Thursday 6 September 2018, 10:30-13:00
Northwood House, Ward Avenue, Cowes, Isle of Wight PO31 8AZ
# Governing Body

**AGENDA**

**Thursday 6 September 2018, 10:30-13:00**

Northwood House, Ward Avenue, Cowes, Isle of Wight PO31 8AZ

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Care Home Framework Presentation</td>
<td>MR</td>
<td>10:30</td>
</tr>
<tr>
<td><strong>1.1</strong></td>
<td>Apologies for absence: Gillian Baker, Laurence Taylor, Michele Legg</td>
<td>MD</td>
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<tr>
<td><strong>1.2</strong></td>
<td>Declaration of Interests</td>
<td>MD</td>
<td>GB18-038</td>
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<tr>
<td><strong>1.3</strong></td>
<td>Confirmation that the Meeting is Quorate</td>
<td>MD</td>
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<tr>
<td><strong>2.</strong></td>
<td>Minutes of the last Governing Body Meeting 19 July 2018</td>
<td>MD</td>
<td>GB18-039</td>
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<tr>
<td><strong>3.</strong></td>
<td>Matters Arising from the Minutes</td>
<td>MD</td>
<td>GB18-040</td>
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<tr>
<td><strong>3.1</strong></td>
<td>Schedule of Actions from the 19 July 2018</td>
<td>MD</td>
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<td><strong>4.</strong></td>
<td>Questions from the Public</td>
<td>MW/MD</td>
<td>Verbal</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Chair / Managing Director Report</td>
<td>MW/MD</td>
<td>GB18-041</td>
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<tr>
<td><strong>5.1</strong></td>
<td>Local Care Board Update</td>
<td>MW</td>
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<td><strong>6.</strong></td>
<td>Items for Approval</td>
<td>MW</td>
<td>Verbal</td>
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<tr>
<td><strong>6.1</strong></td>
<td>Partnership Governance</td>
<td>MW</td>
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<tr>
<td><strong>6.2</strong></td>
<td>Health and Wellbeing Strategy (Public Health)</td>
<td>LO</td>
<td>GB18-042</td>
</tr>
<tr>
<td><strong>6.3</strong></td>
<td>Budget and Financial Plan</td>
<td>JC</td>
<td>GB18-043</td>
</tr>
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<td><strong>6.4</strong></td>
<td>Vacancy and Investment Freeze</td>
<td>LO</td>
<td>Verbal</td>
</tr>
<tr>
<td><strong>6.5</strong></td>
<td>Clinical Senate Terms of Reference (Phil Hartwell)</td>
<td>LO</td>
<td>GB18-044</td>
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<td><strong>6.5</strong></td>
<td>Information Governance Policies</td>
<td>LO</td>
<td>GB18-045</td>
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<tr>
<td><strong>6.6</strong></td>
<td>Mental Health Blueprint (Sue Lightfoot)</td>
<td>JS</td>
<td>GB18-046</td>
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<td><strong>7.</strong></td>
<td>Items for Assurance</td>
<td>JS</td>
<td>GB18-047</td>
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<tr>
<td><strong>7.1</strong></td>
<td>Autism Spectrum Disorder Update (Sue Lightfoot)</td>
<td>JS</td>
<td>GB18-048</td>
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<tr>
<td><strong>7.2</strong></td>
<td>Integrated Performance Report</td>
<td>JC</td>
<td>GB18-048</td>
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<tr>
<td><strong>7.2.1</strong></td>
<td>Performance</td>
<td>LO</td>
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<td><strong>7.2.2</strong></td>
<td>Quality</td>
<td>MR</td>
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<td><strong>7.2.3</strong></td>
<td>Commissioning</td>
<td>JS</td>
<td></td>
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<tr>
<td><strong>7.2.4</strong></td>
<td>Finance</td>
<td>JC</td>
<td></td>
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<td><strong>7.3</strong></td>
<td>CCG Improvement and Assessment Framework</td>
<td>LO</td>
<td>GB18-049</td>
</tr>
</tbody>
</table>
7.4 Governing Body Assurance Framework (Phil Hartwell) – To Follow

8. Minutes to Receive
8.1 Clinical Senate Minutes July 2018
8.2 Finance, Performance and Planning Committee Minutes June 2018
8.3 Primary Care Committee June 2018

9. Any Other Urgent Business

10. Motion to exclude the Press and Public

11. Date of Next Meeting –
To be confirmed.

Circulation:

Members
Martyn Davies – Governing Body Lay Member – Governance (Deputy Chair)
Jane Cole (JC) – Chief Finance Officer (Seconded)
Dr Michele Legg – CCG Chair
Loretta Outhwaite – Deputy Chief Officer
Melanie Rogers – Director of Nursing and Quality / Governing Body Nurse
Dr Mark Sopher – Secondary Care Doctor
Laurence Taylor – Governing Body Lay Member-Independent
Carole Truman – Governing Body Lay Member – Patient and Public Involvement
Martin Wakeley – Managing Director
Dr Timothy Whelan – Clinical Executive

In attendance:
Gillian Baker – Director of Strategy and Partnerships
Phil Hartwell, Head of Governance
Jonathan Smith, Assistant Director of Integrated Commissioning
Cabrini Salter – Clinical Executive
Sarah Westmore – Clinical Executive
Rebecca Berryman, Governance Support Officer (Minutes)

For Information (Agenda):
For Information (Minutes):
Invited:
## Governing Body

### Declaration of Governing Body Members’ Interests

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Loretta Outhwaite, Deputy Chief Officer</th>
</tr>
</thead>
</table>
| **Summary of issue:** | This paper sets out the relevant and material interests of the members of the CCG Governing Body. It represents the Register of Interests as required by the Standing Orders in accordance with the NHS Code of Accountability.  
This paper supports the CCG Governing Body to fulfil its Standing Orders in accordance with the NHS Code of Accountability. |
| **Action required / recommendation:** | The CCG Governing Body is being asked:  
• To receive and note the register of interests of members and ensure that members play no part in discussion or decision where a conflict of interest is established.  
• To receive any oral updates on the interests of members. |
| **Principle risk(s) relating to this paper:** | There are no risks relating to this paper. |
| **Other committees where this has been considered:** | This paper has not been considered at any other committee. |
| **Financial / resource implications:** | There are no financial or resource implications arising from this paper. |
| **Legal implications / impact:** | There are no legal implications arising from this paper. |
| **Public involvement /action taken:** | There has been no public involvement or action taken. |
| **Equality and diversity impact:** | This paper does not request decisions that impact on equality and diversity |
| **Author of Paper:** | Rebecca Berryman, Governance Support Officer |
| **Date of Paper:** | August 2018 |

**Date of Meeting:** 6 September 2018  
**Agenda Item:** 1.2  
**Paper number:** GB18-038
Declaration of Interest

1. Introduction

1.1 The NHS Code of Accountability requires the Governing Body to declare interests which are relevant and material to the Governing Body of which they are a member.

1.2 Interests which should be regarded as “relevant and material” are:

- Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

- Majority or controlling share-holdings in organisations likely or possible seeking to do business with the NHS;

- A position of authority in a charity or voluntary organisation in the field of health or social care;

- Any connection with a voluntary or other organisation contracting for NHS services;

- Research funding/grants that be received by an individual or their department;

- Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the CCG must be declared);

1.3 Any Governing Body Member who comes to know that the CCG Governing Body has entered into or proposed to enter into a contract in which he/she or any person connected with him/her (as defined in the Standing Orders) has any pecuniary interest, direct or indirect, the Governing Body member shall declare his/her interest by giving notice in writing of such fact to the CCG Governing Body as soon as practicable.

1.4 The Chief Officer will ensure that a Register of Interests is established to record formally declarations of interests of Governing Body Members. Interests will be declared at Governing Body meetings to ensure they are known to the public.
# 2. Register of Interests

<table>
<thead>
<tr>
<th>Name</th>
<th>Relevant and Material Interests</th>
<th>Last Updated/Noted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gillian BAKER</td>
<td>Gillian’s has no interests to declare.</td>
<td>January 2018</td>
</tr>
<tr>
<td>Director of Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Partnerships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martyn DAVIES</td>
<td>Martyn is: Employed in advisory role and a Governor at the Island Free School. Treasurer for Holy Trinity Church, Bembridge. Trustee for Brading Haven YC</td>
<td>June 2018</td>
</tr>
<tr>
<td>Governing Body Lay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member – Governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Deputy Chair)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phil HARTWELL</td>
<td>Phil’s partner works in Pathology at IOW NHS Trust.</td>
<td>October 2017</td>
</tr>
<tr>
<td>Head of Governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michele LEGG</td>
<td>Michele is: GP Partner at Tower House Surgery. Commercial partnership Island Clinical Academic services. School Governor of Ryde School. President of IOW Osteoporosis society. Michele’s partner is undertaking some work in the spinal triage clinic at St Marys Hospital, he also undertakes sessions in the EAS. Michele also undertakes the occasional session in the EAS when needed. All GP Practices will potentially be receiving funding through My Life A Full Life.</td>
<td>October 2017</td>
</tr>
<tr>
<td>Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loretta OUTHWAITE</td>
<td>Loretta’s sister-in-law is a staff nurse in the Intensive Care Unit at the Isle of Wight NHS Trust.</td>
<td>March 2018</td>
</tr>
<tr>
<td>Deputy Chief Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanie ROGERS</td>
<td>Melanie is: A CQC Specialist Advisor</td>
<td>June 2018</td>
</tr>
<tr>
<td>Director of Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Clinical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Mark SOPHER</td>
<td>Mark is: Consultant Cardiologist and Care Group Medical Lead, Royal Bournemouth Hospital. Medical Director of Technomed – provider of ECG Services. Private Practice at Dorset Heart Clinic / Nuffield Hospital Bournemouth. Is a Council member, British Heart Rhythm Society</td>
<td>October 2017</td>
</tr>
<tr>
<td>Secondary Care Doctor</td>
<td></td>
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<tr>
<td>Jonathan SMITH</td>
<td>Jonathan’s post is a joint appointment with the Local...</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Details</td>
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</tr>
<tr>
<td>Laurence TAYLOR</td>
<td>Governing Body Lay Member</td>
<td>Laurence is: Director of Bembridge Airport Ltd and Bembridge Farm Ltd. He is employed by EU &amp; FT Taylor Ltd</td>
</tr>
<tr>
<td>Carole TRUMAN</td>
<td>Governing Body Lay Member – Patient and Public Involvement</td>
<td>Carole has no declaration of interests.</td>
</tr>
<tr>
<td>Dr Timothy Whelan</td>
<td>Deputy Clinical Chair</td>
<td>Timothy is: A GP Partner at The Dower House Surgery with ownership of land or rental property (accommodation used by the CCG) of The Dower House Surgery, 27 Pyle Street, Newport, Isle of Wight, PO30 1JW. RCGP Regional Ambassador for Hampshire and the Isle of Wight (average 1 or 2 sessions per month since July 2016). Timothy holds nominal £1 Shares with Lighthouse Medical. All GP Practices will potentially be receiving funding through My Life A Full Life.</td>
</tr>
<tr>
<td>Martin Wakeley</td>
<td>Managing Director</td>
<td>Martin is: A Shareholder of Nth Dimension.</td>
</tr>
<tr>
<td>Dr Sarah WESTMORE</td>
<td>Clinical Executive</td>
<td>Sarah is: A GP Partner at Cowes Medical Centre of which is part of the federation One Wight Health. Sarah has a relative who is a staff nurse at Shackleton Ward. All GP Practices will potentially be receiving funding through My Life A Full Life.</td>
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</tbody>
</table>
# Governing Body

## Minutes of the Governing Body 19 July 2018

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Michele Legg, CCG Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of issue:</td>
<td>Minutes of the previous Governing Body Meeting held on 19 July 2018.</td>
</tr>
<tr>
<td>Action required/recommendation:</td>
<td>To approve the minutes of the Governing Body minutes 19 July 2018.</td>
</tr>
<tr>
<td>Principle risks:</td>
<td>There are no risks relating to this paper.</td>
</tr>
<tr>
<td>Other committees where this has been considered:</td>
<td>This paper has not been considered at any other committees.</td>
</tr>
<tr>
<td>Financial /resource implications:</td>
<td>There are no financial or resource implications, other than those within the agenda items discussion.</td>
</tr>
<tr>
<td>Legal implications/impact:</td>
<td>These minutes form a formal public record of the previous meeting.</td>
</tr>
<tr>
<td>Public involvement/action taken:</td>
<td>The Governing Body was held in public.</td>
</tr>
<tr>
<td>Equality and diversity impact:</td>
<td>There is no equality and diversity impact relating to this paper.</td>
</tr>
<tr>
<td>Author of paper:</td>
<td>Rebecca Berryman, Governance Support Officer</td>
</tr>
<tr>
<td>Date of Paper:</td>
<td>20 July 2018</td>
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<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>06 September 2018</th>
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<tr>
<td>Agenda Item:</td>
<td>2</td>
</tr>
<tr>
<td>Paper number:</td>
<td>GB18-039</td>
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</tbody>
</table>
1. **Apologies for Absence**

18-038 Apologies for absence were received from Gillian Baker, Benjamin Browne, Maggie MacIsaac and Loretta Outhwaite. Ros Hartley attended on behalf of Maggie MacIsaac.

Cabrini Salter and Sarah Westmore were welcomed as co-opted members of the Governing Body.

1.1 **Declarations of Interest**

18-039 The Governing Body received and noted paper GB18-023 Declaration of Interests. There were no new declarations made and no declarations in relation to any of the agenda items. It was noted CS and SW’s declarations would be added for the next meeting.

The Governing Body **noted** the Declaration of Interest.

1.2 **Confirmation the Meeting is Quorate**

18-040 Confirmed.

2. **Minutes of the Last Governing Body Meeting 24 May 2018**
The Governing Body received paper GB18-024 Minutes of the last Governing Body Meeting 24 May 2018. The minutes were approved as a true and accurate record.

The Governing Body approved the Governing Body Minutes of the 24 May 2018.

3. Schedule of Actions

The Governing Body received paper GB18-025 Schedule of Actions from 24 May 2018. The following was discussed:

- **17-107 - Thematic Analysis of Serious Incidents** – due to the priority for the Quality Team to support the Isle of Wight NHS Trust (IOWNHST) with Serious Incidents, this has delayed the report to the Governing Body. It will be presented at the September 2018 Governing Body meeting.
- **17-121 (2) / 18-015 Ambulance** – on the agenda – actions closed.
- **18-002 – Declarations of Interest** – ML and TW have updated their record – action closed.
- **18-006 – Board to Board Meeting** – discussing with IOWNHST regarding date and agenda.
- **18-006 (4) – Joint Financial Recovery Board** – formal dates to be arranged.

The Governing Body received the Schedule of Actions.

4. Submitted Questions from the Public

ML advised no questions had been submitted by the public.

5. Chair Report

5.1 Update

ML highlighted that it had been a challenging week for the CCG. She was dismayed to hear the concern raised by the Overview and Scrutiny Committee with specific reference to the Sandown GP Practice temporary list closure and Autism Spectrum Disorder (ASD) Referrals. She confirmed that the CCG takes these concerns seriously, are aware of the issues and are working along with partners across the system. Maggie MacIsaac – CCG Accountable Officer has released a statement which can be found on the CCG’s website.

With regard to ASD referrals the Commissioning Team are working with the IOWNHST and direct communications with those affected have been sent out. Regular public events will also take place.

In relation to the Sandown list closure, the Island has secured transformational funding for Primary Care to assist in addressing recruitment and retention of the Primary Care workforce. The temporary closure of the Sandown list has allowed some space for the practice to put in place a robust action plan to move forward in the future.

ML confirmed that NHS England (NHSE) are supportive of the CCG, both are working closely particularly since the CCG was placed in Legal Directions. It was noted that the CCG hasn’t got everything right, and acknowledges the difficulties, but are committed to
working with the IOW Council and partners for strong, good quality healthcare on the Isle of Wight.

**Local Care Board Update**

18-044 The Governing Body received paper GB18-026 Local Care Board Update presented by ML. The Local Care Board is made up of representatives from the CCG, IOWNHST, IOW Council, One Wight Health (GP Federation) and the voluntary sector. It was highlighted that the following key areas of focus have been identified as areas for further development:

- Discharge to assess
- It
- Workforce
- System Management Culture
- Evening and Weekend Capacity.

Discussion took place regarding communication and engagement. It was confirmed that this workstream was being led by the IOW Council, the emphasis being that the whole system needs to work collectively on this. It was also suggested that the Hampshire and Isle of Wight CCG Partnership will also be able to add strength to it by sharing learning from what has worked well for them. It was agreed that communication and engagement should be embedded in everything the CCG does.

The Governing Body noted the Local Care Board Update.

6. **Minutes to Receive**

6.1 **Clinical Executive Minutes May and June 2018**

18-045 The Governing Body received paper GB18-027 Minutes of the Clinical Executive May and June 2018. It was noted that this would be the last set of Clinical Executive minutes to be received by the Governing Body. A new Clinical Senate forum is now in place. The Capacity and Capability Task and Finish Group is ensuring that nothing gets lost that used to be presented to the Clinical Executive.

The Governing Body noted the Clinical Executive Minutes of May and June 2018

6.2 **Audit Committee Minutes May 2018**

18-046 The Governing Body received paper GB18-028 Audit Committee Minutes May 2018. MD highlighted the Audit Committee’s concern regarding the number of outstanding Internal Audit Actions, some of these long standing. This was also picked up at the Audit Committee in Common. PH and Internal Audit are meeting to go through the actions. MR confirmed she would also take this forward for resolution at the next Audit Committee in Common.

**Annual Audit Letter**

The Governing Body were presented with the External Audit Annual Audit Letter. There was one technical ‘except for’ qualification relating to the Value for Money conclusion which reflects the financial pressure the CCG is under in 2018/19. This is the same
qualification as 2017/18 and there are no legal implications associated with this otherwise clean set of accounts.

It was confirmed that the Audit Letter was on the CCG’s website. It was agreed that this should be shared more widely and suggested that Communications took this forward.

The Governing Body noted the Audit Committee Minutes of May 2018 and the External Audit Annual Audit Letter.

<table>
<thead>
<tr>
<th>ACTION:</th>
<th>To resolve outstanding Internal Audit Actions.</th>
<th>PH/MR Comms</th>
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<tr>
<td></td>
<td>To communicate the CCG’s Annual Audit Letter.</td>
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7. Items for Assurance
7.1 Integrated Performance Report

The Governing Body received paper GB18-029 Integrated Performance Report presented by AH, MR and JS. It was noted that the Performance Report was in a new format to allow more capacity for analysis. The report highlighted the following:

Performance:
- **A&E** – has seen improvement in March and April 2018 meeting 88% of the target.
- **Length of Stay** – the national target to reduce length of stay is 25% the Island has a local target of 26%, this will be included in future reports.
- **Ambulance** – improvement has been seen in 111.
- **Referral to Treatment (RTT)** – performance dropped over the winter months; however there is an operational plan in place for increased activity over the summer.
- **Referrals** – there has been an increase in waiting times for ENT, Neurology, Memory Service referrals, these are being monitored.
- **Cancelled Operations** – there have been no operations cancelled for a second time.
- **Cancer** – there has been a number of Cancer nurse posts recruited to.
- **Harm Reviews** – for Cancer patients who exceed 62 day or referral to treatment should all have harm reviews, it was agreed these should be reviewed at the Clinical Senate.
- **Delayed Transfers of Care (DTOC)** - is ahead of the national target.
- **Diagnostics** – has recovered.

Quality:
- **Serious Incidents** – have seen an increase. The CCG Quality Team is actively working with the IOWNHST and a new, more streamlined process is in place. Better reporting has been seen as a result of this support.
- **Root Cause Analysis (RCA)** – investigations are of a better quality, showing embedded learning. Themes include, deteriorating patient, safeguarding, end of life care, and agency staff.
- **C.Difficile** – one case has been reported by the IOWNHST. The CCG is working with the Trust.
- **Care Quality Commission** – a quality summit has taken place and a 10 week improvement plan is in place to move forward.
• **Slips, Trips and Falls** – a lot of work is ongoing relating to this.

• **Primary Care** – a Primary Care Quality Committee has been established with a focus on assurance, Clinical Governance and Safeguarding in Primary Care.

• **Care Home Quality** – a multifaceted approach to care home quality has been established and recognised by NICE. It was agreed this should be presented to the Governing Body and Clinical Senate.

Discussion took place the need to ensure that quality issues that are being raised as included within reports, for example ASD. It was highlighted that this will be addressed at the Isle of Wight Quality Committee, which will feed to the Governing Body.

**Commissioning:**

• **Winter Planning** – will need sign off at the Governing Body. There is a potential financial risk as there has been no confirmation of any additional funding for Winter Resilience. The CCG received £1.8m in 2017/18.

**Finance**

• The CCG has been given a £5m deficit control total for 2018/19.

• There is a £11m Quality, Innovation, Productivity and Prevention (QIPP) target for 2018/19; £4.5m of this is unidentified.

• The variation to contract with the IOWNHST is still not signed.

• The CCG is £77k behind plan.

MD highlighted that a quarter of the year has passed and it needs to be clear what is happening regarding the QIPP as this is a real risk. It was confirmed that this would be discussed at the Seminar.

**The Governing Body noted** the Performance Report.

**ACTION:** Care Home Quality to be added to Clinical Senate and Governing Body agendas. 

**8. Ambulance Update**

The Governing Body received and noted paper GB18-030 Ambulance Update. Bob Williams attended as a representative from the IOW NHS Trust and tabled handouts. The presentation highlighted the following:

• Ambulance is now its own division, with a dedicated Head of Service in place.

• The current CAD system for Ambulance reporting is not good enough to deliver the Ambulance Response Programme (ARP). A new system has been procured and will be in place in October 2018 where data will be live with daily reporting. Currently data is physically transferred.

It was queried what is the confidence in relation to the accuracy of the data. It was confirmed to be around 90% accurate.

• Emergency Preparedness, Resilience and Response (EPRR) is inadequate across the
Trust. The Ambulance service cannot comply with the National Ambulance Resilience Unit (NARU) standards. There needs to be 12 staff trained in decontamination in order to be compliant. The Island has 4 and only 5 crews, so they physically cannot be compliant. Collaboration with the South Coast Ambulance Service (SCAS) is in place; however the time to get deployment to the Island would be 2.5 hours. The risk of a major incident requiring this is low. NARU are supportive of the position and are working with the Ambulance Service.

- The Acute Services Redesign (ASR) has implications for the Ambulance Service relating to critical transfers, 1 ambulance equates to 25% of the fleet.
- 6/9 of the Ambulance standards have been met.
- Category 1 standard which has not been met relating to life threatening incidents equate to one job a day. It is therefore unlikely to have an ambulance in an area 7 minutes away, the average response time is 9 minutes.
- A new balance scorecard is being implemented which included operational performance, clinical indicators and call information.

The Governing Body were encouraged by the improvement made in the Ambulance Service. It was queried when a standard is not achieved what is the mechanism for review. It was confirmed that a review takes place, however more will be known once the new CAD is in place as it will show live data.

LT queried whether the mainland retrieval was realistic. It was confirmed that the cost of retrieval would be high and it was dependant on who would undertake the retrieval. Conversations have been started with SCAS in relation to this.

The Ambulance Team were thanked for attending. It was agreed they would be invited back at the end of October once the new CAD system was in place.

The Governing Body noted the Ambulance Update.

**ACTION:** Ambulance Service to be invited in October for a further update once the new CAD system is in place.  

9 Items for Approval

9.1 Isle of Wight Objectives, Priorities and Delivery Plan 2018-19

18-049 The Governing Body received and paper GB18-031 Isle of Wight Objectives, Priorities and Delivery Plan 2018-19 presented by JS. The objectives, priorities and delivery plan have been developed from a number of workshops. They also include the priorities of the wider Hampshire and IOW CCG Partnership. Updates will be presented to the Governing Body on a bi-monthly basis.

There is a risk to pace of delivery due to the capacity of some teams, particularly are there is currently a recruitment freeze.

The Governing Body approved the Isle of Wight Objectives, Priorities and Delivery Plan 2018-19.

9.2 CCG Governance Changes
The Governing Body received and paper GB18-032 CCG Governance Changes presented by PH and MD. The paper highlighted the changes to the CCG Governance Structures as a result of the recommendations from the Capacity and Capability Review:

- The Clinical Executive held their final meeting on 21 June 2018.
- GP Members from the Clinical Executive have been co-opted to the Governing Body to improve clinical input into decision making.
- The first of the new Finance, Performance and Planning meeting took place on 28 June 2018. The Governing Body were presented with the Terms of Reference for this committee, which were approved.
- The first Clinical Senate took place on the 12 July 2018.

With regard to the Audit Committee, it is proposed that the committee is held in common with the other CCGs in the Hampshire Partnership. The Governing Body approved this approach and the Terms of Reference for the Committee in common.

It was noted that the Remuneration Committee in Common Terms of Reference were approved that the Governing Body meeting held in May 2018.

The Governing Body noted the CCG Governance Changes and approved:
- The Audit Committee in Common Terms of Reference.
- The Finance, Performance and Planning Committee Terms of Reference.

9.3 Mental Health Rehabilitation, Reablement and Recovery

The purpose of the paper was to agree the commissioning/procurement process to ensure the delivery of the Mental Health Recovery, Reablement and Rehabilitation Business Case approved in November 2017. Two distinct contractual frameworks are proposed which CCGs nationally are currently delivering more integrated service delivery via either a Prime (or lead) contract or via an Alliance Contract. The recommendation is that a Prime Provider contractual arrangement is put in place with a view to this developing into an Alliance Contract.

It was queried whether this paper had been signed off by finance and contracts. It was confirmed it had been and there was a printing error on the front sheet.

The Governing Body approved the Prime Provider contractual arrangement.

10. Items for Discussion/Assurance

10.1 Governing Body Assurance Framework

The Governing Body received and paper GB18-034 Governing Body Assurance Framework (GBAF) presented by PH. It was noted that the GBAF had been revised to bring it in line with the Hampshire and Isle of Wight Partnership. The GBAF is aligned with the CGG’s corporate objectives, partnership priorities and risk register.

It was highlighted that there are no timescales, and the wording needs to be revised to
include this.

With regard to Communications and Engagement plan it was suggested that the wording required revision to indicate what the gap/issue is in relation to this.

The Governing Body noted the Governing Body Assurance Framework.

**ACTION:** Governing Body Assurance Framework (GBAF) to be revised to include timelines. Wording on Governing Body Assurance Framework (GBAF) in relation to Communications and Engagement plan to be revised to indicate what the gap/issue is in relation to this.

### 10.2 Risk Register

18-053 The Governing Body received and paper GB18-035 Risk Register presented by PH. The summary highlighted the following:

Two new risks have been added to the Risk Register.

- 33 – Staffing within Continuing Healthcare (CHC) Service covering assessment, review, FNC and Safeguarding.
- 34 – Continuing Healthcare QIPP Delivery.

Two risks have been removed from the Risk Register.

- 28 – CHC Case management
- 22 – Infection Prevention and Control (nurse is now embedded within the CCG)

One Risk has decreased in score

- 2 – Ambulance Service from 20 – 16.

For June 2018 there are currently 25 risks in total

- 8 very high risks scoring 20
- 5 high risks scoring 16
- 12 medium risks scoring 12

It was noted that risk should be owned across the organisation. It was queried whether the outstanding audit actions was included on the register. It was also suggested that CCG Leadership should also be included. It was confirmed that outstanding audit actions were in train and the CCG Leadership was included on the register.

The Governing Body noted the Risk Register.

### 10.3 Information Governance Quarter 1 Report

18-054 The Governing Body received paper GB18-036 Information Governance Quarter 1 Report. The contents were noted with regard to the new General Data Protection Regulation (GDPR).

The Governing Body noted the Information Governance Quarter 1 report.

### 10.4 Urgent and Emergency Care Delivery Blueprint
The Governing Body received and paper GB18-037 Urgent and Emergency Care (UEC) Delivery Blueprint presented by ER. A key driver in the Urgent and Emergency Care Delivery Plan is the drive away from medical and acute hospital responses, to community, mobile/flexible, and self-care responses. It was highlighted that a number of the key milestones have slipped against the national timetable or are behind schedule to achieve within the plan.

The Governing Body were presented with a number of Commissioning Priority actions which were approved. There are also a number of risks including the blueprint not being delivered in the timescales required. The benefits of a new service will not be realised unless energy and effort is focussed on the re-commissioning of the UEC.

Discussion took place regarding Primary Care engagement, which is vital to give them the opportunity to design the service. There is an event on 31 July which GPs have been encouraged to attend.

It was queried whether Healthwatch had been involved. ER confirmed that they had been involved and were due to be involved again in the next series of meetings.

The Governing Body noted the Urgent and Emergency Care Delivery Blueprint and approved the Commissioning Priority actions.

11. Any Other Urgent Business
18-056 ML highlighted that Benjamin Browne; Clinical Executive member would be leaving the CCG at the end of the month. ML thanked Benjamin for his contributions which have been invaluable.

12. Motion to exclude the Press and Public.
18-057 ML read the following statement: “that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’, (Section 1 (2), Public Bodies (Admission to Meetings)”

13. Date of Next Meeting:
18-058 Thursday 06 September 2018, 10:30-13:00hrs, Northwood House, Ward Avenue, Cowes, Isle of Wight, PO31 8AZ
<table>
<thead>
<tr>
<th>Circulation: Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martyn Davies – Governing Body Lay Member – Governance (Deputy Chair)</td>
</tr>
<tr>
<td>Dr Michele Legg – CCG Chair</td>
</tr>
<tr>
<td>Loretta Outhwaite – Deputy Chief Officer</td>
</tr>
<tr>
<td>Melanie Rogers – Director Quality, Safeguarding and Clinical Services / Governing Body Nurse</td>
</tr>
<tr>
<td>Dr Mark Sopher – Secondary Care Doctor</td>
</tr>
<tr>
<td>Laurence Taylor – Governing Body Lay Member - Independent</td>
</tr>
<tr>
<td>Carole Truman – Governing Body Lay Member - PPI</td>
</tr>
<tr>
<td>Dr Timothy Whelan – Deputy Clinical Chair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In attendance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gillian Baker – Director of Strategy and Partnerships</td>
</tr>
<tr>
<td>Phil Hartwell – Head of Governance</td>
</tr>
<tr>
<td>Jonathan Smith – Assistant Director of Integrated Commissioning</td>
</tr>
<tr>
<td>Rebecca Berryman, Governance Support Officer (Minutes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Invited:</th>
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</table>

<table>
<thead>
<tr>
<th>For Information (Agenda):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cath Love, Acting Head of Quality</td>
</tr>
<tr>
<td>Linda Rann, Sue Lightfoot, Eleanor Roddick - Heads of Commissioning, Lesley Mew – Head of CHC</td>
</tr>
<tr>
<td>Tracy Savage, Assistant Director of Medicines Management, Rebecca Wastall – Deputy Chief Finance Officer</td>
</tr>
<tr>
<td>Lucy Long, Information Governance Manager</td>
</tr>
</tbody>
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</tr>
<tr>
<td>Lucy Long, Information Governance Manager</td>
</tr>
</tbody>
</table>
### Governing Body

**Matters arising: Schedule of Actions – Part 1**

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Michele Legg, Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of issue:</strong></td>
<td>Actions identified from previous meeting together with updates on progress to date and expected completion dates</td>
</tr>
<tr>
<td><strong>Action required/recommendation:</strong></td>
<td>To gain assurance that the actions requested by the Governing Body are in train</td>
</tr>
<tr>
<td><strong>Principle risks:</strong></td>
<td>There are no risks associated with this paper.</td>
</tr>
<tr>
<td><strong>Other committees where this has been considered:</strong></td>
<td>This paper has not been considered at any other committee.</td>
</tr>
<tr>
<td><strong>Financial /resource implications:</strong></td>
<td>There are no financial or resource implications in relation to this paper.</td>
</tr>
<tr>
<td><strong>Legal implications/impact:</strong></td>
<td>There are no legal implications or impact relating to this paper.</td>
</tr>
<tr>
<td><strong>Public involvement/action taken:</strong></td>
<td>There has been no public involvement in this paper.</td>
</tr>
<tr>
<td><strong>Equality and diversity impact:</strong></td>
<td>There is no equality and diversity impact relating to this paper.</td>
</tr>
<tr>
<td><strong>Author of paper:</strong></td>
<td>Rebecca Berryman, Governance Support Officer</td>
</tr>
<tr>
<td><strong>Date of Paper:</strong></td>
<td>20 July 2018</td>
</tr>
</tbody>
</table>

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**Date of Meeting:** 6 September 2018

**Agenda Item:** 3.1

**Paper number:** GB18-040
<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Minute No</th>
<th>Action</th>
<th>Lead</th>
<th>Update</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.02.18</td>
<td>17-107</td>
<td>Thematic Analysis of Serious Incidents to be presented to the next Governing Body meeting.</td>
<td>MR</td>
<td>To be added to July 2018 Governing Body Meeting. <strong>July 2018 update:</strong> To be presented at September 2018 Governing Body Meeting.</td>
<td>July 2018 Closed</td>
<td></td>
</tr>
<tr>
<td>26.04.18</td>
<td>18-006 (3)</td>
<td>A Board to Board Meeting to be arranged.</td>
<td>LO/RB</td>
<td>Discussions taking place with Isle of Wight NHS Trust to arrange a date.</td>
<td>May 2018 Open</td>
<td></td>
</tr>
<tr>
<td>26.04.18</td>
<td>18-006 (4)</td>
<td>A Joint Financial Recovery Board to be set up.</td>
<td>JC</td>
<td>Agreed with the Isle of Wight NHS Trust. Dates of the meeting are to be advised. <strong>September 2018 update:</strong> Jane Cole met with the IOW NHS Trust Director of Finance. They are going to meet weekly to take forward to the Joint Financial Recovery Board.</td>
<td>May 2018 Open</td>
<td></td>
</tr>
<tr>
<td>19.07.18</td>
<td>18-046</td>
<td>To resolve outstanding Internal Audit Actions.</td>
<td>PH/MR</td>
<td>Interim Chief Finance Officer and Head of Governance have met with Internal Audit and reviewed all outstanding actions. A significant number have been closed.</td>
<td>July 2018 Closed</td>
<td></td>
</tr>
<tr>
<td>19.07.18</td>
<td>18-046 (2)</td>
<td>To communicate the CCG’s Annual Audit Letter.</td>
<td>Comms</td>
<td>Actioned and included on the CCG website.</td>
<td>July 2018 Closed</td>
<td></td>
</tr>
<tr>
<td>19.07.18</td>
<td>18-047</td>
<td>Care Home Quality to be added to Clinical Senate and Governing Body agendas.</td>
<td>RB</td>
<td>Care Home Quality added to both Clinical Senate and Governing Body agendas.</td>
<td>July 2018 Closed</td>
<td></td>
</tr>
<tr>
<td>19.07.18</td>
<td>18-048</td>
<td>Ambulance Service to be invited in October for a further update once the new CAD system is in place.</td>
<td>RB</td>
<td>RB to make contact with Head of Operations at the IOW NHS Trust.</td>
<td>October 2018 Open</td>
<td></td>
</tr>
<tr>
<td>19.07.18</td>
<td>18-052</td>
<td>Governing Body Assurance Framework (GBAF) to be revised to include timelines.</td>
<td>PH</td>
<td>Updated.</td>
<td>September 2018 Closed</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Ref</td>
<td>Action Description</td>
<td>Responsible</td>
<td>Completed Date</td>
<td>Status</td>
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<td></td>
</tr>
<tr>
<td>19.07.18</td>
<td>18-052 (2)</td>
<td>Wording on Governing Body Assurance Framework (GBAF) in relation to Communications and Engagement plan to be revised to indicate what the gap/issue is in relation to this.</td>
<td>PH</td>
<td>September 2018</td>
<td>Closed</td>
<td></td>
</tr>
</tbody>
</table>
## Governing Body
### Local Care Board Update

<table>
<thead>
<tr>
<th><strong>Sponsor:</strong></th>
<th>Nicola Longson, Programme Director, Isle of Wight Local Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of issue:</strong></td>
<td>This report gives the Board an overview of progress of the Local Care Plan up to August 2018. The key messages from Local Care Board meeting on 9 August 2018 are detailed as Appendix A. The Local Care Plan Programme Summary Report provides an overview of key progress and risks/issues against the five initiatives within the Local Care Plan. The overall Programme status is currently RED, indicating that key milestones are behind schedule and there are significant issues to delivering agreed outcomes. The Black/Red/Amber/Green rating of each initiative is broken down in Appendix B. Further development of programme reporting is underway to ensure delivery of impact is reported alongside delivery of key milestones.</td>
</tr>
<tr>
<td><strong>Action required/recommendation:</strong></td>
<td>To note</td>
</tr>
<tr>
<td><strong>Principle risks:</strong></td>
<td>The Local Care Board Risk Register is currently under development. Key programme risks and issues are escalated from Programme Task &amp; Finish Groups to Operational Delivery Group for action.</td>
</tr>
</tbody>
</table>
| **Other committees where this has been considered including SMT:** | The Local Care Plan Summary Report will be made available to:  
- Trust Leadership Committee  
- Trust Board  
- IW Council Corporate Management Team |
| **Has this been agreed with the following areas; Please tick and gain signature:** |  
- Finance  
- Quality  
- Contracts  
Signed  
Finance__________ Quality__________ Contracts  
<p>| <strong>Financial /resource implications:</strong> | There are no direct resource implications within the report. |
| <strong>Legal implications/impact:</strong> | There are no legal implications within the report. |
| <strong>Public involvement/action taken:</strong> | The Local Care Plan Summary Report is for information only. |</p>
<table>
<thead>
<tr>
<th>Equality and diversity impact:</th>
<th>The Local Care Plan Summary Report is for information only.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Paper:</td>
<td>Rachael Knight</td>
</tr>
<tr>
<td>Date of Paper:</td>
<td>09/08/18</td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td>06/09/18</td>
</tr>
<tr>
<td>Agenda Item:</td>
<td>5.1</td>
</tr>
<tr>
<td>Paper number:</td>
<td>GB18-041</td>
</tr>
</tbody>
</table>
Appendix A

Local Care Board key messages from 9 August meeting

A&E delivery board
The board discussed recent performance against a particularly challenging period with the heatwave/additional events with services seeing an increase of 7.8% in attendances on the same period last year. This situation has resulted in a dip in delayed transfers of care performance over last two weeks. Development of the 18/19 winter plan is continuing, but a number of data gaps are causing delays to its finalisation as per timetable.

The board agreed to an urgent meeting of key individuals to unblock any outstanding issues. Councillor Clare Mosdell reiterated the positive impact the Living Well service was having across the system and Maggie Oldham advised the Board of the 3% decrease in attendances translating in to admissions despite the recent increase in attendance rates.

STP update
John Metcalfe and Maggie Oldham gave feedback to the group on recent attendance at the STP executive delivery group and the emerging business model for the region and its implications for Island localities, care systems and commissioning arrangements.

The HIOW STP is keen that local boards and councils consider this model in the very near future with a view to endorsing the proposals. Importantly for the Island’s health and care system, it strengthens the integrated approach we have been developing through the local care board, with a vision of achieving an integrated care system as an end goal.

Funding
The board received updates on the allocation of transformation funding both from the Better Care Fund (BCF) and the Vanguard transformation funding. The group considered a number of funding requests to utilise the remaining balance of transformation monies to support the acute services review and the work of enabling groups. The group also agreed the indicative BCF/iBCF outline plan and spend plan for 18/19.

Vanguard to Local Care Plan
Further to discussion at LCB some months ago, a film [summarising the transformation work](http://iowstartwelllivewellagewell.com/) to date and next steps to Local Care Plan has been completed and can be viewed.

