ups AH AOM

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1816	Planned Care Group	Obstetric Band 3 Technicians undertaking First Assistant Role	This risk is one of 2 replacing risk register entry 1554 Cause 1) Within obstetric theatres, due to a lack of 24-hour junior medical cover the Band 3 LW Technicians undertake the role of First Assistant for emergency LSCS operations out of hours. This practice is not aligned to guidance and standards issues by professional groups. 2)Association of Peri-operative practice states that "a surgical first assistant is a registered healthcare professional who provides continuous competent and dedicated assistance under the direct care of the operating surgeon throughout the procedure whilst not performing any form of surgical intervention" (PCC 2012) 3)The Perioperative Collaborative recommends registered practitioners should complete a nationally recognised competency training programme - these programmes are at Masters level and include dedicated time in the role to complete the associated clinical competency programme. Staff employed in this role nationally are RN/ODPs with the above qualification and are usually employed at Band 6 level. Annual updates are required with review of competencies to provide assurance around patient safety. 4)No other trusts are reported as employing support workers within the first assistant role and majority of trusts have now stopped all registered practitioners without a recognised qualification from undertaking this role 5) Lack of registered theatre staff with advanced competencies to undertake this role out of hours 6) Role not funded as part of theatre establishment to	10/02/2021	4x4=16	4x1=4	[Baker, Chelsey 07/06/21 13:00:55] 07/06/21: Update from action lead. The technician's competencies have been assessed by the Obs & Gynae Consultants. New medical model to be in place by August 2021. Risk review date amended.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
			enable recruitment to this role at appropriate level Consequence Risks associated with this practice were highlighted in HSIB recent maternity investigation 1903-494 Patient safety risk in the event of surgical complication or haemorrhage during LSCS with unskilled first assistant Does not fulfil CQC standards for safe theatre practice increasing risk of adverse report Litigation risk in the event of a patient safety or serious incident occurring Risk to other theatre registered professionals seen as not challenging and/or accepting the practice Adverse reputation of Trust in not complying with national guidance/standards Inequitable standards of care delivery out of hours				

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1730	Planned Care Group	Consultant Radiologist Recruitment Issues	Cause: 1. Lack of Consultant Radiologist's having impact across all Imaging services. 2. Despite multiple recruitment drives we have been unsuccessful at recruitment, the registrar has also been pulled by the Deanery, and our HEE global fellows program candidate has also dropped out. 3. The Department has carried multiple vacancies and lost several Radiologists to retirement, the gap has been plugged by teleradiology services however these services only provide reporting not general queries, vetting, protocolling, physical patient contact activities or MDT work. 4. Currently the Department has only 4 Consultant Radiologist's 2 in Breast Screening and 2 covering CT, MRI, Ultrasound, Plain film. All 4 also provide all MDT and sub speciality work which takes up the majority of their time. Consequence: 1. Multiple recent incidents regarding Consultant Radiologist availability for interventional procedures, emergency work, head and neck availability, general queries from Drs, failure to find one to act as the prescriber for CT contrast, and unavailability for	06/08/2020	4x5=20	2x2=4	[Stant, Andrew 17/11/20 13:34:05] 23/09/2020 Arranging with PHT for SOR rep for an ASAP (ACS Deputy Head of Imaging) [Stant, Andrew 23/09/20 08:23:32] 17.09.20 - Email to risk owner for update (LBL Snr QM) [Stant, Andrew 05/01/21 13:14:17] 16/12/20 Approval for additional locum granted. (ACS) [Clark, Michelle 12/01/21 12:36:33] 05/01/2021 2 X Consultant Radiologists have given their notice in, this leaves the Radiologists at 3WTE out of 7.6WTE + £552,326 of outsourcing budget which represents additional Radiologist WTE [Stant, Andrew 18/12/20 09:56:16] 17/11/20 AAC Complete for one candidate. Sill have multiple vacancies impacting service. An additional Radiologist is reducing his hours. (ACS Deputy Head of Imaging)

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
			MDT's 2.The above has led to both 2 and 6 week wait breeches along multiple pathways and direct harm to patients 3.Any further reduction in Radiologist numbers either from sickness or levers will result in a reduction of services across the trust 4.Due to low Radiologist numbers there is a lack in range of sub speciality we are able to provide e.g. we have no Paediatric interest sub speciality Radiologist to serve the islands 30000 children.				[Stant, Andrew 18/12/20 09:58:39] 27/11/20 Urgent meeting with HR with the following outcomes / actions Ref Action Who 1 Follow up on the HEE global programme – seek clarification on candidates for the IW Lesley 2 Contact and arrange a site visit for Wednesday 2nd November for the candidate to meet with Stephan and the team at SMH Lesley 3 Medical HR to contact the candidate from Germany to 'keep warm' while travel restrictions remain in place Lesley to work with Medical HR Team on maintaining contact 4 Locum cover – Lesley to link Andy with Alex Richardson on current/future requirements Lesley/Alex Richardson 5 Job description for Consultant radiologist post to be reviewed by Lesley and to include a proposed recruitment strategy for the department. Stephan and colleagues to work with Lesley on review and refinement Lesley/Stephan (ACS)
1802	Planned Care Group	Risk of patient harm caused by a long delay to treatment as a result of activity suspension in Phases 1 and 2 of Covid response.	Risk of patient harm caused by a long delay to treatment as a result of activity suspension in Phases 1 and 2 of Covid response. Rise in Emergency Activity impacting on this	08/02/2021	5x4=20	4x2=8	[Robinson, Daniel 08/02/21 09:11:15] Implement recovery plan approved by the Board in October 2020. Clinical review of patients to expedite care to appropriate location including off-island Inpatient, outpatient and day cases have recovered to 90%. of pre-Covid levels; Diagnostics delivering at 110% of pre-Covid levels.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1810	Planned Care Group	Risk of reduced outcomes/ mismanagement of pt care from pressure on urgent care pathway services are outstripping demand in PC	Risk of reduced patient outcomes arising from late presentation of symptoms by patients, associated with Covid related reluctance to engage with primary and community related services. Risk of reduced outcomes / mismanagement of patient care arising from pressure on the urgent care pathway due to demand for services outstripping demand in primary care.	08/02/2021	5x4=20	4x2=8	[Robinson, Daniel 08/02/21 13:44:11] Trust cooperates with the local health economy to promote timely access to treatment including through communication and engagement campaigns.
1829	Planned Care Group	No patient details being inputted into PARIS resulting in lack of contemporaneous records for Children	Cause: 1) All live births and children moving into the area are no longer being added to the PARIS system. 2) All children born after 01 November 2020 are not logged on PARIS. Consequence: 1) Team moved to Southern Health with no mitigating factors put in place to ensure that details are continued to be added to the PARIS. 2) Possibility for duplicate records. 3) Risk that important documentation could be missed by health professionals if duplicate record. 4) Risk that child could be missed unless accessing Trust Health Professional. 5) Reliance on child accessing health care through the Trust in order to be added to the PARIS system. 6) PARIS used by multiple departments.	03/03/2021	4x5=20	2x2=4	[Baker, Chelsey 11/06/21 09:49:16] Update sought for risk owner. Communication sent. CB QM [Baker, Chelsey 25/05/21 14:55:40] 07 May meeting held with Assistant Director of IT, Information Systems, Lead for Children's Safeguarding and Matron for Paediatrics discussed. It was identified in the meeting that this was a risk. Assistant Director of IT has made contact with the CHIS team to look at the CHIS process, with a view to possibly set up a service level agreement for them to continue to cover this service under Southern Health. Discussion was also had regarding getting Safeguarding and Paediatrics on to SystemOne. Roll out plan not yet identified and further discussion to be had.

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1907	Unplanned Care Group	Risk of impaired patient outcomes and harm arising from reduced flow through the hospital and beyond.	Cause: - Lack of community capacity in care homes and domiciliary care. - Loss of care staff who do not have the Covid jab Consequence: - increased DTOC - increased pressure on existing beds	14/10/2021	4x4=16	3x2=6	

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1431	Unplanned Care Group	Gastroenterology capacity impacting service delivery	Cause: Lack of capacity in Gastroenterology due to 1 Consultant vacancy, 2 specialty registrar vacancies and long-term sickness in the IBD specialist nurse team. In addition to the current vacancies 1 of the 2 substantive Consultants will be retiring in May 2019. The service also has no department and insufficient outpatient clinic space resulting in outpatient clinics being undertaken in areas across the organisation with the support of 1 Bank HCA when available. Consequence: 1. Reduction in outpatient clinics to enable consultants to cover the role of the Registrar as well as their own role. 2. Deterioration in patients condition due to delays in outpatient diagnosis, treatment, and review. 3. Delay in responding to inter consultant inpatient referrals leading to a delay in treatment. 4. Lack of advice for IBD patients needing to contact the telephone helpline due to the fact that the helpline is currently suspended. 5. Lack of consultant availability to undertake in hours GI bleeds resulting in a delay in treatment. 6. Stress and fatigue of the remaining clinicians as they attempt to manage the service. 7. Inability to develop IBD nurse and junior doctors due to lack of available outpatient clinic space.	03/10/2018	4x4=16	4x1=4	[Hayward, Sarah 09/10/21 09:46:10] 9 Oct 21: Position as at 12 May 21 remains. - One substantive consultant with revised job plan covering, inpatients, outpatients and endoscopy weekly - Consultant recruitment advertising during October - Agency consultant attended 6wks during summer; agency sourced for November - 1 gastro SpR left Sep 21, another due to leave Dec 21; recruited 1 to start early 2022; agency being sourced - PUH and UHS requested to support, however, limited response - Acute Partnership scoping in early stages reviewing potential opportunities - Medefer continue to support OP activity, however, approx. 80% of patients being referred back to hospital for diagnosis and treatment - Currently reviewing Medefer increasing their scope of patient care (SH)

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1698	Unplanned Care Group	Community Heart Failure nurse caseload and waiting list size	Cause: 1)continued increase in community heart failure referrals (this is largely because of an increase in population size and age) 2)patients are diagnosed earlier leading to an increase in referral 3)population of patients previously optimised in medical therapies now requiring/suitable for device and advanced therapies being referred back 4)inequity of service Consequence: 1)at present 16 week waiting time for first appointment (Nice recommend review after 10 days of being referred) 2)increased risk of admission for Heart Failure patients 3)increased risk of death for Heart Failure patients 4)119% increased on active caseload which is not sustainable	06/03/2020	4x4=16	2x2=4	[Oliver, Rosie 27/07/21 10:25:03] Business case resubmitted to the CCG 23.07.21 for further discussion and pushing forward for funding approval in order to sustain the service and make it safe. RO AOM [Oliver, Rosie 28/09/21 10:08:45] Meeting took place on 24.08.21 and final version of the business case was submitted to the CCG for onward management. Update requested on 15.09.21, response from CCG that another meeting would be set up to discuss - currently arranged for 7th October. RO AOM [Oliver, Rosie 17/06/21 15:24:10] Meeting with the CCG took place in May, team are collating information as requested and will submit to the CCG by 23.06.21. We will then await confirmation of approval for an increase in funded establishment in order to sustain the service and manage the backlog [Oliver, Rosie 29/04/21 14:41:42] 29.04.21 process pathway mapping taken place with the PMO team. Changes to the staffing within the team are upcoming based on vacancies and the implementation of the inpatient HF service. Caseload sizes unmanageable, nurses struggling to meet the demands of the capacity - escalation to senior nursing and management team submitted. RO AOM [Robinson, Daniel 11/03/20 09:57:34] 15 Jan 2020: Risk rating increased to 16 following discussion with Clinical Lead and Triumvirate due to longevity of the ongoing risk. Detailed update to follow. (SH)

ID	Division / Care Group	Title	Description	Opened	Risk Score (Current)	Risk Score (Target)	Latest Update
1872	Unplanned Care Group	Demand and Capacity - Significant Waiting List Size (excluding Bowel Screening)	Cause: 1) COVID-19 caused the temporary shutdown of the Endoscopy Unit and when the Unit re-opened, there was reduced capacity in procedure lists (due to infection control measures). There was a period in January 2021 whereby due to significant staff sickness, procedure lists needed to cancel - this wasn't solely related to COVID-19. It is also anecdotally reported that the DNA rate and cancellation rate increased due to people not wanting to attend hospital due to the COVID-19 pandemic. Cancellations within 3 days of an appointment meant that under the previous COVID-19 testing regime that the appointment slot couldn't be given to someone else. Consequence: 1) Significant waiting list size and more frequent breach of target dates. This increases the risk to people's health as they will not receive the timely service they were assessed as needing.	24/05/2021	5x4=20	5x2=10	[Pyner, Bryan 30/06/21 14:06:10] 30/06/2021 - Ongoing.

Agenda Item No	13	Meeting	Trust Board held in Public		11 November 2021
Title	Integrated Performance Report				
Sponsoring Executive Director	Darren Cattell – Deputy Chief Executive /Director of Finance & Estates				
Author(s)	Various				
Report previously considered by:(including dates)	Executive Team and Divisional Boards				

Purpose of the Report		Reason for submission to Trust Board in Private only (please indicate below)		Link to CQC Domain		Link to Trust Strategic Objectives 2020-2025	
Trust Board Approval		Commercial Confidentiality		Effective	X	SO 01: Make our Trust a great place to work and receive care	x
Committee Agreement		Patient Confidentiality		Caring		SO 02: Work with our partners and our community to improve services	
Assurance		Staff Confidentiality		Safe		SO 03: Deliver high quality compassionate care	
Information Only	X	Other Exceptional Circumstance		Responsive	X	SO 04: Make sure our services are clinically and financially sustainable	x
				Well-led	X	SO 05: Join up health and care services by working more closely with our partners	
						SO 06: Invest in building and IT that helps our teams make a positive difference to our island community	x

Key Recommendations to be considered:

There is an Executive summary outlining headlines and risks at the front of each performance domain and Service and more detailed information in the rest of this Report.

The Chair of each Board Committee will report to the Trust Board on the level of assurance received and that level of assurance will be largely based on the detail contained within this report.

Each responsible Executive Director will provide a more contemporary update on current performance wherever possible

The Board are asked to receive the following Integrated Performance Report for information

Trust Integrated Performance Report

11 November 2021

Contents

Quality Information

Quality Headlines

	Key Risks	Controlling actions
1	**Complaint Handling** • At the time of reporting 47% of complaints were overdue. • 5 Returning complaints received (slight decrease on July (7)) • Communication continues to be key theme - with carers / patients reporting inability to contact wards / services.	• Meetings are held at least weekly in Acute Division to support complaint handling process • Pilot for PHSO Complaint Standards due to commence in October starting in MH&LD • New Complaint Policy to be approved next month. • Patient Experience Lead and Chief Executive to commence weekly meetings to monitor and discuss complaint handling • PALS service has being single person service however the team have now successfully recruited to vacancy which will support more early resolution of complaints • New process in place on wards to support returning calls to loved ones
2	**Frequent failure of lift(s) leading to St Helen's & Wellow Ward** – resulting in incidences of transfer of patients, delays in surgery and diagnostics and poor patient experience.	• Estates rapid response plan regarding mitigation and access to engineers including sourcing of on island support as interim measure to try to improve timeliness of repairs. • Review of admissions to St Helens re: high risk patients if lift failure occurs, • Contingency plan for transfer of patients from Wellow developed and implemented. • Option to consider review of speciality on St Helens proposed given increased risk with emergency patients regarding access to diagnostics and theatre
3	**Staffing** **Planned Care**: Gaps in Senior Nursing Structure – impacting on level and quality of professional support and key governance issues. **Unplanned care**: Falls of have increased slightly this month due to acuity of patients and lack of staff available for providing 1:1 Support – HCA shortage remains a concern in the division. **Mental Health & Learning Disabilities:** RMN & Medical Vacancies **Ambulance**: Loss of skilled / experienced paramedics to similar roles in Primary Care **Community**: Increased demand and vacancy levels could impact on quality of service provided.	• Priorities identified for focus and roles reviewed for existing staff. Focus on health and well-being across senior team. Interim support for theatres being investigated. New Head of Nursing commencing November 21. Actie absence management introduced to support staff and facilitate return as appropriate. • Staffing reviewed daily to address enhanced or bay watch needs. • First IR recruitment in December • Joint working across ICS to address nurse vacancies • Some B5 posts converted to B4 Nurse associates • Additional psychology recruitment to address Must do for division. • Review out of hours provision • Continue to recruit to vacancy • Increase educational opportunities • Explore joint working opportunities • Use of bank and agency staff to cover vacancies and support services with high demand. • Weekly review of Business continuity plans. • Escalation process in place. • Triage process in place. • Services prioritising urgent & high risk patients

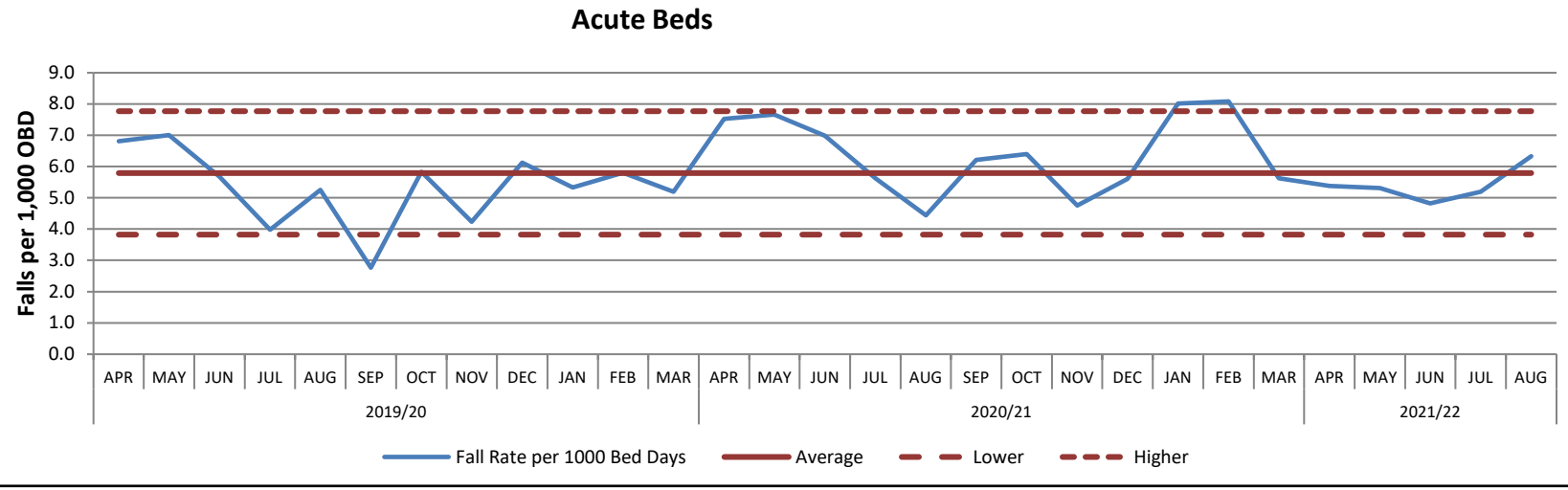
Quality Headlines – Divisional / Care Group Quality Updates

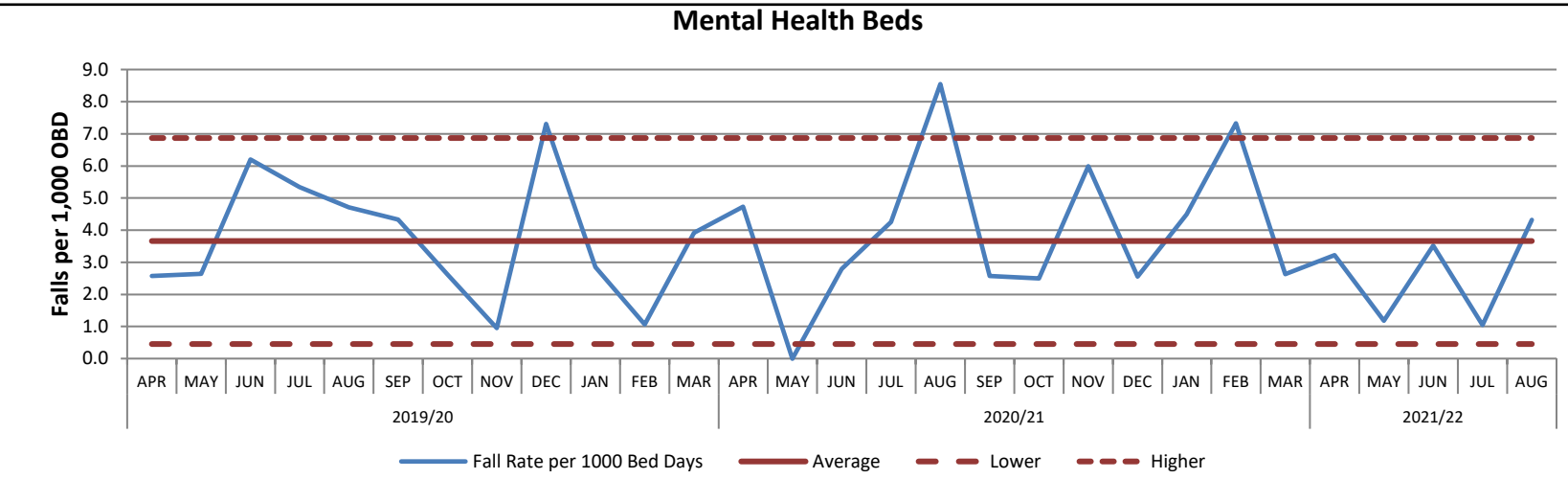
Key achievements this period

- Good Rating from CQC following the Trusts inspection
- Continued achievement of standards of cleanliness audit scores for August – all areas achieving their target percentage compliance.
- Compliance with antibiotics for sepsis remains about >90% for whole Trust; number of patients with AKI remains low.
- NEWS2 audit is consistently over 90%
- No PSI's declared for August relating to Deteriorating patient
- No patients are being discharged home from ICU which is an indicator of patient safety and quality improvement and remains consistent.
- Cardiac arrest and anaphylaxis drugs adapted as per new guidelines / procurement for roll out late September / October 2021; relocation of Resuscitation service on site for training and clinical purposes.
- Improvement seen in compliance with mandatory training in relation to Resuscitation; although DNA rate still at 17%.
- Duty of Candour remains at 100% compliance for August 2021
- FFT overall score at 98.68% for August 2021
- Volunteer service is linking with the Isle of Wight College to recruit Health and Social Care students as volunteers.

Trust-wide Falls Prevention Report

For in-patient areas, falls rates continue to be presented per 1000 occupied bed days (OBD) in line with the National Audit of In-patient Falls (NAIF). Lower falls rates are indicative of fewer falls.





Key Points:

- There was an increase in falls over July and August, we have to keep in mind, the rise in covid and naturally we lose up to 30% of our workforce in the summer months.
- The month of August saw the highest OBD we have had since April.
- There has been some really great work on Appley, Colwell and Luccombe. We have seen patients not come to harm from falls on Appley thanks to initiatives taken.
- Afton Ward embraced falls week with incorporating strength and balance exercise into their activity sessions.
- The race is on for the best falls tree!

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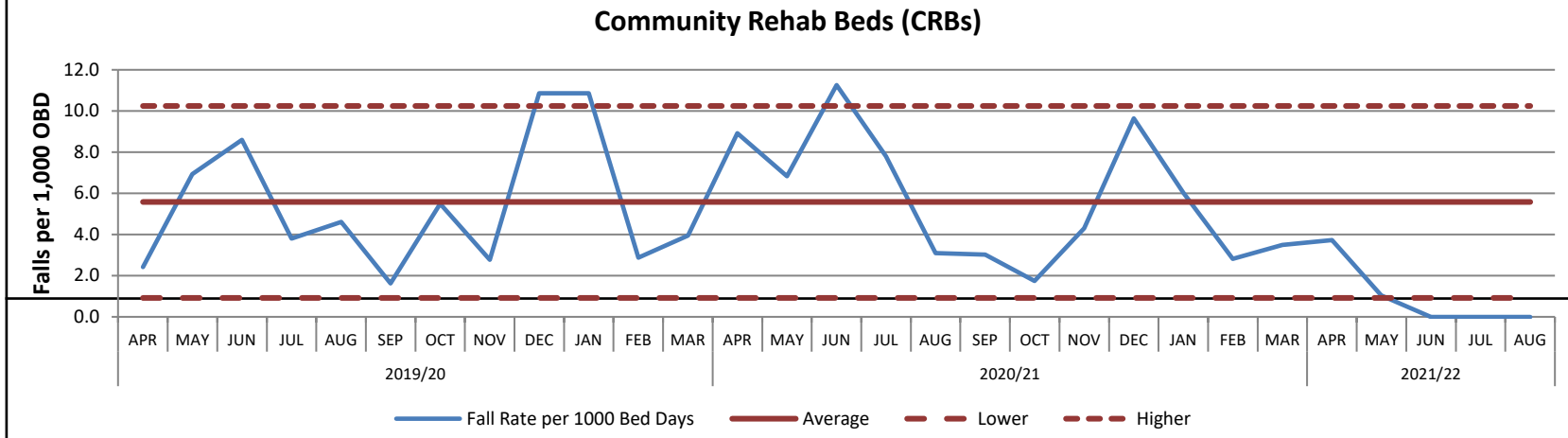
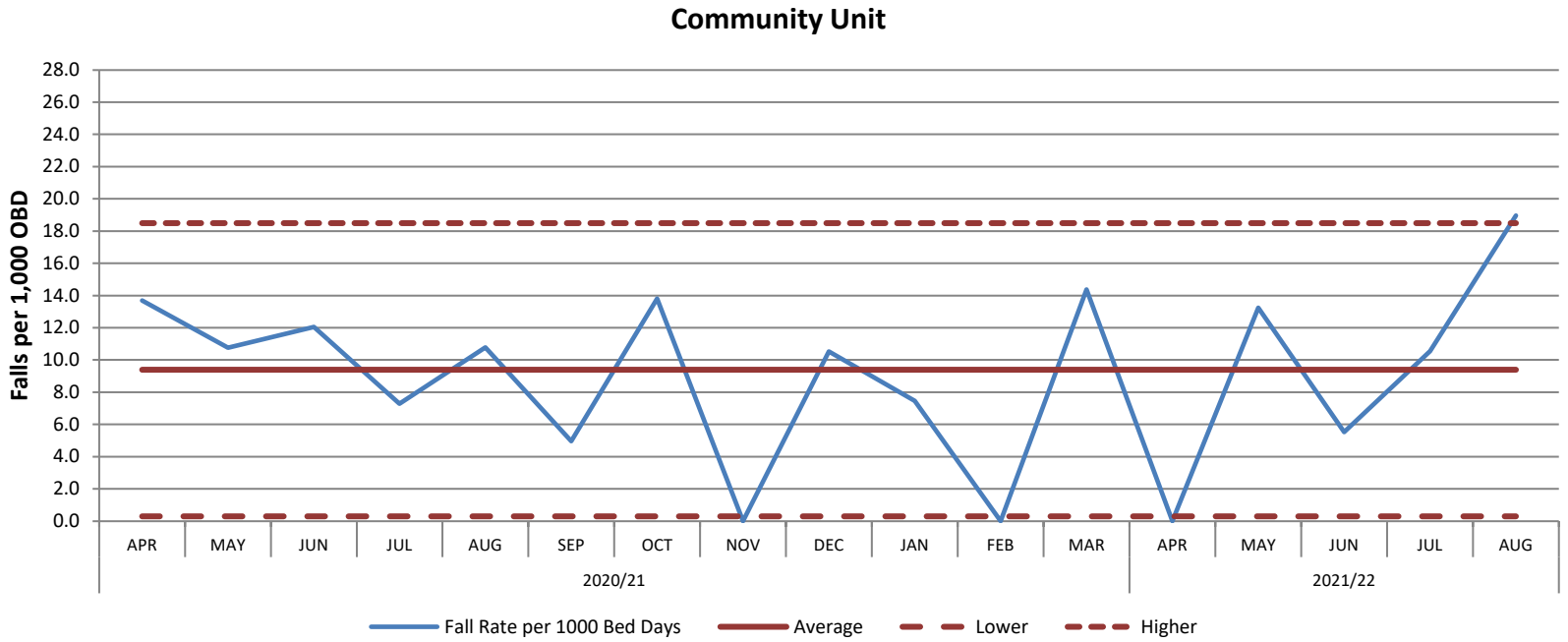
Trust-wide Falls Prevention Report (cont)





- 4 patients had 7 Falls between them on the community Unit in Aug 21. 2 of the patients were known fallers from Community Locality Teams and previous admissions. Plan to follow these patient journeys as a learning experience for the team.
- There were 2 falls in each of the 3 CRBs in Aug. Both falls in Highfield were the same person. Awaiting Hot debrief info for all these falls.
- **Falls Prevention Awareness week takes** place in the community 27th - 1st Oct. Community clinics will be provided with Falls Prevention material and the Falls Prevention Team will be running sessions across the island for advice and intervention.
- Community Unit and more CRB staff have recently undergone Falls prevention training. Community falls Lead plans to visit these areas next month.
- Ongoing work is needed in the CRBs around hot debriefs

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Pressure Ulcers (PIF, Quality Contract, CQUIN)

2021/2022

Category 2

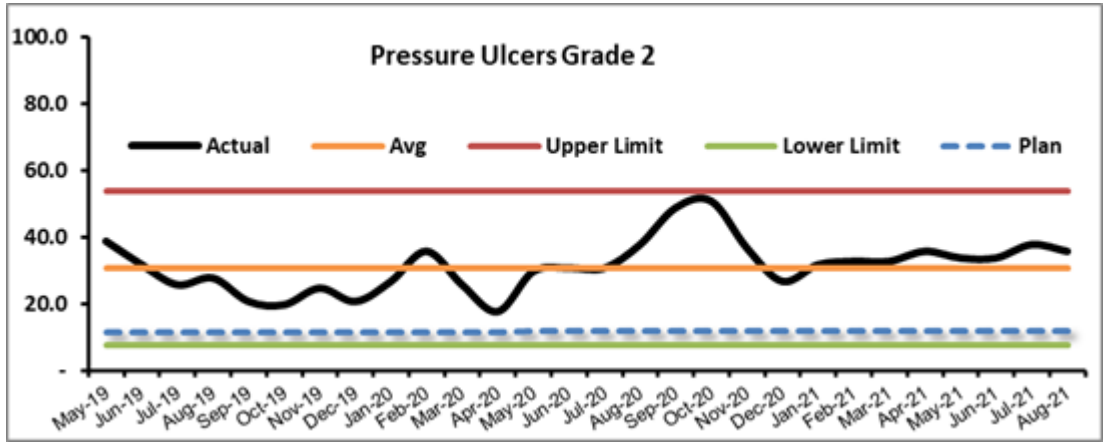
- **Last period (July 2021): 38**
- **This period (Aug 2021): 36**
- **Year to Date: (April 2021 – March 2022) 178**

Category 3

- **Last period (July 2021): 1**
- **This period (Aug 2021): 0**
- **Year to Date:(April 2021 – March 2022) 4**

Category 4:

- **Last period (July 2021): 0**
- **This period (Aug 2021): 0**
- **Year to Date: (April 2021 – March 2022) 0**



- The Pressure Ulcer Collaborative has shown some improvements with cohort 1, however the project has stalled due to poor engagement caused by patient pressures COVID and TVN leave. TVN is now liaising with the quality improvement team to support this project moving forward.
- All Datix incident reports are appraised by the Tissue Viability Nurse (TVN) and handlers to check the accuracy of categorisation or duplicate reports.
- Pressure ulcer prevention competency is available on clinicalskills.net and is available for all staff to complete, the responsibility for completing this is down to individual staff and monitoring is the responsibility of team leaders/ward sisters.
- Moisture lesion and pressure ulcer pocket guides and visual aids are available for all staff on request, as well as educational posters for all clinical areas.
- Bespoke training on pressure area care and prevention can be delivered to clinical areas on request.
- Category 2 injuries remain the highest reported injury. The number of category 3 and 4 injuries remain low.
- The number of injuries reported coming into NHS care has continued to be considerably higher than those under NHS care. Despite efforts to benchmark these against other trusts there continues to be reluctance to share data from other areas as a comparison.
- Target of 12% reduction in the number of PU occurring under NHS care set for 2021 – 2022.
- Concordance with PU prevention policy and documentation is audited by individual clinical areas.

