Isle of Wight NHS
NHS Trust

Annual Report and Accounts 2013/14

Hospital Ambulance Community Mental Health

Isle of Wight NHS Trust

Annual Report and Accounts 2013/14

Presented to Parliament, pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.

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Introduction – bringing quality to healthcare

Welcome to our annual report for the period 1 April 2013 to 31 March 2014.

This has been another landmark year for Isle of Wight NHS Trust, characterised by progress, innovation and continual quality improvement. We are intent on providing **quality care for everyone, every time** and this report outlines how we performed in 2013/14, and how we will realise our vision over the next two years, as we move towards Foundation Trust status. This is a natural evolution that will allow us to develop as a responsive organisation, within a membership and governance framework. It will also give us the ability to form formal partnerships and retain surpluses, while constantly upgrading the care that we provide.

FACT FILE: IOW NHS Trust

- We provide hospital, community, mental health and ambulance services.
- We run St Mary's Hospital in Newport, the only NHS hospital on the Island – it has 246 beds and handles around 23,000 admissions each year.
- Our turnover is around £166m.
- We are the largest employer on the Island.
- We employ around 2,800 staff.
- Our catchment population is 138,000 (relatively small compared to other Trusts).

Our bid to become a Foundation Trust is supported by 4,219 public members, and 2,832 staff members (19 May 2014). The cornerstones for the emerging organisation have already been laid. Our Trust, previously part of Isle of Wight Primary Care Trust, was formed in April 2012 and offers a patient centred model of care. This is achieved through a joined-up approach that has been developed in response to local needs. To meet the challenges inherent with living on an Island, we have become an integrated provider of hospital, community, mental health and ambulance services – no other Trust in England offers such a breadth of services. This enables patients to receive care across traditional boundaries in a seamless, efficient way. Our integrated care hub is a good example of this – it combines a number of services into one high quality unit, including 999, 111, community nursing, community physiotherapy, occupational therapy, and out of hours GP provision.

Just back from #Fracture Clinic #Luccombe Ward thanks for professional care with really friendly staff going the extra mile @IoWNHSTrust

How healthy are Islanders?

Overall the health of Island residents is better than the English average – however, Islanders are statistically more likely to die early from cancer, suffer from diabetes, or be diagnosed with malignant melanoma and these are a focus of some services which the Trust provides.

Due to the ageing population, local health needs are also skewed towards illnesses associated with age and frailty, notably long-term and complex conditions.

To continue to address the needs of Islanders, the next step for us will be to integrate with other care services. We have been working alongside the Island's Clinical Commissioning Group, and the Isle of Wight Council, to develop a five year plan for health and social care. Central to this is a programme entitled 'My Life A Full Life',

My life a full life

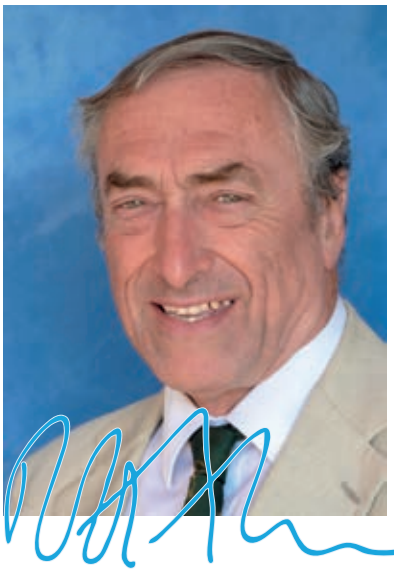
which brings together health and social care providers and acts as a catalyst to change cultures, attitudes and behaviours.

The initiative works in partnership with local people, voluntary organisations and the private sector to co-ordinate the delivery of services for older residents and patients with multiple long term conditions. We are now looking at how the model can be rolled out across other services and organisations, to meet the needs of all Islanders, including children and the under 65s.

Five of the Island's unique challenges

1. **Non-resident population** – the large influx of visitors during the summer months puts pressure on urgent care services. Spread evenly over the year, this equates to an extra 16,000 residents per day (11% increase). This peaks in June (with the Isle of Wight Festival) and September (with Bestival).
2. **Geographical factors** – ferries or helicopters are required to transport patients to and from the mainland. Sometimes the Island is 'cut off' and has to cope on its own.
3. **Deprivation** – the Isle of Wight is among the 40% most deprived local authorities in England, with 5,000 children living in poverty.
4. **Rapidly ageing population** – this is in part because the Island is a popular place to retire to. Nearly a quarter of our residents are over the age of 65 (one of the highest proportions in the UK).
5. **Sustainability** – the population of the Island, even when visitors are included, would not usually warrant the level of hospital services provided.

Over the next year, we will continue to refine our services in response to local needs. On many performance indicators, the Trust is already achieving impressive results – for example we are one of the best in the country at appropriately keeping people out of hospital, despite our elderly population. Now we want to become even better: more responsive, compassionate, skilled, efficient and innovative. As outlined in this report, we have achieved a great deal over the past year – and now the hard work is set to continue as we move even closer to becoming the outstanding provider of care services that the Island deserves.



Danny Fisher, Chairman

Karen Baker, Chief Executive

Your NHS in numbers

In 2013/14 the Isle of Wight NHS Trust…

…built a new helipad at St Mary's which was used by the Air Ambulance **95** times and the Coast Guard **55** times.

…reached out to our local population of **138,000** people – with over **4,000** signing up for membership of our proposed Foundation Trust.

…conducted **10,934** biopsies to look for conditions including cancer.

…carried out 17,069 tests for breast cancer (screening and symptomatic examinations).

…tested 1,171,760 samples of blood.

…answered **30,000** calls to 999 and **55,000** calls to the new 111 service.

… delivered **1,338** babies at St Mary's Hospital.

…employed **2,832** staff (**125** doctors and dentists, **879** nurses and midwives, **404** allied health professionals, scientists and technicians, **553** healthcare assistants and other support staff, and **871** people in administration and estates).

…admitted 22,685 patients to St Mary's Hospital in Newport and cared for them in our 246 beds.

…conducted thousands of investigative tests including **80,158** X-rays, **14,899** ultrasounds, **14,259** CT examinations and **4,230** MRI scans.

…took **477,662** blood samples from patients in the Phlebotomy department.

…welcomed the support of **551** amazing volunteers.

…dispatched **24,444** emergency vehicles to people in need across the Island.

…transported **588** patients to the mainland for specialist care.

…used 2,746 litres of hand sanitiser gel.

Our unique, integrated provision

We are the only NHS Trust in England that provides hospital, community, mental health and ambulance services. The table below illustrates the vast scope of our provision…

Acute care

St Mary's Hospital in Newport is our base – it has an emergency department, a total of 246 beds, and receives around 23,000 admissions each year. We also jointly run the Beacon Centre with Lighthouse Medical (an Island GP collaborative) giving patients walk-in access to a GP.

Services include emergency medicine and surgery, planned surgery, intensive care, maternity, neonatal intensive care, and paediatrics.

Community services

We work in patients' homes, in community settings, and from St Mary's Hospital. Services include district nursing, health visiting, community nursing, primary dental care, orthotics, and inpatient and community stroke rehabilitation. Until 31 May 2013, we provided in-prison healthcare services to an Island prison population of 1,100.

Mental health services

We provide inpatient and community based care to around 1,300 patients, with 50 dedicated beds. This covers child and adolescent mental health, Tier 3 (community based) drug and alcohol services, early intervention in psychosis, memory therapy, and outreach into residential and nursing homes.

Ambulance services

As well as managing the Integrated Care Hub, we provide all emergency and non emergency ambulance transport for the Island – and respond to over 24,000 incidents each year. We also transport patients to mainland hospitals as required.

For more information, please visit http://www.iow.nhs.uk/about-us/ or read our Statement of Purpose, which is available on the Care Quality Commission's website at http://www.cqc.org.uk/

Looking back

2013/14 was a period of significant change, and as a Trust we were able to adapt and evolve, in preparation for the next phase of our development as a Foundation Trust. Across the country, Strategic Health Authorities and Primary Care Trusts were abolished, and replaced with the NHS Trust Development Authority (TDA) and Clinical Commissioning Groups (CCGs).

Locally, we launched the Trust's five year Integrated Business Plan, which brings together all our plans and strategies for the next five years, ensuring that we move from a one year planning vision to five years. In addition, an extensive piece of work was led and undertaken by senior clinicians following Robert Francis QC's Report into the failings of the Mid Staffordshire NHS Foundation Trust. This, together with the outcome of a number of other national reviews, has influenced our approach towards quality improvement, and we are implementing a number of the key recommendations including the publication of staffing levels on our wards and services.

Looking forward

This is our vision and mission...

Our **vision** is to provide **quality care for everyone, every time**.

Our **mission** is to improve the health, well-being and life chances of the Island's residents and visitors. We will contribute to the long-term sustainability of the Island by working with our partners to deliver seamless and efficient, person centred, integrated, health and social care services.

> Thank you for the amazing care you all provided... it was second to none. We understand that you went the extra mile to provide comfort and support during a difficult time and words cannot express how grateful we are.

... and this is how we will make this a reality.

The following **strategic objectives** support the delivery of our **vision** and **mission**. Critical success factors are used by the Board to assess our performance.

1. Improve quality

Strategic objective:
To achieve the highest possible quality standards for our patients, in terms of outcomes, safety and positive experiences of care.

Critical success factors:
CSF1. Improve the experience and satisfaction of patients, carers, partners and staff.

CSF2. Improve clinical effectiveness, safety and outcomes for patients.

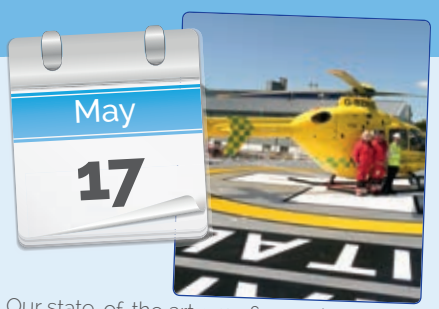
2. Deliver our integrated clinical strategy

Strategic objective:
To deliver the Trust's clinical strategy, integrating service delivery within our organisation and with our partners, and providing services locally wherever clinically appropriate and cost effective.

Critical success factors:
CSF3. Continuously develop, and successfully implement, our Integrated Business Plan.

We've been busy...

12 Pathology staff gained NVQ Level 2 and 3 Diplomas in Clinical Pathology support skills. The hard-working individuals included medical laboratory assistants, specimen reception staff and phlebotomists.



Our state-of-the art-new £1.45m helipad, supported by a generous £250,000 grant from the County Air Ambulance Trust, was used for the first time. This facility will save lives by cutting the time it takes for patients to receive emergency treatment (at St. Mary's and on the mainland).

CSF4. Develop our relationships with key stakeholders to further integrate the health, social care and voluntary/third sectors, to collectively deliver a sustainable local system.

3. Increase resilience

Strategic objective:
To build the resilience of our services and organisation through partnerships within the NHS, with social care, and with the private and voluntary/third sectors.

Critical success factors:
CSF5. Demonstrate robust linkages with our NHS partners, the Local Authority, the third sector and commercial entities, for the clear benefit of our patients.

CSF6. Develop our quality governance and financial management systems and processes, to deliver performances that exceed the standards set down for Foundation Trusts.

4. Improve productivity

Strategic objective:
To improve the productivity and efficiency of the Trust, building greater financial sustainability within the local health and social care economy.

Critical success factors:
CSF7. Improve value for money and generate our planned surplus whilst maintaining or improving quality.

CSF8. Develop our support infrastructure to improve the quality and value of the services we provide.

Coming up...

In May 2014, the Chief Inspector of hospitals invited Islanders to give their views on the care provided by Isle of Wight NHS Trust. Professor Sir Mike Richards asked members of the public to tell his inspection panel what they think of the services provided by our Trust.

A formal inspection by the Care Quality Commission was held between 3 and 6 June 2014.

Their report will be published later in 2014.

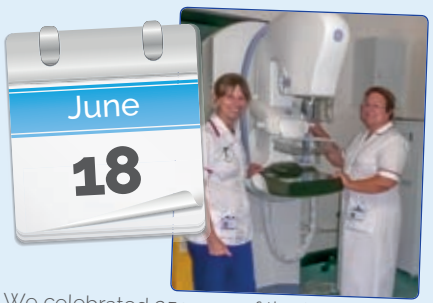
5. Develop our workforce

Strategic objective:
To develop our people, culture and workforce competencies to implement our vision and clinical strategy. Engender a sense of pride amongst staff in the work that they do, and they services they provide. Position the Trust as an employer of choice.

Critical success factors:
CSF9. Redesign our workforce so people with the right attitude, skills and capabilities are in the right places, at the right time, to deliver high quality patient care.

CSF10. Develop our organisational culture, processes and capabilities to be an outstanding organisation and employer of choice.

Facilities for patients with dementia moved from Ryde, to Shackleton Ward at St. Mary's Hospital in Newport. An estimated 2,600 Islanders have dementia and this is forecast to increase by 40% by 2021. In August, the Trust was awarded £399,033 to support the creation of a 'dementia friendly' environment.



We celebrated 25 years of the National Breast Screening Programme. The Unit at St Mary's was one of the first in the country, established in 1988. 9,500 women on the Island are now invited for screening every year (78% attend).

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

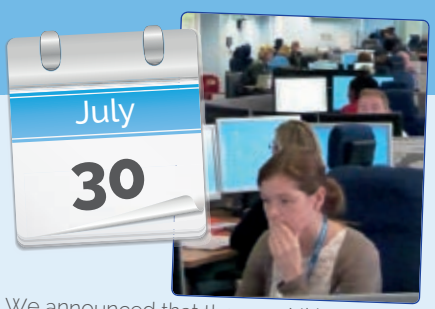
Provider: Isle of Wight NHS Trust

Area	Metric	Target	2010/11	2011/12	2012/13	Jun-13	Sep-13	Dec-13	Mar-14	13/14 YTD
Unscheduled care	Unplanned re-attendance rate at A&E within 7 days of original attendance	<5%		4.8%	1.6%	2.5%	2.5%	3.0%	1.8%	
	Total time spent in A&E department – 95th percentile	<4 hours (240 mins)		324	309	238	315	239	309	
	Left department without being seen rate	<5%		1.0%	0.5%	1.0%	0.0%	0.4%	0.2%	
	Time to initial assessment – 95th centile	<15 mins		1	2	2	2	1	1	
	Time to treatment in department – median	<60 mins		34	29	27	23	22	21	
	Emergency care 4 hour standard	95%	98.1%	95.0%	95.3%	97.9%	95.6%	98.2%	96.3%	97.0%
	Ambulance – Cat A % < 8 min	75%	77.8%	76.2%	76.8%	76.2%	76.6%	76.2%	76.4%	76.2%
	Ambulance – Cat A % < 19 min	95%	96.6%	98.6%	97.4%	97.3%	96.4%	95.7%	96.2%	96.6%
	Stroke: % spending 90%+ time on stroke unit	80%	60.0%	81.5%	88.0%	100.0%	90.0%	95.7%	92.3%	91.7%
	% of people who have a TIA who are scanned and treated within 24 hours	60%	49.0%	61.5%	73.5%	83.3%	76.9%	92.9%	66.7%	81.5%
Planned care	RTT: % of admitted patients who waited 18 week or less	90%	86.0%	92.7%	93.4%	95.3%	92.3%	91.1%	92.3%	91.0%
	RTT: % of non-admitted patients who waited 18 weeks or less	95%	98.5%	96.4%	97.3%	97.6%	97.2%	95.4%	95.8%	96.8%
	RTT: % of incomplete patients who waited 18 weeks or less*	92%			95.6%	94.9%	96.6%	94.8%	96.3%	95.8%
	RTT admitted 95th percentile	23	21.0	20.8	19.1	18.0	19.4	20.0	18.9	19.9
	RTT non-admitted 95th percentile	18.3	16.0	17.7	17.1	16.4	17.3	17.8	17.0	17.2
	RTT incomplete pathways 95th percentile	28		18.9	17.8	18.1	17.5	18.1	17.3	17.7
	Patients waiting more than 6 weeks for diagnostic	<100 per year	22	0	13	2	3	2.0	0.0	43
	% patients waiting > 6 weeks for diagnostic*	<1%			0.1%	0.2%	0.4%	0.2%	0.0%	0.4%
	Symptomatic breast cancer referrals seen <2 weeks	93%	95%	93%	93.8%	91%	98%	100%	94%	94%
	Cancer patients receiving subsequent chemo/ drug <31 days	98%	100%	100%	100%	100%	98%	100%	100%	99.5%
	Cancer patients receiving subsequent surgery <31 days	94%	99%	100%	98%	100%	100%	100%	100%	99%
	Cancer patients treated after screening referral <62 days	90%	94%	100%	100%	100%	100%	92%	100%	99%
	Cancer patients treated after consultant upgrade <62 days	86%	100%	100%	100%	No data	No data	No data	No data	100%
	Cancer diagnosis to treatment <31 days	96%	99%	100%	99%	98%	100%	97%	100%	99%
	Cancer urgent referral to treatment <62 days	85%	90%	93%	92%	94%	97%	96%	94%	94%
	Cancer patients seen <14 days after urgent GP referral	93%	95%	97%	93%	94%	98%	98%	96%	96%
Patient safety & quality	HCAI: Clostridium Difficile (C. Diff.) infection rates	12	24	16	13	2	0	1	1	7
	HCAI: Incidence of MRSA	0	4	1	2	1	0	0	0	2
	Mixed sex accomodation	0 breaches		26	15	0	0	0	0	0
	Summary Hospital-level Mortality Indicator (SHMI)**	–	1.18	1.16	1.08	1.06	1.08	1.12	1.12	1.12
	VTE risk assessment*	95%		92.8%	93.3%	88.3%	88.0%	88.2%	100%	88.6%
Mental health services	New cases of first episode psychosis	18	26	24	13	1	4	1	6	44
	CPA – 7 day follow up	95%		96%	95%	98%	92%	95%	97%	95%
	Crisis resolution home treatment	95%		93%	95%	98%	100%	100%	91%	98%
	Episodes of home treatment	249	412	472	446	32	28	34	34	368

*Target introduced in 2012/13
**Reflects figures published Oct 11 & Oct 12

ISLE OF WIGHT HEALTH TRAINER SERVICE

The NHS Health Trainer Service launched their new volunteer network at the Isobel Centre, Newport. Volunteers act as 'buddies' to support Islanders with activities that promote a healthy lifestyle, including walking, swimming and dancing.