Other shorter videos for the specific transformation work discussed in the New Care Models quarterly reviews are also on the new website [iowstartwelllivewellagewell.com](http://iowstartwelllivewellagewell.com/)
### RAG status criteria

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Multiple key milestones are significantly behind schedule. Sponsor identified significant risk to outcomes being achieved</td>
</tr>
<tr>
<td>R</td>
<td>Key milestones behind schedule (30+ days) /significant issues to delivering agreed outcomes</td>
</tr>
<tr>
<td>A</td>
<td>Key milestones within 30 days of schedule/ work underway to address delays</td>
</tr>
<tr>
<td>G</td>
<td>Key milestones completed/project on schedule</td>
</tr>
</tbody>
</table>

### Headline Status (delivery of key milestones)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Milestone RAG</th>
<th>Impact Update</th>
<th>Headlines – key reason(s) for RAG status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Service Redesign</td>
<td>Amber</td>
<td>Not applicable for current scope</td>
<td>Of the 14 Workforce &amp; Resilience projects within the programme, a number have yet to identify project teams to enable the clinical and operational involvement and oversight. This is currently impacting development of delivery plans for September deadlines.</td>
</tr>
<tr>
<td>Urgent &amp; Emergency Care</td>
<td>Red</td>
<td>Impact KPI’s still in development. % of calls to 111 triaged to a clinician = 43.01% (May data). Progress against KPI remains amber, further work is needed on the clinical assessment service for 111 in order to improve this figure.</td>
<td>As reported last month, milestones for Enhanced Hub project continue to fall behind schedule – no modelling work yet underway. Re-designed Urgent Care Floor project experiencing similar delays with modelling work to be completed by CCG/Trust.</td>
</tr>
<tr>
<td>Community Service Redesign</td>
<td>Amber</td>
<td>Full set of Tier 3 KPI’s to be signed off at CSR Task &amp; Finish Group 24/07/18. Initial data on four indicators provided in main report.</td>
<td>Further to change request submitted and approved last month a number of milestones within the 30/60/90 day plan are currently experiencing delays, mitigating actions identified to get planned delivery dates back on track.</td>
</tr>
<tr>
<td>Mental Health Transformation</td>
<td>Red</td>
<td>Draft Tier 3 KPI’s agreed by the MH Transformation Steering Group. Most baseline data is not available until the end of August 2018 due to capacity within the Performance Information Decision Support (PIDS) Team.</td>
<td>Review of options for Shackleton Business Case being undertaken by the Trust which has led to a delay in further agreement and implementation.</td>
</tr>
<tr>
<td>Transforming Learning Disabilities Care</td>
<td>Amber</td>
<td>The 10% target increase in the number of supported units available for people with a learning disability was exceeded in March 18 with 111 units reported against a target of 105. The reduction in the number of people with a learning disability living in residential/nursing care placements sits at 169 for May against a target of 168. Figures improving.</td>
<td>As escalated last month, delay in decision on how to manage Bluebell Meadow and deregistration is continuing to impact on delivery milestones. Recent changes to Operational Team resources have also led to some incomplete actions/minor delays.</td>
</tr>
</tbody>
</table>
The LCP Enabling Groups are still developing the core elements for governance set up, areas of concern are:

- Continued lack of detailed workplans for all groups
- Whole set up for System Communications & Engagement Group – currently not meeting
- Target dates for OPE & Digital Group Charters have been moved back a month from the last report
- No System Finance Group report submitted this month

<table>
<thead>
<tr>
<th>Group</th>
<th>Governance</th>
<th>Programme Management Set Up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enabler Groups – ToR in place</td>
<td>Programme Charter</td>
</tr>
<tr>
<td>System Finance Group</td>
<td>Group in place, terms of reference agreed – under review</td>
<td>N/A for this group</td>
</tr>
<tr>
<td>(from June update)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>System Workforce Group</td>
<td>Group in place, terms of reference agreed 18/06/18</td>
<td>Target date for first draft 30/09/18</td>
</tr>
<tr>
<td>One Public Estate Group</td>
<td>Group in place, revised terms of reference agreed March 2018</td>
<td>Target date for first draft 27/07/18</td>
</tr>
<tr>
<td>System Quality Group</td>
<td>ToR for the Quality Group have been drafted and will go to inaugural meeting for sign off on 30/08/18</td>
<td>N/A for this group</td>
</tr>
<tr>
<td>System Digital Group</td>
<td>Group in place, revised terms of reference agreed February 2018</td>
<td>Target date for first draft 20/07/18</td>
</tr>
<tr>
<td>System Communications &amp;</td>
<td>Awaiting further information since ownership move to IW Council</td>
<td>Not in place</td>
</tr>
<tr>
<td>Engagement Group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Programme Overall Status

Key progress in reporting period

Acute Service Redesign:
• 04/06 - Radiology SAA/IW Workforce & Resilience Scoping meeting to establish a future way of working together across the SAA for continued sustainability
• IW Radio & County Press ASR briefings/Public engagement event at Newport Cricket Club/Public panel event at Cowes Enterprise College
• 06/06 – Leads for Paeds/Obs/Mat/Neo – SAA/IW Workforce & Resilience discussion to keep clinical teams engaged towards future meetings
• 18/06 – ASR Stabilise & Transfer project update at IW Helicopter Governance & Operations Group
• 21/06 – Maternity & Obstetrics SAA/IW Workforce & Resilience T&F group;
• 28/06 – Lead commissioner for Hampshire & IW CCGs, visit to paed/Obs/Mat/Neo & ED services

Urgent & Emergency Care:
• Integrated Urgent Care - Updates completed in preparation for 111 online to go live in July.
• Redesigned Urgent Care Floor - Ambulatory and Emergency Care service implemented 5th June in MAU, monitoring ongoing.
• Commissioner and provider initial discussions commenced on model, service specification and workforce.

Community Service Redesign:
• Draft localities dashboard developed
• Case review processes agreed
• TEC business case approved though Trust Board for 1 year funding
• 60 day localities plan milestones identified and implementation underway
• 30 day frailty prototype plan developed and implementation underway
• Frailty pathway workshop held 15th June 18
• Locality Management Groups Terms of Reference agreed

Risks/Issues for escalation

OVERALL PROGRAMME ISSUE - Lack of full set Tier 3 KPI's with trajectories, data and analysis in place for Urgent & Emergency Care, Community Service Redesign and Mental Health Transformation. Reducing opportunity to understand and report on impact of LCP initiatives.

Acute Service Redesign:
• ISSUE - Lack of Clinical engagement and leadership from SAA/IW. Project teams with IW/SAA clinical leads are yet to be identified for emergency & elective surgery, urology, acute medicine & haematology. Mitigation: Continued engagement from the ASR Programme team is limited. New Trust Medical Director in place, however there needs to be a leadership push to take this forward. Clear LCB direction is needed for a lead to drive this on a clinical level. Linked to ODG Action 192.

Urgent & Emergency Care:
• ISSUE – Continual lack of Health and ASC care involvement in Enhanced Hub leading to no assurance on progress of agreed milestones impacting delivery. Linked to outstanding ODG action 183.
• ISSUE - Programme resource – Operational support recently lost and Operational Lead is unavailable. There is a lack of capacity to drive forward specific projects that are behind e.g. Enhanced Hub. Mitigation: Operational Support resource is being identified where possible in existing services, ODG to further advise.

Community Service Redesign:
• ISSUE – No resource available for frailty training and awareness, required by July 2018. Implementation of frailty pathway will be delayed. Mitigation: Ask sent to Workforce Enabling Group - lead requested clarification of ask, which has been supplied. No further correspondence received so no progress has been made. Request to System Workforce Group for urgent prioritisation of resources for frailty awareness and training. Linked to outstanding ODG action 193.
**Community Service Redesign (continued):**
- RRR Alliance Co-design underway
- Modelling of CSR impact - approach to identify impact of CSR agreed by core group
- “Mary’s Story” developed for CSR communications, engagement commenced (E.g. Healthwatch etc)

**Mental Health Transformation:**
- Creating a New Vision for Improved Mental Health - event took place with Healthwatch to coproduce an action plan for the Blueprint with people who use services
- Transforming Needs Led Acute Provision - high level overarching models and pathways approach were agreed with key programme stakeholders on 12/06/18. Format for the new care models and care pathways are in progress and have been shared with Project leads. All final project Task and Finish groups (prior to implementation phase) held in June or booked for July (with the exception of Eating Disorder which commenced later) to finalise and sign off new pathways and models of care proposals.

**Transforming Learning Disabilities Care**
- Interviews and appointments made for LD and Mental Health apprenticeships
- Teleconference held with HR Leads to deliver employment elements of commissioning strategy
- Shared Lives week launch w/c 18th June completed with 6 presentations scheduled across the Island
- Shared Lives, PA Market Place, HOLD scheme added to full dashboard for Task & Finish group to be monitored
- Tenants identified for Brooklime House by ASC and CCG
- Approval received from Secretary of State to add Brooklime and Gembrooke to the Councils housing stock
- Gembrooke (Wroxall bungalow) purchase remains in progress.
- Detailed update for deregistration of council provision provided to council Leadership Group.
- New Team Leader appointed for Learning Disability Team, initial induction of project provided by Head of Commissioning and Project Manager.

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**Risks/issues for escalation**

- **Mental Health Transformation** – no items identified for escalation
- **Transforming Learning Disabilities Care** - no items identified for escalation
### Governing Body

#### Health and Wellbeing Strategy

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Loretta Outhwaite, Deputy Chief Officer</th>
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</table>
| **Summary of issue:** | The statutory roles of the health and wellbeing board (HWB) are:  
  - to improve the health and wellbeing of local people;  
  - to reduce health inequalities; to promote the integration of services; and to oversee the production of a joint strategic needs analysis (JSNA) and joint health and wellbeing strategy (JHWS).  
  
The formation of the Local Care Board (LCB) that reports to the Health and Wellbeing Board has the potential to bring clarity to the prevention agenda by building on the work already done to set priorities for projects and actions. It will ensure that there is clear, strong and coherent leadership in order to have the focus and capacity to make a difference. This includes the need to take both a ‘whole population’ and targeted approach for communities with greater challenges.  
  
  This strategy builds on the aim of the council’s corporate plan to move towards one public service by developing joint commissioning across council departments and the wider NHS, regeneration and environmental system, and in doing so to start looking beyond integration itself to the outcomes it produces to improve the wider determinants of health and wellbeing.  
  
  By taking a ‘life course’ approach (Start well, live well, age well) and building on the place-based work with communities and voluntary and community partners, using an asset based approach to preventing ill-health, building resilience and self-care it will bring together the many strategies and plans we have in place under one clear vision. This will enable the HWB and LCB to evidence the impact of the work of the board, its members and their organisations in improving health and wellbeing outcomes and reducing inequalities. |
| **Action required/recommendation:** | To approve the Health and Wellbeing Strategy. |
| **Principle risks:** | No risks associated with this paper. |
| **Other committees where this has been considered including SMT:** | None |
Has this been agreed with the following areas; Please tick and gain signature:

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<th></th>
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<th>N/A</th>
<th>Quality</th>
<th>N/A</th>
<th>Contracts</th>
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<tr>
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</table>

Financial /resource implications:
No financial / resource implications.

Legal implications/impact:
Statutory role of Health and Wellbeing Board.

Public involvement/action taken:
Public document.

Equality and diversity impact:
Equality and Diversity is considered as part of the strategy.

Author of Paper:
Public Health

Date of Paper:
August 2018

Date of Meeting: 6 September 2018

Agenda Item: 6.2

Paper number: GB18-042
Health and wellbeing strategy for the Isle of Wight
2018 to 2021
Foreword

Many things influence our health and wellbeing – the lifestyles we lead, our social contacts, the environment around us, our jobs and homes, as well as the health and care services which support us.

Everyone on the Island should have the right to enjoy good health and wellbeing and the majority do, however we are aware that some groups and communities systematically experience poorer health than others.

While this strategy aims to improve the health and wellbeing of everyone on the Island, it focuses on making faster improvements for those who are most vulnerable and experience a poorer quality of life.

This is the first health and wellbeing strategy under the new conservative leadership of the council, overseen by a reinvigorated health and wellbeing board. Many people and organisations have contributed to the strategy, so that we have a shared vision for health and wellbeing for the Island.

We can’t tackle everything that impacts on health and wellbeing at once, but together we have agreed to take a ‘life course’ approach under three themes: **Start well**, **live well**, and **age well**. We want to make a significant difference to the lives of people across the Island.

Alongside the three main themes we have agreed to two ‘place-based’ initiatives in Newport (Pan) and Ryde (North East) taking an asset-based community development (ABCD) approach to support and develop citizen-led action to improve the health of their communities. Much is already going on, but in a recent consultation, you have said to us that you really value that sense of community and you would like to develop it even more. The board and local public organisations can help with this but it cannot be done without local people playing their part.

Our health and wellbeing is fundamental to how we live our lives and everyone has a role in improving it for ourselves and the people around us. Together we have agreed the areas we want to focus our efforts on, and we now have to ask ourselves what we could do to play our part, either as an individual, as part of a community or as part of a group or organisation.

**Councillor Dave Stewart**
Chair, Isle of Wight Council Health and Wellbeing Board

For details of meetings held by the health and wellbeing board please visit: www.iwight.com/Meetings
Executive summary

The statutory roles of the health and wellbeing board (HWB) are: to improve the health and wellbeing of local people; to reduce health inequalities; to promote the integration of services; and to oversee the production of a joint strategic needs analysis (JSNA) and joint health and wellbeing strategy (JHWS).

The Island system has undergone significant challenges in recent years and will continue to face the challenges of an ageing population and increasing demand on health and care services for the duration of this strategy. We have also seen changes to the leadership of our NHS trust and the formation of a local care board (LCB) that will focus on key priority areas for ensuring high quality and sustainable health and care services for the Island.

With the Isle of Wight Council under new political leadership since May 2017, the HWB has been reinvigorated with the aim of ensuring that it is accorded the necessary corporate, political and partnership priority to develop this strategy based on the health and wellbeing needs of local people. This, along with the formation of the LCB that reports to the HWB, has the potential to bring clarity to the prevention agenda by building on the work already done to set priorities for projects and actions. It will ensure that there is clear, strong and coherent leadership in order to have the focus and capacity to make a difference. This includes the need to take both a ‘whole population’ and targeted approach for communities with greater challenges.

This strategy builds on the aim of the council’s corporate plan to move towards one public service by developing joint commissioning across council departments and the wider NHS, regeneration and environmental system, and in doing so to start looking beyond integration itself to the outcomes it produces to improve the wider determinants of health and wellbeing.

By taking a ‘life course’ approach (Start well, live well, age well) and building on the place-based work with communities and voluntary and community partners, using an asset based approach to preventing ill-health, building resilience and self-care it will bring together the many strategies and plans we have in place under one clear vision. This will enable the HWB and LCB to evidence the impact of the work of the board, its members and their organisations in improving health and wellbeing outcomes and reducing inequalities.
Health and wellbeing strategy for the Island

Shared vision for health and wellbeing on the Island:

People live healthy and independent lives, supported by thriving and connected communities with timely and easy access to high-quality and integrated public services when they need them.

This strategy sets out a shared vision using a ‘life course’ approach for improving health and wellbeing on the Island. It is now generally acknowledged that a life course approach that promotes a holistic view of an individual’s total health and wellbeing is an effective means of reviewing public health in a community. This approach emphasises social perspective looking back across an individual’s or group’s life experiences for clues to current patterns of health and disease, while recognising that both past and present experiences are shaped by the wider social, economic and cultural context. By agreeing this approach jointly, we can all work together as individuals, groups, communities and organisations to make sure we are all pulling together in the same direction.

The strategy has not attempted to cover everything that impacts on health and wellbeing. Following consultation with key stakeholders, priorities would be identified and focused on during the period of this strategy. Consultation for this strategy was scheduled from July to December 2017 and had three phases:

1. Workshop with stakeholders with the results from this presented as a business plan for approval at the HWB.
2. Individual meetings with major stakeholders including elected members, representatives from the voluntary sector and council officers leading on housing, regeneration and place.
3. Draft report submitted for comment to corporate management team and the HWB for comment.
From this consultation, the priorities identified are based on what is believed to be the most important issues, which when addressed will have the biggest impact on our health and wellbeing locally. Information and data available for the Island has also been used to help us agree these priorities.

**START WELL**

Children are supported to get the best start in life that will lead to good health and wellbeing. This will provide the foundation to ensure they are able to achieve the best opportunities and wellbeing outcomes throughout their lives.

**LIVE WELL**

Families, individuals and communities are thriving and resilient, with access to good jobs, affordable housing, leisure activities, lifelong training, education and learning, health and care services, and are able to enjoy the place that they live.

**AGE WELL**

People are able to live independently in their own homes with appropriate care and support. Older and disabled residents are supported to play an active role in their communities and encouraged to maintain and develop their social and community networks.

**Place-based initiatives**

Alongside the life course approach we have agreed to two ‘place-based’ initiatives in **Newport (Pan)** and **Ryde (North East)**, taking an asset-based community development (ABCD) approach to support and develop citizen led action to improve the health of their communities and reduce inequalities. Much is already going on in these communities and there has been a significant amount of funding and intervention over the years. The decision to use an asset based approach to tackle the causes of inequalities in these communities was made after conversations with community members. They told us they didn’t want to be done ‘to’ and ‘for’ but wanted to be supported to lead action to improve the health and wellbeing of their neighbourhoods.
Underlying principles

The focus of the Health and Wellbeing Strategy 2018 to 2021 is to improve health and wellbeing overall and to deliver swift and significant improvements for groups and communities that experience poorer health and quality of life. To make the best use of resources the work contributing to this strategy will apply the following principles:

**EQUITY**
Provision of services should be proportional to need and targeted to the areas, groups and individuals that need them most.

**ACCESSIBILITY**
Services should be accessible to all, with factors including geography, opening hours and physical access being considered for all including disabled persons.

**INTEGRATION**
Where the integration of services provides an easier system and better outcomes for people within the same overall cost, all relevant organisations should work together to maximise the local benefits.

**EFFECTIVENESS**
Activities and services should be evidence-based and provide value for money.

**SUSTAINABILITY**
The work contributing to this strategy should be developed and delivered with due regard to the environmental, economic and social dimensions of sustainability.

**DIVERSITY**
Activities and services should have due regard to the specific needs of protected groups and foster good relations between different people when carrying out their duties.
Relationship to other strategies

This health and wellbeing strategy does not sit alone. The priorities set out in the strategy will inform related core strategic commissioning and delivery plans, helping to consolidate action in these areas of importance.
It is clear from figure one that there are a broad range of plans and strategies that will have an influence on the community’s health and wellbeing and this is something that the HWB will need to review and influence. It is not the purpose of the health and wellbeing strategy to include or reiterate the contents of these documents but to identify the areas where there are gaps within these range of strategies that need to be addressed.

This is set in the context of the planning for a ‘One Public Service’ approach which aims to support cross public sector partnerships to work collaboratively on land and property initiatives leading to new jobs, new homes, joined up public services and savings for the taxpayer. The health and wellbeing strategy aims to support this by engaging with partners to identify how other areas of work such as regeneration, housing and digital connectivity can impact on the community’s wellbeing.
Start well

Children are supported to get the best start in life. Good health and wellbeing will provide the foundation to ensure they are able to make the best of opportunities throughout life and achieve their maximum potential.

Why is this important?

We know that giving every child the best possible start in life is crucial to reducing health inequality across the life course. The foundations for a good life are laid in these early years (starting in the womb) and the effects are felt on many aspects of health and wellbeing from obesity, heart disease and mental health, to educational achievement and economic status.

Nationally, the Department for Education and Department of Health has issued statutory guidance for local authorities, clinical commissioning groups and NHS England to promote the health and wellbeing of looked-after children. This guidance states that the health needs of looked-after children should be taken into account in developing the local Joint Strategic Needs Assessment (JSNA) and the Joint Health And Wellbeing Strategy (JHWS).

Locally, the JSNA articulates the needs of children on the Isle of Wight. Based on the JSNA, the Children’s Trust board has published the new Children and Young People’s Plan (CYPP) 2017 to 2020. This plan sets out the vision of working together to achieve high quality outcomes for children and families through the provision of sustainable support and services. The outcomes and priorities in the plan are reflected in the Isle of Wight Council’s corporate plan and in the Commissioning Intentions 2017 to 2019 published by the clinical commissioning group.

To achieve the outcomes and priorities for children, this will require the JHWS to address the wider determinants of health such as reducing childhood poverty, providing access to affordable housing and the availability of jobs and sustainable transport through inward investment and regeneration.

The provision of sustainable support and services includes the offer of early help and intervention through family hubs in local communities, the Strengthening Families programme, education and special educational needs and disability services support for children, families and schools. Children’s social care provides a range of services and support to protect and safeguard children. This includes supporting children to remain within, or return to the care of, their families where and when it is safe and appropriate to do so and to provide the best outcomes for children in care and care leavers, including fostering and adoption.
The corporate parenting responsibilities of local authorities include having a duty under section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child’s physical, emotional and mental health and acting on any early signs of health issues. Directors of children’s services, directors of public health and lead members for children’s services have a responsibility to ensure there are systems in place so that this duty is properly discharged.

Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. Delays in identifying and meeting their emotional wellbeing and mental health needs can have far reaching effects on all aspects of their lives, including their chances of realising their potential and leading happy and healthy lives as adults. There is growing evidence of the impact of adverse childhood events on health and wellbeing in adulthood. Children subject to child protection and children in need, like children in care and care leavers, are likely to have experienced such adverse childhood events. Therefore, the JHWS needs to set out the life courses and care pathways for these children to support them to achieve happy and healthy independent adulthood.

Locally, child poverty levels are in line with national figures with one in five (20.7 per cent) of all children on the Isle of Wight classed as being in relative poverty (21.2 per cent of under 16s). This is higher than for the south east of England and is an increase of 585 children on 2013 numbers.

Across the country, at any one time, one in ten young people aged five to 16 years have a mental health problem. We also know that many adults with mental health problems first experienced them from their mid-teens. When asked in the most recent school survey 16 per cent of secondary school pupils said they had used mental health or counselling services in the past year.

When pupils were asked about their social media habits, 92 per cent in Year 8 and 10 said they use social media, and 63 per cent in year 6, with 38 per cent of year 8 and 10, and 25 per cent of year 6 receiving a nasty, hurtful or scary message. When local children were asked if they have ever been bullied, just under half of year 6 (49 per cent) and 45 per cent of secondary school pupils said they had been bullied.

Pupils were asked a series of questions to determine an overall self-esteem score and a resilience score. In secondary schools seven per cent of pupils have low self-esteem, and 27 per cent have low resilience, while among Year 6 pupils five per cent have low self-esteem and 15 per cent have low resilience.

Evidence shows that the population’s diet is getting worse and obesity and poor health outcomes are increasing as a result. On the Isle of Wight the National Child Measurement Programme (NCMP) data showed that 32.7 per cent of children in Year 6 were classed as overweight or obese which is above the national average (22.1 per cent).

The Department of Health (DoH) recommends that those aged five to 18 should exercise for 60 minutes every day to be healthy. Locally, when we asked about exercise only 16 per cent said they met this guideline. For both boys and girls, physical activity decreases with age.
The JSNA draws upon data from a wide range of indicators of health and wellbeing which have been used to identify our priorities for working in partnership to improve the health and wellbeing of children. For more detailed information visit the children’s and young people’s factsheets (including pregnancy and maternity information):


What will the health and wellbeing board focus on?

The HWB acknowledges the priorities and work plan set by the Children’s Trust plan as follows:

• Children, young people and families enjoy the best possible mental, emotional and physical health.
• Children, young people and families feel safe and behave safely
• Children and young people have high aspirations and are able to achieve their full potential

Alongside the Children and Young People Plan and the Children’s Mental Health Transformation Plan priorities we will focus on including the following:

1  Improving children’s resilience, knowledge and skills to improve their health and wellbeing.

2  Developing new integrated prevention and early help services across health and social care to meet the needs of children and families.

Priority 1: Improving children’s resilience, knowledge and skills to improve their health and wellbeing

Public health, schools and key stakeholders are working together to coproduce a new ‘whole school’ programme of interrelated provision that schools can use to improve pupils’ health and wellbeing.
to reduce inequalities which affect attainment and aspiration. The Partnership for Educational Attainment and Children’s Health (PEACH) programme will build on the previous ‘healthy schools’ programme and will incorporate accredited awards. Initially PEACH will incorporate four domains (as shown in figure two):

- Personal, social, health and economic education.
- Emotional wellbeing and mental health.
- Physical activity.
- Healthy eating.

Within each domain, a set of key criteria are outlined which need to be met to improve the health and wellbeing of children and young people.

Currently, there is variation in uptake of evidence-based and quality provision by local schools, alongside differing levels of engagement in implementing health promoting policies and incorporating the four key areas. Equally, there is a lack of opportunities for schools to share best practice with each other in the areas of the four domains and to plan island wide approaches to new and emerging areas to focus on or how different elements can become integrated. PEACH is that collaboration and will enable additional funding to be bid for and best value made of existing resources.
What will we do?

We aim to achieve this through a whole-school and family centred approach working with key stakeholders and schools, to offer an effective, evidence-based range of interventions and a support network to schools which they buy into through a membership. PEACH has been developed during a process of bringing key stakeholders together to develop and implement the programme. As a result stakeholders agreed the four domains of PEACH should include accredited awards and that schools wanted support from public health in ensuring the interventions provided to children are evidence based. The aim is to make the offer of such good value to schools that they choose to invest their school PE premium and other funding to pay for their engagement in PEACH.

The offer will include:
- training for school staff;
- an accreditation/award process;
- a panel of providers delivering evidence based approaches;
- offers to schools of new opportunities and resources;
- sharing of good practice between schools;
- networking between schools and providers;
- updates to schools on latest policies and strategies relevant to the four domains.

Work has already started to:
- plan, develop and coordinate PEACH through a partnership model;
- develop a process to pool resource to ensure PEACH becomes self-funding and brings best value for money to schools;
- support the training and development of staff to better equip them in improving health and wellbeing, behaviour and attainment;
- improve pupil attainment, aspiration, health and wellbeing;
- improve engagement and capture stakeholder insight, ideas and solutions to local issues.

Priority 2:
Developing new integrated prevention and early help services across health and social care, to meet the needs of children and families

Health and care services for children on the Isle of Wight are commissioned by local authority public health, local authority children’s services, the Isle of Wight Clinical Commissioning Group and NHS England. Locally through the work of the Local Care Board we are moving toward integrated provision of services and therefore to support this new model of delivery we are committed to integrating the commissioning functions across the system. For children and young people the aim is to streamline the complexity that exists in the planning of services for children’s health and wellbeing.
What will we do?

Establish an integrated children’s commissioning unit (ICCU) that will initially focus on integrating the commissioning within the local authority regarding children’s and family services. As the unit develops it is proposed that elements of the clinical commissioning group’s (CCG) commissioning could be integrated into the unit, specifically services relating to child wellbeing, mental health and services for children with learning difficulties and disabilities.

The unit will initially focus on the joint commissioning of public health nursing (0 to 19 years) and children’s services early help contracts to realise benefits and ensure:

• understandable and identifiable connectivity between universal, targeted and specialist provision making services easily accessible;
• the use of evidenced-based interventions and services that we know work;
• the interventions and services are cost effective and outcomes focused;
• robust processes for quality and performance and contract management;
• the best possible services at best value.

By working in this way, the ICCU will contribute to the aims of this strategy to create the conditions for families to be resilient and better able to improve their own health and wellbeing.
Live well

Families, individuals and communities are thriving and resilient with access to good jobs, affordable housing, leisure activities, lifelong training, education and learning, health and care services and are able to enjoy the place where they live.

Why is this important?

People who live in thriving and resilient families and communities enjoy a sense of belonging, of being cared for and valued. These feelings provide the foundations for better health, a sense of wellbeing and foster the conditions which support people to thrive and aspire to their potential. Unfortunately, not all people and families on the Island experience these benefits: some are vulnerable and live fragile lives, which are affected by even small changes to their circumstances.

We all have a role to play in maintaining and improving the health and wellbeing of ourselves and our families. We need to support and motivate individuals, families and communities to take responsibility for their own health and wellbeing and provide support to those who need help to do so.

The lifestyles we lead play a significant part in our health and wellbeing. Heart disease and cancers remain the main causes of premature deaths and health inequalities on the Island, but for the most part, these diseases are preventable by changing our everyday habits.

On the Isle of Wight it is estimated 22,000 people aged 16 plus smoke. Of these each year on average 850 (3.8 per cent) will be admitted to hospital and around 115 will die from a smoking attributable condition. It has been highlighted that 22 per cent of pregnant women smoke throughout their pregnancy, one of the highest rates in the country although this is an improving picture.

The percentage of adults completing less than 30 minutes of activity per day is 33.2 per cent, which is significantly worse than the national average of 22.7 per cent. This means one in three adults on the Island are inactive. It is estimated that 66.2 per cent of adults on the Island have excess weight which is similar to the national average. It is now clear that inactivity along with high-calorific food and large portion sizes, has contributed to an increase in obesity.

Alcohol is the leading risk factor for deaths among men and women aged 15 to 49 years in the UK. It is now the third biggest risk factor for preventable ill-health and death behind smoking and raised blood pressure.
Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually. Locally it has been indicated that alcohol admissions to St Mary’s have cost £1.6 million per year but it is likely that this represents a significant underestimate.

The Isle of Wight faces significant health challenges and pressures on local services with the same number of people drinking harmfully as the number of people with diabetes (10,000) and at least a third of people on the Island are drinking above recommended guidelines.

Our mental health is an important indicator of our ability to cope with everyday life. It is reported that 1,600 people on the Island have a mental health problem at any one time, often influenced by multiple factors including low educational attainment, social isolation, unemployment and financial and relationship problems.

Added to this is the issue of those adults and young people with coexisting severe mental illness and problematic substance misuse use. These people have some of the worst health, wellbeing and social outcomes. While the interdependence of mental health and substance misuse (formerly known as dual diagnosis) is widely acknowledged and documented, the collaborative tackling of the issue remains far from systematic or integrated.

Adverse childhood experiences (ACE) can have a tremendous impact on lifelong health and opportunity. This is now being seen as an important public health consideration for services providing interventions for working age adults who are living with the impact of their ACEs not only on their health and wellbeing but also on but also on their economic status.

We know from the 2011 census that the majority of householders (70 per cent) on the Island own their properties, with 41 per cent of those owning them outright; being older retired people who have paid off their mortgages. This rate of home ownership is higher than for both the south east and for England being 67 per cent and 63 per cent respectively with outright ownership also being higher at 33 per cent and 31 per cent respectively.

This does not leave a lot of room for manoeuvre for those looking to purchase accommodation and given that the average house price for the Isle of Wight in April 2017 was £198,865 which is 7.9 times the average full time earnings of £25,297. This means the ability for many to purchase is not an option.

There is, therefore, great pressure on the rented housing sector on the Island. This is particularly so for social housing given that the percentage of social housing stock on the Island amounts to 10 per cent of all housing tenure as opposed to 14 per cent in the south east and 18 per cent in England. This, coupled with the numbers on the register for social housing far exceeding the number of allocations made, means demand far exceeds supply.

In November 2017 there were 2016 households registered for social housing, and while an average of 430 allocations has been made over the last three years, the level of allocations per year has dropped by 25 per cent over the same period.
Access to the private rented sector is not a viable alternative option for many households given the unaffordability of such accommodation, particularly those who are benefit reliant or on low incomes. The following table shows the level of rents charged in the private sector as opposed to the assistance a household can get from the Local Housing Allowance to help pay rent and compared to social housing rents.

<table>
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<th>Type of rented unit</th>
<th>Private rent levels per month at March 2017</th>
<th>Local Housing Allowance (LHA) rates per month with effect Nov 2017</th>
<th>Social rented per month from Nov 17</th>
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<td></td>
<td></td>
<td></td>
<td>General needs</td>
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<tr>
<td>Room/bedsit</td>
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<td>£297</td>
<td>£316</td>
</tr>
<tr>
<td>1 bed</td>
<td>£450</td>
<td>£403</td>
<td>£358</td>
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<tr>
<td>2 Bed</td>
<td>£595</td>
<td>£528</td>
<td>£464</td>
</tr>
<tr>
<td>3 bed</td>
<td>£750</td>
<td>£648</td>
<td>£488</td>
</tr>
<tr>
<td>4+ bed</td>
<td>£950</td>
<td>£798</td>
<td>£511</td>
</tr>
</tbody>
</table>

(Source, Valuation Office)

Many households struggling to secure or maintain accommodation, seek advice and assistance from the local authority’s housing services. Over the last three years the service has received an average of 1,456 approaches a year and this year is starting to register an increase in approaches. Wherever possible, homeless prevention is the desired outcome and over the last three years, an average of 312 households have been assisted in this way, but the numbers assisted have dropped by 12 per cent over this period due to the lack of suitable affordable accommodation available for households to access.

The ability to move people on to suitable accommodation is also reflected in the number of households in temporary accommodation which has seen a rise from 141 in March 2013 to 174 at the present time.

What will the health and wellbeing board focus on?

The HWB is keen to focus greater attention on prevention and early help for individuals, families and households. It welcomes the intended outcomes of the council’s developing plans to regenerate local areas in order to attract new business, create jobs and increase personal wealth. It is hoped that this will help to address the local levels of unemployment and economic deprivation, which are seen to have clear impact on Islander’s health and wellbeing. Alongside this it is now recognised that digital technology and connectivity now underpin almost every aspect of modern living across work, travel, leisure and health, and good internet access is now widely viewed as the ‘fourth utility’. The Island’s ‘digital pathfinder’ plans, which aim to attract new digital businesses to the Isle of Wight, and support existing Island organisations with opportunities presented by the digital economy, will also have an impact on our local community.
Alongside these corporate plans, supported by the use of JSNA data and the Isle of Wight Prevention Strategy, we have identified five main areas of focus for this strategy:

1. Ensuring people get timely support to maintain secure and appropriate housing.

2. Encourage people to be more active and structure places to be more conducive to activity with a focus on health inequalities for disabled people.

3. Work together to develop inclusive and resilient communities and support access to good work.

4. Reducing the occurrence and impact of Adverse Childhood Experiences (ACEs).

5. Addressing the issue of complex needs (formally known as ‘dual diagnosis’).
Priority 1: Ensuring people get timely support to maintain secure and appropriate housing

Housing clearly impacts on health, education, crime and employment. Without good quality housing, people are less likely to be able to maintain good health, steady employment or education. Good quality and affordable housing has also been proven to help reduce crime. This strategy aim is to create the conditions for stronger and more resilient communities. We want everyone to be able to live in a decent, safe home that they can afford. Delivering on the Island’s vision for ‘One Public Service’ will enable a more integrated and timely intervention to stop people becoming homeless and to help people adapt their homes to changes in their circumstances such as disability or illness.

What will we do?

We will develop and implement a homelessness strategy that focuses on prevention, early intervention and the changes the system needs in order to support people to maintain secure and appropriate housing.

In April 2018 the Homelessness Reduction Act 2017 was due to be implemented. The act places a duty on all public bodies to ensure that where a threat of homelessness is recognised, a referral is made to the housing authority to help to prevent homelessness.

We will ensure that all public bodies on the Island adhere to these new duties and that early intervention is put in place to ensure that all residents facing homelessness are given the appropriate advice, assistance and support to access and sustain suitable accommodation to meet their needs.

We will do this by:
• ensuring that all services put recognising the need for homelessness prevention at the core of their services;
• supporting public bodies and other agencies to work with housing services to develop and implement pathways for referrals where homelessness has been identified;
• improve the resilience within households to prevent future threats of homelessness.

Priority 2: Encouraging people to be more active and structure places to be more conducive to activity

Our 2016 public health annual report focused on physical activity and recommended the need for a whole-system approach to tackling inactivity. There is strong evidence that physical inactivity is
detrimental to health, both physical and mental and the benefits of even moderate levels of activity on health and wellbeing are also well documented. Focusing attention on this priority by the HWB will help to reduce forecasted pressures on our health and care system, and will revitalise our approach to physical activity, transport and sport.

What will we do?

The council’s place-shaping role is crucial to creating the structural environment and directing how sport, physical activity and active travel can join-up to create a more integrated approach to increasing physical activity.

- We will build on work already happening from existing and new partnerships (locally and regionally) to work better together to be more effective in how we use our local resource, access external resources and address the barriers for people to be more active through joined-up, innovative and sustainable initiatives.

- Our active travel work will be linked into the local action plan for physical activity and sport, as part of our approach for how we encourage people and their families to be more active within their communities.

- We will continue to build from our asset-based approaches to working alongside, and within communities to identify and mobilise assets to create opportunities for new formal and informal physical activity.

- Ensure that as we integrate our commissioning functions so that physical activity and green transport are considered in all specifications for the workforce and service users.

- We will develop an appropriate training and development workforce plan for staff working within or connected to the physical activity sector to build competencies.

Priority 3: Work together to develop inclusive and resilient communities and support access to good work

The local economy, and access to good quality work, is a major determinant of health. Long-term unemployment worsens health in three important ways: financial problems which affect living standards; depression or anxiety triggered by a lack of a positive self-identity; and its association with poor health behaviours, such as alcohol consumption.
What will we do?

Recognise the value of local community and neighbourhoods as places where health is created and people are mutually supported to age well, flourish and contribute. Our Public Health Team and Regeneration Team will work closely together as we clearly recognise that good health and employment are closely linked, as are poor health and worklessness. This will lead to the following areas of work:

• Harness the skills, gifts and experiences of people in the community and support them to utilise their strengths in contributing to the regeneration of their community.

• Build and grow welcoming and inclusive communities, where everyone has the opportunity to participate.

• Work with the Community Safety Partnership to identify and address issues that have an impact on community wellbeing, eg perception of safety/risk of crime.

• Work with regeneration to supply the data and intelligence needed to target programmes of work and resources.

• Work through our team of local area coordinators to ensure that individuals who have physical or learning disabilities and mental health needs have the opportunity to be in control of their lives and are able to contribute to and benefit from work opportunities suitable for their abilities and increased prosperity.

Priority 4: Reducing the occurrence and impact of adverse childhood experiences (ACEs)

Childhood experiences, both positive and negative, have a tremendous impact on lifelong health and opportunity. Therefore, early experiences are an important public health issue. As the experiences occur in early life but continue to impact throughout life right up to old age, the ACEs priority is a thread connecting all three phases of the life course focused on by this strategy. We have placed it in live well because of the impact parents have on the occurrence of ACEs. We already have good early help and prevention in place for children within children’s services but little to address the impact of ACEs, and little understanding of ACEs in services for working age adults who are living with the impact of their ACEs.

We have known for a long time that children raised in disadvantage are likely to experience worse health and life chances as children and as adults as well. Research which began in the late 1990s on the impact of this disadvantage, which were named adverse childhood experiences (ACEs), demonstrated the mechanism by which this happens.
Adverse childhood experiences have been linked to:
- risky health behaviours;
- chronic health conditions;
- low-life potential;
- early death.

As the number of ACEs increases, so does the risk for these outcomes. The wide-ranging health and social consequences of ACEs underscore the importance of preventing them before they happen.

Adverse Childhood Experiences (ACEs) are common. Almost two-thirds of a typical adult population report at least one ACE, and 15 per cent report four or more ACEs. ACEs are a set of abusive and neglectful childhood experiences: including direct abuse, eg sexual, emotional, and physical and neglect; and indirect, ie household dysfunction, domestic violence, drug and alcohol misuse, mental ill health, criminality, or separation from parent.
Children and young people exposed to ACEs have an increased risk of health harming behaviours and poor health outcomes across the life course.

Tackling the causes, presence and impact of ACEs will be an important factor in achieving our aspiration to reduce inequalities on the Island. People living with deprivation and poverty have fewer protective factors and are likely, on average, to have a higher prevalence of ACEs. Children and young people exposed to ACEs are more likely than those who are not to grow up to live in conditions that have a negative impact on their health. Parents with higher ACEs are more likely to have children who also have higher ACEs. Adults with four or more ACEs score are more likely to live with long term conditions; prematurely die; commit violent crime; or be a victim of violent crime; experience unemployment; and therefore require more interventions and support during their adulthood, and are less likely to work, pay taxes and contribute positively to their community.
What will we do?

A period of coproduction called the ‘big conversation’ will help us decide what we will do. This phase has been launched by a screening of the documentary ‘Resilience’ with a discussion afterwards. As a result of that discussion we agreed to meet again in late January 2018 with a wider group of people working in a range of agencies to agree an action plan. Initially there is likely to be a need to understand what percentage of the population live with four or more ACEs, and to raise awareness amongst staff and the community. Possible actions to be implemented are:

- routine enquiry about ACEs;
- trauma informed care including talking therapies;
- training to ensure staff can do this.

This will be overseen by the multi-agency group which is taking forward other aspects of the live well priorities.

Priority 5:
Addressing the issue of complex needs (formally known as ‘dual diagnosis’)

Adults and young people with coexisting severe mental illness and substance misuse have some of the worst health, wellbeing and social outcomes. It is not clear how many people in the UK have a coexisting severe mental illness and misuse substances, partly because some people in this group do not use services or get relevant care or treatment. While the interdependence of mental health and substance misuse (formerly known as dual diagnosis) is widely acknowledged and documented, the collaborative tackling of the issue remains far from systematic or integrated.
What will we do?

The most recent national guidance is very clear. All staff that may be the first point of contact with young people and adults with coexisting severe mental illness and substance misuse should be able to identify and provide support to people with coexisting severe mental illness and substance misuse. In addition, secondary care mental health services should “not exclude people with severe mental illness because of their substance misuse”. Mental health services should adopt a person-centred approach to reduce stigma and address any inequity to access to services people may face. Signatories to the substance misuse strategy pledge the following:

To address coexisting severe mental illness and substance misuse in community health and social care services. Guidance will be developed in partnership with the NHS trust and Public Health to draw together the expertise of mental health and substance misuse practitioners as well as wider agencies and stakeholders as appropriate into a framework that will standardise aims, objectives and processes across the Isle of Wight. Delivery of the guidance will be monitored by the Drug and Alcohol Action Team (DAAT) board.
Age well

People are able to live independently in their own homes with appropriate care support. Older residents are supported to play an active role in their communities and supported to maintain and develop their social and community networks.

Why is this important?

Older people can, and often do, make a valuable social, economic and civic contribution to their local communities, and to the Island, alongside other generations. Remaining active helps people age well and we need to encourage more people, of all ages, to maintain and develop their social and community networks. People should be supported to live independently in their own homes with appropriate care support as they age.

Over one in four Island residents are older than 65. This is the 15th highest level of any local authority in England and Wales. Over the next ten years, the number of 65 to 79 years old will increase by nearly 17 per cent, while the over 85s will increase by 40 per cent.

Most people want to stay living independently for as long as possible and have strong emotional ties to their neighbourhoods. Having the right kind of accommodation in the right place is one of the major factors that determine our ability to maintain independence, particularly as we get older.

In line with population changes, the proportion of people living with long-term conditions will increase. Dementias currently affect five per cent of people aged over 65 and 20 per cent of those over 80 years. The changing age profile will result in significant increases in the number of people living with a dementia.

The role undertaken by carers will become even more crucial so that people are able to remain independent. Services for carers should be joined-up across organisations on the Island to ensure that the most effective and efficient support is provided.

Older people at risk of losing their independence following an illness or hospital admission currently receive care and support from a number of organisations, often experiencing several handovers between professionals. These services need to be more integrated with a focus throughout the system on regaining and promoting independence. The adult social care strategy ‘Care closer to Home’ sets out how this will be delivered for the Island. It uses the PIP approach (promote wellbeing
– improve wellbeing – protect wellbeing) as its underlying principles and focuses on working with people and the local community to help people remain in their own homes.

Carers are an essential component of the health and social care economy and save the government approximately £119 billion each year (NHS England 2014). On the Island we have more than 16,000 carers providing the help and support that keeps people living within their own homes. Without this support, the Island’s services simply could not cope with demand.

Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer’s effectiveness and lead to the admission of the cared for person to hospital or residential care.

What will the health and wellbeing board focus on?

The HWB is keen to focus greater attention on prevention and early help for older people and carers. Therefore, alongside supporting the outcomes of the Care Closer to Home strategy, the local care board priorities and other plans that aim to address the issues raised by the JSNA, we have identified three main areas of focus for this strategy:

1. **Integrate activity that focuses on prevention and self-care.**

2. **Support for carers including those who formally care and informal carers.**

3. **Work to promote inclusion, independence and resilience through strengthened neighbourhood and social networks.**
Priority 1: Integrate activity that focuses on prevention and self-care

What will we do?

We will continue to build on our asset/strength based approaches to working alongside, and within communities to identify and mobilise assets to:

- help people maximise income, including benefits they are entitled to supporting aging well (eat and heat);
- commit to developing the workforce through MECC (making every contact count);
- be able to use a person-centred approach that enables people to live well whatever their goals;
- increase community engagement, undertake intergenerational activity and encourage volunteering to foster understanding, build relationships and resilience;
- work with our fire service to introduce the STEER (safety through education and exercise for resilience) course to the Island.

Priority 2: Support for carers including those who formally care and informal carers

We recognise the invaluable contribution that carers on the Island make to our families and communities. The role undertaken by carers will become even more crucial so that people are able to remain independent. Services for carers should be joined-up across organisations on the Island to ensure that the most effective and efficient support is provided.