Divisional Management Teams

- The monthly safety thermometer audits are not undertaken at the moment by the Divisional Management Teams as they remain postponed by NHSE until further notice.

(Trustwide (acute and community) data kindly produced by PIDS)

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Infection Prevention & Control: Standards of Cleanliness

CLEANLINESS AUDITING SCORES OVERALL FOR THE PERIOD SEPTEMBER 2020 – AUGUST 2021

- Target % - Very High Risk Areas 98%, High Risk Areas 95%, Moderate Risk Areas 90%
- Very High Risk = ICU, Main Theatres, High Risk = General Ward Areas, Moderate Risk = Clinics
- Auditing largely suspended during March / April due to Covid 19. **Fewer results for October @ 29.10.20, as tablets sent for upgrade and delay in receiving replacements**

	Monthly Trend Analysis													
Functional Area/Ward	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Total For Functional Areas	Mean (Average) Score
Acute Assessment Unit (AAU)	97.80%	N/A	97.20%	N/A	98.90%	97.40%	96.60%	N/A	96.70%	92.10%	92.60%	N/A	96.10%	96.10%
Alverstone Ward	98.60%	98.30%	98.10%	98.90%	96.90%	98.90%	98.90%	98.60%	98.60%	97.70%	99.20%	98.90%	98.50%	98.50%
Appley Ward	93.10%	N/A	93.50%	94.30%	94.90%	91.20%	94.50%	N/A	96.60%	96.70%	97.50%	95.40%	95.50%	94.70%
CCU Coronary Care	98.10%	97.40%	97.30%	94.50%	97.80%	97.90%	97.10%	98.00%	98.40%	98.40%	98.30%	98.00%	97.90%	97.60%
Colwell Ward	95.10%	N/A	94.90%	94.80%	96.00%	N/A	N/A	N/A	96.40%	96.10%	94.30%	93.80%	95.30%	95.20%
Day Surgery (Theatres)	97.60%	98.60%	N/A	97.60%	99.00%	96.80%	96.80%	97.00%	95.30%	97.80%	98.50%	N/A	97.60%	97.50%
Emergency Department (ED)	98.20%	98.00%	98.00%	97.10%	98.00%	98.30%	N/A	N/A	97.50%	97.60%	98.10%	N/A	97.90%	97.90%
Emergency Dept. ED MINORS	96.30%	97.50%	98.90%	99.50%	98.90%	97.90%	97.30%	97.50%	97.30%	97.30%	95.70%	97.30%	97.60%	97.60%
ITU	99.10%	98.90%	N/A	97.60%	98.80%	98.10%	99.40%	99.40%	99.30%	99.10%	98.50%	98.30%	98.80%	98.80%
Luccombe Ward	95.90%	N/A	95.80%	97.70%	97.50%	95.90%	97.10%	97.60%	97.90%	97.40%	98.40%	98.00%	97.20%	97.20%
Maternity - Labour Suite	98.40%	97.70%	98.20%	97.40%	98.40%	98.90%	98.40%	97.90%	98.70%	98.30%	97.90%	97.30%	98.10%	98.10%
Maternity Lower Ground Floor (OPD & Obs Clinic)	96.10%	97.00%	94.70%	92.30%	94.60%	95.90%	98.00%	95.50%	98.70%	95.00%	98.10%	N/A	96.00%	96.00%
Mottistone Suite	97.40%	N/A	95.50%	92.80%	N/A	97.50%	96.80%	97.90%	96.20%	96.90%	97.90%	97.40%	96.60%	96.60%
SCBU	99.50%	N/A	99.30%	99.50%	99.10%	99.50%	99.00%	98.40%	99.30%	92.30%	99.00%	98.80%	99.10%	98.50%
Seven Acres - Male	97.80%	97.00%	98.50%	98.80%	N/A	98.00%	N/A	97.40%	97.40%	98.10%	98.10%	97.40%	97.90%	97.90%
Seven Acres - Osborne Ward	97.30%	99.10%	97.60%	98.30%	N/A	97.30%	N/A	98.00%	98.60%	98.00%	98.60%	98.60%	98.10%	98.10%
Seven Acres - Seagrove Ward (PICU)	98.10%	97.80%	98.40%	98.40%	99.10%	98.10%	N/A	96.90%	95.30%	98.20%	98.70%	N/A	97.90%	97.90%
Seven Acres- Afton Ward	97.70%	N/A	97.00%	97.90%	97.40%	97.50%	N/A	98.40%	97.80%	97.50%	97.50%	96.80%	97.60%	97.60%
Short Stay Unit (SSU)	96.00%	N/A	97.10%	97.60%	96.20%	96.60%	94.20%	N/A	96.50%	96.20%	96.70%	95.60%	96.30%	96.30%
Stroke Ward 1	98.10%	N/A	N/A	99.20%	97.90%	98.20%	98.90%	99.60%	95.70%	97.90%	95.10%	93.30%	97.40%	97.40%
Theatres (Main)	98.70%	99.60%	98.10%	98.50%	98.30%	97.70%	99.60%	98.60%	98.90%	96.70%	98.30%	98.20%	98.50%	98.40%
Urgent Treatment Centre	96.40%	97.40%	97.60%	98.50%	N/A	97.70%	97.50%	94.70%	96.00%	97.00%	96.50%	97.50%	97.20%	97.00%
Total for Functional Areas	**97.40%**	**98.00%**	**97.20%**	**97.20%**	**97.70%**	**97.20%**	**97.80%**	**98.00%**	**97.60%**	**97.40%**	**97.70%**	**97.40%**	**97.60%**	
MEAN (AVERAGE) score for Each Functional Area	**97.40%**	**98.00%**	**97.20%**	**97.20%**	**97.70%**	**97.20%**	**97.80%**	**98.00%**	**97.60%**	**97.40%**	**97.70%**	**97.40%**		**97.40%**

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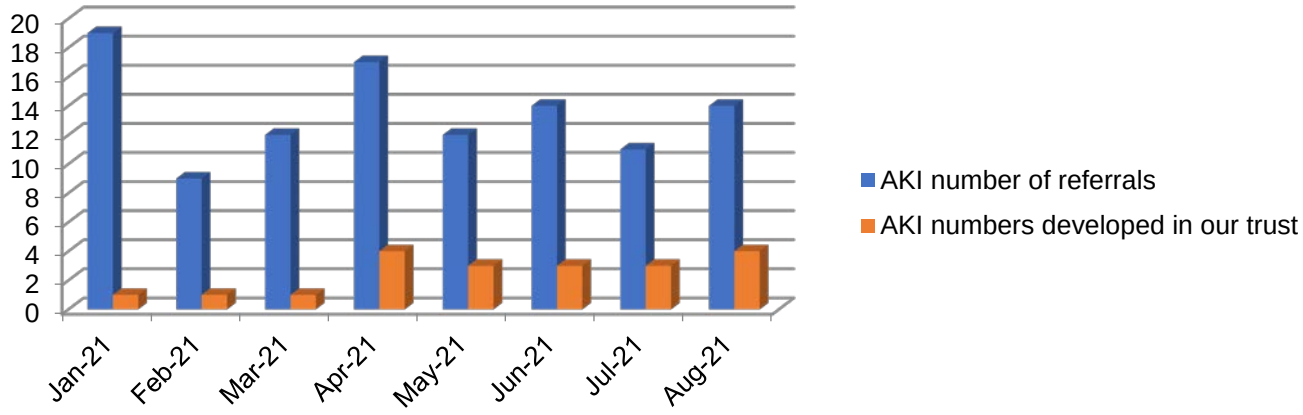
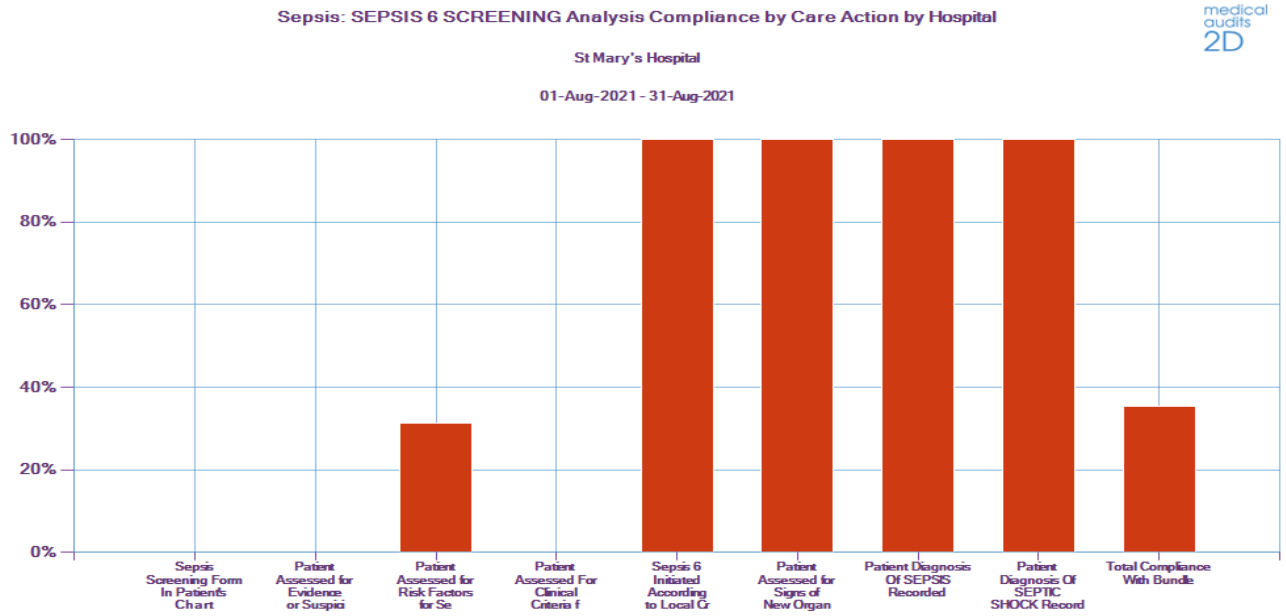
Acute Kidney Injury (AKI) and Sepsis



What the data is telling us

Of the 4 patients that developed AKI whilst in hospital, 1 patient developed AKI as a result of urology complication - the patient had an obstructive cause of AKI, 1 patient developed AKI because of a long lie at home, 2 patient developed AKI due to cardiology complications.

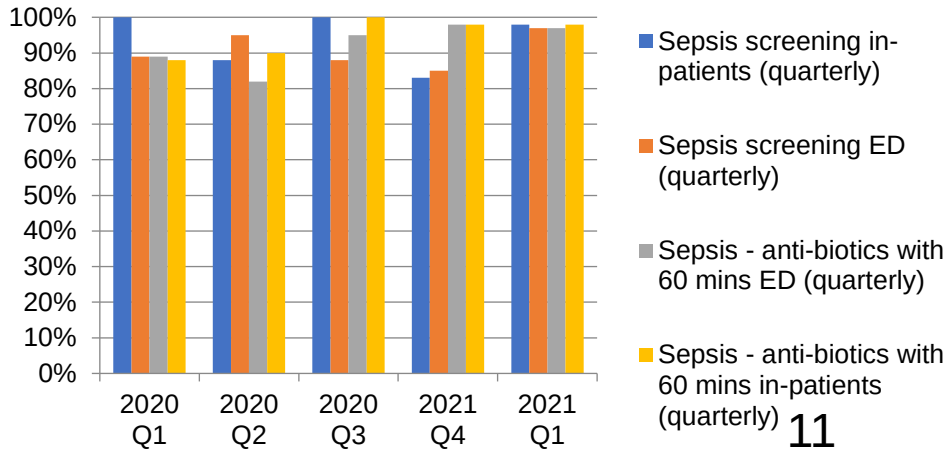
Overall the numbers remain low with the majority of patients being admitted with AKI.



What the data is telling us

Overall compliance with screening and Antibiotic administration remains good for ED and in-patients in the quarterly audit.
Compliance with antibiotics remains >90% for whole Trust.

Sepsis 6 audit captures 20 sets of notes per month to determine compliance across 5 measures. Improvements are required in assessing for risk factors. The policy is in the process of being reviewed and changes will be made to align us to national developments.



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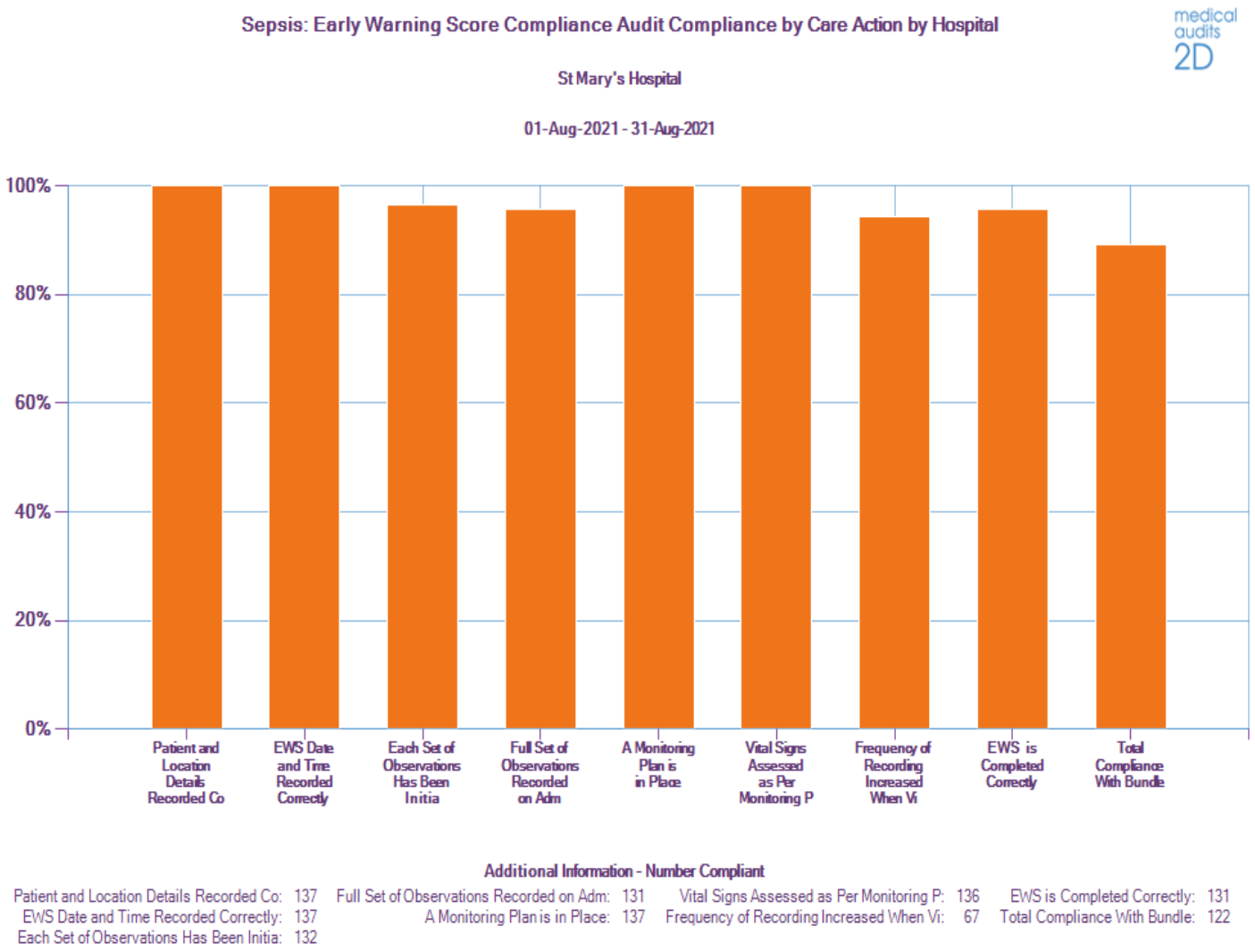
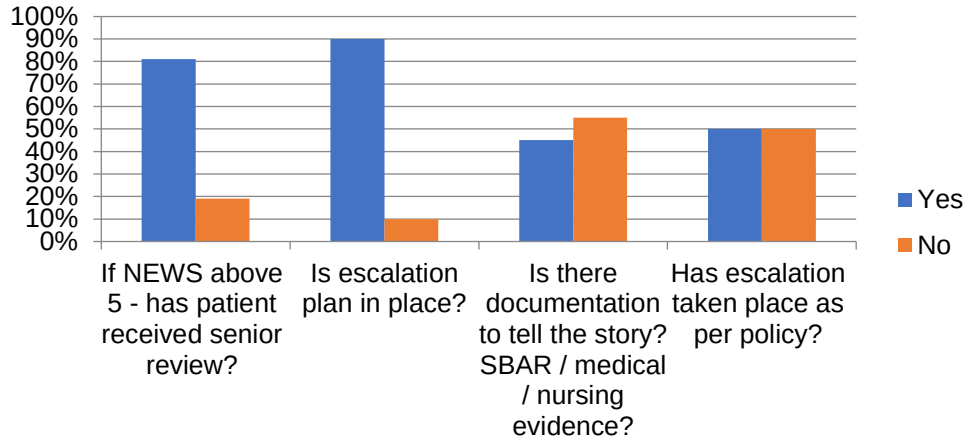
NEWS2 compliance

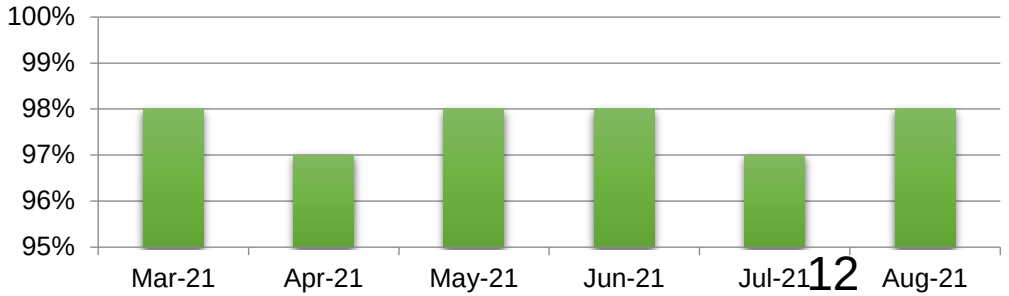


What this data is telling us

- Compliance is consistently over 90% with NEWS2 audit.
- Wards are submitting useful data to inform actions taken which are responsive to findings during auditing.
- SBAR is not consistently completed
- In a recent audit of 20 sets of notes to further determine compliance with escalation, there is a clear gap in the documentation to evidence actions (although there is evidence of actions taking place as a medical review happens but very minimal in notes).



NEWS Compliance Trust overall



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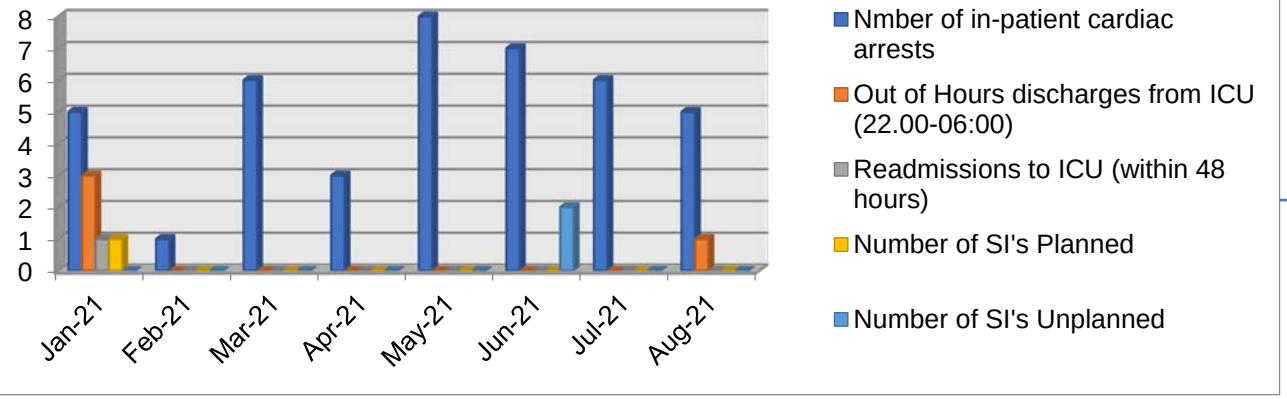
Deteriorating patient – escalating care



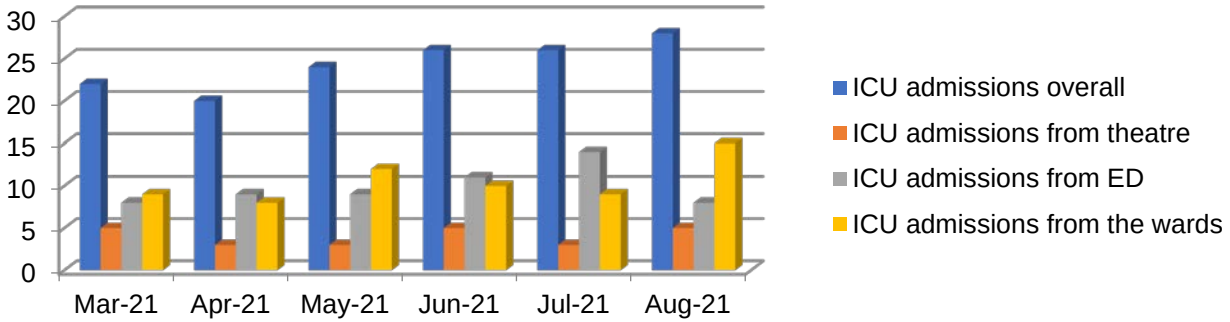
What the data is telling us

Out of hours discharges form ICU remain very low. Readmissions to ICU remain 0 which shows patients are well managed after discharge by CCOS and the ward based teams.

In-patient cardiac arrests are consistent (5):

- 3 patients had sudden deterioration and were in critical care areas so were being actively treated but continued to deteriorate.
- 1 patient was admitted to the ICU but continued o deteriorate and was made for end of life care.
- 1 patient had a cardiac arrest on the main ward and appropriate escalation took place. This patient was too sick to be on a main ward but didn't meet the criteria for admission to ICU.

No SI's declared for the month of August in relation to deteriorating patient.



What the data is telling us

There is a spike in admissions to ICU from the main ward as to be expected with COVID – 2 ICU's open.
In August we set up the COVID high care beds again which worked well.

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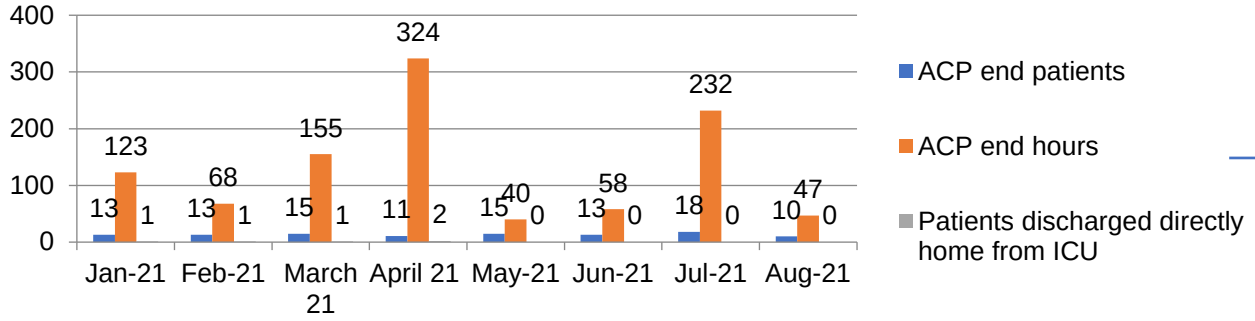

What the data is telling us

ACP end hours have reduced again following a spike in July data which is good given the system pressures over the last month.
We are consistently not discharging patients home from ICU which is an indicator of patient safety and quality improvement.

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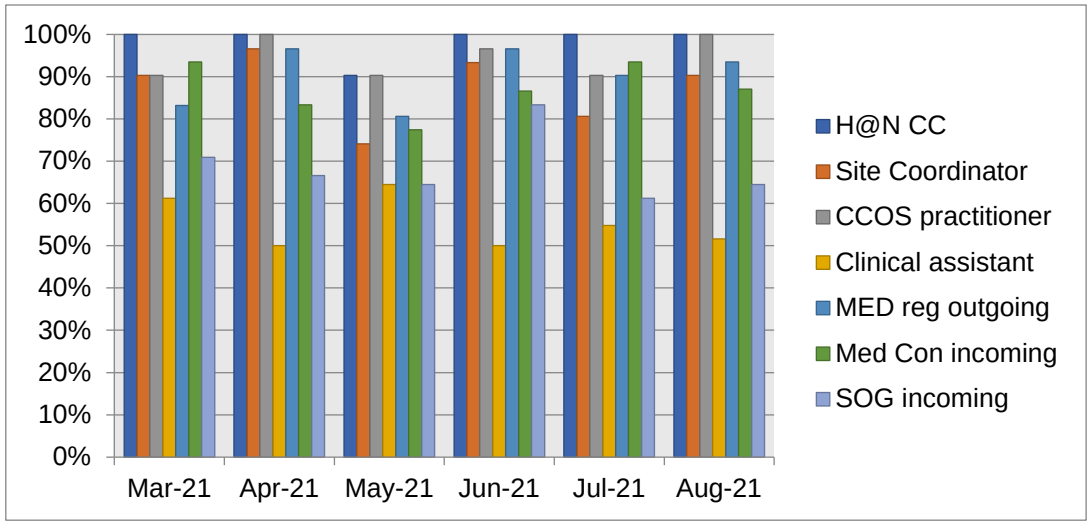
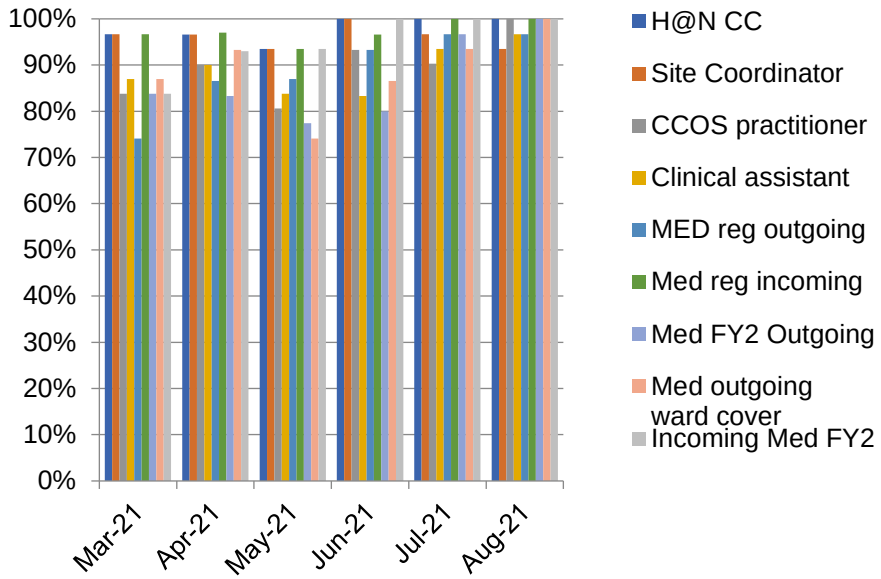
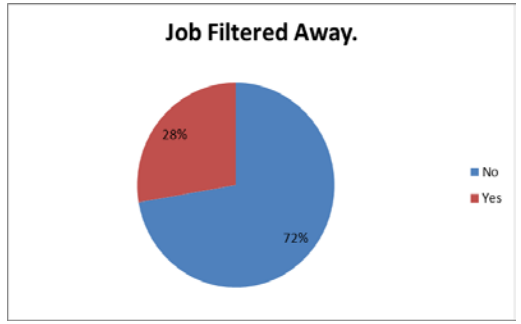
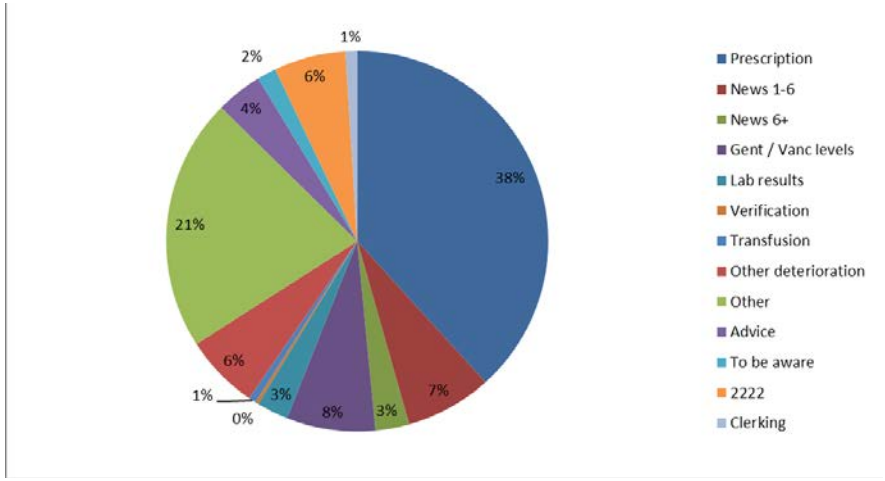
Hospital at Night attendance of key members – 8am (left) and 9pm (right) meeting









What the data is telling us

There continues to be around 30% of bleeps being filtered out of the medical and CCOS work load by the clinical coordinators.

Attendance is consistent and most non-attendance is caused by a clinical priority.

Jobs rolled over from the day are continuing to be between 20-30% of bleeps made.

Prescriptions continue to be a large proportion of the bleeps made. There is a relatively even divide of bleeps between medicine and surgery.

