Isle of Wight NHS
NHS Trust

Quality Account
2013/14

Hospital Ambulance Community Mental Health

Contents

PART 1

Chairman's and Chief Executive's Statement on Quality

Danny Fisher,
Chairman

Karen Baker,
Chief Executive

"Patients and our staff are at the heart of what we do – providing world class services for the patients we serve."

We aim to provide care that offers excellent clinical outcome for our patients, and to do so with compassion that is evident to those patients and their carers. The central goal of delivering compassionate care is firmly enshrined in the organisation's vision: quality care for everyone, every time. We are fully committed to delivering quality care for everyone, every time through caring; team work; innovating and improving.

Along with our partners we have made real progress during the course of 2013/14 in improving further the quality of the care that we provide across our integrated organisation. However the publication of the Report of the Public inquiry into events at Mid Staffordshire NHS Foundation Trust by Robert Francis QC in February 2013, along with several additional reviews into the care and safety of NHS Hospitals serves as a reminder of the importance of maintaining a true focus on quality and compassion.

It gives me great pleasure to introduce the Isle of Wight NHS Trust's 2013/14 Quality Account, designed to assure our patients; local population, stakeholders and commissioners, that we provide the highest level of safe, care with patient experience and clinical effectiveness at the heart, and that we continuously seek to improve what we do.

This Quality Account has been developed with internal and external stakeholders and partner organisations, including the Trusts Patients Council, Healthwatch; Patient Representation Groups, Clinicians, Senior Managers, Commissioners from the Isle of Wight Clinical Commissioning Group (CCG) and the Local Authority's Overview and Scrutiny Committee (OSC) – **see full list in Appendix 1**. This Quality Account has been approved by the Isle of Wight NHS Trust Board.

This report focuses on the year 2013/14, tracking our progress over the past year against a number of quality improvements and outlining our priorities for the year ahead. It is an open and honest account of the quality of services for which the Trust Board is accountable. Although there has clearly been significant improvement, the Board remain dissatisfied with the current levels of patients developing community and hospital acquired pressure ulcers (bed sores), and are therefore pleased to see continued commitment in the 2014/15 Trust Quality Goals.

The Trust Board is committed to the delivery of effective, safe and personal healthcare to every patient, every time. This is underpinned by the Trust strategic goals, which are applied by all staff working at the Trust.

During 2013/14 we launched our Quality Strategy, which describes a five-year vision for the organisation and aims to deliver continuous quality improvement focusing on the three key areas; patient safety, patient experience and clinical effectiveness. It places an emphasis on a smaller number of quality goals which will be agreed each year by patients, staff and stakeholders. We will continue to review our progress annually to ensure we are meeting all relevant national and locally agreed quality standards and to ensure that our declared objectives remain relevant, stretching and effective in helping us achieve our vision. We are extremely keen for the experience of our patients and staff to drive changes across the organisation. In 2013/14 our Organisational Quality Goals consisted of the following priorities:

1. **Reduce our Hospital mortality rates.**
2. **Reduce the number of Hospital Acquired Pressure Ulcers (HAPU).**
3. **Reduce the number of complaints related to communication.**
4. **Improve patients access to the Amber Care Bundle (ACB) – end of life care.**

Our Successes

We have had notable successes during 2013/14 year which include the following;

- An overall reduction in Hospital Mortality Rates.
- A reduction in overall hospital acquired pressure ulcers.
- A significant reduction in overall complaints and a noticeable reduction in complaints related to communication.
- Improved use of the Amber Care Bundle (ACB) – End of Life Care.
- The Emergency Care Standard (ECS) – patients being seen, treated and discharged within 4 hours was maintained and exceeded 2012/13 achievement.
- The referral to Treatment Standard (RTT) for both admitted and non-admitted patients has been consistently met at organisational and this is also reflected at specialty level.
- All cancer standards have been achieved.
- The number of patients developing *Clostridium difficile* infections is significantly reduced with our internal stretch target achieved.
- Services across the Trust have, for the first time, worked to identify and share specific quality improvement priorities at a local level.
- We introduced an award programme to recognise staff members and volunteers who go above and beyond the call of duty in serving our patients. These include 3 categories in which nominations can be made by patients, staff or peers:

  Employee role model –
  - Attitude and behaviours.
  - Going the extra mile.
- Recruitment of 100 Quality Champions.
- Quality Care and Innovation – improving quality for our patients.
- Partnership Working – recognising the achievements of working with our partners in delivering high quality patient care to our island community.

Academic partnerships

Academic Health Science Networks (AHSNs) are a core element of 'Innovation Health and Wealth' (2011), the NHS contribution to the Government's 'Plan for Growth'. AHSNs are intended to improve the identification, adoption and spread of innovation and best practice across the NHS. The core purpose of the networks is to enable the NHS and academia to work collaboratively with industry to spread innovation, enhance patient care and generate wealth.

Wessex AHSN's vision is to bring discovery and innovation into the Wessex health system so that the population has better health and benefits from a thriving health innovation sector. This will be driven through a focus on tackling key local health issues over individuals' whole life course and across entire patient pathways.

The Isle of Wight is a formal member of the Wessex AHSN (WAHSN). Out links with the WAHSN will support the translation of research into innovative practice.

Noteworthy local services where we've seen excellent examples of Research and innovation include:

- David Hide Asthma and Allergy Research Centre. With an active research programme focusing on various aspects of childhood asthma and other allergic diseases as well as the prevention of allergy, The David Hide Centre has become internationally renowned for the excellence of its research. Findings published over the last two decades have been of fundamental importance in promoting the understanding of childhood asthma.

- The Memory Service who provide assessment and facilitate a multi-disciplinary team to meet the needs of people with dementia and their carers. Staff work across a range of settings and in partnership with carers, other staff and teams. The Memory Service offers dementia assessment and screening, as well as specialist psychological and behavioural assessment and therapy.

Key Priorities

In the coming year we aim to continue to deliver quality improvements across a range of our services. These will all be underpinned by our "vision, values and behaviours." Patients come first in everything we do and we will fully involve our patients; staff and volunteers to support the decisions we need to make.

Our Vision & Values

Quality Care for everyone, every time is our guiding principle. Our vision is 'to be an excellent and trusted provider of integrated patient focused services that are globally admired'. We will pursue greater integration – internally and with primary and social care – with a focus on the patient. Our strategic objectives are to:

1. **Improve quality –** by not only ensuring the results of treatment and care (outcomes) are as good as the best achieved elsewhere; but by making sure our patients feel (and say) we are treating them with compassion and dignity.

2. **Deliver our integrated clinical strategy –** ensuring the various services we offer in hospital and in the community work closely together, so that care is provided as locally and smoothly as possible; and ensuring our services are always organised to be safe and secure.

3. **Improve our resilience (as an isolated provider) –** by working with others, such as GPs, other NHS providers, the Council, local charities and the private sector, we will build on strengths and overcome the potential weaknesses of being a small and geographically isolated provider.

4. **Improve productivity –** ensuring we run as efficiently as possible, so that taxpayers' money is spent as it should be – on improving patient care.

5. **Develop our workforce –** ensuring we develop our staff to have the skills to work flexibly across the Island, and to be ready for the challenges of working in tomorrow's NHS.

The work described in this report builds on a number of key strategies:

1. **Integrated Business Plan (IBP) 2013 – 2018/19.**

2. **Long Term Quality Plan (LTQP) 2013 – 2018/19.**

3. **Clinical Service Strategy – Beyond Boundaries.**

4. **Workforce Strategy.**

5. **Organisational Development Strategy (in development).**

Long term Quality Strategy – Goals

Our Quality Strategy is supported by a Long-Term Quality Plan (LTQP that explains our priorities and ambitions over the next 5 years, taking us to 2018/2019. Assurance on the quality agenda will be provided through our Quality and Clinical Performance Committee (QCPC) (the sub group of the Trust Board established in 2012).

To improve our focus on quality and safety in 2013/14, we have worked directly with our patients to learn more about their experiences. Executive members of the Trust Board continue to undertake Board to Ward Assurance Visits increasing their frequency to weekly in February 2013. Non Executive Directors participate in monthly assurance visits. This has provided an opportunity for Trust Board members to meet patients, their relatives, and the dedicated staff who care for them. These visits provide an ideal opportunity for the Board to gain assurance and test the performance information they receive. It also gives the board the opportunity to assess services against the feedback received from our patient stories.

Regulation

We have continued to work in close partnership with the Care Quality Commission (CQC), the official body that monitors whether the Trust meets essential quality and safety standards. Throughout the year we received several visits from the CQC; including an Essential Standards visit and a number of routine visits to our Mental Health (MH) Services. During the Essential Standards visit in September 2013, the Trust was found to fall short in 3 of the standards assessed. Following actions taken by the Trust, the CQC conducted a follow up inspection in February 2014 and judged that we were meeting all of the essential standards assessed. The CQC assessment carried out in June 2014 was significantly different to previous forms of assessment and considered all elements of the Trust including Acute, Ambulance, Community and Mental Health. The Isle of Wight Clinical Commissioning Group (CCG) also visited 11 areas of the Trust in response to the CQC comment that patients/visitors could not easily complain without recourse to staff due to the lack of available and visible information on how to do so. The Trust welcomes all forms of assessment as a means to confirm we are getting things right for patients and staff.

This year we have worked closely with Clinicians and staff to improve the quality of services delivered. Following a Care Quality Commission Mock Inspection day in March 2014; we have assessed ourselves against the CQC Key Lines of Enquiry (KLOE). These self assessment days will continue. We welcome our staff, visitors and members of the Patients Council to undertake assessments of our services; identifying areas for improvement and celebrating those areas who deliver the highest standards of care. The CCG were also involved in the mock CQC inspection of the Maternity Service. We welcomed the CQC inspection team in June 2014.

In addition to the above, the Trust has been contacted on a number of occasions by Healthwatch who undertook an "enter and view" visits in December 2013. The Enter and View Panel visited Colwell, Medical Assessment Unit (MAU) and St Helens wards to find, highlight and share examples of good practice alongside providing evidence to contribute to the ongoing programme of development at the Trust.

Moving the support functions of Portering, Cleanliness, Catering and Medical Equipment to the Executive Director of Nursing & Workforce portfolio has improved direct impact on patients and their experience. This ensures the services are led and delivered as near to the patient as possible. Gaining real time feedback from patients and staff continues to provide us with the opportunity to respond to concerns quickly. The Patient Led Assessment of the Care Environment (PLACE) audit was undertaken in March 2014 utilising three teams to review services across the Trust. Teams included representatives from Healthwatch; Patients Council. Results were variable, with some areas achieving good cleanliness scores, but others scored lower; Food was scored generally good by two groups and poor by one. The need for storage space was highlighted. The Trust Place Lead has instigated mini Place audits to run through the year to deliver actions from the Audit.

Our aspiration to deliver the Island an integrated Foundation Trust (FT) continues. We continue to deliver a strategic programme of integration in partnership with our colleagues in the Clinical Commissioning Group (CCG) and Local Authority (LA) Social Care. This has enabled patients to receive treatment and care in the most appropriate setting for their needs including, where possible, closer to home. The ambition to continue this work is realised by patients and providers, and with the expansion of the My Life a Full Life (MLFL) project, we hope to see this vision go from strength to strength.

Karen Baker
Chief Executive

Ensuring patients get the best quality care possible is the aim of a new, ground-breaking 'Quality Champions' initiative which was launched on in January 2014 when 75 of the Champions attended their induction day. The Quality Champions come from all areas across the organisation to help ensure our Trust's vision of 'quality care, everyone, every time' is delivered across all areas of work. The Champions are promoting and raising awareness of the Trust's quality goals, which include the continued development of a culture of care, teamwork, improvement and innovation. The Champions meet with Trust Executive members every month, as an opportunity to discuss their thoughts, share good news of their team's successes and raise any issues. The overall aim is to ensure a culture of quality across all areas of the Trust, with the expected values and behaviours becoming an important part of staff appraisals and the recruitment process.

We have made significant progress in many areas, and plan to continue with the same level of enthusiasm in 2014/15. Our staff remain fully committed to the provision of safe and effective care for all our patients and we look forward to making further improvements. Our plans and priorities are all explained further in this account and our progress will continue to be overseen and supported by the Trust.

Danny Fisher
Chairman

PART 2

2.1 Priorities for Improvement

2.1.1 Progress against Key Priorities for Action 2013/14

Progress made in 2013/14 quality goals that contribute to the delivery of the Trust's overarching priorities which can be found in Part Three – Review of quality performance on pages 23 onwards.

2.1.2 Key Priorities for Action 2014/15

The Trust Board in consultation with key stakeholders, including Healthwatch and staff groups has identified 3 overarching priorities for quality improvement during 2014/15. These priorities are derived from the Trust's performance over the past year against its quality and safety indicators; national and regional priorities and are outlined in the following sections. Progress to achieve the quality goals will be monitored by the Safety; Experience & Clinical Effectiveness Triumvirate (SEE) and reported to via the Trust's Quality Report and Trust Board Performance Report, with assurance provided to the Quality & Clinical Performance Committee (QCPC).

2.1.3 PRIORITY 1: Prevention of Pressure Ulcers

As part of the Trust's continuing commitment to Patient Safety, the Prevention of Pressure Ulcers (PU) continues to feature as part of the Quality Account for 2014/15. The initiatives in the coming year will build upon our previous years' work in competence, clinical standards and public awareness. The table below outlines the performance from 2013/14 which will be used as a baseline against which the Trust will measure performance for 2014/15.

2013/14 baseline – Hospital	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Grade 1	6	2	3	2	4	4	3	0	2	0	2	6
Grade 2	9	10	10	8	2	7	10	6	9	8	8	11
Grade 3	1	0	0	0	0	1	0	0	0	0	0	0
Grade 4	2	2	4	1	2	0	1	0	2	0	2	3
2013/14 baseline – Community												
Grade 1	1	4	4	4	2	3	5	2	3	2	1	1
Grade 2	7	7	7	9	10	9	8	16	5	8	8	14
Grade 3	2	1	3	0	1	1	1	0	1	0	2	1
Grade 4	3	3	4	1	1	3	1	1	2	0	0	4

2013/14 baseline	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total incidence of pressure ulcers	1.75%	1.28%	1.66%	1.00%	0.71%	1.18%	1.21%	0.57%	1.30%	0.76%	1.25%	2.14%

Patients who are incontinent often have skin breakdown due to the contact of moisture with the skin. This presence of moisture often contributes to the development of pressure ulcers and can sometimes be misclassified as pressure ulceration. Over the past year the Nutrition & Tissue Viability Service has supported wards and clinical teams with education and resources designed to make the identification of skin damage easier. This has seen an improvement in the correct classification of skin damage and the reasons for it developing. However it is also recognised that skin damage is an undesirable consequence of incontinence and is something that clinical areas should seek to avoid by good care planning and good personal care. As part of its commitment to reduce all types of avoidable skin damage, the Trust will work towards using our incident reporting software to report and measure the problem of moisture related skin damage, and then as we begin to understand the size of problem we can put in place measures to avoid these issues in the future.

Patients who are nutritionally compromised are significantly more at risk of developing pressure ulcers. The Trust recognises that the issues of skin breakdown and malnutrition are closely linked. As part of its audit cycle, the Nutrition & Tissue Viability Service will extend its auditing to cover nutritional assessment and care planning in order to provide assurance that hospital areas are addressing this important area of patient risk and further reduce the influence of malnutrition on the development of pressure ulcers.

Building on last year's success relating to the Essential Competencies for Registered Nurses (RN), the Nutrition & Tissue Viability service will also develop and implement Pressure Ulcer Prevention and Management competencies for Healthcare Assistants (HCA) and Allied Health Professionals (AHP). The Trust recognises that introducing processes that provide assurance that all of their frontline staff are capable of contributing to this goal is a high priority.

This priority also links with the National Safety Thermometer Commissioning for Quality and Innovation (CQUIN) scheme – pressure ulcer reduction and local communication CQUIN scheme – pressure ulcer public awareness campaign.

Key performance indicators for 2014–2015

Measure	Data source	Frequency	Data collected and reported by
Hospital setting			
Zero tolerance of grade 4 pressure ulcers.	Datix Incident Reporting Software	Monthly	Nutrition and Tissue Viability Service
50% reduction in grades 1, 2 and 3 pressure ulcers on 2013/14 baseline.	Datix Incident Reporting Software	Monthly	Nutrition and Tissue Viability Service
25% reduction in overall incidence of patients developing pressure ulcers in hospital.	Datix Incident Reporting Software for pressure ulcer figures; Hospital episode statistics from Performance Information and Decision Support	Monthly	Nutrition and Tissue Viability Service
Community setting			
50% reduction in grades 1 to 4 pressure ulcers on 2013/14 baseline.	Datix Incident Reporting Software	Monthly	Nutrition and Tissue Viability Service

2.1.4 PRIORITY 2: Improving Communication

Over the last twelve months, the Isle of Wight NHS Trust has been pro-actively working to reduce the number of complaints and concerns relating to poor communication or a lack of communication.

Whilst we have seen an improvement in the number of complaints and concerns received relating to poor or lack of communication during the year, the Trust remains committed to developing specific communication initiatives which will enhance the effective and efficient flow of information to support patients, carers, visitors and staff. The aim of these initiatives will be to use a variety of communications to help our patients understand their care and treatment and be able to easily navigate our services, including easier access to information, therefore ensuring a positive patient experience.