What will we do?

Carers need early identification and appropriate support to ensure that they are able to remain in their caring role therefore we will:

- develop our workforce especially within the three Integrated locality services and primary care to be able to identify and offer appropriate support to unpaid carers, enabling carers to remain in their caring role for as long as possible, while ensuring that we recognise when a carer needs to opt out of caring;
- introduce a carer’s lounge offering unpaid carers a safe place to look at their needs and what help they require to support their cared for person while in hospital;
• offer training for carers in delivery of personal care – Independent living equipment and manual handling can be offered at the Independent Living Centre to improve the unpaid carer’s confidence in caring for their person at home.

Priority 3:
Work to promote inclusion, independence and resilience through strengthened neighbourhood and social networks

Evidence shows us that experiencing loneliness in older age has serious potential negative health impacts. There is also good evidence to show having good social networks as you age can serve to protect you against various health risks. We recognise that communities are enriched through the inclusion and contribution of older people, people with disabilities, mental health needs and carers.

What will we do?

• Working with partners in the community, we will ensure that individuals have the opportunity to be in control of their lives and be heard.

• Create the conditions for the development of sustainable natural friendships and connections within communities that are mutually supportive. Connect people with shared interests and experiences, to enable meaningful social networks to develop.
Alongside the three main themes we have agreed to two ‘place-based’ initiatives in Newport (Pan) and Ryde (North East), taking an ABCD approach to support and develop citizen-led action to improve the health of their communities. Much is already going on in these communities, and there has been a significant amount of funding and intervention over the years. The decision to use an asset-based approach to tackling inequalities in these communities was made after conversations with community members, who told us they didn’t want to be done ‘to’ and ‘for’ but wanted to be supported to lead action to improve their neighbourhoods.

‘Place-based’ is a term used to describe how we will work with colleagues across public, voluntary and private sectors and people within a location/community area to co-produce a set of actions which lead to structural changes and improvements to the place that they live in. This will result in reducing the inequalities that cause poorer health outcomes for people who work, live, age and grow within that ‘place’.

The starting point is the conversation we have with people where they understand what is important to them about their place and health and wellbeing, then building to:

- discover and establish what the priorities, ideas and opportunities are;
- establish what already exists that can be built from – who can support in taking the next steps.

This is what leads to the structural changes with the aim of adding life to years not just years to life through joint efforts of the system and communities.

Place-based initiatives are designed to promote change around fundamental determinants of health and wellbeing in local communities. Place-based health initiatives share an emphasis on concentrated investments in social, economic and human capital within local settings to achieve measureable health improvements. This approach is preferred to the more individualised/targeted approaches we have employed in the past that focus on a single risk factor or behaviour, as this has limited the opportunity to address ‘the cause of the causes’ of poorer health outcomes and inequalities within a place.
We will take action to:
- design the approach to meet the unique needs and priorities of the locations;
- engage with people across all sections of the ‘place’ in collaborative decision making;
- seize opportunities, particularly local skills, interests and gifts;
- evolve to new learning and people’s interests;
- encourage collaborative actions by crossing and moving beyond organisational boundaries;
- attempt to change behaviours, norms and inequalities which cause poorer health.

People are more likely to engage within activity as close to their doorsteps as possible, since people will engage and connect around the things they care about, and most people will mobilise around the things that are close to home, therefore have more influence on the factors that underpin good health.
How will we know we have made a difference?

The HWB needs to have a shared understanding of how well it is doing in achieving the goals of this strategy and the outcomes for the Local Care Board. This will enable the HWB to have a robust oversight of the health and wellbeing of the whole population and its progress towards improvements goals.

The HWB recognises the importance of health and care services but at the same time acknowledges the research undertaken by the Health Foundation\(^1\) that shows as little as 10 per cent of people’s health and wellbeing is linked to access to health and care services. Therefore our measures for success need to be wider than just the health and care metric that focuses on demand for, quality of and access to health and care services.

Because of this we will develop a shared ‘dashboard’ that all partners are signed up to and that can be monitored both collectively and within their own organisations. These will include the local care board indicators alongside a local wellbeing indicator set developed based on the work produced by Happy City, a UK charity that develops measures to indicate social wellbeing and prosperity.

The delivery and monitoring of the priorities for health and care services will be through the Local Care Board. The delivery and monitoring of the priorities for the wider determinants of health and reduction in inequalities as set out in this strategy will be through the creation of a local wellbeing board as shown in figure six.

\(^1\) [www.health.org.uk/blog/infographic-what-makes-us-healthy](http://www.health.org.uk/blog/infographic-what-makes-us-healthy)
It is proposed that a local wellbeing board will be formed to measure the success of this strategy in reducing inequalities and improving overall wellbeing by using a local wellbeing indicator set (LWIS). The set is the product of a six-month scoping project commissioned by the Office for National Statistics and Public Health England and developed by Happy City and What Works Centre for Wellbeing.

The indicator set was developed to meet the need for local measures that provide a consistent framework that uses local authority level indicators so that local decision makers can better understand the wellbeing of their constituents, and how they can act to improve it. The LWIS final framework is built around seven domains (personal wellbeing, economy, education and childhood, equality, health, place and social relationships) as shown in figure seven.

Each domain consists of several sub-domains – there are 26 in total (see figure eight). One ‘ideal’ indicator set has been identified for each sub-domain. In 11 cases, this indicator is not currently available at the local authority level – in most of these cases there is a proposed alternative indicator which is widely available at present to create a ‘currently available’ set. There are a further 37 additional indicators across the sub-domains, for if more in-depth, nuanced understanding is required.

By the use of these measures we will, for the first time, be able to measure the effect of the identified actions within a health and wellbeing strategy. By undertaking this, it is the aim to quantify either the achievements and improvements that we are making within the local community, or areas of health inequalities that require addressing.
Figure eight
Sub-domains

- **PERSONAL WELLBEING**
  - Autonomy
  - Happiness
  - Life satisfaction
  - Worthwhile
  - Anxiety

- **ECONOMY**
  - Unemployment
  - Job quality
  - Material deprivation

- **EDUCATION AND CHILDHOOD**
  - Child learning
  - Adult learning
  - Children’s wellbeing

- **EQUALITY**
  - Wellbeing inequality

- **HEALTH**
  - Health behaviour
  - Overall health
  - Mental health

- **PLACE**
  - Green space
  - Housing
  - Democracy
  - Local environment
  - Crime and security
  - Culture

- **SOCIAL RELATIONSHIPS**
  - Close support
  - Generalised trust
  - Personal relationships
  - Community cohesion
  - Volunteering
Health and wellbeing strategy for the Isle of Wight
2018 to 2021
### Governing Body

#### Budget and Financial Plan 2018/19

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Jane Cole, Interim Chief Finance Officer</th>
</tr>
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<tbody>
<tr>
<td><strong>Summary of issue:</strong></td>
<td>The NHS Isle of Wight CCG 2018/19 Financial Plan and Summary Budgets.</td>
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<tr>
<td><strong>Action required/recommendation:</strong></td>
<td>The Governing Body is asked to <strong>approve</strong> the updated 2018/19 Financial Plan and Budget for NHS Isle of Wight CCG.</td>
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<tr>
<td><strong>Principle risks:</strong></td>
<td>The financial plan for 2018/19 has a challenging QIPP target of £11.1m (4.8%), and un-mitigated risks of £5.3m</td>
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<tr>
<td><strong>Other committees where this has been considered including SMT:</strong></td>
<td></td>
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<tr>
<td>Has this been agreed with the following areas; Please tick and gain signature:</td>
<td>Finance [ ] Quality [ ] Contracts [ ]</td>
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<tr>
<td>Signed Finance [ ] Quality [ ] Contracts [ ]</td>
<td></td>
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<tr>
<td><strong>Financial/resource implications:</strong></td>
<td>Detailed in the report. The 2018/19 updated plan delivers a £5m deficit control total for 2018/19.</td>
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<tr>
<td><strong>Legal implications/impact:</strong></td>
<td>Not applicable</td>
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<tr>
<td><strong>Public involvement/action taken:</strong></td>
<td>The 2018/19 Financial Plan and Budget is in line with the CCG’s Strategy, which has been developed with public and patient engagement.</td>
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<tr>
<td><strong>Equality and diversity impact:</strong></td>
<td>Any service changes required to deliver this plan will be subject to consultation, where appropriate and an Equality Impact Assessment.</td>
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<tr>
<td><strong>Author of Paper:</strong></td>
<td>Becky Wastall Deputy Chief Finance Officer</td>
</tr>
<tr>
<td><strong>Date of Paper:</strong></td>
<td>29th August 2018</td>
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<td><strong>Agenda Item:</strong></td>
<td>6.3</td>
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<tr>
<td><strong>Paper number:</strong></td>
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Updated Financial Plan and Budgets

2018-2019

Governing Body 6 September 2018
The Governing Body approved an Interim Financial Budget Plan at its meeting on 29 March 2018.

Summary of Interim Plan agreed was as follows:-

- Break-even plan which met control total.
- QIPP savings target of £9.4m.
- Unidentified QIPP of £2.8m, further £2.5m requiring firmer plans and relating to IW Trust Contract.
- Contingency held (as per business rules) of 0.5% £1.3m.
- Unmitigated risks of £8.4m.
- Contract offer to the IW Trust £125.2m - assumptions differences with IW Trust of £11m+.
Updated Financial Plan – movement in position

- £5m Deficit Plan submitted 30 April (agreed with NHSE).
- QIPP target increased by £1.7m to £11.1m.
- An Isle of Wight system control total deficit for 2018/19 of £22.1m (£5m CCG, £17.1m Trust) has been agreed with regulators.

Reasons for movement are as follows:

- The contractual agreement with the Trust was £5.5m higher (£130.7m as opposed to original offer of £125.2m).
- A CCG risk reserve of £1.6m was created.
- Other changes in budgeted assumptions to reflect other agreed contract values (£0.4m).
- Unmitigated risks have reduced from £8.4m to £5.3m – mainly due to the contract variation with the IW Trust being agreed.
Financial Summary of Budgets

<table>
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<td>Recurrent baseline allocation</td>
<td>209,754</td>
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<tr>
<td>Delegated Primary Care allocation</td>
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<tr>
<td>Running Cost allocation</td>
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<td>Increase to recurrent baseline allocation</td>
<td>1,756</td>
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<tr>
<td>In year non-recurrent allocations</td>
<td>254</td>
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<tr>
<td><strong>Notified Resource limit</strong></td>
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**Expenditure**

- Acute: 113,723
- Mental Health: 25,881
- Community: 28,935
- Continuing Care: 16,051
- Delegated Primary Care: 19,778
- Primary Care Other: 30,987
- Programme Staff costs: 1,153
- Running Costs: 3,081
- Reserves: 3,731
- Unidentified QIPP: (3,698)

**Total Application of funds** 239,623

**Control Total** (5,000)

- The table sets out the CCG's allocation and expenditure plans.
- Budgets have been based upon 2018/19 National Planning Guidance and allocations (apart from in-year Break Even requirement).
- CCG not eligible for the Commissioner Sustainability Fund (CSF) due to the deficit plan.
- Plan incorporates pay and price changes – 2% efficiency deflator and 2.1% inflation uplift (1% pay award).
- Growth has been applied where appropriate to budgets.
- Expenditure on CCG running costs within allocated amount.
- Budgets set following the business rules of holding a 0.5% contingency.
- Additional reserves created to manage in-year contract risks and other pressures.
- Budget reductions for QIPP savings (unidentified QIPP £3.7m).
### Detailed 2018/19 Budgets

<table>
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<th>Gross Budgets</th>
<th>QIPP Applied</th>
<th>Net Budgets</th>
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<td>IOW Dermatology SLA</td>
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<tr>
<td>Other Community Non NHS</td>
<td>2,469</td>
<td></td>
<td>2,469</td>
</tr>
<tr>
<td>Wheelchair contract</td>
<td>647</td>
<td></td>
<td>647</td>
</tr>
<tr>
<td><strong>Continuing Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing Care</td>
<td>14,815</td>
<td>(1,337)</td>
<td>13,478</td>
</tr>
<tr>
<td>Funded Nursing Care</td>
<td>2,573</td>
<td></td>
<td>2,573</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPA Prescribing</td>
<td>25,732</td>
<td>(1,775)</td>
<td>23,957</td>
</tr>
<tr>
<td>Central Drugs/Dressings</td>
<td>1,699</td>
<td></td>
<td>1,699</td>
</tr>
<tr>
<td>Other Prescribing</td>
<td>2,125</td>
<td>(496)</td>
<td>1,629</td>
</tr>
<tr>
<td>Enhanced services/Extended access</td>
<td>3,703</td>
<td></td>
<td>3,703</td>
</tr>
<tr>
<td>Delegated Primary Care</td>
<td>19,778</td>
<td></td>
<td>19,778</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Staff Costs/Reserves</td>
<td>5,186</td>
<td>(302)</td>
<td>4,884</td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>(11,152)</td>
<td></td>
<td>(3,698)</td>
</tr>
<tr>
<td><strong>Running Costs</strong></td>
<td>3,081</td>
<td></td>
<td>3,081</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>239,623</td>
<td>(7,454)</td>
<td>239,623</td>
</tr>
</tbody>
</table>
Contract with IW Trust

- CCG original contract offer £125.2m.
- Final contract agreed £130.7m.
- Agreed basis - PbR for Acute and block for Ambulance, Community and Mental Health.
- There is a risk to the CCG that if activity and referrals are not contained within the contract level, then the Acute element of the contract will over-perform.
QIPP Plan 2018/19

- QIPP required to deliver the in-year control total of £5m deficit = £11.1m (4.8%) of allocation.
- £2.6m Acute Demand Reduction Schemes - £1.5m linked to ASR, risk of delivery within this financial year due to pace of change.
- CHC additional spend to save scheme approved and currently on track to deliver the QIPP target.
- Medicines Management – clear plans and deliverables.
- Rehabilitation configuration – delivered.
- Savings solutions and opportunities are being pursued within the CCG and with system partners to address the unidentified balance and to deliver the Acute QIPP.

<table>
<thead>
<tr>
<th></th>
<th>QIPP Plans 08-Mar-18</th>
<th>QIPP Plans 30-Apr-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute demand reductions</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>CHC</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>0.3</td>
</tr>
<tr>
<td>un-identified QIPP</td>
<td>2.7</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9.4</strong></td>
<td><strong>11.1</strong></td>
</tr>
</tbody>
</table>
CCG Risks

- Unmitigated risks have reduced this month from £8.4m to £5.3m due to the contract being agreed with IW Trust.

- The risks represent the CCGs assessment of potential financial pressures, based on current expenditure levels together previous experience of possible downsides.

- The mitigations represent reserves set aside together with expectations around potential underspends based on previous experience.

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>IW trust contract overperformance</td>
<td>Contract reserve: 1.6</td>
</tr>
<tr>
<td>risk of QIPP non-delivery</td>
<td>Contingency: 1.2</td>
</tr>
<tr>
<td>Mental Health placements</td>
<td>Risk Reserve: 1.6</td>
</tr>
<tr>
<td>prescribing risks</td>
<td>Balance sheet items: 0.2</td>
</tr>
<tr>
<td>Total Risks</td>
<td>Delegated Primary care underspend: 0.5</td>
</tr>
<tr>
<td></td>
<td>Budget setting reserve: 0.5</td>
</tr>
<tr>
<td></td>
<td>Total Mitigations: 5.6</td>
</tr>
<tr>
<td>Un-mitigated risks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total: (10.9)</td>
</tr>
</tbody>
</table>
IOW System

• The Regulators have agreed an overall system control total for the Isle of Wight health partners of £22.1m (CCG £5m, Trust £17.1m).

• There is a requirement for the system to work together to produce a financial recovery plan.

• The CCGs Interim Chief Finance Officer is working with the IW Trust’s Director of Finance to understand the overall system financial picture and to develop a joint financial recovery plan.
Recommendations

• The Governing Body are asked to:

  • Approve the Updated Financial Plan and Budgets for the 2018/19 financial year amounting to £239.6m, including the requirement to deliver an in-year deficit control total of £5m and QIPP saving of £11.1m.
  • Note the challenging QIPP target for 2018/19 and the requirement to find robust plans to deliver the £3.7m unidentified QIPP.
  • Note the system control total of £22.1m.
  • Note the significant risks within the plan of delivering the deficit control total.
  • Note the requirement for the system to work together to produce a Joint Financial Recovery Plan.
# Governing Body

## Clinical Senate Terms of Reference

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Loretta Outhwaite, Deputy Chief Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of issue:</strong></td>
<td>One of the recommendations from the Capacity and Capability Review, undertaken as part of the Legal directions placed on the CCG, was to establish a clinical forum. The purpose of the forum was to allow discussion of clinical commissioning decisions with a wider range of clinicians to ensure greater clinical input throughout the commissioning process.</td>
</tr>
<tr>
<td><strong>Action required/recommendation:</strong></td>
<td>• To <strong>approve</strong> the Clinical Senate Terms of Reference.</td>
</tr>
</tbody>
</table>
| **Principle risks:** | CCG Legal Directions are dependent on the completion of actions from Capacity and Capability Review. 
To ensure Clinical Leadership is effectively embedded in the decision making processes of the CCG. |
<p>| <strong>Other committees where this has been considered including SMT:</strong> | • Clinical Senate |
| <strong>Has this been agreed with the following areas; Please tick and gain signature:</strong> | Finance N/A Quality N/A Contracts N/A |
| <strong>Signed:</strong> | Finance_________ Quality_________ Contracts __________ |
| <strong>Financial /resource implications:</strong> | Commitment outlined as part of the Capacity and Capability Review action plan. |
| <strong>Legal implications/impact:</strong> | Will form part of the CCG’s governance handbook. |
| <strong>Public involvement/action taken:</strong> | Minutes of the meetings will be reported to the Governing Body Meeting in public. |
| <strong>Equality and diversity impact:</strong> | Equality and Diversity is considered as part of all commissioning decisions. |
| <strong>Author of Paper:</strong> | Phil Hartwell, Head of Governance |</p>
<table>
<thead>
<tr>
<th>Date of Paper:</th>
<th>August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>6 September 2018</td>
</tr>
<tr>
<td>Agenda Item:</td>
<td>6.5</td>
</tr>
<tr>
<td>Paper number:</td>
<td>GB18-044</td>
</tr>
</tbody>
</table>
Terms of Reference – Clinical Senate

1.0 Constitution

1.1 The Clinical Senate is a clinical forum set up by the Isle of Wight CCG Governing Body as constituted by the CCG Constitution and the Scheme of Reservation and Delegation and in these Terms of Reference, which will be reviewed annually by the CCG Governing Body.

2.0 Purpose

2.1 The Clinical Senate is a clinical forum to allow discussion of clinical commissioning decisions with a pool of clinicians, to ensure there is sufficient clinical input throughout the commissioning process.

3.0 Responsibilities

3.1 The responsibilities of the Clinical Senate are as follows:
   a) To highlight and promote evidence based guidelines to relevant parts of the CCG organisation,
   b) To review the relevance of NICE publications to CCG commissioned services and to primary care and make recommendations for implementation,
   c) To develop, review and help implement changes to clinical pathways, referral criteria and referral processes,
   d) To review and recommend approval of major changes to clinical pathways or referral processes to Governing Body,
   e) To review project initiation documents and provide assurance to the CCG in relation to the clinical safety and evidence-base relied upon within the project,
   f) To approve project evaluation reports regarding the clinical effectiveness, efficiency and safety of projects and other pieces of work,
   g) To review other service reports or proposals for reviews and make recommendations in relation to clinical effectiveness and patient safety as required by the organisation.

4.0 Scope of Authority and Decision Making

4.1 The Clinical Senate is required to work in accordance with these Terms of Reference and the CCG’s Standing Orders, Prime Financial Policies and Scheme of Reservation and Delegation.

4.2 The Clinical Senate will work to the professional and legal standards required of its members.

4.3 The Clinical Senate will ensure that it reports to the CCG Governing Body on any matters which properly fall within the CCG Governing Body’s ‘Schedule of matters Reserved to the Board’

5.0 Membership and Attendance

July 2018
5.1 Membership of the Clinical Senate shall include the following:
   a) CCG Chair;
   b) GP Governing Body Members;
   c) CCG Clinical Leaders;
   d) Any interested Clinicians from the Member Practices;
   e) Director of Nursing and Quality;
   f) Deputy Director of Quality and Head of Medicines Optimisation
   g) Head of Governance.

5.2 The Clinical Senate will be chaired by the CCG Chair or in their absence one of the Governing Body GP Members.

5.3 Attendees may be invited to attend for specific items/strategic priorities with prior agreement of the Chair.

5.4 The meeting will be a clinical forum and open to all interested clinicians from the member practices.

5.5 The Clinical Senate must be quorate when any recommendations are made or votes taken.

6.0 Frequency

6.1 The Clinical Senate will meet monthly.

7.0 Management

7.1 The Clinical Senate shall operate in line with the requirements of the NHS Codes of Conduct and Accountability, the NHS Constitution and the CCG Constitution, reflecting the Nolan Principles.

7.2 Recommendations will generally be made on the basis of consensus.

7.3 The Clinical Senate shall receive support from the Governance Team.

7.4 The agenda and papers shall normally be circulated to members 5 working days before the meeting date.

8.0 Reporting
8.1 The Clinical Senate is accountable to the Governing Body of the CCG. The minutes of the Committee shall be formally recorded and submitted to the Governing Body.

8.2 The Clinical Senate Chair will provide reports on the work to the CCG Governing Body meeting.

8.3 The Clinical Senate Chair shall draw to the attention of the CCG Governing Body any issues which require full disclosure to the CCG Governing Body.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Approved by</th>
<th>Amendments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>July 2018</td>
<td></td>
<td>First document</td>
</tr>
<tr>
<td>0.2</td>
<td>July 2018</td>
<td></td>
<td>Amended after first meeting</td>
</tr>
</tbody>
</table>
# Information Governance Policies

## Governing Body

### Information Governance Policies

| Sponsor: | Melanie Rogers – Director of Nursing and Quality, Caldicott Guardian  
|          | Loretta Outhwaite – Deputy Chief Officer, SIRO |

### Information Governance Policy

This policy helps staff understand how they must look after personal data and special categories of data under the GDPR. It sets out the key rules for staff to follow in relation to information governance. It details the legal compliance, definitions, key processes and information security along with the key roles and responsibilities within the CCG.

The updates include:

- Updates to terminology – such as personal data, special categories of data, DPIAs
- Incorporation of the new legislation – GDPR and DPA 2018
- Updated breach reporting procedures
- Incorporation of the new Data Protection Officer role
- Data Privacy Impact Assessment (DPIA) process (replaces previously know PIAs)
- Updated training requirements (E-Learning For Health)

### Confidentiality and Safe Haven Policy

This policy details how the CCG will meet its legal obligations concerning confidentiality, information security standards and operates such procedures ensuring that confidential information sent to and from the CCG is handled in such a way as to minimise the risk of inappropriate access or disclosure. The policy has been updated to incorporate the new GDPR and DPA 2018 legal requirements.

The updates include:

- Updates to terminology – such as personal data, special categories of data, DPIAs
- Incorporation of the new legislation – GDPR and DPA 2018
- Incorporation of the new DPO role
- Legal basis for sharing data under the GDPR
- Updated training requirements (ELFH)

This policy now incorporates the ‘Safe Haven Policy’ procedures and therefore the Safe Haven Policy is no longer required as a standalone policy.
<table>
<thead>
<tr>
<th>Policy Statement on Data Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>This new policy provides clarity on the terminology used under the General Data Protection Regulation (GDPR) and Data Protection Act (DPA) 2018 and provides an explanation on the following definitions:</td>
</tr>
<tr>
<td>Personal Data</td>
</tr>
<tr>
<td>Special Categories of Personal Data</td>
</tr>
<tr>
<td>Personal Confidential Data</td>
</tr>
<tr>
<td>Commercially Confidential Information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Governance Staff Handbook</th>
</tr>
</thead>
<tbody>
<tr>
<td>The IG staff handbook is intended to support and assist staff in meeting their obligations in relation to information governance and sets out some of the responsibilities and expectations staff are required to demonstrate in their everyday working practices for the CCG. The handbook has been reviewed and updated in accordance with the GDPR and DPA 2018.</td>
</tr>
</tbody>
</table>

**Key changes:**
- Updates to legislation – including the GDPR principles
- IG Structure – particularly DPO
- Updates to the section on confidentiality
- New DPIA section (replaces PIA)
- New section on Data Processing Agreements
- New section on Individuals Rights
- Updates to breach reporting
- Updates to IG training section – reflective of ELFH requirement
- New glossary of terms/abbreviations, conditions for processing under GDPR

<table>
<thead>
<tr>
<th>Information Asset Owner (IAO) and Data Custodian Handbook</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Staff Induction handbook contains the advice and guidance to support the roles and responsibilities of the Information Asset Owner (IAO) and Data Custodian (DCs)/Information Asset Administrators (IAA’s) within the CCG and explains how the IAO’s and DC’s support the Information Governance work plan, and the organisations’ Data Security &amp; Protection (DSP) Toolkit submission. The handbook has been updated to reflect changes introduced by the GDPR and DPA.</td>
</tr>
</tbody>
</table>

**Key changes:**
- Updates to legislation – including the GDPR principles
- Roles and responsibilities – in particular new DPO role
- Data Security and Protection Toolkit – replacement of the IG toolkit
- Updated IG structure – Appendix E
- Updated TNA – Appendix D
- Updated IAO/DC Work Programme schedule for 18/19 – Appendix B
- New DPIA section (replaces PIA)
Update to SAR process (incorporation of individuals rights under the GDPR)
Updates to breach reporting
Updates to IG training section – reflective of ELFH requirement
DSP toolkit assertions included within the handbook – Appendix C
New glossary of terms/abbreviations

**Training Needs Analysis**
Training Needs Analysis (TNA) details what Information Governance (IG) training staff must complete. The TNA has been updated to show that all staff must complete mandatory IG training (called Data Security Awareness training) through the E Learning for Health website. The TNA also details supplementary training which other members of staff such as the SIRO and Caldicott Guardian must complete using NHS Digital provided workbooks.

**Records Management Policy**
This policy sets out how the CCG will approach the management of its records. The policy has been updated to incorporate the GDPR and DPA 2018 but also includes more detailed process requirements including, records inventory, disposal schedules/legal holds, naming electronic documents, accredited file shares and security.

The policy includes key records management requirements under legislation/standards, protective marking scheme and categories of data as defined under the GDPR/DPA.

**Data Protection Impact Assessment (DPIA) Template and Guidance Framework**
The DPIA (previously known as a PIA) guidance framework and template have been updated to incorporate changes that have been introduced by the GDPR. DPIAs are mandatory when ‘processing special category data on a large scale’ which will often be the case for the health sector.

The guidance framework provides staff with guidance on what a DPIA is, when one must be completed, who should carry one out and the review process. The guidance contains a template DPIA which all staff must use when completing a DPIA along with a ‘processor’ and information security checklist.

The template has been updated to reflect the changes in legislation.
Key changes to the template:
Screening questions
Inclusion of legal basis under the GDPR
Consultation with the Data Protection Officer (DPO)
Processor assurances
Risk identification
Individuals Rights under the GDPR
Consultation process
<table>
<thead>
<tr>
<th>Action required/recommendation:</th>
<th>To endorse the approval of the changes to the policies made by the SIRO, Caldicott Guardian, Conflict of Interest Guardian.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle risks:</td>
<td>Non-compliance with GDPR legislation</td>
</tr>
<tr>
<td>Other committees where this has been considered:</td>
<td>SCW CSU Information Governance Steering Group.</td>
</tr>
</tbody>
</table>
| Has this been agreed with the following areas; Please tick and gain signature: | Finance  ✗  Quality  ☐  Contracts  ☐  
Signed
Finance__________ Quality_______ Contracts__________ |
| Financial /resource implications: | None                                                                                                                           |
| Legal implications/impact:     | To ensure compliance with the General Data Protection Regulation and Data Protection Act 2018                              |
| Public involvement/action taken: | Not Required                                                                                                                   |
| Equality and diversity impact: | None                                                                                                                           |
| Author of Paper:               | SCW CSU Information Governance Team                                                                                           |
| Date of Paper:                 | 21st June 2018                                                                                                                 |

<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>6 September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item:</td>
<td>6.5</td>
</tr>
<tr>
<td>Paper number:</td>
<td>GB18-045</td>
</tr>
</tbody>
</table>
## Governing Body
### Mental Health Transformation Programme Blueprint

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Gillian Baker, Director of Strategy and Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of issue:</td>
<td>The attached Blueprint for the future vision of Mental Health services on the Island has been developed in close consultation with a wide range of stakeholders, with close oversight from the Mental Health Transformation Steering Group and has undergone extensive public engagement and consultation between January and June 2018. Feedback from the consultation has informed the attached final version.</td>
</tr>
</tbody>
</table>

### A Mentally Healthy Island, Our Blueprint for Mental Health 2017-2022

The current model for mental health services on the Isle of Wight is not recovery focussed, so it needs to move towards a more preventative and collaborative model with people with lived experience. The priority for the island is to deliver the NHS Five Year Forward View to improve people's mental health and wellbeing by supporting a cultural shift in provision. The models will need to recognise the wider social networks and the importance of physical wellbeing, resilience, and recovery, including employment and housing control to promote independence.

Mental Health services will be redesigned to be integrated across health, social care and 3rd sector, working alongside people to support them to help change elements of life style.

### Our aim

With our partners and local communities we will become a mentally healthy island. We will promote self-care and prevention through the delivery of high quality mental health services, at all times focusing on the person themselves being in control and developing personal resilience.

### Our ambitions

#### Supporting people to maintain good mental health and renewing our focus on delivering prevention
- We will encourage the public to have good mental health and work with us to develop services that better meet their needs.
- We will address the factors that can lead to poor mental health and wellbeing.
- We will reduce the number of lives lost through suicide.

#### Reducing stigma and raising mental health awareness
- We commit to eliminating stigma and discrimination by starting and leading conversations which promote positive perceptions of mental health.

#### Revitalising our approach to health and care services
We will develop integrated pathways for mental health that start in the community and connect effectively with other specialist services.

We will break down the boundaries between GPs, community and hospital services.

Through a renewed commitment to partnership between the NHS, the council, the voluntary sector and the public, our focus will be on enabling people to live a full and meaningful life despite mental ill health.

Recovery

Our mental health services will support recovery to promote, hope, independence, wellbeing and choice.

Developing our workforce

Our services will have the right mix of trained, skilled, experienced and compassionate staff.

We will extend our employment of peer workers and work with the local voluntary sector workforce.

Making the money work

We will change the way we spend our money and focus more on prevention and community based services.

Improving quality, outcomes and holding to account

We will set new standards for the quality of our local mental health services.

We will agree the outcomes to be achieved by those providing services and we will hold them to account.

We will evaluate the experience of service users and involve them in how we respond to what they tell us.

A consultation closure report has been produced which details the extensive consultation that was undertaken in developing and finalising the Blueprint. This is available from the commissioning team.

The draft action plan for implementation of the Mental health Blueprint has been coproduced with individuals with lived experience of mental health issues and this will be finalized following further stakeholder engagement.

---

**Action required/recommendation:**

The CCG Governing Body are asked to approve the attached Mental Health Transformation Blueprint and Action Plan which has been noted and endorsed by the Health and Wellbeing Board.

*Please note this Blueprint is currently in draft presentation word format pending any final comments from Governing Body. The presentation and format of the document will be finalised once approved by relevant Boards.*

**Principle risks:**

- Mental Health Services fail to improve with sufficient pace to meet acceptable quality standards
- User experience fails to improve despite transforming services
- Culture shift within workforce is not realised
| Failure to recruit and retain staff with sufficient skills and experience |
| Failure to recruit and retain staff with sufficient skills and experience |
| Despite service changes performance does not improve to meet required standards |
| Current identified safety concerns are not resolved. |
| Unintended safety consequences of transformation work |
| Service reconfiguration fails to make the savings anticipated |

**Other committees where this has been considered including SMT:**

- The Mental Health Transformation Steering Group has had close oversight of the development of this Mental Health Blueprint and Action Plan.
- The following Boards/committees approved this Blueprint for wider stakeholder consultation in November and December 2017.
  - CCG Clinical Executive
  - Operational Delivery Group of the IOW Local Care Board
  - IOW NHS Trust Board
  - Local Care Board
- The consultation closed in June 2018 and the final Blueprint, along with the consultation closure paper and draft action plan was signed off by Health and Wellbeing Board in July 2018

**Has this been agreed with the following areas; Please tick and gain signature:**

- See above.

**Financial /resource implications:**

Any financial and resource implications will be closely monitored by the Mental Health Transformation Steering Group, who hold operational responsibility for delivering the Transformation Programme to achieve the vision set out in the Blueprint.

The Local Care Board (LCB) will oversee the Mental Health Transformation Programme, including the financial, performance and risk aspects.

**Legal implications/impact:**

- There are no legal implications associated with this paper.

**Public involvement /action taken:**

Feedback from a wide range of stakeholders and stakeholder groups has been considered in the development of this Blueprint. Wider stakeholder consultation will be undertaken, subject to approval from Clinical Executive, IOW NHS Trust Board, Operational Delivery Group and Local Care Board.

**Equality and diversity impact:**

- The CCG as a public body must meet its statutory obligations under the Equality Act 2010 and have due regard to eliminate unlawful discrimination, provide equal opportunities between people from different groups and to foster good relations between people who share a protected characteristic and people who do not share it.

- There are no negative equality and diversity impacts associated with this document.

**Author of Paper:**

- Steve Appleton, Contact Consulting and the Mental Health Transformation Programme Steering Group
<table>
<thead>
<tr>
<th>Date of Paper:</th>
<th>28th August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>6 September 2018</td>
</tr>
<tr>
<td>Agenda Item:</td>
<td>6.6</td>
</tr>
<tr>
<td>Paper number:</td>
<td>GB18-046</td>
</tr>
</tbody>
</table>
Talking mental health

A draft blueprint for the island

join the conversation
A mentally healthy island
Our blueprint for mental health 2018-2022

Foreword

Improving the mental health of our local population is a key priority for our health and care services on the Isle of Wight. This ‘blueprint’ document sets out our vision of how we might achieve this goal. We have been listening to people about what is important to them in order to develop this plan and we have developed this final document based on the feedback we have received.

In recent years, the need to improve mental health care has risen up the agenda, and rightly so. We know we need to support people to have improved mental health, and we can and must do better for everyone who needs more specialist help at times of their lives when they are vulnerable. If people are living with poor mental health this has a major impact on all aspects of their lives, so it is essential that we do more to give people support which works for them.

People should be able to rely on services which are easy to access, which are safe, and which are of high quality. We cannot honestly say that this is always the case, for everyone, today, but that is the ambition we must strive towards.

On our island we are fortunate to have strong and vibrant communities, which can play an active part in helping to support good mental health. Many people from those communities have already played a part in getting this blueprint to this point, but we want that involvement to continue, and to hear from more people who can help us to get mental health services right.

I hope you find this blueprint useful in describing the ‘big picture’ of the future of mental health care on the island. But more importantly, I hope it encourages you to get involved as we take this work forward and implement our plans. If you would like to do that, then please see the section near the end of this document, which includes a variety of ways in which you can get in touch with us. We look forward to hearing from you.

Dr Michele Legg
Chair, NHS Isle of Wight CCG

Clare Mosdell (Cllr)
Cabinet Member for Adult Social Care and Public Health and Local Authority Mental Health Champion

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A summary of our proposals

Our aim

*With our partners and local communities we will become a mentally healthy island. We will promote self-care and prevention through the delivery of high quality mental health services, at all times focusing on the person themselves being in control and developing personal, family and community resilience.*

Our ambitions

**Supporting people to maintain good mental health and renewing our focus on delivering prevention**

We will encourage the public to have good mental health and work with us to develop services that better meet their needs.

We will address the factors that can lead to poor mental health and wellbeing.

We will reduce the number of lives lost through suicide.

**Reducing stigma and raising mental health awareness**

We commit to eliminating stigma and discrimination by starting and leading conversations which promote positive perceptions of mental health.

**Revitalising our approach to health and care services**

We will develop whole life integrated pathways for mental health that start in the community and connect effectively with other specialist services.

We will break down the boundaries between GPs, community and hospital services and third sector partners.

Through a renewed commitment to partnership between the NHS, the Council, the voluntary sector and the public, our focus will be on enabling people to live a full and meaningful life despite mental ill health.

**Recovery**

Our mental health services will support recovery to promote, hope, independence, wellbeing and choice.

**Developing our workforce**

Our services will have the right mix of trained, skilled, experienced and compassionate staff.

We will extend our employment of peer workers and work with the local third sector and independent sector workforce.

**Making the money work**

We will change the way we spend our money and focus more on prevention and community based services.
Improving quality, outcomes and holding to account

We will set new standards for the quality of our local mental health services.

We will agree the outcomes to be achieved by those providing services and we will hold them to account.

We will evaluate the experience of people who use our services and involve them in how we respond to what they tell us.

Why we need a mental health blueprint

Poor mental health can affect all of us, regardless of our gender, ethnic background or social status. The Isle of Wight is no different to other places in that the effects of poor mental health impact not only individuals, but their families and friends, carers, employers and communities across the island.

The Isle of Wight has a statistically higher prevalence of mental illness than the English national average. The percentage of people diagnosed with a mental health problem and on a GP register is approximately 1.1%, this equates to 1,602 people; this is higher than the English national average of 0.9%.\(^1\) The rate of GP registered people with diagnosed depression is around 5%.

It is estimated that there are almost 2,000 people living with dementia on the island. Current estimates suggest a 24% rise in dementia by 2024.\(^2\)

Carers are an essential component of the health and social care economy and save the government approximately £119 billion each year. (NHS England 2014). On the Island we have over 16,000 carers providing help and support that helps to keep people living within their own homes. Without support the Island's services simply could not cope with demand.

Mental health and wellbeing among children and young people can set the pattern for their mental health throughout their lifetime. Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24.\(^3\) Across the country, at any one time, one in ten young people aged 5 to 16 years have a mental health problem, and many continue to have mental health problems into adulthood.\(^4\) By applying this 1 in 10 measure to the Island's population, around 1,700 young people aged 5 to 16 could be experiencing such mental health problems.\(^5\)

Nearly as much ill health is mental illness as all physical illnesses put together. There really is no health without mental health.

We know that our mental health services have not performed as well as they should and that for some people, their experience has not been as good as it should have been. Some have described the experience as 'like being in a pinball machine, bouncing around'. On too many

\(^1\) IoW Joint Strategic Needs Assessment fact sheet – Mental Health February 2017
\(^2\) Living well with dementia on the Isle of Wight 2014-19
\(^3\) The Five Year Forward View for Mental Health, 2016
\(^4\) http://youngminds.org.uk/media/1410/strategic_plan_2016-20_key_objectives.pdf
\(^5\) For similar figures also see: estimated prevalence of mental health disorders 5-16 year olds: https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh/data#page/
occasions people have not been able to get the care they need, when they need it, or they have not had access to the right services.

The NHS, the Council, the voluntary sector and other organisations involved in the delivery, or supporting the delivery of mental health services have agreed that we must all work together to make further changes to the way in which services are delivered, but also to address some of the factors that influence the mental health of islanders.

We have heard from a wide range of people in our communities and from those using mental health services about their experiences and how they think they could be improved. Through our My Life, A Full Life programme, from the findings from local Healthwatch reviews and the Care Quality Commission report, we have heard and reflected carefully on what people have said. In developing this blueprint, we have drawn upon those views and experiences in order to ensure they have informed our thinking about the future.

We've already started making improvements, but we're committed to doing more. That is why we have developed this blueprint for mental health. It sets out our vision and describes our shared aspirations for change. We want you to join us as we develop more detailed plans for the delivery of this blueprint.

Good mental health and wellbeing are central to living a healthy, productive and enjoyable life. Achieving the ambition of being a mentally healthy island that enables everyone to thrive is our aim for the people of the Isle of Wight.

**What we mean by mental health**

When we talk about mental health, we are talking about both good and poor mental health. It's possible to have poor mental health but no mental illness.

A mental illness is an illness that affects the way people think, feel, behave, or interact with others. There are many different mental illnesses, and they have different symptoms that impact peoples’ lives in different ways. Mental illness includes a wide spectrum of mental health problems from common conditions such as depression and anxiety to severe mental illnesses such as schizophrenia and bipolar disorder.6

We believe that it is important to address mental health and mental illness jointly. Our future focus will be on improving the mental health and wellbeing of the population of the island as a whole and ensuring high quality services for those affected by mental illness.

**Things which can affect our mental health**

Our mental health can be affected by lots of different things. These can include our physical health, the use of alcohol or drugs, where we live, our finances, our education, having a child and our relationships. In thinking about our approach to improving mental health, we have considered the impact of some of these areas.

Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer’s effectiveness and lead to the admission of the cared for person to hospital or residential care.

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6 Canadian Mental Health Association
Physical health

Poor physical health increases the risk of mental illness. Mental ill health and poor mental health are associated with increased chances of physical illness, increasing the risks of the person having conditions such as coronary heart disease, type two diabetes or respiratory disease. Other long term conditions, pain and living with the effects of cancer are all associated with high levels of mental illness.

Life expectancy of people with severe mental health problems today is the same as it was for the general population in 1950. On average people with severe mental illness are likely to die 10-20 years younger than other members of the population.

Life expectancy for both men and women on the island is similar to the England average. However at a local level, life expectancy is 4.9 years lower for men in the most deprived areas of Isle of Wight than in the least deprived areas.

People with mental health conditions are less likely to receive the physical healthcare they’re entitled to. We don’t believe this is acceptable and we will work to fix this gap. When considering mental health and physical health, the two should not be thought of as separate.

Housing

A settled home in good quality, safe and affordable accommodation is vital for good mental health. People with mental health problems are much more likely to experience uncertainty in relation to their housing, including about how long they can remain in their current property.

For people with poor mental health, gaining access to general or supported housing can be difficult. Without a settled place to live, access to treatment, recovery and independence can be problematic. Housing provides the basis for individuals to recover, receive support and return to an independent life.

We believe that affordable and safe housing and housing with support that responds to crisis and provides longer-term support for recovery should be key elements in the range of services available in our community.