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In hospital Cardiac Arrest Data October 2021

Total Number Arrests 1st April- 31st Aug= 34 (32 patients)

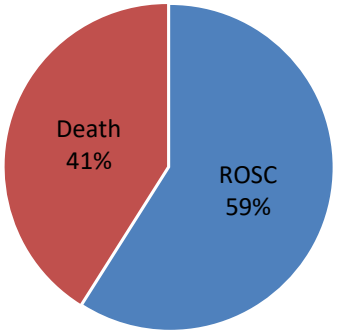
Same period 2020-21=21

Apr-Aug ***excluding ED & ICU 1.5/1000 admissions*** (UK avg. 1/1000)

Apr-Aug: overall 2.3 cardiac arrests/1000 admissions

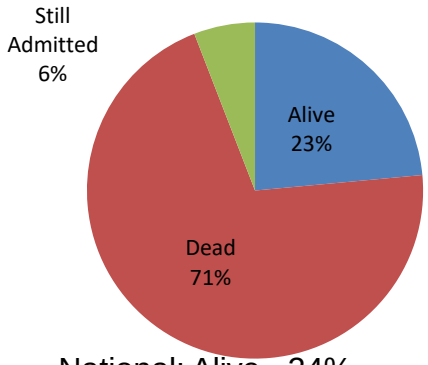
Includes arrests *commencing* in the ED and specialist care areas (i.e. ICU) not included by all trusts

Resuscitation Attempt Outcome



National: ROSC ~50%

Survival to discharge (ROSC patients)

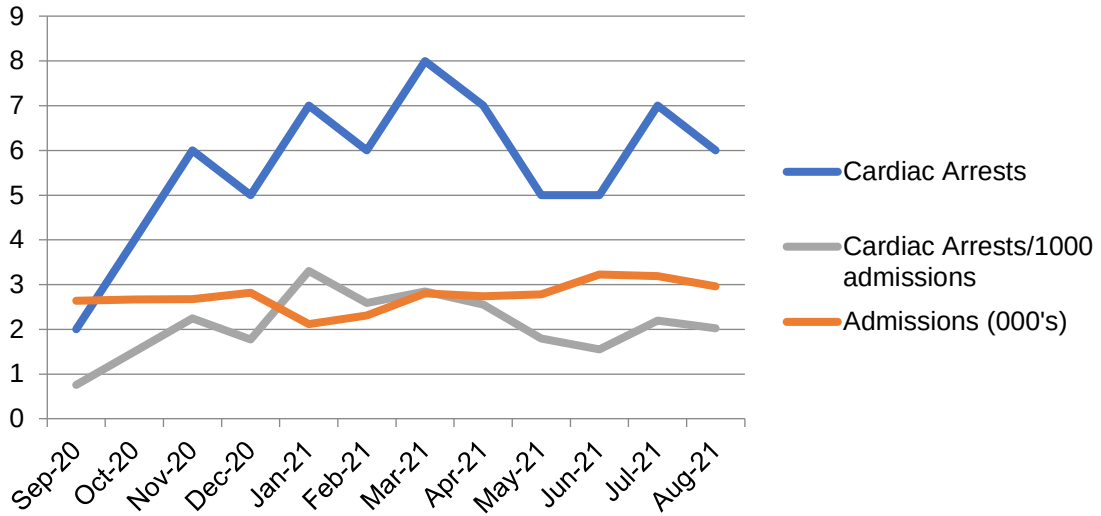


National: Alive ~24%

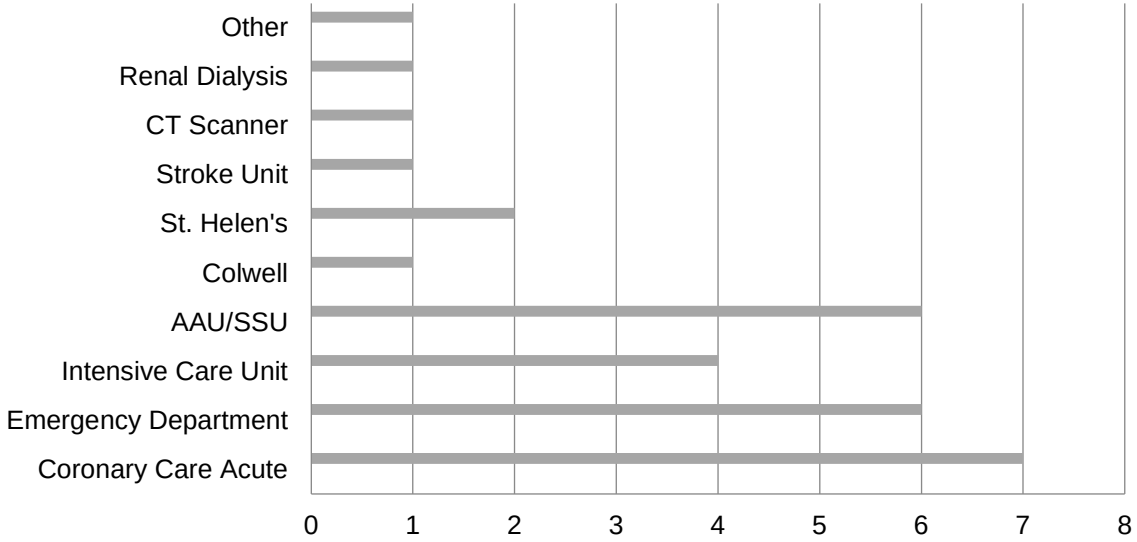
Areas of concern:

- 8 of 30 events (26.6%) have been flagged by the Resuscitation Service as warranting further investigation. There are zero SI's resulting solely from these concerns. 5 events were reviewed locally or otherwise debriefed after concerns were noted.
- Themes arising from these reviews include: failure to effectively and appropriately implement DNACPR decisions, failure to complete observations according to policy, resuscitation not following ALS guidelines

12 month rolling Cardiac Arrest data



Cardiac Arrest Locations



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In hospital Cardiac Arrest Data

Resuscitation Group September 14th

Top 3 risks identified:

- AED Battery shortage-submitted to Trust risk register with mitigation/management plan
- Training compliance data from ESR is unavailable
- COVID & winter pressure foreseeable disruption to services (inc. post IOW Festival increase in cases?)

Top 3 improvements:

- Cardiac arrest and anaphylaxis drugs adapted as per new guidelines/procurement for roll out late Sep/Oct 21
- Relocation of Resuscitation Service on site for training and clinical purposes
- Recruitment of Administrative/Technical Officer to support the Resus Service (initial 1 year fixed term contract for review & extension tbc)

Special mention: addendum to DNACPR policy last year empowering Jnr Doctors (FY2) to record DNACPR decisions (72hr expiry) to protect patients from inappropriate resuscitation attempts-at audit forms recorded by these clinicians were overwhelmingly of a high standard meeting policy requirements

Training Activity April-September 2021

	Max	Booked	Attended	DNA
Grand Total	2150	1405	1107	240
		65%	78%	17%
			51.4%	

Red deterioration on last quarter
Green improvement on last quarter

Adult Mandatory Sessions			Paediatric Mandatory Sessions			Neonatal Mandatory Sessions		
Max	**Booked**	**Attended**	**Max**	**Booked**	**Attended**	**Max**	**Booked**	**Attended**
	60%	79%		55%	77%		53%	95%
		48%			42%			51%

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Trust Incidents

Graph A: the graph below shows the total number of incidents reported by degree of harm, as captured on Datix, and is a comparison between August 2021 data and the same month in the previous year.

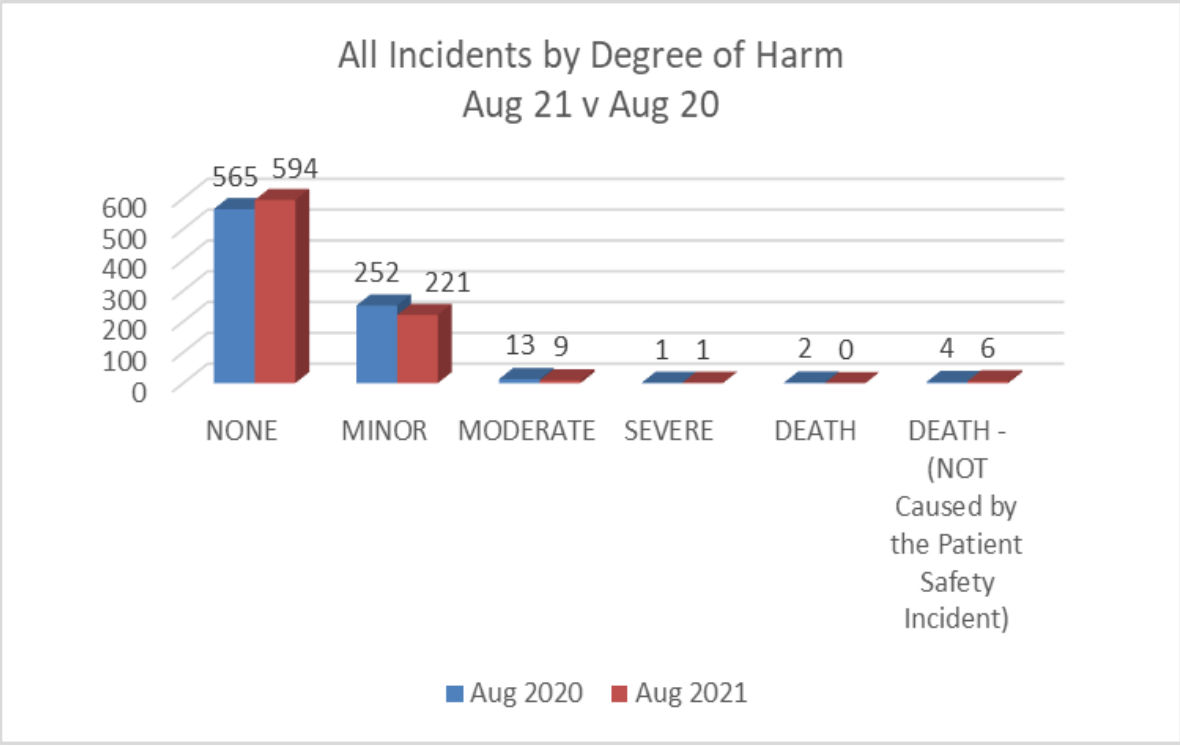

Table 1: Total incidents reported compared to the same month in the previous year:

Total Incidents Reported	
Aug-20	Aug-21
837	831

Table 2: this shows the top 10 categories of reported incidents, compared with the same categories in the same month in the previous year.

Top 10 Categories of all Incidents Reported	Aug-20	Aug-21	RAG
Pressure Ulcer / Moisture Lesion present on admission to IW NHS care	127	95	↓
Patient slip / trip / fall	49	71	↑
Infection Control	12	48	↑
Pressure Ulcer / Moisture Lesion developed under IW NHS care	61	48	↓
Physical or Verbal Abuse	48	38	↓
Information Governance Issues	44	38	↓
Delay in treatment	30	37	↑
Communication Issues	30	37	↑
Admission Issues	19	32	↑
Bed Availability / Capacity	26	26	↔

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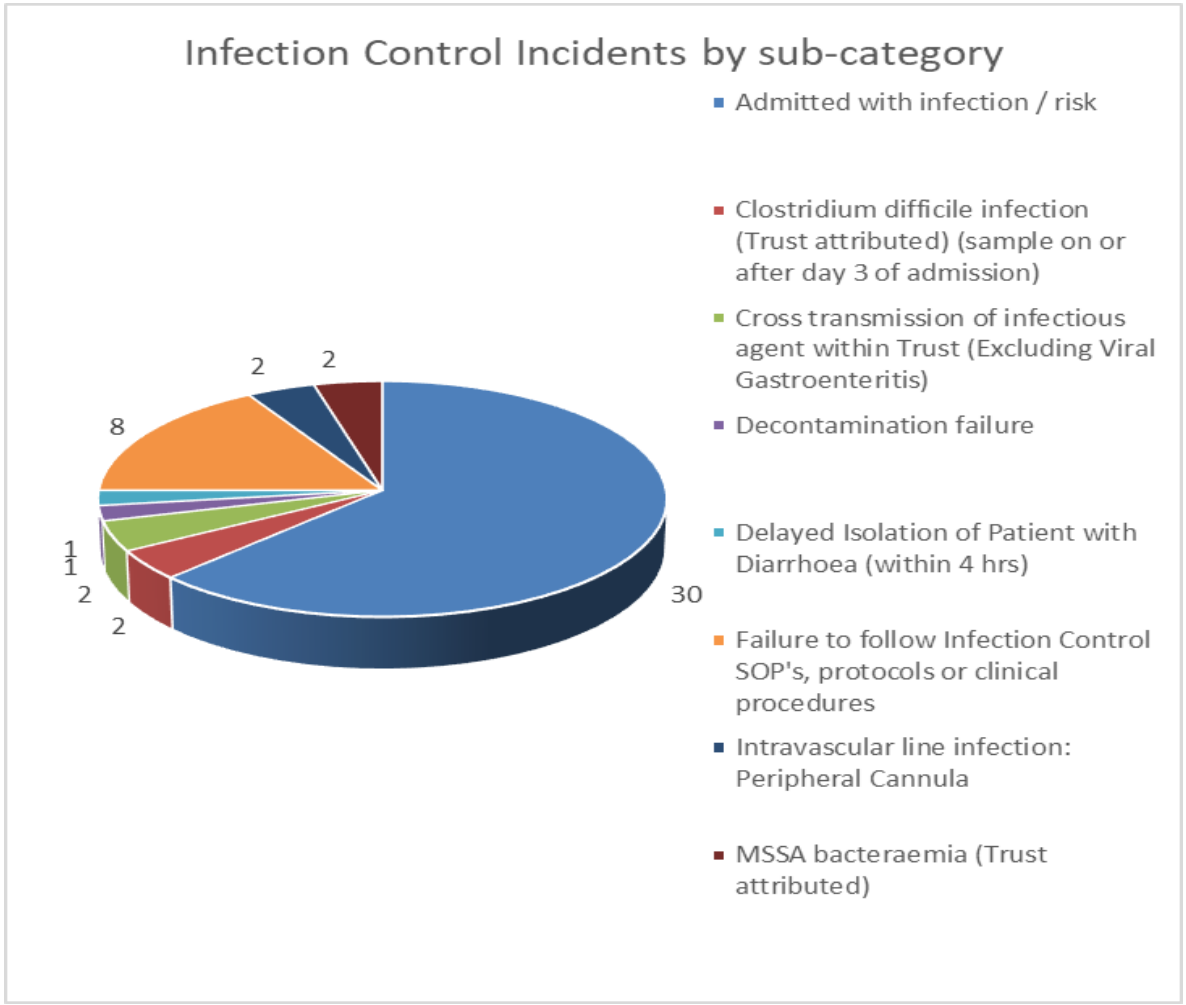
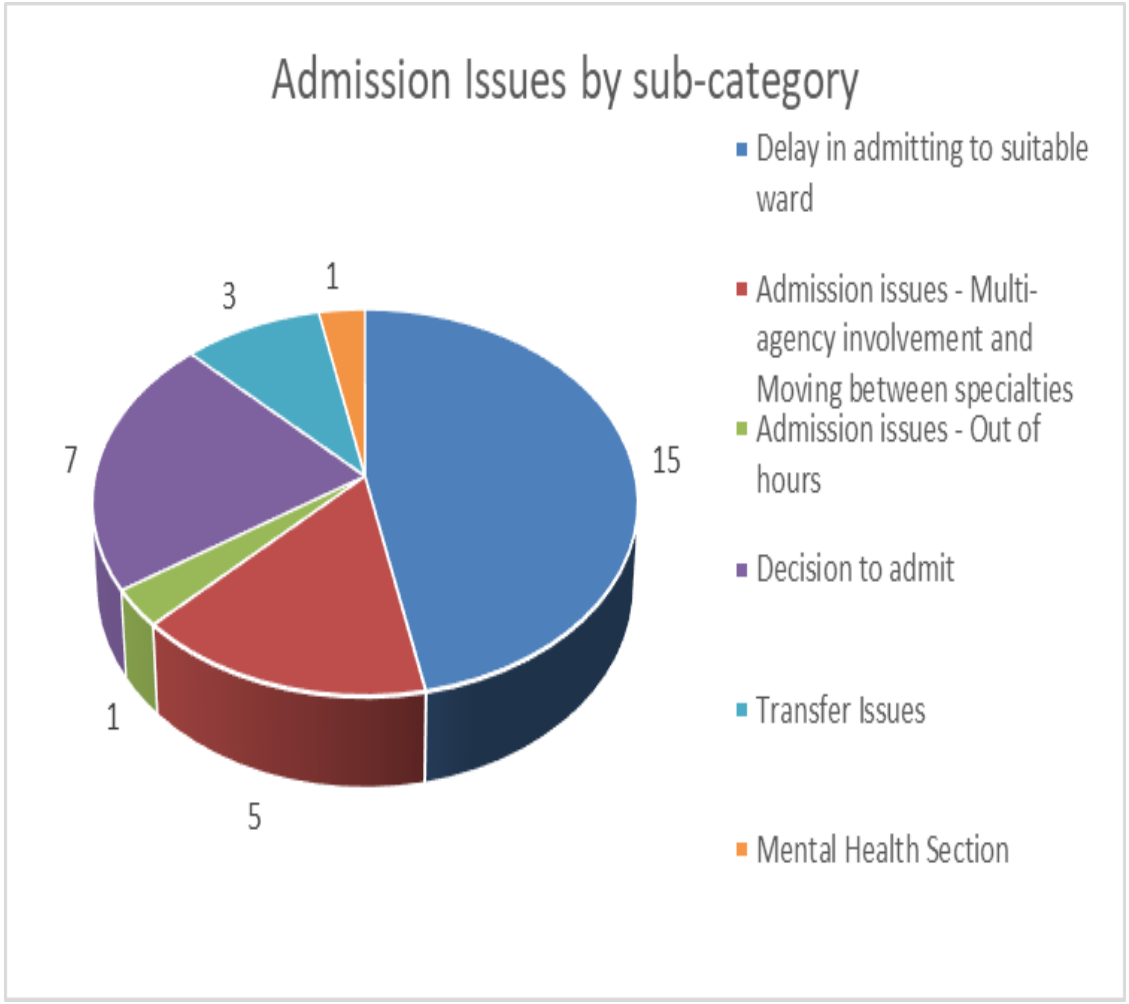
Incidents & Categories

Of the categories with increases, the following 2 graphs give a breakdown of their sub-categories, which are: Infection Control Issues and Admission Issues.





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Serious Incidents, PSIRF and Never Events

Patient Safety Incident Response Framework (PSIRF):

This slide contains incidents relating to August 21 data, which is the fifth month under the early adopter phase of the new Patient Safety Incident Response Framework

PSIIs (patient safety incident investigation)

In August 2021, there were no PSIIs declared.

Never Events

There have been no new Never Events since the one reported in May 2021.

Serious Incident (SI) Cases:

As of 24.09.21 the status of open SI cases under the old SI Framework is as follows:

Open SI cases	Overdue SI cases (not yet with CCG)	Cases with CCG for closure
5 4 are "returners" from CCG 1 is under review outside agreed extended timescale(external IL)	**1**	**7**

Serious Incident (SI) Actions:

As of 24.09.21 the status of open SI actions from across the Trust is as follows:

SI actions	SI actions overdue
10	**0**

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PSIRF update – Service Improvements

Examples of service improvements

- All Trauma/Emergency calls in ED; team members expected to attend and sign in/out after reviewing the patient, regardless if emergency “stood down”
- Introduction of pre-printed procedure-based consent forms that outline risks associated with specific procedures (Gynae)
- Respiratory Service now added to new postal system for outgoing post, to avoid future delays in communications to patients
- All decisions to start non-invasive ventilation to be documented in notes prior treatment starting, to include CXR review.
- Ambulance admission; Standard Operating Procedure being developed to ensure lateral flow tests are completed for patients before leaving ambulance vehicle and patient will remain in ambulance until results known and then transferred according to results
- CCOS to be informed of all tracheostomy/laryngectomy patients within the hospital setting to ensure awareness of the location of these patients and ensure appropriate safety measures are in place.
- For patients having procedure without knowledge of PCR covid result, patient to wear mask to protect other patients – shared at Safety Huddle
- Positive result status not made known when requesting new test - Procedure amended to state ‘check original request form when a positive antibody screen is detected’. Staff will now staple the request form to the worksheet to confirm it has been checked
- Since clustering and aligning to an on-going improvement plan, Maternity have seen a reduction in incidents relating to PPH
- Padlocks now added to external gates in community unit grounds to prevent patients “wandering”
- All beds now purchased by Trust (via Medical Electronics) are “low” beds to reduce risk of falls
- Safety huddle proforma introduced for Labour ward for when patients about to undergo urgent procedure, to improve communication and leadership of event

Central Alert System (CAS) Alerts

Progress

- CAS alerts are not currently being managed in a timely manner.
- At the time of reporting this is the current status of alerts that are on-going.

New Alert Received - None

Ongoing PSA Alerts

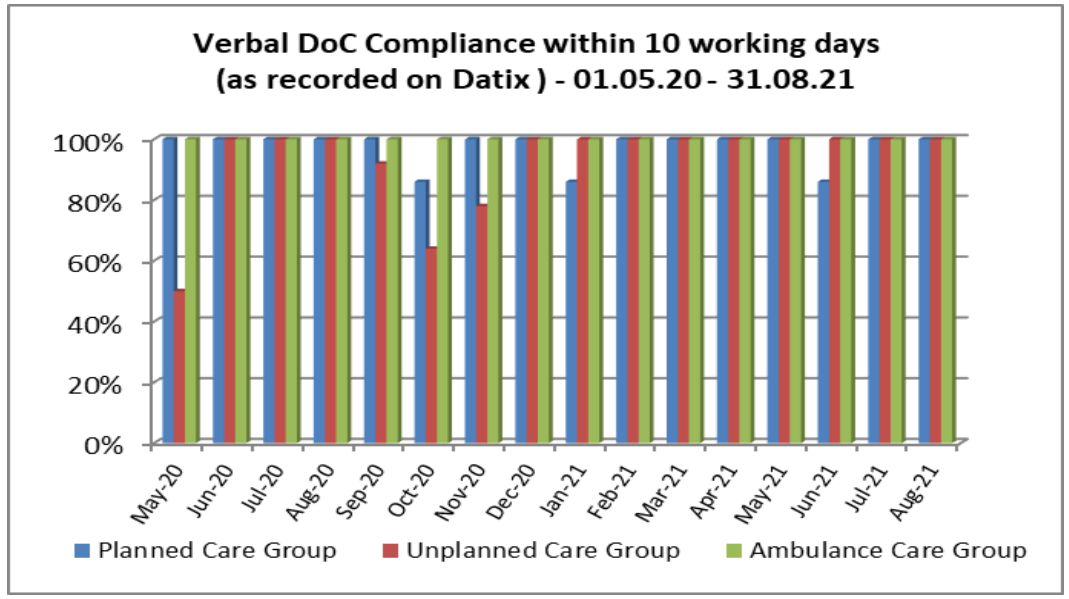
Date Issued	PSA Number	Response Category	Completion By Date	Lead	Alert Description	Action Taken	Current Status
01-09-20	NatPSA/2020/006	Immediate	01-06-21	Kathryn Taylor, Isobel Rice, Oliver Cramer	Foreign body aspiration during intubation, advanced airway management or ventilation.	It is widely acknowledged that it is difficult to be compliant until the market starts producing appropriate product. Added to Risk Register	Overdue
19-05-21	NatPSA/2021/002	Immediate	19-08-21	Immad Qureshi	Urgent assessment/treatment following ingestion of 'super strong' magnets	Still awaiting sign off from Exec.	Overdue
16-06-21	NatPSA/ 2021/003	Action	16-11-21	Nat Ford and Pharmacy	Eliminating the risk of inadvertent connection to medical air via a flowmeter	Areas have been given till 30th September to respond to the emails they were sent. Actions will continue after this date.	Ongoing
24-06-21	NatPSA/ 2021/005	Immediate	17-12-21	Marcia Meaning	Philips ventilator, CPAP & BiPAP: Potential for patient harm due to inhalation of particles and volatile organic compounds.	All actions currently being addressed.	Ongoing
25-08-21	NatPSA/2021/008	Immediate	25-02-22	Steph Stanley	Elimination of bottles of liquefied phenol 80%	Lead is trying to source alternative swabs	Ongoing
25-08-21	NatPSA/2021/009	Immediate	25-11-21	Mary Aubury	Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures	Sent to Lead	Ongoing

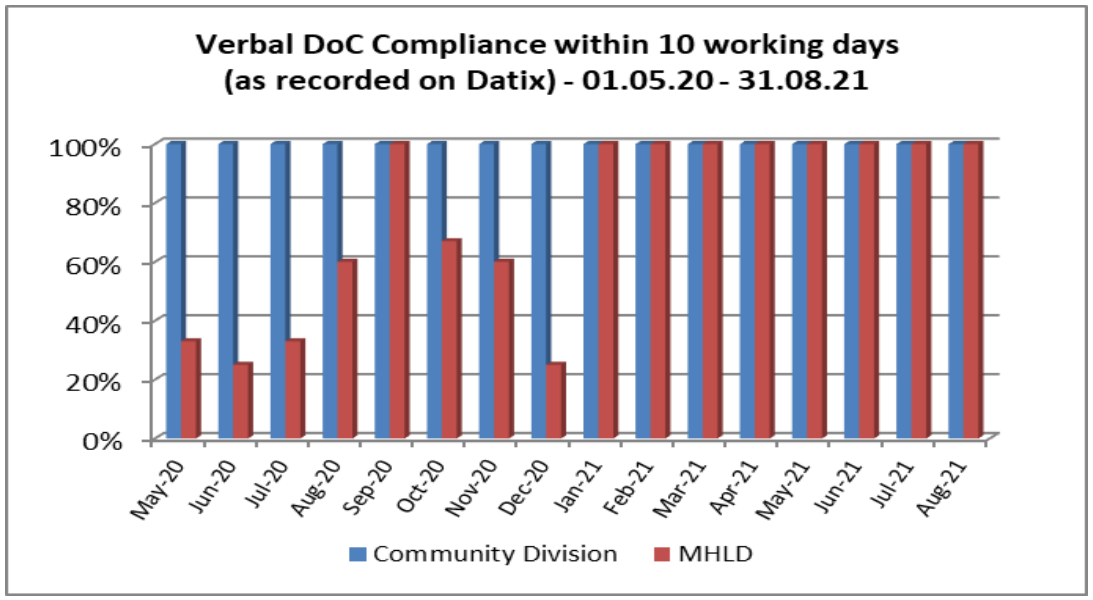
New Supply Disruption Alerts

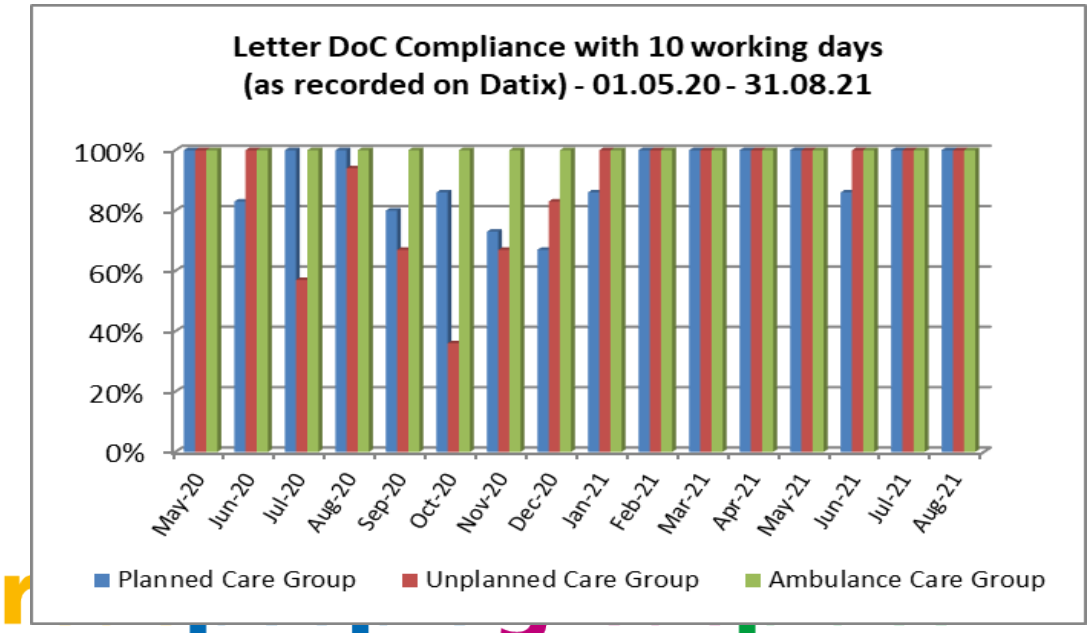
Date Issued	EFA Number	Response Category	Action By Date	Completion By Date	Alert Description	Action Taken	Current Status
26—8-21	SDA 011	Action		21-09-21	Becton Dickinson blood specimen collection – supply disruption	Sent to Path Lab	Completed

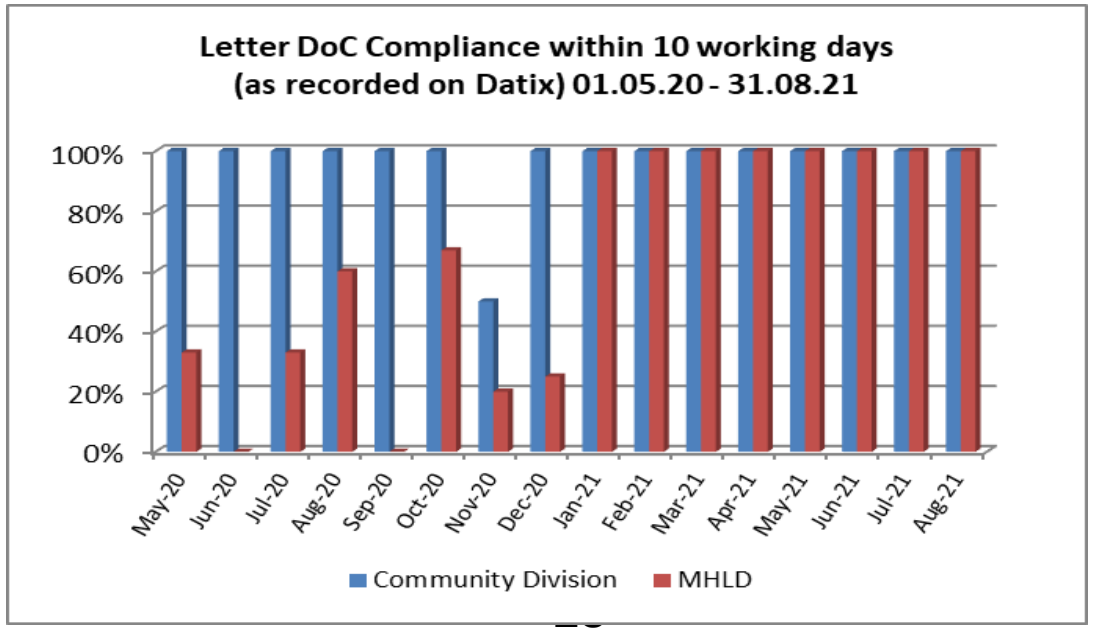
Patient Experience – Trust wide

Duty of Candour Compliance (Trust Compliance target is 95%)



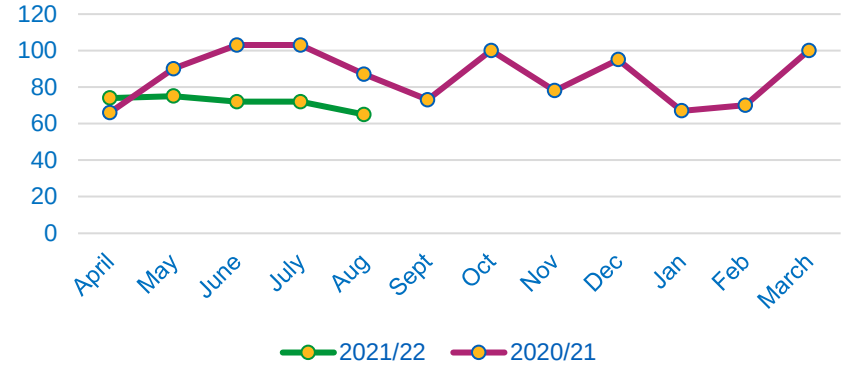




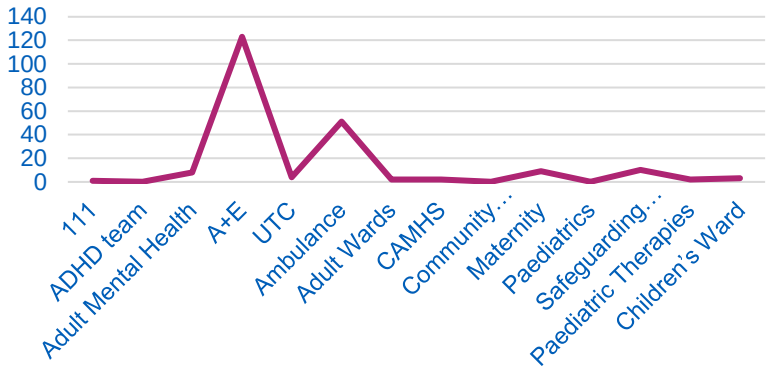


Integrated Safeguarding Report - September 2021

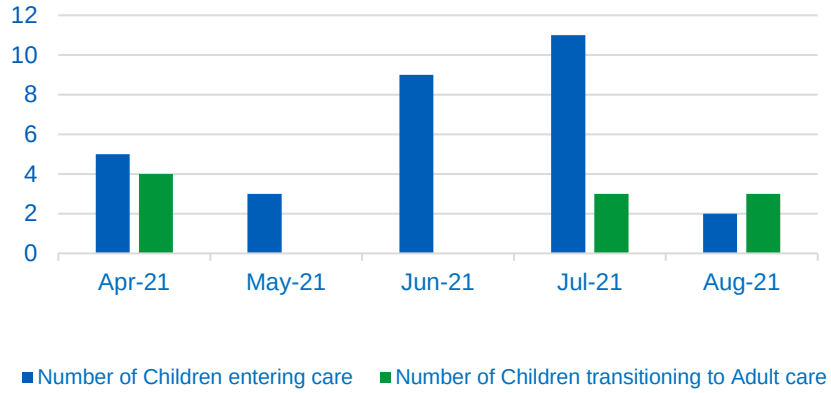
Number of Adult Safeguarding Alerts raised



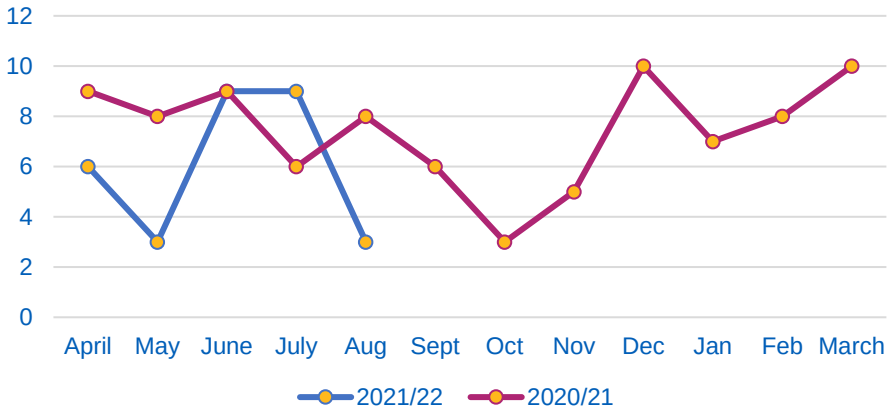
Referrals to MASH April 21 to End of Aug 21



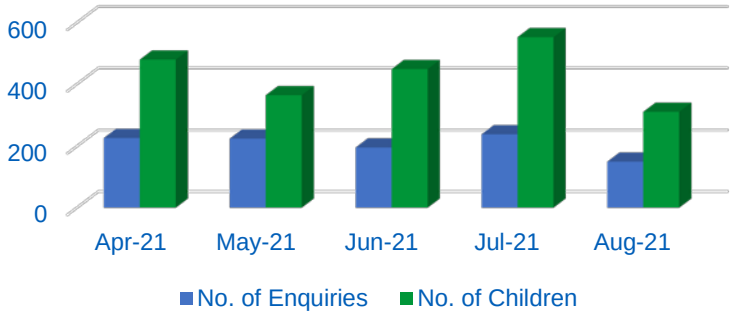
Number of Children Entering Care and Transitioning to Adult Services



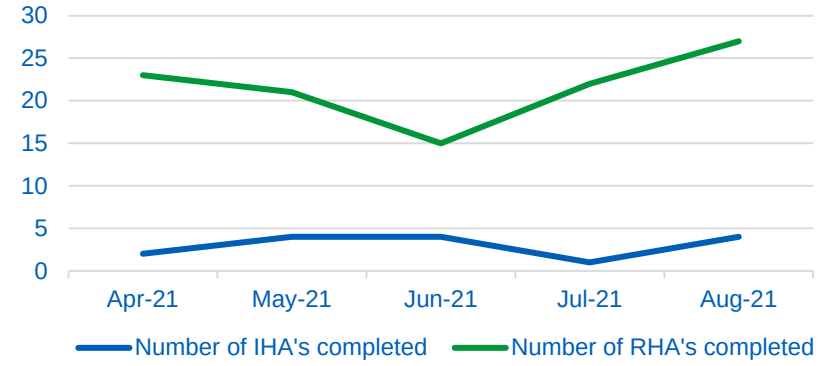
Number of section 42 Enquiries Received



MASH Enquiries made to the Safeguarding Children Team



Number or IHA's and RHA's Completed



IHA – Initial Health Assessment RHA – Review Health Assessment

Child Deaths since April-end of August 21

2 unexpected deaths during this time.