We announced that the new NHS 111 service is working well on the Island, giving people fast access to non emergency advice and care. 111 enquiries are dealt with by our Integrated Care Hub, which also handles calls to 999, GP out of hours, and other health and social services.

A new Pathology Laboratory opened at St. Mary's to upgrade facilities and meet the increased demand for services. Around 1 million pathology tests are performed each year on the Island. The high tech lab deals with biopsies, blood and urine tests.

Our performance against national targets

In many respects, Isle of Wight NHS Trust is a high performing organisation and our health services compare favourably with those on the mainland – for example the Island is the third best in the country at keeping people out of hospital, even though the population we serve is one of the most elderly in the UK.

Performance is reviewed on a monthly basis at the public Trust Board meetings. The following summary enables year on year comparisons to be made for the last three operating years (from April to March) against 2013/14.

The following commentary includes details of the improvements required against the above targets.

Key

Green – meets target
Red – not does meet target
Amber – borderline
Black – target not set for that year

RTT – Referral to treatment
HCAI – Healthcare acquired infection
VTE – venous thromboembolism

Please contact us if you need further information on the terms used in this chart.

> Just wanted to say a big thank you for helping us deliver our baby. For a minute we thought we were on our own and can't describe the relief we felt when you arrived. What a wonderful team you all were. Thank you again for your help and support.

The Trust's Stoma Care team won a prestigious Purple Iris award from the Colostomy Association. Many other talented staff members won awards this year. In December, the Community Child and Adolescent Mental Health Services (CAMHS) Team was named Child and Adolescent Psychiatric Team of the Year 2013 by the Royal College of Psychiatrists.

Actor and Islander Melvyn Hayes opened the new Children's Ward garden in memory of an inspirational former patient, James Sparks, who died aged 17 in 2009. The garden has a railway theme and is proving popular with young patients. Our children's unit has 13 beds in the ward and six day beds.

A new garden was opened for the Psychiatric Intensive Care Ward at St Mary's, thanks to a grant of £5,000 from the Friends of St Mary's and a £2,000 legacy held by the Trust's Healing Arts programme. This is a relaxing, healing environment for patients, with flowers, mosaics and solar lighting.

Our performance against strategic objectives

In 2013/14 our strategic objectives were to focus on **quality**, **workforce** and **finance**. We established a Transformation and Quality Improvement Programme to oversee service developments and the integration of our health and social care provision. Overall we performed well against our strategic objectives, as outlined below, and we have also identified some areas for improvement.

Strategic objective 1: Quality

Achievements

- Our quality governance framework provides a high level of assurance about quality and safety standards. The evidence for this is our Monitor self-assessment risk rating, which has fallen from 3.5 in 2012 to 2.0 in 2013. Monitor is the regulatory body for Foundation Trusts, and in order to achieve Foundation Trust status, organisations must score less than 4.
- Board members now attend weekly, unannounced, Walk Assurance Visits.
- Patient Experience videos are presented at the opening of every Trust Board meeting, which has led to improvements in care.
- We are working closely with the Isle of Wight Clinical Commissioning Group and Local Authority to support the delivery of integrated health and social care for the Island.
- The national Commissioning for Quality and Innovation target is for 95% or more patients to be risk assessed for venous thromboembolism (VTE) on admission to hospital. The upgrade to the pharmacy system in February 2014 has eliminated previous data collection problems and we are now achieving 100%.
- Through careful planning we were able to provide extra beds at St Mary's Hospital during the winter months, to ease pressures on the system.
- We have restructured our Quality Directorate and introduced a Safety, Experience and Clinical Effectiveness Triumvirate management team. This will focus on the delivery of our quality objectives.
- We have recruited 100 Quality Champions – they meet monthly with the Executive team to improve communication throughout the organisation and focus on quality improvement.
- We achieved a reduction in complaints and concerns following a review of our processes.

The Trust set up a group for local lesbian, gay, bisexual and transgender (LGB&T) people to ensure that their views, like other groups, influence how local health services are managed.

We launched a life saving treatment for patients in the community, which in the past has only been delivered in hospital. The Trust's 'PrePip' project enables specially trained Paramedics to deliver intravenous high dose antibiotics to certain patients with suspected sepsis (a life-threatening condition caused by the body overreacting to an infection).

400 members of staff and volunteers packed into Medina Theatre for the Trust's annual Awards ceremony where excellence and innovation in healthcare were recognised alongside individual achievements. You can view videos of the shortlisted applicants at **www.youtube.com/user/IsleofWightNHS**

- The 'compliments to complaints' ratio increased significantly – from 8:1 to 23:1.
- We have consistently stayed within our maximum threshold for Clostridium difficile infection (CDI).
- We have had no mixed sex occurrence breaches.
- We have seen a reduction in our hospital standardised mortality ratio.
- Since August 2013, there has been a reduction in the number of reported Serious Incidents Requiring Investigation (SIRI).
- Our trauma care provision has been improved with the opening of the new Helipad. All nurses in our Emergency Department are now trauma trained.
- Although we exceeded the agreed thresholds for avoidable pressure ulcers, we have made substantial improvements since 2012/13 and our record, compared with other Trusts, is good.
- In line with nationally recognised safe practice, we have implemented a revised prescribing practice. GPs will prescribe non urgent medication recommended by our Consultants.
- We have improved the way that we communicate with patients and as a result over 96% would recommend us to a friend or family member.
- Triage services have been introduced by Maternity to support patients during their pregnancy. This provides women with fast advice and has reduced bed usage.
- We are within the top 1% of Trusts for stroke performance.
- We received national recognition for our high performance in Improving Access to Psychological Therapy.

Our quality goals for 2014/15

Our Quality Account (QA) sets out the Trust's **quality goals** that have been determined following extensive consultation with key stakeholders, including patients, the wider public, and Healthwatch. The agreed quality goals for 2014/15 are:

1. **Patient safety** – emphasising the prevention of pressure ulcers.
2. **Clinical effectiveness** – focusing on a reduction in cancelled or re-arranged Outpatient appointments.
3. **Patient experience** – with an emphasis on improving communication.

For more information, please see our Quality Account which is available at **www.iow.nhs.uk/publications** or on request from **comms@iow.nhs.uk**

Community Child and Adolescent Mental Health Services (CAMHS) Team are named Child and Adolescent Psychiatric Team of the Year 2013 by the Royal College of Psychiatrists.

HRH The Duke of Kent officially opened the Integrated Care Hub and Helipad at St Mary's. These developments will give Islanders and visitors faster access to life-saving care and help to avoid unnecessary admissions.

Islanders were urged to play a role in shaping their local health services by Danny Fisher, the Trust's Chairman. He told the crowd at our first ever Medicine for Members event: "We're handing the NHS over to you!" Over 4,000 people have signed up for membership to support our bid to become a Foundation Trust and we launched our own magazine for members in February 2014. **See page 23**

Areas for improvements

- Methicillin-Resistant Staphylococcus Aureus (MRSA): we reported two cases of MRSA, breaching our ambitious target of zero.
- Avoidable pressure ulcers: although there has been a reduction, we exceeded our agreed thresholds (with the exception of grade 3 pressure ulcers within the hospital setting).

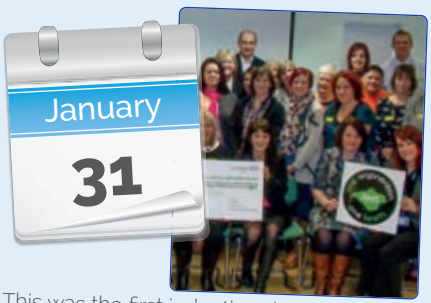
Strategic objective 2: Workforce

Achievements

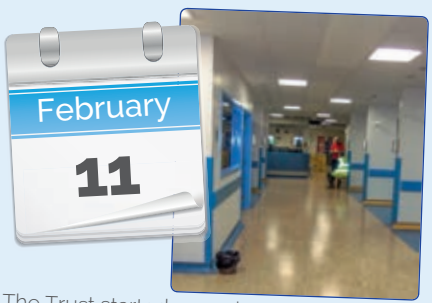
- ✓ Various staff members have received prestigious awards, including national recognition for our Child and Adolescent Mental Health Service and Stoma Service.
- ✓ We set up a new Organisational Culture Development Group – staff from across the Trust now meet up every month to drive forward cultural improvements.
- ✓ The Trust's Vision, Values and Behaviour document was formulated and distributed to all staff.
- ✓ 'Values-based' recruitment has been introduced, to ensure that new staff share the values of the organisation.
- ✓ The 2013 NHS Staff Survey showed a marked improvement in morale, compared with the previous year, and the rating for the Ambulance service is among the best in the country; however communication remains an issue.
- ✓ A Raising Concerns Toolkit has been launched to give staff the confidence to raise quality and safety issues.
- ✓ Employee recognition schemes and long services awards have been introduced – these help staff to feel engaged, motivated and valued.
- ✓ We are compliant with auto enrolment legislation for pensions, enrolling staff into appropriate schemes as required.
- ✓ We have transformed pre-assessment processes, so that nurses now take medical histories, freeing up doctors for clinical work.
- ✓ We have introduced a lesbian, gay, bi-sexual and transgender patient and staff group.

> The clinic is how every clinic should be. Every person in the team was brilliant...

The Children's Ward received Christmas presents donated by Islanders. These were distributed to children on the Children's Ward and to children who are cared for at home by the Children's nursing team.



This was the first induction day for our new Quality Champions. Over 100 volunteers from across the organisation have stepped forward to help ensure that the Trust's vision of 'quality care for everyone, every time' is delivered across all areas of work.



The Trust started a number of schemes to upgrade St Mary's Hospital and grounds to create a more attractive environment for staff, patients and visitors.

> The brilliant nurse put me at ease with laughter!!!

Areas for improvement

Compared with the 2012 NHS Staff Survey, the 2013 survey indicated that we need to focus more on improving:

- Work-related stress.
- Communication.
- The quality of appraisals.

Plans have been put in place by the Trust to deal with these issues.

Strategic objective 3: Finance and governance

Achievements

- ✓ Our 'continuity of services' risk rating is as good as it can be (4). This is an indication, devised by Monitor, of the likelihood of the Trust staying solvent and maintaining the continuity of services provided.
- ✓ We have achieved our financial statutory duties.
- ✓ We have achieved our planned surplus (**see Accounts on page 49**)
- ✓ We have implemented new systems to support our Value Improvement and Transformation programmes.
- ✓ We have invested £8m on improving our property, plant and equipment.
- ✓ We have introduced additional capacity and expertise to the Board in the form of Designate Non-Executive Directors.
- ✓ We have signed up 4,219 public members and 2,832 staff members to support our bid to become a Foundation Trust (figures correct for 19 May 2014).

Areas for improvement

- Delivery of our full Cost Improvement Programme, which aims to ensure that the best value for money is continually achieved (so that funds can be reinvested in healthcare). This is a significant issue for the Trust which affects the organisation's sustainability.• Our Trust Board has seen a turnover in its membership over the past year including the appointment of three designate Non-Executive Directors, which brought new skills and expertise. Substantive appointments are planned for the remaining vacant positions in 2014/15.

Norovirus struck St Mary's, causing diarrhoea and vomiting. We controlled the situation by closing affected wards, restricting visiting, and tightening up on good hand hygiene for all staff and visitors. A small number of scheduled operations were rearranged but day surgery, outpatient appointments and clinics were not disrupted.

Our risk rating was reduced by the Care Quality Commission – this is a key indicator that our hospital is safe, effective, caring, responsive and well led.

Financial performance 2013/14

We kept within budgets, achieved a planned surplus and remained within our External Financing Limit.

We achieved our planned surplus

The Trust had a year end surplus of £1,837k and after technical adjustments for donated assets (the net effect of depreciation and in-year receipts) this resulted in an adjusted retained surplus of £1,613k. This is an acceptable performance against our planned surplus of £1,598k.

We achieved our statutory duty to remain with our External Financing Limit

The Trust had an underspend against our External Financing Limit (EFL) of £7,810k. This means that the Trust spent less cash than we originally planned, although the level of capital creditors did contribute to the significant surplus of cash over the original planned EFL of £3,456k.

We spent less than we'd allocated for capital expenses

From 1 April 2013, fixed assets transferred from the Isle of Wight Primary Care Trust. Based on the estimated depreciation charge on those assets, and in-year Public Dividend Capital received for national schemes relating to Dementia and Safer Hospitals, the Trust had a Capital Resource Limit of £8,283k. Against this, the Trust spent £8,279k and therefore had a £4k underspend.

More information about the financial performance of the Trust can be found in the full accounts for 2013/14 which form part of this report (**see page 49**).

> Thank you for the skill, time and care you gave me following my recent heart attack. You put me at ease in a traumatic situation. You kept me calm, comfortable and informed. More importantly you got me there in good time. I shall be forever grateful.

Breaking new ground – our research and innovation

The Trust's participation in clinical research demonstrates our commitment to excellence, innovation and giving our patients fast access to the very latest therapies. During 2013/14…

Groundbreaking research into chronic pain

In November 2013, a neuroscience research project was launched at St Mary's Hospital, to examine chronic pain in Fibromyalgia Syndrome (FMS) and Chronic Fatigue Syndrome (CFS). The researchers are focusing on activity in the central nervous system and enhanced sensitivities to touch, sound, light and temperatures.

The hope is that if more is understood about the neurology behind these conditions, then new therapies could be developed. At least 200 people suffer from FMS and CFS on the Island.

More information can be found in the Research & Development Annual Report for 2013/14 at **www.iow.nhs.uk/publications** or on request from **comms@iow.nhs.uk**.

- We received £404,277 from the Hampshire and Isle of Wight Comprehensive Local Research Network. This was to support studies within the National Institute for Health Research Clinical Research Network's portfolio.
- 41 studies were approved by the Research and Development Committee.

Research excellence on the Island

The David Hide Asthma and Allergy Research Centre is a registered charity based at St Mary's Hospital in Newport. The centre has an international reputation for its active research, which focuses on various aspects of childhood asthma, and other allergic diseases and allergy prevention. Staff deliver high quality publications and explore funding opportunities.

Their research has led to improvements in clinical practice, including the management of food allergies in childhood. The Centre's work has also influenced guidance on best infant feeding practices.