Employment

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7 Prevalence, incidence and mortality from cardiovascular disease in patients with pooled and specific severe mental illness: a large-scale meta-analysis of 3,211,768 patients and 113,383,368 controls Correll, C et al World Psychiatry 2017
8 Mental health patients face ‘unacceptable mortality gap The Independent newspaper 25 October 2016
10 IoW Health Profile Public Health England September 2016
11 The Mental Health Foundation: www.mentalhealth.org.uk
12 Housing & mental health Appleton, S. Molyneux, P. NHS Confederation Mental Health Network 2011
13 A basic need: housing policy and mental health Bradshaw, I. Centre for Mental Health 2016
14 Mental Health and Social Exclusion, Social Exclusion Unit 2004, Office of the Deputy Prime Minister
On average, at any one time nearly one in six of the UK workforce is affected by a mental health condition such as depression or anxiety.\textsuperscript{15} People who are unemployed are between four and 10 times more likely to develop anxiety and depression.\textsuperscript{16}

We know that suitable work is good for our physical and mental health.\textsuperscript{17} However, nationally, less than 10\% of people using mental health services are in paid employment although at least half would like the opportunity to be in work.

People who experience mental ill health often find it hard to access support to help them recover and get back into work or to maintain their employment. For most people, being in or getting back to work is an important part of both their recovery and maintaining their independence. We believe that having effective services like Individual Placement and Support (IPS)* can provide crucial support to address the employment gap.

**Education**

Mental health problems have been linked with poor educational achievement and consequent lifetime disadvantage.\textsuperscript{18} Research shows that the impact of poor mental health on educational attainment is significant.\textsuperscript{19}

Poor mental health is positively associated with the probability of being ‘not in education, employment or training’.\textsuperscript{20} We know that excluding children from school may lead to long-term mental health problems and psychological distress. In turn, it is also found that poor mental health can lead to school exclusion.\textsuperscript{21}

We believe that promoting and ensuring the mental health and wellbeing of young people who are pupils or students within schools and colleges has the potential to improve their educational outcomes and their mental health and wellbeing outcomes.\textsuperscript{22}

**Mental health inequalities faced by particular groups**

Although mental health affects everyone, it does not do so equally. People from Black and Minority Ethnic BAME communities, and other groups such as lesbian, gay, bisexual and transgender (LGBT+) people are disproportionately affected by mental health problems.

Similarly homeless people, those dealing with addictions and those in contact with the criminal justice system are at higher risk of experiencing poor mental health, and are less likely to seek and access support.\textsuperscript{23}

\*IPS is a ‘place then train’ supported employment model, in which trained employment specialists work intensively with clients to quickly help them find paid, competitive work and then continue to support them and their employer for as long as necessary. Doing what works: IPS into employment Sainsbury Centre for Mental Health 2009.

15 Employee Outlook CIPD July 2016

16 Mental Health and Work Lelliott, P. Tulloch, S. Boardman, J. Harvey, S. Henderson, H Royal College of Psychiatrists 2008


18 Child mental health and educational attainment Johnston, D. et al Institute for Social & Economic Research 2011


20 Mental health and education decisions Corgnalia, F. et al London School of Economics 2012

21 Ford, T et al University of Exeter DOI: 10.1017/S003329171700215X To be published in Journal of Psychological Medicine 2017

22 The link between pupil health and wellbeing and attainment Brooks, Prof. F. Public Health England 2014

23 Thrive West Midlands, an action plan to drive better mental health and wellbeing in the West Midlands January 2017
People who have had adverse childhood experiences, been victims of crime, who are unemployed, lone parents, carers or who are having financial difficulties, people with long-term physical conditions or learning disabilities and looked after children are also more likely to experience poor mental health.

**Our current situation**

Many people have expressed their views and thoughts about what is going well and where things need to improve. We have reflected on the feedback we have received from people who use services and the wider public following local engagement events, and the findings of local Healthwatch reports and the Care Quality Commission report, where mental health services were rated inadequate.

We have also talked to a range of people who are involved in commissioning, managing and providing mental health services on the island. We also reviewed national policies and strategies and our current local strategies and plans to inform our thinking about how we set a new direction. Some important issues emerged and we want to share those with you to provide a context for why we need to set a new course.

'It was hard when my son was admitted to hospital, as the staff wouldn't talk to me, they just said: I cannot talk to you without your son's permission. However, it was ok to discharge him to my home without consulting me. I wanted to be considered as part of the team, my son would come home and I would then be on my own and take over from the professionals.'

*Carer’s Viewpoint*

**How our services operate**

We agree that our mental health services have not developed in a way that has kept pace with improvements in other parts of the country. They remain too dominated by traditional clinical approaches to care and support that rely too much on healthcare professionals, they are fragmented and are not well integrated. They take a paternalistic approach that is not recovery focused. The consequence of this is twofold.

Firstly, it results in higher levels of bed occupancy, with some people in hospital who we know in other parts of the country would not be there. Secondly, it results in caseloads that contain many people who are not receiving anything other than sporadic review. People are then not able to move between hospital and the community resulting in a blocked system that delays rapid access and timely discharge.

We want to focus on preventing mental ill health and we will ask people with lived experience to guide our work.

Evidence gathered through local work to compare caseload profiles and national benchmarking data shows that there are a significant number of people in contact with community health services and in hospital who would not meet the threshold for similar services in other parts of the country. There is a lack of clarity within the system about the role and purpose of secondary care mental health services.

We know that mental health historically has not had sufficient focus in our organisations. The Isle of Wight Trust has recognised that clinical and operational leadership have been
undertaken at a lower managerial level than they should have been. The recent appointment of a Director of Mental Health brings renewed focus and commitment.

In the Clinical Commissioning Group, steps have been taken to strengthen commissioning. The appointment of an Assistant Director of Integrated Commissioning will give additional focus and leadership to mental health and how services work more effectively.

Local authorities have a key role in promoting wellbeing and improving mental health in their communities. The Isle of Wight Council has reaffirmed its commitment to mental health by appointing a Cabinet member as Mental Health Champion. Their role will help in ensuring the priority of mental health within the Council, strengthen partnership working, and will link to a national network of local authority mental health champions.24

Prevention and community based approaches

There has not been a concerted or coordinated programme of work led by Public Health that is focused on preventing the occurrence of poor mental health. We agree that more can be done to improve mental health awareness, to tackle stigma and discrimination, and to engage those using services and the wider public in discussions about future developments. We need to do more to support children’s mental health, as poor mental health in childhood is a prediction of poor mental health in adulthood and impacts on life chances and equality.

Alternatives

We have developed the safe haven hub, which is piloting a safe place in the community for people experiencing an emotional, mental health crisis, where they can go for advice and support by individuals who have experienced mental health crisis themselves, but we need more alternatives to admission to hospital and to help timely discharge. This includes improving our crisis resolution and home treatment services and our community mental health services. It may also require a shift in resources from hospital to community services. We also need more housing and support services and ways to help people into work.

Carers are usually the first to be aware of a developing crisis and usually the first to notice the early warning signs of a relapse. We have developed the Carers Lounge based at St Marys Hospital, run by Carers IW a third sector organisation, that offers carers a place to unwind, get some advice, emotional support especially when things get overwhelming.

Working together

The CCG, the Trust and the Council want to strengthen our partnership to deliver improvements in the islands mental health. We have listened to the views of local communities and people who use mental health services. In response to those views and the findings of the Care Quality Commission report, we are already putting in place detailed plans to improve three specific areas: acute, community and rehabilitation and recovery, but this is just the start of the work we need to do as we work together to improve mental health services on our island.

Investment

24 http://www.mentalhealthchallenge.org.uk
The CCG invests over £24.5m each year on mental health and learning disability. This includes the money we spend on services outside the island, and the funding to voluntary sector organisations. The Council invests around £14.5 m in mental health. This includes staffing as well as residential and nursing home payments, and direct payments.

The Five Year Forward View for Mental Health, the national plan for mental health, sets out expectations for the levels of investment. We believe the ambitions in this blueprint help us to make the best use of the resources we have and to demonstrate our commitment to allocating appropriate levels of funding to investment in mental health.

**Continuous improvement**

Some elements of our services are doing well, most notably the Improving Access to Psychological Therapies (IAPT) service, which is among the top performing IAPT services in England. Operation Serenity, the Island's street triage service that identifies people in the community in emotional, mental health crisis and arranges for them to be seen jointly at home (in community) by qualified mental health nurses and police officers, is a service that has been highlighted as a model of good practice. However, we know that for many people, getting help when they need it remains harder than it should be, with some waiting a long time to get support.

The Care Quality Commission (CQC) inspection report found that our services for adults and older people with mental health problems were inadequate and highlighted particular concerns about safety.

They also found that our electronic records systems were not of a good standard and that care planning could be significantly improved. The CQC also found that we need to improve our in-patient services, in particular those for older people and that the provision of specialist dementia beds was affected by the lack of alternative provision in the community.

The need for improvements to the standard of the environment in our in-patient wards was also highlighted.

Healthwatch Isle of Wight is an independent consumer champion created to gather and represent the views of the public on health and social care. Mental health was the top issue in their annual prioritisation surveys for 2016/17 and 2017/18. Healthwatch are playing a key role in speaking to people who are using services to ensure that their care has improved.

We have made progress in addressing the CQC's concerns. This blueprint is a further demonstration of our collective commitment to make continuous improvements to our mental health services. In particular we are committed to doing further work to make sure the experience of people using local services is positive and that their experience is used as part of our improvement processes.
Our proposals for the future direction of mental health services

We are setting a new direction for mental health in the Isle of Wight. This blueprint is built on a collective ambition to address the improvement of everyone's mental health. Our vision for the future is one that will tackle the issues that affect the mental health of islanders and will improve the quality of services available.

Our aim

With our partners and local communities we will become a mentally healthy island. We will promote self-care and prevention through the delivery of high quality mental health services, at all times focusing on the person themselves being in control and developing personal, family and community resilience.

To achieve our aim we have set out seven initial proposals for improvement. Each one is supported by changes or developments that will have a positive impact in achieving our overall aim. Our proposals are based on evidence of what works, areas highlighted by the Care Quality Commission, national policy and what people have told us will make a difference to their lives.

1. Supporting people to maintain good mental health and renewing our focus on delivering prevention

- We will encourage the public to have good mental health and work with us to develop services that better meet their needs.
- We will address the factors that can lead to poor mental health and wellbeing.
- We will reduce the number of lives lost through suicide.

Public health is about improving the health of the population through preventing disease, prolonging life and promoting health. Addressing public mental health can help deliver a range of benefits including reduced levels of mental ill health, reduced suicide risk, better general health, and less use of health services. This involves the promotion of mental health as an important issue and work to better engage the public in the debate about mental health and the improvement of local services.

We are proposing to give particular focus to three main areas of prevention:

- Self-care, mental health promotion and prevention.
- Enabling our communities to be mentally healthy and have their say.
- Reducing suicide.

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25 Guidance for commissioning public mental health services JCP-MH 2012
26 Guidance for commissioning public mental health services JCP-MH 2012
Self-care, mental health promotion and prevention

We will give renewed focus to mental health promotion and self-care for the whole island. By doing so we will equip individual islanders with the skills and tools to manage the challenges of daily life and make them more resilient.

A case example of an approach to self-care and prevention

Five Ways to Wellbeing – Warwickshire

Public Health Warwickshire’s Mental Health and Wellbeing Team led the development of the Five Ways to Wellbeing (5WtW). The programme provided and commissioned good information, evidence, support and resources to improve the mental health and wellbeing of people living in Warwickshire. 5WtW used a public health perspective on population mental health by championing good mental health and wellbeing for all.

The campaign raised awareness of wellbeing and supported the community to talk about wellbeing and build the ways to wellbeing into their lives. Bright and engaging resources were developed which encouraged people to make a pledge for their wellbeing and signposted to mental health and wellbeing services and supported frontline staff to start conversations about wellbeing.

This example is one that the Isle of Wight can learn from as we develop our plans.

Case example – SilverCloud

The Isle of Wight has already put in place a service called Silver Cloud. SilverCloud offers secure, immediate access to online supported cognitive behavioural therapy (CBT) programmes, tailored to individuals specific needs. The programmes consist of seven to eight modules - completed at the persons own pace, in their own time.

The goal of each module is for the person to take the information and techniques learned and to start applying them in their day-to-day life. SilverCloud can be accessed on a computer, tablet or mobile phone.

This is an example of local innovative work that supports people in maintain good mental health.

We know that some of the things that can prevent poor mental health lie outside the role of mental health services. They include environmental planning, public transport, education, access to leisure facilities and availability of general housing.

We will work closely with Council departments and local organisations in the public, private and voluntary sector across the island to ensure a joined up approach to the prevention of poor mental health through joint initiatives and educational work across the island.

Enabling our communities to be mentally healthy and have their say
We know that our island is not simply a collection of individuals with specific needs; when one person experiences poor mental health, it affects many more around them.

For us to effectively develop prevention efforts, we must have a thorough understanding of how mental ill health affects people in our communities. We know that when local people are empowered to have a say in their health, and to address and influence it, they are likely to be healthier and happier. That’s why we have listened to what people have told us and we want to ensure we enable a co-ordinated approach to ongoing engagement with the people using services and the wider public.

We will continue to gather information from islanders about the things they think most affect their mental health and how they would like to see these addressed.

This could involve the development of a citizens’ panel, drawn from a cross section of the population, who would meet to consider the challenges faced on the island in relation to mental health, make suggestions for areas of work that might help and to play a part in reviewing proposals and ideas for change.

Citizens’ panels are an innovative and proven way of engaging with the public and enabling them to participate. They are successful because they can convey to the wider community that citizens like them are being given complete access to information, are studying detailed evidence and hearing from subject-matter experts of their own choosing. Citizens’ panels focusing on mental health have been successfully used in the West Midlands, London Boroughs, the States of Jersey in the Channel Islands, in Australia and the United States.

We are committed to the principles of co-production to support mental health service development, delivery and evaluation. Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Our aim has been to involve as many people as possible in the development of this Blueprint and continue to involve people in how it is implemented.

Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change. We will continue to build upon our earlier work to involve the public and those with lived experience of mental ill health to plan, deliver and review our services through this commitment to co-production and regular meaningful engagement.

**Reducing suicide**

Every death as a result of suicide is a tragedy. It affects individuals, families and communities. We will do more to prevent this happening. Several approaches to prevent death by suicide are proving to be effective in reducing the numbers of completed suicides.

A number of areas in England have adopted what is known as a zero suicide approach. Developed in Detroit, zero suicide is now being used by health and social care organisations in Merseyside, the East of England and the West Midlands.

The zero suicide approach is rooted in the belief that suicide is not inevitable. In Detroit, this approach led to a 75% drop in suicides in the first four years, and for two years there were

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27 Thrive London July 2017
28 NewDemocracy February 2016
29 Co-production network definition New Economic Foundation/NESTA
no suicides amongst the patient population.  

**Case example - Mersey Care zero suicide programme**

Mersey Care became the first trust in the UK to adopt a Zero Suicide policy. It ratified that policy last year, committing to eliminating suicide from within its care by 2020. An online course is delivered to help staff look out for signs of distress. It also challenges the myths about inevitability and selfishness that still exist around suicide. Mersey Care’s plan also includes easier access to crisis care, better safety plans for each patient, and swifter investigations after deaths or suicide attempts, with a focus on learning rather than blame.

Every service user with a history of intent or self-harm is given a personalised safety plan while a Safe from Suicide Team has been created as part of the new assessment and immediate care service. The team continually monitors the highest risk people who use services who have either been referred to us or are already in our care and intervene rapidly and effectively to reduce risk.

*We will review the learning from the Mersey Care experience and elsewhere and use this to inform our work in developing a zero suicide ambition.*

We are reviewing and refreshing our existing suicide prevention strategy, learning from the good practice in other parts of the country and adopting their approach. We will galvanise local leaders and commit ourselves to the aspiration of achieving zero suicide for the Isle of Wight. This will take time and is a long-term goal. We will start with a commitment to reducing suicide among those people known to our mental health services.

*We must continue to talk openly about suicide to help people and end the stigma that surrounds suicide. If we give people the space and time to share their stories and experiences then this could be a big factor for saving people’s lives.*

*We must listen, we must care, we must talk about suicide to stop the stigma.*

*Feedback from someone who has used mental health services on the Island.*

We will also work with local communities to raise awareness of suicide and its impact. Our focus will be on those people who are most at risk on the island, initially with men over 50, given they are at greater risk, with the aim of extending this work to other groups.

**Public Health Pilot Programmes**

**PEACH Pilot** - (Partnership for Education, Attainment and Children’s Health) working with engaging schools and families to improve attainment through increased health and wellbeing. PEACH has the potential to provide training to teachers to enable them to identify the risks associated with suicide and implement strategies to mitigate the risks to a child or young person. Currently PEACH is aimed at primary school age with the aim of expanding into secondary schools.

**ACES Pilot (Adverse Childhood Experiences)** - There is greater understanding about the impact of adverse childhood experiences on adults and children, especially at ‘transitional stages’. The pilot is to raise awareness of ACEs across the system.
2. Reducing stigma and raising mental health awareness

We commit to eliminating stigma and discrimination by encouraging conversations which promote positive perceptions of mental health.

Many people with mental health problems continue to experience stigma and discrimination. This can affect not only their view of themselves as a person, but can also affect their experience of relationships, employment, or where they live. Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives.\footnote{Stigma and discrimination Mental Health Foundation http://bit.ly/1RxUdZL}

This stigma and discrimination is not equal even within mental health. For example a person with schizophrenia is less likely to be accepted into society compared with a person with depression.\footnote{Attitudes to mental health problems and mental wellbeing British Social Attitudes NatCEn Social Research July 2016} We also know that people who have mental health problems who are from black and ethnic minority communities, or members of the LGBT+ community often face a double discrimination.

Although attitudes are beginning to change, stigma and discrimination have a big effect on a person’s self-esteem and confidence. More stigma is associated with mental health problems than other health problems.\footnote{Stigma: a review of the evidence, Young Minds} It can also prevent people with mental health problems from seeking help.

We will improve the awareness and understanding of mental health across the island, with the aim of improving mental health literacy in all parts of our population.

We will do this by drawing upon the experience of other places, notably New York and Philadelphia in the United States, but also in the West Midlands and London by using forms of training, such as mental health first aid to enable people to know how to spot the signs of mental ill health in their fellow citizens and how best to respond to it.

We will raise awareness of mental health in our own organisations and in local businesses. In particular we will encourage the adoption of the Time to Change pledge by local employers. Now established for ten years, Time to Change is a national campaign to improve mental health awareness.

We will identify a Carers Champion on each ward who will promote carer engagement and ensure that they help co-ordinate whole team attention on carer issues and promote good practice among colleagues. We will work with the Carers Lounge to ensure Carers are offered support through Carers IW.
Case example - Time to Change Employer Pledge

The Time to Change Employer Pledge enables organisations to demonstrate their commitment to change how we think and act about mental health in the workplace and make sure that employees who are facing these problems feel supported. Over 500 employers in England across all sectors from FTSE 100 companies and leading retailers to Government departments and local authorities have signed up.

We will encourage local employers to sign the Time to Change Employer pledge as part of our commitment to improving mental health in the workplace. We will start with our services and partner organisations.

By encouraging organisations to sign this pledge, we will be able to demonstrate an island wide commitment from employers to change how they and we think and act about mental health in the workplace and make sure that employees who are facing these problems feel supported. To demonstrate our commitment, we will start by ensuring our own services and partner organisations sign the pledge.

Our communications teams will develop a local media campaign and use this to focus on raising public awareness about mental health.

Case example - Thrive London (Thrive LDN)

Thrive LDN ran a poster campaign to raise awareness and encourage conversations about mental health in the capital. The posters which ask “Are we OK London?” appeared on 200 Underground stations for two weeks in July 2017. The Thrive LDN campaign aims to improve Londoners’ understanding of mental health, stamping out discrimination by working with schools, youth organisations and employers.

We can learn from the Thrive LDN approach to awareness raising and will consider how such a campaign could be delivered on the island.
Our ambition is that all islanders will be able to understand and talk about mental health, and feel empowered to recognise and act early and positively to poor mental health as it arises, both in themselves and others.

3. Revitalising our approach to health and care services

We will develop whole life integrated pathways for mental health that start in the community and connect effectively with other specialist services.

Being able to get help, support and treatment when it is needed is vital. Those services need to be responsive and of high quality. Too often our services have been fragmented and have not been able to offer support at the right time, in the right place and we have relied too heavily on hospital beds as a way of responding to people’s needs. This needs to change.

We are committed to improving not only how people get a service, but their experience of it, and this means changing the way we work across the island. We have started transforming our mental health services and are dedicated to improving access and integrating provision, making recovery our focus and delivering person-centred care. These are our touchstones of success.

Levels of risk, needs and support

We want to move to a tiered model which enables us to give people the support they need, when they need it by focusing our resources in the right place.

To help us understand what we need to provide, we will look at each individual’s levels of risk, the nature and complexity of their needs and the levels of support required to enable recovery and hope.

We have developed new pathways for eating disorder, mood and anxiety disorder, and work is being completed on emotionally unstable personality disorder, psychosis and dementia. We are proposing other changes too, some of which are already being developed. Others will form part of a wider conversation with people who use our services, mental health professionals, other organisations and the public that builds upon the things they have already told us need to change.

Services for children and young people

The case for addressing poor mental health among children and young people is compelling. We know that helping children and young people does prevent or reduce the impact of mental health problems in later life. Most poor mental health begins early in life. Half of all cases of diagnosable mental illness begin by age 14.

Tackling mental health problems early in life improves educational achievement, employment opportunities and physical health, and reduces the levels of substance misuse, self-harm and suicide, as well as family conflict and social deprivation.

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35 No health without mental health: the case for action Royal College of Psychiatrists 2010
We will make sure that our children and young people have access to effective mental health services. We will embed the ‘Think Family’ approach in all that we do. We will review and produce plans for improvement to our current community services and ensure children only have to travel to mainland for specific types of care.

We will examine the liaison between mental health services and schools and establish a mental health schools network across the island. Such a network would enable our schools to work together to promote better mental health for children and young people.

We also want to focus on young people, and in line with recently announced government policy, we will put in place plans to develop mental health awareness programmes in our schools and colleges.

Our Children’s and Young People’s Mental Health Transformation plan has recently been developed and refreshed.36

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**Case example - Youth Mental Health First Aid in Schools programme**

This three-year programme launched in Easter 2017 and is fully funded by the Department of Health with a value of £200 per person trained. In year one the programme will train a member of staff in over 1000 secondary schools to become a Youth MHFA Champion, someone with the skills to spot the signs of mental health issues in young people and guide them to a place of support.

By the end of 2020 every secondary school in England will have been offered the opportunity to attend this training.

**Case example - Thrive NYC Mental Health Services in All Community Schools**

In New York Community Schools are neighbourhood hubs where students receive high-quality academic instruction, families can access social services, and communities congregate to share resources and address their common challenges. Through Thrive NYC, City Mental Health Clinics are opening at a number of Community Schools.

This follows a model that uses mental health staff to not only treat individuals, but also to help the entire school staff play a role in providing more preventive interventions. This includes training staff to better identify and support at-risk students, de-escalate conflicts, or lead mindfulness and relaxation groups. Engaging more school leaders in the effort to carry out mental health promotion is helping improve overall school climate.

*Both these examples demonstrate the importance of mental health in schools. We will draw upon the evidence from this work and from elsewhere in developing proposals for service development.*

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Perinatal mental health

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. Up to one in five women and one in ten men are affected by mental health problems during pregnancy and the first year after birth. Currently only 50% of these are diagnosed.

Without appropriate treatment, the negative impact of mental health problems during the perinatal period is enormous and can have long-lasting consequences on not only women, but their partners and children too. When problems are diagnosed early and treatment offered promptly, these effects can be mitigated. We have already increased our support to perinatal mental health.

Services for adults

We have already started to develop more effective models of service. Through our plans we are focusing on improving the range of community based mental health services available to those who need them, including for those with the highest level of need, of any age.

We will re-locate our community mental health services away from the hospital site so that they are at the heart of the communities they serve.

We are committed to delivering services on the Isle of Wight that are responsive to the needs of each individual accessing the service, and supporting them to gain and retain hope and live a meaningful life. Our specialist services will focus on those who are most unwell.

From now on our services will work together, and with partner agencies to deliver seamless care that is safe, effective and aligns with current best practice. Care will be delivered by skilled and compassionate staff who are supported and developed to deliver evidence based pathways of care.

We will give particular focus to the provision of integrated teams that can provide early intervention and respond to crisis. These are the two key elements of service that islanders should expect to be available as a priority. We will continue to support Operation Serenity as a model of best practice.

In response to what we have heard from people using services, we have already developed specific plans to improve people’s mental health and wellbeing. We are doing this by making a cultural shift in our model of care that recognises wider social networks and the importance of physical wellbeing, resilience and recovery, including employment and housing and choice and control to promote independence within their communities. Our ambition is that wherever possible people with mental health needs will be managed in the community.

We will more clearly communicate the role and function of our specialist mental health services to our partners, in particular colleagues in GP practices, the police, the criminal justice system and the public.

Effective care planning is central to ensuring that people only stay in hospital for as long as their needs require. We will make sure that planning to leave hospital starts at the point of admission and that the services that can enable that are in place, through more responsive community teams, and providing housing and employment support.

**Fair Horizons**

Fair Horizons is 2gether Foundation NHS Trust’s way of providing a person-centred model of mental health care that does not discriminate on grounds of age or intellectual level. It draws on concepts of ‘capable teams’ and attempts to steer specialist mental health services away from artificial ‘silos’ of working age adult, older people and learning disability services. Instead, it focuses on a more fluid approach where services can be offered in a multidisciplinary and interdisciplinary way so that people can benefit from any aspect of the service that meets their needs and do not become caught on artificial team and service boundaries. The basis of care within Fair Horizons is a ‘one stop shop’, providing the majority of mental health needs and supported by more specialist, tertiary teams.

*This example provides useful learning for us to take into account as we further develop our plans for more integrated services.*

**Case example from the Isle of Wight – Serenity**

Launched in 2013, the Serenity project comprises a police officer and a qualified mental health practitioner responding to mental health crisis calls directly in the community. By working together, the award-winning project has delivered improved outcomes for people who use services, increased team and partnership efficiencies and made significant (over 70%) reductions in the number of Section136 Mental Health Act inpatient admissions.

**Case example – Isle of Wight Serenity Integrated Mentoring (SIM)**

A number of people who use our services were repeatedly requesting police attendance whilst simultaneously using Accident and Emergency, ambulance, GP and other core services. Serenity Integrated Mentoring (SIM) is a mentoring programme for people who use our services struggling to cope with highly intensive patterns of behaviour. This integrated approach made a significant contribution to individual recovery and as a result the IOW used police custody for a mental health crisis for the last time in July 2013. In addition to improvement of quality of life and improved outcomes for people who use our services, crisis calls to police and ambulance services reduced and in most cases had been eliminated altogether. Furthermore, excessive use of 111 and attendances to A&E have been greatly reduced.

**Dementia and older people’s mental health**
The Isle of Wight has a high proportion of older people within its population. Figures show a current population of over 65’s of approximately 37,000. This is predicted to rise to around 49,000 by 2030. This means we need to ensure our mental health services are able to respond to the likely increase in demand.

Some of our services for people with dementia, including our memory assessment services have been recognised as being of good quality and have been accredited by the Memory Services National Accreditation Programme (MSNAP).

Mental ill health in older people does not just mean dementia though. It includes other things like depression, anxiety, schizophrenia, suicidal feelings, personality disorder and substance misuse.

As with services for adults under the age of 65, our aim for older people’s mental health services is that wherever possible their needs will be managed in the community. Where this isn’t appropriate we will ensure that care and treatment is provided in the least restrictive environment. Our strategy for Dementia and Older People’s Mental Health has been updated.

We know that our services have been fragmented and have not been able to offer the best environment for care and treatment. In response to what people have told us, and the findings of the Care Quality Commission report, we are already making improvements to our older people’s mental health services, and reviewing the dementia pathway of care.

We are putting in place plans to bring our memory services and older peoples mental health team into one, integrated service. This will mean we can meet people’s needs and support them in a more effective way.

We are supporting the establishment of a new model for our hospital and community based mental health services for older people. This will involve the co-location of staff and the establishment of dedicated management for these services. We are also committed to the improvement of our hospital wards, so that they are safe and provide an appropriate environment for the care and treatment of older people.

**Learning disability**

Many people with learning disabilities live full and rewarding lives as part of their local communities. In order to do this, they need support to have good mental health and wellbeing. This is especially important because the prevalence of mental health problems in people with learning disabilities is considerably higher than the general population.

We will continue to fulfill the NHS Mandate by ensuring that the CCG works closely with the Council to ensure that people with learning disabilities and people with autism, who have mental health problems, receive safe, appropriate, high quality care. Our starting point remains that these services should be community based and that when hospital care is needed it will be provided in the most appropriate and least restrictive setting.

**Autism**

Autism Spectrum Condition (ASC) is a lifelong developmental 'hidden' disability that affects...
the way a person communicates with, and relates to, people and the world around them. Although some people can live independently or relatively independently, others have high dependency needs requiring a lifetime of specialist care. Many people with ASC have no obvious disability and find they are often misunderstood and can easily fall between services, not getting the right support, which can often lead to further problems including, but not limited to anxiety, depression and other mental health issues.

We are currently working with the Autism Inclusion Matter (AIM), a user led group, to review and refresh the 2014-19 Isle of Wight joint strategy for children, young people and adults with ASC.

**Alcohol and drugs**

It is common for people to experience problems with their mental health and alcohol/drug use (co-occurring conditions) at the same time. Research shows that 70% of drug users and 86% of alcohol users in community substance misuse treatment experience mental health problems.41 42

Local authorities commission drug and alcohol treatment services and recent Public Health England guidance, published in 2017 sets out the standards for the commissioning and provision of those services. We will ensure that people with co-occurring conditions get the most appropriate care and treatment as quickly as possible.

**Eating Disorder**

Eating disorders are mental health problems where someone experiences issues with their body weight and shape, and engages in behaviour which will disturb their everyday diet and attitude towards food, for example controlling the amount of food they eat.

We are reviewing and redesigning the way we deliver care for people with eating disorders with people who use our services, to develop care that is responsive to individual need, and delivered by appropriately skilled and supervised staff. The pathway will cover transitions from children's services, assessment, community treatment, inpatient care when required and ongoing discharge and support.

**Rehabilitation services**

Mental health rehabilitation services specialise in working with people whose long term and complex needs cannot be met by general adult mental health services.

On the Isle of Wight, our service is provided at Woodlands a ten bedded rehabilitation unit. It is provided off the hospital site within a local community and offers longer term rehabilitation approaches for people who need to learn or re-learn the skills required to live independently.

41 Comorbidity of substance misuse and mental illness in community mental health and substance misuse services Weaver et al The British Journal of Psychiatry Sep 2003, 183 (4) 304-313
We know that currently the service model is outdated with insufficient focus on recovery. We also know there is not enough provision of rehabilitation on the island and that some people are being placed on the mainland due to lack of capacity locally.

That’s why we are already taking steps to improve things. A review of the current provision and out of area placements has been completed and a hybrid model of supported living units and seven day a week community support has been developed and formally agreed. The current community day service and employment services will be reconfigured with people who use our services and people with lived experience.

Our ambition is to deliver integrated provision that works alongside people to support them more effectively. The services will be aimed at enhancing all elements of their lives, to help them address the issues affecting their mental health and to live as independently as possible.

**Use of hospital beds**

Understanding how hospital beds and community services can best be used as part of a reshaped mental health care system is a key issue for the island. The main consideration should be about ensuring the right number and mix of beds, in the right place, with the best environment.43

Our focus will not be simply on the number of beds available. Instead we will concentrate on how they are used. Supporting people in the most appropriate and least restrictive environment that meets their needs is our aim.

The more able our community services are, the fewer beds will be used. We are already making improvements and this will prevent inappropriate admissions through community based treatment. People will then only be admitted to hospital through clearly defined thresholds.

By improving our community settings, we aim to reduce our current levels of inpatient bed use. By doing so we will transform the way in which hospital and community services work together to promote recovery and achieve improved outcomes for people who use our services.

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43 Defining mental health services, Appleton, S. NHS Confederation 2012
New ways of providing services

We will also examine the evidence for, and experience of, the use of social enterprise or community interest companies for the delivery of mental health services on the island. These types of organisations are not-for-profit and have voting members who have a direct say and influence on the services provided, how they operate and who is employed within them. They have been successful in other parts of the country and we believe that they could provide a means through which we can improve our mental health services through greater public participation in decision-making.

Case examples - NAViGO Community Interest Company

NAViGO is a successful not for profit social enterprise that emerged from the NHS, to run all local mental health and associated services in North East Lincolnshire. The Government defines social enterprises as “businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners.” This means NAViGO is owned by its members (both staff and community) and unlike private healthcare providers, it does not make a profit. Any money that is saved through working more efficiently stays within the NHS. NAViGO employs 550 staff with a turnover of £24 million, and serves a population of 165,000 people.

Case example - Six Degrees – Salford

Six Degrees Social Enterprise is a Community Interest Company based in Salford that provides support for people who are experiencing mental health problems. Its social mission is to build resilient communities in which people with problems such as depression and anxiety are accepted, supported and equipped with skills to deal with the challenges they face. They provide talking therapy for people who are struggling with common mental health problems such as depression or anxiety. This can be face to face or on the telephone. They also work closely with specialist teams to support people with chronic health problems such as diabetes and Coronary Obstructive Pulmonary Disease (COPD).

We will use these examples, and others, to develop options for the future delivery of mental health services.

Primary care

We recognise that alongside our specialist community services provision, colleagues in primary care do a huge amount to support people with mental health problems. We need to do more to enable GPs to be confident and effective in delivering that support.

It is appropriate that mental health problems should be managed mainly in primary care by the primary health care team working collaboratively with other services, with access to specialist expertise and to a range of secondary care services as required.44

To support our local GPs and primary care staff, we will consult with them on developing a system of named liaison between mental health professionals working in community services and GP practices. Their role will be to provide advice about how to support people with mental health needs who do not need a specialist service, but may require some limited

44 Guidance for commissioners of primary mental health care services JCP-MH 2012
or ongoing support. We will change the way in which people who have mental health needs, but who are stable and no longer need for a specialist service are supported. This will include the planned transfer of a number of people to the care of GPs or other services.

Carers IW have employed a GP Link Carer Support Worker who will liaise with the GP Surgeries to offer support to carers in the community as well as offer training to staff in regards to carers.

Case example - Primary Care Plus – West London

Primary Care Plus is a service in West London (Hammersmith and Fulham, Hounslow and Ealing) based in GP practices for those who may need some extra mental health support over and above what is available from their GP. By moving those with stable mental health problems from receiving support from specialist services to their GP practice, they receive care in the least restrictive setting, closer to home, and they have both their physical and mental health needs met.

Primary care mental health workers are employed by West London Mental Health NHS Trust and are attached to GP practices. GPs are able to refer people directly to them. Importantly there are no strict criteria for referral, except an assessment that people will require more in-depth support. Other mental health professionals such as consultant psychiatrists and psychologists also provide support to the service.

The primary care mental health workers provide one-to-one support to people within GP practices, helping with discharge from secondary care, liaising between services and providing ongoing mental health support. They are also able to signpost to wider social support in the community. These workers also provide support to other primary care staff by providing advice on consultations, as well as training for staff (reception staff, practice nurses, GPs etc.) to meet their needs.

We will use the learning from this example, and others, to inform our future developments.

Links with physical health care

We know that physical and mental health are closely linked and that people with mental health problems have much higher rates of physical illness. The case for seeking to support physical and mental health in a more integrated way is compelling given the high rates of mental health conditions among people with long-term physical health problems and the reduced life expectancy among people with the most severe forms of mental illness.\(^{45}\)

Given that mental health services are currently provided by the same NHS organisation that provides physical health care, we believe there should be opportunities to treat people in a more holistic and integrated way that addresses both their physical and mental health care needs.

As a starting point we will ensure that all clinicians and practitioners working in the acute hospital are provided with a foundation of common competencies in mental health, with an understanding of the mental health support available on the island.

\(^{45}\) Bringing together physical and mental health care Naylor, C. et al The King’s fund March 2016
Social prescribing provides an opportunity to link people living with long term conditions with sources of support within the community that work alongside existing treatments to improve their physical and mental health. Social prescribing schemes can involve a variety of activities that are typically provided by voluntary and community sector organisations. Examples include volunteering, arts and creative activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.46

A study into a social prescribing project in Bristol found improvements in anxiety levels and in feelings about general health and quality of life. The Bristol study also showed reductions in general practice attendance rates for most people who had received the social prescription.47

We will work with the Trust, colleagues in primary care and the voluntary sector to promote the use of social prescribing across the island. By referring people to physical activities, social activities, or learning, the mental and physical health of islanders could be improved.

**Digital**

For most of us, life without the internet and our smartphones and tablets is hard to imagine. It is reported that 38 million adults in the UK now access the internet every day.48

The use of technology to support and improve mental health, including the use of online resources, social media and smartphone applications is gathering pace.49 Digital mental health has been associated with benefits such as improved access to services, including online self-help and reduced barriers such as stigma.50

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**Case example - Positive Mindfulness - Feeling Good App**

Positive Mental Training is available across the Isle of Wight via GP practices and is an easy-to-use audio programme which research shows can help lift mood out of depression, stress and anxiety and build confidence and coping strategies. 85 people have used this App during 2016/17 and the outcomes show improvements for this group of people following use of it.

*The Feeling Good App are good examples of where we have adopted new, digital based approaches to providing mental health support to local people.*

Although it is sensible to be cautious about the effectiveness of all digital approaches there are a range of online based therapy programmes, mindfulness courses, self-help guides and computer based counselling available. This is a fast moving area of development that can offer benefits, especially in terms of accessibility, prevention and self-care.

We want to find ways to further develop digital mental health that can complement local services. Our ambition is to work with our regional partners to investigate the range of

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46 What is social prescribing? The King’s Fund, February 2017
48 Internet and online content: The Communications Market 2015 Ofcom 2015.
49 Digital Mental Health Mental Health Foundation www.mentalhealth.org.uk/a-to-z/d/digital-mental-health
possible digital solutions that are available or being developed and where we can, provide opportunities for islanders to trial them.

4. Adopting and promoting recovery principles

*Our mental health services will support recovery to promote independence, wellbeing and choice.*

Recovery focused services are a central component to making health services fit for the twenty first century. At the heart of recovery is a set of values about a person’s right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms.51

Recovery is based on ideas of self-determination and self-management. It emphasises the importance of ‘hope’ in sustaining motivation and supporting expectations of an individually fulfilled life. Recovery does not necessarily mean cure. Instead it focuses on the unique journey of an individual living with mental health problems to build a life for themselves beyond illness (‘social recovery’). Thus, a person can recover their life, without necessarily ‘recovering from’ their illness.52

In many parts of the country, recovery colleges have been developed. Built on the principles of recovery they exist to offer education and training opportunities to people experiencing mental health difficulties and the family, friends and professionals who support them. Courses support adults to enhance their knowledge and understanding of mental health conditions, recovery, wellbeing and life skills. The added aim is to provide hope, opportunity and empowerment to students. Courses are co-designed and often delivered by peer trainers, with lived experience, and a co-trainer, with professional expertise in the topic area.

Our services will adopt the principles of recovery in everything they do. We will place the principles of recovery at the heart of our approach to commissioning, developing and measuring services across all areas of mental health.

We will conduct work to establish how a recovery college could be established on the Isle of Wight, drawing on the evidence of what works from other places, including those close to us in Southampton and Sussex, as well as London and Jersey.

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‘Every person is an individual, who must find their own unique pathway to wellness. However, general principles exist that can help everyone. Principles that can be seen in those who make the most rapid and enduring progress in their recovery...’

Recovery text and images taken from 'Crisis or Awakening' documentary by local filmmaker Sam Schroeder55
Peer support

Peer support is when people use their own experiences to help each other. The Mental Health Foundation defines peer support as the “help and support that people with lived experience of a mental illness or a learning disability are able to give one another”.\(^{53}\)

Forms of peer support include: community groups, mentoring, self-help groups, online communities and support groups. Support is based on sharing experiences and agreeing a reason for meeting. How you choose to meet up or connect with people is very flexible and depends on your personal preferences. Peer support can improve emotional health, wellbeing and sense of belonging.\(^{54}\)

A key element in recovery is the importance of having access to a wide range of experiences

\(^{53}\) Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. HSMC March 2015
\(^{54}\) Mind factsheet
and activities.

Figure 1: Extract from Addendum & companion document to Crisis or Awakening booklet to accompany a documentary on mental health and mental health services filmed on the Isle of Wight by Sam Schroeder

Crisis or Awakening: http://wednesdayfilms.com/stuff/crisis-or-awakening-info.pdf
Three peer support link coordinators have been employed by the Trust and we will accelerate the development of peer support on the island so that people with lived experience of mental health problems can help and support each other and contribute to improving their recovery.

I came into Community Mental Health Services 3 years ago having been in and out of mental health services for many years. I didn’t realise how different this experience would be for me!

I was given a Community Psychiatric nurse (now called Care co-ordinators). During our sessions he complimented me on my insight into my own diagnosis and I mentioned to him I loved researching, learning and writing. He told me I would make a great Mental Health worker and went on to explain to me that he himself had been a service user and had been an inpatient many years ago.

I was shocked as no professional had ever shared this before. Over the next few sessions we broke down the barriers of being ‘normal’ and having Mental Health problems. For many years I had put my life on hold – No work, no education, until I was ‘cured’. He made me see I could still have a life whilst working on my own Mental Health.

The manager of Community Mental Health Services met with me and I began volunteering at Chantry House, It was amazing to feel part of team again and to feel as though I was contributing to society.

No one ever treated me differently and I enjoyed it so much. The manager wrote me a reference to start a degree at university and eventually over the next few months I felt better and better until I was able to be discharged completely for the service.

I continued to volunteer and attend university whilst successfully managing my mental health problems myself. I still had bad days but everyone was so understanding and so supportive it never set me back.

The staff gave me the confidence and push I needed to apply for a support worker job at Chantry house which I got and a year later I went on to apply for an associate mental health practitioner’s position and got. 2 years on I now work, do university and run the volunteering side of Chantry House. I still suffer with mental health problems at times and have bad days but they are so manageable now as I am able to use the tools and skills I actually teach at work that are so helpful.

My life is very full now and my self-esteem gets better every day. I wouldn’t recognise who I was 2 years ago and I am extremely grateful to Chantry house and the staff for supporting me into recovery and beyond.