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Complaints Summary:

New Complaints received August 2021 - Total Received: 22

Division	Total complaints received Aug 2021	Total complaints received July 2021 (n=30)
Planned	9	15
Unplanned	10	14
Community	0	1
Ambulance	0	0
MH&LD	3	0
Finance/Estates/IM&T	0	0
Quality Governance	0	0

Returned complaints	5	7
End of life care complaints	**0**	
Dementia complaints	0	

The current status of formal complaints in the Trust as of 4 November 2021 is:

Total open complaints: **93**
Total Overdue complaints: **41 (44%)**

The oldest overdue complaints as of 4 November 2021 are:

- Planned – **130** days overdue (SI requested to be kept open)
- Unplanned – **56** days overdue
- Ambulance – **126** days overdue (awaiting unplanned response)
- MH&LD – **31** days overdue

Weekly Complaint meetings continue to be held with the Acute Division, to enable us to reduce the overdue complaint backlog, and streamline the complaint handling process. The Director of Operations and the Associate Directors of Nursing within the Acute Division are providing additional scrutiny of the investigation and the final complaint response prior to submission to the Chief Executive.

Delays in complaint handling has been discussed at Patient Experience and Safety Sub-Committee, and it has been recognised that some of the delays are due to increased clinical pressures and reduced capacity in the teams responsible for complaint handling.

National Patient Survey: Update

2020 Inpatient Survey

- Survey closed . The response rate for Isle of Wight NHS Trust was 50%. Overall mean response rate for Trusts surveyed was 45%. Detailed Results Tables received and under review. Results due for release October 2021 (tbc)

2021 Mental Health Community

- Fieldwork closed, response rate for Isle of Wight NHS Trust 25%. Overall mean rate for Trust's surveyed 27%. Full Management Report received and shared with MH&LD staff for review and to consider alongside the areas for improvement from previous survey. The expected month of national publication is currently November 2021 (tbc)

2021 Maternity Survey

- As of 20/8/21, the response rate for the Isle of Wight NHS Trust was 41%. Survey results to the Trust in August 2021 with full Management Report due end September 2021.

2020 Mental Health Inpatient Survey

- Survey closed. The final response rate for Isle of Wight NHS Trust was 20%. The overall mean response rate was 22%. Full Management Report to the Trust received 1 June 2021 and being reviewed.

2021 Cancer Patient Experience Survey

- For the first time since 2015, the CPES questionnaire has been extensively redesigned to reflect developments in cancer care and treatment, and national policy. Fieldwork will begin in late October, with results available next year.

Friends & Family Test – overview 1 – 31 August 2021

Please click the above arrow to see the next page of results.

Friends and Family Test Summary (Combined)

NHS Isle of Wight NHS Trust

Showing: Friends and Family Survey Results across all surveys

Start Date: 01/08/2021 **End Date:** 31/08/2021

Data Collection Method

Number of responses received via each mode of collection							
SMS/ Text/ Smartphone app	Electronic tablet/ Kiosk	Paper/ Postcard in care/at discharge	Paper survey sent to home	Telephone survey	Online survey	Other	
0	0	757	0	0	1	0	758

Results by ward/service

Division	Service Area	Ward/ Clinic/ Service	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Acute	Cancer Services	Chemotherapy Unit	100.00%	0.00%	3	3	0	0	0	0	0
	Cardiology	Community Heart Failure	100.00%	0.00%	1	1	0	0	0	0	0
	Critical Care Services	Coronary Care Unit	100.00%	0.00%	2	2	0	0	0	0	0
	Critical Care Services	Intensive Care Unit	100.00%	0.00%	1	1	0	0	0	0	0
	Diabetes Centre and Endocrinology	Diabetes Centre	100.00%	0.00%	66	62	4	0	0	0	0
	Diabetes Centre and Endocrinology	Endocrinology	100.00%	0.00%	38	36	2	0	0	0	0
Acute	Diagnostic Services	Endoscopy	100.00%	0.00%	63	57	6	0	0	0	0
	Diagnostic Services	Breast Screening Unit	100.00%	0.00%	91	85	6	0	0	0	0
	Emergency Department	Emergency Department	93.55%	6.45%	31	27	2	0	0	2	0
	Emergency Department	Emergency Department - Children	100.00%	0.00%	37	35	2	0	0	0	0
	Maternity	Antenatal Services	93.75%	6.25%	16	13	2	0	1	0	0
	Maternity	Postnatal Ward	100.00%	0.00%	16	14	2	0	0	0	0
	Maternity	Labour Ward	100.00%	0.00%	16	13	3	0	0	0	0
	Medical Assessment Unit	Medical Assessment Unit	95.35%	0.00%	43	29	12	2	0	0	0
	Medical Wards	Appley	100.00%	0.00%	5	4	1	0	0	0	0
	Medical Wards	Colwell	90.91%	0.00%	11	9	1	1	0	0	0
	Mottistone Suite	Mottistone Suite	100.00%	0.00%	25	22	3	0	0	0	0
	Outpatients	Fracture Clinic	100.00%	0.00%	20	14	6	0	0	0	0
	Outpatients	Outpatients Department	100.00%	0.00%	9	7	2	0	0	0	0
	Paediatric Services	Paediatric Ward	100.00%	0.00%	20	20	0	0	0	0	0
	Respiratory Services	Respiratory Team - Pulmonary Function and Sleep Laboratory	100.00%	0.00%	14	13	1	0	0	0	0

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Friends & Family Test – overview 1 – 31 August 2021
cont/d

Acute	Stroke Services	Stroke Early Supported Discharge Team (SLSD)	100.00%	0.00%	4	4	0	0	0	0	0
	Stroke Services	Stroke Ward	100.00%	0.00%	9	8	1	0	0	0	0
	Surgical Wards	Alverstone	100.00%	0.00%	14	13	1	0	0	0	0
	Surgical Wards	Lucombe	100.00%	0.00%	11	9	2	0	0	0	0
	Theatre Services	Day Surgery Unit	100.00%	0.00%	30	29	1	0	0	0	0
	Theatre Services	Pre-Assessment and Admissions Unit	98.36%	1.64%	61	57	3	0	1	0	0
	Urgent Care	Urgent Treatment Centre	94.87%	2.56%	39	37	0	1	0	1	0
Ambulance	Community Practitioners	Community Practitioners	100.00%	0.00%	1	1	0	0	0	0	0
	Patient Transport Service (PTS)	Patient Transport Service (PTS)	97.73%	0.00%	44	40	3	1	0	0	0
Community	Frailty Services	Community Rapid Response Team	100.00%	0.00%	11	9	2	0	0	0	0
Mental Health and Learning Disabilities	Mental Health Inpatient Services - Older people	Alton	100.00%	0.00%	5	5	0	0	0	0	0
Mental Health and Learning Disabilities	Mental Health Inpatient Services - Older people	Electroconvulsive Therapy (ECT Clinic)	100.00%	0.00%	1	1	0	0	0	0	0
		Total	98.68%	0.66%	758	680	68	5	2	3	0

Overall Trust satisfaction score – 98.68%

Training on CIVICA has been delivered during August and September to various teams to ensure staff are able to utilise system to full potential. Work continues with CIVICA to ensure system is updated and meets Trust requirements.

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Patient Experience - Initiatives / improvements

- Maturity Matrix Self Assessment for the Trust has been undertaken to identify the areas of focus for the Trust re NHS Complaints Standards Pilot; plan to commence in Mental Health & Learning Disability Division during October 2021
- Approval given to enable recruitment of Main Receptionist – post uploaded to NHS Jobs.
- Volunteer videographer recruited to support filming and editing of Patient Stories for the Board, and this is to be publicised across the Trust
- Hospital website has been updated in conjunction with the Communication Team to ensure hospital MAP is easily located from the Front Page following patient feedback.
- Patient Experience Module on Datix has been revised and is now accessible across Trust – new templates being piloted with Planned Care initially

Volunteer Service update

Number of active volunteers	100
Numbers in recruitment process	17 (8 are Community First Responders, 3 are Chaplaincy)

Current priority roles to fill continues to be :

Family Liaison Volunteers / Ward Helpers
Reception desk / Corridor Marshalls

Other Activity:

- The Service are in communication with the college regarding recruiting Health and Social care students and have been informed there is a high number wishing to apply.

- The Team now have login details for the new database and are pending training in preparation to transfer all volunteer records on to it.

- Essential Items drop off point has been moved to the white tent at the main entrance and is being manned by volunteers and bank staff. This has reduced footfall in to the hospital and has reduced queues at the main reception desk.

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Medical Audit Data – Trust wide

Medical Audit Data 1.8.21 – 31.8.21

(Nb. Those areas in grey are either audits not completed or not applicable)

Compliance Overview

	Antimicrobial Audit	SEPSIS Management Audit	Alert Organism Management Audit	Medication Management Audit	Saving Lives Care Bundle Audit	Saving Lives: Hygiene Audit	Saving Lives: Hand Hygiene Audit	Super Ward Audit Tool	Ceiling of Treatment & Resus Management Audit	Dementia Assessment	Nutrition And Hydration Audit	Total Compliance
AAU		90.00%			77.80%		100%	99.00%	96.20%			98.30%
Alverstone Ward		90.00%			100%		100%	100%				99.50%
Ambulance Station						69.20%						69.20%
Appley Ward		80.00%			100%	84.20%		97.70%	83.90%			95.40%
CCU		83.30%			84.20%	100%	100%	97.00%	88.90%	100%		92.40%
Chemotherapy				100%			100%					100%
Colwell Ward		100%			55.60%		100%	95.50%	98.10%	92.10%	94.30%	94.90%
Compton Ward				97.80%		98.00%		98.50%	100%			98.30%
Day Surgery Unit		100%		100%		100%	96.70%	99.90%				99.80%
ED	100%	70.00%		100%	100%		100%	95.80%				95.70%
Endoscopy Unit				99.20%	100%	100%		98.10%				98.50%
ENT							100%	100%				100%
Fracture Clinic							100%	100%				100%
Infusion Service					100%		100%	96.10%				97.50%
ITU			20.00%	98.10%	93.10%		100%	98.30%	100%	100%	91.40%	96.90%
Luccombe Ward		66.70%			66.70%			97.90%	94.40%			96.90%
Maternity Ward								100%				100%
Mottistone Suite		100%			100%		100%	99.90%				99.90%
Ophthalmology - Main Dept.								91.30%				87.50%
Outpatients - NEW							100%	99.40%				99.40%
Phlebotomy - St Mary's							100%	96.30%				96.40%
PAU							100%	99.70%				99.70%
ECT Clinic							100%	100%				100%
Osborne Ward							100%	96.30%				97.10%
Afton Ward						100%	100%	100%				100%
SSU		20.00%			93.30%		88.90%	99.60%	88.60%			95.80%
St Helen's Ward		92.90%	50.00%	100%	96.90%		98.30%	99.70%	100%	100%	100%	99.50%
Stroke Ward		100%		99.50%	61.10%		93.50%	100%	97.50%	83.30%		98.20%
Anaesthetics								100%				100%
Theatres (Main)								100%				100%
UTC						100%	100%	100%				100%
Wellow Ward					75.00%		100%	99.20%	96.20%			98.40%
Overall Compliance	100%	83.10%	28.60%	99.60%	87.70%	97.50%	97.80%	98.80%	93.50%	94.50%	95.50%	97.90%

Workforce – Trust wide

Corporate Nursing

Nursing fill rates

Of the 18 reporting wards, 25% of these achieved the 90-110% desired fill rate. 17% were above 110% fill rate and 58% were below 90% fill rate. There is work underway between the Deputy Director of Nursing and Governance and the Clinical Lead for E-Rostering to ensure that the bed numbers are correct for each area

Quality metrics

Luccombe record two falls, eight staffing incidents and two official complaints
SSU had one drug error, two official complaints, seven falls and five pressure injuries
Stroke Unit recorded two drug errors, three falls and two pressure injuries
Colwell had 15 falls and one pressure injury. Cluster review will be presented to PSIRF on 28th September, overseen by Alexis O'Shaughnessy. There was no significant harm from any of the falls in August
Appley had two staffing incidents, one complaint, eight falls and ten pressure injuries
ICU had one staffing incident, one drug error and seven pressure injuries
CCU recorded one official complaint
Emergency Department had one staffing incident, three complaints, one drug error and seven falls
AAU had two official complaints
Wellow Unit showed one fall and two pressure injuries
Community unit had one staffing incident, one drug error and seven falls
Seagrove reported one fall
Osborne had two staffing incidents and two falls
Afton had one fall

Care Hours Per Patient Day (CHPPD)

Overall care hours per patient day averaged 15 hours

Mandatory training

Mandatory training reporting is not available this month due to the migration from Pro4 to ESR

Divisional / Care Group Quality Updates

Quality Headlines: Community Division

- ANTT training levels remain good across the Division
- In July there was a total of 101 patient safety incidents reported. 68 (67%) incidents related to pressure injuries. 27 (40%) of the 68 related to pressure injuries that developed or deteriorated under our care. Of 101 incidents, all 101 resulted in minor or no harm.
- The Division has 0 overdue incidents without appropriate mitigation. (at the time the report was pulled).
- The number of falls on the community unit has increased, this is likely due to an increase in acuity and dependency of patients. The unit lead is working with the falls team to cluster, review and develop an action plan.
- KPI's from Mortality Reviews were all 100%
- Division wide MT figures are currently 85%, Information Governance Training is at 88%.
- Use of priorities of care for patients at end of life, solely cared for by Community Division teams has been maintained at 100%.
- FFT across the division has now recommenced this month. Staff and teams are encourage to capture feedback for data analysis.
- Patient Safety Incidents are now also monitored via SPC charts to allow us to identify abnormal reporting levels earlier.
- The new QI Forum commenced last month. The session was well attended and staff have fed back how useful and informative the forum was.

Community Division

Key achievement this period

- **Complaints & Concerns –** We received 4 concerns but one was incorrectly logged which means we had 3 against the divsion, all managed within time and 0 complaints.
- **Mandatory training –** Mandatory training figures remain good during the transition to ESR.
- **Overdue Incidents** – The number of overdue incidents is back to zero without mitigation.
- **QI Forum** – The new QI Forum commenced last month. The session was well attended and staff have fed back how useful and informative the forum was.

Key Risks		Controlling actions
1	Increased demand and vacancy levels could impact on quality of service provided.	• Use of bank and agency staff to cover vacancies and support services with high demand. • Weekly review of Business continuity plans. • Escalation process in place. • Triage process in place. • Services prioritising urgent & high risk patients

Highlights Quality Planned

Key achievements/successes this period

- Confirmation of surgery achieving outstanding in caring and good rating across the majority of other services inspected within planned care
- RSV paediatric escalation plan completed and submitted to CCG
- Colorectal patients are contributing to NHSE elective surgery covid pathway review
- Radiology CQC IRMER inspection – preliminary feedback positive with no significant findings from the inspection but anticipate a number of recommendations will be made.
- Positive pathology ISO accreditation visit with only a few minor non-conformities reported
- Purchase of new DSU trolleys and 2 x cell savers for maternity and general theatres replacing condemned equipment, facilitating compliance with national guidance re: autologous blood transfusion within maternity and for patients from cultures who do not accept traditional blood transfusion and enabling closure of 2 risks on register
- High percentage maternal satisfaction via FFT and Facebook feed
- Establishment of collaborative working between radiology and # clinic supporting improvements in patient flow, social distancing across both departments and improved patient feedback
- Partnership working across trust, tertiary centres and Wessex cancer alliance to facilitate consistency in standards of care and practice and seamless transition between providers
- Introduction of prehab project and integrated working with pre-assessment service to optimise patients in advance of preoperative assessment with aim of reducing number of long waiting patients who are medically unfit for surgery and reducing access delays
- Collaborative working across surgical wards necessary due to the significant change in footprint and subsequent establishment requirements to ensure safer staffing
- Recruitment of 2 X Nurse Associates within planned care surgery and OP areas
- Significant reduction in concerns for ophthalmology associated with timely answering of telephone calls – reduction from 30+ to 8 in past month as result of actions taken and learning from concerns raised
- Confirmed funding from CCG for psychological support for CYP diabetes service improving compliance with national standards and addressing immediate risk from recent peer review.

Highlights Quality Planned

Risk/Concern	Mitigating Action
• Gaps in senior nurse structure within care group due to delays with recruitment, capacity and absence for health reasons impacting on level and quality of professional support and ability to address key governance issues i.e. backlog of complaints and investigations.	Priorities identified for focus – review of roles of existing staff to ensure key areas covered in line with safety, quality and care agenda. Focus on health & well being across the senior team. Options of interim support for theatres being investigated as deemed areas of greatest risk and impact having least senior nursing support. New Head of Nursing commencing in post November '21 and active absence management introduced to support staff and facilitate their return as appropriate.
• Increased pressure on Outpatient waiting areas due to increasing templates, return face to face appts and lack of compliance by public at attendance. Particular risk identified around # clinic and significant increase in templates compounded by walk ins from UTC putting increased pressure on staff, patients and safe social distancing within this area	Risk assessments of all OP waiting areas revisited and reinforced with staff, posters displayed prominently in all areas, collaborative working with security and volunteer teams to mitigate against unnecessary attendance by relatives supporting patients and to support patients to get to clinics, screen now in place in radiology supporting segregation of inpatient and outpatients to improve privacy and dignity, escalation plans in place in ophthalmology and # clinic to be rolled out to other OP areas. Traffic light system in place and reactivated in North corridor. Increased engagement with clinicians to smooth activity in clinics across all sessions to reduce impact of peaks and troughs in activity and overbooking of planned clinics
• Frequent failure of lift(s) leading to St Helens resulting in incidents relating to transfer of patients to and from Wellow and St Helens, delays in surgery and diagnostics and poor patient experience – increasing incidence over past 6 months compounded by delays in engineer support from mainland. Failures on one/both lifts remain a risk until lifts can be replaced	Estates rapid response plan regarding mitigation and access to engineers including sourcing of on island support as interim measure to try to improve timeliness of repairs. Review of admissions to St Helens re: high risk patients if lift failure occurs, contingency plan for transfer of patients from Wellow developed and implemented. Option to consider review of speciality on St Helens proposed given increased risk with emergency patients regarding access to diagnostics and theatre.

Quality Headlines: Acute Division: Unplanned Care

Increased attendance to emergency care. The challenges persists in the Emergency Department and the number of patients attending the ED remains high regularly overcrowding and patients being nursed out of bays. This has impacted our ability to place the right patient at the right place, posing risks to patient pathway leading to non-clinical patient moves.

Covid plans being implemented to manage increase in covid. ICU 2 have been opened successfully to accommodate increased number of covid patients requiring level 3 care. Also increased the capacity for the patients requiring NIV in CCU environment. Two bays have been converted into AGP and staff have been managing this effectively with no outbreaks or increased infections within this area. ED rooms are designated areas for positive patients. There was an outbreak in stroke ward, impacting on the stroke patients pathway, however, this was mitigated by having patients effectively cared for in CCU and the step downs in stroke ward.

Visiting restriction. Due to strict no visiting status (EoL exceptions) the quality of care and experience for those living with dementia or learning difficulties may be impacted. Increased stress and anxiety for patients and families. The telephone enquiry form is continuing to be used. Volunteers being brought in to support family liaison and individuals at this time, including the use of tablets/ facetime with family.

Appley covid ward. Appley ward continues to be the designated covid ward for managing both positive bays and quarantine bays. This creates a greater patient dependence and change of nursing model. Staffing reviewed daily to address enhanced or bay watch needs. All nursing staff are mask fit tested in this area.

Quality indicators – We have seen a decline in pressure ulcers due to increased awareness and education around this topic last month. Falls have increased slightly due to the acuity of patients and the lack of staff available for providing 1:1. HCA shortage remains a concern for the division. We have achieved 100% compliance for Duty of Candour.

Risks – Six outstanding risks have met their target level and been submitted for closure.

Acute Division: Unplanned Care

Key achievements this period

1. Robust and timely response to the covid outbreak in stroke ward. Managed to successfully contain the infection and protect our staff.
2. Continuing decreasing trend in pressure ulcers across the division.
3. Complaints – 30% decrease in patient concerns.
4. Compliance for mask fit testing within the division is high – mostly 100% in all inpatient areas with the exception of few staff members who have access to perso hood.
5. Duty of candour – 100% compliance for all incidents meeting threshold for duty of candour.
6. Mandatory training – mandatory training figures to ward settings remain good.
7. Overdue Incidents – continuing trend in decreasing overdue incidents due to additional support.

Key Risks		Controlling actions
1	**Endoscopy : Demand and Capacity - Significant Waiting List Size (excluding Bowel Screening)**	This is controlled by maximising capacity, regular reviews and (re)prioritization of significant waiting list, additional procedure lists, COVID-19 testing being completed on the day of appointment and increasing substantial staff.
2	**Emergency Department: Symphony data quality issues causing patients to be discharged in error from JAC**	Pharmacy IT systems manager retrospectively reviews the systems twice a day. The pharmacy IT systems manager compares Symphony against JAC every working day to highlight residual patients and deals with them
3	**Cardiology: Community Heart Failure nurse caseload and waiting list size**	The controls on this are the triage of patients, communication with GP's regarding both waiting list and advice for patients that could be seen by alternative services, escalation of situation to CCG, networking with Wessex heart failure group, NHS England, Consultant Cardiologists (both on IOW and QA) and the development of service improvement plan

Quality Headlines: Mental Health & Learning Disabilities Division

➢ All MHLD service lines rated as GOOD by the CQC

- Mental Health Safety Improvement Partnership (MHSIP) supporting QI on Afton ward to reduce restrictive practice linked to personal care of older adults**.**
- Reduction in outliers to Afton ward so ensuring an appropriate patient mix.
- Admission avoidance/DTA is starting to impact positively on the bed state.
- Nurse recruitment in the division with roles being developed to create sustainable nursing workforce. 5 NA's appointed and 5 offers made, 5 RNDA's have job offers and contracts have been issued., UCAS Students - 3 have been appointed.
- Improved Appraisal compliance across the division
- International recruits confirmed to start in the Trust in December 21.
- Community Mental Health Service – 'Enjoying Work Collaborative (RCPsych). Staff are motivated and actively involved in testing change ideas.
- Increase in covid risk assessment completion of staff to 85.5%
- Vaccination clinics for MH inpatients continue weekly.

Mental Health & Learning Disabilities Division

Key Risks		Controlling actions
1	ICT systems - The majority of teams are reporting a high volume of ICT issues.	• Mitigation only in place for some issues. Staff flexing to manager where possible. Transformation Programme Director following up with Information Systems/Information Technology. • Equipment identified for renewal – likely to be upgraded in October/November
2	RMN and Medical Vacancies	• First IR recruitment in December. • Joint work across the ICS to address nurse vacancies . • Some B5 posts converted to B4 Nurse Associates (HTT and Seagrove) • Additional Psychology recruitment to address Must Do for MHLD
3	Appraisals Compliance =Compliance has increased in M5 to 60.69% (43.54%)	• AOM' have been asked to support in developing trajectories
4	Mandatory Training Compliance = M5 compliance is 78%. Any anomalies with the data set will be addressed during September.	• AOM' have been asked to support in developing trajectories • HON undertaking deep dive following ESR roll out. Still unable to undertake due to data migration completing in October 21. • HON and clinical education reviewing training profiles for all roles ongoing in month
5	Supervision compliance remains below target, but is improving with increased oversight , further improvement in M5.	• AOM' have been asked to support in developing trajectories • Division SOP now approved for dissemination
6	Estates work across the division	• Redecoration in Seagrove due to start in October 21 • Work on new Seagrove entrance to be progressed from the end of June 21. • 136 suite works priority following CQC feedback (Must do)

Key achievements this period

- 18 week waiting time target in Memory service improved from 49% to 54% as a result of locum consultant recruited and in post. Improved responsiveness and experience for service users. Nurse Led Assessments to be put in place to support further reduction of the waiting list.
- 2 service users placed in mainland dementia beds have been repatriated to the Island in the month.
- Initial meeting held with team leads from across the division to review required improvements with risk assessment and care planning. (MHLD Must Do.) Small working group developing to work through QI process.
- No gatekeeping breaches in the month which means that any service user being admitted to hospital would have least restrictive options reviewed prior to a bed being allocated.
- We now have Peer Support Workers (PSW) routinely working in the ECT clinic, supporting people before, during and after their treatment. We are the first clinic in the country to introduce PSW to ECT in this way, making us national leaders.
- New restrictive practice report and audit presented and agreed for quarterly reporting.

Quality Headlines: Ambulance Service August 2021

- 0 complaints received in month
- 4 compliments received
- 100% compliance for duty of candour
- Second Critical Care and Transfer Team trial week, attended 50 cases.
- PTS liaison for site team, supporting effective discharge process
- FFP3 testing complete for all available frontline ambulance staff
- Visit by local MP to Hub and Frontline
- Recruited 12 further volunteer Community First Responders
- Successful recruitment of two further clinical advisors for the Hub

great people great place

Ambulance Service- July 2021

Risk/concern		Mitigating actions
1	Sustained increase in demand on service resulting in longer waits for patients, especially category 3 and 4.	• Use of REAP action cards • Continued use of mutual aid form St John Ambulance • Ring fencing Community Practitioners for Cat3&4 to reduce conveyances • Daily tactical brief • Use of officer car to support at times of surge • Use of Community First Responders
2	Loss of skilled/ experienced Paramedics to similar posts in primary care	• Review of out of hours provision • Continue to recruit to vacancy • Increase educational opportunities • Explore joint working opportunities
3		

Ambulance Service August 2021

Key achievements this period

- 100% compliant with duty of candour in month
- 0 formal complaints received for 5 months
- 4 concerns
- 4 compliments received in August
- 111 able to book patients direct to the Emergency department
- Increased access to GP appointments via 111
- 3 further call handlers trained.
- National funding secured for iPads for frontline staff
- Second Critical Care and Transfer team clinical trial week with positive outcomes, seeing around 50 cases and providing a positive impact, especially around enhance analgesia and sedation.
- PGD for use of ketamine signed off.
- Demonstration of Ortivis electronic patient record system

Performance Information

Acute Division Performance Update

Operational Performance Overview Month 6 Sept

Metrics	Latest Period	Target	Month	Last Month	Trajectory
Accident & Emergency:					
4 Hour Performance - All Types (%)	Sep-21	*95%*	79.4%	81.4%	▼
4 Hour Performance - Type 1 (%)	Sep-21	*95%*	66.5%	69.4%	▼
4 Hour Wait Performance - Type 3 (%)	Sep-21	*95%*	100.0%	100.0%	–
12 Hour Breaches (number)	Sep-21	*0*	6	4	▼
Referral to Treatment:					
18 Weeks Incomplete (%)*	Sep-21	92%	63.4%	64.7%	▼
52 Week Waits (number)*	Sep-21	0	558	538	▼
Total Incomplete List Size (number)*	Sep-21	10,884	10,920	10,519	▼
Cancer:					
2 week GP referral to 1st outpatient , cancer (%)*	Sep-21	93%	94.9%	96.0%	▼
2 week referral to 1st outpatient - breast symptoms (%)*	Sep-21	93%	93.1%	100.0%	▼
31 day wait from diagnosis to first treatment (%)*	Sep-21	96%	100.0%	98.7%	▲
62 Day urgent GP referral to treatment for all cancers (%)*	Sep-21	85%	79.6%	78.5%	▲
28 Day Suspected Cancer (%)* **	Aug-21	75%	78.9%	79.9%	▼
Discharge Summaries					
Discharge summaries completed within 3 days of discharge (%)	Sep-21	100%	90.0%	88.5%	▲
Discharge summaries completed within 24 hours of discharge (%)	Sep-21	100%	87.5%	86.8%	▲
Diagnostics:					
%. Patients waiting < 6 weeks for diagnostics*	Sep-21	97%	89.2%	90.1%	▼

** These provisional figures and are therefore subject to further validation and may change.*

Improved ▲
Same –
Worse ▼

Highlights Operational Performance Month 6 Sept 21

Risk/Concern	Mitigating Action
Delivery of the emergency care standard due to lack of flow out of the department. No available bed capacity is causing long delays for patients waiting to be admitted. This has meant that patients have been accommodated overnight in the ED while waiting for a bed.	Additional capacity has been created on Compton ward and a further 8 beds held in reserve Additional support to ED to help meet additional demand SDEC development programme designed to pull activity from the ED department Daily bed and senior operational meetings Escalation plans reviewed with systemwide partners. Fit to Sit and Frailty areas converted into bedded accommodation to ensure patients have a bed in the department while waiting for admission over night.
Increasing numbers of patients presenting as COVID positive High numbers of inpatients quarantining in hospital as exposed to COVID – inability to discharge these patients to Care Homes or for Packages of care until 14 day quarantining period complete Staff isolation following notification from the NHS Track and Trace App, affecting operational capacity delaying treatments and services to patients	Daily IPC meetings to ensure safe management of patients with COVID Dedicated wards and quarantine areas established 2 ICU opened to ensure safe delivery of care to all patients Fast track PCR Testing available to staff to return to work within revised guidelines Closely monitoring staff sickness Senior Clinical and Operation review of daily management of patients
The number of medically optimised patients in the hospital is increasing. On average there are 50 patients waiting for packages of care or short term placement. Care sector reporting inability to recruit and retain staff. This situation is likely to continue for sometime and may deteriorate further as Care Staff unvaccinated leave. This delays patients going home and or to most appropriate care setting and prevents patients being admitted leading to congestion in the ED department.	Daily review of bed base and altered according to need System wide meeting to review capacity in social care – daily management meetings and twice weekly Gold System Wide meetings. Funding application to system to further increase capacity in the community Roll out of electronic patient management system to support more patients at home. Joint recruitment strategy between health and social care being developed Escalation to ICS and NHS I / E On going support for the ED Additional beds – mitigations outlined above are leading to increasing pressure on the unplanned budget.
Emergency Admissions are increasing – 206 more admission in August 21 compared to same period 2019, this means the trust requires an additional 40 beds to manage these additional admissions, and compromises all of the above.	Medical Director is leading a review of admissions to provide further information on reasons for increase in admission.