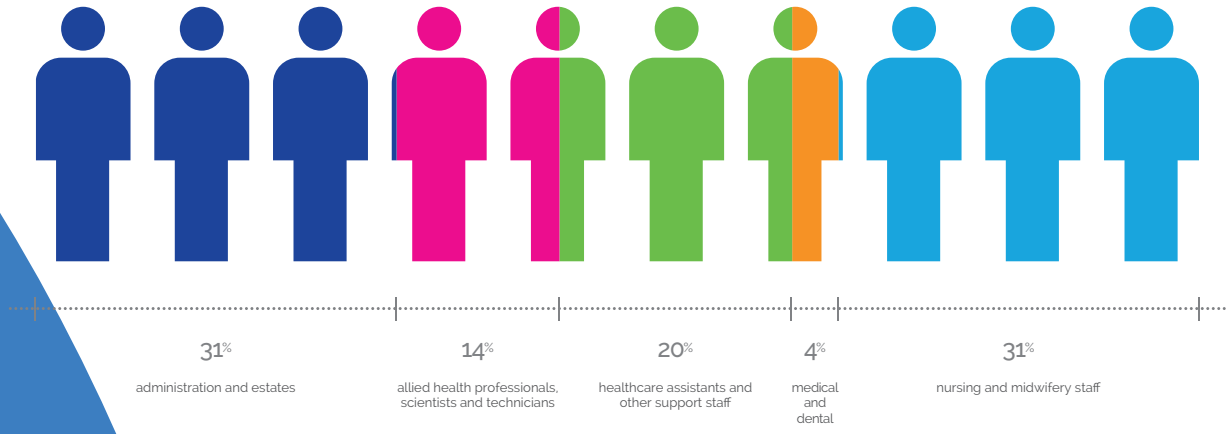
Visit:
http://www.davidhideallergyresearch.co.uk/

- 789 patients were recruited to participate in research approved by a research ethics committee and received NHS services provided or sub-contracted by Isle of Wight NHS Trust.
- 32 clinical staff participated in research approved by a research ethics committee at the Trust. The research covered the following clinical specialties: Blood, Cancer, Cardiovascular, Diabetes, Mental Health, Stroke and Rehabilitation, Musculoskeletal, Renal & Urogenital, Ophthalmology, Paediatrics, Reproductive Health, Childbirth and Respiratory Medicine.

Our people, our future

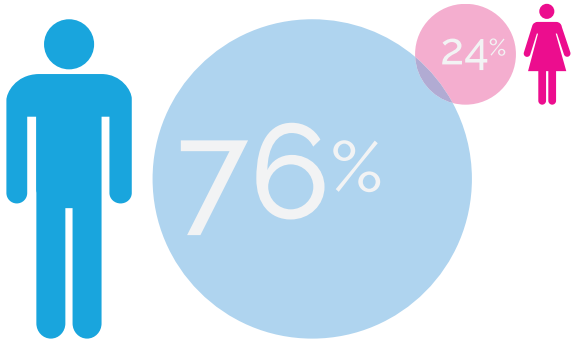
Isle of Wight NHS Trust employs 2,832 staff (circa 2,700 full time employed). The overall structure of the workforce is summarised in the chart below.

@IoWNHSTrust I am home many thanks to #iownhs you are the best

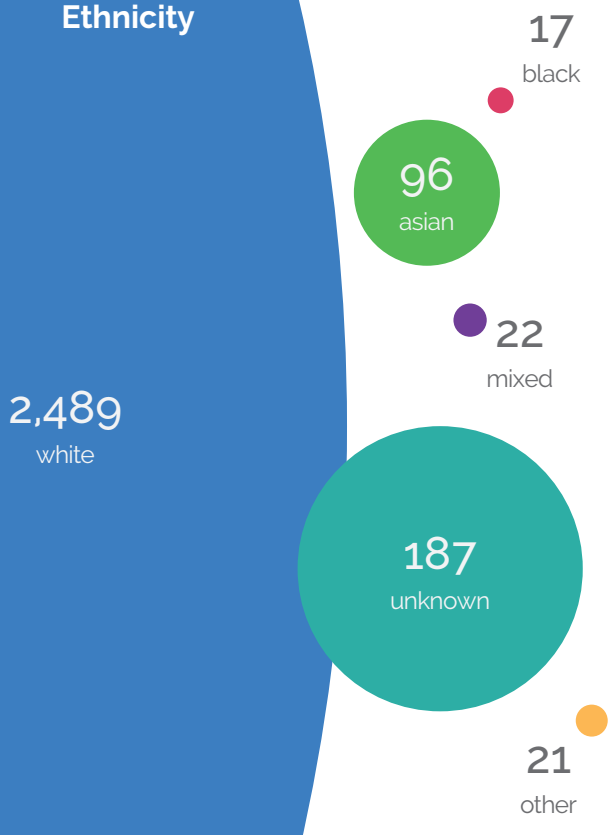


The gender, age and ethnicity distribution of staff is as follows:

Gender



Ethnicity



Age

Although the Trust is in a robust financial position, we do 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 and skill mix reviews, and planned redeployment, to retain existing staff.

To enhance quality and productivity we have developed a workforce strategy that will promote:

- 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 corporate plans. Central to this is the emphasis on leadership development and embedding patient focused care at strategic, managerial and individual levels.

Training and development in 2013/14

It's been a busy year for the Education, Training and Development team, who are at the forefront of ensuring that our staff are appropriately skilled and up to date with the latest developments that could benefit our patients. Here are a few of the highlights...

- Our leadership development programmes attracted over 180 participants.
- We secured funding to pay for simulators for adults, babies and ambulance equipment, so that staff can learn advanced life-saving skills in a safe environment.
- E-learning activity has increased with 36,897 modules completed during the year – an increase of 64% on the previous year.
- We have reduced unnecessary training requirements, which will save an estimated 2,026 hours every year.
- Mandatory training compliance across the Trust is now 77% – the highest ever.

Corporate social responsibility

As the largest employer on the Island we are conscious of our duty to contribute to the area's social and economic sustainability. Wherever possible, we use local people to deliver goods and services through local procurement frameworks.

Alongside Shaw Trust (www.shaw-trust.org.uk) and Smart Training and Recruitment (www.smarttar.co.uk), we support the long term unemployed through our volunteers' programme. This helps people to regain their confidence and rebuild their skills in the workplace.

Through the Island Innovation Trust (www.islandinnovationtrust.org.uk), we work with local schools to raise the aspirations of children and young people. We support the national Step into the NHS initiative and run a Careers in Healthcare Induction Programme (CHIP), which offers students in Years 10, 11 and the Sixth Form, the opportunity to find out about careers first hand from staff working at the Trust. The programme gives students privileged access to areas such as Pharmacy, the Ambulance station and the Emergency Department at St Mary's Hospital.

Sustainability in action

We are committed to embedding sustainability principles in our work, and reducing the Trust's environmental impact. Since 2010 our work on a Carbon Management Programme has brought together a wide cross-section of services and helped to create a shared vision of a sustainable future. We are actively taking steps to improve our energy efficiency, lower our water consumption, and reduce the environmental impacts of the waste we generate. The Trust has delivered a 10% reduction against our 2008/09 'carbon footprint'.

Using the NHS Sustainable Development Unit's reporting template we can show that for 2013/14 we have:

- Delivered savings of 6% for carbon emissions (against a 2011/12 baseline).
- Increased domestic waste recycling from 18% to 27% (from 2012/13 to 2013/14).
- Lowered our water consumption by 15% (against a 2011/12 baseline).
- Made significant progress towards procuring an Energy Performance Contract which is expected to deliver savings of over 30% in carbon emissions (against a 2012/13 baseline).

A copy of the Sustainability Report for 2013/14 is available on our website at www.iow.nhs.uk/publications or on request from comms@iow.nhs.uk.

> A big thank you for looking after me so well during my recent admission to your ward... The care I received was by far the best I have ever experienced as an inpatient. It made such a difference to my recovery.

Directors' Report

Governing your health service

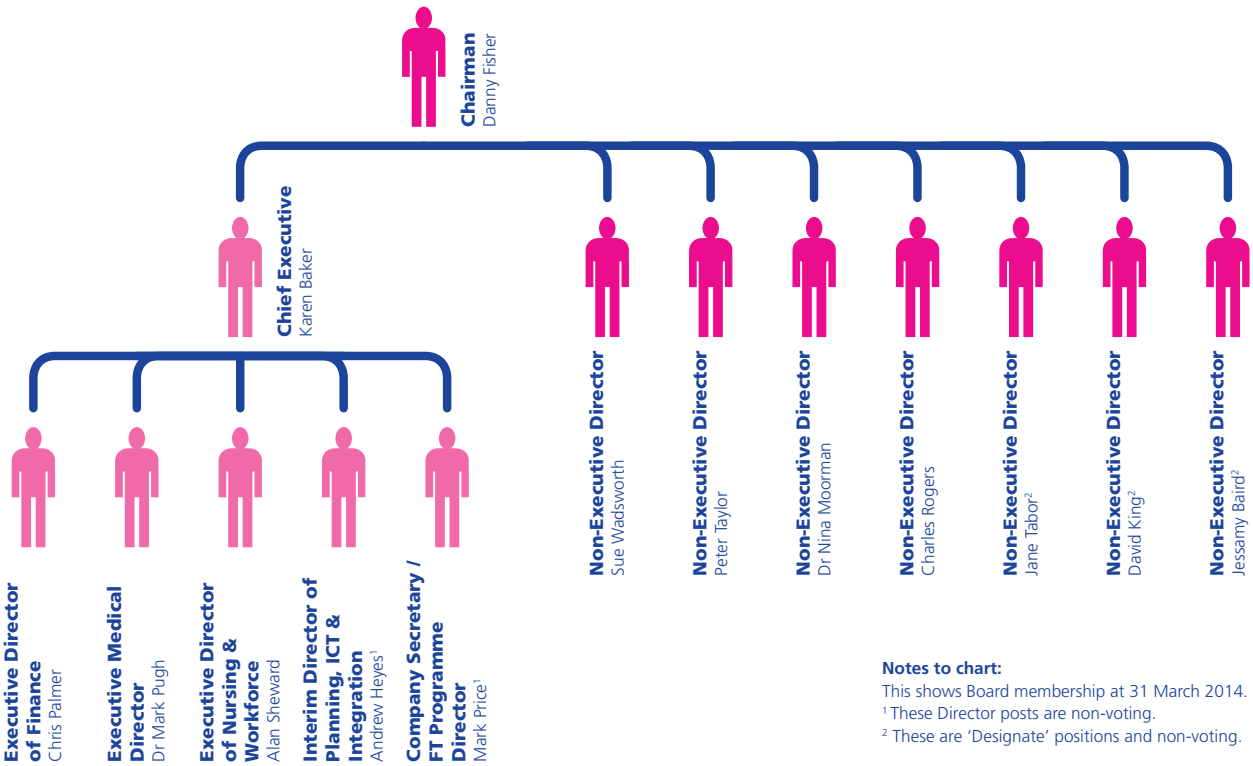
The Trust has three Clinical Directorates:

- Acute Clinical Directorate
- Community Health Clinical Directorate
- Planned Clinical Directorate

Each one is led by a Clinical Director with support from an Associate Director and Head of Clinical Services. The Clinical Directors are responsible for ensuring that high quality patient care is delivered within the available resources and that the Trust's strategic objectives are met. Their progress is continually assessed and overseen by the Trust's Board.

Corporate governance

The Trust Board structure is shown in the chart below:



Notes to chart:
This shows Board membership at 31 March 2014.
[1] These Director posts are non-voting.
[2] These are 'Designate' positions and non-voting.

Leadership of the Trust Board is provided by our Chairman, Danny Fisher, and our Chief Executive, Karen Baker, who was formerly the Chief Operating Officer and has a background as a nurse and midwife.

The Chairman and Chief Executive work collaboratively with the workforce, key external partners, and the local community. They provide strong visible leadership and espouse the Nolan Principles (The Seven Principles of Public Life described in Lord Nolan's 1995 report).

Introducing the Board of Directors

The Trust's Board of Directors is comprised of the following Executive and Non-Executive Directors. We have only included their joining date if they joined this year.

- Chairman – Danny Fisher (appointment review date 31/03/15)
- Non-Executive Director – Sue Wadsworth (appointment review date 31/03/15)
- Non-Executive Director – Peter Taylor (appointment review date 31/03/15)
- Non-Executive Director – Nick Wakefield (left 04/07/13)
- Non-Executive Director – John Matthews (left 31/01/14)

Transparency at the Trust

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 is available for inspection at Audit and Corporate Risk Committee meetings and at Board meetings on request.

You can also obtain a copy by emailing **board@iow.nhs.uk** or calling **01983 822099 ext 5741**.

- Non-Executive Director – Dr Nina Moorman joined 01/05/2013 (appointment review date 19/05/17)
- Non-Executive Director – Charles Rogers joined 08/07/13 (appointment review date 28/07/15)
- Non-Executive Director Designate – Jane Tabor joined 08/01/14 (appointment review date 31/12/16)
- Non-Executive Director Designate – David King joined 08/01/14 (appointment review date 30/06/17)
- Non-Executive Director Designate – Jessamy Baird joined 08/01/14 (appointment review date 30/06/16)
- Chief Executive – Karen Baker
- Executive Director of Finance – Chris Palmer
- Executive Medical Director – Dr Mark Pugh
- Executive Director of Strategy and Commercial Development – Felicity Greene (left 08/11/13)
- Executive Director of Nursing and Workforce – Alan Sheward
- Company Secretary & Foundation Trust Programme Director – Mark Price
- Interim Director of Planning, ICT and Integration – Andrew Heyes (joined 23/12/13)

Our Non-Executive Directors are, by definition, not part of the Trust's management team. They play a key role on the Board, providing independent judgements on issues including strategy, performance and resources.

We commissioned the Thames Valley and Wessex Leadership Academy to undertake an assessment of the Board at the end of 2013/14. The outcome of this assessment will be used to update the Board's development programme for 2014/15.

You can find out more about the current Board of Directors on our website at www.iow.nhs.uk/about-us/our-trust-board/trust-board.htm

Membership and the Patient Council

This is your NHS – we're handing it over to you!

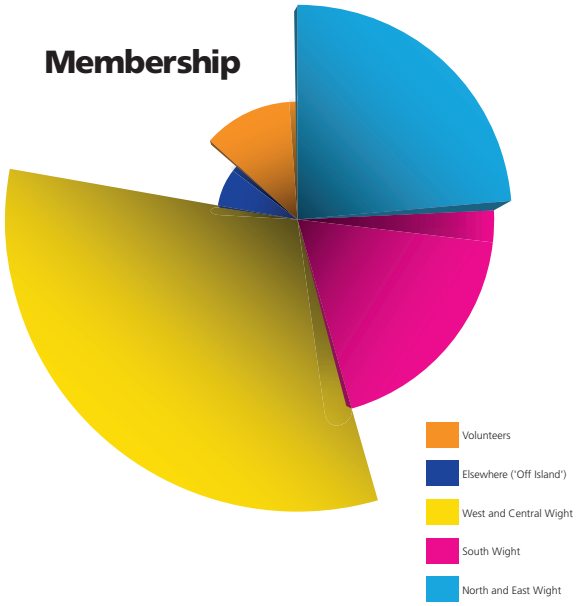
Danny Fisher, Chairman,
at a Medicine for Members meeting in 2014

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 festivals and other 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. Having a strong membership base is also a prerequisite for becoming a Foundation Trust.

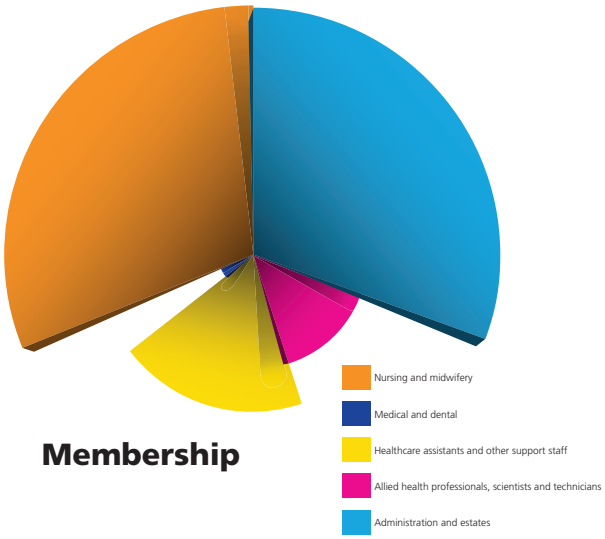
The Trust currently has 4,219 'public members' (19 May 2014) and we are on target to attract a total of 6,000 by April 2017. These are members of the public, who want to make a difference to healthcare on the Island.

