NHS
Isle of Wight
NHS Trust

Annual Report and Accounts

2017/18

Getting to Good

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Getting to Good

Getting to Good staff guide launched

We launched a Getting to Good staff guide, a pocket-sized resource providing helpful information about the Trust's improvement journey. The guide was designed to support staff so they can play their part in delivering improvements for the benefit of patients and colleagues, and work towards achieving a 'Good' Care Quality Commission rating by 2020.

For further information about this and the 'Getting to Good' programme visit **www.gettingtogood.net**.

Overview

Welcome to our Annual report and Accounts for 2017/18. This document details our recent progress in, and continuing journey towards, delivering our vision of providing quality care for everyone, every time. The national, regional, and local context are set out in some detail on pages 14-16. In line with this context, in 2017/18 the Trust faced a number of quality, performance, and financial challenges, and also delivered some successes.

As in 2016/17, despite the efforts of all staff, performance against some of our access and outcomes targets fluctuated in 2017/18. The island has an older population with increased and sometimes complex medical needs, and there are capacity issues within the wider island health economy. In addition, the Trust continues to deal with changes in demand, systemic issues, and financial constraints. These factors have a direct impact on the Trust's ability to deliver against elective and non-elective key performance targets.

The Trust was inspected by the Care Quality Commission (CQC) in November 2016 with further inspections in early 2017. In April 2017 the Trust's overall CQC rating was downgraded to 'Inadequate'. This rating started what has been a year of transition for the Trust. A substantial programme of change has been initiated and is already underway. NHS Improvement, the Trust's regulator, is providing enhanced support delivering additional capability and capacity to the Trust as part of its oversight role. The Trust was subject to a further inspection of all of its services in January 2018, and the results of this inspection are awaited.

Notwithstanding the additional challenges, work continued to address the future sustainability of the Trust and its services. Together with partners including the Local Authority and the Isle of Wight Clinical Commissioning Group (CCG) progress has continued on the My Life a Full Life (MLAFL) concept of care. The Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) published plans for Hampshire and the Isle of Wight endorsing the concept, which aims at improved health, wellbeing, and care of the population, improving care and quality outcomes, delivering appropriate care at home and in the community, and making health and wellbeing clinically and financially sustainable. The progress on this concept of care over the last three years reflects the NHS's national Five Year Forward View (5YFV) aspirations through its triple aims – a better patient experience, better population health, and more effective use of resources.

2017/18 has been demanding for all who work in the Trust either as employees or volunteers. We would like to thank everyone who worked at the Trust during the year for their very hard work and commitment to the Trust's patients and service users.

The coming years are likely to be very challenging too. We will need to work ever more closely with our mainland and island partners to redesign care, and to address the issues raised by the CQC. In 2018/19 we will lay the foundations for a sustainable model of care for the island, and work towards our aim of getting to 'Good' by 2020.

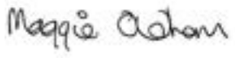
Vaughan Thomas
Chair

Maggie Oldham
Chief Executive Officer
24 May 2018

The responsibilities of an ‘Accountable Officer’

I have been with the Trust since the 1 May 2017. My responsibilities as Accountable Officer are set out in a memorandum (financial governance) for Chief Executives of NHS Trusts. In essence, I am responsible for the propriety and regularity of public finances in the Trust; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; for the efficient and effective use of all the resources in my charge; and for ensuring that officers of the Trust abide by these.

I am responsible for signing accounts that must disclose a true and fair view of the Trust’s income and expenditure, cash flows, gains and losses, and of its state of affairs. I sign these accounts, along with the Executive Director of Finance, on behalf of the Board. Although I have only been with the Trust for a short period of time, as far as I am aware there is no relevant audit information of which the Trust’s auditors are unaware. I have taken all steps to make myself aware of any relevant audit information, and to establish that the Trust’s auditors are aware of that information.



Maggie Oldham
Chief Executive Officer
24 May 2018

Getting to Good

New training for community nurses to improve care for patients

Community nurses at the Trust have been given new, individualised training in order to help them to better meet the health needs of our local community. The training comes in the wake of a serious incident at the Trust which triggered an external investigation. The team were supported by Health Education England to undertake a review into the way in which community nurses work, which identified issues in the clinical standards of community nurses, and recommended a range of training programmes to help transform the standard of care provided.

Funded by Portsmouth University, the training is bespoke for Isle of Wight community nurses. It covers a number of areas including: pride and ownership of work; professionalism and accountability, as well as observation and environment, where staff are trained to undertake a full assessment of a patient’s care setting, and make adjustments to ensure they provide the best possible care.

The training programme was rolled out in December 2017 and saw community nurses in the three localities on the Isle of Wight take three training sessions each.

Trust profile

The Isle of Wight NHS Trust is unique in the NHS: we are the only organisation to have integrated community, ambulance, mental health and acute services. Designing a single organisational operational plan therefore presents greater challenges than those seen by traditional NHS providers.

The financial year 2017/18 has been an exceptionally challenging year for the Trust, something that is reflected in the delivery of quality, access and financial performance standards. The Trust was rated ‘inadequate’ following a 2016 inspection by the Care Quality Commission (CQC) and placed into special measures for quality reasons in April 2017.

In response to the CQC rating, a Quality Improvement Plan (QIP) has been developed, aligned with the Trust’s Integrated Improvement Framework (IIF). The IIF is our vehicle for change. It sets out our immediate priorities in order to see real, and rapid, improvement and establishes a long term plan that details everything we need to do to develop a culture of continuous improvement. Our improvement journey is about “Getting to Good” by 2020 and is designed to effectively engage staff to ensure that we are all focused on the priority work that improves care and safety for the people we serve.

The Trust’s financial position has deteriorated during the year and we are now subject to enhanced financial oversight by NHS Improvement. Targeted support has been provided to develop a financial recovery plan (FRP) and this has been focused on effective financial stewardship, securing income and identifying and implementing efficiency and cost reduction opportunities. Longer term, the FRP will be part of a wider change programme that delivers financial, quality and operational sustainability.

Recruitment and retention has remained a significant issue for the Trust and this has continued to impact on our financial position. We have a firm focus on ensuring we can attract key staff, to not only reduce agency spend, but also to enhance the quality and efficiency of the services we provide.

Both the Trust and the Isle of Wight CCG have seen changes in leadership. There have been significant changes to the Trust’s Board and Executive Team during 2017/18, including a new Chairman, Chief Executive Officer and Director of Quality. There have also been a number of interim roles within the Executive Team including: the Turnaround Chief Financial Officer; Medical Director and Chief Nurse, together with additional senior support. Following a Board leadership review by Carnall Farrar, and the appointment of a substantive Chief Executive Officer, a new executive structure that is fit for purpose has been implemented to ensure the breadth and complexity of the Trust is represented at Board level.

Significant work has been undertaken with partners to address the sustainability of acute services through the Acute Services Redesign (ASR) programme. A preferred option has been recommended and this will go out to public consultation during 2019/20, following due diligence by NHS Improvement and NHS England. We have also agreed a Local Care Plan (LCP) through the Local Care Board, which informs our direction of travel for on-island services.

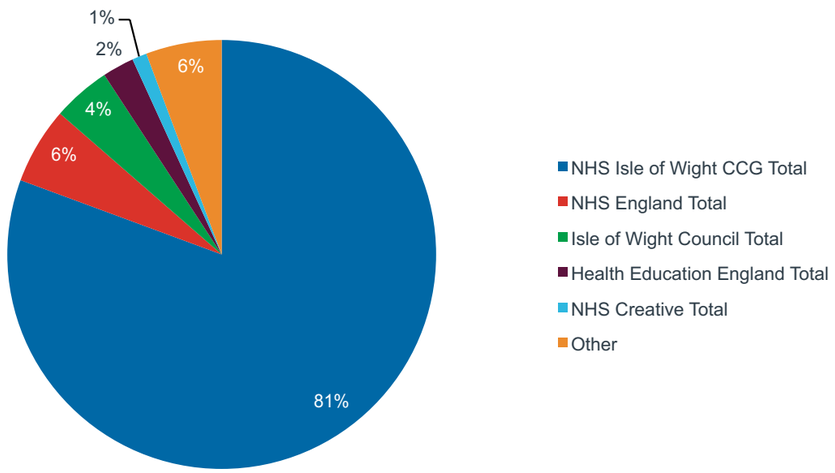
Our service profile

Income

The Trust's coterminous relationship with the Isle of Wight CCG and Isle of Wight Council is illustrated by the Trust's principal income streams outlined below:

Income Source	2015/16 £m	2016/17 £m	2017/18 £m
NHS Isle of Wight CCG Total	134.7	135.2	138.2
NHS England Total	11.6	12.3	9.9
Isle of Wight Council Total	5.9	6.6	7.5
Health Education England Total	3.7	3.8	4.1
NHS Creative Total	2.6	2.5	1.9
Other	11.8	10.7	9.8
Total	**170.3**	**171.1**	**171.4**

Income Source 2017/18 £m



Demand

Forecast demand for 2018/19 compared to actual for 2017/18 is expected to rise in all but two areas – walk-in attendances and some outpatient appointments.

Activity Demand Plan	15/16	16/17	Growth	17/18 (FOT)*	Growth	18/19	Growth
Inpatient - Planned (spells)	10,296	12,827	24.6%	12,222	-4.7%	12,338	0.9%
Inpatient - Emergency (Spells)	13,651	13,703	0.4%	14,414	5.2%	14,582	1.2%
Outpatient (Appointments)	133,582	131,050	-1.9%	129,043	-1.5%	130,333	1.0%
111 (Calls)	56,798	67,771	19.3%	70,873	4.6%	77,961	10.0%
Ambulance (Calls)	24,355	27,760	14.0%	28,915	4.2%	29,891	3.4%
A&E (Attendances)	43,776	42,896	-2.0%	46,622	8.7%	48,487	4.0%
Walk In Centre (Attendances)	3,855	3,554	-7.8%	1,848	-48.0%	1,756	-5.0%
Critical Care (Bed Days)	3,657	3,928	7.4%	3,310	-15.7%	3,347	1.1%
Pathology (Sets)	1,335,483	1,398,185	4.7%	1,393,114	-0.4%	1,423,702	2.2%
Imaging (Requests)	111,988	113,994	1.8%	114,989	0.9%	118,503	3.1%
Other Outpatients (Appointments)	36,520	33,438	-8.4%	31,457	-5.9%	30,470	-3.1%
Community - Nurse (Contacts)	124,729	117,251	-6.0%	127,716	8.9%	131,547	3.0%
Community - AHP (Contacts)	90,357	96,035	6.3%	93,645	-2.5%	96,454	3.0%
Community - Other (Contacts)	1,742	1,414	-18.9%	542	-61.6%	559	3.0%
Mental Health Referrals	6,465	5,982	-7.5%	6,072	1.5%	6,163	1.5%

Notes to the Activity Demand Plan table

* Forecast outturn

Staff

Staff are our largest asset and the area of greatest expenditure

Average Staff Numbers audited (WTE basis)	Permanent	Other	2017/18 TOTAL	2016/17 TOTAL
Medical and dental	212	59	271	253
Ambulance staff	104	0	104	98
Administration and estates	646	26	672	640
Healthcare assistants and other support staff	597	105	702	705
Nursing, midwifery and health visiting staff	767	136	903	879
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	353	9	362	374
Healthcare Science Staff	0	0	0	0
Social Care Staff	0	0	0	0
Agency and contract staff	0	0	0	0
Bank staff	0	0	0	0
Other	1	1	2	1
TOTAL	**2,680**	**336**	**3,016**	**2950**
Staff engaged on capital projects (included above)	7	0	7	7

Getting to Good

Faster patient safety action thanks to incident review panel

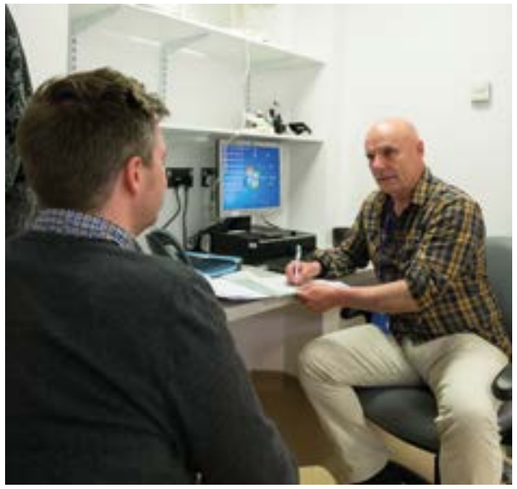
A more collaborative and robust approach to reviewing incidents means the Trust is now making quicker decisions and taking faster action to resolve patient safety issues. The Trust was struggling to formally declare serious patient safety incidents within the 48-hour target set by NHS England. Furthermore, difficulties in finding investigating officers to review incidents categorised as a 'serious incident' (SI) requiring investigation meant lessons from incidents were taking too long to be identified, and learnt.

An Incident and SI Review Panel, made up of heads of nursing and quality, as well as health and safety representatives and senior members of the corporate team was established in June to tackle the problem. The panel meets twice-weekly to review every incident initially deemed moderate, or above, so it can make an early formal decision on whether it, in fact, meets the criteria of an SI. Incidents originally deemed minor or below are also being reviewed to ensure they have been rated correctly and that learning is captured.

Our strategic direction and longer term plans

Our vision and associated strategic goals articulate and drive our sense of purpose. They enable us to configure our organisation appropriately, and deploy resources in ways that make services more productive and good value for money. Our strategy was approved by the Board in March 2016. It outlines the priorities and enablers that will help the Trust to deliver on its goals, and overall vision. The Trust's vision, strategy and priorities remain unchanged at the start of 2017/18.

In April 2017, the Trust was rated 'inadequate' by the CQC and placed in special measures. The CQC specifically identified weaknesses in the Trust's strategy. These observations were also reflected in the later governance review undertaken by Carnall Farrar, received by the Trust Board in February 2018. The Trust's strategy was effectively paused pending a strategy review process in 2018. As a consequence of the Trust's deteriorating position in 2016/17 resulting in its special measures status, an Integrated Improvement Framework (IIF) was developed, in conjunction with NHS Improvement, focusing on short and medium term priorities. The delivery status of IIF priorities and enablers, together with other factors including the delivery of national quality and access standards and financial performance, will therefore be used to inform the assessment of overall delivery against our goals.



Alignment of Integrated Improvement Framework and Trust Goals

The IIF was effectively developed as a 'turnaround' plan against the backdrop of a strategy that was determined to not be fit for purpose by external reviews. Due to the pace of development, and focus of the IIF, work was not undertaken to directly align it with the Trust's goals. The intent of the IIF was to address deficiencies across the Trust in terms of quality, access and financial standards. This is broadly the purpose of the Trust's goals, which are ultimately intended to deliver ongoing sustainability. Delivery of the IIF will therefore provide a proxy against which a broad assessment can be made of the extent to which we have progressed in the delivery of our goals.

The IIF initially outlined 10 overarching priorities and a significant number of activities (c.1,700) that would be undertaken to deliver the required improvements.

Initial Integrated Improvement Framework Priorities

As detailed earlier in this report, during 2017/18 the Trust substantially changed its Board and executive team, including the appointment of a new Chairman and Chief Executive Officer, and significantly bolstered its senior level capacity. This led to a fresh perspective on the Trust's recovery plans, and the IIF has been subject to extensive review and revision. In March 2018 it was reported to the Board that the original IIF work streams were now either completed or transferred to other work streams: work deemed to be 'business as usual' was moved to oversight via routine performance management arrangements. This included the finance work stream that would now be overseen by the Financial Recovery Board.

Initial Integrated Improvement Framework Priorities

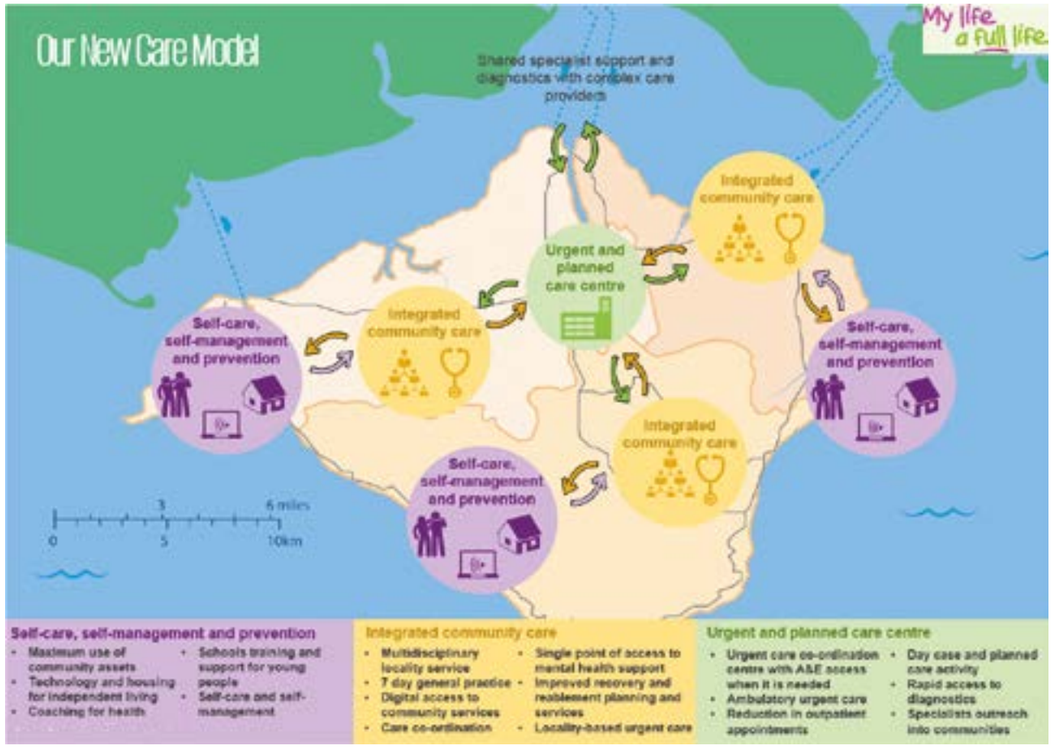
P1	Ambulance	To effectively deploy resources and direct patients to the most appropriate level of service for their needs.
P2	Mental Health & Learning Disabilities	To develop and improve Mental Health services which meet the needs of clients and carers.
P3	Community Services	To develop an infrastructure with partners that delivers more care, that is safe and closer to home.
P4	Acute Hospital Services	To develop an infrastructure to support the treating of patients safely through the unscheduled care and elective pathways.
E1	Finance	Establish and implement systems and processes for more effective financial decision making and control.
E2	Workforce	To improve workforce recruitment, retention and organisational development to support our services.
E3	Information Management and Technology	To improve informatics to inform efficient and effective decision making.
E4	Estates	To ensure the Trust has a fit for purpose Estates and Facilities.
E5	Leadership	To develop a Trust that is well-led with a clear vision and objectives.
E6	Communications	To improve communications and engagement with staff, service users and carers and our stakeholders

The My Life a Full Life New Care Model

Our wider Health and Social Care Community came together to develop a new model of care known as My Life a Full Life (MLAFL). The MLAFL care model was started in 2013 as a catalyst for change, bringing together local partner organisations to deliver a significant programme to change cultures, attitudes and behaviours. The focus has been on person-centred community responses that ensure people receive coordinated care and support. Care on the island has historically been heavily reliant on statutory services, which has limited the range of care available to island residents and is based on forecast demand that is no longer clinically, or financially, sustainable. The new care model will see people have greater support from their community, family and friends by:

- Building on assets and mobilising social capital to help reshape care delivery to meet peoples' changing needs
- Integrating services to improve quality and increase system efficiencies using technology as the key enabler
- Being delivered in the community, or at home
- Making a significant shift to prevention and early intervention, self-help/care, with the aim of reducing health inequalities and the health and wellbeing gap
- Reducing reliance on statutory services

The MLAFL new model of care has made good progress towards shaping care around people's individual needs, and keeping them happy and healthy through self-care, self-management and active communities. This has been achieved by working across organisational boundaries in order to share resources and expertise. Greater partnership working with the island's incredibly active 1,500 voluntary sector organisations, combined by with national Vanguard funding of £4.74m in 2017/18 to help drive forward an island-wide Transformation Programme, has resulted in meaningful progress that will be built upon for years to come.



Progress in this area includes:

- Establishing and embedding Care Navigators and Local Area Coordinators across the island
- Delivering End of Life training across partner organisations
- Implementing a number of Primary Care Projects to explore new ways of working
- Progressing the Whole Integrated System Redesign programme implementation of best practice e.g. implementing ambulatory care and starting a detailed Acute Services Redesign programme
- Implementing Integrated Locality Services to improve joint-working across all community health and care services
- Developing an island-wide Local Estates Strategy
- Engaging with Town and Parish Councils across all three localities to support local joint-working across all sectors across the island
- Implementing case management of highest-risk patients in GP practices using the Risk Stratification Tool
- Increase in the number of 'avoided' admissions against national projections through increased usage of 111, Crisis Team, MDT, Falls Clinic, Isle Help, Pharmacy First, Care Navigators and Local Area Coordinators which have all contributed to diverting people away from Emergency Services in the first instance.

The above measures have contributed to a reduction in a particular cohort of patients attending accident and emergency by approximately 3% compared to 2014/15, and a cost avoidance of £2,175,000.

The Trust's Operating Plan has been developed in the context of its longer term partnership arrangements, and the MLAFL new model of care. Our aims are drawn from our shared locality vision and, although pre-dating the Five Year Forward View (5YFV), reflect its aspirations, articulated through its triple aims – a better patient experience, better population health and more efficient use of resources.

This local groundwork enabled the Trust and its partners to be included within the first wave of NHS England's Vanguard sites for the development of new models of care. There are a number of system-wide workstreams which focus on strategic enablers including estates, IT and workforce. The Trust has key personnel engaged in the development and delivery of these workstreams. A principal focus following the award of Vanguard status was to initiate a Whole Integrated System Redesign programme (WISR) to develop the architecture for a sustainable health and social care system on the Isle of Wight. This work has been completed and an Acute Service Redesign is underway to ensure that acute hospital services are planned for the future using the MLAFL principles. Whilst this work develops, the Trust will continue to implement internal changes to address significant challenges with respect to patient flow through the system, and recruitment and retention in critical areas to ensure that quality and performance standards are maintained, or improved, and resources are used as efficiently as possible.
The local operating plan includes ongoing support for the development of the single point of access hub, crisis support teams, locality hubs, support for staff engagement and development, and ongoing cost base reviews. There are of course risks in pursuing transformative activity whilst the future system architecture is designed, and these risks are mitigated through our close working relationships with our partners on a day to day basis.

In addition to the Trust's role in the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP), we have also entered into a formal strategic partnership agreement with the Isle of Wight Council. The stated objectives of the partnership are consistent with the Five Year Health and Social Care Vision which has been signed by the Isle of Wight Council, Isle of Wight NHS Trust and the Isle of Wight CCG. This agreement will enable us to develop shared service teams which will integrate identified services from the Trust and the Council.

Our clinical strategy

We have an ambition to deliver health and social care in a radically different way than we do now. We want to break down the boundaries that exist within the Trust to improve the quality and efficiency of what we have, in order to meet the needs and expectations of patients now and in the future. This not only covers our departments, but also the conventional professional and vocational boundaries we all observe. We also want to break down the boundaries that exist between the Trust, Primary Care and the Council to develop a highly-integrated model care.

The Trust is committed to delivering the widest possible range of safe, high-quality, cost-effective services in partnership with patients, the public, our commissioners, the Local Authority and other health providers. Our current range of services is based on ensuring appropriate access for people on the Isle of Wight to modern healthcare. In the absence of a fixed-link to the mainland, this need will still be there in five years, as will the need for a broad range of services. What will evolve is how it is delivered.