Highlights Operational Performance Month 6 Sept

- ED overall performance in September was 79.4% compared to 81.4% for August. The Emergency Care Standard Performance has declined in line with increased bed occupancy since mid June 2021. The mean number of patients requiring emergency care attendance remains relatively static, however emergency admissions continues above 100% in comparison to 2019 data. The number of patients who have a length of stay over 21 days has more than doubled from June 2021 to date. Performance continues to be significantly impacted by the issues outlined in the risks on the previous slide. These risks are preventing timely flow through the hospital and cause considerable congestion in the ED. We continue to progress with the mitigating actions.

- Elective activity volumes continue to deliver across all 4 areas shown below, whilst supporting the ICU COVID-19 workforce requirements

Area	Variance % of 19/20 for September
Outpatient Activity	98.8%
Day Case Activity	114.3%
Inpatient Activity	108.5%
Diagnostic Activity	122%

- RTT incomplete performance reduced slightly to 63.4% from 64.7% at an aggregate level.

- 52 week waits marginally increased by 20 patients to 558, following a reduction from 1128 in March 2021

- DMO1 6 week diagnostic standard for September reduced to 89.2% from 90.1%.
  Endoscopy, Echocardiogram, and Urodynamics for both gynae and Urology remain key areas of challenge

- Finalised Cancer Performance for August reports achievement of all core standards with the exception of 62day FDT, 78.5% against the standard of 85% 10 Breaches 7 local breaches, 3 tertiary. Further details can be seen in slide 9.
- September Provisional Cancer performance highlights achievement of all core standards with the exception of 62 day FDT, snapshot performance for Month 6 records 79.6% against a standard of 85%, this is forecast to improve to 81.58% *subject to shared provider uploads*
- Total Cancer PTL size increased in September to 553 patients from 516 +37, Breast and Urology experienced an increase in 2ww demand exceeding pre covid values. Both teams are providing additional capacity with support from imaging where required
- Patients waiting above 62 days increased to 50 from 31 in August up by 19. Tumour site specific recovery plans are in progress with H2 Trajectories shared with the Wessex network
- The number of patients waiting over 104 days reduced to 6 patients, down 3 from August. All patients are diagnosed and have a clear plan to progress their pathway

Recovery Programme

Figures below provide an overview of activity restoration against the same period as 2019

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD	From w/e To w/e	26-Sep-21 17-Oct-21
Total Referrals	6,586	6,503	7,218	6,731	5,906	6,339	-	-	-	-	-	-	39,283		5,400
% Variance 19/20	102.7%	101.4%	112.5%	104.9%	92.1%	98.8%	-	-	-	-	-	-	102.1%		81.2%
Total Outpatients	13,144	12,879	14,637	13,458	12,342	13,253	-	-	-	-	-	-	79,713		11,632
% Variance 19/20	98.7%	98.2%	121.7%	93.6%	99.9%	100.1%	-	-	-	-	-	-	101.6%		84.8%
% Virtual Activity	30.3%	25.4%	23.9%	23.9%	23.7%	23.0%	-	-	-	-	-	-	25.0%		21.2%
Diagnostic	3,651	3,793	4,137	3,905	3,813	3,978	-	-	-	-	-	-	23,277		3,727
% Variance 19/20	107.0%	107.0%	118.0%	111.0%	107.0%	122.0%	-	-	-	-	-	-	111.9%		116.7%
Endoscopy	508	439	489	511	412	482	-	-	-	-	-	-	2,841		462
% Variance 19/20	86.2%	79.7%	85.8%	81.2%	74.6%	78.6%	-	-	-	-	-	-	81.1%		93.9%
Day Cases (DC)	897	880	1,058	1,081	1,048	1,037	-	-	-	-	-	-	6,001		977
% Variance 19/20	105.8%	109.7%	130.5%	108.3%	113.9%	114.5%	-	-	-	-	-	-	113.5%		105.9%
Inpatient Elective (EL)	125	123	150	164	125	140	-	-	-	-	-	-	827		130
% Variance 19/20	99.2%	93.9%	118.1%	105.8%	91.9%	107.7%	-	-	-	-	-	-	102.7%		89.7%
ED Attendances	4,645	5,238	5,624	5,931	5,622	5,370	-	-	-	-	-	-	32,430		4,761
% Variance 19/20	92.9%	104.3%	115.6%	110.3%	101.4%	110.1%	-	-	-	-	-	-	105.7%		110.9%
ECS Performance	95.3%	97.6%	89.4%	88.3%	81.4%	79.5%	-	-	-	-	-	-	88.4%		78.9%
Inpatient Emergency	1,477	1,624	1,727	1,647	1,545	1,510	-	-	-	-	-	-	9,530		1,406
% Variance 19/20	107.5%	119.5%	127.3%	114.7%	110.8%	107.7%	-	-	-	-	-	-	114.5%		112.3%
% Same Day	22.1%	21.3%	22.5%	21.6%	16.8%	16.5%	-	-	-	-	-	-	20.2%		16.4%
Waiting List	9,987	10,187	10,069	10,041	10,380	10,839	-	-	-	-	-	-	10,251		10,863
% 52+ Week Waits	9.6%	6.9%	5.2%	5.0%	4.9%	5.1%	-	-	-	-	-	-	6.1%		5.0%

Relative Performance

Recent report released by the ICS information team indicates that the Trust is doing well compared to others in two key indicators

Patients waiting more then 100 weeks

Priority 2 patients (urgent) waiting more than 5 week for procedure

	IOW	HHFT	PHT	UHS FT
104 week waits P1-4s	0	6	1	133
P2 patients waiting over 5 weeks	26	96	317	763
P2 waiting over 5 weeks % of total wait list	25%	53%	39%	64%

Emergency Care Activity September 2021

Isle of Wight NHS Trust

ED Activity headlines for week ending 26 Sep 21

		% Variance to Two Years Ago	
		This Week	Previous 4 Weeks
Total ED Attendances	1,299	121%	105%
ECS Performance		80.4%	79.8%
% ED Attendances resulting in Admission		22%	20%
ECS Performance Forecast for Sep 21		79.5%	

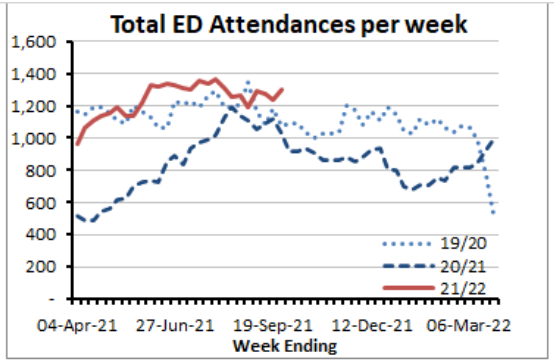
ED activity 1,299 are (121%) of the level seen in the same period two years ago and 50 higher than the average for the last 4 weeks. ECS performance 80% this week and 80% on average over the previous 4 weeks. Current forecasts indicate ECS Performance Forecast for Sep 21 Target will not be achieved

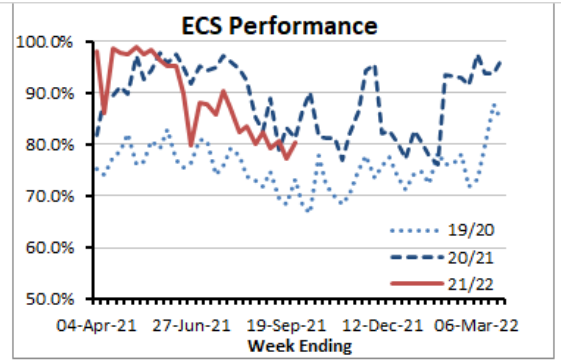
Previous Week

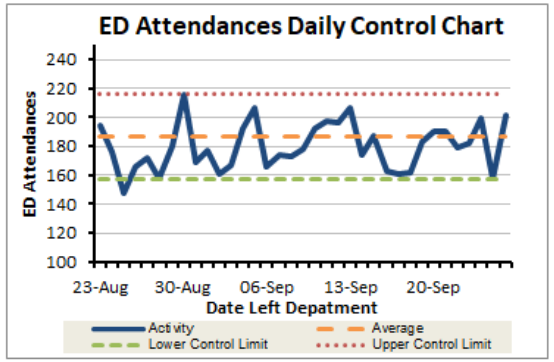
	29-Sep-19	26-Sep-21	% Variance
Total ED Attendances	1,077	1,299	121%
Type 1	917	801	87%
Type 3	160	498	311%
ECS Performance	73.2%	80.4%	
Admissions via ED	170	275	162%
% Admissions	16%	22%	

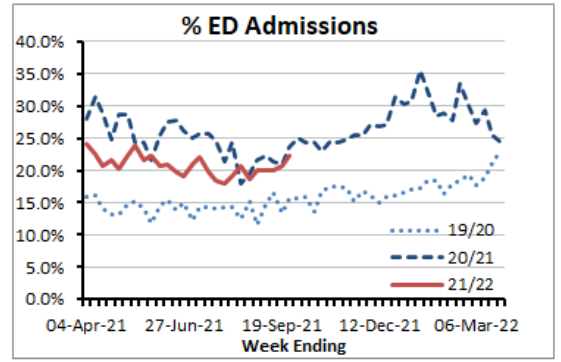
Previous 4 Weeks

	ED Attendances	ECS Performance	Admissions via ED	% Admissions
2 Years Ago	4,774	71.2%	667	14%
01-Sep-19	1,350	71.9%	157	12%
08-Sep-19	1,162	74.6%	172	15%
15-Sep-19	1,083	69.6%	179	17%
22-Sep-19	1,179	68.4%	159	13%
Current Year	4,996	79.8%	1,005	20%
29-Aug-21	1,194	82.2%	239	20%
05-Sep-21	1,289	79.4%	257	20%
12-Sep-21	1,276	80.7%	254	20%
19-Sep-21	1,237	77.1%	255	21%
% Variance	105%			

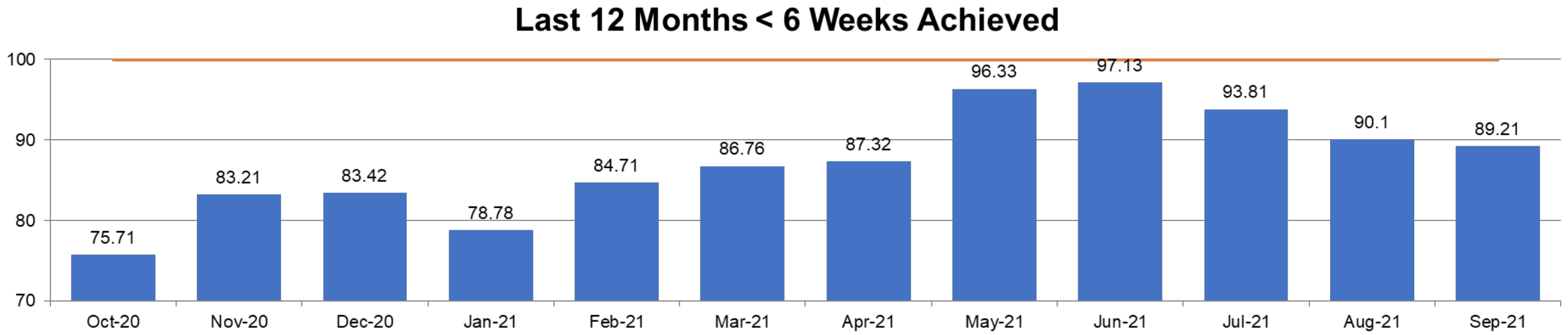








Diagnostics Data – September 2021



Area	Service	Apr-21			May-21			Jun-21			Jul-21			Aug-21			Sep-21		
		WL	6+ Wks	% <6 Wks	WL	6+ Wks	% <6 Wks	WL	6+ Wks	% <6 Wks	WL	6+ Wks	% <6 Wks	WL	6+ Wks	% <6 Wks	WL	6+ Wks	% <6 Wks
Imaging	Magnetic Resonance Imaging	222	0	100.0%	213	0	100.0%	296	0	100.0%	334	0	100.0%	354	4	98.9%	290	1	99.7%
	Computed Tomography	368	1	99.7%	237	0	100.0%	383	0	100.0%	403	0	100.0%	350	0	100.0%	377	2	99.5%
	Non-obstetric ultrasound	457	0	100.0%	499	0	100.0%	533	0	100.0%	631	0	100.0%	642	11	98.3%	702	16	97.7%
	Barium Enema	0	0		0	0		0	0		0	0		0	0		0	0	
	DEXA Scan	0	0		0	0		0	0		0	0		0	0		0	0	
Physiological	Cardiology - echocardiography	155	92	40.6%	110	14	87.3%	117	8	93.2%	121	7	94.2%	95	21	77.9%	126	35	72.2%
	Neurophysiology - Nerve conduction studies	18	0	100.0%	13	0	100.0%	33	1	97.0%	51	0	100.0%	46	0	100.0%	35	0	100.0%
	Respiratory physiology - sleep studies	28	0	100.0%	8	0	100.0%	26	0	100.0%	44	0	100.0%	26	0	100.0%	30	2	93.3%
	Urodynamics - pressures & flows - Urology	6	1	83.3%	33	3	90.9%	19	5	73.7%	11	1	90.9%	27	0	100.0%	41	10	75.6%
	Urodynamics - pressures & flows - Gynae	11	4	63.6%	13	5	61.5%	10	3	70.0%	8	0	100.0%	14	0	100.0%	28	20	28.6%
Endoscopy	Colonoscopy	155	65	58.1%	113	18	84.1%	176	15	91.5%	171	47	72.5%	197	88	55.3%	121	42	65.3%
	Flexi sigmoidoscopy	54	30	44.4%	57	4	93.0%	66	15	77.3%	65	14	78.5%	81	44	45.7%	95	45	52.6%
	Cystoscopy	23	1	95.7%	34	3	91.2%	27	1	96.3%	75	53	29.3%	53	16	69.8%	56	23	58.9%
	Gastroscopy	104	9	91.3%	88	5	94.3%	127	4	96.9%	121	4	96.7%	115	14	87.8%	175	28	84.0%
	Total	**1601**	**203**	**87.3%**	**1418**	**52**	**96.3%**	**1813**	**52**	**97.1%**	**2035**	**126**	**93.8%**	**2000**	**198**	**0.901**	**2076**	**224**	**0.8921**

* These are provisional figures and are therefore subject to further validation and may change.

Cancer Performance as at August 2021

2020/21 Updated from NHS Digital 6 month refresh

		Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
14 days to first seen	Suspected cancer	93%	87.3%	89.7%	94.9%	95.4%	93.5%	95.8%	95.3%	93.5%	94.0%	95.8%	95.6%	97.8%	97.4%	97.3%	94.1%	95.2%	96.0%
	Breast symptomatic	93%	91.7%	100.0%	97.7%	100.0%	97.1%	97.9%	95.1%	95.0%	93.3%	95.6%	97.9%	97.8%	93.3%	100.0%	96.2%	91.4%	100.0%
28 days to diagnosis		75%	53.1%	68.6%	71.9%	81.4%	75.8%	69.2%	75.7%	71.6%	71.0%	64.9%	73.4%	77.6%	77.4%	82.9%	82.9%	79.9%	78.9%
31 days decision to treatment	First treatment	96%	100.0%	90.7%	94.8%	95.9%	98.5%	97.7%	97.9%	98.0%	100.0%	100.0%	98.6%	98.9%	98.7%	97.5%	98.8%	100.0%	98.7%
	Subsequent surgery	94%	87.5%	100.0%	85.2%	96.0%	100.0%	88.9%	75.0%	95.2%	100.0%	77.8%	100.0%	100.0%	91.7%	100.0%	100.0%	90.9%	100.0%
	Subsequent drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 days referral to treatment	Urgent GP referral	85%	69.3%	56.5%	70.4%	83.1%	83.6%	81.4%	68.1%	65.1%	74.3%	65.6%	76.7%	76.1%	91.5%	87.0%	75.5%	88.4%	78.5%
	From screening	90%	100.0%	25.0%	40.0%	No Patients	60.0%	66.7%	100.0%	95.5%	100.0%	100.0%	100.0%	88.2%	83.3%	76.2%	89.5%	75.0%	66.7%
	Consultant upgrade		100.0%	100.0%	80.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%	No patients	100.0%	No pts	100.0%	100.0%	100.0%

Key Messages:

Improvement across 2 key areas during August

1. 2ww performance -6 breaches compared to July
2. 2wwBreast Symptomatic – zero breaches compared to 5 in July
3. 28 Day – 17 breaches compared to 93 in July
4. 28 Day - Cancer Screening Programme – zero breaches compared to 28 in July * PHU Bowel Screening data activity change , resulting in 100% compliance

The 85% 62 Day FDT standard was not met in August due to 10 Breaches [7 local reasons given below and x3 Tertiary]. Without the local breaches there were 46.5 treatments undertaken and with just the 3 tertiary breaches this would have results in performance of 93.5%

1 x due to Patient choice and change of treatment plan
1 x Elective capacity inadequate
1 x Delay to local investigation (EUA)
1 x complex diagnostic pathway
3 x due to complex diagnostic pathway, delay to tertiary centre investigation, Delay to local investigation (TP biopsy)

COVID Update as at 10 October

Isle of Wight NHS Trust

COVID Metrics Headlines

Last updated on Sunday 10 October 2021 at 4:20pm

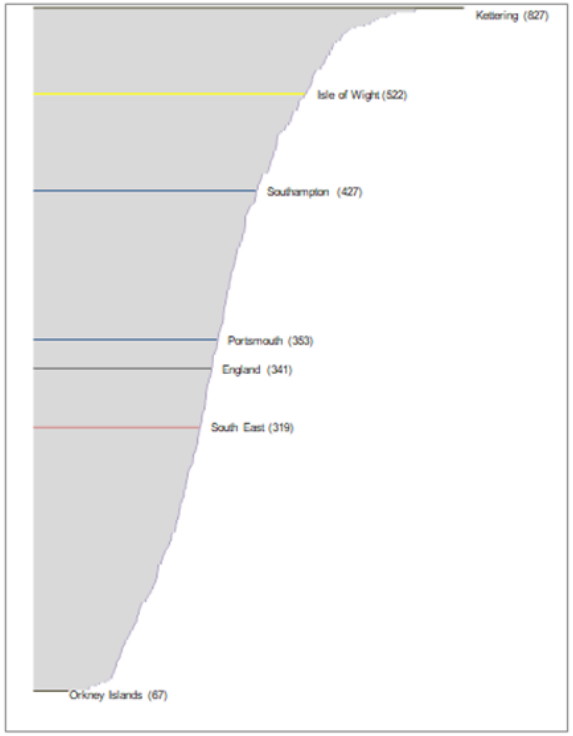
	Isle of 'Wight	South East Region	England
COVID Cases per 100,000 Population	522.2	318.7	341.3

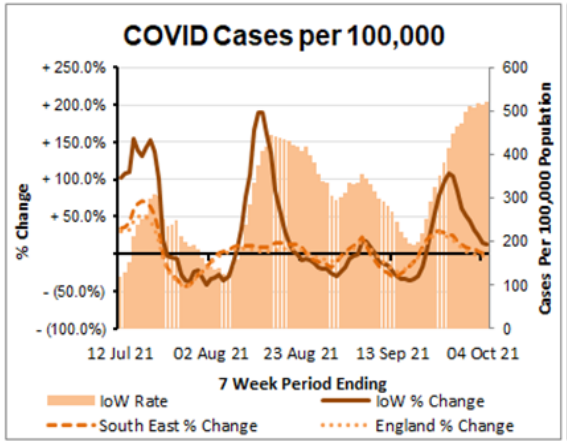
	As at 05 Oct	Previous Week	Growth
Cases per 100,000 Population (Age 0-59)	759.0	664.3	+ 95
Cases per 100,000 Population (Age 60 +)	104.8	110.6	- (6)
New Cases reported on specimen date	88.1	102.6	- (14)

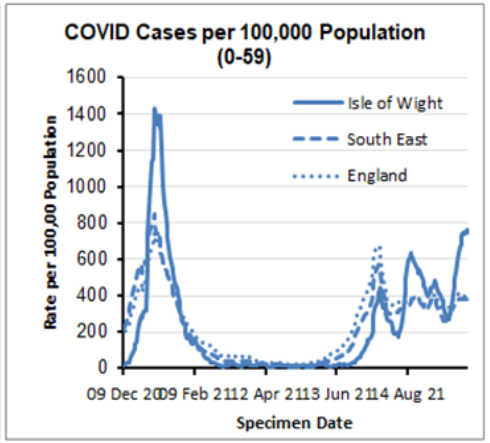
Rolling 7 Day Value	7 Days Ending 06-Apr	Previous 7 Days	Growth
Average New People Tested	3,736	4,254	- (51'8)
Average New Cases Reported	21	22	- ('1)
% Positive Cases	0.6%	0.5%	+ 0.0%

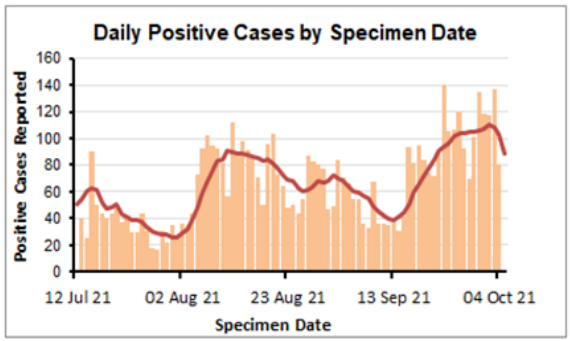
Data taken from .gov COVID website

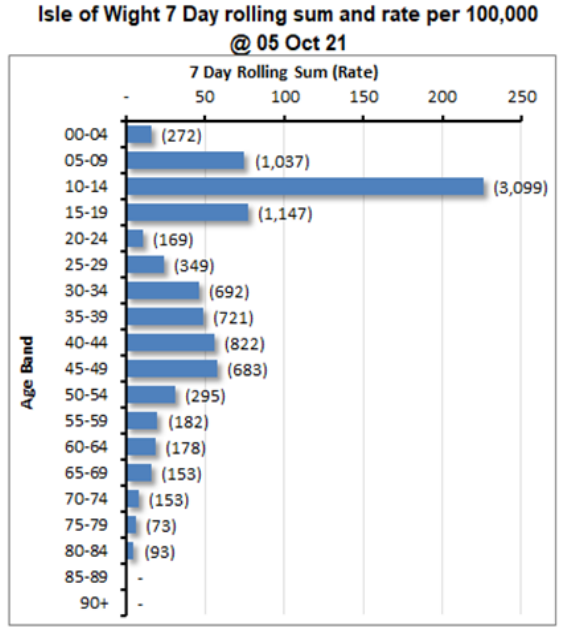
COVID Cases (Last 7 Days)

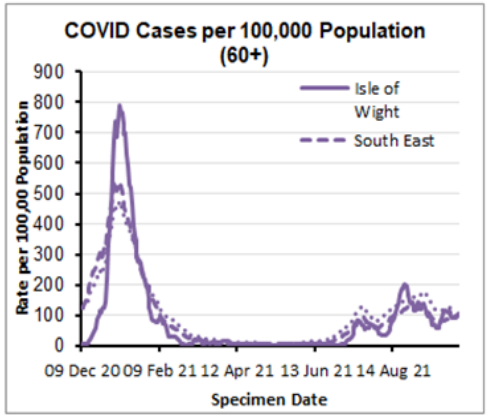












Highlights Quality Acute Month 6 September 2021

Risk/Concern	Mitigating Action
• Gaps in senior nurse structure within care group due to delays with recruitment, capacity and absence for health reasons impacting on level and quality of professional support and ability to address key governance issues i.e. backlog of complaints and investigations.	Priorities identified for focus – review of roles of existing staff to ensure key areas covered in line with safety, quality and care agenda. Focus on health & well being across the senior team. Options of interim support for theatres being investigated as deemed areas of greatest risk and impact having least senior nursing support. New Head of Nursing commencing in post November '21 and active absence management introduced to support staff and facilitate their return as appropriate.
• Increased pressure on OP waiting areas due to increasing templates, return F2F appts and lack of compliance by public at attendance. Particular risk identified around # clinic and significant increase in templates compounded by walk ins from UTC putting increased pressure on staff, patients and safe social distancing within this area	Risk assessments of all OP waiting areas revisited and reinforced with staff, posters displayed prominently in all areas, collaborative working with security and volunteer teams to mitigate against unnecessary attendance by relatives supporting patients and to support patients to get to clinics, screen now in place in radiology supporting segregation of inpatient and outpatients to improve privacy and dignity, escalation plans in place in ophthalmology and # clinic to be rolled out to other OP areas. Traffic light system in place and reactivated in North corridor . Increased engagement with clinicians to smooth activity in clinics across all sessions to reduce impact of peaks and troughs in activity and overbooking of planned clinics
• Frequent failure of lift(s) leading to St Helens resulting in incidents relating to transfer of patients to and from Wellow and St Helens, delays in surgery and diagnostics and poor patient experience – increasing incidence over past 6 months compounded by delays in engineer support from mainland. Failures on one/both lifts remain a risk until lifts can be replaced	Estates rapid response plan regarding mitigation and access to engineers including sourcing of on island support as interim measure to try to improve timeliness of repairs. Review of admissions to St Helens re: high risk patients if lift failure occurs, contingency plan for transfer of patients from Wellow developed and implemented. Option to consider review of speciality on St Helens proposed given increased risk with emergency patients regarding access to diagnostics and theatre.

Highlights Quality Month 6 September 2021

Key achievements/successes this period

- Confirmation of surgery achieving outstanding in caring and good rating across the majority of other services inspected within planned care
- RSV paediatric escalation plan completed and submitted to CCG
- Colorectal patients are contributing to NHSE elective surgery covid pathway review
- Radiology CQC IRMER inspection – preliminary feedback positive with no significant findings from the inspection but anticipate a number of recommendations will be made.
- Positive pathology ISO accreditation visit with only a few minor non-conformities reported
- Purchase of new DSU trolleys and 2 x cell savers for maternity and general theatres replacing condemned equipment, facilitating compliance with national guidance re: autologous blood transfusion within maternity and for patients from cultures who do not accept traditional blood transfusion and enabling closure of 2 risks on register
- High percentage maternal satisfaction via FFT and facebook feed
- Establishment of collaborative working between radiology and # clinic supporting improvements in patient flow, social distancing across both departments and improved patient feedback
- Partnership working across trust, tertiary centres and Wessex cancer alliance to facilitate consistency in standards of care and practice and seamless transition between providers
- Introduction of prehab project and integrated working with pre-assessment service to optimise patients in advance of preoperative assessment with aim of reducing number of long waiting patients who are medically unfit for surgery and reducing access delays
- Collaborative working across surgical wards necessary due to the significant change in footprint and subsequent establishment requirements to ensure safer staffing
- Recruitment of 2 X Nurse Associates within planned care surgery and OP areas
- Significant reduction in concerns for ophthalmology associated with timely answering of telephone calls – reduction from 30+ to 8 in past month as result of actions taken and learning from concerns raised
- Confirmed funding from CCG for psychological support for CYP diabetes service improving compliance with national standards and addressing immediate risk from recent peer review
- Lessons learned from complaints are being shared across areas working through improvement plans linked to CQC action plan across all wards areas.
- Common themes for concerns is communication, making up for 40% of concerns logged which has remained at a constant level from February 2021. The wards have introduced communication aides to support with message taking and team communications.