The NHS Constitution (2013) states that:

"We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes."

The Isle of Wight NHS Trust supports this value and has, therefore, taken a decision that improving communication must remain one of the organisation's key quality priorities for 2014/15 and will measure progress against the following key performance indicators:

Key performance indicators for 2014–2015

Measure	Data source	Frequency	Data collected and reported by
A Patient Advice and Liaison Service (PALS) will be placed in a centralised location, which is highly visible to patients, carers and visitors.	N/A	Once	Quality Manager
A Trust wide action plan developed to capture all actions from National Patient and Staff Surveys undertaken during 2014/15.	National Patient & Staff Survey results	As surveys reported	Quality Manager
A scoping exercise undertaken on all clinical areas at St. Mary's Hospital site, to identify areas requiring a 'Ward Board' to be installed by 1 June 2014.	Scoping report	1 June 2014	Quality Manager
All areas identified in the scoping exercise will have a corporate Ward Board in place by 31 December 2014.	Quality Team log	Monthly from July 2014	Quality Manager

This priority also links with the local communication Commissioning for Quality and Innovation (CQUIN) scheme.

2.1.5 PRIORITY 3: Reducing Cancelled or Re-arranged Outpatient Appointments

This year the Trust will focus on reducing the number of cancelled outpatient appointments. The issue of cancelled outpatient appointments is a key theme within complaints received over the last 12 months.

There are a number of schemes in place to try and prevent 'patient led' cancellations such as text message reminders. However the Trust needs to reduce the number of cancellations that are instigated by the hospital also. Cancellation of an outpatient appointment is not in line with the Trust's mission statement of 'Quality Care for everyone, every time'. It leads to a poor experience for our patients in the outpatient part of their care. It also promotes inefficiency within the system resulting in unnecessary re-work for booking teams who have to undertake a number of administrative steps to cancel patients and reinstate new appointments for them.

A key area to enable the achievement of a reduction in hospital led cancellations will be to ensure the Trust can collect and monitor the right information which will help us to understand the volume of cancellations that are taking place, where they are taking place (i.e. a particular specialty) and if there are any occurrences of multiple cancellations that are taking place for an individual patient. It will also be important to understand the root cause of why a cancellation is taking place. Currently the hospital only uses broad categories to capture the reason for cancellations. However for the Trust to truly improve the cancellation rates; it must seek to understand the underlying issues which contribute to a cancellation such as capacity issues, not enough notice of leave or poor planning.

Currently detailed cancellation data is not consistently collected or regularly monitored by the Trust. The first milestone during quarter 1 of 2014/15 will be to ensure that there is a systematic means of collecting baseline data via the Patient Administration System (PAS) of the volumes of hospital led cancellations taking place.

A priority alongside establishing a set of baseline data will be to establish a working group to help understand the reasons for why cancellations are taking place and to collectively put measures in place which will result in their reduction. The outputs of this group will be monitored via the Planned & Acute Directorate Quality Meeting.

Key performance indicators for 2014–2015

Measure	Data source	Frequency	Data collected and reported by
A 10% reduction in the % of hospital led outpatient cancellations.	PAS system	Monthly (from Q2)	Assistant General Manager / Access Lead
A reduction in the % of patients experiencing more than 3 x hospital led outpatient cancellations in one episode of care.	PAS system	Monthly (from Q2)	Assistant General Manager / Access Lead

2.2 Statements of Assurance from the Board

2.2.1 Review of Services

During 2013/14 the Isle of Wight NHS Trust provided and/or sub-contracted 75 NHS services.

The Isle of Wight NHS Trust has reviewed all the data available to them on the quality of care in 71 of these NHS Services.

The income generated by the NHS services reviewed in 2013/14 represents 83% per cent of the total income generated from the provision of NHS Services by the Isle of Wight NHS Trust for 2013/14.

The quality of services is reviewed using a RAG system to record CQC quality standards compliance by individual department / services and progress reported on the Healthassure system.

Ongoing progress reports showing the RAG ratings for all departments are produced for review at Directorate Board meetings. Directorate Boards are reporting the progress of their departments and services in their monthly quality and risk reports to the Quality and Clinical Performance Committee. Directorate quality managers are also undertaking spot checks to ensure that good quality standards relating to the inputting of the compliance evidence are being maintained.

2.2.2 Participation in Clinical Audits

During 2013/14, 37 national clinical audits and 3 national confidential enquiries covered NHS services that the Isle of Wight NHS Trust provides.

During that period the Isle of Wight NHS Trust participated in 92.5% national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Isle of Wight NHS Trust was eligible to participate in during 2013/14 are outlined in Appendix 2.

The national clinical audits and national confidential enquiries that the Isle of Wight NHS Trust participated in during 2013/14 are outlined in Appendix 2.

The national clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in, and for which data collection was completed during 2013/14 are listed in Appendix 2, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Future plans are in place to ensure that when national audit reports are published, they are reviewed by the most appropriate quality group, either at directorate or corporate level, to ensure lessons are learnt and actions taken in line with recommendations. This is part of the internal audit action plan.

The report of 1 national clinical audit was reviewed by the provider in 2013/14 and Isle of Wight NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has purchased better software to enable data to be taken from the defibrillators which will record the actions of staff.

The reports of 16 local clinical audits were reviewed by the provider in 2013/14 and Isle of Wight NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Improve the communication with women regarding induction of labour, including better utilisation of patient information literature.
- Develop new guidelines in relation to monitoring intrauterine growth.
- Improve the documentation in relation to observations taken during the prescription of combined oral contraception.
- Improve the training in relation to the newly implemented documentation in the Community Stroke Rehabilitation Team.
- Improve awareness of the Modified Early Warning System (MEWS) Policy to ensure patients at risk of deterioration are quickly identified and appropriately managed.

Annual Clinical Audit Prize

The Isle of Wight Healthcare Trust continues to be committed to raising the profile of clinical audit and the Medical Education team in conjunction with the Quality Team run the Annual Clinical Audit Prize. This annual event allows staff from across the trust to their promote audit activity and ensure that lessons are shared from the findings. The prize is open to medical and non-medical staff and has been well supported by members of both the Executive and Non Executive Teams who participate in the judging of the audit projects to determine the Annual Award Winner.

The Annual Clinical Audit Prize winner for 2013/14 was Dr Jilly Boden an FY2 (Foundation Year 2 Doctor) who undertook an audit into clinical staffs understanding of what a DNACPR (do not attempt cardiac pulmonary resuscitation) order means. The findings of the audit were that overall accuracy had improved, however, there remained room for improvement, and that there needed to be more face to face teaching to ensure that there was clear understanding regarding the process of DNACPR.

2.2.3 Research

Participation in Clinical Research

The Research and Development Committee continues to receive research proposals for approval from both primary and secondary care professionals. During 2013/14, 41 studies were granted research governance approval. A central annual allocation of £404,277 was made available by the Hampshire and Isle of Wight Comprehensive Local Research Network (CLRN) to provide NHS infrastructure support to studies within the National Institute for Health Research Clinical Research Network (NIHR CRN) portfolio, which covers clinician sessions, research nurses and associated staff, NHS service support (Pathology, Radiology and Pharmacy) and research management and governance.

The number of patients receiving NHS services provided or sub-contracted by the Isle of Wight NHS Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 789.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

There were 32 clinical staff participating in research approved by a research ethics committee at

the Trust during 2013/14. These staff participated in research covering the clinical specialties of Blood, Cancer, Cardiovascular, Diabetes, Mental Health, Stroke and Rehabilitation, Musculoskeletal, Renal & Urogenital, Ophthalmology, Paediatrics, Reproductive Health and Childbirth and Respiratory

The impact of research activities of the David Hide Asthma & Allergy Centre continues to be substantial, delivering high impact publications and facilitating the development of further funding applications. The Centre has continued recruiting families to its 3rd Generation Study of the original 1989/90 cohort and has plans to assess the IoW cohort at age 25 during the coming year. They have collaborated with Nottingham University Hospital on a study looking at silk clothing and eczema and also with the University of Manchester providing samples and data from our IOW cohort to a MRC-funded network of all UK-based birth cohorts designed to study asthma (STELAR consortium).

Our engagement with clinical research shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS but equally demonstrates our commitment to testing and offering the latest medical treatments and techniques.

2.2.4 Goals Agreed with Commissioners

A proportion of Isle of Wight NHS Trust's income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Isle of Wight NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through Commissioning for Quality and Innovation (CQUIN) payment framework.

A summary of CQUIN achievement, quality improvement, during 2013/14 can be reviewed in the table below:

Health, Wealth & Innovation		
Child in a Chair in a Day (community)	Review the provision of wheelchair services to ensure outcomes similar to those achieved by the best-performing providers of mobility services for children.	ACHIEVED
International and Commercial Activity (acute, ambulance, community, mental health services)	Demonstrate that clear plans are in place to exploit the value of commercial intellectual property – either standalone or in collaboration with Academic Health Science Network.	ACHIEVED
Carers for people with Dementia (acute, mental health services)	Demonstrate that plans have been put in place to ensure that for every person who is admitted to hospital where there is a diagnosis of dementia; their carer is sign-posted to relevant advice and receives relevant information to help and support them.	ACHIEVED

Acute		
Compassionate Care: To review the Mid Staffs Report (Francis: February 2013) in conjunction with Compassion in Practice (Nursing & Midwifery Council: December 2012) and identify key recommendations, that through robust implementation and monitoring, will promote and embed a culture of Compassionate Care throughout the healthcare services provided by Isle of Wight NHS Trust.	Francis Report and Compassion in Practice – Implementation of recommendations.	ACHIEVED
	Francis Report and Compassion in Practice – Measuring the outcome of implemented recommendations.	ACHIEVED

Acute		
Friends and Family Test: To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience.	Phased expansion – Maternity.	**ACHIEVED**
	Increased response rate.	**ACHIEVED**
	Staff survey – better result 2013/2014 to 2012/2013.	**ACHIEVED**
NHS Safety Thermometer:	To collect data on the following three elements of the NHS Safety Thermometer: pressure ulcers, falls and urinary tract infection in patients with a catheter. Provider submission to the Information Centre.	**ACHIEVED**
	Achievement of 95% or greater of the agreed improvement goal for the first 6-month period (April 2013 – September 2013) (shown through special cause 7) followed by maintenance of that goal for the second 6-month period (October 2013 – March 2014) will trigger full payment of the CQUIN.	**PARTIALLY ACHIEVED** Against a reduction target of 3.35%, up to February 2014 the provider has achieved 4.99%.
Dementia: Provider has achieved an average of 90% or greater in each of the elements of the indicator each month for any three consecutive months in the first year.	Find, Assess, Investigate and Refer.	**ACHIEVED**
	Clinical Leadership.	**ACHIEVED**
	Supporting carers.	**ACHIEVED**
VTE: To reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE).	VTE Risk Assessment.	**NOT ACHIEVED** Agreed 'achieved' in Q4 based on evidence of 100% assessments for March
	VTE Route Cause Analyses.	**ACHIEVED**
Right Place, First Time: To reduce the number of medical outlier patients and patients subjected to multiple moves, by admitting to the right place the first time.	Progress of the actions within plan; 20/09/13 and 31/12/13 and a final written report detailing an evaluation of the implemented action plan. To be submitted with this report, data to demonstrate reduction, or otherwise, in the numbers of medical outlier patients in the reporting period 13/14 compared to the baseline period in 12/13.	**ACHIEVED**
Children's Safeguarding: Early identification of additional needs of pregnant women and their families.	Evidence that: (E) at least 98% of pregnant women and their families have a completed family health assessment undertaken by a named midwife within the first 24 weeks of pregnancy. (F) at least 98% of pregnant women and their families, identified by the named midwife as requiring a targeted antenatal visit by the named health visitor, have been visited by the Health Visitor within 34 weeks to develop a care plan in line with the Healthy Child Programme.	**ACHIEVED**
Maternity – Term Babies: To pro-actively manage the care of term babies requiring interventions to reduce admissions to NICU, reduce length of stay on the maternity unit and reduce readmissions to NICU and the children's ward.	Submit final progress report against Trust action plan. Submit final progress report evidencing at least 30% reduction in admissions to NICU, reduction in length of over 3 day stays on maternity unit, reduction in readmissions to NICU and children's ward.	**ACHIEVED**
Paediatric Patient Experience: Use the Patient Reported Experience Measure (PREM) to evaluate paediatric patient experience within urgent and emergency care, and to evaluate paediatric patient experience in the inpatient setting.	Evidence that a response rate of 20% or over has been achieved (urgent and emergency care).	**NOT ACHIEVED**
	Evidence that a response rate of 20% or over has been achieved (In-patient care).	**ACHIEVED**

Acute		
Amber Care Bundle: Use AMBER for patients' in whom recovery is unknown but who are still receiving treatment, so that patients and/or their carers are given the opportunity to express their preferred place of care and care delivery.	Evidence to show that all adult in-patient wards identified as implementers of the AMBER Care Bundle, have met the green evaluation criterion 'The ward is able to demonstrate implementation of AMBER.	ACHIEVED
	Evidence of completed audit which demonstrates that patients have at least 60% of their AMBER Care Bundle completed. Audit report evidencing robustness and compliance with the Amber Care Bundle.	ACHIEVED
Rapid Access To Diagnostics: Work with the Ambulatory Emergency Care Service to develop, implement and utilise a referral pathway for defined ambulatory care sensitive conditions, which will provide immediate access to diagnostics and return results more quickly.	Summary paper to commissioners detailing, for example, development of pathway/s, implementation, effect on patient care and number of avoidable admissions, challenges and opportunities arising from this CQUIN.	ACHIEVED
OHPIT:	To support the OHPIT team to deliver a range of IV services in the community and establish patient pathways for these therapies, by working with GPs, hospital doctors and the Ambulatory Emergency Care service to develop care protocols, referral processes and clinical governance arrangements.	ACHIEVED
Digital First: To reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions.	Remote Follow-Up: Report detailing results of pilot, lessons learnt and recommendations for implementation in other, named areas, with plan for additional roll-out.	NOT ACHIEVED
	Sending secondary care clinic letters to GPs: Report detailing results of pilot, lessons learnt and recommendations for implementation in other, named areas, with plan for additional roll-out.	NOT ACHIEVED

Ambulance – Patient Transport Service (PTS)		
Patient Experience: To capture the experiences and satisfaction levels of patients who use Patient Transport Services PTS) in order to inform service delivery and staff development.	Report detailing survey methodology, survey findings and recommendations for improvements, if required.	ACHIEVED

Ambulance		
Public Campaign: To promote greater public awareness and understanding of the role of the ambulance service and its different components – 999; 111; PTS, to enable patients to understand how the ambulance service responds and what patients can reasonably expect.	Report detailing the number of eligible staff identified as requiring dementia and learning disabilities awareness training and the number and % of those staff that have completed both dementia and learning disabilities awareness training and a copy of the training materials for courses utilised by staff.	ACHIEVED
Patients with Cognitive Impairment, Dementia and LD: To improve the assessment of care and support provided by ambulance staff to patients with cognitive impairment through an increased awareness of the needs of people with dementia and or learning disabilities.	Report detailing the number of eligible staff identified as requiring dementia and learning disabilities awareness training and the number and % of those staff that have completed both dementia and learning disabilities awareness training and a copy of the training materials for courses utilised by staff.	ACHIEVED
	Report detailing how the scoping exercise was undertaken and by whom, the tools identified to support the additional needs of people with dementia and or learning disabilities and an analysis of the appropriateness and feasibility of ambulance clinicians using the tools in their practice.	ACHIEVED

Mental Health		
Accreditation:	To utilise the Royal College of Psychiatrists 3 year AIMs process, to gain first level accreditation, and ensure services are developed to maintain or improve the accreditation rating.	**ACHIEVED**
Emergency Hub (Mental Health):	Emergency Hub; Mental Health Integration. MHAS performance data (Dec 2013 – Feb 2014). Mental health awareness training completed for all of the NHS 111 call handlers and evaluation of the training.	**ACHIEVED**
	Mental Health –Tele-health schemes. Outcomes for each pilot to be agreed. Progress report to be submitted by 28th February 2014. Evaluation Report of Pilots including outcomes, costs and recommendations on completion of treatment pathways.	**ACHIEVED** The tele-health schemes will be reported against in September 2014.
Learning Disabilities Self-Assessment Framework: To scope, develop and implement a project to enable provider to deliver the mandated SAF national return, using an integrated electronic system to measure meaningful completion and improvements.	To support completion of the 2013/14 Learning Disability Self-Assessment Framework (LD SAF) and develop an implementation plan against the actions identified from the 2012/13 return.	**ACHIEVED**

Community		
Integrated Community Services (Allied Professionals): To scope existing and proposed services which support patients to maintain mobility and independence, to inform the development of an integrated model of service delivery.	Scoping services – Podiatry; orthotics; multi-professional triage team; 'splinting services' (adults and children); community pain management service (proposed service); wheelchair service; falls service.	**ACHIEVED**
My Life A Full Life: Implement and monitor the quality of revised community nursing care documentation for assessing, planning and monitoring care delivered to community patients.	Report detailing number of community nurse referrals, reasons for referrals and the services to which referrals are made.	**ACHIEVED**
Assistive technology: To implement a pilot project to increase the number of patients with COPD who are supported through the use of assistive Tele-health and reduce admissions of those patients by at least 12%.	Provision and evaluation of assistive Tele-health for a minimum of 79 patients with COPD (to include the 10 patients with COPD included in the 2012/13 pilot funded through the high impact innovation CQUIN only).	**ACHIEVED**
Psychology for long term conditions: Exploring the use of psychological interventions within GP practices to help achieve productive behavioural change for staff members and patients with LTC.	Submission of report "How could Psychology in LTC work best in Primary Care on the IoW?	**ACHIEVED**

Details of the agreed goals for 2014/15 are available from the Quality Team; Isle of Wight NHS Trust, St. Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG or via email – **quality@iow.nhs.uk**.