Fundamental to this process is the integration of the island's health and social care systems, which we have been working on for the last few years. Our healthcare system is almost uniquely placed to develop a highly-integrated model of health and social care: through working with partners to develop My Life a Full Life new care model, we believe we can evolve a sustainable system which will best meet the needs of the island for the foreseeable future.

The development of a highly-integrated IT system will also massively transform what we do by revolutionising how we communicate with each other and our patients. This will break down conventional health and social care boundaries enabling the development of a very different model of care to the one we have now. All of this will be led by our clinicians, with engagement from our other partners and supported by effective corporate services.
This is detailed in our Operational Business Plan, which outlines how activity, quality and finance run together. The Trust's Operational Business Plan can be found at **www.iow.nhs.uk/Publications/publications.htm**.

Over the coming years, we will need to develop the capacity to meet the needs of an increasingly elderly island population, with increasingly complex health needs. Changes to how we shape and deliver care will also be driven by the changing expectations of the patients we serve. The need to deliver demonstrably high standards of care that is sustainable in clinical and financial terms is absolutely fundamental. What is exciting is that much of what we want to deliver is in embryonic form already. The development of locality capacity should provide us the ability to manage more patients, who would currently otherwise be referred to St. Mary's Hospital, in the community. In particular we need to develop collaborative models of care which ensure patients only spend the minimum appropriate amount of time attending St. Mary's hospital. The best bed is after all, your own bed.

Our clinical vision for the future envisages a Trust which continues to supply the fullest range of appropriate services to a high standard, delivered within a cost the local health economy can afford. How we deliver our services will change as we rapidly develop highly-integrated services with our CCG and the Council. Clinician-led services will be characterised by their high quality and run by staff who have been developed and empowered to work in a sustainable way, in an environment that will be optimised for our services.

Our values and behaviours

Our values and behaviours are not just words; they are aligned to the NHS Constitution and have been developed through wide consultation. They are a critical element of how we run our organisation and guide everything we do – our planning, our decision making and how we behave with our patients and each other. By living these values and demonstrating these behaviours every day, we can ensure that we remain highly-valued and supported by the community we serve, and provide 'quality care for everyone, every time'. Patients come first in everything we do. We fully involve our patients, staff, volunteers, families, carers and community.

We are committed to delivering quality care for everyone, every time through:

Caring…
- about everyone's safety and wellbeing
- by valuing and respecting every person
- by being open and honest
- by finding time

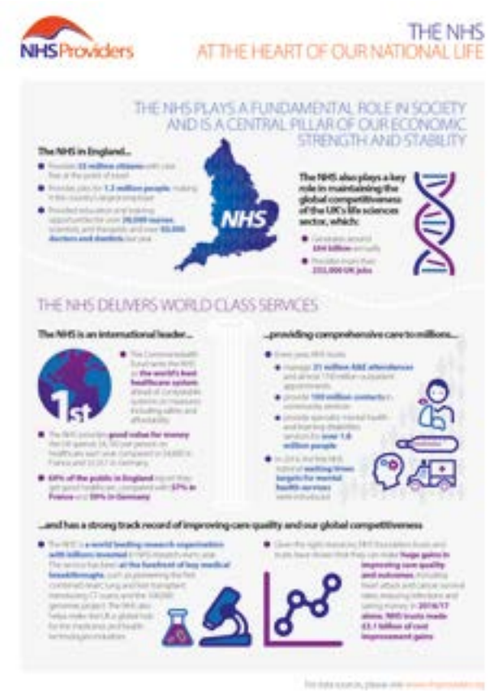
Teamwork…
- working in partnership with others
- building high-trust relationships
- striving for excellent communication
- acting professionally

Innovating and improving…
- by continuously developing and learning, maintaining competency
- by giving, welcoming and using feedback to improve
- by trying new things; simplifying and being more efficient

In order to generate the best ideas, the best plans and deliver them well, we need to create the right working culture. Our values and behaviours will ensure that our working culture is strong and supports delivery of quality care for everyone, every time.

National context

2017/18 was the second year that we were required to report to NHS Improvement (following the merger of the Trust Development Authority with Monitor, the regulator of NHS Foundation Trusts). National joint planning guidance was published on the 22 September 2016 and last updated on the 2 February 2018 by NHS England, in partnership with NHS Improvement, Health Education England, the National Institute for Clinical Excellence, Public Health England and the Care Quality Commission. The guidance explicitly sets out how the sector is expected to deliver the Five Year Forward View by 2020, 'restore and maintain financial balance' and 'deliver core access and quality standards for patients'. Our Trust is a member of NHS Providers, the representative body for NHS Trusts and NHS Foundation Trusts. The following sets out their view of the contribution the NHS makes to national life, and the investment and support needed.



Regional context

Across England, every health and care system has worked together to produce plans supported by a Sustainability and Transformation Partnership (STP), showing how local services will deliver a sustainable, transformed health service, and improve the quality of care, wellbeing and NHS finances over the next five years. The island has worked with Hampshire on plans to enable health and care partners across Hampshire and the Isle of Wight find solutions that can only be implemented at a larger scale to transform the health and wellbeing of our population. This will supplement and enhance (not replace) our local plans and initiatives, which are currently underway through our Local Delivery System as part of the new models of care Vanguards programme, as part of the Five Year Forward View.

The plan for Hampshire and Isle of Wight was published in October 2016 and identifies the following as key initiatives:

- Reducing unnecessary delays in leaving hospital
- Living healthier for longer - reducing the gap between how long people live, and how long they live in good health
- Taking control of our own health – enabling more people to take control of their own health and information
- Providing the highest quality acute care for southern Hampshire and the Isle of Wight
- Providing more care nearer to home
- Improving mental health services

There are some changes we can bring in quickly because they involve adapting the way we do things within NHS organisations. Some proposals will take longer because they are more complex and may mean a significant change in how services are provided in future. In those circumstances, we will involve local people in developing these plans and, where appropriate, hold a formal consultation about them.

Local context

In line with the national position, 2017/18 presented significant quality, performance and financial challenges for the Trust. Performance has fluctuated in year with some of our access and outcome targets being affected (including: referral to treatment; emergency care standards (ECS) and a range of cancer targets) due to increased demand and systemic issues, such as system-wide community bed capacity and primary care capacity. Capacity issues in the wider island health economy, including the closure of care home beds, has had a direct impact on the Trust's ability to deliver against elective and non-elective key performance targets.

We set ourselves very ambitious targets and had a number of unexpected pressures during the year (namely, unprecedented bed pressures in acute, community services supporting escalated discharges). To respond to winter bed pressures, we reduced our scheduled surgery so that we could concentrate on the increase in urgent medical cases.

Our operational directorates were subject to a significant organisational change process during 2015/16 to create a structure that would better support future sustainability. The benefits from the implementation of this new structure were affected by the unprecedented pressures felt across the organisation throughout 2016/17 and 2017/18. The Trust is now implementing a revised structure, as agreed in February 2018, based on the Trust's four core business areas.

Resources and capacity have been stretched and this has impacted on the delivery of transformation and cost improvement schemes and the projected financial outturn.

There continue to be a number of thematic challenges facing the Trust; some of these challenges are within the Trust's control to address, while others require closer and more effective working with our partners and stakeholders, these include:

- Recruitment and retention
- IT infrastructure
- National Agency cap
- Capacity within the wider care economy
- National mandates, such as seven day working
- Financial constraints

A number of these thematic issues come through in the most recent Care Quality Inspection (CQC) reports from November 2016 and April 2017. Overall, the CQC rated us as 'inadequate' although some areas were 'good'. In response, we developed an Integrated Improvement Framework (IIF) to deliver substantial change across a wide range of areas in 2017/18. The improvement work identified in the IIF included:

- Leadership
- Performance Management
- Planning
- Risk Management and Reporting

Financial constraints in general terms affect many of the other thematic issues and are a principal driver to deliver change. By 2019/20 the whole system financial deficit for the island is projected to be £70.7m. To address future sustainability, we have - with our partners - ramped up progress with our new model of care, My Life a Full Life. National funding has been secured and resources to drive radical change across the island's care economy are in place.

The Isle of Wight ranks among the 40% most deprived local authorities in England, with 5,000 children (20%) living in poverty. Deprivation is reflected in worse than average rates for smoking, alcohol consumption and obesity. Local health inequalities exist with the life expectancy gap, between the most and least deprived areas, being 5.4 years for men and 3.8 years for women.

In health terms, there are worse than average early deaths from cancer, diabetes prevalence and incidence of malignant melanoma. However, overall the health of island residents is better than the English average. Mortality rates have been declining over the last decade in line with a national trend, though cancer deaths continue to run at the national average. Local health needs are skewed towards illnesses associated with age and frailty, e.g. long-term conditions which affect an estimated 60% of people aged over 65; slightly more than half of these people have two or more long-term conditions, adding to complexity. Our plans respond to the priorities of the Local Care Board and the island's Health and Wellbeing Board.

More information about the demographic and socio economic profile of the island can be found on the Isle of Wight Council website: **www.iwight.com/Council/OtherServices/Isle-of-Wight-Facts-and-Figures**.

Getting to Good

New careers programme gives local students invaluable experience

Students from local schools are getting invaluable insight into what it's like to work at the Trust as part of a new volunteer team programme.

Recognising recruitment issues and the need to develop the next generation of staff, the volunteer team has set up a Career in Healthcare Induction Programme (CHIPs) that invites students to the Trust for two days to hear inspiring talks from different healthcare specialists.

During the programme, students gain an insight into a number of different professions, as well as a better overall understanding of life working in the NHS. The course puts them in good stead to be successful when applying for further experience at the Trust.

The Trust works with nine secondary schools and one college on the island to help encourage students to adopt the scheme, and plans to extend this to primary schools soon too. It also welcomes college students studying Level 3 Health and Social Care to volunteer for four hours a week, giving them invaluable experience to add to their university applications. A number of 'alumni' from the programme have already landed their first choice of university.

Corporate social responsibility

Our community engagement continues to grow via our Volunteers and Future Careers Team. Ensuring we have a highly-skilled and diverse future workforce is a key priority and we continue to promote NHS careers to our community on the Isle of Wight. We value the commitment and dedication of our volunteers to enhancing our patient and staff experience, and we continue to provide volunteering opportunities across our services.

Future careers

The work that we do is aimed at inspiring and engaging students to encourage and support them in achieving their career goals. By having strong links with local schools and colleges, we are able to showcase our various careers to the next generation of workers. The NHS has 350 different roles - there really is something for everyone. When promoting careers, we start by creating informative and practical sessions which students can enjoy while still learning.

We invest time in building strong links with careers advisors at local schools, and the Trust is now a key stakeholder at the Isle of Wight Careers Forum, where all island secondary school careers advisors meet to discuss progress, best practice and exciting opportunities for their students.

We are able to offer pre-employment programmes and support students to access volunteering opportunities to help with evidence to add to university applications and/or provide essential experience to support employment applications.

The pre-employment programmes that we offer include the following schemes:

- Careers in Healthcare Induction Programme (CHIPs)
- Work experience
- Hospital tours
- Q+A Sessions (which can be facilitated at St. Mary's Hospital or in schools)
- Dementia awareness training
- CPR training
- Medical ethics workshop
- School assemblies
- 1:1 careers advice
- Careers fairs
- Health careers clinic (due to be launched in summer 2018)
- Supporting mock interviews for students

Volunteering

We are fortunate to have over 300 dedicated volunteers supporting our clinical and non-clinical staff in the delivery of high quality patient care. Our volunteers support patients, visitors and staff by offering extra time and small acts of kindness which make a positive impact on the services that we provide.

From our close links with the Isle of Wight College, we have recruited Health and Social Care Level 3 students as volunteers. The college has dedicated four hours of their timetable to volunteering within the Trust. We link the volunteering opportunity to their study requirements and have been able to place students on wards, in the community, in mental health, with allied health professionals and in various other placements. This experience has shown good results, with some students achieving their first place choice of university after completing the programme.

Working with our Dementia Lead Nurses, we have developed a new role of "Volunteer Dementia Friend". These volunteers receive extra training and are able to interact with dementia patients to ensure that their time spent in hospital is less stressful or emotional. We have various resources including games, virtual reality glasses, touch/feel boards to help make patients feel at ease, and to give them the best experience possible.

With the help of our volunteers, we are now able to meet and greet patients and visitors at the North Reception of our St. Mary's site, and within the new Theatre Admissions Lounge. These areas are not staffed by employees of the Trust, but are instead fully supported by volunteers who kindly give their time and offer a friendly face when patients arrive.

Developing research excellence on the island

During 2017/18, 31 studies were opened at the Trust alongside 15 other studies that were already underway. A central annual allocation of £368,365, together with a Performance Premium of £25,358 (£18,414 for non-commercial studies and £6,944 for commercial studies), making a total of £393,723 was made available by the Local Clinical Research Network (Wessex). This funds NHS infrastructure support to studies within the National Institute for Health Research Clinical Research Network (NIHR CRN) portfolio and covers: clinician sessions; research nurses and associated staff; NHS service support (pathology, radiology and pharmacy) and research set-up and management. Additionally, the Trust received funds through a research grant for the David Hyde Asthma and Allergy Research Centre. The commercial team also receives funds to undertake drug studies on behalf of pharmaceutical firms.

During 2017/18, the Trust recruited 816 patients to participate in research. Participation in clinical research allows our patients to benefit from cutting-edge treatments, whilst contributing to future treatments for other patients - not just in the NHS, but around the world. Our staff benefit too, by staying abreast of the latest developments in treatment possibilities, and through networking with other researchers. The skills learnt while undertaking research can also be used to improve the care of patients.

Twenty two clinical staff participated in research approved by a research ethics committee at the Trust during 2017/18. These staff participated in research covering the clinical specialties of:

- Cancer
- Cardiovascular disease
- Children
- Dementia and degenerative diseases

- Diabetes
- Gastroenterology
- Haematology
- Hepatology
- Mental health
- Metabolic and endocrine disease
- Ophthalmology
- ENT
- Reproductive health and childbirth
- Respiratory disorders
- Stroke

The impact of research activities at the David Hide Asthma & Allergy Centre continues to be substantial, delivering high impact publications and facilitating the development of further funding applications. The Centre has completed a review of the 89/90 Birth Cohort at 26 years of age with 70% of participants taking part. Recruitment to the Third Generation Study continues with additional reviews at two, three and six years of age. The MAPS/ITEC Study participants are six to seven years of age and are being recruited for a further follow-up. Further grant funding has been secured from the Asthma, Allergy and Inflammation (AAIR) Charity to conduct a sub-study to assess Bronchial Hyper-reactivity in 150 of the Birth Cohort at 26 years, together with Wellcome Trust funding to study pulmonary epithelial barrier and immunological functions at birth, and in early life, in 200 children over the next two years. Two five-year grants have also been secured from the National Institutes of Health (NIH) USA which will enable the team to continue follow-up the Third Generation at six years in collaboration with the University of Memphis and also to assess the MAPS/ITEC children at six to seven years of age. Their collaboration with the University of Manchester continues with the provision of data from our Isle of Wight cohort for a four year MRC-funded network of birth cohorts designed to study asthma (STELAR/ UNICORN consortium).

Our engagement with clinical research shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. It equally demonstrates our commitment to testing, and offering, the latest medical treatments and techniques. In 2018/19 we intend to increase patient participation by opening new trials in new areas, as well as growing the volume of commercial work, we undertake.

For further information visit **www.davidhideallergyresearch.co.uk**.

Operational performance analysis

Isle of Wight NHS Trust's performance against a range of targets for the past four years

Area	Metric	Target	2013/14	2014/15	2015/16	2016/17	2017/18
Unscheduled Care	Emergency care 4 hour standard	95%	97.00%	93.52%	88.78%	86.00%	85.17%
	Ambulance – Cat A % < 8 min	75%	76.20%	75.78%	71.25%	63.20%	65.84%
	Ambulance – Cat A % < 19 min	95%	96.60%	96.25%	94.93%	91.90%	89.82%
	Stroke: % spending 90%+ time on stroke unit	80%	91.70%	91.80%	86.05%	84.80%	86.60%
	% of people who have a TIA who are scanned and treated within 24 hours	60%	81.50%	69.13%	72.48%	98.90%	100.00%
Planned Care	RTT: % of admitted patients who waited 18 weeks or less	90%	91.00%	85.95%	58.80%	57.00%	57.20%
	RTT: % of non-admitted patients who waited 18 weeks or less	95%	96.80%	93.01%	94.79%	90.00%	89.00%
	RTT: % of incomplete pathways where patients waited 18 weeks or less*	92%	95.80%	93.98%	90.95%	88.00%	90.00%
	Patients waiting more than 6 weeks for diagnostic	<100 pa	43	25	53	53	264
	% patients waiting > 6 weeks for diagnostic*	<1%	0.40%	0.16%	0.47%	0.50%	1.70%
	Symptomatic breast cancer referrals seen <2 weeks***	93%	94%	92.27%	97.41%	96.40%	97.00%
	Cancer patients receiving subsequent chemo/drug <31 days***	98%	100%	100.0%	99.6%	99.8%	99.7%
	Cancer patients receiving subsequent surgery <31 days***	94%	99%	98.37%	98.24%	98.00%	99.30%
	Cancer patients treated after screening referral <62 days***	90%	99%	95.00%	97.22%	93.20%	97.20%
	Cancer diagnosis to treatment <31 days***	96%	99%	99.12%	99.12%	99.50%	99.00%
	Cancer urgent referral to treatment <62 days***	85%	94%	87.09%	82.96%	84.20%	81.00%
	Cancer patients seen <14 days after urgent GP referral***	93%	96%	95.96%	96.03%	97.10%	97.40%
Patient safety & Quality	HCAI: Clostridium Difficile (C. Diff .) infection rates	7	7	12	23	12	18
	HCAI: Incidence of MRSA	0	2	1	3	1	0
	Mixed sex accomodation breaches	0	0	10	59	12	146
	Summary Hospital-level Mortality Indicator (SHMI)**	-	1.12	1.06	1.003	1.015	1.097
	VTE risk assessment*	95%	88.60%	98.64%	99.24%	99.00%	99.00%
Mental Health Services	CPA - Formal review within 12 months	95%				97%	98%
	CPA – 7 day follow up	95%	95%	97%	97%	95%	94%
	Crisis resolution home treatment	95%	98%	99%	95%	95%	96%
	% of EIP pathways completed within two weeks	50%				81%	83%

Notes to the operational performance table

* Target introduced in 2012/13

** Reflects figures published Apr 15, Jan 16, Jan 17, Jan 18

*** Cancer figures for March 2017/18

The challenges faced across the system have continued to impact on the achievement of key performance targets during the year. Current benchmarked performance is outlined in the table on page 20. The Trust monitors performance through the Board Assurance Committees and in a comprehensive performance report which is discussed at the monthly Trust Board meetings held in public. The Trust's Integrated Improvement Framework (IIF) addressed areas of poor performance indicated in the table during 2017/18. The development of the My Life a Full Life new model of care, funded by NHS England's Vanguard programme is helping with the system redesign work and the implementation of the plans for sustainability and transformation across Hampshire and Isle of Wight, which will address fundamental underlying issues about performance in these areas.

The Trust's performance against the Emergency Care four (4) hour standard under-performed, also due to workforce vacancies, delayed mobilisation of best practice recommendations and the impact of insufficient system wide response for improved patient flow. The Trust is committed to improving its current operational performance and delivering the Emergency Care Standard (ECS) at 90% in September 2018 and at 95% in March 2019, and the following improvement actions will contribute to this:

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

In addition, the Trust is continuing to implement the Emergency Care Data Set during the year, is working towards increasing access to enhanced NHS 111 services and integrating urgent care through the Urgent Care Redesign project within the Co-ordinated Access Programme.

The Trust's performance against Referral to Treatment (RTT) has worsened in 2017/18 due to the reduced elective capacity over the winter period, and under-utilisation of some theatre lists. The Trust continues to be committed to reducing its RTT waiting list size and ensuring they are no higher in March 2019 than in March 2018, along with the elimination of patients waiting more than 52 weeks for treatment; this will be partly achieved through the recommended:

- Implementation of a robust and realistic RTT recovery plan at specialty and 'point of delivery' level
- Making best and flexible use of available capacity across Hampshire and the Isle of Wight

In addition, the Trust has developed two RTT projects, theatres and outpatients, which will contribute to the improved efficiency and effectiveness of these support services. Various elective scenarios have been developed for the delivery of RTT services in 2018/19 which will include known service and operational changes, and realising identified efficiencies. The trajectory impact of these scenarios has been modelled to enable Trust Board to agree the Trust's delivery plan for 2018/19.

Non-achievement of the cancer 62-day target was due to inconsistent performance in the year because of complex pathways requiring multiple diagnostic tests both at the Trust and at tertiary providers. The Trust is committed to ensuring all eight waiting time standards for cancer are met, including the 62-day referral to treatment cancer standard and acknowledges the impact of implementing '10 high impact' actions on being able to achieve this. In addition, the Trust is developing, a cancer and diagnostics project which will incorporate the recommended improvement actions from the Cancer Deep Dive Report (December 2017) under the headings of process, organisation, leadership and culture. The deep dive report particularly identified and highlighted the following options for improving performance delivery in 2018/19:

- Increase the number of cancer pathway trackers in the cancer pathways team
- Increase local diagnostic imaging capacity
- Increase local endoscopy capacity
- Increase cancer nurse specialist capacity to manage increased referrals and increased activity per patient

In addition, the Trust will work towards NHSE/NHSI's recent planning guidance and recommendations for delivering objectives during the next one-to-three years, in particular, implementing national pathways and the new cancer waiting times system ahead of the 28-day Faster Diagnosis Standard, as well as working towards the national bowel screening programme targets.

For delivery of mental health and learning disability targets, the Trust welcomes NHSE/NHSI's recent planning guidance and the recommendations for delivering objectives over the next one-to-three years. The deliverables for 2018/19 is acknowledged as follows:

- 53% of patients requiring early intervention for psychosis receive NICE concordant care within two weeks
- Children and young people access to community services increases to 32% (a relatively new metric which we are starting to be monitored on through our monthly submissions)
- Improving Access to Psychological Therapies Access nationally increases to 19%, however, locally we have agreed a 22% target with the Isle of Wight Clinical Commissioning Group (CCG)

Against the national ambulance targets the Trust continued to under-perform for 2017/18 against the trajectory and the national target due to workforce vacancies and worsening handover times in ED constraining vehicle availability to match demand levels. The Trust is committed to ensuring:

- A review of ambulance hub and operational processes has been undertaken which will deliver the Ambulance Response Programme (ARP) sustainably by September 2018
- A new Computer Aided Dispatch system is rolled out by September 2018, one benefit of which will be to provide a sustainable reporting tool to demonstrate the outcomes against the ARP
- A review of ambulance service governance and leadership requirements has been completed by May 2018
- A review of current ambulance transfer and discharge processes has been completed by May 2018
- Handovers between the Ambulance Service and the hospital's Emergency Department do not exceed 30 minutes
- A safe reduction in ambulance conveyances to the Emergency Department with demonstrable changes to "see and treat" and "hear and treat" outcomes for patients making contact with the Ambulance Service

Sustainability

Our vision is to provide high quality health care services in an environmentally sustainable manner. We are taking active steps to improve our energy efficiency, lower our water consumption, and reduce the impact of the waste we generate. We have a Sustainable Development Management Plan titled 'Greener Care', which was published in June 2015. The plan sets out our ambitions for reducing our environmental impact and embedding sustainability principles in the organisation. Further information and copies of our Annual Sustainability Reports are available at: **www.iow.nhs.uk/about-us/environment-and-sustainability/Environment-and-Sustainability.htm**.