Workforce Headlines Acute Month 6 Sept

- Substantive staffing has increased by 6 FTE since Month 5 and remains 151 FTE below the substantive plan of 1788 at Month 6, with 1637 FTE in-post.
- Sickness absence has seen an increase within M6 Acute to 5.56% (4.94% M5), of which 0.86% (0.59% M5) is Infectious Diseases (COVID-19 Related), and of which 1.29% is Anxiety/Stress related absence (1.18% M5)
- Latest benchmarking data available from NHS Digital is at May 21 – this shows 12 month rolling absence figure for Acute Trusts is 4.63% (June 20-May 21), IOW NHS Trust Acute division is 4.73% for the same period
- 12 month Rolling Turnover at Month 4 is 9.06%
- The Appraisal rate was zeroed on the 1st April and by the 30th September the Division has increased this to 67.80%
- Statutory training reporting is currently at 83%. This is an increase of 2% this month

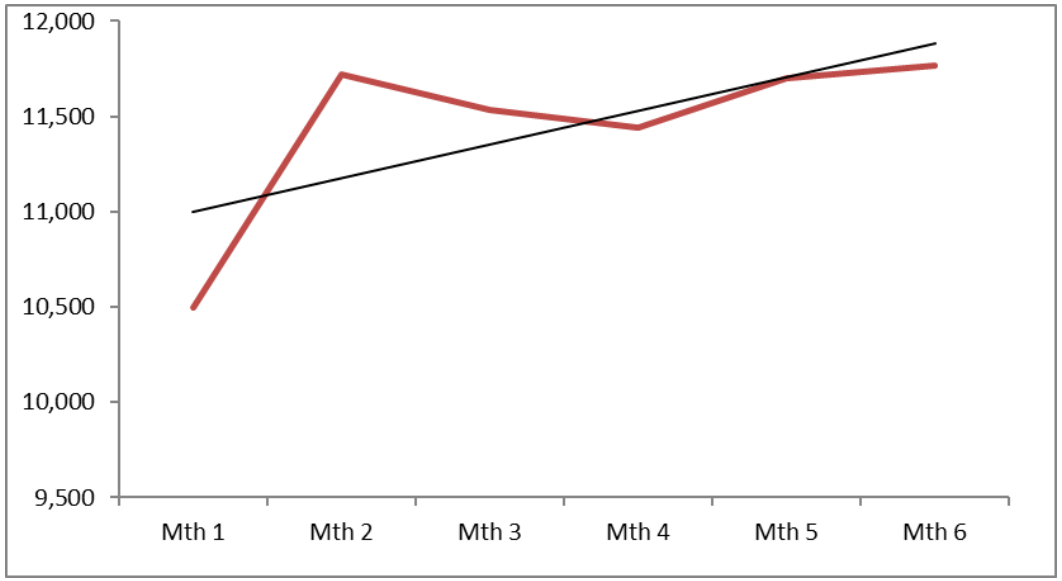
Key Capacity Indicators

TEMPORARY STAFF: **Agency 4.09%***	**TEMPORARY STAFF:** **Bank 7.67%***
VACANCIES: 8.43%* **(Sep 21 data)**	**SICKNESS:** 5.56% **(Sep 21 data)**

*% of planned workforce capacity

Acute Performance Month 6 2021/22

Acute Division inc Ambulance	Year to date		
	Plan £m	Actual £m	Variance £m
Planned	-39.4	-39.7	-0.3
Unplanned	-29.5	-30.8	-1.3
COO Management	-0.0	-0.2	-0.2
Ambulance	-5.7	-5.8	-0.1
Acute Division	**-74.6**	**-76.5**	**-1.9**



Planned – increased costs in areas such as Luccombe and Theatres

Unplanned – Urgent Care Floor cost pressures and increased costs of medical workforce
In month additional costs incurred for ICU 2 have been reallocated to covid budgets

COO management – overspend relates to Remedium costs and unfunded Non-PBR drugs

Increased costs due to covid patients and continuation of elective activity

Highlights Finance Planned Care Group Month 6

Key achievements/successes this period
• Focus on efficiency target – ADHD service due to cease Sept 2021 • PMO roll out of project implementation plans to achieve long term financial savings • Current overspend on establishments supported by underspend on recovery and ERF accelerated £402k

Risk/Concern	Mitigating Action
ERF income – the Trust is reporting £1.3m below plan £1m relates to threshold changes £0.3m relates to underperformance against activity	Assurance required that additional expenditure will result in additional income/activity PMO PiD's reflects the requirement to capacity plan and target activity and efficiencies
H2 forecasts Ensure all known risks and opportunities included	Finance revisiting for completion 29th October

Highlights Finance Unplanned Month 6

Key achievements/successes this period
• Divisional finance meetings with Director of Operations and Clinical Director established • Targeted areas to reduce on-going costs • Long covid income received in month £64k • PMO roll out of project implementation plans to achieve long term financial savings

Risk/Concern	Mitigating Action
H2 forecasts Ensure all known risks and opportunities included	Finance revisiting for completion 29th October
Increased costs in month 6	Deep Dive required and risks for H2 required

Ambulance Division Performance Update

Ambulance Operational Performance Highlights M6 September 2021

Key achievements this period

- Average Category 1 & Category 4 response times remained static or improved
- Total turnaround time improved in month
- Handover performance improved this period waits > 15 mins reduced by 3%
- Non conveyance rates increased while activity levels also saw a significant spike

Risk/ Concern		Mitigating Action
1.	Not meeting statutory standards Causes: • Increased demand on service resulting in poor response times • Attrition rates/vacancy rates of Call Handlers • Staff abstractions remain high • Vacancies within 999 and 111 service • Primary care recruitment of IWAS specialist paramedics	• Recruitment of emergency care assistants, call handlers and paramedics is ongoing • Officer on Rapid Response Vehicle to support surge - BAU • Use of REAP action cards • Continued use of mutual aid from St John when available • Continued use of private providers • Working with HR to secure agency paramedics – starting beginning November • Ongoing recruitment to vacancies • Deep dive into reasons for leaving • Exit interviews with staff • Regular service/HR meetings to support staff returning to work
2.	Increase in demand across 999,111 and PTS service	• Transformation schemes to review operational model including introduction of specialist paramedic in the control room and urgent care response service in community division
3.	Increased call abandonment rate in 999 and 111 service	• Ongoing recruitment of call handlers

Ambulance Performance – September 2021

999:

- 999 calls offered Increased by 24% in comparison to the previous month and remains high in comparison to 2019 at 49% up.
- Call abandonment rate increased to 11.8% from 7.5% due to the call volumes
- Daily incident numbers set another service high, Daily average of 86 compared to 80 in August and a previous high of 82.
- Total incident levels increased a further 8% to a service high 86 per day in September and were 30% above the same period in 2019, particular spike the week commencing 6th.
- Cat 1 incidents remained static in comparison to the previous month.
- Cat 2 incidents saw a significant increase, 23% in month and remain 25% above 2019 levels.
- Number of Cat 5 incidents also increased 5% in month.
- Response times for all categories worsened significantly in comparison to August, with the exception of Category 1 where the mean remained static and the 90th centile improved by 50 seconds.
- Number of long waits increased in September by 23% – average of 85 per week excluding w/c 6th (112 including)
- Overall non conveyance rate increased marginally from 34% to 36% in month.
- Hear & Treat rate remained static at 12%.
- Average job cycle time increased across all categories in September driven by the call start to assign duration
  - Category 1 increase of 16 seconds (15%) Call start to assign
  - Category 2 increase of 05:26 (45%) Call start to assign
  - Category 3 increase of 17:51 (41%) Call start to assign
- Handover performance improved in month, waits over 15mins reduced to 15%, and waits above 30mins dropped to 1.5%. Proportion of handovers recorded remained high at 97%.
- Average clear up time was 15:20, consistent with the previous month and proportion over 15mins was 38%
- Break compliance dropped significantly in month from 86% to 75%

111:

- Daily 111 call volumes decrease by 1.8% in September compared to the previous month but levels are still 48% above Sep-19
- Calls answered in 60 seconds dropped slightly to 79% in month, still below the service average for the previous 2 years of 89%
- 111 call abandonment rate increased to 7.6% in month from 5% in August

PTS:

- PTS journey's increased 14% in month and remain high in comparison to previous years - 17% above 2020 and 25% up on 2019
- Proportion of mainland journey's remained static at 8% in September.
- % of Journey's booked on the day also remained consistent in month (22%)
- Work continues to extract performance data from the new PTS CAD and develop KPI reporting outputs

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Ambulance Quality Highlights – September 2021

Key achievements this period

- 0 complaints received (in past 6 months)
- 100% compliance for duty of candour
- GoodSam (video consultation) installed in Emergency Operations Centre for use by 111, NHSE funded
- £42k health and wellbeing funding secured form NHSE/I to support wellbeing projects specifically for ambulance staff.
- Issues log opened as part of risk management live for Ambulance Service (1st area in the Trust with the risk maturity to be able to open an issues log).
- Telephony risk register entry closed after successful implementation of telephony project.
- British Heart Foundation National Defibrillator Network went live

Risk/ Concern		Mitigating Action
Risk	Supply chain issues with supply of Tempus ECG dots, and high costs related to life span of consumables/reusable consumables	• Identification of alternate manufactures for ECG dots • Exploring replacement defibrillators through digital funding that will integrate with electronic care patient records, and provide improved interoperability with south central ambulance as both defib and EPCR will align to their equipment
Concern	Potential for patient harm and reputational damage due to increased activity and demand on service, resulting in longer waits for patients, especially Category 3 and Category 4	• REAP actions, mutual aid • Long wait, mortality and re-attendance audits • Duty of candour and being open process • PSIRF process and actions from investigations • Specific ambulance communications messages being developed to inform public of increased demand • Continued use of St John Ambulance • Ring fencing community practitioners for C3 and C4 to reduce conveyances • Daily tactical brief • Use of officer car to support time surges in demand • Active recruitment of paramedics and community first responders
	Loss of skilled/experienced paramedics to similar posts in primary care	• Review of out of hours provision with UTC and commissioners • Continue to recruit into vacancy • Increase education and explore joint working opportunities (e.g. into UTC)

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Ambulance Quality Spotlight report – September 2021

- 100% compliant with duty of candour in month
- 0 formal complaints received for 6 months
- 15 compliments received
- 4 concerns received
- No new incidents waiting review
- Delay in arrival, most common reason for incident reporting
- No new clinical negligence claims received
- Regional multiagency working group set up to review sudden deaths process
- Telephony risk register entry closed
- 1 risk register entry rated 15 – no pre-hospital enhanced care team available on island
- JRCALC updates agreed and adopted where relevant
- Significant improvement in numbers of medi audits undertaken by Frontline with good compliance
- National PTS COVID guidance now published
- 8 new community first responders passed their course
- 408 hours of volunteering completed attending 59 incidents

Ambulance Finance Highlights Month 6

Key achievements/successes this period
• Breakeven position in Training and ambulance HQ • Continued recruitment to support frontline and reduce private provider provision • Additional income confirmed from the CCG for Q1 of £42k (Not in divisional figures but in Trust bottom-line) and for future months to support 111/IUC of £103k

Risk/Concern	Mitigating Action
Overspend in M6 PTS staffing to support increased response required to support on the day discharges	Take a finish group set up by CCG to review PTS demand
Continued overspend in fleet repair costs where additional old fleet was kept on the road to support increased activity during COVID (would normally have been disposed when new vehicles arrived)	Agreement has been made to move transport repair costs for additional fleet brought in to support COVID activity to COVID cost centre Request for additional lease vehicles
Increase spend in surgical and medical equipment causing a cost pressure. This is a direct correlation to the increased activity within the frontline service	Some costs do relate to Covid activity – will be transferred
Continued reduction in frontline income	This is road traffic incident income, if their were low/no incidents then we would not receive any income.

Financial Performance – September 2021

Ambulance Service M6 2021/22 – Summary position

Subjective Class	In month (£000s) Budget	Actual	Variance	YTD (£000s) Budget	Actual	Variance
PAY	875,231	872,287	(2,945)	4,569,125	4,596,671	27,546
NON-PAY	204,735	212,058	7,322	1,228,414	1,288,462	60,049
INCOME	(21,953)	(30,832)	(8,879)	(131,720)	(120,195)	11,525
Grand Total	**1,058,014**	**1,053,512**	**(4,502)**	**5,665,819**	**5,764,939**	**99,120**

- PAY – Overspent year to date due to additional PTS shifts
- NONPAY – Vehicle maintenance costs higher than forecast
- INCOME – Underachieved year to date due to low Non-Contracted income
- Additional £43k of CCG income has been received by the Trust for Q1 but not reflected in above position.

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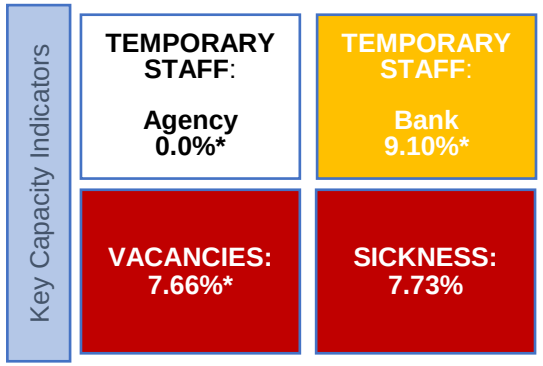
Ambulance Workforce Headlines September 2021

Month 6 - September 2021 Data

- Substantive staffing in M6 is 207 FTE, below the substantive plan of 224 FTE.
- Bank usage for M6 is 20.38 FTE against M5 which was 21.19 FTE
- Sickness absence has seen an increase in month 6 to 7.73% (M5 7.36 %), of which 1.17% is Infectious diseases (COVID-19 Related) (M5 0.77%).
- Latest benchmarking data available from NHS Digital is at May 21 – this shows 12 month rolling absence figure for Ambulance Trusts is 6.20% (June 20-May 21), IOW NHS Trust Ambulance division is 7% for the same period
- 12 month rolling Turnover stands at 5.54%
- The appraisal rate was zeroed at the 1st April 2021 to begin the new cycle and by the 30th September the Ambulance Division have now taken this to 85.35%.
- Statutory training compliance is currently 81%.



*% of planned workforce capacity

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Key Risks		Controlling actions
1	Covid-19 Risk Assessments	• M6 compliance has had no change 95.2% - area of focus required for ambulance emergency services
2	Appraisals	• Compliance at M6 is 85.35%. • Area of focus is ambulance Emergency services who are currently at 45.45%
3	Frontline Ambulance Recruitment Programme Hotspots: 1. Starting candidates in post without full clearances	• Meetings with Ambulance Resourcing Manager moved to monthly. • Interviews/Assessments to take place on 11th October with a view to fill remaining Paramedic positions 1. Reiterate to recruiting managers via the Divisional Task & Finish the importance of liaising with recruitment to ensure checks are in place prior to starting appointees in post
4	Mandatory Covid Vaccinations for staff working in care homes	• 6 cost centres have identified that their staff may be required to attend care home. 110 staff have not responded to request to verify vaccination status. HR team working with line manager to verify records. • Slide 6 of pack provides the detail
5	Pay progression	• 5 Pay Progression updates due, the Workforce Information team will be sending information directly to the line managers of the outstanding pay progression staff members with supportive information to highlight the appropriate process moving forwards to ensure pay is correct for our staff.
6	Health and Wellbeing	• Sickness has increased in M6 to 7.73% - ensure absence is being managed in accordance with policy framework • Monthly sickness absence review meetings in place for frontline staff. • Continued promotion of HWB offer to staff • Ensure staff are taking annual leave proportionally (25%)

Ambulance Transformation – September 2021

Key achievements/successes this period

- Implementation of new Telephony system complete
- Pre hospital Urgent Care transformation initiation document drafted and agreed – Schemes include but not limited too;
  - Care homes
  - Falls Pathway
  - Telehealth Pathways
- Ambulance HR Task and Finish Group established and key schemes of work agreed to include;
  - Recruitment and Retention
  - Long Term workforce plan
  - Efficient use of agency / temporary staffing
- Good Sam Video application installed, full roll out plan being devised.
- 2hr Urgent Care Response Team clinical coordinator located within the hub
- Discussions held with Mental Health Commissioners in relation to funding of MH rapid response vehicle on the Island.
- Community Practitioner pilot in Hub commenced

	Risk/Concern	Mitigating Action
Risk	Expiration of funding on 31.03.2022 for programmes such as; Additional resilience for 999 call Handlers Additional resilience for 111 Call Handlers Specialist paramedics within the Hub for 2hr Urgent Care Response programme.	Ongoing conversations with local Commissioners to identify recurrent funding opportunities
Concern	Availability and capacity of workforce to meet business as usual demand and additional transformational requirements	Robust costings to include agency premium where possible
Concern	Movement of commissioning to ICS	Weekly cross system huddles maintained to ensure real time updates and potential implications

Items for Escalation

Removal of Risk from Risk Register due to implementation of new Telephony system.

New Risk – Expiration of funding on 31.03.2022

New Risk – Availability and capacity of workforce

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Mental Health & Learning Disabilities Division Performance update

Performance

Afton ward: Number of overspill patients from Acute admission ward continues to reduce.

Osborne ward: Admission rates are reducing; due to gatekeeping process and admission avoidance by services as a whole.

Early Intervention in Psychosis team: The team have 100% for the national target of treating within 2 weeks

Mental Health Support Teams in schools: All trainees have now met local standard for clinical competence

Learning Disabilities: integration with local authority LD services is progressing. Face to face integration workshops are proceeding

Locality networks: Despite challenges with agency staffing CMHS still remains in a positive position with some recent substantive recruitments. Some challenges with wearing of face coverings by people accessing the service – admin teams are screening people at the door before entry which appears to have improved compliance

	Key Risks	Controlling actions
1	3 and 7 day follow up target not being met:- 7 day = 94.7% (Current national target 95%) 3 day = 84.2% (Direction of travel in terms of national target)	Oversight is being maintained in the Patient Status as a Glance meetings and by HT admin. These are fairly new processes and expected to see an improving picture next month.
2	Dementia Diagnosis waiting list RTT = 54.9% against a target of 92%	• 3rd Consultant now in place and additional Nurse due to take up post in October. After a short period of induction they will commence nurse led assessments • Review of waiting list and RAG reviews in progress • Agency Nurses to be recruited to support the move to Nurse Led assessments • Increasing B4 capacity to carry out post diagnostic work.
3	Psychological Therapies waiting list Waiting list = 170 Average wait = 69 weeks Longest wait = 180 weeks	• The service has recruited two DBT trainees to expand capacity to meet referrals regarding emotional dysregulation • Recruitment of 3 x 12 month fixed term assistant psychology posts, to enable further support to those on the waiting list, expand group work, and hold small caseloads • Business case to be developed for additional clinical psychologist / psychological therapist roles, including clinical associate psychologists • Implementation of SHaRON platform to provide peer support for those on waiting list • Provision of psychosis training to whole CMHT team to upskill staff on working with complex presentations • All referrals for psychological therapies will be discussed in locality meetings. This will enable the opportunity to identify other forms of support earlier in the referral process.

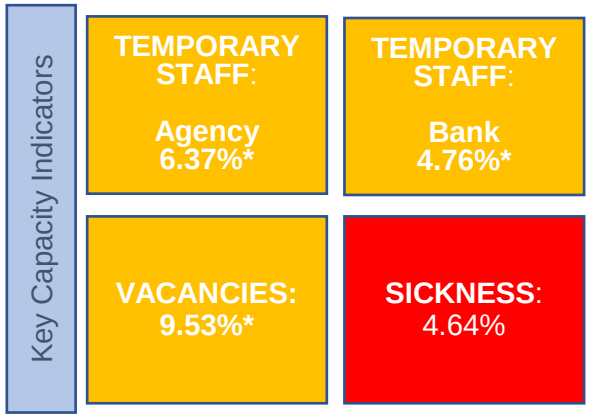
Quality

- All MHLD services inspected by CQC in 2021 rated as Good
- MHLD early adopter of new Parliamentary and Health Service Ombudsman (PHSO) complaints handling pilot.
- Improving Bed occupancy
- Several Quality Improvement programmes in place, including:
  - Royal College of Psychiatrists Enjoying Work Collaborative – CAMHS and CMHT
  - Increasing and embedding coproduction in LD services
  - Coproducing an approach to the Green Light Tool Kit (an approach to improving health care for people with a learning disability)
  - Royal College of Psychiatrists Sexual Safety Collaborative – Osborne ward
  - Mental Health Safety Improvement Programme – Reducing Restrictive Practice – Afton ward
- We now have peer support workers routinely working in our ECT team, providing support before, during and after ECT treatment. We are the first ECT service in the country to offer this service.

	Key Risks	Controlling actions
1	CQC Compliance: 2021 = 3 x CQC must do and 24 CQC should do actions required 2018 = all outstanding actions have been reviewed. 19 will be updated and moved to the new quality improvement plan	Governance arrangements in place within the Division. Action plans being worked up to address requirements
2	ICT systems /issues- the majority of teams are reporting a high volume of ICT issue impacting on patient care	Transformation Programme Director following up with information systems/ Information technology
3	Estates	Redecoration in Seagrove due to start in Oct 21 Health Based Place of Safety plans progressing (CQC Must do) Estates masterplan in development with Solent NHS Trust support

Workforce

- **Month 5 - MH 2021 Data**
- Substantive staffing M5 has increased to 408 FTE, from M4 406 FTE
- Overall Bank & Agency usage in M5 is 50.20 FTE a decrease against M4 which was 53.89 FTE.
- Sickness absence has decreased to 4.64% (M4 5.53%), of which 0.14% is Infectious Diseases (COVID-19 Related) (M3 0.01%), of which 1.87% is Anxiety/Stress absence
- 12 month rolling Turnover is at 10.64%
- Annual Leave usage from 1st April 2021 is 12.43% (aim for 25% usage per quarter)
- The appraisal rate was zeroed at the 1st April 2021 to begin the new cycle and by the 31st July the MH&LD Division have taken this now to 77.37%.
- Statutory training Compliance is currently 78%



*% of planned workforce capacity

Key Risks		Controlling actions
1	RMN Vacancies	• International recruitment we have 7 candidates in process. Planned deployment for 4 RMNs anticipated early December. • Engaged with colleagues across the ICS to adopt a collaborative approach to direct appoint RMNs from overseas. • Awaiting establishment review approvals to support the development of workforce strategy • Divisional grow your own nursing workforce group established
2	Support Time Recovery Workers	• Scheduling a virtual event with the support of INDEED who are supporting the NHS nationally with recruitment and advertising events – early October • Awaiting establishments reviews to be completed to confirm the numbers of additional recruits required
3	Medical Vacancies	• Remedium – Two roles within Executive Search (General Adult and Child and Adolescent Mental Health psychiatrists). • Recruitment to junior posts continues, one starter in September. All gaps being managed • SAS General Adult & OPMH post to commence 27th September

Transformation

- Formal procurement process complete for new Electronic Patient Record System. Business Case has been agreed by the Digital Transformation Committee and Finance and Infrastructure Committee.
- Sevenacres feasibility estates plan complete. Bed modelling complete and approved by Divisional Leadership Team.
- Estates master plan for MH&LD and Community division services under development with Solent support
- Medical Workforce – plans in place to implement a new middle grade doctor day time rota
- Psychological therapies work stream progressing. SHaRON platform to be implemented in the next 8 months
- Newly described OPMH pathway agreed through Clinical reference group
- South locality foot print pilot progressing, and appointing additional Mental Health co-ordinators

Key Risks		Controlling actions
1	Capital requirements for refurbishment of newly acquired estate	• Work with estates to identify options for phased approach to refurbishment
2	Electronic Patient Record System Business Case approval	• Business Case to be submitted 28.10.21 to Digital Transformation Committee, and from there to Finance and Infrastructure Committee and Trust Board in November.
3	Electronic Patient Record: Interdependencies- Smart cards, devices & data migration	• Mapping of interdependencies being shared with IT

Mental Health Performance Data

Operational Performance Overview

Metrics	Latest Period	Target	Month	Last Month	Trajectory
Single Point of Access Referrals	Aug 21	-	223	246	▬
% CMHT Caseload on CPA with in date Risk Assessment*	Aug 21	*95%*	90.4%	93.7%	▼
% of people experiencing a First Episode Psychosis taken onto the EIP Pathway within 2 weeks	Aug 21	*60%*	100.0%	75.0%	▲
CAMHS % RTT Incomplete	Aug 21	*92%*	100.0%	100.0%	▬
OPMH % RTT Incomplete	Aug 21	*92%*	54.9%	49.7%	▲
IAPT - 18 Weeks from Referral to Entering Treatment %	Aug 21	*95%*	100.0%	100.0%	▬
IAPT - 50% Recovery Rate	Aug 21	*50%*	52.2%	46.5%	▲
IAPT - 25% Access Rate	Aug 21	*25%*	13.9%	15.1%	▼
7 Day Follow Up	Aug 21	*95%*	94.7%	89.5%	▲
% Gatekeeping of Admissions	Aug 21	*95%*	100.0%	71.4%	▲
Bed Occupancy - Adult Acute Beds - Excluding Home Leave***	Aug 21	*85%*	104.4%	108.9%	▲
MH Adult Acute Beds - LOS in days Excluding Leave	Aug 21	***32*	32.4	11.4	▲

** Includes Risk Assessments also includes Risk Assessments where the Service User is Open to Inpatients/Home Treatment*

** Mean taken from the National Benchmarking output report 18/19 data

*** Based on admissions to specialty 710 on Acute MH Wards

Improved ▲

Same ▬

Worse ▼

- EIP performance is still above the 60% target. Reporting 100% for August.
- Bed Occupancy for Adult aged people has seen a decrease this month however beds on the older persons ward are still being utilised.

There are 4 indicators not achieving in August 2021 and 1 reporting amber. 3 of the 4 not achieving reported an upwards trend in performance against the previous month.

- CMHT Caseload on CPA with an in date Risk Assessment continues on a downwards trend. Reporting 90.4% against the 95% target. Weekly data shows that this position continues to deteriorate reporting 86% as at the 4th October.
- The % of people waiting within18 weeks for an OPMH consultant appointment has increased again this month to 54.9%. There were 155 people waiting 18 weeks or over a the end of August (an increase of 4 compared to the previous month). The longest wait is 64 weeks (up from 62 weeks at the end of July)
- The IAPT Recovery rate achieved in August following 4 consecutive months of under achievement.
- IAPT Access rate continues to report under target and is on a downwards trend.
- There was 1 7 day CPA follow up breach in month.
- There were no gatekeeping breaches in month.

Community Division – Performance update

Quality Headlines

- Aseptic Numb Touch Technique (ANTT) training levels remain good across the Division
- In July there was a total of 101 patient safety incidents reported. 68 (67%) incidents related to pressure injuries. 27 (40%) of the 68 related to pressure injuries that developed or deteriorated under our care. Of 101 incidents, all 101 resulted in minor or no harm.
- The number of falls on the Community Unit has increased, this is likely due to an increase in acuity and dependency of patients. The Unit lead is working with the Falls Team to undertake a review and develop an action plan.
- Since the Trust decision to stop reporting falls that occur in homes in the community, we can see a correlation between this and the overall number of incidents reported since April 2021. Incidents that are logged but do not fall within our remit of responsibility to investigate, are now able to be recorded on Datix.
- Division wide Mandatory Training figures are currently 86%, Information Governance Training is at 88%. Services utilising 12 week Quality Improvement Plans to drive up levels of compliance.
- Use of priorities of care for patients at end of life, solely cared for by Community Division teams has been maintained at 100%.
- Use of Friends and Family Test (FFT) across the division has recommenced. Staff and teams are encouraged to capture feedback for data analysis.
- The use of Statistical Process Control Charts (SPC) is now in place to allow us to identify abnormal reporting levels around patient safety incidents.
- Divisional Audit Plan 21/22 in place and being reported in detail through Quality Improvement Forum
- The Division received 14 compliments that were logged via Datix. The following is an extract from one received: Continence Service - Email from GP *'Thank you for your advice. It is really appreciated, to confirm what is being used locally. Please pass on my thanks to your team for the work that you are doing in this difficult period'.*

Key achievement this period

- **SNNAP audit** – best in region for compliance against targets for Speech & Language Therapy, Occupational Therapy and Physiotherapy.
- **Complaints & Concerns –** received 4 concerns but one was incorrectly logged which means 3 against the Division, all managed within time and 0 complaints.
- **Overdue Incidents** – The number of overdue incidents is back to zero without mitigation.
- **QI Forum** – The new QI Forum commenced last month. The session was well attended and staff have fed back how useful and informative the forum was.
- **Key Performance Indicator -** KPI's from mortality reviews were all 100%

Key Risks		Controlling actions
1	Increased demand and vacancy levels could impact on quality of service provided.	• Use of bank and agency staff to cover vacancies and support services with high demand. • Weekly review of Business continuity plans. • Escalation process in place. • Triage process in place. • Services prioritising urgent & high risk patients

Performance Headlines

Frailty Cluster – performance of 2 hour response for D2A continuing to be recorded and reported to Divisional Quality & Performance Committee; targets and trajectories under development.

Regaining Independence Cluster – services continue to carry a number of risks relating to system capacity, waiting lists, increasing acuity of patients and lack of adequate gym space for complex rehab patients. Average LOS in community beds is also reported as increasing to 62 days. The daily position for staffing and demand continues to be challenging

Acute & Stroke Cluster – Occupational Therapy seeing improvement in urgent response times, response to non-urgent referrals suboptimal. Speech & Language Therapy achieving 100% of referrals responded to on day received. Working with Stroke services to train front door stroke specialist nurses to complete initial swallow assessment - new way of working which should reduce time patients spent nil by mouth out of hours. Physiotherapy under pressure with increased beds, further locum request in process.

Community Support Services Cluster – caseloads are generally rising across services with complexity identified as issue. Continence service continues to escalate breaching of 12 week waits in August - recovery actions agreed to address capacity issues.

Outpatient Cluster – waiting times continue to be monitored closely with a deep dive planned for Podiatry. Significant recruitment underway across Cluster including apprenticeships and succession planning for specialist roles. Lack of suitable gym space for some services continues to be an issue and negatively impacting wait times, working with Estates team for urgent solutions.

Children's Services Cluster – waiting times across therapies continue to be a concern. Successful recruitments made this period which will support recovery plans.

Localities – Therapy wait times continue to be a concern. August data demonstrated that Routine A appointments (10 days) have 117 patients waiting, longest wait 131 days; Routine B appointments (30 days) have 17 patients waiting, longest wait 138 days. Recovery plan in place.

Community Nursing - CQC fed back that there was strong evidence of person centred care in all community nursing.

Technology Enabled Care – team reported a drop in Attend Anywhere uptake from 233 in July to 149 in August, further investigation in to services reducing use of TEC to be reported back and discussed with Cluster Leads through monthly governance.

Covid Testing Site – now commissioned until March 2022.

Key achievements this period

Frailty Cluster are making preparations for their shortlisting in 'Care for Older People' category of Nursing Times Awards.

Key Risks		Controlling actions
1	Missing data in performance dashboard leading to reduced divisional oversight and assurance (not all risks in the Q&P slides are visible through the dashboard)	• Performance Dashboard in development • Fortnightly Divisional/PIDS working group set up to begin to reduce gaps and align tiled reports with dashboard so all data pulled into one report • Q&P tiled reports- received at detailed service level • Quality & Performance Review Meetings at Cluster level in place and effectively highlighting risks • Deep dive assessments where risk or further information required • Improving performance strategy (driver diagram) shared at CLT and next steps supported.
2	Long wait times resulting in risk of reduced patient outcomes – currently highest risks are in locality therapies; o/p physio (Regaining Independence) and Childrens therapies	• Locality therapy action plan in place – recovery plan to reduce backlog with additional staff agreed with CLT • Estates options for gym space in process of being scoped with support of Space Utilisation Group • Workforce and recruitment review across Children's Cluster

Transformation Headlines

Frailty
- Mapping and gathering Terms of Reference for any current workstreams, groups or meetings across the Trust relating to Frailty
- Review of Task & Finish group priorities against GIRFT recommendations and previous benchmarking information
- Frailty strategy / pathways discussions have taken place with Programme Director Strategy IOWT and now linked into KPMG review and also refresh of IOW Health and Care Plan

Localities
- Mapped and shared current and proposed structures and SOPs including operational & professional responsibilities
- Collated and shared current data reports & in-house reporting improvement plans including demands, schedule, responsible person/ team

Regaining Independence
- High level programme plans in place and impact defined
- Key stakeholders identified and CCG resource in place for progression of Bedded Care Review

IT Transformation
- Deep dive service level meetings have taken place during August – excellent engagement from service/clinical teams and input from Solent
- Revision and update of draft Business Case and Implementation Plan for Systm1 ongoing – Being presented for sign off at next Finance & Infrastructure Committee

Estates Transformation
- Laidlaw Community Unit improvement – Delays due to asbestos within the roof – plan being developed
- Orthotics and Prosthetics Improvements – Drawing following first project meeting has been produced and issued to Surveyor

	Key Risks	Controlling actions
1	Discontinuation of HDS2 funding - Trust will no longer meet national discharge requirements - reduced flow and outcomes for patients	• H1 and H2 funding agreed for 2021/2022 - Awaiting agreement nationally regarding recurrent funding
2	Operational pressures due to COVID surge and Flow issues due to lack of system care provision	• Reporting to continue to monitor progress • Extra resource requested for new initiatives to ensure retain resource to continue
3	Asbestos identified in roof space at Laidlaw delaying planned improvements	• Work underway with estates to plan approach to rectify situation to enable required improvement works to continue

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Workforce Headlines

Isle of Wight NHS Trust

Key achievement this period

First draft of Community Workforce data set developed and circulated which includes: Vacancy Heat Map by department; Agency & Bank Usage Hot Spots; Rostering & Unused Hours. Next steps: Recruitment pipeline, attrition rates and age profiling under development for the Division.

- Substantive staffing has increased to 398.53 FTE
- Vacancy % stands at 5.56%
- Vacancy position has been rectified by the inclusion of the Hospital Discharge Scheme (HSD2) 33.8 FTE. Community budgeted establishment :423 FTE
- Overall Bank & Agency usage increased in M5 19.62 FTE against M4 to 14.09 FTE.
- Sickness absence has seen an increase in month 5 to 5.43% (4.38% M4), of which 0.62% (0.44% M4) is Infectious Diseases (COVID-19 Related), and of which Anxiety/stress/depression/other psychiatric illnesses is 1.83%
- 12 month rolling Turnover stands at 11.60% (0-19 Service TUPE excluded)
- Annual Leave usage from 1st April 2021 stands at 13.65% (aim for 25% per quarter)
- The appraisal rate was zeroed at the 1st April 2021 to begin the new cycle and by the 31st August the Community Division have taken this to a highly respectable 89.40% (as of 28/09 the rate is 95.93%)
- Statutory training reporting has been reinstated this month and compliance is currently 86%
- AHP Job Planning Busines Case – successful meeting with Allocate levered a reduction in costs for licences, uploading of job plans and training – Next steps; business case to be refreshed.

	Key Risks	Controlling Actions
1	Covid 19 Risk Assessments	• Covid 19 risk assessments: M5 compliance 98.9%
2	Sickness absence	• Sickness has increased in M5 to 5.43% • Managers to ensure sickness absence is being managed appropriately in line with the policy framework • Continued promotion of HWB offer to staff including the HIOW ICS people portal • Ensure staff take annual leave proportionally (25%)
3	AHP Apprenticeships	9 AHP apprenticeships – • Education providers have been identified for the different specialties • A detailed mobilisation plan to be developed – anticipated start date January 2022 • Funding for AHP apprenticeships escalated to Chief Nurse
4	Mandatory Training	• M5 compliance is 86%. Any anomalies with the data set will be addressed during September. Moving & Handling 64%; Resuscitation 56%.