> You were all brilliant.

The table below identifies the current public membership by constituency:



We also have 2,832 'staff members' (19 May 2014). These are staff directly employed by the Trust, on permanent contracts of 12 months or more. A breakdown follows:



Activities are being arranged for the coming year, including regular Medicine for Members meetings. These give members the opportunity to help shape our future plans, and quiz the senior team in a friendly open forum. These events are usually oversubscribed. We will also continue to take opportunities to discuss our health and social care provision with the wider public.

In addition, members now have a magazine that provides updates on our news and plans – launched in February 2014, this has been well received and readers will influence its future direction.

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 – this 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 – this meets every two months (or as required) and represents the interests of the medical staff. The membership includes the Chief Executive, Executive Medical Director and a representative from the Staff Partnership Forum.

As the organisation moves forward, we are looking at additional models of representation, such as the introduction of Staff Governors. We will also be trialling 'roadshows' where staff can talk to the senior team in an informal setting.

Patient Council

Our Patient Council meets on a regular basis to discuss plans and developments that could impact on patients and the wider public.

There are 25 patient representatives, who are all members of the Trust, and are also invited to attend a number of committees and Board Meetings. Ultimately, we anticipate that the Patient Council will be replaced by an elected Council of Governors in late 2014/early 2015.

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. The Trust is represented at the Council's Health Scrutiny Sub Committee and we provide various briefings for Councillors and Officers.

Disclosure to auditors

So far as the Directors are aware there is no relevant audit information of which the company's auditor is unaware.

We have taken all steps as Directors to make ourselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Board committees

The business of the Trust is managed through seven Board committees which are listed in the Annual Governance Statement.

Full details of these committees, their membership and terms of reference are available on our website at www.iow.nhs.uk/aboutus and in the Annual Governance Statement.

Pension liabilities

Details of how pension liabilities are treated can be found in note 10.6 in the Accounts and the Remuneration Report. **Please see page 27**

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 2013/14.

Sickness absence data

Details of the Trust's sickness absence rate can be found in the full Accounts and also in the Trust's Performance Report which is published monthly with the Trust Board papers.

Cost allocation and charges for information

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

Serious Incidents Requiring Investigation (SIRIs)

These are reported, investigated and managed in accordance with national requirements. The Trust is committed to monitoring incidents to ensure that they are robustly investigated, that any necessary action is taken to improve patient safety, and that lessons are learned in order to minimise the risk of similar incidents occurring in the future.

Under the Health and Social Care Act 2008, we are required to notify the Care Quality Commission (CQC) about events that indicate, or may indicate, risks to ongoing compliance with registration requirements, or that lead or may lead to changes in the details about the organisation in the CQC's register. Reports from the Isle of Wight NHS Trust are made via the National Patient Safety Agency (NPSA).

Further information can be found in the Annual Governance Statement on page 33 and the Trust's separate Quality Account (available at www.iow.nhs.uk/publications).

Equality disclosures

The Trust has comprehensive policies in relation to disabled employees and equal opportunities. These are available on request.

Health and safety

The Trust has an excellent health and safety record and as a responsible employer, we encourage staff to report any incidents to promote a healthy, open culture.

In 2013/14:

- 16 reports were submitted to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 – this compares with 14 reports in 2012/13.
- There were 34 manual handling incidents (such as strains and sprains) – this compares with 40 incidents in 2012/13 and 42 in 2011/12.

The Trust continues to take a zero tolerance approach on violence and abuse towards staff and we will take legal action against those who are criminally responsible for their actions.

In 2013/14:

- All cases taken to court resulted in convictions.
- A total of 106 assaults against staff were reported – 98% of these resulted in either no harm or low harm to the member of staff.

- Most of the incidents were non criminal in nature and arose from the patients' medical conditions.

- There were 310 reports of verbal abuse (we believe this was under reporting).

The Trust has a comprehensive policy covering health, safety and security, which is available on request. More information can be found in the Trust's annual Health and Safety Report which can be found at www.iow.nhs.uk/publications or on request from comms@iow.nhs.uk or by telephoning 01983 822099 ext 6175.

Fraud

The Trust has a robust and effective counter fraud service provided by CEAC (www.ceac.nhs.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 11 to the accounts. **See page 71**.

Emergency preparedness

The Trust has a Major Incident Plan that is fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all the associated guidance in place. Details of the Trust's performance can be found in the Emergency Preparedness and Resilience Annual Report available at www.iow.nhs.uk/publications.

Principles for Remedy

The Trust supports the Principles for Remedy published by the Parliamentary and Health Service Ombudsman in May 2010 and implements these principles as part of the Trust's complaints handling procedure.

Karen Baker
Chief Executive Officer
Accountable Officer
Isle of Wight NHS Trust

5th June 2014

Remuneration Report

Introduction

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration.

In the NHS the report is in respect of 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

The Trust Development Authority determine the Remuneration of the Chairman and Non-Executive Directors nationally.

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 any 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.

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 3 months period of notice. Other Director contracts are required to give 6 months period of notice.

Exit packages and severance payments

Details of exit packages and severance payments can be found in the annual accounts at note 10.4.

Off-payroll engagements

There are no employees with employment arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements).

Tables showing the Salary and Pension entitlements of senior managers follow.

Salary and Pension entitlements of senior managers – Remuneration (subject to audit)

Name and title	2013/14					2012/13				
	Salary	Other remuneration	Bonus payments	Benefits in kind	Total	Salary	Other remuneration	Bonus payments	Benefits in kind	Total
	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	rounded to nearest £100	£000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	rounded to nearest £100	£000
Mr D Fisher – Chairman (note 3)	–	20–25	–	–	20–25	–	20–25	–	–	20–25
Mr J Matthews – Non-Executive Director (note 3)	–	5–10	–	–	5–10	–	0–5	–	–	0–5
Dr N Moorman – Non-Executive Director (note 2 & 8)	–	5–10	–	–	5–10	–	–	–	–	–
Mr P Taylor – Non-Executive Director (note 3 & 10)	–	5–10	–	–	5–10	–	5–10	–	–	5–10
Mrs S Wadsworth – Non-Executive Director (note 3)	–	5–10	–	–	5–10	–	5–10	–	–	5–10
Mr N Wakefield – Non-Executive Director (note 4)	–	0–5	–	–	0–5	–	0–5	–	–	0–5
Mr C Rogers – Non-Executive Director (note 2 & 8)	–	0–5	–	–	0–5	–	–	–	–	–
Mrs J Baird – Non-Executive Director (designate) (note 2 & 8)	–	0–5	–	–	0–5	–	–	–	–	–
Mr D King – Non-Executive Director (designate) (note 2 & 8)	–	0–5	–	–	0–5	–	–	–	–	–
Mrs J Tabor – Non-Executive Director (designate) (note 2 & 8)	–	0–5	–	–	0–5	–	–	–	–	–
Mr N Dobbs – Non-Executive Director (note 9)	–	–	–	–	–	0–5	–	–	–	0–5
Mrs C Kenwright – Non-Executive Director (note 9)	–	–	–	–	–	0–5	–	–	–	0–5
Ms K Baker – Chief Executive (note 3, 5 & 6)	145–150	–	–	–	145–150	115–120	–	–	–	115–120
Mr K Flynn – Chief Executive (note 9)	–	–	–	–	–	35–40	–	–	–	35–40
Ms F Greene – Executive Director of Strategy & Commercial Development (note 4 & 5)	55–60	–	–	–	55–60	45–50	–	–	–	45–50
Mr A Heyes – Interim Director of Planning, ICT and Integration (note 1, 2, 5 & 8)	30–35	–	–	–	30–35	–	–	–	–	–
Mrs C Palmer – Executive Director of Finance (note 3, 5 & 6)	105–110	–	–	–	105–110	105–110	–	–	–	105–110
Mr M Price – Foundation Trust Programme Director / Company Secretary (note 1, 1a, 3 & 5)	85–90	–	–	–	85–90	80–85	–	–	–	80–85
Mr M Pugh – Executive Medical Director (note 3)	50–55	150–155	–	–	50–55	45–50	140–145	–	–	45–50
Mr A Sheward – Executive Director of Nursing & Workforce (note 3 & 5)	95–100	–	–	–	95–100	20–25	–	–	–	20–25
Mrs C Alstrom – Chief Nurse (note 9)	–	–	–	–	–	60–65	–	–	–	60–65
Mr T Hart – Director of Human Resources & Org. Dev. (note 9)	–	–	–	–	–	20–25	–	–	–	20–25
Mrs S Johnston – (Acting) Executive Director of Nursing & DIPC & HR (note 9)	–	–	–	–	–	35–40	–	–	–	35–40
Band of highest paid director's total remuneration (£000)	145–150					115–120				
Median total remuneration (£)	25,783					27,525				
Ratio (note 7)	5.7					4.3				

Notes

(1) All the above senior managers are/were voting members of the Board of Directors except Mr M Price, Mr A Heyes and the three Non-Executive Director (designates).

(1a) From April 2013, Mr M Price assumed additional responsibilities relating to the Company Secretary role.

(2) The following appointments were made in the year:

- In May 2013 Dr N Moorman was appointed Non Executive Director.
- In July 2013 Mr C Rogers was appointed Non Executive Director.
- In December 2013 Mr A Heyes was appointed Interim Director of Planning, ICT and Integration.
- In January 2014 Mrs J Baird was appointed Designate Non Executive Director.
- In January 2014 Mr D King was appointed Designate Non Executive Director.
- In January 2014 Mrs J Tabor was appointed Designate Non Executive Director.

(3) The remaining Directors not shown in note 2 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 1st April 2013 but ceased to serve on the Board during the year:

- In November 2013 Ms F Greene left as Executive Director of Strategy & Commercial Development.
- In July 2013 Mr N Wakefield left as Non-Executive Director.
- In January 2014 Mr J Matthews left as Non-Executive Director.

(5) The above named executive directors have service contracts with the Trust.

(6) The CEO and EDOF 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 2013/14 was £145,000–£150,000. This was 5.7 times the median remuneration of the workforce, which was £25,783.In 2013/14, two employees received remuneration which was proportionately higher than that received by the highest paid director. Total remuneration includes salary, on-call payments, non-consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration ranged from £14k to £243k. The ratio increased from 4.3 in 2012/13 to 5.7 in 2013/14. Primarily, this was because the pay banding of the highest paid individual rose from £115k–£120k in 2012/13 to £145k–£150k in 2013/14, which was due to the Chief Executive only being in post for part year, July 2012 to March 2013, in 2012/13.

(8) Prior year figures not available as these senior managers not in post during 2012/13.

(9) Current year figures not available as these senior managers not in post during 2013/14.

(10) As a post balance sheet event, Mr P Taylor will leave as Non Executive Director after 6 June 2014.

Salary and Pension entitlements of senior managers – Pension benefits (subject to audit)

Name and title	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2014	Total related lump sum at age 60 at 31 March 2014	Cash equivalent transfer value at 31 March 2014	Cash equivalent transfer value at 31 March 2013	Real increase in cash equivalent transfer value	Employers contribution to stakeholder pension
	(bands of £2.500) £000	(bands of £2.500) £000	(bands of £5.000) £000	(bands of £5.000) £000	£000	£000	£000	To nearest £100
Ms K Baker – Chief Executive	10.0–12.5	35.0–37.5	60.0–65.0	185.0–190.0	1,225	940	264	0
Mrs C Palmer – Executive Director of Finance	0.0–2.5	2.5–5.0	30.0–35.0	95.0–100.0	604	557	35	0
Mr M Pugh – Executive Medical Director	2.5–5.0	7.5–10.0	40.0–45.0	125.0–130.0	796	710	70	0
Mr A Sheward – Executive Director of Nursing & Workforce	5.0–7.5	20.0–22.5	20.0–25.0	65.0–70.0	313	205	103	0
Ms F Greene – Executive Director of Strategy & Commercial Development	0.0–2.5	2.5–5.0	0.0–5.0	10.0–15.0	73	45	27	0
Mr M Price – Foundation Trust Programme Director / Company Secretary	2.5–5.0	7.5–10.0	30.0–35.0	95.0–100.0	577	497	69	0
Mr A Heyes – Interim Director of Planning, ICT and Integration	0.0–2.5	0.0–2.5	0.0–5.0	0.0–5.0	5	0	5	0

Notes

There are no entries for Non-Executive Directors in the table because their remuneration is non-pensionable.

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, contributions paid by the employee (including 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.

> I cannot praise too highly all aspects of my treatment – the sheer hard work, constant cheerfulness, and the amazing competence of you all left me in awe.

Karen Baker
Chief Executive Officer
Accountable Officer
Isle of Wight NHS Trust

5th June 2014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Annual Governance Statement

The Chief Executive Officer of every NHS Trust is appointed by Parliament as the NHS officer – known as the 'Accountable Officer' – responsible and accountable for funds entrusted to their Trust.

In essence the 'Accountable Officer' at Isle of Wight NHS Trust is responsible for the propriety and regularity of public finances in the NHS; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; and for the efficient and effective use of all the resources in their charge. In their Annual Report every NHS Trust is required, in accordance with national guidance, to include an explanation of the Accountable Officer's responsibilities and a Governance Statement which reflects the circumstances in which the Trust operates.

The Accountable Officer for Isle of Wight NHS Trust is Karen Baker.

Statement of Accountable Officer's responsibilities

The Isle of Wight NHS Trust Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding public funds and the organisation's assets as set out in the Accountable Officer Memorandum.

All members of the Board have subscribed to the NHS Code of Accountability for NHS Boards, which identifies the Board's responsibilities and accountability arrangements, and to the Standards of Business Conduct.

Scrutiny by the Non-Executive Directors and our Auditors is undertaken through the Audit and Corporate Risk Committee which provides direct assurance to the Board in respect of our systems of internal control, including probity in the application of public funds and in the conduct of the organisation's responsibilities. The Audit and Corporate Risk Committee's reports and minutes are reviewed in public Board meetings, and their recommendations are individually considered to ensure that the Trust takes an integrated and comprehensive approach to governance and risk management.

The Corporate Governance Framework comprises the systems and processes, and culture and values, by which the Trust is directed and controlled. It enables the Trust to monitor the achievement of its strategic objectives. The Board Assurance Framework and the system of internal control are significant parts of that framework and are designed to manage risk providing reasonable assurance of effectiveness. The Board Assurance Framework and the system of internal control are based on an on-going process to identify and prioritise for management the risks to the achievement of the Trust objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised.

A governance framework has been in place throughout the year ended 31 March 2014 and up to the date of approval of the annual accounts for 2013/14.

The Non-Executive Directors (NEDs) play an active part in the independent scrutiny of Trust activities, through their role as 'portfolio' holders. NEDs hold positions as Chairs, Vice-chairs and members of many of the Board-level committees and sub-committees. A schedule of Non-Executive Director responsibilities as at 31 March 2014 is included as an appendix to this statement.

The governance framework of the organisation

The Trust Board has a sub-committee structure currently consisting of seven formal sub-committees of the Board as shown below:

- Audit and Corporate Risk Committee.
- Quality and Clinical Performance Committee.
- Finance, Investment and Workforce Committee.
- Charitable Funds Committee.
- Remuneration and Nominations Committee.
- Mental Health Act Scrutiny Committee.
- Foundation Trust Programme Board.

All Board sub-committees produce annual reports for scrutiny by the Audit and Corporate Risk Committee. Reports include the number of meetings held in year, confirmation of compliance with Terms of Reference, key achievements of the committees and future plans.

Attendance records related to the Board and Board sub-committees are maintained and a summary of attendance for period April 2013 – March 2014 is included as an appendix to this statement.

In 2012/13 the Audit and Corporate Risk Committee was formally identified as the senior scrutiny committee of the organisation and the Audit and Corporate Risk Committee has highlighted the following issues within its monthly reports to the Board during 2013/14.