Water

The Trust has a comprehensive water management service in place, to ensure a reduction in the water consumption and trade effluent generated on our estate. Measures taken to date include:

- Databases set up with water bureau services and a complete analysis of all historical and current billing
- Analysis of key consumption processes
- Complete trade effluent survey and analysis of TE for the site
- 870 monitoring reports issued
- 983 bills validated for payment
- 50 bill queries have been dealt with and resolved
- 15 over-consuming site investigations and 15 resolved
- 25 washroom controls installed
- 25 over-consumption investigations undertaken
- 5 automatic metering units installed and maintained

Energy

We aim to reduce our energy consumption and carbon footprint by encouraging staff, patients and visitors to adopt simple energy-saving actions. Good energy behaviours, such as turning off lights and equipment when not in use, or closing doors to avoid draughts, can make a significant difference when replicated across an organisation. Those measures have also been proven to enhance patient experience. Initiatives already well-underway and new initiatives planned for 2018/19 include:

- Bill validation to carry out a further complete validation of all energy bills; gas, electricity, fuel oil, renewable energy and Carbon Reduction Commitment to ensure the organisation is being billed on the correct tariffs
- Clinical engagement to engage clinicians at ward level in understanding and undertaking energy efficient behaviours
- Further renewable energy evaluation by carrying out an Investment Grade level evaluation for potential renewable energy solutions across the Trust estate
- Install energy efficient 'smart' lighting solutions (including LED's and lighting controls) to all viable areas of the estate
- PC power management to reduce energy consumption from PCs/Laptops and improved data collection for ongoing measurement and monitoring

Waste and recycling

In 2017/18 the Trust maintained its waste recycling rate with 51% of all domestic waste generated being recycled. The Trust is still recognised nationally as a hub of good practice on waste management, and continues to work very closely with its waste contractors to implement new systems to help further reduce our environmental impacts and lower our carbon footprint. Initiatives already well-underway and new initiatives planned for 2018/19 include:

- Waste reuse by diverting bulky furniture waste away from landfill and into the community for reuse, positively impacting society
- Waste behaviour change by re-categorising waste at ward level through focused and data-driven training, education and knowledge

Financial performance 2017/18

Outturn delivered (2016/17 figures in brackets)

As reported in the annual accounts, the Trust posted a deficit in 2017/18 of £23.25m (£10.96m). This deficit position was an increase against the planned deficit of £18.84m (£4.63m) due to:

- Additional costs from investment in a patient quality improvement programme, as a result of the Trust being placed in Quality Special Measures
- Increased use of temporary agency staff
- Non-delivery of the full cost improvement programme (CIP) challenge.

Investing in capital equipment (2016/17 figures in brackets)

The Trust had a capital investment plan of £9.09m (£6.95m) consisting of an initial limit of £6.43m and slippage of capital projects from 2016/17 into 2017/18 of £1.70m. The Trust also received Public Dividend Capital of £0.96m for A&E Streaming and Cyber Security.

Capital investment for 2017/18 was £8.30m (£5.23m) which included:

Information Management & Technology (IM&T)	£1.6m
Backlog Maintenance	£1.3m
Mental Health Services Refurbishment	£1.3m
A&E Streaming	£1.0m
Equipment RRP	£1.1m
Service Relocation	£1.3m
Information Management & Technology (IM&T) RRP	£0.5m

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Private healthcare supports public healthcare

The Mottistone is the island's private healthcare provider, run by the Trust and based on the St. Mary's Hospital site. The Mottistone offers private healthcare to those who have healthcare insurance or choose to self-pay. It had a turnover in excess of £900k in 2017/18. The Mottistone is entirely self-supporting from private income and the Trust benefits by being able to use its free capacity at peak times to ensure NHS operations still go ahead. Over the winter period, the Mottistone underwent essential refurbishment which encompassed three patient room upgrades, admission room and nursing station upgrades as well as the re-siting of the kitchen facilities. The Mottistone continues to receive positive feedback in relation to the services provided.

Pension liabilities

Details of how pension liabilities are treated can be found in Note 9 in the full Accounts and the Remuneration Report.

External auditor's remuneration

We are required to declare any remuneration paid to auditors in respect of any non-audit work undertaken by them. Disclosure is required by regulations made under s494 of the Companies Act 2006. We can confirm that our external auditors have not undertaken any non-audit work for the Trust during 2017/18.

Cost allocation and charges for information

The Trust has complied with HM Treasury's guidance on setting charges for information.

Fraud and corruption

The Trust has a robust and effective counter fraud service provided by TIAA Ltd (**www.tiaa.co.uk**). This minimises the cost of fraud and corruption and frees up resources for better patient care.

Better payments practice code and prompt payments code

The Trust has signed up to the 'Better Payments Practice Code' and 'Prompt Payments Code'. Details of the Trust's performance are included in Note 34 to the full Accounts.

Disclosure to auditors

All current Directors have made statements that - so far as they are aware - there is no relevant material information or third party transactions of which the company's auditor is unaware. All Directors have taken steps to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Looking forward

Significant service and recruitment challenges remain in 2018/19. Our Board-approved budget for 2018/19 is a planned deficit of £18.53m, including an £8.0m savings plan. This savings requirement equates to around 5% of turnover. The Trust's capital plan for 2018/19 is an expected investment of £6.56m.

The business as a 'going concern'

Overall Performance

At the end of the 2017/18 financial year, the Trust achieved a pre-audited deficit of £23.250m. For 2017/18 the forecast position was a Board-approved plan with a deficit of £18.835m, although this was revised to £22.2m after Month 9. The Trust had a capital investment plan of £9.09m consisting of an initial limit of £6.43m and slippage of capital projects from 2016/17 into 2017/18 of £1.70m. The Trust also received Public Dividend Capital of £0.96m for A&E Streaming and Cyber Security. Capital Expenditure for 2017/18 was £8.298m.

Financial Planning for Future Years

The Trust has produced its financial plans for 2018/19 based on its internal budget-setting process and framework, and an assumption of the level of contracting income from its commissioners. The Board has approved a financial plan for 2018/19 of £18.526m deficit, with a Cost Improvement Programme of £8.0m.

The Trust has not yet concluded the contracts in place for 2018/19 with the Isle of Wight CCG for the expected value of £134.2m, however has concluded a contract with NHS England for £8.6m.

Based on an income and expenditure deficit of £18.526m, the normalised EBITDA position is £8.599m deficit for 2018/19.

Cash-flow

The Trust borrowed £23.8m during 2017/18 to support the deficit, bringing the total Department of Health loan funding to £37.830m. Deficit funding will also be required for 2018/19 and loan requests for April (£1.6m) and May (£1.762m) have already been approved as part of the cash management process through NHS Improvement.

There is a requirement to commence repayment of the loans in April 2020 in the following profile, with further amounts borrowed repayable three years after receipt. Interest on loans is charged at 1.5% (3.5% for amounts borrowed to March 2017), with the expected interest charge for 2018/19 being £1m.

The Trust's banking is conducted through the Government Banking Service.

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Loan Repayment £m	9.34	1.938	1.552	15.292	1.593	3.639	1.399	1.432	1.407	3.211	2.500	2.933	11.600	1.762

Overall Conclusion

International Accounting Standard 1 (IAS1) requires the Board to consider which of the following three scenarios is appropriate:

1. The Trust is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis;
2. The Trust is a going concern but there are uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view;
3. The Trust is not a going concern and the accounts will need to be prepared on an appropriate alternative basis.

The Audit Committee considered the going concern concept on the 2 May 2017, and recommend that the Board approve the 2017/18 accounts are prepared on the basis that the Trust is a going concern but there are uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view.

Following discussions with the Trust's external auditors, the following has been included in the accounts as Note 1.1.2 Going Concern:

These accounts have been prepared on a going concern basis, as there is no indication that that the healthcare and other services will not continue to be provided by the public sector for the foreseeable future and that continuing financial support will be provided by DHSC.

This year the Trust has struggled to meet its financial targets against a backdrop of increased financial pressure across the NHS. The Trust has returned a deficit of £23.250m and has achieved £5.4m savings through the Cost Improvement Programme. The DHSC provided deficit funding of £23.8m as revenue support loans in year bringing the total revenue support loan funding to £37.8m at 31 March 2018. Regulatory oversight undertakings have been in operation during the year and the Trust is focused on exiting from Quality Special Measures by 2020.

The Trust's control total for 2018/19 is a surplus of £4.286m, however it is expected the Trust will deliver a deficit of £18.5m. The plans reflect agreed continued revenue deficit support funding from DHSC, and this support funding is authorised by the DHSC monthly in advance. Deficit support funding of £1.6m for April and £1.762m for May has been provided to the Trust.

The Trust has a contract expectation with the Isle of Wight CCG for 2018-19 for an expected value of £134.2m. The Trust also has in place a contract with NHS England for £8.6m.

The Trust's 2018/19 cash flow forecast is based on the assumptions in the 2018/19 financial plan. The key assumptions underpinning the cash flow are receipt of £18.5m revenue support loan from the DHSC to finance the revenue deficit. The cash flow position is reported to the Performance Committee and the Board monthly and this is based on the Trust's detailed cash flow forecast which is updated daily.

Taking into account all these factors, the assumption that the healthcare and other services will continue to be provided by the public sector for the foreseeable future and that the DHSC will continue to provide financial support, the Board consider the Trust will continue to operate as a going concern. The conditions described above do, however, indicate the existence of material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern.

The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

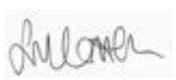
Statement of directors' responsibilities in respect of the accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the Directors are required to:

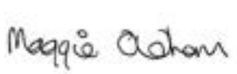
- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board.



Darren Cattell
Interim Turnaround Chief Financial Officer



Maggie Oldham
Chief Executive Officer

24 May 2018

Corporate information

Trust Board structure and operational management arrangements

The Trust Board has undergone some significant change since publication of the CQC Inspection Reports in April 2017. The Trust's Board currently comprises seven Non-Executive (including the Chair) and eight Executive Directors. Non-voting Non-Executive and Executive Directors and Board Advisors are appointed as required. A diagram of the composition of the board is available on page 60 of this Report.

It should however be noted that since 31 March Paul Evans, Kevin Bond and Shaun Stacey have left the Trust and Bob Ghosh has joined the Trust as Director of Clinical Improvement. Biographies of the Trust's Non-Executive and Executive Directors can be found at **www.iow.nhs.uk/about-us**.

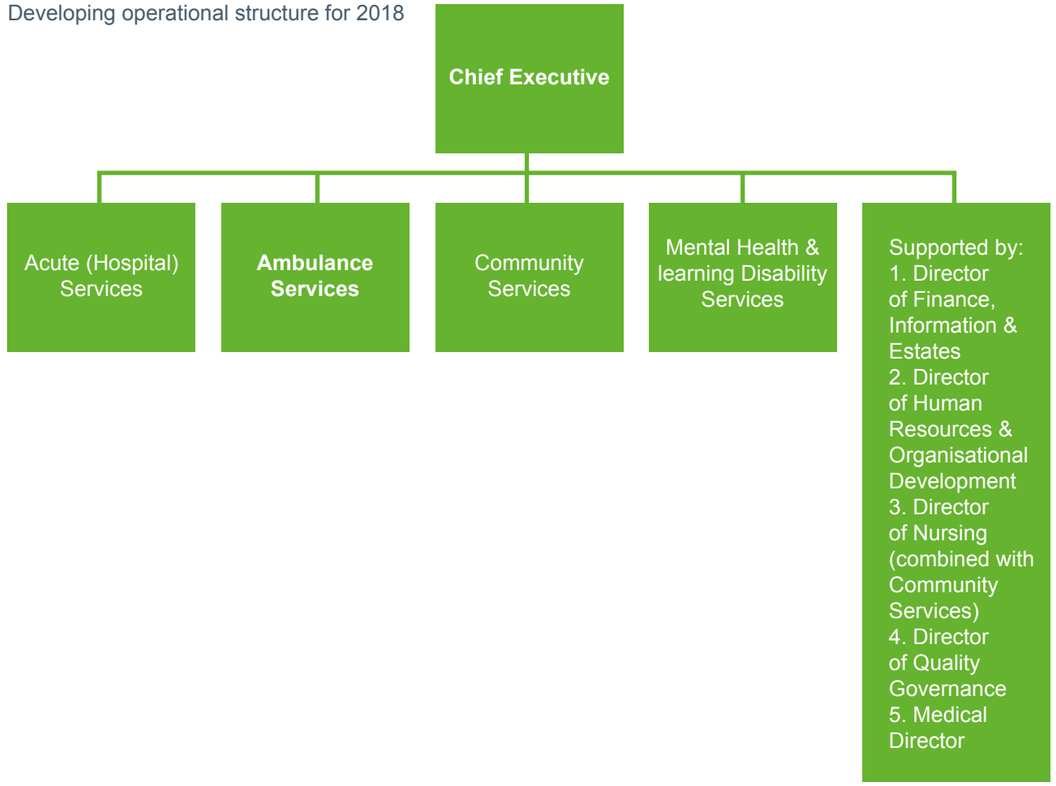
During 2017/18, the Trust's operational services were organised as discrete clinical business units (CBUs) that were introduced in November 2015. The CBUs are supported by a range of corporate services. With the agreement of NHS Improvement the structure of the Trust is being changed to reflect the four key core areas of the Trust's business shown on page 29.

More information about the Trust's governance arrangements can be found in the Annual Governance Statement (see page 36).

Board committees

The business of the Trust is managed through nine Board Assurance Committees which are shown on page 37. Full details of these committees, their membership and terms of reference are available on our website at **www.iow.nhs.uk/about-us** and in the Annual Governance Statement.

Developing operational structure for 2018



Transparency at the Trust – the Register of Interests

Every year, senior staff and Board members are required to declare any interests, particularly those which could conflict with the business of the Trust. The Register of Interests has been considered under the new governance structure by the Assurance, Risk and Compliance Committee. You can obtain a copy by emailing board@iow.nhs.uk or calling 01983 822099 ext. 5741.

Being Open and the Duty of Candour

The Trust fully supports the need to be open and transparent in line with national guidance and the Duty of Candour placed on organisations and staff. During the year the Trust has revised and approved the Being Open and Duty of Candour Policy, and has improved the training to ensure that staff have the knowledge and are supported to apply the duty. The Trust has refined the incident reporting process to ensure that we are able to provide assurance on the actions taken in relation to candour.

Membership

The Trust is a key part of the island community and we run programmes of engagement to strengthen our relationships with local groups and individuals. Our staff attend events to talk about the work that we do and encourage people to sign up for our membership programme. We use the feedback we get from members and others to refine our services.

The Trust remains committed to being a membership organisation and currently has circa 5,500 'public members'. These are members of the public, who want to make a difference to healthcare on the Island.

Activities during this year included five 'Medicine for Members' meetings, with each one being very well attended. These inform members what is happening across the four services giving members the opportunity to help shape our future plans, and quiz the clinicians and senior team in a friendly open forum. This year members have also participated in a number of surveys and attended events focussed on the Acute Services Redesign (ASR) work.

Patient Council

Our Patient Council meet on a regular basis to discuss developments and plans that could impact on patients and the wider public. There are currently 19 patient representatives including an elected Chair, who are members of the Trust, who help provide a patient perspective and help address matters identified as important by patients. Members of the Council are involved in shaping strategies and new initiatives within the local health scene and they also provide regular representation to various committees and Board meetings.

In August 2017 the Patient Council elected a new chair, Doreen Britton for a maximum of two years. Doreen reports:

It has been a busy year but our primary focus has been on the purpose of the Patient Council and if it needs meets those of the Trust and the general population of the Island. In the coming year we will be making ourselves more known and available to the public so we can seek out the themes and areas of concern and take them forward to the Trust but we also want to highlight the areas that are being praised for their good work. We will also be looking to recruit a maximum of six new members to the Patient Council.

There have been many changes within the Trust and within the Executive Structure. The Patient Council now report directly into the Quality Committee which is co-ordinated by the Director of Quality, Suzanne Rostron and chaired by a Non-Executive Director. This allows for the concerns of the Patient Council to be heard at the right level and escalated to Trust Board if necessary. Our first report into the Quality Committee was around the Assisted Feeding of patients who may need help by members of staff.

The Patient Council has a variety of roles. The majority of members sit on committees held within the Trust but a number of them have also been involved with the Acute Service Redesign that is still ongoing. In the last year Members have been invited to sit on interview panels and have carried out interviews on new Directors to the Trust and new Consultants.

The Patient Council continues to support the need for Wi-Fi within the Trust for patients and visitors and also the need for Integrated Care Records so the Community, Hospital, GP and Ambulance systems can communicate with one another.

Finally, I would like to thank all the members of the Patient Council who give freely of their time in order to help contribute to the best possible experience for the patient. We hope to continue providing the voice of the patient over the next challenging years whilst the Trust achieves Getting to Good by 2020.

Doreen Britton
Patient Council Chair, Isle of Wight NHS Trust

Getting to Good

Pioneering initiative results in no transfers for end-of-life patients

Patients who are dying, vulnerable or require complex care are no longer being transferred unnecessarily thanks to a new initiative pioneered by the Isle of Wight NHS Trust.

The "Blue Ribbon" scheme sees blue stickers placed on the front of patient notes and care plans to identify those patients who should not be moved to another ward. This enables site managers to keep track of patients using a "Blue Ribbon List" which is discussed at bed meetings and ensures clinicians are either alerted to or reminded that the individual is not to be moved.

The scheme is already paying dividends; since coming into effect just before Christmas – one of the busiest periods for the Trust – not a single end-of-life patient has received a non-clinical transfer.

The scheme was devised after the Trust's end-of-life nurse facilitator, Lucy Merry-Williams, noted bed pressures were resulting in dying patients being moved multiple times to make way for new patients, causing unnecessary stress.

The Trust acted immediately and, following a two-hour discussion with key teams and stickers ordered and returned from the printers within 24 hours, the "Blue Ribbon" scheme was born.

Although the scheme was predominantly started to benefit end-of-life care, it has been extended to other vulnerable patients.

Quality Governance and Nursing Services

Formerly, Quality Governance and Corporate Nursing all sat within the portfolio of the Executive Director of Nursing and Quality. During a recent realignment of Executive portfolios, this has now been divided into two discrete portfolios: Quality Governance is overseen by the Director of Quality Governance, Suzanne Rostron. The corporate quality services provided include:

- Patient safety and experience
- Complaints
- Patient Advice and Liaison Service (PALS)
- Chaplaincy
- Implementation of guidance from the National Institute of Clinical Excellence (NICE)*
- Clinical Audit*
- Risk and litigation
- Healing arts
- Main reception
- Health, safety and security

The team is also responsible for:

- Quality strategy and contract
- Quality account
- Care Quality Commission
- Serious incidents
- Quality strategy and priorities
- Ward accreditation programme
- Clinical governance
- Friends and family test
- Duty of candour
- Patient safety alerts
- Safety thermometer

*reporting into the Medical Director.

Nursing as a corporate function is overseen by the Director of Nursing, Midwifery, AHP's and Out of Hospital Services; Dr Barbara Stuttle CBE. Services include:

- Adult safeguarding
- Children's safeguarding
- Safe staffing
- Infection prevention and control
- Tissue viability and nutrition
- Estates medical electronics
- Midwifery
- Allied health professionals
- Out of hospital services

The team is responsible for:
- Nurse staffing, conduct and clinical standards
- AHP / midwifery staffing, conduct and clinical standards
- Staff nurse bank

Principles for Remedy

The Trust supports the Principles for Remedy published by the Parliamentary and Health Service Ombudsman (PHSO) in May 2010 and implements these principles as part of the Trust's complaints handling procedure. We regularly review our complaints handling processes to ensure we are working in line with the 'user led vision for raising concerns and complaints', and have worked with Healthwatch Isle of Wight during the year to help review our complaints process.

Information Governance

During 2017/18 there were eight level two information governance incidents which were reported to the Information Commissioners Office. More details of these can be found in the Annual Governance Statement on page 53.

Working with others

The Trust benefits from having close relationships with a number of organisations, including Healthwatch Isle of Wight. This consumer-championing organisation provides feedback to the Board and helps us to provide an even better service.

We also work extensively with the Isle of Wight Council on our shared vision of integrating health and social care services through the My Life a Full Life new model of care. The Trust is represented at the Council's Health and Adult Social Care Scrutiny Sub Committee, on the Health and Wellbeing Board Executive Committee and we provide various briefings for Councillors and Officers.

Emergency Preparedness, Resilience and Response

In 2017/18 the Trust met a number of challenges in respect of Emergency Preparedness, Resilience and Response (EPRR). This included significant work undertaken in the build up to the island's events season following the terrorist atrocities in London and Manchester and the subsequent move to CRITICAL (an attack is expected imminently – from the threat from international terrorism). Winter saw a period of significant snowfall, combined with freezing rain and low temperatures, the demands of which were met through planning for such events and the flexibility of staff.

The Trust's EPRR Team experienced turnover and instability in 2017/18. In addition, inspections by NHS England and the National Ambulance Resilience Unit identified numerous areas for improvement within the NHS England Core Standards for EPRR.

In April 2017, a service level agreement for the provision of business continuity services by the South Central Ambulance Service (SCAS) to the Ambulance Service commenced. In October 2017, the remainder of the Trust entered into a similar arrangement for business continuity with the Isle of Wight Council. The arrangement with the Council has now been extended, from April 2018, to include emergency planning.

Getting to Good

Nurses don pyjamas to help improve patient mobility

Senior nurses at the Trust took to wearing pyjamas instead of their uniforms as part of a campaign to encourage patients to wear their 'everyday' clothes and, in turn, become more active around the ward.

It is felt that by encouraging patients to change out of their pyjamas and hospital gowns as soon as they feel able to move around, they get closer to their regular routine, becoming more confident and active, and so aiding their recovery.

The national campaign aims to help prevent complications related to being immobile, which include chest infections and muscle degeneration, and is due to extend more widely to all staff nurses in the near future.

Research has indicated that for patients over the age of 80, 10 days in a hospital bed equates to 10 years of muscle ageing, so it is vital that they are more active during their time in hospital.

Natalie Mew, Matron of Medicine, who has been working hard to promote the campaign, said: "Raising awareness of the benefits of being active when in hospital is so important, so it's great to help drive this national campaign here.

"Patients' recovery and wellbeing are of the utmost importance to staff across the Trust and we're looking forward to seeing the benefits of this campaign as it is adopted more widely."

Health, safety and security

The Trust has an excellent health and safety record and as a responsible employer, we encourage staff to report any incidents as part of a healthy, open culture. We have a comprehensive policy covering health, safety and security, which is available on request.

In 2017/18, seven reports were submitted to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 – this compares with 13 reports last year, 10 reports in 2015/16, 11 reports in 2014/15, 16 reports in 2013/14 and 14 reports in 2012/13.

There were 23 manual handling incidents (such as strains and sprains) – this compares with 30 incidents in 2016/17, 46 incidents in 2014/15, 34 incidents in 2013/14, 40 incidents in 2012/13 and 42 in 2011/12.

We continue to take a zero tolerance approach towards violence and abuse directed at staff, and will take legal action against those who are criminally responsible for their actions. During the year:

- There were 189 (183 in 2016/17) assaults on staff of which 176 (174 in 2016/17) were due to a mental health or physical condition impacting on their capacity. Thirteen assaults were criminal acts and were dealt with by the police.
- There were 374 (293 in 2016/17) reports of verbal abuse. Due to conflict resolution training, staff are more likely to report these incidents as there are more support mechanisms in place to safely manage these situations.
- Security were called 411 times to assist the wards with situations such as violence and aggression, verbal altercations causing alarm and distress and missing patients.

One of the major threats to healthcare is the outbreak of fire in a building and the Trust works hard to prevent fire and train for an outbreak. Fire safety management is a crucial element within a modern healthcare setting. Good fire safety management will help the Trust to meet set objectives (Quality, Innovation, Productivity, Prevention, Reform) and achieve the critical success factors in two key areas, Quality (Patient Safety, etc.) and Productivity (Develop the Estate, etc.).