2.2.5 What Others Say about the Provider

Statements from the CQC

Isle of Wight NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is fully registered with no compliance conditions attached.

The Care Quality Commission has not taken enforcement action against Isle of Wight NHS Trust during 2013/14.

The Isle of Wight NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14.

1. **Sevenacres (Inpatient Wards) – 10 & 11 September 2013 Essential Standards Routine Inspection (unannounced)**

The CQC reviewed all three wards and inspected two of the wards that form Sevenacres. The inspection was carried out over two days with the inspection team speaking with 11 patients, 11 staff; including ward managers, the Modern Matron and the newly appointed Clinical Quality and Safety Lead. All the patients were happy with their care and treatment and stated they felt safe and respected by the staff whilst on the unit. All felt that there were enough staff, that staff were helpful and friendly, and that they were being cared for appropriately. The Inspectors did, however, find that patient's views and experiences were not always taken into account and a lack of clear involvement of patients' family members and other people who had an interest in the patient's welfare. Suitable arrangements were in place for reporting safeguarding concerns and staff had the necessary training to keep people safe. There were enough qualified, skilled and experienced staff to meet patient's needs. They found that the Isle of Wight NHS Trust did not have a robust system to regularly assess and monitor the quality of service that patients received.

Summary of findings

Respecting and involving people who use services	✘	Action needed
Care and welfare of people who use services	✘	Action needed
Safeguarding people who use services from abuse	✓	Met this standard
Staffing	✓	Met this standard
Support workers	✓	Met this standard
Assessing and monitoring the quality of service provision	✘	Action needed

Care Quality Commission

The Isle of Wight NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

Issues identified	Actions to be taken to meet requirement
Patients did not feel enabled to make decisions relating to their care and treatment. Family members' views were not actively taken into account or made to feel part of the assessment process.	A focus group will be facilitated by the Service User and Carer Link Co-ordinator and Lead Nurse, to include the Modern Matron, Clinical Quality and Safety Lead, Service Users and Carers, Volunteers and Ward Managers to develop independent patient and carer feedback meetings.
	Review feedback from patients regarding provision of activities to identify any revisions required in the programme. Link feedback from Getting it Right surveys relating to therapeutic environment activity programme. Share feedback with patients.
	A regular forum for patients and carers to engage with the provision of services is necessary.
	The Mental Health Act (MHA)/Mental Capacity Act (MCA) Lead for the Trust to attend Acute Leads to provide guidance on how patients' views can be balanced against the legal requirements within the Acts.
	Audit all nursing and Multi Disciplinary Team documentation.
Patients experienced care, treatment and support that met their needs. However, their care plans did not always reflect the level of support they required. This increased the risk that patients may not receive the care they needed.	Ensure patient care plans will be discussed and developed with the patient; and any reasons for the exclusion of patients' involvement will be clearly documented in the patient record together with a plan for engaging patient in their care planning.
The provider did not have an effective system in place to regularly assess and monitor the quality of service that people received in relation to auditing aspects of the service and gaining patients' views and experience.	The Modern Matron audit will provide essential assurance and the template will be updated to ensure the above standards are met. An audit pro-forma has been designed for use with the new Paris records and is being rolled out.
	Audit all nursing and Multi Disciplinary Team documentation.
	The review sheet for weekly ward reviews includes capacity to consent and patient views regarding their care plans and treatment; Ward staff will ensure this is fully completed. Patients will be offered individual time with staff or advocate before the review to ensure they are supported to make their views and comments, time will also be available following the review to discuss the outcomes. This will be clearly documented in patient record and be subject to internal documentation audit.
	Mental Health has a specially designed questionnaire with a mental health focus; this includes the friends and family test – this is in use and is fed back on a quarterly local basis.

The Isle of Wight NHS Trust has made the following progress by 31st March 2014 in taking such action:

- The focus group has been set up.
- Feedback process developed.
- Care plans amended to include pt comment/signature.
- Care Plan proforma has been amended to include patient opinion of plan.
- Audit tools compiled and/or updated and audits undertaken.
- Patient feedback received on a regular basis.
- Mental Health Act (MHA) / Mental Capacity Act (MCA) Lead for the Trust attended Acute Leads meeting.
- CQC on follow up visit identified that there was an effective system to assess and monitor quality in place.

2. Sevenacres (Inpatient Wards) – 11 February 2014 Follow up Inspection to make sure that the improvements required had been made (unannounced)

The previous inspection on 10 and 11 September 2013 found patients' privacy, dignity and independence were respected. However, patients' views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care. This inspection found improvements had been made and the Trust demonstrated its commitment to ensure it continued to improve and embed the practice ensuring it would be sustained. Inspectors spoke with three members of staff, seven patients and observed care over two of the inpatient wards, Osborne and Seagrove Wards. The patients' they spoke with were positive about their experience. The Inspection identified that the Trust had an effective system to regularly assess and monitor the quality of service that people received.

Summary of findings

Respecting and involving people who use services	✓	Met this standard
Care and welfare of people who use services	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

The CQC inspection of Sevenacres included no specific recommendations and therefore no action plan was required by the CQC. However, the CQC did note in their report that…

"The provider may find it useful to note that where patients' had declined to sign a care plan we found no evidence of further discussion documented in the daily progress notes or case review notes of how this was resolved or taken forward."

This action has been picked up by the Trust through weekly care plan audits and the monthly Modern Matron audit and continues to be monitored closely.

3. Woodlands; Osborne Ward; Afton Ward and Sevenacres (2) – participated in reviews relating to the Mental Health Act Standards in May 2013; June 2013; October 2013 September 2013 and December 2013 respectively.

The Isle of Wight NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- Alternative solution to be found for meal trolley.
- Training for medical staff to be facilitated.
- Change to the PARIS system (a single system solution embracing all aspects of care delivered within a community environment for both health and social care).
- Estates to assess feasibility of altering nursing station to ensure confidentiality is maintained.

- Staffing to be dedicated to the provision of therapeutic activity on the ward.
- All staff to be reminded about confidentiality when on the nursing station.
- Review of HCA staffing to ensure provision of activities.
- A Service User and Carer Forum has been established. The forum is establishing links with other service user and carer groups to provide them with a formal route for feedback on services via a variety of modes.
- A programme of education and awareness sessions will be provided for staff to support understanding of information sharing and confidentiality.
- Section 117 Policy to be reviewed and local paperwork revisited to ensure that it is still fit for purpose.

The Isle of Wight NHS Trust has made the following progress by 31st March 2014 in taking such action:

- Review of Healthcare Assistant staff and provision of activities undertaken.
- Medical staff have received the relevant training.
- Staff spoken to with regards to confidentiality whilst at the nurses station.
- Staffing dedicated to the provision of therapeutic activity on the ward.
- Patient records reflect patient opinion of care and treatment.
- Training information has been developed and will be rolled out in future training provision and via staff supervision processes.

A large inspection by a team from the CQC was undertaken between 2nd and 6th June 2014. The final report from the inspection is expected late summer 2014.

2.2.6 Data Quality

i) Statement on relevance of Data Quality and actions to improve data quality

High quality information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning, performance and business management that all help to demonstrate the quality of the services we provide. Therefore the Trust views Data Quality as an essential element of delivering high quality health care service.

Whilst some elements of our data quality are extremely high work to monitor and improve data quality is ongoing in order to drive continual improvement. To help support this goal the Trust has recently developed a Data Quality Framework to compliment the approved and implemented Data Quality Policy.

The Trust Data Quality Policy sets our clear roles and responsibilities with regard to data quality and is intended to support a culture and ethos of good data quality throughout the organisation. In doing so it helped the Trust achieved level 2 compliance in all data quality requirements within the Information Governance Toolkit.

The Data Quality Framework sets out the performance and reporting framework the Trust will adopt to assess compliance with the policy. The framework will enable the Trusts to identify priority requiring action and to enable assurance to be provided that the data collected within the Trust is of a sufficient quality for the purpose intended.

In addition the Isle of Wight NHS Trust will be taking the following actions to improve data quality: Continuation of the Counting and Coding Group – this group has been set up to address any areas where data capture could be improved, as well as providing assurance that activity data accurately reflects care provided. The benefits of complete and consistent data delivered via this project include:

- Enablement of patients and commissioners to compare services, based on quality.
- Enablement of effective benchmarking analysis.
- Provision of clear understanding of the needs of service users.
- Supporting the consistent application of the PbR (payment by results) tariff and a consistent basis for savings and investment plans.
- Supporting the delivery of better care through accurate, timely funding.

The Trust is subject to a series of Audits that cover elements of data quality (both internal and external undertaken to review various business processes – Payments by Results, Clinical Coding, Information Governance) and these report to Board via the Audit Committee and Information Governance Steering Group.

ii) NHS Number and General Medical Practice Code Validity

The Isle of Wight NHS Trust submitted records during 2013/2014 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

which included the patient's valid NHS number was:

98.2% for admitted patient care;

99.4% for outpatient care; and

98.3% for accident and emergency care.

which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;

100% for outpatient care; and

99.9% for accident and emergency care.

All of which are above the national average with the exemption of NHS Number for admitted patient care (1% lower than national average).

iii) Information Governance Toolkit Attainment Levels

The Isle of Wight NHS Trust's Information Governance Assessment Report score overall score for 2013/14 was 86% and was graded Green.

iv) Clinical Coding Error Rate

The Isle of Wight NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect [3.0%].
- Secondary Diagnoses Incorrect [23.7%].
- Primary Procedures Incorrect [10.6%].
- Secondary Procedures Incorrect [7.6%].

Benchmarking data for clinical coding payment by results audits is currently available only for the financial year 2011/2012. The next update for audit data nationally is due to be published July 2014 for the year 2012/2013; as such the information is very retrospective and, therefore, not included in the report.

In the meantime, although figures for the Isle of Wight NHS Trust have shown a decrease in performance for 2013/2014 compared to the previous year, improvements have already taken place to improve the overall percentages.

The main reason for the decrease in accuracy rates was due to a lack of information supplied for secondary diagnosis on discharge summaries. Increased information is now available, compared with that at the time of the audit, with Clinicians inputting more clinical details onto the Integrated Services Information System (ISIS).

There has also been a large increase in the percentage of coding undertaken from case notes (currently over 60%); with additional wards coding from case notes due to start in the near future. As this develops, the Clinical Coders will have more information readily available to them, and the accuracy rate should continue to improve and this should be reflected in the next audit.

PART 3

3.1 Review of Quality Performance

3.1.1 Reducing Mortality Rates

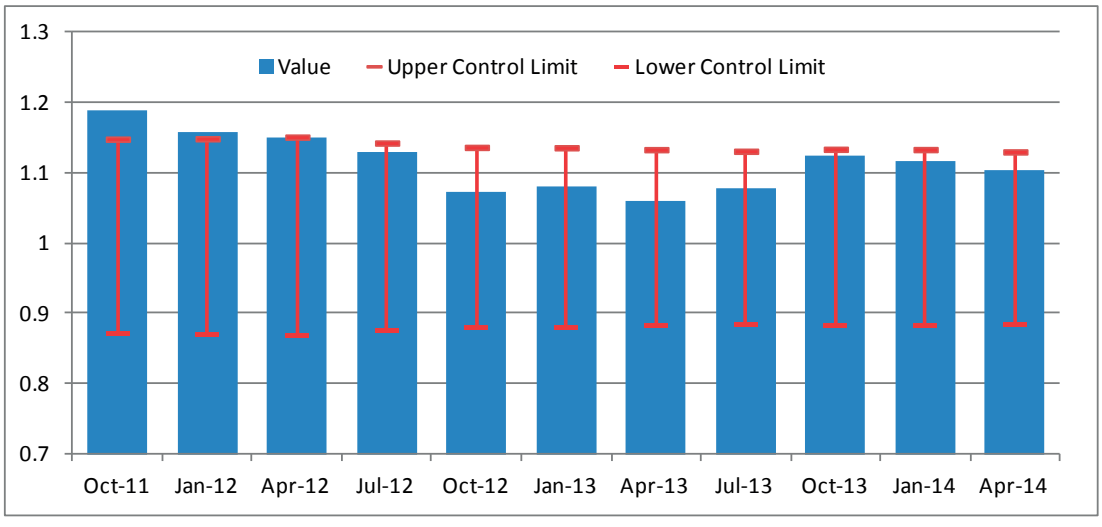
KPI 1: Standardised Hospital Mortality Index (SHMI)	ACHIEVED
KPI 3: Hospital Standardised Mortality Ratio (HSMR)	ACHIEVED

The Isle of Wight NHS Trust set out to reduce mortality rates during 2013/14; building on the good progress made during 2012/13. Performance is regularly reported via the Trust's monthly Quality Report. The indicators included the Standardised Hospital Mortality Index (SHMI) and the Hospital Standardised Mortality Ratio (HSMR).

Over the last 12 months the organisation has been able to achieve a reduction for both measures. The SHMI, although it has fluctuated, there has been an overall reduction over the reporting period, reducing from 1.12 (period April 2012 – March 2013) to 1.10 (period October 2012 – September 2013) (latest published data period), as outlined in the table below.

April 2012 to March 2013	July 2012 to June 2013	October 2012 to September 2013
1.12	1.11	1.10

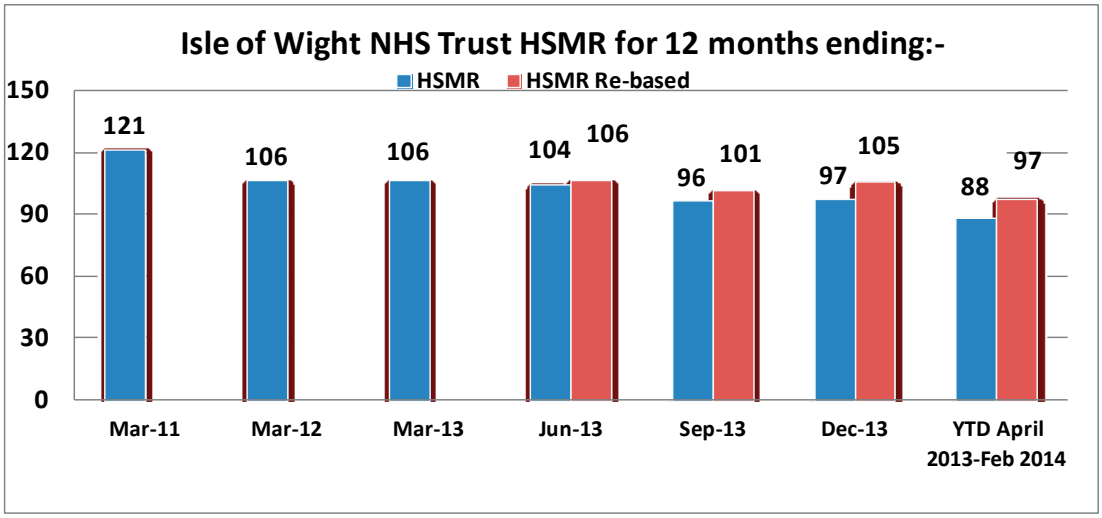
The chart below shows the Trust's performance is in line with expected limits for this indicator, although higher than average.



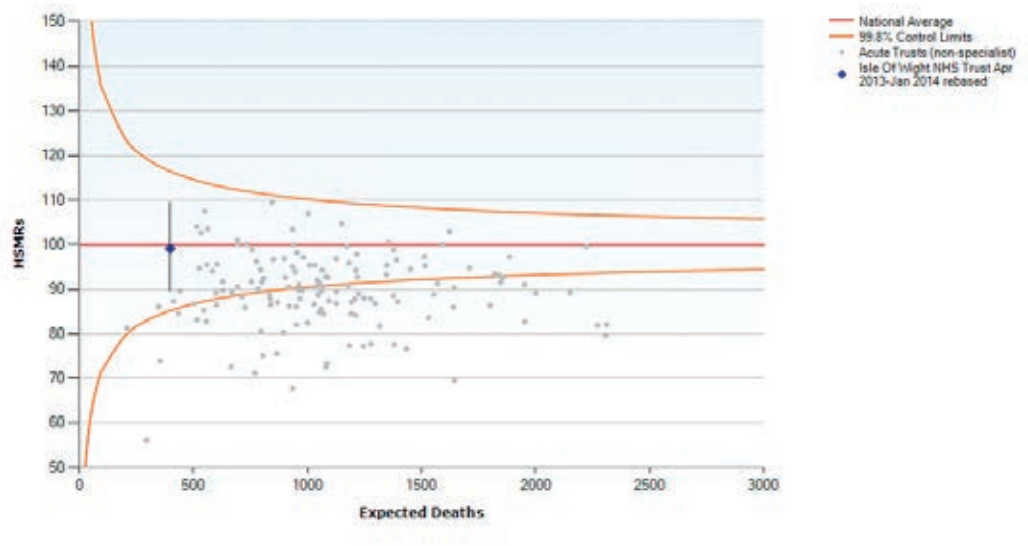
The higher than average SHMI is found in the emergency admission group and includes deaths in hospital and deaths post discharge. The difference in the SHMI and HSMR is largely explained by the way patients with palliative care codes are treated in the 2 measures. Actions taken like 24/7 Critical Care Outreach and The Prepip project were taken in the second half of 2013 and so their effect will not feature in the current data and we expect to see improvements from this in the coming year. In January 2014 the Trust commenced coding community deaths

from patient notes which should allow a more accurate expected death calculation in this group in the future. We have developed a Mortality and morbidity process, currently being rolled out across the Organisation. This describes the governance arrangements required to ensure all deaths are reviewed. In 2013/14 we have undertaken a review of a number of reviews where a theme was detected. These included a review of all patients in month that died from aspiration pneumonia. We have also undertaken a full review of patients who have been identified as having a skin related death.