A story about peer support from someone who has used mental health services on the Island
Housing

Housing is critical to the prevention of mental health problems and the promotion of recovery.\textsuperscript{56} Often people who are in hospital are unable to leave because of a lack of appropriate housing. Equally, some people are admitted to hospital because of a lack of alternatives to admission, such as those that provide for short-term accommodation for use in crises. Support with housing can improve the health of individuals, and in many cases provide a stable base for them to recover and live independently.\textsuperscript{57}

We know that it is important to ensure better access to a mix of types of housing and to promote greater flexibility in its use.\textsuperscript{58} The availability of a range of housing and support can help to avoid admission, reduce delayed discharges from inpatient services and offer long-term accommodation.

Case example - Look Ahead Housing & Care – Tower Hamlets Crisis House

Look Ahead provides a Crisis House to offer a community-based alternative to hospital admission. The service seeks to empower, support and encourage each individual to focus on goals that will have an immediate and lasting impact on their circumstances and presentation of their complex needs. The service is provided in collaboration with East London NHS Foundation Trust. The service has been designed to provide support to customers in crisis as an alternative to hospital admission where this is deemed to be clinically safe/appropriate. Independent evaluation showed the cost per positive move-on reduced by 59.96% and the volume of positive outcomes increased by 81.5%.

One Housing Group & Camden & Islington NHS Trust partnership – Tile House

Tile House works with people with high levels of risk and complex needs who have previously been excluded from supported housing, including those with forensic backgrounds and those who are subject to Section 37/41 of the Mental Health Act. In the two years prior to the service opening, nine of the customers living there spent an average of 317 days as inpatients, with a total of 2,856 occupied bed days. In the two years since Tile House opened, this had fallen to an average of 81 days in hospital for each admission, with 404 occupied bed days for the five customers who had admissions. Tile House has saved the local health and social care system £443,964 per annum.

These two examples show the effectiveness of good housing and support services. We will draw upon them as we develop our plans for future housing provision.

Our local partners in housing, the NHS Trust and housing associations are supporting us in our ambition to create a broader range of housing and support options so that more people have the opportunity to live in general housing or housing with some form of support. This is the right approach and will enable islanders to achieve recovery and independence.

Employment

\textsuperscript{56} Five Year Forward View for Mental Health February 2016
\textsuperscript{57} Housing & mental health Appleton, S. Molyneux, P. NHS Confederation Mental Health Network 2011
\textsuperscript{58} Old Problems, New Solutions – Improving Acute Psychiatric Care for Adults in England (The Commission on Acute Adult Psychiatric Care,) Crisp, N., Smith, G. and Nicholson, K. (Eds.) 2016
Gaining appropriate work can sometimes be hard for people who have experienced mental health problems. We know that work is good for our mental health. There is significant evidence to show that people with mental health problems who gain employment (not sheltered work) experience enhanced self-identity and social functioning, improved quality of life and reduced symptoms.59

We have developed new proposals for employment so that our island will become a place where people are supported to gain and retain work. We will achieve this by working with employers, local NHS providers, the voluntary sectors and other partners to provide Individual Placement and Support (IPS) across the island for people with severe and enduring mental health issues. We have already committed to increasing IPS for people with severe mental illness in secondary care services by 25% by April 2019.60

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**Case example - Individual Placement and Support in the Isle of Wight**

Recent work done for the Centre for Mental Health has shown that IPS services had many benefits, not only in helping people to get jobs but also in building individuals confidence. The evaluation identified a number of organisational factors which can help with the adoption of IPS, such as a recovery-focused culture and good relationships with other employment services.

The CCG and Council commissions OSEL Employment Services and No Barriers to work with people with mental health support needs, physical and learning disabilities and other impairments to gain access to employment and education. It is a successful service and in 2016/17 172 people gained paid employment (one in self-employment). Of these 157 were for more than 16 hours a week and 101 of these were sustained for more than six months. 100 people were supported to gain voluntary work, 78 gained access to education and 108 were supported to retain their existing employment.

*This is example of local development that has been effective and upon which we can build further to help more people into work.*

Our public services will set a standard for other employers to follow. That’s why we will promote ways to help people with mental health problems to gain work in our own services, for our organisations to adopt the principles of the Public Health England Workplace Wellbeing Charter and to encourage implementation of the six core standards as set out in the recent ‘Thriving at Work’ review61, which has informed ‘Improving Lives the Future of Work, Health and Disability’62, the government’s ten year programme of reform

- Produce, implement and communicate a mental health at work plan;
- Develop mental health awareness among employees;
- Encourage open conversations about mental health and the support available when employees are struggling;
- Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development;

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59 Making a Reality of Employment for People with Mental Health Problems Across London
60 Isle of Wight CCG Operational Plan 2016-19 December 2016
• Promote effective people management through line managers and supervisors;
• Routinely monitor employee mental health and wellbeing.

This will demonstrate their commitment to providing mentally healthy workplaces.

5. Developing our workforce

*Our services will have the right mix of trained, skilled, experienced and compassionate staff.*

*We will extend our employment of peer workers and make the best use of the local voluntary, third sector and independent sector workforce.*

Delivering the right range of high quality mental health services requires a skilled workforce that can respond effectively to the differing needs of our population.

The Five Year Forward View for Mental Health (FYFV-MH) workforce plan states that across England there is a need for “motivated and multi-professional teams focused on delivering person-centred care: expert clinicians, doctors, nurses, psychologists, allied health professionals, and social workers, combined with new and enhanced roles such as peer support workers, nursing associates, assistant practitioners and assistant psychologists.” We agree.

Like other island communities, we have to work hard to attract people to live and work here and to retain them. We can’t simply recruit from elsewhere though. We will do more to develop our workforce from within the population of the island and provide opportunities for professional development and promotion within our existing staff.

We will make it easier for professionals to work together, by locating them in the same buildings and offices, so they can communicate effectively, share information and work as teams.

We will develop a workforce that is less clinically dominated and draws upon the skills and expertise of other professions and workers. There is huge potential in recruiting support workers and other types of staff, who may not have clinical qualifications but who can bring other valuable skills. We will also work closely with the voluntary sector to develop their role in the provision of some services.

We will make sure there are appropriate opportunities for people with mental health problems, including those who have used our services, to work in those services.

**Case Example – Cambridgeshire & Peterborough NHS Foundation Trust**

In England, an increasing number of NHS Trusts are employing peer support workers. For example, Cambridgeshire and Peterborough NHS Foundation Trust are committed to training and employing 80 peer support workers in their first wave. Peer support specialists and recovery coaches are powerful recovery role models that engage each individual served in a personal recovery programme. In May 2012, CPFT appointed 5 peer workers to their Integrated Offender Management (IOM) teams based in Peterborough, Cambridge and Huntingdon police stations.
The role was very new and a lot of work was done to ensure that the peers worked out their roles in relation to the nurses also employed by the Trust in the IOM teams and with the police and probation staff who form the main staff groups. The peers are working in partnership with the trained nurses on the recovery needs of prolific offenders with mental health problems. They work with a number of external organisations, including drug and alcohol services, housing and adult education and have a particular role in training staff from other agencies (e.g. police) in relation to mental health issues.

This learning from this example, and others, will be used to inform the development of our plans to increase peer workers in our services.

Workforce planning and development takes time. We are responding to the messages of the national plan and updating our existing plans. We are also going to review the mix of skills and professions working in mental health to make sure we have what we need, and where we don’t, we’ll fill those gaps.

6. Making the money work

We will change the way we spend our money and focus more on prevention and community based services

The Clinical Commissioning Group (CCG) invests just over £24.5m a year on mental health and learning disability services; nearly £20m of which is expenditure with the IOW NHS Trust. Mental health placements account for just under £2m and continuing health care costs amount to just over £2.5m.

The IOW Council invested £14.5m in the year 2017/18. £4.2m of this was related to mental health residential and nursing home care, direct payments/personal budgets and Homecare Managed Accounts. £9.2m was allocated to memory and cognition services (generally for older people) covering residential and nursing home care, direct payments/personal budgets and Homecare Managed Accounts. Just over £1m was allocated to dedicated mental health social work staff, staff with responsibilities under the Mental Capacity Act, staff working in mental health day services and independent mental health and mental capacity advocacy. The Council’s budget for mental health is rebased on an annual basis so investment amounts are likely to change.

As the figures show, most of the money is spent on specialist mental health services provided by the NHS Trust. Too much of it has been focused on bed-based care and not enough has been spent on developing our community mental health services, or on supporting the development of alternative forms of care and support.

There is an expectation from the NHS nationally, contained in its planning guidance for 2017-19 that CCGs, who purchase local health services will continue to invest properly in mental health. As part of the Five Year Forward View for Mental Health (FYFV-MH) NHS England has committed to invest £1.4 billion nationally for the improvement of mental health services for children and young people. £15 million has been allocated for further development of crisis care services nationally.

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63 Continuing Health Care is free care outside of hospital that is arranged and funded by the NHS. This means that a person will receive care and support to meet their assessed needs at no cost to them.

We will ensure that mental health services on the Isle of Wight benefit from our share of these funds.

Like many areas of the country, our public finances are tight. We will have to take some tough decisions about prioritising our resources. Despite that, we reaffirm our commitment to investing in mental health with any additional national funding we are given. We believe that focusing our investment on community service development, primary care and prevention is the best way to improve mental health in our communities and to ensure good quality services.
7. Improving quality, outcomes and holding to account

We will set new standards for the quality of our local mental health services.

We will agree the outcomes to be achieved by those providing services and we will hold them to account.

We will evaluate the experience of people who use our services and involve them in how we respond to what they tell us.

Our mental health services should have a positive effect on the lives of those who use them. Reviewing quality and outcomes is a way of understanding whether this is happening and if not, enabling us to focus on making improvements.\(^\text{65}\)

We know we need to improve the quality of mental health services and the Care Quality Commission report has highlighted some specific areas for urgent work and we are actively addressing these now.

We have created a set of locally developed and agreed quality and outcome measures. These will be specific to the Isle of Wight and reflect the particular issues we face and the priorities we have set. These will be in addition to the quality and outcome measures, standards and imperatives contacted in the FYFV-MH and other national policy documents.

When we develop contracts for organisations to provide mental health services, we will set out clearly the outcomes we expect them to achieve. We will regularly review performance against those standards.

We will put in place a process to routinely seek the views of those who have experienced mental health services, with the particular aim of learning what we could do better to improve their experience. This could form part of the work of the citizens’ panel.

We are committed to mental health having a renewed and sustained focus. We will ensure that the blueprint and the ambitions it contains form a central part of the work of our Mental Health Transformation programme.

We will regularly review developments and progress with the improvement of mental health services and provide a direct route for information to the Isle of Wight Health and Wellbeing Board. We will be held to account for delivery by the Local Care Board.

\(^{65}\) Quality Improvement in Mental Health WHO 2003
Mental Health Blueprint Outcomes for people using our services

Creating a New Vision for Improved Mental Health

- Supporting people whose mental health impacts on them or those around them is everyone’s business.

Supporting people to maintain good mental health and renewing our focus on delivering prevention

- People living on the Isle of Wight are aware of how to stay mentally healthy, aware of those around them, aware of the support available to them and how to access it.
- People have access to good quality housing, transport, education and leisure facilities, reducing isolation.
- People know about mental health and know how to get their voices heard to help improve and promote local services.
- A person with suicidal thoughts has a safe place to access specialist, empathetic, confidential support.

Reducing stigma and raising mental health awareness

- People with experience of mental ill health feel able to talk to their peers about it and are open with their employers and the wider population without fear of being judged or discriminated against.

Revitalising our approach to health and care services

- People have access to the right level of care and support at the right time, and are able to move in and out of services freely, according to their needs.
- People experience seamless care and support on their journey to recovery.
- People are enabled to live a full and meaningful life despite mental ill health.
- Children and young people know about mental health, are aware of how to stay emotionally and mentally healthy, aware of those around them, aware of the support available to them and how to access it.

Recovery

- People have hope and aspirations to learn and recover through access to a wide range of activities and opportunities to use their own knowledge and experience to help and support others, thereby taking ownership of their own recovery.
- People are supported to return to work or meaningful activity with choice and control.
- A person will be supported to stay in their accommodation or move into accommodation.

Developing our workforce

- People working in mental health services are supported to feel confident in their work, and enabled to deliver high quality services with compassion, in a healthy work environment.
- Peer workers and experts by experience are embedded in all organisations across the sector, offering insight and hope to those they support and work with.

Making the money work

- People have access to the support they need, when they need it.

Improving quality, outcomes and holding to account

- People feel confident that they have access to good quality mental health services on the Island.
- People using mental health services on the Isle of Wight are achieving their chosen outcomes and there is better understanding of how services are performing.
- People are able to share their views and experiences of using mental health services on the Isle of Wight and are confident that this is being used to improve care and support in the future.
What happens now and how you can be involved

Our intentions and aspirations will bring the improvement we want if they are widely adopted by the communities we serve. Mental health is everyone’s business – this blueprint is the beginning of a process to improve the mental health of every islander.

We have already begun to make changes in response to the things we have heard from people who use our services, the public and the findings of the Care Quality Commission report. We want and need to do more, and we want islanders to continue to be involved in how we can realise our ambitions.

We wish to continually seek input and feedback on our plans, our services and the future of care on the Island. We welcome any input or feedback you would like to share and invite you to get in touch:

- **Email:** mhstrategy@iow.nhs.uk
- **Call:** 01983 822099 x 5457 to reach the mental health commissioning team
- **Write:** Mental Health Commissioning Team, Isle of Wight Clinical Commissioning Group, Building A, the Apex, St Cross Business Park, Newport, Isle of Wight. PO30 5WN
- **Website:** Go to www.isleofwightccg.nhs.uk/get-involved/mental-health-blueprint

We also actively welcome involvement in our forums and meetings so that everyone’s voice can be heard. As we take our plans forward, we want to come out to local communities, local meetings and to local services to hear from as many people as possible so that our implementation plans can be widely discussed and feedback received.

We are also inviting our key partners and stakeholders to join us in the delivery of our aspiration for a mentally health Isle of Wight by encouraging them to contribute to the development of a set of actions that we can all sign up to. A detailed set of further commitments and actions will follow from this Blueprint so that the communities on the island understand what we will do and by when.

We encourage all of our partners, staff and the public to hold us to account for delivering on the promise to make the island mentally healthier and for meeting the standards they rightly expect of a high quality mental health service.

We will be judged not simply by what we say we will do, by what we do and what we deliver.
Appendix One

The population of the Isle of Wight

In June 2017 it was recorded that 139,395 people live on the Isle of Wight. Approximately 14.8% of population is aged 14 or under, almost 59% are aged 15-64 and just under 27% are aged 65 or over.66

The gender split of the population is approximately 68,100 males and 71,300 females.67

The Isle of Wight has a high proportion of older people within its population. Figures show a current population of over 65’s of approximately 37,000. This is predicted to rise to around 49,000 by 2030.68 The percentage of those aged 15 or under is lower than the national average and the 15-64 population is effectively shrinking. It is clear that the Isle of Wight therefore has an ageing population, in line with national trends.

The overwhelming majority of the Isle of Wight population identify themselves as White-British (94.8%) There are signs of a diversifying population on the Isle of Wight, with the non-white ethnic population more than doubling from 1.3% in 2001 to 2.7% in 2011 (compared with an increase from 8.7% to 14.1% for England as a whole).69

There are 70,776 residential households on the Isle of Wight.70 One in six households is occupied by a single person aged 65 or over. Just over 4,000 households consist of a lone parent with dependent children and two out of five of these comprise a lone parent not in employment. About 4,500 of children living on the Isle of Wight live in a low income family.71

The Isle of Wight has seven areas that are rated as being within the 20% of most deprived areas in England, with a further four being within the 10% of most deprived areas.72

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66 IoW Joint Strategic Needs Assessment fact sheet - Demographics June 2017
67 Mid-2015 Population Estimates: Single year of age and sex for local authorities in the United Kingdom; estimated resident population - Isle of Wight. ONS
68 Institute of Public Care POPPI data: Accessed August 2017 Oxford Brookes University
70 IoW Joint Strategic Needs Assessment fact sheet – Equality & Diversity January 2017
71 IoW Joint Strategic Needs Assessment fact sheet - Demographics June 2017
72 English Index of Multiple Deprivation 2015
Appendix Two

Mental health on the Isle of Wight

The Isle of Wight has a statistically higher prevalence of mental illness than the English national average.

The percentage of people diagnosed with a mental health problem and on a GP register is approximately 1.1%, this equates to 1,602 people. This is higher than the English national average of 0.9%.  

The trend of prevalence in the Isle of Wight for mental ill health remains upwards and this is in line with the English national trend. However the rate of rise, around 8% is slower than the national growth rate.

Self-reported prevalence of depression and anxiety as recorded in the NHS England GP patient survey in 2016 showed a prevalence of 15%.

The rate of GP registered people with diagnosed depression is around 5%.

The Isle of Wight has slightly higher rates of anti-depressant prescribing than the English national average, though not all anti-depressants prescribed are solely for the treatment of depression.

It is estimated that there are almost 2,000 people living with dementia on the island. Of these, 1,700 are aged 65 or over. Given that the over 65 population is predicted to rise by 35% by 2030, it is anticipated that the prevalence of dementia will also rise significantly. Current estimates suggest a 24% rise in dementia by 2024.

Across England as a whole, one person dies every two hours as a result of suicide. Suicide is the biggest killer of men under 45 in the UK and suicide is the second leading cause of maternal death.

The suicide and undetermined death rate for the Isle of Wight currently is 13.7 per 100,000 population for the period 2013-2015. The England average for the same period is 10.15 per 100,000. 51 people died by suicide in this period.

Significantly more men than women take their own lives on the Isle of Wight. The majority of these men are aged 50 or over. On average men are four times more likely to take their own lives. A rate for female suicide on the Isle of Wight cannot be calculated because the number of cases is too small.

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73 IoW Joint Strategic Needs Assessment fact sheet – Mental Health February 2017
74 IoW Mental Health Strategy 2014-19
75 IoW Mental Health Strategy 2014-19
76 IoW Mental Health Strategy 2014-19
77 Living well with dementia on the Isle of Wight 2014-19
78 Suicide Audit Report Isle of Wight Council February 2016
79 Thrive West Midlands, WMCA, Lamb, N. Appleton, S. Norman, S. & Tennant, M January 2017
80 IoW Joint Strategic Needs Assessment – Suicide February 2017
One third of those people who ended their lives by suicide were in contact with specialist mental health services on the Isle of Wight.\textsuperscript{81}

In the period 2013-2015 146 women and 123 men on the Isle of Wight attempted to take their own lives.\textsuperscript{82}

Admissions to hospital for self-harm have dropped significantly between 2013 and 2015. However there remains a high rate of admission compared to other parts of England. In part this reduction may be attributed to the development of a new service, Operation Serenity, a street triage scheme, which is a collaborative between the police and the NHS.\textsuperscript{83}

\textsuperscript{81} IoW Joint Strategic Needs Assessment – Suicide February 2017
\textsuperscript{82} IoW Joint Strategic Needs Assessment – Suicide February 2017
\textsuperscript{83} IoW Joint Strategic Needs Assessment – Suicide February 2017
Emotional Wellbeing and Mental Health for Children and Young People

Mental health and wellbeing among children and young people can set the pattern for their mental health throughout their lifetime. Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters by their mid-20s. Nationally, the status of children’s mental health has come to the fore as many feel the cuts in mental health services and the increased pressures placed on young people have led to deterioration in their mental health.

Child Line’s Annual Report 2015-16 states that their website received over 3.5 million visits and almost 140,000 new users registered for a Childline account. There were national increases in the key areas outlined to the right.

Across the country, at any one time, one in ten young people aged 5 to 16 years have a mental health problem, and many continue to have mental health problems into adulthood.

By applying this 1 in 10 measure to the Island’s population, around 1,700 young people aged 5 to 16 could be experiencing such mental health problems.

Extending Access to Mental Health support for CYP

Services on the Island are committed to extending access to appropriate emotional wellbeing and mental health support to the local population. Partner organisations and Community CAMHS specifically are on track to extend the range and number of CYP accessing Mental Health support. IOW CCG tracks and monitors these figures on a yearly basis to ensure the collective intent to expand access is achieved. The below table provides details of the predicted estimated prevalence for Children and Young People living on the Isle of Wight with a diagnosable Mental Health disorder.

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<tbody>
<tr>
<td>Prevalence</td>
<td>1630</td>
<td>1646</td>
<td>1662</td>
<td>1679</td>
<td>1696</td>
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<tr>
<td>Prevalence Increase year on year</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
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<tr>
<td>Target - CYP with a diagnosable MH condition receive treatment from an NHS-Funded Community MH Service</td>
<td>28%</td>
<td>30%</td>
<td>32%</td>
<td>34%</td>
<td>35%</td>
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<tr>
<td>No. Patients to hit Target</td>
<td>456</td>
<td>494</td>
<td>532</td>
<td>571</td>
<td>594</td>
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</tbody>
</table>

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84 IOW JOINT STRATEGIC NEEDS ASSESSMENT CHILD HEALTH AND WELLBEING
85 For similar figures also see: estimated prevalence of mental health disorders 5-16 year olds: https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh/data#page/0
condition until 2020:

**Child Hospital Admissions**

The current position for child hospital admissions for mental health the Isle of Wight has rate of 162.0 per 100,000 of hospital admissions for mental health conditions (0 to 17 year olds). This puts the Isle of Wight statistically higher than five of its comparator regions as well as against the national England average (85.9 per 100,000).

This higher than national average rate is also reflected in the local quarterly data from the National Drug Treatment Service (NDTMS) which indicates that between 40% and 53% of those open to the service experience mental health problems as compared to between 18% and 20% nationally.

When reviewing this rate over the past few years, it should be noted that it had reduced significantly from 2012/13 to fall in line with regional and national averages by 2014/15. However, it is in the most recent data from 2015/16 which the significant rise on the Isle of Wight has occurred.

### Inpatient admission rate for mental health disorders per 100,000 population aged 0-17 years
**Isle of Wight and its CSSNBT statistical neighbours, 2015/16**

<table>
<thead>
<tr>
<th>Children's Comparator Group</th>
<th>Isle of Wight</th>
<th>Cumbria</th>
<th>East Sussex</th>
<th>Cornwall</th>
<th>Norfolk</th>
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<tr>
<td>Rate per 100,000</td>
<td>170.4</td>
<td>120.6</td>
<td>96.3</td>
<td>85.9</td>
<td>75.6</td>
<td>70.7</td>
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**Source:** Hospital Episode Statistics (HES) Copyright © 2016, PHE Fingertips accessed November 2017

### Inpatient admission rate for mental health disorders per 100,000 population aged 0-17 years
**Isle of Wight, South East and England, 2010/11-2015/16**

<table>
<thead>
<tr>
<th>Year</th>
<th>Isle of Wight</th>
<th>South East</th>
<th>England</th>
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<tr>
<td>2010/11</td>
<td>220.9</td>
<td>149</td>
<td>70.5</td>
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<tr>
<td>2011/12</td>
<td>254.3</td>
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<td>2014/15</td>
<td>70.5</td>
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</tr>
<tr>
<td>2015/16</td>
<td>162</td>
<td>162</td>
<td>70.5</td>
</tr>
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</table>

**Source:** Hospital Episode Statistics (HES) Copyright © 2016, PHE Fingertips accessed November 2017
Community Child and Adolescent Mental Health Service (CCAMHS)

Targeted support for young people for mental health issues includes the Community Child and Adolescent Mental Health Service (CAMHS). In 2016/17, the service saw an increase in referrals to a peak in Quarter 4 with 219 referrals.

In 2016-2017, IOW CAMHS service has been performing well within national standards. Demand has been rising and Waiting Times are being well managed within national standards.
Appendix Three

Mental Health Services on the Island

The Isle of Wight NHS Trust provides NHS specialist mental health services on the island. As well as mental health services, the Trust provides acute care services, community care services and the ambulance service.

Mental health services span all ages and include inpatient & community based mental health care. They include:

Community Child and Adolescent Mental Health Services

This service provides support for ages 0 – 18 experiencing mental, emotional and wellbeing difficulties. The Community Mental Health Clinic offers support, consultation and training to Children's Services and provides specialist mental health services, both in the community and on an in-patient basis.

Improving Access to Psychological Therapies Service (IAPT)

The IAPT service is located in GP surgeries and other community venues across the island, and provides support for people suffering from common mental health problems such as anxiety, depression, stress, and low self-esteem. They provide services such as Group sessions, Cognitive Behavioural Therapy and signposting.

Community Mental Health Services (Three Locality Teams)

These three teams provide assessments and treatments in the local communities for people aged 18 and over, who have mental health problems, including people who have complex needs. They provide a single point of entry to mental health services, and carry out screening and assessments, signposting, referrals for social care assessments, outpatient clinics, and home visits if necessary. Early Intervention in Psychosis and Crisis Resolution and Home Treatment Teams are part of these services.

Memory Service

The Memory Service works within a clinic and at home and offers assessments for those who have noted memory problems. They offer initial assessments, and provide those with a diagnosis of dementia post-diagnostic support and services, such as Occupational Therapy, and Cognitive Stimulation Therapy.

Admiral Nurses (Dementia)

Admiral Nurses work with families to ensure that they are better able to understand and cope with the changes that can occur with dementia, by giving them the knowledge to understand the condition and its effects, and the skills to improve communication and behaviours. This collaborative working enables the family to stay together for as long as possible.
In-patient beds

- Afton Ward: a 12 bedded acute ward for older people
- Osborne Ward: an 18 bedded acute ward for adults
- Seagrove Ward: an eight bedded psychiatric intensive care unit (PICU)
- Shackleton Ward: an eight bedded ward for people with dementia

There are already plans in place to reduce overall bed number, with Shackleton ward already having reduced by four. Afton is planned to reduce by two beds, Osborne by three and Seagrove by two. This is in line with national policy to provide community based care.

Rehabilitation

Woodlands is a 10 bedded rehabilitation unit. It is provided off the hospital site within a local community. It offers longer-term rehabilitation approaches for people who need to learn or re-learn the skills required to live independently. Individuals are offered help and support with a range of self-care and life skills to equip them in their recovery.

Serenity Integrated Mentoring

Serenity Integrated Mentoring SIM is an award-winning mentoring programme for people struggling to cope with highly intensive patterns of behaviour. NHS Isle of Wight CCG commissioned the UK’s first SIM officer in July 2015 - a police officer who has undertaken specialist training and works in the local community mental health team to assist with the clinical and risk management of people who regularly experience mental health crisis.

Evaluation has shown that with consistent support, SIM can eliminate crisis calls and other high risk events, can also eliminate A&E attendance and mental health bed admissions and help people to use their local services more appropriately. It can also assist people to avoid contact with the criminal justice system.
Appendix Four

The policy and strategic context

This blueprint takes account of current national mental health policy. The Isle of Wight will continue to respond to the imperatives set by the Department of Health, the Department for Communities and Local Government and by NHS England nationally.

We have set out the key elements of national policy here. It is not an exhaustive list, but it provides a snapshot of the context for and framework in which mental health service planning and delivery takes place.

NHS England’s Five Year Forward View for Mental Health (FYFV-MH) published in February 2016 sets out the actions to be taken to deliver the recommendations and its plans for investment to support that work. Its key objectives are:

- A call for all NHS staff to have greater knowledge and awareness about mental health.
- The implementation of access and waiting time standards for adult Improving Access to Psychological Therapies services and for Early Intervention in Psychosis.
- Expansion of the Improving Access to Psychological Therapies programme, with a particular focus on long-term physical conditions and medically unexplained symptoms.
- Investment in new specialist perinatal mental health (community and inpatient) services.
- Investment in ‘core-24’ liaison psychiatry services in general hospitals.
- Improvements to community mental health care, including crisis resolution and home treatment and Individual Placement and Support employment services.

In July 2016 NHS England published an implementation plan for the FYFV-MH. The plan sets out the actions to be taken to deliver the recommendations and its plans for investment to support that work. In March 2017 NHS England published a report on the progress of implementation. The FYFV-MH also encourages organisations to focus more on prevention and on co-production and working with those with lived experience in the planning and delivery of mental health services.

On the Isle of Wight we are ensuring that our plans are aligned with the national aims contained in the FYFV-MH.

Achieving Better Access to Mental Health Services by 2020 sets out the first access and waiting time standards for mental health services. The objective described in the document is for treatment within six weeks for 75% of people referred to the Improving Psychological Therapies programme, with 95% of people being treated within 18 weeks and treatment within two weeks for more than 50% of people experiencing a first episode of psychosis by 2020.89

Future in Mind was published by the Department of Health in March 2015. It made a

number of proposals to improve mental health services for young people by 2020. These included tackling stigma and improving attitudes to mental illness, introducing access and waiting time standards for services, and improving access for children and young people who are particularly vulnerable.

*The Care Act 2014* has changed many aspects of how social care support is arranged, and is intended to give greater control and influence to those in need of support. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.\(^9\)

*Sustainability and Transformation Plans* (STPs) are a planning framework for NHS services. STPs are intended to provide a means to deliver the ambitions local NHS bodies have for achieving the changes described in the FYFV-MH, by looking at place based care rather than individual NHS Trusts and organisations. Plans for the development and improvement of mental health services are part of the STP plans locally.

There are three specific work streams underway in the Isle of Wight:

- Mental health acute care pathway redesign
- Mental health crisis pathway redesign
- Mental health recovery (rehabilitation and reablement)

The Isle of Wight has an existing mental health strategy, which is due to run until 2019. This blueprint will lay the foundations for the revision of that strategy, which will also encompass the developments in place as part of the STP.

Other strategies in place include a dementia strategy and a suicide prevention strategy. These also run until 2019 but may be refreshed in response to the direction of travel set out in the blueprint.

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\(^9\) Care Act factsheet Department of Health updated April 2016
## MENTAL HEALTH BLUEPRINT ACTION PLAN DRAFT v2.0

### OUTCOMES

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<td>Supporting people whose mental health impacts on them or those around them is everyone’s business.</td>
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<td>• Implementation of Mental Health Blueprint Action Plan - see below</td>
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<td><strong>5. Supporting people to maintain good mental health and renewing our focus on delivering prevention</strong></td>
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<td>People living on the Isle of Wight are aware of how to stay mentally healthy, aware of those around them, aware of the support available to them and how to access it.</td>
<td>Self-care, mental health promotion and prevention</td>
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<td></td>
<td>• Develop mental health promotion interventions relevant to the IOW population</td>
<td>Public Health</td>
<td></td>
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<td>Underway</td>
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<td></td>
<td>• Develop innovative approaches to self-care, such as online apps and digital mental health solutions, working with local partners.</td>
<td>MOW STP and Local Partners</td>
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<td></td>
<td>• Develop long term plans to address external factors affecting good mental health such as environment, public transport, housing, education, access to leisure facilities (NHS Infrastructure workplan – Tony Corcoran)</td>
<td>IWV</td>
<td></td>
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<td>Underway</td>
<td>Underway</td>
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<td>People know about mental health and know how to get their voices heard to help improve and promote local services.</td>
<td>Enabling our communities to be mentally healthy and have their say</td>
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<td></td>
<td>• Develop communications &amp; engagement programme, with an emphasis on promotion of individual and community resilience, and to involve the public and those with lived experience of mental illness to plan, deliver and review our services through a commitment to co-production and regular meaningful engagement, for example, consider options for developing a ‘citizen’s panel’</td>
<td>MHTP</td>
<td></td>
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<td>Underway</td>
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<td>A person with suicidal thoughts has a safe place to access specialist, empathetic, confidential support.</td>
<td>Reducing the number of lives lost through suicide.</td>
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<td></td>
<td>• Review and refresh of suicide prevention strategy, including ‘zero suicide’ ambition with partners</td>
<td>Public Health</td>
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<td>Underway</td>
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<td></td>
<td>• Implement the suicide prevention strategy action plan, including awareness and training</td>
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<td><strong>2. Reducing stigma and raising mental health awareness</strong></td>
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<td>People with experience of mental ill health feel able to talk to their peers about it and are open with their employers and the wider population without fear of being judged or discriminated against.</td>
<td>We commit to eliminating stigma and discrimination by starting and leading conversations which promote positive perceptions of mental health.</td>
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<td>• Develop plans to encourage the adoption of the ‘Time to Change’ principles by local employers, starting with our services and partner organisations.</td>
<td>MHTP / Partner Organisations / Public Health</td>
<td></td>
<td></td>
<td></td>
<td>Not started</td>
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<td>• Identify Carers Champions on each ward to promote carer engagement and good practice.</td>
<td>IOW NGS Trust</td>
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<td>Underway</td>
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<td></td>
<td>• Communications team to promote national public awareness campaigns on the Island and further develop local awareness.</td>
<td>MHTP / Comm Team</td>
<td></td>
<td></td>
<td>Underway</td>
<td>Underway</td>
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</table>
### 3. Revitalising our approach to health and care services

| People have access to the right level of care and support at the right time, and are able to move in and out of services freely, according to their needs. | We will develop whole life integrated pathways for mental health that start in the community and connect effectively with other specialist services. | * Vision for future tiered models of care coproduced and agreed  
* Whole life, integrated care pathways agreed  
* Develop and agree strategy for Dementia and Older People’s Mental Health  
* Implement Dementia and Older People’s Mental Health Strategy  
* Implement LD Strategy - ‘Living Well with Learning Disability on the Isle of Wight’ | MHTP | Complete | Underway | Underway |
|---|---|---|---|---|---|---|
| People experience seamless care and support on their journey to recovery. | We will break down the boundaries between GPs, community and hospital services and third sector partners. | * Integrated community models coproduced, agreed and implementation plan developed  
* Integrated acute models coproduced, agreed and implementation plan developed  
* Implementation of acute and community models  
* Develop plans to improve support for Primary Care including awareness raising, advice, named liaison with MH professionals to improve confidence and effectiveness in delivering support to those with MH problems | MHTP | Not started | Underway | Underway |
| People are enabled to live a full and meaningful life despite mental ill health. | Through a renewed commitment to partnership between the NHS, the Council, the voluntary sector and the public, our focus will be on enabling people to live a full and meaningful life despite mental ill health. | * Develop and implement safe haven  
* Implement plans for reconfiguration of rehabilitation and reablement services  
* Primary Care to review the opportunity for the use of social prescribing  
* Review and implement Public Health Guidance for commissioning and provision of co-occurring substance misuse and mental illness - timelines TBD | MHTP | Complete | Underway | Underway |
<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Gillian Baker</th>
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<tbody>
<tr>
<td><strong>Summary of issue:</strong></td>
<td>In late 2017 the incumbent provider, Autism Diagnostics Research Centre (ADRC) informed the CCG that they were no longer able to continue to deliver ASC Assessments to children and young people. This left a gap in service for patients waiting for a diagnosis which has caused much anxiety for families.</td>
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<td></td>
<td>The CCG tested the market place for potential NHS providers of Children and Young People’s triage, screening and diagnosis provision with little success, nationally, regionally and locally the picture demonstrates long waiting lists and a shortage of key professionals available to recruit.</td>
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<td>The Isle of Wight NHS Trust is providing the service and have recruited clinical leadership but are unable to put the full service in place until April 2019.</td>
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<td>To support the Trust to address the significant waiting list an agreement to procure an interim provider/providers has been undertaken, this has included;</td>
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<td>1. IOW CCG working jointly with Hampshire Commissioners completed a mini tender procurement process to ensure that an interim service is place for the Isle of Wight as quickly as possible. The procurement process was completed on Friday 17\textsuperscript{th} August. The successful provider is Psicon Ltd who have committed to undertaking and completing 150 assessments, diagnostics by 31\textsuperscript{st} March 2019.</td>
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<td>2. The IOW CCG working jointly with Hampshire Commissioner’s has also now completed via a single tender waiver a pilot with Helios Ltd to deliver 50 online autism assessments commencing September 2018. This is a new provision nationally that is being put in place due to the local, regional and national issues.</td>
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<td>It is therefore anticipated that 200 cases will be cleared by 31\textsuperscript{st} March 2019; further capacity will be added over the next few months to increase the volume.</td>
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<td>The CCG is working with Procurement leads to identify additional service providers more quickly to address the remaining waiting list of 200 plus which is potentially increasing by 15-20 a month referrals.</td>
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<td>The Isle of Wight NHS Trust is providing the clinical leadership and working in partnership with both Psicon and Helios Ltd. Both services are due to commence week beginning the 3\textsuperscript{rd} September 2018. An</td>
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</table>
Information Sharing Agreement and Privacy Impact assessment is in place.

The Trust has a database which reflects both chronological referral date and clinical triage, thus ensuring that all urgent and priority cases are prioritised and thereafter all referrals will be processed by longest waiting time.

A comprehensive action plan has been developed and is overseen weekly by senior leaders from the Trust and CCG.

The CCG has committed to putting in place a sustainable long term service by April 2019 to deliver to Island children and young people for autism triage, screening and diagnostics service, in co-production with children, young people and their families and key stakeholders.

**Action required/recommendation:**
For noting current position and future actions.

**Principle risks:**
- Insufficient capacity short term to clear the waiting list by the 31st March 2019
- Without securing additional services the timeframes for families and children is still considered unacceptable
- Potential legal challenge by service providers
- The Trust service may be further delayed due to issues in recruiting to the substantive team

**Other committees where this has been considered including SMT:**
This has not been to any formal committees due to the tight timeframes needed to commence delivery. Executives and Clinical leads have been fully involved.

**Has this been agreed with the following areas; Please tick and gain signature:**
- Finance
- Quality
- Contracts

**Financial /resource implications:**
Financial envelope of £409k (Recurrent) and £175k (Non recurrent) has been previously agreed. The current commissioned services are within the financial envelope, however additional resource may be required to meet demand.

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>Notes</th>
<th>2018/19 Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Core Funding</td>
<td>Annual baseline funding for service provision</td>
<td>£204k</td>
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<tr>
<td>Recurrent funding</td>
<td>Additional funding into baseline in anticipation of increased activity</td>
<td>£205k</td>
</tr>
<tr>
<td>Non recurrent funding</td>
<td>Addition funding to address backlog of referrals (2018/19 only)</td>
<td>£175k</td>
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<td>Legal implications/impact:</td>
<td>Potential legal challenge by prospective providers (see risks). Commissioners are following guidance provided by the South of England Procurement Team.</td>
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<td>Public involvement/action taken:</td>
<td>Families, Healthwatch and AIM (Autism Partnership Board) have been engaged with throughout this process.</td>
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<td>Equality and diversity impact:</td>
<td>This activity is considered compliant with Equality and Diversity Policies and Legislation and a EIA is currently finalised.</td>
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<tr>
<td>Author of Paper:</td>
<td>Sue Lightfoot: Head of Commissioning Children’s &amp; Young People, Mental Health, Learning Disability &amp; Dementia</td>
<td></td>
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<tr>
<td>Date of Paper:</td>
<td>28.8.2018</td>
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<tr>
<td>Date of Meeting:</td>
<td>6th September 2018</td>
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<td>Agenda Item:</td>
<td>7.1</td>
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<td>Paper number:</td>
<td>GB18-047</td>
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Isle of Wight Interim Autism Diagnostic Service for Children and Young People

In late 2017 the incumbent provider, Autism Diagnostics Research Centre (ADRC) informed the CCG that they were no longer able to continue to deliver Autism Assessments to children and young people. This left a gap in service for patients waiting for a diagnosis which has caused much anxiety for families. The issue has quite rightly been the subject of intense media scrutiny by families, politicians and the media. Isle of Wight NHS Trust has agreed to provide the Children and young people Autism service but will be unable to establish the service until April 2019.

As an interim measure, to ensure that patients are provided with a service as quickly as possible the Hampshire and IOW CCG Partnership commenced a ‘light touch’ mini tender procurement process to secure an interim service for the Isle of Wight as quickly as possible. The database of patient case files has been created and the current numbers are in the region of 450 plus children awaiting a diagnostic service.

To expedite the procurement process, a short term select list was identified of 3 providers who had expressed an interest. These providers were invited to tender for this contract. Commissioners acknowledge that there are some risks associated with a rapid ‘light touch’ procurement process. However guidance from the South of England Procurement Team has been followed throughout.

Following an evaluation process on the 17th August 2018, Psicon Ltd has been chosen as the successful provider. The CCG is satisfied that the provider is able to provide the service as per the requirements outlined in the ratification document.

It has been agreed that the interim service will start from 3rd September 2018 allowing for mobilisation and due diligence of care records. There will be clear monitoring and performance reporting during the length of the contract; the contract will be concluded when the activity levels agreed have been delivered, which is expected to be the 31st March 2019 for historic cases. The recently implemented GP screening tool will support the clinical triage of new referrals into the service.

Following the procurement process and to add further resilience to the service, Healios Ltd have been commissioned, via a Single Tender Waiver, to provide online autism assessments. Hampshire and Isle of Wight CCGs have been working closely with Healios over recent months to identify a suitable opportunity to pilot online assessments. 50 children and young people aged between 10 and 12 years old will be offered online assessments which can be carried out from the family home, if internet access is available. The take up of this service will be through patient choice. If the pilot is deemed successful, consideration will be given to commissioning Healios to take on a second cohort.

Professor Jeremy Turk, the Clinical Lead for the Isle of Wight Autism Service will provide a SPA (Single Point of Access). All referrals will be received by the SPA, triaged and forwarded onto Psicon or Healios as appropriate. All providers will meet on the 29th August 2018 to formalise the pathway. Information Sharing Agreements and Privacy Impact Assessments have been completed, with QIA and EIA currently being finalised.