Fire Service Audit Report Update:

- That the digitalisation of patients' records is undertaken as soon as possible and a project team set up as a priority to take forward the fire safety issues, particularly surrounding the Social Club.

Annual Report & Accounts 2012/13:

- Accounts be formally signed off on 5 June 2013.
- The Annual Report should be strategic, setting out how the Trust has met its corporate objectives, priorities and targets, and should be short and concise. Focus should be on the 8 page summary document.
- The Quality Account to be presented on 5 June 2013 for sign off subject to Stakeholder Statements.

Review of Achievement of Corporate Objectives:

- The Trust Board to determine the assessment criteria for success for the current year.

The NHS Constitution:

- Options to be endorsed by the Trust Board at the June 2013 meeting.

Legal Service Agreement:

- The service should go out to tender no later than the end of October 2013.

Annual Report 2012/13 Incorporating the Quality Account:

- The Annual Report to be a single, comprehensive and concise document.
- A timescale for the production of the Report to be prepared for commencement in January.
- A standardised template to be prepared with a deadline for receipt of completed templates (maximum number of words stated).
- The editor when appointed should drive the co-ordination of the Report with the respective committees to ensure that production of the Report is aligned with annual accounts.
- In-year targets within the BAF to be used as the framework for the content of the Trust's Annual Report.

Cost Improvement Programmes (CIP) Quality Assurance Process:

- The quality impact assessments to be presented to the Quality and Clinical Performance Committee for assurance purposes.

Internal Audit Report – Payroll Workforce Transactions – Limited Assurance:

- As a result of the continuing concern over procedures within the HR Department, the Committee recommended that an unannounced visit is carried out.

Consolidation of Charitable Fund Accounts:

- The Committee recommended not to consolidate Charitable Fund Accounts in the 2013/14 Trust Accounts for presentation to the Trust Board for approval.

The Internal Audit Programme for 2013/14 included a review of Risk Management and Board Assurance and significant assurance was identified in these areas.

The Board undertook a comprehensive self assessment of its own effectiveness at Board Seminar meetings in March and April 2013. The assessment evaluated the collective performance of the Board, the performance of the Board's committees and the individual performance of Directors. Positive outcomes of the self assessment included improving patient care, achievement of patient access standards, achievement of financial targets, improving workforce effectiveness, improving the quality of our buildings, delivering in-year service developments, maintaining and updating our Integrated Business Plan and developing relationships with stakeholders and partners. The Board also concluded that its sub-committees were working effectively, providing good assurance to the Board; that the working of the Board has been to the best interest of the overall organisation; and that the Board had met its statutory duties of care and quality.

A number of areas for improvement were also identified and action plans developed to cover all of these areas in order that the performance of the Board Directors would continue to be enhanced through ongoing Board development plans, personal development plans and mentoring arrangements. A further Board level review of its performance and effectiveness is planned to take place in May 2014.

All Executive Directors have clear objectives, and I have established a schedule of regular one-to-one meetings with each member of the Executive team to oversee progress, culminating in a year-end appraisal of performance. Moreover, I further exercise internal management controls through my regular executive management team meetings and attendance at various Committees.

On a monthly basis the Trust self certifies against the Monitor Board Statements and Licence Conditions outlined in the Trust Development Authority's Accountability Framework for NHS Trust Boards. Validation of the Trust's status is provided by senior officers and assurance is provided to the Trust Board via the Finance, Investment and Workforce sub-committee and the Quality and Clinical Performance Board sub-committee. As of 31 March 2014 all Board Statements and Licence Conditions have been certified as compliant. Furthermore the Board Performance Report, reviewed at public Board monthly meetings, contains a balanced scorecard including commentary against any national priorities and standards either achieved or not achieved.

Corporate Governance Code

It is the policy of the Trust to identify, minimise, control and where possible eliminate any risks that may have an adverse impact on patients, staff and the organisation. As Chief Executive I carry ultimate responsibility for all risks within the organisation. The Trust's risk management strategy, policy and procedures, describe the responsibilities for risk management from the organisational responsibility of the Board, through all managers, clinicians and staff, ensuring their commitment to the principles of risk management which apply throughout all areas of the organisation regardless of the type of risk – organisational, financial, environment and facilities, clinical and non-clinical.

Through the operation of this governance framework I am assured of our compliance to the Corporate Governance Code and I am not aware of any instances of non-compliance with relevant laws, regulations or governance codes. For example, papers to the Board and Committees are required to highlight legal implications and legal advice is sought by the Trust, as required.

Quality Governance and the publication of the Quality Account

Quality Governance arrangements for the Trust were reviewed in October 2013 and the new proposed arrangements were agreed at the Trust Executive Committee on 18 November 2013.

Governance arrangements set out the responsibility for delivery against the Quality Governance Framework and the Trust's associated Action Plan through the newly developing Patient Safety, Experience and Clinical Effectiveness Triumvirate, ensuring action is taken where appropriate. Monitoring takes place via the Foundation Trust Programme Board and assurance provided through the Quality and Clinical Performance Committee (a sub-committee of the Trust Board).

Audits reports from both internal and external audits confirmed that the Trust's Quality Account for the year 2012/13 was compliant with national requirements.

Statements received from CCG; the Patient Council; Healthwatch and the Isle of Wight Council's Health and Community Well-being Scrutiny Panel were included in final version of the Quality Account.

The Trust's approach to improving quality and safety is to ensure there are clearly defined roles, responsibilities and processes that support improvement. This includes where responsibility for delivery, monitoring and assurance sits within the organisation.

A recent restructure has led to the development of the Patient Safety, Experience and Clinical Effectiveness Triumvirate (SEE); which will be responsible for driving forward the quality and patient safety agenda.

The organisation's Long Term Quality Plan (LTQP) outlines the Trust's aims and objectives for Patient Safety, Clinical Effectiveness and Patient Experience for the next 12 months; together with the longer term (3 – 5 year) priorities. Key to achieving this is the need to take a strategic approach to quality improvement with three primary drivers:

1. **Building the will to make measurable and systemic improvements as quickly as possible.**

   Encouraging and spreading ideas about alternatives to the current situation which are robust enough to form the basis of new ways of working and also ideas about how to introduce them.

2. **Attending relentlessly to the execution of a range of aligned improvement activities, and bringing them into the day to day business of the Trust.**

3. **Each Clinical Directorate has a local quality plan, outlining how they will deliver the four overarching organisational quality goals and detailing local quality goals. These are appropriately monitored and reported within the Clinical Directorate Structure.**

Two trust wide quality related action plans have been developed: the Quality Governance Framework (QGF) Action Plan and the Integrated Action Plan (IAC) – External reviews (Keogh; Cavendish; Berwick & Francis). These support delivery of quality related priorities and recommendations and are governed by defined structures, including monitoring and assurance being facilitated through the Patient Council; The Foundation Trust Programme Board and the Quality and Clinical Performance Committee (QCPC).

The organisation has a Patient Experience Strategy which outlines our commitment to ensure services are developed and improved as a direct result of patients' experience and involvement. Excellent Patient Experience is supported by the Trust's five Strategic Objectives and is clearly embedded throughout the Trust's Integrated Business Plan (IBP). This is to ensure the Trust has a co-ordinated approach to listening, learning and routinely capturing feedback in order to continue to improve.

The Trust's annual Quality Account outlines priorities for the coming year and provides a review of performance against the previous year's quality related goals. Reporting in year is provided through the monthly Quality Report and reviewed in depth at the Quality and Clinical Performance Committee. Annual external and internal reviews of the Quality Account give assurance of the consistency of information provided.

Key organisational quality goals identified for delivery in 2013/14 included reducing mortality rates; prevention of pressure ulcers; improving communication; and end of life care (AMBER Care Bundle). These were published in detail within the Trust's Quality Account. These quality goals are in the process of being reviewed and new goals for 2014/15 will be agreed following consultation with key stakeholders (e.g. patients, public and Healthwatch), as part of the development of the Quality Account. Goals are expected to cover the breadth of the five Care Quality Commission domains of quality: safe, caring, effective, responsive and well-led.

> We are impressed by your kindness, your dedication and professionalism. You do a fantastic job.

Monitoring

As well as the four key organisational quality goals, the Trust continues to monitor the 26 improvement and sustainability quality indicators, originally outlined in the 2012/13 Quality Improvement Strategy and these continue to form the basis of quality reporting.

Progress to achieve quality and safety priorities is monitored and measured through the performance management process using our integrated quality dashboard. These Performance Reviews oversee the performance of the core elements of a Directorate's business and link to organisational Critical Success Factors.

There are weekly Risk and Quality Reviews with attendance of both the Executive Director of Nursing and Workforce, and the Executive Medical Director. These Reviews monitor incident reporting, serious untoward incidents, and 'never events', in line with the Trust's Serious Incidents Requiring Investigation (SIRI) policy; plus outcomes of local investigations of incidents; potential and actual litigation claims; and serious complaints received by the Trust.

Unannounced Board to Ward inspections are undertaken, both formally and informally by Non-Executive and Executive Board Members, some supported by a member of the Senior Directorate team. These offer the opportunity for the Trust Board to link directly with services delivered in all areas of the Organisation; providing patients, relatives and staff with the opportunity to discuss issues directly with the Trust Board. These are pivotal in seeking assurance at the point of service delivery and demonstrate the Trust Board's leadership commitment of setting a culture to be fostered across the entire organisation. Feedback is provided to the relevant areas visited, and actions arising from the visits are monitored by the Public part of the Trust Board on a monthly basis. A well led organisation ensures that clinical managers maintain a base with the clinical services. To support this, Senior Nurses work with ward based staff on a monthly basis, through a structured programme of assurance to the Executive Director of Nursing and Workforce who also participates in the programme.

Indicators within the Care Quality Commission (CQC) Intelligent Monitoring are used to ensure that the Trust is meeting standards of quality and safety and thereby maintain compliance with the CQC's registration requirements.

Assurance

Assurance relating to quality and safety is provided through the Quality and Clinical Performance Committee, a formal sub-committee of the Trust Board.

This committee, chaired by a Non-Executive Director of the Board, has overarching responsibility for assurance on Quality, Clinical Effectiveness, Patient Experience, Patient Safety and Clinical Performance within the organisation. Directorates hold monthly quality reviews, feeding the outputs of these reviews directly to the Quality and Clinical Performance Committee.

The risk and control framework

The overall responsibility for the management of risk rests with the Chief Executive, supported collectively and individually by the Board of Directors. Specific risk management responsibilities for Executive Directors and Senior Managers have been agreed and are documented within the Board approved Risk Management Strategy, as well as in individual job descriptions as appropriate.

The Trust Executive Committee acts as the overarching committee with responsibility for risk management within the Trust and this responsibility is clearly reflected in the Executive Committee's Terms of Reference. Reporting directly to the Company Secretary, the Head of Corporate Governance and Risk Management provides leadership and management for the risk management function within the Trust.

Risk management is embedded within the Trust's activities in several ways:

- A revised and updated Board Assurance Framework (BAF), described in more detail below, was approved by the Trust Board in July 2013, together with an action plan to address any gaps in controls and/or assurance.
- The Trust's internal auditors, Mazars, have worked closely with senior managers to review and report on the organisation's systems of internal control and risk management.
- The Audit and Corporate Risk Committee conducts a regular review of the Trust's risk management systems, including the risk register and the BAF.
- The Corporate Governance Framework has been revised and updated during 2013/14 following a comprehensive review of Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation and other relevant documents.
- The revised Corporate Governance framework has been formally approved by the Board and up to date copies of all the framework documents together with the terms of reference of all Board sub-committees are maintained on a Corporate Governance Framework intranet site for access as necessary by Trust staff.
- A number of sub-committees and groups have reported monthly to the Trust Executive Committee throughout 2013/14, enabling the Committee to be informed of any significant risk management issues occurring within the Trust.
- A departmental/service specific risk assessment and register system is in place which links to the corporate risk register, thus ensuring that all areas of the organisation are actively involved in the risk management activity of the Trust.
- At the time of this report there are 80 risks included on the Trust Corporate Risk Register covering all aspects of Trust business. New risks identified during 2013/14 include Paediatric Occupational Therapy extended waiting times; Ophthalmology case notes; Diagnostic Imaging Department facilities; Endoscopy Decontamination machines and Operating Theatres walls and floors refurbishment. All new risks included within the corporate risk register are noted on the BAF linked to the most appropriate Trust objective and any new risks added to the risk register throughout the year are cross-referenced to the BAF at the time of entry. All risks on the register have action plans in place and

underway which are regularly monitored and performance managed. Risks are only removed from the register following a formal sign-off process by an Executive or Associate Director and an assessment of the completed action plans by the appropriate sub-committee of the Board. During the year April 13 – March 14 a total of 37 risks were formally signed off the register following appropriate action taken to mitigate these risks.

- An electronic intranet-based incident reporting system is now embedded across the organisation, supported by a comprehensive training and awareness programme for staff.

Risk management strategy

The Trust's Strategy for Risk Management was updated and re-approved by the Board in December 2012 and covers the period November 2012 – October 2014.

The Strategy sets out the organisation's attitude to risk, and defines the structures for the management and ownership of risk throughout the organisation. Specific sections within the Strategy cover:

- Corporate responsibility and accountability.
- Values and principles underpinning service delivery with the emphasis on patient safety, quality of care, and patient and public involvement.
- Risk management systems in place within the Trust including the key stages of risk identification, risk analysis and evaluation, risk control and reduction, and processes for ongoing monitoring and review.
- Processes in place for ongoing performance review and learning, e.g. from incidents, complaints and claims.

Board Assurance Framework (BAF)

The Board has continued to maintain an up to date Assurance Framework. The latest formal revision of the framework, incorporating a series of new organisational objectives and critical success factors, was approved by the Board in July 2013.

The Assurance Framework includes a set of principal objectives and principal risks linking directly to Care Quality Commission Essential Standards of Quality and Safety. An Executive Director lead has been identified for each principal objective/ risk within the framework. The Assurance Framework is updated continuously and has been reported to the Board every month throughout the year.

The Assurance Framework enables the Board to be properly informed about the principal risks to the achievement of the organisation's key objectives, and the controls in place which are intended to manage these risks. The framework document comprises:

- The organisation's principal objectives.
- The principal risks associated with achieving these objectives.
- The key controls/systems in place to minimise the risks.
- The positive assurances available to the Board in the form of internal and external assessments and reports.
- A cross-reference to all risks currently included within the corporate risk register.

The framework also includes details of any gaps in controls and/or assurance and describes the specific actions designed to address these gaps. In 2013/14 the framework includes strategic risks relating to:

- Improving the experience and satisfaction of patients.
- Improving clinical effectiveness and safety for patients.
- Development and implementation of the Trust Clinical Strategy.
- Relationships with key external stakeholders and building on integration between health and social care.
- Improving value for money whilst maintaining high quality services.
- Developing our Foundation Trust application.
- Developing our support infrastructure particularly IT systems and our Estates Strategy.
- Developing our organisational culture and redesigning the workforce.

The Assurance Framework, which includes all action plans for the management of the risks listed above, has been reviewed throughout the year at both public and private meetings of the Board and an end of year review of the Framework was undertaken by the Executive Committee and Board in March 2014.

Risk management training

A risk management training programme for Trust staff is well established. Half day risk management/self assessment workshops provide senior staff with the necessary skills and tools to undertake risk self assessments within their own departments and services. A programme of annual refresher training sessions is also maintained.

Our basic risk management training programme provides staff with information and guidance on how they can engage with the risk management process – for example by reporting accidents and incidents, participating in risk assessments, or by highlighting operational risks for possible inclusion within local and corporate risk registers. Many e-learning programmes have also been developed and are now available for all staff to access. The programmes include Risk Management, Incident Reporting, Incidents, Complaints and Claims Management and Counter Fraud.

Our annual risk assessment programme, and the systems and training in place to support this, has been actively performance managed throughout 2013/14.

Information governance / data security

All reported information governance / data security incidents are logged on the Trust's incident reporting system and 287 such incidents were reported during 2013/14 (there were 387 incidents in 2012/13).

All information governance incidents are graded from level 0 – 2 in accordance with the Health and Social Care Information Centre (HSCIC) checklist guidance for reporting, managing and investigating information governance incidents. Any incident graded at level 2 is reported via the Information Governance Toolkit, which subsequently notifies the Information Commissioner. In addition all level 2 incidents are reported via the Strategic Executive Information System (STEIS) to the Trust Development Authority (TDA) in accordance with our general Serious Incidents Requiring Investigation (SIRI) policy.