In relation to the HSMR figures, that chart below demonstrates the reduction achieved over time.



Although there was a slight increase in the April to December period, the HSMR continues to reduce and is currently at 97 (re-based figure). This reduction positions the Trust just below the national average, as depicted by the graph below.



During 2013/14 the Trust continued to build on its Mortality Action plan to further drive through improvements in clinical care and in the quality of its clinical coding.

Actions taken to enable continued improvement of performance during 2013/14 include:

- Trust Quarterly Mortality Review Group has been set up including Annual Meeting. First meeting held to discuss new policy.
- New Mortality and Morbidity Policy being moved through ratification process.

- New Rapid Review Template developed to allow exploration of any Care Quality Commission mortality outlier alerts and the onward processing of the information.

- The Critical Care Outreach team has been embedded as a 7 day a week service.

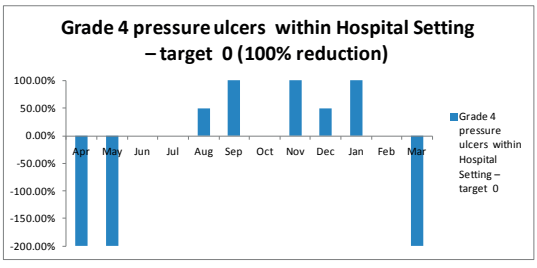
Reducing Mortality Rates has not been carried forward as a Quality Account goal for 2014/15, but will remain a key performance indicator for the Trust; with work continuing and performance monitored via the Trust Quality and Board Performance reports.

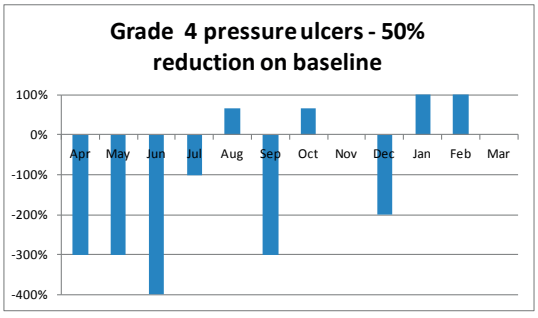
3.1.2 Prevention of Pressure Ulcers

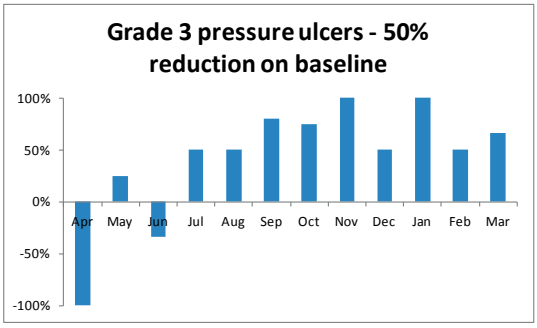
KPI 1: Zero Grade 4 Pressure Ulcers in the hospital setting	NOT ACHIEVED
KPI 2: 50% reduction in pressure ulcers of grade 3 in the hospital setting	ACHIEVED
KPI 3: 50% reduction in pressure ulcers of grade 2 in the hospital setting	NOT ACHIEVED
KPI 4: 50% reduction in pressure ulcers of grade 4 in the community setting	NOT ACHIEVED
KPI 5: 50% reduction in pressure ulcers of grade 3 in the community setting	NOT ACHIEVED
KPI 6: 50% reduction in pressure ulcers of grade 2 in the community setting	NOT ACHIEVED

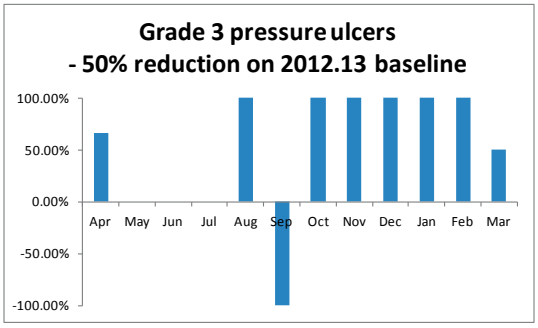
Pressure ulcers are areas of skin breakdown caused by the application of pressure to the skin and can cause distress and harm. In many cases the reasons why these pressure ulcers developed were avoidable; which is why they are considered to be an effective barometer of patient safety and why the Isle of Wight NHS Trust continues to be committed to reduce numbers of pressure ulcers and protect patients.

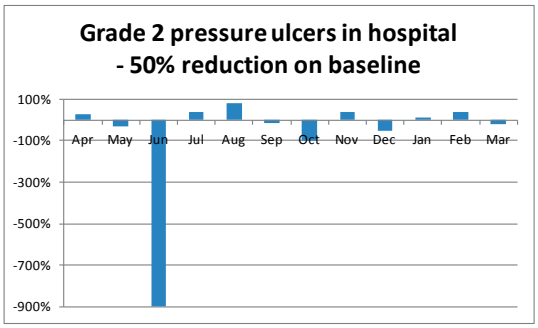
The Trust's ambitious targets for 2013/14 were zero grade 4 pressure ulcers in the hospital setting and a reduction by 50% (on 2012/13 baseline) of all grade 2s and 3s. The Trust also committed to a target of 50% reduction of grades 2 to 4 (on 2012/13) baseline in the community setting. The graphs below highlight how the Trust performed against each of these targets month by month. The red line shows the target, anything above shows an achievement against the target for that month.

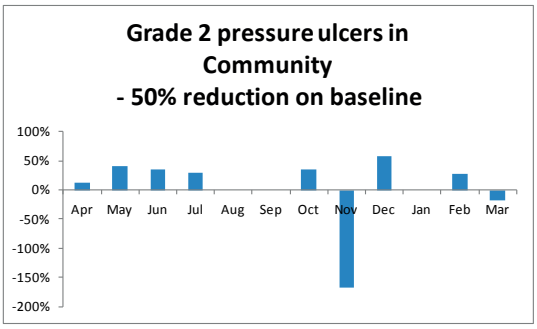












The Trust purposely set very high expectations in relation to the prevention of pressure ulcers to highlight the need for improvement and although the Trust was unable to achieve 5 of the 6 targets set for the last year, there was a significant reduction in pressure ulcers in most grades. The Trust only marginally missed the 50% reduction target for grade 3 pressure ulcer reduction in the community, achieving a total reduction of 47%.

The table below highlights where reductions have been achieved:

Hospital		Community	
Grade 4	13.6% reduction	**Grade 4**	44% increase
Grade 3	76.5% reduction	**Grade 3**	47% reduction
Grade 2	3.9% reduction	**Grade 2**	13.5% reduction

The only category that did not see a reduction was grade 4 pressure ulcers in the Community setting; these disappointingly increased by 44% during 2013/14. The Trust is working on improved reporting, education and training in order to make required improvements within the community.

Several activities were undertaken during the year in or to support an improvement in performance.

The beginning of the year saw the introduction of the Essential Competencies Programme of which Pressure Ulcer Prevention and Management was the first; setting a standard of competency which registered nurses were expected to demonstrate. The programme was supported by master classes delivered by the Clinical Nurse Specialist (CNS) and once assessed as competent; Senior Nurses were supported in cascading the training and competency assessments to their clinical teams.

In September 2013 the Nutrition & Tissue Viability Service embarked on the first phase of a Pressure ulcer awareness campaign. Drop in session were facilitated for staff; attended by 73 members of staff from all professional groups within the hospital.

During October 2013, the Deputy Director of Nursing (DDoN) and the Clinical Nurse Specialist (CNS) undertook a tour of the Community Nursing teams to raise awareness of pressure ulcer prevention and management in the community setting. The Executive Director of Nursing & Workforce (EDoNW) also attended a Link Practitioner meeting to highlight the importance of preventing pressure ulcers.

Although partial progress has been made against the 2013/14 targets, the Trust remains committed to further improvements and Prevention of Pressure Ulcers will remain an organisational quality goal for 2014/15 and has developed new key performance indicators to support this (see section 2.1.2).

3.1.3 Improving Communication

KPI 1: 20% reduction in complaints relating to communication	ACHIEVED
KPI 2: 20% reduction in concerns relating to communication	NOT ACHIEVED

The organisation's Communication and Engagement Strategy 2010 – 2013 stated that 'the way in which the organisation engages with its many stakeholders, communicates with them and involves them will have a large bearing on its success.' The overall aim of this Strategy was to develop and use excellent communications and engagement activity to support delivery of the aims and objectives of the organisation and promote meaningful and productive engagement with stakeholders. The Trust received a number of complaints and concerns relating to poor communication or a lack of communication and, therefore, set out to improve communication over the last 12 months and reduce the number of complaints and concerns received relating to this by 20%. It is acknowledged that it is beneficial to receive feedback via concerns, as this enables the Trust to learn valuable lessons and improve services.

Work undertaken throughout the year led to the Trust achieving its target in relation to complaints received, reducing the number received by 34%. Unfortunately the Trust failed to achieve the target relating to concerns, although a reduction of 5% was achieved. The total performance month by month is detailed in the table below:

KPI description	Target (cumulative)	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Reduction in complaints relating to communication	▼ 20%	12/13	3	4	6	3	4	6	8	7	1	7	5	2	56
		13/14	4	1	3	5	2	2	3	2	4	5	5	1	37
Reduction in concerns relating to communication	▼ 20%	12/13	20	19	12	14	8	10	11	6	6	10	8	8	132
		13/14	17	12	8	8	7	5	18	10	11	9	10	10	125

Following consultation with key stakeholders, it is clear they feel effective communication is essential and improving communication will remain a key organisational quality goal for 2014/15 with new key performance indicators developed to drive this forward (see section 2.1.3).

3.1.4 End of Life Care (AMBER Care Bundle)

KPI 1: Number of agreed wards using the AMBER Care bundle – 100%	ACHIEVED
KPI 2: Audit of patient healthcare records in January 2014 – 60% of patients audited have completed AMBER Care Bundle	ACHIEVED

The Department of Health's (DoH) End of Life Care Strategy: Promoting High Quality Health Care for all Adults at End of Life (2008) highlighted the need to improve the quality of care received by patients nearing the end of their lives. The outcome was to develop an intervention that supported clinical judgements and decision making and enabled conversations with patients and carers. It needed to allow patients to receive active treatment alongside an end of life care planning approach and reflect existing best practice. Devised by Guys and St Thomas' Hospital Trust in London, the AMBER Care Bundle (ACB) is concerned with the implementation of a process of assessment and care

management for patients whose recovery is uncertain but who continue to receive treatment.

The Isle of Wight NHS Trust commenced a project to implement the ACB across all relevant adult wards. The Trust initially agreed the 2 areas in which to implement ACB, as being the Stroke Unit and the Coronary Care Unit (CCU) & Step-down. The rationale for choosing these wards was that it is of paramount importance that we had staff with the right skill set undertaking the conversations necessary with carers / patients to ensure successful implementation of the ACB, in order that it achieves what we believe it can and should achieve for those families involved. The wards chosen were already used to having those difficult conversations to a certain extent, and would be best placed to work closely with the Palliative care team to ensure sensitive and successful delivery of the ACB.

Implementation was initially slow, and remains so in these 2 areas due to a lack of patients identified as suitable. The project, therefore, extended implementation to other Wards and once training had taken place and daily support provided for wards and Doctors from a registered band 7 Sister, implementation across the other inpatient areas was far greater. In total the Trust placed 20 patients on the ACB, across 5 inpatient areas. The highest number of patients identified as suitable were on Colwell Ward. Monthly progress is outlined below:

KPI description	Target	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number relevant wards using the AMBER Care Bundle	2 (100%)	0	0	0	0	0	0	0	0	2	5	5	5
Number of patients on the AMBER Care Bundle	N/A	0	0	0	0	0	0	0	0	1	11	19	20
Audit – 60% patient audits have completed AMBER Care Bundle	60%												100%

Whilst progress initially was not as fast as we would have liked, the time spent in preparation of implementation of the ACB and the discussions this has provoked around the end of life strategy and integrated ways of taking this forward have been very beneficial. Significant steps have been taken and feedback has highlighted initial successes including:

- Patients are being identified for palliative care earlier so treatment is more timely.
- Palliative care are being involved with every patient on the ABC regardless of their diagnosis providing more support and a safer discharge.
- Patients and relatives are being involved in their care.
- An open and honest conversation is occurring with the patient and family.
- Daily conversations are taking place with the patient/family.
- Patients have time to consider how they want to plan the last 1 to 2 months of their lives.
- Members of staff see this as a good support now that the Liverpool Care Pathway is no longer in use.
- Better GP and Care home involvement.
- The introduction of using Anticipatory care plans has provoked consideration of its use in patients not needing to be supported by the ABC but who, without it, might be admitted unnecessarily.
- Potential for fewer complaints due to improved care and communication.

- Potential for reducing hospital admissions.

Progress has also been made towards the use of the ABC being embedded. Whippingham ward, for example, now have Doctors accessing the documentation and using their professional judgement to commence the ABC without further support. A dedicated site for resources and information was developed on the Trust's Intranet and training continued by providing a resource folder for when patients have been supported by the ABC. An ongoing rolling programme of education; to include other aspects of end of life care has also been introduced. There remain challenges with the implementation, but implementation of ABC will continue to be progressed as part of the wider work being undertaken in relation to end of life.

3.1.5 Further Performance Information – Quality Indicators

Key quality performance indicators were monitored during 2014/14 via the monthly Quality Report; which is reviewed by the Quality & Clinical Performance Committee each month and made available on the Trust's website. The tables below outline the annual performance against each indicator.

KPI description	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Latest month Mar-14	Last month Feb-14	Current YTD 2013/14	Prev. Year 2012/13	RAG Trend	Sparkline
Number of new SIRIs reported in month	▼ 20%	11	14	9	8	4	6	9	3	5	4	5	3	3	5	81	168		
Number of ongoing SIRIs	N/A	74	71	74	69	51	39	22	23	21	22	19	23	23	19	N/A	N/A		
Number of SIRIs closed in month	N/A	25	17	6	9	19	18	23	8	4	5	4	3	3	4	141	252		
Clinical incidents resulting in harm	▼ 20%	56	46	67	43	42	48	56	53	84	39	42	62	62	42	608	728		
Clinical incidents – Major resulting in harm	▼ 20%	6	6	10	3	6	6	4	2	5	0	2	3	3	2	53	64		
Clinical incidents – Catastrophic resulting in harm	▼ 20%	1	0	2	0	1	0	0	1	1	1	1	2	2	1	10	10		
Slips, trips & falls resulting in injury	▼ 20%	13	5	18	12	11	13	19	17	9	14	10	14	14	10	155	192		
Slips, trips & falls resulting in serious injury	▼ 20%	1	0	0	0	2	2	1	1	0	0	1	0	0	1	8	14		
Clostridium difficile cases	12	0	2	2	0	0	0	1	0	1	0	0	1	1	0	7	13		
MRSA bacteraemia	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	2	2		
MSSA bacteraemia	N/A	0	1	1	2	0	0	0	0	0	1	0	0	0	0	5	6		
GRE bacteraemia	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
E.Coli bacteraemia	N/A	12	8	4	7	8	7	7	4	7	11	6	7	7	6	88	74		
MRSA Screening – Elective	100%	112%	109.4%	75.4%	88.8%	89.4%	92.6%	96.8%	98.6%	96.1%	97.8%	98.6%	92.9%	92.9%	98.6%	N/A	N/A		
MRSA Screening – Non elective	100%	83.4%	81%	94.3%	93.5%	92.3%	95.7%	92.8%	92.9%	94.1%	94.4%	96.4%	95.2%	95.2%	96.4%	N/A	N/A		
Venous-Thromboembolism (VTE)	95%	89.2%	92%	88%	90.2%	83.8%	88%	90.3%	89.8%	88.2%	90.8%	94.12%	100%	100%	94.1%	N/A	N/A		