Effective fire safety depends upon a combination of physical fire precautions and a robust system of effective management. Fire safety in the healthcare environment is particularly challenging since many healthcare building occupants will require some degree of assistance from healthcare staff to ensure their safety in the event of a fire. Whilst physical fire precautions within a building are intended to provide protection to building occupants, effective fire safety management ensures that the incidence of fire is minimised, the physical fire precautions are maintained in an operational state, the organisation is able to respond effectively should a fire occur, and that the impact of a fire incident is minimised.

This is particularly true of healthcare premises on the island, especially the main general hospital (St. Mary's): in the event of a fire emergency, there is no local alternative hospital refuge and therefore emergency patients cannot be diverted to another hospital, unlike our mainland counterparts. It is crucial that there are robust contingency plans in place to be able to carry on caring for patients in a safe environment.

Another important part of health and safety practice is the completion of Control of Substances Hazardous to Health (COSHH) reviews, which are undertaken on a regular basis at the Trust.

Back care can be a significant issue for NHS employers, with staff required to assist patients whose weight is increasing in line with a general increase in population weight. Training is provided to staff on moving and handling both patients and equipment. The back care advisors also carry out ergonomic referrals for staff, patients, commercial premises, research on new equipment and assist the health and safety team on area audits.

More information can be found on the Trust's website at **www.iow.nhs.uk** or by telephoning 01983 822099 ext 4891.

Getting to Good

New pain assessment tool helps improve care for children unable to speak

Children who are unable to speak, or whose language skills are still developing because of their young age, are receiving improved care after school nurses adopted a new method to help them to convey their pain.

The technique involves children using a diagram and chart to point to where their pain is coming from and on what scale it is affecting them. It helps school nurses to decide what pain relief to give them, and where to focus treatment.

A team of school nurses from the Trust used evidenced-based research to implement the pain tool, and it's already receiving positive feedback from children and parents.

It can be used by both young children and children with communication and learning difficulties aged up to 19 years of age. The tool is completely child-focused, with symbols tailored to a child's individual likes and interests. For children with chronic pain, nurses are able to build a relationship and can use pictures and symbols that are more specific to the child's interests.

Annual Governance Statement 2017/18

1. INTRODUCTION

1.1 I was appointed as Interim Chief Executive on 2 May 2017, and subsequently appointed substantive Chief Executive on 1 December 2017.

2. SCOPE OF RESPONSIBILITY

2.1 As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

3. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

3.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

3.2 The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Isle of Wight NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Isle of Wight NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

4. CAPACITY TO HANDLE RISK

4.1 REGULATORS

4.1.1 In April 2017 the Care Quality Commission (CQC) reported their findings of the inspection into the Trust which took place in November 2016, and determined overall that the Trust was inadequate, which included an inadequate assessment for Well Led. The Trust was placed in to special measures by NHS Improvement in April 2017. This also followed an investigation by NHS Improvement into the Trust's leadership in September 2016 that identified weaknesses in leadership and governance.

4.1.2 Since I was appointed and during the course of 2017/18 improvements regarding well led including governance have been made to address the concerns raised by CQC. This has included the establishment of a new Board with a number of new Non-Executive Director and Executive Director appointments, underpinned by a leadership restructure and an updated governance framework with risk management systems and processes established.

4.2 WELL LED REVIEW

4.2.1 The Trust and NHS Improvement jointly commissioned a review of Board leadership, performance and effectiveness. This culminated in a final report that was considered and accepted by the Board in January 2018.

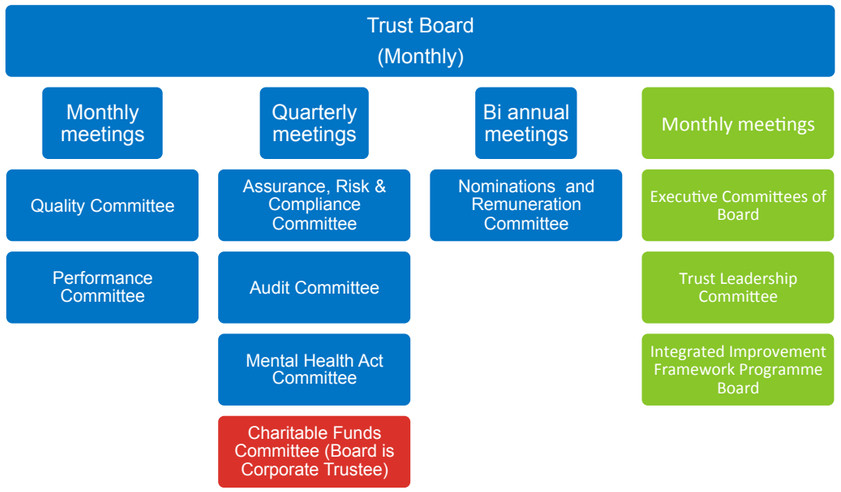
4.2.2 Over a three month period, a series of structured interviews were conducted to understand more about how well the Board had performed and had been effective, including addressing the Trust's response to the CQC rating and the challenges it faced in terms of providing high quality, safe and sustainable care to the population of the Isle of Wight. Additionally Board, seminar and committee meetings were observed and numerous documents were considered.

4.2.3 Through the use of a Change Capability Assessment tool, a series of comparisons were made with empirical evidence from strategic change programmes undertaken in leading public and private sector organisations. Additionally, a self-assessment survey was undertaken with clinicians, managers and executives across the Trust.

4.2.4 The review identified significant findings and these were grouped under the following headings: vision, strategy, culture, Board leadership, executive leadership, Clinical Business Units (CBUs), governance (including risk management), external relationships, engagement with staff and leadership development. The findings supported many of the previous reviews and showed that, at the time of the review during 2017, little had been progressed in many areas. The Board agreed plans to take on-board the recommendations made within the report.

4.3 BOARD GOVERNANCE

4.3.1 The Board agreed revised Board governance arrangements in December 2017 which became effective from January 2018. This included a new Committee structure as follows:



4.4 STRATEGIC, CORPORATE AND OPERATIONAL RISK MANAGEMENT

4.4.1 Whilst the Board has overall accountability for ensuring a robust risk management strategy and that an underpinning risk management policy are agreed, implemented and adhered to, each of the Board's Committees has specific delegated risk management responsibilities.

4.4.2 The terms of reference for each Committee were agreed by the Board and include risk management responsibilities of agreeing strategic risks for each strategic objective and their associated inherent, actual and target risk scores, considering the risk appetite, receiving assurance from Executive Directors as to the plans for enhancing controls to mitigate each risk and assessing how corporate risks may impact upon each strategic risk.

4.4.3 The Performance Committee has responsibility for considering strategic risks in relation to operational delivery, workforce, finance and enabling support services.

4.4.4 The Quality Committee has responsibility for considering strategic risks in relation to quality, including patient safety, clinical outcomes and patient experience.

4.4.5 The Assurance, Risk and Compliance Committee has responsibility for considering strategic risks in relation to compliance with regulatory standards and for receiving reports from the Operational Risk Sub-Committee fundamentally regarding corporate risks.

4.4.6 The Audit Committee has responsibility for overseeing appropriate processes and reporting mechanisms are in place for the Board Assurance Framework and risk management. Assurance is received by the Committee through Executive Director reporting, triangulated through internal audit reports.

4.4.7 The Trust Leadership Committee is an executive led Committee of the Board and receives updates from each Clinical Business Unit including those areas of concern and risk to each CBU.

4.4.8 The Board leads sustained improvement in risk management and has been supported through a specific Board Seminar session regarding risk management, which included the agreement of strategic objectives for 2017/18 and consideration of the strategic risks against each objective.

4.4.9 Executive Directors are responsible for overseeing the implementation of the risk management strategy and compliance with the risk management policy. This forms the specific responsibility of the Director of Quality Governance who, with the support of the Governance Advisor, has developed a revised strategy and formulated a new policy, both of which have been considered for approval during April and May 2018.

4.4.10 The Operational Risk Sub-Committee was established in February 2018, following the appointment of the Director of Quality Governance on 1 February 2018, and meets monthly. Whilst still in its infancy, the Sub-Committee has made initial improvements in the way that Clinical Business Units (CBUs) consider risk management as a vehicle to support the planning and management of each CBU rather than the "tick-box" approach previously in place. A key remit of the Sub-Committee is to review the high scoring risks from each CBU and corporate function and for those with an agreed risk score of 15 or above to assign them as corporate risks and align accordingly with strategic risks.

4.4.11 The Assurance, Risk and Compliance Committee receives reports from the Operational Risk Sub-Committee regarding assurances as to the appropriate management of the corporate risks.

4.4.12 This fresh approach to risk management has been underpinned by a series of training for each Clinical Business Unit. Risk training sessions have been provided within the CBUs and corporate functions and tailored to the individuals' authority and duties. This has been based upon the learning from other organisations and during the training opportunities have been given for the learning between and within CBUs. Additionally, those responsible for risk management have been provided with improved access to the range of tools available as part of the risk management system. However, there remains further progress and improvements to be made during 2018/19. This will be supported and aligned to the new Executive Director appointments for each of the divisions and clinical services.

4.4.13 The Director of Quality Governance has utilised good practice from other organisations and these have been incorporated within the Risk Management Strategy, Risk Management Policy and underpinning risk management training.

5. THE RISK AND CONTROL FRAMEWORK

5.1 RISK MANAGEMENT STRATEGY

5.1.1 During 2017/18 the Trust did not have a Risk Management Strategy that was appropriate. Since the appointment of the Director of Quality Governance on 1 February 2018, she has developed a Risk Management Strategy and this has been supported and approved during April and May 2018.

5.1.2 The Strategy sets out the strategic direction for risk management for the Trust for the next three years. It has been developed to comply with legal and statutory requirements, assist in compliance with national standards, promotes proactive risk management and to improve the safety and quality of patient care.

5.1.3 The Strategy states that risks are managed at two levels; strategic risks and operational risks.

5.1.4 Strategic risks can be considered as those business risks that, if realised, would fundamentally affect the way in which the organisation exists or conducts its business. These risks may have a detrimental effect on the Trust's Annual Business Plan and thus achievement of its key business objectives. This risk realisation could lead to material failure, loss or lost opportunity. Strategic risks are detailed in the Trust's Board Assurance Framework (BAF) and mapped against the Trust's strategic aims. Each of the Board Committees is responsible for managing the strategic risks aligned to them, with oversight at the Assurance Risk and Compliance Committee and ownership at Trust Board level.

5.1.5 Operational risks can be considered as the risks associated with the key business processes at specialty and clinical business unit level. The issues arising from these will be considered at specialty and clinical business unit level in the first instance, and then escalated to the Operational Risk Sub-Committee and the Assurance Risk and Compliance Committee if required, (i.e. if the risk is rated 15 or above or the Operational Risk Sub-Committee observe trends). This approach will ensure effective use of key business processes, streamlining information and risks towards the Trust's strategic aims.

5.1.6 The Strategy is applicable to all members of staff within the organisation, including members of the Trust Board, Clinical Directors, General Managers, all Medical Staff, all Nursing and Midwifery Staff, all Allied Health Professionals and all non-clinical staff.

5.1.7 The Strategy is also applicable to staff contracted to provide services to the Trust, both on and offsite. It applies to all honorary contract holders and to all workers of other organisations visiting the Trust sites in the course of their employment or studies.

5.1.8 The Strategy expresses that an awareness of, and responsibility for, risk issues must be linked explicitly to key objectives in order to build a sustainable risk management culture. There must be delegated responsibility for risks at every level in the organisation. This is crucial to embedding risk management into the organisation and its culture, with risk management seen as an intrinsic part of the way the organisation works.

5.1.9 The Trust is committed to the management of risk in order to:

- Monitor continuously and seek to improve the quality of care provided in partnership with patients, carers, staff and the public
- Provide a safe environment for the benefit of patients, staff and visitors by reducing and, where possible, eliminating the risk of loss/harm
- Protect its assets and reputation

5.1.10 The Trust is committed to mitigating those risks within its control and preparing contingencies for risks beyond its control. As the Trust seeks to manage risks according to the appetite for those risks, it recognises the need to balance the costs and benefits of measures to reduce risk levels.

5.1.11 In order to succeed, risk management must be embedded at all levels within the Trust. To this end, the following components are critical:

- Clear and effective governance arrangements
- Strong, respected and impactful leadership with accountability
- Explicit strategic objectives
- Appropriate resource allocation
- Integrated planning arrangements
- Effective stakeholder involvement
- Education and training strategies
- Recognising the value of innovation that all staff can contribute to the overall management of risk
- A system of risk identification, recording and action planning (Risk Register)
- Learning lessons and changing practice both within the divisions / health groups and organisation wide
- Sharing lessons to learn with the wider health community
- Promotion of a fair and open culture

5.1.12 Risk Management Strategy priorities are:

- To ensure that risks that could prevent objectives being achieved are proactively identified, quantified and managed to an acceptable level and in doing so provide a robust risk management framework with appropriate reporting arrangements and individual responsibilities clearly identified
- For all strategic risks to be managed in line with the Trust Board's risk appetite
- To improve organisational risk maturity, at all levels of the Trust

5.1.13 The Trust is at an early stage of formally agreeing risk appetite. However, as part of the reporting of the Board Assurance Framework for quarter 4, risk appetite has been considered for each strategic objective with proposals made for discussion at each of the respective Board Committees and Trust Board in early May. This will support a more dynamic approach to the consideration of risk appetite as part of future strategic decision-making processes regarding the mitigation of risk. Additionally, this will support consideration of risks at Clinical Business Unit and Corporate Function level.

5.2 RISK MANAGEMENT POLICY

5.2.1 Although the Trust previously had a Risk Management Policy, it was outdated and did not reflect the recently revised working practices. A totally revamped Policy has recently been written by the Governance Advisor on behalf of the Director of Quality Governance.

5.2.2 The Policy clearly sets out the expectations and requirements of individuals and meetings through the governance structure at each level within the Trust regarding the management of risk. It includes a number of useful templates as appendices to support the practical implementation of the Policy. The Policy received support from the Operational Risk Sub-Committee in April 2018 and will be presented to the Policy Management Sub-Committee in May for approval.

5.2.3 The Policy emphasises that all staff have a responsibility for risk management; however, the following provides an overview of those with specific responsibilities to ensure the implementation of the Policy.

5.2.4 Chief Executive is responsible for:

- Reviewing the strategic objectives of the Trust with the Board
- ensuring that the Trust has a Risk Management Policy in place and that it is delivered

5.2.5 Executive Directors are responsible for:

- Ensuring delivery of the strategic objectives
- Identification, control, monitoring and reporting of the risks which may threaten achievement of strategic objectives
- Maintaining accurate and up to date risk registers, relevant to their objectives and report through the Board Assurance Framework

5.2.6 Quality Governance Department is responsible for:

- Development and review of the Risk Management Policy
- Provision of education, support and expertise in relation to Risk Management
- Provision of education and training on the Risk Management Policy
- Provision of training of Datix Risk Management system
- Facilitating the reporting of appropriate risks to the Board, Committees and Operational Risk Sub-Committee
- Facilitating the provision of a Board Assurance Framework to the Board and Committees
- Monitoring and reporting compliance with the Risk Management Policy
- Facilitating the reporting of appropriate risks to specialist corporate groups

5.2.7 Clinical Directors, Heads of Operations and Heads of Nursing and Quality (or equivalent for non-clinical business units) are responsible for:

- Leading and overseeing implementation of the Risk Management Policy at business unit Level which includes the effective identification, control, monitoring and reporting of the risks which may threaten achievement of business unit objectives
- Facilitating the reporting and where necessary, escalation of appropriate risks to the Operational Risk Sub-Committee from the business unit
- Maintaining accurate and up to date risk registers, relevant to their business unit / service objectives

5.2.8 Quality Managers (or equivalent for non-clinical business units) are responsible for:

- Facilitating implementation of the Risk Management Policy at business unit Level which includes the effective identification, control, monitoring and reporting of the risks which may threaten achievement of business unit objectives, in accordance with the procedure set out within this policy
- Monitoring and reporting compliance with the Risk Management Policy at business unit level, as directed by the Quality Governance Department

5.2.9 'Risk Owners' including all Departmental / Ward / Service Managers are responsible for:

- Identification, assessment, put in place control measures to reduce risk, monitoring and reporting of the risks which may threaten achievement of business unit objectives, in accordance with the procedure set out within this policy
- Use the outputs of the risk assessment process identified within the Health and Safety Policy to support the determination of the identification of risks using the four levels of assessment
- Maintaining accurate and up to date risk registers, relevant to business unit objectives

5.2.10 Chairs of Specialist Sub-Committees (e.g. Information Governance Sub-Committee) are responsible for:

- Identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken
- Reporting to the relevant Committee
- Reporting, where appropriate, to the Operational Risk Sub-Committee

5.2.11 Chairs of Specialist Groups (e.g. Infection Prevention Control Group) are responsible for:

- Identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken
- Reporting to the relevant Sub-Committee

5.3 QUALITY GOVERNANCE STANDARDS AND STRUCTURES FRAMEWORK

5.3.1 A recently produced framework titled "Quality Governance Standards and Structures" compiled by the Director of Quality Governance emphasises that NHS Improvement defines Quality Governance as:

'…the combination of structures and processes at and below board level to lead of trust-wide quality performance including:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best-practice
- Identifying and managing risks to the quality of care'

5.3.2 This framework aims to address the following:

- An understanding of what Quality Governance is
- What is expected by the Trust at various levels of the organisation
- The roles of key individuals in supporting the governance process
- Supporting infrastructure, including information sources and template documents

5.3.3 The standards and structures set out within the framework are the minimum requirements to ensure there is a good quality governance system in place that aligns with Trust expectations and should be read in conjunction with the recently approved Quality Strategy and Risk Management Strategy.

5.3.4 The Framework explains that our patients deserve and expect the very best care and it enables all our staff throughout the organisation to work to the same standards and ethos. We need to check that we are providing excellent care to ensure that our patients are safe and well looked after. We must therefore have transparent systems in place to demonstrate the quality of care that we give. We will achieve this by:

- Asking questions to fully understand the quality of care we are providing
- Ensuring that we constantly strive to not only maintain but improve quality
- Evidencing what we are achieving
- Maintaining clinically effective, caring and responsive care at every contact

5.3.5 The Framework sets out what needs to be achieved in order to keep our patients safe:

- That we are meeting the CQC's fundamental standards of care
- We understand how we are performing clinically and benchmark against similar organisations
- We understand our mortality performance
- We recognise and adhere to NICE guidance and other similar standards e.g. Royal College
- We review and improve our clinical practice
- We disseminate and implement safety alerts in a timely manner
- We identify, assess and manage risks
- We identify, report and learn from incidents
- We adhere to infection control requirements
- We understand how our patients feel about their experience and learn from their feedback
- We listen to staff and act upon their concerns
- We investigate and learn from complaints and serious incidents
- We ensure that staffing levels are sufficient to provide the care we aspire to and that staff are adequately and appropriately trained to carry out their duties
- Where barriers exist and local resolution cannot be found, we escalate to senior personnel in a timely manner to assist in resolution

5.3.6 The Framework sets out that governance arrangements should ensure that prompt action is taken at the correct level to ensure that our patients are kept safe; whilst ensuring that their experience in our care and the outcomes of their treatment are maximised.

5.3.7 There is a need to provide robust assurance in terms of safety, patient experience and clinical practice at all levels; demonstrating that lessons have been learned and improvements made without delay.

5.3.8 It is therefore essential that governance structures at all levels interject to facilitate effective escalation of issues, and the communication of changes and lessons learned is seamless.

5.3.9 The Trust has therefore implemented quality governance structures which combine informal weekly meetings focused on prompt action, with formal monthly / bi-monthly or quarterly meetings focused on learning and improvement, and on obtaining assurance. To ensure that the different meetings work as part of one, coherent system, all meetings are required to escalate key matters to the next level, and to communicate lessons to be learned down throughout the organisation to all relevant staff groups.

5.3.10 Every member of staff throughout the organisation has a responsibility to ensure that the Trust provides safe, high quality care. Quality governance structures will only work effectively if each individual takes responsibility for their contribution.

5.3.11 The Framework pertains to the Trust's quality governance framework rather than its detailed processes for delivery of care, and for the reporting and investigating incidents, near misses, complaints; and other sources of patient feedback.

5.3.12 It is important that all those involved in quality governance across the trust create a culture of personal responsibility for commitment to safety and quality; and ensure compliance with the policies and procedures in order for the Trust to meet the required standards for our patients.

5.3.13 The requirements set out below have been agreed to provide a coherent 'operating system' for quality governance in the Trust, and to set out minimum standards. They are designed to minimise bureaucracy and are not in any way intended to inhibit clinical leadership from developing approaches to governance, using these structures, which best engage their teams and meet their specific needs.

5.3.14 The appendices of this framework provide links to the terms of reference for the committees listed in this table along with template agendas, work-plans and escalation reports for use in the CBUs.

Level	Meeting	Purpose	Membership
Board	Quality Committee	Seeks assurance, on behalf of the Board, on Quality (safety, effectiveness and experience), achievement of CQUINs, the delivery of the Quality Strategy and the delivery of the OD Strategy.	Non-Exec Directors CEO Director of Nursing Medical Director Director of HR Director of Quality Governance CBU Directors
Board	Performance Committee	Seeks assurance, on behalf of the Board, on all aspects of operational, workforce and financial delivery.	Non-Exec Directors CEO Director of Finance Director of HR CBU Directors
Board	Assurance, Risk and Compliance Committee	Seeks assurance, on behalf of the Board, on the management of risk, alignment of the BAF with corporate and operational risk registers, external visits and compliance with legislation, including CQC.	Non-Executive Directors Medical Director Director of Nursing Director of Quality Governance CBU Directors
Board	Audit Committee	Seeks assurance, on behalf of the Board, on all matters of internal control and overseeing the process of risk management.	Non-Executive Directors
Board	Mental Health Committee	Ensures that all requirements of the Mental Health Act are complied with.	Non-Executive Directors Medical Director Director of Nursing Director of Mental Health Services
Board	Nominations and Remuneration Committee	Sets terms and conditions of office for Executive Directors and monitors performance.	Chairman Non-Executive Directors
Board	Charitable Funds Committee	The Trust was appointed as Corporate Trustee of the Charitable Funds and the Committee makes and monitors arrangements for the control and management of the charitable funds and reports to the Corporate Trustee.	Non-Executive Directors Director of Finance Medical Director Director of Nursing
Executive	Patient Safety Sub-Committee	Executive oversight of the investigation and learning from incidents, claims and inquests, implementation of safety alerts and progress against the Safety Domain priorities of the Quality Strategy.	Director of Nursing (Chair) Deputy Director of Quality (Vice Chair) Medical Director CBU senior representation
Executive	Patient Experience Sub-Committee	Executive oversight of investigation and learning from complaints, the Friends and Family Test, patient surveys, PALs and of progress under the Experience Domain priorities of the Quality Strategy.	Director of Quality Governance (Chair) Deputy Director of Nursing (Vice Chair) Deputy Medical Director CBU senior representation
Executive	Clinical Effectiveness Sub-Committee	Executive oversight of clinical effectiveness including delivery of the clinical audit forward plan, national audit participation, findings and actions, NICE compliance, peer reviews, clinical outcomes, benchmarking, morbidity and mortality and progress against the Effectiveness Domain in the Quality Strategy.	Medical Director (Chair) Associate Medical Director – Clinical Effectiveness (Vice Chair) Director of Quality Governance CBU senior representation
Executive	Operational Risk Sub-Committee	Executive oversight of operational risk management, including CBU and Directorate risk registers of risks >12, external agency visits and overview of policy management.	Director of Quality Governance (Chair) Board Secretary (Vice Chair) CBU senior representation
Executive	Health Safety & Security Sub-Committee	Executive oversight of health, safety and security legal requirements including the risks to health & safety and security.	Assistant Director of Health & Safety and Security CBU senior representation Corporate Functions representatives
Executive	Policy Management Sub-Committee	Executive approval of the majority of the Trust policies, with the exception of those requiring approval at Trust Board (e.g. Standing Financial instructions, Scheme of Delegation).	Board Secretary (Chair) CBU senior representation Corporate Functions representatives
Executive	Information Governance Sub-Committee	Executive oversight of information governance legal, statutory and mandatory requirements, including the risks to information governance and data security and the control of those risks.	Senior Information Responsible Officer (SIRO (Chair) CBU senior representation Corporate Functions representatives

Executive	CBU Board	Executive oversight of functioning within the CBU.	Executive Director of Acute/Community/Mental Health/Ambulance (Chair) Senior CBU representation Service leads
CBU	Quality Committee	CBU oversight of clinical performance (mortality, audit data, benchmarking), service level patient feedback, ward audits, service level risk registers, complaints, incidents.	Senior CBU representation (Chair) Matrons / Clinical leads Quality Manager Representation from corporate quality team
CBU	Performance Committee	CBU oversight of key performance targets, financial performance and workforce management.	Senior CBU representation (Chair) Service Managers Representation from finance, HR and Information.
Specialty / service	To be determined locally (e.g. Ambulance CQEG)	To look at clinical performance (mortality, audit data, benchmarking), service level patient feedback, audits, service level risk register, complaints, incidents and lessons learned.	Service Lead (Chair) Complaints/claims/ incident/risk representation Ward/locality/team leaders
Ward / team	Ward / Team meetings	The expectation is that wards/teams will share knowledge and experience; particularly good practice and lessons learned	Team leader Team members
Corporate – lead	SI meeting	Exec overview of incidents reported to inform SI declarations, monitoring of DoC and learning from incidents.	Director of Nursing / Medical Director or Director of Quality Governance Deputy Director of Quality/Deputy Director of Nursing Patient Safety Lead/SI Co-ordinator Service representatives from clinical services
Quality Team	Triangulation meeting	Weekly overview of complex cases, triangulation of information, action tracking and monthly themes/trends.	Claims, inquests, complaints, PALS, incidents, risk and clinical effectiveness representatives.