The communications plan has been written which includes stakeholder letters, frequently asked questions and media statements. Letters to families will be sent out early September informing them of process and next steps. To ensure that patients receive a service as quickly as possible the CCG team is continuing to actively working to identify additional capacity.
**Governing Body**

Integrated Performance Report – September 2018

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Jane Cole, Interim Chief Finance Officer</th>
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<tbody>
<tr>
<td><strong>Summary of issue:</strong></td>
<td>The Governing Body is presented with a CCG Performance Report in a format that seeks to provide assurance on key performance indicators associated with Quality; NHS Constitution and CCG Outcomes Framework to note and comment upon.</td>
</tr>
<tr>
<td><strong>Action required/recommendation:</strong></td>
<td>The Governing Body is invited to: Note and comment on the content of the Performance Report.</td>
</tr>
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</table>
| **Principle risks:** | *Key Risks for the Performance Report include:*
Complexity and wide range of metrics and indicators with differing measurement for different purposes (eg COF, Quality Premium, CCG Assurance process) – systems in development and embedding – risk of missing vital information on all indicators continuously.
Availability of data due to Health & Social Care Act compliance with Patient Identifiable Data for CCGs. New systems not yet agreed at NHS England level. |
| **Other committees where this has been considered including SMT:** | Information contained in the report has been considered at:
Clinical Executive
Quality & Patient Safety Committee
Contract Review Meetings
Internal Performance Review Meetings |
| **Has this been agreed with the following areas; Please tick and gain signature:** | [ ] Finance [ ] Quality [ ] Performance |
| Signed | Finance___JC____ Quality___ MR__ Performance ___AH_____ |
| **Financial/resource implications:** | Over-performance on contract activity could result in financial pressure where contracts are PBR based. |
| **Legal implications/impact:** | There are no significant legal issues within the Report. |
| **Public involvement/action taken:** | Report is publicly available and provides patients and public with information on the CCG’s financial position and use of resources. |
| **Equality and diversity impact:** | Requirement of providers and CCG to ensure all patients are treated in line with rights set out in the NHS Constitution. |
| **Author of Paper:** | Andrew Heyes, Head of Performance and Contracts |
| **Date of Paper:** | 28 August 2018 |

**Date of Meeting:** 6 September 2018

**Agenda Item:** 7.2

**Paper number:** GB18-048
Isle of Wight Clinical Commissioning Group

Governing Body

Quality Report –

September 2018
Quality Report - Summary

The CCG Quality Team reviews the quality indicators on a monthly basis to understand and create actions where appropriate for exceptions in performance. The indicators for June (M03) AND July (M04) where available at the time of writing show the following exceptions:

The CCG is reviewing the Quality reporting to ensure it is robust without duplicating information provided relating to Performance, and aligns with both reporting across the Hampshire and Isle of Wight Partnership and the new Quality Team structure within the CCG. As such the format of this report will be changing over the coming months.

Isle of Wight NHS Trust:

Trust wide

CQC –

- Ten week improvement programmes, as described in last month’s report, for services rated as inadequate continue. These programmes are service led and include assurance visits to check progress and evidence of the improvements made. CCG are being invited to participate in assurance visits, alongside other external stakeholders such as Healthwatch and NHSI. All areas have now commenced on their programmes (these were staggered and started with Medicine as the area with the greatest amount of concerns).
- CCG staff as a part of the integrated Quality Team trial, continue to support the divisions within the Trust on their improvement programmes and the development of their divisional strategies which underpin the Trust wide quality strategy.

Serious Incidents (SIs) –

- The number of reported Serious Incidents has reduced for July, with eight cases reported month to date at the time of writing on 24th July 2018. This is believed to be in part due to more appropriate mechanisms being in place for investigating incidents without reporting as Serious Incidents when the criteria has not been met. The high number of cases reported and subsequently being approved for removal from STEIS indicates there had been an element of over-reporting in recent months
- Investigations in to all reported serious incidents are underway. An integrated Serious Incident ‘flash report’ for Trust and CCG Executive / Senior Teams has been developed and is circulated on a weekly basis for greater awareness of the current situation. This is broken down to Business Unit level and includes detail around cases reported, themes, and cases overdue for closure.
- Themes from Serious Incidents are being identified and captured as part of the weekly flash report, and included on the Patient Safety sub-committee agenda for action and monitoring of lessons learned. Themes are starting to be considered more widely than from Serious Incidents alone, so now include complaints, concerns and claims for example.
- Root Cause analysis training has begun to be delivered across the Trust, with a number of staff receiving refresher training in June (approximately 30 staff), and a further cohort of staff receiving full training in July (approximately 40 staff). This training is beginning to be evidenced in the quality of reports being received which, although still variable at present, are showing improvement. This improvement was also noted and commented on by NHSE when they attended the CCG SI panel.

Health Care Acquired Infections –

- One new case of C. Difficile in June gives a cumulative total year to date of six cases. The nationally set trajectory for the Trust for 2018/19 is to not exceed six cases. The CCG Infection Prevention and Control Nurse continues to support the Trust, and the CCG Quality Manager for Acute services has noted an increase in focus and discussion around IPC requirements and concerns at Trust meetings.

Complaints –

- The number of complaints which are out of time for response continues to be high. A complaints amnesty week was held in June to try and improve the position but has had limited success. Changes have been made to the team to bring fresh eyes to the complaints and PALs functions, with a PALs officer very experienced in complaints coming in to support complaints, and a member of the CCG quality team who has worked previously in PALs going in to PALs to review their processes.
Acute / Hospital Services

Emergency Re-admissions within 30 days –

- Concerns were previously raised regarding a spike in readmissions in December 2017 and January 2018. The CCG Quality Manager for Community and Primary Care has undertaken an audit into the readmissions to determine the levels of avoidability, any harm to patients or effects on patient experience, and any resulting learning. The report presenting the findings of the audit is being taken to a future Operational Delivery Group meeting for discussion.

- **A quality strategy for Acute services** is under development, underpinning the Trust wide quality strategy. This work is being supported by the CCG Quality Manager for Acute and Ambulance services.

- As mentioned above, **CQC 10 week improvement programmes** are underway for Acute services. These are broken down to: Medicine (including End of Life Care); Surgery (including End of Life Care) and Urgent and Emergency services. This work is being supported by the CCG Quality Manager for Acute and Ambulance services.

Cancer breaches / clinical harm reviews –

- CCG has asked for discussion around how they are included in the harm reviews for these breaches. Kettering model has been shared as an example of good practice with the request that this model be considered. Proposed process has been shared by the Trust for comment.

Ambulance Service

- As detailed in the Performance section of the report the revised standards for Ambulance attendance applied nationally were reported for the first time in April 2018 for the Isle of Wight Ambulance Trust. Where concerns are raised relating to any delay in Ambulance attendance, as with all other areas these are reviewed and Serious Incidents declared as appropriate.

- As mentioned above an improvement in the overall CQC rating for the ambulance services was seen, with the services moving from 'Inadequate' to ‘Requires Improvement’.

- Ambulance services are still participating in the CQC improvement programme despite not being rated as ‘inadequate’ with their focus being on what measures need to be taken to further improve the service to ‘good’. The CCG Quality Manager for Acute and Ambulance services is providing support with this work and the development of the Ambulance strategy underpinning the Trust wide strategy.

Community Services

- Community Alliance; once fully established the management meeting will replace the Community OLM. Currently bringing performance data together from the alliance partners to agree a collective reporting 'dashboard'.

- Rehabilitation, Reablement and Recovery (RRR) Alliance is progressing; co-design workshops are supporting alliance development across partner agencies. The third workshop on 17 July 2018 focussed on strengthening and streamlining decision making of alliance partners using the RASCI model. The first business management meeting takes place 1 August 2018.

- Clinical review of a select number of healthcare records studying patient pathway in and out of RRR community beds – appropriate use of beds; readmissions from beds to SMH.

- Following Board approval of the IW NHS Trust-wide Quality Strategy in June 2018, the Community Services Division is developing an operational divisional quality strategy in response. The first draft has been circulated to senior managers with a view to holding staff engagement sessions to work up the final version.

- The 10 week programme for 0 – 19 service, in response to the CQC inadequate rating in the safe domain, is progressing. The service’s action plan in response was presented to the Trust Safety Board on 25 July 2018.

- IW NHS Trust Community Services Division Quality meeting is in development; service level quality reporting to inform Divisional Quality meeting also under development. CCG Quality Manager meeting with Trust Leads 01 August 2018 to support progression.

- Grade 4 pressure ulcer (deterioration under the care of community nurses) under current investigation; concern about timely assessment and provision of equipment by commissioned service Millbrook, forming part of this investigation.
Mental Health Services

- The CCG Clinical Quality Lead for Mental Health, Learning Disabilities, CAMHS and Dementia, completed the first of the 10 week assurance visit in conjunction with the Trust and NHSI, in which there were some positive steps identified with regards to the change in culture and ownership by service managers and their team of the 10 week CQC plan.

- The deep dive into Mental Health and Learning Disability suicides has now commenced and now being completed jointly between Clinical Quality Lead and Head of Safeguarding to support the Trust Head of Nursing and Quality.

- There is now robust LA, CCG and Trust processes and systems around Learning Disability Mortality Reviews, which has been recognised by NHS England and they will be supporting the IOW with undertaking the initial LeDeR reviews as from August. They will also provide support with training more reviewers in September as part of the sustainability plan.

- The draft outline of the Trust MH Quality Strategy was devised and sent to all service managers and their team to outline what their key priorities were which will be included in the overall MH Quality Strategy.

- As a result of the Shackleton deep dive, there is a now a plan in place being considered which will address the long term plan of this ward to ensure that the needs and concerns of people with dementia are addressed.

- Draft MH Quality indicators for business as usual indicators completed, which will be used in conjunction with the MH Quality Strategy. These will be used in conjunction with the KPIs identified for the MH transformation programme.

- Support from the Clinical Quality Lead will continue to be provided to support the Trust with complex clinical quality issues that involve people with mental health, dementia and learning disabilities, which may potentially affect service delivery.

Isle of Wight CCG:

Serious Incidents Requiring Investigation –

- No further serious incidents relating to Primary Care have been reported throughout May or June.

Health Care Acquired Infections –

- **C.Difficile** – There were three cases reported in June for the CCG, two of which were indicated to have occurred in the wider CCG community. The total number in month was fewer than were reported for June 2017 (7 cases) but was above the trajectory number for the month by one case.

- **MRSA** – There were no reported cases in month for either the IWNHST or IWCCG.
The following table details IWCCG performance against each of the key constitutional standards, where available –

### NHS Constitution Measures

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<tbody>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>90%</td>
<td>64.0%</td>
<td>64.78%</td>
<td>58.52%</td>
<td>54.65%</td>
<td>53.11%</td>
<td>52.00%</td>
<td>46.14%</td>
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<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>95%</td>
<td>88.99%</td>
<td>88.93%</td>
<td>85.25%</td>
<td>85.09%</td>
<td>85.49%</td>
<td>85.13%</td>
<td>86.19%</td>
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<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>92%</td>
<td>83.68%</td>
<td>84.45%</td>
<td>84.13%</td>
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<td>Diagnostic test waiting times</td>
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<td>Patients waiting for a diagnostic test should have been waiting no less than 6 weeks from referral</td>
<td>&gt;99%</td>
<td>94.82%</td>
<td>97.01%</td>
<td>94.82%</td>
<td>97.91%</td>
<td>97.66%</td>
<td>95.41%</td>
<td>96.93%</td>
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<td>A&amp;E waits</td>
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<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department (CCG)</td>
<td>95%</td>
<td>61.21%</td>
<td>55.70%</td>
<td>50.46%</td>
<td>82.49%</td>
<td>88.08%</td>
<td>77.37%</td>
<td>82.66%</td>
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<td>Cancer wait 2-week wait</td>
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<tr>
<td>Maximum 2-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>67.93%</td>
<td>66.56%</td>
<td>65.74%</td>
<td>96.30%</td>
<td>95.12%</td>
<td>96.33%</td>
<td>95.67%</td>
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<tr>
<td>Maximum 2-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>67.18%</td>
<td>68.53%</td>
<td>65.77%</td>
<td>95.11%</td>
<td>93.14%</td>
<td>96.43%</td>
<td>96.79%</td>
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<tr>
<td>Cancer waits 31 days</td>
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<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>90%</td>
<td>68.59%</td>
<td>68.60%</td>
<td>69.74%</td>
<td>96.85%</td>
<td>97.75%</td>
<td>100%</td>
<td>96.30%</td>
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<tr>
<td>Maximum 31-day wait for a subsequent treatment where the treatment is surgery</td>
<td>94%</td>
<td>100%</td>
<td>98.28%</td>
<td>98.39%</td>
<td>100%</td>
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<tr>
<td>Maximum 31-day wait for a subsequent treatment where the treatment is an anti-cancer drug regime</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>99.29%</td>
<td>100%</td>
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<tr>
<td>Maximum 31-day wait for a subsequent treatment where the treatment is a course of radiotherapy</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Cancer waits 62 days</td>
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<tr>
<td>Maximum two month (62-days) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>78.09%</td>
<td>78.29%</td>
<td>80.45%</td>
<td>72.73%</td>
<td>83.27%</td>
<td>68.09%</td>
<td>67.74%</td>
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</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>90%</td>
<td>100%</td>
<td>90.00%</td>
<td>95.71%</td>
<td>100%</td>
<td>75.00%</td>
<td>88.93%</td>
<td>85.71%</td>
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<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)</td>
<td>88%</td>
<td>57.14%</td>
<td>40.00%</td>
<td>89.00%</td>
<td>100%</td>
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<td>Category A Ambulance calls:</td>
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<tr>
<td>Category 1: Calls from people with life threatening illness or injuries - Mean time</td>
<td>00:07:00</td>
<td>00:07:44</td>
<td>00:16:31</td>
<td>00:16:27</td>
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<tr>
<td>Category 2: Emergency calls - Mean time</td>
<td>00:18:09</td>
<td>00:12:21</td>
<td>00:14:41</td>
<td>00:14:03</td>
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<td>Category 3: Urgent calls - 90th Percentile</td>
<td>02:06:00</td>
<td>00:17:56</td>
<td>01:34:53</td>
<td>01:21:12</td>
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<td>Category 4: Less urgent calls - 90th Percentile</td>
<td>03:06:00</td>
<td>03:01:40</td>
<td>03:45:20</td>
<td>03:32:48</td>
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### NHS Constitution Support Measures

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<tr>
<td>Mixed sex accommodation Breaches:</td>
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<tr>
<td>Minimum breaches</td>
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<td>59</td>
<td>42</td>
<td>14</td>
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<td>12</td>
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<tr>
<td>Cancelled operations</td>
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<tr>
<td>All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another booking date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice</td>
<td>100%</td>
<td>96.97%</td>
<td>95.92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Mental Health</td>
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<tr>
<td>Care Programme Approach (CPA) the proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period</td>
<td>95%</td>
<td>61.58%</td>
<td>69.53%</td>
<td>94.11%</td>
<td>96.09%</td>
<td>100.00%</td>
<td>93.94%</td>
<td>96.39%</td>
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</tr>
<tr>
<td>Referral to Treatment waiting times for non-urgent consultant-led treatment</td>
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<tr>
<td>Zero tolerance of over 52 week waiters (all reported occasions)</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
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<tr>
<td>A&amp;E waits</td>
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<tr>
<td>No waits from decision to admit to admission (trolley wait) over 12 hours</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Cancelled Operations</td>
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<tr>
<td>No urgent operation to be cancelled for a second time</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Ambulance handover</td>
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<tr>
<td>All handovers between ambulance and A&amp;E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases for delays over 30 minutes and over an hour.</td>
<td></td>
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</tbody>
</table>
## Comparator CCG Performance:

### Are patients rights under the NHS Constitution being promoted?

<table>
<thead>
<tr>
<th>Target</th>
<th>Isle of Wight CCG</th>
<th>National</th>
<th>Hastings &amp; Rother CCG</th>
<th>Eastbourne, Hailsham and Seaford CCG</th>
<th>Hampshire, Richmondshire and Whitley CCG</th>
<th>Herefordshire CCG</th>
<th>Gt Yarmouth &amp; Waveney CCG</th>
<th>East Riding of Yorkshire CCG</th>
<th>Lincolnshire CCG</th>
<th>Northumberland CCG</th>
<th>South Kent CCG</th>
<th>South West CCG</th>
<th>West Norfolk CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Treatment waiting times for non-urgent consultant-led</td>
<td>92%</td>
<td>Jun-19</td>
<td>84.31%</td>
<td>87.80%</td>
<td>89.31%</td>
<td>91.15%</td>
<td>91.05%</td>
<td>75.02%</td>
<td>85.14%</td>
<td>83.23%</td>
<td>64.77%</td>
<td>94.10%</td>
<td>88.64%</td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (put to bed treatment) should have been waiting no more than 18 weeks from referral</td>
<td>95%</td>
<td>Mar-18</td>
<td>95.83%</td>
<td>97.31%</td>
<td>98.02%</td>
<td>97.84%</td>
<td>98.68%</td>
<td>99.91%</td>
<td>99.28%</td>
<td>91.01%</td>
<td>94.11%</td>
<td>90.28%</td>
<td>96.28%</td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td>&gt;99%</td>
<td>Q1 2018</td>
<td>95.89%</td>
<td>91.37%</td>
<td>94.05%</td>
<td>95.25%</td>
<td>93.73%</td>
<td>90.39%</td>
<td>99.36%</td>
<td>93.27%</td>
<td>80.32%</td>
<td>92.93%</td>
<td>93.67%</td>
</tr>
<tr>
<td>Cancer waits - 2 week wait</td>
<td>93%</td>
<td>Oct-18</td>
<td>97.84%</td>
<td>83.82%</td>
<td>94.00%</td>
<td>97.18%</td>
<td>91.75%</td>
<td>58.62%</td>
<td>96.60%</td>
<td>89.50%</td>
<td>27.68%</td>
<td>96.28%</td>
<td>87.31%</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>Oct-18</td>
<td>95.89%</td>
<td>91.37%</td>
<td>94.05%</td>
<td>95.25%</td>
<td>93.73%</td>
<td>90.39%</td>
<td>99.36%</td>
<td>93.27%</td>
<td>80.32%</td>
<td>92.93%</td>
<td>93.67%</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>Oct-18</td>
<td>97.84%</td>
<td>83.82%</td>
<td>94.00%</td>
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<td>89.50%</td>
<td>27.68%</td>
<td>96.28%</td>
<td>87.31%</td>
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<tr>
<td>Cancer waits - 31 days:</td>
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</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to definitive treatment for all cancers</td>
<td>95%</td>
<td>Mar-19</td>
<td>98.87%</td>
<td>97.48%</td>
<td>96.76%</td>
<td>96.21%</td>
<td>96.31%</td>
<td>96.48%</td>
<td>99.62%</td>
<td>97.51%</td>
<td>97.83%</td>
<td>98.28%</td>
<td>96.94%</td>
</tr>
<tr>
<td>Maximum 31-day wait for a subsequent treatment where the treatment is surgery</td>
<td>94%</td>
<td>Mar-19</td>
<td>100%</td>
<td>94.39%</td>
<td>100%</td>
<td>94.59%</td>
<td>95.56%</td>
<td>93.02%</td>
<td>90.28%</td>
<td>96.67%</td>
<td>90.82%</td>
<td>95.04%</td>
<td>77.14%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime</td>
<td>98%</td>
<td>Mar-19</td>
<td>100%</td>
<td>99.41%</td>
<td>100%</td>
<td>100%</td>
<td>97.10%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98.28%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td>94%</td>
<td>Mar-19</td>
<td>100%</td>
<td>97.06%</td>
<td>100%</td>
<td>99.02%</td>
<td>94.74%</td>
<td>100%</td>
<td>100%</td>
<td>97.87%</td>
<td>98.74%</td>
<td>100%</td>
<td>96.66%</td>
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<tr>
<td>Cancer Weights 62 days:</td>
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<td>72.31%</td>
<td>73.56%</td>
<td>80.73%</td>
<td>77.66%</td>
<td>78.60%</td>
<td>72.41%</td>
<td>71.73%</td>
<td>83.26%</td>
<td>71.70%</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>90%</td>
<td>Mar-19</td>
<td>85.50%</td>
<td>88.57%</td>
<td>66.57%</td>
<td>22.22%</td>
<td>100%</td>
<td>88.89%</td>
<td>100%</td>
<td>74.00%</td>
<td>91.30%</td>
<td>93.36%</td>
<td>62.50%</td>
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<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)</td>
<td>85%</td>
<td>Mar-19</td>
<td>100%</td>
<td>85.31%</td>
<td>65.38%</td>
<td>76.00%</td>
<td>100%</td>
<td>91.00%</td>
<td>80.60%</td>
<td>26.57%</td>
<td>87.72%</td>
<td>68.64%</td>
<td>71.45%</td>
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<td>Mixed Sex Accommodation Breaches</td>
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<td>Minimum breaches</td>
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<td>Care Programme Approach (CPA)</td>
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<tr>
<td>The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period</td>
<td>95%</td>
<td>Mar-19</td>
<td>93.39%</td>
<td>95.76%</td>
<td>92.55%</td>
<td>98.20%</td>
<td>100%</td>
<td>99.02%</td>
<td>99.63%</td>
<td>99.02%</td>
<td>100%</td>
<td>100%</td>
<td>96.68%</td>
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<tr>
<td>A&amp;E waits</td>
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<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department (CCG)</td>
<td>95%</td>
<td>Mar-19</td>
<td>82.69%</td>
<td>89.91%</td>
<td>85.21%</td>
<td>95.00%</td>
<td>84.26%</td>
<td>98.74%</td>
<td>87.11%</td>
<td>90.73%</td>
<td>87.80%</td>
<td>92.86%</td>
<td>86.67%</td>
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</tbody>
</table>
Emergency and Unscheduled Care

Accident and Emergency < 4 Hour Wait:
National Target 95%

The June result for Accident and Emergency performance at CCG level, for breaches of achieving a less than 4 hour wait, was 77.37%. This represented a deterioration to the rate achieved in May (88.00%). NB: Performance in June 2018 was down on the rate achieved in June 2017 (80.84%).

Total numbers attending A&E in June was reduced on the previous month’s total, with just under a third of these indicated to have arrived by Ambulance.

Accident & Emergency < 4 Hour Wait (IWCCG)
(Source: CCG Sitrep Reporting - CSU, CCG Portal)

A&E 4hr waits data is collected as provider totals and allocated to CCGs based on providers, whereby the proportion is 1% or more.

<table>
<thead>
<tr>
<th>% Attendances within 4 hours</th>
<th>2017/18</th>
<th>Apr 2018</th>
<th>May 2018</th>
<th>June 2018</th>
<th>July 2018</th>
<th>YTD 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Brighton And Hove CCG</td>
<td>84.43%</td>
<td>83.92%</td>
<td>85.34%</td>
<td>86.31%</td>
<td>85.76%</td>
<td>85.36%</td>
</tr>
<tr>
<td>NHS Coastal West Sussex CCG</td>
<td>92.57%</td>
<td>93.81%</td>
<td>95.97%</td>
<td>95.41%</td>
<td>94.15%</td>
<td>94.83%</td>
</tr>
<tr>
<td>NHS Fareham And Gosport CCG</td>
<td>77.42%</td>
<td>85.50%</td>
<td>83.70%</td>
<td>83.68%</td>
<td>81.77%</td>
<td>83.55%</td>
</tr>
<tr>
<td>NHS Isle Of Wight CCG</td>
<td>85.17%</td>
<td>82.41%</td>
<td>88.00%</td>
<td>77.37%</td>
<td>82.37%</td>
<td>82.57%</td>
</tr>
<tr>
<td>NHS North East Hampshire And Farnham CCG</td>
<td>89.36%</td>
<td>87.55%</td>
<td>88.28%</td>
<td>90.32%</td>
<td>91.06%</td>
<td>89.38%</td>
</tr>
<tr>
<td>NHS North Hampshire CCG</td>
<td>87.37%</td>
<td>89.68%</td>
<td>86.08%</td>
<td>85.84%</td>
<td>84.53%</td>
<td>86.38%</td>
</tr>
<tr>
<td>NHS Portsmouth CCG</td>
<td>86.63%</td>
<td>91.74%</td>
<td>90.50%</td>
<td>89.99%</td>
<td>89.12%</td>
<td>90.29%</td>
</tr>
<tr>
<td>NHS South Eastern Hampshire CCG</td>
<td>83.44%</td>
<td>88.37%</td>
<td>87.67%</td>
<td>87.65%</td>
<td>86.58%</td>
<td>87.52%</td>
</tr>
<tr>
<td>NHS Southampton CCG</td>
<td>91.95%</td>
<td>91.37%</td>
<td>91.41%</td>
<td>95.23%</td>
<td>93.46%</td>
<td>92.88%</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>89.22%</td>
<td>87.57%</td>
<td>88.19%</td>
<td>90.16%</td>
<td>91.18%</td>
<td>89.37%</td>
</tr>
<tr>
<td>NHS West Hampshire CCG</td>
<td>89.44%</td>
<td>90.45%</td>
<td>88.83%</td>
<td>91.07%</td>
<td>89.59%</td>
<td>89.95%</td>
</tr>
</tbody>
</table>

DATA SOURCE: UNIFY and DH published percentages for provider splits by CCG (via CSU Performance Portal)

- Trust performance in July had improved in month compared with June, having achieved 82.37% (compared with 77.37% for June) but continued to miss the National target rate of 95%.
- Reported numbers for those patients attending A&E in month (5,559) demonstrated an increase in month, as had the total for 4 hour breaches (980). The target rate of 95% was reported to have been achieved on one day in July.
- Numbers for Type 3 attendances increased significantly between June and July. This was explained by the Trust having re-included Urgent care attendances, previously excluded with the movement of patients to Laidlaw day hospital and subsequent recording of numbers on a different system. The revision is a reporting change to rectify what is considered to have previously been an incorrect decision. The impact of the inclusion of these additional patient numbers may result in an improvement to the monthly performance rate achieved in subsequent months.

12 hour trolley waits – National target zero

<table>
<thead>
<tr>
<th>Trolley waits in A&amp;E</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>2017/18</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- There were no (zero) confirmed breaches at the IWNHST in June or July, for patients having waited for 12 hours plus on a trolley from the time when the decision to admit, or treatment in A&E is complete, to the time the patient was admitted.
- For the purposes of comparison, the total numbers of breaches nationally reported for June was 99 and for July 147, an increase of 48.5% between months. At a local level, PHT reported zero breaches in July, while UHS reported four breaches.
Action(s):

- Additional communications and press releases have been circulated aimed at visitors to the Isle of Wight. Visitor numbers attending A&E continues to be high. Communications focus on what support is available and where to get it, with the message that people could be spending more time enjoying themselves rather than sorting their healthcare unnecessarily.

- A whole system bed modelling exercise is in place to assess overall system capacity and how it is being used. This should also highlight where there are current capacity gaps. The Trust has now reduced beds on Compton (winter ward) as per plans. However the demand for beds continues to make this challenging as patients are waiting in A&E extended periods while an acute bed becomes vacant. Bed availability has recently been impacted by some temporary capacity constraints in the Domiciliary Market, meaning discharge levels have also been challenged.

- Longer term plans to provide more Primary Care urgent care at the front door continue with proposals gathering pace to develop an Urgent Care floor. This will also meet national expectations around delivering Urgent Care Centres. The Floor could include GP Urgent Care, Ambulatory Care, potentially GP extended Access and well as A&E.

Ambulance Calls:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Count of Incidents</th>
<th>Total Hours (hrs)</th>
<th>Response times</th>
<th>June WNHST</th>
<th>June England</th>
<th>June SCAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls from people with</td>
<td>53</td>
<td>9</td>
<td>Mean ≤7 minutes</td>
<td>10:27</td>
<td>7.37</td>
<td>6.35</td>
</tr>
<tr>
<td>life threatening illness</td>
<td></td>
<td></td>
<td>90th Percentile ≤15 minutes</td>
<td>18:22</td>
<td>13:19</td>
<td>12:39</td>
</tr>
<tr>
<td>or injuries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 2:</td>
<td>730</td>
<td>171</td>
<td>Mean ≤18 minutes</td>
<td>14:03</td>
<td>21:38</td>
<td>15:12</td>
</tr>
<tr>
<td>Emergency calls</td>
<td></td>
<td></td>
<td>90th Percentile ≤40 minutes</td>
<td>35:50</td>
<td>44:35</td>
<td>30:02</td>
</tr>
<tr>
<td>Category 3:</td>
<td>857</td>
<td>482</td>
<td>Mean ≤33:44</td>
<td>33:44</td>
<td>1:00:15</td>
<td>47:17</td>
</tr>
<tr>
<td>Urgent calls</td>
<td></td>
<td></td>
<td>90th Percentile ≤120 minutes</td>
<td>1:21:12</td>
<td>2:20:01</td>
<td>1:40:08</td>
</tr>
</tbody>
</table>

The nature of calls is now categorised, based on the nature of the emergency, with the response time varied according to the predicted level of urgency.

The principal measurement is the average time achieved for response and attendance across four categories, each of which is based on the level of urgency applied to the nature of the event reported.

During June, the Trust achieved better than target on three of the seven new ambulance standards. The indicators that were off target were CAT 1 mean response time where they achieved 10:27 minutes against 7 minutes standard and the CAT 1 90th percentile response time where they achieved 18:22 minutes against 15:00 minutes target, CAT 3 90th percentile response time was 01:21:12 against 120 minutes and CAT 4 90th percentile response time was 03:33:08 minutes against 180 minute target.

- The Count of Incidents represents the number coded to that category of response and received a response on scene.
- The Total response time is aggregated across all incidents.
- A 90th centile incident response time of 13 minutes means that 9 out of 10 incidents were responded to in less than 13 minutes. Centiles for England are the means of trusts' centiles, weighted by their counts of incidents.

Call answer times (seconds)

<table>
<thead>
<tr>
<th>June</th>
<th>Contact Count</th>
<th>Calls Answered</th>
<th>Total call time</th>
<th>Mean</th>
<th>Median</th>
<th>95th Centile</th>
<th>99th Centile</th>
</tr>
</thead>
<tbody>
<tr>
<td>IW Trust</td>
<td>2,790</td>
<td>1,570</td>
<td>9,585</td>
<td>6</td>
<td>1</td>
<td>20</td>
<td>76</td>
</tr>
<tr>
<td>England</td>
<td>951,964</td>
<td>724,568</td>
<td>7,718,074</td>
<td>11</td>
<td>1</td>
<td>59</td>
<td>122</td>
</tr>
<tr>
<td>SCAS</td>
<td>63,502</td>
<td>40,462</td>
<td>336,453</td>
<td>8</td>
<td>3</td>
<td>42</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table provides an indication to the time taken to respond to calls:

- Contact Count – the count of all ambulance control room contacts – a measure of overall demand and includes all calls to 999, 112 and transfers from NHS111.
- Total call time – representing the time taken to answer each call, aggregated across all calls in the period.
- The Mean is the average time taken to answer each call (in seconds), while the Median time taken is the midpoint for the times taken to answer each call in the period.
**Action(s):**

- The Ambulance Service is now a specialist division, with a dedicated Head of Service in place. The CQC second report acknowledged a significant improvement in leadership. An ex ambulance CEO was brought in as a temporary advisor to the Board and strategic lead for the service. Discussions have started with regulators, commissioners and SCAS regarding future options of strategic partnerships. A new governance structure is being implemented and coaching for teams and individuals for the Ambulance SMT is taking place over a three month period. Other workforce and leadership improvements continue, with opportunities for partnership working being further explored.

- Ambulance Performance against the new standards continues to be monitored as it is recognised that there are data accuracy issues due to some local mechanisms. Planning improvements to the service are difficult until there is 100% confidence with the data.

**Planned Care**

**18 week RTT:**

National Target: Overall Incompletes 92%

Performance for Incompletes in June 2018 (84.31%) demonstrated a marginal decline from the rate achieved in May. However, the target rate of 92% had continued to be missed by the CCG. Performance in month had also demonstrated a deterioration to performance for both Non-admitted and for Admitted. The IWNHST achieved 84.95% (provisional) for Incompletes, missing the National target rate of 92% and also demonstrating deterioration to the revised outcome for May (85.22%).

- Red Target missed; Amber rate within 5% of target; Green Target achieved

In addition and for the treatment of Island patients:

- UHS – (Incompletes: 73.08% (619/847)).
- PHT – (Incompletes 86.07% (210/244)).
- Salisbury- (Incompletes: 91.67% (55/60)).
- Southampton NHS Treatment Centre (Incompletes: 97.01% (162/167))
- University College London Hospitals (Incompletes: 88.00% (22/25))
- Spire Southampton Hospital (Incompletes: 96.00% (48/50))
- Spire Portsmouth Hospital (Incompletes: n/a)).

**Patients waiting >52 weeks** – National Target: Zero

- For June, there had been two reported cases of an individual having had to wait more than 52 weeks for treatment. Both were for Admitted patients in Neurosurgery.

---

### Table: Planned Care 18 week RTT 2017/18 vs 2018/19 Trend in month

<table>
<thead>
<tr>
<th>Target</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Trend in month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec</td>
<td>Jan</td>
<td>Feb</td>
</tr>
<tr>
<td></td>
<td>Admitted</td>
<td>Non-admitted</td>
<td>Incompletes</td>
</tr>
<tr>
<td>IWCCG (overall)</td>
<td>90.0%</td>
<td>69.30%</td>
<td>65.68%</td>
</tr>
<tr>
<td>IWNHST</td>
<td>90.0%</td>
<td>55.10%</td>
<td>59.53%</td>
</tr>
<tr>
<td>UHS</td>
<td>90.0%</td>
<td>70.33%</td>
<td>73.21%</td>
</tr>
<tr>
<td>Non-admitted</td>
<td>95.0%</td>
<td>67.50%</td>
<td>73.72%</td>
</tr>
<tr>
<td>Incompletes</td>
<td>92.0%</td>
<td>88.42%</td>
<td>85.72%</td>
</tr>
<tr>
<td>PHT</td>
<td>90.0%</td>
<td>91.18%</td>
<td>87.18%</td>
</tr>
<tr>
<td>Non-admitted</td>
<td>95.0%</td>
<td>82.14%</td>
<td>78.41%</td>
</tr>
<tr>
<td>Incompletes</td>
<td>92.0%</td>
<td>84.03%</td>
<td>81.85%</td>
</tr>
<tr>
<td>Salisbury</td>
<td>90.0%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-admitted</td>
<td>95.0%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Incompletes</td>
<td>92.0%</td>
<td>80.65%</td>
<td>75.00%</td>
</tr>
</tbody>
</table>

Red Target missed; Amber rate within 5% of target; Green Target achieved

- Reported performance achieved for Incompletes in June 2018, was below the rate reported for June 2017 (90.91%). However, total patient numbers reported as a backlog for June 2018 at 10,518 were 1,970 (23.05%) higher than in the same month last year, with the majority of this increase seen at the IWNHST.

- Performance in month reported by the IWNHST: (Admitted 43.13% (251/582); Non-Admitted 85.94% (2,316/2,695) and Incompletes 85.13% (8,089/9,502)).
Action(s):
• The Trust and CCG are in the final stages of a revised plan taking into account the Trust’s ability to deliver more activity in the summer months.
• GPs continue to offer patient choice at Mainland ISP providers.
• The commissioning team are progressing initiatives in demand management relating to high impact interventions for MSK and Ophthalmology.

Mainland Trusts:
• Contract monitoring meetings with Trusts are continuing to discuss activity, performance and pathway issues.

Cancer

<table>
<thead>
<tr>
<th>Isle of Wight CCG – trend comparison 2016/17</th>
<th>Target</th>
<th>Feb</th>
<th>Mar</th>
<th>2017/18</th>
<th>Apr 18</th>
<th>May 18</th>
<th>June 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seen within 2 weeks of referral</td>
<td>93%</td>
<td>2017/18</td>
<td>98.11%</td>
<td>94.70%</td>
<td>97.25%</td>
<td>96.30%</td>
<td>95.12%</td>
</tr>
<tr>
<td>Seen within 2 weeks of referral - Breast Symptoms</td>
<td>93%</td>
<td>2017/18</td>
<td>87.50%</td>
<td>93.65%</td>
<td>96.77%</td>
<td>85.11%</td>
<td>88.14%</td>
</tr>
<tr>
<td>Treated in &lt;31 days of diagnosis</td>
<td>96%</td>
<td>2017/18</td>
<td>100%</td>
<td>100%</td>
<td>98.51%</td>
<td>98.85%</td>
<td>97.75%</td>
</tr>
<tr>
<td>Treated in &lt;31 days - Surgery</td>
<td>94%</td>
<td>2017/18</td>
<td>100%</td>
<td>100%</td>
<td>99.16%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Treated in &lt;31 days - Drug Treatment</td>
<td>98%</td>
<td>2017/18</td>
<td>97.87%</td>
<td>100%</td>
<td>99.73%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Treated in &lt;31 days - Radiotherapy</td>
<td>94%</td>
<td>2017/18</td>
<td>100%</td>
<td>100%</td>
<td>98.32%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Treated in &lt;62 days - urgent referral to treatment</td>
<td>85%</td>
<td>2017/18</td>
<td>90.24%</td>
<td>88.24%</td>
<td>78.45%</td>
<td>72.73%</td>
<td>63.27%</td>
</tr>
<tr>
<td>Treated in &lt;62 days - Consultant upgrade</td>
<td>86%</td>
<td>2017/18</td>
<td>100%</td>
<td>50.00%</td>
<td>51.85%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Treated in &lt;62 days - Screening service</td>
<td>90%</td>
<td>2017/18</td>
<td>100%</td>
<td>100%</td>
<td>95.16%</td>
<td>100%</td>
<td>75.00%</td>
</tr>
</tbody>
</table>

• Performance in June saw the achievement of target across six of the nine pathways monitored, with a rate of 100% reported for five of these.
• For the pathway ‘Treated in <62 days - urgent referral to treatment’, which remains a focus for performance by NHS England, the target rate was missed at both CCG and Trust levels, although there was some improvement seen to the rate achieved between the months of May and June 2018.
• With the exception of Radiography, the majority of the activity for April was undertaken by the IWNHST.
• Due to changes in the mechanisms for reporting Cancer performance that have been introduced by NHS England, there are no breach reports currently available to help identify the circumstances for failures to meet the time limits associated with each cancer pathway. The CSU are currently working to determine how this might be rectified.
• Reflecting on reported performance in the first quarter 2018/19 by Tumour type:
  'Treated in <62 days - urgent referral to treatment', treatments not meeting the 62 day standard across each of the three months occurred for both Lower Gastrointestinal (average Apr-Jun – 33.33%) and Urological (excluding testicular) (average Apr-Jun – 41.86%). There were also failures for two from the three months for Haematological (excluding Acute leukaemia) (average 57.14%) and Upper gastrointestinal (average 55.56%).
  'Treated in <62 days - Screening service', treatments not meeting the 62 day standard across two of the three months for Lower gastrointestinal (average 60.00%).
**Actions:**

- A number of staff have been recruited recently including Clinical Nurse Specialists for Gynaecology, Breast and Colorectal, Cancer Care Co-ordinators for Breast and Urology and Cancer Nurse Specialists to support implementation of the Cancer Recovery Package. There is also increased diagnostic capacity.
- Tumour specific meeting between commissioners, local Cancer Unit at IOW Trust, and the mainland tertiary Cancer Centres in PHT and separately with UHSFT have continued, with the most recent focusing on lung cancer. The aims of these meetings are to facilitate discussions between the local Cancer Unit and the mainland Cancer Centres to look at specific tumour site pathways to consider where in the pathway changes could potentially be made to reduce possible delays.
- To help reduce the numbers of DNAs, the CCG are supporting Trusts by producing a credit card sized information card for patients, emphasising the importance of attending their appointment and providing a contact number should they not receive their appointment date. These cards have now been printed and distributed to practices week commencing 13 August 2018. Practices that book the appointment at the time of the GP appointment where the suspect diagnosis is made will offer the card to those individuals affected. The Trust has been asked to undertake an audit of appointments for patients due to be seen within two weeks of referral, to see if the introduction of these cards is proving beneficial.

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**Diagnostics – National Target: <1%**

Diagnostics performance for June continued to miss the target rate of <1%. Total activity was reduced in month on the figure reported for May. However, there had been an increase to the numbers for over six week waits between months of 90%.

- The number of waits of six weeks or more incurred by the CCG, increased by 52 between the months of May and June, the majority of these breaches having occurred at the IWNHST, rising from 48 in May, to 97 in June.

At a CCG level, the main speciality for which breaches had occurred in month was Non-Obstetric Ultrasounds which rose from 31 to 72 cases between months. The majority (70) of these breaches were reported to have occurred at IWNHST.

<table>
<thead>
<tr>
<th>IWCCG</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>Mar 18</th>
<th>2017/18</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Waiting List &lt; 6 weeks</td>
<td>1,849</td>
<td>2,002</td>
<td>2,114</td>
<td>19,901</td>
<td>2,198</td>
<td>2,317</td>
<td>2,284</td>
<td>6,799</td>
</tr>
<tr>
<td>Total Waiting List &gt;13 weeks</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>101</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total numbers waiting &gt;6 weeks</td>
<td>32</td>
<td>25</td>
<td>39</td>
<td>516</td>
<td>47</td>
<td>58</td>
<td>110</td>
<td>215</td>
</tr>
<tr>
<td>Total Waiting List</td>
<td>1,881</td>
<td>2,027</td>
<td>2,153</td>
<td>20,417</td>
<td>2,245</td>
<td>2,375</td>
<td>2,394</td>
<td>7,014</td>
</tr>
<tr>
<td>Diagnostic key tests waiting &gt;6 weeks</td>
<td>1.70% (98.30%)</td>
<td>1.23% (98.77%)</td>
<td>1.81% (98.19%)</td>
<td>2.09% (97.91%)</td>
<td>2.09% (97.91%)</td>
<td>2.44% (97.56%)</td>
<td>4.59% (95.41%)</td>
<td>3.07% (96.93%)</td>
</tr>
</tbody>
</table>

**Breaches (June 2018):**

- **IWNHST:** 70 x Non-Obstetric Ultrasounds; 24 x Echocardiography; 1 x MRI Scans; 1 x Flexi Sigmoidoscopy and 1 x Sleep Studies.
  (From a total waiting list of 2,002, representing a breach rate of 4.85%)
  - Total activity between May and June had demonstrated a decrease from 4,944 to 4,703, but with an increase to both the Total waiting List (1,947 to 2,002) and in the numbers achieving < 6 week waits (1,899 to 1,905).
  - The numbers reported to have experienced waits of >6 weeks had increased between months by 49, with the numbers with a >13 week wait, increasing by one to a total of two. In the same period, the numbers for <6 week waits were reduced: June (766) compared with May (784).
  - The two >13 week breaches for June were indicated to have been for a Non-Obstetric Ultrasound.
  - The numbers of breaches associated with Non-Obstetric Ultrasounds demonstrated a marked increase between months with a total of 70 reported for June (breach rate of 8.37%), numbers were up by 39 cases from the 31 reported for May (breach rate of 3.80%).
  - The speciality registering the highest breach rate in June was Echocardiography at 26.97% with a total of 24 individuals registering waits of more than six weeks (an increase by 15 on the total in May). Between months, total activity had fallen from 358 in May to 301 in June.