Caesarean section rates	=<22%	19%	21%	22%	10%	23%	23%	18%	21%	25%	18%	18%	16%	16%	18%	19.5%	21%	
Normal vaginal deliveries	=>70%	65%	64%	59%	73%	69%	69%	75%	65%	60%	71%	74%	69%	69%	74%	67.8%	67%	
Breastfeeding figures	>85%	78%	79%	83%	70%	72%	78%	74%	74%	76%	73%	72%	75%	75%	72%	75%	75%	
Number of admissions to Neo-natal ICU	▼	21	8	6	9	8	11	11	10	7	16	12	6	6	12	125	N/A	
Emergency readmissions within 30 days	▼	90	77	53	58	70	80	84	76	68	58	74	71	71	74	859	1484	
Number of deaths – Mortality data	N/A	50	47	50	51	29	32	64	48	44	43	42	53	53	42	553	N/A	
Number of healthcare cases going to inquest	N/A	2	3	2	5	2	4	5	6	5	11	4	9	9	4	58	N/A	
Percentage allergy status documented	=>98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98.7%	
Percentage review & stop date	=>95%	95%	77%	87%	71%	72%	90%	88%	75%	87%	89%	84%	81%	81%	84%	83%	71%	
Percentage of missed doses	=<4%	2.4%	2.7%	4.3%	5.4%	2%	6%	3%	4.8%	7%	2.6%	4.1%	4.3%	4%	4%	4.05%	5.42%	
Number of complaints	▼ 20%	22	14	15	18	15	17	9	21	10	24	17	12	12	17	194	333	
Number of PALS queries	▼ 20%	75	66	36	60	46	46	81	75	42	74	74	76	76	74	751	847	
Number of compliments	N/A	334	409	385	441	271	326	372	297	632	379	256	345	345	256	4447	2561	
Friends & Family Test response rate – Inpatient	15%	52.1%	45%	28%	30%	32%	34%	35%	32%	33%	47%	35%	29%	29%	35%	36%	N/A	
Friends & Family Test response rate – A&E	15%	6.2%	4%	2%	2%	5%	13%	20%	22%	15%	12%	12%	12%	12%	12%	10.43%	N/A	
Number of single sex accommodation breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15	
Number of patient discharges after 10pm	tbc	39	35	28	37	49	30	31	35	20	26	13	1	1	13	344	N/A	
Number of Chaplaincy visits	N/A	868	721	592	660	640	585	888	740	694	903	776	550	550	776	8617	N/A	

Quality Goals 2013/14	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Latest month Sep	Last month Aug	Current YTD 2013/14	Prev. Year 2012/13	RAG Trend	Sparkline
Improving Mortality Rates																			
Standardised Hospital Mortality Index (SHMI)	▼ 2012/13	*	*	*	*	*	*	*	*	*	*	*	*	*	*	N/A	N/A		* * * * *
Hospital Standardised Mortality Ratio	▼ 2012/13	**	**	**	**	**	**	**	**	**	**	**	**	**	**	N/A	N/A		** ** ...
Reduction in Pressure Ulcers – Hospital																			
Grade 4 pressure ulcers	0	2	2	4	1	1	0	2	0	2	0	3	2	2	3	19	22		
Grade 2 pressure ulcers	▼ 50%	9	9	10	8	2	7	11	7	9	8	8	11	11	8	99	103		
Grade 3 pressure ulcers	▼ 50%	1	0	0	0	0	1	0	0	0	0	0	2	2	0	4	17		
Reduction in Pressure Ulcers – Community																			
Grade 2 pressure ulcers	▼ 50%	7	8	9	10	9	9	9	16	5	8	8	13	13	8	109	126		
Grade 3 pressure ulcers	▼ 50%	2	3	4	1	2	1	1	0	1	0	2	2	2	2	19	36		
Grade 4 pressure ulcers	▼ 50%	3	3	4	2	1	3	1	2	3	0	0	4	4	0	26	18		
Improving Communication																			
Reduction in complaints	▼ 20%	4	1	3	5	2	2	3	2	4	5	5	1	1	5	37	55		
Reduction in concerns	▼ 20%	17	12	8	8	7	5	18	10	11	9	10	10	10	10	125	132		

End of Life Care																			
All relevant wards using AMBER Care Bundle	100%									2	5	5			5	N/A	N/A		
Number of patients on the AMBER Care Bundle	N/A									1	11	19			19	N/A	N/A		
Audit of inpatient records (annual)	60%															N/A	N/A		

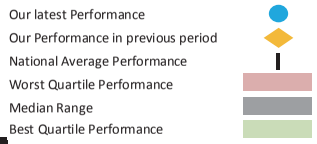
Mortality	**Apr-12**	**Jul-12**	**Oct-12**	**Jan-13**	**Apr-13**	**Jul-13**	**Oct-13**
SHMI*	1.1495	1.128	1.0734	1.081	1.061	1.0769	1.12

Mortality + Re-based	**Year ending Mar 2011**	**Year ending Mar 2012**	**Year ending Mar 2013**	**Year ending Jun 2013**	**April 2013 to July 2013**	**April 2013 to Aug 2013**	**April 2013 to Sep 2013**	**April 2013 to Nov 2013**	**April 2013 to Dec 2013**	**April 2013 to Jan 2014**
HSMR**	121	106	106	104	96	89	87	92	92	90
HSMR Re-based				106	103	97	95	101	102	99

The following table provides an overview of the Trust performance against a core set of indicators set by the Department of Health and Monitor.

The information has been taken from the Health and Social Care Information Centre (HSCIC). Although the Isle of Wight NHS Trust cannot confirm with any certainty that this information is incorrect, the Performance Information Team have highlighted that there are a number of cases where the information is out of date and there are a number of examples where the data is not consolidated for the full year, leading to instances where the information reported contains only one month/quarter. Therefore, further work has been undertaken to support this information, where possible, please refer to the last two columns in the table.

Quality Accounts 2013/14 - Isle of Wight NHS Trust



		Data from Health & Social Care Information Centre - Indicator Portal								Local Data Update	
Ref	Indicator Description	Period	Latest Performance	Previous Performance	National Target	National Worst	National Best	National Average	Performance	Period	Performance
1	Summary Hospital-level Mortality Indicator (SHMI)	Oct 12 - Sep 13	**1.10**	1.12	n/a	1.19	0.63	1.00		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- Whiilst the Trust is intending to code all activity from patient notes as opposed to the discharge summary, deceased patients has been made a priority. We do know that some of these were missed particularly those patients dying shortly after discharge from hospital. We have now implemented robust processes to ensure this is no longer the case. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to implement improvements in the quality of its clinical coding. Fully utilise the Dr Foster tool and other benchmarking data to help identify areas to improve clinical practice and regulare reviews by the Executive Medical Director of patients dieing in hospital.										
2	The % of patient admissions with palliative care coding	Oct 12 - Sep 13	**24.20**	22.00	n/a	44.90	0.00	20.60		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- Current palliative care coding encompasses a wide variety of pathways and due to a misinterpretation of clinical terminology in relation to the strict national coding standards there have been some instances where Palliative care has been coded inappropriately. In order to assign the palliative care code the patient must have received specialised palliative care support, in some instances a patient was receiving palliative support as described on the discharge summary yet on further investigation this was not specialised therefore the Z51.5 ICD-10 code was not appropriate and a Z51.8 should have been utilised. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to implement improvements in the quality of its clinical coding by coding based on information contained within the patients notes as opposed to a discharge summary, this allows the clinical coders to more accurately reflect the appropriate clinical codes.										
3	Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay.	Q4 2013/14	**96.1%**	90.7%	95.0%	93.3%	100.0%	97.4%		2013/14	**95.2%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has exceeded the national target of 95% for 2013/14 The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to follow up patients within 7 days of discharge.											
4	Category A telephone calls (Red 1 and Red 2 calls) ; emergency response within 8 minutes.	Mar-14	**76.4%**	76.2%	75.0%	62.8%	80.9%	74.8%		2013/14	**76.2%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has exceeded the Ambulance Red 1 & Red 2 target of 75% for 2013/14. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to monitor performance to achieve the required performance standards and to continually improve the quality of its service.											
5	Category A telephone calls (Red 1 and Red 2 calls) ; emergency response within 19 minutes.	Mar-14	**96.2%**	95.6%	95.0%	90.9%	98.3%	96.1%		2013/14	**96.6%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has exceeded the Ambulance Red 1 & Red 2 target of 95% for 2013/14. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to monitor performance to achieve the required performance standards and to continually improve the quality of its service.											
6	Patients with suspected ST elevation myocardial infarction who received an appropriate care bundle.	Dec-13	**100.0%**	84.6%	n/a	68.2%	100.0%	80.2%		2013/14 (Apr-Dec)	**75.8%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- Patient numbers relating to this quality indicator are very low (potentially only 1 or 2 patients per month). Performance can therfore fluctuate significantly month to month. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Actively monitoring all incidents of myocardial infarction and addressing any shortfalls in clinical practice that may be identified.											

		Data from Health & Social Care Information Centre - Indicator Portal								Local Data Update	
Ref	Indicator Description	Period	Latest Performance	Previous Performance	National Target	National Worst	National Best	National Average	Performance	Period	Performance
7	Patients with suspected stroke assessed face to face who received an appropriate care bundle.	Dec-13	**94.7%**	100.0%	n/a	90.5%	99.6%	96.2%		2013/14 (Apr-Dec)	**97.4%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation's performance for the year to date is amongst the best in the country. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to monitor performance and maintaining the high levels of performance.											
8	Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team.	Q4 2013/14	**96.2%**	100.0%	95.0%	75.2%	100.0%	98.3%		2013/14	**96.0%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has exceeded the national target of 95% for 2013/14 The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to develop existing good practice and further enhancing communication between services.											
9	Patient reported outcomes measures for elective procedures - (i) Groin Hernia Surgery.	2011/12	**0.109**	0.104	n/a	-8.091	13.917	-0.037		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has higher than average participation rates due to the robust system in place within Pre Assessment & Admissions Unit, where participants are informed and consulted about completing PROMS data returns. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to ensure that as many hernia patients participate as possible.											
10	Patient reported outcomes measures for elective procedures - (iii) Hip Replacement Surgery	2011/12	**18.972**	0.396	n/a	-4.375	30.286	10.334		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has higher than average participation rates due to the robust system in place within Pre Assessment & Admissions Unit, where participants are informed and consulted about completing PROMS data returns. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to ensure that as many hernia patients participate as possible.											
11	Patient reported outcomes measures for elective procedures - (iv) Knee Replacement Surgery	2011/12	**16.048**	0.348	n/a	-11.556	23.286	6.806		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has higher than average participation rates due to the robust system in place within Pre Assessment & Admissions Unit, where participants are informed and consulted about completing PROMS data returns. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuing to ensure that as many hernia patients participate as possible.											
12	Emergency readmissions to hospital within 28 days of discharge : indirectly standardised percent, 16+ years	2011/12	**8.8%**	9.2%	n/a	17.2%	4.9%	11.5%		2013/14	**7.6%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- Despite a small percentage rise in readmissions during 2013/14 compared with 2011/12 our internal monitoring shows that our number of readmissions is now reducing over time. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Continuoulsy reviewing the data in particular to identify common causes of avoidable re-admissions and where appropriate taking actions to address these for example the introduction of the Crisis Intervention Team.											
13	Emergency readmissions to hospital within 28 days of discharge : indirectly standardised percent, <16 years	2011/12	**10.1%**	10.3%	n/a	14.9%	5.1%	10.0%		2013/14	**11.1%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The Trust has an open access policy for a cohort of children who need quick access to the childrens ward. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Reviewing the management of open access patients.											

		Data from Health & Social Care Information Centre - Indicator Portal								Local Data Update	
Ref	Indicator Description	Period	Latest Performance	Previous Performance	National Target	National Worst	National Best	National Average	Performance	Period	Performance
14	Responsiveness to the personal needs of it's patients (Score out of 100)	2013/14	**77.30**	75.40	n/a	67.10	87.00	76.90		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The Trust continues to review outcome of patient surveys and implement actions to improve services based on results. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Encouraging patients feedback on the quality of services, making feedback mechanisms more accessible and discussing feedback from patients at Trust Board.											
15	Staff who would recommend the trust to their family or friends.	2013	**52.471**	n/a	n/a	39.574	93.924	66.212		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The Trust icontinues to go through a period of organisational change which has immpacted on staff morale, as indicated in the wider staff survey results. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- The Trust continues to review outcomes from the staff surveys and implements actions to improve performance based on the results. Also, the Trust has implmented the staff Friends & Family survey so that it can review findings more regularly than from the annual survey and from a wider number of staff to more regularly inform service improvements.											
16	Patient experience of community mental health services.	2013	**84.6%**	87.7%	n/a	80.9%	90.9%	85.8%		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- Patient experience now forms part of the monitoring undertaken by the Mental Health & Learning Disabilities Quality Group and actions taken to address performance issues. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- Encouraging patients feedback on the quality of services, making feedback mechanisms more accessible and discussing feedback from patients at Trust Board.											
17	Patients admitted to hospital who were risk assessed for venous thromboembolism.	Q3 13/14	**89.5%**	87.5%	95.0%	77.7%	100.0%	96.0%		Mar-14	**100.0%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The Trust has struggled to collect accurate data due to manual systems in place, this has recently been rectified. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- The Trust has recently implemented an Electronic Prescribing system which is set so that prescribing will not be enabled unitl the required assessment has been completed, this will ensure assessment is undertaken every time and is illustrated by our performance in March 2014.											
18	The rate per 100,000 bed days of cases of C.difficile infection that have occurred within the trust amongst patients aged 2 or over.	2012/13	**13.10**	13.90	n/a	0	30.8	17.3		2013/14	**6.1**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The information includes incidentes reported across Acute, Mental Health, Ambulance and Community services, so the figure will be higher compared to other Trusts and therefore the national average. This means the figures are not truly comparable for benchmarking purposes. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- continually developing and improving robust working processes for prescribing, cleanliness and patient flow guided by learning points developed in the root cause analysis programmes, inspection and assurance.											
19	Patient safety incidents and the % that resulted in severe harm or death. (i) Total Incident rate per 100 Admissions	Apr 13 - Sep 13	**9.40**	11.30	n/a	3.54	27.88	7.75		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The information includes incidents reported across Acute, Mental Health, Ambulance and Community services, so the figure will be higher compared to other Trusts and therefore the national average. This means the figures are not truly comparable for benchmarking purposes. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- ensuring root cause analysis is undertaken on incidents and that lessons are learnt and shared across the organisation.											

		Data from Health & Social Care Information Centre - Indicator Portal								Local Data Update	
Ref	Indicator Description	Period	Latest Performance	Previous Performance	National Target	National Worst	National Best	National Average	Performance	Period	Performance
20	Patient safety incidents and the % that resulted in severe harm or death. (ii) % Incidents that resulted in severe harm or death	Apr 13 - Sep 13	**3.9%**	2.4%	n/a	0.0%	4.8%	0.7%		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The information includes incidents reported across Acute, Mental Health, Ambulance and Community services, so the figure will be higher compared to other Trusts and therefore the national average. This means the figures are not truly comparable for benchmarking purposes. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- ensuring root cause analysis is undertaken on incidents and that lessons are learnt and shared across the organisation.											
20	Patient Friends & Family test, combined result for Inpatients & A&E	Feb-14	**69.0**	n/a	n/a	4.0	94.0	66.0		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The Trust is continue to review and improve the mechanisms to capture patient feedback. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:- ensuring all patients are given the opportunity to provide feedback using a variety of methods, and that action is taken on the results to improve the patient experience											

The source data for this analysis is provided by The Health and Social Care Information Centre (HSCIC) within their Indicator Portal. Please note in order to supplement this information with the latest available data, analysis of performance from local data sources has been included where possible.

* It is not possible to replicate the method used for standardisation to our local data, therefore the difference between local data and HSCIC standardised data in 2011/12 has been applied to 2013/14 local data in order to make this comparable. This may mean there may be a small vairance between these figures and the final HSCIC figures for 13/14 when they are published.

** As there is no detailed guidance on how the HSCIC calculate the number of bed days, the rate for 13/14 has been caclulated using the actual number of cases by the number of bed days used by HSCIC in 12/13. This is likely to mean that the actual rate from HSCIC will be lower when publihsed.

3.1.6 Healthcare Associated Infections (HCAI)

The Isle of Wight NHS Trust has continued to focus on HCAI as a quality indicator for 2013/14 alongside the ethos of harm free care. The overall trends in HCAI have been monitored and reported in the monthly Quality Report and Quarterly Directorate Performance Reports.

KPI description	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Clostridium difficile cases	0	2	2	0	0	0	1	0	1	0	0	1	7
MRSA bacteraemia cases	0	0	1	0	0	0	0	0	0	1	0	0	2
MSSA bacteraemia cases	0	1	1	2	0	0	0	0	0	1	0	0	5
E. Coli bacteraemia (whole system)	12	8	4	7	8	7	7	4	7	11	6	7	88

MSSA bacteraemia and E.Coli cases are monitored monthly, although specific targets are not allocated, therefore they are not colour rated in the table above.

Methicillin Resistant Staphylococcus Aureus (MRSA)

The Trust was allocated a target of 0 MRSA Bacteraemia cases for 2013/14; unfortunately the target was breached with a total of 2 cases for the year. The first detected case presented in June 2013. The patient was MRSA positive on admission; reduction therapy which includes skin washes should have been commenced and this was not done. The peripheral venous access device (PVAD) should have been inserted, monitored and maintained in a specific manner; however there was limited documentation to provide assurance this was done (PVAD's are used to access a patient's circulation for the purpose of giving intravenous fluids or drugs). The PVAD site was infected and therefore this was the most likely cause of the infection.

The second case presented in January 2014 with issues arising from an analysis of the root cause relate to poor documentation around catheter insertion and ongoing care documentation, non-recognition of previous MRSA positive status. There was an incomplete MRSA admission risk assessment; thus not managed in accordance with policy (reduction therapy was not commenced on admission). A lack of PVAD insertion and monitoring documentation was identified, along with poor ward compliance with the Infection Prevention & Control self audit programme.