During 2013/14 there was one level 2 information governance incident and brief details of this are disclosed in the 'significant issues' section of this statement.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. 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.

Executive managers 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 principal 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.
- Quarterly governance and assurance reports to the Trust Executive Committee.
- Reports and minutes to the Board from the Audit and Corporate Risk Committee.
- Monthly updates on progress against the Assurance Framework and associated action plans.
- Monthly review of the Corporate Risk Register.
- CQC confirmation of registration of all regulated activities with no compliance conditions attached.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit and Corporate Risk Committee and the Trust Executive Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Specific responsibilities of Trust Committees in relation to the system of internal control, and operational throughout 2013/14 include:

The Trust Board

- Development and approval of the Board Assurance Framework and associated action plan.
- Receiving and reviewing the minutes of the Audit and Corporate Risk Committee and other sub-committees of the Board.
- Receiving and reviewing monthly performance reports relating to activity, quality, finance and workforce.

The Audit and Corporate Risk Committee

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.
- Providing assurance to the Board through the minutes of the Committee in relation to:
    - The adequacy of all risk and control disclosure statements.
    - The underlying assurance processes that indicate the degree of the achievement of corporate objectives and the effectiveness of the management of principle risks.
    - The effectiveness of the Trust's risk management arrangements.
    - The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
    - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the Counter Fraud NHS Protect Service.
    - The process for the production of the Quality Account.

The Trust Executive Committee

- Maintaining a constant review of corporate governance arrangements and ensuring the Board is fully briefed on any significant issues.
- Ensuring the Assurance Framework action plan is effectively performance managed.
- Ensuring the Corporate Risk Register is regularly reviewed and updated.
- Overseeing the performance management and reporting arrangements relating to the Trust's Care Quality Commission registration.
- Monitoring compliance with external agency visits and inspections ensuring any actions and/or recommendations are followed up appropriately.
- Reviewing quarterly corporate governance and risk reports detailing trends in incident reporting, risk assessments, non-clinical claims and information governance, making recommendations for further action as appropriate.

Internal audit

I am also assisted by the Trust's internal auditors, Mazars who provide assurance to the Board through reviews of the effectiveness of the organisation's management of risk.

Between January and March 2014 an internal audit review examined the processes by which the Board obtains assurance on the effective management of key risks relevant to the organisation's strategic objectives. The audit opinion of the assessment of controls in place and of the level of compliance with these controls was 'substantial assurance'. Specifically the audit confirmed that:

- The Trust has an up to date risk management strategy in place which outlines the strategic approach to risk management.
- Risk management awareness training for Board members and senior managers has been undertaken.
- A risk management structure presents clear reporting and reviewing lines for risk management.
- Regular risk assessments are undertaken by ward staff to ensure that all risks the Trust is exposed to are documented and managed.
- Testing a sample of local risk registers, directorate risk registers, and the corporate risk register, confirmed sufficient detail was present in all three.
- Strategic objectives are defined and mapped to risks and assurances in the Board Assurance Framework (BAF).
- Objectives within the BAF are cross referenced to Care Quality Commission requirements where appropriate.
- Risk registers are maintained setting out the key risks facing the Trust and the registers help enable the Trust to understand its comprehensive risk profile.
- The terms of reference of key risk management committees – including the Audit and Corporate Risk Committee; the Trust Executive Committee; and the Quality and Clinical Performance Committee – had all appropriately detailed the committee's responsibilities for risk management.
- Testing of a sample of 20 risks on the Board Assurance Framework confirmed controls identified as mitigating the risk had been recorded by the Trust in each case.

However there was one area identified for further improvement, namely:

- Directorate-level quality, risk and patient safety committees should meet each month to help ensure that the Directorate is aware of the strategic risks that it faces.

A management action plan has been put in place to address this issue.

Other internal audits which are relevant to this Annual Governance Statement include reviews in respect of the Care Quality Commission Essential Standards of Quality and Safety and the Trust's Governance systems. For both of these reviews the auditors gave an opinion of 'substantial assurance'.

By agreement with the Trust's internal auditors, our audit plan for 2013/14 incorporated some areas of suspected weakness and particular focus, acknowledging that the outcome of this approach could be an increase in the number of limited assurance reports. As a result of this approach there were six internal audits undertaken during 2013/14 where the outcome was rated as 'limited assurance' and these were:

- Estates management (3 recommendations, 1 complete / 2 outstanding)
- Disaster recovery and IT out of hours support (15 recommendations, 4 complete / 11 outstanding)
- Private patients and overseas visitors (11 recommendations, 8 complete / 3 outstanding)
- Payroll and workforce transactions (5 recommendations, 4 complete / 1 outstanding)
- Staff and patient safety (6 recommendations, all complete and none outstanding)
- Clinical audit (10 recommendations, only 2 completed to date, as report was received in April 2014).

The six limited assurance audits represent 25% of the total number of internal audits completed during the period 1/4/13 – 31/3/14. The majority of audits completed in the same period resulted in 'substantial assurance' level reports (58%).

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HOIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes – i.e. the organisation's system on internal control. The Head of Internal Audit Opinion for the year ended 31 March 2014 is that 'significant 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'.

Significant issues

As previously outlined in the information governance / data security section of this statement, the following information governance incident was reported to the TDA and the Information Commissioner during 2013/14 and this is disclosed as a significant control issue:

- A set of health records was found discarded on a road near to St Mary's Hospital by a member of Trust staff on 25 January 2014.

This incident has been subject to local investigation in order to identify 'root causes', to ensure plans are in place for improvement, and to prevent the likelihood of recurrence. Specific actions being taken in response to this incident include:

- Ensuring staff involved undertake further information governance training.
- Ensuring staff involved are fully aware of their responsibilities regarding the Data Protection Act.
- Production of formalised process for safeguarding health records and ensuring this is fully explained to new staff.
- Development and implementation of new guidance relating to the transportation of information / data for the benefit of all staff.

With the exception of the issue outlined above no other significant issues have been identified by the Trust and I believe that this Annual Governance Statement is a balanced reflection of the risks and controls operating within the Trust during 2013/14.

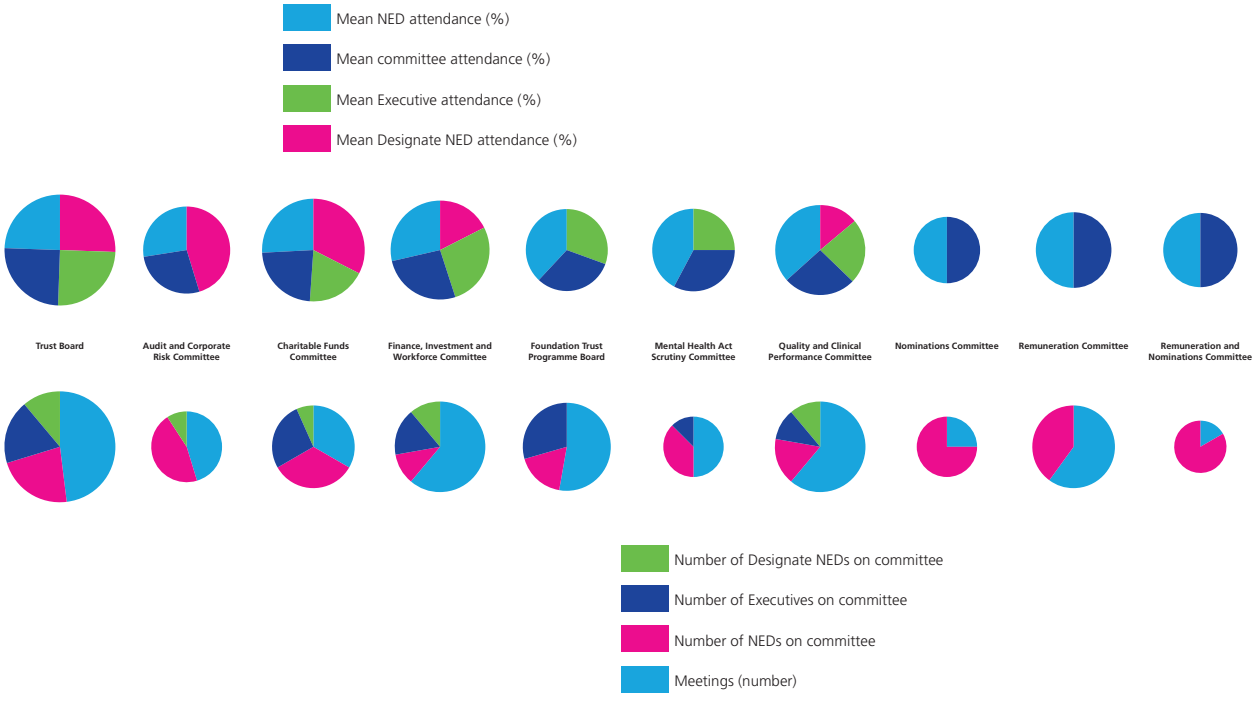
Karen Baker, Chief Executive Officer
5th June 2014

Appendix 1

Analysis of Trust Board members' meeting attendance in 2013/14

NED = Non-Executive Director
Exec/Executive/ED = Executive Director

Committee	Mean NED attendance (%)	Mean Designate NED attendance (%)	Mean Executive attendance (%)	Mean committee attendance (%)	Meetings (number)	Number of NEDs on committee	Number of Designate NEDS on committee	Number of Execs on Committee	Notes
Trust Board	87	92	89	89	13	6	3	5	1 ED position has been vacant since Nov 2013 and I NED position has been vacant since Feb 2014.
Audit and Corporate Risk Committee	60	100	0	60	5	5	1	0	There were change of members mid-year with new Designate NED joining in Jan 2014. There are no EDs on this committee.
Charitable Funds Committee	79	100	57	70	5	5	1	4	A number of members resigned during the period: membership shown is at April 2013.
Finance, Investment and Workforce Committee	81	50	78	75	11	2	2	3	One NED left at the end of June 2013 and a replacement joined in July 13. One ED left in Nov 2013. An interim ED joined in Dec 2013.
Foundation Trust Programme Board	74.07	0	60	61.11	9	3	0	5	In the majority of instances when Executives are unable to attend then deputies are in attendance.
Mental Health Act Scrutiny Committee	83.33	0	50	64.58	4	3	0	1	Apart from one NED other attendees are not members of the Board.
Quality and Clinical Performance Committee	86	33	55	61	11	3	2	2	A new NED joined In June 2013. Designate NEDs joined in Jan 14. One NED left at the end of Jan 14.
Nominations Committee	64	0	0	64	2	6	0	0	This used to meet on an ad hoc basis aligned with FT programme requirements. Ceased on 31 Jan 14 and is now incorporated within the Remuneration & Nominations Committee.
Remuneration Committee	83	0	0	83	9	6	0	0	Ceased on 31 Jan 14 and is now incorporated within the Remuneration & Nominations Committee.
Remuneration and Nominations Committee	80	0	0	80	1	5	0	0	Commenced February 2014.



Appendix 2

Non-Executive Director responsibilities (as at 31 March 2014)

Sub-committee	Non-Executive Directors						Designate NED		
	Danny Fisher	Sue Wadsworth	Charles Rogers (SID)	Peter Taylor (retiring from Board on 6 June 2014)	Dr Nina Moorman	Vacant	David King	Jane Tabor	Jessamy Baird
Corporate Trustee	Yes	Yes	Yes	Yes	Yes				
Trust Board	Chair	Vice Chair	Member	Member	Member		Attendee	Attendee	Attendee
Trust Board Seminar	Chair	Vice Chair	Member	Member	Member		Attendee	Attendee	Attendee
Audit and Corporate Risk Committee		Member	Vice Chair	Chair	Member			Attendee	
Charitable Funds Committee		Vice Chair		Member	Chair		Member		
Finance, Investment and Workforce Committee			Chair	Vice Chair			Member	Member	
Foundation Trust Programme Board	Member	Member		Member					
Mental Health Act Scrutiny Committee				Chair	Member				Vice Chair
Quality and Clinical Performance Committee		Chair			Vice Chair		Member		Member
Remuneration and Nominations Committee	Chair	Vice Chair	Member	Member	Member				


MEMBERSHIP CARD
Isle of Wight NHS
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Primary financial statements and notes to the accounts

Introduction to the annual 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 by the NHS Trust Manual for Accounts published by the Department of Health.

Statement of Comprehensive Income for year ended 31 March 2014

	NOTE	2013-14 £000s	2012-13 £000s
Gross employee benefits	10.1	**(116,847)**	(117,562)
Other operating costs	8	**(53,182)**	(50,681)
Revenue from patient care activities	5	**159,383**	159,729
Other Operating revenue	6	**12,484**	9,028
Operating surplus/(deficit)		**1,838**	514
Investment revenue	12	**32**	19
Other gains and (losses)	13	**6**	(1)
Finance costs	14	**(39)**	(23)
Retained Surplus/(deficit) for the financial year		**1,837**	509

Other Comprehensive Income

	2013-14 £000s	2012-13 £000s
Net gain/(loss) on revaluation of property, plant & equipment	**3,309**	0
Total Comprehensive Income for the year	**5,146**	509

Financial performance for the year

Retained surplus/(deficit) for the year	**1,837**	509
Impairments (excluding IFRIC 12 impairments)	**0**	112
Adjustments in respect of donated gov't grant asset reserve elimination	**(224)**	(78)
Adjusted retained surplus/(deficit)	**1,613**	543

The Trust's reported NHS financial performance position is derived from its retained surplus, as adjusted for the following:-

(i) Donated and Government grant funded assets incur capital charges, whilst the donations and grants are credited to income. TheTrust's reported financial performance position is adjusted for this cost/income stream.

The notes on pages 5 to 38 form part of this account.

Statement of Financial Position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment (PPE)	15	**97,613**	78
Intangible assets	16	**4,150**	0
Trade and other receivables	20.1	**277**	0
Total non-current assets		**102,040**	**78**
Current assets:			
Inventories	19	**2,200**	2,021
Trade and other receivables	20.1	**6,930**	9,215
Cash and cash equivalents	21	**13,358**	1,601
Total current assets		**22,488**	12,837
Total assets		**124,528**	12,915
Current liabilities			
Trade and other payables	22	**(20,395)**	(11,582)
Provisions	26	**(711)**	(824)
Borrowings	23	**(48)**	0
Total current liabilities		**(21,154)**	(12,406)
Net current assets/(liabilities)		**1,334**	431
Non-current assets plus/less net current assets/liabilities		**103,374**	509
Total Assets Employed:		**103,374**	509
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**6,762**	0
Retained earnings		**72,124**	509
Revaluation reserve		**24,488**	0
Total Taxpayers' Equity:		**103,374**	509

The notes on pages 5 to 38 form part of this account.

The financial statements on pages 1 to 4 were approved by the Board on 5th June 2014 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2014

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**0**	**509**	**0**	**509**
Changes in taxpayers' equity for 2013-14				
Retained surplus/(deficit) for the year		1,837		**1,837**
Net gain / (loss) on revaluation of property, plant, equipment			3,309	**3,309**
Transfers between reserves		90	(90)	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs		90,918		**90,918**
Reclassification Adjustments				
New PDC Received - Cash	623			**623**
New PDC Received/(Repaid) - PCTs and SHAs Legacy items paid for by Department of Health	6,139			**6,139**
Other Movements	0	39	0	**39**
Net recognised revenue/(expense) for the year	**6,762**	**92,884**	**3,219**	**102,865**
Transfers between reserves in respect of modified absorption - PCTs & SHAs		(21,269)	21,269	**0**
Balance at 31 March 2014	**6,762**	**72,124**	**24,488**	**103,374**
Balance at 1 April 2012	**0**	**0**	**0**	**0**
Changes in taxpayers' equity for the year ended 31 March 2013				
Retained surplus/(deficit) for the year		509		509
Net recognised revenue/(expense) for the year	**0**	**509**	**0**	**509**
Balance at 31 March 2013	**0**	**509**	**0**	**509**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

31 March 2014

	NOTE	**2013-14 £000s**	2012-13 £000s
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)		**1,838**	514
Depreciation and Amortisation	8	**7,560**	0
Impairments and Reversals		**0**	112
Other Gains/(Losses) on foreign exchange	13	**(4)**	(1)
Donated Assets received credited to revenue but non-cash	15.1	**(97)**	(78)
Interest Paid	14	**(39)**	(23)
Dividend (Paid)/Refunded		**9**	(9)
(Increase)/Decrease in Inventories	19	**(179)**	(2,133)
(Increase)/Decrease in Trade and Other Receivables	20.1	**(4,131)**	(9,206)
Increase/(Decrease) in Trade and Other Payables	22	**3,768**	11,582
Provisions Utilised	26	**(411)**	0
Increase/(Decrease) in Provisions	26	**298**	824
Net Cash Inflow/(Outflow) from Operating Activities		**8,612**	1,582
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	12	**32**	19
(Payments) for Property, Plant and Equipment	see below	**(3,052)**	0
(Payments) for Intangible Assets	see below	**(501)**	0
Proceeds of disposal of assets held for sale (PPE)	13	**36**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(3,485)**	19
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**5,127**	1,601
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received	see below	**6,762**	0
PDC Repaid		**(9)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(123)**	0
Net Cash Inflow/(Outflow) from Financing Activities		**6,630**	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**11,757**	1,601
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,601**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**13,358**	1,601

Note:-

The Trust held no PPE or Intangible Assets in 2012-13 therefore no prior year comparative figures are available for Payments or Depreciation.