- **UHS:** 5 x Gastroscopy; 2 x MRI scans; 2 x Colonoscopy and 1 x Peripheral Neurophysiology.
  (From a total waiting list of 168, representing a breach rate of 5.95%)
  - Total Activity associated with the IWCCG reported for UHS in June at 209, was below the level achieved in May (238).
  - Between months the number of <6 week waits had risen marginally (+2), as had the Total Waiting List (+3).
- Numbers for >6 week waits had also risen marginally between months by one with a subsequent increase to the breach rate from 5.45% in May to 5.95% in June.
- The only specialty demonstrating an increase to the numbers of >6 week breaches between May and June was for Gastroscopy (plus three), the others reported having either reduced marginally or remained the same as in the previous month.
  - PHT: 1 x Non Obstetric Ultrasound.
    (From a total waiting list of 119, representing a breach rate of 0.84%)
  - Southampton NHS Treatment Centre: 1 x Non Obstetric Ultrasound.
    (From a total waiting list of 5, representing a breach rate of 20.00%)
  - InHealth: 1 x Echocardiography.
    (From a total waiting list of 77, representing a breach rate of 1.30%)
- NB: InHealth is a privately owned, UK based company that specialises in Diagnostic services, that provides diagnostic and imaging services to the NHS and private providers.

Actions:
- Performance will continue to be monitored to ensure the position stabilises and returns to achieving the target rate of <1%.
- Performance for Gastroscopy at IWNHST may in part be explained by staff shortages, with the Trust currently actively seeking to recruit a Consultant for this speciality. In respect of Non-Obstetric Ultrasounds there are ongoing issues with this department and the process for referral and the commissioners continue to work with the Trust to resolve the current situation.

Audiology: National Target ≥95%

COMPLETE PATHWAYS - Length of RTT period for patients whose clock stopped during the month with a treatment.
INCOMPLETE PATHWAYS - Length of RTT period for patients whose clock is still running

For performance in June, all tests were undertaken by PHT.
- Completed pathways: 94.83% (165/174) – longest wait 1 x 50 to 51 weeks.
- Incomplete pathways: 57.79% (397/687) – longest wait 1 x 42 to 43 weeks.
- All breaches are indicated to have occurred at PHT.

With this month’s data release, the CCG advised: ‘The inclusion of data submitted by Portsmouth Hospitals again this month has more than significantly changed the numbers for the associated CCGs. We received the below response from Portsmouth Hospitals last month and will be contacting them again to see if they have a further update.’

Previous statement from Portsmouth Hospitals

“Following concerns raised within the service there has been a full and detailed review of reporting of audiology RTT waiting times. As a result all pathways where patients were waiting for a hearing aid appliance has been corrected. The submission for April which totalled 593 patients on an Incompletes pathway was not reflective of the full Incompletes waiting list size for this speciality. Outcomes from the actions taken within the service have resulted in an updated reporting position taking the total size of Incompletes to 3,561. Commissioning partners have been made aware of this and are working with the Trust manage to manage the reduction in waiting times for patients. Weekly intensive support continues which includes additional training for the administration team within the department”.

Actions:
- The IWCCG is actively involved as a part of the Discussion relating to Audiology. Whilst there is no quick fix available, steps are being taken to consider both outsourcing and subcontracting activity to independent sector providers.
No Urgent Operation should be cancelled for a second time:
National Target zero cases

- In June there had been no (zero) reported cases of individuals with cancelled operations, which were ‘Not re-booked within 28 days’, resulting in a performance rate of 100%.

<table>
<thead>
<tr>
<th>No urgent operation should be cancelled for a second time</th>
<th>Target</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>Mar 18</th>
<th>2017/18</th>
<th>Apr 18</th>
<th>May 18</th>
<th>Jun 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>9</td>
<td>0</td>
<td>0</td>
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<tr>
<td>2018/19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

All patients who have operations cancelled on or after day of admission, for non-clinical reasons, to be offered another binding date within 28 days, or the patient’s treatment to be funded at the time and hospital of the patient’s choice

<table>
<thead>
<tr>
<th>Mixed Sex Accommodation breaches – National target zero</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
</tr>
<tr>
<td>Isle of Wight CCG</td>
</tr>
<tr>
<td>Dec</td>
</tr>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

- There were 14 reported cases of Mixed Sex Accommodation breaches for June 2018. Twelve cases were reported for the IWNHST, with the remaining two occurring at University Hospital Southampton.

Delayed Transfers of Care (DToC)

- The provisional number for June, for the total number of bed days delayed, was 102 (33 NHS (Acute) / 69 Social Service (Acute)).

<table>
<thead>
<tr>
<th>IWNHST</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly delayed transfers of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Acute</td>
<td>7</td>
<td>110</td>
<td>77</td>
<td>31</td>
<td>50</td>
<td>106</td>
<td>140</td>
<td>74</td>
<td>33</td>
<td>247</td>
<td></td>
<td></td>
<td></td>
<td>247</td>
</tr>
<tr>
<td>Non-Acute</td>
<td>38</td>
<td>79</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>All</td>
<td>45</td>
<td>189</td>
<td>110</td>
<td>31</td>
<td>50</td>
<td>106</td>
<td>140</td>
<td>74</td>
<td>33</td>
<td>247</td>
<td></td>
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<td></td>
<td>247</td>
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<tr>
<td>2017/18</td>
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<td>133</td>
<td>124</td>
<td>389</td>
<td>596</td>
<td>344</td>
<td>187</td>
<td>389</td>
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<td>Social Services</td>
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</tr>
<tr>
<td>Acute</td>
<td>112</td>
<td>34</td>
<td>25</td>
<td>80</td>
<td>61</td>
<td>106</td>
<td>109</td>
<td>97</td>
<td>69</td>
<td>275</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Non-Acute</td>
<td>22</td>
<td>39</td>
<td>58</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>All</td>
<td>134</td>
<td>73</td>
<td>84</td>
<td>99</td>
<td>61</td>
<td>106</td>
<td>109</td>
<td>97</td>
<td>69</td>
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<tr>
<td>2017/18</td>
<td>134</td>
<td>73</td>
<td>84</td>
<td>99</td>
<td>61</td>
<td>106</td>
<td>103</td>
<td>140</td>
<td>98</td>
<td>379</td>
<td>203</td>
<td>251</td>
<td>268</td>
<td>379</td>
</tr>
<tr>
<td>Both</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td></td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>174</td>
<td>203</td>
<td>194</td>
<td>136</td>
<td>111</td>
<td>214</td>
<td>276</td>
<td>273</td>
<td>250</td>
<td>768</td>
<td>768</td>
<td>635</td>
<td>553</td>
<td>768</td>
</tr>
</tbody>
</table>

Friends and Family

<table>
<thead>
<tr>
<th>Friends and Family – IWNHST</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E – Response rate</td>
<td>2.35%</td>
<td>1.62%</td>
<td>3.09%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>A&amp;E - Recommending</td>
<td>85.19%</td>
<td>78.38%</td>
<td>80.72%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Inpatients – Response rate</td>
<td>18.14%</td>
<td>15.06%</td>
<td>17.36%</td>
<td>8.30%</td>
<td>10.74%</td>
<td>12.51%</td>
</tr>
<tr>
<td>Inpatients – Recommending</td>
<td>95.80%</td>
<td>95.61%</td>
<td>96.28%</td>
<td>95.65%</td>
<td>91.40%</td>
<td>98.28%</td>
</tr>
<tr>
<td>Maternity – Response Rate</td>
<td>2.25%</td>
<td>7.32%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.62%</td>
<td>7.69%</td>
</tr>
<tr>
<td>Maternity – Recommending</td>
<td>n/a*</td>
<td>83.33%</td>
<td>n/a</td>
<td>n/a</td>
<td>100%</td>
<td>83.33%</td>
</tr>
</tbody>
</table>
Performance Report – Constitutional Measures

Emergency Readmissions

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number</th>
<th>2017/18</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>Actual</td>
<td>1,084</td>
<td>102</td>
<td>84</td>
<td>92</td>
<td>100</td>
<td>93</td>
<td>101</td>
<td>294</td>
</tr>
<tr>
<td></td>
<td>Admissions</td>
<td>18,413</td>
<td>1,363</td>
<td>1,391</td>
<td>1,490</td>
<td>1,469</td>
<td>1,641</td>
<td>2,040</td>
<td>5,150</td>
</tr>
<tr>
<td>%</td>
<td>5.89%</td>
<td>7.49%</td>
<td>6.04%</td>
<td>6.17%</td>
<td>6.81%</td>
<td>5.67%</td>
<td>4.95%</td>
<td>5.71%</td>
<td></td>
</tr>
</tbody>
</table>

(Payment by results (PBR) authorised national bundle excluding maternity, children under 3 years, cancer diagnosis and specified trauma)

Performance in month 2017/18

<table>
<thead>
<tr>
<th>Month</th>
<th>2017/18</th>
<th>2016/17 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>4.20%</td>
<td>5.92%</td>
</tr>
<tr>
<td>May</td>
<td>5.61%</td>
<td>5.61%</td>
</tr>
</tbody>
</table>

Source: IWNHST Performance & Information Team

NB: The analysis includes all readmissions and uses recognised exclusions to facilitate national benchmarking as per PbR guidance. Without clinical review of all admissions it is difficult to determine if the readmission is related to the previous discharge.

The initial outcome reported for June was 4.95%, which was above the target rate of 4% but demonstrated an improvement on the revised rate reported for May (5.67%).

A review of patients being re-admitted identified that, of the 101 patients re-admitted in June, a total of 52 individuals (51.49% of all re-admissions) were re-admitted within the same week of discharge. Over 95% were re-admitted within 20 days of discharge.

Emergency re-admissions – June 2018:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>2017/18</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 – 30 days</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21 - 27 days</td>
<td>8</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>116</td>
<td>12</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>14 – 20 days</td>
<td>15</td>
<td>25</td>
<td>22</td>
<td>14</td>
<td>197</td>
<td>20</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td>7-13 days</td>
<td>33</td>
<td>22</td>
<td>18</td>
<td>25</td>
<td>244</td>
<td>19</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Same Week</td>
<td>68</td>
<td>42</td>
<td>32</td>
<td>40</td>
<td>510</td>
<td>46</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>Percentage of total readmissions in month</td>
<td>53.54%</td>
<td>41.18%</td>
<td>38.10%</td>
<td>43.48%</td>
<td>47.05%</td>
<td>46.00%</td>
<td>55.91%</td>
<td>51.49%</td>
</tr>
</tbody>
</table>

- When compared with May, and despite there having been a marginal increase to the overall numbers being re-admitted, the proportion of those patients re-admitted within the same week of discharge in June, had remained at a similar rate, 55.49% for June and 55.91% in May. (NB: The total of 52 re-admissions within the same week, as a percentage of all discharges in June was 2.55%).
- The majority of the readmissions that had been discharged on medical advice were Non-Electives (95).
- Of the 101 re-admissions reported for April, the majority were admitted for General Medicine (77); General Surgery (9) and Paediatrics (8). These were the same specialities reported for April and May.

The Quality team undertook an audit of Emergency Re-admissions earlier this year and concluded that these were unrelated to the cause for the original admission.

NB: An emergency readmission is any admission which meets the following criteria:
- Where the time period between discharge from the initial admission and the readmission is equal to or less than 30 days.
- Which has an emergency admission method code of 21-25, 28, 2A or 2D.
Where multiple admissions precede a readmission, the admission immediately preceding the readmission should be considered the initial admission.

The activity has been adjusted to take into account the following exclusions set out within the guidance:
(a) Maternity and Childbirth - (specialties 501 - Obstetrics and 560 Midwifery).
(b) Mental Health - (specialties 700 - Learning Disabilities, 710 - Adult Mental Health and 715 - Elderly Mental Health).
(c) Cancer, chemotherapy and radiotherapy - where the initial admission or readmission includes a spell primary diagnosis of cancer (ICD-10 codes C00-C97 and D37-D48).
(d) Young children – where the patient is under 4 at the time of readmission.
(e) Patients admitted in an emergency due to a transport accident – identified by secondary ICD-10 codes beginning with V in the readmission.
(f) Patients who are readmitted having self-discharged against clinical advice – included in discharge method code 2 in the initial admission.
Mental Health

Care Programme Approach

A rate of 93.94% was achieved in June, missing the target rate of 95%, and down on the 100% achieved in May.

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Target</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>2017/18</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>The proportion of people under adult mental illness specialities on the Care Programme Approach (CPA) who were followed up within seven days of discharge from psychiatric inpatient care (NHS Constitution)</td>
<td>Numerator: People on CPA who were followed up within 7 days of discharge</td>
<td>95%</td>
<td>(21/22)</td>
<td>95.45%</td>
<td>(33/36)</td>
<td>91.67%</td>
<td>(19/19)</td>
<td>100%</td>
</tr>
</tbody>
</table>

Comparison performance is released by NHS England on a quarterly basis. For Q1 2018/19 the following rates were given for ‘Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (QA)’ (Source: NHS England website):
- England 95.76%; South East Commissioning Region 96.17%; IWCCG 96.25%; Portsmouth CCG 100%; Southampton CCG 95.50%; Fareham & Gosport CCG 90.00%; North Hampshire 100%; SE Hampshire CCG 100% and NE Hampshire and Farnham CCG 96.97%.

Improved Access to Psychological Therapies – Entering treatment

Performance in June for accessing the service was reported at 24.66%, which an improvement on the reported performance rate for May (20.06%) and achieving the annual target rate of 22%.

Indicator | Target | Jan | Feb | Mar | 2017/18 | Apr | May | June |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved access to psychological services: Numerator: No. of people who receive psychological therapies</td>
<td></td>
<td>251</td>
<td>207</td>
<td>183</td>
<td>2,670</td>
<td>253</td>
<td>218</td>
<td>268</td>
</tr>
<tr>
<td>Denominator: No. of people who have depression and/or anxiety disorders</td>
<td></td>
<td>1,087</td>
<td>1,087</td>
<td>1087</td>
<td>13,044</td>
<td>1087</td>
<td>1,087</td>
<td>1,087</td>
</tr>
<tr>
<td>Percentage</td>
<td></td>
<td>23.09%</td>
<td>19.04%</td>
<td>16.84%</td>
<td>20.47%</td>
<td>23.28%</td>
<td>20.06%</td>
<td>24.66%</td>
</tr>
</tbody>
</table>

Comparison of performance for the last quarter of 2017/18 (Q4) based on a rolling three month access rate (Source: NHS England; IAPT Recovery Rate dashboard – June 2018):
- IWCCG 4.45%; SE Hampshire CCG 3.40%; N. Hampshire CCG 3.41%; Fareham & Gosport CCG 3.47%; Southampton CCG 3.92%; Portsmouth CCG 4.99% and NE Hampshire and Farnham CCG 5.42%.

Improved Access to Psychological Therapies – Moving to Recovery

For those moving to recovery, a rate of 54.76% was achieved, down on the previous month’s result but continuing to achieve the target rate of 50%.

Indicator | Target 2017/18 | Jan | Feb | Mar | Apr | May | Jun |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved access to psychological services: Numerator: No. of people who are moving to recovery (of those who have completed treatment, those who at initial assessment achieved ‘caseness’ and at final session did not) during the reporting quarter</td>
<td></td>
<td>81</td>
<td>70</td>
<td>68</td>
<td>92</td>
<td>92</td>
<td>69</td>
</tr>
<tr>
<td>Denominator 1: No. of people who have completed treatment (min 2 treatment contacts) during the reporting quarter</td>
<td></td>
<td>160</td>
<td>136</td>
<td>140</td>
<td>185</td>
<td>164</td>
<td>130</td>
</tr>
<tr>
<td>Denominator 2: The number of people who have completed treatment who did not achieve clinical ‘caseness’ at initial assessment</td>
<td></td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>14</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Denominator = (1 - 2)</td>
<td>150</td>
<td>126</td>
<td>129</td>
<td>171</td>
<td>154</td>
<td>126</td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>54.00%</td>
<td>55.56%</td>
<td>52.71%</td>
<td>53.80%</td>
<td>59.74%</td>
<td>54.76%</td>
<td></td>
</tr>
</tbody>
</table>

Comparison of performance of a rolling 3 month Access rate at the close of 2017/18 (Source: SCW CSU):
- IWCCG 53.09%; N. Hampshire 48.28%; SE Hampshire CCG 46.15%; Fareham & Gosport CCG 46.15%; Southampton CCG 52.89%; NE Hampshire and Farnham CCG55.47% and Portsmouth CCG 57.34%.
Early Intervention in Psychosis (EIP First Episode Psychosis) RTT Pathways

EIP pathways completed in month (IWNHST):

<table>
<thead>
<tr>
<th>IWNHST</th>
<th>% people seen &lt;2 weeks</th>
<th>% people seen &gt;2 weeks</th>
<th>Weeks Waiting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>0-1</td>
</tr>
<tr>
<td>December</td>
<td>100%</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>January</td>
<td>100%</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>February</td>
<td>100%</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>100%</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>April</td>
<td>100%</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>May</td>
<td>100%</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>June</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
</tbody>
</table>

Dementia – National target >66.7%

<table>
<thead>
<tr>
<th></th>
<th>Feb.18 Estimated</th>
<th>Dementia 65+ Diagosis rate</th>
<th>March 18 Estimated</th>
<th>Dementia 65+ Diagnosis rate</th>
<th>April 18 Estimated</th>
<th>Dementia 65+ Diagnosis rate</th>
<th>May 18 Estimated</th>
<th>Dementia 65+ Diagnosis rate</th>
<th>Jun.18 Estimated</th>
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</thead>
<tbody>
<tr>
<td><strong>North &amp; East</strong></td>
<td></td>
<td></td>
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<tr>
<td>ARGYLL HOUSE</td>
<td>82.7</td>
<td>47</td>
<td>56.60%</td>
<td>83.198</td>
<td>44</td>
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<td>46</td>
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<td>EAST COWES MEDICAL CENTRE</td>
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<td>75</td>
<td>61.11%</td>
<td>123.479</td>
<td>75</td>
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<td>117</td>
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<td>116</td>
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<td><strong>West &amp; Central</strong></td>
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<tr>
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<td>201</td>
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<td>94</td>
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<td>129.321</td>
<td>59</td>
<td>45.02%</td>
<td>128.495</td>
<td>59</td>
<td>45.14%</td>
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<tr>
<td>VENTNOR MEDICAL CENTRE</td>
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<td>64</td>
<td>68.49%</td>
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<td>83</td>
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<td>94.930</td>
<td>85</td>
<td>68.78%</td>
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<td>1,739</td>
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<td>2,526.92</td>
<td>1,751</td>
<td>69.24%</td>
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Using the estimated figure of 2,542.41 for June, and the 65+ dementia register figure of 1,772 – a diagnosis rate of 69.70% was provided. This represents a slight reduction to the reported rate for May.

In month there had been an increase of 16 to the dementia register aged 65+, with the most marked increase having occurred in Carisbrooke (+5 between May and June), while Sandown Health Centre had seen a reduction between months (-8 between May and June).
Urgent Care and Community Services

System Resilience

The Isle of Wight system has experienced heightened pressure through an elongated hot spell through June and July which has seen increased urgent and emergency attendances and admissions, including those by visitors to the island. Early August saw the Whole IW system escalate to Operational Pressure Escalation level (OPEL) 3 and the IW NHS Trust escalate to OPEL 4. There have been spikes in demand but escalation was also contributed too by a temporary capacity constraint in the Domiciliary Care market, which had impacted on the level of discharges. As a result the early August period saw an increase in Delayed Transfers of case as well as the patients experiencing a long length of stay in hospital greater than 21 days. The system had stabilised by mid-August and de-escalated. Additional capacity was created with more senior staffing at the front door and additional Adult Social Care, as well as health, support staff on site over weekends.

Longer term planning for winter continues and the following areas are highlighted as key focus areas for supporting sustainable system resilience;

- **Discharge To Assess (DTA)** – Hasten full implementation of DTA.
- **System referral management** – Discharge/referral bureau to avoid less appropriate referrals.
- **IT tools** – effective use of SHREWD Alerting systems and bed management systems.
- **Evening and Weekends** – Matching capacity to demand.
- **Domiciliary care market management** – Home First Policy / threshold management.
- **Step Down Bedded Care Escalation** – review funding arrangements and trigger points for implementing escalation beds.
- **Acute Contingency Beds** – Agreement of trigger points or time period when contingency acute bed capacity will be available.
- **Non-Weight bearing patient pathway** - Review and demand and capacity planning for non-weight bearing patients.
- **Workforce** – Breaking the cycle of reliance on agency staffing.
- **Implementation of Urgent Care Floor model** – Reconfiguration of front door management of demand.

New Care Model Alliances

The Local Care Board (LCB) has agreed to the **formation of National Care Model (NCM) Alliances** to progress Local Care Plan 2017 – 2021 priorities to establish an improved financial, governance and contractual framework for the delivery of integrated care for the Isle of Wight.

The **Integrated Community Care (ICC) Alliance** was launched in April following work in February and March to co-design core elements of the Alliance Agreement. Chief Executives of Age UK, Council, NHS Trust and CCG formalised the ICC Alliance by signing the Heads of Agreement. ICC Alliance members meet on a regular basis to continue to build the alliance relationship and learn new ways of collaboratively working at a tactical level to ensure improved coordination of care delivery for services in scope of the community care agreement.

The **Rehabilitation, Reablement and Recovery (RRR) Alliance** was launched in July. Members of the RRR Alliance have been co-designing the core elements of the Alliance Agreement modelled on the core terms developed by the ICC Alliance. The Heads of Agreement for the RRR Alliance is now ready for Chief Executives to sign off. The independent nursing home provider Hartford Care is included in this NCM alliance.

Work is underway to build a collaborative approach to bringing primary and secondary care together through a series of engagement events, in readiness for co-developing the **Urgent and Emergency Care Alliance**. This is fundamental to achieving a whole system shift in demand from acute to community. The first of these events was supported and co-facilitated by Dr Karen Kirkham who is a National GP Advisor working with NHS England on New Care Models, as well as being a practicing GP and Assistant Clinical Chair at Dorset CCG. This alliance will support development of the contracts linked to the seven pillars of the National Urgent and Emergency Care Delivery Plan with the LCB Urgent and Emergency Care Task and finish Group taking an overview of delivery.

The diagram below illustrates the business the NCM Alliances do together beginning with co-designing the Alliance Agreement; then launching the Alliance relationship driven by regular business meetings; and system readiness co-design with wider stakeholders.
NHSE New Business Model Teams have taken a keen interest in our NCM alliance development approach and consequently have submitted a proposal to case study the development of the NCM Alliance outcomes framework and support developing the payment & incentives elements of emerging Alliances’ Business Models. This NHSE offer is as an opportunity for the Isle of Wight to be a potential exemplar in bottom up approach to building an integrated care environment. Furthermore there is opportunity to harness the NCM alliance approach as the vehicle for embedding the infrastructure for STP cluster teams on the Island by March 2019.

Primary Care

Sandown List Closure

The CCG continues to work with Sandown Health Centre to ensure the practice reopens its list by November this year. Following recruitment of a new GP, the practice is now putting in place alternative methods of working to allow this to happen.

Improved Access Service

This service continues to operate across three localities on Saturday with evening working on Monday to Thursday in Shanklin and Sandown. The service will be due for retendering shortly and there is ongoing work looking at the way this will be done and how this service could be linked to the Urgent Care Service at St Marys.

Workforce Planning & Retention

Work has been ongoing around the £400k funding awarded to the Isle of Wight for the GP Retention fund. There has been a consultation meeting with GPs and other stakeholders and the feedback from this is being used to compile a work plan and planning document for the project. Engagement has been very positive and there have been a wide range of possible ideas to help workforce and retention.

Mental Health

Mental Health Transformation Programme

The Mental Health Blueprint has now been finalised and approved at Health and Wellbeing Board, along with the Consultation Closure Report and Draft Action Plan. These now need to go the respective statutory organisations for final sign off. The draft Action Plan has been coproduced, detailing how the practical delivery of the Island’s agreed ambitions will be undertaken, and is being circulated more widely for comment and feedback.

The Mental Health Transformation Programme team have been facilitating professional and user attended workshops based upon the new tiered model of care. These workshops have been completed for Eating Disorder, Psychosis, Emotionally Unstable Personality Disorder and Mood and Anxiety. Further workshops for Dementia and Older Persons Mental Health are scheduled for September and will incorporate the work undertaken by the Dementia and Older People’s Mental Health Steering Group.
Performance Report – Constitutional Measures

Review and Redesign of Mental Health Day Services and Employment Support

A paper outlining the vision for Community Mental Health and Wellbeing Services, incorporating Mental Health Day Services and Employment Support, has been coproduced and will be circulated for wider feedback and comment review by key stakeholders following the inclusion of additional supporting data.

Mental Health 24/7 Single Point of Access

Single point of access is now available to all ages and links in to the wider Community Children’s and Adolescent Mental Health services. A review of the CYP training within the team is currently being undertaken by the CCG. Quality lead to ensure demand is being met and good outcomes are being achieved for children and young people in emotional and/or mental health distress.

Confirmation of funding and commissioning intentions for the Eating Disorder Service has been formally provided by the CCG to the IoW Trust, enabling the next stage of service development.

Future in Minds Improved Access to Psychological Therapies for Children and Young People (CYP)

CYP IAPT Network scoping sessions, linked in with the London and South-East CYP-IAPT Learning Collaborative, continue.

Third sector providers have had training places / funding confirmed by NHSE and the training Network. This will see the Island benefitting from an additional 3 x therapists from Barnardos undergoing CYP IAPT compliant training plus a ‘recruit to train’ post at the Isle of Wight Youth Trust being funded.

Pilot Perinatal Service

CCG Commissioners have linked with the Perinatal Service Manager regarding evaluation of the qualitative and quantitative impact of the Perinatal Mental Health service. Southern Health has received the first set of questionnaires for analysis and reports will be provided to the CCG in due course.

Isle of Wight OFSTED Inspection

CCG Commissioners have been supporting preparation work for an expected OFSTED inspection of Special Needs Education for the Isle of Wight.

Working in partnership with colleagues in social care, education and the IoW NHS Trust, a ‘2018 Isle of Wight Area Self Evaluation’ has been completed and is now in final draft form for final review.

The evaluation reviews current provision system-wide, across special educational needs and incorporates an action plan for further improvements that will improve quality, accessibility and effectiveness of services. Much of the work of the CCG that is already underway or has been completed such as the CYP LTP refresh, has been shared by the CCG and has contributed to areas reviewing mental health, learning disability and autism.

Learning Disability

The Learning Disabilities Transformation has continued to progress against the commitments outlined within the new, co-produced strategy launched April 2018:

Theme: ‘Living My Life’

We committed to making sure there is more choice of where to live that is in their local community, progress this month included the appointment of a new Independent Living Commissioning Officer within the Integrated Commissioning Team who will be assisting with the housing elements of the programme.

Theme: ‘Staying Healthy’

We committed to enabling a culture of reasonable adjustment within health services, this has included commencement of facilitating five GP surgeries to become ‘Learning Disability Friendly’.

We also made the commitment that by March 2019 the health and social care teams will become one community learning disability team. We are currently facilitating a series of workshops which work through how representatives from the statutory and third sector organisations, as well as experts by experience, envision how the new service should look.
Children and Maternity Commissioning

Steps for closer integrated working with the Children and Maternity Collaborative has been underway with the advertisement of a shared Band 8a Children’s and Maternity Commissioning role as well commissioning support coming from the mainland to assist with the Autism Assessment and Diagnostic Service development.

Planned Care

Musculoskeletal (MSK) Triage Project (NHSE Elective Care High Impact Intervention Programme)

The MSK transformation project mandated by NHSE continues to progress with a stakeholder workshop led by the GP Clinical leads planned for the 18th September with business case to follow. There has been positive feedback and interest from stakeholders in the project and it is hoped this workshop will help to identify an effective model for the Island. Regular liaison with the STP MSK team has enabled the team to test and discuss plans.

NHSE have recently announced that First Contact Practitioners (FCP) for MSK will be rolled out in 2018/19 as another mandated High Impact Intervention Project.

It is intended to include the implementation of FCP’s in the current project if feasible.

Dermatology Re- Procurement

The current contract for the Isle of Wight Integrated Intermediate and Specialist Dermatology Service is due to expire on 31st March 2019. Under OJEU rules, this contract is out to tender, supported by South of England Procurement Service. The Invitation To Tender (ITT) closed on 20th August 2019, and bids will be evaluated by the Project Board during September. The Procurement is on track to deliver to current timescales with new contract commencing 1st April 2019.

IOW Audiology service – provided by Portsmouth Hospital NHS Trust (PHT)

Concerns regarding service performance have been raised by the lead commissioners (Portsmouth City and South East Hampshire CCG’s) and the IOW as associates at the contract review meeting in February 2018 and PHT were asked to carry out a service ‘deep dive’ and present the findings to commissioners.

The result of the deep dive was shared with all commissioners in June 2018. At this meeting PHT informed the commissioners of the following issues:

- An internal inquiry had identified data processing issues which had resulted in a large number of patients not being added to the waiting list.
- Staff shortages; at one stage in 2017 the service were 14 clinical staff down – approx. 40% of total clinical staff.
- Across the region more than 7,000 patients are on the waiting list, representing a huge backlog for an already understaffed team to work through. Currently the waiting list for IOW patients is 693 patients, 296 over 18 weeks.
- A decision was made by PHT that existing staff would initially work through Paediatric and complex audiology patients – this exercise has been completed. Commissioners were assured that these cohorts of patients would be prioritised whilst the backlog is cleared.

Remedial action plan actions are progressing:

- Recruitment and retention has improved – staff recruitment ongoing to fill current vacancies. However, the service is still five staff short.
- Extra clinics and overtime has been agreed and put in place to reduce the backlog.
- Currently the Trust is confident they will maintain the diagnostics 6 week target and there has been no breaches of the 52 week wait standard.
- All patients on the waiting list have been contacted with a contact number to use if their hearing deteriorates.
- Communication regarding the current situation sent out to primary care for awareness.
- Explore options for PHT to subcontract activity to an alternative provider, or Commissioners to contract with an alternative provider.

Risks:

- Routine patients including those waiting for hearing aid fitting will experience longer waiting times for their appointment
- PHT is unlikely to clear the backlog of patients this financial year creating a pressure on 2019/20 capacity and finances.
A press statement regarding the issues with the service was released by Portsmouth City CCG, however patient complaints are likely.

Next steps:

- Discussions are continuing with PHT to explore use of a subcontractor to deliver activity or Commissioners to contract with alternative provider.
- Regular joint meetings are scheduled to monitor progress against the remedial action plan.

**Healthwatch Report - Cancer Services for Isle of Wight Residents – (Co-ordination, travel and urgent assistance) July 2018**

Healthwatch have just released their report ‘Cancer Services for Isle of Wight Residents – (Co-ordination, travel and urgent assistance) July 2018’. Cancer services were identified as a priority topic for Healthwatch Isle of Wight for 2016/17 as a result of engagement with the local community. A questionnaire survey was carried out with local people who had used cancer services since January 2016, focusing on Co-ordination, travel and urgent assistance these being key themes emerging from patient experiences recorded from a Healthwatch survey undertaken in 2015. The key recommendations from the report are:

- The Report to be shared with all managers and clinicians involved with cancer services for Isle of Wight residents to ensure co-ordination between services.
- Improvement required in co-ordination between cancer services across different NHS Hospitals.
- Improvement in communication between specialist cancer services, general practice and community support services.
- Development of a Charter setting out standards expected of NHS providers with regard to travel needs of patients.
- Decisions about financial assistance to people travelling for cancer treatment should involve all partners including the local NHS, Local Authority, voluntary and community sector, and jointly explore all options to maintain and improve travel support.
- Cancer patients who require admission should by-pass Accident and Emergency, ensuring ward moves and discharge take place at appropriate times and with a suitable level of planning and support.

Commissioning will liaise with the IW Trust and the Local Authority to inform progress so far, develop actions and a response back to Healthwatch to address their concerns. The full report and CCG Action Plan will be presented to the Clinical Senate and Governing Body in September 2018.
Finance Report –

September 2018
Summary Key Issues

- As at the end of July 2018 (Month 4) the CCG is £97k behind plan.
- The CCG is forecasting to achieve the planned deficit position of £5m.
- As at Month 4 the CCG has £3.7m of unidentified QIPP. (Reduction of £0.8m)
- System control total agreed of £22.1m.
- The contract variation with the Isle of Wight Trust has been agreed. The contract value for 2018/19 is £130.7m.
- The Final Financial Plan, incorporating the £5m deficit control total, is being taken to the Governing Body for approval on 6th September.

Month 4 position

<table>
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<tr>
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<th>YTD Budget (£000)</th>
<th>YTD Actual (£000)</th>
<th>YTD Variance (£000)</th>
<th>Annual budget (£000)</th>
<th>Year End Forecast (£000)</th>
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Application

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<th>YTD Actual (£000)</th>
<th>YTD Variance (£000)</th>
<th>Annual budget (£000)</th>
<th>Year End Forecast (£000)</th>
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</tbody>
</table>

Surplus: (1,667) (1,764) (97) (5,000) (5,000) 0

Headlines:

- As at the end of July 2018 (Month 4) the CCG planned deficit is £1,667k, with a reported deficit of £1,764k which is £97k behind plan.
- The CCG is forecasting to achieve the planned deficit of £5m.
- Based on Payments by Results (PbR) contract, non-activity is over-performing by £1.3m YTD
  - If expenditure continues at same rate this element of the contract will be £3.5m overspent at year end.
  - A review of the drivers/causes is in progress.
- The Acute 3.5% QIPP demand reduction scheme has yet to deliver.
- Primary Care – The underspend is predominantly due to prescribing expenditure being less than plan.
- The contingency and 50% of risk reserve have been phased in to the year to date position.
QIPP

<table>
<thead>
<tr>
<th>Delivery Plan Grouper</th>
<th>2017/18 QIPP TOTAL</th>
<th>Year to date Budget</th>
<th>Year to date Actual</th>
<th>Year to date variance</th>
<th>Year end Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Demand Management reduction schemes</td>
<td>2,553</td>
<td>851</td>
<td>0</td>
<td>(851)</td>
<td>2,553</td>
<td>0</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>1,975</td>
<td>658</td>
<td>658</td>
<td>0</td>
<td>1,975</td>
<td>0</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>1,975</td>
<td>446</td>
<td>446</td>
<td>0</td>
<td>1,975</td>
<td>0</td>
</tr>
<tr>
<td>Rehab Reconfiguration</td>
<td>791</td>
<td>264</td>
<td>264</td>
<td>0</td>
<td>791</td>
<td>0</td>
</tr>
<tr>
<td>Non-recurring items</td>
<td>264</td>
<td>797</td>
<td>797</td>
<td>0</td>
<td>797</td>
<td>0</td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>3,698</td>
<td>702</td>
<td>(702)</td>
<td>0</td>
<td>(3,698)</td>
<td>(3,698)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,151</strong></td>
<td><strong>3,717</strong></td>
<td><strong>2,165</strong></td>
<td><strong>(1,553)</strong></td>
<td><strong>7,453</strong></td>
<td><strong>(3,698)</strong></td>
</tr>
</tbody>
</table>

- Acute Demand Management Reduction Schemes – £1.5m linked to ASR, risk of delivery within this financial year due to pace of change.
- Continuing Health Care additional spend to save scheme approved to deliver the QIPP target.
- Medicines Optimisation – clear plans and deliverables.
- Rehabilitation configuration – delivered.
- Further savings solutions and opportunities are being actively pursued within the CCG and with system partners.

Financial Risks and Mitigations – as at Month 4

<table>
<thead>
<tr>
<th>Risks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unidentified QIPP</td>
<td>(3.7)</td>
</tr>
<tr>
<td>risk of QIPP non-delivery</td>
<td>(0.9)</td>
</tr>
<tr>
<td>Mental Health placements</td>
<td>(0.5)</td>
</tr>
<tr>
<td>prescribing risks</td>
<td>(0.4)</td>
</tr>
<tr>
<td><strong>Total Risks</strong></td>
<td><strong>(5.5)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mitigations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance sheet items</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total Mitigations</strong></td>
<td><strong>0.2</strong></td>
</tr>
</tbody>
</table>

| Un-mitigated risks | **(5.3)** |

- Unmitigated risks have reduced this month from £8.4m to £5.3m due to the contract being agreed with IW Trust.
- Further QIPP opportunities are being sought.
- The risks in the CCG’s positon are shared every month with NHS England.
Other Performance Indicators

<table>
<thead>
<tr>
<th>Balanced Scorecard - Monthly</th>
<th>Target</th>
<th>Jul-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance Efficiency: Invoice payment: &lt;30 days % achievement - value</td>
<td>95%</td>
<td>99.59%</td>
</tr>
<tr>
<td>Finance Efficiency: Invoice payment: &lt;30 days % achievement - volume</td>
<td>95%</td>
<td>99.46%</td>
</tr>
<tr>
<td>Finance Efficiency: Debtors &gt;30</td>
<td>&lt;=5%</td>
<td>1.52%</td>
</tr>
<tr>
<td>Finance Efficiency: Creditors &gt;30</td>
<td>&lt;=5%</td>
<td>67.72% £153k</td>
</tr>
<tr>
<td>Finance Efficiency: Liquidity cash balance % of drawdown</td>
<td>1.25%</td>
<td>11.11% £1,940k</td>
</tr>
</tbody>
</table>

- Creditors over 30 days – these have now been paid.
- The excess cash value of £1.9m relates to timing differences for Better Care Fund transactions.
### Governing Body

**CCG Improvement & Assessment Framework (CCG IAF)**

<table>
<thead>
<tr>
<th>Sponsor:</th>
<th>Loretta Outhwaite (Deputy Chief Officer)</th>
</tr>
</thead>
</table>
| **Summary of issue:** | **CCG Improvement and Assessment Framework (CCG IAF)**  
2017/18 Annual Assessment for the Isle of Wight  

The CCG Improvement and Assessment Framework (IAF) has been updated for 2017/18. It builds on the IAF introduced in April 2016, which replaced both the existing CCG assurance framework and CCG performance dashboard, and was designed to provide a greater focus on assisting improvement, alongside our statutory assessment function.  

The IAF aligns with NHS England’s Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.  

The framework is intended as a focal point for joint work and support between NHS England and CCGs. It draws together the NHS Constitution, performance and finance metrics and transformational challenges and plays an important part in the delivery of the Five Year Forward View.  

The focus is around key facets of our functions, including:  

- **Leadership and Sustainability** that are rated by our Regional NHS England Team based on assessments of areas such as the CCG’s financial position and plans along with the strength of our relationships, engagement and governance.  

- **Better Health and Better Care** based on the assessment of a large number of clinical performance indicators which are benchmarked against all other CCG’s.  

For the year 2017/18 the overall final position of the CCG published in July 2018 had been rated as ‘Requires Improvement’. This included Leadership rated as ‘Red’ and Sustainability rated as ‘Amber’.  

The full and latest indicator ratings can be found on the:  
[https://www.nhs.uk/service-search/performance/search](https://www.nhs.uk/service-search/performance/search)  

<p>| Action required/ recommendation: | For Information |</p>
<table>
<thead>
<tr>
<th>Principle risks:</th>
<th>The CCG is determined by the assessment as ‘Requires Improvement’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other committees where this has been considered including SMT:</td>
<td></td>
</tr>
<tr>
<td>Has this been agreed with the following areas; Please tick and gain signature:</td>
<td>Finance [ ] Quality [ ] Contracts [ ]</td>
</tr>
<tr>
<td>Signed</td>
<td>Finance [ ] Quality [ ] Contracts [ ]</td>
</tr>
<tr>
<td>Financial /resource implications:</td>
<td>The sustainability indicators are a measure the level of risk associated to the CCG financial plans.</td>
</tr>
<tr>
<td>Legal implications/impact:</td>
<td>Failure to deliver improvement may lead to legal interventions.</td>
</tr>
<tr>
<td>Public involvement /action taken:</td>
<td>The assessment is in the public domain.</td>
</tr>
<tr>
<td>Equality and diversity impact:</td>
<td>The indictors included in the assessment highlight areas of equality and diversity performance.</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Andrew Heyes, Head of performance and contracting</td>
</tr>
<tr>
<td>Date of Paper:</td>
<td>24th August 2018</td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td>6th September 2018</td>
</tr>
<tr>
<td>Agenda Item:</td>
<td>7.3</td>
</tr>
</tbody>
</table>
Monday 9 July 2018

Dear Maggie,

2017/18 CCG annual assessment for Isle of Wight

The CCG annual assessment for 2017/18 provides each CCG with a headline assessment against the indicators in the CCG improvement and assessment framework (CCG IAF). The CCG IAF aligns key objectives and priorities as part of our aim to deliver the Five Year Forward View. The headline assessment has been confirmed by NHS England’s Commissioning Committee.

This letter provides confirmation of the annual assessment as well as the leadership and finance ratings that have been used as part of this assessment. These ratings reflect our assurance discussions and follow-up letters that we have shared with you throughout 2017/18. For your reference we have included the IAF definition for quality of leadership at Annex A.

Detail of the methodology used to reach the overall assessment for 2017/18 can be found at Annex B. The categorisation of the headline rating is either outstanding, good, requires improvement or inadequate.

The final headline rating for 2017/18 for Isle of Wight is Requires Improvement. The quality of leadership rating (indicator 165a) is Red and the finance rating (indicator 141b) is Amber. These ratings are heavily weighted in the overall rating as described in Annex B.

The 2017/18 annual assessments will be published on the CCG Improvement and Assessment page of the NHS England website in July. At the same time they will be published on the MyNHS section of the NHS Choices website. The dashboard with the data will be issued with year-end ratings in July.

Thank you for your CCG’s contribution to delivering the Five Year Forward View, and your focus on making improvements for local people. I look forward to working with you and your colleagues during 2018/19, including following up on the annual assessment.
I would ask that you please treat your headline rating in confidence until NHS England has published the annual assessment report on its website. This rating remains draft until formal release. Please let me know if there is anything in this letter that you would like to follow up on.

Yours sincerely,

[Signature]

David Radbourne
Director of Commissioning Operations
NHS England (South East)
Annex A – IAF indicator definition used as part of the assessment

Please refer to the wider CCG IAF framework for 2017/18 for full details.

Quality of leadership (indicator 165a)

Assessment for this indicator was undertaken by NHS England's local team, drawing on senior level conversations, system meetings and meetings between director level members of the DCO and CCG teams. Focussed meetings were held in response to any specific areas of concern e.g. quality or finance. An evidence based judgement was made against this indicator, under four key lines of enquiry:

- Leadership capability and capacity;
- Quality;
- Governance; and
- Leadership around transformation.