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Finance Headlines

NHS Isle of Wight NHS Trust

Key achievements this period

- Headline position for Community Division as at August 2021 is £47k under spend (expecting this to reduce as recruitment progresses and incremental pay rises cause a potential cost pressure)
- National pay inflation will be funded centrally, net nil impact to Division
- Non recurrent Ageing Well funding for HY1 and HY2 has been verbally agreed with CCG (up to c£700k)

Divisional Position

Subjective	In Month			Year to date			Full Year	%
Class	Budget	Actual	Over / (Under) Spend	Budget	Actual	Over / (Under) Spend	Budget	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Pay	1,416	1,240	(177)	7,246	6,983	(263)	8,126	-3.6%
Non-Pay	260	225	(34)	1,208	1,043	(165)	1,439	-13.7%
Income	(71)	33	103	(289)	(249)	40	(343)	-13.8%
Community Division Total	**1,605**	**1,498**	**(108)**	**8,165**	**7,778**	**(388)**	**9,222**	**-4.7%**
Vacancy Factor Impact	(68)	-	68	(340)	-	340		
Corporately Reported Position	**1,537**	**1,498**	**(40)**	**7,825**	**7,778**	**(47)**		

Risk/Concern	Mitigating Action
Forecasting of half year 2 (October 2021 – March 2022), considering full year effect of recruitment	To incorporate robust forecasting including cash releasing efficiency savings The position will need close monitoring with regular budget reviews with budget holders as recruitment continues
Prosthetics, Amputee increased demand now 50% of caseload	Request to be made at contract meeting to determine whether additional funding available outside of NHS England Block and planning for half year 2
Recovery for 2021-22	Demand & modelling underway to review impact of 5 recovery workstreams Wave 3, Long COVID, Supressed Demand, Recovery Impact (Acute) and back log waiting list. Elective Recovery posts recruitment progressed at risk.
Staff Incremental pay rise cost pressure	2021-22 Budgets rolled over following FRB approval. No increase for staff annual incremental pay rise is included. However, staff turnover may offset this, as new starters should commence at the bottom of the scale.

Integrated Workforce & Financial Performance Update

Workforce & Finance Headlines

- Substantive staffing has increased by 9 FTE in M6 to 3170 FTE compared to M5
- Overall Bank & Agency usage was 394 FTE in M6 compared to M5 361 FTE.
- Sickness absence has seen an increase in M6 to 5.80% (M5 4.94%), of which, COVID related sickness is 0.75% (M5 0.50%) and Anxiety/stress/depression/other psychiatric illnesses is 1.46% (M5 1.28%), and Cold Cough, Flu is 0.62%
- 12 month rolling turnover stands at 10.33%, below the regional average of 14%
- The Trust is making progress in improving Appraisal compliance with 75.58% completion as at 18.10.2021.
- 2021/22 6-month (H1) financial plan achieved
- Financial planning for 2021/22 H2 now underway across all organisations within HIOW ICS
- H2 financial plans required to be submitted to ICS and NHSE in mid-November
- Supplier payment performance remains a major focus at national level – Trust continues to exceed the national performance target of 95% of invoices paid within 30-days
- Elective Recovery Fund income reimbursement will be below plan in Q2 due to:
    - Change in national thresholds from 85% to 95% (of 2019 elective activity) effective from 1 July
    - Reduction in planned elective recovery due to non-elective operational pressures

Key Risks		Controlling actions
1	Ability to attract & Fulfil vacancies Medical Nursing AHP	**Medical:** • We have 19 Doctors going through onboarding from Oct-Dec 21; 12 international and 7 UK doctors. • Reviewed all medical vacancies from planned and unplanned and are working on a recruitment plan for the Acute Divisions to be confirmed with the COO and Operations Directors in early November • AAC Panel established 25 October for ED Consultant and 02 November for Consultant Geriatrician • 4 Substantive Staff undergoing CESR to become consultants. (2 ED candidates to be interviewed , 2 Acute Medicine) **Nursing:** • Recruitment through "Indeed" campaign commenced on the 14 October with a view to attract 50 HCSWs. A second Trust run event will also be held 27 October to support the programme. Outcomes to be confirmed • 7 Registered Mental Health Nurses (RMHN) recruited with plan to deploy 4 in December 21, 3 still in process. • International Deployment: For 2020/21: The Trust deployed 70 nurses who have now commenced in Band 5 roles. • For 2021/22 (April 2021 - February 2022): 38 nurses have commenced and are in supernumary roles ahead of being confirmed in post substantively. • The outstanding balance 74 nurses is broken down below: • - 29 October: 14 nurses are arriving - November: 20 nurses are planned to arrive (date to be confirmed) - December: 16 nurses are planned to arrive (date to be confirmed) - January/February 2022: 24 nurses are planned to arrive (date to be confirmed) NHSIE have confirmed that we have an extension to end of Feb 22 to complete the nurse recruitment plan owing to the challenges during Jun- Aug 21 due to Covid and travel restrictions **Allied Health Professionals:** • 9 AHP apprenticeships will be deployed across the Trust with anticipated start date is Jan/Feb 22.
2	Impact of the pandemic on Staff Health & Wellbeing	• Our staff can access(i) Monthly Thrive newsletter putting a spotlight on the HWB service offer across the trust; (ii) Mental Health First Aid Training; and (iii) mental health support service developed by the Hampshire and Isle of Wight Integrated Care Service (ICS). • The Trust has been identified as a NHSE/I Trailblazer site to pilot the new HWB Framework to further strengthen the delivery of leadership, communication, environment, mental health, physical health and healthy lifestyles. Interventions. Enhanced interventions to tackle burnout will be delivered October – December 2021 via communication, engagement and webinars.
3	OH Resource for Covid Booster Vaccination.	• OH Vaccination campaign commenced beginning of September – Covid booster campaign extended to mid-November and the Flu campaign will continue to the end of the year • Up to date picture as at M6 are circa 1500 vaccinations for each campaign
4	Elective Recovery Fund	• Risk from changes in national thresholds, and reduction in planned elective recovery due to non-elective operational pressures • Overall H1 financial plan has been achieved by cost mitigation and other income opportunities • Any actual shortfall against estimates for Q2 will need to be carried over into H2

Key achievements this period

- **International Nurse Recruitment:** Deployed 19 International nurses in September and 19 doctors going through onboarding between Oct – Dec 2021.
- **Flu Campaign:** The Flu campaign is ahead of target compared to the same time last year
- **H1 Financial plan achieved**

Finance - Month 6 Summary

Area	Key issues	Current month (ytd)	Previous month (ytd)
Overall Plan	The Board approved financial plan from April to September (HY1), with a deficit of £3m has been achieved. The year to date position includes an estimate of income from the Elective Recovery Fund (ERF) of £3.4m, £1.3m below plan, the reported position assumes £1.5m of additional funding from the ICS to support the shortfall in the ERF.	On Plan	£6k positive variance to plan
Pay and Non Pay Expenditure	Pay and non-pay overall above plan. Pay costs were above plan due to Agency cost and pay pressures in Acute, part of this was due to additional resource required for the CQC inspection in June and high pay cost in August and September. ICU 2 also reopened at the end of August. Non pay is below plan year to date due to lower than planned cost of elective recovery.	£0.7m above plan	£0.1m above plan
External Income	Non contract income was above plan, including increased private patient income and RTA cost recovery	£0.7m positive to plan	£0.1m positive to plan
Contract Income	Year to date contract income is below plan. Due to the increase in thresholds and the risk around ERF H1 was £1.3m below plan. This was partially offset by £1.0m of additional assumed income.	£0.1m below plan	£0.1m below plan
Capital	Year to date underspend on a number of projects, but are expected to be recovered by year end. Current forecast is that all internal capital programme funding will be utilised in full.	£2.5m below plan	£1.7m below plan
Cash	The cash balance held at the end of September is £17.0m, a £4.2m decrease on the previous month, mainly due to payment of PDC dividend and pay award back-dated to April. The revised financial framework in place for 2021/22 enables the Trust to maintain a positive cash balance without the need for external cash support.	£17.0m Cash Balance	£21.2m Cash Balance
Cumulative monthly supplier payment performance	Trusts are expected to pay 95% of all suppliers within 30 days. As at the end of September the supplier payment performance was 96.9% for volume and 95.4% for value of invoices paid within 30 days. The in-month performance for September was 96.9% for Volume and 94.1% for Value	Volume 96.9% Value 95.4%	Volume 96.9% Value 95.7%

Finance - Month 6 Overall Financial Performance

The planned H1 deficit for the Trust has been achieved at £3.0m.

The in-month position is a deficit of £533k, against a plan of £547k.

The actual deficit includes assumed income of:

- £3,397k of estimated income from the Elective Recovery Fund (ERF), based on elective activity from July to September plus actuals for April to June.
- The plan at this stage was £4,700k
- £2,050k of income and cost from the Accelerator Fund which is on plan

There is risk to these ERF assumptions (see graph):

- Actual income to be received will be calculated nationally based on the Trust submission of monthly elective activity.
- The income for July is based on actual data together with an estimate for activity that was still uncoded
- The income for August and September is only estimated based on average costs

Year to date (YTD)	Month			Year to date		
	Submitted plan	Actual	Variance to plan	Submitted plan	Actual	Variance to plan
	£m	£m	£m	£m	£m	£m
Pay	-16.9	-17.3	-0.4	-89.1	-90.3	-1.2
Non Pay	-7.3	-7.6	-0.2	-44.2	-43.7	0.5
Other external income	1.2	1.8	0.5	7.4	8.2	0.7
Sub Total	**-23.0**	**-23.1**	**-0.1**	**-125.9**	**-125.8**	**0.0**
Contract income	22.4	22.5	0.1	122.8	122.8	-0.1
Surplus / (Deficit)	**-0.5**	**-0.5**	**-0.0**	**-3.0**	**-3.0**	**-0.0**

Pay costs were above plan due to Agency cost and pay pressures in Acute, part of this was due to additional resource required for the CQC inspection in June and high pay cost in August and September. ICU 2 also reopened at the end of August.

Non pay is below plan year to date due to lower than planned cost of elective recovery.

Overall the H1 position against plan was achieved.

Finance - Month 6 Financial Performance (by division)

The H1 plan has been devolved to Divisions and individual budgets.
This ensures that all budget holders have sight of their initial budget from the start of the year, aiding good financial governance and budget ownership for the H1 6-month period.

Financial and operational performance against these plans continues to be monitored through Divisional assurance meetings.

Work has begun on developing financial plans, at Divisional level, for H2. This will ensure a smooth transition after the current financial funding settlement ends in September. This will be completed in time for the required submission to HIOW ICS and NHSE in mid-November.

By Divisions	In month			Year to date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Acute & Ambulance Division	-13.6	-14.3	-0.6	-74.6	-76.5	-1.9
Mental Health & LD Division	-2.3	-2.3	0.0	-12.4	-11.8	0.6
Community Division	-1.9	-1.7	0.2	-9.7	-9.5	0.2
Non Clinical & Covid	-4.3	-3.9	0.4	-24.0	-22.5	1.4
Capital Charges & Financing	-0.9	-0.9	-0.0	-5.2	-5.4	-0.3
Sub-Total	**-23.0**	**-23.1**	**-0.1**	**-125.9**	**-125.8**	**-0.0**
Contract income	22.4	22.5	0.1	122.8	122.8	-0.1
Surplus / (Deficit)	**-0.5**	**-0.5**	**0.0**	**-3.0**	**-3.0**	**0.0**

Divisional performance against plan

The key variances to plan year to date by Divisions are:

- **Acute:** Overspend of £1.9m due to ward establishments (safer staffing and impact of recovery), combined cost pressure on Non-PBR drugs.
- **MH & LD:** £0.6m underspend due to vacancies in Transformation not covered by Agency combined with lower non-pay cost associated reduced need for off Island Dementia beds.
- **Community:** Overall within plan, HDP funded for H1 at £979k and fully funded by CCG.
- **Non Clinical & Covid:** underspend of £1.4m mainly due to higher non-pay costs, inflationary increases causing cost pressures, which were offset by a reduction in required spend on Covid.

Highlights Finance Planned & Unplanned

Key achievements/successes this period

Planned:

- Elective recovery income – SLA income is £704k below plan due to change in thresholds (within overall Trust position).
- Focus on efficiency target – ADHD service due to cease September 2021.

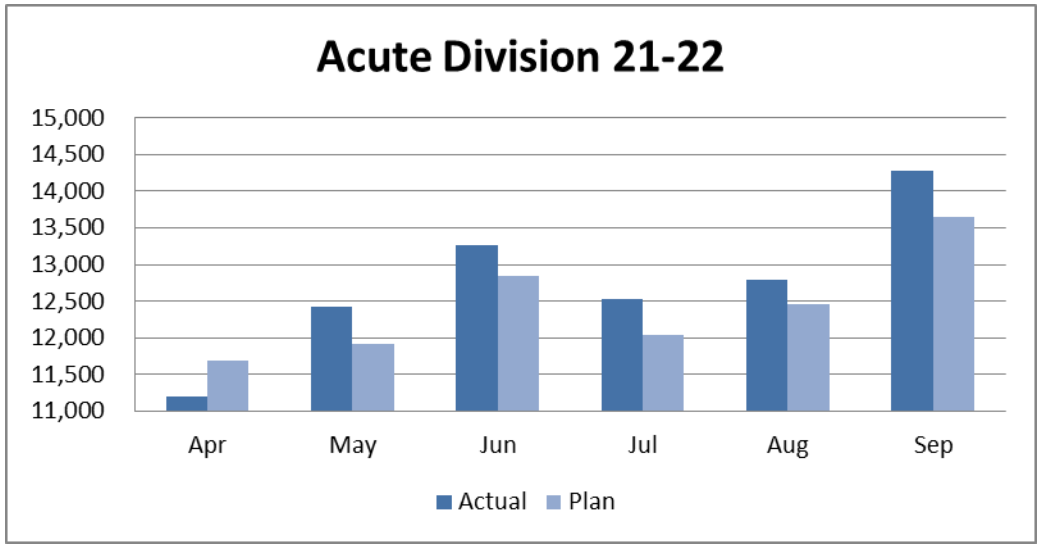
Unplanned:

- Divisional finance meetings with Director of Operations and Clinical Director established.
- Targeted areas to reduce on-going cost.

Risk/Concern	Mitigating Action
Establishment reviews	**Planned** Finance reviewing to allocate dedicated resources and work with Head of Nursing to align both workforce and £. Work is likely to result in requirement for business case to support additional requirements **Unplanned** Work underway to review ED floor – cost pressure identified of £1.7m against budget. Review underway to aim to reduce this request Review of medical workforce due to start shortly
H2 forecasts	To incorporate robust forecasting including cash releasing efficiency savings
Cost pressures resulting from both capital investment and ensuring resilient workforce	Need to ensure efficiencies are established to off set additional costs. Workforce in some areas are over-establish to mitigate risks of under delivery of ERF and potential high agency costs

Acute Performance M06 21-22

Acute Division inc Ambulance	Year to date		
	Plan £m	Actual £m	Variance £m
Planned	(39.5)	(39.7)	(0.2)
Unplanned	(29.5)	(30.8)	(1.3)
COO Management	-	(0.2)	(0.2)
Ambulance	(5.7)	(5.8)	(0.1)
Acute Division	**(74.6)**	**(76.5)**	**(1.9)**



Comment year to date:

- **Planned** – increased costs in areas such as Luccombe and Theatres
- **Unplanned** – Urgent Care Floor cost pressures and increased costs of medical workforce. In month additional costs incurred for ICU 2 have been reallocated to covid budgets
- **COO** management – overspend relates to remedium costs and unfunded Non-PBR drugs

Increased costs due to covid patients and continuation of elective activity

Highlights Finance Mental Health & LD

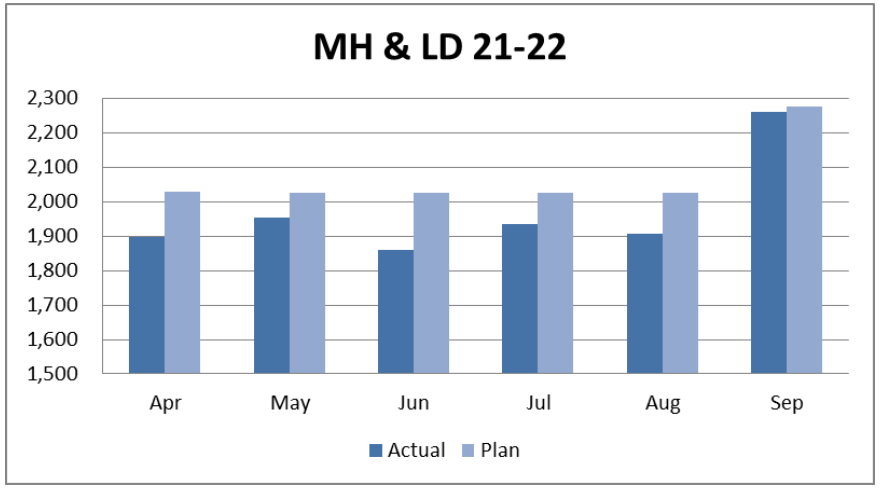
Key achievements/successes this period

- CQC results are awaited – although all indications are the MH & LD Division is improving, while maintaining costs within the financial envelope provided. A snapshot of achievements include the following being achieved within this financial envelope:
- CMHT – Waiting list stabilised and maintained, with a zero waiting list forecast for October
- MH Acute – Pressure on Acute inpatient services remains high, however OPEL 2/3 is now being consistently maintained, avoiding OPEL 4.
- Recovery service is bedding in, supporting the CMHT and Acute Services in avoiding OPEL 4 while actively managing complex cases.
- Liaison service is supporting the discharge process within Physical Health Acute Services
- CYP – Reduced the pressures on Paediatric Services and increased Community provision for Eating Disorder

Risk/Concern	Mitigating Action
Psychological Therapies (Highlighted through CQC) OPMH (Waiting List Initiative)	A solution is being presented to MH Board to support this concern through existing MH division budgets recurrently. A bid is being developed to try and obtain non recurrent slippage funding through the CCG to reduce the impact on divisional budgets forecast in H2. The need to address the OPMH waiting list is forecast in H2 with a request going forward to the CCG to support via slippage in year.
Forecasts for H2 are based on demands on MH services remaining consistent with H1. There is limited capacity to support any potential impact the pandemic may bring to the Division.	Any opportunity to seek additional resource to support any activity pressures will be pursued on a similar basis to that of the Psychological Therapies & OPMH.
Cost pressures resulting from both capital investment and ensuring resilient workforce	Need to ensure efficiencies are established to off set additional costs. There are on-going programmes to review and support both Medical & Nursing recruitment.

MH & LD Performance M06 21-22

Mental Health & LD Division	Year to date		
	Plan £m	Actual £m	Variance £m
Pay	(11.7)	(11.3)	0.4
Non-Pay	(1.4)	(1.2)	0.2
Income	0.7	0.7	-
Mental Health & LD Division	**(12.4)**	**(11.8)**	**0.6**



Comment Year to date:

- **Pay –** There are a number of vacancies within the division (partially off set by agency spend in some areas). Medics costs remain similar to M5 in 2020/21 with the main underspend seen against nursing posts.

- **Non Pay –** There are various small underspends in Non Pay, although a main contributing factor currently is a lower than budgeted mainland bed spend for OPMH/Dementia patients, however this is partially offset by additional security costs in MH due to Covid. Back dated costs of £150k

Highlights Finance Community

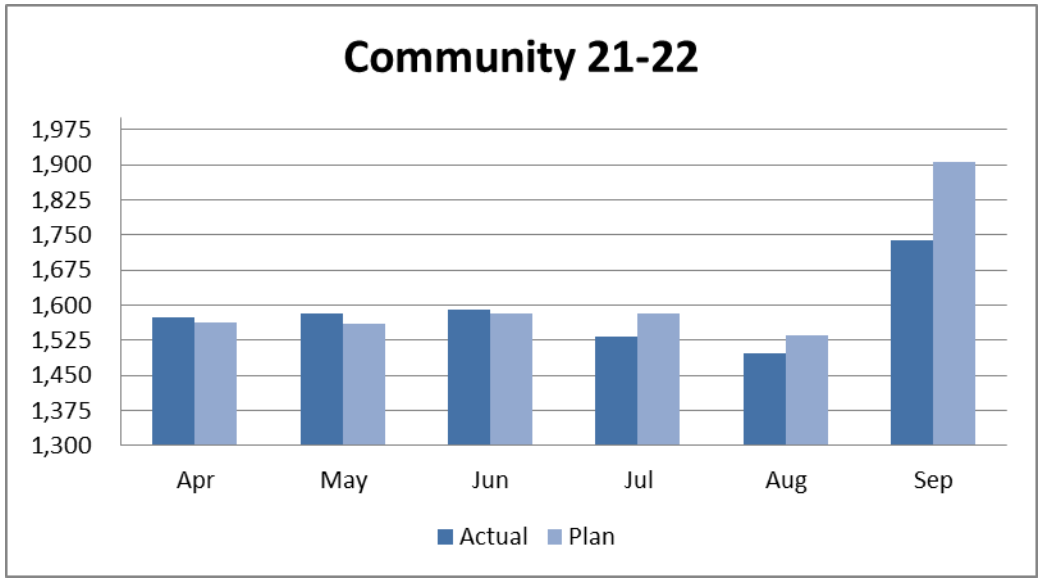
Key achievements this period

- Successful completion of audited accounts 2020-21
- Budgets available for half year 1 April 2021 – September 2021
- National pay inflation will be funded centrally, net nil impact to Division
- Surge funding bid submitted by Division to request support for increased demand (awaiting outcome)
- All Hospital Discharge costs for half year 1 agreed to be funded (no longer risk across ICS region up to September)

Risk/Concern	Mitigating Action
Forecasting of H2 (October 2021 – March 2022), considering full year effect of recruitment	To incorporate robust forecasting including cash releasing efficiency savings The position will need close monitoring with regular budget reviews with budget holders as recruitment continues
Prosthetics, Amputee increased demand now 50% of caseload	Request to be made at contract meeting to determine whether additional funding available outside of NHS England Block and planning for half year 2
Recovery for 2021-22	Demand & modelling underway to review impact of 5 recovery workstreams Wave 3, Long COVID, Supressed Demand, Recovery Impact (Acute) and back log waiting list. Elective Recovery posts recruitment progressed at risk
Staff Incremental pay rise cost pressure	2021-22 Budgets rolled over following FRB approval. No increase for staff annual incremental pay rise is included. However, staff turnover may offset this, as new starters should commence at the bottom of the scale

Community Performance M06 21-22

Community	Year to date		
	Plan £m	Actual £m	Variance £m
Pay	(8.6)	(8.6)	-
Non-Pay	(1.4)	(1.2)	0.2
Income	0.4	0.3	(0.1)
Community	**(9.7)**	**(9.5)**	**0.2**



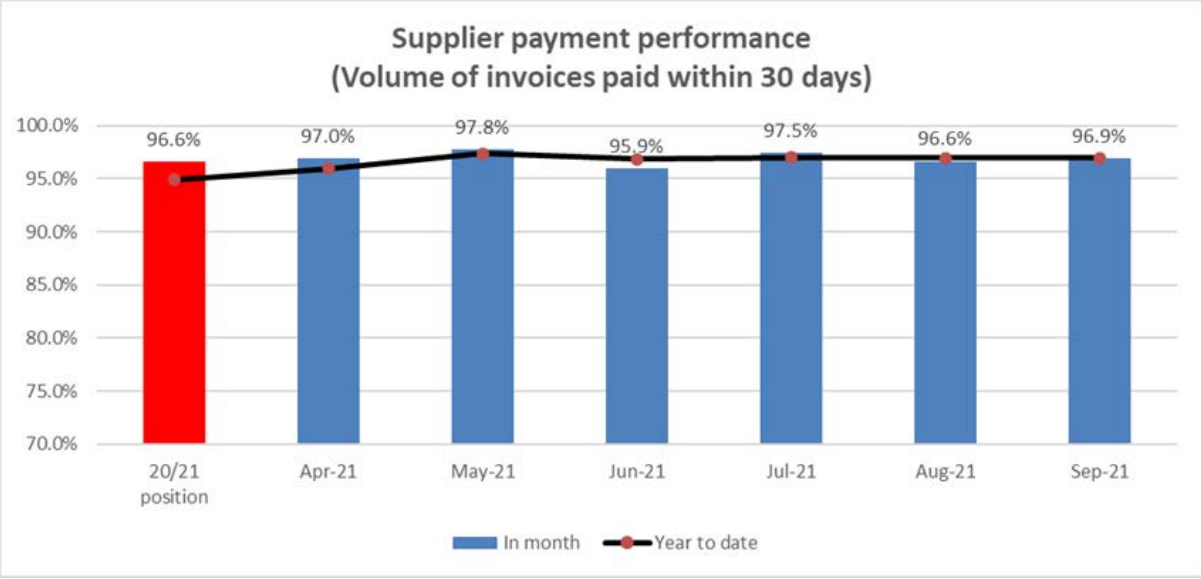
Comment Year to date:

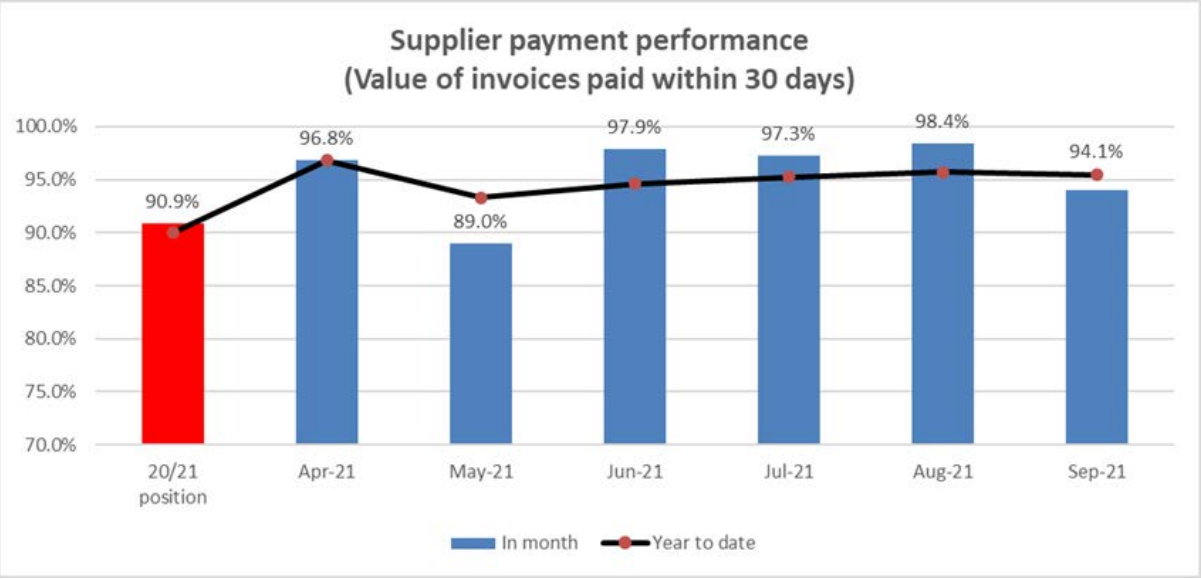
- Traditionally Community have been unable to fill vacancies therefore have not been fully establish, however to influence discharges and maintain patients out of hospital there has been an increase in in-post establishments as a result impacting on variance to budget.

Finance - Month 6 Supplier Payment Performance

The revised financial framework has allowed the Trust to maintain a positive cash balance and to be able to pay most suppliers within 30 days.
This has resulted in improved performance in meeting the NHS Better Payments Practice Code and in satisfying the increased scrutiny that NHSE/I are placing on this measure during 2021/22.

For the year to date the Trust has achieved figures of 96.9% for volume and 95.4% for value of invoices paid within 30 days.

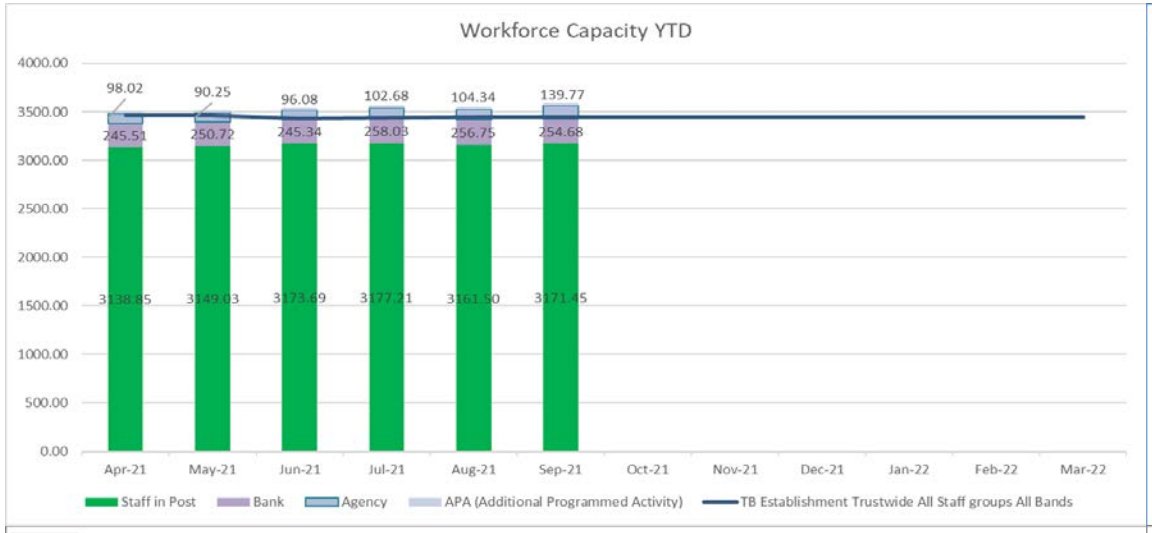


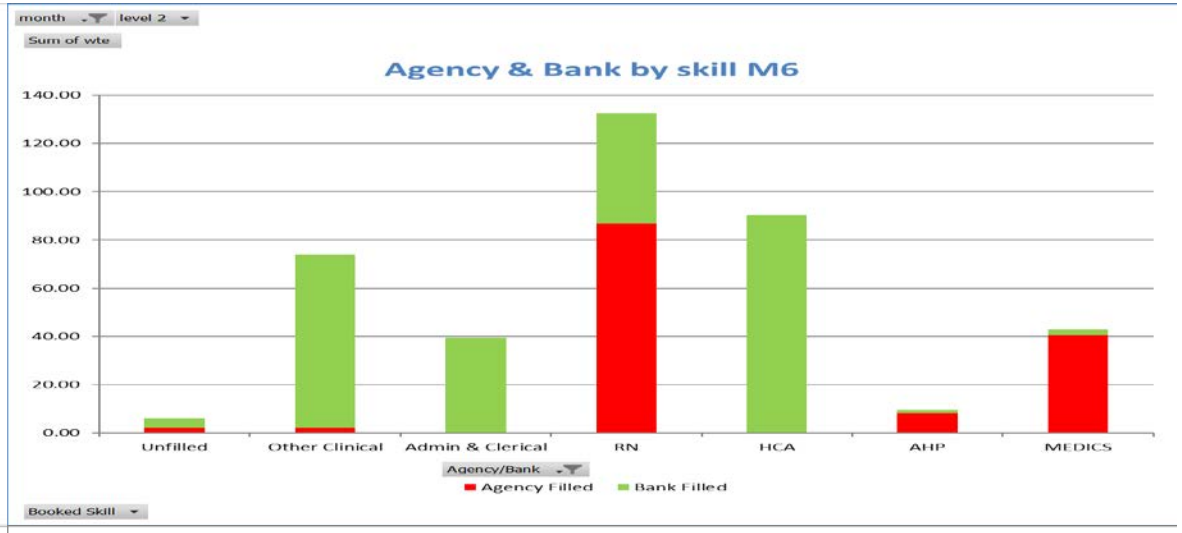


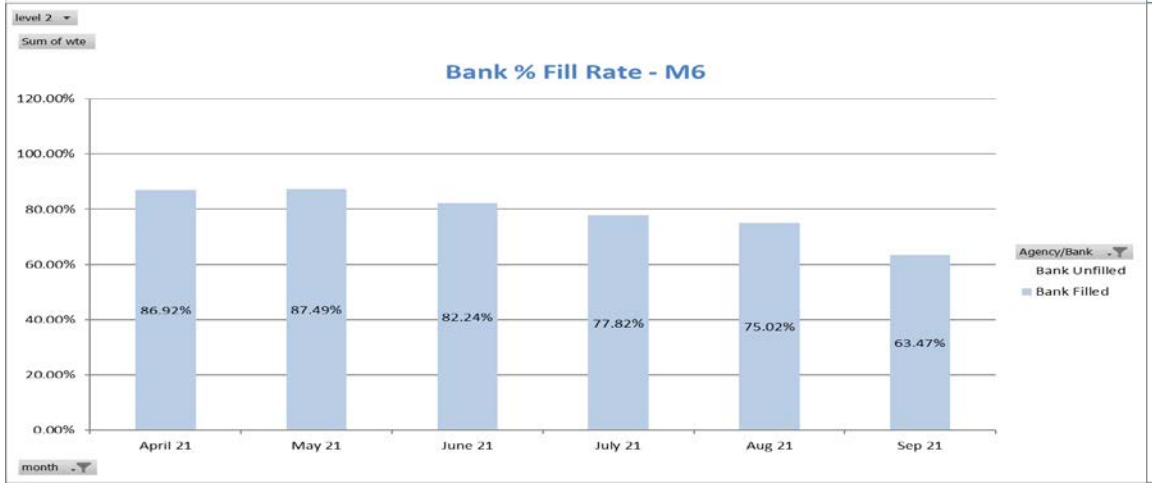
Workforce capacity

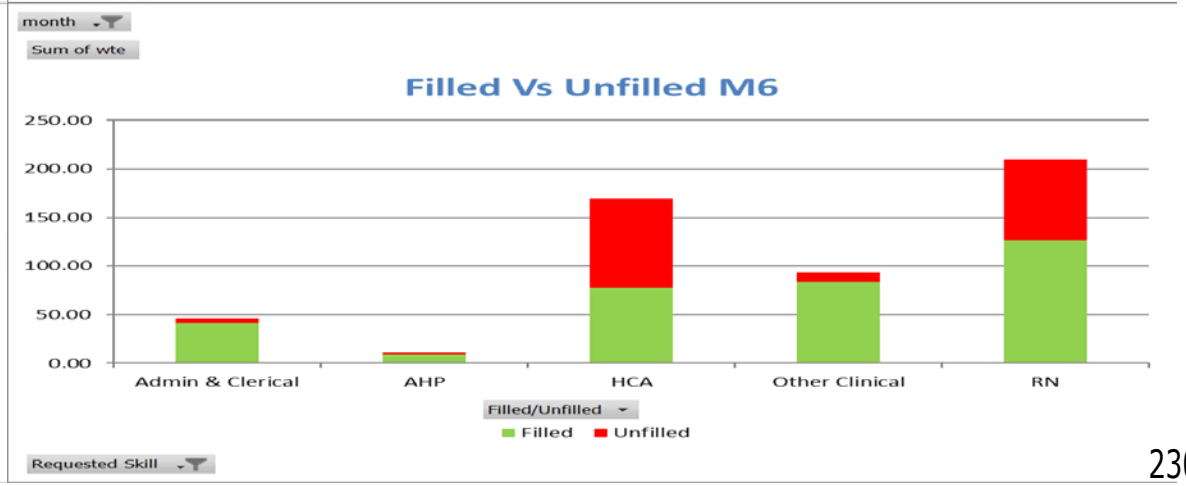
Summary

- Overall workforce capacity (substantive, bank, agency) was 3,564 FTE, which was over M6 budgeted establishment by 116 FTE. This is due to a operational pressures. Sickness has increased in M6 resulting in additional requirements on bank and agency staff. "Nursing Establishment Reviews" are still being undertaken to consider future budgeted establishment levels.
- Substantive staffing increased by 9 to 3170 FTE, and was 279 FTE below the M6 operational plan of 3450.
- Bank utilisation was 256 FTE in M6, against M5 which was 257 FTE. Agency usage for M6 was 138 FTE, 34 FTE increase on the 104 FTE used at M5. This has been to support operational pressures. HCSW recruitment drive will also support increasing bank to support the increased demand.