The PDC of £6,762k received represents £6,139k relating to Legacy Balances, £399k for Dementia Friendly and £224k for Safer Hospitals Safer Wards.

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013-14 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.4 Charitable Funds

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns where material. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust's Charitable Funds are not considered to be material and are therefore not consolidated into the financial statements.

The charitable funds are 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 the Isle of Wight NHS Trust. The Corporate Trustee delegates authority to the Charitable Funds committee in accordance with Standing Financial Instructions.

1.5 Pooled Budgets

The Trust has entered into a pooled budget with the Isle of Wight Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for occupational therapy services and a note to the accounts provides details of the income and expenditure.

The pool is hosted by the Trust. Payments for services provided by the Trust in 2013-14 are accounted for as income from the Isle of Wight CCG. The Trust accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's 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 60 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 15.8% as per the Manual for accounts guidance. In addition, debts related to legacy Primary Care Trusts, Department of Health & Foundation Trusts have been impaired.

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 appropriate point on the scale for the individual employee as at the end of the financial year 13/14. Overtime and travel for March have been estimated based on the average of the preceding months.

Employers' Liability Provision – Based on actual named cases referred to solicitors. Value estimated by assessing likely outcome and allowing for solicitors fees. These are reflected in the Provisions note 26.

1.6.2 Key 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

1.7 Revenue

Revenue 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 revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

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

1.8 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- 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, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Notes to the Accounts - 1. Accounting Policies (Continued)

Revaluations 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. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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 but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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
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.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it

Notes to the Accounts - 1. Accounting Policies (Continued)

- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants
The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 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.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust’s surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.17 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 [NHS body]'s cash management.

1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 26.

1.20 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 the NHS Litigation Authority 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 as and when they become due.

1.21 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.24 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.

1.25 Foreign currencies

The Trust's functional currency 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.

1.26 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS Trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Under the NHS Transforming Community Services in 2013-14 those organisations receiving asset transfers were not subject to a PDC charge in that financial year. The Isle of Wight NHS Trust therefore did not make any PDC payments in 2013-14.

1.28 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries. The Trust has no other subsidiaries other than the Isle of Wight NHS Charitable Funds. These accounts are required to disclose material items, i.e. those items where their omission or misstatement would affect a user's understanding of the accounts. Materiality is assessed annually and will vary depending on the NHS organisation's accounts as well as the NHS Charity's accounts, it will encompass both qualitative and quantitative aspects. This will often be a percentage (1 or 2%) of income, expenditure, assets or liabilities.

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.30 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost.

1.31 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year :

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Isle of Wight Council pooled budget

The Trust has a pooled budget arrangement with the Isle of Wight Council. The Trust is the host.

The Trust's shares of the income and expenditure handled by the pooled budget in the financial year were:

	2013-14 £000s	2012-13 £000s
Income for occupational therapy services from Isle of Wight CCG	**1,090**	**1,080**
Expenditure for occupational therapy services	**(1,061)**	**(1,050)**
Surplus	**29**	**30**
Creditors	**(83)**	**(150)**
Cash	**112**	**180**
Increase in working capital	**29**	**30**

3. Operating segments

The Trust has a number of separate Directorates which all provide a healthcare service and are reported to the Board as part of its normal operational business. Contract income is not routinely separated over service Directorates and is consolidated into a single heading. These separate segments are reported below, after due consideration of the following requirements of IFRS8, Operating Segments.

		Acute		Planned		Community		Income		Support Services		Total	
		2013-14 £'000s	2012/13 £'000s	**2013-14 £'000s**	2012/13 £'000s	**2013-14 £'000s**	2012/13 £'000s	**2013-14 £'000s**	2012/13 £'000s	**2013-14 £'000s**	2012/13 £'000s	**2013-14 £'000s**	**2012/13 £'000s**
Income	Education & Training Income	916	1,085	753	1,337	800	376	-	0	2,373	936	4,842	3,734
	NHS Income	6,655	2,943	1,488	371	2,629	176	140,236	150,066	1,910	342	152,918	153,898
	Private Patients Income	81	50	1,362	1,225	-	0	-	0	-	0	1,443	1,275
	Other Operating Income	1,144	1,499	866	391	1,402	1,406	4,048	2,262	5,205	4,311	12,665	9,869
	Total Income	8,796	5,577	4,469	3,324	4,831	1,958	144,284	152,328	9,488	5,589	171,868	168,776
Expenditure	Employee Benefits Expenses	(34,949)	(36,205)	(32,300)	(32,739)	(32,262)	(31,520)	-	-	(17,336)	(17,098)	(116,847)	(117,562)
	Clinical Services & Supplies	(11,775)	(7,196)	(7,630)	(8,807)	(2,988)	(2,751)	-	-	(213)	(186)	(22,606)	(18,940)
	Establishment Expenses	(1,318)	(1,173)	(251)	(281)	(774)	(803)	-	-	(2,956)	(1,200)	(5,299)	(3,457)
	General Supplies & Services	(274)	(239)	(339)	(369)	(158)	(160)	-	-	(965)	(906)	(1,736)	(1,674)
	Miscellaneous Services	(3,443)	(721)	(217)	(635)	(165)	(119)	-	-	(616)	(2,957)	(4,441)	(4,432)
	Other Establishment Costs	(49)	(163)	(53)	(173)	(223)	(136)	-	-	(3,636)	(3,295)	(3,961)	(3,767)
	Premises & Fixed Plant	(286)	(3,203)	(293)	(326)	(680)	(759)	-	-	(13,882)	(14,147)	(15,141)	(18,435)
	Total Expenses	(52,094)	(48,900)	(41,083)	(43,330)	(37,250)	(36,248)	-	-	(39,604)	(39,789)	(170,031)	(168,267)
	Surplus/(Deficit)	**(43,298)**	**(43,323)**	**(36,614)**	**(40,006)**	**(32,419)**	**(34,290)**	**144,284**	**152,328**	**(30,116)**	**(34,200)**	**1,837**	**509**

4. Income generation activities

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.

Summary Table - aggregate of all schemes	**2013-14 £000s**	2012-13 £000s
Income	**2,165**	0
Full cost	**(2,230)**	0
Surplus/(deficit)	**(65)**	0

The income & expenditure above relates to the activities of NHS Creative a new trading entity for the Trust in 2013-14. This is an element of the Trust run with a view to making a profit to contribute to patient care. In year, income of £145k has been deferred as it relates to the financial year 2014-15.

5. Revenue from patient care activities

	2013-14 £000s	2012-13 £000s
NHS Trusts	**202**	146
NHS England	**14,921**	0
Clinical Commissioning Groups	**138,062**	0
Primary Care Trusts		152,550
Strategic Health Authorities		638
NHS Foundation Trusts	**568**	516
Department of Health	**0**	6
NHS Other (including Public Health England and Prop Co)	**0**	42
Non-NHS:		
Local Authorities	**3,620**	2,431
Private patients	**1,443**	1,275
Overseas patients (non-reciprocal)	**139**	3
Injury costs recovery	**355**	534
Other	**73**	1,588
Total Revenue from patient care activities	**159,383**	159,729

6. Other operating revenue

	2013-14 £000s	2012-13 £000s
Recoveries in respect of employee benefits	**2,342**	2,318
Patient transport services	**99**	0
Education, training and research	**4,842**	3,734
Receipt of donations for capital acquisitions	**347**	78
Income generation	**2,165**	1,479
Rental revenue from operating leases	**128**	161
Other revenue	**2,561**	1,258
Total Other Operating Revenue	**12,484**	9,028
Total operating revenue	**171,867**	168,757

Income generation consists of NHS Creative which is the only scheme over £1m as detailed in Note 4 above.

The Trust has applied NHS guidance in relation to the disclosure of individual activities where costs are in excess of £1m. To ensure appropriate comparison the income generation value of 2012-13 should be added to other revenue. The value of income generation in 2013-14 solely relates to the NHS Creative trade.

The material items included within other revenue are car parking £569k; catering £400k; ferry tickets £250k & R&D Culyer levy £345k;

7. Revenue

Revenue is almost totally from the supply of services. Note 4 shows the income position relating to the Trusts largest trading activity.

8. Operating expenses

	2013-14 £000s	2012-13 £000s
Services from other NHS Trusts	**1,683**	1,543
Services from CCGs/NHS England	**9**	
Services from other NHS bodies	**0**	98
Services from NHS Foundation Trusts	**609**	735
Services from Primary Care Trusts		57
Total Services from NHS bodies	**2,301**	2,433
Purchase of healthcare from non-NHS bodies	**28**	0
Trust Chair and Non-executive Directors	**67**	60
Supplies and services - clinical	**22,606**	18,940
Supplies and services - general	**1,736**	1,674
Consultancy services	**269**	571
Establishment	**4,432**	3,457
Transport	**865**	841
Premises *	**7,312**	18,435
Hospitality	**49**	
Insurance	**42**	
Legal Fees	**174**	
Impairments and Reversals of Receivables	**442**	(22)
Inventories write down	**35**	112
Depreciation *	**6,100**	0
Amortisation *	**1,460**	0
Audit fees	**126**	124
Other auditor's remuneration	**0**	30
Clinical negligence	**2,592**	2,190
Research and development (excluding staff costs)	**6**	20
Education and Training	**1,104**	879
Change in Discount Rate	**0**	0
Other	**1,436**	937
Total Operating expenses (excluding employee benefits)	**53,182**	50,681
Employee Benefits		
Employee benefits excluding Board members	**115,968**	116,551
Board members	**879**	1,011
Total Employee Benefits	**116,847**	117,562
Total Operating Expenses	**170,029**	168,243

* Under the NHS Transforming Community Services agenda in 2013-14 organisations, including the Isle of Wight NHS Trust, received asset transfers from Primary Care Trusts. The reduction in premises expenditure is a result of the transfer of assets from the Isle of Wight Primary Care Trust on the 1 April 2013. The Trust therefore did not make any rental payments in 2013-14 as it did in 2012-13. However, by taking on the fixed assets transferred on 1st April 2013, depreciation charges and amortisation charges apply.

9 Operating Leases

The Trust leases medical equipment, property and vehicles under operating lease arrangements. There are no individually material leases. The lease terms range from 1 to 15 years.

In 2012-13 the Isle of Wight PCT acted as lessor for the land and buildings at St. Mary's Hospital, Newport and other properties and locations where services are delivered. Lease assets were transferred to the Trust on 1 April 2013 making the Trust the beneficial owner (rather than the lessee) resulting in the material difference between payments in 2012-13 and 2013-14.

9.1 Isle of Wight NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2013-14 Total £000s	2012-13 £000s
Payments recognised as an expense in year:					
Minimum lease payments		444	292	**736**	10,609
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total	0	444	292	**736**	10,609
Total Future Minimum Lease Payments:					
No later than one year	0	260	33	**293**	356
Between one and five years	0	815	0	**815**	749
After five years	0	657	0	**657**	820
Total	**0**	**1,732**	**33**	**1,765**	1,925
Total future sublease payments expected to be received:				0	0

9.2 Isle of Wight NHS Trust as lessor

The income relates to the rental of premises to various organisations.

	2013-14 £000	2012-13 £000s
Recognised as revenue		
Rental revenue	128	161
Contingent rents	0	0
Total	**128**	161
Receivable:		
No later than one year	101	143
Between one and five years	40	40
After five years	0	0
Total	**141**	183

10 Employee benefits and staff numbers

10.1 Employee benefits

	2013-14 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**98,063**	91,620	6,443
Social security costs	**7,235**	7,039	196
Employer Contributions to NHS BSA - Pensions Division	**11,217**	10,913	304
Other pension costs	**3**	3	0
Termination benefits	**378**	378	0
Total employee benefits	**116,896**	**109,953**	**6,943**
Employee costs capitalised	**49**	49	0
Gross Employee Benefits excluding capitalised costs	**116,847**	**109,904**	**6,943**

Employee Benefits - Gross Expenditure	2012-13 Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	98,621	92,012	6,609
Social security costs	7,460	7,254	206
Employer Contributions to NHS BSA - Pensions Division	10,854	10,554	300
Other pension costs	0	0	0
Termination benefits	627	627	0
Total employee benefits	117,562	110,447	7,115
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	117,562	110,447	7,115

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

10.2 Staff Numbers

	2013-14 Total Number	Permanently employed Number	Other Number	2012-13 Total Number
Average Staff Numbers				
Medical and dental	**219**	219	0	227
Ambulance staff	**104**	97	7	97
Administration and estates	**630**	591	39	610
Healthcare assistants and other support staff	**698**	617	81	669
Nursing, midwifery and health visiting staff	**818**	788	30	862
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**372**	357	15	355
Social Care Staff	**0**	0	0	0
Other	**1**	1	0	0
TOTAL	**2,842**	**2,670**	**172**	2,820
Of the above - staff engaged on capital projects	**1**	1	0	0

10.3 Staff Sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total Days Lost	23,451	30,023
Total Staff Years	2,643	2,685
Average working Days Lost	8.87	11.18

The Department of Health require these figures to be based on the calendar year. As the Trust was formed on 1 April 2012, for 2012/13 figures are based on the nine months April 2012 to December 2012. For 2013/14 the figures relate to the period January 2013 to December 2013.