5.3.15 Key roles and responsibilities are described within the Framework as follows.

5.3.16 The Trust Board is responsible for defining and leading the strategies that are in place to support the delivery of the Trust's strategic direction, and to ensure that assurance is received that objectives are being delivered. The Trust Board is responsible for:

- Defining the priorities for quality improvement and setting realistic, measurable goals
- Identifying the risks to quality and the steps needed to mitigate these risks
- Setting out the vision for quality in a way that engages staff, patients and the local community
- Managing risks to the achievement of strategic objectives using the Board Assurance Framework
- Seeking assurance from the Board Committees

5.3.17 The Chief Executive has overall accountability for all quality governance and assurance arrangements within the Trust. The Director of Nursing has Executive responsibility for Patient Safety. The Medical Director has Executive responsibility for Clinical Effectiveness. The Director of Quality Governance is the 'nominated individual' responsible for continuous compliance with the fundamental standards. As such, the DQG is responsible for the effectiveness of this framework and has Executive responsibility for Patient Experience. All Executive Directors are responsible for supporting the Trust Board in the maintaining high quality governance standards, identifying, assessing and managing risks in their portfolio areas.

5.3.18 The Non-Executive Directors provide an independent voice at the Trust Board. Their role is to scrutinise and challenge all aspects of Trust business including Quality Governance. In addition to this collective role, all Non-Executive Directors are members and/or Chairs of Board Committees.

5.3.19 The Quality Governance Department is responsible for the systems and processes required to support the delivery of quality governance. The Department must evaluate continuously the efficacy of risk management and assurance systems and committee communication to ensure the Trust Board and senior managers receive information and intelligence they require. Liaising with all inspectorates also falls into the remit of this department. The department will implement systems and processes to ensure the Trust can demonstrate compliance with the Care Quality Commission Key Lines of Enquiry for Quality and Safety on a continuous basis. Any gaps in assurance should be identified and escalated in a timely manner.

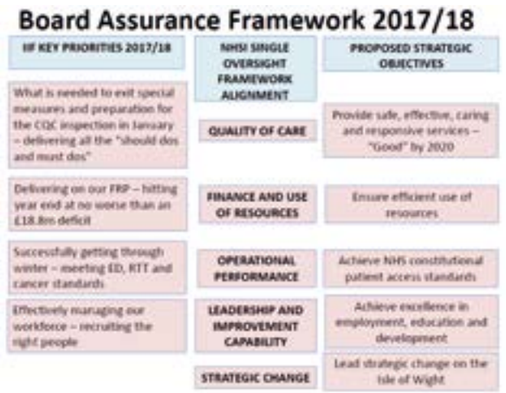
5.3.20 The Information Department is responsible for supporting quality governance through the provision of timely and accurate performance data.

5.3.21 Each CBU Director is the accountable officer within their CBU. They are accountable to Chief Executive and Trust Board for the delivery of quality governance within their CBU and should ensure robust systems and processes are in place to support this.

5.3.22 An Integrated Improvement Framework (IIF) Programme Board was established early in 2017 with responsibility for overseeing actions to address the issues raised by the CQC inspection in 2016 and the Trust being placed in Special Measures in April 2017. This IIF Programme Board continued to operate during 2017/18 and has supported the Chief Executive in reporting to the Board regarding progress in addressing the issues.

5.4 BOARD ASSURANCE FRAMEWORK

5.4.1 The Trust had not agreed strategic objectives or strategic risks during the early part of 2017/18. However, using a model template developed by the Director of Quality Governance, the Governance Advisor, in conjunction with Executive Directors, developed a Board Assurance Framework that included proposed strategic objectives and strategic risks.



5.4.2 This was presented to Board in December 2017 and resulted in Board level agreement as to the strategic risks, associated inherent, actual and target risk scores, controls in place, gaps in controls and actions during the remainder of 2017/18 to mitigate those risks. These were subsequently reported to Committees and Board in late January / early February 2018 to reflect the position at quarter 3.

5.4.3 In May 2018 the Committees of Board and Board received an updated version of the Board Assurance Framework to reflect the closing position for 2017/18 at quarter 4. The risks scores at the end of quarter 4 in 2017/18 were supported.

5.4.4 The following table provides a summary of risk scores for each of the five strategic objectives and underpinning strategic risks as at quarter 4 for 2017/18 and being reported through Committees and to Board in May 2018:

STRATEGIC OBJECTIVES AND RISKS	INHERENT RISK SCORE			PREVIOUS RISK SCORE AT Q3			CURRENT RISK SCORE AT Q4			TARGET RISK SCORE			LEAD COMMITTEE	EXECUTIVE LEAD
	Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score		
STRATEGIC OBJECTIVE 01: PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES – GOOD BY 2020														
Regulatory Compliance	4	5	20	4	4	16	4	4	16	3	4	12	Assurance, Risk & Compliance	Director of Quality Governance
Learning from Events	4	4	16	3	4	12	3	4	12	2	4	8	Quality	Director of Nursing (with Medical Director)
Patient Experience	4	4	16	3	4	12	3	4	12	2	4	8		
Best Clinical Outcomes	4	4	16	3	4	12	3	4	12	3	4	12		Medical Director
STRATEGIC OBJECTIVE 02: ENSURE EFFICIENT USE OF RESOURCES														
Expenditure	5	5	25	4	5	20	4	5	20	3	5	15	Performance	Director of Finance
Income	5	5	25	4	5	20	4	5	20	3	5	15		
STRATEGIC OBJECTIVE 03: ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS														
Patient Access Targets	5	5	25	4	5	20	4	4	16	3	4	12	Performance	Chief Operating Officer
STRATEGIC OBJECTIVE 04: ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION AND DEVELOPMENT														
Recruitment & Retention	4	5	20	3	4	12	3	4	12	3	3	9	Performance	Director of Human Resources & OD
STRATEGIC OBJECTIVE 05: LEAD STRATEGIC CHANGE ON ISLE OF WIGHT														
Strategy	4	4	16	4	4	16	4	4	16	2	4	8	Performance	Deputy Chief Executive

5.4.5 A further matter considered with each respective lead Executive Director is the risk appetite for each of the strategic objectives and associated risks. A risk appetite view has been included for each of the strategic objectives and associated risks. Following support to these views by respective Committees and the Board, they will be used as a guide through the organisation as part of risk management processes.

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

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

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

5.4.9 The Good Governance Institute (GGI) has produced a briefing paper on risk appetite for NHS organisations with a matrix to support better risk sensitivity in decision-taking and has been used to assess risk appetite for each of the Trust's strategic objectives.

5.4.10 A summary of the proposed risk appetite position statements for each of the strategic sub-level objectives is as follows:

STRATEGIC & SUB-LEVEL OBJECTIVES	RISK APPETITE LEVELS					
	Avoid	Minimal	Cautious	Open	Seek	Mature
1a: Quality: Regulatory Compliance						
1b: Quality: Learning from Events						
1c: Quality: Patient Experience						
1d: Quality: Best Clinical Outcomes						
2: Ensure Efficient Use of Resources						
3: Achieve NHS Constitutional Patient Access Standards						
4: Achieve Excellence in Employment, Education and Development						
5: Lead Strategic Change on Isle of Wight						

5.4.11 The risk appetite levels were supported although it was agreed that further consideration would be given to risk appetite at a Board Seminar in June 2018 as part of considering the risks of achieving the strategic objectives in 2018/19.

5.5 OPERATIONAL RISK SUB-COMMITTEE

5.5.1 The formation of the Operational Risk Sub-Committee from February has been a catalyst for bringing together the work with the Board and Committees regarding the Board Assurance Framework and strategic risks and the development of risk management with all operational and corporate functions.

5.5.2 A series of risk management training was developed and put in place from October 2017 and continues to be rolled-out across all operational services and corporate functions, led by Director of Quality Governance.

5.5.3 Governance principles, as described above, continue to be implemented in each of the Clinical Business Units, with a CBU Board having responsibility for the overall management of the CBU, a Quality Committee for CBU oversight of clinical performance (mortality, audit data, benchmarking), service level patient feedback, ward audits, service level risk registers, complaints, incidents and a Performance Committee for CBU oversight of key performance targets, financial performance and workforce management. Underpinning these meetings are specialty and service meetings to look at clinical performance (mortality, audit data, benchmarking), service level patient feedback, audits, service level risk register, complaints, incidents and lessons learned. Additionally, ward and team meetings held with the expectation that they will share knowledge and experience; particularly good practice and lessons learned.

5.6 BOARD REGULATORY STATEMENTS

5.6.1 The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

5.6.2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

5.6.3 The Board is satisfied that the Trust has established and implements:

- Effective board and committee structures
- Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees
- Clear reporting lines and accountabilities throughout its organisation

5.6.4 The Board is satisfied that the systems and/or processes should include but not be restricted to systems and/or processes to ensure:

- That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided
- That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations
- The collection of accurate, comprehensive, timely and up to date information on quality of care
- That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care
- That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources
- That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate

5.6.5 However, the Board is not yet fully satisfied that the Trust has established and effectively implemented systems and/or processes:

- To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively
- For timely and effective scrutiny and oversight by the Board of the Licensee's operations
- To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions
- For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)
- To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making
- To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence
- To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery
- To ensure compliance with all applicable legal requirements

5.6.6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

5.6.7 The Trust has a number of strategic risks associated with being compliant with the above requirements and these correlate with and will be aligned to the Board Assurance Framework for 2018/19.

5.7 CARE QUALITY COMMISSION COMPLIANCE

5.7.1 The Trust is not fully compliant with the registration requirements of the Care Quality Commission (CQC). As a consequence the Trust was placed in to Special Measures by NHS Improvement in April 2017. The Trust remains in Special Measures and following a further inspection by CQC during January and February 2018, the Trust has recently received draft feedback from CQC which is in the process of being validated and responded to accordingly.

5.8 NHS PENSION SCHEME

5.8.1 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

5.9 EQUALITY, DIVERISTY AND HUMAN RIGHTS

5.9.1 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

5.10 CARBON REDUCTION DELIVERY PLANS

5.10.1 The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

6. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

6.1 THE TRUST AND THE BOARD

6.1.1 The Trust exists to 'provide goods and services, namely hospital accommodation and services, community health services and ambulance and associated transport services for the purposes of the health service.

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

6.1.3 The Trust Board leads the Trust by undertaking the following key roles:
- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping and role-modelling a positive culture for the Trust.

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

6.1.5 Reporting to Performance Committee of Board, a Financial Recovery Board was established in January 2018 with the primary duties and responsibilities being to assure the Performance Committee of:
- Oversee delivery at an Executive level of the Financial Recovery Plan
- Ensure that appropriate action is taken to minimise the deficit
- Monitor progress of delivery against financial and CIP targets
- Hold to account those responsible for the delivery of financial and CIP targets
- Ensure Clinical Business Units and Corporate functions have the capacity and capability to realise financial benefits
- Approve all CIP schemes and receive assurance via the Quality Impact Assessment process that there will be no risk of negative impact upon the quality of services
- To provide leadership, advice and guidance to sponsors and project managers including unlocking issues or barriers preventing progress
- To ensure service changes align to Trust strategy, objectives and values

6.1.6 The membership of the Financial Recovery Board has included:
- Chief Executive (Chair)
- Director of Finance (Vice-Chair)
- Chief Operating Officer
- Medical Director
- Chief Nurse
- Director of Human Resources and Organisational Development
- Clinical Business Units – Clinical Directors x 5
- Head of Project Management Office

6.1.7 Additionally, the following have been invited to attend:
- NHSI Senior Financial Advisor
- NHSI Financial Turnaround Manager
- Non-Executive Director member of Performance Committee

6.1.8 This Board has met regularly on a fortnightly basis and has been complemented by a Financial Performance Review Meeting which has also been held fortnightly.

6.1.9 The primary duties and responsibilities of the Financial Performance Review Meetings are to assure the Financial Recovery Board of:
- Performance against the financial and CIP targets through receipt of:
- Clinical Business Unit finance reports
- RAG reports on all schemes including QIA status
- Status on Project Initiation Documents
- Deficits and gaps in plans
- New ideas
- Plans for "Cross Cutting Schemes"
- Define the RAG status of each scheme
- Recommend that additional projects be added to the programme of work so that risks to the delivery of financial targets are minimised
- Assess the need for extra resource to be provided to projects that are underperforming but which are key to success
- Support cross-CBU discussion and review of all schemes
- Monitor the PID status for all schemes

6.1.10 The membership has included the following:
- Director of Finance (Chair)
- Director of Human Resources and organisational Development
- Deputy Director of Finance (Vice Chair)
- Clinical Business Units – Heads of Operations x 5
- Clinical Business Units – Finance Managers x 5
- Senior Representative from Estates
- Senior Representative from Human Resources and Organisational Development
- Senior Representative from IM&T
- Representative of the Project Management Office

6.1.11 The combination of the Financial Recovery Board and the Financial Performance Review Meetings has provided significantly improved governance arrangements for ensuring that resources are used economically, efficiently and effectively.

6.1.12 The Financial Recovery Board has reported to the Trust's Performance Committee where scrutiny and challenge regarding financial performance and the effective use of resources has enabled the Board to receive overall reports from the Director of Finance, triangulated with reports from the Chair of Performance Committee.

7. INFORMATION GOVERNANCE

7.1 SERIOUS INCIDENTS RELATING TO INFORMATION GOVERNANCE

7.1.1 The following are the details of serious incidents during 2017/18 in relation to information governance (IG) and recorded as level 2 according to the IG incident reporting tool.

Date	Reference	Summary Details
13-Oct-17	IGI/13859	A complaint response letter was sent via post to the wrong address (wrong house number) and opened by an unauthorised recipient.
05-Oct-17	IGI/13853	A clinic letter sent by post, containing the sensitive personal data of a patient (relating to autism), was opened and read by an unauthorised recipient.
19-Sep-17	IGI/13997	Information Governance Breach. Following visit at patient's home by a community mental health agency practitioner, a printed list containing PID for 41 patients (current caseload) was left at patient's home.
19-Jul-17	IGI/12331	Excel spread sheet attachment left on an email in error.
14-Jul-17	IGI/12332	Alleged confidentiality breach following a patient attending Ante Natal Clinic.
17-May-17	IGI/11881	A patient was sent home upon discharge with an envelope containing medical notes relating to a different individual, and medicines for that individual.
08-May-17	IGI/11821	Emails containing the name, school and medical conditions relating to 58 individual schoolchildren were inappropriately sent to 29 local schools. Each school received information relating to patients who were not pupils at their school, and which they were not authorised to access. The emails were not sent via secure system and the information, which was in an attachment, was not password protected.
02-May-17	IGI/11820	Information relating to 515 patients was transmitted via an insecure email to a trusted third party organisation. Information included an identifier in the form of their Hospital Number and identified the related medical conditions.

7.1.2 Although all the above cases were referred to the Information Commissioners Office (ICO), no action was been taken by ICO in any of the instances. The ICO did, however, undertake an inspection of the Trust's IG systems and process in February 2018 and a final report with management responses is in the process of being agreed with the ICO.

8. ANNUAL QUALITY ACCOUNT

8.1 QUALITY ACCOUNT

8.1.1 The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

8.1.2 The Trust has had a wide variety of 'initiatives' and external reviews with limited success in identifying planned quality improvements and seeing through to achievement of goals. A Quality Improvement Framework was in place at the previous CQC inspection (November 2016). This was criticised for not including any priorities that applied to Mental Health. It is essential that our Quality Improvement priorities can be translated into action and outcomes across the services we provide.

8.1.3 At Quality Committee on 28 February 2018 draft quality priorities for the next three years were discussed and subsequently approved by the Trust Board. These priorities were shared with stakeholders to consult on the elements should be incorporated into the annual Quality Accounts. This was a difficult task for those who participated as many agreed that all the priorities are of equal importance.

8.1.4 A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

8.1.5 Each year, the Trust follows a process to enable completion of the Quality Account. This commenced in December 2017 by identifying potential Quality Priorities for the forthcoming year and producing a long list of options which are then consulted upon. The consultation went out on an electronic survey to over 70 key areas including all Trust staff, CCG, Healthwatch, local police, Local Authority and multiple other agencies.

8.1.6 In order to ensure that we are compliant with the regulations surrounding the Quality Account, it is audited by Ernst and Young LLP. As part of the audit process, two indicators are selected for review. These are:

- Patients on Care Programme Approach (CPA) followed up within 7 days
- Category A telephone calls (Red 1 and Red 2 calls): emergency response within 8 minutes

8.2 PRIORITIES FOR 2017/18

8.2.1 Quality Priorities that were identified within the Quality Account were historically monitored through the Patient Safety, Experience and Clinical Effectiveness (SEE) Committee. This did not happen prior to it being disbanded in Q3 2017/18. When it was disbanded, the responsibility transferred to the Operational Management Group (OMG). This has also since been disbanded which has meant there has been no robust monitoring of the Quality Priorities over the last year. This is not acceptable and would not occur with the Trust's new Quality Committee governance structure.

8.3 PRIORITIES FOR 2018/19

8.3.1 Monitoring throughout 2018/19 will be through committee work-plans and alignment to the Quality Strategy. Going forward we will be able to clearly demonstrate in tables for easy assessment:

- Baseline information
- Targets
- Actual outcomes
- Whether the target was met

8.3.2 It is proposed that the targets that have not been met this year are included in the improvement plans for specific areas as part of the Quality Strategy priorities.

8.3.3 This year we are adopting a new approach to ensure that our organisational Quality Priorities for the Quality Account are aligned with the Quality Strategy priorities.

8.3.4 An electronic survey has been distributed to all Trust staff and multiple external agencies. The survey established that of the 188 responses, 61.35% felt we had got the priorities right whereas 38.65% felt we hadn't. However, the majority of those that felt the priorities weren't right actually suggested priorities that fell within the broad quality priorities.

8.3.5 It has been agreed that the following are taken forward for 2018/19 as the Trust's Quality Priorities for the Quality Account:

- Patient Safety: Deteriorating patient; we will recognise deteriorating patients at the earliest opportunity and identify the most appropriate course of treatment for them
- Clinical Effectiveness: Right Patient, Right Place, Right Time; we will ensure that all our patients are located in the most appropriate place from admission to discharge
- Patient Experience: End of Life Care; we will continue to ensure that patients at the end of their lives are treated in line with their wishes and with the utmost dignity and respect, working in partnership with the hospice and others across the Island

9. REVIEW OF EFFECTIVENESS

9.1 EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL

9.1.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that have responsibility for the development and maintenance of the internal control framework.

9.1.2 I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Assurance, Risk and Compliance Committee, Quality Committee and Performance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

9.1.3 The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

9.1.4 The overall Head of Internal Audit Opinion for 2017/18 is "Limited" assurance. The Head of Internal Audit stated that he was satisfied that sufficient internal audit work has been undertaken to allow him to draw a reasonable conclusion as to the adequacy and effectiveness of Isle of Wight NHS Trust's risk management, control and governance processes. In his opinion, Isle of Wight NHS Trust does not have adequate and effective management, control and governance processes to manage the achievement of its objectives.

9.1.5 Internal Audit carried out 12 reviews, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. Details of these are provided in Annex B, and a summary is set out below.

Assurance Assessments	Number of Reviews	Previous Year
Substantial Assurance	-	3
Reasonable Assurance	6	10
Limited Assurance	6	3
No Assurance	-	-

9.1.6 Details of those reports where "Limited" assurance has been provided are detailed below. The areas on which assurance assessments have been provided can only provide reasonable and not absolute assurance against misstatement or loss, and their effectiveness is reduced if the internal audit recommendations made during the year have not been fully implemented.

9.1.7 The actual against planned Internal Audit Work during 2017/18 was as follows:

System	Type	Planned Days	Actual Days	Assurance Assessment
Medical Device Management	Assurance	12	12	Limited
Safety Alert System	Assurance	12	12	Reasonable
NICE Guidance	Assurance	12	12	Reasonable
Cyber Security	Assurance	13	13	Limited
Financial Accounting	Compliance	10	10	Reasonable
Consultant Job Planning and Medical Revalidation	Assurance	15	15	Limited
Readiness Assessment EU GDPR		-	10	Limited
IG Toolkit Part I	Advisory	5	5	N/A – Advisory
NHS Data Security Standards Review	Compliance	10	10	Limited
Payroll	Compliance	10	10	Reasonable
IG Toolkit Part II	Compliance	5	5	Limited
Data Quality – Key Performance Indicators (KPI's)	Compliance	20	20	-
Risk Assessment & Care Planning	Compliance	15	15	Reasonable
Board Assurance Framework & Risk Management	Assurance	15	15	-
Job Planning Follow Up		-	5	Reasonable
Major Incident and Business Continuity Planning	Assurance	15	-	N/A
E-Rostering	Compliance	12	-	N/A
Safe Staffing Levels	Compliance	12	-	N/A
Follow ups	N/A	9	9	N/A
Audit Committee Attendance and Reporting	N/A	9	9	N/A
Annual Plan Audit Needs Assessment	N/A	5	5	N/A
Annual Report including Head of Internal Audit Opinion	N/A	3	3	N/A
Audit Management and Liaison	N/A	6	6	N/A
	Total Days	**225**	**201**	

9.1.8 The internal audits above include a specific data quality audit which supplemented the Trust's internal on-going assessments of data quality of the monitoring and reporting of key performance indicators, such as elective waiting time data.