Evidence would be drawn from, but not limited to, CCG IAF data and the CCG's own documents such as board papers, annual report and governance statement, reporting, monitoring and assurance systems, records of improvement actions undertaken, risk logs, clinical, internal and external audit reports, staff survey results, the organisational development (OD) plan, and staff turnover rates. STP footprint documents and NHS England STP assessments will also be relevant in assessing the CCG leadership's approach to its STP. For this indicator it would be usual to seek the relevant STP lead's view of the contribution of the CCG to the STP. This is in addition to feedback provided as part of the CCG annual 360 stakeholder survey.
Annex B – overall assessment methodology

NHS England’s annual performance assessment of CCGs 2017/18

1. The CCG IAF comprises 51 indicators selected to track and assess variation across policy areas covering performance, delivery, outcomes, finance and leadership. This year, assessments have been derived using an algorithmic approach informed by statistical best practice; NHS England’s executives have applied operational judgement to determine the thresholds that place CGCs into one of four performance categories overall.

Step 1: indicator selection

2. A number of the indicators were included in the 2017/18 IAF on the basis that they were of high policy importance, but with a recognition that further development of data flows and indicator methodologies may be required during the year. However, by the end of the year, there was just one indicator that was excluded as there is no data available for the measure: mental health crisis.

Step 2: indicator banding

3. For each of the 207 CCGs, the remaining indicator values are calculated. For each indicator, the distance from a set point is calculated. This set point is either a national standard, where one exists for the indicator (for example in the NHS Constitution); or, where there is no standard, typically the CCG’s value is compared to the national average value.

4. Indicator values are converted to standardised scores (‘z-scores’), which allows us to assess each CCG’s deviation from expected values on a common basis. CCGs with outlying values (good and bad) can then be identified in a consistent way. This method is widely accepted as best practice in the derivation of assessment ratings, and is adopted elsewhere in NHS England and by the CQC, among others.  

5. Each indicator value for each CCG is assigned to a band, typically three bands of 0 (worst), 2 (best) or 1 (in between).  

Step 3: weighting

6. Application of weightings allows the relatively greater importance of certain components (i.e. indicators) of the IAF to be recognised and for them to be given greater prominence in the rating calculation.

7. Weightings have been determined by NHS England, in consultation with operational and finance leads from across the organisation, and signal the

---

1 Spiegelhalter et al. (2012) Statistical Methods for healthcare regulation: rating, screening and surveillance
2 For a small number of indicators, more than 3 score levels are available, for example, the leadership indicator has four bands of assessment.
significance we place on good leadership and financial management to the commissioner system:

- Performance and outcomes measures: 50%;
- Quality of leadership: 25%; and,
- Finance management: 25%

8. These weightings are applied to the individual indicator bandings for each CCG to derive an overall weighted average score (out of 2).

Figure 1: Worked example

Anytown CCG has:
- Quality of leadership rating of “Green” (equivalent to a banded score of 1.33)
- Finance management rating of “Green” (equivalent to banded score of 2)
- For the remaining 48 indicators, the total score is 49.5.
- These scores are divided through by their denominator and weighted to produce an overall domain weighted score:

\[
\left( \frac{1.33}{1} \right) \times 25\% + \left( \frac{2}{1} \right) \times 25\% + \left( \frac{49.5}{48} \right) \times 50\% = 1.35
\]

Step 4: setting of rating thresholds

9. Each CCG’s weighted score out of 2 is plotted in ascending order to show the relative distribution across CCGs. Scoring thresholds can then be set in order to assign CCGs to one of the four overall assessment categories.

10. If a CCG is performing relatively well overall, their weighted score would be expected to be greater than 1. If every indicator value for every CCG were within a mid-range of values, not significantly different from its set reference point, each indicator for that CCG would be scored as 1, resulting in an average (mean) weighted score of 1. This therefore represents an intuitive point around which to draw the line between ‘good’ and ‘requires improvement’.

11. In examining the 2017/18 scoring distribution, there was a natural break at 1.45, and a perceptible change in the slope of the scores above this point. This therefore had face validity as a threshold and was selected as the break point between ‘good’ and ‘outstanding’.

12. NHS England’s executives have then applied operational judgement to determine the thresholds that place CCGs into the ‘inadequate’. A CCG is rated as ‘inadequate’ if it has been rated red in both quality of leadership and financial management.

13. This model is also shown visually below:
Deriving the CCG IAF assessment ratings

Step 1:
Indicators selected and calculated
There are 51 indicators in the 2017/18 CCG IAF...
...of which, 50 are included in the end of year rating
(1 indicator, Mental health crisis team provision, is excluded because data are not yet available)

Values are derived for each CCG for each indicator. There is 1 indicator in the Finance domain and 1 for Quality of leadership.

Step 2:
Indicators banded
Measure of deviation ("z-score") calculated for each CCG value. Outlying CCGs assigned to bands with scores of 0 (worst) to 2 (best).

The process is repeated for all 50 available indicators (example scores shown for Anytown CCG).

Step 3:
Weights applied, average score calculated
Weightings set to:
- Finance: 25%
- Leadership: 25%
- The rest: 50%

Bandings for each domain are summed and divided by the count of indicators in that domain, then multiplied by the relevant weighting.

Worked example for Anytown CCG
Overall score calculated for CCG at sum of:
[Finance] 25% * (2 / 1 indicator) +
[Leadership] 25% * (1.333 / 1 indicator) +
[The rest] 50% * (49.5 / 48 indicators)

= score of 1.35
(out of a possible 2)

Step 4:
Scores plotted and rating thresholds set
The distribution of average scores (out of 2) is plotted for all 207 CCGs. The threshold between "Requires Improvement" and "Good" is then set at the mid-point of 1; for "Outstanding" it is set at a natural break at the upper end of the distribution and for "Inadequate" an auto-rule is applied to include all CCGs whose Finance and Leadership ratings are both red. In the example shown, there is a step change at 1.45 which forms the lower threshold for "Outstanding".

In the worked example for Anytown CCG, 1.35 equates to "Good".
2017
Cancer / Maternity Assessment
&
IAF Outcome
# 2017/18 Cancer & Maternity Assessment

<table>
<thead>
<tr>
<th>Clinical Priority Area</th>
<th>Headline Rating 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Maternity</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

## Cancer

<table>
<thead>
<tr>
<th>Indicator value</th>
<th>Benchmark used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancers diagnosed at early stage (2016)</td>
<td>52%</td>
</tr>
<tr>
<td>People with urgent GP referral having definitive treatment for cancer within 62 days of treatment</td>
<td>78.90%</td>
</tr>
<tr>
<td>One-year survival from all cancers</td>
<td>71.2</td>
</tr>
<tr>
<td>Cancer patient experience</td>
<td>8.6 out of 10</td>
</tr>
</tbody>
</table>

## Maternity

<table>
<thead>
<tr>
<th>Indicator value</th>
<th>Benchmark used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillbirth &amp; neonatal mortality rate</td>
<td>3.5 per 1,000 births</td>
</tr>
<tr>
<td>Women’s experience of maternity services</td>
<td>85.3 out of 100</td>
</tr>
<tr>
<td>Choices in maternity services</td>
<td>55.4 out of 100</td>
</tr>
<tr>
<td>Rate of maternal smoking at delivery</td>
<td>14.30%</td>
</tr>
</tbody>
</table>
The CCG met the 7/9 cancer targets for the year 17/18. Failing the 62 day urgent referral to treatment achieving average 78.5% against the 85% target. The 62 day target at June is running at 68%.

- A number of staff have been recruited recently including Clinical Nurse Specialists for Gynaecology, Breast and Colorectal, Cancer Care Co-ordinators for Breast and Urology and Cancer Nurse Specialists to support implementation of the Cancer Recovery Package. There is also increased diagnostic capacity
- Tumour specific meeting between commissioners, local Cancer Unit at IOW Trust, and the mainland tertiary Cancer Centres in PHT and separately with UHSFT have continued, with the most recent focusing on lung cancer. The aims of these meetings are to facilitate discussions between the local Cancer Unit and the mainland Cancer Centres to look at specific tumour site pathways to consider where in the pathway changes could potentially be made to reduce possible delays.
- To help reduce the numbers of DNAs earlier in the pathway, the CCG are supporting Trusts by producing a credit card sized information card for patients, emphasising the importance of attending their appointment and providing a contact number should they not receive their appointment date. Practices that book the appointment at the time of the GP appointment where the suspect diagnosis is made will offer the card to those individuals affected.

<table>
<thead>
<tr>
<th>Cancer Indicator</th>
<th>Target</th>
<th>2017/18 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer – Max 2-week wait for first appointment for patients referred by GP urgently with suspected cancer</td>
<td>93%</td>
<td>97.25%</td>
</tr>
<tr>
<td>Cancer - Max 2-week wait for first appointment for patients referred by GP urgently with breast symptoms</td>
<td>93%</td>
<td>96.24%</td>
</tr>
<tr>
<td>Cancer - Max 31-day wait from diagnosis to first definitive treatment for all cancers</td>
<td>96%</td>
<td>98.51%</td>
</tr>
<tr>
<td>Cancer - Max 31-day wait for a subsequent treatment where the treatment is surgery</td>
<td>94%</td>
<td>99.16%</td>
</tr>
<tr>
<td>Cancer - Max 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime</td>
<td>98%</td>
<td>99.78%</td>
</tr>
<tr>
<td>Cancer - Max 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td>94%</td>
<td>98.32%</td>
</tr>
<tr>
<td>Cancer - Max 62-day wait from referral from an NHS screening service to first definitive treatment all cancers</td>
<td>90%</td>
<td>95.16%</td>
</tr>
<tr>
<td>Cancer – Max 62-days wait from urgent GP referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>78.5%</td>
</tr>
<tr>
<td>Cancer - Max 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patient (all cancers)</td>
<td>86%</td>
<td>51.85%</td>
</tr>
</tbody>
</table>
Maternity

There are two areas where the CCG does not meet the national benchmark performance position in relation to maternity services.

**Choice: (55.4 vs 60.8 per 1,000)**

- The IOW CCG is part of the SHIP Local Maternity System (LMS). The LMS is working as a regional system to improve maternity care, and aims to achieve equity of access and choice across the SHIP system by working across organisational boundaries. Choice is a particular area of focus with further support to improve choice through SHIP Maternity Pioneer: Choice and personalisation. Implementation of personalised care plans across the SHIP systems is a priority.

- The IOW CCG is currently in the process of joining the existing Commissioning Children’s and Maternity Collaborative within the Hampshire and IW CCG Partnership. This is a mature and well-established collaborative arrangement for Commissioning Children’s and Maternity services within Hampshire across the five CCGs. Joining the Children’s & Maternity collaborative will add benefit to extending choice through commissioning at scale across the Hampshire and Isle of Wight geography.

**Maternal smoking at delivery: (14.3% vs 9.7%)**

- The IOW is delivering a project to meet the requirements of the Saving Babies Live Care Bundle. This includes screening for cigarette smoking using carbon monoxide monitors. The project is being undertaken through NHSI Maternal and Neonatal Health Safety Collaborative to complete CO monitoring at every contact, provide weekly support for smoking mothers and provide 12 weeks of NRT. The aim is to use these monitors at all antenatal appointments.
CCG Assurance Framework 2017/18

For the year 2017/18 the overall final position of the CCG published in July 2018 had been rated as ‘Requires Improvement’. This included Leadership rated as Red and Sustainability rated as Amber. (Both Amber in 2016/17)

The table below summarises where the IOW CCG was benchmarked against other CCG’s:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Number of indicators</th>
<th>IOW CCG in best quartile</th>
<th>IOW CCG in worst quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Health</td>
<td>9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Better Care</td>
<td>34</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Sustainability</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Leadership</td>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43</strong></td>
<td><strong>13</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

The following table highlights the indicators where the CCG benchmarked in the best or worst quartile:

**Worst Quartile**

<table>
<thead>
<tr>
<th>Better Health</th>
<th>Better Care</th>
<th>Sustainability</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with Diabetes diagnosed less than 1 year who Attend structured education course</td>
<td>High quality care – acute (CQC)</td>
<td>High quality care – adult social care (CQC)</td>
<td>Staff engagement index (NHS Staff Survey Provider)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Choices in maternity services</td>
<td>Working relationship effectiveness (360 degree survey)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 week RTT standard</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 Day Services - achievement of standards</td>
<td></td>
</tr>
</tbody>
</table>
Areas for improvement (1)

• **Diabetes structured education:**
  – The current service is being evaluated. Early findings suggest that the provision is not responsive to patient need and at a time that is most convenient for this patient cohort.
  – The service evaluation will be finalised and options to ensure improved patient outcomes will be commissioned.

• **High quality care - acute (CQC):**
  – 10 week improvement programmes for all services rated as ‘inadequate’ for safe are underway
  – Second Quality Summit scheduled for September.
  – Improvement programmes are service led and include assurance visits to check progress and evidence of the improvements made. CCG are being invited to participate in assurance visits, alongside other external stakeholders such as Healthwatch and NHSI

• **High quality care – adult social care (CQC):**
  – Through increasingly integrated working arrangements in relation to both quality and commissioning, the CCG is influencing and supporting improvements in the quality of adult social care

• **7 day services achievement of standards:**
  – Standard 2 – current performance 73%:
    • Improving documentation; developing SOP for surgery; embed rolling daily ward round
  – Standard 5 – generally good access
    • Working on improved access to echocardiography and cardiac pacing Out of Hours
  – Standard 6
    • Working on improving interventions for stroke and access to interventional radiology
  – Standard 8
    • Working on Improving handover process and clear identification of patients not requiring review by Consultant
Areas for improvement (2)

• **Choices in maternity services**: - see previous slide

• **18 weeks RTT**:
  – GPs continue to offer/encourage patient choice to centres with lower waiting times; actively working with IW Trust on options to fulfil elective requirements.

• **Staff engagement**:
  – Executive Director of People & team are actively working to improve staff engagement. For example, a series of regular “Have your Say” events. Interim (3-6 month) communications and engagement plan will be finalised by the end of August & an OD plan will be developed over the next few weeks. Both will be implement without delay.

• **Working relationship effectiveness (360)**:
  – Interim (3-6 month) communications and engagement plan will be finalised by the end of August. Work to develop primary care engagement will start in September, and include a “you said, we did” approach in relation to the 360 survey results.
# CCG Assurance Framework 2017/18

## Best Quartile

<table>
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<tr>
<th><strong>Better Health</strong></th>
<th><strong>Better Care</strong></th>
<th><strong>Sustainability</strong></th>
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<td>Hospital bed use following emergency admission</td>
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<td>IAPT Access</td>
<td>Primary care access</td>
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<td>Completeness of the GP learning disability register</td>
<td>% NHS CHC full assessments taking place in acute hospital setting</td>
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<td>Primary care workforce</td>
<td>% of deaths with 3+ emergency admissions in last three months of life</td>
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<td>MH – Out of Area Placements</td>
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Progress against the Workforce, Race, Equality Standard
## Governing Body

### Minutes of the Clinical Senate 12 July 2018

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<td>6 September 2018</td>
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<td>3</td>
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<td>Paper number:</td>
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Minutes of the Clinical Commissioning Group (CCG) Clinical Senate held on **12 July 2018** at 12:30hrs in Carisbrooke Room, CCG HQ, The Apex, St Cross Business Park, Newport, Isle of Wight, PO30 5XW

**PRESENT**
- Dr Benjamin Browne (BB) – Clinical Executive
- Phil Hartwell (PH) – Head of Governance
- Dr Michele Legg (ML) – CCG Chair (CHAIR)
- Melanie Rogers (MR) – Director of Nursing and Quality
- Dr Sarah Westmore (SW) – Clinical Executive

**IN ATTENDANCE:**
- Emma Pugh (EP) - Community Rehab Service/Chief SLT: Adults (Item 6)
- Becky Wastall (BW) – Deputy Chief Finance Officer (Item 7)

**MINUTED BY:**
- Rebecca Berryman (RB) – Governance Support Officer

1. **Apologies for Absence**

   - Apologies were received from Cabrini Salter, Tracy Savage and Timothy Whelan.

2. **Declarations of Interest**

   - The Clinical Senate received paper CS18-001 Declarations of Interest.

   - SW declared that her sister is employed by the Isle of Wight NHS Trust. A new form would be sent to her to update her declarations.

   - BB confirmed that his wife still worked for Grove House Surgery.

   The Clinical Senate received the Declarations of Interest.

   **ACTION:** SW to update her declarations of interest form. SW/RB

3. **Clinical Senate Terms of Reference**

   - The Clinical Senate received paper CS18-002 Clinical Senate Terms of Reference. It was agreed that the purpose of the Clinical Senate was to be a forum to allow discussion of clinical commissioning decisions with a pool of clinicians, to allow clinical input throughout the process.

   - It was highlighted that this forum is not designed to replace the Clinical Executive or the Clinical Executive Seminar. It needs to be a clinical discussion forum.

   - With regard to membership, it was agreed that it should be flexible to include CCG Clinicians and CCG Clinical Leads. ML also asked if PH could be a member of the meeting, this was agreed.

   - As the forum is not a decision making forum it was agreed there was no need for quoracy to be included within the Terms of Reference.

   - It was queried where Locality meeting minutes should be presented. It was suggested that discussions took place with Tracy Savage regarding this. In addition discussion took place as to where SHIP Priority Committee policies should be reviewed. It was suggested that this may be through a quality route.

   The Clinical Senate received and approved the Clinical Senate Terms of Reference, subject to
4. Confirmation the Meeting is Quorate
18-004 As agreed in the Terms of Reference discussion it was agreed there was no quoracy required as the forum was not a decision making forum.

5. Introductions / Format of Meeting
18-005 The Clinical Senate received introductions and discussed the format of the Clinical Senate meetings. It was agreed that the purpose of the Clinical Senate forum was to allow the discussion of clinical commissioning decisions with a pool of clinicians, to allow clinical input throughout the process.

The Clinical Senate noted the introductions and format of the meeting.

6. Frailty Pathway
18-006 The Clinical Senate received paper CS18-003 Frailty Pathway presented by Emma Pugh, Community Rehab Service/Chief SLT (IOW NHS Trust).

As a result of the Care Quality Commission (CQC) Report the Frailty Pathway was identified as needing high impact change. A workshop to refresh the pathway took place which included representation from Adult Social Care, the Voluntary Sector and Health. There was no GP input as a result the late notice given of the event.

Discussion took place regarding some of the services that were in place including a Falls Clinic and some new initiatives. These included ‘my health’ an app validated by NHS England which puts together care plans, nutrition advice and exercise programmes based on the individual patient’s requirements.

It was highlighted that GPs need to be involved and aware of the developments in relation to the Falls Pathway for example referring to Falls Clinics. It was agreed that an email out to all GPs would be sent to give the update.

EP queried what the next steps were to operationalise the Frailty Pathway. It was suggested that the Frailty Pathway is presented to the Membership Locality all Island event and the individual Membership Locality Meetings. RB to send EP contact details for the Membership Locality meetings.

The Clinical Senate noted the Frailty Pathway.

ACTION: Email to all GPs to give an update in relation to the Falls Pathway. Contact details for Membership Locality Meetings to be sent to Emma Pugh. Emma Pugh to make contact to attend Membership Locality Meetings, both all Island and individual meetings.

7. Finance Tutorial
18-007 The Clinical Senate received a Finance update from BW. ML asked BW if she would be prepared to attend on a monthly basis to give updates on finance to improve the Clinical Senate’s
The update highlighted the following:

- The system financial deficit was £47m.
- The contract with the IOW NHS Trust is still not signed.
- The CCG have a control total deficit of £5m.
- The CCG are required to have a plan in place to clear the £5m deficit.
- There is £4.4m of unidentified Quality, Innovation, Productivity and Prevention (QIPP). It was agreed that the QIPP is every department in the CCG’s responsibility. It was proposed that each area should have a 5% QIPP target in place and if this was not achievable it needs to be demonstrated why.

The Clinical Senate noted the Finance Tutorial.

8. **Clinical Development for GPs / Clinical Leads**
18-008 Due to time constraints on the agenda it was agreed this discussion would be carried forward to the August 2018 Clinical Senate.

9. **Any Other Urgent Business**
18-009 There was no any other urgent business discussed.

10. **Date of Next Meeting:**
18-010 Thursday 09 August 2018, 12.30 – 15.30hrs, Carisbrooke Room, Block A The Apex, St Cross Business Park, Newport

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**Circulation:**

**Members**
- Dr Benjamin Browne – Clinical Executive
- Dr Phil Hartwell – Head of Governance
- Dr Michele Legg – CCG Chair
- Dr Myrto Kaklamanou – Clinical Lead for Primary Care
- Melanie Rogers – Director of Nursing and Quality
- Dr Cabrini Salter – Clinical Executive
- Dr Sarah Westmore – Clinical Executive
- Dr Timothy Whelan – Clinical Executive

**In attendance:**
- Rebecca Berryman - Governance Support Officer (Notes)

**For Information (Agenda):**

**For Information (Minutes):**

# Governing Body

## Minutes of the Finance, Performance and Planning Committee

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<tr>
<th>Sponsor:</th>
<th>Loretta Outhwaite, Deputy Chief Officer</th>
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<td>Minutes of the Finance, Performance and Planning Committee held on 28 June 2018</td>
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| Date of Meeting: | 6 September 2018 |
| Agenda Item: | 8.2 |
| Paper number: | GB18-052 |
Finance, Performance and Planning Committee

Minutes of the Finance, Performance and Planning Committee held on Thursday 28 June 2018, 15:00 to 16:30hrs, CCG HQ, Carisbrooke Room.

PRESENT: Martyn Davies – Lay Advisor – Governance (Chair)
Michele Legg – CCG Chair
Lesley Macleod – Interim Chief Finance Officer (dialled in)
Loretta Outhwaite – Deputy Chief Officer
Melanie Rogers – Director of Nursing and Quality

IN ATTENDANCE: Phil Hartwell – Head of Governance

MINUTED BY: Rebecca Berryman - Governance Support Officer

1. Apologies for absence
   18-001 Apologies were received from Gillian Baker, Benjamin Browne, Cabrini Salter, Jonathan Smith, Sarah Westmore, Timothy Whelan and Jonathan Smith.

2. Declarations of Interest (If applicable)
   18-002 The Finance, Performance and Planning Committee received paper FP18-001 Declarations of Interest. No new declarations of interest were made or raised in relation to agenda items.

   The Finance, Performance and Planning Committee received the Declarations of Interest.

3. Confirmation the Meeting is Quorate
   18-003 Confirmed.

4. Introductions
   18-004 All were welcomed to the inaugural Finance, Performance and Planning Committee.

5. Terms of Reference
   18-005 The Finance, Performance and Planning Committee received paper FP18-002 Terms of Reference.

   Discussion took place regarding the membership of the committee. With regard to the two lay members on the committee it was agreed one would be MD and David Grist, Lay Advisor to the Audit Committee would be approached to see if he would be available to attend.

   The terms of reference states three GP Members from the Governing Body. The CCG has 5
GPs on the Governing Body until the end of July and four thereafter. It was agreed to invite all GPs in the first instance to see who would have capacity to attend. ML agreed to discuss attendance at the Committee with GPs.

It was noted that in section 4.4 b) the Head of Procurement was listed as being in attendance. It was agreed that the Head of Procurement would only need to attend as required.

It was agreed the meetings would be held monthly.

The Finance, Performance and Planning Committee approved the Terms of Reference.

| ACTION: | MD to discuss with David Grist, Lay Advisor to the Audit Committee whether he is available to be a member of the Finance, Performance and Planning Committee. | MD |
| ML to discuss attendance at the Finance, Performance and Planning Committee with the GP members from the Governing Body. | ML |
| Head of Procurement to be in attendance as required to be updated in the Finance, Performance and Planning Committee Terms of Reference. | PH/RB |

6. Confirmation of Membership and Chair

18-006 MD agreed to Chair the inaugural meeting; however it wasn’t clear if he was conflicted as Audit Chair. PH agreed to confirm with the Hampshire Partnership who Chairs their Finance and Performance Committee. It was agreed that MD would continue to Chair the committee with a view to review this in a few meetings time.

| ACTION: | To confirm with the Hampshire Partnership who Chairs their Finance and Performance Committee. Add review of Finance Committee Chair to a future Finance, Performance and Planning Committee agenda. | PH |
| RB |


18-007 The Finance, Performance and Planning Committee received a presentation Financial Recovery Plan (FRP) for NHS England submission. It was noted that the Isle of Wight CCG has a Quality, Innovation, Productivity and Prevention (QIPP) target for 2018/19 of £11.2m with a £4.5m unidentified. It was also noted that the Governing Body have not signed on the Financial Plan and Budget.

It was queried how the joint Financial Recovery Board with the Isle of Wight NHS Trust was progressing. It was confirmed that dates have been shared with the CCG and LM is hoping to attend on Monday 2 July 2018 to observe the Trust meeting. Ideally the Board will include the Isle of Wight Council. It is hoped to have the joint Board in place by the end of
September 2018.

Discussion took place regarding the unsigned Contract with the Isle of Wight NHS Trust. It has been proposed that the CCG splits the £6.5m risk with the Trust. It was queried whether this had been planned for in the FRP. It was confirmed that it had been considered but the figures would need finessing in relation to this as it would mean the CCG would have no reserves left. If any underspends occur during the year, it would need to be carefully managed with regard to the rationale if they are used towards the bottom line.

The focus of the Financial Recovery Plan was the slide indicating the best, worst and most likely financial year end position. It was agreed that it was felt that the plan should reflect the £5m deficit control total as being the most likely position indicating the worst would be c£10m. It was also agreed that the CCG should propose to split the contract with the Trust in order to move things on. It was also highlighted that the CCG needs to have some narrative to indicate the challenge the CCG faces in order to be open and transparent as well as acknowledging the Capacity and Capability Review.

It was highlighted that the entire organisation need to take ownership of risk, and take note there is an urgency regarding savings.


8. Finance Report

The Finance, Performance and Planning Committee received paper FP18-004 Finance Month 2 Report. At month 2 the CCG is £77k off-plan. It was agreed that activity needs to be closely monitored and it would be beneficial for the Trust and CCG to share their financial plans.

The Finance, Performance and Planning Committee noted the Finance Report

9. Performance Report

The Finance, Performance and Planning Committee received paper FP18-005 Performance Report. The more concise report was an improvement on previous versions. It was agreed that the data and analysis was important for future reports.

It was noted that there was new information provided that hadn’t been included in previous reports. Discussion took place regarding what to include in the report to reduce duplication across committees. Discussion also took place regarding the role of the committee in relation to performance. It was agreed that it will need to be triangulated with risk and finance.
With regard to Ambulance MD commented that he was pleased to see that the new Ambulance Standards were now being reported, showing an improvement of the Ambulance service. This was also recognised after the Care Quality Commission (CQC) report highlighted that the service is no longer rated inadequate. It was highlighted that at the next Governing Body meeting on 19 July a presentation relating to Ambulance is scheduled. It was suggested that Bob Williams, Advisor to the Isle of Wight NHS Trust – Ambulance was invited to present to the Governing Body the improvements that are being made to Ambulance at the Trust. ML agreed to invite Bob Williams to the meeting.

The Finance, Performance and Planning Committee noted the Performance Report

**ACTION:** ML to invite Bob Williams, Advisor to the Isle of Wight NHS Trust – Ambulance for the Ambulance presentation scheduled at the Governing Body on 19 July 2018.

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10. **Any Other Business**

18-010 **Mental Health Procurement Options Paper** - a late paper was requested to come to the Finance, Performance and Planning Committee. MD declined to take the paper on the basis of it being late and the front sheet not being signed off by the finance, quality and contracts team.

**Future Agenda Items** – it was agreed that a Quality, Innovation, Productivity and Prevention (QIPP) detailed update would be presented to the next meeting.

**ACTION:** QIPP detailed update to be added to the next Finance, Planning and Performance Committee agenda.

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11. **Date and Time of the Next Meeting:**

18-011 It was agreed the next meeting would be Thursday 26th July 2018, 15:00-16:30, Carisbrooke Room, CCG HQ, Block A, The Apex, St Cross Business Park, Newport IOW
Cabrini Salter – Clinical Executive
Sarah Westmore – Clinical Executive
Timothy Whelan – Clinical Executive
TBC- Lay Member
## Governing Body

### Minutes of the Isle of Wight Primary Care Commissioning Committee 14 June 2018

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<td>Agenda Item:</td>
<td><strong>8.3</strong> Paper number: GB18-053</td>
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Isle of Wight Primary Care Commissioning Committee

Minutes of the Clinical Commissioning Group (CCG) Isle of Wight Primary Care Committee held on Thursday 14 June 2018 at 14:00hrs at Northwood House, Ward Avenue, Cowes, Isle of Wight PO31 8AZ.

PRESENT: Laurence Taylor (LT) – Lay Member Independent (Chair)  
Loretta Outhwaite (LO) – Deputy Chief Officer  
Melanie Rogers (MR) – Director of Nursing and Quality (Deputy Chair)  
Tracy Savage (TR) – Deputy Director of Quality and Head of Medicines Optimisation

IN ATTENDANCE: Dr Myrto Kaklamanou (MK) – GP Clinical Lead  
Matthew Leek (ML) – Finance Manager  
Chris Orchin (CO) – Healthwatch  
Steve Sollitt (SS) – Head of Primary Care  
Dr Timothy Whelan (TW) – Deputy Clinical Chair

MINUTED BY: Rebecca Berryman (RB) – Governance Support Officer

1. Introductions and Apologies for Absence  
18-001 Apologies for absence were received from Lesley Macleod (LM)

It was confirmed that the committee was quorate. It was noted that TS is formally acting up in the Assistant Director of Primary Care role whilst Caroline Morris is undertaking work relating to the Acute Services Redesign (ASR) for a period of 6 months. TS was welcomed as a member of the committee.

2. Declarations of Interest  
18-002 The Isle of Wight Primary Care Commissioning Committee received paper PC18-001 Declarations of Interest. There were no new declarations made. It was agreed that to improve transparency the Declarations of Interest paper would be updated to take into account both members and those in attendance.

With regard to items on the agenda the following was declared: TW and MK declared an interest in item 12 as they are partners at Carisbrooke Health Centre and Dower House Surgery and the Prescription Ordering Direct (POD) is proposed to be established in the Newport area affecting these practices. It was agreed that they could remain in the room and partake in the discussion.

The Isle of Wight Primary Care Commissioning Committee noted the Declaration of Interests.

| ACTION: Declaration of Interest paper to be updated to include members and those in attendance at the Primary Care Commissioning Committee. |

Page 2 of 9
3. Minutes of the Isle of Wight Primary Care Committee 08 March 2018

The Isle of Wight Primary Care Commissioning Committee received paper PC18-002 Minutes of the Isle of Wight Primary Care Commissioning Committee dated 08 March 2018. These were approved as a true and accurate record.

It was queried with regard to p.4 Performance Report whether this had been circulated. It was confirmed that it hadn’t but a new style Performance Report was on the agenda and being presented to the committee.

The Isle of Wight Primary Care Commissioning Committee approved the Minutes from 08 March 2018.

4. Matters Arising

i. Schedule of Actions from 08 March 2018

The Isle of Wight Primary Care Commissioning Committee received paper PC18-003 Schedule of Actions from 08 March 2018. The following actions were discussed:

- 17-023 – Leg Ulcer Local Service Proposal – an update will be presented to the committee in September. MR confirmed that Island-wide Tissue Viability work is ongoing looking at pathways for patients throughout the healthcare system – action to remain open.
- 17-064 – Primary Care Performance Report – on the agenda – action closed.
- 17-071 – Winter Resilience – now known as Seasonal Resilience to be added to the September 2018 agenda – action to remain open.

The Isle of Wight Primary Care Commissioning Committee received the Schedule of Actions from 08 March 2018.

5. Primary Care Update

The Isle of Wight Primary Care Commissioning Committee received a verbal update from LO. The update highlighted the following:

- Clinical Engagement – findings from the CCG’s recent Capacity and Capability Review highlighted the need for the CCG to be more clinically led and to improve clinical engagement with Primary Care. Hampshire and Isle of Wight CCG Partnership colleagues are giving support to take this forward.
- 360 Stakeholder Survey – has highlighted material deterioration of Primary Care’s confidence in the CCG, confirming the findings of the Capacity and Capability Review.
- Communications and Engagement Plan – is being developed and will have a clear focus on Primary Care engagement and involvement.
- All Island Locality Meeting – the first meeting has now taken place, the plan is to have one all Island locality meeting and individual locality meetings every other month. The feedback from the All Island meeting was positive and will help to improve engagement with Primary Care. It was noted that the Half Day Practice closure events are going to be re-established.
• Practice Resilience – national schemes that could support local practices are being looked into.

• Primary Care Workforce Meeting – took place earlier in the week, the meeting had positive feedback. It was noted that as well as GPs it was crucial to consider the wider workforce. It was agreed to source additional workforce figure data relating to administrative, nursing and wider Primary Care workforce.

The Isle of Wight Primary Care Commissioning Committee noted the Primary Care Update.

**ACTION:** Wider workforce figure data to be obtained including administrative and nursing.  

**Items for Discussion/Assurance**

6. Five Year Forward View

18-006 The Isle of Wight Primary Care Commissioning Committee received a verbal update from SS. The update highlighted the following:

- **7 Day Working** – Carisbrooke Health Centre commences extended hours this week. This increases the number of appointments and localities available to patients Island wide. Sessions continue to be well attended, however the number of ‘do not attends’ (DNA) was 10% for Saturday appointments, which is higher than it should be.

- **E-Consultation** – 2 practices are implementing E-Consultation with another 2 practices commencing soon.

- **Training** – Active Signposting for Reception staff has been rolled out and is nearly completed.

- **Workflow Optimisation** – 12 out of 16 practices have been trained.

MR commented that there should be ongoing evaluation of the 7 day service and E-Consultation, as it is important to measure patient experience. With regard to Signposting it would be useful to confirm the level of Safeguarding training Reception staff have received. This was agreed to be included in future Five Year Forward View reports.

MK commented that in relation to Workflow Optimisation it was important that Secondary Care colleagues were aware what is in place. LO agreed to discuss this with the Executive Director of Clinical Improvement at the Isle of Wight NHS Trust.

The Isle of Wight Primary Care Commissioning Committee noted the Five Year Forward View.

**ACTION:** Patient experience / evaluation to be included in future Five Year Forward View Reports.  

To establish the level of Safeguarding Training Practice Reception staff receive.  

LO to make Secondary Care colleagues aware of Workflow Optimisation taking place in Primary Care via the Executive Director of Clinical Improvement at the Isle of Wight NHS Trust.
7. **Primary Care Performance Report (Quality/Performance)**

The Isle of Wight Primary Care Commissioning Committee received paper PC18-004 presented by TS and SS. Discussion took place regarding the indicators within the report and whether there may be some duplication across other committees. It was noted that the indicators came from discussions held at the Primary Care Commissioning Committee Seminar in September 2017. The report will be iterative and feedback is welcomed. It was highlighted that the CQC domains may be useful measurements as these will also be meaningful for GP Practices.

The report presented to the committee highlighted the following:
- **C. Difficile** – it was noted that trajectories are attributed to the hospital or community. The figures presented relate to the community.
- **Medication** – there has been a downward trend of the prescribing of hypnotics and opioids.
- **Serious Incidents** – 1 has been reported from Primary Care.
- **Referral to Treatment** – waiting times are increasing.
- **A&E Attendances** – have seen an increase. An audit is taking place to look in to the increase.

The Isle of Wight Primary Care Commissioning Committee noted the Primary Care Performance Report for Quality and Performance.

**ACTION:** Performance Report to be further developed using the committee’s feedback.  SS

8. **Finance Report**

The Isle of Wight Primary Care Commissioning Committee received paper PC18-005 Finance Report presented by ML. The report highlighted the following:

**Primary Care Budget – 2017/18 Year End Position**

Underspend within Primary Care service is approximately £2.1m. This is mainly due to a £1m underspend within delegated budget lines and slippage against the GP Access Fund (£697k).

**Primary Care Delegated – 2017/18 Year End Position**

Delegated funding included £458k non-recurrent Premises allocations from NHSE. Underspend of £401k within delegated budgets is primarily due to Premises Other (£275k) and the Capital Grants for Primary Care Improvements (£119k).

**Prescribing Budgets – 2017/18 Year End Position**

Prescribing budgets shows overspend of £161k. This overspend is due to estimates for 16/17 spend (accruals) costing less than anticipated across GP Prescribing (£323k). The annual budget on GP Prescribing was set with a QIPP target (savings) of £1.4m removed. Schemes put in place to support the delivery of the QIPP between the Medicines Optimisation Team and General Practice enabled this to be delivered in year. Delivery of the QIPP became more...
challenging as nationally NHS England adjusted the CCG’s allocation for the benefit of national price reductions for Category M drugs. The budget line for Non GP Prescribing costs reflected this overspend by £200k. The adjustment was returned to all CCG’s to support the financial position at year end, leading to £4k underspend at year end.

LO highlighted for 2018/19 that the CCG will need to have plans developed to enact quickly should any underspend or additional allocations materialise during a financial year. The committee noted that a paper is being developed on to explain in more detail how funding was spent in the past year. This is to make the information more open and transparent and to increase awareness and understanding.

The Isle of Wight Primary Care Commissioning Committee noted the Finance Report.

9. Risk Register (Primary Care)

The Isle of Wight Primary Care Commissioning Committee received paper PC18-006 Risk Register. The following was discussed:

- **9 - 7 Day Access** – should refer to implementing and sustaining the national requirement for GP 7 Day Access.
- **27 Primary Care Resilience** – national and regional support is being pursued to improve primary care resilience.
- **25 Safeguarding in Primary Care** – the aim is for an Island GP to take on the Safeguarding GP lead role. Funding is also being sought to continue the Primary Care Safeguarding Nurse role which has had a significant impact in Primary Care.
- **7 GP Out of Hours** – the Community and Urgent Care Commissioning Team are working to ensure a value for money and sustainable service, as the contract for this service is up for renewal soon.
- **CI 6 Anti-coagulation Service** – new contract arrangements are moving forward at pace.

The Isle of Wight Primary Care Commissioning Committee noted the Risk Register.

**ACTION:** Risk 9 – 7 Day Access to refer to implementing and sustaining the national requirement for GP 7 Day Access.  

LO/TS

10. Primary Care Quality Network

The Isle of Wight Primary Care Commissioning Committee received paper PC18-007 Primary Care Quality Network presented by TS. It was confirmed the Network would report to the Primary Care Commissioning Committee and the terms of reference were currently being developed.

The Isle of Wight Primary Care Commissioning Committee noted the Primary Care Quality Network.
The Isle of Wight Primary Care Commissioning Committee received paper PC18-008 Pharmacy Integration Fund – Medicines Optimisation in Care Homes presented by TS. NHS England has made funding available to each STP area to support improved medicines optimisation in care homes. Each Local Delivery System has produced a plan tailored to the needs and priorities of their care home population and which builds on the established MDT infrastructure in each area to deliver an improvement in outputs and outcomes.

The committee welcomed this very positive piece of work, noting the difference it will make to patient care.

The Isle of Wight Primary Care Commissioning Committee noted the Pharmacy Integration Fund – Medicines Optimisation in Care Homes.

**Items for Decision**

**12. Prescription Ordering Direct (POD) in Primary Care**

TW and MK declared an interest as they are both partners at Carisbrooke Health Centre and Dower House Surgery and the Prescription Ordering Direct (POD) is proposed to be established in the Newport area affecting these practices. It was agreed that they could remain in the room and partake in the discussion. The voting members of the committee were reminded to take this in to consideration when making a decision.

The Isle of Wight Primary Care Commissioning Committee received paper PC18-009 Prescription Ordering Direct (POD) in Primary Care. Funding has been made available from NHS England to support practice transformation. NHSE have promoted the use of 10 high impact actions that will release GP time to care. They are designed to help practices release capacity and work together at scale, enable self-care, introduce new technologies, and make best use of the wider workforce, so freeing up GP time and improving access to services. It is proposed that a ‘Prescription Ordering Direct’ (POD) is established in the Newport area.

Prescription Ordering Direct (POD) follows the call-centre model where patients from more than one GP practice telephone a central location to request repeat prescriptions. The POD will provide an additional method for patients to order their repeat prescriptions enabling increased patient empowerment and the ability to take control of their own repeat medication requirements.

Evidence from Telford and Wrekin and Coventry and Rugby CCGs is that a reduction in prescribing costs of 6% has been achieved due to reduced waste, reductions in over-ordering...
and patients better understanding their long-term conditions and how to manage them.

MR highlighted the need to be cautious in being equitable to other practices in relation to choosing where the initiative is implemented. The committee agreed that before a decision is made an email should be sent to the other localities to ensure they are aware and have no objections. A decision can then be taken outside of the meeting by the committee.

The Isle of Wight Primary Care Commissioning Committee did not approve the Prescription Ordering Direct (POD) in Primary Care.

**ACTION:** An email to North and East and South Localities to ensure they are aware of the Prescription Ordering Direct (POD) proposal and have no objections.

**TS**

13. **Minutes to Receive – For Noting**
18-013 The Isle of Wight Primary Care Commissioning Committee received paper PC18-010 Primary Care Operational Group (PCOG) minutes and PC18-011 Primary Care Prescribing Committee Minutes.

The Isle of Primary Care Commissioning Committee noted the Primary Care Operational Group Minutes and Primary Care Prescribing Committee Minutes.

14. **Any Other Urgent Business**
18-014 There was no any other urgent business.

15. **Motion to exclude the Press and Public**
18-015 The Chair of the Isle of Wight Primary Care Commissioning Committee read the following statement:

‘that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’, (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)

16. **Date of Next Meeting:**
18-016 Thursday 27 September 2018, 14:00-16:00hrs, Northwood House, Ward Avenue, Cowes, Isle of Wight PO31 8AZ
<table>
<thead>
<tr>
<th>Members</th>
<th>In attendance:</th>
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<tr>
<td>Laurence Taylor – Governing Body Lay Member (Chair) – Director of Public Health, Local Authority Melanie Rogers – CCG Director of Quality and Nursing &amp; Governing Body Nurse Loretta Outhwaite – Deputy Chief Officer Lesley MacLeod - Interim Chief Finance Officer Tracy Savage - Deputy Director of Quality and Head of Medicines Optimisation</td>
<td>Rebecca Berryman – Governance Support Officer (Notes) Dr Myrto Kaklamanou – GP Lead for Primary Care Steve Sollitt – Head of Primary Care Matthew Leek – Finance Manager – Non Acute Representative of the Health and Wellbeing Board Chris Orchin – Healthwatch Locality Manager Representative from NHS England (NHSE) Dr Timothy Whelan – Deputy Clinical Chair</td>
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