Actions to be implemented: Improvement of documentation by development of a urinary catheter care bundle and embedding of a self audit programme including monthly PVAD audits.

Performance is outlined in the table below.

MRSA	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Acute target	0	0	0	0	0	0	0	0	0	0	0	0	0
Actual	0	0	1	0	0	0	0	0	0	1	0	0	2

Clostridium Difficile Infection (CDI)

In comparison to 2012/13 the Isle of Wight NHS Trust was able to improve performance and reduce cases of CDI by 6 on the previous year (2012/13 = 13 cases). This led to the Trust over achieving the annual target of 12 by reporting a final number of 7 cases during 2013/14.

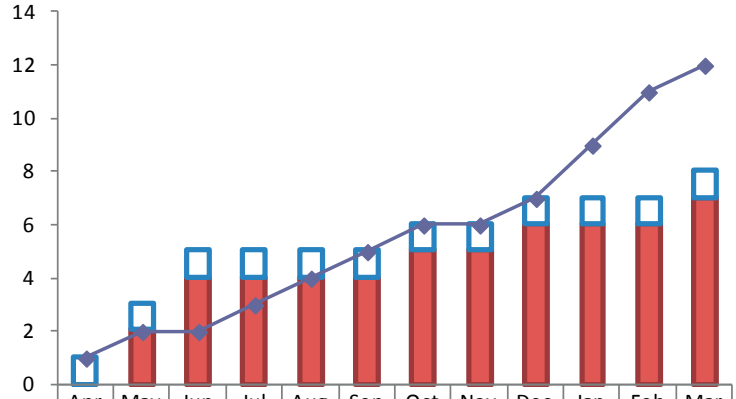
An investigation into the root cause is undertaken for all cases of hospital attributed C difficile infection.

The main issues arising included missed opportunity to collect stool specimen, documentation of diarrhoeal episodes not fully complete, delay in isolation and not identifying previous colonisation with C difficile.

Actions arising include reviewing 'flagging' system of previously colonised patients, reminding staff about available on-line c difficile training and the importance of timely specimen taking, isolation and accurate diarrhoeal monitoring. Information has been included in IPC newsletters. C difficile toxin positive and diarrhoea care plans developed and introduced.

The annual breakdown of performance is outlined in the graph below:

Isle of Wight NHS Trust C.Difficile Performance (Cumulative)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mainland Hospital Acquired	1	1	1	1	1	1	1	1	1	1	1	1
IW NHS Trust	0	2	4	4	4	4	5	5	6	6	6	7
IW NHS Trust Target	1	2	2	3	4	5	6	6	7	9	11	12

3.1.7 Complaints; Concerns and Compliments

During 2013/14 reporting of complaints data has continued to be part of the Performance Report to the Trust Board and the monthly Quality Report that is reviewed at the Quality & Clinical Performance Committee, as well as reported at various other Committees as part of performance reports. At the beginning of the year, the Trust set a local target of a 20% reduction in both complaints and concerns.

During the year 194 formal complaints were received by the Isle of Wight NHS Trust, a decrease of 42% on 2012/13. There were 751 concerns received compared to 847 in 2012/13. Although the Trust did not achieve its target of a 20% reduction, there was an overall decrease in the number of concerns received of 11.3% when compared to 2012/13.

Outlined below is the month on month performance in relation to complaints and concerns:

KPI description	Target (cumulative)	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of complaints logged within the NHS COMPLAINTS procedure	▼ 20%	12/13	19	34	24	31	26	27	40	35	23	23	33	18	333
		13/14	22	14	15	18	15	17	9	21	10	24	17	12	194
Number of Patient Experience (PALS) CONCERNS	▼ 20%	12/13	79	100	91	86	76	73	65	61	36	69	43	68	847
		13/14	75	66	36	60	46	46	81	75	42	74	74	76	751
Complaints Process Compliance (based on those closed within month – not received)	0–20 days		3	5	2	8	6	2	3	7	1	4	3	4	48
	21–45 days		14	7	9	7	8	6	10	5	8	6	11	7	98
	> 45 days		15	17	11	9	3	4	2	6	1	2	5	5	80
Number of Concerns resolved in 3 working days (based on those closed within month – not received)			46 70%	43 64%	21 66%	37 67%	25 60%	28 70%	64 81%	46 69%	35 67%	47 77%	56 77%	47 76%	495

The main areas of concern raised within the complaints received included:

- Clinical care – concerns about diagnosis / treatment.
- Appointment delays / cancellations in outpatients
- Communication – failure to communicate / lack of information provided.
- Staff attitude

Areas receiving the highest number of complaints in each of the 3 Clinical Directorates are outlined below:

Clinical directorates	Service area
Planned Clinical Directorate	General Surgery/Urology
	Orthopaedics
Acute Clinical Directorate	Emergency Department
	Medical Services
Community Health Clinical Directorate	District Nursing Service
	Mental Health – Community Services

During 2013/14 there were 9 complaints referred to the Parliamentary Health Service Ombudsman (PHSO). These are cases where the complainant was not happy with the outcome they received from the Trust. Of the 9 cases; 5 were not upheld; 1 was not taken on by the PHSO but they requested the Trust re-engage with the complainant; 2 are still undergoing investigation and 1 was upheld. For the 1 upheld case; the

Trust accepted the recommendations and developed an action plan to ensure lessons are learnt.

All complaints received by the Isle of Wight NHS Trust are investigated and reviewed directly with the staff involved, with lessons learnt developed and shared with the wider clinical area. The following positive outcomes and actions have been identified from a sample of complaints received in order to prevent similar situations occurring:

Speciality	Complaint	Root Cause	Action
General Surgery / Urology	Delay in operation.	Decision to admit paperwork not available.	Electronic system being developed to place patients on a waiting list at time of decision rather than paper based system – planned implementation 2014/15.
General Surgery / Urology	Complaint regarding Botox injections that had left patient needing to have a catheter.	Poor communication regarding known complications leading to patient not being able to make an informed choice regarding surgery.	In future all patients coming in for these procedures are given a trial at trying to self catheterise; if they are not able to do this, they are given the option of not having the procedure.
Orthopaedics	Patient developed embolism.	Confusion regarding whether clinician required patient to have anti-clotting prophylaxis medication.	Standard operating procedure for knee surgery put in place to ensure all consultants manage patients in the same way. Modern Matron to lead in changing inpatient paperwork.
Emergency Department	Alleged missed diagnosis.	Patient developed symptoms of a stroke. There was a delay in recognising this.	Raise the profile of diagnosis and treatment of stroke. Reflective training for clinician involved. Additional training sessions for all team.
Medical Services	Poor communication with relatives.	Telephone messages not responded to.	Clinical Nurse Specialist will review logs to ensure contacts to nurse specialist are not being missed and responded to.
District Nursing	Delay in escalating deterioration in patient's condition.	Poor documentation in community notes.	Audit to be undertaken.
Mental Health Community	Delay in receiving appointment.	Patient had moved and not informed service.	New contact details placed on system for future contacts.
Ambulance	Patient given misleading information on discharge about the cost of hospital car.	Out of date information regarding costs and criterion for hospital car on wards.	Up to date list of pricing and terms sent to all ward and outpatient areas and price list also published in the staff bulletin to raise awareness.

"Thank you all for the kindness and help you have given me over the last 12 months."

The numbers of compliments about Isle of Wight NHS Trust services continue to exceed complaints with 22 compliments for every one formal complaint received, an improvement on 2012/13 where there were 8 compliments for every 1 formal complaint. The table below highlights month on month performance:

"We are sending you a huge THANK YOU for all the care you gave to (relative)... we are impressed by your kindness, your dedication and professionalism. You do a fantastic job."

KPI description	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of compliments	334	409	385	441	271	326	372	297	632	379	256	345	4447

During 2013/14 the Trust implemented a review of complaints management, in order to improve systems and processes. This review has led to required changes, including service leads and Directorate Quality Managers taking a more active role in the management of complaints, so that complaints are responded to as close to the patient as possible. From 1 April 2014 the Trust will be implementing action plans for each complaint to enable better tracking of required actions, following a complaint and to enable more effective monitoring.

Further analyses, including trends, has been undertaken by the Trust; for further detail, please refer to the Trust's Annual Complaints Report.

3.1.8 Patient Feedback (including Friends & Family Test – FFT)

Since the implementation guidance on the NHS Friends and Family Test on 4 October 2012; the Trust has continued to implement the Friends and Family Test which provides a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the Quality of the care received by patients.

The patients that must be surveyed are all adult acute inpatients (staying at least one night in hospital) and all adult patients who have attended Accident & Emergency and left without being admitted to hospital or assessed in a Medical Assessment Unit and since 1 October 2013, pregnant women and mothers of new-born babies have been asked to give their views on the services they receive throughout their pregnancy.

The question asked is:

"How likely are you to recommend our <ward/ A&E Department> to friends and family if they needed similar care or treatment?"

Response rates & satisfaction scores

KPI description	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Friends and Family Test: Inpatient	15%	52%	45%	28%	30%	32%	34%	35%	32%	33%	47%	35%	29%
Friends and Family Test: A&E	15%	6%	4%	2%	2%	5%	13%	20%	22%	15%	12%	12%	12%
Score		66	66	68	74	70	61	68	67	65	71	69	69

Action being taken to improve FFT performance:

- Roll out the Tablet devices to all inpatient areas and Maternity.
- Ensure posters are visible raising the profile to patients regarding FFT.
- Ensure Volunteers are used to support capture FFT questionnaire responses.
- Review process for managing FFT in ED, look at other methods of data capture including coin box solution.

- Explore alternative solutions linking with mainland trusts who are high achievers, including looking at text and call back solutions.

The Isle of Wight NHS Trust values feedback from patients; carers and relatives and is keen to build on work undertaken during 2012/13. Feedback obtained during the last year has supported the Trust in the decision making process for agreeing the new quality priorities, this is evidenced within section 2 of this Quality Account; Key Priorities for Improvement 2014/15.

As well as providing postcard surveys, the question can be completed via the Trust's Website, and the data is collated monthly and reported to clinical areas as well as Board.

Other mechanisms for our patients to feedback are via the NHS Choices Website and the Patient Opinion Websites and via Healthwatch Isle of Wight or the Care Quality Commission. There is regular sharing of information, including themes of complaints, concerns and issues raised, between Healthwatch and the Trust to ensure wider lessons are learnt and key themes identified.

During 2013/14 the Trust has implemented Patient Experience Video programme, where patients are interviewed regarding their experience of healthcare and this is then shared with the Board. All of these videos are available to the clinical staff to ensure that lessons are learnt.

All of these mechanisms are monitored and reviewed regularly by the Board as well as being shared with the appropriate clinical services to ensure learning.

Below are some of the actions taken in response to patient feedback:

You said...	We did...
There is a lack of pillows available in the Emergency Department (ED).	Ordered more pillows and have ensured they are marked to indicate that they are property of ED.
There was a lack of clocks in patient bays.	Audited this to ensure that clocks are in all patient areas and clearly visible.
The food needs to be improved.	Improved the menu choices, and this continues to be reviewed regularly by the Hotel Services Manager based on patient feedback.
Nurses are very busy, and sometimes wards appear short staffed.	Undertook a full review of all wards and services to ensure that they were in line with safe staffing levels.
We do not know who is looking after us.	Have implemented a project for clinical areas to have ward photo boards, so staff are easily identifiable.

3.1.9 Learning from Serious Incidents Requiring Investigation / Never Events

Serious incidents are defined as an incident that occurred in relation to NHS-funded services and care, which resulted in one or more of the following:

- Unexpected or avoidable severe harm to one or more patients, staff, visitors or members of the public.
- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public.
- Any Never Event. All never events are defined as a serious incident, even those that do not result in severe harm or death.
- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services.
- Allegations or incidents of abuse.
- Allegation against a healthcare or non healthcare professional.
- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

The Isle of Wight NHS Trust has a responsibility to ensure there are systematic measures in place to protect patients and learn from incidents so as to minimise the risk of them happening again. The Quality Managers in the clinical directorates have been integral to supporting the improvements in the process to ensure that we share the learning from Serious Incidents that Require Investigation (SIRI) and that the investigation process is undertaken in a timely manner.

Following a SIRI investigation, the learning is extracted from the evidence gathered and, where applicable, an action plan is developed to reduce the risk of a similar situation occurring again (learning from mistakes). The action plan is appropriately shared with relevant senior staff and the overall process monitored by the Quality and Clinical Performance Committee.

Below is some of the learning that has come from the serious incident investigations.

What did not go quite so well	Remedial action taken	Summary of what lessons were learnt by incident
(Pressure ulcer) Poor communication between district nurse and care home.	Staff from both teams met to develop written action plan to address communication issues, which will be shared with the district nurse team and all care home staff.	Care home staff were not fully informed in appropriate action to take in managing patients' pressure care. This was in part due to poor communication with District Nurse Team.
(Patient fall) Faulty bed sensor led to fall by patient resulting in injury to patient.	Raised awareness with staff that patients at high risk of falls, not to be left until bed sensor working correctly. Trust Wide case for more bed sensors to be purchased to ensure adequate supply; raised awareness of Medical Electronics out of hours services.	Staff now aware of correct process for replacing / repairing equipment out of hours. Patients at high risk of falls whose bed sensors are faulty to be nursed 1:1 until equipment repaired or replaced.
(Pressure ulcer) Incorrect information on district nurse referral form to manage wound care appropriately, including lack of care plan and wound sizing; discharge not co-ordinated as staff unaware of referral forms.	Staffing review to include 2 team leaders being present on each shift to ensure supervision of Healthcare Assistants. All trained nurses to attend Pressure Ulcer Care Master Class and undertake competency test.	Was a clear question regarding competency of the registered nurse in this case, and a lack of accountability for the care they and the Healthcare Assistants provided.
(Patient fall) Failure to recognise fracture on x-ray, compounded by a delay in receipt of a formal x-ray report.	Associate Director of medical education informed of action point. Head of Clinical Standards received the Education Programme for 2012/13 which clearly includes x-ray tutorials and other relevant subjects.	Importance of reminding Foundation Year 1+2 Doctors about importance of following up all investigations requested in a timely manner.
(Pulmonary Embolism (PE) 11 days post admission) VTE assessment not completed on admission or at any other point in the patient's stay; delay in the patient's assessment and application of TED stockings.	All Clinicians reminded that VTE assessments are mandatory for all admissions; Complete: all staff received training in the assessment and application of TED stockings. Staff made fully aware of the need to ensure plan of care is fully documented on admission and updated throughout patients' stay.	Patient unable to receive VTE prophylaxis as contraindicated with haematuria as this would have exacerbated bleeding; All staff to receive a copy of NMC record keeping guidance for nurses and midwives. Monthly documentation audits to be undertaken by Ward Sister/ Matron. As of March 2014 our compliance with VTE Assessment has reached 100% against national target of 95%.

3.1.10 Dashboards & Scorecards

Following on the work undertaken last year in dashboard development for Clinical Quality Indicators, Incident tracking and prescribing and Pharmacy information, new developments are taking place to enable the collection and analysis of real time data, with the continued focus on the different aspects of quality and overall comparison of service areas. Dashboards will continue to be used at the monthly Directorate Performance Reviews as part of the overall performance management process to highlight positive performance trends and to enable root cause analysis on service issues. This will be further enhanced through the use of real time data which will be provided by the Ward Dashboard which is being redeveloped in QlikView dashboard software.

The Isle of Wight NHS Trust continues to seek innovative ways of data visualization providing accurate performance information that supports the drive for continuous improvement in services provided to our patients and this will continue throughout 2014/15.

3.1.11 Patient Safety Walkrounds

The Board Assurance Walkround Programme commenced during the latter part of 2012/13 following a review of the previous Patient Safety Walk round process. The visits have been undertaken during 2013/14, on a weekly basis to one area of the Trust; with more areas being visited as part of the Trust Board meeting on a monthly basis.

The Board Assurance Walkrounds offer the opportunity for the Trust Board to link directly with services delivered in all areas of the Organisation. This process provides patients; relatives and staff the opportunity to discuss issues directly with the Trust Board and also provides an opportunity for the Trust Board to seek assurance from all services.

The Walkrounds are pivotal in the Trust to seek assurance at the point of service delivery. This also demonstrates the Trust Boards leadership commitment to quality and setting a culture to be fostered across the entire organisation.

The visits have primarily been undertaken weekly by the Trust Chairman and a member of the Executive team, with the support of a member of the senior nursing team. All of the visits continue to be timetabled throughout the year, visits are unannounced except in the situation where there is only a small team, or the visit is to a base such as in District Nursing Services. A small number of the visits during the year were undertaken out of hours.

The Executive Team also undertake informal unannounced visits which are also noted as part of the process.

During the course of 2013/14 a total of 53 areas were visited, covering a variety of services across the Trust, for both clinical and non-clinical settings. As part of the process key issues are identified and monitored by the Trust Board on a monthly basis to ensure actions are taken to address these issues.

Key issues identified during the Walkrounds where action has been taken to resolve these included:

- Improvements to environment, including minor estates issues being resolved, and areas being de-cluttered and alternative storage solutions found.
- Improved information to patients / visitors and staff.

- Improved access to equipment (e.g. Bed Sensors).
- Better access to IT systems and review of software processes.
- Review and improvements to systems and processes to aid the patient pathway.
- Review of signage.
- Raised awareness of confidentiality and security issues.
- Review of staffing levels.
- Replacement of lockers for staff in Theatres.
- Space utilisation review for some areas.
- Review of Uniforms including for Junior Doctors.