9.1.9 Board Assurance Committees, as detailed above, provide me with the opportunity for my Executive Directors to report to respective Committees regarding progress and performance against the agreed strategic objectives, regulatory targets and agreed plans and other operational measures. The Non-Executive Directors provide challenge in seeking assurance from the Executive Directors in order for Committee Chairs to report to the Board.

In summary:

- Performance Committee – is responsible for overseeing all aspects of financial performance and use of resources, operational performance and workforce performance.
- Quality Committee – is responsible for overseeing all aspects of quality, including patient safety, patient experience and clinical outcomes. Additionally, it is responsible for overseeing improvement in organisational development.
- Assurance, Risk and Compliance Committee – is responsible for overseeing compliance with all regulatory and statutory requirements and the risk management processes.

9.1.10 Additionally, a Financial Recovery Board was established in January 2018, accountable to Performance Committee for overseeing the financial recovery plans. This Board has met fortnightly and has provided an impetus for driving through further cost savings during the remainder of 2017/18.

9.1.11 In conjunction with this Board, Financial Performance Review Meetings have also been held on a fortnightly basis, creating the opportunity for detailed challenge to Clinical Business Units and Corporate Functions.

9.1.12 Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed. My review is also informed by:

- Detailed reports from both internal and external auditors
- Monthly activity, quality, finance and workforce performance reports to the Board
- Clinical Business Unit reports to Trust Leadership Committee
- Reports to the Board from Audit Committee
- Regular review of the Principal Risk Register, through the Trust Board
- CQC confirmation of registration of all regulated activities
- Information Governance Toolkit self-assessment
- Internal auditor opinion following internal audit of compliance

9.1.13 However, despite these controls, the Trust remains in Special Measures for quality and continues to have significant financial challenges. As Chief Executive and Accountable Officer I have advised the Trust Board, the Audit Committee and the Trust Leadership Committee on the implications of the result of my review of the effectiveness of the system of internal control and collectively we have generated quality, workforce, financial and operational plans which will be monitored and delivered during 2018/19 through the Financial and Service Improvement Board.

10. CONCLUSION

10.1 In summary, there have been a number of significant internal control issues during 2017/18.

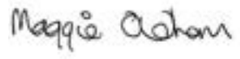
10.2 The Trust had a year-end deficit of £23.25m. This compares to an original Trust plan of £18.8m deficit. The internal auditors' opinion on the organisation's system of internal control has taken this factor into account.

10.3 The Head of Internal Audit's opinion is that 'Limited' assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. This opinion is based on an assessment of the design and operation of the underpinning Assurance Framework and supporting processes and an assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

10.4 Additionally, the Care Quality Commission published a report for the Trust, based on the inspection visits undertaken in November 2016. The resulting overall rating for the organisation was 'Inadequate', with inadequate ratings also attributed to the individual CQC domains of Safe, Responsive and Well-Led. On the basis of the report's findings the Trust was placed in special measures by NHS Improvement. The CQC revisited the Trust in January and February 2018 and the final follow up reports are still awaited at the time of writing this Annual Governance Statement.

10.5 The Trust did not achieve a number of NHS constitutional targets during 2017/18 and, in part, a contributory factor has been insufficient internal controls, governance, performance management and risk management arrangements in place throughout the year.

10.6 Despite the unacceptable level of internal controls issues during 2017/18 identified above, it is assuring to note the recognised improvements in governance, structures, performance management and risk management that have been made and have started to be embedded during the final four months of 2017/18. This has provided the basis for strengthening the internal controls in place during 2018/19.

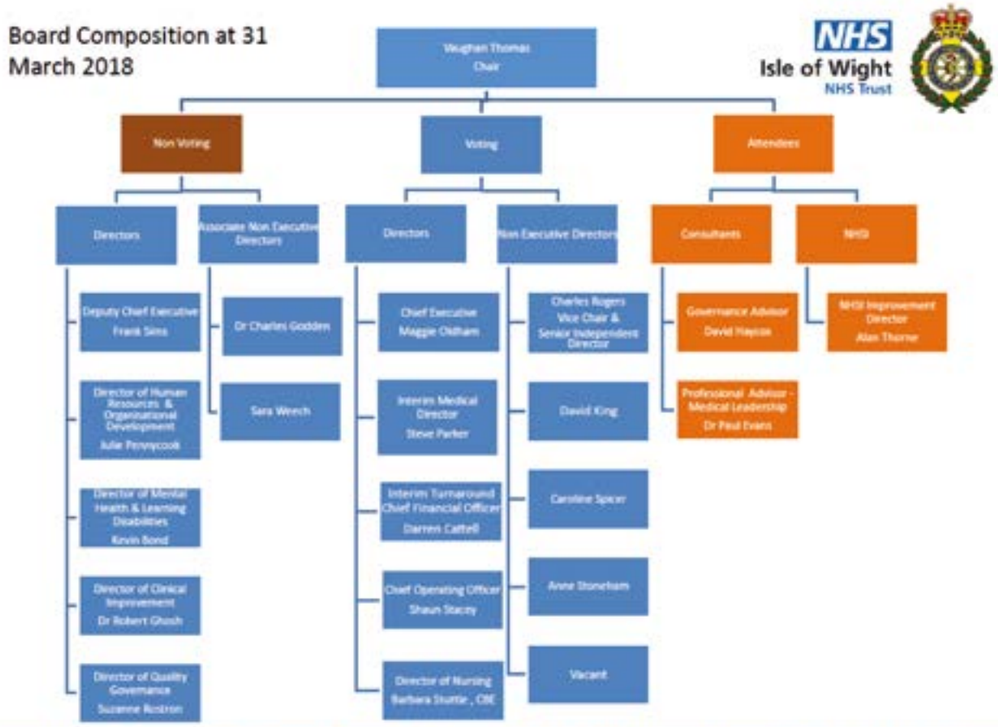


Maggie Oldham
Chief Executive Officer

24 May 2018

Appendix A – Non-Executive Director Responsibilities as at 31 March 2018'

Staff and remuneration report



Appendix B - Analysis of Trust Board Members meeting attendance in 2017/18 (Voting and Non-Voting)

Appendix B

Analysis of Trust Board members' meeting attendance in 2017/18 (Voting & Non Voting)

Committee	Mean NED Attendance (%)	Mean Associate NED Attendance (%)	Mean Executive Attendance (%)	Mean Whole Committee Attendance (%)	Meetings (No.)	No.NEDs on committee	No.Associate NEDS on committee	No.Execs on Committee
Trust Board	92	100	76	82	11	6	2	11
Audit & Corporate Risk Committee (Audit Committee	91	50	0	85	5	4	2	0
Charitable Funds Committee	0	0	0	0	0	3	0	2
Finance Investment, Information & Workforce Committee (Performance Committee	76	0	75	75	9	4	0	5
Mental Health Act Committee	100	0	0	33	4	2	0	4
Quality Governance Committee (Quality Committee	68	65	36	50	9	1	2	5
ICT Assurance Committee	75	0	100	62	2	2	0	1
Nominations & Remuneration Committee	100	0	0	100	6	4	0	0

Staff report (figures in brackets relate to previous year)

The Isle of Wight NHS Trust employed an average of 3,016 (2,950) staff and at the 31 March 2018, the equivalent of 2,723 (2,675) full-time staff were employed. The overall structure of the workforce is summarised in the charts below.

Employees by staff group

During the course of the year the average staff numbers and full time employed were:

Average Staff Numbers	Full-time employed	Other	TOTAL
Medical and dental	212	59	271
Ambulance staff	104	0	104
Administration and estates	646	26	672
Healthcare assistants and other support staff	597	105	702
Nursing, midwifery and health visiting staff	767	136	903
Nursing, midwifery and health visiting learners	0	0	0
Scientific, therapeutic and technical staff	353	9	362
Social Care Staff	0	0	0
Healthcare Science Staff	0	0	0
Other	1	1	2
TOTAL	2,680	336	3016
Staff engaged on capital projects (included above)	7	0	7

NB: These figures include bank and agency staff.

The organisation employs a number of individuals at Bands 8 and 9 who are shown in the following table as full-time employed numbers and as a 'headcount'.

Band	Full-time employed	Headcount
8a	75.10	105
8b	29.37	33
8c	14.38	17
8d	11.40	12
TOTAL	**130.25**	**167**

NB: These are the numbers as at 31 March 2018

The gender of employees is as follows:

Gender	Headcount	Directors	Senior Managers	All other employees	Total full-time employed
Female	2,348	5	110	2,233	1,989.54
Male	781	5	57	719	733.94
TOTAL	3,129	10	167	2,938	2,723.47

NB: These are the numbers as at 31/3/2018

Employee consultation

Our aim is to be a responsive, listening organisation. The senior leaders engage with their teams in a number of ways, including:

- The Staff Partnership Forum which meets every month (or as required) and includes representatives from professional associations. The forum discusses organisational change and receives updates from the Chief Executive.
- The Joint Local Negotiating Committee which meets every two months (or as required) and represents the interests of the medical staff. The membership includes the Chief Executive, Medical Director, representatives from medical staff and the British Medical Association (BMA).

We need to reduce costs over the coming years so that we can continue to meet demand for services and, within the funding available, deliver high quality services. We are keen to minimise redundancies and will continue to take measures such as banding reviews, skill mix reviews and planned redeployment, to retain existing staff.

To enhance quality and productivity we have a workforce strategy that promotes:

- A flexible workforce (to ensure that we have the right skills, in the right place, at the right time)
- Good leadership
- Improved capacity and skills
- A healthy and positive workforce
- Increased management efficiency
- Better on call systems
- Safe staffing levels across all areas

Change is being managed through our Integrated Improvement Framework (IIF). Central to this is the emphasis on leadership development and embedding patient-focused care at strategic, managerial and individual levels.

Staff sickness and morale

The Trust supports staff through an active Occupational Health team and a variety of measures to help avoid staff sickness, including stress-related absences. The level of sickness reported at the Trust during the year was:

Staff sickness absence	2017/18 Number	2016/17 Number	2015/16 Number	2014/15 Number
Total Days Lost (Completion only required at Q4)[1]	27,256	27,327	25,258	26,308
Total Staff Years (Completion only required at Q4)[2]	2,669	2,632	2,582	2,609
Average working Days Lost (Completion only required at Q4)[2]	10	0	9.8	10
Number of persons retired early on ill health grounds (Completion only required at Q4)[2]	3	6	2	1
Total additional pensions liabilities accrued in the year (£000s) (Completion only required at Q4)[2]	117	296	28	60

[1] These figures are taken from the employee roster system as is for the period 1 January 2017 to the 31 December 2018

[2] These figures are for the period 1 January 2017 to the 31 December 2017 and are collected, and provided, by NHS Pensions

The Trust, with the support of the Charitable Funds Committee funded Staff Activities Co-ordinator, organised a range of activities to help raise morale amongst staff. In part, this was a response to a series of staff surveys and studies which showed that a more contented and satisfied workforce delivers better services. Staff were consulted about what activities they would like to see provided; feedback included Trust Awards, a 'bake off', fitness classes and a visit by Santa for the children of Trust staff.

Remuneration report

Section 421 of the Companies Act 2006 requires the preparation of a Remuneration Report containing an annual report on remuneration in accordance with the requirements of Part 3 of Schedule 8 of Statutory Instrument 2008 No 410. Certain information is subject to audit and will be referred to in the audit opinion.

Within the NHS, the remuneration report looks at the senior managers of the NHS body. 'Senior managers' are defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole, rather than the decisions of individual directorates or departments.' For the purposes of this report, this covers the Trust's Non-Executive and Executive Directors.

Remuneration policy – Executive and Non-Executive Directors

NHS Improvement determines the remuneration of the Chairman and Non-Executive Directors nationally, and the Trust has no reason to believe that this position will change in the future.

Exit packages, payment for loss of office or payments or awards to past senior managers

During 201718, the Trust did not pay any exit packages or compensation for loss of office to senior managers. A small number of senior managers left the Trust during 2017/18, either through secondment or through alternative employment, and the Trust continued to pay the agreed salary for the senior manager until the date of final contract termination.

Exit packages (audited)

The remuneration of any senior manager on 'Agenda for Change' terms and conditions of employment would be in line with National Agreements, as negotiated by the Staff Council. Any other Executive Directors' contract is in accordance with national guidance on executive pay. Where no guidance is given, a discussion would be held at the local Remuneration and Nominations Committee. The membership of this committee is detailed in the Annual Governance Statement. The Trust has no reason to believe that this position will change in the future.

Other departures

There were no exit packages or other (non-compulsory) departure payments during 2017/18.

Table 1:

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	2	12,153			2	12,153		
£10,000 - £25,000	4	61,826			4	61,826		
£25,001 - £50,000	1	48,514			1	48,514		
£50,001 - £100,000					0	0		
£100,001 - £150,000					0	0		
£150,001 - £200,000					0	0		
>£200,000					0	0		
TOTAL	**7**	**122,493**	**0**	**0**	**7**	**122,493**	**0**	**0**

Table 2:

Analysis of Other Departures	Agreement number	Total value of agreements £000s
Voluntary Redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice		
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval		
TOTAL	**0**	**0**

Salary and pension entitlements of senior managers (audited)

"Remuneration Name and Title"	2017-18						2016-17					
	(a) Salary (inc Other remuneration) "(bands of £5,000)	(b) Expense payments (taxable) To nearest £100 £00	(c) Performance Pay & Bonuses (bands of £5,000) £000	(d) Long Term Performance Pay & Bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000	(a) Salary (inc Other remuneration) (bands of £5,000) £000	(b) Expense payments (taxable) To nearest £100 £00	(c) Performance Pay & Bonuses (bands of £5,000) £000	(d) Long Term Performance Pay & Bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Mrs J Tabor - Non-Executive Director (note 8)	-	-	-	-	-	-	0-5	-	-	-	-	0-5
Ms L Samuels - Associate Non-Executive Director (note 8)	-	-	-	-	-	-	0-5	-	-	-	-	0-5
Ms E Peers - Non-Executive Financial Adviser (note 8)	-	-	-	-	-	-	0-5	-	-	-	-	0-5
Mrs K Gray - Executive Director of Transformation & Integration (note 8)	-	-	-	-	-	-	40-45	-	-	-	0-2.5	40-45
Ms E Richardson - Chair (note 4)	15-20	-	-	-	-	15-20	30-35	-	-	-	-	30-35
Dr N Moorman - Non-Executive Director (note 4)	0-5	-	-	-	-	0-5	5-10	-	-	-	-	5-10
Mr C Rogers - Non-Executive Director (note 3)	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Mrs J Baird - Non-Executive Director (note 4)	0-5	-	-	-	-	0-5	5-10	-	-	-	-	5-10
Mr D King - Non-Executive Director (note 3)	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Mr V Thomas - Non-Executive Director (note 2,3,4)	20-25	-	-	-	-	20-25	0-5	-	-	-	-	0-5
C Spicer - Non-Executive Director (note 2)	0-5	-	-	-	-	0-5	-	-	-	-	-	-
A Stoneham- Non-Executive Director (note 2)	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Mr C Godden- Non-Executive Director (note 2)	0-5	-	-	-	-	0-5	-	-	-	-	-	-
S Weech- Non-Executive Director (note 2)	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Mr F Sims - Deputy Chief Executive (note 1,9)	-	-	-	-	-	-	-	-	-	-	-	-
Mr R Ghosh - Director of Clinical Improvement - Advisor to Board (note 1,2)	15-20	-	-	-	2.5-5.0	20-25	-	-	-	-	-	-
Mr P Evans - Medical Leadership - Advisor to Board (note 1,2)	50-55	-	-	-	0-2.5	55-60	-	-	-	-	-	-
Ms K Baker - Chief Executive (note 1,4)	75-80	-	-	-	10-12.5	90-95	145-150	-	-	-	20-22.5	165-170
Mrs C Palmer - Executive Director of Financial & Human Resources (note 3,5 & 6)	85-90	-	-	-	12.5-15	100-105	115-120	-	-	-	15-17.5	130-135
Mr A Sheward - Executive Director of Nursing & Quality (note 3,5,9)	95-100	-	-	-	12.5-15	110-115	60-65	-	-	-	12.5-15	75-80
Mrs M Oldham - Chief Executive (note 2, 6)	165-170	-	-	-	0-2.5	170-175	-	-	-	-	-	-
Mr D Cattell - Interim Turnaround Chief Financial Officer (note 2,5,9)	160-165	-	-	-	0-2.5	165-170	-	-	-	-	-	-
Mr S Parker - Medical Director (note 2,5)	85-90	-	-	-	7.5-10	100-105	-	-	-	-	-	-
Mrs J Pennycook - Director of Human Resources and Organisational Development (note 1,2,5,9)	140-145	-	-	-	12.5-15	155-160	-	-	-	-	-	-
Mr K Bond - Director of Operations - Mental Health Services (note 1,2,4,5)	80-85	-	-	-	10-12.5	95-100	-	-	-	-	-	-
Mrs B Stuttle - Director of Nursing (note 2,5)	80-85	-	-	-	0-2.5	85-90	-	-	-	-	-	-
Mrs S Rostron - Director of Quality Governance (note 1,2,5)	15-20	-	-	-	2.5-5.0	20-25	-	-	-	-	-	-
Mr J Burwell - Executive Director of Strategy & Planning (Note 1,4,5)	100-105	-	-	-	12.5-15	115-120	90-95	1,900			5-7.5	95-100
Dr M Pugh - Executive Medical Director (note 4,5)	140-145	-	-	-	17.5-20	160-165	185-190	-	-	-	17.5-20	200-205
Mr M Price - Company Secretary (note 1,4,5)	120-125	-	-	-	2.5-5.0	125-130	100-105	-	-	-	12.5-15	110-115
Mrs S Johnston - Acting Executive Director of Nursing & Quality (Note 2,5)	20-25	-	-	-	2.5-5.0	25-30	20-25	-	-	-	2.5-5	25-30
Mr S Stacey - Chief Operating Officer (note 3,5)	105-110	-	-	-	0-2.5	110-115	105-110	-	-	-	0-2.5	105-110
Band of Highest Paid Director's Total Remuneration (£000)	**170-175**						**185-190**					
Median Total Remuneration (£)	**26,565**						**26,302**					
Ratio (note 7)	**6.3**						**6.9**					

Notes

1) All the above senior managers are/were voting members of the Board of Directors except:

A Sheward (until 22 June 2017)	J Pennycook (from 1 July 2017)
M Price (until 30 June 2017)	F Sims (from 1 July 2017)
K Baker (until 5 October 2017)	P Evans (from 10 July 2017)
J Burwell (until 27 February 2018)	S Rostron (from 1 February 2018)
K Bond (25 June 2017 – 31 March 2018)	R Ghosh (from 6 February 2018)

2) The following appointments were made in the year:

1 April – 1 June 2017	M Pugh acted as CEO
2 May 2017	M Oldham was appointed Interim CEO
26 June 2017	K Bond appointed Director of Operations - Mental Health Services
1 July 2017	F Sims appointed as Deputy Chief Executive
1 July 2017	J Pennycook appointed Interim Director of Human Resources and Organisational Development
3 July – 30 September 2017	S Johnston acted as Director of Nursing
10 July 2017	P Evans appointed Medical Leadership, advisor to Board
10 July 2017	P Evans appointed Medical Leadership, advisor to Board
17 July 2017	D Cattell appointed Interim Turnaround Chief Financial Officer
1 September 2017	C Godden appointed Non-Executive Director
25 September 2017	B Stuttle appointed Interim Director of Nursing and Quality then Director of Nursing and Quality
25 September 2017	S Parker appointed Interim Medical Director
2 October 2017	V Thomas appointed as Chair
6 December 2017	M Oldham appointed CEO
1 January 2018	J Pennycook appointed Director of Human Resources and Organisational Development
1 January 2018	C Spicer appointed Non-Executive Director
1 January 2018	S Weech appointed Non-Executive Director
1 February 2018	S Rostron appointed Director of Quality Governance
1 February 2018	A Stoneham appointed Non-Executive Director
6 February 2018	R Ghosh appointed Director of Clinical Improvement, advisor to Board

3) The remaining Directors not shown in Note 2 - Shaun Stacey, Vaughan Thomas, Charles Rogers and David King - continued to serve on the Board throughout the year, and remain as Directors as at the date of this Annual Report and Accounts.

4) The following persons were Directors at 1 April 2017 but ceased to serve on the Board during the year:

30 June 2017	M Price was made redundant as Company Secretary
19 July 2017	N Moorman resigned as Non-Executive Director
8 September 2017	M Pugh resigned as Medical Director
30 September 2017	E Richardson resigned as Chair
30 September 2017	J Baird resigned as Non-Executive Director
1 October 2017	V Thomas resigned as Non-Executive Director
27 February 2018	J Burwell ceased as Executive Director of Strategy and Planning
31 December 2017	C Palmer retired as Executive Director of Financial & Human Resources
22 June 2017	A Sheward ceased as Director of Nursing and commenced a secondment to an external organisation

5) The above named Executive Directors have service contracts with the Trust.

6) The Chief Executive Officer and Executive Director of Financial & Human Resources are contractually entitled to performance bonuses as part of their remuneration but both declined to be paid this element.

7) Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Director in the Isle of Wight NHS Trust in the financial year 2017/18 was £170,000 - £175,000 (2016/17 - £185,000 - £190,000). This was 6.3 times (2016/17 - 6.9 times) the median remuneration of the workforce, which was £26,565 (2016/17 - £26,602). In 2017/18, three employees received remuneration which was proportionately higher than that received by the highest paid Director (2016/17 - three employees). Total remuneration includes salary, on-call payments, non-consolidated performance-related pay, 'benefits in kind' as well as severance payments and is calculated on a Full Time Equivalent basis. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Remuneration ranged from £12,000 to £301,000.

8) These are only included to show comparative figures for 2016/17.

9) D Cattell held the non-substantive post of Interim Turnaround CFO from 17 July – 8 August 2017. This was paid via MILL STREET CONSULTANCY LTD.

J Pennycook held the non-substantive post of Interim Director of HR from January 2017. This was paid via N & J PENNYCOOK LTD.

F Sims is funded by NHS Improvement.

Employee benefits 2017/18

Employee benefits	2017-18 Total £000s	2016-17 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	109,997	102,571
Social security costs	9,971	9,517
Apprenticeship Levy	483	-
Employer Contributions to NHS BSA - Pensions Division	11,725	11,493
Other pension costs	10	8
Termination benefits	122	193
Total employee benefits	**132,308**	123,782
Employee costs capitalised	**438**	278
Gross Employee Benefits excluding capitalised costs	**131,870**	123,504

See next page for table showing the Pension Benefits of senior managers.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, the value of any benefits transferred from another pension scheme or arrangement, and uses common market valuation factors for the start and end of the period. A CETV is not provided once a scheme member reaches age 60.