	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	**3**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**165**	225

10.4 Exit Packages agreed in 2013-14

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	2012-13 *Number of compulsory redundancies	2012-13 *Number of other departures agreed	2012-13 Total number of exit packages by cost band
	Number	£s	Number	£s	Number	£s	Number	£s	Number	Number	Number
Less than £10,000	1	6,056							0	2	2
£10,000 - £25,000	-	-							0	5	5
£25,001 - £50,000	1	44,032							2	0	2
£50,001 - £100,000	1	82,688							2	5	7
£100,001 - £150,000	1	134,544							0	1	1
£150,001 - £200,000	1	168,194							0	0	0
>£200,000									0	0	0
Totals	5	435,514	0	0	0	0	0	0	4	13	17
Total resource costs (£000s)									170,973	607,693	778,666

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda For Change compulsory redundancy scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5 Exit packages - Other Departures analysis

	2013-14 Agreements Number	2013-14 Total value of agreements £000s	2012-13 Agreements Number	2012-13 Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	13	607,693
Mutually agreed resignations (MARS) contractual costs	0	0		
Early retirements in the efficiency of the service contractual costs	0	0		
Contractual payments in lieu of notice	0	0		
Exit payments following Employment Tribunals or court orders	0	0		
Non-contractual payments requiring HMT approval*	0	0		
Total	0	0	13	607,693

Single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2013-14 Number	2013-14 £000s	2012-13 Number	2012-13 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**30,898**	**44,253**	28,572	34,785
Total Non-NHS Trade Invoices Paid Within Target	**29,412**	**42,753**	26,580	32,382
Percentage of Non-NHS Trade Invoices Paid Within Target	**95.19%**	**96.61%**	93.03%	93.09%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,904**	**8,113**	2,058	**23,318**
Total NHS Trade Invoices Paid Within Target	**1,674**	**7,604**	1,901	**22,389**
Percentage of NHS Trade Invoices Paid Within Target	**87.92%**	**93.73%**	92.37%	96.02%

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 a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-14 £000s	2012-13 £000s
Amounts included in finance costs from claims made under this legislation	**0**	8
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	8

12 Investment Revenue

	2013-14 £000s	2012-13 £000s
Interest revenue		
Bank interest	**32**	19
Subtotal	**32**	19
Total investment revenue	**32**	19

13 Other Gains and Losses

	2013-14 £000s	2012-13 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(26)**	0
Gain (Loss) on disposal of assets held for sale	**36**	0
Gain/(loss) on foreign exchange	**(4)**	(1)
Total	**6**	(1)

14 Finance Costs

	2013-14 £000s	2012-13 £000s
Interest		
Interest on obligations under finance leases	**28**	0
Interest on late payment of commercial debt	**0**	8
Total interest expense	**28**	8
Other finance costs	**11**	15
Total	**39**	23

15.1 Property, plant and equipment

2013-14	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2013	**0**	**0**	**0**	**78**	**0**	**0**	**0**	**78**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**8,212**	**71,242**	**1,175**	**7,539**	**1,448**	**2,423**	**549**	**92,588**
Additions of Assets Under Construction			**4,476**					**4,476**
Additions Purchased	0	1,537		726	0	654	24	**2,941**
Additions Donated	0	0	0	97	0	0	0	**97**
Additions - Purchases from cash donations & Government Granted	0	0	0	250	0	0	0	**250**
Reclassifications	0	1,170	(1,170)	0	0	2	0	**2**
Disposals other than for sale	0	0	0	(28)	0	0	0	**(28)**
Upward revaluation/positive indexation	15	3,294	0	0	0	0	0	**3,309**
At 31 March 2014	**8,227**	**77,243**	**4,481**	**8,662**	**1,448**	**3,079**	**573**	**103,713**
Depreciation								
At 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged During the Year	0	2,622		1,977	358	1,075	68	**6,100**
At 31 March 2014	**0**	**2,622**	**0**	**1,977**	**358**	**1,075**	**68**	**6,100**
Net Book Value at 31 March 2014	**8,227**	**74,621**	**4,481**	**6,685**	**1,090**	**2,004**	**505**	**97,613**
Asset financing:								
Owned - Purchased	8,227	74,347	4,481	6,187	1,059	2,004	505	**96,810**
Owned - Donated	0	274	0	474	31	0	0	**779**
Held on finance lease	0	0	0	24	0	0	0	**24**
Total at 31 March 2014	**8,227**	**74,621**	**4,481**	**6,685**	**1,090**	**2,004**	**505**	**97,613**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	0	0	0	0	0	0	0	**0**
Movements	5,114	19,019	0	297	15	4	39	**24,488**
At 31 March 2014	**5,114**	**19,019**	**0**	**297**	**15**	**4**	**39**	**24,488**

The revaluation reserve was created on 1st April 2013 following the transfer of fixed assets from the Isle of Wight Primary Care Trust under Transforming Community Services.

Additions to Assets Under Construction in 2013/14

	£000's
Buildings excl Dwellings	4,042
Plant & Machinery	434
Balance as at YTD	**4,476**

15.2 Property, plant and equipment prior-year

2012-13	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:								
At 1 April 2012	0	0	0	0	0	0	0	0
Additions - donated	0	0	0	78	0	0	0	78
At 31 March 2013	**0**	**0**	**0**	**78**	**0**	**0**	**0**	**78**
Depreciation								
At 1 April 2012	0	0	0	0	0	0	0	0
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 31 March 2013	**0**	**0**	**0**	**78**	**0**	**0**	**0**	**78**
Donated								0
Total at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Asset financing:								
Owned	0	0	0	78	0	0	0	78
Total at 31 March 2013	**0**	**0**	**0**	**78**	**0**	**0**	**0**	**78**

15.3 (cont). 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 2014 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 held for sale. Current asset lives are as follows:

	Minimum life (years)	**Maximum life (years)**
Buildings, excluding dwellings	9	72
Plant and machinery	3	25
Transport equipment	5	10
Information technology	2	10
Furniture and fittings	1	10

Other than for building, revalued by the District Valuer at 31 March 2014, asset lives have not been re-assessed during the year.

No compensation from third parties has been received for assets impaired, lost or given up.

Donations towards property, plant and equipment in the year have been provided by the following organisations:
- Friends of St Mary's Hospital
- Hampshire & Isle of Wight Air Ambulance

16.1 Intangible non-current assets

2013-14	IT - in-house & 3rd party software £000's
At 1 April 2013	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**4,750**
Additions - purchased	862
Reclassifications	(2)
At 31 March 2014	**5,610**
Amortisation	
At 1 April 2013	**0**
Charged during the year	1,460
At 31 March 2014	**1,460**
Net Book Value at 31 March 2014	**4,150**
Asset Financing: Net book value at 31 March 2014 comprises:	
Purchased	4,150
Total at 31 March 2014	**4,150**

16.2 Intangible non-current assets prior year

The Trust had no non-current intangible assets.

16.3 Intangible non-current assets

Intangible assets comprise purchased computer software which is carried at amortised historical cost, as a proxy for fair value, together with development expenditure which is carried at a nominal value.

Assets are capitalised and amortised over the useful lives on a straight-line basis. Useful lives are all finite and range from 1 to 10 years.

17 Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2014 £000s	31 March 2013 £000s
Property, plant and equipment	**4,185**	0
Intangible assets	**0**	0
Total	**4,185**	0

These include commitments under Procure 21 arrangements relating to Ryde Community Clinic, Dementia Friendly Environment and the relocation of the Intensive Care Unit.

17.2 Other financial commitments

The trust has not entered into any non-cancellable contracts.

18 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	2,467	0	4,708	0
Balances with Local Authorities	1,374	0	43	0
Balances with NHS bodies outside the Departmental Group	20	0	2	0
Balances with NHS Trusts and Foundation Trusts	1,246	0	673	0
Balances with Public Corporations and Trading Funds	0	0	1	0
Balances with bodies external to government	1,823	277	14,968	0
At 31 March 2014	**6,930**	**277**	**20,395**	**0**
prior period:				
Balances with other Central Government Bodies	5,629	0	655	0
Balances with Local Authorities	117	0	67	0
Balances with NHS bodies outside the Departmental Group	1	0	4	0
Balances with NHS Trusts and Foundation Trusts	321	0	401	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,147	0	10,455	0
At 31 March 2013	**9,215**	**0**	**11,582**	**0**

19 Inventories

	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2013	**793**	**1,183**	**0**	**45**	**2,021**	0
Additions	10,605	2,976	0	0	**13,581**	0
Inventories recognised as an expense in the period	(10,477)	(2,884)	0	(6)	**(13,367)**	0
Write-down of inventories (including losses)	(35)	0	0	0	**(35)**	0
Balance at 31 March 2014	**886**	**1,275**	**0**	**39**	**2,200**	**0**

20.1 Trade and other receivables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
NHS receivables - revenue	**1,970**	5,574	**0**	0
NHS prepayments and accrued income	**1,604**	0	**0**	0
Non-NHS receivables - revenue	**2,525**	2,525	**0**	0
Non-NHS prepayments and accrued income	**1,154**	0	**277**	0
Provision for the impairment of receivables	**(673)**	(340)	**0**	0
VAT	**157**	265	**0**	0
Other receivables	**193**	1,191	**0**	0
Total	**6,930**	9,215	**277**	0
Total current and non current	**7,207**	9,215		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Groups . As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Outstanding invoiced receivables are reviewed monthly and any invoices that are greater than 60 days past their due date are assessed for impairment. The Trust does not hold collateral for any of its non-NHS receivables.

20.2 Receivables past their due date but not impaired

	31 March 2014 £000s	31 March 2013 £000s
By up to three months	**1,000**	99
By three to six months	**195**	0
By more than six months	**93**	0
Total	**1,288**	99

20.3 Provision for impairment of receivables

	2013-14 £000s	2012-13 £000s
Balance at 1 April 2013	**(340)**	(362)
Amount written off during the year	**109**	0
(Increase)/decrease in receivables impaired	**(442)**	22
Balance at 31 March 2014	**(673)**	**(340)**

Injury cost recovery has been impaired at 15.8% as per Department of Health guidelines.
Non-NHS receivables greater than 60 days have been impaired in full. NHS debts greater than 60 days have been impaired for Foundation Trusts, legacy Primary Care Trusts and Department of Health balances.

21 Cash and Cash Equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	**1,601**	0
Net change in year	**11,757**	1,601
Closing balance	**13,358**	1,601
Made up of		
Cash with Government Banking Service	**5,344**	1,587
Cash in hand	**14**	14
Current investments	**8,000**	0
Cash and cash equivalents as in statement of financial position	**13,358**	1,601
Bank overdraft - Government Banking Service	**0**	0
Cash and cash equivalents as in statement of cash flows	**13,358**	1,601
Patients' money held by the Trust, not included above	**0**	0

22 Trade and other payables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
NHS payables - revenue	**609**	896	**0**	0
NHS accruals and deferred income	**995**	0	**0**	0
Non-NHS payables - revenue	**1,780**	1,472	**0**	0
Non-NHS payables - capital	**5,045**	0	**0**	0
Non-NHS accruals and deferred income	**8,085**	7,871	**0**	0
Social security costs	**1,094**	63		
Tax	**1,156**	56		
Payments received on account	**0**	654	**0**	0
Other	**1,631**	570	**0**	0
Total	**20,395**	11,582	**0**	0
Total payables (current and non-current)	**20,395**	**11,582**		
Included above:				
Outstanding Pension Contributions at the year end	**1,530**	0		

23 Borrowings

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Finance lease liabilities	**48**	0	**0**	0
Total	**48**	**0**	**0**	**0**
Total other liabilities (current and non-current)	**48**	**0**		

Loans - repayment of principal falling due in:

	31 March 2014 DH £000s	Other £000s	Total £000s
0 - 1 Years	0	48	**48**
1 - 2 Years	0	0	**0**
2 - 5 Years	0	0	**0**
Over 5 Years	0	0	**0**
TOTAL	**0**	**48**	**48**

24 Deferred revenue

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
Opening balance at 1 April 2013	**937**	0	**0**	0
Deferred revenue addition	**1,296**	937	**0**	0
Current deferred Income at 31 March 2014	**2,233**	937	**0**	0
Total deferred income (current and non-current)	**2,233**	937		

25 Finance lease obligations as lessee

Finance lease obligations relate to equipment in Diagnostic Imaging. This lease ends during 2014-15. The Trust does not have building or land finance leases. Minimum lease payments and their present values are shown in the tables below:

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
Within one year	**54**	0	**48**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	(6)	0		
Minimum Lease Payments / Present value of minimum lease payments	**48**	0	**48**	0
Included in:				
Current borrowings			**48**	0
Non-current borrowings			**0**	0
			48	0

26 Provisions

	Total	Early Departure Costs	Legal Claims	Restructuring	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**824**	0	40	232	135	417
Arising During the Year	**751**	0	43	0	455	253
Utilised During the Year	**(411)**	0	(6)	0	(75)	(330)
Reversed Unused	**(453)**	0	(20)	(232)	(114)	(87)
Balance at 31 March 2014	**711**	**0**	**57**	**0**	**401**	**253**
Expected Timing of Cash Flows:						
No Later than One Year	**711**	0	57	0	401	253
Later than One Year and not later than Five Years	**0**	0	0	0	0	0
Later than Five Years	**0**	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2014	961
As at 31 March 2013	47

Other provisions include figures for Industrial Tribunal cases (£239k), Carbon Reduction Commitment (£86k) and provision for various property dilapidations (£130k).

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.

27 Financial Instruments

27.1 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 NHS Trust has with Commissioners and the way those Commissioners are financed, the NHS 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 NHS 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 NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within theTrust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal 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 is able to borrow from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority & Department of Health. 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.

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 2014 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 & NHS England Commissioners, 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.

27.2 Financial Assets

	Loans and receivables	Total
	£000s	£000s
Receivables - NHS	3,774	**3,774**
Receivables - non-NHS	2,045	**2,045**
Cash at bank and in hand	13,358	**13,358**
Total at 31 March 2014	**19,177**	**19,177**
Receivables - NHS	5,574	5,574
Receivables - non-NHS	3,376	3,376
Cash at bank and in hand	1,601	1,601
Total at 31 March 2013	10,551	10,551

27.3 Financial Liabilities

	Other	Total
	£000s	£000s
NHS payables	926	**926**
Non-NHS payables	13,456	**13,456**
Total at 31 March 2014	**14,382**	**14,382**
NHS payables	896	896
Non-NHS payables	9,913	9,913
Total at 31 March 2013	10,809	10,809

28 Events after the end of the reporting period
There are no known post balance sheet events requiring disclosure.

29 Related party transactions

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

The Department of Health 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. For example :

	Expenditure £'000's	Revenue £'000's
Isle of Wight CCG	0	136,039
NHS England - Wessex Area Team	0	13,241
NHS England - Thames Valley	0	1,235
University Hospital Southampton NHS Foundation Trust	424	839
Portsmouth NHS Trust	4,128	189
NHS Litigation Authority	2,588	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 the Isle of Wight Council in respect of a pooled budget arrangement (see note 2).

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.

30 Losses and special payments

The total number of losses and special payment cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	51,930	65
Special payments	19,724	41
Total losses and special payments	71,654	106

The total number of losses and special payment cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	38,806	18
Special payments	7,459	31
Total losses and special payments	46,265	49

31. Financial performance targets

31.1 Breakeven performance

	2012-13 £000s	2013-14 £000s
Turnover	168,757	**171,867**
Retained surplus/(deficit) for the year	509	**1,837**
Adjustment for:		
Adjustments for Impairments	112	
Adjustments for impact of policy change re donated/government grants assets	(78)	**(224)**
Break-even in-year position	**543**	**1,613**
Break-even cumulative position	**543**	**2,156**

	2012-13 %	2013-14 %
Materiality test (i.e. is it equal to or less than 0.5%):		
Break-even in-year position as a percentage of turnover	0.32	0.94
Break-even cumulative position as a percentage of turnover	0.32	1.25

31.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets. During 2013-14, Trusts subject to the NHS Transforming Community Services agenda were not required to pay Public Dividend Capital.

31.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2013-14 £000s	2012-13 £000s
External financing limit (EFL)	**(3,456)**	(486)
Cash flow financing	**(5,127)**	(1,601)
Unwinding of Discount Adjustment	**0**	0
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**(5,127)**	(1,601)
Under/(Over) Spend against EFL	**1,671**	1,115

31.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2013-14 £000s	2012-13 £000s
Gross capital expenditure	**8,626**	78
Less: donations towards the acquisition of non-current assets	**(347)**	(78)
Charge against the capital resource limit	**8,279**	0
Capital resource limit	**8,283**	0
(Over)/underspend against the capital resource limit	**4**	0

Karen Baker
Chief Executive Officer
Accountable Officer
Isle of Wight NHS Trust

5th June 2014

Independent auditor's report

The role of the auditor

External auditors are appointed by the Audit Commission and 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 Isle of Wight NHS Trust

We have audited the financial statements of Isle of Wight NHS Trust for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 31. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is described as subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of Isle of Wight NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. 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.

Respective responsibilities of Directors and auditors

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. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Trust; and
- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

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 2014 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998

We have nothing to report in these respects

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditors

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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.

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

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2013, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those 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 2014.

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.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2013, we are 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 ending 31 March 2014.

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 Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul King
for and on behalf of Ernst & Young LLP
Reading
6 June 2014

I will never forget you and the wonderful way you looked after me.

Doctors and nurses in ICU are the most caring professionals we have come across. Friendly all the time, always happy to explain things...

We are impressed by your kindness, your dedication and professionalism. You do a fantastic job.

Get in touch

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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?

Becoming a Quality Champion (if you're one of our Staff Members) and taking an active role in one of the many initiatives designed to improve the patient and staff experience.

Standing as a Public, Staff or Volunteer Governor when the elections are held for the Council of Governors.

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

Tell us what you think

Isle of Wight NHS Trust welcomes feedback and questions from staff, stakeholders and the wider public on this document and any other issue relating to our services.

Corporate Communications, Engagement and Membership Team, Isle of Wight NHS Trust, Trust HQ, South Block, St Mary's Hospital, Newport, Isle of Wight, PO30 5TG

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