3.1.12 Improving Quality Performance / Quality Action Plans

Quality continues to drive the Isle of Wight NHS Trust's strategy with the first key objective for the organisation being "to achieve the highest possible quality standards for our patients in terms of outcomes, safety & experience" and the Trust continues to take steps in order to improve.

The Trust's approach to improving quality and safety has been and continues to be 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. The restructure of the Executive Director of Nursing & Workforce's portfolio has led to the development of the Patient Safety; Experience and Clinical Effectiveness Triumvirate (SEE); which is now responsible for driving forward the quality & patient safety agenda across the organisation.

Long Term Quality Plan

The Trust has developed a Long Term Quality Plan (LTQP) that supports the above objective so that the Trust can deliver safe and effective services, delivering excellent outcomes and doing so in a way that achieves an excellent patient experience, with excellent customer care. It outlines the Trust's aims and objectives for Patient Safety, Clinical Effectiveness and Patient Experience and sets out the formal structures, accountabilities and early warning systems.

The LTQP builds on the recommendations in the National Quality Board reports and guidance issued since 2010 and ensures quality is kept at the forefront of everything we do in providing safe and effective care to meet the individual needs of our patients and their families and carers.

Quality Action Plans

The *Integrated Action Plan* includes all relevant actions and recommendations that have come out of the following independent reviews / Public Enquiries:

- *The Francis Review* – Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry.
- *The Cavendish Review* – An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings.
- *The Keogh Review* – Review into the quality of care and treatment provided by 14 hospital trusts in England.

- *The National Advisory Group (Professor Berwick) Review* – A promise to learn; a commitment to act: Improving the safety of patients in England

- *A Review of the NHS Hospitals Complaints System* (Clwyd/ Hart) Right Honourable Ann Clwyd MP and Professor Tricia Hart – Putting patients Back in the picture

The Trust hopes this provides assurance to key stakeholders that the implications and recommendations arising out of the Francis inquiry have been taken into account and reflected in the Trust's approach to ensuring that the standard of care, treatment and behaviour is of the highest standard. This was a key area identified by the Isle of Wight Council's Health and Community Well-being Scrutiny Panel in their statement on last year's Quality Account.

The ***Quality Governance Framework Action Plan*** has been developed to support the requirement for the organisation to undertake a self assessment against Monitor's Quality Governance Framework, as part of the Foundation Trust application process. Actions have been included following external reviews undertaken by the University Hospital Southampton NHS Foundation Trust peer review KPMG and the Trust Development Authority (TDA).

Both action plans are reviewed on a monthly basis and progress monitored through the Patient Safety; Experience & Clinical Effectiveness Triumvirate. Assurance on quality performance is provided to the Trust Board through the regular updates to the Quality & Clinical Performance Committee.

Quality Champions

An initiative to recruit 100 quality champions was undertaken to support the organisation to achieve its quality goals and plans to improve the quality of care for patients as well as staff experience. The Quality Champions meet with the Chief Executive; Executive Director of Nursing & Workforce and the Executive Medical Director on a monthly basis to feedback on quality related issues. They have been helping the organisation to test itself against recommendations within the Integrated Action Plan to enable gaps to be identified and relevant action to be taken in order to maintain continuous quality improvement.

3.1.13 Workforce

There has been much workforce related activity over the past twelve months, supporting the organisation's drive to deliver quality services for all its patients. This has included:

- Proactive management of sickness absence.
- Ensuring staff receive an annual Appraisal / Professional Development Plan.
- Review of staff survey to identify key areas where improvement can be made.
- Continuing to Increase the use of Volunteers – to improve the experience for patients.
- The launch of our "100 Quality Champions" scheme. Staff with an interest in promoting our quality agenda have become our Quality Champions and are working across the organisation.
- The creation of Lesbian; Gay; Bisexual and Transgendered (LGBT) groups for staff and service users.

The 2013 Staff Survey results identified areas where the Trust had improved since the 2012 survey and also areas where the Trust did not do so well. The key comparison points from each of the areas surveyed are outlined below:

Acute

Top 5 Scores

	Improved	2012	2013	+ / -		Declined	2012	2013	+ / -	
1	Hand washing facilities are always available for staff.	65%	74%	9%*	↑	1 In the last three months had not felt pressure from colleagues to attend work when they have not felt well enough to perform their duties.	75%	66%	9%*	↓
2	Agreed that they know who the senior managers are, where they work.	75%	83%	8%*	↑	2 Satisfied with the support received from immediate manager.	66%	58%	8%*	↓
3	Received equality and diversity training in the last 12 months.	56%	64%	8%*	↑	3 In the last three months had not felt pressure from manager to attend work when they had not felt well enough to perform their duties.	69%	62%	7%*	↓
4	Agreed that training helped to do job more effectively.	66%	71%	5%*	↑	4 Agreed that they are able to do their job to a standard they are personally pleased with.	79%	72%	7%*	↓
5	Hand washing facilities are always available for patients / service users.	60%	64%	4%	↑	5 Agreed that senior managers try to involve staff in important decisions.	36%	29%	7%*	↓

*Values which are statistically significant

Ambulance

Top 5 Scores

	Improved	2012	2013	+ / -		Declined	2012	2013	+ / -	
1	Staff saying that in an average week they have not worked additional PAID hours over and above the hours for which they are contracted.	38%	61%	23%*	↑	1 Appraisal helped agree clear objectives for their work.	67%	57%	11%*	↓
2	Agreed that preventative action is taken when errors are reported.	36%	58%	21%*	↑	2 In the last month witnessed no errors or near misses that could have potentially hurt patients.	79%	69%	10%*	↓
3	Received equality and diversity training in the last 12 months.	51%	70%	19%*	↑	3 Appraisal helped staff to improve how they did their job.	48%	38%	10%*	↓
4	In the last three months had not felt pressure from manager to attend work when they had not felt well enough to perform their duties.	60%	78%	18%*	↑	4 Staff saying that in an average week they have not worked additional UNPAID hours over and above the hours for which they are contracted.	66%	56%	10%*	↓
5	Staff given feedback about changes made in response to reported errors or incidents.	15%	32%	17%*	↑	5 Agreed that training helped staff to stay up-to-date with professional requirements.	72%	65%	7%*	↓

*Values which are statistically significant

Mental Health

Top 5 Scores

Improved		2012	2013	+ / -	Declined		2012	2013	+ / -
1	Satisfied with the support received from work colleagues.	77%	86%	8%* ↑	1	Disagreed that organisation blames or punishes people who are involved in errors, near misses or incidents.	41%	30%	11%* ↓
2	Agreed their immediate manager is supportive in a personal crisis.	78%	85%	7%* ↑	2	Agreed that there are enough staff at their organisation for them to do their job properly.	40%	30%	10%* ↓
3	Satisfied with the support received from immediate manager.	69%	75%	6%* ↑	3	Staff / colleagues reported error that could hurt patients / service users.	97%	87%	10%* ↓
4	Agreed that they would be happy with standard of care for friend / relative.	47%	51%	4% ↑	4	Agreed that preventative action is taken when errors are reported.	57%	47%	9%* ↓
5	Agreed that immediate manager gives clear feedback on work.	65%	69%	4% ↑	5	Agreed that they are able to deliver the patient care they aspire to.	75%	67%	8%* ↓

*Values which are statistically significant

Issues for action:

- Communicate the strategic plan to staff continually through multiple channels.
- Show how the Trust is improving services for patients / service users in difficult times.
- Demonstrate how valued staff are in delivering the services and engage with them to develop good ideas for service development.
- Ask whether the issues raised in 2012 have been addressed.
- Recognise that staff away from the corporate centre are the least likely to know what's going on.
- Work with the staff side to identify common goals and actions where possible: strong evidence that working together builds confidence and loyalty.
- Recognise that confidence in staff treating the patient is linked to better outcomes for patients.
- Use the appraisal system as a means of communicating key messages to staff.

3.1.14 Equality & Diversity

In November 2011 the NHS Equality and Diversity Council launched the Equality Delivery System (EDS); a framework developed to assist NHS organisations to ensure they comply with equality legislation and embed equality matters across the National Health Service (NHS).

The EDS has proven to be most successful in organisations where they have made it work for them. Even so, the Equality and Diversity Council published a revised version of the EDS in November 2013.

The table below illustrates the progress this organisation has made against each of the EDS Goals

Goal*	Rating 2012	Rating 2013	Grading
1 Better health outcomes.	Developing	Developing	The majority of patients in up to five of the protected groups fare as well as people overall.
2 Improved patient access and experience.	Developing	Developing	The majority of patients in up to five of the protected groups fare as well as people overall.
3 A representative and support workforce.	Achieving	Achieving	The majority of staff in up to eight of the protected groups fare as well as people overall.
4 Inclusive leadership.	Developing	Developing	The majority of staff in up to eight of the protected groups fare as well as people overall.

*Revised using EDS 2 Goals – timescales for achieving goals is yearly

The assessment has involved gathering evidence such as reports, surveys and complaints, along with working with patients and service users to help us arrive at an initial assessment. For most outcomes the key question is: ***how well do people from protected groups fare compared with people overall?***

The outcome of our EDS assessment is used to inform the Trust's Equality Objectives which can be found at **http://195.217.160.2/index.asp?record=2049**

During 2013/14 the Trust has been working with Stonewall, a professional lobbying and campaign group whose aim is to prevent discrimination against and unfair treatment of lesbians, gay men since we undertook our baseline assessment. The assessment requires the Trust to evidence that different groups of people (e.g. people over the age of 35) have the same, or better, outcome/experience as those under the age of 35. The groups of the community and our staff we have to consider are: people of different ages; people who are married or in a civil partnership; people who may be pregnant; people with varying religions and beliefs; sexual orientation as well as Transgender individuals and those who have undergone a gender reassignment; people from different ethnic backgrounds; people who have a disability, men and women. These are referred to as "Protected Group".

and bisexuals. Through the Stonewall Health Champion's Programme the Trust has:

- Established an NHS Lesbian, Gay, Bisexual and Transgender (LGBT) Patient and Staff Network.
- Provided Equality Monitoring training to staff who have direct contact with the public.
- Improved the Trust's performance against the Stonewall Healthcare Equality Index. In 2013 we were ranked 29/32; in 2014 we were ranked 19/44.
- Produced a "Diversity and Inclusion – Team Members" Handbook.
- Instigated changes to some of the systems the Trust uses to monitor equality to include sexual orientation as an option.

3.2 Statements Provided by Clinical Commissioning Group (CCG); Healthwatch; Isle of Wight Council Health Overview & Scrutiny Committee and Patient's Council

Statement from Councillor Bob Blezzard; Chairman of the Isle of Wight Council's Health Scrutiny Sub Committee

As Chairman of the newly formed Health Scrutiny Sub Committee I welcome the opportunity of providing a response to the Isle of Wight NHS Trust's Quality Account for 2014.

The Trust has demonstrated its continuing primary focus on improving service delivery to the Island community over the past year.

At the time of writing this statement the Trust is ready to undergo an inspection by the Care Quality Commission. This will, if successful, assist the move to Foundation Trust status which is fully supported by the Council. The Council's Corporate Plan includes delivering person centred, co-ordinated social care and health services; working in partnership to improve outcomes and protecting the public. All these are reflected within the Trust's own aims within the Quality Account which shows how public bodies on the Island work together for the overall benefit of residents.

The Council's statutory health scrutiny function receives the full co-operation of the Trust. The Chief Executive, or one of the Executive Directors, attends formal meetings of the sub-committee and provides an update on key issues. In addition in the past year there were informal meetings with the chairman of the previous scrutiny panel which enabled more in depth discussion on a range of service delivery issues.

The importance placed upon the prevention of pressure ulcers is rightly a key priority because of the impact that these can have. It was noted in discussions with the Trust that one cause of the higher levels seen was due to improved reporting. This will hopefully however identify where actions should be directed.

The second priority, improving communication, and the third priority, reducing cancelled or re-arranged outpatient appointments, indicates how the Trust is taking on board the views of patients. Once a better understanding has been obtained of these two issues the Trust will be in a position to take positive action to address them.

The Sub Committee intends to have each priority area as a specific agenda item at its meetings during the course of the year. This will enable the Trust to report on the outcomes being achieved as the result of actions being taken.

Whilst accepting that the Quality Account follows the guidance contained in the toolkit produced by the Department of Health there is still a need to ensure that the style is in a form that can be readily understood by the public, patients and others with an interest in the Trust's services. The Sub Committee will undertake its scrutiny role with this in mind as it seeks to both hold the Trust to account and also act as a critical friend.

Councillor Bob Blezzard
Chairman of the Health Scrutiny Sub Committee
Isle of Wight Council
28 May 2014

Isle of Wight Clinical Commissioning Group (CCG) 'Statement in Response'

Isle of Wight Clinical Commissioning Group (CCG) welcomed the opportunity to participate in the governance 'sign-off' process and provide a statement in response to the presented Quality Account from Isle of Wight NHS Trust.

The Quality Account has been shared with representatives of the Clinical Commissioning Group; Clinical Executives, Heads of Commissioning, and CCG Clinical Leads for their comments.

It is felt that as a 'public facing' document, the 2014 Quality Account is easier to read than in previous years and is supported by a useful glossary of terms and acronyms. The CCG acknowledges that, as an integrated Trust, it is not always possible to establish priorities in all services.

The three priorities identified by the Trust going forward are considered to be appropriate however, it has to be noted that the CCG has expressed to the Trust, concerns about some aspects of quality in mental health and paediatric services. These concerns need to be prioritised by the Trust outside of the scope of this quality account.

The continued focus on patient safety and the reduction of pressure ulcers in hospital and community settings will be supported by both the locally agreed 2014/15 Communication CQUIN, which incentivises the Trust to raise public awareness of pressure ulcers and their prevention and the national safety thermometer CQUIN, which focuses on reducing the prevalence of pressure ulcers.

Improving communication will also be supported by the local Communication CQUIN and builds upon work in response to Francis recommendations; it is pleasing to see that the Trust recognises that positive patient experience is as important as good clinical outcomes. It is felt however, that an opportunity may be missed if communication with primary care is not also considered.

Throughout 2013/14 the CCG has expressed concerns about the implementation of the Friends and Family Test question and patient response rates, particularly in maternity services. As the question is rolled out to other service areas during 2014/15 it is hoped that, with a continued focus, the Trust can drive up response rates which in turn, will ensure more statistically significant rates of satisfaction.

For some time the CCG has also expressed concerns over the number of outpatient appointments cancelled by the hospital. This concern has been reflected as a quality indicator within the contract between the CCG and the Trust for the last two years. It is therefore reassuring to see this as a priority, as cancellations have the ability to impact on both patient experience and clinical outcomes.

The Provider has demonstrated quality improvement in the priorities it set out in last year's Quality Account. Where improvement has not been as significant as hoped, for example 'prevention and management of pressure ulcers', this work will continue.

Whilst it is noted that the level of participation in clinical audit has improved; only one national clinical audit was reviewed by the Trust in 2013/14; this is felt by the CCG to be a missed opportunity for wider learning, therefore welcomes the action the Trust will be taking to review more national clinical audits in the coming year.

It is disappointing to note the non-achievement of a small number of Commissioning for Quality Incentive Schemes (CQUINS); the CCG considers non-achievement as missed opportunities for the Trust to demonstrate quality

improvements, particularly in the use of technology and reducing unnecessary face to face contacts and improved electronic communication with GPs. It is hoped that, whilst these schemes have ceased, action is on-going in these areas.

The CCG acknowledges the support given to the Trust's workforce as reported in the Quality Account; the impact of this support may have been demonstrated through the results of the staff survey; the inclusion of a summary and actions to be taken in response is helpful, as it is well documented that staff satisfaction and quality of patient care is closely related.

Quality Account priorities, together with CQUINS and other quality outcomes in contracts, will continue to be monitored in detail by Commissioners, as part of the performance management of the Provider through monthly Clinical Quality Review Meetings and Contract Review Meetings.

Overall, Isle of Wight Clinical Commissioning Group would commend the Quality Report as a fair reflection of the Provider's positive achievement across the quality agenda and the high level of commitment and effort across a diverse organisation to constantly improve the quality of services provided.

Isle of Wight Clinical Commissioning Group

Statement from Healthwatch, Isle of Wight

The board of Healthwatch Isle of Wight notes the improvement in performance in some of the targets set in last year's quality account, but notes the work to improve communication has been carried forward to this coming year as there have not been many tangible outcomes in 2013/14. Healthwatch IW looks forward to working with the IW NHS Trust in this area in the next 12 months to look more broadly at communication issues arising for outpatients and those who have a sensory impairment. The Trust's engagement with My Life a Full Life is welcome and we look forward to seeing more joined up services for patients, meaning they have co-ordinated care and do not have to keep repeating their story.

It is good to see the incidence of pressure ulcers in some areas has improved and that the work around improving the incidence of pressure ulcers remains a priority. It is disappointing that it could be some time before lasting changes are seen to the amount and seriousness of pressure ulcers within the Trust. Inevitably, these issues will affect the most frail and vulnerable patients

Healthwatch Isle of Wight's Enter & View panel conducted 7 visits to 3 wards at St Marys Hospital in December 2013, these focussed on quality of care issues. We spoke to staff, patients and families and were largely re-assured by what we found. However, some recommendations were made, largely around improving communication with patients and their families. It was very positive to see the excellent practice on St Helen's ward which we recommended be shared throughout the hospital and which we know has been picked up on Colwell. The development of 'ward boards' should further support this sharing of good practice and ensure that whichever part of the hospital a patient visits, they get the same experience.