Pension Benefits Name and title	(a) Real increase in pension at age 60	(b) Real increase in pension lump sum at age 60	(c) Total accrued pension at age 60 at 31 March 2018	(d) Lump sum at age 60 related to accrued pension at 31 March 2018	(e) Cash Equivalent Transfer Value at 1 April 2017	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2018	(h) Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	£000
Ms K Baker - Chief Executive	0.0 - 2.5	0.0 - 2.5	50.0 - 55.0	170.0 - 175.0	0	0	1,444	0
Mrs C Palmer - Executive Director of Financial & Human Resources	0	0	30.0 -35.0	105.0 - 110.0	0	0	791	0
Mr A Sheward - Executive Director of Nursing & Quality	0.0 - 2.5	0.0 - 2.5	25.0 - 30.0	0.0 - 5.0	429	0	403	0
Mrs M Oldham - Chief Executive	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Mr D Cattell - Interim Turnaround Chief Financial Officer	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Mr S Parker - Interim Medical Director	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Mrs J Pennycook - Director of Human Resources and Organisational Development	20.0 - 22.5	0	20.0 - 25.0	60.0 - 65.0	438	438	0	0
Mr K Bond - Director of Operations - Mental Health Services	20.0 - 22.5	0	25.0 - 30.0	80.0 - 85.0	605	464	0	0
Mrs B Stuttle - Director of Nursing	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Mrs S Rostron - Director of Quality Governance	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Mr J Burwell - Executive Director of Strategy & Planning	0.0 - 2.5	0.0 - 2.5	5.0 - 10.0	0.0 - 5.0	38	12	24	0
Mr M Price - Company Secretary	0	0	40.0 - 45.0	120.0 - 125.0	823	11	770	0
Dr M Pugh - Executive Medical Director	0.0 - 2.5	0.0 - 2.5	50.0 - 55.0	150.0 - 155.0	1,052	38	956	0
Mr S Stacey - Chief Operating Officer	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Mrs S Johnston - Acting Executive Director of Nursing & Quality	0.0 - 2.5	0.0 - 2.5	25.0 - 30.0	75.0 - 80.0	469	19	387	0

Fair pay disclosure

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires that from 31 March 2017, any public sector organisation that has 250 or more employees must publish and report specific figures about their gender pay gap. The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings. For example, 'women earn 15% less than men per hour'. Employers must both publish their gender pay gap data and a written statement on their website and report their data to government online - using the gender pay gap reporting service. The overall pay difference at the Isle of Wight NHS Trust is 19% higher for men than women. More information can be found in our Gender Pay Gap Report published at **www.iow.nhs.uk/Publications/gender-pay-gap-report.htm**.

Appraisal and performance

The review of the performance of any senior manager on Agenda for Change terms and conditions of employment would be in accordance with the Trust's Appraisal Policy. The Trust Board are also appraised. The Chairman undertakes the appraisal of the Chief Executive and Non-Executive Directors. The Executive Directors are appraised by the Chief Executive.

Agenda for Change terms and conditions of employment allow for pay progression to be held at the first, and second, gateways should performance not be satisfactory. Any pay award to other Directors would take account of national guidance and appraisal outcomes.

Duration of contracts, notice periods and termination payments

Substantive appointments are made on a permanent basis, and temporary arrangements would be on the appropriate period of a fixed-term contract. Any senior manager on Agenda for Change terms and conditions of employment (Pay Band 8 and above) are on three months' period of notice. Other Director contracts are required to give six months' period of notice.

Off-payroll engagements

As part of the Review of Tax Arrangements of Public Sector Employees, published by the Chief Secretary to the Treasury on the 23 May 2012, NHS bodies are required to publish information in their Annual Report regarding off-payroll engagements where payment was more than £220 per day and lasted six months or longer. Between the 1 April 2017 and the 31 March 2018, the Trust had no 'off-payroll' engagements of this nature.

Consultancy services

The financial accounts show that the Trust spent £1.648m on consultancy services in 2017/18 compared to £611,000 in 2016/17 and £621,000 in 2015/16.

Equality disclosures

The Trust has a comprehensive range of policies and procedures promoting equality, diversity and inclusion, and the elimination of harassment, bullying and discrimination. The Trust's Equality Report (an Equality Act 2010 requirement) can be found at **www.iow.nhs.uk/about-us/Equality-and-diversity/equality-and-diversity.htm**. Our Patients with a Disability Group goes from strength-to-strength and is actively involved in using patient feedback to enable the Trust to improve services for patients and staff. Ninety-six per cent of staff have received some form of equality and diversity training. Seventy-five per cent of staff have received Specific Disability Awareness training which is now mandatory for all staff. Staff who raise concerns of bullying, harassment or discrimination are supported by Human Resources, Trade Union representatives and Occupational Health. A 'Diversity and Inclusion Handbook' is available.

Staff policies in respect of disabled persons

The Trust has a range of policies which provide for the full and fair consideration to employment applications made by people with a disability, having regard to their particular aptitudes and abilities. Where issues arise during employment, policies provide for continuing the employment of, and for arranging appropriate training for, employees who have become disabled during their employment. The Trust policies do not permit discrimination against disabled people in respect of training, career development and/or promotion. Our policies can be found at **www.iow.nhs.uk/about-us/policies_and_strategies.htm**.

Education, training and organisational development

We have had a successful Education Quality Review meeting with Health Education England. All of the Trust's quality standards - through our Learning and Development Agreement - were met. The Education, Training and Organisational Development team are at the forefront of ensuring our staff are appropriately skilled and up to date with the latest developments that could benefit our patients.

Highlights from 2017/18 include…

Clinical Education, Mandatory and general training

- We have recruited three clinical practice educators and a medical devices trainer to support the delivery of education and training in the work place.
- We have supported in the region of 80 WTE student placement hours.
- We have launched a CPD programme for clinical bands 1-4
- We have achieved phase one of improvement work for Mandatory Training.

Leadership & OD

- Over 60.83% of staff had an annual appraisal during the year. This is a significant increase from the 2015/16 total which was just over 36%.
- 363 staff attended Corporate Inductions during 2017 /2018 (as at 31 March 2018)
- 84 staff attended the High Performing Leaders course during 2017/18 (as at 31 March 2018). This course has been revised to include extra sessions run by Human Resources and Finance as suggested in the initial feedback and is now a five day course for 2018.
- 11 Anti-Bullying Advisors and three Freedom to Speak Up Advocates have been recruited and trained during August – October 2017. They posts were launched to the organisation during November 2017, and to date, 30 individuals have come forward for support or to raise concerns.
- A further 18 members of staff are attending an Introduction Q&A session during June 2018 with a view to taking on more members of staff from across the organisation to support this work
- A Theatre Forum-style interactive training has been introduced on behaviours at work; 12 members of staff have volunteered to be actors, creating a scenario for the audience to observe and suggest how behaviour could be improved.

Medical education

- We submitted a successful proposal to Health Education England (Wessex) to develop a high-fidelity academic clinical skills suite. We have been awarded £283,000 to implement this exciting multi-professional project.
- Our GMC review took place on the 23 February 2018. This helped us to develop action plans to improve the training experience of doctors in training on the island.
- The Trust Leadership Committee approved the new Resident Medical Officer/F3 posts
- We appointed a Lead Registrar, who is working closely with the Medical Education Team on exciting transformational projects
- Successful Quality visits from Health Education Wessex Foundation School and the Southampton Medical School took place in December.

Library and knowledge services

- Our Clinical Outreach Librarian is now based in the Emergency Department twice a week, providing immediate access to evidence for patient care decisions
- 1,566 members of staff have signed up for Wi-Fi access, enabling access to online evidence and educational resource at their fingertips
- A listing of published local health research is now available at: **www.iow.nhs.uk/Working-With-Us/oliveira-library/local-research.htm**
- Services provided received an average of 95% good/excellent rating in our annual library survey, with 'helpful' and 'friendly' staff the most frequent comment.

Maggie Oldham
Chief Executive Officer / Accountable Officer
Isle of Wight NHS Trust

24 May 2018

Primary financial statements and notes to the Accounts

NHS organisations have a statutory duty to produce annual accounts (also known as financial statements). The annual accounts are the main way in which trusts discharge their accountability to taxpayers and service users for their stewardship of public money.

The Trust Board is required to formally approve the accounts once they have been audited. Whilst the accounts reflect the immediate past performance during the last 12 months, they also set out the financial foundations on which the organisation will build its future performance. The format of the accounts is specified in the Department of Health Group Manual for Accounts published by the Department of Health.

Maggie Oldham
Chief Executive Officer / Accountable Officer
Isle of Wight NHS Trust

24 May 2018

Getting to Good

Relocations help reinstate conference room meetings

The Trust's popular conference room has been reinstated as an area for meetings and activities requiring a large space – an area where the Trust can hold 'showcase' events. The often-in demand room previously hosted several important meetings and activities, including Trust Board and health and wellbeing open days, but has been home to the operations team for the past three years.

The room, located opposite the Full Circle Restaurant at St. Mary's Hospital, has been freed up again thanks to several relocations managed by the facilities and IT teams, with the operations team moving to a new dedicated space co-located with the medical assessment unit. The move means large meetings no longer need to be held in the old health sciences building, allowing the Trust to close some of its old estate and save significant money in the process.

Annual Accounts for the year ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	155,529	154,410
Other operating income	4	15,866	16,700
Operating expenses	6, 8	(190,608)	(178,423)
Operating surplus/(deficit) from continuing operations		**(19,213)**	**(7,313)**
Finance income	11	16	16
Finance expenses	12	(679)	(237)
PDC dividends payable		(2,873)	(3,356)
Net finance costs		**(3,536)**	**(3,577)**
Other gains / (losses)	13	(5)	(22)
Share of profit / (losses) of associates / joint arrangements		-	-
Gains / (losses) arising from transfers by absorption		-	-
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		**(22,754)**	**(10,912)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	-	-
Surplus / (deficit) for the year		**(22,754)**	**(10,912)**

Other comprehensive income
Will not be reclassified to income and expenditure:

	Note	2017/18 £000	2016/17 £000
Impairments	7	-	1,809
Revaluations	18	6,080	675
Share of comprehensive income from associates and joint ventures		-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset		-	-
Other reserve movements		-	1
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available-for-sale financial investments		-	-
Recycling gains / (losses) on available-for-sale financial investments		-	-
Foreign exchange gains / (losses) recognised directly in OCI		-	-
Total comprehensive income / (expense) for the period		**(16,674)**	**(8,427)**

Financial Performance for the Year		
Surplus / (deficit) for the year	(22,754)	(10,912)
Remove capital donations / grants I&E impact	87	(48)
CQUIN Risk Reserve - 17/18 CT non achievement adjustment	(583)	-
Adjusted financial performance surplus / (deficit)	**(23,250)**	**(10,960)**

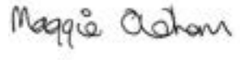
Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	2,643	1,789
Property, plant and equipment	16	122,438	115,407
Investment property		-	-
Investments in associates and joint ventures		-	-
Other investments / financial assets		-	-
Trade and other receivables	20	286	158
Other assets		-	-
Total non-current assets		**125,367**	**117,354**
Current assets			
Inventories	19	2,279	2,273
Trade and other receivables	20	10,610	6,900
Other investments / financial assets		-	-
Other assets		-	-
Non-current assets held for sale / assets in disposal groups		-	-
Cash and cash equivalents	21	5,999	7,295
Total current assets		**18,888**	**16,468**
Current liabilities			
Trade and other payables	22	(20,339)	(17,920)
Borrowings	25	(109)	(106)
Other financial liabilities		-	-
Provisions	27	(312)	(583)
Other liabilities	24	(2,278)	(2,128)
Liabilities in disposal groups		-	-

	Note	31 March 2018 £000	31 March 2017 £000
Total current liabilities		**(23,038)**	**(20,737)**
Total assets less current liabilities		**121,217**	**113,085**
Non-current liabilities			
Trade and other payables	22	(22)	-
Borrowings	25	(38,252)	(14,561)
Other financial liabilities	23	-	-
Provisions	27	(165)	(32)
Other liabilities	24	-	-
Total non-current liabilities		**(38,439)**	**(14,593)**
Total assets employed		**82,778**	**98,492**
Financed by			
Public dividend capital		7,722	6,762
Revaluation reserve		47,290	41,242
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		27,766	50,488
Total taxpayers' equity		**82,778**	**98,492**

The notes on the following pages form part of these accounts.

Name **Maggie Oldham**
Position **Chief Executive**
Date **29 May 2018**

Signed 

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**6,762**	**41,242**	**-**	**-**	**-**	**50,488**	**98,492**
Surplus/(deficit) for the year	-	-	-	-	-	(22,754)	**(22,754)**
Other transfers between reserves	-	(32)	-	-	-	32	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	6,080	-	-	-	-	**6,080**
Public dividend capital received	960	-	-	-	-	-	**960**
Taxpayers' equity at 31 March 2018	**7,722**	**47,290**	**-**	**-**	**-**	**27,766**	**82,778**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**6,155**	**38,781**	**-**	**-**	**-**	**61,376**	**106,312**
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	**6,155**	**38,781**	**-**	**-**	**-**	**61,376**	**106,312**
Surplus/(deficit) for the year	-	-	-	-	-	(10,912)	**(10,912)**
Other transfers between reserves	-	(23)	-	-	-	23	**-**
Impairments	-	1,809	-	-	-	-	**1,809**
Revaluations	-	675	-	-	-	-	**675**
Public dividend capital received	607	-	-	-	-	-	**607**
Other reserve movements	-	-	-	-	-	1	**1**
Taxpayers' equity at 31 March 2017	**6,762**	**41,242**	**-**	**-**	**-**	**50,488**	**98,492**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are de-recognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(19,213)	(7,313)
Non-cash income and expense:			
Depreciation and amortisation	6	6,484	6,458
Net impairments	7	3	-
Income recognised in respect of capital donations	4	(46)	(184)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(3,838)	(473)
(Increase) / decrease in inventories		(6)	(36)
Increase / (decrease) in payables and other liabilities		2,005	(514)
Increase / (decrease) in provisions		(138)	208
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**(14,749)**	**(1,854)**
Cash flows from investing activities			
Interest received		16	16
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(1,381)	(430)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(6,300)	(2,585)
Sales of property, plant, equipment and investment property		2	2
Receipt of cash donations to purchase capital assets		-	139
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**(7,663)**	**(2,858)**

	Note	2017/18 £000	2016/17 £000
Cash flows from financing activities			
Public dividend capital received		960	607
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		23,800	12,295
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		(106)	(102)
Capital element of PFI, LIFT and other service concession payments		-	-
Interest paid on finance lease liabilities		(18)	(22)
Interest paid on PFI, LIFT and other service concession obligations		-	-
Other interest paid		(585)	(215)
PDC dividend (paid) / refunded		(2,930)	(3,194)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		(5)	-
Net cash generated from / (used in) financing activities		**21,116**	**9,369**
Increase / (decrease) in cash and cash equivalents		**(1,296)**	**4,657**
Cash and cash equivalents at 1 April - brought forward		**7,295**	**2,638**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**7,295**	**2,638**
Cash and cash equivalents transferred under absorption accounting		-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	21	**5,999**	**7,295**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis, as there is no indication that that the healthcare and other services will not continue to be provided by the public sector for the foreseeable future and that continuing financial support will be provided by DHSC.

This year the Trust has struggled to meet its financial targets against a backdrop of increased financial pressure across the NHS. The Trust has returned a deficit of £23.250m and has achieved £5.4m savings through the Cost Improvement Programme. The DHSC provided deficit funding of £23.8m as revenue support loans in year bringing the total revenue support loan funding to £37.8m at 31 March 2018. Regulatory oversight undertakings have been in operation during the year and the Trust is focused on exiting from Quality Special Measures by 2020.

The Trust's control total for 2018/19 is a surplus of £4.286m, however it is expected the Trust will deliver a deficit of £18.5m. The plans reflect agreed continued revenue deficit support funding from DHSC, and this support funding is authorised by the DH monthly in advance. Deficit support funding of £1.6m for April and £1.762m for May has been provided to the Trust.

The Trust has a contract expectation with the Isle of Wight CCG for 2018-19 for an expected value of £134.2m. The Trust also has in place a contract with NHS England for £8.6m.

The Trust's 2018/19 cash flow forecast is based on the assumptions in the 2018/19 financial plan. The key assumptions underpinning the cash flow are receipt of £18.5m revenue support loan from the DHSC to finance the revenue deficit.

The cash flow position is reported to the Performance Committee and the Board monthly and this is based on the Trust's detailed cash flow forecast which is updated daily.

Taking into account all these factors, the assumption that the healthcare and other services will continue to be provided by the public sector for the foreseeable future and that the DHSC will continue to provide financial support, the Board consider the Trust will continue to operate as a going concern. The conditions described above do, however, indicate the existence of material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern.

The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Inventories – In general the value of all inventories is determined by annual stock take as at 31st March or as close to that date as is reasonably practical. Inventories are valued at the lower of cost and net realisable value using the first-in first-out formula (except pharmacy stocks which are at weighted average cost).

Income Accruals – Where possible these are based on actual activity and price. Where it is not possible to quantify actual activity, accruals are estimated based on historical data available for the specific activity taking into account cyclical patterns where this is considered relevant.

Impairment of and Reversals of Financial Assets – All non-NHS receivables other than those covered by the Compensation Recovery Unit above 90 days excluding NHS bodies are impaired on an invoice by invoice basis. All debts relating to the Compensation Recovery Unit will be provided for at 22.84% as per the Accounting Manual guidance.

Expenditure Accruals – Where possible these are based on actual activity and price applicable. Where it is not possible to quantify actual activity, accruals are estimated based on historical data available for the specific activity taking into account cyclical patterns where this is considered relevant.

Employee Benefits – Accrual for untaken annual leave is based on number of days carried forward and calculated at the mid-point on the scale. Overtime and travel costs for March have been estimated based on the average of the preceding months.

Note 1.2.1 Sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.3 Interests in other entities

The Isle of Wight NHS Trust Charitable Funds Accounts, for which the Isle of Wight NHS Trust is a Corporate Trustee, are not material and are therefore not consolidated.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

In addition to healthcare related activities the Trust also trades under the name of NHS Creative. This activity is a design, print and marketing function. The income and costs related to this trade are included in Note 4 to the accounts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust also makes contributions to an occupational pension scheme set up in accordance with the Automatic Enrolment (Miscellaneous Amendments) Regulations 2012. The scheme is a defined contribution scheme, for which the Trust accounts for its employer contributions within 'other pension costs' in these financial statements.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- The cost of the item can be measured reliably
- The item has cost of at least £5,000
- Collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

All assets are measured subsequently at valuation. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred. Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised.

Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- The sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	55
Dwellings	-	-
Plant & machinery	4	25
Transport equipment	5	16
Information technology	3	14
Furniture & fittings	5	17

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- The Trust intends to complete the asset and sell or use it
- The Trust has the ability to sell or use the asset
- How the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- The Trust can measure reliably the expenses attributable to the asset during development

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Information technology	1	5
Development expenditure	-	-
Websites	-	-
Software licences	-	-
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Derecognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 33 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Where the time value of money is material, contingencies are disclosed at their present value.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) Donated assets (including lottery funded assets),
(ii) Average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
(iii) Any PDC dividend balance receivable or payable

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Foreign exchange

The NHS Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

Note 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

- IFRS 9 Financial Instruments – This standard is still subject to HM Treasury adoption being for implementation in 2018/19, and comes into effect from 1st April 2018
- IFRS 15 Revenue from Contracts with Customers - This standard is still subject to HM Treasury adoption being for implementation in 2018/19, and comes into effect from 1st April 2018
- IFRS 16 Leases – Government implementation date still subject to HM Treasury consideration

Note 2 Operating

Segments
The Board receives regular reports of the financial performance and financial position of the Trust, and as an integrated Trust the key financial information for decision making is based on the entity as a whole. It is therefore considered that the Trust has just one reportable segment, a healthcare segment. There are no other segments that constitute 10% or more of the Trust's operations. The Trust receives income from a number of healthcare commissioners, and the respective income levels are disclosed in note 3 to these accounts.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute services		
Elective income	13,772	13,316
Non elective income	27,988	29,103
First outpatient income	4,822	4,229
Follow up outpatient income	3,819	5,212
A & E income	4,910	4,712
High cost drugs income from commissioners (excluding pass-through costs)	577	-
Other NHS clinical income	41,158	37,813
Mental health services		
Cost and volume contract income	-	-
Block contract income	19,685	20,049
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	-	-
Ambulance services		
A & E income	6,549	6,547
Patient transport services income	700	699
Other income	4	4
Community services		
Community services income from CCGs and NHS England	25,387	25,945
Income from other sources (e.g. local authorities)	4,559	5,278
All services		
Private patient income	1,146	1,166
Other clinical income	453	337
Total income from activities	**155,529**	**154,410**

Note 3.2 Income from patient care activities (by source)

	2017/18 £000	2016/17 £000
NHS England	**9,275**	**10,265**
Clinical commissioning groups	139,991	137,031
Department of Health and Social Care	-	-
Other NHS providers	105	333
NHS other	-	-
Local authorities	4,559	5,278
Non-NHS: private patients	1,146	1,166
Non-NHS: overseas patients (chargeable to patient)	55	6
NHS injury scheme	368	301
Non NHS: other	30	30
Total income from activities	**155,529**	**154,410**
Of which:		
Related to continuing operations	155,529	154,410
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18 £000	2016/17 £000
Income recognised this year	55	6
Cash payments received in-year	46	3
Amounts added to provision for impairment of receivables	7	-
Amounts written off in-year	2	5

Note 4 Other operating income

	2017/18 £000	2016/17 £000
Research and development	834	605
Education and training	4,436	3,792
Receipt of capital grants and donations	46	184
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	5,640	1,309
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	469	1,750
Rental revenue from operating leases	101	123
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis 2,642		496
Other income	3,844	6,295
Total other operating income	**15,866**	**16,700**
Of which:		
Related to continuing operations	15,866	6,700
Related to discontinued operations	-	-

Material items included within Other Revenue include NHS Creative Income Generation £1.9m, Car Parking £432k, Catering £380k, Minor income generation £231k, Estates Recharges £163k and Ferry Ticket Sales £87k

Note 5 Fees and charges

Income Generating Activities - NHS Creative

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

	2017/18 £000	2016/17 £000
Income	1,866	2,458
Full cost	(1,817)	(2,481)
Surplus / (deficit)	**49**	**(23)**

Note 6 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	2,676	2,194
Purchase of healthcare from non-NHS and non-DHSC bodies	-	-
Purchase of social care	-	-
Staff and executive directors costs	131,748	123,311
Remuneration of non-executive directors	73	71
Supplies and services - clinical (excluding drugs costs)	12,414	12,738
Supplies and services - general	1,714	1,471
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	12,585	12,275
Inventories written down	15	35
Consultancy costs	1,648	611
Establishment	3,395	3,656
Premises	6,975	7,137
Transport (including patient travel)	2,052	1,786
Depreciation on property, plant and equipment	5,583	5,339
Amortisation on intangible assets	901	1,119
Net impairments	3	-
Increase/(decrease) in provision for impairment of receivables	64	(29)
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	76	81
other auditor remuneration (external auditor only)	10	10
Internal audit costs	57	57
Clinical negligence	3,856	3,513
Legal fees	245	348
Insurance	22	5
Research and development	-	-
Education and training	570	695
Rentals under operating leases	710	622
Early retirements	-	-
Redundancy	122	160
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	-	-
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-
Car parking & security	321	245
Hospitality	105	49
Losses, ex gratia & special payments	-	33
Grossing up consortium arrangements	-	-
Other services, e.g. external payroll	144	156
Other	2,524	735
Total	**190,608**	**178,423**
Of which:		
Related to continuing operations	190,608	178,423
Related to discontinued operations	-	-

Material items of Other Expenditure include External Contractors £2.2m, Insurance £118k and Non-Statutory Audits £92k

Note 6.1 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	10	10
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**10**	**10**

Note 6.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	3	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	-	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**3**	**-**
Impairments charged to the revaluation reserve	-	(1,809)
Total net impairments	**3**	**(1,809)**

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	99,106	94,954
Social security costs	9,971	9,517
Apprenticeship levy	483	-
Employer's contributions to NHS pensions	11,725	11,493
Pension cost - other	10	8
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	122	193
Temporary staff (including agency)	10,891	7,617
Total gross staff costs	**132,308**	**123,782**
Recoveries in respect of seconded staff	-	-
Total staff costs	**132,308**	**123,782**
Of which		
Costs capitalised as part of assets	438	278

Note 8.1 Retirements due to ill-health

During 2017/18 there were 3 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £117k (£296k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The Trust also makes contributions to an occupational pension scheme set up in accordance with the Automatic Enrolment (Miscellaneous Amendments) Regulations 2012. The scheme is a defined contribution scheme, for which the Trust accounts for its employer contributions within 'other pension costs' in these financial statements.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 10 Operating leases

Note 10.1 Isle of Wight NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Isle of Wight NHS Trust is the lessor.