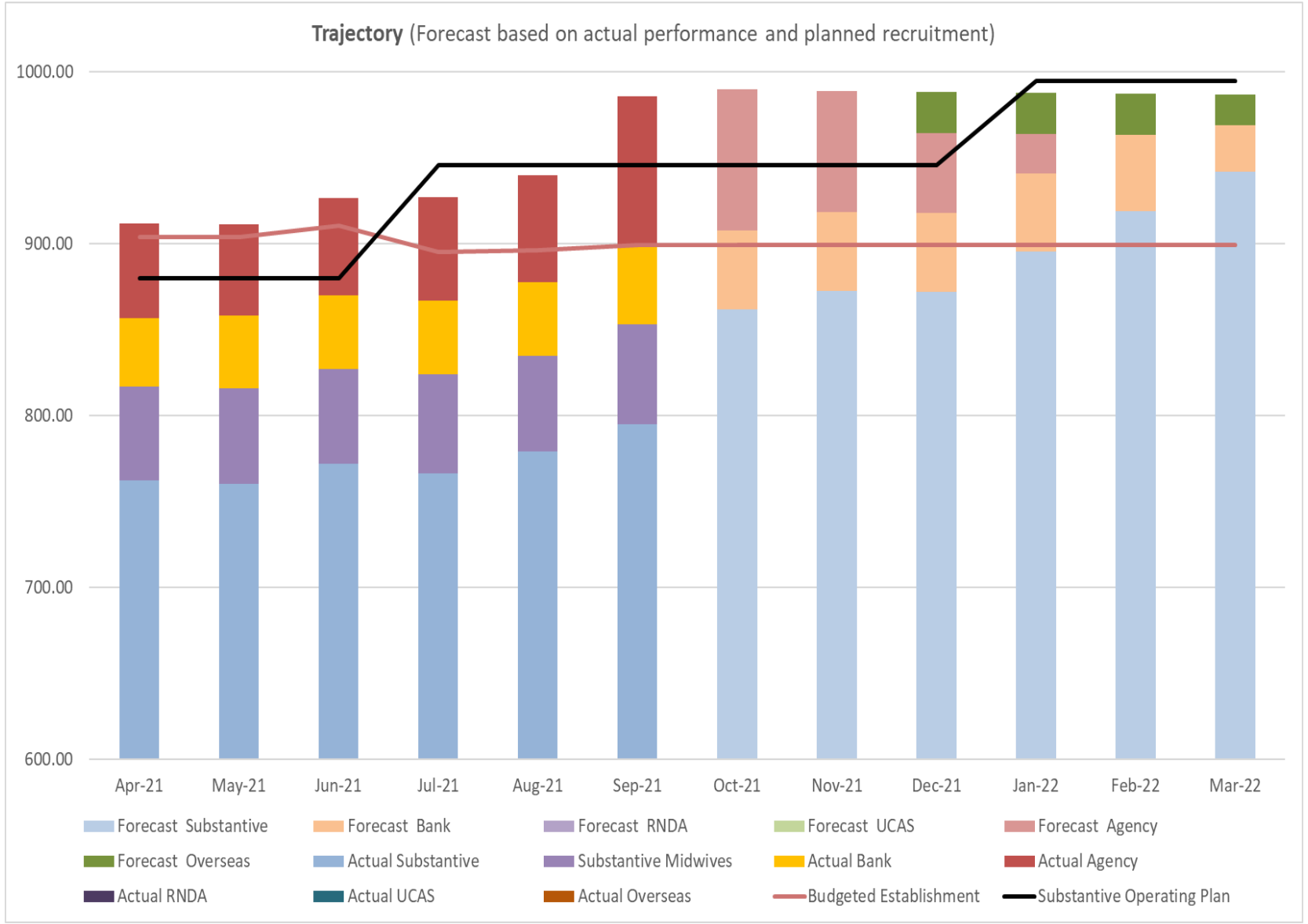


Registered Nurse Trajectory

Nurses 2021/22 Trajectory
Black line represents our Substantive Operating Plan FTE figures
Red Line represents our Budgeted Establishment Plan FTE

Overseas Recruitment

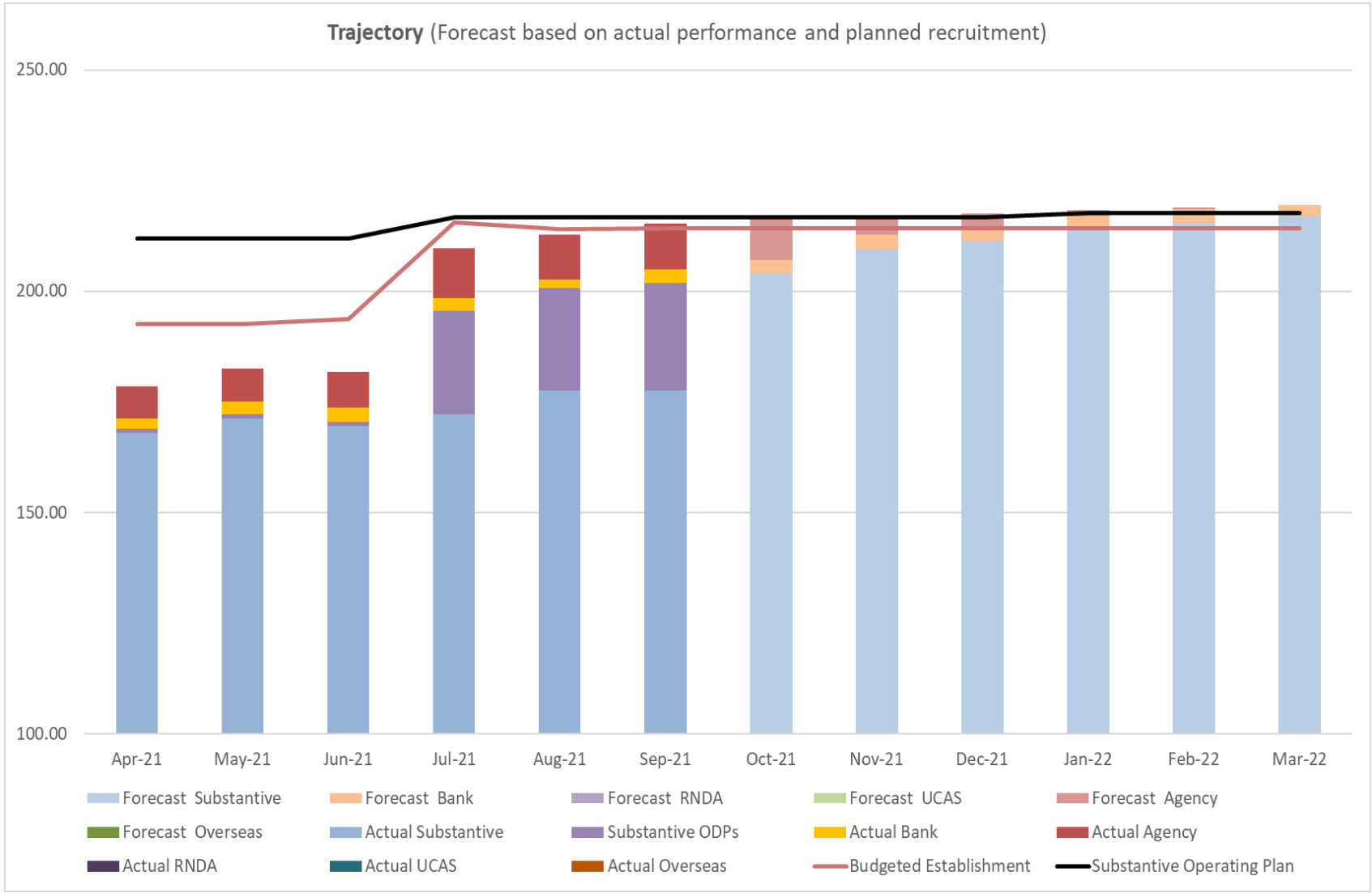
- International Deployment: For 2020/21: The Trust delivered 70 nurses who have now started and are in Band 5 roles.
- For 2021/22 (April 2021 - February 2022): 38 nurses have started work and are in a supernumerary role ahead of being confirmed in post substantively.
- The outstanding balance 74 nurses is broken down below and for noting we have a firm date for nurses arriving in October but not yet for the remaining months:
  - 29 October: 14 nurses are arriving
  - November: 20 nurses are planned to arrive (date to be confirmed)
  - December: 16 nurses are planned to arrive (date to be confirmed)
  - January/February 2022: 24 nurses are planned to arrive (date to be confirmed)
- NHSIE have confirmed that we have an extension to end of Feb 22 to complete the nurse recruitment plan. The extension is reflected on the challenges for the Trust to deploy during Jun- Aug 21 due to Covid and travel restrictions
- Continued challenges with recruiting RMHNs. We now have a cohort of 4 RMHN's anticipated deployment early December. 3 RMNH currently in process
- We are partnering with Yeovil NHS Trust and ID Medical to support recruiting acute registered nurses from overseas
- In September we deployed 19 acute RN's
- We are aiming for 2 deployments per month to meet the remaining target of nurses and have engaged with Yeovil NHS Trust to support with OSCE delivery as we intend to increase the number of cohorts per month.



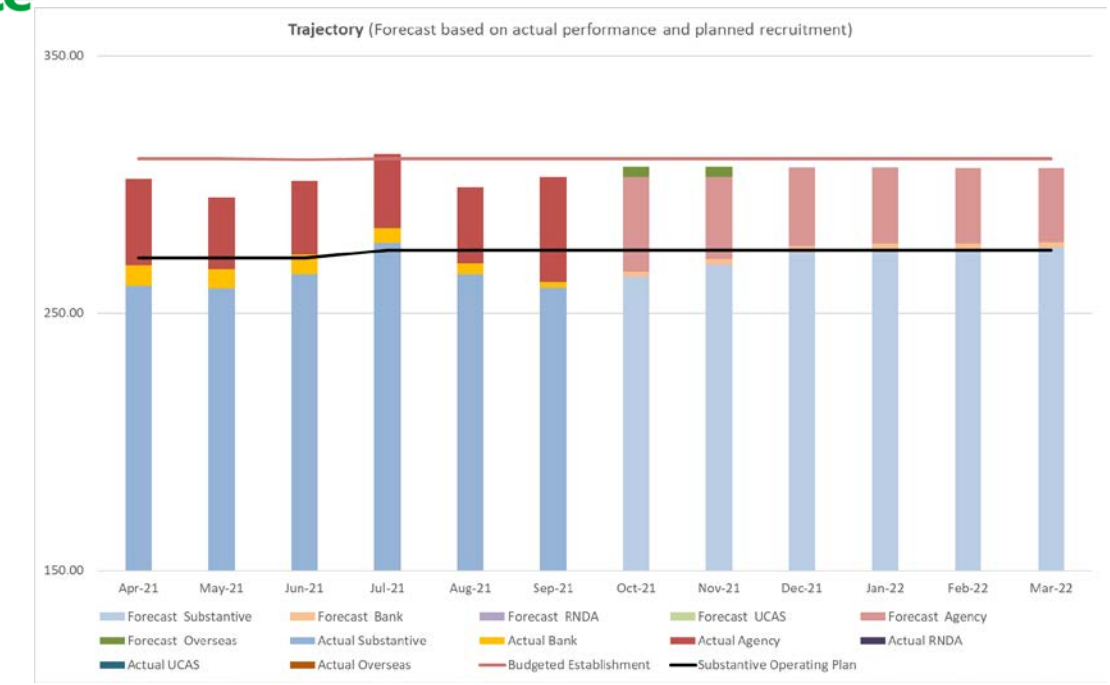
Allied Health Professionals Trajectory

Summary

- Recruitment to the 9 AHP apprenticeship posts in Oct/Nov with anticipated start date Jan/Feb 22
- Allied Health Professionals form part of the roll-out programme for e-rostering job planning.
- Appointed/Started in month:
  - 2 x Occupational Therapists (1 x international recruitment)
  - 2 x Physiotherapists
  - 1 x Paramedics



Medical Workforce Recruitment Status



Total Trust Medical and Dental Planned Establishment = 282.37 vs In post = 238.38, variance = 43.99 fte

Current Situation & Key Recruitment Risks:

- 3 FTE Consultant Radiologist vacant
- 2 FTE Consultant Stroke vacancies
- 2 FTE Consultant Gastroenterologist vacancies
- 1 FTE Consultant Urologist vacancy
- 4 FTE Consultant Emergency Medicine
- General Medicine SpR gaps continues to pressure out of hours junior rota.
- 5 FTE Consultant Vacancies in MHLD division (General Adult x2, OPMH, Learning Disabilities, CAMHS).

Mitigation:

- Radiologist booked until 31st December 2021 and active sourcing on further posts.
- Locum Consultant Stroke post offered and accepted to commence in November 2021.
- Stroke Consultant secured until 31st December, alongside weekday support from PHUT. Weekend trial to commence upon completion of project plan.
- Gastroenterology, GIM and Geriatrics roles being reviewed.
- Consultant Geriatrician AAC being arranged for 2nd November.
- Offer being developed for CESR candidate to commence in 2022.
- Locum to be extended for 12 months and further requirements being sourced.
- AAC for Consultant Emergency Medicine scheduled for 25th October; three prospective appointments.
- Specialty Doctor in General and OPMH appointed to commence in October 2021 following GMC delay.
- HOLT locums secured until 31st December and into January 2022.
- Offer to be developed to convert CAMHS doctor to NHS locum contract.

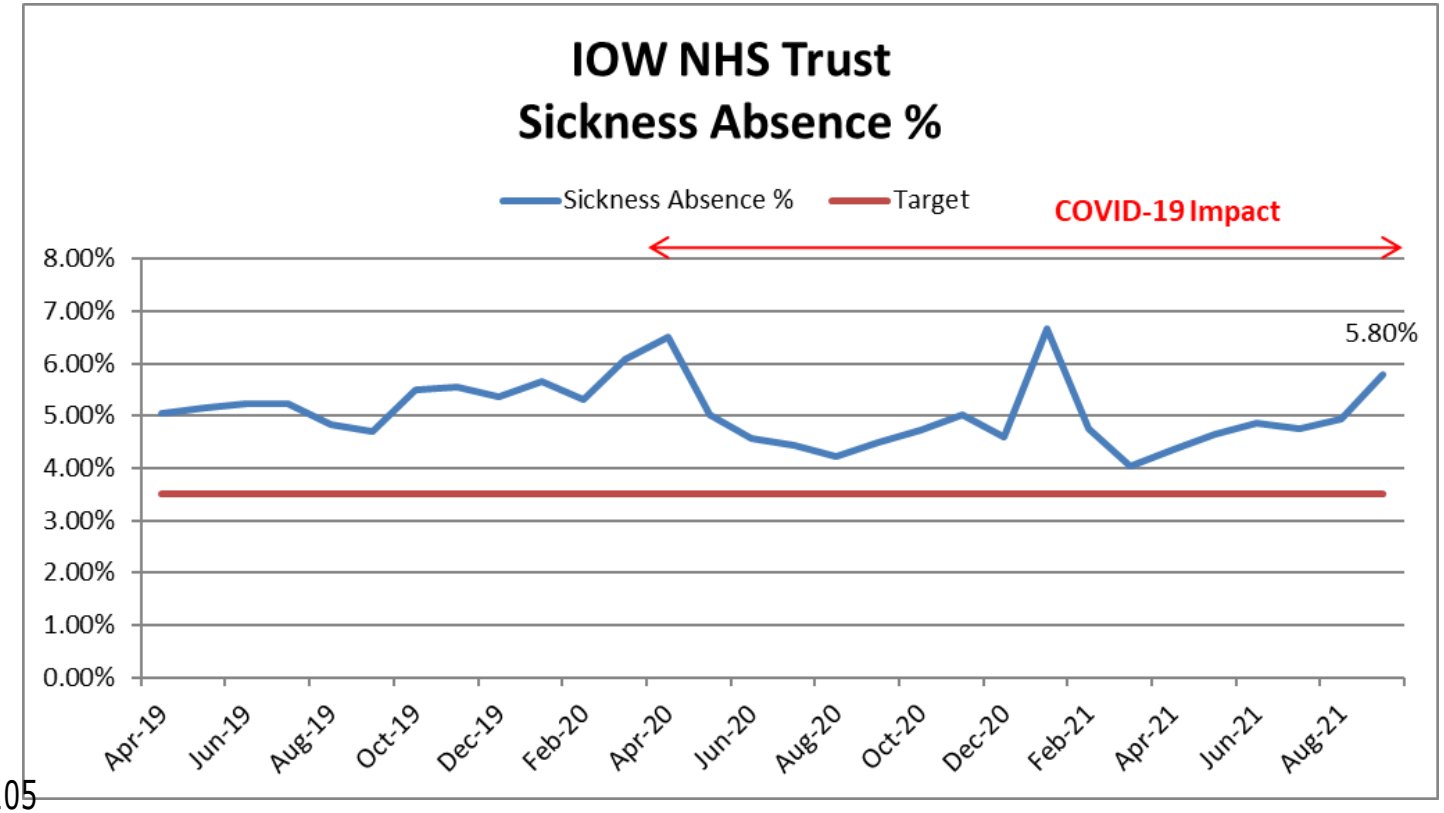
Staff Sickness Absence

Summary

- Sickness absence has seen an increase in M6 to 5.80% (M5 4.94%), of which, COVID related sickness is 0.75% (M5 0.50%) and Anxiety/stress/depression/other psychiatric illnesses is 1.46% (M5 1.28%), and Cold Cough, Flu is 0.62%
- "Stress, anxiety, depression" remains the highest cause of sickness absence, primarily through long term sickness. Specialist mental health support is being provided by Occupational Health as part of the Trust's Health and Wellbeing offer.
- Highest reasons of sickness absence: 1. Anxiety/stress/depression/other psychiatric illnesses, 2. Infectious diseases 3. Cold, Cough, Flu - Influenza 4. Other musculoskeletal problems 5. Back Problems

Month 6 staff absence - performance by division

Division	Target	Actual	Variance
Acute Services	3.50%	5.56%	2.06%
Ambulance & Patient Transport	5.50%	7.73%	2.23%
Community Division	3.50%	6.10%	2.60%
Corporate Nursing	3.50%	4.02%	0.52%
Finance & Performance Mgt	3.50%	6.39%	2.89%
HR & Organisational Developmen	3.50%	2.85%	-0.65%
Medical Directorate	3.50%	1.28%	-2.22%
Mental Health & Learning Disab	4.50%	7.07%	2.57%
Quality Governance	3.50%	0.45%	-3.05%
Trust Administration	3.50%	0.68%	-2.82%
Trust	**3.50%**	**5.80%**	**2.30%**



HR Actions to Mitigate Areas of High Sickness:

- HR Officers are developing a reasonable adjustment framework to support managers which will be accompanied with a bespoke bitesize practical training session for managers.
- Monthly LTS meeting reinstated between HR & Occupational Health to proactively review LTS across the Trust

Ambulance:

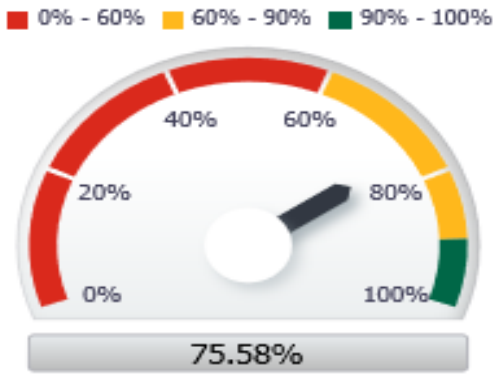
- Monthly meeting with HR Officer, OH and frontline service manager in place to review attendance management cases and to provide additional support.
- HR colleagues are working in collaboration with ambulance operational manager on extraction rates in the division
- HR Officer to establish monthly meetings with all ambulance service managers to review sickness absence.

Community:

- HR Officer to set up monthly sickness meetings with Cluster Leads to review sickness absence.

Organisational Development Report

Appraisal Compliance

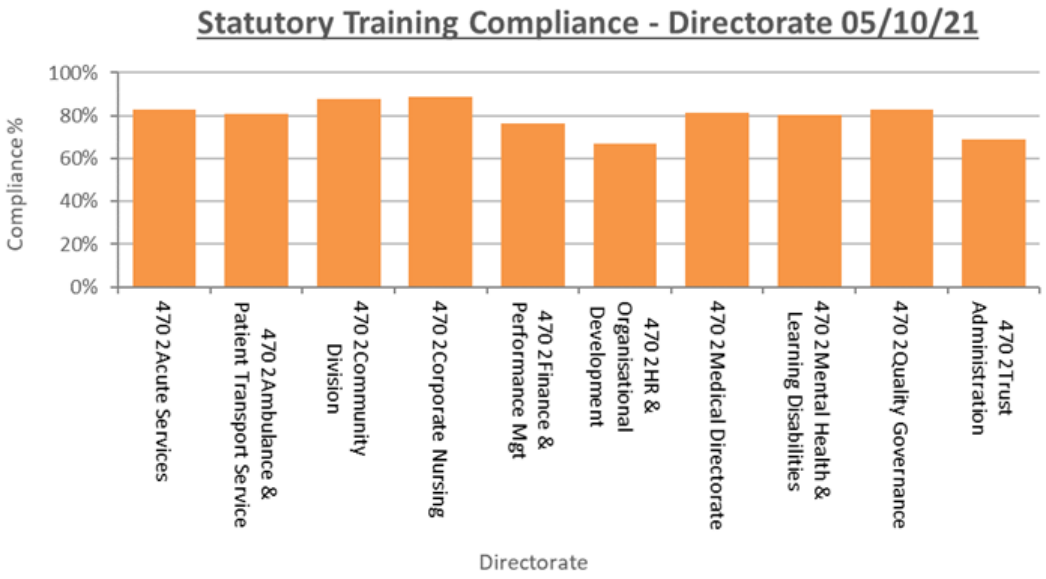


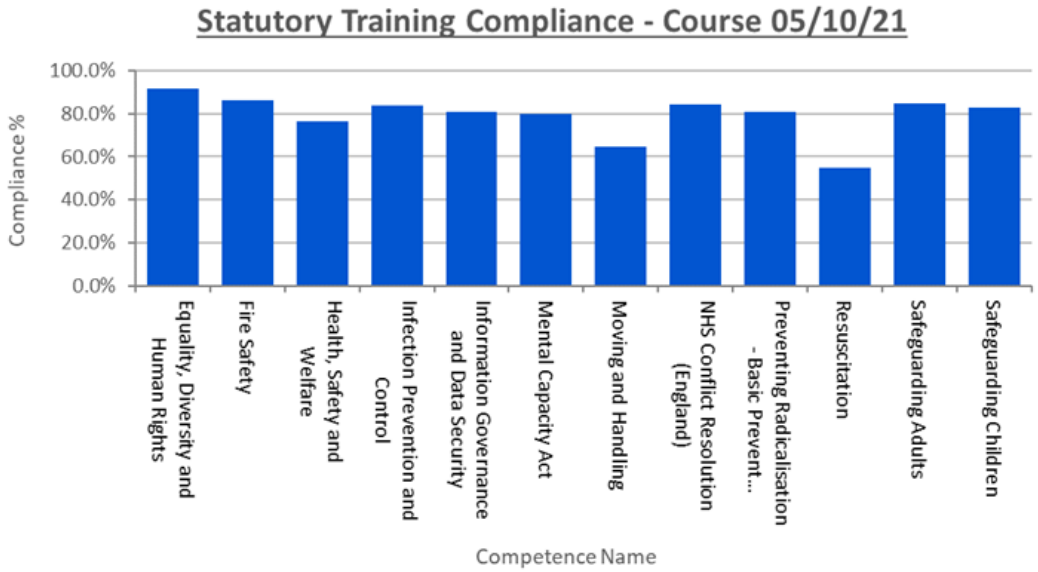
- The Trust is making progress in improving Appraisal compliance with 75.58% completion as at 18/10/2021 against a target of (95%) by March 2022
- Appraisal Bitesize clinics have been extended for delivery in September and October 2021 to support our people understanding and completing the paperwork.
- The Appraisal process will be reviewed in Q4 2021/22

Org L2	Assignment Count	Reviews Completed	Reviews Completed %
470 2Acute Services	1,461	990	67.76
470 2Ambulance & Patient Transport Service	215	146	67.91
470 2Community Division	399	370	92.73
470 2Corporate Nursing	34	34	100.00
470 2Finance & Performance Mgt	306	208	67.97
470 2HR & Organisational Development	101	83	82.18
470 2Medical Directorate	21	19	90.48
470 2Mental Health & Learning Disabilities	371	334	90.03
470 2Quality Governance	30	29	96.67
470 2Trust Administration	35	34	97.14
Grand Total	**2,973**	**2,247**	**75.58**

Statutory Mandatory Training

Statutory Mandatory Training Compliance – 05/10/2021





Statutory Mandatory Training Compliance – 05/10/2021

Commentary

- Trust compliance overall is currently 80%, which is a 2% increase on last month.
- Health, Safety and Welfare, Mental Capacity Act, Moving & Handling, and Resuscitation are currently below 80%.
- All Statutory training is available online with the exception of Resuscitation which is face to face and Moving & Handling Level 3, which is a departmental competency assessment.
- Training & Education are continuing to work through remaining data anomalies and profile amendment requests with regard to Statutory training requirements during October with the aim to have the data fully aligned by the end of the month.

Organisational Development Report

1. Diversity and Inclusion

This report highlights key activity in regard to the Diversity and Inclusion actions set out in the Trust People and OD Strategy:

- Celebration of diversity calendar events via Staff Equality Networks (including Black History Month October 2021)
- WRES/WDES submission to NHSE/I achieved and data will be further analysed and improvement actions co-produced via the Staff Equality Networks in Q3 2021/22
- GPG submission will be reported by 5 October 2021 as per national guidelines.
- Achievement of Disability Confident 'Leader' status (Disability Confident) which focuses on improving staff engagement; staff experience and employee relations. This has been further enhanced via improvements in NHS Staff Survey 2020 WDES data.
- Launch of Equality Standard in Q3 2021/22; this will focus on building organisational understanding and capability to the service delivery and workforce impacts of equality and diversity and strengthen existing governance and reporting arrangement.

2. Staff Engagement

This report highlights key activity in regard to the staff engagement actions set out in the Trust People and OD Strategy:

- NHS Staff Survey has been launched with a 24.9% response rate w/c 18 October 2021
- Q3 staff engagement activity is focussed on NHS Staff Survey
- Working form Home Staff Network continues to provide support and wellbeing offer to our people
- TeamCARE interventions is being delivered virtually via MS Teams with an enhanced focus on the Paediatric Team (Acute Division)and Children's Physiotherapy Team (Community Division)
- The Trust has been requested by NHS Employers to build a case study to put a positive spotlight on the NHS Staff Survey improvements (NHS Staff Survey 2020)

3. Collective Leadership

This report highlights key activity in regard to the Collective Leadership actions set out in the Trust People and OD Strategy:

- Project initiation documents are being designed for (i) values based recruitment and exit interviews; and (ii) Just Culture.
- LeaderFest 2021 will delivered in Q3 2021 involving members of the Executive team delivering leadership seminars
- Delivery of Leadership and Management Essentials with an evaluation to be completed by end of October 2021.
- The Introduction to Line Management Programme is currently outstanding (pending Trust decision for face to face delivery)

4. Health and Wellbeing

This report highlights key activity in regard to the Health and Wellbeing actions set out in the Trust People and OD Strategy:

- Health and Wellbeing remains a critical priority for the Trust and the Trust has been identified as a national Trailblazer site to pilot the new HWB Framework. Q3 focus on (i) organisational enablers (Leadership; Data and Communication; and Healthy Work Environment) and (ii) organisational interventions (Mental Health; MSK; and Healthy Lifestyle).

Established Programmes

- Health and Wellbeing Champions Network
- Menopause Matters Network
- Thrive Newsletter
- TeamCARE – team development programme
- HIOW ICS Enhanced HWB Service

New Programmes Q3 2021/22

Wellbeing Essentials - a dedicated programme of health and wellbeing virtual events focusing on improving mental and physical health

Schwartz Rounds - provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care