Healthwatch IW's maternity report has been well received by the NHS Trust and we look forward to seeing what actions will be taken demonstrating positive change for people using

those services. We remain committed to working with the Trust on these and issues in Paediatrics.

Last year, Healthwatch Isle of Wight commented on the readability of the NHS Trust Quality Account and its accessibility as a public document. We have made detailed suggestions on the content separately and some of these have been implemented. It is good to see the addition of a glossary of terms, but we feel more could have been done to make it user-friendly.

Dominic Crouch
Chair of the Board,
Healthwatch Isle of Wight

Statement by the Chairman of the Patient's Council

As can be imagined the Patient Council has had a busy year supporting the move to Foundation Trust and in the development of quality services for Island residents and visitors. Our role includes reviewing plans, participating in service improvement groups and monitoring services. This we undertake with presentations to the Council and visits to services. Our views and recommendations are made known directly to the Trust Board on which we are represented. We welcome the opportunity to comment on the Quality Account.

The Isle of Wight NHS Trust is to be commended on the improvements demonstrated in this Quality Account and we congratulate the Trust on the progress being made. We make specific comment as listed below:

- We welcome the setting of the three priorities – Prevention of Pressure Ulcers, Improving Communication and Reducing Cancelled or Re-arranged Outpatient Appointments.
- The development of a clear vision and set of values and behaviours is an important development for the Trust and all staff.
- Whilst the VTE target was not achieved in 2013/14 it is reassuring that in April 2014 the target was achieved and that this is being maintained.
- The introduction of the Trusts Integrated Services Information System (ISIS) is an important development which will support the delivery of many targets for 2014/15.
- The reduction in the mortality ratio for the Trust is important as a key indicator of care and as a measure to build confidence in staff and the organisation.
- Overall the document is easier to read and better than the 2012/13 Quality Account.

The Patient Council, consisting as it does of the 'customers of the service' is very aware of the fine services that the Trust delivers, but at the same time will not let complacency creep in. The Council will monitor and comment as appropriate upon the service that we receive. The Patient Council congratulates Isle of Wight NHS Trust on its many achievements during 2013/14 and, recognising the challenges ahead, looks forward to working with the Trust and wider NHS over the coming year.

Mike Carr
Chair, Patient Council

3.3 Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the above legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010(as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health Guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Date: 5 June 2014
Danny Fisher,
Chairman, Isle of Wight NHS Trust

Date: 5 June 2014
Karen Baker,
Chief Executive, Isle of Wight NHS Trust

3.4 Changes Made to the Final Version of the Quality Account

Chairman & CEO statement (3rd paragraph)	Wording changed to 'our patients, local population, stakeholders and commissioners…'
Chairman & CEO statement (successes) and 3.1.3 Improving Communication	Removed reference to concerns in successes and acknowledged importance of concerns as feedback from which to learn lessons in 3.1.3.
Chairman & CEO statement (Long term quality strategy and Goals)	Reference added to Non Executive Directors monthly assurance visits.
Chairman & CEO statement (Regulation)	Information added relating to initial inspection of Sevenacres and 3 standards not met.
Chairman & CEO statement (Regulation)	Reference to Clinical Commissioning Group CCG involvement in mock CQC inspection of maternity service.
Chairman & CEO statement (Regulation)	Commentary added relating to PLACE audit results.
Chairman & CEO statement (Regulation)	Reference to Healthwatch "inspection" changed to "visits".
2.1.2 Key Priorities for Action 2014/15	Text added "with assurance provided to the Quality & Clinical Performance Committee."
2.1.3 Prevention of Pressure Ulcers	Reference linking to national Safety Thermometer CQUIN 14/15 – pressure ulcer reduction and local communication CQUIN – pressure ulcer public awareness campaign.
2.1.4 Improving Communication	Reference linking to local communication CQUIN 14/15.
2.2.1 Review of services	Commentary added outlining how services are reviewed and monitored.
2.2.2 Participation in Clinical Audits	Reference added to future plan; lessons learnt and actions taken in line with recommendation.
2.2.2 Participation in Clinical Audits – Clinical Audit Prize	"FY2" definition added to and explained in glossary.
2.2.6 Data Quality (Clinical coding error rate)	Reference to benchmarking data not available. Commentary added regarding actions to improve performance.
3.1.1. Reducing Mortality Rates	"Re-based" definition added to and explained in glossary.
3.1.2 Prevention of Pressure Ulcers	Revision of KPIs to include grade 2 pressure ulcers.
3.1.6 Healthcare Associated Infections (HCAI)	Additional text added relating to MSSA and E.Coli cases and legend in C.Difficile graph updated.
3.1.7 Complaints; Concerns & Compliments	Different examples of complaints; root causes & actions added, more reflective of services with highest numbers of complaints for each directorate and reference added to Annual Complaints Report.
3.1.7 Complaints; Concerns & Compliments	Date in 2nd paragraph changed from 2013/14 to 2012/13.
3.1.8 Patient Feedback (including Friends & Family Test – FFT)	Response rates; score and actions added.
3.1.8 Patient Feedback (including Friends & Family Test – FFT)	Reference to sharing f information between the Trust and Healthwatch added.
3.1.13 Workforce	Added key findings from staff survey and actions planned in response.
3.1.14 Equality & Diversity	Timescale for achievement of goals in the table added as Yearly.

3.5 How to Provide Feedback on the Account

This important document sets out how we continue to improve the quality of the services we provide.

Your Views on Quality

We welcome your views and suggestions on our Quality Priorities for 2014/15 set out in Part 2 of this Quality Account. We also welcome feedback at any time on our Quality Account. This can be sent to the Quality Team Isle of Wight NHS Trust, St. Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG or emailed to **quality@iow.nhs.uk**.

You can read more about the national requirements for Quality Accounts on the NHS Choices or Department of Health websites. You can download a copy of this Quality Account from **www.iow.nhs.uk** (Publications section) or **www.nhs.uk**.

APPENDIX 1

Stakeholders engaged in the development of the Quality Account

The following list outlines individuals / organisations that were invited to provide feedback and / or contributed to the development of this Quality Account.

Staff Members
Message in Members Magazine
Trust Board
Isle of Wight Youth Trust
Members of the Quality & Clinical Performance Committee
Clinical Commissioning Group (CCG)
The Safety; Experience & Clinical Effectiveness Triumvirate
Healthwatch Isle of Wight
Patients Council
Isle of Wight Health Overview & Scrutiny Committee
Members of the Public
Echotech Ltd
Local MP
GPs, GP Practice Managers and GP Practice Staff
Chamber of Commerce
Children's Trust
Cardiovascular Disease Network
Friends of St. Mary's
Hampshire Partnership Trust
Hampshire Police
Hampton Trust
Isle of Wight Dental Committee
Isle of Wight Anglican Churches c/o Portsmouth Diocese
Action on Hearing Loss (formerly RNID) Isle of Wight
Rural Community Council
Salisbury NHS Trust
Scio Healthcare
Island Business Magazine Editor
Town and Parish Councils
Isle of Wight Council
Local Dental Committee
Local Medical Committee
Local Pharmaceutical Committee
Practice Based Commissioning (PBC) Consortium
Professional Executive Committee
Portsmouth Hospitals NHS Trust
Riverside Centre

APPENDIX 2

List of national clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in during 2013/14

	Audit	Participation	% cases submitted
1	Adult Critical Care: Case Mix Programme (CMP)	**Yes**	All cases – ongoing
2	Emergency use of oxygen	**Yes**	100%
3	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death • Tracheostomy Care • Subarachnoid Haemorrhage* • Alcohol related liver disease	 **Yes** **Yes** **Yes**	 100% 0% 100%
4	National audit of seizures in hospitals (NASH)	**Yes**	100%
5	National emergency laparotomy audit	**Yes**	0% – data collection still ongoing
6	National joint registry	**Yes**	All cases – ongoing
7	Paracetamol overdose (care provided in emergency departments)	**Yes**	100%
8	Severe sepsis and septic shock	**Yes**	100%
9	Severe trauma (trauma audit and research network TARN)	**Yes**	53.9%
10	National comparative audit of blood transfusion programme: Audit of the use of Anti-D	**Yes**	150 cases
11	Bowel cancer (NBOCAP)	**Yes**	All cases – ongoing
12	Head and neck oncology (DAHNO)	**Yes**	All cases – ongoing
13	Lung cancer (NLCA)	**Yes**	All cases – ongoing
14	Oesophago-gastric cancer (NAOGC)	**Yes**	All cases – ongoing
15	Acute coronary syndrome or Acute myocardial infarction (MINAP)	**Yes**	All cases – ongoing
16	Cardiac rhythm management (CRM)	**Yes**	75 cases
17	National cardiac arrest audit (NCAA)	**Yes**	122 cases
18	National heart failure audit	**Yes**	All cases – ongoing
19	Diabetes (adult) ND(A) includes national diabetes inpatient audit (NADIA)	**Yes**	100%
20	Diabetes (Paediatrics) (NPDA)	**Yes**	107 cases
21	Inflammatory bowel disease (IBD)	**Yes**	3 cases submitted
22	National chronic obstructive pulmonary disease (COPD) audit programme	**Yes**	Data not available – audit still open
23	Paediatric bronchiectasis (British Thoracic Society)***	**No**	
24	Renal replacement therapy (Renal Registry)**	**Yes**	Submission rate not available
25	Rheumatoid and early inflammatory arthritis	**Yes**	0% – at time of reporting – audit still ongoing
26	Mental health clinical outcome review programme: National confidential inquiry into suicide and homicide for people with mental illness (NCISH)	**Yes**	100%
27	National audit of schizophrenia (NAS)	**Yes**	94%
28	Prescribing observatory for mental health (POMH)	**Yes**	100%
29	Falls and fragility fractures audit programme (FFFAP) – National hip fracture database	**Yes**	100%
30	Sentinel stroke national audit programme (SSNAP)	**Yes**	All cases – ongoing
31	Elective surgery (National PROMS programme)	**Yes**	HES episodes not available
32	Child health clinical outcome review programme (CHR-UK)	**No**	No eligible cases
33	Epilepsy 12 audit (childhood epilepsy)	**Yes**	5 cases
34	Maternal, Newborn and infant clinical outcome review programme (MBRRACE)	**Yes**	100%
35	Moderate or severe asthma in children (care provided in emergency departments)	**Yes**	36%
36	Neonatal intensive and special care (NNAP)	**Yes**	All cases – ongoing
37	Paediatric asthma (British Thoracic Society)***	**No**	
38	Care of the dying in hospital	**Yes**	100%

* Isle of Wight NHS Trust were eligible to be included in the NCEPOD study into Subarachnoid Haemorrhage but had no eligible cases during the study period.

** Isle of Wight Patients are included in the Renal Replacement Therapy Audit, data for this audit is submitted by Portsmouth Hospital NHS Trust and therefore submission rates are not available.

*** The Paediatric Team were unable to participate in the British Thoracic Society Audits, due to a lack of junior medical staff in the team.

APPENDIX 3

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF ISLE OF WIGHT NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of Isle of Wight NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Friends & Family Test – patient element score, (page 34); and
- Percentage of admissions to acute wards gatekept by the Crisis Resolution Home Treatment Team (CHRT), (page 32).

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to June 2014;

- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;

- feedback from the Commissioners dated 23/05/2014;

- feedback from Local Healthwatch dated 05/06/2014;

- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 26/06/2013;

- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;

- the latest national patient survey dated 08/04/2014;

- the latest national staff survey dated 25/02/2014;

- the Head of Internal Audit's annual opinion over the Trust's control environment dated 28/05/2014;

- the annual governance statement dated 05/06/2014;

- the results of the Payment by Results coding review dated 31/01/2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, 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. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Isle of Wight NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Isle of Wight NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Ernst & Young LLP
Reading
6 June 2014

APPENDIX 4

GLOSSARY

ACB	**AMBER Care Bundle** A process of assessment and care management for patients whose recovery is uncertain but who continue to receive treatment – linked to End of Life Care.
Accreditation	A process in which certification of competency, authority, or credibility is presented.
Allied Health Professionals	Health care professions distinct from nursing, medicine, and pharmacy – they provide a range of diagnostic, technical, therapeutic and direct patient care and support services.
Antenatal	Occurring before birth.
CCG	**Clinical Commissioning Group** A clinically led group that includes all of the GP groups in the geographical area. (An NHS organisation set up by the Health & Social Care Act 2012 to organise the delivery of NHS services in England).
C.Difficile	**Clostridium difficile** A type of bacterial infection that can affect the digestive system. Most commonly affects people who have been treated with antibiotics.
Clinician	A health professional, such as a Physician, Psychiatrist, Psychologist, or Nurse, involved in clinical practice.
Cognitive Impairment	A condition involving problems with cognitive function (mental abilities such as thinking, knowing and remembering).
Competencies	Provide a structured guide enabling the identification, evaluation and development of the behaviours in individual employees.
COPD	**Chronic obstructive pulmonary disease** The name for a collection of lung diseases, including chronic bronchitis, emphysema and chronic obstructive airways disease.
CQC	**Care Quality Commission** The independent regulator of all health and social care services in England.
CQUIN	**Commissioning for Quality and Innovation** A scheme within a framework that enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
DATIX	A patient safety and risk management software application that enables users to spot trends as incidents/adverse events occur and reduce future harm.
EDS	**Equality Delivery System** A framework developed to assist NHS organisations to ensure they comply with equality legislation and embed equality matters across the National Health Service (NHS).
FFT	**Friends & Family Test** Aims to provide a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience.
FY2	**Foundation Year 2** (FY1 or FY2) is a grade of medical practitioner undertaking the Foundation Programme – a 2-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.
HCAI	**Healthcare Associated Infections** Infections that are acquired as a result of healthcare interventions.
Healthcare Assistants	Work in hospital or community settings under the guidance of a qualified healthcare professional. Most commonly, they work alongside nurses and are sometimes known as nursing auxiliaries or auxiliary nurses.
HSMR	**Hospital Standardised Mortality Ratio** The HSMR is a calculation used to monitor death rates in a trust.
ISIS	**Integrated Services Information System (ISIS)** A shared electronic patient record for clinicians and managers.
KPMG	Provider of professional services including audit, tax and advisory.
LD SAF	**Learning Disabilities Self Assessment Framework** A tool to capture data, bringing together many of the standards for learning disability service. It enables commissioners, providers and other stakeholders to have a good understanding of the strengths and weakness of the health and social care services provided for people with learning disabilities.
LGBT	**Lesbian, Gay, Bisexual and Transgender (LGBT)** Intended to emphasise a diversity of sexuality and gender identity-based cultures.

Medical Outlier	A patient admitted to a ward different from the Internal Medicine ward.
MHAS	**Mental Health Assessment Service** An emergency mental health assessment service that will refer to the agency or service that best meets patient needs and will liaise with healthcare providers about a patients care and assessment.
MRSA	**Methicillin Resistant Staphylococcus Aureus** A type of bacterial infection that is resistant to a number of widely used antibiotics – can be more difficult to treat than other bacterial infections.
Never Event	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS Constitution	Establishes the principles and values of the NHS in England.
NMC	**Nursing & Midwifery Council** The nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands.
NHS Safety Thermometer	A local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
OHPIT	**Outpatient and Home Parenteral Infusion Therapy** Provides care to outpatients with conditions which require long-term therapy with medications administered intravenously, or through a needle or tube inserted into a vein.
PALS	**Patient Advice & Liaison Service** Offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
Personal Development Plan	A formal means by which an individual sets out the goals, strategies and outcomes of learning and training.
PREM	**Patient Reported Experience Measure** A tool developed to measure the experience of paediatric patients 0–16 years in all urgent and emergency care settings.
Psychological interventions	Methods used to facilitate change in an individual. Specifically they are activities used to modify an individual or group's behaviour, emotional state or feelings.
PTS	**Patient Transport Service** Provides non emergency transport to and from hospital for patients.
PU	**Pressure Ulcer** A type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure (sometimes known as "bedsores" or "pressure sores").
PVAD	**Peripheral Venous Access Device** Used to access a patient's circulation for the purpose of giving intravenous fluids or drugs.
Re-based figure	**Mortality re-based figure** Trust's figure re-aligned against the national figure (i.e. the standard).
SHMI	**The Summary Hospital-level Mortality Indicator** An indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology.
SIRIs	**Serious Incidents Requiring Investigation** An incident that occurred in relation to NHS-funded services and care resulting in unexpected or avoidable death; serious harm; prevents ability to deliver services; abuse; adverse media coverage; never event.
TDA	**Trust Development Authority** Provide support, oversight and governance for all NHS Trusts.
Tele-health	The delivery of health-related services and information via telecommunications technologies.
Term Babies	Babies born following the full 40 weeks of pregnancy.
VTE	**Venous thromboembolism** A condition that includes both deep vein thrombosis (DVT) and pulmonary embolism (PE). DVT is the formation of a blood clot in a deep vein— usually in the leg or pelvic veins. The most serious complication of a DVT is that the clot could dislodge and travel to the lungs, becoming aPE.

Get in touch

Get involved with your NHS

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.

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