The Leases comprise of rental of the Renal and Audiology Units by Portsmouth Hospitals NHS Trust and other smaller value leases of Land and Buildings

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	101	123
Contingent rent	-	-
Other	-	-
Total	**101**	**123**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	98	123
- later than one year and not later than five years;	41	42
- later than five years.	-	-
Total	**139**	**165**

Note 10.2 Isle of Wight NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Isle of Wight NHS Trust is the lessee.

The Trust leases medical equipment, property and vehicles under operating lease arrangements.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease payments	710	622
Contingent rents	-	-
Less sublease payments received	-	-
Total	**710**	**622**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	575	465
- later than one year and not later than five years;	602	370
- later than five years.	339	340
Total	**1,516**	**1,175**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18 £000	2016/17 £000
Interest on bank accounts	16	12
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	4
Other finance income	-	-
Total	**16**	**16**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	652	208
Other loans	-	-
Overdrafts	-	-
Finance leases	18	22
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**670**	**230**
Unwinding of discount on provisions	-	7
Other finance costs	9	-
Total finance costs	**679**	**237**

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18 £000	2016/17 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2017/18 £000	2016/17 £000
Gains on disposal of assets	-	-
Losses on disposal of assets	(4)	(22)
Total gains / (losses) on disposal of assets	**(4)**	**(22)**
Gains / (losses) on foreign exchange	(1)	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	**(5)**	**(22)**

Note 14 Discontinued operations

	2017/18 £000	2016/17 £000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	**-**	**-**

Note 15 Intangible assets

Note 15.1 Intangible assets - 2017/18

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**6,800**	**-**	**6,800**
Transfers by absorption	-	-	**-**
Additions	1,572	183	**1,755**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	(3)	-	**(3)**
Gross cost at 31 March 2018	**8,369**	**183**	**8,552**
Amortisation at 1 April 2017 - brought forward	**5,011**	**-**	**5,011**
Transfers by absorption	-	-	**-**
Provided during the year	901	-	901
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	-	-	**-**
Transfers to / from assets held for sale	-	-	**-**
Disposals / derecognition	(3)	-	**(3)**
Amortisation at 31 March 2018	**5,909**	**-**	**5,909**
Net book value at 31 March 2018	**2,460**	**183**	**2,643**
Net book value at 1 April 2017	**1,789**	**-**	**1,789**

Note 15.2 Intangible assets - 2016/17

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**6,293**	**-**	**6,293**
Prior period adjustments	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**6,293**	**-**	**6,293**
Transfers by absorption	-	-	**-**
Additions	507	-	**507**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Valuation / gross cost at 31 March 2017	**6,800**	**-**	**6,800**
Amortisation at 1 April 2016 - as previously stated	**3,892**	**-**	**3,892**
Prior period adjustments	-	-	**-**
Amortisation at 1 April 2016 - restated	**3,892**	**-**	**3,892**
Transfers by absorption	-	-	**-**
Provided during the year	**1,119**	**-**	**1,119**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Amortisation at 31 March 2017	**5,011**	**-**	**5,011**
Net book value at 31 March 2017	**1,789**	**-**	**1,789**
Net book value at 1 April 2016	**2,401**	**-**	**2,401**

Note 16 Property, plant and equipment

Note 16.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**8,625**	**99,805**	**-**	**1,982**	**11,831**	**1,802**	**3,475**	**1,592**	**129,112**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	-	-	4,605	1,174	198	446	120	**6,543**
Impairments	-	(3)	-	-	-	-	-	-	**(3)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	270	2,451	-	-	-	-	-	-	**2,721**
Reclassifications	-	2,956	-	(3,017)	61	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(67)	(6)	-	-	**(73)**
Valuation/gross cost at 31 March 2018	**8,895**	**105,209**	**-**	**3,570**	**12,999**	**1,994**	**3,921**	**1,712**	**138,300**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**5,463**	**-**	**-**	**6,455**	**1,190**	**603**	**(6)**	**13,705**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,358	-	-	1,112	149	823	141	**5,583**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(3,359)	-	-	-	-	-	-	**(3,359)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(61)	(6)	-	-	**(67)**
Accumulated depreciation at 31 March 2018	**-**	**5,462**	**-**	**-**	**7,506**	**1,333**	**1,426**	**135**	**15,862**
Net book value at 31 March 2018	**8,895**	**99,747**	**-**	**3,570**	**5,493**	**661**	**2,495**	**1,577**	**122,438**
Net book value at 1 April 2017	**8,625**	**94,342**	**-**	**1,982**	**5,376**	**612**	**2,872**	**1,598**	**115,407**

Note 16.2 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**8,520**	**99,874**	**-**	**1,024**	**10,278**	**1,560**	**2,442**	**1,332**	**125,030**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**8,520**	**99,874**	**-**	**1,024**	**10,278**	**1,560**	**2,442**	**1,332**	**125,030**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	-	-	1,786	1,606	245	1,033	260	**4,930**
Impairments	-	(2,875)	-	-	-	-	-	-	**(2,875)**
Reversals of impairments	-	1,809	-	-	-	-	-	-	**1,809**
Revaluations	105	169	-	-	-	-	-	-	**274**
Reclassifications	-	828	-	(828)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(53)	(3)	-	-	**(56)**
Valuation/gross cost at 31 March 2017	**8,625**	**99,805**	**-**	**1,982**	**11,831**	**1,802**	**3,475**	**1,592**	**129,112**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**5,464**	**-**	**-**	**5,441**	**999**	**(112)**	**(118)**	**11,674**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**5,464**	**-**	**-**	**5,441**	**999**	**(112)**	**(118)**	**11,674**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,275	-	-	1,043	194	715	112	**5,339**
Impairments	-	(2,875)	-	-	-	-	-	-	**(2,875)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(401)	-	-	-	-	-	-	**(401)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	(29)	(3)	-	-	**(32)**
Accumulated depreciation at 31 March 2017	**-**	**5,463**	**-**	**-**	**6,455**	**1,190**	**603**	**(6)**	**13,705**
Net book value at 31 March 2017	**8,625**	**94,342**	**-**	**1,982**	**5,376**	**612**	**2,872**	**1,598**	**115,407**
Net book value at 1 April 2016	**8,520**	**94,410**	**-**	**1,024**	**4,837**	**561**	**2,554**	**1,450**	**113,356**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018									
Owned - purchased	8,895	99,351	-	3,570	4,694	653	2,495	1,532	121,190
Finance leased	-	-	-	-	509	-	-	-	509
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-
PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	396	-	-	290	8	-	45	739
NBV total at 31 March 2018	**8,895**	**99,747**	**-**	**3,570**	**5,493**	**661**	**2,495**	**1,577**	**122,438**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned - purchased	8,625	93,961	-	1,982	4,439	601	2,872	1,559	114,039
Finance leased	-	-	-	-	621	-	-	-	621
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-
PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	381	-	-	316	11	-	39	747
NBV total at 31 March 2017	**8,625**	**94,342**	**-**	**1,982**	**5,376**	**612**	**2,872**	**1,598**	**115,407**

Note 17 Donations of property, plant and equipment

Donations towards equipment to the value of £46k have been provided by Friends of St.Mary's Hospital.

Note 18 Revaluations of property, plant and equipment

Land and property assets are carried at valuation on the Statement of Financial Position. All of the Trust's land and building assets have been revalued as at 31 March 2018 by the District Valuers of the Revenue and Customs Government Department.

The valuations have been carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

The Trust's plant and equipment assets continue to be carried at depreciated historical cost as a proxy for fair value. Property, plant and equipment is depreciated at rates calculated to write them down to estimated residual values on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets under construction.

Note 19 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	878	858
Work In progress	-	-
Consumables	1,382	1,391
Energy	19	24
Other	-	-
Total inventories	**2,279**	**2,273**
Of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £15,781k (2016/17: £14,216k).
Write-down of inventories recognised as expenses for the year were £15k (2016/17: £35k).

Note 20 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	4,244	4,045
Capital receivables (including accrued capital related income)	-	-
Accrued income	3,899	1,283
Provision for impaired receivables	(392)	(342)
Deposits and advances	-	-
Prepayments (non-PFI)	1,010	1,027
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	-	-
VAT receivable	826	466
Corporation and other taxes receivable	-	-
Other receivables	1,023	421
Total current trade and other receivables	**10,610**	**6,900**

	31 March 2018 £000	31 March 2017 £000
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	286	158
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**286**	**158**
Of which receivables from NHS and DHSC group bodies:		
Current	5,773	3,563
Non-current	-	-
Of which receivables from Non-NHS and DHSC group bodies:		
Current	4,837	3,337
Non-current	286	158
Total trade and other receivables	**10,896**	**7,058**

Note 20.1 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April as previously stated	**342**	**416**
Prior period adjustments	-	-
At 1 April - restated	**342**	**416**
Transfers by absorption	-	-
Increase in provision	64	(29)
Amounts utilised	(14)	(45)
Unused amounts reversed	-	-
At 31 March	**392**	**342**

Injury Cost Recovery debtors have been impaired at 22.94% as per Department of Health guidelines.

Non-NHS receivables and receivables relating to Foundation Trusts that are greater than 121 days have been impaired in full.

Note 20.2 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	128	-	-	-
Over 180 days	201	-	342	-
Total	**329**	**-**	**342**	**-**

Ageing of non-impaired financial assets past their due date

0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	44	-	601	-
90- 180 days	122	-	102	-
Over 180 days	69	-	56	-
Total	**235**	**-**	**759**	**-**

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18 £000	2016/17 £000
At 1 April	**7,295**	**2,638**
Prior period adjustments	-	-
At 1 April (restated)	**7,295**	**2,638**
Transfers by absorption	-	-
Net change in year	(1,296)	4,657
At 31 March	**5,999**	**7,295**
Broken down into:		
Cash at commercial banks and in hand	19	14
Cash with the Government Banking Service	5,980	7,281
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**5,999**	**7,295**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**5,999**	**7,295**

Note 22 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	7,341	5,727
Capital payables	3,803	3,232
Accruals	4,365	4,763
Receipts in advance (including payments on account)	-	-
Social security costs	2,735	1,338
VAT payables	-	-
Other taxes payable	-	1,085
PDC dividend payable	9	66
Accrued interest on loans	72	-
Other payables	2,014	1,709
Total current trade and other payables	**20,339**	**17,920**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	22	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**22**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	2,980	3,387
Non-current	-	-
Of which payables from Non-NHS and DHSC bodies:		
Current	17,359	14,533
Non-current	22	-
Total trade and other payables	**20,361**	**17,920**

Note 22.1 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	1,614		1,568	

Note 23 Other financial liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**

Note 24 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,278	2,128
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**2,278**	**2,128**
Non-current		
Deferred income	-	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 25 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Social Care	-	-
Other loans	-	-
Obligations under finance leases	109	106
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	-	-
Total current borrowings	**109**	**106**
Non-current		
Loans from the Department of Health and Scoial Care	37,830	14,030
Other loans	-	-
Obligations under finance leases	422	531
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	-	-
Total non-current borrowings	**38,252**	**14,561**

Note 26 Finance leases

Note 26.1 Isle of Wight NHS Trust as a lessor

Future lease receipts due under finance lease agreements where Isle of Wight NHS Trust is the lessor:

	31 March 2018 £000	31 March 2017 £000
Gross lease receivables	**-**	**-**
Of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Unearned interest income	-	-
Allowance for uncollectable lease payments	-	-
Net lease receivables	**-**	**-**
Of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Note 26.2 Isle of Wight NHS Trust as a lessee

Obligations under finance leases where Isle of Wight NHS Trust is the lessee:

	31 March 2018 £000	31 March 2017 £000
Gross lease receivables	**531**	**637**
Of which liabilities are due:		
- not later than one year;	109	106
- later than one year and not later than five years;	422	531
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	**531**	**637**
Of which payable:		
- not later than one year;	109	106
- later than one year and not later than five years;	422	531
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

Note 27 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Re-structuring £000	Continuing care £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	**-**	**73**	**-**	**-**	**-**	**160**	**382**	**615**
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	-	55	-	-	-	122	257	434
Utilised during the year	-	(3)	-	-	-	(160)	(141)	(304)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	(10)	-	-	-	-	(258)	(268)
Unwinding of discount	-	-	-	-	-	-	-	-
At 31 March 2018	**-**	**115**	**-**	**-**	**-**	**122**	**240**	**477**
Expected timing of cash flows:								
- not later than one year;	-	50	-	-	-	122	140	312
- later than one year and not later than five years;	-	65	-	-	-	-	100	165
- later than five years.	-	-	-	-	-	-	-	-
Total	**-**	**115**	**-**	**-**	**-**	**122**	**240**	**477**

Other provisions include figures for Industrial Tribunal cases (£35k), Carbon Reduction Commitment (£120k) and provision for various property dilapidations (£85k).

It is not possible to be precise regarding dates of settlement for industrial injury and other legal claims and therefore there is uncertainty over the calculation and timings of amounts due.

Note 27 Clinical negligence liabilities

At 31 March 2018, £23,068k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Isle of Wight NHS Trust (31 March 2017: £8,504k).

Note 28 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**-**
Net value of contingent assets	**-**	**-**

Note 29 Contractual capital commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	1,319	1,207
Intangible assets	144	486
Total	**1,463**	**1,693**

Note 30 Other financial commitments

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 31.2 Carrying values of financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity at £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	9,060	-	-	-	**9,060**
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	5,999	-	-	-	**5,999**
Total at 31 March 2018	**15,059**	**-**	**-**	**-**	**15,059**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity at £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	5,537	-	-	-	**5,537**
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	7,295	-	-	-	**7,295**
Total at 31 March 2017	**12,832**	**-**	**-**	**-**	**12,832**

Note 31.3 Carrying value of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	37,830	-	**37,830**
Obligations under finance leases	531	-	**531**
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	15,911	-	**15,911**
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	**54,272**	**-**	**54,272**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	14,030	-	**14,030**
Obligations under finance leases	637	-	**637**
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	15,497	-	**15,497**
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2017	**30,164**	**-**	**30,164**

Note 31.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 31.5 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	16,020	15,603
In more than one year but not more than two years	112	109
In more than two years but not more than five years	38,140	14,380
In more than five years	-	72
Total	**54,272**	**30,164**

Note 32 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	15	14	20	47
Stores losses and damageto property	13	13	23	29
Total losses	**29**	**27**	**43**	**76**
Special payments				
Compensation under court order or legally binding arbitration award	2	3	5	26
Extra-contractual payments	-	-	-	-
Ex-gratia payments	14	2	20	7
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**16**	**5**	**25**	**33**
Total losses and special payments	**45**	**32**	**68**	**109**
Compensation payments received		-		-

Note 33 Related parties

During the year none of the Department of Health and Social Care Ministers, Isle of Wight NHS Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Isle of Wight NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Isle of Wight NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entries are:

	2017/18		2016/17	
	Expenditure £'000s	Revenue £'000s	Expenditure £'000s	Revenue £'000s
Isle of Wight CCG	0	138,234	0	135,154
NHS England - Wessex	0	9,181	354	9,694
University Hospital Southampton NHS Foundation Trust	1058	694	661	514
Portsmouth Hospitals NHS Trust	3318	591	3,149	456
NHS Resolution (formerly NHS Litigation Authority)	3856	0	3,516	0

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HM Revenue and Customs, NHS Pensions Agency and the Isle of Wight Council.

The Trust has also received revenue and capital payments from the NHS Trust's charitable funds currently registered with the Charity Commission under number 1049606 in the name of Isle of Wight NHS Trust Charitable Funds. The Corporate Trustee of the charitable funds is Isle of Wight NHS Trust. The Trust makes purchases on behalf of the Charity in accordance with Standing Financial Instructions and procurement procedures for which the Charity reimburses the Trust on a monthly basis.

Note 34 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	26,676	60,014	28,105	52,304
Total non-NHS trade invoices paid within target	22,327	44,689	25,359	46,352
Percentage of non-NHS trade invoices paid within target	83.70%	74.46%	90.23%	88.62%
NHS Payables				
Total NHS trade invoices paid in the year	2,633	5,711	2,017	6,270
Total NHS trade invoices paid within target	2,313	4,617	1,886	5,674
Percentage of NHS trade invoices paid within target	87.85%	80.84%	93.51%	90.49%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

During 2017/18 the Trust incurred late interest payments of £4k

Note 35 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	25,950	8,143
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	25,950	8,143
External financing limit (EFL)	29,934	14,423
Under / (over) spend against EFL	3,984	6,280

Note 36 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	8,298	5,437
Less: Disposals	(6)	(24)
Less: Donated and granted capital additions	(46)	(184)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	8,246	5,229
Capital Resource Limit	9,230	6,953
Under / (over) spend against CRL	984	1,724

Note 37 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(23,250)
Remove impairments scoring to Departmental Expenditure Limit	3
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	583
Breakeven duty financial performance surplus / (deficit)	(22,664)

Note 38 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Breakeven duty in-year financial performance		-	-	-	543	1,613	15	(8,358)	(10,960)	(22,664)
Breakeven duty cumulative position	-	-	-	-	543	2,156	2,171	(6,187)	(17,147)	(39,811)
Operating income		-	-	-	168,757	171,867	174,386	170,276	171,110	171,395
Cumulative breakeven position as a percentage of operating income		0.00%	0.00%	0.00%	0.32%	1.25%	1.24%	-3.63%	-10.02%	-23.23%

The role of the auditor

External auditors have two broad objectives:

- To review and report on the Trust's annual accounts and statement on governance; and
- To review whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Auditors are required to comply with the Code of Audit Practice (published by the Audit Commission) and International Standards on Auditing (United Kingdom and Ireland) (ISAs (UK&I)).

The appointed auditor will audit the Trust's annual accounts and give an opinion stating whether the accounts give a true and fair view of the organisation's affairs at the end of the financial year.

Auditors will also consider the Annual Report and make a statement, in their audit opinion, if its contents are inconsistent with their knowledge of the organisation.

In addition to their opinion on the accounts, auditors are also required to issue:

- A report to those charged with governance (in most cases the Audit Committee) incorporating the report required under ISA (UK&I) 260 and setting out the main matters arising from the audit of the annual accounts; and
- An annual audit letter summarising the key issues arising from audit work throughout the year.

Auditors also have special reporting powers and can issue a public interest report or make a referral to the Secretary of State.

Independent auditor's report to the Directors of the Isle of Wight NHS Trust

Opinion

We have audited the financial statements of Isle of Wight NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 38. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of Isle of Wight NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

This report is made solely to the Trust Board of Isle of Wight NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust has struggled to meet its financial targets and has reported a significant deficit in year and is budgeting for a further deficit in the next financial year. The Trust is reliant on continued revenue support loans from the Department of Health and Social Care to continue operating. As stated in note 1.1.2, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon. In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects

In respect of the following we have matters to report by exception:

Referral to the Secretary of State

We referred a matter to the Secretary of State under section 30(1)(b) of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency. On 16 May 2018 we referred a matter to the Secretary of State under section 30(1)(b) of the Local Audit and Accountability Act 2014. The statutory accounts indicate the Trust has a cumulative deficit at 31 March 2018 of £39.811 million over the three year period from 1 April 2015 to 31 March 2018, and therefore has not met its rolling breakeven duty

Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion on reporting by exception

The Trust reported a deficit of £23.25 million in its financial statements for the year ending 31 March 2018, thereby breaching its duty under paragraph 2 (1) of Schedule 5 the National Health Service Act 2006, to break even.

The Trust has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £18.491 million for 2018/19.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

The Trust did not have an approved Board Assurance Framework for a significant period of 2017/18.

This issue is evidence of weaknesses in the oversight function of the Board to support effective risk management over the quality and safety of services delivered by the Trust and its operations.

Qualified conclusion (Adverse)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in August 2017, we are not satisfied that, in all significant respects, Isle of Wight NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

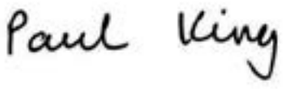
We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Isle of Wight NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Paul King (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Southampton

29 May 2018

The maintenance and integrity of the Isle of Wight NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

5. Glossary

The NHS can be confusing with its use of acronyms. The following jargon buster is included to help explain some of the terms used. If you can't find an explanation here please try **www.england.nhs.uk/participation/resources/involvejargon**.

CCG - Clinical Commissioning Group
A clinically-led group that includes all of the GP groups in the geographical area. An NHS organisation set up by the Health & Social Care Act 2012 to organise the delivery of NHS services in England.

C. Difficile - Clostridium difficile
A type of bacterial infection that can affect the digestive system. Most commonly affects people who have been treated with antibiotics.

CPA - The Care Programme Approach (CPA)
A way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

CQC - Care Quality Commission
The independent regulator of all health and social care services in England.

DH - Department of Health
The Department of Health and Social Care (DHSC) is a department of the UK government responsible for heath and adult social care policy matters in England, along with a few elements of the same matters which are not otherwise devolved to the Scottish Government, Welsh Government or Northern Ireland Executive. It oversees the NHS.

EDS - Equality Delivery System
A framework developed to assist NHS organisations to ensure they comply with equality legislation and embed equality matters across the NHS.

FFT - Friends & Family Test
Aims to provide a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience.

HCAI - Healthcare Associated Infections
Infections that are acquired as a result of healthcare interventions.

IM&T - Information Management & Technology
An umbrella term for the processes, systems, hardware and software a company uses to conduct its day-to-day operations.

KPIs - Key Performance Indicators
A way of monitoring and managing performance against a pre-determined target.

LGBT - Lesbian, Gay, Bisexual and Transgender (LGBT)
Intended to emphasise a diversity of sexuality and gender identity-based cultures.

MRSA - Methicillin Resistant Staphylococcus Aureus
A type of bacterial infection that is resistant to a number of widely used antibiotics – can be more difficult to treat than other bacterial infections.

Never Event
A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.

NHSI - NHS Improvement
A new body resulting from the merger of the Trust Development Authority and Monitor.

NICE - National Institute for Health and care Excellence
Provides national guidance and advice to improve health and social care.

RRP - Rolling Replacement Programme
Covering a wide category of clinical equipment, an RRP helps organisations to anticipate the costs of medical devices and assess capital expenditure over the mid- to long-term.

RTT - Referral to treatment
The time it takes between a GP referral and a definitive secondary care treatment being provided.

SHMI - The Standardised Hospital-level Mortality Indicator
An indicator which reports on mortality at Trust level across the NHS in England, using a standard and transparent methodology – also known as Standardised Hospital Mortality Indicator.

SIRIs - Serious Incidents Requiring Investigation
An incident that occurred in relation to NHS-funded services and care resulting in unexpected or avoidable death; serious harm; prevents ability to deliver services; abuse; adverse media coverage; never event.

STP - Sustainability and Transformation Plan
Provided support, oversight and governance for all NHS Trusts prior to the 1 April 2016.

Get in touch or get involved

We want to know what you think of your NHS. How can we improve? You can make a difference by…

- Joining the Trust as a Public Member – and if you have time to spare, why not become one of our valued volunteers?
- Attending our Medicine for Members meetings and other events
- Becoming a Quality Champion (if you're a member of staff) and taking an active role in one of the many initiatives designed to improve the patient and staff experience
- Becoming a member of our Patient Council

Please get in touch. Telephone: **01983 822099** ext. 5703 or e-mail **membership@iow.nhs.uk**

Tell us what you think

The Isle of Wight NHS Trust welcomes feedback and questions from staff, stakeholders, members and the wider public on this document and any other issue relating to our services. If you have feedback please contact the Corporate Communications, Engagement and Membership Team:

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Online

This report is available on our website at **www.iow.nhs.uk/Publications/publications.htm**

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10 March 2012 as a new body to legally come into being on 1 April 2012.

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